“They Seem to Want to Help Me”: Health, Rights, and Indigenous Community Resurgence in Urban Indigenous Health Organizations

by

Sarah Elizabeth Nelson

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Graduate Department of Geography
University of Toronto

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2019

Abstract

At least 52 percent of the Indigenous population of Canada lives in cities (Statistics Canada, 2017a), yet urban Indigenous experiences continue to be underrepresented in both research and policy (Place, 2012; K. Wilson & Young, 2008). Health care policy in particular is jurisdictionally complex for Indigenous people living in urban areas, leading urban Indigenous people to have limited options for culturally safe health care. Indigenous people living in urban areas frequently report negative experiences in health care settings, often associated with discrimination based on Indigenous identity (Browne et al., 2011a; Evans, White, & Berg, 2014). Indigenous-led health organizations are one way that urban Indigenous communities have developed of counteracting such difficulties.

This dissertation uses qualitative methods, grounded in principles drawn from Indigenous and decolonizing research, to examine the everyday experiences of Indigenous clients in health care settings in Prince George, British Columbia, Canada. Interviews and focus groups involving 50 Indigenous community members and 15 health services workers were conducted in 2015-2016. Intent on investigating the connections between urban Indigenous peoples’ inherent rights and
Indigenous peoples’ experiences accessing health care, this research also draws on the growing body of literature on Indigenous community resurgence. It is guided by the following question:

*How does the work of Indigenous-led health organizations, in the context of settler colonialism, bring together Indigenous rights and Indigenous community resurgence for Indigenous community members in urban areas?*

Discussions about how to improve Indigenous people’s experiences in health care rarely touch on Indigenous rights, in spite of the fundamental importance of rights to self-government and self-determination to the health of Indigenous individuals and communities (Greenwood, de Leeuw, Lindsay, & Reading, 2015). This study examines how discourses of rights, relationships, and resurgence come together in Indigenous-led health organizations.
Acknowledgments

This dissertation and the work it represents would not have been possible without the support, participation, hard work, encouragement, and time provided by many wonderful people.

First of all, I would like to extend my gratitude and appreciation for all those who gave of their time, ideas, and experiences by participating in this research. This work would not have been possible without you. Thank you for trusting me.

A huge thank you also goes to the members of my Community Advisory Group, past and present: Erin Anderlini, Bertha Cardinal, Lee Anne Deegan, Dr. Margo Greenwood, Dr. Ross Hoffman, Jane Inyallie, Murry Krause, David McAtackney, Sam Milligan, Louella Nome, Darius Pruss, and Leonard Ward. In particular, thank you to Erin for going above and beyond in terms of time, email contact, advice, and providing meeting space, office space, and involving me in community events. Also a special thank you to Ross for all the time you have given and for being an unwavering and honest mentor and friend. To Leonard – for all that you have taught me and continue to teach me, and for accepting me into your life as your little sister/friend. And to Bertha for your generosity, patience, and willingness to help. In addition, I would like to thank all of those who gave their advice and support informally, by making the time to meet with me and teach me, including Darlene McIntosh, June McMullen, Carlene Keddie, Ida Alleman, Dr. Annette Browne, Namaste Marsden, Nicole Cross, Travis Holyk, Antonia Mills, and Grace Rossetti, among others. A special thanks, also, to Barry Wong at UNBC Copy Services for always being willing to print materials at the last minute when I needed them!

This dissertation also would not have been possible without the guidance and support of my amazing supervisor, Dr. Kathi Wilson. Your endless patience, honest advice, constant availability, intelligence and empathy have helped to make this work what it is. You are so good at knowing when to push me and when to offer time and understanding, have weathered the ups and downs of this dissertation with patience and kindness, and always inspire me to new heights. You are an amazing mentor and I hope that we can continue to work together into the future!

A big thank you also to my wonderful committee members, Dr. Emily Gilbert and Dr. Alan Walks. You have been there since the beginning when the courses I took with you opened my eyes to new ways of thinking and inspired me to take critical approaches. Your insights, keen
observations, and critical eye have pushed me to make this work the best it can be. Thank you for always coming up with questions I couldn’t have anticipated and helping me to think about the work in constantly evolving, challenging, and inspiring ways. Thank you, also, to my final examination committee members – Dr. Sarah Wakefield, Dr. Vincent Kuui, and Dr. Neil Hanlon – for your insight, fairness, and challenging and useful discussion.

I am also grateful for the support of the Population Health Intervention Research Network, and the Social Sciences and Humanities Research Council (SSHRC) in providing doctoral research fellowships that supported me while undertaking the research for this dissertation; and for that of the Royal Canadian Geographical Society, the University of Toronto Mississauga, and the University of Toronto School of Graduate Studies for providing research travel and conference support, without which I would not have been able to be present in Prince George as often as I was.

To all of the friends who have helped me along the way in so many ways – by being there to watch Anthony, to provide a shoulder to cry on, to offer advice based on your own PhD experiences, to provide food and companionship – thank you. You are too many to name but you know who you are. My life and my work would not be the same without you.

Finally, a big thank you is due to my family, who have been through the ups and downs alongside me and who will be so happy to see this dissertation complete! To Anthony, who has grown with kindness, patience, and most of all, happiness, and who brings such light into our lives. To my parents and my parents in law, who are an unfailing source of unbelievable amounts of support and love, who encourage me to hope for justice and seek out knowledge, who have changed their lives and their plans at a moment’s notice to help us, and who are always proud of me. To my brother, my original inspiration to go into graduate studies, who has been pursuing a similar journey alongside me, and who is a constant source of inspiration and my lifelong friend. And to Brent, who has never once complained about taking up slack and making sacrifices so that I can pursue my goals, who is always there when I need emotional (or any other kind of) support, and who constantly inspires me to be a better person.

This dissertation is dedicated to Anthony, and Aurora, and Aunt Lani, and Leonard.
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Author Contributions

This dissertation is a collection of four related manuscripts, all of which have been, or will be, submitted to peer-reviewed journals for publication. The following gives details of the co-authors on three of these manuscripts, including their contributions to each chapter.

Chapter Three: Indigenous Health, Health Services, and Rights in the City (Co-Author: Kathi Wilson)

Kathi Wilson contributed intellectually, including assisting with the development of interview questions and contributing to the analysis, and assisted extensively with editing the chapter. I performed the main interview analysis and writing.

Chapter Four: Understanding Barriers to Health Care Access Through Cultural Safety and Ethical Space: Indigenous People’s Experiences in Prince George, Canada (Co-Author: Kathi Wilson)

Kathi Wilson contributed intellectually to the analysis, and assisted extensively with editing the chapter. In addition, she helped develop the interview questions and performed some validation of interview analyses. I performed the main interview analysis and writing.

Chapter Five: Indigenous health organizations, Indigenous community resurgence, and the reclamation of place in urban areas (Co-Author: Kathi Wilson)

Kathi Wilson contributed intellectually, including assisting with the development of interview questions and contributing to the analysis, and assisted extensively with editing the chapter. I performed the main interview analysis and writing.
Chapter 1
Dissertation Introduction

This dissertation examines the everyday experiences of Indigenous clients in health care settings in Prince George, British Columbia. Intent on investigating the connections between urban Indigenous peoples’ inherent rights and Indigenous peoples’ experiences accessing health care, it also draws on the growing body of literature on Indigenous community resurgence that is focused on the multi-scalar, everyday work of revitalizing and healing Indigenous communities in order to examine the processes of resurgence at work in urban Indigenous-led health organizations. Given the complex geographies and identities involved with invoking Indigenous rights in urban areas, as well as the ways in which Indigenous-led organizations provide community space that cuts across such geographies and identities, this dissertation aims to answer the following question:

*How does the work of Indigenous-led health organizations, in the context of settler colonialism, bring together Indigenous rights and Indigenous community resurgence for Indigenous community members in urban areas?*

It answers this overarching question through addressing three related sub-questions:

a) How do Indigenous rights to self-government and self-determination interact with Indigenous rights to health care in urban areas?

b) How does the settler colonial context in which health care is provided arise as a barrier to Indigenous people accessing health care services in urban areas?

c) What are the roles of Indigenous-led health organizations in fostering Indigenous community resurgence in urban areas?

These questions have grown from two major places. The first is a set of questions that arose while I was working on my Master of Arts thesis in Prince George, doing research in partnership with one Indigenous-led health organization. I recruited interview participants one day by walking out into the waiting room and asking if there was anyone there who would be interested in participating in an interview. As I spoke with people I was interested to learn that there were a few who came in who were not actually clients of that particular clinic. These people were there to see friends, to use the computer with Internet access or the telephone that were freely available
in the waiting room, or to have coffee, also free of charge. That the waiting room of a medical clinic – a clinic based in Indigenous values and Indigenous communities, but a medical clinic nonetheless – was perceived as a safe and welcoming space for community members to spend time in, intrigued me. What was it that this organization had been doing that made it a place where people wanted to spend their free time? How were they supporting the community in ways that went beyond the provision of health care services? It is the idea of a space in which everyone can feel safe and yet where everyone can still be welcome, that provides the motivation for the current research.

The other impetus for this research comes from the literature on Indigenous critical theory and in particular, Indigenous community resurgence (Byrd, 2011; Corntassel et al., 2018; A. Simpson, 2014; L. B. Simpson, 2011, 2017). Indigenous community resurgence as a concept will be described in more detail below; it refers to processes by which unequal relationships among Indigenous communities and nations and the settler colonial state can be balanced, through acts of taking back power on the part of Indigenous communities themselves. The concept of resurgence is often put forward in contrast to discourses of rights and recognition – discourses that scholars argue serve, in practice, to uphold the power of the state over Indigenous communities, livelihoods, and rights, rather than honouring the inherent rights of Indigenous peoples (Alfred & Corntassel, 2011; Coulthard, 2014). For Indigenous peoples in urban areas, for whom recourse to Indigenous rights through formal government processes is often not an option, this dissertation sets out to examine the ways in which Indigenous community resurgence, as an alternative framework, may be put to use, in particular within the settings of urban Indigenous-led health organizations. Indigenous community resurgence provides a lens through which to envision the achievement of some level of justice for people who have been denied it through the settler colonial maneuvering of the state. In spite of repeated calls for action (Royal Commission on Aboriginal Peoples, 1996; Truth and Reconciliation Commission of Canada, 2015), the federal government has to this point refused to take responsibility in a meaningful way for the well-being of Indigenous peoples living in cities. This dissertation seeks to understand the implications of this lack of action for urban Indigenous peoples in the context of health care services, as well as to look at some of the ways in which Indigenous community members are pursuing solutions to health and health care problems for urban Indigenous community members.
Indigenous peoples in Canada: identities and urbanization

1,673,780 people living in Canada identified as Indigenous in the 2016 Census, making up 4.9 percent of the overall Canadian population (Statistics Canada, 2017a). Referring to “Indigenous” people living in Canada is an inadequate, inaccurate, and misleading short form for all of the first peoples or original inhabitants of the land, who belong to a multitude of different bands, communities, councils, and nations. In Canada, “Indigenous peoples” speak over 70 different languages, from 12 distinct language families (Statistics Canada, 2017a). Federal definitions and Census counts do not begin to encompass the range, diversity, or likely even the correct numbers of people identifying as Indigenous in Canada, in particular when it comes to people living in cities (Rotondi et al., 2017; Toronto Well Living House, 2018). Many of those who identify as Indigenous reject the blood-quantum-based definitions of Indigeneity imposed by settler colonial governments, preferring to base Indigenous identity in Indigenous communities (Garroutte, 2003; Palmater, 2011). In recent years in Canada and beyond, ways of defining Indigenous identity have been complicated through high-profile, individual Indigenous identities, such as those of author Joseph Boyden or critical scholar Andrea Smith, being questioned (Andrew-Gee, 2017; Jaschik, 2015). This type of questioning has been happening since the 1970s, as growing recognition of Indigenous rights, and fascination with Indigenous healing and spirituality, have led some people to make claims of Indigenous identity motivated by a desire for belonging to Indigenous land and culture rather than based on family or community roots. Such identity claims have a problematic resonance with national narratives in Canada and the United States and other settler colonial countries, in which settlers appropriate Indigenous identity, place names, and symbols in order to assert belonging to place on Indigenous lands (Garroutte, 2003). Publicly questioning the authenticity of people’s claims to Indigenous identity, however, can also potentially undermine the legitimacy and rights of Indigenous nations, since government policy in Canada and the United States with respect to Indigenous peoples involves complex ways of restricting the numbers of people who can be legally considered Indigenous (Bruyneel, 2007b; Lawrence, 2003).

This dissertation does not seek to intervene into specific definitions of Indigenous identity; yet it is necessary to acknowledge the tensions involved in such definitions and the complex ways in which identities are tied to geographies and communities, or restricted with respect to rights and services. With this in mind, the dissertation makes use of Census numbers and proportions when
discussing Indigenous peoples’ relationships with the geographies of Canada, and uses self-identification on the part of participants to define who among them are Indigenous. This is done for practical reasons – in terms of the Census, this is information that is publicly and readily available about Indigenous populations in Canada, and in terms of the self-identification of participants, this is a way of acknowledging that it is not the place of a settler researcher to question Indigenous identity when it is self-proclaimed, nor to seek recourse to other means of identification which could be even more problematic. In spite of the high-profile and problematic cases of self-identification referred to above, self-identification combined with community recognition remain the most commonly accepted means of determining Indigenous identity internationally (Fraser, 2009; Palmater, 2011).

In Canada, as in much of the Americas and other settler colonial countries, there exists a settler narrative that places Indigenous peoples in rural and remote wilderness areas and outside of cities, in spite of the high proportion of Indigenous people living in urban areas – in Canada, currently about 52 percent (Statistics Canada, 2017a). Discourse placing Indigenous people outside of cities is reinforced by Canada’s system of reserves and legislation relating to the administration and governance of reserves. Reserves, developed in part through historical treaty-making and the imposition of the Indian Act, are small parcels of land held in trust by the Crown for the use of Indigenous groups. The federal government distinguishes between those Indigenous people eligible for registration under the Indian Act, also referred to as “status” First Nations people, and all other Indigenous peoples who are called “non-status.” Only status First Nations, who comprise about 45 percent of the Indigenous population in Canada, are deemed eligible by the government to live on reserves and receive federal services, including health services (Government of Canada, 1985; Laliberte, R.; Settee, P.; Waldram, J.B.; Innes, R.; Macdougall, B.; McBain, L.; Barron, 2000; Lavoie, Forget, & Browne, 2010). Although there are some urban reserves, for the most part reserve land is located in rural and remote areas in Canada (Peters, 2007).

Due to the persistence of the above narrative as well as legislation designed to enforce it, urban Indigenous experiences continue to be underrepresented in both research and policy (Place, 2012; K. Wilson & Young, 2008). This narrative associating Indigenous peoples with the wilderness, combined with the location of most reserves – the only Indigenous lands consistently recognized in Canadian legislation – outside of urban areas, performs the function of making
urban, cultivated, and densely populated areas seem to be the domain of settlers and non-Indigenous peoples. Indigenous assertions of intimate cultural, political, and spiritual relationships with land are often misunderstood and appropriated in service of the Indigenous-wilderness narrative, and enactments of racism, exclusion, and discrimination in housing, employment, and service provision serve to further alienate Indigenous people from urban environments (The Environics Institute, 2010a).

Legislation exacerbates the discursive exclusion of Indigenous peoples from urban space, as many Indigenous people lose access to special status, rights, and benefits associated with being Indigenous as soon as they move off-reserve (Snyder, Wilson, & Whitford, 2015). For example, in the decades leading up to 1985, Indigenous women with status under the Indian Act who married non-status men lost their status completely, along with their entitlement to live on reserve. This led to a substantial growth in urban Indigenous populations, especially among Indigenous women and their families, although these women were no longer recognized legally as being Indigenous. Recent bills designed to correct this gender imbalance in the Indian Act have only partially, and temporarily, resolved the problem, by re-instating status for women who lost it and their descendants. These descendants can lose status again if two successive generations of women marry non-status men (Lawrence, 2003; Palmater, 2011). Still, a large number of Indigenous people living in urban areas have been able to reclaim a legal Indigenous identity in recent years, both through the reinstatement of status as well as increasing numbers of people feeling empowered to embrace Indigenous identity (Hanselmann, 2001; Norris & Clatworthy, 2003). This reclaiming of identity, combined with increased movement to cities and the overall growth of Indigenous populations, has resulted in over 50 percent of Indigenous individuals in Canada living in urban areas since 2006 (Aboriginal Affairs and Northern Development Canada, 2014; Statistics Canada, 2017a), yet the increase in urban Indigenous populations has not been adequately or appropriately acknowledged in research and policy.

**Indigenous health and health care**

In Canada, responsibility for health care services is governed by the federal Canada Health Act, but services themselves are designed and delivered by provincial and territorial governments using funding allocated by the federal government (Government of Canada, 1985a). Jurisdiction over health care is particularly complex for Indigenous people, due to the complicated ways in
which the special relationships that Indigenous peoples have with the Crown (and now, the federal government) have been interpreted.

Federal responsibility for Indigenous health services stems from the Constitution Act, and from historical and contemporary treaty agreements made in various areas of what is now Canada (Boyer, 2003). Treaties, broadly, are agreements for sharing land in exchange for certain benefits and entitlements, including ensuring the well-being of Indigenous nations (Lavoie, Forget, & Browne, 2010). Section 91.24 of the Constitution Act gives the federal government legislative authority over “Indians, and lands reserved for Indians” (Government of Canada, 1982). The federal government, however, interprets this responsibility only in its narrowest sense, as applying to people registered under the Indian Act, living on reserve, even in spite of a recent court ruling, known as the Daniels decision, that declared federal responsibility towards all Indigenous peoples (Macdougall, 2016).

Indigenous people living off reserve, including in urban areas, regardless of status, use provincial or territorial health services because special rights and benefits associated with status do not generally apply in the city (the one exception being Non-Insured Health Benefits, under which status First Nations people living off-reserve have access to coverage for certain prescription medications, vision and dental care, and medical travel costs). The provinces and territories do not have the same constitutional responsibilities with respect to Indigenous peoples that the federal government has, so although some Indigenous-focused policy and services exist at the provincial and territorial level, they tend to be uneven in scope and inconsistently offered (Lavoie, Gervais, Toner, Bergeron, & Unite de sante publique des Autochtones, 2008; Snyder et al., 2015). This is significant because Indigenous people using provincial or territorial services consistently report negative experiences in health care, related to both discrimination based on Indigenous identity as well as links to historical mistreatment in institutional settings such as residential schools or Indian hospitals (Browne, 2017a; Goodman et al., 2017; Hole et al., 2015; Meijer Drees, 2013).

In practice, the federal-provincial division of responsibility over health care services for Indigenous people leaves gaps where it is not clear which government should have jurisdictional authority. Across Canada, Indigenous-led health services have been developed to fill some of these gaps, both on- and off-reserve. On-reserve, the federal Health Transfer Policy provides
funding to individual First Nations communities to take on the design and delivery of their own health services. There are a range of different agreements that can be made, with varying divisions of responsibility, depending on what the community wants and negotiates with the government (Government of Canada, 2004; Lavoie et al., 2005). In British Columbia, since 2013 the First Nations Health Authority has taken over formerly federal responsibilities for on-reserve health care, and is updating services and connecting with communities to ensure culturally appropriate, responsive, and responsible care and services (First Nations Health Authority, 2017).

In urban areas, health transfer agreements do not apply, federal health services are not available, and Indigenous people often experience discrimination in provincial health care services (The Environics Institute, 2010a). Not-for-profit organizations led by Indigenous people and communities have been created, sometimes under umbrella programs from government such as the federal Urban Aboriginal Strategy or Ontario’s Aboriginal Healing and Wellness Strategy (Indigenous and Northern Affairs Canada, 2016; Ontario Ministry of Community and Social Services, 2016), and sometimes through grassroots community movements on the part of urban Indigenous communities, in order to try to address some of these problems for Indigenous people in cities. Beginning with Aboriginal Friendship Centres, the first of which appeared in Winnipeg in the 1950s, Indigenous-led organizations have seen an increase in both numbers and influence since the 1980s (Lavoie, 2014; National Association of Friendship Centres, 2012). Indigenous-led health organizations generally receive funding from federal or provincial governments or health authorities (Varcoe, Browne, & Einboden, 2014a). Such services are still unevenly offered, as the existence of a not-for-profit Indigenous health organization depends on community capacity to provide staff and support and to secure funding. Still, these organizations can be found in almost every city in Canada and have been the focus of research worldwide (Harfield et al., 2015; Lemchuk-Favel & Jock, 2004). These organizations are generally governed by Indigenous community members; have very high levels of community engagement; base their services and mandates in Indigenous knowledge and practices; and offer services that are open to all regardless of Indigenous identity (Davy, Harfield, McArthur, Munn, & Brown, 2016; Lavoie et al., 2015; Lemchuk-Favel & Jock, 2004).

This study examines Indigenous people’s relationships with urban Indigenous health organizations, in terms of how these organizations impact people’s health care experiences; how
they provide support for Indigenous peoples’ rights, and how they contribute to Indigenous community resurgence. The following section discusses Indigenous rights in Canada and how they relate to health and to the concept of Indigenous community resurgence.

**Indigenous rights and resurgence in Canada**

Indigenous health and Indigenous rights in Canada are linked in complex ways. As mentioned above, the federal government has responsibilities with respect to Indigenous peoples’ health and well-being through treaties as well as the *Constitution Act* (Boyer, 2003; Government of Canada, 1982). In addition, the recommendations of national commissions such as the Royal Commission on Aboriginal Peoples (1996) and the Truth and Reconciliation Commission of Canada (2015), as well as international declarations such as the United Nations Declaration of the Rights of Indigenous Peoples (2008), draw attention to the important roles of Indigenous rights to health care and to self-government in improving the health of Indigenous peoples. Scholars working in Indigenous health agree that acknowledging the inherent rights of Indigenous peoples to self-government and self-determination are the best ways to improve the health of Indigenous peoples, in Canada and elsewhere in the world (Czyzewski, 2011; Maxwell, 2011b). The right of Indigenous peoples to self-government, or the means to enact and enforce laws and make decisions without the interference of another nation or state, is recognized by the Canadian government in policy, although in a very limited way (Borrows, 2002; Government of Canada, 2010). Self-determination is a broader concept than self-government. The right to self-determination is understood as an inherent right of Indigenous peoples, as the original inhabitants of land now held under the structures of settler colonialism, to not only make decisions and govern themselves, but also to re-structure relationships of power with respect to the settler colonial state (Walker, 2006a). The interactions between rights and health in this instance can be understood through the framework of the social determinants of health, in which colonialism, which limits the exercise of Indigenous peoples’ inherent rights to self-government and self-determination, is recognized as a structural determinant of Indigenous peoples’ health, having impacts that reach into many aspects of Indigenous communities and everyday lives (Greenwood, de Leeuw, Lindsay, & Reading, 2015; Loppie Reading & Wein, 2009).

One problem with Indigenous rights is that they are often not recognized as inherent; instead, they are portrayed as a position that (some) Indigenous peoples may hold with respect to the
Canadian state (Government of Canada, 2010; Senese & Wilson, 2013a). This places the state in charge of defining both what the rights involve, and who is entitled to them, creating a system in which the state retains power and control over the process of recognizing and implementing Indigenous peoples’ rights (Coulthard, 2014). In turn, this means that the state can limit the extent of such rights in whatever way it deems to serve its own interests; for example by limiting eligibility to rights to only certain populations and geographic spaces such as First Nations living on reserve, in spite of the fact that the court has recognized this to be in violation of the federal government’s constitutional responsibilities towards all Indigenous peoples, including non-status First Nations, Inuit, and Métis (Macdougall, 2016). Through such processes of limitation, the legal and political discourses created by the state in apparent recognition of Indigenous peoples’ rights, function instead to limit the potential of Indigenous peoples to retain Indigenous identity, practice, and autonomy. Indigenous scholars Alfred and Corntassel describe the results of this process in the context of identity, values, and practices, which then become tied to rights:

[The] political-legal compartmentalization of community values often leads Indigenous nations to mimic the practices of dominant non-Indigenous legal-political institutions and adhere to state-sanctioned definitions of Indigenous identity. (2011, p. 600)

That is, in spite of the seeming promise of state recognition of Indigenous legal rights, the structures of the colonial state actually use this promise to their own advantage, appearing to be granting Indigenous autonomy while retaining ultimate control over communities and nations (Borrows, 2002; Coulthard, 2014). As Borrows (2002) points out, federal government policy purports to recognize the inherent rights of Indigenous communities to self-government, but in practice recognizes only the right of Indigenous communities to have authoritative power over practices deemed “inherent” to an Indigenous group, that can be shown to have continuity with practices existing within that group before contact with Europeans (Government of Canada, 2010). As Borrows argues, this eliminates consideration of any practices that have developed over the past several centuries, taking many adaptive and survival-based practices out of the realm of Indigenous self-government, and effectively limiting the potential for Indigenous cultural and physical survival (Borrows, 2002). The concept of Indigenous community resurgence has grown from these types of critiques, recognizing that the ultimate result of the circumscribed rights offered by the federal government is far from Indigenous self-determination and can in fact result in lessened potential for Indigenous survival. Resurgence also stems from
the knowledge that Indigenous communities do not need recognition from the Canadian
government in order to exercise authority over their own affairs.

As an alternative to state recognition – a framework of limited utility in terms of re-placing
power and control in the hands of Indigenous communities – Indigenous community resurgence
involves “being Indigenous” as a conscious, political act. That is, Indigenous community
resurgence involves refusing to compartmentalize Indigenous identity or entitlement to rights
and resources according to government policy, instead using Indigenous legal and political
institutions as the basis for identification of both peoples and rights (Alfred & Corntassel, 2011;
resurgence is rooted in Indigenous experiences and communities:

> It is ultimately our lived collective and individual experiences as Indigenous peoples that
yield the clearest and most useful insights for establishing culturally sound strategies to
resist colonialism and regenerate our communities. (2011, p. 601)

Audra Simpson (2014) draws out the concept of “refusal” as a rejection of state-sanctioned gifts
such as the offers of rights or citizenship in her study of Mohawk sovereignty, pointing out that
what can seem like a gift often ends up entrenching state control (see also Bruyneel, 2007a).
Garoutte calls the practice of turning to Indigenous sources of knowledge and authority “radical
Indigenism” (2003). The term “resurgence” is also used in reference to Indigenous legal rights –
as in, the resurgence of Indigenous law. Borrows (2002) writes about the resurgence of
Indigenous law in response to the colonial foundations of Canada’s assertions of sovereignty. He
argues that placing Indigenous legal traditions on an equal footing with Canadian law would
honour the spirit of the original relationships between Indigenous peoples and settlers, and align
with the fundamental concepts of inherent Indigenous rights enshrined in the Canadian
constitution (Borrows, 2002).

The aim of practices of resurgence, in putting authority and control back into the hands of
Indigenous communities, is not to absolve the Canadian government of responsibility for living
up to its promises to provide support to Indigenous communities in perpetuity, in exchange for
its occupancy of the many Indigenous territories that now make up the land base claimed by
Canada. Rather, instead of taking on this responsibility as a burden that stems from the good will
of the Canadian government, the obligation through treaty promises and other negotiations needs
to be recognized, and support should be provided as from one nation to another, rather than positioning Indigenous peoples as dependents of the state. This would differ from the limited rights to self-government criticized by Borrows (2002) and others (Coulthard, 2014; A. Simpson, 2014) in that the rights to be recognized would be the rights of sovereign nations to govern their own affairs, taking away the federal government’s right to have the final say in terms of legal and other jurisdiction. The way in which the government of Canada deals with Indigenous rights in practice – by making them into a set of specific services and benefits proffered to individuals based on their “status” and on where they live – misreads the scale of Indigenous rights. That is, rather than dealing with rights on a nation to nation basis, rights are narrowed to the individual level, making some Indigenous individuals eligible for benefits and others not, and creating divisions within Indigenous nations, communities, and even families. Indigenous resurgence then draws attention to the misrepresentation inherent in the currently existing governmental frameworks of Indigenous rights and recognition by emphasizing the collective rights and abilities of Indigenous communities and nations to govern themselves on their own terms, and by rejecting the divisions imposed on Indigenous communities, in response emphasizing the importance of unity and relationship-building.

Drawing on Fanon (1963), Alfred and Corntassel emphasize the importance of unity for Indigenous communities in the face of colonialism’s divisions of communities and the colonial emphasis on “individualism and predatory capitalism” (2011, p. 603). As they put it, “large-scale Indigenous efforts to confront state power by mimicking state institutions (via land claims and self-government processes) only deepen these divisions” (Alfred & Corntassel, 2011, p. 603). They also emphasize the sacred significance of relationships within Indigenous identity, Indigenous resurgence, and Indigenous law:

We consider relationships (or kinship networks) to be at the core of an authentic Indigenous identity. Clearly, it is the need to maintain respectful relationships that guides all interactions and experiences with community, clans, families, individuals, homelands, plants, animals etc. in the Indigenous cultural ideal. (2011, p. 609)

This concept of relationship is important in healing the divisions and disruptions of relationships brought on by the years of colonialism. In urban contexts, where placing sovereignty in the hands of an already-existing Indigenous governing body or nation may not be possible,
relationships can be an important way of moving forward with concepts of self-government or resurgence. Leanne Betasamosake Simpson draws attention to Anishinaabe internationalism as a form of treaty-making, not between Indigenous peoples and the federal government but as a long-standing practice among Indigenous peoples and between human and animal nations (2017). The Royal Commission on Aboriginal Peoples (1996) long ago proposed the concept of “communities of interest” as a way of articulating the relationships formed among Indigenous peoples from diverse nations in urban areas and bringing them together for the purpose of self-government. Different forms of relationships exist in urban areas, and attention to these is important in understanding processes of Indigenous community resurgence, if considerations of urban processes of self-government are to be seriously undertaken.

Urban Indigenous-led health organizations have a role to play in processes of Indigenous community resurgence as well as, potentially, in urban Indigenous self-government (Lavoie et al., 2015; Walker, 2006b). Although Indigenous-led health organizations are institutions that mimic those of the state and the non-Indigenous not-for-profit sector in the provision of health and social services, they do not perpetuate the same divisions among Indigenous peoples. Being open to people of all backgrounds (Indigenous or not), and retaining the ability to provide services beyond the model of strict hierarchical bureaucracy exemplified in many non-Indigenous-led health care organizations means that Indigenous-led health organizations are able to create different types of spaces in urban areas that are more responsive to Indigenous community needs, practices, and forms of healing; possibly even forms of governance (Davy, Harfield, et al., 2016; Lavoie et al., 2015; Lemchuk-Favel & Jock, 2004).

**Rationale for this study**

This dissertation focuses on health care, because health care is so infused with hierarchies of power and vulnerability. Because of the ways in which these hierarchies and structures of power impact Indigenous people, health care is the site of much work and activism to bring awareness of these hierarchies to the forefront, for example through cultural safety training or through the implementation of Indigenous-led health care organizations. Those structures of power embedded in health care institutions are also, for Indigenous people, linked to settler colonialism, which is why it is important to bring discussions of Indigenous rights into health care settings.
In the narratives that Indigenous people tell about negative experiences in health care settings or discrimination in the city, or about the care and comfort they receive in Indigenous-focused settings (Browne et al., 2011a; Kurtz, Nyberg, Van Den Tillaart, Mills, & The Okanagan Urban Aboriginal Health Research Collective, 2008), there is an underlying story about the structures of colonialism that have damaged relationships and detached Indigenous peoples from the places and land that now constitute cities in Canada. In response, this study examines what people might be able to accomplish – or are already accomplishing – on an everyday basis with respect to reimagining the spaces of the city. While in the interim this may be simply a way of making the structures of colonialism in urban areas more tolerable for Indigenous individuals, this work of making space also holds the potential, through concepts of resurgence, to reshape both the concept and the experience of urban health services – and, maybe one day, the city itself.

This research takes place in Prince George, British Columbia (BC), Canada – a small city that, due to its remote location relative to other large cities (just under 800 kilometres north of Vancouver and 740 kilometres west of Edmonton), functions as the main urban centre for most communities in northern BC. Prince George was chosen as a research site for two main reasons. First, the network of Indigenous-led health organizations is strong in Prince George due to the high proportion of Indigenous people living in the city (almost 15 percent (Statistics Canada, 2017a)) as well as in communities surrounding it. These organizations are often on the cutting edge in terms of how to provide health services based in Indigenous values, and work together quite closely in spite of representing a great diversity of Indigenous nations (approximately 54 First Nations are served by the Northern Health Authority in Prince George). For example, a number of Indigenous-led health and other social service organizations recently collaborated with a doctoral student at the University of British Columbia to create a research protocol to screen researchers looking to partner with them (Dingwall et al., 2016).

Second, this researcher’s personal and professional connections in Prince George are strong. I completed a Master’s degree in the city, during which I partnered with one major Indigenous-led health organization and came to know people working in others. I thus had a strong sense of the range and scope of Indigenous-led health organizations prior to beginning this study, as well as several contacts through which to form a community advisory group to help guide the research. Knowing the city in general has also proven valuable to this study, as I was able to understand
participants’ references to various health and other services around the city as well as have a sense of common ground with participants.

Contributions to the literature

This study focuses on urban Indigenous peoples, a population still underrepresented in research as well as policy in Canada. Discussions of Indigenous rights – in spite of calls to the contrary dating back to the report of the Royal Commission on Aboriginal Peoples in 1996 – continue to exclude urban Indigenous peoples (Government of Canada, 2010; Royal Commission on Aboriginal Peoples, 1996). In health care settings, the settler colonial context of Indigenous people’s negative experiences is not generally brought fully into account (Browne, 2017a). In addition, discussions about how to improve Indigenous people’s experiences in health care rarely touch on Indigenous rights, in spite of the fundamental importance of rights to self-government and self-determination to the health of Indigenous individuals and communities (Greenwood et al., 2015). Although a great deal of work has been put into recognizing power hierarchies and their role in creating differential access to health care for Indigenous peoples, especially in the area of cultural safety, the literature on this topic generally stops short of recognizing the importance of inherent rights, including to self-determination, for Indigenous peoples’ health. Cultural safety, for example, is the subject of a large body of literature examining the assumptions and practices of health care providers (Indigenous or non-Indigenous) in encounters with Indigenous clients (Baba, 2013; Kirmayer, 2013; Richardson, Yarwood, & Richardson, 2017). Cultural safety aims to make the health care encounter a more comfortable one, particularly for Indigenous clients, through a process of self-reflection and education on the part of the health care provider about local Indigenous histories as well as about the culture of the health care institution itself and how it reinforces power differences between client and provider that can be exacerbated by colonial relationships. Cultural safety as a framework does not, however, include possibilities for broader solutions to colonialism in the form of Indigenous control over health care services as well as Indigenous self-government and self-determination more generally. While contributing to self-government and self-determination is beyond the scope of this dissertation, this research argues that it is necessary to take into account the concepts and discourses around rights to self-government and self-determination, specifically in the realm of health care, in order to improve the health of Indigenous communities in Canada (Browne, 2017a).
The participants in this study come from a range of different Indigenous nations as well as life situations and socioeconomic positions. Those urban Indigenous people who are most often represented in research, and in Indigenous-led health care services, tend to be those most in need: people with insecure housing, low to non-existent incomes, and often, substance use problems (Evans, White, & Berg, 2014; Goodman et al., 2017). While it is important to gear services towards those who need them most – and it makes sense for research to follow suit in order to determine need – it is also important to make visible those Indigenous people living in cities who are healthy, stable, and financially successful. To do otherwise is to potentially contribute to stereotypes about urban Indigenous people as poorly equipped to cope with life in the city, when in fact many people fare extremely well. A small body of work on the Indigenous middle class contributes to this (Fitzmaurice, 2012; Wotherspoon, 2003), and strategies were used in the recruitment for this study in order to include the socio-economic diversity of Indigenous people living in Prince George (see Chapter Two).

This study aims to examine how discourses of rights, relationships, and resurgence come together in Indigenous-led health organizations. It takes as a starting point the idea that closing the gaps in health outcomes between Indigenous and non-Indigenous populations requires simultaneously closing the gaps created in Indigenous peoples’ lives by colonial structures, institutions, policies and behaviours. In the process, it also endeavours to focus on the already-existing strengths in urban Indigenous communities, by highlighting the work of Indigenous community resurgence that is already under way.

Structure of the dissertation

This dissertation has been written as a series of three stand-alone manuscripts, one of which has been submitted for publication in a peer-reviewed journal, as follows:


The content of each of the following chapters is summarized here:

**Chapter 2: Methodology and Methods**
This chapter describes the relationship-based approach taken to the research involved in this study; one that draws on Indigenous research principles, decolonizing methodologies, and principles and techniques from community-based research. It also outlines the qualitative methods used, specifically semi-structured interviews and focus groups undertaken with Indigenous health service users and health services workers who work with Indigenous clients, and the urban-focused study setting of Prince George, BC. In accordance with Indigenous and decolonizing methodologies, this chapter also positions the researcher with respect to the participants, the study setting, and the research itself, outlining in particular the questions that arise when a settler researcher undertakes research with Indigenous communities, as well as some of the strategies undertaken to deal with these questions and lessons learned in the course of doing the research.

Chapter 3: Indigenous Health, Health Services, and Rights in the City

This chapter engages with the fact that there are gaps between the health of Indigenous peoples in Canada and that of the general population, as well as the fact that the origin of these gaps can be traced to Canada’s settler colonial context and the resulting treatment of Indigenous individuals, communities, and nations. It elaborates on Indigenous rights to health care as well as to self-government or self-determination, in the context of health care, from the perspectives of people using and working in health care settings. It uses an analysis of interviews and focus groups with 50 Indigenous community members and 15 health services workers on the topic of rights, as understood within the context of interactions with various health care institutions and settings, to understand how rights are seen as fitting into health care. Three main findings emerge: violations of rights in health care settings; strategies for supporting peoples’ rights; and inconsistencies regarding entitlement to rights. In discussing these topics, participants more clearly emphasized human rights – including dignity, equal treatment, and the right to help when it is needed – than Indigenous rights to self-determination. In addition, participants pointed to the complex geography- and identity-based nature of rights, especially when it comes to health-related services and benefits for Indigenous people. This suggests that Indigenous rights in a legal sense are not perceived as coming into play in health care settings, and that the fundamental connection between Indigenous rights to self-determination and health is not being made within
health care settings on an everyday level. Actions taken to improve health care services for Indigenous people, in light of colonial legacies, must be complemented by attention to Indigenous legal and inherent rights to self-government and self-determination, in the pursuit of health equity for Indigenous peoples in Canada.

Chapter 4: Understanding Barriers to Health Care Access Through Cultural Safety and Ethical Space: Indigenous People’s Experiences in Prince George, Canada

This chapter highlights problems of access to health care for Indigenous people in Prince George in the context of settler colonialism, arguing that the barriers Indigenous peoples experience in accessing health care are not fully comprehensible without bringing settler colonialism into the analysis. It situates this argument with respect to the complex ways in which access to health care and benefits changes based on both identity and geography for Indigenous people living in urban areas in Canada. It then analyzes the results of interviews and focus groups with 50 Indigenous health services users and 15 people working in health care using the lenses of cultural safety and ethical space, to understand the barriers to accessing health care that Indigenous people face in light of settler colonialism. Substandard quality of care, long wait times, and experiences of racism and discrimination are the most frequently reported barriers to accessing health services. These barriers, when analyzed using cultural safety and ethical space, reveal the ways in which settler colonialism creates distance between health care providers and Indigenous clients, and borders around the spaces of health care that are experienced as exclusionary for Indigenous clients. They also highlight the moral responsibilities that health care providers, institutions, and governments hold with respect to preserving the well-being of Indigenous clients. These results also highlight an urgent need to redefine health care policy in Canada to take better account of Indigenous peoples’ particular needs and experiences in health care, especially in the city. Cultural safety and ethical space allow for the ways in which settler colonialism embeds itself in health care institutions to become more visible as a structural problem as well as an individual-level problem.

Chapter 5: Indigenous health organizations, Indigenous community resurgence, and the reclamation of place in urban areas

This chapter engages with the work of urban Indigenous-led health organizations through the lens of Indigenous community resurgence. It aims to investigate the particular approaches to
service provision taken by these organizations, through the perspectives of 50 Indigenous community members and 15 health services workers, many of whom but not all use the services of or work in Indigenous-led health care settings. Findings show that Indigenous-led health organizations are perceived to take three particular approaches in the delivery of services: prioritizing client-centred care; creating safe spaces; and advocating on behalf of clients to the wider community. These findings highlight a focus on relationships, a key element in the work of Indigenous community resurgence. The place-making work of these organizations happens through placing a priority on relationships with clients as well as larger communities in the urban area and beyond. This work resonates with Indigenous theories of place, and contributes to feelings of community and belonging for Indigenous community members through a mechanism of resurgence that takes place on an everyday basis.

Chapter 6: Conclusions

This chapter provides an overview of the empirical results, theoretical findings, and policy implications of this dissertation, situates the dissertation within the discipline of health geography, and points towards future research directions.
Chapter 2
Indigenous and Decolonizing Approaches to Research

This chapter begins with an outline of the methodological principles used in the research undertaken for this dissertation. It gives an overview of those principles from Indigenous and decolonizing research methodologies that are most relevant to this particular research, including why decolonizing methods are needed; how decolonizing methodologies are different from decolonization itself; how these research methodologies are informed by Indigenous community resurgence; and relational paradigms in Indigenous research. It then describes the specific methods used in this research, including how these methodological principles from Indigenous and decolonizing research were put into practice. It closes with a statement on positionality that situates the non-Indigenous researcher with respect to this research, the community in which the research was undertaken, and Indigenous and decolonizing methodologies.

Methodology

Research in Indigenous communities

The methodology chosen for this research is grounded in the principles of Indigenous research and decolonizing research. Indigenous research is research whose principles and methods are drawn from the ontologies and epistemologies of Indigenous communities; Indigenous methodologies are thus often specific to a particular Indigenous group or nation (Kovach, 2009; S. Wilson, 2008). Indigenous research involves a decentring of colonial knowledge systems that is similar to the purpose of decolonizing research. Decolonizing research refers to “those methodologies that actively work to deconstruct colonizing practices while endeavoring to advance Indigenous self-determination” (Stanton, 2014, p. 573). While Indigenous research and decolonizing research are not the same thing, they share many similarities, such as having the purpose of working with (as opposed to conducting research on) Indigenous communities in a balanced and respectful manner, whose outcomes will be of some benefit to the communities involved (Mertens, Cram, & Chilisa, 2013; L. T. Smith, 1999).

Indigenous research is based on the premise that, as Anishinaabe scholar McGregor and colleagues point out, “Indigenous people have always been engaged in research processes as part of their ethical ‘responsibility to keep the land alive’” (McGregor, Bayha, & Simmons, 2010, p.
Indigenous communities have always practiced research, in the sense of systematic observation and theoretical development, especially related to the natural world. Such research has always had a strong ethical component in terms of the responsibilities held by those doing research and holding knowledge towards the subjects of research – including, or perhaps especially, the non-human parts of the world (Cram, Chilisa, & Mertens, 2013; McGregor et al., 2010). Indigenous research reflects an acknowledgement of this and a continuation of such traditions.

However, non-Indigenous forms of research, in the sense of information-gathering projects conducted under the auspices of the academy, have long played a role in the surveillance and oppression of Indigenous communities around the world (Mahuika, 2008; L. T. Smith, 1999). This has led to the development of decolonizing methods in research, which are intended to counteract the oppressive effects of research practices rooted in colonial knowledge systems. Decolonizing research methodologies have grown from early work in post-colonial theory and critical race theory as well as decolonization and nationalist movements in Africa and Asia, and have been developed in a wide variety of colonial, post-colonial, and settler colonial contexts around the world (Denzin, Lincoln, & Smith, 2016a; Duara, 2003; Fanon, 1963; Weiner, 2018). Decolonizing methodologies draw attention to the colonial basis of all research, not only research conducted in or related to Indigenous communities (Hodge, 2017), although this colonial foundation tends to be most visible in research focused on Indigenous lives and communities (Beeman-Cadwallader, Quigley, & Yazzie-Mintz, 2012; Stanton, 2014). Frequently employed in the service of colonization, research has created and circulated negative images of Indigenous peoples that are reflected back to the populace in colonizing countries to justify colonial projects (Mertens et al., 2013; L. T. Smith, 1999), or served to justify medical interventions, the relocation of Indigenous communities, and other means by which Indigenous peoples are dispossessed of, and disconnected from, land (Healey, 2016; Lux, 2012; Meijer Drees, 2013). Research has frequently been conducted without the proper informed consent of the Indigenous communities or individuals involved, and the products of research have frequently been published and disseminated without the knowledge of Indigenous participants. The practice of a researcher from outside of a community entering a community setting, gathering information, and then leaving, never to be heard from again, has led to great concern among Indigenous communities over the ways in which this kind of “helicopter” research
removes not only knowledge, but power from communities (Castleden, Morgan, & Lamb, 2012; L. T. Smith, 1999; Struthers, 1999). Decolonizing research strategies, like Indigenous research, have been employed in Indigenous contexts in order to re-centre the knowledge and power of, and in, Indigenous communities. This dissertation draws primarily from the methodologies of decolonizing research, in two main ways. One way in which it adheres to these methodologies is through using community-based methods; the other is by engaging with theories and principles drawn from Indigenous research. Because of the researcher’s position as a non-Indigenous researcher, it is not appropriate to refer to this dissertation as involving Indigenous research. Rather, this dissertation engages with the work of scholars in Indigenous research in order to align better with decolonizing methodologies and to work towards the overarching goal of re-centring Indigenous knowledge in, and control over, the research.

Indigenous communities in Canada and elsewhere in the world have re-asserted authority over the research process in a variety of ways. In Canada, the principles of Ownership, Control, Access, and Possession (OCAP) – which assert that research data drawn from or produced with Indigenous communities must be accessible to, and governed by Indigenous communities – are now generally accepted guidelines that must be followed in any type of research with Indigenous communities (Schnarch, 2004). The concept of Free, Prior, and Informed Consent (FPIC), which asserts that Indigenous communities must have the final say in whether or not research involving them will go ahead, has also been emphasized as central in research involving Indigenous peoples (Pimbert, 2012; Swiderska et al., 2012). In addition, many individual Indigenous communities and organizations have developed their own research ethics protocols that a researcher wishing to work with them must apply to, and adhere to, in addition to university-based research ethics board requirements (Dingwall et al., 2016; Maar, Sutherland, & McGregor, 2007). The ways in which these guidelines have been applied in the current research are discussed below.

Research with Indigenous communities thus comes with a high degree of responsibility for all researchers, but especially on the part of non-Indigenous researchers. This responsibility includes being aware of the history of research in specific Indigenous communities, as well as in Indigenous communities more generally, and how research processes continue to pose a threat to the integrity of Indigenous communities and Indigenous sovereignty over knowledge (Hornung, 2013). It also includes responsibility towards those who are involved in the research as well as
the broader community. Cree researcher Cora Weber-Pillwax notes two primary areas of responsibility in Indigenous research:

1. The researcher is accountable for the effects of the research project on the lives of the participants; and

2. The purpose of research is to benefit the community and the people of the community. (Weber-Pillwax, 2004, p. 80)

Morton Ninomiya and Pollock (2017) elaborate on the goals shared by various Indigenous or decolonizing research approaches, writing that these:

Share overlapping commitments urging researchers to build authentic relationships, take risks to push mainstream academic boundaries, foster openness to different ways of doing research, practice humility, and integrate Indigenous ways of knowing into research. (p. 32)

Colonialism, and research informed by colonial paradigms, have caused harm to Indigenous communities for centuries. Indigenous and decolonizing research approaches place responsibility on the researcher to conduct research that benefits participants or communities rather than harming them. Māori scholar Linda Tuhiwai Smith points to the type of care that must be taken throughout the process of doing research, in order to avoid perpetuating the harms of colonialism:

The methodologies and methods of research, the theories that inform them, the questions which they generate and the writing styles they employ, all become significant acts which need to be considered carefully and critically before being applied. In other words, they need to be ‘decolonized.’ (L. T. Smith, 1999, p. 39)

Thus, a decolonizing approach to research must take into account the potential for harm at all stages of the research, and look for ways to reduce this potential, avoid causing harm, and find ways for the research to bring benefits to Indigenous communities.
Decolonizing research

It is important to have a clear sense of what ‘decolonizing’ research means in practice. As Tuck and Yang (2012) point out, decolonization as a term can be easily overused in social justice research, and it is important not to lose sight of what it actually means – that is, decolonization of land and place. As the authors put it, “decolonization brings about the repatriation of Indigenous land and life; it is not a metaphor for other things we want to do to improve our societies and schools” (Tuck & Yang, 2012). These authors express concern over the ways in which decolonization can become an “empty signifier” that enables settlers to avoid or escape their own complicity in settler colonialism. This can happen when any of a number of “track[s] towards liberation” are taken to be forms of decolonization even though they do not lead to the repatriation of land (Tuck & Yang, 2012). Sustained attention to decolonization as the repatriation of land is particularly important in Turtle Island, or what is now referred to as North America. The early and still influential work by Linda Tuhiwai Smith on decolonizing methodologies was developed in the settler colonial context of New Zealand (L. T. Smith, 1999) where it has principally been applied in the fields of education and language, for example through the development of Maori language nests, or Te Köhanga Reo, and in the application of Kaupapa Māori, a concept expressing adherence to Māori ontologies and commitment to Māori self-determination (Denzin, Lincoln, & Smith, 2016b; Mahuika, 2008). Kaupapa Māori, as a philosophy or framework, does not ignore questions of repatriation of land, but it is not so directly associated with land as the model of decolonization put forward by scholars such as Tuck and Yang in the Canadian context (Mahuika, 2008; Tuck & Yang, 2012). Work in both Canada and New Zealand was preceded by scholarship on decolonization in parts of Africa and Asia, where decolonization historically involved the formal transfer of governmental powers from the colonizing nations to Indigenous peoples (Duara, 2003; Fanon, 1963) – something which has not happened in the settler colonial contexts of New Zealand or Canada (or other settler colonial nations in the world), which is partly why scholars in Canada insist on maintaining a focus on the repatriation of land. In Canada in particular, decolonizing methodologies must be applied with care in order to avoid using decolonization as a metaphor or appearing to make unwarranted claims when decolonization related to land is not actually the focus of research. The intent in using decolonizing research in this dissertation is to centre Indigenous experiences as well as Indigenous critical theory and Indigenous methodologies; the
repatriation of land is acknowledged as a goal but is itself beyond the scope of this dissertation. Even this centring is only possible to a somewhat limited extent; claims to decolonization itself are beyond the scope of this work.

Decolonizing research works mainly in the realm of metaphor, thought, and intention rather than the repatriation of land, seeking as it does to undo the harms caused by colonial paradigms as they are incorporated – consciously and unconsciously – into (mainly, academic) research. As Gerlach writes, decolonizing approaches to research have the aim of:

> Revealing, resiting, and dismantling the colonizing potential of taken-for-granted ways of organizing, doing, and disseminating knowledge and research. (Gerlach, 2018, p. 2)

That is, decolonizing approaches seek to stop the perpetuation of colonizing methodologies and epistemologies in research. This does not rule out the repatriation of Indigenous land and life – in fact, this repatriation could be argued to be the end goal of decolonizing research approaches. Although individual research projects may not accomplish the actual repatriation of land, they may still allow for steps to be taken that in the long term will accomplish such a goal. Keeping such a long-term goal in mind could be considered an important part of the practice of decolonizing research. However, decolonizing research approaches should not be conflated with decolonization itself.

Decolonizing research must be undertaken without avoiding the necessary “unsettling” that accompanies decolonization – that is, without downplaying truths or avoiding situations that make settlers (or other non-Indigenous peoples) feel uncomfortable, guilty, or responsible (Tuck & Yang, 2012). The work of decolonization is necessarily uncomfortable and contradictory; at times even confrontational (Fanon, 1967; Lawrence & Dua, 2005; Tuck & Yang, 2012). Decolonizing research approaches are not exempt from this discomfort; research informed by decolonizing principles often requires navigating difficult situations and competing interests, as well as balancing the needs of not only universities and communities, but often differing needs within communities or difficult relationships between Indigenous and other communities local to where the research is being conducted (Castleden et al., 2012; Morton Ninomiya & Pollock, 2017). The research undertaken for this dissertation has required some of this balancing, which is discussed in more detail below (see “ethics and decolonizing research principles,” under Methods; also see Positioning).
Decolonizing approaches to research also involve re-centring Indigenous perspectives while remaining open to multiple epistemologies. This can include those from colonizing nations, as long as these can be respectfully brought into dialogue with Indigenous epistemologies without superseding or silencing them (Kovach, 2009; L. T. Smith, 1999). The primary focus, however, should be on Indigenous ways of knowing; a position that is facilitated by research informed by movements – intellectual as well as grassroots – towards Indigenous community resurgence.

**Concepts of Indigenous Community Resurgence**

Conducting research using decolonizing approaches requires centring Indigenous epistemologies, with the goal of “reconstruct[ing] the entire research process and the epistemologies that inform [it]” (Gerlach, 2018, p. 2). Decolonizing methodologies also require avoiding research that is deficit-focused or overly informed by the negative impacts of colonialism on Indigenous communities. While these negative impacts cannot be ignored, Indigenous individuals and communities should not be portrayed as hapless victims of colonialism (Tuck, 2009). Achieving these goals, especially for a non-Indigenous researcher, requires constantly checking and engaging in critical reflection in order to ensure that the ways in which Indigenous individuals and communities are being portrayed are informed by the communities themselves and their realities rather than by colonial stereotypes or discourses (Gerlach, 2018). In this research, one useful way of informing this critical reflection has been through maintaining ongoing conversations about the research with people in the community, throughout the research process. Another way – and one which has also facilitated these conversations – has been through drawing on the discourses and scholarship of Indigenous community resurgence.

Indigenous community resurgence, as discussed in the introduction, is a broad term used to signify research, education, or community movements grounded in Indigenous knowledge (L. B. Simpson, 2011). Without trapping Indigenous communities by requiring them to adhere to past versions of themselves (Borrows, 2002), Indigenous community resurgence provides a way of understanding how communities are engaged in decolonial practices on an everyday level; acknowledges community strengths in the face of colonialism; and does not require recognition by the state or any outside entity (Alfred & Comtassel, 2011; A. Simpson, 2014; L. B. Simpson, 2017). In the context of decolonizing research, scholarship related to Indigenous community...
resurgence provides useful context for the ways in which knowledge is understood in different communities; the impacts of colonial structures and histories on the production and intergenerational sharing of knowledge; and the hope inherent in decolonizing research practices. It complements literature on Indigenous and decolonizing methodologies by providing theoretical grounding as well as moral imperatives for the use of decolonizing approaches. It also shares with decolonizing research a focus on relationships and relationality.

Relational Paradigms in Indigenous Research

Relational paradigms, dealing with the interconnectedness of people and all life, and the ways in which the world is socially constructed through relationships with others, are a central feature of Indigenous or decolonizing research (Coombes, 2013; Johnson & Larsen, 2013; Kovach, 2010). Relational paradigms are also found in scholarship on relational ethics in research, which is based on the idea that “knowledge necessary to ethics lies in our relationships with others” (Austin, 2015, p. 23). Relationality – referring to these paradigms that centre relationships in the construction of social life, self, and place – is an important way of understanding place as well as Indigenous identity in Indigenous or decolonizing research. For example, Cree scholar Shawn Wilson describes how space is created through the web of interconnections among human and non-human beings (2008), and Māori scholar Brad Coombes points out how his identity as a Māori researcher is constructed in equal parts by his lineage and by how he is viewed or identified by others (2013). Relationality is equally a fundamental part of doing research with Indigenous communities (Coombes, 2013; Gerlach, 2018; Weber-Pillwax, 2004). Relationality, as a research approach, means that attention must be paid to forming and sustaining respectful, mutually beneficial relationships throughout the entirety of the research process, from conceptualization to framing and dissemination of results, and beyond (Hornung, 2013; Kovach, 2009; L. T. Smith, 1999). This is often expressed through concepts such as the four Rs (Kirkness & Barnhardt, 1991): respect, relevance, reciprocity, and responsibility (Castleden et al., 2012; Gerlach, 2018). The specific ways in which these are operationalized in this research are elaborated below (see “ethics and decolonizing research principles,” under the Methods section).

Knowing – or getting to know – an Indigenous community is an important first step of Indigenous or decolonizing research. Scholars writing about Indigenous research describe primary research methods as conversation, visiting, and listening to and learning from
community members and knowledge holders (Castleden et al., 2012; Johnson, 2008; Tobias, Richmond, & Luginaah, 2014). Coombes describes “the longer-term research partnerships that are often coveted by researchers who work with Indigenous peoples but that are typically rare” (2013, p. 84). Researchers (Indigenous or not) who work with Indigenous communities desire these longer-term partnerships because such partnerships indicate that mutually beneficial research relationships have been established. Without these types of relationships, good quality, relevant research is not possible.

Indigenous communities and other funding and governing bodies that oversee research with Indigenous communities increasingly recognize the ways in which relationships intersect with ethics in research with Indigenous communities, and look for ways to enforce research that is grounded in relationships (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014; McGregor et al., 2010; Morton Ninomiya & Pollock, 2017). As Morton Ninomiya and Pollock, non-Indigenous researchers working with Indigenous communities in Labrador, Canada, point out, accountability mechanisms to enforce the ethical principles of decolonizing research at the level of research institution or funder are lacking. They write that:

“Having principles and guidelines for Indigenous health research and funding is an attempt to ensure work in this field is conducted collaboratively with Indigenous community vetting, involvement, input, and benefits. There is however, no mechanism to consistently enforce or hold researchers and their institutions accountable to Indigenous communities” (Morton Ninomiya & Pollock, 2017, p. 32).

Universal or standardized accountability mechanisms to hold researchers accountable to the principles of Indigenous or decolonizing research are difficult if not impossible to elucidate. In fact, creating accountability mechanisms that are “too prescriptive” would counteract the goals of Indigenous and decolonizing research to distance Indigenous community-based research from colonial research methods and assert local community control over research (Castleden et al., 2012, p. 165). Mechanisms for accountability are not absent from Indigenous or decolonizing research paradigms, however. These mechanisms can be found in the ways in which community-researcher relationships promote respectful collaboration, provide opportunities to correct mistakes, and hold researchers accountable to the communities with whom they work (Morton
Thus a great deal is riding on the quality and depth of such relationships.

As with any relationship, developing respectful, trusting, and mutually beneficial research relationships requires attention, time, and effort. Indigenous communities are diverse and complex; relationships and differing perspectives among community members must be taken into account to try to avoid the researcher being perceived as taking sides (Castleden et al., 2012). Research collaboration does not always go smoothly. Morton Ninomiya and Pollock (2017) outline specific examples of how “relational tensions” arise and are resolved in their Indigenous community-based health research (p. 29). Weber-Pillwax (2004), similarly describes situations in which relationships between the researcher and the research participants are complicated by the political situation of the community. Most Indigenous communities with previous experience working with researchers have at least one story of researcher missteps, sometimes resulting in the termination of the research and/or the relationship. Often, a great deal is riding on the outcomes of the research for the communities involved, for example in terms of Indigenous communities being granted access to resources or having their positions supported in land claims or governance negotiations (McGregor et al., 2010; Morton Ninomiya & Pollock, 2017). Researchers, in collaboration with Indigenous individuals and communities, must carefully consider these implications of research, both before a research project begins and on an ongoing basis throughout the project.

Methods

Geographic Setting

This study is located in Prince George, British Columbia, Canada; a city almost at the centre of British Columbia (BC). It sits in the northern interior of BC, at just below 54 degrees of latitude in the Central Interior Plateau – between the Rocky mountains in the east, the Omineca and Skeena mountains in the north, the Coast mountains in the west and the Cariboo mountains to the southeast. It is a city of 85,135 people, of which 14.6 percent reported Indigenous identity in the 2016 Census of Canada (Statistics Canada, 2017b). This compares to 5.9 percent of people reporting Indigenous identity in the province of BC overall, and 4.9 percent in Canada (Statistics Canada, 2017b). The largest cities in Canada have much lower proportions of Indigenous people; for example, 0.8 percent of people in Toronto identify as Indigenous and 2.5 percent in
Vancouver (Statistics Canada, 2016a). Smaller cities such as Winnipeg and Halifax vary in the proportion of people reporting Indigenous identity, at 12.2 percent in Winnipeg and only 4 percent in Halifax (Statistics Canada, 2016a).

Just under 57 percent of people identifying as Indigenous in Prince George identified as First Nations in the 2016 Census of Canada; 40.2 percent identified as Métis, and 0.2 percent as Inuit. Of those who speak an Indigenous language, the majority reported speaking Carrier, the language of the Dakelh or Carrier group of Indigenous peoples, followed by Cree (Statistics Canada, 2017b). The Indigenous population in Prince George is young, as in the rest of Canada – the average age being 30 years, compared with 40.6 years for the non-Indigenous population of Prince George, although the older Indigenous population is growing (Statistics Canada, 2016a, 2017b).

Prince George is located on the traditional territory of the Lheidli T’Enneh First Nation. In addition, there are 54 different First Nations in northern British Columbia served by the Northern Health Authority, for whom Prince George is the central service area as well as the largest urban centre (Aboriginal Health, 2014). Prince George is the largest city in the north of BC and the fourth largest in the province overall, functioning as a hub for communities across northern BC and the Yukon (Varcoe, Browne, & Einboden, 2014b). This follows from the area’s history as a hub where Indigenous travellers would meet and gather (Varcoe et al., 2014b).

People in Prince George are fairly well-off in terms of income, although educational levels are lower than in the rest of Canada (Statistics Canada, 2016a). The median income for Prince George in 2016 was higher ($78,427), than the overall Canadian median of $70,336 (Statistics Canada, 2016a). Similarly the percentage of people with low income was 12.6 percent in 2016, compared with 15.5 percent in all of British Columbia and 14.2 percent in all of Canada (Statistics Canada, 2016a). Higher incomes may be a result of a relatively high dependence on the natural resources sector and the trades and transport sectors (22.3 percent, compared with 16.2 percent in Canada overall) (Statistics Canada, 2016a) as well as Prince George’s northern, relatively remote location. Higher proportions of Indigenous peoples in Prince George report low income, however; at 14.4 per cent according to the 2016 Census (Statistics Canada, 2017b). Education rates are lower in Prince George than in the rest of the country, with 30.3 percent of people having secondary school or the equivalent as their highest level of education (23.7
percent in Canada), and 14.1 percent having no diploma or certificate (11.5 percent in Canada) (Statistics Canada, 2016a).

Prince George also has something of a reputation for violent crime, being named the most dangerous city in Canada for two years in a row in 2009 and 2010 – although Prince George now ranks at 11th in Canada in 2018 (Maclean’s magazine, 2018; MacQueen & Treble, 2011). It is located along the infamous Highway of Tears – a section of Highway 16 between Prince George and Prince Rupert, BC, where many women and girls, especially from Indigenous communities, have gone missing or been killed in the past several decades, with minimal police or government intervention (Morton, 2016). Its history of colonization, including residential schools, repressive government policies, and Indigenous displacement, has led to experiences of many forms of violence for Indigenous peoples locally (Varcoe et al., 2014b). Prince George is a unique setting for this study, but has insights to offer that apply to cities in other contexts as well.

Prince George was selected as the geographic focus of this research for several reasons. First, it is where I completed my Master’s degree, during which I formed many strong connections, both personal and research-based, with Indigenous communities and health care organizations in Prince George. Having these strong pre-existing relationships, as well as a good level of background knowledge about the area, the people, and the network of health support services and Indigenous-led organizations, facilitated the relationship-based character of this research. As pointed out above, long-term relationships are highly prized by scholars undertaking Indigenous, decolonizing, or other community-based forms of research (Castleden et al., 2012; Coombes, 2013). In addition, a central principle of Indigenous or decolonizing research is that a researcher must honour the relationships formed through the course of doing research and not abandon them once a given research project is over (Louis, 2007; Weber-Pillwax, 2004). Prince George was thus a logical choice for the location of this study.

Second, Indigenous-led health organizations in Prince George have shown leadership and innovation with respect to providing health care services, forming collaborative networks, and engaging in research in recent years. Prince George is home to a research centre focused on Indigenous health (the National Collaborating Centre for Aboriginal Health), as well as a strong network of Indigenous-led health organizations that provide a range of services for Indigenous communities, such as the Central Interior Native Health Society, an Indigenous-led primary
health care clinic that has been operating since 1991 (Varcoe et al., 2014a). It is home to Canada’s largest Aboriginal Friendship Centre, which was founded almost fifty years ago and provides a wide variety of programs and services to the urban community (Prince George Native Friendship Centre, 2011). Several Indigenous-led organizations in Prince George collaborated to develop research ethics protocols that those wishing to work with them must follow, in part because these organizations are in high demand for collaboration on research projects (Dingwall et al., 2016; Varcoe et al., 2014a). The province of British Columbia has also been a leader in Indigenous health in Canada, with the formation in 2013 of the First Nations Health Authority that took over the responsibilities of the federal First Nations and Inuit Health Branch of Health Canada in British Columbia (First Nations Health Authority, 2017). All of these Indigenous-led organizations in Prince George and in British Columbia have strong leadership and operate with an eye to the political situation of Indigenous peoples in the province, the nation, and the world. These organizations have a great deal of experience and insight to offer related to serving Indigenous communities in urban areas and understanding community needs on an everyday basis, including areas of innovation and areas of frustration. Grounding this study in the work of Indigenous-led health organizations in Prince George can provide useful insights for researchers, health care providers, and decision makers working in similar contexts across Canada and around the world.

Third, Prince George, as a small, northern city, adds a useful comparative setting to studies undertaken in larger urban centres such as Vancouver and Toronto (Benoit, Carroll, & Chaudhry, 2003; Goodman et al., 2017; Howard & Proulx, 2011). As in other other cities – in Canada and beyond – people of a wide variety of backgrounds come to Prince George in increasing numbers for educational or economic opportunities, leading to the increasing urbanization being experienced worldwide. In Prince George, however, the major source of diversity within the city comes from people of different Indigenous nations. The proportion of people reporting being part of a visible minority (not including Indigenous peoples) was 8 percent in 2016, whereas Indigenous peoples living in Prince George form almost 15 percent of the population and come from 54 different First Nations, 9 tribal councils, and 17 distinct language families in northern British Columbia alone (Aboriginal Health, 2014; Statistics Canada, 2016a). Cities like Prince George, that are relatively small, relatively northern, and close to a number of different Indigenous communities, tend to attract a high proportion of Indigenous people because of the
way that First Nations communities in Canada, and Indigenous communities in other settler colonial countries, tend to be located in rural and remote areas farther away from the largest population centres (Australian Bureau of Statistics, 2018; de Leeuw, Maurice, Holyk, Greenwood, & Adam, 2012; Statistics Canada, 2016a). Prince George provides an example of an urban context that is internationally diverse in a manner not often recognized as “international” (L. B. Simpson, 2017).

**Indigenous-Led Health Organizations**

Indigenous-specific health care in Prince George consists of four major organizations: Central Interior Native Health Society (CINHS), a primary care clinic; Carrier Sekani Family Services (CSFS), a child welfare organization that coordinates health care on reserve for member communities and offers a limited range of health services in Prince George; Positive Living North (No kēyoh t’sih’en t’sehena Society, or PLN), an organization focused on support for people living with HIV/AIDS which also operates the Fire Pit, a cultural drop-in centre; and the Prince George Native Friendship Centre (PGNFC) which offers many services including a dental clinic, access to traditional healing and land-based activities, and the Native Healing Centre, a youth and adult substance use counseling centre. In addition to these and other Indigenous-focused organizations, health care in Prince George consists of one large hospital that serves much of northern BC (the University Hospital of Northern British Columbia, or UHNBC) and several services offered through the Northern Health Authority including mental health services, outreach, and an Adult Withdrawal Management program (colloquially referred to as “detox”).

The rise of Indigenous health and social service organizations in urban areas in Canada has followed on the heels of growing Indigenous populations in cities. Indigenous-led health organizations, as referred to in this dissertation, are generally not-for-profit organizations that have a mandate to serve the needs of Indigenous peoples and are grounded in Indigenous values and world views. Originating with Native Friendship Centres in the 1950s and ‘60s, there are now networks of social services for Indigenous peoples in all major cities in Canada – although such networks differ from city to city in terms of the diversity and number of services (The Environics Institute, 2010a). Indigenous health and social services include (but are not limited to) “education, training, employment, economic development, child care, health, housing, cultural support and corrections” (The Environics Institute, 2010b). In providing these types of
services, Indigenous-led organizations also provide spaces for urban Indigenous communities to gather, and perform advocacy roles for their clients within networks of urban and rural health care and other social services.

**Ethics and Decolonizing Research Principles**

As described above, this study follows the principles of community-based participatory research and Indigenous or decolonizing research. The research was guided by an awareness of the responsibility of the researcher towards the communities involved – in particular, as outlined above, the research had the goal of ensuring that research participants benefited and were not adversely impacted by the conduct of the research; and that the community as a whole would benefit from the outcomes of the research (Weber-Pillwax, 2004). As a way of adhering to these guidelines, the research followed the four Rs of research: the principles of respect, relevance, reciprocity, and responsibility (Kirkness & Barnhardt, 1991). Respect for people, communities, health care institutions of all kinds, and knowledge was demonstrated through maintaining as much face-to-face presence in the community as possible, such as volunteering at or attending community events while in Prince George; visiting with friends; and presenting results in community presentations. The researcher also regularly participated in Indigenous ceremonies in Prince George as well as while away, as a way of connecting spiritually to the work, understanding how to be respectful of cultural protocols, and building relationships of respect.

Relevance, as described above, means ensuring that the research outcomes are relevant, and of benefit, to those involved. This was ensured, in part, through the researcher’s many years of engagement with people in the community. This engagement meant that research ideas and questions grew from the relationship between the researcher and the community. In addition, the involvement of a Community Advisory Group (discussed below), helped to ensure relevance of research results as well as benefit (and prevention of harm), since the Community Advisory Group is composed of people who are well placed to advise on the study’s relevance and benefit to community members.

The relevance of an academic study is an area in which community and university needs must be balanced. In particular, the theoretical framing of an academic study, and contributions of the research to academic literature may be perceived as of low utility to the community. This is perhaps especially true when it comes to health care, because health care involves very practical
needs in, at times, quite urgent situations. Theory, however, is important to the work. The depth
and breadth of understanding that theory can bring is important for understanding health care
within its broader national and international context, as well as for understanding and bringing to
light differing epistemologies (Bradbury-Jones, Taylor, & Herber, 2014). In this study, utilizing
Indigenous critical theory as a lens has been one way of balancing these requirements and
making the theoretical contributions relevant to communities. The concept of Indigenous
community resurgence, in particular, has resonated very well with participants, Community
Advisory Group members, and community members in Prince George.

Reciprocity involves making sure that the researcher’s relationships are mutually beneficial and
the researcher finds ways to give back to the community – both through the research and by
other means. One way in which this was accomplished in this research was through the offering
of gift cards to participants as well as offering plentiful food and drink whenever there was a
gathering, such as a focus group. It was also expressed through the offering of volunteer grant-
writing assistance, to help organizations to apply for other small pools of funding when the
opportunity came up, and through volunteering at community events. It is also expressed through
helping with other writing projects, such as the memoir of the late Leonard Ward, respected Cree
Elder, friend, and Community Advisory Group member. Perhaps most importantly, efforts have
been made to ensure that the results of the research itself are available to organizations and
community members. Preliminary results have been printed in quick-to-read formats (one-page
summaries and brochures) and handed out at community events. Community presentations were
held in Prince George at the Prince George Native Friendship Centre in February 2018, and via
videoconference at the Central Interior Native Health Society in May 2018. Preliminary results
have been shared with participants by email, and a summary of the final results will also be
emailed when the dissertation is complete. The Community Advisory Group has been emailed
summaries of preliminary results as well as draft chapters, and the full dissertation will be shared
prior to the final defense. Further community presentations will take place in the fall of 2018,
and on an ongoing basis as long as there is interest.

Responsibility rests with those undertaking Indigenous or decolonizing research in a variety of
ways, in particular to ensure that participants are not harmed and that participants and
communities benefit from the outcomes of research, as discussed above. Responsibility is
interwoven with the other three principles of respect, relevance, and reciprocity – it is the
researcher’s responsibility to adhere to all of these. Several times during the course of the research, participants reminded the researcher of the responsibility that I held towards them. For example, one participant in a focus group described feeling that they were repeatedly not heard in health care settings. This participant emphasized that groups like the focus group we were participating in were important, because I was there to listen to community members. They placed the responsibility on me to tell others, in particular health care organizations and those working in them, what I had heard. Another participant explained in detail the devastating impacts of colonialism on himself, his friends, and his community. He linked colonialism, residential school experiences, poverty, and the resulting feelings of powerlessness and anger together in a way that served to remind me of the close links between these structures and the research – both in terms of the content of the research and its process.

The four Rs of research – respect, relevance, reciprocity, and responsibility – are upheld in this research through nurturing and respecting relationships, whether professional, personal, or often, both. These relationships extend backwards in time beyond this research project as well as forwards. I am already in the process of organizing interviews in the capacity of research assistant on another project – interviews that will be held at, and facilitated by, the Prince George Native Friendship Centre. Participating together in further research endeavours will also provide me with the opportunity to continue to share the results of this dissertation, in various forms, with communities and community members. Having long-term relationships helps to maintain researcher accountability, since I have an interest in maintaining these relationships and will avoid anything that might do harm or show disrespect in the course of the research.

Relationships are not the only method of ensuring accountability in research with Indigenous communities, however. Relationships are key in Indigenous and decolonizing research but they are not enough – Indigenous communities have made it clear that there are formal principles to be followed by anyone undertaking research with Indigenous communities, in addition to the informal ones just described. OCAP, which stands for Ownership, Control, Access, and Possession, is one example (First Nations Information Governance Centre, 2018; Schnarch, 2004). These are principles articulated by the First Nations Information Governance Centre, which deals with issues of governance over data for First Nations communities in Canada (First Nations Information Governance Centre, 2018). Ownership means that Indigenous communities own their personal information in the same way that an individual does – it refers to issues of
community consent. In this research, ownership was acknowledged by seeking consent, from multiple Indigenous-led health organizations as well as local Indigenous communities, to undertake the research, and by renewing this consent through meetings and discussions at multiple phases of the research. Control refers to the rights of Indigenous communities to control all aspects of the research process when such research concerns them. In this research, the researcher made sure to follow advice when it was given, and in addition, final approval of the results rests with the community partners and the Community Advisory Group, as discussed below. Access means that Indigenous communities must have access to all of their data, and have the right to manage this data. This principle was difficult to implement in this particular research project for two reasons. First, it conflicts with the University Research Ethics Board requirement that the researcher retain sole access to raw data in order to preserve confidentiality. Second, there was not one specific “home” for the data in the community where it could be accessible to all participants. This is part of the complexity of doing research in an urban setting; it involves participants from multiple communities, and even housing the data in an urban Indigenous-led organization would not have preserved access for everyone, since not all participants used or had connections with Indigenous-led health organizations. This is a practice that should be further investigated in urban settings, and in future research I will endeavour to find a means of offering access to urban Indigenous communities or community representatives – perhaps this would be possible by dividing data according to where it could be most easily accessed by participants. This principle was therefore applied to the extent possible in this research project, by providing each individual participant with access to their own interview or focus group transcripts, and by reaching out to participants to share preliminary as well as final results and analysis of the research.

Another key set of guidelines for research involving Indigenous communities is Free, Prior, and Informed Consent (FPIC) (Swiderska et al., 2012). Often outlined in the context of the protection of biodiversity and Indigenous intellectual property related to plant medicines, these guidelines “[involve] processes in which communities decide whether or not to allow projects affecting their land or resources to go ahead, and on what terms” (Swiderska et al., 2012, p. 26). This involves ensuring that research processes and goals are discussed in a transparent manner at a community level, prior to the commencement of research, and that communities are given the power to decide whether or not a given research project will go ahead. As discussed further
below, this information as well as decision making control over whether or not this research project would go ahead in its presented form were given to both the Prince George Native Friendship Centre and members of the Community Advisory Group. Were the research to have been rejected in its current form, the researcher would have solicited advice on what types of questions would be acceptable to the community and altered the project accordingly. Thus, a negative response to the proposed research would not necessarily have meant an end to the researcher undertaking any research at all in this community – although this was also a possibility that remained open. Community Advisory Group members are experienced in dealing with researchers and research in many capacities, and would not hesitate to terminate a project or turn away a researcher if this was determined to be in the best interest of community members.

One of the reasons that many Community Advisory Group members are well versed in research processes and ethics is because they have been involved in developing a customizable set of community research protocols for urban Indigenous-led organizations or communities (Dingwall et al., 2016). These protocols, particularly timely because of their urban focus, have been implemented in several Indigenous-led health organizations in Prince George since just before the beginning of this research project. This research went through the process of approval for two of these organizations; one of which was the Prince George Native Friendship Centre, who approved the research and took on a partnership role, and the other of which was the Central Interior Native Health Society, which vetted the research and decided not to be a formal partner but to have a representative in the Community Advisory Group. In addition, formal research ethics approval for this research was obtained from the Northern Health Authority’s Research Review Committee as well as from the University of Toronto’s Research Ethics Board (see Appendix A for information and consent information used in the research).

Community Advisory Group

As discussed above, part of following the principles of Indigenous and decolonizing research included seeking involvement and advice related to the research of a wide range of members of the health care community in Prince George, in particular health care providers and decision makers who worked in various capacities with Indigenous people. Research questions grew from and were refined through a series of one-on-one conversations with members of the Indigenous-led health organizations this study focuses on, facilitated by long-term research relationships.
with many of these individuals who then connected the researcher with others in the community. These conversations were held over the course of a year and a half, before the research proposal was defended and well before information gathering (“data collection”) began. In addition to soliciting ideas and feedback regarding the research questions, this time was also spent inviting people to be a part of a Community Advisory Group, whose role was to maintain a certain level of involvement with the research through 1-2 meetings per year, to assist with recruitment of participants, and to provide feedback and advice on the outcomes and products of the research. The Community Advisory Group currently consists of eight health care professionals, researchers, decision makers, Elders and community leaders in Prince George. The composition of the group has changed slightly over the duration of the project, as some people moved away from Prince George, stepped down from their roles in health care organizations, or, most unfortunately, passed away. The group has fluctuated from eight to twelve members at any given time, although the eight who are now involved have been part of the group from the beginning. This group has provided input into the study questions and design through initial group meetings, assisted with recruitment of participants and the facilitation of focus groups, offered advice and guidance regarding the results of the research in its early and final stages, and assisted with the dissemination of results.

The Prince George Native Friendship Centre (PGNFC) is a formal partner on the research, through an agreement made via PGNFC research protocols (Dingwall et al., 2016). PGNFC provided advice on study design, support for recruitment including space for interviews, meetings, and temporary office space, and has a final say in the form and content of results as well as how they are disseminated – as discussed above. The involvement of PGNFC and the frequent location of interviews and meetings there have potential implications for the research. Many participants might feel much more at ease in this community setting for interviews and focus groups than they would have had these been conducted at, for example, the university. Conducting interviews in people’s homes would have prevented those without stable housing from being able to participate. Using space at PGNFC also saved costs for the researcher who might otherwise have had to rent space. However, utilizing this space could potentially have influenced results by making the researcher appear to be affiliated with PGNFC. Some of the possible implications of this are discussed in chapter four; for example, making the researcher appear to be a health care provider, thus leading participants to (potentially) wish to avoid saying
too many negative things about health care, or – on the other hand – leading participants to feel more comfortable discussing personal health details with the researcher. The fact that I was a researcher and not a health care provider was clarified in the introduction to interviews and focus groups, but the difference between a health care provider and a researcher in terms of someone in a position of some authority, asking questions of them, could be somewhat indistinguishable – or irrelevant – for some participants.

Although PGNFC was quite involved in the research they were also quite “hands-off;” they were happy to be included and to receive and disseminate the information produced by the study, but they did not take ownership of the conduct of the study, choosing instead to leave the details of method and analysis in the researcher’s hands (a decision also taken in other Indigenous community contexts (see, e.g., Morton Ninomiya & Pollock, 2017)). Further, through the deliberate involvement of people from a diverse range of Indigenous-led and other health organizations in the Community Advisory Group, other members were able to organize meetings, focus groups, and interviews, in other locations as well, so that the settings for interviews and focus groups were diverse.

The decision to allow community partners to have, essentially, “veto power” over the research is one that can cause a great deal of researcher anxiety (Castleden et al., 2012). However, it is not possible to conduct research in true accordance with the principles of Indigenous and decolonizing research approaches without offering communities this power. If the researcher retains the final say over whether the research goes ahead or whether material is published, as well as over the content that is to be included in the final research products, then community consultation has been in name only. The risk of having the results restricted, held back from publication, or withdrawn, is a risk that researchers wishing to distance themselves from former extractive research methods, that have caused so much damage to Indigenous communities, must be willing to make (Kovach, 2009; L. B. Simpson, 2017; L. T. Smith, 1999). This risk is what can hold researchers fully accountable, and attentive, to their ongoing research relationships (Castleden et al., 2012; S. Wilson, 2008). In addition, offering communities the level of trust that is involved in giving them the final say, often means that the researcher receives such trust in return. Indigenous community members and leaders, especially in the field of health care, are often extremely busy with front-line community work, and so will not often want to take part in detailed analysis of data or read academic papers unless they feel that there is a risk of
misrepresentation or misinterpretation (Morton Ninomiya & Pollock, 2017). Trust and researcher transparency thus can reduce the risk of cancellation or restriction of the research.

Participants and Recruitment

Recruitment methods were purposive (Cresswell, 2007), meaning that participants were sought who had specific characteristics that would add value to the study (as opposed to the random sample often sought in quantitative research). The goal of recruitment was to speak with people who are both clients and staff of as many different Indigenous and non-Indigenous health and social service organizations in Prince George as possible. Most Indigenous-led health organizations in Prince George focus on specific clientele – for example, Central Interior Native Health Society (CINHS) “strives to recognize the unique health care needs of Aboriginal People and people who live on, or close to, the street” (Central Interior Native Health Society, n.d.); the Fire Pit “is a street-level HIV/AIDS/HCV prevention and support program” (Positive Living North Society, 2017); and Carrier Sekani Family Services (CSFS) “has been given the mandate to establish a comprehensive infrastructure for social, health and legal programs, for the eventual take-over of these services, consistent with the Tribal Council's objective of working towards Indian Self-Government” (Carrier Sekani Family Services, 2018). Not all Indigenous people in Prince George are eligible to make use of these services – for example, people who are not members of Carrier or Sekani nations are not eligible to go to CSFS, and people who have stable housing are not a priority group served at CINHS or the Fire Pit; nor do all Indigenous people in Prince George necessarily wish to use these specific services. It was an important part of recruitment for this study to include people who both used these services and who did not, as well as to include people from differing socio-economic backgrounds and life situations in order to include differing perspectives on health care services and, specifically, Indigenous-led health organizations. To accomplish this, all major Indigenous and non-Indigenous health organizations, known to the researcher to be key players in shaping approaches to service delivery for Indigenous peoples in Prince George, were approached as part of participant recruitment. Initial meetings solicited advice from health care providers and decision makers on who else I should talk to, and often lists of available services in Prince George were provided from which I could make contact with other services.
Recruitment of participants was limited to community members who used or did not use health care services in Prince George, lived in Prince George, were over 18 years old, and who identified as Indigenous; and people working in health care, broadly conceived, whether Indigenous or not, who worked in Prince George. Multiple methods were used for recruitment, as suggested by the Community Advisory Group as well as from examples in the literature (Kovach, 2010; Weber-Pillwax, 2004). Recruitment methods included: phone calls; in-person visits to health organizations or community groups; posters in Indigenous- and non-Indigenous health organizations, grocery stores, the public library, and coffee shops, and disseminated by email; setting up a booth during various events at PGNFC; and snowball sampling whereby participants already involved in the study passed information about it to friends and family who they thought might be interested in participating (Cresswell, 2007). Face to face engagement and engaging respectfully with the community – listening and learning as well as talking about the study – were primary concerns during participant recruitment. Participants who identified as Indigenous community members were offered a $20 gift card to a local grocery store and provided with bus tickets to offset travel costs; a measure often undertaken in research with Indigenous communities as a way of acknowledging people’s time and contribution (Gerlach, 2018).

The initial goal of recruitment was to find 60 participants, representing approximately equal numbers of health services workers and Indigenous community members. In total, 65 participants – 50 Indigenous community members and 15 health services workers – participated. The high number of community members who participated was not anticipated, and resulted from snowball sampling (information about the study circulated quickly by word of mouth once information gathering began); the open door nature of many client interviews (wherein the researcher was available at PGNFC for drop-in interviews for a given time slot over the course of several days), and the higher than expected number of focus groups (discussed below).

The researcher also attempted to maintain a high degree of visibility in Prince George, especially at the Prince George Native Friendship Centre, while interviews and focus groups were ongoing; this was facilitated by office space being provided at PGNFC as well as through attendance at community events. Being known, or at least recognizable, to people is an important way of showing commitment to the community on the part of the researcher (L. T. Smith, 1999) – this was important to both participants and to Community Advisory Group members. For example,
recruitment was facilitated in several cases by researcher participation in crafting groups, where I learned various skills and spent an enjoyable number of hours while getting to know community members and telling them about myself and about the study. As many Indigenous researchers have pointed out, face-to-face contact and being present or visible is an important part of conducting research in Indigenous communities (Kovach, 2009; L. T. Smith, 1999). As a researcher who maintains both research and personal connections to Prince George but lives outside of the province, it has been particularly important to be present and available during time spent in Prince George in the course of this study.

All participants in both interviews and focus groups were over the age of 18 and currently living in the city of Prince George. Clients who were interviewed were mainly in the 25-45 age range; 9 participants had been living in Prince George for ten or more years. The majority (16 of 21) of client interviewees reported having a regular health care provider. Socio-economic status was not directly measured; however, both interviews and focus groups included participants who reported having experienced homelessness, participants who had stable housing but reported struggling with poverty, and participants who reported both stable housing and income, thus including participants at various places on the socio-economic spectrum. Seventeen women and 12 men in total participated in interviews; 25 focus group participants were women and 9 were men.

Most health care providers in both interviews and focus groups were women (14), except for one man who was both health care provider and Indigenous Elder. Eight health care providers identified as Indigenous or as having some Indigenous ancestry; 11 worked for Indigenous-focused health organizations and 3 worked in government-run health care institutions. One was an Elder working as a traditional healer and teacher outside of any organization.

Eight Elders and two other health care providers responded both as clients and as health care providers, as they had experience in both capacities. For the purposes of this study these 10 have been counted as clients, since this was the primary capacity in which they participated in the study. Interviews and focus groups took place between October, 2015 and January, 2016.

1 Indigenous Elders or Elders, in this study, refer to community-recognized knowledge holders or leaders who work in a formal capacity to support their communities.
Interviews and Focus Groups

The 15 health services workers and 50 Indigenous community members involved in this study participated, in total, in 29 individual semi-structured interviews and four focus groups. Twenty-one interviews and three focus groups were with clients; 8 interviews and one focus group involved health services workers. Interviews were semi-structured, with a set of questions that were asked to all participants, but maintaining an open-endedness that allowed participants to take the conversation in a direction of their choosing, should a particular question or topic evoke a particular response for them (Kvale & Brinkmann, 2009). It is possible that the context of the interviews influenced, to a certain extent, their content (Mazanderani & Paparini, 2015). As already mentioned, many interviews took place at PGNFC, which may have led to assumptions that the researcher was affiliated with that organization; further, another research study had been recently conducted on health care equity for Indigenous peoples in Prince George, and some of the same people may have participated in those interviews as well. This was balanced, however, by holding interviews in multiple settings and with participants from diverse backgrounds. The interview was chosen as a method because it has proven to be of enduring value in qualitative research (Delyser & Sui, 2014) and because it aligns with the concept of “research as conversation” outlined by many researchers conducting Indigenous or decolonizing research (Castleden et al., 2012; Kovach, 2010). As scholars working in Indigenous or decolonizing research with Indigenous communities point out:

The methods used in decolonizing or Indigenous research are not specific to it, but rather, what makes them decolonizing or Indigenous may be the intent or mindfulness taken when practicing the methods. (Beeman-Cadwallader et al., 2012, p. 7).

When undertaken in a safe manner that is not invasive, in the context of established relationships in the community, interviews can be a comfortable experience for participants and an appropriate format for having conversations on the research topic in the context of Indigenous and decolonizing research.

Focus groups were a planned part of the research and were chosen for two main reasons. First of all, focus groups offer participants a different dynamic than individual interviews (Bosco & Herman, 2015). Speaking within a group of people with similar backgrounds, in similar professions, or with similar experiences, can allow people to open up more freely than they
would in conversation alone with the non-Indigenous researcher, who is not a health care practitioner and does not live in Prince George. Participants in focus groups were able to collaboratively think about the topic in new ways, or reach new conclusions, together. This would have been less likely to happen in individual interviews (Bosco & Herman, 2015; Neuwelt, Kearns, & Browne, 2015). Second, focus groups share many similarities with Indigenous talking circles. Focus groups were used as a part of my Master’s research and were conducted in the form of talking circles guided by Leonard Ward, a respected Cree Elder – who also guided one of the focus groups for this research. Leonard was not available for the other three focus groups and although they were not formally conducted as talking circles, cultural advisor Bertha Cardinal performed an opening for two of these groups according to Cree protocol, and facilitated one of these. The remaining focus group was facilitated by an Indigenous community leader but was not conducted in accordance with a formal Indigenous talking circle protocol. Talking circles are used for healing or for knowledge sharing in many different Indigenous communities, and have been adapted in Indigenous research as well (Cargo, Peterson, Lévesque, & Macaulay, 2007; Kovach, 2010; Leonard Ward, personal communication). Using the terminology of “focus group” acknowledges that these groups were not conducted according to formal Indigenous talking circle protocols. However, they were generally informal discussions guided by a standard but open-ended set of questions and shared many similarities with talking circles. Questions were fewer in number than in interviews, in order to allow more time for free discussion. Community advisory group members strongly endorsed the focus group format, leading to more focus groups being conducted than initially planned. The extra focus groups took place during meetings that were already scheduled – one of a parents’ group and the other a group of Elders – which were adjusted to allow time for the focus group discussion. This led to a high level of comfort on the part of participants, since they were in a familiar setting with people they already knew.

Health services worker interviews were conducted in people’s offices or over the phone; client interviews took place in designated rooms at the Prince George Native Friendship Centre or at Friendship Lodge, a housing program affiliated with PGNFC. It was a requirement of the research agreement with PGNFC that one-on-one interviews with community members take place during hours when drop-in counseling was available at the Native Healing Centre, in case participants wanted or needed to follow up with a counselor after the interview. Interviews that
did not take place at the Native Healing Centre had another staff member available to participants, and focus groups were facilitated by someone able to provide counseling or support if needed.

Interviews focused on the delivery of health care services to Indigenous people in Prince George, the role of health service organizations in supporting Indigenous communities in the city, as well as links between health service organizations, health, and rights for Indigenous people in Prince George (see Appendix B for interview and focus group guides). For clients, interview questions asked about their personal experiences with health care services, whereas health care providers were asked about challenges in delivering health services as well as their perceptions of the political and policy environment in which services were being offered. Interviews lasted an average of 25 minutes, ranging from 7 minutes for one interview, to one hour and 20 minutes.

Focus groups were asked the same types of questions but were asked fewer questions to allow for discussion. Again, clients were asked about their personal experiences whereas health care providers were asked about the delivery of services as well as the political and policy contexts in which services are offered. Focus groups lasted an average of one and a half hours, ranging from 47 minutes to two hours.

Results were analyzed using a textual analysis guided by the three major themes in the interview and research questions: Indigenous clients’ experiences in health care settings; Indigenous health organizations’ contributions to the community in urban settings; and the relationships between health care and Indigenous rights. Most interviews and all focus groups were audio recorded and transcribed. All participants were given the option of not using the audio recorder and six interview participants chose this option; for these interviews notes were made either during or immediately following the interview. Analysis followed the three stages of coding outlined in grounded theory, namely, open coding, axial coding, and selective coding (Corbin and Strauss, 2008). Open coding is the first stage, a process by which interview and focus group transcripts are read and the text is categorized according to emerging themes. Axial coding then is used to draw connections among themes and subthemes and regroup or re-code the data accordingly. Selective coding then identifies core themes and arranges them in order to form a coherent story or message (Vickers, n.d.). Notes and transcripts were open coded using NVivo, a qualitative computer-based analysis software, then axial and selective coding were done using a word
processing program as well as printouts of each transcript. Analysis was performed primarily by the researcher, with assistance and verification of key emerging themes from Dr. Kathi Wilson, my doctoral thesis supervisor. Verification of results and the way they were interpreted was also conducted periodically in meetings with members of the Community Advisory Group, during which the researcher presented and discussed the initial interpretations of the results to see whether they resonated with Community Advisory Group members’ experiences and perspectives. In accordance with guidelines for research with Indigenous communities (Canadian Institutes of Health Research et al., 2014), research protocols from Indigenous-led health organizations in Prince George (Dingwall et al., 2016), and requests by the Community Advisory Group, results have been and continue to be presented to members of the community in a variety of settings in order to make the research and the results accessible; this has also resulted in some feedback which has been taken into account in the writing of the dissertation. Results have been made available in a variety of formats: as one-page summaries and a brochure summarizing the research and its conclusions; in meetings and community presentations; and on a website dedicated to this research project, with the goal of increasing transparency as well as engagement with the communities involved (Dingwall et al., 2016; Morton Ninomiya & Pollock, 2017).

Limitations

The major limitation of this study is that it was carried out by a non-Indigenous researcher living outside of Prince George. Living distant from the area of research can limit my perceptions of local events and undertakings that may impact the ways in which health services are provided in the area. This limitation has been mitigated through keeping in regular contact with people in Prince George, and reading daily headlines and articles in the Prince George newspaper. The small number of health care providers in this study may also be considered a limitation. In terms of numbers, this study represents the views of Indigenous clients far better than those of health services workers. However, the perspectives of health care providers are already the subject of much research looking at the provision of health services for Indigenous peoples (Browne et al., 2016; Lavoie et al., 2015). There are also some studies that have been undertaken from the perspectives of Indigenous clients in urban areas with respect to health care; however, these focus on people living in unstable housing situations or with substance use problems (Evans et al., 2014; Goodman et al., 2017). Therefore, presenting the viewpoints of Indigenous clients who come from a broad range of life situations makes a valuable contribution to the literature.
Finally, the study’s location in one small, northern, urban setting raises questions about transferability of results. However, when one looks at the similarities in Indigenous peoples’ experiences accessing health care services around the world, it seems likely that the results of this study can provide useful insight for other cities in Canada and internationally, especially in countries with settler colonial contexts.

Positioning

This section is written in accordance with Indigenous and decolonizing methodologies, in which it is necessary to offer the reader some context regarding who is writing in order to offer them the appropriate tools to evaluate and understand the research and writing (Hornung, 2013). It also follows other critical scholarship such as feminist methodologies, in which critical reflexivity on the part of the researcher (that avoids privileged white self-indulgence) is an important part of situating the research (Kobayashi, 2009). It is thus appropriate to dedicate some space to who I am and how I relate to this research.

I do not come from or belong to an Indigenous community. I grew up on the unceded territory of the Algonquin people about an hour southwest of Ottawa, descended on my mother’s side from Scottish and Welsh families who settled locally, and German and Scandinavian ancestors who settled in the American Midwest, on my father’s. Until very recently I knew only that the original people of the land where I grew up were Algonquin. I knew little to no Algonquin history and had little to no awareness of Algonquin communities in the present day. I was raised with a heightened sensitivity to social justice, however, as well as a great deal of curiosity that was very much encouraged. This combination led me to take a minor in African Studies during my undergraduate degree, and to spend some time in West Africa during the same time period. Through these experiences and education, I learned critically and intensively about colonialism, and back in Canada, started to look around me with a new understanding. I wondered, tentatively, what colonialism in Canada was really all about.

Eventually I decided that I needed to learn more. I moved to Prince George, in northern British Columbia, and completed a Master’s in First Nations Studies. There, in a program heavily focused on community involvement, I formed many connections – both personal and research-related – that have lasted over the years. This is where I met Leonard Ward, a well-respected Cree Elder who worked for many years in Indigenous-led health services and the communities in
and surrounding Prince George as well as in northern Alberta. He accepted my offering of
tobacco and my quiet presence unproblematically, and taught me many things, keeping in touch
even after I moved away from Prince George to start my PhD in Toronto, and helping a great
deal with my PhD research. He also asked me to help him write his memoir, a project that is
ongoing.

The journey of this PhD has been a complicated one and my relationship with this work and the
communities, emotionally charged. When I started the program I was pregnant with our first son,
Anthony, who was born partway through my first year. A couple of years later, trips to Prince
George became more emotionally fraught as I miscarried during one visit there. I was then
visibly pregnant with our second son while conducting interviews and focus groups in Prince
George in the fall of 2015 – a son who was stillborn at eight months of pregnancy only a few
months later. One year following the death of our second son, Leonard unexpectedly passed to
the spirit world after a short battle with thyroid cancer. These births, friendships, hopes, and
losses have marked my life and work, and the presences of both of my sons as well as Leonard
are contained within the spaces of these pages.

Throughout the course of this PhD I have been fortunate to be introduced to the works of critical
Indigenous theorists who have made the work of so many, Leonard among them, legible within
the spaces of the academy, at the same time showing how such work is theoretically and
empirically self-contained, without needing to run it through the lens of colonial academic
thought. I am drawn to this work because of its honesty, and the ways it stays connected to the
earth and the land in order to both expose and avoid the destructive outcomes of colonial
thinking. However, when it comes to enacting and producing this work, or even using it as a
theoretical lens, my own role becomes unclear. Leanne Simpson (2017) powerfully reminds us
of the importance of identity, and what it comes down to is simply that the type of work that is
accomplished by Indigenous critical theory needs to be done by people who are of Indigenous
identity. This assertion seems to exclude someone such as myself, and relates to the debates over
Indigenous identity referred to in the introduction to this dissertation, wherein claims to be
Indigenous have been employed in order to give researchers authenticity in the realm of
Indigenous critical theory; claims which have later been contested (Jaschik, 2015).
What non-Indigenous researchers generally turn to, in order to defend their engagement with the realms of Indigenous theorizing, is twofold. First, non-Indigenous researchers fall back on their relationships with Indigenous communities (Castleden et al., 2012; Gerlach, 2018). Individual personal and research relationships give non-Indigenous researchers the validation that they need to continue to work with Indigenous communities, and this includes eventually taking the path of following Indigenous leads in understanding and interpreting Indigenous knowledge. Having solid, long-term, caring relationships with Indigenous communities that they work with makes non-Indigenous researchers feel empowered. Some scholars have drawn attention to the problems inherent in (and the power imbalances still perpetuated by) these types of close relationships, drawing attention to the need to foreground relational accountability (De Leeuw, Cameron, & Greenwood, 2012; S. Wilson, 2008). Still, these close relationships are the main source of validation that non-Indigenous researchers have access to under the paradigms of Indigenous or decolonizing research (Weber-Pillwax, 2004).

Second, in light of the colonial nature of academic knowledge and the fact that the university continues to privilege specific forms of knowing over others, it is in fact important for non-Indigenous scholars to engage with Indigenous critical theory. This creates safe space for Indigenous scholars who engage with Indigenous critical theory, and challenges accepted ways of knowing so that multiple other epistemologies can be valued in the academy. This work is the work of allyship and solidarity (Byrd, 2009; Kovach, 2009). In terms of how a non-Indigenous scholar can become an independent thinker and theorist by drawing on Indigenous critical theory – I think that it is not only not impossible; I think that it must be done. If Indigenous critical theory is to become an accepted academic framework (and not everyone thinks that it should (see L. B. Simpson, 2017)), non-Indigenous scholars need to use it. Engage with it, learn from it, let it lead them to new heights and depths of knowledge. This is what imbues a theoretical perspective with authority, and this is what leads to having real power in the academy.

Discussions about identity can easily become fraught with tension and entangled with colonialism and the racist ideologies embedded in the Indian Act, yet identity remains a fundamentally important factor in anti-colonial work. There are multiple layers to identity; it is not as simple as belonging to a vague and contested group called “Indigenous peoples.” The concept of being Indigenous, as a general term, came into being at the advent of colonialism and as such tends to be defined in opposition – that is, it is an identity defined by what one is not (as
in, not a colonizer), rather than being a positive identifier that is nation-specific (such as Dakelh or Anishinaabeg)(Alfred & Corntassel, 2011). For Simpson, scholars need to be cognizant of working within specific Indigenous intellectual traditions: for example, certain questions need to be asked before she will draw on the work of intellectuals from outside of the Nishnaabeg nation, including other Indigenous scholars or scholars working in anti-oppression or anti-racist traditions. These questions include: “do I have consent to take this intellectual thought and labor from a community that I am not a part of?” (2017, p. 63). Questions like this have a long history and have yet to be fully answered (Spivak, 1988).

This particular question brings up highly charged points for me, as a researcher and scholar working from outside of an Indigenous nation or epistemology. Whether or not I have consent, and from whom, shifts and changes depending on the context in which I am working. Because I do not belong to an Indigenous community or nation, I have a responsibility to be constantly aware of where I need to seek consent, from whom, and for what, and to make sure that I have this consent before I do the work. One way in which I have tried to maintain accountability is through my own personal and professional relationships. Here, again, Leonard has been significant and his loss leaves me to a certain extent unmoored. However, orienting my loyalties based on personal relationships in turn implicates me in the politics of community. It is not appropriate, nor is it necessary, for me to go into details regarding these politics; suffice to say that, like any communities impacted by systematic processes of oppression, such as colonialism, urban Indigenous communities have often been divided and forced to compete with one another. Various organizations, nations, communities, and groups are often competing for the same, scarce resources. This leads to differences in opinion and approach that mean that my alliance with some people or organizations can potentially rule out the possibility of my working with others. While I was constantly aware of this potential during the course of this research study, it did not in fact happen. When it comes to issues of consent, however – consent to do the research, or consent to use the theories – the potential for this type of exclusive alliance meant that I often had to make an effort to reach out beyond my existing relationships, in order to ensure fairness to communities, and evenness of the feedback that I received. I believe that fairness in this sense entails not taking sides – this is part of the job of the outsider (non-Indigenous) researcher. Therefore I have sought the consent of as many people as I can reach.
I have not always done this perfectly. Scholars working in Indigenous research and attempting to follow principles of relationality mention these types of difficulties, but it is difficult to feel completely at ease revealing these “relational tensions” in academic outputs (Adelson, 2008; Morton Ninomiya & Pollock, 2017; Pasternak, 2017). My first reaction at times, when seeking community involvement in research, is to underestimate the importance of the research and, if I do not hear back from someone, to assume that they are not interested. It is not at all clear how far I should push people to be involved or to meet with me to hear about what I’m doing (Morton Ninomiya & Pollock, 2017). After a certain point – after a certain number of overtures or attempts to establish communication on my part – it starts to feel as though I am making myself and my research a priority over people’s everyday work and lives, which then feels like a reproduction of privilege that is almost comparable to doing the work without asking for consent at all.

For example, when doing community presentations of the work, I found that people felt it was important that they be invited, but in the end very few people actually came. When presenting the initial findings from interviews and focus groups, I engaged with more people in individual meetings, phone calls, or email exchanges than I did in the officially scheduled community presentations. But if I did overlook inviting someone to the presentations, this was taken with offense – and understandably so. This is a mistake that I made at one point. I assumed that since one individual worked at the same organization as someone who knew about the presentations, they would already have been informed. By the time I realized that they did not know and had not yet been invited, the presentations were only three days away, and my last-minute invitation was taken as a sign of disrespect. This was also a person whose involvement was quite important in terms of respectful engagement with the community, and although it was a misunderstanding, the responsibility for making sure this person was involved from the start did in the end rest with me. I was able to talk with them and make amends, but this is a mistake that I will be very careful not to make again. Some other researchers working in Indigenous community contexts have pointed to such difficulties (Adelson, 2008; Pasternak, 2017). The need to avoid excluding people can be tricky, depending on community dynamics.

There are standards for engagement with communities, but for each community and each organization they are different (Gerlach, 2018; Morton Ninomiya & Pollock, 2017). They need to be learned, and sometimes it is possible that they can only be learned by making mistakes.
Indigenous and decolonizing research approaches offer broad guidelines and principles, but they do not offer step-by-step guides for each potential complication that may arise, or even for each stage of the research process. As Gerlach points out, decolonizing approaches “[do] not include prescribed or mandatory methods” (Gerlach, 2018, p. 2). Morton Ninomiya and Pollock concur:

While ethical and methodological frameworks in Indigenous health offer theoretical underpinnings, they do not always provide sufficient guidance for how to apply these in real-world settings of CBPR and decolonizing research. (Morton Ninomiya & Pollock, 2017, p. 29)

I am not sure that it is ever possible to do research based in decolonizing approaches without some complications arising – as a non-Indigenous researcher, which is the standpoint from which I can speak, but I am sure as an Indigenous researcher as well. However, this is a risk that (at least, non-Indigenous) researchers have to be willing to accept. Decolonizing approaches – like decolonization – are messy (Tuck & Yang, 2012). There is no template because the ultimate goals have not yet been accomplished; if they were, we would no longer have any need for decolonizing methodologies (Gerlach, 2018). If non-Indigenous researchers are going to continue to do research in Indigenous communities, we will need to expose ourselves to these risks, and not be afraid to learn from our mistakes. We should not allow complications to stop respectful, engaged research from being attempted, or we risk a return to being detached researchers doing extractive research – or being blocked from doing research in Indigenous communities altogether. For now, being humble, as well as brave enough to go back to make apologies – over and over if necessary – and to try again to get it right, is difficult but, I believe, quite necessary.
Chapter 3
Indigenous Health, Health Services, and Rights in the City

Introduction

Health outcomes for Indigenous peoples in the settler-colonial nation of Canada show gaps when compared with the general Canadian population. For example, Indigenous peoples generally have worse outcomes than non-Indigenous populations in the areas of maternal and child health, mental health, environmental health, and certain communicable and chronic diseases (National Collaborating Centre for Aboriginal Health, 2012). The specific health issues facing Indigenous peoples differ depending on geographical context, such as whether a person is living in a rural or urban area (Browne, McDonald, & Elliott, 2009; Place, 2012). Indigenous peoples in Canada, as around the world, have a large, and growing, presence in cities (Edmonds, 2010; Peters, 2004). For example, “84 percent of Indigenous peoples in New Zealand, 70 percent in Australia and 60 percent in the USA live in urban areas” (Snyder & Wilson, 2012). In Canada, approximately 52 percent of Indigenous people live in urban areas (Statistics Canada, 2017a), although this fact is not yet fully represented in research or policy (K. Wilson & Young, 2008). Health issues in urban areas in general are found to be slightly different than those faced by Indigenous peoples outside of the city. Indigenous peoples living in urban areas, for example, have better self-reported health than those living in rural or remote areas, yet also experience higher rates of racism and discrimination, including in health care settings (National Aboriginal Health Organization, 2003; The Environics Institute, 2010a).

Negative health outcomes for Indigenous communities in Canada are linked in the literature with a range of social and economic determinants of health, including, most prominently, those determinants that can be traced to the impacts of colonialism on Indigenous individuals and communities in Canada (Greenwood et al., 2015; National Collaborating Centre for Aboriginal Health, 2012). These impacts of colonialism include violations of the inherent rights of Indigenous peoples to self-government and self-determination; rights that existed prior to European contact and settlement in North America and have never been extinguished (Borrows, 2015; Coulthard, 2014). They also include interruptions of Indigenous healing practices, destruction of Indigenous peoples’ food supplies, and many other colonial practices and policies that have directly impacted Indigenous peoples’ health (Boyer, 2003; Lux, 2001). All of these
impacts can be traced as causes of the differential health outcomes for Indigenous peoples, in Canada as in other settler colonial contexts. Thus, the improvement of Indigenous peoples’ health can be connected to honouring Indigenous peoples’ rights (Boyer, 2003).

Indigenous rights are conceived of, for the purposes of this study, as including negotiated rights of self-government as well as inherent rights to self-determination (United Nations Declaration, 2008). Self-government refers to “the delegation – through negotiation – of administrative authority from the state to Aboriginal/Indigenous institutions” (Walker, 2006b, p. 2347). Self-determination is a broader and more comprehensive concept that:

Encompasses cultural, economic, political, and legal content and refers to the inherent right of Indigenous peoples to continue governing their own affairs through the reform of relations within the settler state in which they are located. (Walker, 2006b, pp. 2346–47)

The “Aboriginal and treaty rights” of Indigenous peoples – Aboriginal rights referring to inherent rights, and treaty rights being those affirmed through historical or contemporary treaties – are “recognized and affirmed” in the Canadian constitution (Government of Canada, 1982). In spite of this, those Indigenous rights recognized by the federal government in practice are very limited in scope. Recognized Indigenous rights tend to be restricted to access to services such as education and health services, or limited rights to resource use or to self-government (Government of Canada, 2010; Senese & Wilson, 2013a). There are further geographical and identity-based limitations to Indigenous rights as well; specifically, rights to services provided by the federal government are limited to Indigenous individuals who are registered under the Indian Act and living on reserve (Lavoie et al., 2010); and rights to self-government are limited to those practices and groups that can be proven to be continuous with pre-contact societies (Borrows, 2002).

Canada’s system of reserves has developed in part through treaty-making and the imposition of the Indian Act, which is legislation by which the federal government purports to define who is and is not Indigenous, as well as defining areas of federal responsibility and intervening into many aspects of Indigenous people’s lives (Government of Canada, 1985b). Small parcels of land (“reserves”) are held in trust by the Crown for the use of Indigenous groups. The federal government distinguishes between those Indigenous people eligible for registration under the Indian Act, also referred to as “status” First Nations people, and all other Indigenous peoples.
who are called “non-status.” Only status First Nations, who comprise about 45 per cent of the Indigenous population in Canada, are deemed eligible by the government to live on reserves and receive federal services, including health services (Government of Canada, 1985b; Laliberte, R.; Settee, P.; Waldram, J.B.; Innes, R.; Macdougall, B.; McBain, L.; Barron, 2000; Lavoie et al., 2010). In urban areas, therefore, except for the few urban reserves (Peters, 2007), people identifying as Indigenous are either non-status – and therefore ineligible for federal health services or benefits – or status First Nations living off-reserve, and therefore also ineligible for most federal rights and benefits (Shewell, 2016).

In spite of being enshrined in the Canadian constitution (Government of Canada, 1982), the particulars of Indigenous rights continue to be worked out case by case in the legal system. As legal scholar John Borrows has argued, government and legal articulation of Indigenous rights tend to be focused on maintaining Indigenous communities the way they were before contact, with the courts refusing to engage with Indigenous rights to societal change, contemporary governance, or economics (Borrows, 2015). These rights have also remained geographically limited, for the most part – to reserves or to portions of traditional territories – and generally exclude urban areas. Over 20 years ago, the Royal Commission on Aboriginal Peoples identified the rights of urban Indigenous peoples to self-government and a distinct identity as crucial to the physical and cultural survival of all Indigenous peoples (Royal Commission on Aboriginal Peoples, 1996). In spite of this, and the growing urban Indigenous population in Canada, the federal government continues to show reluctance to engage with urban Indigenous populations, except when they are members of First Nations associated with, but not living on, a reserve (Government of Canada, 2010).

With this in mind, the aim of this paper is to examine how Indigenous clients of Indigenous and non-Indigenous health care services and health services workers who serve them conceptualize Indigenous rights in the city when it comes to health care services. It analyzes the perspectives of Indigenous community members and health service workers living in Prince George, British Columbia. In order to contextualize the results, we first discuss in more detail the history and current contexts of health care policy and Indigenous rights with respect to Indigenous people living in urban areas in Canada.
Indigenous rights and geographies of rights

Indigenous peoples have specific rights with relation to the Canadian state, enshrined in treaties and other agreements with the federal government, in addition to having inherent rights apart from those recognized through the state (Coulthard, 2008). Indigenous rights include rights to land and to self-government, as well as access to services such as education, housing, or health care (Blackburn, 2007) and, as recently acknowledged in court, Indigenous title to land (Borrows, 2015). “Aboriginal and treaty rights” which apply to First Nations (whether or not registered under the Indian Act), Métis and Inuit peoples, have been affirmed in the Canadian Constitution Act, 1982, which specifies that “treaty rights’ includes rights that now exist by way of land claims agreements or may be so acquired” (Government of Canada, 1982). Treaty rights include those negotiated through historical treaties, in a nation-to-nation fashion before the assertion of Canadian sovereignty, as well as those falling under modern treaties or land claims (Asch, 2014; Government of Canada, 2015).

Indigenous rights in Canada, while attached to an Indigenous identity, are often also in practice tied to the existence of a band located on a reserve (Blackburn, 2007; Keay & Metcalf, 2004; Murphy, 2001). There are a small number of urban reserves in Canada (Peters, 2007), but most reserves are located in rural or remote spaces. As such, Indigenous rights are more difficult to articulate in urban areas, in spite of the fact that cities in Canada are located within the traditional territories of different Indigenous nations and more than 50 percent of the Indigenous population lives in urban areas (C. Andersen & Denis, 2003; Kulchyski, 2011; Senese & Wilson, 2013b). Geographers have amassed an important body of work dealing with this type of differential applicability of rights depending on geography (Blomley, 2009b; Blomley & Pratt, 2001; Kohn, 2004). Key themes in this work are the distinctions between rights in public and private spaces, and the related tension between private property rights and collective rights, as well as the concept of the “right to the city” (Lefebvre, 1968).

Geographers argue that rights discourse is understood in different ways, depending on the spaces in which it is mobilized (Blomley, 2009a; Blomley & Pratt, 2001). One example is in the distinction made between public and private space, which has particular implications along racial and class lines, as certain groups tend to be overrepresented in public arenas, whereas other population groups, such as urban Indigenous peoples, are at times rendered almost invisible from
This invisibility has implications when groups are claiming rights. The issue is further complicated by the priority accorded to individual and exclusive property rights in Canada and North America, leading to rights being enforced as the right of an individual to control access to one’s property, effectively removing that property from public space (Blomley, 2004). In Canada, the exercise of collective rights such as Indigenous rights seems thus to be limited to the “public” sphere, one which excludes private property and limits both the locations and the types of rights that can be claimed (Blomley & Pratt, 2001; Bondi, 1998; Butler, 2004; Kohn, 2004; Ruddick, 1996).

This tension between private and public space, as it relates to group rights and individual rights, is particularly relevant in Indigenous contexts. For example, land allocated to reserves (which is most often, but not always, in rural areas) is excluded from the laws of private property. Reserve land is allocated rather than bought and sold, is tied to membership in a band under the Indian Act, and remains under the control of the Crown (Laliberte, R.; Settee, P.; Waldram, J.B.; Innes, R.; Macdougall, B.; McBain, L.; Barron, 2000). The right to land on reserve is a collective right defined by an identity, that can only be exercised within a certain geography – that of the reserve. In cities, with the exception of urban reserves, individual property rights take precedence over collective rights, and Indigenous rights, especially to land and self-government, become much more difficult to articulate and define (Blomley, 2004, 2009a). In a recent study, Senese and Wilson (2013b) found that Indigenous people who moved to Toronto from a reserve or rural area outside of the city felt that their Indigenous rights were less respected in the city, in part through decreased access to social services such as education, health care, or transportation. Their research also suggests that Indigenous health and social services in urban areas are an important aspect of the fulfillment of Indigenous rights.

Another concept explored by geographers related to rights in urban areas is the “right to the city,” originally articulated by Lefebvre (1968). Lefebvre argued that those who inhabit a city have the right to both define and contribute to social and political change within the city. He imagined the new city as a kind of masterpiece; an “oeuvre,” created by those who occupy its everyday space. According to Lefebvre:
Only groups, social classes and class fractions capable of revolutionary initiative can take over and realize to fruition solutions to urban problems. It is from these social and political forces that the renewed city will become the *oeuvre.* (1968, p. 154)

Geographers have examined the right to the city through a distributive social justice framework, using the concept to expose injustices in terms of differential access to city spaces and resources (Marcuse, 2012). For example, Skinner and Masuda (2013) put Lefebvre’s concept to use examining the impact of the perceived right to the city on health for Indigenous youth in Winnipeg, Canada. A reflection by a co-researcher in this research is illuminating of the differential access that the space of the city can create. The youth co-researcher writes:

> Buildings are designed for a purpose and if you don’t fit that purpose you’re not welcome... The streets in my mind are an even playing field. I say this because on the streets there is no social hierarchy. (Quoted in Skinner & Masuda, 2013, p. 215)

This youth articulates a right to the streets – which no one person can be said to “own” – in contrast to a right to the buildings, which are generally considered under the rules of private property. The perceived effect of privatization and private property rights is thus to spatially (and socially) restrict the right of certain people to the city (Blomley, 2004; Kohn, 2004; Mitchell, 2003). The individual nature of the right to the city envisions urban inhabitants as all different but equal – a vision that can efface the uniqueness of Indigenous rights. However, the right to the city also makes the workings of private property rights explicit, which in turn opens up space for Indigenous rights to be articulated in contrast with private property rights (Blomley, 2004, 2015).

Indigenous rights, in the city and elsewhere, are often articulated in relation to the federal government. The government of Canada engages with Indigenous rights in several ways. Two key policies are the Comprehensive Claims Policy and the Inherent Right To Self-Government Policy (Government of Canada, 2010, 2015). Comprehensive claims are sometimes referred to as modern day treaties, although their form and process differ significantly from historic nation-to-nation treaties signed between Indigenous nations and the British Crown. The purpose of comprehensive claims, according to the federal government, is to “deal with the unfinished business of treaty-making in Canada” (Government of Canada, 2015). Several land claims have been negotiated in Canada, such as the James Bay and Northern Québec Agreement (1975) and the Nunavut Land Claims Agreement (1993). Others have been under negotiation for several
decades, such as the Algonquin land claim on the Ontario side of the Ottawa River watershed. However, the federal government approach to land claims and self-government is problematic, since their insistence on ultimate control over all aspects of the land claim process undermines any reference to Indigenous sovereignty as part of the negotiations. This makes the contemporary process substantially different from the nation-to-nation negotiations that characterized at least some of the early treaties in what is now Canada.

The Inherent Right to Self-Government Policy, implemented in 1995, shares many of the problems of the Comprehensive Claims Policy. The federal government’s stance on Indigenous peoples’ inherent right to self-government is that “the Aboriginal peoples of Canada have the right to govern themselves in relation to matters that are internal to their communities, integral to their unique cultures, identities, traditions, languages and institutions, and with respect to their special relationship to their land and their resources” (Government of Canada, 2010). This stance is based on a test for Indigenous rights laid out in the 1996 Supreme Court Van der Peet decision (Borrows, 2002), in which Indigenous rights, in order to be recognized by the court, must be shown to be associated with practices integral to a distinctive culture and that also demonstrate continuity with an Indigenous culture before the arrival of Europeans in North America. Legal scholar John Borrows explains that this takes full consideration of Indigenous rights completely out of the equation:

The Supreme Court [of Canada]’s ‘integral to a distinctive culture’ test does not extend protection to Aboriginal practices that developed solely as a result of European influence, even if those practices are essential to their contemporary physical and cultural survival. Surely this result is less than a full recognition and affirmation of Aboriginal rights. Aboriginal peoples are entitled to expect legal protection for their continued existence as normative communities and nations within North America. Why entrench Aboriginal rights in the constitution if the societies they were meant to protect cannot survive? (Borrows, 2002, p. 75)

In other words, under government policy Indigenous communities may exercise a right to self-government, but not on the community’s own terms. Which affairs are considered integral and internal to an Indigenous culture are defined by the federal government, while the burden to prove adherence to these definitions is laid on the Indigenous communities claiming Indigenous
rights. This process of definition leads to the reduction of legal and political processes to “culture,” enabling the recognition of cultural difference while preventing shifts in political, legal or economic power towards Indigenous communities. Browne and Varcoe call this “culturalism:” a process that employs a “narrow conceptualization of culture [and] is founded on the idea that culture is something fixed or static” (Browne & Varcoe, 2006, p. 158). Lawrence terms this process the “culturalization” of Indigenous rights, in that, for example, “the Aboriginal right to fish for food, which should have simply been a question of survival for contemporary Aboriginal people, is defined as an Aboriginal right because it is ‘distinctive to the Aboriginal culture claiming the right’” (Lawrence, 2012, p. 56, citing Borrows, 2002). This leads discussion of Indigenous rights away from questions of Indigenous survival and focuses instead on creating narrow definitions of what an “Aboriginal culture” is, in the process completely ignoring rights in an economic or political sense and failing to relate rights to land.

Indigenous self-government as supported in government policy remains ultimately subservient to federal and provincial law. As the policy states, in the case of self-government for Indigenous communities:

The Government takes the position that negotiated rules of priority may provide for the paramountcy\(^2\) of Aboriginal laws, but may not deviate from the basic principle that those federal and provincial laws of overriding national or provincial importance will prevail over conflicting Aboriginal laws. (Government of Canada, 2010)

Thus, while the administrative and financial burdens of negotiating and implementing self-government agreements for Indigenous communities are high, the resulting powers that the federal government is willing to recognize are extremely limited. Borrows (2002) argues that since Canadian law as it currently exists is based upon a meeting of European and Indigenous legal traditions, the diverse legal traditions of Indigenous communities should be respected in their own right alongside the Canadian legal system. This would mean that Indigenous communities would be empowered to follow Indigenous laws according to Indigenous values,

\(^2\) The paramountcy of Aboriginal laws refers to the process within self-government by which Indigenous communities would have the authority to create rules and laws for the purpose of governance that would take precedence over, or override, provincial, territorial, or federal law.
instead of having to adjust Indigenous legal traditions to harmonize with Canadian federal and provincial law.

Honouring Indigenous laws in their own right requires circumscribing, to a certain extent, the reach of the powers of the state. Some geographers have highlighted the revolutionary aspects of Lefebvre’s vision of the right to the city, imagining a right to the city that similarly circumvents the state (Kipfer & Goonewardena, 2013; Purcell, 2013). This point is perhaps particularly relevant for Indigenous peoples, whose claims, as Byrd (2011) and others point out (see, e.g., Bruyneel, 2007b; Coulthard, 2008; Kulchyski, 2013), surpass the state both temporally and geographically. A right to the city can be part of a framework that pushes inhabitants of the city to think outside of the state and outside of a capitalist system to envision new forms of urbanism, rather than merely pushing for more recognition within the already existing system (Purcell, 2013). Borrows and other Indigenous scholars argue that Indigenous rights should be independent of the need to seek recognition of such rights from the state, promoting broader concepts of self-determination over more limited rights to self-government (Coulthard, 2014; L. B. Simpson, 2011).

An analysis of Indigenous rights with respect to health care requires attention to the ways in which health care policy ignores Indigenous rights and is unevenly applied to Indigenous peoples in Canada. The next section of the paper introduces the context of how health care and health policy relate to settler colonialism for Indigenous people living in urban areas.

**Health care policy and determinants of health for urban Indigenous people**

In the early 1950s, due to colonial policies restricting Indigenous peoples’ movements as well as identities, the percentage of the population in Canada identifying as Indigenous and living in urban areas was less than 7 percent (Government of Canada, 1985b; Kalbach, 1987). As of 2016, according to the Census of Canada, the percentage of Indigenous peoples living in metropolitan areas (cities of 30,000 people or more) increased to 52 percent (Statistics Canada, 2017a), and one Toronto-based study suggests that the Census is dramatically under-representative of urban Indigenous population numbers (Toronto Well Living House, 2018). In spite of the large and growing populations of Indigenous peoples living in urban areas in Canada, most academic research and literature remains focused on rural areas and reserves (K. Wilson & Young, 2008).
Despite the lack of urban-based research and policy related to urban Indigenous populations, networks of Indigenous institutions have developed in cities across Canada to provide services, support, and recreation opportunities for Indigenous people living in urban areas. Native Friendship Centres – agencies designed to provide support for people adjusting to life in the city – began to appear in many cities throughout Canada in the 1950s and ‘60s (National Association of Friendship Centres, 2012).

Health care policy in Canada for Indigenous peoples is limited in similar ways to the limitations placed on Indigenous rights. The federal government provides funding for health care services nationally under the Canada Health Act, but the provinces are responsible for the administration and delivery of health care services (Government of Canada, 1985a). Legally, under the British North America Act, 1867, the federal government has responsibility over “Indians, and Lands reserved for the Indians,” which Indigenous scholars and leaders interpret as including responsibility for safeguarding the wellbeing of Indigenous peoples (Boyer, 2003; Government of Canada, 1982; Laliberte, R.; Settee, P.; Waldram, J.B.; Innes, R.; Macdougall, B.; McBain, L.; Barron, 2000). However, as in the case of Indigenous rights, the federal government interprets its responsibility as being limited to people registered under the Indian Act and living on a reserve. For anyone not living on-reserve, the responsibility for providing health services falls to the provinces. Provinces are often reluctant to formulate specific policies with respect to Indigenous peoples, seeing that as an offloading of responsibility on the part of the federal government.

Health care policy for Indigenous peoples in urban areas, falling mainly under the jurisdiction of provinces and territories, thus remains uneven (Lavoie et al., 2008). In Ontario, for example, there is a network of Aboriginal Health Access Centres set up across the province in urban, rural, and on-reserve areas under the provincial Aboriginal Healing and Wellness Strategy (Ontario Ministry of Community and Social Services, 2016). The First Nations Health Authority in British Columbia retains responsibility for health services in First Nations reserve communities while also supporting Indigenous-led health organizations operating in urban areas (First Nations Health Authority, 2017). These provinces are unique in Canada, however; elsewhere, health care policy intended to support Indigenous people in urban areas is applied on a smaller scale or is entirely non-existent (Lavoie et al., 2008; Snyder et al., 2015).
In addition, health services provided by provinces and territories that are aimed at the general population in urban areas in Canada tend to operate within a cultural paradigm that is not only unfamiliar to many Indigenous peoples, but at times actively hostile (Goodman et al., 2017). Indigenous people accessing mainstream health care services in cities frequently report experiences of racism or discrimination (Allan & Smylie, 2015; Loppie, Reading, & de Leeuw, 2014). This racism and discrimination is associated in the literature with the colonial structures that form the foundation of the Canadian nation-state (Asch, 2014; Browne, 2017a). These colonial structures, in turn, are described as determinants of health that impact Indigenous peoples in unique ways, collectively and at an individual level (Greenwood et al., 2015). Colonialism as a determinant of Indigenous peoples’ health is what makes the health care needs of Indigenous peoples in Canada unique when compared with other population groups; the generally lower health outcomes of Indigenous peoples can be traced to the various and widespread impacts of colonial policies, legislation and practices, thus making it important to take Indigenous peoples’ unique experiences of colonialism into account when providing health care services (Czyzewski, 2011; Greenwood et al., 2015; Maxwell, 2011b).

Given the importance of Indigenous rights to self-determination in improving Indigenous peoples’ health, the goal of this study is to examine links between health care services and discourses of Indigenous rights in urban areas. In order to do so, this paper examines how both urban Indigenous clients of health care services and health services workers understand Indigenous rights in the context of health care settings in the city.

Methods

This paper draws on the results of a qualitative research study done in the city of Prince George, British Columbia, Canada, between 2012 and 2016. The methods used were semi-structured interviews and focus groups, undertaken using a community-based research methodology and with the guidance and advice of a community advisory group of eight Indigenous leaders, Elders, and health care providers and decision makers based in Prince George. In total, 50 Indigenous community members and 15 health services workers in Indigenous or non-Indigenous health care services but focused on providing care for Indigenous clients, participated in the study. Interview and focus group questions asked about Indigenous peoples’ experiences using health care services; the roles of Indigenous-led health organizations in providing Indigenous community
members with a sense of community and support; and the ways in which Indigenous community members perceived their rights to be supported through health care services in the city. We turn now to an examination of participants’ responses to the final set of questions, those dealing with Indigenous participants’ perceptions of support for their rights within health care services in the city.

Results

Indigenous clients were asked how they felt their rights were supported by Indigenous-led and other health organizations in the city, if at all, and health services workers were asked how they perceived the rights of Indigenous clients to be supported in health care settings. These questions were asked in an open-ended manner to allow participants to articulate their own understandings of what rights are, and what rights they felt Indigenous community members accessing health services had. Interestingly, responses reveal that the rights that clients and health services workers articulated a need for were at a much more basic level than the right to self-government or self-determination. The rights participants discussed fell into three main categories: violations of rights in health care settings; strategies for supporting peoples’ rights; and the inconsistencies regarding entitlement to rights. In discussing these categories, human rights, including dignity, equal treatment, and the right to help when it is needed, were more clearly emphasized than Indigenous legal rights by participants. In addition, participants pointed to the complex geography- and identity-based nature of rights, especially when it comes to health-related services and benefits for Indigenous people in the city. Participants are quoted anonymously according to their role as either “clients” (e.g., “Client 5”) or “health services workers” (HSWs) (e.g., “HSW 1) when drawing from interviews, or else quotes are attributed to participants in one of four focus groups (FG) (e.g., “FG 3”).

Violations of the right to receive care

Twenty-six participants – both Indigenous clients and health services workers – described instances in which clients’ rights had been violated or disregarded, when asked about how Indigenous clients’ rights were supported by health care organizations in the city. This was mainly described as the violation of a right to receive care, which included feeling that the right to receive care was upheld in some places but disregarded in others; that health care was not provided unless clients or their advocates insisted on it; or that participants were not being given
equal treatment compared with other (non-Indigenous) clients. Participants described being treated differently depending on which institution they were in, and feeling that they had a right to be cared for that was not always upheld. Rights were generally described as being respected in Indigenous-led organizations. As one participant responded, when asked whether they felt that their rights were supported in health care:

Mm, not really. No. Maybe here, when I come to [this Indigenous organization]. That’s why I come here a lot, because I feel like I got support here. They seem to want to help me, so that’s where I’ve been going to get a lot of counseling, is here, too. Like for my health and stuff, because I believe if you don’t get that kind of help, then you know you get depressed, and then you don’t eat right, and then it affects your whole area of your life and stuff. So yeah, I try to come here as much as I can. (Client 11)

This participant described their rights as being upheld when services were offered willingly (“they seem to want to help me”), but stated that this was not the case in most health care settings in the city. Another participant made a similar point, when asked whether their rights were respected in health care in the city:

Depends on where you go. Some, some places they never let you in there. Other places, they’ll chat with you while you’re doing whatever. (Client 4)

This participant described being excluded from certain places and welcomed in others. As with the previous participant, this client felt that their rights were upheld when services were offered willingly and openly (“they’ll chat with you”) but in some places they were actually denied care (“they’ll never let you in there”). This unevenness of respect for the right to receive care can lead to a feeling of uncertainty when approaching a service, in that Indigenous clients were not always sure whether or not a given place would respect their right to be cared for.

Violations of the right to receive care were often described using the language of human rights. As one participant put it:

Human rights? No, there are some places that, I think they violate your rights, but I just stay away from them, so, doesn’t matter to me. (Client 6)
This participant expressed a sense of having had their human rights violated in some health care settings – they did not specify which places, whether Indigenous-led or non-Indigenous led – but articulated a sense of independence as a way of protecting themselves from such violations. This was expressed as a way of preserving this individual’s human rights and dignity, but carried a negative connotation as well, since the avoidance of health services in a city where the choices for health care are not extensive, can have the effect of limiting the quality of a client’s health care.

Several participants described feeling a need to insist on being cared for before health care would be provided, even when they had already been granted access to the spaces of health care; for example having to seek out a health care provider and specifically ask for something before anyone would come to help. One participant in a focus group discussion described a situation in which their mother was not receiving what they felt was appropriate care, and the subsequent need to be forceful in getting their needs addressed:

When we went to the hospital, when [my mom’s] appendix burst, when all of that stuff happened, she was, in the fricking Emergency [department], like, in the hallway, on her bed.... And my little niece... if she didn’t phone me, and it was just her down there, like she wouldn’t have been able to be like, ‘hey you,’ like get, like you know, be pushy like that. (FG 2)

The implication here is that if this participant’s niece had not called someone else for support, their mother’s health might have been severely compromised through not receiving the care that she required. As another example, participants in a focus group described needing to beg to get help for Elders who had trouble affording “extra” health supports such as dentures:

P1: As you get older, health care for Elders is very bad... because Elders, they get only a set income coming in, and after they get their food, their shelter, and their little side expense, you know – they have no monies for their glasses, if they need, their dentures, or if they need a hearing aid, or anything. Extras... if they need a knee brace, or a wrist band, or something... ten dollars, twenty dollars for an Elder, is really, really hard to save, because they get only a set income.... To me, Elders should get – after you’re sixty, I think all the health care should be taken care of for the Elders, all the health care. And it’s not happening. So what is it, what is it telling us?
P2: Let me down Harper. [laughter] I don’t know, government has lots to do with that, eh?....

P1: There’s certain people that will help. There’s certain agencies that will help. But you have to beg. And so, honest – sometimes I am begging for people. It’s – it should just automatically be there. (FG 1)

Participants in this discussion indicated that when the government offers financial support for some aspects of health care but not others, it seems quite unfair. Participants clearly felt that people shouldn’t have to beg to receive support that they feel is both necessary and just – when they do, it is experienced as a violation of the right to receive care.

The need to speak up in order to receive proper health care was also linked to a sense of being treated differently than other clients would be, because of being Indigenous. This was also expressed as a violation of the right to be cared for or to have one’s needs met. For example, one participant said:

[My partner], he always thinks I’m making a big scene, wherever I go. And he’s not from a minority, so he doesn’t know what it’s like to have to really stand up for things that you want to get done... and I’m just like, ‘... I have, you know, needs, and rights.’ (FG 2)

Here, this participant linked the need to speak up with being Indigenous. The violation of the right to care was linked to a violation of their entitlement to being treated on an equal basis with non-Indigenous people.

Overall, when asked about how their rights are upheld in the city, participants frequently described the violation of a perceived right to receive health care on an equal basis with all other people. In some health care settings, participants felt that their rights as human beings were violated. The implications of this were that participants felt they could not expect consistent treatment from different institutions, and that they had to play an active role in advocating for themselves or their family members in order to receive the appropriate level of health care for their needs. Further, the reasons participants understood for being treated differently had to do with being of Indigenous identity.
Ways of supporting Indigenous peoples’ rights in health care

Twenty-two participants described ways in which Indigenous clients’ rights were supported in health care. The rights that participants described were related to being respectful of Indigenous healing approaches, and awareness on the part of health service providers of people’s unique health care needs based in Indigenous identities. This was related more closely to concepts of cultural safety, the right to care, and human rights, than to Indigenous rights as articulated through Canadian legal and policy frameworks. Expressed by both Indigenous clients and health services workers, support for Indigenous clients’ rights in health care was generally described as changes being made within non-Indigenous health care services to improve cultural safety and feelings of inclusiveness and support; or as advocacy work done by Indigenous health organizations and their staff, to recognize Indigenous clients’ rights in the framework of holistic health care.

Changes being made to non-Indigenous health care services to better accommodate Indigenous peoples’ rights were often expressed in terms of cultural sensitivity or cultural safety. For example, one health care worker, who works in a non-Indigenous-led health care service, described making accommodations at an organizational policy level as well as at an individual level, as a part of upholding rights:

One way [of upholding rights for Indigenous people], as we mentioned, was to make sure that our policies, for example in smudging, are used to make sure that we’re using culturally sensitive spiritual health care. And that becomes very complex for the Indigenous people, because, for example, in this area, often Indigenous people are Roman Catholic, and so there is both, sometimes, a fear of and a desire for end of life ritual in the Roman Catholic tradition. So to be sensitive to that... and to find ways to work with families that might be in conflict, in and around that. (HSW 4)

This participant described upholding Indigenous people’s rights through ensuring that health care is culturally safe, including accommodating specific cultural or spiritual practices. This included even those practices that are not always necessarily associated with Indigenous traditions, such as those within the Roman Catholic tradition.
One client described cultural safety in terms of taking into account local Indigenous histories in a non-judgmental way:

That [Indigenous-led health organization]’s a really nice place too. Like, they don’t judge you or anything.... I find that they’re way more nicer, yeah [than non-Indigenous health care organizations]. And because I think of the history of, of Natives and stuff like that. (Client 5)

Another health services worker from a non-Indigenous health care organization, whose interview was not recorded, pointed out that when people talk about Indigenous rights they are usually referring to rights to land, resources, or self-government. These rights were felt to be in a separate category from health care. Within health care, this participant felt that what could be done was to improve respect for Indigenous healing traditions and Indigenous perspectives on health care, including, for example, the need to have extended families gather together when someone is sick (HSW 1). Again, this indicates a sense that what is needed is the right to care, provided in a culturally sensitive or culturally safe manner, rather than Indigenous rights on the level of self-governance or self-determination.

In terms of advocacy work in support of Indigenous clients’ rights, several health care providers from Indigenous-led health organizations described going to court with clients, to support them and advocate for them as a way of upholding people’s rights. This is not an intuitive part of health care practice, and was described by some participants as extra work that is taken on outside of the usual job description. For example, one health services worker from an Indigenous-led organization explained:

The majority of us have gone to court for our clients, and contacted other agencies for our clients, and gone to bat for our clients, regardless. That’s just, and I don’t even think it’s in our job descriptions, it’s just what we do. Right, in support of our clients. (HSW 7)

Another health services worker described advocacy for Indigenous clients in the spaces of health care as a core element of their job:

What I do is if somebody wants assistance going to a doctor’s appointment, I go with them, or if I have a client in the hospital, I go to the hospital and I attend family meetings
in the hospital, so I make sure the client’s needs are being met. And sometimes the client can’t get their needs across, and they feel they’re not being heard, so then that’s what I do. I go to make sure they’re being heard and their needs are being met. (HSW 5)

Advocacy was also framed by participants as necessary because of racism embedded in the community, including in many non-Indigenous-led health care organizations. As another participant explained:

This is a very conservative town, and so, is there a lot of racism here? Yeah. It goes both ways, but there’s a lot of racism here, and a lot of times, for instance like going into, even in a MSP [Medical Services Plan] office, to get their cheque – we’ve had our counselor go with a person to do that, even, right? Court – that’s a big thing. Right, because it’s not a – for Aboriginal people, it’s kind of a foreign concept, and so we don’t understand, when you don’t have that advocate, it makes it so much harder, so... I can definitely say we do advocate for our clients... There have been times when senior [staff] have found out about something, a death, or something that affects the Aboriginal community, and they let us know right away, and then we all get together and do what we can. (HSW 7)

Supporting Indigenous clients’ health was not perceived to be possible without being accompanied by advocacy on behalf of clients in other areas, whether outside of Indigenous-led health organizations or outside of the health care system. In addition, the core purpose of Indigenous-led health organizations themselves was perceived to be to challenge racism through advocating on behalf of Indigenous clients and communities.

Clients also discussed advocacy work undertaken by Indigenous-led health organizations as a way in which their rights were supported. As one client put it:

I know [one Indigenous-led health organization] advocates a lot.... They do – they connect with – if somebody comes in, no matter who it is, the connection with the social worker at the hospital [can be made], the Native liaison, or, you know. (FG 1)

In all, when articulating how Indigenous peoples’ rights are supported in health care spaces, participants described both the importance of cultural safety and sensitivity within non-Indigenous health care services, and the need to advocate for clients and to challenge racism that
is embedded in health care and other services and policies, in order to uphold Indigenous peoples’ rights. Rights in this case are again perceived to be rights to health care, rights to cultural safety, or human rights in the sense of preserving safety and dignity, and treating people on an equal basis in an environment free from racism or discrimination.

**Inconsistent geographies and identities with respect to Indigenous legal rights**

Eighteen participants – both Indigenous clients and health service workers – spoke about the confusing and inconsistent nature of Indigenous rights when it comes to health and health care. Rights were described as being limited based on both a person’s identity and geography. Specifically, when asked about how they felt Indigenous clients’ rights were supported in the city, clients and health services workers described differences between support received in the city and on reserve; the inconsistency of status cards or other forms of identification in terms of linking to rights and benefits; and that it can be hard to discern what rights an individual is entitled to because of the complex and inconsistent ways in which Indigenous rights are allocated by geography and identity.

When living in an urban setting, participants felt that they did not have access to the same type of financial support for access to health care services, prescriptions, benefits, and travel, as they would have on a reserve. For example, two participants in a focus group who were registered with a reserve but lived in the city had the following exchange during a conversation about medical travel benefits:

P1: Well I mean, we live in an urban setting, eh. We live in Prince George, and it’s an urban setting, eh, so we all get looked at differently, because we live in an urban setting.

P2: They [referring to band leadership on reserve] call us outsiders.

P1: Yeah. But we’re still registered in a reserve. When voting time comes, we get a letter in the mail, [right now], to vote. But when we need help, we’re waiting a long time.

(FG1)

These clients were discussing the need to travel for medical services and the difficulties they faced in accessing financial support for things like medical travel when not living on reserve.
Another client described a similar feeling of geographical differences in entitlement to rights, during a discussion of coverage of non-insured health care services such as prescription medication. As she said:

Most people, like [my son’s] grandmother on the other side said we’re entitled to have our health care paid for, but I’m like, ‘not around here [in an urban setting].’ So it’s different how they treat people on-reserve, than how they’re treated off-reserve. (Client 18)

Levels of support were also said to differ depending on which band one was a member of. As another Indigenous client said during a focus group:

Our band around here, they arrange everything. All you have to do is be there. Know what I’m saying? Like, you guys have to pay for your trip and stuff like that, eh? They should make it all the same.... Even [one Indigenous organization]... if they don’t work with you [i.e. if you are not affiliated as part of a member nation]... they don’t help, right. They sort of bar you off, bar you out, sort of thing, eh. Like if you were... joined [as] their member, then they do everything for you. (FG 1)

These participants expressed rights as entitlement to services and financial support, which they saw as being inconsistent depending on where a person lived (geography) or which band they were a member of (identity). It is important to note that although the federal government (and now, in British Columbia, the First Nations Health Authority) does offer a certain amount of coverage for medical travel and prescription medication for status First Nations people living off reserve, First Nations participants still found that these benefits were difficult to access and described having a harder time than their counterparts who lived on reserve.

Some participants mentioned status cards or other identification cards when asked about rights. Status cards refer to cards issued by the federal government that are used to identify First Nations people who are registered under the *Indian Act* – approximately 45 per cent of Indigenous people in Canada (Statistics Canada, 2016a). These and other identification cards were described by participants as prerequisites for access to certain rights, whether the right to health care or to other health-related benefits provided by the federal government. Participants described these types of cards as not being extremely useful. One client, for example, felt that having an
identification card was not of much use to them; as they said, “I got a card that says that I’m Métis\(^3\), and my picture, but it doesn’t stand for anything” (Client 5). Several participants expressed this kind of skepticism towards formal Indigenous rights, feeling that there were many barriers in the way of getting identification or status cards as well as that the cards did not bring with them the rights or benefits, such as coverage for prescription medication, that had been promised. In addition, participants expressed confusion over how to access status cards or where to get help when they had problems. As one client responded when asked about health care services:

R: Have you used any health services [since you moved to] Prince George?

P: Um, no, I haven’t.... I had a hard time with my status card, so I don’t even, I’ve never bothered with a doctor.... And I was unable to get prescriptions because – I was given the wrong year for my status card... And I would like to get that straightened out, but I just have to find out some information where I could get my card fixed. (Client 14)

This participant felt that without a status card they were not even entitled to go to see a doctor – which is not in fact the case. Had they seen a doctor and been given a prescription, however, they would not have been able to afford to pay for the medication without the coverage provided by a status card.

Interestingly, one participant described being happy with the limited benefits associated with the status card. They responded to a question about rights in the following way:

R: So do you feel that your rights as an Aboriginal person are supported by Aboriginal health services in Prince George?.... So I guess if you could talk a little bit about what rights you feel you have in the city as an Aboriginal person, and if, if those connect—

P: I’m doing good, because in a couple of weeks or maybe this week, [or] next week I’m going to get my status card, so that’ll help me.... my rights as a Native person in this community, I think my – I’m not like everybody else out there, like I got, I think I got it made pretty good.... I’m on the right meds... I got, like, two doctors, so. (Client 10)

\(^3\) This card is a membership card for the Métis Nation of British Columbia, which comes with certain rights and benefits but is not recognized by the federal government the way a status card would be.
Although this client asserted that having a status card would help them, it is not clear exactly how it would do so. Still, they associated having a status card with having some kind of benefits in terms of Indigenous rights, and considered themself to be luckier than many in the urban Indigenous community in terms of their access to health care and medication, and their living situation.

Reflecting the inconsistency of the rights themselves, the importance of formal or distinct Indigenous rights – including those invoked through status cards, as discussed above – was emphasized by some participants while others distanced themselves from the concept. One health services worker said, “I do think that there’s a specialness to Aboriginal peoples’ rights, we need to pay special attention because the general population has made a point not to” (HSW 1). Another health services worker, however, felt that most members of their community did not identify with the need for Indigenous rights:

I would never say, you know, ‘it’s my right as a First Nations person to get this or that.’ Like, it’s my right to be treated like a person. But I don’t think we really have that, like in my community – I can only speak for my community – I don’t think anybody says ‘it’s our right to this or that.’ (HSW 5)

This participant distanced themself as well as their community from the concept of formal Indigenous rights.

Finally, participants described a need for more information about Indigenous peoples’ rights. Participants felt that the majority of Indigenous people in the city, often including themselves, did not know what they were entitled to in terms of Indigenous rights, with respect to health care. For example, as one client said:

R: Is there anything else you want to add?
P: I think more understanding of our rights. Like I don’t know – they said that the First Nations health always changes, on what we’re covered and what’s not covered. I don’t know. I don’t know any of that. (Client 18)

Other participants advocated for developing an organization that could help people understand what their rights are with respect to health. For example:
What might be very beneficial is to have a place where it’s – there’s not medical doctors and things, but that there’s somebody that can walk through the process or procedures, with First Nations, right? And give them a run down. ‘Here’s your rights. Here’s your this, here’s your that,’ so more of an information [place], but face to face, not on the phone. That would be quite a help. (FG 2)

In these cases, participants described Indigenous rights as being difficult to understand – which is in part related to identity (for example, as First Nations people), and in part related to government policy (as in, the coverage is always changing). In general, participants felt that more information was needed within urban Indigenous communities about their rights, especially when it came to health care.

Overall, participants described Indigenous rights, in general or with respect to health care, as inconsistent and difficult to understand. There was a great deal of uncertainty expressed in interviews and focus groups with respect to the concept of rights and how people felt that their rights were being respected, often expressed in terms of the inconsistent application of rights depending on where people lived or on how they were identified. Rights, again, were also expressed as a set of benefits or services; participants did not link rights in the context of health care or other services to Indigenous rights in the sense of self-government or self-determination.

**Discussion and Conclusions**

The discourse of Indigenous rights is not easily brought into conversation with discussions about health care services for Indigenous people. As indicated by participants’ responses in this study, health care services were often perceived to be associated with a right to receive care when needed, a right to culturally appropriate or culturally safe services, or respect for human rights. There was also a strong sense of inconsistency in how and where rights were applied and to whom, leading to confusion on the part of participants about what Indigenous rights mean in an urban context. When Indigenous rights become narrowed to a set of benefits or services that are only available in certain places and for people who are identified as Indigenous in specific ways, discussions of the inherent rights of Indigenous peoples to self-government and self-determination then become essentially absent or consciously separated from Indigenous peoples’ rights within health care settings.
For example, in the first finding, when asked about rights, participants responded by sharing experiences of the violation of their right to receive needed services when accessing health care services in the city. Participants felt that this right to receive services when they were needed was honoured in some settings – generally Indigenous-led health care settings – but violated in others; told stories of having to insist on being cared for before care was provided; or reported feeling that Indigenous clients were given poorer or lesser treatment than other clients would receive in health care settings. This finding indicates that there is an urgent need for Indigenous clients to have better experiences in health care, including better respect for human rights, and points toward perceived discrimination or structurally embedded racism as core problems that participants associate with rights.

In the second finding, participants described ways in which rights were upheld in health care services. These participants pointed out the importance of both cultural safety and advocacy for Indigenous clients. Attention to cultural safety and advocating for Indigenous peoples’ needs, in health care and beyond, were perceived as a solution to the racism that Indigenous clients often experience in health care settings. This was portrayed, in turn, as a means of supporting Indigenous peoples’ health. Similar to the first finding, racism is reported as a main problem that needs to be overcome, and again, rights to self-determination or self-government do not seem to be associated with rights in health care settings.

Finally, in the third finding, participants reported differences in access to rights – rights being described as financial support, health services or benefits – between urban areas and reserves, and also depending on what group, band, community, tribal council or First Nation a person was a member of. Participants thus identified that “Indigenous people” are far from one homogenous group when it comes to rights – rather, different Indigenous peoples have dramatically different access to rights depending on differing geographies and identities. These distinctions mirror the complexities embedded in Canadian health care policy and legislation with respect to Indigenous peoples, in terms of who has jurisdiction over health care services and who is entitled to access which services. They also mirror the complexities of Indigenous legal rights. These complexities have their roots in both geographies and identities, as governments have created careful delineations between groups of Indigenous peoples living in differently classified areas, in the process creating different Indigenous identities that come with different rights and benefits. Participants reported having differing experiences with respect to status cards or other means of
identification as well as expressing different opinions with respect to legal Indigenous rights. Participants also expressed confusion around Indigenous rights and a desire to have their entitlements to services and benefits clarified.

These confusions have their root in the distinct and specific ways in which Indigenous rights have limitations and boundaries placed around them. As Senese and Wilson (2013b) explain:

Though generally construed as the inherent, collective rights of Aboriginal peoples, what Aboriginal rights have meant practically has been a set of services and benefits... that are provided by the federal government for status First Nations who live on reserve (apart from post-secondary education assistance and Non-Insured Health Benefits (NIHB), which are available off-reserve). (p. 221)

There is extremely limited recognition of Indigenous legal rights in urban areas on the part of the federal government, especially when it comes to health care. Federal policies related to self-government and the inherent rights of Indigenous peoples focus almost exclusively on regions outside of urban areas, and so in practice, urban Indigenous rights become narrowed to the provision of services such as vision and dental care. Participants feel the effects of these limitations and boundaries quite clearly in their experiences of accessing health care and associated health care benefits. It is therefore not surprising that many Indigenous participants felt that their only recourse to rights in a legal sense was through access to services.

It is important, however, to bring conversations about Indigenous legal rights into health care settings, because of the tensions between colonial goals and Indigenous rights to self-government or self-determination, and the impacts of these tensions on Indigenous peoples’ health. Many scholars point out that self-government and self-determination for Indigenous peoples are needed to close gaps in health outcomes between Indigenous and non-Indigenous individuals and communities (Czyzewski, 2011; Maxwell, 2011a; Reading & Wien, 2009). One of the lingering processes that has had the greatest structural impact on the health of Indigenous peoples, in Canada and around the world, is the lack of self-determination brought about by colonization (de Leeuw et al., 2012; Gone, 2008). Colonialism as a determinant of Indigenous peoples’ health is a recurrent theme in Indigenous health literature, both in Canada (Greenwood et al., 2015) and beyond (O’Sullivan, 2012). Experiences of racism, including in health care, are part of the mechanism through which colonialism impacts Indigenous peoples’ health (Allan & Smylie,
The structural racism that becomes embedded in the health care system and expressed in individual behaviours (Browne, 2017a) is one and the same with the structural racism underpinning the limitations and boundaries placed on Indigenous legal rights over land and natural resources, and restrictions on Indigenous communities’ ability to govern themselves (Asch, 2014; Government of Canada, 2010). All of this has its foundation in the colonial desire for power over Indigenous peoples’ land (Blackburn, 2007; Borrows, 2015).

Participants’ descriptions of violations of the right to receive care, specifically the feeling that some health care organizations are reluctant to provide them with health care, has a dark kind of resonance with Borrows’ (2002) observations that Indigenous rights as articulated by the state do not seem to have as their goal the actual physical survival of Indigenous peoples. Participants describe situations in which Indigenous clients have to speak out, often forcefully, in order to receive a basic level of health care – something that is in policy guaranteed as a fundamental right to all Canadians (Health Canada, 2017). The stated aims of a universal health care system to ensure health for all peoples cannot be achieved when rights to those activities and services that provide for the physical survival of Indigenous peoples are not fully upheld and forthcoming. Attention to Indigenous rights to physical and cultural survival is of the utmost importance in health care settings – where individual people’s physical survival is often in question, but in most cases (with the exception of palliative care) is the end goal. However, in spite of health care providers’ and Indigenous-led health organizations’ ongoing efforts in terms of providing advocacy and giving voice to the needs of Indigenous people in urban areas, the broader community in mainstream health care provision – like the Canadian government – appears to remain uncommitted to Indigenous people’s rights to survival.

Indigenous peoples’ engagement with Indigenous rights, especially in urban areas, is also complicated by the approach that the government takes with respect to Indigenous rights to land and self-government. As discussed above, this approach tends to be one in which the federal government retains final decision-making power as well as sole sovereignty over land, while limiting Indigenous practices to those already being practiced at the moment of contact with European settlers, ignoring the past two to four hundred years of societal adaptation and change (Borrows, 2002; Lawrence, 2012). The exercise of Indigenous rights with respect to the Canadian state is also for the most part limited to registered First Nations people living on reserve and Inuit residing in traditional territories, with urban Indigenous peoples accorded
limited rights to self-government that do not include rights to land (Government of Canada, 2010). It is thus perhaps not surprising that Indigenous community members in this study do not seek recourse to Indigenous rights in order to improve access to health care services and quality of life in the city.

These findings have important implications for the geographies of Indigenous rights. Nicholas Blomley (1994) and other geographers emphasize not only the spatiality of rights, but that the utility of rights discourse may be dramatically different depending on the space in which it is deployed (James, 2013; Purcell, 2013). Blomley points to the difference, for example, between claiming rights in community settings and claiming rights in court (1994). Participants’ distinctions between individual rights to dignity and respect, and the more distant and seemingly less relevant legal rights and benefits accessed through the government, reflect such a place-based distinction. In addition, literature on the right to the city engages with questions of who has a right to be in, and participate in shaping, urban spaces, as well as which parts of the city are perceived to be off-limits for certain population groups (Lefebvre, 1968; Mitchell, 2003). In this study, the perceived low utility and high levels of confusion surrounding rights discourse for Indigenous people living in the city are linked to the geographic specificity of Indigenous rights in Canada, and perceptions that the rights of people of certain identities are restricted to certain geographies. Indigenous rights in Canada, in a contemporary colonial gesture with a long history, are usually confined to reserves (Government of Canada, 2010; Shewell, 2016), leaving urban Indigenous residents feeling that they must fend for themselves, since Indigenous rights are not perceived as including a right to the city.

The geographies of rights research also emphasizes the “scaling up” that happens in rights discourse when local violations of, or agitations for, human rights are linked with global human and Indigenous rights movements (Laliberté, 2015). Supporting the human rights of Indigenous clients and the right to receive care at an extremely local, individual scale, when combined with advocacy in the broader community, can have impacts at broader scales. When spaces are created for Indigenous clients in which everyone’s rights as human beings are respected, people can feel empowered enough to take steps towards correcting the more fundamental structural imbalances in Indigenous peoples’ lives. As many scholars continue to point out, what is needed to close gaps in health outcomes and access to health care between Indigenous and non-Indigenous individuals and communities is self-government and self-determination; that is,
action needs to be taken at multiple scales simultaneously (Greenwood et al., 2015; Loppie Reading & Wein, 2009; Tuck & Yang, 2012). By beginning where change is needed most immediately, at the level of service provision in order to promote individual Indigenous survival, Indigenous-led health organizations have the potential to expand and uphold urban Indigenous rights to self-determination, and Indigenous cultural, political, and physical survival at a much larger scale.

The Report of the Royal Commission on Aboriginal Peoples (RCAP), published over twenty years ago, employs strong language in its 25 recommendations with respect to the need to reorganize health care services in conjunction with legal rights for Indigenous peoples in Canada – whether in urban, rural, or reserve areas. For example, one recommendation with respect to health care planning recommends that:

Federal, provincial and territorial governments, in consultation with Aboriginal nations and urban communities of interest, co-operate to establish procedures and funding to support needs assessment and planning initiatives by Métis and other Aboriginal collectivities, in rural and urban settings. (Royal Commission on Aboriginal Peoples, 1996, s.3.3.9)

In addition, the RCAP report explicitly recognizes the fundamental need for self-government in health for Indigenous peoples. The report recommends that:

Governments recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore a core area for the exercise of self-government by Aboriginal nations. (Royal Commission on Aboriginal Peoples, 1996, s.3.3.2)

The Truth and Reconciliation Commission of Canada (TRC)’s Calls to Action include six recommendations dealing with health and health care. Among them is a call for the recognition of legal and treaty rights to health care, although these rights are no longer explicitly described using the language of self-government:

We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of
previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties. (Truth and Reconciliation Commission of Canada, 2015, call to action no. 18)

The TRC places emphasis on the impacts of residential schools specifically, rather than discussing residential schools in the context of the more general and widespread impacts of settler colonialism. This recommendation refers the reader to legislation and treaties that advocate self-government, but without explicitly making links between self-government and health in the text of the recommendation itself.

With respect to rights, the TRC’s recommendations again take a step back compared with the RCAP report when it comes to off-reserve and urban Indigenous peoples. In this case the TRC recommends attention to “health needs,” rather than health care rights:

We call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples. (Truth and Reconciliation Commission of Canada, 2015, call to action no. 20)

In spite of the continued need for action with respect to health care in Canada for urban Indigenous peoples as well as attention to rights in the context of health care, the TRC’s calls to action are much less strong than the RCAP recommendations, in terms of the number of recommendations, the language used, and the extent of recognition of Indigenous rights, especially in urban areas.

Moving forward, studies of Indigenous health should explicitly take into account Indigenous legal rights when investigating the provision of health care for Indigenous peoples in Canada. This would highlight the responsibilities of various actors in health care settings to uphold both human and Indigenous rights (Laliberté, 2015), furthering geographies of responsibility and accountability in order to expand geographical scholarship on rights. Future research should also take on the task of more clearly articulating and defining the leadership roles of Indigenous-led health organizations in terms of Indigenous rights, as well as investigating how to develop alternative mechanisms by which Indigenous legal rights and human rights can be asserted and protected in health care in urban areas.
The findings of this study show that scholars as well as health care leaders, practitioners, and policy makers need to remember the recommendations of the Royal Commission on Aboriginal Peoples from so many years ago, in order to draw attention to what has still not been accomplished with respect to urban Indigenous health and Indigenous rights to health care and self-government in Canada. The foundational impact of colonial policy and structures on Indigenous peoples’ health is still recognized by the TRC, as is the need to revisit health care funding and policy structures (Truth and Reconciliation Commission of Canada, 2015). Action in these areas should be complemented by attention to Indigenous legal and inherent rights to self-government and self-determination, in the pursuit of health equity for Indigenous peoples in Canada.
Chapter 4
Understanding Barriers to Health Care Access Through Cultural Safety and Ethical Space: Indigenous People’s Experiences in Prince George, Canada

Introduction

In the settler colonial nation of Canada, almost 1.7 million people (4.9 per cent) identify as Indigenous, including First Nations, Métis, and Inuit (Statistics Canada, 2017a). About 45 percent of Indigenous people are registered under the Indian Act and are referred to as “status First Nations” (Government of Canada, 1985b). It is important to note that the Constitutional division of Indigenous peoples into First Nations, Métis and Inuit overlooks immense cultural diversity. For example, there are over 618 First Nations in Canada, and Indigenous peoples speak over 70 Indigenous languages within 12 distinct language families (Statistics Canada, 2017a).

The jurisdictional context within which services such as health care for Indigenous peoples are organized in Canada is complex and tied strongly to both identity and geography. The Indian Act is a piece of legislation that governs the organization and delivery of services, and has been imposed upon Indigenous communities since 1876 by the Canadian government (Lavoie et al., 2010). Under the Indian Act, portions of land called reserves are set aside “for the exclusive use of an Indian band.” (Hanson, 2009, n.p.). There are currently 618 reserves recognized by the federal government in Canada, many of which are small, with fewer than 1000 affiliated members. Some reserves are large in size, however, such as the Six Nations of the Grand River in Ontario with over 27,000 members (McCue, 2015; Six Nations Council, 2013; Statistics Canada, 2017a). Authority over the process of setting aside reserve land and deciding who is eligible to use it rests primarily with the federal government rather than with Indigenous communities themselves (Government of Canada, 1985b). Reserves are provided with primary health care and public health services, some education, and other services and infrastructure by the federal government (Kelly, 2011; Lavoie & Forget, 2008). Status First Nations people (that is, First Nations people who are registered under the Indian Act (Statistics Canada, 2017a)) living off-reserve only have access to the federal Non-Insured Health Benefits program (NIHB), which provides coverage for health services such as dental work, prescription medication, and medical travel (Health Canada, 2013). Otherwise, health services falling under the medical health care
system for all Indigenous peoples living off-reserve (i.e., living in rural or urban areas), including status First Nations, non-status First Nations, Métis, and Inuit peoples, are provided by the provinces and territories (Kelly, 2011).

Indigenous peoples in other settler colonial nations have similar spatially-ordered and identity-driven jurisdictional contexts for health or medical care. In the United States, for example, Indian Health Services (IHS) provides health care services only to members of federally-recognized tribes or tribal organizations. IHS services are located mainly on reservations, with services in urban areas in only 20 of the 51 states, but services are chronically underfunded in both reservation and urban contexts (Indian Health Service, n.d.). In Australia, Aboriginal Community Controlled Health Organizations (ACCHOs), combined with government-provided services that focus on serving the needs of Indigenous Australians, together make up what are called Aboriginal Medical Services (AMS) (Gomersall et al., 2017; National Aboriginal Community Controlled Health Organization, 2018). These are primarily available in the Northern Territory and north Queensland, where the proportions (in the case of the Northern Territory) and numbers (in Queensland) of Indigenous Australians are highest (Australian Bureau of Statistics, 2018; Gomersall et al., 2017). Eligibility for Indigenous services in Australia is primarily based on self-identification (Australian Bureau of Statistics, 2018).

While reserves in Canada are experiencing population growth, Indigenous populations in urban areas have also expanded dramatically over the past several decades in Canada and elsewhere around the world (Australian Bureau of Statistics, 2018; Norris & Clatworthy, 2003; Snyder & Wilson, 2012). In Canada, about 52 percent of the overall Indigenous population now lives in cities, compared to only about seven per cent in the early 1950s (Kalbach, 1987; Statistics Canada, 2017a). In Australia, 70 per cent of Indigenous peoples live in cities; in New Zealand, 84 per cent; and in the United States, 60 per cent (Snyder & Wilson, 2012). In spite of these high proportions of Indigenous populations living in urban areas, in Canada, research and policy related to Indigenous health remain disproportionately focused on rural and reserve areas (Edmonds, 2010; Newhouse & Peters, 2003; K. Wilson & Cardwell, 2012). This is in large part due to the persistent exclusion of Indigenous peoples, both legally and discursively, from cities in Canada, which may be why the percentage of Indigenous peoples in Canada is lower when compared with other settler colonial countries (Newhouse & Peters, 2003; Snyder & Wilson, 2012). The geographical focus of research is slightly different in other areas of the world; for
example in Australia, research is often conducted with urban Indigenous populations examining access to health care services (A. L. Nelson, Macdonald, & Abbott, 2012; Priest, Thompson, Mackean, Baker, & Waters, 2017; Waugh & Mackenzie, 2011). However, this research often does not include an examination of urban Indigenous peoples’ experiences within the context of geographical and identity-based jurisdictional complexities.

Indigenous people in Canada, in both rural and urban areas, experience difficulties accessing health care services. On reserves in rural areas, services are few and tend to be understaffed and underfunded, making availability of services the main barrier (O’Neill, George, Koehn, & Shepard, 2013; Shah, Gunraj, & Hux, 2003). In urban areas where services are more plentiful, Indigenous people report discrimination and differential treatment based on Indigenous identity or racialization (Browne, 2017a; Evans et al., 2014; Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective, 2008; National Aboriginal Health Organization, 2003). Research finds that in spite of the generally higher burden of morbidity and mortality among Indigenous peoples in settler colonial countries such as Canada, the United States, Australia and New Zealand, Indigenous people experience particular barriers to accessing health care services (Marrone, 2007; K. Wilson, Rosenberg, & Ning, 2015).

The barriers encountered by Indigenous people when accessing health care are rooted in the context of settler colonialism in which they live. In British Columbia, as in the rest of Canada, this settler colonial context has involved a series of geographical restrictions, such as limiting First Nations peoples to living on reserves that decreased in size as settlement by non-Indigenous peoples increased, which in turn made people dependent on wage labour, for example in the canneries of the West Coast where living conditions were poor (Kelm, 1998). It also brought a rise in the influence of institutions with strict hierarchical power structures in Indigenous peoples’ lives, for example Indian Residential Schools and tuberculosis hospitals set up through the Indian Health Service (Kelm, 1998; Meijer Drees, 2013). All of these changes have had clear impacts on peoples’ health, by limiting access to land and therefore traditional food sources and land-based economies, and through exposure to overcrowding, poverty, and generally poor living conditions (Kelm, 1998). These changes also have had lasting impacts on how Indigenous peoples interact with institutional settings that have clear hierarchies and bureaucracies, such as hospitals and other forms of health care (Hole et al., 2015; Maxwell, 2011b).
The context of settler colonialism is a reality that is generally acknowledged in research (Maar et al., 2009; Reeves & Stewart, 2014), but rarely clearly articulated or analyzed (but see, e.g., Browne, 2017a; Maxwell, 2011b). To address this gap, the present study draws on two frameworks developed by Indigenous scholars – cultural safety and ethical space – in order to bring settler colonialism into the analysis of barriers to health care among urban Indigenous peoples.

Focused on the encounter between health care provider and patient, cultural safety draws attention to power imbalances rooted in colonialism that become embedded in the institutions of health care, and highlights clients’ needs to feel safe within this encounter (Browne, Varcoe, et al., 2009; Dyck & Kearns, 1995; Ramsden & Spoonley, 1994). Within the framework of cultural safety it is the client who decides whether or not a particular encounter has been culturally safe. This avoids further exacerbating power differentials (Jungersen, 2002; Taylor, 2003). Studies dealing with cultural safety in Canada investigate how best to implement it in health care services or in policy (Browne, Varcoe, et al., 2009; Wong et al., 2011) or provide examples of health care services that are described by clients as being culturally safe – often in the context of Indigenous-led organizations (Maar & Shawande, 2010a; Reeves & Stewart, 2014).

Ethical space is a framework that is often applied in the context of resource co-management between Indigenous and non-Indigenous leaders. Developed by Cree scholar Willie Ermine, ethical space describes a method of preparing a space for a meeting of world views that is non-hierarchical, in which colonial rankings of knowledge systems (epistemologies) and world views (ontologies) are countered and each world view is given space in which to be articulated and understood (Alberta Energy Regulator, 2017; Ermine, 2007). That is, creating ethical space involves consciously creating space for Indigenous authority and leadership, where such space has been lacking before (Ermine, 2007). The resulting space is simultaneously physical, psychological, and social. The concept of ethical space has been applied to a limited extent in health care settings. Barina (2015) uses ethical space to analyze how the space of health care “promotes certain habits, practices, representations, and ideals” (p. 100). Brunger and colleagues (2016) employ ethical space as a model for collaboration in the review of ethics protocols for health research in Indigenous communities. The present study aims to engage with the concept of ethical space in order to examine the impacts of the socio-spatial relations of settler colonialism in the spaces of health care. This is important because the barriers Indigenous peoples experience
in accessing health care are not fully comprehensible without bringing settler colonialism into the analysis. The purpose of this study is thus to provide a critical understanding of urban Indigenous people’s access to health care in light of Canada’s settler-colonial reality, drawing on cultural safety and ethical space.

In the context of settler colonialism, health care policy in Canada poses unique challenges for Indigenous peoples, related to differences in jurisdictional authority over decision-making, resource allocation, and provision of health care services. These policy and jurisdictional challenges are discussed in more detail in the next section.

Health care policy in Canada

Under the Canada Health Act (CHA) (Government of Canada, 1985a), the federal government delivers health care funding to provinces and territories, who then provide services free of charge to residents. The CHA lists five criteria that provinces and territories must meet in order to receive funding, one of which is accessibility, meaning “provid[ing] for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons” (Government of Canada, 1985a, n.p.). “Reasonable access” is understood as economic and physical access; the former meaning that clients do not have to pay for medically necessary services covered under provincial public health insurance plans, and the latter defined by the “where and as available” rule, meaning that every insured person will not, for example, have access to identical services in small, remote towns and large urban centres. These rules are intended to preclude discrimination, whether based on fees incurred at the point of service delivery or on identifiers such as age, sex, or racialization (Health Canada, 2017; K. Wilson & Rosenberg, 2004).

The Canadian government provides partial funding for health care services, but provinces administer and deliver the services. The federal government, however, retains responsibility in much of Canada for providing health care services to status First Nations individuals living on reserve, creating a separate system of health care for a subsection of the Indigenous population. Provinces and territories, including BC, are mainly responsible for providing care for non-status Indigenous peoples as well as status First Nations people accessing services off-reserve, creating a jurisdictional divide between governments. In British Columbia (BC), the First Nations Health
Authority (FNHA) has taken over federal responsibility for health services on-reserve and takes a holistic, community-centred approach, including supporting Indigenous-led health organizations in urban areas. The impact that the FNHA may have on jurisdictional boundaries between status and non-status, or on-reserve and off-reserve, is still being worked out (Aboriginal Health, 2014; Shewell, 2016). While the jurisdictions of federal and provincial/territorial governments appear to be clear in policy, in practice boundaries can easily become blurred and translate into barriers to access (Shewell, 2016).

While not required to do so, some provinces and territories have developed health-related policy specific to Indigenous peoples, such as the Aboriginal Health and Wellness Strategy in Ontario (Ontario Ministry of Community and Social Services, 2016). Other provinces are reluctant to formulate specific policies with respect to Indigenous peoples, seeing it as an offloading of responsibility on the part of the federal government (Lavoie et al., 2008). The federal government, in turn, increasingly delegates responsibility for Indigenous health services to the provinces, not-for-profit organizations, or Indigenous communities themselves (Lavoie et al., 2010). This delegating of responsibility for providing services to Indigenous communities is both celebrated as an example of community empowerment and authority, and resisted as a form of the federal government’s limiting of its own responsibility for Indigenous physical, cultural, and political survival (Lavoie et al., 2005). Indigenous people’s encounters with the health care system in Canada thus take place within a complicated “patchwork” of policy and jurisdiction (Lavoie et al., 2008).

In other parts of the world, similar policies govern Indigenous peoples’ interactions with health care systems, for example policies that restrict access to Indian Health Services in the United States, including in urban areas, to members of federally registered American Indian or Alaska Native tribes (Indian Health Service, n.d.). In particular, whether a person is eligible for Indigenous-focused health care services tends to be carefully delineated by both identity and by geography in settler colonial countries, as outlined above (Champion, Franks, & Taylor, 2008; Indian Health Service, n.d.; Marrone, 2007).
Understanding access to health services for Indigenous people in Canada

In Canada, access to health care as outlined in federal health policy is limited to the removal of financial barriers and the “where and as available rule.” Access to health care, however, involves many more factors than the location and availability of the health care services themselves (J.-F. Levesque, Harris, & Russell, 2013). Scholarly research provides a more detailed understanding of what “access” to health care means, as well as the relationships between health care need, access, and utilization of services. Aday and Andersen (1974) developed an early and widely used framework for studying access to health care in the United States, incorporating “predisposing characteristics,” “enabling resources,” and “need” in explaining and predicting the patterns of health care access within a population. Geographers Joseph and Phillips also engage with the concept of accessibility in a comparative study of health systems around the world, delineating “potential access,” which refers to the availability of services, and “realized access,” measured by rates of utilization (Joseph & Phillips, 1984). Other research on health care access worldwide takes into account waiting times, availability of services, work or family responsibilities, and client perceptions of accessibility (Davy, Cass, et al., 2016; J.-F. Levesque et al., 2013; Sanmartin & Ross, 2006; Wellstood, Wilson, & Eyles, 2006; K. Wilson & Rosenberg, 2004).

Traditional frameworks for understanding access, such as Aday and Andersen’s (1974) model, have been expanded on in ways that make them more applicable to urban Indigenous people’s experiences, taking into account such concepts as the “approachability” and “acceptability” of health care services, and also analyzing access in the context of how Indigenous-led health care organizations make their services a good “fit” for a mainly Indigenous clientele (Davy, Harfield, et al., 2016; Penchansky & Thomas, 1981). For example, access is improved when attention is paid to the quality of the time spent by Indigenous clients in the waiting room, such as by making Indigenous clients feel welcomed by medical office assistants at the front desk, or able to talk and interact with other clients that they may know or recognize (Jowsey et al., 2012; Neuwelt et al., 2015).

In spite of models of access to health care that take into account the specific experiences of Indigenous clients and propose new ways of improving access (Jowsey et al., 2012; Neuwelt et
al., 2015), the general consensus in the literature is that Indigenous peoples have worse access to quality health care than settler populations around the world, and face a unique set of barriers to access, such as transportation difficulties; jurisdictional gaps as outlined above; perceived differences in quality of care compared to non-Indigenous populations; or cultural inappropriateness of services (Browne et al., 2016; Davy, Harfield, et al., 2016; National Aboriginal Health Organization, 2003). It is found that Indigenous people have higher rates of hospital admissions for conditions that should be treatable in primary care settings, as well as less access to specialists such as nephrologists for the treatment of kidney disease (Gao et al., 2008; Kendall, 2007; Shah et al., 2003). Indigenous peoples living in rural or remote areas in Canada are found to have worse availability of services and less utilization of health care than their urban counterparts; however, Indigenous peoples in urban areas report more instances of racism or discrimination and less cultural appropriateness of health care services (Browne, McDonald, et al., 2009; National Aboriginal Health Organization, 2003; Place, 2012).

In Canada, the role of racism in impeding Indigenous peoples’ access to non-Indigenous-led health services has been well documented in recent years (Allan & Smylie, 2015; Browne, 2017a; Goodman et al., 2017; Tang & Browne, 2008). For example, Indigenous clients accessing acute care in an Emergency department in British Columbia reported feeling that they would be negatively judged by health care providers, before they ever entered the hospital (Browne et al., 2011b). Indigenous clients of urban health services in southern British Columbia reported feeling that doctors don’t believe them when they try to express their feelings and symptoms (Evans et al., 2014). Deaths of clients within health care settings due to total negligence have also been linked to structural racism that becomes embodied in the behaviour of health care workers (Browne, Hill, Lavallee, Lavoie, & Logan McCallum, 2017). The need to ensure Indigenous peoples’ safety is emphasized in the literature and related to experiences of racism, as Indigenous peoples in health services experience verbal, implicit, or overt physical violence in health care settings (Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014; Evans et al., 2014; Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective, 2008). This racism has been shown to be a product of settler colonialism and the structures and attitudes that accompany it, and can lead to increased feelings of fear or anxiety for Indigenous peoples accessing health care.
While research has found several unique barriers to health care access that Indigenous peoples face, the settler colonial context of these barriers can become hidden when the focus is placed on correcting the behaviour of individual health care providers or on individual experiences of racism (Browne, 2017a). Cultural safety and ethical space, applied together, can demonstrate how broader structures are implicated in individual behaviours to show that action is needed on multiple scales. The goal of this study is to examine barriers to health care access for Indigenous peoples in light of the ways in which broader structures of colonialism influence Indigenous peoples in their everyday lives. Cultural safety and ethical space provide lenses through which to examine these barriers, in order to highlight the individual-level impacts of these broader structures and how they become embedded in the everyday spaces of health care settings.

Methods

The results presented in this paper are drawn from a study undertaken using qualitative methods, specifically semi-structured interviews and focus groups, within a community partnership model of research based on the principles of decolonizing research and community-based research. Fifty Indigenous community members living in Prince George and fifteen health care providers who work with Indigenous clients participated in the study in 2015-2016. The study was guided by a community advisory group composed of eight Indigenous Elders, health care providers and decision makers, and researchers based in the city of Prince George, British Columbia. Participant recruitment was done with the help of advisory group members and others in various Indigenous and non-Indigenous health care organizations in Prince George, and included Indigenous community members living in a variety of socio-economic situations. Questions asked in interviews and focus groups of Indigenous clients focused on experiences with accessing health care in the city of Prince George (for example, “How would you describe your experience with health services in Prince George?”), and those asked of health care providers focused on how they perceived Indigenous clients as being positioned with respect to the health care system in the city, as well as challenges and strengths in health care service delivery for Indigenous clients (for example, “Can you describe any challenges you experience in providing services to clients?” “Are there specific needs in the Aboriginal communities in Prince George that you feel your organization fulfills?”). Participants’ responses were analyzed using an open, iterative coding process; the resulting findings are presented below.
Results

Participants’ discussions of access to health care are clustered into the following three themes: quality of care; wait times; and experiences of racism and discrimination, representing the most frequently reported barriers to accessing health services. These three themes are presented here as distinct barriers for clarity, but it is important to note that the interviews and focus groups reveal that there is clear overlap between them, in particular between perceptions of racism and discrimination, and quality of care.

Quality of care

Nineteen participants mentioned problems with quality of care, relating stories of how their needs had not been met in health care situations. Most of the issues raised about a perceived lack of quality of care related to delays in diagnosis of a health problem; denial of medication, in particular pain medication; delays in seeing a medical professional or lack of treatment altogether; or cases of serious neglect. Delays in diagnosis or mistakes in diagnosis were interpreted with great mistrust, suggesting that participants felt they were being deliberately mistreated or discriminated against. Participants reported having an understanding of the appropriate procedure or diagnosis, and not being told why these were not being undertaken. This is experienced as a breach of safety, making participants feel ill at ease in health care settings and distrustful of health care providers. For example, one client explained:

I had an infection, and the doctor said it’ll heal on its own, and I went to another doctor, and they said, ‘you have an infection,’ and I said, ‘really?’, and she put me on medicine right away.... This one doctor – she said it would heal on its own. And that kind of disappointed me, eh? ... I just – why did she do that? I said, ‘oh, why did she make me feel that way for that long time?’ (Client 17)

Another client related that a large, heavy steel rod had fallen on his back at work, but his doctor did not undertake any diagnostic tests. This participant felt that he should at least have been given an x-ray. He stated that he has to take muscle relaxants to deal with the pain, but reported that doctors keep telling him there’s nothing wrong. He came to the interview to tell his story because, he said, he wanted to effect change in the system. This implies that he feels he has had an unfair experience – that the system is working against him (Client 8, unrecorded).
With respect to denial of medication, clients reported that health care providers do not believe they are in pain and deny them medication because of concerns about substance misuse within the urban Indigenous population. Several participants reported living with chronic pain, and feeling that because they are Indigenous they face judgment and discrimination when asking for pain medication from a health care provider. One participant expressed a sense of unfairness:

People with chronic arthritis, you know. It don’t matter if you take it [pain medication] to feel good, at least you feel good and you’re not paining, you know? That’s what I mean.... If they’re hurting, I say help them. (Client 6)

In terms of delays in seeing a health care provider or issues related to lack of treatment, participants described feeling that they had to insist on receiving care. For example:

When I first got arthritis, it was in that shoulder, and I was paining so bad, and I was gritting my teeth. And I waited there for five hours and nobody came. No nurse, nothing. So I told my husband, stand out there and get that nurse in here. And I told the nurse, I said, ‘you let me out of this hospital,’ and she said, ‘what for?’ And I said, ‘because I’m going to get my husband to start the power saw, and cut my arm off.’ I told the nurse this. Ten minutes later she came with a shot of morphine to kill the pain. It took that, to get them to look at me.

Having to insist on care being provided led to feelings of frustration for many participants. With respect to cases of serious neglect when accessing health care services, several participants had heard stories in which Indigenous people died from neglect or lack of treatment, or suffered physical injury. For example, as one Elder – who had worked as a health care provider – described:

It’s not just Prince George, I think it’s all over. This guy in Burns Lake, he said his mom was in a nursing home. And she fell out of bed, broke her hip. And then she had bruises on her face, and her body. They have been really mean to her. It’s not – I worked as a patient liaison for a while, eh? And I seen that first hand.... They don’t treat, I don’t know about now, how they [Indigenous clients] are being treated, but before that, holy – that was sure bad. (FG 3)
This account implies that the woman in question was abused during her stay at the home. In addition, the way in which this participant takes a third-hand account and generalizes it spatially (“it’s all over”) as well as relating it to their own experiences (having seen it first hand) demonstrates the way this type of narrative tends to resonate with people and inform their own subsequent experiences in health care.

Overall, the responses in this theme reflect distrust of health care institutions on the part of Indigenous participants. Participants often report feeling denied health care through not receiving adequate quality of care, which, in turn, is linked to perceived racism and discrimination based on Indigenous identity, as will be further discussed below. This lack of adequate care, in their own experience or as shared through others’ stories, leads to a sense of fear for many participants when accessing health care services. This sense of fear and distrust is related to a sense that participants are putting themselves at risk of harm in the spaces of health care.

**Wait times, wait lists, and restrictions on time**

Another key barrier, mentioned by eighteen participants, is related to long wait times. Indigenous clients in this study interpreted long wait times or wait lists for services as a form of denial, in effect making services unavailable to them. Participants described a variety of scenarios: either having an extended wait when accessing services at the Emergency department or walk-in clinics; having to schedule appointments with a regular health care provider weeks or months in advance; having to wait to be matched with a regular health care provider or for space in a treatment centre; or being put on a wait list for specialized services such as surgery or withdrawal management. For example, one participant in a focus group described the following related to waiting in the Emergency department:

P1: I had a tubal pregnancy, and it was ten weeks, and it erupted but I didn’t know it was a tubal pregnancy. And they just shut me in the Emergency room and just left me.... The next morning they take me in to do an ultrasound, and then it’s like, ‘oh my god, you’re internally bleeding, and we need to go in for emergency surgery right now.’... The tube erupted, and they were soaking the blood out with towels, right? And so if they would have left me much longer–

P2: You would have bled to death. (FG 2)
Waiting times were regarded as a barrier preventing access to what is considered life-saving treatment in the face of a potentially fatal situation.

Health services workers also reported wait times to be an issue, focusing on the time allotted to clients once they are in contact with a health care provider. Many of these participants described a need to take more time with Indigenous clients in order to facilitate their access to – and comfort with – the space and the services. As one health care worker said:

As an Aboriginal agency, we don’t need to target, you know, one hour per client – that’s kind of what we’re allotted, but you know what? If clients have different needs, if we need to advocate for them, we have the freedom to do that. (FG 3)

The above quote involves an implicit comparison with non-Indigenous health care institutions, in which this ability to allow for extra time is missing. Other participants also referred to the lack of time for quality consultation in non-Indigenous health care. Participants explained this lack of time in terms of lack of capacity; as one client put it:

The hospital’s not really nice to you, but it’s just like, they haven’t got the time to deal with certain things or whatever, like, sit there and talk about whatever I need today, all these pains and stuff like that. (Client 9).

It is important to note, however, that Indigenous-led health organizations do not provide extra time to clients because they have more resources or capacity compared to non-Indigenous health organizations. Rather, the extra time allocated in Indigenous-led settings reflects different priorities in the delivery of care.

Overall, wait times and limitations on the time a client could spend with a provider were seen as significant obstacles to care for Indigenous people. Participants understood that the capacity of the health care provider or service may be limited, but still associated being made to wait with disrespect and unfairness. Wait times were seen as emblematic of a system that feels uncaring and disrespectful to Indigenous clients, in effect denying them care. When health care providers do not have time to listen to Indigenous clients’ needs or experiences, Indigenous clients feel dismissed. When participants are told they have to wait, they also feel dismissed. These types of dismissal both reflect power imbalances in terms of who has the power to grant and control
access to health care and related services, and also place limitations on who is allowed into the spaces of health care; limitations that participants in this study perceive as acting against them.

**Perceived racism or discrimination**

Sixteen participants described experiences of perceived racism or discrimination in the health care encounter based on their Indigenous status, identity, or appearance. For example, one participant described wanting to find a new doctor because her current family physician “made a comment against Aboriginal people and I didn’t like it” (Client 2). The same client described similar experiences at the hospital:

> The only ones I found that were rude to me is the hospital, the nurses. When I was in a lot of pain and I coughed, [one of the nurses] says, ‘cover your damn mouth.’ Like, oh my god. What kind of nurse are you? Because I was Native, I think that’s – I just got that feeling, she’s prejudiced. (Client 2)

Another client described feeling uncomfortable when filling prescriptions for herself or her son:

> Depends on which pharmacy you go to.... as soon as they see me, they always say, ‘okay, how are you going to pay for this?’ I find it... labeling [me as a First Nations person].... and I find them, I’m sure they don’t mean to, but they always... make me feel like I’m lower than I am. As a person. Because they always ask, like, ‘how are you going to pay for this? You even got money?’ (Client 18)

Concerns about racism were raised by both clients and health care providers, but interestingly about twice as frequently by health care providers. With few exceptions, most clients appeared to be more reserved when talking about these experiences during the interviews than health care providers. For example, one health care worker said, “I don’t think the system is borderline. I think the system is a racist system” (FG 2). Clients, on the other hand – including those quoted above – often followed their descriptions of racist or discriminatory experiences with comments later in the discussion such as “I’m sure they don’t mean to” (Client 18), or “it doesn’t bother me anymore” (Client 5).

There was one client, a residential school survivor, who carried a great deal of anger at the way he had been treated throughout his life, and did not hesitate to speak out. In an unrecorded
interview, he said, ‘when you don’t care if you live or die, you’re not afraid of anything’ (Client 7). He spoke at length about the effects of colonialism and racism on Indigenous individuals and communities in Canada and emphasized the fundamental, devastating impacts of these forms of oppression on people’s health.

In some cases, instances of perceived racism or discrimination were described as discrimination against an Indigenous-led agency. For example, in the following quote, one health services worker discussed being concerned when not included in the shared care of a client she had already been seeing for some time:

I don’t want to make the assumption that I wasn’t being listened to because I’m from an Aboriginal agency. It did cross my mind. I don’t know – that was never said... it just felt that... I was “Other,” so whoever that could be. (FG 3)

In other cases health services workers from Indigenous-led organizations expressed concern for how their clients were treated in non-Indigenous organizations. For example:

So many people are treated so badly, because they’re Aboriginal, and a lot of that comes from the government organizations. I have a lot of people come in here and they’re like, ‘I’m not going back there. They treat me like dirt. They treat me like I’m an Aboriginal person who has no rights. I’m nothing, I’m second rate human.’ I’ve heard lots of people say stuff like that. (HSW 6)

Although most Indigenous clients appeared to be at times more reluctant to discuss issues of racism in health care, racism and discrimination were seen by both clients and health services workers as significant barriers impacting Indigenous clients’ access to health services.

**Discussion and conclusions**

The purpose of this study was to examine barriers to health care access for Indigenous peoples in light of broader structures of colonialism. Results reveal key barriers to access to health services among Indigenous clients, including low quality of care; long wait times; and perceptions of racism and discrimination. Overall, participants felt they could not trust the system to provide the care they needed; they felt they were made to wait even when urgently requiring services; and they associated many of these experiences with perceived racism or discrimination. Reading
these responses through the lenses of cultural safety and ethical space provides an important way of understanding Indigenous participants’ experiences in the context of settler colonialism.

Cultural safety is an important concept for interpreting power imbalances in health care because it emphasizes the need for health care institutions to critically reflect on the colonial precedents of the care that they provide that contribute to these power imbalances. It promotes the provision of culturally as well as physically, mentally, and spiritually safe care that is culturally adaptable (Ramsden & Spoonley, 1994). In describing their own and others’ experiences in health care, participants in this study outline feelings of denial and rejection, often linked to racism and discrimination, in the spaces of health care that lead to a sense of being unsafe, all of which are related to distinct power imbalances rooted in colonialism.

While cultural safety provides a framework through which to begin to understand these power imbalances, it does not provide a complete understanding on its own. For example, in practice, cultural safety can be misunderstood (Browne & Varcoe, 2006; Gerlach, 2012). Operationalizing the concept of “culture” in health care proves difficult, often relying on superficial, easily accommodated aspects of “culture” which may fall short of offering real decision-making power to culturally or racially marginalized patients in a health care setting (Browne & Varcoe, 2006; J B Waldram, 2009). Cultural safety also does not make room for the concept of justice related to authority or governance, which is a necessary part of addressing colonial power imbalances. Extending the framework of cultural safety using the concept of ethical space can fill in some of these gaps.

In the context of this study, participants described feeling a difference between themselves and health care providers, in that they often do not understand the reasons behind health care providers’ actions, pointing towards a difference in world view among the different actors in these health care encounters that suggests a need for ethical space. Although the actors in a health care encounter cannot be simplistically divided into Indigenous clients and non-Indigenous health care providers, a difference in world view can be identified based on the embeddedness of health care institutions in the colonial system, which becomes an orientation adopted by health care providers (Browne, 2017a). Both clients and health care providers carry experiences, orientations, and assumptions based in settler colonialism with them into the spaces
of the health care encounter, all of which need to be taken into account if the barriers that Indigenous clients experience are to be fully understood.

For example, the first barrier shows that the quality of care that Indigenous people in this study receive is often reported as substandard. This can create a negative feedback loop in which the experience of low quality care functions as a barrier to future access by leading people to expect substandard care. Delayed or lower rates of accessing care may in turn lead to judgment on the part of health care providers, based in discourses that associate regular health care use with better responsibility for one’s health (Leake, Birch, Main, & Ho, 2006). This in turn can increase clients’ reluctance to access services. Further, many participants who discussed receiving inadequate care were dealing with chronic pain, the management of which is complex, requiring a balance among clear patient-provider communication; empathy on the part of the health care provider; and differing cultural understandings of pain, all with an undercurrent of suspicions surrounding potential misuse of pain medication (Anderson, Green, & Payne, 2009; Jimenez, Garrouette, Kundu, Morales, & Buchwald, 2011). Research suggests that the decision to offer or withhold pain medication may more often be based on the appearance of a client than on clinical judgment (Browne et al., 2011b). Studies also find that Indigenous peoples and other racialized groups tend to receive lower quality care for pain management, in spite of experiencing higher rates of chronic pain (Anderson et al., 2009; National Opioid Use Guideline Group, 2010). For health care providers involved in the care of Indigenous patients dealing with chronic pain, treatment decisions are frequently informed by popular discourse that perpetuates negative portrayals of Indigenous peoples (S. E. Nelson, Browne, & Lavoie, 2016). For Indigenous clients, health care institutions that provide substandard care can be seen as shirking ethical or moral responsibilities – both as health care providers with a responsibility to promote and protect health, and as governments in relationship with Indigenous peoples through treaties and the Constitution Act. These differing positions serve to distance health care providers, embedded in the colonially-informed culture of health care, from Indigenous clients who cannot understand why they receive differential treatment in spite of their recognized rights to health care and to be treated with dignity and respect (see chapter three).

By emphasizing ethics, ethical space focuses attention on the ways in which people should be treated, drawing out the moral obligation that health care providers and institutions have in caring for people in vulnerable positions. This ethical stance has the potential to bridge the
distance between health care providers and Indigenous clients outlined above, through bringing people together while simultaneously encouraging distance from societal discourses and stereotypes. For example, the second barrier, long waiting times to receive care, can be easily dismissed as a concern that is common to everyone, not only Indigenous peoples (Canadian Institute for Health Information, 2017; Harrington, Wilson, Rosenberg, & Bell, 2013; Sanmartin & Ross, 2006). Indigenous clients in this study, however, may be interpreting extended wait times based on past experiences in health care or other government-led institutions (Hole et al., 2015). A situation in which a health care provider requires a client to arrive at the clinic on time, only to spend an unpredictable amount of time waiting, may reasonably be interpreted as the misuse of power for its own sake, something which Indigenous peoples and communities have experienced much of throughout Canada’s colonial history. As discussed above, previous experiences in settler colonial institutional settings, such as Indian Residential Schools or Indian Health Service hospitals – whether first-hand, intergenerational, or even second- or third-hand experiences – may cause distrust and fear to be carried forward into other institutional settings. Chronic and discriminatory underfunding of services, related to health, child welfare, education, and other infrastructure and services, is a persistent experience for Indigenous communities in Canada (Blackstock, 2011; Lavoie et al., 2010). Wait times based on lack of capacity may therefore still be experienced as discriminatory for Indigenous clients. Ethical space highlights the moral imperative that rests with actors in various positions within health care services, as well as all levels of government, to address the needs of Indigenous clients in health care, and to find new – and perhaps unfamiliar – ways of addressing participants’ concerns, for example through removing time restrictions or eliminating the use of a waiting list. This must also be done with attention to the broader structures and experiences that inform Indigenous peoples’ health care needs, at the same time addressing the broader structural barriers rooted in settler colonialism that exist outside of health care as well (Browne, 2017b).

Participants’ responses also lend themselves to a spatial analysis grounded in ethical space, in that they draw attention to the boundaries that are created around the spaces of health care. By emphasizing space, ethical space not only draws attention to the environments in which people who access and who provide health care interact, but it also recognizes the roles that individuals play in creating the spaces in which they live, work, and relate to one another. Participants in this study describe the spaces of non-Indigenous health care and other social services as being
policed by gatekeepers – health care providers or other staff – who enforce seemingly arbitrary rules regarding who can enter the space and who must stay out. For example, the third and final barrier covered in this paper relates to participants’ experiences of racism and discrimination while receiving care, which acts as a significant impediment to participants’ willingness to utilize services. Experiences of racism and discrimination make things like wait times and waiting lists seem like arbitrary rules intended to uphold colonial power over individual Indigenous peoples’ lives. In turn, this puts up boundaries around health care settings that feel as though they are meant to keep Indigenous clients out. These boundaries are reminiscent of – indeed, replicate the same processes as – the physical and geographical barriers that have been placed around Indigenous peoples under settler colonialism: barriers that separate people from one another as well as from traditional lands. These barriers include the borders of reserve lands as well as the perceived “frontiers” created in cities, where Indigenous peoples, as distinct cultural and physical bodies, are perceived as being displaced from settler society by the very processes of urbanization (Edmonds, 2010). They also include the barriers erected through health care policy between reserve and urban geographies, excluding Indigenous peoples living in urban areas from the government-defined categories of who is considered “Indigenous” and therefore eligible for federally-funded health care benefits and services (Government of Canada, 1985b; Lavoie et al., 2010; Snyder et al., 2015). Indigenous clients’ responses in this study can then be understood as reactions to structural forces, as well as to individual interactions that are unique to their personal experiences.

The boundaries that are created around the spaces of health care provide a demonstration of how models of access to health care services apply in practice. These boundaries are created through a series of processes rooted in settler colonialism, part of the broader environment that impacts how the structures of health care are created and perceived (R. M. Andersen, 1995; Neuwelt et al., 2015). Within colonial structures, racism and discrimination become acceptable practices in face-to-face encounters between health care providers and Indigenous clients. Racist and discriminatory treatment is compounded by standards and requirements that are rooted in a particular cultural worldview, as well as previous experiences with other colonial institutions, that cause Indigenous clients to feel uncomfortable and unwelcome within a space and to encounter these boundaries. The acceptability and approachability of a given health care space thus become compromised, in turn impeding Indigenous peoples’ access to that space.
Many Indigenous clients in this study were more reluctant to discuss racism than health care providers, who were much more explicit and outspoken about these types of problems. This may be related to perceived power differentials between the researcher and participants. In addition, some of the interviews took place in a health care setting. It is possible this created associations between the researcher and health care workers that may have made clients want to avoid offending the researcher. It may also reflect power differentials in general, which cause clients to feel that they are not authorized to offer critiques of the health care system. It may reflect past experiences such as in residential schools, in which clients may have experienced not being believed or listened to when critiquing the way they were being treated. Disturbingly, it may reflect a normalization of experiences of racism for clients who face such treatment on a regular basis. Or, it may reflect a strategy on the part of clients to reassert power in the face of discrimination that might otherwise make one feel powerless. Denial or downplaying of the power imbalances in health care settings, places the power to describe how such experiences impact the client back in that person’s own hands. There were of course exceptions to this – in particular one client who spoke at length about the effects of colonialism and racism on Indigenous individuals and communities in Canada and emphasized the fundamental, devastating impacts of these forms of oppression on people’s health.

Ethical space, with its basis in legal frameworks and emphasis on colonialism at a societal scale, helps to make connections among health services, health systems policy and other aspects of the colonial system of government. It places the issues raised by participants (i.e., substandard quality of care, wait times, and racism and discrimination) in the context of what colonialism does to Indigenous individuals in their everyday lives, especially in encounters with government-led institutions including, but extending beyond, health care. Understanding the colonial context in which these institutions have developed highlights where difference between people is created and then perpetuated in institutional settings. It opens possibilities for re-imagining health care policy in Canada for Indigenous peoples, by keeping in mind the unique ways in which Indigenous peoples’ experiences of colonialism are carried with them, perpetuated, and exacerbated within health care settings. It also opens possibilities for re-structuring health care policy and spaces in order to make space for Indigenous jurisdiction and authority.

Health policy in Canada would benefit both from the understandings of Indigenous clients’ experiences in health care settings brought out through cultural safety and ethical space, and also
from application of the concept of ethical space in the reimagining of policies themselves. The Canada Health Act neither acknowledges federal responsibilities towards Indigenous peoples, nor addresses barriers to health care access experienced by Indigenous people. Federal health policy relating to Indigenous peoples remains segregated from health care policy in general; is limited to status First Nations and excludes all Indigenous people living in urban areas off-reserve; and incrementally relieves the federal government of responsibility for Indigenous peoples’ well-being. It also fails to address the concept of access to health care for Indigenous peoples in light of structural barriers erected through processes of settler colonialism. In order to begin to address these shortcomings, federal health policy specific to Indigenous peoples should be incorporated into the Canada Health Act, in the process taking research findings on Indigenous peoples’ access to health care into account. The federal government should recognize its responsibilities to all Indigenous peoples, not only status First Nations, and provinces and territories should take responsibility for Indigenous focused health care in a much more robust and consistent manner. The Calls to Action from the Truth and Reconciliation Commission of Canada, convened in response to a lawsuit from Indigenous residential school survivors, include recommendations regarding jurisdictional issues related to health (Truth and Reconciliation Commission of Canada, 2015). Call to Action 20, for example, reads:

In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples. (Truth and Reconciliation Commission of Canada, 2015)

Federal and provincial governments have a responsibility to work together to streamline policy and remove jurisdictional barriers to access to health care for all Indigenous peoples, including urban and off-reserve populations. Reading this responsibility through the lenses of cultural safety and ethical space draws attention to the power imbalances that have been created in health care policy for Indigenous communities, and creates the potential for spaces in which these power imbalances can be addressed. While consultation with Indigenous peoples in Canada has been frequently misinterpreted and misused to achieve the government’s own ends (Nguyen, 2014), it is imperative that urban Indigenous clients of health care services and urban Indigenous health care providers are given power in any decision making surrounding changes to the Canada Health Act or to federal health policy related to Indigenous peoples. Ethical space has been
utilized as a framework in discussions surrounding conservation and sustainability of resources involving Indigenous leaders and the federal, provincial and/or territorial governments (Alberta Energy Regulator, 2017) – the most successful of these prior experiences could be drawn on to inform discussions on changes to health care policy grounded in ethical space and informed by Indigenous leadership and authority.

According to the results of this study, cultural safety and ethical space help to situate the barriers encountered by Indigenous participants in accessing health care in relation to the intrusion of colonial structures into Indigenous peoples’ lives. The perspective provided by ethical space enhances cultural safety frameworks in two ways. First, the focus on ethics allows for a broader emphasis on the policy context of Indigenous peoples’ lives in Canada, rather than only focusing on power dynamics as they are played out in specific settings. That is, it allows for a jumping of scale, from individual-level interactions to society-wide power dynamics and inequities. Second, looking at the ways in which space is created in health care settings, through the experience of barriers to access, broadens understandings of power dynamics by showing how power differentials can become a tangible part of a given space. When power becomes spatially absorbed or incorporated through the creation of boundaries policed by gatekeepers, even those individuals not currently experiencing discrimination can feel the power differences being reflected back on them, upon entering a space.

Incorporating cultural safety and ethical space into policy and service delivery at both federal and provincial levels would greatly improve Indigenous clients’ access to, and experiences in, health care settings. Ethical space shares the goals of cultural safety, in that it seeks to re-draw the lines of power in colonial and colonized society. If cultural safety can achieve the goals of making the spaces of health care approachable, acceptable, and safe for Indigenous people, ethical space might also make these spaces more just, in the sense that the relative power of different forms of knowledge might be balanced.
Chapter 5
Indigenous health organizations, Indigenous community resurgence, and the reclamation of place in urban areas

Introduction

According to the 2016 Census, over 1.6 million people in Canada (4.9 percent of the total population) identify as Indigenous, and this number is growing (Statistics Canada, 2017a). Indigenous peoples’ unique rights are enshrined in the Canadian Constitution Act, which identifies three major groups of Indigenous peoples: First Nations, Inuit, and Métis (Government of Canada, 1982). The division of Indigenous peoples into these three broad groups overlooks immense political and linguistic diversity, however: for example, there are over 618 First Nations in Canada, and Indigenous peoples speak over 70 Indigenous languages within 12 distinct language families (Statistics Canada, 2017a).

In Canada, about 52 percent of the Indigenous population now lives in cities, compared to less than seven per cent in the early 1950s (Kalbach, 1987; Statistics Canada, 2017a). Information regarding the general health status of urban Indigenous people in Canada remains scarce (Browne, McDonald, et al., 2009; Place, 2012; K. Wilson & Young, 2008). Data is rarely disaggregated for specifically urban populations and usually includes all off-reserve Indigenous people including those living in rural areas, or focuses on Indigenous populations in specific cities (Browne, McDonald, et al., 2009; Cardinal & Adin, 2005; Place, 2012). Although much research finds that specific indicators such as income and education levels, rates of diabetes and other chronic conditions, and life expectancy show worse outcomes for Indigenous people living off-reserve than for non-Indigenous people living in urban areas, the results are mixed – and contradictory – when comparing on-reserve and off-reserve Indigenous people, and in addition many of these outcomes seem to be improving (Fitzmaurice, 2012; Place, 2012). Recent research conducted with Indigenous populations in various cities in Canada reveals that, for example, Inuit adults living in Ottawa have disproportionally high burdens of chronic disease and also experience significant barriers to health care access (Tungasuvvingat Inuit, 2017). Social determinants of health, such as lower labour force participation rates or education levels, or more frequent experiences of racism and discrimination, also tend to disadvantage urban Indigenous populations compared with urban non-Indigenous populations (Loppie et al., 2014; Place, 2012).
Overall, urban Indigenous populations show better health than non-urban Indigenous populations but worse health outcomes than non-Indigenous populations, although this varies dramatically by population group or geographical area (Place, 2012; Toronto Well Living House, 2018). Indigenous people living in cities often experience high levels of racism and discrimination from non-Indigenous people, both in everyday life and in health care situations (Browne et al., 2011b; The Environics Institute, 2010). At the same time, however, many Indigenous people feel at home in the city, with a strong sense of belonging, creative and strong ties to Indigenous cultures, and hope for – or already realized – financial and socioeconomic success (The Environics Institute, 2010; K. Wilson & Peters, 2005). The Indigenous urban middle class is growing in Canada, with education levels rising and employment and income levels subsequently improving, and a concurrent decline in poverty for urban Indigenous people (Fitzmaurice, 2012). In addition, many Indigenous people living in urban areas are able to create space and strategies for ceremony and contemplation, in order to maintain connections to the traditional land bases that cities now occupy (K. Wilson & Peters, 2005). Determinants of health, including access to health care services, are emphasized in discussions of how to improve Indigenous peoples’ health in Canada and beyond. Addressing the determinants of Indigenous people’s health is specifically related to addressing the impacts of colonialism in health care services and in urban Indigenous people’s everyday lives (Davy, Harfield, et al., 2016; Greenwood et al., 2015; Horrill, Mcmillan, Schultz, & Thompson, 2018; Tungasuvvingat Inuit, 2017).

Although access to health care and other social services is important for preserving Indigenous peoples’ health and improving quality of life on an everyday basis, Indigenous clients frequently report negative experiences in encounters with health care institutions, especially in urban areas (Browne et al., 2011a; Evans et al., 2014; Goodman et al., 2017). Policy and practice responses aimed at ameliorating these negative experiences include implementing cultural safety training for health care providers and decision makers, supporting the expansion of primary health care, and/or supporting Indigenous-led primary health care organizations (Health Council of Canada, 2012; Lavoie, 2014). This chapter focuses on the role of Indigenous-led health organizations in improving Indigenous clients’ experiences in health care settings, by examining the unique ways in which they provide services and the impact this has on clients’ everyday lives.
Indigenous-led health organizations are part of a movement that began with Aboriginal Friendship Centres in the 1950s (Lavoie, 2014; National Association of Friendship Centres, 2012). Aboriginal Friendship Centres, in Canada, are organizations focused on supporting urban populations in a manner that is grounded in Indigenous values and cultural practices (National Association of Friendship Centres, 2012). Initially, they were places where Indigenous peoples – many of whom were moving to the city for the first time after government policies restricting them to reserve geographies were lifted – could go to access services such as employment services, housing support, or counselling (Lavoie et al., 2010; Peters, 2000). Today, Aboriginal Friendship Centres maintain much the same role in bringing urban Indigenous populations and other urban populations together in a supportive environment (Kurtz, Nyberg, Van Den Tillaart, Mills, & The Okanagan Urban Aboriginal Health Research Collective, 2008). Since the 1980s, cities in Canada have also seen an increase in the numbers of health-focused, Indigenous-led organizations delivering a range of health care services, from physician access, perinatal support, and addictions treatment to counseling and dental clinics (Browne et al., 2016; Lavoie, 2014; Lavoie et al., 2010). These organizations grew from desires on the part of urban Indigenous communities to control their own institutions, and provide services in a manner more accessible and appropriate for Indigenous populations than many mainstream health care services (Lavoie, 2004; Varcoe et al., 2014a). In general, although to varying degrees, Indigenous-led health and other social service organizations base their practices in Indigenous values and knowledges, prioritizing Indigenous methods of healing as well as Indigenous models of governance and social support over the biomedical models and hierarchical approaches still common in other types of health services (Maar & Shawande, 2010b).

The ways in which Indigenous-led health organizations operate in Canada and internationally, in particular their basis in Indigenous knowledge and values, have been consistently shown to be beneficial to Indigenous peoples’ health (Freeman et al., 2014; Gomersall et al., 2017; Lavoie, 2014). These organizations also have the potential to positively impact determinants of health for urban Indigenous peoples beyond health care access, such as contributing to urban Indigenous community leadership or self-determination (Lavoie et al., 2015; Walker, 2006b). The prioritization of Indigenous knowledges and ways of life that is undertaken in Indigenous-led health organizations can be well understood through engagement with an area of scholarly inquiry that has come to be termed Indigenous critical theory. Indigenous critical theorists have
as their goal the re-orientation of Indigenous knowledge at the centre of academic work, resisting its displacement within colonial structures of knowledge (Byrd, 2011; Tuck, 2009). Indigenous critical theorists have been developing an increasingly robust body of work on a process called Indigenous community resurgence, which is a way of theorizing processes of Indigenous community revitalization that go beyond the recognition of Indigenous rights by the Canadian government, instead finding their expression in the everyday lives of Indigenous individuals, communities, and political movements (Borrows, 2002; Corntassel et al., 2018; Coulthard, 2014; L. B. Simpson, 2011, 2017). While engaging with Indigenous community resurgence is an important enterprise in many fields of research and practice, links between Indigenous critical theory and health remain limited. Some scholars in the field of Indigenous health engage with Indigenous critical theory, in particular in New Zealand, where the concept of Kaupapa Māori (perspectives grounded in Māori knowledge), applied with the goal of tina rangatiratanga (self-determination), have been applied in health research and studies of various aspects of health and health care (Huria, Palmer, Beckert, Williman, & Pitama, 2018; Rolleston, Doughty, & Poppe, 2016). A handful of recent studies in Canada have also applied concepts from Indigenous critical theory, such as focusing on relational practices, or “relational accountability,” in relation to early childhood development support (Gerlach, Browne, & Suto, 2016; S. Wilson, 2008), or analyzing concepts of health care access through the lens of postcolonial theory (Horrill et al., 2018). The concept of Indigenous community resurgence, being inherently engaged with issues of community well-being, provides a useful means to engage with and understand Indigenous-focused health care services.

The goal of this study is to understand how Indigenous-led health organizations improve Indigenous community members’ experiences in health care settings in urban areas, and what is unique about the ways in which they offer services compared to non-Indigenous-led health organizations. It uses Indigenous critical theory and Indigenous community resurgence to examine the place-making work of urban Indigenous-led health organizations by examining participants’ perspectives on the services they provide. It does so through an analysis of twenty-nine interviews and four focus groups (65 participants in total) with Indigenous community members and health services workers who work with Indigenous clients in the urban community of Prince George, Canada. Before presenting results, the following sections offer more detailed
background information regarding urban Indigenous-led health organizations, Indigenous critical theory, and Indigenous community resurgence, in order to provide context for the results.

**Indigenous-led urban health organizations**

One way in which Indigenous community members provide support to one another is through working in Indigenous-led health organizations. The growth of Indigenous-led organizations in cities began with Aboriginal Friendship Centres – agencies designed to provide support for people adjusting to life in the city, that began to appear in many cities throughout Canada in response to growing urban Indigenous populations throughout the 1950s (National Association of Friendship Centres, 2012). As Indigenous populations in urban areas have continued to grow, diverse networks of Indigenous health and social service organizations have grown extensive and influential, especially since the 1980s, providing a range of cultural, health, and social services including primary health care, legal services, employment services, food banks, counseling services, community events, and access to traditional healing (Fitzmaurice, 2012; Skye, 2006; The Environics Institute, 2010a). The sense of community and cultural connectedness provided by Indigenous-led health organizations, as well as the ways in which these organizations provide a means of exerting Indigenous control over health services, are very important for many Indigenous people living in urban areas (Kurtz, Nyberg, Van Den Tillaart, Mills, & The Okanagan Urban Aboriginal Health Research Collective, 2008; Lavoie et al., 2015; Sookraj, Hutchinson, Evans, & Murphy, 2010). As a result, Indigenous health and social service agencies have become a central part of life for many people living in the city, and often serve as a voice for members of urban Indigenous communities to be heard collectively on a service provision and a policy level.

In Canada, jurisdiction over health policy and services for urban Indigenous peoples is awkwardly divided among federal, provincial or territorial, and Indigenous governments. The federal government, with some exceptions, limits its provision of health services to persons registered under the *Indian Act* living on-reserve (Shewell, 2016). Under the federal *Health Transfer Policy*, responsibility for the design and delivery of health services for many reserve-based First Nations communities has been devolved to the communities themselves (Government of Canada, 2004; Lavoie & Dwyer, 2015). Provincial and territorial governments receive funding for the delivery of health care services to the general population, which according to federal
government definitions includes off-reserve and non-status Indigenous people. However, provinces and territories do not have consistent commitments to developing services for urban Indigenous peoples, resulting in uneven and inconsistently offered policy and services at a provincial or territorial level and often, a great deal of cultural incongruence for, as well as discrimination towards, Indigenous clients accessing services in urban areas (Lavoie et al., 2008; Snyder et al., 2015).

The geographies of health care governance in Canada do not match well with Indigenous peoples’ lived realities. Peters (2006) writes: “the differentiation between urban and reserve areas created by federal and provincial legislation and practice does not match the cultural reality or the maps of identity of many First Nations [people] in cities” (p. 324). For example, mobility between reserves and cities is a common way of maintaining cultural and familial ties for urban Indigenous peoples, yet this mobility is incongruous with the ways in which most services are designed to be used (C. Levesque, 2003; Snyder & Wilson, 2012). Indigenous-led health services in urban areas both draw attention to and disrupt these geographic and jurisdictional divides. Often established in urban areas where health care agreements between Indigenous communities and the federal government do not apply, and where many Indigenous people have adverse experiences with provincially-run health services that are not designed to accommodate them, Indigenous-focused health organizations not only fill an important gap in services for urban Indigenous peoples, but often provide a certain amount of leadership in urban Indigenous communities (Jowsey et al., 2012; Lavoie et al., 2015; D. Smith, Edwards, Martens, Varcoe, & Davies, 2008; Sookraj et al., 2010).

Indigenous-led health organizations tend to be organizations designed to strengthen Indigenous communities in urban areas and provide support where it may be missing in the gaps between federal and provincial health services. Health care-focused organizations also coordinate with more peripherally health-related organizations in order to provide holistic support to Indigenous people living in urban areas. These organizations generally follow a commitment to ensure that their services are grounded in Indigenous values and practices. This centring of Indigenous values is a primary goal of Indigenous critical theory, the main tenets of which are discussed below.
Indigenous critical theory

Indigenous critical theory is a school of thought led by prominent Indigenous feminist and anti-racist scholars such as Eve Tuck, Jodi Byrd, Audra Simpson, and Leanne Simpson, among others. It is a field concerned with decolonization and Indigenous sovereignty, and with making Indigenous presence and sovereignty visible in settler colonial spaces where these have been rendered to a certain extent invisible (Byrd, 2011). There are several threads discernible in the writing of scholars within Indigenous critical theory. The most important of these is the priority given to Indigenous epistemologies and ontologies in formulating theory and informing cultural and political practice. Indigenous critical theory involves taking Indigenous communities, knowledges, institutions, and norms as the starting point, and refusing to diminish them by reading or analyzing them through a colonial lens (Byrd, 2011; Garroutte, 2003; A. Simpson, 2014).

As part of this (re-)orientation, Indigenous critical theory engages with the importance, and the agency, of place. As Jodi Byrd puts it, “where something takes place is more important than when” (2011, p. 118). Indigenous critical theorists assert that places hold memory that transcends the present, and that being in a place can function as a mnemonic device that connects past, present, and future (Basso, 1996; Byrd, 2014). In addition, Indigenous critical theorists emphasize the active and interactive roles of land and place in concert with human beings and communities – that is, the ways in which human beings both impact and are impacted by the places in which they live, work, and travel (Tuck & McKenzie, 2015).

Related to the centrality and active role of place is the concept of the interconnectedness of all things. As Shawn Wilson writes, “relationships do not merely shape reality, they are reality” (2008, p. 7). In this worldview, relationships are the primary area of accountability. In addition, relationships can be conceptualized as intimately connected with, even constitutive of, space itself. As Shawn Wilson explains:

The space and therefore the relationship between people or between people and their environment is seen as sacred, a key concept within many Indigenous peoples’ spirituality. By reducing the space between things, we are strengthening the relationship that they share. (2008, p. 87)
The space between people, or among living things, can be reduced through ceremony, thus strengthening relationships. This concept of space being inextricably tied to – in fact, constituted by – relationships offers a way of describing the pivotal connections between human beings and other living beings in the world as well as to the land itself, and reorients discussions of place.

Much of the work of critical Indigenous theorists is done within the realm of politics and governance (Byrd, 2011; Deloria, 1972), education (Battiste, 2002; Cajete, 2014), or cultural studies (Byrd, 2009; Garrouste, 2003) and has not been taken up in research on Indigenous health (although, see work done in the New Zealand context for exceptions to this rule (Durie, 2004; Filoche et al., 2018)). Although the majority of the literature related to Indigenous health in Canada refers to the negative impacts of colonialism on Indigenous peoples’ health (Czyzewski, 2011), work relating to how the de-centering of colonial perspectives improves and sustains the health of Indigenous people and communities is more limited (Gerlach et al., 2016; Lavoie & Dwyer, 2015). Overt references to critical Indigenous theoretical perspectives in health research are rare.

Literature on Indigenous-led health organizations worldwide shows that they have positive impacts on the experiences of Indigenous clients accessing health care services, as well as high levels of community responsiveness and embeddedness that have been a goal of primary health care on a global level for several decades (Aizenberg, 2014; Rifkin, 1996). This role is important, especially in urban areas where Indigenous peoples are less supported in government policy and practice and experiences of racism stemming from colonialism can be amplified (Lavoie et al., 2015). Indigenous critical theory provides a framework for analyzing the work of Indigenous-led health organizations using Indigenous paradigms. It contributes a valuable analytical approach that both prioritizes Indigenous knowledges and offers a unique understanding of place in the city. This research brings Indigenous critical theory into the analysis, to examine how Indigenous-led health organizations create places in the city where Indigenous knowledges are prioritized and embodied. It does so in particular by engaging with the concept of Indigenous community resurgence.
Indigenous community resurgence and urban Indigenous governance

The concept of resurgence grows out of current debates around Indigenous self-government and self-determination, which centre around two key ideas: first, that Indigenous sovereignty is inherent, pre-dates colonial contact, and has never been relinquished (Clark, 1990; A. Simpson, 2014); and second, that it is inappropriate and dangerously misleading for a settler-colonial government to confer recognition of sovereignty upon the very peoples whose sovereignty they strive to extinguish (Alfred & Corntassel, 2011; Coulthard, 2008). While discourses of recognition and reconciliation through the Canadian state mark a positive turn in state-led discourse on Indigenous peoples’ autonomy, in practice recognition and reconciliation tend to produce a circumscribed set of rights defined by the state without being accompanied by broader moves towards self-government, self-determination, or sovereignty (Coulthard, 2014; Daigle, 2016; L. B. Simpson, 2011). In addition, many Indigenous scholars emphasize the importance of human responsibility and interconnectedness over the individualistic sense of entitlement engendered through rights discourse (McDermott & Wilson, 2010; Vasantha Thumbadoo, 2005).

Scholars have countered these problems using the concept of ‘resurgence’ (L. B. Simpson, 2011). Resurgence describes the ways in which Indigenous communities are reclaiming and reinstating Indigenous processes of governance, language, economics, and law after the colonial oppression of the past centuries. Resurgence takes place without the intervention of or the need to be recognized by the Canadian state; it is led, supported, and achieved by Indigenous peoples and Indigenous communities.

Resurgence as a concept has not often been applied in urban areas. Most in-depth scholarly work on the related topics of Indigenous community self-determination and resurgence has been undertaken in rural First Nations, in communities with a considerable amount of continuity and congruity (Daigle, 2016; Michell, 2005). Internationally, resurgence or related concepts of self-determination are also mainly investigated among communities with high levels of cohesion, rather than among the diversity of Indigenous nations that tend to reside in urban areas – although in some cases scholars caution that this cohesion can be created or assumed in research rather than existing in practice (Fraser, 2009; Mahuika, 2008). In urban areas moves towards self-determination and self-governance are also taking place, although it often looks different
among such a diversity of Indigenous peoples, not all of whom can lay claim to a land base in the city. For example, Toronto Indigenous social service agencies came together in the 1980s to form the Toronto Aboriginal Support Services Association (now the Toronto Aboriginal Support Services Council, or TASSC); an organization which, “in the absence of an elected Aboriginal Council... is increasingly looked to as the representative voice for the Toronto Aboriginal community” (McCaskill et al., 2011, p. 335). Later, the Aboriginal Council of Toronto was established in 2001 with the vision of having 18 elected representatives who would govern on behalf of all Indigenous people living in Toronto in matters of social services, Indigenous and treaty rights, economic development, justice and policing, and inter-community and inter-governmental relations (McCaskill et al., 2011) – although, for reasons that are not clear, the Aboriginal Council was not in the end realized. In other urban areas in Canada, Indigenous-led health organizations including Friendship Centres are working to not only help improve the health and living conditions of the most marginalized members of urban Indigenous communities, but at the same time to draw attention to the structural issues embedded in the colonial state and its attendant institutions – such as the health care system – that create such marginalization. This in turn positions such organizations as leaders in a “community of interest” model of governance that functions in dialogue with city and other levels of Canadian governments (Lavoie et al., 2015; McCaskill et al., 2011; Royal Commission on Aboriginal Peoples, 1996).

These communities of interest that develop through Indigenous-led health and social service organizations have the potential to both support Indigenous rights and embody the concept of Indigenous community resurgence, possibilities which deserve closer attention. The relationships among health care services, health care policy, and rights were explored in chapter three, which found that Indigenous rights to self-government and self-determination, in spite of being emphasized in international research and declarations, continue to be ignored in health care settings in favour of a focus on the individual. This theme was reinforced in chapter four with reference to the barriers that Indigenous clients face when accessing health care services, which, analyzed through the lenses of cultural safety and ethical space, are linked to broader structures of settler colonialism. Attention needs to be paid to these broader structures in order to better understand individual experiences in the context of the culture of health care and settler colonialism. The present chapter focuses more deeply on Indigenous community resurgence, as a
way of emphasizing the ways Indigenous communities are sustained through relationships on an everyday basis in the spaces of Indigenous-led health organizations. Resurgence goes beyond the recognition-based discourse of rights – in which the rights of a community, group, or individual are only upheld when recognized by an outside power – to highlight the abilities inherent in communities themselves to pursue self-determination. Indigenous community resurgence also allows for attention to health and experiences in health care on an individual level, but at the same time links individual experiences to collective community processes, situating individual health and health care experiences within the broader contexts of settler colonialism and Indigenous self-determination.

Methods

The information that this paper draws on comes from interviews and focus groups conducted with 50 Indigenous community members and 15 health services workers who work with Indigenous clients in the city of Prince George, British Columbia, Canada. The study was guided by an eight-member community advisory group, consisting of health care providers, researchers, and Indigenous Elders and community leaders, based in Prince George. Participants were asked about Indigenous people’s experiences in health care settings in the city; about how health care intersects with rights for Indigenous peoples, and about how Indigenous-led health organizations impact people’s rights and sense of community in the city, as well as what the perceived differences are between Indigenous services and other health care services. Interviews and focus groups were conducted between October of 2015 and January of 2016. This paper deals with the latter two parts of the interview and focus group discussions; that is, discussions about what is unique about Indigenous-led health organizations and how they impact people’s lives and support Indigenous communities in urban areas, including through the provision of health care and beyond.

Results

Participants were asked how Indigenous-led health organizations are perceived as supporting Indigenous communities in urban areas, as well as what the perceived differences are between Indigenous-led and non-Indigenous-led health services in their approaches to providing care. Participants described several ways in which Indigenous-led health organizations create places in the city where Indigenous lives and communities are central, the three most commonly discussed
being: (1) by prioritizing client-centred care; (2) through creating safe spaces; and (3) through advocacy on behalf of clients to the wider community. These findings demonstrate how Indigenous-led health organizations focus on relationship building in the provision of health care. They are discussed in descending order according to how many participants raised each topic.

**Client-centred care**

When asked about how Indigenous-led health organizations support Indigenous communities in Prince George, twenty-one participants pointed to the important ways in which Indigenous-led organizations focused on client-centred care in the delivery of services. Indigenous-led health care services were described by clients and health care workers as being client-centred in several ways: by making time and space for clients to get to know health care providers as well as one another; by giving clients authority over the direction and focus of their care; and by being supportive and non-judgmental. All of these responses contribute to a sense of belonging for clients, health care workers, and staff within the spaces of Indigenous-led health care. With respect to having the time and space to get to know other clients and staff, this included both feeling comfortable within the spaces of an organization as well as not feeling rushed by health care providers during appointments. One client, for example, described the space of the waiting room in one Indigenous-led organization as a place in which clients could talk to one another about their health problems:

> It’s more comfortable [in an Indigenous-led health organization], [you can] go in and have coffee, sit down, wait for appointments, and there’s other people there, and you get to talk with other, like, Native – and some non-Native people too – and they tell you what’s going on with theirs – problem, I mean, whatever, and it’s sort of – like, if they have the same problem, then you talk about it. It’s a little better, yep, so. (Client 11)

This client found that being able to talk about mutual experiences with other clients helped her to feel a sense of both comfort and support.

In terms of being allowed time to develop relationships between clients and health care providers, one health services worker in an Indigenous-led health organization described a client...
that she had been working with for over five years, and continued to work with even though the client was no longer living in Prince George:

Our organization was kind of like, ‘well, you know, we’re not supposed to see people who don’t live here.’ And I’m like, ‘yeah, but.’ [laughs] ‘Hear me out!’ You know, like again, we like to go case by case. And so I kind of fought for this guy and I said, like ‘I’m his counselor. That’s it. Like, he has tried others, hundreds of others, and it hasn’t worked, and I’m his person, and he will vouch for that.’ And so then we looked over his file, and my bosses are like, ‘he can’t see anyone else.’ I’m like, ‘no.’ .... I just, I love, yeah, the flexibility, and the client-centred care, and like, above and beyond. And like, five years, are you kidding? No organization – non-Aboriginal organization that I know of would ever allow for that, a five year client. And like, this guy’s still bi-weekly, he’s not even once in a while check-ins, this is a regular client. (FG 3)

This participant described her ongoing relationship with this particular client as an important element in his success in gradually improving his own health. It was not access to services in general that this client needed; it was the freedom to maintain a trusting, long-term relationship with one particular counselor.

Health care providers described the client-centred nature of the care offered in Indigenous-focused organizations in part through the use of time. These participants described time as relatively unrestricted; clients were offered extra time for an appointment when needed. Unlike they would be in most non-Indigenous health care settings, clients were still welcomed in if they came late for an appointment, and there was not a limit on the time period during which a client could see a provider regularly. As one health services worker said:

What we can do for clients is amazing. Just yesterday I had a youth crying in my office, saying ‘I didn’t think I could come back, because I missed four appointments, and I know that the rule is, anywhere that I go, the rule is, if I miss three appointments, I can never come back.’ And so she was scared to call, scared to ask. Her teacher called and said, ‘can she come back?’ I’m like ‘oh my gosh, of course!’ .... Any other agency in town would have turned them away, they would have needed a new referral, a new intake, a new wait list. (FG 3)
In addition to allowing clients the time they need, being client-centred, according to participants, also means giving clients authority to direct the health care encounter according to their own needs. One way of doing this is for providers to focus on listening to clients rather than on giving advice, as the following participant who works in an Indigenous-focused organization described:

Countless times, I’ve had clients, like – I want to say on a weekly basis – say, ‘you know, nobody has listened to me like you have, nobody has given me the time, nobody has asked me what I want,’ you know, and coming here the first time, the focus is on them, not agency agendas, but just truly on the client. (FG 3)

Client-centred care was also achieved through providing a sense of non-judgmental support. Participants described support in terms of getting to know people as friends and human beings rather than only as clients. For example, one Indigenous-led health organization regularly had barbecues for clients – “like a block party” (HSW 3). Another health services worker emphasized the importance of getting to know the community she works in:

If you’re not supporting your community, you’re not going to be able to get to know them, and how can you support somebody you don’t know? Yeah. I think that involvement needs to be there. (HSW 6)

Clients also described Indigenous-led organizations as supporting them by promoting a sense of community in the city, as the following participant described:

It was nice to be around, like Natives, eh [in an Indigenous-led organization]. And it’s not all that bad, like, I was scared of them for many years, because I grew up in a white family. Took me a long time to accept Native people, but eventually I did. And now I got lots of friends around town. And that’s, you know, another reason why I call this my home. (Client 17)

Another client also said that accessing services at an Indigenous-led organization helped him to feel like part of a community. As he put it, “At the [Indigenous-led organization], my counselor up there makes me feel like a part of the community more than anybody else would” (Client 3).

Several clients also mentioned feeling a non-judgmental attitude within Indigenous-led health organizations that led them to feel welcome. For example, one client described an Indigenous-
focused health clinic in the following way: “they’re non-judgmental, and you feel like you can just talk to them about anything.... they actually give me a sense of hope after I leave there” (Client 12). Another client echoed this sentiment, saying, “that’s why I come here [to this Indigenous-led health organization] a lot, because I feel like I got support here... They seem to want to help me” (Client 11). Another participant mentioned the non-judgmental aspect of two different Indigenous-focused agencies in Prince George as a key aspect of what made her feel comfortable there. She said, “there’s no judging. Like, that’s one thing, that – because before, everything was ‘cause I was Native” (Client 5).

The ways in which Indigenous-led organizations were described as prioritizing client-centred care demonstrate the client- and community-led nature of these organizations. Giving clients the time that they need, and making sure that clients feel supported, welcome, and that they can talk about anything without being judged, were described as central features of Indigenous-led health organizations by both health services workers and clients. These features in turn allow for relationships to develop and be sustained within the spaces of health care, thus creating spaces in the city where Indigenous participants feel supported and at home.

### Creating safe spaces

The second most frequently reported finding that emerged from the interviews and focus groups was related to the role of Indigenous-led health organizations in creating safe spaces in the city. Fifteen Indigenous clients and health services workers discussed two major aspects of creating safe spaces: counteracting racism that is experienced elsewhere; and paying attention to cultural safety.

In terms of counteracting racism in the city, Indigenous-led health organizations were perceived as important spaces where clients could access services knowing that they would not face discrimination. As two participants in a focus group discussed:

P1: Why is there, like a Native-specific health? You know what I mean? Like, what’s the diff—?

P2: To make it friendly to Native people, because Native people don’t – they don’t access services, so they thought they would have that organization, so people would access services.
P1: So they pretty much had Native Health because the system’s somewhat, borderline, what – racist [to] people of colour. (FG 2)

Participants described racism as being a common experience in non-Indigenous health care organizations, both on an interpersonal level and at a structural level, which they described Indigenous-led health organizations as being able to counteract. As a health services worker also pointed out in an interview:

I think if there were more Aboriginal-friendly health services, clinics, even in the hospital – I know the Prince George hospital here is really trying, they’ve got the Native piece [of art work] in the foyer, but they – it needs to be, it needs to be a lot more. You shouldn’t go into the Emergency and right away, oh, you’re a Native person, so you know, one, you’re an alcoholic; two, you’re a drug addict; three, oh you’re here for an abortion, or something like that.... There totally needs to be a big learning curve in the health care. (HSW 5)

Indigenous-led health organizations or Indigenous-focused programming in other health care institutions were perceived as ways of counteracting the racist and discriminatory treatment that is described as often confronting Indigenous clients (see also chapter 4 for a discussion of participant experiences of racism and discrimination).

With respect to cultural safety, one important aspect discussed by participants was education for health care staff about the histories and contemporary experiences, practices, and values of local Indigenous communities. For example, one health services worker, describing the work that her Indigenous-led organization does in educating those who work in non-Indigenous-led health care services, outlined what cultural safety entails:

In many ways cultural safety is at the forefront of things and there is a lot of education around that for front lines all the way up to [the CEO] herself. And a lot of that has to do with learning what the difference is between cultural awareness, cultural competence and what cultural safety in fact is – as an experience, rather than as a credential you can tick off.... And that includes a holistic approach, so, you know, physical, mental, spiritual, emotional; also for me it would include spiritual and social; also for me it would include
acknowledging right relationship with land... acknowledging settler histories, settler guilt; acknowledging anti-Indigenous racism. (HSW 2)

Interviews and focus groups revealed that cultural safety was also related to clients’ senses of belonging and safety in health care spaces. For example, as one health services worker explained:

I think First Nations people relate better to First Nations people, and especially if you talk about our older people, they don’t like to be touched sometimes, and maybe sometimes if you have a doctor that doesn’t understand that.... I think it’s very important if doctors would talk a bit more, like ‘okay this is what we’re going to do, and I just need to take a look at your foot, so I’m going to lift the blanket now.’... There totally needs to be a big learning curve in the health care. I think it should start when the doctors and nurses are in training.... I think everybody needs to know about residential school, and the impact of that. (HSW 5)

Cultural safety involves an understanding of history and what has happened to Indigenous communities (such as the impacts of residential schools), that in turn can lead to better understanding of what might make an individual client feel more comfortable and safe. Participants described Indigenous-led health and social services as contributing to Indigenous community members’ sense of belonging and therefore safety in Prince George, especially for people who come to the city from outside of it:

Especially when you have someone who, maybe, comes from a really rural, or really remote community. They come to Prince George, who are they, who do they belong to now? They’re not in their home territories anymore. So Aboriginal health and social services act as that beacon, that place where they can come and they can meet other people.... It’s unfortunate that they had to seek out a service for help, but at the same time, they’re getting so much more out of it. They’re getting something that they potentially couldn’t have if they weren’t in some kind of distress. (FG 3)

Indigenous clients also emphasized the feelings of belonging and safety that they feel in the spaces of Indigenous-led health organizations within Prince George. As one client put it:
It just seemed like [one Indigenous-led health organization] was, um, more compassionate than the other health services around here, like the hospital – they’re very cold, it seems. Yeah, didn’t care. (Client 2)

Cultural safety and counteracting experiences of racism, in these interviews and focus groups, were described by participants as contributing to safe spaces for Indigenous clients in the city. Cultural safety involves a process of developing a thorough and place-specific understanding, informed by history as well as the present day, of where Indigenous community members are coming from. Counteracting racism was related to feeling supported without being judged, as also discussed under the theme of client-centred care. Client-centred care and the creation of a feeling of safety in the spaces of Indigenous-led health organizations both require developing and sustaining good relationships in Indigenous-led health organizations.

**Advocating on behalf of clients**

When asked about how Indigenous-led organizations support urban Indigenous communities, fourteen participants described advocacy on behalf of clients and communities. Health services workers described the advocacy that they themselves performed on behalf of clients, either as part of their job or as extra work on top of their normal duties; clients described situations in which health services workers in Indigenous-led health organizations spoke up on their behalf or helped them to navigate non-Indigenous health and other social services. These participants explained how advocacy creates space to address the needs of Indigenous clients in the broader network of health services in the city. During the interviews and focus groups, advocacy was described, by both Indigenous clients and the health care professionals who work with them, as being crucial for three key reasons: as essential work for health service providers within Indigenous-led organizations; as part of being integrally involved in Indigenous communities in urban areas; and as a way of making space for Indigenous people and Indigenous ways of being in what is often a hostile urban environment.

The first way in which health services workers described advocacy work was that it is a taken-for-granted part of the job: that is, working for an Indigenous-led organization automatically involves advocacy on behalf of clients, because simply providing services is not enough. For example, as one health care worker put it, “I’m advocating for a lot of families, a lot of people. And that’s what we do, as health care providers” (FG 1). Often this advocacy was described as
taking place outside of the formal job itself, as in the following remark by a health care worker: “I don’t even think it’s in our job descriptions, it’s just what we do” (HSW 7).

Indigenous clients also described Indigenous-led services as advocating on their behalf, in many cases by facilitating connections with other services. For example, in a focus group discussion, one client said the following:

I know [one Indigenous-led organization] advocates a lot.... They connect with – if somebody comes in, no matter who it is, the connection with the social worker at the hospital [can be made], the Native liaison, or, you know. (FG 1)

Another client described the way in which an Indigenous-led health organization advocated on their behalf when dealing with child welfare services:

They’re always so, like positive [at the Indigenous-led health organization] and it’s like, ‘well you can do it, you can do it,’ and, because I’m like, I’m alcoholic, and it’s like, dealing with the Ministry, my children and all that, and then getting all that in one area, it’s like, yes. Thank you. (Client 12)

This advocacy was one feature that set this Indigenous-led health organization apart from non-Indigenous-led health organizations, for this client.

Second, participants discussed advocacy as a way of being integrally involved in Indigenous communities. One health services worker emphasized that advocacy work was a natural part of her work, because she felt like a part of the community:

That’s what you do. You’re out there working in the community, you’re working with those community members. You are a voice for them. You’re – yeah, you advocate for them... Yes. That’s what you do. Cause they’re your clients, they’re your community, they’re your people. (HSW 6)

The third and final way in which participants described the importance of advocacy work was through a perceived need to create space for Indigenous clients’ perspectives and needs in non-Indigenous-led health care institutions in the city. This need to create space was often described as necessary due to experiences of racism in non-Indigenous-led health organizations, as
described above (see also chapter four), as well as systemic racism, and was linked to improving access to services for Indigenous community members. For example, as one health care provider put it:

I mean, there’s constant – from [this Indigenous organization], I don’t know about the others – but there’s constant negotiation-slash-advocacy challenging with the Ministry of Children and Family Development, for example, where it would appear to most of us that child protection policies are implemented in a biased way against Aboriginal families. So that’s reality, and we’re constantly having those – dealing with it. So, yes we advocate, but we’re also watch dogs, you know, that’s our thing. (HSW 8)

There is perceived to be a great need for advocacy for Indigenous clients in non-Indigenous health services among participants in this study, to help make all health care spaces safe and welcoming ones. This type of advocacy work originates in the spaces of Indigenous-led organizations but represents efforts to expand these safe and welcoming, community-based places across the network of health care and health-related services in the city. As the above health services worker also said:

I think that all three bodies [major Indigenous health-related organizations] work constantly, really, at challenging the embedded racism in our community. You know, challenge the police, challenge some of the policies that we have, and there’s been improvement.... I believe that [one Indigenous-led health organization] has a voice with our mainstream health services, but holy shit, there’s a little further to go there. But you know, do I think it would be significantly worse if these organizations, these three organizations didn’t exist? Um, yeah. For sure. (HSW 8)

Health services workers described the ways in which advocacy on the part of their organizations might have impacts in the community more broadly. Indigenous clients also described the advocacy work undertaken by health services workers on their behalf, in terms of connecting them to additional supports while in the hospital or speaking up on their behalf with respect to services such as child welfare. Overall, the need for advocacy belies a general atmosphere in health services in the city that is antagonistic, rather than supportive, towards Indigenous clients’ needs. This atmosphere is intimately related to ongoing colonialism in Prince George and in Canada more broadly. This atmosphere may be improving but, as one health service worker put
it, there is still a long way to go. In general, advocating for clients in the broader community was described by participants as a prominent part of the work of expanding the range of safe and welcoming places for Indigenous clients, on the part of staff and health care providers in Indigenous-led health and social service organizations.

Discussion

The findings of this study contribute important understandings of the unique approaches Indigenous-led health organizations take towards providing services for Indigenous communities in urban areas. The key finding of this research is that Indigenous-led health care organizations create supportive urban spaces through focusing on relationships, an important element of Indigenous community resurgence. This focus on relationships is evident in participants’ responses in three main ways: Indigenous-led health organizations prioritize client-centred care; they create safe spaces through counteracting racism and promoting cultural safety; and they perform a strong advocacy role on behalf of Indigenous clients.

First, Indigenous-led health organizations prioritize the needs of Indigenous clients and communities in the city by focusing on client-centred care. In so doing, they give Indigenous clients authority and responsibility in their own relationships with these organizations and the health care staff who work in them, as well as making Indigenous clients feel as though their needs are a priority. Participants describe care being given, not out of a sense of duty, but because care providers in Indigenous-led organizations want to help them – as people and as fellow community members. Participants also feel that health care providers in Indigenous-led organizations take the time to get to know them, and accept their needs and problems without judgment. Participants also highlight that in Indigenous-led health organizations they have the ability to sit and talk with other community members, which contributes to their sense of comfort and support. Early findings by Robin Kearns in Aotearoa (New Zealand) showed that this ability to connect and interact with other community members in the waiting room contributed an important element of community connectedness in the context of Māori health care settings in New Zealand (1991). All of these factors lead to both a sense of empowerment and a sense of connectedness, qualities that are emphasized as important features of Indigenous-led health care (Lemchuk-Favel & Jock, 2004), and that strengthen relationships among people within Indigenous-led health organizations.
Second, Indigenous-led health organizations create safe spaces where Indigenous peoples and perspectives can find free expression on an everyday basis. The ways in which participants describe this space – as being created through attention to cultural safety as well as by counteracting racism – are common in Indigenous-led health organizations around the world. As Davy and colleagues point out in an international scoping review of access to health care for Indigenous peoples:

> Indigenous health care services are more likely to be free of racism and are generally more culturally appropriate than mainstream services. They also tend to employ Indigenous staff who are able to speak the local language and are often known by people accessing the service. (Davy, Harfield, et al., 2016, p. 163)

Cultural appropriateness and freedom from racism are two elements that contribute to Indigenous clients’ abilities to form relationships with one another as well as with staff within Indigenous-led health services. Giving attention to relationships in the treatment of health problems also creates the sense, as discussed by participants in this study, that people working in Indigenous-led organizations are part of a shared community with their clients and that they give the interests of the community priority. This sense of community, in turn, creates a space that is interwoven with relationships among people both using and working in the services. The meaning infused in the space by these multiple relationships in turn creates a place focused on the needs of Indigenous community members, which enables Indigenous knowledges and practices to be central.

The goals of cultural safety are to foster understanding and empathy among health care providers and clients, as well as to develop recognition of, and resistance to, colonial power dynamics and the ways in which oppressive structures are perpetuated in health care institutions (Browne et al., 2016; Papps & Ramsden, 1996). The specific ways in which Indigenous-led organizations work towards achieving these goals are intertwined with having a focus on relationships. Participants describe Indigenous-led health organizations as contributing to cultural safety through demonstrating historical awareness that is community-specific; and through prioritizing, attending to, and successfully promoting clients’ senses of belonging and safety within these organizations. The key to achieving this specific understanding of local context, and knowing how to foster safety and belonging for people, is to have relationships with them. In these
relationships, the contextual experiences of peoples’ lives – experiences that inform their health and influence what makes them feel safe – can be shared and the mutual understanding can be reached that contributes to the shifts in power needed for cultural safety.

Third, Indigenous-led health organizations advocate on behalf of Indigenous clients and communities. Health care providers working in Indigenous-led health organizations describe advocacy as a natural and essential part of the work that they do, although it is also often described as work undertaken beyond their job descriptions. As outlined above, participants describe advocacy work as flowing naturally from the relationships that health care providers in Indigenous-led organizations have with clients and communities. Indigenous clients describe advocacy on their behalf as something that they appreciate about Indigenous-led health services. Advocacy thus functions as a way of demonstrating strong relationships – of showing clients that health care providers are on their side. Indigenous-led health organizations, through providing such advocacy and gaining the trust of the people they are in relationships with, counteract negative experiences in many places in the city that not only do not advocate for Indigenous clients and communities, but that actively work to oppose Indigenous interests (Browne, 2017b; Fiske & Browne, 2006; Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective, 2008). Advocacy work both supports communities and creates places where Indigenous communities can come together and feel safe and supported, creating an environment in which Indigenous people, lives, and knowledges, are given priority.

In creating space for Indigenous ontologies and reimagining Indigenous places in urban areas, Indigenous-led health organizations thus show attentiveness to relationships. Participants’ descriptions of prioritizing Indigenous clients, creating safe spaces for clients and communities, and advocating on behalf of clients, indicate the importance of relationships among people and places within Indigenous-led health organizations. Indigenous critical theory describes the importance of relationships in reference to how everything is interconnected in the creation of space and place (Byrd, 2011; Tuck & McKenzie, 2015). Shawn Wilson’s (2008) articulation of how spaces are constituted by these interconnected relationships among all living things, for example, facilitates an understanding of how Indigenous-led health organizations’ prioritization of community needs and the relationships that sustain communities, in institutional mandate and service provision, help to create Indigenous-focused places in the city.
Participants in this study articulate a sense of caring and trust in their encounters with Indigenous-led health organizations that suggests what Shawn Wilson terms “relational accountability” (2008). Relational accountability refers to the type of responsibility that is owed to other living beings when one acknowledges that relationships form the basis of space and reality. Under the framework of relational accountability, each human being has the responsibility to cultivate good relationships with other living beings that are based on mutual respect (Gerlach et al., 2016). This responsibility also extends to non-living beings, and the land itself. Because life is dependent on reciprocal relationships with the land and other beings, it is necessary to both recognize and respect this dependence, and to renew relationships of respect on an ongoing basis (Daigle, 2016; L. B. Simpson, 2017). Indigenous scholars and others have long recognized the disruptive impact that colonial institutions and power relations have had on relationships among peoples as well as between peoples and land (Pasternak, 2015; Taiaiake Alfred, 2009). Re-centring relational accountability in the context of Indigenous-led health organizations suggests a turn towards Indigenous ontologies in the spaces of health care that can be considered a form of Indigenous community resurgence.

The concept of Indigenous community resurgence provides an important framing by which to understand the work that Indigenous-led health organizations are doing in the city. Indigenous community resurgence involves not just challenging the status quo, but enacting and living day to day within a different status quo (L. B. Simpson, 2011). It involves choosing to base one’s life decisions and day-to-day activities, beliefs, and values in Indigenous ontology, Indigenous law, and Indigenous language. This is possible to varying degrees, in the city or anywhere else, as it is necessary to also take into account the realities and limitations of everyday life in a settler colonial nation. Indigenous community resurgence is made possible, however, through the creation of spaces in which Indigenous lives and knowledges can be lived on a day-to-day basis; spaces which prioritize Indigenous cultural and physical survival (Borrows, 2002). In urban areas, this space is more difficult to make than it is outside of cities, and this is partly why the work falls to Indigenous-led health and social service organizations, which might not otherwise take on community leadership roles.

Indigenous community resurgence also takes place in the context of renewing relationships to land. The importance of land, and the function of relationships to land within Indigenous epistemologies, has not often been analyzed in urban areas (K. Wilson & Peters, 2005). Although
there are projects underway in cities such as Toronto and Vancouver to reclaim Indigenous histories in urban places and thereby re-connect urban Indigenous peoples to urban land (First Story Toronto, 2017), sites of reclamation of Indigenous connections to place and land tend to be more often situated outside of urban areas (C. Andersen & Denis, 2003; Peters, 2004). For example, Indigenous scholar Michelle Daigle (2016) gives an example of Indigenous resurgence based in processes of relational place-making in her own community of Achikamaw in northern Ontario. In this case, resurgence through place-making is grounded in relationships to the land itself, as embodied through food practices as well as seasonal ceremonial cycles expressing gratitude and reciprocity to the land (Daigle, 2016).

How do urban Indigenous people, especially those for whom the land on which a city is built is not their ancestral territory, express this resurgence in relation to land? The work of Daigle and other Indigenous scholars such as Leanne Betasamosake Simpson indicates a possible answer. The relational place-making involved in Indigenous community resurgence occurs, in part, through inter-nation(al) treaties and agreements among Indigenous nations and between Indigenous nations and animal nations (Daigle, 2016; see also L. B. Simpson, 2017). The turn towards Indigenous ontologies and Indigenous authorities does not need to be restricted to the colonial geographies that have re-defined Indigenous land – that is, Indigenous resurgence does not have to take place only on reserves or in places currently recognized by the settler colonial government as Indigenous land. As Daigle points out:

Certain places in this colonial landscape, such as reserves and treaty territories, become naturalized as the spaces where Indigenous, or more accurately Aboriginal, self-determination can exist while all other land under Canada’s jurisdiction becomes marked as readily available for privatization, capitalist accumulation, and settlement. However, Indigenous responsibilities to their ancestral lands reach well beyond the boundaries of reserves and treaty territories and thus cannot be constrained to these colonialscapes. (Daigle, 2016, p. 6)

In other words, land and place can be re-claimed through processes of negotiation that take place between Indigenous communities and between Indigenous communities and non-human nations. Land and place do not have to be conceptualized through recourse to colonial geographies that restrict Indigeneity to bounded lands defined by the state, outside of urban areas. Given both the
centrality of place in Indigenous epistemologies, as articulated by Indigenous critical theorists (Byrd, 2011; L. B. Simpson, 2011), and the dynamic nature of relationships between Indigenous communities and traditional land bases (Basso, 1996; A. Simpson, 2014; K. Wilson & Peters, 2005), it is still possible to assert and reinvigorate Indigenous relationships to land and place within urban areas.

With reference to the present study, the question of land did not arise in interviews and focus groups, but the concept of belonging to place did – both through colonial geographies of identity or membership (see chapter three for a discussion of these geographies in relation to rights) and through belonging within the spaces of Indigenous-led organizations, as addressed in the present chapter. Results suggest that processes of Indigenous community resurgence through connections to place in urban areas are at work in the urban Indigenous-led health organizations discussed by participants. Future research could delve more deeply into the question of whether the reclamation of Indigenous land in urban areas can be furthered through the place-making work of Indigenous-led health organizations or other Indigenous organizations in the city.

Resurgence is embodied within the communities of interest that develop through Indigenous-led health and social service organizations, as Indigenous community members create space in which to live according to Indigenous knowledges and ways of life. Waldram (1990), in a study of health care access in the city, describes how “traditional peoples” move smoothly between the use of state-run medical services and “traditional” or informal healing services, without the perception that they are switching between two distinct systems. The majority of the time, Indigenous community members go about their lives and pursue Indigenous ways of life without the intervention or the attention of the Canadian state. Urban Indigenous health organizations draw on, facilitate, and mesh with these ways of life in a variety of ways and at a variety of scales. Indigenous-led health organizations operate – in various ways and degrees – according to Indigenous ontologies and as such build the capacity of the community for self-determination in a manner closely resembling the resurgence that Indigenous scholars have described.

**Conclusion**

Results of this study show that the ways in which Indigenous-led health organizations are able to centre relationships, through client-centred care, creating safe spaces, and providing advocacy, leads to the centring of Indigenous needs and perspectives in the provision of health care.
Looking at the approaches taken by Indigenous-led health organizations through the lens of Indigenous critical theory and Indigenous community resurgence allows for a consideration of how Indigenous understandings of place and relationships are activated in urban areas by these organizations. If places are created through networks of relationships, the attention given by Indigenous-led health organizations to relationships with clients and communities has the potential to make new types of places available to Indigenous people in the city.

Institutions, including health care, in cities are often felt to be unaccommodating and even hostile to Indigenous clients, reflecting longstanding colonial relationships and attitudes (Evans et al., 2014; Goodman et al., 2017). The results of this study demonstrate that Indigenous-led health organizations, to the extent that they are able to make Indigenous perspectives, needs, and values the foundation of how services are offered, succeed in creating safe, welcoming, and non-judgmental places in the city where Indigenous communities can be supported and thrive. These places align with what Indigenous critical scholars advocate with respect to Indigenous community resurgence – namely, prioritizing Indigenous knowledge and practice through ongoing attention to the relationships that are formed or maintained in a particular space.

The concept of community resurgence has important implications for rethinking the concept of Indigenous self-governance, both as imagined through government legislation and “rights,” as well as from within Indigenous communities, especially in urban areas where formal Indigenous rights tend to be ambiguous and ill-defined. Indigenous community resurgence is a concept that both has the potential to empower communities to create change in the face of administrative and governmental resistance, and to highlight the work that is already being done on an everyday basis by Indigenous community members, groups, and organizations in urban areas. A deeper understanding of this type of everyday work could help in the development of more formal structures of urban Indigenous governance, whether these structures become a part of Indigenous-led health and social service organizations or develop as separate, although interconnected, entities.
Chapter 6
Dissertation Conclusion

Canada’s settler colonial context informs health care policy and Indigenous rights discourse, and also serves to portray cities as settler spaces, in spite of the high proportions of Indigenous peoples living there. This context has impacts on Indigenous peoples’ health as well as experiences accessing health care services. With this in mind, the main goal of this dissertation was to answer the following question:

*How does the work of Indigenous-led health organizations, in the context of settler colonialism, bring together Indigenous rights and Indigenous community resurgence for Indigenous community members in urban areas?*

This main question was addressed through three sub-questions:

a) How do Indigenous rights to self-government and self-determination interact with Indigenous rights to health care in urban areas?

b) How does the settler colonial context in which health care is provided arise as a barrier to Indigenous people accessing health care services in urban areas?

c) What are the roles of Indigenous-led health organizations in fostering Indigenous community resurgence in urban areas?

The interplay between Indigenous rights and Indigenous community resurgence, as having an important influence on Indigenous peoples’ health and access to health care services, is a foundational concept informing this dissertation. While Indigenous rights are an important determinant of Indigenous peoples’ health, Indigenous community resurgence grows from critiques by Indigenous scholars of the discourses of recognition inherent in discussions of Indigenous rights. Because Indigenous rights, in a legal sense, are dependent on recognition of such rights by the settler colonial state, they are necessarily limited by the vested interest of the state in maintaining control over Indigenous lands (Coulthard, 2014; L. B. Simpson, 2017; Taiaiake Alfred, 2009), and therefore on their own are not sufficient to overcome the disparities in Indigenous peoples’ health and access to health care when compared to non-Indigenous populations. Indigenous self-government and self-determination, while important to consider in any discussion of Indigenous peoples’ health, are not given full recognition by the Canadian
state, which limits the scope of its own responsibilities for the well-being of Indigenous communities. While Indigenous rights remain an important avenue in the pursuit of Indigenous community well-being, therefore, Indigenous community resurgence presents a complementary framework based in Indigenous autonomy and sovereignty (A. Simpson, 2014; L. B. Simpson, 2017).

Indigenous community resurgence is a way of understanding the work that is done on an everyday basis within Indigenous communities, with the purpose of reclaiming and living out Indigenous ways of knowing and being. Resurgence is understood as the application of Indigenous legal, political, cultural, and economic practices in the everyday lives of members of Indigenous communities (Corntassel et al., 2018; L. B. Simpson, 2011). It is intrinsically related to Indigenous individual and community health, through the ways in which power and control are acknowledged as always existing in Indigenous communities, whether or not they are recognized by the colonial state (Coulthard, 2014). Because of this intrinsic relationship to health, and because it represents a shift away from centring colonial ways of knowing and living, Indigenous community resurgence offers a useful and novel framework in this research for understanding the work of Indigenous-led health organizations in supporting urban Indigenous communities.

The questions guiding this dissertation were investigated using qualitative methods, and in accordance with ethical principles of decolonizing research and research with Indigenous communities and organizations. Sixty-five Indigenous community members and health care providers participated in the research in total. The research took a relational approach, in that fostering, respecting, and maintaining good relationships was a key aspect of the methodology. This aligns with principles of Indigenous and decolonizing research as well as with Indigenous critical theory. A Community Advisory Group composed of eight Indigenous leaders, Indigenous Elders, health care providers and decision makers, and researchers in Prince George provided guidance and advice on the research throughout the process, as a way of checking to make sure the research was being carried out in a respectful and responsible manner, as well as to help the researcher to make contacts and develop relationships related to the research and in the community in general. The Community Advisory Group also allowed for the researcher to engage in critical self-reflection with feedback, to keep the practice of self-reflection grounded in the research and the community and prevent it from becoming a self-indulgent examination of
researcher privilege; something that scholars have cautioned against (Caretta & Jokinen, 2017; Kobayashi, 2009).

Summary of findings

Chapter three, *Indigenous Health, Health Services, and Rights in the City*, addresses the first sub-question: “how do Indigenous rights to self-government and self-determination interact with Indigenous rights to health care in urban areas?” This chapter examines interview and focus group discussions about Indigenous rights in the context of health care. Participants described rights to care or human rights being violated in health care settings; ways in which health care services were being improved to better respect Indigenous clients’ rights; and the unevenness of eligibility for Indigenous rights depending on geography and identity. These responses mirror the ways in which Indigenous rights tend to operate in practice, in urban areas in Canada: that is, through entitlement to specific services or benefits for those who fit within certain government-defined identities. Indigenous rights to self-government and self-determination were described quite separately from rights to health care in urban areas. Overall, participants emphasized human rights and the right to cultural safety in health care, rather than Indigenous rights to self-government or self-determination, demonstrating a lack of association between health care and Indigenous rights.

This lack of association suggests three things. First, the perceived lack of association between health care institutions and Indigenous rights to self-government or self-determination reflects a lack of consideration within these institutions for the broader structural factors impacting Indigenous peoples’ experiences in, and access to, health care. Cultural safety frameworks recognize institutional orientations and have the goal of altering individual health care provider behaviours; however, without attention to the broader goals of Indigenous self-determination the colonial context of health care cannot be fully accounted for. Second, participants’ attention to human rights in health care indicates that the treatment of Indigenous clients in health care settings in Canada is in urgent need of change. If Indigenous clients feel that they cannot expect good quality health care, provided in a timely manner, when entering a health care institution in Canada, this is evidence of systematic discrimination that in turn demonstrates a lack of respect for Indigenous physical and cultural survival (Borrows, 2002). Third, participants’ disassociation with Indigenous rights discourse and emphasis on the need for human rights and human
treatment indicates that Indigenous community resurgence may be a more compelling framework for understanding Indigenous clients’ relationships with health and health care than Indigenous rights, as investigated in detail in chapter five.

This chapter contributes novel understandings of health care in the context of Indigenous rights – discourses that have not often been brought into dialogue and yet that have key implications for one another, since Indigenous health is closely tied to Indigenous rights in Canada, in particular to the negative effects of ongoing colonial violations of inherent Indigenous rights to self-government and self-determination. The chapter also highlights how the complex ways in which Indigenous rights are offered by the federal government serve to confuse the people who are entitled to such rights, and thereby limit people’s access to these rights, both in terms of services and benefits and in terms of broader, more fundamental rights such as the right to self-determination. It also flags human rights violations in the context of Indigenous clients’ frequently reported negative experiences in a variety of non-Indigenous-led health care settings (Browne et al., 2011b; Evans et al., 2014; Goodman et al., 2017), linking these negative experiences to violations of internationally-accepted standards for the treatment of human beings (United Nations, 1948) and highlighting the urgent need for action. This calls attention to the intrinsic links between rights and responsibilities, in particular highlighting the responsibilities of the Canada government, through treaties, the Constitution Act, and international agreements, to promote and protect the well-being of Indigenous peoples. Ways of upholding these responsibilities include linking Indigenous rights with health and health care; in addition, some potential policy approaches are outlined in chapter four.

Chapter four, Understanding Barriers to Health Care Access Through Cultural Safety and Ethical Space: Indigenous People’s Experiences in Prince George, Canada, addresses the second sub-question guiding the research: “how does the settler colonial context in which health care is provided arise as a barrier to Indigenous people accessing health care services in urban areas?” This chapter identifies three key barriers reported by participants for Indigenous clients accessing non-Indigenous-led health care services: substandard quality of care; long wait times; and perceived racism and discrimination. These three interrelated barriers to access, when analyzed through the lenses of cultural safety and ethical space, demonstrate that from the perspectives of Indigenous clients, the spaces of health care often appear unsafe or inaccessible due to reasons traceable to colonialism. For example, cultural safety highlights the power
imbalances inherent in health care institutions that lead to experiences of racism or
discrimination, and ethical space foregrounds the ethical responsibilities of governments and
government-run institutions to promote and protect Indigenous peoples’ cultural and physical
survival – responsibilities that are perceived as being evaded when Indigenous clients feel that
they are receiving substandard care.

Analyzing these barriers through the lens of cultural safety and ethical space highlights the
conceptual distance separating health care providers and Indigenous clients in mainstream health
care settings – a distance that often leads to differential treatment and poor experiences for
Indigenous clients. This distance – created through differing understandings of the world and, in
particular, misrepresentations of Indigenous peoples and what it means to fulfill Indigenous
peoples’ health care needs – is directly related to the settler colonial context in which Canadian
health care is offered, and must be understood within this context in order to be remedied so that
Indigenous clients’ experiences in health care settings can be improved. Reducing the distance
between people is directly related to creating place in Indigenous critical theory, as described in
chapter five, and according to the results of this study, is an important way of improving the
experience of health care for Indigenous clients.

The analysis based in cultural safety and ethical space also focuses attention on the moral
responsibilities embedded in health care on the part of providers, institutions, and governments,
towards those in the vulnerable position of needing health care who are also Indigenous peoples
in special relationships with the federal government. The particular responsibilities of the federal
government towards Indigenous peoples are often expressed in the form of Indigenous rights, as
discussed in chapter three. In the context of health care, this responsibility also translates into
ensuring that health care policy aligns with the unique needs of Indigenous peoples. In spite of
calls for this alignment to take place, through attention to jurisdictional and identity-based issues
(Royal Commission on Aboriginal Peoples, 1996; Truth and Reconciliation Commission of
Canada, 2015), health care policy in Canada does not properly account for the particular barriers
and the settler colonial context of the health care system and its resulting impacts on Indigenous
clients accessing health care services. The results of this research indicate an urgent need for this
to change.
Finally, the results presented in this chapter encourage a spatial understanding of the boundaries that can form around health care for Indigenous peoples, and how these boundaries appear to be policed, from the perspectives of Indigenous clients, to promote their exclusion. The processes of exclusion that are practiced in a settler colonial society – through the spatial boundaries put up around Indigenous identity, such as the regulated spaces of reserves or the discursive exclusion of Indigenous peoples in cities – are replicated on a small scale in the spaces of health care; cultural safety and ethical space help to demonstrate this. Health care providers are seen as gatekeepers with arbitrary abilities to permit or deny entry to a space; as a result, Indigenous clients do not feel that they can rely on receiving help in the form of health care when it is needed.

This chapter responds to calls for analyses of Indigenous clients’ negative experiences in health care based on the structural factors impacting the health care system as a whole, in order to contextualize individualized experiences of racism (Browne, 2017b). It offers novel ways of engaging with cultural safety in dialogue with ethical space in order to understand the ways in which broad colonial structures impact individual experiences. In addition, this chapter has policy implications with respect to Indigenous people’s access to health care in Canada (discussed below). Ethical space and respect for cultural safety demonstrate ways of understanding power differentials in health care spaces as well as potential paths forward through creating shifts in colonial structures of power.

Chapter five offers an understanding of the work of Indigenous-led health organizations in light of Indigenous clients’ negative experiences in other health care settings. This chapter, entitled Indigenous Health Organizations, Indigenous Community Resurgence, and the Reclamation of Place in Urban Areas, addresses the final research sub-question: “what are the roles of Indigenous-led health organizations in fostering Indigenous community resurgence in urban areas?” In this chapter, participants’ responses describing how Indigenous-led health organizations’ work is unique fall under three key findings: client-centred care, creating safe spaces, and advocating for clients. Employing perspectives on place and relationships drawn from Indigenous critical theory and Indigenous community resurgence to analyze these findings demonstrates that Indigenous-led health organizations prioritize relationships in their day-to-day work, in a way that resonates with the values of many of the Indigenous community members they serve. To the extent that a given organization can place this importance on good
relationships – with clients, among clients, among staff, and with broader communities – these organizations create space where Indigenous community resurgence is enacted on an everyday basis.

This chapter contributes novel understandings of the work of Indigenous community resurgence, in particular in urban areas and in the realm of health care – areas that are not often analyzed with regard to processes, like Indigenous community resurgence, that relate to self-determination for Indigenous communities. It highlights the already-existing strengths of Indigenous communities in urban areas through the ability of Indigenous-led health organizations to provide support for urban Indigenous community members in need, while acknowledging that these organizations cannot be the only answer; as demonstrated in chapters three and four, the federal government may not sidestep its own responsibilities in terms of honouring Indigenous rights and upholding Indigenous cultural as well as physical survival. Indigenous community resurgence is a complementary process to Indigenous rights that nevertheless goes a long way towards improving both access to health care and a sense of community and rights, for those who participated in this research.

Indigenous community resurgence takes place on an everyday level and involves individual and collective actions that can happen equally in public, organized, grassroots movements as in intimate relationship settings with family and friends. As Corntassel and colleagues describe it:

> Everydayness reveals the choices we make on a daily basis to engage with our lands, cultures and communities. These seemingly small actions are significant in informing both the micro and macro processes of community resurgence. Resurgence also entails a consciousness of being in a daily struggle to regain rebellious dignity. (Corntassel et al., 2018, p. 18)

This “struggle to regain rebellious dignity” is something that health care providers in Indigenous-led organizations engage with on a regular basis, together with their clients and Indigenous communities. By advocating for clients in the broader context of health care and the urban community, health care providers and Indigenous-led health organizations work to expand the safe spaces available to Indigenous community members. They undertake this work through everyday actions that span public and private space, and that advocate for human and Indigenous rights while simultaneously carrying on the independent work of community resurgence.
Limitations of the research

This research includes many more Indigenous clients of health care services than health services workers. While this is in some ways a strength of the research, it also limits in-depth discussions of the conscious or mandated roles of Indigenous-led health organizations in terms of Indigenous rights, Indigenous self-government, or Indigenous self-determination in urban areas. Future research could focus on this role – or potential role – of Indigenous-led health organizations in more depth. This being said, Indigenous community members who participated in the research included members of the middle class as well as people in much less stable socio-economic situations. It included people who used Indigenous-led health care services as well as those who did not. Thus, this research included Indigenous clients with a reasonably wide range of differing perspectives, rather than focusing solely on more marginalized populations, which is a feature of much research relating to Indigenous-led health organizations due to the fact that these organizations tend to be geared towards serving those most in need.

The location of the research in Prince George contributes some limitations as well as some strengths. While Prince George is unique in terms of what tends to be considered “urban” – being relatively small and quite distant from other cities – and thus provides an important setting to consider for urban health services and urban Indigenous communities, this may also mean that findings from Prince George are less applicable in other cities that are larger in size and less remote. The type of smaller, remote urban setting of which Prince George is an example is, however, important to examine and may offer insight for other small cities in Canada and internationally. Health care policy for Indigenous peoples in urban areas needs to take into account the full range of urban experiences and contexts, and for this reason as well a city such as Prince George supplies an important example.

Finally, my position as a non-Indigenous researcher, of white settler descent, conducting research while living thousands of kilometres distant from the city in which the research is based, constitutes a limitation as well. The face-to-face contact required in Indigenous and community-based research, although it has been maintained to the extent possible, is necessarily limited. Further, the ability of a non-Indigenous researcher such as myself to meaningfully employ the principles of Indigenous critical theory and other theories such as ethical space in an analysis may be limited by my position in a settler colonial society. However, this research represents an
attempt to follow the lead of Indigenous scholars rather than non-Indigenous scholars in the analysis of research based in Indigenous communities. I have endeavoured to remain vigilant in the ways I take these ideas and apply them in my own work, ensuring that I have community checks in place and trying to avoid misrepresenting the ideas and concepts developed by Indigenous scholars or appropriating them as my own. The structure of the research, being based as it is on relational accountability, has – I hope – helped to prevent too many of these mistakes being made.

**Contributions of the research**

Overall, this dissertation contributes to the fields of Indigenous geographies, urban environments, and health geographies, by foregrounding the ways in which Indigenous people, through the work of Indigenous-led health organizations, are resisting and counteracting colonialism and the concomitant exclusion of Indigenous bodies and knowledges within health care in the city. In doing so, the dissertation makes key empirical, conceptual, and methodological contributions to these fields of study.

The key empirical contributions are threefold. First of all, this research finds that participants perceive Indigenous rights and health care services to be unrelated – a separation that is also reflected in practice through the ways in which the federal government confers limited entitlement to Indigenous rights through services and benefits. Second, participants report that Indigenous clients tend to have significantly negative experiences in non-Indigenous-led health care settings; a finding that may stem from a lack of acknowledgement of Indigenous rights as well as the settler colonial context in which health care is offered in Canada. The third major empirical contribution of this work is the finding that Indigenous-led health organizations in urban areas support Indigenous community members in a variety of ways, all of which centre around the promotion and maintenance of good relationships. These findings, taken together, contribute in-depth understandings of how settler colonialism influences health care on an individual level, leading to human rights violations that must not be tolerated; as well as how honouring Indigenous rights – far from being separate from either human rights or from health care – is an essential path by which to keep human rights violations from occurring in health care settings.
In terms of its conceptual or theoretical findings, this research contributes to the literature in three major ways. First, it offers novel understandings of rights to health and health care as inseparable from Indigenous rights. In examining this link between Indigenous rights and health care, the research demonstrates how processes of settler colonialism act within and outside of health care settings in similar ways, and that thinking of health care or human rights as separate from Indigenous rights creates blind spots in which the poor treatment of Indigenous clients in health care somehow becomes allowable. It also provides an example of the impacts of differential geographies of rights in a novel setting – that of health care in the city, from Indigenous people’s perspectives. Second, in order to understand the impacts of settler colonialism in health care, this research engages with cultural safety, a framework that is often used to understand Indigenous people’s engagement with health care, and also with ethical space. Ethical space is a framework that has not been applied so frequently in health care settings, but one that extends and complements cultural safety in a way that allows for both a spatial analysis and a focus on social and legal concepts of justice. In using both of these concepts together, this research is able to focus on the safety in cultural safety and the space in ethical space. Creating safe spaces in health care, understood through these frameworks, requires a thorough acknowledgement of settler colonialism in health care settings – an acknowledgement that is often achieved in the spaces of Indigenous-led health organizations. Finally, the main conceptual framework this research engages with, and endeavours to extend through its application to a real-world situation, is that of Indigenous community resurgence. The work of Indigenous-led health organizations in urban areas, when these organizations succeed in placing good relationships at their centre, is found to contribute to Indigenous community resurgence in ways that have the potential to re-connect urban Indigenous communities to place, to land, and to one another.

Methodologically, this research was guided by principles of Indigenous research and decolonizing research. Through prioritizing these principles, the key contributions of this research stem from the people who participated in and guided the research, and from the methodological focus on building and maintaining good relationships – whether these were one-time meetings or long-term relationships. First of all, this research contributes to filling a significant gap in the literature by focusing on urban Indigenous peoples, who as a group remain underrepresented in both research and policy in Canada. It also includes participants living in
urban areas who come from a range of socio-economic backgrounds as well as health statuses. Part of the research design was to consciously recruit people living in both stable and unstable housing situations, and people doing well financially as well as those living in poverty. It also includes participants who are both users and non-users of Indigenous-led health care services. Second, this research contributes methodologically to an understanding of the importance of relational accountability in research, and provides examples of how this might be accomplished. Relational accountability is a concept drawn on by Indigenous critical theorists, and one that is receiving increasing attention as an element of research methodology (Gerlach, 2018; Morton Ninomiya & Pollock, 2017; S. Wilson, 2008). In this dissertation, a variety of strategies were used to ensure that the researcher remained accountable to the relationships that were formed – with me as well as with the research itself – including efforts to solicit advice on the research from a variety of community members involved in health care work with Indigenous peoples; the involvement of the Community Advisory Group; and ethical agreements through research protocols with several different organizations or institutions. Relationships require work and attention, and relationships in cross-cultural research often involve missteps or misunderstandings; in this dissertation I attempt to show how these can be used as valuable learning experiences. Opportunities to correct mistakes will also be more readily available when ongoing relationships based on mutual respect have already been established. These methodological insights contribute to the literature on the practicalities and ethics of Indigenous and decolonizing research in Canada, and offer a timely contribution to discussions of who should be doing such research, how, and why.

Overall, this dissertation makes important contributions to the literature on health geography, by bringing the complex interplay among Indigenous rights, settler colonial contexts, and Indigenous community resurgence to light within health care settings, and the impacts of these processes on the lives of urban Indigenous community members on an everyday basis. It contributes innovative work to the field of health geography in its examination of the place-making work of Indigenous-led health organizations, as understood through relationships and relational accountability, both theoretically and methodologically.

This research also speaks to the current and potential roles of urban Indigenous-led health service organizations in both the health care system and in processes of Indigenous self-government or self-determination. It examines the impact of health care policy in Canada on Indigenous
peoples, while laying the foundation for further research in a national and international context. The following sections outline the policy implications of this work and possible directions for future research.

**Policy implications**

With respect to policy and the governance of health care services for Indigenous people, this study has several implications. First of all, the role of Indigenous-led health organizations in the broad picture of Indigenous health services deserves close attention, especially in light of shifts in responsibility for health care service oversight and provision from the federal government to Indigenous communities and, in British Columbia, the First Nations Health Authority (First Nations Health Authority, 2017; Lavoie & Dwyer, 2015). Strengthening the capacity of Indigenous-led health organizations in urban areas makes sense as a way of addressing urban Indigenous health care needs and filling in gaps in jurisdiction, as well as increasing community control over health care services (Lavoie & Dwyer, 2015). However, this type of shift must be advocated with care. If Indigenous-led health organizations are to take on increasing responsibility for Indigenous-focused health care in urban areas, and especially if they are to be given increased responsibilities in terms of urban Indigenous self-government, issues of underfunding and overwork of health care providers will need to be addressed. Attending closely to relationship building in health services means that health care providers must put in extra investments of time, often outside of work hours (see chapter five). The orientation towards community support and relationship building on the part of Indigenous-led organizations requires that difficult decisions be made with respect to where to allocate what is generally quite limited funding, often resulting in lower wages for the staff and health care providers who work in these organizations (Davy, Cass, et al., 2016). Staff burnout can be an issue as well as relatively high staff turnover. If urban Indigenous governance roles are to be formalized in Indigenous-led health organizations, staff will be required to take on increased responsibilities; this expansion of responsibility must be accompanied by measures to increase both funding and capacity for these organizations (Browne et al., 2016).

Second, the results of this study show that health policy in Canada needs to be updated in order to better account for the geographical and spatial realities of Indigenous lives. The Canada Health Act (CHA) needs to take into account the unique jurisdictions and responsibilities of
different levels of government for Indigenous health, especially when specifying guidelines for accessibility of health care services. Understandings of access to health care, as outlined in the Canada Health Act, do not account for Indigenous people’s experiences in health care settings; updating the CHA to reflect recent research frameworks of access to health care would make this federal policy much more relevant.

In addition, as has been called for for more than two decades, jurisdictional boundaries governing access to health care services for urban and non-status Indigenous peoples must be broken down, and provincial or territorial and federal policy and services must be streamlined. Perhaps most importantly, those Indigenous peoples currently excluded from federal policy related to both health care and Indigenous rights – including urban and non-status Indigenous peoples – must be included under federal responsibilities, as recently indicated in the Daniels decision (Macdougall, 2016; Royal Commission on Aboriginal Peoples, 1996; Truth and Reconciliation Commission of Canada, 2015). Federal divisions of Indigenous peoples based on federal government definitions of identity and geography must be ended.

Strategies for policy change must be approached using the principles of ethical space, in consultation and collaboration with Indigenous communities. One example that has already been implemented, although with extreme reluctance on the part of the federal government, is Jordan’s Principle, under which the provider of first contact is required to pay for services, leaving the jurisdictional issues to be dealt with after the patient – in this case, First Nations children with special needs – has been provided with the care they need (First Nations Child and Family Caring Society, 2017; Lavallee, 2005). This type of principle could be applied to health care policy governing urban or off-reserve Indigenous people of all ages as well.

In proposing any policy changes related to Indigenous peoples’ health, however, it is imperative to allow the final decisions regarding such changes to rest with Indigenous communities. Ethical space has been successfully employed to govern interactions between the federal government and Indigenous communities in land and resource management and has been proposed as a model for co-management or for negotiating Indigenous environmental jurisdiction (Alberta Energy Regulator, 2017; Indigenous Circle of Experts, 2018). This type of interaction thus has precedents that would facilitate its being applied in the context of health care. Using the foundational principles of ethical space places all parties on an equal level, allowing Indigenous
knowledge to be engaged with in its own right rather than being judged by other standards. It also makes room for Indigenous government and self-determination to take centre stage, addressing the most fundamental determinant of Indigenous health.

**Possibilities for future research**

The findings of this study open up possibilities for future research examining the impacts of Indigenous self-government and rights to land on health in urban areas. Although federal government policy addresses Indigenous community self-government and many First Nations communities have some form of self-government agreement in place, urban Indigenous communities are generally excluded from such agreements (C. Andersen & Denis, 2003; Government of Canada, 2010). Indigenous self-government agreements have an important focus on relationships to land, which are a key element of health for Indigenous people and communities. Future research could examine the interrelated questions of land (including Indigenous title to land), self-government for urban Indigenous communities, and health. For example, if Indigenous communities are to pursue self-government in urban areas, should urban Indigenous self-government proceed the way it has thus far – that is, informally, through the work of Indigenous-led health and social service organizations – or would it be more appropriate to develop new organizations specifically focused on urban Indigenous self-governance? Urban Indigenous individuals and communities find creative ways to maintain connections to land and community while living in urban areas; these strategies can be broadened and strengthened by attention to Indigenous governance of land in high density urban areas. Investigating the impacts on health through these connections to land alongside questions of Indigenous governance of urban land bases would shed light on the relationships among Indigenous peoples, settler descendants, and arrivants in Canada, contributing in a complex and fundamentally important way to the work of truth and reconciliation.
Bibliography


to primary care from the perspective of Aboriginal patients at an urban emergency
department. *Qualitative Health Research, 21*(3), 333.

to primary care from the perspective of Aboriginal patients at an urban emergency
department. *Qualitative Health Research, 21*(3), 333.
http://doi.org/10.1177/1049732310385824


(2016). Enhancing health care equity with Indigenous populations: evidence-based
strategies from an ethnographic study. *BMC Health Services Research, 16*, 544.

Cultural safety and the challenges of translating critically oriented knowledge in practice.
*Nursing Philosophy, 10*, 167–179.

Brunger, F., Schiff, R., Morton-Ninomiya, M., & Bull, J. (2016). Animating the Concept of
Ethical Space: The Labrador Aboriginal Health Research Committee Ethics Workshop.

relations* (pp. 97–121). Minneapolis, MN: University of Minnesota Press.


Byrd, J. (2009). ‘In the City of Blinding Lights:‘ Indigeneity, cultural studies and the errants of


Canadian Institute for Health Information. (2017). *Wait times for priority procedures in Canada*. Ottawa, ON.


Hanson, E. (2009). Indian Reserves.


Lavoie, J. G., Gervais, L., Toner, J., Bergeron, O., & Unite de sante publique des Autochtones.


York, NY: Guilford Press.


National Collaborating Centre for Aboriginal Health. (2012). *State of Knowledge of Aboriginal Health: A Review of Aboriginal Public Health in Canada*, 1–128. Retrieved from http://ubc.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwbZuxDslwDEQtdpYiEEUM_EBRajdNOiMqPoA9spN47ET_nxaBVBCrh5usd5J9B0B4NtUPE9hwsmJLMhdBbZiRMuWWI2qOUfkqrMAff_AKg9bOPTX--VWhRLD-6wRHM7NBqQdrHkOgw-PV2ks7eGkrqs5fek0jinXHeqOXtORg2TLWHzR6mE43L6-f4EZ1s_reo


http://doi.org/10.1016/j.socscimed.2013.02.016

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Appendices

Appendix A: Information and Consent Letters

Informed Consent: Health care providers/Executive directors

Hello,

This letter is to ask you to participate in a one-on-one interview with me as part of a research project I am doing. The purpose of the project is to look at links between Aboriginal rights in cities and Aboriginal health services. I am interested in your personal experiences with working in Aboriginal health services, as well as in your thoughts and experiences about Aboriginal rights. Overall, I am trying to find out how having Aboriginal rights influences health services, and also how having access to Aboriginal health services connects to Aboriginal rights.

This research project is part of my PhD program at the University of Toronto, in the Department of Geography. My supervisor is Kathi Wilson. I have done a similar project as part of a Master’s program at the University of Northern British Columbia in Prince George, focused on mental health. My interest in the topics of Aboriginal rights and health comes from a background in Health Sciences as well as study and work in Aboriginal Health since 2009.

The interview will take about an hour of your time and participation is completely voluntary. You are free to leave at any point, and you may decline to answer any questions that you choose. Later, if you would like to withdraw the information that you give me from the study, please contact me and I will do so without questioning your reasons. Your decision to participate or not to participate in this study will not affect your employment in any way.

If you agree, I would like to make an audio recording of the interview to help me remember accurately what we discuss. If you do not wish to be recorded, I will take notes, or work from memory if you prefer.

Your information will be kept confidential and I will only identify you in any reports or final products of the research as part of a group of people who have experience working in Aboriginal health services. For participants in administrative or executive director positions, the specific nature of your expertise may limit confidentiality. Every effort will be made to anonymize your information. I will remove all identifiers and will not include any information, including quotations, that might identify any participant, including executive directors. However, it is possible that, in spite of my best efforts, simply identifying even anonymized participants as ‘executive directors’ may limit confidentiality.

As the researcher, I will be the only person to have access to raw data, with the exception of professional transcribers who are governed by a confidentiality agreement. No data collected from participants will be stored on the research website. Data will be retained for five years following the completion of the dissertation. At this time, all data collected from participants will be permanently erased (for electronic records or audio recordings) or shredded (for written records or documents).
I hope that this research will help improve access to Aboriginal health services, by showing their importance and by linking them with rights. However, there may not be any direct benefit to you from participating in this study, aside from any personal interest you might have in the topic. Potential risks include the possibility that sensitive or personal subjects may be brought up related to Aboriginal health services or related to Aboriginal rights, and discussing these subjects may result in experiencing negative emotions. If you feel uncomfortable at any point you are free to stop the interview, and if you feel that you need to follow up your interview with further conversation, please let me know or contact a health service provider or someone you feel comfortable talking with, or consult the list of support services at the end of this document. Drop-in counseling is also available at the Prince George Native Friendship Centre.

You are welcome to bring your children with you to the interview; or, if you need child care in order to attend, you will be reimbursed for child care expenses upon presenting receipts to the researcher. If you leave the interview or withdraw from the study you will not be asked to return any compensation.

If you are interested, please provide me with your contact information and I will keep you updated on what I am doing throughout the research project. After the interview, you will be sent a copy of your interview transcript or my notes regarding the interview; feel free to make any corrections. If you make corrections, I will send you the revised version of your transcript for you to verify. As soon as I have finished all of the interviews for this project, I will analyze the results and send you a summary of my initial thoughts about what everyone has said. You are welcome to provide feedback on any aspect of the results at any point in the process. I will also send you a copy of the final write-up of the research before it is finalized.

It is likely that I will want to publish academic papers and give public presentations on the results of this research. Information related to these activities will be kept up to date on the research website (see below).

I will keep this website updated with information about the research project, including my contact information and all of the information in this letter. You can access this page at any point at: http://sarahnelson.ca.
Contact Information

If you have any questions about your rights as a participant, or any questions or concerns about how the research is being conducted, please contact any of the people below.

Researcher
Sarah Nelson
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905-828-3864

Office of Research Ethics
University of Toronto
ethics.review@utoronto.ca
416-946-3273

Counselling/Support Services

Prince George Native Friendship Centre
Native Healing Centre
1600 - 3rd Avenue (3rd Floor), Prince George, BC V2L 3G6
Phone (250) 564-4324 Fax (250) 614-7728
Hours: Monday to Friday from 8:30 am to 4:30 pm (Closed Thursdays between 1 pm and 4:30 pm for clinical supervision and staff meetings.

Crisis Prevention, Intervention and Information Centre for Northern BC
Crisis Line: 250-563-1214 or 1-888-562-1214

Northern Health Community Response Unit (CRU)
#201 - 1705 3rd Avenue
Prince George, BC V2L 3G7
Phone: 250-565-2668
Fax: 250-565-2633
Consent

Please circle one response to each statement.

Audio recording:
I agree to have the interview audio recorded (and I know that I am free to ask you to turn off the recorder at any point): Y N
I agree to have you take notes during the interview: Y N

Contact information:
I am interested in being contacted as the research progresses, to verify my transcripts and the results of the research: Y N

(If you answered yes to the above) My contact information is:
Email: __________________________________________
Phone: __________________________________________
Mailing Address: __________________________________
________________________________________________________________________
________________________________________________________________________

Participation (written consent):
I understand the research project, my role in it, and have had my questions answered in a way that I feel comfortable with: Y N
I agree to participate in the study in the ways that I have specified above: Y N

Signature of participant:

Researcher (verbal consent):
I confirm that I have received verbal consent from the participant, answering yes to the following questions:

Do you, the participant, understand the research project and your role in it, and have you had your questions answered in a way that you feel comfortable with? Y N
Do you, the participant, agree to participate in the study in the ways that you have specified above? Y N

Signature of researcher:
Informed Consent: Clients

Hello,

This letter is to ask you to participate in a one-on-one interview with me as part of a research project I am doing. The purpose of the project is to look at links between Aboriginal rights in cities and Aboriginal health services. I am interested in your personal experiences with Aboriginal health services, as well as in your thoughts and experiences about Aboriginal rights. Overall, I am trying to find out how having Aboriginal rights influences health services, and also how having access to Aboriginal health services connects to Aboriginal rights.

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The interview will take about an hour of your time and participation is completely voluntary. You are free to leave at any point, and you may decline to answer any questions that you choose. Later, if you would like to withdraw the information that you give me from the study, please contact me and I will do so without questioning your reasons.

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I hope that this research will help improve access to Aboriginal health services, by showing their importance and by linking them with rights. However, there may not be any direct benefit to you from participating in this study, aside from any personal interest you might have in the topic. Potential risks include the possibility that sensitive or personal subjects may be brought up related to Aboriginal health services or related to Aboriginal rights, and discussing these subjects may result in experiencing negative emotions. If you feel uncomfortable at any point you are free to stop the interview, and if you feel that you need to follow up your interview with further conversation, please let me know or contact a health service provider or someone you feel comfortable talking with, or consult the list of support services at the end of this document. Drop-in counseling is also available at the Prince George Native Friendship Centre.

As a thank you for your time and help with this project, I am offering a $20 gift card, as well as reimbursement for any public transportation that you had to take to come to the interview (in the
form of bus tickets). You are welcome to bring your children with you to the interview; or, if you need child care in order to attend, you will be reimbursed for child care expenses upon presenting receipts to the researcher. If you leave the interview or withdraw from the study you will not be asked to return any of these items or compensations.

If you are interested, please provide me with your contact information and I will keep you updated on what I am doing throughout the research project. After the interview, you will be sent a copy of your interview transcript or my notes regarding the interview; feel free to make any corrections. If you make corrections, I will send you the revised version of your transcript for you to verify. As soon as I have finished all of the interviews for this project, I will analyze the results and send you a summary of my initial thoughts about what everyone has said. You are welcome to provide feedback on any aspect of the results at any point in the process. I will also send you a copy of the final write-up of the research before it is finalized.

It is likely that I will want to publish academic papers and give public presentations on the results of this research. Information related to these activities will be kept up to date on the research website (see below).

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416-946-3273

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Consent

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I agree to have the interview audio recorded (and I know that I am free to ask you to turn off the recorder at any point): Y  N
I agree to have you take notes during the interview:  Y  N

Contact information:
I am interested in being contacted as the research progresses, to verify my transcripts and the results of the research:  Y  N

(If you answered yes to the above) My contact information is:
Email: ___________________________________________ Phone: ____________________________
____________________________________________________________________________________
Address: ____________________________________________________________________________
____________________________________________________________________________________

Thank you/reimbursement:
I have received a $20 gift card in compensation for my time:  Y  N
I have received bus tickets or tokens as reimbursement for my travel expenses:  Y  N

Participation (written consent):
I understand the research project, my role in it, and have had my questions answered in a way that I feel comfortable with:  Y  N
I agree to participate in the study in the ways that I have specified above:  Y  N

Signature of participant:

Researcher (verbal consent):
I confirm that I have received verbal consent from the participant, answering yes to the following questions:

Do you, the participant, understand the research project and your role in it, and have you had your questions answered in a way that you feel comfortable with?  Y  N
Do you, the participant, agree to participate in the study in the ways that you have specified above?  Y  N

Signature of researcher:
Hello,

This letter is to ask you to participate in a focus group with me as part of a research project I am doing. The purpose of the project is to look at links between Aboriginal rights in cities and Aboriginal health services. I am interested in facilitating a discussion about how Aboriginal health and social services may (or may not) create a sense of community in the city, and how this sense of community may (or may not) contribute to Aboriginal rights. Overall, I am trying to find out how having Aboriginal rights influences health services, and also how having access to Aboriginal health services connects to Aboriginal rights.

This research project is part of my PhD program at the University of Toronto, in the Department of Geography. My supervisor is Kathi Wilson. I have done a similar project as part of a Master’s program at the University of Northern British Columbia in Prince George, focused on mental health. My interest in the topics of Aboriginal rights and health comes from a background in Health Sciences as well as study and work in Aboriginal Health since 2009.

The focus group will take about three hours of your time and participation is completely voluntary. You are free to leave at any point, and you may decline to answer any questions that you choose. Later, if you would like to withdraw the information that you give me from the study, please contact me and I will do so without questioning your reasons.

With the group’s permission, I would like to make an audio recording of the group discussion to help me remember accurately what we discuss. If the group does not wish to be recorded, I will take notes instead.

Your personal information, including transcripts and recordings of the discussion, will be kept confidential and I will only identify you in any reports or final products of the research as part of a group of people who have experience accessing Aboriginal health services. However, you should be aware that in a group setting it is more difficult to guarantee confidentiality. I ask that, as a participant in the group, you treat the discussion as confidential and do not use other participants’ names when speaking with others about the discussion. As the researcher, I will be the only person to have access to raw data, with the exception of professional transcribers who are governed by a confidentiality agreement. No data collected from participants will be stored on the research website. Data will be retained for five years following the completion of the dissertation. At this time, all data collected from participants will be permanently erased (for electronic records or audio recordings) or shredded (for written records or documents).

I hope that this research will help improve access to Aboriginal health services, by showing their importance and by linking them with rights. However, there may not be any direct benefit to you from participating in this study, aside from any personal interest you might have in the topic. Potential risks include the possibility that sensitive or personal subjects may be brought up related to Aboriginal health services or related to Aboriginal rights, and discussing these subjects may result in experiencing negative emotions. If you feel uncomfortable at any point you are free to leave the discussion, and if you feel that you need to follow up your interview with further conversation, please let me know or contact a health service provider or someone you feel
comfortable talking with, or consult the list of support services at the end of this document. Drop-in counseling is also available at the Prince George Native Friendship Centre.

As a thank you for your time and help with this project, I am offering a $20 gift card, as well as reimbursement for any public transportation that you had to take to come to the focus group (in the form of bus tickets or tokens). You are welcome to bring your children with you to the focus group; or, if you need child care in order to attend, you will be reimbursed for child care expenses upon presenting receipts to the researcher. If you leave the focus group or withdraw from the study you will not be asked to return any of these items or compensations.

If you are interested, please provide me with your contact information and I will keep you updated on what I am doing throughout the research project. After the focus group, you will be sent a copy of the transcript or my notes regarding the focus group; feel free to make any corrections. If you make corrections, I will send you the revised version of the transcript for you to verify. As soon as I have finished all of the interviews and focus groups for this project (I am hoping to conduct about 60 interviews and two focus groups), I will analyze the results and send you a summary of my initial thoughts about what everyone has said. You are welcome to provide feedback on any aspect of the results at any point in the process. I will also send you a copy of the final write-up of the research before it is finalized.

It is likely that I will want to publish academic papers and give public presentations on the results of this research. Information related to these activities will be kept up to date on the research website (see below).

I will keep this website updated with information about the research project, including contact information and all of the information in this letter. You can access this page at any point at: http://sarahnelson.ca.
Contact Information

If you have any questions about your rights as a participant, or any questions or concerns about how the research is being conducted, please contact any of the people below.

Researcher
Sarah Nelson
PhD Candidate, University of Toronto, Department of Geography
sarah.nelson@mail.utoronto.ca
778-764-1081 OR
647-463-9457

Supervisor
Kathi Wilson
Associate Professor, University of Toronto, Department of Geography
kathi.wilson@utoronto.ca
905-828-3864

Office of Research Ethics
University of Toronto
ethics.review@utoronto.ca
416-946-3273

Counselling/Support Services

Prince George Native Friendship Centre
Native Healing Centre
1600 - 3rd Avenue (3rd Floor), Prince George, BC V2L 3G6
Phone (250) 564-4324 Fax (250) 614-7728
Hours: Monday to Friday from 8:30 am to 4:30 pm (Closed Thursdays between 1 pm and 4:30 pm for clinical supervision and staff meetings.

Crisis Prevention, Intervention and Information Centre for Northern BC
Crisis Line: 250-563-1214 or 1-888-562-1214

Northern Health Community Response Unit (CRU)
#201 - 1705 3rd Avenue
Prince George, BC V2L 3G7
Phone: 250-565-2668
Fax: 250-565-2633
Consent

Please circle one response to each statement.

Audio recording:
I agree to have the interview audio recorded (and I know that I am free to ask you to turn off the recorder at any point): Y  N
I agree to have you take notes during the interview: Y  N

Contact information:
I am interested in being contacted as the research progresses, to verify my transcripts and the results of the research: Y  N

(If you answered yes to the above) My contact information is:
Email: ___________________________________________________________________
Phone: ___________________________________________________________________
Address: ___________________________________________________________________
Mailing Address: ___________________________________________________________________

Thank you/reimbursement:
I have received a $20 gift card in compensation for my time: Y  N
I have received bus tickets or tokens as reimbursement for my travel expenses: Y  N

Participation (written consent):
I understand the research project, my role in it, and have had my questions answered in a way that I feel comfortable with: Y  N
I agree to participate in the study in the ways that I have specified above: Y  N

Signature of participant:

Researcher (verbal consent):
I confirm that I have received verbal consent from the participant, answering yes to the following questions:

Do you, the participant, understand the research project and your role in it, and have your questions answered in a way that you feel comfortable with? Y  N
Do you, the participant, agree to participate in the study in the ways that you have specified above? Y  N

Signature of researcher:
Appendix B: Interview and Focus Group Guides

Interview Guide: Health care providers

Basic introductions and thank you; go through main points of information letter and consent form; ask permission to record (with options to take notes or work from memory instead).
• Do you have any questions regarding the consent information?
• Do you have any questions regarding why or how this research project is being done?
• Do you feel comfortable going ahead with this interview?

Background:

Can you tell me a bit about yourself?
1. Do you identify as an Aboriginal person?
2. How long have you been in this position? What did you do before? What drew you to work in Aboriginal health services?

Aboriginal health organization (specific):
• Can you describe the organization that you work for and how it serves Aboriginal peoples or communities in Prince George?
• What does your position here involve?

Who are the clients that you most often work with? Are there specific needs in the Aboriginal communities in Prince George that you feel your organization fulfills? Is there anything that you feel your organization contributes to the community beyond specific health needs? Are there any needs that you would like to see your organization fulfill, but that it currently is not able to fulfill? Can you describe any challenges you experience in providing services to clients? Do you, as part of your job, form linkages with other organizations (Aboriginal health; non-Aboriginal health; other organizations)? Do you, as part of your job, refer clients to other organizations?

Aboriginal health services (general):
• What makes a service Aboriginal?

Have you ever worked in Aboriginal health services outside of an urban environment (if so, what are the main differences)? Do you think that Aboriginal health services as they currently exist meet the needs of Aboriginal peoples in cities in Canada? What are some of the challenges involved in delivering Aboriginal health services in Prince George?
Governance and support:

- How would you describe the political support for Aboriginal health services in Prince George?
- How would you describe the policy environment that Aboriginal health services operate in in Prince George?

Community and rights:

- What do you feel this organization contributes to the urban Aboriginal community?
- Do you feel that Aboriginal health services contribute to a sense of community in Prince George?
- Do you feel that urban Aboriginal health services play a role in supporting urban Aboriginal rights?
- Do you feel that Aboriginal health services are of political importance for urban Aboriginal communities?

Conclusion:

- Is there anything else you would like to add?
- Do you have any questions/comments/concerns?
- Can you think of anyone else who might be interested in participating in this study?
Interview Guide: Clients or potential clients of services

Basic introductions and thank you; go through main points of information letter and consent form; ask permission to record (with options to take notes or work from memory instead).

• Do you have any questions regarding the consent information?
• Do you have any questions regarding why or how this research project is being done?
• Do you feel comfortable going ahead with this interview?

Background:
• Can you tell me a bit about yourself?
  a. Age, family, employment, living arrangements
  b. Where are you from, how long have you lived in Prince George?
  c. Do you identify as an Aboriginal person?

General health and health access:
• How would you describe your health? What do you consider to be good health? What kinds of things make you feel healthy?
• How would you describe your experience with health services in Prince George?

Do you have a regular health care provider in Prince George (such as a family doctor)? In the past 12 months, have you seen your regular health care provider? In the past 12 months, have you used other health services in Prince George besides those of your regular health care provider? In the past 12 months, has there been a time when you needed health services in Prince George but weren’t able to access them? What impact do you feel this had on your health/your life? Has the past 12 months been unusual in terms of the way you have used health services? Do you ever go outside of Prince George to access health services?

Aboriginal health services:
• What, in your opinion, makes Aboriginal health services different from other health services?

In the past 12 months, have you used Aboriginal health services in Prince George? Can you give me some specific examples? Would you choose Aboriginal health services over other health services if given the choice? Do you think that Aboriginal health services meet the needs of Aboriginal peoples in cities in Canada? Do you feel represented by the Aboriginal health services that are out there? Are there more services that you would like to see?

Community and Rights:
• Do you feel a sense of belonging within an Aboriginal community in Prince George?
• Do you think that Aboriginal health services play a role in the local community?
How would you describe the local community? What does it consist of? People? Places? Organizations?

Do you feel that your rights as an Aboriginal person are supported by Aboriginal health services in Prince George?

Conclusion:

• Is there anything else you would like to add?
• Do you have any questions/comments/concerns?

Recruitment:

Can you think of anyone else who might be interested in participating in this study?
Focus Group Questions

Aboriginal health and social services:

1. Can you give me a sense of the range of Aboriginal health and social services in Prince George?
   a. What kinds of services are available to clients, who can access them, what is missing, what would be nice to have.

How these services may contribute to a sense of community in the city:

2. Do you think that Aboriginal health and social services have a role to play in creating a sense of community among Aboriginal peoples in Prince George?
   a. How? Or why not?
   b. Is there a sense of community among Aboriginal people in Prince George? Multiple communities?
   c. Are there other things that contribute to this sense of community?
   d. Are there other roles that Aboriginal health and social services have in the community in Prince George, beyond simply providing health care services?

How a sense of community in the city may contribute to Aboriginal rights for urban Aboriginal peoples:

3. What kind of advocacy or voice do you feel that Aboriginal people in Prince George have?
4. Do Aboriginal health and social services have a role in supporting this advocacy or voice?
   a. How? Or why not?
5. Do Aboriginal health and social services have a role in supporting Aboriginal rights in Prince George?
   a. How? Or why not?