The Influence of Governance on Organizations' Experiences of Improving Care for Aboriginal People: Decolonizing Possibilities

Dawn Smith[1], RN, PhD, Assistant Professor,
School Of Nursing, University of Ottawa

Nancy Edwards, RN, PhD, Professor, School Of Nursing
Department of Epidemiology and Community Medicine,
University of Ottawa

Patricia J. Martens, PhD, Associate Professor,
Director, Manitoba Center for Health Policy
Department of Community Health Sciences, University of Manitoba;
CIHR/PHAC Applied Public Health Chair.

Colleen Varcoe, RN, PhD, Associate Professor,
Associate Director, Research, School of Nursing,
University of British Columbia

Barbara Davies, RN, PhD, Associate Professor
School Of Nursing, University of Ottawa

1. Address correspondence to: Dawn Smith, RN, PhD, Assistant Professor, School of Nursing, University of Ottawa, Room 3251B, 451 Smyth Road, Ottawa, ON Canada K1H 8M5 Tel: (613) 562-5800 x8420 dsmith@uottawa.ca

ABSTRACT

Governance is a key issue in the struggle of Aboriginal people in Canada to survive historical and ongoing colonization. Yet, little attention has focussed on the influence of governance on the quality and relevance of health care for Aboriginal people. The purpose of this study was to describe the influence of contextual factors on Aboriginal health care organizations' experiences improving care for pregnant and parenting Aboriginal people. Participatory research principles were used in a comparative case study design with two Aboriginal health care organizations in British Columbia, Canada. Data were collected through exploratory interviews and small group discussions with purposefully selected leaders, providers, and community members; document review; and researcher field notes. Interpretive descriptive analysis was used to develop themes related to dimensions of governance that highlighted important similarities and differences between the two organizations' experiences. Dimensions of governance identified included: the importance of a historically grounded vision; the extent to which Aboriginal community members had a voice in decision making; the autonomy of their organizations; their views of organizational accountability; and approaches to decision making. Findings suggest that greater attention to governance and use of models of governance that facilitate rather than thwart efforts to decolonize health care for Aboriginal people are needed.

Keywords: Governance, Aboriginal peoples, self-determination, population health, comparative case study, health care decision-making, decolonization

> To do the things we need to do — to build a house, to teach our children, to heal us when we're ill, to obtain the many things we use or want, and so on — we need each other, and we have to be able to work together effectively.... How can we do that? How should we make decisions? What set of rules or understandings should control how we interact with each other?
> (Cornell et al., 2004, p. 3).

Governance is the process of making decisions about direction and roles in any form of collective action. It is "the traditions, institutions and processes that determine how power is exercised, how citizens are given a voice, and how decisions are made on issues of public concern" (Graham and Wilson, 2004, p. 1). Because governance is about the exercise of power and control, there is a wide diversity of values-based views about how and by whom decisions are made (Edgar and Chandler, 2004; Graham and Wilson, 2004). The 1997

United Nations Development Program [UNDP] document "Governance and Sustainable Human Development" enunciated a set of nine internationally endorsed principles for good governance. These principles include: participation, consensus orientation, strategic vision, responsiveness, effectiveness and efficiency, accountability, transparency, equity, and rule of law. Graham and Wilson (2004) consolidated these into five UNDP-based principles: legitimacy and voice, fairness, accountability, direction, and performance. Without effective models of governance that attend to and develop rules in relation to each of these principles, cooperation becomes cumbersome and difficult, disputes become more common and are more likely to go unresolved or to be resolved in violence, social relationships deteriorate, and the society fails to achieve its goals (Cornell et al., 2004).

Governance of health care serving First Nations, Inuit, and Métis people is a highly charged issue stemming from our sociopolitical history of colonization in Canada and other colonized nations (O'Neil, 1995; Royal Commission on Aboriginal[2] People [RCAP], 1996; Romanow, 2002; Smylie, 2000; Waldram et al., 1995). Twenty years of research in the Harvard projects for Indian Economic Development concluded that effective solutions to indigenous poverty depend on, among other things, indigenous self-determination in governance of community processes and institutions (Cornell, 2006; Cornell and Kalt, 2003). The evidence shows that no matter the enterprise, self-determination is the cornerstone of sustainable progress towards improved health, economic, and social conditions among indigenous people (Cornell and Kalt, 2005; Besaw et al., 2004). The importance of indigenous self-determination in governance of indigenous affairs is a central element in international movements to recognize the rights of indigenous people and recognized in the United Nations Declaration on the Rights of Indigenous People (United Nations, 2008), recently acknowledged by the Canadian government.

Canadian federal health transfer policy, introduced in the 1980s, intended to enable indigenous people to assume greater self-determination in governance and more/independent control of health programs (Lavoie, 2004; Lavoie et al., 2007). However, changes made under the federal health transfer policy have been criticized for creating inequalities in financing among First Nations communities (Lavoie et al., 2007), and have made no provision

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2. The term Aboriginal "refers to organic political and cultural entities that stem historically from the original Peoples in North America, rather than collections of individuals united by so-called 'racial' characteristics" (Royal Commission on Aboriginal Peoples, 1996). These include the First Nations, Inuit, and Métis peoples of Canada.

to increase First Nation participation in other levels of the Canadian health care system (Lavoie, 2004). This is particularly troubling given the growth of Aboriginal populations living in provincial jurisdictions for health care (Statistics Canada, 2008).

Touati et al. (2007) found that the impact of specific forms of governance on health policy implementation depends on pre-existing contextual factors such as relationships among stakeholders, financial resources, and the presence of leaders. This fits with the notion that governance is important to Aboriginal health care planning as a mechanism to advance the broader vision of self-determination (Cargo et al., 2003; RCAP, 1996). Quantz and Thurston (2006) examined strategies to encourage greater involvement of Aboriginal people in regional health planning as a means to reduce disparities in Aboriginal health outcomes, acknowledging that demonstrating links to such outcomes is "nearly impossible" (p. 249). However, no studies have examined how governance mediates the influences of broader policy and social contexts on local Aboriginal organizations' efforts to improve care. Furthering our understanding of the mediating role of governance is essential to reduce the gap in health outcomes between Aboriginal and non-Aboriginal peoples (Canadian Population Health Initiative, 2004). Furthermore, greater understanding is needed of the barriers and facilitators to health system improvement undertaken by local Aboriginal health care organizations operating within the complicated landscape of jurisdiction, governance, and administration of health care for Aboriginal people in Canada. This is particularly important given recent tripartite agreements involving First Nations, provincial, and federal governments (First Nations Leadership Council, Government of Canada and Government of British Columbia, 2007).

In this study, we examined governance from the perspective of Aboriginal health care service delivery organizations and the communities they serve. The study focussed on care for pregnant and parenting Aboriginal people. The need for more culturally appropriate care, relevant to the needs and strengths of Aboriginal women and families, has been well documented (Browne and Smye, 2002; Long and Curry, 1998; Powell and Dugdale, 1999; Sokolowski, 1995; Westenberg et al., 2002), as has the widespread pattern of late or no access to prenatal services and poor pregnancy outcomes among Aboriginal women (DeCosta and Child, 1996; Goldman and Glei, 2003; Luo et al., 2004a; Luo et al., 2004b; Public Health Agency of Canada, 2005). The authors of these studies have emphasized the need for culturally appropriate care and identified the critical role of governance in shaping client-provider relationships.

In this paper, we outline the historical evolution of jurisdiction, administration, and funding of health care for Aboriginal people in Canada. We use different terms depending on which people and contexts we are discussing. The term "Aboriginal" is inclusive and reflective of the diversity of people being served by the organizations involved in this study. Thus when discussing more heterogeneous populations, such as those served by urban Aboriginal health centres, we use the term Aboriginal. However when referring to the more culturally homogenous on-reserve communities, we use the term First Nations. The term "indigenous" reflects the language used on a global/international scale and thus is used only in relation to international trends and contexts. Salient aspects of health and social policy in the provincial context of the study are highlighted. We outline study methods and share themes describing the influence of local governance on community-based stakeholders' experiences improving care for Aboriginal people. We discuss implications for policymakers, administrators, and managers involved in health care for Aboriginal people and propose that greater attention to governance may open the possibility for constructive approaches to decolonizing health care relationships and reconciling diverse stakeholder views and values influencing Aboriginal health care decision-making.

Background

The Historical Evolution of Health Care for Aboriginal People

Allocation of responsibility for Aboriginal people to the federal government in Canada was initially set out by the *British North America Act* in 1867. The colonial administrative structures and relationships between Aboriginal people and the federal government were then set down by the original *Indian Act.* This historic policy, last updated in 1979, established a legal, socioeconomic, governance, and administrative context that has denied Aboriginal people many basic human rights and freedoms for decades. Indian reserves were established as a mechanism of control over Indian people, to legislate and regulate their lives and the natural resources on their tribal lands (Ware, 1975). The *Indian Act* precipitated colonizing policies which included banning indigenous forms of governance, such as the potlatch and hereditary processes, and instigating residential schools and the seizing of children for adoption by non-Aboriginal families during the 1960s. These policies and practices decimated Aboriginal cultural heritage, values, and beliefs (Aboriginal Healing

Foundation, 2002). Under these same policies, governance and administration of health care for Aboriginal people living on reserves was established as a federal responsibility. This entrenched a paternalistic orientation in Aboriginal healthcare relations. It also resulted in complicated fiscal and administrative arrangements for providing health care for Aboriginal people.

Federal jurisdiction

About 40% of the nearly 1,172,790 people identifying themselves as First Nations, Métis, or Inuit live in federal jurisdiction for health care (Statistics Canada, 2008). The health care delivery arm of Health Canada, the First Nations and Inuit Health Branch [FNIHB], formerly known as the Medical Services Branch, was set up to govern and administer these federal health care services. Until recently, health care services have been governed nationally, designed and evaluated by national and regional level administrative bodies, and delivered at the local level through a highly bureaucratized hierarchical organizational structure.

Over the last four decades, delivery of federal "on reserve" health care services has undergone considerable change through health transfer processes. In the 1960s, the federal government's position was to discontinue special services, remove treaty status, and move to increase assimilation of Aboriginal people into Canadian society (FNIHB, 2000; Lavoie, 2004). In contrast, while Aboriginal organizations reiterated the federal responsibility for health care to First Nations, Inuit, and more recently Métis people, they emphasized a desire for greater control over their lives and government delivered community programs (FNIHB, 2000; Lavoie et al., 2007). This set the agenda for a process intended to enable First Nations to exert more local control over health care and the federal government to meet its fiduciary responsibilities. Over the next two decades of federal government-First Nations' relations, the health transfer process was developed (FNIHB, 2000). At the community level, operationalizing this transfer process was arduous and often took many years. It involved providing funding to First Nations communities for planning and development activities such as setting up a health management structure, assessing health needs, and developing a community health plan, prior to taking control over local planning and delivery of health programs (FNIHB, 2004; Lavoie et al., 2007). As of September 2005, 47% of eligible First Nations communities were involved in the First Nations Control Process through transfer agreements. An additional 32% of First Nations communities were involved through Integrated Community-based Health Services

Contribution Agreements, which limited First Nations discretion over local use of health resources, enabling less control than through transfer agreements (FNIHB, 2005).

Within these transfer processes, First Nation's health organizations have worked to innovate programs and services in an effort to better fit the values, priorities, and concerns of their constituent populations. In some communities, greater congruence between health care services and local values and beliefs increased emphasis on the role of family, culture, and prevention; and allowed more effective integration between traditional and western approaches (RCAP, 1996; Smylie, 2000). However, significant concerns about the delivery of services within federal jurisdiction remain, including weaknesses in health information systems (Smylie et al., 2006), concerns about community capacity for effective management and governance of services (Auditor General, 2000) and the failure of transfer agreements to meet the evolving needs of Aboriginal people (O'Neil, 1995; Lavoie et al., 2007).

Provincial jurisdiction

In Canada, 67% of Aboriginal people live in urban or rural areas where health care provision is a provincial responsibility (Statistics Canada, 2008). In the province of British Columbia, the majority of health services are managed by regional health authorities [RHAs]. In 1993, 52 health authorities of various sizes and mandates were formed to bring governance of health care "closer to home." In 2001, with the intention of "streamlining the system, improving its efficiency, strengthening its accountability and allowing better planning and co-ordination of services" (Canadian Centre for Analysis of Regionalization and Health Care, 2005, p. 3), the newly elected provincial government again changed the regional structure. The 52 health governance structures were changed into 5 regional health authorities, each governed by a board of 6–9 members who were appointed by the Minister of Health Planning. Public health and specialized services, such as support for women at risk during pregnancy, were still the responsibility of the provincial Ministries of Health and Children and Families. However, governance and administration of the Pregnancy Outreach Program was moved to the regional health authorities and the Aboriginal Health Councils within the Ministry of Health were dissolved.

Thus, at the time of the study in British Columbia, health care for Aboriginal people during pregnancy and parenting was governed either: a) through a RHA accountable to the province; or b) directly by the British

Columbia Ministry of Health Services; and on reserve either: c) through a transferred health authority such as a Tribal Council accountable to the federal government through the regional office of FNIHB; or d) directly by the regional office of FNIHB. This context is unique, but mirrors the complexity of arrangements in other jurisdictions.

Theoretical and Methodological Approach

The study was shaped by a critical postcolonial stance (Battiste, 2000; Reimer-Kirkham and Anderson, 2002) and participatory research principles (Cargo et al., 2003; Fletcher, 2002; Macaulay et al., 1998). A critical postcolonial stance takes issue with unequal relations of power resulting from the colonial past and neocolonial present and the ways in which dominant groups assume control over meanings and social structures, including health care delivery systems (Anderson et al., 2003). Postcolonial scholarship aims to:

> …expose, describe and change ideological and social structures that maintain inequities between Aboriginal and non-Aboriginal populations. A critical post-colonial perspective recognizes Aboriginal people as central agents of this change, and moves beyond 'us-them' ways of thinking, towards recognition and valuing of the strengths made available through integrating diverse ways of knowing, doing and being. (Smith et al., 2006, p. E31)

Further details of the study's participatory methodology have been discussed elsewhere (Smith et al., 2005; Smith et al., 2006).

Methods

Ethical approval was obtained from both the University of Ottawa Health and Social Science Ethical Review Board and the participating Aboriginal organizations. One remote, on-reserve organization and one urban, off-reserve Aboriginal organization participated. Both are responsible for preventive and primary health care for pregnant and parenting Aboriginal people in specific areas of British Columbia, Canada. Data collected included relevant documents; field notes; and interviews with purposefully selected Aboriginal people, providers, and organizational leaders involved in providing care to pregnant and parenting Aboriginal people. The study sample is shown in Table One. Community leaders included Elders from both communities where the organizations were located and several leaders at both organizational and health authority levels (e.g., RHA and Tribal Council). Because this study explored organizations' experiences in improving care, the significant influence of health system change processes was identified as a major theme

during analysis but had not been a planned focus of study and thus did not inform sample selection.

Descriptive analysis pieced together a history of each community's experience improving care. Interview transcripts were inductively analyzed and themes identified using the constant comparative method. Critical reflection, diagramming, and peer debriefing related to these inductively developed themes identified governance as an overarching influence. Inductively developed themes were compared with recognized dimensions of governance to determine the fit with participants' descriptions. Themes from each case were then deductively coded. These early results were brought to a participatory discussion with leaders and providers involved in each of the two organizational cases to question and challenge the fit of this analysis with their experience. Participants in each case strongly endorsed the emergent themes. Two participants in each case reviewed the results of the final analysis.

Results

Description of Cases

The two cases varied in terms of date of program initiation, population size, geographical remoteness, jurisdiction, and model of governance and administration.

Case A

Case A was a health service delivery organization governed by a transferred First Nations Tribal Council in a small, geographically isolated First Nations community. This organization was recruited because of its reputation for having developed an approach to maternal child health care that resulted in early and regular participation in care. Service organizations, administered and governed by the Tribal Council, provided preventive health and social services. Community members also accessed provincial health services administered through the RHA available in an urban centre approximately two hours away. These services included: high-risk prenatal care services, tertiary care (e.g., hospital care during birth), midwifery, and medical care services (e.g., hospitals, physicians, obstetricians). As a result, Case A leaders and providers had been influenced by changes to provincial health care activities and policy changes.

The innovation to improve health care for First Nations community members began in the mid-1990s as a result of the change in governance

structure following transfer of health care to the First Nations Tribal Council in the mid-1980s. The terms of reference of the Tribal Council mandated a partnership approach that was markedly different from the previous FNIHB model of local health service provision. Community-based stakeholders were included in the change to a partnership model of governance and program delivery between the Tribal Council, the community governments (e.g., Chief and Council), and the health service organization and providers.

Case B

Case B was an urban Native Friendship Centre in operation since the late 1960s. Native Friendship Centres in Canada provide health, social, cultural, and recreational services to urban, Aboriginal populations (National Association of Friendship Centres, 2005). This centre operated under provincial jurisdiction, serving Aboriginal people living both on- and off-reserve and non-Aboriginal people. Case B was recruited into the study because of its reputation for having developed a program approach that improved early access and participation in care for pregnant and parenting Aboriginal people. Staff of the Friendship Centre was integrally involved in developing the program that was later adopted as the model for the provincial Pregnancy Outreach Program. This Friendship Centre started out in a leadership position, working collaboratively with other community and regional agencies. The program was based on the Friendship Centre's understanding of the issues and needs of pregnant and parenting Aboriginal people (as well as other populations being served) and their vision for change. Once the program was adopted, with partial financial support from the Ministry of Health, senior administrators of the Friendship Centre reported directly to a provincial program coordinator. Funding for the Case B health programs came from a variety of sources including philanthropic organizations (such as the United Way), provincial and federal contracted programs (such as Canadian Prenatal Nutrition Program), and local and regional fund raising efforts.

Comparison of Case A and Case B

Participants in both cases identified the importance of governance in their work. Participants identified similarities and differences in how governance influenced organizations' experiences improving care along several dimensions. These dimensions included: the importance of a historically grounded vision; the extent to which Aboriginal community members had a voice in decision making; the autonomy of their organizations; and their views of organizational accountability; and approaches to decision making.

Historically situated view and vision

A historically situated understanding of root causes for health and social conditions and a vision for a better future shaped the approach to care of both Aboriginal organizations. Organizations and providers in both cases shared and constantly renewed their understanding of communities' and clients' vision for a better future, based on an understanding of the past and the impact of collective violence on Aboriginal people. In particular, understanding and acknowledging the intergenerational impact of residential schools as a root cause for health and social conditions and capacity for healthy parenting, was described as crucial (Smith et al., 2005). Participants in both cases described their goal as providing safe and responsive programs that build Aboriginal people's capacity to manage their own lives in a healthy, productive, and meaningful way for themselves and their children (Smith et al., 2006).

Case A stakeholders described how the historically situated vision and understanding of leaders was essential to starting and sustaining initiatives to improve care:

> Well I think [name withheld]'s type of leadership — [She] understands the historical context, the current political context of the tribal councils, the culture and the differences in the culture. She understands all of that. It's [the] understanding and appreciation and respect. So that's sort of grounding in First Nations and then she's very grounded in professional nursing and committed to improving the health of the people. (Case A provider)

Case B stakeholders described a similar visionary leadership grounded in an understanding of history, political contexts, and diversities among cultures of Aboriginal people.

> The way forward, the innovation, comes from having a vision. The vision is just knowing the history of Aboriginal people and knowing what there was then, and the strength that was there and a way of life. I'm not saying it was perfect, but it was certainly productive and self- governed for Aboriginal people. Then working from that is looking at holistic health and making sure that there is education … that we get through the impacts of residential school. And it's having people look at what they need to do to create a healthier community, individually and community-wise. (Case B leader)

Delivering care according to Aboriginal people's values, beliefs, and priorities was foremost in the innovation of program approaches of both cases. However, the extent to which governing organizations (Tribal Council for Case A; RHA for Case B) understood the significance of this differed. In both

cases, a central motivation for change was to lessen the imposition of values and beliefs of the dominant society on Aboriginal people. In Case A, this understanding pervaded all levels. For example, one provider said:

> There was always a worry that in the past the emphasis had always been on perceived rigid rules and regulations coming from the outside. The anxiety was "we don't want to continue to do that." We wanted to honour our professional code [e.g., standards for practice], but also wanted to honour the cultural codes and protocols of the [local] people. We needed to understand the [local cultural] code, to respect it, to abide by it, and to be guided by it. So that the cultural code was the main code, and the professional code was the add-on piece, rather than the other way around. (Case A provider)

However, in Case B these same views and vision were not well understood by most staff and decision makers within the mainstream RHA health service delivery organizations. A RHA stakeholder explained:

> Most of our staff are non-Aboriginal people, who don't have that context. They come from white middle class backgrounds, and feel that [colonization] was years and years ago and it doesn't affect our relationships in the present; [they feel that the past] doesn't affect us across this table and our relationships. Whereas conversations with my Aboriginal colleagues, they'll say, "You can't do that, that's impossible. You need to acknowledge the history and [the impact of] all the triggers and words that you would use.

The congruence between local level stakeholders and the governing health authorities' views and vision for care had a significant impact on the organizations' experiences in attempting to improve care. These experiences were influenced by their voice, autonomy, accountability, and approaches to decision making.

Voice
Both organizations developed processes and infrastructure for people to have a voice in decision making. Providers, leaders, and community members described a process of creating spaces and opportunities for citizens and the community to have a voice in how programs were designed and delivered. Voices and representation of Aboriginal organizations in broader policy decision-making were described as critical to both cases' experiences improving programs.

In Case A, the Tribal Council's terms of reference recognized the importance of stakeholder voice in decision making at multiple levels and formal

structures such as health advisory committees were put in place to accommodate that priority. One provider described the emphasis placed on creating space and opportunity for community voice in decision making during development of the new approach to care:

> I think what is important to me about the model itself is the process that went together to build it. And it maybe wasn't perfect, but it was a very strong and very honest attempt to build that model with the community base, as well as having professional input. (Case A provider)

In contrast, participants in Case B described a loss of processes and infrastructure for voice in governance particularly following the provincial government dissolution of the Aboriginal Health Planning Councils.

> There's a little unit left in the provincial government. We thought we would be proactive and we pulled everyone in and worked on input to the [Aboriginal Health Plan]. They had an original plan that was done by, I think, one or two nurses and I think they had a couple of native people that they had talked to, but it didn't include some of the really important issues and things that needed to be included. So we had [well respected Aboriginal leaders representing different Nations and areas of the region] and people that had been really involved in health and social services for years do a lot of work redoing that document. We turned it in and they didn't use any of our information. They never talked to us. We finally called them in for a meeting. They went with this skeleton thing that they did, which I felt wasn't even reflective of the needs of the community. (Case B leader)

This process was used in developing the provincial Aboriginal Health Plan. It illustrates the challenges encountered by this Aboriginal organization when they proactively attempted to bring Aboriginal perspectives to the decision-making table for the regional and provincial health care system.

Autonomy
Participants in both cases described organizational, provider, and client autonomy as critical factors in improving care. In Case A, the Tribal Council buffered macro-level policies in order to allow communities and organizations to have the autonomy to respond to community needs and priorities:

> There is a health transfer agreement with the Tribal Council [which is] this umbrella administrative body that looks after 14 First Nations. They understand completely what is in the Health Transfer Agreement at their level. They understand it inside and out. And from there, the money just gets divvied up to each First Nations. [The Tribal Council] sends you this budget that says, 'You've got

> $100,000 for health. Spend it on health, but there's no restriction on it.' So, it's kind of like, you spend it where you need it. But in health transfer agreements, there are targets that you have to meet. They say some things, you know … it's for this, this and this … but I guess why [the Tribal Council] is doing that [mediating the decision making regarding allocation of funds to specific program needs] is to allow for flexibility for the needs. (Case A leader)

Participants in Case B described experiencing a loss of autonomy and voice in governance of services for Aboriginal people as a consequence of health system changes.

> They [the RHA] might have their own opinion of how we operate. Pushing back, we're trying to meet our mandate in accordance and keeping in mind our own policies and procedures, right? So we find sometimes the RHAs will impede or impose. They think that they know how things should be and they have told us [how to do our business]. (Case B leader)

This perception of RHA interference was shared by decision makers from the RHA, who acknowledged that there had been a sudden change in the relationship between Case B and the RHA as a result of transferring administration of the pregnancy outreach programs to the regional health authorities in the province. As one RHA leader explained:

> The history about those services [the pregnancy outreach programs], a lot of them really started because there was a community development process with key people, who worked in those health units, nurses and nutritionists connecting with their friendship centres and Aboriginal partners. [Prior to 2001] the relationship between the pregnancy outreach coordinators and agencies were directly to the Ministry of Health, with the health unit over here [motions to the side] even though they were often very involved. So then regionalization happened and health authorities were responsible, and even though there had been a contract relationship between the pregnancy outreach providers and the RHA, it really was a rubberstamp. But now, there are other questions asked and direction given like 'Why don't you think about this in this way' and 'maybe you should shift services' … there's a real change in control. I don't think any of the agencies in the province would have had a different experience. They would have felt "What's going on here, this is ours!"

While the RHA experienced increased autonomy and flexibility in health planning as a result of greater centralization of health authorities, these changes were experienced by the Case B organization as having less autonomy, less voice in health planning, and as a result less flexibility to be responsive to the community.

> We [the case B organization] have phone calls [from the newly appointed RHA contract manager] asking what we're doing and … I said, "Why are you doing this? I would never dream of phoning [another organization] and asking why you are making those kinds of decisions. Because I don't work in a day-to-day situation to know what's going on and [I can't] even pretend that I would know what was going on. So I would never interfere with your [business], with what you're doing. (Case B leader)

View of accountability

All local stakeholders in both cases believed that their first accountability was to the community and that they were also accountable to the local administrative authority. In Case A, the conflicts that resulted from this dual accountability were identified early on and precipitated change:

> We were all finding our way [as individual nurses, as administrators and leaders]. I felt like I was on a teeter-totter in a way … with directives from community and directives from the Tribal Council. Plus there was the other layer, which many of us were always talking about, the layer of our nursing standards of practice. So there are really 3 layers. (Case A provider)

Over several years, Case A developed a framework for a model of care based on the community's values and priorities and then found the common ground with the accountability requirements of all stakeholders.

> There were really broad opportunities for people to talk about what health meant to them, what health workers meant to them. And then they looked at different programs for various populations.… And then they gathered those into themes and then went from the themes to the development of cultural meetings and then it was from all that, that the mountain itself developed. So it really has … there was an enormous attempt to have a grassroots based [approach]. (Case A provider)

In their newly configured relationship as a subordinate to the RHA, Case B's formal accountability was to program goals and deliverables set by their various funders, including philanthropic, local, regional, provincial, and federal organizations. Yet, they also aimed to remain responsive to community priorities. The following quote identifies the potential for fractured accountability to goals from multiple funding sources and conflict when contractual commitments were not congruent with community priorities:

> We receive different sources of funding for different programs, health, education and social services, that each have criteria and contractual commitments we

> have to abide by. We train the staff to understand each of their positions, to stay within the boundaries of each of the programs, and to listen to what the community needs are. (Case B leader)

This fractured accountability was evident in Case B in their program deliverables and reporting requirements. In contrast, accountability was more collaboratively negotiated in Case A. For example, when problems with charting and measurement systems were recognized, a more congruent charting and record system that fit the community's approach was developed. This strengthened the program approach and enabled measurement of program impact as described in this quote:

> So we had the visual framework. That was really nice but then we had this medical model charting. So like we're trying to do this traditional holistic nursing that really values the culture and yet all of our charting was medical model that totally didn't fit. So you couldn't really practice your nursing as you wanted to. So we had to develop new charting systems. (Case A provider)

In contrast, Case B's fractured accountability was further complicated by the huge burden of reporting requirements demanded by a plethora of contractual relationships with multiple funding organizations. One Case B provider described how reporting requirements included six levels of reporting, variously on annual, quarterly, and weekly bases, using indicators required for six different stakeholder groups. Further, contractual relationships with multiple funding sources did not provide infrastructure funding to develop skills and resources for the efficient management of information.

> So can you imagine the statistics that I have to keep? I have all of this upstairs in the filing cabinet in the reception area. And every time I want to record something, I have to go upstairs, go through to the filing cabinet in that front office and record it by hand. It's not on computer, none of this. It is sort of a capacity thing. We have a disk upstairs, right. And we have the how-to manual. We just don't have the computers or the people, or the time (Case B provider).

For Case B, fractured accountability interfered with relationships and drew limited resources away from direct service provision. Lack of voice in broader level decision-making meant that problems remained unresolved, leaving providers and the organization in a difficult position. In Case A, a single entity dealing with the funding relationships created a single direct line of accountability and shielded the local organizations from dissipating their energies on multiple reporting mechanisms.

Approach to decision making

One of the most important differences between the experiences of Case A and Case B was the way decisions about care were made and the degree of congruence in decision-making approaches between stakeholders at local (e.g., organization, providers, community, clients) and broader levels (e.g., RHA, Tribal Council). In Case A, the tribal council, the community, and the nursing department believed in and used consensus decision-making, as reflected in the Tribal Council Terms of Reference.

In Case B, the organizational mandate and terms of reference for the board and advisory committee used a similar approach to decision making. However, the new regulations for Regional Health Boards that accompanied the enlarged RHA introduced another layer of bureaucracy and operated under priorities that discouraged community stakeholders from participating in decision making. For example, study participants reported that Aboriginal people were not represented on the Board and perceived that many factors discouraged participation in Board discussions and decision making. As one participant explained:

> With the Regional Health Boards and then the Aboriginal dollars that are sitting there, if you go to a meeting you have to put a brief in. I don't know how many weeks ahead … and if they don't like what's in there, they take it out and you can't bring that forward and you've only got so many minutes to speak. (Case B leader)

In both cases, the role of community participation that was inherent in the health authorities' approach to decision making demonstrated the importance of healthy relationships at local levels of planning and administration. Maintaining authentic community participation when there were so many reporting mechanisms was challenging, especially with ongoing funding and support being contingent on having the appropriate accountability mechanisms in place. This suggests that strong working relationships need to be in place not only with the community to ensure responsiveness but also with a substantial number of funders and decision-making authorities.

Discussion

These results raise critical issues and questions regarding the role of governance in delivering relevant and responsive care to pregnant and parenting Aboriginal people. Governance affects every level of a health system's capacity to deliver relevant and effective care. The findings suggest that flexible

models of governance are required to accommodate diverse views, values, and priorities in a complex and varied health care context. Local Aboriginal health care delivery organizations play a crucial mediating role between citizens' and communities' needs and priorities, and the broader levels of health care decision-making. The governance models that structure the roles and relationships of local organizations directly influence their capacity to develop responsive programs and contribute to either perpetuating colonial relations, or to decolonization of societal institutions and reduction of health disparities. Continuation of colonizing relations and non-Aboriginal control over Aboriginal people can only deepen and entrench health and social inequities for Aboriginal peoples (Cornell and Kalt, 2005). Further, as O'Neill (1995) has shown more broadly, governance dynamics that provide responsibility to Aboriginal organizations, but withhold authority and voice, can set up those organizations to fail.

Governance Models

What sort of governance model will most effectively mediate the multiple stakeholder views and values among organizations and jurisdictions involved in care for pregnant and parenting Aboriginal people? Our findings highlight a myriad of governance models at play. The experience of Case B after the provincial legislation changes of 2001 is an example of the rational goal governance model (Newman, 2001). In the rational goal model, governments exert power through managerial means (e.g., contracts). The rational goal model is oriented to control, focuses on short time lines, and attempts to maximize outputs (Newman, 2001). Rational goal models are incongruent with Aboriginal views of governance, which put voice, strategic or historically situated vision, and respect for autonomy and self-determination in the forefront (Graham and Wilson, 2004).

Case A's experiences illustrate some of the characteristics of open system, network, and relationship-centred models of governance (Newman, 2001). The open systems governance model is oriented towards networks, where power is dispersed and relationships are constantly adapted to meet changed demands. The open system model is "fluid, fast and highly responsive" and "accountability is low but sustainability is high" (Newman, 2001, p. 35). The relationship-centred governance model is oriented inwards and focuses on peer accountability and on fostering relationships of interdependence and reciprocity. Similar to the dynamics of both Case A and Case B organizations, research in other contexts has demonstrated real progress towards improving

indigenous socioeconomic conditions through nation-building approaches to governance and change (Cornell and Kalt, 2005). As these authors suggest, successful models

> put genuine, decision-making power in indigenous hands, backs up that power with capable institutions of self-governance, matches those institutions to indigenous political culture, has a strategic orientation toward long-term outcomes, and is guided by public-spirited leadership. (2005, p. 1)

Establishing successful governance models requires recognition of and significant efforts to reconstruct past capacities as well as attempts to decolonize values, ideologies, and institutions that have historically structured relationships between stakeholders.

More recently, mixed models for governance have emerged, which combine self-governing organizations in market or network-based relationships with each other, yet maintain hierarchical relationships to government. Because of the multijurisdictional nature of health care delivery to Aboriginal people in Canada, both cases were necessarily mixed models of governance. These mixed models maintain accountability to governments' priorities, but enable self-governing organizations considerable autonomy for delivering outcomes (Davies et al., 2004).

Our results suggest that mixed governance models may be especially important in a context where multiple layers of decision making about care are involved, including: community and individual clients; providers delivering care; organizations implementing care; the Tribal Council or Regional Health Authority; and the provincial or federal government. However, attention must be paid to how, and by whom, mixed governance models and relationships are constructed during large health system change (Mhatre and Deber, 1992; Lewis and Kouri, 2004; Cornell and Kalt, 2005). Mixed models may be effective in preserving Aboriginal self-determination in contexts involving multiple Aboriginal, non-Aboriginal, government, and philanthropic actors, thereby enabling Aboriginal organizations to effectively mediate between Aboriginal client and community interests and the needs and priorities driving decision-making at broader levels (e.g. regional, provincial, federal). However, in this study, failure to involve stakeholders from these multiple layers produced significant barriers to making changes, often extending the time required to plan and obtain approvals and funding for innovative programs. Thus, mixed governance models that explicitly attend to preserving historically situated vision, stakeholder voice, and greater autonomy in

decision making are required to diminish barriers to improving care in these multiple layers of decision making. This would allow local organizations the autonomy they need to tailor care more appropriately to local needs and to respond more quickly to changing community and client needs.

Governance and Decolonization

The legacy and enduring presence of colonization in governance systems serves to maintain power inequities between Aboriginal and non-Aboriginal players. Attending to governance of health care for Aboriginal people relates directly to the decolonization of relationships between Aboriginal people and broader society. The linkage between *culture* and effective governmental and social institutions, policies and programs is not simply a matter of a need for "cultural sensitivity." Rather,

> for institutions, policies, and programs to work effectively, they must be legitimate in the eyes of the community.... Everything from the managerial structure to the hours of operation, from the priorities of service delivery to the standards of personnel review, contributes to the legitimacy of a program. Getting such things "right" is the sum of innumerable decisions that commonly flow from a community's culture — its values and shared, often unspoken, approaches of how to get things done. (Besaw et al., 2004, p. 2)

Both Aboriginal organizations in this study strove to shape care that was responsive to the strengths, priorities, values, and beliefs of the Aboriginal people they served. "Cultural governance" is a social and cultural as well as an institutional practice (Newman, 2001). Cultural governance "concentrates on the kinds of knowledge and power through which social activity as a whole is regulated. It draws on the Foucauldian notion that power is constitutive and that it constructs and normalizes practices" which are viewed as "new strategies of control" (Davies et al., 2004, p. 74). Recognition of cultural governance suggests, for example, that health care stakeholders discuss how Aboriginal voice, autonomy, views of accountability, and strategic vision will inform decision-making processes. In this way, thoughtful choice of governance models could develop relationships and capacity to move beyond colonizing relationships, values and institutions that have created the current morass that is health care for pregnant and parenting Aboriginal people.

Implications

Explicit attention to governance must become part of decision making within and among multiple levels of health care: policy, organizational, provider,

community, and client. Health care decision-makers at all levels must support stakeholder involvement in health system change as a worthwhile investment in responsive care. This may open the door for knowledge sharing among stakeholders, a critical prerequisite to improving the safety and responsiveness of health programs serving Aboriginal people. Senior decision-makers in federal and provincial governments must attend more closely to the impact of their policy decisions on governance at local levels. Results also suggest that administrators and leaders in local care delivery systems need to recognize and engage in purposeful dialogue to develop and maintain constructive decision-making relationships and processes. Such efforts should measure progress towards improved governance using indicators related to key governance dimensions such as capacity and opportunity for voice among stakeholders. The congruence of program aims and measures with stakeholders' vision, values, and priorities should be regularly evaluated. Further, steps to build congruence of accountability measures with local goals should be explicitly addressed in funding agreements.

Conclusion

This comparative case study involved two Aboriginal health care delivery organizations in the province of British Columbia, Canada. Our analysis illustrated how governance affected the Aboriginal organizations' efforts to improve care for pregnant and parenting Aboriginal people. Greater attention to governance in health systems serving Aboriginal people is needed. The study highlights the importance of governance models that can successfully and equitably mediate values and priorities among multiple layers of stakeholders involved in health care for pregnant and parenting Aboriginal people. Results underscore the imperative for governance models that facilitate rather than thwart efforts to decolonize institutions that mediate the relationships between Aboriginal people and broader Canadian society.

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