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Indigenist and Decolonizing Research Methodology

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Abstract
European colonization of Indigenous nations has severely impacted the health of Indigenous peoples across the globe. Much of the burden of ill health suffered by Indigenous people today can be traced directly back to colonization. Indigenous peoples of all first world nations where colonization has occurred are experiencing epidemic proportions of chronic disease, higher levels of morbidity and mortality, and poorer health outcomes compared to non-Indigenous populations. Indigenist and decolonizing approaches to research with Indigenous peoples have emerged in recent years with the overall aim of recognition and inclusion of Indigenous epistemologies and ontologies within the western research paradigm. A significant barrier to achieving this is the disconnection between the dominant

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biomedical approach to health and the holistic understandings of health based on Indigenist philosophies and traditional healing practices and knowledges. Conducting research that can successfully inform and improve health services and outcomes for Indigenous peoples requires a decolonizing approach where the voices of Indigenous Elders and communities are the primary informants. Integrating Indigenous ways of knowing, being, and doing with western biomedical approaches requires respect for and inclusion of Indigenous Knowledge as healing methods that have preserved community and individual well-being for thousands of years.

**Keywords**
Indigenous Knowledge · Colonization · Trauma aware practice · Healing culture · Dominant western paradigms

### 1 Introduction: What Is an Indigenist Research Paradigm?

Indigenist research respects and honors Indigenous ways of knowing, being, and doing through using methods that are informed by, resonate with, and are driven and supported by Indigenous peoples. Researchers working respectively with, and learning from Indigenous peoples aim to decolonize western research methodologies and methods in order to include Indigenous ways of seeking, analyzing, and disseminating new knowledge. In order to apply an Indigenist research paradigm to the health services sector, researchers from non-Indigenous backgrounds must firstly examine their own worldview(s) to enable them to understand that their view of the world is different than that of the Indigenous peoples with whom they are working. Indigenist research is characterized by approaches grounded in relationality and the inclusion of Indigenous ways of communicating such as storytelling or “yarning” as it is referred to in Australia (Bessarab and Ng’andu 2010; Rix et al. 2014; Wilson 2008). Applying Indigenist ways of conducting research is in accord with the United Nations Declaration on the Rights of Indigenous Peoples which states that:

> Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State. (United Nations 2008, Article 5, p. 5)

Indigenist research has been a growing body of new knowledge production over the past two decades, led by Indigenous scholars from Canada, Australia, and New Zealand. Indigenous scholar and Maori woman Linda Tuwhai Smith’s groundbreaking book *Decolonizing Methodologies: Research and Indigenous Peoples* (Smith 1999) articulated Indigenous research methodologies that ensure Indigenous intellectual sovereignty of projects involving Indigenous people, interests, and concerns. A number of international scholars have built on the body of knowledge
about Indigenist research methodologies. The work of Indigenous scholars in the Americas, Africa, and Australasia has illuminated the core principles of an Indigenist paradigm for conducting respectful and safe ways for Indigenous peoples to conduct research with both their own people and other Indigenous communities. From an Indigenous methodological perspective, the entire research process must be redefined and reframed (Rigney 1997; Weber-Pillwax 2001; Martin 2008; Wilson 2008; Kovach 2010; Chilisa 2012; Kite and Davy 2015).

While Indigenous scholars from first, second, and third world nations do share methodological commonalities, researchers must be mindful not to categorize these as a homogenous group, and outsiders have no right to do so. One thing that we do share is our colonized histories and the contemporary impacts on the social, health, and political positioning of Indigenous peoples living under western governance. We are also connected via our evolving Indigenous methodologies (Walter and Anderson 2013). The collective work of these groundbreaking Indigenous scholars has built an international body of work that is now making inroads into western academic methodologies and protocols (see also “Kaupapa Māori Health Research,” “Using Indigenist Framework for Decolonizing Health Promotion Research,” “Engaging Aboriginal People in Research,” and “Indigenous Statistics”).

2 Some History

Everything on Earth has a purpose, every disease a herb to cure it, and every person a mission. This is the Indian Theory of Existence. (Morning Dove, Salish)

Indigenous peoples colonized by Europeans share a history of dispossession, trauma and loss of culture. The United States, Canada, Aotearoa/New Zealand, and Australia, for example, are all developed nations with common experiences of European colonization. For Indigenous peoples in these wealthier nations, seizure of land and extermination of whole communities or tribal groups were universally common and carry ongoing repercussions (Stephens et al. 2006). While the non-Indigenous populations of these countries generally enjoy high standards of living and health, Indigenous populations experience significantly poorer socio-demographic and health outcomes (Anderson and Whyte 2008). Indigenous peoples also share significantly lower life expectancy, with “epidemic” levels of chronic conditions such as cardiovascular disease, diabetes, and renal failure (King 2010; Centres for Disease Control and Prevention 2014; Australian Institute of Health and Welfare 2015).

Since the initial shock of invasion by Europeans, Indigenous peoples have been forced to give up language culture and understandings through generational impositions that separated individuals, families, and whole nations from their original knowledge systems and social structures. These traumatic events have disintegrated family and community relationships, structures, and traditional lifestyles. The profound impacts of colonization have been further compounded by the enduring
history of successive failed government policies and practices (Durie 2004; King et al. 2009). For example, the removal of Indigenous children from their families and their detention in government-controlled and Christian church-run residential schools were reinforced through government policy in both Canada and Australia throughout the nineteenth and twentieth centuries. Similar negative and traumatizing experiences when engaging with all government services further connect Indigenous peoples from the United States, Canada, Aotearoa/New Zealand, and Australia (Walter and Anderson 2013).

In her 1998 book, Colonizing bodies, the author Kelm explored how Canadian Indigenous peoples were not only materially affected by the colonizer’s Canadian Indian policies; restricting hunting and fishing and the forced removal of children into unhealthy residential schools, traditional healing, and cultural practices were criminalized. The author discusses the impact of the use of humanitarianism and western medicine to pathologize Aboriginal bodies and inflict a monoculture of biomedical approaches in the name of assimilation (Kelm 1998). The removal of entire communities from their lands into missions and reserves was common practice, with the use of missionaries and Christian doctrine to further demonize and eliminate entire family and cultural frameworks (Kelm 1998).

Indigenous peoples in Australia and the United States experienced similar treatment under colonial policies aiming to assimilate Aboriginal peoples and destroy cultural and family structures using extreme inhumane measures, including removal of children from their families and communities.

The deliberate state-led destruction of Aboriginal communities, languages, and cultural practices has inflicted profoundly damaging levels of trauma. The systematic removal of Indigenous Australian children from their families and communities, creating the Stolen Generations, has deeply impacted social and emotional well-being, with these impacts being passed on via trans-generational trauma (Atkinson 2002). This trauma is an antecedent to Indigenous Australian peoples now suffering a huge gap in health and well-being when compared to non-Aboriginal Australian populations. Emerging theories generated by the study of epigenetics have now linked damaging environmental factors in utero and during early life and begin to explain the causation of the current epidemic of chronic disease and early mortality (Hoy and Nicol 2010). The disconnection of generations of Indigenous children from their land, families, and communities created a direct causal pathway to the current epidemic proportions of chronic disease across all first world colonized nations. Indigenous scholars stress the impact of “cultural detachment” which includes separation from people and country, loss of traditional diet, lifestyles, language, and stories on their people, evidenced in the spiralling incidence of diabetes and other chronic conditions in Indigenous populations (Sanderson et al. 2012).
3 Institutional Racism and Health: Ongoing Colonization

While we could delve further into the ongoing impact of historical trauma, it is important to recognize the ongoing nature of colonial experiences for Indigenous people. Experiencing racism is now known to have a direct physiological impact on health and well-being. Recent work has reviewed the scientific research on how racism adversely affects the health of non-dominant cultural groups. Multiple causal pathways have been identified by which racism can affect health, with institutional and cultural forms of racism being major contributors to health inequalities (Williams and Mohammed 2013). Concepts such as black inferiority and white superiority have been historically embedded in American culture and continue to impact American First Nations people today.

The link between poor health and racism for Aboriginal people was explored in depth by Australian Indigenous scholar Yin Paradies in his doctoral thesis entitled “Race, racism, stress and Indigenous health” (Paradies 2006). This epidemiological study showed strong and persistent associations between chronic stress resulting from experiences of racism and poor physical and mental health, including depression, and increased risk factors for heart disease and other chronic health conditions.

Racism is inherent within colonial government organizations and is beginning to spawn its own research. Reluctance to engage with western biomedical health services by Indigenous peoples is underpinned by a complex blend of historical, political, and economic drivers. Mainstream health services continue to lack acknowledgment and understanding of the historical trauma and racism that are the antecedents to Indigenous people’s avoidance of and lack of confidence in mainstream biomedically driven health services (Larson et al. 2007). Originating at colonization and reinforced by ongoing experiences of overt individual and institutionalized racism, Indigenous people and communities remain highly suspicious of engaging with government services. In the health services context, there remains a culture of blaming and judgment of Indigenous people suffering chronic illness, despite the rapidly increasing incidence of similar patterns of “lifestyle-induced” chronic conditions in all non-Indigenous populations of first world nations (Rix et al. 2014).

Despite contemporary research showing inclusion of cultural and traditional healing methods as the way forward in addressing the serious health disparities suffered by Indigenous people, this is not translating into practice (Poche Indigenous Health Network 2016). Indigenous peoples’ fear and avoidance of western healthcare systems coupled with the “one-size-fits” approach of the biomedical model remain major institutional barriers. In view of this history, it is vital that any research performed with the aim of improving health services acknowledges this by incorporating and utilizing Indigenous ways of creating new knowledge. Dissemination of findings and recommendations requires researchers to collaborate with community to ensure methods are negotiated with and approved by Indigenous Elders and community.
### 4 Survival and Resilience

Survival and resilience are fundamental qualities that unify colonized Indigenous peoples (Tousignant and Sioui 2009; Ramirez and Hammack 2014). Despite the deficit-based approach to “problematizing” Indigenous peoples and their health, a universal strength of all colonized Indigenous peoples is their remarkable survival and resilience, even in the face of the relentless attacks by dominant western governments, aiming to annihilate Indigenous cultural traditions and silence Indigenous voices. This shared history of extreme violence, trauma, and dispossession has, however, highlighted Indigenous peoples’ abundant resilience and strengths. Indigenous peoples’ ability to survive and heal from a succession of damaging and hegemonic government policies unites them (Fast and Collin-Vezina 2010).

Cultures of resistance emerge within these dominated populations fostering forms of non-compliance and aberrant behaviors that protect individuals and communities and ease the burdens of dominance. These weapons of the weak often divert and delay actions instigated by the dominant and conceal resistance because they are interpreted to be evidence of the lesser ability of the dominated. The essential tactic of avoidance is a part of resilience and also a key factor in externally applied research because approaches such as surveys may not truly reflect the Indigenous population (see also “Indigenous Statistics”). In this way Indigenous populations routinely subvert research, avoid treatment, and ignore initiatives (Sheehan et al. 2009).

There is an urgent need to transform western government and policy dialogues about Indigenous peoples’ health and well-being from a negative, deficit-based focus. We do not need more research that tells us how well colonialism is still working (Walter and Anderson 2013). Indigenous leaders and culturally competent and skilled healthcare professionals are stipulating a strength-and right-based approach to health policy and practice for Indigenous people (Tsey et al. 2007; Jackson et al. 2013; Neumayer 2013). Elders and Indigenous communities have been calling for Indigenous Knowledge and healing methods that have sustained Indigenous societies for thousands of years to be incorporated with western medical practices (Moodley 2005; Shahid et al. 2010).

### 5 Why Indigenist and Decolonizing Research in the Health Social Sciences

Indigenous Peoples must look to new anti-colonial epistemologies and methodologies to construct, re-discover and/or re-affirm their knowledges and cultures. Such epistemologies ... strengthen the struggle for emancipation and liberation from oppression. (Rigney 1997, p. 115)

Indigenous peoples have suffered a long history of having been “researched on” by western anthropologists and academics from other disciplines. As a result, many are cynical about the benefits of participating in western academic research, being wary of the colonial lens, and assumed superiority of western researchers (Prior
2006). Australian Indigenous peoples, for example, have witnessed some two centuries of being “over researched” with no prior consultation, permissions sought or any form of post research feedback or positive outcomes. There is a common recognition among many Indigenous peoples that western research paradigms contributed to their ongoing oppression. Research that is framed and supported by the very system that has dispossessed and oppressed Indigenous people has an inherent bias toward maintaining that system. Aboriginal communities in Australia have long held practices that subtly disable intrusive research (Sheehan et al. 2009).

Given this history and the urgent need to address the immense health disparities suffered by Indigenous peoples in colonized first world nations, there is an urgent need to conduct research differently. We cannot expect the same system of thinking that has caused such large health disparities to be able to envision a solution. Research must, therefore, be conducted in a way that fully captures and honors the voices and perspectives of Indigenous peoples but, more importantly, emanates from an Indigenous ontological and epistemological basis. This is Indigenist research. It ensures that Indigenous Knowledges, experience, and wisdom are captured, applied, and disseminated in ways that resonate with Indigenous ways of knowing, being, and doing. Sherwood (2010), Australian Indigenous nurse and scholar, has applied this approach to decolonizing Indigenous health services and research in her doctoral thesis “Do no harm: Decolonising Aboriginal health research.” Sherwood argues that any research aimed at decolonization of Indigenous healthcare must be initiated and guided by Elders and underpinned by Indigenous critical theory and the balancing of two ways of knowing. This approach leaves no room for the “problematizing” of Aboriginal people in the healthcare context, which results in the silencing of Indigenous voices, subjugation of Indigenous Knowledges, and Indigenous peoples being viewed as the “Other” (Sherwood 2010).

All research is appropriation, and, therefore, it should be conducted in a way that ensures that both the researched and the researcher benefit (Chilisa 2012). Normalized positions of dominance must be recognized and deconstructed and deficit discourses replaced with respectful representation that leads to opportunities for sharing, growth, and learning. This approach restores hope and belief in a community’s capacity to resolve challenges (Chilisa 2012). Elders and community members are indeed the experts in the health and well-being of their own people, with knowledge and expertise reaching back thousands of years prior to the evolution of the biomedical model of health and the colonization of their nations by Europeans.

Indigenist researchers have developed theoretical frameworks and research methods that are congruent with Indigenous belief systems that have been known for millennia. As the substantive theory underlying Indigenist research continues to be further articulated, Indigenous truths that are informed by Indigenist methodologies have emerged. These truths are based on our own ontological and epistemological foundations and, therefore, have the ability to envision solutions to seemingly intractable health problems. A common feature among many Indigenous peoples’ ontology is that we are relational. That is to say, we do not engage in relationships, nor are we in relationships, but we are relationships. Our very being,
and the nature of reality itself, is relational. We are relationships with people and communities, with the Land, with ideas, with everything. Indeed, nothing would be (or exist) without relations (Wilson 2008). Aboriginal scholar Mary Graham builds on this relational ontology with her statement “You are not alone in the world.” Here Professor Graham describes the survival of a contemporary Indigenous kinship system based on relationality, despite the damage inflicted by the colonizer’s urbanization of Aboriginal people using (attempted) cultural genocide. The central role of Indigenous people’s connection and relationship to land is clear in her writing:

Although Indigenous people everywhere are westernised to different degrees, Aboriginal people’s identity is essentially always embedded in land and defined by their relationships to it and to other people. The sacred web of connections includes not only kinship relations and relations to the land, but also relations to nature and all living things. (Graham 2008, p. 187)

Fundamental to Indigenist research is an understanding that the researcher is not outside of reality looking in but has entered into a different set of relationships with the people and issues that they are researching. So, among the truths that emerge from an understanding of relationality is that researchers, as knowledge producers in relation, are in themselves accountable for maintaining healthy relationships with the communities, environment, and ideas that they are researching (Wilson 2008).

Reflexive practice is essential for any researcher in examining their motivations and intent in working with Indigenous people. Just as Indigenous scholars apply a critical lens to their work with their own people or other Indigenous communities, examining why and how they are doing research, close scrutiny is vital:

If my work as an Indigenous scholar does not lead to action, it is useless to me or anyone. I cannot be involved in research and scholarly discourse unless I know that such work will lead to some change out there in that community, in my community. (Weber-Pillwax 2001)

Indigenist methodologies view the rigor and validity of research as determined through relational accountability (Wilson 2001). Researchers have relational accountability to participants, co-investigators, and the overall conduct of the study. For the non-Indigenous researcher, relational accountability is encapsulated by principles of respect, responsibility, and reciprocity (National Health and Medical Research Council 2003; Rix et al. 2014). The long-term destiny or agency of research findings can work against or in favor of the researched, and this reinforces the responsibility of the researcher (Glowszewski et al. 2012). The principles of reciprocity underpin Indigenous cultural and social identity. They relate to Indigenous rights and obligations of sharing within community (Schwab 1995). As reciprocity implies collaboration, choice, and respect, it must be deeply embedded within the research methodology and methods. Consideration must be given to where money is spent in community, what protocols are acknowledged, and how the researcher is giving back to those being researched. Opportunities to co-author research, leave knowledge, learnings and skills within the community, and respecting protocols all constitute reciprocity (Ellis 2016).
6 Indigenous Knowledge as a Protective Factor

Once we understand the relational nature of reality, we can see that Indigenous cultures are built upon complex systems of relationships and relational accountability. Therefore, Indigenous culture itself is a pathway to healthy relations and healing for Indigenous people (McDonald 2006; Aboriginal and Torres Strait Islander Healing Foundation 2014). When combined with western medicine, Indigenous Knowledge and cultural healing can provide ways for people to gain control over their lives.

Mainstream initiatives that engage with Aboriginal cultural practice, philosophy, spirituality and traditional Aboriginal medicines are examples of how to enact the theoretical concept of Indigenous Knowledges into reality and practice. However, there are too few examples of where this is happening in a meaningful and enduring way. (Poche Indigenous Health Network 2016)

Healing for Indigenous people takes place by way of reconnection to country, family, and culture (Maher 1999; Watson 2001; Kirmayer et al. 2003). Cultural healing may be from reconnecting to Indigenous ways of knowing, being, and doing, art, dance, or simply sitting down with Elders and listening to the traditional stories passed down through the generations (Hunter et al. 2006; Aboriginal and Torres Strait Islander Healing Foundation 2013).

Any superficial acknowledgment of culture must be accompanied by a fundamental acceptance of Indigenous ontology and epistemology at the foundational level of research planning. It is not enough to window dress western practices with cultural artifacts; the issue of power imbalance of the two knowledge systems needs to be addressed. This entails collaboration, trust, and the ability to push back against our conditioned belief that the western biomedical way is the only right way. It cannot be simply acknowledging that we have two proven knowledge systems; there must be systemic change. To change the system, we must be able to understand both knowledges, value them equally, and implement what is important. It is about allowing the historically oppressed to find their voice and power and sit with equality at the table when decisions are being made. If we want true equality and healing, one side must be willing to give up the power of control.

Indigenous culture has never been static. Indigenous communities have always placed the well-being of their people and their lands at the center of their governance and have been able to evolve and embrace change with resilience. Culture is not just dance, ceremony, and language; it is a philosophy and worldview that is based on collective ways of knowing and being. Collective community is the relationship to all things from the wind and weather to the waters, lands, and its peoples. To pay lip service to culture by engaging artifacts results in a hollow attempt to show cultural safety. True healing will happen when culture is not filtered through the western ways of knowing. It is when Indigenous peoples can make decisions for the services that govern them.
Non-indigenous Researchers Using Indigenist Methods

Working with Indigenous peoples in a research capacity requires the non-Indigenous researcher to bracket their own worldviews and apply a critical reflexive lens to any project they contribute to (Rix et al. 2014). Reflexivity can be an effective instrument for mitigating power, class, and cultural differences in research (Bott 2010). When working with Indigenous peoples and communities, with the aim of improving health services delivery, it is crucial to proceed respectfully and remain ever vigilant of applying an epistemological approach which privileges Indigenous voices. Self-determination, addressing power imbalances, and community control must remain central to any research project performed by outsiders and non-Indigenous researchers with Indigenous communities (Rigney 1997).

According to Wilson (2007), working within an Indigenist paradigm is not limited to Indigenous researchers, just as working with a western paradigm is not restricted to researchers of “white” descent, or working with a “feminist” methodological approach is not restricted to being female. Non-Indigenous researchers are accountable to Indigenous community and elders, and it is essential that they develop mutual trusting relationships. Taking responsibility for the cultural safety of Indigenous research participants via deep consultation with elders and community to confirm that any proposed research is in accord with the needs and desires of that community is essential in the commencement of any research project.

Notions of white privilege and white guilt have emerged over roughly the same time frame as the Indigenist paradigm has been evolving. In her pivotal work, Peggy Macintosh, an American feminist and antiracism activist, described the “invisible knapsack” containing all the privileges that being a member of white middle-class society delivers (McIntosh 1990). White guilt is a concept that is defined as the individual or collective guilt felt by some white people for harm resulting from racist treatment of ethnic minorities by other white people both historically and currently (Steele 1990).

Both these concepts may form part of the non-Indigenous researcher’s personal process of unpacking their own worldviews using critical reflexive practice. They are, however, of no value in the role of the non-Indigenous researcher seeking to advocate for and find creative ways to contribute to the honoring and inclusion of Indigenous Knowledges into mainstream health services research. Of more importance here is the non-Indigenous researcher’s ability to develop open listening skills and bracket their own worldviews in order to view the world through the lens of the Indigenous peoples with whom they are working.

Critical Self-Reflexivity

It is of vital importance that before any first meeting or consultation with Indigenous community takes place, the non-Indigenous researcher must undertake a personal journey of critical reflexive practice in order to examine and comprehend their own position as a white person of privilege (McIntosh 1990). This process extends
beyond mere awareness of colonizing histories and power imbalances, to examining one’s own worldviews and the biases and assumptions that come with being a member and product of the dominant western culture. Without a genuine and ongoing process of critical examination of self, reflecting on the privileged lens through which the world is viewed, the non-Indigenous health services researcher is at risk of merely contributing to and continuing the colonization process, further embedding the dominant western paradigm that cannot provide either re-empowerment or self-determination (see also “▶ Using an Indigenist Framework for Decolonizing Health Promotion Research,” “▶ Engaging Aboriginal People in Research,” and “▶ A Culturally Competent Approach to Suicide Research with Aboriginal and Torres Strait Islander Peoples”).

Practicing critical reflexive practice requires a toolkit. This may include, for example, regular journaling and development of strong relationships with Indigenous people as research colleagues and co-investigators. Examining one’s influence on and positioning within any research performed with Indigenous communities is a crucial ingredient of preparation to work with Indigenous peoples using a relational and Indigenist methodology. It is important, however, to be aware that positioning and clarification of roles in any research endeavor are of far less importance than the non-Indigenous researcher’s effectiveness as a research “instrument” who can contribute to improvements to health services in ways that resonate with and reflect the Indigenous peoples with whom they are working (Rix et al. 2014). To be successful in informing policy and positive change requires researchers to manage complex relationships between Indigenous individuals, communities and organizations, and the dominant biomedical world they are required to negotiate to access healthcare and treatment.

### 7.2 Supporting Indigenist and Decolonizing Methods

There are a number of important strategies that non-Indigenous researchers can use as advocates for and practitioners of Indigenist and decolonizing methodologies:

- Citing the co-creation of new knowledge as a relational exercise that cannot occur in isolation. An individual cannot own new knowledge.
- Not trying to know or understand too quickly because relational approaches with Indigenous peoples operate to an inside learning timetable; true change is paced to things other than research programs or publishing deadlines (Gnibi Elders Council 2016; Murphy 2017).
- Use of Indigenous ways of disseminating research findings, for example, storytelling, artwork, and use of metaphors.
- Publishing in health and medical journals with Indigenous Elders, community members, or research participants as co-authors.
- Publishing research results in the voice of the Indigenous participants.
- Illustrating research output such as new theory and data analysis using Indigenous artwork.
Introducing co-authors and a little of their stories or background in publications, to enable the reader to build their own relationship with authors.

This list while by no means comprehensive provides examples of ways that non-Indigenous researchers can contribute to the use and acceptance of Indigenist methods. Academic processes often act to block or negate the influence of paradigms that challenge the dominance of western and biomedical worldviews. The inclusion of Indigenous research methods that resonate with individual participants, Indigenous Elders, and community members are becoming more commonly used and accepted within western academic conventions.

8 Conclusion and Future Directions

The purpose of this chapter is to familiarize health social scientists with the rapidly growing prominence of Indigenist and decolonizing methodologies, providing an emphasis on how these can make important and significant contributions to the health services research arena. In fact, we strongly argue that without the inclusion of Indigenous ways of knowing, being, and doing and the voices of Elders, community members, and individual Indigenous participants, there can be little or no improvement to provision of effective health services or improved health outcomes for Indigenous peoples.

The profoundly damaging impact of European colonization on Indigenous nations is the known primary driver of the current burden of ill health suffered by Indigenous peoples across many countries. Performing research with Indigenous peoples using epistemological and ontological approaches that incorporate Indigenist philosophies and traditional knowledge and practices is now known to be a genuinely decolonizing approach to research aimed at improving health and well-being.

Researchers aiming to work with Indigenist methodologies are required to use ongoing critical self-reflection to both unpack their own existing worldviews and acknowledge their privilege. Awareness of and insight into the relational and interconnected worldviews and philosophies of Indigenous peoples are vital for anyone wishing to work in this area. Any project must be approached with “respect, responsibility, and reciprocity” as the foundational principles of ethical research performed with Indigenous communities and individuals. It is also vital that researchers be mindful of the underpinning driver of Indigenist methodologies and methods: to increase the empowerment and self-determination of the Indigenous population under investigation.

In writing this chapter, we sincerely hope that more non-Indigenous researchers will be motivated and inspired to incorporate Indigenist methods and ways of knowing being and doing into any research project aiming to improve health services design and delivery for Indigenous populations. Until the western and biomedical dominance of research is broken, it is difficult to envisage how mainstream health services can successfully address the current and ongoing epidemic of chronic
disease suffered by Indigenous peoples and reduce the disparities in morbidity and mortality between Indigenous and non-Indigenous populations in colonized nations across the globe.

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