



Urban First Nations Health Research Discussion Paper

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Under the *Canadian Constitution Act, 1982*, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population. NAHO makes every effort to ensure the term is used appropriately.

URBAN FIRST NATIONS HEALTH RESEARCH DISCUSSION PAPER

Prepared for the First Nations Centre, National Aboriginal Health Organization

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Section 1.0: Introduction

In 2008, the First Nations Centre (FNC), National Aboriginal Health Organization (NAHO) requested a discussion paper that would address health research as it pertains to urban First Nations people in Canada. We attend to this request by presenting a synthesis and critical analysis of a wide range of literature, data and information gathered from a variety of sources. The focus of this report is on First Nations people. Specifically, the FNC requested that the following topics be addressed in this report:

- **Demographics of urban/off-reserve First Nations population;**
- **Major data sources for urban/off-reserve First Nations health information;**
- **Health status of urban/off-reserve First Nations population (where possible, compared to on-reserve or mainstream);**
- **Determinants of urban/off-reserve First Nations health;**
- **Jurisdictional issues affecting health care for urban/off-reserve First Nations population;**
- **Trends in urban/off-reserve First Nations health research (i.e. is research activity concentrated in particular areas or on particular issues); and,**
- **Suggested topics or areas for future research.**

The goal is not to provide an exhaustive review of the available data, but rather, to highlight data from various sources that provide insights into trends and patterns in health and health research in urban contexts. In certain sections, this report may be seen to have a certain “Western bias” in that we draw on research that is often generated in Western Canada. In part, this reflects our own positioning as researchers in British Columbia. However, it also reflects the patterns of data collection, information gathering, and research occurring in Canada. Our review of the literature indicates that the large majority of research related to urban First Nations peoples is being carried out in cities and centres in Western Canada and Ontario. This pattern of research also fairly reflects the socio-spatial reality that almost 2/3 of urban Aboriginal people live in the Western provinces in Canada (Hanselmann, 2003b).

1.1 Key Definitions

Several key definitions are reviewed to ensure that readers are clear about the various terms used in this report. We draw on the Royal Commission on Aboriginal Peoples (RCAP) (Royal Commission on Aboriginal Peoples, 1996) which describes **Aboriginal peoples** as referring generally to the indigenous inhabitants of Canada including First Nations, Métis and Inuit peoples. These three groups reflect “organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called ‘racial’ characteristics” (xii). Specifically, the term First Nation replaces the term Indian, Inuit replaces the term Eskimo, and Métis refers to people of mixed European and Aboriginal ancestry. The labels ‘Native’ or ‘Indian,’ however, continue to be used in federal legislation and policy enshrined in the *Indian Act*, and in statistical reports and wider public discourses. Under the *Indian Act*, First Nations people are categorized as status Indian or non-status Indian, which distinguishes those who receive legal recognition by the state and those who do not. In this report, the term “Aboriginal peoples” is used to refer generally to the diverse groups of indigenous peoples within Canada. Where specific groups are being discussed, these are identified in the text of the report.

The term **First Nations** is used in this report to refer to indigenous people of Canada who are not Métis or Inuit. It is important to note, however, that First Nations is defined in varying ways in research and in reports. For example, the definition of First Nations in the Aboriginal Peoples Survey (APS)¹ differs from the definition used by Statistics Canada² and the Canadian Community Health Survey (CCHS).³ Many reports in the published and grey literature refer to data pertaining to “First Nations” people when in fact they are referring to a wider group of Aboriginal peoples. This makes it challenging to sift out information that pertains solely to people who self-identify as First Nations. These challenges relate in part to the history of categorization of Aboriginal peoples by the Canadian state, and to changing definitions used by census Canada over the years. Our goal in this report is to highlight trends pertaining to First Nations people specifically. Wherever possible, we draw distinctions between information pertaining to Aboriginal people more widely and First Nations people more specifically. To do this, we use the term Aboriginal people to refer to First Nations (including status and non-status people), Métis and Inuit people as a group, and limit our use of the term First Nations to refer specifically to First Nations people.

Our use of the term ‘**marginalized**’ in relation to First Nations and other Aboriginal people recognizes that marginalization is entrenched in the history of relations between Aboriginal people and the nation-state, and has resulted in a disproportionate burden of ill health and social suffering within Aboriginal populations (Adelson, 2005, p. S45). Marginalized therefore refers to people who have been most affected by historical, structural and social inequities (Adelson, 2005; Browne, Smye, & Varcoe, 2005; Monture-Angus & Conroy, 1995). Although this report ‘targets’ groups who are marginalized, this does not imply that all Aboriginal people are necessarily marginalized. Our use of the term is also inclusive of the many strengths and capacities accumulated in the context of people’s history and circumstances (Greenwood, Tagalik, Joyce, & de Leeuw, 2004; Smith, Edwards, Varcoe, & Martens, 2006; Smith, Varcoe, & Edwards, 2005).

Given the focus of this report, it is important to highlight the challenges inherent in defining urban in categorical terms. Statistics Canada (2007c) provides the following definitions. A census metropolitan area (CMA) is a large urban area and has a population of at least 100,000. More specifically, a CMA or a census agglomeration (CA) is “formed by one or more adjacent municipalities centred on a large urban area (known as the urban core). A CMA must have a total population of at least 100,000 of which 50,000 or more must live in the urban core. A CA must have an urban core population of at least 10,000. To be included in the CMA or CA, other adjacent municipalities must have a high degree of integration with the central urban area, as measured by commuting flows derived from census place of work data” (Statistics Canada, 2007c). Urban non-census metropolitan areas are smaller urban areas with a population of less than 100,000. Urban areas are defined by Statistics Canada as having a population of at least 1,000 and no fewer than 400 persons per square kilometre, based on the current census population count (Statistics Canada, 2007b). All territory outside urban areas is classified as rural. Urban areas include both census metropolitan areas and urban non-census metropolitan areas.

In some areas of Canada, these definitions become blurred in relation to First Nations people who live on-reserve but adjacent to or within large urban cities. For example, within the cities of Vancouver and North Vancouver are reserve communities such as Musqueam, Squamish and Tsleil-Watuth First Nations. Because of their geographical proximity to large urban centres, people move back and forth in relation to health services, work, recreation, schooling etc. As we discuss in the section that follows, there is a great deal of mobility within cities and between cities and rural or remote regions. It is therefore difficult to situate people as living solely in urban contexts, or solely in on-reserve contexts. To the best of our ability, we attempt to focus on trends in health and health research that are particularly pertinent in urban contexts.

1.2 Patterns of Urbanization: Historical Context and Current Trends

The landscapes of Canadian urban centres continue to shift and transform. Part of the transformation is due to the shifting nature of urban populations, a larger reflection of federal and provincial policies regarding settlement, employment and immigration. In the case of Aboriginal people, there has been a dramatic increase in the proportion of peoples living in Canadian urban centres.

In 2006, the proportion of First Nations people living “off-reserve” (60%) exceeded those living “on-reserve” (40%) (Statistics Canada, 2008a). This compares with fewer than 7% of Aboriginal people who lived in cities according to the 1951 census (Peters, 2004). In many Canadian urban centres, First Nations people have come to represent a significant portion of the population, and, if trends continue, their presence in urban centres will continue to grow (Newhouse & Peters, 2003). For example, among people who identified as Aboriginal in the 2006 Canadian census, 54% lived in urban areas (including census metropolitan areas and smaller urban centres) (Statistics Canada, 2008a). This is particularly true in Western Canada as discussed in Section 2.

To engage in any meaningful discussion about urban First Nations health or health research, it is critical to view patterns of Aboriginal urbanization in a historical context. As Evelyn Peters (2004) and Newhouse and Peters (2003) emphasize, any discussion of urban Aboriginal demographics, or health or social trends, must take into account the historical conditions that created these urbanization patterns in the first place. Many Canadian cities grew in places that were historically used by Aboriginal people as settlements or gathering places. Current urbanization patterns must be understood as stemming from the actions that removed Aboriginal people from emerging urban areas. As Peters (2004) explains, these actions varied from moving or situating reserves away from cities, to enforcing a pass system, to enforcing government policies aimed at containing Aboriginal people away from urban centres. These historical realities remind us

that patterns of urbanization for Aboriginal people are not like other migrants to cities in Canada. Although Aboriginal people may encounter some similar challenges and opportunities, many Aboriginal people are travelling within their traditional territories. As Peters (2004) writes, “Many [Aboriginal people] have expectations that their Aboriginal rights and identities will make a difference to the ways that they structure and live their lives in urban areas. The clarification of Aboriginal rights in urban areas, represents a major contemporary challenge for governments, both Aboriginal and non-Aboriginal” (p. 3).

The factors influencing the current trend in increased urban migration by First Nations people result from a complex interplay of economic, social, and historical issues. Indigenous scholars and other researchers have identified the following as key factors: lack of opportunities for education and employment in reserve or rural communities; the need to improve overall living conditions and socioeconomic status; some women’s need to leave violent circumstances at home; the need for specialist health services; the lack of access to adequate housing in some rural and reserve communities; and an expectation of opportunity and in some cases excitement in city life (Levesque, 2003; Newhouse & Peters, 2003; Peters, 2004; Royal Commission on Aboriginal Peoples, 1993, 1996; Solicitor General of Canada, 1998). Importantly, while cities may have attracted Aboriginal people because of greater services, educational or economic opportunities, they also represent places in which many Aboriginal people experience racism, poverty, marginalization and exclusion (Peters, 2004).

There is also evidence to suggest that the contemporary legal limitations of the *Indian Act* (such as band membership, definitions of how one can claim status, treaty negotiations, and the ramifications of Bill-C31) may also be impacting the complexity of Aboriginal urbanization. For example, Bill C-31, which allowed for the reinstatement of individuals (largely women) and their children who had lost status due to the *Indian Act* regulations, resulted in an increase in the Registered Indian population, particularly in urban areas.

Unlike many other urban residents, First Nations people often maintain strong ties with rural and/or reserve communities, moving back and forth on a regular basis, contributing to the challenge of providing accurate profiles of urban Aboriginal populations and communities (Newhouse & Peters, 2003; Norris & Clatworthy, 2003; Peters, 2004). Migration back and forth between rural, reserve and urban communities may represent not a failure to adjust to city life (as is sometimes assumed), but an attempt to maintain vital and purposeful community relationships (Peters, 2004). Patterns of mobility between and within communities, however, can also result in an under-representation of urban Aboriginal health and social trends, especially among people who are living in unstable housing arrangements.

There are some important misconceptions related to Aboriginal urbanization to consider critically before proceeding to discuss demographic, health or social trends, or health research agendas. One is that the current trend toward urbanization does not necessarily imply rural and reserve depopulation (Newhouse & Peters, 2003; Peters, 2004). Rather, the most recent pattern is one of movement back and forth between urban places, and reserves and rural communities. A second misconception is that while Aboriginal people have a greater chance of living in poor neighbourhoods, people who identify as Aboriginal are increasingly found in a wide variety of locations in the city. The notion of inner city ghettos as the location of urban First Nations people must, therefore, be problematized. At the same time, consideration must be given to the ways in which Aboriginal peoples' historical marginalization is often replicated in the city where many are economically excluded from particular areas of residence.

A third misconception is that Aboriginal people face major challenges in creating community and culture in urban places. As Peters (1998, 2004) points out, ideas about the incompatibility of Aboriginal people and city life have been historically generated, and continue to be reiterated in current times. This has contributed to the assumption within government, policy makers, and some members of the public that cities are largely places of loss of culture and community for Aboriginal people. David Newhouse (2000) and Peters (2004) argue otherwise; many Aboriginal people are working to build culture and community in urban areas, and urbanization is occurring along with reinforcement of cultural identities. These factors need to be recognized to understand the full and complex patterns of health, illness and quality of life for urban First Nations populations.

Section 2.0: Selected Demographic Trends for Urban/Off-reserve First Nations Populations

2.1 Quantifying Cultural Identity

As we attempt to tease out First Nations specific information on demographics, health, and health research from larger data on Aboriginal health, we are reminded of the history of inclusionary and exclusionary government practices surrounding citizenship and identity. Val Napoleon in her critical account of the *Indian Act* and First Nations membership clearly demonstrates how government practices of defining citizenship and nationhood, which became increasingly narrow in definition, were primarily about limiting access to valuable resources and land (Napoleon, 2001). The fewer the First Nations counted, the less resources the government had to hand over. Thus, definitions of what constitutes “First Nations” should be considered from a critical analytical perspective to account for colonial bureaucratic practices used to disconnect First Nations from their rights.

But even if there is agreement concerning the current legal definition of what constitutes First Nations identity, researchers, and users of research, will need to be wary of the power of numbers and counting as another governmental technology. Social scientists have demonstrated the way in which numbers and quantification are used in governing populations and the consequences of such practices (Greenhalgh, 2005; Neylan, 2005; Rose, 1999). Particularly, these studies illustrate how the counting and quantification of particular groups of people may be used to justify coercive governmental practices (Greenhalgh, 2005). Kerr, Norris and Guimond (2002) also provide a critical discussion of the challenges in producing accurate population estimates for Aboriginal and First Nations peoples in the Canadian context. They highlight how changes in *Indian Act* legislation (for instance the reinstatement of women and children as registered Indians under Bill C-31); the move to use ‘Aboriginal identity’ (a subjective indicator that flows with societal discourses about what it means to identify oneself as Aboriginal) as *the* indicator for population

counts; and issues relating to census coverage (for example, incomplete enumeration on some reserves), all create a situation demanding tentativeness in our interpretation of Aboriginal population numbers. With this in mind, we cautiously present the following demographic profiles of urban First Nations living in Canadian cities.

2.2 Proportion of First Nations Living Off-Reserve and in Cities

The 2006 census data (Statistics Canada, 2008a) reports that 698,025 Canadians identified themselves as either status or non-status First Nations peoples. First Nations people represented 60% of the Canadian population who defined themselves as Aboriginal in 2006; 81% reported being status Indian. According to the 2006 census data, the First Nations population increased by 29% in ten years (1996 – 2006).

As noted in the introduction, First Nations people are more likely to live off-reserve than on-reserve. In 2006, 60% of First Nations reported living off-reserve, a 2% increase from 1996. Importantly, in relation to the interpretation of census and other population-level data, in 2006, approximately 76% of the off-reserve First Nations population lived in urban settings, while the remainder resided in rural locations (Statistics Canada, 2008).

Among the CMAs or CAs in Canada, Winnipeg, Saskatoon, Regina and Edmonton had the largest proportion of Aboriginal peoples (including people who identified as First Nations, Métis, or Inuit) in 2006 (10%, 9%, 9%, and 5% respectively) (Statistics Canada, 2008a). Aboriginal people represented 2% of the population in the cities of Vancouver, Calgary and Ottawa-Gatineau, and 0.5% in Toronto and Montreal (Statistics Canada, 2008a). The proportion of people in some of these cities who identified specifically as First Nations is provided below. These data are drawn from Statistics Canada data (Statistics Canada, 2001, 2008a) except when otherwise noted.

Vancouver: 2006 Census data reports that 40,310 of the city's population identified as Aboriginal, accounting for 2% of the total city population. Of those, 23,515 identified as First Nations (58 %). In Vancouver, in the Downtown Eastside (DTES) (recognized as one of Canada's poorest communities), 10% of the neighbourhood population identifies as Aboriginal (City of Vancouver Central Area Planning Department, 2004). Information about the breakdown of the proportion of Métis, First Nations, status and non-status people in the DTES is not available.

Edmonton: 2006 Census data reports that 52,100 of the city's population identified as Aboriginal, accounting for 5% of the total city population. As a proportion of the Aboriginal population in Edmonton, 22,440 identified as First Nations (43%).

Regina: 2006 Census data reports that 17,105 of the city's population identified as Aboriginal, accounting for 9% of the total city population. As a proportion of the Aboriginal population in Regina, 9,495 identified as First Nations (56%).

Saskatoon: 2006 Census data reports that 21,535 of the city's population identified as Aboriginal, accounting for 9% of the total city population. As a proportion of the Aboriginal population in Saskatoon, 11,510 identified as First Nations (53%).

Winnipeg: 2006 Census data reports that 68,380 of the city's population identified as Aboriginal, accounting for 10% of the total city population. As a proportion of the Aboriginal population in Winnipeg, 25,900 identified as First Nations (38%).

Toronto: 2006 Census data reports that 26,575 of the city's population identified as Aboriginal, accounting for 0.5% of the total city population. As a proportion of the Aboriginal population in Toronto, 17,275 identified as First Nations (65%).

Ottawa: 2006 Census data reports that 20,590 of the city's population identified as Aboriginal, accounting for 2% of the total city population. As a proportion of the Aboriginal population in Ottawa, 10,790 identified as First Nations (52%).

Montréal: 2006 Census data reports that 17,865 of the city's population identified as Aboriginal, accounting for 0.5% of the total city population. As a proportion of the Aboriginal population in Montréal, 10,130 identified as First Nations (57%).

To summarize, for the most part, urban residence for First Nations peoples in large cities is a Western Canadian phenomenon. Winnipeg, Saskatoon, Edmonton, and Vancouver have large First Nations populations in contrast to cities in the Eastern provinces where the proportions of urban First Nations populations are far lower. Further, it is worthy to note that the proportion of First Nations people in the Aboriginal population in the above large cities is high.

Aboriginal people also make up a considerable share of the population in several smaller regional cities in Western Canada (Statistics Canada, 2008a). For example, they accounted for 36% of the population in Thompson, Manitoba, 35% in Prince Rupert, British Columbia and 34% in Prince Albert, Saskatchewan. Demographic breakdowns for people who self-identified as First Nations were not available. Cities that border large CMAs can also have high proportions of Aboriginal people. For example, cities such as Surrey and North Vancouver in B.C. are also home to substantial numbers of urban Aboriginal and First Nations communities – some of whom live on urban-reserve communities.

Aboriginal peoples living in urban settings are more likely to live in poor-income neighbourhoods due to the disproportionate burden of poverty experienced by many Aboriginal people and families (Peters, 2004). However, as discussed earlier, people who identify as Aboriginal are increasingly residing in a wide variety of locations in the city, not only in inner city neighbourhoods (as is commonly assumed). However, specific data pertaining to the proportion of First Nations in various city neighbourhoods is not available.

The definitions of what is an Aboriginal community are shifting – which complicates the picture of who is living in rural settings off-reserve, and who is living in off-reserve urban or smaller regional centres. Recently, the APS ‘concepts and methods guide’ has introduced a new term called “on community”. This term is used to refer to Aboriginal people who are living in communities that have very high proportions of Aboriginal people. The definition of ‘on community’ is “a minimum of 250 Aboriginal people with a concentration of 40% or more comprising Aboriginal people.” Currently, the following communities have been labelled in this way: Prince Albert, North Battleford, Wood Buffalo, Yellowknife and Whitehorse.

It is not clear whether statistical information will be organized and reported in relation to this new term. This speaks to the changing definitions of what it means to be living off-reserve and or living in an Aboriginal community, and for understanding and interpreting what it means to live in an urban Aboriginal or First Nations community – if in fact these communities are interpreted to be “Aboriginal” communities.

2.3 Age Trends

As is well known, census data for 2006 (Statistics Canada, 2008a) continue to indicate that the urban Aboriginal population is younger overall – in Regina, Saskatoon and Prince Albert more than half the Aboriginal peoples living in these cities were 24 years of age or younger. Specific age breakdowns for First Nations people in cities are not often reported or easily located. For example, although a recent environmental scan conducted in Winnipeg found that the median age of the Aboriginal population was 24.7 years compared to 37.3 years for the non-Aboriginal population, disaggregated data for First Nations people was not, however, provided (Aboriginal Task Group, 2004).

2.4 Children

In relation to Aboriginal children, data collected by Statistics Canada from 2006 show that overall, Aboriginal children are twice as likely to live with a lone parent compared to non-Aboriginal children. The majority of Aboriginal children age 14 and under (58%) lived with both parents, while 29% lived with a lone mother and only 6% with a lone father. In addition, 3% of Aboriginal children lived with a grandparent (with no parent present) and 4% lived with another relative (Statistics Canada, 2008a).

For First Nations children specifically, 54% on-reserve lived with two parents as compared to 50% of their off-reserve peers. The rates of First Nations children living in foster homes were not provided in the Statistics Canada data, however, of the Aboriginal children surveyed in the 2006 Census, the vast majority lived with a member of their family; less than 1% lived with someone who was not related to them. This does not in any way diminish the importance of recognizing that high proportions of children in care are Aboriginal and First Nations children. Indeed, it is difficult to understand this statistic in light of the extremely high proportion of children in care who are Aboriginal in cities like Vancouver (70%) – as discussed in Section 4. A review of those particular statistics was beyond the scope of this report, however, the numbers of First Nations children⁴ in care in urban settings must be considered in any discussion related to health, family health, mental health, and overall community wellbeing.

Section 3.0: Major Data Sources for Urban/Off-reserve First Nations Health Information

There are significant gaps in data and reporting specific to urban First Nations people – particularly those who are non-status. Many data sources do not differentiate among First Nations groups (for example, whether people are living in primarily urban on-reserve settings, urban off-reserve, rural on-reserve, rural off-reserve, whether they are status or non-status, treaty or non-treaty, and so on). Some published and grey literature also fails to distinguish between First Nations, Métis or Inuit. Presented as composite data, it can be difficult to tease out if there are differences in health and wellness, what those might be, and what factors might be contributing to those differences. As Cardinal and Adin (2005) have clearly stated, the lack of systematic data collection and analysis regarding urban Aboriginal health and the diverse groups of people involved, prevents us from understanding the complex and multifaceted contexts in which urban Aboriginal peoples live.

There are very few sources of data that pertain strictly to urban/off-reserve First Nations health and well-being but we can construct snapshots from various sources to provide a general overview. We do not offer a comprehensive synthesis of data sources but instead highlight data sets that offer valuable insights into First Nations health and wellness. Here we consider a range of sources, acknowledging that all data sources, regardless of the methods employed to collect and analyse the data, are partial.

Many of the descriptive reports that do provide information on urban First Nations health are based on Statistics Canada census data. While these data are extensive in relation to Aboriginal peoples' demographic characteristics, they need to be approached with a critical lens for two main reasons. As Guimond (2003) and others (see for example, Newhouse & Peters, 2003) have discussed in depth, there continue to be differing ways of defining the various categories of Aboriginal people in census definitions, and Aboriginal peoples' responses to the census questions about Aboriginal identity have changed over time.

The scope of this report precludes a discussion of all possible data sources -- however, it is important to remember that sources of data that address social and political dimensions of life – for example, access to child care, access to disability and social assistance, housing, violence, governance, and treaty negotiations – should also inform an understanding of urban First Nations health.

3.1 Population-Based Federal, Provincial and Municipal Data

Key sources of population-based demographic and health indicators data for First Nations and off-reserve First Nations populations include the following data bases. We indicate, where possible, whether disaggregated data for urban First Nations in particular are available within these data sources.

We also want to highlight a cautionary note raised Dr. Judy Bartlett (2005) regarding self-reported survey-based prevalence rates for Aboriginal people in population-based surveys conducted in Canada. She argues that since little is known about how various groups of Aboriginal people might differently interpret survey questions, particularly as compared to non-Aboriginal Canadians, results should be cautiously interpreted. As noted by Bartlett (2005), “Most health survey questions, even in Aboriginal-driven surveys, have not been validated for congruency with Aboriginal culture” (p. S22) and we would add, ways of knowing. A lack of congruency has the potential to lead to inaccurate results and interpretations. The degree to which results may be inaccurate, and the direction of the inaccuracy (e.g. is there a lack of congruency in some cases, and if so, does the lack of congruency result in higher or lower reported rates?) is unknown (McDonald, 2008).

Statistics Canada 2006 Census (released in 2008)

In the 2006 census, First Nations was defined as either self-identifies as North American Indian or member of an Indian band or Registered Indian (Statistics Canada, 2006) (see also footnotes 1-3 in introduction). From the census key reports have been generated that are important sources of demographic and social factors such as housing, language, identity, etc. (e.g. Statistics Canada, 2008a), as well as many other supplementary publications from Statistics Canada pertaining to issues related to language, geographical location, etc. (Statistics Canada, 2008a). Census data allows searching by community for detailed statistics. Further, searching by Aboriginal population profile is possible, which produces a breakdown of population numbers belonging to each of the Aboriginal population groups (i.e. First Nations, Inuit, and Métis).

Aboriginal People's Survey (APS)

This is the chief source of off-reserve data on the social and economic conditions of First Nations, Métis, and Inuit peoples living off-reserve in urban, rural and remote locations in Canada (Statistics Canada, 2008a). However, more recent cycles have also attempted to survey Aboriginal peoples on-reserve. Survey data collected between October 2006 and February 2007 will be available for release beginning in fall 2008.⁵ The survey was developed by Statistics Canada in partnership with national Aboriginal organizations and federal and provincial/territorial governments. In the most recent survey, approximately, 60,000 people were interviewed across Canada, sampled from the 2006 Census. APS data can also be searched by community although the list of communities is not exhaustive. Search results provide information broken down as above. Data for children can also be specifically searched (<http://www12.statcan.ca/english/profil01aps/home.cfm>).

As noted in a report by the FNC, NAHO (First Nations Centre, 2007), several limitations must be noted. First, the term “off-reserve” can also pertain to First Nations people living in rural areas, so the findings cannot be interpreted as representative of urban populations only. Secondly, the samples sizes used to determine various descriptive statistics

vary from topic to topic because respondents were permitted to respond only to those questions they wished to respond to. This can make interpretation of results difficult. Third, the definition of First Nations used in the survey was very broad, and could have included people whose primary identity was other than First Nations. First Nations was defined as: self-identification as a North American Indian (singly, or in conjunction with co-identification as Métis or Inuit); Indian status; membership in an Indian band; and/or ancestral affiliation with one or more Aboriginal groups.

First Nations Regional Longitudinal Health Survey (RHS)

These surveys provide comparative data for the on-reserve First Nations population. These are the only national surveys that are governed by First Nations themselves through the First Nations Information Governance Committee at the Assembly of First Nations. The surveys include:

- a) the 1996-1997 First Nations Regional Longitudinal Health Survey;
- b) the 2002/2003 First Nations Regional Longitudinal Health Survey;
- c) and the 2008 First Nations Regional Longitudinal Survey that is currently being rolled out across the country (personal communication, Bartlett, L. (at AFN), April 29, 2008).

Canadian Community Health Survey (CCHS)

The CCHS survey collects a wide range of information about the health status of Canadians, factors determining their health status and their use of health care services. Information was reported by the respondents themselves. As in previous cycles of the CCHS, residents of Indian reserves, health care institutions, some remote areas, and full-time members of the Canadian Forces were excluded.

The CCHS did not make distinctions between those who were First Nations, status/non-status, Métis, or Inuit, or between Aboriginal people living in urban or rural areas. Any respondent who answered yes to being a member of the Aboriginal peoples of North America was considered “Aboriginal” (Tjepkema, 2002).

The category used in the CCHS, “Aboriginal off-reserve,” could have some relevance to urban First Nations people, however, these would be approximate since there were not distinctions made about people living off-reserve in urban areas, or off-reserve in rural areas.

Starting in 2007, the CCHS began collecting information every year from more than 65,000 individuals aged 12 or older in all provinces and territories. Previously, the CCHS collected information on over 130,000 individuals, but only every other year. As of June 18, 2008, Statistics Canada began releasing selected health indicator data from the CCHS data collected from January to December 2007 (Statistics Canada, 2008b).

The CCHS has reported that it plans to also capture longitudinal data on children. However, explicit timelines for this have not been established. For instance the Statistics Canada website overview of cycle 1.1 states “ For the first collection cycle only those 12 years of age and over are eligible for selection, although it is expected that in future cycles child-specific content will be included.” (Statistics Canada, 2003c). Importantly, the current general CCHS website information on “target population” states the target at Canadians aged 12 and over.

Vital Statistics

Provincial vital statistics are collected from all the provinces and territories across Canada and provide basic information on mortality, life expectancy, and birth related statistics. These almost exclusively pertain to status First Nations people. Statistics are often reported by health service delivery areas, some of which CMAs or CAs, for example, the city of Vancouver. These figures can then be compared to the overall population. Data from British Columbia and Alberta include on and off-reserve status populations (Health Canada, 2007). Data for Manitoba and Saskatchewan include only the on reserve population. Hence off-reserve non-status First Nations people are subsumed under the general population data.

First Nations Comparable Health Indicators from Health Canada and First Nations and Inuit Health

The February 2003 First Ministers’ Accord on Health Care Renewal directed health ministers to further develop health indicators to supplement previous work on comparable indicator reporting (Health Canada, 2007). This resulted in a suite of 70 indicators which address a number of themes and priority areas identified in the Accord. These indicators were developed by an inter-jurisdictional Performance Reporting Technical Working Group (PRTWG) with assistance from the Canadian Institute for Health Information (CIHI) and Statistics Canada.

The Federal Comparable Indicators Report (Health Canada, 2006) concentrates on the reporting of a featured set of 18 health indicators out of a total list of 70. First Nations and Inuit Health Branch (FNIHB) has reported on 10 indicators in this report. First Nations data for these indicators was obtained from a variety of sources, including, for example, the NAHO telephone survey *What First Nations Think About Their Health and Health Care* (2004).

In most cases, data for these indicators pertains to status First Nations on-reserve, though some indicators, for example, for HIV, reflect information obtain from First Nations, Métis, and Inuit people in a variety of settings. Most of these data do not specifically report on urban First Nations people, however, the move toward greater accountability through indicators and performance measures make this set of data worthy of mention.

Provincial and Territorial Government Sources

Because each province has its own infrastructure, there is no consistent equivalent source of data across provinces that speak specifically to urban First Nations health. However, the following sites do offer data that may be pertinent to urban First Nations health issues.

Ontario

<http://www.health.gov.on.ca/english/hlinks/aboriginal.html>
The Ministry of Health and Long Term Care

Alberta

[http://www.international.gov.ab.ca/International and Intergovernmental Relations/Aboriginal Relations](http://www.international.gov.ab.ca/International%20and%20Intergovernmental%20Relations/Aboriginal%20Relations)
[http://www.aboriginal.alberta.ca/Aboriginal Relations \(Alberta\)](http://www.aboriginal.alberta.ca/Aboriginal%20Relations%20(Alberta))

British Columbia

Report on the health of British Columbians Provincial Health Officer's Annual Report 2001, The health and wellbeing of Aboriginal People in British Columbia
<http://www.health.gov.bc.ca/aboriginal/pho.html>

Saskatchewan

<http://www.publications.gov.sk.ca/department.cfm?d=71>
First Nations and Métis Relations

Manitoba

<http://www.gov.mb.ca/ana/>
Manitoba Aboriginal and Northern Affairs

Communicable Disease Control Branch,
Province of Manitoba
Winnipeg, MB
<http://www.gov.mb.ca/health/publichealth/cdc/surveillance/index.html>

Newfoundland and Labrador

Newfoundland and Labrador Aboriginal Affairs –
Government of Newfoundland and Labrador
<http://www.laa.gov.nl.ca/laa/publications/default.htm>

Québec

http://www.autochtones.gouv.qc.ca/publications_documentation/publications_en.htm
Secrétariat aux affaires autochtones

City/Municipal Sources

The following are examples of municipal sources provide city specific data on issues related to First Nations health and well-being but do not specifically address urban First Nations health.

Winnipeg, Communicable Disease Control Branch, Manitoba Health

<http://www.gov.mb.ca/health/publichealth/cdc/index.html>

City of Toronto

http://www.toronto.ca/invest-in-toronto/aboriginal_pop.htm
<http://www.toronto.ca/invest-in-toronto/demographics.htm>

City of Ottawa, Public Health

(Ottawa Public Health, 2006)
http://ottawa.ca/residents/health/publications/index_en.html

Health Montréal

<http://www.santemontreal.qc.ca/En/population/etat.html>

City of Vancouver

<http://www.city.vancouver.bc.ca/fourpillars/>
<http://www.gvrd.bc.ca/growth/aboriginal.htm>

3.2 Qualitative Data Sources

For the large part, policy-makers employ statistical data quantifying health, illness and well-being to understand First Nations and Aboriginal peoples' social context even though many researchers have commented on the challenges and limitations of relying so heavily (and often solely) on these data sources. In this report, we outline the conventional sources of data related to health, but also highlight other data sources that inform understandings of the complex facets of urban health, life, life opportunities, and determinants of health. These include narrative sources of data derived from ethnographic research, and fictional and personal narrative that shed light on peoples' experiences of health and illness.

Ethnographic Research

There are outstanding ethnographic studies exploring and documenting the health and wellness of First Nations peoples living in urban and rural settings. Such studies highlight the complex web of factors that shape health and well-being for First Nations men and women living in urban areas. A few examples are provided here.

Several ethnographic projects have focused on the DTES of Vancouver, one of Canada's poorest neighbourhoods. For example, the edited collection by Leslie Robertson and Dara Culhane (2005) presents the stories of both Aboriginal and non-Aboriginal women living in Vancouver's inner city – stories that disrupt stereotypical constructions of poor First Nations women living on the streets and take discriminatory constructions head on. Additionally, the biographical stories of these women speak directly to the experience of health care in urban centres, the experience of disease, illness and dying, and to personal practices of care and healing. Additional work by Culhane (2003; in press) and Benoit, Carroll and Chaudry (2003) speak directly to questions of wellness and healing for Aboriginal women living in the DTES. Collectively, these works provide insights about the experiences of some First Nations and Aboriginal women living in inner city communities in Canada.

Browne (2005, 2007) and Tang and Browne (2008) provide analyses of First Nations women, and Aboriginal peoples' health care experiences drawing on ethnographic work conducted in urban hospital settings. These papers offer insights into the marginalizing practices in health care, the impact on First Nations people, and the ways that health care providers can inadvertently contribute to health care inequities.

Sherene Razack's work on racializing space and her critical examination of the Pamela George case (Razack, 2000) similarly provides insights into the social determinants of health in urban centres. Her work highlights the racism, discrimination, and structural violence embedded within the Canadian legal system. Her analysis of such contexts is critical for a complete understanding of the way in which everyday trauma and experiences of discrimination influence health and wellness.

Fictional/personal narratives

Fictional and narrative accounts are often marginalized data sources but they can provide powerful, first hand accounts of disease, illness and the social, economic, political and historical facts which shape them. Often considered subjective and too personalized to speak to larger trends, we suggest the use of fictional and personal narratives in exploring and analysing urban First Nations health and well-being is consistent with indigenous epistemologies of knowing (Smith, 1999). They offer first-hand accounts of the challenges of moving to urban centres, experiences of health and illness (addictions, HIV, trauma), and vividly account for the socio-historical determinants of health (colonial legislation, residential schools, *Indian Act*).

For instance, the following texts, while fictionalized accounts, are examples which address contemporary experiences of Aboriginal peoples and speak to health, illness, and healing:

- Lee Maracle's *I Am Woman* (Maracle, 1988)
- Jeannette Armstrong's *Slash* (Armstrong, 1985)
- Beatrice Culleton's *In Search of April Raintree* (Culleton, 1983)
- Janice Acoose's *Iskwewak--kah' ki yaw ni wahkomakanak: Neither Indian princesses nor easy squaws* (Acoose, 1995)
- Tomson Highway's *Kiss of the Fur Queen* (Highway, 2000)
- Shirley Sterling's *My Name is Seepeetza* (Sterling, 1992)
- Eden Robinson's *Traplines* (Robinson, 1996)

3.3 Research Reports, Other Published Compilations, and Grey Literature

Outside of the traditional sources of demographic and quantitative data such as those reviewed above, there are various sources that provide current, often cutting edge and critically oriented sources of information on health and health inequities. Some of this material focuses specifically on Aboriginal peoples (but, again, rarely focuses specifically on First Nations) but other material focuses on urban populations as a whole, requiring further synthesis to pull out information on First Nations or Aboriginal peoples. Some of these sources of literature are described below.

In British Columbia a number of large, comprehensive research projects have included First Nations populations. For instance, the **British Columbia Centre for Excellence in HIV/AIDS** epidemiological cohort VIDUS (Vancouver Injection Drug Users Study) has followed 1300 injection drug users in Vancouver's DTES resulting in numerous papers on Aboriginal peoples living in Vancouver (e.g., Craib et al., 2003; Miller et al., 2006; Wood et al., 2007; Wood et al., 2008). The Community Health And Safety Evaluation (CHASE) Study, another Centre for Excellence in HIV/AIDS project, could also provide glimpses into First Nations health and wellness in the community although to date analysis of First Nations specific health and wellness has not been published (Community Health and Safety Evaluation Project Team, 2005). More recently, the "Cedar project" has comparatively explored HIV status among Aboriginal youth in Vancouver and Prince George, British Columbia (Pearce et al., 2008; Spittal et al., 2007). Yet, the specificity of these projects (focusing on injection drug users and/or HIV/AIDS) and the fact that they are cohort studies (samples not meant to be representative) means that the data sheds light on particular groups of people with particular health and social issues, but should not be used to infer conclusions about all urban First Nations peoples. In fact, the intense scrutiny and focus on this particular population likely contributes to unwanted and unwarranted stereotypes of Aboriginal and First Nations people.

In Winnipeg, the **Eagle's Eye View** (Aboriginal Task Group, 2004) environmental scan of the urban Aboriginal community included First Nations people. Many

of the facets of life discussed in this report have direct relevance to urban First Nations health and determinants of health. An innovative aspect of this report was the inclusion of information from a number of existing resources, from interviews and focus groups, and the presentation of this information using a framework called the Aboriginal Life Promotion Framework (Bartlett, 2005), grounded in an Aboriginal understanding of connectedness or interdependence of all elements of living.

The Institute of Urban Studies, University of Winnipeg, while not having an Aboriginal-focused mandate, does directly and indirectly address issues relating to urban First Nations health and wellness (Institute of Urban Studies, 2004). The 2005 study, "Home is Where the Heart is and Right Now that is Nowhere," in particular highlights the on-going challenges and barriers that exist as First Nations and Aboriginal peoples living in Saskatoon, Regina and Vancouver seek safe, secure and affordable housing (Distasio, Sylvestre, & Mulligan, 2005). The affiliated Winnipeg Inner City Research Alliance (WIRA) has also produced a number of reports that speak to various aspects of the health of urban First Nations people (Sheldrick, Dyck, Myers, & Michell, 2004; Silver, Mallett, Greene, & Simard, 2002). The "Urban Dakota and Dene: Quality of Life Indicators Report" (Ten Fingers, 2005) reflects on the quality of life for some groups of urban First Nations people in Winnipeg, Manitoba, adopting indigenous methodologies in data collection and analysis.

The Native Women's Association of Canada (NWAC) similarly conducts research on issues that may overlap or cut across the question of urban First Nations health and wellness. Their research on Aboriginal women's health (Native Women's Association of Canada, 2002) the social determinants of health (Native Women's Association of Canada, 2007b), women and homelessness (Native Women's Association of Canada, 2007a) are particularly relevant to urban contexts.

The Aboriginal Women's Health and Healing Research Group (AWHHRG) has also bibliographies available through their website that include some key readings on health and social issues that impact First Nations women in urban settings.

The **Centre for Native Policy and Research** in Vancouver, British Columbia has a mandate to conduct progressive public policy related research on issues pertinent to Aboriginal and First Nations peoples. Their Urban Aboriginal Life project (Cardinal & Adin, 2005) developed Aboriginal specific indicators as a means to evaluate and measure social, economic and environmental conditions of Aboriginal peoples living in urban centres. The project focuses on the development of indigenous frameworks for understanding health in the holistic sense.

The research articles published in **The Journal of Aboriginal Health (JAH)** published papers and analyses that often speak to the health of urban First Nations people. Launched in 2004 by NAHO, the JAH's peer-reviewed articles reflect the latest research findings and analyses from leading health scholars, academics and Aboriginal community members.

The Royal Commission on Aboriginal Peoples (1996) and related reports contain comprehensive analyses that remain relevant in today's context. The more recent collection of works in the report *Not Strangers in These Parts* (Newhouse & Peters, 2003) includes a series of important papers that reflect on key issues for urban Aboriginal peoples. A number of reports have also been compiled by NAHO, the Aboriginal Nurses Association of Canada, and the Assembly of First Nations, that speak either directly or indirectly to issues of urban First Nations health.

It has been well documented that housing is directly and indirectly related to the health of individuals and families. Housing shortages and the increasing economic marginalization of the urban poor has resulted in dramatic increases in homelessness in many Canadian cities, resulting in various **reports on housing and homelessness**. Some of these reports speak directly to the issue of unsafe and unaffordable housing for urban Aboriginal peoples yet, others, oddly do not mention the high rate of homelessness among some urban Aboriginal peoples (City of Toronto, 2003).⁶ Many simply report the percentages of how many of the urban homeless self-identify as Aboriginal, however, they do provide a starting point for thinking about the larger determinants of health in urban settings for First Nations peoples (Edmonton Homelessness Count Committee, 2002; Gardiner & Cairns, 2002).

The **Canada Mortgage and Housing Corporation (CMHC)** conducts yearly policy-related studies on housing and homelessness issues, some of which directly speak to First Nations peoples. For instance, the 2005 report "An Exploration of Housing Options for Aboriginal People in Edmonton, Alberta and Winnipeg, Manitoba" highlights that urban Aboriginal peoples living in these two Western cities are typically younger and more likely to live in poverty and have less education than non-Aboriginal peoples (Canada Mortgage and Housing Corporation, 2005). Such reports similarly inform our understanding of the socio-economic factors that shape urban First Nations health.

3.4 Urban Aboriginal Organizations and Urban Aboriginal Health Clinics

Increasingly, community-based Aboriginal organizations are engaging in research initiatives. As Dion Stout noted (Dion Stout, 2003), urban Aboriginal organizations like Friendship Centres⁷ and Aboriginal health centres and clinics⁸ are positioned well to highlight key research questions and develop research agendas that reflect the needs of urban Aboriginal communities. The shift in research funding strategies at the national level to support community-campus collaborations means that community organizations are increasingly being invited to participate in collaborative projects as community partners. But, they are also increasingly leading their own research initiatives.⁹ Urban Aboriginal health clinics (Aboriginal Healing and Wellness Strategy, 2008) in metropolitan centres are potential sources of critical data regarding the spectrum of health issues impacting urban Aboriginal peoples and some researchers, recognizing this, have partnered with urban clinics to address relevant health issues (Browne et al., 2007). However, as discussed in Section 8, sustainable, adequate resources – both human and financial – will be needed to support urban aboriginal health organizations to engage meaningfully in research. Such funding will need to be in addition to funding reserved for programs and service delivery.

Section 4.0: Health Status of Urban and Off-reserve First Nations Populations

4.1 “Fuzziness” of Interpreting Health Status Indicators

There are challenges inherent in attempting to describe the health status of urban First Nations people (with or without status) using population-based datasets from the off-reserve First Nations population. For example, data cannot be disaggregated into categories reflective of (a) First Nations people living in urban vs rural settings, or (b) people who move frequently back and forth between urban and rural areas. Boundaries between these groups of people are blurred, making categorical claims difficult at best.

Statistics Canada (and therefore the data in the CCHS) tends to dichotomize its reports on the basis of on-reserve and off-reserve populations, with the off-reserve populations typically positioned as a proxy for urban populations. However, people living off-reserve do not all live in urban areas, and many reserves are located in urban and suburban areas, giving rise to an urban on-reserve population, and a rural off-reserve population. The situation is made more complex by the lack of available health-specific data pertaining to non-status people residing in urban settings.

Where possible, we highlight health status indicators for First Nations people in urban settings. However, where that information is not available, we draw on trends within the wider off-reserve or urban Aboriginal population that are likely to be reflective of some urban First Nations peoples' health.

4.2. Limitations Regarding Data that is Specific to Urban First Nations' Health

We highlight several dimensions of the health status of the urban First Nations population by pulling together information from a variety of sources. In keeping with prevailing practices, we review health statistics of off-reserve populations as compared to on-reserve. However, it must be recognized that off-reserve population data from Statistics Canada, as a proxy for the urban population, excludes urban on-reserve populations (approximately 2% to 3% of the urban First Nations population, as calculated using 2006 Census data) and includes rural off-reserve populations (which is 24% of the total off-reserve First Nations population).

According to the 2006 census (Statistics Canada, 2008a), approximately 76% of the off-reserve population live in urban settings while the remainder reside in rural locations. Since statistics indicate that the off-reserve populations tends to have (or at least report) better health than on-reserve populations, these statistics likely overestimate the health of the total urban population, which, for accuracy, should include urban on-reserve populations. This potential to overestimate health may or may not be balanced by the possibility that urban First Nations living off-reserve have better health than rural off-reserve populations.

At first glance the literature appears paradoxical with off-reserve individuals typically reporting better health than their on-reserve counterparts, yet urban research typically painting a rather dire picture of the health of Aboriginal people. As described above, neither the off-reserve statistics nor the urban research should be taken completely at face value.

4.3 Selected Indicators of Health and Social Status

The following comparative health statistics were derived primarily from self-report surveys: the Canadian Census, the Canadian Community Health Survey (CCHS), the Aboriginal People's Survey (APS), and the First Nations Regional Longitudinal Health Survey (RHS). While the general limitations of survey results have been well described elsewhere, we also underscore two additional caveats in interpreting these comparisons. First, the age at which a respondent is considered an adult varies between surveys. For instance, the APS includes respondents over 15 years of age whereas the RHS includes respondents over the age of 18.

The second caveat relates to the populations included in various published reports: we note that the populations sampled will rarely be "homogeneous" in the sense that on-reserve populations include primarily but not exclusively First Nations people. For example, according to the 2001 census, approximately 10% of people living on-reserve do not report Aboriginal ancestry. In the case of the RHS, each community participating in the RHS used its own definition of community/band membership to determine who participated (First Nations Centre/First Nations Information Governance Committee, 2006). Furthermore, off-reserve statistics include self-reporting of Aboriginal identity without necessarily indicating peoples' particular Aboriginal group membership (First Nations, Métis or Inuit).

To paint the picture of the health of urban First Nations people we first consider the health of the off-reserve First Nations population as compared to the general Canadian population. Then we consider off-reserve health as compared to health in the on-reserve First Nations population. To do so we draw primarily but not exclusively on an analysis conducted by the FNC, NAHO (First Nations Centre, 2007). Lastly, we review health indicators of urban Aboriginal people (not just First Nations) versus rural Aboriginal people, because this too highlights some important trends in health status that are relevant to First Nations people in urban settings.

4.3.1 Comparing the Off-Reserve Population to the Total Canadian Population

4.3.1.1 Vital Statistics

Vital statistics on mortality rates exclusive to the off-reserve First Nations population in Canada have not been compiled or at least are not easily accessible. We were unable to locate these. The surprising dearth of information probably reflects a limitation in the way vital statistics are collected and a lack of engagement of researchers in this topic area since currently, production of these statistics would require linking data sets to geographic residence. Given that mortality rates are generally acknowledged as key indicators of population health, we find this an important gap in our understanding. However, we did find one source that reports life expectancy (no year provided) at birth for Aboriginal men on-reserve as 67.1 years, off-reserve as 72.1 years and 76 years amongst the general Canadian population. Similarly for Aboriginal women life expectancy at birth was reported as 73.1 for on-reserve women, 77.7 for off-reserve women and 81.5 years for the general Canadian population (Frohlich, Ross, & Richmond, 2006). These statistics reflect our findings below which report a trend towards better health for First Nations people living off-reserve as compared to on-reserve. Health and social indicators for people residing in the Vancouver area, however, are an exception. They show a greater gap between First Nations people and other residents. For example, life expectancy for status First Nations people compared with other residents is 12.2 years less for women, and 14.0 years less for men (British Columbia Provincial Health Officer, 2002). These large gaps may reflect the very high mortality and morbidity rates for people living in Vancouver's DTES, an inner city neighbourhood that has very high rates of poverty, drug addiction, and violence. We report more on the DTES and other inner city contexts below.

We report mortality rates for registered First Nations in BC owing to the large number of off-reserve and urban First Nations people in BC, which suggests that these statistics may somewhat reflect urban First Nations health in this province: in 2002, mortality rates from all causes was 79.1 per 10,000 for status First Nations as compared to 55.2 for other British Columbians (British Columbia Vital Statistics Agency, 2004).

We were able to find one comprehensive and interesting report on infant mortality which we present in section on children below. Together these statistics suggest relative health differences with on-reserve First Nations faring worse than off-reserve who in turn fare worse than the general Canadian population.

4.3.1.2 Other Health Indicators

The APS 2001 Initial Findings report (Statistics Canada, 2003a) and the Statistics Canada report on the Health of the off-reserve Aboriginal Population by Tjepkema (2002) based on CCHS data both document poorer health amongst Aboriginal populations as compared to the general Canadian population on nearly every indicator imaginable. For instance 60.1% of off-reserve Aboriginal people reported having a chronic illness versus 49.6% of non-Aboriginals in Canada and 13.2% of the Aboriginal population reported a major depressive episode as compared to 7.3% of non-Aboriginals (Tjepkema, 2002). Hence, presenting an exhaustive list of other indicators here seems redundant.

One of the most interesting and potentially important set of statistics in the APS 2001 Initial Findings report is around self reported overall health. According to the report, although overall off-reserve Aboriginal populations rated their health lower than the general population, Aboriginal youth ratings showed negligible differences between these populations (69% of Aboriginal youth reported good or better health versus 71% of general population). This may signal a positive trend in overall perceived health.

4.3.2 Comparing the Off-reserve Population to the On-reserve Population

The following group of health status indicators were taken from the report *A Snapshot of Off-Reserve First Nations Health* (First Nations Centre, 2007). On the whole these data, compiled from the *Aboriginal Peoples Survey 2001 (APS)* and the *First Nations Longitudinal Regional Health Survey (RHS) 2002/03*, describe a picture of better health for First Nations living off-reserve than on-reserve and better health for men than for women. As discussed below, these gender specific trends are not fully corroborated by other analyses, for example the analysis done by Cooke and colleagues discussed below. This difference underscores a crucial point about the importance to critically examine sources of data used to make health claims about particular population. It points particularly to the limitations of survey data as stand alone information about the health of populations.

According to the *Snapshot of Off-Reserve First Nations Health* (First Nations Centre, 2007), overall, 57% of First Nation people who live off-reserve believe that they enjoy a state of health that is “very good” or “excellent”, compared to only 40% of First Nations people who live on-reserve. Some specific health status indicators are listed:

- 8.3% of First Nations people living off-reserve report they suffer from diabetes, compared to 19.7% of the on-reserve population;
- 12% of First Nations people living off-reserve report they suffer from high blood pressure, compared to 20.4% of the on-reserve population;
- Overall, 79% of off-reserve First Nations men report income from employment, compared to only 60.8% of on-reserve men;
- 68% of off-reserve First Nations women report income from employment, compared to only 52.1% of on-reserve women;
- 37% of the off-reserve First Nations smokers population aged 18 to 29 are daily smokers, compared to 53.9% of the on-reserve population.

However, there are some areas where people living off-reserve report poorer health than their on-reserve counterparts:

- 12.5% of First Nations people living off-reserve report they suffer from asthma, compared to 9.7% of the on-reserve population;
- 10.3% of First Nations people living off-reserve report they suffer from heart problems, compared to 7.6% of the on-reserve population.

The overall better health of off-reserve population as compared to the on-reserve population is corroborated by a report by Cooke and colleagues (2004) for INAC using Census data over the time period 1981-2001. Using the United Nations Human Development Index (HDI)¹⁰, average general wellbeing is higher for off-reserve populations as compared to on-reserve populations.

In terms of gendered comparisons, according to the Snapshot (First Nations Centre, 2007), men on and off-reserve report being in better health than women. For instance off-reserve, 60% of men and 55% of women deem themselves to be in “very good” or “excellent” health; and, on-reserve, 43% of men and 37% of women deem themselves to be in “very good” or “excellent” health. This trend reflects morbidity trends in the general Canadian population, which show women tend to suffer from illness more than men, given higher life expectancies in women than men, in both the general Canadian population and in Aboriginal populations. Conversely Cooke and colleagues’ (Cooke et al., 2004) analysis finds women’s average general wellbeing (as per the HDI, which combines life expectancy, education and income indices) more favourable than men’s in both on-reserve and off-reserve settings. This analysis of health incorporates important determinants of health and thus perhaps presents a more complete picture of the health differences between men and women that that painted using self report survey data.

4.3.3 Urban-Rural Comparisons

In a recent report using the CCHS 2001 (Tjepkema, 2002), off-reserve population data were broken down into urban and rural counterparts. While this breakdown is useful for understanding urban First Nations health, the major caveat is that it includes all Aboriginal identity respondents, not just First Nations. The statistics reviewed in this report show quite similar findings between urban and rural populations and although there does seem to be a trend towards slightly better statistics for urban populations versus rural, the intention of the report was to compare Aboriginal and non-Aboriginal populations and hence statistical significance tests have not been conducted to see if these small differences between urban and rural areas are due to chance or not. As such, interpreting the numbers below as reflecting any real difference is not recommended. Indeed, the importance of reviewing this data here is to suggest that the health of urban off-reserve populations may not be that different from rural off-reserve populations allowing more comfort in interpreting off-reserve statistics (which collapse urban and rural) as at least somewhat appropriate as a reflection of urban off-reserve health. A few of the urban-rural comparisons are provided below.

- Self perceived health: 78% of urban respondents reported good to excellent health versus 74.3% of rural;
- Long-term activity restriction: 15.5% of urban people report restrictions as compared to 18.1% of rural respondents;
- Heavy smokers: 14.1% of urban people report they are heavy smokers versus 16% of rural;
- One or more chronic conditions: 62.6% of urban versus 59.6% of rural;
- Major depressive episode in last 12 months: 13.8% of urban people report depression versus 13.1% of rural.

However, there is likely an important difference between urban and rural in the way unmet healthcare needs were reported. For instance urban Aboriginals tended to report that needs were unmet because of acceptability of services (56% of urban people reported this versus 43% of rural dwellers) while rural Aboriginals tended to report needs were unmet because of unavailability of services (42.8% of urban people reported this versus 51.4% of rural dwellers).

Another potentially important health indicator that has been reported for urban versus rural populations is access to traditional medicines. According to Statistics Canada (2003a), “About 31% of the off-reserve Aboriginal population had access to First Nations, Métis or Inuit traditional medicines, healing or wellness practices in their city, town or community... [t]he highest percentage was found in urban areas, where 34% of the population reported having access to traditional medicines, compared with 26% in rural areas and 14% in the Canadian Arctic” (p. 17). While one-third of the urban Aboriginal population reported having access to traditional healing practices, just as many reported that they did not know if such health practices were available in their community. About 7% of the urban Aboriginal population had contacted a traditional healer about their physical, emotional or mental health in the 12 months prior to the survey.

4.4 Mental Health

The mental health of the Aboriginal population has received increasing attention in recent years despite the fact that it continues to be largely glossed over by health authorities, in policy, and in health care planning (Smye, 2004). Persistent socio economic inequities, intergenerational trauma, and colonial and neo-colonial processes including racialization and discrimination have taken a serious toll on the mental health of Aboriginal peoples as reflected in alarming rates of suicide, depressions, substance abuse, and violence. However, information that points to the mental health of urban First Nations people is sparse and the picture painted by available sources is complex and at times contradictory.

In keeping with the above analysis, some information indicates that off-reserve First Nations’ mental health may be better than on-reserve mental health. For instance the Snapshot (First Nations Centre, 2007) reports that while 20% of the on-reserve population reports attending residential school, only 6% of the off-reserve population reports the same. While some may interpret this to indicate that fewer people living off-reserve may suffer from the mental health sequelae from residential schools, our knowledge of the intergenerational effects of residential school (Royal Commission on Aboriginal Peoples, 1996) bring this interpretation into question. Finally, the Snapshot also shows more access to social support for off-reserve populations as compared to on-reserve populations across the categories of ‘someone to confide in’ (86% of off-reserve report vs 75% of on-reserve); ‘someone to do something enjoyable with’ (84% vs 80%); ‘someone to show you love and affection’ (91% vs 84%), and; ‘someone to take you to the doctor’ (87% vs 80%). Hence, there is some reason to suspect that urban First Nations living off-reserve enjoy better mental health than their on-reserve counter parts.

Conversely, in many urban areas, issues of homelessness, substance abuse, lack of affordable housing, and deinstitutionalization of patients with mental illness, all likely contribute to the high rates of mental illness among some Aboriginal peoples that has been described in many sources (British Columbia Provincial Health Officer, 2002; Commission on the Future of Health Care in Canada, 2002; First Nations and Inuit Health Branch, 2001; O’Neil, Reading, & Leader, 1998; Royal Commission on Aboriginal Peoples, 1996). Suicide rates in some Aboriginal communities have also continued to rise for the last two decades (Kirmayer et al., 2007). Although there are enormous variations across communities, bands, and nations, the overall suicide rate within First Nation communities is about twice that of the total Canadian population. Importantly, as Kirmayer and colleagues emphasize, suicide is never the result of a single cause, but arises from a complex web of interacting personal, social, historical and political circumstances (p. xv). These issues – compounded by the lack of mental health services – are pressing issues in urban settings.

4.5 Health Status of Specific Populations

In this section we review information related to three specific sub-populations that warrant independent examination: women, children and inner-city residents. While much has been written about each of these sub-populations in terms of Aboriginal health, we focus on what can be garnered about the health of these populations in an urban context.

4.5.1 Women's Health and Well-being

Within the total Aboriginal population, women's health status remains significantly worse in comparison to men's (Native Women's Association of Canada, 2007b). As discussed in the recent NWAC report, the situation of Canadian Aboriginal women illustrates the intersecting issues of racialization and gender, the continuation of multiple forms of systemic discrimination, and the extent to which health and social inequities shape the lives of many. Within the statistics pertaining to Aboriginal women in national datasets, it is difficult to locate data specific to urban First Nations women. However, there are some trends pertaining to off-reserve women that we highlight here.

Urban First Nations women face some particular challenges that affect health status: a larger proportion of women leave reserve communities than men (Lévesque, 2003). Reasons are complex: for example, some women leave after a marital breakdown, many flee violence in the home, and some are seeking opportunities available in urban centres (Native Women's Association of Canada, 2007b; Norris & Clatworthy, 2003). Violence against women continues at alarming rates. In 2004, Statistics Canada's General Social Survey (GSS) reported that rates of spousal assault against Aboriginal women in the previous five years by a current or ex-spouse was more than three times higher (at 24%) than that of spousal assault reported by non-Aboriginal women (Native Women's Association of Canada, 2007b). In an urban health context, it may be important to consider specific sub-populations such as urban women who are single parents, economic marginalization and high rates of violence and crime (Norris & Clatworthy, 2003). Young urban women are reported to experience the highest rates of mobility, and the highest rate of housing instability (Norris & Clatworthy, 2003), making them particularly vulnerable to related problems and risks.

Recognizing that not all First Nations women move into inner city neighbourhoods, there are some trends – taken from health statistics collected in Vancouver's DTES – that point to the disturbing realities experienced by some First Nations and Aboriginal women. For example, Aboriginal women are disproportionately represented in the inner city core (DTES) and account for about 1/3 of the total population (Culhane, 2003). These women are at an extremely high risk of sexual exploitation and violence. And conditions may be poised to worsen since British Columbia's current elected government seems set on implementing health, social and economic policies resulting in further deterioration of socio-economic conditions for Aboriginal women in inner city Vancouver. These are health and social issues that are serious concerns for First Nations women in urban areas.

4.5.2 Children

Over the past few years, the health of Aboriginal children off-reserve has become a topic of interest for the federal government. Statistics Canada (Statistics Canada, 2004) produced their first report focused on this population, and while that report is limited in scope, a more comprehensive survey is planned: the Aboriginal Children's Survey (ACS) will have results available beginning in the fall of 2008¹¹ (Statistics Canada, 2007a).

Although data, obtained largely through the APS surveys rarely reports on First Nations as opposed to the larger Aboriginal population, the Statistics Canada website on the APS allows searching by community for breakdown of Aboriginal identity and general Aboriginal health and social rates on a small number of variables (such as self reported health, physical activity, dental visits etc.). The ACS may be more comprehensive. One trend worth noting is the trend for rates of self reported health (or more accurately reports of overall child health as reported by significant other/proxy) for Aboriginal children to approach rates equivalent to the general Canadian population at adolescence. While differences in self reports of overall health between off-reserve children and the general population are small to begin with (e.g., 83% of children up to four years of age report very good or excellent health versus 90% of the general population) in the six to 14 age group a difference of only four percent is noted (82% versus 86%).

Of course, overall these findings underscore the persistent trend of Aboriginal children's health statistics showing poorer health as compared to statistics from the general population of Canada. We report a few examples.

- 13% of Aboriginal children suffered an accident serious enough to require professional health as compared to 11% in the general population (Statistics Canada, 2004);
- 73% percent of Aboriginal children off-reserve were breastfed as compared to 82% of other Canadian children (Statistics Canada, 2004).

The other similar trend is that off-reserve children's data seems to reflect better health than on-reserve children. For instance the proportion of children experiencing injuries that are serious enough to require medical attention (one year period-1999-2000) was 17.5% for on-reserve children, 12% for off-reserve children and 10% for the general Canadian population (RHS and National Longitudinal Survey of Children and Youth, First Nations Centre, 2005).

4.5.2.1 Children in Care

The large proportion of Aboriginal children in care continues to be a topic of concern as provincial and territorial data continue to suggest that between 30% and 40% of children in care are Aboriginal despite their proportion of the population being less than 5% (Gough, Trocme, Brown, Knoke, & Blackstock, 2005). While this data is rarely broken down to the level of First Nations in urban setting, data from the Vancouver region suggests that an alarming 70% of children in care are of Aboriginal descent (Culhane, 2003). This is particularly alarming given the comments of B.C.'s official representative for children and youth who noted that "Children under government care are 36 per cent more likely to end up in the correctional system than complete high school...[and]As a result, more than 40 per cent of children in care have been brought up on charges, and they are getting into trouble younger and staying involved with the criminal justice system longer" (CBC News, 2008). Hence, the implications of these large numbers of urban Aboriginal children are deeply concerning.

4.5.2.2 Infant Mortality

In a very comprehensive and methodological sophisticated research study, Luo and colleagues (Luo et al., 2004) analysed data comparing infant mortality rates (IMRs) amongst First Nations children in urban as compared to rural settings over the period 1981-2000. They report that overall there is an increasing proportion of First Nations children being born in urban as compared to rural areas. Unfortunately a greater proportion of First Nations mothers living in urban areas lived in the poorest quintile of neighbourhoods (40% of urban mothers compared to 23% of rural mothers). Another difference was the proportion of unmarried mothers with 57.6% of urban mothers being unmarried compared to 63.9% of rural mothers.

According to their analysis, IMRs show interesting trends. While overall rates show decline over the study period, a sharp spike was noted in mortality rates for both urban and rural First Nations during the years 1981-1992 attributable almost entirely to Sudden Infant Death Syndrome (SIDS) deaths, a spike was not seen in non First Nations data. While the spike has been reversed and steady improvements can be seen, a persistent gap remains between First Nations and non-First Nations infants (but is negligible between urban and rural) in rates of death from SIDS. A similar gap exists in overall IMRs with urban and rural First Nations rates comparable (although urban rates are slightly more favourable at 12.7% and 13.8%), but significantly higher than urban and rural non-First Nations (6.1% for both). The gap between First Nations and non First Nations is startling and of great concern.

When the rates are broken down to compare neonatal and post neonatal deaths we see some divergence between urban and rural First Nations populations. While average rates for neonatal mortality and post neonatal mortality are higher in rural populations versus urban (e.g. neonatal rural 5.6 versus urban 5.4 and postneonatal 8.3 versus 7.4), a closer look at the most recent rates show a slightly different story. As shown in the Figures 1 and 2 from Luo et al. (2004), for the period 1997 to 2000, urban neonatal mortality rates were higher than rural while they were lower than rural for post neonatal deaths. We can also see the gap in First Nations as compared to non-First Nations

diminishing. While this paper does not speak to the higher rates of urban neonatal deaths, the authors do conclude that most of the post neonatal deaths are attributable to accidental or preventable causes. The authors also conclude infant mortality among First Nations living in urban areas fluctuates over time.

Figure 1 – Urban/Rural First Nations Neonatal and Post neonatal Mortality Rates 1981-2000 (Luo et al., 2004)

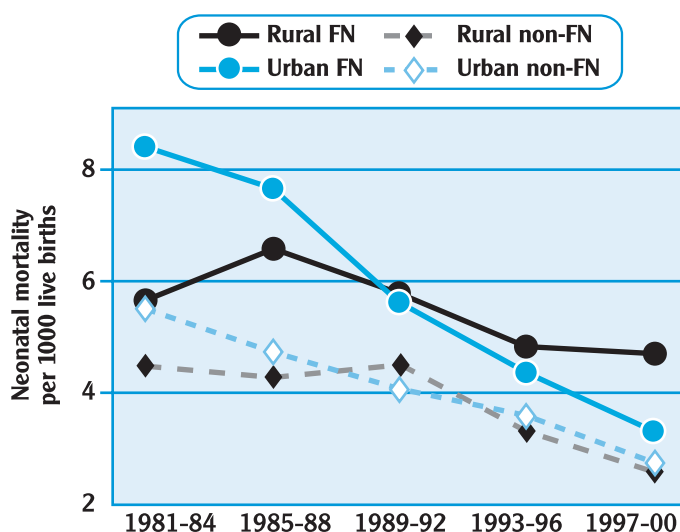
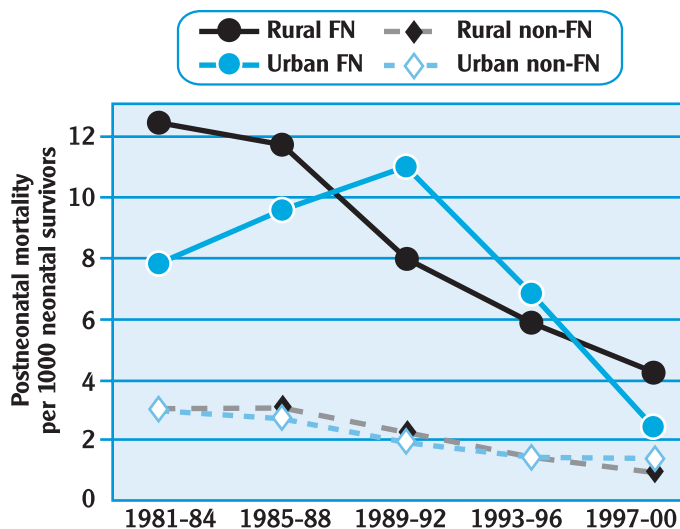


Figure 2 – Neonatal and postneonatal mortality among First Nations (FN dots) versus non-FN (diamonds) infants in rural (dashed lines) versus urban areas (solid lines) of British Columbia, 1981-1984 through 1997-2000.



4.5.3 Health Status of People Living in Poor Inner City Neighbourhoods

Although it is difficult to extract information specific to First Nations people in urban settings, there are important realities of residing in inner city poor neighbourhoods that we highlight here. As we have reiterated throughout this report, it is a misconception to assume that First Nations people will necessarily reside in inner city poor neighbourhoods (Peters, 2004) and that all people living in inner city neighbourhoods are similarly disadvantaged. Further, we wish to underscore the point that health issues experienced by inner city dwellers are also experienced in every other setting, although not necessarily at the same rates.

Because of the high rates of poverty within First Nations populations, there can be high numbers of First Nations people who move into, or in and out of, poor inner city areas – for example, Winnipeg, Regina and Vancouver (Canadian Institute for Health Information, 2006). Given the well documented links between poverty and health (e.g. see Raphael, 2007), inner city residents are most likely to experience higher levels of morbidity and mortality than almost any other comparative group. Thus, while many Aboriginal people come to the city to seek a better life, many find multiple and sometimes insurmountable barriers to accessing available opportunities (Adelson, 2003). This trend may be reversing: for example, in 2001 in Winnipeg, just over 41% of the Aboriginal population lived in the inner city, down from 43% in 1996 (Aboriginal Task Group, 2004). However, statistics from the Downtown Eastside of Vancouver (DTES) continue to be disturbing in relation to the health and well-being of Aboriginal people living there.

In relation to data from the DTES, we urge great caution in interpreting these statistics as much of the research that has produced these statistics has been conducted in a way that does not always lend itself to a balanced representation of the people living in the DTES. We present them primarily to underscore the complex and disturbing reality that some Aboriginal and First Nations people experience in poor inner city neighbourhoods. For example, in the DTES, there are widespread intravenous drug use/drug addiction concurrent high rates of HIV/AIDS and high rates of homelessness (Culhane, 2003). There are also many women and men involved in the sex trade. In addition, many inner city Aboriginal people rely on foodbanks, whose available resources are often heavily dominated by low nutrient value foods (Culhane, 2003).

Culhane (2003), in her thoughtful analysis of the health and social issues that some Aboriginal women experience in the DTES, notes that Currie's "study done in 2000 estimated that 70 percent of street prostitutes working in the most dangerous and lowest paying 'tracks' in the DTES were Aboriginal women under the age of twenty-six, and most are mothers" (p. 597). She also notes that men who seek out these women are "buying license to commit violence, to degrade, and to demean women considered disposable by 'Johns' and by society as a whole" (p. 598). At the same time, some women, particularly those who are older and who have been able to heal from addiction, have emerged as important leaders and supporters of others in the DTES who have not.

4.5.3.1 HIV/AIDS

Given the high prevalence of HIV/AIDS amongst Aboriginal people in the DTES of Vancouver, we devote some specific examination to this topic. We somewhat reluctantly include it in this sub-section because of the risk of perpetuating the misconception that HIV/AIDS is only an inner city problem - which it clearly is not. However, because much of the research has been conducted in this context, we speak directly to the data and literature that is available.

In the DTES of Vancouver, HIV/AIDS rates are significantly higher amongst women as compared to men (this is *not* the case for other settings, for example Aboriginal women represent only 45% of HIV case in all Aboriginal people as reported in 'Aboriginal women with HIV/AIDS') and twice as high among Aboriginal men and women compared to non-Aboriginal people (Spittal et al., 2002). In the DTES particularly, the rate among Aboriginal people is 25.1% versus 16% for non-Aboriginal people. The burden of HIV/AIDS among Aboriginal women is clear with this group representing 25% of all cases in Canada (Health Canada, 2004). The highest risk group is Aboriginal youth ages 17-25 (Culhane, 2003). The Cedar Project, a study that tracked the health of young Aboriginal people who used injection drugs from two BC cities, HIV risk was associated with having a history of sexual abuse (Pearce et al., 2008).

To summarize, the data discussed in this section show that First Nations people living in urban settings experience the full range of health and illness patterns experienced within the wider Aboriginal population. For certain, the health of urban First Nations people lags behind the health of the general population. However, the overall health of the urban First Nations population as a whole may be better than rural and reserve populations owing to the fact that reserve populations tend to report poorer health than off-reserve populations.

Section 5.0: Determinants of Urban First Nations Health

Taking a social determinants approach, we pay specific attention to those critical social, historical, political and economic factors that support health and well-being in the broadest sense of the term. We pay particular attention the long term systemic influences on health (such as education, employment, income, social exclusion) rather than the sometimes more often considered behavioural determinants of health (such as smoking, exercise, self-care, etc.).

The collection of work on urban Aboriginal peoples' contributed by researchers and scholars (Native Women's Association of Canada, 2007b; Newhouse & Peters, 2003; Peters, 2000, 2002, 2003, 2004; Wilson & Peters, 2005) is a significant body of work that speaks indirectly to the determinants of poor health – including jurisdictional issues, historical forces, urban planning policies, and contemporary colonial bureaucratic practices. In this section, our aim is not to provide an exhaustive discussion of the full range of determinants, but rather, to discuss determinants of health that would seem to be particularly relevant in urban contexts.

5.1 The Ongoing Impact of Colonialism

The determinants of health for First Nations people in urban centres, and Aboriginal peoples more widely, cannot be understood in isolation of the backdrop of colonial relations that continue to shape access to health care, health care experiences, and health outcomes (Browne et al., 2005; Browne, Smye, & Varcoe, 2007; Browne & Varcoe, 2006). Persistent disparities in health and social status are thus entrenched in the history of relations between Aboriginal peoples and the nation-state (Adelson, 2005; Dion Stout, 2001; Kelm, 1998). For example, the continued regulation of First Nations and other Aboriginal peoples' lives through social policies embedded in the *Indian Act*, and the ongoing restrictions placed on Aboriginal self-government, land claims and economic development in many First Nations communities, shape the overall health, well-being and quality of life in communities. These, in turn, shape life opportunities, economic conditions, and the overall health and social status of First Nations individuals, families, and communities in urban areas.

The current crisis caused by extremely high rates of HIV/AIDS among women is one of the most devastating manifestations of the cumulative effects of poverty, violence, despair and intergenerational trauma, particularly in large urban centres such as Vancouver (Pearce et al., 2008; Spittal & Schecter, 2001). On the one hand, it is imperative to use statistics to leverage funds and services for prevention, treatment, and social support, and to lobby for actions to address the underlying issues associated with HIV. On the other hand, publicizing these statistics, and the risk factors associated with HIV, can perpetuate images of Aboriginal women as necessarily identified with drug and alcohol problems. Unless explicit connections are made between the high rates of HIV and the wider social and historical determinants of health, it is easy to overlook the intersecting conditions that influence these disturbing health statistics (Browne et al., 2007; Varcoe & Dick, 2008; Varcoe, Dick, & Walther, 2004). For example, in many urban, rural, and reserve settings, welfare colonialism continues to result in high rates of unemployment and dependency on meagre social assistance payments. High rates of violence, personal histories of trauma, intergenerational trauma, substance abuse, and the economic dependence of some women on the sex trade underlie the current epidemic of HIV among Aboriginal women in urban areas (Aboriginal Nurses Association of Canada, 1996; McKay-McNabb, 2006; Varcoe & Dick, 2008). These are not issues pertaining only to women, nor can persistent social and health inequities be glossed over as “lifestyle”, behavioural, or cultural issues. Rather, they are manifestations of the complex interplay of historical, social, political, and economic determinants of health. These issues continue to be highly relevant as determinants of health in urban contexts.

5.2 Socio-Economic Status, Access to Employment and Educational Levels

Indicators of socio-economic status (SES) suggest that there is greater than average polarization of urban Aboriginal populations. Some are highly marginalized and disadvantaged (e.g. nearly half, approximately 47%, of urban Aboriginal people live below the low income cut off), and others are much more favourably situated, positioned for entry into the 'new' middle class (Wotherspoon, 2003). Indeed, the Aboriginal Task Group (2004) in Manitoba explored this in more detail, and noted that urban centres tend to have high concentrations of qualified and experienced Aboriginal people whose presence opens doors to other Aboriginal people in terms of networks, contacts and spheres of influence, and in doing so fosters further opportunities for growth, development and sustainability. Hence, while urban areas are well known to attract displaced, marginalized and disadvantaged people they also have an important ability to attract, educate, house and employ the most qualified persons (Wotherspoon, 2003).

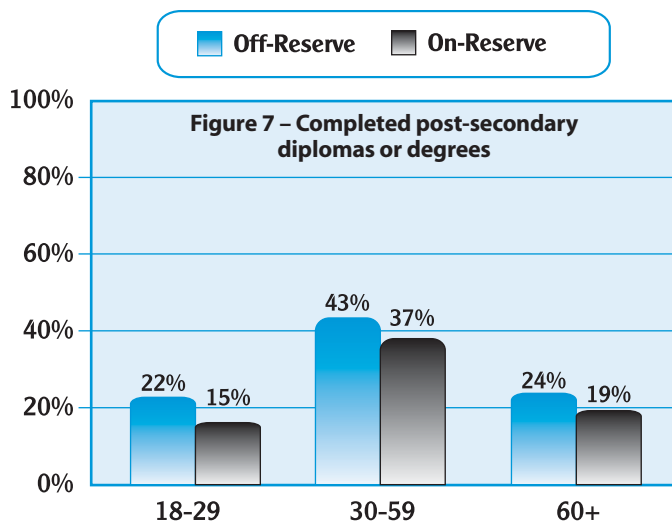
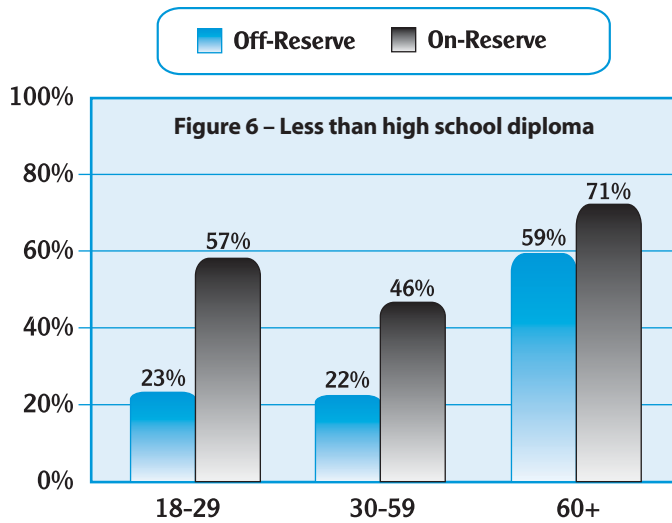
Income profiles are interesting because statistics show that off-reserve incomes are increasingly better than on-reserve but, for women living off-reserve these gains are just recently putting off-reserve women ahead of on-reserve men (Cooke et al., 2004). Currently, on-reserve men and women have approximately the same average annual income due to the fact that on-reserve men have had a flat income index over time while women have made steady gains in annual income. Conversely, a gender gap, although declining, persists between men and women off-reserve. As of 2001, the gender gap was \$2,730.

Employment opportunities in urban areas seem to be improving. A growing number of Aboriginal-focused organizations have created opportunities for employment through head offices in urban areas. There have also been an increasing number of Aboriginal people employed in urban centres in public sector jobs. In terms of representative levels, Aboriginal people occupied 4.3% of the public sector jobs in 2005 (this exceeds the representative level of 2.5%). Further, as discussed by Wien and Loxley (2003) economic development strategies have led to many entrepreneurial opportunities that have been capitalized on by urban Aboriginal people.

The data collected as part of the Eagle Eye Report (Aboriginal Task Group, 2004), provides a window onto emerging employment trends in Winnipeg. For example, the number of self-employed Aboriginal people increased 24.9% between 1996 and 2001 while the number of self-employed people who were not Aboriginal declined by 6.9% (distinctions were not made about First Nations people in particular). Aboriginal people own or operate over 1,000 businesses in Manitoba. Of these, 108 businesses that participated in a recent survey indicated that their average number of years in business is 13.5 years. And in Winnipeg (as elsewhere) Aboriginal people participate in all walks of life including business, the judiciary, education, entertainment, government and the professions (Aboriginal Task Group, 2004).

Given the recognized links between educational level and health status, we review a few key indicators here. According to the Snapshot (First Nations Centre, 2007) educational achievement is better for off-reserve populations as compared to on-reserve populations. As shown in Figure 3, there are fewer First Nations off-reserve than on-reserve with less than high school diploma in all age groups and similarly more off-reserve who have completed post secondary education. While the data for off-reserve populations is encouraging, it is important to note that educational attainment still lags behind rates for the general Canadian population (First Nations Centre, 2007).

Figure 3 – Educational Attainment for First Nations On and Off-Reserve
(First Nations Centre, 2007)



5.3 Violence Against Women

The recent NWAC (2007b) report on the social determinants of health for Aboriginal women prepared for the *WHO Commission on the Social Determinants of Health* identifies violence against women as a major determinant of health. It is very well documented that Canadian Aboriginal women experience alarmingly high rates of spousal, sexual and other violence (Native Women's Association of Canada, 2007b). While this report does not discuss First Nations women in urban contexts in particular, there is evidence that indicates that First Nations women leaving reserve communities and moving into cities are often relocating due to intimate partner violence or other forms of violence (Smye, 2007). As NWAC describes,

One of the most crucial social determinants of health which intersects with gender to such a magnitude, that it commands its own treatment, is violence against Aboriginal women. No other issue has had – and continues to have – such an impact in such significant ways as this experience affecting so many Aboriginal women, their children and families (p. 11).

Since the violence against Aboriginal women includes First Nations women – and since violence intersects with so many other determinants of women’s health and health outcomes, including premature mortality – it is imperative to consider its impact in urban contexts.

5.4 Access to Appropriate, Responsive Health Care Services

Access to appropriate, responsive primary health care (PHC) services has been identified as critical to achieving overall improvements in health status among Aboriginal populations (Adelson, 2005; British Columbia Provincial Health Officer, 2002; Canadian Institute for Health Information, 2004; Waldram, Herring, & Young, 2006). Despite this, access to PHC services continues to be problematic for many First Nations and other Aboriginal people. In urban core areas, there are high numbers of people who face major access challenges related to issues of poverty, social exclusion and discrimination (Newhouse & Peters, 2003; Tang & Browne, 2008). Increasingly, it is recognized that ‘mainstream’ models of PHC service delivery have not been sufficient in serving either Aboriginal people, or people who have been marginalized due to systemic inequities (Adelson, 2005; Dion Stout, Kipling, & Stout, 2001; National Aboriginal Health Organization, 2002, 2003).

Despite efforts to provide culturally appropriate health services, many Aboriginal people continue to experience barriers to accessing health care (Adelson, 2005; British Columbia Provincial Health Officer, 2002; Canadian Institute for Health Information, 2004). Research continues to show that tacit and sometimes overt discriminatory practices and policies continue to marginalize many Aboriginal people in the mainstream health care system (Benoit et al., 2003;

Browne, 2005, 2007; Browne & Fiske, 2001; Culhane, 2003; Dion Stout & Kipling, 1998; Dion Stout et al., 2001; Royal Commission on Aboriginal Peoples, 1996; Smith et al., 2006; Smith et al., 2005; Tang & Browne, 2008; Varcoe & Dick, 2007, 2008). These findings remind us that the micropolitics of health service delivery cannot be separated from the sociopolitical and historical contexts in which they occur. For example, Smith and colleagues' recent work (Smith et al., 2006; Smith et al., 2005) shows that safe and responsive health care is predicated on understanding the intergenerational impact of residential schools. This is not generally a feature of health care service in the mainstream health care sector.

Lavoie and colleagues (Lavoie, Forget, Rowe, & Dahl, 2008) are currently studying medical relocation as a determinant of health affecting First Nations people from reserve communities who need to relocate to cities to access specialized health services. First Nations people who relocate for medical reasons face many challenges. For example, there is a lack of inconsistent financial support; a lack of access to transportation for medical appointments; lack of suitable, affordable housing located near medical appointments; and challenges related to maintaining a connection to family and supports in their reserve communities. Given the increasing rates of chronic illness in First Nations populations, it is likely that many more First Nations families and individuals will need to relocate to urban centres to access specialist services.

In relation to specialist services, there are particular issues to consider in relation to access in urban areas. For instance, a recent study showed that while specialty arthritis services were available in an urban city in Western Canada, these services were utilized more often by rural on-reserve First Nations (who travel sometimes huge distances to access these services) rather than urban First Nations people who lived in close proximity to those services (e.g., in neighbouring urban and suburban reserve communities) (McDonald, 2007b). It may be that well organized community health centres that exist in some rural First Nations communities provide a necessary interface between First Nations people in terms of facilitating access to specialty health care services.

5.5 The Role of Urban Aboriginal Health Centres

In response to concerns about access in urban settings, there has been a move in some provinces to create alternate models of PHC delivery that are specifically tailored to the needs of Aboriginal (and non-Aboriginal people) whose needs are not well served by the mainstream sector (Healy & McKee, 2003; Lavoie, 2005; National Aboriginal Health Organization, 2002). In countries such as Canada, New Zealand and Australia, indigenous organizations have taken the initiative to become providers of PHC, and have developed agencies such as urban Aboriginal health centres (National Aboriginal Health Organization, 2002). For example, the eight Aboriginal Health Access Centres (AHACs) in Ontario, which are similar to Community Health Centres, offer a blend of traditional Aboriginal approaches to health and wellness and contemporary primary health care in a culturally appropriate setting. Programs may include: pre and post-natal care, nutrition, health education, disease prevention, and counselling (Aboriginal Healing and Wellness Strategy, 2008). These AHACs are one of 18 programs developed as part of Ontario's Aboriginal Healing and Wellness Strategy (AHWS), a policy and service initiative that brings together Aboriginal people and the Government of Ontario in a unique partnership to promote health and healing among Aboriginal people. In 1990, Aboriginal organizations and the government ministries that developed the AHWS expressed a commitment to address the alarming conditions of poor health and family violence that many Aboriginal people in Ontario experienced. Because several of these AHACs are in urban and suburban areas, they represent an important feature of primary health care for urban First Nations people.

There are other examples of urban Aboriginal health clinics opening in various other cities. However, because of our ongoing research relationships with two particular centres in BC, we draw on those as examples, realizing that there are other urban Aboriginal health clinics that deserve mention. In BC, two urban Aboriginal health centres (UAHCs), founded in BC in the mid-1990s, were also established as alternate entry points into the health care system for the explicit purpose of making services accessible to

highly marginalized Aboriginal and non-Aboriginal people in the inner cities of Prince George and Vancouver. Both evolved from the same health policy and funding context, and share the same mandates: (a) to specifically reach out to Aboriginal and non-Aboriginal people who are most severely affected by poverty, historical trauma, social exclusion, racialization and discrimination, and (b) to base their model of service delivery on indigenous approaches to health and healing. The UAHCs provide an important coordination role, helping patients to navigate through the complex networks of health and social services. They also uphold an explicit social justice agenda and work in close partnership with community agencies (e.g., low-income housing services, Aboriginal Head Start programs, shelters, and training programs) to address patients' health and social needs. As alternate points of entry into the PHC sector, these organizations are largely funded through a patchwork of project-based and short-term funding that is usually quite limited (Lavoie, 2004, 2005). They are in fact 'patches' in the system tasked with addressing persistent inequities in access, particularly for those who 'fall through the cracks.' These clinics, therefore, are important features of the urban First Nations landscape in cities.

5.6 Access to Adequate Housing

Access to affordable, safe housing is recognized as a key determinant of health. Repeatedly, health experts maintain that inadequate housing can be associated with a host of health problems (Statistics Canada, 2008a). For example, crowded living conditions can lead to the transmission of infectious diseases such as tuberculosis and hepatitis A, and can also increase risk for injuries, mental health problems, family tensions and violence. Although statistics are largely derived from First Nations people living off-reserve, there are some important trends that signal significant housing problems in urban contexts.

The 2006 census indicated that First Nations people, in general (both on-reserve and off-reserve), were five times more likely than non-Aboriginal people to live in crowded¹² homes (Statistics Canada, 2008a). More specifically, 15% of First Nations people in Canada lived in crowded housing compared with just 3% of the non-Aboriginal population. Despite these trends, the census indicated an overall reduction in crowding observed among First Nations people living off-reserve. In 2006, for example, 7% lived in a home with more than one person per room, down from 10% in 1996, however, the improvement was more pronounced in rural areas.

The census also showed that First Nations people were four times more likely than non-Aboriginal people to live in dwellings requiring major repairs. In 2006, 28% of First Nations people (both off-reserve and on-reserve) lived in a home in need of major repairs, compared with just 7% of the non-Aboriginal population (the need for major repairs was in the judgment of respondents). The poor condition of dwellings was especially common on reserves, where about 44% of First Nations people lived in a home requiring major repairs. In contrast, about 17% of off-reserve First Nations people lived in dwellings requiring major repairs, which is still more than twice the proportion of 7% among non-Aboriginal people.

Furthermore, the condition of dwellings inhabited by off-reserve First Nations people varied by place of residence. In rural areas, one-fifth (21%) of off-reserve First Nations people lived in dwellings requiring major repairs, compared with 17% of their counterparts living in small cities, and 14% living in large cities.

Among off-reserve First Nations people, 22% of those in the Yukon Territory lived in a dwelling in need of major repairs, followed by 20% each in Saskatchewan and Manitoba, and 19% in the Northwest Territories. In all four western provinces, off-reserve First Nations people were 2.5 times more likely to live in dwellings in need of major repairs than non-Aboriginal people.

5.7 Homelessness

A recent CIHI (2007) report confirms that it is impossible to determine the extent of homelessness in Canadian cities, in large part because the definitions used in various estimates differ, as do counting methods. Also, different methods for sampling or counting a city's homeless population can result in over or underestimates. Regardless of the approach used, Aboriginal people are over-represented in the homeless population in Canada (Native Women's Association of Canada, 2007a, p. 1). While disaggregated data for First Nations people were not available, the trends for the Aboriginal population as a whole raise serious concerns for First Nations people in particular.

In Winnipeg, for example, estimates suggest that between 60 – 70 % of the homeless population of Winnipeg were Aboriginal (Native Women's Association of Canada, 2007a). The experience of other urban areas is similar. In the Greater Vancouver Regional District (GVRD), the proportion of Aboriginal people in the homeless population is approximately 30%. Statistics from Toronto suggest a similar level of over-representation of Aboriginal people in the homeless population. Smaller cities also show the same pattern: for example, in Sioux Lookout, it was estimated that 99% of the homeless street population was Aboriginal.

Disaggregated rates of homelessness for First Nations people in particular are not typically reported. However, the over representation of Aboriginal people in the homeless population raises serious concerns. Reports focusing on Aboriginal people living in cities indicate, for example, that even among those who have some form of shelter, frequent changes of residence are common (Canada Mortgage and Housing Corporation, 2001). These moves can signal social, economic, or family-related problems, which in turn can be further exacerbated by frequent changes in residency. The issues related to housing and homelessness are particularly concerning given the long waitlists for social housing when people move into the cities (Aboriginal Task Group, 2004).

Many studies show that people who are homeless are more likely to experience mental illness compared to the general population. For some Aboriginal people,

the factors that influence mental health – such as histories of violence or trauma, intergenerational effects of residential school, experiences of discrimination, poverty, and persistent addictions, among others – are related to the risks of becoming or remaining homeless.

5.7.1 Homelessness and Women

As discussed in the recent NWAC (2007a) report, the experience of homelessness is different for Aboriginal women than for others. There are more women among the Aboriginal homeless population than are found in the non-Aboriginal population. In Vancouver, for example, 35% of the Aboriginal homeless population are women, compared to only 27% among the non-Aboriginal population who are homeless. Despite these higher proportions of Aboriginal women in the homeless population, services and programs are more oriented towards the male population. The availability of emergency beds and other services for Aboriginal women are limited even in the largest cities. In smaller cities and towns, services targeting homeless women are sometimes so constrained as to be virtually non-existent.

Studies have also shown that Aboriginal women and youth tend to underutilize the existing shelters or programs – many of which are located in urban settings. This may be due to structural barriers that act to exclude Aboriginal women and children (Native Women's Association of Canada, 2007a). For example, Aboriginal women who are caring for children experience even greater difficulties finding appropriate services and programs. Women with children often experience “relative homelessness” (p. 2); that is, they pay a large proportion of their income for housing, and/or live in substandard or unsafe housing. As discussed by NWAC, relative homelessness places women at risk for other issues:

The expenditure of a large proportion of their limited income on housing means that they are unable to afford food, clothing, medication or other necessities for themselves and their children. They are also at increased risk of losing their children to social service agencies, as their dwellings may be deemed to fail to meet minimum standards of safety and repair (p.2).

In urban communities, many women leave their homes, and can become homeless, due to violence in the home or the end of a relationship. The links between homelessness and mental health also reflect the experiences of some First Nations women, and NWAC (2007a) reports that Aboriginal women who have mental health or substance use issues also find it very difficult to find an emergency shelter that will offer them space.

NWAC (2007a) also identifies key structural factors that play a significant role in homelessness for many Aboriginal women. The negative impacts of residential schools on individuals and their families is a key causal factor. Other structural factors that result in homelessness or relative homelessness include:

- the shortage of housing in First Nations communities;
- low minimum wage rates and low income assistance rates;
- the lack of affordable, appropriate housing in cities and other communities;
- the condemnation or demolition of rental units, the conversion of rental units into condominiums or higher-cost rental units, and the elimination of Single Room Occupancy (SRO) units; and
- the deinstitutionalization of individuals without adequate supports, and the release of individuals from jail without adequate supports (p.2).

5.8 Community Networks in Urban Areas

The urban context itself is an important determinant of health for First Nations peoples for a number of reasons. RCAP (Royal Commission on Aboriginal Peoples, 1993), for example, identified the potential risk to cultural identity in urban areas because of the lack of accessibility to sources of Aboriginal culture “including contact with the land, elders, Aboriginal languages and spiritual ceremonies” (p. 4). These aspects of life are, for many people, fundamental to their health and well-being. First Nations people who may feel the brunt of “colliding world views” (Cajete, 2000) may experience cultural confusion, emotional pain and self-doubt (Royal Commission on Aboriginal Peoples, 1993). These have clear implications for mental, physical and emotional health (Kirmayer, Brass, & Tait, 2000).

There are also tensions that exist between loss and opportunity for First Nations people in urban areas. For example, Newhouse (2003) describes how loss can also be accompanied by emergent Aboriginal cultures, reconfigurations of cultures, and reassertion of cultural identities in urban contexts. Although many Aboriginal people continue to experience marginalization and discrimination in urban areas, others experience success. Increasingly, there is growing recognition of the contribution of Aboriginal people to the social and economic future of urban settings in Canada. At the governmental level (i.e., the federal, provincial, municipal, Aboriginal), there are also attempts to coordinate responses to the situation of Aboriginal people, through, for example, the Urban Aboriginal Strategy.¹³

Urban centres have a long history of promoting community networks primarily although not exclusively through the work of Friendship Centres (Dion Stout, 2003). Friendship centres play a pivotal role in many urban Aboriginal communities because they are often the first point of contact for people coming to the city. Not surprisingly, these Centres have grown to become integral points of connection for urban Aboriginal people and as a point of access to health and social services. As Dion Stout emphasizes, Friendship Centres influence urban health for Aboriginal peoples for several reasons: (a) as of 2003, there were 117 Friendship Centres across Canada, indicating that they are highly accessible in many centres; (b) they have a long history in the policy sphere; (c) they are known to serve a large number of Aboriginal peoples, and; (d) they are assuming an increasing role as providers of health services. Friendship Centres have also become important centres of urban Aboriginal culture; they are, therefore, central to shaping health and wellness.

Section 6.0: Jurisdictional Issues Affecting Health Care for Urban/Off-reserve First Nations Populations

6.1 Positioning Jurisdictional Issues Within the Canadian Policy Context

In Canada, as articulated by The Canada Health Act (1984), health services have been positioned as a right rather than as a commodity (Department of Justice Canada, 2008; Kluge, 1999). As a result, the Canadian government acts as a single public insurer for funding of a range of services that are deemed ‘medically necessary’, while the provincial and territorial governments are responsible for the administration and delivery of those services. However, there are exceptions to this formula; for select populations in Canada, including registered First Nations and Inuit, military personnel, the RCMP and inmates of federal prisons, the federal government bears responsibility for the delivery of direct health services (Health Canada, 2003). Because of this, in the case of First Nations peoples in Canada, jurisdictional issues abound between the various levels of government about who is responsible for what services.

Jurisdictional debates about the relative responsibilities of the federal and provincial government have been ongoing “since the British North American Act defined healthcare as a provincial responsibility and the ‘general care of Indians’ as a federal responsibility” (Bowen, 2000, p. 14). Federal governments have long argued they bear responsibility only for registered First Nations living on-reserve (and Inuit in Inuit communities) and that the provincial governments bear responsibility for all other Aboriginal peoples in Canada. Despite the consistent arguments put forward by provincial governments that the federal government is responsible for all Aboriginal people in Canada, the federal position has only softened slightly over the past many years (Hanselmann, 2003a). The current federal position affirms their primary responsibility for First Nations living on-reserve (and Inuit in Inuit communities) and acknowledges that although provinces have primary responsibility to all other Aboriginals, provinces do not bear the sole responsibility. Hence the issue of which Aboriginal people in Canada qualify for which federal Aboriginal-specific service remains a muddy one. In many cases non-registered First Nations people living

on-reserve and all Aboriginal peoples living off-reserve (except Inuit in Inuit communities) exist in a somewhat tenuous situation having, for the most part, experienced similar histories and social circumstances but having less access to available federal Aboriginal-specific services. Many Aboriginal organizations, including the AFN, have long argued that all federal Aboriginal-specific services ought to be available to all Aboriginal peoples (Assembly of First Nations, 2005; British Columbia First Nations Leadership Council, 2005; Lemchuck-Favel, 1999). Currently, that vision remains more of an ideal than a reality.

As a result of its rural and reserve orientation, the federal government has historically been very reluctant to create policies specific to urban Aboriginal people (Hanselmann, 2001). Likewise, provincial and municipal governments have been hesitant to assume responsibility. Fortunately, as thoroughly discussed in the findings of the Urban Aboriginal Initiative (Hanselmann, 2001, 2002, 2003b; Hanselmann, Nyhof, & McGuire, 2002), a project designed to understand policy and service development for urban Aboriginal people living in Western provinces, reluctance to assume responsibility has not entirely precluded policy and service development for urban Aboriginal people in Western Canada. According to their analysis, urban Aboriginal specific programming by federal, provincial and municipal governments does exist in the areas of education, training, employment, income support, economic development, health, homelessness, housing, justice, human rights, urban transition, and cultural support. However, there are few services in the area of family violence, childcare, addictions, or suicide and there are large gaps in income support, housing and urban transition. According to the findings of the Urban Aboriginal Initiative, despite the seeming abundance of policy and programming, most of these services are available in only one or a few locations. There has been no coordinated or systematic approach to ensure anything close to comprehensive coverage across the provinces. The current situation leaves urban Aboriginal peoples at a significant disadvantage in terms of policies and programs for health and wellbeing.

There are some indicators of a changing landscape in urban Aboriginal policy and programming related to health and the social determinants of health. One important initiative has been the Urban Aboriginal Strategy (UAS), a federal government strategy developed in 1997 (Indian and Northern Affairs Canada, 2008). Although the first five years reportedly delivered few outcomes (Hanselmann, 2003b), more recent infusions of money and infrastructure have a more promising feel. For instance, as reported on the Indian and Northern Affairs website (<http://www.ainc-inac.gc.ca/interloc/uas/index-eng.asp>), in 2003/4 the UAS was allocated \$50 million to fund pilot projects to support urban Aboriginal people in a few cities. In 2007, \$68.5 million was promised for the UAS over a five year period to set priorities and make a long term commitment. The UAS now is active in 12 cities including Vancouver, Prince George, Lethbridge, Calgary, Edmonton, Prince Albert, Regina, Saskatoon, Winnipeg, Thompson, Toronto and Thunder Bay. Investments are focused in three priority areas: improving life skills; promoting job training, skills and entrepreneurship; and supporting Aboriginal women, children and families. While the cash infusion appears impressive, it remains too early to assess the effectiveness of the UAS in ultimately contributing to better social and health outcomes.

6.2 Jurisdictional Issues Influencing Access to Services

Today, a First Nations person's ability to access services is determined by a complex interaction of questions of ancestry (status or not), place of residence (reserve or not), legislation (provincial and municipal), and treaty negotiations (Lemchuk-Favel & Jock, 2004). While status, residence, and treaty affect an individual's ability to access primarily federal Aboriginal-specific services, legislation and geographic jurisdiction affects an individual's ability to access provincial and municipal services. Hence, who you are and where you live are important determinants of what is available for access.

For First Nations people living in urban areas, then, access to federal Aboriginal-specific service is marked by two key factors, registered or non-registered, living on-reserve or off. For instance, a registered First Nations person living off-reserve in an urban area could be supported by Non-Insured Health Benefits to access

pharmacy, dental, and medical equipment/supplies. However, they would likely be in-eligible to receive financial support for items such as transportation to medical appointments and associated meals. Eligibility for specific programs/services, especially for registered off-reserve First Nations, has not been straightforward and much responsibility is placed on individual 'technicians' working in Health Canada offices to make decisions about eligibility. Indeed, government technicians sorting out eligibility have noted that they experience a lack of program clarity because program definitions carry ambiguities. Currently these ambiguities are sorted out on a case by case basis. Not only is this process onerous for all involved, gaps and inconsistencies are virtually unavoidable (Lavoie et al., 2008). A further restriction in the ability of registered First Nations who live off-reserve in accessing federal services is in drug and alcohol services. As noted by the CIHI roundtable (2003), registered First Nations youth on-reserve are prioritized over their counterparts living off-reserve. The roundtable results also point to access difficulties for status children living off-reserve in that the Aboriginal Headstart program has not been adjusted for the urban context because it is "micro-managed federally, does not fund parental involvement, and is not responsive to local issues" (p. 11). These gaps in services accessible to registered First Nations people on the basis of their location represent jurisdictional issues which must be addressed.

6.3 Jurisdictional Issues Affecting First Nations People Who Relocate to Urban Areas for Health-Related Issues

Canadian federal policy on supporting status First Nations people who must relocate to urban areas for medical reasons, although currently problematic, may be changing for the better. A report will be released shortly which focuses on the policy and health services gaps experienced by people who need to relocate to Winnipeg from First Nations reserve communities in Manitoba (Lavoie et al., 2008). The reasons for relocation most often relate to the need to access secondary or higher level healthcare services (e.g., oncology, rehabilitation, neonatology, dialysis services, etc.), which are typically available only in urban settings. The Manitoba report looks specifically at First Nations people who relocated to Winnipeg. However, these issues are likely occurring in other provinces as

well. For example, in Manitoba, First Nations people receiving social assistance in their on-reserve home communities, who then need to relocate to an urban centre such as Winnipeg, continue to receive social assistance support for only three months after relocation (see Figure 4). As it stands today, coverage is available only after 12 months of residency in an urban off-reserve area and only if a new permanent address reflects off-reserve residency. This runs the risk of leaving people without any source of income for a nine month period.

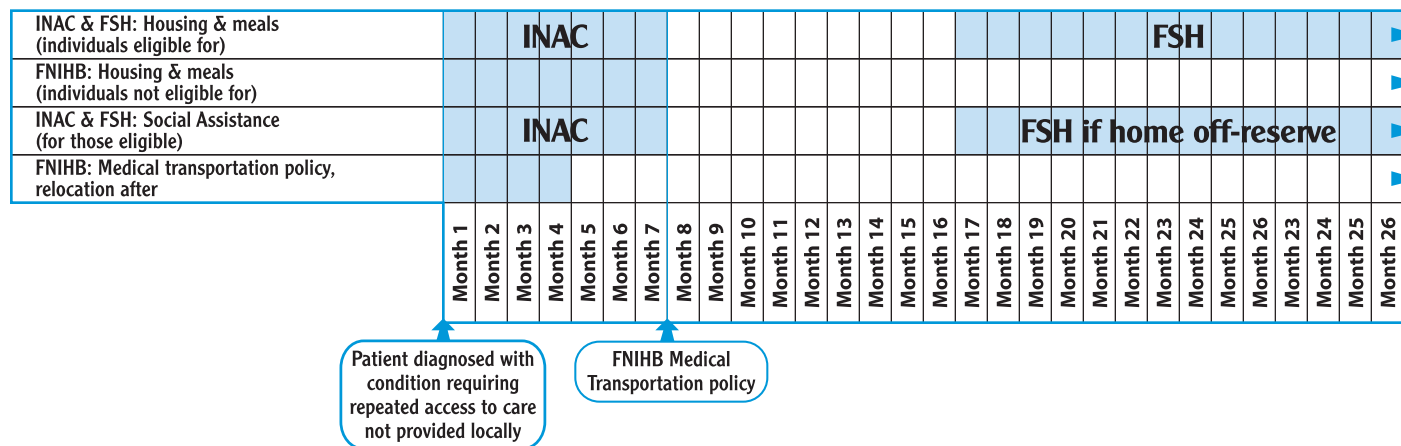
A new federal policy could potentially address part of this gap. This new policy allows INAC funding of social assistance to continue as long as the individual

is ordinarily a resident of a reserve. As such, people who relocate for medical purposes could be considered ordinarily a resident of a reserve and thus continue to receive support. However, according to the report, there is no evidence that this new policy has been implemented. Indeed implementation promises to be complex because there is currently no definition of medical relocation and no available system for INAC to deliver social assistance off-reserve. Hence, although there is movement towards policy and programming improvements to address jurisdictional issues, the real effects of any of these changes have yet to be felt. Thus, the urban Aboriginal policy vacuum described by the Royal Commission appears to be relatively intact (Hanselmann, 2001).

Figure 4 – Health Care Coverage for First Nations Relocating from Reserve to Winnipeg, MB
(Lavoie et al., 2008)

Documented jurisdictional gaps are shown in Figure 6. Coverage is represented by the shaded squares. White squares reflect a lack of coverage.

Figure 6, Without change to the INAC Social Assistance Section 2.3.2



6. 4. Self-Governance

The jurisdictional issues discussed above related largely to the federal government’s fiduciary responsibility towards registered First Nations peoples. We argue, as many have before, that the current conceptualization of this responsibility by the Canadian government is inadequate. Specifically, it disadvantages not only Aboriginal people who are not recognized as having status, but also those who are status but who currently live off-reserve and in urban areas.

The notion of self-government is often positioned as a solution to these jurisdictional issues, and there is recognition of how significant self-government is in relation to reserve communities. However, as discussed by Newhouse (2003), Todd (2003) and others, particularly in *Not Strangers in These Parts* (Newhouse & Paters, 2003), models of self-government in urban areas are complex and fraught with the difficulties associated with bringing together diverse groups of people. Thus, the question, ‘What would self-government look like in an urban context?’ continues to warrant ongoing exploration.

Section 7.0: Trends in Urban/Off-reserve First Nations Health Research

There are several trends in health research that have shaped the type of information and knowledge generated in relation to urban First Nations health and health care. The following summarizes selected key trends.

7.1 Prevalence of Population Level Survey-Based Information

Published information that provides a window onto urban First Nations health – that is, information that is largely based on off-reserve First Nations’ health – tends to be derived from analyses of large population-based datasets (e.g., the census, the APS), and descriptive compilations of quantitative measures of health and social status (the CCHS). These provide description of trends and patterns in health and illness, and self-perceived ratings of health status and well-being. The limitations of using as the sole proxy for urban peoples’ health have been discussed elsewhere. Nonetheless, because off-reserve data is highly accessible and in the public domain (for the most part), it is drawn on most often by policy makers, university researchers, the media, and health authorities.

In relation to self-reported survey-based prevalence rates, Bartlett (2005) has issued a note of caution. She argues that, because little is known about how diverse groups of Aboriginal people may interpret some of the survey questions, particularly in comparison to the total Canadian population, there is the potential for misinterpretations of the data collected. As Bartlett (2005) writes, “Most health survey questions, even in Aboriginal-driven surveys, have not been validated for congruency with Aboriginal culture” (p. S22). This lack of congruency has the potential to lead to inaccurate results. Unfortunately, the degree to which results may be inaccurate, and the direction of the inaccuracy (e.g. whether the lack of congruency result in higher or lower reported rates) is unknown (McDonald, 2008).

7.2 Focus on Lack of Services

There tends to be a focus in urban health research on the ‘problems of lack’ (Newhouse, 2003); that is, lack of access to appropriate health services, lack of social supports, lack of health care that respectful and non-discriminatory, lack of opportunities, etc. While these are helpful in identifying areas for solutions that can fill particular deficiencies, less is devoted to health research on ‘what may be working’ in urban health contexts to support health. In addition, much of this research stops at description and fails to adequately analyze the ‘*reasons for the lack*’ in ways that are comprehensive and critical. This is identified in Section 8 as an important area for future research.

7.3 Focus on HIV/AIDS and Addictions in Poor Inner Cities

In BC, there are productive programs of research based on epidemiological studies that focus on the interrelated risk factors for HIV/AIDS among Aboriginal people who use injection and non-injection drugs in inner cities in BC (Craib et al., 2003; Pearce et al., 2008; Spittal et al., 2005; Spittal et al., 2007; Spittal & Schecter, 2001; Wood et al., 2007; Wood et al., 2008). This research has been particularly important in generating epidemiological evidence of the correlations between historical trauma, violence, sexual abuse, impoverishment, and drug addictions. These research programs have been, and will continue to be, successful at providing evidence-based data. This data can (potentially) be used in policy sectors, by governments, and by leaders in the urban health care sector to promote safe injection practices, policy changes in addictions treatment, and best practices in treatment protocols for HIV/AIDS care and prevention.

7.4 Focus on Inner City Populations

There is a dominant public perception in Canada that the life circumstances of urban First Nations people are necessarily linked to impoverished inner city areas. While this is true in some inner cities, this would not accurately represent many urban First Nations people. The health research literature tends to mirror this public perception. For example, although some have suggested that urban First Nations people are the least studied, it appears paradoxically as if the urban Aboriginal community in Vancouver's DTES (as one example) may be among the *most* studied. The intense surveillance of the community due to unprecedented rates of HIV and Hepatitis C infection and a public illicit drug market, has resulted in a multitude of research. However, within these studies, First Nations health has often been limited to 'Aboriginal identity' as a risk factor in epidemiologic analyses.

The focus in health research on inner city populations (often as the proxy for urban First Nations health) raises additional concerns. Focusing on particular geographical areas within cities can shift the focus away from the broader determinants of health disparities, or the policy decisions that underlie health or health care inequities. Furthermore, as Peters (2004) identifies, if First Nations people are assumed to be concentrated in particular neighbourhoods, then it is easy to assume that their concerns are not relevant in other neighbourhoods. This can lead to inequities in the allocation of health or social services.

Section 8.0: Suggested Areas for Future Research

The lack of research specific to First Nations people in urban contexts represents a significant gap in the health research literature. However, there is a meta-level question that could be asked when considering areas for future research: this pertains to why it may (or may not) be important to focus on First Nations people in particular, as a unique group within the wider group of Aboriginal peoples living in urban settings. Research addressing this kind of meta question will require the expertise of indigenous scholars and researchers, people living in urban communities, organizations involved in urban health service delivery, leaders in the field of Aboriginal health, social scientists and health researchers.

As Newhouse (2003) describes, policy and health care responses have often been based on assumptions and misconceptions about the nature of the urban Aboriginal experience. It will be important, in terms of mobilizing research for action, that a range of methodological and theoretical approaches be used to explore the complex facets of First Nations peoples' health and well-being in urban contexts. The following are suggested areas for future research that would address specific gaps in the current state of knowledge.

8.1 Forming Sustainable Research Partnerships with Urban Aboriginal Health Centres and Organizations

In urban settings, urban Aboriginal health centres, Friendship centres, and social service organizations are integral to health care systems in urban settings. They are instrumental in helping to identify health research priorities; they could also be central players in health research partnerships in urban settings. The general lack of resources that plagues many of these organizations, however, means that many will not have the infrastructure or human resources to engage in the research process independently. Most organizations will need to devote their energy, human resources, and funding to direct service provision. Thus, without adequate funding for research – in addition to adequate funding for direct service provision – opportunities for these organizations to control and lead the research will be constrained.

While such centres and medical clinics may well be critical sites of research for exploring urban First Nations health issues, a legitimate concern is that such sites will become venues for academic or government research projects without meaningfully involving the organizations or patients/participants in the research process. In sites such as Vancouver's DTES, where there is an abundance of research projects exploring urban health issues, one concern is that such organizations are simply used as "farms" to feed participants to university-based research projects. To counter this disturbing trend, it will be critical for organizations to be more adequately funded so that they can engage in research and be positioned as leaders and experts in the research process. In the interim, other creative ways of foregrounding the knowledge and expertise existing in these agencies within the research process must be explored.

8.2 Focusing on Urban Communities and Urban Living as Sources of Opportunity and Support

In formulating research agendas and ideas, Newhouse and Peters (2003) emphasize, "what is important is that we begin to see urban Aboriginal peoples both as individuals and communities, with interests, aspirations, needs and goals, and objectives that they wish to pursue within the urban landscape rather than as objectives of public policy or victims of colonization or displacement" (p. 9). Because health literature tends to focus on issues of loss, marginalization, and lack of access to services, more consideration needs to be given to the factors that promote health and healing in urban settings, both at the individual and community levels. For example, studies are needed that explore the processes that support health and healing – that is, the strategies used by people to stay healthy, mobilize social support, and develop a sense of community in urban settings. Newhouse (2003) and Peters (2004) also emphasize that more research is needed to better understand how moving into cities can represent opportunities for reinforcement of cultural identities and resiliency. These are all significant determinants of health which have remained relatively unexplored in relation to urban First Nations peoples' health and healing.

8.3 Urban Health and Indigenous Knowledges

As Dion Stout (2001) has argued, “until very recently, Western scientists and scholars paid little attention to the validity of non-Western indigenous knowledge. Since indigenous knowledge generation does not use the same methods of data collection, storage, analysis and interpretation as the scientific tradition, those trained in the scientific tradition have great difficulty in acknowledging the validity of data generated in unfamiliar ways” (p.2). In the area of urban First Nations health, learning from, and acting on the knowledge developed by indigenous scholars, researchers, community members and leaders will be critical to understanding the full range of experiences shaping the health of First Nations people in urban settings, and also, pathways to healing. This will require explicit commitments within the health research community (and in relation to research funding) to seek out and support indigenous knowledges, and the “indigenization” of research processes (Dion Stout et al., 2001, p. 1).

8.4 Health Care Delivery Approaches in Urban Contexts

Studies in the field of Aboriginal health have tended to focus on the barriers to healthcare, and the negative experience of people with healthcare systems, providers and structures. What has been less well studied are approaches to service delivery that may be effective in increasing access to services for First Nations people in urban contexts. As Dion Stout (2003) writes, a research question requiring close examination is “what are the most appropriate health services for First Nations people who live in urban areas?” (p. 8)

More needs to be known, for example, about the approaches to service delivery that are effective in increasing access to services, particularly for First Nations people who may be moving in and out of urban contexts. In part, such work is constrained because current frameworks for studying and tracking health services have been developed in the context of mainstream delivery models. Research that explores what services are needed, how best to track them, and how best to provide them, continues to be needed.

8.5 Indicators of Primary Health Care (PHC) Relevant in Urban Contexts

The current emphasis in Canada (and internationally) on the need for greater accountability in PHC has an influence on the Aboriginal health service sector. Urban Aboriginal health centres, Aboriginal community access centres, and other agencies are under increasing pressure to conform to PHC performance indicators and measures of accountability. As leaders in Aboriginal health have noted, there is a lack of understanding of what PHC indicators would look like if they were to reflect or relate to indigenous perspectives on health, healing, and service delivery, or take into account the context of community-based Aboriginal service delivery (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006; Giles & Findlay, 2002; Jeffery, Abonyi, Labonte, & Duncan, 2006; National Aboriginal Health Organization, 2003; Smylie, Anderson, Ratima, Crengle, & Anderson, 2006). Without a better understanding of what PHC indicators may be most meaningful in indigenous health care contexts, the capacity to measure the effectiveness of services may be constrained. This is an area of research that is likely to take on increasing importance as urban Aboriginal health centres compete with other agencies to demonstrate their “effectiveness.”

8.6 Impact of Moving To and From Cities and Reserve Communities

There have been few studies focused on the impact of moving frequently between urban and rural or reserve communities on health and continuity of health services. This warrants further research, particularly given the potential impact on continuity of care in relation to health service delivery, the ability to maintain connections with networks of support, and the ability to access housing, social assistance, child care, etc.

Currently, Lavoie and colleagues (Lavoie et al., 2008) at the Manitoba First Nations Centre for Aboriginal Health Research are engaged in a research program focused on the issue of medical relocation to urban centres for First Nations people from Manitoba reserve communities. Although the raw numbers of people requiring relocation from reserve communities to urban settings for issues such as homecare, long-term care, palliative care or dialysis (among others) are still relatively small, these numbers are expected to increase in concert with the rise in chronic illness incidence and prevalence (Lavoie et al., 2008). These are issues that will require ongoing exploration in specific contexts in urban centres if health and social services are to be responsive to the unique health and social needs of First Nations people who relocate from reserve communities.

8.7 First Nations Women’s Health in Urban Contexts

The intersecting risks of high rates of poverty, single parenting, and experiences of violence for First Nations women highlight the importance of research that builds in intersectional analyses in the area of First Nations women’s health. Research is needed to explore – and ultimately, disrupt – the mechanisms that underlie these key determinants of health for women. Research is also needed to better understand the kinds of supports and services that women need in urban settings. For example, little is known about the process of relocating to the city for women leaving intimate partner violence, or what constitutes “support” and safe, effective care for First Nations and Aboriginal women (Smye et al., 2007). These issues (and others) are of pressing concern in many different urban contexts. NWAC (2007a) has also identified the need for research initiatives to address the systemic causes of women’s homelessness as a priority area for research. Although this recommendation pertains to Aboriginal women more generally, the issue of homelessness and housing has particular relevance for First Nations women in urban contexts.

8.8 Managing Chronic Illness and Mental Health Issues in Urban Settings

Given the rising numbers of people in the First Nations population who are (or who will be) experiencing multiple chronic illness such as arthritis, diabetes or heart disease, an under explored area of research is how First Nations people navigate within the health care system. In particular, attention needs to be paid to how First Nations people access needed services such as community health, rehabilitation, specialist services, and the extent to which people may “fall through the cracks.” Mental health services are particularly lacking for Aboriginal people in urban settings (Smye, 2004). More research is needed to explore the full impact of the lack of mental health services – and the kinds of policy and organizational changes that need to occur to ensure greater availability of appropriate, responsive mental health services in urban settings.

Recent research also has shown that despite the proximity of some services in urban settings, compared to rural areas, utilization of some specialist services by First Nations people continues to be low (McDonald, 2007a, 2007b, 2008). Research is needed to explore the factors that may be shaping the under-utilization of services - for example, the sense of alienation that some people experience in the dominant health care system, among others. Studies are also needed to better understand – and rectify – the full impact of the lack of continuity of care for those with chronic illness and mental health issues. This is particularly important for people who move back and forth between health care regions, and whose medical records may or may not ‘follow’ them as they attempt to seek services.

8.9 Ethical Issues in Research in Urban Contexts

There are a number of important ethical issues to explore in future research, which are still relatively “understudied” in relation to urban contexts. A recent paper by Glass and Kaufert (2007) explores several areas of consideration. One that is particularly significant relates to the implications of ownership, control, access and possession (OCAP) in urban health research (First Nations Centre, 2003).

OCAP principles are often discussed in relation to research within First Nations communities (e.g., on-reserve communities). However, these principles are likely to hold a different set of implications in urban communities where there are diverse groups of First Nations and Aboriginal people residing. Given this layer of complexity in urban contexts, questions to explore in future research could address:

- who constitutes the “community” in urban settings?;
- how is the diversity of people in urban settings accounted for in relation to “community consent”;
- what does community consent mean in urban contexts?; is it possible? ;
- how is community or individual ownership of data addressed when diverse communities of people, leadership and organizations are involved?;
- who can reasonably be involved in community reviews of research protocols in urban contexts?
- once community is defined, how are the relevant authorities within the community to be ascertained when multiple authorities may be involved?

These are issues that will require ongoing consideration in specific contexts in order to tease out the full range of ethical implications involved.

8.10 Applying Research to Improve Health Services, Policy and Health Outcomes

To address persistent inequities in health and social status, research will need to make the visible linkages between past and current inequities, the root causes of those inequities, and strategies for redressing injustices in urban contexts. At the same time, there continues to be concern in the Aboriginal health sector about the ability to affect change in today’s political and policy climate (Native Women’s Association of Canada, 2007b). Thus, research that is explicitly praxis-oriented will be critical to achieving social change. This will require meaningful collaborations between Aboriginal leaders and researchers, policy-makers, health services leaders, urban communities and organizations, community members, and university researchers. Through meaningful collaborations – and by bringing together various perspectives and sources of knowledge – it will be possible to work toward greater equity and social justice in the area of First Nations and Aboriginal peoples’ health.

List of Acronyms

Acronyms which appear more than once in the preceding report are included in the list below.

ACS – Aboriginal Children’s Survey

AFN – Assembly of First Nations

AHAC – Aboriginal Health Access Centre

AHWS – Aboriginal Healing and Wellness Strategy

APS – Aboriginal Peoples’ Survey

CA – Census agglomeration

CCHS – Canadian Community Health Survey

CIHI – Canadian Institute for Health Information

CMA – Census metropolitan area

DTES – Downtown Eastside (of Vancouver)

FNC – First Nations Centre (National Aboriginal Health Organization)

FNIHB – First Nations and Inuit Health Branch

HIV/AIDS – Human Immunodeficiency Virus
Acquired Immunodeficiency Syndrome

IMR – Infant mortality rate

INAC – Indian and Northern Affairs Canada

NAHO – National Aboriginal Health Organization

NWAC – Native Women’s Association of Canada

OCAP – Ownership, Control, Access and Possession

PHC – Primary health care

RCAP – Royal Commission on Aboriginal Peoples

RHS – First Nations Regional Longitudinal Health Survey

SIDS – Sudden Infant Death Syndrome

UAHC – Urban Aboriginal Health Centre

UAS – Urban Aboriginal Strategy

UNHDI/HDI – United Nations Development Human
Development Index

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Endnotes

- ¹ The APS attempts to reports on the total Aboriginal population in Canada. It combines two populations. The ‘Aboriginal identity’ population those self reporting to being North American Indian, Métis and/or Inuit OR having status as a registered or treaty Indian OR having band or First Nations membership. The ‘Aboriginal ancestry’ population includes respondents who reported having ancestors that belonged to an Aboriginal group (Statistics Canada, 2003b).
- ² Statistics Canada (2008a) defines First Nations in the following way: as respondent who self-identified as ‘North American Indian; however, the term ‘First Nations people’ is used when referring specifically to this group of people. Although both single and multiple responses to the Aboriginal identity question are possible, only the population reporting a single response of ‘North American Indian’ is included in their statistics about First Nations people.
- ³ The CCHS asks respondents questions that lead to the construction of an Aboriginal ancestry population and an Aboriginal identity population (see <http://www.statcan.ca/english/concepts/health/pdf/sociodemog.pdf>). As such, people who draw on the CCHS have the option of using either or both. Since the CCHS data is widely used in reports of all sorts, it becomes important to clearly examine each individual report to determine how the CCHS data is being used.
- ⁴ For example, a recent report on urban Aboriginal children (Longfield & Godfrey, 2003) found that according to INAC estimates, Aboriginal children are four to six times more likely than their non-Aboriginal counterparts to come into the care of child welfare. Of greater concern is the fact that the number of Aboriginal children in the care of child and family services continues to increase dramatically. Rates specific to First Nations children in urban areas were not easily locatable.
- ⁵ In January 2009, the Aboriginal Peoples Survey published School Experiences of Off-Reserve First Nations Children Aged 6-14 (see http://dsp-psd.pwgsc.gc.ca/collection_2009/statcan/89-637-X/89-637-x2009003-eng.pdf).
- ⁶ For instance, First Nations and Aboriginal peoples are absent from the City of Toronto’s housing report (City of Toronto, 2003).
- ⁷ For example, the Alberta Native Friendship Centres Association; the Indian and Métis Friendship Centre of Winnipeg; the Odawa Native Friendship Centre, or the Native Friendship Centre of Montreal; the Vancouver Aboriginal Friendship Society and the Lu’ma Native Housing Society in Vancouver, British Columbia. These organizations would potentially also offer critical information on demographics and the social determinants of health.
- ⁸ For example, provincially funded health clinics specifically targeting urban Aboriginal people exist in BC, Manitoba, and Ontario (Lemchuk-Favel & Jock, 2004). Anishnawbe Health Toronto; Wabano Centre for Aboriginal Health in Ottawa; the Aboriginal Health Access Centres in cities and smaller regional centres in Ontario; the Aboriginal Health and Wellness Centre in Winnipeg; the Vancouver Native Health Society in Vancouver; and the Central Interior Native Health Society in Prince George, BC.
- ⁹ For example, the Complete HIV Care for Native Urban People (CHCNUP) Project at Vancouver Native Health Society, and the Aboriginal Health and Healing (AHAH) research project (Krawczyk et al., 2007).
- ¹⁰ The UNDP methodology for calculation of the HDI involves calculating three separate sub-indices; life expectancy, educational attainment, and GDP, which are combined to form the Human Development Index (United Nations Development Program, 2000). Each of these sub-indices is essentially a measure of the distance between the actually achieved scores and theoretical minimum and maximum scores. To account for the diminishing marginal utility of income, the UNDP currently uses a log formula to discount GDP per capita in the calculation of the GDP index (UNDP, 2000). Each of the three sub-indices are given equal weight in the Human Development Index, which will have a positive value, to a maximum of 1.0 (Cooke et al., 2004, p. 5).
- ¹¹ In October, 2008 Aboriginal Children’s Survey, 2006: Family, Community and Child Care was released, examining the topics of family, community, and child care of Aboriginal (off-reserve First Nations, Métis and Inuit) children under six years of age (see <http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?lang=eng&catno=89-634-X2008001>).
- ¹² Crowding was defined as more than one person per room.
- ¹³ The Urban Aboriginal Strategy (UAS) is a federal government strategy developed in 1997 (see Indian and Northern Affairs Canada, 2008). The UAS is discussed further on page 44 of this paper.



National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
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