Exploring Gendered Relationships Between Aboriginal Urbanization, Aboriginal Rights And Health

by

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Abstract

Aboriginal urbanization has increased dramatically in Canada over the last half century. Aboriginal rights may be an important factor in shaping Aboriginal peoples' experiences of urbanization, as they are largely restricted to those living on reserves. Through their impacts on social determinants of health, these differences in spatial access to Aboriginal rights may have implications for the health of Aboriginal peoples living in urban areas. Using mixed quantitative (statistical analysis of the Aboriginal Peoples Survey) and qualitative (in-depth interviews with Aboriginal women and men in Toronto) methods, this thesis explores relationships between Aboriginal urbanization and Aboriginal rights, focusing on how they may differentially impact the health of Aboriginal women and men living in urban areas. Findings suggest that the perceived lack of respect for Aboriginal rights in urban areas is negatively related to health, and that Aboriginal women and men may experience these impacts differently.

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List of Abbreviations

Aboriginal Affairs and Northern Development Canada – AANCD

Aboriginal Peoples Survey – APS

Assembly of First Nations – AFN

Body Mass Index – BMI

Canadian Community Health Survey – CCHS

Commission on the Social Determinants of Health – CSDH

Confidence Intervals – CI

First Nations Regional Longitudinal Health Survey – RHS

Greater Toronto Area – GTA

Indian and Northern Affairs Canada – INAC

Native Women's Association of Canada – NWAC

Native Women's Resource Centre – NWRC

Non Insured Health Benefits – NIHB

Not Significant – ns

Odds Ratio – OR

Public Use Microfile – PUMF

Royal Commission on Aboriginal Peoples – RCAP

United Nations Declaration on the Rights of Indigenous Peoples – UNDRIP

World Health Organization – WHO

Chapter 1

1 Introduction

1.1 Background and Research Questions

Aboriginal[1] urbanization is an increasingly important trend in Canada that warrants public, governmental and scholarly attention. From just 13% in 1961 to 54% in 2006, the proportion of the national Aboriginal population living in an urban area has increased at an unprecedented rate over the last half century (Canada 2009; Norris and Clatworthy 2011). Levels and trends in urbanization vary by Aboriginal group (i.e. status First Nations, non-status First Nations, Métis and Inuit peoples) and by gender; women, non-status First Nations and Métis peoples are overrepresented in urban areas. Often erroneously equated with a mass exodus from rural and reserve[2] areas, Aboriginal urbanization is actually characterized by high levels of urban mobility, both between urban and other areas (other urban or rural/reserve areas), and within urban areas (Norris and Clatworthy 2003; Norris, Cooke et al. 2004). The factors underlying these patterns are not well understood, though urban mobility literature has tended to assume that high levels of mobility reflect instability, a lack of opportunities in rural/reserve areas and difficulty adjusting to urban areas (Norris, Cooke et al. 2004; Norris and Clatworthy 2011).

Adding further complexity to trends in Aboriginal urbanization is ethnic mobility, or changes in affiliation with an identity group (Guimond 2003; Guimond, Robitaille et al. 2009). An important factor contributing to ethnic mobility has been legislative changes in the *Indian Act,* a colonial document that continues to define the legal identity of status First Nations.

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[1] The term Aboriginal is used in this thesis to describe the Indigenous inhabitants of the land that is now Canada. Section 35(2) of the *1982 Constitution Act* states that Aboriginal peoples of Canada include “Indian, Inuit and Métis peoples”. As employed in the 1996 Royal Commission on Aboriginal Peoples (RCAP), use of the term Aboriginal peoples in this work refers to “organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called ‘racial’ characteristics” (Canada 1996b, p. xiv). The term First Nations is used throughout this thesis instead of Indian. First Nations populations can be further differentiated based on ‘Indian status’. Status First Nations (or Registered First Nations) are those who are registered under the *1876 Indian Act of Canada*, while non-status First Nations are not registered under this *Act*.

[2] Reserves are legally defined in the *1876 Indian Act of Canada* as tracts of land that have been set aside by the federal government for use by First Nations or Indian Bands.

Notably, prior to the 1985 Bill C-31 amendments to the *Indian Act*, status First Nations women who married non-status men lost their status, as did their children. Among other implications, this forced many First Nations women off of their reserves. As a result, many relocated to urban areas, contributing to their overrepresentation there, compared to men (Peters 2000a). The Bill C-31 amendments to the *Indian Act* reinstated status to many of these women, though for various reasons which will be explored further in Chapter 2, many remained living in urban areas (NWAC 1999; Peters 2005).

In order to better understand this complexity, it is imperative to examine Aboriginal urbanization within the context of colonialism, which continues to have implications for the ways in which Aboriginal peoples experience urbanization. Specifically, it is essential to consider how colonialism has shaped Aboriginal identities and urban spaces, constructing urban areas as antithetical to Aboriginal identities, in order to more fully understand these trends. Aboriginal peoples do not move to urban areas in the exact same way as other migrants; rather, in moving to urban areas they are moving to spaces that may form a part of their traditional territories, and are also spaces from which they were actively removed through the processes of colonialism (i.e. through the creation of reserves for status First Nations and the relocation of Métis communities to regions far from emerging urban spaces) (Peters 2000b; Peters 2006). Linked to the physical separation of Aboriginal peoples from urban areas, the construction in Western thought of Aboriginal cultures/identities as the embodiment of nature and wildness, in contrast to the envisioned rationality and strict planning of urban areas, has also contributed to the social separation of Aboriginal peoples from urban areas (Peters 2002; Wilson 2005). The enduring nature of the assumed incompatibility of Aboriginal peoples and urban areas can be seen in early Aboriginal urban mobility literature, which reasoned that urbanization indicated a willingness to give up Aboriginal identities/cultures, that lingering attachment to such identities/cultures was responsible for any difficulty that Aboriginal peoples experienced in urban areas, and that return migration to rural/reserve areas was an indication of failure to adapt to urban life (Frideres 1974; Peters 2002). The federal government's policy of limiting their responsibility for Aboriginal rights only to those with status, who live on-reserve, is a further contemporary manifestation of these colonially constructed incompatibilities (Peters 2005).

It is important to note, however, that these colonial constructions have not gone uncontested; Aboriginal peoples continue to negotiate and resist these forces in urban areas (Peters 1998; Browne, McDonald et al. 2009). The reterritorialization of urban space, through the assertion and celebration of Aboriginal identities in urban areas, and in advocating for the recognition of Aboriginal rights in urban areas, are important components of this resistance (Peters 1998; Wilson and Peters 2005). Examining the spaces and scales at which Aboriginal rights are enacted is helpful in understanding how these heterogeneous geographies of Aboriginal rights impact Aboriginal peoples' experiences of urbanization and how they are contested. Owing to the differing patterns and experiences of urbanization between Aboriginal women and men, it is important to highlight the ways in which the negotiation of these geographies of Aboriginal rights may differ by gender.

The focus on geographies of Aboriginal rights and their implications for urbanization raises questions about how this may impact the health of Aboriginal women and men living in urban areas. Aboriginal health research has documented and explored the pervasive health inequities that exist between Aboriginal peoples and the rest of the Canadian population (Adelson 2005; Smylie 2009). However, much of this research has focused on reserve-based populations and as a result, little is known about the health of Aboriginal peoples living in urban areas (Wilson and Young 2008). Given the vast bodies of health geography research and social determinants of health-based research that explore the importance of place and specifically, social, political and economic environments in shaping health, it is important to consider how this widespread change in place (i.e. between reserve/rural and urban areas), and its attendant interconnections with heterogeneous geographies of Aboriginal rights, may impact the health of Aboriginal women and men living in urban areas (Macintyre, Ellaway et al. 2002; Curtis 2004). In this thesis, a social determinants of Aboriginal health conceptual framework is used as the basis from which to explore these relationships (Loppie-Reading and Wien 2009). Contributing to gaps in Aboriginal health and health geography research, this master's thesis explores the specific research question: How are Aboriginal rights implicated in urbanization and what effect does this have on the health of Aboriginal women and men living in urban areas? A mixed quantitative and qualitative methods approach is used to address this main research question. Through statistical analysis using the 2006 Aboriginal Peoples Survey (APS) and in-depth interviews with Aboriginal peoples living in Toronto, this thesis is guided by three main

empirical, theoretical and policy-oriented research objectives: (i) to develop an understanding of how urbanization may differentially impact the health status of urban Aboriginal women and men at a national level, with attention to a potential role for Aboriginal rights, (ii) to expand understandings of gendered dimensions of urbanization, focused in particular on the role of Aboriginal rights in shaping these processes and how they are related to health, and (iii) to generate knowledge that will help to create an impetus to include urban Aboriginal perspectives in discussions on health care and rights, ultimately informing public policy.

1.2 Thesis Outline

This thesis is presented in five chapters. Chapter 2 critically reviews the relevant literature on Aboriginal urbanization, Aboriginal rights and health, in an effort to contextualize the research questions and overall thesis objectives, which are detailed at the conclusion of the chapter. Chapter 3 presents the first phase of the thesis research, a quantitative analysis using the APS, providing a national picture of gendered relationships between Aboriginal urbanization, Aboriginal rights and health. Building on the findings from the quantitative analysis, Chapter 4 presents the methods and findings from the qualitative phase, which explores the ways in which experiences of urbanization and Aboriginal rights are interconnected, and how they are implicated in the health of Aboriginal women and men living in Toronto, through in-depth, semi-structured interviews. In Chapter 5, the results of the qualitative phase are discussed, focusing on the implications of the research findings. The overall contributions of the research in reference to the three main research objectives are also discussed in the final chapter, as well as some suggested areas for further research.

Chapter 2

2 Literature Review: Aboriginal Urbanization, Rights and Health

2.1 Aboriginal Urbanization: Trends, Gender Differences and Underlying Factors

2.1.1 Trends in Urbanization

In 2006, Statistics Canada reported that there were over one million Aboriginal peoples in Canada, representing approximately 4% of the country's total population. Among the Aboriginal population, 60% identified as First Nations (53% status First Nations, 7% non-status First Nations), 33% as Métis, 4% as Inuit and 3% identified as having multiple or other Aboriginal identities (Canada 2009c). Since 1996, the Aboriginal population has increased by 45%, a growth rate nearly six times higher than that of the non-Aboriginal population over the same time period (Canada 2009c). The population is quite young with a median age of 27 (compared to 40 in the non-Aboriginal population), and almost 50% of the population under the age of 24 (compared to 31% of the non-Aboriginal population) (Canada 2009c).

The Aboriginal population in Canada is increasingly living in urban areas[3]. From just 12.9% of the total Aboriginal population in 1961 to 53.2% in 2006, Aboriginal urbanization has increased dramatically over the last half century (Peters 2002; Norris, Cooke et al. 2004; Canada 2009c; Norris and Clatworthy 2011). Despite this massive increase in the proportion of Aboriginal peoples living in urban areas, the level of urbanization among the Aboriginal population remains lower than that among the non-Aboriginal population in Canada, which was 81.0% in 2006 (Norris and Clatworthy 2011). Winnipeg is home to the largest urban Aboriginal[4] population (10% of the city's overall population), followed by Edmonton, Vancouver, Toronto and Calgary (Canada 2009c). Levels of urbanization vary quite considerably among Aboriginal populations. In 2006, 74.5% of non-status First Nations and 69.2% of Métis peoples lived in an urban area, while these proportions were just 40.4% among status First Nations and 36.8%

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[3] Urban areas include census Metropolitan Areas (CMAs – an urban area with a core population of at least 100,000) and non-CMAs (urban areas with a core population of at least 10,000).

[4] It is important to note that when using the term 'urban Aboriginal peoples', the suggestion is not that by virtue of the fact that they live in urban areas, they are necessarily different or less authentic than Aboriginal peoples living on-reserve or in rural areas (Peters 2011). Use of this terminology is simply for clarity.

among the Inuit (Canada 2009c). Only 40% of First Nations were living on-reserve in 2006, though this proportion was considerably higher among those with status (48%) than among those without status (3%) (Canada 2009c; Norris and Clatworthy 2011). The proportion of Aboriginal women living in urban areas (55%) is greater than the portion of men (52%), whereas the opposite is true of rural and reserve areas (Canada 2011a).

Though the trend towards an increasingly urban Aboriginal population is clear, its implications are often obscured by stereotype-based misconceptions. Chief among these is the notion that increasing Aboriginal urbanization indicates a mass exodus from reserve and rural areas (Norris, Cooke et al. 2004; Norris and Clatworthy 2011). In reality, Aboriginal urbanization is much more complex. Trends indicate that over the past 35 years, there have been consistent net inflows to reserves, and variable net in and outflows in rural and urban areas (Norris and Clatworthy 2011). Further, Aboriginal urbanization is characterized by high levels of mobility. Movement within the same community is referred to as *residential mobility* (e.g. changing place of residence within an urban area), movement between two different communities (e.g. between a reserve and an urban area or between two different urban areas) is called *migration*, frequent migration between rural/reserve and urban areas has been referred to as '*churn*' and *mobility* is the term used to describe all such movement (Norris and Clatworthy 2003; Norris, Cooke et al. 2004; Peters 2005). Levels of mobility (migration and residential mobility) are higher among the Aboriginal population than the non-Aboriginal population (Norris and Clatworthy 2003). While migration among residents of reserves (mostly status First Nations) tends to be lower than among the non-Aboriginal population, migration among Aboriginal peoples living off-reserve is much higher than among this population, both in rural areas and urban areas (Norris and Clatworthy 2003; Clatworthy and Norris 2007). Mobility tends to be higher for Aboriginal peoples in urban areas than in rural areas and is characterized by high levels of churn and residential movement, compared to the non-Aboriginal population (Norris and Clatworthy 2003; Norris and Clatworthy 2011). As in the non-Aboriginal population, mobility is highest among young Aboriginal adults. The Aboriginal population is consistently more mobile than the non-Aboriginal population across the life course, so it is unlikely that these mobility trends are merely a function of the fact that the Aboriginal population is quite young (Norris and Clatworthy 2003; Clatworthy and Norris 2007). Interestingly, analyses comparing

the 2001 and 2006 census data reveal that levels of mobility between Aboriginal and non-Aboriginal populations are converging over time (Norris and Clatworthy 2011).

Trends in mobility vary considerably within the Aboriginal population, that is, between status First Nations, non-status First Nations, Métis and Inuit populations. Status First Nations tend to be the most mobile Aboriginal group in urban areas (Norris and Clatworthy 2003). In their analysis using 2001 census data, Clatworthy and Norris show that migration between urban areas accounts for the largest proportion of migration among all four Aboriginal populations (2007). Urban-urban migration was highest among non-status First Nations (59.7%), followed by Métis (53.0%), status First Nations (34.3%) and Inuit peoples (26.7%). Non-status First Nations and Métis peoples exhibit similar migration patterns, almost all of which occur between urban areas, and between rural and urban areas. By contrast, nearly a quarter of all migration among the Inuit is between rural areas. The migration patterns among status First Nations are distinct from those of the other three Aboriginal population groups as they are characterized by high levels of migration between reserves and urban areas (10.7% reserves to urban; 18.2% urban areas to reserves according to the 2001 Canadian census). Residential mobility is quite high in all Aboriginal populations, though levels are highest among status First Nations in urban areas (Clatworthy and Norris 2007).

Trends in urbanization and urban mobility also differ considerably by gender. Aboriginal women have been overrepresented in urban areas compared to men since trends in increasing urbanization began in the 1950s (Peters 2005). This gender differential in urbanization is not fully understood, but is linked to the patriarchal colonial legislation of the *1876 Indian Act of Canada*, which continues to define the legal identity of status First Nations. Prior to 1985, status First Nations women who married men without status lost their legal status and were denied the ability to pass on status to their children. An amendment to the *Act* in 1951 ensured that women who lost their status also lost their rights to Band membership and residency on-reserve (Stevenson 1999). Effectively forced off-reserve, many of these women ended up migrating to urban areas (Peters 2000a). Since the Bill C-31 amendment to the *Indian Act* in 1985, many of these women and their descendents have regained status. However, for a number of reasons, including the discrepancies between legal status and Band membership that were the result of this amendment, many women who regained status continue to live in urban areas (NWAC 1999;

Peters 2005; Fiske 2006) (The implications of Bill C-31 on Aboriginal women and urbanization will be explored further in section 2.2). Despite the Bill C-31 amendments, out migration from reserves continues to be higher among women, whereas the level of in migration to reserves is higher among men (Norris, Cooke et al. 2004; Norris and Clatworthy 2011). This gendered trend is not restricted to the largely First Nations population that migrates to and from reserves: out migration from rural to urban areas is higher among women than men in all Aboriginal groups (Norris and Clatworthy 2003). As in the non-Aboriginal population, Aboriginal women also tend to be more mobile (migration and residential mobility) than men (Norris and Clatworthy 2003).

2.1.2 Underlying Push and Pull Factors

Though the direction and size of mobility flows have been relatively well documented, the factors underlying the complex patterns of urban mobility among Aboriginal peoples are not well understood. In keeping with the erroneous equation of Aboriginal urbanization with a mass exodus from reserves, early literature attributed the increase in Aboriginal urbanization largely to a lack of economic possibilities and population pressure on reserves (Peters 2002). However, it is clear from the 'churning' of Aboriginal populations that rural and reserve areas continue to serve important roles in the lives of many Aboriginal peoples. Though it has been acknowledged that the factors underlying urban mobility likely vary considerably by place and individual, that is, what may serve as a pull factor for one individual could be a push factor for another, the literature suggests some common themes (Jaccoud and Brassard 2003; Norris, Cooke et al. 2004; Cooke and Bélanger 2006; Clatworthy and Norris 2007).

Factors that are thought to push people from reserves/rural areas include lack of opportunities (employment, housing and educational), difficult social and economic conditions, marriage and family formation or conflict, quality of life, health facilities, and Band politics (in the case of reserves specifically) (Norris and Clatworthy 2003; Norris, Cooke et al. 2004; Cooke and Bélanger 2006; Peters and Robillard 2009). Reserves/rural areas are thought to draw migrants as they foster and safeguard Aboriginal cultures and identities by, for example, providing a means of maintaining important connections with the land, a place to raise children and teach them about traditions and culture in a space perceived to be less culturally discriminatory, and a place where services are offered in culturally appropriate ways (Peters 2004; Wilson and Peters 2005; Cooke and Bélanger 2006; Richmond and Ross 2009). Further, it

has been found that social support through networks of family and friends, and the perceived better quality of life with lower rates of crime and less access to drugs and alcohol, may also pull people to reserves/rural areas (Cooke and Bélanger 2006; Clatworthy and Norris 2007). It is important to note some pull factors that are unique to reserves, such as funding for housing, tax exemption and access to funding for post-secondary studies (Norris and Clatworthy 2003; Peters and Robillard 2009). These benefits stem from Aboriginal rights, which are largely restricted to status First Nations living on reserves (Aboriginal rights will be explored in greater detail in section 2.2). The pull factors associated with urban areas are thought to be centered primarily on better opportunities (employment, housing, educational) and the excitement of living in a city, while the push factors include racism and discrimination, which can hinder access to opportunities (Norris, Cooke et al. 2004; Cooke and Bélanger 2006). Personal and family relationships are also highly important in shaping push and pull factors in all directions (Skelton 2002; Jaccoud and Brassard 2003).

In line with the gendered patterns of urbanization, the push and pull factors underlying urban mobility are also thought to differ between women and men. Factors related to family priorities, such as best environments in which to raise children, caring for family members, access to social services, escaping social stigma and domestic violence are thought to more often impact women's decisions to move (Cooke and Bélanger 2006; Peters and Robillard 2009). The Royal Commission on Aboriginal Peoples (RCAP) found that the erosion of women's roles in Aboriginal communities through the imposition of colonial norms and values is an important contributor to their decisions to migrate to urban areas (Canada1996b; Peters 2005). As noted above, the implications of the *Indian Act*'s legislation of the identities of First Nations women on their (lack of) choice to migrate from reserves cannot be overestimated. By contrast, men's decisions to move are thought to be more often motivated by economic factors, such as employment, education and housing (Norris, Cooke et al. 2004; Peters 2005; Cooke and Bélanger 2006; Peters and Robillard 2009).

2.1.3 Other Factors Contributing to Urbanization

The high levels of urban mobility both within urban areas and between urban and reserves/rural areas are clearly very important in understanding the complexity of Aboriginal urbanization. However, mobility alone does not account for the massive increase in the number

of Aboriginal peoples living in urban areas since the 1950s. In fact, Norris and Clatworthy state that "[w]hile migration was a major factor at the beginning period of Aboriginal urbanization, its impacts on urbanization clearly diminished over later periods, with large urban areas experiencing either small net inflows or net out-flows of migrants" (2011, p. 52). Factors such as high fertility rates linked to natural population increase and intermarriage/family formation also impact Aboriginal urbanization (Norris, Cooke et al. 2004). It has been suggested that ethnic mobility, or changing patterns of self-identification, has been highly important in contributing to the growth of the urban Aboriginal population (Guimond 2003; Guimond, Robitaille et al. 2009). Ethnic mobility has been linked to changes in the socio-political environment impacting individuals' decisions to affiliate with a particular group, such as improved public perception of Aboriginal peoples, a social environment perceived to be more open to difference and less wrought with racism and discrimination, and renewed political awareness among Aboriginal peoples (Guimond 2003; Guimond, Kerr et al. 2004; Lawrence 2004). This may be particularly important in explaining the increases in non-status First Nations, Métis and Inuit populations in urban areas (Guimond, Kerr et al. 2004).

Perhaps more significant in terms of growth in the status First Nations population, ethnic mobility is also closely linked with government policy and legislative changes (Guimond 2003; Norris, Cooke et al. 2004). Following the reinstatement of status to many women and their children through 1985's Bill C-31 amendments to the *Indian Act*, there was tremendous growth in the status First Nations population, many of whom were in urban areas, due to prior forced removal from reserves. It has been noted that between 1985 and 1995, almost 85% of those who had their status reinstated through Bill C-31 lived off-reserve and though reinstatement affects both women and men, the effects have been greater among women (Peters 2000c; Norris, Cooke et al. 2004; Cannon 2008). Recently, Bill C-3 *Gender Equity in Indian Registration Act*, which will reinstate status to the grandchildren of women who had lost status, was passed and will further increase the status First Nations populations in urban areas (Canada 2011). However, many have noted that this amendment fails to deal with the fundamental gender discrimination in the *Indian Act* and ensures that the *Act* continues to convey different status eligibilities based on gendered descent (Chiefs in Ontario 2010; NWAC 2010). It is important to note that in the context of these legislative changes, ethnic mobility is not so much the result of an individual's

decision to affiliate with a specific group, but rather is a state-defined identity category. The imposition of this identity category is also thought to be tempered by place of residence – the social relations shaped by state policy around loss of status have created social spaces in which Bill C-31 reinstatees living in rural/reserve areas may have less choice in their ethnic affiliation than do those living in urban areas, which are generally more multicultural and provide a greater chance for changes in self-identification due to the relative anonymity that they provide (Fiske 2006).

2.2 Aboriginal Urbanization in Context: Colonialism, Aboriginal Rights and Citizenship

In order to more fully grapple with the complexity of Aboriginal urbanization, it is imperative to examine these trends in the context of colonialism, which continues to fundamentally structure the lives of Aboriginal peoples in Canada. More specifically, we must consider Aboriginal urbanization in the context of a colonial state that has had as its mandate the social and legal eradication of Aboriginal peoples (Napoleon 2001; Lawrence 2004). In doing so, it is important to consider how colonialism has constructed identities and restructured gender relations among Aboriginal peoples, in addition to the ways in which it has created conceptions of urban space as fundamentally incompatible with Aboriginal identities. These factors contribute greatly to the ways in which Aboriginal peoples experience urbanization.

2.2.1 Colonial Constructions of Identity and Gender

The *1876 Indian Act*, which has been referred to as "the most oppressive legislation in Canadian history", is the colonial tool with which the Canadian state governs the identities, lives and lands of Aboriginal peoples, primarily status First Nations, who are registered under the *Act* (Voyageur 2000, p. 88). The *Indian Act* has defined Aboriginal identities in terms of constructed racial divisions, based more on convenience for the state than on the political and cultural groupings that actually characterize Aboriginal peoples (Napoleon 2001; Lawrence 2004). This and other state legislation (i.e. the *1982 Constitution Act*) that defines peoples as status or non-status First Nations, Métis or Inuit under the umbrella term Aboriginal can be highly divisive (Lawrence 2004). It is important to note that while these legislated identities were largely the constructs of the colonial state, they now reflect real differences among Aboriginal peoples based

on different lived experiences and access to resources/rights, and have thus taken on deeper meaning (Restoule 2000; Lawrence 2004; Thobani 2007).

Colonial constructions of Aboriginal identities have implications for the ways in which Aboriginal peoples experience urban areas. As described in the previous section, levels of urbanization and trends in urban mobility differ between status First Nations, non-status First Nations, Métis and Inuit peoples, however, the reasons underlying these differences are not well understood. The ways in which colonial legislation of identities impacts the formation of Aboriginal communities in urban spaces are slightly more clear. It has been suggested that internalized racism, expressed through some Aboriginal people's acceptance of the *Indian Act*'s identity categories in a commonsense way despite the rhetoric of rejecting these classifications, can present itself as divisions amongst urban Aboriginal communities (Weaver 2001; Lawrence 2004; Silver 2006; Peters 2011).

The impacts of colonialism on the identities and roles of Aboriginal women are particularly important to consider in terms of the complexities of urbanization. The imposition of male-dominated hierarchies and European hegemonic values through colonialism have subordinated Aboriginal women and eroded the positions of political, economic and social power that they held in many Aboriginal societies pre-contact (Stevenson 1999; Voyageur 2000; Martin-Hill 2003). The gender discrimination in the *Indian Act* severely circumscribed women's autonomy in virtually all aspects of life from marriage, divorce and sexuality to land ownership, political decision-making and Band membership (Peters 1998; Stevenson 1999; Thobani 2007). While the *Indian Act* also certainly undermined the autonomy of Aboriginal men, women were more severely subordinated through this *Act* as it ensured that in addition to being under the control of the colonial state, they were also subjugated by Aboriginal men (Jamieson 1978; NWAC 1999; Stevenson 1999; Green 2001). As noted previously, this is exemplified by section 12(1)(b) of the *Indian Act*, which mandated that upon marrying men who did not have status, women and their children lost their status. By contrast, non-Aboriginal women who married status First Nations men gained status, as did their children. Aboriginal women's identities were thus defined in terms of their husbands, replacing traditional Aboriginal lineage systems, many of which were matrilineal, with a patriarchal system. In 1951, the *Indian Act* was further amended so that in addition to losing their status upon 'marrying out', women also lost their

Band membership. This meant that women lost "the right to live on-reserve free from taxation or liens; be buried on-reserve; receive their fair share of First Nation annuities, revenues, and any on-reserve services like health and education", in addition to the less tangible but no less important loss of the "right to live on traditional lands, participate in First Nations local activities (cultural, social, economic, spiritual), and raise their children in the traditional extended family system" (Stevenson, 1999, p. 68). Even for women who did not 'marry out', rights to live on-reserve were more precarious than they were for men; patriarchal *Indian Act* legislation recognized only men as the marital property owners, leaving many women with no choice but to leave the reserve upon the dissolution of their marriage (Peters 1998).

Given the ways in which many Aboriginal women found themselves in urban areas, it is not difficult to see how colonialism has contributed to the poverty and marginalization that many experience there (Canada 1996b; Peters 1998). Dominant representations and stereotypes of urban Aboriginal women construct them as poor, transient, socially and sexually excluded and exploited, and involved in prostitution and drug abuse; they are simultaneously the objects of much voyeuristic public attention and are systemically ignored and made invisible in urban areas (Razack 2002a; Culhane 2003; Pratt 2005). The patriarchal policy that is at the root of Aboriginal women's increased presence and marginalization in urban areas is also linked to representations of women more broadly as out of place in urban areas, owing to dominant conceptions of them as disorder and chaos, in contrast to the strict and rational planning of the Western city (Wilson 1991; Peters 1998). The forced removal of many women from reserves, and the political disempowerment and loss of connections with family and culture that this essentially forced migration path precipitated, were also accompanied by considerable financial loss for these women, through for example, the loss of property on-reserve (Stevenson 1999; Lawrence 2004). This further contributed to the marginalization of many, but it is important to note, by no means all, Aboriginal women in urban areas (Peters 2000b; Howard-Bobiwash 2003; Lawrence 2004). Following the 1985 Bill C-31 amendments to the *Indian Act,* many women and their children had their status reinstated, though for reasons including discrepancies between status and Band membership, competition for limited housing and resources on-reserve, employment and education opportunities in urban areas, and issues such as family conflict, domestic violence and fear of discrimination on-reserve, many women remained in urban areas,

adding further to the numbers of urban status First Nations women (NWAC 2002; Culhane 2003). It is important to acknowledge that while the loss and reinstatement of status directly impacted women, it also impacted their children, both male and female (Cannon 2008). Further, though the loss of status applies only to First Nations women, the colonial subjugation of Aboriginal women was not limited to this group and certainly contributes to the marginalization of Métis and Inuit women living in urban areas as well (Fiske 1996; Voyageur 2000; Lawrence 2004; Boyer 2006).

2.2.2 Colonial Construction of 'Urban' Space as Antithetical to 'Aboriginal' Identity

In addition to its effects on Aboriginal identities[5] and gender roles, it is essential to consider the role of colonialism in shaping the very meaning of 'urban' as a place, specifically, a place defined in opposition to colonial conceptions of Aboriginality. Urbanization for Aboriginal peoples is not the exact same type of experience as it is for other migrants to urban areas, though of course there are many similarities (Peters 2006). Rather, moving to an urban area for some Aboriginal peoples involves migrating within one's traditional territories and for many, means moving to an area from which they were actively removed (Peters 1998; Peters 2000a; Peters 2000b; Peters 2004; Taylor and Bell 2004; Peters 2006). As Aboriginal peoples have been conceived of in Western thought as the embodiment of nature and wildness, Aboriginal identities and cultures have been seen as incompatible with modern civilization, as represented by urban areas (Peters 2002; Wilson 2005; Willow 2009). The colonial state thus physically separated Aboriginal peoples from emerging settler societies in an effort both to legitimize settler development on 'empty' land and to spatially reinforce the differences between Aboriginal and non-Aboriginal peoples on which the colonial project was predicated (Lawrence 2004; Wilson and Peters 2005). This was achieved largely through the relocation of Métis settlements to remote regions and the creation of First Nations reserves in regions that were out of the way and distinct from emerging urban spaces (Peters 2004). Reserves are small sections of Aboriginal

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[5] The use of the term 'Aboriginal identity' does not adequately reflect or acknowledge the diversity of Aboriginal peoples' identities and cultures, and can thus serve to perpetuate the homogenization of this diversity. It is therefore imperative to acknowledge that while employing this term for the sake of brevity, the realities of Aboriginal identities can only really be understood by way of anti-essentialist conceptions of identity, which grapple with the fluidity and constant evolution and negotiation of identity (Comaroff and Commaroff 1991; Restoule 2000; Wilson 2003; Lawrence 2004; Silvey 2007).

peoples' land partitioned off by the state for the 'use and benefit' of First Nations communities. They were heavily bounded and regulated spaces where, at one time, residents required the permission of an Indian agent to leave (Lawrence 2004; Wilson and Peters 2005). Despite their original conception as sites where First Nations would remain until they were sufficiently prepared to assimilate into settler society, or as places where they could live out their remaining days before their assumed inevitable extinction, reserves have become sites of resistance where First Nations cultures and identities are 'safeguarded' (Peters 1998; Lawrence 2004; Thobani 2007; Peyton and Hancock 2008). Reserves thus came to be seen by the government, the general public and earlier academic literature as 'authentic' Aboriginal spaces, in contrast to urban spaces, which have been viewed not only as incompatible with Aboriginal identities, but as threatening to them (Peters 2000b; Peters 2002).

The physical and social separation of Aboriginal peoples from urban areas is closely linked to the problematization of their presence in urban areas and contributes to a number of erroneous assumptions regarding Aboriginal urbanization (Peters 2000b; Peters 2002). The enduring nature of these underlying judgments can still be found in the urban mobility literature, much of which fundamentally envisages urban mobility among Aboriginal peoples as a problem. Explanations for the high levels of mobility within urban areas and between urban and rural/reserve areas centre on mobility as an indicator of instability, assuming that it is socially disruptive, leading to exclusion and marginalization in urban areas (Frideres 1974; Williams 1997; Norris, Cooke et al. 2004; Cooke and Bélanger 2006). In earlier urbanization literature, migration to urban areas was seen as a rejection of Aboriginal culture/identity and a willingness to assimilate into settler society, while migration back to reserves was taken as an indication of failure to adjust adequately to urban life or find employment (Frideres 1974; Peters 2000b; Peters 2002; Peters 2004; Browne, McDonald et al. 2009). Aboriginal culture has been treated as an impediment to adjustment to urban life and blamed for the social problems associated with many Aboriginal peoples in urban areas, rather than looking to the systemic neglect and active subordination of Aboriginal peoples that are actually at the root of these issues (Peters 2000b). These misconceptions are rooted in the colonial construction of Aboriginal urbanization as problematic and do not reflect the diversity and realities of urban Aboriginal populations. Among other points that will be further discussed below, the success of many Aboriginal peoples living

in urban areas and the growing urban Aboriginal middle class contribute to countering assumptions of the incompatibility of urban spaces and Aboriginality (Howard-Bobiwash 2003; Wotherspoon 2003; Environics 2010).

In addition to colonial constructions of urban space as non-Aboriginal space that still pervade urban mobility literature, the enduring nature of these constructions can also be seen contemporarily in the federal government's very limited support for Aboriginal peoples living off-reserve (Peters 2001; Peters 2005; Peters 2006). Since the 1950s, the federal government has operated under the policy that their responsibility for Aboriginal peoples is largely restricted to status First Nations living on-reserve (Peters 2006). In a document designed to help status First Nations peoples determine what rights and benefits they are entitled to, Indian and Northern Affairs Canada (INAC – recently changed to Aboriginal Affairs and Northern Development Canada, AANDC) states that "[w]hat you are eligible for depends largely on where you live" (Canada, 1999, p.3). For those living on-reserve, important rights and benefits/services include: exemption from federal and provincial taxes on real and personal property (including services, income and goods – if acquired off-reserve but delivered to an on-reserve address), funding for housing, educational funding (including post-secondary funding, accessible to some living off-reserve as well), programs to assist with community economic development, health services (including Non-Insured Health Benefits – NIHB[6]) and some youth services (Canada 1999). For the most part (apart from NIHB and post-secondary assistance), these are not available to status First Nations living off-reserve, who are viewed as "citizens of the province like all other citizens, without Aboriginal rights or benefits" (Peters 2001, p. 142). Non-status First Nations, Métis and Inuit peoples do not have access to these rights and benefits, though some federal funding and services are available for Inuit and Métis peoples. Jurisdictional wrangling over federal and provincial government responsibilities for Aboriginal peoples in urban areas, and the framing of these responsibilities as voluntary services, rather than the result of Aboriginal rights, have created considerable confusion and gaps in services for Aboriginal peoples living there (Hanselmann 2003; Peters 2006). Clearly, the colonial construction of urban areas as incongruent

[6] Non-Insured Health Benefits (NIHB) is a health benefit program that covers the costs of some prescription drugs, dental work, vision care etc. and is available to status First Nations and Inuit peoples.

with Aboriginal peoples continues to have implications for Aboriginal people's experiences of urban areas.

2.2.3 Resistance to Colonial Constructions: Reterritorialization of Urban Space and Geographies of Rights

Though the role of colonialism in shaping the lives of Aboriginal peoples cannot be overestimated, focusing solely on the oppressive ways in which the colonial state has structured experiences of urbanization among Aboriginal women and men overlooks the resiliency that they have and continue to display in negotiating and resisting these forces (Peters 1998; Stevenson 1999; Browne, Syme et al. 2005; Cannon 2006; Thobani 2007). An important way in which Aboriginal peoples challenge both colonial constructions of spaces and identities is through the reterritorialization of urban space (Peters 2000b; Wilson and Peters 2005). That is, challenging the dominant coding of urban areas as non-Aboriginal space by continuing to assert and celebrate Aboriginal identity and advocating for the recognition of Aboriginal rights in urban space (Peters 1998; Howard-Bobiwash 2003; Lobo 2003; Peters 2004). Rather than losing ties to Aboriginal culture and identity in urban areas, it has been noted that maintaining these connections is an important component of success upon migration to urban areas (Peters 2000a; Bélanger, Barron et al. 2003; LeClair, Nicolson et al. 2003; Wilson and Peters 2005; Silver 2006). Aboriginal cultures are increasingly evolving in urban areas and many urban Aboriginal communities are thriving (Lobo 2001; Peters 2005; Cooke and Bélanger 2006; Peters 2011). In a paper focused on service provision for First Nations who had recently moved to an urban area, Janovicek discussed the importance of providing programs that "emphasized cultural retention and promoted pride in their Indigenous culture", noting that this "engendered a conception of Aboriginal identity that opposed the view that it could not exist off-reserve" (2003, p. 549). Asserting Aboriginal identities in cities is thus important in terms of adjusting to urban life while at the same time contributing to the re-imagination of geographies of Aboriginal identities in ways that counter colonial constructions of identity, through the reterritorialization of urban space. Related, some have noted that the high levels of migration between urban and reserve/rural areas that characterize Aboriginal urbanization (i.e. churn) are an important means of maintaining supportive social and cultural connections with rural/reserve communities as well as creating a sense of balance (Weaver 2001; Peters 2005). There has also been some suggestion

that mobility in and of itself is a cultural propensity linked to the traditional ways of some Aboriginal groups (Peters 2005; Cooke and Bélanger 2006; Prout and Howitt 2009). This churn may also reflect efforts to remain engaged with aspects of Aboriginal cultures that are not easily accessible in urban areas, such as connections with land (Peters 2005; Wilson and Peters 2005). Wilson and Peters examined how First Nations peoples living in urban areas found ways of maintaining land-related spiritual practices in urban areas "through the creation of individual, small-scale cultural spaces within the city" (2005, p. 404). These points counter the notion of urban mobility as strictly problematic and highlight the importance of creating spaces to celebrate and foster Aboriginal identities in urban areas. It is clear that Aboriginal identities are not 'out of place' in urban areas and that working to maintain and support them is an important component of challenging colonial constructions through the reterritorialization of urban space.

Advocating for the recognition of Aboriginal rights in urban space is another important component of the reterritorialization of urban space. Aboriginal urbanization has challenged the state to re-examine the scale at which Aboriginal rights are recognized (Peters 2006). Increasingly, Aboriginal peoples are expressing their opposition to the federal government's policy of responsibility largely restricted to status First Nations living on-reserve (Peters 2006). At the 1993 public hearings of the RCAP, Sandi Funk, a representative of the Aboriginal council of Winnipeg, said:

> we should enjoy the full benefits of our treaty and [A]boriginal rights in an urban environment. We do not accept the interpretation of government bureaucrats that treaty and [A]boriginal rights are confined to the small plots of homelands that they refer to as reservations and Métis communities (Peters 1998, p. 678).

The RCAP hearings provided an important opportunity for urban Aboriginal peoples to voice what they felt were important issues facing them. As Peters has noted, what emerged from many urban Aboriginal women in particular was the insistence that their access to Aboriginal rights, and the services/benefits that they afford, should not be bounded by reserves (1998).

Aboriginal women have been an important force in the Aboriginal rights movement, which experienced a significant resurgence in the 1970s in response to the federal government's 1969 'White Paper'. This paper sought to terminate the *Indian Act* and eliminate Aboriginal rights in an effort to improve Aboriginal participation in Canadian society and foster a more

'equal' citizenship (Dickason 1997; Turner 2006; Peyton and Hancock 2008). Not surprisingly, this galvanized Aboriginal resistance and activism, which coalesced in the Aboriginal rights movement. However, the intersection of the Aboriginal rights movements and the women's movement created a difficult situation for many Aboriginal women advocating for Aboriginal rights, often pitting their political efforts against those of Aboriginal peoples more broadly (Green 1993; Fiske 1996; Peters 1998). The forced removal of women from reserves powerfully mobilized them to fight for gender equity in the *Indian Act*. Organizations such as Indian Rights for Indian Women (IRIW) and the Native Women's Association of Canada (NWAC) were instrumental in these struggles. In the 1970s, the Supreme Court of Canada ruled against two Aboriginal women who had mounted legal challenges to the gender discrimination in the *Indian Act* (Jeanette Lavell and Yvonne Bedard) after having lost their status upon 'marrying out'. It was not until another Aboriginal woman, Sandra Lovelace, brought her case to the Human Rights Commission of the United Nations, embarrassing the Canadian government internationally, that amendments to the *Indian Act* that eventually resulted in the 1985 Bill C-31 amendments were initiated (NWAC 1999; Janovicek 2003). These efforts divided Aboriginal communities; many Aboriginal organizations (e.g. the National Indian Brotherhood, which is now the Assembly of First Nations, and almost all provincial Aboriginal organizations) worked against Aboriginal women as they feared that any amendment to the *Indian Act* would enable the federal government to further curtail Aboriginal rights (Jamieson 1978; Peters 1998). Women who fought for gender equity were accused of blindly taking up the directives of the women's movements (led at the time largely by white women) and putting their rights as individuals above their collective rights as Aboriginal peoples (NWAC 1999; Janovicek 2003; Lawrence 2004). Further, despite the widespread loss of status among First Nations women who 'married out', women's efforts to gain restitution through regaining status and Band membership were often framed as individual struggles (resulting from their choice to marry a man without status), rather than the collective struggles of large communities of women and their families who had been systematically denied their rights to status through colonial legislation (Fiske 1996; Lawrence 2004).

The strength of Aboriginal women's activism throughout the resurgence of the Aboriginal rights movement provides important context for their central role in more recent

movements focused on the reterritorialization of urban space through advocacy for the recognition of Aboriginal rights in urban areas (Peters 1998; Peters 2006). In part, this is because women continue to be disproportionately affected by this spatially inequitable government policy on the applicability of Aboriginal rights, as they are overrepresented in urban areas (Jamieson 1978; Peters 1998; NWAC 1999; Janovicek 2003; Peters 2006). Further, it has been suggested that the important role of Aboriginal women in fighting for Aboriginal rights in urban areas and thus, the recognition of Aboriginal identities in urban areas, may be linked to the traditional roles of Aboriginal women in maintaining, preserving and passing on culture in Aboriginal societies (Peters 1998).

Implicit in this discussion of the reterritorialization of urban space by way of asserting Aboriginal identities and claiming Aboriginal rights in urban space are the important geographic concepts of spaces and scales of rights. Rights are socially constructed and contingent on the social and political spaces in which they are deployed. As such, they are also inherently spatial; rights and space are mutually constitutive, that is, the coding of space determines the applicability of rights, and spaces naturalize social relations, which in turn impact the ways in which rights are interpreted (Blomley 1994; Blomley and Pratt 2001). As is clear in the distinctions made by some between Aboriginal women advocating for what some see as individual rights (i.e. gender equality) and Aboriginal peoples more broadly advocating for collective rights, the scales at which rights are enacted are also an important consideration. Disagreement between federal, provincial and municipal levels of government over responsibility for upholding Aboriginal rights is another important issue of scale. Attending to the spaces and scales at which rights are asserted is essential in deciphering the heterogeneity of Aboriginal rights (which, from the perspective of the federal government, are clearly not universally applicable to all Aboriginal peoples and will be further explored in the next section) and the ways in which they can inhabit competing geographies, making them difficult to reconcile (e.g. the competing individual and collective scales at which rights are claimed) (Silvey 2007). Specifically, geographies of rights are integral to examining how Aboriginal women and men claim Aboriginal rights against the dominant coding of urban space, thus contributing to its reterritorialization (Peters 1998; Peters 2006). In doing so, Aboriginal peoples are engaging with

the often-oppressive rights discourse and taxonomic categories of the law in order to subvert their dominant oppressive functions (Blomley 1994; Peake and Ray 2001; Razack 2002a).

Focusing on geographies of Aboriginal rights also provides an important means of examining how the assertion of Aboriginal rights differs between women and men as a result of the different social and political spaces in which they exist. Drawing on some of the contributions of feminist geography in attending to difference at the intersections of race, gender and space, among others, this spatial perspective enables consideration of the ways in which multiple systems of oppression work together to constitute space (Kobayashi and Ray 2000; Nagar, Lawson et al. 2002; Razack 2002b; Wilson 2003; Silvey 2007). This geographic perspective thus creates avenues of inquiry through which to explore how these gendered, spatial manifestations of rights impact differential roles in the reterritorialization of urban space and experiences of urbanization among women and men. A geographic focus on Aboriginal rights that highlights the importance of spaces and scales of rights is thus a useful perspective to bring to investigations of the complex heterogeneity of Aboriginal rights and how they are implicated in Aboriginal urbanization. In exploring this geographic perspective, a brief discussion of conceptions of Aboriginal rights and citizenship is necessary.

2.2.4 (Differentiated) Citizenship

Though the breadth of literature engaging with citizenship clearly acknowledges it as a fluid, non-linear and constantly evolving concept, citizenship can be understood as individual rights and responsibilities that stem from belonging to a political community (Mitchell 2009). Contemporary citizenship is largely based on membership in nation-states and is widely held to be "most fully actualized in the conditions of democratic society" (Green 2001, p. 719). Universal citizenship is often characterized by interconnected civil, legal, political and social rights that are guaranteed by the state to all citizens equally and is associated with a set of attendant duties and responsibilities (Castles and Davidson 2000). In Canada, citizenship centres on the Canadian Charter of Rights and Freedoms (hereafter referred to as *the Charter*) in the *1982 Constitution Act*, which specifies a number of fundamental freedoms as well as democratic, mobility, legal, equality and social rights guaranteed to individual citizens (Canada 1982a). All federal and provincial legislation is subject to *the Charter* and respect for the law is based on Canadian citizens' participation in the democratic process (Dupuis 2002).

However, the ideal of universal citizenship has been amply critiqued both for its failure to translate formally articulated equality into lived realities and more fundamentally, for serving as a homogenizing project that privileges generality and sameness over attending to particularity and difference (Young 1995; Castles and Davidson 2000; Kobayashi and Ray 2000). This is particularly pertinent in the context of Aboriginal peoples in Canada, who do not fit readily into the imagined norm of general Canadian citizens. The glaring misalignment between the ideal of a universal Canadian citizenship and the reality for Aboriginal peoples lies largely in the historical and contemporary colonial relationship between Aboriginal peoples and the Canadian state (Green 2001; Barker 2009). Historically, the theft of land and concomitant displacement of Aboriginal peoples, and the policy of overt assimilation, the cornerstone of which was the residential school system, are important colonial roots of present day inequities. Particularly noteworthy in the context of citizenship is the *1869 Enfranchisement Act* (which, along with other colonial acts, would later be consolidated into the *1876 Indian Act*) and its various attempts to assimilate Aboriginal peoples into the general Canadian citizenry by having them renounce their Aboriginal identities and all claims to Aboriginal rights. The extension of this ‘invitation’ to citizenship thus sought to destroy Aboriginal peoples’ collective/communal rights and ownership of land in order to claim individual rights as Canadians (Thobani 2007). It is telling that enfranchisement was initially set up on a voluntary basis, under the assumption that Aboriginal peoples would chose to renounce their culture, identities and political communities for the opportunity to gain colonial citizenship and thus the right to vote federally, but due to extremely low success rates, was later more coercively enforced (Johnston 1993). In constructing this dichotomy (membership in one’s Aboriginal community vs. Canadian citizenship), enfranchisement basically set up Aboriginality and Canadian nationality as incompatible with one another; one must be renounced for the other to be gained. Contemporarily, adherence to the ideal of equal or universal citizenship in Canada frames those Aboriginal peoples who resist assimilation into settler society by asserting their sovereignty as ingrates who are unfairly seeking special rights that other Canadian citizens do not have (Restoule 2000; Thobani 2007). It seems that seeking a universal Canadian citizenship inclusive of Aboriginal peoples presupposes the erasure of the fundamental political differences that distinguish the first peoples of the land that is now Canada and the generations of settler Canadians that have unjustly appropriated this land.

Differentiated citizenship, or "the legal entitlement of particular groups to different rights in addition to the individual rights common to all citizens of a polity", is an interesting concept that takes up these issues and can be productively applied in examining relationships between Aboriginal peoples and Canadian citizenship (Blackburn 2009, p. 66). A differentiated Canadian citizenship that is inclusive of Aboriginal peoples would be based on recognition of their inherent Aboriginal rights, in addition to the rights of all Canadians citizens. Young argues that in order to avoid perpetuating oppressive processes of marginalization and social exclusion through adherence to homogenizing conceptions of universal citizenship, the articulation of "special rights that attend to group difference" are required (1995, p. 177). This would involve the inclusion of all citizens in a political community (read: nation state) through the recognition of their differences in ways that are politically significant, for example, through the recognition of Aboriginal rights (Green 2001).

2.2.5 Aboriginal Rights

Though a complex and contested subject, Aboriginal rights are generally construed as the collective rights of Aboriginal peoples, including the right to self-determination in terms of governance, land, resources and culture, which stem from their occupation of the land that is now called Canada since time immemorial (Asch 2001a; Bell and Henderson 2011). Thus, they are the inherent rights of the first peoples of this land and their decedents, and they do not derive their legitimacy from colonial authority or recognition (Kulchyski 1994). Further supporting this historical origin, the textual origin of Aboriginal rights is the *1763 Royal Proclamation*, a British colonial document that has the legal force of a statute, has never been repealed, and legally protects the land of Aboriginal peoples (Johnston 1993). The *Royal Proclamation* also established a formal policy for surrendering Aboriginal lands and thus made clear that they were not subjects of the British monarch, but were citizens of their own political communities (Johnston 1993; Kulchyski 1994). Section 35 of the *1982 Constitution Act* recognizes and reaffirms existing Aboriginal and treaty rights, while section 25 of *the Charter* ensures that the rights and freedoms that it prescribes "shall not be construed so as to abrogate or derogate from any [A]boriginal, treaty or other rights or freedoms that pertain to the [A]boriginal peoples of Canada" (Canada 1982a; Canada 1982b). Other pertinent legislature in terms of Aboriginal rights includes section 91 of the *1867 British North America Act*, which entrenched the notion of

federal responsibility for Aboriginal peoples and section 88 of the *1876 Indian Act*, which ensures that federal legislation regarding Aboriginal peoples and treaty rights take precedence over provincial legislation (Kulchyski 1994).

Despite their clear historical origin and constitutional recognition, a definition that specifies exactly what Aboriginal rights entail remains elusive. The vague terminology used in the *Constitution Act* in recognizing and affirming 'Aboriginal and treaty rights' contributes to the confusion and complexity of specifically defining their content, but also provides room for a diversity of legal interpretations of Aboriginal rights. As noted in the previous section, the fluidity of rights means that they are also laden with subversive possibility (Blomley 1994). That is, the vague definitions of Aboriginal rights create the possibility that they can be re-imagined in ways defined *by* Aboriginal peoples, rather than by the colonial state *for* them (Blomley and Pratt 2001).

However, the open-textured nature of rights can also result in oppressive legal regimes, which are exemplified by the historical and contemporary colonial relations between Aboriginal peoples and the state. Related, it is important to acknowledge that the recognition of Aboriginal rights in the pursuit of a more equitable differentiated citizenship is by no means an uncontested goal among Aboriginal peoples in Canada. A number of scholars have advised against engaging in a rights discourse in any capacity as it may serve to reinforce the power relations that the recognition of Aboriginal rights seeks to disrupt (Alfred and Corntassel 2005; Ermine 2007). Further, the applicability of Western liberal conceptions of 'Aboriginal rights' has been substantially called into question for their incompatibility with Aboriginal world views, noting for example, the differing conceptions of justice and thus articulation of rights between the two bodies of thought (Turpel 1989; Kulchyski 1994; Henderson 2002; NWAC 2002; Turner 2006). The notion that the underlying goal of extinguishing Aboriginal rights lies at the heart of their recognition by the state is another important grounds on which to base caution in engaging with such a discourse (Thobani 2007). Further, some have argued that engaging with any aspect of Canadian citizenship (even as a component of differentiated citizenship based on respect and recognition of difference), serves to undermine the constitutional relationship between Aboriginal nations and Canada as sovereign political units, a point which is closely linked to the

discussion of self-determination as oppose to self-government (see below) (Henderson 2002; Thobani 2007).

Despite these important considerations and valid critiques of engaging in the pursuit of Aboriginal rights-based differentiated citizenship in Canada, further exploration of Aboriginal rights in an effort to examine their implications for Aboriginal urbanization is warranted. Basically, broad and narrow interpretations in terms of the content (what they mean) and applicability (who can access them and where) of Aboriginal rights exist. A detailed account of the extensive jurisprudence surrounding Aboriginal rights is beyond the scope of this literature review. However, as summarized by the Canadian Human Rights Commission, jurisprudence since their affirmation in 1982 suggests that the content of Aboriginal rights includes the "inherent right to self-government; hunting, fishing and gathering rights; collective land rights; and the right to the preservation of traditional languages, cultures and traditions" (Canada 2005, p. 25). This suggests a fairly broad view of Aboriginal rights that highlights their collective nature. A telling point of comparison in terms of broad and narrow interpretations of the content of Aboriginal rights is the contrasting use of the terms 'self-government' and 'self-determination'. 'Self-government', which is frequently employed in federal government documents, amounts essentially to the state's delegation of political power to Band councils[7], and reflects the fact that the federal government "has been reluctant to commit to a post-colonial relationship with Aboriginal peoples, of restructuring federalism and meaningful restitution of land, resources and political power" (Green 2001, p. 716). By contrast, the use of the term 'self-determination' by many national Aboriginal organizations (e.g. the Native Women's Association of Canada, Assembly of First Nations) and the United Nations Declaration on the Rights of Indigenous Peoples (i.e. UNDRIP – to which Canada became a signatory in November of 2010) signifies a more abstract political right based on the reconfiguration of political relations between Aboriginal peoples and the Canadian state founded on the principles of sharing and mutual respect (Asch 2001a; Asch 2001b; AFN 2003; NWAC 2007; UN 2007). The *Constitution Act*

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[7] Band councils are a form of local governance on reserves that were created through colonial policy, are not reflective of Aboriginal political structures, and receive funding exclusively from the federal government.

does not specifically use either of these terms, which contributes to the ongoing negotiation of the terms.

Despite the potential for broad interpretations of their content, predominant practical manifestations of Aboriginal rights are quite narrow and are centered on services and benefits provided by the federal government to individuals. As outlined by the federal government, they include: exemption from federal and provincial taxes on real and personal property (including services, income and goods), funding for housing, educational funding (including post-secondary funding), programs to assist with community economic development, some health services (including NIHB) and some youth services (Canada 1999). It is important to note that the provision of these services/benefits is often framed as a matter of federal government policy, rather than as rights the government is legally obligated to provide owing to its constitutional recognition and affirmation of Aboriginal and treaty rights, and its fiduciary relationship with Aboriginal peoples in Canada (Canada 1996b; Boyer 2004).

Of great importance in the context of asserting Aboriginal rights in urban spaces are the different interpretations of the *applicability* of Aboriginal rights. Currently, federal policy reveals quite a narrow interpretation of the applicability of Aboriginal rights; they are largely restricted to status First Nations who live on-reserve (Canada 1999; Green 2001; Peters 2001). In this way, colonial constructions of identities and spaces continue to dictate who has access to Aboriginal rights. It has been suggested that colonial control over Aboriginal identities through legislation was ultimately an effort to define and limit those who could lay legitimate claim to land and Aboriginal rights (Napoleon 2001; Mawani 2002). The services/benefits that are largely construed as Aboriginal rights are almost exclusively restricted to status First Nations, despite the entrenchment of *Aboriginal* rights, more broadly in the *Constitution Act*, which states that the “"[A]boriginal peoples of Canada" includes the Indian, Inuit, and Métis peoples of Canada” (Canada 1982b). Beyond exclusion on the basis of legislated identities, access to Aboriginal rights is further circumscribed by place of residence. As noted previously, the federal government’s paternalistic provision of Aboriginal rights and the services/benefits that stem from them reflects their spatially inequitable policy of responsibility only for those living on reserves (though some federal programs, such as NIHB and post-secondary assistance are available to those with status living off-reserve). The discrepancies between Band membership,

status and ability to live on-reserve further complicate these legal issues as they further limit the spaces in which Aboriginal peoples can live and thus access Aboriginal rights. Federal, provincial and municipal governments provide a few services and programs for Aboriginal peoples living in urban areas, but their lack of coordination and funding reflects the refusal of any level of government to take official responsibility for ensuring that Aboriginal rights are respected (Peters 2000c; Hanselmann 2003). This has resulted in considerable jurisdictional wrangling between scales of government and has created " a complex amalgam of legal categories", which clearly engenders inequity (Peters 2005, p. 335). As explored above, the nexus of patriarchy and racism that structures the lives of Aboriginal women further complicates the heterogeneous terrain of Aboriginal rights, and ensures restricted access to rights for women (Jamieson 1978; Turpel 1989; NWAC 1999; Green 2001).

It is in contesting this narrow interpretation of the applicability of Aboriginal rights that the reterritorialization of urban space, through advocacy for Aboriginal rights in urban space, is best understood. In challenging the federal government's spatially inequitable policy on the provision of Aboriginal rights, Aboriginal peoples challenge the colonial construction of Aboriginal identities as incompatible with urban space and advocate for broader interpretations of the applicability of Aboriginal rights. This assertion of Aboriginal rights for urban Aboriginal peoples also opens up the doors for a more inclusive interpretation of who can access Aboriginal rights. That is, debunking the notion that living on a reserve is a prerequisite for a legitimate claim to Aboriginal rights (opening up conceptions of space), may help to legitimize the claims of Aboriginal peoples without status (non status First Nations, Métis, and Inuit peoples – expanding links between identities and rights) to Aboriginal rights (Lawrence 2004).

Examining in greater detail the concept of differentiated citizenship based on the recognition of Aboriginal rights reveals the utility of engaging a geographic perspective to explore how Aboriginal rights and the reterritorialization of urban space are implicated in the complexity of Aboriginal urbanization. Focusing on geographies of rights helps to make sense of the heterogeneity of Aboriginal rights (i.e. how access to Aboriginal rights is contingent on colonial constructions of identity and space) and the ways in which Aboriginal women and men negotiate and contest these colonially defined geographies of rights. This in turn allows for a more in-depth and contextually grounded exploration of how the reterritorialization of urban

space may differentially impact the experiences of urbanization of Aboriginal women and men, thus contributing to better understandings of the complexities of Aboriginal urbanization. In considering the implications of these gendered relationships between geographies of Aboriginal rights and urbanization, one important area of inquiry is in the ways that they may shape the health of Aboriginal peoples living in urban areas.

2.3 Aboriginal Urbanization: Implications for Health?

It is interesting to examine the heterogeneity of Aboriginal rights, based on colonial constructions of identities and spaces, through a health lens and consider how these *spatial* inequities may contribute to *health* inequities. In doing so, it is useful first to briefly note some key elements of Aboriginal health research.

2.3.1 Aboriginal Health Inequities

Most Aboriginal health research focuses on the pervasive health inequities that exist between Aboriginal and non-Aboriginal populations in Canada (Canada 1996a; Adelson 2005; Waldram, Herring et al. 2006; Smylie 2009). For example, compared to the non-Aboriginal population, the Aboriginal population suffers from lower life expectancies, higher infant mortality rates, and higher rates of chronic disease such as hypertension and diabetes, though there is of course a great deal of diversity within different Aboriginal populations (Adelson 2005; Frohlich, Ross et al. 2006; Waldram, Herring et al. 2006; Gracey and King 2009; Smylie 2009).

Most Aboriginal health research has focused on reserve-based populations and as a result, little is known about the health of Aboriginal peoples living in urban areas (Wilson and Young 2008). Given the huge increase in the proportion of Aboriginal peoples living in urban areas over the last half century, it is important to consider how a significant shift in place, from rural and reserve areas to urban areas, impacts the health of Aboriginal women and men. An extensive body of literature from the field of medical/health geography has examined the essential role of place in shaping health (Kearns 1993; Macintyre, Ellaway et al. 2002; Curtis 2004; Gatrell and Elliott 2009; Meade and Emch 2010). Prior to the 1990s, the field of medical geography was rooted primarily in biomedical perspectives and was characterized by empirical methodologies that utilized a human ecology of disease model to examine the spatial distribution of disease and health care (Andrews and Evans 2008; Meade and Emch 2010). The emergence of twinned

streams, or more recently, a 'braided river' of medical and health geography research pursuits has emerged, shifting the focus towards more subjective, and socially grounded conceptions of health and wellness, which are constituted through (socially constructed) space (Rosenberg 1998; Gesler and Kearns 2002; Kearns and Moon 2002; Curtis 2004). Aboriginal health literature's more recent engagement with the holistic conceptions of health shared by many Aboriginal peoples, centered on health as the process of seeking balance between interconnected physical, mental, emotional and spiritual states, often represented by the medicine wheel, parallels this shift in medical/health geography (Canada 1996a; Adelson 2005; Waldram, Herring et al. 2006; Loppie-Reading and Wien 2009). Aboriginal conceptions of health also often conceive of the health of individuals as fundamentally interconnected with the health of their families, communities, nations, as well as with nature and the Creator (Canada 1996a; Richmond, Ross et al. 2007; King, Smith et al. 2009). The shift in medical/health geography towards more culturally specific conceptions of health makes room for engaging these types of perspectives in health research. Another important contribution of medical/health geography that has relevance for understanding the health of Aboriginal peoples is its deeper engagement with social and cultural theory through exploration of the complex ways in which, for example, gender, social class, and race/ethnicity intersect in specific places to create different experiences of health (Dyck, Davis Lewis et al. 2001; Gesler and Kearns 2002; Kearns and Moon 2002; Wilson 2003; Parr 2004).

From this rich medical/health geography base, it is important to ask how a significant change in place, through the process of moving from rural/reserve areas to urban areas, is expected to impact health. Broadly, urbanization is thought to impact health through the physical environment (e.g. impacts of pollution, overcrowding), the social environment (e.g. stress related to living in an urban area, violence, injuries associated with urban life) and changed access to health care (Galea and Vlahov 2005; CSDH 2008). Though some efforts have been made to examine how this may function in the context of Aboriginal peoples living in urban areas, there remains a dearth of research that explores specifically the ways in which urbanization and urban mobility impact the health of urban Aboriginal peoples and many questions remain to be answered (Benoit, Corral et al. 2003; Browne, McDonald et al. 2009; Gracey and King 2009).

The lack of focus on the health of urban Aboriginal peoples may reflect colonial constructions of Aboriginal identity as incompatible with urban spaces and the misguided notion

that when Aboriginal peoples move to urban areas, they effectively assimilate into general Canadian society, and thus do not require a specific focus in terms of health research. Indeed, in line with the construction of the high levels of urban mobility that characterize Aboriginal urbanization as distinctly negative and problematic (as discussed in the previous section), the few studies that have examined relationships between Aboriginal urbanization and health suggest that urbanization and urban mobility may negatively impact the health of urban Aboriginal peoples through, for example, the stress of living in an urban area and the assumed lack of social cohesion among urban Aboriginal communities as detrimental to mental health and well-being (Kirmayer, Brass et al. 2000; Norris and Clatworthy 2003; King, Smith et al. 2009). Countering these assumptions, there has been some suggestion that urban mobility is actually beneficial for health as it can promote a sense of balance that is integral to many Aboriginal conceptions of health and may foster supportive reconnections with land/the natural environment, culture and community, which are also integral to Aboriginal conceptions of health (Weaver 2001; Peters 2005). Clearly, many questions regarding the implications of urbanization on the health of urban Aboriginal peoples remain to be addressed.

Given that geographies of Aboriginal rights (based on colonial constructions of Aboriginal identities and spaces) are integral to understanding Aboriginal urbanization (as discussed in the previous section), it is important to ask how the spatially inequitable policy on the applicability of Aboriginal rights may be implicated in relationships between Aboriginal urbanization and health. Further, the demonstrated gender differentials in terms of Aboriginal rights invites consideration of how these implications may differ between urban Aboriginal women and men. These questions have not received consideration in Aboriginal health literature. Internationally, rights and health have been explored at the intersection of human rights and health equity research (Mann, Gostin et al. 1994; Hunt 2006). Efforts to achieve health equity draw importantly on human rights laws and principles (e.g. the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights) as a rationale for the right to health (which is distinct from the right to be *healthy*) (Braveman 2010). In essence, what is being discussed is the importance of respect for human rights as a precursor to health, by fostering societal conditions that promote and produce health (Chapman 2010). These links have salience in the context of Aboriginal peoples in Canada; Aboriginal rights may be

linked with health by way of their impacts on social factors that underlie health, such as education and assistance with housing, many of which are recognized by the federal government as the services/benefits that stem from Aboriginal rights. Thus, in exploring how urbanization may impact the health of Aboriginal peoples, an important area of inquiry centres on the ways in which geographies of Aboriginal rights may impact the health of urban Aboriginal women and men through their impacts on social determinants of health.

2.3.2 Social Determinants of Health

Social determinants of health are essentially the factors underlying health and root causes of health inequity. Though terminology differs slightly depending on the specific conceptual model being employed, there is general agreement that health inequities stem from several overlapping spheres of social determinants that work together to create disparities in health outcomes. The most immediate social determinants of health are behaviour/lifestyle, biological/genetic and psychosocial factors, material living conditions, and health care services that determine health outcomes among populations (Solar and Irwin 2007; Raphael 2009). These immediate determinants of health are variously referred to as proximal, intermediary, horizontal and downstream determinants in different conceptual models, but they all point essentially to the factors that most directly impact health outcomes (Graham 2004; Marmot 2007; Solar and Irwin 2007; Loppie-Reading and Wien 2009; Raphael 2009). Immediate social determinants of health are themselves determined by peoples' positions in a social hierarchy created by broad political, economic and social contexts (expressed in systems of governance, policies, cultural/social values), based on gender, race/ethnicity, income, education, occupation and social class (Diderichsen, Evans et al. 2001; Solar and Irwin 2007). Broad determinants structure the immediate determinants and are variously referred to as distal, structural, vertical, upstream, and fundamental social determinants of heath (Link and Phalen 1995; Graham 2004; Marmot 2007; Solar and Irwin 2007; Loppie-Reading and Wien 2009; Raphael 2009). Though terminology is important as it can draw attention to or obfuscate those systems and groups that are responsible for health inequities and has implications for policy (e.g. the absence of the term social class and specific reference to power in the final model of the World Health Organization's (WHO) social determinants of health conceptual framework, which has garnered criticism), what is most important here is the concept that broad political, economic and social contexts create hierarchies

in society that structure peoples' differential exposure and vulnerability to various immediate social determinants, which ultimately create inequity in health outcomes (Diderichsen, Evans et al. 2001; Graham 2004; Solar and Irwin 2007; CSDH 2008; Krieger 2008; Navarro 2009).

Despite the recognition that health inequities are structured by political, economic and social contexts, much social determinants of health-based research has been critiqued for its apparent unwillingness to deal with and sufficiently engage the abstract ways in which structural contexts actually create health inequities (Raphael, Curry-Stevens et al. 2008). Related critiques have focused on social determinants of health-based research as too positivist at the expense of sufficiently dealing with the subjectivity of health (a particularly important consideration in the context of Aboriginal conceptions of health), not engaging sufficiently or explicitly with theory, not being policy relevant or clear enough so that policy can effectively address root causes of inequity, thus enabling neo-liberal government retrenchment, and finally neglecting the importance of context by insufficiently exploring the role of place in shaping health (Kearns and Moon 2002; Graham 2004; Parr 2004; Labonte, Polanyi et al. 2005; Raphael, Curry-Stevens et al. 2008; Muntaner, Sridharan et al. 2009; Navarro 2009).

2.4 Conceptual Framework and Research Questions

With an awareness of both the potential of a social determinants approach and these various critiques, this thesis uses a social determinants of health framework that engages with the importance of context/place to guide questions regarding how geographies of Aboriginal rights may differentially impact the health of Aboriginal women and men living in urban areas. When considering social determinants of health in the specific context of Aboriginal health, the fundamental role of colonialism in shaping all other social determinants of health for Aboriginal peoples is well recognized (Adelson 2005; Loppie-Reading and Wien 2009; Smylie 2009). Further, it has been noted that any effective effort to improve health equity between Aboriginal and non-Aboriginal peoples must examine and address colonialism and how it has and continues to impact the health and life experiences of Aboriginal peoples. Health geography's commitment to engage more subjective conceptions of health and well-being highlights the importance of considering conceptions of health that are relevant to Aboriginal peoples, that is, Aboriginal conceptions of health as balance between interconnected physical, mental, emotional and spiritual states. Thus, the social determinants of Aboriginal health framework that guides this

master's thesis emphasizes the ways in which broad political, economic and social contexts, including the fundamentally important role of historical and contemporary colonial relations between Aboriginal peoples and the Canadian state, create hierarchies in society (particularly in terms of gender, Aboriginal identity and status) that structure immediate social determinants (e.g. material living conditions, health behaviours, psychosocial stress, interpersonal relationships, physical environments, health care services), which ultimately create inequity in interconnected physical, mental, emotional and spiritual health.

This framework provides a fruitful means of investigating how spatially inequitable access to Aboriginal rights, which is important in understanding the complexity of Aboriginal urbanization, may differentially impact the health of urban Aboriginal women and men. The framework highlights various ways in which heterogeneous geographies of Aboriginal rights (an expression of broad determinants) may impact health. The emphasis on the ways in which broad determinants create social hierarchies that determine differential exposure and vulnerability to immediate determinants of health is useful in considering how gender, Aboriginal identity and status may impact health based on the differential access to Aboriginal rights associated with each. Access to Aboriginal rights may impact health as they determine access to a number of intermediate determinants of health, such as education, housing, and income (via taxation). They may also impact mental, emotional and spiritual health by way of the psychosocial toll that, for example, not having control over one's life (e.g. self-determination vs. self-government) and not having one's existence as a sovereign political group recognized, may take on health. The framework thus highlights the ways in which both the broad (self-determination, respect for political relationships) and narrow (specific services/benefits) interpretations of the content of Aboriginal rights discussed in the previous section may impact the health of urban Aboriginal peoples. The narrow interpretations of the applicability of Aboriginal rights, which reflect the federal government's spatially inequitable policy on Aboriginal rights and result in heterogeneous geographies of rights based on identity (Aboriginal identity and gender) may thus be expected to differentially impact the health of Aboriginal peoples depending on where they live, what Aboriginal identity group they are a part of, and their gender. One would expect that if Aboriginal rights are linked to health through control/respect and the more tangible immediate determinants of health noted above, then those who have the greatest access to them (i.e. men,

status First Nations, those living on-reserve) might enjoy better health than those whose access to Aboriginal rights is more restricted.

Using this social determinants of Aboriginal health framework, this master's thesis focuses on the specific research question:

- How are Aboriginal rights implicated in urbanization and what effect does this have on the health of Aboriginal women and men living in urban areas?

In addressing this main question, interconnected quantitative and qualitative research phases have been conducted. The quantitative phase (Chapter 3) makes use of the 2006 Aboriginal Peoples Survey (APS), a national survey of Aboriginal peoples living off-reserve, to examine the following specific questions using statistical analysis:

- What does the health of urban Aboriginal women and men look like?
- Does urbanization differentially impact the health women and men?

Building on the national view of urbanization – health relationships gained from the quantitative phase, the qualitative phase (Chapter 4) consists of a more in-depth examination of these relationships through interviews with Aboriginal women and men who have moved from a rural or reserve area to Toronto. This phase focuses on gendered relationships between urbanization, Aboriginal rights and health, and explores the specific questions:

- How are Aboriginal rights and urbanization related to one another and does this differ between women and men?
- How do Aboriginal rights and urbanization impact health and does this differ between women and men?

In addressing these specific research questions, three main empirical, theoretical and policy-oriented objectives are pursued:

- The empirical objective is to develop an understanding of how urbanization may differentially impact the health status of urban Aboriginal women and men, with attention to a potential role for Aboriginal rights.
- The theoretical objective is to expand understandings of gendered dimensions of urbanization, focused in particular on the role of Aboriginal rights in shaping these processes and how they are related to health.

- The policy-oriented objective is to generate knowledge that will help to create an impetus to include urban Aboriginal perspectives in health care and rights discussions, ultimately informing public policy.

Chapter 3

3 Quantitative Analysis of Relationships Between Urbanization and Health Using the Aboriginal Peoples Survey (APS)

3.1 Introduction: Background and Research Questions

Aboriginal urbanization in Canada has increased dramatically over the last half century and at present, over half of the national Aboriginal population lives in an urban area. Characterized by high levels of urban mobility, Aboriginal urbanization is quite complex and is thought to be experienced differently between women and men. It is important to examine Aboriginal urbanization within the context of colonial constructions of Aboriginal identities and spaces, which have defined Aboriginal peoples as incompatible with urban areas. Geographies of Aboriginal rights are important in grasping the complexity of Aboriginal urbanization and may have a role in the ways in which Aboriginal women and men differentially experience urbanization (see Chapter 2).

This massive geographical shift raises many questions about the implications of urbanization on the health of Aboriginal peoples, yet most Aboriginal health research has focused on reserve-based populations (Wilson and Young 2008). This analysis uses the social determinants of Aboriginal health conceptual framework presented in Chapter 2 to explore associations between urbanization and health among Aboriginal peoples in Canada, focusing on differences between women and men. In considering how urbanization may impact the health of urban Aboriginal peoples, numerous different lines of inquiry could logically be pursued. The framework guides this analysis by drawing attention to the ways in which urbanization may differentially impact the health of Aboriginal women and men living in urban areas through one important expression of the broad political, economic and social contexts shaping their lives: differential access to Aboriginal rights. An effort is made to explore how these broad determinants interact with more immediate social determinants of health in the context of urbanization, to impact the health outcomes. The specific research questions addressed in this statistical analysis are:

1) What does the health of urban Aboriginal women and men look like?
2) Does urbanization differentially impact the health of Aboriginal women and men?

The attempt is therefore to address the empirical objective of this master's thesis by contributing to improved understandings of urban Aboriginal health and specifically how urbanization may impact health outcomes among urban Aboriginal women and men. Using the 2006 Aboriginal Peoples Survey (APS), a profile of the national, adult, urban Aboriginal population focused on a number of standard immediate determinants of health and health outcomes, is presented. Urbanization is examined as a potential determinant of health, and Aboriginal rights, proxied by Aboriginal identity and status, are considered as a potential factor impacting links between urbanization and health among urban Aboriginal women and men.

3.2 Data and Methods

3.2.1 Dataset: 2006 Aboriginal Peoples Survey (APS)

The Public Use Microfile (PUMF) of the 2006 Aboriginal Peoples Survey (APS) was used for this analysis. The 2006 APS is a weighted, national, post-censal survey of individuals living off-reserve. The objective of the 2006 APS was to provide information on the social and economic conditions of Aboriginal peoples living off-reserve in Canada by collecting data in a number of areas such as mobility, education, labour and health. The survey was designed and implemented by Statistics Canada in partnership with national Aboriginal organizations. Participants were identified by way of four screening questions in the 2006 census long form. These questions asked what the ethnic or cultural origins of the respondent's ancestors are, whether the respondent self-identifies as Aboriginal (i.e. North American Indian – hereafter referred to as First Nations, Métis or Inuit), whether they are a member of an Indian Band/First Nation and whether they are a Treaty Indian or Registered Indian as defined by the *Indian Act* of Canada (Canada 2009d). A sample of those who answered positively to the screening questions and lived off-reserve was selected to take part in the APS. Participation in the survey was voluntary and the sample size was 61,041, with an overall national response rate of 80.1%. Data were collected by Statistics Canada between November 2006 and May 2007, and were released in December 2008 (Canada 2009d). The 2006 APS is an incredibly important source of cross-sectional data as it is the only national survey focused on the off-reserve Aboriginal population.

To address the research objective of exploring links between urbanization and health among Aboriginal peoples, the sub-sample of adults (≥20 years of age) who self-identify as

Aboriginal (First Nations, Métis, Inuit and multiple or other Aboriginal identities) was selected (n=17,129). It was important to exclude those who reported having only Aboriginal ancestry as this may include those who do not self-identify as Aboriginal, but have Aboriginal family roots and the focus of this study is on those who self-identify as Aboriginal peoples. Individuals who are younger than 20 years of age were excluded from the analysis as the focus is on adults who make decisions regarding mobility, rather than dependent children, who move largely as a result of the decisions of others. Further, it is expected that the experiences of urbanization and impacts on health among younger people will be substantially different from those among adults. Three quarters of this sub-sample live in an urban area (75.1%), 55.6% are female and 90.8% identify as First Nations (47.6%) or Métis (43.2%). Geographic place of residence is divided in the APS into census metropolitan areas (CMAs), other urban areas, other rural areas and the arctic. As the focus of this research is the health of the urban Aboriginal population, only those who are living in CMAs ("one or more adjacent municipalities situated around a major urban core with a population of at least 100, 000") or other urban areas ("with a population of at least 1,000 and no fewer than 400 persons per square kilometer") were selected for analysis (Canada 2009e, p. 24). As percentages of participants who identify as Inuit or as having multiple or other Aboriginal identities are very small in urban areas, they were excluded from further analyses. Thus, the focus of this quantitative analysis is the sample of adult (≥20 years of age), First Nations and Métis individuals living in urban areas (n=9,738).

3.2.2 Variables: Identity, Urbanization, Socioeconomic/Demographic and Health

Given that this research seeks to explore how urbanization may shape the health of urban Aboriginal women and men, a number of categorical variables provided in the PUMF were of interest and are presented in Table 1. Following the social determinants of Aboriginal health conceptual framework outlined in Chapter 2, several variables representing social determinants of health were included in the analysis (Table 1). As explored in Chapter 2, current practical manifestations of Aboriginal rights are quite narrow in their content and applicability. That is, what one is entitled to in terms of Aboriginal rights is largely contingent on one's status (i.e. Treaty/Registered Indian, according to *Indian Act* or not; most of those with status will self-identify as First Nations, but some may self-identify as another Aboriginal identity, depending on family relationships) and Aboriginal identity (i.e. First Nations, who may or may not have

status, and Métis peoples, most of whom will not have status). These two variables thus serve as proxies for Aboriginal rights, an important component of the broad political, economic and social context, in this quantitative analysis. As the research seeks to examine how urbanization and implications for health differ between women and men, gender (female, male) is examined throughout the analysis.

The analysis is focused on exploring on how urbanization may differentially impact the health of urban Aboriginal peoples. In order to do so, three variables that examine different aspects of urbanization were selected from the PUMF. The 'time in urban area' variable provides a measure of how long individuals have been living in the urban area in which they resided at the time the survey was conducted. It approximates the degree to which individuals are likely to be accustomed to living in an urban area and offers a measure of stability. This variable is based on survey questions G1 ("Have you lived in this city, town or community your whole life?") and G4 ("How long ago did you move to this city, town or community?") (Canada 2006, p. 32). As this is a novel study focused on urbanization among Aboriginal peoples, norms to guide the categorization of urban residents according to the time they have spent in an urban area are not available. However, following the convention in international migration literature that those who have moved to a country within the past five years are considered 'recent immigrants' and those who have moved and lived in a country for longer than five years are considered 'long term immigrants', responses to these questions in the 2006 APS were grouped into three categories: life-long urban residents (those who answered yes to G1), long-time urban residents (those who had moved to their current place of residence more than five years prior to the survey, according to G4) and recent urban residents (those who had moved to their current place of residence within five years of the survey, according to G4) (Baker and Benjamin 1994; Newbold 2005). Though questions G1 and G4 include participants who live in non-urban areas, the use of data filters to select only individuals living in urban areas (described in section 3.2.1) ensures that this variable does assess length of time living in an *urban* area, specifically. However, due to the way the questions are posed in the survey, it is not possible to deduce from where participants living in urban areas have moved (see section 3.4.1).

Mobility, which can provide a measure of an individual's stability in an urban setting in addition to highlighting potential relationships with people and places in other areas, was also

examined (Norris and Clatworthy 2003; Clatworthy and Norris 2007). The mobility variable is based on a survey question asking participants the number of times they had moved within the five years preceding the survey (question G2). This question captures both inter and intra-community moves, and therefore includes both migration (mobility between two different communities) and residential mobility (mobility within one community), but it is not possible to distinguish between these types of moves using the PUMF. The mobility variable was also grouped into three categories: no moves, one move and two or more moves.

The final urbanization variable examined was motivation for moving to the urban area in which respondents lived at the time of the survey. This variable captures some potential underlying push-pull factors that impact respondents decisions to migrate. Reasons for moving are assessed by question G3, which asked “Why did you move to this city, town or community?”, followed by a list from which multiple potential reasons could be chosen (Canada 2006, p. 32). The question also specified that in instances where people had moved multiple times, the most recent reasons for moving were to be recorded. The reasons for moving reported in the PUMF are: family, school, work/to find a job, better housing, cheaper housing, better services and other. The specifications provided by participants for the ‘other’ option are not available in the PUMF.

In addition to the identity and urbanization variables that were explored as potential determinants of health, several conventional immediate determinants of health were also examined. Age, widely accepted as an important determinant of health, was divided into three groups (20-34, 35-54, ≥55 years of age), providing a fairly even distribution of the sample. Though age 65 is often considered the cut off point for older age in Canadian health research, researchers and policy makers have argued that given the young age structure of the Aboriginal population, age 55 is a more appropriate marker of old age for this group (Barratt, Chambers et al. 2006; Fiest, Currie et al. 2011; Wilson, Rosenberg et al. 2011). Consistent with the abundant social determinants of health-based research that has demonstrated the importance of socioeconomic factors for health, several socioeconomic variables were also examined: highest level of educational attainment (less than high school, completed high school, some post-secondary school, completed post-secondary school), employment (employed – worked for pay or self-employed or temporarily absent, unemployed), total individual income (≤ $9,999,

Table 1: Determinants of Health, Health Related Measures and Health Outcomes Variables

Variable	Category
Identity	
Gender	Female, **Male**
Aboriginal identity	First Nations, **Métis**
Indian status (Registered or Treaty Indian)	Yes, **No**
Urban Mobility	
Time in urban area	**Life-long urban resident**, Long-time urban resident (>5 years), Recent urban resident (≤5 years)*
Mobility in past 5 years	**0**, 1, 2+
Reasons for most recent move:	
Family	Yes, **No**
Work/To find a job	Yes, **No**
School	Yes, **No**
Better housing	Yes, **No**
Cheaper housing	Yes, **No**
Better services	Yes, **No**
Other	Yes, No
Demographic Factors and Socioeconomic	
Age	**20-34**, 35-54, ≥55
Education	Less than high school, Completed high school, Some post-secondary school, **Completed post-secondary school**
Employment	**Employed**, Unemployed
Income	≤ $9,999, $10.000-$19,999, $20,00-$39,999, **≥$40,000**
Family Status	Single/Lone parent, **Family**
Health Related Measures	
Body Mass Index (BMI)	Obese/Overweight, **Normal/Underweight**
Smoking	Smoker, **Non-smoker**
Drinking	Drinker, **Non-drinker**
Health Care Use	
Consultation with Family Doctor	Yes, **No**
Consultation with Nurse	Yes, **No**
Consultation with Traditional Healer	Yes, **No**
Health Outcomes	
Self-rated health	**Healthy**, Unhealthy
Total number of chronic health conditions	0, 1, 2+ (**0**, 1+ for logistic regression)

Bold indicates the reference category for logistic regression analysis.

* *For urban migrant models, long-time residents are the reference category (Tables 8 and 10).*

$10,000-$19,999, $20,00-$39,999, ≥$40,000) and family status (family member/partnered, single – lone parent of not living with family, which provides an indication of social support) (CSDH 2008; Raphael 2009).

Research suggests that health related measures and health care utilization are also important immediate determinants of health (CSDH 2008; McGibbon 2009; Raphael 2009). Body mass index (BMI), smoking status and drinking status were selected as health related

measures because they are risk factors for a number of chronic health conditions (Must, Spadano et al. 1999; Sturm 2002; Canada 2010a) (Table 1). BMI calculations are provided in the PUMF, based on individuals' self-reported weights and heights (questions E31-E32). The survey BMI classifications were regrouped into a dichotomous BMI variable: obese/overweight (≥25.0 kg/m^2) and normal/underweight (≤24.9 kg/m^2). Smoking status is an aggregated variable provided in the PUMF based on participants' responses to questions E33-E41 regarding smoking habits. It was regrouped into a dichotomous variable: smoker (daily and occasional) and non-smoker (non-smoker now and never smoked). Drinking status is also an aggregated variable provided in the PUMF based on questions E42-E45 and was regrouped into a dichotomous variable: drinker (regular and occasional) and non-drinker. Consultations with family doctors or general practitioners (GP), nurses and traditional healers were included as measures of health care use. These variables were gauged by responses to a survey question that asked if participants had seen or talked on the phone with various health professionals within the year preceding the survey (question E2). The yes or no responses regarding consultation with a family doctor/general practitioner, a nurse and a traditional healer were selected in an effort assess utilization of both Western biomedical care and traditional healing care centered on Aboriginal conceptions of health.

Finally, two variables, that assess health outcomes, self-rated health and total number of chronic health conditions, were selected for analysis (Table 1). Self-rated health provides an assessment of overall health status and was determined from question E1, which asked individuals to rate their health as excellent, very good, good, fair or poor. Responses to this question were regrouped into a dichotomous variable: healthy (excellent, very good or good health) or unhealthy (fair or poor health). While self-assessed health has been criticized as being subjective and has yet to be tested extensively for validity among Aboriginal peoples in Canada, studies have shown that self-assessments of health align well with those of physicians, re-rest reliability is quite good, and that it is a valid health measure among various other ethnic groups, including Aboriginal peoples in Australia (Miilunpalo, Vuori et al. 1997; Chandola and Jenkinson 2000; Sibthorpe, Anderson et al. 2001). The total number of chronic health conditions is an aggregated variable provided in the PUMF based on individuals' answers to questions E6 to E28, which asked about specific chronic health conditions (such as diabetes, cancer and high

blood pressure). For cross tabulation analysis, chronic health conditions were grouped into three categories (none, one chronic health condition and two or more chronic health conditions) and for logistic regression analysis, two categories were examined (none and one or more chronic health conditions).

3.2.3 Data Analysis: Cross Tabulation, Logistic Regression

In seeking to contribute to improved understandings of the health of urban Aboriginal peoples, the analysis was conducted in three phases. Addressing the first specific research question, focused on the current health status of urban Aboriginal women and men, Phase I provides a broad picture of health determinants and health outcomes among the national urban Aboriginal population and explores how they may differ by gender, Aboriginal identity and status. Specifically, cross tabulations for socioeconomic/demographic (age, education, employment, income, family status), urbanization (time in urban area, mobility, reasons for moving) and health (self-rated health, total chronic health conditions, BMI, smoking, drinking, consultation with family doctor/GP, nurse or traditional healer) variables by gender, Aboriginal identity and status were conducted (Table 2a/b). As age is significantly associated with almost all of the variables examined, supplementary cross tabulations stratified by age group were conducted and full results are available in Appendix 1. Age-stratified cross tabulations for urbanization and health variables by gender, Aboriginal identity and status are presented in Table 3, as they are the focus of the analysis.

Addressing the second specific research question regarding the differential impacts of urbanization on the health of urban Aboriginal women and men, Phases II and III explore how urbanization may function as a determinant of health by examining relationships between health outcomes and urbanization variables. In Phase II, self-rated health and total number of chronic health conditions were cross tabulated by the urbanization variables (time in urban area, mobility and reasons for moving), and stratified by gender, Aboriginal identity and status in order to assess how these relationships may differ between women and men, and by access to Aboriginal rights. Results are presented in Tables 4-6. As age group is significantly associated with the urbanization and health outcome variables, cross tabulation analyses were further stratified by age and full results are presented in Appendix 2. Pertinent age-stratified cross tabulations for health outcomes by mobility and reasons for moving are presented in Tables 5 and 6a/b. Results

for age stratified analyses of relationships between health and moving for school, better housing, cheaper housing and better services are not included in Tables 6a/b because the cross tabulation sample sizes were too small (<10) to produce estimates (Canada 2009d). Chi-square test statistics were calculated for all cross tabulation analyses and levels of significance are presented Tables 2-6.

Phase III builds on the results of the first two phases by utilizing binary logistic regression analysis to examine how urbanization impacts health outcomes when controlling for many other determinants of health. Binary logistic regression was used as it predicts the likelihood of observing a particular dichotomous health outcome (e.g. the probability of assessing one's health as unhealthy vs. healthy) based on a set of predictor variables in the sample. This method of analysis is useful as one can calculate the odds ratio (OR) for an association between a predictor variable and an outcome variable within the sample without having to define the specific values of the predictor variable. In order to calculate an easily interpretable odds ratio, one must apply the logit transformation to the standard logistic function (Kleinbaum 1994). The logit form of the logistic function allows for the calculation of the log odds of observing a particular health outcome based on estimated coefficients for the predictor variable. Coefficients are estimated using the maximum likelihood method (Aldrich and Nelson 1984). This method seeks to maximize the number of correct outcome predictions through an iterative process of estimating sample coefficients that approximate the population parameters (Kleinbaum 1994). The odds ratio is a comparison of the probability of an outcome (e.g. likelihood of assessing one's health as unhealthy rather than healthy) between two values, or categories of a predictor variable. In order to do this, a reference category for the predictor variable, which indicates how the comparison of the probabilities will be made, must be defined. The odds ratio provides an estimation of how the probability of an outcome at one category of a predictor variable compares to the probability at the reference category for that predictor variable, when all of the other predictor variables in the model are held constant. An odds ratio of greater than one indicates that the likelihood of observing an outcome at that category is greater than that at the reference category while an odds ratio of less than one indicates that the likelihood of an outcome at that category is less than that at the reference category.

The dependent or outcome variables in the models are self-rated health (0=healthy, 1=unhealthy) and total number of chronic health conditions (0=none, 1=one or more chronic health conditions). The independent or predictor variables in the models include a number of determinants of health. The conventional immediate health determinants included in all models are: demographic/socioeconomic predictors (age, education, income, employment, family status), health related measure predictors (BMI, smoking status, drinking status), and health care use predictors (consultation with a doctor, nurse, traditional healer). Self-rated health and total number of chronic health conditions are also included as predictor variables for models in which they are not examined as outcome variables. Beyond these determinants of health, the models test whether identity variables (gender, Aboriginal identity and status) and urbanization variables (time in urban area, mobility, reasons for moving) differentially impact the health of Aboriginal women and men living in urban areas. In order to do this, three distinct sets of models were examined: gender-aggregated models (combined women and men) and gender-disaggregated models (focused on women and men separately). Gender is only included as a predictor variable in the aggregated models. Additionally, distinct models were developed to explore how urbanization-health relationships may differ in the whole urban population (Tables 7 and 9, inclusive of life-long, long-time and recent urban residents), compared to the urban migrant population (Tables 8 and 10, inclusive only of long-time and recent urban residents). It is reasonable to expect that the ways in which Aboriginal peoples experience urban areas, and thus the ways in which urbanization may impact health, will differ between those who have lived their whole lives in urban areas and those who have transitioned to urban areas from rural/reserve settings (Cooke and Bélanger 2006). Further, the separation of the total urban population and the urban migrant population into distinct models allows for the inclusion of reasons for moving to an urban area as predictor variables in the urban migrant models, which provides an indication of the factors underlying decisions to migrate to urban areas. In total, 12 distinct models exploring relationships between urban mobility and health were examined (Tables 7-10).[8]

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[8] Bivariate correlation analysis did not suggest high levels of multicollinearity between variables.

For each of the predictor variables, a reference category was defined. For ease of interpretation, categories that were hypothesized to be least likely associated with the outcome variable were chosen as reference categories (e.g. for the prediction of unhealthy self-assessed health, the 20-34 age group was defined as the reference category for the age variable since the youngest age group was hypothesized to be the least likely to be unhealthy). Reference categories for each of the predictor variables included in the models are noted in bold in Table 1. The outputs from the logistic regression analyses are presented in Tables 7-10, which include adjusted odds ratios and 95% confidence intervals. The model sensitivity (i.e. the proportion of unhealthy cases that the model correctly predicted as unhealthy), the specificity (i.e. the proportion of healthy cases that the model correctly predicted as healthy) and the overall proportion of correct predictions are included below each table as indicators of the predictive efficiency of the models. Providing a measure of the goodness of the fit of the models, Rho squared values (i.e. one minus the ratio of the maximized likelihood values of the fitted and constant only term models) are also included below each table. Rho squared values between 0.2-0.4 are considered a good fit for the model (Wrigley 1985). Samples were selected using data filters and the sample weights were adjusted accordingly.[9] All analyses were conducted using SPSS 16.0.

3.3 Results

3.3.1 Phase I: Profile of Health Determinants and Health Outcomes (Tables 2-3)

3.3.1.1 Socioeconomic and Demographic Factors

The focus of this analysis is the national population of First Nations and Métis adults (≥20 years of age) living off-reserve in urban areas (n=9,738). In order to provide context, comparisons to the general Canadian population and the national, on-reserve Aboriginal population are provided whenever possible. Over half of the urban population examined in this analysis are women (56.5% – which is consistent with Aboriginal women's overrepresentation in urban areas – see Chapter 2) and self-identify as First Nations (53.8%), while 39.4% report

[9] New weight variables were created for samples by dividing the survey weight variable provided in the PUMF by the mean of the weight for the new sample and applying this new weight variable to the new sample.

having status. The urban Aboriginal population is quite young compared to the overall Canadian population: 35.4% are 20-34 years of age (vs. 20.6% of all Canadians), 45.8% are 35-54 years of age (vs. 29.7%) and just 18.8% are 55 years of age and older (vs. 26.6%) (Table 2a) (Canada 2010b). However, the age structure of the urban population is older than the national Aboriginal population living on-reserve. Just over 65% of the on-reserve population is under the age of 35 (20-34: 21.0%, 0-19: 44.4%) while only 23.6% are between the ages of 35-54 and 11.0% are 55 years of age or over (Canada 2009b).

The urban population is quite highly educated with 43.5% having completed post-secondary education and 17.4% having some post-secondary educational experience (Table 2a). The proportion of post-secondary school graduates (college and university) in the urban population is quite a bit higher than that among the on-reserve population (28%) but is similar to that among the general Canadian population (43.8%) (AFN 2007). There are significant differences in educational attainment between women and men, First Nations and Métis, and those with and without status. Women are overrepresented among those who have completed post-secondary studies (45.4% of women vs. 41.0% of men), whereas men are overrepresented among those with less than a high school education (21.6% of women vs. 24.9% of men) ($p<0.001$). Educational attainment is lower among First Nations and those with status compared to their Métis and non-status counterparts. These differences are consistent upon stratification by age (Appendix 1).

The employment rate among Aboriginal peoples living in urban areas is high at 68.3%[10] (Table 2a). As reported in the First Nations Regional Health Survey, this is higher than the proportions of general Canadians and of on-reserve Aboriginal peoples working for pay (57.0% and 50.2%, respectively) (AFN 2007). Despite women's higher educational attainment, the proportion of unemployed women is significantly higher than that among men: 37.0% of women and 24.9% of men are unemployed ($p<0.001$). First Nations and those with status are also overrepresented among the unemployed compared to their Métis and non-status counterparts

[10] Note, in the 2006 APS, those who are employed include those who have worked for pay or in self-employment and those who are temporarily absent from the workforce.

Table 2a: Overview of Socioeconomic, Demographic, and Urbanization in Urban Aboriginal Population

		Gender			Aboriginal Identity			Status		
	Total Population	Female	Male	P	First Nations	Métis	P	Status	Non-Status	P
DEMOGRAPHIC and SOCIOECONOMIC VARIABLES (%)										
Total Population	100.0	56.5	43.5		53.8	46.2		39.4	60.6	
Age										
20-34	35.4	36.2	34.3		35.9	34.8		37.9	33.7	
35-54	45.8	45.1	46.6		45.1	46.5		43.5	47.2	
55+	18.8	18.7	19.0	ns	19.0	18.7	ns	18.6	19.0	***
Education										
Less than high school	23.1	21.6	24.9		26.2	19.4		27.9	19.9	
Completed high school	16.0	15.3	16.9		15.3	16.9		14.2	17.2	
Some post-secondary	17.4	17.6	17.1		18.3	16.4		17.8	17.2	
Completed post-secondary	43.5	45.4	41.0	***	40.2	47.4	***	40.1	45.7	***
Employment status										
Employed	68.3	63.0	75.1		63.4	73.9		62.0	72.3	
Unemployed	31.7	37.0	24.9	***	36.6	26.1	***	38.0	27.7	***
Income										
<$10,000	22.0	25.2	18.0		25.0	18.7		27.8	18.3	
$10,000-19,999	24.1	27.8	19.3		26.1	21.8		25.2	23.4	
$20,000-39,999	28.3	30.1	26.0		27.0	29.8		27.0	29.1	
>=$40,000	25.6	16.9	36.8	***	21.9	29.8	***	20.1	29.1	***
Family status										
Family/Partner	62.5	56.5	70.3		59.2	66.4		58.7	65.0	
Single	37.5	43.5	29.7	***	40.8	33.6	***	41.3	35.0	***
URBANIZATION VARIABLES (%)										
Time in urban area										
Life-long urban	28.6	27.6	29.9		27.3	30.1		26.8	29.8	
Long-time urban (>5 yrs.)	44.5	44.8	44.1		45.1	43.7		44.6	44.4	
Recent urban (<5 yrs.)	26.9	27.6	26.0	*	27.6	26.2	*	28.6	25.8	**
Mobility within last 5 years										
Did not move	37.7	37.1	38.5		35.6	40.1		35.3	39.2	
Once	22.4	22.0	22.8		22.6	22.1		22.2	22.4	
Two or more times	39.9	40.9	38.7	ns	41.8	37.8	ns	42.4	38.3	ns
Reasons for moving to urban area										
Family	23.7	38.5	28.4	***	33.7	34.7	ns	32.9	35.1	ns
Work/Find job	24.1	28.7	42.6	***	32.9	36.8	***	34.0	35.0	ns
School	7.0	11.4	8.2	***	11.7	8.0	***	13.6	7.6	***
Better housing	4.0	6.6	4.7	***	6.0	5.5	ns	5.8	5.7	ns
Cheaper housing	2.9	4.3	3.9	ns	4.3	4.0	ns	3.3	4.7	**
Better services	2.4	3.4	3.5	ns	4.0	2.7	**	4.1	3.0	*
Other	15.4	22.4	21.9	ns	23.5	20.6	**	23.1	21.6	ns

p<0.05 = * p<0.01=** p<0.001=*** p≥0.05=ns (not significant)

Levels of significance for associations between determinants of health variables and identity variables (gender, Aboriginal identity, status) are indicated in the last category for each variable.

(p<0.001) (Table 2a). These gender, identity and status differences are consistent when stratified by age group (Appendix 1).

Comparable proportions of individuals earn annual incomes of less than $10,000 (22.0%), between $10,000 and $19,999 (24.1%), between $20,000 and $39,999 (28.3%) and $40,000 or more (25.6%). Levels of income among the urban population are quite a bit higher than those on-reserves, where 41.0% of residents earn less than $10,000 and only 13.0% earn over $40,000 annually (Canada 2009b). However, individual income among the urban Aboriginal population is much lower than levels among the general Canadian population, 41.9% of whom earn at least $40,000 annually (Canada 2010b). Levels of income are significantly higher (i.e. proportions earning <$10,000 are lower and proportions earning ≥$40,000 are

Table 2b: Overview of Health Measures in Urban Aboriginal Population

		Gender			**Aboriginal Identity**			**Status**		
	Total Population	**Female**	**Male**	**P**	**First Nations**	**Métis**	**P**	**Status**	**Non-Status**	**P**
HEALTH VARIABLES (%)										
Self-rated health										
Healthy	81.8	80.0	84.0		79.5	84.4		80.0	82.9	
Unhealthy	18.2	20.0	16.0	***	20.5	15.6	***	20.0	17.1	***
Total number of chronic health conditions										
None	43.9	40.8	48.0		43.5	44.3		45.2	43.0	
One	25.3	24.4	26.5		25.2	25.4		24.5	25.9	
Two or more	30.8	34.8	25.5	***	31.2	30.2	ns	30.2	31.1	ns
Body mass index (BMI)										
Normal/Underweight	38.3	45.2	29.8		39.3	37.2		36.6	39.4	
Overweight/Obese	61.7	54.7	70.2	***	60.7	62.8	*	63.4	60.6	**
Smoking status										
Non-smoker	55.6	54.5	57.1		52.4	59.3		52.1	57.9	
Smoker	44.4	45.5	42.9	*	47.6	40.7	***	47.9	42.1	***
Drinking status										
Non-drinker	21.8	23.7	19.2		24.5	18.6		26.0	19.0	
Drinker	78.2	76.3	80.8	***	75.5	81.4	***	74.0	81.0	***
Consulted family doctor/general practitioner (GP)										
Yes	74.5	80.3	66.8	***	74.3	74.7	ns	73.9	74.8	ns
Consulted nurse										
Yes	26.9	29.9	23.0	***	29.0	24.5	***	27.3	26.6	ns
Consulted traditional healer										
Yes	6.9	8.2	5.2	***	9.4	4.0	***	11.2	4.1	***

p<0.05 = * p<0.01=** p<0.001=*** p≥0.05=ns (not significant)

Levels of significance for associations between determinants of health/health outcome variables and identity variables (gender, Aboriginal identity, status) are indicated in the last category for each variable.

higher) in the urban population among men, Métis and non-status individuals compared to women, First Nations and individuals with status. The differences between women and men are striking: the proportion of men earning more than $40,000 annually is 20% higher than that among women while the proportion of women earning <$10,000 annually is 7.2% higher than that among men ($p<0.001$) (Table 2a).

Most of the sample (62.5%) reported that they are in a partnered relationship or are a member of a family household, compared to 37.5% who are lone parents or not members of a family household. By contrast, the on-reserve population consists of only 20.8% lone parents or not members of a family household (Canada 2009b). Significantly higher proportions of women, First Nations and those with status are single parents or not members of a family, compared to their male, Métis and non-status counterparts. For example, 43.5% of women are single parents or not members of a family compared to just 29.7% of men ($p<0.001$).

3.3.1.2 Urbanization/Urban Mobility

Most of the urban population has been living in the same urban area for a long period of time, either for their whole life (life-long urban residents: 28.6%) or for at least five years prior to the survey (long-time urban residents: 44.5%) (Table 2a). Recent urban residents, who had moved to the urban area in which they were living at the time of the survey less than five years before the survey, represent the smallest portion of the urban population with 26.9%. A lower percentage of those aged 55 years and over had moved recently (within five years of the survey) to an urban area compared to the younger age groups. The opposite is true of long-time urban residents, who were older than the other groups: 60.2% of those aged 55 and over, 50.5% of 35-54 year olds and 28.4% of 20-34 year olds had moved to an urban area more than five years prior to the survey (Table 3). When samples were further stratified by gender, Aboriginal identity and status, patterns in age were quite consistent.

Levels of urban mobility are quite evenly distributed in the urban Aboriginal population: comparable proportions of individuals reported having moved two or more times within the five years preceding the survey (including moves within the same city – 39.9%) and not having moved at all during that time (37.7%) (Table 2a). There are no significant differences between women and men, First Nations and Métis or those with and without status in terms of five year

Table 3: Age Stratified Overview of Urbanization and Health Outcome Variables in Urban Aboriginal Population

		Gender			Aboriginal Identity			Status		
	Total Population	Female	Male	P	First Nations	Métis	P	Status	Non-Status	P
URBANIZATION VARIABLES (%)										
Time in urban area										
Life-long urban	**28.6**	**27.6**	**29.9**		**27.3**	**30.1**		**26.8**	**29.8**	
20-34	32.9	32.2	34.0		31.0	35.3		30.2	35.0	
35-54	26.8	26.1	27.6		25.1	28.7		24.7	28.0	
55+	24.8	22.3	28.0		25.6	23.9		24.9	24.7	
Long-time urban (Moved more than 5 years ago)	**44.5**	**44.8**	**44.1**		**45.1**	**43.7**		**44.6**	**44.4**	
20-34	28.4	28.5	28.2		30.8	25.5		29.3	27.7	
35-54	50.5	51.4	49.3		50.0	51.1		50.6	50.4	
55+	60.2	60.2	60.1		60.8	59.3		61.6	59.3	
Recent urban (Moved within last 5 years)	**26.9**	**27.6**	**26.0**	*	**27.6**	**26.2**	*	**28.6**	**25.8**	**
20-34	38.7	39.3	37.8	ns	38.2	39.2	**	40.5	37.3	*
35-54	22.7	22.4	23.1	ns	24.9	20.2	***	24.6	21.6	*
55+	15.1	17.5	11.9	**	13.6	16.7	ns	13.5	16.0	ns
Mobility within last 5 years										
Did not move	**37.7**	**37.1**	**38.5**		**35.6**	**40.1**		**35.3**	**39.2**	
20-34	17.7	17.9	17.6		16.6	19.1		16.7	18.5	
35-54	43.7	44.0	43.2		40.8	46.9		40.8	45.4	
55+	60.5	57.5	64.4		58.9	62.5		60.7	60.4	
Once	**22.4**	**22.0**	**22.8**		**22.6**	**22.1**		**22.2**	**22.4**	
20-34	21.4	20.4	22.6		21.5	21.2		21.2	21.5	
35-54	24.2	23.4	25.2		24.7	23.6		23.9	24.4	
55+	19.8	21.8	17.1		19.7	19.9		20.4	19.3	
Two or more times	**39.9**	**40.9**	**38.7**	ns	**41.8**	**37.8**	ns	**42.4**	**38.3**	ns
20-34	60.9	61.7	59.8	ns	61.9	59.7	ns	62.1	60.0	ns
35-54	32.1	32.6	31.5	ns	34.4	29.5	***	35.3	30.2	**
55+	19.7	20.7	18.5	**	21.4	17.7	ns	18.8	20.2	ns
Reasons for Moving to Urban Area										
Family	**23.7**	**38.5**	**28.4**	***	**33.7**	**34.7**	**ns**	**32.9**	**35.1**	**ns**
20-34	37.3	40.3	32.9	***	36.9	37.6	ns	35.1	39.0	ns
35-54	31.6	35.8	26.1	***	31.1	32.1	ns	29.8	32.7	ns
55+	35.1	41.3	26.6	***	34.3	36.1	ns	36.0	34.6	ns
Work/Find job	**24.1**	**28.7**	**42.6**	***	**32.9**	**36.8**	***	**34.0**	**35.0**	**ns**
20-34	31.1	25.5	39.0	***	28.9	34.0	*	31.0	31.3	ns
35-54	37.3	30.5	45.9	***	35.3	39.6	*	36.0	38.0	ns
55+	34.3	29.9	40.2	***	34.0	34.7	ns	35.0	33.9	ns
School	**7.0**	**11.4**	**8.2**	***	**11.7**	**8.0**	***	**13.6**	**7.6**	***
20-34	18.2	20.1	15.5	**	20.3	15.5	**	22.4	14.9	***
35-54	7.2	8.2	5.8	*	8.5	5.6	**	10.6	5.0	***
55+	3.1	3.9	2.1	ns	4.3	1.8	**	4.0	2.6	ns
Better housing	**4.0**	**6.6**	**4.7**	***	**6.0**	**5.5**	**ns**	**5.8**	**5.7**	**ns**
20-34	4.6	5.5	3.5	*	5.1	4.0	ns	4.1	5.0	ns
35-54	6.6	7.8	5.1	**	6.4	6.9	ns	6.9	6.4	ns
55+	5.7	5.8	5.7	ns	6.8	4.7	ns	6.6	5.2	ns

Cheaper housing	**2.9**	**4.3**	**3.9**	**ns**	**4.3**	**4.0**	**ns**	**3.3**	**4.7**	**
20-34	3.3	3.4	3.1	ns	3.7	2.8	ns	2.5	4.0	ns
35-54	4.4	5.1	3.5	*	3.9	5.0	ns	3.3	5.1	*
55+	4.8	4.1	5.9	ns	6.0	3.7	ns	4.4	5.1	ns
Better services	**2.4**	**3.4**	**3.5**	**ns**	**4.0**	**2.7**	**	**4.1**	**3.0**	*
20-34	2.5	3.0	1.8	ns	3.3	1.5	**	2.6	2.5	ns
35-54	3.2	2.9	3.8	ns	3.8	2.6	*	4.5	2.5	**
55+	5.4	5.3	5.5	ns	5.7	5.0	ns	5.8	5.0	ns
Other	**15.4**	**22.4**	**21.9**	**ns**	**23.5**	**20.6**	**	**23.1**	**21.6**	**ns**
20-34	17.9	18.3	17.3	ns	19.5	15.8	*	19.6	16.5	ns
35-54	23.0	23.2	22.9	ns	24.4	21.5	ns	23.9	22.5	ns
55+	24.3	27.6	27.1	ns	28.6	26.0	ns	27.7	27.1	ns
	Total Population	**Female**	**Male**	**P**	**First Nations**	**Métis**	**P**	**Status**	**Non-Status**	**P**
HEALTH VARIABLES (%)										
Self-rated health										
Healthy	**81.8**	**80.0**	**84.0**		**79.5**	**84.4**		**80.0**	**82.9**	
20-34	92.0	91.1	93.3		90.4	94.0		90.8	92.9	
35-54	80.5	77.8	83.9		78.2	83.1		79.0	81.4	
55+	65.4	63.7	67.7		61.8	69.7		60.1	68.8	
Unhealthy	**18.2**	**20.0**	**16.0**	***	**20.5**	**15.6**	***	**20.0**	**17.1**	***
20-34	8.0.	8.9	6.7	*	9.6	6.0	***	9.2	7.1	*
35-54	19.5	22.2	16.1	***	21.8	16.9	***	21.0	18.6	*
55+	34.6	36.3	32.3	ns	38.2	30.3	***	39.9	31.2	***
Total number of chronic health conditions										
None	**43.9**	**40.8**	**48.0**		**43.5**	**44.3**		**45.2**	**43.0**	
20-34	62.0	57.8	67.8		60.6	63.6		63.4	60.9	
35-54	40.6	37.8	44.3		40.7	40.5		41.8	39.9	
55+	17.2	14.1	21.2		17.0	17.5		14.8	18.7	
One	**25.3**	**24.4**	**26.5**		**25.2**	**25.4**		**24.5**	**25.9**	
20-34	24.7	25.6	23.6		25.2	24.0		23.7	25.5	
35-54	27.0	26.0	28.3		26.7	27.4		25.9	27.7	
55+	22.2	18.1	27.5		21.6	23.0		22.8	22.0	
Two or more	**30.8**	**34.8**	**25.5**	***	**31.2**	**30.2**	ns	**30.2**	**31.1**	ns
20-34	13.3	16.6	8.6	***	14.1	12.3	ns	12.9	13.6	ns
35-54	32.3	36.2	27.4	***	32.6	32.0	ns	32.3	32.3	ns
55+	60.5	67.7	51.4	***	61.4	59.5	ns	62.3	59.3	ns

*p<0.05 = *   p<0.01=**   p<0.001=***   p≥0.05=ns (not significant)*

Levels of significance for associations between determinants of health/health outcome variables and identity variables (gender, Aboriginal identity, status) in each age group are indicated in the last category for each variable.

mobility (Table 2a). As is the case generally, age is significantly associated with mobility such that as age increases, the proportions of those who had not moved during the five years preceding the survey increase and the proportions who had moved two or more times decrease (Table 3). Age trends are consistent in the gender, Aboriginal identity and status-focused analyses.

The most frequently reported reasons for moving to current urban place of residence are to find employment (24.1%), for family (23.7%) and for school (7%). Less than 5% of the sample reported having moved for better housing, cheaper housing and better services, respectively. Approximately 15% of individuals reported moving for 'other' reasons (indicating perhaps that the options provided in the survey do not adequately assess the range of factors that motivate urban Aboriginal peoples' decisions to move). Interesting differences between women and men are apparent for many of the reasons for moving to an urban area. Higher proportions of men than women reported having moved to seek employment (42.6% among men vs. 28.7% among women), whereas higher proportions of women than men reported having moved for family reasons (38.5% among women vs. 28.4% among men), for school (11.4% among women vs. 8.2% among men) and to seek better housing (6.6% among women vs. 4.7% among men) (Table 2a). Significantly higher proportions of First Nations and those with status reported moving for school (11.7% among First Nations vs. 8.0% among Métis; 13.6% among individuals with status vs. 7.6% among those without status) and for better services (4.0% among First Nations vs. 2.7% among Métis; 4.1% among individuals with status vs. 3.0% among those without status) than their Métis and non-status counterparts, respectively (Table 2a). Employment is a more important motivator for moving among the Métis (36.8%) than among First Nations (32.9%; $p<0.001$). Proportions of individuals who moved for family reasons did not differ by Aboriginal identity or status. Age is significantly associated with all of the reasons for moving and age trends are quite consistent upon gender, Aboriginal identity and status stratification (Table 3).

3.3.1.3 Health Status, Health Related Measures and Health Care Use

Overall, 81.8% of the urban population reported that their health is excellent, very good or good (hereafter, such self-assessed health is referred to as healthy) (Table 2b). Though considerably lower than the overall proportion of healthy Canadians 20 years of age or older (89.8% – according to the 2007/8 Canadian Community Health Survey – CCHS – Canada 2007/8), the proportion of healthy urban Aboriginal peoples is slightly higher than that among the on-reserve population (79.7% – according to the First Nations Regional Longitudinal Health Survey – RHS, 2002/03 – AFN 2007). In the urban population, the percentages of healthy women, First Nations and individuals with status are significantly lower than those of their male,

Métis and non-status counterparts, respectively ($p<0.001$ for all three associations). For example, 84.0% of men considered themselves healthy, compared to 80.0% of women. As would be expected, proportions of individuals who reported that they are healthy decrease with age. The gender, Aboriginal identity and status differences seen in the unstratified analysis are largely consistent upon stratification by age (Table 3).

The largest proportion of the population (43.9%) reported having no chronic health conditions, while one quarter reported having one condition and 30.8% reported having two or more conditions (Table 2b). In line with the gender differences in self-rated health, proportions of women with no chronic health conditions and one chronic health condition are significantly lower than those among men while the opposite is true of proportions with two or more chronic health conditions ($p<0.001$) (Table 2b). These findings are similar to those in the on-reserve population, among whom 22.3% have at least one chronic health condition, 31.4% have two or more chronic health conditions and higher proportions of women than men have multiple chronic health conditions (AFN 2007). Neither Aboriginal identity nor status is associated with chronic health conditions. Age is predictably associated with total number of chronic health conditions such that proportions of individuals with no conditions decrease with age (62.0% of 20-34 year olds vs. 17.2% of those 55 years and older) and proportions with two or more conditions increase with age (13.3% of 20-34 year olds vs. 60.5% of those 55 years and older) (Table 3). In the age-stratified analyses, women are significantly less healthy than men (i.e. proportions of women with no chronic health conditions are significantly lower than among men and proportions of women with two or more chronics conditions are significantly higher than among men in all age groups), but differences between First Nations and Métis and those with and without status are not apparent (Table 3).

The health related measures examined also reveal some interesting findings (Table 2b). Nearly 62% of urban Aboriginal peoples are overweight or obese (BMI $\geq$25.0 kg/m^2). This is quite a bit higher than the rate of overweight/obesity in the total adult ($\geq$18 years of age) Canadian population, 47.1%, yet lower than that among the adult (>18 years of age) on-reserve population, 73.0% (AFN 2007; Canada 2008). As in the total Canadian population, the percentage of men who are overweight or obese is considerably higher than the percentage of women (70.2% of men vs. 54.7% of women; $p<0.001$ for the urban population, 55.3% of men vs.

38.6% of women in the general Canadian population) (Canada 2008). This contrasts with the on-reserve population, in which proportions of overweight/obesity are quite similar between men (73.6%) and women (72.2%) (AFN 2007). In the urban Aboriginal population, levels of overweight/obesity among Métis individuals and those with status are significantly higher than those among their First Nations and non-status counterparts, though the differences are not striking (e.g. 60.7% of First Nations and 62.8% of Métis are overweight/obese) (Table 2b). The proportion of urban Aboriginal peoples who drink alcoholic beverages (occasionally or regularly) is lower than that among the total Canadian population, though considerably higher than that among Aboriginal peoples living on-reserve (78.2% among urban population vs. 82.4% among Canadian population vs. 65.6% among on-reserve population) (AFN 2007; Canada 2007/8). More men, Métis peoples and individuals without status are drinkers than their female, First Nations and status counterparts, respectively (Table 2b). Smoking is quite prevalent among the urban Aboriginal population: 44.4% are smokers (occasional or daily), compared to just 25.0% of the total adult Canadians population (Canada 2007/8). However, the level of smoking among Aboriginal peoples living in urban areas is still considerably lower than among those living on-reserve, 58.8% (AFN 2007). The proportion of smokers is significantly higher among women, First Nations and those with status compared to men, Métis and those without status, respectively (Table 2b).

Finally, levels of health care use among urban Aboriginal peoples appear to be quite high. In the 12 months preceding the survey, 74.5% of the population reported that they had consulted with a family doctor or general practitioner and 26.9% reported having consulted with a nurse. Rates of consultation with a family doctor are only slightly lower than those among Canadians generally (76.0%) and rates of consultation with a nurse are considerably higher than among all Canadians (11.0%) (Canada 2007/8). Additionally, 6.9% of the urban population reported having consulted with a traditional healer in the year prior to the survey (Table 2b). Proportions of women who had consulted with a health professional (family doctor, nurse and traditional healer) are significantly higher than those among men (Table 2b). The gender differences in consultation with a family doctor are particularly striking: 80.3% of women compared to just 66.8% of men ($p<0.001$). Levels of consultation with nurses and traditional healers are significantly higher among First Nations than among Métis peoples ($p<0.001$ for both associations). Those with

status consulted traditional healers more often (11.2%) than those without status (4.1%; $p<0.001$) (Table 2b).

3.3.1.4 Summary

The profile of Aboriginal (First Nations and Métis) adults living in urban areas developed in Phase I provides a picture of determinants of health and health outcomes in the urban population and how they vary between women and men, First Nations and Métis, and those with and without status. Overall, results show that this population is young, highly educated, mostly partnered or members of a family of adults and is quite evenly distributed in terms of levels of income, but has high levels of unemployment. The population consists largely of urban migrants, though most of the population has lived in the same urban area for more than five years. Levels of mobility are moderate, with approximately equal proportions of the sample having not moved at all and having moved two or more times during the five years preceding the survey. The most commonly reported reasons for moving an urban area are for family, employment and education. Over 80% of the population reported that they are healthy, while almost 60% have at least one chronic health condition. Levels of overweight/obesity, smoking, drinking and health care use are quite high.

This profile also indicates that important differences in terms of gender, Aboriginal identity, status and age exist for health determinants and health outcomes. With the notable exception of educational attainment, women, First Nations and those with status appear to fair worse than their male, Métis, non-status counterparts in terms of socioeconomic factors. These subgroups also fair worse in terms of health outcomes, which is reflected in their higher levels of health care use. Urbanization variables also differ by gender, Aboriginal identity and status, particularly in terms of motivation for moving to urban areas. With these differences in mind, further cross tabulations focusing on relationships between urbanization variables and health outcomes, stratified by gender, Aboriginal identity, and status were conducted in an effort to explore how urbanization may be associated with health outcomes among urban Aboriginal peoples.

3.3.2 Phase II: Exploring Relationships between Health Outcomes and Urbanization Using Cross Tabulation (Tables 4-6)

3.3.2.1 Self-Rated Health

Results from cross tabulations for health outcomes by urbanization variables, stratified by gender, Aboriginal identity, status and age are presented in Tables 4-6. The first set of analyses examined relationships between time in urban area and self-rated health (Table 4). Self-rated health is significantly associated with time in urban area such that a higher proportion of long-time urban residents are unhealthy (20.6%, fair or poor self-rated health) compared to life-long urban residents (16.5%) and recent urban residents (16.1%) ($p<0.001$) (Table 4). This finding holds true when cross tabulations are further stratified by gender, Aboriginal identity and status. Women, First Nations and those with status are less healthy than their male, Métis, non-status counterparts among life-long, long-time and recent urban residents. However, when analyses are further stratified by age group, relationships between time-in-urban area and self-rated health by gender, Aboriginal identity and status are not often apparent (Appendix 2).

Mobility and self-rated health are not significantly associated in the combined-age cross tabulation analysis (Table 5). Stratification by age, however, reveals significant associations between mobility and self-rated health in all three age groups. In the youngest age groups (20-34 and 35-54), those who had moved two or more times are the unhealthiest. By contrast, in the oldest age group, individuals who had moved once in the five years preceding the survey are the unhealthiest and individuals who had never moved are the healthiest ($p<0.001$) (Table 5). There are also significant differences in self-rated health between women and men, First Nations and Métis, and status and non-status peoples, at various levels of mobility (Tables 5 and Appendix 3). Consistent with the profile presented in Phase I, male, Métis and non-status individuals are quite consistently healthier than their female, First Nations and status counterparts, at various levels of mobility.

Relationships between most recent reasons for moving to an urban area and self-rated health were also examined (Tables 6a/b). In the whole urban sample, and when stratified by gender, Aboriginal identity and status, moving for school and work are associated with higher proportions of healthy individuals while moving for family, better housing, and better services are associated with higher proportions of unhealthy individuals, compared to those who did not

report moving for those reasons. It is interesting to note that women who moved for family reasons are less healthy than those who did not move for those reasons ($p<0.05$) and that this relationship is not seen among men (Table 6a). Moving for better housing is not associated with self-rated health among women or First Nations. However, among men and Métis individuals, those who had moved for better housing are significantly less healthy than those who did not move for this reason ($p<0.001$). Individuals with and without status do not differ in terms of the relationships between motivation for moving to an urban area and self-rated health (Table 6b). Cross tabulations examining relationships between moving to an urban area for family or work and self-rated health were further stratified by age and results are presented in Appendix 2.[11]

Table 4: Relationships between Time in Urban Area and Health

		SELF-RATED HEALTH			TOTAL CHRONIC HEALTH CONDITIONS			
Sub-Sample	**TIME IN URBAN AREA**	**Unhealthy**	**Healthy**	**P**	**None**	**One**	**Two or more**	**P**
Total Population	Life-long	16.5	83.5	***	48.0	25.5	26.4	***
	Long-time	20.6	79.4		38.6	25.5	35.8	
	Recent	16.1	83.9		48.3	24.6	27.1	
Male	Life-long	14.2	85.8	***	52.1	25.6	22.3	***
	Long-time	18.8	81.2		43.3	26.9	29.8	
	Recent	13.3	86.7		51.7	26.2	22.2	
Female	Life-long	18.4	81.6	**	44.7	25.4	29.9	***
	Long-time	21.9	78.1		35.1	24.5	40.3	
	Recent	18.1	81.9		45.9	23.4	30.7	
First Nations	Life-long	16.6	83.4	***	49.2	25.2	25.6	***
	Long-time	23.8	76.2		37.9	25.0	37.1	
	Recent	18.8	81.2		47.6	25.2	27.2	
Métis	Life-long	16.4	83.6	**	46.9	25.8	27.3	***
	Long-time	16.7	83.3		39.5	26.1	34.4	
	Recent	12.7	87.3		49.2	23.8	27.0	
Status	Life-long	17.3	82.7	***	50.7	24.4	24.9	***
	Long-time	23.4	76.6		38.6	25.0	36.4	
	Recent	16.7	83.3		50.8	23.9	25.3	
Non-Status	Life-long	16.1	83.9	*	46.5	26.2	27.4	***
	Long-time	18.7	81.3		38.6	25.9	35.5	
	Recent	15.6	84.4		46.6	25.1	28.4	

*$p<0.05$ = * $p<0.01$=** $p<0.001$=*** $p\geq0.05$=ns (not significant)*

Levels of significance for associations between time in urban area and each health outcome indicated in the first category for each variable.

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[11] Age stratified analyses of relationships between self-rated health and moving for school, better housing, cheaper housing and better services were not included in Table 2 because the cross tabulation sample sizes were too small (<10) to produce estimates (Canada 2009e).

3.3.2.2 Total Number of Chronic Health Conditions

The total number of chronic health conditions reported by individuals is significantly associated with time in urban area (Table 4). As with self-rated health, long-time urban residents are the least healthy (i.e. higher proportions of individuals reporting having two or more chronic health conditions and lower proportions reporting having no chronic health conditions), compared to both life-long and recent urban residents. The relationship between chronic health conditions and time-in-urban area is consistent when the sample is stratified by gender, Aboriginal identity and status, though when further stratified by age group, many of these relationships disappear (Table 4 and Appendix 2). Women are less healthy than their male counterparts in all three categories of time-in-urban area (Table 4 and Appendix 3). Neither Aboriginal identity nor status is significantly associated with chronic health conditions in any of the time in urban area groups (Appendix 3).

Outputs from cross tabulations for five year mobility and total chronic health conditions are presented in Table 5. Higher mobility is associated with better health outcomes in the combined age sample (i.e. percentages of individuals with no chronic health conditions increase and percentages with two or more conditions decrease, with increasing mobility). For example, 35.3% of non-movers had two or more chronic health conditions, compared to 29.9% among those who had moved once and 27.1% among those who had moved two or more times ($p<0.001$). This finding is quite consistent when stratified by gender, Aboriginal identity and status. Again, gender is significantly associated with chronic health conditions such that women suffer more from chronic health conditions than men, across all of the mobility groups (Appendix 3). This relationship is not seen with Aboriginal identity or status. When analyses were further stratified by age, results are less clear. Among the youngest age group, mobility is not significantly associated with total chronic health conditions (Table 5). In the oldest two age groups, those who are more mobile have worse health outcomes than those who are less mobile (i.e. individuals who had moved two or more times have the highest proportions of individuals with two or more chronic health conditions and the lowest proportions of those without any chronic health conditions).

Table 5: Relationships between Five Year Mobility and Health

			SELF-RATED HEALTH			TOTAL CHRONIC HEALTH CONDITIONS			
Age Group	**Sub-Sample**	**FIVE YEAR MOBILITY**	**Unhealthy**	**Healthy**	**P**	**None**	**One**	**Two or more**	**P**
All Ages	**Total Population**	None	18.4	81.6	ns	38.2	26.5	35.3	***
		One	18.2	81.8		45.0	25.1	29.9	
		Two+	17.8	82.2		48.3	24.6	27.1	
	Male	None	16.0	84.0	ns	43.2	27.5	29.2	***
		One	18.0	82.0		48.7	25.1	26.2	
		Two+	14.8	85.2		52.0	26.4	21.6	
	Female	None	20.3	79.6	ns	34.2	25.7	40.1	***
		One	18.4	81.6		4.02	25.2	32.8	
		Two+	19.9	80.1		45.6	23.2	31.2	
	First Nations	None	19.6	80.4	ns	37.7	26.3	36.0	***
		One	21.3	78.7		43.7	25.4	30.9	
		Two+	20.5	79.5		47.9	24.5	27.6	
	Métis	None	17.2	82.8	*	38.7	26.7	34.6	***
		One	14.4	85.6		46.4	24.8	28.7	
		Two+	14.2	85.8		48.8	24.7	26.5	
	Status	None	20.0	80.0	ns	37.8	26.4	35.8	***
		One	21.1	78.8		43.4	25.2	31.3	
		Two+	18.8	81.2		52.0	23.0	25.0	
	Non-Status	None	17.5	82.5	ns	38.4	26.6	35.0	***
		One	16.3	83.7		45.9	25.0	29.0	
		Two+	17.0	83.0		45.6	25.7	28.7	
20-34 year olds	**Total Population**	None	7.2	92.8	*	62.9	26.5	10.6	ns
		One	5.6	94.4		61.5	25.2	13.3	
		Two+	8.7	91.3		61.8	24.2	13.9	
	Male	None	3.6	96.4	*	71.5	23.4	5.0	ns
		One	5.3	94.7		69.5	21.5	9.0	
		Two+	8.3	91.7		66.0	24.1	9.9	
	Female	None	9.8	90.2	ns	57.1	28.4	14.5	ns
		One	5.5	94.5		55.4	28.1	16.5	
		Two+	9.1	90.9		58.9	24.2	16.9	
	First Nations	None	6.9	93.1	**	61.7	28.2	10.1	ns
		One	6.1	93.9		58.4	25.3	16.3	
		Two+	11.0	89.0		61.4	24.5	14.0	
	Métis	None	7.5	92.5	ns	64.3	24.5	11.2	ns
		One	4.9	95.1		65.7	25.0	9.3	
		Two+	6.0	94.0		62.3	23.8	13.8	
	Status	None	7.1	92.9	*	61.6	28.0	10.3	ns
		One	5.4	94.6		64.0	24.3	11.6	
		Two+	10.5	89.5		63.9	22.7	13.4	
	Non-Status	None	7.2	92.8	ns	64.2	25.3	10.5	ns
		One	5.7	94.3		60.0	25.7	14.2	
		Two+	7.4	92.6		60.3	25.3	14.4	
35-54 year olds	**Total Population**	None	15.8	84.2	***	41.9	27.3	30.8	**
		One	18.4	81.6		42.4	27.5	30.1	
		Two+	25.1	74.9		36.8	26.8	36.4	
	Male	None	11.7	88.3	***	48.1	27.8	24.1	*
		One	19.8	80.2		41.7	28.6	29.7	
		Two+	18.9	81.1		40.4	29.2	30.4	

	Female	None	19.0	81.0	***	37.1	26.9	36.0	**
		One	17.2	82.8		43.1	26.4	30.5	
		Two+	29.8	70.2		34.0	24.9	41.0	
	First Nations	None	16.8	83.2	***	42.3	26.0	31.7	ns
		One	22.2	77.8		40.9	28.5	30.6	
		Two+	27.5	72.5		37.6	26.6	35.9	
	Métis	None	14.8	85.2	***	41.5	28.6	30.0	*
		One	13.8	86.2		44.3	26.2	29.6	
		Two+	22.0	78.0		35.8	27.1	37.1	
	Status	None	17.7	82.3	**	43.0	25.7	31.3	ns
		One	20.9	79.1		38.3	29.9	31.9	
		Two+	25.1	74.9		42.0	23.7	34.4	
	Non-Status	None	14.8	85.2	***	41.3	28.1	30.5	***
		One	17.0	83.0		45.0	25.9	29.1	
		Two+	25.0	75.0		33.3	28.9	37.8	
55+ year olds	**Total Population**	None	29.2	70.8	***	17.5	25.2	57.3	**
		One	43.6	56.4		18.1	18.1	63.8	
		Two+	40.8	59.2		15.5	17.8	66.7	
	Male	None	29.1	70.9	*	21.3	29.1	49.6	ns
		One	41.5	58.5		23.8	20.6	55.6	
		Two+	35.9	64.1		17.9	27.9	54.3	
	Female	None	29.3	70.7	***	14.1	21.7	64.2	*
		One	44.9	55.1		14.7	16.6	68.7	
		Two+	44.2	55.8		13.4	10.9	75.6	
	First Nations	None	31.1	68.9	***	16.9	25.7	57.4	**
		One	49.7	50.3		20.9	15.8	63.3	
		Two+	45.9	54.1		14.0	16.0	70.0	
	Métis	None	27.1	72.9	ns	18.2	24.6	57.2	ns
		One	36.1	63.9		15.0	20.6	64.4	
		Two+	33.8	66.2		17.6	*20.4*	62	
	Status	None	31.2	68.8	***	15.8	26.3	57.9	*
		One	55.3	44.7		11.8	13.4	74.8	
		Two+	46.5	53.5		14.5	22.6	62.9	
	Non-Status	None	28.0	72.0	**	18.7	24.4	56.9	*
		One	35.6	64.4		21.9	21.0	57.1	
		Two+	37.5	62.5		15.7	15.2	69.1	

*p<0.05 = *   p<0.01=**   p<0.001=***   p≥0.05=ns (not significant)*

Levels of significance for associations between five year mobility and each health outcome indicated in the first category for each variable.

Total number of chronic health conditions is also significantly associated with several of the motivations for moving to an urban area (Tables 6a/b). As with self-rated health, individuals who report having moved for work or for school have better health outcomes (higher proportions of individuals with no chronic health conditions and lower proportions of those with two or more chronic health conditions) than those who do not report moving for these reasons (p<0.001). The opposite is true of those who had moved for family, better services, better housing and cheaper housing (though associations between chronic conditions and the latter two motivations do not reach significance). Upon stratification by gender, Aboriginal identity and status, the associations

Table 6a: Relationships between Reasons for Moving and Health among Total Population and by Gender

			SELF-RATED HEALTH			TOTAL CHRONIC HEALTH CONDITIONS			
Sub-Sample	**REASON FOR MOVING**		**Unhealthy**	**Healthy**	**P**	**None**	**One**	**Two or more**	**P**
Total population	Family	Yes	20.1	79.9	ns	39.0	27.7	33.2	***
		No	18.3	81.7		43.7	24.0	32.3	
	Work	Yes	15.4	84.6	***	46.2	25.4	28.4	***
		No	20.7	79.3		39.9	25.2	34.8	
	School	Yes	9.7	90.3	***	54.1	26.2	19.7	***
		No	19.9	80.1		40.8	25.2	34.0	
	Better housing	Yes	26.1	73.9	***	39.3	25.2	35.5	ns
		No	18.4	81.6		42.3	25.3	32.4	
	Cheaper housing	Yes	18.6	81.4	ns	38.2	25.1	36.7	ns
		No	18.9	81.1		42.3	25.3	32.4	
	Better services	Yes	35.5	64.5	***	23.9	30.6	45.5	***
		No	18.3	81.7		42.8	25.1	32.1	
Male	Family	Yes	16.2	83.8	ns	45.5	28.2	26.4	ns
		No	16.9	83.1		46.3	26.3	27.3	
	Work	Yes	14.9	85.1	*	49.4	26.9	23.8	**
		No	18.1	81.9		43.6	26.8	29.5	
	School	Yes	8.4	91.6	***	56.3	26.0	17.7	**
		No	17.5	82.5		45.1	27.0	27.9	
	Better housing	Yes	29.6	70.4	***	37.8	31.5	30.7	ns
		No	16.1	83.9		46.5	26.6	26.9	
	Cheaper housing	Yes	21.6	78.4	ns	40.4	28.4	31.2	ns
		No	16.5	83.5		46.3	26.8	26.9	
	Better services	Yes	34.0	66.0	***	32.0	37.1	30.9	*
		No	16.1	83.9		46.6	26.5	26.9	
Female	Family	Yes	22.2	77.8	*	35.5	27.5	37.0	***
		No	19.4	80.6		41.5	22.0	36.6	
	Work	Yes	16.0	84.0	***	42.8	23.7	33.6	*
		No	22.3	77.7		37.8	24.3	38.0	
	School	Yes	10.5	89.5	***	52.9	26.3	20.7	***
		No	21.8	78.2		37.4	23.8	38.8	
	Better housing	Yes	24.2	75.8	ns	39.8	22.1	38.2	ns
		No	20.2	79.8		39.1	24.3	36.6	
	Cheaper housing	Yes	16.6	83.4	ns	36.7	22.9	40.4	ns
		No	20.7	79.3		39.3	24.1	36.5	
	Better services	Yes	36.6	63.4	***	17.6	25.6	56.8	***
		No	19.9	80.1		39.9	24.0	36.0	

*$p<0.05$ = * $p<0.01$=** $p<0.001$=*** $p\geq0.05$=ns (not significant)*

Levels of significance for associations between Reasons for Moving and each health outcome indicated in the first category for each variable.

between chronic conditions and motivation for moving to an urban area that reach significance vary among the stratification groups, but the basic trends noted above are consistent. Notably, moving for family reasons is not associated with chronic health conditions among men but is

Table 6b: Relationships between Reasons for Moving and Health by Aboriginal Identity and Status

			SELF-RATED HEALTH			TOTAL CHRONIC HEALTH CONDITIONS			
Sub-Sample	**REASON FOR MOVING**		**Unhealthy**	**Healthy**	**P**	**None**	**One**	**Two or more**	**P**
First Nations	Family	Yes	23.5	76.5	ns	38.1	26.3	35.6	*
		No	21.1	78.9		43.2	24.5	32.4	
	Work	Yes	18.8	81.2	**	44.9	25.3	29.8	**
		No	23.4	76.6		39.8	25.0	35.2	
	School	Yes	10.9	89.1	***	52.8	26.1	21.1	***
		No	23.4	76.6		39.9	25.0	35.1	
	Better housing	Yes	26.0	74.0	ns	39.1	28.6	32.3	ns
		No	21.7	78.3		41.6	24.9	33.5	
	Cheaper housing	Yes	19.0	81.0	ns	38.5	28.8	32.7	ns
		No	22.1	77.9		41.6	24.9	33.5	
	Better services	Yes	39.2	60.8	***	26.8	32.4	40.8	**
		No	21.2	78.8		42.1	24.8	33.2	
Métis	Family	Yes	16.0	84.0	ns	40.1	29.5	30.4	**
		No	14.7	85.3		44.4	23.4	32.2	
	Work	Yes	11.7	88.3	***	47.8	25.3	26.9	***
		No	17.2	82.8		40.1	25.6	34.3	
	School	Yes	7.8	92.2	**	56.2	26.6	17.2	***
		No	15.8	84.2		41.8	25.4	32.8	
	Better housing	Yes	26.2	73.8	***	39.5	20.4	40.1	ns
		No	14.6	85.4		43.1	25.8	31.1	
	Cheaper housing	Yes	18.0	82.0	ns	38.3	20.0	41.7	*
		No	15.1	84.9		43.1	25.7	31.1	
	Better services	Yes	28.9	71.1	***	18.5	27.2	54.3	***
		No	14.8	85.2		43.6	25.5	30.9	
Status	Family	Yes	22.3	77.7	ns	39.9	27.0	33.1	*
		No	20.3	79.7		44.7	23.4	31.9	
	Work	Yes	18.6	81.4	*	46.9	22.7	30.3	*
		No	22.2	77.8		41.2	25.6	33.2	
	School	Yes	10.5	89.5	***	53.6	27.9	18.5	***
		No	22.6	77.4		41.5	24.1	34.4	
	Better housing	Yes	29.4	70.6	**	36.8	27.1	36.1	ns
		No	20.4	79.6		43.6	24.4	32.0	
	Cheaper housing	Yes	17.0	83.0	ns	37.9	28.7	33.3	ns
		No	21.1	78.9		43.3	24.5	32.2	
	Better services	Yes	36.0	64.0	***	26.4	34.9	38.7	**
		No	20.3	79.7		43.9	24.2	31.9	
Non-Status	Family	Yes	18.6	81.4	ns	38.4	28.2	33.4	**
		No	16.9	83.1		43.1	24.4	32.5	
	Work	Yes	13.3	86.7	***	45.8	27.1	27.1	***
		No	19.7	80.3		39.1	25.0	35.9	
	School	Yes	8.9	91.1	***	54.5	24.2	21.2	***
		No	18.2	81.8		40.3	25.9	33.8	
	Better housing	Yes	23.8	76.2	**	41.2	23.5	35.3	ns
		No	17.1	82.9		41.5	25.8	32.7	
	Cheaper housing	Yes	19.3	80.7	ns	38.3	23.4	38.3	ns
		No	17.4	82.6		41.6	25.8	32.6	
	Better services	Yes	35.0	65.0	***	21.6	26.7	51.7	***
		No	16.9	83.1		42.0	25.7	32.3	

*$p<0.05$ = * $p<0.01$=** $p<0.001$=*** $p\geq0.05$=ns (not significant)*

Levels of significance for associations between Reasons for Moving and each health outcome indicated in the first category for each variable.

significantly associated with poorer health outcomes among women ($p<0.001$). Women are significantly less healthy than men among those who had moved for family, work and better services. First Nations are significantly less healthy than Métis only among those who had moved family reasons (Appendix 3).

3.3.2.3 Summary

Overall, some interesting relationships have emerged between urbanization and health. In general, long-time urban residents and those who had moved two or more times in the five years preceding the survey appear to be less healthy (i.e. higher proportions of individuals who rated their health as fair or poor, lower proportions with no chronic health conditions and higher proportions with two or more chronic health conditions) than life-long urban residents, recent urban residents, non-movers and those who had moved only once and those who had not moved in the five years preceding the survey, respectively. Further, moving for family reasons, better housing or better services seem to be associated with poorer health while the opposite is true of moving for work or for school. Many of these health-urbanization relationships are apparent in analyses stratified by gender, Aboriginal identity and status, though some interesting age and gender differences emerged. Though this analysis provides important context and is necessary to frame questions concerning relationships between urbanization and health, it is difficult to examine directly how urbanization may impact health using cross tabulations because of the numerous other factors that are also likely to impact health outcomes. Thus, logistic regression models were developed to explore how urbanization impacts health outcomes, while controlling for a number of determinants of health.

3.3.3 Phase III: Exploring Impacts of Urbanization on Health Outcomes (Tables 7-10)

3.3.3.1 Self-Rated Health

The models predicting self-rated health (0 = healthy, 1 = unhealthy) among the total urban population (life-long, long-time and recent urban residents) based on a set of identity, socioeconomic, demographic, health and urbanization predictor variables are summarized in Table 7. Results are presented for the aggregated (combined gender) and gender-disaggregated models. Many of the determinants of health examined are predictive of self-rated health among the sample of urban Aboriginal women and men in the aggregated model. Women are 21% less

Table 7: Self-Rated Health among Total Urban Population

Variable	Combined Gender			Women			Men		
	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper
Female (Ref: Male)	**0.790****	0.680	0.918						
First Nations (Ref: Métis)	**1.128**	0.961	1.325	**1.071**	0.864	1.328	**1.087**	0.847	1.396
Status (Ref: Non-status)	**1.057**	0.898	1.243	**1.147**	0.926	1.419	**1.067**	0.828	1.375
Age (Ref: 20-34 years)									
35-54	**2.201*****	1.795	2.698	**2.598*****	1.994	3.385	**1.833*****	1.321	2.543
55+	**1.741*****	1.364	2.223	**1.625****	1.180	2.239	**2.012*****	1.365	2.966
Education (Ref: Completed post-secondary)									
Some post-secondary	**1.136**	0.918	1.405	**1.125**	0.850	1.490	**1.170**	0.838	1.633
Completed high school	**1.313***	1.054	1.635	**1.296**	0.971	1.729	**1.489***	1.052	2.107
Some high school	**2.130*****	1.777	2.554	**2.124*****	1.662	2.715	**2.321*****	1.757	3.066
Unemployed (Ref: Employed)	**2.595*****	2.215	3.041	**2.576*****	2.092	3.172	**2.696*****	2.099	3.463
Income (Ref: $40,000)									
$20,000-39,999	**1.574*****	1.251	1.980	**1.521***	1.075	2.152	**1.574****	1.147	2.160
$10,00-19,999	**2.266*****	1.792	2.866	**2.524*****	1.782	3.568	**1.776****	1.263	2.496
≤$9,999	**2.311*****	1.813	2.945	**2.201*****	1.537	3.152	**2.647*****	1.869	3.747
Single/Lone parent (Ref: Family/Partner)	**1.148**	0.989	1.334	**1.241***	1.022	1.506	**1.015**	0.793	1.299
Total chronic health conditions (Ref: None)									
One	**3.205*****	2.500	4.109	**3.205*****	2.263	4.539	**3.281*****	2.290	4.700
Two or more	**14.247*****	11.325	17.922	**16.354*****	11.937	22.405	**12.220*****	8.671	17.222
Overweight/Obese (Ref: Normal/Underweight)	**1.250****	1.072	1.458	**1.190**	0.980	1.443	**1.340***	1.030	1.743
Smoker (Ref: Non-smoker)	**1.368*****	1.178	1.587	**1.269***	1.048	1.538	**1.531****	1.203	1.949
Drinker (Ref: Non-drinker)	**0.695*****	0.595	0.812	**0.727****	0.593	0.890	**0.630*****	0.491	0.808
Consulted doctor (Ref: No)	**1.557*****	1.267	1.912	**1.646****	1.234	2.197	**1.533****	1.137	2.068
Consulted nurse (Ref: No)	**1.463*****	1.251	1.711	**1.696*****	1.387	2.075	**1.165**	0.901	1.505
Consulted traditional healer (Ref: No)	**0.927**	0.715	1.204	**0.882**	0.637	1.221	**0.994**	0.640	1.542
Time in urban area (Ref: Life-long urban resident)									
Long-time urban resident	**1.255***	1.051	1.497	**1.1177**	0.884	1.410	**1.479****	1.123	1.947
Recent urban resident	**0.877**	0.708	1.087	**0.812**	0.613	1.077	**1.008**	0.719	1.411
Mobility (Ref: Never moved)									
Moved once	**1.249***	1.023	1.526	**1.274**	0.979	1.656	**1.298**	0.947	1.780
Moved two or more times	**1.524*****	1.261	1.843	**1.611*****	1.260	2.060	**1.462***	1.078	1.984
Constant	**-5.700*****								

	Total Population	*Women*	*Men*
N	*8128*	*4496*	*3632*
Model Chi-Square	*2521.601****	*1519.990****	*1016.144****
Sensitivity	*81.9%*	*80.8%*	*80.3%*
Specificity	*79.1%*	*78.7%*	*79.7%*
Overall Correct Predictions	*79.6%*	*79.1%*	*79.8%*
Rho	*0.333*	*0.342*	*0.326*

(OR = Odds Ratio; CI = Confident Interval) **p<0.05* ***p<0.01* ****p<0.001*

likely to rate their health as fair or poor (hereafter referred to simply as unhealthy) than men (Table 7). This contrasts with the descriptive cross tabulation analysis, in which the self-rated health of women is consistently worse than that of men. Neither Aboriginal identity nor status, proxies for Aboriginal rights, are predictive of self-rated health in the aggregated model. The associations between self-rated health and the demographic and socioeconomic variables, standard immediate determinants of health, are as one would expect. Older individuals are more likely rate their health status as unhealthy than those between the ages of 20-34. The unemployed are 2.60 times more likely to report that they are unhealthy than those who are employed. Those with higher levels of educational attainment and higher levels of income are less likely to be unhealthy. Family status is not significantly associated with self-rated health in the gender-aggregated model (Table 7).

With respect to health status, as the number of total chronic health conditions increases, the likelihood of assessing one's health as unhealthy increases (e.g. those who have two or more chronic health conditions are 14 times more likely to report that they are unhealthy than those with no chronic health conditions). Those who are overweight/obese and those who are smokers are significantly more likely than normal/underweight and non-smokers, respectively, to report being unhealthy. By contrast, drinkers are less likely than non-drinkers to be unhealthy. Individuals who had consulted with doctors and nurses are more likely to report that they are unhealthy, compared to those who had not consulted these health professionals. Consultation with a traditional healer is not significantly associated with self-rated health (Table 7).

Interestingly, the length of time spent living in an urban area and five year mobility are significant predictors of self-rated health. Consistent with the descriptive cross tabulation analysis in Phase II, long-time urban residents are 1.26 times more likely to assess themselves as unhealthy than life-long urban residents. However, a significant difference is not found between the self-rated health of recent urban residents and life-long urban residents. Mobility is associated with health such that as mobility increases, the likelihood of being unhealthy increases. Compared to non-movers, those who had moved once during the five years preceding the survey are 1.25 times more likely and those who had moved two or more times are 1.52 times more likely to report that they are unhealthy (Table 7).

In the gender-disaggregated models, relationships in terms of education and employment are similar to those in the combined gender models and again, neither status nor Aboriginal identity is significantly predictive of self-rated health (Table 7). However, some notable differences between the gender aggregated and disaggregated models did emerge. Interestingly, family status is a significant predictor of self-rated health among women, but not men: women who are single or lone parents are 1.24 times more likely to report that they are unhealthy than those who are members of family households (either in a partnered relationship or adult members of families). As in the aggregated model, BMI is predictive of self-rated health among men, but no such relationship is apparent among women. As in the aggregated model, women who had consulted a nurse are 1.70 times more likely to report being unhealthy than those who had not seen a nurse whereas among men, no significant difference in these odds is observed. In terms of urbanization predictors, long-time urban male residents are significantly less healthy than life-long urban residents (as was the case in the gender aggregated model), but this relationship is not seen among women. Among both women and men, moving once is not a significant predictor of self-rated health, but moving two or more times is predictive of fair/poor self-rated health (Table 7).

Results from the series of models exploring relationships between urbanization variables and self-rated health among urban migrants specifically (long-time urban residents and recent urban residents, but not life-long urban residents) are presented in Table 8. Similar to the total urban population models, the results show that urban migrant women are significantly less likely than men to report that they are unhealthy (OR=0.74). Among urban migrants, First Nations are 1.23 times more likely to report that they are unhealthy than Métis migrants. However, this association is not apparent in the gender-disaggregated models. Status is not predictive of self-rated health in any of the analyses among urban migrants. The associations between the socioeconomic variables and self-rated health among urban migrants followed the same expected patterns as seen in the total urban population. One notable difference is that in contrast to the total urban population model, family status is not predictive of self-rated health among urban migrant women.

Table 8: Self-Rated Health among Urban Migrant Population

Variable	Combined Gender			Women			Men		
	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper
Female (Ref: Male)	**0.744****	0.624	0.888						
First Nations (Ref: Métis)	**1.228***	1.017	1.484	**1.244**	0.964	1.605	**1.186**	0.883	1.591
Status (Ref: Non-status)	**1.021**	0.844	1.236	**1.083**	0.840	1.397	**0.945**	0.699	1.278
Age (Ref: 20-34 years)									
35-54	**2.225*****	1.744	2.837	**2.980*****	2.156	4.118	**1.528***	1.040	2.246
55+	**1.803*****	1.348	2.413	**1.753****	1.188	2.586	**1.835****	1.163	2.897
Education (Ref: Completed post-secondary)									
Some post-secondary	**1.149**	0.902	1.463	**1.100**	0.796	1.518	**1.235**	0.847	1.801
Completed high school	**1.330***	1.024	1.727	**1.497***	1.056	2.123	**1.374**	0.910	2.074
Some high school	**2.399*****	1.945	2.959	**2.535*****	1.902	3.378	**2.465*****	1.783	3.408
Employment (Ref: Employed)	**2.628*****	2.138	3.165	**2.591*****	2.027	3.312	**2.683*****	2.000	3.599
Income (Ref: $40,000)									
$20,000-39,999	**1.339***	1.033	1.737	**1.370**	0.923	2.032	**1.363**	0.949	1.958
$10,00-19,999	**2.192*****	1.683	2.856	**2.793*****	1.890	4.127	**1.533***	1.037	2.267
≤$9,999	**2.136*****	1.623	2.811	**2.212 *****	1.475	3.316	**2.429*****	1.620	3.641
Single/Lone parent (Ref: Family/Partner)	**1.133**	0.951	1.350	**1.226**	0.977	1.539	**1.071**	0.801	1.432
Total number of chronic conditions (Ref: None)									
One	**2.445*****	1.844	3.241	**2.567*****	1.722	3.827	**2.559*****	1.705	3.842
Two or more	**11.910*****	9.236	15.359	**14.299*****	10.055	20.335	**10.762*****	7.341	15.776
Overweight/Obese (Ref: Normal/Underweight)	**1.123**	0.940	1.342	**1.010**	0.806	1.265	**1.304**	0.958	1.774
Smoker (Ref: Non-smoker)	**1.312****	1.103	1.561	**1.209**	0.963	1.517	**1.522****	1.152	2.010
Drinker (Ref: Non-drinker)	**0.760****	0.633	0.913	**0.771***	0.607	0.980	**0.717***	0.534	0.962
Consulted doctor (Ref: No)	**1.639*****	1.283	2.095	**1.629****	1.151	2.306	**1.686****	1.184	2.401
Consulted nurse (Ref: No)	**1.382****	1.151	1.660	**1.676*****	1.322	2.124	**1.024**	0.756	1.386
Consulted traditional healer (Ref: No)	**0.941**	0.700	1.266	**0.878**	0.603	1.278	**0.988**	0.596	1.638
Recent urban resident (Ref: Long-time urban resident)	**0.669*****	0.545	0.822	**0.689****	0.527	0.900	**0.675***	0.485	0.939
Mobility (Ref: Never moved)									
Moved once	**1.368***	1.078	1.736	**1.5532****	1.117	2.101	**1.201**	0.821	1.757
Moved two or more times	**1.779*****	1.413	2.240	**2.083*****	1.540	2.817	**1.456***	1.008	2.103
Moved for family (Ref: No)	**1.035**	0.847	1.264	**1.066**	0.825	1.379	**1.048**	0.749	1.468
Moved for work/To find job (Ref: No)	**1.044**	0.848	1.264	**1.080**	0.813	1.435	**1.070**	0.782	1.466
Moved for school (Ref: No)	**0.601****	0.421	0.860	**0.643**	0.406	1.020	**0.706**	0.390	1.278
Moved for better housing (Ref: No)	**2.099*****	1.511	2.917	**1.802****	1.184	2.744	**2.833*****	1.630	4.925
Moved for cheaper housing (Ref: No)	**0.761**	0.505	1.146	**0.562***	0.322	0.979	**1.038**	0.554	1.948
Moved for better services (Ref: No)	**1.410**	0.973	2.165	**1.210**	0.709	2.065	**2.103***	1.139	3.884
Constant	**-5.386*****			**-6.192*****			**-5.111*****		

	Total Population	*Women*	*Men*
N	*5858*	*3266*	*2592*
Model Chi-Square	*1840.548****	*1152.174****	*723.824****
Sensitivity	*80.0%*	*81.1%*	*79.4%*
Specificity	*78.2%*	*78.3%*	*78.6%*
Overall Correct Predictions	*78.5%*	*78.9%*	*78.8%*
Rho	*0.328*	*0.349*	*0.316*

(OR = Odds Ratio; CI = Confident Interval) * $p < 0.05$ ** $p<0.01$ *** $p<0.001$

Recent urban migrants are 33% less likely than long-time urban migrants to be unhealthy. This association is seen both in the aggregated and disaggregated models, with similar odds ratios in all three groups (Table 8). The associations between mobility and self-rated health are quite similar in the urban migrant analysis as in the total urban population: as mobility increases, the likelihood of assessing one's health as unhealthy increases. Some interesting associations were detected in terms of motivation for moving. Moving for family and moving for work are not predictive of self-rated health in any of the urban migrant models. However, moving for better housing is significantly associated with self-rated health in all three models. Compared to women who did not report moving for better housing, those who did are 1.80 times more likely to assess their health as unhealthy. Among men, this odds ratio is 2.83. Men are also more likely to report that they are unhealthy if they had moved for better services than if they had not moved this reason (OR = 2.10). Women who had moved for cheaper housing are less likely to assess their health as unhealthy than those who did not report moving for this reason (OR = 0.56). In the aggregated model, those who had moved for school are less likely to assess their health as unhealthy than those who had not moved for this reason (OR=0.60), though this was not seen in the gender disaggregated models (Table 8).

3.3.3.2 Total Chronic Health Conditions

Results from the analysis of total number of chronic health conditions (0 = no conditions, 1 = one or more conditions) among the total urban population are presented in Table 9. There are several differences between the models focused on chronic health conditions and self-rated health. Interestingly, the odds ratio for gender suggests that women are 1.2 times *more* likely than men to have at least one chronic health condition. This finding is more consistent with the descriptive cross tabulation analyses presented in the previous sections but contrasts with the findings in the self-rated health models. In the aggregated and the women-focused model (but not the male model) individuals with status are less likely than those without status to report

Table 9: Total Number of Chronic Health Conditions among Total Urban Population

	Combined Gender			**Women**			**Men**		
Variable	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper
Female (Ref: Male)	**1.211****	1.086	1.350						
First Nations (Ref: Métis)	**0.962**	0.858	1.080	**1.003**	0.857	1.173	**0.895**	0.753	1.063
Status (Ref: Non-status)	**0.816****	0.724	0.920	**0.719*****	0.612	0.845	**0.945**	0.789	1.132
Age (Ref: 20-34 years)									
35-54	**2.235*****	1.982	2.521	**1.901*****	1.618	2.232	**2.698*****	2.244	3.244
55+	**5.472*****	4.554	6.575	**5.700*****	4.404	7.378	**5.457*****	4.163	7.153
Education (Ref: Completed post-secondary)									
Some post-secondary	**1.065**	0.924	1.227	**1.021**	0.845	1.233	**1.110**	0.893	1.380
Completed high school	**0.874**	0.754	1.013	**0.896**	0.731	1.097	**0.834**	0.669	1.040
Some high school	**1.057**	0.910	1.228	**1.105**	0.816	1.262	**1.114**	0.902	1.375
Employment (Ref: Employed)	**1.332*****	1.168	1.518	**1.421*****	1.200	1.682	**1.242***	1.004	1.537
Income (Ref: $40,000)									
$20,000-39,999	**1.109**	0.967	1.273	**0.963**	0.787	1.178	**1.191**	0.978	1.450
$10,00-19,999	**1.388*****	1.184	1.626	**1.074**	0.859	1.342	**1.779*****	1.400	2.260
≤$9,999	**1.105**	0.936	1.304	**0.837**	0.664	1.055	**1.497****	1.164	1.926
Single/Lone parent (Ref: Family/Partner)	**0.956**	0.857	1.068	**0.959**	0.839	1.108	**0.887**	0.745	1.056
Unhealthy (Ref: Healthy)	**7.771*****	6.258	9.651	**8.777*****	6.508	11.837	**6.782*****	4.935	9.321
Overweight/Obese (Ref: Normal/Underweight)	**1.510*****	1.358	1.680	**1.676*****	1.460	1.924	**1.359****	1.143	1.616
Smoker (Ref: Non-smoker)	**1.278*****	1.149	1.422	**1.266****	1.098	1.460	**1.246****	1.058	1.468
Drinker (Ref: Non-drinker)	**0.818****	0.713	0.938	**0.840**	0.700	1.009	**0.796**	0.644	0.983
Consulted doctor (Ref: No)	**2.439*****	2.163	2.749	**1.998*****	1.682	2.373	**2.948*****	2.490	3.490
Consulted nurse (Ref: No)	**1.271*****	1.127	1.434	**1.292****	1.102	1.514	**1.256***	1.041	1.515
Consulted traditional healer (Ref: No)	**1.313***	1.068	1.614	**1.565**	1.207	2.030	**0.968**	0.685	1.367
Time in urban area (Ref: Life-long urban resident)									
Long-time urban resident	**1.103**	0.974	1.250	**1.106**	0.932	1.312	**1.198**	0.912	1.322
Recent urban resident	**1.1011**	0.874	1.170	**0.935**	0.769	1.137	**1.116**	0.895	1.393
Mobility (Ref: Never moved)									
Moved once	**0.963**	0.834	1.113	**0.907**	0.747	1.102	**1.032**	0.830	1.282
Moved two or more times	**1.012**	0.882	1.162	**0.905**	0.752	1.088	**1.154**	0.935	1.424
Constant	**-1.813*****			**-1.211*****			**-2.092*****		

	Total Population	***Women***	***Men***
N	*8128*	*4496*	*3632*
Model Chi-Square	*2204.247****	*1192.785****	*1016.372****
Sensitivity	*64.5%*	*63.6%*	*68.8%*
Specificity	*76.1%*	*79.2%*	*73.7%*
Overall Correct Predictions	*69.6%*	*69.9%*	*71.2%*
Rho	*0.198*	*0.197*	*0.203*

(OR = Odds Ratio; CI = Confident Interval) * $p < 0.05$ ** $p<0.01$ ***$p<0.001$

having at least one chronic health condition. Aboriginal identity is not a significant predictor of chronic health conditions in any of the three models.

While age is significantly predictive of total number of chronic health conditions (as age increases, likelihood of having one or more chronic health conditions increases), few of the socioeconomic status variables that were examined are significant predictors of chronic health conditions. The likelihood of having one or more chronic health conditions is not consistently associated with education, family status or income (though in the gender aggregated model and the male model, the likelihood of having one or more chronic health conditions is higher among those with some lower income levels). However, employment is an important predictor of chronic conditions in all three models: the odds ratios indicate that compared to the employed, those who are unemployed are more likely to have at least one chronic health condition. The health predictor variables are as one would expect: those who reported that they are unhealthy, overweight/obese, smokers and had consulted a doctor or nurse are more likely to have at least one chronic health condition and results are quite similar in the aggregated and gender disaggregated models. One exception is consultation with a traditional healer, which is predictive of having one or more chronic health conditions in the gender aggregated model (OR = 1.31), but not among women and men separately. In contrast to the self-rated health models, neither of the urbanization variables (time in urban area and five year mobility) is significantly associated with total number of chronic health conditions (Table 9).

The models focused on total number of chronic health conditions among urban migrants are presented in Table 10. In contrast to the total urban population models, gender is not predictive of chronic health conditions among urban migrants. In the gender-aggregated and female models, individuals with status are less likely than those without status to have at least one chronic health condition (OR=0.85), though this association is not seen among men. The socioeconomic/demographic and health context predictor variables in these migrant-focused models closely parallel the total-urban population models. As in the total urban population models, neither time in urban area nor mobility is predictive of chronic health conditions among urban migrants. However, some interesting results in terms of motivation for moving to an urban area are apparent. As with self-rated health, moving for family is not predictive of chronic health conditions among urban migrants. However, in contrast to self-rated health, the aggregated and female models indicate that individuals who had moved for work are less likely to have at least one chronic health condition (OR=0.86 for combined women and men; OR=0.79 for women).

Table 10: Total Number of Chronic Health Conditions among Urban Migrant Population

Variable	Combined Gender			Women			Men		
	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper	Adjusted OR (Exp ß)	95% CI for Exp ß Lower	Upper
Female (Ref: Male)	**1.135**	0.998	1.291						
First Nations (Ref: Métis)	**0.970**	0.846	1.113	**0.984**	0.816	1.187	**0.918**	0.747	1.129
Status (Ref: Non-status)	**0.850***	0.737	0.979	**0.793***	0.654	0.962	**0.904**	0.729	1.120
Age (Ref: 20-34 years)									
35-54	**2.130*****	1.842	2.463	**1.642*****	1.349	1.998	**2.947*****	2.358	3.684
55+	**5.553*****	4.454	6.925	**5.620*****	4.125	7.658	**5.899*****	4.244	8.199
Education (Ref: Completed post-secondary)									
Some post-secondary	**1.044**	0.883	1.234	**1.095**	0.873	1.373	**0.971**	0.752	1.254
Completed high school	**0.808***	0.675	0.968	**0.830**	0.648	1.065	**0.765**	0.584	1.002
Some high school	**1.005**	0.840	1.203	**0.961**	0.740	1.247	**1.086**	0.842	1.401
Employment (Ref: Employed)	**1.365*****	1.169	1.594	**1.534*****	1.257	1.872	**1.141**	0.884	1.473
Income (Ref: $40,000)									
$20,000-39,999	**1.210***	1.030	1.421	**0.944**	0.748	1.191	**1.457****	1.152	1.843
$10,00-19,999	**1.409*****	1.170	1.698	**0.941**	0.726	1.220	**2.168*****	1.625	2.894
≤$9,999	**1.011**	0.830	1.231	**0.697****	0.531	0.915	**1.560****	1.145	2.125
Single/Lone parent (Ref: Family/Partner)	**0.954**	0.839	1.086	**1.004**	0.847	1.190	**0.838**	0.681	1.031
Unhealthy (Ref: Healthy)	**6.429*****	5.067	8.157	**7.367*****	5.300	10.241	**5.764*****	0.582	0.973
Overweight/Obese (Ref: Normal/Underweight)	**1.414*****	1.247	1.603	**1.567*****	1.331	1.846	**1.303***	1.062	1.600
Smoker (Ref: Non-smoker)	**1.284*****	1.132	1.456	**1.333****	1.126	1.579	**1.185**	0.977	1.437
Drinker (Ref: Non-drinker)	**0.830***	0.705	0.977	**0.896**	0.722	1.111	**0.752***	0.582	0.973
Consulted doctor (Ref: No)	**2.568*****	2.223	2.967	**2.186*****	1.774	2.694	**3.028*****	2.470	3.711
Consulted nurse (Ref: No)	**1.172 ***	1.018	1.348	**1.243***	1.032	1.497	**1.100**	0.882	1.371
Consulted traditional healer (Ref: No)	**1.233**	0.972	1.562	**1.515****	1.117	2.054	**0.846**	0.574	1.248
Recent urban resident (Ref: Long-time urban resident)	**0.957**	0.824	1.111	**0.872**	0.713	1.066	**1.055**	0.838	1.327
Mobility (Ref: Never moved)									
Moved once	**0.902**	0.755	1.077	**0.829**	0.651	1.055	**1.038**	0.793	1.359
Moved two or more times	**0.962**	0.809	1.144	**0.838**	0.664	1.057	**1.115**	0.854	1.455
Moved for family (Ref: No)	**1.090**	0.938	1.266	**1.074**	0.883	1.306	**1.069**	0.841	1.360
Moved for work/To find job (Ref: No)	**0.859***	0.742	0.996	**0.788***	0.643	0.967	**0.914**	0.734	1.140
Moved for school (Ref: No)	**0.841**	0.685	1.033	**0.681****	0.522	0.887	**1.066**	0.758	1.499
Moved for better housing (Ref: No)	**0.905**	0.689	1.189	**0.830**	0.593	1.162	**0.971**	0.597	1.579
Moved for cheaper housing (Ref: No)	**1.185**	0.869	1.615	**1.319**	0.882	1.971	**1.013**	0.614	1.670
Moved for better services (Ref: No)	**1.404**	0.958	2.057	**2.016***	1.146	3.548	**0.958**	0.563	1.631
Constant	**-1.584*****			**-0.986*****			**-1.918*****		

	Total Population	***Women***	***Men***
N	*5858*	*3266*	*2592*
Model Chi-Square	*1524.624****	*863.630****	*698.948****
Sensitivity	*64.6%*	*63.9%*	*69.8%*
Specificity	*75.2%*	*80.3%*	*74.8%*
Overall Correct Predictions	*69.1%*	*70.3%*	*72.1%*
Rho	*0.192*	*0.198*	*0.198*

(OR = Odds Ratio; CI = Confident Interval) * $p < 0.05$ ** $p<0.01$ *** $p<0.001$

Women who had moved for school are also less likely to have one or more chronic health conditions. By contrast, women who had moved for better services are two times more likely than those who had not moved for this reason to have at least one chronic health condition. None of the motivations for moving to an urban area are predictive of chronic health conditions among men.

3.3.3.3 Summary

The logistic regression models point to some interesting health-urbanization relationships in addition to differences between women and men, and between the total urban and urban migrant populations. Gender is significantly predictive of health outcomes, though there are differences depending on whether the focus is self-rated health or total chronic health conditions: women are less likely to report that they are unhealthy, but are more likely to have one or more chronic health conditions than men. Aboriginal identity and status are sometimes predictive of health outcomes, though less consistently than gender. In most cases, the socioeconomic and demographic variables are predictably associated with health outcomes: worse health outcomes are associated with older age, less education, less income and unemployment. Being single or a lone parent is only predictive of unhealthy self-rated health among women. The health variables indicate that overweight/obesity, smoking, not-drinking, and consultation with health professionals are predictive of poorer health outcomes. Time spent living in an urban area and five year mobility are predictive of self-rated health, but not total chronic health conditions. The odds ratios suggest that long-time urban residents and those who are the most mobile have the worst health outcomes. In addition, there are many differences between women and men in terms of motivation for moving to an urban area.

3.4 Discussion

This analysis sought first to provide a current picture of the health of Aboriginal women and men living in urban areas and second to examine potential relationships between urbanization and health, in an effort to contribute to improved understandings of Aboriginal urbanization and health in Canada. An important focus throughout the analysis has been on exploring how Aboriginal rights may factor into these relationships.

3.4.1 Limitations

Before considering the implications of these findings, it is important to acknowledge some limitations of this study. While the 2006 APS is an incredibly important source of data as it is the only national survey of Aboriginal peoples living off-reserve, it does have some weaknesses. The survey sample is drawn from the Canadian census, so those who refused to participate in the census are not included in the APS.[12] However, Statistics Canada has taken sampling measures to ensure that the sample is nationally representative (Canada 2009d). All information collected is based on the self-reports of participants, and therefore is potentially subject to recall bias (Cleary and Jette 1984; Roberts, Bergstralh et al. 1996; Stone and Shiffman 2002). More specific to the objectives of this study, the cross sectional study design of the APS does not allow for an examination of the effects of urbanization over time on the health of individuals. A longitudinal study that assessed health outcomes at multiple time points as Aboriginal peoples from rural/reserve areas transitioned to urban areas would more effectively assess these impacts and would thus be more helpful in determining causal links between urbanization and health, but no such data is available. However, as the objective of this study is more to explore links between urbanization and health, the impossibility of determining causality is not of utmost importance. As the survey includes only Aboriginal peoples living off-reserve, it is not possible to compare the health of those living in reserve/rural areas with those living in urban areas in order to directly consider this change in place on the health of Aboriginal women

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[12] Some First Nation communities, particularly in Québec and Ontario, refuse to participate in the census and are therefore incompletely enumerated.

and men.[13] As noted in the section 3.2.2, the urban mobility variables do not provide specific information regarding place of origin, so it is difficult to distinguish between migration from rural/reserve areas and urban residential mobility in the national urban Aboriginal population. Related, though the 'time in urban area' variable is the best available approximation of the degree to which an individual is likely to be accustomed to living in an urban area, the fact that the survey does not provide information regarding the respondents' places of origin means that it is not possible to determine whether those who have moved to an urban area (either more than five years prior to the survey or five or fewer years prior to the survey) have moved from another urban area, or from a rural/reserve area. If they have moved to their current urban area from another urban area, they are likely to be much better accustomed to urban life. Further, as the survey questions regarding motivation for moving are somewhat vague, it is difficult to interpret some of the factors underlying mobility. Such interpretation requires one to make certain assumptions (see discussion of the potentially positive and negative assumptions regarding, for example, moving for better housing), and owing to the problematic ways in which urbanization and urban mobility have been discussed in most Aboriginal urbanization literature, it is important to acknowledge the potential implications of such implicit assumptions on these interpretations (Frideres 1974; Williams 1997; Peters 2002). Finally, it is difficult using the APS to directly assess the implications of access to Aboriginal rights on relationships between urbanization and health. There are no questions in the survey that even mention Aboriginal rights and the use of Aboriginal identity and status as proxies for Aboriginal rights is difficult to interpret among the urban population (as explored in the following section).

3.4.2 Health Profile of Urban Aboriginal Women and Men (Question 1)

In addressing the first specific research question, a national profile of determinants of health and health outcomes among urban Aboriginal women and men was developed. The analyses summarized in Tables 2 and 3 demonstrate interesting gender differences. Both in terms

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[13] It would have been possible to compare the health of people living on and off-reserve using the 2001 APS, but this data is now 10 years old and thus would be less useful in assessing current health implications of urbanization. Using the 2006 APS, it would have been possible to compare the health of peoples living in rural and urban areas, but as the rural component does not include reserves, this would have provided an incomplete picture of the impacts of urbanization on health.

of self-rated health and total number of chronic health conditions, raw cross tabulation analysis reveals that urban Aboriginal women are less healthy than men. With the exceptions of education and BMI (which show that women are more highly educated and less often overweight/obese than men), the worse health outcomes among women make sense given the gendered trends in the various conventional determinants of health examined: higher proportions of smokers, higher levels of consultation with family doctors/GPs, nurses and traditional healers, lower levels of income and employment, and lower levels of partnered relationships are seen among women than men.

In line with this rather negative picture of the health of urban Aboriginal women compared to men, logistic regression analyses indicate that women are 1.2 times *more* likely than men to have at least one chronic health condition, when all other factors are controlled for (Table 9). By contrast, women are significantly *less* likely than men to rate their health as fair/poor, when these factors are controlled for (Tables 7 and 8). This may suggest that the observed poorer self-rated health of women largely reflects gender differences in the determinants of health that are controlled for in the logistic regression analyses (age, Aboriginal identity, status, socioeconomic/demographic indicators, health-related measures, health care use and urbanization variables), since controlling for these determinants reversed the direction of the association between gender and health. The difference in findings between self-rated health and total chronic conditions may suggest that the variables capture different aspects of health. Despite the fact that the two health measures correlated well with one another (i.e. those who reported that they are unhealthy had significantly more chronic health conditions and those who are unhealthy are significantly more likely to have at least one chronic health condition), self-rated health may more effectively capture holistic Aboriginal conceptions of health, based on balance between interconnected states of physical, mental, emotional and spiritual balance, while chronic health conditions may assess only physical health, which is more aligned with a Western biomedical perspective. Further, the gender differences may indicate that women and men have different thresholds at which they gauge their health as fair/poor and thus may differ in their conceptions of health.

Given this picture of relationships between conventional determinants of health and health outcomes, it is important to consider what can be gleaned from the raw cross tabulations

for urbanization variables in this population. Though women and men do not differ considerably from one another in terms of time in urban area or five year mobility, important gender differences in terms of motivation for moving are apparent. The proportion of women who moved for family reasons was over 10% higher than that among men and the proportion of men who moved for work was almost 14% higher than that among women. This is consistent with the literature suggesting that urban mobility among men is more motivated by economic reasons while for women, family relationships are more important (Cooke and Bélanger 2006; Peters and Robillard 2009). Higher proportions of women also moved for school and for better housing than men, possibly suggesting an effort among women to improve their situation. Motivation for moving, however, can be interpreted either positively (e.g. as an opportunity to improve chances) or negatively (e.g. as an attempt to get away from a damaging situation); it is difficult to make any such judgments, or to consider how these gender differences may be implicated in health, without more in-depth assessment of factors underlying mobility.

As proxies for Aboriginal rights, it is important to consider how Aboriginal identity and status factor into this health profile. Interestingly, First Nations and those with status cited moving for school and better services significantly more often than did Métis and non-status individuals. This may be indicative of a potential role for Aboriginal rights in shaping such decisions to move, as services such as funding for post-secondary education are quite important manifestations of these rights and First Nations and those with status are presumed to have better access to them, relative to their Métis and non-status counterparts. In terms of the more conventional determinants of health, First Nations and those with status fair worse than their Métis and non-status counterparts, so it is perhaps not surprising that they rate themselves as unhealthy more often than do Métis and individuals without status (no difference is seen in terms of total chronic health conditions). In terms of access to Aboriginal rights however, these findings are somewhat counterintuitive: it might be expected that First Nations and those with status will have better access to Aboriginal rights, because the federal government's policy on Aboriginal rights largely restricts them to those with status (thus excluding First Nations who do not have status and excluding Métis peoples altogether). The logistic regression analyses do not really help to clarify the situation: when all other determinants are controlled for, status is not predictive of self-rated health, but those with status are less likely than those without status to

have at least one chronic health condition. Aboriginal identity is not consistently predictive of self-rated health or chronic health conditions in the logistic regression analyses. As a result, it is difficult to make inferences regarding differences in access to Aboriginal rights and health promoting determinants of health (such as services/benefits that improve access to education, and income/employment help) between First Nations and Métis people, and those with and without status.

In attempting to interpret these results, it is important to recall the differential geographies of Aboriginal rights, namely that Aboriginal rights are largely restricted to those living on reserves. Thus, it may perhaps be that urban areas serve to temper the potential impacts of Aboriginal rights on health (since regardless of identity and status, access to Aboriginal rights is limited in urban areas), so that in urban areas, status and Aboriginal identity are less effective proxies for access to Aboriginal rights. Another possibility is that the provision of the benefits/services that stem from Aboriginal rights is so wrought with problems that those who have better access to them are not really afforded better immediate determinants of health (i.e. even though those with status are expected to have better access to Aboriginal rights, the provision of these rights is so problematic that potential health benefits are negated). Another consideration could be that the hypothesized links between Aboriginal rights and health by way of better access to immediate determinants of health are a bit too narrowly conceived and to truly grasp the implications of Aboriginal rights on health, consideration of broader conceptions of Aboriginal rights is needed (i.e. Aboriginal rights impacting health not just via services/benefits, but also through the effects of respecting the political/social existence of Aboriginal peoples). Taken together, the findings seem ultimately to indicate that the picture in terms of Aboriginal rights and health is very complex and may not be easily assessed through statistical analysis of the APS in its current form. It does however provide an initial picture of differences in determinants of health and health outcomes along identity and status lines among urban Aboriginal peoples, which may serve as a basis from which to tease out a potential role for Aboriginal rights in shaping health when more information is available (i.e. more specific survey data that deals with Aboriginal rights more directly or in-depth qualitative data).

3.4.3 Relationships between Urbanization and Health (Question 2)

The results present some interesting findings in terms of the second research objective, to explore gendered implications of urbanization on the health of Aboriginal peoples living in urban areas (which is still considered with attention to a potential role for Aboriginal rights). Logistic regression analyses indicate that urbanization variables are associated with health outcomes, and that some of these relationships differ between women and men. Time spent living in an urban area is an important predictor of self-rated health (but not total chronic health conditions). Long-time urban residents (moved to urban area more than five years prior to the survey) are significantly more likely to report that they are unhealthy than life-long urban residents in both the total urban population and among urban migrants (Tables 7 and 8). This is found in the combined gender sample and among the male sample, but not among women. By contrast, among both men and women, recent urban residents (moved to urban area less than five years prior to the survey) are significantly healthier than long-time urban residents. These findings are reminiscent of the trends in international migration-health literature, in particular, the healthy immigrant effect, which suggests that while immigrants are often in better health than the Canadian-born population initially upon immigrating, their health declines over time (Asanin and Wilson 2008; Setia, Quesnel-Vallee et al. 2011). The observed decline in the health of urban Aboriginal peoples as time spent in an urban area increases could be rooted in numerous different factors. Particularly important may be the effects of the continued contemporary colonial relations between Aboriginal peoples and the Canadian state through, for example, discrimination, social exclusion and the federal government's spatially inequitable policies on Aboriginal rights that imply that urban spaces are not Aboriginal spaces, taking their toll on the health of Aboriginal peoples living in urban areas over longer time periods. It is also important to consider why long-time urban residents are more likely to be unhealthy than life-long urban residents among men, but not women. Perhaps, because they have been so severely marginalized and subjugated by the colonial state, Canadian society and even within Aboriginal communities, urban Aboriginal women have developed better coping mechanisms and are more resilient than men, making the impacts of such discrimination and social exclusion less detrimental to the health of women.

There was some indication in the cross tabulation analyses that those who are more mobile are also healthier (Table 5). This could be indicative of a positive impact of mobility on health, consistent with literature suggesting that mobility may be a way for Aboriginal peoples to maintain a sense of balance that is important in Aboriginal conceptions of health (Weaver 2001; Peters 2005). Related, self-selection may impact the relationship between mobility and health such that those who have not moved are too unhealthy to move and those who are more healthy have the option to be more mobile. However, logistic regression analyses indicate that when all factors are controlled for (including age), the likelihood of assessing one's health as healthy decreases with increasing mobility among both women and men (no such relationship is seen with chronic health conditions). This finding is more in line with the literature suggesting that frequent urban mobility is problematic as is engenders instability and social marginalization (Norris, Cooke et al. 2004; Peters 2004). This trend is seen among the total urban population and among urban migrants, in both men and women, though the association is particularly strong among the latter (e.g. among urban migrants, women are twice as likely to be unhealthy if they have moved two or more times, whereas this odds ratio is 1.5 among men – Table 8). Further, self-rated health among urban migrants decreases in a graded manner among women (i.e. odds of being unhealthy increase with each increase in the level of mobility) while among men, a significant difference in self-rated health is only observed between non-movers and those who have moved two or more times (Table 8).

Finally, the analysis suggests that in addition to being motivated by different factors to move to urban areas, these underlying factors also differentially impact the health of urban Aboriginal women and men. The role of family factors in shaping urbanization and impacts on health appear to be more important among women than men. Women who moved for family reasons are less healthy (self-rated health and total chronic health conditions) than those who did not move for those reasons (Table 6a). Further, among those who moved for family reasons, women are significantly less healthy than men (Appendix 3). Interestingly, family status is a significant predictor of self-rated health among women, but not men in the total urban population: women who are single or lone parents are 1.24 times more likely to report that they are unhealthy than those who are members of family households (either in a partnered relationship or adult members of families) (Table 7). Though the importance of family factors in

shaping women's decisions to move to urban areas has been suggested in Aboriginal urban mobility literature, it is interesting to find that moving for family reasons may also take a toll on the health of women and not men (Norris, Cooke et al. 2004; Peters 2005; Cooke and Bélanger 2006). This may be due to the increased levels of stress and personal sacrifice associated with women's roles as primary family caregivers in many families, which may be related to the fact that significantly fewer urban Aboriginal women are in a partnered relationship than men (Table 2). Related, it appears that women's health is negatively impacted by moving for better housing and better services, while these associations are weaker (in the case of housing) or not seen at all among men. This may be further indication of the negative health impacts of being primary care givers on women's health, which awaits further research consideration.

Underlying urban mobility factors that are positively associated with women's health, but not men's health, include moving for school, work and cheaper housing. By contrast, men who moved for better services are twice as likely as those who did not move for this reason to be unhealthy, but this association is not seen in women. While the existence of gender differences is clear, it is also difficult to interpret due to the limited contextual information available in the APS. For example, there is no indication as to whether 'better housing' in the city represents a positive underlying factor, such as improved access to housing in the city or suggests a negative impact of a lack of good housing in their original place of residence. It is also possible that self-selection may impact these health-motivation for moving relationships, and that this may occur differently by gender. For example, perhaps women who are healthier have the option to move to the city for better opportunities such as education, work and housing, while those who are less healthy cannot, but again, it is difficult to determine how these relationships function without further contextual information.

3.4.4 Implications and Future Questions

This analysis contributes to improved understandings of gendered relationships between urbanization and health among urban Aboriginal peoples. It seems that urban Aboriginal women and men differ in terms of health outcomes and may possibly conceive of health in different ways. Motivation for moving to urban areas differs between urban Aboriginal women and men. Further, moving to an urban area may have negative impacts on the health of urban Aboriginal peoples over time and this may occur somewhat differently among women and men. These

findings suggest that Aboriginal women and men may experience urbanization differently, with different implications for their health. However, it is difficult to understand how these differences occur, or indeed to how the complexity of heterogeneous geographies of Aboriginal rights may be implicated in these findings, without further information and a deeper engagement with Aboriginal peoples.

Some important related concerns that are raised by this analysis include questions regarding the cultural relevance of the current health questions in the APS. It will be important to determine whether the health questions, as they are currently posed in the APS, adequately assess Aboriginal conceptions of health and whether self-reporting of health is an appropriate health measure among Aboriginal peoples in Canada. Related, questions regarding differing conceptions of health between women and men remain and it would be interesting and informative to determine if the development of gender-specific health questions is possible. As a starting point, including in the APS questions regarding mental, emotional, spiritual and physical health, which are important components of conceptions of health shared by many Aboriginal peoples, may serve as a useful way of assessing the culture and gender relevance of the questions. Further, including in the next version of the APS questions that focus on the context in which Aboriginal peoples move to urban areas (e.g. where they moved from, more detail regarding why they moved) and questions that ask directly about people's access to and use of services/benefits that stem from Aboriginal rights, would certainly help to enrich understandings of relationships between urbanization, Aboriginal rights and health among Aboriginal women and men at a national level.

Ultimately, the best way to tease out these links may be through engaging with Aboriginal peoples living in urban areas and asking them about the ways in which they experience health and Aboriginal rights in a specific urban context. The qualitative component of this thesis takes up this challenge and begins to address some of these questions through an analysis of in-depth interviews with urban Aboriginal women and men living in Toronto.

Chapter 4

4 Exploring Links between Urbanization, Aboriginal Rights and Health among Aboriginal Women and Men Living in Toronto

4.1 Introduction

Building on the statistical analysis presented in Chapter 3, findings from in-depth interviews with Aboriginal women and men who had moved from a rural or reserve space to Toronto, Ontario are presented in this chapter. Interviews focused on exploring the ways in which urbanization, Aboriginal rights and health are related to one another and how this may differ between Aboriginal women and men, an important issue, which has not been taken up in Aboriginal health literature. The specific research questions addressed in the qualitative component of this thesis are:

- How are Aboriginal rights and urbanization related to one another and does this differ between women and men?
- How do Aboriginal rights and urbanization impact health and does this differ between women and men?

In exploring these question, an effort is made to address the theoretical objective of this thesis, to expand understandings of gendered dimensions of urbanization, including the role of geographies of Aboriginal rights in shaping these processes and impacts on health.

4.2 Data and Methods

4.2.1 Research Setting

This research was conducted in Toronto, Ontario. With 21% of the national Aboriginal population, Ontario is home to the largest number of Aboriginal peoples in Canada. The largest Aboriginal population in the province, and the fifth largest nationally, is in Toronto (Aboriginal identity population = 26,575) (Canada 2009a). Though the Aboriginal population represents only 0.5% of the city's total population, it is growing very quickly with a 46% increase between 1996 and 2001. As Toronto also saw a large net out migration of Aboriginal peoples over the same time period, it is likely that this population increase is primarily due to natural increase and ethnic mobility, rather than migration (Norris and Clatworthy 2011). The majority of the Aboriginal population in Toronto identifies as First Nations (65%), while 29% identify as Métis

and just 1% identify as Inuit (the remaining 5% reported multiple or other Aboriginal identities) (Canada 2009a). Consistent with the national urban Aboriginal population, women are overrepresented in Toronto compared to men with 54.2% of the total Aboriginal population in the city. According to the 2006 census, the majority of Aboriginal adults in Toronto rated their health as excellent or very good (Canada 2009a). As the largest and most diverse city in Canada, Toronto presents a unique opportunity to explore the ways in which Aboriginal peoples coming from rural and reserve areas all over the country experience urbanization and how this may be related to their health.

4.2.2 Research Design, Data Collection and Participants

Rooted in the social determinants of Aboriginal health framework that guides this master's thesis, the objective of this component of the thesis was to explore gendered relationships between urbanization, Aboriginal rights and health, in an effort to flesh out and address some of the questions that arose from the quantitative analysis presented in Chapter 3. As such, a qualitative study design, specifically, semi-structured, in-depth interviews were appropriate. This format enabled exploration of the complex ways in which one expression of broad political, economic and social determinants of health, Aboriginal rights, may impact immediate determinants of health and ultimately health outcomes, in the specific urban context of Toronto. Also highlighted by this guiding framework and in line with trends in health geography research more broadly, is the necessity of utilizing qualitative research methods that grapple with subjective and culturally specific experiences of health (Kearns 1993; Dyck 1999). In the context of Aboriginal health research, it is particularly important to employ such methodologies as they allow for a more complete exploration of Aboriginal conceptions of health, based on balance between interconnected mental, emotional, spiritual and physical states, which can be difficult to gauge effectively using quantitative methods, as noted in Chapter 3 (Wilson 2003; Richmond and Ross 2008). The use of semi-structured interviews allows both participant and researcher the opportunity to reflect on issues and concepts as they arise throughout the interviews, thus enabling a more purposeful exploration of the complex interview themes through a reciprocal dialogue rather than a rigid interrogation (Dunn 2005; Valentine 2005).

Interviews focused on three main themes: experiences of urbanization (e.g. when and why participants moved to Toronto, challenges and benefits of living in the city), Aboriginal rights (e.g. conceptions of Aboriginal rights, access to Aboriginal rights in Toronto, perceptions of gendered differences in Aboriginal rights) and health (e.g. conceptions of health, impacts of urbanization and access to Aboriginal rights on health, health services in Toronto). An interview guide with specific questions was used, though interviews flowed differently in accordance with the responses of participants (See Appendix 4 for interview guide).

Purposeful sampling was used to select participants for this research based on their in-depth understanding of and experience with the themes addressed in the study. Rather than seeking a large random sample of participants, purposeful sampling seeks to engage 'information-rich' cases (participants) who can share a great deal of specific information regarding their understandings and perceptions of the topics under investigation (Patton 2002). Such a sampling method is appropriate for this exploratory study, which aims to better understand relationships between urbanization, Aboriginal rights and health based on existing social theory through the development of more specific theories that may link them together, rather than testing a priori hypotheses or making statistical generalizations (Curtis, Gesler et al. 2000).

As the study is focused on the ways in which Aboriginal peoples transition to urban areas and how this may be implicated in their conceptions of and access to Aboriginal rights and health, participants who self-identified as Aboriginal (either First Nations, Métis or Inuit) and had moved to Toronto from a rural or reserve setting were recruited for participation in this study. Following other studies involving urban Aboriginal peoples, a multi-pronged strategy was employed to recruit participants (Jaccoud and Brassard 2003; Peters and Robillard 2009). Recruitment emails inviting people to participate in the project were sent out to relevant University of Toronto (U of T) community listservs (i.e. Supporting Aboriginal Graduate Enhancement – SAGE), First Nations House and the Collaborative Program in Aboriginal Health); recipients were requested to forward the information more broadly as they saw fit. With the permission of Aboriginal service organizations in Toronto, posters with information regarding the study and researcher contact information were placed in the Native Canadian Centre, Toronto Council Fire Native Cultural Centre, U of T's First Nations House, Native Child

and Family Services and the Native Women's Resource Centre (NWRC). Further, posters were put up in various public community spaces in the approximate region between Carlton Street, Queen Street East, Church Street and River Street, where many Aboriginal service organizations in Toronto are located. Finally, in a process known as snowball sampling, participants who had completed an interview were asked whether they would pass on the project information to other potentially eligible participants so that they might contact the researcher if they were interested in participating in the project (Esterberg 2002; Valentine 2005) (See Appendices 5-6 for recruitment copy).

In recruiting participants for this research, an informal working relationship was developed with the Native Women's Resource Centre (NWRC), a community organization that provides a drop in centre and many social programs (e.g. employment, education, housing programs) for Aboriginal women in Toronto. Though they did not participate in designing the study, they were very supportive of the project and assisted greatly in recruiting eligible participants among their clients, organizing a schedule for the interviews and providing a quiet and comfortable space in which to conduct interviews. The researcher spent a good deal of time over the course of several weeks with the women at the centre, participating in various community activities such as the women's beading class, in between interviews and thus developed a strong and friendly working relationship with the centre staff and clients. Plans have been initiated to share the research findings with the NWRC and the many Aboriginal women who participated, upon completion of the study through a presentation-event at the centre.

Once a potential participant indicated their interest in participating in the study (either by calling, emailing or coming up in person to the researcher at the NWRC), a letter of information was provided and they were invited to ask any questions of the researcher that they may have. The letter of information provided contact information for the researcher and thesis supervisor, explained the overall objectives of the study, the potential risks and benefits associated with participation, and participant's rights in terms of confidentiality, compensation and withdrawal from the study (See Appendix 7). Importantly, participants were ensured complete confidentiality and were allowed to refuse to answer any questions that they did not feel comfortable answering, without any penalty in terms of compensation (no participants chose to

withdraw from the interview). Once interest in the study was confirmed, a mutually agreed upon time and place to conduct the interview was determined.

Ethical approval from the U of T Office of Research Ethics was granted before recruitment strategies were initiated. In accordance with these guidelines, informed consent was obtained from participants before the interviews took place. In an effort to be inclusive of all potential participants, some of whom, it was anticipated, may not have been very comfortable with reading and writing, or may have put more stock in verbal rather than written agreements (in line with the traditions of many Aboriginal groups), both written and verbal consent were accepted and obtained prior to the interview (See Appendix 8 for consent forms). Only one participant chose to provide verbal, rather than written consent. With permission, interviews were audio-recorded and notes were taken throughout the interviews. It is beneficial to audio-record interviews so that the researcher can focus more on engaging the participant in discussion rather than writing everything down while conducting the interview (Valentine 2005). However, four participants preferred not to have the interviews audio-recorded, three noting that they had general discomfort with being recorded and one participant indicating that the 'Potential Risks' section on the consent form had frightened her (after the interview, this participant noted that the interview had not been upsetting in any way). For interviews that were not audio-recorded, the researcher took extensive interview notes (with permission) and reflected on them in writing immediately after the interview. Interviews were transcribed verbatim and transcripts were verified with the audio files to ensure accuracy.

In total, 36 interviews that varied in length from half of an hour to three hours were conducted in person throughout February and March, 2011. Two thirds of the interviews were conducted in spaces provided by Aboriginal community organizations (primarily the NWRC, but also the Native Canadian Centre and Toronto Council Fire Native Cultural Centre) and one third were conducted at coffee shops that were more convenient for participants. Conducting interviews in settings familiar to participants was important in creating a sense of comfort for them (Valentine 2005). As is standard in community-based research, monetary compensation ($20) was provided to participants, costs of transportation to the interview location were reimbursed, and when applicable, costs of a beverage during the interview were covered (Salmon

2007). Staff at the NWRC confirmed that this level of compensation was appropriate for participation in the project.

Though the invitation to participate was inclusive of all peoples 18 years of age or over who self-identify as Aboriginal (First Nations, Métis, Inuit, or a specific First Nations identity such as Cree or Mohawk) and had moved to Toronto from a rural or reserve location, the sample consisted of a majority of people who self-identify as status First Nations (86% of total sample) and most were women (78% of total sample) (See Table 11 for an overview of identity and socioeconomic factors among interview participants). However, six men, two people who identify as two-spirited[14], one woman who identifies as Inuit and four women who identify as First Nations and indicated that they were in the process of sorting through the application process to regain status, were also interviewed. Younger adults (20-35 years of age – 16 participants) and middle-aged adults (36-55 years of age – 17 participants) were quite well represented in the sample, though only three older individuals (55 years of age or older) were interviewed (Table 11). In terms of highest level of educational attainment, participants were quite similar to the national urban Aboriginal population examined in Chapter 3, with high levels of post-secondary education completion (inclusive of college and university – 39% of the sample), as well as high levels of incomplete high school education (22%). In contrast to the national urban Aboriginal population, most of the interview participants were single (78%) and most were unemployed (56%). Many regions throughout Canada were represented in the sample, with participants originally from Ontario, Manitoba, Saskatchewan, Alberta and Nunavut, though the majority were from Ontario.

4.2.3 Data Analysis

As the study is exploratory, a grounded theory approach was taken in analyzing the interview data. Rather than testing specific theories, the interviews were analyzed with attention to emergent themes in an effort to generate theories about links between Aboriginal urbanization, Aboriginal rights and health (Esterberg 2002). Specifically, a three step grounded theory

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[14] Two-spirited is a culturally specific gender orientation, rather than a sexual orientation, and does not fit easily into Western sexual and gender dichotomies, or the intersections of these dichotomies (Cameron 2008).

Table 11: Overview of Identity and Socioeconomic Factors among Interview Participants

	Total Number of Participants	Proportion of Total (%)	Total Number of Women	Proportion of Women (%)	Total Number of Men	Proportion of Men (%)
Gender						
Woman	28	77.8	28	100.0	0	0.0
Man	6	16.7	0	0.0	6	100.0
Two-Spirited	2	5.6	0	0.0	0	0.0
Total	***36***	***100.0***	***28***	***100.0***	***6***	***100.0***
Age						
20-35	16	44.4	13	46.4	3	50.0
36-55	17	47.2	13	46.4	2	33.3
55+	3	8.3	2	7.1	1	16.7
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*
Aboriginal Identity and Status						
Status First Nations	31	86.1	24	85.7	6	100.0
Non-Status First Nations	4	11.1	3	10.7	0	0.0
Inuit	1	2.8	1	3.6	0	0.0
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*
Education						
Incomplete High School	8	22.2	7	25.0	0	0.0
Complete High School	5	13.9	4	14.3	1	16.7
Some Post Secondary	9	25.0	7	25.0	2	33.3
Finished Post Secondary	14	38.9	10	35.7	3	50.0
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*
Employment						
Employed	11	30.6	10	35.7	1	16.7
Unemployed	20	55.6	15	53.6	3	50.0
Student	5	13.9	3	10.7	2	33.3
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*
Family Status						
Single	21	58.3	16	57.1	4	66.7
Single with kids	7	19.4	7	25.0	0	0.0
Partner	5	13.9	2	7.1	2	33.3
Partner with kids	3	8.3	3	10.7	0	0.0
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*
Region in Canada						
Ontario	24	66.7	20	71.4	3	50.0
Manitoba	4	11.1	4	14.3	0	0.0
Saskatchewan	5	13.9	2	7.1	3	50.0
Alberta	2	5.6	1	3.6	0	0.0
Nunavut	1	2.8	1	3.6	0	0.0
Total	*36*	*100.0*	*28*	*100.0*	*6*	*100.0*

approach to interview analysis was taken (Strauss and Corbin 1998). The first step, open coding, was completed while the transcripts were compared with the audio files for accuracy. This step

also allowed the researcher to note intonations in participants' voices and other specific details of the interviews that would not have been clear from the transcripts alone. Through open coding, broad themes that appeared in the interview data were highlighted and categorized. In the second step, axial coding, interview transcripts and categories generated from open coding were revised as sub-groups and themes became apparent in the interview data. Finally, selective coding was conducted as the themes and sub-themes that emerged from the first two steps were re-examined in the specific context of the research questions, in an effort to link them together and generate new theories. All interview analysis was conducted using NVivo 7, a computer software program used commonly in social sciences research that assists with the evaluation and organization of interview data (Peace 2005). The researcher who conducted the interviews also analyzed the data, which minimized the chances of misinterpretation of participants' contributions.

4.2.4 Evaluation of Qualitative Research Methods and Positionality

An effort was made to ensure validity and relevance throughout this qualitative research process. Following Mays and Cope's widely cited paper examining the evaluation of qualitative health research, the validity of this thesis research can be assessed based on a number of criteria (2000). Triangulation and 'fair dealing' in the form of multiple and diverse data sources was achieved by interviewing 36 people who brought unique perspectives to the interviews. Though 24 of the 36 interviews were conducted at the NWRC and 21 of these interviews were set up through the centre, the participants differed greatly and thus spoke very differently to the interview themes and questions. Despite the vast breadth of responses and issues raised by participants, information saturation was reached. Addressing another important consideration in terms of validity, every effort has been made throughout this chapter to ensure transparency of data collection and data analysis, so that the reader can judge whether the analysis is sufficiently supported by the data (Mays and Pope 2000). Related, an effort to present a balanced and nuanced representation of participant responses has been made by presenting negative or contradictory cases throughout the results section.

Reflexivity, or "sensitivity to the ways in which the researcher and the research process have shaped the collected data" is also an important consideration when appraising qualitative research projects (Mays and Pope 2000, p. 51). A reflexive approach to this research process highlights the importance of positionality and the ways in which power differentials may shape

the research. In particular, when conducting research with Aboriginal peoples, it is important to be mindful of the ways in which historical and contemporary colonial relations shape interactions between Aboriginal peoples and settler Canadians and their potential to impact research relationships. It is important to be aware of the potential for academic research to perpetuate and reinforce problematic power differentials that can exist between these groups (Smith 1999; Browne, Syme et al. 2005). As a non-Aboriginal, settler Canadian, in a position of relative power as a member of a large academic institution, it was imperative for the researcher to be reflexive in her role as researcher and to acknowledge the ways in which this positionality might affect her interactions with participants (Marx 2001). The in-depth, semi-structured interview research design, which allowed for more of a dialogue between researcher and participants, rather than an interrogation, and thus greater participant control in the research setting, was an important means of addressing this challenge (Valentine 2005). It was made clear to participants that they had the right not to answer any questions that they did not want to and they were invited to ask the researcher any questions throughout the interview process, in an attempt to add to their level of control in the research setting. It has been noted that qualitative research methods can serve an important role in creating spaces for the voices of marginalized[15] peoples to be heard in academic research (Parr 2001; Winchester 2005). In a reflexive effort not to appropriate the voices of those who shared their experiences with the researcher through her specific positional interpretations, an effort has been made throughout the analysis to use many direct quotes from participants (Peters 1998; Parr 2001). Further, participants who were interested in hearing about the results of the study were invited to provide contact information (email or personal address) in order to be sent a research summary upon completion of the study; all but two participants requested a summary. This, in conjunction with the proposed research-sharing event with the NWRC, is reflective of an effort to share research with, rather than take it away from, the community. Though they fall short of the ideal of true collaborative research efforts, these measures represent the researcher's best efforts to acknowledge and deal with her positionality in this research, given the time constraints of a master's thesis.

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[15] The intention is not to imply that all Aboriginal peoples living in urban areas are marginalized, but just to draw attention to the fact that the colonial subjugation of Aboriginal peoples is very important to consider as it continues to shape present day inequities.

4.3 Results

The purpose of the interviews was to explore gendered relationships between Aboriginal rights and urbanization, and the ways in which they may impact the health of Aboriginal women and men living in urban areas, specifically, Toronto. In analyzing the interviews to tease out these relationships, two main themes emerged. The first is focused on experiences of urbanization, in particular, the important impacts of the widespread lack of Aboriginal awareness, and the existence of a strong network of Aboriginal community organizations, in shaping participants' experiences in Toronto. The second theme is focused on conceptions and experiences of Aboriginal rights in the city, namely the pervasive sense of a lack of respect for Aboriginal rights, which occurred in geographically specific ways. These two themes intersect interestingly in terms of health, with an indication both that the lack of respect for Aboriginal rights in the city negatively impacts health, and that Aboriginal peoples negotiate these impacts in gendered ways, as they contribute to the reterritorialization of urban space.

4.3.1 Experiences of Urbanization

4.3.1.1 Overview of Urbanization Factors among Participants

Broad spectrums of experience and time spent living in Toronto were represented among the interview participants. Eight participants had lived in Toronto for 25 years or more and thus had had a chance to experience changes in the city over time. Four participants were very new to the city, having moved in the year preceding the interview. The bulk of the sample had lived in Toronto between 1-5 years (31%), 5-10 years (25%) or 10-25 years (11%). Just over 80% of participants (30) were originally from reserves, while three participants were from rural areas and three participants were from cities, but had spent much of their lives living on-reserve. In their most recent move, half of the participants had come from a city, while 15 had come from a reserve and three had come from a rural area.

Participants were drawn to Toronto for a number of different reasons. Though often motivated by complex and contradicting factors, an effort was made in analyzing the interviews to pull out the main motivating factors impacting participants' decisions to move to the city. As noted in Chapter 3, it can be difficult to classify these motivations as either positive (drawing someone to a city) or negative (pushing them from their place of origin), because the factors are

often a complex combination of these types of motivation. However, amid these varied motivations, the most commonly discussed factors that impacted participants' decisions to move to Toronto were opportunities in the city: schooling, employment, excitement/things to do, reconnection with family, to provide better services/opportunities for family and to get a fresh start; the majority of participants talked about their decisions to move to Toronto in a primarily positive way, as a *choice* to move. Though it would be ill-advised to read very much into gender differences since the sample is so skewed towards women (28 women vs. 6 men), it is interesting to note that reasons related to one's family factored into the decisions to move of only two men (framed positively in both cases as opportunities for family and a chance to reconnect with family) while family was important in the decisions to move of 10 women (framed as opportunities for their kids in the city, as a chance to reconnect and more negatively as an escape from a damaging/abusive relationships in their places of origin in four cases).

4.3.1.2 Aboriginal Awareness in Toronto

The most common themes that arose in terms of participants' experiences of urban life can be thought of in terms of their interactions with the broader Toronto community and their interactions within the Aboriginal community in Toronto. In discussing the former, the perceived lack of Aboriginal awareness in the city among the non-Aboriginal population was the most widely discussed experience:

> …people think we're extinct, you know? It's like they've really never seen a Native person, in person. And they're like wow, can we take a picture of you? Like wow, it's like, we're not extinct, you know? We're not in museums. (Doug, City, 25+ years)[16]

> We're not going away, you know, we need to get more awareness. Like a lot of people don't even…have any idea about residential schools. (Marrilynne, City, 1-5 years)

Many participants shared experiences that revealed pervasive stereotypes and misconceptions regarding Aboriginal peoples among the general Toronto community. While often quick to note that it was by no means all people that they encountered, emphasizing that there was good and

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[16] Participants' names have been replaced with pseudonyms. Included with all quotes are the participant's place of origin for their most recent move (city, rural area or reserve) and the approximate time that they have been living in Toronto (<1 year, 1-5 years, 5-10 years, 10-25 years, 25+ years).

bad among all groups of peoples, almost every participant (29 participants) indicated that they had experienced some discrimination living in the city based on their Aboriginal identities:

> Some of them are cool and some of them... actually I ran into some racism on Spadina... me and my friend were going in there to eat and this guy said, 'oh you just come in here just to use the washroom?', stuff like that, you know? Like holy. (Janice, Reserve, 1-5 years)

> All I see is discrimination, hatred and resentment. For whatever reason, I don't know. Sometimes I think that people act like we don't belong here and we don't have any rights here at all. (Mary, City, 1-5 years)

> Well I see a lot of people being racist about Aboriginal people…Like they'd be all rude and like I don't know, like say that they're all drunks and stuff… It's like, let's say that you seen an Aboriginal man all drunk and, uh, you're going to be saying 'oh, Aboriginal people are drunks' because you seen like a couple of Aboriginal people that had been drinking, but like, there's other people out there that don't drink and try their best to like improve…(Julia, City, 5-10 years)

Eleven participants attributed the discrimination that they had experienced through encounters with non-Aboriginal people in Toronto to a lack of Aboriginal awareness, which was often linked to a lack of education. In particular, the education system's completely inadequate coverage of Aboriginal histories, politics and cultures, as well as honest accounts of the ways in which colonialism continues to shape present day realities, were noted:

> They don't really know, like the history or that we have our own culture and that we have our own beliefs and it's, they believe what was put, put forward to them in the history books… It's people who have grown up here too. And it's just, they believe what was written and what was written is not really the truth. So their beliefs are like, you know, just what they, what they've read and it's like no, that's not how it is. I'm Native, I can tell you. You know? And it's just talking to them. And then once I do tell them, you know, a little bit about the history and a little bit about what I know and my culture, then they say oh, well I didn't know that. I say well, you know, open your mind, you know? Pick up a different book. Don't pick up that book. Here, I'll give you a book to read, you know? (Lynne, Reserve, 5-10 years)

> The only thing they're teaching in the schools is…They're not talking about the history of Aboriginal people. They're not talking about Aboriginal rights. All they're accessing is the culture and traditional knowledge and they're seeing, the only thing they know about Aboriginal people is, you know, the John Wayne movies. (Adam, City, 25+ years)

A few participants noted that they often took it upon themselves to inform people whose discrimination and stereotyping seemed more the result of ignorance rather than hostility. However, this was not a role they necessarily always wanted to have to play:

> I actually took a course, an Aboriginal studies course…the atmosphere of the students in the room, it was like, they had no idea of any kind of…. lack of awareness of issues or that, or the ignorance… that Native people get everything paid for, or different, those kind of things. And it's like almost upsetting to the point where you can't, it's like you don't even know what to say, cause you want to say something but you have to realize too that they have no idea. And it's like where do you begin to start? (Yvonne, Reserve, 1-5 years)

> Well considering it is our land, you know. At the very least, you could understand where we're coming from… Cause, I'm kinda tired of giving my speech. (Patricia, City, 1-5 years)

A few participants also spoke about the ways in which broader city structures and institutions (e.g. media, public spaces) showed a lack of awareness of Aboriginal peoples:

> Look at Toronto…all of this is Anishnawbe land. It's Native land. The city doesn't give respect to… recognition, as much to the Aboriginal communities… I mean there's…like Chinatown… and then there's Little Italy and then there's South Korea town…how come there's not a Native Aboriginal community town, you know, in the GTA? (Andrew, City, <1 year)

Despite the many examples of experiences that communicated to the participants that there is a lack of Aboriginal awareness in the city, five participants who had lived in the city for longer observed that the situation is improving:

> I remember things, and how I felt and I remember what I went through. I don't see the kids nowadays; it is not a thing anymore. Back then, I was fighting to be who I was, to stay who I was…and people not even knowing what an Ojibway person was. It was like 'you are a Paki-Indian'? Now, people are more aware… Toronto society is more aware of the Aboriginal culture and the population I think, because we are just everywhere now. (Donna, Reserve, 25+ years)

Overall, participants indicated that the lack of Aboriginal awareness, often expressed through stereotyping, discrimination and general lack of representation in city institutions is an important part of their experience in Toronto. They also identified more education as playing an important role in countering the negative impacts of this lack of awareness, and that the situation is improving.

4.3.1.3 Aboriginal Community-Services

The second broad theme drawn from participants' experiences of the city centers on their interactions with other Aboriginal peoples in Toronto. Three sub-themes emerged from these experiences: the sense of Aboriginal community created through service provision, the importance of connecting with Aboriginal cultures in the city, and the diversity of the Aboriginal community. The majority of participants (26 participants) spoke positively about the sense of Aboriginal community in Toronto, some noting its importance in providing social support for them in the city:

> Just being with people, like, people that have a like-mindedness to that. Who've probably had that same encounter and that same struggle. And it just kinda makes sense that they feel like home. Even though I might not know who they are, but just the same kind of atmosphere that they provide. (Yvonne, Reserve, 1-5 years)

> Exactly, if anything was to go wrong, you can always call on the Native Aboriginal Community to help you out… everybody is kind of close. It is just the way we were all raised. (Heather, City, 10-25 years)

Participants often linked a sense of Aboriginal community in Toronto with Aboriginal service organizations, emphasizing their important role in fostering this sense of community:

> Like because there's so many agencies but it's like, you know somebody at this agency who knows somebody at this agency who can help you over here and you know, there's always, there's always that kind of link. So it's a good, I think it's a good thing because, like I personally, I worked for Native Community Centre, I worked for Miziwe Biik[17]. I did a training program at Anishnawbe Health[18], here at Native Women's… and at Council Fire… You know, I know a lot of people, so when somebody comes, new that comes into the city that I know and they're like 'oh, hey, oh I need this', I'm be like oh, wait, hold on a minute, I'll get you the information and I'll, you know, send them off to where they need to go. …these organizations have a lot of social events and stuff going on, that's where you meet a lot of people too… And a lot of people go to those and then you know, that's how you get to meet everybody, you know, a lot of people and then you just kind of grow your friendships from there… (Lynne, Reserve, 5-10 years)

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[17] Miziwe Biik is an Aboriginal employment and job training centre in Toronto.

[18] Anishnawbe Health is a community health organization that has three locations in Toronto and provides holistic health services for Aboriginal peoples.

However, 18 participants noted some negative aspects of the Aboriginal community, explaining that it had less of a 'community feel' than their reserve communities and that while Aboriginal people were social and friendly enough in the city, they didn't really *know* each other. Some noted that as newcomers to the community, they were not always easily welcomed, which was attributed to a perceived lack of trust and a sense that the community can be somewhat cliquey:

> Being at a, you know, place that has your, like your own kind of people, and uh it's still hard to, you know, because it's, a lot of these people have been going there for a long time and to fit in….It still takes a while to fit in with people or… you know, maybe they're thinking oh, you know, someone new, or you know, are they going to, you know who are they? You know, it's just like being into a totally different person. Now I can understand how you know, immigrants feel. They come into a new city and, uh, getting…And they don't even know the language. (Marrilynne, City, 1-5 years)

> Like here, like the Aboriginals here, they kinda like, kinda keep to themselves….Maybe because they've never seen me around before or … (Lauren, City, 1-5 years)

Three participants indicated that they felt somewhat excluded from the Aboriginal community, and as a result, from the Aboriginal services in Toronto, because of their higher social class in relation to their perception of the majority of the community. They indicated feeling uncomfortable going to some of the Aboriginal service centres as they felt that they were located in a dangerous part of the city. One participant indicated that she was not able to get the support that she wanted from an Aboriginal childcare assistance program, because there seemed to be a willingness among the Aboriginal services organizations only to help those who are *really* struggling:

> I tried out one but I find that they…they are towards more people who are living on welfare and stuff. I went to this one program cause I have two daughters now. One is going to be two and one is going to be one this year… I need help so I thought maybe they have this program at this Anishnawbe Health. The lady comes and helps you like, you know, raise your children blah blah blah, so she came over for a visit this one time and she's like oh she's like 'this seems to be… you are doing fine here. You don't need my help'. I'm like 'are you serious?'. Maybe I don't know if I have to be in some other programs to get that special help almost. It seems like you have to be really down in the dumps where they are going to help you. (Nina, Rural, 5-10 years)

Overall, it seems that the sense of Aboriginal community in Toronto, which is largely created through Aboriginal service organizations, is an important part of participants' experiences in

Toronto. Though many people felt there is a strong and positive sense of community in Toronto, this sense of community was not uniformly constructed or experienced.

Related, the second sub-theme focuses on the important role of Aboriginal community/services in connecting Aboriginal people with their cultures in the city. It was clear from the interviews that in contrast to the construction of Aboriginal identity as antithetical to urban space, maintaining and asserting their Aboriginal identities and cultures in the city is very important to participants (Peters 2002; Wilson and Peters 2005). The vast majority of participants (31) contribute to the reterritorialization of urban space through their efforts to maintain and explore their cultures in Toronto. Aboriginal service organizations play an important role in creating spaces for peoples to engage in traditional practices in the city:

> Sometimes I go to, like, certain ceremonies, full moon ceremonies here at Native Women's. I go for resources they have at Native Women's Resource Centre. If they have any events going on, like a pow wow or something, I'll go…. Well, I grew up going to ceremonies and stuff like that, so it's nothing really new to me. I just like to keep in tune with my culture, I guess. (Lily, City, 5-10 years)

> There's opportunities, like examples, there's at least about three or four different sweat lodges I believe here in the GTA, that is just one example. (Nicolas, City, <1 year)

> They have a lot of Aboriginal services like all the information is there so you if you had a question about sweats they will probably tell you where to go… but umm they have smudgings there. They have drumming circles… (Cynthia, Rural, 1-5 years)

Twelve participants spoke in particular about how they had become more interested in their cultures and were more involved in practicing traditional ways since moving to Toronto:

> I feel like I'm more connected to my spirituality and, uh sense of be. I tell you when I'm in Toronto, because of the resources….Just various places where I can pray…like Council Fire, this place [the Native Canadian Centre], Anishnawbe Health. (Doug, City, 25+ years)

> Now I know my family, and I come here. I had a pipe ceremony and I got my name. I'm going to my first sweat tonight and I'm so excited. I'm doing all this stuff and I'm observing everything. (Mary, City, 1-5 years)

> Well I try to attend their, like, outings and that has to deal with culture. Cause I'm not like really into my culture and I want to learn more about it. So, I try and like, here, I try and like they do the smudging and the praying and so, I get involved with that. And I want to get involved with their, like, they have open sharing circles and – what else do

> they have? They have their feasts and their pow wows. So I try to get involved with that as much as I can. (Lauren, City, 1-5 years)

However, some participants (8) also noted difficulties in engaging with their cultures in the city, namely through restricted access to the natural environment, language and elders:

> There still seems like a disconnect because we are so … we are in the city, like, so there is a disconnect with culture I think because … mainly because our culture has … is constantly surrounded by nature, it kind of … that is what it kind of feels like to me. (Nicolas, City, <1 year)

> The reason why it was hard for me was because I had nobody to talk to. Only me, I was living in Hamilton then and I lived there for 13 or 14 years. There was nobody to talk to unless I go to my reserve. That is when I can talk. (Francine, City, 25+ years)

> Like, it's hard to practice culture, like, every day here….It's like, mostly, like, smudging and stuff like that with the medicines and … It's like, I guess on the reserve, it's like, you don't have to make appointments to see your elders. (Janice, Reserve, 1-5 years)

Finally, a few participants expressed frustration about the ways in which cultural teachings seemed to be monopolized by small groups and organizations in the city that claim to be authorities on these matters, a point that these participants refuted:

> … there is a lot of spiritual abuse out there. A lot of spiritual abuse. And what I teach clients here too, because I told them like all my life too I was raised 'oh, be clean for four days. Be sober for four days'. I'm sorry but there's no rulebook for traditions and there's no, um, author that says, um, you need to do that. From my understanding is that those medicines are there….they're there for… to help you. If you were drinking the night before, I don't care. If you need to smudge that very next day, then you smudge and you ask the Creator to help you. That's just one day at a time. So a lot, there's a lot of spiritual abuse I find in the community. I find like it's always, you know, you have to be this way or that way. No, there's no, yeah, there's no conditions to our traditions. That's my saying. I always say that. And that's how they teach a lot of our youth too. No, who told you that? Where's the rule book for that? And they're just like, 'uh, I don't know'. Well that's what I'm saying. There's no rule book for that. This is all oral. This is how you learn. (Beverly, City, 10-25 years)

> We were never taught back in the day… we were taught to learn and respect and love, that's it. And now it's 'oh, you drank, well then you can't come to the centre for four days'. You know, like, it's, not here [NWRC], but like some of the places, you can't attend ceremonies if you've been drunk for, you know like…When did the Creator send down the bible of the Aboriginal people? No, never did, right? Like who came up with that line? (Alex, City, 1-5 years)

The importance of engaging with their cultures in Toronto is linked to the third sub-theme, the diversity of the Aboriginal community in Toronto. Many participants (14) indicated that this diversity, in terms of representation from different First Nations and different Aboriginal identity groups (i.e. First Nations, Métis and Inuit), is beneficial to the community as it affords a cultural richness through sharing and learning among different groups:

> Like, everybody comes together and it's not only just, like, Ojibway and, it's all different Nations. It's, like, Mi'kmaq, Soto, Cree… It teaches, like, you could get different teachings from different people and it's really good. It helped me. Like, I got a lot of Mohawk teachings. I had, I've learned a lot of Mi'kmaq songs and, people are looking at me like, 'holy smokes, like, how do you'? And it's, like, well, and then I learned to and I was starting to learn how to speak Cree and it was, like, people are looking at me like 'you're Ojibway, like, why are you picking up other Nations'? And it's, like, well somebody has to learn them and teach them. (Rebecca, Reserve, 25+ years)

> I feel a slight disconnect because I am … I don't see as much Cree people and me being Cree, but at the same it's kind of fitting because Toronto itself means gathering place and this … this specific land was a meeting place for a lot of, many tribes that would come here to trade....so I mean just … just historically looking at that to nowadays, people come from all over the country and all over the world to the city so it's fitting and it does help shape it in a more positive way cause we do learn from each other and we still have each other as a community regardless of what tribe you're from. (Nicolas, City, <1 year)

Though she indicated that there seemed to be few Inuit peoples in Toronto, and not much in terms of service provision for them, the one Inuit woman interviewed indicated that it was important to her to connect with other Aboriginal cultures in the city:

> Well there's not much Inuit culture related so I try to, uh, stick with the Native cultures, you know, making the dream catchers, uh, drumming with the women's drum and like singing their songs. Like if there was like places where you can go, like drop-ins for Inuit people, um, I'd go there also but I love the Aboriginal culture and I love the traditions and stuff. I like to like learn it. (Julia, City, 1-5 years)

There has been some suggestion in the Aboriginal urbanization literature that Aboriginal community formation in urban areas may be hampered by status and identity divisions linked to internalized racism among Aboriginal peoples (Weaver 2001; Silver 2006; Peters 2011). Many participants indicated that they had not sensed tensions along these lines in the Aboriginal community in Toronto:

> See because I am pretty open. I am very accepting to people because we all come from one place really. We all share the same Creator. We all share the same breath. We all

> have a purpose and that is to go forward and grow with family life and children. (Donna, Reserve, 25+ years)
>
> [referring to her daughter, who identifies as non-status First Nations] …they realize that she comes from, that's her home land, like Manitoulin Island. Um, going back to the status, so she didn't have to present the status to be accepted. (Caitlyn, Reserve, 10-25 years)

However, important tensions, mostly in terms of status and the Aboriginal identity groups, rather than between specific First Nations groups (e.g. Iroquois, Cree, Ojibway etc.) were highlighted by 13 participants, a few of whom were quick to distance themselves from this type of discrimination within the Aboriginal community:

> …I think they [Aboriginal organizations whose official mandate is to be status-blind] do discriminate. I hear there's a lot of Métis people that I know, they're like 'oh you can get those benefits and I don't', you know…Yeah they would fund if you have your status card and if you don't have it, they wouldn't fund it. (Nina, Rural, 1-5 years)
>
> I know a lot of Native people that are not involved in the Native community because they choose not to. Only because, well one family in particular, they felt that they were being discriminated because their mom was white.... so they disappeared from the community. (Donna, Reserve, 25+ years)
>
> I just avoid it [tensions-discrimination]. I just ignore it. I just, um, like sure, it's there… (Marrilynne, City, 1-5 years)
>
> …people play a big importance on the whole, the blood quantum thing and I don't really think that's, I've learned over time, that it's not really right to do that. Like, but I was on that train of, like, well you're only a half or, you know, like that whole…but I mean, that's just like suppressing our people, like, trying to identify us. Like, you know, that person is us. The government's put a card or that kind of thing… (Yvonne, Reserve, 1-5 years)

The Aboriginal community in Toronto is thus perceived by participants to be a source of rich cultural diversity, with some tensions or fractures along identity and status lines.

4.3.1.4 Gendered experiences in Toronto

Some interesting points of divergence between women and men emerged both in terms of their interactions with the broader city community and within the Aboriginal community in Toronto. Though it is difficult to make strong inferences about gender differences because the

sample consisted primarily of women, these differences are worth exploring. Many women (11) observed that there seem to be more resources in the city for Aboriginal women than for men:

> Just being able to come to this centre [NWRC] and having it woman only and just having that atmosphere of being comfortable and having the services that are available here, like with the investing in women's futures, just those kind of things are, I find are a little more, I don't know about the men…I don't know too many Aboriginal men that utilize any services really. (Lynne, Reserve, 5-10 years)

> The men are kind of left, they seem to be left struggling. I don't know if they have their…like we have Native Women's Resource Centre. It's like they don't have a…they have Native Men's Residence, but they don't have, like, a men's resource centre like this, like, that would be … I know the men are struggling. (Rebecca, Reserve, 25+ years)

> I think basically the women maybe we are given more, I am not sure, maybe it's easier for us to integrate…in the community, I don't know. I feel like for men, I don't know, it sounds bad, but I don't know too many successful men, Native men in the city. Like a lot of them are unemployed, the ones that I have met here, a lot of them are unemployed some of them even, yeah almost at the point of poverty and stuff like that. Yeah, I don't feel like, I don't know if that's because they are Aboriginal or maybe that's just because of their lack of ambition. I am not exactly sure, but I know a lot more successful Aboriginal woman than men. (Cynthia, Rural, 1-5 years)

In addition to their perceptions that men do not have access to an Aboriginal resource organization that paralleled the NWRC, as is clear in the previous comments, a few women identified housing in particular as an area in which Aboriginal men experience difficulty:

> They need shelter. There are so many Native men out here but they don't have any shelters. This one guy told me it was safer living on the streets than living in the shelters or on the reserve. (Mary, City, 1-5 years)

> Because women, uh, a lot of women unfortunately have been uh in abusive relationships and um, if they're in the shelter system, uh, you know, they're more a priority. Where men, maybe you know, they, to be in a shelter is a whole different ball game and a lot of them are, they prefer to like, live in a park than be in these shelters. And so how do they get housed? I think men do have it a lot, well, say, harder…like for women, we shouldn't have to be dealing with this either. No one should. But I think in a lot of, um, when it comes to housing, that I could think of, I'm assuming, you know, men are on the bottom of the list. When mostly the women have the children, so they're higher priority. (Marrilynne, City, 1-5 years)

Marrilynne's comment suggests that women have greater responsibility, particularly as a result of their primary role in providing childcare, which sometimes makes them a priority for services and can thus result in improved access to resources for them. However, she also notes that

Aboriginal women can be more vulnerable than men because they are often the victims of domestic abuse. Interestingly, though the sense that Aboriginal women in the city are vulnerable did not often come up among the female participants, half of the men interviewed made this observation, for example:

> I think that there is a different, definitely a difference between being an Aboriginal man and a woman; I can't really say because I'm, for one, not an Aboriginal woman, but I know that just that, that demographic alone is one of the most at risk demographics so it's tough to say… (Nicolas, City, <1 year)

In trying to explain the perceived lack of resources and general difficulty for men in the city, a few women spoke about how they felt that gender norms and expectations made it more difficult for men who are struggling to find employment and housing in the city, and about the disproportionate role of negative stereotypes impacting Aboriginal men, which may prevent them from accessing the resources that are available to them:

> I think they have more of a, a, they have more of a bad rap. So I think it's harder for Native men to, to go out and utilize agencies because, especially for employment and stuff, they always, they have that stigma on them that they're unemployed, they're homeless, they're you know, drunk or druggies or you know. And that's what a lot of people think, so when they go to an agency for help then that's like oh well, did you just get out of jail, are you an alcoholic, are you a drug addict, you know, and it's, and I think that's part of the reason why, like the men I know don't go to agencies because they don't want to have to deal with that, you know. Because they're not, none of that, but they just don't want to have to, you know, deal with it. (Lynne, Reserve, 5-10 years)

> Women, it's gonna be easier. Because the way we're all raised is that a man's supposed to be a man….he's supposed to be strong. So, if he's not working or looking after his kids or, you know, if he's not doing anything, then he's a bum. That's what he is. So he, an Aboriginal man, would get a lot less respect and they do…I think it's worse if you are Aboriginal and you're not doing anything…Just for the sheer fact that people don't know enough about us that, you know. It's just worse. It's just worse for them. (Patricia, City, 1-5 years)

In explaining the perceived gender differences in service organization availability and use, women also spoke about how their resourcefulness and sense of community/mutual support helped them to create for themselves the necessary resources and services in the city to succeed:

> Women are, um, more resourceful for looking for things that would be positive or beneficial towards their lifestyle. Men are just so lost. (Meredith, Reserve, <1 year)

> I think there, there's more women that just have always come out and wanted to, uh, so they started to up that service. Whereas men, whereas men aren't… Um, men kind of just 'ah, whatever', kind of thing you know, whereas women, like we need this, and they're more vocal about it. (Caitlyn, Reserve, 10-25 years)

In contrast, it was perceived that men are more solitary and less supportive of one another:

> I think every male that I know has never really accessed anything. They just kind of make it on their own and go and, um, just find their own way. Like they go and work and do whatever they can to, to survive on their own. (Lynne, Reserve, 5-10 years)

Both the women and men interviewed also linked the availability of resources for Aboriginal women in the city to their strength and leadership. A few participants echoed the literature explored in Chapter 2, which suggested that the strength of Aboriginal women in advocating for their needs (and rights) in the city stems in part from their more severe subordination through the interconnected racial and gender oppression as a result of colonialism (NWAC 1999; Stevenson 1999; Green 2001):

> We just, uh, we're very vocal, like we're vocal, we're more out there. Um, than men, men are kind of, men are different. Obviously, but they're just, I don't find them, like especially the men in Toronto. Aboriginal men in Toronto they'll tolerate all kinds of stuff whereas women, Native women, like through what I see between the two of them, um, they're more powerful, they're more out there. They're, to speak their rights opposed to men. (Caitlyn, Reserve, 10-25 years)

> They are very outspoken. They are very… activism ...like throughout activism. I think they stand out more than the guys too sometimes. Cause they have that strong, stronger voice and just the way their beauty, the way how they represent themselves…I think women are faced with a lot challenges. You know being a woman and being [in] a political arena… because that wasn't, that wasn't possible like even 70 years ago right, so I think there, I think there is definitely a challenge for them as well because their voices, like people want to, people want to crush the voice of somebody who speaks strong you know, like some people can't handle it…Having that, with the struggle that they have had to deal with, I think it's, they are taking a lot, more woman are taking it upon themselves to pave the way for more women I guess. (Andrew, City, <1 year)

Three participants linked the proactive role of Aboriginal women specifically to their positions as the primary family caregivers, particularly as single mothers:

> Women, women always strive. We are always struggling because we are the ones that have the children. It is our responsibility and role as women to teach and that is who we have to teach, in life how to be. Men, since the beginning of time they just plant their seed and go if they want. That is how it has been and that is something I have accepted a

> long time ago. I don't wait for a handout from the baby's dads or nothing. I strive for what I want, this program I am in it because it is going to help me in the end. (Donna, Reserve, 25+ years)

> …women have to take, like, especially single women, their two, double role. Like the role of man and the woman….They're [Men] struggling big time and I don't know, maybe it's cause they don't have, like, they've never had proper leadership, or, like, cause it's always, like, a lot of these men are raised from single parent homes too. And that's kind of like why I worry about my sons. Cause they're all, you know, it's a single parent home and it's, like, who's gonna, like, my 16 year old son, who's gonna teach him to be a man? I can't teach him. (Rebecca, Reserve, 25+ years)

It was noted by two participants that the strength of Aboriginal women in the city seems to contrast with their experiences living on-reserve:

> On reserve it's kind of different. It's kind of different I feel cause the men seem to take over more cause the woman do. I mean, I can't…it's just my opinion. I don't know for sure but, [that's] what I've seen right. (Andrew, City, <1 year)

> On the reserve it's different, it's opposite…. Men are more, uh, I don't know. There's more power to them. They, maybe it uplifts them in some way, that they feel more powerful on their own land. (Caitlyn, Reserve, 10-25 years)

In speaking about their experiences in Toronto, participants in this study highlighted the widespread lack of Aboriginal awareness in the city, expressed in the forms of discrimination and stereotyping, and the important role of Aboriginal service organizations in creating a sense of Aboriginal community in the city, which enabled them to connect with their culture in the city and to learn from each other as a diverse Aboriginal community. Aboriginal women seem to be a strong and important force who have mobilized themselves effectively to develop the resources that they need, while it is perceived that Aboriginal men seem to be struggling more in the city.

4.3.2 Aboriginal Rights

4.3.2.1 Conceptions of Aboriginal Rights: Content and Access

The second major theme that emerged from the interviews focuses on the ways in which Aboriginal peoples both conceive of and experience Aboriginal rights in Toronto. Though conceptions varied considerably among participants, Aboriginal rights were discussed mainly as the rights to specific services/benefits, to self-determination/government (which were used

interchangeably by participants) and to respect, in various forms. These conceptions align quite well with the narrow and broad interpretations of Aboriginal rights discussed in Chapter 2.

The vast majority of participants (31) shared a narrow interpretation of Aboriginal rights as access to specific services and benefits such as affordable housing, reduced costs for transportation, tax exemption, funding for education and health services. Education and health services emerged as particularly important rights of Aboriginal peoples. Twenty-nine participants felt that they had a specific Aboriginal right to education. In speaking about this right, participants focused primarily on unrestricted post-secondary education funding and the importance of ensuring that education systems actually work for them (i.e. on-reserve education systems adequately preparing students for the mainstream education system and creating space in this mainstream system for Aboriginal students without compromising the quality or rigour of their education):

> I do know that our people need to be educated and um so I think that's our right to um for allow our people to get educated. (Katherine, Rural, 5-10 years)

> You have to, we should just be able to walk into a school and start without cutting through the red tape, right?... Apply for this, apply for that. No. We should just, an Aboriginal person should just walk in the school and start without having to pay for everything. Our education's free. (Alex, City, 1-5 years)

> …we don't want to set them up for failure. We want to set them up to succeed…. And I said that's what they… to design that. In the school system, whether it be college or university. They say well what's going on? We can't keep spending our money and spinning our wheels… I do want to see our people, uh be able to sustain themselves in the education department. (Ted, Reserve, 1-5 years)

The vast majority of participants (27) also felt that they had a specific Aboriginal right to health care. Discussions of this right focused on the need to ensure that Aboriginal peoples had access to good quality care, particularly in light of the health inequities between Aboriginal peoples and the rest of Canada, which a few participants noted. Additionally, 14 participants discussed the need for health care services that are provided in culturally appropriate ways. Key benefits to this type of health care provision identified by participants include familiarity with the complexity of health issues facing Aboriginal peoples:

> …you have to come here for say some emergency surgery or something, well maybe they've been so traumatized they don't want to be touched and that. You have to have

> the understanding. You have to have people there that can talk through with them or walk through with them or have the Aboriginal, some kind of health people there that they can go to. (Beverly, City, 10-25 years)
>
> I went there like Anishnawbe [Health]…they would know more about the difference health issues cause clearly like there is more health issues in our community… our background than others like diabetes and stuff and you know helping with that kind of stuff so we don't develop it or you know they would probably be more educated on that…(Cynthia, Rural, 1-5 years)

Participants noted approaching health care with methods that better coincide with Aboriginal conceptions of health as another advantage of this type of service provision:

> …a non-Native organization, they just think that you are ill and they want to put you away somewhere, or medicate you. They don't really teach you how to deal with the illness that you're going through or the health problems that you are going through… where in the Native community they try to define your problems, what it is, and they try to help you through it, whether it's through counseling or the healer or sweat lodges or ceremonies. (Charlotte, City, 5-10 years)
>
> …St. Michael's Hospital like I had to wait there for a couple of hours. And they look at you 'oh oh okay you are fine. You are good. Here's a couple of you know painkillers just just rest' …whereas Anishnawbe Health they actually like, they care about your well-being. They make sure that everything is good about you. (Andrew, City, <1 year)

In analyzing the ways in which participants discussed the services and benefits, it was apparent that for some, the justification for Aboriginal rights lay in the clear need for them (7). Apart from the discussion of honouring treaties, few participants spoke of a legal imperative for Aboriginal rights, but rather a moral one. This moral argument as justification for claims to Aboriginal rights may be indicative of fundamentally differing conceptions of rights, or perhaps the notion that Western liberal conceptions of rights do not function well in Aboriginal systems of thought (a point which will be further explored in Chapter 5). As one participant put it in describing the right to Aboriginal health care, "it is not a right. It is what the people need and want…" (Charlotte, City, 5-10 years). Similarly, the right to education was spoken about by a few participants as necessary so that Aboriginal peoples might pull themselves up and start to contribute more to solving the complex problems facing their communities. One participant referred to the need "to utilize the white man's tools and beat them in their own game, with their own tools and that is the white man education" (Donna, Reserve, 25+ years). Following this line

of thought, in discussing the right to education, another participant noted that "we need to be more educated in order to be able to handle our own affairs" (Katherine, Rural, 5-10 years).

Related to the justification of a right to education as a means of gaining more autonomy, many participants spoke specifically about self-determination/government as an Aboriginal right. In line with the broad conceptions of Aboriginal rights outlined in Chapter 2, the importance of the right to have a role in the ways in which Aboriginal peoples govern themselves, sometimes using the specific terminology of self-determination or self-government, was discussed by many participants (10). One participant explained that the manner in which the government has controlled the lives of Aboriginal peoples has clearly shown that it is not well equipped to develop solutions to the problems plaguing Aboriginal peoples in Canada and increasingly, Aboriginal peoples are articulating the need to come up with solutions themselves. Similarly, drawing on a traditional political agreement, the Two Row Wampum, another participant explained self-determination as the basis from which all other Aboriginal rights should stem:

> I think anything that would fall under the umbrella of that [Aboriginal rights] is under self-determination and self-government, because if we are a self-determining nation within a nation and we're self-governed and we're self-run, then we can better work for our own community with … with this country, a nation within a nation. I don't know if you're familiar with the Two Row Wampum…basically it's where a river … well both on a river flowing towards the same destination which is the future, that there's one canoe and one boat and the canoe is the Aboriginal people and the boat is … all the settlers came to this country and we're all flowing towards the future and we're flowing together in partnership, and you can't have one foot in the canoe and one foot in the boat and you can't jump back and forth, so it's an interesting philosophy and that was actually the Two Row Wampum which was their recorded … way of recording history, so that was a treaty and a promise made. (Nicolas, City, <1 year)

Some participants, particularly women, expressed caution at the notion of obtaining the right to self-determination/government. Specifically, some participants felt that First Nations are not well equipped to exist as self-determining political entities at present, since they have become so accustomed to working within the problematic and paternalistic government funding system, and would thus not be able to support themselves financially, independent of the federal government. Others feared that problems associated with Band council politics, such as issues with nepotism, would ensure that self-determination would further fracture their communities.

The notion that self-determination seemed like a distant goal that should only be sought once existing specific political agreements were dealt with (e.g. treaties), was also expressed:

> I know everybody's pushing for independence and those kind of things, but I think we need to start off small with even people recognizing, like, the treaties and different stuff that are in existence and even trying to get those things, like, you know, if we seen that kind of leeway, I think those kinds of things would help us, like, kinda of, do some kind of reclaiming and deciding and thinking of stuff that we want to actually see, as opposed to, like, the government money and how those rules suppress and keep us down. (Yvonne, Reserve, 1-5 years)

> I don't think my reserve is ready for self government. It never has, because they don't have the funds to. Mind you they can get by and what not, because they are government funded…so if they go self-government, where are they going to get the money? My reserve is going to go broke. (Heather, City, 10-25 years)

Fundamentally linked to self-determination, the third main way in which participants conceived of the content of Aboriginal rights was as respect, in multiple different forms (15 participants). Six participants felt that respecting Aboriginal rights means respecting existing treaties:

> Uh, I think just basically uphold the treaty rights, the rights that, you know, when they signed those treaties way back when, just uphold those rights even though they were made back then for that situation but it's still over, it still covered your housing, it covered you know all your, all your living standards… Just to have those up with everybody else in society, that would be great. (Lynne, Reserve, 5-10 years)

> So with the treaties, I said whatever, what's promised in your treaty, then that's what you deserve...Maintain it. It's that simple…if you didn't mean as long as the river flows and the grass grows, don't kill the grass and stop the river from flowing so that you don't have to hold your agreement, right? (Ted, Reserve, 5-10 years)

Echoing components of the Canadian Human Rights Commission's definition of Aboriginal rights as noted in Chapter 2, which stated that Aboriginal rights include the right to the preservation of traditional languages, cultures and traditions, 14 participants also related respect for Aboriginal rights to respect for Aboriginal cultures and identities in Canadian society:

> Respect is one, right. And under that you have to have the understanding. What I really like about here [NWRC] is that we, we can smudge at any given time. Any other kind of building or whatever, you wouldn't be able to do it unless you had some special permission or whatever. That's our right as First Nations people, that's our sacred medicine. We should be able to do that at any given time. (Beverly, City, 20-25 years)

> As far as far as um Aboriginal rights… rights to just being respected and rights to having our land being properly treated. Like if you cut down a tree, plant two trees, plant 10 trees. (Andrew, City, <1 year)

Overall, participants' conceptions of Aboriginal rights spanned both narrow and broad interpretations, and focused primarily on the provision of services/benefits, self-determination/government, and respect. Though they did not use the specific terminology, most participants thus supported the notion of an Aboriginal rights-based differentiated citizenship, as explored in Chapter 2. That is, most participants conceived of Aboriginal rights as the inherent rights of Aboriginal peoples that exist for them in addition to the rights afforded to all Canadians. It is important to note however, that this was not universally true of participants and that some were uncomfortable with the notion of special rights for Aboriginal peoples (12). The reasons underlying this disquiet varied considerably. Linked to the moral vs. legal imperative for Aboriginal rights noted above, a few participants felt that for example, everyone should have access to education and health services because everyone needs those services. Thus, they appealed to a sense of common humanity to counter the notion of special privilege through rights:

> Because for me, skin colour doesn't matter. It doesn't matter if you're Scottish or like it doesn't matter if you're black or it doesn't matter if you're Aboriginal. You're one person and I guess that's what I have to say is that I respect you for being a human being. (Julia, City, 5-10 years)

Others indicated that they were uncomfortable with Aboriginal rights as they felt that expecting the government to provide for you (i.e. primarily in the context of Aboriginal rights as services/benefits) creates dependency and keeps Aboriginal peoples from obtaining autonomy:

> But we got we have, to learn that how we can look after ourselves like our own and how we can grow. (Katherine, Rural, 5-10 years)

One participant had a slightly different take on the issue and expressed caution at depending on the government to provide Aboriginal rights as he felt sure that soon, no Aboriginal rights would exist, as no Aboriginal peoples that fit the government's definitions of such peoples, would exist. Similarly, a few participants were cautious of Aboriginal rights because they felt that they are the constructions of the Canadian state and do not really represent the views of Aboriginal peoples:

> They make it up for us. They make up all the rights up for us. They don't ask us what our rights are…We know what our rights are, we know what are our rights are, and if you were to ask them, tell them this is what our rights are. Respect these and they are not doing that. (Andrew, City, <1 year)

> In a sense, yes….only because that's what we were told, right? That's your, I guess in a sense, that's your compensation for living on our land and doing whatever. That's our right….but it doesn't feel like a right… It's like, yeah, it's our right. But for what? Like, that's where I get lost. It's our right. Like, the right doesn't seem like it's right, in the right context. (Yvonne, Reserve, 1-5 years)

> I don't like that and I don't do that and I don't hear other people doing that... 'I'm Native and this is my land'…This is nobody's land. If you look back at the history, Natives didn't believe that anybody could only own a piece of land. We don't own nothing, we're just inhabitants right now...we're just taking up space. (Mary, City, 1-5 years)

The sense from these participants was that Aboriginal rights are not in keeping with their worldviews and are not reflective of a reciprocal political relationship between Aboriginal peoples and the Canadian state. Rather, Aboriginal rights feel more like diversions created by the government to keep Aboriginal peoples from engaging in meaningful political negotiations with the state. These perceptions are related to the sense of government distrust that some participants expressed, which will be further explored in the next section focused on *experiences* of Aboriginal rights.

By contrast to this active discomfort with the notion of Aboriginal rights, 12 participants indicated that Aboriginal rights were simply "not something that I think about" (Victoria, City, <1 year), or something that they felt was important, but that they did not feel they knew enough about:

> …I don't even know what treaties are… like land agreements, but I don't even know anything about it and that's what I am saying, I don't know, I don't feel that educated on it. Yeah and that's weird cause I come from a family I have very big source like my father knows a lot about that stuff but that's, but that's, I have to go and source that out, I have to go research and do that, to learn more... (Cynthia, Rural, 1-5 years)

> Oh, hmm. Jeez, that's a really hard question…. because I don't, I don't, unfortunately I don't have enough education. (Marrilynne, City, 1-5 years)

Though the reasons underlying these participants' discomfort with Aboriginal rights differ, together, they suggest that a more critical evaluation of the compatibility of Western liberal

conceptions of rights and Aboriginal political epistemologies is needed (which will be discussed in Chapter 5).

Despite these differing conceptions of Aboriginal rights, it emerged from the interviews that for the most part, participants felt that Aboriginal rights should be accessible to all Aboriginal peoples, regardless of their specific Aboriginal identity or status:

> Like they should be allowed to have that, that right also. Like they are Aboriginal people. They were here first, you know, and just because they didn't sign a piece of paper…doesn't mean they're not Aboriginal people. (Lynne, Reserve, 5-10 years)
>
> Well, Aboriginal rights apply to First Nations, Métis and Inuit, those Indigenous people. (Adam, City, 25+ years)
>
> Your rights should be passed down to your kids, no matter what. (Trevor, Reserve, 1-5 years)

Importantly, participants also spoke directly to the notion that Aboriginal rights should not be geographically bounded to reserves. In contrast to the federal government's spatially inequitable policy on the provision of Aboriginal rights, as explored in Chapter 2, participants in this study felt that their rights should be respected no matter where participants are:

> I think we should have rights no matter where you live, whether it's in the city or on-reserve. I don't think it really matters where you are, to me anyway. That's my opinion. We should have all equal rights at all times. (Beverly, City, 10-25 years)
>
> Well, the Aboriginal and treaty rights should be portable but the government says, you know, because of the *Indian Act*, they can't be portable. (Adam, City, 25+ years)
>
> I think my rights are always going to be with me...so wherever I want to use them I can use them, right? (Trevor, Reserve, 1-5 years)
>
> I just wish that everybody was treated the same. If you're a part of the Band, how is it any different, right? (Nina, Rural, 1-5 years) [in reference to divisions in access to rights between Band members living on and off-reserve]

Overall, participants conceived of Aboriginal rights primarily as the right to specific services/benefits (e.g. education and health care funding), to self-determination/government, and to respect for Aboriginal peoples (e.g. cultures, identities, treaties). Though important and varied misgivings regarding these rights were raised, participants also largely felt that they should be accessible to all Aboriginal peoples, everywhere. However, though it was clear that their

conceptions of Aboriginal rights had a uniform geography, their *experiences* with Aboriginal rights in Toronto point to heterogeneous geographies of Aboriginal rights.

4.3.2.2 Experiences of Aboriginal Rights

The most persistent theme that arose from participants' experiences with Aboriginal rights was the sense that they are not being respected (31 participants). Geographies of rights, in terms of interconnected spaces and scales of rights, factored significantly into this perceived lack of respect for Aboriginal rights in Toronto. Though conceptions of Aboriginal rights among participants centered on services/benefits, respect for Aboriginal cultures/identities and self-determination/government, as explored in the previous section, the latter was largely left out of discussions regarding their experiences of Aboriginal rights in Toronto (the implications of which will be further explored in Chapter 5). Rather, the perceived lack of respect for Aboriginal rights was expressed somewhat abstractly through the lack of respect *for respect* as an Aboriginal right (i.e. respect for Aboriginal cultures and identities, framed by participants as an Aboriginal right, is lacking, as evidenced by the lack of Aboriginal awareness and the discrimination participants experienced in the city, as explored above). More tangibly, participants described their sense that their Aboriginal rights are not being respected because the services/benefits that stem from them are being reduced. These reductions in services/benefits intersect with respect for Aboriginal culture/identity as an Aboriginal right, and play out in geographically specific ways.

The Aboriginal Right to Respect for Aboriginal Cultures and Identities

Framing the perceived lack of respect for specific Aboriginal rights, participants spoke broadly about their sense that their rights are not being respected (20), for example:

> I don't feel like we're being listened to. I think we're just being shunned back. Like, shut to the back burner and it's, like, yeah, okay, we'll deal with it. When the next government comes, we'll hand it off to them and then we have to do the process all over again. (Rebecca, Reserve, 25+ years)

> Our rights? [laughs...] They're horrible. They, we, you know, under the *Indian Act*, we have so many different, so many human rights violations going on… (Yvonne, Reserve, 1-5 years)

As explored in the previous section, some participants described the widespread discrimination and lack of Aboriginal awareness that they experienced in Toronto as a violation of their Aboriginal right to have their identities and cultures respected:

> …they think that… what a culture is, cause… like everybody knows that Natives collect a lot welfare checks and stuff like that, and people think that's our culture. I don't recognize that as my culture….do you know what I mean?...I don't recognize that as my culture. (Cynthia, Rural, 1-5 years)

An important area in which participants described this lack of respect for Aboriginal cultures/identities in the city was through the difficulty in accessing the Aboriginal services and organizations (which were identified by participants as an important means of asserting their identities in the city) upon arrival in the city. In discussing the difficulties in accessing services in the city, the lack of any initial resources for newcomers and the fact that the onus seems to be primarily on the individual to figure out the services in the city, were noted in particular:

> It's hard to, um, find the Native organizations. I know they're here, uh, but it's hard to find them. There's no big list or anything to show you where to go, how to get there, um, schedules, what people to talk to. You just have to figure it out yourself. (Meredith, Reserve, <1 year)

> Maybe they could have, like, something, like for like, newcomers coming from the reserve to here…. They don't know where to go. (Caitlyn, Reserve, 10-25 years)

Related, in describing their perceived lack of respect for Aboriginal rights via respect for Aboriginal identities and cultures, 10 participants made comparisons to other groups in Canada, particularly immigrants, whose rights, it was perceived, were taken more seriously by the government than theirs:

> I don't like to be prejudiced and stuff like that, but sometimes when things like that happen it is just overwhelming sometimes… seeing people getting housing and stuff like that, meanwhile I am on the list, and they just came to Canada and within a year they have a house, a job, a car, or whatever income they have to help provide them; and we are all homeless and that should not be. It should be Native people first and then the rest of the people that come to Canada. The government is all backwards when it comes to that. (Charlotte, City, 5-10 years)

> … look at everybody else, how, you know, how even what is it, the police how, what is it Sikhs? They get to wear their turban, they say that's a religious…like everybody has their right. It's like 'what about us'? You know we have our, you know, rights, or

> religious, you know rights or…Things that should be uh, we should be, you know, allowed to practice too. (Marrilynne, City, 1-5 years)

Clearly, part of what gave participants the impression that their rights mean less to the government than those of other groups in Canada, particularly immigrants, was the seeming mismatch in services, resources and respect for Aboriginal cultures/identities in Canada, compared to other groups.

The Aboriginal Right to Specific Services/Benefits

Somewhat more concretely, 15 participants discussed their sense of a widespread and gradual reduction of the services and benefits that stem from Aboriginal rights as indication of the lack of respect for them. They sensed that treaty rights were being unfairly cut back on and highlighted in particular the changes to Ontario taxation policy in 2010[19] as an attempt to eliminate the tax exemption that they are entitled to. Reductions in health care coverage were also discussed as evidence of this lack of respect for Aboriginal rights:

> I just think that they're just slowly trying to take our rights away…. For instance, our treaty right with the tax. And I think probably, soon enough, they'll try to take away the educational rights. Like, Band funding and stuff. (Lily, City, 5-10 years)

> They only cover for a certain amount of things; there are a lot of cutbacks...a lot a lot a lot... I feel that we are getting less in regards to certain health care things…(Donna, Reserve, 25+ years)

> It is becoming less and less. We are only allowed a certain amount every year. Like for instance your glasses, at one time you could get as many pairs as you need in one year. My son wears glasses and I had to get him three or four pairs a year because he would break them as he is a kid. But now you can only get them every two years. The same with dental work, you can only get a certain amount of dental work. The card will only cover a certain amount but before it used to cover anything….It just feels like it's slowly being taken away from us. It's like they are trying to be sneaky about it, the government. But they are not being sneaky, we know. (Charlotte, City, 5-10 years)

In addition to their widespread erosion, many participants felt that their access to Aboriginal rights-based services/benefits was hindered to some extent in the city (24), compared

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[19] Ontario switched from Goods and Services Tax (GST)/Provincial Sales Tax (PST) to Harmonized Sales Tax (HST), and failed to account for the tax exemption implications for status First Nations at the outset.

to their experiences living on-reserve or in rural areas. In describing their experiences of heterogeneous geographies of Aboriginal rights, eight participants noted services that they simply could not access in Toronto, such as funding for transportation for education and health services, which they had been able to access on-reserve:

> I've tried getting funding for transportation for one of my daughters. I couldn't do that. I couldn't get, not really. Some things you can, some things you can't. For, like, high school, you can't get funding for. For college, you can get funding for. (Rebecca, Reserve, 25+ years)

Further, many participants explained that it was more difficult and complicated to access many services/benefits that stem from Aboriginal rights in Toronto, noting issues concerning tax exemption, education funding and health care funding in particular (24). In terms of the use of status cards, many participants expressed reluctance to use their cards when shopping in the city because it was too much of a hassle for small purchases and they felt discriminated against when they used them:

> But, um, you have to fight to use your status card….Yeah, they [store employees] don't want to fill out the forms. (Alex, City, 1-5 years)

> I think for small purchases if I'm … if I'm only going to save like $5.00 I don't like to because it's a hassle; there's a certain protocol you have to go by, they want to take all your information, sometimes employees don't know how to do it so that people in line will get mad at you… (Nicolas, City, <1 year)

> I don't want to beg, plead or whatever, that is not me and if they say no that is okay. If I am buying something that is a lot of money, if they say no, I will say alright, I will go over here [a different store], it's ok. (Donna, Reserve, 25+ years) [in response to having a store reject her status card]

Further, a few participants noted that in order to be exempt from both federal and provincial tax, proof of address on-reserve is required for some purchases, which means that for the majority of those living in urban areas, there is restricted access to this Aboriginal right:

> …taxation issue with the Status Card, okay, I always leave my, I own a home on the reserve, so I left my driver's license there and they said 'oh, if you move and you live in Toronto for more than um…', you know, I said well my home, that I've lived in for all my life, is over there [on-reserve]. I don't live in it. I rent here in Toronto….if I was to buy, uh, a TV here, uh unless they give you, you live at the reserve, they'll give you the GST and PST. But if you take it, they'll just take the PST off. You still have to pay GST. (Ted, Reserve, 5-10 years)

Implicit in the difficulty that participants expressed in using their status cards in Toronto are the roles of both the lack of respect for Aboriginal identities in the city (e.g. discrimination in using status cards) and the importance of scales, in shaping access to Aboriginal rights. In terms of scales, the lack of communication between the federal, provincial and municipal governments regarding taxation policy changes shaped participants access to Aboriginal rights in Toronto.

The interconnections between spaces and scales in impacting experiences of Aboriginal rights was also quite clear in participants' discussions of their restricted access to education funding and health care funding in Toronto, compared to their experiences on-reserve. Many participants explained that the extensive bureaucracy spanning many scales of government made it confusing and difficult to access the necessary services (19):

> In the old days, you'd go in and just get your teeth fixed. Nowadays it's, now you got to get this approved, you get that approved, and you got to wait, and you got to pay such and such amount. (Ted, Reserve, 5-10 years)
>
> There's time, the whole system of bureaucracy between yes, there's INAC and um, there's like so many different groups that it's so disconnected. There's always a middle man. There's never…there never seems to be a, there's a disconnect with, with partnership I feel. (Nicolas, City, <1 year)
>
> …it's just trying to find a way to, so it will work that the education and the, uh, economic development kind of work together to try and put the money together because it's a lot of money, so....It's just to try and get them to work together to do it. You know because it's coming from two separate locations…. (Lynne, Reserve, 5-10 years) [in reference to accessing funds from her Band council and the government]

As the last quote highlights, access to Aboriginal rights is also importantly shaped by another scale of government, First Nations Band councils (7). When speaking about accessing funding for education, participants noted that Band councils differ in terms of their education funding policies, with differing impacts on participants' abilities to access funding in the city. Some sensed a divide in their communities between those living on and off-reserve, which they felt reduced their access to Band-funded services in the city:

> Just like my treaty money or post-secondary education funding….I've been on the waiting list for two years…. So, it depends on your reserve, what the demand is. And then it goes down to Chief and Council. And then it goes to the post-secondary education. So, by that time it's like, it's really whittled away…. It really depends on your

> reserve….But on mine it has a lot to do with nepotism…. So it depends on your last name. I mean, that's the quiet part about that. (Patricia, City, 1-5 years)

> …being off-reserve, it was kind of a tough, a tough maybe have them understand or you have to present a case, that this is what we want, our son to go to, we got him into a private school…it's um pulling your teeth like for your education. It's a big thing about your education. (Katherine, Rural, 5-10 years)

> If I want, yeah, I could [access education funding through her Band]. But it's just so difficult. It's like a long process and stuff too…. And it's hard for me because I live here and it's just, communication wise. (Linda, City, 5-10 years)

Many participants expressed frustration that they were provided with no assistance in navigating the complex geographies of Aboriginal rights (in terms of both spaces and scales) that they encountered living in Toronto (17). As one participant noted, "[i]t just seems like it is a lot of work you know, to educate yourself about it…you pretty much have to do it on your own" (Nina, Rural, 5-10 years), indicating the difficulty she had experienced in accessing her Aboriginal rights in the city. For some, it seemed that what was lacking was a government will to communicate effectively about how to access one's Aboriginal rights in the city. This was linked to the sense that a fight or struggle was necessary to access these rights in the city. In conjunction with broader frustrations with reductions in services/benefits, this apparent lack of government will contributed to a strong sense of distrust in the government among many participants (12):

> You really have to focus and really, and it's, to try and get help it's, uh, you know that's a challenge too. You have to, you have to know to go to what agency and, um, what department and you know you have to kind of start, you know learning yourself to be able to help yourself. (Marrilynne, City, 1-5 years)

> It's been brought up the last few days, that apology they got for the residential school. And, you know, some people are in acceptance with it. Some people aren't. The first thing, when I heard about it… I said, the next thing is what are they gonna take away now? What is that apology costing? What else are they gonna, these rights that we have? What are they gonna take away now?...Just like, they're always threatening to cut off different things. Again, with the, cause we're not dying out fast enough. We're not getting, you know, the blood thing is not, you know …It's not happening as fast as they wanted it to happen. So, you know, we're still a part of the problem. We're still 'give these Indians their money'. And, there's always, constantly, cutbacks. Like, you know, your eye, you know, coverage is getting cut back. Or you're allowed an exam every two years. Oh wait, it's only if you're diabetic… So, to me that's, like, what is that apology costing? (Yvonne, Reserve, 1-5 years)

> And that's a big thing that bothers me is that they cut the funding. You know, they're always cutting funding to all the, every, every aspect of anything that Native, when it, when they think it's benefiting them or they're moving up they kind of cut it, cut your funding off. And they say oh, well, you know we don't have any more funding or you know and then that's what bugs me. It's like well, look how many millions of dollars you're spending and you're sending out of this country, why don't you take those millions of dollars and put them back into the Aboriginal communities that need it? (Lynne, Reserve, 5-10 years)

Ultimately, the reduced access to Aboriginal rights-services in the city and the apparent lack of effort to provide assistance for Aboriginal peoples to navigate the complex geographies of Aboriginal rights may be indicative of a persistent underlying notion that urban spaces are not Aboriginal spaces, which is explored below.

Implications of Lack of Respect for Aboriginal Rights

Despite the demonstrated restricted access to services/benefits that stem from Aboriginal rights in Toronto, owing to spaces and scales of rights, most participants noted that the city provides better access to services in general, compared to their experiences on-reserve and in rural areas (25). That is, the abundance of other services (e.g. education, health, housing) in the city, and the convenience in terms of transportation, counteracted their restricted access to Aboriginal rights-based services/benefits in the city:

> Well, if you ever were to get sick, like really sick, Toronto's the place to be. If you're going to get sick, do it in Toronto. (Patricia, City, 1-5 years)

> You can always combine different avenues to different communities to help you. There are always people to help you...fix your teeth sort of thing. It doesn't have to be a status card but there have to be some other avenues to go through. (Francine, Reserve, 10-25 years) [indicating that if you cannot access health care as a result of Aboriginal rights, there are other options available to use in Toronto]

For a few participants, the decision to move to Toronto was a trade-off in which heterogeneous geographies of Aboriginal rights factored significantly. In this trade-off, they chose gaining Toronto services at the expense of losing access to the services that stem from Aboriginal rights as the best option:

> I know a lot of people a lot of people talk about you are a member of the First Nation and they are, they do get the resources for their membership but since I don't live on-reserve that it is not accessible. There is a big divide and they say they say there isn't but there

> is….and I don't know, I think, at the end of the day I prefer to live off-reserve…Cause of the opportunities. (Katherine, Rural, 5-10 years)

Thus, urban areas seem to be both spaces that restrict access to Aboriginal rights, but also mitigate this lack of access, through the provision of other services. This raises questions as to how this trade-off plays out in smaller cities, which perhaps provide fewer services than Toronto and thus may serve as a less effective mediator for the restricted access to Aboriginal rights off-reserve.

Ultimately, this trade-off, and the lack of respect for Aboriginal rights in terms of reduced access to the services that stem from them, have deeper implications for the spaces in which Aboriginal identities are deemed legitimate. It is an expression of the broader sense that Aboriginal cultures and identities are not being respected in the city (framed by participants as a violation of Aboriginal rights), and supports the literature examined in Chapter 2 regarding the government's implicit stance that urbanity and Aboriginality are antithetical (Green 2001; Peters 2001). Participants spoke to this sense in contrasting but complimentary ways. In explaining his observation that there are more services in general in the city than on-reserve, Doug said:

> But then again, it's part of the White Paper policy that was established in the sixties… this is their White Paper policy in action….to assimilate… it's like funneling, yeah, that's the word. Funneling us…into the cities financially….By making us move to the cities so we'll become assimilated so they don't have to take care of us financially anymore. (Doug, City, 25+ years)

This perspective indicates that by creating a situation in which the most effective way to access the services that they need is by coming to a city and making use of general services, rather than those that stem from Aboriginal rights, Aboriginal peoples are effectively being made to chose the necessity of meeting their needs over their Aboriginal rights. A contrasting view, which also ultimately points to a sense that urban areas are antithetical to Aboriginal identities, is seen in participants' discussions of the difficulty in accessing Aboriginal rights in the city and the lack of government will to help navigate these complex geographies of rights:

> But now I know there is a Native clinic, but we never knew that on the reserve. They don't show anything, um, in regarding different types of organizations. If you should want to leave the reserve it's just, you have to learn through word of mouth…. Nothing. There's nothing there. [Researcher: Why?] I have no idea. I have no idea. Maybe it's to keep, keep us there? I don't know… (Meredith, Reserve, <1 year)

Overall, these perspectives seem to indicate that in order to have good access to the services that stem from Aboriginal rights, one must stay on-reserve, which is the rightful place for Aboriginal peoples; in order to access to the best services, one can migrate to the city, where access to Aboriginal rights will be restricted. However, it is clear that participants are not assimilating upon arrival in Toronto, and though they have chosen to live in a space that makes it more difficult to access their Aboriginal rights, and thus often access general services in the city, they do so while asserting their Aboriginal identities. It is in this negotiation of the complex heterogeneous geographies of Aboriginal rights that gender differences among participants are apparent.

4.3.2.3 Aboriginal Rights and Gender

For the most part, participants did not identify gender differences in access to Aboriginal rights. Generally, participants noted that this was not something that they had thought much about, but that they felt that access was probably quite equal between women and men. With prompting, a few participants made reference to the impacts of Bill C-31, but opinions on the matter differed greatly. For example, Joselyn, who did not want to be recorded, said that she did not think about the loss of rights to women who married men who did not have status, since it did not affect her or anyone she knew (Reserve, 25+ years). Trevor noted that the Bill C-31 amendments to the *Indian Act* have "balanced everything out" (Reserve, 1-5 years). However, Ted explained that there was reluctance on his reserve to accept people who had regained status as a result of Bill C-31, which he did not agree with:

> It's like the Bill C-31. We don't want those people on here. Go build them a village way up in the, on the hill there somewhere in the bush and I said what? Those are your sisters, those are your mothers and your grandmothers and your aunts and your daughters. (Reserve, 5-10 years)

Judy, who preferred not to be recorded, had had her status reinstated through Bill C-31, and explained that she had played a role in advocating for the amendments to the *Indian Act*, felt that this had helped to rectify the loss of Aboriginal rights that she had incurred (Reserve, 25+ years). By contrast, Adam noted that "we didn't see this coming until, I don't know, a couple of years ago when we found out that this Bill C-31 was not in the best interest of First Nations", explaining the

> legislative extinction of status Indians. That's what it's called. That's what's happening. So because of the second generation cut-off, what the government is doing with their legislative extinction of status Indians so there'll be no more status Indians after that. (City, 25+ years)

Similarly, Yvonne explained that though she wasn't sure about the details, she felt that women have less access to Aboriginal rights than men do:

> You know, even the status, women in the Aboriginal Act. You know, men are still above us. Anything, like, even to do with land rights or anything, those things still, you know, those things, like, even the marriage thing too, you know….Everything, we're just not considered equals. I can't even put it into words right now, but I know we're not. Like, it's not remotely even fair. Like, I've got so many different thoughts in my mind, I can't see to like explain it. I know that we're not. (Reserve, 1-5 years)

It is clear that though Aboriginal women and men living in Toronto did not seem to differ greatly in terms of their conceptions or experiences of Aboriginal rights, perceptions of gendered access to Aboriginal rights varied considerably among participants. Further, their differing experiences of urbanization (as explored in the previous section) suggest that the ways in which they negotiate the perceived lack of respect for Aboriginal rights in Toronto, in terms of a lack of respect for Aboriginal identities/cultures in the city and reduced access to rights-based services/benefits, also differed. That is, participants felt that Aboriginal women in Toronto contributed differently to the reterritorialization of urban space by proactively negotiating the perceived lack of respect for Aboriginal rights in the city, compared to men. Aboriginal women thus challenge the government's spatially inequitable policy on applicability of Aboriginal rights not necessarily by *fighting* for rights in the city, but by creating support systems in the city to deal with their absence. For example, in dealing with the restricted access to Aboriginal rights in the city, women created positive spaces to celebrate Aboriginal identities and cultures in the city, and services to connect Aboriginal women with education, employment, housing resources in the city. Aboriginal women's active role in creating the supports that they need in the city is an important negotiation of the heterogeneous and inequitable geographies of Aboriginal rights that participants identified.

Overall, though conceptions and experiences of Aboriginal rights differed considerably, participants identified Aboriginal rights as services/benefits, the right to self-determination, and the right to respect for Aboriginal cultures/identities. They observed that these rights are not

being respected, as evidenced by the lack of respect for Aboriginal identities/cultures and the reduction in services/benefits. This lack of respect for Aboriginal rights was experienced in distinctly geographic ways, importantly impacted by both spaces and scale of rights. Though gender differences in conceptions and access to Aboriginal rights in the city were not identified by participants, the ways in which these heterogeneous geographies of Aboriginal rights were negotiated did seem to differ between women and men.

4.3.3 Implications of Experiences of Urbanization and Aboriginal Rights on Health

Drawing together their experiences of Aboriginal rights in Toronto, participants identified some interesting health implications. The clearest links were made between narrow interpretations of Aboriginal rights as services/benefits and health, though participants also identified some relationships between their broader conceptions of Aboriginal rights as respect for Aboriginal cultures/identities and health. Though the identified Aboriginal rights-health relationships are largely negative, participants also noted some ways in which they are negotiated in urban space in a more positive manner, namely through supportive Aboriginal community spaces in the city.

The majority of participants (30) discussed their health in holistic terms, noting the medicine wheel specifically, or the importance of relationships and balance between mental, emotional, spiritual and physical states as integral to their conceptions of health:

> I guess, you know, being in balance with, you know, your mental, emotional, spiritual, physical self. And you can feel it when it's off. Like, if one of the elements is off, you know, you're off. And it's always trying, about, like, balance and that's, kind of, your healthy self, you know. (Yvonne, Reserve, 1-5 years)

> Being healthy means being, just being able to eat properly, being able to, uh, live your life in a good way. To just enjoy life, like exercise, you know, take care of everything around you. That's healthy. And to have healthy relationships. To be okay with yourself and then carry that to others, you know. Make sure everybody else is okay and that, to me, that's like a healthy lifestyle. (Lynne, Reserve, 5-10 years)

> [Explaining as he created a visual representation of his conception of health/healing] Well healthy means that you just, I have this and also there's me, and then there's my family and then there's my, next my community. And then on the other side is my Nation. So this to me is the healing, this is the healing process. (Adam, City, 25+ years)

These conceptions are important in fully grasping the links that participants made between Aboriginal rights and their health. Gender differences in conceptions of health were not apparent from the interviews. Almost 60% of the sample indicated that they were healthy (excellent, very good or good health). A higher proportion of women than men rated their health as healthy (57% of women compared to 50% of men), while both of the participants who identified as two-spirited indicated that they were healthy. Again, it is difficult to read very much into these gender differences, as the sample consists primarily of women. However, what can be taken from the interviews is a sense of the ways in which urbanization and Aboriginal rights are related to health, and how this may differ between women and men.

In mapping out the links between experiences of Aboriginal rights and health in Toronto, it is useful to recall the social determinants of Aboriginal health conceptual framework that guides this thesis, as outlined in Chapter 2. This framework draws attention to the ways in which heterogeneous geographies of Aboriginal rights, as an expression of the broad socio-political context, structure immediate determinants, in particular, psychosocial factors, education, employment and health services, and ultimately impact balance between interconnected mental, emotional, spiritual and physical aspects of health. The ways in which participants explained the health implications of their experiences of Aboriginal rights in Toronto can be effectively understood and interpreted using this framework.

Perhaps not surprisingly, given the suggestion in the previous sections that Western conceptions of rights may not fully align with Aboriginal worldviews, many participants had difficulty explaining whether they felt that Aboriginal rights impacted their health; others simply stated they did not feel that there is a link between the two. However, half of the participants indicated that Aboriginal rights, specifically the lack of respect for them in urban areas, do impact their health in some capacity. Many participants (12) explained links between conceptions of Aboriginal rights as services/benefits and their health, noting how they felt that the services themselves and the struggle to access them in urban areas, impacted health. These links can be understood as the direct impacts of immediate social determinants on health, through, for example, education, material living conditions (housing), income (tax exemption) and health services, which have been well established in social determinants of health literature (CSDH 2008; Raphael 2009). As explored in the previous section, access to these rights-based

services is heavily impacted by geographies. That is, spaces and scales of rights impact access to these services, such that Aboriginal peoples living in urban areas have less access to them. Participants described how they felt this negatively impacts health:

> …policies that we were promised that aren't met…that affects my health cause I need those things right? I need those things for my daily living and if they are not given to me then how can I function and try to do what I am trying to do, right? (Andrew, City, <1 year)

> Right now no, but maybe down the line because all the changes that are taking effect, they are not affecting me as yet…the government with the cutbacks and all these things. In regards to my son, and the reserve and the monies, yes I am feeling. In regards to the health and all the health changes and stuff I will probably see that in the next little while. (Donna, Reserve, 25+ years)

> Because some people, some people wouldn't, I don't know. Some people just wouldn't go to the doctor I guess, I don't know. (Janice, Reserve, 1-5 years)

> Well, yeah. Because you know, when you're diabetic, you have to try and take what you can to keep you alive and like some certain pills, they can't pay for me, so I just, nothing I can do. …Cause being on a fixed income, you can't pay like maybe something like thirty something dollars for a bottle of pills. (Lauren, City, 1-5 years)

In addition to the direct impacts of these services/benefits on health, 10 participants explained how they felt that the constant struggle to access them in Toronto also impacts their health. These explanations centered on the negative health implications of another type of immediate social determinant of health, psychosocial factors. In particular, participants noted stress and frustration as important ways in which this struggle relates to their health:

> Yeah, because you always feel like you're always fighting. Like always having a battle. Um, you know, yes definitely…you know, worrying, stress and is it going to happen, are they going to take it away from us, you know…. You're always worried. Are they taking your few pennies away? And lower your standard of living? And where am I gonna have to cut like, you know, you can't buy good food or maybe you have to go to a food bank. You know, and to make up for, because they say to you they won't cover certain medicine and then now where am I gonna have to cut to be able to pay. Yeah, of course, it's always stress and yeah, and it's, uh, it takes away of your well-being and you know, you're definitely affects your health…(Marrilynne, City, 1-5 years)

> … if you're having a stressful time trying to access certain rights or certain services that, that stress could, could definitely uh, be affecting your health. (Nicolas, City, <1 year)

> And then especially with the NHIB thing, is like, even the pharmacy's that way with you… You know, they have to call and then double check and do all of this and you have to have your card. You have to have this. It's like okay, that's acceptable, right? But, it's still a lot of hoops to jump through just to get your medication. And even then, a lot of it is not covered so then you have to go back to your doctor and say okay, this isn't covered. Do you have something equally to it, cause I'm gonna be honest with you, I'm broke. I can't afford, you know, $70 for some antibiotic that may or may not help me. (Patricia, City, 1-5 years)

A few participants indicated that the struggle to access these Aboriginal rights-based services/benefits also intersects with respect for Aboriginal cultures/identities as an Aboriginal right in the specific context of accessing health services in the city, with negative implications for health. Specifically, participants described experiences of discrimination in trying to use their Aboriginal rights-based health insurance in the city and how this negatively impacts their health both because it results in them not getting the care that they need (or forces them to seek care from what they perceive to be a health care professional of lesser quality) and because of the mental/emotional/spiritual health impacts of being belittled and not having your identity/culture/rights respected:

> They're just, like, they basically just say, we don't accept those here. You have to, like – and then you go to, like, a funded optometrist or whatever, dentist – might not be as good as, like, one that, you know, is supposed to be covered. Like, you know what, do you know what I mean? (Janice, Reserve, 1-5 years)

> … you know who can be real jerks are the dentists… a lot of them say, no we don't deal with NHIB….And I go why, is it too much work? I go, all you have to do is and then, you know… 'Oh, well then we have to go through like insurance purposes and when we start work, nah, nah, nah, nah'….I go, you know, it is like my right as an Aboriginal person and an original person of Canada that I'm entitled to this. (Patricia, City, 1-5 years)

In this situation, the restricted access to Aboriginal rights in the city is intimately linked with geographies of rights. That is, the construction of urban space as non-Aboriginal space (as evidenced by the discrimination), combined with the complicated scales of government that one is required to navigate in order to access these rights in the city, come together in a health care context to limit access to health services, which negatively impacts health.

A few participants described other ways in which the lack of respect for Aboriginal cultures/identities (as an Aboriginal right) impacts their health in the city. The discrimination,

stereotyping, and struggle to be recognized as a distinct group with specific cultural identities in the city can take a toll on mental, emotional, spiritual and physical health over time. In explaining how he felt that lack of respect for Aboriginal rights impacted health broadly, one participant explained that the government's denial of Aboriginal cultures and identities, specifically Aboriginal healing practices, was detrimental to health:

> Because the Canadian government policies or legislation outlawed our identity. They outlawed our languages. They outlawed our culture. So I think medicine, Aboriginal medicine is an Aboriginal right and, cause before, they outlawed our identity, they outlawed our languages, they outlawed our culture and we, cause we weren't to talk our language in the Native residential schools. And we weren't allowed to participate in ceremonies and sweat lodges. All those were taken away from us…(Adam, City, 25+ years)

Related, another participant noted that the lack of respect for Aboriginal cultures/identities, as evidenced by broken treaties and agreements, is something that Aboriginal peoples are still in the process of healing from:

> Yes and to be able to tell people how I feel about it is even better because Native people are trying to heal themselves as we speak... through all the treaties and all the stuff that was taken away. They are not honoring the treaties and people are still trying to heal themselves over that for hundreds of years. (Charlotte, City, 5-10 years)

Linking the health implications of this lack of respect specifically to her experience in Toronto, another participant explained that "it takes a lot of stamina to keep your perseverance up and self-esteem to live in this city", indicating that it can be challenging to deal with the consistent disavowal of one's identity/culture in the city (Meredith, Reserve, <1 year).

Overall, the ways in which participants explained relationships between health and their experiences with Aboriginal rights in the city highlight the toll that having to navigate the complex and heterogeneous geographies of Aboriginal rights in urban areas, with the interrelated weight of having little government support and effectively being told that you do not have a place in the city, can take on health. However, despite these decidedly negative links between health and the lack of respect for narrow and broad conceptions of Aboriginal rights in the city, participants discussed some important ways in which they cope with these challenges. Participants spoke about the ways in which engaging with their culture in the city is good for their health:

> I need to do that, yeah. In order for my physical health and my, like, to be on the, like, up and up, I have to take care of me mentally and, like, spiritually. Spiritually, I get taken care of when I go to the socials on Thursday and hear the drum. I participate in ceremonies. It's just – and then, we talk afterwards and we talk about, you know, or we sing, or we sing with the drum. That takes care of me, like, just emotionally. (Rebecca, Reserve, 25+ years)

> I think I've done a lot of growth, like, spiritually and emotionally out here. Just because it's a different environment. You know, like, I don't know everybody here and there's not the fear of being judged, like, you know, they have different, they have health centres and different programs and different services... (Yvonne, Reserve, 1-5 years)

In talking about hip hop as a "social and cultural response to oppression and colonization through creative art forms", one participant framed his engagement with his Aboriginal identity/culture in the city as a form of resistance to the lack of respect for Aboriginal rights in the city and explained how this positively impacts his health:

> Ah, if you look the art forms of hip hop there is dancing, there is MC-ing, graffiti and B-Boying and DJ-ing…you break down to this when you do these things we are expressing our medicine wheel. We are expressing our physical, our mental, emotional and spiritual self and that's, that's an ancient spirit. Cause if you look at MC-ing or rapping, I am going to give you like kind of like a parallel, cause it's like storytelling, right. It's like it's like oral tradition cause it's the microphone commander. The person telling a story is kind of like an MC or a rapper. Kind of like a chief talking amongst his people right so if you can look at it that way. And then there's the dance, which is like, I mean our ancestors dance for everything I mean uh somebody had a baby you know they would do a dance…It was always about celebrating life, so dancing was a big thing right. So we have round dance, hollow dances all these different types of dance and then there is DJ-ing which is like the centre piece of the music right, hip hop. So if you look at it, it's kind of like the drum. It's kind of like you know you have that hand drum. As soon as somebody hits that hand drum I mean you feel like the energy right. You feel like you are captivated. Everything you are paying attention to turns off. Cause music does a lot things to a person right, I mean that. So it's beautiful right so and then there is also graffiti. Graffiti is kind of to me kind of reminds me of our ancestors who etch on stones and stuff like that. Etch little, little I mean they used to etch characters they used to etch little writings on stones and it's kind of like ancient even like hieroglyphics on the pyramid you know. That was like graffiti so I am just giving you an understanding of how that spiritual energy of ancient energy is vibrant in today in today's hip hop right… When I am doing these art forms I mean like nothing else in the world matters to me right now. All is me focusing on this piece and you know I get this bliss from it. It really helps me…you can find yourself through these art forms and this music and in this movement and use that movement to put onto other people. Pave the way make people see the light for themselves you know. And I think that's how like people start living better lives. It's an example anyways cause we do it hip hop. People do it people have different ways of

> doing it I mean hip hop is just our thing right. People can take that energy and use it into beading or learning how to chop wood… (Andrew, City, <1 year)

In connecting with their Aboriginal identities and cultures in the city, these participants are both helping to mitigate the negative health impacts of the lack of respect for Aboriginal rights in the city and contributing to the reterritorialization of the urban space of Toronto.

Interestingly, another means of dealing with the negative health implications of the lack of respect for Aboriginal rights in Toronto that a few participants identified was through efforts to create and maintain balance, an important component of conceptions of health described by participants. Specifically, participants talked about urban mobility between the city and the reserve as a way of coping with the stress and constraints of the city:

> Summertime I will go up. We have family reunion in the summer and a big pow wow and then the pow wow trail. I try to maintain balance the lifestyle of living in the city and trying to still be me, who I am culturally. (Donna, Reserve, 25+ years)

> Yeah, going back, I felt like there is something part of me, I got, always got to be back there. Either, whatever I am doing right now in my life, I feel like got to [go] back there cause like…the city and I can't do that here. I am not free to do just, go out and do it … (Andrew, City, <1 year)

One participant explained how she used to go back to her reserve when she felt the need to "recharge [her] batteries" due to the stresses of the city, but that her lifestyle was such that she could no longer feasibly do that (because of the time constraints of school and work), so she had to make an effort to establish that same feeling of balance while remaining in the city. She explained that engaging with the Aboriginal community in Toronto was an important means of achieving this:

> But those things [Aboriginal community resources], I think, why I seek them out now is just the importance, because I'm spending more time here. But I need to find that balance here that, kind of, reflects home. So I'm not going back and forth as much… Even when I miss it. Like, you know, like, my first year here, my only solution was to go home. Now, it's like, realistically, I can't. I could, but I'm also trying to challenge myself, like, you need to learn to, you know, cope with things here and not just, kind of, run of back and forth like I used to. (Yvonne, Reserve, 1-5 years)

Other participants also spoke specifically about the important role of the Aboriginal community in Toronto in helping to deal with the negative health implications of the lack of

respect for Aboriginal rights in the city. The Aboriginal service organizations that contribute importantly to this sense of Aboriginal community in the city help to mitigate the effects of the lack of respect for narrow interpretations of Aboriginal rights (services/benefits) by helping peoples to navigate the complicated terrain of heterogeneous geographies of Aboriginal rights in the city. They also provide an important buffer for Aboriginal peoples in terms of the negative health implications of the lack of respect for Aboriginal cultures and identities in the city. This is achieved through the provision of social support and the opportunities to engage with Aboriginal cultures (as explored in section 4.3.1). Participants noted how the Aboriginal community in Toronto is an important source of healing and support that they draw on to deal with the discrimination that they face in the city:

> …in the Aboriginal community I find in the urban sense that when you're, when you're encircled by our people you're protected… like strongly, like we are, and then we have to go out of it, out of that circle and go back to daily life. And that's when all this troubles happen, right. Your self-esteem shhh like that [decreases], and you know, um, if you're too happy people think that uh you're drunk or you're high because you're Aboriginal, right. (Alex, City, 1-5 years)

> … they still go for the terms 'squaw, blah blah blah'….Oh yeah, now I am able to shake it off or laugh it off. Before I couldn't do that, I would get so upset and cry. Sometimes I would go home and just cry that is how bad it used to get back then. Being in the Native community, it helps to deal with that…what you learn in the Native community too, is about healing and how to heal yourself. (Charlotte, City, 5-10 years)

In considering the ways in which the Aboriginal community in Toronto can serve as an important means of coping with detrimental health effects of the lack of respect for Aboriginal rights in the city, it is important to consider the gender differences identified by participants in terms of the availability and access to these resources in Toronto. Specifically, participants perceived a greater availability of Aboriginal resources and a greater degree of social support among Aboriginal women than men the city. This was importantly linked to women's effective role in advocating for their needs in the city through the creation of the resources and services that they need. Aboriginal women in Toronto thus contribute to the reterritorialization of urban space through asserting their identities and cultures (via Aboriginal services provision) in the city, in ways that were perceived by participants to be more effective than men. They do so not necessarily by fighting for recognition of Aboriginal rights in the city, but by developing systems and resources that help to mitigate and cope with the lack of respect for them in the city. The

social support and positive spaces in which to connect with Aboriginal cultures/identities in the city may thus more effectively buffer Aboriginal women's health from the negative health effects of the lack of respect for Aboriginal rights in the city than Aboriginal men's health in Toronto.

4.3.4 Summary

Ultimately, the results presented in this Chapter suggest that Aboriginal rights do impact the health of Aboriginal women and men living in urban areas, and that this occurs in geographically specific ways, owing to heterogeneous geographies of Aboriginal rights. Results also suggest that while Aboriginal rights-health links exist, hypothesized better health outcomes among those with the best access to Aboriginal rights are probably too simple as they do not account for the ways in which women and men navigate and negotiate the complex heterogeneous geographies of Aboriginal rights in urban areas. Further, though it is difficult to make strong inferences about gender differences because of the skewed composition of the sample, results suggest that Aboriginal women may be more effective than men at negotiating the negative health implications of the widespread lack of respect for Aboriginal rights in urban areas. The implications of these results will be further discussed in Chapter 5, along with some final thoughts and future research questions.

Chapter 5

5 Discussion and Implications

5.1 Summary of Key Findings

This thesis sought to examine the links between gender, Aboriginal health and Aboriginal rights in an urban context by answering the following research question: How are Aboriginal rights implicated in urbanization and what effect does this have on the health of Aboriginal women and men living in urban areas? In addressing this question, three interrelated research objectives were pursued: (i) to develop an understanding of how urbanization may differentially impact the health status of urban Aboriginal women and men at a national level, with attention to a potential role for Aboriginal rights, (ii) to expand understandings of gendered dimensions of urbanization, focused in particular on the role of Aboriginal rights in shaping these processes and how they are related to health, and (iii) to generate knowledge that will help to create an impetus to include urban Aboriginal perspectives in discussions on health care and rights, ultimately informing public policy. Guided by a social determinants of Aboriginal health conceptual framework, mixed quantitative and qualitative research methodologies have been used to pursue the first two objectives. This chapter discusses some important findings from this two-phased research project and draws attention to some practical, policy-oriented concerns, in an effort to address the third objective.

Chapter 3 presented the results of statistical analysis of associations between urbanization and health among urban Aboriginal peoples in Canada using the 2006 APS. This analysis contributes to improved understandings of the health of urban Aboriginal peoples, showing that urban Aboriginal women and men differ in terms of health outcomes (higher levels of chronic health conditions among women, as seen in raw cross tabulation and logistic regression analyses, but better self-rated health among women in logistic regression analyses). Further, the analysis indicates that important links between urbanization and health exist among this population, and some of these relationships differ by gender. In particular, moving for family reasons is predictive of worse health among urban Aboriginal women, but not men, suggesting that moving for such reasons may take a particular toll on the health of women, perhaps through the stress and strain associated with being the primary providers for children. A significant relationship

between mobility and health was detected through logistic regression analysis, indicating that those who are more mobile are less healthy, though there was some suggestion from the cross tabulation analysis that higher levels of mobility may be associated with better health outcomes, in some cases. Self-rated health among long-time urban residents was found to be worse than among both recent urban residents and life-long urban residents, with a more consistent association found among men than women (i.e. among men, long-time urban residents are less healthy than recent urban residents and life-long urban residents, while among women, long-time urban residents are less healthy than recent urban residents, but not life-long urban residents). Though an attempt was made throughout the analysis to examine how Aboriginal rights may factor into these relationships by examining Aboriginal identity and status as proxies for Aboriginal rights, the results were difficult to interpret and it was noted that these may not be the most effective proxies, since they may not necessarily confer better access to Aboriginal rights in urban areas (see discussion in the following section). Chapter 3 concluded by noting that while these national statistical findings are interesting and important in framing further approaches to examining urbanization-health-Aboriginal rights relationships, they are difficult to interpret without more contextual information.

The in-depth interviews with 36 Aboriginal women and men living in Toronto presented in Chapter 4 sought to examine the ways in which Aboriginal rights and urbanization are related to one another, how they impact health, and how this may differ between women and men. In discussing their experiences in Toronto, participants highlighted the widespread lack of Aboriginal awareness in the city, expressed in the forms of discrimination and stereotyping, and the important role of Aboriginal service organizations in creating a sense of Aboriginal community in the city, which enabled them to connect with their culture and to learn from each other as a diverse urban Aboriginal community. These interview themes set the context and inform the links between Aboriginal rights and health that participants identified. Aligning quite closely with the broad and narrow conceptions of the content of Aboriginal rights recognized by the federal government, both women and men in this study conceived of Aboriginal rights largely as the rights to specific services/benefits, self-determination/government and respect for Aboriginal cultures and identities. Where participants differed significantly from the government's stance was in their conceptions of the rightful *applicability* of Aboriginal rights.

That is, in contrast to the very limited identities and spaces in which the government recognizes a legitimate claim to Aboriginal rights (i.e. status First Nations living on-reserve), many participants felt that all Aboriginal peoples, regardless of their status or place of residence, should be entitled to these rights.

Not surprisingly, despite this inclusive perspective, the participants' experiences of Aboriginal rights told quite a different story. In fact, they perceived a widespread lack of respect for Aboriginal rights, an important part of which resulted from heterogeneous geographies of rights that ensure restricted access to Aboriginal rights for those living in urban areas. Their perceptions of the lack of respect for and restricted access to Aboriginal rights in Toronto were rooted in the discrimination they regularly faced in the city (lack of respect for respect as an Aboriginal right), the gradual erosion of their services/benefits, and the specific difficulty in accessing these services/benefits in the city. This difficulty was linked largely to the bureaucratic complexity generated by confusion between different scales of government, the apparent unwillingness of governments to assist in navigating this complexity, and the discrimination that they faced in the city in utilizing their services/benefits (e.g. in making purchases with status cards or using NIHB for health care costs). Ultimately, this lack of respect for Aboriginal rights seems to reinforce and further propagate the notion that Aboriginal identities are out of place in urban areas, though of course, these ongoing colonial constructions have not gone uncontested. It is in examining the ways in which Aboriginal women and men negotiate and contest these colonially defined geographies of rights, through the reterritorialization of urban space, that the potential for gendered health implications can be most clearly seen.

The main ways in which participants expressed relationships between lack of respect for Aboriginal rights and health were through Aboriginal rights-based services/benefits, as well as the stress and frustration associated with the struggle to access these services/benefits in Toronto. These represent familiar immediate determinants of health such as education, income (tax-exemption), health care and psychosocial factors. They are also linked importantly to the third means through which participants expressed Aboriginal rights-health links: the lack of respect for Aboriginal cultures and identities (as an Aboriginal right), as experienced through persistent discrimination in Toronto, which negatively impacted health by way mostly of psychosocial factors. The examples of participants' experiences of discrimination in trying to use NIHB in

seeking health care in Toronto illustrate one specific way in which heterogeneous geographies of Aboriginal rights are implicated in health: the construction of urban space as non-Aboriginal space (as evidenced by discrimination in health care setting), combined with the complicated scales of government that one is required to navigate in order to access these rights in the city, come together in a health care context to limit access to health services, which negatively impacts health. Overall, the ways in which participants explained relationships between health and their experiences with Aboriginal rights in the city highlight the toll that having to navigate the complex and heterogeneous geographies of Aboriginal rights in urban areas, compounded by the implicit governmental message that one's culture/identity are not respected in the city, can take on health. The interviews also suggested various ways in which Aboriginal peoples negotiate and cope with these affronts. In particular, they highlight the importance of connecting with their cultures in the city, finding ways to maintain balance, and drawing social support and other resources from the Aboriginal community in Toronto, as important ways of dealing with the negative health effects of the lack of respect for Aboriginal rights that they experience in the city. As it was perceived by participants that Aboriginal women in Toronto are more effective than men at advocating for their needs and coming together through Aboriginal community and service provision to support one another, they may suffer less from these negative health impacts than men.

5.2 Discussion of Overall Findings

In considering the implications of these findings, a few issues warrant further discussion. As summarized in the previous section, conceptions of Aboriginal rights among participants focused predominantly on the rights to specific services/benefits, self-determination/government and respect for Aboriginal cultures and identities, which participants thought should be accessible equally to people of all Aboriginal identities and all geographies. However, an examination of the diversity and nuances within these primary themes among participant responses reveals the need for a more critical evaluation of the compatibility of Western liberal conceptions of rights with Aboriginal worldviews. As noted in Chapter 4, some participants framed their discussions of the content of Aboriginal rights not in terms of *rights*, but rather in terms of *needs*. The moral imperative implicit in the responses of these participants stands in contrast to the legal imperative for Aboriginal rights recognized by the federal government and

regularly drawn on in Aboriginal rights literature (Kulchyski 1994; Asch 2001a). As an extension of this moral imperative, some participants felt uncomfortable with the notion of Aboriginal rights as a unique and distinct legal entity as they felt that all people should be entitled to the types of supports afforded by Aboriginal rights, by virtue simply of the fact that they are human. These perspectives on Aboriginal rights seem to be more in keeping with Aboriginal worldviews, based on respect for and reciprocity among all beings (Blue, Darou et al. 2002; Hart 2010). Related, it has been suggested that Aboriginal ways of knowing are fundamentally at odds with the discourses of contemporary Aboriginal rights, and that these differences can only begin to be reconciled “once a vigorous intellectual culture allows indigenous voices to help determine the normative language used for defining the meaning and content of Aboriginal rights discourse” (Turner 2006 p. 120). Still, a majority of participants in this study did conceive of rights in ways that were largely aligned with Western liberal Aboriginal rights as articulated by the federal government. Over the course of the interviews, even those participants whose responses raised these interesting underlying theoretical questions about the compatibility of such conceptions of Aboriginal rights also often discussed Aboriginal rights from a Western liberal viewpoint, suggesting that the two may not be mutually exclusive. Rather, it may be that the differing Aboriginal and Western epistemologies at the root of conceptions of Aboriginal rights stand in tension with one another and are reconciled by Aboriginal peoples variably, depending on specific contexts.

Another finding that warrants further scrutiny in terms of conceptions of Aboriginal rights is linked to the differential ways in which participants’ discussed their conceptions of, and experiences with, self-determination as an Aboriginal right. Despite the frequent discussion among participants of the right to self-determination in a theoretical sense, in terms of what Aboriginal rights *should* look like, it was rarely discussed in a practical sense, in terms of their experiences of Aboriginal rights in Toronto. Perhaps as the right to self-determination is normally contingent on a specific land base, participants envision self-determination more in the context of their reserves and Bands rather than in an urban context (Walker 2006). This points to important questions regarding the possibility of urban self-determination, the necessity of having a specific land-base on which to exercise this political autonomy, and the ability (and desirability) to reconcile the vast diversity of the Aboriginal population in Toronto under an

autonomous self-determining political body associated with a specific urban location. Further to these important considerations, this already highly complex and contested issue in the context of Canada as a nation-state is made even more complex by factors such as the multiple overlapping scales of government coming to bear on the overlapping physical spaces of the city. It is beyond the scope of this thesis to consider further the practical manifestations of the Aboriginal right to self-determination in urban areas, but it is certainly an important area that warrants further investigation.

Given that a focus throughout this research has been on investigating gender differences in terms of relationships between Aboriginal rights, urbanization and health, it is important to consider how the contributions of this research compare to the literature in terms of these gendered relationships. In discussing perceptions of gender differences in Aboriginal rights, a vast array of responses ranging from the strong impression that the situation is still wholly unfair for Aboriginal women to the assertion that there were absolutely no differences between women and men in terms of Aboriginal rights, arose among participants. However, neither gender differences in conceptions of, nor experiences with, Aboriginal rights in Toronto were found among participants in this study. This stands in contrast to the literature reviewed in Chapter 2, which suggests that Aboriginal women may be disproportionately affected by spatially inequitable government policy on the applicability of Aboriginal rights, as they are overrepresented in urban areas and have borne the historical brunt of greater colonial subjugation than their male counterparts (Peters 1998; NWAC 1999). It then follows that the gendered spatial manifestations of Aboriginal rights would elicit differences between women and men, both in terms their roles in reterritorializing urban space and in terms of implications for their health. The fact that the findings of this research do not align completely with these expectations (i.e. gender differences in access to Aboriginal rights were not found, but differences in the ways in which women and men contribute to the reterritorialization of urban space were found) may be reflective of the sample composition, which is an important limitation of the study that should be acknowledged. That is, participants consisted primarily of First Nations women who had status. It is therefore possible that they had been less directly affected by the gender discrimination in the *Indian Act*, and so were less likely able to speak to the specific effects of such discrimination on their experiences of Aboriginal rights. Further investigation of these relationships among

Métis, Inuit and non-status First Nations peoples, including importantly, the voices of more men, are important areas for further research. Another factor that may contribute to the absence of gender differences could be that the overwhelming lack of respect for Aboriginal rights experienced by all Aboriginal peoples trumps any gender differences that might exist, making such differences less perceptible. However, despite the potentially homogenizing effects of this widespread disrespect for Aboriginal rights, owing to its severity, important gender differences in the negotiation of this lack of respect, with potentially different outcomes for health, did emerge.

This gendered negotiation of heterogeneous geographies of Aboriginal rights highlights the important health implications that emerged from this analysis. As summarized in the first section, participants expressed links between Aboriginal rights and health by way of specific services/benefits, the struggle to access these services/benefits in Toronto, and through respect for Aboriginal cultures/identities as an Aboriginal right. These links are interestingly interrelated. The interviews suggest that the struggle to access services/benefits in the city is linked to complex spaces and scales of rights, which negatively impact health by way of the discrimination, stress and frustration that they are associated with. These theoretical pathways are helpful in interpreting national level results from Chapter 3. Specifically, the negative health toll described by participants, in terms of the lack of respect for their cultures and identities, and the discrimination and ignorance that they are continuously met with in the city, suggests a possible way of understanding the finding that long-time urban residents are consistently less healthy than recent urban residents. This is supported by research in the broader health literature that has examined the specific impacts of racism on health outcomes, in which mental health implications are found to be an important part of the pathway (Paradies 2006).

A related issue that arose from the interview analysis centered on the restricted access to the services/benefits that stem from Aboriginal rights in Toronto and how this has effectively forced many Aboriginal peoples living in the city to seek services provided for the general city population. It was suggested that the increased availability of such services in a large city such as Toronto may serve to mitigate the detrimental health effects of being able to access Aboriginal rights-based services/benefits in the city. However, studies examining mainstream health service provision in Canadian cities have found a reluctance among services providers to create space for

and accommodate the specific cultural-health needs of Aboriginal peoples, which raises concerns as to how effective the mainstream health care services will be in meeting the needs of growing urban Aboriginal populations who are largely being denied the heath service supports that their Aboriginal rights should provide (Kurtz, Nyberg et al. 2008; DeVerteuil and Wilson 2010). Related, this raises questions as to the degree to which these findings are city-specific; it is likely that relationships between Aboriginal rights and health will differ between urban areas, which is an area of investigation that should be considered in future research.

The lack of respect for Aboriginal cultures/identities also has negative implications outside the realm of service provision. In dealing with the negative toll that the lack of respect for Aboriginal cultures/identities in the city takes on their health, participants sought to redouble their engagement with this identity. While the importance of connecting with Aboriginal identity/culture for adjustment in urban areas has recently emerged in Aboriginal urbanization literature (in contrast to earlier literature, which assumed that urbanization was accompanied by loss of culture, as explored in Chapter 2), it has not been specifically linked to implications for health, nor has is it been discussed in the context of Aboriginal rights (Janovicek 2003; Peters 2011). Participants spoke about the many ways in which engaging with their cultures/identities in the city positively impacted their health, most of which was facilitated through the Aboriginal community in Toronto.

As the ‘Aboriginal community in Toronto’ has been discussed a great deal throughout this thesis, it is important to consider the phrase more closely. Specifically, though used in a general way for simplicity, it is important to acknowledge that the ‘Aboriginal community’ in Toronto is very diverse and has different meanings and functions differently in the lives of differently peoples. This was abundantly clear in the interviews as participants shared, for example, opposing experiences with this community in terms of the sense of underlying tensions resulting from different Aboriginal identity/status groups and the degree to which the community felt welcoming and inclusive. Further, it is reasonable to assume that the population that is often lumped together as the ‘Aboriginal community’ in the city is even more diverse than those represented by the sample, because interview participants represent a somewhat narrow cross-section of the community as they are largely status, First Nations, women, many of whom are already service users. It is important to acknowledge this limitation as it could have implications

for the ways in which participants spoke about the role of the community in relation to Aboriginal rights (e.g. the fact that many of the participants were services users might mean that the perceived importance of the positive role of Aboriginal community-services in mitigating the negative implications of the lack of respect for Aboriginal rights could be greater among the sample than among other peoples in the Aboriginal community in Toronto). It is therefore important to acknowledge the plurality of voices shared in this research in an effort to avoid the problematic homogenization and false representation of the diversity of the Aboriginal community in Toronto, while at the same time attempting to tease out common themes and relationships from the interviews that may help to potentially inform policy.

A related concern lies in the easy equation of the health promoting impacts of the Aboriginal community in Toronto as a means of coping with the implications of the lack of respect for Aboriginal rights in the city. Without denying the importance of the supportive role of the community, this cannot be the only source of restitution for this denial of Aboriginal rights. This caution is offered with a mindfulness of the critiques of much social determinants of health based research noted in Chapter 2, and related critiques of the burgeoning social capital – health research, focused on the ease with which research findings related to the positive potential of community initiatives and support can be used as an excuse for government neglect and cutbacks on funding (Raphael, Curry-Stevens et al. 2008; Takahashi and Magalong 2008; Muntaner, Sridharan et al. 2009). Despite these important cautions, the social support and opportunities to engage with identity affirming cultural practices that participants gained from the Aboriginal community in Toronto were important in helping to mitigate the negative health implications of the lack of respect for Aboriginal rights in Toronto among participants. This finding is in keeping with Aboriginal health literature that has examined relationships between social support and health, though these too have importantly highlighted the need to examine the role of social support critically (Richmond, Ross et al. 2007; Richmond and Ross 2008).

5.3 Implications, Recommendations and Future Considerations

In an effort finally to address the third research objective to inform public policy, it is important to note what can be taken from these findings and to offer some policy recommendations. Overall, this mixed methods research suggests that Aboriginal rights are importantly implicated in the health of Aboriginal peoples living in urban areas, and that these

relationships play out in gender and geographically specific ways. The results suggest some specific areas in which improvements should be made in terms of increasing understanding of these complex issues and easing detrimental effects on the health of Aboriginal women and men living in urban areas. As Aboriginal rights and urbanization do seem to be implicated importantly in health among urban Aboriginal peoples, amendments to the APS that would allow it to generate more useful data regarding the complexity of urbanization (e.g. context surrounding reasons for moving, further detail on place of origin), culturally specific health measures (e.g. incorporate the medicine wheel into questions regarding health) and Aboriginal rights (e.g. include questions about the use of rights based service/benefits and barriers to access), which could be used to further explore the intersections of these themes at a national level, are recommended.

Further, in an effort to address the widespread lack of respect for Aboriginal rights, the most widely discussed experience concerning Aboriginal rights among participants, it is recommended that improved education throughout the country, and in particularly in cities, regarding not just the histories and traditional ways of Aboriginal peoples, but also their contemporary political, economic and social presence in the country, be introduced through education. It would likely be most effective if such education initiatives were led by Aboriginal peoples, but supported and disseminated widely. Improved education and awareness about Aboriginal issues was raised by many of the participants in the study. This would ameliorate the situation in terms of the lack of respect for Aboriginal rights both through increased understanding of and thus respect for cultures and identities as an Aboriginal right and reduced discrimination in accessing the services/benefits that stem from Aboriginal rights. This would then likely reduce the negative health implications that such a lack of respect takes on the health of urban Aboriginal peoples. Initiatives that increase recognition of Aboriginal peoples in cities, for example through representation in the public spaces of the city, could be a part of such efforts to increase awareness about Aboriginal issues. Further, holding events that fostered communication and positive dialogue between Aboriginal communities in Toronto and the rest of the city would be another helpful way of contributing to this education, as people are probably more likely to learn from specific positive personal encounters than top down campaigns, though they both play an important role.

Another important implication of this research is the highly important role of Aboriginal service providers in the city in creating a sense of community for Aboriginal peoples and related, in providing an invaluable source of social support and cultural resources that help to mitigate the detrimental health impacts of the lack of respect for Aboriginal rights in the city. It is hoped that this research might help to maintain and possibly bolster funding from any and all scales of government that could be convinced that they have a role to play in ensuring the health and well-being of Aboriginal peoples living in urban areas.

This relates to a final important recommendation, to improve transparency in terms of complex and heterogeneous geographies of Aboriginal rights. Many participants expressed frustration and a deep distrust of the government as a result both of the unexplained reductions in the services/benefits that stem from Aboriginal rights, and the confusion resulting from the incoherence of multiple overlapping scales of government that they are required to navigate in utilizing their Aboriginal rights-based services/benefits in the city. The seeming unwillingness of governments to assist in this navigation contributes further to the sense of government ill-will. Thus, a relatively simple recommendation is to take measures to reduce the complexity by providing clearer directions and guidelines for the provision of Aboriginal rights, particularly in cities. In order to do this effectively, the active engagement of the Aboriginal peoples that the streamlining would seek to impact, would be imperative.

Of course, there is no easy solution to the culmination of an oppressive colonial history resulting in fraught relations between Aboriginal peoples and the Canadian state. However, as participants implied in the ways in which they discussed Aboriginal rights, taking steps to improve their everyday lives, working within the confines of an admittedly frustrating and dysfunctional system, while simultaneously working towards more fundamental restructuring of political relationships between Aboriginal peoples and the state, seems the best course of action.

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Appendices

Appendix 1: Age Stratified Overview of Socioeconomic, Demographic, Urban Mobility and Health in Urban, Adult, First Nations and Métis Sample

		Gender			Aboriginal Identity			Status		
	Total Population	**Female**	**Male**	**P**	**First Nation**	**Métis**	**P**	**Status**	**Non-Status**	**P**
SOCIOECONOMIC and DEMOGRAPHIC VARIABLES (%)										
Age										
Combined/Unstratified	100	56.5	43.5		53.8	46.2		39.4	60.6	
20-34	35.4	57.8	42.2		54.6	45.4		42.2	57.8	
35-54	45.8	55.8	44.2		53.1	46.9		37.5	62.5	
55+	18.8	56.1	43.9	ns	54.1	45.9	ns	38.9	61.1	***
Education										
Less than High school	**23.1**	**21.6**	**24.9**		**26.2**	**19.4**		**27.9**	**19.9**	
20-34	19.5	17.4	22.3		24.2	13.8		25.6	15.0	
35-54	19.3	17.1	22.2		21.4	17.0		23.0	17.1	
55+	38.8	40.7	36.4		41.6	35.5		44.2	35.5	
Completed High school	**16.0**	**15.3**	**16.9**		**15.3**	**16.9**		**14.2**	**17.2**	
20-34	18.3	16.0	21.3		17.7	19.0		15.6	20.2	
35-54	16.2	15.9	16.7		14.9	17.8		13.8	17.7	
55+	11.2	12.5	9.6		11.5	10.8		12.1	10.6	
Some Post-Secondary	**17.4**	**17.6**	**17.1**		**18.3**	**16.4**		**17.8**	**17.2**	
20-34	23.4	25.0	21.0		24.0	22.6		23.6	23.2	
35-54	15.1	14.7	15.6		16.3	13.8		15.7	14.8	
55+	11.9	10.3	13.9		12.3	11.3		10.9	12.4	
Completed Post-Secondary	**43.5**	**45.4**	**41.0**	***	**40.2**	**47.4**	***	**40.1**	**45.7**	***
20-34	38.9	41.5	35.4	***	34.1	44.6	***	35.2	41.6	***
35-54	49.3	52.3	45.6	***	47.4	51.4	***	47.5	50.4	***
55+	38.1	36.5	40.0	**	34.5	42.3	**	32.8	41.5	***
Employment Status										
Employed	**68.3**	**63.0**	**75.1**		**63.4**	**73.9**		**62.0**	**72.3**	
20-34	72.1	65.6	80.9		66.8	78.3		63.6	78.2	
35-54	77.0	72.3	82.8		72.7	81.7		71.77	80.1	
55+	39.9	35.3	45.8		34.7	46.1		36.2	42.3	
Unemployed	**31.7**	**37.0**	**24.9**	***	**36.6**	**26.1**	***	**38.0**	**27.7**	***
20-34	27.9	34.4	19.1	***	33.2	21.7	***	36.4	21.8	***
35-54	23.0	27.7	17.2	***	27.3	18.3	***	28.3	19.9	***
55+	60.1	64.7	54.2	***	65.3	53.9	***	63.8	57.7	*
Income										
<$10,000	**22.0**	**25.2**	**18.0**		**25.0**	**18.7**		**27.8**	**18.3**	
20-34	27.4	30.0	23.8		31.4	22.6		34.4	22.3	
35-54	17.9	21.0	14.0		20.3	15.3		23.3	14.7	
55+	22.1	25.8	17.4		24.0	19.9		24.5	20.5	
$10,000-19,999	**24.1**	**27.8**	**19.3**		**26.1**	**21.8**		**25.2**	**23.4**	
20-34	27.6	31.4	22.5		29.4	25.6		27.5	27.7	
35-54	18.2	21.7	13.8		20.0	16.2		20.1	17.1	
55+	31.8	35.5	27.0		34.0	29.0		32.3	31.4	
$20,000-39,999	**28.3**	**30.1**	**26.0**		**27.0**	**29.8**		**27.0**	**29.1**	
20-34	29.8	29.4	30.3		28.0	31.9		26.9	31.9	
35-54	28.7	33.4	23.0		27.9	29.7		27.6	29.4	
55+	24.5	23.6	25.5		23.2	25.9		25.8	23.5	
>=$40,000	**25.6**	**16.9**	**36.8**	***	**21.9**	**29.8**	***	**20.1**	**29.1**	***
20-34	15.2	9.2	23.4	***	11.3	20.0	***	11.2	18.1	***
35-54	35.1	23.9	49.2	***	31.8	38.8	***	28.9	38.8	***
55+	21.7	15.2	30.1	***	18.8	25.2	***	17.3	24.5	**

Family Status									
Family/Partner	**62.5**	**56.5**	**70.3**		**59.2**	**66.4**		**58.7**	**65.0**	
20-34	63.6	58.1	71.2		60.5	67.4		61.2	65.4	
35-54	65.3	60.2	71.8		63.3	68.8		60.3	68.4	
55+	53.5	44.3	65.1		49.0	58.7		50.1	55.6	
Single	**37.5**	**43.5**	**29.7**	***	**40.8**	**33.6**	***	**41.3**	**35.0**	***
20-34	36.4	41.9	28.8	***	39.5	32.6	***	38.8	34.6	*
35-54	34.7	39.8	28.2	***	37.7	31.2	***	39.7	31.6	***
55+	46.5	55.7	34.9	***	51.0	41.3	***	49.9	44.4	*
	Total Population	**Female**	**Male**	**P**	**First Nation**	**Métis**	**P**	**Status**	**Non-Status**	**P**
URBAN MOBILITY VARIABLES (%)									
Time in Urban Area									
Urban-Born	**28.6**	**27.6**	**29.9**		**27.3**	**30.1**		**26.8**	**29.8**	
20-34	32.9	32.2	34.0		31.0	35.3		30.2	35.0	
35-54	26.8	26.1	27.6		25.1	28.7		24.7	28.0	
55+	24.8	22.3	28.0		25.6	23.9		24.9	24.7	
Long Time Urban *(Moved more than 5 years ago)*	**44.5**	**44.8**	**44.1**		**45.1**	**43.7**		**44.6**	**44.4**	
20-34	28.4	28.5	28.2		30.8	25.5		29.3	27.7	
35-54	50.5	51.4	49.3		50.0	51.1		50.6	50.4	
55+	60.2	60.2	60.1		60.8	59.3		61.6	59.3	
Recent Urban *(Moved within last 5 years)*	**26.9**	**27.6**	**26**	*	**27.6**	**26.2**	*	**28.6**	**25.8**	**
20-34	38.7	39.3	37.8	ns	38.2	39.2	**	40.5	37.3	*
35-54	22.7	22.4	23.1	ns	24.9	20.2	***	24.6	21.6	*
55+	15.1	17.5	11.9	**	13.6	16.7	ns	13.5	16.0	ns
Mobility within last 5 years									
Did not move	**37.7**	**37.1**	**38.5**		**35.6**	**40.1**		**35.3**	**39.2**	
20-34	17.7	17.9	17.6		16.6	19.1		16.7	18.5	
35-54	43.7	44.0	43.2		40.8	46.9		40.8	45.4	
55+	60.5	57.5	64.4		58.9	62.5		60.7	60.4	
Once	**22.4**	**22.0**	**22.8**		**22.6**	**22.1**		**22.2**	**22.4**	
20-34	21.4	20.4	22.6		21.5	21.2		21.2	21.5	
35-54	24.2	23.4	25.2		24.7	23.6		23.9	24.4	
55+	19.8	21.8	17.1		19.7	19.9		20.4	19.3	
Two or more times	**39.9**	**40.9**	**38.7**	ns	**41.8**	**37.8**	ns	**42.4**	**38.3**	ns
20-34	60.9	61.7	59.8	ns	61.9	59.7	ns	62.1	60.0	ns
35-54	32.1	32.6	31.5	ns	34.4	29.5	***	35.3	30.2	**
55+	19.7	20.7	18.5	**	21.4	17.7	ns	18.8	20.2	ns
Reasons for Moving to Urban Area									
Family	**23.7**	**38.5**	**28.4**	***	**33.7**	**34.7**	**ns**	**32.9**	**35.1**	**ns**
20-34	37.3	40.3	32.9	***	36.9	37.6	ns	35.1	39.0	ns
35-54	31.6	35.8	26.1	***	31.1	32.1	ns	29.8	32.7	ns
55+	35.1	41.3	26.6	***	34.3	36.1	ns	36.0	34.6	ns
Work/Find Job	**24.1**	**28.7**	**42.6**	***	**32.9**	**36.8**	***	**34.0**	**35.0**	**ns**
20-34	31.1	25.5	39.0	***	28.9	34.0	*	31.0	31.3	ns
35-54	37.3	30.5	45.9	***	35.3	39.6	*	36.0	38.0	ns
55+	34.3	29.9	40.2	***	34.0	34.7	ns	35.0	33.9	ns
School	**7.0**	**11.4**	**8.2**	***	**11.7**	**8.0**	***	**13.6**	**7.6**	***
20-34	18.2	20.1	15.5	**	20.3	15.5	**	22.4	14.9	***
35-54	7.2	8.2	5.8	*	8.5	5.6	**	10.6	5.0	***
55+	3.1	3.9	2.1	ns	4.3	1.8	**	4.0	2.6	ns
Better housing	**4.0**	**6.6**	**4.7**	***	**6.0**	**5.5**	**ns**	**5.8**	**5.7**	**ns**
20-34	4.6	5.5	3.5	*	5.1	4.0	ns	4.1	5.0	ns
35-54	6.6	7.8	5.1	**	6.4	6.9	ns	6.9	6.4	ns

55+	5.7	5.8	5.7	ns	6.8	4.7	ns	6.6	5.2	ns
Cheaper housing	**2.9**	**4.3**	**3.9**	**ns**	**4.3**	**4.0**	**ns**	**3.3**	**4.7**	**
20-34	3.3	3.4	3.1	ns	3.7	2.8	ns	2.5	4.0	ns
35-54	4.4	5.1	3.5	*	3.9	5.0	ns	3.3	5.1	*
55+	4.8	4.1	5.9	ns	6.0	3.7	ns	4.4	5.1	ns
Better Services	**2.4**	**3.4**	**3.5**	**ns**	**4.0**	**2.7**	**	**4.1**	**3.0**	*
20-34	2.5	3.0	1.8	ns	3.3	1.5	**	2.6	2.5	ns
35-54	3.2	2.9	3.8	ns	3.8	2.6	*	4.5	2.5	**
55+	5.4	5.3	5.5	ns	5.7	5.0	ns	5.8	5.0	ns
Other	**15.4**	**22.4**	**21.9**	**ns**	**23.5**	**20.6**	**	**23.1**	**21.6**	**ns**
20-34	17.9	18.3	17.3	ns	19.5	15.8	*	19.6	16.5	ns
35-54	23.0	23.2	22.9	ns	24.4	21.5	ns	23.9	22.5	ns
55+	24.3	27.6	27.1	ns	28.6	26.0	ns	27.7	27.1	ns
	Total Population	**Female**	**Male**	**P**	**First Nation**	**Métis**	**P**	**Status**	**Non-Status**	**P**
HEALTH VARIABLES (%)										
Self-rated health										
Healthy	**81.8**	**80.0**	**84.0**		**79.5**	**84.4**		**80.0**	**82.9**	
20-34	92.0	91.1	93.3		90.4	94.0		90.8	92.9	
35-54	80.5	77.8	83.9		78.2	83.1		79.0	81.4	
55+	65.4	63.7	67.7		61.8	69.7		60.1	68.8	
Unhealthy	**18.2**	**20.0**	**16.0**	***	**20.5**	**15.6**	***	**20.0**	**17.1**	***
20-34	8.0	8.9	6.7	*	9.6	6.0	***	9.2	7.1	*
35-54	19.5	22.2	16.1	***	21.8	16.9	***	21.0	18.6	*
55+	34.6	36.3	32.3	ns	38.2	30.3	***	39.9	31.2	***
Total Number of Chronic Health Conditions										
None	**43.9**	**40.8**	**48.0**		**43.5**	**44.3**		**45.2**	**43.0**	
20-34	62.0	57.8	67.8		60.6	63.6		63.4	60.9	
35-54	40.6	37.8	44.3		40.7	40.5		41.8	39.9	
55+	17.2	14.1	21.2		17.0	17.5		14.8	18.7	
One	**25.3**	**24.4**	**26.5**		**25.2**	**25.4**		**24.5**	**25.9**	
20-34	24.7	25.6	23.6		25.2	24.0		23.7	25.5	
35-54	27.0	26.0	28.3		26.7	27.4		25.9	27.7	
55+	22.2	18.1	27.5		21.6	23.0		22.8	22.0	
Two or more	**30.8**	**34.8**	**25.5**	***	**31.2**	**30.2**	ns	**30.2**	**31.1**	ns
20-34	13.3	16.6	8.6	***	14.1	12.3	ns	12.9	13.6	ns
35-54	32.3	36.2	27.4	***	32.6	32.0	ns	32.3	32.3	ns
55+	60.5	67.7	51.4	***	61.4	59.5	ns	62.3	59.3	ns
BMI										
Normal/Underweight	**38.3**	**45.2**	**29.8**		**39.3**	**37.2**		**36.6**	**39.4**	
20-34	47.3	54.3	38.7		47.5	47.2		45.8	48.5	
35-54	34.3	41.4	25.9		35.8	32.8		31.7	36.1	
55+	31.4	37.8	23.3		32.5	30.1		30.2	32.1	
Overweight/Obese	**61.7**	**54.7**	**70.2**	***	**60.7**	**62.8**	*	**63.4**	**60.6**	**
20-34	52.7	45.7	61.3	***	52.5	52.8	ns	54.2	51.5	ns
35-54	65.6	58.6	74.1	***	64.2	67.2	*	68.3	63.9	**
55+	68.6	62.2	76.7	***	67.5	69.9	ns	69.8	67.9	ns
Smoking										
Non-Smoker	55.6	54.5	57.1		52.4	59.3		52.1	57.9	
20-34	52.9	52.3	53.6		49.3	57.2		48.5	56.1	
35-54	53.1	52.1	54.4		50.4	56.2		49.5	55.3	
55+	66.9	64.5	69.9		63.4	71.1		65.8	67.7	
Smoker	44.4	45.5	42.9	*	47.6	40.7	***	47.9	42.1	***
20-34	47.1	47.7	46.4	ns	50.7	42.8	***	51.5	43.9	***
35-54	46.9	47.9	45.6	ns	49.6	43.8	***	50.5	44.7	***
55+	33.1	35.5	30.1	*	36.6	28.9	**	52.1	57.9	ns
Drinking										
Non-drinker	21.8	23.7	19.2		24.5	18.6		26.0	19.0	

20-34	12.5	14.4	10.0		13.9	10.9		15.0	10.7	
35-54	22.4	23.6	20.8		25.7	18.5		27.7	19.2	
55+	37.8	42.2	32.1		41.4	33.5		44.4	33.6	
Drinker	78.2	76.3	80.8	***	75.5	81.4	***	74.0	81.0	***
20-34	87.5	85.6	90.0	***	86.1	89.1	**	85.0	89.3	***
35-54	77.6	76.4	79.2	*	74.3	81.5	***	72.3	80.8	***
55+	62.2	57.8	67.9	***	58.6	66.5	**	55.6	66.4	***

Appendix 2: Age Stratified Relationships between Urbanization Variables and Health

TIME IN URBAN AREA			SELF-RATED HEALTH			TOTAL NUMBER OF CHRONIC HEALTH CONDITIONS			
Age group	Sample	Length of time in urban area	Unhealthy	Healthy	P	None	One	Two+	P
All ages	Total population	Always	16.5	83.5	***	48.0	25.5	26.4	***
		Long-time	20.6	79.4		38.6	25.5	35.8	
		Recent	16.1	83.9		48.3	24.6	27.1	
20-34	Total population	Always	6.6	93.4	ns	64.5	24.3	11.2	ns
		Long-time	9.1	90.9		60.8	25.4	13.8	
		Recent	7.9	92.1		61.4	24.3	14.3	
	Male	Always	4.7	95.3	ns	69.0	23.7	7.3	ns
		Long-time	7.9	92.1		69.1	24.0	7.0	
		Recent	7.1	92.9		66.7	22.5	10.8	
	Female	Always	7.9	92.1	ns	61.0	24.7	14.3	ns
		Long-time	9.9	90.1		55.0	26.3	18.7	
		Recent	8.4	91.6		57.7	25.5	16.8	
	First Nations	Always	6.4	93.6	*	63.5	26.2	10.4	*
		Long-time	10.2	89.8		62.5	24.1	13.4	
		Recent	10.7	89.3		57.8	25.5	16.7	
	Métis	Always	6.8	93.2	ns	65.6	22.1	12.3	ns
		Long-time	7.4	92.6		58.4	27.2	14.4	
		Recent	4.7	95.3		65.8	22.8	11.5	
	Status	Always	5.8	94.2	*	67.3	23.5	9.2	ns
		Long-time	10.3	89.7		61.2	24.3	14.5	
		Recent	9.5	90.5		63.6	23.3	13.1	
	Non-Status	Always	7.0	93.0	ns	62.7	24.8	12.5	ns
		Long-time	8.1	91.9		60.6	26.2	13.3	
		Recent	6.7	93.3		59.7	25.1	15.2	
35-54	Total population	Always	19.3	80.7	ns	42.4	28.4	29.2	ns
		Long-time	19.0	81.0		39.8	26.6	33.6	
		Recent	20.8	79.2		40.0	26.7	33.3	
	Male	Always	16.8	83.2	ns	48.6	27.0	24.4	ns
		Long-time	15.4	84.6		43.5	27.6	28.9	
		Recent	17.1	82.9		40.8	31.1	28.1	
	Female	Always	21.4	78.6	ns	37.1	29.7	33.3	ns
		Long-time	21.8	78.2		37.1	25.9	37	
		Recent	24.0	76.0		39.1	23.4	37.4	
	First Nations	Always	19.8	80.2	ns	45.8	26.2	28.0	**
		Long-time	22.5	77.5		37.5	26.7	35.9	
		Recent	23.0	77.0		42.3	26.9	30.8	
	Métis	Always	18.9	81.1	ns	39.0	30.6	30.4	ns
		Long-time	15.2	84.8		42.5	26.5	31.0	
		Recent	17.8	82.2		36.4	26.8	36.9	
	Status	Always	21.5	78.5	ns	44.2	26.1	29.7	ns
		Long-time	20.8	79.2		40.5	25.7	33.7	
		Recent	21.3	78.7		41.6	26.2	32.1	
	Non-Status	Always	18.1	81.9	ns	41.5	29.6	28.9	ns
		Long-time	17.9	82.1		39.4	27.1	33.5	

		Recent	20.4	79.6		38.7	27.1	34.2	
55+	Total population	Always	34.2	65.8	ns	21.1	20.9	58.0	*
		Long-time	34.2	65.8		15.7	23.5	60.7	
		Recent	38.1	61.9		15.1	17.8	67.2	
	Male	Always	28.6	71.4	ns	22.8	26.7	50.5	ns
		Long-time	34.7	65.3		20.9	28.0	51.1	
		Recent	31.9	68.1		15.4	25.3	59.3	
	Female	Always	40.0	60.0	ns	19.4	15.2	65.4	*
		Long-time	33.4	66.6		11.7	20.0	68.3	
		Recent	41.7	58.3		14.9	13.7	71.4	
	First Nations	Always	33.1	66.9	ns	23.2	20.2	56.6	*
		Long-time	39.5	60.5		14.2	22.7	63.1	
		Recent	43.5	56.5		16.0	15.2	68.8	
	Métis	Always	35.9	64.1	ns	18.6	21.8	59.6	ns
		Long-time	27.4	72.6		17.6	24.3	58.1	
		Recent	33.3	66.7		13.5	20.3	66.2	
	Status	Always	35.6	64.4	ns	23.8	22.5	53.8	**
		Long-time	41.4	58.6		11.7	24.2	64.1	
		Recent	41.9	58.1		9.1	18.2	72.7	
	Non-Status	Always	33.5	66.5	ns	19.5	19.8	60.7	ns
		Long-time	29.3	70.7		18.3	23.1	58.6	
		Recent	36.4	63.6		18.1	17.5	64.3	
FIVE YEAR MOBILITY			**SELF-RATED HEALTH**			**TOTAL NUMBER OF CHRONIC HEALTH CONDITIONS**			
Age group	Sample	Number of times moved in past 5 years	Unhealthy	Healthy	P	None	One	Two+	P
All ages	Total population	None	18.4	81.6	ns	38.2	26.5	35.3	***
		One	18.2	81.8		45.0	25.1	29.9	
		Two+	17.8	82.2		48.3	24.6	27.1	
20-34	Total population	None	7.2	92.8	*	62.9	26.5	10.6	ns
		One	5.6	94.4		61.5	25.2	13.3	
		Two+	8.7	91.3		61.8	24.2	13.9	
	Male	None	3.6	96.4	*	71.5	23.4	5.0	ns
		One	5.3	94.7		69.5	21.5	9.0	
		Two+	8.3	91.7		66.0	24.1	9.9	
	Female	None	9.8	90.2	ns	57.1	28.4	14.5	ns
		One	5.5	94.5		55.4	28.1	16.5	
		Two+	9.1	90.9		58.9	24.2	16.9	
	First Nations	None	6.9	93.1	**	61.7	28.2	10.1	ns
		One	6.1	93.9		58.4	25.3	16.3	
		Two+	11.0	89.0		61.4	24.5	14.0	
	Métis	None	7.5	92.5	ns	64.3	24.5	11.2	ns
		One	4.9	95.1		65.7	25.0	9.3	
		Two+	6.0	94.0		62.3	23.8	13.8	
	Status	None	7.1	92.9	*	61.6	28.0	10.3	ns
		One	5.4	94.6		64.0	24.3	11.6	
		Two+	10.5	89.5		63.9	22.7	13.4	
	Non-Status	None	7.2	92.8	ns	64.2	25.3	10.5	ns
		One	5.7	94.3		60.0	25.7	14.2	

		Two+	7.4	92.6		60.3	25.3	14.4	
35-54	Total population	None	15.8	84.2	***	41.9	27.3	30.8	**
		One	18.4	81.6		42.4	27.5	30.1	
		Two+	25.1	74.9		36.8	26.8	36.4	
	Male	None	11.7	88.3	***	48.1	27.8	24.1	*
		One	19.8	80.2		41.7	28.6	29.7	
		Two+	18.9	81.1		40.4	29.2	30.4	
	Female	None	19.0	81.0	***	37.1	26.9	36.0	**
		One	17.2	82.8		43.1	26.4	30.5	
		Two+	29.8	70.2		34.0	24.9	41.0	
	First Nations	None	16.8	83.2	***	42.3	26.0	31.7	ns
		One	22.2	77.8		40.9	28.5	30.6	
		Two+	27.5	72.5		37.6	26.6	35.9	
	Métis	None	14.8	85.2	***	41.5	28.6	30	*
		One	13.8	86.2		44.3	26.2	29.6	
		Two+	22.0	78.0		35.8	27.1	37.1	
	Status	None	17.7	82.3	**	43.0	25.7	31.3	ns
		One	20.9	79.1		38.3	29.9	31.9	
		Two+	25.1	74.9		42.0	23.7	34.4	
	Non-Status	None	14.8	85.2	***	41.3	28.1	30.5	***
		One	17.0	83.0		45.0	25.9	29.1	
		Two+	25.0	75.0		33.3	28.9	37.8	
55+	Total population	None	29.2	70.8	***	17.5	25.2	57.3	**
		One	43.6	56.4		18.1	18.1	63.8	
		Two+	40.8	59.2		15.5	17.8	66.7	
	Male	None	29.1	70.9	*	21.3	29.1	49.6	ns
		One	41.5	58.5		23.8	20.6	55.6	
		Two+	35.9	64.1		17.9	27.9	54.3	
	Female	None	29.3	70.7	***	14.1	21.7	64.2	*
		One	44.9	55.1		14.7	16.6	68.7	
		Two+	44.2	55.8		13.4	10.9	75.6	
	First Nations	None	31.1	68.9	***	16.9	25.7	57.4	**
		One	49.7	50.3		20.9	15.8	63.3	
		Two+	45.9	54.1		14.0	16.0	70.0	
	Métis	None	27.1	72.9	ns	18.2	24.6	57.2	ns
		One	36.1	63.9		15.0	20.6	64.4	
		Two+	33.8	66.2		17.6	*20.4*	62.0	
	Status	None	31.2	68.8	***	15.8	26.3	57.9	*
		One	55.3	44.7		11.8	13.4	74.8	
		Two+	46.5	53.5		14.5	22.6	62.9	
	Non-Status	None	28.0	72.0	**	18.7	24.4	56.9	*
		One	35.6	64.4		21.9	21.0	57.1	
		Two+	37.5	62.5		15.7	15.2	69.1	

REASONS FOR MOVING				SELF-RATED HEALTH			TOTAL NUMBER OF CHRONIC HEALTH CONDITIONS			
Age group	Sample	Reason		Unhealthy	Healthy	P	None	One	Two+	P
All ages	Total population	Family	Y	20.1	79.9	ns	39.0	27.7	33.2	***
			N	18.3	81.7		43.7	24.0	32.3	
		Work	Y	15.4	84.6	***	46.2	25.4	28.4	***

			N	20.7	79.3		39.9	25.2	34.8	
		School	Y	9.7	90.3	***	54.1	26.2	19.7	***
			N	19.9	80.1		40.8	25.2	34.0	
		Better Housing	Y	26.1	73.9	***	39.3	25.2	35.5	ns
			N	18.4	81.6		42.3	25.3	32.4	
		Cheaper Housing	Y	18.6	81.4	ns	38.2	25.1	36.7	ns
			N	18.9	81.1		42.3	25.3	32.4	
		Better Services	Y	35.5	64.5	***	23.9	30.6	45.5	***
			N	18.3	81.7		42.8	25.1	32.1	
20-34	Total population	Family	Y	9.7	90.3	ns	55.4	28.9	15.7	***
			N	7.8	92.2		64.0	22.7	13.3	
		Work	Y	7.0	93.0	ns	66.4	22.4	11.1	**
			N	9.1	90.9		58.2	26.2	15.6	
	Male	Family	Y	5.8	94.2	ns	65.7	25.9	8.4	ns
			N	8.3	91.7		68.0	22.4	9.6	
		Work	Y	7.7	92.3	ns	69.1	24.0	7.0	ns
			N	7.3	92.7		66.2	23.3	10.5	
	Female	Family	Y	11.9	88.1	**	49.2	30.6	20.2	***
			N	7.4	92.6		60.7	23.0	16.3	
		Work	Y	6.3	93.7	*	63.6	20.8	15.7	**
			N	10.2	89.8		53.6	27.9	18.6	
	First Nations	Family	Y	11.8	88.2	ns	55.1	27.7	17.3	ns
			N	10.3	89.7		61.8	23.5	14.6	
		Work	Y	9.0	91.0	ns	65.6	23.1	11.4	**
			N	11.5	88.5		56.9	25.9	17.2	
	Métis	Family	Y	7.0	93.0	ns	55.4	30.5	14.1	**
			N	4.7	95.3		66.9	21.6	11.5	
		Work	Y	5.1	94.9	ns	67.6	21.5	10.9	ns
			N	5.8	94.2		59.9	26.7	13.4	
	Status	Family	Y	10.4	89.6	ns	57.1	28.5	14.4	*
			N	10.0	90.0		64.9	21.3	13.8	
		Work	Y	11.1	88.9	ns	68.3	20.7	11.0	*
			N	9.7	90.3		59.3	25.3	15.4	
	Non-Status	Family	Y	9.1	90.9	*	54.3	29.0	16.7	**
			N	6.0	94.0		63.2	23.9	12.8	
		Work	Y	3.8	96.2	**	65.0	23.8	11.3	*
			N	8.8	91.2		57.3	26.9	15.8	
35-54	Total population	Family	Y	21.6	78.4	*	36.5	28.9	34.6	*
			N	18.6	81.4		41.4	25.7	32.9	
		Work	Y	16.2	83.8	***	44.5	26.9	*28.6*	***
			N	21.6	78.4		37.1	26.6	*36.3*	
	Male	Family	Y	16.9	83.1	ns	38.0	29.6	32.5	ns
			N	15.6	84.4		43.7	28.6	27.8	
		Work	Y	13.8	86.2	*	48.1	27.3	24.7	***
			N	17.8	82.2		37.2	30.2	32.6	
	Female	Family	Y	24.3	75.7	ns	35.7	28.5	35.7	*
			N	21.2	78.8		39.3	23.1	37.5	
		Work	Y	18.8	81.3	*	40.4	26.4	33.2	ns
			N	23.8	76.2		37.0	24.5	38.5	

	First Nations	Family	Y	25.6	74.4	*	34.0	27.5	38.5	**
			N	21.2	78.8		41.6	26.3	32.1	
		Work	Y	19.9	80.1	*	43.7	26.8	29.5	**
			N	24.1	75.9		36.9	26.6	36.5	
	Métis	Family	Y	17.0	83.0	ns	39.4	30.5	30.1	ns
			N	15.4	84.6		41.2	24.9	33.9	
		Work	Y	12.1	87.9	**	45.5	27.0	27.5	**
			N	18.4	81.6		37.3	26.6	36.1	
	Status	Family	Y	23.6	76.4	ns	38.2	25.8	36.0	ns
			N	20.2	79.8		42.1	25.9	32.0	
		Work	Y	17.9	82.1	*	45.4	23.7	30.9	ns
			N	23.0	77.0		38.5	27.1	34.4	
	Non-Status	Family	Y	20.6	79.4	ns	35.6	30.7	33.8	*
			N	17.5	82.5		40.9	25.5	33.5	
		Work	Y	15.1	84.9	**	44.1	28.7	27.2	***
			N	20.7	79.3		36.2	26.3	37.5	
55+	Total population	Family	Y	35.2	64.8	ns	14.6	23.0	62.4	ns
			N	34.6	65.4		16.1	22.0	61.9	
		Work	Y	26.3	73.7	***	18.8	26.1	55.1	**
			N	39.2	60.8		14.0	20.4	65.7	
	Male	Family	Y	35.6	64.4	ns	21.0	29.4	49.7	ns
			N	33.3	66.7		19.7	26.9	53.5	
		Work	Y	29.1	70.9	*	20.6	30.7	48.6	ns
			N	37.3	62.7		19.6	25.5	54.9	
	Female	Family	Y	35.0	65.0	ns	11.6	20.2	68.2	ns
			N	35.7	64.3		12.9	17.2	69.9	
		Work	Y	23.6	76.4	***	16.9	21.5	61.6	**
			N	40.4	59.6		10.4	17.1	72.4	
	First Nations	Family	Y	41.2	58.8	ns	14.2	21.0	64.8	ns
			N	39.4	60.6		14.7	21.5	63.7	
		Work	Y	31.0	69.0	***	16.2	25.1	58.7	ns
			N	44.6	55.4		13.7	19.4	66.9	
	Métis	Family	Y	28.6	71.4	ns	15.2	25.2	59.5	ns
			N	28.9	71.1		17.8	22.5	59.8	
		Work	Y	20.9	79.1	**	22.2	27.1	50.7	**
			N	32.8	67.2		14.3	21.4	64.3	
	Status	Family	Y	42.2	57.8	ns	10.5	26.2	63.4	ns
			N	40.4	59.6		11.4	21.2	67.4	
		Work	Y	33.0	67.0	**	13.5	24.0	62.6	ns
			N	45.7	54.3		9.8	22.5	67.7	
	Non-Status	Family	Y	30.5	69.5	ns	17.0	21.0	62.0	ns
			N	30.9	69.1		18.9	22.4	58.7	
		Work	Y	21.9	78.1	***	22.2	27.4	50.4	**
			N	35.3	64.7		16.3	19.1	64.6	

*p<0.05 = * p<0.01=** p<0.001=*** p≥0.05=ns (not significant)*

Levels of significance for associations between determinants of health/health outcome variables and identity variables (gender, Aboriginal identity, status) in each age group are indicated in the last category for each variable.

Appendix 3: Summary of Associations between Health Outcomes and Gender, Aboriginal Identity and Status across Urbanization Sub-Samples

Health Outcome	Urbanization Category	Gender	Aboriginal Identity	Status
Self-Rated Health	**Time in Urban Area**			
	Urban-born	**	ns	ns
	Long-time	*	***	***
	Recent	**	***	ns
	Mobility			
	None	**	ns	ns
	One	ns	***	**
	Two+	***	***	ns
	Reasons for Moving			
	Family	**	***	*
	Work	ns	***	***
	School	ns	ns	ns
	Better Housing	ns	ns	ns
	Cheaper Housing	ns	ns	ns
	Better Services	ns	ns	ns
Total Chronic Health Conditions	**Time in Urban Area**			
	Urban-born	***	ns	ns
	Long-time	***	ns	ns
	Recent	***	ns	ns
	Mobility			
	None	***	ns	ns
	One	**	ns	ns
	Two+	***	ns	**
	Reasons for Moving			
	Family	***	*	ns
	Work	***	ns	*
	School	ns	ns	ns
	Better Housing	ns	ns	ns
	Cheaper Housing	ns	ns	ns
	Better Services	**	ns	ns

*p<0.05 = *   p<0.01=**   p<0.001=***   p≥0.05=ns (not significant)*

Levels of significance for associations between health outcome variable and gender/Aboriginal identity/status, in each urbanization variable category.

Appendix 4: Interview Guide

Urbanization/mobility basics:
When did you move to Toronto (how long have you lived here)? *Where* did you move from? *Why* did you decide to move here? Do you go back and visit another community/community you grew up in? How often? Why? Have you ever moved within Toronto? Or between Toronto and other cities/places? How often? Why? Do you have strong ties to the community you came from? How? Participate in community? Voting? Family? Are you eligible to receive reserve services, when you're in Toronto? Do you want to be?

Experiencing life in Toronto (gender, identity):
As an Aboriginal person, how do you like Toronto as a place to live (*welcoming, inclusive, difficult, intense etc.*)? As an Aboriginal person, what are some of challenges/benefits to living in Toronto? What do you like about the city? How do these compare to challenges/benefits/things you like/don't like about where you used to live? Do you feel a sense of community or connectedness to friends/family here? Could you describe it? Do you feel that there is a strong sense Aboriginal community here? Why do you think so? How do you personally access it? Are you involved with this community in any way?
Is self-identifying as an Aboriginal person important to you? Do you feel that this sense of identity is reflected/respected in the city (places to celebrate culture, festivities, community groups, public services inclusive of Aboriginal peoples)?
How does this compare to where you used to live?
Does the way that you self-identify change, depending on where you are (in a city vs. on-reserve or in a rural town)?
Do you think there are any tensions/divisions within the Aboriginal community in Toronto in terms of status/non-status, First Nation/Métis/Inuit or otherwise? …diverse group of people with diverse cultures/histories coming together in Toronto? What has that experience been like for you? Pan-Aboriginal community?
Is there something about being an Aboriginal *woman/man* that makes your experience here unique – (how does your experience, as a woman/man in the city, differ from women/men that you know)?

Aboriginal rights:
As an Aboriginal person, how would you describe your rights compared to other groups in Canada?
Do you think you should be entitled to Aboriginal rights…in addition to the rights of all people in Canada? What do Aboriginal rights mean to you/ what do you think you should be entitled to due to these rights/what does this mean to you? (*…right to health care, specific health services, self-government, self-determination, right to vote on-reserve when off, right to same services as available on-reserve, tax breaks, assistance with education, land and resources, specific rights due to treaties etc*….?)
Thinking about those rights (Aboriginal rights and/or rights as Canadians), are there differences in the ways that these rights affect your life in Toronto, compared to where you used to live? …maybe access to different rights or services that stem from these rights?
…do you think much about Aboriginal rights in daily life? Do you think about rights differently or feel you have access to different rights in Toronto compared to where you used to live? Have

you experienced a *lack of access* to some rights since moving to Toronto? Have you experienced *access to any* additional rights since moving to Toronto? Do you think this had an effect on your decision to move to Toronto? How? Do you think you have access to the same level of rights/types of rights as other people living in Toronto? How/why/explain? Is there something about being an Aboriginal *woman/man* that makes your access to rights unique?

Health:
Compared to other people your age, would you describe your health as excellent, very good, good, fair or poor? Why? What does health mean to you? What does being healthy mean to you? (just physical, or mental, emotional, spiritual too? Land? Being well? Relationships with other?) Has this changed at all since moving to Toronto? (i.e. The way you think about health/what it means to you?) Has your health changed (improved, worsened) since you moved to Toronto (…how do you think it is different now compared to before you moved here?)? What factors have contributed to this change? Was health a factor at all in your decision to move to Toronto? How?
Thinking about the rights we discussed earlier, do you think these rights affect your health at all? (…maybe access to them/lack of access to them, ways of thinking about them, ways of engaging with them, advocacy for them…) How (*mentally, emotionally, physically, through well—being, stress, sense of control*)? Is this different in Toronto vs. where you used to live?

What health services do you use? (*family doctor, hospitals, traditional healing centres, NIHB…*)? Where do you access them (*if you feel sick, where do you go to get help…)*? Do you go to Anishnawbe Health Toronto? What about other Aboriginal health services? Is it *important to you to have access* to Aboriginal health services? Do you feel you have adequate access to them (long wait times, services needed always available?...)? Are there additional Aboriginal services that you would like to have access to (health or otherwise)?
Is access to these services an important Aboriginal right? Do you have better/worse access to these services now compared to where you used to live? How so?

Basic demographic/economic:
Age: 18-30 30-40 40-50 50-60 60+
Family: live w/ family? Single? Kids?
Employment: do you have a job?
Education: what's the last type of schooling that you did?

Conclusion:
Anything else you'd like to add? Any questions/comments/concerns?

Recruitment:
Can you think of anyone else who you think might be eligible and willing to participate in this study?

Appendix 5: Listserv Email

Hello all,

My name is Laura Senese and I'm a Masters student in Geography and the Collaborative Program in Aboriginal Health (CPAH), under the supervision of Dr. Kathi Wilson, at the University of Toronto. For my thesis research, I am conducting a study on the health of Aboriginal peoples who have recently moved to Toronto. The goal is to better understand how Aboriginal peoples experience **moving to the city** and how this may impact **health**. I would like to invite you to participate in an interview for this research study.

The interview would take approximately one hour. In order to participate, you should be 18 years of age or older, have moved to Toronto within the last 5 years from a rural or reserve location and identify as **First Nations, Métis or Inuit**. If you are not eligible to participate, but you know someone who is, I would really appreciate you passing this message on to them. Participation is completely voluntary and participants have the right to refuse to answer any question and/or withdraw from the study at any time. You will be provided with **monetary compensation** to thank you for taking the time and effort to participate.

This study has received ethics clearance from the University of Toronto Office of Research Ethics. If you have any questions or concerns about your rights as a participant, please feel free to contact the University of Toronto's Ethics Review Office at ethics.review@utoronto.ca or 416-946-3273.

If you have any questions or concerns about the study itself, please feel free to contact me (905-569-4417, laura.senese@utoronto.ca) or my thesis supervisor, Dr. Kathi Wilson (905-828-3864, kathi.wilson@utoronto.ca). We would be happy to speak with you.

Thank you for taking the time to consider participating. I look forward to hearing from you.

Laura Senese
MA Candidate
Geography, Collaborative Program in Aboriginal Health
University of Toronto
905-569-4417
laura.senese@utoronto.ca

Appendix 6: Poster

First Nations, Métis or Inuit?

New to Toronto?

If you've **moved to Toronto** from a reserve or rural area within the past 5 years, please consider participating in a health research project with the University of Toronto. You'd be asked questions about your experiences in moving to Toronto and your health in an interview (about 1 hour). **Monetary compensation** will be provided.

If you have any questions or think you might want to participate, please contact Laura at **905-569-4417** or **laura.senese@utoronto.ca**.

Thank you!!

Laura 905-569-4417 laura.senese@utoronto.ca	Laura 905-569-4417 laura.senese@utoronto.ca	Laura 905-569-4417 laura.senese@utoronto.ca	Laura 905-569-4417 laura.senese@utoronto.ca	Laura 905-569-4417 laura.senese@utoronto.ca	Laura 905-569-4417 laura.senese@utoronto.ca

Appendix 7: Letter of Information for Participants

Thank you for your interest in the *Aboriginal Urbanization and Health: Exploring a Role for Aboriginal Rights* research study. The purpose of this study is to examine relationships between urbanization, Aboriginal rights and health among Aboriginal peoples who have recently moved to Toronto. The research is being conducted by Laura Senese, a Masters student in Geography and the Collaborative Program in Aboriginal Health, under the supervision of Dr. Kathi Wilson, at the University of Toronto.

I am requesting your voluntary participation in this study. Participation is limited to people who are 18 years of age or older, who have moved to Toronto within the last 5 years from a rural or reserve location and who self-identify as First Nations, Métis or Inuit. Should you agree to participate, you will be asked a series of questions about your move to Toronto, your thoughts about Aboriginal rights and your health, as well as some basic demographic and economic information. Interviews will last approximately 1 hour, will be conducted with the principal investigator (Laura Senese) and with permission, will be audio recorded. You will be under no obligation to answer any questions that you would prefer not to and you will have the right to withdraw from the study at any point, without any consequences. Your responses will be kept completely confidential and your personal information will be protected during and after the completion of the study.

Should you agree to participate, you will be compensated for your time with $20 and will be reimbursed for transportation costs to the interview site. Beyond this, your participation will contribute to better understandings of experiences of urbanization and impacts on health among Aboriginal peoples in urban areas, with the goal of helping to improve health and other service provision for Aboriginal peoples living in urban areas.

If you have any questions about the purpose of the *Aboriginal Urbanization and Health: Exploring a Role for Aboriginal Rights* research study or the process involved, please feel free to contact me, or my thesis supervisor, Dr. Kathi Wilson.

Laura Senese
MA Candidate
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Study Information Overview

Project Title:

Aboriginal Urbanization and Health: Exploring a Role for Aboriginal Rights

Principal Investigator: Laura Senese
MA Candidate
Geography and Collaborative Program in Aboriginal Health
University of Toronto
905-569-4417
laura.senese@utoronto.ca

Purpose of Study:

The purpose of the study is to examine relationships between urbanization, Aboriginal rights and health among Aboriginal peoples who have recently moved to Toronto.

Potential Risks:

The potential risks associated with this study are no greater than the risks you encounter in everyday life. Some questions may bring up difficult memories, but you can chose not to answer any questions you would prefer not to. If you do experience some upset, it may be helpful to seek support. Some potential resources for this support include Anishnawbe Health Toronto (416-360-0486), Noojimanwin Health Authority (416-598-1001) and Native Women's Resource Centre (416-963-9963).

Potential Benefits:

The goal of this study is to better understand experiences of urbanization among Aboriginal peoples in Toronto including how moving to the city impacts health. Sharing your experiences will help to clarify the benefits and challenges associated with moving to an urban area, with the goal of helping to inform urban service provision for Aboriginal peoples.

Confidentiality:

Your personal information will be completely protected throughout the study. The interview audio file and transcript will be coded. Your name and identity will be stored separately from your responses, in secured locations. None of what you share during the interview will be attributable to you. Codes will be used to protect your identity in any reports or presentations generated from the research study. All audio files and interview transcripts will be destroyed 5 years after the study is completed.

Participation:

Your participation in this study is voluntary. Participation is limited to people who are 18 years of age or older, who have moved to Toronto within the last 5 years from a rural or reserve location and who self-identify as First Nations, Métis or Inuit. Should you agree to participate, you will be asked a series of questions about your move to Toronto, your thoughts about Aboriginal rights and your health, as well as some basic demographic and

economic information. If you would like a summary of the study findings, they will be mailed or emailed to you after completion of the study (approximately August 2011). You will be asked to provide your email or mailing address if you would like to receive a research summary.

Withdrawal:

You may refuse to answer any question and/or stop the interview for any reason, even after signing the consent form. If you decide to withdraw from the study, the audio file will be destroyed, unless you indicate otherwise. There are no consequences for withdrawal.

Rights of Research Participants:

If you have any questions about your rights as a participant in this study, feel free to contact the University of Toronto's Ethics Review Office (ethics.review@utoronto.ca, 416-946-3273).

Appendix 8: Consent Forms (Written and Verbal)

Written Consent

I understand the purpose of the *Aboriginal Urbanization and Health: Exploring a Role for Aboriginal Rights* research study conducted by Laura Senese at the University of Toronto. I understand that participation in this research study is limited to people aged 18 or over, who have moved to Toronto within the last 5 years from a rural or reserve location and who self-identify as First Nations, Métis or Inuit. I understand my rights as a participant in this study and my questions have been answered satisfactorily. I agree to participate in a research interview for this study. I have been given a copy of this form.

____
Name of Participant

____________________ ____________________
Signature of Participant Date

I agree to have this interview audio-recorded: ____________________________
Signature of Participant

Yes, I would like to have a research summary sent to me when the study is completed.

☐ Mailing Address:
Apt/House # and Street: ____________
City: ________________
Postal Code: _______________

☐ Email Address: ______________

☐ Yes, I have received $20 for participating in this research study interview.
☐ Yes, I have received $_____ compensation for transportation to the interview.

____
Signature of Participant

Verbal Consent

To be read to the participant after the Study Information Overview page has been gone over to them and all questions have been answered.

The purpose of the study is to examine relationships between urbanization, Aboriginal rights and health among Aboriginal peoples who have recently moved to Toronto. Participation is limited to people aged 18 or over, who have moved to Toronto within the last 5 years from a rural or reserve location and who self-identify as First Nations, Métis or Inuit.

Participation is through an interview in which you'll be asked questions about your move to Toronto, your thoughts about Aboriginal rights and your health, as well as some basic demographic and economic information. The interview will last approximately 1 hour. You will receive $20 for participating in the interview and compensation for transportation costs.

All information provided will be confidential. Your name and identity will be stored separately from your responses, in secure locations. None of what you share during the interview will be attributable to you.

You may refuse to answer any questions and/or withdraw from the study at any time, without any consequences. If you withdraw, any information data that you have contributed will be destroyed, unless otherwise stated.

Do you consent to participate in this study? Yes: ______ No: _______

Do you consent to have the interview audio-recorded? Yes: ______ No: _______

Would you like to receive a research summary after the study is completed? Yes: ______ No: _______

If yes, what is your mailing address?
Apt/House # and Street: ____________
City: ________________
Postal Code: _______________

Or email address? ______________

___________________ ______________________
Name of Participant Signature of Interviewer

____
Date and Time

☐ Yes, I have received $20 for participating in this research study interview.
☐ Yes, I have received $_____ compensation for transportation to the interview.

____________________ Name of Participant

____________________ Signature of Interviewer

____________________ Date and Time