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Indigenous Initiative for the Start-Up of Health Services in Urban Areas: The Holistic Health Strategy Project

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Abstract

The report of the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec (2019) reported problems in accessing health and social services, specifically in urban areas. In order to better serve their members, the Centre d'amitié autochtone de Trois-Rivières (CAATR) launched the Holistic Health Strategy Project. The objectives were: (1) to assess the needs of CAATR members and of the partners in health and social services, and (2) to create a directory of resources intended for the Indigenous people in the region. An assessment of health and services needs was completed through consultation with members of the community. A literature review was carried out to draw a portrait of the health and social care services and models intended for Indigenous people. A total of 25 participants took part in the consultation. Better access to services (e.g., transport and daycare) and a need for liaison with non-native institutions (e.g., interpreters in hospitals and liaison officers with schools) are expressed. A directory of resources intended for Indigenous people has been created, bringing together more than 20 services and organizations. The results of the Holistic Health Strategy Project highlight the health needs and health particularities of Indigenous people living in urban areas. Measures adapted to the realities of Indigenous people in urban areas must support and facilitate their access to services.

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Glossary

Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec (CERP)

Centre d'amitié autochtone [Native Friendship Centre] de Trois-Rivières (CAATR)

Regroupement des centres d'amitié autochtones du Québec (RCAAQ)

Introduction

Following events revealing discriminatory practices against Indigenous people[1], the government of the province of Quebec, in Canada, ordered the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec (CERP) in 2016, commonly known as the Viens Commission (CERP, 2019). Among the findings presented in the commission's report, problems of access to health and social services are reported, specifically in urban areas (CERP, 2019). On the one hand, services do not meet the needs of Indigenous people; and, on the other hand, failures in communication and patient follow-up are denounced (CERP, 2019). The current health and social services system is strongly imbued with a biomedical approach (CERP, 2019) where the vision of care is essentially centred on the disease itself and not on the individual in their full biopsychosocial dimension, as favoured by Indigenous people. The effects of this gap, combined with a variety of insecure personal and familial situations experienced by Indigenous people, may explain the underuse of public services (CERP, 2019).

In fact, the services do not optimally meet the needs of the community living in urban areas, as nearly one in five Indigenous people say they have not been provided with satisfactory responses to their needs in the Québec network (Regroupement des centres d'amitié autochtones du Québec, 2018). Experiences of racism and discrimination are also reported by a majority of Indigenous people (RCAAQ, 2018). Moreover, the circumstances of the recent death of Joyce Echaquan, a woman from the Atikamekw Nation, testify to the systematic racism present in the Québec health care system (Tremblay, 2020). These findings therefore demonstrate the relevance of focusing on this issue.

[1]The term "Indigenous people" includes First Nations, Inuit, and Métis. However, it should be noted that the government of Québec does not recognize the existence of a Métis nation on its territory (Huot, 2015).

The Centre d'amitié autochtone de Trois-Rivières (CAATR) serves an Indigenous clientele of just over 2,000 individuals (Statistics Canada, 2017a, 2017b). There is a lack of exhaustive data on the demographic and socioeconomic aspects of Indigenous people living in urban areas in Québec (Lévesque et al., 2019). Furthermore, according to a survey carried out in Trois-Rivières with 142 Indigenous people, it seems that the majority of First Nations people are from the Atikamekw Nation (RCAAQ, 2018). Their average age is 33 years, 45% have no diploma, the annual household income of more than half is less than $20,000, and most have children (RCAAQ, 2018).

Aim and Objectives

In light of the previous findings and regional realities, the CAATR wanted to intervene to ensure community well-being and to develop an intervention strategy rooted in the democratization of health care and social services. The Holistic Health Strategy Project was therefore initiated in the fall of 2018. The term "holistic" refers to the whole person, including ophysical, psychic, emotional, and spiritual aspects (Dunn, 2019). In this regard, the Holistic Health Strategy Project has two missions. First, to assess the needs of Indigenous members in urban areas and CAATR partners, in terms of health and social services; and second, to create a directory of resources for Indigenous people and CAATR partners.

Background

Definition of Health

According to a review of nine studies published between 2008 and 2018 on the perception of Indigenous health, the concept of the medicine wheel remains ubiquitous, as does the connection with land (Tremblay Leclerc, 2019). The notion of balance between the different spheres of life is also a central concept (Muise, 2019). However, some Indigenous communities do not at all use the concept of the medicine wheel, which expresses health as a balance between physical, mental, emotional, and spiritual aspects (Douglas, 2013). For example, according to a study carried out with First Nations people living in urban areas in the region, health is defined as the autonomy to live without pain, the balance between physical and psychological aspects, as well as a healthy diet and engaging in physical activities (Leclerc et al., 2020).

Health Status

For decades, health inequalities have persisted between Indigenous people and non-Indigenous people in Canada (Smylie Firestone, 2016). For example, the risk of dying from preventable causes is higher among First Nations people than among non-Indigenous people (Park et al., 2015), and life expectancy remains shorter for Indigenous compared to the entire population (Tjepkema et al., 2019). These health inequalities can be linked to socioeconomic determinants, the impact of colonization, racism, and difficulties in accessing resources (Smylie Firestone, 2016). Some social determinants have a negative impact on health, such as smoking, obesity, living in severely dilapidated housing, not having completed high school, and having experienced food insecurity, among others (Rotenberg, 2016). Fortunately, several protective factors are recognized as levers within Indigenous communities, such as family ties, the contribution of Elders, community health programs and services, cultural knowledge, ties to the land, and community resilience (First Nations of Quebec and Labrador Health and social services commission, 2018a).

In order to illustrate Indigenous characteristics and health inequalities, some statistics concerning perinatal care, cardiovascular disease, and diabetes are presented below.

Perinatal Care

The prevalence of early pregnancies is more common among young Indigenous women (Boulet Badets, 2017). Indeed, several risk factors explain this phenomenon, such as the precocity of sexual relations, lower contraceptive use, consumption of drugs and alcohol, and being victims of sexual assault (Joncas Roy, 2015). As well, the social determinants of Indigenous health also have repercussions for the course of pregnancies among Indigenous women in Canada. They are at a higher risk of premature births, fetal macrosomia, and stillbirth, as well as neonatal and perinatal mortality after childbirth (Shah et al., 2011; Sheppard et al., 2017). The remoteness of Indigenous communities limits access to specialized care, especially when Indigenous women have high-risk pregnancies (Kolahdooz et al., 2016). The travel costs required to access care and services, combined with low income and poor weather conditions, are examples of barriers that reduce the quality of follow-up care, delayed diagnoses, and health care management (National Collaborating Centre for Indigenous Health, 2019). In addition, Indigenous mothers report several barriers hindering the use of health services for their children, such as the fear of racism and being discriminated against, fear of losing custody of their children, and language barriers, among other factors (Wright et al., 2018).

Cardiovascular Disease

Overall, in Canada, the prevalence of obesity among First Nations people living outside of communities, and among the Inuit, is 1.6 times that of non-Indigenous people (Public Health Agency of Canada, 2018). Furthermore, First Nations people living outside of communities have a higher death rate from cardiovascular disease than non-Indigenous people (Tjepkema et al., 2012). Low income and level of education are the two factors that explain the majority of mortality disparities between both groups (Tjepkema et al., 2012). In addition, the rate of cardiovascular disease appears to be increasing among Indigenous women, especially among younger women (Prince et al., 2018). It is important to remember that colonization has also had a direct impact on cardiovascular disease by limiting access to healthy foods, creating barriers to a physically active lifestyle, and promoting social exclusion, among other factors of oppression (Diffey et al., 2019).

Diabetes

The incidence of diabetes is both appearing earlier and increasing faster in First Nations compared to the rest of the Canadian population. Moreover, the prevalence of this disease among First Nations people living outside of communities is 1.9 times higher than among non-Indigenous people (Public Health Agency of Canada, 2018). Additionally, the prevalence of diabetes among children and adolescents is increasing rapidly, and women are more affected (Halseth, 2019). According to the Indigenous perspective, diabetes is connected to colonization, a loss of traditional lifestyles and spirituality, displacement, and loss of community wellness (Halseth, 2019).

These worrying statistics only offer a tiny glimpse of the reality of the Indigenous health context, and therefore justify the relevance of the Holistic Health Strategy Project.

Access to Services

A survey carried out by the RCAAQ among 1,723 people who used services at the Native Friendship Centres (Centres d'amitié autochtone) highlights the fact that 15% of respondents were not familiar

with the Quebec network of health and social services (RCAAQ, 2018). According to the same survey, 12% listed cultural barriers (including language barriers), inadequate adherence to Indigenous values, and the fear of racism as additional factors preventing access to health and social services (RCAAQ, 2018). Specifically, in the city of Trois-Rivières, just over 50% of Indigenous respondents believed they had been victims of racism and discrimination within the Quebec service network (RCAAQ, 2018). This finding is worrying, since frequent exposure to discrimination is associated with almost twice the risk of suffering from a chronic disease, such as diabetes, cancer, or cardiovascular disease (Siddiqi et al., 2017). In fact, chronic stress stimulates coping behaviours, such as poor eating habits and smoking, that are often precursors of chronic diseases (Siddiqi et al., 2017).

Models of Care for Indigenous People in Urban Settings

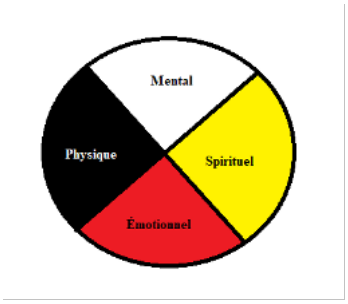
In 2020, the survey of health services for Indigenous people in urban areas revealed six points of service across Quebec. Surprisingly, no Indigenous-specific health service is provided in the city of Trois-Rivières or within a radius of about 150 km. Several front-line health care and social services are offered by several types of workers, whether medical professionals or members of the community. For example, the Mino Pimatisi8in clinic in Val-d'Or provides routine health services (e.g., blood samples, immunization, health monitoring), perinatal services (e.g., prenatal education, pregnancy monitoring), health promotion, disease prevention, chronic disease management, and more (Cloutier et al., 2018). In addition, there are general psychosocial services (e.g., screening, consultation, crisis management, and postvention), preservation of cultural identity of Indigenous children, mental health services, addiction services, and services for clients with intellectual disabilities, autism spectrum disorders, and physical disabilities (Cloutier et al., 2018).

From a holistic health perspective, there are other examples of Indigenous partnership services across Canada: follow-up by a midwife, support by a doula during the perinatal period, the use of medicinal plants, access to an Elder, activities on the territory (e.g., hunting, fishing, community gardens), community walking, holding of sharing circles, ceremonies (e.g., sunrise ceremony, fasting, fumigation, and sweat lodge) and language teaching (Allen et al., 2020; Cloutier et al., 2018; First Nations of Quebec and Labrador Health and Social Services Commission, 2018b; First Nations Health Authority, n.d.).

Method

The framework for the Holistic Health Strategy Project is based on the medicine wheel, which represents the holistic vision of health for Indigenous people. The medicine wheel (Figure 1) illustrates the notion of balance with the four elements of life: the physical, the mental, the emotional, and the spiritual (Muise, 2019). This is also the reference framework used by the CAATR (2020) to represent its values of respect, teamwork, loyalty, and mutual aid. For the project, the framework has proven to be useful for the creation of the data collection tools.

Figure 1
The medicine wheel



Needs Assessment Component (Objective 1)

The first objective of the Holistic Health Strategy project was to assess the needs of CAATR members regarding health and social services. The methodology planned for the data collection was to conduct semi-structured group interviews in the form of a sharing circle. For reasons of feasibility, there was only one large consultation group.

Based on the results of the literature review, and with the participation of the working committee, an interview outline was designed. The questions were mainly intended to explore possible improvements to meet health and educational needs, as well as to specify the services and care desired. To obtain a portrait of the participants consulted, a sociodemographic questionnaire was created. It included questions about age, sex, marital status, level of education, family income, occupation, number of children, nation, number of years of residence in the city of Trois-Rivières, and affiliation to a family doctor.

For data collection, an opening ceremony was conducted by an Elder. Then, the event was facilitated by three CAATR personnel and a member of the working committee of the Holistic Health Strategy Project. Service needs were divided into three categories: the culture, education, and health. In order to properly capture the participants' interventions, three audio recordings were collected, and three people were assigned to take notes during the session. A daycare service was provided to support and encourage the presence of parents. In addition, dinner and attendance prizes were offered as tokens of appreciation. The objective was to create a culturally safe environment.

Indigenous Resources Directory Creation Component (Objective 2)

The second objective of the project was to create a directory of resources for Indigenous people. The goal was to provide it to CAATR members, health care professionals, and stakeholders working with the Trois-Rivières community. The creation of the directory was carried out in several stages of validation and content research in collaboration with the Holistic Health Strategy committee, and various partners in the region were solicited. In addition to refining the searches for the resource directory, these meetings revealed the great openness of non-Indigenous community organizations toward the integration of services intended for Indigenous people. While some do not count Indigenous people among their clientele, others mentioned their lack of knowledge about how to provide culturally appropriate services.

Relationship

Considering the nature of the project, an ethics certificate was not required. Nevertheless, confidentiality measures were ensured. The team members who collaborated on the collection and analysis

all signed a confidentiality agreement. The mere fact of attending the consultation itself signified tacit consent on the part of the participants, so no consent form was used; however, this was discussed with participants. Finally, to preserve anonymity, no participants' names were revealed when the results were released.

Results

Needs Assessment Component (Objective 1)

A total of 25 participants took part in assessing the health and service needs of CAATR members during the group consultation. Among these participants, just over half were women (52%), and the majority of participants were from the Atikamekw Nation. The average age of participants was 36 years, and nearly 65% had resided in the city of Trois-Rivières for five years or less. Regarding the marital status of the participants, more than half were either living common law or married, and more than half of the members had children. One in two participants also mentioned having access to a family doctor. On the financial level, over 70% of the participants reported an annual household income of less than $20,000. In addition, for most participants, the highest level of education achieved was a high school or vocational diploma.

The consultation revealed that members' views were unanimous regarding the quality of support and accessibility of CAATR. In terms of cultural services, members wanted better transport, more flexible hours, and a daycare centre. In the category of education, members wanted guidance and a liaison with local public the school. Lastly, in the category of health services, members proposed access to a variety of support roles, such as a midwife and interpreter.

Indigenous Resource Directory Component (Objective 2)

The directory of resources intended for Indigenous people includes health and social services (in urban areas and in communities), Native friendship centres, social services and daycare, education and accommodation, and cultural services, as well as national programs specific to Indigenous clients. More than 500 copies of the Indigenous Resource Directory were printed and distributed personally by CAATR employees to partners in the region.

Limitations

One of the limitations of the project is the time required to mobilize the participants. For instance, the high turnover of CAATR staff necessitated continuous mobilization. This was also, however, a strength of the project, since the CAATR directors, employees, members, Indigenous collaborators, and the research team have all worked toward a common goal. It is possible that certain information and documents from the gray literature were overlooked during the research phase of the Indigenous resource directory. During the months of its development, several updates were required to ensure it was as complete as possible. An annual update will be desirable to maintain the resource directory's accuracy.

Discussion

The results of the consultation carried out with CAATR members confirm the importance of the organization's support role in urban settings. Moreover, since the consultation, several changes have already been made to the CAATR in order to better meet the needs of members, whether in terms of governance or the new living environment. As participants mentioned, access to services is an important issue. For instance, according to a review of the literature, central elements of Indigenous primary health care models include affordable and accessible services, including transportation, extended hours of operation, and flexible appointment times (Harfield et al., 2018).

Participants express the need for support by emphasizing accessibility to services. Whereas educational services are handled by a liaison worker, it is interesting to look into health services, since the CAATR does not yet ensure follow-up in this aspect. In fact, several types of workers can work in an Indigenous care and social services clinic. For example, community health workers who are members of the community (without professional qualifications required) can act as a bridge between the community and the health and social services system (Boisvert Bush, 2019). Finally, the presence of a nurse makes it possible to assess the physical and mental condition of a symptomatic person, to provide education and disease prevention, and to carry out screenings and even vaccinations (Ordre des infirmières et infirmiers du Québec, 2016).

The contribution of Elders to the individual and collective well-being is also important, as they contribute to the transmission of Indigenous knowledge (Tu et al., 2019; Viscogliosi et al., 2020). They can play an especially unique role in education, health promotion, and cultural transmission by providing education on medicinal plants and disease prevention (Viscogliosi et al., 2020). CAATR already recognizes these contributions and facilitates their presence. To promote better access to an Elder, an Elder in a permanent position is desirable.

The calls to action of Viens Commission report encouraged collaborative action with local partners to set up health and social services modelled on the Minowé clinic in Val-d'Or. Trois-Rivières has no health service for Indigenous people. The deployment of health and social services can be carried out in several ways, such as providing mobile and local services (e.g., at home, at school), or by integrating services into existing support institutions (Boisvert Bush, 2019). The experience of virtual follow-ups during the COVID-19 pandemic will likely make virtual services more accepted. Virtual services can be online educational resources, virtual consultations (e.g., telehealth, telephone support, or counselling by text messaging) or computerized follow-up programs (Virtual Care Task Force, 2020; Khan et al., 2017; Reilly et al., 2020). In general, young people respond well to this type of intervention (Reilly et al., 2020). However, although virtual care has the potential to improve accessibility to services, it can also exacerbate inequalities, since not everyone has access to the same technological tools (Virtual Care Task Force, 2020).

Conclusion

At the end of this first stage of the Holistic Health Strategy Project, which first and foremost aimed to assess the needs of members, several observations emerged. This project enabled us to better understand the portrait of the clients served by the CAATR. From the outset, the very definition of health from an Indigenous perspective differs from the provision of care and services in urban settings. Likewise, it also revealed glaring difficulties in access to care for Indigenous clients. These findings have convinced us of the urgency to act. Subsequently, the exploration of the different models of care and services intended for Indigenous people has brought about the dream to realize a project for the CAATR. Thus, the CAATR offers invaluable support for its members, and the Holistic Health Strategy Project is only the premise for all other achievable projects in health and social services.

Concretely, the Holistic Health Strategy Project provides written resources about its process for assessing the needs of its members in terms of health and social services. These traces can inspire and guide future initiatives on Indigenous health in urban areas. Indeed, the resource directory will be a very useful tool for CAATR clients and their partners. Considering the region's enthusiasm for Indigenous initiatives, a second version will certainly be planned soon in order to integrate new resources and partners.

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