

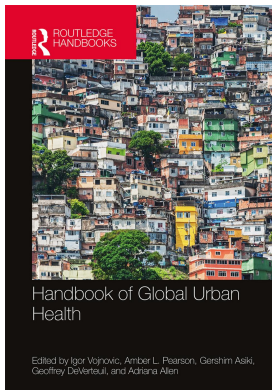
This article was downloaded by: 10.2.97.136

On: 21 Mar 2023

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Handbook of Global Urban Health

Igor Vojnovic, Amber L. Pearson, Gershim Asiki, Geoffrey DeVerteuil,
Adriana Allen

Taking Action to Improve Indigenous Health in the Cities of Québec and elsewhere in Canada

Publication details

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-22>

Carole Lévesque, Édith Cloutier, Ioana Radu, Dominique Parent-Manseau,
Stéphane Laroche, Natasha Blanchet-Cohen

Published online on: 20 May 2019

How to cite :- Carole Lévesque, Édith Cloutier, Ioana Radu, Dominique Parent-Manseau, Stéphane Laroche, Natasha Blanchet-Cohen. 20 May 2019, *Taking Action to Improve Indigenous Health in the Cities of Québec and elsewhere in Canada* from: Handbook of Global Urban Health Routledge

Accessed on: 21 Mar 2023

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-22>

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: <https://test.routledgehandbooks.com/legal-notices/terms>

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

19

TAKING ACTION TO IMPROVE INDIGENOUS HEALTH IN THE CITIES OF QUÉBEC AND ELSEWHERE IN CANADA

The Example of the Minowé Clinic at the Val-d'Or Native Friendship Centre

*Carole Lévesque, Édith Cloutier, Ioana Radu,
Dominique Parent-Manseau, Stéphane Laroche and
Natasha Blanchet-Cohen*

Introduction

According to the 2016 Canadian census, 5% of the country's total population declared an Indigenous identity (1,673,785 individuals). Today, more than half of this population is established in rural or regional towns and cities, or in large metropolitan areas such as Vancouver, Calgary, Regina, Saskatoon, Winnipeg, Toronto, Ottawa, or Montreal. The rate of Indigenous urbanization has grown tremendously when considering it was barely 12% in 1961 (Norris and Clatworthy 2013). The other component of this population lives on 630 reserves (called Indigenous communities) spread out across the country. Generally speaking, these are lands that the Crown has set aside for the benefit of Indian groups at different times in history, sometimes within the framework of treaties. In reality, these lands represent only a very small fraction of the ancestral territories that these groups and nations utilized for their subsistence, and that were historically confiscated from them. These reserved lands, pursuant to the Indian Act, still belong to the Crown.

In Canada, the term 'Aboriginal' or 'Indigenous' applies to three groups of descendants of the first inhabitants of Canada: First Nations, Métis, and Inuit (Constitutional Act of 1982). The First Nations include the population designated for a long time by the term 'Indian' or again 'Amerindian'. Statistics Canada, the official federal government body, designates them by the expression 'Indians of North America'. Furthermore, Canada includes ten provinces and two territories. Our team works more specifically in the province of Québec, which explains our reference to both the global situation of the country and the situation of this province in particular. In 2016, for the province of Québec, the Indigenous population was reported to be 182,890, of which 92,655 were members of First Nations, and represented 2.3% of the total population (Statistics Canada 2016). Other than the Inuit People living in the northern part of the province (in the region called Nunavik), there are ten First Nations: Abénakis, Anicinape, Atikamekw Nehirowisiw, Cree-Eeyou, Huron-Wendat, Innu, Malecite, Miq'maq, Mohawk, and Naskapi. However, it is important to specify that

not all Indigenous people are accounted for during federal census-taking; many individuals or First Nations refuse to participate for political reasons. Consequently, the numbers corresponding to the population accounted for during Canadian census-taking may be inferior to the total Indigenous population. However, Statistics Canada estimates that 55.8% of the total Indigenous population (all origins combined) in Canada lived in urban areas in 2016. They are the fastest growing segment of the population in the country, that is, at four times the rate of the Canadian population.

It is well known and well documented that there are significant gaps between the social and economic life conditions, as well as the health conditions, of the Indigenous population in Canada, on the one hand, and that of the Canadian population as a whole, on the other hand (Boyer 2015; CCDP 2013; Greenwood et al. 2015). While the Human Development Index (HDI) regularly positions Canada among the five best countries in the world, it also places the Indigenous Peoples of the country at the 70th rank order. Starting from birth, Indigenous people of all origins are exposed to high health risks in all areas of their personal, family, and social life: greater risk of chronic disease (including diabetes and tuberculosis), accidents, suicide, and physical and psychological violence; overcrowding in homes; major psychosocial issues; exacerbated poverty; endemic obesity; very high frequency of child placement in foster homes; weaker schooling and activity rates; lower life expectancy; gender inequalities; and limited access to safe drinking water (CSSSPNQL 2014; Macdonald and Wilson 2013).

There are additional challenges for the urban Indigenous population: lack of care and appropriate resources; hindered access to health services in the Canadian or Québécois public health system; social isolation; overrepresentation among the homeless and prison populations; substandard and unsafe housing conditions; food insecurity and nutritional deficiencies; repeated situations of racism and discrimination; and chronic unemployment. Therefore, there is more pressure on public services in the cities, which rarely have the resources necessary to adequately meet the multiple and growing needs of this Indigenous clientele, which for the most part are not well known and are especially misunderstood (DeVerteuil and Wilson 2010). Furthermore, the interpersonal cohabitation between Indigenous people and Canadians is difficult and often a source of tension and insecurity, for both the Indigenous and the Québécois or Canadian populations concerned.

It also turns out that many Indigenous individuals do not trust the services and personnel of the public health networks; therefore, they rarely go to the clinics, health centres, and hospitals except for emergency situations or even only in extreme emergency situations. These situations often result in more serious problems, such as delayed diagnosis, more complex treatments, lack of accompaniment and resources, inappropriate medication, and lack of follow-up and prevention measures (Allan and Smylie 2015). These disparities are further exacerbated by manifestations of institutional and personal racism, as well as discrimination experienced by a majority of urban Indigenous people when they are in contact with healthcare and nursing personnel (Allan and Smylie 2015).

Moving toward Indigenous-Oriented Health Services

For many years already, Indigenous organizations and researchers, both Indigenous and non-Indigenous, have denounced the inequalities and injustices at the root of these problems (Graham and Stampler 2010; Greenwood et al. 2015; Kelly 2011; Lavoie 2013; Mitchell 2006). Already, during the Royal Commission on Aboriginal Peoples (RCAP) which was held in Canada between 1991 and 1996, many studies, stories, and testimonies had witnessed to the poor health and living conditions of a great majority of Indigenous Peoples throughout the country, and to the lack of services and resources required to meet their needs. The Commission, while bringing to light Canada's colonial history and the ensuing serious and ever-present consequences for the health and quality of life of Indigenous populations, had also attracted attention to the necessity of developing new health

models, based on Indigenous practices, knowledge, and approaches with regard to care, prevention, psychosocial intervention, and healing (RCAP 1996; Spear 2014).

Since then, many innovative initiatives have emerged and new government programmes have been established, but there are still many obstacles to overcome, more particularly the recognition of the authority, jurisdiction, and expertise of Indigenous bodies and organizations for the development and implementation of these new models (Martin and Diotte 2010). Furthermore, in order for these initiatives to be successful and create sustainable positive impacts, it is also important: 1) to modify the logical determinants underpinning the development of contemporary governmental policies designed for Indigenous Peoples, as well as the majority of the ensuing funding programmes; 2) to better inform medical personnel (both Indigenous and non-Indigenous) about the population's realities and challenges; and 3) to renew the nature and the objectives of the services offered.

In spite of a few gains registered since the end of the 20th century, particularly in health and education, existing laws and policies generally aim at encouraging the integration and assimilation of Indigenous people into Canadian society and Canadian cities, rather than their social and political recognition. Consequently, the rights infringement, abuse, and exactions of all sorts perpetrated towards them over the centuries through Canadian colonial policies are obscured. Their rights to self-determination, recognized repeatedly by the Supreme Court of Canada and major international bodies, including the UN, are not taken into account. Their individual and collective capacity to take charge of their own destiny is ignored. Yet, according to the terms used in the Truth and Reconciliation Commission report (TRC 2015), Canada's endeavour to destroy, wipe out, and render invisible Indigenous Peoples started systematically in the 18th century, and was nothing short of cultural genocide, of which the manifestations are present today in new forms owing to the rise of neoliberalism and neocolonialism. There is therefore no doubt as to the Indigenous exception and its exclusive character among the Canadian population as a whole.

As regards more particularly the situation of urban Indigenous people, the main challenge remains that of the affirmation and recognition of their cultural, social, citizenship, and legal specificity within a Québécois or Canadian population of which they are but a small population segment. In fact, in the most progressive circles of the Canadian society, it is more easily acknowledged that Indigenous people residing on reserves do have a specific identity as well as rights on the land they inhabit and use; it is generally denied that such a distinction could be made in the cities, where the majority of inhabitants are not Indigenous, and where urban gatekeepers and services are ill prepared and ill suited for incoming Indigenous populations (DeVerteuil and Wilson 2010).

There is no doubt in this context that the issue of Indigenous health, far from being limited to epidemiological or biomedical manifestations, necessarily refers to dimensions that are of a systemic and structural nature, that engage the Canadian and Québécois governments in their jurisdictional relations, nation to nation, with the Indigenous Peoples, and that put into play nothing less than their legal status, their constitutional recognition, their capacity for self-determination, and their legitimate place within society. In the process, avenues to be explored must ensure a genuine contribution from these peoples in decision-making and in the governance of their social and public affairs; they must propose an authentic division of powers and be based on a collective, democratic, and comprehensive vision of health for the benefit of those concerned.

These are the principles and vision that accompanied the creation and deployment of the Minowé Clinic (in the Anicinape language, Minowé means 'to be healthy') established by the Val-d'Or Native Friendship Centre (VDNFC) in 2011, in order to meet the needs of the Indigenous population in the area with more relevance, and efficiency, as well as provide more culturally and socially safe services and programmes. Val-d'Or is a small mining city in Mid-Northern Québec, 325 miles (525 kilometres) from Montréal; its total population is about 25,500 people, of whom 1,300 are First Peoples, an increase of 450 persons since 2011. This city is situated at the very heart of the Anicinape

ancestral territory, a territory occupied and used by the Anicinape for thousands of years. Owing to colonization and the development of natural resources (forestry, mining, and hydroelectricity), this ancestral territory was gradually taken away from its original occupants. Today, three Anicinape communities including approximately 2,700 people are established within a radius of about 100 miles (161 kilometres) from Val-d'Or. Many Anicinape families therefore live in the city.

This clinic's project, which was implemented less than ten years ago in this small Mid-Northern Québec town, is far from being an isolated initiative, though for many years it was the only Québec initiative of its nature to be established in an urban setting and intended for the Indigenous population. However, across Canada, dozens of similar projects have emerged since the beginning of the 21st century. As well, on an international scale, it is sufficient to recall the efforts of the Maori bodies in New Zealand or those of the Indigenous in Australia to also develop health clinics in cities where there is a growing Indigenous population.

In fact, it is in a spirit of sharing common experiences that the Val-d'Or Native Friendship Centre and the Maori organization Te Whanau o Waipareira signed a friendship agreement, in Val-d'Or itself, in June 2013. These two organizations face similar challenges in their project of offering services more attuned with the respective cultures and visions for health of the Indigenous population they serve, and that, through the programmes they implement, aim to reduce the gaps between the health conditions of Indigenous people and those of the other inhabitants of their country. These programmes attempt to supplement the deficiencies in the national healthcare systems which, still today and for both sides of the planet, are unable to adequately address Indigenous particularities, in health as well as in other areas.

In the next pages, we retrace the path and brief story of this clinic by first of all considering its position within the Canadian and Québécois Friendship Centre Movement; we then put an emphasis on the Indigenous people's relation to health, and the process towards cultural safety implemented at the Minowé Clinic; and finally, as an example, we more fully explore the case for social Indigenous perinatality.

The Native Friendship Centre Movement in Canada and Québec

Although only recently established, the Minowé Clinic is not an isolated initiative. On the contrary, it is the result of more than 60 years of the community solidarity, social commitment, and citizenship involvement of Indigenous people living in Canadian cities. After the Second World War, the presence of Indigenous people in Canadian cities slowly began to be apparent (Anderson 2013; Desbiens et al. 2016; Lévesque 2016a; Lévesque and Cloutier 2013; Peters and Andersen 2013). Very quickly, however, these people faced many challenges. First, for the sole reason that they had left their home reserve, they no longer had access to health or social services previously offered to them, since the availability of these services was limited to the internal boundaries of the reserve. Second, being very few, they found themselves isolated, without resources, and without employment for the majority of the time. Third, life in a city, and even in a non-Indigenous village in a rural area, was very different from the life they had known, in terms of social reference points and codes of individuals responding to other forms of socialization.

Already in the 1950s, in many places such as Toronto, Vancouver, and Winnipeg, Indigenous people took the initiative to gather together in order to break their isolation and share their experiences. This is how the first groups or associations were established, later becoming the Canadian Native Friendship Centres. From the very beginning, the mission was clear: collectively provide the means to raise awareness about Indigenous cultures in the cities in question, assist each other in this new reality, and work at improving their living conditions, which were mainly characterized by poverty and social marginalization.

Over the next few decades, the Indigenous presence in cities grew and the number of Friendship Centres multiplied across Canada. In the mid-1970s, the National Association of Friendship Centres was created in order to represent the interests of the urban Indigenous population with government bodies, gain access to public funding to implement assistance, care, and support programmes, and coordinate initiatives implemented across the country. In Québec, the first Friendship Centre was established in the northern city of Chibougamau (Chibougamau Eenu Friendship Centre) and in 1974 was followed by the Val-d'Or Native Friendship Centre and the Centre d'amitié autochtone de La Tuque: regional cities in Mid-Northern Québec. A provincial association, the Regroupement des centres d'amitié autochtones du Québec, was launched in 1976, much like many other provincial associations across the country. Today, there are close to 120 Friendship Centres in Canada, which all share a common community vision, social project, and objective: that of improving the quality of life and health of Indigenous people and families in the cities where they are established.

In spite of all these efforts and resources deployed over many decades, it took until the 1990s and even the 2000s for the actions of the Friendship Centres to be recognized and for government investments to be made. In fact, it was after the work of the Royal Commission on Aboriginal Peoples that the situation of Indigenous people residing in Québec and Canadian cities was brought to the political forefront and, for the first time, considered as a major issue in the contemporary Indigenous world; it was also at this time that the role of the Friendship Centres in maintaining Indigenous identity and providing support to the Indigenous population in Canadian cities was evoked and commended (Lévesque 2016b; RCAP 1996). It was reported at the time that 40% to 45% of the total Indigenous population in Canada resided in cities rather than on reserves. As mentioned previously, this proportion is closer to 60% today, reflecting an ongoing in-migration but also a natural increase.

Also, it was only at the beginning of the 2000s that research pertaining to the urban Indigenous population moved into new directions and new scientific output emerged. Until then, existing information remained very fragmented and, more often than not, was part of an evolutionary point of view according to which moving from an Indian reserve to the city was a clear sign of entering into 'civilization' and wanting to be freed from one's original culture. For a long time, the Indigenous presence in the city appeared to be an anachronism, an incompatibility that was political, economic, administrative, and cultural all at once. But, contrary to what many observers had expected, not only did this identity not become diluted, but instead it became a unique and innovative social and political force (Anderson 2013; Lévesque and Cloutier 2013; Newhouse 2008; Newhouse and Peters 2003; Peters and Andersen 2013).

Today, the Native Friendship Centres in Canada have become foremost actors in the renewal of public policies for the urban Indigenous population. Their leaders and members are constantly refining and redefining the means of action at their disposal, and the citizens' initiatives implemented are now enshrined under the banner of social innovation. Though their mission is still to improve the living conditions and health for Indigenous people of all ages and genders, they have become places of learning and of dynamic and innovative training, social enterprises firmly anchored in their environment, and essential institutional partners in the fight against racism and systemic sexism (Lévesque 2016a). From the very beginning, the Friendship Centres stood out from other Indigenous organizations, because their existence always originated from grassroots mobilization, necessarily community-based, and their operating mode was always participative.

Such a situation has a direct impact on the nature, composition, and scope of the service offer. The Indigenous population itself is at the heart of its social transformation project and constitutes the foundation of the Minowé Clinic, much like numerous similar projects created in other Friendship Centres across the country in the past decade (CCNSA 2012). The Wabano Centre in Ottawa, the federal capital, is one of these examples. It is known to be a leader in holistic and community health-care, acting as a link between Indigenous cultural practices and Western medicine in the fight against

poverty and disease among the First Nations of Canada. This medical clinic offers complete services, working in close collaboration with the patients to help them lead a healthy life. The clinic provides basic and holistic medical care integrated with traditional Indigenous approaches (CCS 2012).

The History and Strategic Positioning of the Minowé Clinic

The Minowé Clinic officially opened in 2011, but the project took many years to materialize and gain momentum. In this section, we alternately examine the different phases and the conditions of its implementation, from the first planning stages to its current integration. Such a project would not have been possible without the combined elements of favourable circumstances and a collective willingness to circumvent the obstacles; it is important to discuss these briefly.

Context of Emergence

Between 1996—the year of publication of the Report of the Royal Commission on Aboriginal Peoples—and 2011, the Canadian government adopted many new strategies in terms of public policies, particularly in the health sector with the launch of the Aboriginal Health Transition Fund (AHTS) in 2004, whose main objective was ‘aimed at addressing the gap in health status between Indigenous and non-Indigenous Canadians by improving access to existing health services’. Following this, dozens of projects, whose main characteristic was that they were led by Indigenous governments or organizations, were implemented across Canada in order to enhance the integration of services and increase the participation of Indigenous Peoples in their development and delivery. One of the programme streams of the AHTS aimed more particularly at funding promising initiatives that proposed innovative responses to the challenges of service organization, accessibility, and offer (Cloutier et al. 2009). It is within this context that the project for the creation of the Minowé Clinic actually originated (GRH 2011).

In 2006, the First Nations and Inuit Socioeconomic Forum was held in Québec, which, while bringing together hundreds of First Nations and Inuit leaders and representatives from across the province, also mobilized dozens of decision-makers from the federal and provincial governments, as well as numerous partners from the Indigenous and Québécois civil societies (AFNQL 2006). Among the many themes addressed and the departmental commitments that emerged from these discussions, health was evidently the focus of attention. From the decisions reached at this forum, a specific agreement fostered the creation of a new partnership between the Québec Ministry of Health and Social Services and the Regroupement des Centres d’amitié autochtones du Québec, to encourage ‘the transfer of knowledge and expertise between them and the Québec Government Health and Social Services Centres [and] the identification of service complementarity in the urban environment for Indigenous people’ (Ouellette and Cloutier 2010, p. 7).

In the Abitibi-Témiscamingue region, where the VDNFC is located, and elsewhere in Canada, a great number of First Nations members avoid the health services offered in the Québec and Canadian network of establishments, owing to the reception reserved for them and the lack of understanding they must generally confront. This situation is even more of an issue, since it concerns a growing segment of the local and regional population. In fact, the Indigenous population residing in the city has practically tripled since 2006, when it accounted for less than 1.5%, and now accounts for close to 5%, of the total population. Its needs are diversified, as families are larger (the birth rate is close to three times higher than for the rest of the population), as is the number of single persons and women in situations of single parenting: the request for housing and public services thus becomes more urgent.

Furthermore, it is known and documented that the traffic between Val-d’Or and the Cree and Anicinape communities located close to or farther away from the city, as the case may be, is also

increasing, which contributes to a temporary Indigenous presence, with the ensuing new forms of residential and professional mobility (Lévesque et al. 2014). Val-d'Or is a prime destination for the intake of Aboriginal patients from the Abitibi-Témiscamingue region, as well as that of Eeyou Istchee, a northern region north of the 49th parallel. For a long time (or since the early 1970s), Cree and Anicinape women have come to Val-d'Or to give birth: some will stay for a number of weeks, others for months if their condition requires it. Many people from the Cree communities also spend extended periods of time in Val-d'Or in order to receive more specialized healthcare. Hence, the challenges of the accessibility and offer of services to Indigenous people who reside in Val-d'Or either permanently or temporarily, or again are passing through for a few days or weeks, constitute a reality which the VDNFC must deal with on a daily basis.

Implementation

In 2008, the VDNFC obtained its initial funding from the AHTS (GRH 2011). Since the objective was to build bridges with the partners in the Québec health network, a steering committee was established, action plans were developed, and agreements for the sharing of services were signed. In addition to the VDNFC staff, the committee also brought together partners from the Abitibi-Témiscamingue Health and Social Services Centre (one of the regional components of the Québec network) and from the youth centre in the region (whose mission is to supervise the services offered to young children and teens); representatives of other Indigenous and non-Indigenous organizations played an ad hoc role. The committee's first activities aimed at identifying service delivery interface and complementarity zones, each partner proposing specific services in light of its mandate, the skills and qualities of its personnel, and its sphere of action.

At the beginning, steering committee meetings were numerous, each partner being little aware of the services offered by the others, and especially those offered by the Friendship Centre in Val-d'Or. The centre is open 24/7 and already provides a wide range of family and community activities for the Indigenous population in the city and in the surrounding area, as well as offering food and housing services for patients in medical transit. It employs about 100 people, the majority of whom are Indigenous. As the most significant Indigenous employer in the city, it is however rarely visited by the local non-Indigenous population; even after 40 years of existence, few people are interested in its action and mediation role between the Indigenous and Québécois worlds. Consequently, the realities experienced by the Indigenous population in the cities of the region are not very well known by the Québécois health network. This experiential phase will gradually be transformed into a phase of awareness and familiarity with regard to the realities and particularities of the Indigenous world: its origins, values, heritages, trajectories, knowledge, practices, social benchmarks, and conditions of existence. It therefore becomes essential to foster a better knowledge of the challenges and issues involved, as much for the local population as for the service providers, whether or not they are Indigenous.

In the fall of 2009 and with the close collaboration of the ODENA Research Alliance, the VDNFC organized a day for knowledge sharing related to the issues and challenges of the Minowé Clinic project (Cloutier et al. 2009). Funded by the Social Sciences and Humanities Research Council of Canada (SSHRC), ODENA brings together representatives from the Indigenous civil society, and researchers and students from many universities, engaged in a process of co-construction and mobilization of knowledge in order to improve the quality of life of the urban Indigenous population, and to renew relationships between the First Peoples and the other citizens of Québec in a spirit of equality and mutual respect.

To these ends, the activity brought together researchers, service providers, and various partners from local and regional institutions involved in issues of Indigenous health. The sharing sessions quickly emphasized the necessity of redefining and renewing existing services so that they better

correspond to the First Peoples' actual realities, rather than expect the First Peoples to adapt to the system in place. More particularly, the discussions led to highlighting the complexity of the legal relations between governments and Indigenous entities, and then learning about the effects of the new experiences of exclusion and marginalization of many Indigenous individuals once they have left their home reserves. The main question constituting the guiding theme for the day's discussions was that of defining the parameters and mechanisms such that the different partners engaged in this innovative creation project for a new service corridor would be able to interact (Cloutier et al. 2009).

At the beginning of 2011, as a continuation of the existing agreements and current reconciliation efforts, a nurse and a psychosocial counsellor from the provincial network came to work on the premises of the Val-d'Or Friendship Centre in order to build closer relations with the Indigenous population. With the assistance of the administrative coordinator and a clinical advisor of the VDNFC, the first multidisciplinary intervention team was formed under the auspices of the clinic. New services were offered: prenatal and postnatal care for infants and mothers, vaccination, prevention, and accompaniment for individuals and families in difficulty.

Visitor rates increased quickly: between 2011 and the end of 2013, more than 4,000 consultations were recorded, three-quarters of which were individuals and the other quarter being families. In its 2013–2014 annual report, the youth centre in the region indicated a decrease of 40% in young Indigenous children in difficult situations being reported or possibly at risk (CJAT 2014). There is no doubt that the clinic then became better known and visited; furthermore, in barely a few years, it has demonstrated its capacity as an essential service by establishing a welcoming environment, free of prejudice, where Indigenous individuals of all ages, genders, and origins can be accompanied and reassured, find answers to their questions, and receive care and accompaniment corresponding to their situation.

The Clinic Today

After seven years of operation, the Minowé Clinic currently offers a range of integrated services that are continually adjusting: 1) services for pregnant women, their children, and their family (contraception, pre- and postnatal follow-up, vaccination for children from birth to five years, and evaluation of child development); 2) prevention services for chronic diseases (screening and support for people with diabetes, high cholesterol, or hypertension), promotion of healthy lifestyle habits, and a vaccination campaign against influenza; and 3) psychosocial intervention services providing support to families and youth in difficulty, accompaniment in cases of reporting and placement of children and teens, and mental health services.

The objective of this collective model is certainly to find a viable solution to the various observations relative to the disastrous health conditions of the Indigenous population. It is not only a question of increasing the accessibility and provision of healthcare, but is mainly to offer Indigenous people living in the city 'culturally adapted care, where funding and organizational structure ensure avoiding political and jurisdictional obstacles, that often limit or impede delivery of services' (Lainé and Lainé 2011, p. 90). The complementary services model, based on the concern for renewing practices and considering living conditions, thus becomes a priority for each of the partnering organizations.

The establishment of the clinic and its deployment required no modification to the existing legal or political context, even if the protocols, procedures, and standards in effect within the Québecois health system, by their rigidity and lack of Indigenous anchorages, further complicate the work of personnel and regularly hinder the actions to be taken or the decisions to be made. Furthermore, it is evident that Western medicine constitutes the primary reference for caregivers, but the way this medicine is exercised at the clinic, as well as the conditions in which it is practised, has changed

since: over and above medical acts, emphasis is put on prevention, listening to patients, the collective responsibility of personnel, and a sense of community (CCS 2012). From this perspective, the Minowé Clinic is not the project of just a few actors; it is the initiative of a community for the well-being and the incarnation of a specific quest, that of Mino Madji8in.

Wellness, Worldview, and the Impacts of Colonialism

In the Anicinape language, Mino Madji8in refers to a state of global wellness, harmonious and in balance, and more generally the quality of life of the Indigenous population in its relationships with humans, living things, and the universe. Reflecting the spirit of the ancestors and in constant evolution, Mino Madji8in is a specific Indigenous way of being, of understanding the world and interacting with it, in the respect of traditional and contemporary values (RCAAQ 2012).

Mino Madji8in evokes both a state of mind and a certainty that wellness consists of cultivating our willingness to be in harmony in all things, in time, and in space. This quest for wellness, individually and collectively, is based on a balance of the different dimensions of the Circle of life and of the interactions between them. This quest for wellness is embodied in a perpetual movement that can be anchored in life without ever being fixed.

(RCAAQ 2012, pp. 8–9)

Mino Madji8in's main quality is that of being based on a double anchorage—as an identity and an individual, on the one hand, and collective and community-based, on the other hand—which positions the individual, in all circumstances, within a community, as a learning, acting, and reflective member of this community. This approach is definitely holistic in the sense that it reflects a balance where the different dimensions and strengths are deployed in a combined and integrated fashion in the individual, family, community, territorial, and cosmological aspects. Accordingly, to isolate individuals (whether they are 5 or 80 years old) from their meaningful and relational universe leads to a rupture in their development and the attainment of their full potential, thus interrupting the circle of transmission of knowledge and skills that ensures the connection with Mino Madji8in (RCAAQ 2012).

Colonization, for which the Indigenous Peoples of Canada paid the consequences, caused these types of social and personal disruptions, erosions, and fragmentations. It is common to mention colonialism when we attempt to understand the contemporary realities and conditions of existence of Indigenous Peoples. However, to move past colonialism and therefore build the reconciliation desired, we must look beyond observations and consider their effects and scope. It is important to reconstitute the processes and understand how they operated, and still do in many contexts (Newhouse 2008).

Colonialism is clearly a manifestation of humans being stripped of everything. Such a political system translates a state's affirmation, domination, force, and authority over specific individuals and social groups. As for Canada, and therefore Québec by extension, the manifestations of colonialism for Indigenous Peoples resulted in territorial dispossession, loss of individual control over their own existence, family dysfunction, identity crisis, deterioration of the conditions of belonging to the group, and a prioritization of statutes celebrating patrilineal filiation in that they transcend generations and time, as well as profound transformations of social and economic organization (Menzies 2010).

For Indigenous Peoples, their vision of the world, of nature, and of living beings (humans as much as animals) is based on a set of relational mechanisms, social meanings, and obligations that influence the behaviours, choices, and aspirations of individuals regarding existence and other persons who interact within their universe. Accordingly, the equilibrium of a person is the result, on the

one hand, of an ongoing quest for harmony between these different dimensions and, on the other hand, of their sense of belonging to a community whose members share the same quest. When this equilibrium is broken, or even destroyed, when the chain of relations and meaning is disrupted (as was the case with the residential school system, for example), and when people are isolated from their community living environment, they no longer find answers to their questions, and their ability to act is reduced and undermined (TRC 2015). The Indian residential schools were teaching establishments which welcomed, through force and against their will and that of their parents, thousands of Indian children under 16 years of age, from the middle of the 19th century to their official closure in 1996, in order to ‘Christianize’ and ‘civilize’ them. These establishments were managed by religious communities on behalf of the Canadian government. The time these children spent there, often very long periods, was characterized by abuse, food deprivation, manual labour, physical and psychological violence, and infringement of their identity and their culture; many hundreds of them died in these residential schools. The existence of these residential schools was fully a part of the assimilation policies implemented against Indigenous Peoples.

For a long time, the survival and reproduction of groups and families have relied upon the existence of social regulation and family association mechanisms to which the different members of the group adhered. These mechanisms provided for intervention when there were difficulties or dissent of various kinds. They were based on values and life principles that encouraged mutual assistance, sharing, and cohesion being preferred over individualism and competition. These values and principles were passed on from one generation to the next, and were valued through the daily and seasonal obligations and responsibilities. Being placed in reserves, the residential school episode, and sedentarization greatly modified the scheme of things, channels of transmission were cut off, and practices that had enhanced equilibrium for groups and families, as well as the modes of interaction and collaboration that presided over relations between groups of the same band and between different bands, were eroded. In other words, there were rules, standards, obligations, responsibilities, and practices on which relations between individuals were based. Despite the passing of time, despite the losses and dispossessions, founding principles which are the very essence of these rules and practices that regulate cohabitation and encourage social cohesion still exist. It becomes necessary to reconstitute and regenerate these.

The Minowé Clinic was established on these bases, both historical and contemporary. Therefore, it proposes a scope of services in continual reconfiguration, enhancing the well-being and community reconnection for persons and families experiencing various challenges, while meeting the immediate needs of vaccination, screening, treatment, accompaniment, and prevention. This offer of services is meant to eventually counter the harmful effects of colonialism, one of the main determinants of poor health for Indigenous people (Greenwood et al. 2015). The social and cultural safety approach adopted by the Friendship Centre provides a response to this effect.

Cultural Safety and Social Transformation

Combating Inequalities at Their Source

The cultural safety approach was developed in New Zealand in the 1990s, within the context of nursing care for the Maoris. Nursing Professor Irihapeti Ramsden, a Maori herself, wrote extensively on this topic and made it known at the international level (Ramsden 2002; Wepa 2005). This approach took shape in response to alarming concerns about the health of the Maoris, and their discontent with regard to health services deemed to be non-culturally safe. These non-safe practices corresponded to ‘any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual’ (NCNZ 2011, p. 7).

Intended mainly to ‘build confidence with Aboriginal patients . . . by recognizing the role of socioeconomic conditions, history, and politics with regards to health’ (CCS 2012), such an approach also seeks to review the practices of the actors and intervenors, so that they take into account their cultural identity and respond, in a safe manner, to their needs and expectations for their health and social services concerns. Cultural safety implies mutual respect, and the sharing of know-how and knowledge: it is based on modes of interaction, learning processes, and transmission and communication mechanisms that are specific to Indigenous culture. This approach refers back to all the social determinants related to Indigenous health: unfavourable socioeconomic conditions, colonization, oppression, discrimination, lack of housing, poor housing, food insecurity, and social isolation (Greenwood et al. 2015).

The cultural safety approach requires a full understanding of health issues (in a broader sense) relative to the Indigenous population. It refers to the colonial heritage shared by the Indigenous Peoples and its intergenerational impact on health and quality of life. It explains how the relationships the Indigenous people developed with political and cultural institutions imposed by the Canadian State were detrimental to their cultures, their societies, and their development, as individuals and communities. Hence, from a societal viewpoint, a cultural safety approach:

- aims at reducing the gaps and inequalities that exist between the Indigenous population and the Canadian and Québécois populations, in the area of health as well as others;
- recognizes the legitimacy of the Indigenous social and cultural difference, as evidenced through knowledge, practices, and skills;
- considers the sustainable effects of colonization, systemic racism, and the ensuing intergenerational trauma;
- aims at creating safe and welcoming environments for the Indigenous population in the areas of health and education, that of justice and the environment, and employability;
- enhances the deployment of services, practices, and initiatives consistent with Indigenous methods of accompaniment, care, prevention, healing, social transaction, and intake;
- reflects a collective and community willingness for social transformation and innovation on the part of Indigenous people;
- is based on the founding principle of social justice in its objective to reduce inequalities; and
- is especially part of a clear and legitimate intention of a political and identity assertion, and of Indigenous governance.

The equation is relatively simple: colonization, sexism, and systemic racism have jeopardized the safety nets and mechanisms and practices of social regulation which were (and often still are) operative in Indigenous societies. It is important to reconstitute these, on the one hand, but also to resituate them within the context of today’s world, on the other. Indeed, the objective conditions of existence were greatly transformed owing to demographic growth, sedentarization, a more significant presence in the cities, globalization, and the development of information technologies. This is the ground where cultural safety initiatives can take root within an Indigenous context. The example of social Indigenous perinatality, as developed at the Minowé Clinic, allows for such a concrete application.

The Example of Social Indigenous Perinatality

From the start of its activities, the Minowé Clinic particularly targeted pregnant women and their children (0–5 years) owing to their more troubling situation among the Indigenous population as a whole, as much as for their health as for their socioeconomic conditions: high child mortality rate; weaker vaccination rate; poor nutritional state for babies, children, and their mothers; infant motor

skills hindered; and learning difficulties across all ages. It is also mentioned that there are a great number of women and children involved. In fact, the fertility rate for First Nations teens is at least eight times higher than that of Canadian teens, and Indigenous teens less than 15 years old have a birth rate that is 18 times higher than that of young Canadians (UNICEF 2009). Furthermore, in the province of Québec, the poverty rate for Indigenous children is 33%, double that of non-Indigenous children, which is established at 16% (Macdonald and Wilson 2013).

The Val-d'Or region is not immune to these global socioeconomic realities, because the income of Indigenous people is considerably lower than that of the non-Indigenous, families are more numerous, and single-parent situations are at least twice as frequent as in the rest of the population. Geographical remoteness in the cases of women who must leave the community to which they belong in order to give birth, the oftentimes ensuing isolation, the lack of support during the pregnancy, the youth and inexperience of the mothers, the poor housing conditions, and the lack of money are all sources of marginalization and powerlessness, or even emotional destabilization, which are apt to limit the mothers' physical and psychological fulfilment, as well as the motor and cognitive development of their children.

The approach adopted by the Val-d'Or Native Friendship Centre was based on a broader and systemic understanding of social perinatality that involves not only the pregnant woman and the unborn child, but also the father, siblings as the case may be, the extended family, and, on a wider scale, the urban Indigenous community. In order to achieve this, it was important to work on many fronts at the same time: 1) by creating a safe and stimulating living environment to allow for the optimal development of the pregnant woman, the mother, and the infant; 2) by encouraging the active and ongoing involvement of parents, as well as support for the extended family, so that the infant's well-being and holistic equilibrium are maintained; 3) by contributing to the development of a healthy social environment that respects traditional and contemporary Indigenous values; and 4) by redefining the services and practices so that they reflect consciousness, awareness, skills, and a safe space that are all culturally Indigenous.

Aiming for nothing less than an authentic social and systemic transformation, actions to foster a feeling of safety were implemented at the VDNFC, thus allowing for a renewal in the way things were done, for the organization and delivery of services based on the resurgence of Indigenous practices and knowledge. In fact, much like the large social systems in different areas, the offer of public services for health and social services in Canada and in Québec is based on a standardization and universalization of protocols in care and intervention. From this perspective, there is little room for the development of outside or alternative practices. Likewise, the reference categories are the same for society as a whole. Hence, the age group targeted from the start, children from birth to five years, when considered globally, did not really allow for the accounting for the individual and collective indicators that are milestones in a young child's life experience. The VDNFC therefore introduced a distinction between the groups of children, first of all from birth to two years, and then considering those who were older as a category in itself, that is, from three to five years. This distinction can seem insignificant from the outside; yet taking this into account has allowed the association of these stages of life to specific social and family practices much more in line with the Indigenous way of doing things.

According to the evaluation report of the first phase of the project completed in the spring of 2014, the positive impacts of the deployment of new practices, combined with an increased accessibility to the programmes offered owing to the concentration of the activities and the personnel at the centre, were evidenced by an improvement in the physical and social health of young Indigenous children, as well as their immediate and extended families (Blanchet-Cohen and Trudel 2014). The evaluation also demonstrated the efficiency of the ecosystemic approach, on which the VDNFC bases its service offer, since the social Indigenous perinatality project contributed to the creation of a new services gateway that starts with the child, reaches out to his/her parents, and is deployed to the extended family and the community to which they belong.

Conclusion: Challenges of a Shared Governance and a Renewed Service Offer

With regard to Indigenous health, the urban-based challenges are still numerous and varied for the Indigenous population of Canadian cities (CCS 2012), but encouraging steps have already been taken in little time across Canada. To this effect, the example of the Minowé Clinic is particularly eloquent. Its local scope in no way limits the impact such an initiative may have on the international scale. According to the Indigenous vision of health, physical health coexists with mental and environmental health within a holistic perspective. In this optic, actions must include all aspects simultaneously and in particular start by establishing conditions for a greater access to culturally safe care and healing services, since culture is a wonderful therapeutic tool. In fact, many researchers, health practitioners, and Indigenous actors now converge towards a common finding: culture represents a powerful healing vector, facilitating the management of both physical and psychosocial issues (diabetes, obesity, addictions, depression, multiple forms of instability, mental illnesses, and suicide attempts). Since the association between well-being and culture prevails within Indigenous collective representations, this kind of perception must be taken into account in the development of programmes intended for Indigenous persons, in order to increase the chances of success for such initiatives (Castellano 2006; Kirmayer et al. 2014; Menzies 2013; Rowan et al. 2014; Yellow Horse Brave Heart et al. 2011).

From the very beginning, the establishment of the Minowé Clinic was thought of as a long-term process; it is not sufficient to offer more numerous and more adequate services to Indigenous persons. It is important that the Indigenous bodies that work in the area of health (in general) can also take an active part in decision-making with regard to the services offered, programmes to be designed, and policies to be developed. Longitudinal data allowing assessment of the state of health of populations (Indigenous or other) must be compiled over a period of many years, if not decades, to be able to see the gains obtained. It is therefore still too early in the case of the Minowé Clinic to know if the new services offered were able to curb the dominant trends which characterize the health conditions of the urban Indigenous population of the city and the surrounding area. However, it is clear that a greater proportion of the Indigenous population of Val-d'Or now has access to the care it did not have access to previously. Screening for diabetes or respiratory diseases is extended to hundreds of individuals and families; those dealing with diverse health issues are less often in hospital emergency wards; parents who are concerned about their children are finding that they get personalized attention from personnel; and young girls and women with their newborns now have the possibility of interacting with female elders, who facilitate the transmission of knowledge regarding childcare.

The experience of the Minowé Clinic is first of all that of a relationship that has become respectful between a governmental health system and a visionary Indigenous organization. The challenges along the way were nonetheless numerous, and they must often be recalled. In line with its participative philosophy, the authorities of VDNFC greatly desire to extend caring actions and practices within a transformational and educational vision at all decision-making levels, always keeping in mind the individual and collective needs of the Indigenous population. The Val-d'Or Friendship Centre therefore insisted from the start on the necessity of including real-time scientific oversight and evaluative monitoring of the clinic's actions, in order to ensure their continuous convergence with the holistic vision that is characteristic of its mission. The ensuing research work led to the creation of a new corpus of knowledge and practices, which in turn constituted the necessary pedagogical and methodological basis for the acquisition of new learning, on the part of both the Indigenous and the non-Indigenous personnel concerned.

These learning opportunities also led to collective reflection on which skills needed to be mobilized within the clinic to ensure a smooth functioning according to shared expertise and Indigenous teachings. If the situation is less complex, without it being totally free from challenges, collaboration

between an Indigenous entity and a constituent of the health network requires the presence of Indigenous professionals with academic training. It is still too often the case that Indigenous persons whose expertise, experience, and knowledge are not recognized by diplomas are not taken seriously. For example, adjustments have been and are still necessary so that Indigenous cultural caregivers (elders, knowledge keepers, and guides) can be integrated into the work teams, and can pursue their accompaniment activities in the best possible conditions.

At the root of a project such as the Minowé Clinic are all the components of identity reaffirmation by the urban Indigenous community in Québec: taking charge of their own destiny as a society, meaningful participation in decisions that concern them, a recognition of the injustices and inequalities, a willingness to fight discrimination, a commitment towards civic engagement, and a concern for equity and respect between individuals and peoples. Such a social project finds its full meaning in the objective of offering Indigenous children, youth, women, and men the means for acquiring greater control over their life and health, and tools to collectively become agents of change and providers of hope.

The Minowé Clinic is more than just a positive example of greater accessibility to health services and social services for the urban Indigenous population. It constitutes a meaningful manifestation of the reconciliation desired between Canadian society and the Indigenous world. The clinic provides an extensive and innovative response to action calls formulated in the final report of the Canadian Truth and Reconciliation Commission (TRC 2015), by contributing in the realignment of power relationships that exist between the State (Canadian and Québécois) and Indigenous Peoples and fully engaging in the journey of decolonization. Their leaders were successful in promoting a renewed vision of democratic citizenship based on openness, justice, respect, and recognition within a system that still too often advocates for the integration (assimilation) of Indigenous actors in the dominant society, irrespective of social and cultural exceptions.

References

- AFNQL (Assembly of First Nations of Québec and Labrador). 2006. *First Nations socioeconomic report: Acting now . . . for the future*. Wendake: AFNQL.
- Allan, Billie and Smylie, Janet. 2015. *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous Peoples in Canada*. Toronto: Wellesley Institute.
- Anderson, Alan B. (Ed.). 2013. *Home in the city: Urban Aboriginal housing and living conditions*. Toronto: University of Toronto Press.
- Blanchet-Cohen, Natasha and Trudel, Monique. 2014. *Rapport d'évaluation du projet Abinodjic*. Université Concordia.
- Boyer, Yvonne. 2015. *Moving Aboriginal health forward: Discarding Canada's legal barriers*. Saskatoon: Purich Publishing.
- Castellano, Marlene B. 2006. *Un cheminement de guérison: Points sommaires du Rapport final*. Ottawa: Fondation autochtone de guérison. Retrieved from www.fadg.ca/downloads/sommaire-rapport-final.pdf
- CCDP (Commission canadienne des droits de la personne). 2013. *Rapports sur les droits à l'égalité des Autochtones*. Ottawa: CCDP.
- CCNSA (Centre de collaboration nationale de la santé autochtone). 2012. *L'espace sacré de la féminité: Le maternage à travers les générations*. Ottawa: CCNSA.
- CJAT (Centre jeunesse de l'Abitibi-Témiscamingue). 2014. *Rapport annuel 2013–2014*. Val-d'Or: CJAT.
- Cloutier, Édith, Dugré, Suzanne, Salée, Daniel, Comat, Ioana, and Lévesque, Carole. 2009. *Enjeux et défis en santé et services sociaux pour les Autochtones en milieu urbain*. Cahier ODENA no. 2009–04. Montréal: Alliance de recherche ODENA, Réseau de recherche et de connaissances relatives aux peuples autochtones (DIALOG), and Regroupement des centres d'amitié autochtones du Québec.
- CSSSPNQL (Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador). 2014. *Plan stratégique 2014–2017*. Wendake: CSSSPNQL.
- Desbiens, Caroline, Lévesque, Carole, and Comat, Ioana. 2016. 'Inventing new places': Urban Aboriginal visibility and the reconstruction of civil society in Quebec. *City and Society*, 28(1), 74–98. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/ciso.12074/full>

- DeVerteuil, Geoffrey and Wilson, Kathi. 2010. Reconciling Indigenous need with the urban welfare state? Evidence of culturally-appropriate services and spaces for Aboriginals in Winnipeg, Canada. *Geoforum*, 41(3), 498–507.
- Graham, Holly and Stamler, Lynnette Leeseberg. 2010. Contemporary perceptions of health from an Indigenous (Plains Cree) perspective. *International Journal of Indigenous Health*, 6(1), 6–17.
- Greenwood M., de Leeuw, S., Lindsay, N.M., and Reading, C. 2015. *Determinants of Indigenous Peoples' health in Canada: Beyond the social*. Toronto: Canadian Scholars' Press.
- GRH Recherche/Évaluation. 2011. *Évaluation du projet FTAS Adaptation au Centre d'amitié autochtone de Val-d'Or*. Québec: GRH Recherche/Évaluation.
- Kelly, Miranda D. 2011. Toward a new era of policy: Health care service delivery to First Nations. *International Indigenous Policy Journal*, 2(1), 14.
- Kirmayer, Laurence J., Gone, Joseph P., and Moses, Joshua. 2014. Rethinking historical trauma. *Transcultural Psychiatry*, 51(3), 299–319.
- Lainé, Amélie and Lainé, Mathieu-Joffre. 2011. La clinique Minowé: Un modèle de services de santé et de services sociaux en milieu urbain pour les autochtones de la Vallée-de-l'Or. In A. Maire and M. Fay (Eds), *Le bien-être et la santé autochtones* (pp. 87–93). Les Cahiers du CIÉRA no. 8. Québec: Université Laval.
- Lavoie, Josée G. 2013. Policy silences: Why Canada needs a national First Nations, Inuit and Métis health policy. *International Journal of Circumpolar Health*, 72, 10.3402/ijch.v72i0.22690. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC3875351/
- Lévesque, Carole. 2016a. *La présence autochtone dans les villes du Québec: Actions, tendances et enjeux*. Cahier ODENA no. 2016–01. Montréal: Alliance de recherche ODENA, Réseau DIALOG, and Regroupement des centres d'amitié autochtones du Québec.
- Lévesque, Carole. 2016b. La Commission royale sur les peuples autochtones: Les premiers pas d'une réconciliation annoncée. In *L'état du Québec 2017* (pp. 159–164). Montréal: Institut du Nouveau-Monde and Del Busso.
- Lévesque, Carole and Cloutier, Édith. 2013. Les Premiers Peuples dans l'espace urbain au Québec: Trajectoires plurielles. In A. Beaulieu, S. Gervais, and M. Papillon (Eds), *Les Autochtones et le Québec: Des premiers contacts au Plan Nord* (pp. 281–296). Montréal: Presses de l'Université de Montréal.
- Lévesque, Carole, Radu, Ioana, Polèse, Geneviève, and Sokoloff, Mélissa. 2014. *Dossier documentaire: Le concept de sécurisation culturelle: Origine, portée et application*. Montréal: INRS and CAAVD.
- Macdonald, David and Wilson, Daniel. 2013. *Poverty or prosperity. Indigenous children in Canada*. Ottawa: Canadian Centre for Policy Alternatives and Save the Children Canada.
- Martin, Thibault and Diotte, Eric. 2010. Politiques publiques et santé des Autochtones résidant en milieu urbain: L'autonomie gouvernementale, une condition de la redéfinition d'un partenariat équitable entre l'État et les Autochtones. In Jerry P. White and Jodi Bruhn (Eds), *Aboriginal policy research: Exploring the urban landscape* (pp. 107–131). Ottawa: Institute on Governance/Institut sur la gouvernance.
- Menzies, Peter. 2010. Intergenerational trauma from a mental health perspective. *Native Social Work Journal*, 7, 63–85.
- Menzies, Peter. 2013. Developing an Aboriginal healing model for intergenerational trauma. *International Journal of Health Promotion and Education*, 46(2), 41–48.
- Mitchell, Michael Kanentakeron. 2006. *The Haudenosaunee code of behaviour for traditional medicine healers*. Report submitted to the National Aboriginal Health Organization.
- NCNZ (Nursing Council of New Zealand). 2011. *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Wellington: NCNZ.
- Newhouse, David. 2008. Economic and social development issues. In *Emerging realities of Métis, non-status and urban Aboriginal populations: Building a new policy research agenda*. Report on Colloquium. Carleton University, Ottawa.
- Newhouse, David and Peters, Evelyn J. 2003. Introduction. In D. Newhouse and E.J. Peters (Eds), *Not strangers in these parts: Urban Aboriginal Peoples* (pp. 5–14). Ottawa: Policy Research Initiative.
- Norris, Mary J. and Clatworthy, Stewart. 2013. Aboriginal mobility and migration within Canada's friendship centre areas: Patterns, levels, and implications based on the 2006 census. In P. Dinsdale, J. White, and C. Hanselmann (Eds), *Urban Aboriginal communities in Canada: Complexities, challenges, opportunities* (pp. 173–218). Toronto: Thompson Educational Publishing.
- Ouellette, André and Cloutier, Édith. 2010. *Vers un modèle de services de santé et de services sociaux en milieu urbain pour les Autochtones de la Vallée-de-l'Or*. La Clinique MINOWÉ, une ressource intégrée au réseau local de la Vallée-de-l'Or. Une initiative conjointe du Centre de santé et des services sociaux de la Vallée-de-l'Or, du Centre de jeunesse de l'Abitibi-Témiscamingue, et du Centre d'amitié autochtone de Val-d'Or.
- Peters, Evelyn J. and Andersen, Chris (Eds). 2013. *Indigenous in the city: Contemporary identities and cultural innovation*. Vancouver: UBC Press.

- Ramsden, Irihapeti. 2002. Cultural safety and nursing education in Aotearoa and Te Waipounamu. PhD thesis (Nursing). University of Wellington, Victoria.
- RCAAQ (Regroupement des centres d'amitié autochtones du Québec). 2012. *Mino Madji8in—Innovation et développement en économie sociale autochtone*. Wendake: RCAAQ.
- RCAP (Royal Commission on Aboriginal Peoples). 1996. *Report of the Royal Commission on Aboriginal Peoples*. Erasmus Georges and René Dussault (Eds). Ottawa. Retrieved from www.bac-lac.gc.ca (28 November 2017).
- Rowan, Margo, Poole, Nancy, Shea, Beverly, Gone, Joseph P., Mykota, David, Farag, Marwa, Hopkins, Carol, Hall, Laura, Mushquash, Christopher, and Dell, Colleen. 2014. Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy*, 9(34). Retrieved from <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-9-34>
- Spear, Wayne K. 2014. *Full circle: The Aboriginal Healing Foundation and the unfinished work of hope, healing and reconciliation*. Ottawa: Aboriginal Healing Foundation.
- Statistics Canada. 2016. Retrieved from www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-pr-eng.cfm?LANG=Eng&GK=PR&GC=24&TOPIC=9
- TRC (Truth and Reconciliation Commission). 2015. *Summary of the final report of the Truth and Reconciliation Commission of Canada*. Ottawa: Truth and Reconciliation Commission of Canada.
- UNICEF. 2009. *Aboriginal children's health: Leaving no child behind: Canadian supplement to the State of the World's Children 2009*. Toronto: Canadian UNICEF Committee.
- Wepa, Dianne. 2005. *Cultural safety in Aotearoa New Zealand*. Auckland: Pearson Education New Zealand.
- Yellow Horse Brave Heart, Maria, Chase, Josephine, Elkins, Jennifer, and Altschul, Deborah B. 2011. Historical trauma among Indigenous Peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, 43(4), 282–290.