THE HEALTH OF INDIGENOUS PEOPLE RESIDING IN URBAN CENTRES

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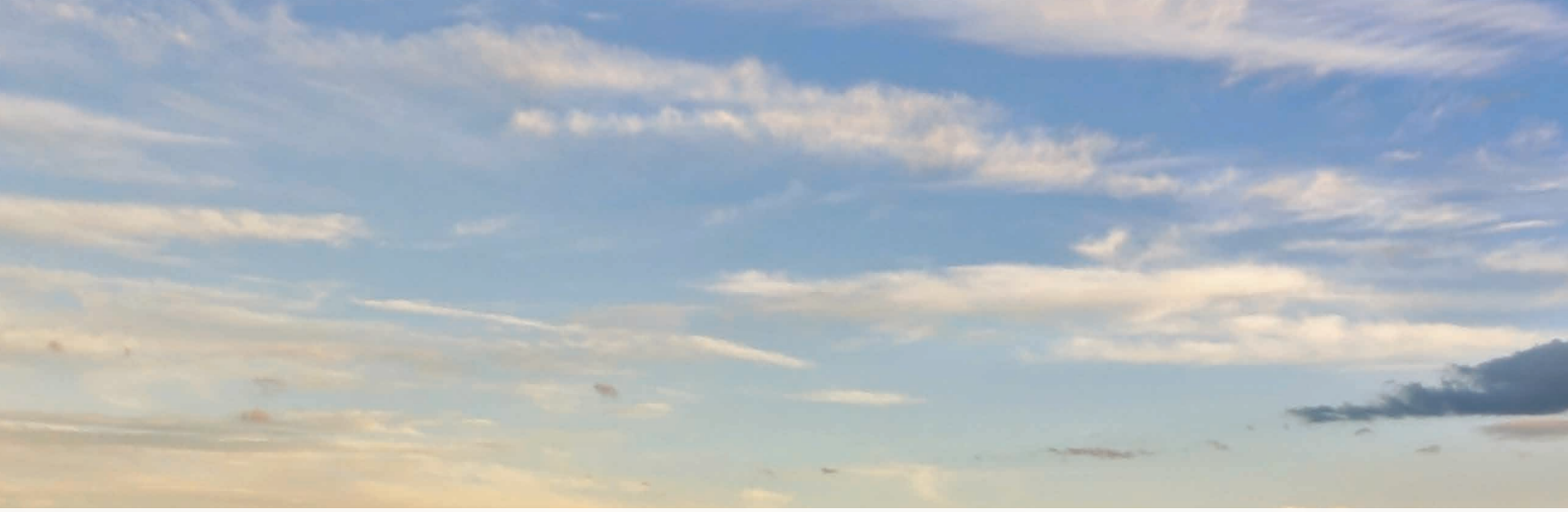
CHILD, YOUTH, AND FAMILY HEALTH



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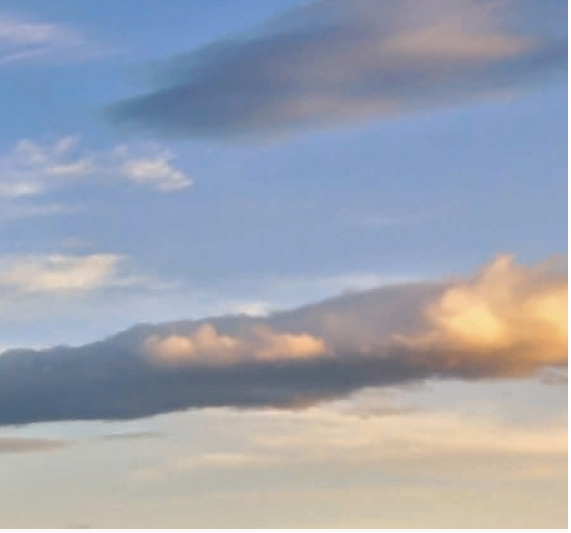

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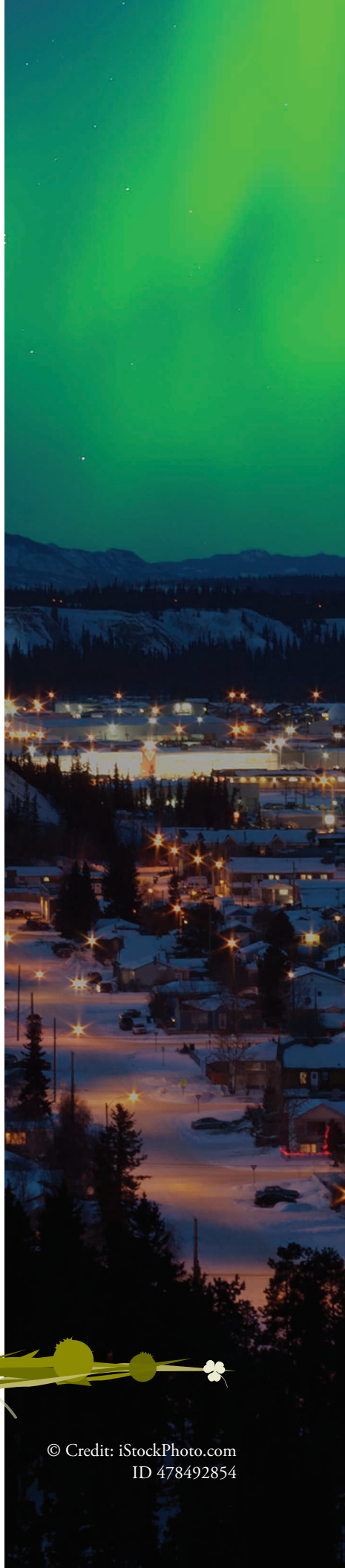

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INTRODUCTION

Indigenous Peoples[1] in Canada are increasingly urbanized, especially in western parts of the country (Congress of Aboriginal Peoples, 2019). Over the past 80 years, many First Nations people, Inuit, and Métis people have moved to urban centres. Today, more than half of the Indigenous population in Canada reside in urban centres (Collier, 2020). Despite this recognized and growing trend, there is still much to learn about the health of urban Indigenous people.

Data describing urban Indigenous people are limited. Available literature on Indigenous people residing in urban centres mainly focuses on issues related to socioeconomic well-being. As well, most studies pertaining to urban Indigenous people tend to report on dated evidence usually focused on First Nations people, with minimal attention given to Inuit and Métis people (British Columbia Association of Aboriginal Friendship Centres [BCAAFC], 2020). What's more, first-hand accounts of the diverse lived experiences, knowledge, and perspectives of urban Indigenous people are seldom included in research reports or reflected in policies and services affecting them (Alaazi et al., 2015; Allan, 2013; Nejad et al., 2019).

Indigenous Peoples comprise a demographically and culturally diverse population that is relatively mobile in ways that do not fit dominant migration models. In the context of current patterns of urbanization and mobility, this report is a follow-up to *The health of Aboriginal people residing in urban areas*, published in 2012 (Place, 2012). It brings together accessible data and literature on Indigenous people residing in urban settings to describe the health status of urban Indigenous populations and key issues that affect their health and the provision of health

[1] The term *Indigenous Peoples* is used throughout this report to refer collectively to the original inhabitants of the lands that comprise Canada, including First Nations people, Inuit, and Métis people. Where possible and appropriate, the distinction between First Nations people, Inuit, and Métis people is noted.

care services for them. Few pan-Canadian studies on urban Indigenous people are available, but there is a growing number of regional studies that offer new and important insights into the distinct characteristics and particular health needs of this population in Canada (see for example, Alaazi et al., 2015; Cidro et al., 2015; Hayward et al., 2020; Richmond et al., 2020; Tang et al., 2015; Wicklum et al., 2019).

This report covers three broad areas:

1. the urbanization and mobility patterns of urban Indigenous populations;
2. key factors influencing the health status and health outcomes of urban Indigenous people; and
3. challenges affecting the provision of health care services for Indigenous people residing in urban centres.

Throughout this report, specific attention is drawn to the social determinants of health and health outcomes of urban Indigenous people. Health care utilization data are reported, and the impacts of urbanization on the provision of health care services are discussed. To conceptualize some of the ways in which urban centres are working to address the health needs and priorities of urban Indigenous people, an overview of selected national and regional programs, services, and other initiatives aimed at supporting the health of this population is provided. In closing, this report highlights key considerations for future research, policy development, and programming related to the health of Indigenous people residing in urban centres.

DATA AND LITERATURE

Building on the work of Place (2012), this report includes updated terminology, statistical data, and cited works that were developed after *The health of Aboriginal people residing in urban areas* was published in 2012 to the end of December 2023. Numerous databases and search engines were used to gather data and literature pertaining to the health of urban Indigenous people in Canada, including Google and Google Scholar, ScienceDirect, CMAJ Open, PubMed and PMC, SpringerLink, BMJ Open, Scilit, ResearchGate, and SocINDEX. Selected government, university-based, and community-based websites also were explored for current information on urban Indigenous populations. Preliminary search terms included: Aboriginal/Indigenous, First Nations, Inuit, Métis, urban, off-reserve, urbanization, demographic trends, mobility patterns, health status, health outcomes, determinants of health, programs and services, and knowledge/service gaps. Additional search terms included: colonization, structural violence, health and social inequity/inequality, racism, discrimination, stigma, trauma-informed care, violence-informed care, harm reduction approach/practice, sovereignty, self-determination, equity-oriented health care, and mental health.

The data and literature that this report draws on vary, not only in how populations and geographies are defined, but also on the availability of information at the time of writing. The focus of this report is on urban Indigenous people. Consistent, up-to-date, and accessible information specific to this population is growing but remains limited, lagging, and largely focused on off-reserve First Nations populations. Therefore, the information presented in this report was synthesized from a variety of sources for the purpose of identifying general trends in health and health care for urban Indigenous populations in Canada.

KEY TERMS AND DEFINITIONS

This report focuses on Indigenous people residing in urban centres throughout Canada. *Indigenous Peoples* is a collective term used to describe the original peoples of North America and their descendants (Crown-Indigenous Relations and Northern Affairs Canada [CIRNAC], 2021). Indigenous Peoples in Canada include First Nations people, Inuit, and Métis people, regardless of whether they reside on or off reserve or have registered status pursuant to the *Indian Act*. It is common to use the collective term, *Indigenous Peoples* to emphasize the diverse and distinct colonial histories, languages, cultural practices, spiritual beliefs, rights, contributions, and homelands of First Nations people, Inuit, and Métis people (Younging, 2018). As such, this report uses the term *Indigenous Peoples* when referring to First Nations people, Inuit, and Métis people collectively. The term *Indigenous people* is used in reference to a subset of Indigenous individuals, except where distinct Indigenous identities are described, such as with studies involving First Nations people, Inuit, or Métis people, specifically.

A *reserve* refers to a tract of Crown land that is set aside and held in trust by the federal government for the use and benefit of a First Nation (the administrative body of a reserve) (Department of Justice, 2021). An *urban reserve* refers to reserve land that is located within or adjacent to an urban centre (Indigenous Services Canada [ISC], 2017). Generally, only registered members of a First Nation may reside on reserve lands, unless the First Nation has adopted a residency bylaw that regulates who has the right to reside on the reserve lands allocated to that First Nation (Indigenous Corporate Training [ICT], 2021). Most First Nations residents encompass both First Nations people who are recognized by the federal government (via registration on the federal *Indian Register*) as a First Nations person (*status First Nations*) and First Nations people who self-identify as a First Nations person but are not recognized by the federal government (not registered on the *Indian Register*) as a First Nations person (*non-status First Nations*), pursuant to the *Indian Act* (CIRNAC, 2021).

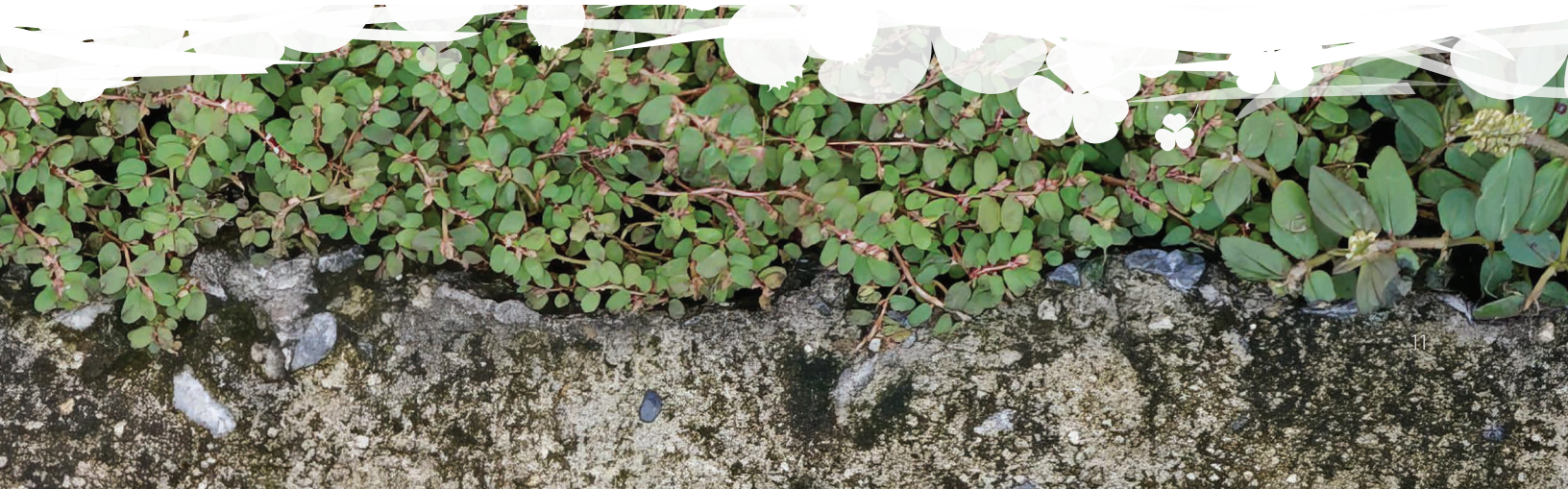
First Nations residents of a First Nation community are often referred to as residing *on reserve*. First Nations people who do not reside in a First Nation community are referred to as residing *off reserve*. Generally, Inuit and Métis people do not reside in First Nations reserves (ICT, 2021). Rather, most Inuit reside in *Inuit Nunangat,* the Inuit homeland encompassing 51 Inuit communities within four Inuit regions along the northern Arctic coastline of Canada (ISC, 2020). Inuit residents of Inuit

communities are often referred to as residing *in Inuit Nunangat*. Inuit who do not reside within the Inuit homeland are referred to as residing *outside Inuit Nunangat*. There are also distinct Métis communities that have been established in rural and urban areas throughout Manitoba, Saskatchewan, and Alberta, as well as in parts of Ontario, British Columbia, and the Northwest Territories. Together, these Métis communities, which are mainly located in towns and urban centres along the routes of the historical fur trade, constitute the *Métis Nation Homeland* (Library and Archives Canada, 2020). However, Alberta is the only province in Canada with a recognized Métis land base, which is comprised of eight Métis settlements (Canadian Geographic, 2018a; Metis Settlements General Council [MSGC], 2018).

The term *urban* is widely used to refer to a concentration of population at a high density. It is the opposite of the term *rural*, which refers to a population that is not concentrated but rather dispersed at low density (Statistics Canada, 2017a). Formerly called an *urban area*, a *population centre* is an area with a population of at least 1,000 people and a population density of 400 or more people per square kilometre. All area outside population centres is recognized as *rural area*. Further, *small population centres* are comprised of 1,000 to 29,999 people; *medium population centres* are comprised of 30,000 to 99,999 people; and *large urban population centres* are comprised of 100,000 or more people (Statistics Canada, 2017b). A *census agglomeration* (CA) is an urban area with a core population of at least 10,000 people, while a *census metropolitan area* (CMA) is a large urban area with a total population of at least 100,000 people, of which 50,000 or more people reside in the core of the urban area (Statistics Canada, 2019).

This report uses the term *urban centre* in reference to populations with a highly dense concentration of at least 30,000 people. The term *urban Indigenous people* is used when referring to Indigenous people who reside in urban centres with a population of 30,000 or more people (Wilson, 2018), including off-reserve First Nations people, Inuit residing outside Inuit Nunangat, and Métis people.

Data for Indigenous populations tend to follow the on-reserve/off-reserve divide rather than the rural/urban divide. There is an interchange between on reserve and rural, and off reserve and urban, but these sets of terms do not perfectly align and they do not provide a true representation of Indigenous people residing in urban centres. This is mainly because *off reserve* is a term associated with First Nations people and there are rural areas situated outside reserve lands, as well as small urban population centres located in rural areas. There is also a small population of Indigenous people who reside on reserves located within or adjacent to urban centres (Mason, 2019). Nevertheless, although off reserve is acknowledged by researchers as being different from urban, it is often used as a proxy for urban Indigenous populations (Place, 2012). The limitations associated with this practice are acknowledged in this report.



URBANIZATION AND MOBILITY PATTERNS

The urbanization of Indigenous Peoples predominantly involves the movement of First Nations people, Inuit, and Métis people from First Nations communities, Inuit Nunangat, and rural communities to medium and large urban population centres. This section focuses on the growth of urban Indigenous populations in Canada and related factors associated with the mobility patterns and profile of urban Indigenous people.

Urbanization of Indigenous Peoples

Statistics Canada counted 1,807,250 people who identified as Indigenous in the 2021 Census, accounting for 5.0% of the country's total population (Statistics Canada, 2022a). Of this Indigenous population, 801,045 Indigenous people (44.3%) were recorded as residing in urban centres, representing an increase of 12.5% since 2016. A further breakdown reveals that 32.5% of Indigenous people resided in large urban centres,[2] 11.0% resided in medium population centres,[3] 20.9% resided in a small population centre,[4] and 35.9% resided in rural areas (Statistics Canada, 2022b). Table 1 provides a breakdown of the total Indigenous population, Table 2 provides a breakdown of status First Nations people residing off reserve and on reserve, and Table 3 provides a breakdown of Inuit residing in and outside Inuit Nunangat.

[2] Defined as a population of 100,000 or more (Statistics Canada, 2015b).
[3] Defined as a population between 30,000 and 99,999 (Statistics Canada, 2015b).
[4] Defined as a population between 1000 and 29,999 (Statistics Canada, 2015b).

TABLE 1: INDIGENOUS POPULATION IN CANADA, BY INDIGENOUS GROUP, 2021

	Total population (n)	Percentage of total Indigenous population (%)
Indigenous	1,807,250	100.0
First Nations	1,048,405	58.0
Status	753,115	41.7
Non-status	295,290	16.3
Métis	624,215	34.5
Inuit	70,540	3.9

Source: Statistics Canada, 2022b.

TABLE 2: STATUS FIRST NATIONS POPULATION IN CANADA, 2021

	Total population (n)	Percentage of total status First Nations population (%)
Off reserve	447,350	59.4
On reserve	305,765	40.6

Source: Statistics Canada, 2022b.

TABLE 3: INUIT POPULATION IN CANADA, 2021

	Total population (n)	Percentage of total Inuit population (%)
Inuvialuit region	3,174	4.5
Nunatsiavut	2,116	3.0
Nunavik	12,556	17.8
Nunavut	30,826	43.7
Outside Inuit Nunangat	21,868	31.0

Source: Statistics Canada, 2022b.

Most Inuit residing outside Inuit Nunangat were residing in and around the nation's Capital, making the Ottawa-Gatineau area the largest urban Inuit community in southern Canada (Canadian Geographic, 2018b).

Over the last eight decades, Canada has seen a steady increase in the number of Indigenous people residing in urban centres (Congress of Aboriginal Peoples, 2019). According to the 2021 Census, Winnipeg, Edmonton, and Vancouver had the highest numbers of urban Indigenous people. However, these numbers do not necessarily equate to the largest proportions of Indigenous people in the total population. Indigenous people made up a much larger share of the total population in several smaller urban centres in the western provinces, such as Thompson, Manitoba (45.5%), Prince Albert, Saskatchewan (41.9%), and Prince Rupert, British Columbia (40.5%) (Statistics Canada, 2022b).

Of the total Indigenous population, Métis people were most likely to reside in urban centres. In 2021, 55.4% of the Métis population were residing in an urban centre of at least 100,000 people (Statistics Canada, 2022a). Many Inuit (15.3%) residing outside Inuit Nunangat were also residing in large urban centres. According to Statistics Canada (2022b), 31.0% of Inuit now reside outside Inuit Nunangat. In Ontario alone, the Inuit population has grown from less than 100 in 1987 (Canadian Geographic, 2018b) to an estimated 4,310 in 2021 (Statistics Canada, 2022b). Most Inuit residing outside Inuit Nunangat were residing in and around the nation's Capital, making the Ottawa-Gatineau area the largest urban Inuit community in southern Canada (Canadian Geographic, 2018b). Edmonton and Montreal also have high Inuit populations compared with other urban centres. Table 4 lists the number and percentage of Indigenous people in the total CMA population of ten selected urban centres.

TABLE 4: NUMBER AND PERCENTAGE OF INDIGENOUS PEOPLE IN TOTAL POPULATION OF SELECTED CMAS AND BREAKDOWN OF TOTAL INDIGENOUS POPULATION IN SELECTED CMAS, 2021

CMA	Total Indigenous population (n)	Percentage of total CMA population (%)	First Nations population n (%)	Inuit population n (%)	Métis population n (%)
Winnipeg	102,075	12.5	42,540 (41.7)	485 (0.5)	56,525 (55.4)
Edmonton	87,600	6.3	39,305 (44.9)	1,300 (1.5)	44,305 (50.6)
Vancouver	63,340	2.4	35,950 (56.8)	515 (0.8)	24,105 (38.1)
Calgary	48,625	3.3	20,890 (43.0)	505 (1.0)	25,250 (51.9)
Ottawa-Gatineau	46,540	3.2	23,395 (50.3)	1,730 (3.7)	19,295 (41.4)
Montreal	46,085	1.1	25,350 (55.0)	1,140 (2.5)	16,270 (35.3)
Toronto	44,635	0.7	25,770 (57.7)	590 (1.3)	15,325 (34.3)
Saskatoon	34,890	11.2	17,505 (50.2)	125 (0.3)	16,290 (46.7)
Regina	24,520	10.0	14,405 (58.8)	140 (0.6)	9,360 (38.2)
Victoria	19,455	5.0	10,795 (55.4)	140 (0.7)	7,665 (39.4)

Source: Statistics Canada, 2022b.

Ethnic mobility in urban Indigenous populations

Data from Statistics Canada (2017c) showed that between 2006 and 2016, the Indigenous population had grown by 42.5%, which was more than four times the growth rate for the non-Indigenous population over the same period. By 2021, the Indigenous population had grown by another 9.4%, surpassing the 5.3% growth of the non-Indigenous population over the same period (Statistics Canada, 2022a). Although the pace of growth has slowed, it was projected that the total Indigenous population will continue to grow exponentially, reaching between 2.5 million and 3.2 million Indigenous people over the next two decades (Statistics Canada, 2022a). This projected population growth includes First Nations people residing on reserve, Inuit residing in Inuit Nunangat, and Indigenous people residing in urban centres (Statistics Canada, 2017c).

Two main factors have contributed to the rapid growth of Indigenous populations – natural growth, such as increased life expectancy and relatively high fertility rates, as well as changing patterns of self-reported Indigenous identification (Statistics Canada, 2017c). Ethnic mobility, or response mobility, refers to the phenomenon in which people change their response to questions about their ethnic origin and/or ethnic identity from one census to the next (Statistics Canada, 2015a). In cases of Indigenous identity questions, more people are newly identifying as Indigenous in the Census (Statistics Canada, 2017c). In the context of this continuing trend, there is an increased likelihood for respondents who have not previously done so, particularly in urban centres, to identify as First Nations, Inuit, or Métis, thus leading to growth in urban Indigenous populations that cannot be explained by traditional factors such as births, longevity, and residential migration (Anderson, 2019a).

Understanding the changing patterns of self-reported Indigenous identification is important because of its implications not only on the size, composition, and characteristics of urban Indigenous populations, but also on efforts to address the legitimate needs and priorities of urban Indigenous people. The 2016 Census revealed that 24.6% of the total Indigenous population had identified as non-Indigenous in the previous census (O'Donnell & LaPointe, 2019). The data further showed that ethnic mobility was more prevalent in non-status First Nations (52.4%) and Métis (39.1%) populations, and less common in status First Nations (4.6%) and Inuit (6.6%) populations. This could help to explain not only why most of the growth in Indigenous populations had occurred in urban settings, but also why there was increased geographic integration of Indigenous people throughout urban centres (Anderson, 2019a).

Most urban Indigenous people tend to be disproportionately concentrated in and around the inner-city areas of urban centres (Bingham et al., 2019; Kruz et al., 2016; Nejad et al., 2019; Tu et al., 2019). In recent decades, however, Indigenous people have become more geographically dispersed. Considering recent trends in ethnic mobility, what appears to be an increase of Indigenous people in different parts of urban centres might actually be the result of people who were already geographically integrated reporting an Indigenous identity for the first time in the Census (Anderson, 2019a).

To illustrate this point, Anderson (n.d.) reported that the Indigenous population in Saskatoon had gradually increased in absolute numbers and proportionately from 11,920 (5.7% of the city's population) in 1991, to 15,550 (7.5%) in 1996, and to 20,275 (9.1%) in 2001. More recently, approximately one in 10 residents of Saskatoon had identified as Indigenous from all but two of the city's 60 neighbourhoods. In two inner-city neighbourhoods, which happened to be the poorest neighbourhoods in the city, close

to half of the population identified as Indigenous; and in another two neighbourhoods, which were also poor neighbourhoods, more than one third of residents identified as Indigenous. Among the rest of the city's 60 neighbourhoods, people who identified as Indigenous comprised 20- 29% of the population in four neighbourhoods; 10- 19% of the population in 11 neighbourhoods; and less than 10% of the population (many as few as 1-3%) in the remaining 38 neighbourhoods (Anderson, n.d.).

The rapid growth and widening disbursement of urban Indigenous people may be due to social factors, people's newly acquired understandings of their family history, changes in legislation, and even recent court decisions (Caron-Malenfant et al., 2014; O'Donnell & LaPointe, 2019; Organization for Economic Co-operation and Development [OECD], 2020). For example, Bill C-31 was passed into law in 1985 to address gender discrimination embedded in the *Indian Act*.[5] It restored registered status to First Nations people who had been forcibly enfranchised and allowed First Nations communities to control their own membership as a step towards self-determination (Indigenous Foundations, 2009a). With the implementation of Bill C-31, an estimated 76,000 First Nations women and their children who had lost registered status through previous marriage-related policies, as well as several other enfranchised First Nations people, became eligible for status reinstatement under the provisions of the new statute. Accordingly, over 100,000 people (most of whom were residing in urban centres) were added to the population of status First Nations people (Trovato & Price, 2015). Similarly, Bill C-3, which was implemented in 2011, provided reinstatement to the grandchildren of First Nations women who had lost registered status through marriage prior to 1985. As a result, more than 37,000 First Nations people acquired First Nations status between 2011 and 2017 (Assembly of First Nations, 2020).

[5] Implemented in 1876, the *Indian Act* is an amendment and consolidation of early federal legislation concerning First Nations people. It was intended to serve as a framework for the establishment and administration of land reserves and First Nations. It also served to disrupt the social, political, and spiritual structures of First Nations societies and assimilate First Nations people into Canadian society (Zach, 2020).

The case of *Daniels v. Canada* involved a lengthy legal dispute pertaining to the federal government's fiduciary responsibility and legal recognition of non-status First Nations people and Métis people as *Indians* under Section 91(24) of the Constitution Act, 1982. In 2016, this 17-year legal battle concluded with the Supreme Court of Canada's decision that the federal government has a constitutional obligation to non-status First Nations and Métis people, which includes a fiduciary duty to respect their unique and diverse rights, interests, and needs as Indigenous people (Congress of Aboriginal Peoples, 2019). With this ruling, over 600,000 non-status First Nations and Métis people assumed not only the possibility of future litigation with the federal government over land claims, but also potential entry into post-secondary education, health care benefits, and other government programs and services for Indigenous people (Conn, 2019).

Flanagan (2017) asserted that there are numerous incentives for people to self-identify as Indigenous, including health care benefits, tax benefits, social support for advanced education, hunting and fishing rights, and benefits that stem from Indigenous community membership. Palmater (2011), on the other hand, explained that Indigenous identity constitutes much more than simply gaining access to status entitlements and Aboriginal rights negotiated in treaties and comprehensive land claim agreements; it is about establishing and fostering a sense of individual Indigenous identity and communal cultural belonging. Whatever the connection, cultural continuity through Indigenous identity remains an essential part of ensuring the overall well-being of Indigenous Peoples and communities (ICT, 2018).

Despite the steady growth of urban Indigenous populations, Indigenous Peoples are often thought of as rural, northern, and reserve-based; not urban. This belief has contributed to longstanding tensions over the presence of Indigenous people in urban centres, which continue to affect their health and well-being (BCAAFC, 2020; Congress of Aboriginal Peoples, 2019; Senese & Wilson, 2013).

Urban migration and mobility in Indigenous populations

Despite the steady growth of urban Indigenous populations, Indigenous Peoples are often thought of as rural, northern, and reserve-based; not urban. This belief has contributed to longstanding tensions over the presence of Indigenous people in urban centres, which continue to affect their health and well-being (BCAAFC, 2020; Congress of Aboriginal Peoples, 2019; Senese & Wilson, 2013). Much of the contention regarding urban Indigenous people is rooted in the long history of European sovereignty and related colonial processes of oppression and dispossession (Nejad et al., 2019; Senese & Wilson, 2013; Snyder & Wilson, 2015). Through the implementation of the *Indian Act* and reserves, for instance, First Nations people were forced to relocate to remote tracts of land that were set apart from mainstream populations, generally at great distances from urban centres. Additional federal policies, such as the *Pass System*,[6] also served to restrict the movement of First Nations people, keep them away from urban centres, and ensure their separation from mainstream populations (Joseph, 2018).

Inuit and Métis people share similar experiences of displacement, including the forced migration of Inuit to the High Arctic to accommodate federal sovereignty over the Arctic islands and surrounding area (Madwar, 2018), and the forced relocation of the Métis following the implementation of the *Scrip System*[7] and subsequent dispossession of their ancestral land base (Robinson, 2019). At odds with the idea of assimilation, these early exclusionary efforts reinforced notions of indifference that paved the way for the socioeconomic exclusion and discriminatory treatment of Indigenous people residing in urban centres (BCAAFC, 2020).

Since the release of the final report of the Truth and Reconciliation Commission (TRC) of Canada[8] in 2015, there has been increased interest in understanding the colonial experiences of First Nations people, Inuit, and Métis people. However, there is still little awareness about the historical conditions associated with Indigenous urbanization (Congress of Aboriginal Peoples, 2019). Canadian assimilation policies had contributed to the movement of First Nations people, Inuit, and Métis people to urban centres. For example, prior to 1985, policies embedded in the *Indian Act* ensured not only that First Nations women lost their registered status and legal recognition as an *Indian* when they married non-status men, but also that when they lost their registered status, they were prohibited from residing on reserve (Joseph, 2018). Forced to leave their homes on reserve, many First Nations women relocated to urban centres for employment, education,

[6] Between 1885 through 1951, First Nations people were required to obtain a travel pass, signed by an Indian Agent, if they wanted to leave their reserves. The authorized pass documented when First Nations people could leave their reserve, where they were permitted to go, and when they had to return to their reserve (Joseph, 2018).

[7] In the 1870s through 1920s, the federal government implemented a Scrip System which entitled the holder of a provisional certificate (a scrip) to acquire possession of certain portions of public land. Much like the numbered treaties, the basic premise of the scrip system was to extinguish Métis occupation and title over their traditional territories (Robinson, 2019).

[8] Published in 2015, the multi-volume final report of the Truth and Reconciliation Commission of Canada served to inform all Canadians about what happened in, and as a result of, Canada's *Indian Residential School* system and document important truths about Canada's history and Indigenous-Canada relations that extend far beyond residential schools (Fontaine et al., 2015).

and health and social services (Collier, 2020; Congress of Aboriginal Peoples, 2019). The forced enfranchisement of First Nations people who served in the military prompted a similar migration of First Nations people from reserves to urban centres (Desbiens et al., 2016). Many Métis people also made their way into urban centres, after losing title and rights to traditional homesteads via the Scrip System (Canadian Geographic, 2018c; Robinson, 2019).

Residential schools and Indigenous child welfare policies further contributed to the urbanization of Indigenous Peoples (Howard-Bobiwash & Lobo, 2013). Beginning in the early 1800s, the federal government implemented residential industrial and boarding schools to intern and prepare Indigenous children for integration into Canadian society by breaking their links to their cultures and identities and teaching them basic trades and husbandry skills (TRC, 2015). The schools were generally located in urban areas, usually at great distances from Indigenous children's home communities, which was part of the strategy to alienate them from their families and familiar surroundings (Hanson et al., 2020). Many Indigenous people who were educated through residential schools did not return to their reserve families and communities (TRC, 2015). In like manner, Indigenous children were frequently removed from the influences of their families and communities through use of the child welfare system (Hanson et al., 2020). Indigenous children removed from their families were generally placed with non-Indigenous foster families, often in distant urban centres (TRC, 2015). Cut off from their family and culture, many Indigenous people who were fostered out as children never returned to their home communities.

Federal policies aimed at controlling the spread of tuberculosis in Inuit Nunangat also sparked an influx of Inuit to large urban centres in southern Canada (Canadian Geographic, 2018b). In the 1920s, tuberculosis infections in Inuit communities began to reach epidemic proportions. By the 1940s, the incidence of tuberculosis among Inuit was staggering (ITK, 2018), with rates ranging from 1,500 to 2,900 cases per 100,000 population (Orr, 2013). Rather than treat tuberculosis right in their Arctic communities, the federal government opted to transport mass numbers of Inuit with the disease to sanatoria and hospitals in the south (ITK, 2013). Inuit were commonly interned in these institutions for lengthy periods of time (ITK, 2018). After many years of hospitalization, some Inuit returned to their home communities, while others remained either permanently or temporarily in urban centres throughout southern Canada (Bonesteel, 2006).

Indigenous Peoples become urbanized for a variety of reasons. With the encroachment of mushrooming towns and urban centres, for example, First Nations people may become urbanized because their reserve lands are located adjacent to or within urban centres. Other reasons include housing shortages, increased population pressures, and limited opportunities on reserve (Collier, 2020; Trovato & Price, 2015). The absence of high schools in some First Nations communities, particularly in remote regions of the country, requires many First Nations youth to move to urban centres to complete high school (Bennett, 2016; Talaga, 2017). Likewise, the lack of services in Inuit Nunangat has compelled many Inuit to relocate to urban centres for education and health care, for addictions treatment, to access assisted living facilities, and for a variety of child and family services and justice-related reasons (National Inquiry into Missing and Murdered Indigenous Women and Girls [NIMMIWG], 2019). Indigenous people also turn to urban centres to escape social dysfunction in rural/northern communities, to flee domestic violence situations, or to find refuge from family

breakdown and social alienation stemming from residential schools and enfranchisement policies (NIMMIWG, 2019).

Specific data on Indigenous Peoples' rural to urban migration generally are lacking and most available information is based on census data (Trovato & Price, 2015). Population trends have shown consistent net inflows of Indigenous people to reserves, as well as variable net inflows and outflows of Indigenous people in rural, northern, and urban areas (O'Donnell & LaPointe, 2019; Senese & Wilson, 2013). This means that the movement of First Nations people, Inuit, and Métis people from rural/northern communities to urban centres is not unidirectional, but rather includes a good deal of back-and-forth movement and residential mobility (Snyder et al., 2015).

Of the three distinct groups of Indigenous people, First Nations and Métis peoples demonstrate higher levels of off-reserve migration. According to Trovato & Price (2015), Inuit generally are more isolated from urban centres and adhere to a more traditional way of life. As such, they tend to be less inclined to move to urban centres. Even so, census results persistently have shown that First Nations people, Inuit, and Métis people are highly mobile (Trovato & Price, 2015). Compared with the non-Indigenous population, Indigenous people tend to move around more frequently within urban centres, as well as between rural/northern communities and urban centres (Amorevieta-Gentil et al., 2015; Cidro & Siddiqui, 2016; Snyder et al., 2015). Much of this movement may be attributed to the colonial dispossession that underlies Indigenous urbanization patterns, and to push and pull factors related to Indigenous people's transition to and adaptation within urban environments (Snyder & Wilson, 2012).

Several factors influence Indigenous people's movements to, from, and within urban centres, including the degree to which they are connected to their cultural background and traditional heritage, the length and intensity of their contact with non-Indigenous people, their proximity to rural/northern communities, and the extent of their involvement with urban services (Trovato & Price, 2015). For instance, urban Indigenous mobility patterns may be influenced by education and employment opportunities, adequate and affordable housing, availability of social services and cultural supports (Cidro & Siddiqui, 2016; Snyder et al., 2015), as well as experiences of racism and discrimination, cultural isolation, and alienation from family and friends (Alaazi et al., 2015; Genereux et al., 2021; Nejad et al., 2019).

Urban Indigenous population profile

Indigenous people residing in urban centres are not homogenous. Urban Indigenous populations are comprised of First Nations people, Inuit, and Métis people from diverse nations, with distinct colonial histories, cultures, and languages (Anderson, 2019a; Collier, 2020). Urban Indigenous people have different lived experiences and variable degrees of connection to Indigenous cultures (Fast et al., 2017). Many urban Indigenous people maintain close ties to a First Nation, Inuit Nunangat, or rural community, which is integral to sustaining traditional cultural practices and identities (BCAAFC, 2020). Some urban Indigenous people, particularly second and third generation city dwellers, may be more loosely connected to their ancestral homelands but maintain a sense of Indigeneity through connections to urban-based Indigenous organizations and involvement in urban pan-Indigenous cultural activities (BCAAFC, 2020). Despite their differences, urban Indigenous people share common experiences and characteristics that make them unique as a population.

Data from the 2016 Census showed that compared with the non-Indigenous population, more Indigenous women were residing in urban centres than Indigenous men (Statistics

TABLE 5: AVERAGE AGE (YEARS) OF INDIGENOUS AND NON-INDIGENOUS POPULATIONS IN SELECTED CMAS, 2021

CMA	Total Indigenous population (yrs)	First Nations population (yrs)	Inuit population (yrs)	Métis population (yrs)	Non-Indigenous population (yrs)
Winnipeg	31.6	28.4	28.1	34.1	40.9
Edmonton	31.2	29.3	29.4	33.0	38.8
Vancouver	34.8	33.9	33.9	36.2	41.5
Calgary	32.1	30.2	30.3	33.7	38.6
Ottawa-Gatineau	36.8	36.7	28.6	37.8	40.3
Montreal	40.0	42.5	28.1	36.5	40.6
Toronto	36.1	35.4	37.9	36.9	40.5
Saskatoon	29.4	27.0	26.8	32.2	39.1
Regina	28.9	26.8	27.8	32.0	39.7
Victoria	34.6	33.6	32.4	35.8	44.7

Source: Statistics Canada, 2022b.

Canada, 2016a). In each of the CMAs with the highest numbers of Indigenous people (Winnipeg, Edmonton, Vancouver, and Calgary), women made up almost 53% of the total Indigenous population. Census data further showed that compared with the non-Indigenous population, urban Indigenous populations were relatively young but aging. Age-related data specific to urban Indigenous people are not available, but census data from 2016 showed a median age of 30 years and an average age of 32.7 years for Indigenous people residing off reserve.[9] In comparison, the median and average ages for the non-Indigenous population were 41.3 and 40.9 years, respectively (Statistics Canada, 2016a). More recent data from the 2021 Census showed a continuing trend in which Indigenous people were generally younger than the non-Indigenous population, with an average age of 33.6 years vs. 41.8 years (Statistics Canada, 2022a).

Table 5 lists the average age for Indigenous and non-Indigenous populations in selected CMAs. Table 6 shows the percentage of Indigenous and non-Indigenous populations under the age of 15 years in selected CMAs.

TABLE 6: PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS POPULATIONS AGED 14 YEARS AND YOUNGER IN SELECTED CMAS, 2021

CMA	Indigenous population (%)	Non-Indigenous population (%)
Winnipeg	26.8	15.8
Edmonton	26.3	18.3
Vancouver	21.1	14.1
Calgary	24.6	18.5
Ottawa-Gatineau	19.3	17.1
Montreal	18.1	17.1
Toronto	18.4	15.7
Saskatoon	28.9	18.2
Regina	31.3	17.9
Victoria	21.5	12.5

Source: Statistics Canada, 2022b.

Some urban Indigenous people, particularly second and third generation city dwellers, may be more loosely connected to their ancestral homelands but maintain a sense of Indigeneity through connections to urban-based Indigenous organizations and involvement in urban pan-Indigenous cultural activities (BCAAFC, 2020).

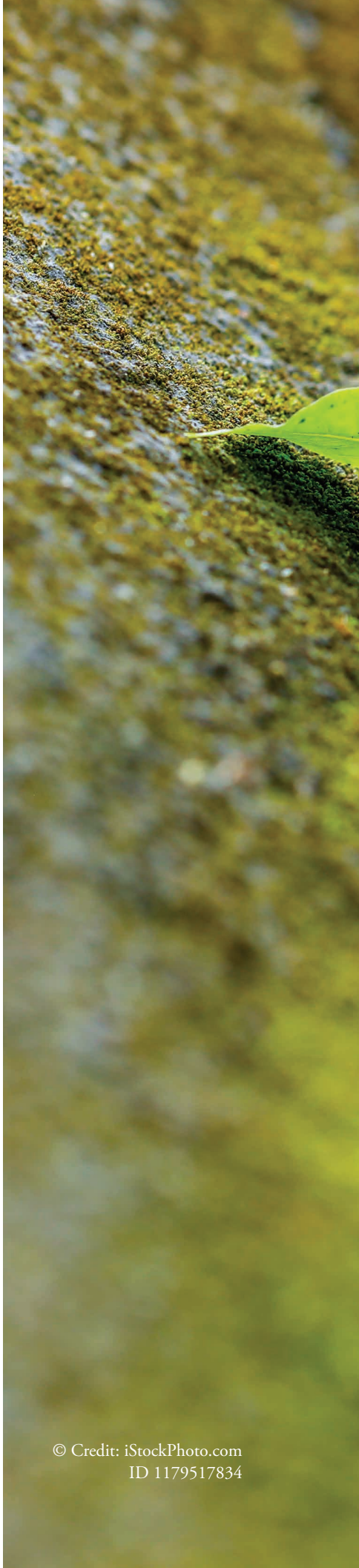
[9] Throughout this report, the terms *off reserve* (vs. *urban*) and *on reserve* (vs. *rural*) are generally used to coincide with the manner in which available data and literature are reported. Although there is an interchange between off reserve/urban and on reserve/rural, it is important to consider that reserve lands are specific to First Nations people and off reserve may include rural areas situated outside reserve lands. Accordingly, residing off reserve does not necessarily equate to residing in an urban centre.

Research on urban Indigenous seniors is limited, but available census data showed the number of Indigenous people aged 65 years and older more than doubled from 2001 to 2011, and more than half (52%) of the population of Indigenous seniors were residing in urban centres in 2016 (O'Donnell et al., 2017). Results from the 2021 Census showed that despite the relatively young Indigenous population, the proportion of Indigenous people aged 65 years and older continues to grow, with an increase from 7.3% in 2016 to 9.5% in 2021 (Statistics Canada, 2022a). Table 7 lists the percentage of Indigenous and non-Indigenous populations over the age of 54 years in selected CMAs.

TABLE 7: PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS POPULATIONS AGED 55 YEARS AND OLDER IN SELECTED CMAS, 2021

CMA	Indigenous population (%)	Non-Indigenous population (%)
Winnipeg	17.1	30.6
Edmonton	15.1	26.7
Vancouver	20.1	30.5
Calgary	15.9	25.5
Ottawa-Gatineau	24.2	30.2
Montreal	30.9	30.1
Toronto	21.4	29.0
Saskatoon	13.1	27.7
Regina	12.7	28.7
Victoria	20.3	37.4

Source: Statistics Canada, 2022b.

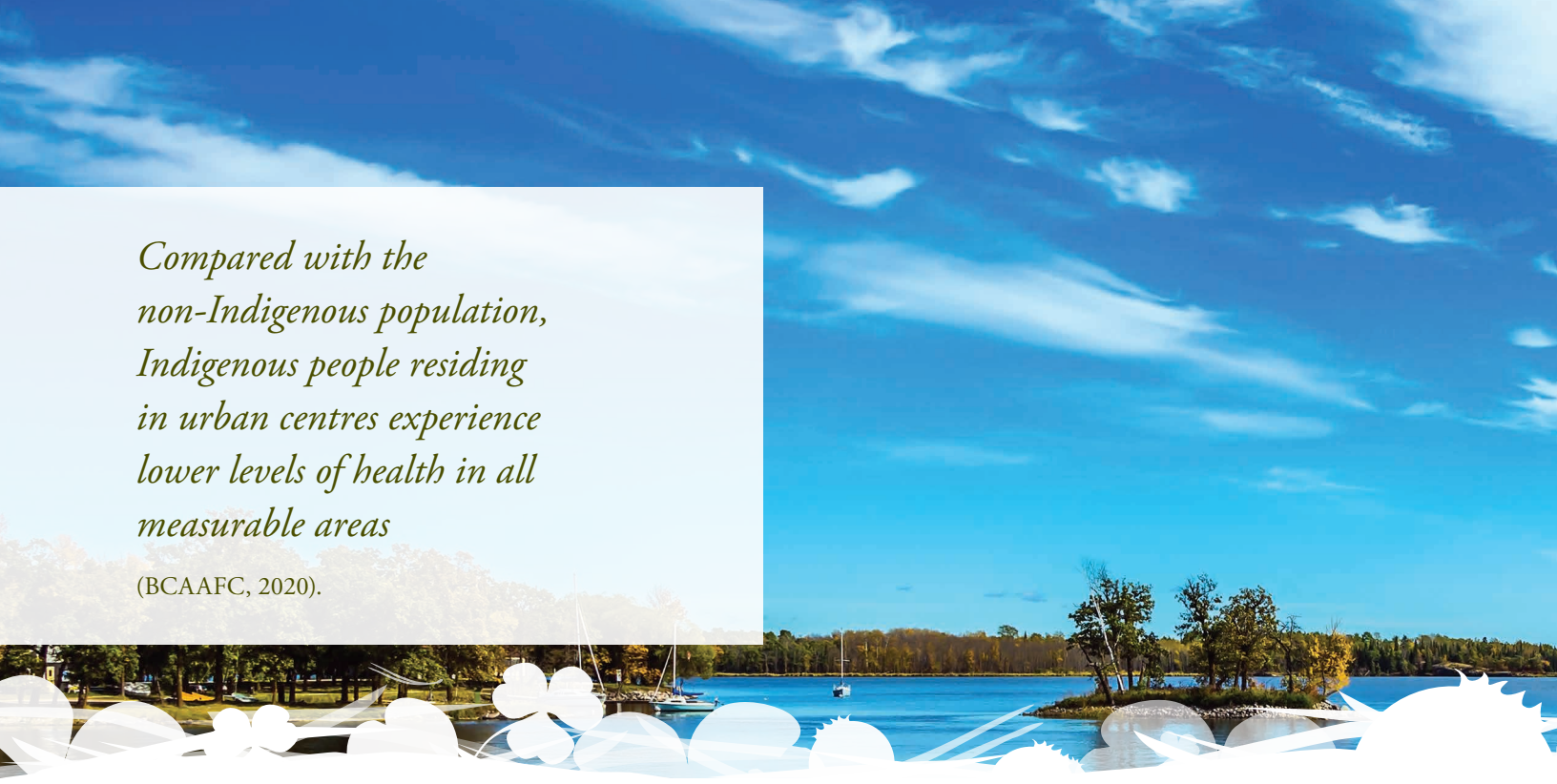


HEALTH STATUS

Health status deals with people's level of wellness and illness, including their state of physical, mental, emotional, and spiritual well-being. For many complex reasons, urban Indigenous people generally experience poorer health status and a lower quality of life than their non-Indigenous counterparts (BCAAFC, 2020). This section focuses on key issues that influence the health status and health outcomes of Indigenous people residing in urban centres.

Social determinants of health

Health is often described as being much more than merely the absence of disease and illness (Lane, 2020); it also involves physical, mental, emotional, and spiritual well-being (BCAAFC, 2020; Lane, 2020). From an Indigenous perspective, conceptualizations of wellness further include life stages, cultural continuity, and land-based relations that are not captured in colonialist definitions of wellness, which mainly focus on the physical and mental well-being of individuals (Ansloos et al., 2021; Kim, 2019; Thistle, 2017). This construct of holistic well-being takes into consideration not only the wide-ranging social, cultural, economic, and environmental factors that directly and indirectly influence the health status of individuals and populations, but also the way these contributing factors (or determinants of health) are interrelated and intersect across the life course (BCAAFC, 2020, Canada, 2020a; Loppie & Wien, 2022).



Compared with the non-Indigenous population, Indigenous people residing in urban centres experience lower levels of health in all measurable areas

(BCAAFC, 2020).

Social determinants of health frameworks increasingly have become a well-established means for understanding Indigenous health inequities, especially as they relate to colonialism, which is perhaps the most significant driver of poor health amongst Indigenous populations (National Collaborating Centre for Indigenous Health [NCCIH], 2018). Compared with the non-Indigenous population, Indigenous people residing in urban centres experience lower levels of health in all measurable areas (BCAAFC, 2020). To a large extent, the health status of urban Indigenous people is determined by their conditions of daily life (the circumstances in which they are born, grow, live, work, and age) that are the consequence of poor social policies and programs, unfair socioeconomic arrangements, and deficient politics (Public Health Agency of Canada [PHAC], 2018).

In essence, social determinants of health relate to an individual's place in society (Canada, 2020a) and include influences such as income, shelter, education, food, sustainable resources, social justice and equity, as well as geographic location and residency (BCAAFC, 2020). Experiences of discrimination, racism, and historical trauma are also important social determinants of health, particularly for urban Indigenous people. All these factors can impact not only urban Indigenous people's socioeconomic position in society and, subsequently, their own health and well-being, but also the health and well-being of the communities within which they interact (Centers for Disease Control and Prevention [CDCP], 2019; Rotenberg, 2016).

Colonialism and structural inequities

The health of urban Indigenous people is distinctly and differentially influenced by a broad range of complex, interrelated, and intersecting factors [10] (Loppie & Wien, 2022). As a distal factor, colonialism is a powerful root determinant involving the imposition of foreign cultures, governance structures, and ideologies that have profoundly reshaped the lives of First Nations people, Inuit, and Métis people (Reading & Wien, 2009/2013). The structural violence of colonialism has been justified through erroneous notions of white supremacy in which people who are racialized as white are inherently superior and exclusively possess all forms of power and privilege (Loppie & Wien, 2022). The health disparities, structural inequities, and additional health problems experienced by urban Indigenous people can be attributed to the long history of racism and discrimination, dislocation, marginalization, and social exclusion associated with colonialism (Allan & Smylie, 2015; Browne et al., 2011; Varcoe et al., 2019). Colonial structures like reserves, "Indian" hospitals, residential schools, and the child welfare system lie at the heart of the strained relationship between urban Indigenous people and Canadian institutions, including housing, education, health care, and social services (Ansloos et al., 2021). Moreover, they have preserved the historical, socioeconomic, and political conditions that determine the racial inequalities experienced by Indigenous people residing in urban centres (Ansloos et al., 2021; Brooks-Cleator et al., 2019; Hayward et al., 2020).

[10] Social determinants of Indigenous health include proximal factors that directly influence the health of an individual (i.e., education, food insecurity, health behaviours); intermediate factors which influence and explain proximal determinants (i.e., healthcare and education systems, community infrastructure, cultural continuity); and distal factors which represent the foundation from which all other health determinants are developed and sustained (i.e., colonialism, racism and social exclusion, self-determination) (Reading & Wien, 2009/2013).

Structural inequities embedded in healthcare systems have a significant impact on the health and well-being of urban Indigenous people. Health inequities refer to the unjust health and health care differences between and within populations that are caused by socially structured (and avoidable) marginalizing conditions (Varcoe et al., 2019) such as income inequality, historical and ongoing colonialism and racism, and stigma and discrimination against people with disability, mental health, or substance use issues (Raphael, 2015). Experiences of discrimination are often amplified when people facing issues of poverty, substance use, or other stigmatizing conditions like HIV also experience being treated differently on the basis of ethno-cultural or other identities (Tang et al., 2015; Varcoe et al., 2019). Unfavourable experiences of racial discrimination in childhood are proven to adversely affect the adult stress biology of urban Indigenous people, which not only takes its toll on the health and well-being of urban Indigenous people, but also exacerbates inequities between and within urban Indigenous populations (Currie et al., 2019).

According to Varcoe et al. (2019), people in marginalized positions have the least access to appropriate health care and are more likely to experience lower quality, under-resourced healthcare services, which may exacerbate harms through misdiagnoses, under-treatment, medical errors, untimely care, and increased conflict. Numerous studies have shown that people who experience structural inequities also experience stigmatization when seeking health care (Gilmer & Buccieri, 2020; Glynn et al., 2019; Purkey et al., 2020). For example, it is not uncommon for urban Indigenous people to experience inadequate and inequitable treatment in emergency departments, which makes them less likely to access health care and, paradoxically, more reliant on emergency departments as a result of delayed health care and required re-admissions (Varcoe et al., 2019). Urban Indigenous people are not only amongst the most severely structurally disadvantaged populations, but also demonstrate the highest ratings of discrimination in both emergency departments and everyday life, the lowest ratings of care, and the highest numbers of emergency department visits (Varcoe et al., 2022a).

Indigenous youth homelessness provides another example of the heavy toll of colonialism on the health of urban Indigenous people. Indigenous youth homelessness has been attributed to a variety of structural factors, system failures, personal circumstances, and relational problems rooted in colonialism (Ansloos et al., 2021; Gaetz et al., 2016; Gaetz et al., 2014). Societal conditions that restrict opportunities for urban Indigenous youth, inadequate policies and service delivery that allow urban Indigenous youth to slip through the cracks, and ineffective support systems such as child welfare, foster care, juvenile detention, and group homes which offer little if any support to Indigenous youth who have "aged out" of the very systems that were supposed to care for and protect them are just some of the reasons why many urban Indigenous youth experience homelessness (Ansloos et al., 2021; Patrick, 2014). The higher rates of poverty and food insecurity; lack of access to safe, affordable housing; shortfalls in higher education, job training, and employment; barriers to loans and investments; and higher rates of injury, chronic pain and illness, and poor mental health experienced by urban Indigenous people have all been linked to the health and social inequalities associated with colonialism (Hunting & Browne, 2012; Nelson & Wilson, 2017; Neufeld et al., 2020), and to the institutionalized discrimination enshrined in colonial policies and discourses that continue to racialize and marginalize the experiences and needs of Indigenous people (Hunting & Browne, 2012).

Despite the proliferation of age-friendly cities to support people in their later years of life, urban Indigenous older adults continue to experience inequalities that seriously hamper their health and well-being (Brooks-Cleator et al., 2019; O'Donnell et al., 2017). As noted by Brooks-Cleator et al. (2019), this is because most initiatives to support quality of life for older adults fail to account for the influences of historical and ongoing colonialism on urban Indigenous older adults. Specifically, their research with older First Nations and Inuit adults (aged 55 years and older) in Ottawa identified two main areas where participants felt their health and well-being could be better supported: the social environment (including responsive health and community support services, respect and recognition, and communication and information) and the physical environment (including transportation, housing, accessibility, and gathering space). Within each of these themed areas, urban First Nations and Inuit older adults emphasized the lack of recognition and respect they experienced, not only for their diverse languages, cultures, and histories, but also in relation to their different and unique experiences of colonization, racism and discrimination, and displacement.

It is well recognized that the influences of colonialism have affected virtually all aspects of urban Indigenous people's health and well-being, including their resiliency (Neufeld et al., 2020). What is not well understood, however, is how structural violence has affected modern day patterns of health determinants. Many works on the social determinants of urban Indigenous people's health fail to contextualize health within the historical, social, and economic systems of power and structural disadvantage (Hunting & Browne, 2012). What's more, they fail to acknowledge that colonial influences vary greatly within and between urban Indigenous populations, not only in terms of variations in lifestyles, traditions, languages, and cultures, but also with regards to the socioeconomic differences that exist between Indigenous people and their cultures due to historical and ongoing colonization (Ghosh & Spitzer, 2014; Currie et al., 2019).

Colonialism operates on many levels, including individual, systemic or community, and societal. Though it is important to account for colonialism when considering the health and well-being of urban Indigenous people, consideration must be given to both its point of origination and to individual and community or systems levels to effect change (Ansloos et al., 2021). Nelson and Wilson (2017) explain that it is easy for these levels to become confused. Sometimes, racism and poor health are effectively equated with colonialism, which causes a shift in focus away from the broader colonial structure. Focusing on the effects of the broad structure of colonialism on individuals can cause colonialism to become an individual-level problem, like in the treatment of historical and intergenerational trauma. Likewise, the push for ethnocultural diversity and inclusion can actually function to culturalize colonialism as a societal norm by focusing attention on efforts to be inclusive and accepting of all cultures, while ignoring Indigenous sovereignty and the unique and distinct, individual and collective colonial experiences of First Nations people, Inuit, and Métis people in Canada. As such, although discussions of colonialism are essential for understanding urban Indigenous people's health and well-being, it is imperative that these discussions be approached carefully, with prudent attention to the bigger picture of colonialism.

Education, employment, and income

Education, employment, and income are important social determinants of health; they are all intricately intertwined with socioeconomic status, which is directly associated with health status and health behaviours (Place, 2012). There are persistent differences in health by socioeconomic status, particularly between Indigenous and non-Indigenous populations (Canadian Institute for Health Information [CIHI], 2016; Haan et al., 2020; Hajizadeh et al., 2018; Hajizadeh et al., 2019; Hamdullahpur et al., 2017). Socioeconomic status among urban Indigenous people is determined by several interlinking factors (such as social distance, education, gender, occupational characteristics, and income), but education, skill level, and industry of employment are major indicators of socioeconomic status (Haan et al., 2020).

Higher education greatly improves the chances of urban Indigenous people for stable employment and higher earnings (Statistics Canada, 2018a). The acquisition of skills (such as computer skills, numeracy skills, and the ability to read and write) also plays a vital role in labour market success (Anderson, 2019b). In 2016, 40% of First Nations people aged 15 years and older residing off reserve had completed a post-secondary certificate, diploma or degree, up from 36% in 2006. The percentage of off-reserve First Nations people with less than a high school diploma dropped from 40% in 2006 to 32% in 2016 (Statistics Canada, 2018b). Additionally, 36% of off-reserve First Nations people participated in some sort of training to enhance their employment skills, with 78% of this population engaging in job-specific training such as professional, equipment, and occupational health and safety training (Anderson, 2019b).

Correspondingly, employment rates for off-reserve First Nations people vary with level of education. In 2016, 75% of off-reserve First Nations people with a college diploma or apprenticeship certificate (Statistics Canada, 2018a) and 77% with a university degree were employed, while only 56% who completed high school and 29% with less than a high school diploma were employed (Statistics Canada, 2018b). Among those who were employed, 82% had a permanent job and 11% were self-employed; 36% of self-employed off-reserve First Nations people owned an incorporated business, and 30% of these incorporated businesses had employees (Statistics Canada, 2018b). In 2020, 22.8% of employed off-reserve Indigenous people were working part-time (less than 30 hours per week at their main job), with more women than men working part-time (28.4% vs. 17%) (Statistics Canada, 2023). Off-reserve Indigenous youth (15 to 24 years) were also more likely than those of core working ages (49.8% vs. 15.6%) to work part-time. Table 8 list the top five employment industries for off-reserve Indigenous people of core working ages (25 to 64 years).

The link between education and employment, particularly high-paying employment, is well-established. With each higher level of education attained, the likelihood of employment increases significantly (Statistics Canada, 2013; Zhao et al., 2017). For urban Indigenous people, the rate of return on education is higher than among the non-Indigenous population. For example, Ciceri and Scott (2006) found that non-Indigenous university graduates were three and a half times more likely to be employed than non-Indigenous people without any formal education qualifications. In comparison, Indigenous university graduates were five times more likely to be employed than Indigenous people without a degree or diploma. Further, the gap in employment between women and men was slightly narrower among Indigenous people than among non-Indigenous people (Ciceri & Scott, 2006). Still, off-reserve Indigenous women with lower education are less likely to be employed than their male counterparts (Statistics Canada, 2018b, 2018c, 2018d).

TABLE 8: TOP 5 EMPLOYMENT INDUSTRIES FOR OFF-RESERVE INDIGENOUS WOMEN AND MEN, 2021

Indigenous women		Indigenous men	
Industry	% of employed	Industry	% of employed
Health care and social assistance	24.8	Construction	17.6
Educational services	11.2	Manufacturing	9.4
Public administration	10.5	Public administration	9.2
Retail trade	9.9	Retail trade	7.7
Accommodation and food services	5.3	Transportation and warehousing	7.1

Source: Statistics Canada, 2023.

TABLE 9: EDUCATION, EMPLOYMENT, AND INCOME FOR OFF-RESERVE INDIGENOUS AND NON-INDIGENOUS POPULATIONS, 2021

Social determinant of health	Total Indigenous population	First Nations population	Inuit population	Métis population	Non-Indigenous population
Education					
No certificate, diploma, or degree	26.2	28.0	49.8	22.1	15.5
High school diploma or equivalency certificate	30.9	31.4	23.7	31.1	26.5
Apprenticeship or trades certificate or diploma	9.7	9.2	7.0	10.5	8.7
College, CEGEP or other non-university certificate or diploma	19.6	18.7	13.5	21.3	18.9
University certificate or diploma below bachelor level	2.2	2.2	1.2	2.3	3.0
Bachelor's degree	8.3	7.7	3.6	9.3	17.9
Master's degree	1.9	1.9	0.9	2.0	5.9
Earned doctorate	0.2	0.3	0.1	0.2	1.0
Employment					
Labour force participation rate	62.2	59.5	56.7	66.1	63.9
Employment rate	53.1	49.8	46.4	57.6	57.4
Unemployment rate	14.7	16.3	18.1	12.8	10.1
Income in 2020					
Median after tax income	$33,600	$32,400	$31,400	$35,600	$37,200
Composition of total income – employment	66.8	65.2	67.6	68.6	66.8
Composition of total income – government transfers	23.9	26.5	26.1	21.0	17.5
Percentage with employment income	71.7	69.0	73.3	74.8	72.4
Prevalence of low income after tax, as per based on low-income measure, after tax	16.1	18.9	16.5	12.8	10.7
Poverty rate	11.8	14.1	10.2	9.2	7.9

Note: Except where otherwise indicated, data represent proportion (%) of population.
Source: Statistics Canada, 2016.

Overall, urban Indigenous people have made significant educational gains at every level (Statistics Canada, 2018a) and their socioeconomic conditions appear to be improving. Nevertheless, they continue to demonstrate lower rates of labour force participation, higher levels of unemployment, lower median income, and lower levels of education than non-Indigenous people (Sawchuk, 2020). Table 9 provides an overview of some of the socioeconomic differences between off-reserve Indigenous and non-Indigenous populations.

Core housing and homelessness

Safe, accessible, and sustainable housing is integral to the health and development of urban life, yet housing insecurity continues to be a major concern for Indigenous people residing in urban centres, particularly amongst women, youth, gender-diverse people, and elderly people (Congress of Aboriginal Peoples, 2019; Gaetz et al., 2016; Native Women's Association of Canada [NWAC], 2019). In 2016, nearly half (49%) of all urban Indigenous people were living in rented dwellings and just over one in five (21%) urban Indigenous people were living in subsidized housing. In comparison, 29% of non-Indigenous people were living in rented dwellings and 11% were living in subsidized housing (Anderson, 2019a). Urban Indigenous people also remained largely concentrated in neighbourhoods where housing conditions and income fall below levels found in other urban areas (Anderson, n.d.; Anderson, 2019a). Although urban Indigenous people were less likely than non-Indigenous people (51% vs. 71%) to live in a dwelling that was owned by a member of the household in 2016, the proportion of urban Indigenous people living in owned dwellings had increased since 2006 from 40% to 43% among First Nations people, from 45% to 48% among Inuit, and from 57% to 61% among Métis people (Anderson, 2019a).

Regardless of whether their dwellings were rented or owned, in 2021, 16.4% of urban Indigenous people were living in dwellings that needed major repairs, which was almost three times the rate of non-Indigenous people (5.7%) (Statistics Canada, 2023). Household crowding, which occurs when there is more than one person per room in a household, is another area where there are stark differences between urban Indigenous and non-Indigenous populations. In 2021, 11.3% of First Nations people, 29.1% of Inuit, and 2.4% of Métis people in urban centres were living in crowded households compared with 5% of non-Indigenous people (Statistics Canada, 2023). What's more, urban Indigenous people face significant barriers to housing affordability, which not only have a profound effect on their quality, safety, and accessibility of suitable housing, but also position them at disproportionately high risk of becoming homeless (Congress of Aboriginal Peoples, 2019; Gaetz et al., 2014; Gaetz et al., 2016; Patrick, 2014).

Nearly one in five (18%) Canadian renter households experience extreme housing affordability problems (Gaetz et al., 2014). This means they have low household incomes, are paying more than 50% of their household income on rent, have very little room for spending on other necessities, and are at increased risk of homelessness. Over 235,000 Canadians are affected by homelessness each year, with over 35,000 Canadians experiencing homelessness on any given night (Gaetz et al., 2016). Among all homeless populations, Indigenous people are significantly over-represented (Anderson & Collins, 2014; Falvo, 2019; Gaetz et al., 2016; Kidd et al., 2019; Thistle & Smylie, 2020).

Homelessness is rapidly increasing in urban centres across the country for Indigenous people, especially in the Prairie regions (Belanger et al., 2013). For instance, in Gaetz et al.'s (2014) study of homelessness in Canada, Indigenous people comprised 46% of the homeless population in Saskatoon, over 60% in Winnipeg, and over 70% in Regina. The inventory of reasons for urban Indigenous homelessness are long and varied, but they generally entail a range of individual, societal, and systemic forces that lead to homelessness

(Belanger et al., 2013), such as issues related to mental health, addiction, and substance use (Belanger & Weasel Head, 2013; Bingham et al., 2018; Bingham et al., 2019; Employment and Social Development Canada, 2021); child welfare involvement and low educational attainment (Alberton et al., 2020); lack of opportunity for education and employment (Belanger & Weasel Head, 2013); migration and mobility (Anderson & Collins, 2014; Snyder et al., 2015); family conflict and violence (NWAC, 2019); and an inadequate and declining supply of affordable rental housing (Council of Community Homelessness, 2017; Snyder et al., 2015).

Access to subsidized housing greatly reduces the risk of homelessness and the need for core housing, but subsidized housing is limited. In most urban centres, affordable, quality housing for Indigenous people is in short supply and reflected in low vacancy rates (Brandon & Peters, 2014). Additionally, private and public rental housing are often inaccessible to urban Indigenous people due to their inability to meet identification and rental reference requirements; challenges associated with policies and processes concerning security deposits (particularly for urban Indigenous people receiving income assistance); and national occupancy standards that control for overcrowding by placing restrictions on the allowable number of persons per rental unit, in accordance with the maximum number of children, by age and gender, per bedroom (Brandon & Peters, 2014).

In addition to navigating the housing crisis (Congress of Aboriginal Peoples, 2019), many urban Indigenous people are forced to grapple with racism and discrimination in the rental market, lack of Indigeneity in housing policy and practices, and cultural differences (Alaazi et al., 2015). For example, one study of the At Home/Chez Soi (AHCS) project[11] in Winnipeg found that First Nations and Métis people's sense of place and home were adversely affected by a number of structural factors, such as incompatibility between Indigenous mobility patterns and current models of social

[11] Launched in 2009, the At Home/Chez Soi (AHCS) project was a four-year Housing First project of the Mental Health Commission of Canada that aimed to address chronic homelessness among people struggling with mental illnesses, substance addictions, and behavioural challenges by providing them with subsidized rental housing (public and private) and optional support services (medical treatment, counseling, skills training). Five demonstration sites (Moncton, Toronto, Montreal, Vancouver, and Winnipeg) were selected to pilot the Housing First model (Alaazi et al., 2015). In Winnipeg, the majority (71%) of AHCS participants were Indigenous (Distasio et al., 2014).

housing provision; landlord expectations and restrictions on accommodating family, friends, and other networks of support; and subtle tensions between Western understandings of home as a place for privacy and solitude and Indigenous conceptions of home, where cultural practices and ceremony, and connections to land and community, are indistinguishable from spaces of habitation (Alaazi et al., 2015).

Feeling safe, comfortable, and welcome (*home* as opposed to *housed*) is a fundamental part of urban Indigenous people's health and well-being. Considering the limited regard for Indigeneity across the urban sociocultural and political landscape (Alaazi et al., 2015), together with the adverse effects of intergenerational trauma and colonization, and lack of skills and experience needed for urban living, urban Indigenous people are significantly challenged in their ability to meet their core housing needs, which is a determining factor in their health status (Brandon & Peters, 2014).

Food security and traditional/country foods

The importance of food security cannot be overstated. Food security is jeopardized when people do not have certain or adequate access to an acceptable amount of affordable, nutritious food (Expert Panel on the State of Knowledge of Food Security in Northern Canada, 2014). Food insecurity is a contributing factor to numerous health and social issues, including poor general health and chronic health conditions, poor mental health, low educational outcomes, and life dissatisfaction (Anderson, 2015; Expert Panel on the State of Knowledge of Food Security in Northern Canada, 2014; Rotenberg, 2016).

Food insecurity is a nation-wide problem, but the odds of experiencing food insecurity increase with the mounting presence of certain factors, like being Indigenous, being a female lone parent, being a renter as opposed to a home owner, being in receipt of income assistance, and having an income that falls below the Low Income Measure.[12] Women are more likely than men to be affected by food insecurity and the prevalence of food insecurity is higher in households

[12] Low Income Measure defines low income as being below a fixed percentage of income. A household is considered low income if its income is below 50% of median household incomes (adjusted for family size). The low income cut off is based on after-tax income, which is the most widely used measure of low income that allows for comparison over time (Canada, 2016).

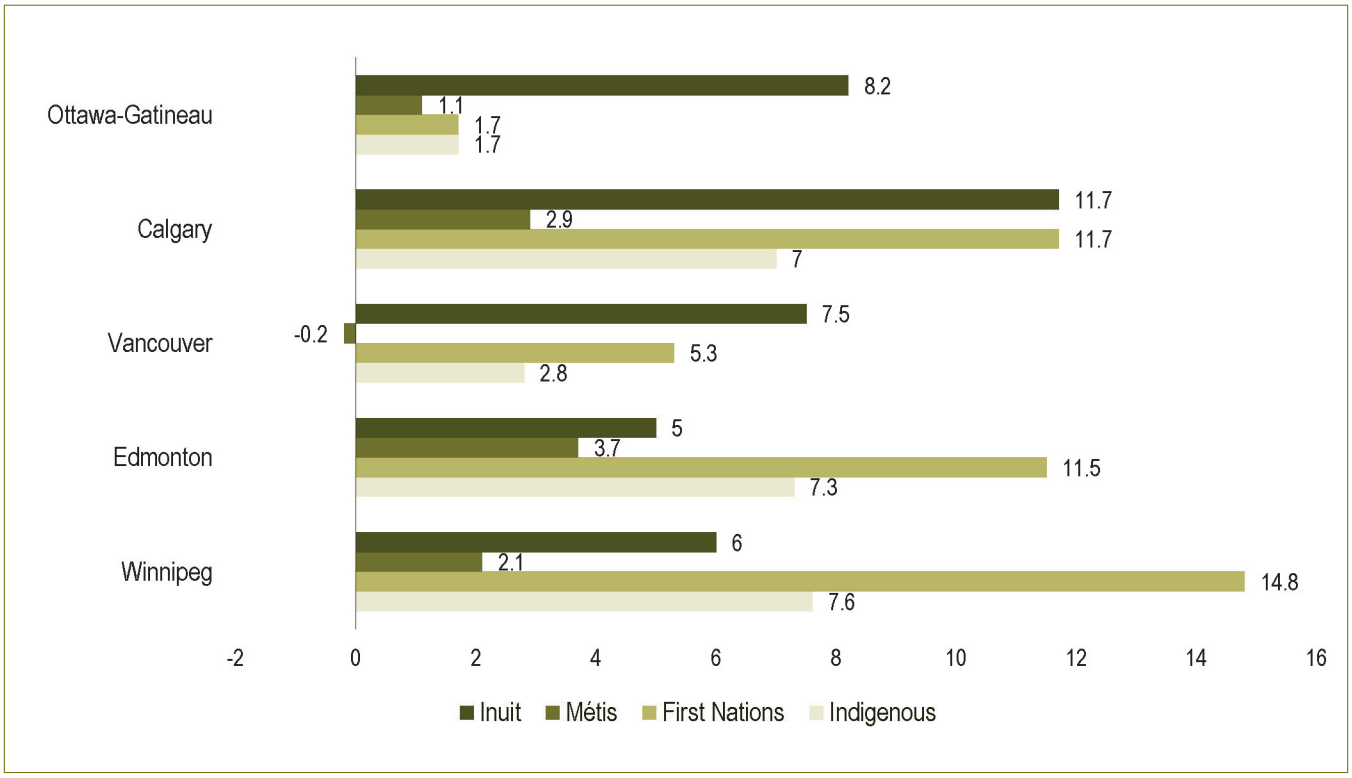
with children (Expert Panel on the State of Knowledge of Food Security in Northern Canada, 2014; Richmond et al., 2020). In 2017, 43% of First Nations people, 53% of Inuit, and 31% of Métis people residing in urban centres reported living in food insecure households, with urban Indigenous women more likely than urban Indig-enous men (41% vs. 34%) to experience food insecurity (Arriagada et al., 2020). Urban Indigenous women were also more likely than their male counterparts (44% vs. 33%) to be unable to cover unexpected ex-penses of $500 from their own resources. In comparison, 8.3% of non-Indigenous Canadians reported living in food insecure households (Richmond et al., 2020).

Food insecurity among urban Indigenous people is a complex issue involving a complicated web of social, economic, cultural, and health considerations (Skinner et al., 2016). It requires attention not only to the connections between food, environmental health, and human health (the food environment), but also to the colonial influences on urban Indigenous people's diet, their unique circumstances, and the cultural implications around harvesting, sharing, and consuming traditional/country foods (Bergeron et al., 2015; Kumar et al., 2019; Phillipps, 2021). Urban Indigenous people's access to food depends on the availability, quality, and affordability of food (Parker et al., 2018).

A major driver of food insecurity is poverty (Richmond et al., 2020). In 2016, 24% of urban Indigenous people were living in low-income households, compared with 14% of the non-Indigenous population (Anderson, 2019a). Moreover, 30% of urban Indigenous children and youth under the age of 18 years were living in poverty (Arriagada et al., 2020). The percentages of poverty were even higher for urban Indigenous children and youth living in lone-parent families (51%), living with grandparents without any parent present (43%), and living in foster care (37%) (Arriagada et al., 2020). While no comparable data are available for 2021, disaggregated trends in poverty from the 2021 Census of Population showed that in 2020, partly due to pandemic relief benefits, the poverty rate for Indigenous people residing off reserve in the provinces dropped from 23.8% in 2015 to 11.8% (Statistics Canada, 2022e). The corresponding rate for the non-Indigenous population was 7.9%. Of the five urban centres with the largest Indigenous populations, Winnipeg had the highest poverty rate for urban Indigenous people (16%), while Ottawa-Gatineau had the lowest poverty rate (8.8%). Within these urban centres, the poverty gap between Indigenous and non-Indigenous populations was consistently lowest among Métis. Inuit living in Ottawa-Gatineau and Vancouver and First Nations living Winnipeg and Edmonton had the highest poverty gap compared to the non-Indigenous population (Figure 1).

For many urban Indigenous people, poverty determines how, when, and where they access food, as well as which foods they acquire and consume (Cidro et al., 2015; Phillipps, 2021). Lack of choice and the time, money, distance, and transportation required to access quality (fresh, hygienic, nutritious) food greatly influence what foods are eaten by urban Indigenous people (Phillipps, 2021; Richmond et al., 2020). Higher costs involved with urban living; decreased ability to cook in shared accommodations; convenience of fast-food outlets; lower costs of convenience store food; and lack of access to traditional/country foods, breakdown of traditional culinary skills to procure and consume traditional/country foods, and removal of traditional practices involving physical exertion and food sharing also determine the diet and subsequent health of urban Indigenous people (Cyr & Slater, 2016; Ermine et al., 2020; Parker et al., 2018; Phillipps, 2021).

FIGURE 1: POVERTY GAP BETWEEN INDIGENOUS AND NON-INDIGENOUS POPULATIONS LIVING IN FIVE MAJOR URBAN CENTRES (2020)



Source: Statistics Canada (2022e).

To address food insecurity in urban Indigenous populations, Indigenous people residing in urban centres must have access to both market foods and traditional/country foods (Cidro et al., 2015; Cidro et al., 2016). Traditional/country foods and Indigenous food systems are not only intrinsic to the health and social, cultural, and economic well-being of urban Indigenous people (Maudrie et al., 2021; Ray et al., 2019; Richmond et al., 2020), but also essential for the cultural transmission and practice of Indigenous cultural values (Earle, 2011; Ermine et al., 2020). For example, one study showed that bannock[13] represented a distinct part of urban Indigenous people's cultural identity and belonging, and its creation, sharing, and consumption were deeply connected to their social holistic well-being (Cyr & Slater, 2016). Bannock was associated with personal learning experiences, family histories, community cultural events, ceremonies, and food security. As well, it offered a sense of comfort, cultural pride, and family and community connectedness, so much so that urban Indigenous people reported going to great lengths to keep bannock in their diets, despite the health risks associated with its high fat and

[13] Bannock is a flat quick bread that is made with few ingredients. Although its origin stems from Scottish settlers, Bannock is recognized as a traditional food that is very much a part of many Indigenous cultures (Cyr & Slater, 2016).

Urban Indigenous people ... spoke of revitalizing the dwindling practice of bannock-making through community-based workshops and classes to ensure practical knowledge of recipes and culinary techniques ... were not lost to younger generations and contemporary urban lifestyles.

refined carbohydrate content, particularly for those living with diabetes. Urban Indigenous people reported renewing bannock recipes and modifying bannock consumption to satisfy doctor-prescribed dietary restrictions. They also spoke of revitalizing the dwindling practice of bannock-making through community-based workshops and classes to ensure practical knowledge of recipes and culinary techniques (including the cultural teachings that accompany the making and serving of traditional/country foods) were not lost to younger generations and contemporary urban lifestyles.

Another study found that growing, nurturing, and harvesting or catching food reinforced urban Indigenous people's connections to the environment, spirituality, people, and other beings; and acquiring, preparing, sharing, and consuming traditional/country foods enhanced their opportunities for transmitting cultural knowledge, mentoring cultural values and practices, and building meaningful relationships within an urban setting (Cidro et al., 2015). Moreover, access to traditional/country foods empowered urban Indigenous people to address food insecurity through food sovereignty. Although challenging, urban Indigenous people reported being able to sustain their access to traditional/country foods and connections to the land and cultural values through sharing and reciprocity, like at gatherings and feasts where cultural foods are highly valued, by acquiring wild meat (bison, moose meat or fish) through family and friends, and by participating in urban gardening programs or other community shared agriculture programs.

These efforts speak to the concept of Indigenous food sovereignty, where urban Indigenous people possess the ability to improve their access to healthy, culturally appropriate foods and diet quality, while facilitating cultural connections and ultimately improving the health and well-being of urban Indigenous communities (Maudrie et al., 2021). As a strategy for addressing food insecurity, Indigenous food sovereignty provides urban Indigenous people the freedom to make decisions over the amount and quality of food they grow, harvest, prepare, and eat. It also provides a basis for practice-driven policy aimed at addressing the underlying issues that affect their well-being and their ability to respond to their own needs for fresh, hygienic, and nutritious foods (Indigenous Food Systems Network, 2022; Jennings et al., 2020; Kamal et al., 2015).

Nutrition and physical activity

Nutrition and physical activity are important for the maintenance of good health. Poor nutrition and physical inactivity are risk factors for several chronic health problems, including cancer, obesity, diabetes, heart disease, and respiratory diseases (Bergeron et al., 2015; Rand et al., 2018). Physical wellness, which helps to prevent chronic diseases, entails leading an active lifestyle, eating healthy foods, and sleeping well (BCAAFC, 2020). Urban Indigenous people have experienced significant changes in their diet and lifestyle that challenge their physical wellness. Historically, they lived active, healthy lifestyles, with balanced diets that included proteins, healthy fats, and essential nutrients (First Nations Health Authority [FNHA], 2022). Today, many urban Indigenous people are predisposed to commercially based diets that are high in refined sugars, trans fat, and sodium; and low in essential nutrients like iron, zinc, and vitamins A, B, C, and D (Bergeron et al., 2015). Combined with more sedentary lifestyles, the outcome for urban Indigenous people has been more chronic illnesses (Rand et al., 2018).

Over the past two decades, there has been a national trend towards healthier eating that includes higher consumption and greater diversity of fruits and vegetables, higher consumption of whole grains and plant-based sources of protein, and lower consumption of red meats and other sources of saturated fats (Richmond et al., 2020). However, these healthy dietary components are not generally accessible or affordable for urban Indigenous people. For example, one study that looked at the quality of diets for First Nations people in southwestern Ontario found that urban First Nations people had an insufficient consumption of both meat and milk and alternatives; low intake of fruits and vegetables; and an over-reliance on highly processed foods such as salty snacks, sweets, and soft drinks (Richmond et al., 2020). Further, common experiences of Indigeneity, dispossession, and marginalization were linked to their dietary over-reliance on processed foods of lower nutrient density; and processes of environmental dispossession [14] made it extremely difficult for them to access healthier, culturally preferred traditional/country foods.

Like dietary changes, urban Indigenous people have adopted modern conveniences and Western lifestyle practices that have greatly reduced their involvement in physical activity (Pelletier et al., 2017). Even in moderate amounts, physical activity has been shown to reduce urban Indigenous people's risks of chronic diseases, enhance their holistic well-being, and strengthen their social networks (Hsu & Warburton, 2018; Kentel & McHugh, 2015). Still, urban Indigenous people face persistent adversities that hinder their participation in physical activity, such as low socioeconomic status and inadequate finances, transportation barriers, personal stress and family responsibilities, inadequate space and infrastructure, and unfamiliarity with and/or discomfort in accessing available resources (Hsu & Warburton, 2018; Wicklum et al., 2019).

[14] Environmental dispossession refers to the processes (assimilationist policies, environmental contamination) through which Indigenous people's access to traditional food systems (fish, game, and plants) and other resources of their traditional environments is reduced (Richmond & Ross, 2009).

… financial obstacles, lack of resources, and racially based discrimination and prejudice (from both peers and teachers) strongly [influence] the participation of urban Indigenous youth in organized sports and physical activity programs.

Quite often, poor nutrition and physical inactivity are framed as lifestyle choices, but the socioeconomic factors that influence nutritional insecurity and physical inactivity need to be contextualized to fully understand urban Indigenous people's capacity to make changes concerning their overall health and well-being (Mason et al., 2018; Pelletier et al., 2017; Wicklum et al., 2019). Take urban Indigenous youth, for example. Compared with the non-Indigenous population, Indigenous youth residing in urban centres have disproportionate levels of illness and are at higher risk of diabetes and obesity-related diseases (Crowshoe et al., 2018). Physical inactivity is a known factor in poor health outcomes among urban Indigenous youth (Streit & Mason, 2017). Although physical activity offers a promising way to promote positive youth development (Baillie et al., 2017; Kentel & McHugh, 2015; Physical Literacy, 2022), the effectiveness of physical activity initiatives for urban Indigenous youth requires careful consideration, especially regarding their participation experiences (Mason et al., 2018).

Mason et al. (2018), for instance, investigated the distinct barriers that Indigenous youth residing in Kamloops, Edmonton, and Winnipeg encounter with exercise, physical activity, and sports programs. Their study found that financial obstacles, lack of resources, and racially based discrimination and prejudice (from both peers and teachers) strongly influenced the participation of urban Indigenous youth in organized sports and physical activity programs. Family support (from parents, siblings, and extended family members) was also found to either curtail or enhance the participation experiences of urban Indigenous youth, depending on their family members' level of involvement in their sport or physical activity.

Another study explored the effectiveness of culturally relevant obesity and diabetes prevention programming for urban Indigenous women in Lloydminster (Wicklum et al., 2019). Core components of the program included physical activities (including open access to exercise equipment and instruction), nutrition education and healthy eating strategies, peer and Elder support services, and individually tailored resources to meet the unique and holistic needs of program participants. The study showed that cultural components were just as important as physical activity components of wellness programming; and multifaceted programming promised greater success than unvaried programming in influencing healthy behaviours. Urban Indigenous women reported

improved physical activity and nutrition skills; greater confidence in group exercises and healthy eating; increased peer and family support networks; and greater awareness of health resources and social services. They also reported noticeable health improvements, such as weight loss, lowered blood pressure and cholesterol levels, increased energy, and decreased back and joint pain, thus demonstrating the critical significance of accessibility, cultural relevance and sensitivity, family networks, and well-rounded social supports in wellness programming for urban Indigenous people (Wicklum et al., 2021).

Smoking, alcohol, and substance use

Tobacco plays an important medicinal and ceremonial role in many Indigenous communities, but outside of its spiritual use, the recreational use of commercial tobacco has been strongly linked to a long list of health and socioeconomic problems. These have included lung, mouth and throat, colorectal and pancreatic cancers (Cancer Care Ontario, 2016); heart and lung diseases, type 2 diabetes, stroke, and respiratory illnesses (Heart and Stroke Foundation of Canada, 2019; Jetty, 2017; Primack et al., 2016); perinatal mortality, preterm birth, low birth weight, and sudden infant death syndrome; ear infections, hearing loss, neurocognitive deficits, and behavioural problems in children; and increased gambling, alcohol consumption, and substance use (Jetty, 2017). In fact, cigarette smoking has been recognized as the single-most important modifiable cause of cancer (Cancer Care Ontario, 2016), and tobacco misuse remains the leading preventable cause of premature death in the world (Jetty, 2017). When combined with tobacco alternatives such as e-cigarettes and vaping, the health risks associated with cigarette smoking are further compounded (Alzahrani et al., 2018; Métis Nation British Columbia [MNBC] and BC Office of the Provincial Health Officer [OPHO], 2021).

In 2020, approximately 11% of Canadians aged 15 years and older reported being current smokers (Statistics Canada, 2021). The Heart and Stroke Foundation of Canada reported that both cigarette smoking and vaping rates have substantially increased for Indigenous people residing off reserve, particularly among younger populations (Heart and Stroke Foundation of Canada, 2019). Smoking rates for Indigenous populations are perpetually two to five times higher than in the general population (Canadian Partnership Against Cancer [CPAC], 2019; Canadian Public Health Association [CPHA], 2021). In 2012, 15% of the non-Indigenous population reported being daily or occasional smokers (Gionet & Roshanafshar, 2013). In comparison, the smoking rates were 37% for First Nations people residing off reserve, 58% for Inuit residing outside Inuit Nunangat, and 35% for Métis people (Heart and Stroke Foundation of Canada, 2019). Among urban Indigenous youth (15 to 19 years), the smoking rates were 33% for First Nations youth, 56% for Inuit youth, and 31% for Métis youth, compared with 11% of non-Indigenous youth (Statistics Canada, 2012, as cited in Canadian Paediatric Society, 2024). The average age of smoking initiation among urban Indigenous people was 12 years, which was seven years earlier than the age at which non-Indigenous people reported starting to smoke (Jetty, 2017). Although smoking prevalence varies by province (Canadian Public Health Association [CPHA], 2021), other studies have reported similar trends in smoking (Elton-Marshall, 2013; MNBC & BC OPHO, 2021; Sikorski et al., 2019; Wolfe et al., 2018). Studies have also shown that the proportion of urban Indigenous people who smoke has gone down over time (Chiefs of Ontario and Cancer Care Ontario, 2016; MNBC & BC OPHO, 2021).

Several factors influence the prevalence of smoking in urban Indigenous populations. For instance, smoking has been linked to mental health challenges, such as depression and suicide ideation (MNBC & BC OPHO, 2021; Smith et al., 2020). The Canadian Public Health Association stated that people living with mental health disorders such as schizophrenia, mania, and depression have a higher prevalence of smoking because they are more likely to have stressful living conditions, lower annual household incomes, and limited access to cessation programs (CPHA, 2021). Likewise, the Chiefs of Ontario and Cancer Care Ontario (2016) reported that smoking rates were greatest among First Nations people who were the most disadvantaged, particularly in terms of education. Nearly 60% of First Nations adults in Ontario who had not completed high school, whether residing on or off reserve, smoked cigarettes in 2013, compared with 30% to 40% of First Nations adults who were post-secondary graduates. Among urban Indigenous youth, low self-esteem, boredom, high levels of family stress, problems with peers, and peer pressure have all been influential, not only in their use of tobacco (First Nations Information Governance Centre [FNIGC], 2021; Jetty, 2017; Smith et al., 2020; Wardman et al., 2014), but also in their use of cannabis, alcohol, or other substances (CPHA, 2021).

Alcohol remains the substance with the highest prevalence among youth, followed by cannabis (marijuana, hash, and hash oil) (Health Canada, 2019). Sikorski et al. (2019) examined differences in tobacco, alcohol, and marijuana use among off-reserve Indigenous and non-Indigenous youth. Although notable decreases in smoking, alcohol use, binge drinking, and marijuana use were observed in both Indigenous and non-Indigenous populations, the study showed that off-reserve Indigenous youth continue to demonstrate higher rates and younger ages of substance use than non-Indigenous youth. Table 10 provides more information on the prevalence of smoking, alcohol consumption, and marijuana use among off-reserve Indigenous and non-Indigenous youth populations.

Like smoking, alcohol and substance use have taken a toll on the health of urban Indigenous people, not only in relation to diseases and illnesses, but also in connection to accidents, mental health disorders, violence, and premature death (Carrière et al., 2021; Firestone et al., 2015; Marsh et al., 2015). Heavy alcohol consumption is especially harmful for urban Indigenous youth (Ryan et al., 2016). Research has shown that urban Indigenous people, in general, are less likely than non-Indigenous people to consume alcohol, but when they do drink alcohol, they tend to drink more heavily than do non-Indigenous people (Gionet & Roshanafshar, 2013; Ryan et al., 2016). From a social determinants of health lens, recognizing the historical, social, economic, and policy influences that have shaped the living situations and continue to drive behaviours that affect the length and quality of life for urban Indigenous people is crucial to reducing the prevalence of tobacco, alcohol, and substance misuse among this population (Heart and Stroke Foundation of Canada, 2019; Jetty, 2017; Wolfe et al., 2018).

TABLE 10: PERCENTAGE OF SMOKING, ALCOHOL USE, AND MARIJUANA USE IN OFF-RESERVE INDIGENOUS AND NON-INDIGENOUS POPULATIONS, GRADES 9 TO 12 STUDENTS, 2014/15

Variable	Indigenous population	Non-Indigenous population	Males		Females	
			Indigenous population	Non-Indigenous population	Indigenous population	Non-Indigenous population
Smoking status						
Current smoker	21.9	5.0	17.0	6.0	27.3	4.1
Non-smoker	78.1	95.0	83.0	94.0	72.7	95.9
Quitting behaviour						
Never tried to quit	18.9	29.5	26.0	29.3	11.4	29.9
Have tried to quit at least once	81.1	70.5	74.0	70.7	88.6	70.1
Alcohol use						
Never	23.9	38.5	25.7	39.9	21.9	37.0
Only a sip or >12 months ago	12.4	10.0	14.2	9.6	10.4	10.5
Past year	63.7	51.5	60.0	50.4	67.7	52.5
Monthly	39.3	29.7	39.0	30.6	39.6	28.8
Weekly	13.8	7.9	13.0	9.0	14.7	6.7
Binge drinking						
Never or >12 months ago	40.2	48.4	40.7	47.0	39.6	49.7
Past year	59.8	51.6	59.3	53.0	60.4	50.3
Monthly	35.0	27.1	36.4	30.3	33.6	23.9
Weekly	10.7	5.8	11.2	7.1	10.1	4.5
Marijuana use						
Ever tried marijuana	58.3	28.2	54.7	29.2	62.1	27.1
Never or >12 months ago	55.1	78.2	61.5	77.9	53.0	79.3
Past year	44.8	21.8	38.5	22.1	47.0	20.8
Monthly	36.4	12.5	31.1	13.6	38.2	11.0
Weekly	27.5	6.9	24.7	8.2	27.7	5.2
Daily	15.8	2.4	15.2	2.8	14.9	1.8

Source: Canadian Student Tobacco, Alcohol and Drugs Survey, cited in Sikorski et al., 2019.

Access to health care services

It is not uncommon for urban Indigenous people to experience problems when accessing health care services (Beckett et al., 2018). Poverty, social exclusion, and discrimination are common access barriers that have been linked to urban Indigenous people's use of health care services (National Association of Friendship Centres [NAFC], 2021; Tang et al., 2015; Wyton, 2020). In fact, racially based stereotypes, stigmatization, and discrimination have often led to delayed health care treatment or lack of treatment altogether, which has had detrimental, even fatal, consequences for Indigenous people residing in urban centres (Allan & Smylie, 2015; Turpel-Lafond, 2020; Wylie & McConkey, 2019). Urban Indigenous women, in particular, are significantly affected by past experiences of poor treatment and subsequent anticipated mistreatment from healthcare providers, such as being belittled and blamed for their own health problems; having their health concerns ignored or discounted; being presumed to be intoxicated, using substances, or narcotics-seeking; and for urban Indigenous women with children, being accused of bad mothering, which runs the risk of potential child welfare involvement (Allan, 2013; Allan & Smylie, 2015; NIMMIWG, 2019).

There are ample studies that illustrate the social, political, and historical influences on urban Indigenous people's access to health care services and the ways in which urban Indigenous people endure a disproportionate burden of ill-health (Allan & Smylie, 2015; Horrill et al., 2018; Nguyen et al., 2020). Take for example Tang et al.'s (2015) study of under-classism,[15] which explored the effects of structural violence and inequities within the context of urban health care centres. The study showed that urban Indigenous people were not only viewed by healthcare providers as underclass patients, but were also prone to marginalization, discrimination, and lesser quality care than non-Indigenous people. Specifically, the study revealed a hidden process of social triaging that was happening in emergency departments, whereby decisions about who gets seen first were based less on the triaged clinical priorities of patients than on the social positioning of the patient. Because of their socio-historical positioning and generalized assumptions of mental health and addiction issues, urban Indigenous people were perceived by healthcare providers as over-demanding, ungrateful, unmotivated, deviant, potentially dangerous, and personally responsible for their own demise. Moreover, they were described by healthcare providers as unimportant and less deserving of health care services than non-Indigenous people. In addition to being kept waiting, having their concerns discounted or ignored, and being dismissed and disciplined (escorted out, forbidden to self-administer pain medication), urban Indigenous people generally were discouraged from returning to emergency departments for what were perceived by healthcare providers as nonclinical needs (food, shelter).

A Toronto-based study also identified a link between discrimination by a healthcare provider and having unmet health needs, but a key factor that appeared to modify this association was access to a regular healthcare provider such as a physician or nurse practitioner (Kitching et al., 2020). To explain, 27.3% of urban Indigenous people who participated in the

[15] Tang et al. (2015) used the term under-classism to emphasise the intersecting nature of factors such as discrimination, poverty, stigma, racism, social exclusion, and other facets of oppressive social relations.

study reported having unmet health needs, 28.5% reported experiencing discrimination by a healthcare provider, and 63.1% reported having access to a regular healthcare provider. Among urban Indigenous people who did not have access to a regular healthcare provider, exposure to discrimination was associated with significantly higher odds of having unmet health needs. Even though access to a regular healthcare provider did not guarantee that all their health care needs would be met, the lack of culturally safe health care services, together with increased short-term interactions with healthcare providers at walk-in clinics and emergency departments, increased urban Indigenous people's potential for discrimination and affected their continuity of health care.

To fully comprehend how social circumstances and access to primary health care are intertwined, it is important to consider the complex structural conditions of peoples' lives and how health care is structured to respond to their holistic needs (Varcoe et al., 2022a; Wright et al., 2019). Urban Indigenous people are more likely to experience difficulties around managing their health concerns when the health services they receive are not culturally appropriate (Beckett et al., 2018; Genereux et al., 2021; Jacklin et al., 2017). For example, Inuit residing in Ottawa experience a striking burden of socioeconomic deprivation (high rates of poverty, unemployment, household crowding, and food insecurity), elevated rates of chronic disease (allergies, hypertension, COPD, cancer), and multiple barriers to health care access (Smylie et al., 2018). Cross-cultural communication problems such as difficulties understanding what healthcare providers are saying and discomfort with healthcare providers not culturally understanding them also serve as major access barriers for Inuit (Smylie et al., 2018). Other barriers that have been reported include long waiting lists, difficulties accessing traditional Inuit medicines, and having no doctor available after 5:00 p.m., on weekends, or during business hours.

Access to and availability of health care services are important, but only insofar as the services are considered acceptable (BCAAFC, 2020; Goodman et al., 2017; Place, 2012). In fact, research has shown that it is not uncommon for urban Indigenous people to strategically avoid public hospitals in favour of clinics that are managed and staffed by Indigenous people (Gouldhawke, 2021). For urban health care services to be effective, they must consider the socioeconomic adversity and diverse practices, worldviews, cultures, languages, and values of urban Indigenous people who use these services (BCAAFC, 2020; Crowshoe et al., 2018; Genereux et al., 2020; Smylie et al., 2018; Van Herk et al., 2012).

The evidence linking discrimination in urban health care settings to disparities in urban Indigenous people's health care access reinforces the critical need for culturally safe, patient-centred care (Allan & Smylie, 2015; Crowshoe et al., 2018; Kitching et al., 2020). Cultural competency training may help to create awareness and understanding of the interactions and cultural differences between urban Indigenous people and healthcare providers, but cultural safety training is also needed to directly address the role and impact of racism in health care access, inequities in health outcomes, and the historical and contemporary power dynamics underlying these interactions (Allan & Smylie, 2015; Beckett et al., 2018; Browne et al., 2021).

Enhancing equity in health care is an important strategy for improving population health (Varcoe et al., 2019). Health equity encompasses "the critical analysis of power and the workings of discrimination dynamics in the pursuit of social justice" (p. 4). Equity-oriented health care is grounded in understanding that discrimination is a socially constructed preconception, "justified by ideology and expressed in

Further, efforts to mitigate the impacts of structural conditions and barriers associated with health inequities must include broader structural efforts to address housing and homelessness. The problem currently is that most healthcare systems do not operate this way

(Varcoe et al., 2022b).

interactions among and between individuals and institutions in ways that maintain privileges for members of dominant groups, and contribute to inequities for others, with profound impacts" (p. 4).

With particular attention to Indigenous people's experiences of health and health care (Varcoe et al., 2022a), Browne et al. (2011, 2012 & 2016) identified key dimensions of equity-oriented health care – including trauma- and violence-informed care, culturally safe care, and contextually tailored care (as cited by Ford et al., 2018). They subsequently developed EQUIP (Equipping Health Care for Equity), an organizational intervention designed to promote equity at the point of care in primary health care settings (Browne et al., 2015). A study of EQUIP's health equity-enhancing framework found that equity-oriented health care gave patients greater comfort and confidence in health care, and in managing their own health, which resulted in improved health outcomes, including fewer depressive and trauma symptoms, less disabling chronic pain, and better quality of life (Ford et al., 2018). Research also found that health care staff involved with EQUIP had greater confidence and skills in providing equity-oriented health care, but more concrete tools to translate abstract ideas of equity-oriented health care into action was needed (Browne et al., 2018; Levine et al., 2021).

Building on this promising research (Browne et al., 2015), the research team adapted EQUIP to test its effectiveness and scalability in promoting equity at the point of care in three demographically and geographically diverse emergency departments (urban, suburban, rural/remote) serving Indigenous and non-Indigenous people in British Columbia (Varcoe et al., 2019). The EQUIP Emergency study showed an intersection and association between structural inequities and higher ratings of discrimination (Varcoe et al., 2019). Repeat emergency department visits were largely accounted for by patients who were less likely to have a primary care home and were facing the greatest economic and housing instability; the majority of which were urban Indigenous people. The study also established that efforts to reduce stigma and discrimination in emergency departments must be prioritized to improve urban Indigenous people's experiences and health outcomes, as well as the efficiency and effectiveness of healthcare

systems in meeting their needs (Varcoe et al., 2022a). Further, efforts to mitigate the impacts of structural conditions and barriers associated with health inequities must include broader structural efforts to address housing and homelessness. The problem currently is that most healthcare systems do not operate this way (Varcoe et al., 2022b).

According to Varcoe et al. (2022b), "training and educational interventions alone cannot enhance the equity-orientation of organizations, and shifting knowledge, attitudes, and behaviours of individuals is not sustainable without organizational supports, policy directives, accountability mechanisms, and whole-organization actions" (p. 11). Although there is little guidance on how to affect change beyond the level of individual staff members, EQUIP shows promise in promoting equity-oriented health care at an organizational level.[16] At the time of writing, the EQUIP Emergency study was ongoing, but preliminary results showed improved patient ratings of care, a significant decrease in the percentage of marginalized patients who leave emergency departments before their care is completed, and the promise of a scalable organizational intervention to effectively promote equity at the point of care in diverse primary health care settings.

Cultural connection and community belonging

Plenty of factors contribute to inequities in urban Indigenous people's health. Just the same, the determinants of health include positive, affirming, and health promoting factors (Jardine & Lines, 2018). Indigenous knowledge, cultural practices, identity and sense of belonging, and relatedness to the land have all proven to have positive influences on the health and well-being of urban Indigenous people (Bethune et al., 2019; Crowshoe et al., 2018; Genereux et al., 2020; Landry et al., 2019). Likewise, numerous studies have highlighted the critical need for urban Indigenous people to socialize; stay connected with Elders, family, and community; and participate in land-based and cultural activities (Alaazi et al., 2015; Cidro et al., 2015; Oster et al., 2014; Ryan et al., 2016). For example, Landry et al. (2019) explored the notion of *mino-pimatisiwin*[17] and established that access to the bush and relationships with family and friends were essential for urban First Nations people to fully experience complete well-being. Additionally, culturally safe places within urban centres were deemed crucial for Indigenous knowledges and cultural practices to be shared, and for Indigenous identities and belonging to be safeguarded. Even though urban centres generally favour non-Indigenous conceptions of space (Nejad et al., 2019), the study demonstrated how urban First Nations people had developed ways to maintain their links to the land, most notably by embracing broader views of the land to include smaller-scale urban spaces and by expanding their definitions of community to include Indigenous people from different nations (Landry et al., 2019). Noted examples of urban places of cultural safety included private backyards and public parks, where urban Indigenous people not only felt physically, symbolically,

[16] Achieving equity-oriented health care at an organizational or systems level requires integration and direct involvement of management and executive leadership, as well as interprofessional engagement (Varcoe et al., 2022b). An EQUIP Equity Action Kit to help guide organizations in enhancing their capacity for equity-oriented services is available at https://equiphealthcare.ca/.

[17] Indigenous people of the Algonquian language group (i.e., Anishinaabe, Atikamek, Cree, Innu) use subtle variations of the term *mino-pimatisiwin* (living the good life) to describe a state of comprehensive well-being encompassing balance or harmony between all elements of life, including physical, emotional, mental, and spiritual aspects, as well as solidarity with family, community, non-human beings, the environment, Creator, and the spirit world (Landry et al., 2019).

and spiritually connected to the land and to each other, but also developed feelings of security and trust, which reinforced their sense of belonging to a place within their urban environments.

Social support is also important for health and well-being, particularly among youth. One Ottawa-based study that looked at the role of social support as a health determinant among urban First Nations and Inuit youth (aged 12 to 17 years) found measures of cultural safety meant being responsive to the unique challenges endured by urban Indigenous students within their home environments (Richmond & Smith, 2012). These forms of support not only created a sense of belonging for at-risk Indigenous youth, but also an urban school environment within which they could achieve their educational goals. The study showed that experiences of violence had long-lasting negative effects on student perceptions of belonging, as did failure in school and verbal and physical altercations with teachers. Feeling segregated across various social, cultural, and curricular lines overwhelmingly fostered a sense of marginalization – not belonging – among urban First Nations and Inuit students. In contrast, positive school experiences such as experiential learning (i.e., field trips), academic achievements, and cultural connections with other Indigenous students enhanced their educational experiences. The study also found that the most important characteristic of social support for urban First Nations and Inuit students was their ability to receive guidance or help when they needed it; but even then, students admitted that they would not seek out support from teachers and other support staff if trust had not been established. As such, two types of social supports were identified: structural supports which offered the *potential* to help, and functional supports which represented *actual* help. Perceived trust, which was contingent upon an appreciation of the personal issues faced by urban First Nations and Inuit students, was key to their use of available social supports and vital to fostering a sense of belonging within their school environments.

Other studies have emphasized the value of cultural identity in determining the holistic well-being of urban Indigenous people (Fast et al., 2016; Fast et al., 2017). Indeed, the development and progression of health concerns in urban Indigenous populations have sparked interest in Indigenous culture-based strategies for improving the health of urban Indigenous people. Health initiatives grounded in Indigenous cultures have been recognized as beneficial in rebuilding individual and communal cultural identity, sustaining health and well-being, and promoting healthy life choices among urban Indigenous people (Benoit et al., 2016; Marsh et al., 2015). At the same time, however,

it has been acknowledged that culturally adapted initiatives need to consider the vast differences that exist in the cultures, lifestyles, and identities of urban Indigenous people. Take Fast et al.'s (2017) research with Indigenous youth residing in Montreal, for example. Fast et al. (2017) identified two broad understandings of urban Indigenous identity: the first pertained to youth who had resided in an urban setting for all or most of their lives, had mixed backgrounds, had grown up somewhat distanced from their cultural identities, were looking to better understand their family histories and cultures, and had commonly experienced feeling unsafe, in both Indigenous and non-Indigenous settings. The other applied to Indigenous youth who had lived in Montreal for shorter amounts of time, were more likely to speak an Indigenous language, and were looking for ways to maintain their cultural identities while residing in the urban centre. Given these different aspects of urban Indigenous identity, ensuring the cultural safety of urban Indigenous people includes considering not only the varying concepts of urban Indigenous cultural identity, but also the power dynamics around who defines urban Indigenous identity, authenticity, and culture, particularly in relation to the ways in which urban Indigenous people maintain connections to their cultures and to each other.

Health outcomes

Health outcomes reflect the physical and mental well-being of a population, including people's length and quality of life (University of Wisconsin Population Health Institute [UWPHI], 2022). As such, they provide a good measure of how well systems are working to keep people healthy. For instance, health status may be influenced by the quality of medical care and attention received, or by the availability of good jobs, clean water, and affordable housing. Moreover, these health determinants may be influenced by programs and policies that are in place at municipal, provincial/territorial, and federal levels (UWPHI, 2022). By looking at data related to health outcomes, it is possible to determine not only where investments and partnerships need to be made to improve the health of a population (CIHI, 2022; Firestone et al., 2014), but also where and why health outcomes differ across populations, how a variety of factors combine to influence health outcomes, and how policies and programs are supporting—or restricting—opportunities for improved health (UWPHI, 2022). The information presented in this section shows that the overall health of urban Indigenous people is improving, but gaps remain between the health outcomes of urban Indigenous and non-Indigenous populations.

Life expectancy and mortality

Life expectancy, which focuses on length of life, is a key indicator of the health of a population. It measures the estimated number of years a person at a given age can expect to live, based on current age-specific death or mortality rates for a given population (Ortiz-Ospina, 2017). Although life expectancy reflects differences in mortality, it does not consider quality of life (PHAC, 2018) and is relatively resistant to differences in age structure and other population characteristics (Musić Milanović et al., 2006). Accordingly, differences in mortality rates are observed to track and predict the age-at-death for people within population groups (Ortiz-Ospina, 2017). Table 11 (next page) provides an overview of life expectancy and mortality for off-reserve Indigenous and non-Indigenous populations.

Several factors contribute to increased life expectancy, including improvements in living standards, advancements in medical technology and practice, and higher levels of educational attainment (PHAC, 2018). In contrast, larger exposure to risk factors such as greater tobacco use, excessive alcohol consumption, and less healthy diets may result in more deaths from heart diseases, cancer, and

TABLE 11: LIFE EXPECTANCY AND MORTALITY FOR OFF-RESERVE INDIGENOUS AND NON-INDIGENOUS POPULATIONS, 2011

Mortality indicator	First Nations population	Inuit population	Métis population	Non-Indigenous population
Life expectancy at birth (yrs)	70.5	69.7	74.8	81.8
Infant mortality per 1,000 live births (n)	8.1	13.5	6.6	4.8
Unintentional injury mortality per 100,000 people (n)	104.8	96.4	80.7	30.3
Suicide mortality per 100,000 people (n)	40.2	72.0	29.6	11.3

Source: Canadian Vital Statistics Death Database, cited in PHAC, 2018.

other ailments (OECD, 2021; Park, 2021). Analysis of the differences in mortality rates, especially avoidable (preventable and treatable) mortality, helps to determine, more exactly, the underlying causes of potentially avoidable deaths and the interventions needed to reduce deaths from various diseases and injuries (OECD, 2021). Underlying causes of death may encompass either a disease or injury that initiates a chain of events leading directly to death or to the circumstances of an accident or violence that produce a fatal injury (Park, 2021).

Urban Indigenous people generally have a shorter life expectancy and are more likely than their non-Indigenous counterparts to die prematurely from avoidable causes such as intentional and unintentional injuries (Kumar, 2021; Park et al., 2015; Park, 2021; Tjepkema et al., 2019). For example, one study of First Nations people's excess mortality[18] reported that mortality rates (per 100,000 people) from all causes were 419 for First Nations people residing off reserve, compared with 335 for the non-Indigenous population (Park, 2021). Cancer and heart disease were the most important causes of death among both off-reserve First Nations people and non-Indigenous people, but mortality differentials between populations were driven by deaths from assault, chronic liver disease and cirrhosis, diabetes, suicide, and unintentional injuries, which altogether were responsible for more than two-thirds of excess mortality among First Nations people residing off reserve. Further, mortality differentials were more pronounced in younger age groups (50 years and younger), and differences in early and premature deaths were greater

[18] Excess mortality occurs when there are more deaths than were expected for a certain period of time. The number of excess deaths is measured as the difference between the number of observed deaths and the number of expected deaths over a certain time period (Statistics Canada, 2022c).

TABLE 12: MORTALITY RATE PER 100,000 PEOPLE BY CAUSE OF DEATH FOR OFF-RESERVE FIRST NATIONS AND NON-INDIGENOUS POPULATIONS, 2016

Cause of death	Off-reserve First Nations population (n)	Non-Indigenous population (n)
Assault (homicide)	5.6	0.8
Intentional self-harm (suicide)	17.4	8.0
Accidents (unintentional injuries)	40.3	18.2
Nephritis, nephrotic syndrome and nephrosis	6.5	4.3
Chronic liver disease and cirrhosis	17.3	3.8
Chronic lower respiratory diseases	18.6	14.5
Influenza and pneumonia	9.2	7.3
Cerebrovascular diseases	15.0	17.1
Diseases of heart	66.6	67.0
Alzheimer's disease and other dementias	2.5	5.9
Diabetes mellitus	18.9	8.7
Malignant neoplasms	101.9	108.8

Source: Canadian Census Health and Environment Cohorts, cited in Park, 2021.

than in deaths that occurred at older ages. Table 12 provides more information about the mortality rates and leading causes of death identified through this study.

Studies have consistently shown increasingly lower rates of mortality among Indigenous people residing in urban centres as opposed to rural/northern communities, which may be attributed to the health and social benefits that come with living in urban centres, such as greater education and employment opportunities, better access to health care services, and higher socioeconomic status (Akee & Feir, 2018; Carson et al., 2018; Park, 2021). Indigenous people generally have made significant gains in life expectancy, though not as great as the gains made in the non-Indigenous population (Tjepkema et al., 2019). In 2011, life expectancy at age 1 was about 9 to 10 years shorter for First Nations people, about 11 years shorter for Inuit, and about 4.5 to 5 years shorter for Métis people, compared with the non-Indigenous population. Life expectancy for Métis people, specifically, has become more closely aligned with the non-Indigenous population (Tjepkema et al., 2019). While promising, these gains in life expectancy should be interpreted with caution given the increasing numbers of census respondents newly identifying as Métis (Statistics Canada, 2017c; Tjepkema et al., 2019).

Infant mortality and adverse birth outcomes

Infant mortality[19] has been widely recognized as a cornerstone of population health (OECD, 2022; PHAC, 2018). Over the past few decades, infant mortality rates have improved, but not equally across populations. Reportedly, 3.7 out of 1,000 babies born in Canada will not live beyond their first birthday (PHAC, 2018). Infant mortality is strongly associated with socioeconomic status. People who reside in the most materially deprived areas[20] have rates of infant mortality that are 1.6 times higher than the rates for people residing in the least deprived areas. Areas with high populations of Indigenous people have even higher infant mortality rates. Compared to areas with low concentrations of Indigenous people, the infant mortality rate is 2.3 times higher in areas with a high concentration of First Nations people, 3.9 times higher in areas with a high concentration of Inuit, and 1.9 times higher in areas with a high concentration of Métis people (PHAC, 2018). Key risk factors for infant mortality include low maternal education, inadequate housing, lack of access to health care, food insecurity, poverty, and unemployment (PHAC, 2018). The leading causes of infant mortality include immaturity (not fully grown), structural or functional birth defects, severe lack of oxygen, infection, and sudden infant death syndrome.

The loss of an infant can have devastating effects on the psychological well-being of parents and families (PHAC, 2018). Moreover, children's health at birth has been associated with health outcomes later in life (Chartier et al., 2020). For instance, babies who are born with high[21] or low[22] birth weight are at increased risk of adverse health outcomes (Canadian Institute of Child Health [CICH], 2022). Specifically, babies who are born with low birth weight (small-for-gestational-age) are more likely than average weight babies[23] to have wheezing disorders in childhood; have lower levels of intelligence in adolescence; be overweight or obese in adulthood; and have coronary heart disease, all-cause mortality, and chronic kidney disease (Belbasis et al., 2016; CICH, 2022). Babies who are born with high birth weight (large-for-gestational-age) are at greater risk of immediate health issues, including low blood sugar immediately after birth, birth defects, trouble breathing, injuries sustained through birth, and jaundice (Belbasis et al., 2016; CICH, 2022). They also are at greater risk of developing long term health concerns such as cancer, obesity, and type 2 diabetes, which ultimately put them at higher risk of premature death.

Relatively little national perinatal information is available for urban Indigenous populations, but studies have shown that Indigenous people generally face greater risks of adverse birth outcomes than non-Indigenous people (Bushnik et al., 2016; Chen et al., 2015; Johnson & Donkin, 2022; McIsaac et al., 2015). There are also disparities in birth outcomes between First Nations people, Inuit, and Métis people (Sheppard et al., 2017). For example, Sheppard et al. (2017) studied national birth outcomes data and found that the rates of infant death, neonatal death, and post-neonatal death were more than twice as high for each Indigenous identity group compared with the non-Indigenous population. Likewise, except for small-for-gestational-age births, Indigenous infants had higher rates of adverse birth outcomes than non-Indigenous infants. Table 13 provides further comparisons of adverse birth outcomes in Indigenous and non-Indigenous populations.

[19] Infant mortality refers to the death of an infant under one year of age (PHAC, 2018).
[20] Materially deprived areas include a high percentage of people with no high school diploma, low employment, and low average income (PHAC, 2018).
[21] High birth weight equates to weighing more than 4.0 kg at birth (CICH, 2022).
[22] Low birth weight equates to weighing less than 2.5 kg at birth (CICH, 2022).
[23] Average weight babies weigh between 2.5 kg and 4.0 kg at birth (CICH, 2022).

TABLE 13: ADVERSE BIRTH OUTCOMES FOR INDIGENOUS AND NON-INDIGENOUS POPULATIONS, 2004-2006

Birth outcome	Total Indigenous population (n)	First Nations population (n)	Inuit population (n)	Métis population (n)	Non-Indigenous population (n)
Pre-term birth per 100 live births	8.7	9.0	11.4	7.6	6.7
Small-for-gestational-age per 100 live births	6.6	5.8	8.0	8.3	8.6
Large-for-gestational-age per 100 live births	18.8	20.9	15.6	14.4	10.6
Stillbirth (fetal death) per 1,000 births	9.0	10.4	9.7	5.7	5.6
Infant death per 1,000 live births	9.6	9.2	12.3	10.5	4.4
Neonatal death per 1,000 live births	4.9	4.4	7.2	7.5	3.4
Post-neonatal death per 1,000 surviving births	4.8	4.8	5.1	3.1	1.1

Source: 2006 Canadian Birth-Census Cohort database, cited in Sheppard et al., 2017.

Chartier et al. (2020) conducted research that included an examination of birth outcomes for First Nations infants in Manitoba. Although the study focused specifically on status First Nations people in comparison with all other identity population groups, it did look at data for status First Nations people residing in urban settings. The study showed that compared with all other Manitoba infants, status First Nations infants had higher rates of preterm births, large-for-gestational-age births, and newborn re-admissions to hospital, as well as lower rates of breastfeeding and small-for-gestational-age births. Further, teen pregnancy and teen birth rates were higher among status First Nations teens compared with all other Manitoba teens. Table 14 offers further comparisons of adverse birth outcomes among status First Nations people residing in urban settings in Manitoba.

Given the lower rates of low birth weight and higher rates of high birth weight among status First Nations populations, it has been suggested that, on average, First Nations infants may be larger at birth than other Indigenous and non-Indigenous infants (Chartier et al., 2020; Sheppard et al., 2017), which may be attributed to the higher incidence and increasing prevalence of diabetes among First Nations women (Chartier et al., 2017; Oster &

TABLE 14: ADVERSE BIRTH OUTCOMES FOR STATUS FIRST NATIONS AND ALL OTHER POPULATIONS IN MANITOBA, 2012/13-2016/17

Birth outcome	Total status First Nations population (n)	Urban status First Nations population (n)	On-reserve status First Nations population (n)	Total all other population (n)
Pre-term birth per 100 live births	10.1	10.2	10.1	7.0
Small-for-gestational-age per 100 live births	6.2	6.1	6.3	8.8
Large-for-gestational-age per 100 live births	19.0	20.2	18.4	10.4
Breastfeeding initiation per 100 infants	61.0	70.4	55.0	90.4
Teen pregnancy per 1,000 females, 15-19 years	107	96	117	18
Teen birth per 1,000 females, 15-19 years	87	66	99	11
Newborn re-admissions per 100 live births	2.0	2.0	2.1	1.1

Source: Chartier et al., 2020.

Toth, 2015; Vélez et al., 2020). One Manitoba-based study found that gestational diabetes was diagnosed in 6.7% of First Nations (on and off reserve) pregnant women and 2.2% of non-First Nations pregnant women (Shen et al., 2016). Among women with gestational diabetes, post-partum diabetes developed in 76.0% of First Nations women and 56.2% of non-First Nations women, thus indicating that gestational diabetes was a key risk factor for subsequent diabetes, especially among First Nations women. An Alberta-based study of stillbirth epidemiology also found that the prevalence of stillbirths was significantly higher in First Nations pregnancies compared with non-First Nations pregnancies, and pre-existing diabetes was a strong predictor of stillbirth (Oster & Toth, 2015).

Vélez et al. (2020) examined maternal and neonatal outcomes of First Nations women (on an off reserve) with pre-existing (type 1 or type 2) and gestational diabetes in Ontario. They found a higher prevalence (per 1,000 deliveries) of both pre-existing diabetes (40.7 vs. 20.5) and gestational diabetes (108.9 vs. 60.7) among First Nations women compared with non-First Nations women, and among women with gestational or pre-existing diabetes, First Nations women had higher rates of stillbirth and babies with congenital anomalies than non-First Nations women. The study also revealed that

Healthcare providers that foster sincere, non-judgmental, and enjoyable interactions with urban Indigenous patients have been known to elicit more effective treatment and care ...

(Oster et al., 2016).

almost all First Nations women, regardless of diabetes status, had seen a primary healthcare provider during their pregnancy, but their use of specialty care services was lower compared with their non-First Nations counterparts. A similar study examining birth outcomes in Quebec showed persistent and widening disparities in adverse birth outcomes, perinatal mortality, and infant mortality in First Nations and Inuit populations compared with the non-Indigenous population (Chen et al., 2015).

Though not specific to urban Indigenous people, all these studies demonstrate the crucial need for improved perinatal and infant care (especially specialized care), increased health literacy, and enhanced interventions aimed at addressing inequities and enhancing the socioeconomic conditions of Indigenous people (Chartier et al., 2020; Chen et al., 2015; Oster & Toth, 2015; Sheppard et al., 2017; Vélez et al., 2020). Many infant deaths that occur within urban Indigenous populations are preventable (PHAC, 2018). Increased early awareness of pre-existing and gestational diabetes, for instance, may lead to better recognition and management of diabetes during pregnancy, as well as decreased numbers of stillbirths (Oster & Toth, 2015). Baby-friendly initiatives aimed at protecting, promoting, and supporting breastfeeding in urban Indigenous populations may also help to save lives (Pound & Unger, 2012). For example, one study of the impacts of breastfeeding in Indigenous populations reported that 10.6% of otitis media, 41.4% of gastrointestinal infections, 26.1% of hospitalizations from lower respiratory tract infections, and 24.6% of sudden infant deaths could be prevented if Indigenous infants were breastfed (McIsaac et al., 2015). Moreover, the benefits of breastfeeding were two times greater among Indigenous infants compared with non-Indigenous infants.

Interventions aimed at decreasing health disparities early in the life course influence not only the immediate health of urban Indigenous infants, but also their overall health trajectories (McIsaac et al., 2015). Relationships and trust, cultural recognition, expressions of empathy and understanding, and context-specific care are key features of effective perinatal care for urban Indigenous people (Oster et al., 2016). Healthcare providers that foster sincere, non-judgmental, and enjoyable interactions with urban Indigenous patients have been known to elicit more effective treatment and care, particularly during pregnancy (Oster et al., 2016). These aspects of effective health care must all be considered when working towards improving infant mortality and adverse birth outcomes in urban Indigenous populations.

Morbidity and chronic diseases

Morbidity refers to a chronic (long term) or age-related disease or illness that worsens over time and negatively affects quality of life (Basaraba, 2021; OECD, 2019). Urban Indigenous people have disproportionate and increasing rates of morbidity and chronic diseases relative to the general population. Many chronic diseases (cancer, heart attack and stroke, respiratory problems, diabetes) may be prevented by modifying major risk factors like smoking, alcohol use, obesity, and physical inactivity (OECD, 2019).

Obesity

Obesity is a significant and potentially modifiable risk factor for morbidity and chronic disease (Batal & Decelles, 2019), yet it remains a key health concern among urban Indigenous populations. In 2015, 28.1% of the general population (18 to 79 years) were classified as obese (Statistics Canada, 2018e). For Indigenous adults residing off reserve, the rate of obesity was much higher at 36.6%, with women having greater prevalence of obesity than men (40.6% vs. 31.6%) (Kolahdooz et al., 2017). Métis people (42%) had the highest prevalence of obesity, followed by First Nations people residing off reserve (41%) and Inuit residing outside Inuit Nunangat (32.3%).

Most obesity studies have reported that urban Indigenous women are more likely than their male counterparts to be obese, regardless of whether measured or self-reported data are used (Batal & Decelles, 2019). The situation is a little different for urban Indigenous children and youth. For example, Bhawra et al. (2017) explored the weight status of a nationally representative sample of off-reserve First Nations and Métis children and youth (6-17 years) and found that 47.3% of off-reserve Indigenous children (6 to 11 years) and 30% of off-reserve Indigenous youth (12 to 17 years) were classified as either overweight or obese. Off-reserve Indigenous males showed higher rates of overweight/obesity than their female counterparts (40.3% vs. 34.5%); and overweight/obesity rates were more prevalent among First Nations children/youth than among Métis children/youth (40% vs. 34%). The study also found that low socioeconomic status was a significant risk factor for overweight/obesity among off-reserve Indigenous children/youth. Of Indigenous children/youth deemed to be overweight/obese, 44% were from the lowest income quartile (<$9,510); 19.2% were from food insecure households; and 41% had mothers with less than high school graduation. Further, overweight/obesity rates were higher among children/youth who were living in lone-parent vs. two-parent families (41.3% vs. 35.6%), were living in overcrowded vs. capacious households (40.0% vs. 37.2%), and were exposed vs. not exposed to an Indigenous language (40.5% vs. 34.5%) (Bhawra et al., 2017).

With significantly high rates of obesity, urban Indigenous people face an increased risk of adverse health outcomes over the life course. Therefore, it is important to understand the determinants that drive their weight status, particularly at younger ages (Bhawra et al., 2017). For instance, nutrition, gardening, interpersonal relationships, food sovereignty, water quality, and natural built environments have been shown to positively influence urban Indigenous children's perceptions of health, while cumulative stress, screen time, smoking, and violence have shown negative effects on their perceived health (Jennings et al., 2020). Other factors that have led to urban Indigenous children's increased risk of obesity include hindered access to healthy, culturally preferred foods (Richmond et al., 2020; Satterfield et al., 2016); poverty, food insecurity, and related problems such as hoarding food and overeating (Brockie et al., 2015); and decreased food sovereignty (Cidro et al., 2015; Cidro et al., 2016; Kamal et al., 2015).

Urban Indigenous people are among some of the most socio-economically disadvantaged populations, with lower rates of high school education, lower rates

of mean annual income, and higher rates of food insecurity compared with the non-Indigenous population. These factors influence their dietary patterns and physical activity and have had a considerable effect on their prevalence of obesity and related health concerns (Batal & Decelles, 2019; Bhawra et al., 2017; Wicklum et al., 2021). Preventing and reducing the prevalence of obesity as early as possible is essential to avoid and counteract the lifelong health repercussions of childhood obesity (Jennings et al., 2020).

Diabetes

Diabetes (type 1 and type 2) is a serious health concern among Indigenous populations, affecting 12.7% of off-reserve First Nations people, 17.2% of on-reserve First Nations people, 4.7% of Inuit, and 9.9% of Métis people, compared with 5.0% of the non-Indigenous population (Diabetes Canada, 2022). Indigenous people are generally diagnosed with diabetes at a younger age than non-Indigenous people (Diabetes Canada, 2022). They also experience more severe symptoms of the disease, greater diabetes-related complications, and poorer treatment outcomes. Diabetes-related complications, such as blindness, limb amputation, and organ failure, are prominent features of urban Indigenous life (Ghosh, 2012; Howard, 2014). As such, early and frequent screening for diabetes are crucial to preventing or delaying and effectively managing diabetes in urban Indigenous populations (Crowshoe et al., 2018). Early identification of diabetes in pregnancy and postpartum are especially important for urban Indigenous women and girls of childbearing age, given their high incidence of maternal obesity and diabetes in pregnancy, and increased risk of childhood obesity and diabetes in the next generation (Crowshoe et al., 2018; Oster & Toth, 2015; Shen et al., 2016; Vélez et al., 2020).

The high prevalence of diabetes in urban Indigenous populations has been attributed to several overlapping and compounding factors, including lower family income; geographic residence (Genereux et al., 2021; Shen et al., 2016); lack of access to healthy, nutritious, and affordable foods; and adverse effects of colonization (Crowshoe et al., 2018; Diabetes Canada, 2022). Mosby and Galloway (2017) attributed the disproportionate burden of chronic diseases, like diabetes, in Indigenous populations largely to the product of childhood malnutrition in residential schools. In fact, they maintained that prolonged undernutrition and sustained exposure to hunger and malnutrition in childhood is one of the most important factors influencing the health of Indigenous people today, with substantial consequences not only on the growth and development of Indigenous people who attended residential school as children, but also on subsequent generations. One Toronto-based study examining the legacy of urban Indigenous people's negative relationships with food that were instilled in residential schools also showed that diabetes is a disease of colonization; that is, particular aspects of residential school socialization such as regimented meal times, the use of food in punishment, and stealing, hiding, and hoarding food to survive left a legacy of negative relationships with food that run counterproductive to preventing and managing diabetes in urban Indigenous populations (Howard, 2014). The study also identified "five white foods" (sugars, salt, milk, lard, and flour) as being foreign to the bodies of urban Indigenous people and central to combatting diabetes.

Culturally inappropriate health care has also been shown to influence urban Indigenous people's perceptions and prevalence of illness, particularly regarding their health-related disclosures, coping mechanisms, and willingness to seek treatment (Beckett et al., 2018). Genereux et al. (2021) explored the experiences of urban Indigenous people undergoing dialysis treatment and found that lack of illness-related education (for both patients and their families), language barriers, and differences in cultures and values negatively

affected urban Indigenous people's medical conditions and treatment processes. Specifically, experiences of cultural isolation, alienation from family and friends, somatic and psychosocial issues, loss of independence, all while attempting to cope with their disease and the demanding lifestyle changes that accompany both the disease and dialysis treatment, had a significant impact on many aspects of urban Indigenous people's lives. For these reasons, urban Indigenous people with diabetes were less likely to receive recommended specialist care and more likely to experience adverse health outcomes.

Giving attention to the cultural, social, and linguistic needs of urban Indigenous people, and to the power dynamics between urban Indigenous people and healthcare providers, is important (Genereux et al., 2021). Health care relationships are central to mitigating past harms, addressing the ongoing colonial influences in Indigenous health care, shifting the power imbalance in clinical settings, and renewing the confidence of urban Indigenous people in healthcare systems (Crowshoe et al., 2018; Jacklin et al., 2017; Rice et al., 2016; Urban Aboriginal Knowledge Network [UAKN] Secretariat, 2016; Wicklum et al., 2021).

Cancer

National cancer patterns and cancer-related population disparities are understudied, mainly because of the lack of ethnic identifiers in cancer registries (Mazereeuw et al., 2018). Although there are no national cancer data on urban Indigenous people, there are a few regional studies of cancer among First Nations people that allude to the cancer patterns and differences in Indigenous and non-Indigenous populations. In British Columbia, for example, First Nations people have demonstrated lower rates of breast and prostate cancers than the general population, but higher rates of cervical and

gallbladder cancers, and rapidly increasing rates of colorectal and lung cancers (McGahan et al., 2017). In Manitoba, First Nations women have shown increasing rates of breast and colorectal cancers, but these cancers appear to be declining for all other Manitobans (Decker et al., 2016). First Nations women are also more likely than all other Manitoba women to be diagnosed with breast cancer at advanced stages of the disease, but there are no population differences in colorectal cancer diagnosis. In Ontario, survival for First Nations people is improving for breast and prostate cancers, but for all other cancers, their survival is either declining or unchanged (Nishri et al., 2014). They also demonstrate significantly poorer cancer survival than all other Ontarians. Other studies have also shown that certain types of cancer are quickly increasing among First Nations populations and survival is becoming worse (Doering & DeGrasse, 2015; Kewayosh et al., 2015; Withrow et al., 2017).

Breast cancer, prostate cancer, colorectal cancer, and lung cancer are common among First Nations people (Jull et al., 2018; Nishri et al., 2014). Little is known about cancer prevalence and survival for Inuit and Métis populations, but there is evidence to suggest that their cancer rates are disproportionately high compared with the non-Indigenous population (Bartlett et al., 2012; Carrière et al., 2012; Jull et al., 2018). According to the World Health Organization, at least one-third of all cancer cases are preventable and tobacco use is the single greatest avoidable risk factor for cancer mortality (World Health Organization, 2013). Obesity, smoking, and alcohol consumption, which are highly prevalent in Indigenous populations, are major contributors to cancer and other chronic diseases (Cancer Care Ontario, 2019). Late-stage diagnosis, high rates of comorbidities, increased risk factors, inequities in access to treatment, and lack of survivorship supports also add to Indigenous people's poorer health outcomes and lower rates of cancer survival (Chan, 2020; Gifford et al., 2018; Kewayosh et al., 2015).

Prevention offers the most cost-effective, long-term cancer control strategy (Kewayosh et al., 2015). Cancer screening is an important prevention strategy to improve cancer outcomes. Some provinces, like Manitoba and Ontario, have established organized breast, cervical, and colorectal cancer screening programs to reduce cancer prevalence and ensure that people who do develop cancer receive timely access to services (Cancer Care Ontario,

2019; Tobias et al., 2020). Still, Indigenous people are less likely than non-Indigenous people to participate in cancer screening programs (Tobias et al., 2020). Federal and provincial/territorial level policies, jurisdictional ambiguity, inappropriate program design, and lack of cultural safety are known barriers to Indigenous people's participation in cancer screening (Tobias et al., 2020).

Limited understanding of the distinct and diverse cultural and socio-historical positions of urban Indigenous people has had a negative impact not only on urban Indigenous people's participation in cancer care (Jull et al., 2018), but also on the implementation of effective cancer survivorship strategies and psychosocial supports that recognize the unique needs and strengths of urban Indigenous people (Gifford et al., 2018; Hammond et al., 2017). For instance, a review of support services for Indigenous cancer survivors following the end of their cancer treatment identified a need for Indigenous-specific survivorship care, including personalized spiritual care, involvement of family members, and connections to other Indigenous cancer survivors (Cavanagh et al., 2016). The importance of family support throughout the survivorship period, negative effects of community stigmatization, fatalistic attitudes towards cancer, and the importance of spirituality in coping with and understanding the cancer experience were key themes identified through the review. The review also found that Indigenous cancer survivors faced significant fears around cancer recurrence, which served as a potential barrier to follow-up care.

Although there has been some attention directed to cancer screening, few studies have focused on cancer treatment, leaving very little quantifiable data to inform cancer policies and treatment practices, especially for urban Indigenous people (Chan, 2020). Advancements in cancer survivorship care have shown that holistic approaches such as long-term follow-up, regular monitoring for early detection, and interventions tailored to the specific needs of cancer patients can increase survival rates and enhance the quality of life for people living with cancer (CPAC, 2013). Most of these interventions, however, tend to target middle-class, non-Indigenous populations, with little attention given to the cancer survivorship needs of Indigenous people residing in urban centres (Gifford et al., 2018).

Heart disease

Heart disease, or cardiovascular disease, was the second leading cause of death in 2020, accounting for 17.5% of all deaths in the general population, following deaths from cancer (26.4%) (Statistics Canada, 2022d). Data and literature focusing exclusively on heart disease among urban Indigenous populations are not available, but evidence shows that Indigenous people generally experience greater incidence of heart disease and higher rates of cardiovascular disease mortality than the non-Indigenous population (Anand et al., 2019; Hutchinson & Shin, 2014; Schultz et al., 2018); heart disease is on the rise among Indigenous people, but declining for non-Indigenous people (CIHI, 2013; McGibbon et al., 2013); and rates of heart disease and cardiovascular disease mortality are higher for Indigenous women than for Indigenous men (Anand et al., 2019; Prince et al., 2018). Compared with the non-Indigenous population, cardiovascular disease mortality is 30% higher for First Nations men and 76% higher for First Nations women (Tjepkema et al., 2012). Additionally, Indigenous women die from heart disease at younger ages than non-Indigenous women (Heart and Stroke Foundation of Canada, 2018); and heart disease is higher among Indigenous people living with diabetes (Chu et al., 2019; Gregg et al., 2014; Stark Casagrande et al., 2013).

Studies have shown a link between lifestyle changes (including lack of physical activity and a diet high in carbohydrates,

fat, salt, and sugar) and obesity, glucose intolerance, and diabetes, which ultimately increase urban Indigenous people's risk not only for heart disease, but also for heart attack and stroke (Anand et al., 2019; Chu et al., 2019; Heart and Stroke Foundation of Canada, 2018; Yeates et al., 2015). High blood glucose is a major independent risk factor for heart disease, but urban Indigenous people living with diabetes often experience additional risk factors such as hypertension, dyslipidemia, and being overweight, which further increase their risk for heart disease (Chu et al., 2019; Heart and Stroke, 2018). Although improvements in diabetes management and better care of co-existing risk factors for heart disease have contributed to substantial decreases in heart disease rates and associated deaths among the general population (Gregg et al., 2014; Stark Casagrande et al., 2013), heart disease remains higher for urban Indigenous people living with diabetes (Chu et al., 2019; Yeates et al., 2015). Indigenous children and youth residing off reserve (often in urban areas) are especially vulnerable to heart disease later in life, given their higher rates of obesity and physical inactivity (Yeates et al., 2015).

Yeates et al. (2015) reported that modifying risk factors such as elevated cholesterol, diabetes, high blood pressure, smoking, stress, diet quality, and low leisure time activity can reduce the burden of heart disease among vulnerable populations by 80%. Anand et al. (2019) conveyed that socioeconomic advantage, greater trust of neighbours, and higher education and social support influenced better heart health, but access barriers to routine health care and inability to afford prescription medications were associated with higher rates of heart disease among First Nations people. There is also strong evidence that heart disease across Indigenous populations reflects their poorer socioeconomic circumstances and shift away from Indigenous knowledge and the practices that served to protect and care for their heart health (Anand et al., 2019; Heart and Stroke Foundation of Canada, 2018; McGibbon et al., 2013).

According to Sekwan Fontaine et al. (2019), First Nations people historically approached heart health holistically by integrating it into a way of life that included caring for the psychological, physical, emotional, and spiritual needs of individuals, families, and communities. Relationships with the land were equally important, and maintaining balanced connections with families, communities, and the land were not only necessary for ensuring their health and well-being, but also integral to caring for their heart. However, the transition from traditional to westernized lifestyles and diets, trauma from residential schools, racism in health care, subjugation of culturally rooted medicines and Indigenous healing knowledge, economic and geographic marginalization, and deterioration of land, family, and community structures have all affected the heart health of First Nations people. The authors maintained that although healing from the effects of colonization and overcoming continued colonial practices are important for restoring and sustaining heart health, it is equally important for First Nations people to find ways to take care of themselves as First Nations people, despite not necessarily returning fully to the traditional ways that kept them holistically healthy.

Sexually transmitted and blood borne infections

There are many different types of sexually transmitted and blood borne infections (STBBIs). Some STBBIs can cause short-term illness, while others can have lifelong health repercussions. Some STBBIs can be prevented through immunization; others cannot (Government of British Columbia, 2022). Some STBBIs are spread almost exclusively through sexual contact, while others are spread through blood or through both blood and sexually (Manitoba Health, Healthy Living and Seniors [MHHLS], 2015). Common features among STBBIs include the multiple

ways they can be spread; the socio-demographic characteristics that can substantially increase the risk of contracting infection; and the possibility of untreated asymptomatic (without symptoms) infections that can lead to spreading, secondary illnesses, and/or late complications. Co-infections (having two or more infections) can also create challenges in managing one infection due to the presence of another (MHHLS, 2015).

STBBIs are a priority health concern among urban Indigenous populations. Trends show not only that the prevalence of STBBIs is increasing (Choudhri et al., 2018; PHAC, 2020), but also that urban Indigenous people are over-represented in STBBI diagnoses and prevalence (Minichiello et al., 2013; Uhanova et al., 2013). They also become infected at a younger age than non-Indigenous people (Woodgate et al., 2017a). Take syphilis, for example, which is the third most reported STBBI after chlamydia and gonorrhea, respectively (Choudhri et al., 2018). In 2015, there were 3,321 reported cases of infectious syphilis, representing an 85.6% increase from 2010 (Choudhri et al., 2018). Although most syphilis cases are among males (93.7%), and primarily among young adult men (20–29 years), sex workers, adults in correctional facilities, and people residing in urban centres (Eickhoff & Decker, 2016), evidence strongly

suggests that urban Indigenous people make up a large proportion of syphilis cases. In Saskatoon, for instance, cases of syphilis among urban Indigenous people have skyrocketed, with a 110% increase to 242 cases over the 12-month span of 2020 (McKay, 2021). In Winnipeg, there was an unparalleled spike in syphilis rates, with more cases in the first six months of 2018 (120 cases) than the urban centre had counted since 2008, and rates continued to rise (Froese, 2018). About 60% of these cases were among individuals who self-reported as being Indigenous; 30% were among crystal meth users; and 20% were among those who reported being homeless. Similar trends of increasing syphilis rates were also observed in urban centres across Alberta and British Columbia (Alberta Health Services, 2022; Benoit et al., 2022; Bernardo & Martins, 2020).

Left untreated, syphilis can cause significant harm with long-term complications, particularly for pregnant women (Eickhoff & Decker, 2016). Congenital syphilis, which occurs when syphilis infection is passed from a pregnant woman to a fetus during pregnancy (Benoit et al., 2022), can lead to asymptomatic infection, spontaneous abortion, stillbirth, and other severe consequences for infant health like birth defects, partial or permanent impairment, and disabilities (Arnold & Ford-Jones, 2000; Benoit et al., 2022). Syphilis infection has also been linked to increases in human immunodeficiency virus (HIV) viral load and chances for HIV

transmission. In fact, HIV acquisition is reportedly two to five times higher among people infected with syphilis than those without syphilis infection (Choudhri et al., 2018; Eickhoff & Decker, 2016). Additionally, people with HIV are more vulnerable to hepatitis C virus (HCV) co-infection (Moqueet et al., 2021). Approximately 20% of people with HIV are co-infected with HCV (Moqueet et al., 2021).

The rate of HCV infection among Indigenous people is at least five times higher than in the non-Indigenous population (Fayed et al., 2018). This includes disparities in incidence, prevalence, and outcomes such as viral load, disease progression, and mortality (Minuk et al., 2013; Parmar et al., 2016; Sadler & Lee, 2013). The number of reported HCV cases increased from 10,553 in 2010 to 12,447 in 2018, with a corresponding rate increase from 31.0 to 33.6 per 100,000 population (PHAC, 2020). Young Indigenous women and young Indigenous people who inject drugs are increasingly becoming the face of HCV infection (Fayed et al., 2018, Uhanova et al., 2013). One study showed not only that First Nations people were over-represented among new HCV diagnoses and prevalence, but also that most HCV-infected First Nations people were young, female, and residing in urban centres (Uhanova et al., 2013).

It is important to consider that HCV incidence does not appear to be decreasing. This is also the situation for other STBBIs such as HIV, where Indigenous people comprised 14% of all new HIV infections in 2018, up from 12.3% in 2016 (PHAC, 2020). HIV transmission continues to disproportionately affect certain segments of the population, including gay men, bisexual men, and men who have sex with men (MSM); sex workers; people who use injection drugs; and Indigenous people (CATIE, 2016, 2017a; PHAC, 2020). However, a shift in the distribution of new HIV infections has been observed, with the proportion of HIV cases since 2016 decreasing among gay, bisexual, and MSM populations, and increasing among Indigenous people, heterosexual people, and females (PHAC, 2020). Similar trends have been noted among reported syphilis cases where, in 2018, the proportion of cases among women and heterosexual people increased, and the proportion of female cases doubled since 2014 (PHAC, 2019).

These data suggest an overlap between HIV infection and other STBBIs may be contributing to an increased health burden for urban Indigenous people, since the same behaviours and circumstances that put them at risk for getting other STBBIs also increase their risk for HIV infection (PHAC, 2020). Numerous studies have linked urban Indigenous people's increased HIV and HCV vulnerability to early sexual contact, unprotected sex, sex work, residential transience, intravenous drug use, and sharing drug use paraphernalia (Bingham et al., 2014; Duff et al., 2013; Pearce et al., 2015; Woodgate et al., 2017a). Negin et al. (2015) explored HIV-related behaviors in Indigenous populations and found that increased exposure to HIV infection was influenced by childhood abuse (emotional and sexual); family instability; foster care involvement in youth; intimate partner violence; substance use; mistrust of healthcare systems; and social disadvantage, including high rates of unemployment, low educational achievement, housing and food insecurity, poor access to health resources (condoms), and limited access to health care services for HIV prevention and care. Many of these inequities may be linked to broader social issues such as stigma, homophobia, racism and colonialism, social exclusion, and the repression of self-determination (CATIE, 2016, 2017b; Lydon-Hassen et al., 2022; Negin et al., 2015).

Despite better understanding of the issues that increase risk for STBBIs and advances to help stop the spread of infection among urban Indigenous populations, structural and social barriers

continue to hamper urban Indigenous people's linkage to care and initiation of STBBI treatment (Murti et al., 2019; PHAC, 2020). Antiretroviral treatment (ART) has been successful in lowering the amount of HIV in the blood to levels that are so low, HIV cannot be measured by routine tests (CATIE, 2017a). ART greatly improves overall health, increases life expectancy, and significantly reduces the risk of HIV transmission. However, not everyone undergoing ART is able to achieve and/or maintain an undetectable viral load, especially if they face challenges staying engaged in HIV care and taking medications regularly (CATIE, 2017a). Compared with the non-Indigenous population, urban Indigenous people have lower rates of viral suppression (Benoit et al., 2017; Lefebvre et al., 2014).

Identifying predictors and groups at increased risk of not achieving viral suppression can help to target intervention efforts (PHAC, 2020). For example, one Vancouver-based study found that establishing routines helped HIV-infected people who inject drugs achieve an undetectable viral load, regardless of ongoing drug use, but external factors that disrupted their regular routine such as housing transitions, challenges in managing co-occurring health concerns like mental health issues, and increases in drug use or involvement in the drug scene led to rebound episodes in which their viral load did not stay undetectable (Small et al., 2016). Another study showed that 94% of Indigenous inmates living with HIV were on treatment, and 92% of those on treatment had a suppressed viral load (PHAC, 2020), thus reinforcing the value of established routines in HIV treatment and care.

Late HIV diagnoses among urban Indigenous people suggests that their access to STBBI testing is a major unmet need (Ontario HIV Treatment Network [OHTN], 2019). Stigma and discrimination serve as significant barriers to testing and related STBBI services for urban Indigenous people with HIV (Gilbert et al., 2019; PHAC, 2020; Woodgate, 2017b). Other known barriers include fear of positive results, difficulties accessing sexual health care in general, provider perceptions of low risk, lack of provider knowledge around trans-sexual behaviour, and limited clinic capacity to meet gender segregated STBBI testing needs (Scheim & Travers, 2017). One study even found that negative impacts of gentrification (displacement of marginalized populations) influenced barriers to health care services (Goldenberg et al., 2020).

The lack of coordination between mainstream biomedical approaches and Indigenous worldviews has been recognized as a contributing factor to STBBIs among urban Indigenous populations (OHTN, 2019). To be successful then, prevention and intervention strategies aimed at addressing STBBIs among urban Indigenous populations must remain flexible enough to adapt to the holistic (spiritual, emotional, mental, and physical) needs and changing dynamics of urban Indigenous populations. It has been well-established that cultural foundations continue to function as buffers to protect urban Indigenous people from severe health outcomes, including vulnerability to HIV and HCV infection (Fayed et al., 2018; Flicker et al., 2013; Lambert, 2017; Pearce et al., 2015). Providing culturally appropriate primary care that is sensitive to, informed by, and focused on urban Indigenous people living with HIV and other STBBIs is important, not only for supporting their cultural identities, pride, and resilience, but also for empowering them to become more involved in reducing STBBIs and related mortality (Klakowicz et al., 2016; Pearce et al., 2015).

Mental health

Mental health refers to a state of well-being that allows people to feel, think, and act in ways that enhance their ability to enjoy life and deal with the life challenges they face (Varin et al., 2019). This includes emotional well-being, healthy social skills, and good cognitive functioning (Lane, 2020). Mental health also reflects community and social well-being (Anderson, 2015). Mental illness, on the other hand, negatively affects the way people think, feel, behave, or interact with others (Canadian Mental Health Association [CMHA] BC, 2015). Not everyone will experience mental illness, but all people will, at some point in their lifetime, encounter challenges or setbacks in maintaining positive mental health (CMHA BC, 2015). Some people live with mental health conditions like depression, anxiety, or other mood disorders and go through periods of mental well-being, as well as periods of poor mental health. Other people may not be living with a mental health condition but will still go through times of either positive or poor mental health (CMHA, 2022). In 2017, more than two-thirds of the general population reported having excellent or very good mental health (Varin et al., 2019). Off-reserve First Nations people, Inuit, and Métis people reported rates of poor mental health that were 1.3 to 1.9 times higher than the non-Indigenous population (PHAC, 2018), but for the most part, they also reported being in excellent or very good mental health (Cruddas, 2019).

Some urban Indigenous people face high levels of poor mental health outcomes such as depression and suicide (Cruddas, 2019). These poor mental health outcomes are not the product of a single cause, but rather are embedded within a complex arrangement of biological, environmental, and social circumstances, behaviours, and relationships that are associated with their mental well-being (Anderson, 2015). For instance, poor mental health outcomes among urban Indigenous people have been linked to social determinants such violence, poverty, inadequate housing, addictions, problems finding work or getting an education, and lack of social support and community belonging (Bingham et al., 2019; Cruddas, 2019; PHAC, 2018); the long-term negative effects of residential schools, ongoing colonial structures, and systemic racism (Cruddas, 2019; Kirmayer et al., 2016; PHAC, 2018); as well as dislocation and disconnection from the land, disruption of traditional ways of life, cultural oppression, loss of autonomy, and systematic degradation of Indigenous knowledges and identities (Loppie et al., 2014; PHAC, 2018; Tait et al., 2013; Wilk et al., 2017). Poor mental health outcomes have also been linked to chronic physical conditions, heightened levels of stress, and adverse psychological reactions (Anderson, 2015; Hackett et al., 2016; Jacklin et al., 2017).

Puri et al. (2017) examined mental health among sex workers in Vancouver and found that depression, anxiety, post-traumatic stress disorder (PTSD), and bipolar disorder were common concerns among urban Indigenous women involved in sex work. The study identified linkages between high levels of burnout, unfavourable working conditions, and being diagnosed with a mental health condition. The study also identified a complex interplay between being a gender diverse person, experiencing structural challenges (stigma, discrimination, violence), and having a mental health diagnosis. In other research, Currie et al. (2013) identified connections between racial discrimination, problem gambling, and PTSD symptomology (avoidance/numbing) that could not be explained by assumed factors such as separation from birth parents, abuse in childhood, and poverty over the life course. More than 80% of urban Indigenous participants in this study experienced high levels of racial discrimination in the past year, as well as elevated PTSD symptoms. Gambling to escape negative emotions associated with racial discrimination was

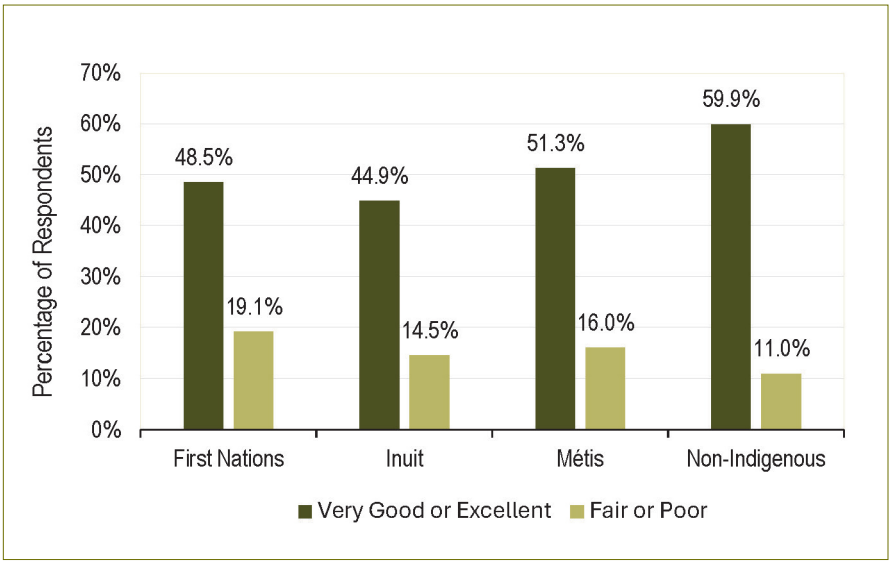
strongly linked to problem gambling, independent of gambling involvement. The study also identified a threefold increase in suicide attempts by problem gamblers over the past year, thus emphasizing the devastating impact of problem gambling on the mental health outcomes of urban Indigenous people.

Poor mental health outcomes can lead to a myriad of problems for urban Indigenous people. Poor mental health plays a significant role in suicide, but it is not the only relevant factor in suicidal thoughts or attempts (Anderson, 2015; PHAC, 2018). Many people who die by suicide have a mental illness, but most people living with a mental illness will not die by suicide (PHAC, 2018). Substance use and addictions, social identity (sex/gender), cultural background, socioeconomic inequities (education, employment, income), exposure to trauma, and lack of cultural connectedness are known risk factors for suicide (Hajizadeh et al., 2019; PHAC, 2018). One study found that mental distress among urban Inuit was associated with the presence of a chronic physical condition, food insecurity, difficulties accessing health care, and poor family ties (Anderson, 2015). Another study identified several unique determinants that affected the mental health of urban Indigenous Elders (55 years and older), including limited transportation to cultural activities outside the urban centre, few opportunities for social networking and support, and access barriers associated with racism, discrimination, and inequitable care. Moreover, the study reported that access to land-based activities, such as medicine picking, was vital to urban Indigenous Elders' mental health, as was respecting and accommodating their unique and diverse cultural and spiritual practices (Schill et al., 2019).

Mental health outcomes vary considerably between and within urban Indigenous populations (Auger, 2019; Cruddas, 2019). Key to reducing negative mental health outcomes such as suicidal ideation is the willingness and ability to seek help (Cruddas, 2019). Mental health promotion and mental illness prevention are key priorities for urban Indigenous people's holistic well-being (Varin et al., 2019). While there has been much focus on negative mental health outcomes (Nelson & Wilson, 2017), little attention has been given to the positive aspects of urban Indigenous people's mental health (Hill & Cooke, 2014), such as the protective factors, or resilience, that positively influence their capacity to manage and cope with stressful situations (Cruddas, 2019; Petrasek Macdonald et al., 2015).

Suicide rates, for example, vary significantly across First Nations and Inuit populations because of different degrees of cultural continuity (Chandler & Lalonde, 1998, 2008; Hicks, 2015). Cultural continuity encompasses self-engagement, identification, social and cultural recognition, and a sense of belonging (Auger, 2016; Greenwood & Jones, 2015). Other protective factors include spirituality, connectedness, and social support (Burnette & Figley, 2016; Chartier et al., 2020). Indigenous cultural engagement through practices such as hunting, fishing, and gathering; artistic expression; visiting Indigenous organizations in the community; speaking and practicing Indigenous languages; and spending time with Elders have also shown a positive effect on the mental health of urban Indigenous people (Cruddas, 2019). One study that looked at the powers of Elder inclusion in an urban health centre found that access to Elders as part of routine primary health care offered an important avenue for urban Indigenous people to participate in cultural practices, become more engaged with healthcare providers, and alleviate suicidal ideation (Hadjipavlou et al., 2018). A similar study found that interacting with an Elder as part of their routine primary care significantly reduced depressive symptoms and suicide risk among urban Indigenous people, as well as their use of emergency health services (Tu et al., 2019).

FIGURE 2: SELF-PERCEIVED HEALTH FOR OFF-RESERVE INDIGENOUS AND NON-INDIGENOUS POPULATIONS, 12 YEARS AND OLDER, 2011-2014



Source: Statistics Canada (2016b), Canadian Community Health Survey.

Urban Indigenous people have been known to actively avoid mental health services that are considered unsafe, particularly services that undermine their cultural identity, instill fear, fail to treat them with dignity or respect, and are highly discriminatory and reflective of broader colonial institutions (residential schools) that act as both a cause of poor mental health and a barrier to mental well-being (Schill et al., 2019). Urban Indigenous people's mental health may be significantly improved through evidence-informed interventions that not only recognize diversity within and between urban Indigenous populations (Auger, 2019; Schill et al., 2019), but also adopt resiliency perspectives that promote pride and self-determination, improve self-esteem and identity, transmit Indigenous traditions, and employ culturally appropriate mental health practices as a meaningful alternative to conventional mental health services (Tu et al., 2019).

Self-perceived health

Self-perceived health is a measure of how people perceive their own health status. Typically, people are asked to rate their own health on a scale of excellent, very good, good, fair, or poor. This measure of health generally provides a good indicator of actual health status because it reflects the absence of disease or injury and offers a more holistic measure of health that includes physical, psychological, and social dimensions (Bonner et al., 2017; OECD, 2021). However, caution is required when making population comparisons of self-perceived health status, since the measure is subjective and can be affected by cultural influences (Ahmed et al., 2021; OECD, 2021).

Self-perceived health does not vary considerably by Indigenous identity, but there are considerable disparities between the self-perceived health of urban Indigenous people and the non-Indigenous population. Figure 2 provides an overview of self-perceived health ratings for off-reserve First Nations, Inuit, Métis, and non-Indigenous populations.

Compared with the non-Indigenous population, urban Indigenous people are more likely to report higher rates of smoking, exposure to second-hand smoke, food insecurity, obesity, and chronic health conditions, which may account for their poorer ratings of self-perceived health (Gionet & Roshanafshar, 2013). The factors that influence health inequities have been linked to urban Indigenous people's self-perceptions of health status. For example, one study of self-perceived health among off-reserve First Nations and Métis peoples found that being older, female, and residing in an urban setting significantly influenced negative ratings of self-perceived health, whereas higher education and income levels strongly influenced positive ratings of self-perceived health

(Bethune et al., 2019). The study also showed that volunteering in the community was associated with better self-perceived health, thus emphasizing the positive influences of culture and community connections on urban Indigenous people's perceived health status.

In other research, an Ontario-based study of chronic stress and mental health among urban Indigenous women living with and without HIV found that perceived stress was an important correlate of highly depressive symptoms, regardless of HIV status (Benoit et al., 2016). Study participants reported elevated levels of HIV co-morbidities (82.2%), perceived stress (57.8%), stress related to urban living (84.2%), severe depressive symptoms (82.2%), and severe PTSD (83.2%). A Vancouver-based study found that child removal and family separation were linked to poorer ratings of self-perceived health, with the poorest health ratings reported by urban Indigenous women facing two or more generations of child removal (Kenny et al., 2019). Compared with the non-Indigenous population, urban Indigenous women were more than twice as likely to have experienced child removal (60.7% vs. 25.6%); three times more likely to have experienced intergenerational family separation through the child welfare system (34.7% vs. 10.9%); more likely to be structurally and socially marginalized; and more likely to have experienced residential instability, street-based sex work, injection or non-injection drug use, and intimate physical and/or sexual violence in the past six months. All these factors are indicative of larger cumulative effects of intergenerational child removal and family separation on the perceived health of urban Indigenous people.

What each of these studies show is that self-perceived health serves as an effective tool for predicting emerging health problems and assessing the underlying factors that contribute to urban Indigenous people's health outcomes. Though not a direct measure of absolute health, self-perceived health is a validated and effective indicator of the overall health status of urban Indigenous people and associated health outcomes (PHAC, 2018).

Urban Indigenous people have been known to actively avoid mental health services that are considered unsafe, particularly services that undermine their cultural identity, instill fear, fail to treat them with dignity or respect, and are highly discriminatory and reflective of broader colonial institutions (residential schools) that act as both a cause of poor mental health and a barrier to mental well-being (Schill et al., 2019).

It has been established that urban Indigenous people experience a disproportionate burden of health problems compared with the non-Indigenous population, and their health inequities are rooted in a host of interrelated factors that perpetually serve to their disadvantage (Wilk et al., 2018).

IMPLICATIONS FOR SERVICE DELIVERY

It has been established that urban Indigenous people experience a disproportionate burden of health problems compared with the non-Indigenous population, and their health inequities are rooted in a host of interrelated factors that perpetually serve to their disadvantage (Wilk et al., 2018). A major challenge in improving urban Indigenous people's health involves the complex nature of Indigenous healthcare systems and related difficulties in coordinating activities and mobilizing resources for First Nations people, Inuit, and Métis people residing in urban centres (Wilk et al., 2018; Wrathall et al., 2020). This section focuses on the jurisdictional and demographic implications of urbanization on the provision of health care services for urban Indigenous people.

Jurisdictional implications

Governments have long debated over the provision of health care services for Indigenous people residing in urban centres. The organization of Canada's healthcare system is largely determined by the Canadian Constitution, in which roles and responsibilities pertaining to health care are divided between federal and provincial/territorial governments (ISC, 2021). Essentially, provinces/territories have primary jurisdiction over the administration and delivery of healthcare services, including setting their own priorities and standards of care, administering their own budgets, and managing their own resources. The federal government's role, as defined by the Canada Health Act (Canada, 2020b), is to oversee national standards on provincial health care insurance plans (ISC, 2021). The Act requires that all medically necessary hospital, physician, and surgical dental health care services be covered by provincial/territorial health care insurance plans for all eligible residents of the province/territory, including Indigenous Peoples. Although the Act establishes broad, national principles that govern the country's healthcare system, it does not set standards (timeliness, quality of care) for the delivery of provincial/territorial health care services (ISC, 2021).

The Canadian health system is a complex patchwork of policies, legislation, and relationships (ISC, 2021). Federal and provincial/territorial governments share some degree of jurisdiction with respect to health care for First Nations people, Inuit, and Métis people, but for the most part, these services are uncoordinated and not widely available or accessible (BCAAFC, 2020, Collier, 2020; Lavoie et al., 2015). For example, the federal government provides funding for direct health care services in First Nations communities; certain community health programs for Inuit residing in Inuit Nunangat; non-insured health care benefits (Non-Insured Health Benefits [NIHB] program) for status First Nations people and recognized Inuit, regardless of where they live in Canada; and programs that target, in part, Indigenous people residing in urban centres and off reserve in rural/northern communities (ISC, 2021).

For status First Nations people residing off reserve, non-status First Nations people, Inuit residing outside Inuit Nunangat, and Métis people, the federal position is that services and benefits are the responsibility of the provinces/territories (ISC, 2021; TRC, 2015), which is where the jurisdictional

wranglings begin, with each level of government believing the other is responsible for providing health care services for Indigenous people residing in urban centres (NAFC, 2021). Canada contends that the federal government is responsible for funding only on-reserve services (TRC, 2015). The provinces/territories, on the other hand, maintain that the federal government has constitutional responsibility for all Indigenous Peoples, but has off-loaded that responsibility to the provinces/territories to provide services to an increasingly urban, non-reserve population. The result is that there are often disputes over which level of government is responsible for paying costs related to urban Indigenous people (Richmond & Cook, 2016; Snyder et al., 2015; TRC, 2015). The repercussions of these jurisdictional disputes can be serious, especially for urban Indigenous people living with complex developmental, mental health, and physical health conditions (TRC, 2015).

The framing of health care responsibilities as voluntary services rather than the result of Aboriginal rights has created considerable confusion and gaps in health care services for urban Indigenous people (Senese & Wilson, 2013). Aboriginal rights, which refer to the collective, inherent rights that flow from Indigenous Peoples' continued use and occupation of certain areas of land (Indigenous Foundations, 2009b), are commonly understood by urban Indigenous people to entail the right to specific services and benefits that support quality of life for Indigenous people, as well as the right to respect for Indigenous cultures and identities (Senese & Wilson, 2013). Largely tied to land bases that lie outside urban centres, Aboriginal rights often are perceived to be geographically bound to reserves, which is why they are not always respected in urban centres (Senese & Wilson, 2013).

There are few federal and provincial/territorial health initiatives that specifically target urban Indigenous people (BCAAFC, 2020). Status First Nations people and Inuit residing in urban centres may be able to access some health-related services and benefits, such as prescription medications, through the federal NIHB program but may be ineligible for other benefits like transportation to medical appointments (Lavoie et al., 2015; Snyder et al., 2015). Consequently, status First Nations people and Inuit residing in urban centres find they do not have access to the same range and quality of health care services provided federally on reserve and in Inuit Nunangat (Richmond & Cook, 2016; TRC, 2015). With fewer service options, urban Indigenous people are inclined to access public health services intended for mainstream populations (Collier, 2020). These services may not be culturally appropriate for urban Indigenous people, thus creating barriers to access. Urban Indigenous people also may encounter racism and discrimination when accessing these services, which can negatively affect their health (Collier, 2020; Senese & Wilson, 2013).

There is also the issue of inequitable funding. Federal funding for Indigenous Peoples tends to be reserve based (Snyder et al., 2015). With much ambiguity surrounding jurisdictional responsibility, urban Indigenous people generally receive lower levels of funding for health and social supports, the majority of which is short-term, provided annually, and based on project proposals (Collier, 2020; Snyder et al., 2015). This means that organizations offering services to urban Indigenous people spend much of their time on reporting and trying to secure funding when they could be focusing on service delivery (Collier, 2020). In 2020, for example, the federal government introduced an Indigenous Community Support Fund to support First Nations people, Inuit, and Métis people during the global COVID-19 pandemic (ISC, 2022). Although most Indigenous people are known to be residing in urban centres (Arriagada et al., 2020), over 80% of the federal funding for Indigenous-specific pandemic support was given directly to rural/northern First Nations, Inuit, and Métis communities, with the remaining balance allocated for Indigenous people residing off reserve and in urban centres (ISC, 2022). What's more, none of this funding was provided directly to Indigenous organizations that served urban Indigenous populations. Instead, urban Indigenous organizations were eligible to apply for needs-based funding, on a one-time basis (Collier, 2020).

Advancement toward self-determination has been conceptualized as a potential remedy to the jurisdictional misalignment of federal and provincial/territorial governments, but the process is slow-going, particularly since self-determination is largely tied to a land base and the distinct languages, cultures, beliefs, and practices of Indigenous people inherent to those lands (BCAAFC, 2020; Henderson, 2021; Senese & Wilson, 2013). Through various self-government and land claim agreements, First Nations people and Inuit have realized enhanced control of health care services, resulting in many emerging trends in Indigenous health transformation, jurisdictional coordination, and collaborative processes that are helping to provide some coherence around Canada's complex healthcare system (ISC, 2021). Improving the provision of health care services for urban Indigenous people remains a pressing issue and top priority on federal, provincial/territorial, and Indigenous health care agendas (BCAAFC, 2020; Collier, 2020; Congress of Aboriginal Peoples, 2019).

Demographic implications

Service providers play an important role in addressing the health care needs and priorities of urban Indigenous people. However, the rapid growth of urban Indigenous populations has had a significant impact on urban centres, especially regarding service provision (NAFC, 2021; Nejad et al., 2019; Nelson & Rosenberg, 2021). To ensure the provision of services is useful and effective in making a positive difference in quality of life and well-being, careful consideration must be given not only to the demographic characteristics of urban Indigenous populations, but also to understanding what these attributes mean for service delivery. Recognition of urban Indigenous people's rights and needs – and the barriers and challenges they face – is essential for improving their health outcomes (Cidro & Siddiqui, 2016).

A prominent characteristic of urban Indigenous populations is that they are vastly diverse, with distinct cultural traits, unique histories and experiences, different rights and benefits, and varied degrees of resilience (Kirmayer et al., 2011). Collectively, urban Indigenous people have made significant strides in narrowing the inequality gap between urban Indigenous people and

the non-Indigenous population, demonstrating increased educational achievements, advances in employment, and growing numbers of higher income households (Parriag & Chaulk, 2013; Statistics Canada, 2018a, 2018b, 2018c, 2018d). At the same time, urban Indigenous people face significant health and socioeconomic inequities, characterized by poverty, food and housing insecurity, high risk behaviours, racism and discrimination, social exclusion, and other facets of oppressive social relations (Arriagada et al, 2020; Belanger et al., 2013; Tang et al., 2015). Urban Indigenous children, specifically, are more likely than non-Indigenous children to have lone-parent families; live in foster care (Chartier et al., 2020; Ontario Human Rights Commission [OHRC], 2018); and face significant barriers to conventional services, including discrimination based on their race, gender and sexual orientation, age, and spiritual beliefs (Indigenous and Northern Affairs Canada [INAC], 2017; NAFC, 2021). Oftentimes, these discriminatory experiences are not disclosed for fear of further racism or other repercussions (NAFC, 2020).

Urban Indigenous populations also are highly mobile, frequently moving both between rural/northern communities and urban centres, and within urban neighbourhoods (Congress of Aboriginal Peoples, 2019; Senese & Wilson, 2013). The movement within urban centres implies a need for programs and services aimed at reducing residential mobility rates, such as those which address housing conditions (Snyder et al., 2015). Movement between rural/northern communities and urban centres, on the other hand, points toward services that support urban Indigenous people's connections to family, communities, and culture. In this case, initiatives focused solely on urban centres may not address significant push-pull influences that exist outside urban centres. Alienation from family and community, for instance, has been shown to have a significant effect on the health of Indigenous people who relocate to urban centres for medical reasons, but when provided the opportunity to maintain close connections with family and friends, such as through coordinated visits to home communities or within urban centres, the hardships associated with medical treatment and urban Indigenous people's quality of life improved (Genereux et al., 2021). This implies that health care services must remain flexible enough to adapt and respond to the diverse needs and changing dynamics of urban Indigenous populations.

Urban Indigenous populations are over-represented by women and youth, but there also is a growing presence of Indigenous seniors (particularly women) in urban centres (O'Donnell et al., 2017). Urban Indigenous women generally live longer than their male counterparts, but they also experience greater prevalence of morbidity and chronic diseases and are more frequent users of the healthcare system (Allan & Smylie, 2015; Bingham et al., 2019). Further, urban Indigenous women are more likely than other populations to be single parents, to live in poverty, and to have been victims of violence, which are major determinants of health (Arriagada et al., 2020; NIMMIWG, 2019; Palmater, 2016). They also are at greater risk than women not experiencing poverty to encounter situations that negatively impact their physical, mental, emotional, and spiritual health (NIMMIWG, 2019). Moreover, urban Indigenous women's encounters with the healthcare system are shaped by socioeconomic factors such as employment, education, housing, income, food, and sustainable resources. All of these variables need to be factored in when considering the priority focus for service delivery (vulnerable vs. affluent populations); geographic scale and scope of programs and services; whether to focus on individuals or communities, or both; how to ensure culturally safe and appropriate services for highly diverse urban Indigenous populations; how organizations

and services might effectively interact to reflect the needs of highly mobile, often marginalized, urban Indigenous populations; and whether to develop programs and services that are concentrated in targeted neighbourhoods or initiatives that have a wider urban focus (Place, 2012).

Another demographic implication of Indigenous urbanization centres around the accuracy of data. Accurate data are essential not only for ensuring that equitable funding is allocated to support vital programs and services, but also for identifying existing needs, service gaps, and priorities (Collier, 2020). Oftentimes, urban Indigenous people are missed in population data counts, particularly if they are homeless or living in non-permanent or collective dwellings. As a result, they are under-represented in health and social trends (Collier, 2020; Howard-Bobiwash et al., 2021). For instance, the 2016 Census reported 1,280 Inuit residing in the Ottawa-Gatineau area, but organizations providing services to Inuit in the urban centre counted between 3,700 and 6,000 Inuit service users (Collier, 2020). Similarly, Smylie et al. (2018) counted 3361 Inuit residing in Ottawa, thus confirming that many Inuit had been missed in the Census. In another study, Rotondi et al. (2017) used respondent-driven sampling to survey Indigenous people residing in Toronto and found that urban Indigenous people were under-counted in the Census by a factor of 2 to 4. Specifically, the study counted approximately 55,000 urban Indigenous people, which was more than double the census estimate of 19,270.

Given the large number of Inuit residing in Ottawa, one other implication for the provision of health care services pertains to the issue of targeted vs. pan-Indigenous programming. Status-blind services are cost effective, non-discriminatory, and may function to develop a sense of community within urban environments (Place, 2012). However, more direct, culturally specific, and meaningful services could play an important role in supporting the distinct cultural identities, diverse health inequities, and unique service needs of specific urban Indigenous populations (Ghosh & Spitzer, 2014; Schill et al., 2019), like the rapidly increasing Inuit population in Ottawa.

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PROGRAMS AND SERVICES

Urban centres offer a wide range of programs and services to support Indigenous people. Programs may be specific to a particular illness, such as diabetes or HIV/AIDS; targeted to a certain segment of urban Indigenous populations, like children and families, youth, or women; or be part of a larger initiative, such as cultural revitalization, Indigenous inclusion, ending urban Indigenous homelessness, or reducing the number of Indigenous children in foster care (Place, 2012). Urban Indigenous services may be funded by multiple levels and sectors of government, community-based organizations, and even private stakeholders. They may also be community-based, Indigenous designed and delivered, or part of a nation-wide endeavour. This section highlights selected national and regional initiatives to support Indigenous people residing in urban centres.

Selected national initiatives

As far back as the 1950s, there has been a recognized need for specialized agencies to support the continued growth of urban Indigenous populations (Manitoba Association of Friendship Centres [MAFC], 2022). Several federal initiatives have been implemented to address the diverse and distinct needs and priorities of Indigenous people residing in urban centres, including national service organizations and federal support for Indigenous-led political agencies, targeted associations, and local community-based organizations. For example, Indian and Métis Friendship Centres were established in the mid-1950s to provide referral services and Indigenous arts and culture to Indigenous people transitioning from rural/northern communities to urban centres (Congress of Aboriginal Peoples, 2019; MAFC, 2022). Friendship Centres were initially designed to help urban Indigenous people transition to urban living in safe, caring ways that reduced the impacts of discrimination. They started as volunteer organizations, with the first three newly formed friendship centres emerging in Winnipeg, Vancouver, and Toronto (MAFC, 2022). Friendship Centres continued to evolve and expand with growing numbers of urban Indigenous people across the country. Today, there is the National Association of Friendship Centres, which serves as a national Indigenous organization (non-governmental) representing a network of over 100 local friendship centres and provincial/territorial associations, each providing aid to First Nations, Inuit, Métis, and non-Indigenous members of their respective communities, regardless of their legal status as an Indigenous person (NAFC, 2021).

Friendship Centres have been recognized as the most significant grassroots urban Indigenous service delivery infrastructure in the country (NAFC, 2021). All Friendship Centres offer a wide range of culturally relevant programs and services to support urban Indigenous people, including shelters, food banks, child care, culture and language programming, education and training supports, sports and recreation, and public health programs. Some Friendship Centres even have social enterprises, such as the First Light St. John's Friendship Centre in Newfoundland and Labrador, which offers affordable housing, an Indigenous-run childcare centre, and an Indigenous-led arts centre (Collier, 2020). For many urban Indigenous people, the programs and services offered by Friendship Centres are a lifeline to much needed support structures spanning the areas of health, housing, education, recreation, language and culture, justice, employment, economic development, and community wellness (NAFC, 2021).

In 1997, the federal government launched an Urban Aboriginal Strategy (UAS) to support the social and economic participation of urban and off-reserve Indigenous people in the Canadian economy. In 2012, the UAS was extended and moved alongside three other national urban Indigenous programs (the Aboriginal Friendship Centres program, Cultural Connections for Aboriginal Youth, and Young Canada Works for Aboriginal Urban Youth) to allow for a greater focus and coordination of federal efforts to support urban and off-reserve Indigenous people (Aboriginal Affairs and Northern Development Canada [AANDC], 2012). In 2014, federal programming for urban Indigenous people was consolidated into the UAS to enable the federal government to maintain a meaningful level of visibility on urban Indigenous issues, while facilitating greater collaboration among partners and stakeholders (INAC, 2017). Part of this restructuring included redirecting funding and oversight of the UAS to the NAFC.

An evaluation of the UAS was conducted in 2016 to determine whether the consolidation of urban Indigenous programming achieved positive results. The evaluation revealed that a federal role, community partnerships, and multi-year funding were essential to improving the effectiveness and efficiency of urban Indigenous program delivery (INAC, 2017). The evaluation also identified the need for more culturally sensitive programs and services. Urban Indigenous youth remained a top priority for required programming.

Urban Programming for Indigenous Peoples (UPIP) was implemented in 2017 to replace the UAS and strengthen supports for Indigenous people residing in or transitioning to urban centres (ISC, 2018). With a $53 million annual budget (Collier, 2020), more than 120 organizations, programs and projects across the country received up to five years of funding to support urban Indigenous focused organizational capacity; programming and transition services for women, youth, seniors, and persons with disabilities; outreach and community wellness; coalition efforts; and research/innovation (ISC, 2018).

High quality Indigenous services are those that are culturally appropriate and respond to the unique needs and priorities of specific Indigenous groups such as Indigenous people residing in urban centres (Collier, 2020). Many organizations struggle to meet the challenge of providing culturally appropriate programs and services to highly diverse populations of urban Indigenous people (Congress of Aboriginal Peoples, 2019). Recognizing this, the Urban Aboriginal Knowledge Network (UAKN) was created in 2007 to fill existing and emergent knowledge gaps in urban Indigenous research and provide policy makers with high-quality, policy-relevant information to effectively address urban Indigenous concerns and contribute to a better quality of life for urban Indigenous people (NAFC, 2022).

As a national, interdisciplinary network, the UAKN brought together perspectives from academia, government, and urban Indigenous communities for research, scholarship, and knowledge mobilization (NAFC, 2022). At the community level, Friendship Centres and other urban Indigenous organizations played a critical role in the UAKN's research development and policy improvement processes, especially in terms of easing social dislocation, assisting with family separation, and countering racial discrimination experienced by urban Indigenous people. Moreover, using evidence collected by urban Indigenous communities for urban Indigenous communities, the knowledge network helped to ensure that adequate funding was allocated to programs and services aimed at meeting the unique needs of First Nations people, Inuit, and Métis people residing in urban centres (Collier, 2020).

In 2018, the National Urban Indigenous Coalition Council (NUICC) was established to engage urban Indigenous coalitions from nearly all provinces and territories across the country in a national dialogue aimed at raising the profile of local urban Indigenous perspectives and issues and supporting the overall health of Indigenous Peoples—and Canadian society (NUICC, 2024). Through the NUICC, council gatherings of coalition representatives focus on increasing awareness and understanding of the needs and priorities of urban Indigenous organizations to fulfill mandates at local levels; building relationships between coalitions and coalition members; and providing direction to NUICC consultation, knowledge mobilization, capacity-building, and advocacy initiatives such as the Indigenous Knowledge Mobilization Hub (NUICC, 2024). The Hub, which serves as an Indigenous-led platform for open communication and relationship building between coalition members, establishes awareness and builds knowledge through community-engaged data collection and analysis, storytelling, art, and other Indigenous-led initiatives to create greater understanding of current practices and strategies for responding to challenges facing urban Indigenous populations.

Selected regional initiatives

All provincial/territorial governments have a ministry, secretariat, or office that is dedicated to Indigenous affairs, but not all provinces/territories provide funding for urban Indigenous people (Collier, 2020). Even so, provincial/territorial governments have become increasingly involved in the delivery of programs and services for urban Indigenous people. Some of these programs and services specifically target First Nations people, Inuit, or Métis people, while other initiatives offer blanket, pan-Indigenous supports. Many of these initiatives are delivered in partnership with Indigenous organizations (Cidro & Siddiqui, 2016). Vancouver and Winnipeg, which are among the top three urban centres with the highest populations of Indigenous people, provide excellent examples of some of the different types of Indigenous led supports available for Indigenous people residing in urban centres.

Vancouver

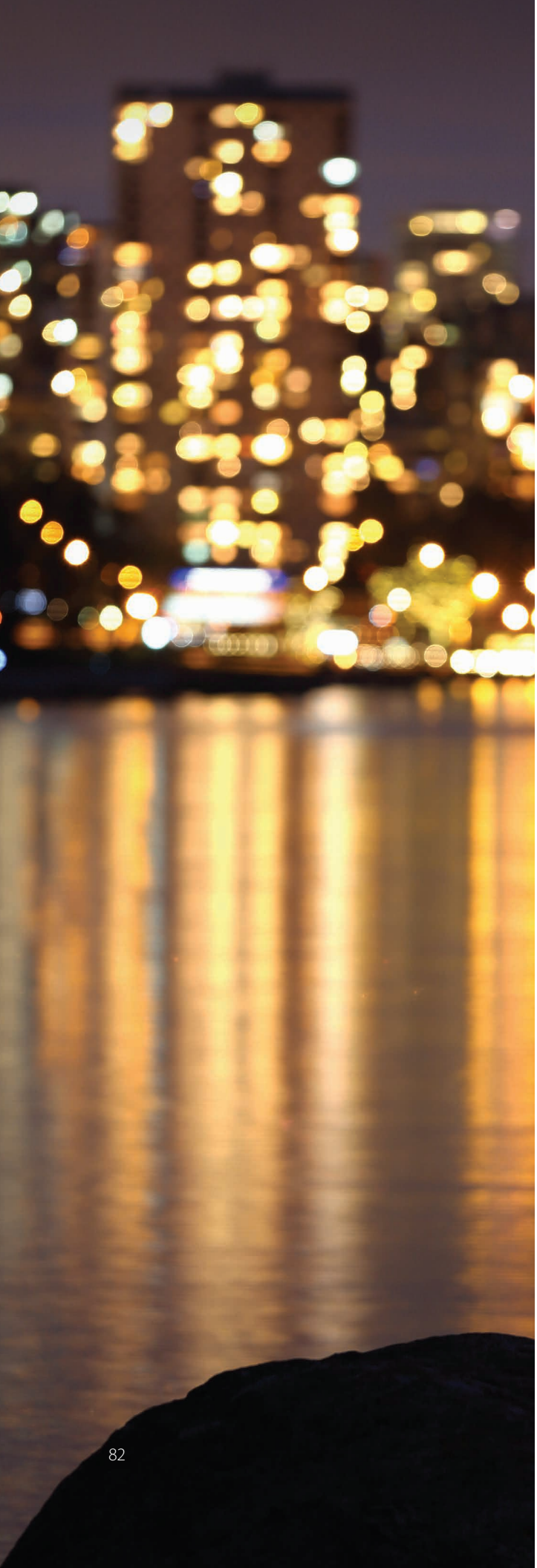
Vancouver is home to numerous community-based Indigenous organizations that support urban Indigenous people. One such organization is the Vancouver Aboriginal Friendship Centre Society (VAFCS). For over 50 years, the VAFCS has been providing programs and services to Indigenous people residing in the Greater Vancouver Regional District (VAFCS, 2022). With an established client base of over 40,000 urban Indigenous people across all age groups, the VAFCS administers community-driven supports in areas such as health and wellness, early childhood development, Child and Family Services (CFS) prevention and family reunification, education and employment, sport and recreation, housing and other social services, human rights, culture, and gender equality. All programs and services offered by the VAFCS are grounded in the philosophies and values of varied Indigenous cultures and traditions, and aim to help children, youth, individuals, and families maintain cultural and traditional connections.

Access to health care is a critical aspect of health outcomes. In Vancouver, there are a wide range of Indigenous health care services to address a multitude of urban Indigenous health care priorities such as medical and dental care, diabetes prevention, mental health and addition, and support for people living with HIV/AIDS or Hepatitis C. For example, The Hey-way'-noqu' Healing

Circle for Addictions Society provides outpatient addiction services, therapeutic counseling, sexual abuse intervention, and mental health service referrals for urban First Nations and Métis peoples (Chooper's Guide, 2012). The Aboriginal Front Door Society (AFDS) also offers a culturally safe place for urban Indigenous people residing in Vancouver's Downtown Eastside to get support (AFDS, 2022). Here, urban Indigenous people can experience, learn about, and participate in traditional Indigenous teachings, cultural practices, and ceremonies as part of their first steps toward their healing journey out of poverty, homelessness, the sex industry, and addiction.

The Helping Spirit Lodge Society (HSLS) is a leading Indigenous women's organization in Vancouver's Lower Mainland whose mission is to alleviate family violence and enhance community well-being through a traditional, holistic approach (HSLS, 2019). The HSLS provides wrap-around services, including safe, protective shelter, educational programs, health and social supports, and advocacy for both Indigenous women and children fleeing domestic violence, and homeless Indigenous individuals and families. The Pacific Association of First Nations Women (PAFNW) offers programming that focuses on the health of female Indigenous Elders, as well as various other Indigenous-led initiatives such as a drum circle, home care services, language and art courses, peer support and mentorship programs, and the Urban Butterflies Initiative, which provides unique and fun opportunities for Indigenous girls (7 to 14 years) to practice cultural art and dance, learn about their spirituality, and gain skills to survive emotional pain associated with living in foster care (PAFNW, 2022).

The Vancouver Aboriginal Health Society (VAHS) is another Indigenous-led initiative that was established to address the lack of culturally safe health care for Indigenous people residing in Metro Vancouver (VAHS, 2022). Located in Vancouver's Downtown Eastside, the VAHS strives to improve the physical, emotional, and spiritual health of urban Indigenous people through trauma- and violence-informed programs and services, and by proactively addressing the social determinants of health rather than simply treating the illnesses they cause. Using both Indigenous and Western approaches to urban Indigenous health and well-being, VAHS has created a safe and community-driven health care



environment, characterized by a culture of caring that is free of judgment. The VAHS provides a range of holistic wellness programs and services that are rooted in respect, safety, and Indigenous knowledges and cultures. Notable services include: parent-child early childhood development programming; an early intervention home visiting program for first-time parents; family violence prevention and intervention; parenting skills development, advocacy, and peer support for families dealing with fetal alcohol spectrum disorder (FASD); CFS prevention and family reunification supports; culture and land-based healing activities; education, counseling, addictions management, housing, and parenting supports for pregnant or parenting women living with substance use issues; and a healing centre offering medical, dental, pharmacy, mental health, and spiritual supports.

Indigenous philosophies and values are incorporated into all VAHS programs, services, and facilities. Elders play an essential role in bringing cultural traditions into the programs and services that are offered, often in partnership with other community and government organizations. Through culture and understanding of people's unique circumstances and experiences, Elders provide guidance to support urban Indigenous people in finding their strong sense of identity and in moving into a space of thriving.

Vancouver offers several other Indigenous-led programs and services that focus specifically on empowering and strengthening urban Indigenous children, youth, and families. For example, the Spirit of the Children's Society (SOTCS) serves First Nations, Inuit, and Métis families in the Burnaby, New Westminster, and Tri-Cities area (Coquitlam, Port Coquitlam, Port Moody) of Vancouver (SOTCS, 2019). With a vision of family health, community well-being, and cultural prosperity, the SOTCS offers culturally safe supports in the areas of

infant and child development, parenting, living with fetal alcohol spectrum disorder (FASD), spiritual and cultural revitalization, and housing.

The Urban Native Youth Association (UNYA) is a centre of Indigenous youth excellence, dedicated to empowering and supporting urban Indigenous youth (12 to 29 years) through programs and services focused on education and training, health and wellness, housing and transitions, and community and connections (UNYA, 2022). Understanding that the challenges facing urban Indigenous youth are wide-ranging and significant, and that a one-size-fits-all approach is not the best approach to effectively support urban Indigenous youth, the UNYA utilizes a philosophy of person-centred care that incorporates culture as therapy, trauma-informed care, and harm reduction supports to ensure urban Indigenous youth are provided meaningful opportunities to realize their full potential.

Also in Vancouver, the Aboriginal Mother Centre Society (AMCS) is a key organization offering connection, culture, and healing to urban Indigenous women and their children who are homeless or at risk of homelessness and have had or are at risk of having their children apprehended (AMCS, 2021). The AMCS helps women achieve self-sufficiency to regain and retain custody of their children by connecting them with culture and building their resiliency, both individually and as a community. The range of services offered by the AMCS include transformational housing, licensed childcare, and family wellness programming such as parenting and life skills workshops, housing resources, and a community kitchen for urban Indigenous community members to gather and develop a sense of belonging within their urban environment.

Winnipeg

Winnipeg is home to the largest Indigenous population of any Canadian city and several reputable organizations whose sole purpose is to serve urban Indigenous people. Many of these organizations are in and around the inner-city where the density of Indigenous people is highest (University of Manitoba, 2019). Most Indigenous organizations in Winnipeg deliver pan-Indigenous programs and services, but there are a couple of Indigenous organizations that offer culture-specific supports. For example, Tunngasugit was created to ensure Inuit residing in Winnipeg have a culturally safe, welcoming, and supportive place to turn for help in overcoming the multiple and unique barriers they face when transitioning to urban living (Tunngasugit, 2021). The Inuit-specific resource centre assists with medical and dental services, education and training, employment and income, CFS involvement, identification cards, laundry facilities, housing, and service referrals. Tunngasugit also offers ample opportunities for Inuit to maintain connections with Elders and other members of the urban Inuit community through cultural activities such as beading, sewing, and soapstone carving workshops; Inuktitut language classes; community feasts and dances; cultural presentations; and opportunities for storytelling.

The Eagle Urban Transition Centre (EUTC) serves as a culturally relevant and non-discriminatory single-window gateway for urban First Nations people to access support, advocacy, and needed programs for economic independence (EUTC, 2022). The EUTC is recognized as a valuable First Nations-led resource to help relocated First Nations people successfully transition to urban life in Winnipeg. Service sectors include employment and income, education and training, housing, mental health and addiction, and counseling. The EUTC employs a team approach and community partnerships to address programming gaps for urban First Nations people, as well as utilizes holistic practices to meet their physical, emotional, mental, and spiritual needs.

Though not specific to urban Indigenous populations, the Red River Métis Community Resource Department (MCRD) of the Manitoba Métis Federation offers Métis-specific services in Winnipeg (Manitoba Métis Federation [MMF], 2022). Much like Tunngasugit and the EUTC, the MCRD offers a wide range of culture-based supports, such as employment and income assistance, outreach services, referrals and advocacy, family reunification, Elder services, bereavement support, and community development. The MCRD also delivers a vision care program for Métis seniors, a prescription drug program, and several early childhood development and parenting education programs that promote Métis culture and history, family literacy, and other essential life skills.

Many Indigenous organizations in Winnipeg focus on helping Indigenous people advance their education and find employment, while also supporting their holistic needs for improved health and well-being. For example, Ka Ni Kanichihk provides meaningful prevention and intervention programs and services aimed at helping Indigenous people heal from trauma, succeed, and become leaders (Ka Ni Kanichihk, 2022). All programs and services are grounded in Indigenous knowledge; build on the strengths and resilience of Indigenous people; focus on wholeness and well-being; and help children, youth, and families develop greater independence. Ka Ni Kanichihk is a recognized leader in culturally authentic programming, particularly for urban Indigenous girls, gender-diverse people, and women who are experiencing or at risk of violence and/or sexual exploitation. Key service areas of Ka Ni Kanichihk include education and job-skills training, support and advocacy for women and families, and mentorship.

The Neeginan Centre serves as a vital service hub for urban Indigenous education, training, economic development, and social services (Neeginan Centre, 2018). Some of the different services offered at the Neeginan Centre

include the Aboriginal Council of Winnipeg (ACW), which serves as a political and advocacy voice for urban Indigenous communities (ACW, 2019); Shinnecock Native Printers; Canadian Plains Gallery; a number of enhanced education and training programs, including the Centre for Aboriginal Human Resource Development, the Aboriginal Community Campus, the Neeginan College of Applied Technology, and the Neeginan Learning & Literacy Centre; and Kookum's Place Daycare and Kookum's Infant Centre, both of which provide childcare services for students enrolled in educational programming at the Neeginan Centre. The Neeginan Centre is also home to the Aboriginal Health & Wellness Centre (AHWC) of Winnipeg, which offers a wide range of Indigenous-based, wrap-around health services for urban Indigenous individuals and families, including programming in the areas of early childhood development, CFS prevention and family reunification, FASD support, men's healing, and housing support for youth and other individuals with multiple barriers (AHWC, 2018).

The Urban Circle Training Centre (UCTC), together with the neighbouring Makoonsag Intergenerational Children's Centre (Makoonsag) and the Merchant's Corner student resource centre and housing complex, serve as another vital resource hub for Indigenous people in Winnipeg (ISC, 2014; UCTC, 2022). The UCTC delivers a range of Indigenous-led certified programs, as well as numerous services to facilitate the academic success of Indigenous students, including Elder's support services; admission to the Merchant's Corner student resource centre and 30-unit family housing complex offering one, two and three-bedroom configurations (University of Winnipeg, 2015); and access to Makoonsag, which offers 52 infant and pre-school spaces for children of UCTC students. Based on a vision for intergenerational learning and bringing urban Indigenous families back together, Makoonsag is grounded in Indigenous cultures and knowledges, and best practices in early childhood development and training for Indigenous childcare workers. In addition to community volunteer and educational internship opportunities, Makoonsag provides a special place for urban Indigenous students to remain close to their children when attending classes and ensures that young children maintain daily connections to Elders, parents and grandparents, and other family members (ISC, 2014).

The Ma Mawi Wi Chi Itata Centre (Ma Mawi) is a well-recognized, respected, and prominent leader in the provision of urban Indigenous-designed and delivered programs and services for Indigenous people residing in Winnipeg (Ma Mawi, 2022). Through partnerships with multiple levels and sectors of government, community-based organizations, corporate donors, and private stakeholders, Ma Mawi serves as a multi-service hub for culturally relevant initiatives aimed at helping urban Indigenous children and families thrive and prosper. Working from the standpoint that the entire community is responsible for the healthy development of future generations, and with guidance from urban Indigenous communities on all aspects of its work, Ma Mawi strives to empower urban Indigenous individuals and families to better care for themselves, their children, and each other. All programs and services offered by Ma Mawi are community driven, culturally safe, relevant, and strengths-based; and most involve wrap-around supports. Some of the more longstanding programs and services include: emergency, short-term, and long-term foster care; CFS prevention and family reunification; family violence prevention and intervention; early childhood development and parent-child programming; adolescent sexuality and reproductive health supports; cultural revitalization initiatives; education, employment, and recreation supports; and independent living and housing programming for youth. Ma Mawi's services are offered at multiple locations throughout the urban centre where Indigenous people reside.

RESEARCH, POLICY DEVELOPMENT AND PROGRAMMING

Identifying gaps and barriers, as well as goals and opportunities for improvement, is important not only for assessing the current structure and capacity of service providers to meet the specific health care needs of urban Indigenous people, but also for ensuring the approach to services and program delivery is effective, culturally appropriate, and culturally responsive to the changing needs, priorities, and demographic characteristics of urban Indigenous populations. This section highlights some of the gaps in research, policy development, and programming pertaining to urban Indigenous people.

Service gaps

Cultural continuity is an essential part of ensuring the holistic health and well-being of Indigenous Peoples and communities (Auger, 2016; ICT, 2018; Landry et al., 2019). As such, this is one area where policy and programming could be developed to better support and build on the Indigenous knowledges and unique strengths of First Nations people, Inuit, and Métis people residing in urban centres.

Another area where further policy development and programming is required centres around cultural safety. Greater efforts are needed to get beyond the thinking that Indigenous people are rural, northern, and reserve-based, and not urban. Work should continue towards building awareness and understanding in health care and related sectors about the long history of European sovereignty and related colonial processes of oppression and dispossession (Nejad et al., 2019; Senese & Wilson, 2013; Snyder & Wilson, 2015), not just on Indigenous Peoples collectively, but also on First Nations people, Inuit, and Métis people, uniquely. There is strong evidence that racially-based stereotypes, stigmatization, and discrimination have led to urban Indigenous people's delayed health care treatment or lack of treatment altogether (Allan & Smylie, 2015; Turpel-Lafond, 2020; Varcoe et al., 2022a; Wylie & McConkey, 2019). Education and awareness efforts should include cultural safety training for health care providers to understand not only the social, political, and historical influences on urban Indigenous people's access to health care services and the ways in which they endure a disproportionate burden of ill-health, but also the role and impact of provider-patient power dynamics in influencing inequities in health outcomes (Allan & Smylie, 2015; Beckett et al., 2018). This would include enhanced understanding of Aboriginal rights and benefits and their unique influences on health care coverage and service provision, and on health outcomes for urban Indigenous people.

The changing dynamics of urban Indigenous populations call for more targeted programs and resources to support the unique health and socioeconomic needs of increasing segments of urban Indigenous populations, such as Indigenous seniors and Inuit. Similarly, increased programs and services are needed to address specific health and safety concerns facing urban Indigenous populations, such as homelessness, food insecurity, lack of affordable and accessible rental housing, and addictions.

Finally, greater investment in public health surveillance and related policies and practices around collecting and disseminating more accurate,

complete, and culturally appropriate demographic data is needed to ensure equitable funding and resource allocation for vital urban Indigenous-targeted programs and services, and to identify existing needs, service gaps, and priorities for specific segments of urban Indigenous populations such as Inuit and Métis people residing in urban centres, who may require a more targeted (vs. pan-Indigenous) approach to programs and services, in order to address their unique and specific needs.

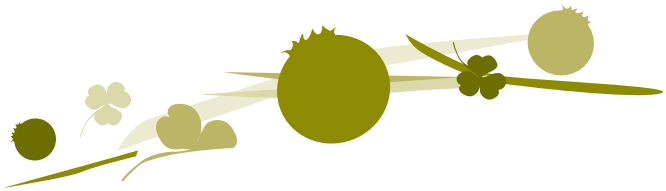
Recommendations for future research

More research is needed to deepen understanding of the changing patterns of self-reported Indigenous identification. This is particularly important for identifying and addressing existing and emergent health needs and priorities of urban Indigenous populations, especially regarding non-status First Nations and Métis peoples whose needs may be missed in policy development and program planning due to the growing phenomenon of self-Indigenization. Understanding the reality of Indigenous self-identification could also help to inform knowledge of urban Indigenous people's mobility patterns, both between rural/northern communities and urban centres, and within urban neighbourhoods. Specific data on urban Indigenous people's mobility patterns are generally lacking and based on census data (Trovato & Price, 2015). More community-targeted research on the movement of recognized First Nations people, Inuit, and Métis people residing in urban centres, particularly on a national scale which would allow for cross comparison, could create understanding of what these mobility patterns mean for the provision of useful and effective health care services for urban Indigenous people.

While there has been much focus on the socioeconomic conditions of Indigenous people residing off reserve, there should be more culturally appropriate and timely research directed to the social determinants of health for First Nations people, Inuit, and Métis people residing in urban centres, especially in the areas of housing insecurity and homelessness, food insecurity and Indigenous food sovereignty, and the socioeconomic factors that influence poor nutrition and physical inactivity. Further, more research is needed to better understand the prevalence and factors associated with smoking, vaping, and cannabis use, particularly in relation to the mental health of urban Indigenous people.

Other gaps in research that were identified through the writing of this report include urban-specific data on infant mortality and adverse birth outcomes for Indigenous populations; national cancer patterns of urban Indigenous people and related disparities between Indigenous and non-Indigenous populations; data and literature on heart disease and stroke among urban Indigenous populations; STBBI testing, transmission, and treatment, particularly among young urban Indigenous women and young urban Indigenous people who inject drugs; and mental health stressors and protective factors, especially as they relate to gender-diverse urban Indigenous people and urban Indigenous seniors. Also missing from current data and literature are urban-based studies focusing on urban Indigenous people's oral and vision, health, respiratory illnesses (tuberculosis, asthma, bronchitis), and disabilities.

CONCLUSION



This report was intended to serve a threefold purpose:

1. to describe current patterns of Indigenous urbanization and mobility;
2. to summarize current health trends among urban Indigenous populations, based on available data and literature; and
3. to provide an overview of available programs and services to support the health of Indigenous people residing in urban centres.

Gathering data and literature to fulfill the intent of this report was not an effortless task. Although there has been an increase in research and reporting pertaining to urban Indigenous people over the past decade, the quantity and quality of information remains limited. The bulk of available literature is based on outdated evidence collection, and available data remains largely focused on off-reserve First Nations populations rather than First Nations people, Inuit, and Métis people residing in urban centres. In fact, there is little information specific to Inuit and Métis people residing in urban centres. What's more, national-scale data is nearly non-existent, and few studies have included cultural and gender-based differences within marginalized urban Indigenous groups. Still, there are localized data and literature sources that provide a general understanding of current trends in the health of Indigenous people residing in urban centres.

From the evidence presented, current trends indicate that the presence of First Nations people, Inuit, and Métis people in urban centres is steadily increasing. Urban Indigenous populations remain vastly diverse and highly mobile, not only in terms of migration between rural/northern communities and urban centres, but also within urban neighbourhoods. Women and youth are over-represented in urban Indigenous populations, but there also is a growing population of urban Indigenous seniors. As a whole, urban Indigenous people experience significant health and socioeconomic disparities, often characterized by high rates of poverty and related factors like food and housing insecurity, high risk behaviours, and access barriers to health care services. The legacy of colonization and adverse effects of residential schools and other colonial structures are key underlying factors influencing the health status and health outcomes of urban Indigenous people. At the same time, urban Indigenous people demonstrate significant resiliency, characterized by strong connections to the land, to their languages and cultural practices, and to their communities and each other.

Overall, urban Indigenous people have seen improvement in their health status, but significant disparities in health outcomes remain. As such, there is a critical need for timely and effective, culturally appropriate health care services. Careful consideration to the demographic characteristics of urban Indigenous populations and the

factors driving their existing and emergent needs and priorities is warranted. Service providers play a critical role in supporting urban Indigenous people's health, particularly at organizational or systems levels. There are increased numbers of Indigenous-based organizations that provide health services to urban Indigenous people, but federal and provincial/territorial health care supports are minimal, as is urban Indigenous health policy. Urban Indigenous people have become greatly proactive in working to improve their quality of life and health outcomes. Indigenous cultures, knowledges, languages, identities, and spirituality underlie much of this work, but more is needed, particularly with respect to incorporating Indigeneity into health research, policy development, and programming for urban Indigenous people.

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Centre de collaboration nationale de la santé autochtone

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