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Nurses: The First and Last Line of Defence for Not Only Patients But Physicians as Well

On June 1, 2012, several London newspapers, including the *Independent* and the *Guardian,* reported the findings of the British National Confidential Enquiry Into Patient Outcomes and Death (NCEPOD) concerning the deaths of acutely ill patients who had a cardiac arrest while in hospital. The *Independent* focused on that part of the report dealing with the general assessment of warning signs prior to cardiac arrest, the *Guardian* on that part dealing with the appropriateness of resuscitation.

The *Independent* (Edgar, 2012) reported that the inquiry found that more than 38% of the cardiac arrests could have been avoided if the junior physicians had assessed the situation and responded in a timely manner, that warning signs were not picked up in 35% of the patients, that these were not acted upon in 56%, and that junior doctors had not communicated with senior doctors in 55%. According to the *Independent*, the inquiry laid the blame on lack of skill among junior doctors and lack of communication between junior and senior doctors.

The *Guardian* (Boseley, 2012), in contrast, focused on the finding that, of the acutely ill patients who had a cardiac arrest — many of whom were nearing the end of their lives — less than a third (29%) did not receive "good" care and were subjected to what the inquiry considered "futile resuscitation attempts that prevent them dying with dignity." In nearly half of the 526 cases investigated, the patient's condition had not been properly assessed on admission to hospital. One in four patients were expected to die shortly, and of these only 44% had end-of-life directives written in their charts. The *Guardian* reported that the inquiry laid the blame on senior doctors, who should have the "expertise and experience and the ability to communicate effectively and with compassion to make these tough decisions."

In reading these two newspaper accounts, I was struck by the glaring omission of nursing's part in patient care and the role that nurses have traditionally played in the education of junior doctors. I was also struck by the focus on the junior physician–senior physician partnership, with no attention given to other partnership models, such as nurse-physician, that might make the system more responsive to the needs of patients. Let me explain.

In the United States and Canada (and, I suspect, in Great Britain and elsewhere), nurses have been the unsung teachers of interns and residents. In their book *Clinical Wisdom and Interventions in Acute and Critical Care,* Patricia Benner and colleagues describe many cases of nurses pointing out to junior physicians the warning signs of deterioration, correcting their misinterpretations of signs and symptoms, suggesting diagnoses, and anticipating when and how to intervene (Benner, Hooper-Kyriakidis, & Stannard, 2011).

In speaking with experienced physicians, one often finds that they will recount some "near misses" from their internship or residency days. They will recall their failure to recognize the early warning signs of a patient "turning sour" and those almost failure-to-rescue patients — "almost" because of the competence of a knowledgeable, experienced nurse who protected them as young doctors and, more importantly, protected and safeguarded the patient. Many seasoned physicians still have a profound sense of gratitude for these nurses and may even, dare I say it, be in awe of those who "saved" them in the early years of their career when there was no time to consult with a senior physician. They depended on these expert nurses, who knew the patient and were attuned to subtle changes in his or her condition before they became fully manifest. Yet nurses have never been recognized or given credit for their role as educators of physicians in training.

Who are these nurses who serve as the first and last line of defence for both patients and physicians? They are nurses who possess a depth of theoretical and practical knowledge, acquired in the classroom and utilized, developed, integrated, and honed in care settings. Theoretical knowledge gives nurses the flexibility to understand and interpret observations, whereas practical knowledge enables nurses to "situate" that knowledge and use it in ways that are responsive to the particular patient. Theoretical knowledge *ensures* that patients and families get the best care possible. We now have a body of research that attests to the complexity of nursing care and the years of practice it takes to amass the knowledge and skills needed to achieve a high level of expertise. Those in nursing and many other professions know that knowledgeable nurses protect the system in countless ways, not least by ensuring that physicians have the most up-to-date and salient information about their patients on which to make medical judgements and take appropriate action. Unbelievable as it may seem considering all the evidence, we still hear from certain quarters, in nursing as well as in medicine, that nurses do not need the benefits of basic or advanced university education. It may be that some physicians have not had the privilege of working alongside well-educated nurses who have undergone this level of preparation and training.

We all have something to learn from the report of the NCEPOD inquiry. If the British health-care system lacks a sufficient number of university-trained nurses, it might consider investing in additional educational opportunities for nurses. If it has a sufficient number of university-educated nurses, it might consider how better to use them so that they are given the opportunity to use their training to the fullest capacity and to use all of their competencies.

Another characteristic of these invaluable frontline nurses is their years of experience in the workplace. They are professional nurses who value ongoing learning and evidence-based care and who are keenly aware of the need to spend time getting to know patients and families. They are reflective practitioners — they think rather than depend on routinized, prescriptive care.

They work in institutions and agencies whose senior administrators and nurse leaders give priority to investing in and retaining their nurses. Two decades of research has exposed the deleterious and tragic effects of devaluing and undermining nurses and nursing. The cost has been high in terms of nurse burnout and patient morbidity and mortality (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Research has also revealed the conditions needed to retain professional nurses (e.g., Kramer, Schmalenberg, & Maguire, 2010). Nurses who are rewarded, recognized, and respected for their expertise are those most likely to commit to a career in nursing. Moreover, when nurses are given status, resources, control over their own practice, opportunities to function autonomously within their scope of practice, and the ability to use their knowledge and skills to the fullest, they choose to stay and are satisfied with their workplace. Most intriguing in this body of research: One of the best and most consistent predictors of nurse satisfaction and good personal health (i.e., low burnout) is positive professional relationships with physicians (Laschinger, Shamian, & Thomson, 2001; Needleman, Buerhaus, Pankratz, Leibson, & Stevens, 2011; O'Brien-Pallas, Tomblin Murphy, Shamian, Li, & Hayes, 2010; Schmalenberg et al., 2005). Physicians also benefit from such relationships. Most important of all, when physicians partner with nurses and there is clear communication within the partnership, patients' voices are heard and their needs are met.

These are some of the invaluable lessons learned from the past two decades of research. Our British colleagues would do well to heed these lessons. They need to rethink recommendations that are based on a narrow focus such as the junior physician-senior physician relationship and consider the value of interprofessional partnerships, particularly between nurses and physicians. They need to consider strengthening their frontline staff — those nurses who are with the patient 24/7 and are readily available to intervene if and when necessary. However, such a transformation can be realized only when nurses are educated, are allowed to practise to the full extent of their training, and are given recognition for their unique contribution to patient care — complementary to that of their medical colleagues (Institute of Medicine, 2012). And it can be realized only when nurses are accorded the status, respect, and power accorded to any professional — that is, when they have the preparation and experience necessary to care for patients and families with dignity and respect, promoting their health, facilitating their healing, and ensuring their safety.

Let us in Canada and elsewhere also learn from the lessons of those recent decades when nursing was devalued and even dismantled. The effects were profound and will reverberate for years to come, until we have rebuilt a profession of frontline nurses who are well educated, knowledgeable, skilled, compassionate, and committed to nursing as a career. We need to dedicate our efforts to valuing nurses and nursing worldwide, if we are to learn from the past and build a safe and responsive health-care system. Nurses will truly have the power to transform patient care and the health-care system when they become full partners with physicians.

Laurie N. Gottlieb
Editor-in-Chief

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Guest Editorial

Moving Towards *Nahi*: Addressing Health Equity in Research Involving Indigenous People

Annette J. Browne
Guest Editor

Madeleine Dion Stout
Consulting Editor

In 2005 *CJNR* published its first special issue on the health of First Nations, Inuit, and Métis: the Indigenous people of Canada. Articles from that issue of the Journal have been the most frequently downloaded, reflecting the intense interest in this topic nationally and internationally. Seven years later, the Call for Papers for the 2012 focus issue on Indigenous People's Health and Health-Care Equity elicited an extraordinary number of manuscripts from across Canada and internationally. At this juncture in history, it is important for us to reflect on the contexts and conditions that give rise to growing expressions of interest in this topic from within nursing and other health-related disciplines.

May 17, 2012, marked the fifth anniversary of the adoption of the United Nations Declaration on the Rights of Indigenous Peoples. Concomitantly, the 11th Session of the United Nations Permanent Forum on Indigenous Issues, held at UN headquarters in New York City, selected as its Special Theme "The Doctrine of Discovery: Its Enduring Impact on Indigenous Peoples and the Right to Redress for Past Conquests" (http://social.un.org/index/IndigenousPeoples.aspx). The idea of focusing on the influences of the doctrine of discovery on the health of Indigenous people provides a salient backdrop for this 2012 focus issue of the Journal. The articles published herein highlight the extent to which nursing and other health disciplines are shaping the landscape of health research and, in the process, advancing our understanding of the doctrine of discovery, its enduring impact, and strategies for moving forward in partnership with Indigenous people. In publishing this focus issue, *CJNR* is positioning itself as a major contributor to high-quality, respectful health research driven by Indigenous people.

The year 2012 also marks an era of greater recognition of persisting and deepening health and social inequities in Canada and around the world. In Canada, increasing homelessness, social exclusion of people living with mental health or substance-use issues, various forms of violence against women, and systemic discrimination against Aboriginal people and new immigrants are instances of social and structural inequities that can be addressed through praxis-oriented health research.

As Madeleine Dion Stout writes in her Discourse contribution in this issue, for research "to be transformative for Indigenous people, the paradigm shift must focus on interventions that draw on *nahi,* fairness, rather than *tipi,* equal. For *nahi* to be realized, the focus has to be on explicit values and inequities — variations in health status that become unfair." The concept of equity is not synonymous with equality or sameness. Health equity is defined as the absence of systematic and remediable differences in one or more characteristics of health across populations or population groups defined socially, economically, demographically, or geographically (World Health Organization, 2008). Health inequity refers to differences in health or access to care that result from structural arrangements that are remediable, and therefore unjust. The concept of structural violence is increasingly seen within public and population health as a major determinant of the distribution and outcome of health inequities, and is defined as "a host of offensives against human dignity, including extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence" (Farmer, 2003, p. 8). Inequities are structural because they are embedded in the political and economic organizations of our social world, and they are violent because they cause injury to people and negatively impact on quality of life and well-being. As discussed in the articles in this issue of the Journal, inequities are also sites of resistance and action, particularly when linked to policy shifts, structural changes, and innovative approaches to working in partnership.

In their Discourse contribution, David Gregory and Jean Harrowing discuss the sweeping cuts to Aboriginal health organizations now occurring in Canada that will have serious implications for communities and the kinds of sustained research partnerships that are necessary to address health priorities at the local and population levels. These cuts will leave large holes to fill, and are part and parcel of the neoliberal political ideologies that are accelerating health and social inequities in Canada and globally.

Where does this leave the role of health research and health researchers? Research will be an even more powerful tool for transformation in the future, if it is initiated primarily by researchers and Indigenous people working in partnership. What will health research look like in the future? Benchmarks of progress will be research that reflects the epistemologies and ontologies of Indigenous people; research that integrates living Indigenous languages, community perspectives, ideas, and interests; and research that generates critical analyses that move beyond superficial understandings of the significance of culture. The articles included in this issue of *CJNR* chart the direction for the future.

As these articles indicate, nursing and health research that is conducted in partnership with Indigenous people, regardless of the specific focus, must include the following approaches: critical analyses of the root causes of health, social, and health-care inequities; generation of knowledge to mitigate health and health-care inequities; integration of Indigenous epistemologies and decolonizing perspectives; and decolonizing approaches to policy development. The research approaches and analyses discussed in the articles in this issue reflect a broad relational view that draws attention to the interconnections among the determinants of health, community well-being, and quality of life.

The next 7 years will have to be approached with caution, however. Research is increasingly under pressure to be driven by and responsive to the needs of governments and industry — a slippery slope that is already in evidence, aggravated by the imminent closure of community-minded research agencies like the Centres of Excellence for Women's Health and the unmitigated and steady erosion of internationally renowned research entities such as Statistics Canada. Research is also trending towards "passive privatization," which has significant implications. The partnerships that are so essential to research face the enterprise risk of commodifying and vandalizing the cultures of Indigenous peoples. These misappropriations of culture transfix Indigenous people in their communities and nations, maintaining the cultural boundaries that separate them from the larger society. Culture is no longer considered inert, pliant, and dated; rather, it is perceived to be the most modern, creative, and alive force for improving the health of Indigenous people — a position that governments and industry have spurred, and that has spilled into a receptive cost-saving policy context. Given the increasing adoption of culture as the panacea for improving their health, Indigenous people run the risk of being reduced to cultural beings for whom health interventions need not be more than one-dimensional.

It is against the landscape of these realities that the articles in this issue of the Journal provide a *cri de coeur* for moving towards *nahi:* equity in relation to health, social conditions, and health care. Transformational change is exponential — as signalled by these articles — and the contributions of nursing and health researchers will be part and parcel of the transformations.

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Annette J. Browne, RN, PhD, is Professor and Associate Director of Graduate Programs, School of Nursing, University of British Columbia, Vancouver, Canada. Madeleine Dion Stout, RN, BN, MA, LLD, is Honorary Professor, School of Nursing, University of British Columbia.

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Discourse

Ascribed Health and Wellness, *Atikowisi miýw-āyāwin,* to Achieved Health and Wellness, *Kaskitamasowin miýw-āyāwin*: Shifting the Paradigm

Madeleine Dion Stout

Worldwide recessionary economies, "close the gap" adjustments, and community socio-economic and political aspirations are shifting ascribed health and wellness, *atikowisi miýw-āyāwin,* to achieved health and wellness, *kaskitamasowin miýw-āyāwin,* for Indigenous people. The former paradigm has entrenched colonial patterns of domination by and dependency on governments and deference to divine providence. The latter is poised to fully exploit the human agency and traditions of Indigenous people, who, on the whole, have been rendered complacent, fatalistic, and unwell by past injustices. Putting forward an emerging vision for a paradigm shift has fallen on this fertile ground.

Much of the thinking, *māmitonēýihcikēwin,* on the devastating health and social consequences of colonization for Indigenous people has assumed relative homogeneity in the construction and interpretation of this human experience. Little differentiation has been acknowledged on the basis of Indigenous languages such as Cree, *nēhiýiwēwin,* despite the salience of this variable in deepening our understanding of risk factors like enslavement, *awahkānowih,* unhealthy policies and practices, and ensuing imprisonment in pain-wracked minds, bodies, and spirits, *kakwātakitā*. Scant acknowledgement is given to whether and how the responses, *naskomowēnā,* and the human reserves, *sōhkātisiwinā,* of Indigenous people with lived experience might inform new thinking about ancient ideas while drawing on new interventions from old actions.

Shifting from *atikowisi miýw-āyāwin* to *kaskitamasowin miýw-āyāwin* presents other challenges, because while there is ample evidence describing health and health-care inequities internationally, the evidence on ways to reduce those inequities is very limited. In addition, the evidence shows that different populations respond very differently to identical interventions. To be transformative for Indigenous people, the paradigm shift must focus on interventions that draw on *nahi,* fairness, rather than *tipi,* equal. For *nahi* to be realized, the focus has to be on explicit values and inequities — variations in health status that become unfair.

On the one hand, transitioning from *atikowisi miýw-āyāwin* to *kaskitamasowin miýw-āyāwin* will curb expenditures that have not improved the health of Indigenous people. On the other hand, this shift can inadvertently cause a risk pile-up of *kitimakisona,* poverties and pathologies resulting from unmet human needs. However, it is important to acknowledge that framing poverty as merely economic deprivation has proved too narrow, because it factors away the social suffering and inequities associated with *kitimakisona.* Poverties of all kinds have stolen productive capacity and independence from many Indigenous people, leaving them confused, traumatized, and in poor health.

The root causes of the health, social, and health-care inequities experienced by Indigenous people lie in colonization, *mipahi kayás,* an extremely toxic and deadly past that has insidiously disconnected and dislocated individuals, families, and communities. Moreover, *kayás óma ka nóhcikweyā,* the interminable and blunt assault inflicting historic trauma on a massive scale, has become tattooed on Indigenous people. Reserves known as *iskonkana,* leftover plots, or *tipahaskāna,* measured lots, have relegated generations of Indigenous people to the margins of maldevelopment. Residential schools, *kiskinwahamátowikamokwa* — teaching and learning structures — created unnatural, contrived environments that damaged Indigenous cultures, languages, traditions, and heritage. *Māýi-mācihowin,* the bad, ugly, nasty, evil, wicked state of physical, mental, emotional, and spiritual unwellness, is the net effect of these historical patterns on Indigenous people in many communities.

Wholehearted commitment to and personal involvement in constructing solutions has begun the paradigmatic shift, but the process has been burdened by the pain of being strangled by grief and loss, *tāpiscōc kipihkitonēhpitikoweya.* The pain is eased by spiritual assistance, counselling, or the offering of appropriate gifts to a drum song or ceremony, *tipahikēwin,* since traditional practices are perceived by Indigenous people as bestowing a spiritual advantage and a competitive edge socially and politically. When traditional ceremonies facilitate a catharsis of emotions and enhance the ability of individuals to cope with cumulative trauma, then *mōcopiyōwin* — crazed state due to overwhelming experiences and circumstances and corresponding power imbalances — is held in abeyance. Meanwhile, *kitimahitowin,* lateral violence, has Indigenous people at war against themselves where the weaponry is *pāstāhowin,* transgression of taboos.

At the same time, efforts are being made to advance the shift from ascribed health and wellness, *atikowisi miýw-āyāwin,* to achieved health and wellness, *kaskitamasowin miýw-āyāwin.* Adopting traditional perspectives, correcting power imbalances, and riding new waves such as health, social, and health-care equity are increasingly becoming part of the consciousness and health actions of Indigenous people. Because the totality of environments has superseded the entirety of "self," control over health and health care has been lost, unleashing intense emotions like *pakosēýimowin,* a yearning for a better quality of life and happier times. The end point of *wāskāmsiwin,* recovery — to "come to," to become altered, to pass gradually into the present, to pass from one phase to another — is where health, social, and health-care *nahi* equity is located.

Holistic and traditional interventions that call for personal involvement in and commitment to transformative change find expression in modern living contexts. Diabetes s*ēwankānāspinēwin,* the inability to process the sweetness of life, has to be addressed by applying the very principles that are celebrated with feasts: *pimēýimowin,* thinking well of self; *mamāhtāwisiwin,* personal power; and *wāpātikosowin,* manifest, sensorial evidence. People with diabetes do justice to *nahi* equity when, in keeping with cultural and spiritual teachings, they resolve to reverse their illness in order to live longer, happier lives.

The old paradigm of ascribed wellness, *atikowisi miýw-āyāwin,* where health and wellness are granted by outside sources, has to be replaced by the new paradigm, *kaskitamasowin miýw-āyāwin,* achieved wellness where health and wellness are earned through individual autonomy, collective interests, and creative genius. However, this shift has to accrue to the rightful faces, places, and spaces. *Mihkwakākan,* face, unmasks visages of carriers who have the power to create space, a lot of room, *misi-tawow,* in every place, *misiwē,* so that health, social, and health-care equity is realized by Indigenous people even in a complex, hierarchical, and socially and economically fractured health system. Based on soft logic and hard evidence, *kisēwātisowin* — affection; possessing a great, merciful, kind, and gentle disposition — co-exists with *itamahcihowin* — feeling healthy. Indigenous people with inordinately high rates of illness, sickness and disease, and social and mental problems do not have these basic needs met, yet people are increasingly expected to take matters into their own hands.

While Indigenous people are throwing off the shackles of colonization existentially and literally, through *nimihitowin* — dancing, moving rhythmically — the underlying inequitable structures have to be addressed to avert *poni-waskawewin* — death, stoppage of movement. Therefore, structural violence has to be isolated and treated as a health, social, and health-care determinant, to be corroborated and calibrated first by Indigenous people. Clear destinations from ascribed wellness, *atikowisi miýw-āyāwin,* towards *kaskitamasowin miýw-āyāwin* have to be established, along with coordinated efforts and pooled resources. This journey has to consider as essential *āniskētastāwin* — attachment; all things are connected — and *wāhkōhtowin* — kinship; everyone is related. Creativity, *ōsihickēwin,* will build on the pragmatism and traditions of individuals and families who are personally involved in and responsible for their own health, social well-being, and health care. Advancing the innate ability to channel distant memory, *ochcikiskisiwin,* with its original instructions will translate knowledge to action.

The old paradigm *atikowisi miýw-āyāwin* will have to give way to the new one, *kaskitamasowin miýw-āyāwin,* since the latter is more humane for Indigenous people. However, until *miýo-paýowin* — good turns from changing fortunes — takes hold and becomes their common fate, Indigenous people will be fearful and ambivalent about the virtual shocks and constant changes being brought about by the shifting paradigm. The sacred objects that sometimes get sold through the twinning of opposites, such as ascribed and achieved health and wellness, is the balance of payment that Indigenous people will have to make unless assisted health and wellness, *nātamakéwin miýw-āyāwin,* is added to the shifting paradigm. Negotiating both sides of the middle initially will maximize the will and ability of Indigenous people to struggle towards health, social, and health-care equity.

Madeleine Dion Stout, RN, BN, MA, LLD, is Honorary Professor, School of Nursing, University of British Columbia, Vancouver, Canada.

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Discourse

Indigenous People's Health and Health-Care Equity: Seven Years Later

David Gregory, Jean Harrowing

Seven years ago, when *CJNR* devoted an issue to Aboriginal Health Research (Gregory, 2005), the future was full of promise. The potential of nursing research and its role in effecting policies, health services, and equity was revealed in the power (as well as the limitations) of postcolonial theoretical perspectives. Fundamental to the quest for health equity are bona fide research partnerships with Aboriginal people, communities, non-governmental organizations, and the political bodies of the First Nations, Inuit, and Métis.

In this issue of *CJNR,* we speak to the challenges of nursing research with, for, and by Aboriginal peoples that have emerged since the publication of that 2005 focus issue. The root causes of health, social, and health-care inequities can be remedied only with the full participation of Aboriginal people as researchers, partners, and leaders in the research enterprise and as advocates for change. Such participation encompasses the development of capacity for policy reform, interprofessional education, and the discovery, synthesis, and application of knowledge.

Recent news headlines speak to the crisis at hand. The federal budget presented in April 2012 has resulted in drastic and systematic funding cuts to Aboriginal organizations, which in turn affect their ability to enact social and health-care change. The shutting down of the National Aboriginal Health Organization (NAHO) is explained and justified as a consequence of Aboriginal governance issues (infighting over resources and political mandates at cross-purposes). But is eliminating NAHO the best approach to solving a resource-distribution problem? Are there not alternatives to seemingly disparate political mandates? The impact of losing this not-for-profit organization will be immediate and far-reaching for all concerned. During the past 12 years, NAHO "has completed over 200 health reports, guides and fact sheets; video footage and audio tapes of Aboriginal Elders' Indigenous knowledge; completed the only publicly available databases on Métis health; issued 12 volumes of the *Journal of Aboriginal Health*; and holds thousands of copies of research files" (Federal budget cuts Aboriginal health programs, 2012). NAHO's mandate was to advance the health and well-being of First Nations, Métis, and Inuit people in Canada. Annihilation of its voice sparks an ominous trend.

With respect to health equity, federal funding cuts can further marginalize those who often experience the greatest inequities: Aboriginal women. The Native Women's Association of Canada (NWAC) and the Pauktuutit Inuit Women of Canada will be unable to sustain health programming for Indigenous women. The federal minister of health, Leona Aglukkaq, justifies the diminishment of NWAC and the Pauktuutit Inuit Women by redirecting monies saved to support health care in on-reserve and northern communities. This despite the reality that the majority of Aboriginal people (including women) in Canada live off-reserve and in cities. NWAC has established best practices with respect to programming and research in the areas of early diabetes, childhood development, HIV, and suicide prevention. Knowledge from within communities and the research literature indicates that it is essential we foster the health and well-being of women — to support not only the health of their families but also the health of Aboriginal nations (Dion Stout & Downey, 2006).

Researchers can and do challenge governments (provincial and federal) and government policies. Unfavourable research findings can hold governments accountable for failed social policies, exposing the veritable underbelly for all to see. The federal budget cuts will weaken the ability of Aboriginal organizations to partner with researchers and to fully actualize the Aboriginal health-care agenda in Canada. These researchers include nurse researchers who are concerned with health, social, and health-care inequities and whose findings often challenge the status quo.

The Aboriginal Nurses Association of Canada (ANAC) also underwent cuts to its budget. As a consequence, it has cancelled its 2012 national forum, Mobilizing Indigenous Nursing Knowledge in Primary Health Care. The purpose of this gathering was to have practitioners, educators, and health-care providers meet and share culturally relevant practices in caring for Aboriginal peoples, families, and communities. Indigenous knowledge was to be central to the forum. Loss of that knowledge exchange will seriously and negatively impact the work of nurses. It is but the first of many consequences of the current round of systematic cuts by the federal government, which will diminish not only the voices of Aboriginal peoples and their organizations, but also the potential for research partnerships with nurse researchers. Unless there is agitation and action to reverse these funding cuts, we will have to rethink how such partnerships can be forged in light of diminished resources. In

2005 there was a clarion call to address the dearth of Aboriginal nursing students in master's and doctoral programs. This matter has suddenly become vital for research on health and health-care equity.

The creation of strong partnerships to advance the agenda of cultural safety and social justice is an imperative among Canadian nurse researchers. For far too long, those with much to teach us about respectful, holistic, resource-conserving approaches to the enhancement of well-being and quality of life were silenced. Systematic and institutional discrimination embedded in funding policies, dominant research ideologies, policy environments, and other conditions effectively muzzled and discredited Aboriginal ontology, epistemologies, and Indigenous knowledge (Dion Stout & Downey, 2006).

The Canadian Institutes of Health Research (CIHR) recently funded a meeting of nurse scholars and health professionals to discuss strategies for "troubling culture" and creating powerful and effective learning environments for our students, in order to improve the care offered to all Canadians. The discourse on this topic has thus far failed to help us to negotiate diversity and to address inequities in health outcomes. In fact, our teachings on culture appear to have reinforced our complicity with imperialist practices, with the exoticizing of difference, and with essentialism (Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010). Culture is often taught in isolation from other fundamental concepts and frameworks, such as social determinants of health, advocacy, and social justice. At the CIHR meeting, three critical concepts were introduced as meaningful to nursing care and as having the potential to resolve the conundrum of culture: equity, as the mobilization of social justice; citizenship, whereby the imperative of equity is enriched and expanded by a commitment to fostering citizenship through clinical encounters between health-care provider and patient-as-person; and respectful relations, which connects equity and citizenship to a foundation for the enactment of culture, cultural knowledge, and cultural safety in the relationship between health-care provider and client. This is where nurses engage in human-to-human relationships characterized by humility and deep respect for the lived experience of others. Assumption of knowledge, cultural or otherwise, is pre-empted by an attitude of inquiry to more fully honour the health-care needs, vulnerabilities, and preferences of persons in this relational space.

This initial gathering received the full support of and was attended by representatives of ANAC, the Indigenous Physicians Association of Canada, the Association of Faculties of Medicine of Canada, the Mental Health Commission of Canada, and the Canadian Association of Schools of Nursing, as well as academics and practitioners from western Canadian universities. Perspectives were shared, progress was made, and plans were drawn up to continue this important conversation. Those assembled, courtesy of the CIHR funding, realized that "troubling culture" meant addressing power over others in the name of culture and its essentialist bias within the discipline of nursing, including research. The intellectual richness at play during the gathering was a consequence of having our Aboriginal colleagues present at the table. Such initiatives must continue — this is imperative — but the effective removal of key partners from the discussion of health and health-care equity serves to silence Aboriginal people.

This is our reality, 7 years later.

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David Gregory, RN, PhD, is Professor and Dean, Faculty of Nursing, University of Regina, Saskatchewan, Canada. Jean Harrowing, RN, PhD, is Associate Professor, Faculty of Health Sciences, University of Lethbridge, Alberta, Canada.

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Résumé

L'approche à double perspective : un cadre pour comprendre les approches autochtones et non autochtones à la recherche en santé autochtone

Debbie H. Martin

Cet article présente l'approche à double perspective (*two-eyed seeing*) en tant que cadre théorique englobant les apports des modes de connaissances (visions du monde) autochtones et occidentaux. Il présente les caractéristiques et les principes clés de ces différentes perspectives et suggère des façons dont elles pourraient être utilisées conjointement pour répondre à nos questions les plus pressantes sur la santé des Autochtones et leurs collectivités. Contenant une critique du positivisme, qui a dans le passé miné ou rejeté les modes de connaissances autochtones jugés non scientifiques, l'article traite des origines des approches occidentales et autochtones en matière de compréhension de la santé; de l'importance d'accorder la même attention aux diverses visions du monde occidentales et autochtones de manière à ce que l'une d'elles ne domine pas ou ne sape pas les apports de l'autre; et de la manière dont un examen équilibré des apports des diverses visions du monde, effectué dans un cadre fondé sur une double perspective, peut reformuler les questions que nous posons dans le domaine de la recherche en santé autochtone.

Mots clés : Autochtones, santé, recherche en santé, visions du monde, double perspective

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Two-Eyed Seeing: A Framework for Understanding Indigenous and Non-Indigenous Approaches to Indigenous Health Research

Debbie H. Martin

This article presents two-eyed seeing as a theoretical framework that embraces the contributions of both Indigenous and Western "ways of knowing" (worldviews). It presents key characteristics and principles of these different perspectives and suggests ways in which they might be used together to answer our most pressing questions about the health of Indigenous people and communities. Presenting a critique of positivism, which has historically undermined and/or dismissed Indigenous ways of knowing as "unscientific," it discusses the origins of both Western and Indigenous approaches to understanding health; the importance of giving equal consideration to diverse Indigenous and non-Indigenous worldviews such that one worldview does not dominate or undermine the contributions of others; and how balanced consideration of contributions from diverse worldviews, embraced within a two-eyed seeing framework, can reshape the nature of the questions we ask in the realm of Indigenous health research.

Keywords: Indigenous peoples, Aboriginal peoples, health, health research, theory, worldviews, two-eyed seeing

Introduction

> Two-Eyed Seeing adamantly, respectfully, and passionately asks that we bring together our different ways of knowing to motivate people, Aboriginal and non-Aboriginal alike, to use all our understandings so that we can leave the world a better place and not compromise the opportunities for our youth (in the sense of Seven Generations) through our own inaction. (Bartlett, Marshall, Marshall, & Iwama, in press, p. 11)

There are many ways of seeing and understanding the world. How health is understood within our academic and health-care institutions is predominantly shaped by conventional scientific approaches, but there are other, equally valuable, ways to understand health. Discussions about the importance of alternative ways of knowing, such as those encompassed by Indigenous[1] perspectives, are often absent from research generally (Smith, 1999) and health research specifically. Through an uncritical reliance upon only conventional scientific, or Western, understandings of health (Denzin & Lincoln, 2008), we disregard other avenues that may hold key insights into the health and well-being of populations. This article presents and builds upon a framework called two-eyed seeing proposed by Mi'kmaw Elders Albert and Murdena Marshall as a means to bridge Western science and Indigenous knowledge (Bartlett et al., in press). This article argues that two-eyed seeing offers a way in which diverse perspectives might work together to answer our most pressing questions about the health of Indigenous people and communities.

Epidemiological data suggest that in many Indigenous communities the burden of chronic disease is worsening and that health disparities between Indigenous and non-Indigenous populations are widening (Gracey & King, 2009; Loppie-Reading & Wien, 2009). The significant health inequities between Indigenous and non-Indigenous populations can largely be explained by inequitable access to many of the social determinants of health (King, Smith, & Gracey, 2009; Loppie-Reading & Wien, 2009; Richmond & Ross, 2009). In Canada, for example, a country consistently ranked in the top 10% of the world's most developed nations according to the United Nations Development Index, one need look no further than Indigenous communities to find living conditions more reminiscent of developing countries than other parts of Canada — communities that are characterized by unemployment, poor sanitation, overcrowded housing, and often desperate poverty (Adelson, 2005). Given these social and living conditions, it is not surprising that members of Indigenous communities experience poor health compared to non-Indigenous Canadians (Adelson, 2005; King et al., 2009; Waldram, Herring, & Young, 2006). Researchers who study Indigenous health are in agreement that the causes and consequences of ill health within Indigenous communities are multi-faceted, complex, and predominantly social in origin; health issues are so intertwined with social, political, eco-

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[1] No set definition of the term "Indigenous peoples" exists, although certain characteristics are deemed to be common among collectives who identify themselves as Indigenous peoples, including the claim that they are the original inhabitants of a particular territory (United Nations, 2004, 2006). This term, rather than "Aboriginal people," is specifically chosen for this article, because although "Aboriginal peoples" is more commonly used to describe the Indigenous inhabitants of Canada (Royal Commission on Aboriginal Peoples), it is politically charged and includes specific collectives (i.e., those who are identified by the Government of Canada as either First Nation, Inuit, or Métis). This article chooses to avoid these political distinctions, as there are Indigenous peoples in Canada who identify as Indigenous to a particular location or territory, despite a lack of recognition by the Government of Canada.

nomic, and environmental issues that one cannot hope to address them without a thorough understanding of the context within which health is situated (King et al., 2009).

The prevention and treatment of a variety of chronic and non-chronic illnesses can be directly attributed to scientific advances in the fields of public health, medicine, nursing, and other health disciplines (Wilkinson & Marmot, 2003). Undeniably, research conducted within these disciplines and the application of research findings in health programs, policies, and services have positively influenced the overall health and longevity of populations, including Indigenous communities (Loppie, 2007). Despite these advances, however, there continues to be a noticeable gap between the health of Indigenous populations and that of their non-Indigenous counterparts (Gracey & King, 2009). Taking into account even the most diligent efforts by health disciplines, research findings do not appear to be translating into better health for Indigenous communities.

With growing recognition of the complex nature of the causes and consequences of ill health in Indigenous communities, it is not enough to simply define and describe the health issues being experienced. To address the significant health disparities between Indigenous and non-Indigenous peoples, Indigenous health researchers and communities are calling for health research that is participatory, community-based, and action-oriented; they are also calling for research processes and methodologies that reflect the needs, issues, and concerns of community members themselves (Bull, 2010; Kovach, 2009; Minkler, 2005). For far too long, Indigenous peoples have been subjected to research in its various forms without receiving its benefits (Marker, 2003; Smith, 1999). There is a groundswell of support for research that is driven by the needs of the community and that can recommend solutions to some of the health crises being experienced.

Just as important as the engagement and involvement of Indigenous peoples in research, though less clearly understood, is the need for research involvement to go beyond participation, to include thinking carefully about how knowledge gets created (Kovach, 2009; Smith, 1999). The means through which Indigenous health issues are identified, defined, and addressed must uphold Indigenous worldviews. Otherwise, simply put, even well-intentioned research within Indigenous communities may at best be less than useful and at worst perpetuate harm by adding to the scepticism and trepidation that many Indigenous peoples feel towards research (Kovach, 2009; Smith, 1999). The term "worldviews" is used here to elucidate the ways in which diverse groups of people create knowledge about the world around them and principles for engaging with it. In upholding Indigenous worldviews, the motive is not to diminish or dismiss the important work of Western health research but, rather, to critically examine the lens through which health research is interpreted and understood and to offer, in place of this dominant view, an alternative lens through which health research can embed Indigenous perspectives and realities. The lens proposed here is one that has been developed and proposed by Mi'kmaw Elders Albert and Murdena Marshall, called two-eyed seeing. Two-eyed seeing holds that there are diverse understandings of the world and that by acknowledging and respecting a diversity of perspectives (without perpetuating the dominance of one over another) we can build an understanding of health that lends itself to dealing with some of the most pressing health issues facing Indigenous peoples and communities (Bartlett et al., in press; Iwama, Marshall, Marshall, & Bartlett, 2009).

This article will explore the origins of Western thought and the Indigenous origins of many of the ideas often assumed to have emerged from Western science. It will re-imagine a health framework that does not position one "way of knowing" above another. Finally, it will offer two-eyed seeing as a theoretical framework that honours and accepts diverse ways of knowing.

Origins of Western Scientific Understandings of Health

Health research as we know it today has been almost exclusively understood from the perspective of Western science. With few exceptions, major advances in health research have occurred as a result of Western scientific methods of inquiry, with little attention paid to alternative, much less Indigenous, ways of knowing (Denzin & Lincoln, 2008). The many Indigenous origins of Western scientific thought and the health advances that have resulted have received scant attention (Iaccarino, 2003). With its roots firmly established in positivism, the scientific tradition has become a pervasive (although contested) means of inquiry in the Western world, which has failed to acknowledge the existence of perspectives that might question or contradict some of its fundamental assumptions (Denzin & Lincoln, 2008; Varadharajan, 2000). The dominance of positivism in the Western world can be seen in Canada's education system, which has been noted to teach a colonial version of history that largely overlooks the key roles played by Indigenous peoples in the settlement of what is now known as Canada (Truth and Reconciliation Commission of Canada [TRC], 2012). Consequently, Canada's education system has established a "truth" about its past that fundamentally ignores Indigenous perspectives (Marker, 2004). It has been claimed that this absence of Indigenous history in curricula across Canada contributes to the ignorance and lack of respect for Indigenous experiences, knowledge(s), and perspectives (Bartlett, 2011; TRC, 2012).

With its claims to "truth," scientific method, or what has been called "positivist science" or "positivism," assumes that there is only one reality "out there," which can be discovered through scientific procedure (Iaccarino, 2003). The ultimate goal of science conducted in a positivist paradigm is to make claims about reality by offering proof of its existence through scientific inquiry. According to this logic, value can be placed only on knowledge that meets the acceptable standards of objectivity as defined by positivist, scientific research. No other forms or ways of knowing about the world hold legitimacy. Anything that falls outside of scientific reasoning is disregarded as inconclusive and ideological (Marker, 2003; Mills, 1997; Petch, 2000). Thus, studies that cannot be replicated, that use tools or methods that have not been standardized or verified, or that reach conclusions that veer away from the questions asked are dismissed as unscientific and lacking in credibility. Yet even though positivism and post-positivism remain a dominant and pervasive means of inquiry, it continues to be contested, even among researchers who conduct scientific research in its most basic, conventional form (Pohl, 2011), suggesting that its established dominance should not be taken as an indication that it is the only correct way of thinking about science or scientific methodologies. Within health research specifically, certain "types" and styles of research are viewed as having more credibility than others (e.g., the randomized controlled trial continues to be the gold standard of Western health research, whereas storytelling may be interpreted as anecdotal and lacking in evidence) (Denzin & Lincoln, 2008; Marker, 2003).

It is interesting to note that some of the greatest health-research contributions of our time (e.g., the importance of hand-washing in disease prevention) have not emerged as a result of these strict research standards (Wilkinson, 1996) but have come from methods that might bear more resemblance to Indigenous ways of knowing than to positivist research. Indeed, if we look closely at the origins of Western science we learn that there has never been one, pure definition of science or one "best" way to make scientific discoveries or health research advances, since science has stemmed from a variety of decidedly non-Western locations (Turnbull, 1997; van Eijck, 2007). As van Eijck (2007) points out, "the very foundation of European science is itself the result of a mélange of many peoples from the empire of Alexander the Great, including from then-current countries like Persia, Anatolia, Syria, Phoenicia, Judea, Gaza, Egypt, Bactria, Mesopotamia and even Punjab" (p. 609). Thus, "Western science" is not purely Western or even European; rather, it is a social and cultural construct with global, and often Indigenous, origins.

The word "science" comes from the Greek *scientia,* and its roots can be traced back to 15th-century Britain, where there was a growing demand for empirical evidence to replace the authority of the Church and the Crown as an alternative knowledge system (Aikenhead & Ogawa, 2007). Originally, "science" was referred to as "natural philosophy," and in 1661 the Royal Society of Natural Philosophers emerged to represent the interests of those who wished to advance empirically based knowledge. Although natural philosophy recognized that knowledge about the world could be gained through experience and circumstance, its intent was to divorce itself from the spiritual or divine elements of knowing that were considered the purview of the Church. The Society's success and influence grew throughout the Industrial Revolution and "the name *science* was chosen to replace *natural philosophy* in 1831, with the birth of the British Association for the Advancement of Science (BAAS)" (Aikenhead & Ogawa, 2007, p. 554). The founding of BAAS situated "the word *science* squarely in a political arena of elite social privilege," giving rise to science as a "professionalized philosophy" that is associated only with Eurocentric, or Western, knowledge (Aikenhead & Ogawa, 2007, p. 554). With the professionalization of this knowledge through BAAS (concurrent with the growing importance of social class in Britain), the global origins of science were forgotten and science became redefined as only that which was taught in university. Only those who were university-trained, with ties to institutions and funding bodies, could contribute to this version of science, and the experience and circumstance that had originally played an important role in natural philosophy were replaced with strict standards of objectivity (Aikenhead & Ogawa, 2007). Science became narrowly associated with that which could be verified within the academy; the Indigenous origins of scientific inquiry were all but forgotten.

It is not only the Indigenous origins of science that are ignored, but also, frequently, the Indigenous origins of particular scientific "discoveries." Within the positivist paradigm, Indigenous knowledge is used to inform and uphold many of the claims made within positivist science, but without the consent of the Indigenous holders of that knowledge (Posey, 2004). Fragments of Indigenous knowledge have been appropriated for scientific use, which can be observed in everything from forestry-management practices to the identification and use of certain pharmaceuticals, such as digoxin (Little Bear, 2000; Posey, 2004). This contributes to the colonization of Indigenous ways of knowing, because knowledge is abstracted from its *source* as well as from its *originators,* in order to meet the strict confines of the positivist approach. Thus the social and cultural context in which knowledge is situated is lost or ignored. The very success of positivism lies in its ability to take knowledge(s) from many diverse sources and claim them as discoveries within positivism (Michell, Vizina, Augustus, & Sawyer, 2008). For example, important scientific advances in the fields of medicine, pharmacy, forestry, engineering, and many other disciplines can be attributed to the knowledge generated by diverse Indigenous cultures:

> Traditional Native knowledge about the natural world is often extremely sophisticated and of considerable practical value . . . Traditional Bolivian healers use some six hundred different medicinal herbs, and their counterparts in Southeast Asia may use up to sixty-five hundred kinds of plants for their medical concoctions. In addition, more than seventy-five percent of the 121 prescription drugs used around the world that are derived from plants are said to have been discovered on the basis of initial clues found in traditional indigenous medical practices. (Knudtson & Suzuki, 1992, p. 12)

Despite the clear Indigenous origins of many pharmaceuticals, Indigenous knowledge has been used by pharmaceutical companies for monetary gain, without crediting or compensating Indigenous peoples (Posey, 2004).

It is important to point out that positivist research is not always associated with a particular method or methods of conducting scientific research. It is the *perspective* with which certain methods are employed that is the most troubling, not the methods themselves (Denzin & Lincoln, 2008; Marker 2003). This means simply that positivist science can be either quantitative or qualitative, and, alternatively, a decolonized research agenda may include either quantitative or qualitative methods (Denzin & Lincoln, 2008). This distinction is important, since a research agenda that attempts to move towards a *decolonized* approach to research (an approach that positions Indigenous knowledge as a veritable source of knowledge generation) is not about *carte blanche* advocating or dismissing certain methods over others but, instead, critically interrogating the way in which those methods are applied.

Diversity of Thought Within Western Science

While Indigenous peoples have perhaps been the group most undermined and ignored through the proliferation of positivist thought, many others have also railed against the narrow conceptualizations of the world advocated by positivism. Substantial Western-derived schools of thought, including constructivism, critical theories, feminist theories, and queer theories, all stem from a well-established critique of positivism, questioning the notion that it offers the only correct way to acquire knowledge about our world (Denzin & Lincoln, 2008). Critics of positivism are deeply troubled by its domination over other forms of knowledge.

Within the critiques of positivism, alternative methods of thinking about and seeing the world are reflected upon, compared, and constantly changing. It is from these alternative places of theorizing that people of diverse races, sexualities, abilities, and religions have expressed their perspectives on how knowledge is produced, re-produced, understood, and accepted or rejected within various social locations.

Unlike non-positivist scientific approaches to research, such as critical theories or feminist theories, Indigenous ways of knowing have not emerged from a critique of positivism, nor have they always been required to use positivism as a benchmark for articulating the emergence of Indigenous thought. Indigenous worldviews, as far as we know, have existed since time immemorial, which suggests that positivism is in fact "newer." Since Indigenous worldviews do not emerge from within a critique of positivism and yet are required to navigate within a colonized world, Indigenous knowledges are distinct from Western theories that have emerged as a response to positivism. Nevertheless, alternative Western perspectives can and do assume various forms of imperialism, domination, and colonization through junctures of sexuality, age, dis/ability, religion, and/or race, which can be attributed to the dominating effects of positivist science and thought. Since these positions are marginalized within the borders of Western science, they offer a different lens through which to understand the imperialistic tendencies of positivist science and thought. In this sense, these alternative perspectives stand not only to inform but also to benefit from Indigenous ways of knowing.

Respect for diversity of thought has been inherent to Indigenous sciences and philosophies, since this is what allows one's own perspectives and experiences to respond to changes and fluctuations in the world (Loppie, 2007). Sharing diverse perspectives has been integral to all cultures, even those in the Western world, since learning about and understanding the perspectives of others is essential to cultural survival (Turnbull, 1997). It has long been recognized by Indigenous peoples that the health of Mother Earth is directly linked to the health of people: If we do not pay attention to the knowledge that exists among diverse cultures regarding how to take care of local ecologies, we risk abandoning the very solutions that we seek with respect to the world's most pressing health and ecological crises (Davis, 2000). The scholar and anthropologist Wade Davis (2000) argues that the diversity of thought that results from cultural diversity is at least as important for the protection and preservation of Mother Earth as biodiversity. Without cultural diversity and, perhaps more importantly, the recognition and acceptance of diverse ways of knowing that accompany cultural diversity, the very health and well-being of Mother Earth is jeopardized.

If we accept the notion that diverse ways of knowing are integral to the promotion and protection of the health of people and Mother Earth, then we must reject positivism and positivist thought altogether, as positivism and Indigenous worldviews cannot co-exist. Although rejecting positivism might seem contradictory to the acceptance of diverse perspectives, positivist thought does not allow or acknowledge alternative expressions of knowing, and so rejecting positivism is an exception to the general principles of acceptance in Indigenous cultures. It is not the lending or borrowing of knowledge that is problematic for Indigenous cultures; indeed, lending and borrowing knowledge is a characteristic of many Indigenous worldviews (Loppie, 2007). It is when Indigenous knowledge is undermined through appropriation that Indigenous peoples risk further colonization. In fact, the need to appropriate knowledge and then claim that the origins of that knowledge are positivist is precisely what supports the existence and proliferation of positivism. An important aspect of a decolonized research agenda is avoidance of re-inscribing a colonial agenda in Indigenous research (Smith, 1999). This does not mean isolating Indigenous knowledge(s) from Western sciences; indeed, this would undermine the pluralistic nature of Indigenous knowledge (Loppie, 2007). Rather, a decolonized research agenda requires careful reflection on the role that colonization plays in the articulation of Indigenous knowledges today and on how Indigenous knowledges are shaped by experiences of colonization. Thus, decolonized Indigenous scholarship does not assume that a state of pre-colonization can ever be achieved, but in the process of reflecting on how Indigenous knowledge has been shaped by colonization we can begin to identify colonial practices and move beyond the boundaries created by colonization, rejecting forms of knowledge that perpetuate a colonial agenda.

The concept of two-eyed seeing offers a framework from which to explain not only how different types of knowing can be brought together, but why they are important. Identifying Western theories that are closely aligned with Indigenous thought might, at first glance, appear to reinforce the idea that the similarities between Western theories and Indigenous thought are so great that there is no need for both perspectives to exist. However, as Bartlett, Marshall, and Marshall (2007) point out, diverse perspectives always have roots that emerge from very different places — even though they may be similar in many ways, they have been created to respond to the needs and desires of a particular group of people. Just as Indigenous sciences and philosophies have emerged from a direct and intimate relationship with local ecologies, creating an unending diversity of perspectives, languages, understandings, and knowledge(s) of the world and how to live in it, Western theories emerged as a means to convey different perspectives within Western sciences. We must be attentive to the strengths and insights of each perspective, and must recognize the diverse places from which they have come and the diverse purposes for which they were intended (Bartlett et al., 2007).

Re-imagining the Landscape of Indigenous Health Research

The previous section argued that conventional Western scientific approaches to health research often ignore or undermine alternative ways of knowing, preferring to focus on the pursuit of objective, detached research that can uncover the "truth" about a particular topic (Denzin & Lincoln, 2008; Marker, 2003; Petch, 2000). As a direct result of the colonization, appropriation, and suppression of Indigenous knowledge, Indigenous health researchers and their allies strive towards a *decolonized* approach to research. A decolonized approach asks whether conventional scientific research contributes to the oppression and colonization of Indigenous peoples worldwide (Smith, 1999). As Denzin and Lincoln (2008) argue, "Indigenous knowledge systems are too frequently made into objects of study, treated as if they were instances of quaint folk theory held by the members of a primitive culture. The decolonizing project reverses this equation, making Western systems of knowledge the object of critique and inquiry" (p. 6).

A decolonized approach to research requires that all stages of research critically reflect on *how* questions are asked, *why* they are being asked and by *whom* (Smith, 1999). Through the process of reflecting on the entire research *process,* the purpose of research becomes more than just the production of new knowledge; it upholds the pedagogical, political, moral, and ethical principles that resist oppression and contribute to strategies that reposition research to reflect the unique knowledge, beliefs, and values of Indigenous communities. Thus, it creates research that always "begins with the concerns of Indigenous people. It is assessed in terms of the benefits it creates for them" (Denzin & Lincoln, 2008, p. 2). In doing so, it offers a means for Indigenous peoples to address the political and social conditions that perpetuate ill health, poverty, and lack of educational opportunities in their communities (Smith, 1999).

If Indigenous struggles for autonomy and freedom from oppression begin at the level of epistemology (Kovach, 2009), and if the health inequities experienced within Indigenous communities stem from the greatest of all oppressors, colonization, whose intent is to silence Indigenous voices, then a decolonized approach to research means that Indigenous worldviews *must* be included in discussions that influence their health and well-being. This means that for Indigenous communities to witness health improvements, the solutions to health and social crises must include Indigenous perspectives and understandings about health and social issues. We need a framework that positions Indigenous knowledge as an integral source of information about health and well-being. Such a framework, however, must also recognize the important and undeniable contributions that non-Indigenous, or more specifically Western scientific, understandings of health have made to Indigenous health and well-being. It must tease apart the contributions of Western science that maintain and perpetuate colonization from those that make space for Indigenous perspectives to inform and shape the health and well-being of not only Indigenous peoples, but also Mother Earth and all of her inhabitants.

The Origins of Two-Eyed Seeing

Two-eyed seeing is a concept introduced to the world of research by Mi'kmaw Elders Albert and Murdena Marshall from Eskasoni, a First Nation in Cape Breton, Nova Scotia. It has gained renown for its role in the development of the Integrative Science Program at Cape Breton University (led by Canada Research Chair Cheryl Bartlett and Elders Murdena and Albert Marshall). Here, Indigenous knowledge and Western sciences interact in a science program that offers Mi'kmaq and non-Mi'kmaq students the opportunity to learn about diverse ways of understanding our world. Two-eyed seeing acts as "an important guiding principle for one's journey while here on Mother Earth" (Bartlett et al., 2007, p. 13). It stems from the belief that there are many ways of understanding the world, some of which are represented by European-derived (Western) sciences and others by various Indigenous knowledge systems and sciences. Albert Marshall contends that aspects of both Western and Indigenous ways of knowing about the world are important for Indigenous communities. If we learn to appreciate multiple perspectives, we can draw on what is useful and relevant to inform and build upon our existing knowledge. Essentially, we can learn to "see through both eyes." Two-eyed seeing stresses the importance of being mindful of alternative ways of knowing (multiple epistemologies) in order to constantly question and reflect on the partiality of one's perspective. It values difference and contradiction over the integration or melding of diverse perspectives, which can result in the domination of one perspective over the others. As a result, one "eye" is never subsumed or dominated by the other; rather, each eye represents a way to see the world that is always partial. When both eyes are used together, this does not mean that our view is now "complete and whole," but a new way of seeing the world has been created — one that respects the differences that each can offer.

An important aspect of two-eyed seeing is that it responds to the idea that our perspectives of the world are never static but are constantly shifting and changing in response to the changing world around us. Local ecosystems are composed of interdependent parts that are in a state of constant flux. No one part can be altered or changed without causing changes to all the other parts. Each part of the ecosystem has a responsibility to the whole, such that if for some reason one part does not fulfil its role the entire ecosystem is affected (Henderson, 2000; Knudtson & Suzuki, 1992). Albert Marshall likens this interdependence to the roots of trees beneath a forest floor, where trees of different types — birch, pine, fir — are all "holding hands" (Bartlett et al., in press). Indigenous philosophies recognize interconnections and relationships, rather than narrowly seeing them as discrete elements unrelated to the whole. Human beings represent one part of this web of life and are connected to all things living and non-living. Thus, like all other parts of the ecosystem, humanity has a responsibility to contribute to the whole in a way that ensures "interactive harmony" (Henderson, 2000). Interactive harmony means that we must accept the strengths, beauty, and limits of our ecology. In many Indigenous societies, this way of being is constantly reinforced through prayers, rituals, songs, and dances that are tailored to specific localities and the corresponding needs and desires of their people (Little Bear, 2000).

What we are able to know is shaped not only by our physical surroundings, but also by our social surroundings. The social construction of knowledge with which two-eyed seeing is imbued recognizes that we are social beings and in order for knowledge to be produced anew "we all need one another" (Marshall, n.d.). The fluid nature of two eyes that can look back and forth and assist one another to attain a more complete picture of the world indicates that Indigenous knowledge merits a place in the world both broadly and in the realm of health research, and that this place is not "greater or lesser than" the place held by Western scientific understandings of health but is, simply, different. It also recognizes that, through the acceptance of diverse perspectives, those solutions that appear to be the most beneficial for addressing a particular set of circumstances or situations, whether they are Western or Indigenous in origin, or even if they are some variation of the two, can be employed. The intent is to share knowledge with the understanding that it will be used for the greater good.

As a concept that values both Western and Indigenous ways of thinking, two-eyed seeing embraces diverse understandings of reality. Beyond recognizing and accepting the existence of diverse perspectives, two-eyed seeing suggests that different perspectives must be reflexively considered. The concept of reflexivity is one that has us reflect on our firmly established beliefs and assumptions and constantly question them through the incorporation of new ideas and experiences (Tomaselli, Dyll, & Francis, 2008). An exceedingly important aspect of reflexivity in research is what Bartlett et al. (in press) call "co-learning," whereby the relationship between researchers and communities develops in such a way that different epistemologies and ontologies are shared and form the basis for working together in a manner that "involves learning from each other, learning together, learning our commonalities and differences, and learning to see how to weave back and forth between our cultures' actions, values and knowledge as circumstances require" (p. 5).

In addition to the importance of understanding the physical and social elements of our world, reflexivity in two-eyed seeing challenges us to include the wisdom of the spiritual and the humility of the emotional in our quest to conduct health research and improve the lives of Indigenous peoples (Bartlett, Marshall, & Marshall, 2012). In this perspective, the spiritual and emotional dimensions of human understanding are not positioned as more important than the physical or social, but each dimension is necessary for a complete understanding of our world. This permits us to ask what value can be added to our understanding of the world if we incorporate these human dimensions into all varieties of health research, Indigenous and non-Indigenous alike.

Reflexivity also requires us to do more than simply look at ourselves, to also consider how different beliefs and values inform and shape how others see the world (Tomaselli et al., 2008). Marker (2003) argues that reflexivity calls for researchers to question the structures (social, political, economic, etc.) that serve to perpetuate the issues that are being researched. This entails using a "mirror" to reflect on the role of the researcher in conducting research, whereas research has tended to use only a "microscope" to understand populations of interest. For health researchers specifically, it suggests a responsibility to go beyond what might be viewed as the "expertise" of the research (which might, for example, be related to virology, prenatal health, or diabetes), to look at how the lenses through which Indigenous and Western scientific knowledge gets interpreted have dislocated Indigenous peoples from the traditional methods of healing and living that have contributed to and ultimately "caused" the health issues being experienced.

Indigenous Knowledge Generation

The ability to learn, express, and convey Indigenous knowledge is closely related to health (Bartlett et al., 2012; Chandler & Lalonde, 2008). Within our conventional health and social systems, Indigenous knowledge remains at the margins of knowledge generation, through a process referred to as "cognitive imperialism" (Battiste, 2000). Cognitive imperialism positions positivism as the only correct way of understanding the world. It does so by denying the existence of alternatives in order to support its own legitimacy. In the context of health inequities experienced within Indigenous communities, the success of cognitive imperialism does not lie, as many would suggest, in the failure of existing health systems to treat the health problems of Indigenous peoples, although this is certainly part of the issue. Rather, it lies in the concerted effort to dismiss, undermine, or ignore the very existence of Indigenous approaches to health and healing, and in the failure to acknowledge the fact that Indigenous communities have thrived for many, many millennia using medicines and healing techniques developed according to their own forms of knowledge generation, without the need for Western medical intervention. In working towards the dismissal of cognitive imperialism and towards a space where Indigenous knowledge can be embraced, the means by which knowledge is generated in Indigenous communities must be viewed as veritable in its own right. Such a process requires opportunities for respect, reflexivity, and co-learning.

Among Indigenous peoples, the generation and application of knowledge tend to be participatory, communal, experiential, and reflective of localized geography (Loppie, 2007; Smylie et al., 2004). This means that more value is placed on the traditions, laws, customs, and philosophy of the group than on the successes and achievements of individuals. It also means that a diversity of perspectives and opinions is valued, since it is believed that no one perspective is right or wrong; all views are seen to contribute something unique and important; diversity is also respected in that individuals often need to know a little bit about a great number of things.

The collective nature of Indigenous knowledge rests on stories derived from practical experience. The oral tradition of storytelling provides the foundation for local knowledge by helping people to connect their own experiences with those from the past. By sharing their personal experiences and learning about the experiences of others through stories, individuals develop wisdom, which is then passed on to the younger generations (Battiste, 2000; Cruickshank, 1998; King, 2003). A unique feature of Indigenous stories is that contradictory perceptions of the same event are often accepted, because they are seen as specific to the individual (Henderson, 2000). No perspective is dismissed, since all perspectives offer something important. For example, if particular phenomena cannot be fully explained through certain versions of a story, those versions are put aside, rather than forgotten, so that if new information arises it can be used to complement what is already known. This collective process of knowledge-building ensures that very little is forgotten and that all perspectives, even those that are contradictory, are given value.

An additional feature of Indigenous knowledge-generation is the integral importance of historical knowledge (Knudtson & Suzuki, 1992). Since stories have their roots in thousands and thousands of years of history, they are a means of reminding us where we have been and the issues and problems that others have faced — as well as how they reacted and responded to various issues and crises. Essentially, history not only tells us where we have been, but also helps us to understand the future. Paying careful attention to the lessons learned and the experiences of the past ensures that present generations are able to learn from the successes and failures of their ancestors and Elders and do not have to constantly generate new solutions to modern-day problems. Building on historical knowledge in this way means that new information is continually used to augment existing knowledge, in order to achieve a deeper understanding of a particular phenomenon.

Embracing Two-Eyed Seeing

> Science is part of culture, and . . . how science is done largely depends on the culture in which it is practiced. (Iaccarino, 2003, p. 220)

Often, diverse perspectives of reality, and thus approaches to health research, are seen as on a continuum, with Western scientific understandings of health at one end and Indigenous knowledge(s) about health at the other. In this conceptualization, overlapping, blending, or blurring will occur at some point on the continuum. Brandt (2007) and Aikenhead and Ogawa (2007) argue that conceiving of knowledge in this way reinforces dichotomies that are not aligned with Indigenous perspectives. Brandt proposes that if knowledge is considered from a *both/and* rather than an *either/or* position, one can begin to "challenge the fixed notion of the binary to reveal positions that were previously erased and ignored simply because they did not fit into normative categories" (p. 602). If, as Brandt suggests, knowledge is not a dichotomy between Indigenous knowledge(s) and Western sciences and there is, in fact, overlap between the two systems, then we need to re-conceptualize how we think about the production of knowledge that does not reinforce this dichotomy.

According to Turnbull (1997), one way of thinking about the production of knowledge is through a conceptual framework where "all knowledge systems can be equitably compared" (p. 557) and where differences are recognized and embraced. Turnbull argues that there is no "great divide" between many Western sciences and Indigenous knowledge(s), but that the two systems operate within "different knowledge spaces with different devices and strategies for assembling and moving the knowledge" (p. 557). He proposes a "thirdspace," where knowledge systems can be reframed and re-negotiated.

The notion of thirdspace as proposed by Turnbull (1997) entails two overlapping concentric circles, with the shared space between them being the thirdspace. Brandt (2007) argues that thirdspace, while useful to the extent that it moves beyond the either/or continuum separating Western and Indigenous knowledge, it still implies that many aspects of diverse knowledge systems are "out of reach" of one another, since the only point at which knowledge is shared is that where they converge. Brandt envisages an expansion of this shared space, proposing that it be thought of as "common ground," where diverse knowledge systems co-exist, each informing and building upon the knowledge of the other, to varying degrees, depending on the context, so that one type of knowledge is never subsumed by the other.

In her research with students from linguistically and culturally diverse backgrounds attending university in a Western setting, Brandt (2007) was constantly searching for a "border" between Indigenous knowledge and Western science. She realized that by making such a distinction she was reinforcing rather than questioning the very dichotomies she was trying to avoid. Brandt found that the "bridge" linking Indigenous and Western knowledge systems was illusive, so she began to look at the ways in which her research participants were simultaneously embracing multiple epistemologies. Her research participants "held firm to their traditional worldviews" (p. 602) but added certain aspects of Western epistemology that served to expand and diversify their traditional worldviews. For example, one participant "held multiple epistemologies where she references her Indigenous Navajo worldview, beliefs through the Native American Church, teachings from her education in the Catholic school, oral traditions within her family, and Eurocentric science" (p. 602). For Brandt, "common ground implies that one does not have to relinquish either position, but . . . can simultaneously embrace elements of Eurocentric societies and Indigenous knowledge" (p. 603), depending on the circumstances.

Brandt's (2007) "common ground" approach aligns with the conceptualization that Marshall, Marshall, and Bartlett (2011) use to describe the "bringing together" of cosmologies, philosophies, stories, and worldviews contained within two-eyed seeing. They propose that if we envisage these two versions of knowing (Western and Indigenous) as two people sitting around a campfire sharing knowledge, suspending judgements and opinions and simply listening to what the other has to say — then we have the essence of two-eyed seeing. Moreover, they suggest that if such topics as the health of communities were to be tackled during such "campfire discussions," the same conclusions about health and healing would be reached, but through very different approaches and channels.

Moving beyond the Indigenous knowledge/Western science continuum also presents an opportunity to reflect upon which elements of Indigenous and Western sciences are best suited to addressing the issue at hand — be it a health crisis, a chronic health problem, or a systemic issue that contributes to ill health. Of integral importance are the *critical contributions* that Western sciences have offered Indigenous peoples, and vice-versa. This is not to suggest that Western sciences have not also been the source of much harm, or that such harm should be ignored, but it is important to distinguish among the various epistemologies that inform diverse Western sciences. Too often, criticism of non-Indigenous sciences is rooted in the idea that they are all attached to positivism, at least to some degree. This ignores the myriad holistic approaches to research that are commonly found in the social sciences, as well as those within the natural sciences that embrace the existence of multiple realities (van Eijck, 2007). Reducing Western sciences to those forms that are rooted in positivist or reductionist approaches is incongruent with both current and past Indigenous approaches to knowledge-making and knowledge generation. Aikenhead and Ogawa (2007) argue that criticizing Western science without regard for its diversity not only reduces science to that which is understood through positivist approaches to science, but also under-values the important contributions that Indigenous knowledge has made to science. This contributes to, and one might argue *enhances,* the very reductionist, narrowly conceived arguments that are born of positivist thought.

Two-eyed seeing is not about nursing, specifically, nor even about health singularly. It is intended to apply to life itself. It does not offer new methodologies, nor does it offer ideas about the types of knowledge that it might generate. Rather, it challenges us (Indigenous and non-Indigenous peoples alike) to understand the larger dimensions (physical, social, emotional, spiritual) of our knowledge systems and the limitations and challenges that accompany any single approach to viewing the world. The ultimate challenge is to find new and better ways of doing research in order to create a healthier place for our children and our children's children, for Seven Generations forward. The implications of doing so may not be immediately evident, but, as Albert Marshall points out, even though an ash tree drops its seeds on the ground at the end of each season, if the conditions are not right it may take many seasons for the seed to decide to germinate (Bartlett et al., in press). The same is true when we attempt to "measure" the benefits of approaching health issues using two-eyed seeing; it takes time for Indigenous approaches to health and healing to translate into reduced health inequities, but we must believe that the process we are following will result in a healthier Mother Earth — which will ultimately create a healthier place for us all.

Conclusion

This article has offered a way to re-think how the production of knowledge about Indigenous health is understood. It is by no means conclusive, as learning is a dynamic process. Two-eyed seeing presents both Indigenous and Western perspectives as distinct knowledge systems unto themselves, but as knowledge systems that can offer only a "partial" perspective on reality. When these partial perspectives are viewed together, the result is not a "complete" view of the world but one that is different and that can perhaps offer a new way of thinking about how knowledge is produced, one that could not emerge if we looked through "one eye" only. Thus, it presents a conceptualization of knowledge production that does not rely upon dyadic or dualistic thinking, since each "eye" must continually weave back and forth between its own understandings and those of others, which hold new understandings and opportunities. The "new" perspective gained by seeing through two eyes provides clarity and insight that might help us to understand the health crises experienced by many Indigenous communities.

Two-eyed seeing is a way of drawing upon Indigenous knowledge and non-positivist Western sciences that addresses the needs of the community while not pitting one view against another or favouring one perspective over another. It moves beyond the simple dichotomies of Western sciences and Indigenous knowledges. Through the analogy of two eyes, we learn that no one perspective is ever complete and whole, and that the very creation of dichotomies and dualisms assumes that borders can be drawn between one type of knowledge and another.

By embracing non-positivistic Western perspectives we are upholding one of the guiding principles of two-eyed seeing — that all things are related and share similar issues and concerns, even human beings whose differences may appear vast. As Elder Albert Marshall suggests, we human beings would do well to enact our humility in dealing with the problems and concerns that face us.

> Only when we come to realize that everything we do to the water, the air and the earth, we also ultimately do to ourselves . . . will we treat our environment and ourselves with equal reverence . . . and only with the understanding that all must be maintained and that all must be equal, will we be healthy. This is the path that will lead us to good health and wellness — for humans and all others in our environment and the Earth itself. (Bartlett et al., in press, p. 7)

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Debbie H. Martin, PhD, MA, BRec, is Assistant Professor, Faculty of Health Professions, Dalhousie University, Halifax, Nova Scotia, Canada.

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Résumé

Nos terres, notre langue : les liens entre la dépossession et l’équité en santé dans un contexte autochtone

**Helen J. Brown, Gladys McPherson, Ruby Peterson,
Vera Newman, Barbara Cranmer**

L’entrecroisement des relations coloniales (passées et actuelles) et des politiques et pratiques néolibérales créent des formes subtiles de dépossession qui nuisent à la santé des Autochtones d’aujourd’hui et limitent leur accès à des services de santé appropriés. S’appuyant sur des idées du géographe critique David Harvey, les auteures montrent comment la dépossession des terres et des langues autochtones menace la santé et le bien-être de ces populations, et empirent l’état de santé des Autochtones déjà malades. Compte tenu des constatations qualitatives issues d’un programme de recherche communautaire auprès de la Première Nation de ‘Na̱mg̱is, dans la province de la Colombie-Britannique, les auteures préconisent qu’il soit rendu compte des manières dont fonctionnent les mécanismes néolibéraux pour accroître « l’accumulation par la dépossession » associée au colonialisme historique et actuel. Elles montrent en particulier comment les idéologies néolibérales opèrent pour maintenir le colonialisme médical et les inégalités en santé pour les Autochtones. Enfin, elles discutent de l’incidence des interventions infirmières dans l’atteinte de l’équité en santé dans les collectivités des Premières Nations en milieu rural.

Mots clés : colonialisme, politiques néolibérales, santé des Premières Nations, terres, langue autochtone, équité en santé

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Our Land, Our Language: Connecting Dispossession and Health Equity in an Indigenous Context

Helen J. Brown, Gladys McPherson, Ruby Peterson, Vera Newman, Barbara Cranmer

For contemporary Indigenous people, colonial relations (past and present) intersect with neoliberal policies and practices to create subtle forms of dispossession. These undermine the health of Indigenous peoples and create barriers restricting access to appropriate health services. Integrating insights from the critical geographer David Harvey, the authors demonstrate how the dispossession of land and language threaten health and well-being and worsen existing illness conditions. Drawing on the qualitative findings from a program of community-based research with the 'Na̱mg̱is First Nation in the Canadian province of British Columbia, the authors argue for an account of how neoliberal mechanisms operate to further the "accumulation by dispossession" associated with historical and ongoing colonialism. Specifically, they show how neoliberal ideologies operate to sustain medical colonialism and health inequities for Indigenous peoples. The authors discuss the implications for nursing actions to achieve health equity in rural First Nations communities.

Keywords: colonialism, neoliberalism, First Nations health, cultural identity, land, Indigenous language, health equity

Introduction

Nurses engaged in the public health and primary health care sectors in Canada and elsewhere are increasingly challenged by what is becoming blatantly obvious: that even in a "first world" or industrialized country, access to the material conditions that determine health is inequitably based on gender, race, class, age, ability, and sexual orientation. Among Indigenous people, experiences of trauma, oppression, marginalization, and stigmatization that are easily traceable to colonial relations (both past and present) compound these inequities and further reduce access to health and health care. Poor health, violence, lack of education, and widespread poverty are evidence of and contributors to the many losses experienced by Indigenous people, and are believed by many to be reflections of what Harvey (2006) describes as the dispossession of the many by a powerful few — for Indigenous people this has included deprivation of land, position, and opportunity. Because health is determined by economic, cultural, social, and historical contexts and experiences (Raphael, 2010; Reading, Wien, & National Collaborating Centre for Aboriginal Health, 2010), knowledge about the complex pathways through which particular dispossessions, with their nuances of loss and disconnection, is critical for understanding what creates and sustains inequities in local contexts.

In Canada, nursing claims to have made a professional and ethical commitment to social justice and health equity and the values of fairness and respect that are central to this commitment. For such a commitment to be met, nurses must comprehend and connect particular paths of loss and dispossession for their health effect in efforts to redress inequities. In this article we draw on the findings from a program of community-based research in a rural Aboriginal community to argue for an analysis of how health inequities are worsened by health-care structures and practices that obscure the intersections among loss, dispossession, and health. Integrating Harvey's (2006) analysis of the oppressive effects of neoliberalism through the process of "accumulation by dispossession," we argue for nursing actions that tackle the conditions that contribute to and sustain health inequities for Canadian Aboriginal people. Specifically, we show how the dispossession of land and language create "spaces of exclusion" (Sparke, 2007) that shape the health and well-being of people living in one First Nations rural community in the province of British Columbia. The analysis is discussed in relation to its implications for nurses as they partner with First Nations communities in order to strive for equity.

Health Inequity Among Indigenous People in Canada

In recent decades research has exposed significant health inequities affecting Canada's Indigenous peoples. In comparison to the overall population, Indigenous people are at higher risk for unintentional injuries and accidental death, have considerably higher rates of chronic illness, and have shorter life expectancies (O'Donnell & Wallace, 2011; Reading, 2009). Although these health disparities have been linked to conditions of social and economic marginalization (the social determinants of health), we have a limited understanding of the mechanisms that have created and now sustain these conditions. There is increasing evidence suggesting that the social determinants of health only partially explain these inequities and that the historical trauma and ongoing oppression experienced by Aboriginal peoples must be taken into account (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006; Browne, Smye, & Varcoe, 2005).

Historical relations between the dominant Western society and Indigenous peoples in Canada — relations shaped by the colonization[1] and imperial expansion activities of Western European powers beginning in the 17th century (Castagna & Dei, 2000; Dua, Razack, & Warner, 2005) — led to the displacement of Aboriginal peoples from their lands, erosion of their languages, and disintegration of their social structures (First Peoples' Heritage Langauge and Culture Council, 2010). Values of assimilation and acculturation that characterized 20th-century political agendas resulted in the decimation of traditional healing practices, the introduction of new health risks, and the creation of health-care systems that had no place for holistic understandings of human well-being (Kelm, 2004). Redressing the harms caused by colonization requires an examination of the systems and structures that shape and constrain the lives of Indigenous people — and the ideologies that sustain these systems and structures. Youngblood Henderson (2000) claims that restoring respect for the diverse worldviews, governance, languages, identities, and treaty orders of Indigenous peoples to the supreme law of Canada is not merely a dream but a right enshrined in the Canadian Constitution (Department of Justice Canada, 1982).

Given the magnitude of this challenge, how can nurses seeking to uphold social justice begin to account for and tackle the multiple intersecting causes of health inequities (Weber & Parra-Medina, 2003)? The conditions that sustain inequities are largely structural, embedded in the political and economic organization of our social world and, in many instances, causing injury in people's lives (Farmer, 2003). Among nurses working in primary health care and public health settings, there is a pressing need for practices that address the structural conditions and practice contexts that serve to sustain health inequity. Our research with the 'N̲am̲gis First Nation is generating health interventions to inform such contexts.

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[1] A process that includes geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and the creation of ideological formations around race and skin colour that position the colonizers at a higher evolutionary level than the colonized (Frideres, 1983, pp. 295–296).

Sustaining Mechanisms: Intersections of Colonialism and Capitalism

Hall (2010) reports on the disastrous effects of capitalism on Indigenous peoples:

> The saga of colonialism's ascent and transformation to form the worldwide basis for monopoly capitalism is well recorded. There is extensive documentary evidence to demonstrate empirically the force of this trajectory of commercialized appropriation of colonialism's expansionary machinery. This continuity of warring aggression on imperialism's moving frontiers has never ended in many parts of the world where the ownership and control of natural resources is still heavily contested. (p. 886)

Hall goes on to highlight the strategic importance of the appropriation of Indigenous lands — dispossession not only of land, but also of connections to history and culture, traditional ways of life, and economic opportunities.

The dispossessions, displacements, and disconnections associated with historical colonialism continue. Neoliberalism operates as a colonial tool shaping the lives and health of Canadian Aboriginal peoples. It is a market-driven approach to economic and social policy that stresses the efficiency of private enterprise. Prices, outputs, and income distributions in markets are determined by supply and demand. The prosperity of entrepreneurs is mediated through a hypothesized maximization of utility by income-constrained individuals and of profits, and it depends on disparities between rich and poor (Harvey, 2006). The neoliberal political commitments that dominate contemporary Canadian economic policy have served to continue the oppression and exploitation of First Nations people and their resources. With a central commitment to the well-being of individuals rather than of communities, and to free market capitalism rather than to the sharing of social responsibilities, neoliberal policies and practices maintain the conditions that sustain historical injustice and contemporary forms of colonialism.

These neoliberal commitments to individual well-being and free market capitalism manifest in striking ways in health care. The privilege accorded to Western conceptualizations of the body underlies policies that support acute treatment of physical ailments. Some authors use the term "medical colonialism" to describe the tendency of Western medical practices and conceptions of health to undermine the integrity of Indigenous communities, and, in Kelm's (2004) words, "to disrupt Indigenous social structures as a way of enforcing acculturation" (p. 344).

For this reason, Kelm states, "Health and decolonization . . . go hand in hand" (p. 344). In our work with the 'Na̲mgis people, Elders draw attention to the critical importance of preserving language and sustaining a connection to the land — indicators of health and well-being not generally recognized in Western biomedical traditions.

In the current health-care context, neoliberal ideologies discourage us from addressing threats to cultural integrity and the complexities of historical trauma, and tempt us to interpret health challenges in Aboriginal communities as decontextualized individual problems. As a result, the solid evidence on the social determinants of health has minimal impact on policies and practices, and the place of recovering culture and identity as the "social capital" crucial to improving the health of Indigenous people tends to be absent from health policy and planning priorities (Reading et al., 2010).

Accumulation by Dispossession and Spaces of Exclusion

In describing the consequences of neoliberalism, Harvey (2006) uses the phrase "accumulation by dispossession" to illustrate how political processes such as privatization and deregulation serve to generate prosperity for a few while sustaining inequities for those who have been dispossessed of land or stripped of services. While Harvey's discussion of how capitalism operates to sustain dispossession globally is beyond the scope of this article, we draw on his analysis of how accumulating forms of dispossession may generate equity-oriented health actions for nurses working in partnership with Indigenous communities. That is to say, we take the idea of accumulating forms of dispossession in the lives of Aboriginal people to show how and why particular losses and injustices have significance. Our community research partners frequently remind us how one axis of view — for example, the collapse of the fishing industry — is impactful today precisely because it is interconnected with so many losses that are at once social, cultural, and economic. The ability to see the ways in which multiple and intersecting forms of dispossession accumulate and lead into spaces of deprivation and exclusion may help nurses to comprehend how historical colonial relations take neocolonial forms and are manifested in the health and well-being of Indigenous people today. This perspective brings to light the fact that the people, structures, practices, and policies within health care actually shape and create the spaces where First Nations experience health care. Sparke (2007) claims that any repossession of space for a better world, such as one where health equity can be realized, calls for an examination of "space-making processes and space-framing assumptions" (p. 338). He continues:

> Dispossession, whether political, social, historical, economic, is geographical insofar as it creates spaces of exception: spaces where people can be controlled, tortured, or even killed with impunity because their geographical location is imagined and administered as somehow beyond the reach of justice. (p. 339)

Harvey (2005) is also unequivocal about the harms caused by the economic sequelae of neoliberal policies: "the redistributive tactics of neoliberalism are wide ranging, sophisticated, frequently masked by ideological gambits but devastating for the dignity and social well-being of vulnerable populations and territories" (p. 156). MacDonald (2009) argues that while achieving Indigenous self-governance might *appear* to benefit from neoliberalism's politics of privatization through rejection of state interventions known to undermine Aboriginal autonomy and self-determination, in fact vulnerable populations face

> further domination and exclusion, albeit in newer and less obvious forms, as the traceability of government policy and state accountability are altered in troublesome ways under the "progressive" auspices of accommodation and recognition. (p. 258)

This economic-policy context shifts health policy away from holistic, transformative, and capacity-building approaches known to redress health inequities in local contexts (Hills, LeGrand, & Piachaud, 2002; Raphael, 2010). While Harvey is generally referring to the economic well-being of vulnerable groups, economic well-being is intertwined with physical and social well-being, with effects on communities as well as on individuals. Furthermore, with the impact, both economic and social, of environmental dispossession on Canada's Aboriginal population becoming increasingly apparent, we need to map the linkages between environmental dispossession, cultural identity, and the social determinants of health (Richmond & Ross, 2009). Inequities in colonial contexts can be mitigated only with knowledge of how cumulative and intersecting experiences of dispossession are themselves "space-making" in Aboriginal health and health-care contexts.

Research Program With the 'Na̲mg̲is First Nation

Our program of research with the 'Na̲mg̲is First Nation in Alert Bay, British Columbia, was begun in 2005, with several studies now completed. A study investigating rural Aboriginal maternity care revealed how history, economics, and the loss of traditional practices negatively shape women's birth experiences and outcomes (Brown, Calam, & Varcoe, 2011). Building on these findings, we conducted two subsequent studies on the relationships between history, culture, tradition, and health and health experiences, then using these insights to map health services, policies, and practices that take account of the inseparability of culture and health. An intervention study is currently implementing local know-how for community health actions across areas, from youth mental health, to chronic illness care, to Elder social support. Theorizing on our findings to inform our ongoing work leads to new questions. The present theoretical analysis draws on the qualitative findings and health action research while also informing studies with other rural and semi-urban First Nations communities in British Columbia.

All of our studies are conducted using a community-based participatory research design. Community-based researchers and a community advisory committee develop the research questions, refine the data-collection methods, and guide the analysis and knowledge-dissemination strategies. We have three broad research goals: (1) investigating the connections between culture and Indigenous knowledge and health, (2) eliciting and recording cultural knowledge identified as essential to health-promotion programs and services, and (3) opening spaces for bringing community voices into dialogue with health leaders. Informed by postcolonial theory (taking a critical view of past and ongoing effects of colonialism) and Indigenous knowledge (framing the research based on local knowledge, history, culture, and meaningful life-ways), we work as community and academic partners committed to safety and inclusion. Our primary data sources are individual interviews, focus groups, and engagement with community members during local events and celebrations. A documentary film (Cranmer, 2008) has been produced to share oral and visual data for the purpose of knowledge dissemination within and beyond the community. Our analysis process is led by community leaders, researchers, and advisory members who bring Indigenous knowledge to the coding and interpretation of the data.

Dispossession of Land and Language

> *History matters. Throughout history our people have been challenged by outside forces, government, religious institutions and residential schools that almost took our identity away. At present we are bringing back all that was almost lost. We will achieve our greatest health and potential when we can live fully and thrive holistically as a community with our language, culture and potlatch system in place.* ('N̲am̲g̲is Elder)

Like many First Nations communities in Canada, the ‘Na̱mg̱is people living in a rural community in British Columbia have felt the effects of historical and contemporary social, economic, and political forces on their everyday health and well-being. In our research, two interconnected pathways of dispossession have become evident in the accounts of ‘Na̱mg̱is participants. *Uncertain identity* and *displaced connections* each undermine well-being and health equity. These pathways of dispossession accumulate in ways that have a greater impact than either path alone and, when understood within the context of neoliberal ideology and medical colonialism, indicate how nurses can participate in various forms of “repossession” that might contribute to health equity.

Dispossession of Language: Uncertain Identity

In the findings, Indigenous language emerges not only as a means of communicating but also — and more importantly — as an expression of cultural identity: defining all that is important in the past, present, and future. Being dispossessed of language creates the risk of, as Schouls (2003) puts it, being “washed out in a sea of undifferentiated Canadian citizenship” (p. 45). Preserving uniqueness through language and culture is seen to be both restorative and constitutive of identity. Speaking the language is a form of restoring, preserving, and creating identity amidst the dispossessions caused by historical patterns of Western political and cultural hegemony.

In various ways, Elder participants in our studies express how the preservation of Kwak’wala language serves two essential purposes: It is a medium for the transmission of cultural knowledge, and it is an expression of connections and relationships that constitute cultural history and identity. Elders associate the decline of Kwak’wala language with assimilationist policies and the legacy of residential schools, where “we were punished for being Indian . . . stripped of our language, our dances, our identity.”

> *Not speaking my language and being ashamed of who I was did not end when they closed the school. I did not want anyone to know I was Indian then and for a long time . . . I used to tell my granny, “Don’t tell me anything.” It took me over 20 years since I left residential school to get back to feeling empowered, to wanting to know and speak who I am.*

This profound loss of identity and sense of belonging, of displacement and dispossession, is echoed in the words of many of the participants in the studies. Elders indicate that being unable to speak the language has undermined, if not extinguished, the primary mode through which culture is kept alive and history is passed on. The threatened sustainability of the language is understood by the Elders as present-day colonialism. In their quest to embrace cultural identity, many youths describe a yearning to revive and sustain the Kwak'wala language. Youths in particular say that when language and identity are discussed only in a historical context — which they may or may not relate to — then culture becomes a source of exclusion rather than a "warm blanket that wraps around you" (Elder participant). Yet when youths share their views on culture, they indicate that speaking the language is a way of expressing identity, of learning from the past to live in today's world. Language and identity are in this sense less about differentiating Aboriginal from non-Aboriginal people and more about gaining a contemporary feeling of value and self-worth. One youth gives this advice: "Go out and learn about the culture and the language, it will help you be proud . . . just go and do it, you won't regret it."

In all of our studies, being dispossessed of language is understood as threatening cultural identity, resulting in uncertainty about the past, present, and future. One Elder states that without language "we are a throwaway society," while a younger participant says that "without language the expression of our Nativeness is threatened, and that means, even today, the residential school legacy continues to destroy who we are and what is among us." An Elder describes the ongoing health effects of the dispossession of language, and the great potential when language is revived:

> *People live here with their heads hanging low, not knowing who they are, where they have come from, and who they can be. Speaking Kwak'wala is and can still be a medium for knowing that. Even for our young people it can be a medium . . . to learn about who they are and who they can be, because culture and how we see ourselves never stays the same.*

Elders make references to the "almost" successful assimilation policies and residential school legacy. Speaking the language and dancing the dances are described as forms of cultural revitalization and its expression in contemporary times. These positive and vibrant forms of expression build community connections that are known to be protective factors against a range of negative forces, such as unemployment, chronic pain, social isolation, and substance use and mental health issues. With the dwindling number of traditional knowledge holders and fluent speakers in the community, efforts to revitalize and preserve the language are constantly challenged by a lack of time and material resources.

Being dispossessed of language means far more than lacking a communicative form. It is a symbol of and a vehicle for experiencing connections fundamental to being 'Na̱mg̱is, a *being* expressed through dances, ceremonies, legends, and relationships with the creator, family, other relatives, and the community. The passing on of traditional knowledge and ensuring its many forms of expression rests on "knowing our language" as central to every expression of cultural identity. Elders understand language revitalization to be the essential medium for "knowing who you are, where you come from and where you are going" and to be fundamentally connected to health:

> *Our language is our culture; it is the medium, or the form, or the process, that allows us to give full expression to who we are, mentally, physically, spiritually, collectively, as friends and family, individually, historically [and] looking forward. It's the only medium we have that can do that. As long as we have our mind-set we're not going to be struggling with Western concepts [like] what's right or wrong. The creator never intended that to be the way it is. We're Kwakwaka'wakw and he gave us laws that are spiritual, that will sustain us through time. We will be the healthiest when we can give expression to that.*

Participants describe how the decline of language when constructed as "inevitable" obscures the effects of historical colonialism, particularly church- and state-run residential schools. Portrayals of minority languages in the Canadian media as "threatened" due to, in the case of Indigenous peoples, the dwindling numbers of fluent speakers as a natural consequence of aging can be understood as a present-day form of colonialism. One Elder says that the term "lost language" fundamentally obscures the role that church- and government-run residential schools played in trying to "get the Indian out of us, when we were punished for speaking our language." Other participants speak of how the intentional subjugation of "being Native" is continually subverted today through referring to Aboriginal languages as "vanishing." Our data indicate that particular discourses obscure our view of these pathways of dispossession, leaving us more simplistic explanations of the ability of First Nations peoples to preserve their own languages. The very conditions of dispossession are playing out today, in that resources and initiatives for Kwak'wala language preservation are not systematic and sustained but are reliant on committed volunteers and imaginative educators in the Band school. Volunteers and educators strive to ensure that language is a mechanism for preserving, sharing, and evolving traditional knowledge and culture, yet such efforts are sustained primarily by personal resources.

Dispossession of Land: Displacement and Disconnection

As language is understood to be both a communicative pattern and an expression of cultural identity, connections to the land are seen as fundamental to Indigenous knowledge systems and ways of living and relating (Greenwood & de Leeuw, 2009). In each study, participants have indicated that being dispossessed of language and land together undermine the connections that nourish people and the conditions necessary for "holding our heads high." As children were removed from home territories during the residential school era and, later, commercial fishing licences were lost to market forces, small villages were abandoned and few 'Na̱mg̱is people now live in their traditional territories. The impact of living away from home territories is described by one participant as "undermining sacred connections that nourish the relationship between the people and their land, between the past and present, and between one and another." Going back to home territory is a form of repossession that continues the tradition of being "stewards of the land."

Young participants and Elders describe oneness with the land, a sacred connection that cannot be translated into English. They say that separateness from the land has never existed despite state policies and practices based on Eurocentric conceptions of Mother Earth. Where non-Aboriginal references to Mother Earth are metaphorical, participants in our studies describe Native territories in existential terms, as fundamental to and inseparable from being. Being "one with the land" suggests a profound physical and spiritual connection, a connection that constitutes life itself. Displacement from ancestral lands, villages, or territories causes disconnections from conditions and relationships that are fundamental to being and creation:

> *When DIA [Department of Indian Affairs] decided to ship us all here, everybody now thinks they're Nimpkish, but they're not. It is important that you know your history and your territory, because when we got told where to go, there was so much lost, like a piece of you who are dies too, not living in the territory that is home.*

Through connections with the land, there a process of continual creation; creation and being are intertwined, and being one with the land confers responsibilities and obligations regarding the maintenance of creation:

> *There is a much larger and richer context to being connected to the land. To be one with your territory means you were never separate from it in the first place. Culture is learned through a lifetime of personal experience travelling through and conducting ceremonies on the land. We can only continue to teach, develop, and renew knowledge systems fully by our own means of cultural sharing and experiencing. Our ceremonies renew our relationships with the land; we become stewards of the land, so we can*

> *never be detached geographically or use our ceremonies elsewhere without completely losing their meaning.*

Clearly, the relationship with the land entails not simply the physical geography of the land: It is a direct and personal kinship with the animal and plant species that co-exist with humans in the territory. In one of our studies, a practitioner and student of traditional medicine described her work harvesting medicinal plants. This involved visiting the plants, praying with them, and, through ceremonies, helping them. Knowledge of ecology and the use of plants, rituals, and medicine are intertwined, and together they create "oneness" with the land.

Related to the displacement and disconnection from traditional territory is an understanding that being in one's home territory is better for one's health. Several Elders associate displacement and the reserve system as severing spiritual connections that affect the procurement of traditional foods and the diet that today is associated with poor health:

> *I think back to when we lived in Karleqwes. You know, we lived off the land . . . we had all the fresh salmon, clams, mussels, crabs, fresh deer when the season would come around. Now I found out that when we moved out of Karleqwes it's the first time that I really got sick, and, you know, could never understand why I was going through all that as a kid. The doctors couldn't do anything. Mom did everything to get me better, and the funny thing too is that when I first came out here I couldn't eat hamburger or beef and I couldn't eat Kraft dinner [laughing], but I found that if we could make use of our old village and just go back there and do our harvesting and stuff like that . . .*

The connection to traditional territory "bonds the community together," in the words of one participant. Youth in particular speak of the importance of going into the territory to "find out who you are and where you come from." Being displaced from traditional territories dismisses the importance, throughout history, of engaging with the land as a "living classroom," as the ancestors would have. Participants in all of the studies explain that being assigned land in the reserve systems undermines the very connections to land that are meaningful — being connected to the land is very different from being *assigned* land:

> *Reserve systems do not honour the nomadic history of our people. We never stayed in one place. We had our summer home, our spring home, our winter home. Remember the flood in Kingcombe? The medical people said, "Why don't they just move?" They couldn't. It was their seasonal land, their territory — and that connection is sacred. Telling us, "There is your*

> *land" is not our way. Meaningful connection to the specific land is not honoured in the reserve system.*

When considering the social and material conditions under which health equities are produced and reproduced, these particular experiences of disconnection and displacement can be seen as barriers to the social inclusion and identity that are known to optimize health and well-being. One Elder's phrase "heads hanging low" is symbolic of what another describes as "poverty of the soul," which threatens health equity across diverse illness and disease categories. Language, cultural strength, and connections with ancestral territories have a central place in sustaining well-being:

> *To me, the land is culture. We know the land. We should be able to connect the land with everything healthy for our people. We are stewards of what we have been given, and we have to look after it. That should be the starting point and not a separate conversation when we plan to make us healthier as a First People.*

Health Equity Through Geographies of Repossession and Spaces of Inclusion

Despite Canada's leadership in the field of population health, there have been few successes in this country in reducing health and health-care inequities for Indigenous people, and on many fronts the inequities are worsening. Despite the progress made, wide gaps remain in understanding fully the root causes of inequities, including the complex ways in which the determinants of health relate, intersect, and reinforce one another. While it is well established that experiences of social exclusion contribute to poor health and health inequities (Hills, Le Grand, & Piachaud, 2002), there remains the question of how connections to land and language specifically shape identity and cultural strength to foster the social inclusion that is foundational to health and health equity. From a policy perspective, White and Maxim (2003) argue that particularities of the history, culture, and geography of Aboriginal communities in Canada contribute to different population outcomes, with different social and physical resources interacting and affecting the health and cohesion of these collectivities.

The 'Na̱mg̱is participants indicate that dispossession of land and language impact on health and well-being through particular pathways of uncertainty, identity, and displacement and disconnection. These pathways of dispossession suggest the urgent need for attention to the social and political forces that sustain the patterns of relating and access to the resources necessary for human flourishing — particularly with respect to land and language. The neocolonial context of health and health-care inequities is both situated in and constituted through the neoliberal tendency to ignore social, cultural, traditional, and ecological considerations, giving way to a "mentality of plundering" (Sparke, 2007). In other words, to better understand and respond to the "foundational" causes of illness and disease and ensure equitable access to both health care and the conditions and contexts that determine health, we must include in our scope of activity those public health actions that sustain the identities and connections that are fundamental to *being* Indigenous. Cultural identity and connections to space and place are not objects of utilization, nor are they reducible to determinants of health; they are aspects of being that can be rendered invisible when individualism, efficiency, and the free market are given more weight, in our policies and practices, than connection and possession (Harvey, 2006).

Scholars and researchers in the field of Aboriginal linguistics are debating the relative benefits of language propagation. One of the arguments against the preservation of Indigenous languages is based on an economic analysis: cost-benefit (O'Sullivan, 2003). Some suggest that language recovery and preservation may have the effect of "ghettoizing" Aboriginal communities. O'Sullivan describes a spectrum of perspectives, citing several studies that claim that Aboriginal language preservation plays a role in lowered community moral, decreased human capital, lowered socio-economic status, and non-participation in the labour force. Social "progress" is considered under threat due to the preservation of minority languages. Yet, considering the connections between language, identity, cultural strength, and "holding our heads higher" made in our studies, new determinants of health may supplant those centred on capital accumulation as foundational to well-being. Our findings indicate that kinship, connection, oneness, and attachment as forms of being are the "capital" necessary for health.

Sparke (2007) discusses neoliberalism and accumulation of dispossession:

> . . . new human and nonhuman geographies delineated and organized on the basis of the capitalist market — yet it is a form of dispossession that is frequently dependent on extra-economic forms of violence — such as the often racially targeted violence of state interventions — for its own impetus and organization. (p. 346)

Because language is fundamental to social identity, a kind of violence is sustained when language decline is constructed as "inevitable" or when its value is judged solely in neoliberal economic terms. The basis upon which productivity is generally determined obscures the fundamental injustices inflicted in the name of "progress," rendering invisible the conditions and roots of language decline. We argue that such analyses of language "retention" processes are driven by neoliberal ideology that fundamentally limits access to the conditions and contexts known to contribute to human flourishing and health equity. Harvey (2006) claims that accumulation of dispossession creates mechanisms of creative destruction that produce and reproduce what Sparke describes as "spaces of exclusion and exceptions . . . that are the result of the reimposition of architectures of enmity that have deep colonial foundations" (Sparke, p. 346). In our studies, Elders in particular explain that being dispossessed of language, identity, and connections to original territories has accumulated to influence the cohesion and connections that are fundamental to optimal health. In one study a woman reported that she was viewed as a "less than capable second-rate citizen at the doorstep of health-care facilities," adding that uncertain identity, displacement, and disconnection serve to reduce the strength and ability of the 'Na̱mg̱is to counter the alienation and degradation of people who are considered undeserving of health care. Our analysis supports the valuing of connections to language and land as an essential form of repossession tightly intertwined with human health. The possession of language and land creates spaces for the expression of identity and the experience of connections. These specific pathways of social inclusion create a very different form of human capital necessary for equity in health and health-care access for Indigenous people.

Implications for Nursing Action

Our analysis supports nursing action oriented towards dismantling the "spaces of exception" produced by colonialism, both past and present, and contemporary neoliberal forms of dispossession. By resisting the "naturalization" of language decline and disconnection from traditional territories, nurses can orient their actions towards creating opportunities for repossession as a fundamental dimension of health-promoting care for Indigenous people. Nurses can denaturalize "losses" through colonization and can engage with Indigenous people, knowing how dispossession causes disconnection and oppression and contributes to health and health-care inequities. Curiosity about the connections between identity, land, language, and health could be understood as a useful component of health assessment. There are opportunities to learn about the meaning and power of culture for Indigenous persons. For example, one can elicit their life-stories by asking basic questions: Where do you come from? Is this your territory? Did you grow up in your territory? Nurses can honour connections by knowing the name of the language spoken, learning something about the territories they are working within, and being aware of the Nation to which the traditional land belongs. Nurses may have opportunities to partner with Elders and leaders in order to learn how ongoing forms of dispossession contribute to serious health issues in the community. For example, in our current project, a lack of access to affordable healthy food and low levels of medication adherence have been associated with poor management of diabetes. When devising strategies to improve adherence, community health representatives (CHRs)[2] recognize that social isolation and the lack of access to traditional foods are also playing a role. The CHRs are devising a Kwak'wala immersion program that will bring people with chronic conditions together, tap the strengths of culture and traditional foods for improved medication self-management, and integrate the language into medication pictograms. Working with 'N̲amg̲is youth, nurses are partnering with cultural leaders to bring these young people to traditional territories for cultural immersion as the basis for a self-esteem program.

If dimensions of the "social" are constituted through cultural identity and connections to the land, then the scope of nursing action directed towards increasing access to the social determinants of health will necessarily expand. By working with community members and cultural leaders, nurses can partner to create the *spaces of repossession* that are fundamental to experiences and contexts for achieving health and health-care equity. A 'N̲amg̲is Elder reminds us why this is so:

> *That is one reason why not only we but the entire world must do everything possible to keep these languages, songs, dances, and stories alive. If they die, our people and our children — and the human race — will lose something that no one can ever recover. Our languages, celebrations, and traditions define who we are, and they keep our heritages alive.*

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[2] According to the National Indian and Inuit Community Health Representatives Organization (Hammond & Collins, 2007), the primary role of the CHR in Canada relates to the promotion of wellness, the protection of health, and the prevention of injury and illness. CHRs help individuals, families, and groups of people in the community to take responsibility for their own health; they work with health-care teams to improve and maintain the spiritual, physical, intellectual, social, and emotional well-being of individuals, families, and the community. CHRs have become the gateway to health services in First Nations communities; they educate non-First Nations professionals in cultural protocols, the family history of the membership, the political process, and other important areas related to the community.

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Helen J. Brown, RN, PhD, is Assistant Professor, School of Nursing, University of British Columbia, Vancouver, Canada. Gladys McPherson, RN, PhD, is Assistant Professor, School of Nursing, University of British Columbia. Ruby Peterson, BSW, MEd, is a member of the ‘Na̱mg̱is First Nation. Vera Newman is a member of the ‘Na̱mg̱is First Nation. Barbara Cranmer is a member of the ‘Na̱mg̱is First Nation.

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Résumé

Des récits de vie autochtones constituant des récits sur la santé et la résistance : une analyse narrative dialogique

Bodil Hansen Blix, Torunn Hamran, Hans Ketil Normann

Dans le passé, les Sami ont été exposés à d'importants processus d'assimilation. La présente étude visait à explorer les expériences de personnes âgées sami en matière de santé. Au total, 19 aînés sami vivant en Norvège ont été interviewés. Le présent article constitue une analyse narrative dialogique des récits de vie de trois femmes du peuple sami. Les histoires de vie sont perçues comme des récits sur la santé et la résistance. La théorie postcoloniale procure un cadre pour comprendre l'incidence des facteurs historiques et socio-économiques sur la vie et la santé de ce peuple. Les récits de résistance montrent que les gens ne sont pas des victimes passives de l'héritage du colonialisme. La résistance n'est pas un état passif, mais un processus actif, tout comme la santé. La résistance constitue une ressource dont les services de santé devraient être conscients, tant au niveau systémique, par exemple le partenariat avec les aînés autochtones dans la planification et l'établissement des services, que dans les relations individuelles entre les patients et les fournisseurs de soins de santé.

Mots clés : Sami, santé, résistance, théorie postcoloniale, Norvège

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Indigenous Life Stories as Narratives of Health and Resistance: A Dialogical Narrative Analysis

Bodil Hansen Blix, Torunn Hamran, Hans Ketil Normann

The Sami people have historically been exposed to severe assimilation processes. The objective of this study was to explore elderly Samis' experiences of health. A total of 19 elderly Sami individuals in Norway were interviewed. This article is a dialogical narrative analysis of the life stories of 3 Sami women. The life stories are perceived as narratives of health and resistance. Postcolonial theory provides a framework for understanding the impact of historical and socio-economic factors in people's lives and health. Narratives of resistance demonstrate that people are not passive victims of the legacy of colonialism. Resistance is not a passive state but an active process, as is health. Resistance is a resource that should be appreciated by health services, both at a systemic level — for example, through partnership with Indigenous elderly in the planning and shaping of services — and in individual encounters between patients and health-care providers.

Keywords Indigenous people, Sami, health, resistance, postcolonial theory, narrative inquiry, Norway

Introduction

While conducting research in the field of Indigenous people and health, one frequently encounters a distinct tendency in the research and theoretical literature: the view that "cultural competence" is of great significance in the interactions between health-care providers and "minority patients." This view is described as an emerging "mantra of contemporary nursing practice" (Dreher & MacNaughton, 2002, p. 181). Over the last decades, matters of culture, health, and health care have been discussed extensively (cf. Vandenberg, 2010). The focus on cultural competence is also reflected in various government documents (e.g., Joint Commission on Hospital Accreditation, 2008; Office of Minority Health, 2001; Romanow, 2002) and in the education of health-care providers (Like, 2011; Mancuso, 2011; Office of Minority Health, 2002; Ring, Nyquist, & Mitchell, 2008). In our opinion, the focus on cultural competence is too narrow and has several implications. Culture appears to be perceived as relevant only to people who are different from the majority. Furthermore, the focus on culture might divert attention away from the broader historical and social contexts that influence people's health and their experiences of health services.

This article is based on a qualitative study of elderly Sami individuals' experiences of aging, health, and illness. Through the presentation and discussion of the life stories of three elderly Sami women, we illuminate how the history of colonization is present in elderly women's lives and impacts their health experiences. The three women, while telling their stories, actively engage with the impact of history on their lives and their health. We argue that an acknowledgement of health as an active engagement with history renders the focus on "cultural competence" in health care too narrow. We begin with a brief description of the Sami and some significant events in their history within the Norwegian national state. This is followed by a review of the research literature on the Sami and their health issues. We next present some central key concepts, including life story, health, postcolonial theory, and narratives of resistance. This is followed by a description of our research method and methodological considerations. Then we present and discuss the life stories of the three Sami women. We argue that understanding health as a condition of subjectivity and as influenced by broader historical and social contexts is essential to gaining a richer understanding of the health of Indigenous people.

The Sami

The Sami are an Indigenous people living in Norway, Sweden, Finland, and Russia. The Sami population is estimated to be between 50,000 and 80,000 (Sámi Instituhtta, 2008). The majority of Sami live in Norway; Statistics Norway (2010) estimates the Sami population of Norway to be 40,000. Historically, the Sami were reindeer herders, small-scale farmers, and fishermen. Today, approximately 10% of the Sami in Norway are engaged in the traditional ways of living (Statistics Norway, 2010). A 2000 report by the Sami Language Council estimated that there are approximately 25,000 Sami-speaking persons in Norway (Ministry of Local Government and Regional Development, 2001).

National governments have made strong efforts to assimilate the Sami into the majority population. In Norway, the process of assimilation, frequently referred to as "Norwegianization," lasted from 1850 to approximately 1980. According to the *Land Act* of 1902, property could be transferred only to Norwegian citizens (i.e., persons able to speak, read, and write Norwegian), and proficiency in the Norwegian language continued to be a criterion for buying or leasing state land until the 1940s. The Sami language was prohibited in Norwegian schools from 1860 to 1959.

Residential schools were important arenas for the Norwegianization of Sami children. The assimilation process was paralleled by individual experiences of stigmatization and discrimination (Minde, 2003).

During the 1950s a growing Sami movement initiated a process of ethnic and cultural revitalization. The establishment of general education based on the Sami language and culture was of great importance to the Sami movement (Eidheim, 1997). The 1970s and 1980s witnessed the "aboriginalization of Sami ethnopolitics and self-understanding" (Eidheim, 1992; Thuen, 1995). The Sami movement established contact with organizations representing Indigenous people in other parts of the world. The raising of Norway's living standards and general improvements in its welfare and health-care systems during the 1960s and 1970s contributed to the process of ethnic revitalization.

The public assimilation policy culminated in 1980 with "the Alta affair," whereby the Norwegian state decided to dam the Alta-Kautokeino river despite considerable protest by the Sami, who argued that this would threaten the grazing and calving areas used by the reindeer-herding Sami. The dispute brought national and international attention to the rights of the Sami. The *Sami Act* (Ministry of Government Administration Reform and Church Affairs, 1987), enacted in 1989, enabled the Sami people in Norway to safeguard and develop their language, culture, and way of life. In 1989 a Sami Parliament was established and in 1990 the Norwegian government ratified International Labour Organisation Convention 169 (*Indigenous and Tribal Peoples Convention Concerning Indigenous and Tribal Peoples in Independent Countries*).

In many communities, especially those outside the "Sami core area," the differences between the Sami and Norwegians are not always obvious (Kramvig, 2005; Olsen, 2010). The coastal Sami population have been greatly affected by assimilation and stigmatization. In coastal areas, fewer people speak the Sami language and many people might not identify with symbolic expressions of a collective Sami cultural heritage. To some people in these areas, "Saminess" is associated with the distant past and of little relevance to their everyday lives (Gaski, 2008; Olsen, 2010). Today's elderly Sami have lived their lives in this atmosphere of tension between assimilation, revitalization, and ambiguity. Considering the history of assimilation, stigmatization, and discrimination, it is reasonable to assume that the contesting of Sami heritage throughout the course of a lifetime might affect one's health and well-being in old age. As noted by Minde (2003), "'the Sami pain' . . . may have been widespread among those who were in opposition, but probably even more deep-felt and traumatic among those who tried most eagerly to adapt to the assimilation pressure" (p. 141).

Literature Review

Research on health issues among the Sami has been primarily quantitative, and results for the Sami are often compared with those for the majority population. The focus has been on health behaviour (e.g., Spein, 2008; Spein, Sexton, & Kvernmo, 2004), risk for disease (e.g., Hassler, 2005; Nystad et al., 2008), and causes of death (Hassler, Johansson, Sjölander, Grönberg, & Damber, 2005). Research suggests that the Sami do not face the same health-related challenges as Indigenous people in Canada, the United States, Russia, or Greenland (Symon & Wilson, 2009). Many health problems experienced by Indigenous people in the circumpolar region, such as increased risk for diabetes, cardiovascular diseases, infectious diseases, and lung cancer, are not prevalent among the Sami (Hassler, Kvernmo, & Kozlov, 2008). Life expectancy at birth is virtually the same for Sami and non-Sami people, and mortality rates for specific causes are similar (Brustad, Pettersen, Melhus, & Lund, 2009; Hassler et al., 2005). Some researchers (e.g., Gaski, Melhus, Deraas, & Førde, 2011) have attributed the apparent absence of health differences between the Sami and the Norwegian population to the assimilation process, as though health equity were a positive side effect of assimilation. We believe that the causal relations are more complex. In Norway, health services are largely public, which might contribute to higher levels of access to health services than in other countries (Hassler et al., 2008), and living standards are generally high.

Regardless of statistics showing an absence of health differences between the Sami and the majority population, research has identified several health-related challenges. Sami-speaking patients are less satisfied than other patients with the services provided by municipal general practitioners (Nystad, Melhus, & Lund, 2008), and a study of mental health care found that Sami patients were less satisfied with treatment, contact with staff, and treatment alliance than Norwegian patients (Sørlie & Nergaard, 2005). Self-reported health is poorer for the Sami than for the Norwegian majority population. This difference is most significant in Sami women living outside the Sami core area (Hansen, Melhus, & Lund, 2010). Sami individuals are more likely to experience discrimination and bullying than the general population in Norway (Hansen, Melhus, Høgmo, & Lund, 2008), and discrimination is closely associated with elevated levels of psychological distress (Hansen & Sørlie, 2012). These findings suggest that merely looking at statistics for life expectancy, mortality rates, and disease incidence may be insufficient when grappling with health and health-care issues among Sami people.

With the exception of quantitative measures of self-reported health as "poor," "not very good," "good," and "very good" (Hansen et al., 2010), we found no studies exploring experiences of health among Sami people. In the present study, we explore the life stories of elderly Sami as sources of insight regarding their perceptions of health. Frank (2006) states, "People understand themselves as selves through the stories they tell and the stories they feel part of. Stories about *health* are, sooner or later, stories about the contemporary shaping of that particular human aspiration, being a *healthy self*" (p. 434; original italics).

Life Stories, Health, Postcolonial Theory, and Narratives of Resistance

In the present study, we defined life stories as the stories people tell about their lives in the context of the qualitative research interview. The plural form, "stories," was used intentionally, to emphasize both that an individual has many life stories and that the stories he or she tells do not necessarily constitute one continuous and coherent *life history*. A dialogical perspective, such as the one chosen for this study, opens the possibility of multiple truths about lives. Riessman (2008) reminds us that "we revise and edit the remembered past to square with our identities in the present" and that "stories must always be considered in context, for storytelling occurs at a historical moment with its circulating discourses and power relations" (p. 8). In the present study, this plurality of truths and stories is not considered a problem but rather is seen as an opportunity for deeper understanding.

According to the philosopher van Hooft (1997), health is an experience and a condition of subjectivity, which he defines as "the pre-intentional activity of constituting oneself as a self" (p. 24). The material dimension of health refers to all of the processes of an organism that are necessary for biological life, such as respiration, circulation, and metabolism. The pragmatic dimension of health comprises everyday practical concerns and the activities in which we engage. The conative dimension of health concerns our "reaching out of subjectivity towards the world and others" (van Hooft, 1997, p. 25) through care and desire. Finally, the integrative dimension of health entails striving for meaning, the "need to give our lives a structure analogous to the narrative form of a history" (p. 26). The notion of health espoused by van Hooft as a condition of subjectivity justifies an interest in life stories as sources of insight into perceptions of health. Life stories reflect all four of his dimensions of health, the integrative being the most obvious. In addition to providing life structure, life stories are *about* something: everyday life, care, and desire. Furthermore, life stories are embodied; they are about bodies and are told through bodies. However, research suggests that health inequities between "ethnic" or "cultural" groups are largely the consequence of socio-economic differences (Ahmed, Mohammed, & Williams, 2007). By focusing exclusively on health as a condition of subjectivity, we risk ignoring the impact of historical, social, political, and economic factors on people's health.

Postcolonial theory provides a framework for understanding how people's health is closely related to historical, social, political, and economic factors. Browne (2005) sums up postcolonial theory as "a body of critical perspectives that share a political and social concern about the legacy of colonialism, and how this legacy shapes relations at the individual, institutional, and societal levels" (p. 69). Critics of postcolonial theory point to a tendency to focus on the presumed shared experiences of colonization among group members and a tendency to overlook the agency of "the oppressed" (cf. Browne, Smye, & Varcoe, 2005). In the present study, however, we focus on the agency of "the oppressed" by studying the life stories of elderly Sami. Based on the material presented, we argue that there is no contradiction in perceiving the elderly Sami as active and engaged while simultaneously acknowledging the impact of a history of colonization on their lives. Several scholars (e.g., Mishler, 2005; Stone-Mediatore, 2003) have advocated for considering "marginal experience narratives" that might function as *narratives of resistance*. Stone-Mediatore (2003) argues that stories of marginalized people "precisely by virtue of their artful and engaged elements, can respond to the inchoate, contradictory, unpredictable aspects of historical experience and can thereby destabilize ossified truths and foster critical inquiry into the uncertainties and complexities of historical life" (p. 9). We believe that the stories presented in this article can be regarded as narratives of resistance.

Methods

Participants and Recruitment

The 19 participants in the study (11 women and 8 men) were between 68 and 96 years of age, considered themselves Sami, and were experiencing various health problems. Of the 19 participants, 1 lived in a nursing home, 3 lived in assisted living facilities, and 15 lived in their own homes with or without help from home care services. The participants lived in two municipalities in the two northernmost counties of Norway. Both municipalities have ethnic composite populations. One municipality is part of the Sami core area and a considerable proportion of its population is Sami. The other municipality is not considered part of the Sami core area and only a small minority of its population is Sami.

The participants were recruited in two ways: through managers of local nursing homes and home care services, and through local seniors' associations. Information letters written in both Sami and Norwegian were distributed, and people interested in learning about the study and possibly participating sent letters of consent in postage-paid envelopes. After receiving the letters of consent, we contacted the individuals to provide additional information about the study and to make appointments for interviews. Initially, 22 people agreed to participate; 3 were excluded due to doubts about their ability to provide informed consent.

Interviews

A thematic interview guide was used. All of the interviews began with the interviewer inviting the interviewee to talk about her or his life in the manner of her or his choosing. The interviewer took care not to interrupt the stories, but the interviewees varied in the manner in which they told their stories. Some participants spoke continuously without solicitation; others needed assistance, including more or less specific probes to help them continue with their stories. The interviews moved thematically back and forth between stories about the past, reflections on the present, and thoughts about the future.

The interviews were conducted either in the interviewee's home or in the nursing home/assisted living facility where the interviewee resided. The interviews lasted between 45 and 150 minutes and were digitally audiorecorded.

Ethics

The study was approved by the Regional Committee for Medical Research Ethics. The participants were limited to persons capable of providing informed consent. The participants were informed of their right to withdraw from the study without stating a reason and were assured of confidentiality.

All interviews were conducted in the Norwegian language. Sami was the first language for all interviewees from the Sami core area and for one interviewee from outside the Sami core area. Norwegian was the first language for nine of the interviewees from outside the Sami core area. Seven of the Sami-speaking interviewees reported speaking Norwegian fluently and maintained that it was not problematic for them to be interviewed in Norwegian. However, three of the Sami-speaking interviewees did voice concerns about whether they would be able to express themselves satisfactorily in Norwegian. These concerns were expressed when the interviewer, upon receiving the letter of consent, made contact to set up the interview. The interviewer then offered to use an interpreter, but the interviewees all chose to do the interviews in Norwegian. We realize, in retrospect, that the interviewer should have offered to use an interpreter in *all* interviews with Sami-speaking interviewees. We have reflected on how interviews not conducted in the first language of the interviewees may have affected the material. This shortcoming may have influenced *how* the interviewees told their stories, because one's first language is usually richer in detail and nuance than languages acquired later in life. It may also have influenced *what* was related in the interviews. A Norwegian-speaking interviewer might be perceived as a representative of the majority society, which in turn might contribute to any distancing between the interviewer and the interviewee. Before the interviews, we were concerned that this perception would keep the interviewee from addressing issues such as assimilation and minority experiences. While this may have been so, interview material rich with descriptions and stories concerning these issues suggests that it may not have had a significant impact. The transcriptions indicate a clear willingness among the interviewees to share their life stories. During or after the interviews, all of the participants expressed appreciation for being interviewed on this matter.

Dialogical Narrative Analysis

The audiorecordings were transcribed verbatim. Field notes were recorded and were used at several stages in the research process. Following transcription, the tapes were replayed, the transcribed texts were reread to allow the researcher to become reacquainted with the material, and summaries of all interviews were written. We then began to search the transcriptions for stories. The interviewer noticed some stories during the interviews, and some stories became evident during the transcription process. However, more subtle stories, some amounting to only a few sentences, were revealed through this purposeful reading. As noted by Riessman (2008), the stories in a text often do not have clear-cut "borders," and the researcher participates in the creation of stories, rather than "finding" them in the interviews, by deciding what to present as stories.

In the present study, the stories were created in the context of the qualitative research interview and should be considered neither as direct representations of historical events nor as direct reflections of the identities of the participants. Stories are "acts of engagement with researchers" (Frank, 2005, p. 968) and are intended for particular recipients (Riessman, 2008). The stories developed from the dialogue between the interviewer and the interviewee. This dialogue continued into the analysis.

Given the nature of the study — exploring the health experiences of elderly Sami individuals through the stories they tell about their lives — a dialogical narrative analysis, as suggested by Frank (2005, 2010, 2012), appeared to be a suitable approach. According to Frank (2010), dialogical narrative analysis "studies the mirroring between what is told in the story — the story's content — and what happens as a result of telling that story — its effects" (p. 71). The purpose of dialogical narrative analysis is not to locate themes as finalizing descriptions or statements about who the research participants are, but, rather, to capture individual struggles in all of their ambivalence and "unfinalizability" (Frank, 2005). A dialogical narrative analysis treats stories as actors. The analysis is narrative not because the stories are the data but because we study *how stories act*. Frank (2010) poses several questions that initiate the analysis by calling attention to *what the stories do*: What is at stake, and for whom? How does the story and the particular way it is told define or redefine the stakes, raising or lowering them? How does the story change people's sense of what is possible, what is permitted, and what is responsible or irresponsible? Keeping these questions in mind, we now turn to the stories.

Results

The three stories chosen for close attention in this article are not representative in the statistical sense of the word. They were selected because of their particular clarity and distinctness with regard to the issues discussed in the article: elderly people's experiences of health as expressed through their life stories and their active engagement with colonial history in the telling of their stories. As noted by Frank (2012), the selection of stories in dialogical narrative analysis is based on what has been learned during the research process, even if a considerable part of this knowledge remains tacit to the researcher. In this perspective, the interpretation and discussion of the three stories is informed by the knowledge developed through engagement with the stories of the other participants in the study.

Inga: Born in a Turf Hut

Inga is a woman from a reindeer-herding family in the core Sami area. She says that she has been trying to live as decently as possible all her life to show that the Sami are not inferior: "Perhaps people think the Sami are not as good as other people. I think this is because they don't know any better." However, Inga does not believe that all Norwegians perceive the Sami as inferior: "A lot of Sami girls marry Norwegian men. Perhaps the men who are marrying Sami girls don't see the Sami as bad."

After making this statement, Inga starts to tell a story about her own birth. She was born around 1920 in a turf hut of the type reindeer herders used intermittently while tending their herds. In addition to her mother, her father, and her grandmother, several other people were in the hut when Inga was born. Inga's parents were sleeping on the floor when her mother went into labour:

> *Then my grandmother said, "What's going on? The house is crowded!" Then my father replied, "We're trying to bring a new human being into*

> *the world." There was a fireplace there, and there was a fire in there. They had just cooked some meat. There were a lot of Sami people there. My father just threw away the meat broth and put water into the pot to heat it. Then I was born. My father cut the umbilical cord. And my father washed me. It was my dad who washed me! Two waters: the first water he threw away, and then another water. And my grandmother lay on the bed. They put my mother on the bed and me next to her. We stayed there for a couple of weeks before they drove away. It was just a hut of the kind the reindeer herders used. There, I was born. There were no white clothes . . . [laughs] It was my father who delivered me, and he almost washed me in meat broth . . .* Vuoi vuoi! *And I became human too! Nowadays the clothes are so white. Everything is so white and clean. But I was born there. [laughs] And I was healthy! I've never been sick. No nuisances. . . . I'm not sick, and I've had children myself. Lots of children. And they came so easily. That's how it is!*

Inga attended residential school as a child. She says, "We had to go there, the Sami kids. Luckily, I knew the language before I went to school." If the teachers heard the children speaking Sami, they told them to stop. Inga tells a story about a teacher from the South who wanted to take Inga with her to the South:

> *There was this older teacher. She came all the way from the South. . . . She had no children of her own, and she wasn't married either. She wanted to bring a Sami child to the South, to let the child go to school there, and she would pay for school for this child. . . . If I would come with her I would have my own room and she would buy me clothes and everything. She promised. And I was so happy! I could go there and attend school! But then I went home and told [my mother] what the teacher said . . . "She wants to take me there so I can learn. I can go to school there — there are lots of schools there." At first my mother didn't say anything. Then she said, "You will learn to sew Sami boots (*skalla*) and all Sami clothes. That's enough school for you!" She said that she would teach me to sew Sami clothes and that I would marry a Sami man, a reindeer herder. "No, I don't want to get married. Never!," I said. I told the teacher, "You have to talk to my mother!" But my mother said no. "Inga is not going anywhere! She will learn to sew Sami clothes, and she will marry a Sami man with reindeer." And so it was. I was really angry with my mother. I cried and cried, but it didn't help. The teacher took another girl, from the orphanage. . . . My mother said, "You can live from sewing Sami clothes. Not everybody can do that! But you can learn to do it." [pause] And so it was.*

There is an undertone of vulnerability in Inga's stories. In her own words, "all her life" she has been conscious of her conduct, trying to prove wrong those who think Sami people are inferior. The vulnerability contained in her lifelong fight for equality emerges in statements such as "I became human too." This is an individual expression of the history of assimilation. The story about the teacher who wanted to "save" her by taking her away from her parents and giving her the type of education, clothing, and housing that was valued in the majority society is likewise an individual history of colonization.

While Inga's stories are individual expressions of the colonial history of assimilation of the Sami, they are, simultaneously, narratives of resistance. Through her birth story, Inga resists the standards of the majority society "where everything is so white and clean." The majority society is represented by the absence of "white clothes" and a midwife, but these appear not to be missed at her birth. The birth story brings force and energy to Inga's lifelong project of proving the majority wrong. The turf hut, the delivery on the floor, and, perhaps most strikingly, the meat broth bring tremendous force to Inga's story. The statement "It was my father who delivered me, and he almost washed me in meat broth" adds strength to her story.

The story about the teacher from the South is also a narrative of resistance. In this story, it is Inga's mother who represents the resistance. One aspect of this resistance is the mother prohibiting Inga from going to the South with the teacher, but she also opposes the teacher. Given the historical and social circumstances and the power relations between a Sami woman and a teacher from the South, the mother's statement "Inga is not going anywhere!" is a strong expression of resistance. Inga is making her mother's resistance her own by including it in her life story. The tension between the majority society represented by the teacher and the resistance of Inga's mother is expressed through several binaries in the story. The teacher's tempting offer is opposed by the mother's "You should learn to sew Sami boots and all Sami clothes. That's enough school for you!" Furthermore, the teacher's enticing promise of manufactured clothes is countered by the mother's "Sami boots and Sami clothes," and Inga's prospect of having a room of her own sits in opposition to the crowded turf hut at her birth. Inga lets her mother have the upper hand with the statement "You can live from sewing Sami clothes. Not everybody can do that! But *you* can learn to do it." In this statement, Inga, through the voice of her mother, expresses the privilege of being a Sami. Anybody can go to school and wear manufactured clothes, but not everybody can learn to sew Sami clothes. Through the birth story, Inga's resistance to being inferior is expressed in the narration of her *healthy self*. The apparently frail elderly woman, nearly blind and barely able to walk, states, "I'm not sick, and I've had children myself. Lots of children. And they came so easily. That's how it is!"

Laila: No Special Treatment Wanted

Laila was born in the early 1930s. She grew up with seven brothers and sisters in a remote coastal area. "It was a lonely spot. You had to go there by boat." She had a hard childhood, losing her father and a brother to the sea when she was only 7 years old. Laila has a congenital physical handicap, but she says, "When everything works up here [points to her head], it's okay."

Laila had to leave home and go to a residential school as a child. She says, "I can't complain about school. Lots of people do, but I can't complain. I liked school. I guess they had to be that strict . . . No, I can't complain." Laila did not speak Norwegian when she attended school: "Not knowing the language was the worst part. I didn't know when to say yes or no." She says that this was frightening, but that she was not the only one affected: "We were what I would call equal, all the children attending school then, at that school . . . There were only a few who spoke Norwegian." The children were not allowed to use the Sami language at school, but Laila says, "We did speak Sami. We did. We had a Norwegian teacher but she . . . didn't care. She was old. She was a teacher for many years. She was the teacher for all my siblings, so you can imagine how old she was."

After her Confirmation, Laila "knew enough Norwegian" to go to the nearest town and enrol in cooking and sewing courses. Despite her physical handicap, Laila had several jobs as a domestic, working as a seamstress and as a cook. "Whenever something happened — a funeral, a christening, or a confirmation — I was in charge." She says,

> *I wasn't the type to lie around moping. I was active all the time. . . . I went to school and everybody was equal. . . . I wasn't the type to shut myself away. Oh no! I wanted to be out. I wanted to be in the midst [of things]. And the other kids in school — there was no bullying back then! Oh no! I was accepted everywhere, so it didn't bother me.*

Laila has been active in interest groups for people with various handicaps all her adult life.

Laila's late husband "was a kind man." He subsisted on casual work. "He had a small . . . a *big* handicap. He was illiterate. He didn't have any schooling . . . He had to struggle at home. . . . And they had a teacher . . . who ignored those who didn't . . . know anything."

Laila is clear about her Sami heritage. She states immediately that she is a Sami. However, she dislikes the focus on the Sami people in society: "I must say, I think it's almost too much about the Sami now. They say, 'We are Sami, we are Sami, I am Sami, I am Sami.' [raises her voice] No, it's too much! . . . I think so. They demand too much. That's the problem."

In addition to her congenital physical handicap, Laila has used a wheelchair for the last 3 years. "It was my feet that couldn't . . . my feet refused." Despite all this, Laila says this about her health: "My health? I must say, my health is good. I'm satisfied with my health. Of course, I have a few small nuisances. I do. But other than that . . . no."

Like Inga's story, Laila's story is underlaid with the fight for equality. Being treated as an equal is at stake throughout Laila's life story. Although she was born with a physical handicap, her life story, in which "being in the midst [of things]" is a central theme, embodies her with a *healthy self*. To be healthy is to participate. Laila's story about her husband is quite different. She refers to his illiteracy as "a *big* handicap." One can easily imagine how her husband's opportunities for participation and equal treatment were restricted by his illiteracy. Laila's reflections on residential school life underline her emphasis on equality. She "can't complain" about school because, after all, almost all of the children were in the same situation; few of them spoke any Norwegian when attending school. The way she describes the aged Norwegian teacher gives her and the other Sami children the upper hand. Moreover, Laila eventually mastered Norwegian well enough to take courses in the town.

We perceive Laila's life story as a narrative of resistance. Like Inga, Laila expresses her resistance through the narration of her *healthy self*. She resists being different; she resists special treatment as a "handicapped" person. From this perspective, Laila's indignation at "Sami activism" is reasonable. Claiming special rights is exactly what she has been refraining from doing all her life. What she perceives as Sami people "demanding too much" raises the stakes of her equality.

Marit: No Need to Go to the Gym to Row

Marit was born in the early 1930s in a remote coastal community as one of six siblings. "We lived in a spot where, I would almost say, not even birds would pay a visit." School was one of Marit's first encounters with society outside the home. "Imagine that it's possible! I started school without understanding what the teacher talked about. I know I read because I had learned to spell. So I did put the letters together, but I didn't know what I was reading! . . . No, I didn't know what I was reading. *Now* I can read."

Marit and the other children were not allowed to speak the Sami language at school. "The teacher said, 'You have to speak Norwegian.' Of course, we should have spoken Norwegian, but none of us understood

. . . If it was *today,* I would have told her, . . . but, of course, I didn't say anything. Who could I tell?"

Marit relates how the children were treated differently at school. She discusses the teacher's preferential treatment of two Norwegian brothers in her class. There were those who were not treated so well. "There were differences. None of us were wealthy, but I remember one boy who came from particularly poor conditions. I can't understand why they treated him like that . . . He was put down. But when he grew up he attended schools, and he became a writer. Now he's dead."

Marit had severe asthma as a child. She spent a great deal of her childhood ill with asthma and people would say that she was a bashful child. She says:

> *I never was bashful among people speaking Sami, but I didn't speak Norwegian back then. I didn't know enough Norwegian to participate in talking. . . . I didn't know Norwegian back then. Nowadays, some Norwegians say, "We remember, you used to be here — you spoke Norwegian well." Yes, a little . . . I guess I planned for hours the things I said. That's how it was. But they should discuss with me now — because now I can talk! I'm not bashful now!*

Marit dismisses the idea that the asthma robbed her of her youth:

> *A lot of people have said to me, "You had no youth." Youth? What do they mean by that? I had a youth like everybody else! While I was sick, the other youths visited. Back then, people visited! And when we went skiing, we all were together. If I was short of breath, the others waited for me. Yes, they did.*

Throughout her adult life as well, Marit has been ill with asthma.

Marit is direct and candid when speaking of her Sami heritage. She says, "We are Sami! I just think: I am a Sami. I am not at all a Norwegian. And everywhere I go I say, 'I am from here, and I am a Sami!'" She associates being a Sami with being active.

> *I think it has been nice to be a Sami. When we were kids, we had to work outdoors with our parents. We didn't sit inside watching television and then have to exercise at the gym. Nowadays, people have to exercise because they're only sitting. We had to row. Row! Nowadays, people row at the gym. They do! That's the difference, if I may say so, in being a Sami.*

In Marit's story, her *healthy self* is at stake, but the stakes are lowered by the manner in which she tells her story. In Marit's story, as in Laila's, health is associated with participation. To Marit, the Sami language is essential for her participation. She denies that she was a bashful child while among Sami and able to participate in her mother tongue. Furthermore, her severe asthma was not a problem in that it did not prevent her from socializing with the other children. The other children made it possible for her to participate by visiting her when she was sick and adjusting the speed of their skiing when she was short of breath. The stakes for her healthy self are lowered through the community with other Sami-speaking people.

As in Inga's and Laila's life stories, colonial history is evident in Marit's story, particularly in her narrations about residential school life. Similar to the two other women, Marit presents a narrative of resistance. She resists being ill and bashful, and it is her Sami heritage that is key to a healthy, participatory self. In Marit's story, her Sami heritage allowed her to engage in healthy activities such as rowing. She gains the upper hand by ridiculing people who go to the gym to row; she says that this is the difference between Sami and Norwegians.

Marit is proud to be a Sami; she states that she is "not at all a Norwegian." The history of assimilation is nevertheless present in the way she narrates her life. Statements like "*Now* I can read," "If it had been *today* I would have told her," and "they should discuss with me *now* — because *now* I can talk! I'm not bashful now!" suggest that the capacity to resist is at least partly contingent upon her mastery of the Norwegian language.

Discussion and Implications

Life stories, such as the three stories presented above, are a source of insight into health experiences. The stories could be read through the lens of van Hooft's (1997) notion of health as an experience and a condition of subjectivity. Through such a reading, one could identify elements of all four dimensions of health: the material dimension expressed in Marit's shortness of breath and Laila's physical handicap; the pragmatic dimension expressed in rowing, sewing, and cooking; the conative dimension expressed in Laila's desire to be in the midst of the crowd; and the integrative dimension expressed in the structure and coherence of the stories. Van Hooft's notion of health is useful because it promotes a broad understanding of health that does not focus only on the absence of disease. If we focus exclusively on health as a condition of subjectivity, the key to quality care lies in the relationship between patients and health-care providers, which has been referred to as "micro-ethics" (Mishler, 2004, p. 98). From such a perspective, the call for cultural sensitivity and culturally congruent care, understood as "culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients" (Leininger & McFarland, 2006, p. 15), in encounters with Sami and other minority patients appears reasonable. However, if people's experiences of health are perceived as also having historical and socio-economic influences, such a "micro" perspective is too narrow. We argue that the study of people's life stories allows for an examination of their health experiences as a condition of subjectivity and as influenced by historical and socio-economic contexts. The stories are, of course, subjective accounts, but they occur "at a historical moment with its circulating discourses and power relations" (Riessman, 2008, p. 8), which are echoed in and have an impact on what can and cannot be told in the individual stories. A collective history, such as the history of assimilation and colonization, has effects at the individual level (cf. Adelson, 2005), and post-colonial theory provides a framework for understanding how present-day experiences are shaped by history (Browne et al., 2005).

The women's Sami heritage has a central place in all three stories and is closely connected to their experiences of health, not necessarily because being Sami implies that the women have certain cultural traits in common, but because being Sami in this particular historical period may have produced experiences that persons from the majority group would not have. In this sense, the legacy of colonialism is inevitably present in the women's stories. This is evident in all of their stories about residential schools and being forbidden to speak their own language. The experience of belonging to a stigmatized minority group is evident in the way that Inga, by being constantly conscious of her conduct, takes responsibility for how all Sami are perceived by the majority population. A person belonging to a non-stigmatized majority would not necessarily feel responsible for the reputation of the whole group. Herein, perhaps, lies a key to Laila's indignation with Sami claiming special rights: The special rights of some Sami representatives brand the Sami as a group of people with special needs.

Health-care providers who focus on Sami and other minority patients exclusively as minorities or cultural "others" risk ignoring the agency of their patients. From such a perspective, patients are "products" of their culture and even passive victims of the majority policy. Postcolonial theory calls attention to the impact of historical and socio-economic factors on people's lives and forestalls attempts to represent these as issues of "cultural difference." Narratives of resistance, such as those presented in this article, illustrate that people are not necessarily passive victims of the legacy of colonialism; on the contrary, they are expressions of the agency of "the oppressed." Resistance is not a passive state but an active process, as is health. The importance of considering Indigenous people as active in response to their colonial situation, rather than simply as passive victims, is described elsewhere (Adelson, 2005). According to Frank

(1995), "the truth of stories is not only what *was* experienced, but equally what *becomes* experience in the telling and its reception" (p. 23; original italics). Such stories are a means for people to take control of their own representation (Stone-Mediatore, 2003).

Through their narratives of resistance, the participants in this study become the narrators of their own stories without completely becoming the authors of their lives (Ricoeur, 1986). They cannot change the historical and social settings of their life stories, but they certainly do control the part that these settings play in their stories. As noted by Stone-Mediatore (2003), narratives of resistance can destabilize ossified truths and thereby suggest that historical life might be more complex than it appears at first glance. One example is Marit's ridiculing of Norwegians who go to the gym to row. Another is Inga's dismissing of the whiteness and cleanliness of modern maternity care. Yet another expression of resistance is Laila's indignation over special treatment for Sami people. According to Ewick and Silbey (2003), narratives of resistance reveal the tellers' consciousness of how opportunities and constraints are embedded in the taken-for-granted structures of social action. This is evident in Inga's story about her mother opposing the teacher from the South. While telling the story of her mother standing up to the teacher, Inga makes known her consciousness of the opportunities and constraints embedded in social structures. The firm "Inga is not going anywhere" reverses the power relations between the Sami woman and the teacher from the South. Likewise, Marit's story about the tormented boy who grew up to be a writer demonstrates awareness of opportunities and constraints. The present study illustrates that a narrative approach to issues with respect to health and the Sami people unveils "truths" other than those described in statistics on mortality rates and disease incidence. Health is not a passive condition but an active process. The stories of these three women indicate that being a healthy self can be an act of resistance.

In this article, we have argued for the need to combine micro and macro perspectives when grappling with issues regarding Indigenous people, health, and health services. The micro perspective focuses on the face-to-face encounters between health-care providers and Indigenous patients, while the macro perspective demands a contextualization of interpersonal encounters. The narratives of resistance discussed in this article illustrate the importance of recognizing that the legacy of colonialism is present in the lives of Sami elderly today without regarding them as passive victims. Such narratives of resistance demonstrate that envisaging Indigenous elderly solely as passive victims and ignoring their role as active agents is not only insufficient but offensive. Resistance is a resource that should be appreciated by health services both at a systemic level — for example, through authentic partnership with Indigenous elderly in the planning and shaping of services — and in individual encounters between patients and health-care providers.

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Bodil Hansen Blix, RN, MA, is a PhD student at the Centre for Care Research, Department of Health and Care Sciences, University of Tromso, Norway. Torunn Hamran, RN, is Professor, Centre for Care Research, Department of Health and Care Sciences, University of Tromso. Hans Ketil Normann, RN, PhD, is Professor, Centre for Care Research, Department of Health and Care Sciences, University of Tromso.

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Résumé

Le travail en collaboration avec les collectivités pour favoriser la santé : la participation d'enfants et de familles d'un milieu urbain défavorisé à des cercles d'apprentissage

M. Judith Lynam, Erin Grant, Katie Staden

Les auteures présentent brièvement un projet de clinique externe innovateur en raison des types de partenariats qu'il a établis dans le contexte d'un milieu urbain défavorisé. Le projet visait à permettre à des enfants et à des familles vulnérables, à cause de leurs situations sociale et matérielle, d'avoir accès à des soins de santé primaires et à des services spécialisés. Grâce à un engagement et à un dialogue continus, les cliniciennes et la collectivité ont établi un certain nombre d'engagements avec les enfants et les familles. Les auteures utilisent le cas des cercles d'apprentissage pour décrire l'incidence des connaissances et des façons d'être autochtones sur les méthodes mises en œuvre pour travailler avec les enfants et les familles autochtones. Elles réfléchissent également aux effets que cette approche a eus sur l'engagement de la collectivité et examinent comment elle pourrait permettre de réaliser l'équité en santé.

Mots clés : cercles d'apprentissage, engagement de la collectivité, enfants et familles autochtones, soins de santé primaires

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Engaging With Communities to Foster Health: The Experience of Inner-City Children and Families With Learning Circles

M. Judith Lynam, Erin Grant, Katie Staden

The authors briefly introduce a clinical outreach initiative that is innovative because of the types of partnerships that have been formed within an inner-city community context. The initiative was designed to foster access to primary health care and specialized services for children and families who are vulnerable because of their social and material circumstances. Through ongoing engagement and dialogue, the clinicians and the community have developed a number of points of engagement with the children and families. The authors use the case of Learning Circles to describe ways in which Indigenous knowledge and ways of being influenced the approaches taken to working with children and families. They reflect upon the ways in which this approach influenced community engagement and consider its potential for achieving health equity.

Keywords: Learning Circle, community engagement, Aboriginal children and families, primary health care

Nursing has a long tradition of working within, and in some cases with, communities and other disciplines to provide illness care and promote health. The substantive knowledges drawn upon in framing nurses' work have been influenced by an array of theoretical perspectives but are derived primarily from (Western) biomedicine and social sciences. Increasingly, however, as we question our assumptions about knowledge, critically appraise and reflect on our practice, and recognize and seek to address the conditions underlying health inequities, new traditions are being drawn upon. Postcolonial scholars recognize that such reflection can direct our attention to the ways in which the "authoritative voices" that arise out of dominant discourses, and associated processes and practices, can contribute to conditions that silence and marginalize. Researchers are challenged to make visible the consequences of such silencing and to explore strategies for recognizing "subjugated knowledges" (Bhabha, 1994; Browne, Smye, & Varcoe, 2005) and incorporating them into broad discourses.

In this article we share insights from a community-based participatory study of the RICHER[1] clinical outreach initiative introduced to foster access to health services for inner-city families (Lynam, Loock, Scott, & Khan, 2008; Lynam, Scott, Loock, & Wong, 2011; Lynam et al., 2010). We use the case of Learning and Sharing Circles to illustrate how work with children and families, conducted by both the community and clinicians in a culturally diverse community context, was influenced by Indigenous knowledge and ways of being. We describe the ways in which the Learning Circle emerged as a strategy for fostering engagement and capacity-building. We explore the epistemological roots of the Learning Circle approach, illustrate its uniqueness and its conceptual links with Western professional knowledge, and share community members' perspectives on its impact. We end the article with our own observations of the mutual learning that occurred as the strategy was proposed, introduced, and thoroughly explored.

The community proposed the Learning Circle strategy and requested support for introducing the concept to broader audiences. The investigators responded by working with two undergraduate students, each of whom brought different areas of expertise to the project, including a history of engagement within the community, knowledge of the Learning Circle concept, and experience working with children with different abilities. In undertaking this exploration, we drew upon the expert knowledge of community members and engaged in considerable dialogue and reflection. Once we completed our analysis of the principles, practices, and processes of Learning Circles, we took the analysis to Learning Circle participants to seek their input.

The Community-Based Research and Clinical Practice Initiative

Health inequities arise out of a complex interplay of structural and social factors. Addressing these inequities therefore requires an array of interventions. Perhaps more importantly, evidence suggests that it requires a transformation of relationships in order to create avenues for engagement. In our case the point of entry to the inner-city community was a concern with fostering access to primary health care and specialized services for children and families. In particular we worked in partnership to foster access to supports and clinical resources to nurture children's development. The census data for this inner-city neighbourhood indicate that more than two thirds of the families live in significant poverty, more than

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[1] The Responsive Intersectoral Children's Health, Education, and Research (RICHER) initiative: http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm.

half of the children live in households headed by a single parent, approximately one third of the families report being of Aboriginal heritage, one third of the families report being new immigrants (Statistics Canada, 2005), and up to 66% of the children enter school developmentally vulnerable (Kershaw, Irwin, Trafford, & Hertzman, 2005).

From the outset of our work together, the professionals were concerned with supporting engagement and capacity-building. This is reflected in how the clinical initiative was constructed and the nature of the relationships that were established between clinicians and the community. Concomitantly, our community partners were developing a comprehensive "place-based" strategy such that the RICHER clinical program is a component of the broader community strategy.

We engaged with the community, listened as people recounted their experiences, and analyzed the research data. We came to "see" that the conditions of poverty and disadvantage experienced by the majority of families were, for the Aboriginal families, compounded by the persistent and pervasive structural violence and the legacy of colonial policies (e.g., residential schooling) that separated parents from children and created a generation who did not know how to engage within the family in order to nurture child development — because they had no opportunity to learn to do so. Such colonial policies have undermined the ability of many Aboriginal parents to support their children's development. As well, in many instances the displacement of both Aboriginal and immigrant families from their traditional communities, and practices that have disrupted their place in history, have contributed to a sense of marginality in this urban community. This article presents one example of how the partnership approach has been enacted to achieve the broad aim of health equity.

Social conditions associated with health inequities include poverty, social exclusion, marginalization, and isolation. Furthermore, population analyses have shown that the impact of social and material disadvantage is cumulative over the life course (Power, Stansfield, Matthews, Manor, & Hope, 2002). The RICHER initiative has sought to take direction from evidence showing that, with appropriate supports and interventions, the negative effects of social and material adversity on child health and development can be mitigated (Shonkoff & Phillips, 2000) and that social connectedness, purposeful participation in society, social engagement, support, and affirmation can mitigate the negative impact of material disadvantage (Killoran & Kelly, 2010; Lynam, 2005; Lynam et al., 2010; MacIntyre, 1997; Werner & Smith, 2001).

Such analyses show that while health inequities manifest as poor health or developmental delay, *many of the solutions are social.* In RICHER, in addition to providing access to typical primary health care and specialized services, the clinicians and their community partners *engage with such pathways of influence.*

As RICHER has evolved, new processes have been instituted for ensuring ongoing dialogue and community input into how services are developed and delivered (Lynam et al., 2010). The partnering organizations are particularly mindful of the legacy of history and are clear about the strengths they bring to the "table."

Since RICHER's inception, both professional and community partners in the initiative have made an explicit commitment to capacity-building. To date, however, our analyses have not systematically accorded attention to the conditions and approaches used to nurture the development of community capacity and knowledge. While all partners voiced a commitment to mutual capacity-building, it was through dialogue with our community partners that we became aware of the extent to which our stance on capacity-building was taken from a traditional "professional expertise" model, which places an emphasis on building the professionals' capacity to work more effectively with the community. Similarly, although we were committed to developing practice approaches informed by community-based expertise and knowledge, we recognized the need to enhance the approaches taken and acknowledge the expertise of community members in the ways that the program engages to build capacity, particularly in domains deemed important in the community. Thus, we shifted our focus to the community's strategy for engagement and capacity-building.

Learning Circles: The Community's Strategy for Fostering Inclusion and Capacity-Building

The community introduced the Learning Circle in order to acknowledge the expertise of community members while building (knowledge) capacity through ongoing sharing and engagement. The authors of this article participated in developing resources to be used in some of the group activities, conducting background research, and creating a teaching tool to introduce the concept to professionals and to groups and organizations exposed to it.

The Learning Circles were introduced and used to "structure" engagement of different groups (e.g., parents' group, safety committee, children's summer day camp) in addressing issues that had been identified by the community as priority areas of concern. It quickly became evident that the Learning Circle offered a mechanism for drawing upon participants' insights and a means for bringing individual and community expertise together with, in some instances, professional knowledge to extend and enrich understandings.

As the community strategy unfolded, and as we reflected upon it, attention was drawn to the underlying tenets of the approach, such as being grounded in Indigenous knowledge and ways of being. While the concept of Learning Circles was implicitly meaningful for the community leaders and many community members, the professionals and researchers among us needed to have the concept "translated" and its value illustrated. And, as the concept was being taken up in an urban context, we anticipated that some of the principles would be adapted to the new context. This article is the product of the process of explicating the tenets of Learning Circles, illustrating how these were introduced, exploring the conceptual links with other literatures, and sharing the views of community members on their experiences of engaging with Learning Circles.

We illustrate the processes by focusing on two of the cases.

Parents' Group

A mothers' group evolved into a parents' group. In these Learning Circles, parents identified areas of concern or interest and, with support, learned how systems governing the issues operated, what avenues were open to them for addressing issues, and how to share their knowledge and their position on the issue of interest. Through this process, they gained skills in navigating such systems (e.g., learned about which city departments are responsible for social planning and the rules that govern consultation with communities, about the relationship between school board trustees and neighbourhood schools, and how to go about securing funding for a community-based parenting initiative).

Children's Summer Camp

In this neighbourhood a disproportionately high number of children have developmental and/or learning challenges that interfere with participation in typical community programs. The community therefore sought to create a mechanism for supporting the inclusion of children in summer activities. It introduced a counsellor-buddy program whereby the staff-to-child ratio was raised by pairing each child with a buddy to help him or her navigate group activities and to provide additional support. The buddies and counsellors were trained using a Learning Circle approach. The circle was a strategy for training the counsellors/buddies to include children with different abilities and disabilities in play and activity groups with peers of the same age. The Learning Circle concept and the peer buddies were introduced as new features of the counsellor training program.

Our Analytic Stance: Methods Used to Explicate Tenets of Learning Circles

Our starting point for making visible the tenets of Learning Circles, as operationalized in this context, is the recognition that health-care knowledge and expertise extend beyond the biomedical domain to include knowledge that patients hold and acquire in order to manage complex and chronic health conditions or to navigate their day-to-day lives. Our strategy built on this premise and set out to explicate the elements of Learning Circles. We then examined the roots of Learning Circles in traditional Aboriginal knowledge and practices and identified points of connection with Western science. In this process of explication, we drew upon community members' knowledge of traditional practices and engaged in discussion about the ways in which the Learning Circle traditions are being adapted to the urban context.

In setting out to analyze the conceptual roots of Learning Circles, we became aware of the inherent contradictions of doing so. If we value different forms of "expertise," then why "evaluate" expertise in relation to more empirical or Western theoretical understandings? Does the affirmation of traditional practices and knowledge on the basis of Western or professional understandings of science increase their value? And if so, increase their value to whom, and what processes are operating in making such a hegemonic claim?

While we have not resolved the tension inherent in such contradictions, our decision to engage with these perspectives in this article builds upon a number of scholarly traditions.

The first premise follows from the literature reviewed above. That is, if we are to take a stance that recognizes multiple forms of expertise while creating avenues for the academy and practitioners to engage with "subjugated knowledges," we must identify points of connection between different knowledge traditions. Moreover, we must develop ways to recognize different knowledge traditions and bring them into professional discourses. We believe that the approach we have taken locates traditional knowledge alongside professional knowledge, and we hope that our analysis addresses the concern raised by Anderson, Pakula, Smye, Peters, and Schroeder (2011) that scholars must avoid "the placement of Indigenous knowledge in a secondary position behind science" (p. 44).

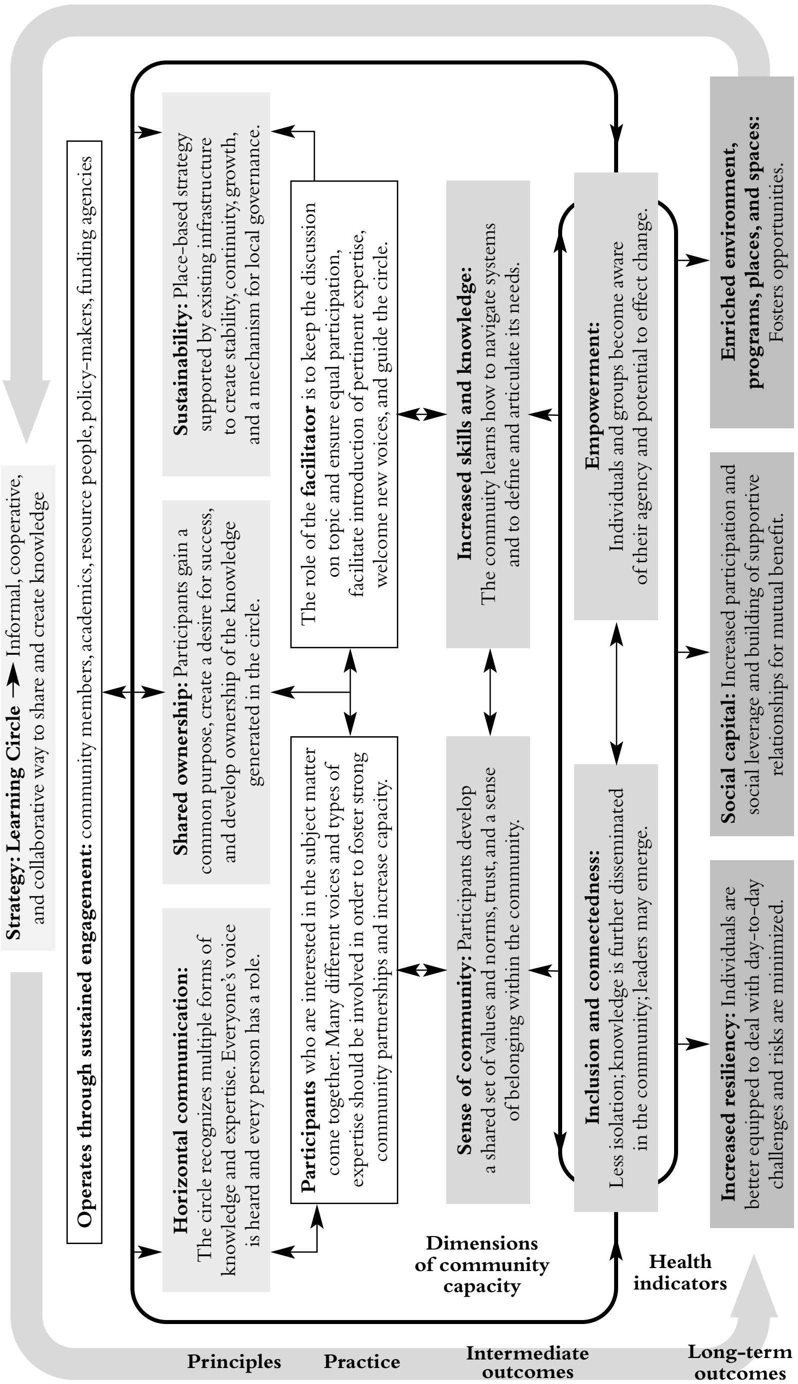
As our literature review attests, marginalization and exclusion are social processes and practices with negative health consequences. As well, in recent years the role of identity has been recognized as a cornerstone of healthy child development (Julien, 2011; Shonkoff & Phillips, 2000) and as a key concern of Aboriginal communities. Scholarship has shown that marginalization and inclusion are shaped by a number of structural and social conditions, including day-to-day discourses. Individuals who "see" themselves — their heritage, their history, their language — positively reflected in their daily lives are more likely to feel included. Introducing the discourse of Learning Circles into day-to-day practices in the community is one means of recognizing the cultural heritage and expertise of many community members. Introducing the concepts in multiple forums and formats and illustrating their points of connection to other knowledge traditions could expand the everyday discourses of practitioners and community organizations while also reconnecting Aboriginal families with their own knowledge traditions.

We are mindful, however, of the need to guard against health professionals' commodification of, or construction of, Learning Circles as standard practice or as a formulaic solution to health challenges. As cautioned by Smith (1999), the alignment of Aboriginal ways of knowing/being and critical theory is not straightforward — there are tensions and contradictions surrounding issues of identity, culture, and epistemological assumption, with no consensus among Indigenous scholars and researchers as to whether Indigenous methodologies should draw from Western theoretical traditions. In presenting our analysis, therefore, we caution readers about the need for all those involved in such endeavours to refrain from co-opting traditional practices, to continually reflect on the impetus for the introduction of such practices, and to ask whose interests are being served.

As we embarked on our analysis, we created "points of connection" with our own understandings and those of others, while also accessing the expertise of our team members. For me (Lynam), the process led to the view that if we are to engage in dialogue to extend and enrich our understandings and to value different viewpoints, such points of connection give us purchase to begin the conversation. In theory, the partnerships between community, professionals, and scholars will strengthen the capacity for dialogue.

For me (Grant), similarly, the process of analysis helped to draw out these points of connection. Initially I was sceptical about the feasibility of working with low-income families and facilitating the type of participation and outcomes that are meaningful to all partners while at the same time safeguarding the principles of self-determination and individual autonomy. During the analysis, it became clear that, in theory, the Learning Circle could act as a mechanism to address this issue. The community, professional, and academic partners involved in the project have voiced a commitment to fostering resident participation, knowing that it is crucial to reducing the reliance on professionals and increasing the capacity of the community. The point of connection here is that the type of engagement that characterizes the circle not only can be traced back

Figure 1 *Explicating Elements of Learning Circle Strategy*



to Aboriginal tradition, but also resonates with certain feminist/critical methodologies and, more importantly, the values of our community partners.

For me (Staden), an interest in working with children to build their capacity was the initial point of contact. As the project evolved, engagement with the community and new theoretical discourses deepened my understanding of science and the relevance of different research approaches. Through engagement, I also developed an understanding of the ways in which broader circumstances influenced these children's health and I came to appreciate the role of community in working with and for the children.

The Learning Circle

In conceptualizing the Learning Circle process, we reflected on observations of the ways in which they were enacted to identify the principles operating, then considered these in relation to the literature on Learning Circles. This approach enabled us to make visible the underlying philosophy that characterized how participants engaged with one another and the community. We also named the processes and outcomes of this engagement. The product of our dialogue and analysis is represented in Figure 1.

Although Learning Circles are traditional practices of Aboriginal communities, their form and functions vary to reflect different cultural traditions. We explore Learning Circles in this article not to essentialize Aboriginal cultural practices but rather to illustrate how engagement with particular traditions can create avenues for dialogue while also enriching community and professional discourses. These points are particularly salient for this inner-city community, as the Aboriginal families are members of, or identify with, a number of different nations and many have lived only in urban settings. These diversities are reflected in their experiences with, and knowledge of, traditional practices. This community has much in common with other urban communities in Canada. As observed by Deane, Morrissett, Bousquet, and Bruyere (2004), "urban Aboriginal cultures . . . are fragmented and complex . . . a collage of jigsaw puzzle fragments . . . an amalgam of traditional values, mainstream adaptations, and inner city survival skills" (p. 246).

A number of scholars have observed that the roots of the Learning Circle can be traced back to a traditional form of dialogue among North American Aboriginal people (Nabigon, Hagey, Webster, & Mackay, 1999; Nicholles, 2009; Zapf et al., 2003). The Learning Circle is an informal, cooperative, collaborative approach to fostering engagement and dialogue within a community and for building capacity from the ground up. This model is particularly effective in engaging those who have traditionally been excluded from decision-making processes and individuals who have not had a positive experience in more conventional learning environments (Mohajer & Earnest, 2009). These were important considerations for children and families in this community.

The Learning Circle is meant to be an *educational and relationship-building process* aimed at addressing issues identified by the community. In our cases, and in keeping with the literature, the agenda is set by and for the community. This ensures that participants have the power to construct their own culturally relevant notions of well-being or empowerment, instead of having Western/academic learning constructs imposed on them. By tapping into multiple forms of expertise, all participants gain a more holistic understanding of local conditions and are better positioned to develop integrated solutions to the challenges or barriers faced by the community. The engagement can also enhance the community's ability to access both formal and informal systems as they gain a clearer picture of the policy and political climate. Participants learn what systems look like, how to navigate them, and the types of barriers that exist (Ravensbergen & VanderPlaat, 2010).

One of the *central premises* of a Learning Circle is that it is characterized by *horizontal communication*. Horizontal communication legitimizes and validates community-based knowledge, or "tacit knowledge" (informal practices, know-how, creative ideas) derived from lived experience and local conditions (Bradford, 2005). Feminist and health scholars taking a critical stance observe that these forms of knowledge are generally unacknowledged by professionals. Horizontal communication is achieved when participants feel that the viewpoints and knowledge they bring to the circle are valued and "heard."

The validation that accrues from the horizontal structure is reinforced by messages of community ownership of the circle. In keeping with traditional practices, the neighbourhood circles operated in ways that were familiar to the community participants. The purpose of the circle explicitly aligned with issues of concern to the participants, thus contributing to the creation of a culturally safe environment for engagement.

In our cases, groups met in neutral and accessible spaces that were publicly "owned" or were governed by community organizations (e.g., community centres, schools), where people feel comfortable or have a legitimate point of entry. This ownership of space is particularly important for Learning Circles (Jarvis-Selinger, Ho, Lauscher, & Bell, 2008). In our cases, individuals also had built relationships with others and the trust that grew from these relationships appeared to nurture participation in the Learning Circle.

While in some respects Learning Circles create a sense of informality, as the above observations suggest, they are intentionally structured to foster engagement of people despite their social location. It is this openness and this strategy for respecting different viewpoints that distinguish the Learning Circle from professional and Western institutional organizational structures, which typically are characterized by hierarchical and role-related participation. In such formal or Western models, one's participation needs to be legitimated within the organizational structure. In forums dominated by a Western or professional perspective, many community members are structurally excluded, or, if invited, are often disadvantaged as they frequently have little exposure to, experience with, or knowledge of the implicit and explicit rules that govern or shape participation. It is not surprising, therefore, that community members indicated that they were often reluctant to share their views or ideas at this type of meeting because of their lack of knowledge about the rules and norms. As well, community members indicated that typically their knowledge or their perspectives were not perceived as relevant to the discussion. Such reflections draw attention to the contrasts between the Learning Circle approach and typical professional and institutional approaches to engagement.

These reflections on the Learning Circle led us to observe that *shared ownership* of the knowledge generated within the group is another key condition of the process. When participants have this sense of ownership, their commitment to the circle and their satisfaction with the process and outcomes are increased. At the same time, a sense of safety is created.

The importance of shared ownership may be particularly important for Aboriginal communities because of the persistent and pervasive impact of structural violence and the legacy of colonial policies (e.g., residential schooling). Similarly, the displacement experienced by many of the Aboriginal and immigrant families in this neighbourhood, both from their place in traditional communities and from their place in history, has, for many, contributed to a sense of marginality in their new (mostly urban) communities.

Our community partners have sought to develop a place-based strategy for inner-city families, the majority of whom live in the social and material margins. This strategy seeks to link people with community in ways that nurture the development of individuals' capacity to build networks of support and to "take their place" within a socially and culturally diverse inner-city community. The Learning Circle, when introduced in this community context, aligns with these broader goals.

There is an additional consideration for Aboriginal families. When the community claims shared ownership of its collective knowledge, the possibilities for appropriation of that knowledge are reduced. Shared ownership arises when participants engage in a process that is meaningful to themselves and the community. Participants possess the collective power to define and make their own decisions and have ownership of these decisions.

As described by Nabigon et al. (1999) in their discussion of Learning Circles, the *facilitator* or leader of the traditional circle acknowledges, supports, and encourages; is responsible to the group; may give information in the form of best practices or research findings; has "intervention power" — can ask follow-up questions or can ask for clarification; and works to infuse humour, build trust, and create an environment where people can heal themselves.

Nabigon et al. (1999) explain that in traditional communities the Elder does not necessarily facilitate in every circle but is consulted on how to conduct a circle because of his or her historical knowledge and expertise.

These observations indicate that the function of a Learning Circle facilitator is to coordinate the discussion as an equal participant in the dialogue. Similar principles have been identified as aligning with emancipatory educational practices by such scholars as Freire (2000) and recognized as influencing engagement within Aboriginal communities (Anderson et al., 2011).

At the starting point of a Learning Circle, some of the facilitator's first goals may be to link groups together, network, and bring in other forms of expertise (Jarvis-Selinger et al., 2008). To achieve these aims the facilitator should be familiar with local conditions and have the ability and credibility to cross different networks (Bradford, 2005). For example, a facilitator might have contacts in regulatory bodies, community agencies, and cultural organizations. Facilitators may be appointed by the group, or may rotate (Mohajer & Earnest, 2009; Nicholles, 2009). In our cases, the facilitators established connections with individuals and organizations in a position to further the aims of the group (for example, the children's circle involved individuals possessing expertise in working with children with behavioural or learning challenges).

The *participation* of individuals in a Learning Circle is based on their personal or professional identification with or engagement with the values, goals, and interests of the group. While the core group is drawn from community members, membership or participation opportunities may be extended to a broader group, including policy-makers, academics, and resource people (Jarvis-Selinger et al., 2008; Nabigon et al., 1999; Nicholles, 2009).

In Learning Circles, *learning extends beyond "facts,"* with a view to ensuring reciprocity. In our cases, the parents' group Learning Circle invited people who might be able to describe the social organization of municipal departments and their respective jurisdictions. This initiative not only provided the parents with information but also drew attention to the gap between municipal processes and procedures and community involvement through community consultation processes.

In the summer camp circles, two of the authors introduced the Learning Circle concept as a strategy and then consulted with a variety of experts (consultants in child development and early childhood education) as they developed a series of "cases" to use as learning activities for the camp counsellors and peer facilitators. The circle activities complemented the typical counsellor training activities and, when accompanied by a mentoring strategy, created a mechanism for including children with developmental or learning challenges in summer activities with their peers.

A central consideration in structuring learning is the mechanism for bringing in additional expertise. In some contexts, participants may invite resource people into the circle. A parent explains:

> *We wanted amenity money from the City so we could develop a program for our kids, but we couldn't explain it in ways that the City understood. The Learning Circle facilitator brought this paper [referring to a City document] to the table, explaining how the City works for us. . . . I didn't understand how to get my words out until that example was shown to me. . . . I've taken everything I've heard from every mum in this neighbourhood, turned that paper over, flipped it, and said, "Okay, here's the start of it and this is how it's spread and this is how we can get them from point A to point B" . . . because I'm different, I do things differently.*

With these insights, the parents involved in the Learning Circle developed a multi-pronged neighbourhood strategy to build parenting knowledge, skills, and networks of support. Another parent describes the experience:

> *We did the circle and we did another project where [parents] . . . attended a preschool. They went on outings with families, they built relationships, they got to know the kids, they got to know what kinds of resources were available in the community and experienced 2 months of really, really good direct, hands-on experience . . . The hands-on really made a big difference.*

Strategy and Outcomes of the Learning Circle

Our analysis identified increased resiliency and social capital and enriched community environments as outcomes of engagement with the Learning Circles. We will briefly consider these outcomes in relation to the literature and then provide examples of how they were manifested in our data.

We characterize *resiliency* as the capacity to manage the day-to-day challenges of parenting, of living with limited material resources, or of making friends and coping with a particular health or developmental challenge. As shown in our literature review, a significant proportion of children and families in this neighbourhood live with the consequences of social and material adversity. To thrive in spite of adversity is to be resilient.

Our conception of *social capital* has theoretical roots in the work of Bourdieu (Bourdieu, 1983; Bourdieu & Wacquant, 1992), who uses it to draw attention to the inherent and often taken-for-granted value of social (and societal) infrastructure and to make visible the contextual (e.g., social, historical, and gendered) influences on what (and who) is recognized as holding value. Our use of the term "social capital" as a health benefit, or outcome, of engagement with RICHER aligns with Hutchinson's (2006) conceptualization of the (health) protective nature of practices that foster engagement and inclusion. Hutchinson and other scholars extend the conceptualization of social capital to include its "bridging" and "bonding" functions. Such processes are viewed as offering "a meaningful structure from which to theorize and empirically study potential pathways between social environmental factors and health" (Mignone & O'Neil, 2005, p. 27).

Social capital is increasingly being taken up in popular discourse and is understood by many as aligning with Western notions of the value of particular social skills, attributes, or abilities. For these reasons, and because many perceive it as aligning with Western economic conceptions, social capital has been the subject of critique (Brough et al., 2006; Hunter, 2006). Despite their support for the concept, Mignone and O'Neil (2005) alert us to the conditions necessary for ensuring that its benefits are accessible to all:

> In the urban areas where Aboriginal youth tend to concentrate there might well be very little social proactivity and very low tolerance of diversity. If social capital is to be a resource for youth resilience it must be accessible, not just in some ideal Aboriginal community, but in the many different real life communities where Aboriginal youth find themselves. (p. 42)

As suggested by the literature cited above, *enriched social environments* offer protection against the adverse health outcomes associated with marginalization and social isolation. Enriched community environments that create avenues of access to social (and material) resources are viewed as products of effective engagement strategies. Other scholars have identified the collective advocacy, or the "capacity to realize collective goals," as an outcome that is linked with, or is a product of, social capital (e.g., Sampson, Morenoff, & Earls, 1999; Sampson, Raudenbus, & Earls, 1997, p. 918). These scholars' conceptions of collective efficacy combine the concepts of social control and social cohesion. To achieve its goals, a community must also have "community social capital" or "control over" its strategies.

Our conceptualization proposes that engagement with Learning Circles has the potential for increased participation in community life; enhanced understanding of how to navigate community and institutional structures; and increased recognition of the knowledge, abilities, and skills of community members. We will now draw upon our interview data to illustrate the community members' views of their engagement with Learning Circles.

Community Perspectives on Engagement With Learning Circles

The Learning Circles introduced a new "language" and modality of learning into the training repertories and prompted broader dialogue and awareness of day-to-day practices of exclusion and their impact. In each case, individuals' *expertise* was introduced into the circle through sharing, and the members of the circle incorporated these different perspectives and ideas into their plans for achieving their goals.

In the youth circles, the participants shared challenges they might have met in dealing with the behaviour of a particular child (e.g., not wanting to wait his or her turn and being disruptive in the group; not being able to follow complex directions for an activity) and discussed ways that such situations might be handled. These teens drew upon ideas and strategies shared by others in the circle and applied them to their engagement with the particular buddy they were supporting. At other points a teen would share his or her expertise to help another teen. In the process, some of participants felt affirmed and realized that they already possessed or had acquired valuable knowledge and skills. One shy young mentor gained the confidence to have a discussion with the parents of his buddy at the end of each camp day. He described their child's daily successes and achievements and also shared some of the strategies used to support the child's positive outcomes.

The youth circles not only developed the capacity of the counsellors and buddies, but also taught other children how to engage effectively with their peers, thereby fostering inclusion. A mother recounted her experience:

> *They teach the other children how to recognize my son's behaviours so that they can back away as quickly as possible for their safety and for my son's safety. They understand that my son has no control . . . But the [commu-*

> *nity centre] has worked . . . to include him, and not only to include him but to include everybody else around him and educate them.*

Another mother described how the buddy strategy positively influenced her son's summer experience:

> *He liked the buddy thing . . . he did feel safer having somebody there to help him by crossing the street, doing things, or just having somebody beside him . . . and they had the field trips and stuff like that. He said he enjoyed it.*

A participant in the parents' group noted that engaging with others using the circle concept

> *taught me a lot in terms of who I am and and how I deal with my community and the people around me. And it really acknowledges the Aboriginal way of checking on the world and how everybody is. It gave me an opportunity . . .*
>
> Researcher: *Do you see that it's important for your kids, who are living in an urban centre that is dominated by white people like me?*
>
> Parent: *I think it's very important for them to see that. It's very important for them to understand that everybody has the right to their own cultures and everybody has the right to do things in a way that makes them feel good.*

The participants in the group went on to describe ways that respect for others and recognition of the value of inclusion had extended into the broader community.

> Parent: *I make the effort. I went to . . . English-as-a-second-language classes, even though I spoke English already, because I wanted to see the women that were learning English so I could learn their language so I could actually communicate with them when it came time . . . because they seemed to be a minority that was being left out. Nobody was taking any initiative, or making efforts to connect with these Asian women.*

Such comments signal not only an increased understanding of how to navigate community and institutional social structures but also suggest that such insights prompt broader community participation. The following comment illustrates how engagement with the circle can instil confidence and inspire the group to take its insights forward to others in order to address issues of concern in the neighbourhood:

> Parent: *The ideal of everything is: the better you feel, the stronger you feel, the more secure you feel, the better you're going to do in life, the better your*

> *children are going to be — to see your positive role modelling, which will reduce apprehension, drinking, drugging, depression.*

Through engagement with different Learning Circles, family members realized the value of their particular forms of expert knowledge and skill not only for themselves, but also for their families and their community. Participants spoke of how their engagement created a sense of connection to others, and they viewed this engagement as enriching the community environment.

Concluding Comments

Fostering engagement through the use of Learning Circles takes into account multiple forms of expertise. For the Aboriginal women and children involved, it resonated with their experiences and was a way for them to locate their "ways of knowing" alongside other knowledges, with positive, affirming effects. Also, it was observed that the circles created a space or place where the person sharing an issue or problem could feel included and valued as a contributor. Through this engagement, individuals became part of the solution to the issues being explored. Parents and young people expressed this feeling in various ways, and their comments indicate that their engagement altered their self-perceptions. Instead of expecting to be directed, or to be told what to do, as is typical in professional learning or training models, individuals became part of the circle (collective), taking ownership and playing a role in resolving the issue.

As we traced the history of Learning Circles, reflected on the ways in which they were being enacted, and considered them in relation to our own disciplinary perspectives, we identified points of connection. Some of us saw the Learning Circle as aligning with key tenets of a feminist stance, while others reconciled or interpreted it in light of such concepts as capacity-building and engagement. On reflection, however, we came to see the wisdom of using the traditional language to name the strategy. The intentional use of the language provided a point of reference — and visibility — for a traditional Aboriginal strategy of dialogue and engagement within an integrated (mainstream) context. It was also affirming to examine the process and recognize its value for individuals and for the community. This point is underscored by scholars who remind us that language carries culture and worldviews (Smith, 1999). Language also has the potential to marginalize or to convey messages of inclusion (Lynam, 2005, 2007). In our cases, the insights from Aboriginal traditional practices not only informed work with Aboriginal community members but also fostered dialogue and shaped engagement with their neighbours.

A core structural element of the RICHER initiative is its "community table," a weekly forum for engagement and problem-solving (Lynam et al., 2010). As we engaged in writing this article, we observed that the RICHER community table shares many features with Learning Circles. In this instance, we have perhaps implicitly merged traditional and professional knowledges to create a mechanism for ongoing dialogue and engagement. The implications of the present analysis can, we believe, inform broader dialogue within nursing about the nature of our practice, the conceptual roots of the knowledges upon which we draw, and, perhaps most importantly, the ways in which we choose to engage in order to foster health equity.

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M. Judith Lynam, RN, MSN, PhD, is Professor, School of Nursing, University of British Columbia, and Research Lead, RICHER Social Pediatrics Initiative, Vancouver, British Columbia, Canada. Erin Grant is completing a BA in Women, Sexuality and Gender Studies at Simon Fraser University, Burnaby, British Columbia. Katie Staden is completing a BSc in Kinesiology at Simon Fraser University.

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Résumé

Comment contrer les inégalités en santé en faisant participer les Autochtones aux discours politiques en matière de santé

Alycia J. Fridkin

Les inégalités structurelles ont un effet sur la santé des Autochtones, mais les interventions menées pour s'attaquer à ces inégalités en matière de santé sont souvent axées sur les collectivités plutôt que sur la structure où elles pourraient jouer un rôle transformateur. S'attaquer aux inégalités structurelles en matière de santé en faisant participer les Autochtones aux discours politiques relativement aux soins peut permettre de contrer les déséquilibres sur le plan du pouvoir qui font partie intégrantes des processus d'élaboration des politiques. À l'aide d'un cadre analytique reposant sur des perspectives interdisciplinaires issues des approches critiques et de décolonisation, l'auteure analyse les considérations théoriques visant à inclure les Autochtones dans les discours politiques pour contrer les inégalités en santé. Elle soutient que la participation des Autochtones aux discours politiques en santé pourrait réduire le colonialisme épistémologique, faire avancer un programme de décolonisation et venir à bout des inégalités en santé causées par des systèmes de pouvoir inéquitables. L'article se termine avec des suggestions de recherches à effectuer et des commentaires concernant l'implication des professionnels des sciences infirmières et de la santé dans l'élimination des inégalités structurelles en portant attention aux discours politiques.

Mots clés : santé des Autochtones, discours politiques en santé, inégalités structurelles, santé, inégalités en santé

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Addressing Health Inequities Through Indigenous Involvement in Health-Policy Discourses

Alycia J. Fridkin

Although the health of Indigenous peoples is affected by structural inequities, interventions to address health inequities are often focused locally rather than at a structural level where they could play a transformative role. Addressing structural health inequities by involving Indigenous peoples in health-policy discourses can serve to address power imbalances that are implicit in policy-making processes. Using an analytical framework based on interdisciplinary perspectives rooted in critical and decolonizing approaches, the author presents a discussion of theoretical considerations for including Indigenous peoples in policy discourses as a means of addressing health inequities. She argues that the involvement of Indigenous peoples in health-policy discourses has the potential to mitigate epistemological colonialism, push forward an agenda of decolonization, and address health inequities caused by inequitable systems of power. The article concludes with suggestions for future research and implications for nursing and health professionals of addressing structural inequities through attention to policy discourses.

Keywords: Aboriginal health, decision-making, discourse and social structure, health, health disparities, health policy, Indigenous, inequity, equity

Introduction

Despite recent innovations in public health and health care in Canada, health and social inequities between Indigenous and non-Indigenous people persist. Health inequities among Indigenous peoples are illustrated by disparities in national and provincial health indicators, with Indigenous peoples consistently experiencing lower life expectancy, higher mortality, and higher infant mortality compared to other populations in Canada (Health Council of Canada, 2005). Significant inequities in the health status of Indigenous peoples in Canada have been documented across many areas of health, including chronic diseases such as diabetes, infectious diseases such as tuberculosis and HIV/AIDS, self-reported disability, mental health and suicide (Health Canada, 2009), addictions and substance use, and trauma and violence (Pearce et al., 2008). Health inequities are also illustrated by Indigenous peoples' inequitable access to social determinants of health such as housing, education, employment and income, food security, and health care (Loppie Reading & Wien, 2009).

Health inequities are inherently structural, as they are "embedded in the political and economic organization of our social world" (Farmer, Nizeye, Stulac, & Keshavjee, 2006, p. 1686). This is clearly reflected in the overwhelming health inequities among Indigenous peoples in Canada, which are firmly connected to a history of colonialism and neocolonialism (Bourassa, McKay-McNabb, & Hampton, 2004; Browne, Smye, & Varcoe, 2005). The disproportionate burden of poor health and social suffering on Indigenous peoples has resulted from the legacy of colonial policies and practices in Canada, including

> the creation of the reserve system; forced relocation of communities to new and unfamiliar lands; the forced removal and subsequent placement of children into institutions or far away from their families and communities; inadequate services to those living on reserves; inherently racist attitude towards Aboriginal peoples; and a continued lack of vision in terms of the effects of these tortured relations. (Adelson, 2005, p. S46)

Addressing health inequities for Indigenous peoples therefore requires engagement at the level of social and political structures, as this is the level at which the root causes of inequities lie. However, too often public health and health-care interventions aimed at addressing inequities are focused at the individual or community level, not at the level of broader social and political structures. This article explores the potential for Indigenous involvement in health-policy discourses to address health inequities at a structural level.

Drawing on interdisciplinary perspectives rooted in critical and decolonizing theory, this article explores issues related to the inclusion of Indigenous peoples in health policy as a means of addressing health inequities. The purpose is to present a theoretical discussion of how Indigenous involvement in health-policy discourses can shift power relations, address issues of health equity, and advance broader social-justice agendas. I argue that the involvement of Indigenous peoples in health policy at the level of discourse has the potential to mitigate epistemological colonialism and shift power relations implicit in policy-making processes, which are integral steps in promoting health and social equity for Indigenous peoples. The analysis presented here is intended to inform future research exploring what is needed to foster health equity for Indigenous peoples through health policy and decision-making.

The article will first offer a rationale for why the involvement of Indigenous peoples in health policy is essential for addressing health inequities, and then unpack the relationship between discourse, power, and equity in order to explore how Indigenous involvement in policy discourses can mitigate colonialism and promote decolonization of policy-making processes, which is integral to addressing health inequities. The next section will discuss theoretical considerations for addressing health inequities through Indigenous involvement in policy discourses, which includes navigating epistemological tensions within health-policy decision-making, re-conceptualizing the role of the state in deliberative processes, and re-conceptualizing notions of collaboration between Indigenous and non-Indigenous people. A concluding section will suggest directions for future research and discuss the role of nursing and other health disciplines in addressing health inequities through structural changes to the Canadian heath-policy system.

Why Indigenous Involvement in Health Policy Is Integral to the Achievement of Health Equity

As health and social policies play a key role in determining health and health inequities (Mechanic, 2002), the people involved in decisions on health and social policy likewise play a key role in influencing health and health inequities. Yet those who are most severely impacted by inequities tend to be the least involved and the least represented in policies and decisions that affect their health (Whitehead & Dahlgren, 2007), which contributes to policy decisions that continue to exclude and marginalize (Lombe & Sherraden, 2008). Indigenous peoples, whose health inequities are largely shaped by policies stemming from a history of colonialism, have likewise been excluded and marginalized not only by health and social policies, but also by the processes of health policy-making (Fiske & Browne, 2006). Consequently, Indigenous peoples have long advocated for Indigenous participation in health policy and decision-making as a way of ensuring that policies are relevant and meaningful for Indigenous communities and will lead to improved health for Indigenous peoples (Fredericks, Adams, & Edwards, 2011).

However, often when Indigenous peoples are included in health-policy or decision-making processes, such as community consultations, the resulting decisions neither reflect the desires of communities nor lead to equitable outcomes (McConaghy, 2000). Indigenous peoples are often misrepresented or included in superficial or tokenistic ways, which can have harmful implications. Negative representations, for example, can "undermine Aboriginal people's assertions that they are capable of taking on responsibilities of self-government" and provide justification for preserving the status quo (Fiske & Browne, 2008, p. 14). Such consultative processes have also contributed to the essentialization of Indigenous peoples as having one, singular voice (McConaghy, 2000), thereby constructing Indigenous peoples as a monolithic entity, which can serve to undermine Indigenous diversity and cause further marginalization within Indigenous communities. Furthermore, governments often include community input with the aim of legitimizing decisions that are already being implemented (Abelson et al., 2003; Anderson, Shepherd, & Salisbury, 2005), which not only results in policies that uphold the status quo but also holds Indigenous people accountable for decision that were actually made by governments (LaRocque, 2001). As governments are not held ethically or morally accountable to Indigenous communities for the implications of their policy decisions, Indigenous peoples' involvement in and control over health decision-making is integral to the promotion of ethical health-policy decisions (Tait, 2008) that are made with the interests of Indigenous peoples in mind.

Consequently, it is not enough for Indigenous peoples to be involved in health-policy decisions; they need to be involved at the core of health decision-making in order to promote policy decisions that are effective in addressing health inequities (Fredericks et al., 2011; Reading, 2009). The nature and level of Indigenous peoples' involvement in health policy and decision-making therefore require considerable attention. Smye and Browne (2002) raise questions that are helpful in assessing the level of Indigenous peoples' involvement in health policy and in prompting thinking on the implications of such involvement for Indigenous peoples:

> In the context of a consultative process, we [the authors] are also concerned about whether or not the voices represented are those of Aboriginal people or simply the rhetorical voice of policy makers espousing the benefits of reform, in the absence of real material gains for Aboriginal people. Are Aboriginal people involved and how: at the symbolic level or is their involvement influential and meaningful? (p. 54)

Building on the above questions, this article attempts to provide a theoretical foundation for further thinking on *how* Indigenous peoples can be involved in health policy at a deeper, more influential, and more meaningful level.

Discourse, Power, and Equity: Implications for Indigenous Inclusion in (and Exclusion From) Canadian Health-Policy Discourses

Policy-making environments are not neutral grounds. Unequal power relations underpin the foundational structures of Canada as a nation-state, permeating every aspect of society with ideologies of colonialism, oppression, and domination. These inescapable power relations are implicit in all forms of contemporary political life, with severe implications for people who have been marginalized by political processes and must become engaged in those processes in order to change them. Democracy becomes questionable (Begaye, 2008) when people are asked to participate in the very decision-making system that created their marginalization, exclusion, and unjust treatment (Bourassa et al., 2004; Labonte, 2004; McConaghy, 2000). For example, in her research with Indigenous communities in northern Canada, Irlbacher-Fox (2009) found that "self-government negotiations marginalize and exclude Indigenous peoples' experiences and aspirations, to the point that agreements reached do not represent a form of self-determination but rather another iteration of colonization and forced dependence" (p. 5). The pervasive colonizing and marginalizing effects of policy processes perpetuate Indigenous peoples' suffering (Irlbacher-Fox, 2009) and exclusion from social and political life, severely hampering the political engagement of Indigenous peoples, who are, paradoxically, excluded through supposed processes of inclusion. Labonte (2004) notes the inherent contradiction in including people who have been politically excluded in policy as a means to effect change. He asks, "How does one go about including individuals and groups into a set of structured social relationships that were responsible for excluding them in the first place?" (p. 256).

To address the question of how to include Indigenous peoples in the very policy system that created their exclusion, marginalization, and inequitable health status, critical theoretical perspectives point us in the direction of discourses. Fiske and Browne (2008), drawing on the work of Foucault, argue that health policy is a "'technology of power' that operates through various discourses" to construct what is normal and who is credible and deserving in society (p. 8). Health-policy discourses have the power to shape the positioning of individuals or groups in relation to the broader social world, and this effect trickles down to people's everyday experiences. Dorothy Smith (2005) defines discourse as "translocal relations coordinating the practices of definite individuals talking, writing, reading, watching, and so forth, in particular local places at particular times" (p. 224). She theorizes that "people *participate* in discourse, and that their participation reproduces [and modifies] it" (p. 224). Such critical perspectives help to unpack the relationship between policy discourses, power, and equity; discourses are a technology of power that shape the organization of our social world, including social hierarchies and power structures such as those that produce health and social inequities.

However, critical perspectives also suggest that discourses are not fixed, and although they determine who can and cannot participate at various levels of decision-making, discourses can also be shifted through participation in their reproduction. Participating in policy discourses can thus foster discursive shifts that have the potential to change social and political structures, which are essential to the achievement of health and social equity (Ahn & Bae, 2009; Yamin, 2009). Challenging or shifting policy discourses can serve not only to change the process by which policy decisions are made and the outcomes of policy processes, but also to shift relations of power between dominant, colonial institutions and colonized or subjugated peoples.

Decolonizing Health-Policy Discourses

The Canadian policy system is based on colonial underpinnings, whereby participating in policy-making means participating in a system built on colonial assumptions, such as the assumption that Canada is a legitimate nation-state. Indigenous people engaged in policy-making are consequently forced to engage with policy discourses that are rooted in colonial assumptions, such as the discourse of *citizen engagement* often used in the context of health policy (Fiske & Browne, 2008). The term "citizen engagement" suggests that to be eligible for engagement a person must be a *citizen,* a legally defined member of the nation-state. This criterion for engagement relies on the nation-state's definition of a person's identity, which is the ultimate affirmation that it is the nation-state that defines not only a person's identity, but also who is included in and excluded from engagement. Citizen engagement thus exemplifies a form of discursive colonialism, as it implicitly negates and excludes people who resist such definitions and/or who define themselves according to different systems of governance, such as Indigenous systems of governance, which largely remain unrecognized and thus delegitimized by the state.

Canadian policy discourses, which have colonial underpinnings, are Eurocentric. Such policy discourses singularly rest on Western worldviews and ideologies while simultaneously oppressing and negating Indigenous knowledges. As Abu-Laban (2007) points out, participation in Canadian public policy, including the examination of Canadian systems of governance, "has tended to be shaped by a selective understanding of Canadian society. This in turn refracts a selective attention to history and in particular the variety of historical narratives that exist in contemporary Canada" (p. 137). The exclusion of Indigenous peoples' histories and knowledges from policy discourses is a form of epistemological colonialism, whereby Indigenous epistemologies are subjugated via the dominance of Western epistemologies. Colonialism at the level of policy discourse has severe implications for Indigenous peoples, as Indigenous worldviews, knowledges, and histories are omitted from policy-making, thereby forcing Indigenous peoples to engage in policy by taking up colonial discourses as their own — an ultimate form of assimilation.

Indigenous involvement in heath-policy discourses, however, can serve to mitigate epistemological colonialism by bringing discourses rooted in Indigenous knowledges to the dominant policy system and creating an Indigenous presence within the foundations of policy-making environments that shape health and health inequities. Including Indigenous peoples in policy discourses may serve decolonizing aims by reshaping policy-making processes, which are deeply rooted in colonialism, and achieving transformative structural change. Participation in policy processes is inextricably linked to power, and participating in decision-making provides opportunities to challenge political decisions and policy discourses that exclude and marginalize (Yamin, 2009). Including Indigenous peoples in decision-making can facilitate discursive shifts that disrupt dominant and colonial relations of power in policy-making processes, which is essential for decolonizing policy-making (Fredericks et al., 2011), mitigating continued epistemological colonialism and creating policy outcomes that are relevant and meaningful to Indigenous peoples.

Addressing Health Equity Through the Involvement of Indigenous Peoples in Health Policy: Theoretical Considerations

Although there is a substantial literature on strategies for public participation in health policy and decision-making (see Anderson et al., 2005; Carpenter & Brownhill, 2008), few studies have applied these strategies in an Indigenous policy context and addressed the problems associated with colonial ideologies embedded in policy-making processes. Given the entrenched power inequities between Indigenous peoples and Canadian governments (Irlbacher-Fox, 2009), we need further theorizing around how Indigenous peoples can be ethically and meaningfully included in health-policy and decision-making processes.

Navigating Epistemological Tensions

Although diverse forms of knowledge are required for policy change (Bryant, 2002), the dominance of Western-based epistemologies in the

Canadian policy system oppresses and silences Indigenous epistemological perspectives. Kenny (2004) illustrates this by describing the tensions between Western (rationalist) and Indigenous (holistic) views of policy:

> By its very nature, rationalist policy is not holistic in its intent or application. Rather, it is grounded in a divisible world in which people are placed according to a range of implicit and explicit categories that are socially divisive . . . Dichotomous positioning of the problem and solution leads to linear progressive strategies that can be evaluated through time to monitor change and progress. This manner of thought not only fails to embrace holistic approaches, it positions itself against holistic world views precisely because they are not marked by linear progression and evaluative norms grounded in before/after differences. (p. 14)

Navigating such epistemological tensions is essential if policy-makers and Indigenous people are to work together to arrive at policy decisions and engage in policy discourses that are inclusive of Indigenous perspectives. However, such epistemological navigation is difficult to achieve, as it requires a paradigmatic shift in philosophical thinking about policy-making, and, not surprisingly, there is little policy literature on how diverse people can work together when the knowledges of one group delegitimize and negate those of the others.

Based on his research on Aboriginal rights in Canada, Turner (2006) suggests a possible strategy for working across epistemological differences. He describes how the exclusion of Indigenous peoples and worldviews from discourses on Aboriginal rights has resulted in the development of theories that perpetuate colonialism and that are neither relevant nor meaningful to Indigenous peoples. Turner asks, "How are Indigenous voices to be accommodated in the legal and political discourses of the state?" (p. 7). To address this question, Turner calls on Indigenous intellectuals to become educated in discourses based on Indigenous knowledges as well as discourses based on Western European epistemologies and to act as "word warriors" whose role is to reconcile knowledges rooted in Indigenous communities with legal and political discourses of the state. An example of Turner's proposal might be increased hiring of Indigenous people in high-level policy-making positions in the federal government.

Turner's (2006) strategy for including Indigenous peoples in policy discourses is based on ideologies of Indigenous sovereignty and self-determination, and, as Turner argues, it is the responsibility of Indigenous scholars to take up this work. However, this argument could resonate within the neoliberal underpinnings that are increasingly common in health-policy discourses, where the onus is placed on communities to address their own needs, relieving government of responsibility for the inequitable conditions it creates (Anderson, 2000; Murray, 2004). The call for Indigenous responsibility in initiating policy change prompts questioning about the role of policy-makers in facilitating an equity agenda.

Ermine's (2007) work on the "ethical space of engagement" can inform thinking about ways in which governments and colonized peoples can work together in the context of policy. He conceptualizes a separate, mutual space of engagement that is not solely rooted in the epistemological underpinnings of either group and where groups with differing worldviews can collaborate. Engagement in this space requires the following: agreement by both parties to acknowledge underlying assumptions and complexities; an ethical lens brought by each party to the forefront of engagement; a focus on the commonalities between the engaged human communities; and acknowledgement and suspension of colonizing and oppressing assumptions, which undermine dialogue between nations.

Though conceptually innovative, Ermine's (2007) ethical space of engagement begs several questions. Where does such a mutual space exist? How could such a space be fostered, given the current neocolonial and Eurocentric policy climate? And if such a space exists, what would it take to get dominant or colonizing groups to agree to enter it, thereby surrendering their power? Additional questions arise around how to promote engagement at the level of ideology, when ideologies become so deeply entrenched that they are invisible to their beholders. Although difficult to conceptualize, an example of Ermine's approach might involve the development of a new policy language — including new discourses — by both Indigenous and non-Indigenous parties, resulting in a hybrid policy culture rooted in both Western and Indigenous epistemological perspectives in which new Western- and Indigenous-infused policy-making processes could emerge.

Re-conceptualizing the Role of the State in Deliberative Processes

Building on Ermine's (2007) assertion that collaboration must take place in a space free from epistemological domination, Dryzek (2005) argues for a discursive democracy that can facilitate engagement with deep epistemological differences. Dryzek suggests that for deliberative processes to be truly democratic, and for such processes to address deeply rooted differences, deliberative processes must be removed from the sovereign state. Drawing on international contexts of conflicts between nations, Dryzek argues that the resolution of such differences must occur through the development of a power-sharing state. For example, Dryzek's proposal might involve the development of a new "multi-nation-state" based on both Indigenous and European systems of governance. Alfred (2005) suggests an even more radical approach, one that involves a complete resurgence of Indigenous peoples against the dominant society, which can be achieved only through spiritual connection in the self and as collective Indigenous communities. Perhaps Alfred's approach would involve the development of an entirely new and globally recognized state with a system of governance based solely on Indigenous worldviews.

Although they differ in their proposed strategies, Ermine, Dryzek, and Alfred share the view that decision-making processes between nations with epistemological differences and power inequities must take place in a context outside of the colonial state. Theses authors' arguments implicitly acknowledge the colonizing and marginalizing effects of state-sponsored policy processes and their potential for inhibiting the development of policy agendas that promote equity. Consequentially, a re-conceptualization of the role of the state in policy-making processes is warranted. Such theoretical considerations prompt further questions: What *is* the role of the state in policy-making processes? Is equitable policy-making possible in the face of a colonial nation-state — even if deliberative processes are removed — or is the dismantling of a colonial nation-state an inevitable prerequisite for equity?

Re-conceptualizing Collaboration

Policy-making processes are wrought with power. The very notion of Indigenous peoples being involved in policy is an expression of power, as it implies that Indigenous peoples need to be involved because dominant non-Indigenous groups have been engaged from the start; it is as if dominant groups grant permission to hear the voices of Indigenous peoples, while dominant voices permeate society. Based on these assumptions, the onus is on Indigenous peoples to make themselves visible to the powerful (Jones & Jenkins, 2008), which places the burden of change on Indigenous peoples instead of on dominant and colonial groups.

Shifting power relations implicit in policy-making processes requires a change in the way that colonized and colonizing groups come together from the start. Notions of collaboration, however, suggest a range of problems yet to be resolved. In addition to questions of *with whom, with what methods,* and *under what conditions* collaboration occurs in an Indigenous context, the emergence of collaborative approaches has resulted in "collaborations" where white people enter fields of legitimacy previously restricted to Indigenous people, resulting in white people gaining credibility for speaking about Indigenous issues. Collaboration can also detract from self-determination, as Indigenous voices can become enveloped by and suppressed within the notion of "us" (McConaghy, 2000). Focusing on differences between collaborating parties is essential, as to ignore difference is to ignore the power differences between groups, differences that ultimately shape health inequities and perpetuate inequitable power relations (Jones & Jenkins, 2008; Young, 2002).

Strategies for collaborative policy development can be informed by these criticisms of collaboration, as well as the above theoretical discussion on what is needed to foster shifts in power relations that create and are created by policy discourses and policy processes. Such processes of policy development can lead to policy outcomes that are relevant and meaningful for Indigenous peoples, halt the perpetuation of marginalization and colonialism, move towards decolonization, and promote health equity for Indigenous peoples.

Concluding Comments

Considering that policy-making processes and policy discourses perpetuate inequities and marginalization, without a paradigm shift and transformative change in policy development processes, policy-making processes will likely continue to exclude and marginalize and consequently produce health and social inequities. While this article has discussed theoretical considerations for involving Indigenous peoples in health policy and shifting power relations to address systemic health inequities, further research is needed on strategic directions for ethically and meaningfully involving Indigenous peoples in health policy in ways that will lead to health equity.

As we have seen, foundational changes to the Canadian policy system are integral to addressing health inequities. However, policy reform is difficult to achieve and implementation will likely take a long time. Consequently, it is important to develop strategies on multiple levels in order to push forward policy agendas that address the more immediate health and social needs of Indigenous peoples. Pragmatic strategies are necessary for involving Indigenous peoples in policy debates, and such strategies may have the potential to effect small-scale changes that can incrementally contribute to large-scale systemic change. For example, Matthews, Pulver, and Ring (2008) suggest the need for increased Indigenous involvement in policy formation at a senior governmental level, increased participation of community-controlled health organizations in policy-making processes, and commitment to ensuring that there are sufficient resources for policy implementation. Although these recommendations do not call for policy reform, advocacy for including Indigenous peoples in system-level decision-making extends beyond the theoretical level and is an important step towards eventual structural change.

Nurses and other health professionals typically are not trained to address health inequities through structural change (Farmer et al., 2006). However, they have an important role to play in addressing health inequities. Consequently, we need additional pragmatic recommendations such as those discussed above in order to address health inequities at a structural level. For example, nurses who work in clinical settings may not be attuned to the way in which policy discourses are carried out and reproduced in nursing practice. Paying attention to the policy discourses that are manifested in nursing practice may foster an awareness of how such discourses perpetuate or mitigate power inequities, and subsequently provide opportunities for nurses to resist and challenge their continued use.

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Alycia J. Fridkin is a PhD candidate in the Interdisciplinary Studies Graduate Program, University of British Columbia, Vancouver, Canada.

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Happenings

Core Competencies for Indigenous Public Health, Evaluation and Research (CIPHER): A Health Inequity Mitigation Strategy

Lauren Y. Baba, Jeffrey L. Reading

Indigenous populations across the globe, though culturally diverse and geographically dispersed, share a common struggle to overcome health disparities and cultural conflict with mainstream health services. Indigenous people around the world, including members of First Nation, Inuit, and Métis communities in Canada, have higher rates of communicable disease, chronic disease, mental illness, and preventable injury, as well as shorter life expectancies, than their non-Indigenous counterparts (Cunningham, 2009; Health Canada, 2007; Reading, 2009). Historic trauma, socio-economic disadvantages, and conflict between traditional health beliefs and the dominant, often Western, health-care system also negatively impact Indigenous health (Durie, 2004). These inequities are an emerging global health priority. However, strategic actions to address gaps in Indigenous health and health-service quality have not been adequately developed. Public health interventions delivered by informed and culturally competent practitioners are urgently needed in order to address the growing health crisis faced by Indigenous populations.

The United Nations, the World Health Organization (WHO), and the Pan American Health Organization (PAHO) have in recent years called for consultation with Indigenous communities on matters of health program planning (Pacari & Vega, 2009; United Nations Permanent Forum on Indigenous Issues, 2003). Separately, these organizations have also promoted the development of core competencies in public health, as a means of improving education, training, and service delivery (Koplan, Puska, Jousilahti, Cahill, & Huttunen, 2005; World Health Organization [WHO], 2005). But what if the Indigenous perspective were applied to public health core competencies? This question has been raised by 12 Indigenous scholars from Australia, New Zealand, the United States, and Canada, initiating the idea for an international program to establish Competencies for Indigenous Public Health, Evaluation and Research (CIPHER). In July 2011 the group convened at the University of Hawaii in Honolulu and agreed by consensus that Indigenous health could be improved by promoting culturally safe public health practices through the development and implementation of core competencies for Indigenous public health.

Global Indigenous Health

The experiences of Indigenous people around the world vary greatly, by age, gender, education, cultural identity, community framework, geographic location, rural/urban setting, and political circumstances. However, many Indigenous peoples share experiences of colonization, sociocultural marginalization, and health inequity, leading international organizations to promote the integration of Indigenous perspectives into health-care systems. In 1992 a hemispheric workshop on the health of Indigenous peoples was held in Winnipeg, resulting in the PAHO Health of Indigenous Peoples Initiative, which emphasizes collaboration with Indigenous communities (PAHO, 2003a; WHO, 2006). In 2002 the United Nations established a Permanent Forum on Indigenous Issues, which has since recommended that WHO and PAHO incorporate Indigenous healers and cultural perspectives into health policies and programs (United Nations Permanent Forum on Indigenous Issues, 2005). Most recently, the United Nations adopted the Declaration on the Rights of Indigenous Peoples, articles 21 and 23 of which assert the right of Indigenous peoples to improved health and self-governance of health programs (United Nations, 2007).

Core Competencies in Public Health

Core competencies in public health represent a set of skills, knowledge, and values necessary for the provision of effective health services. Although core competencies cannot address every health topic or every determinant of health, WHO has published a number of reports and articles on the benefits of implementing core competencies in the public health field. For example, Koplan et al. (2005) describe the implementation of core competencies as a critical function of public health institutes, where the purpose of competencies is to influence Master of Public Health (MPH) program curricula, training for practitioners, and evaluation of health-care systems. Also, the WHO Department of HIV/AIDS has published a report addressing core competencies for HIV/AIDS health and community workers (WHO, 2005). WHO, UNAIDS, and the

Global Fund to Fight AIDS have since implemented training and certification guidelines, because core competencies "promote clarity in defining tasks and roles . . . are a foundation for the development of standardized training programmes [and] guide quality assurance activities" (WHO, 2005).

The CIPHER Program

The CIPHER scholars propose to apply the public health core competencies model to the Indigenous public health discipline as a strategy for mitigating Indigenous health inequities. The CIPHER strategy is aimed at improving the cultural safety of Indigenous health services, through standardized training of public health practitioners and formal integration of Indigenous health perspectives into public health education, practice, and governance. The result will be a higher quality of Indigenous health services and reduced Indigenous health disparities. Given the plurality of Indigenous populations, the core competencies must balance unique community approaches with a consensus on what constitutes a core set of knowledge, skills, and values for the transnational workforce in Indigenous public health. To initiate a dialogue on how this balance might be achieved, CIPHER scholars are recruiting stakeholder participants, designing a core competency framework, and discussing implementation strategies. These activities are intended to coordinate the international CIPHER project while affording each country and community the flexibility necessary to tailor the core competencies to the distinct histories, cultures, and circumstances of their Indigenous populations.

The CIPHER project is recruiting Indigenous stakeholders to participate in the research, design, and implementation of the core competencies. These partnerships are in accordance with the integrated knowledge translation definition of the Canadian Institutes of Health Research (CIHR), the Health of Indigenous Peoples Initiative of PAHO, and the United Nations Declaration on the Rights of Indigenous Peoples (Canadian Institutes of Health Research, 2009; PAHO, 2003b; United Nations, 2007). Although the international scope of the project will limit the engagement of local representatives, CIPHER scholars plan to consult with regional Indigenous health-care organizations, national Indigenous health-advocacy organizations, Indigenous health-professional associations, and traditional healer organizations. The consultation process will reveal themes in health, history, and culture to address in the core competencies.

The themes identified through consultation will inform the design of the core competency framework. For example, a theme identified in the history category could be "historic treaties, laws, and politics that impact Indigenous health." The theme will be addressed by a specific competency stating that "the practitioner must be knowledgeable about the treaties, legal rulings, and political relations that historically and currently impact the health services received by the Indigenous population he/she works with." By attending to topics of Indigenous health knowledge and cultural competence, as shown in the example, the CIPHER competency model is meant to (1) address specific issues related to global Indigenous public health; and (2) remain broad enough to allow Indigenous communities, health organizations, and governments to tailor the competencies to the particular circumstances of each Indigenous population. Local ownership of the competencies can then contribute to the decolonization of health services and formalization of cultural safety standards in Indigenous health care.

Finally, the CIPHER implementation strategy is aimed at impacting Indigenous public health on three levels: academic institutions, practitioners, and employers/communities. Academic institutions can be shown how to enhance coursework and design competency-based education from the Indigenous perspective. Public health practitioners can assess their current skill levels and use the competencies to inform professional development. Employers and communities can assess overall Indigenous public health capacity and address gaps by developing training programs, adopting Indigenous health-care mandates, and advocating for government health policies that support culturally safe Indigenous health resources and services.

CIPHER, Canada, and the Next Steps

Thus far, CIPHER scholars at the University of Victoria's Centre for Aboriginal Health Research (CAHR) have secured funding from CIHR, the National Collaborating Centre for Aboriginal Health (NCCAH), and the Public Health Agency of Canada to conduct preliminary research. CAHR and NCCAH are also co-hosting a national meeting in Vancouver in June 2012 to engage Canadian scholars and First Nation, Inuit, and Métis stakeholders. CAHR hopes to host the international CIPHER scholars at a 2012 planning meeting, where preliminary research findings will be presented and the next steps planned. The project is an opportunity for Canada to become a founding member of an international CIPHER consortium, demonstrate Canadian leadership in global Indigenous health, and help to improve health status and health-service quality for First Nation, Inuit, Métis, and other Indigenous peoples around the world.

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Lauren Y. Baba, BA, is a Fulbright Student Scholar, Centre for Aboriginal Health Research, University of Victoria, British Columbia, Canada. Jeffrey L. Reading, PhD, FCAHS, is Director, Centre for Aboriginal Health Research, and Professor, Faculty of Human and Social Development, University of Victoria.

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Résumé

Offrir un lieu sûr : l'adoption d'une perspective de sécurisation culturelle dans les soins prodigués aux femmes autochtones vivant avec le VIH-sida

Jane McCall, Bernie Pauly

Les femmes autochtones qui vivent avec le VIH-sida sont plus susceptibles de mourir de maladies liées au sida et moins susceptibles d'avoir accès à des traitements pour leur infection au VIH que la population générale infectée par le VIH. Une étude examinant la vie et l'expérience de femmes autochtones faisant face à d'importants obstacles socio-économiques et vivant avec le VIH-sida a mis à jour divers thèmes liés à leur expérience des soins de santé, y compris la peur du rejet. Les participantes étaient réticentes à accéder aux services de santé parce qu'elles craignaient les jugements et la discrimination. Il était évident qu'elles ne se sentaient pas en sécurité dans un contexte de prestation de soins. Les auteures examinent la façon de mettre en œuvre les principes de sécurisation culturelle dans les relations thérapeutiques avec les femmes autochtones afin de faciliter le processus d'accès aux soins et le rendre acceptable, en temps opportuns.

Mots clés : femmes autochtones, VIH-sida, sécurisation culturelle

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Providing a Safe Place: Adopting a Cultural Safety Perspective in the Care of Aboriginal Women Living With HIV/AIDS

Jane McCall, Bernie Pauly

Aboriginal women living with HIV/AIDS are more likely to die of AIDS-related illnesses and less likely to access treatment for their HIV infection than the general population infected with HIV. A study examining the lives and experiences of Aboriginal women facing significant socio-economic barriers and living with HIV/AIDS uncovered a number of themes related to their experiences with health care, including fear of rejection. The participants were reluctant to access health services because they feared judgemental and discriminatory attitudes. It was evident that they felt unsafe accessing care. The authors examine how cultural safety principles might be applied in therapeutic relationships with Aboriginal women as part of the process of facilitating access to care that is acceptable and timely.

Keywords: Aboriginal women, HIV/AIDS, cultural safety, access to health services

The history of Aboriginal peoples in Canada is fraught with discrimination, marginalization, and disempowerment as a result of the colonial forces that have shaped (and continue to shape) Canadian law, policy, and program delivery (Loppie Reading & Wien, 2009). Many Aboriginal women have borne the effects of colonization, and have been left to struggle with disproportionate rates of poverty, ill health, and violence (Dion Stout, Kipling, & Stout, 2001).

Despite the development of numerous innovative HIV prevention and treatment programs designed for hard-to-reach populations, there are still high rates of infection, poor uptake of treatment programs, and disproportionately high rates of mortality and morbidity amongst Aboriginal women living with HIV/AIDS (Public Health Agency of Canada, 2010; Wood et al., 2003). Compared to non-Aboriginal women, Aboriginal women are diagnosed later in the course of their infection, are less likely to access treatment, and tend to have poorer treatment outcomes (Legare, Ross, & Bognar, 2003; Vernon, 2000).

A qualitative study examining the experiences of a small group of Aboriginal women living with HIV/AIDS with the health-care system has illuminated the struggle faced by Aboriginal women as a result of judgement, discrimination, and stigma (McCall, Browne, & Kirkham Reimer, 2009). For the most part, the women's experiences with the health-care system contributed to suffering and feelings of being unsafe when accessing care. Structural inequities or the way in which policies and practices reflect embedded racism, discrimination, and stigma impact both the health and the ability of people, including Aboriginal women, to access health care (Farmer, 2001, 2009). Such inequities are structurally produced and are remediable (Whitehead & Dahlgren, 2006). Redressing them can positively impact women's ability to access the resources needed to improve and maintain their health.

The purpose of this article is to interpret the findings from a qualitative study with eight Aboriginal women living with HIV infection and their experiences accessing health care, in order to inform understandings of cultural safety in the provision of health care. It is clear from the findings that it is critical for nurses and other health-care workers to understand the positioning of Aboriginal women in the health-care system and the need for safer environments. We begin with a discussion of culture, followed by a review of the concept of cultural safety. We next provide a review of key findings and how these may be interpreted in light of cultural safety. We then discuss the implications of the findings for culturally safe nursing practice.

What is culture?

It has long been acknowledged that, when planning and delivering care, it is important to consider the cultural heritage of people who use the health-care system and to take ethnicity into account. Although most if not all nurses understand and support this concept, there are large differences in shared meanings and understandings of culture. Traditionally, culture has been viewed as synonymous with ethnicity. There has been considerable work done in nursing to acknowledge "other cultures" that have tended to emphasize understanding of different cultural traditions. This approach tends to highlight differences in groups or whole societies that can lead to generalizations. It also runs the risk of inadvertently stereotyping people by creating lists of what we think they do or what we think they believe based on assumptions about the group we think they belong to (De & Richardson, 2008). A further problem with this approach is that it tends to restrict cultural considerations to minority groups and has the effect of emphasizing the differentness of those who have less power and fewer resources. A third concern is that this approach suggests that "others" have culture and it often obscures or misses the importance of culture in social structures such as health care.

Coward and Ratanakul (1999) observe that health care itself is a culture, "with its own belief system, social structure, initiation rituals, language, dress and educational system. Modern medicine does not occupy a neutral position from which to relate itself sensitively to other cultures. Rather modern Western medicine is itself a culture alongside other cultures — Muslim, Buddhist, Hindu, Chinese, etc." (p. 13). Thus, we are urged to expand our view of culture to include a much broader and deeper set of influences on the behaviours that shape both the personal and the social (Stephenson, 1999).

An expanded view of culture positions us to understand culture as a relational process with accompanying power differences. Culture is embedded within a shifting set of meanings that are related to historical, social, economic, and political processes. Culture is neither reducible to an easily identifiable set of characteristics nor politically neutral (Browne & Varcoe, 2006). Such a view brings into focus not only relational processes but also the power differentials associated with different positions in society. We use relational processes to refer not only to interpersonal processes but also to the organizational and systemic processes that produce structural inequities affecting both the health of Aboriginal women and their ability to access care.

What is cultural safety?

Cultural safety is a concept developed in New Zealand to address the needs of Maori health-care users who were experiencing poor health outcomes as a consequence of cultural inappropriateness and insensitivity on the part of the health-care system (Ramsden, 1996). It has now become apparent that cultural safety has the potential to address the needs of a wide range of social groups when factors such as age, gender, sexual orientation, socio-economic status, ethnicity, religion, and different ability or lifestyle contribute to discriminatory behaviours or practices (De & Richardson, 2008). For example, nurses at Insite, a supervised injection facility, have identified cultural safety as an important aspect of caring for people with problematic drug use (Lightfoot et al., 2009).

Cultural safety is about recognizing one's own privilege and the positioning of certain groups within a society (Anderson et al., 2003; Browne et al., 2009). It is predicated on understanding the power differentials in health-service delivery (Aboriginal Nurses Association of Canada, 2009). This understanding is critically important for redressing inequities — more important than what the members of a particular group think or do (Polaschek, 1998). The goal of cultural safety is to counter tendencies in health care that create cultural risk or cause patients to feel unsafe, which in turn can cause people to avoid or delay seeking care.

Cultural safety is based on health-care providers' analyses of their own cultural selves, the cultural meanings that they bring to the therapeutic relationship, and their reflection on the broad structural factors that shape such interactions (Anderson et al., 2003; Browne et al., 2009). It calls for recognition of the power imbalance that exists between providers and users of health care (Doutrick, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). Unlike transcultural nursing or cultural competence, which require the learning of cultural characteristics of particular groups and application of this knowledge to individuals, cultural safety demands that the provider form a relationship with the user such that the user is able to make a judgement about whether the therapeutic relationship is safe and appropriate (McEldowney & Connor, 2011). It is important to be culturally aware and sensitive to practices and customs, but it is *critical* to ensure that providers examine how their own beliefs, values, and assumptions can impact on the therapeutic relationships they form with their patients (Bearskin, 2011). Our cultural beliefs are internalized; generally, we do not consciously think about them. There is a tendency to perceive one's beliefs and practices as the norm and others as different. However, our beliefs form the basis of our judgements about people and events. In other words, the manner in which health care is provided starts from the perspective of one's own culture and an understanding of what the provider brings to the relationship and the culture in which care is provided. Cultural safety helps health-care providers resist the temptation to pigeonhole and stereotype based on beliefs about the group to which they think people belong.

The concept of cultural safety prompts nurses to reflect on the structures, discourses, and assumptions that frame the delivery of health care (Browne et al., 2009). It makes nurses consider the impact of not just relational processes but also systemic and organizational processes and their effect on patients. Cultural safety also prompts nurses to question their cultural selves and how their self impacts on those with whom they work. It allows us to form a relationship with patients that is based on the values and beliefs that each patient holds as an individual. Most importantly, cultural safety serves to remind us that the power relationship is skewed in favour of the health-care provider. In a culturally safe relationship, the service user is given the power to say when he or she feels that an encounter is safe or unsafe. A culturally unsafe relationship is reflected in signs that express a lack of tolerance for foul language or abusive behaviour. There are no signs warning against both subtle and overt behaviours that can affect patients' sense of safety, such as labelling patients as "frequent flyers" or "junkies." Cultural safety is a concept that can be used to operationalize equity and social justice in nursing and health-care practice (Anderson, 2003; Browne et al., 2009; Pauly, 2012). Given that inequities in access to health care are structurally produced and remediable (Whitehead & Dahlgren, 2006), cultural safety is a strategy that nurses can use to enact social justice in nursing practice.

From a perspective of culture that seeks to illuminate power inequities and to challenge organizational discourses and assumptions, cultural safety aligns with the goals of social justice in nursing practice. For example, the Canadian Nurses Association Code of Ethics specifies nurses' responsibility to not discriminate when providing health care, to preserve dignity, and to redress health inequities (Canadian Nurses Association, 2008).

Research Methodology

Theoretical Underpinnings

Allen (1999) points out that cultures and cultural differences are constructed, and that unless this construction is well articulated, social inquiry will inevitably create an "other," an "outsider," a "not us." In order to minimize the potential for colonialist appropriation, we used a postcolonial feminist perspective to inform the research approach for the study. Such a perspective allows for identification of the multi-layered sociopolitical contexts of health and illness and for the inclusion of subaltern voices (Anderson, 2000). Since the study sample comprised Aboriginal women whose voices are not typically heard within the health-care system, it was crucial that the research design provide ways of ensuring that their voices be heard.

Research Objectives and Question

This interpretive, descriptive, qualitative study had three objectives: to explore Aboriginal women's experiences of living with HIV/AIDS in their daily lives; to gain an understanding of how Aboriginal women living with HIV/AIDS experience formal support systems, including AIDS service organizations and health services; and to make recommendations for program design and policy development specifically addressing the needs of Aboriginal women living with or at risk for HIV/AIDS. The following research question was considered most pertinent to the study: *What are the experiences of Aboriginal women when they are accessing health care?*

In this article we focus on aspects of the findings that indicate whether the participants felt safe, with no fear of stigmatization and rejection, when accessing care.

Methods

The study used an interpretive descriptive methodology (Thorne, Reimer Kirkham, & MacDonald Emes, 1997). This is an appropriate methodology for such a study given that it acknowledges the constructed and contextual nature of human experience whilst allowing for shared realities (McCall et al., 2009; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Its emphasis on examining the constructed and contextual nature of everyday life made this methodology a good fit with the postcolonial feminist perspective that framed the study. A postcolonial perspective allows for identification of the multilayered sociopolitical contexts of health and illness and for the inclusion of subaltern voices (Anderson, 2000). Further, a postcolonical perspective fits well with the concept of cultural safety, which acknowledges that an individual's or group's positioning affects their experiences of the health-care system and that power differentials impact on patient safety.

Data analysis in interpretive description involves movement beyond the theoretical framework towards an abstracted interpretation that will illuminate the phenomenon being investigated in a novel and meaningful fashion (Thorne et al., 2004). The researcher becomes immersed in the narrative accounts in order to develop themes within each account and, through constant comparison, to describe patterns between and amongst the narratives (Irwin, Thorne, & Varcoe, 2002).

Ethical Considerations

Strategies to protect the participants' identities included the use of a unique code number for each person on all data sheets, avoidance of participant identification in transcripts and analytic memos, and the use of fictitious names in the final report. Ethical approval was obtained.

Sample

The sample consisted of eight Aboriginal women who self-identified as HIV positive. This number aligns with the recommendations of Sandelowski (1995), who proposes that qualitative studies to capture the essence of experiences have approximately six participants. Participants were recruited through one inpatient HIV unit and one outpatient HIV clinic. Nurses at these sites identified potential participants, gave them information about the study, and asked them if they were willing to be approached by the researcher. If the women agreed, the researcher approached them, reviewed the study protocol to ensure that they understood it, and obtained their consent.

Procedure

Data were collected via in-depth semi-structured interviews, which were audiorecorded and transcribed verbatim. The interviews took place in private rooms at the two sites. Interview questions were broad-based "trigger questions" intended to stimulate conversation. For example, the women were asked to tell the researcher about their experiences in the hospital. The participants' responses were used to generate more in-depth exploration of a particular area.

Data Analysis

The transcripts were read repeatedly to identify recurring, converging, and contradictory patterns of interaction; key concepts; emerging themes; symbolic examples; and possible connections to the underlying theory. The transcripts were coded and emerging themes and categories were identified. The emerging themes and categories were reviewed with two of the participants in a follow-up phone interview; the insights and feedback of these two participants were incorporated into the analysis.

Findings

The study produced some disturbing data (McCall, 2006). The women in the study were subject to marginalization in a variety of ways. They were of Aboriginal ethnicity, they were HIV positive, and a number of them used illicit drugs. Although they lived in a province with a universal HIV treatment program, most of the women were not being treated for their HIV infection and five had AIDS-related illnesses. Previous research has shown that the lack of medical follow-up for HIV is an issue, so this finding was unsurprising (Legare et al., 2003; Wood et al., 2003). A number of themes emerged. These included *looking for friendship, finding strength in adversity, the struggle to stay well,* and *HIV is just one problem among many.* All of these themes are relevant in some way to the concept of cultural safety, but the theme that is most relevant and that will be explored in this article is *fear of rejection* (McCall, 2006).

Fear of rejection by health-care providers is clearly linked to feelings of being unsafe as a result of the marginalizing social processes of stigma and discrimination. There is a wealth of research, particularly that conducted amongst people who use drugs, indicating that fears related to rejection or poor treatment are significant barriers to accessing health services (Latkin et al., 2010; McLaughlin, McKenna, Leslie, Moore, & Robinson, 2006; Room, 2005). Whilst not explicitly stated, such fears are underlaid with concerns related to stigma and discrimination, with implications for future access to health services and the development of trusting relationships with health-care providers (Browne, Johnson, Bottorff, Grewal, & Hilton, 2002; Pauly, in press). The finding of fear of rejection is discussed in this article with an emphasis on how it relates to Aboriginal women's sense of safety when accessing the health-care system and implications for the delivery of culturally safe care.

The participants all indicated that fear of rejection had a significant influence on how they lived their daily lives, including who they disclosed to, who they associated with, and where they lived. All but one of the women chose to live in a large city, where they believed they would be less subject to stigma and to censure by their neighbours and by service providers. As reserve communities are small and not conducive to maintaining confidentiality and anonymity, almost all of the women isolated themselves from their families and traditional support systems in order to protect their privacy.

The women spoke of both a reluctance and an inability to access health care due to fear of rejection or poor treatment. Cathy[1] said, "Why should I put myself in that position? I know what they're going to say and what they're going to do . . . I don't go to the hospital until I'm practically dead." Elizabeth, who had gone through a miscarriage, described her experience in a hospital emergency room: "I told them I was HIV positive, pregnant. They just — they were so cold." Justine found it difficult to bear the stigmatization and the disregard for her positioning in society: "We're mainly labelled as the drug addicts and the prostitutes and the unworthy, right?" Elizabeth's lifestyle precluded access to the health care she needed. She acknowledged that "leaning on the crack pipe" made it difficult for her to get to the clinic during its regular hours. People who use substances often prioritize their needs because it is difficult to manage their addiction. The women's experiences speak to fears about labelling by health-care workers and reflect the values of the dominant society with regard to who is worthy and unworthy. Labelling of these women served to associate them with the drug culture and the sex trade, in accordance with social norms, and subjected them to censure and judgement.

All of the women were reluctant to disclose their HIV status to health-care workers because they feared that confidentiality would not be respected and that they would be judged and censured. They were concerned that their status would be disclosed to other health-care providers and other patients without their consent. Fiona said, "When they ask me if I have___, I just say, 'Look in my file,' you know, because sometimes they ask me in front of a whole bunch of people." After Elizabeth's daughter was born, a nurse disclosed her status in front of some other patients and their visitors: "And the nurses and everything, they didn't even care, they just blurted everything out right in front of everybody else . . . and right away they threw it an AIDS case: Look at what you did to your kid . . . How can you live with yourself? What kind of . . . woman are you to have kids in the first place? . . . You shouldn't even have sex."

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[1] All names are fictitious.

The women also experienced some overt stigmatizing behaviour. Cathy spoke of having "doctors who won't even let me in their office because they figure I'm going to infect everything, infect their whole staff members." Mary spoke at length about her negative experiences with health-care workers: "I've had some experiences with health care in hospitals . . . when I had my daughter. God. They had big signs saying I was positive and, you know, the whole nine yards — the gown and the mask." Aboriginal identity complicated the stigmatization. Fiona explained that her Aboriginal identity made her a target for discrimination: "Being First Nations, well . . . it just makes it worse. People treat you badly." It is clear that these women were subjected to intersecting stigmas of gender, race, ethnicity, lifestyle, socio-economic status, and disease, which made it that much more difficult for them to navigate the health-care system (Benoit & Shumka, 2009; Wailoo, 2006). They recounted numerous episodes of judgemental and racist behaviour by nurses and others. In addition, the participants felt that nurses did not take the time to develop a therapeutic relationship with them based on communication and respect for or understanding of them as Aboriginal women.

Fear of rejection is almost universal amongst people living with HIV/AIDS (Paxton, 2002), but the fear of rejection expressed by the women in this study was complicated by a number of intersecting factors, including assumptions around "bad" behaviour such as illicit drug use or sex work, the idea that they were polluted in some way, and the perception that they posed risks to others. The racism that is inherent in the lives of many Aboriginal women compounded the stigma. The fear of rejection is unsurprising when the context of their lives is considered. Most of the women had experienced poverty, abuse, and issues around substance use, and these factors intersected with their social positioning as Aboriginal women and concomitant racist stereotyping. They all had firsthand experience with rejection on many levels. There are many dimensions to HIV/AIDS-related stigma, and the women's personal and social vulnerability put them at high risk for rejection. They were already experiencing marginalization and exclusion, so they were pushed even further away from the supportive elements of human society (HIV/AIDS Legal Network, 1999).

Wood and Schwass (1993) describe culturally unsafe practice as that which diminishes, demeans, and disempowers. It is clear from the women's stories that they experienced not only a feeling of being unsafe but also a lack of culturally safe care. A predominance of culturalist discourses in nursing and health care use popularized, stereotyped representations of culture as the primary analytical lens for understanding presumed differences in various groups (Browne et al., 2009). These marginalizing processes create cultural risk. It is important for nurses to examine their own selves as well as the systemic and organizational processes that put patients at risk for marginalization within health care and that perpetuate rather than mitigate harm. This is essential in order to promote access to health care and to ensure that Aboriginal women receive appropriate and adequate treatment. It is ethically concerning to think that women in need of care are not receiving it because of their social position.

Culturally Safe Nursing Practice

It is clear that the women in this study felt unsafe within the health-care system. They related experiences of being judged and stigmatized by the health-care workers with whom they came in contact. It is apparent from their stories that assumptions were made about them based on their "culture," drawing on societal norms related to drug use, HIV status, gender, and Aboriginal identity. The findings suggest that women often delay or avoid seeking health care as a consequence of feeling unsafe. This has significant implications in terms of both timely access to health care and their ongoing health and well-being.

The first step towards the provision of culturally safe care is for health-care providers, including nurses, to engage in a process of self-examination. Being aware of one's own culture, including dominant values and beliefs as well as privilege, is essential in recognizing how innate concepts impact on others. According to Regan (2005), "unsettling the settler within" is required in the effort to move from unconsciousness, denial, racism, and guilt about our history to an attitude of critical inquiry, reflection, and social action in which history is used as a catalyst for change. Hart, Hall, and Henwood (2002) propose that practitioners develop an "inequalities imagination" to help them understand how different constellations of disadvantage can come into play for their patients. In this approach, health professionals take a questioning attitude towards the subject of inequality and disadvantage. It allows the practitioner to reflect upon and adopt strategies that will close the inequality gap and lead to safe care. Such a process is particularly important for the population from which the participants in the present study were drawn, as these women were clearly disadvantaged in a number of ways, including poverty, gender, identity, historical trauma, and HIV status.

Culturally safe nursing practice is about acknowledging people's differences and taking these differences into consideration when drawing up each plan of care. It is about providing care that is regardful, not regardless, of difference. It is important for the nurse to establish a partnership with the patient that fosters respectful, holistic care (Bearskin, 2011). Fulcher (2002) describes this partnership as a "ritual of encounter" that uses a cultural lens along with a baseline assessment. A ritual of encounter is based on four criteria: positively expressing caring, understanding cultural practices, understanding the patient's background, and purposeful relationship building. For women such as the participants in the present study, who had negative health-care experiences on a frequent basis, it is important to establish a relationship based on trust and respect. It is imperative that they be partners in care and be given an opportunity to contribute to the decisions that are made about their treatment.

Two important considerations in the provision of culturally safe care are respect and communication. Nurses must endeavour to develop a therapeutic relationship that gives patients a safe space in which to communicate their needs and preferences. There are significant power differentials between health-care practitioners and people who are marginalized. These power differentials can make it difficult for those requiring care to communicate with health-care providers, who are perceived to be in a position of authority. Nurses need to be alert to subtle forms of communication such as non-verbal behaviours and need to create an environment that gives patients the confidence to express their needs and wants. People who are frequently marginalized and mistreated by the health-care system are very sensitive to non-verbal cues (Latkin et al., 2010). Even seemingly innocuous behaviour such as not responding to requests immediately or failing to make eye contact may be misconstrued as rejection.

The concept of cultural safety was developed to address the structural inequities that have been part and parcel of the experience of colonized Indigenous peoples, although it has become apparent that in fact this is a general concept that can be applied to other oppressed groups. Nurses need to routinely ask themselves and their clients if the health-care situation in which their patients find themselves can be considered safe. The cultural dimension in health care is not an abstraction. It is located in a specific context that structures relationships between care providers and patients (Polaschek, 1998). Cultural safety is an integral aspect of ethical nursing practice.

Conclusion

It is crucial that patients feel safe when accessing and using health care. When patients feel unsafe, they delay treatment and avoid accessing health services. The participants in this study faced barriers to forming therapeutic relationships with the providers with whom they came in contact, due to a lack of communication and a sense of powerlessness and fearfulness about how they would be treated. The women's experiences of judgement and stigma compounded their discomfort with the care that was provided. The findings show clearly that the women felt unsafe. Through the use of a cultural safety framework, nurses are able to develop therapeutic and safe relationships with their patients. When nurses practise in a culturally safe manner, they not only help to improve the lives of their patients but also stand to achieve a heightened state of self-awareness and professional growth.

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Jane McCall, RN, MSN, is Nurse Educator, HIV Program, St. Paul's Hospital, Providence Health Care, Vancouver, British Columbia, Canada. Bernie Pauly, RN, PhD, is Associate Professor, School of Nursing, University of Victoria, British Columbia.

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Résumé

La recherche en santé autochtone : les perspectives théoriques et méthodologiques

Adele Vukic, David Gregory, Ruth Martin-Misener

Les chercheuses et les chercheurs en sciences infirmières qui sont formés suivant les traditions euro-occidentales prennent conscience de l'importance des systèmes de connaissances et des méthodes de recherche autochtones. L'approche à double perspective *(two-eyed seeing)* est un exemple de l'effet que peuvent avoir les systèmes de connaissances autochtones sur la conduite des recherches. L'approche à double perspective et l'ouverture d'un espace éthique pour la cocréation de connaissances sont en accord avec les traditions autochtones et elles honorent la fusion des compréhensions autochtones et occidentales de l'éthique. Les auteurs expliquent comment la recherche communautaire participative et les principes de la propriété, du contrôle, de l'accès et de la possession aident à intégrer l'approche à double perspective et l'espace éthique dans des travaux de recherche en sciences infirmières traitant des priorités en matière de santé des Autochtones, avec les Autochtones. Ces notions respectent divers systèmes de connaissances et méthodes autochtones et, plus important encore, les considèrent comme essentiels à la recherche autochtone. Cette position est en accord avec celle des universitaires qui préconisent une recherche autochtone soutenant les principes du respect, de la pertinence, de la réciprocité et de la responsabilité.

Mots clés : connaissances autochtones, approche à double perspective, espace éthique, recherche en sciences infirmières, recherche communautaire participative, recherche en santé

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Indigenous Health Research: Theoretical and Methodological Perspectives

Adele Vukic, David Gregory, Ruth Martin-Misener

Nurse researchers schooled in Euro-Western traditions are learning the importance of Indigenous knowledge systems and research methodologies. Two-eyed seeing is an example of how Indigenous knowledge systems can influence the conduct of research. Two-eyed seeing and the opening of ethical space for the co-creation of knowledge are in keeping with Aboriginal traditions and honour the blending of Aboriginal and Western understandings of moral governance. The authors explain how community-based participatory research and the principles of ownership, control, access, and possession help to integrate two-eyed seeing and ethical space in shaping nursing research to address health priorities with Aboriginal peoples. These concepts respect diverse Indigenous knowledge systems and methodologies, and, importantly, position them as central to Indigenous research. This stance is consistent with that of scholars who advocate for Indigenous research that supports the principles of respect, relevance, reciprocity, and responsibility.

Keywords: Indigenous knowledge, two-eyed seeing, ethical space, critical inquiry, health research, community-based research, nursing research

In the Canadian context Aboriginal[1] health research is evolving and Canadian nurse researchers are contributing to the emergent theoretical and methodological perspectives of critical inquiry to reduce health inequities of Aboriginal peoples. The epistemological and ontological stances of diverse Indigenous knowledge[2] systems and research method-

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[1] The term "Aboriginal" refers generally to the Indigenous habitants of Canada, including First Nations, Inuit, and Métis. The Royal Commission on Aboriginal Peoples stresses that the term "Aboriginal peoples" refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called racial characteristics. The term "First Nations" replaces "Indian" and the term "Inuit" replaces "Eskimo." "Indian" and "Eskimo" continue to be used — for example, under the Indian Act. "Native" also continues to be used — for example, Canadian Native Mental Health Association. In this article we refer to Aboriginal when including First Nations, Inuit, and Métis, and refer more specifically to First Nations and/or Mi'kmaq, depending on the context.

[2] Indigenous knowledge is derived from Indigenous peoples. More than 5,000 Indigenous peoples live in 70 countries, with a world population of over 300 million. In each Canadian province, Aboriginal people represent a diversity of peoples, languages,

ologies reveal the need for commensurate research approaches. Thus we suggest that community-based participatory research (CBPR) and the principles of ownership, control, access, and possession (OCAP) are methodological approaches in correspondence with the context of existing and developing Indigenous knowledge systems. Specifically, we explore the Indigenous theoretical perspectives of two-eyed seeing and ethical space. The purpose of this article is to show how CBPR and the OCAP principles may help to integrate two-eyed seeing and ethical space into the shaping of nursing research to address health priorities with Aboriginal peoples in their communities.

Two-Eyed Seeing and Ethical Space

It is within CBPR that two-eyed seeing can be enacted and ethical space created. Two-eyed seeing refers to the ability to see with one eye the strengths of Indigenous ways of knowing and with the other eye the strengths of Euro-Western ways of knowing, and using both of these eyes together (Hatcher, Bartlett, Marshall, & Marshall, 2009; Iwama, Marshall, Marshall, & Bartlett, 2009). The principle of two-eyed seeing is grounded in the Integrative Science Program at Cape Breton University in the province of Nova Scotia, Canada, by Aboriginal and non-Aboriginal peoples. Albert Marshall, a co-creator of two-eyed seeing, is a respected Elder of the Mi'kmaq Nation. He was an "inmate" of the Indian Residential School in Shubenacadie, Nova Scotia, for much of his childhood and youth and was profoundly affected by the experience (Hatcher et al., 2009). Hatcher et al. (2009) explain how this experience launched Marshall on a lifelong quest to connect with and understand both the world he was removed from and the world he was forced into. Two-eyed seeing does not imply an essentialist notion of Indigenous and Euro-Western knowledge systems; it is critical that nurse researchers appreciate this. Awareness of two-eyed seeing stems from the belief that there are many worldviews, some of which are represented by Euro-Western perspectives and others by Indigenous perspectives. Employing two-eyed seeing in Aboriginal research does not mean that researchers should reduce Indigenous knowledge systems to categories that remain static or to quantifiable, observable elements. When two-eyed seeing is integrated into research, it promotes different ways of knowing by enabling

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cultures, traditions, beliefs, and values. Such diversity at the world level has been difficult to capture in a working definition (Battiste, 2005). The International Labour Organization defines "Indigenous peoples" as tribal peoples in independent countries whose social, cultural, and economic conditions distinguish them from other sections of the national community and whose status is regarded wholly or partially by their own customs or traditions or by special laws or regulations (Battiste, 2005).

researchers and participants to acknowledge different worldviews. A fundamental assumption of this concept is the need for a relationship of trust and respect between Indigenous groups and nurse researchers. Two-eyed seeing acknowledges the entrenched power imbalances between Indigenous groups and the dominant health-care system, which has historically suppressed Indigenous worldviews and practices. To avoid suppressing Indigenous knowledge systems, nurse researchers can use the lens of Marshall's concept of two-eyed seeing to build relationships based on mutuality and different understandings.

The concept of ethical space expands on the idea of two-eyed seeing. Willie Ermine, who originally developed this concept for Aboriginal research, is a Cree member of the faculty at First Nations University of Canada with an appointment to the Indigenous Peoples' Health Research Centre. Ethical space as outlined by Ermine means that people with different worldviews move from talking about or to one another to talking together (Estey, Kmetic, & Reading, 2008; Tait, 2008; Warry, 2007). Whereas two-eyed seeing entails learning to see with the strength of Indigenous and Euro-Western ways of knowing for the benefit of all, ethical space entails creating space for dialogue and discussion between people holding different worldviews. Ethical space, Ermine (2005) claims, can be a space for the procreation of future possibilities.

It is important that research with First Nations be informed by the concepts of two-eyed seeing and ethical space. Two-eyed seeing promotes a common ground between researcher and participants by acknowledging and respecting different worldviews. Ethical space enables the creation of a space for dialogue that is inclusive of the dominant society and local contextual Indigenous knowledge systems, in order to move forward with actions that promote Aboriginal health and reduce disparities. As Tait (2008) explains, "as a theoretical landscape, ethical space facilitates development of cross-cultural linkages that are ethically sustainable and strive for equality of thought amongst diverse human communities" (p. 33). In an ideal ethical space, Indigenous inquiry and Indigenous knowledge systems strive together with Euro-Western inquiry and Euro-Western knowledge systems to generate understandings that are meaningful and that are transferable to Indigenous communities. Ethical space provides a context that is respectful and mindful of different understandings and provides researchers and participants with an avenue for creating knowledge that is beneficial to communities.

Ermine (2005) acknowledges that Euro-Western knowledge has always dominated the research process and that we need participatory research that is conscious of ethical space in order to build meaningful partnerships between Aboriginal communities and researchers from universities embedded in Euro-Western ways of knowing. Williams (2007), of the Prairie Region Health Promotion Research Centre, stresses the need for ethical space in health promotion in the province of Saskatchewan. He claims that when Indigenous and Euro-Western knowledge systems are recognized, the dominant concepts pertaining to Indigenous knowledge systems and health become apparent and the practice of health promotion becomes more democratic. By interacting meaningfully to build research processes that are informed by diverse Indigenous groups, nurse researchers can prevent the imposition of ideologies that ignore Aboriginal views of health and healing. Although often unintentional, knowledge claims that do not acknowledge Indigenous knowledge systems are unethical and can be demoralizing, stigmatizing, and detrimental to self-determination. To acknowledge Indigenous knowledge systems yet appropriate Indigenous knowledge is equally detrimental (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERCC], & Social Sciences and Humanities Research Council of Canada [SSHRCC], 2010). For example, medicinal plants that have been used by Aboriginal healers for centuries have been appropriated by the pharmaceutical industry without benefit to Aboriginal peoples (Little Bear, 2000).

Ethical space requires a dialogue about intentions, values, and assumptions throughout the research process (CIHR, 2008, p. 17). Ethical space is fundamental, as scholars partner with communities to identify understandings and action plans for health promotion. Further, as Chandler and Lalonde (2004) suggest, the overlooked and underdeveloped resource of diverse Indigenous knowledge systems is necessary to transmit relevant knowledge and practice from community to community. Indigenous knowledge systems reside with Aboriginal peoples in their communities. The knowledge is fluid and shared in the local context, history, and agency of Aboriginal peoples.

Community-Based Participatory Research (CBPR)

Community-based participatory research is an approach that can honour two-eyed seeing and ethical space. It is an umbrella term used interchangeably with action research, participatory research, participatory action research, and collaborative inquiry (Israel, Eng, Schultz, & Parker, 2005; Kemmis & McTaggart, 2005; Minkler & Wallerstein, 2003). Although there are differences among these approaches, they all involve a commitment to conducting research that is of direct benefit to the community and all recognize the notion of equitable power between researcher and community (Israel et al., 2005). This is not a matter of non-Aboriginal researchers sharing their power with Aboriginal people;

rather, the power balance between nurse researchers and Aboriginal communities is equitable. Beyond simple acknowledgement, CBPR demands equitable power relationships within the research process. Such relationships enhance the building of partnerships and the establishment of collaboration.

Community-based participatory research is a systematic approach for understanding Aboriginal health and for identifying action plans for health promotion. MacAulay et al. (1999) explain that participatory research promotes lay involvement, encourages community development, and builds mutual partnerships, all of which address Aboriginal health. Community-based participatory research is not a method per se; rather, it is a collaborative approach to research that draws from a wide range of research designs and methods (Israel et al., 2005; MacAulay et al., 1999; Wallerstein & Duran, 2003).

According to Israel et al. (2005), critics of CBPR claim that action research and participatory research lack scientific merit and rigour and are synonymous with community development and social activism. Although there are similarities, CBPR differs from community development in that it employs research designs and systematic research methods for generating knowledge (Greenwood & Levin, 1998; Kemmis & McTaggart, 2005). Creswell (2003) explains that participatory knowledge claims can more adequately address social justice issues, as researchers collaborate with participants to advance action for change. Creswell (2003) clarifies how knowledge claims based on multiple meanings of individual experiences or socially constructed knowledge align with advocacy research to address issues of social justice with individuals and groups who are marginalized.

Action research has been shown to have roots going back to the 1940s and Kurt Lewin (Greenwood & Levin, 1998; Minkler & Wallerstein, 2003), who is known for his work on change theory (unfreezing, changing, and refreezing). Lewin's action research was instrumental in shifting the role of the researcher from distant observer to involved co-participant in concrete problem-solving; however, he saw the researcher's co-participation with participants in the research as limited. In Lewin's view, the researcher possessed the expert knowledge, involved participants in the change, and evaluated the change (Greenwood & Levin, 1998). In this initial action research approach, the researcher retained the role of "expert" and there was minimal collaboration with participants in the research process.

Participatory action research has evolved since then, with community participants taking on roles formerly filled by researchers from outside the social setting (Kemmis & McTaggart, 2005). Contemporary participatory action research is a process of critical and reflective inquiry that gives voice to those who are usually silenced — through equitable power relations, people analyze their experiences as a means of effecting change (Etowa, Thomas Bernard, Oyinsn, & Clow, 2007; Israel et al., 2005; Kemmis & McTaggart, 2005; Koch & Kralik, 2006; McNiff & Whitehead, 2006; Park, 1993). Community involvement in research design, implementation, and analysis, with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities, is fundamental to CBPR (Israel et al., 2005; Minkler & Wallerstein, 2003).

MacAulay et al. (1999) — researchers who have worked with First Nations to address diabetes in the community — identify the key components of CBPR as follows: mutually created knowledge, sharing of community members' expertise and resources through collaboration, mutual education, and acting on the results of research to address questions that are relevant to the community. The process is based on mutually respectful partnerships between community and researcher. Such partnerships are strengthened through agreement with regard to the research question, design, implementation, analysis, and dissemination.

In CBPR, the involvement of laypersons in data analysis is important. Szala-Meneck and Lohfeld (2003) describe the significance of the community advisory team's involvement in developing interview questions and analyzing interview data for a Canadian caregiver respite project. They report that inclusion of the community advisory team in the analysis increased the rigour of their qualitative data analysis and provided community members with an opportunity to learn new skills. Castleden, Garvin, and Huu-ay-aht First Nation (2008) carried out a CBPR project whereby the Huu-ay-aht First Nation wished to better understand the environment and health-risk perspectives in Huu-ay-aht traditional territory. The research process was inclusive of the Huu-ay-aht community from inception to dissemination of findings and serves as an excellent example of CBPR principles: equitable power relations, fostering trust, developing ownership, engaging in community development, and building capacity with First Nation and academic institutions.

Archibald, Jovel, McCormick, Vedan, and Thira (2006) incorporate the principles of respect, relevance, reciprocity, and responsibility into their work on creating transformative Aboriginal health research. They believe that one demonstrates respect for Aboriginal peoples and communities by valuing their diverse knowledge in health matters and its contribution to the health and wellness of Aboriginal communities; also, it is critical that the research be relevant for Aboriginal cultures and communities. Reciprocity is achieved through a process of engaged learning between the researcher and Aboriginal participants, to the benefit of both parties (Riecken, Tanaka, & Scott, 2006).

Ownership, Control, Access, and Possession (OCAP)

As a result of increased interest in the issue of First Nation ownership of information, the OCAP principles were developed during the drawing up of the Regional Health Survey by the National Aboriginal Health Organization (First Nations Centre, 2007). The abbreviation OCA was framed in 1998. "Possession" was added later, in response to critical issues of First Nation research. First Nations have expressed many concerns about the way in which research has been conducted, including the following: lack of meaningful research, research that does not benefit the community, exertion of pressure on First Nations to support a particular research project, agendas dictated by others, lack of respect for First Nations, misinterpretation of traditional knowledge and practices, stigmatizing and stereotyping, and lack of control by First Nations over data. The First Nations Centre (2007) explains that the OCAP principles are a response to "colonial, oppressive and exploitive research; an increase in First Nations research capacity and involvement; and widely shared core values of self determination" (p. 9). The OCAP principles have added a new dimension for nurse researchers to consider in relation to who owns data, who has control over data, and what can be done with data once they are collected. Issues of confidentiality, anonymity, and privacy need to be considered and negotiated with Aboriginal leaders and Aboriginal organizations. Further research conducted with communities within communities needs to be reconciled as to how the OCAP principles can be enacted through the inclusion of vulnerable groups such as Aboriginal women who experience various forms of violence and youths who are alienated from the leaders in their community (Interagency Advisory Panel on Research Ethics, 2008).

Community-based participatory research is often aligned with the OCAP principles outlined by Schnarch (2004) and the Canadian Institutes of Health Research (CIHR, 2008). According to CIHR, participatory research is a valuable means for Aboriginal people to be agents of research and change. Further, the Interagency Advisory Panel on Research Ethics (2008) and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (CIHR, NSERCC, & SSHRCC, 2010) support engagement between the community involved and the researcher that is initiated prior to any research activity and that promotes mutual trust and communication. First Nation, Inuit, and Métis organizations and communities wish to be included as partners in all phases of the research process, to protect their heritage, to ensure that their knowledge systems are genuinely reflected in research practices, and to secure equitable distribution of the benefits (Interagency Advisory Panel on Research Ethics, 2008). By obtaining community consent before initiating research, and by including a community advisory team in the development of research questions, design, data analysis, and dissemination, researchers can create opportunities for research that is inclusive of Indigenous knowledge systems and promote the formation of Indigenous research methodologies.

Indigenous Knowledge and Decolonizing Research

There is no one Indigenous methodology; however, the generally accepted principles of Aboriginal health research call for scholars to include dialogue, community, self-determination, and cultural autonomy in the process. According to the Maori scholar L.T. Smith (2000), "critical theory must be localized, grounded in the specific meanings, traditions, customs, and community relations that operate in each Indigenous setting" (p. 229). Smith claims that localized critical theory can be effective if critique, resistance, struggle, and emancipation are not treated as universal characteristics independent of history, context, and agency. She advocates for these ideas particularly when non-Indigenous scholars conduct research with Indigenous peoples. Her concern is that Indigenous peoples have been researched "to death" but still have not seen any benefits. To engage in research with Indigenous peoples, researchers must build relationships and partnerships with Indigenous communities. Although the process may take more time than accepted in Western-dominated academic institutions and funding agencies, researchers cannot afford to do otherwise. Partnerships and collaboration are central to critical inquiry that supports local contextual Indigenous knowledge systems and methodologies.

Battiste (2005), an educator and world-renowned Indigenous scholar from Mi'kmaq territory, explains that Indigenous knowledge has been referred to as cross-cultural or multicultural and that this is problematic for understanding the diversity and complexity of Indigenous knowledge systems:

> To date, Eurocentric scholars have taken three main approaches to Indigenous knowledge. First, they have tried to reduce it to taxonomic categories that are static over time. Second, they have tried to reduce it to its quantifiably observable empirical elements. And third, they have assumed that Indigenous knowledge has no validity except in the spiritual realm. None of these approaches, however, adequately explains the holistic nature of Indigenous knowledge or its fundamental importance to Aboriginal people. (p. 502)

The theoretical and epistemological frameworks underlying Euro-Western knowledge systems and Indigenous knowledge systems have fundamental differences. Acknowledgement of such differences does not necessarily precipitate a dichotomous framework of Euro-Western and Indigenous knowledge (Vukic, Gregory, Martin-Misener, & Etowa, 2011). Rather, it creates awareness of Western hegemonic science and its dominance not only over the conduct of research, but also over research participants (Denzin & Lincoln, 2008; Native Mental Health Association of Canada, 2007; Smylie et al., 2004). Denzin and Lincoln (2008), in the Introduction to their *Handbook of Critical and Indigenous Methodologies,* claim that the decade of critical Indigenous inquiry has arrived. The essence of this approach is not to essentialize Indigenous ways of knowing, but to acknowledge differences and not impose a hierarchy of Euro-Western science.

There is great diversity among Aboriginal peoples in Canada. This diversity influences worldviews, demonstrating that there cannot be one uniform, fixed, collective Aboriginal identity or one Indigenous knowledge system. Although not every Aboriginal person believes in the ceremonies or traditional values of Aboriginal culture, "the resurgence of interest in traditional practice . . . is part of a more global movement to regenerate Aboriginal identity and explore the significance of an evolving tradition in the contemporary world" (Kirmayer, Brass, & Tait, 2000, p. 614). The Aboriginal Healing Foundation (Waldrum, 2008) defines Indigenous approaches to healing as holistic and inclusive of a central role for Elders and Traditional people, use of the structure of the circle and outdoor physical setting, as well as traditional teachings and medicines, storytelling, and ceremony based on Indigenous ways of knowing.

For non-Aboriginal nurse researchers conducting research with Aboriginal peoples, it is especially important that critical inquiry be informed by Indigenous peoples. Postcolonial Indigenous thought rejects the use of any European postcolonial theory or its categories. "'Indigenous thinkers' use the term 'postcolonial' to describe a symbolic strategy for shaping a desirable future, not an existing reality" (Battiste, 2000, p. xix). Kincheloe and McLaren (2005) concur: "From a Western perspective there is a risk that uncovering colonialism and postcolonial structures of domination may in fact unintentionally validate and consolidate such structures as well as reassert liberal values through a type of covert ethnocentrism" (p. 325). For instance, postcolonial policies and structures of Western domination may advocate for accommodating difference as opposed to developing action plans for structural changes that include Aboriginal ways of knowing that are empowering and that build capacity. Getty (2010) cautions that "the findings of a study using a postcolonial lens may reflect the values of the White researchers, such as focusing on individual health issues, rather than health challenges of the collective" (p. 9). The focus of Indigenous scholars is on uncovering the realities of current colonial practices in order to shape a desirable future.

This warrants a process of critical inquiry inclusive of Indigenous knowledge systems.

Browne, Smye, and Varcoe (2005) echo the concerns about a postcolonial stance in nursing and offer valuable insight into how postcolonial theories advance nursing research to address decolonizing research approaches for promoting health equity. While nursing scholars need to be mindful of the concerns about postcolonial perspectives, it is important that they recognize the strengths of postcolonial theoretical perspectives for decolonizing research. Anderson et al. (2009) describe how a postcolonial feminist lens sets out to break down the structures perpetuating inequity in health and in access to health care. Browne et al. explicate how postcolonial theories draw attention to issues of partnership and voice in research, apply knowledge for social change, and consider continuities between past and present — that is, how socio-historical conditions continue to shape health, healing, and access to health care. Postcolonial theories do not assume that colonial practices are past. As Browne et al. state, "by remaining cognizant of the distinctions between postcolonial theory and postcolonial Indigenous thinking we can use each to inform the other while resisting both imposition and appropriation" (p. 24).

Decolonizing research methodologies provide an avenue for research that is consistent with diverse Indigenous knowledge systems and Indigenous research methodologies. According to Bartlett, Iwasaki, Gottlieb, Hall, and Mannell (2007), "Not only does decolonizing research privilege Indigenous thought as the most rational approach to Indigenous research, but it also offers Indigenous cultural ways of conducting research for general population researchers" (p. 2376). These authors discuss the implementation of an Aboriginal-guided research approach to examining the lived experiences of Métis and First Nation people with diabetes in Winnipeg, Manitoba. Their approach included six processes: being Aboriginal-guided, using participatory action, negotiating relationships, using Indigenous methods, using reciprocal capacity-building, and crediting Indigenous knowledge. Framing research as decolonizing may be misleading, as Bartlett et al. claim, as no single research study could decolonize Aboriginal peoples. That said, the research process they describe is in keeping with recognizing, respecting, and crediting diverse Indigenous knowledge systems.

Indigenous Methods

The validity of data collecting with participants who have been marginalized also warrants consideration. Liebenberg (2009), a researcher with Aboriginal populations responding to Aboriginal youth resilience, asks, "If, however, the very basis of our research, that is the questions asked in the research setting, are based in existing 'knowledge' formulated by dominant voices, how valid then is the data we analyse, and by extension, the findings of our research?" (p. 443). Liebenberg describes how photo elicitation engages participants in a process of self-exploration and understanding with the researcher that promotes a more collaborative and balanced relationship.

Similarly, Loppie (2007) states that the processes of storytelling and talking circles are consistent with Indigenous methodologies. Storytelling is similar to narrative inquiry but in storytelling the interviewee shares his or her story with the interviewer and is less directed by the interviewer. The interviewer may use prompts or ask for explanations as the interviewee tells his or her story. Storytelling creates a space for the person to share meanings based on his or her conceptions without the distraction of the interviewer's preconceived questions. Similar to photo elicitation as described by Liebenberg (2009), storytelling engages participants in an oral process of self-exploration and understanding with the researcher as participants share their stories of how they have come to understand a phenomenon — for example, mental health. Talking circles are similar to focus groups but are a process whereby each participant in the circle shares ideas with the others without interruption. A talking circle should be facilitated by an Elder who has his or her own style for conducting a talking circle. Although talking circles may not be perceived as interactive, the presence of a circle, where all members are equal, facing each other, actively listening and sharing their thoughts, elicits interactions that promote engagement of all members in the circle as they co-create knowledge. In these methods of data collection, the social construction of knowledge is based on the lived realities of participants and knowledge is shared in a collaborative process that is inclusive of two-eyed seeing and ethical space.

Conclusion

In Canada the importance of diverse Indigenous knowledge systems and Indigenous research methodologies is increasingly being recognized. The theoretical perspectives of two-eyed seeing and ethical space are examples of Indigenous knowledge systems that nurse researchers can incorporate when conducting critical inquiry with Indigenous peoples. Indigenous knowledge systems can inform decolonizing research to advance the health of Aboriginal peoples in the spirit of self-determination and autonomy.

Critical inquiry addresses power in the context of research, reveals the relative power of researchers, and goes beyond token efforts to address power differentials between researcher and participant. It locates the researcher as powerful and privileged while at the same time recognizing the power of the participant. Importantly, while such an understanding necessitates a re-evaluation of traditional Euro-centric inquiry in nursing research, the paradox of critical theory emerges. That is, as the nurse researcher develops emancipatory consciousness through critical inquiry, he or she is challenged to see the limits of Euro-Western theorizing (including critical theory) and research methods (including qualitative approaches) in the context of research with Aboriginal peoples. Researchers are challenged all at once not only to acknowledge the parameters of Euro-Western research approaches, but also to see that other approaches (e.g., Indigenous) can be at odds with Euro-Western traditions. Further, development of the OCAP principles in Canada brings an opportunity for nurse researchers to conduct critical inquiry with Indigenous peoples in a manner that is respectful, relevant, reciprocal, and responsible and that acknowledges the power differentials between researchers and participants. However, nurse researchers need to be cognizant of the pitfalls of negotiating these principles with the community. Concerns may arise as these principles are enacted in the research process. Community-based participatory research is one approach to Indigenous health research that is in keeping with the theoretical perspectives discussed in this article. We present these concepts in order to take part in the dialogue on critical Indigenous theoretical and methodological perspectives for nurse scholars to bear in mind in their research, so as to decrease Aboriginal health disparities in Canada.

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Adele Vukic, RN, is a PhD candidate in the School of Nursing, Dalhousie University, Halifax, Nova Scotia, Canada. David Gregory, RN, PhD, is Professor and Dean, Faculty of Nursing, University of Regina, Saskatchewan, Canada. Ruth Martin-Misener, RN-NP, PhD, is Associate Professor, School of Nursing, Dalhousie University.

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Book Review

Indigenous Methodologies: Characteristics, Conversations and Contexts

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Reviewed by Helen J. Brown

In *Indigenous Methodologies* Margaret Kovach invites the reader to join her in a thoughtful and critical exploration of the place of Indigenous inquiry within contemporary academic contexts. Orienting the reader to praxis and social justice in the opening chapter, she outlines the need for research that honours Indigenous knowledge systems and their tribal epistemological basis. Kovach describes how the very notion of research poses questions, many of which have not yet been pursued — in particular, how the ideology of knowledge production within Eurocentric academic contexts ascribes positional authority to Western research paradigms, thereby marginalizing the Indigenous approach to inquiry. Claiming a place for Indigenous methodologies, she asserts, requires us to grapple with the politics of knowledge production and the rightful place of tribal epistemologies within the academy.

In chapter 2 Kovach provides a critical and thoughtful scrutiny of the field of qualitative research, indicating the connections, intersections, and disconnections among tribal epistemologies and those underpinning qualitative research in the "seventh moment." She skilfully navigates the tensions and the possibilities for locating Indigenous methodologies both inside and outside of qualitative research paradigms, resisting the need to categorize within dominant academic discourse. While Kovach distinguishes Indigenous and qualitative methodologies at the level of epistemology in this chapter, she demonstrates a sophisticated handling of the challenges arising from positioning Indigenous methodologies through a politics of difference. She carefully examines intersecting and unique concepts, process and practices of Indigenous methodologies, and qualitative approaches by teasing out their epistemological similarities and differences. In fact, Kovach delivers on distinguishing and relating both research traditions and their relational, pragmatic, and process/content orientation. The reader glimpses the "both/and" intersections in Indigenous and qualitative inquiry while also seeing how and why tribal knowledge is not Western knowledge. Kovach considers the goal of equity within the sphere of knowledge construction in stating that "an environment, research or otherwise, that allows for equitable valuing of ideas and relationships in understanding the world, and the living entities within it, is necessary for relational approaches such as indigenous methodologies to thrive" (p. 38).

In chapter 3 Kovach tackles what constitutes the conventional research framework. In indicating how Western cognitive imperialism underpins the role of theory in academic inquiry, she describes the ways in which research frameworks in Indigenous approaches are relational, storied, and experiential rather than purely cognitive. She discusses the interconnections among postcolonial, critical, narrative, and interpretive perspectives and Indigenous methodologies while also noting the distinct contribution of tribal epistemologies. Kovach explains that Indigenous methodologies go beyond the "human centric" and "non-animistic" epistemological claims underlying qualitative approaches. To illustrate the contribution of tribal epistemologies to research frameworks, she shows how Nêhiyaw epistemology locates language, place, values, customs, and sacred ceremony as integral methodologies within research. An interview with Michael Hart, a Cree scholar, demonstrates how Indigenous methodology is fundamentally about relating to self, elders, ceremony, and one's academic life, to bring greater consciousness to the place and politics of knowing, being, and researching.

Kovach claims that all researchers have a responsibility to open up space for decolonizing lenses in Indigenous research frameworks. In chapter 4 she revisits the marginalization of Indigenous knowledge within Western research processes: "colonial interruptions of Indigenous culture continue, and there is no way to address tribal epistemologies and Indigenous research frameworks without considering these relations" (p. 76). She maintains that the suppression of Indigenous knowledge is an instrument of colonial-settler relations that is anything but "post." Focusing on issues of representation and voice within the power/knowledge nexus, Kovach describes the various challenges, complexities, and contradictions that are inherent in decolonizing inquiry. The reader is, then, well prepared, in chapter 5, to move on to a more detailed exploration of methods and the place of oral history, narrative, and story in Indigenous inquiry. The text of an interview with Jeannine Carriere reveals how story is both method and meaning within a holistic epistemology.

In chapter 6 Kovach shifts to the preparatory considerations for Indigenous inquiry. She describes how the epistemic is enacted methodologically, indicating that self-location, purpose, and culture are the grounding for reflexive research processes. Kovach carefully navigates the subjectivity and knowing interface and positions truth claims as inseparable from both the politics and the personal process of knowledge construction. In chapter 7 she extends the discussion to knowledge-gathering methods, sampling, protocols, data analysis, and "meaning making" with tribal interpretations. This shift to "application" reflects Kovach's praxis intent. When describing open-ended data-collection methods, the author makes an important distinction between engaging in conversation as method and conventional qualitative interviews. Eliciting stories is the basis for research-sharing circles within Indigenous methodologies. Kovach describes the relational context and reciprocity of relationship as foundational to sampling and analytical decisions and processes. This chapter provides readers with strategies and process for engaging in the analytical (meaning making) process of Indigenous methodologies, primarily observation, sensory experience, contextual knowledge, and pattern recognition.

Returning to a central premise of the book, Kovach outlines how societal and institutional structures manifest power dynamics that can be traced to historical and current Indigenous-settler relations. She then turns to the topic of research ethics. In chapter 8 she describes Indigenous research ethics as integral to methodologies guided by tribal epistemologies. In examining how ethical conduct, principles, guidelines, and protocols have evolved in Canada, Kovach provides a synthesis of protocol documents, such as OCAP principles (ownership, access, control, and possession) and ethical practice of research in Indigenous communities outlined by the Canadian Institutes of Health Research in 2007. She reminds the reader that such documents are guidelines, not policy statements, and that it is the responsibility of each researcher to carefully consider how each moment of research is an ethical endeavour. Kovach connects values and ethics espoused within Cree traditions to illustrate this critical element of Indigenous approaches. Kovach again delivers on the practical implications of Indigenous ethics by describing the nuances of confidentiality and validity when the goal is to honour truth and knowledge in stories and in the *miyo,* or "giving back," ethic in Cree tradition.

Chapter 9 draws the insights from the entire book into a thoughtful and provocative call for situating Indigenous research within the academy. Kovach argues for always locating Indigenous methodologies against the backdrop of historical influence of Indigenous-settler relations for educational policy, practice, and research. Ongoing recognition of the uniqueness of Indigenous people from other minority groups is described as central to this effort. Outlining the colonial context of education policy, in the final chapter the author points to the need for a decolonization of research practices and academic relations. Kovach's concluding discussion on Indigenous graduate education brings the book's critical insights to fruition. She reminds Indigenous graduate students of the critical role of Indigenous knowing and inquiry as decisions are made about method, committee, supervision, and so forth. The suggestion that non-Indigenous scholars engage with Indigenous research offers a principled means of transcending the "us-other/other-us" dynamic of relations described throughout the book. The goal of creating a "decolonizing academy" implicates everyone, and Kovach's book goes far enough to chart the territory but not so far as to prescribe a route for advancing Indigenous methodologies; however, the obligations and responsibilities of those working within academic structures and contexts are undeniably clear.

Helen J. Brown, RN, PhD, is Assistant Professor, School of Nursing, University of British Columbia, Vancouver, Canada.