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Northern Québec James Bay Cree Regional Health Governance In Support Of Community Participation: Honouring the “Butterfly”

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Abstract

Successful responses to the Truth and Reconciliation Commission of Canada's (TRC, 2015) calls to action require “joint leadership, trust-building, and transparency” between Canadian public institutions and First Nations (p. 4). In the area of health and wellness, community participation in priority setting and planning constitutes one important step forward. In 2013, the Québec Cree regional health and social services agency launched a unique wellness planning initiative involving community participation in regional level policy-making. This article reports on a qualitative study conducted with key agency staff, an early component of a broader developmental participatory evaluation. Focusing on contextual challenges to and ways forward on community participation in planning, thematic analysis of 17 semi-structured interviews revealed important nuances between Cree and non-Cree perspectives: These perspectives reflected an empowerment versus a utilitarian view of participation, respectively. Cree Elders consulted on these results highlighted the ontological and epistemological distinction of Cree perspectives, and the importance of bringing these forth. These interpretations point to the relevance of extending cultural safety to institution-level processes bearing on relationships with communities and potentially building capacity for participation.

Keywords

community participation, Indigenous health and wellness, cultural safety, participatory research, qualitative research, developmental evaluation, health and wellness planning

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Currently, a confluence of sociopolitical forces challenge Canadian public sector institutions to examine their governance policies and practices in relation to First Nations. The need for transparency, trust building, and joint leadership between the State and Indigenous Peoples—which in Canada inclusively refers to First Nations, Métis, and Inuit—is indeed explicitly recognized in the wake of the 2015 report of the Truth and Reconciliation Commission of Canada (TRC, 2015). Increased First Nations participation and self-determination are, likewise, promoted and embodied in social movements and their outcomes. For example, in Québec, Canada, recent repatriation of child protection services by the Atikamek Nation is celebrated as “reconciliation in action,” highlighting the broader historical, legal, and sociopolitical issues at stake (Fast, 2018, para. 1).

Against this backdrop, the ways and means by which First Nations participate in health planning continue to evolve across Canada, often focusing on the reduction of health inequities through participatory mechanisms of empowerment, cultural sensitivity, and democracy (Lavoie, Boulton, & Gervais, 2012). However, in the general absence of Canadian legislation and policies ensuring Indigenous representation in provincial or regional health systems, participation has been taking place predominantly at the local community level, with a few exceptions (Lavoie et al., 2012). The Northern Québec Cree are one such exception. Indeed, as beneficiaries of the James Bay and Northern Québec Agreement (JBNQA), a modern land claim treaty with the Québec and Canadian governments, the over 18,000 Cree of the region (Cree Board of Health and Social Services of James Bay [CBHSSJB], 2018) access health and social services provided by Cree institutions set up under Québec law (James Bay and Northern Québec Native Claims Settlement Act, 1976-77). The CBHSSJB, founded in 1978, effectively ensures Cree involvement in the administration, design, and delivery of health and social services. Notably, at the time of writing, approximately 40% of management positions at the CBHSSJB were held by Cree (S. Tétreault, personal communication, July 5, 2018).

The JBNQA also promotes community involvement in health planning, which intersects with a provincial public health law requiring regional public health departments to integrate community input into strategic planning (Loi sur la santé publique [Public Health Law], 2001). In 2013, to facilitate community participation in health and wellness planning, the CBHSSJB launched Iiyuu Ahtaawin Miyupimaatisiun Planning (IAMP), which translates to English as Eeyouch (James Bay) Cree Community Wellness Planning. An ambitious region-wide endeavor, IAMP’s original design included support and training for the nine remote Cree communities to develop and sustain wellness committees; these committees were to undertake local strategic planning and collaborate with the multiple Cree regional entities, including the regional health authority, to align and address community-identified priority health determinants (CBHSSJB, 2013).

Given its unique historical, social, and political context, the IAMP planning initiative constitutes a rare opportunity to develop understandings about structures, processes, and perspectives that may inform efforts by other healthcare organizations, policy makers, and First Nations aspiring to enhance participation in health and wellness planning. In 2015, the CBHSSJB began partnering with an applied research team at McGill University to conduct a developmental and participatory evaluation of the IAMP initiative. This article reports on an early component of this evaluation, a qualitative study

exploring the perspectives of CBHSSJB staff regarding the goals and challenges of the planning initiative. Future manuscripts will describe our developmental evaluation process in more detail as well as community-level perspectives and planning experiences.

Indigenous Community Participation in Health Planning

In the general health planning literature, the concept of community participation has been recognized to suffer from definitional and political ambiguity, with associated meanings that tend to fall under sometimes opposing “utilitarian” or “empowerment” perspectives (Morgan, 2001). However, the literature on Indigenous community participation in health documents a number of studies of community development projects (Campbell, Pyett, & McCarthy, 2014; Snijder, Shakeshaft, Wagemakers, Stephens, & Calabria, 2015) or community-based participatory research (Cidro et al., 2017; Rice et al., 2016; Wallerstein & Duran, 2010) wherein, by design, particular methodologies are adopted in an effort to reduce power imbalances between the community and the academic partner, and to enhance community capacity, at the individual or group level, for engagement. These studies generally address planning at the level of a “program” (i.e., focused on specific health promotion or prevention agendas such as diabetes prevention). Challenges to participation reported in these contexts include trust, power dynamics, cross-cultural communication, and value prioritization among partnering organizations and individuals (Christopher et al., 2011; Fraser, Vrakas, Laliberté & Mickpegak, 2018; Kyoon-Achan et al., 2018; Smylie, Kirst, McShane, Firestone, Wolfe, & O’Campo, 2016; Voyle & Simmons, 1999).

Literature addressing First Nations community participation in systems-level and regional health strategic planning (e.g., priority setting, resource allocation) is sparser. Indeed, the rapidly growing field of citizen participation in health systems has generated little academic literature in terms of the involvement of Indigenous Peoples (Cheema, 2007). In her study of First Nations community participation in planning with British Columbia’s Interior Health Authority, Cheema (2007) highlighted the importance of mutual engagement and power redistribution between the regional- and community-level structures, as well as role definition, accountability or “answerability” in relationships. Cheema’s study also suggested a natural compatibility between Indigenous epistemologies and the values underpinning the social determinants movement in health, a possible lever for engaging community participation in regional and intersectoral health planning. More broadly, attention to intercultural understanding in the process of health systems-level planning with communities may enhance and promote governance and policy-making approaches inclusive of Indigenous values (Chatwood et al., 2017). Our team’s evidence review of health planning for Indigenous populations had drawn attention to cultural safety issues at the organizational level, emphasizing the current knowledge gap (Loutfi, Law, McCutcheon, Carlin, & Torrie, 2018). With its bicultural environment, involving both Indigenous and non-Indigenous staff, the CBHSSJB provides a rich setting for collaborative research to generate understandings about culture, safety, and First Nations community participation in health planning.

Developmental and Participatory Evaluation Framework

Our study with key informants is nested within the broader aims of the IAMP developmental evaluation, as framed within a memorandum of understanding between the CBHSSJB and academic partners at McGill University. As an approach distinct from formative or summative evaluation, developmental

evaluation emerged in the early 2010s in response to social innovators' need for research to inform "visionary intervention during a period of exploration" (Patton, 2011, p. 4). Relying on close collaboration and researcher espousal of social innovation goals and vision, developmental evaluation implies that research questions, design, and methods are co-developed through iterative and dialogical group processes, in order to enhance and orient the developing innovation (Patton, 2011). Our developmental evaluation team also works to uphold the democratic and emancipatory ideals of community-based participatory research through shared decision-making and respect for all participants' knowledge, regardless of institutional hierarchy (Cargo & Mercer, 2008). Evaluation team membership was established to include IAMP leads and support team staff (6 in total, 4 of whom are Cree) as well as the CBHSSJB Director of Research (1 member who is non-Cree) and applied researchers from McGill University (3 members who are non-Cree).

Key Informant Study Questions

The general objective of this sub-study with key informants was to help gain a richer understanding of CBHSSJB staff perceptions of the Northern Québec Cree health and wellness planning context. The following research questions were agreed upon by our evaluation team:

- a. In the context of their understandings and experience, how do CBHSSJB staff members perceive the challenges to health and wellness planning with the Northern Québec James Bay Cree communities?
- b. Given their perceptions of planning challenges, how do CBHSSJB staff members understand the IAMP objectives and purposes?

Emerging from group discussion and without explicit grounding in any particular theoretical model or conceptual framework, these questions reflected a collective concern for creating situated and useful knowledge that could invite further dialogue and, hopefully, inform a shared vision for the implementation of IAMP. We were also intent on avoiding potentially constraining theory derived from processes foreign to Indigenous epistemologies (Kovach, 2018).

Methods

Key Informant Selection

Key informants were identified by our team members based on their experience and position within the CBHSSJB, as well as recommendations by other key informants. This sampling approach aimed to ensure representation from a variety of departments and health files, and to access holders of collectively developed knowledge and history within the organization. A total of 17 key informants (10 women and 7 men), with an age range of mid-30s to late-50s, were recruited. Participants signed consent forms approved by the CBHSSJB Research Committee and the McGill University Faculty of Medicine Institutional Review Board. Key informants self-identified into Cree ($n = 10$), based on shared Cree history, culture, and beneficiary status, or non-Cree ($n = 7$) categories. Informants were differentially positioned within the institutional hierarchy and included staff closely involved with the planning initiative and those capable of providing insight into local community contexts and contingencies.

Data Collection and Analysis

Individual semi-structured interviews were conducted using a collectively developed interview guide addressing health planning concepts and values, perceived challenges to health planning for the Northern Québec James Bay Cree, and perceived aims of IAMP. Half of the interviews were conducted in person in Montreal, and half were conducted by telephone given the challenges associated with the geographic spread of participants' locations. Interviews lasted on average 75 minutes, were audio-recorded, listened to in the following days to identify key messages, and formally transcribed verbatim by hired professional transcribers in following weeks. This process yielded approximately 600 pages of interview data. Spacing interviews over many months (February to September 2016) facilitated our early immersion in and reflection on the data and allowed its collection and analysis to unfold iteratively (e.g., patterns of meaning gleaned from early interviews could be explored in later ones).

We began a formal thematic analysis (Braun & Clarke, 2006) of the interview transcripts, led by our first author, following the final interview. Concretely, this largely inductive analytical work entailed the following:

- a. Identification and annotation of meaning units (Tesch, 1990) linked to our broad research and interview guide questions, but also to emergent topics of concern (e.g., health and social issues experienced in communities);
- b. Derivation and definition of higher order conceptual categories cutting across and frequently subsuming several meaning units (Paillé, 1994);
- c. Constitution of an advanced data organizational coding system (Tesch, 1990) presenting the resulting themes, and their associated codes and interrelations;
- d. Application of the coding system to all interviews; and
- e. Grouping of meaning units according to their new code, providing a new context within which to deepen our understanding of their meaning (Tesch, 1990).

Writing marked the final step of analysis, allowing us to nuance meaning within themes and examine and describe their interrelations, leading to a rich synthesis of important patterns of meaning held by key informants (Paillé, 1994).

Early on, preliminary themes were presented to our entire evaluation team, providing an opportunity for team discussion and input into the interpretations and decisions concerning the analysis. For example, interest in highlighting and contrasting differences in perspectives between non-Cree and Cree key informants came as an early suggestion on the part of team members, a request the data allowed us to accommodate. Later iterations of our understandings were presented within a two-hour focus group that took place in the community of Chisasibi in February 2018. Eight members of the CBHSSJB Nishiiyuu Council of Elders participated in the focus group and provided feedback and discussion on meanings and implications of the emerging themes. Ongoing debriefing sessions among McGill University partners also took place throughout the analysis to establish consensus on the data reduction approach and application of the coding scheme, and to reflect on any assumptions or beliefs influencing our process.

Results

As a team, we concluded that key informant perspectives might best be represented through the morphology and metaphor of the butterfly, where upper and lower components (see Figure 1) refer, respectively, to the two study questions (see Key Informant Study Questions section above). As patterns of meaning took shape, this configuration for presenting themes inspired team discussions and helped us synthesize the concerns, hopes, and stories of participants. Use of this element of the natural world also resonates with Indigenous epistemological beliefs emphasizing holism, interconnectivity, and integration as it allows us to move from the part to the whole as we seek to best present the results of our analysis (Kovach, 2018). We do so by progressing from *the Core* (in pale yellow)— themes recurring throughout the entire data set—to *the Wings* (in blue), perspectives predominantly held on the part of Cree or non-Cree participants, which provide an opportunity to explore cross-cultural understandings.

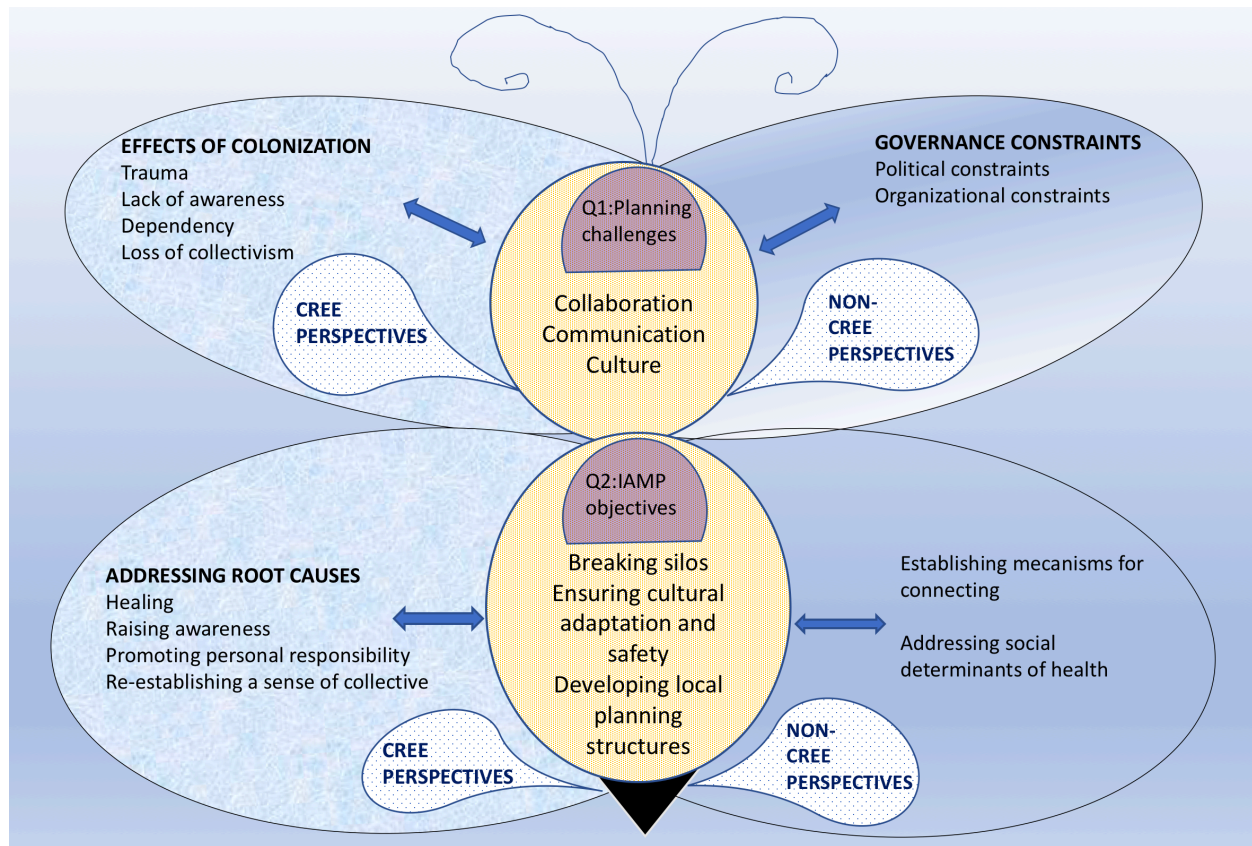


Figure 1. The Butterfly representing the results of the key informant study.

The Core (Body of Butterfly)

Key informants are on common ground regarding several core concerns and perceived goals for achieving Cree health and wellness through IAMP. Jointly recognized challenges (our butterfly's thorax) comprise the interconnected issues of collaboration, communication, and culture. Perspectives on how IAMP is to address these (our butterfly's abdomen) refer to breaking silos, ensuring cultural adaptation and safety in healthcare, and developing local planning structures in the communities. We describe these interconnected themes below including illustrative quotes from the interviews. Longer quotes are indented and identified with a number indicating participant's ordering within the data set; shorter excerpts are woven verbatim into the text and are identified using quotation marks. Please note that we refer to key informants alternatively as *participants* or *interview participants* for sake of varying the text.

Collaboration and breaking silos. Without exception, participants recognized the importance and challenge of collaboration. This sweeping theme involves many jurisdictions (e.g., community, regional, provincial) and relates to multiple sectors, organizations, structures, and roles.

Despite noted efforts and several successes in working across sectors, the Cree regional entities (e.g., the school board, justice department, health agency) are perceived to fall short with regards to addressing intersectoral collaboration, in particular at the local community level. Participants frequently mentioned health planning "silos" and the lack of structured collaboration between what are considered the "major players" in the communities (e.g., the band, the local school board, and local health structures). Key informants conveyed a sense of confusion associated with the "haphazardness" of multiple initiatives addressing, in isolation, the same health or social problem in a given community. They disapproved of the resultant "service duplication," which they associate with poor resource management in the region, as well as with over-solicitation and role multiplication for community members frequently called upon to volunteer their time and skills.

Another concern was the productive alliance of regional-level and community-based organizations (e.g., a local community wellness team). Regional managers from the health agency recognized that "different types of community initiatives [for wellness] have been completely separate from the health board" and are often "not systematically considered or consulted."

Power dynamics within the regional health agency itself were also identified by participants. Participants gave examples of decisions they perceived to have been made regionally and imposed upon community-level departments in the absence of consultation. Such occurrences, referred to as "top-down" decision-making, were reported by participants in community-level positions to have thwarted their motivation for embarking on an initiative.

According to many participants, "breaking silos" constitutes a unifying rationale for pursuing the IAMP initiative, designed in its original written formulation to ensure alignment and integration between regional and local community health priorities and action plans. Breaking silos is considered to be key in addressing health and wellness issues outside the sole jurisdiction of the health board (e.g., education, housing needs), for balancing regional capacity (e.g., professional health services delivery) with local knowledge and expertise, for fostering trust in community members, and for avoiding practices that might be associated with oppressive colonialist governance. Though concrete strategies on how to proceed were not the focus of the interviews, one suggested avenue consisted of developing "protocols"

or agreements on the roles and responsibilities among collaborating partners. These approaches to collaboration are considered to inspire trust and constitute a solution for contexts in which partners are having to “overcome resistance” and “learn how to work together.”

Communication. Communication, as a means of information transmission, but also of connection between people, constitutes another core theme, closely related to breaking silos within and among entities. The majority of key informants identified underlying challenges taking on one or several of the following forms: access to and understanding of community realities, fears about sharing certain Cree knowledge, and the translation of information for community members or organizations. Each form will be described below.

According to participants, achieving an authentic understanding of community members’ lived realities, contexts, perceived needs, and concerns represents a foundational best practice for health planning; participants recognized that “you just don’t plan something somewhere, in Montreal, and go up to the community and say, ‘Hey, I’ve got this plan for you . . .’” Yet at times, insufficient communication is considered to have contributed to a mismatch between the health agency program goals—based on health data—and community preoccupations focused on upstream causes of ill health. The IAMP initiative itself was said to have been born from a recognition that community members’ concerns differed significantly from those behind an earlier more centrally driven diabetes prevention program.

When we went to this first community . . . it just seemed that diabetes [. . .] wasn’t the first priority of the population; the Elders were more concerned about the community spirit. They were more concerned about the social life in the community and overcrowding. (P9)

A second form of communication challenge relates to fears, on the part of Cree, associated with sharing information and knowledge about individuals and community practices. Participants noted the risk of confidentiality breaches if health stories are told in public within a process of community-based planning, given the small size of several communities and the traditional storytelling approach to convey concerns. The possibility of reinforcing global stigma and negative stereotypes through online publishing of community or population health data represents yet another fear. Finally, sharing solutions to health and wellness issues online, for example regarding the use of traditional medicine, evokes the specter of knowledge theft and appropriation, historical examples of which participants shared during interviews.

Effectively translating health information for community members represents a third type of challenge. Participants highlighted the considerable amount of health data, reports, program descriptions, and protocols produced or circulated within the health board, which were “not always in a digested or digestible form,” meaning they are inaccessible to those without a background in data analysis or appraisal. The original IAMP planning framework itself is considered to have been “much too complex.” Executive-level staff stressed the importance of synthesizing and distilling information into user-friendly forms, which some effort had been made to do. Upper-level management was also concerned with ensuring the cultural and contextual relevance of health knowledge and information transmitted to community members.

Communication challenges are amplified by significant contextual factors including the geographic spread of communities, the related prioritization of “European styles” of communication (e.g., email, teleconference, or video conference), and the linguistic parameters set by the Québec Ministry of Health and Social Services (French) and the Cree Nation Government (English, Cree). Although relatively few practical solutions to communication challenges were discussed in the interviews, participants were cognizant of the stakes involved—that is, community members’ level of trust and engagement. Participants insisted that efforts aimed at continuity and transparency in the flow of information were needed.

Culture, ensuring cultural adaptation, and safety. The majority of key informants raised concerns about culture in healthcare and health and wellness planning, and these concerns permeated their interviews. Participants described many examples of cultural adaptations made to (or being implemented within) programs and services. These adaptations depict a process of accounting for traditional knowledge; providing access to traditional activities, objects (e.g., traditional moss bag infant carriers), and practices; maximizing contact with the land (e.g., land-based healing); and mobilizing traditional values (e.g., collectivism). For example, participants reported that physical activity promotion initiatives encouraged people to form teams or pairs. They reported, “for any kind of health movement to be more successful, it’s better to be done in a group setting” or “by targeting or mobilizing extended family groups.” Several participants emphasized the importance of seeking out the experience, knowledge, guidance, and involvement of Elders.

Another dominant thread in the interviews was the importance of holism as a lens through which to approach, critique, and improve healthcare. In the CBHSSJB tobacco cessation initiative, for example, holism translates into program components addressing the spiritual (e.g., self-reflection, prayer), physical (e.g., walking), emotional (e.g., examining underlying suffering and past wounds), and social (e.g., engaging support of family) dimensions of wellness.

Participants linked cultural adaptation within healthcare to the therapeutic virtues of connection to the land; ancestral knowledge and teachings; rites of passage; and skills, habits, and beliefs—all of which are considered essential to Cree identity as well as to cultural transmission to future generations. Senior management recognized that reinforcing Cree identity through culturally oriented care (e.g., low-risk birthing in the territory) may provide a positive lever in the promotion of healthy living (e.g., eating well throughout pregnancy to avoid gestational diabetes). At the same time, cultural adaptation of care was associated with the recognition that turning back the hands of time is not possible. In other words, “. . . you can’t drop everything and just walk into the land and survive off the land and live [the way your ancestors did].”

Some participants framed the challenges associated with the adoption and adaptation of external (Western) health programs in terms of the time and resources required to engage with local community members to validate services or initiatives and to conduct evaluations. Nonetheless, for several key informants, continuing the process of cultural adaptation represents an explicit objective for IAMP:

[What we try to do] with the IAMP is that we try to look at programs that are going to be more geared to Aboriginal traditions. Culture, you know. (P1)

IAMP, it's trying to probably adapt [to] cultural methods and philosophies of health and wellbeing of Cree people in the territory. Aside from having Cree employees in some areas, we do very little to culturally adapt things in all aspects that we do as an organization. So, I see more of that happening. (P2)

A few participants wished that the planning initiative seek to fill gaps in specific types of care. They perceived that, historically, care had been focused on physical health at the expense of emotional health:

You know with this IAMP coming on board, the approach is keeping everything holistic. We keep hearing our Elders saying that, you know, going back and keeping things balanced . . . So, I think that's why IAMP work is so important, is we're addressing all aspects. (P11)

Finally, according to several key informants, the cultural challenge extends to “safety” within clinical care and beyond. Some participants mentioned the risk that unconscious bias on the part of planners will compromise program success. With respect to clinical care, participants linked patient “no-shows” with a lack of “cultural safety” in their relationships with care providers. Key informants also discussed issues surrounding the lack of cultural understanding among non-Indigenous professionals, insufficient “trauma awareness” on the part of the Cree themselves, and the departure of employees who had gained unique cultural insight and sensitivity. Participants emphasized the need for systematic and ongoing cultural safety and sensitivity training and orientation for all employees—Cree and non-Cree. Through IAMP, they hoped to increase attention to these issues across the entire institution.

Supporting the development of a local structure. A final core theme refers to the perception that an important IAMP goal is to support or facilitate, in each of the communities, the development of a local miyupimaatisiin (wellness) committee (MC). This structure is recognized as the key to accessing “grassroots community voice and input” on health services and program delivery, identifying community health and wellness priorities, and improving the coordination of community entities around shared goals (i.e., help break silos).

In particular, MCs are regarded as having an essential role to play in relation to the local community clinic:

It's a forum to provide local feedback. We don't have any clear community participation in local health structures. There's a local [clinic] director, there are usually people [employees] from the community. But there's not like a user's group . . . so, it has a bit of a role even to provide some information back to the local clinics. (P3)

Senior management voiced their interest in having MCs act as “pathfinders” who will identify agreed upon priorities in their communities and collaborate to establish “partnership agreements” on projects linked to the health board's strategic plan.

Several participants raised concerns about potential power issues in the establishment of MCs. They perceived that IAMP would introduce “new ways of doing things,” including a form of power devolution from the health board to communities. Interview participants advocated for greater decision-making and control on the part of the committees; however, they voiced concern that MCs may fail if no real power sharing among the MC, local clinics, and regional management takes place. One participant reflected on

how the Cree colonial past may add weight to the sensitivity and importance attributed to local participation structures by community members. It is a context where “they haven’t always had their local structures or cultural relationships respected.”

Another participant presented a contrasting perspective, asserting that MCs should have no direct power in relation to regional entities: Their power lies in having intimate knowledge of the community. According to this key informant, any influence on social or health policy would be the result of the MC advocating for such a change to their chief and council.

The Wings

Throughout our analytical process, we noted contrasts in perspectives between Cree and non-Cree key informants, wherein certain themes were almost exclusively attributable to one or the other. The Elders consulted on our study confirmed the importance of highlighting these contrasts through the butterfly metaphor and seeking a balanced consideration of both perspectives in order to “fly and move forward.”

Cree Perspectives. Predominantly, Cree perspectives refer to challenges posed by ongoing and interrelated effects of colonization on health, and the perception that IAMP should be addressing these “root causes” (see Figure 1). Four sub-themes constitute the challenges described, each of which is linked to an IAMP goal.

Trauma and healing. A majority of Cree informants believed that trauma resulting from the residential school system continues to affect generations of community members “even though the Canadian government has apologized.” Trauma is perceived to hinder a person’s capacity to engage in health planning through various mechanisms, including an altered orientation to time:

Because, a lot of times, we make short-term decisions, and we lack long-term vision. So, because we’re always, we’re still trying to survive, what happened to us, as individuals . . . the Indian Residential [School] System . . . (P10)

A second mechanism is the inhibition of self-expression as a result of rigid school-based assimilation policies, notably regarding the use of Indigenous languages. Participants described having difficulty speaking out because “you were not allowed to talk about anything [in the residential schools],” which in turn affects engagement in community-based activities. It is also believed to be linked to the development of mental health problems and detrimental coping mechanisms including substance abuse, overeating, and gambling.

Most Cree informants emphasized the need to heal from trauma and post-traumatic stress disorder (PTSD), which were said to present a challenge in the lives of many community members and healthcare workers. Supporting the latter through employee assistance plans and training in “trauma-informed” approaches are two strategies key informants suggested their healthcare administrators consider. When asked what a healthy Cree community looks like, one participant stated:

Well-trained community workers who strive and work for a wellness path in their professional and personal lives, who support community members who struggle with addictions, mental health, and PTSD. (P17)

An individual “healing process” and “journey” involving stages of “awareness, forgiveness, and acceptance” is regarded as essential to moving beyond a “state of stuck” limited to “blaming colonialism.” The planning process itself is perceived to present an opportunity for individual healing through engagement in a community-based process involving group discussions on health. Informants expressed the hope that MC members and their collaborators would include individuals having “advanced on their healing journey” who could model the process for others.

Lack of awareness and raising awareness about the effects of colonialism. Cree key informants also emphasized, both explicitly and implicitly, that many Cree lack awareness of the effects of colonization on their lives and wellness. Recurrent statements, such as “we need to know where we come from; what happened to us; the impact of hydroelectricity, forestry, and mining developments,” reflect key informants’ concerns about the links between individual health and upstream causes of illness or of being unwell. In the words of one participant:

... a lot of them don’t understand. They know they’re carrying a lot, but they don’t understand what they’re carrying. (P11)

Consequently for these participants, one of the goals of IAMP is to raise awareness about the effects of colonialism: to “talk about how colonial policy affected people” and “take the blinders, so to speak, off of our people . . .” Key informants described IAMP training activities educating community members about the effects of colonialism:

That’s what we’re doing through IAMP, we’re acknowledging the things that we went through as people. (P11)

We try to show them the state of the situation that we’re in . . . we look at the situation that we’re in, how we got to that state of the situation. (P1)

Similarly, participants apply these concerns to CBHSSJB workers:

We need to be teaching the workers who they are, where they came from, how to make them stronger workers. (P2)

Participants elaborated on the pre-colonial state of wellness and ways of being well, and framed current levels of “diabetes, addiction, learned self-helplessness” as “symptoms of oppression.”

Dependency and promoting personal responsibility. Consistent with preceding themes, Cree key informants recognized that the Cree contend with a problem of “learned self-helplessness” or dependency:

[. . .] I’m just trying to tell you, there’s something called learned self-helplessness that has a lot to play in what’s going on in the communities. And people who are health planning have to understand that. You and I, we can sit here one week and come up with a health plan, but we’re still not going to help the people. We could go to the community. They’re going to look at us, say we’re crazy, “It’s your health plan. You do it, you know?” (P1)

The informants noted dependency on various structures: the local Chief and Council, regional entities (e.g., the health agency), and perceived figures of authority (e.g., the physician, God). As alluded to previously, discourse around dependency refers to a sense of being “caught” or “stuck in this situation.” Consequently, a healthy community is perceived to be one in which families are less dependent on psycho-social services and better able to manage their own affairs. Key informants associate the roots of “learned self-helplessness” with colonial policy and consider dependency to be “almost inbred.” Cree key informants recognized that services, including ones under their leadership, can potentially further “breed dependency.” They felt it was very important for health agency actors involved in health planning to be cognizant of it. Finally, Cree informants expressed hope that their people might become less dependent on health and social services. They saw community engagement with IAMP as promising in this respect:

So, if we have community people involved in the healthcare planning process, maybe we would get them to be more autonomous in terms of taking care of their own health. (P5)

Loss of collectivism and re-establishing a sense of collective. Finally, Cree key informants regret a loss of traditional collectivism. The current silos and lack of collaboration in health and wellness planning are experienced as estrangement from former ways of living and of facing the vicissitudes of life:

[. . .] if somebody’s territory got burned out, they didn’t . . . they weren’t told they’ll go on welfare. Somebody else . . . the community got together, and they decided, “Well yes, I can take them for this winter, or we’re going over to this section of my land, they can come live here . . . Next year they can come live with me because there’s lots of beaver where I’m going to go next year there’s enough to share.” It’s not like that anymore. (P9)

. . . you see families or extended families who do not support each other, right? Who do not step in to help out, so . . . I mean, that needs to be looked at. It wasn’t the case in the past. (P2)

Reciprocity, trust, and mutual support among families and individuals, historically essential to survival, should continue to play an important role in the area of health and wellness, according to participants. They were also concerned that a community’s leadership might “defer responsibility” on certain issues to the regional health board rather than seeking to promote community involvement and collaboration.

Perceived as an opportunity to break silos among community organizations and sectors and revive traditions, philosophies, and values, the planning initiative imparts hope for contributing to re-establish a sense of collectivity. One participant made the analogy between sports teamwork and community engagement and responsibility for health and wellness:

You know, for somebody to heal from addictions, it’s everything. You need, somebody from the health board, somebody that works in addictions. Also, you need these people to be physically active, so you need the recreation, the sports team. The people need to eat healthy, so you need the nutritionists. You need the grocery store to supply the food. It all has to work as a team. (P1)

Specific interpersonal dynamics were seen as part of the colonial legacy associated with loss of collectivism. Examples of these interpersonal dynamics include “lateral violence,” neoliberal individualist ideology, and conflict among “the traditionalists and the religious fundamentalists.” Regarding the latter, participants identified and associated particular elements of religious indoctrination and residential

school teachings to having contributed to extremism and intra-Cree discrimination. As such, they consider raising awareness on the effects of colonization to be integral to making progress toward greater collectivism:

So, when I see a healthy community, I see people being able to openly get help from their neighbours and [for] that, having an understanding of what happened to us in the past. And then being able to move forward. (P14)

Non-Indigenous perspectives. The predominant perspective among non-Cree participants related to perceived governance challenges that can be best categorized as political and organizational constraints. Non-Cree participants also discussed health planning objectives, which are explored in subsequent sub-sections: Addressing Social Determinants of Health and Establishing Mechanisms to Connect.

Political constraints. The political constraints identified by non-Cree participants are linked to CBHSSJB's accountability structure. For example, participants perceived pressure to answer to their principal funder, the provincial Ministry of Health and Social Services. The Ministry's Provincial Public Health Plan emphasized service-oriented policies, which undermined the capacity and propensity to focus on planning beyond direct care services. Participants also described having to meet expectations contained within CBHSSJB's Strategic Regional Plan, while simultaneously ensuring their health board's funding through the provincial government was not jeopardized.

We work for an organization whose primary mandate is delivery of healthcare, with huge pressures. There's always this balance of making sure that people have a space to plan their health services, but to not neglect the fact that health services won't solve all of the health issues. (P3)

Pressure to focus on direct care was perceived to significantly limit reflection on and planning around upstream causes of ill health. As one community-based manager noted, "... we stray from our health prevention and promotion role, because we are pulled towards that need [to consolidate direct clinical service delivery]." Ministerial demands for "clinical care plans" as a prerequisite for obtaining infrastructure funding (e.g., a new healing lodge or birthing center) also monopolized planning resources and time. Case in point, a relatively recent increase in infrastructure funding resulted in staff having to set aside efforts focused on primary care integration, an earlier and heavily invested planning project. Recognizing that access to healthcare minimally influences health status, participants deplored that employees lack opportunity and awareness of the potential benefits of collaborating with entities outside the health sector to focus on "healthy environments," "community development," and "population health."

With respect to pressure for direct care, senior management staff present a contrasting perspective, framing infrastructure and improvements in services as key community trust-building mechanisms: "What is visible will have an impact ... we set up patient services, the [airplane] shuttle, the professional services on board ..." Gaining credibility and trust on the part of community members are framed, by senior leadership, as stepping stones towards planning related to other health determinants.

Organizational constraints. Organizational constraints refer to several elements considered to undermine the functioning of the regional-local healthcare nexus and to weigh on health planning. First,

the high turnover rate of staff in various positions at both the regional and local levels is associated with loss of collective knowledge and expertise, and ultimately of “cultural safety” in clinical practice. Participants highlighted the “underestimated” burden of staff turnover in a context where hiring non-Indigenous staff requires orienting, supporting, moving, and housing employees.

Second, participants emphasized weak role definition for certain staff positions and structures, including those involved with the planning initiative:

But the role of the community has never been clarified. They talk about these health planning committees. But, as I say, where’s the teeth in it?” (P4)

Speaking about the staff positions involved in supporting local health committee processes, another participant reflected on how it is not clear what exactly their role is and how they might support communities. Health information management presents another organizational challenge identified by participants who expressed their concern about the reliability of data on service delivery. Beyond the question of accountability to the Ministry, improving the health services information system is perceived as a basic support to health planning.

Addressing social determinants of health. Notwithstanding political constraints discussed by non-Indigenous participants, there is strong agreement that the IAMP process should address upstream causes and “social determinants” of ill health, within the communities and in collaboration with other entities:

This is a process where we want to develop a plan, but not only a health plan. Because we are looking towards [addressing other] health determinants. For example, housing, which may be an important preoccupation. (P8)

Really . . . those are issues [diabetes, mental distress] that aren’t solved with having more nurses, or doctors, or clinical services. You have to do something much more upstream in the community. (P3)

However, participants hesitated to attribute a leadership role to the CBHSSJB in this area and expressed concern over the lack of awareness and involvement of other Cree Nation entities, which may be called upon and have the power to oversee change and action in their respective sectors (e.g., school board, housing authority). Senior management staff in particular considered their role in addressing social determinants as circumscribed to direct actions within the range of their sector’s jurisdiction, providing several examples of how housing, employment stability, and transportation may be supported through the CBHSSJB policy (e.g., helping employees obtain CBHSSJB housing, creating permanent CBHSSJB employment).

Establishing mechanisms for connecting. Finally, it is hoped that the planning initiative, as a system-wide endeavor, will help develop the many linkages necessary to achieve or improve regional and intersectoral health and wellness planning. These linkages refer to mechanisms for connecting various CBHSSJB programs, for example those related to mental health and health promotion, but also for linking provincial Ministry policy- and community-level action:

I think it's a challenge within public health when you're looking on health promotion to engage local communities—sort of a bottom-up type of approach—but then you also have this top-down structure of responsibility and evidence that you want to bring to people. So, it's [the planning initiative] a way to bring that together somehow. (P3)

Finally, local wellness committees are viewed as potential connectors of other community-level structures and of financial resources flowing from various funding sources (e.g., federal initiatives) for which communities are eligible.

Discussion

The results of our study with key informants were presented to members of the CBHSSJB Nishiiyuu Council of Elders, a request on the part of our team members and in line with Indigenous methodologies that recognize and promote Elder knowledge and wisdom (Kovach, 2018; Loutfi et al., 2018). Although other lines of discussion could have been explored, we have prioritized the Elders' interpretations of our results and contend this constitutes an important strength of this article. We have integrated their voices, through verbatim quotes, into our discussion.

The Elders regarded the results as reflective of the importance of “seeking balance” in health and wellness planning through consideration of two “ways of knowing and being,” one Cree and the other Western, and “both [are] important for moving forward.” They recognized and associated the central butterfly core (Figure 1) challenges of collaboration and communication with other community development initiatives taking place within their nation. However, it was their in-depth focus on the meaning and implications of connecting “the needs of the spirit, the left wings,” with the necessary imperatives of “the mind, the right wings,” that helped us reflect on and propose new understandings regarding community participation, in particular how it intersects with culture, power, and capacity. We now discuss the Elders' insights, interweaving them with knowledge and theory from the literature, following which we highlight possible implications for the CBHSSJB and beyond.

Indigenous Community Participation in Health and Wellness Planning, Cultural Safety, Power, and Capacity

The Elder Council members validated the emancipatory aspirations identified by Cree key informants, which emphasize the existence among the Cree of an “empowerment perspective” on community participation: The view that through participation, communities “take responsibility for diagnosing and solving their own health and development problems” (Morgan, 2001, p. 221). Such a perspective contrasts with the more “utilitarian” viewpoint reflected in planning objectives that target mechanisms for connecting structures to maximise resources and address social determinants of health (Morgan, 2001). Indeed, Cree key informants invest hope in community mobilization and participation in health planning and processual projects of consciousness raising, healing, and improving personal and collective responsibility, all of which are associated with ambitions to revitalize identity. These perspectives reinforce participants' association between culture and tradition in health and social services with the transmission of Indigenous identity. Moreover, Cree perspectives translate the will and wish for participation in health and wellness planning to embed, enable, and embrace processual and relational ontologies that Elders contrasted with outcome-focused goals associated with the “mind,” the right wing. Finally, Elders stated that Cree spiritual ways of being and ways of knowing reflected in the

left wing have not always been acknowledged. For example, an earlier IAMP planning document (CBHSSJB, 2013) was devoid of reference to Cree epistemologies and the identity revival stakes in planning. Elders directly expressed their desire to be “better known” and for “wanting to be known” by regional-level authorities. As one Elder put it, “It is not only about breaking silos, but also about breaking silence.”

The Elders’ views confirm the importance of intercultural understanding (Chatwood et al., 2017) in health and wellness planning, a challenge particularly salient in contexts where health managers are explicitly attempting to bridge Western healthcare system design and governance with Indigenous worldviews. Furthermore, Elder perspectives on our results support the relevance of applying the cultural safety concept to uphold an empowerment perspective in community participation in health and wellness planning. This is a unique contribution to the emergent literature on cultural safety in health governance and management. As a more radical approach to culture in healthcare, one that integrates “changing power structures underlying the growth of trust” (Brascoupé & Waters, 2009, p. 7), the notion of cultural safety provides a promising avenue in a context where Indigenous people are expressing a desire and intention for greater visibility, recognition, and presence. As Brascoupé and Waters (2009) stated, “through cultural safety, the power of cultural symbols, practices and beliefs extends political power to the Aboriginal people” (p. 11). Power-through-culture thus provides a relevant heuristic that is supportive of “power redistribution” (Cheema, 2007) and, in the case of our study, of power devolution and avoidance of “top-down” or oppressive modes of governance.

At the same time, cultural safety, located within bicultural relationships among First Nations and non-Indigenous peoples, although essential, remains insufficient, as the unique context of the CBHSSJB suggests. Our study results and Elders’ consultation indicate, rather, that intergenerational effects of historical trauma undermine the cohesion, trust, and relational processes governing collaboration and communication among the Cree themselves, a phenomenon observed in some community-based participatory research projects (Fraser et al., 2018). As such, cultural safety, as a way forward in health and wellness planning, implies a complex prerequisite First Nations capacity-building process founded on cultural and historical self-awareness and self-knowledge. Such a process may be conceived as a building block for successful, respectful, and reciprocal cross-cultural engagements (Brascoupé & Waters, 2009) and, in the case of the Cree and in the words of their Elders, for increasing awareness of “the need to work with the right wing” of the model.

Policy and Practice Implications for Involving First Nations Communities in Health Planning

In light of the results of the study and discussion with Elders, our project team considered what might constitute a regional-level institutional agenda for achieving cultural safety in health and wellness planning with First Nations communities. Indeed, while contextually bound to the Northern Québec James Bay Cree, we suggest that the implications of our study are transferable to other Canadian institutional settings—whether Indigenous run or not—concerned with supporting First Nations community participation in health planning (for a discussion of transferability, see Guba & Lincoln, 1989). A first step is conceptual and transformational, calling for a reframing of the role of culture within regional-level organizations. In the case of the CBHSSJB, current efforts largely focus on cultural adaptation of programs and services (i.e., culture as an *end* and as an isolated strategic orientation). An evolving commitment to culture might extend to Cree ways of working, meeting, communicating, and

being together (i.e., cultural safety as a *process* in health planning). Moreover, following a reconciliatory agenda, regional leadership could facilitate dialogue and develop a cultural safety framework explicitly acknowledging historical trauma and its effects on First Nations' ways of communicating, collaborating, and governing. An integral approach to institutional cultural safety could also promote revivalist stakes and aim to bring forth First Nations traditions, values, ways of knowing, and of decision-making into priority-setting, planning, and design of policy, programs, and services. As such, in our study, holders of "right-wing" perspectives are challenged to develop the spaces and places for dialogue addressing this agenda, notwithstanding the governance constraints under which the regional agency operates. Advocating for policy and funding in support of such institutional action may well constitute one explicit imperative for the CBHSSJB.

An organizational cultural safety agenda would present implications for regional health and social services authorities specifically in terms of their relationships with community-based organizations and members of local structures. Whereas senior management, predominantly non-Cree in our study, expressed their conviction that community trust in the regional authority rests on the visibility of services and infrastructure, we suggest that dedication to capacity-building for health planning should also rely on "visibility of culture" (Brascoupé & Waters, 2009). As our study suggests, this undertaking rests on the recognition and support of communities grappling with the ongoing insidious effects of colonization and residential schools in order to improve community wellness, collectivism, and responsibility for development. Such an acknowledgement would constitute a discursive innovation and a departure from institutional framings of health and social problems as symptoms of economic and social developmental delays (CBHSSJB, 2017). At a pragmatic level, support for "left-wing" perspectives would entail that institutional action, in support of community-based planning and development, integrate training activities directly aimed at discussing and collaboratively addressing the effects of colonization on community participation. Although capacity building likely constitutes a long-term goal, investing in this process may provide a way forward in building a safe basis and bridges for negotiating partnerships and agreements necessary for strategic planning with communities.

Conclusion

Our study aimed to contribute to contextual understandings essential to supporting a health and wellness planning initiative designed by the CBHSSJB and involving the participation of remote communities. The results of our study and their interpretation by Cree Elders confirmed support for increased community participation in systems-level health and social services planning, and revealed dimensions of identity, cultural revival, and survival that are at stake. The study also helped identify challenges to community participation in planning, including those related to the ongoing effects of oppressive colonial history on Cree health and wellness and planning capacity. We suggest these challenges likely apply to other First Nations populations in Canada sharing the same colonial history. We propose that addressing these root causes, through *institutional-level* cultural safety, may contribute to the development of institutional capacity for supporting First Nations community participation. Such an agenda for institutional transformation would be timely, responsive to First Nations communities, and address reconciliatory aspirations for redressing past injustices in the Canadian context.

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