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## **The Social Determinants of Health: Defining a Research Agenda for Canada's Urban Aboriginal Population**

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### **Introduction**

In the past few decades, the health of Aboriginal peoples has become a priority among Canadian health researchers (Adelson 2005; Reading and Nowgesic 2002). To date, however, the bulk of this literature has been overrepresented by research seeking to establish rates of disease and mortality, with considerably less attention paid to the social and economic processes underlying them. Indeed, while it is vital to characterize the health inequalities borne by Aboriginal Canadians—as they are vast, and, in some cases, growing—the fact remains that these observations have not transformed into a common understanding of the underlying causes of inequality, such as the important role played by the social determinants of health (SDOH) (Loppie and Wien 2009; Richmond and Ross 2009). What's more, this body of research has tended to concentrate its efforts on segments of the Aboriginal population living on-reserve and in rural and remote areas, with appreciably less regard for patterns of urbanization that now characterize vast segments of the Aboriginal population. As of the last census count, 54% of the Aboriginal population lived in an urban centre, which includes large cities, or Census Metropolitan Areas (CMAs), and smaller urban centres. This was an increase from 50% in 1996 (Statistics Canada 2006). In spite of the recognition that increasing numbers of Aboriginal people now live in urban centres, and the challenges that this pattern of urbanization poses for Aboriginal health policy and program development, little substantive research has explored SDOH within the urban Aboriginal context.

In this chapter, we examine if the current base of research on the social determinants of Aboriginal health reflects the population and geographic diversity of Canada's increasingly urbanized population. We also describe what this base of literature looks like; specifically, we illustrate which SDOH have been examined, and through which methods this research is occurring. As an introduction, we begin with a discussion of the SDOH, and we demonstrate why the urban Aboriginal context is deserving of such research. We then describe the methodology we undertook in this review, followed by a discussion of our results. We conclude with a description of areas in which research is most urgently needed.

## The Social Environment and the Social Determinants of Health

The World Health Organization (WHO) defines health as “a complete state of physical, mental, social, and emotional well-being . . . it is a resource for living that enables people of all ages to realize their hopes and needs, and to change or cope with the environments around them” (WHO 1946). The evolution of conceptualizations of health—from more than simply the absence of disease—set the stage for a critical reflection of the biomedical paradigm and the emerging interest in non-medical determinants of health (Rootman and Raeburn 1994), such as those that may be found within the social environment. The social environment refers to the places and spaces wherein we live, work, and play. Within this environment, various social, economic, and cultural conditions work to affect the daily lives of individuals and communities. These conditions are known as the SDOH (Marmot and Wilkinson 1998). Over the past three decades, research on the SDOH has revealed that people’s health is strongly influenced by their lifestyles and the social and economic conditions in which they work and live.

Along these same lines, a wide body of research illustrates that those of increased socio-economic position will have greater access to social determinants (e.g., better child programming, improved transportation networks, higher quality social supports) and the resulting health benefit, which those in lower socio-economic positions do not receive. Perhaps the best empirical evidence linking mortality with SDOH comes from the *Whitehall Study of British Civil Servants* (Marmot et al. 1984). In the study, 17,530 civil servants were classified according to their social position (i.e., grade) within the United Kingdom’s government hierarchy (from lowest grade to highest grade) and their mortality was recorded over ten years. Marmot et al. (1984) found a steep inverse relationship between social position and mortality. Compared with those in the highest grade, men in low-grade positions had three times the mortality rate from coronary heart disease, from a range of other causes, and from all causes combined. Between 1985 and 1988, Marmot et al. (1991) repeated these methods in the *Whitehall II Study*, to examine the degree and causes of the social gradient in morbidity in a new cohort of 10,314 civil servants (6,900 men, 3,414 women) aged thirty-five to fifty-five. Despite the twenty years separating the two studies, Marmot et al. (1991) found no decrease in social class difference in morbidity. Results indicated an inverse association between employment grade and prevalence of a number of diseases, including angina, electrocardiogram evidence of ischemia, and symptoms of chronic bronchitis.

Since the Whitehall studies, literally hundreds of studies have identified the association between one’s health and their social position. Poverty, social exclusion, poor housing, and poor health systems are among the main social causes of ill health, those which Rose (1992) refers to as the “cause of the causes.” These refer to the social conditions that give rise to high risk of non-commu-

nicable disease, whether acting through unhealthy behaviours (e.g., smoking, drinking) or through the effects of very stressful lives (Marmot 2004). Increase in social position means increased access to resources, such as money, power, and prestige, and it also means increased access to the kinds of interpersonal resources embodied in the concepts of social support and social networks. Link and Phelan (1995) point to these resources as the “fundamental” cause of health and disease. Increased access to these resources means that those in higher levels of social standing are better able to avoid health risks or to minimize the consequences of disease once it occurs (Link and Phelan 1995).

In 1998, WHO commissioned a report called “The Solid Facts.” Written by Sir Michael Marmot and Richard Wilkinson, two pre-eminent scholars in the field of social epidemiology, this report reviewed the global base of research on the SDOH. Based on evidence from this vast literature, Marmot and Wilkinson identified and developed a framework for conceptualizing the key SDOH. These include: addiction, social support, social exclusion, food, social gradient, transport, stress, early life, unemployment, and work. Since the release of “The Solid Facts,” scholars and policy writers from around the globe have recognized its utility as a framing guide for policy and research on the SDOH.

## **The Urban Aboriginal Context**

As mentioned, upon the last census count, 54% of the Aboriginal population lived in an urban centre, an increase from 50% in 1996 (Statistics Canada 2006). In spite of the increasing numbers of Aboriginal people who now live in urban areas of Canada, little substantive research has explored health determinants within the urban Aboriginal context. The omission of urban Aboriginal peoples from this research area stems in large part from a lack of awareness of this rapidly growing pattern of urbanization, though it also reflects public policy discussions centred on the reserve-based population. As Hanselmann (2001) points out, this oversight is problematic as it ignores the urban realities of Canada’s Aboriginal population. He further explains that an acute public policy need exists for a broadening of perspectives to include not just on-reserve Aboriginal communities but also urban Aboriginal communities (Hanselmann 2001).

The SDOH are an important focus for health and social scientists interested in the health of urban Aboriginal peoples. Evidence overwhelmingly suggests that these determinants operate along a social gradient. Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, they tend to get sicker, and they die earlier than people in more privileged social positions (Evans et al. 2001). That is, even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than those in the highest earning brackets (Marmot and Wilkinson 2003).

The effect of the social gradient is all too evident in the current health and social realities of Canada's urban Aboriginal population. As Adelson (2005) notes, health disparities are directly and indirectly associated with social, economic, cultural, and political inequities, the end result of which is a disproportionate burden of ill health and social suffering upon Aboriginal populations of Canada. Compared with the general population of Canada, Aboriginal people experience a significantly higher burden of morbidity and mortality (Frohlich et al. 2006; Codon 2005; Adelson 2005; MacMillan et al. 1996), and like other vulnerable populations (Krieger 2001; Navarro 1990), factors such as poverty, poor education systems, inadequate access to health services, and lacking infrastructure strongly influence patterns of Aboriginal health and well-being.

The pattern of urbanization that we now witness among Canada's Aboriginal peoples is a result of various political, social, and economic processes, the roots of which lay in a legacy of colonial relations, dispossession from traditional lands and territories, and rapid cultural change (Waldram et al. 2006; Bartlett 2003). The consequences of Canada's assimilationist policy mean that many of our rural and remotely located Aboriginal communities tend to experience living conditions that are significantly poorer than those experienced by non-Indigenous peoples living in similarly remote or rural communities. Hence, the shift to urban areas by Aboriginal peoples is often reflective of health-care needs, or to seek employment and educational opportunities that may not be available on-reserve. However, once in cities, the Aboriginal population experiences marginalization along various political, social, and economic lines, and quite often, does not benefit from the health-care, employment and/or educational resources that originally lured them to the city (Peters 2001; 2000a; 1996a; 1996b). Indeed, while there is a plethora of evidence detailing the poor socio-economic conditions of urban Aboriginal peoples, what is less understood are the ways that these socio-economic patterns link to health and well-being in the urban context. In this paper, we draw from Marmot and Wilkinson's (2003) framing of the SDOH to examine if the current base of urban SDOH research is keeping pace with the geographic and demographic trends of Aboriginal Canadians. Given the unprecedented move of Aboriginal Canadians into urban places, and the health inequalities endured by Aboriginal peoples in these contexts, we see this analysis as useful for setting research and policy agendas on the social determinants of Aboriginal health.

## Methods

Since we were interested in exploring the base of published Canadian research on the social determinants of Aboriginal people's health in urban places, we searched for articles on this topic in two key databases relevant to Aboriginal health and social sciences: PubMed and Scholars Portal. We searched these two databases for articles published for the time period from 1970 to January 2009. As a strategy for searching articles, our three thematic search areas related to Aboriginal peoples, SDOH, and urban location. We drew from a broad range of search

terms to reflect Canada's Aboriginal peoples, including "Indigenous," "Native," "North American Indian," "First Nation(s)," "Inuit," and "Métis." The search terms we used to locate articles on the SDOH were defined by Wilkinson and Marmot's (2003) "The Solid Facts," and included "addiction," "social support," "social exclusion," "food," "social gradient," "transport," "stress," "early life," "unemployment," and "work." The final search terms used relate to our focus on urban research. In meeting this requirement, our search terms included "urban" and "city."

When selecting papers for inclusion in our analysis, we chose only papers that focused on Canada's Aboriginal population, and specifically those focused on Aboriginal peoples living in urban areas. Papers that were not relevant were eliminated from the search. We quickly realized that at least half of the resulting papers were not based on analyses of data or review of literature relating specifically to the SDOH<sup>1</sup>, but that these papers tended to draw from various SDOH as a means of contextualizing their research findings. Because of the relative dearth of research on social determinants of Aboriginal health in the urban context, we made the decision to retain these review papers as part of our analyses.

Papers selected for inclusion were coded according to four main categories: Aboriginal identity; geographical region; topic (e.g., SDOH); and methodological design. See **Table 15.1** (page 232) for the coding system used in this analysis. The Aboriginal identity group was coded to determine if it focused on one or more of Canada's Aboriginal identity groups (First Nation, Inuit, Métis), as in Wilson and Young (2008). In the case that the authors examined all three groups, or failed to specify which identity group they were referring to, we coded them as "All Aboriginal." Geography was coded by the province or territory within which the research occurred. Some of these papers were focused at the national level; in these cases, the geographical code we used was "CAN" to indicate that the study was of a national scope. As we were interested in understanding which SDOH were actually being measured in this base of literature, papers were coded by the topic area(s) they covered. These topic areas were based on the SDOH as identified in Marmot and Wilkinson's (1998) framework. In some cases, papers focused on one or more SDOH. Our final method of coding related to the methodological approach utilized in this base of literature. Articles were placed into qualitative, quantitative, mixed methods, or review/article categories.

### ***Analysis***

After eliminating irrelevant articles, our database search of PubMed and Scholars Portal resulted in a total of twenty-eight published manuscripts that explored the SDOH among Aboriginal peoples in urban areas of Canada. Of the twenty-eight published manuscripts that matched our search criteria, we found that only half of these papers directly incorporated SDOH in their data analyses, while the other fourteen papers drew from various determinants as a means of contextualizing their research findings. In the following paragraphs, we describe how the current

**Table 15.1: Coding System Used in Analyses**

Aboriginal identity	First Nations (status, non-status), Métis, Inuit, All Aboriginal (all three groups included)
Geography	Manitoba (MN), Ontario (ON), National study (CAN), Saskatchewan (SK), British Columbia (BC), Quebec (QC), Nunavut (NU), and Alberta (AB)
Social determinants of health	addiction, social support, social exclusion, food, social gradient, transport, stress, early life, unemployment, work.
Methodological design	qualitative, quantitative, mixed methods, review/article

base of published literature on the social determinants of Aboriginal health reflects the population and geographic diversity of Canada's increasingly urbanized population. We also describe which SDOH have been examined in this small base of literature, and through which methodological approach this research has occurred.

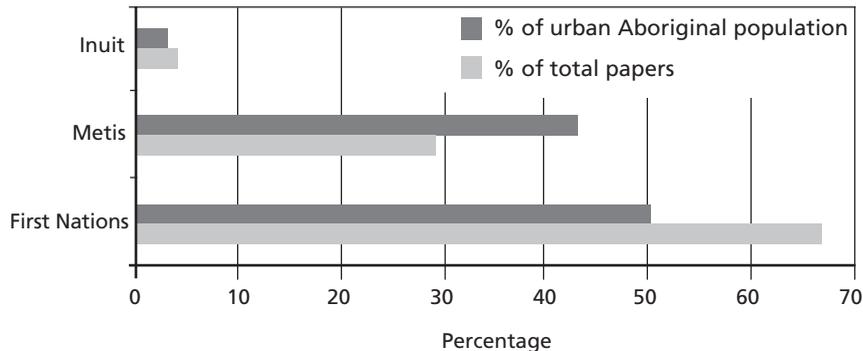
### ***Population Diversity: Aboriginal Identity***

In the 2006 census, 1,172,790 Canadians self-identified as Aboriginal. Of this number, 54% lived in an urban centre. Urban areas include large cities, or CMAs, and smaller urban centres. The Métis population boasted the highest proportion of its population residing in urban areas (69%), followed by First Nations (45%), and Inuit (17%).

Based on the twenty-eight published papers, we saw that the current base of SDOH research is not adequately reflecting current population demographics. When we look at the overall population distribution of Aboriginal people who live in cities, we see that First Nations account for half (50%) of the urban Aboriginal population, the Métis population accounts for 43% of this population, and Inuit peoples make up just over 3% of the urban Aboriginal population. As illustrated in **Figure 15.1**, however, we see that First Nations are over-targeted in 67% of the published papers, while Métis are significantly under-represented in only 29% of published papers. For Inuit, there is nearly a balance between their proportion of the urban Aboriginal population distribution (3%) and the percentage of papers (4%) dedicated to the social determinants of urban Inuit health.

### ***Geographic Diversity***

In 2006, just less than half (46%) of Canada's urban Aboriginal population lived in one of nine CMAs (**Table 15.2** – page 234). These include Canada's three largest cities (Toronto, Montreal, and Vancouver). Interestingly, the geographic distribution of the urban Aboriginal population reflects a concentration in the western provinces. As demonstrated in **Table 15.2**, for example, the CMAs with the highest proportions of Aboriginal people include Prince Albert (34%), Winnipeg (10%), Saskatoon (9%), Regina (9%), and Edmonton (5%). Aboriginal people accounted for less than 5% in the remaining CMAs.

**Figure 15.1: Urban SDOH Research by Aboriginal Identity**

When examining how the current base of SDOH research reflects the geographic distribution of Canada's urban Aboriginal population at the provincial level, we compared the proportion of the Aboriginal population who lived in urban areas by province/territory with the proportion of SDOH publications by province/territory (**Figure 15.2** – page 234). The provinces with the highest proportions of urban Aboriginal people were Manitoba (10%), Saskatchewan (9.3%), Alberta (3.6%), and British Columbia (2.6%). In the remaining provinces and territories, the proportion of the Aboriginal population residing in urban areas was less than 2%. Comparatively, we saw that the literature on the social determinants of urban Aboriginal health was focused quite heavily on Manitoba (29%), Ontario (18%), Saskatchewan (11%), British Columbia (11%), and Quebec (7%). For Saskatchewan and Alberta there was a close alignment between research focused on these two provinces and the geographic distribution of urban populations in these provinces. However, for all other provinces, there was either a significant underrepresentation or overrepresentation of SDOH research relative to the proportion of urban Aboriginal people in those provinces. For example, the SDOH literature overrepresents the population base in Manitoba, British Columbia, Ontario, and Quebec. At the same time, there were no SDOH publications focused on the Atlantic provinces, nor were any publications focused on Canada's Northern CMAAs in the Yukon or the Northwest Territories.

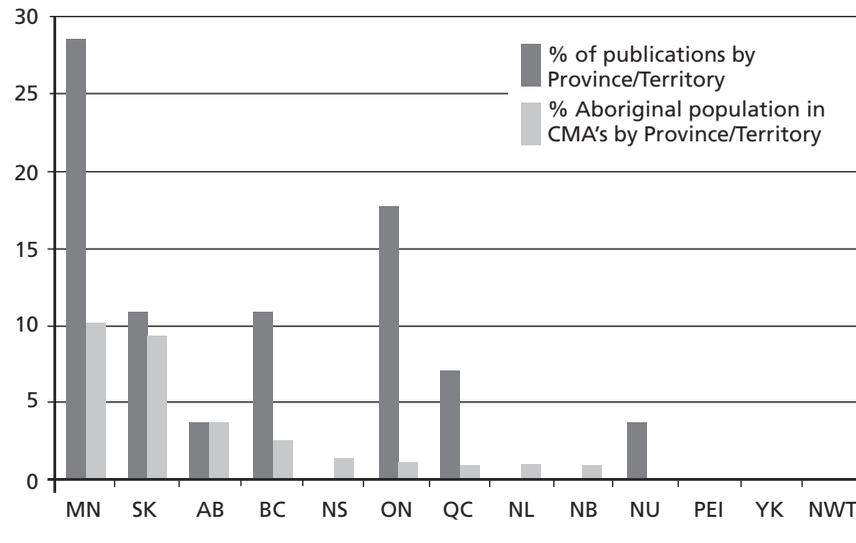
## Social Determinants of Health

As noted in the methods section, in our search for published papers on the social determinants of urban Aboriginal health, we came across two distinct types of published papers. Half of the published papers fit into Category A. This type of publication was focused specifically on measuring, exploring, or describing a particular SDOH, for example substance abuse (Jacobs and Gill 2002), or social support (Goudreau et al. 2008). The other half of the papers fit into Category B. This type of publication did not directly measure, explore, or describe a particular

**Table 15.2: Number and Percentage of Population who Identified as Aboriginal, 2006**

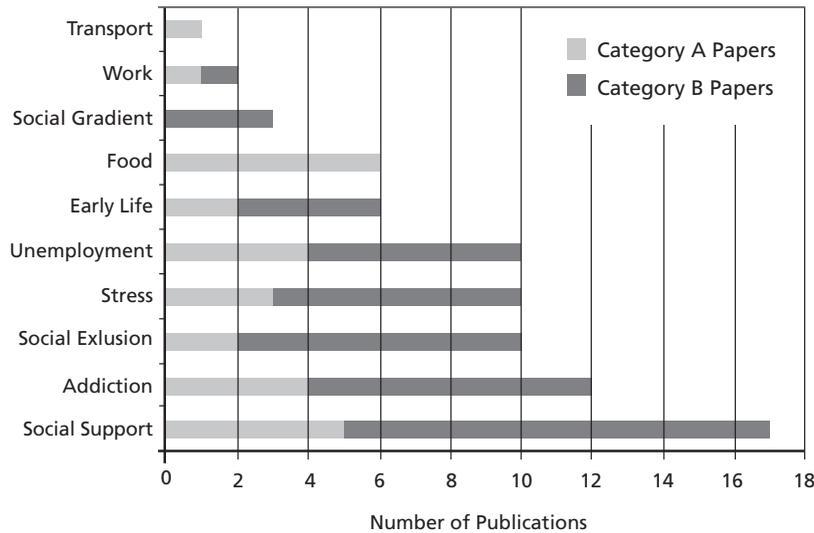
Selected cities	Aboriginal population	Percentage of Aboriginal people in the city's population
Winnipeg (MN)	68,380	10
Edmonton (AB)	52,100	5
Vancouver (BC)	40,310	2
Toronto (ON)	26,575	0.5
Calgary (AB)	26,575	2
Saskatoon (SK)	21,535	9
Ottawa–Gatineau (ON)	20,590	2
Montreal (QC)	17,865	0.5
Regina (SK)	17,105	9
Prince Albert (SK)	13,565	34

Source: Statistics Canada, Census of Population, 2006.

**Figure 15.2: Urban SDOH research by Province**

SDOH; rather, these publications drew on the SDOH as a means of discussing their research findings on various other health topics, for example the stress experienced by Aboriginal people who live in neighbourhoods with high rates of crime (Fitzgerald and Carrington 2008). In the following, we first describe the thematic focus of the total number of publications included in this analysis, and we then distinguish between Category A and Category B papers.

Social support was the social determinant most examined in this base of literature, discussed in 61% of the twenty-eight papers. As illustrated in **Figure 15.3**,

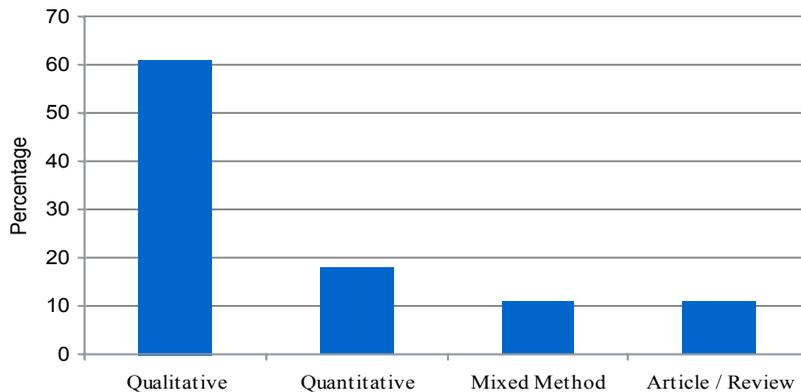
**Figure 15.3: Urban SDOH research by Theme**

other social determinants that featured prominently in the twenty-eight papers were addiction (43%), social exclusion (36%), stress (36%), and unemployment (36%). Early life was examined in 21% of the total papers, as was food. The social gradient was discussed in 11% of the papers, followed by work (7%), and transport (4%).

Interestingly, when we look more closely at how these proportions are composed of Category A and Category B papers, we see a significant overrepresentation of the latter. Within this small body of literature, very few of these social determinants were actually measured or explored as the direct thematic focus in these publications. Rather, there was a propensity by authors to draw on various SDOH as a means of contextualizing research findings that were not directly related to the SDOH. For example, while social support was mentioned in 61% of the papers included in this analysis, only five of the publications directly examined social support, and social support was used to contextualize discussion in twelve Category B papers. This pattern also holds true for publications on addiction, social exclusion, stress, and unemployment. On the flip side however, while food was mentioned in only five of the twenty-eight papers (18%), it was the most directly explored social determinant in this analysis. Also important to note, the social gradient was not directly measured in any Category A papers, but was used in three Category B papers to discuss a particular health outcome.

### **Methodology**

The literature review showed an abundance of research focusing on qualitative methods. This pattern is true for both Category A and Category B papers. In total, seventeen publications (61%) drew from qualitative methods, five publications

**Figure 15.4: Urban SDOH research by Method**

drew from quantitative methods (18%), three publications drew from mixed methods (11%), and three were based on literature review (11%). In the publications that drew from qualitative methods, researchers primarily used interviews and focus-group discussions.

## Discussion and Conclusion

In this paper, we drew from Marmot and Wilkinson's (2003) framing of the SDOH to examine if the current base of urban SDOH research is keeping pace with the demographic and geographic trends of Aboriginal Canadians. We also described the thematic foci of this small literature, including the methodological approaches taken. Given the unprecedented move of Aboriginal Canadians into urban places, and the health inequalities endured by Aboriginal peoples in these contexts, we see this analysis as useful for setting research and policy agendas on the social determinants of urban Aboriginal health. As was demonstrated in the analysis undertaken in this chapter, there is a demonstrable need for health researchers to give greater consideration—and explanatory power—to the forces of the social environment on urban Aboriginal people's health and wellness.

With regard to the demographic representation of the urban Aboriginal population in the base of SDOH literature, we saw a significant overrepresentation of the First Nations population and a severe under-representation of research focused on the Métis and Inuit populations. The overrepresentation of the First Nations population in health and social science research is not a new trend (Young 2003; Wilson and Young 2008). As discussed in an earlier section of this chapter, because the First Nation population is the largest, most accessible, and most politically visible of Canada's three Aboriginal groups, there has been a strong tendency for researchers to centre their research questions on topics related to this demographic. However, current trends of urbanization reveal that the Métis

population, with nearly seven out of ten Métis people living in urban centres, are highly deserving of Métis-specific urban SDOH research. This is a sentiment echoed by others concerned with Métis health (Dyck no date). And while Young (2003) has indicated that Inuit may be overrepresented in Aboriginal health literature, he acknowledges that this focus has taken place only in Northern, Arctic areas, and seldom in urban areas.

In terms of geographic representation of the urban Aboriginal population, our analyses indicate a significant focus on cities in Ontario, British Columbia, and Manitoba, with much less emphasis on the Prairie and Atlantic regions. In our analysis, we compared proportions of Aboriginal peoples living in certain geographic regions with the proportion of SDOH research undertaken in these regions. Specifically, we examined the difference between the two proportions, thereby making the argument that the proportions should be relatively similar. However, the case may also be true that SDOH research is warranted in cities with very small numbers of Aboriginal people; that is, in cities with small proportions of Aboriginal people (e.g., in the Maritimes), it is more likely that Aboriginal people will experience various forms of social and economic marginalization as a result of their under-representation in the greater population (Peters 1996a), which may have serious consequences for the delivery of programs and policies intended to improve health and well-being. At the same time, it may also be true that SDOH research should be a priority in cities with very high numbers of Aboriginal people. For example, we know that Aboriginal people made up a considerable share of the population in several smaller urban centres in Western Canada (see **Table 15.3** – page 238). In 2006, Aboriginal people accounted for 36% of the population in Thompson, Manitoba, 35% in Prince Rupert, British Columbia, and 34% in Prince Albert, Saskatchewan. While much of the urban SDOH literature has focused on large cities (e.g., Toronto, Vancouver), there may be a difference in the way the SDOH work in smaller cities with high proportions of Aboriginal people, and, as such, these considerations must be taken into account by those considering such research in these geographic areas.

Perhaps some of the most interesting results of this analysis relate to the way the SDOH have been explored and discussed in this base of literature. Notably, of the total number of papers that fell within the scope of our search terms, only half of these papers explicitly drew from SDOH theory to examine the health and well-being of target urban Aboriginal populations, while the other half drew from a variety of SDOH as an explanatory framing for their research findings. One key example is that of social support. While social support often appears in the discussions throughout the papers, it is not as often directly measured, nor is the social theory surrounding this determinant used to guide the analyses undertaken in these papers.

Given the growing body of evidence that illustrates the strength of association between one's social environment and their health, greater theoretical consideration must be given to Aboriginal health research, both in urban and non-urban

**Table 15.3: Population Distribution of Ten Canadian Cities wherein the First Nation Population Contributes Significantly to the Overall City Population, 2006**

Urban centres	Number of First Nations people	Percentage of First Nations people in the city's population
Prince Rupert, British Columbia	4,195	32
Thompson, Manitoba	3,300	24
La Tuque, Quebec	3,200	21
Prince Albert, Saskatchewan	6,715	17
Terrace, British Columbia	2,900	16
Whitehorse, Yukon Territory	3,085	14
North Battleford, Saskatchewan	2,250	13
Portage la Prairie, Manitoba	2,375	12
Williams Lake, British Columbia	2,155	12
Yellowknife, Northwest Territories	1,990	11
Sept-Îles, Quebec	2,905	11

Source: Statistics Canada, Census of Population, 2006.

places. This is a particularly pressing concern among the urban Aboriginal population, who experience vast social and economic inequalities, yet whom are often overlooked by federal policy and programming efforts. As stated by Krieger, “to conceptualize and elucidate the myriad social and biological processes resulting in embodiment and its manifestations in populations’ epidemiological profiles, we need theory” (2001, 668). As we aim to construct policy-relevant information that will work towards reducing the health and social inequalities endured by Canada’s Aboriginal peoples, researchers must take into consideration the strength of social and economic forces on health, and build these components into the theoretical frameworks that guide our research. Further, this research must consider the interdependence of various social and economic processes and their impact on health (Richmond and Ross 2009), and, as noted by Loppie and Wien (2009), the ways these processes occur over the course of life.

Finally, in terms of the methodological approach taken in this base of literature, our results pointed to an unprecedented representation by qualitative methods. For decades, Canadian health research (in particular Aboriginal health research) has been overrepresented by positivist methods (Wilson and Young 2008), including large-scale survey analysis and categorical approaches that tend to frame health determinants as discrete influences, thereby discounting their interactional nature (Labonte and Robertson 1996). The shift towards qualitative approaches is therefore a promising shift in the Aboriginal health discourse, as these methods enable and encourage a more interpretive lens through which to understand how

social circumstances become manifested in the health and wellness of Aboriginal peoples. By drawing from qualitative methods and narrative data, health researchers and policy-makers can begin to understand the ways that SDOH operate in the daily lives of people to influence their health and health behaviours. Indeed, while it is necessary to quantitatively measure various health and social phenomena as they relate to health status (e.g., income inequality), it has become evident that such an approach tends to discount the social-structural influences (e.g., “upstream influences”) that initially produced those particular determinants (Coburn et al. 2003; Hayes 1999). As such, in our efforts to improve Aboriginal health, we need to continue to methodologically frame our research in ways that best position us to study the “cause of the causes,” as Rose (1992) refers to SDOH.

The analysis of publications described in this chapter was undertaken via two major databases: PubMed and Scholars Portal. As a result of the nature of our search, various public policy documents not published in academic journals were not included in our analysis. We recognize this as a limitation to our study. Even still, we are confident that the findings of this analysis reflect a greater tendency within the Aboriginal health literature, and we urge Canadian Aboriginal health researchers to consider some of the research directions we point to in this paper as areas of future health research with urban Aboriginal populations. As we strive to build health and social policy that meets the needs of all Canadians, we must continue to focus on describing patterns of health and social well-being, and to what extent contemporary health and social needs of the urban population are being met. Given the context of unprecedented rates of urbanization among the Aboriginal population, it becomes increasingly important that we understand how the health of Aboriginal peoples is shaped by social and economic processes related to their urban environments.

## Endnotes

- 1 Often these papers were focused on biomedical conditions, such as rise in diabetes, or spread of tuberculosis. The authors of these papers often drew from the SDOH as a means of explaining or contextualizing disease patterns.

## References

- Adelson, N. 2005. "The embodiment of inequality: Health disparities in Aboriginal Canada." In *Canadian Journal of Public Health*, 96:S45–S61.
- Bartley, M., and I. Plewis. 2002. "Accumulated labour market disadvantage and limiting long-term illness: Data from the 1971–1991 Office for National Statistics Longitudinal Study." In *International Journal of Epidemiology*, 31(2): 336–341.
- Statistics Canada. 2006 Census. Ottawa.
- Coburn, D., K. Denny, E. Mykhalovskiy, P. McDonough, A. Robertson, and R. Love. 2003. "Population health in Canada: A brief critique." In *American Journal of Public Health* 93 (3): 392–396.
- Dyck, M. No date. "Social determinants of Métis health." Métis Centre at National Aboriginal Health Organization. <[www.naho.ca/metiscentre/english/documents/Research\\_SocialDeterminantsofHealth.pdf](http://www.naho.ca/metiscentre/english/documents/Research_SocialDeterminantsofHealth.pdf)>. Retrieved January 20, 2010.
- Fitzgerald, R.T., and P.J. Carrington. 2008. "The neighbourhood context of urban Aboriginal crime." In *Canadian Journal of Criminology and Criminal Justice*, October 2008, 523–557.
- Goudreau, G., C. Weber-Pillwax, S. Cote-Meek, H. Madill, and S. Wilson. 2008. "Hand drumming: Health-promoting experiences of Aboriginal women from a northern Ontario urban community." In *Journal of Aboriginal Health*, January: 72–83.
- Hanselmann, C. 2001. "Urban Aboriginal people in Western Canada: Realities and policies." Prepared for the Canada West Foundation. <[www.aboriginal-edmonton.com/internet\\_resources/can\\_west\\_urban\\_rpt.pdf](http://www.aboriginal-edmonton.com/internet_resources/can_west_urban_rpt.pdf)>. Retrieved January 21, 2010.
- Hayes, M.V. 1999. "Population health promotion: Responsible sharing of future directions." In *Canadian Journal of Public Health*, 90 (1): S15–S17.
- Jacobs, K., and K. Gill. 2002. "Substance abuse in an urban Aboriginal population: Social, legal and psychological consequences." In *Journal of Ethnicity in Substance Abuse*, 1(1), 7–25.
- Krieger, N. 2001. "Theories for social epidemiology in the twenty-first century: An ecosocial perspective." In *International Journal of Epidemiology*, 30(4): 668–677.
- Labonte, R., and A. Robertson. 1996. "Delivering the goods, showing our stuff: The case for a constructivist paradigm for health promotion research." In *Health Education Quarterly* 23: 431–447.
- Link, B.G., and J. Phelan. 1995. "Social conditions and fundamental causes of disease." In *Journal of Health and Social Behavior*, 35: 80–94.
- Loppie-Reading, C., and F. Wien. 2009. "Health inequalities and social determinants of Aboriginal people's health." A report prepared for the National Collaborating Centre for Aboriginal Health. <[www.nccah-censa.ca/myfiles/NCCAH-Loppie-Wien\\_Report.pdf](http://www.nccah-censa.ca/myfiles/NCCAH-Loppie-Wien_Report.pdf)>. Retrieved January 24, 2010.
- Marmot, M. 2004. *Status Syndrome*. London: Bloomsbury.
- Marmot, M., M.J. Shipley, and G. Rose. 1984. "Inequalities in death—specific explanations of a general pattern?" In *Lancet*, 1 (8384): 1003–6.
- Marmot, M., G. Davey Smith, S.A. Stansfeld, et al. 1991. "Health inequalities among British civil servants: The *Whitehall II Study*." In *Lancet*, 337: 1387–93.
- Marmot, M., and R. Wilkinson. *Social Determinants of Health: The Solid Facts* [Second Edition]. Geneva: World Health Organization, 1998.
- Marmot, M., and R. Wilkinson. 1999 *Social Determinants of Health*. New York: Oxford University Press.
- Peters, E. 1996a. "Aboriginal people in urban areas." In D. Long and O.P. Dickason (eds.). *Visions of the Heart: Canadian Aboriginal Issues*. Toronto: Harcourt Brace & Company. 305–334.
- Peters, E. 1996b. "'Urban' and 'Aboriginal': An impossible contradiction?" In J. Caulfield and L. Peake (eds.). *City Lives and City Forms: Critical Research and Canadian Urbanism*. Toronto: University of Toronto Press. 47–62.

- Peters, E. 1992. "Self-government for Aboriginal people in urban areas." In *The Canadian Journal of Native Studies*, 10 (1): 51–74.
- Reading, J., and E. Nowgesic. 2002. "Improving the health of future generations: The Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health." In *American Journal of Public Health*, 92 (9): 1396–1400.
- Rose, G. 1992. *Strategy of Preventive Medicine*. Oxford: Oxford University Press.
- Rootman, I., and J. Raeburn. 1994. "The concept of health." In Pederson et al. (eds.). *Health Promotion in Canada: Provincial, National and International Perspectives*. Toronto: WB Saunders of Canada.
- Richmond, C., and N. Ross. 2009. "The determinants of First Nation and Inuit health: A critical population health approach." In *Health and Place*, 15 (2): 403–411.
- World Health Organization. 1946. *Constitution*. New York.
- Wilson, K., and T.K. Young. 2008. "An overview of Aboriginal health research in the social sciences: Current trends and future directions." In *International Journal of Circumpolar Health*, 67 (2–3): 179–189.
- Young, T.K. 2003. "Review of research on Aboriginal populations in Canada: Relevance to their health needs." In *British Medical Journal*, 327: 419–422.