

*Résumé*

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**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

# **Addressing Health Inequities Through Indigenous Involvement in Health-Policy Discourses**

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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 health-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 world-views 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 epistemo-

logical 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 health-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) sug-

gests 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. These 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 dif-

ference 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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