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

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ABSTRACT

Research around the world has been nearly unanimous about the positive impacts of Indigenous-led health organizations on Indigenous peoples' qualitative experiences in health care, in the face of often negative experiences in non-Indigenous-led health care settings. Urban environments, including health care environments, are areas of increasing attention with regard to Indigenous peoples' health in Canada. In this study, which took place in the northern city of Prince George, British Columbia, 65 Indigenous community members and health services workers participated in interviews and focus groups, describing their experiences with urban Indigenous-led health organizations— defined in this study as non-governmental organizations that prioritize the values and practices of local Indigenous communities. Employing perspectives on place and relationships drawn from Indigenous critical theory and Indigenous community resurgence to analyze the findings of this qualitative study leads to a focus on how relationships impact and can even constitute places, enabling new understandings of the roles of Indigenous-led health organizations in urban Indigenous community resurgence.

Keywords: Indigenous health, health services, urban, Prince George, Indigenous resurgence

Introduction

A growing body of literature shows that Indigenous peoples' experiences with health care services in urban areas are improved when Indigenous-led, Indigenous-focused health organizations are involved (Kurtz et al. 2008; Browne et al. 2016; Davy, Harfield, et al. 2016). A major reason for this is the high level of control local communities have over Indigenous-led health organizations. These organizations frequently offer a range of services drawn from Western medicine and local Indigenous traditional healing practices, among other practices, offering both a sense of control and of choice to Indigenous community members (Neuwelt 2012; Reeves and Stewart 2014; Hadjipavlou et al. 2018). We were interested in learning about community members' health care experiences in Indigenous-led health organizations, and in finding out what participants perceive to be the difference between how services are offered in Indigenous-led health organizations compared with other health care organizations. In this paper, we examine the work of Indigenous-led health organizations in the Canadian city of Prince George, British Columbia (BC), in order to better understand the ways in which people see Indigenous- led services as being unique.

Urban environments, including health care environments, are areas of increasing attention with regard to Indigenous peoples' health in Canada. Over half of the Indigenous population in Canada were counted in the 2016 Census as living in cities, compared to less than 7% in the early 1950s—although this number does not include those most marginalized, including people experiencing homelessness (Kalbach 1987; The Home-lessness Services Association of BC 2018; Anderson 2019). According to some studies, the number of Indigenous people living in Canadian cities may be dramatically underestimated by Census counts (Rotondi et al. 2017). Urbanization is increasing among Inuit, Métis, and First Nations peoples, but is different across these groups. For example, roughly 63% of Métis people reported living in a metropolitan centre of at least 30,000 people in 2016, whereas only 15% of Inuit reported the same (Statistics Canada 2017a). Canadian cities are more and more being acknowledged as sites of cultural revitalization and powerful movements for Indigenous rights (Smith et al. 2016; Nejad et al. 2019). Research in Canada is increasingly recognizing that Indigenous traditional territories include urban areas, contesting the urban- rural dichotomy that

previously portrayed cities as non-Indigenous land (Peters 2006; Nejad et al. 2019).

In Canada, the federal government assumes responsibility for providing a limited suite of health care services and benefits to "status" First Nations people (as defined under the Canadian government's *Indian Act*), and to some Inuit groups. This leaves out many Inuit, Métis, and "non-status" First Nations people, who therefore depend on provincial and territorial health care services (Lavoie et al. 2010; Health Canada 2013). Provincial or territorial health services are those available to all people living in Canada (with some exceptions), and therefore are often not positioned or designed to meet specific needs that First Nations, Inuit, or Métis individuals or communities may have (Lavoie et al. 2008). Such health services often struggle to provide services in a culturally safe manner for Indigenous individuals and communities as well as other marginalized or culturally distinct communities (Browne et al. 2009; McEldowney and Connor 2011; Hole et al. 2015). In addition, the provinces and the federal government have at times disagreed on the question of who should have responsibility for Indigenous peoples' health care, resulting in Indigenous community members being caught in the middle of jurisdictional disputes, negatively impacting the care that people receive (Lavallee 2005; First Nations Child and Family Caring Society 2017).

Cultural safety, a concept first articulated in Aotearoa in the 1980s and 1990s, is a framework based on understanding how power imbalances resulting from structures such as colonialism affect health care interactions. It promotes education and relationship-building as ways of redressing the negative impacts of these power imbalances on Indigenous or culturally marginalized community members in health care (Papps and Ramsden 1996; Brascoupé and Waters 2009; Browne et al. 2009). Under the framework of cultural safety, the responsibility for change rests primarily with the health care provider or institution, but the ability to determine whether an interaction is culturally safe rests with the person receiving care (Browne et al. 2009). In Canada, there are now online cultural safety training courses available to health care practitioners, and cultural safety curricula form a part of medical or nursing training in many universities, although the efficacy of generalized courses that purport to cover all Indigenous com- munities in Canada is debated (Aboriginal Nurses Association of

Canada et al. 2009; Indigenous Physicians Association of Canada and The Association of Faculties of Medicine of Canada 2009). Related terms such as "cultural humility," which refers to the ability to avoid judgment or hierarchy when comparing one's own culture with others, have also been incorporated into health care agreements led by the First Nations Health Authority in British Columbia (First Nations Health Authority, n.d.).

Indigenous-led health organizations are not-for- profit health service organizations that provide services according to Indigenous community values and needs, often receiving funding from government or health authorities while operating at arm's length from them (Lavoie 2004; Health Canada 2012). For the purposes of this paper, Indigenous-led health organizations are those whose services are explicitly based in Indigenous community values and practices, and whose mandate is primarily to serve Indigenous community members. An early example is Anishnawbe Health Toronto (AHT), an Indigenous-led health organization that developed in response to a research project on diabetes. The research project found that Indigenous communities in Toronto were in need of more "comprehensive care" in order to manage diabetes and other health problems, leading to the creation of AHT—a community-based organization focused on providing a broad spectrum of health care and social services for Indigenous peoples in Toronto (Anishnawbe Health Toronto 2011). In 1989, AHT became the first Aboriginal health centre funded by the Ontario Ministry of Health and Long-Term Care (Skye 2006; Anisnawbe Health Toronto 2011). Building on the success of AHT, there are now ten Aboriginal Health Access Centres across Ontario in urban, rural, and reserve locations that offer services in a similar manner to AHT, providing primary health care in a setting centred on local Indigenous community practices and values (Alliance for Healthier Communities, n.d.).

Research in Canada and beyond has found that Indigenous-led health organizations are generally highly successful in providing what community members consider to be culturally safe care (Davy, Cass, et al. 2016; Gomersall et al. 2017; Hadjipavlou et al. 2018). This paper is focused on how Indigenous-led health organizations in one Canadian city are perceived by Indigenous community members and health services workers. We draw on an analysis of qualitative research under-taken with 65 Indigenous community members and health services workers who

worked with Indigenous community members in the urban community of Prince George, in 2015. Through the lenses of Indigenous critical theory and Indigenous community resurgence, we seek in this paper to understand how Indigenous community members and health services workers perceive Indigenous- led health organizations as operating within, and having an impact on, urban health care spaces.

Indigenous critical theorists place Indigenous knowledge at the centre of academic work, resisting its displacement within colonial structures of knowledge (Tuck 2009; Byrd 2011). Of particular interest to geographers, Indigenous critical theory engages with the importance, and the agency, of place. For the purposes of this study, the distinction between "space" and "place" is associated with degrees of meaning. "Urban space," for example, is used to refer to any physical area that is experienced as part of the city. Place is understood, following Indigenous geographers, in a relational and deeply historical way; land and place play a central role in the health and well-being of Indigenous individuals and com- munities (Larsen and Johnson 2012; Johnson and Larsen 2013). As Wilson (2008, 7) writes, "relation- ships do not merely shape reality, they *are* reality." In this worldview, relationships can be conceptualized as intimately connected with, even constitutive of, places themselves (Wilson 2008).

Indigenous critical theorists also describe a process called Indigenous community resurgence, as a way of theorizing processes of Indigenous community revitalization that find their expression in the everyday lives of Indigenous individuals, communities, and political movements (Coulthard 2014; Simpson 2017; Corntassel et al. 2018). While dis- courses of recognition and reconciliation mark a positive turn in state-led discourse on Indigenous peoples' autonomy, in practice recognition and reconciliation tend to produce a circumscribed set of rights defined by the state without being accompanied by broader moves towards self-government, self-determination, or sovereignty (Simpson 2011; Simpson 2014; Daigle 2016). The concept of Indigenous community resurgence, being inherently engaged with issues of community well-being, pro- vides a useful means by which to engage with and understand Indigenous-focused health care services.

Methods

This research is grounded in the principles of decolonizing research, or "those methodologies that actively work to deconstruct colonizing practices while endeavoring to advance Indigenous self- determination" (Stanton 2014, 573). Decolonizing research also involves working with Indigenous com- munities in a balanced and respectful manner, with the goal of benefiting the communities involved (Smith 1999; Mertens et al. 2013). The current study was conducted by a non-Indigenous researcher (first author) as part of her PhD, and supervised by the second author, also a non-Indigenous researcher, at the University of Toronto. The study was guided by a community advisory group of Indigenous and non- Indigenous health care workers, administrators, com- munity leaders, and researchers based in Prince George. Each of this paper's authors has come to work with Indigenous communities through a slightly different path, and in keeping with decolonizing research following Indigenous community protocols (Smith 1999; Kovach 2009; Tobias et al. 2014), we would like to take a moment to reflect on our relationships to this research.

Sarah moved to Prince George in 2009 to pursue a Master's degree in First Nations Studies at the University of Northern British Columbia. Coming from a background in African Studies had made her want to learn more about colonialism in Canada, and having a background in the life sciences had sparked an interest in health and health care. Her Master's thesis was undertaken in partnership with an Indigenous-led health organization in Prince George, investigating the concept of "mental health" among Indigenous community members and health care providers working in the city. When Sarah decided to start her PhD at the University of Toronto in 2012, she continued to do research with people and organizations in Prince George, in order to both maintain the relationships she had built while living there, and to investigate the work of Indigenous-led health organizations in this city on a broader scale.

Kathi is a non-Indigenous scholar who has been conducting research on the geographies of Indigenous health for over 15 years. Her early work, as part of her doctoral dissertation, focused on land- based activities as a key determinant of health among Indigenous peoples living in a First Nations community in Northern Ontario.

During her time in the community, she listened to community members discuss numerous concerns about access to appropriate health services on the reserve and in urban-based locations. Conversations about health care access in urban settings focused on issues related to continuity of care with movement back and forth between reserve locations and cities, culturally appropriate care, and frustration sur- rounding rights to health care services. This inspired Kathi to switch her research focus to the challenges and opportunities of health care de- livery for urban Indigenous peoples in the context of colonial policies that favour reserve-based health services allocation models. In doing so, she became committed to decolonizing methodologies and conducting research focused on intersections of health, health care, policy, and rights for urban- based Indigenous peoples.

Doing research in allyship with Indigenous com- munities, especially when basing this research on Indigenous paradigms such as those articulated within Indigenous critical theory, brings up questions about relationships and positionality (Tobias et al. 2014). As non-Indigenous researchers it is imperative to respond to calls by Indigenous communities and Indigenous scholars to stop extracting information for our own benefit and to think carefully about why a given research project is considered necessary or useful, and by whom (Haig-Brown 2008; Kovach 2009; Simpson 2017). One paradigm that is often put forward in research with Indigenous communities is the spectrum of insider versus outsider relationships to the research (Brayboy and Deyhle 2000). Being outsider re- searchers i the sense of both identity and geography creates challenges in our research design, analyses, and outcomes. For example, trust can be an issue, stemming from power imbalances in how we value knowledge in a settler colonial society. In many cases, participants and advisory group members suggested having group interviews or focus groups instead of individual interviews. Sharing information with an unfamiliar interviewer in a group setting where participants often knew each other well seemed to make people more at ease, and shifted the balance of power towards participants. Developing relationships by spending time doing crafts together or attending community events also helped to increase familiarity and trust (Castleden et al. 2012; Tobias et al. 2014). It is important to care, and to show that we care, about the people and the community, and to act on this in practical ways; we

continue to read, reflect, and listen to Indigenous communities and scholars on this topic in order to do research in the best way we can.

Prince George has a population of 85,135 people, of which 14.6% reported Indigenous identity in 2016 (Statistics Canada 2017b). This is a high percentage compared with many Canadian cities, making Prince George a good place in which to examine the dynamics of Indigenous-led health organizations in the city. Prince George is located on the traditional territory of the Lheidli T'Enneh First Nation. It is the largest city in the north of BC and the fourth largest in the province overall, functioning as a hub for communities across northern BC and the Yukon (Varcoe et al. 2014). In spite of Prince George's history of colonization, efforts towards expanding the range and quality of Indigenous-led health and social services are active and innovative in the city, and Indigenous claims to land and justice are increasingly being recognized in the area (Dingwall et al. 2016). Findings from this study may be more generalizable to smaller cities with large proportions of Indigenous people than to large cities where Indigenous populations are relatively small.

In order to connect the research with urban Indigenous communities and Indigenous-led health organizations in Prince George, a Community Advisory Group was formed before the study began. This group fluctuated from eight to twelve members at any given time, due to members changing jobs, moving out of Prince George, or, in one case, passing away. Members were health care providers and administrators working in Indigenous-led organizations, Indigenous community leaders, Indigenous Elders, and one researcher from the University of Northern British Columbia. Members provided input into the study questions and design through initial group meetings, assisted with recruitment of participants and the facilitation of focus groups, offered advice and guidance regarding the results of the research in its early and final stages, and assisted with the dissemination of results.

This study draws on interviews and focus groups conducted with 65 participants. Participants included 50 Indigenous community members, the majority of whom used health care services in either Indigenous-led health organizations or provincially funded health care services, or both. It also includes information from 15 health services workers who worked with Indigenous community members in Prince George—13 of

whom worked in 5 different Indigenous-led organizations and 2 in non-Indigenous-led health services. It is worth noting that some Indigenous community members reported not engaging with health care services at all; these perspectives were considered important since they offered "outsider" views of both Indigenous and non-Indigenous-led health organizations, and provided insight into why some people choose not to use health care services.

Recruitment methods were purposive (Creswell 2007), and participants were sought who had specific characteristics that would add value to the study. Participants were recruited through phone calls, emails, posters, contact with the leaders of groups or clubs, and snowball sampling through word of mouth and social media. Initially, only two focus groups were planned, but on the advice of community and group leaders and members of the advisory group, two additional focus groups were added. Participants chose whether to participate in focus groups or individual interviews; each method was employed with both Indigenous community members and health services workers. All participants were over the age of 18 and currently living in the city of Prince George. In total, 44 women and 21 men participated in the study.

In both the interview and focus groups, participants were asked questions related to three broad themes: (1) perceived differences between Indigenous and non-Indigenous health care ser- vices; (2) how health care services impact a sense of community; and (3) how health care services interact with Indigenous rights. Participants' responses to questions about Indigenous rights in health care are examined in a separate paper. Interviews and focus groups were conducted by the first author between October 2015 and January 2016. Interviews and focus groups were audio- recorded (with the exception of some interviews, which were not recorded at the request of participants) and the transcripts and researcher's notes were analyzed using an iterative coding method, in which codes were identified and refined through multiple readings of the transcripts and notes. Responses from all 65 participants were included in this analysis. Results were shared with participants via email, in one-on-one meetings, through the first author's website, and in community presentations in Prince George; they were also shared with the community advisory group. The final products of the research were, and continue to be, shared with participants through email.

Results

The three most commonly discussed themes in transcripts and notes, according to how many individual participants mentioned a given theme, highlighted the work of Indigenous-led health organizations in: (1) prioritizing client-centred care; (2) creating safe spaces; and (3) advocating on behalf of community members to the wider community.

Client-centred care

Twenty-one participants pointed to the ways in which Indigenous-led organizations focus on client-centred care: by making time and space for community members to get to know health care providers, as well as one another; by giving community members authority over the direction and focus of their care; and by being supportive and non-judgmental. One community member described the waiting room in one Indigenous-led organization as a place where people could talk to one another about their health problems:

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

This community member found that being able to talk about mutual experiences with others helped them to feel a sense of both comfort and support. Health care providers described the client-centred nature of the care offered in Indigenous- focused organizations in part through the use of time. These participants described community members being offered extra time for an appointment when needed, and stated that people were still welcomed if they came late for an appointment. As one health services worker said:

> What we can do for clients is amazing. Just yesterday I had a youth crying in my office, saying "I didn't think I could come back, because I missed four appointments, and I know that the rule is, anywhere that I go, the rule is, if I miss three appointments, I can never come back." And so she was scared to call, scared to ask. Her teacher called and said, "can she come back?" I'm like "oh my gosh, of course!"… Any other agency in town would have turned them away, they

would have needed a new referral, a new intake, a new wait list. (FG 3)

Community members also described Indigenous- led organizations as being supportive and pro- viding a sense of community, as the following participant described:

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

Several community members also mentioned feeling a non-judgmental attitude within Indigenous-led health organizations that led them to feel welcome. For example, one community member described an Indigenous-focused health clinic in the following way: "they're non- judgmental, and you feel like you can just talk to them about anything… they actually give me a sense of hope after I leave there" (Community Member 12). Another participant echoed this sentiment, saying, "that's why I come here [to this Indigenous-led health organization] a lot, because I feel like I got support here… They seem to want to help me" (Community Member 11).

Giving community members the time that they need, and making sure that people accessing services feel supported, welcome, and that they can talk about anything without being judged, were described as central features of Indigenous-led health organizations by both health services workers and community members.

Belonging and safety in health care

The second most frequently reported finding, in terms of the number of participants who mentioned it, was related to the role of Indigenous-led health organizations in contributing to a sense of belonging and safety in health care. Fifteen Indigenous community members and health services workers discussed two major aspects of belonging and safety: counteracting racism and paying attention to cultural safety.

In terms of counteracting racism in the city, Indigenous-led health organizations were perceived as important places where community members could access services knowing that they would not face discrimination. This was reflected in the ex- change

between two participants in a focus group:

> P1: Why is there, like a Native-specific health? You know what I mean? Like, what's the diff—?
>
> P2: To make it friendly to Native people, because Native people don't—they don't access services, so they thought they would have that organization, so people would access services.
>
> P1: So they pretty much had Native Health because the system's somewhat, borderline, what—racist [to] people of colour. (FG 2)

Participants described racism as a common experience in non-Indigenous health care organizations, which they described Indigenous-led health organizations as being able to counteract. One health services worker pointed this out in an interview:

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

Indigenous-led health organizations or Indigenous-focused programming in other health care institutions were perceived as ways of counteracting the racist and discriminatory treatment that is described as often confronting Indigenous community members.

With respect to cultural safety, one important aspect discussed by participants was education for health care staff about the histories and contemporary experiences, practices, and values of local Indigenous communities. While it was only health services workers who explicitly referred to "cultural safety" using that specific term, several Indigenous community members also discussed different elements of cultural safety. Interviews and focus groups revealed that cultural safety was also related to community members' senses of belonging and safety in health care spaces. Cultural safety involves an understanding of history and what has happened to Indigenous communities (such as the impacts of residential schools), that in turn can lead to better understanding of

what might make an individual feel more comfortable and safe. Participants described Indigenous-led health and social services as contributing to Indigenous community members' sense of belonging and therefore safety in Prince George, especially for people who come to the city from outside of it:

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

Cultural safety and counteracting experiences of racism, in these interviews and focus groups, were described by participants as contributing to a sense of belonging and safety for Indigenous community members in the city.

Advocating on behalf of community members

Fourteen participants described advocacy on behalf of individuals and communities. Health services workers described advocating for community members, either as part of their job or as extra work on top of their normal duties, and community members described situations in which health services workers in Indigenous-led health organizations spoke up on their behalf or helped them to navigate non- Indigenous health and other social services.

The first way in which health services workers described advocacy work was that it is a taken-for- granted part of the job. While this type of advocacy may be entrenched in the philosophy of many health care organizations—both Indigenous-led and not—health services workers indicated that it is not a formal part of their actual jobs, but is something they are actively involved in. For ex- ample, one health services worker remarked: "I don't even think it's in our job descriptions, it's just what we do" (HSW 7). Indigenous community members also described advocacy on their behalf by Indigenous-led health organizations as a high- light of the services these organizations offered. For example, in a focus group discussion, one community member said the following:

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

Second, participants discussed advocacy as a way of being integrally involved in Indigenous communities. One health services worker emphasized that advocacy work was a natural part of their work, because they felt a responsibility to their community:

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

The third and final way in which participants described the importance of advocacy work was through a perceived need to make room for Indigenous community members' perspectives and needs in non-Indigenous-led health care institutions in the city. For example, one health care provider put it this way:

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

Health services workers described the ways in which advocacy on the part of their organizations might have impacts in the community more broadly. Indigenous community members also described the advocacy work undertaken by health services workers on their behalf.

Discussion and conclusions

While discussing the key contributions of this study, it is important to remember that, as mentioned above, both authors identify as non- Indigenous researchers, and at the time the re- search was being conducted, neither author was living full-time in Prince George. This positions us in relation to the research in specific ways, and although this position potentially involves both strengths and limitations, it is important to keep it in mind when interpreting results. We will not undervalue the contributions of the

community advisory group, however, in bringing this research forward—therefore, we do not wish to portray this as merely or purely an "outsider" research project. It is important, however, to include discussions of researcher positionality in any reporting of re- search with Indigenous communities (Tobias et al. 2014), and we hope that this paper contributes to open-ended discussions about who is doing this kind of research, and why, that may help others in the future.

The key finding of this research is that Indigenous-led health care organizations create supportive urban places through focusing on relationships, an important element of Indigenous community resurgence. The results of this study demonstrate that Indigenous-led health organizations make community members feel that they are being listened to, accommodated, and supported— all important elements of relationship building in health care. To the extent that these Indigenous-led health organizations are able to attend to such non-hierarchical forms of relationship building, they succeed in creating safe, welcoming, and non-judgmental places in the city where Indigenous communities can be supported and thrive.

Looking at the approaches taken by Indigenous- led health organizations through the lenses of Indigenous critical theory and resurgence allows for a consideration of how Indigenous understandings of place and relationships are activated in urban areas by these organizations (Byrd 2011; Tuck and McKenzie 2015). Participants in this study articulated a sense of caring and trust in their encounters with Indigenous-led health organizations that aligns with the framework of cultural safety. Drawing on Indigenous critical theory, this sense of caring and trust also suggests what Wilson (2008) terms "relational accountability," referring to the ways in which human beings have the responsibility to cultivate good relationships with other living beings based on mutual respect (Gerlach et al. 2016). This responsibility extends to non-living beings and the land itself. Because life is dependent on reciprocal relationships with the land and other beings, it is necessary to both recognize and respect this dependence, and to renew relationships of respect on an ongoing basis (Daigle 2016; Simpson 2017). Expanding on cultural safety frameworks, which focus on human relationships in specific client-health care provider encounters, relational accountability frameworks allow places to be seen as mutually constituted through networks of relationships that reach far beyond

individuals in a given health care setting. If places are created through networks of relationships, the attention given by Indigenous- led health organizations to relationships with individuals and communities has the potential to make new types of places available to Indigenous people in the city. Rcentring relational account- ability in the context of Indigenous-led health organizations suggests a turn towards Indigenous ontologies in the spaces of health care that can be considered a form of Indigenous community resurgence.

Indigenous community resurgence involves giving priority to Indigenous ontologies, Indigenous laws, and Indigenous languages (Simpson 2011). This is possible to varying degrees, in the city or anywhere else, as it is necessary to take into account the realities and limitations of life in a settler colonial nation. Indigenous community resurgence is well supported, however, through the creation of places in which Indigenous lives and knowledges are prioritized on a day-to-day basis. Urban Indigenous communities and organizations have been under- taking this type of placemaking work for generations, and examining this work through the inter- connected frameworks of relationship building and Indigenous community resurgence allows us to celebrate, support, and, facilitate this work (DeVerteuil and Wilson 2010; Wendt and Gone 2012; Lavoie et al. 2015).

Our findings are specific to Prince George, a relatively small, northern city by comparison with other urban areas in Canada, and the results of this study may not be generalizable to larger, or more southern, cities. However, these results align well with existing literature on Indigenous-led health organizations across Canada and around the world (Lemchuk-Favel and Jock 2004; Browne et al. 2012; Beswick et al. 2013; Davy, Harfield, et al. 2016; Goodman et al. 2017), and could be used as the basis for studies in other cities.

It is important to acknowledge that relationship- based care is not unique to Indigenous peoples; many cultures (including Western medicine) strive to incorporate better relationships into the health care encounter (Jesmin et al. 2012; Neuwelt 2012). Given this study's focus on Indigenous-led services, a key goal of the paper was to examine how this relationship-based care aligns with principles embedded in Indigenous critical theory; however, this is done with an acknowledgment that all

peoples can benefit from better attention to relationships in health care.

It is important to note that not all participants viewed the work of Indigenous-led health organizations as positive or as meeting their particular needs; relationship building is not simple, and service delivery is not perfect. These findings demonstrate, however, that working towards the goals of relationship building and relational accountability can move these organizations, and the communities they support, in a positive direction in terms of urban Indigenous community resurgence. Future research could expand on this study by delving into relational accountability and the mechanisms at work in Indigenous-led health organizations; studying the workings, impacts, and possibilities of Indigenous governance in urban areas; and looking at the informal ways in which urban Indigenous communities support health and well-being, outside of Indigenous or non-Indigenous health care organizations. Non- Indigenous researchers who wish to do allied work with Indigenous communities may be able to incorporate Indigenous scholarship related to relational accountability and the impact of relationships on place into their work, in order to continue to fulfill responsibilities to human and non-human communities and to bring Indigenous knowledges to the forefront in work that involves Indigenous communities.

Findings such as these should not be interpreted as placing all responsibility for urban Indigenous placemaking, health, and well-being on the shoulders of Indigenous-led organizations. These organizations, rather, need to be better supported in policy and funding frameworks incorporating principles of relational accountability, that allow non-Indigenous health organizations to learn from Indigenous-led organizations in the care of Indigenous community members. Good examples can be found in partner- ships being forged by the First Nations Health Authority with non-Indigenous health organizations and various levels of government. These partner- ships include specific agreements related to cultural safety and cultural humility in the provision of health care (First Nations Health Authority, n.d.). Formalizing these types of commitments, to honour Indigenous ways of knowing in the provision of health care, brings the principles of Indigenous critical theory to the fore, allows Indigenous-led organizations a chance to lead in their areas of strength, and makes room for Indigenous community resurgence in the city and beyond.

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