THE HEALTH OF ABORIGINAL PEOPLE RESIDING IN URBAN AREAS

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INTRODUCTION

Aboriginal people in Canada are increasingly urbanized, especially in western Canada (Peters, 2004); indeed, more than half live in urban cities and towns. Despite this recognized and growing trend, the health of Aboriginal people residing in urban areas is not well understood. It is a demographically and culturally diverse population that is also relatively mobile in ways that do not fit dominant migration models. Furthermore, data describing the population of Aboriginal people residing in urban areas are sparse. In the context of current patterns of urbanization and mobility, this paper examines available data and literature to describe in general terms the overall health status of this population. The objective is to provide an overview of the issues that affect the provision of health services for this population, and to provide some direction for the provision of health care services for Aboriginal people residing in urban areas.

This paper can be conceptualized as covering three broad areas: first, it discusses the urbanization of the Aboriginal population and identifies its characteristics and patterns; second, it provides an overview of health issues specific to the urban Aboriginal population; and third, it examines health services. The paper begins by defining key terms. It then moves into a discussion of current patterns of urbanization and an overview of the composition of the urban Aboriginal population. A literature review on health indicators relevant to urban Aboriginal populations that pays particular attention to social determinants of health follows, and available data on health outcomes of Aboriginal people residing in urban areas comes next. The paper then shifts to health services. Here, health care utilization data are reported, and the impact of urbanization, health status, and other issues on the provision of health services is examined. Finally, in order to provide a sense of how well urban centres are addressing the health needs of Aboriginal people residing in urban areas, an overview of health related services in two urban centres – Vancouver, British Columbia (BC) and Winnipeg, Manitoba (MB) – is provided. In lieu of an extensive tabulation of services nation-wide (which is beyond the scope of this report), these two examples are used to provide a general sense of the types of health services that are available and to identify some gaps. The paper concludes by highlighting the complexity involved in determining both health outcomes and health service needs, identifying gaps in knowledge, and suggesting directions for future research.

2. KEY TERMS AND DEFINITIONS

This paper focuses on Aboriginal people residing in urban areas. Aboriginal people "is a collective name for the original peoples of North America and their descendants" (INAC, 2002). Aboriginal people include First Nation, Inuit and Métis people regardless of whether they live on-reserve or off-reserve, or whether they have *Indian Act* status or not (NCCAH, n.d.). While it is common to employ the term 'Aboriginal peoples' to emphasize the diversity present in the group known as Aboriginal people (i.e. diverse origins and identities), this paper uses 'Aboriginal people' as referring to more than one Aboriginal individual, and recognizes the diversity among Aboriginal individuals and collectives (INAC, 2002).

Statistics Canada defines 'urban areas' as places that have a "population of at least 1,000 and no fewer than 400 persons per square kilometer" (Statistics Canada, 2002a). A census agglomeration (CA) has an urban core population of 10,000 people and census metropolitan areas (CMAs) are those large centres with an urban core population of at least 100,000 (Statistics Canada, 2002b).

A reserve is land held by the Crown for the use and benefit of a First Nation (INAC, 2002). Residents of reserves are often referred to as living 'on-reserve' while Aboriginal people who do not live on a reserve are referred to as living 'off-reserve.' There is an association between on-reserve and rural, and off-reserve and urban, although these terms do not perfectly align. Approximately 76% of Aboriginal people living off-reserve live in urban areas (Statistics Canada, 2008a), and there is also a small population of Aboriginal people residing on reserves located in urban areas. Data for Aboriginal populations tends to follow the on-reserve/off-reserve divide, rather than the rural/urban divide. Thus, although off-reserve is acknowledged by researchers as being different from urban, it is often used as a proxy for the urban population and the limitations associated with doing so are acknowledged in this report.

The data and literature that this paper draws on varies in how populations and geographies are defined. However, up-to-date data specific to Aboriginal people residing in urban areas remains scarce, and thus, it was necessary to synthesize information from a variety of sources for the purpose of identifying general trends in health and health care for this population.

3. URBANIZATION, MOBILITY AND COMPOSITION

The urbanization of Aboriginal people involves their movement from more rural (often on-reserve) communities to urban (usually off-reserve) centres. This section begins with an introduction to the urbanization of Aboriginal people and the growth of the urban Aboriginal population in Canada. The discussion then turns to patterns of rural-urban mobility and the various factors that influence it. Finally, information describing the composition of the urban Aboriginal population is provided.

3.1 Urbanization of the Aboriginal Population

According to the 2006 Census, the number of people who identify as Aboriginal in Canada is 1,172,790 (nearly 4% of the total population of Canada). Of this population, 54% live in urban centres (compared to 81% of the non-Aboriginal population), an increase from 50% in 1996 (Statistics Canada, 2008a). The population of Aboriginal people in urban areas began to increase in the 1950s; prior to that time, the proportion of Aboriginal people residing in urban areas was relatively low (Norris & Clatworthy, 2011). The 1951 Census, for example, indicated that only a few

hundred Aboriginal people resided in any given metropolitan area, amounting to approximately 7% of the total Aboriginal population in Canada (Norris & Clatworthy, 2011; Peters, 2004). In the decades that followed, however, steady growth of the Aboriginal population in urban areas was reported (Norris & Clatworthy, 2011), and in recent years, the increase in the proportion of Aboriginal people residing in cities has been 'dramatic' (Browne et al., 2009).

Compared to the non-Aboriginal population, Aboriginal people residing in urban areas tend to live in smaller cities, or "centres smaller than a census metropolitan area" (Statistics Canada, 2008a, p. 13). For example in 2006, 53% of the urban Aboriginal population lived in census metropolitan areas compared to 80% of non-Aboriginal urban dwellers. With respect to the off-reserve Aboriginal population, both the 1996 and 2006 Census found that approximately 76% of off-reserve First Nations people lived in urban areas (Statistics Canada, 2008a). Of the 22% of Inuit people who live outside the four regions within Inuit Nunangat, 17% reside in an urban setting (Ibid.). Nearly 70% of people of Métis descent lived in small to large urban centres (Ibid.).

Urbanization of the Aboriginal population is considered a "western Canadian phenomenon" (Browne et. al., 2009; see also Peters, 2004; Graham & Peters, 2002; Tjepkema, 2002). The cities with the highest numbers of Aboriginal people in Canada are Winnipeg, Edmonton and Vancouver; however, these numbers do not necessarily equate to a large proportion of the total population in those cities (Statistics Canada, 2008a). In some smaller cities the proportion of the population identifying as Aboriginal is much higher. For example, 36% of the population of Thompson, Manitoba identify as Aboriginal, and in Prince Rupert, British Columbia, Aboriginal people account for 35% of the population. Table 1 lists the population of Aboriginal people as a number and percentage for ten selected Canadian cities.

3.2 Patterns of Rural-Urban Mobility in the Aboriginal Population

Analysis of rural/on-reserve to urban/off-reserve mobility often draws on theoretical frameworks aimed at understanding the experiences of non-Aboriginal migrants (Peters, 2004). Peters (2004) argues that this has led to a series of misconceptions about Aboriginal people residing in urban areas: "that they are leaving reserves and rural Métis communities to live in cities; that they are forming impoverished ghettos in inner cities; and, that they face insurmountable challenges in building culture and community in urban areas" (p. 2). Peters (2004) argues that a more nuanced approach to Aboriginal urbanization is required to understand the experiences (and the health status) of Aboriginal people residing in urban areas.

Aboriginal urbanization is largely a function of historical conditions, and thus, "patterns of urbanization for Aboriginal people are not like other migrants to cities in Canada" (Browne et al., 2009, p.3). The

locations of many Canadian cities coincide with the places where Aboriginal people had historically settled and gathered, but colonial processes of deterritorialization often worked to remove Aboriginal people from newly developing urban areas (Peters, 2004). These colonial strategies ranged from locating reserves at a distance from urban centres to implementing regulations and pass systems that kept Aboriginal people out of cities. Thus, "urbanization patterns are linked to actions that removed Aboriginal people from emerging urban areas," and indeed, unlike other migrants, many Aboriginal people residing in urban areas are in fact residing in their traditional territories (Ibid., p. 3).

Graham and Peters (2002) state that "Aboriginal people are considerably more mobile than non-Aboriginal people" (p. 13); however, migration patterns are neither straightforward nor unidirectional. As Peters (2004) points out, "[t]he migration picture is complicated. Net migration (differences between in and out migration) varies by

place (reserves, rural places, smaller and larger cities), and by Aboriginal group (Registered Indian, non-status Indian, Métis and Inuit)" (p. 4). Reserves have had a net inflow, rural areas and smaller cities a net outflow, and larger cities have experienced both net inflow and net outflow in different years. Thus, the growth of the urban Aboriginal population cannot be entirely attributed to an exodus from reserve and rural communities to cities as Aboriginal people also leave cities in favour of reserves or traditional Inuit communities; "[i]nstead, there is circulation between reserves/rural areas and urban areas" (Graham & Peters, 2002, p. 13). Graham and Peters (2002) have further argued that high mobility rates should not be interpreted to mean that migration from rural and reserve areas is the main contributor to the growth of urban Aboriginal populations (p. 13). Higher fertility rates among Aboriginal people may explain some of the increase in Aboriginal people residing in urban areas, but more likely it is legislative changes (such as Bill C-31 which reinstated individuals who lost their status) as well

Table 1: Number and Percentage of Aboriginal Identity Population in Selected Cities, 2006		
City	Aboriginal Population	Percentage of Total Population
Winnipeg	68,380	10
Edmonton	52,100	5
Vancouver	40,310	2
Toronto	26,575	0.5
Calgary	26,575	2
Saskatoon	21,535	9
Ottawa-Gatineau	20,590	2
Montreal	17,865	0.5
Regina	17,105	9
Prince Albert	13,565	34

Source: Statistics Canada, 2008a

as an increase in self-identification that are behind most of the growth in census counts of Aboriginal people (Peters, 2004; Graham & Peters, 2002; Guimond, 2003; Siggner, 2003).

The urban Aboriginal population is relatively mobile and an important aspect of this mobility is that movement occurs both between rural and urban areas, and within urban areas. This is often referred to as the 'churn factor' or 'churn' (Norris & Clatworthy, 2003; Longfield & Godfrey, 2003). For example, between 1991 and 1996, 70% of Aboriginal people living in large urban centres moved, and 45% of those were moving within the same community (compared to 50% and 20% respectively for their non-Aboriginal counterparts) (Graham & Peters, 2002, p. 14). Of note is that "[r]esidential mobility rates were highest for women and lone-parent families, and house-related issues were the most common reasons for moving" (Ibid., p. 14). Mobility between rural and urban locations, however, is often driven by the desire to maintain close ties with rural and reserve communities, and is not necessarily the result of any failure to thrive in urban places (Browne et al., 2009).

For Aboriginal people who choose to move into urban areas, there are several factors influencing their decision. These are related to: education, employment, living conditions, socioeconomic status, housing, domestic violence, proximity to health services, and the perception that city life is more stimulating (Levesque, 2003; Newhouse & Peters, 2003; Peters, 2004; Royal Commission on Aboriginal Peoples [RCAP], 1993, 1996; Nuffield, 1998). Cities can represent greater access to education and employment opportunities, as well as the promise of improved living conditions and better socioeconomic status. In some reserve communities, access to adequate housing is a problem and movement to urban centres may be driven by these housing shortages. In cases of domestic violence, women and children are often forced to leave their homes and even their communities in search of housing and safety. Finally, health services – especially specialty health services – are usually located in urban centres; for some, moving to an urban centre is driven by the need to be near such services.

Peters (2004) states that "while cities have attracted Aboriginal migrants because they provide more services and greater educational and employment opportunities, they also represent environments in which some Aboriginal people experience racism, poverty and problems finding houses" (p. 5). Indeed, Silver (2006) argues that urban Aboriginal people feel just as isolated from mainstream Canadian society as on-reserve Aboriginal people do. He notes that in Winnipeg, for example, Aboriginal people are rarely seen working in suburban retail shops or in the service sector (p. 17). This kind of social exclusion leaks into other arenas as well (e.g., schooling, housing etc.). Although they are not considered 'ghettoized', Aboriginal people are found in the lowest income neighborhoods of a city, and they are disproportionately represented in penal systems and treatment centres (La Prairie & Stenning, 2003). In other words, there are complex factors affecting mobility and it cannot be assumed that urbanization always improves the health outcomes of Aboriginal people. Despite the lack of services and opportunities in rural reserve communities, they are an important site of social and cultural connection that is critical to well-being.

3.3 The Composition of the Urban Aboriginal Population

The urban Aboriginal population is culturally diverse and "fragmented by legislative distinctions" (Graham & Peters, 2002, p. 14). In 2006, 50% of the urban Aboriginal population was First Nation, 43% was Métis and 17% was Inuit (Statistics Canada, 2008a). Within these three broad categories, there are also individuals who may or may not be registered under the *Indian Act* ('status'), and who may or may not have membership with a particular band (Graham & Peters, 2002).

While it must be acknowledged that Aboriginal people are disproportionately affected by poverty and thus more likely to live in lower-income neighbourhoods, it is important to emphasize that urban Aboriginal populations are not homogenous and their socioeconomic statuses vary substantially (Peters, 2004). Contrary to popular belief, the urban Aboriginal population "is neither ghettoized nor uniformly disadvantaged" (Graham & Peters, 2002, p. iii). Although there are instances in which concentrations of Aboriginal people are found in inner city neighborhoods (e.g., Vancouver's Downtown Eastside [DTES]), for the most part, Aboriginal people

reside in many different neighbourhoods within cities (Peters, 2004) and "levels of segregation [are] low to moderate" (Graham & Peters, 2002, p. 13 citing study by Clatworthy, 1996).

Women account for a higher percentage of the urban Aboriginal population than they do in the non-Aboriginal population (Graham & Peters, 2002). Table 2 indicates that in the five Canadian CMAs with the highest populations of Aboriginal people, women make up more than 50% of the Aboriginal identity population. There is also a significantly higher proportion of the Aboriginal identity population who are women between 25 and 44 in most Canadian cities. Rates of lone-parent families in the Aboriginal population are higher than in the non-Aboriginal population, and most Aboriginal single parents are women (Siggner, 2001 in Graham & Peters, 2002). Furthermore, as the Native Women's Association of Canada (2007) notes, Aboriginal women may move to the city to escape violence and abusive situations at home. These women are more likely to have low incomes and be lone-parents.

Although specific data on the age trends of urban Aboriginal populations are scarce, it is known that Aboriginal people residing in urban areas tend to be

youthful (Browne et al., 2009; Graham & Peters, 2002; Tjepkema, 2002). For example, Browne et al. (2009) report that "in Regina, Saskatoon and Prince Albert more than half the Aboriginal peoples living in these cities were 24 years of age or younger" (p. 7). Table 3 lists the median age of the Aboriginal identity population in five Canadian CMAs.

3.4 Summary

The proportion of Aboriginal people who reside in urban areas is continuing to grow. Factors influencing rural to urban mobility are different than those that influence other migrant groups in Canada, and cannot be separated from Canada's colonial history. While Aboriginal people are more mobile than their non-Aboriginal counterparts (both within urban centres and between rural and urban places), not all mobility should be understood in the same way or as a failure to thrive. The urban Aboriginal population is diverse in every way; however, some general patterns can be identified. For example, there are more Aboriginal women than men in urban areas, and the urban Aboriginal population is also relatively young. In the following section, information about the health status of Aboriginal people residing in urban areas is provided.

Table 2: Percent of Aboriginal Identity Population that are Female in Five Selected Cities, 2006	
City (CMA)	Percent Female
Winnipeg	53%
Edmonton	53%
Vancouver	53%
Toronto	54%
Calgary	53%

Source: Statistics Canada, 2007a, 2007b, 2007c, 2007d, 2007e

Table 3: Median Age of Aboriginal Identity Population in Five Selected Cities	
City (CMA)	Median Age
Winnipeg	25.7
Edmonton	25.1
Vancouver	30.6
Toronto	32.3
Calgary	27.1

Source: Statistics Canada, 2007a, 2007b, 2007c, 2007d, 2007e

4. HEALTH STATUS

Although the population of Aboriginal people who reside in urban areas is significant and growing, "relatively little is known about these individuals' experiences and perspectives" (Environics Institute, 2010, p. 6). Data about the health of Aboriginal people who reside in urban areas are scarce, are often not up-to-date, and fail to adequately reflect the mobility that occurs between rural and urban locations (Browne et al., 2009). Furthermore, data tend to be based on off-reserve populations (rather than specifically urban) meaning that comparisons between rural and urban Aboriginal populations are difficult. Off-reserve data do not capture urban on-reserve populations (approximately 2%) and also include the 24% of Aboriginal people who live off-reserve in rural places (Ibid.). However, since 76% of Aboriginal people living off-reserve are in urban areas, data for the off-reserve population are used here as a proxy for determining health indicators and outcomes for Aboriginal people residing in urban areas. Research on urban Aboriginal populations is also used. As Browne et al. (2009) point out, "neither off-reserve statistics nor the urban research should be taken completely at face value" (p. 15).

In the following section, literature on determinants of health of Aboriginal people residing in urban areas is reviewed and relevant health indicators are discussed. This is followed by data on health outcomes. Data related to urban Aboriginal populations are difficult to disaggregate, however, wherever possible, research and data that focus on specific groups are highlighted.

4.1 Health Determinants Literature

In Canada, Aboriginal people as a whole have poorer health than non-Aboriginal people (Tjepkema, 2002). Scholarship and literature on Aboriginal heath have tended to focus on "Aboriginal people living on reserve, Registered Indians, and the Inuit [...and...] relatively little is known about the Aboriginal population (including Registered and non-status) living off reserve in cities and towns across Canada" (Ibid., p. 2). However, a reasonable body of research has developed in recent years that examines determinants of health of Aboriginal people who reside in urban areas. For example, Browne et al. (2009) reported on the health of First Nations people who reside in

urban areas. In their paper they provide information about demographics, health status and determinants of health as well as jurisdictional issues related to First Nations health and trends in urban and off-reserve research. The information provided in Browne et al.'s (2009) study can, to a limited extent, be extended to all Aboriginal people who reside in urban areas. Tjepkema (2002) analyzed Statistics Canada's 2000/2001 Community Health Survey and compared the "off-reserve Aboriginal population with the rest of the Canadian population in terms of health status, health behaviours, and health care utilization" (p. 1). Although this study is now dated and includes rural off-reserve populations, its findings continue to reflect patterns of health among Aboriginal people who reside in urban areas. The Urban Aboriginal Peoples Study (UAPS) (Environics Institute, 2010) drew on more than 2,614 interviews and 2,501 telephone surveys to report on a number of topics. Although health was not a primary focus of this work, health perceptions as well as several other determinants of health and well-being are discussed. Various works by Peters, Graham and Newhouse (see Peters, 2004; Newhouse & Peters, 2003; Graham & Peters, 2002), though not solely focused on health, do address topics related to well-being among Aboriginal people residing in urban areas. For example, these authors report on determinants of health such as jurisdiction, education and income. McShane et al. (2006) and Hanrahan (2002) both discuss the health issues experienced by Inuit who reside in urban areas. Literature from outside of Canada is also available; Ivanitz (2000) reported on health of Aboriginal people in Australia who reside in urban areas, and Forquera (2001) produced a paper on the health of American Indian people who reside in urban areas in the United States.

What this body of research has in common is that it largely draws on the social determinants of health framework

to analyze and report on the health of Aboriginal people residing in off-reserve and/or urban areas. Social determinants of health "pay specific attention to those critical social, historical, political and economic factors that support health and well-being in the broadest sense of the terms" and tend to focus on "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.)" (Browne et al., 2009, p. 25). While physical influences on health remain important, it is widely acknowledged that health and well-being are affected by a wide-ranging and interrelated set of factors.

The current Western models of health do not suffice for Aboriginal health; these models, ultimately, include the Westernized constructs of the social and political aspects which affect overall health (Commission on Social Determinants of Health, 2007; Dyck, n.d.). de Leeuw et al. (2010) emphasized this inadequacy:

> What the social determinants literature tends not to account for [...] is the ways that colonial institutions, ideas, and practices combine to undermine Indigenous peoples' access to and control over a range of social determinants such as culture, physical environment and healthy development. (p. 283)

Thus, to understand how best to address health concerns and issues, it is essential to consider the social, political, economic and cultural experiences and disparities of Aboriginal people residing in urban areas. This 'holistic' approach to health acknowledges the dynamic interplay between the social, cultural, economic, historic, political and physical aspects of people's lives.

With respect to the health of Aboriginal people in Canada, the history of

colonialism plays a central role. Indeed, Browne et al. (2009) argue that the health of Aboriginal people "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" (p. 25; see also de Leeuw et al., 2010; Browne et al., 2005; Browne et al., 2007; Browne & Varcoe, 2006; Kelm, 1998). Colonialism – "the establishment and maintenance of rule, for an extended period of time, by a sovereign power over a subordinate people" (Watts, 2000, p. 93) – is the primary cause of the social inequities experienced by so many Aboriginal people in Canada. As Browne et al. (2009) explain:

> the continued regulation of [...] Aboriginal peoples' lives through the social policies embedded in the Indian Act, and the ongoing restrictions placed on Aboriginal self-government, land claims and economic development in many [Aboriginal] communities, shape the overall health, well-being and quality of life in communities. These in turn, shape the life opportunities, economic conditions and the overall health and social status of [Aboriginal] individuals, families, and communities in urban areas. (p. 25)

In other words, colonialism has directly and negatively impacted the social determinants of Aboriginal people's health – e.g., higher rates of poverty and unemployment, lower levels of education attainment, and inadequate housing – resulting in higher rates of mortality and morbidity.

4.2 Health Outcomes

In this section, health outcomes are reported including: social determinants of health, mortality rates and life expectancy, health behaviour and other risk factors, morbidity and chronic disease, self-perceived health, women and children's health, and mental health. These data are

intended to provide a general sense of the health and well-being of Aboriginal people residing in urban areas. The information presented here is derived from data for the urban Aboriginal population, the off-reserve Aboriginal population, urban and off-reserve First Nation populations, and the general Aboriginal population.

4.2.1 Social determinants of health

The link between socioeconomic status and health outcomes is well-established (Tjepkema, 2002). Education, employment and level of income are all important indicators of socioeconomic status. Educational attainment is an important element of socioeconomic status, and, as such, has been associated with health status and health behaviours. Research clearly shows that education is intricately connected to income and material security for individuals and families; the higher the level of educational attainment achieved, the higher the income received (NWAC, 2007). Across the board, higher levels of education are linked to better overall health. Table 4 lists selected social determinants of health based on 2006 census data. In summary, Aboriginal people residing in urban areas have higher unemployment rates and lower education attainment levels than their non-Aboriginal counterparts. Furthermore, their incomes are lower. Aboriginal people residing in urban areas tend to have lower unemployment rates and higher education attainment and income levels than Aboriginal people residing in rural areas.

4.2.2 Mortality and life expectancy

Vital statistics on mortality rates specific to the off-reserve and urban Aboriginal populations are not available. For the general Aboriginal population, mortality rates from all causes tend to be higher than for the non-Aboriginal population. Life expectancy of Aboriginal men and women who reside off-reserve is approximately 72 years and 77 years respectively (Frohlich et al., 2006 cited in Browne et al., 2009. No year for this data was provided). These life expectancies were higher than those for Aboriginal

Table 4: Social Determinants of Health: Comparing Urban and Rural Aboriginal and Non-Aboriginal Populations				
Social Determinant of Health	Total Aboriginal Identity Population – Urban	Total Aboriginal Identity Population – Rural	Total Non-Aboriginal Identity Population – Urban	Total Non-Aboriginal Identity Population – Rural
Labour force activity 15 years and over:				
Unemployment rate	11.5	14.4	6.2	6.7
Education 15 years and over:				
No certificate, diploma or degree	162,515 (36.27%)	75,830 (44.15%)	4344730 (21.6%)	1,386,375 (29.55%)
High school certificate	112,280 (25.06%)	36,935 (21.5%)	5,183,255 (25.76%)	1,182,445 (25.20%)
College, CEGEP or other non-university certificate or diploma	74,130 (16.54%)	24,680 (14.37%)	3,506,300 (17.43%)	803,745 (17.13%)
Bachelor's degree	24,650 (5.5%)	5,165 (3%)	2,619,955 (13.02%)	324,605 (6.92%)
Total population 15 years and over by total income:				
Without income	32,050 (7.15%)	13,295 (7.74%)	943,905 (4.69%)	233,120 (4.97%)
Average income	$26,670	$25,680	$36,546	$33,007
Prevalence of low income after tax in 2005 for economic family members	22.2%	8.9%	9.4%	4.0%

Source: Statistics Canada (2008b)

people residing on-reserve, which seem to indicate that health off-reserve tends to be better (Browne et al., 2009).

4.2.3 Health behaviour and other risk factors

Health behaviours are associated with health outcomes (positive and negative). For example smoking increases the risk of heart disease while physical activity reduces this risk (Tjepkema, 2002). Aboriginal people in Canada are also more likely to experience the risk factors for cardiovascular disease, which include poverty, tobacco use, obesity, diabetes, and hypertension. Table 5 lists selected health indicators based on 2000-2001 Canadian Community Health Survey (CCHS) data. In light of this data about health behaviours and other risk factors that influence health, Tjepkema (2002) reported that "[i]n all geographic regions, the off-reserve Aboriginal population was more likely to be current smokers than the non-Aboriginal population" and that "smoking rates among Aboriginal people are not decreasing" (p. 7). As Table 5 indicates, Aboriginal people residing in urban areas are more likely than non-Aboriginal people residing in urban areas, and less likely than Aboriginal people residing in rural areas, to be heavy daily smokers. Aboriginal populations in urban and rural areas have similar rates of heavy drinking, and both are higher than the non-Aboriginal urban population. In terms of physical activity, Tjepkema (2002) reports that there is little difference between the activity levels of the off-reserve Aboriginal population and the non-Aboriginal population. However, obesity rates are highest for Aboriginal people residing in urban areas when compared to Aboriginal people residing in rural areas and non-Aboriginal people residing in urban areas.

Substance use and addiction affects a number of urban Aboriginal people across Canada. Substance use (among other factors such as homelessness and lack of affordable housing) may contribute to the high rates of mental illness experienced by urban Aboriginal people and is an issue that must be addressed. While statistics show that there is a prevalence of alcohol consumption among Aboriginal populations in Canada, there are no data available for urban Aboriginal substance use rates. Kirmayer et al. (2007) found that literature and research pertaining to substance abuse most often looked at the issue from a qualitative (rather than quantitative) perspective; and generally only highlighted the need for community-based strategies and programs to reduce substance use among Aboriginal populations, rather than supplied statistics of use or quantitative analysis of data.

4.2.4 Morbidity and chronic disease

Tjepkema's (2002) work on the health of off-reserve Aboriginal people reports on various morbidity indicators. Table 6 summarizes several morbidity indicators for urban Aboriginal and non-Aboriginal populations, as well as the rural Aboriginal population. The health of urban and rural Aboriginal populations appears to be similar; however, non-Aboriginal people residing in urban areas have lower rates of all morbidity indicators than their Aboriginal counterparts. The difference between off-reserve Aboriginal and non-Aboriginal peoples was most notable in terms of diabetes: the incidence of diabetes in the off-reserve Aboriginal population was nearly double that of non-Aboriginal people. Rates were also higher for high blood pressure and arthritis (Tjepkema, 2002). Diabetes is a serious health concern in the Aboriginal population. Rates of diabetes among Aboriginal people are three to five times higher than the national average; however, rates appear to be higher on-reserve than off, and little is known about incidence of diabetes among Métis peoples (Health Canada, 2000).

Contrary to Tjepkema's (2002) work, a report by the First Nations Centre (2007) focusing on First Nation populations indicates that a difference in morbidity does exist between off-reserve and on-reserve populations. Table 7 summarizes selected morbidity indicators for First Nations populations as reported in *Snapshot of Off-Reserve First Nations Health* (2007). In terms of high blood pressure and diabetes, off-reserve First Nations have lower rates; however, they have higher rates of asthma and heart problems.

The incidence of HIV/AIDS in the Aboriginal population has been studied for over twenty years. During the 1980s, the term "epidemic" was assigned to the rapid increase in the number of HIV/AIDS cases across Canada, many of whom were of Aboriginal descent. In the early years of the epidemic, the majority of the

Table 5: Health Behaviours and Risk Factors for Urban and Rural Aboriginal Populations, and Urban Non-Aboriginal Population			
Health Behaviour/ Risk Factor	Urban Aboriginal Population (%)	Rural Aboriginal Population (%)	Urban Non-Aboriginal Population (%)
Heavy daily smoker	14.1	16.0	8.8
Heavy drinker	22.5	22.9	15.5
Inactive	53.8	53.2	54.5
Obese	25.6	23.5	13.2

Source: Tjepkema, 2002

Aboriginal HIV/AIDS cases resided in Canada's largest urban centres: Vancouver, Toronto, and Montreal (Ministerial Council on HIV/AIDS SWGAI, 2001). Between 1990-1999, the proportion of all reported AIDS cases in Canada that affected Aboriginal individuals rose from 1% to 15% (Ibid.). A similar increase was witnessed in the number of HIV infections. In 1996 there were 1,430 reported HIV infections in Aboriginal individuals; by 1999, this number had increased 91% to 2,740. In 1998, Aboriginal people accounted for 18.8% of all positive HIV tests in Canada; by 2003, this figure rose to 25.3% (PHAC, 2004).

The majority of HIV/AIDS cases are found in urban dwellers and injection drug users. According to the Canadian Aboriginal AIDS Network (CAAN) (n.d.), Aboriginal people are overrepresented among Canadians who use injection drugs. In the inner city neighbourhood of the DTES in Vancouver, Aboriginal individuals experience a high prevalence of HIV/AIDS (Culhane, 2003). Here, rates are much higher among Aboriginal women (which is not the case in the Aboriginal population overall), and "twice as high among Aboriginal men and women compared to non-Aboriginal people" (Browne et al., 2009, p. 24 citing Spittal et

al., 2002). According to Culhane (2003) the group at the highest risk of contracting HIV/AIDS is Aboriginal youth between the ages of 17 and 25.

HIV/AIDS is not confined to 'ghettos' and should not be understood as an inner city problem (Browne et al., 2009). Due to the high levels of mobility between inner cities and rural or on-reserve communities, there is an elevated risk of spreading HIV/AIDS to even the most remote Aboriginal communities (Ministerial Council on HIV/AIDS SWGAI, 2001). Risk factors for this chronic disease are complex, but largely attributable to social determinants including colonization, racism and poverty (CAAN, n.d.). The Ministerial Council on HIV/AIDS SWGAI (2001) has also noted that history of sexual abuse is a risk factor.

4.2.5 Self-perceived health

Tjepkema (2002) reports that 78% of urban Aboriginal people perceive their health to be good, very good or excellent compared to 74.3% of the rural Aboriginal population who report having good to excellent health. The First Nations Centre (2007) reports a similar trend for First Nations populations; 57% of First Nations people residing off-reserve rate their health as 'very good' or 'excellent' compared to only 40% of the on-reserve First Nations population. The UAPS also reports that the majority of Aboriginal people residing in urban areas (8 out of 10) rate their health as excellent (14%), very good (32%) or good (33%) (Environics, 2010).

The UAPS indicates that self-perceived health does not vary considerably by identity group; "however, urban Aboriginal peoples in Halifax (86%), Vancouver (86%), Calgary (82%) and Montreal (82%) are more likely than average to report they are in excellent-to-good health" (Environics, 2010, p. 114). In terms of gendered perceptions of health, the First Nations Centre

Table 6: Morbidity and Chronic Disease for Urban and Rural Aboriginal Populations, and Urban Non-Aboriginal Population			
Morbidity Indicator	Urban Aboriginal Population (%)	Rural Aboriginal Population (%)	Urban Non-Aboriginal Population (%)
One or more chronic condition	62.6	59.6	49.4
High blood pressure	15.7	15.8	13.2
Diabetes	8.8	9.2	4.2
Arthritis	28.7	24.7	15.6
Long-term activity restriction	15.5	18.1	10.2
Major depressive episode in past 12 months	13.8	13.1	7.4

Source: Tjepkema, 2002

Table 7: Morbidity and Chronic Disease for Off-Reserve and On-Reserve First Nation Populations		
Morbidity Indicator	Off-Reserve Aboriginal Population (%)	On-Reserve Aboriginal Population (%)
High blood pressure	12	20.4
Diabetes	8.3	19.7
Asthma	12.5	9.7
Heart problems	10.3	7.6

Source: First Nations Centre, 2007

(2007) reports that First Nations men residing off-reserve consider themselves to be in better health than their female counterparts do, with 60% of First Nations men perceiving their health to be very good or excellent compared to 55% of First Nations women. Cooke et al. (2004) reported different outcomes, with Aboriginal women residing off-reserve rating their health better than Aboriginal men. Health is also perceived more positively by younger individuals, and those with higher incomes and education attainment levels (Environics, 2010).

Tjepkema (2002) notes that Aboriginal people off-reserve are 1.9 times more likely to report fair or poor perceptions of their health than the non-Aboriginal population is. This percentage does not vary significantly between regions. Furthermore, self-perceptions of health are directly correlated with income: people with lower incomes report poorer health

and as income increases, so do perceptions of health (Tjepkema, 2002). However, "the gap between Aboriginal and non-Aboriginal people persisted for all three income levels" (Ibid., p. 3).

4.2.6 Women and children
The Native Women's Association of Canada (2007) asserts that Aboriginal women's health is, in general, much worse than Aboriginal men's (in Browne et al., 2009). Aboriginal women (including those residing in urban areas) face a 'double marginalization' of racism and sexism that results in systemic discrimination (NWAC, 2007). Levesque (2003) has argued that particular challenges exist that affect the health status of Aboriginal women residing in urban areas. These challenges often revolve around the reasons for why First Nations women leave reserve communities in favour of urban areas, namely domestic violence and relationship break-down.

Indeed, more women than men move from rural/on-reserve to urban/off-reserve communities (Levesque, 2003), rates of spousal assault against Aboriginal women is three times higher than for non-Aboriginal women (NWAC, 2007), and rates of mobility and housing instability are highest for young Aboriginal women residing in urban areas (Norris & Clatworthy, 2003).

Infant mortality rates specifically for the off-reserve Aboriginal population are not available. However, one comprehensive study compared infant mortality rates of First Nations children in urban areas to those in rural areas and found that rates in both urban and rural First Nations populations were higher than for the non-First Nations population, and that rates also tended to be lower in the urban First Nations population (Luo et al., 2004). The report also indicated that more First Nations children are being born in urban

areas, but that "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)" (Browne et al., 2009 citing Luo et al., 2004, p. 22). According to the BC Public Health Officer (2009), "[a] long history of colonization, systemic discrimination, and experiences such as residential schools have led to adverse health effects on Aboriginal families and their children. The results of these experiences are the root of inequities in infant health for Aboriginal peoples" (p. 70).

The population of Aboriginal children is growing rapidly, yet there remains insufficient data about this population (Statistics Canada, 2008c). The Aboriginal Children's Survey (ACS) attempts to remedy this situation by providing "an extensive set of data about Aboriginal children under six years of age in urban, rural, and northern locations across Canada" (Ibid., p. 8). Although many topics are covered in the ACS, some information pertaining to health is available. The ACS does not focus solely on urban populations; however, information about First Nations children residing off-reserve is reported. Of off-reserve First Nations children, the majority (78%) live in urban areas (46% of which are in census metropolitan areas and 32% of which are in smaller urban centres) (Ibid., 2008c, p. 10). More Aboriginal children than non-Aboriginal children live in low-income families, particularly in urban areas where over half of First Nations children (57%) live in low-income families compared to 21% of non-Aboriginal children (Ibid.). Eighteen percent of First Nations children living off-reserve are also living in homes that required major repairs (Ibid.). In general, the trend is for Aboriginal children (including those residing off-reserve and in urban areas) to have poorer health compared to non-Aboriginal children, though Aboriginal children residing

off-reserve tend to have better health outcomes than Aboriginal children who reside on-reserve (Statistics Canada, 2004). Aboriginal children in urban areas are also nearly twice as likely to live in lone-parent households and live in poverty, and are four times more likely to have adolescent parents and have experienced hunger (Longfield & Godfrey, 2003, p. 9).

Since the 1960s, there has been a surge in the number of Aboriginal children in the welfare system; despite the fact that Aboriginal people account for less than 5% of the population, approximately 40% of children in care are Aboriginal (Gough et al., 2005). However, statistics about children in care are rarely broken down into on-reserve and off-reserve categories. According to service providers, Aboriginal children in urban areas are not only over-represented in the child welfare system, they also experience much higher levels of disabilities such as Fetal Alcohol Spectrum Disorder (FASD), and are more likely to drop out of school (Longfield & Godfrey, 2003). Moreover, up to 70% of children in care in Vancouver are of Aboriginal descent (Culhane, 2003).

4.2.7 Mental health

Mental health encompasses a wide range of maladies, conditions and issues. According to Browne et al. (2009), "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" (p. 19). Health policy has tended to ignore issues related to the mental health of Aboriginal people residing in urban areas; moreover, mental health data specifically targeting Aboriginal populations in urban areas are difficult to come by, though there is some evidence that mental health is better for Aboriginal populations residing off-

reserve than on-reserve (see, for example, First Nations Centre, 2007). This may be explained by the relatively greater number of mental health services available in urban areas. However, worrisome rates of mental illness among Aboriginal people have been reported by many sources and are likely due to the intersecting issues of homelessness, substance abuse, inadequate housing and deinstitutionalization of mental health patients that persist in urban areas (BC Public Health Officer, 2002; Romanow, 2002).

Findings from the Canadian Community Health Survey show that 21% of off-reserve low-income Aboriginal people reported a major depressive episode in the past year (Longfield & Godfrey, 2003). Furthermore, while suicides in on-reserve or traditional Inuit communities tend to be more prevalent than in urban settings, statistics about suicide among Canadian Aboriginal populations are hard to come by and are generally out of date (Kirmayer et al., 2007).

4.3 Summary

To understand how best to address health concerns and issues, it is essential to consider the social, political, economic and cultural experiences and disparities of Aboriginal people residing in urban areas. This 'holistic' approach to health acknowledges the dynamic interplay between all aspects of people's lives. With this perspective in mind, data regarding health status can provide insight into the kinds of health services needed to better serve the urban Aboriginal population. The following section moves into a discussion of health services, starting with an overview of how they are accessed and utilized by Aboriginal people residing in urban areas, and followed by an examination of the implications of Aboriginal urbanization for the provision of health services.

5. IMPLICATIONS OF URBANIZATION FOR THE PROVISION OF HEALTH SERVICES

The focus of this section is on health services, and in particular, the implications of the urbanization of the Aboriginal population on health service policy and provision. The section begins with an overview of health care utilization and access, which provides important context. This is followed by an explanation of health services jurisdiction, which is closely linked to location, and therefore, to patterns of urbanization. The discussion then turns to making links between the urbanization of the Aboriginal population, health services jurisdiction, and health service policy and delivery.

5.1 Health Care Utilization and Access

As noted in an earlier section, there are many reasons for Aboriginal people to move to urban areas, and one is to improve access to health care services (Newhouse & Peters, 2003). In general, rural and on-reserve communities have fewer health care services (particularly specialist services), making the move closer to these services necessary in some cases. However, these moves are not always unproblematic. In their research about medical relocation, Lavoie et al. (2008) found that Aboriginal people who move to cities in order to access medical services often face a series of challenges, including a lack of financial and transportation support, suitable housing near medical services, as well as isolation from their social support network in their home communities.

Tjepkema (2002) reported that the off-reserve Aboriginal population did not vary significantly from the non-Aboriginal population in terms of health care utilization. Contact with general practitioners, eye-specialists and other doctors was similar, however, some difference was noted in the level of contact the off-reserve Aboriginal population had with dentists (who are not publicly funded) compared to the non-Aboriginal population. Tjepkema (2002) also reported that even when differences in self-perceived health were controlled for, more Aboriginal people residing off-reserve than non-Aboriginal people had unmet health care needs. Unmet health care needs occurred because of reasons related to acceptability and availability; in other words, 51.3% reported that the reason for their unmet health care needs was because available services were considered unacceptable and 47.5% cited lack of availability as the reason (Tjepkema, 2002). Another issue affecting health care utilization in urban areas is the lack of 'interface' that exists for

Aboriginal people in accessing (especially specialty) services (Browne et al., 2009). For example, one study showed that First Nations people residing on-reserve utilized specialty arthritis services more frequently than First Nations people in urban areas, even though they might have to travel very long distances to do so. Urban First Nations people who did not utilize the services even though they lived in relatively close proximity may not have had sufficient support or 'interface' required to access the services (McDonald, 2007).

Access and availability of health services is important, but only insofar as the services are considered acceptable (Adelson, 2005). Poverty, social exclusion and discrimination are common barriers to accessing health care experienced by Aboriginal people residing in urban areas, and it is increasingly acknowledged that mainstream models of health care do not overcome these barriers (Ibid.). Health care services can be discriminatory in practice and policy, sometimes in subtle but nonetheless damaging ways. It is important that health services not only be culturally safe, but that they also be developed out of an awareness and understanding of the intergenerational impacts of the residential school system. Women are among those most affected by lack of culturally safe programming. Benoit et al. (2001) state that women

face "formidable barriers in accessing provincial health services that are sensitive to their health beliefs and responsive to their health concerns" (p. 1).

According to the UAPS (Environics, 2010), just over half of Aboriginal people residing in urban areas utilize city-based Aboriginal services and organizations; of those, 28% use services "often", while 26% use them "occasionally" (p.68). Forty-five percent of respondents reported using Aboriginal services or organizations "rarely" (22%) or "never" (23%) (Ibid., p.68). Breaking these figures down into population groups, urban Inuit are most likely to use city-based Aboriginal services or organizations for assistance or aid (71%); this is followed by off-reserve First Nations people at 59% and Métis people at 48%. Service utilization is also most common in Vancouver and Toronto, which is not surprising given that these cities have the greatest variety of Aboriginal services and cultural activities (Environics Institute, 2010). Of the large Canadian cities with the highest proportion of Aboriginal people, Regina's population is the least likely (40%) to use services or organizations (Ibid., p.68). Services are also more likely to be accessed by Aboriginal people who are 45 years old or more, as well as those who are less affluent (Ibid., p. 68).

One of the biggest barriers to many Aboriginal residents of urban areas is the type of health care available in urban centres (Ivanitz, 2000). According to the UAPS (Environics, 2010), "[a]ccess to traditional healing practices is as, if not more, important than access to mainstream health care for majorities of urban Aboriginal peoples, especially Inuit and status First Nations peoples, and those who strongly identified as Aboriginal" (p. 116). As age and strength of Aboriginal identity increases, so does the perceived importance of access to this kind of health care. The UAPS reports that 72% of Aboriginal residents of urban areas consider access to traditional healing practices to be important or more important than mainstream care, but only 30% have "very easy" access to it (Ibid., p.116). According to Statistics Canada (2003), "[a]bout 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). However, the same proportion did not know if traditional health care was available in their community.

5.2 Jurisdiction of Health Services

Governments have long debated where responsibility for Aboriginal people living off-reserve lies (Browne et al., 2009; Graham & Peters, 2002). The Royal Commission on Aboriginal Peoples (RCAP) (1996) stated that:

Wrangling over jurisdiction has impeded urban Aboriginal people's access to services. Intergovernmental disputes, federal and provincial offloading, lack of program coordination, exclusion of municipal governments and urban Aboriginal groups from discussions and

negotiations on policy and jurisdictional issues, and confusion regarding the political representation of Aboriginal people in cities have all contributed to a situation that has had serious adverse effects on the ability of Aboriginal people to gain access to appropriate services in urban areas. (p. 551)

The result of jurisdictional wrangling is that Aboriginal people living off-reserve do not have access to the range of federally provided health services that First Nations living on-reserve and Inuit living in their communities receive (Browne et al., 2009; Graham & Peters, 2002). Provincial governments largely view Aboriginal people as the responsibility of the federal government regardless of where they reside, and until recently, have not offered services or programs that are not already available to the general population (Longfield & Godfrey, 2003). There is also a lower level of funding provided for urban Aboriginal populations. For example, the Federal Interlocutor for Métis and non-Status Indians notes that despite approximately half of the Aboriginal population residing in cities, almost 90% of federal funding for Aboriginal specific programs and services is allocated for on-reserve residents only (Ibid., p. 6).

Eligibility for specific federal government programs and services for Aboriginal people is not straightforward; it depends on a complex interplay between status, residency, treaty, and provincial and federal legislation (Browne et al., 2009). Differences in eligibility for federal government programs and services exist between status and non-status Indians, Inuit living outside their communities, and Métis (Longfield & Godfrey, 2003). For example, an Aboriginal person may have status but live off-reserve, or live on-reserve but not be registered; every scenario results in a different set of services and benefits, and ultimately, this ambiguity around eligibility has resulted

in gaps and inconsistencies (Lavoie et al., 2008). Off-reserve First Nations people who are registered may be able to access benefits through the federal government's Non-Insured Health Benefits, but may be ineligible for other benefits such as transportation to medical appointments. Off-reserve status First Nations are also not given equal access to federal drug and alcohol services. While there are services and policies for urban Aboriginal people in the areas of "education, training, employment, income support, economic development, health, homelessness, housing, justice, human rights, urban transition, and cultural support [...], there are few services in the areas of family violence, childcare, addictions, or suicide and there are large gaps in income support, housing and urban transition" (Browne et al., 2009, p. 32). Furthermore, the delivery of these services is uncoordinated and services tend not to be widely available or accessible. Ultimately, Aboriginal people residing in urban areas "are at a significant disadvantage in terms of policies and programs for health and wellbeing" (Ibid., p. 32).

5.3 Effective Provision of Health Services: Making the Links

According to Graham and Peters (2002), challenges to policy development fall into two broad categories: demographic and jurisdictional. In this section, the implications of demographic characteristics of urban Aboriginal populations for health service delivery are first considered. A discussion of the implications related to jurisdiction of health services follows.

5.3.1 Demographic implications for the provision of health services
Aboriginal people residing in urban areas are diverse in every way; however, for the purpose of considering the implications of demographic patterns and trends for the appropriate and effective delivery of health services, some generalizations must be

made. These are: 1) Aboriginal people are increasingly urban and relatively mobile (both between communities and within communities); 2) women and youth are over-represented in the urban Aboriginal population; and 3) lower socio-economic status and social exclusion are experienced by many (though not all) Aboriginal people residing in urban areas.

As noted in Section 3, Aboriginal people residing in urban areas represent a significant presence in urban centres, and the growth of this population is expected to continue (Newhouse & Peters, 2003; Environics Institute, 2010). This "urban Aboriginal fact" is both a challenge and an opportunity. As Peters (2004) points out, "[t]he urban Aboriginal population has a significant impact on cities [...and...] cities have an important role to play in the lives of Aboriginal people" (p. 2). At the most basic level, then, policy on health service delivery in urban areas must take into account the growing population of Aboriginal people in cities to ensure that adequate, accessible and safe health care is provided.

Not only is the population of Aboriginal people residing in urban areas significant and increasing, it is highly mobile both between rural/reserve areas and urban areas, and within urban communities. With respect to health service delivery, this 'churn factor' is a challenge in assessing the state of health of Aboriginal people residing in urban areas, and "can also result in an under-representation of urban Aboriginal health and social trends, especially among people who are living in unstable housing arrangements" (Browne et al., 2009, p. 4). According to Chalifoux and Johnson (2003), "[c]hurn also creates much greater difficulties in the provision of vital programs and services for urban Aboriginal people" (p. 11). The challenge for health service delivery is whether to develop "programs and institutions that are concentrated in or spatially targeted toward particular neighbourhoods, [...or]

initiatives that have a wider urban focus" (Peters, 2004, p. 7). In terms of between-community mobility, Graham and Peters (2002) make an important point: "From a policy perspective, it is crucial that we recognize that the urban Aboriginal population in Canada is not distinct from the 'nonurban.' They are interconnected in terms of mobility, culture and politics" (p. iii). In other words, the circulation of population between rural/reserve communities and urban areas should not necessarily be treated as a negative trend; rather, it indicates a desire to maintain connections with family, territory and culture. Thus, "the continued importance of reserves and Métis communities suggests that initiatives focused only on urban areas may not address some of the significant factors at work in urban Aboriginal communities. There may need to be careful attention to the appropriate scale for different aspects of programs and services, and to the interface between organizations as at different locales" (Peters, 2004, p. 5). Mobility within urban areas, on the other hand, is generally associated with housing conditions, so policy aimed at reducing these residential mobility rates is an important focus (Graham & Peters, 2002).

Health services should address the reality that women make up over half of the urban Aboriginal population. Gender is a significant influence on health. While women, as a whole, tend to live longer than men, they also suffer from more instances of ill health and are more frequent users of the health care system (Jennissen, 1992; Native Women's Association of Canada, 2007). Aboriginal women living in urban areas are more likely to have low incomes and be single parents than Aboriginal men. Furthermore, they may have been victims of violence, which is a major determinant of health (Brown et al., 2009). As the Native Women's Association of Canada (2007) states, "[o]ne of the most crucial social determinants of health which

intersects with gender to such 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). Women who have migrated to urban areas to escape violence are particularly vulnerable. For example, Aboriginal women are over-represented in Vancouver's DTES where they are at a higher risk for sexual exploitation and violence (Culhane, 2003). It is crucial that health services meet the needs of women who are experiencing these particular challenges by being available, accessible and safe.

The relative youthfulness of the urban Aboriginal population also has important implications for health services. Off-reserve children are more likely to have lone-parent families and there are also high proportions of Aboriginal children in care in urban areas (Browne et al., 2009). The implications for health services are significant; childcare, education, housing, employment, and addiction services are a few of the areas where a focus on young people is important. Currently, greater restrictions to a number of services exist for Aboriginal youth living in urban areas or who do not have status. For example,

on-reserve youth are prioritized for drug and alcohol services, while status children living off-reserve have difficulty accessing the Aboriginal Head Start program (Ibid.).

The urban Aboriginal population is often mistakenly associated with inner city 'ghettos,' but as Graham and Peters (2002) point out, this assumption is not supported by any concrete evidence. Generally, levels of segregation are low, and "sizable concentrations appeared to be typical of only three centres, Winnipeg, Regina and Saskatoon" (Graham & Peters, 2002, p. 13 citing Clatworthy's (1996) study). Nonetheless, it is important to note that Aboriginal people who do live in poorer neighbourhoods "are less likely to be engaged in labour market activities than Aboriginal people in non-poor neighbourhoods and they are more likely to have low education levels" (Graham & Peters, 2002, p. 19). It is, moreover, very difficult to determine whether residential segregation is the cause or the result of poverty. In terms of health policy, then, it is important to rely on evidence rather than assumptions about urban settlement patterns. Furthermore, neighbourhood-based health services may not uniformly work due to the considerable variability in the level of residential segregation found in Canadian cities.

In broad terms, Aboriginal people residing in urban areas continue to be disproportionately affected by poverty, social exclusion and discrimination (Newhouse & Peters, 2003; Tang & Browne, 2008). Two key implications of this are: 1) Aboriginal people residing in urban areas are at greater risk of poor health outcomes due to poverty, isolation, experiences of violence, etc.; and 2) Aboriginal people residing in urban areas are more likely to face barriers in accessing health services due to discriminatory policies and practices (Adelson, 2005). However, it is also important to acknowledge that characteristics of the urban Aboriginal population vary considerably; although poverty and marginalization continue to challenge Aboriginal people residing in urban areas, there is also a growing number who have completed post-secondary education (Cairns & Flanagan, 2001, p. 110) and a growing middle class of higher-income professionals (RCAP, 1996). Thus, there is a "need for flexibility in program and policy development" (Graham & Peters, 2002, p. 16). Policy around health service delivery will have to consider geographic scale and scope, whether to focus on individuals or communities or both, how to ensure cultural safety of services, and how organizations and services might interact effectively to reflect the needs of a mobile, often marginalized, urban population.

5.3.2 Jurisdictional implications for the provision of health services

The Royal Commission on Aboriginal Peoples (1996) has identified three key areas related to jurisdiction that need to be addressed: 1) the level of services for Aboriginal people living off-reserve is lower than for Aboriginal people living on-reserve; 2) access to provincial programs is lower for Aboriginal people than for other urban dwellers; and 3) access to culturally safe programming is inadequate. The Federal Interlocutor for Métis and non-Status Indians also notes

that programs and services currently available to the urban Aboriginal population are relatively uncoordinated, taking place in "silos both within and between the municipal, provincial and federal levels of government" (Longfield & Godfrey, 2003, pp. 6-7). RCAP (1996) has recommended that governmental roles be better defined, and that the federal government fund services on Aboriginal lands while provincial and territorial governments fund services for Aboriginal people living off Aboriginal lands (in Graham & Peters, 2002). Given the high rates of mobility between rural and/or on-reserve and urban and/or off-reserve areas, jurisdiction based on where an Aboriginal individual resides may not be suitable in the development of effective policies and programming.

Status is an important aspect of jurisdiction that affects access to health services. The notion of 'status-blind' services – those "directed toward all Aboriginal groups regardless of legal status or cultural heritage" – is contentious; many Aboriginal people are opposed to status-blind approaches and argue that "more directed services could play an important role in supporting cultural identities" (Graham & Peters, 2002, p. 22 citing RCAP, 1996). However, evidence suggests that status-blind approaches are cost effective, non-discriminatory, and may function to develop a sense of community among Aboriginal people residing in urban areas (Hanselmann, 2002; RCAP, 1996; Graham & Peters, 2002).

Browne et al. (2009) point out that the federal government's conceptualization of its fiduciary responsibility for registered Aboriginal people may be inadequate as 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" (p. 34). Self-government has been suggested as a possible remedy for jurisdictional challenges, but there

is still a strong conceptual link between self-government and the specific locations of reserve communities. Self-government in an urban context is "complex and fraught with the difficulties associated with bringing together diverse groups of people" (Browne et al., 2009, p. 34 citing Newhouse & Peters, 2003); however, it is worth considering the potential value of self-government models in the development of health service delivery in urban Aboriginal contexts (Browne et al., 2009).

5.4 Summary

The urbanization of the Aboriginal population has important implications for the provision of health services, particularly in light of issues related to health care utilization and the jurisdiction of health services. Many Aboriginal people who move to urban areas to access health care face barriers with respect to health services. Both the level of and access to health services for Aboriginal people residing in urban areas need to be improved, and issues related to utilization and jurisdiction need to be addressed. The urban Aboriginal population is diverse, and not necessarily concentrated in inner city neighbourhoods. Patterns of mobility suggest that geographic scale and location, as well as scope of service, are important considerations in health service delivery. Health services should be available, accessible and culturally safe, and should focus on the needs of women and youth, given the higher proportion of these groups in the population. The following section looks at several national health programs, and then draws on two Canadian cities as examples to examine the availability of health services for Aboriginal people residing in these urban areas.

6. PROGRAMS AND INITIATIVES

Cities offer a wide array of programs and initiatives that provide a variety of services to a variety of populations. For example, programs may be specific to an illness (such as diabetes or HIV/AIDS) or a philosophy (such as cultural revitalization), and they may target specific sub-sections of the urban Aboriginal population such as children and families, youth, or women. Well-equipped hospitals, counseling services, support groups, holistic medicine and traditional healing are just a few of the services found in urban centres. These programs and services are funded through many different sources as well, and may be non-profit or funded through any level of government. They may also be community-based or Aboriginal organizations or even part of a nation-wide initiative.

In the next section, information about several national scale programs is provided. This is followed by two sections in which programs and services available in two urban centres – Vancouver, BC and Winnipeg, MB – are discussed. The aim is to provide an overview of the types of services available and to highlight their diversity; it is not meant to be a comprehensive list of all the programs available for Aboriginal people residing in these two urban areas. Programs and services in this context are difficult to categorize. Many programs and services target multiple aspects of health; for example, a program may focus on traditional healing, diabetes and Elders. Thus, while some effort has been made to categorize the available services for the purposes of clarity, it should be noted that there is a great deal of overlap.

6.1 Selected National Programs and Initiatives

The Urban Aboriginal Strategy (UAS) is a "community-based initiative developed by the Government of Canada to improve social and economic opportunities of Aboriginal people living in urban centres" (AAND, 2010a, para. 1). It started in 1997 and works through partnerships between the federal government and "Aboriginal community and local organizations, municipal and provincial governments and with the private sector" (Ibid., para. 2). The initiatives target several priority areas including life skills, job training, entrepreneurship and women, children and families. In 2007, the Government of Canada committed $68.5 million over a five-year period to respond to these needs (MVUAS, 2010).

The Aboriginal Diabetes Initiative (ADI) is another national-scale health program. It was established in 1999 and aims to "reduce type 2 diabetes among Aboriginal people by supporting health promotion and primary prevention activities and services delivered by trained community diabetes workers and health service providers" (Health Canada, 2011, para. 4). The ADI provides services for Métis, off-reserve Aboriginal, and urban Inuit people, and utilizes local knowledge and culturally appropriate approaches to diabetes prevention and management (Ibid.). The purpose of this initiative is to reduce the incidence of type 2 diabetes among urban dwelling Aboriginal people (Ibid.).

After the Second World War, an increasing number of Aboriginal people began to move to larger urban areas of Canada. This burgeoning population expressed the need for community and cultural initiatives, which led to the establishment of early forms of 'Friendship Centres' (National Association of Friendship Centres, 2006). The first Friendship Centre was established in Toronto, ON in 1951, and another appeared in Vancouver, BC the following year. By 1968, 26 Friendship Centres had been established across Canada (Ibid.). These Centres were primarily autonomous, with the majority of their funding coming from fundraising activities, churches, service groups and a few small grants (Ibid.). As of 2007, there were 118 Centres spread throughout urban regions in Canada (Ibid.). With the large number of Centres, many towns and cities are able to offer this service to Aboriginal residents of urban

areas. Friendship Centres promote justice, fairness and equality for Aboriginal people, provide assistance in transitioning from the rural to urban setting, and support cultural and self-determination activities. Thus, although not specifically focused on health, Friendship Centres may function to improve the well-being of Aboriginal people residing in urban areas through their work on improving various social determinants of health.

Several programs at the federal level focus specifically on the health of Aboriginal children and adolescents. Aboriginal Head Start in Urban and Northern Communities (AHSUNC) is a federal program that provides locally controlled childcare and pre-schools for Aboriginal children residing in urban and northern communities that support their physical,

Table 8: Child and Family Programs in Vancouver			
Program	Target Group	Program Focus	Additional Info
Aboriginal Child and Family Support Services	Aboriginal children 0-6 years old	Promoting parental competency and strengthening family life	Funded by the Ministry of Children and Families via the Vancouver Native Health Society
Vancouver Aboriginal Child and Family Services Society	Urban Aboriginal children and families	Child welfare	
Vancouver Aboriginal Friendship Centre – Sundance Daycare	Children 3-6 years	Childcare	
Collingwood Neighbourhood House – Amlat'si	Newborn-6 years old and their extended family	Child development	
BC Aboriginal Child Care Society – Eagles Nest Preschool	Pre-school children	Childcare	
Kla-how-eya: Aboriginal Centre of SACS	Families	Family and parenting support	Family Development Programs, Community Mentor, Expectant Parent Support Group, Family Drop-In and Aboriginal Parenting Program
Spirit of the Children Society	Children and families	Child development; family and parenting support	Example of programs offered: Fetal Alcohol Spectrum Disorder Program; Aboriginal Infant Development Program (AIDP); Men's and Women's Support Circles; Youth Groups; Traditional Aboriginal Parents Program; Elder Support Group

social and emotional development (PHAC, 2011a). There are over 4000 children in the programs' 129 sites (Ibid.). The Canada Prenatal Nutrition Program (CPNP) is a community-based public health program aimed at improving nutrition and health for pregnant women and their babies (PHAC, 2011b). According to PHAC (2011b), "[t]here are currently 330 CPNP sites serving close to 50,000 women in over 2,000 communities across Canada each year" (para. 3). A third national program focusing on children's health is the Community Action Program for Children (CAPC). The CAPC is a community-based program that has operated since 1993; it focuses on supporting health development for children facing challenging life circumstances (PHAC, 2011c). It serves the Aboriginal and non-Aboriginal populations, but has a number of programs in urban centres that specifically target Aboriginal people residing in urban areas.

6.2 Vancouver: Selected Programs and Initiatives

Vancouver, British Columbia is home to 40,310 Aboriginal people (2% of the total population). A wide range of health-related programs and services for Aboriginal people residing in urban areas are located in Vancouver and its surrounding suburbs. In this section, an overview of the following categories of health programs is provided: childcare

and family support, education and employment, health care, nutrition and physical activity, addiction and mental health, women, and youth. This is not an exhaustive list of the types of services related to health and well-being that are available in Vancouver; however, it offers insight into the diversity of available programs both in terms of population targeted and type of service provided.

6.2.1 Childcare and family support

A number of programs exist in Vancouver for children and families. Table 8 lists some of these programs. Services provided for children and families include childcare, child development and family support. The Spirit of Children Society is a non-profit Aboriginal organization that serves several communities in the Vancouver areas of Burnaby, New Westminster, Coquitlam, Port Coquitlam, and Port Moody (Spirit of Children Society website). All Aboriginal identity groups are welcome to participate in the programs offered by the Spirit of Children Society. Along with child development, parental skills and confidence are supported through educational activities. There is special support offered to families with children who have FASD, including home visits, education and resources. Infant development is also targeted through partnerships with community health care providers such as nurses, doctors and specialists. Respecting and promoting Aboriginal cultures and spiritual beliefs is central to the programs and services offered by the Society, which target the

needs of infants, children, youth, men and women.

6.2.2 Education and employment

Education and employment are both important social determinants of health. Many services and programs for Aboriginal people residing in Vancouver are aimed at supporting individuals to become better educated or find employment. The Kla-how-eya: Aboriginal Centre of Surrey Aboriginal Cultural Society (SACS), which offers a wide range of services that promote economic prosperity and improve the health and well-being of Aboriginal people in Vancouver, includes an apprenticeship program called the Kla-how-eya Culinary Arts Program (Kla-how-eya: Aboriginal Centre of SACS website). The education program is just one of the organization's many programs aimed at developing the Aboriginal community in Vancouver, and this holistic approach reflects an effort by the organization to be culturally relevant to Aboriginal individuals residing in Vancouver. The Native Education College (NEC) is another education initiative and is located in East Vancouver. It is a registered charitable organization and aims to "provide a supportive setting for adults to flourish and connect with Aboriginal culture" (NEC website, Welcome section, para. 1). NEC offers a variety of programs, including BC Adult Graduation Diploma and "college certificates and diplomas that provide access to employment or further post-secondary education" (Ibid., para. 2). The Aboriginal Education Enhancement Agreement, created by the Vancouver School Board (VSB), "embodies the shared visions and commitment of all participating parties to the success of Aboriginal students" in the areas of belonging, mastery of skills, and culture and community (VSB, n.d., para. 2). Aboriginal students are able to access extra support and services that help them achieve success in school.

Table 9: Employment services in Vancouver			
Program	Target Group	Program Focus	Additional Info
First Nations Employment Society	Represents 10 First Nations as well as on/off reserve people residing in the Vancouver Sunshine Coast area	Employment	Non-profit
Native Employment Outreach Services	Aboriginal job seekers in greater Vancouver	Employment	
Aboriginal Community Career Employment Services Society	Urban Aboriginals in Greater Vancouver Regional District	Employment and training services program	Federal government through Human Resources and Skills Development Canada
ACCESS – Essential Skills for Aboriginal Futures Program (ESAF)	Aboriginal men and women	Employment	Metro Vancouver Urban Aboriginal Strategy
ACCESS – Bladerunner Program	Aboriginal youth	Job placement	Metro Vancouver Urban Aboriginal Strategy
Kla-how-eya: Aboriginal Centre of SACS		Employment	Employment Services; Summer Student Job Placement
Pre-Employment Transition Program – VSB	Aboriginal youth diagnosed with FASD	Life and job skills	

Table 9 lists organizations and programs that support employment in Vancouver. These organizations vary by type of service provided, group targeted and type of funding. For example, the First Nations Employment Society (FNES) is a non-profit organization that represents ten First Nations; it "provide[s] support and opportunities to Aboriginal people in member nations' territories to increase employment through building and promoting self-reliance" (FNES website, para., 2). The ACCESS programs, on the other hand, are funded through the Metro Vancouver Urban Aboriginal Strategy (MVUAS) and provide job placement and employment support to Aboriginal men and women (Essential Skills for Aboriginal Futures Program [ESAF]) and Aboriginal youth (Bladerunner Program). Other programs, such as the Aboriginal Community Career Employment Services Society provide job training.

6.2.3 Health care

Access to health care that targets the urban Aboriginal population is a critical aspect of health outcomes. In Vancouver, there is a range of health care services addressing such needs as dentistry, diabetes prevention, and support for people living with HIV/AIDS. The Vancouver Native Health Society runs a medical clinic called the Urban Aboriginal Health Centre located in the DTES for urban First Nations people. It is funded by all levels of government, non-profit organizations, private funding, the University of British Columbia (UBC), and the Vancouver Coastal Health Authority. The clinic's goal is to improve access to quality primary health care services; it provides "a 'one-stop shop' and a wrap-around integrated health care model that provides cultural safety, flexibility and non-judgmental care" (VNHS, 2012, para. 4). The Vancouver Native Health

Society also runs a dental clinic and the Positive Outlook Program, which supports people living with HIV/AIDS. The Pacific Association of First Nations Women Community Health Liaison helps Aboriginal persons and families to access health care and social services support. The Liaison works with "Aboriginal persons and their families in Vancouver and Richmond to assist in identifying and resolving problems associated with access to health care and social services support, with a primary emphasis on the health care system" (VCH, 2011, Table section, para. 7). Kla-how-eya: Aboriginal Centre of SACS provides a variety of health care services including Aboriginal Mental Health Outreach and HIV/AIDS Hepatitis C Outreach.

Two initiatives in Vancouver that target diabetes are the East Vancouver Aboriginal Diabetes Coalition (EVADC)

and Diabetes Awareness, Prevention and Teaching Program (ADAPT). The East Vancouver Aboriginal Diabetes Coalition "is a group of professionals and community members who are working together [...] to support Aboriginal community members living with, affected by, or at risk of developing diabetes by providing health resources to individuals, groups and service organizations" (EVADC website, para. 1-2). This organization's goals include identifying the needs of Aboriginal individuals who have, or are at risk of developing, diabetes and meeting those needs through prevention, education and resources. ADAPT is a program offered through the Vancouver Native Health Society that serves Métis and off-reserve Aboriginal people, and in particular, the Aboriginal residents of East Vancouver. The program is funded by Health Canada's Aboriginal Diabetes Initiative. ADAPT provides "culturally appropriate diabetes prevention and management workshops" including a focus on nutrition and traditional foods (DTES.ca, 2007, ADAPT section, para. 1). Medicine wheel workshops and sessions with Native Elders are other culturally relevant aspects of this program (DTES.ca, 2007).

6.2.4 Nutrition, food security and physical activity

Nutrition, food security and physical activity are very important to the maintenance of good health; poor nutrition and inactivity are risk factors for a number of ailments including diabetes and heart disease. Colonialism and the associated loss of cultural practices around food and nutrition have been blamed for the increase in these illnesses (and others) among Aboriginal people, and thus, cultural appropriateness is particularly important where food and activity are concerned. Vancouver Coastal Health's (VCH) Aboriginal Health Initiative Program (AHIP) promotes local community food security through its funding of local initiatives.

It was "launched in 2002 as a regional community based funding program to support and encourage Aboriginal communities to identify health promotion projects that are culturally meaningful to them" (VCH, 2010, para. 1). The Urban Aboriginal Food Enhancement Program, offered by the Vancouver Native Health Society, is an example of an AHIP. It supports capacity building, addresses food security issues, and supports a food-buying group and community garden for Aboriginal families (Ibid.). Other AHIP funded programs related to nutrition, food security and physical activity include: Creative Nourishment through Art and Food (Native Education College), Back to the Land (Ustlahn Social Society), Healthy Nutrition in Residential Facilities and Holistic Wellness Workshops (Circle of Eagles Lodge Society), and the Aboriginal Intergenerational Landed Learning Project. There are also a number of food-focused programs not funded by AHIP. These include the Urban Aboriginal Community Garden (partially funded by Vancouver Costal Health), Vancouver Native Health Society-IUALLP (MVUAS); Bannock on the Run/Elder's Meals on Wheels; and the Vancouver Aboriginal Friendship Centre's recreation for youth, which promotes physical activity.

6.2.5 Mental health and addiction

There are several mental health and wellness programs available to Aboriginal people residing in Vancouver; these programs are often carried out through contracts with Aboriginal community non-profit organizations (such as in Vancouver Coastal Health where 85% of Aboriginal health services are carried out in this manner) (VCH, 2010). Vancouver Coastal Health offers an Aboriginal Wellness Program which focuses on providing culturally safe mental wellness and addiction programs. This program utilizes the knowledge and experience of traditional healers and Elders and is open to any Aboriginal adult in Vancouver and their family members (Ibid.).

Addictions services are provided by Kla-how-eya: Aboriginal Centre of SACS (including the Sheway program) and the Native Court Workers and Counseling Association of BC. The Hey-way'-Noqu' Healing Circle for Addictions Society provides outpatient addiction counseling, sexual abuse intervention program, as well as a mental health liaison and is funded by the First Nations and Inuit Health Branch. The Aboriginal Front Door Society also offers drug and alcohol addictions services.

6.2.6 Women

Some programs and services focus specifically on the health and well-being of Aboriginal women residing in Vancouver. Examples of such services include BC Women's Hospital and Health Centre in Vancouver, which offers an Aboriginal health program that provides both on-site and outreach services to improve the health of Aboriginal women and their families. The Aboriginal Mother Centre Society offers housing, day care, family support and job training for women. Similarly, the MVUAS funds the Helping Spirit Lodge Society which provides services for women who have suffered physical and psychological abuse including housing, life and job skills training and parenting support (MVUAS, 2011). The MVUAS also funds WISH, a peer assistant, support and training program for Aboriginal survival sex trade workers (Ibid.). The Aboriginal Elders Support Program offered by the Pacific Association of First Nations Women focuses on the health of female Elders, and Vancouver Coastal Health's When Life Hurts Seek Wellness program is for women seeking pathways to wellness and recovery.

6.2.7 Youth

Programs for Aboriginal youth residing in the Vancouver area target many different needs related to health and well-being, including education, nutrition, life skills, and employment. Some programs are gender specific, targeting, for instance,

the needs of young girls. For example, the Aboriginal Health Initiative Program (AHIP) funds several youth-focused programs: Kids in the Kitchen for Better Nutrition (life skills); Saturday Culture Camp for Aboriginal Girls (cultural identity, health awareness and positive self care); and Aboriginal Foster Children and Youth Wellness Program-Vancouver Venture for Diversity Society (cultural workshops for Aboriginal foster children and youth). MVUAS also funds several programs such as the Urban Native Youth Association, an after school music, arts and culture program, and the Mathematics Program for Aboriginal Learners offered through the Native Education College.

The Urban Native Youth Association provides a large number of programs in the areas of education and training, personal support and residential programs. Table 10 lists these programs and provides a brief description where possible; it clearly illustrates the diversity of services provided by this organization.

6.3 Winnipeg

Winnipeg, Manitoba is home to 68,380 Aboriginal people, the highest number of Aboriginal individuals in any Canadian city accounting for 10% of Winnipeg's total population. Many health-related programs and services for Aboriginal people residing in urban areas are located in the City of Winnipeg. In this section, an overview of the following categories of health programs is provided: childcare and family support, education and employment, health care, cultural revitalization, and other services. This is not an exhaustive list of the types of services related to health and well-being that are available in Winnipeg; however, it offers insight into the diversity of available programs both in terms of population targeted and type of service provided.

Winnipeg is a designated Urban Aboriginal Strategy city, which has been guided, since 2004, by the Aboriginal Partnership Committee (APC) working

with the Aboriginal community, other levels of government, stakeholders, and Elders (AAND, 2010b). Now called the Aboriginal Strategic Partnership Circle, the organization focuses on three priority areas related to overall health and well-being: healthy families, education and training, and economic development (Ibid.).

6.3.1 Childcare and family support

The Ma Mawi Wi Chi Itata Centre in Winnipeg serves all ages, but is particularly focused on improving childcare and providing support to families (Ma Mawi Wi Chi Itata Centre website). Some programs offered at the Ma Mawi Wi Chi Itata Centre include the Rising Sun Pow Wow Club and the Cubs and Scouts program, which provide youth with a chance to grow in a positive environment which emphasizes cultural development (Ibid.). Kookum's Place Daycare is a child-focused program located at the Aboriginal Centre of Winnipeg. It is a non-profit organization providing childcare to children aged

3 months to 6 years. The Kookum's Place Daycare is committed to cultural relevance; for example, the "Seven Sacred Teachings and Medicine Wheel philosophy are incorporated into daily programming" (Kookum's Place website, para. 1).

6.3.2 Education and employment

Education and employment services can function to improve the health and well-being of Aboriginal people residing in urban areas. In Winnipeg, these services are found at the Centre for Aboriginal Human Resource Development (CAHRD) (CAHRD website). The Aboriginal Literacy Foundation also provides education support services. It serves urban Aboriginal families and individuals, and involves one-on-one as well as small and large group instruction. In order to facilitate participation in their programs, this organization also provides an on-site daycare. There is a library and a computer lab, and services include peer tutoring, personal support and employment readiness; résumé and job search skills and advocacy; and liaison with funders (Aboriginal Literacy Foundation website). The Aboriginal Youth Internship Program (AYIP) provides Aboriginal high school students with educational internships (Government of Manitoba, n.d.a), while the Urban Circle Training Centre focuses on the urban Aboriginal adult population and offers vocational programs (Urban Circle Training Centre website). Education opportunities for Aboriginal educators can be found at the Aboriginal Circle of Educators (Aboriginal Circle of Educators website).

6.3.3 Health care

The Aboriginal Health and Wellness Centre is located in the Aboriginal Centre of Winnipeg, and offers a comprehensive suite of health services for urban Aboriginal families and individuals. It includes a primary care clinic as well as health promotion and prevention

Table 10: Urban Native Youth Association Programs	
Program	Brief Description
Education & Training:	
Aries Program	Alternative Education
Cedar Walk	Alternative Ed – Day program
Kinnections	Mentorship
Mentorship Program	
Music, Arts & Culture (MAC) Program	
Native Youth Learning Centre	
School support program	Alcohol and drug prevention
Personal Support:	
Aboriginal Outreach Team	Street outreach
Aboriginal Transition Team	One-to-one support for youth
Aboriginal Wellness Counselor	
Aboriginal Youth Workers	DTES
Alcohol & Drug Counselors	
Alcohol & Drug Counselor at BYRC	
Mediation Program	
Overly Creative Minds	Arts and cultural programming
Residential Programs:	
Aboriginal Youth Safe House	Residential program
Ravens Lodge	Female youth
Young Bears Lodge	Alcohol and drug focus
Young Wolves Lodge	Voluntary program for young women
Sports & Rec Programs:	
Aboriginal Youth First Sports and Recreation Program	
Special Project 2011:	
Rookie Radio Program	
Parenting Booklet	
Youth Film Screening	Hosted Aboriginal Youth Film Festival
Anti-Violence Video	
Cree Language Classes	
Education Capacity Cafes	Safe place to talk about how youth's educational experiences can be improved within the Vancouver School Board

Source: Urban Native Youth Association

services involving physicians, nurses, and community health workers. For children, there is Abinotci Mino-Awawin (children's health), an Aboriginal Head Start Program (childcare), and a Fetal Alcohol Syndrome/Effects Prevention Program. Community initiatives include a community development and a community outreach and education program. Culturally appropriate health care is the focus of the Medicine Wheel Awareness Workshop and the traditional healers who are available on site (Aboriginal Centre of Winnipeg, 2008). Other health care services include the Eyaa-Keen Healing Centre for Aboriginal adults requiring therapeutic trauma treatment and physiological rehabilitation (Eyaa-Keen Healing Centre website), and the Winnipeg Regional Health Authority's Aboriginal Health Program which offers three branches of health programming: health services, health education and workforce development (Winnipeg Regional Health Authority, n.d.).

6.3.4 Culture revitalization
There are several health-related services in Winnipeg that put particular emphasis on cultural revitalization. For example, Project Opikihiwawin is for adopted and foster Aboriginal children and their families that aims to promote understanding and pride in the heritage of Aboriginal children (Government of Manitoba, n.d.b). Ka Ni Kanichihk is a community centre that offers culture-focused programs to all age groups of Aboriginal people residing in Winnipeg. These programs include: Aboriginal Youth Circle, Aboriginal Women Reclaiming Power, At Our Relatives' Place (childcare), Circle of Courage (males ages 12-17), Empowering Our Little Sisters (Group Mentorship Model), Honouring Gifts (young Aboriginal single mothers), Keeping the Fires Burning, Medicine Children's Lodge (daycare), Restoring the Sacred (Aboriginal youth mentorship and leadership), Self Employment Program for Aboriginal Women, and The Butterflies

Club (young Aboriginal girls ages 9-13) (Ka Ni Kanichihk website). The Circle of Life Thunderbird House is a non-profit organization that provides gathering space for all age groups to practice traditional and healing ceremonies (Thunderbird House website). Manitoba Indigenous Cultural Education Centre (MICEC) also promotes awareness of Indigenous cultures through its People's Library and the Community Connection Program. It is "a provincial, non-profit, charitable and educational organization that works to promote an awareness and understanding of First Nation culture to all Manitobans" (MICEC website, para. 1). The Manitoba Urban Inuit Association is not specific to Winnipeg, but is based in Winnipeg and approximately 90 % of its programs are located there. Its aim is to enhance quality of life for Inuit living in Manitoba. The Métis Child and Family Services Authority supports the health and well-being of Métis families and communities. Like the Manitoba Urban Inuit Association, it is not specifically a Winnipeg organization, but most of its initiatives are based in Winnipeg (Métis Child and Family Services Authority website).

6.3.5 Other services
Winnipeg also has services for women and youth, and that target needs such as sports and recreation, housing, and crime prevention. For example, the goal of the Winnipeg Aboriginal Sport and Recreation Association is to promote physical activity for all ages (WASRA website). Women can find long term residence through the Native Women's Transition Centre (Native Women's Transition Centre website), and young Aboriginal people will find a wide range of services through Ndinawemaaganag Endaawaad and the Oshki Annishinabe Nigaaniwak or Young Aboriginal People Leading: Aboriginal Youth Strategy. Ndinawemaaganag Endaawaad offers a variety of programs for young people, including sports and recreation, art and culture, and safety and crime prevention

(Ndinawemaaganag Endaawaad website). Oshki Annishinabe Nigaaniwak or Young Aboriginal People Leading: Aboriginal Youth Strategy is an initiative of the City of Winnipeg and is focused on community based employment and employment development projects and civic service initiatives (City of Winnipeg, 2011).

6.4 Summary

There are clearly a number of initiatives, both at the national and municipal scale, that target the health of Aboriginal people residing in urban areas. The programs listed in this section are diverse; they range from mainstream health care models to traditional, community-driven services. However, the question remains: Are the available programs and initiatives enough to fully serve the urban Aboriginal population? To properly answer this question is beyond the scope of this paper. Nonetheless, there is evidence that the level of service is uneven across the country, and that health services continue to be inadequate in terms of availability and acceptability. For example, national initiatives are not uniformly distributed, jurisdiction remains a significant barrier to health services provision, and access to acceptable services (i.e., culturally safe) is limited.

7. CONSIDERATIONS FOR POLICY/PROGRAM DEVELOPMENT AND PRACTICE
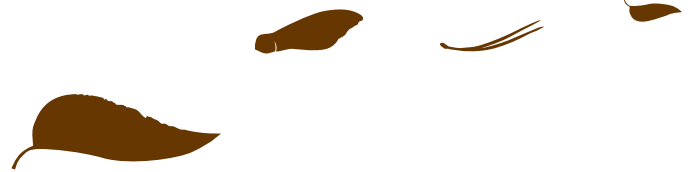
The objective of this paper was threefold: 1) to provide an overview of current patterns in urbanization and mobility; 2) to provide an overview of some general health trends (while keeping in mind the limitations of the data and the variability across the country); and 3) to examine services for Aboriginal people residing in two urban areas in order to emphasize the diversity, but also the gaps, in service provision. Conclusions can be drawn in each of these areas.

First, the population of Aboriginal people residing in urban areas is growing and currently more than half of the Aboriginal population of Canada resides in urban areas. The drivers of this growth are not fully understood, but mobility does play a role. The Aboriginal population is relatively mobile, both between on-reserve/rural communities and off-reserve/urban areas, and within urban areas. The growth of the urban Aboriginal population, as well as the relative mobility of this population, has demographic and jurisdictional implications for health and health service delivery.

Second, a social determinants of health framework is applicable and desirable when trying to understand the health of Aboriginal people who reside in urban areas. While there is literature available that discusses the health of this population, up-to-date data are scarce. Thus, only an incomplete picture is available and more research is needed. However, this picture, incomplete though it may be, does indicate that Aboriginal people residing in urban areas tend to have poorer health than their non-Aboriginal counterparts. While it is acknowledged that many Aboriginal residents of urban areas are well-educated and have adequate incomes, attention to social inequities must continue to top the priority list.

Third, health services specifically for Aboriginal people residing in urban areas do exist at the national, regional and local scale. There remain, however, barriers to utilizing health care related to availability and acceptability of services. Vancouver and Winnipeg both have a wide range of services for various sub-sections of the population (such as women or youth) and targeting various aspects of health care (such as illness specific services, prevention, and socioeconomic determinants). The funding for these services may be governmental or charitable, and there is an increasing focus on cultural revitalization in many programs.

In light of the findings of this report, several recommendations are provided in the following sections. The first set of recommendations highlights gaps in the literature and areas for future research. The second set of recommendations highlights gaps related to health and health care that are not being adequately addressed through available programs.

7.1 Gaps in Literature and Recommendations for Future Research

While literature on the urban Aboriginal population exists, more is needed. In particular, quantitative information about Aboriginal people residing in urban areas is scarce and out-of-date. Research that specifically addresses health outcomes for Aboriginal residents of urban areas at various scales is especially limited. The lack of available long term, stable data related to urbanization, mobility, socioeconomic status, health and demographics mean that longitudinal studies are not possible, and comparisons between urban and rural populations are difficult. Data at various scales should be readily available (i.e., for CMAs, CAs, smaller urban areas, and urban reserve communities). This would allow comparisons between the on-reserve and off-reserve urban Aboriginal population.

Peters (2004) notes that migration frameworks and models based on non-Aboriginal populations do not apply well to Aboriginal populations. Therefore, a gap in research exists around the mobility of Aboriginal people. Currently, there is insufficient understanding of the connections that persist between urban areas and reserve communities, especially with respect to providing services. Instead of viewing the relative mobility of Aboriginal people as negative (i.e., understanding it as transiency and failure to thrive in urban areas), a more nuanced understanding is needed to better inform how health care is delivered.

Similarly, there is a gap in the literature regarding heath care utilization and health care service provision. Not enough is known about what services are available and how well they are utilized. For example, it is acknowledged that Aboriginal residents of urban areas are a diverse population with diverse needs; how well are these needs being met, how evenly or appropriately are services distributed and what affects rates of service utilization?

7.2 Gaps Related to Health and Health Care

Health is not uniformly poor among Aboriginal people residing in urban areas and, clearly, health services are available. However, the main message remains that Aboriginal people continue to have poorer health and that health services continue to be inadequate in terms of availability and acceptability. In other words, there are still too few readily accessible and culturally appropriate services in Canada's urban areas. The level of service is highly uneven, as well, with some larger cities like Vancouver having seemingly countless programs and other (often smaller) urban areas having very few.

Women and children are particularly vulnerable to poor health, and there is an inadequate level of services that address family violence, childcare and urban transition. For example, there are few culturally sensitive programs for women who are victims of violence and trying to transition safely with children to an urban area. Likewise, more services are needed that address income support and mental health (e.g., addictions and suicide prevention).

Jurisdiction is a significant barrier to health services provision. Jurisdictional issues need to be addressed so that services for Aboriginal people residing in urban areas are equally accessible, available and appropriate across the country. Priority should be placed on reducing the confusion and bureaucratic barriers that currently exist around jurisdiction; ultimately there should not be a disadvantage to living off-reserve or in urban areas. Careful work needs to be done in considering whether those services should be 'status-blind', and self-governance structures for health care delivery are strongly encouraged.

The fact that many health programs and initiatives are charitable endeavours is evidence that there is currently inadequate funding of health services for Aboriginal residents of urban areas. Relying too heavily on non-profit funding structures can result in services being unevenly distributed and also unstable. A comprehensive suite of appropriate and acceptable health services should be available and accessible, as well as evenly distributed in urban areas across the country.

Health services still tend to focus largely on health behaviours and physical risk factors. The social determinants of health framework tells us that education and employment are key indicators of health and well-being. Therefore, services focused on increasing education attainment, employment rates and income levels should be prioritized. Safe and affordable housing is also a central concern that continues to demand attention. Finally, the health and well-being of all Aboriginal people, including those who reside in urban areas, has been greatly impacted by colonialism. Improving health, then, requires services that are culturally safe, but moreover, that focus on cultural revitalization and increasing individual and community empowerment.

8. CONCLUSION
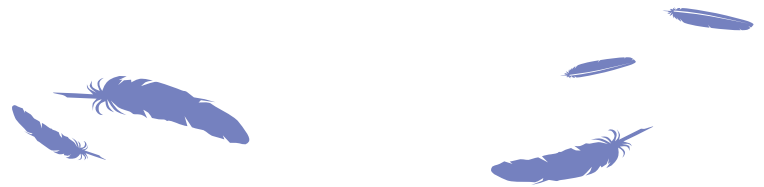
The Aboriginal population in Canada is increasingly urban and more mobile than the non-Aboriginal population. The aim of this paper was to provide an overview of the issues that affect the provision of health services for this population, and to provide some direction for policy and planning of health service delivery for Aboriginal people residing in urban areas. While the health of the urban Aboriginal population is not uniformly poor, there remains a pattern of poorer health outcomes, and social determinants of health continue to be of concern. Health services play an important role in supporting the health of Aboriginal people residing in urban areas, but the level of services is uneven across the country and improvements are required in both availability and acceptability of health services. The focus of health service policy and planning should be on ensuring that programs are culturally safe and on minimizing jurisdictional barriers. The urban Aboriginal population is a vital and important part of Canada's cities, and requires continuation and expansion of comprehensive and evidence-based health service delivery.

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