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"A serious rift": The Indigenous Health Research Community's Refusal of the 2014 CIHR Funding Reforms and Underlying Methodological Conservatism

John Rose et Heather Castleden

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Résumé de l'article

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"A serious rift": The Indigenous Health Research Community's Refusal of the 2014 CIHR Funding Reforms and Underlying Methodological Conservatism

John Rose
Queen's University, Canada, jwlrose@gmail.com

Heather Castleden
University of Victoria, Canada, castleden@uvic.ca

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Abstract

In 2014, the Canadian Institutes of Health Research (CIHR) senior administration established reforms to the Open Suite of Programs and Peer Review processes (OSP), implementing changes that it claimed would improve its funding and peer review structures. The purpose of the research reported in this paper was to investigate how CIHR reforms to the OSP were poised to negatively affect Indigenous health research. We found that the reforms were guided by a governmental and institutional trajectory of methodological conservatism that (a) privileged commercial research over projects that focus on social determinants of health and community relations, and (b) created a peer review system re-designed in ways that reduce inclusiveness. Interventions by the CIHR Institute of Indigenous Peoples Health' Advisory Board and an ad-hoc Indigenous Health Research Steering Committee (kahwa:tsire) were urgently organized and mobilized to reverse the CIHR decisions that were being made under the guise of so-called 'consultation.'

Keywords

Indigenous health, Indigenous health policy, Aboriginal health policy, Canadian health policy, colonialism and health policy

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"A serious rift": The Indigenous Health Research Community's Refusal of the 2014 CIHR Funding Reforms and Underlying Methodological Conservatism

Introduction: Indigenous Health in the Colonial Context

Purpose: Reforms and Research

The Canadian Institutes of Health Research (CIHR) is Canada's health research investment agency that supports biomedical, clinical, health systems services, and population (social, cultural) health research. Comprising 13 Institutes, CIHR invests approximately $1 billion per year toward health initiatives through investigator-driven projects via open project competitions, as well as priority-driven projects identified by the Government of Canada as pressing health issues. The CIHR Governing Council oversees strategic directions, performance, objectives, and budgets, and it appoints Advisory Boards that give non-binding advice to the 13 Institutes. Scientific directors lead each Institute and form a Science Council that develops research and knowledge translation strategies for CIHR (CIHR, 2022). Comparatively speaking, CIHR performs functions similar to the National Institutes of Health in the United States, the National Health and Medical Research Council in Australia, and the Medical Research Council in the United Kingdom.

The purpose of the research reported on in this article was to investigate how CIHR reforms to the Open Suite of Programs (OSP) and peer review processes from 2012 to 2014 affected the Indigenous health research community in actual and perceived ways. CIHR designed the reforms to change funding and peer review structures as administrators "became aware of the need to modernize existing frameworks to better capitalize on Canada's health research strengths" (CIHR, 2012b, p. 36). CIHR management identified a "paradigm shift" in how health research was being conducted around the world, arguing that "multidisciplinary, networked collaborations and timely research in emerging areas" were becoming the norm (CIHR, 2012b, p. 36).

By exploring strategic plans, internal and external reviews, design documents, and interviews with 22 Indigenous health researchers,[1] we problematize the sweeping nature of these reforms. Interestingly, not everyone saw the reforms as problematic. Indeed, at an urgently called Indigenous-led national meeting to call the reforms into question, the then CIHR president, who made a public speech at the time, commented: "I would like to bring my personal views, not only those of CIHR, about the stormy weather we have been experiencing lately . . . But not in the spirit of reconciliation, because I don't think anything has been broken" (Eggertson, 2016, para. 6). The dismissal of Indigenous health researchers' and Indigenous health leaders' concerns created a serious rift in the relationship. Amplifying the voices of Indigenous health researchers, this paper is part of an ongoing movement towards decolonial scholarship to counterbalance conventional Eurocentric or western institutional policies and values (Castleden et al., 2015).

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[1] When we use the term "Indigenous health researchers," we mean both Indigenous and non-Indigenous People who conduct research related to Indigenous Peoples.

The reason for investigating the CIHR reforms is not just to understand the mechanisms that deliver health research funding, but to understand the unintended consequences of reforming funding and peer review processes in an era of so-called truth, healing, and reconciliation in Canada (National Centre for Truth and Reconciliation, 2022). While our focus is on CIHR, our analysis has the potential for transferability to other funding and peer review reform contexts now and into the future, as well as how institutions are still largely ineffective in their responses to the 2015 Truth and Reconciliation Commission's 94 Calls to Action (see, for example, Castleden et al., 2022; White & Castleden, 2022). To understand how such reforms affected the Indigenous health research community, the analysis requires some context about colonialism (not to mention neoliberalism as well, see Swarts, 2013). Understanding the nature of pervasive colonial policies and practices in Canada is integral to comprehending the state of Indigenous health; these policies, practices, and people have had profoundly negative impacts on Indigenous Peoples' livelihoods.

This paper is situated within a larger international discussion about how health policy can marginalize Indigenous health research and community-based projects. Research in New Zealand, for example, criticized the restructuring of national science funding and how health reforms (commercialization) lacked consultation and consideration for culturally distinct Māori knowledge (Prussing & Newbury, 2016). Similarly, research in South America argued that reforms to health care services (contracting out services to the private sector) have created barriers to collaboration between government and communities in providing health care services (Maupin, 2009). Researchers in Asia argued that the inclusion of Indigenous knowledge in health policy is valuable to future medical challenges when integrating biomedical practices (Janes, 1999). Health research in Australia, Canada, New Zealand, South America, and the United States has demonstrated that increased participation of Indigenous community members, self-governance initiatives, and community-motivated health policy improves access to health services (Bernstein, 2017; Feagin & Bennefield, 2014; Kelaher et al., 2014).

Colonizing Indigenous Bodies in Canada

The effects of colonialism are ongoing, and Canadian institutions have historically been responsible for Indigenous health crises (Daschuk, 2013; Royal Commission on Aboriginal Peoples [RCAP], 1996). Dispossession and appropriation have obscured and ruptured cultural continuity by changing and restricting access to the land—yet land is central to maintaining health for Indigenous Peoples (Castleden et al., 2016; Milloy, 1999; Tobias, 1991). Current Indigenous health is connected to the past, as distal determinants of health (the political, economic, and social contexts of colonialism) construct the intermediate determinants (health care systems and delivery and the systemic barriers associated with them) and influence proximal determinants (statistics, indicators, individual behaviours; Reading & Wien, 2009). Current health care systems and frames of analysis often neglect historical context and do not reflect wholistic approaches to health that take physical, emotional, mental, and spiritual dimensions into consideration (Reading & Wien, 2009). Many elements common to Indigenous understandings of health are absent from Canadian health care (e.g., the importance of seasons, directions, the elements of life, and spiritual entities; Castleden et al., 2016). Health data has historically been fragmented as national surveys often neglect Indigenous People, and there has been an absence of health measures that are culturally relevant and reflect Indigenous perspectives (Reading & Wien, 2009).

The harm from historical and ongoing colonialism (see, e.g., Churchill, 2004; Miller, 1991; RCAP, 1996) motivates approaches to research that follow distinct ethical guidelines (Ball & Janyst, 2008; Castellano & Reading, 2010). In the past (and today), academic work involving Indigenous Peoples has often privileged the researcher over the researched, necessitating collaborative approaches (Battiste & Youngblood Henderson, 2000). The 2007 CIHR Guidelines for Health Research Involving Aboriginal People promoted collaborative approaches to research through the four ethical principles of OCAP® (ownership, control, access, and possession of data) underpinning research involving any First Nations (CIHR, 2007, Section 2.3). Those guidelines were replaced in 2010, and updated in 2018, with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; its Chapter 9 provides ethical guidance for Indigenous-focused research in Canada (Panel on Research Ethics, 2018). The document has had a relatively productive influence in cultivating relationships built on ethical principles, allowing researchers to learn what ethics means to Indigenous communities (Moore et al., 2017). The guidelines highlight community-based participatory research, a well-recognized approach in Indigenous research that promotes shared decision-making power between researchers and communities, reducing power imbalances, co-creating knowledge, and encouraging the decolonization of traditional research processes (Castleden et al., 2012). With this context in mind, along with the perspectives of Indigenous health researchers, this paper considers *who* benefits from funding reforms, and the *value* institutions place on scholarship that does not adhere to traditional Eurocentric or western deliverables.

Case Context and Reform Opposition

When CIHR was founded in 2000, the Institute of Aboriginal Peoples' Health (IAPH; now the Institute of Indigenous Peoples' Health or IIPH) was one of 13 founding Institutes.[2] Its purpose is to "[foster] the advancement of a national research agenda to improve and promote the health of First Nations, Inuit and Métis Peoples in Canada through research, knowledge translation and capacity building" (IIPH, 2022). One of the first initiatives of the IAPH was to create the Aboriginal Capacity and Developmental Research Environments (ACADRE) program to build capacity and train Indigenous health researchers. The need for such an initiative was clear, as there were only a handful of senior Indigenous health scholars at the time and the academy was (and continues to be) steeped in colonial and racial ignorance (Godlewska et al., 2010). The ACADRE program evolved into the Network Environments for Aboriginal Health Research (NEAHR) in 2007, which included nine research centres across the country (Richmond et al., 2013). The centres were designed to pursue scientific knowledge, advance capacity and infrastructure in Indigenous health research, provide the appropriate environment for scientists to pursue research in partnerships with Indigenous communities, provide opportunities for Indigenous communities and organizations to identify research objectives in collaboration with health researchers, and provide the appropriate environment for Indigenous and non-Indigenous students to pursue careers in Indigenous health research, services, and professions (NEAHR, 2011).

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[2] In this paper, we use the term "Indigenous" to refer to the original inhabitants of the land now known as Canada, and we use "Aboriginal" if we are referring to a specific organization that uses the term Aboriginal Peoples.

While Indigenous health researchers valued NEAHR (and ACADRE) as an important capacity-building network, CIHR senior administration defunded the program in 2014 (McCormick & Wien, 2014). A report for the IAPH from 2011, produced by an Expert Review Team comprising Dr. Jeffrey Henderson, Professor Linda Tuhiwai Smith, and Professor Fiona Stanley, noted that both the ACADRE and NEAHR programs were the primary vehicles for IAPH to "address student and faculty development and training, institutional infrastructure, community outreach and engagement, bioethics and knowledge translation" (Henderson, 2011, p. 3). The Expert Review Team characterized NEAHR as the "flagship program" of the IAPH. Researchers saw NEAHR as transforming the Indigenous health research landscape by funding graduate work and providing mentorship for building community relations; many researchers attribute their success to the ACADRE and NEAHR programs, which provided training and funding, and supported their ability to make connections that continue in their work as tenured faculty. Scholars, faced with reforms to funding models, peer review processes, and invaluable capacity-building programs, thus organized to protect Indigenous health research from administrative decisions.[3]

CIHR began internally producing reform documents in 2012, and as rumours began swirling about the potential for dramatic change, Indigenous health researchers organized to voice their opposition. In 2014, Dr. Jeff Reading (former scientific director of IAPH) drafted an open letter to CIHR administration addressing "a serious rift" between CIHR and Indigenous health researchers, and invited colleagues to sign in support. In response, 75 Indigenous health researchers, health practitioners, and scholars signed. The letter argued that CIHR was ending a commitment to build capacity by eliminating mechanisms that provided space for Indigenous health priorities. The signatories claimed that CIHR was constructing barriers that would discourage proposals from the Indigenous health research community (McCormick & Wien, 2014). The letter, addressed to then president Alain Beaudet, did not receive a substantive response (kahwa:tsire, 2015).

The letter campaign marked the beginning of an ad hoc Aboriginal Health Research Steering Committee (AHRSC), which formalized itself in November 2014 and became the driving force for opposing the reforms and advocating for trainees as well as early career Indigenous health researchers. AHRSC was formed initially by senior researchers (full professors and professors emerita) and representatives from national Indigenous organizations to raise concerns about the new reforms and to suggest postponing implementation and considering alternatives. It was seen as creating a unifying voice and ensuring the IAPH scientific director, the IAPH Advisory Committee, and Indigenous organizations were involved and informed: "Each of the Steering Committee members wrote compelling letters to the CIHR President and to Governing Council. These letters, too, did not merit a response" (kahwa:tsire, 2015, para. 2). Reflecting on that time, interview participants, by and large, felt the decisions around funding for Indigenous health research were not consultative, were not meaningful, and did not constitute free prior and informed consent.

The AHRSC campaign networked with national Indigenous health organizations and convened a one-day meeting in Ottawa in 2016 with the CIHR president and vice presidents, the scientific director of

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[3] kahwa:tsire, a movement which details the responses of Indigenous health researchers to what they/we considered an emerging crisis between the funding agency and the Indigenous health research community at the time, can be found at https://kahwatsire.files.wordpress.com

the IAPH, and representatives from at least 30 major health organizations across Canada, as well as *CMAJ* (*Canadian Medical Association Journal*). The meeting increased pressure on CIHR senior management to seriously consider AHRSC recommendations regarding the reforms. It was at this meeting that the CIHR president made the previously quoted comments about approaching the meeting "not in the spirit of reconciliation" because he did not believe "anything had been broken" by the reforms (Eggertson, 2016, para. 6). The AHRSC had recommended increasing Indigenous health research funding from its then current amount of less than 1% to 4.6% of the CIHR budget (representing the Indigenous population in Canada; Eggertson, 2016, para. 1). CIHR investment in Indigenous health research slipped from 3.7% in 2009 to 3.3% in 2014 then to 1% (Webster, 2015, para. 6). AHRSC also recommended maintaining face-to-face peer review processes and increasing Indigenous representation on the CIHR Governing Council, as well as adding a new vice president of Indigenous health research.

Methods

Data Collection

We collected two types of data: interviews and documents. We conducted 22 semi-structured interviews with Indigenous health researchers from January 2017 to May 2017 to understand their perspectives on CIHR reforms. We recruited interviewees from the list of signatories to the letter campaign opposing CIHR reforms and/or individuals who were involved in the AHRSC in an effort to reach informed participants about the ongoing changes to CIHR's funding and review structures. Participants were asked open-ended questions about their relationship with Indigenous health research, CIHR, and the proposed changes to funding models and peer review processes to ensure depth in responses (Denzin & Lincoln, 2011). The second author was an active member of the IAPH Advisory Board when the reforms were being enacted. Respondents were interviewed and recorded, by phone or in person, by a trained research assistant. Interviews lasted from 15 to 60 minutes and were then transcribed verbatim. The documents we used in the study include government policy papers, articles from *CMAJ* covering the reforms, and CIHR strategic plans, progress and program reviews, funding statistic reports, and reform design documents. This project was approved by the General Research Ethics Board at Queen's University.

All participants identified as Indigenous health researchers ($n = 22$), 45% identified as Indigenous ($n = 10$), and 68% were women ($n = 15$). A majority 55% of participants identified as senior or late-stage researchers ($n = 12$), and 86% of participants worked under Pillar 4 (socio-cultural research) of CIHR ($n = 19$), but 36% of participants worked under at least two different pillars ($n = 8$). A majority 77% of interviewees had participated in the peer review process either as reviewers or as committee members ($n = 17$), and 86% had CIHR funding at the time of the interview ($n = 19$).

Data Analysis

Coding of both interviews and documents followed a thematic content analysis approach by identifying terms, phrases, and ideas that were either common between interview participants or identified as meaningful by participants through direct statements or repeated use of phrases, terms, or ideas (Berg, 2001; Cope, 2016; Waitt, 2016). The data were coded in qualitative data management software based on themes and subjects of inquiry (e.g., peer review processes, capacity-building programs, funding model reforms). A second round of coding used a similar process, identifying themes stressed in the documents as well as relevant themes identified by interview participants.

Reform Framework

Methodological Conservatism

Methodological conservatism emphasizes positivist or clinical research models and "produces and privileges" specific types of scientific knowledge (Lincoln & Cannella, 2004, p. 7). Institutional governing bodies seek to create a monoculture by promoting "a single discursive and methodological community that speaks the same language and takes concerns from the same perspectives" (Lincoln & Cannella, 2004, p. 8). Alternative modes of inquiry (e.g., qualitative) are often labelled as less rigorous, non-intellectual, "soft," or lacking reason (Denzin & Lincoln, 2011, p. 2; Lincoln & Cannella, 2004, p. 8). An increase in popularity of positivism in government institutions across North America since the mid-1980s leaves qualitative study often treated as a "quasi-discipline" (Atkinson & Delamont, 2006, p. 751). Institutions create "guiding principles" that attempt to shift the defining characteristics of "good" or "appropriate" research toward more positivist approaches (Block, 2004, p. 100). For example, analysis of the No Child Left Behind Act of 2001 in the U.S. found that regulations established what kind of studies would be funded and what kinds of evidence would be considered "scientific" (Lincoln & Cannella, 2004, p. 7). In education research and literacy, empirical strategic interventions like test scores, cost-benefit analyses, and the discourse of "hard scientific evidence" helped define "effective" scientific inquiry (Block, 2004, p. 98). Positivist, evidence-based models of inquiry can neglect the diversity of qualitative inquiry, privileging numbers and figures over stories and narrative; evidence is not singular, and knowledge is relational with contexts (Denzin, 2009; Hammersley, 2001). A critical document analysis of CIHR reforms reveal a methodological conservatism as certain models of scientific inquiry were given an advantage over others. Indigenous health researchers opposed reforms that risked homogenizing research around already-established positivist norms by privileging senior, established researchers rather than acknowledging the cultural contexts necessary to pursue community-engaged research. The documents that animated the CIHR reforms reveal institutional changes that privileged established research in technical pillars over emerging community-based research.

Findings 1: Reform Design and Context

Pre-Reform Documents

Several organizational documents point to the motivations for reforming CIHR's OSP, framing the trajectory of health research largely around industry, technology, and commercial outputs rather than community-based research. The 2007 federal strategy "Mobilizing Science and Technology to Canada's Advantage," released by Industry Canada, prompted the early stages of reform and emphasized a strong private-sector commitment to science and technology. The Conservative government of the day argued that the private sector would "identify and lead new research networks" with government support for "large-scale research and commercialization" (Government of Canada, 2007, p. 13).

The 2009 CIHR "Health Research Roadmap" (HRR) strategic plan drew from the "Mobilizing" strategy and focused on the commercialization of health research, international collaboration, and multidisciplinary training. The HRR stated that "there is considerable room for improvement of commercialization of health research results," noting the importance of patents and that "investing in health research yields significant economic returns" (CIHR, 2009, Context for Strategic Planning section, paras. 6–7). The HRR's Strategic Directions emphasized supporting "commercialization by creating incentives for health researchers to work with private sector partners" (CIHR, 2009, Strategic Direction 3, para. 4). The HRR concentrated on finding ways to yield economic returns on health research and working with private partners like pharmaceutical manufacturers to improve technologies and health products. This emphasis on commercial potential and economic yields formed a trajectory, through clear strategic directives, that posed a challenge to Indigenous health researchers whose approach to improving health included building community relationships, committing to participatory research, and understanding Indigenous Ways of Knowing.

The 2011 CIHR International Review Panel (IRP), comprising health care professionals and scholars largely from the United States but also the United Kingdom, Western Europe, and Australia, also made several recommendations related to funding structures and industry relationships. The IRP called for commercialization of research, echoing the "Mobilizing" strategy and HRR, and argued that the "translation of Canadian science into products and services that can sustain competitiveness" was lacking (CIHR, 2011, p. 1). The IRP noted there was no strategy "to actively commercialize basic research findings" to create high-profile technology, well-paid jobs, and tax revenue for Canada (CIHR, 2011, p. 14). Another major recommendation from the IRP was to issue larger grants with longer terms to relieve peer review fatigue and consolidate grant committees (CIHR, 2011, p. 11). The CIHR's 2014 HRR II strategic plan also focused on "leveraging successful commercialization networks and hubs, forging alliances and creating pre-competitive consortia with new industry partners, and supporting public-private partnerships and collaborations" (CIHR, 2015, p. 24). In short, CIHR's public documents leading up to the reforms all employed language related to conventional industry, biotechnology, and commercialization but almost completely neglected discussing the value of community-engaged research, justice, equity, and Indigenous Ways of Knowing. The CIHR reforms were guided by a governmental and institutional trajectory that explicitly favoured research that promised economic returns.

CIHR Funding Structure

CIHR documents drew from the aforementioned pre-reform documents, recommending a new "streamlined" OSP and a "need to modernize existing frameworks and systems to better capitalize on Canada's health research strengths" (CIHR, 2012a, p. 3; CIHR, 2012b, p. 36). After the federal government released the "Mobilizing" strategy (Government of Canada, 2007) and CIHR issued the HRR (2009), the CIHR Science Council established a reform task force in 2010 that included representatives from each of the four CIHR pillars of health research (biomedical, clinical, health systems services, and socio-cultural). CIHR released a preliminary reform "Design Discussion Document" to Canadian health researchers in February 2012 (CIHR 2012a), followed by a survey detailing health researcher feedback (solicited through meetings and online forums) in August 2012

("What CIHR Heard"; CIHR, 2012c), and a final proposal for the new reforms to the OSP in December 2012 ("Designing for the Future"; CIHR, 2012b).

As a result, two new funding schemes emerged, both of which rewarded established researchers. The new Foundation Scheme was established to create granting opportunities for long-term support to "research leaders" with "demonstrated track records of success" who have made an impact in their field of study (CIHR, 2012b, p. 7). The new scheme aimed to reduce the time these seasoned researchers spent on writing or renewing grant applications. This commitment to established researchers in the Foundation Scheme concerned Indigenous health researchers who, as noted below, worked to support emerging researchers committed to new, participatory methods that did not necessarily conform to established institutional approaches and outputs. A new Project Scheme proposed supporting grants for new, innovative research, and "high-risk lines of inquiry or knowledge translation approaches" (CIHR, 2012b, p. 9). The Foundation Scheme was much more lucrative, and although the Project Scheme was available to emerging researchers, the emphasis on commercially viable research and lack of definition of "high-risk" inquiry left the parameters of the scheme open-ended. The February 2012 "Design Discussion Document" noted that too much peer review committee time was being spent discussing applicants everyone agreed should be funded, or applications that were severely flawed (CIHR, 2012a, p. 4). The new schemes were designed to "help manage applicant and reviewer burden by reducing the number of applicants who move on to full application," and the new screening process was designed to allow for early recognition of outstanding and non-competitive applications (CIHR, 2012a, p. 4).

CIHR Peer Review

Two crucial changes proposed to the peer review process involved creating a College of Reviewers to manage reviewing, and implementing virtual (online) or asynchronous reviews. The rationale for the changes came from the 2009 HRR, which drew from the CIHR's IRP from 2005–2006 and the President's Roundtable Discussion in 2008–2009, both of which noted fatigue in the current peer review system. The main issues were related to time, the high volume of applications, and increasing multidisciplinary proposals. The HRR committed to ensuring that review panels had proper expertise, reviewers were given a reasonable number of applications, there were qualified reviewers with more international experts, and appropriate instructions would be provided to reviewers (CIHR, 2009). While the HRR argued that the CIHR peer review system had served Canadians well and was internationally recognized for its design and effectiveness, the document still called for improvements (CIHR, 2009, Strategic Direction 1). The 2011 IRP included a synopsis of the peer review system and argued it suffered from "excessive complexity"; reviewers were fatigued from reviewing previously submitted proposals multiple times, and the proliferation of grant committees caused confusion amongst scientists applying for grants (CIHR, 2011, p. 11).

The College of Reviewers was created to facilitate access to appropriate expertise and provide frameworks to recruit and train reviewers. It was designed as a framework for organizing and managing groups of reviewers, instead of Institutes organizing committees themselves (CIHR, 2012a, p. 19; CIHR 2012b, p. 22). The new College was imagined as a "centrally-managed resource" providing "support and orientation" for reviewers (CIHR, 2012b, p. 23). As Indigenous health researchers note below, this system risked obfuscating the emerging, nuanced approaches to community-based research and

Indigenous Ways of Knowing amidst a large, centralized system dominated by conventional approaches to research. Moreover, the new review process would involve more impersonal, virtual environments controlled by senior administration through the College of Reviewers. The design documents argued that virtual reviews would "bring reviewers together in a virtual space" for "internet-assisted discussions (virtual peer review)." Reviews, for the most part, "would be individual . . . with opportunities to discuss, justify, and exchange perspectives" (CIHR, 2012a, p. 20).

CIHR Institutes and Budgets

In addition to the new funding schemes and peer review reforms, CIHR senior administration reformed the Institutes in 2014, including reallocating 50% of each Institute budget to a Common Research Fund. The "Institutes Modernization," as it was termed, was designed to "enhance collaboration across research pillars, disciplines, communities and sectors" (CIHR, 2014, Section 1). Many Indigenous health researchers felt this program, in conjunction with the earlier reforms, created a disadvantage for Indigenous health research by drawing away much-needed funds for capacity-building, community-based research (e.g., through NEAHR). CIHR eliminated Institute Advisory Boards and reassigned and laid off several Ottawa-based Institute staff, many of whom had a wealth of knowledge of their specific associations within their Institutes (Eggertson, 2015).

Findings 2: Resistance and Criticism

Reform Criticism

The interview participants (referred hitherto as "participants" were worried about how the reduction of Institute budgets would disproportionately affect Indigenous health research through a common, competitive pool of funds (McCormick & Wien, 2014). They felt the amount of money going into Indigenous health research would decrease with the rumoured reforms, signalling a move away from relying on the IAPH. Some participants went as far as calling the reforms "disastrous" and "chaotic." Ultimately, participants resented the reforms and felt they were problematic. Even participants who felt the reforms may have been well intended were still critical and wondered if the funding process was fair and equitable.

Convention, Competition, and Homogenization: Methodological Conservatism in Reforms

One of the major criticisms from participants related to the privileging of established researchers, and creating more competition between early, senior, and mid-career scholars. Participants felt that Indigenous health research was still "emerging" and not well established in mainstream health scholarship, thus putting their research at a disadvantage in the Foundation Scheme competition which awards "superstars in their field." As one participant noted, the new scheme "marginalizes Indigenous health research and researchers" as "a lot of us are relatively new—we're early or mid-career." Other participants remarked that Indigenous health research is at a disadvantage because it is less established than other fields like cancer research, genetics, molecular biology, or beta cell transplantation in diabetes.

Some participants felt the new funding pool created competition between researchers in a way that failed to take into account disciplinary practices around publishing. Publication numbers become central to the competition, but community-engaged research often puts more emphasis on capacity-building, reflection, and action and less emphasis on publications. As one participant argued:

> In order to obtain a Foundation Scheme grant you really have to demonstrate that you are the top in not just your own field, but you're competing against all these other folks that are in all these other fields that have different measures of success. . . . If you're going up against someone whose whole career has been built around publishing . . . and your career is built around community relationships and understanding different ways of knowing as a means to improve health, then your ability to compete is compromised.

Another participant described reforms as a form of forced homogenization that marginalizes Indigenous health research: "Without thinking about equity. Without thinking about the impact and basically saying 'well, Indigenous health research is just health research. And so, we're going to do everything the same.'" Participants felt that the initial screening process for Foundation Scheme funding emphasized "traditional scholarly success measures" where "one is challenged to see where those who excel in relationship-building with Aboriginal communities and other qualities essential to the field would detail this information." Participants further argued that the "shape of CIHR funding" did not appear to be community-based or in line with Indigenous political, social, health, or policy goals; nor did it involve authentic consultations with communities and researchers but, instead, took a top-down approach. There were concerns that community-engaged research and Indigenous Ways of Knowing might not be seen as valuable in the broader health research world, or that there would be insufficient funds for research into social determinants of health. It is well established that privileging conventional, quantifiable academic metrics of success (number of publications, amount of grant funds held, commercialization) disadvantages community-engaged research (Castleden et al., 2015).

Participants argued that CIHR had a heavy bias toward the biomedical field or at least emphasized biomedical research. Indigenous health researchers acknowledged the importance of the biomedical pillar, but a difficulty in doing biomedical research "without making Indigenous People the objects of research" rather than collaborators. Some participants said there was an expectation from CIHR that scholars should find funds from industry partners, which could be a conflict of interest for Indigenous health research—for example, if a resource extraction company is funding research, but was a source of ill health to the community, or where commodification of intellectual property is not in line with Indigenous values. Participants emphasized the social determinants of health, as one participant noted:

> Indigenous understandings of health tend to be very wholistic and encompassing the spiritual, the emotional, the intellectual, and the physical. That needs to be reflected in health funding. If we overemphasize the biomedical and clinical, which are very, very expensive forms of health services, we're not really reflecting the Indigenous Ways of Knowing . . . we can't really respond effectively to Indigenous health issues, as identified by Indigenous Peoples and nations.

The letter campaign in 2014 indicated the successes of Indigenous health researchers and community partners and noted the dominance of funding for the biomedical pillar and the importance of socioeconomic, cultural, and historical approaches to the IAPH research community (McCormick & Wien, 2014). Participants commented on the specific challenges of doing community-engaged Indigenous research, and the time and energy it takes to develop relationships with community members, put together proposals, and meet unrealistic institutional deadlines, when new reforms may not allow reviewers to appreciate the value and depth of such research. Much of the frustration with the direction of research at CIHR was about endangering engagement with communities and having a level playing field for all research pillars. The funding schemes were not the only point of contention, as the peer review process was also a subject of concern.

Peer Reviews

Participants expressed concerns about the qualifications of peer reviewers for Indigenous health research proposals. Participants favoured Institute-specific review committees, face-to-face meetings, and an iterative review process; they felt the College of Reviewers was limited in its capacity to review, as most health researchers were not informed about community-engaged research. Participants were largely opposed to the College of Reviewers introducing new conditions on who could be accepted as a reviewer. One participant noted that the new peer review process felt like "a lottery," possibly insinuating that the reviewer selection process did not consider expertise on certain subjects. Since Institute-specific review committees no longer existed, participants were concerned that review processes could include unfair bias, and knowledge of Indigenous health research would not be required to review related project proposals. One participant noted that there were "biomedically trained researchers talking about doing cohort studies for my project, which makes absolutely no sense for my proposed community-based, participatory research that was qualitative in nature; a random control trial would have no value in this context."

Others noted that reviews of Indigenous health proposals were being conducted by non-experts, which could disadvantage applications when reviewers do not understand the content. Participants felt that biomedical and clinical researchers were often not qualified to review Indigenous health research proposals and felt reviewers sometimes did not engage meaningfully with their projects and take them seriously. Participants received praise from their fellow Indigenous health researchers for their work, but biomedical colleagues sometimes did not see the value in the achievements and innovations of Indigenous health or traditional medicine. If reviewers did not have certain knowledge—for example, if they did not know what "Two-Eyed Seeing" embodied (an IAPH guiding principle)—then participants felt the reviews were not actually peer-to-peer; it was as if an ophthalmologist was being asked to evaluate a heart surgeon's protocol, or vice versa—they were simply unqualified to do so. It was important to participants that reviewers understand that "certain groups face systemic oppressions that are going to impact their output in ways [that] it's not impacting other people."

The collaborative and personal nature of face-to-face reviews was important to participants. Peer reviewing was regarded as a moment when "everyone learns from each other." Many felt that reviews for Indigenous health research should include Indigenous reviewers "who can articulate whether the research will be successful in terms of the prospective methodologies that they would be comfortable with." One participant noted that having Indigenous and non-Indigenous reviewers at the same table is important for working together and talking about issues, and there should be space for Elders and

Indigenous Knowledge-holders on review committees. Virtual review formats can cut discussions short and make it more difficult to communicate ideas.

Ensuring reviewers were accountable to one another was also important to participants. The value of face-to-face discussions in the review process was expressed by many, who noted that sitting across the table from one another is necessary to read body language, but virtual reviews do not require the same level of "serious review" and nuances that face-to-face reviews offer. One participant noted that face-to-face reviews allow opportunities to catch issues with proposals that might go unnoticed in a virtual process where individual reviewers are not present and attentive and where they "can't engage as deeply with the conversation." Another participant noted:

> Well, there's nothing saying that I couldn't give it [a review] to one of my research assistants and say, "Here, review this. Write up your comments. I'm paying you to do it," and then just enter them in. . . . [A]cross [all four pillars] there was concern that this was happening because we know it happens in other circumstances . . . and it's unethical. But having a face-to-face meeting really forces people to get their work done before they have to show up at the meeting and speak with at least some authority on the subject to be able to say what the strengths are and what the weaknesses are.

Ultimately, the participants felt that face-to-face review meetings ensured accountability, encouraged a deeper consideration of proposals, and were more interactive with "much broader and much deeper and richer conversations" than online. Participants largely felt that the College of Reviewers could not adequately train reviewers to understand the historical context of Indigenous health issues, as providing such training would involve experience in conducting community-based or participatory research. One participant noted that videoconferences are, at least, "much better than the phone" and save on time. Indigenous health researchers, then, were not completely closed to the idea of using online processes, but rather the concern was about quality and accountability.

Conclusion

Fundamental Problems

Participants felt that the reforms seriously threatened Indigenous health research writ large, as the Foundation Scheme privileged senior, established researchers in the biomedical and clinical pillars, while Indigenous health research remained only an emerging field within the funding landscape. Participants noted that an emphasis on conventional and technical scholarly measures of success (publications, commodities) risked homogenizing research at CIHR and marginalizing Indigenous health research, which emphasizes capacity-building and relationships. The peer review reforms created a centrally managed College of Reviewers, eliminating the Institute-specific review boards, leaving participants feeling that reviewers often did not possess the knowledge to understand the methods and/or value of community-led Indigenous health research.

The COVID-19 pandemic has altered the landscape of scholarly communications. Perspectives about virtual peer reviews that were done in 2014 and the view of participants from 2017 data collection may differ considerably in 2022, especially as we have been living through extensive, wide-ranging, and lengthy lock-downs. The concerns that Indigenous health researchers expressed about peer review qualifications, Institute-specific review committees, and knowledge of Indigenous Ways of Knowing remain important to responding to the health needs of Indigenous Peoples. The technological shift we have witnessed over the past two years, due to COVID-19, adds an additional challenge to scholars committed to community-based participatory research and the personal nature of building relationships.

The lens of methodological conservatism illuminates how ideological contexts influence reforms, how certain kinds of research are privileged over others, and what is deemed appropriate research in peer review processes. The reforms constituted a trajectory of supporting established researchers, and homogenizing research by emphasizing commercially lucrative and technologically centred research. CIHR built the reforms on a government framework that emphasized conventional industry and commodification. As participants noted, the reforms reflected a conservatism that valued more accepted research methodologies, designed to standardize and homogenize research.

Defunding capacity-building programs and continuing to support technical pillars normalizes a positivist approach to research, devaluing the work of building connections between researchers and communities; community-based research and collaboration with Indigenous communities caters health research to people's actual needs (Castleden et al., 2012; Reading & Wien, 2009). Indigenous health researchers recognize that they work in the context of colonialism, racism, and intergenerational trauma, all of which require adherence to certain practices that ensure community involvement toward culturally safe decolonizing research (e.g., the previously mentioned Chapter 9 of the Tri-Council Policy Statement and the CIHR Guidelines for Health Research). The gap between what Indigenous health researchers needed to continue their work and what CIHR senior administrators wanted to change through reforms was expressed through one participant's frustrations: "It's like we're talking two different languages."

While CIHR senior administration conducted consultations with health researchers, many participants saw the consultation process as unilateral, top-down, and without free and prior informed consent. CIHR released reform design documents in early 2012, and consultation feedback later that year, including town hall discussions, meetings, emails, letters, and online surveys completed by researchers to gauge perspectives on the reforms. The consultations included 82 discussions with Institutes and associate partners, 22 comments on a web feedback forum, and over 200 emails from mostly senior researchers in the biomedical pillar (CIHR, 2012c). CIHR sent an anonymous feedback survey to 513 researchers across the four pillars, but many researchers from the socio-cultural pillar were not represented in the feedback. Only 16% ($n = 82$) of health researchers in the socio-cultural pillar responded. Such a small fraction of responses makes the AHRSC's work important as a collective voice for the Indigenous health research community, as many participants felt CIHR failed to understand their needs.

Future Considerations

As a result of the actions of the Indigenous health research community, CIHR began to reverse some of its reforms. In 2017, CIHR senior administration released a plan titled "Action Plan: Building a

Healthier Future for First Nations, Inuit and Métis Peoples." This 10-point plan called for the implementation of a new Institute Advisory Board for the IAPH and increased Indigenous health investments to 4.6% of the CIHR budget (CIHR, 2017). However, the socio-cultural pillar is the only one with a fiscal year investment that decreased from 2012 to 2016. Post-reforms, socio-cultural and health systems services were the least funded pillars at 8% of total CIHR funding (CIHR, 2018a). A relatively recent CIHR initiative entitled Pathways to Health Equity for Aboriginal Peoples (CIHR, 2018b) includes the Network Environments for Indigenous Health Research (NEIHR) program. Functioning much like the former NEAHR program, NEIHR commits over $100 million to capacity-building, research, and knowledge translation. This post-reform commitment from CIHR to continue capacity-building is notably responsive to the concerns of Indigenous health researchers.

The 1996 RCAP report and the 2015 Truth and Reconciliation Commission Calls to Action recommended closing the health gaps between Indigenous and non-Indigenous People in Canada, creating equitable health policies with appropriate finances for implementation, and respecting the distinct health needs of Indigenous Peoples (RCAP, 1996; TRC, 2015). Thus, the efforts of the AHRSC were responding to a substantial body of work. Why was it necessary to cancel the NEAHR program, revise the IAPH budget, and implement dramatic changes to funding and peer review processes? It is puzzling that the CIHR senior administration disregarded the praise the 2011 IRP panelists gave the IAPH for excelling at public engagement in research projects (Kondro, 2009). The IRP noted that other Institutes serving non-Indigenous communities ought to embrace the value of more public engagement to put knowledge translation into practice (CIHR, 2011, p. 17). The efforts of Indigenous health researchers to resist the reforms represent an important lesson in why all researchers ought to take a critical interest in how funding agencies are structured and how funding decisions impact equity in the social, health, and natural sciences.

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