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Providing Equity-oriented Care and Services: Perspectives of Primary Care Nurses Working in Nunavik Inuit Communities

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Abstract:
Health inequities experienced by Indigenous Peoples are the consequence of unbalanced structural determinants of health, primarily attributed to systemic racism and colonialism. Primary care nurses encounter numerous obstacles, including inadequate resources to address the health needs of Indigenous communities and mitigate health inequities. This study aimed to explore equity-oriented care and services from the perspectives of primary care nurses operating in Nunavik, located in the Inuit communities of Northern Quebec, Canada. We used a critical postcolonial perspective and an interpretive descriptive design. We conducted ten semi-structured interviews and conducted a thematic analysis of the collected data. The findings showed dynamic conceptualizations of equity-oriented care and services, shaping participants' views on the northern colonial context, healthcare accessibility, and nursing care approach within Inuit communities. Based on these findings, we advocate for implementing accountability measures such as anti-racist policies to foster structural changes toward health equity.

Keywords: Health inequities, Primary care nursing, Northern healthcare, Indigenous Peoples, Equity-oriented care

Positionality statement:
We wish to acknowledge our positions and privileges as white settlers. The knowledge developed in this research project results from our relationships and learnings with Indigenous Peoples.

Background

In Canada, Indigenous Peoples[1] are among the groups with the most marginalized living conditions, which directly affect their health status and well-being (Greenwood et al., 2018). These living conditions and health inequities are the visible symptoms of colonial history, structural violence, and systemic racism that persist within the healthcare system and society (Allan & Smylie, 2015). Among Indigenous Peoples, Inuit populations located in northern Canada face particularly staggering inequities due to their geographic remoteness and specific colonial historical context (Hayward et al., 2020).

One of the most effective ways the healthcare system can reduce health inequities is through primary care (World Health Organization [WHO], 2008). Primary care nursing in rural and remote areas is described as a generalist and complex advanced practice,

[1] Indigenous Peoples include First Nations, Inuit, and Métis.

including acute care and health promotion (Canadian Association for Rural and Remote Nurses [CARRN], 2020). There is little consensus in the scientific literature about the differences between rural and remote nursing practice. Northern regions are often associated with remote practice (CARRN, 2020). However, primary care in Indigenous communities usually prioritizes acute care at the expense of preventive and health promotion activities, which address the determinants of health (Horrill et al., 2018; Wong et al., 2014). Consequently, some organizations may be perpetuating health inequities by not addressing the determinants of health specific to Indigenous Peoples (Browne et al., 2018).

The Nunavik Regional Board of Health and Social Services (NRBHSS), governed by the Quebec provincial government, is responsible for the accessibility, quality, and safety of healthcare services provided to the population. A vast majority of healthcare providers are non-Inuit, resulting from certain similarities in the issues described by Indigenous Peoples when they received health services governed by the colonial state. For example, Inuit found that non-Inuit healthcare professionals often had disrespectful and culturally unsafe attitudes when providing care (NRHBSS, 2021).

Several authors note that nurses' colonial discourses can perpetuate inequities and injustices (Blanchet Garneau et al., 2019; McCullough et al., 2021). In a study by Rahaman et al. (2017), nurses associated health inequities with being an Indigenous person rather than linked to social and structural determinants of health (i.e., they believed Indigenous people were biologically predisposed to poor health outcomes). As a result, nurses focused on treating illnesses rather than providing preventive care, and in doing so, they contributed to racist and colonizing behaviours in their care (Rahaman et al., 2017).

To address the specific needs of Indigenous Peoples more effectively, the equity-oriented care and services (EOCS) approach has demonstrated its potential to bring about transformative changes when implemented by institutions and professionals (Browne et al., 2018). This approach aims to mitigate the impacts of unfair resource distribution related to health determinants, particularly those contributing to structural inequities such as poverty, and to highlight the intersectionality and detrimental effects of racism and discrimination on health (Browne et al., 2018). The EOSC framework, developed by EQUIP Health Care, a research team based in British Columbia, Canada, comprises three core dimensions: culturally safe care, trauma and violence-informed care, and harm reduction (Browne et al., 2018). Findings from a study conducted at primary care clinics in two Canadian provinces, serving predominantly marginalized and underserved populations, indicate that implementing the EOCS approach can lead to enhanced trust in healthcare professionals, improved access to healthcare services, and ultimately, the satisfaction of health needs (Ford-Gilboe et al., 2018). Over the long term, potential outcomes may also encompass reductions in depression and post-traumatic stress symptoms, as well as an overall enhancement in quality of life (Ford-Gilboe et al., 2018).

Since nurse-based clinics constitute the prevailing model for healthcare delivery in northern regions, primary care registered nurses serve as the cornerstone of healthcare provision for Inuit communities in Nunavik (Northern Quebec) (Fournier et al., 2021). Expanded-role nurses operate within the framework of collective agreements, affording them a significant degree of autonomy and enabling them to undertake responsibilities typically assigned to physicians (Fournier et al., 2021). Unfortunately, these nurses working in a remote northern context face many challenges, including a lack of preparation for the colonial context and limited resources to adequately care for these communities, which face persistent health and social inequities (MacLeod et al., 2019; McCullough et al., 2021). To our knowledge, only one specific qualitative study focused on the practice of nurses in Nunavik (Fournier et al., 2021). Given that primary care nursing in remote areas needs to be better documented and remains largely invisible and that little is known about EOCS in this context, further research is warranted.

This study aimed to explore equity-oriented care and services from the perspectives of primary care nurses working in Nunavik Inuit communities. We answered three research questions: 1) What are nurses' conceptualizations of EOCS? 2) What are nurses' challenges in providing EOCS? 3) What are the strategies nurses use to overcome these challenges?

Theoretical Underpinnings

We adopted a critical postcolonial approach to generate contextualized knowledge that accounts for the social, political, and historical dynamics contributing to health inequities (Anderson et al., 2009). Our aim was not to create new Indigenous knowledge but to provide critical insights into nursing practice within Indigenous and colonial contexts. In line with this approach, we used Browne et al.'s (2018) *Key Dimensions of Equity-Oriented Health Care and Strategies to Guide Implementation* as a theoretical framework to guide the study. This framework includes three key dimensions of equity-oriented healthcare: culturally safe care, trauma and violence-informed care, and harm reduction. First, cultural safety highlights the importance of creating safe environments and addressing power issues, discrimination, and racism related to colonialism within healthcare systems (Browne et al., 2018). Trauma and violence-informed care are essential to pay particular attention to historical and intergenerational trauma and contemporary structural violence that affects health, such as the stigma associated with alcohol use or mental health-related illnesses (Browne et al., 2018). Finally, harm reduction helps us see substance use and social conditions as interconnected and advocates for interventions that address unjust or discriminatory policies. (Browne et al., 2018). These key dimensions are connected to 10 strategies rooted in the context and responsive to inequities (Browne et al., 2018). For example, explicit commitment to equity, revising the use of time, and promoting meaningful community and patient engagement are strategies included in this framework (Browne et al., 2018).

Methods

We used an interpretive descriptive approach (Thorne, 2016) to consider nursing practice's social, economic, geographic, and political contexts in Nunavik Inuit communities. The design allowed us to explore EOCS in depth from the perspectives of primary care nurses working in Nunavik Inuit communities.

Nunavik's healthcare and social services organization has been governed by the Quebec provincial system under the James Bay and Northern Quebec Agreement (JBNQA) since 1975. In 2021, the population of Nunavik was 14,050 inhabitants (ranging from 230 to 3000 inhabitants for the most prominent village), and around 90% of them identified themselves as Inuit (Statistics Canada, 2023). The territory of Nunavik covers approximately 500,000 km^2, representing nearly one-third of Quebec's territory. Each of the 14 Inuit communities has a primary care clinic with at least two nurses in an expanded role. These nurses provide daytime services from Monday to Friday and an on-call emergency line when the clinics are closed. The number of inhabitants of Inuit communities determines the presence of a physician. The largest communities of Puvirnituq and Kuujjuaq have care units, including short and long-term hospitalization beds. Air transport is necessary to access the different villages, and the patient is transferred to a southern urban health center when specialized care is needed.

To be included in this study, participants had to be nurses who were 1) practicing in primary care for a minimum of two contracts (approximately sixteen weeks) and 2) actively working in Nunavik or had worked in Nunavik within the last three years. We used purposive (Gentles et al., 2015) and snowball sampling (Biernacki & Waldorf, 1981) to recruit 10 nurses working in primary care clinics.

This research project occurred during one of the most critical moments for Inuit communities, linked to the COVID-19 pandemic. All travel in and out of the communities was forbidden, except for essential workers. Going into the community to conduct this research was unethical and risky. Hence, semi-structured interviews (n=10) were

conducted by the first author in French via a secured videoconference channel between December 2021 and April 2022. Before the interview, participants were asked to complete the Rate Your Organization reflection tool (EQUIP Health Care, 2017). This tool allowed participants to rate (from 0 to 10) some critical aspects of EOCS that their health organizations could implement in their services. The scores were used to prompt participants' reflections on EOCS. Examples of these aspects are: "How does your organization actively counter racism or discrimination?" or "How does your organization enhance access to social determinants of health?".

We used MAXQDA 2020 software for data management and analyzed data iteratively throughout data collection. To enhance reliability, the first author kept a reflexive journal where thoughts, justification of methodological choices, and emotional insights were noted (Guba & Lincoln, 1989). Continuous validation of emerging themes was done with the second author to enhance credibility and transferability (Miles et al., 2018).

We followed Braun and Clarke's (2006) six-step thematic analysis method: 1) The first author immersed herself in the corpus of data by reading and re-reading the transcripts. During this immersion, general observations were noted. 2) The data were coded inductively using keywords, phrases, or sentences. 3) At this stage, linkages and groupings of codes were made to broaden the analysis and highlight the first themes. 4) Tables with the themes and verbatim excerpts were created to ensure they were congruent. Subsequently, the different themes and sub-themes were linked together to create a thematic map. 5) A review of the theme map and an identification of each theme's essence and meaning were made. 6) The report's writing was done iteratively and continuously. Steps 5 and 6 were repeated multiple times, and discussions between both authors helped to refine and confirm the results.

Results

Ten nurses, ranging in age from 29 to 40 years, were involved in this study. Prior to their practice in Nunavik, half of them (n=5, 50%) had previous professional or personal encounters with Indigenous Peoples. The majority (n=6, 60%) had backgrounds in critical care, while two had experience in the primary care sector before their work in Nunavik. All participants were employed by health centers associated with the Quebec healthcare system, except for one who was hired through a private agency. Most participants self-identified as being White.

Sample characteristics (N=10)	**N**
Gender	
Female	8
Male	2
Highest degree	
College	1
Baccalaureate	7
Masters	2
Years of nursing experience	
1-5	2
5-10	5
10-15	2
15 +	1
Years of primary care in Nunavik	
6 months-1 year	2
1-5	6
5 +	2

Table 1. *Sociodemographic Characteristics of the Participants*

First, based on the analysis of data pertaining to the research question, "What are nurses' conceptualizations of equity-oriented care and services?", we have discerned dynamic conceptualizations that encompass both egalitarian and critical perspectives. Within these perspectives, three primary themes emerge: 1) healthcare accessibility, 2) nursing care approach, and 3) the northern colonial context. The tension between quality and equity, which serves as the central intersection of these conceptualizations, is depicted in Figure 1. Subsequently, we elaborate on the challenges and strategies associated with delivering equity-oriented care and services.

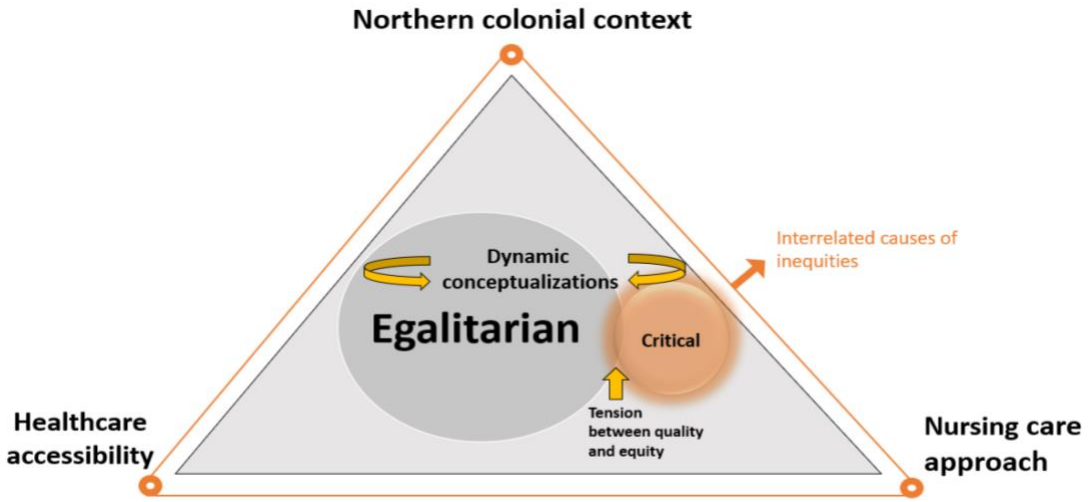

Figure 1: *Primary Care Nurses' Conceptualizations of Equity-oriented Care and Services in Nunavik Inuit Communities*

Participants described two conceptualizations of EOCS: egalitarian and critical perspectives. These perspectives coexist dynamically, with individual participants sometimes embodying both. While few participants espoused a critical conceptualization, the majority (n=6) leaned toward an egalitarian viewpoint. Nurses with extensive experience in Nunavik or additional training in Indigenous health tended to adopt a critical perspective, often prompted by witnessing injustices, reflecting on personal errors, or fostering trusting relationships with Inuit individuals, which cultivated their critical consciousness.

The Egalitarian Conceptualization

Participants articulated an egalitarian conceptualization based on the principle of equality, where everyone is entitled to and receives identical care. Under this perspective, perceived inequities or unjust health situations were minimal, as services were deemed universal and not subject to scrutiny. Nursing practice within this conceptualization is rooted in a biomedical framework, emphasizing high-quality clinical knowledge. Key elements within this perspective include an emphasis on equal accessibility to healthcare services and a culturalist discourse.

Equal Healthcare Accessibility

From an egalitarian standpoint, EOCS primarily concerns ensuring equal access to healthcare services. The expanded role of nurses in Nunavik was deemed an effective strategy to facilitate access to emergency and primary

healthcare services. Despite the need for frequent air transfers outside communities for specialized care, participants perceived accessibility as equitable for Inuit individuals. Challenges in access were attributed mainly to factors such as small population size, geographic isolation, and workforce shortages across the Quebec health system, exacerbated by the pandemic. For example, participant four (P 4) said, “It's not inequitable access because there is a lack of professionals everywhere in Quebec (...) Even if they must take a plane to access more specialized care, it’s the same in rural regions with a small population.”

In addition, since most nurses come from critical care settings (emergency care or intensive care units), nurses adopt the egalitarian conceptualization and compare access with what they witnessed before their northern practice. Hence, participants were more likely to define equity with specific criteria that were closer to a biomedical perspective, which includes **“**effective**”** and **“**efficient**”** discourses grounded in the equality principle. As participant one said, “They don't wait 24 hours in the emergency room like in the South. It’s better services here, they are treated right away.”

Culturalism in Nursing Care Approach

Although most participants acknowledged that the predominance of the biomedical perspective might not align with Inuit worldviews, participants associated their biomedical and clinical knowledge with safe practice that guaranteed equal care for all: “I must say that I believe in Western medicine; that’s how I studied. There are not two ways to treat; there is one... a treatment is a treatment” (P 10).

For these participants, being a non-Inuit worker did not appear to influence their provision of EOCS. Nurses reported adapting their care primarily to cultural values, language barriers, and health beliefs. According to some participants, the power and racial dynamics between Inuit and non-Inuit persons did not impact their approach: **“**I don't care what your skin colour is; my care is the same**”** (P 7). In addition, an "othering" discourse, highlighting cultural differences, was evident in participants' descriptions of their relational approach with Inuit communities: “It’s not a question of superiority or inferiority. I think it's just a question of differences in the sense that we [non-Inuit] don't have the same values or culture as they [Inuit] do” (P 10).

Participants described colonization as a past event with little impact on nurses’ present daily practice. Moreover, being Inuit was portrayed as a primary factor contributing to health issues, rather than acknowledging social determinants of health such as poverty or education. Nurses did not take into account social and structural barriers in the Indigenous context that hinder access to healthcare and services in their daily practice. Since colonization was perceived as a past event, exemplified by incidents like residential schools and the killing of sled dogs, some participants asserted that this historical context did not impact EOCS.

The Critical Conceptualization

The critical conceptualization of EOCS places critical consciousness at its core, aiming to challenge existing care practices to address the specific needs of Inuit communities. Participants within this perspective identified inequities shaped by the historical and ongoing colonial context in the North. They emphasized the provision of contextualized care grounded in two central components: recognizing unjust healthcare accessibility and maintaining awareness of the multiple dimensions connected to inequities.

Unjust Healthcare Accessibility

Regarding healthcare accessibility, participants perceived Nunavik's access to care and services as inequitable, with Inuit not receiving the same level of services as in other parts of Quebec. This inequity was seen as extending beyond mere lack of financial or material resources. Participants highlighted systemic racism and discriminatory policies as major contributors to these access inequities,

resulting in increased mistrust among Inuit patients and delayed care-seeking behavior. As participant eight related:

> Many patients are victims of racism in a very open and shocking way. The impact on our care is an increase of mistrust, coming in later instead of coming as the symptoms start or even refusing transfers outside the communities. (P 8)

Equity, in this perspective, was associated with providing more resources and services to Inuit communities to address their significant health needs, thus acknowledging the systemic barriers rooted in Canada's colonial history:

> Equity is a path for reconciliation, which means reparation and financial compensation. Canada is still a colonial country, so we are not there yet (...) Equity-based is taking all of that into account. If we can't manage to have social determinants of health that have been achieved or that are acceptable, we'll never achieve equity. (P 3)

Nursing Care Approach: Awareness of Various Dimensions Linked to Inequities

Individual reflection on values and biases was central for many participants. The critical conceptualization of EOCS was embedded in how participants positioned themselves in their daily practice (e.g., building relationships). For example, the impact of different dynamics in the care approach between a non-Inuit nurse and an Inuit patient was described as fundamental in providing EOCS. Almost all participants sharing this conceptualization also stated the mistakes they have made in their approach and that it was essential to stay alert to avoid harming a person:

> At first, I was less sensitive to historical realities and did something inappropriate. I felt guilty and questioned my position as a White person who came up North… for the exoticism and the work experience. I realized that I always impact the care I provide and could be harmful. (P 6)

Participants framed their nursing responsibilities around their interactions with Inuit individuals. Establishing a secure and trustworthy relationship was deemed crucial in their understanding of Equity-Oriented Care and Services (EOCS). Consequently, they believed that addressing an individual's needs necessitated a connection to the surrounding community and its specific circumstances. As one participant expressed, "On a daily basis, equity entails building relationships within and alongside the community" (P 6). Their approach to care was tailored to accommodate the unique context and social determinants of health. Participants discussed strategies for assessing and addressing both social and health-related needs, such as providing bottled water for patients or collaborating closely with social workers. They recognized the potential perpetuation of inequities if they failed to consider the colonial context in their nursing practice: As participant two stated, “We [non-Inuit] make them [Inuit] guilty and responsible for our inefficiency in being able to offer them a healthcare system and resources that meet their needs [...] As nurses, we produce this inequitable and unsafe care” (P 2).

Inequities stemmed from not meeting the population's needs and the inadequate approach by some professionals who did not consider or understand the context.

Meeting in the Middle: Tensions Between Quality of Care and Equity

In both conceptualizations, we observed a tension between the notions of quality care and equity. Each participant highlighted the interconnectedness of these concepts in their clinical practice, emphasizing their shared objective of ensuring patient safety. Some participants expressed that quality care was primarily associated with nursing skills grounded in a biomedical perspective; for example, participant eight said, “Quality care must be equitable. But there's also the aspect of medical skills in a more scientific or tangible way. For me, quality is more comprehensive than equitable care; it’s broader” (P 8).

Equity, on the other hand, was associated with relational and contextualized care approaches. Participants also named the ethical issues that could arise in certain situations. These issues could arise between honouring the

patient's preferences and recognizing that doing so might result in compromised quality of care from a biomedical standpoint. Participant four gave this example: “It was not an issue to give birth in her community. We respect her decision, but it was an issue for us [nurses] because medical complications could be avoided by being transferred to an urban center” (P 4).

Challenges: “The Rigid and Broken System in a Box”

A critical perspective facilitated the recognition of additional challenges associated with EOCS, largely due to the contextual nature of nursing practice. This perspective allowed participants to identify inequities stemming from both the care approach and the healthcare system. Many challenges were depicted as external factors, leading nurses to perceive themselves as lacking the transformative influence within organizations to effectively implement EOCS.

Lack of Organisational Accountability Measures Undermining EOCS

Numerous participants reported that unjust incidents were rooted in a deficiency in clinical skills and incompetence among nurses. The responsibility of whistleblowing fell entirely on nurses since there was no established complaint or evaluation system in place for addressing unsafe occurrences. The physical absence of management leadership in the villages, coupled with the lack of formal training and organizational guidelines to ensure equitable care, had led to challenging situations. For instance, the absence of protocols for emergency on-call systems based on nurses' clinical assessments over the phone could result in variations in evaluating health situations. Consequently, factors such as staff turnover, having young and unstable teams from private agencies, and pervasive work overload presented significant challenges. Participants emphasized that adopting an EOCS approach necessitated complete dedication in building relationships with individuals, which demanded time. However, the constant state of urgency and overwork undermined this endeavor:

> With Inuit, the relational approach is central, and you must be a partner with the person and community. The organization must give us time to build this outside of the clinic. But we cannot do so because we are constantly in an emergency relationship. (P 6)

Some participants expressed discomfort in working with non-Inuit colleagues due to differences in work styles and relational approaches. Given the small team sizes in Nunavik, these differences significantly impacted nurses' daily practices and could lead to conflicts within teams. Furthermore, participants noted that fatigue could contribute to unsafe care practices, affecting trust in relationships and sometimes resulting in racist or disrespectful behaviors: “When you're in a work rhythm where you see the bad, you don't have time to rest; you develop intense prejudice. You become more rigid, less accommodating, and less sensitive, and you develop behaviours that are unsafe and racist” (P 5).

Participants with a critical conceptualization expressed greater distress and raised more questions about the care approach, highlighting discomfort with being non-Inuit workers in the colonial context of Nunavik. Witnessing violence and poverty, which were closely linked to emotional burdens, further exacerbated their feelings of powerlessness and shock. Some participants felt isolated in their perspective on injustice, as their colleagues often did not perceive the health situation as unfair. Additionally, insufficient organizational responses to denunciations of inequitable situations exacerbated their sense of helplessness and distress.

A Disconnected Colonial System

The disconnect between the priorities of Inuit communities and colonial health systems was evident, with nurses feeling that building trust with communities relied solely on individual effort. The lack of integration of Inuit health visions and the undervaluing of Inuit

health workers' skills by the organization posed significant challenges. Moreover, the absence of structures to promote the desired care of communities further reinforced the disconnect: "The community doesn't have a say in the care they receive [...] There's no structure in place to promote the care they want and to have their voice heard" (P 2).

Nurses also perceived a lack of value placed on Inuit interpreters by the organization, reflecting power dynamics that permeated both clinical and social spheres. Disparities in living and working conditions between Inuit and non-Inuit staff, such as housing benefits, underscored the systemic inequalities present. This portrayal of the colonial relationship between the state and communities left some participants feeling uncomfortable, as political and public health structures advocated for a biomedical approach to healthcare service, further perpetuating disparities.

Strategies: "Being a Facilitator"

The findings revealed a prevailing sense of powerlessness when confronted with challenges that hindered the implementation of strategies. Many participants expressed sentiments such as, "It's overwhelming, I'm not sure where to begin;" "I didn't come here to change the world;" or, "I feel powerless." These expressions underscored their feelings of helplessness. Overall, the strategies discussed were predominantly focused on the individual rather than addressing structural issues, as articulated by one participant: "Every day, the most significant impact on equity is effective communication. Unfortunately, the employer doesn't prioritize it, so it falls on us to develop it individually" (P 8).

Nurses emphasized that building trusting relationships requires time and experience. They also emphasized the importance of continuously reflecting on their biases through mindful dialogue. Participants identified open-mindedness, respect, and humility as core values crucial to their strategy for improving equitable care. Additionally, they highlighted the importance of effective communication and contextual awareness in adapting their nursing approach to better meet the health needs of their patients.

Discussion

Results showed that the conceptualizations of EOCS were dynamic and not fixed for nurses. This dynamic helps us better understand how nurses in their daily practice may perceive EOCS. The predominance of egalitarian conceptualization and a limitation of implementing strategies to address structural inequities was noted. Our findings are consistent with Horrill et al. (2022), stating that nursing practice focuses more on biomedical, egalitarian, and individualist practices and that nurses need to understand their role in addressing structural inequities. According to Horrill et al. (2022), nursing education greatly influences nurses' perception of the power issues or social construction related to health inequities. Our results align with the increasingly present call for decolonizing the nursing profession and integrating an anti-racist pedagogy into the initial training curriculum (Blanchet Garneau et al., 2018; McGibbon et al., 2014). Indeed, Bell (2021) illuminates that some nurses can be harmful in their approach and perpetuate inequities by acting and taking care in a way they learn at school. One of the key interventions of EQUIP health care is to implement training to develop the knowledge and skills of professionals in their EOCS approach (Browne et al., 2018). This ongoing training would be necessary for nurses in Nunavik, especially for organization leaders.

Moreover, even if nurses saw unsafe care or attitudes in this study, many mentioned not acting on them or that it was not their role to confront their colleagues. It highlights how a non-Indigenous nurse can perpetuate inequities by lacking critical consciousness of the continuing effects of colonization and systemic racism in a colonial context. It also highlights, as raised by other authors (Blanchet Garneau et al., 2019), that health professionals still perceive equity-oriented care as an addition to their current practice rather than being viewed through ethical care practice. Support from organizations and a commitment to provide

EOCS from leaders help to accompany nurses (Blanchet Garneau et al., 2019). Opening dialogue by implementing vicarious trauma programs or implementing policies to address systemic racism are helpful tools described by Browne et al. (2018) and "disturbing the status quo" to ensure an equitable approach.

Another significant finding from this study is the tension observed between the quality of care and equity, which underscores an inherent egalitarian discourse. This tension is also apparent in existing literature, where "quality of care" is synonymous with "equitable care," implying equal and uniform care standards regardless of sociodemographic differences (WHO, 2016). This finding introduces a dimension of quality of care not initially considered in the study's theoretical framework, prompting a re-evaluation of quality within an equitable approach. Moreover, the study reveals that staffing shortages contribute to increased workloads, leaving nurses feeling overwhelmed as they care for a population with escalating health needs, further exacerbating the tension between equity and quality care. These challenges leave little room for developing relationships and addressing broader health issues in the community.

The study also highlights the absence of clear guidelines for clinical competencies among nurses in Nunavik. The organization lacks integrated mechanisms for evaluating the quality and safety of care, instead relying on nurses to shape their roles and practices. Given the variability in nurses' conceptualizations of equitable care uncovered in our results, it is crucial to question whether similar variations exist in the quality of care provided to Inuit communities. As noted by Fournier et al. (2021, p.1), the expanded role of nursing practice in Nunavik can be beneficial when appropriately regulated, ensuring patient safety and enabling professional development. However, what are the implications when we expand nurses' scope of practice without ensuring adequate regulation and oversight of the quality of care?

For many participants, an expanded role did not allow them to provide comprehensive community care since acute care took all their time. Participants called for significant structural changes to respect the minimum safety and quality standards. One of those calls is that organizations should allow nurses to have a more substantial role outside the clinics by making time available and adapting practice models. Building a trusting relationship with the community in which they worked was essential. Although participants wanted to create this relationship, they felt the organization needs to value it. The importance of being visible and known in the community has been mentioned several times in the literature (CARRN, 2020; MacLeod et al., 2019). Creating a partnership with the community and a relationship of trust is also a central concept of EOCS (Browne et al., 2018). Thus, our study highlights the organization's duty to facilitate this community involvement by prioritizing preventive practice models and services.

A key finding of our study is the lack of accountability measures in the face of inequities. Findings suggested that the community's priorities needed to be considered and that Inuit had no real power within the healthcare structures. Internationally, when discussing culturally appropriate primary care models, the importance of community involvement and an Indigenous workforce is emphasized (Harfield et al., 2018). According to Pearson et al. (2020), Indigenous governance models of health systems in Australia have a much more significant impact on structural determinants of health since they are more culturally safe than models embracing biomedical approaches.

Limitations

One significant limitation is that this study was not community-based or rooted in a partnership with Inuit communities. The pandemic context raised specific ethical issues that, unfortunately, prevented the community-based approach. Also, the first author's personal and professional experience as a nurse in Nunavik influenced this study, particularly the data analysis. However, we were actively committed to protecting Inuit interests in all stages of this study, particularly in the presentation of results by removing any content that may be harmful and that perpetuates

stereotypes. We invite readers to consider this significant limitation in interpreting our results as they give voice and illuminate only the perspectives of non-Inuit nurses and White settler researchers.

Conclusion

This study enhances our comprehension of how primary care nurses in Nunavik's Inuit communities conceptualize, face challenges, and employ strategies within an equity-oriented care and service framework. Implementing structural changes that directly impact nurses' roles, such as increased resources (including human, material, and financial), clear anti-racist policies, and recognition of the community nursing role, could be effective strategies to promote equity-oriented care and services. We advocate for nursing leaders to collaborate with communities to enact transformative initiatives and establish accountability mechanisms, such as an Inuit self-governance model and a complaint system. Lastly, a systemic evaluation of equity-oriented care and services within the framework of quality of care is essential within the nursing discipline.

Ethical considerations
The study received ethics approval by the CERSES, project number 2021-1234. All participants provided informed consent.

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Competing interests
All authors have no competing interests.

Data Availability Statement
Due to the nature of the research and ethical considerations, supporting data is unavailable.

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