

Discourse

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

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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.

References

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