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Social Innovation and Institutional Transformation. The Minowé Clinic at the Val-d'Or Native Friendship Centre

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Dominique Parent-Manseau, Stéphane Laroche,
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Montréal 2020



Les Autochtones et la ville au Québec :
identité, mobilité, qualité de vie et gouvernance



REGROUPEMENT
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Cahiers ODENA. Au croisement des savoirs

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Aboriginal people in Québec cities:
identity, mobility, quality of life and governance

At the forefront of social innovation, the ODENA Research Alliance provides alternative paths to understanding and responding to the individual and societal challenges faced by First Peoples living in Québec cities and towns. The ODENA Research Alliance brings together representatives of Aboriginal civil society and academic researchers engaged in a process of knowledge co-creation with a view to improving the quality of life of Aboriginal people in cities and renewing relations between First Peoples and other Québec citizens in a spirit of equality and mutual respect.

ODENA is a joint initiative of the **DIALOG** - *Aboriginal Peoples Research and Knowledge Network*, and the Regroupement des centres d'amitié autochtones du Québec. ODENA seeks to support the social, economic, political and cultural development of Aboriginal people in Québec cities and to recognize the value of the collective action of the Native friendship centres. This alliance focuses on ethical and socially sensitive research, the ongoing sharing of knowledge and the direct application of this knowledge in social reconstruction and reconciliation initiatives developed by the Aboriginal organizations concerned. Since 2014, ODENA's work is also deployed nationally and internationally. ODENA was established in 2009, under the Social Sciences and Humanities Research Council's (SSHRC) Community/University Research Alliances Program (CURA). The ODENA Research Alliance fully subscribes to the objectives of the DIALOG network:

- CONTRIBUTING TO THE IMPLEMENTATION AND MAINTENANCE OF A CONSTRUCTIVE DIALOGUE, that is innovative and sustainable, between the university and Aboriginal organizations and communities, in order to stimulate and promote the coproduction of knowledge, interactive and collaborative research, as well as adherence to ethical research principles with Aboriginal peoples.
- CONTRIBUTING TO A BETTER UNDERSTANDING of the historical and contemporary social, economic, cultural and political realities of Aboriginal peoples and the dynamics of their relations with non-Aboriginal people by emphasizing the co-production of knowledge and by helping to make research and public policies more responsive to Aboriginal needs, approaches and perspectives.
- SUPPORTING UNIVERSITY STUDENTS' TRAINING, guidance and supervision, particularly for Aboriginal students, by associating them with the network's activities and achievements and offering them financial assistance programs and excellence grants.
- PARTICIPATE IN THE ENRICHMENT, ENHANCEMENT, AND IMPLEMENTATION of practices, know-how and knowledge of Indigenous actors in the fields of social and environmental research, and mobilization of knowledge.
- INCREASE THE SCIENTIFIC AND SOCIAL SCOPE of research pertaining to Aboriginal peoples, by developing new knowledge tools that are interactive, participative, and pedagogical, and by increasing initiatives for the broadcasting, sharing, transmission, and mobilization of knowledge, in order to make known and highlight the ensuing results, contributions and progress, in Quebec, in Canada, and worldwide.



Conseil de recherches en
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Introduction

This document outlines the institutional history of the Minowé clinic, which was created to transform the health and social services available to the Indigenous population in the city of Val-d'Or¹. This project, developed by and for Indigenous Peoples, was founded 10 years ago, in 2009, by the Val-d'Or Native Friendship Centre (VDNFC). From the start, VDNFC leaders created a working group composed of stakeholders from Indigenous communities and the Quebec health network, accompanied by academic researchers who have helped ground the project in the field's latest developments at both the national and international level. The research team has documented the evolution of the project from its inception and produced new bodies of knowledge that effectively communicate the project's scope and results, with the aim of guiding the subsequent actions and decision-making of the VDNFC leadership, in addition to expanding the academic knowledge base.

Of course, a project of this nature is never fixed in time or space; it evolves and changes according to funding parameters, the knowledge it acquires, and the institutional actors it successfully mobilizes. Like so many other projects deployed in a community-based context, it encounters obstacles and unplanned-for events as it develops, forcing it to change course and adapt. However, it also has the capacity to continue operating for years, even indefinitely, if it remains solidly anchored to a foundation that reflects its shared vision for improving its users' quality of life; shared values of mutual aid, solidarity, and reconciliation; democratic responsibility among the population involved; and a holistic and sustained understanding of the wellness objectives to be met. From this standpoint, obstacles are also opportunities to make adjustments that better ground the project in its goals.

In this respect, the collaboration between researchers and stakeholders is essential, as it becomes necessary to document the milestones of an Indigenous institutional narrative as it takes place in real time. In fact, this is a defining characteristic of a social research methodology that relies on the co-construction and mobilization of knowledge, whether scientific or Indigenous, and seeks to fully integrate it into the major social, cultural, economic, legal and political issues that characterize reconciliation between Indigenous and non-Indigenous people of Quebec. This methodology is also characterized by its goal of creating bridges of understanding and elucidation between the worlds of thought and action, analysis and operationalization.

¹ Our work in the co-production and mobilization of knowledge is funded by the Social Sciences and Humanities Research Council as part of its partnership program (<https://www.sshrc-crsh.gc.ca/home-accueil-eng.aspx>). Part of this text was published internationally in 2019 as the chapter "Taking action to improve Indigenous health in the cities of Quebec and elsewhere in Canada: the example of the Minowé Clinic at the Val-d'Or Native Friendship Centre," in I. Vojnovic, A.L. Pearson, G. Asiki, G. DeVerteuil et A. Allen (eds): *Handbook of Global Urban Health*: 347-362. Another article, published in 2015, also addressed some of the epistemological and methodological aspects of the Minowé Clinic case study (Lévesque et al. 2015). This present English version is the translation of an expanded version published first in French: Lévesque et al. 2019c.

In the pages that follow, we present the general context of Indigenous living conditions and health, both in Quebec and Canada, and then trace the development of the Minowé Clinic through its fundamental relationship with the Quebec and Canadian Native Friendship Centre movement. We then move on to discuss the relationship that Indigenous individuals have with health, the cultural safety approach promoted by the Minowé Clinic and the example of Indigenous social perinatality that was developed. To conclude, we examine the intellectual, institutional and operational transition that took place in 2018 to support the Minowé Clinic's transformation into the Mino Pimatizi8in Health Centre.

The First Nations Population in Val-d'Or

Well known for its mining and logging industries, Val-d'Or celebrated its 80th anniversary in 2015. Located in western Quebec, in the Abitibi-Temiscamingue region, and within the regional county municipality (RCM) of Vallée-de-l'Or, the city of Val-d'Or had a population of 25,541 inhabitants as per the 2016 census and covers an area of 3,552 km² (Statistics Canada 2017).

Located in the heart of ancestral Anicinape lands, the city is characterized by its large Indigenous population. According to the Canadian census data from 2016, 1,540 individuals self-identified as Indigenous (4.8% of the population). Of that number, more than 1,000 self-identified as First Nations. However, these figures only account for individuals residing in the city on a permanent basis, overlooking those who reside there temporarily (often on a long-term basis) or those in transit. As such, many Indigenous individuals who are experiencing homelessness or circular migration are excluded from official statistics. Many Indigenous communities are located within a one-hundred-kilometre radius of Val-d'Or, including Pikogan, Lac-Simon, Kitecisakik and Winneway, which totalled more than 4,600 registered members with federal Indian status as of December 31, 2017 (INAC 2018).

Source: cited in Lévesque, Comat et al. 2018a: 17; translated from original.

1. Health Conditions and Institutional Shortcomings

There are significant, recognized and well-documented gaps between the economic, social and health conditions of Indigenous populations in Canada and those of Canadian and Quebec populations (Boyer 2015, CHRC 2013, Greenwood et al. 2015.) While the Human Development Index regularly positions Canada within the top five countries in the world, this same index ranks Canada's Indigenous Peoples as 70th in the world. From birth, Indigenous Peoples of all backgrounds are at a higher risk of experiencing health issues in every aspect of their personal, familial and social life: a higher incidence of chronic diseases (including diabetes and tuberculosis); accidents; suicide; physical, psychological and sexual violence; overcrowded homes; major psychosocial difficulties, including alcohol and drug addiction; heightened poverty; endemic obesity; a high frequency of children placed in non-Indigenous foster homes; lower levels of education and economic activity; reduced life expectancy; gender inequalities; and limited access to potable water (FNQLHSSC 2014, Macdonald and Wilson 2013).

In addition to these issues, Indigenous populations living in cities experience further challenges: a lack of appropriate care and resources; limited and unsafe access to public health services;

social isolation; over-representation within homeless and carceral populations; insalubrious housing conditions; food insecurity and nutritional deficiencies; repeated situations of racism and discrimination; and chronic unemployment. This places an additional burden on public services in urban areas, which often lack the necessary resources to adequately meet the needs of their Indigenous clientele—needs which are often misunderstood or wholly unrecognized. In addition, cohabitation between Indigenous and non-Indigenous populations is difficult and often becomes a source of tension and insecurity for both.

It stands to reason that many Indigenous people lack confidence in the public health services and personnel. They rarely visit clinics, health centres or hospitals unless forced to by an emergency and, at that, often only in situations of dire need. This can lead to a number of serious issues, including late diagnoses, more complex treatments, a lack of accompaniment and resources, inappropriate medication, and the absence of follow-up care and preventative measures (Allan and Smylie 2015). These disparities are worsened by experiences of racism and discrimination, both on a personal and institutional level, which colour the exchanges many Indigenous clients have with medical and care personnel (Allan and Smylie 2015; Lévesque et al. 2018b).

The inequalities and injustices at the root of these problems have been publicly denounced by Indigenous organizations and by researchers, both Indigenous and non-Indigenous, for many years (Graham and Stamler 2010, Greenwood et al. 2015, Kelly 2011, Lavoie 2013, Mitchell 2006). Already, during the Royal Commission on Aboriginal Peoples (RCAP), held between 1991 and 1996, numerous studies, statements and testimonies bore witness to the lamentable living conditions and illness experienced by a majority of Indigenous Peoples in the country, in addition to a lack of services adapted to their needs. This Commission, having put the spotlight on Canada's colonial history and its dire, ongoing consequences on the quality of life and health of Indigenous populations, drew attention to the importance of developing new models of healthcare based on Indigenous practices, knowledge and approaches to care, prevention, psychosocial intervention and treatment (RCAP 1996, Spear 2014).

A number of new initiatives and government programs have been developed and implemented in the intervening years, nonetheless many obstacles remain, particularly in regards to recognizing the authority, jurisdictional competence and expertise of Indigenous institutions and organizations in the development and implementation of these new models (Martin and Diotte 2010). Furthermore, the following elements would have significant impacts in ensuring that these initiatives can succeed and continue producing long-term positive outcomes: 1) modifying the underlying logic that still too-often informs the development of contemporary government policy for Indigenous populations and the majority of funding programs that follow from those policies²; 2) better training for medical personnel (both Indigenous and non-Indigenous) so they can understand the realities and challenges faced by the populations they work with; 3) and redesigning the nature, objectives and scope of the services offered.

² The rationales and approaches that underlie the vast majority of modern public policies have neoliberal and universalist origins and fail to correspond with the approaches, perspectives, knowledge, needs, and objectives of Indigenous Peoples.

Despite some small improvements since the end of the 20th century, notably in health and education, existing policies and legislation generally promote the assimilation and integration of Indigenous populations into Canadian society instead of recognizing their social, cultural and political difference. This reality has only served to obscure the attacks on their rights, the abuses, and the many kinds of extortion perpetrated against them over the centuries as a result of the colonial policies enacted by the Canadian state. Their right to self-determination, repeatedly recognized by the Supreme Court of Canada and by major international stakeholders (such as the UN), is disregarded (United Nations 2007). Their individual and collective ability to take responsibility for their own futures is too often ignored.

United Nations Declaration on the Rights of Indigenous Peoples

Article 21.1

Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

- 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
- 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*

Article 29.3

States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Source: United Nations 2007

The primary challenge for urban Indigenous people continues to be the affirmation and recognition of their cultural, social, civic and legal specificity within Quebec or Canadian societies, of which they represent only a small populational segment. While it may be easy for progressive circles of Canadian society to admit that Indigenous Peoples who live on reserves have a specific identity and rights over the territory they use and inhabit, it is rarely accepted that such a distinction could be made in cities where a majority of inhabitants are non-Indigenous.

There is no doubt that, in this context, far from being limited to individual epidemiological or biomedical manifestations, the health of Indigenous populations necessarily gives rise to collective considerations at systemic and structural levels that can only be addressed by the

Governments of Canada and Quebec in their role as states and in a nation-to-nation relationship. The reality is that these issues call into question nothing less than the legal status, constitutional recognition, capacity toward self-determination, and legitimate role of Indigenous Peoples in society. As such, any new initiatives must ensure a real contribution from them in both decision-making and governance for all matters relating to their social and political affairs; they must ensure a true division of powers; and they must be based on a collective, democratic and comprehensive vision of health and wellness that benefits those most affected by the policies.

These were the principles and vision that guided the creation and implementation of the Minowé Clinic by the Val-d'Or Native Friendship Centre in 2011, allowing it to respond with greater insight, effect and relevance to the needs of the region's urban Indigenous population while providing services and programs that offer social and cultural significance and safety.

2. The Native Friendship Centre Movement in Canada and Quebec

Although its operations began only a short time ago, the Minowé Clinic is not an isolated initiative, nor did it develop in a vacuum. To the contrary, it is the fruit of more than 60 years of community-based solidarity, social involvement, civic innovation and personal experiences among Indigenous Peoples living in Quebec and Canadian cities.

After World War II, the Indigenous population in Canadian cities began to gradually increase (Anderson 2013, Desbiens and Lévesque 2016, Lévesque and Cloutier 2013, Lévesque 2016a, Peters and Anderson 2013). However, these new residents quickly faced a number of challenges. First and foremost, the simple fact of having left the reserve meant that these individuals no longer had access to the same health or social services, which were only available within the territorial boundaries of the reserve itself. Secondly, due to their small numbers, these individuals were often isolated and left without resources or employment. Thirdly, life in cities, or even in rural but non-Indigenous villages, differed dramatically from the lives they had previously known: their social codes and references had been calibrated for entirely different forms of socialization and interaction.

During the 1950s, Indigenous people took the initiative and began meeting to break their isolation and share their experiences in major cities like Toronto, Vancouver and Winnipeg. This was the starting point for the first groups and associations that would become the Native Friendship Centres. From the start, their mission was clear: work to improve the living conditions of their members, who were generally experiencing poverty and social marginalization, provide mutual aid in this new social reality and act collectively to spread awareness about Indigenous cultures within their cities.

Over the following decades, Indigenous populations in cities increased considerably³ and the number of friendship centres multiplied across Canada. In the mid-1970s, the National Association of Friendship Centres was created to represent the interests of urban Indigenous populations before the government, coordinate initiatives being developed across Canada and access public funding to develop aid, support and care programs. In Quebec, the first friendship centre was established in the northern city of Chibougamau (the Chibougamau Eenu Friendship Centre) in 1969, followed in 1974 by the Val-d'Or Native Friendship Centre and the Centre d'amitié autochtone de la Tuque. The provincial association of friendship centers (*Regroupement des centres d'amitié autochtones du Québec* - RCAAQ) was created in 1976, around the same time as many other provincial federations of associations. Today, there are nearly 120 friendship centres in Canada with a shared community vision, social project and objective: improving the quality of life and health of Indigenous families and individuals living in cities.

However, the government only began recognizing the work done by friendship centres and providing new investments to support them in the 1990s. The work of the Royal Commission on Aboriginal Peoples put the situation of Indigenous residents in Quebec and Canadian cities at the forefront of the political discourse, finally recognizing it as a critical aspect of contemporary Indigenous realities in Canada. This also meant that the key role played by friendship centres in anchoring Indigenous identity and supporting Indigenous populations in Canadian cities was also noted and applauded (RCAP 1996; Lévesque 2016b). At the time, it was reported that between 40 and 45% of Canada's total Indigenous population lived in cities rather than on reserves.

New directions in research on urban Indigenous populations also began to emerge in the 2000s, with new scientific publications on the subject. Until then, existing information was piecemeal and generally fell within an evolutionist narrative in which the transition from the "Indian Reserve" to the city was a clear manifestation of an entry into "civilization" and a desire to distance oneself from cultural origins. For a long time, the presence of Indigenous identities in the city was seen as an anachronism: a political, economic, administrative and cultural incompatibility. Contrary to what many observers had expected, not only was this identity not diluted by its integration into urban life, it became the foundation of a singular and novel social, civil and political force (Anderson 2013, Lévesque and Cloutier 2013, Newhouse 2008, Newhouse and Peters 2003, Peters and Anderson 2013).

Today, Canada's friendship centres have become key actors in renewing public policies that affect urban Indigenous populations. Their management and members are continually refining and redefining the means of action at their disposal, while the citizen initiatives they have put in place are now understood to be forms of social innovation. While their mission to improve

³ In 2016, about 5% of the total Canadian population identified as Indigenous, or 1,673,780 people according to that year's census. <https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?LANG=Eng&GK=CAN&GC=01&TOPIC=9>. More than half of this population resides in rural or regional cities and in large cities like Vancouver, Calgary, Regina, Saskatoon, Winnipeg, Toronto and Montreal; in 1961, this proportion was barely over 12% (Norris et al. 2003). In Quebec, the proportion of First Nations and Inuit People currently living in cities is also over 50% (Lévesque et al. 2019a).

the living conditions and health of Indigenous individuals of all ages and genders remains unchanged, friendship centres are also dynamic and innovative sites for learning and development. They are social economy enterprises strongly anchored in their urban environment, and they have become indispensable institutional stakeholders in the fight against systemic racism and sexism (Lévesque 2016a).

From the very beginning, friendship centres distinguished themselves from other organizations that provide services to Indigenous populations by virtue of the fact that their very existence is the result of grassroots organizing, rooting them firmly in their milieu and keeping their operations resolutely participatory. This stance has a direct impact on the nature, composition and scope of the services they offer. Indigenous populations are at the heart of each centre's efforts for social transformation and they form the bedrock upon which the Minowé⁴ Clinic was founded, inspired by a number of similar projects created within friendship centres over the past decade (HCC 2012).

3. Evolution and Strategic Position of the Minowé Clinic

The Minowé Clinic officially opened its doors in 2011, but the project took several years to fully develop. The following paragraphs touch on each phase of the project and the conditions for its implementation, from its initial design to its current form. A project of this nature wouldn't be possible without a convergence of favourable circumstances and the presence of a collective will to overcome the obstacles touched on in the introduction. It is therefore important to quickly address those conditions.

- **Early Context**

Between 1996—the date the Royal Commission on Aboriginal Peoples published its report—and 2011, the Canadian government adopted a number of public policy strategies, particularly as regards health, including its 2004 launch of the Aboriginal Health Transition Fund (AHTF) with the primary objective of “[...] addressing the gap in health status between Aboriginal and non-Aboriginal Canadians by improving access to existing health services⁵”. A wide array of projects were initiated across Canada, with several dozen developed by Indigenous organizations or institutions, to encourage the integration of services and increase Indigenous participation in their development and use. One program of the AHTF specifically supported promising initiatives that offered innovative responses to challenges with the accessibility, organization and availability of services (Cloutier et al. 2009). This program provided the initial framework for what would become the Minowé Clinic (GRH 2011).

During this same period, in Quebec, the First Nations Socioeconomic Forum was held for the first time in 2006. In addition to bringing together hundreds of leaders and Indigenous

⁴ The word Minowé means “being healthy” in Anicinape language.

⁵ To learn more on the AHTF: <https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/health-care-services/improving-access-health-services/aboriginal-health-transition-fund.html>. The first version of this program ended in 2011 and was replaced by the Health Services Integration Fund (HSIF), which is still in operation. The VDNFC received a grant from the HSIF in 2016.

representatives from across the province, there were also dozens of ministers and policymakers from the Canadian and Quebec governments in attendance, alongside stakeholders from Indigenous and Quebec civil society organizations⁶ (AFNQL 2006). Among the themes discussed and the resulting commitments made by government ministries, particular attention was given to health, and for good reason. In particular, the Quebec government and the *Regroupement des centres d'amitié autochtones du Québec* made a shared commitment to invite the province's Integrated Health and Social Services Centres⁷ to collaborate with friendship centres located within their administrative region to facilitate "knowledge and expertise transfer [...] [and the] identification of complementary areas in the services offered to Indigenous populations in urban contexts." (Ouellette and Cloutier 2010: 7; translated from original).

Around this time, many First Nations service users avoided visiting Quebec health network institutions in the Abitibi-Témiscamingue region due to poor treatment and the general lack of understanding they tended to experience. This became a growing cause for concern as the local and regional Indigenous population increased, nearly doubling in the city between 2006 (1.5%) and 2011 (2.6%). Demand for housing and public services also became more urgent as this population's needs diversified; the increased population included new families (with a birth rate nearly three times that of the rest of the population), single individuals, and many single-mother households.

At the same time, increasing circulation between Val-d'Or and the Cree/Eeyou and Anicinape communities also meant that the number of temporary Indigenous residents was growing, resulting in new forms of residential and professional mobility (Lévesque et al. 2014). Notably, Val-d'Or is a preferred destination for Indigenous patients from the regions of Abitibi-Témiscamingue and Eeyou Istchee (eastern James Bay). It was already an established practice for Cree/Eeyou and Anicinapek women to come to Val-d'Or to give birth, with some staying for weeks or months afterward, depending on their condition. Likewise, individuals from Cree/Eeyou communities seeking specialized healthcare would often come to Val-d'Or. As a result, issues related to the services offered to members of the urban Indigenous community in Val-d'Or (whether temporary residents, permanent residents, or those only staying a few days or weeks), had become part of the VDNFC's daily reality.

- **Implementation**

In 2008, the VDNFC received its first grant from the Aboriginal Health Transition Fund (GRH 2011). A steering committee was formed, action plans were developed, and service-sharing agreements were signed with the goal of strengthening ties with actors in the Quebec health

⁶ The First Nations Socioeconomic Forum was held from October 25 to 27, 2006 in Mashetueiatsh, Quebec. Co-chaired by the Chief of the AFNQL (Ghislain Picard) and the Quebec Premier (Jean Charest), the Forum offered an opportunity to orchestrate structural changes to improve conditions for First Nations in Quebec through agreements and commitments from relevant stakeholders (AFNQL 2006).

⁷ The provincial government's Health and Social Service Agencies work within each of Quebec's health regions. A recent reform (2015) eliminated those agencies and replaced them with new structures for health and social services called Integrated Health and Social Services Centres (French acronym CISSS) or Integrated University Health and Social Services Centres (CIUSSS).

network. In addition to VDNFC staff, the committee included representatives from the Abitibi-Témiscamingue Health and Social Services Agency and the regional Quebec Youth Centre, which oversees services for youth and adolescents in difficulty⁸. Representatives from other Indigenous and non-Indigenous organizations also played specific roles. The committee's first task was to identify areas where they could interface and complement one another, with each party proposing specific services according to its mandate, skills, staff and fields of action.

The committee met frequently in the early days of the project, as the partners were largely unaware of what services were offered by the others, especially by the Val-d'Or Native Friendship Centre. Open 24 hours a day, 7 days a week, the Centre already offered a wide variety of family and community activities to Indigenous populations in the city and its surrounding area. It also had a cafeteria and offered housing for patients visiting the city to receive care. The centre employed around a hundred people, most of them Indigenous, in a wide variety of fields.

Because the members of Quebec's health institutions generally lacked a concrete understanding of the realities lived by Indigenous peoples in the region's urban centres, this experimental phase transformed into a learning opportunity, allowing them to become familiar with the particularities and realities of the Indigenous world: its origins, values, heritage, trajectories, knowledge, practices, social codes, and living conditions. It became essential to foster a better understanding of the challenges and obstacles facing not only the local population but also the staff working with them, whether Indigenous or not.

In the fall of 2009, the VDNFC, in close collaboration with the ODENA Research Alliance⁹, organized a knowledge-sharing event around the issues and challenges facing the Clinic project (Cloutier et al. 2009). This activity, which was directly in line with the scientific monitoring aspect of the Minowé project, brought together researchers, service providers, and stakeholders, both regional and local, from the institutional landscape involved in the health of Indigenous populations. Discussions quickly turned to the importance of redefining and revising existing services to better match the lived realities of Indigenous Peoples, instead of expecting them to adapt to the existing system.

The question that guided much of the day's discussions was how best to discern existing parameters and mechanisms that the various partners engaged in this new project could collaboratively act on to develop a new service corridor through the VDNFC. And so, the foundations of what would become the Minowé Clinic were laid.

⁸ Quebec Youth Centres were integrated into the new structures created by the 2015 reform (see note 7).

⁹ The ODENA Research Alliance, a collaborative research structure within the DIALOG Network (<https://reseaudialog.ca>), has been supported by the Social Sciences and Humanities Research Council (SSHRC) since its founding in 2009. Representatives from Indigenous civil society work alongside researchers and students from multiple universities on the co-construction and mobilization of knowledge to improve quality of life for urban Indigenous populations and renew the relationship between First Peoples and the citizens of Quebec in a spirit of equality and mutual respect. ODENA seeks to support the social, economic, political and cultural development of Indigenous populations in Quebec's cities and to promote the collective actions undertaken by friendship centres.

The Role and Scope of the ODENA Alliance's Scientific Monitoring

The scientific monitoring integrated in the Minowé project constitutes a continued, reflective process of creating, organizing and following knowledge for the purpose of identifying, documenting, processing and analyzing the scientific and Indigenous information related to the project as it relates to its orientations, governance, practices, activities, impacts and outcomes (including its scientific output). The purpose of this scientific monitoring is to:

- document the progress of the project's different activities, as they are undertaken;
- collect first-hand information on the interventions made and the practices put in place;
- identify and document similar experiences found in scientific, governmental and Indigenous sources;
- determine the trends and types of individual contributions being made to the project;
- situate the project within overarching trends in the field at a national and international level;
- provide policymakers, stakeholders and service providers with synthesized information to support their decisions and actions;
- facilitate the sharing, circulation and transmission of information;
- support the learning and appropriation process deployed within the project.

In early 2011, alongside many existing agreements and partnerships being developed, a nurse and a psychosocial counselor¹⁰ from the provincial network began working out of the Friendship Centre so as to better connect with its Indigenous clientele. With the addition of an administrative coordinator and a clinical counselor from the VDNFC, the Clinic's first multidisciplinary care and intervention team was formed. This allowed it to offer new services, such as pre- and postnatal care for infants and mothers, vaccination, preventative care and accompaniment for families and individuals in difficulty. Visits to the clinic increased quickly, with more than 4,000 visits between 2011 and the end of 2013, three quarters of which were by individuals and one quarter by families. In total, hundreds of files were opened.

In its 2013-14 annual report, the regional Youth Centre noted that its reporting rate for Indigenous youth in difficulty had dropped by about 40% (CJAT 2014). There is no doubt that, at this time, more and more people were becoming aware of the Clinic and accessing its services. Within only a few short years, it had demonstrated the quality of its essential services by creating a welcoming and prejudice-free environment where Indigenous people of all ages, genders and communities could find guidance and comfort, get answers to their questions, and receive care corresponding to their needs.

The Minowé clinic is part of a trend in new spaces for citizen expression: its very existence bears witness to how the Quebec health network is struggling to meet the needs of its Indigenous clientele; the same reason Indigenous populations access the current health system so infrequently. The clinic employs a culturally relevant approach that stems from a global understanding of the economic, social and legal context of Indigenous nations and individuals. The Minowé Clinic addresses critical gaps in the existing system,

¹⁰ As an employee of the Abitibi-Témiscamingue Youth Centre, the counselor worked primarily to support and accompany parents interacting with the child protection system.

provides a link between provincial health services and federal community services, and enables partnerships with different stakeholders in society. (Cloutier quoted in Abitbol et al., 2012; translated from original).

- **The Clinic in 2018**

At the end of 2017, after seven years of operation, the Minowé Clinic offered a variety of integrated services under continual adjustment, supported by a large and expert team of professionals and service providers: 1) Services for pregnant women, children and their families (contraception, pre- and postnatal care, vaccinations for children aged 0 to 5, child development evaluation); 2) Prevention for chronic illnesses, blood tests and support for patients struggling with diabetes, cholesterol, or hypertension, preventative care, promotion of a healthy lifestyle and flu vaccine campaigns; 3) Psychosocial intervention services to support families and youth in difficulty, individuals experiencing mental health issues, or for cases of child welfare reporting and youth and adolescent placement.

The purpose of this collective model was to find a viable solution to the problems caused by disastrous health conditions in Indigenous populations. This meant not only increasing the accessibility and delivery of healthcare for urban Indigenous populations but providing “culturally adapted care with funding and an organizational structure that allow it to avoid political or jurisdictional roadblocks that slow or often impede service” (Lainé and Lainé 2011: 90; translated from original). A model of complementary services, based on a desire to redesign practices and take living conditions into account, became the priority for each partner organization.

Ultimately, the implementation and launch of the Clinic did not require any changes to the existing judicial or political context, even though the protocols, procedures and standards of the Quebec health network, through their rigidity and lack of ties to the Indigenous community, have complicated the work done by the Clinic’s personnel and regularly interfere with the actions and decisions they need to take. Moreover, while it’s clear that healthcare workers primarily turn to Western medicine as their reference point, the ways in which it is applied and the conditions under which it is practiced have changed considerably within the Clinic. Beyond medical treatments, the Clinic emphasizes preventative care, listening to patients, collective responsibility among the staff, and the importance of community (HCC 2012). From this vantage point, the Minowé Clinic is not the project of a small group of stakeholders; it is a collective wellness initiative and the incarnation of a specific goal (that of Mino Madji8in).

4. Well-being, Worldview and the Impacts of Colonialism

In Anicinape language, Mino Madji8in¹¹ describes a state of overall well-being, harmony and balance. More broadly, it encompasses the quality of life of the Indigenous population in its links with humans, living beings and the universe. Reflecting the spirit of the ancestors and in constant evolution, Mino Madji8in is a specifically Indigenous way of being, of understanding the world, and of interacting with it that respects traditional and contemporary values (RCAAQ 2012).

[...] Mino Madji8in evokes both the state of mind and the certainty that well-being consists in cultivating our desire to be in harmony with everything else, in time and space. This quest for individual and collective well-being is based on finding a balance among the different dimensions of the Circle of Life and their interactions with one another, one which is rooted in life but always in perpetual movement [...] which never allows itself to become calcified. (RCAAQ 2012: 8-9; English translation from RCAAQ 2016: 10)

The defining quality of Mino Madji8in is its marker of identity that expresses itself both at the individual and collective levels. As such, the individual is always anchored in the collective and is conceptualized as a learning, acting and reflective member of his or her community. It's an unmistakably holistic approach, in the sense that it represents a balance of different dimensions and strengths that work together at an individual, familial, communal, territorial and cosmological level. As a result, isolating a person, regardless of their age, from their universe of understanding and relationships creates a barrier to their development and ability to flourish, breaking the circle of knowledge and skills transmission that ensures their connection with Mino Madji8in (RCAAQ 2012).

The colonization to which Indigenous Peoples in Canada were subject (like many other Indigenous Peoples around the world) resulted in these kinds of disconnections, erosions and fragmentations among societies and individuals. It's not unusual to invoke colonialism when trying to understand the contemporary realities and living conditions of Indigenous Peoples. However, to overcome colonialism and, in so doing, reach the desired point of reconciliation, we must go beyond merely acknowledging it: we must carefully examine its effects and scope. We must reconstruct its processes and understand how they operated and how, in many contexts, they continue to operate today (Newhouse 2008).

Colonialism is a clear manifestation of human subjugation. It is a political system that enacts the state's will towards dominance, force and power over specific individuals and social groups. In Canada and, by extension, in Quebec, colonialism subjected Indigenous populations to the dispossession of their land, a loss of individual control over their own existence, familial dysfunction, injuries against their identity, a deterioration of their sense of belonging to a community, a hierarchization of status that privileged patrilineage over matrilineage, trauma that we now understand to be intergenerational, in the sense that it transcends generations

¹¹ The spelling of this term varies by source and dialect.

and eras, and profound transformations in their social and economic organization (Dion et al. 2016, Menzies 2010).

Indigenous Peoples' understanding of the world, nature and living beings (humans and animals) rests on a set of relational elements, meanings and social obligations that influence an individual's behaviour, choices and aspirations in relation to the people interacting within their universe and towards existence itself. As a result, an individual's internal balance is the result of both an ongoing pursuit of harmony between all of these different dimensions, on the one hand, and their sense of belonging to a community whose members share that same pursuit, on the other. When this balance is lost, or even destroyed, when the chain of relationships and meanings is broken (as was the case with the residential school system, for example), when a person is isolated from their community's way of life, they can no longer find answers to their questions and their ability to act is reduced and even critically undermined (TRCC 2015).

The survival and reproduction of groups and families has long depended on the existence of codes for social regulation and familial association that were followed by each member of the group. These codes provided the basis for interventions to address various difficulties or forms of dissent and were based on values and life principles that encouraged mutual aid, sharing and cohesion, rather than individualism and competition. These values and principles were transmitted from one generation to the next and were honoured through daily and seasonal tasks and responsibilities.

Placement in reserves, the era of residential schools, and the process of forced settlement profoundly changed Indigenous life, broke the chains of transmission and eroded practices that had maintained balance between groups and families, as well as patterns of interaction and collaboration that had structured relationships between groups within the same band and between different bands. In other words, there were rules, norms, obligations, responsibilities and practices on which the relationships between individuals depended. Yet, despite the time that has passed, despite the losses and dispossession, the founding principles or essence of these rules and practices, which governed how Indigenous individuals lived together and fostered social cohesion, still remain. As such, the critical task becomes to reconstitute, regenerate, and renew these principles.

The Minowé Clinic was built on these foundations, at once historical and contemporary. As a result, it now proposes a wide range of constantly evolving services that foster well-being and reconnection to the community for both individuals and families grappling with various difficulties, all the while responding to more immediate needs like vaccination, blood tests, treatments, accompaniment and preventative care. Over time, these services are designed to counter the pernicious effects of colonialism, one of the primary causes of poor health in Indigenous populations (Greenwood et al. 2015). The cultural safety approach adopted by the Friendship Centre is its response to this problem.

5. Cultural Safety and Social Transformation

The cultural safety approach was developed in the 1990s in New Zealand in the context of health services for Māori people. Professor Irihapeti Ramsden, a Māori nurse and educator, has written extensively on the subject and contributed to increasing international awareness and understanding of it (Baker and Giles 2012, Ramsden 2002, Wepa 2005). This approach was developed in response to concerns about the health of Māori populations and their discontent with practices judged to be culturally unsafe, that is: “Any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual” (NCNZ 2011: 7).

This approach quickly grew beyond issues of accessibility and the organization of services. It became necessary to review the very nature and types of services offered in order to respond more fully to the needs and expectations of the Māori population. Likewise, training for medical staff had to be rethought, along with the unequal power relations between Māori populations and New Zealand care and service structures, which continually failed to improve the overall state of health of the Māori people and, in some cases, even worsened it. The need to create a new model of healthcare that is rooted in cultural identity and acknowledges Māori history, information, practices and cultural means of care, socialization and education became a rallying point for Māori leaders.

In Canada, the cultural-safety approach has been applied several times in the context of healthcare over the past two decades (Blanchet-Cohen and Richardson Kinewesquao 2017, Blanchet-Cohen et al. 2018, HCC 2012). Through the years, the philosophy behind this approach has extended into many other fields, including education, with positive results overall. Its applications vary considerably due to the scope of the changes sought, the rigidity of many public administrations, a poor understanding of Indigenous cultural markers, the limited resources available to many Indigenous organizations, and existing power dynamics. Today, there are two schools of thought on cultural safety that have emerged.

The first is more instrumental and associates the approach with specific adaptive and inclusive measures that would bring minor, so-called cultural, changes to existing healthcare systems. Even if their identification demonstrates awareness or at least some sensitivity to Indigenous realities, the scope remains at an individual and circumstantial level and generally emphasizes the single relationship between a healthcare worker and the Indigenous patient receiving care, admission, or specific support. From this perspective, the only person responsible for making the desired change is the professional. Organizational support is rarely involved and the initiative’s impact on improving patient health and quality of life remains limited. The interpretive framework it uses continues to reflect the conventional biomedical model.

The second school of thought stems from a collective and institutional understanding of discriminatory situations and leads to an examination of the structural conditions that create inequalities in the field of health, and other domains, to create lasting change. This position requires a broad and comprehensive understanding of health issues affecting Indigenous populations and seeks to redefine protocols and programs that structure how services are delivered. It acknowledges the inherited effects of colonialism shared by Indigenous Peoples

and the intergenerational impacts it has on health and quality of life. It offers an explanation for the ways in which relationships developed by Indigenous Peoples with the political and cultural institutions imposed on them by the Canadian state have negatively impacted their culture, societies, and development on both an individual and collective level. It proposes a restoration, regeneration and renewal of those relationships, as well as the construction of meaningful environments that allow the skills of individuals and collectives to flourish (Lévesque 2015).

By reducing the gaps that exist between Indigenous and Canadian populations in terms of health, like in other contexts, the institutional approach to cultural safety:

- recognizes the legitimacy of Indigenous social and cultural differences, whether in terms of knowledge, practices or skills;
- considers the long-lasting effects of colonization, systemic racism, and the intergenerational trauma they produce;
- contributes to the creation of safe and welcoming environments for Indigenous populations in the contexts of health, education, employability and justice;
- encourages the implementation of services, practices and initiatives that are adapted to Indigenous modes of accompaniment, care, prevention, treatment, social transaction and a good understanding of Indigenous life-worlds;
- reflects a collective and communal willingness within Indigenous institutions to transform and engage in social innovation;
- requires an institutional commitment on the part of Canadian and Quebec institutions;
- rests on a founding principle of social justice in its goal of reducing inequality and distinguishes itself through its democratic and humanistic character; and,
- above all, identifies itself in a clear and legitimate act of political and identity affirmation and Indigenous leadership.

All in all, the equation is simple: colonization, heteropatriarchy and systemic racism have damaged the safety net, mechanisms and practices for social regulation that were (and often still are) at work within Indigenous societies. While it's important to reconstruct them, they must also be adapted to fit a modern context. The objective conditions of daily life have been dramatically transformed as a result of demographic growth, sedentarization, population growth within cities, economic diversification, globalization and the development of information technology. This is the new soil in which coordinated, institutional cultural safety initiatives can take root in an Indigenous context. The example of social perinatality, as developed at the Minowé Clinic, can help to illustrate a concrete application of these ideas¹².

¹² The Indigenous social perinatality project (named Abinodjic, which means "child" in Anicinape) was developed at the VDNFC and implemented with the help of a grant from the philanthropic organization Avenir d'Enfants, whose mission is to support young children's development in Quebec. The Abinodjic project operated in two phases: the first taking place from 2011 to 2014, and the second from 2015 to the end of 2018.

6. Indigenous Social Perinatality

- **Context**

From the very beginning of its operations, the Minowé Clinic focused on services for pregnant women and their children aged 0 to 5, due to their particularly concerning situation among the Indigenous population in terms of both health and socioeconomic conditions. These include a higher infant mortality rate; a lower vaccination rate; poor nutrition in babies, children and mothers; poor motor development in newborns; and learning difficulties at all ages. There are also a significant number of women and children affected: the birth rate among First Nations adolescents is eight times higher than Canadian adolescents, and Indigenous adolescents under fifteen have a birth rate eighteen times higher than their Canadian peers (UNICEF 2009). What's more, in the province of Quebec, the poverty rate for Indigenous children is 33%, double that of their non-Indigenous peers (16%) (Macdonald and Wilson 2013).

The Val-d'Or region is not spared from these socioeconomic realities. The incomes of Indigenous people are noticeably lower than those of non-Indigenous people, families are larger, and single-parent families are at least twice as common compared to the rest of the population. Factors like the geographical distance experienced by many women who leave their communities to give birth, the social isolation which often results from it, a lack of support throughout pregnancy, the relative youth and inexperience of many mothers, unhygienic living conditions and poverty are often the source of marginalization, disempowerment, and even emotional instability, which can prevent the mother from flourishing physically or psychologically and can limit the motor and cognitive development of her children. Often, this results in mothers of all ages being subject to interventions by child protective services, whose staff are often unaware of the living conditions, realities and parenting habits of Indigenous families. Incomprehension and failures to communicate lead far too often to the imposition of radical measures that culminate in removing children from their homes.

- **Initial Orientations**

The approach adopted by the Val-d'Or Native Friendship Centre draws on a global and systemic understanding of social perinatality which centres not only the pregnant woman and her unborn child, but also the father, siblings (should there be any), the extended family and, more broadly, the urban Indigenous community. To do so, the Centre had to work simultaneously on a number of fronts, by: 1) Creating a safe and stimulating environment to allow for optimal development of the pregnancy, the mother and the newborn; 2) Fostering active and continuous involvement by the parents and support from the extended family to maintain the child's well-being and holistic balance; 3) Contributing to the development of a healthy social environment that respects traditional and contemporary Indigenous values; 4) Redefining services and practices to reflect Indigenous consciousness, sensitivity, competence and cultural safety.

With the goal of nothing less than a real social transformation, one of the early results of the cultural safety actions put in place at the VDNFC was a re-examination of how services were

organized and delivered, based on a resurgence of Indigenous knowledge and practices. Indeed, like the large social systems present in other fields, health and social services in Canada and Quebec depend on the standardization and universalization of care and intervention protocols. From this perspective, there is very little space for the development of external or alternative protocols.

Similarly, the reference categories used by our society are also standardized. This meant that the age group initially targeted (children from 0 to 5) wasn't able to faithfully reflect the individual and community milestones that mark the development of Indigenous children. The VDNFC team therefore divided their groups in two: one for children aged 0 to 2 and another for those 3 to 5. This may seem a minor distinction from an outside perspective, but this small change allowed the team to better associate these life stages with specific family and social practices carried out by Indigenous Peoples.

According to an evaluation report completed during the first phase of the project in spring 2014, the positive impacts from these new practices, in combination with increased accessibility to available programs due to the concentration of activities and staff in the Centre, resulted in improvements to the social and physical health of young Indigenous children and the members of their immediate and extended families (Blanchet-Cohen and Trudel 2014). The evaluation also highlighted the efficacy of the ecosystemic approach applied to services at VDNFC. The Indigenous social perinatal project contributed to the creation of a new bridge for accessing care that starts with the child, branches out to their parents, and then works its way out to encompass the extended family and wider community.

Second, once confidence had been restored with mothers and families, who had been encouraged to not only participate in official activities but to also help plan them, and their thoughts and experiences had been recorded, the focus shifted to the importance of developing culturally relevant tools and mechanisms to document teachings and to support and diversify the skills and abilities of parents, families, communities and institutions.

- **Towards a New Model for Intervention**

Equipped with these conclusions, the VDNFC developed a new model for interventions in 2017. Inspired by the medicine wheel and centred on a holistic vision of child welfare, it includes four fields of action (cultural knowledge, healthy lifestyle habits, support network and enriching the experience of parenting) under which available services are organized and will, in the long-term, help reinforce families' safety nets, build pride in an Indigenous identity and foster social justice and access to equal opportunity. The redefinition of the Abinodjic model led to a number of positive outcomes, including an increase in the number of parents and children who benefited from accompaniment. The team's initial target was for 20 mothers and 20 fathers; in total, 176 mothers and 60 fathers participated over the three years of the project's second phase (Blanchet-Cohen and Geoffroy 2019).

Moreover, the ecosystemic approach of the multidisciplinary team helped reinforce relationships between service providers and allowed them to adopt a more collective approach

that centred the creation of a community and familial safety net. This contrasted with the more common approach of focusing primarily on the parental relationship, which characterized the project's early days. A number of outcomes were observed following this shift, such as a better understanding of how the needs of Indigenous families were evolving and subsequent changes to the services offered; a reinforcement of cultural-safety skills among service workers and a redefinition of the concepts and indicators underlying their interventions; and closer ties and improved collaboration between stakeholders in the public health network. These stakeholders gradually started to consider the VDNFC team to be especially well suited to respond to interventions from the Director of Youth Protection (DYP) in Indigenous families, as well as those by the de l'Or-et-des-Bois School Board and the Abitibi-Témiscamingue Integrated Health and Social Services Centre (CISSS-AT).

7. From Minowé to Mino Pimatizi8in

In early 2018, the Minowé adventure entered a new phase of maturity and development. No longer just one element among the VDNFC's other activities, it became a new interface that brings together all of the relevant synergies involved in the vast field of Indigenous well-being.

The developmental evaluation and definition of a new intervention model through the Abinodjic project provided the necessary momentum to characterize the foundations of the new Mino Pimatizi8in Health Centre. The positive outcomes for families and the reform of services with regards to Indigenous social perinatality, coupled with an increasingly close collaboration between the VDNFC and the CISSS-AT, helped validate a clear imperative to ground the development, implementation, and review of services in Indigenous systems of knowledge, social norms, and safety nets. Moreover, this process demonstrated the need for a systemic, enhanced and consolidated response to close the gaps in well-being between Indigenous and non-Indigenous populations and to develop innovative new measures.

The relational and collaborative dynamic of the Minowé model, built in 2011, has become the key reference point for this future urban centre for Indigenous well-being. This new space for "mediation and interaction" between the VDNFC and the CISSS-AT will continue working to maintain beneficial conditions for the population's health by further diversifying the services and types of accompaniment offered. Relying on efficient service coordination and shared populational responsibility, defined by an institutional approach to cultural and social safety, this collaborative laboratory (collaboratory) "will allow Indigenous individuals to position themselves as the primary stakeholders in this new collection of services" and to develop trust in the public services available to them (Cloutier et al. 2018: xiv; translated from original).

During the August 20, 2018, hearings by the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec (Viens Commission), Edith Cloutier, the executive director of the VDNFC, presented the vision behind the Mino Pimatizi8in project, saying the following:

[...] the Mino Pimatizi8in initiative, which is an innovative response to renewing available services and building confidence, I'd like to underline that

the obstacles for Indigenous people to turn to public services are linked to this lack of confidence. How did we develop this response? Well, we created an internal approach based on partnership and co-construction of knowledge and skills. A co-construction partnership between the CISSS Abitibi-Témiscamingue and the Val-d'Or Native Friendship Centre that combined our strengths and expertise to create what we called a *collaboratory*. This *collaboratory* is, in effect, a space for reflection, encounters and action that brings together stakeholders from the friendship centre and the CISSS around a shared goal of social transformation and innovation. (Cloutier, testimony to the Viens Commission, August 20, 2018, p. 90 from the transcription; translated from original).

In order to work toward the same goal, a real institutional interface needed to be created between the CISSS-AT and the VDNFC.

An important mechanism for the multilateral transmission of knowledge, skills, and expertise will be enacted within the collaboratory in order to foster the diffusion and appropriation of promising approaches and practices among [stakeholders], including cultural and social safety approaches for an Indigenous context (Cloutier *et al.* 2018, P-729: ix; translated from original).

On a concrete level, this project seeks to offer front-line services (like those offered in Quebec by medical clinics and CLSCs¹³) that are more accessible to an urban Indigenous population by first offering them at the VDNFC and, subsequently, through the creation of specialized teams composed of Indigenous professionals and experts. Services go beyond healthcare to include psychosocial support and community services. Moreover, the new project intends to centre the concept of well-being from an Indigenous perspective and according to Indigenous knowledge. Ultimately, it hopes to offer specifically tailored traditional healing services. The concrete definition of this new range of services will be inspired by promising approaches, like those defined by the Aboriginal Healing Foundation. A five-year plan, a veritable window on the future, was established to “carry out the development and implementation phases of this new collaboratory, including processes for evaluation accompaniment and its scientific grounding” (Cloutier *et al.* 2018, P-729, p. xii; translated from original).

¹³ Local community service centre, or CLSC (*Centre local de services communautaires*).

Conclusion: Challenges of a Shared Governance Structure and Redesigned Service Offer

a) Lessons

The health challenges facing Indigenous populations in Canadian cities are multiple and varied (HCC 2012), but encouraging steps have already been taken across Canada. The example of the Minowé Clinic has been especially apt in this regard as it proposes a holistic understanding of well-being in which physical health is intrinsically related to mental wellness, community health and environmental health.

With this in mind, action must be taken on all fronts and should begin by creating conditions to increase access to culturally safe and significant health and treatment services, given that culture is a powerful therapeutic tool. In fact, many researchers, healthcare practitioners and Indigenous stakeholders are gradually converging on the understanding that culture represents a powerful vector for healing and makes it easier for patients to acknowledge both the physical and psychological challenges they face (diabetes, obesity, addiction, depression, mental illness, suicide attempts). Because the association between well-being and culture is so prevalent within shared Indigenous understandings of the world, it must also be taken fully into account when developing programs for Indigenous populations to increase their likelihood of success (Castellano 2006, Chandler & Lalonde 2009, Kirmayer et al. 2014, Menzies 2010; 2013, Rowan et al. 2014, Yellow Horse Brave Heart et al. 2011).

From the start, the development of the Minowé Clinic was understood as a long-term process. Simply offering more care, or more adequate care, to Indigenous individuals was not enough; a new dialogue had to be developed so that Indigenous institutions working in healthcare (understood in the broadest possible terms) could have an active role in decisions about what services to offer, programs to develop, and practices to employ.

Longitudinal data examining health in populations (Indigenous or otherwise) must be collected over many years, even decades, to properly observe improvements. In the case of the Minowé Clinic, it is too early to know if the new services offered have changed the course of the negative trends characterizing Indigenous health in the city and surrounding region. However, it's clear that a larger proportion of the Indigenous population in Val-d'Or and its surrounding area now have access to new kinds of care: hundreds of individuals and families have access to blood tests for diabetes and respiratory illness; people struggling with health problems are able to avoid visiting emergency rooms; parents worrying about their children have an attentive ear among the personnel; and young women and mothers with their newborns can now interact with elder women who facilitate the transmission of knowledge about childcare.

b) Challenges

The history of the Minowé Clinic and the future Mino Pimatizi8in Health Centre is, above all, one of a relationship between a component of the Quebec health network and a visionary Indigenous institution; a relationship that, over time, has become respectful and cooperative. This does not mean that the challenges encountered were few, nor that they should go unnoted.

- **Active Participation in Decision-making**

The VDNFC never intended to borrow services from the provincial health network, in the form of a simple geographic relocation of staff, with no other changes to their institutional, organizational or structural aspects. On the contrary, it intended to intervene at a much earlier stage in the process than the selection of services to be offered, as its primary objective was to fully participate in the decision-making process for both strategic and operational planning. Towards that end, the joint governance structures put in place at the very beginning allowed for an ongoing process of clarifying and reaffirming the roles and responsibilities of actors involved on both sides of the partnership over time.

- **Maintaining Relationships within the Partnership**

There is no doubt that the Minowé Clinic could not have been created without the courage and engagement of the Integrated Health and Social Services Centre of Abitibi-Témiscamingue (CISSS-AT), which responded positively to the VDNFC's proposals. Even if the partnership was occasionally weakened by the departure of key stakeholders or when certain preconceptions about Indigenous Peoples persisted in discussions, it remained strong enough throughout the process to ensure continuity in the availability and diversity of services for the Indigenous population. The relationship was able to develop within an interface that encouraged communication, mediation, learning and action between the two institutions.

- **The Essential Support of Continuous Funding**

Recent changes to government funding programs for Indigenous health played a significant role in the development of the Minowé Clinic by encouraging collaborative action between components of the Canadian or Quebec health systems and Indigenous institutions. Partnerships like this depend on resources to both develop and persist over time—especially financial resources, which legitimate the initiatives proposed by Indigenous institutions. By positioning itself on the local and national scene when securing public funds, the VDNFC demonstrated its community and civic leadership, its capacity to develop a new service model for Indigenous populations, its active role in mobilizing partner institutions from different sectors and its dedication to the well-being of Indigenous populations.

- **Knowledge Mobilization**

As part of its participatory philosophy, the VDNFC sought to include a truly transformative and knowledge mobilization approach at every level of decision-making for the actions it takes and the care it provides, while always centering the individual and collective needs of Indigenous populations. The mere fact of distributing information, no matter how relevant it may be, is not enough to create change in intervention practices, whether for Indigenous individuals or not. Information must first be organized, clarified, transmitted and understood—in the sense that stakeholders must be able to put it into perspective, appropriate it, and evaluate the ways in which it can most effectively be put into application as a part of their own interventions. With this in mind and in close collaboration with the researchers, a number of training sessions were held from the earliest days of the project, part of a continuous learning approach, to track progress and discuss any difficulties encountered.

- **Complementarity of Skills**

These lessons led participants to reflect collectively on the skills needed within the Clinic to ensure a harmonious operation that could draw upon and respect shared expertise and Indigenous teachings. While the situation is less complicated (although still not free of challenges) when a collaboration between Indigenous institutions and the healthcare system requires the presence of professionals with academic credentials, it is still all too common to have the expertise, experience, and knowledge of Indigenous participants disregarded if they aren't credentialed. For example, adjustments became (and remain) necessary to allow Indigenous cultural helpers (elders and guides) to integrate into teams and pursue their role of accompaniment under the best possible conditions.

- **The Role of Co-production of Knowledge and Evaluation**

The Friendship Centre also insisted from the beginning on the importance of scientific monitoring taking into consideration Indigenous narratives, and an evolving, real-time evaluation of the Clinic's actions to ensure that their convergence upheld the holistic vision characterizing its mission. These efforts, carried out by researchers at the ODENA Research Alliance and the DIALOG network, led to the creation of new bodies of knowledge and practices which, in turn, constituted the pedagogical basis needed for new training, to the benefit of both Indigenous and non-Indigenous staff involved in the project. The research, realized in a co-production perspective evolved alongside the Clinic project in symbiosis with the actions of the VDNFC. While this choice of methodology may have been challenging for the researchers, it also offered them a unique occasion to correlate scientific inquiry and social challenges.

- **Implementation of Cultural Safety**

The Minowé project's participation in an institutional approach to cultural safety endowed both Indigenous and non-Indigenous stakeholders with new conceptual and methodological tools, allowing them to share the same frame of reference and action. Not only was a new physical environment made available within the VDNFC, a new intellectual environment was built around the need to redefine the concept of health itself and come to a broader understanding of well-being. In practice, a cultural safety approach proposes a paradigm shift that places the Indigenous exception back at the very heart of a nation-to-nation relationship between the state and Indigenous Peoples.

- **Identity and Community Recognition**

The elements underlying efforts by urban Indigenous communities in Quebec to reclaim their identity are foundational of a project like the Minowé clinic: efforts to take control of their destiny as a society, effective participation in the decisions that affect them, a recognition of injustice and inequalities, the will to fight discrimination, a focus on civic engagement, and a concern for equity and respect between peoples. This social project came into its own with the objective of offering Indigenous children, youth, women and men the means to acquire greater mastery over their own lives and health, and the tools to collectively become actors for change and ambassadors for hope. It was no longer a question of merely improving access to healthcare

or broadening the nature and scope of what was being provided; it became a question of fostering the fullest expression of each Indigenous man and woman's skills to become artisans of their own lives and unapologetically Indigenous citizens.

- **Contributions to Reconciliation and Decolonization**

The Minowé Clinic is more than a positive example of increasing access to healthcare and social services for urban Indigenous populations. It is a meaningful manifestation of the much-sought-after reconciliation between Canadian society and Indigenous Peoples. The Clinic provides a novel and expanded response to the calls to action formulated by the Truth and Reconciliation Commission of Canada (TRCC 2015). It seeks to address the unequal power dynamics that mar relations between the state (both Canada and Quebec) and Indigenous Peoples and is committed to a path towards decolonization. Its leaders were able to put forward a renewed vision of civic democracy based on openness, justice, respect, cooperation and recognition in the face of a system that still too often seeks to integrate Indigenous identities into the dominant society (otherwise referred to as inclusion or adaptation) without regard for their social and cultural differences.



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