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Guest Editorial

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

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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.

References

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