“We Exist. We’re Not Just Some Fairytale in a Book”:
Migration Narratives of LGBTQ2S Aboriginal People in Toronto

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
Department of Geography and Planning
University of Toronto

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Abstract

Over the past 60 years, the urban Aboriginal population in Canada has increased by almost 700 percent. Toronto’s population is no different; from 2001 to 2011, the Aboriginal population in Toronto grew by 87 percent. While it has been suggested that there is a high rate of Aboriginal mobility between reserves and cities, there are few qualitative studies that examine experiences of migration. Within that, little attention has been paid to narratives of Aboriginal people who are marginalized within this already marginalized community, such as the LGBTQ and two-spirited (LGBTQ2S) population. Utilizing Indigenous methodologies and a critical population health theoretical framework, semi-structured interviews were conducted with twenty-two LGBTQ2S migrants to understand urban transition narratives. The findings suggest that LGBTQ2S migrants have unique migration narratives based on their intersectional identities, which contribute to new challenges accessing housing, employment, culture, and services for this particular population.
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# Table of Contents

**ACKNOWLEDGMENTS**  
III

**TABLE OF CONTENTS**  
V

**LIST OF TABLES**  
VIII

**LIST OF APPENDICES**  
IX

**CHAPTER 1 INTRODUCTION**  
1

1.1 **BACKGROUND**  
1  
1.1.1 **ABORIGINAL DEMOGRAPHY, MOBILITY, AND URBANIZATION**  
1  
1.1.2 **PUSH, PULL, AND GOVERNANCE: QUALIFYING ABORIGINAL POPULATION GROWTH**  
2  
1.1.3 **SHORTCOMINGS OF CURRENT RESEARCH**  
3  
1.1.4 **GEOGRAPHICAL CONTEXT: TORONTO**  
4  
1.1.5 **MARGINALIZED IN AN ALREADY MARGINALIZED COMMUNITY: THE URBAN ABORIGINAL LGBTQ2S POPULATION IN TORONTO**  
5  
1.2 **THESIS OUTLINE**  
7

**CHAPTER 2 CRITICAL LITERATURE REVIEW**  
8

2.1 **THE EVOLUTION OF GENDER AND SEXUALITY**  
8  
2.1.1 **INDIGENOUS GENDER AND SEXUALITY**  
9  
2.1.2 **COLONIZING GENDER AND SEXUALITY**  
12  
2.1.3 **RETHINKING INDIGENOUS FEMININITY AND MASCUINITY**  
16  
2.1.4 **AN AUTHOR’S NOTE ON TERMINOLOGY: FROM BERDACHE TO TWO SPIRIT**  
17  
2.2 **LGBTQ2S ABORIGINAL PEOPLE AND INTERSECTIONS WITH HEALTH, WELLBEING, AND SERVICE PROVISION**  
18  
2.2.1 **AREAS OF CURRENT RESEARCH**  
19  
2.3 **CRITICAL POPULATION HEALTH THEORETICAL FRAMEWORK AND RESEARCH QUESTIONS**  
28

**CHAPTER 3 METHODOLOGY**  
31

3.1 **RESEARCH SETTING**  
31  
3.2 **INDIGENOUS METHODOLOGIES AS A METHODOLOGICAL FRAMEWORK**  
32  
3.3 **RESEARCH DESIGN**  
33
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1</td>
<td>PHASE I</td>
<td>33</td>
</tr>
<tr>
<td>3.3.2</td>
<td>PHASE II</td>
<td>35</td>
</tr>
<tr>
<td>3.3.3</td>
<td>PHASE III</td>
<td>37</td>
</tr>
<tr>
<td>3.4</td>
<td>DATA COLLECTION AND PARTICIPANTS</td>
<td>37</td>
</tr>
<tr>
<td>3.5</td>
<td>DATA ANALYSIS</td>
<td>40</td>
</tr>
<tr>
<td>3.6</td>
<td>EVALUATION OF RESEARCH METHODS AND POSITIONALITY</td>
<td>40</td>
</tr>
<tr>
<td>3.6.1</td>
<td>RESEARCH METHODS</td>
<td>40</td>
</tr>
<tr>
<td>3.6.2</td>
<td>POSITIONALITY</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 4 RESULTS AND DISCUSSION</strong></td>
<td>44</td>
</tr>
<tr>
<td>4.1</td>
<td>AN OVERVIEW OF SERVICES IN TORONTO</td>
<td>44</td>
</tr>
<tr>
<td>4.2</td>
<td>RESITUATING US: CRITICAL POPULATION HEALTH, INTERSECTIONALITY, AND INDIGENOUS METHODOLOGIES</td>
<td>48</td>
</tr>
<tr>
<td>4.3</td>
<td>DISTAL DETERMINANTS OF HEALTH: MIGRATION, COMMUNITY, AND CULTURE</td>
<td>54</td>
</tr>
<tr>
<td>4.3.1</td>
<td>MIGRATION AND COLONIALISM AS DISTAL DETERMINANTS OF HEALTH</td>
<td>54</td>
</tr>
<tr>
<td>4.3.2</td>
<td>DISCRIMINATION AND RACISM AS DISTAL DETERMINANTS OF HEALTH</td>
<td>59</td>
</tr>
<tr>
<td>4.4</td>
<td>INTERMEDIATE DETERMINANTS OF HEALTH: CULTURAL CONTINUITY AND SERVICE DELIVERY</td>
<td>64</td>
</tr>
<tr>
<td>4.4.1</td>
<td>SERVICE ACCESS AND AVAILABILITY AS DETERMINANTS OF HEALTH</td>
<td>64</td>
</tr>
<tr>
<td>4.4.2</td>
<td>SENSE OF COMMUNITY AND CULTURE AS INTERMEDIATE DETERMINANTS OF HEALTH</td>
<td>73</td>
</tr>
<tr>
<td>4.4.3</td>
<td>LGBTQ2S IDENTITY AS DETERMINANT OF HEALTH</td>
<td>80</td>
</tr>
<tr>
<td>4.5</td>
<td>PROXIMAL DETERMINANTS OF HEALTH: HOUSING AND EMPLOYMENT</td>
<td>82</td>
</tr>
<tr>
<td>4.5.1</td>
<td>EDUCATIONAL ATTAINMENT AND HOUSING</td>
<td>82</td>
</tr>
<tr>
<td>4.5.2</td>
<td>EMPLOYMENT</td>
<td>88</td>
</tr>
<tr>
<td>4.6</td>
<td>WEAVING IT TOGETHER: RECOMMENDATIONS FOR SERVICE PROVIDERS AND LGBTQ2S RESURGENCE</td>
<td>91</td>
</tr>
<tr>
<td>4.6.1</td>
<td>TRANSITION TIME</td>
<td>92</td>
</tr>
<tr>
<td>4.6.2</td>
<td>LGBTQ2S RESURGENCE</td>
<td>93</td>
</tr>
<tr>
<td>4.6.3</td>
<td>ANOTHER AUTHOR’S NOTE ON TERMINOLOGY: FROM TWO-SPIRIT TO...</td>
<td>96</td>
</tr>
<tr>
<td>4.7</td>
<td>SUMMARY</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 5 CONCLUSION</strong></td>
<td>99</td>
</tr>
<tr>
<td>5.1</td>
<td>SUMMARY AND DISCUSSION OF KEY FINDINGS</td>
<td>99</td>
</tr>
<tr>
<td>5.2</td>
<td>CONTRIBUTIONS TO THE LITERATURE AND LIMITATIONS</td>
<td>105</td>
</tr>
<tr>
<td>5.3</td>
<td>RETHINKING LOPPIE READING &amp; WIEN (2009)</td>
<td>109</td>
</tr>
</tbody>
</table>
List of Tables

Table 3.4 Demographic, Mobility, and Socioeconomic Characteristics of Participants………….39

Table 4.1 An Overview of Aboriginal Services (TASSC Membership)………………………..45

Table 4.2 Distal, Intermediate, and Proximal Determinants of Health………………..50
List of Appendices

Appendix 1: Interview Guide.................................................................128-9

Appendix 2: Recruitment Poster.........................................................130

Appendix 3: Letter of Information.......................................................131

Appendix 4: Verbal Consent...............................................................132

Appendix 5: Written Consent.............................................................133-4
Chapter 1
Introduction

1.1 Background

1.1.1 Aboriginal Demography, Mobility, and Urbanization

In an era of increasing government decentralization and municipal downloading, cities are the new administrators of federal and provincial programs and services. However, one group of people continues to be governed at the highest level\(^1\) – Canada’s Aboriginal\(^2\) peoples. As of 2011, 4.3 percent of Canada’s population – or 1,400,685 people – identify as Aboriginal and it is their unique demography and mobility trends that warrant a discussion around Aboriginal urbanization, service provision, and government policy (Statistics Canada, 2014a).

Work by Verma (2014) and INAC & CMHC (2007) estimated the Aboriginal population would grow from 1.6 to 2 percent per year from 2001 to 2016, for a population of approximately 1.2 million by 2011. Yet, as of the 2011 National Household Survey, over 1.4 million people identify as Aboriginal, meaning the population’s actual growth far outweighs projected growth (Statistics Canada, 2014a). From 2001 to 2006 alone, the Aboriginal population of Canada grew 20.1 percent – compared to the non-Aboriginal population’s growth rate of 5.2 percent – and continues to grow today at a rate higher than the average Canadian population growth (Statistics Canada, 2014a). Accompanying this growth, 46 percent of the Aboriginal population is under the age of 25 (compared to 29% of Canada’s population), meaning that the population growth rate will continue to be higher than the Canadian average (Statistics Canada, 2014a).

Aboriginal peoples are not only the fastest growing and youngest population in Canada, but they are also one of the most mobile populations (Statistics Canada, 2010; 2014a). Within the

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1 Here, I refer broadly to federal Treaty obligations, the federally implemented and still imposed *Indian Act*, and the federal reserve system.

2 I use Aboriginal here to refer to the Canada’s Indigenous peoples, which can be further divided into First Nations (status and non-status), Inuit, and Métis peoples. While the term is contested, it is what is most widely used in current local, provincial, and federal policy, as well as somewhat accepted within Toronto’s Indigenous community. Wherever possible and appropriate – in response to critiques of the term that Aboriginal reinforces pan-Aboriginal approaches to history, culture, and policy – a more specific term is used to refer to a particular group or groups.
Aboriginal community, rapid urbanization has occurred over the past fifty years. In 1901, only 5.1 percent of Aboriginal people lived in urban areas; this figure remained relatively unchanged for 50 years, as by 1951 only 6.7 percent of Aboriginal people lived in urban areas (Kalbach, 1987). Yet, by 2001, half of all Aboriginal people lived in urban areas, while the 2011 census revealed that the number has climbed to 56 percent of the population (Statistics Canada, 2014a; Statistics Canada, 2014b). The increasing urbanization of Aboriginal peoples is further complicated by diverse patterns of mobility. Between 2005 and 2006, over 25 percent of Aboriginal people changed addresses (Statistics Canada, 2010). Moreover, Aboriginal peoples are more likely to move within cities, frequently migrate from rural or reserve areas, and have a higher rate of natural increase (Statistics Canada, 2014a; Norris & Clatworthy, 2011). Finally, the changing nature of cities – in part influenced by municipal downloading – means that more and more people are encompassed within a city’s boundary, which increases population growth. Knowing this – and moving forward – Verma’s (2014) estimation of 1,431,800 Aboriginal people by 2017 appears to fall considerably short, and means that Canada and cities needs to reconsider how to best meet the needs of this growing and increasingly urban population.

1.1.2 Push, Pull, and Governance: Qualifying Aboriginal Population Growth

The substantial growth of Aboriginal peoples in Canada is attributable to many factors including higher fertility rates, changes to legislation (including who is considered “Aboriginal” vis-à-vis Bill C-31 changes, which restored Aboriginal women’s status, to be discussed in Chapter 2), and higher self-reporting of Aboriginal identity (Statistics Canada, 2010). The increase in self-reporting combined with legislative changes is linked to ethnic mobility, defined as “people changing, from one census to the next, the reporting of their Aboriginal affiliations from a non-Aboriginal identity to an Aboriginal identity” (Siggner & Costa, 2005, p.11). Ethnic mobility can be described as either self-ascribed or imposed, where self-ascribed is when an individual changes the group they identify with, and imposed is when the definition of the group is changed (Andersen, 2014). The rapid increase in the Aboriginal population has both factors: self-ascribed from increased pride and increased awareness of Aboriginal ancestry; and imposed via changes to Bill C-31 and tracing both matrilineal and patrilineal heritage (Andersen, 2014;
Goldmann & Delic, 2014). This both inflates the Aboriginal population and presents new challenges to governance in urban and reserve areas, to be discussed in Chapters 2 and 4.

The non-Aboriginal population has long been urbanized, with 82 percent of non-Aboriginal people living in cities (Statistics Canada, 2014b). However, the rapid urbanization of Aboriginal people requires a culturally-specific investigation into push and pull factors. King, Smith, & Gracie (2009) acknowledge both, citing that general push factors include unemployment and subsequently poor social and economic conditions, a low quality of life, boredom, a lack of housing, health facilities, and educational opportunities, and political pressures. Meanwhile, pull factors include jobs and other opportunities (housing, services) and the excitement of living in a city (King, Smith, & Gracie, 2009). Peters (2005) contends that the push and pull factors are more complicated than this, as they must also include culture and community, where cities can be places of racism or a lack of culture, and home communities have a connection to land and culture. When combined, we understand rural and reserve spaces as places of belonging but also hardship, while cities are places of opportunity but also discrimination. Within that, the Urban Aboriginal Task Force (2007) mentions that 86 percent of Aboriginal migrants maintain some physical connection to home, further complicating both push/pull factors and the cultural component of migration (McCaskill & Fitzmaurice, 2007).

1.1.3 Shortcomings of Current Research

While research has been done in the area of Aboriginal mobility, scholars have relied on government-collected data, making most studies retrospective and quantitative in nature (namely the Aboriginal Peoples Survey, National Household Survey, and the Canadian census). This means that information is not produced in real time, which in part explains why the most recent calculation of the Aboriginal population is from 2011. Accompanying this, a surplus of quantitative data contributes to a dearth in qualitative research, and means that there is little information focusing on the lived experiences of Aboriginal migrants (with some exceptions, namely Skelton, 2002; Snyder, 2013; Senese & Wilson, 2015).

What has been understood about Aboriginal mobility is that there are several migration patterns that emerge, contributing to a “churning” of the population (Clatworthy & Norris, 2013).
This “churning” refers to the usually cyclical high levels of mobility that Aboriginal peoples experience. Aboriginal people who are mobile between a community and a reserve either experience in-migration – returning to reserves from another area – or out-migration – going to an area from a reserve. Meanwhile, all Aboriginal people can be categorized as residential movers (those who move within a community), migrants (those who changing communities entirely), or non-movers (Clatworthy & Norris, 2013). These complex patterns often overlap, and many migrants experience more than one aspect of the churning process throughout their lives. Given the complicated nature of this churning, there is limited data on the phenomenon, and the lived experiences are oftentimes not included within the mobility literature.

Despite the lack of qualitative research on Aboriginal mobility, much has been speculated on the impacts of mobility on Aboriginal peoples. As Beavon & Norris (1999) argue high mobility can lead to weaker social cohesion in communities. As a result of this, Beavon & Norris (1999) suggest that people living in these communities may have greater social problems (such as crime, educational attainment, and suicide). Of course, the final piece of this is that these social problems lead to greater mobility and churn (Beavon & Norris, 1999). When combining this with rapid urbanization, mobility, push/pull factors, and an overall dearth in quantitative and qualitative research, much is left unknown about the urban Aboriginal population.

1.1.4 Geographical Context: Toronto

Toronto’s Aboriginal population is no exception to massive urbanization. Census data suggests that from 2001 to 2011, Toronto’s Aboriginal population nearly doubled, with a growth rate of 82 percent (Statistics Canada, 2001; Statistics Canada, 2013). Toronto’s 36,995 Aboriginal inhabitants make Toronto the home of 3 percent of all Aboriginal people in Canada, despite having a lower proportion of Aboriginal people compared to other cities (Statistics Canada, 2013). However, Toronto service providers estimate that the Aboriginal population is much closer to 70,000 people, and cite high rates of mobility and homelessness, a growing refusal to participate in government-collected surveys, and the scrapping of the long form census as the reasons for underrepresentation (McCaskill, FitzMaurice, & Cidro, 2011). These shortcomings – while acknowledged by Statistics Canada – can be particularly problematic when calculating the need for service provision, and contribute to a policy vacuum, to be discussed in Chapters 2 and 4.
Regarding mobility, Toronto has unique patterns when compared to the eleven other Census Metropolitan Areas (CMAs). Norris & Clatworthy (2011) acknowledge that Toronto has the third highest growth rate in the Aboriginal population (next to Calgary and Hamilton), yet they also experience the highest rate of net out migration. Combining a high growth rate (new population) and a high rate of net out migration, this means that Toronto does experience significant “churning,” which might be higher than other CMAs. While Snyder & Wilson (2012) acknowledge that the low relative population of Aboriginal people in Toronto may influence migration and length of residency, ultimately research on the experiences of Toronto’s Aboriginal migrants is extremely limited (see Senese & Wilson (2013) for one study on Aboriginal urbanization in Toronto).

1.1.5 Marginalized in an Already Marginalized Community: The Urban Aboriginal LGBTQ2S Population in Toronto

As Young (2003) points out in his review of existing Aboriginal health research, urban populations and the most marginalized populations – including women and children – are underrepresented in academic literature. As a result, there is a complete gap in understanding urban Aboriginal health and access to services. Toronto is no exception. Until the recent Toronto Aboriginal Research Project (TARP) – the largest study ever commissioned on the Aboriginal population in Toronto – there was a lack of in-depth and systemic research on the Aboriginal community. While the TARP featured 1,400 respondents, they still acknowledged one group that “constitute[s] a forgotten group within the Toronto Aboriginal community” – two-spirited3 people. This leads us to one area of research that is virtually non-existent – two-spirited experiences of the city, as well as how these experiences intersect with health and service provision (a focus of the TARP report).

From the limited body of research that does exist, incidences of domestic abuse, homelessness, drug use, and HIV/AIDS are higher among two-spirits compared to the non-Aboriginal population (Passante, 2012; Ristock, Zoccole, & Passante, 2011). Furthermore,

3 Broadly speaking, two-spirit or two-spirited refers to Aboriginal lesbian, gay, bisexual, intersex, or trans* people.
research by Ristock, Zoccole & Passante (2011) on mobility of LGBTQ2S Aboriginal people speaks to push and pull factors of migrating, where HIV status, sexuality, and looking for an accepting community were the biggest factors, as homophobia is oftentimes present in home communities (O’Brien-Teengs & Travers, 2006). As a result, two-spirits are no exception to widespread urbanization: half of Toronto’s 1,000 two-spirits – the largest two-spirit community in Ontario – came directly from a reserve (McCaskill et al., 2011). Knowing that Ontario has the highest absolute number of Aboriginal people by province and that Toronto has one of the highest Aboriginal population growth rates, the LGBTQ2S Aboriginal population is growing, representing an area that is demanding study and has major impacts on service providers in Toronto.

In an effort to mitigate this gap and better understand Aboriginal health, geographies of migration, and LGBTQ2S service provision, this master’s thesis asks the following research questions: i) What are the migration experiences of LGBTQ2S Aboriginal peoples in Toronto?; and ii) How do these lived realities intersect with access to housing, employment, culture, community, and service provision? To answer these questions, qualitative research methods informed by Indigenous approaches to methodology and research are used. Furthermore, a comprehensive literature review is provided in order to understand the historical and contemporary realities of being both LGBTQ2S and Aboriginal. Finally, this thesis is guided by two research objectives: i) to understand the different reasons for migration and the migration experiences of LGBTQ2S Aboriginal people, how those experiences interact with wellbeing and service provision, and how they may differ from other Aboriginal narratives of migration; and ii) to acknowledge LGBTQ2S Aboriginal peoples’ lived experiences, with a particular focus on providing knowledge to service providers and policymakers to create the most holistic and inclusive policy and programming directions.

4 I use Lesbian, Gay, Bisexual, Transgendered, Queer, and Two-Spirited (LGBTQ2S) as a blanket acronym throughout this thesis, for it encompasses all of the gender and sexual identities that my participants identified as, and is commonly stylized as that acronym across many disciplines and sectors. Moreover, I use LGBTQ2S to acknowledge the shortcomings of the term two-spirited, and emphasize the many gender and sexual identities that Aboriginal people have.
1.2 Thesis Outline

This thesis is presented in five chapters. Chapter 2 reviews and examines relevant literature on Aboriginal gender and sexuality from pre-contact to present day before discussing colonial and gendered implications on service provision through an overview of Aboriginal LGBTQ2S research. Chapter 2 culminates with the research questions and a discussion of the theoretical framework of this research. Chapter 3 details the research methodology, which is informed by Indigenous methodologies, extensive consultation, and strong community partnerships. Chapter 4 discusses findings from in-depth, semi-structured interviews with 22 LGBTQ2S Aboriginal people in Toronto that focus on their lived migration narratives and experiences accessing housing, employment, and services. Chapter 5 expands on the results of the interviews, with a particular focus on the research’s implications and future directions for policy and programming in Toronto.
Chapter 2
Critical Literature Review

This chapter introduces relevant research to understand and contextualize LGBTQ2S Aboriginal history and contemporary service provision. This chapter begins with a specific history of LGBTQ2S Aboriginal people through an overview of the colonization of gender and sexuality. From there, a discussion on current research on the urban LGBTQ2S Aboriginal community is provided. This chapter culminates with the theoretical framework and research questions underlying the research.

2.1 The Evolution of Gender and Sexuality

Ideas on power are often rooted in understandings of Othering, where some bodies are the dominant – colonizing or controlling – and other bodies are just that – the Other, or the bodies to be colonized and controlled (for more theoretical discussions, see Butler (1990), Foucault (1978), and Said (1978)). In the context of colonization, Foucault’s (1978) theory on biopower argues that states “achiev[e] the subjugation of bodies and the control of population” through sex and sexuality, which ensures that “deployments of power are directly connected to the body” (p. 140, 152). The process of Othering is integral to the initial and continuous subjugation of particular people or peoples, and ultimately, Canada is no exception to this process. As Kelm (1996, p. 52) comments in the prequel article to her book, Colonizing Bodies, “the drama of colonization was acted out in Canada not only on the grand scale of treaty negotiations and reserve allocations but on the supple contours, the created representations and the lived experiences of Aboriginal bodies.” This becomes especially apparent in the Indian Act, which named and categorized Aboriginal people and enfranchised the Othering of Aboriginal peoples in [still enforced] legislation. As de Leeuw & Greenwood (2010, p. 58) argue, “early in the country’s history… nomenclature fashioned social categories that discursively produced a particular people by assigning them a series of constructions.” These constructions manifest today in many forms, from women’s loss (and regaining) of status to health inequities between Aboriginal and non-Aboriginal people. Furthermore, these colonial implications affect policy, programming, and services.
In connecting these ideas of power to conceptions of gender, sexuality, and the colonization of gender and sexuality, Finley (2011) argues in *Queer Indigenous Studies* that you cannot separate heteronormativity and patriarchy from colonization. In other words, heteronormativity and patriarchy are agents of colonization, and ensured that Indigenous men and women’s bodies were “sexualized, gendered, and racialized as penetrable” (Finley, 2011, p. 35). What is absent from Finley (2011) and Foucault’s (1978) analyses of sex and power are the Indigenous histories that are completely separate from systems of heteronormativity and patriarchy. Within that, gender and sexuality are oftentimes hard to differentiate in research on Indigenous histories and oral traditions, as early research and settler and missionary testimonies utilize a conservative and European lens. What we can glean, however, is that there was no single and unified political, economic, or social system within “Canada” prior to colonial contact. To generalize, this means that ideas around sexuality and gender were determined by each community, and were not congruent with the European idylls of heteronormativity and patriarchy at the time of contact. In order to understand this further, the following presents an overview of some of the literature that contextualizes Indigenous understandings of gender and sexuality prior to colonization, and adds commentary on the dissolution and reclamation of these ideas.

### 2.1.1 Indigenous Gender and Sexuality

Oral histories have always maintained the idea that, prior to colonial contact, Aboriginal clan systems and families were the base of their civilization (Armstrong, 1996). Within that, women – not men – were holders of power, as being bearers of life was necessary for the group’s survival and repopulation (Armstrong, 1996). As Emberley (2001) argues, these kinship systems were matrilineal – tracing descent through the women was ‘natural,’ since the woman gave life. Women were further empowered through Indigenous views on domestic work; before anything else, all people were governed first by women, as society depended on the quality upbringing of children (Stirbys, 2008). An example of this is “notokwew mâcîwin” or old lady hunting, where Cree grandmothers were the teachers of hunting and trapping as they were valued for their

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5 I use Indigenous here and elsewhere to refer to First Nations and Inuit peoples prior to colonization.
experience as lifegivers (Anderson, 2010, p. 82). The idea that women were – at the very least – “equal” to men has been widely documented amongst various First Nations and Inuit groups, including Canada’s two largest groups – Anishinaabe (Ojibway) and Cree (see Smith (1999) for a discussion on Anishinaabe women, Struthers (2000) on Ojibway and Cree women as healers, and Grey (2010) on the changing roles of Inuit women).

Defining equality in a pre-colonial Indigenous context has long troubled anthropologists and scholars. On the one hand, some First Nations societies have been described as matriarchal since women “managed the land, the crops, the longhouses, and women were essential to both the tribal economy and political organization, as demonstrated by their clan systems” (Stirbys, 2008, p. 140). On the other hand, Anderson (1991) acknowledges the importance of clans and kinship above matriarchy or matrilinity, and recognizes that Feminist scholars are still decolonizing settler testimonies and early anthropological work, which often viewed women as controlled by men. What we can rely on is language – several Indigenous languages, such as Micmac, do not differentiate between male and female genders (Stirbys, 2008). Meanwhile, other languages (namely Ojibway) define objects as animate or inanimate, in contrast to Indo-European languages that classify objects as male, female, or neutral (Smith, 1999).

This is not to argue that gender and sexuality were non-existent in Indigenous cultures. Anthropologists and settler testimonies acknowledge male, female, and berdache\(^6\) bodies. Etymologically, berdache is a term stemming from Spanish, French, Italian, and Persian origins to refer to a passive homosexual partner, kept boy, or male prostitute (Jacobs, Thomas, & Lang, 1997). As Jacobs \textit{et al.} (1997) better define the term outside of settler gaze, berdache refers to “special gender roles” in Indigenous cultures that were interpreted by settlers as transvestism, homosexuality, and/or gender variance. Many scholars have acknowledged berdache and its many forms. Lang (1997) suggests that three or four genders regularly emerged in pre-colonial societies: women, men, two-spirit/womanly males, and two-spirit/manly females. Cameron (2005) takes it a step further, identifying that some groups had up to six ‘genders,’ adding in gender differentiations based on sexual orientation. Cannon (1998) confirms this, while also

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\(^6\) berdache is now considered a derogatory and insulting term. The term was replaced by two-spirit in 1990.
suggesting that same-sex relationships existed upon initial colonial contact. What all of these scholars illustrate is that there was tremendous variance between Indigenous groups and ultimately between Indigenous groups and eventual settlers, of which the latter would form a tremendous base for processes of Othering, assimilation, and ultimately genocide.

It is particularly important to be cautious here about gender and sexuality prior to colonization. We need to be skeptical of the romanticized perspective that all Indigenous peoples were accepting and open to two-spirits and homosexuality. While settler and missionary accounts of Indigenous peoples do speak about gender crossing and consensual homosexual sex, we cannot deduce gender identity and sexual preference from settler testimonies (Cannon, 1998). As Morgensen (2011, p. 55) states, berdache is a colonial object: “Over time, the object projected a uniformity of sex, gender, sexuality, and indigeneity that let it represent principles of human nature and culture.” Ultimately, without being present in Indigenous communities during colonization, we are limited in our understanding of Indigenous sexuality, especially when we encompass language differences, the reliability of settler and missionary accounts, and the generally conservative settler view on gender roles. Simply put, we can combine the knowledge acquired to date, which paints a picture of an egalitarian society, but there could be significant interpretation errors or stories that significantly vary from this perspective that have yet to be discovered (or are completely lost).

In taking all of this in account, Jacobs (1997, p. 27) perhaps best summarizes understandings of Indigenous views of gender from what we know so far,

“Gender is how people are classified along a continuum from female to male (or vice versa) using endogenous criteria that may include only a few, or all, of the following characteristics: phenotype (body appearance, including primary and secondary sex characteristics; genotype (chromosomal makeup); hair distribution and style; clothing and other body adornments; kinesthetics, or “body language” … vocalization … the use of tools, instruments… occupation or work; and place of residence and age.”

This is vastly different than the European definition of gender as one’s sex characteristics (at the time of colonial contact, which was tied with capitalism as discussed in section 2.1.2), and represents one key distinction that would lead settlers to the process of Othering upon colonial contact.
In sum, borrowing from Tsosie’s (2010, p. 32) three common patterns that emerge when looking at all First Nations perspectives on gender: i) gender roles were complementary, not dichotomous; ii) even when more traditional (in a Western sense) gender roles were established, groups were tolerant towards women in higher power; and iii) Indigenous spirituality features both male and female spirits. Compared to patriarchy in European societies at the time of colonial contact, Indigenous women and men both had roles in ceremonies, Indigenous women and men could own property or resources, Indigenous women and men could be military or political leaders, and oftentimes Creator is an essence bound in all natural entities instead of a male God (Tsosie, 2010, p. 32). When depicted in contrast, the discrepancies between gender and sexuality in Indigenous and colonizing populations ultimately created space for a process of Othering through which domination occurred via the hegemonic Western ideology.

2.1.2 Colonizing Gender and Sexuality

The transition from Indigenous views of gender and sexuality to ideas bound in patriarchy and heteronormativity was not instantaneous. Cooperation and equality were at the forefront of initial colonial encounters. As Samuel de Champlain famously said, “our young men will marry your daughters and we shall be one people” (Saul, 2008, p. 10). While we know that the story ends in assimilation and genocide, the two sides did initially enter into a somewhat mutually beneficial relationship; Indigenous populations gained their livelihoods easier through advanced technology, while European settlers could not have thrived without Indigenous knowledge of agriculture and hunting (Innis, 1999). Moreover, some interior lands were not discovered by explorers, but shown by Indigenous populations by canoe, which would be the main source of transportation throughout the fur trade period (Saul, 2008).

Within this, Aboriginal women were empowered by colonizers for a period of time. First, intermarriages broke down barriers and helped to weave together the two civilizations. Second, many of the newcomers were “marrying up” when they chose Indigenous females since they improved their lives socially, politically, and economically (Saul, 2008; Van Kirk, 2002). Since Indigenous women were accustomed to the climate, food, and lifestyle, they lived in better conditions than settlers’ camps (Saul, 2008). Because of their multilingual abilities, “Aboriginal women advantageously acted as intermediaries between the French and Aboriginal worlds and enhanced their authority, prestige and reputation,” which helped to create trade alliances.
(Thompson, 2009, p. 368). However, this idea of “marrying up” combined with their significance in the fur trade made the women more desirable, which would eventually lead to the women becoming more objectified (and therefore inferior). Alongside this, berdaches were seen as deviants, and it was the goal of the settlers to quickly control and regulate gender and sexuality (Cannon, 1998). These ideas – when combined with colonizing legislation – led to the fragmentation of Indigenous gender and sexuality.

Perhaps what warped Indigenous views of gender and sexuality the most was the gradual transition to make the New World resemble the Old World: capitalism. As Bourgeault (1983) argues, the creation of mixed-race people was favourable to create a large workforce. It also meant that mixed-race people could be governed and controlled by settlers. This manifested in unique ways, namely that mixed-race women would not be sent to the Old World for education, industry could pay “half-breeds” less than settlers (they were, at this period in history, the largest workforce outside of peasantry), and the dissolution of the fur trade made Indigenous women’s trade-related economic roles obsolete (Bourgeault, 1983). Under capitalism, since men were now the only ones to earn wages, women could then fulfill their domestic obligations (Bourgeault, 1983). These impacts of capitalism meshed completely with the politics of the British Empire, under Queen Victoria’s leadership. As Francis (1998, p. 51) argues, the Victorian era – now known for its conservativism, morality, and religious influence – shifted “relatively benevolent attitudes towards Indigenous peoples to a more deeply negative racism.” Within that, the binary of civilized European vs. uncivilized Indigenous person emerged, coinciding with the binary of male vs. female. Restoring civility to Indigenous peoples would become a focal point of New World policies in the Victorian era.

The experiments to carry out Victorian wishes to “civilize” the Indigenous populations commenced in the 1830s, where plots of land – which would later become reserves – were set-aside for Indigenous Canadians to farm, become educated, and learn about Christianity in isolated areas (Tobias, 1976). Following the implementation of such a system, legislation reinforced the reserves as ‘Indian only’ spaces through forbidding non-Indigenous trespassing in two laws passed in 1839 and 1850, respectively (Tobias, 1976). The goal of these reservations was assimilation, which was strengthened by 1869’s *Gradual Enfranchisement Act*, which called for the termination of Indian status and enforced “European patriarchal laws that subsumed the
legal, economic and political rights of women under their husbands and fathers” (Emberley, 2001, p. 75). Emberley (2001) goes on to argue that, at this point – for the first time in history – Indigenous women had fewer roles and rights than men in their communities.

These pieces of legislation were small building blocks to the true transformation of Indigenous populations from egalitarian to patriarchal – the Indian Act. The policies laid out in the Indian Act would go unchanged for over a century, creating inequality within Aboriginal communities. The Indian Act “contained provisions which attacked traditional Indian sexual, marriage, and divorce mores and furthered the Christian-European values... relating to illegitimate children, non-band members on the reserve after sundown, non-Indians on reserves and cohabiting with Indians, and Indian Women in public houses” (Tobias, 1976, p. 18). Accompanying this, Indigenous women were stripped of their legal status and all of its benefits upon marriage to any man not holding status under the Indian Act (Fiske, 1996). Despite these gendered implications for women, “Euro-Canadian notions of patriarchy and derived identity [made] non-Indian women become status Indians upon marriage to a status male, and were able to transmit status to the children of their marriage” (Fiske, 1996, p. 69). Upon implementation, a gendered and racialized hierarchy was officially embedded in Canadian governance, and Canada became the governor of Indigenous peoples.

Beyond the obvious gendered divisions of the Indian Act, the document had profound impacts on emphasizing heterosexuality. In essence, the act created a system of patrilineal descent focused on heterosexual relationships. The Act reinforced that women were to be controlled by their husbands. This subjugation of women created marriage as the “only possible avenue through which to convey “Indian” status and rights, the [Act] legislated European forms of heterosexuality” (Cannon, 1998, p. 10). Within that, of course – to continue to perpetuate capitalism and patriarchy – the Act legislated heterosexuality as the only recognized union (Cannon, 1998). Through the patrilineal system, the subjugation of women, and embedded heterosexuality, it is evident that the Indian Act controlled sexuality through heteronormative, Victorian, and Western dominated legislature.

Coinciding with the implementation the Indian Act, residential schools operated for over 130 years. Residential schools sought to realize the goal of assimilation through the replacement
of language, traditions and religions with mainstream Canadian versions. In total, Roman Catholic, Anglican, United and Presbyterian churches sent at least 150,000 Aboriginal children to these schools, creating generations of disconnected and fragmented conceptions of Indigenous identity (Bird, Land, & MacAdam, 2001). More than that, residential schools have a direct correlation to gender and sexuality. By sending Aboriginal youth to Western school systems, what was left of oral tradition was lost, including traditional knowledge on gender roles and matriarchal nations (McCaslin & Boyer, 2009).

Separate from disconnected gender roles, residential schools oppressed Aboriginal youth sexualities. In addition to physical and mental abuse, sexual abuse occurred in residential schools (McCaslin & Boyer, 2009). This serves as evidence that colonial relationships are sexualized, with sexual violence functioning “as a tool of racism and colonialism” (Kuokkanen, 2008, p. 220). Because of the innate patriarchy and flaws within gender relations, sexual exploitation of Aboriginal women is “integrated linked to their economic inequality and lack of political power both in dominant and in their own societies” (Kuokkanen, 2008, p. 220). It is here where Kelm’s (1999) argument that bodies were the principle sites of colonization is highly apparent, as bodies were repeatedly colonized throughout Canadian history.

The era that encompassed residential schools and assimilation-based government policies continues to dominate society today. With residential schools and male-only status, it meant that there were only 350,000 status people in Canada by 1985 (Lawrence, 2003). In 1969, the White Paper aimed to eradicate legal status entirely and ‘legislate away’ generations of history. Although unsuccessful, challenges over status and gender remained. In 1971, two Indigenous women – who had lost status by marrying white men – took their case to the Supreme Court, suggesting that the Indian Act was in violation of their human rights (Lawrence, 2003). The court ruled against them, for “in losing their status, they gained the rights of white women” (Lawrence, 2003, p. 13). This response by the government illustrates white privilege and the Westernized idea of a binary world that the country was founded on. In addition, many Indigenous male organizations – who were differently affected by the gendered Indian Act – feared supporting the Indigenous women’s movement because of the concern that status would be wiped away permanently (Lawrence, 2003). As a result, the unity that the Indigenous people thrived on pre-contact was at the point of maximum disunion. It was not until 1981 that the Indian Act was
discussed at the United Nations, who concluded that Canada was in violation of the International Covenant on Political and Civil Rights (Lawrence, 2003). Following this, Bill C-31 (An Act to Amend the Indian Act) passed in 1985, which made the Indian Act congruent with the Charter of Rights and Freedoms (1982) on gender equality.

Despite success in reclaiming their Indigenous identities, the reinstalling of Indigenous rights through Bill C-31 (1985) and the Charter of Rights and Freedoms (1982) created massive growth on reservations that the bands were unprepared for. Of all the reservations, 13 percent experienced growth of over 100 percent, while 62 percent of reserves grew by 10 to 30 percent (Lawrence, 2003). Still, less than half of all Indigenous people reclaimed their statuses with Bill C-31, further illustrating the complete breakdown to a severely disjointed culture (Lawrence, 2003).

Today, Aboriginal people are still governed by Bill C-31 and the Indian Act. Recent developments in women’s status do not account for the generations of sexism and the separation of a culture. Moreover, it becomes increasingly challenging to decolonize gender and sexuality, as “for Native people, individual identity is always being negotiated in relation to collective identity, and in the face of an external, colonizing society” (Lawrence, 2004, p. 4). Ultimately, generations of oppressions combined by a century of patriarchal and heteronormative legislature marginalized women within an already marginalized population. While it is somewhat easy to trace the marginalization of women throughout history, most scholarship neglects an even more isolated group – two-spirited peoples.

2.1.3 Rethinking Indigenous Femininity and Masculinity

Within this overview of gender and sexuality from pre-contact to the present day is the absence of a male narrative. As Klopotek (2001, p.241) states:

“hypermasculinity has been one of the foremost attributes of the Indian world that whites have imagined. With squaws [women] and princesses usually playing secondary roles, Indian tribes are populated predominantly by noble or ignoble savages, wise old chiefs, and cunning warriors. These imagined Indian nations comprise an impossibly masculine race.”

This ‘impossibly masculine race’ has been constructed, as “for the violence of conquest you needed a violent opponent” (Alfred, 2011, p. 79). Using Klopotek (2001) and Alfred (2011)
together, colonialism is only justified in the face of a violent, masculine opponent, which is most often depicted in the colonized contemporary imagination of Indigenous peoples as masculine warriors and savages. While I have extensively detailed the devolution of the women’s role, oftentimes scholars do not contrast it to the conflation or devolution of the men’s role. Certainly, patriarchy would assume that Indigenous men would benefit from their newfound role as superior to Indigenous women. However, as shown in the idea that Indigenous peoples are either subjugated women or savages, wise chiefs, and warriors, Indigenous masculinity was heavily colonized.

Today, Indigenous feminism has emerged, virtually jumping out of the gate into scholarship, reclaiming Indigenous women’s power and voices (see Suzack et al., 2010, which discusses Indigenous feminism in both past and present contexts). Nationally, Aboriginal women are more likely to have a postsecondary degree than Aboriginal men (Statistics Canada, 2011). Meanwhile, the Toronto Aboriginal Research Project (2011) revealed that Aboriginal men have lower incomes, educational attainment rates, job security, and home ownership than Aboriginal women. In essence, despite the marginalization of Aboriginal women throughout history, they are now thriving and working towards reclaiming what was lost. This leads to a big gap in understandings of Aboriginal men, presents an area for future research, and also means that we need to further analyze the role of colonization on both Aboriginal women and men’s identities. One area where this all intersects – both the devolution of women’s and men’s status, and the eventual reclamation of women’s status – is among the two-spirited population.

### 2.1.4 An Author’s Note on Terminology: From berdache to two-spirit

As Lang (1997, p. 104) poses, “What implications do systems of multiple genders have on cultural constructions of homosexuality and heterosexuality?” Within this question lies an inherent critique of berdache, two-spirits, and broader LGBTQ labels.

The term “two-spirit” was coined in 1990 at the third Native American/First Nations Gay and Lesbian Conference in Winnipeg (O’Brien, 2008). In many respects, two-spirit replaced berdache – there was no “transition term” between a culturally inappropriate anthropological word and one chosen by the community, with the exception of some who chose to identify on the LGBTQ spectrum. The intention of the term was twofold: one, to distance Indigenous two-spirits
from the non-Aboriginal gay and lesbian community, and two, to emphasize the spiritual and traditional aspects of the identity while downplaying gender and sexual orientation (Jacobs, Thomas, & Lang, 1997). The term’s coining and subsequent popularity coincided with Indigenous HIV/AIDS organizing, which provides both context and contestation to two-spirits today (Morgensen, 2011).

In order to answer Lang’s (1997) question, we must accept three truths that were contextualized earlier. First, we acknowledge the existence of many terms and words for many different concepts of gender and sexuality pre-contact, which varied tremendously from group to group. Second, we acknowledge colonialism’s fixation on and wide use of heteropatriarchy (Morgensen, 2011). Third, we acknowledge that the blanket term – two-spirit – is still clouded by colonialism’s heteropatriarchy; Blackwood (1997, p.289) argues, “neat definitions and categories cannot account for the range of identities. Instead, they force two-spirit people to justify who they are if they are different than the categories anthropologists have created for them.” Combined, multiple terms, colonialism’s heteropatriarchy, and the fact that any term excludes somebody, Kehoe’s (1997, p. 270) words are very clear, “Two-spirit is not a “traditional” term, and if it were it could be traditional only for one or a few nations. It is an example of the vitality of contemporary First Nations cultures, expressing for these persons a mode shared across the diversity of their native nations.”

2.2 LGBTQ2S Aboriginal People and Intersections with Health, Wellbeing, and Service Provision

Literature on LGBTQ2S Aboriginal people in Canada is limited, for a variety of reasons. First, it is already known that there is an underrepresentation in the literature on marginalized people within the Aboriginal community (women and children) and urban Aboriginal people (Young, 2003). Furthermore, there is a general dearth of literature on the LGBT⁷ population, and – like Aboriginal health research – existing research privileges certain topics and people. For example, Boehmer’s (2002) literature review of 20 years of LGBT health research reveals that

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⁷ LGBT is the term most often used to identify literature on LGBTQ2S health, perhaps best illustrating many of the shortcomings of the field.
56 percent of the literature is focused on STDs, with 52 percent focused on HIV/AIDS. This means that participants are distributed unevenly, too, as 80 percent of articles focused exclusively on gay men (Boehmer, 2002). However, Epstein (2003) argues that public policy and research is playing “catch-up” on LGBT health needs, as they have often been negated in literature to date (or at least not analyzed separately). While this does negate some of the problematic nature of biomedical research on LGBTQ peoples, ultimately – as Mule et al. (2009) argue in their discussion on policy recommendations for LGBT health in Canada – research on the health and well-being of LGBT people needs to be prioritized over illness-based research.

Mule et al. (2009) also recognize another troubling point about LGBT health and well-being research – gender identity and sexual orientation have largely been excluded from mainstream research. Within that, the two bodies of research – LGBT health research and Aboriginal health research – do not converse with each other. Ethnicity and racial identity are largely missing from conversations on sexuality, and while large studies like the Aboriginal Peoples Survey do talk about health, they exclude “two-spirit” as a gender category and do not ask about sexual orientation (Addis et al., 2009; Mule et al., 2009, Statistics Canada, 2014c). Finally, there is a tendency for both Aboriginal and LGBT health research to exclude transgender and two-spirit stories. Most notably in Canada, Young’s (2003) review on Aboriginal health does not mention two-spiritedness at all, while Brotman, Ryan, & Cormier (2003) revealed that most research that says it includes bisexual and transgendered people often does not. The following discussion touches on areas of current research in the LGBTQ2S community. Wherever possible, the most scholarly work is used, however in parts this literature review utilizes the grey literature.

### 2.2.1 Areas of Current Research

Knowing that research on LGBTQ2S privileges certain viewpoints and is usually biomedical, it is no surprise that literature on HIV/AIDS prevalence and care is the most discussed topic regarding two-spirit health. Research on LGBTQ2S Aboriginal health in Canada exists largely in the grey literature, with some exceptions, and features small sample sizes. However, research on LGBTQ2S Aboriginal health is much more prevalent in scholarly literature in the United States, while also utilizing larger sample sizes and more diverse findings. While Canada and the United States have different colonial experiences and healthcare systems,
the marginalization of LGBTQ2S Aboriginal people is spoken about in the same way, as both Canadian and American LGBTQ2S Aboriginal people report higher incidences of HIV/AIDS and drug use and acknowledge the intersectional oppression facing the LGBTQ2S population (Ristock, Zoccole, & Passante, 2011; Simoni et al., 2006; Balsam et al., 2004).

2.2.1.1 Two-Spirited Health in the United States

Research on Native American two-spirits tends to focus on mental and sexual health in urban areas and contrasts two-spirit health with the health of the heterosexual Native American population. One of the largest studies on two-spirit health comes from Chae & Walters (2009), who collected data from 447 participants via a three to four hour online self-interview on the relationship between racial discrimination and self-rated health among two-spirited people. While the data cannot be perceived as indicating a causal relationship, those who experienced racial discrimination were more likely to report physical pain and impairment (Chae & Walters, 2009). Chae & Walters (2009) offer several reasons for this relationship – including a biological stressor effect – and conclude that racial discrimination is shifting from hate crimes towards microaggressions that can lead to internalized racism. Microaggressions, in their words, are “everyday encounters of discrimination based on race, including verbal, behavioral, and environmental encounters that implicitly or explicitly invalidate, diminish, or assault racial heritage, identity, culture, or experiences” (Chae & Walters, 2009, p. 146). Methodologically, Chae & Walters (2009) privileged racial discrimination over other forms of discrimination (e.g. gender or sexuality), as they hypothesized that actualization may be a buffer for racial discrimination (the idea that if someone has a positive association between their identity and race, then they experience [real or perceived] less discrimination). While their evidence confirms this, their research takes a more important step towards being able to understand and express intersectional oppression.

With regards to wellbeing, several studies have investigated the link between trauma, substance abuse, and mental health. Balsam, Huang, Fieland, Simoni, & Walters (2004) concede that two-spirit issues are invisible in the literature, as research on sexual minorities tends to exclusively focus on European American populations (albeit somewhat counterintuitive, given their influence on Indigenous sexuality). Balsam et al.’s (2004) research suggests – based on a survey of 25 LGBTQ2S Native Americans and 154 heterosexual Native Americans – that two-
spirit participants reported childhood physical abuse at a rate almost twice as high as heterosexual participants, although they found that there were not significantly higher rates of other types of interpersonal trauma. However, the percentage who experienced sexual abuse/assault and incidences of robbery or physical attack was higher for two-spirits, but the low sample size made it difficult to obtain statistical significance (Balsam et al., 2004). Balsam et al. (2004) found that two-spirits had higher rates of lifetime illicit drug use and concluded that may be because two-spirits battle both racism and heterosexism.

Evans-Campbell, Walters, Pearson, & Campbell (2012) utilized the same data set as Chae & Walters (2009), however looked at Residential Schools, substance use, and mental health among two-spirits. Of those 447 participants, 82 attended a residential school, and findings are consistent with Canadian recounts of high incidence rates of mental, physical, and sexual abuse, as well as cultural genocide (Evans-Campbell et al., 2012). However, Evans-Campbell et al. (2012) found that two-spirits who attended residential schools were more likely to have an alcohol abuse diagnosis, more likely to have used illicit drugs, and more likely to have attempted suicide. Further, Evans-Campbell et al.’s (2012) study found that 39 percent of respondents reported being raised by someone whom attended a residential school. Those participants were more likely to have generalized anxiety disorder and to experience PTSD symptoms and suicidal thoughts (Evans-Campbell et al., 2012). Thus, this research confirms intergenerational health and mental health impacts specifically with reference to two-spirits.

Bridging the gap between victimization, substance abuse and sexual health, Simoni, Walters, Balsam, & Meyers (2006) investigate HIV risk behaviours between two-spirit and heterosexual Native American men in New York City. With 20 two-spirit men and 51 heterosexual men surveyed, rates of substance abuse were similar, however victimization and HIV risk behaviour rates were considerably higher in the two-spirit population, including 68 percent of respondents who indicated they did not use a condom in their last sexual encounter (Simoni et al., 2006). Simoni et al. (2006) found that victimization was a statistically significant predictor of HIV risk behaviours, albeit their cross-sectional analysis meant that there was no accurate way to decipher which came first: victimization, HIV risky behaviours, or identification as a two-spirit (Simoni et al., 2006). Research conducted by Burks, Robbins, & Durtschi (2011) in Oklahoma City on HIV risk and barriers to testing concurs with Simoni et al.’s (2006)
research that HIV risk behaviours are common in the community, yet there needs to be more education on reduction and prevention. Burks, Robbins, & Durtschi (2011) added that culturally-sensitive programs were shown to be more effective in Oklahoma City and need to be further implemented as rates of HIV transmission continue to increase among minority populations.

While many American studies have focused on men, Lehavot, Walters, & Simoni’s (2010) study focuses exclusively on two-spirit women and their sense of agency. Combining colonization and oppression, their research interviewed 152 women whom reported high incidence rates of sexual and physical assault: 85 percent and 78 percent, respectively, compared to a lifetime rate of assault of 51 percent for heterosexual Native women and 20 percent for the general population (Lehavot et al., 2010). The study also found that childhood trauma, partner violence, and physical assault acted as predictors for mental health, while multiple traumatized women had poorer health incomes (Lehavot et al., 2010). In addition, Lehavot et al. (2010, p. 54) confirm two-spirit women’s “triply oppressed status” from stigma from both the Native and LGBTQ communities.

2.2.1.2 Two-Spirited Health in Canada (Scholarly Literature)

Specific to Canada, while census data indicates that Aboriginal peoples represent 3.8 percent of the population, they are disproportionately represented in the prevalence of HIV/AIDS, where they make up 7.5 percent of the incidence rate and 9 percent of new HIV diagnoses (Newman, Woodford, & Logie, 2012). Despite how research focuses on HIV/AIDS, new infections in the Aboriginal population come from intravenous drug use (53%) and heterosexual sex (33%) before MSM (10%) and MSM/intravenous drug users (3%), compared to the general Canadian population, where MSM accounts for 45 percent of new infections (Public Health Agency of Canada, 2010).

In Newman, Woodford, & Logie’s (2012) study on HIV treatment acceptability in the Aboriginal communities in Toronto and Ottawa, they interviewed 23 participants, of whom half identified as LGBTQ2S. While they make the argument that HIV treatments are extremely important to be accessible to a community whose infection rate has increased tenfold since 1992; mistrust in health systems, AIDS stigma in Aboriginal communities, and cost were cited as barriers or apprehensions to treatment (Newman et al., 2012). Accompanying these worries,
participants recognized the discrepancies between traditional and Western medicines, and spoke to the fact that Elders suggest taking traditional medicines while doctors do not acknowledge the importance or potential of traditional medicine, despite the occasional ineffectiveness of antiretroviral therapy (Newman et al., 2012).

Taylor’s (2009) work looks holistically at health and safety issues for Aboriginal two-spirit/transgender people in Manitoba. While Taylor’s (2009) research measured safety, HIV/AIDS, and physical health, she looked most in depth at mental health issues. In her study, her Aboriginal participants in Manitoba (n=27) were asked how often they experienced over fifteen indicators of mental health. Taylor (2009) concluded that deep and suicidal levels of depression are much more common among her participants than the general population, with many suffering from loneliness and anxiety.

Beyond research on two-spirit lived experiences, there is some emphasis on culturally-appropriate dissemination (Knowledge Translation as one model) and resources for two-spirited health. Brotman, Ryan, Jalbert, & Rowe (2002) discuss the healthcare experiences of two-spirit people, and acknowledge that health care policy makers and providers know little about two-spirit people, history, and health needs. As a result, they assert that two-spirit people need to play a role in the education process, policy formations, and research frameworks (Brotman et al., 2002). Brotman et al. (2002) place particular importance on reaching two-spirit people in health policy and provision, as they are crucial windows to improving both LGBTQ and Aboriginal health in general.

2.2.1.3 Two-Spirited Health in Canada (Grey Literature)

As emphasized above, LGBTQ2S people are largely absent from the scholarly literature on Aboriginal health. The following is a collection of some of the grey literature, which features theses and publications by governmental and non-governmental organizations.

Jackson’s (2002) thesis looks at the lived experiences of HIV positive two-spirit men in Winnipeg. Jackson’s (2002) research focuses on their lived experiences before, during, and following diagnosis, and found themes throughout the seven men. Prior to diagnosis, Jackson
(2002) reports that the men found difficulty establishing a gay identity, engaging in lasting intimacy, and achieving self-acceptance, however they were more often engaged in carefree sexual activity and finding their Aboriginal identities. Following diagnosis, the men reported feeling contaminated, in disbelief, or a sense of impeding death, with some resorting to substance abuse (Jackson, 2002). Jackson (2002) also speaks to the pressures of coming out twice experienced by the community: coming out once as LGBTQ2S and another time as HIV positive (Jackson, 2002).

While most of the grey literature studies focus on two-spirit men and HIV/AIDS, Aboriginal two-spirit women are also at risk for HIV infection. O’Brien-Teengs (2008) points out that around 60 percent of new HIV infections in the Aboriginal population are women. While two-spirit women may appear to at less of a risk than two-spirit men, O’Brien-Teengs (2008) argues that it is not who you identify as, but what you do – some two-spirit women have sex with men, intravenous drug use is common, and imprisoned women are being infected at a higher rate due to sharing needles for drugs, tattoos, and/or piercings. Ultimately, both two-spirit men and women are at risk of HIV infection in Canada.

Regarding youth, the Youth Migration Project looked at LGBTQ2S migrants to Toronto from both Canadian and international cities. Relevant to LGBTQ2S Aboriginal health, O’Brien-Teengs & Travers (2006) aimed to understand HIV risk among two-spirit youths in Toronto. O’Brien-Teengs & Travers (2006) point out that two-spirit youth in rural or reserve communities have limited role models or a sense of belonging at home (and potentially harassment and discrimination based on their two-spirit identity) and turn to cities to find a safe place. Unfortunately, inequality and discrimination exist within the city, which makes two-spirit youth isolated from both home and urban Aboriginal communities and vulnerable to enter the substance use culture of the urban LGBTQ community or engage in sex work (O’Brien-Teengs & Travers, 2006). O’Brien-Teengs & Travers (2006) also argue that social determinants of health such as poverty, social exclusion, and a lack of education and employment need to be addressed in order to reduce HIV risk and other health problems. Moreover, O’Brien-Teengs & Travers (2006) recognize that two-spirit youth have to access services alongside adults, making the services less relevant to their age and needs. This is particularly important, since migrating youth risk disconnection from their culture (O’Brien-Teengs & Travers, 2006).
In addition to the Youth Migration Project, research by Ristock, Zoccole, & Passante (2011) on the mobility of LGBTQ2S Aboriginal people speaks to push and pull factors of migrating, where HIV status, sexuality, and looking for a sense of an accepting community were the biggest factors among migrants in Winnipeg. Similar to O’Brien-Teengs & Travers (2006) work, Ristock et al. (2011) found that homelessness, drug use, survival sex, and risk of HIV were some of the biggest negative impacts on health. However, Ristock et al. (2011) also point to the positives of moving to the city, including help transitioning (for transmen and transwomen), reuniting with family members, accessing two-spirit positive teachings, and moving away from abuse and discrimination.

Beyond HIV/AIDS and migration, safety and homophobia was another theme that emerged in the literature, although to a much lesser extent. In Zoccole, Ristock, & Barlow’s (2005) study on homophobia in the HIV/AIDS community, 81 percent of participants had been gossiped about, while about half indicated they had been outed, experienced slander, been harassed, or received threats. Meanwhile, 29.8 percent of participants reported being robbed, 38.1 percent physically hurt, and 21.4 percent raped due to homophobia (Zoccole et al., 2005). At one third, around 40 percent, and around one quarter being robbed, hurt, or raped, violence and homophobia are issues affecting two-spirited people.

With regards to advancing the state of two-spirit health, both the National Aboriginal Health Organization (NAHO) and Thoms (2007) provide reports for the public and service providers on working with two-spirited peoples. NAHO’s (2012) literature review publication, “Suicide Prevention and Two-Spirited People,” is designed as a resource for the public and service providers. NAHO (2012) confirms that suicide rates of the two-spirit population are unknown and vary tremendously, however it is understood that rates of related risk factors suggest that the suicide risk is greater than heterosexual Aboriginal peoples. Accompanying this, the intersectional issues of assault, poverty, and other stressors exist. Thoms’ (2007) report on wise practices for HIV prevention in the two-spirit men’s community found that pamphlets and posters were the biggest source of information for HIV-risk and prevention. Thoms (2007) argues that in order to change social norms – in this instance, community homophobia and unsafe sex – it is necessary to spread knowledge in the way that reaches the most people. Thoms (2007, p. 36) found that the awareness strategy for Aboriginal AIDS is not realistic enough, as
participants pointed out that some of the people featured in the posters “[do not] appear to have gone through a life of hell and abuse,” and therefore are not relatable.

These best practices for service providers are also confirmed elsewhere in the grey literature. Zoccole, Myers, & Day (2005) found that men who are accessing AIDS services prefer to go to an Aboriginal service provider for testing or treatment due to the connection to culture and community. Newman et al. (2012) argued that that Aboriginal right to self-determination with regards to treatment for HIV/AIDS must also be recognized. As such, when talking about vaccination, it is necessary that people in the community know that they can abstain (Newman et al., 2012).

In addition to culturally-relevant resources, the literature also highlights how to improve service provision. Zoccole, Ristock, & Barlow’s (2005) environmental scan on homophobia had participants suggest improvements for reducing homophobia in Aboriginal and non-Aboriginal organizations. Increasing two-spirit/gay-positive staff visibility, increased training/workshops, increasing cultural awareness, and more funding were seen by the community as effective ways to reduce homophobia (Zoccole et al., 2005). However, Everett, MacFarlane, Reynolds, & Anderson (2013) point to the challenges of LGBTQ2S peoples working within their communities as there is a focus in social work and counseling on avoiding “dual relationships,” – that is, living and working within the same community – however that means that two-spirit, transgendered, and queer community is served by ‘the Other,’ or non-community members. While Everett et al. (2013) does refer to two-spiritedness throughout, there are not any specific policy, programming, or service provision recommendations, as they group two-spirited, queer, and transgendered communities together.

While some of the aforementioned studies do take place in Toronto, no one study on Aboriginal people in the city is more comprehensive or holistic than the Toronto Aboriginal Research Project (2011), as it utilizes a sample size of 1,424 and covers all demographics (men, women, youth, children, Elders, and two-spirits), various urban challenges (housing, employment, mobility, poverty, homelessness, governance), and features 58 recommendations to improve well-being for Aboriginal people in Toronto. The report was commissioned by the Toronto Aboriginal Support Services Council – a research and advocacy organization consisting
of the 9 of the main Aboriginal service organizations in Toronto (as discussed in Chapter 4). While representatives from these 9 organizations govern TASSC, it is important to note that the TARP report features the experiences of people from these organizations as well as many others, most notably Anishnawbe Health (the main Aboriginal health service provider). In essence, McCaskill et al. (2011) – the authors of the TARP report – achieved a sample size of 1,424 using 6 different recruitment methods, including surveys (n=623), interviews (n=436), and focus groups (n=242) and – to a lesser extent – case studies, photovoice, and life histories.

Representing the largest study ever conducted on Aboriginal services in Toronto, it also provides the best and most recent investigation into two-spirits in Toronto, which occupies an entire chapter in the report.

Key findings from the Toronto Aboriginal Research Project (2011) on two spirits revolve around the following themes: i) a dearth of literature on two-spirited people and two-spirits in Toronto; ii) there is a large income gap within the two spirited population (where some are highly marginalized and others are very successful); iii) the majority of two-spirits are from a rural or reserve area, and have experienced homophobia and discrimination; iv) two-spirits need acceptance from the Aboriginal community and mainstream society to flourish in Toronto; v) transgendered two-spirits are particularly marginalized within the community; and vi) two-spirits have significant health concerns; and vii) more training and information is needed to provide adequate services in Toronto (McCaskill et al., 2011).

While these findings are significant, only eighteen respondents identified as LGBTQ2S across all surveys, interviews, focus groups, photovoice, and life histories. Even though this is a relatively large sample size for research on LGBTQ2S Aboriginal people in Canada, the multiple-methodologies makes it challenging to analyze the results holistically and make broader recommendations, since the methodological tool is not uniform. This is especially apparent as McCaskill et al. (2011) completed focus groups and life histories with 4 of the 18 people, which then forms the basis of the chapter on two-spirit people in Toronto (negating 14 other responses). As a result, the authors recommended “that a comprehensive research project be undertaken focusing on gaining a greater understanding of the issues and concerns of the two-spirited community including the middle class, transgendered and HIV positive individuals” (McCaskill et al., 2011, p. 28). Furthermore, the broader Aboriginal community sees two-spiritedness as a
core issue – 80 percent of survey respondents (n=185) suggested there was a lack of safe spaces or events for two-spirited people in Toronto, while 87.9 percent of respondents (n=174) said that there were gaps in services for urban Aboriginal two-spirit and transgendered people living in Toronto (McCaskill et al., 2011).

Overall, the research on LGBTQ2S health and wellbeing in Canada is limited, oftentimes manifesting in biomedical research (like most research on LGBTQ health) without acknowledging the lived experiences of the people they are researching. This is especially important to examine, considering the demography, rapid urbanization, and mobility of Aboriginal peoples, and an overwhelming recognition by the Aboriginal community that there are service gaps and a lack of safe spaces for LGBTQ2S Aboriginal people.

A key distinction must also be made here – the research tends to only refer to LGBTQ2S Aboriginal people as two-spirit or two-spirited, which negates other forms of gender and sexual identity. This is particularly important given how gender and sexuality has been colonized, and that there are conflicting opinions over both the term two-spirit and the fact that LGBTQ is based on a Western gender binary. In an effort to mitigate these gaps, generate these safe spaces, and include all LGBTQ2S perspectives, this research aims to provide a comprehensive overview of LGBTQ2S migration and current health and wellbeing in Toronto, with an emphasis on understanding urban LGBTQ2S lived experiences and associated strengths and challenges. This is in direct response to the calls from the community to improve service provision and build capacity in an era of rapid urbanization of Aboriginal peoples to cities.

2.3 Critical Population Health Theoretical Framework and Research Questions

In thinking about the discrepancies between Aboriginal and non-Aboriginal people’s health, population health seeks to understand why some people are healthier than others (Young, 2004). Today, we understand health as a product of many determinants, not simply a result of genetic or biological factors or access to healthcare. Canada officially recognizes 12 determinants of health: i) income and social status; ii) social support networks; iii) education and literacy; iv) employment/working conditions; v) social environments; vi) physical environments; vii) personal health practices and coping skills; viii) health child development; ix) biology and
genetic endowment; x) health services; xi) gender; and xii) culture (Public Health Agency of Canada, 2011). While these determinants do consider health holistically, they are not met without criticism. In particular, scholars have continued to advocate for housing (explicitly and holistically, not as a product of physical environments and income) and Aboriginal status as determinants, which is especially relevant in a Canadian context (see Raphael 2004; NAHO, 2010). As de Leeuw & Greenwood (2010, p. 67) argue, “social determinants cannot be unhinged from characteristics such as gender, geography, age, and indigeneity,” to which I would also add sexuality and sexual identity. In thinking about the impacts of colonialism on gender and sexuality, a theoretical framework cognizant of colonization and the social determinants of health has been adopted, informed by ideas of intersectionality (as outlined in de Leeuw & Greenwood, 2010) but rooted in critical population health (as outlined by Labonte et al., 2005).

As de Leeuw and Greenwood (2010) articulate in Beyond Borders and Boundaries: Addressing Indigenous Health Inequities in Canada through Theories of Social Determinants of Health and Intersectionality, we must acknowledge that the Indian Act does alter how Aboriginal people access the healthcare and social services systems. Within that then, de Leeuw & Greenwood (2010, p. 61) highlight that the Indian Act and other colonial forces (namely the reserve system) should “be conceptualized as a determinant of the twenty-first-century health status experienced by indigenous peoples in Canada.” Intersectionality, as they define, “wrestles with, and attempts to explain, how socio-culturally constructed categories (…such as gender, ethnicity, and sexual orientation) interact with and affect one another to produce differentially lived social inequalities among people” (de Leeuw & Greenwood, 2010, p. 55). The goal of intersectionality – in this context – is to understand how forms of Otherness create different realities, and how these realities may be marginalized, privileged, or exclusionary (de Leeuw & Greenwood, 2010). In thinking about this research, we need to acknowledge that all participants are informed by different lived realities, and have intersectional identities intimately bound up in sexuality, Indigeneity, gender, and the other social determinants of health. This was confirmed in the literature, where Chae & Walters (2009) and Balsam et al. (2004) argue that LGBTQ2S people battle both racism and heterosexism, and NAHO (2012) makes the argument that intersectional oppression – and subsequently rates of risk factors – lead to an elevate risk of suicide. This is particularly true for women, where Lehavot et al. (2010, p. 54) refer to LGBTQ2S Aboriginal women as “triply oppressed”
In an effort to evolve the social determinants of health/population health framework (and encompass more elements of intersectionality), Labonte, Polanyi, Muhajarine, McIntosh, & Williams (2005) lay out a new theoretical framework: critical population health. In this framework, Labonte et al. (2005, p. 10) articulate two twinned goals of critical population health:

“i) a thorough going deconstruction of how historically specific social structures, economic relationships and ideological assumptions serve to create and reinforce conditions that perpetuate and legitimize conditions that undermine the health of specific populations; and

ii) a normative political project that, as a result of deeper understanding, seeks the reconstruction of social, economic and political relations along emancipatory lines.”

In the context of this research, we need to understand and deconstruct colonially-embedded ideas of gender, sexuality, and the determinants of health, for they reinforce and undermine existing steps towards improving LGBTQ2S wellbeing. Furthermore, we need to reconstruct these ideas, and support the LGBTQ2S population to ultimately have better health outcomes and health equity for all. In order to best do that, the following research questions are posed:

1. What are the migration experiences of LGBTQ2S Aboriginal peoples in Toronto?

2. How do these lived realities intersect with access to housing, employment, culture, community, and service provision?

This research is aligned with what de Leeuw & Greenwood (2010, p. 57) argue about intersectional identities, that “these social realities are lived, in various configurations and to varying degrees, as embodied and individualized realities: and they are lived differently depending on the “who’s” and “how’s” of the person experiencing them. Geography, gender, age, background, and class cannot be excluded from understandings of the socio-cultural and health inequities of indigenous peoples.” By orienting this research in critical population health, we can make the biggest strides towards reconciliation and filling the policy, programming, and services gap.
Chapter 3
Methodology

3.1 Research Setting

This research was conducted in Toronto, Ontario. Approximately 80 percent of Aboriginal people live in only half of Canada’s ten provinces – Ontario, British Columbia, Alberta, Saskatchewan, and Manitoba – while 34 percent of the urban population can be found in only 5 cities: Winnipeg, Edmonton, Vancouver, Calgary, and Toronto (Statistics Canada, 2014b; 2010). Despite being one of the top five cities, Toronto has a low population of Aboriginal people relative to the number of people in the city (36,995 Aboriginal people vs. 5,583,064 people in Toronto, using 2011 numbers, or less than 1% of the total population) (Statistics Canada, 2014). This is especially low when compared to Winnipeg, which has the highest relative and absolute number of Aboriginal people, with 78,420 Aboriginal people, compared to 730,018 total residents, or approximately 11% of the population (Statistics Canada, 2014). However, service providers in Toronto speculate that the Aboriginal population is underestimated. According to the City of Toronto (2015), 2006 estimates by service providers indicate that Toronto was home to approximately 70,000 Aboriginal people, estimates later confirmed by the Toronto Aboriginal Research Project (2012) and the Urban Aboriginal Peoples Study (2010).

The underrepresentation of Aboriginal people in Toronto in census data speaks specifically to the urbanization and mobility of Toronto’s Aboriginal population. From 2001 to 2011, Toronto’s Aboriginal population nearly doubled, with a growth rate of 82 percent (Statistics Canada, 2001; Statistics Canada, 2013). Ultimately, this makes Toronto the home of 3 percent of all Aboriginal people in Canada, despite having a lower proportion of Aboriginal people compared to other cities (Statistics Canada, 2014a). Thinking about mobility, Clatworthy & Norris (2013) acknowledge that from 1996 to 2001, Toronto experienced the highest net migration of all major Canadian cities, with an annual outflow of 19.6 migrants per 1,000. However, Toronto also had an annual growth rate of 46.2 per 1,000, which Clatworthy & Norris (2013) indicated as one of the highest rates of Aboriginal population growth across Canadian
cities. Combining rapid growth and mobility, ultimately obtaining a true “count” of the number of Aboriginal people in Toronto has been challenging for researchers. As a result, given the intensive urbanization and mobility that Toronto’s Aboriginal population experiences, as well as how this underrepresentation of the population might affect service availability, funding, and provision, there is a great potential for research to have an impact on Toronto’s service landscape, which makes Toronto the ideal place to conduct this study. Moreover, it is particularly important to consider LGBTQ2S narratives in these conversations, as they represent a new and unique perspective to the field of urban Aboriginal mobility.

### 3.2 Indigenous Methodologies as a Methodological Framework

Historically, research has mistreated and misrepresented Aboriginal people in Canada, and has done so using Western (colonized) methodologies and researchers. It is argued that this led to a devaluation of traditional knowledge, the perpetuation of racism, colonialism, and oppression, and the commodification and mystification of Aboriginal peoples (Louis, 2009). Anchored by Smith’s (1999) *Decolonizing Methodologies*, Indigenous scholars called for a decolonization of research. As Smith (1999, p. 39) best explains:

> “The methodologies and methods of research, the theories that inform them, the questions which they generate and the writing styles they employ, all become significant acts which need to be considered carefully and critically before being applied. In other words, they need to be “decolonized.” Decolonization, however, does not mean and has not meant a total rejection of all theory or research or Western knowledge. Rather, it is about centering our concerns and world views and then coming to know and understand theory and research from our own perspectives and for our own purposes.”

This research uses a decolonized framework (discussed below), and centers Indigenous voices as often as possible in order to do that. Today, there is an increasing and established scholarship in decolonizing and/or Indigenous methodologies (see Louis (2009) for an overview of many of these conversations). The result is a total rethinking of the best practices of Indigenous research, which this research subscribes to.
However, Indigenous and decolonized methodologies\(^8\) are not prescriptions – they are meant to be relative to and reflective of the community you are working with. Indigenous methodologies think about knowledge in an alternative way; they are dynamic and primarily concerned with ensuring that research involving Aboriginal people is accountable, aware, and ethical (Louis, 2009; Smith, 1999; Kovach, 2009). Many Indigenous methodologies center on the longstanding notion of the four Rs of Indigenous research – respect, relevance, reciprocity, and responsibility (Kirkness & Barnhardt, 1991). This means that Indigenous methodologies tend to favour qualitative methods, for they challenge the positivistic past of Aboriginal research in favour of discussing issues of power, representation, and the construction of knowledge (Evans et al., 2009).

### 3.3 Research Design

This research is a product of the conversations on decolonized and Indigenous methodologies. This research situates itself at the intersection of community-based research and Indigenous methods in order to be culturally informed and relevant throughout the entire research process. While Aboriginal health research tends to rely on Western and biomedical models of research, this research attempts to bridge both of these worlds by comprehensively engaging with the Aboriginal community throughout the process and representing the data in both Indigenous and Western ways. It is important to note here that this research was conducted in three overlapping phases – Phase I, which was the research design phase and included engaging with community members, elders, and service providers, Phase II, which included data collection, and Phase III, which focuses on Knowledge Translation (KT).

#### 3.3.1 Phase I

As proposed by Kovach (2009) and Smith (1999), elders and community members should be involved in all aspects of an Indigenous research process. During Phase I, every effort was made to establish a respectful relationship with future participants, service providers, elders,

\(^8\) I use these terms interchangeably for two reasons, i) to acknowledge the immense contribution of Smith’s (1999) *Decolonizing Methodologies* to research; and ii) to acknowledge that Indigenous methodologies is now the “go-to” term that encapsulates Indigenous-centric methodologies.
and other community members throughout the duration of the research project. Before commencing, I met with an elder to talk about the project, which confirmed the need for research that strengthened the LGBTQ2S community. I also conversed with service providers, including 2-Spirited People of the 1st Nations, the 519 Community Centre, and the Native Canadian Centre of Toronto, to talk about the potential for researching LGBTQ2S Aboriginal mobility and service provision. Connecting with many key informants early on in the research invites the opportunity for feedback and improvement, and also creates the most relevant research project for the community (Kovach, 2009). In terms of this research, these conversations ended up forming the basis for the first draft of an interview guide, as well as suggested the need for exploratory research that encapsulated many different LGBTQ2S perspectives. Aside from engaging service providers and elders, I also connected with community members, most notably presenting my research proposal at the Urban Indigenous Teaching Symposium, a community conference hosted by the Native Canadian Centre of Toronto and the University of Toronto. Furthermore, I also conversed with many scholars on Indigenous research at the Toronto Aboriginal Support Services Council’s Conducting Research with Urban Aboriginal Peoples symposium. At both events, I received positive yet critical feedback, which ultimately shaped the project.

Concurrent to this, I formed a partnership with the Native Women’s Resource Centre of Toronto (hereafter referred to as NWRCT). As one of the main Aboriginal service providers in Toronto, the NWRCT provides employment, housing, education, and cultural programs and services, with a particular focus on women. However, the NWRCT explicitly acknowledges that if you are two-spirited, you are welcome to access any and all services there. This makes the NWRCT an important first point of contact for many two-spirit migrants, and an absolutely essential research partner for this research project. Furthermore, the NWRCT was consistently acknowledged as the most welcoming place for LGBTQ2S Aboriginal people in Toronto, a high commendation from participants.

The NWRCT was influential in developing this research project, as recommended by Indigenous methodologies. They immediately recognized the need for research on how to better serve the LGBTQ2S community, which they felt they were not addressing enough in their current programming. At this point, some of the themes that shaped the interview guide began to
emerge. The community wanted to know more about LGBTQ2S access to housing (many service providers provide housing assistance in various forms, yet it is still a big need), employment (the community acknowledged a large gap between the Aboriginal middle and lower classes), and service provision (how do LGBTQ2S people access services?). Furthermore, the community expressed interest in experiences of discrimination and safety, as many community spaces were ‘safe spaces’ in theory, but perhaps not in actuality. Last, the community was interested in knowing about sense of culture and community to know if LGBTQ2S Aboriginal people had a similar or different interpretation of access to culture, especially given Indigenous ideas of gender and sexuality. Further, these trends needed to be considered in light of Toronto’s Aboriginal migration and urbanization patterns, as they affect service provision through funding allocation, space, and programming.

In the end, NWRCT approved and shaped the interview guide, compensation amount ($30.00 plus two tokens), consent forms, and participant recruitment materials, as well as provided space for the interviews to occur. I made myself known around the centre throughout recruitment, by being present at the centre’s events and stopping in for lunch on several occasions, and developed a friendly relationship with staff members and clients. I also received training in Indigenous Ways to Build Relationships with Women and Youth (offered by NWRCT) prior to commencing interviews.

3.3.2 Phase II

The interview guide was created gradually over the course of several months for two reasons: i) so I could ease my way into the community and develop trusting relationships with stakeholders; and ii) to develop the most relevant research project based on the conversations in Phase I. Interviews were semi-structured and in-depth, with questions that focused on personal narrative. Using interviews as a method for researching marginalized peoples allows interviewees to tell their own story in their own words, giving the interviewer an in-depth account of lived experiences (Valentine, 2005). Due to the past exploitation of Aboriginal

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9 This is not to imply that all participants were marginalized or would identify as marginalized. Rather, this is just to suggest that within a critical population health framework, we must consider the historical, intergenerational, and contemporary impacts of colonization, which have and continue to marginalize Aboriginal people in Canada.
peoples in research, interviews are also seen as a way to balance power differences since the researched are seen as the knowers (Chilisa, 2009).

Interview questions (see Appendix 1) are based on a life story model that is increasingly common in Indigenous methodologies, where the interviewee sets the pace of the conversation while the interviewer probes, clarifies, listens, and occasionally redirects conversation using predetermined questions (Chilisa, 2009). This conversational approach aligns with Indigenous methodologies as it honours oral tradition as a method for knowledge exchange, and is “relational at its core” (Kovach, 2010, p. 40). This resulted in building interview relationships that were personal, based on trust, and mutually respectful. As two participants illustrated, this conversational and relational method succeeded in making participants feel comfortable and connected:

“[conversations with service providers] should be as comfortable as the exchanges you and I are doing.” (Margaret)

“Even right now if you think about it, you know, because we are both two-spirited. There is a connection there, and when we are in ceremony it just makes it stronger. Things come forward, what is supposed to come forward I guess.” (Tim)

Interviews questions revolved around six main themes related to LGBTQ2S Aboriginal people in Toronto. First, participants were asked about their experiences with migration and moving. Second, they were asked about their experiences finding a sense of community and culture, with a focus on their intersectional identity as both LGBTQ2S and Aboriginal people. From there, experiences of discrimination and safety was focused on, particularly because it was raised as a concern throughout Phase I. Fourth, questions on housing and employment gauged the success of LGBTQ2S Aboriginal migrants. Finally, services took the forefront, and participants were asked about their service experiences, including their satisfaction with mainstream and Aboriginal services. The interviews culminated with a discussion on recommendations for service provision in Toronto. Having a holistic and exploratory interview guide meant that the research would encapsulate the general picture of LGBTQ2S Aboriginal wellbeing in Toronto, which was a recommendation from service providers in Phase I.
### 3.3.3 Phase III

Kovach (2010, p. 46) argues, “reciprocity, so integral to Indigenous methodologies, begins at the preparation phase (not completion).” As a result, Phase III (Knowledge Translation) is a work in progress. The intention for reciprocity was established in Phase I by generating a relevant, original, and useful research project that would benefit the community. Currently, efforts are underway to disseminate findings with the community members at NWRCT, as well as knowledge translation documents (infographics and information on upcoming community events) are being prepared to distribute to interview participants. With over 50 different service providers acknowledged throughout the interviews, conversations are underway regarding how to best inform these service providers (especially those with negative service reviews) on the LGBTQ2S Aboriginal population in Toronto. Most recently, I have been working with the strategic planning process of 2-Spirited People of the 1st Nations, and will continue to advocate for LGBTQ2S service provision improvement in Toronto, including advertising the 2-Spirited Peoples of the 1st Nations Annual General Meeting in KT documents for participants.

### 3.4 Data Collection and Participants

Purposeful sampling was used to gather the most ‘information-rich’ perspectives (Patton, 2002). Even though purposeful sampling is non-representational, it allows the researcher to gain an in-depth understanding of the research, as opposed to a breadth of understanding (Palinkas et al., 2015). As a result, this research aimed for saturation instead of generalizability, so that the most comprehensive understanding of LGBTQ2S Aboriginal migrants in Toronto could be understood within the confines of a thesis timeline (Palinkas et al., 2015).

In order to ensure that the best information was being received from participants, recruitment was limited to strict criteria. Participants had to self-identify as being Aboriginal, First Nations, Inuit, or Métis, as well as either lesbian, gay, bisexual, transgendered, queer, intersex, or two-spirited. Given that not everyone identifies as two-spirit and the general newness of the term, using LGBTQI2S-friendly language allowed the research to reach as many people as possible. Participants also had to be over the age of 18. Finally, participants had to have lived other places aside from Toronto, although it was not restricted to any timeline (i.e., recent migrants). This meant that participants were able to speak to the change in Toronto’s LGBTQ2S
Aboriginal services landscape holistically and historically.

Participants were initially recruited primarily through posters but also through word of mouth. The recruitment poster (see Appendix 2) was posted at services organizations throughout Toronto (with permission). This included Native Women’s Resource Centre, the Native Canadian Centre, the ENAGB Youth Program, Anishnawbe Health, the 519 Community Centre, Miziwe Biik, and Sherbourne Health Centre, and were replenished frequently. Other participants referred approximately 50 percent of participants, which confirms that snowball sampling is a successful tool for recruitment with marginalized populations (Ristock et. al., 2011). To facilitate this, participants were asked at the end of every interview if they could think of someone else who would be eligible and willing to participate. If so, copies of recruitment materials were given to participants.

Once a participant indicated their interest in participating (through phone, e-mail, or in person), a letter of information was provided about the study, which indicated the study’s overview, confidentiality measures, and benefits and risks to participating, as well as that there were no consequences for withdrawal or not answering a question (see Appendix 3). Participants were encouraged to ask any questions to the researcher at that time. If the participant was still interested, a mutual time and place was set up to meet for an interview. The University of Toronto’s Research Ethics Board approved this research, and informed consent was received from all participants. Participants could consent verbally or in written form – all but two participants gave written consent (see Appendix 4 and 5 for forms). No participants withdrew from the study.

In an effort to mitigate any risk or harm to participants, all but one interview was held at NWRCT. The interviews were held in a private space located on the second floor of the building, away from any windows and the rest of the centre’s activities. Conducting interviews at the NWRCT also meant that participants had access to on site social workers – including housing and employment counselors – who could help with any unresolved feelings that the interviews may have brought up. At the end of the offsite interview, the participants was asked if they wanted to be escorted somewhere or to make a phone call, but they declined.
Table 3.4 – Demographic, Mobility, and Socioeconomic Characteristics of Participants

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<tr>
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<td>Unemployed</td>
<td>Market Rent</td>
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<tr>
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</tr>
<tr>
<td>Small Town/Rural Area</td>
<td>Two</td>
</tr>
<tr>
<td>GTA</td>
<td>Three or more places</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>Including: the Maritimes, Manitoba, Montreal, Calgary, Vancouver, and the United States</td>
</tr>
<tr>
<td>City within Ontario</td>
<td></td>
</tr>
</tbody>
</table>

With permission, all interviews were digitally recorded (audio only) for the purposes of transcription later on. While it was initially the intention for the researcher to take notes throughout the process, I found it easier to utilize active listening and a conversational method if I was fully present in the conversation instead of taking notes. Interviews were transcribed.
verbatim and were compared to the digital recording for accuracy prior to deletion of the recordings. In total, 22 interviews with LGBTQ2S migrants were conducted, as depicted in Table 3.4. These interviews varied in length from 45 minutes to two hours and were conducted in person throughout January, February, March, and April 2015. Monetary compensation ($30) plus two tokens were provided for participants, as recommended by the NWRCT.

3.5 Data Analysis

This study was exploratory in nature, and therefore grounded theory was utilized. Grounded theory can be seen as “a tool of decolonization,” since it involves analytical, open-ended, and flexible inquiry (Denzin, 2010). Furthermore, grounded theory relies on finding the interrelationships between participants, theories, and themes, and inherently labels research as important if it is important to the participants, which results in generating relevant solutions (Bainbridge, Whiteside, & McCalman, 2013). In doing this, open, axial, and selective coding was utilized. Open coding occurred alongside transcription when transcriptions were proofed for accuracy. This allowed the researcher to make some margin notes on words and phrases in context, especially because of the conversational style of interviews, which meant that sometimes sentences were disjointed. Open coding also allowed the researcher to note any broad themes. From there, axial coding was used to integrate some of these broader themes, and interviews were coded around themes and subthemes (Corbin & Strauss, 1990). As recommended by Cope (2005), codes were checked over for any missed data frequently, and were also analyzed in the context of the research questions before drawing conclusions through selective coding. Selective coding was used to tie the story together of the themes that emerged in the first two steps, which allowed for this research to be rooted in critical health geography and intersectionality (Mills, Durepos, & Wiebe, 2010). Data organization and coding was completed using NVivo 10.

3.6 Evaluation of Research Methods and Positionality

3.6.1 Research Methods

Several scholars have cautioned against using grounded theory alongside Indigenous methods (namely Kovach (2011) and Smith (1999) because of the colonization of methodologies). As Denzin (2010, p. 298) bluntly states, “critical theory, and GT, without
modification, will not work within indigenous settings.” Here, Denzin (2010, p. 298) is referring to both the need to decolonize research and institutions, but also fixates on “GT’s concerns for data, basic underlying social processes, and causal narratives may not accord with the pressing social justice concerns of indigenous persons.” Knowing this, grounded theory needs to encapsulate localized and lived realities, and ultimately be rooted in social justice. Charmaz (2006) outlines four criteria – credibility, originality, resonance, and usefulness – for doing just that; these criteria are also addressed in Indigenous methodologies, and reinforced throughout this chapter and the entire thesis. In agreement with what Kovach (2011) argues, this research sees grounded theory as a subset of Indigenous methodologies, rather than grounded theory as the overarching ideology with Indigenous methodologies as one component.

However, privileging Indigenous methodologies is not without criticism. Kovach (2010) criticizes and cautions researchers on using the conversational method (despite her using conversations extensively). Kovach (2010) suggests the importance of preparation, that is, knowing the supports available for your participants if they become upset, and acknowledging that you, the researcher, might also become triggered. I anticipated that participants might (and did) become upset, but I did not think about my own self-care in the process. As Kovach (2010, p. 47) states, “stories have the power to holistically engage. Allowing time to process stories is a way of respecting self and others.” It was challenging to balance processing stories and taking another interview; occasionally another eligible participant would come up to you immediately after I listened to one story. Considering the socioeconomic characteristics of the study’s participants (some did not have regular access to a phone or e-mail), it was a tough judgment call to choose between respecting a story and hearing another, which meant that some stories could never be heard. Here, I would like to acknowledge and respect those voices that did not make it into this thesis.

Kovach (2010, p. 47) also speaks to the difficulty of analyzing the conversational method of interviews – which also makes grounded theory analysis even more difficult. In particular, coding the data can be challenging, since the conversational method tends to create highly contextualized and detailed stories. When necessary to fragment the data, this places the researcher back in power, since they determine the outcome of the analysis, and can opt to fragment their story or present it as a whole. This also creates confidentiality challenges, which – in places – I have chosen not to use pseudonyms, as otherwise one’s story could foreseeably be
weaved together. It must also be acknowledged that using software such as NVivo means that the researcher and computer program have a relationship, and it is up to the researcher to use their reflexivity to acknowledge the program’s biases and scripts (Schiellerup, 2008).

However, knowing these criticisms of Indigenous methodologies and grounded theory, and having an overview of this research, this research has made every effort to showcase varying perspectives, acknowledge themes that were peripheral, and use direct quotes, wherever possible. By doing this, it is up to the reader to gauge if analysis is sufficiently supported, however, it also means that all participants’ voices are truly highlighted.

Furthermore, it is important to be transparent regarding if this research is true “Indigenous methodology.” Certainly, this research has been informed by leading scholars in the field (namely Kovach and Smith) and has followed many of their recommendations such as engaging community service providers, forming partnerships, utilizing conversational, anti-oppressive interview techniques, and beginning knowledge translation from Phase I. However, this research uses a model of health which – while much improved from both biomedical approaches to health research and the social determinants of health – privileges certain ways of sharing information, and occasionally disjoints participants’ stories and narratives. In an effort to mitigate this and continue these conversations, thoughts on combining both Indigenous methods and Aboriginal health models are provided in section 5.3.

3.6.2 Positionality

Today, most research on Aboriginal people is still done by non-Aboriginal people. As a female lesbian settler Canadian who migrated to Toronto, my identity ties in somewhat with my study population. However, intergenerational trauma and the legacies of colonization are not part of my story, history, or memory. Having worked in the Aboriginal community for the past five years both on- and off-reserve, I understand and accept that I will be perceived as a white researcher and my motives will be questioned. I did identify myself as a settler and a lesbian in conversations with participants, and explained my motivations for research at the beginning of every interview if required (only two participants challenged me on this, which was affiliated with past research “not going anywhere”). Otherwise, all participants saw the value in the research.
I borrow from Nicholls’ (2009) three-pronged approach to reflexivity when thinking about my own positionality. Nicholls’ (2009) sees three layers to positionality, i) self-reflexivity, as is common in all research; ii) interpersonal reflexivity or relational reflexivity, which reflects on how one’s identity interacts with institutional and geopolitical aspects of their positionality; and iii) collective reflexivity, which accounts for relationships built among participants and evaluates the conversations as they apply to countercolonial research processes. Utilizing these three prongs, I consistently engaged with reflecting on my own critiques of the research, my relationships with participants, the NWRCT, and other service providers, and the extent to which conversations were beneficial to both research and my participants.

In holistically thinking about evaluating my positionality and research methods, I made every effort to not appropriate participants’ words by emphasizing direct quotations throughout, which also avoids fragmenting one’s story. I consistently evaluated my own positionality [and power] as both a settler and a researcher during the research process, and will continue to break down these barriers throughout Phase III, where all participants requested a summary of research. Ultimately, the goal is to further the research in the community instead of in the academy, in order to also recognize and tear down institutional and geopolitical aspects of positionality as well as countercolonial research processes. To end with a quote from Kovach (2010, p. 47) with an embedded quote by Lynne Davis (2004), who writes extensively on settler-Indigenous alliance-building, the:

“conversational method evokes stories, our own and others. As Lynne Davis states (2004), “Stories cement together generations of collective memory, embodying the historical, spiritual, social, and spatial” (p. 3) Stories have the power to holistically engage. Allowing time to process stories is a way of respecting self and others. It is respectful and ethical. It was important to have general support systems in place while conducting research, this is a part of preparation and care.”

I approached these interviews with care, and will continue to care for them throughout this thesis and beyond. Further, I am grateful that my participants allowed these stories to be cemented here.
Chapter 4
Results and Discussion

The goal of the interviews was to gain an in-depth narrative of LGBTQ2S Aboriginal peoples’ experiences in Toronto, in order to answer the following research questions:

1. What are the migration experiences of LGBTQ2S Aboriginal peoples in Toronto?

2. How do these lived realities intersect with access to housing, employment, culture, community, and service provision?

Throughout the interviews, four key themes emerged surrounding these research questions. First, one’s experience (positive or negative) moving to Toronto is intimately connected to reasons for moving and social networks established or previously existing during the migration process. These networks ultimately influence wellbeing. Second, safe, stable, and affordable housing is perceived as the biggest barrier to employment, wellbeing, and sense of community for LGBTQ2S people. Third, discrimination – with respect to both Aboriginal identity and LGBTQ2S identity – is an ongoing challenge facing these participants. Finally, LGBTQ2S resurgence is ongoing in both the Aboriginal community and the Toronto community, and is spoken about in a very optimistic way by participants; however, services that are culturally-relevant and anti-oppressive are perceived to be missing from the services landscape. This chapter presents an in-depth examination of these four themes. Prior to discussing the themes, an overview of services in Toronto is presented to contextualize the interviews within the service landscape. Following that, I reintroduce the critical population health framework in order to contextualize and organize the results. To conclude the chapter, I push back against social determinants of health frameworks in an effort to recentralize Indigenous narratives and extend models of Aboriginal health.

4.1 An Overview of Services in Toronto
### Table 4.1 – An Overview of Aboriginal Services (TASSC Membership)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Date Established</th>
<th>Services Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native Women’s Resource Centre of Toronto</td>
<td>1985</td>
<td>• Housing support&lt;br&gt;• Advocacy&lt;br&gt;• Employment skills&lt;br&gt;• Education, including literacy&lt;br&gt;• Family programming&lt;br&gt;• Cultural programming</td>
</tr>
<tr>
<td>Native Canadian Centre of Toronto</td>
<td>1962</td>
<td>• Aboriginal education outreach&lt;br&gt;• Seniors and elders’ programming&lt;br&gt;• ENAGB youth program&lt;br&gt;• Cultural programming&lt;br&gt;• Historical programming and tours</td>
</tr>
<tr>
<td>2-Spirited People of the 1st Nations</td>
<td>1989</td>
<td>• Education and outreach&lt;br&gt;• Case management and support services, particularly regarding long-term care&lt;br&gt;• Research&lt;br&gt;• HIV/AIDS awareness</td>
</tr>
<tr>
<td>Aboriginal Legal Services Toronto</td>
<td>1990</td>
<td>• Advocacy&lt;br&gt;• Court workers&lt;br&gt;• Legal clinic&lt;br&gt;• Victim assistance</td>
</tr>
<tr>
<td>Miziwe Biik Aboriginal Employment and Training</td>
<td>1991</td>
<td>• Academic training and bursaries&lt;br&gt;• Employment skills workshops&lt;br&gt;• Various employment initiatives, including small business grants, youth employment, job creation partnerships, and employment assistance</td>
</tr>
<tr>
<td>Native Child and Family Services of Toronto</td>
<td>1986</td>
<td>• Case management&lt;br&gt;• Early childhood education&lt;br&gt;• Summer camps&lt;br&gt;• Youth outreach, education and drop-in services</td>
</tr>
<tr>
<td>Na-Me-Res (Native Men’s Residence)</td>
<td>1985</td>
<td>• Emergency and transitional housing&lt;br&gt;• Outreach services&lt;br&gt;• Mental health support&lt;br&gt;• Life skills program</td>
</tr>
<tr>
<td>Nishnawbe Homes</td>
<td>1984</td>
<td>• Affordable housing provider</td>
</tr>
<tr>
<td>Toronto Council Fire Native Cultural Centre</td>
<td>1976</td>
<td>• Education&lt;br&gt;• The Gathering Place (drop in)&lt;br&gt;• Aboriginal healing and wellness&lt;br&gt;• Child, youth, and family programming</td>
</tr>
</tbody>
</table>

As previously mentioned, there are nine Aboriginal service organizations that are united under the Toronto Aboriginal Support Service Council. The Toronto Aboriginal Support Services Council (TASSC) brings these service providers together in order to collectively raise Aboriginal issues to various forms of government, and advance research, policy, and programming in Toronto (TASSC, 2015).

In addition to the member organizations in TASSC, the other key Aboriginal services organization in Toronto is Anishinaabe Health, which is the main health services provider for Aboriginal people in Toronto and is not included in TASSC membership as its primary mandate is health services, not support services. Anishinaabe Health was established in 1984 and offers holistic wellbeing services, including primary care, mental health and additions, diabetes programming, community health worker training, healing support, oral health, and youth and women’s programming. They are in formal partnership with seven organizations listed in Table 4.1, excluding Nishnawbe Homes and Miziwe Biik. These partnerships between these ten organizations are a significant strength of the Aboriginal community.

It is important to note that these ten organizations represent the largest Aboriginal services organizations in Toronto, but there are more Aboriginal service organizations and many more mainstream organizations that serve Aboriginal people. Regarding health, recently Toronto Public Health, Anishinawbe Health, and the Toronto Central Local Integrated Health Network joined to form the Toronto Aboriginal Health Advisory Circle (Toronto Central Local Integrated Health Network, 2015). The Toronto Aboriginal Health Advisory Circle features eight diverse members representing Toronto’s Aboriginal community, including elder, youth, women, and two-spirit members, with the intention of better informing health services access and delivery in Toronto. This highlights one of the ways in which mainstream and Aboriginal service providers are working together now and in the future (Toronto Central Local Integrated Health Network, 2015). When considering the total number of Aboriginal-specific and mainstream services organizations in the City of Toronto, the result is a – theoretically – rich service landscape for Aboriginal people. However, as introduced in Chapter 2, the existence of an urban Aboriginal “policy vacuum,” has been documented in Aboriginal health and service provision literature.
First appearing in the Royal Commission on Aboriginal Peoples (1996), the policy vacuum was described as “the most critical issue facing urban Aboriginal people”:

“[f]irst, urban Aboriginal people do not receive the same level of services and benefits that First Nations people living on-reserve or Inuit living in their communities obtain from the federal government…. Second, urban Aboriginal people often have difficulty gaining access to provincial programs available to other residents…. Third, … they would like access to culturally appropriate programs that would meet their needs more effectively” (RCAP, 1996, p. 538, cited in Hanselmann, 2001, p. 10).

As the RCAP (1996) elaborates,

“this information and policy vacuum can be traced, at least in part, to long-standing ideas about where Aboriginal people 'belong'. Canadians and their governments seem to believe that Aboriginal people were not meant for city life - or that, if they come to the city, they should live like 'ordinary Canadians'.”

The policy vacuum in action – operating under the assumption that Aboriginal people live in rural or reserve areas – can make urban Aboriginal service landscapes barren, and mainstream Canadian organizations not culturally relevant to Aboriginal peoples. This is especially important to note, given that the majority of the services listed in Table 4.1 have been established for at least 20 years. Despite a longstanding presence of Aboriginal services in Toronto, the Toronto Aboriginal Research Project (2011) found that there are still significant service gaps, especially in education, crisis intervention, prevention and harm reduction, counselling, housing, employment opportunities, social, cultural, and recreation programming, and seniors programming (McCaskill et al., 2011).

While the theoretical richness of the urban Aboriginal service landscape may suggest that we have moved beyond the vacuum, Andersen (2013, p. 58) refers to it in the present day as a “policy coordination vacuum,” and argues that it is not just a service delivery challenge but a jurisdictional challenge: who pays, and at what level of governance? Furthermore, as articulated in Table 4.1, there is also significant doubling of services, which presents other service provision challenges, as many organizations compete for the same funding. As one participant describes, this policy vacuum exists in many ways on the ground, but most often leads to discontinuities in programming and staff:
“What happens is you get funding for a year, we see it all the time, and then you lose that funding, so you know people get comfortable in that space, and then that space is taken away. You know what I mean, and then they felt the disconnect, abandonment issues….” (Cindy, >20 years)

Ultimately, as Cindy highlights, the current programming and policy direction is largely inadequate. As it stands, temporary solutions are created to permanent problems through stopgap programs that exist only because of allocated funding.

Within this, the LGBTQ2S community is no exception to the policy vacuum. McCaskill et al. (2011) repeatedly reinforce the idea that 2-Spirited People of the 1st Nations – the only organization specifically for LGBTQ2S Aboriginal people in Toronto – was initially designed to meet the needs of the HIV+ two-spirit community (which is how their funding is allocated). However, one of the Toronto Aboriginal Research Project’s (2011) recommendations is the dire need for a broader organization (operated as part of or independently of 2-Spirits) that can meet the social and cultural needs of all LGBTQ2S people in Toronto (McCaskill et al., 2011). As Hanselmann & Gibbins (2003) state, “there is, moreover, a legitimate debate over the extent to which urban policy should explicitly recognize Aboriginality; whether there should be programming, for example, for the Aboriginal homeless as opposed to the homeless in general” (cited in Andersen, 2013, p. 58). Discussions around two-spiritedness complicate this further – should there be a space for LGBTQ2S Aboriginal people in addition to spaces for just Aboriginal people? Regardless of this debate, 87.9 percent of respondents (n=174) in the Toronto Aboriginal Research Project said there are gaps in services for urban Aboriginal two-spirited people. In part, the focus of this chapter is to begin to document and understand these gaps.

4.2 Resituating Us: Critical Population Health, Intersectionality, and Indigenous Methodologies

As de Leeuw, Lindsay, & Greenwood (2015) argue, Indigenous peoples have long known that wellbeing is connected to societal factors in addition to biomedical approaches to health. However, these biomedical approaches often dominate non-Indigenous health scholarship, and therefore influence best practices of Aboriginal healthcare. In part, this is because the idea that health can be determined by social circumstances is a relatively recent phenomenon; the concept
has only really been theorized in the past decade as de Leeuw et al. (2015) point out. This new body of literature is referred to as the social determinants of health, and reintroduces health as influenced by a variety of social factors. At last, Indigenous and non-Indigenous understandings of wellbeing have begun to merge.

To date, the social determinants of health literature has attempted to explain some of the reasoning for the large discrepancy between Aboriginal and non-Aboriginal health using determinants such as socioeconomic status, gender, and education (see Greenwood, de Leeuw, & Reading, 2015; Richmond & Ross, 2009; Wilson & Rosenberg, 2002). While the social determinants of health approach occasionally acknowledges colonialism as a determinant of health, de Leeuw et al. (2015) specify that representations of colonialism are inconsistent – and usually at the periphery – and also that the literature is still dominated by non-Indigenous peoples. While this research does not mitigate the latter point, it does intend to consistently emphasize and highlight colonialism’s impact on Aboriginal wellbeing.

In an effort to resituate Aboriginal peoples’ experiences with models of Aboriginal health, recent research has now highlighted colonialism as the largest and most important determinant of Aboriginal health. In doing so, two approaches are often highlighted, Loppie Reading & Wien’s (2009) model of Aboriginal health and Labonte et al.’s (2005) approach of critical population health, as detailed in Chapter 2. It is important to note here that both Loppie Reading & Wien (2009) and Labonte et al. (2005) suggest that structural factors highly impact individual-level health outcomes, which develops and expands upon the social determinants of health (and explicitly situates colonialism as a determinant). This results in a rethinking of much of the literature on social determinants of health, and introduces the idea that two concepts of determinants exist: social determinants of health and social determinants of Aboriginal peoples’ health.

In laying the foundation for the social determinants of Aboriginal peoples’ health, Loppie Reading & Wien (2009) created the Integrated Life Course and Social Determinants Model of Aboriginal Health (ILCSDAH). This model emphasizes colonialism, racism, and social exclusion as key factors that affect health throughout one’s life course, in addition to a variety of other determinants that vary tremendously. The model “depicts life
Figure 4.2 – Distal, Intermediate, and Proximal Determinants of Health

Web of Being:
Social Determinants and Aboriginal Peoples’ Health

Source: Greenwood & de Leeuw (2012)
stages, socio-political contexts and social determinants as nested spheres of origin, influence and impact; each affecting the other in temporally and contextually dynamic and integrated ways” (Loppie Reading & Wien, 2009, p. 25). Loppie Reading & Wien (2009) categorize and expand on the social determinants of health by combining the long-recognized determinants of education, income, employment, physical environments, and health behaviours into one category (proximal determinants), and adding two more – intermediate and distal determinants of health (discussed below). It is important to note here that this understanding of the social determinants of health is situated within a critical population health framework. As Labonte et al. (2005, p. 10, paraphrased) state, critical population health research has two goals: i) to deconstruct historically specific structures and relationships that perpetuate and undermine a specific population’s health; and ii) to reconstruct social, economic, and political relationships in a sphere free from oppression. The ILCSDAH is one proposed way to encapsulate the effects of these historically significant structures and relationships and work towards understanding them with the goal of better health outcomes. As a result, the ILCSDAH can be interpreted as a subset and one model of critical population health.

Using these three new categories of determinants – instead of strictly social determinants of health – allows researchers to understand the “causes of causes” of poor health (Marmot, 2007, p. 13). As Loppie Reading & Wien (2009) specify, there are three different yet often overlapping categories of determinants, as depicted in Figure 4.2.

Proximal determinants of health impact health closely to oneself: health behaviours, physical environments, education, employment and income (and socioeconomic status more broadly) (Loppie Reading & Wien, 2009). Intermediate determinants of health impact one’s health indirectly: health care systems and access, educational systems (beyond educational attainment, factoring in the intrinsic value of education and the cultural relevancy of curriculum), community infrastructure and resources, traditional ties to land and food, and cultural continuity (Loppie Reading & Wien, 2009). Lastly, distal determinants of health affect health from a distance but often in a very pervasive way; distal determinants consider social, political, and economic contexts, such as colonialism, racism, exclusion, and self-determination (Loppie Reading & Wien, 2009).
To date, the ILCSDAH model has been referred to in over 200 publications, most often in the context of articulating the three new categories of determinants of Aboriginal peoples’ health – distal, intermediate, and proximal. This is in direct contrast to strictly “social” determinants of health and/or – as depicted in Chapter 2 – the usually biomedical focus on Aboriginal health. In essence, this model was and still is – groundbreaking in the field of Aboriginal health and Aboriginal health research because of its unique approach and widespread application across academia, the non-profit sector, and governmental organizations.

I use this model throughout this chapter for two reasons. First, this model provides immense transferability to my participants, whom consistently framed their connection to Toronto and their identity in the context of these determinants. This not only helps in organizing this results chapter but also aids in conceptualizing these determinants in a real and very rich research context. In this chapter, these determinants become concrete, tangible, and grounded in participants’ narratives. Second, this model is the most recent and progressive understanding of Aboriginal peoples’ health. As Loppie Reading & Wien (2009, p. 26) state, the ILCSDAH “adds additional layers of abstraction to current Aboriginal health models [and] reflects the reality of what is now clearly understood as a complex and dynamic interplay of social, political, historical, cultural, environmental, economic and other forces that directly and indirectly shape Aboriginal health.” More simply put, Reading (2009) – in a paper published closely after Loppie Reading & Wien (2009, p. A1) – states, “Loppie Reading & Wien (2009)… [showed that] Aboriginal peoples experience health disparities that are simply not explained or understood using mainstream templates for what determines Aboriginal health.” Reading’s (2009) comments extend into what Loppie Reading & Wien (2009) emphasize; the model orients itself in Indigenous understandings of health by emphasizes temporal understandings of health and trajectories of health. This is in direct opposition to mainstream conceptions of health. In using this model throughout this thesis, it is the hope that LGBTQ2S narratives will be highlighted as significantly impacted by all of these determinants, particularly as they apply to the time and space of Toronto.

Most importantly, while these determinants are presented exclusively, they all work together at different levels. As Loppie Reading & Wien (2009, p. 15-20) summarize:
“proximal determinants represent the root of much ill health among Aboriginal peoples, [but] intermediate determinants can be thought of as origins to these proximal determinants… [and] distal determinants have the most profound influence of the health of the populations because they represent political, economic, and social contexts that construct both intermediate and proximal determinants.”

As a result, the ILCSDAH model considers health holistically, and factors in physical, mental, spiritual, and emotional dimensions of wellbeing. This is an integral next step to understanding critical population health as it relates to Aboriginal people in general and LGBTQ2S people specifically.

The use of the word “wellbeing” instead of health above is not explicit in Loppie Reading & Wien’s (2009) analysis, but it is in mine. As the Social Health Reference Group (2004) argues, health is the preferred term for non-Indigenous peoples, but wellbeing better encapsulates the Indigenous view of health as physical, mental, spiritual, and emotional. Here, the SHRC (2004, p. 9) articulates how this translates to mental health, for example:

“The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.”

In an effort to move Aboriginal health research away from biomedical and behavioural understandings of health by focusing on distal, intermediate, and proximal determinants of health, this chapter looks at health as wellbeing, in keeping with Indigenous methodologies. In doing so, this results chapter encompasses proximal, intermediate, and distal determinants of health, and considers physical, mental, spiritual, and emotional dimensions of wellbeing in its analysis. This results in a new approach to thinking about the ways in which LGBTQ2S Aboriginal people come to and experience Toronto.
4.3 Distal Determinants of Health: Migration, Community, and Culture

Distal determinants of health are understood as factors that impact one’s health from a distance. Motivations for Aboriginal urbanization, migration, and mobility are intimately connected to colonialism, exclusion, and racism, which are all noted distal determinants of health (Loppie Reading & Wien, 2009). In many cases, the line between moving to Toronto out of choice as opposed to out of circumstance was blurred for the research participants, which is often acknowledged in the literature (see Clatworthy & Norris, 2013). However, the literature most often addresses those moving from rural or reserve areas to cities instead of those moving from other cities (see Norris, Beavon, Guimond & Cooke, 2004; Wilson & Peters, 2005). As a result, the literature is dominated by polarized narratives, where reserves offer limited opportunity or limited resources, yet a high sense of community and culture, and cities offer more resources and housing, but oftentimes racism and discrimination (King, Smith, & Gracie, 2009; Peters, 2005).

4.3.1 Migration and Colonialism as Distal Determinants of Health

What cannot go unnoticed is that these polarized narratives are constructed by colonialism. The push factors of limited opportunity and resources that are so common in reserve settings and the pull factors to the city of more opportunity and employment are legacies of colonization. As Wilson & Peters (2005) argue, reserves were created to be spatial representations of First Nations peoples; as such, reserves were constructed to be strictly First Nations space, and spaces in between (and far from) were to be settled by non-Aboriginal peoples. Of course, assimilation (education, Christianity, and agriculture, as articulated by Wilson & Peters, 2005) was a part of this spatial imagining of the reserve system. The dichotomy that the reserve system created (reserves as First Nations space, but places where one could be assimilated, and urban areas as settler spaces) resulted in a paradox that would manifest eventually – massive Aboriginal urbanization.

As a result, we begin to understand how colonialism – in part – created Aboriginal urbanization and migration. Moreover, this then becomes a distal determinant of health, for push and pull factors of migration are intimately connected to historical, political, and economic
legacies of colonization. This concept was reinforced by participants, but nuanced by a new viewpoint – LGBTQ2S-specific reasons for moving to Toronto.

Approximately half of the participants (n=9) had lived on reserve at some point in their lives, but only six came to Toronto directly from a reserve. The remaining participants – as expressed in Table 4.1 – came from or had lived across Canada. In addition to the six people that had only ever lived on reserve, only two other people had only lived in one other place aside from Toronto. As a result, fourteen participants have lived in three or more places, and drew many comparisons between Toronto and other cities, towns, and reserves. Moreover, participants expanded upon the usual dichotomy of push and pull factors; however, since only about half of the participants came directly from a reserve or a small town (n=10), the responses were much broader than simply about resources.

While there were a vast number of reasons for migrating to Toronto, opportunities that exist within Toronto were still most often mentioned as the biggest pull factor (n=10). Participants reported feelings of excitement associated with moving to Toronto, as they perceived there were greater opportunities for employment, education, and services availability compared to where they live:

“It is a bigger city, and I figured there would be more, I don’t know, opportunities or places like resources for help and stuff like that. Things that I wanted to do. Schooling and stuff like that.” (Dawn, >20 years)

“I thought it best to come and see what I could do, like instead of having three jobs here and there, waitressing, bartending, like come back and go to school, and figure it out really.” (Tracy, <10 years)

“[There are] better opportunities in regards to like jobs, education, better nutrition [in Toronto].” (Sam, <20 years)

Eight participants explicitly referred to migrating to Toronto for a reason between choice and circumstance, such as court cases, eviction from another place, or lifestyle choice. This unveiled a new – and blurred – migration factor: escaping from a previous life:

“It was kind of a, it wasn’t my intent [to come to Toronto]. It was just circumstance in my life that dropped me off, plopped me out here, and yea…it was just a family court thing,
and I needed to be in town… It entailed me to be here for four years and yea I moved back... but then I had to come back.” (Margaret, <10 years).

“A whole bunch of really bad circumstances forced me back to TO.” (Bev, <5 years).

“So I came to Toronto because I wanted to get away from all that [drugs]. I wanted to start a new life. I wanted to get out of it, and find me, and get clean and sober, that that is what I did, and that is why I am here, going back to school.” (Mary, <5 years)

“Due to my lifestyle out there [old city]. It wasn’t a very good one. I would have probably ended up in jail or dead if I didn’t turn myself around, and get on this bus and come here. So yea it is my lifestyle, like I needed to change it, because I saw, I only thought that’s what life was all about, just alcohol and drugs and crime.” (Tracy, <10 years)

While participants noted many reasons for moving, they also acknowledged the indirect benefits of moving to Toronto. One participant initially reported that she moved to Toronto for work, yet when she discussed her sexuality later in the interview, she recontextualized her motivations:

“That [discrimination] is kind of why I left, because if you went that way [LGBTQ], if you were in any way different, from normal or what society labels as normal, then you were not accepted… I don’t want to tell anybody that I am gay or more gay, leaning towards more being gay, than straight, and you can’t feel comfortable dealing with that, then you tend to come to a place where you can be, and this is where I found that I could do that, and let loose… I was all bottled up inside. I wanted to be who I was, like I wanted to be with a woman, and, but I couldn’t be because society said, no, no, that is not right. That is not cool. You know what I mean, so that kept me in, and bottled up, and then when I got here, it is like, I felt free.” (Linda, >20 years, from a small town)

While this is not to say that the participant was not truthful initially, it connects to the indirect benefits of moving to a bigger city, especially one such as Toronto, which was perceived as open and welcome by participants. This also meant that some participants referred more explicitly to moving to Toronto because of their sexuality; this came up in two participant narratives, both of which were from a reserve:

“I was getting harassed horribly back home in high school [for my sexuality], so I couldn’t even go to school, like it was horrible, and I am a good student. My marks were good, and the only way I could go to school was to come here.”
“I guess going to my own identity and stuff it was too stigmatizing, and it just, I just didn’t deserve it, didn’t feel like being there. It just felt like I needed to grow and go to a bigger city to find myself. So that is what led me to Toronto.” (Cindy, >20 years)

Although not all participants reported discrimination as their main reason for migrating to Toronto, they did identify discrimination on reserves and in smaller cities and towns as a problem:

“Two-spirited people, gay, whatever, lesbian, all that. I never really understood all that like at all, or it was like shhhh – you know when you are from the reserve, it is like don’t talk about that. It is forbidden, you’re not allowed.” (Erin, >20 years)

“There are a few [two-spirited people on reserve], right, and when I go back, I am still seeing bruising there, still seeing the abuse, like sometimes like some of the guys will just drink and beat you up as a two-spirit person. So that is the Western mindset, right, and it is sad, because I was in that position too.” (Jordan, <15 years)

As illustrated above, five different participants reported intolerance as a push factor for LGBTQ2S people. It is important to note that Linda is not from a reserve, but another small town. She further discusses other small towns and cities that are more conservative, which Michael adds to when discussing how he feels safe in Toronto:

“It is really quite conservative. I mean it is almost as bad as Ottawa. Ottawa is another conservative, really conservative city too, and when you grew up in these places, and you feel suppressed being in that environment, and there is nowhere, there is nobody to turn to. What do you do? You hide out, and you keep that stuff suppressed. You keep that sexuality hidden.” (Linda, >20 years)

“Well I think you can just blend into Toronto a bit more. It is just easier to kind of blend in… looser, like nobody will judge you, compared to like a small little place…Ottawa is very conservative, right. So places like Sudbury up north, they are like, you know like Regina, very small, like I think the homophobia is worse there obviously, but like everybody recognizes you as just sort of one thing, right. Either being native or being queer… Toronto is not [like that], I think everybody [all sexualities, ethnicities, cultures] is here.” (Michael, <20 years)

Michael and Linda’s distinctions are important, because it differs from the narrative of reserves as limited opportunity and urban areas as places of opportunity by suggesting that people migrate from other cities. However, particular to the research questions, it differs from
the narrative of only reserve spaces as suppressive towards LGBTQ2S people, but also expands to other places as being oppressive. More than that, cities and towns are spaces separate from highly colonized reserves, and speak to a broader theme that many places (not just reserves, or even small towns, as you see Ottawa, Sudbury, and Regina mentioned) have to go further in welcoming and supporting LGBTQ2S people. Nevertheless, it affirms that Toronto is perceived to be open among the research participants when compared to other places they lived in, and reflects that a main pull factor of Toronto for LGBTQ2S migrants is perceived openness to other cultures, genders, and sexualities.

In thinking about traditional beliefs on Indigenous gender and sexuality as discussed in Chapter 2, the discrimination on reserve seems counterintuitive. However, it is here where colonialism, racism, and exclusion come in to play. When asked why discrimination occurs on reserve, Cindy and Erin attributed this to the traumas associated with residential schools:

“Well I think a lot of it has to do with the residential schools… I think there is a lot of shame that is attached to it [being two-spirited], and I think because, and religion plays a big role. I think people are, because we have been internalized against the Catholic Church and kind of lost a lot of our heritage through all that… after we were colonized or whenever those things happened, it was forbidden to live in those lifestyles. [When] I go back to the reserve, as much as people, yes we know about two-spirit history, they still tend not to practice their culture... then I have talked to survivors of abuse, and I think there is that piece that two-spirit people are looked as predators, right, so that we have to protect our children, or we have to you know what I mean, that we are sexual deviants and stuff, so I think that is a little piece of it somewhere. You know what I mean, so I think that plays a role with a lot of people, and it is shame.” (Cindy, <20 years)

“[talking about an uncle who committed suicide because of his sexuality] I think because it is just a lot of shame based stuff that has come back to you from residential schools and stuff and what happened to you [why LGBTQ2S isn’t as accepted]. A lot of our community members, grandparents really, aunties, uncles, because I think my uncle had a hard time with understanding the sexual whatever, because he was abused by a male priest.”

Motivations for migration for participants are shaped by colonization, racism, and social exclusion. As a result, migration is a distal determinant of health. While each person’s migration narrative is different, the results revealed that participants’ gender and sexual identity added another dimension to migration, especially when it is intersected with Indigeneity. These push
and pull factors shape the circumstances which one enters Toronto, and ultimately influence their narrative as they settle into Toronto, which impacts their wellbeing.

It is important to note here that – in reference to distal determinants of health – Toronto is perceived as a welcoming place for LGBTQ2S people by participants. Aboriginal health research proves that Aboriginal health is lower than non-Aboriginal health (National Collaborating Centre for Aboriginal Health, 2010). However, as participants illustrated above – particularly Cindy and Linda – Toronto gave them a whole new degree of freedom. That freedom directly (and positively) affects their wellbeing and ultimately their health. This was also supported by the fact that the vast majority of participants (n=22) reported that their lives had improved since coming to Toronto.

4.3.2 Discrimination and Racism as Distal Determinants of Health

While participants suggested that Toronto was seen as a place to be free regarding sexuality and gender identity, participants spoke to a larger sense of discrimination, racism, and social exclusion because of their Aboriginal and/or LGBTQ2S identity, which connects to distal determinants of health. Specifically, since colonialism and racism impact health, ultimately instances of discrimination impact health as a distal determinant of health if it is based on colonialism and racism. This manifested most often in concerns about safety and feeling a sense of belonging in their own or other neighbourhoods. In total, seventeen of the participants reported that they experienced discrimination in Toronto, with the majority of discrimination stemming from their Aboriginal identity (n=12). In addition to this, participants acknowledged various forms of discrimination, including how they avoided discrimination based on gender and/or their Aboriginal identity:

“Like I don’t feel as much you know [discrimination], because I am presented as a woman, you know what I mean. I am presented as like the typical ordinary woman.” (Brandy, <5 years)

“I have been called, riff raff, and stuff like that, though that way, but no, not being gay or being native.” (Heather, <10 years)

As Brandy and Heather discuss, they both managed to escape discrimination because of other
identities. Brandy mentions that because she is cisgendered\textsuperscript{10}, she does not experience the same level of discrimination as other LGBTQ2S people. Similarly, Heather’s discrimination aligns with her perceived socioeconomic status (as riff raff or someone living on the margins). Other people’s perceptions of participants were the main source of discrimination for other participants. This most often manifested in discrimination based on Aboriginal identity (n=12), which was often rooted in misconceptions and stereotypes of Aboriginal people:

“I came out as First Nations and I got treated differently, and then got let go [from their job] a week later, because apparently one of the co-workers smelt alcohol on my breath or off of me, and it was hand sanitizer that I had on my hands.” (Jordan, <15 years)

“I was at [a coffee shop]… Some guy came up… he like sat down and just like cracked a beer, and started drinking a beer in [a coffee shop] … then he starts annoying me, and then I go up to the [coffee shop] lady and I am like, ‘listen you have got to get this guy out of here, like he is annoying me, he is bothering me, and he is drinking beer in your restaurant’… And I guess he saw what I was doing and he got pissed off… He got his beer, and stood up to walk away, and he told me to go back to the reserve and he walked out. I am like, seriously? That is the best you have got. Go back to the reserve? As I am sitting here drinking San Pellegrino and you are walking out with a beer in your hand, and I need to go back to the reserve?” (Kaitlyn, <1 year).

“I think regardless of my gender identity, native people are looked at differently as a whole. It doesn’t matter if you are straight, LGBTQ, whatever, native people are still stigmatized for what we are depicted as on TV or the stereotypes that we are all drunks, and we all have addictions and grant it, I do, but I don’t go to bingo all the time. I am not at the casino 24-7. I didn’t grow up on Kraft dinner and wiener, but this still stigmatized of native people, that we are greasy, that we have bugs, or that are like our houses, that we have ten children and our cousins are our cousin’s kid or whatever… that stigma is still very much alive” (Lauren, <1 year).

There was some variation in the transgendered community, as they experienced different forms of discrimination. All transgendered participants (n=6) reported incidences of discrimination, which were more often escalated in participants’ recollections if they were transgendered. This is best summarized in one participant’s story:

\textsuperscript{10} cisgendered refers to someone whom identifies their gender with their sex characteristics.
“I waited eight years to get into [social housing] to find out a week later I was attacked by two guys with a baseball bat, because I was transgendered… I asked about a transfer and they said I would have to stay there at least a year. I am not staying there another eight - nine months. Hell no.”

As the participant illustrates, she was assaulted in her own home because of her transgendered identity, and it directly interfered with her wellbeing and sense of safety and community. Moreover, more than half of the transgendered participants (n=4) spoke to the undermining of their gender identity because of people perceiving them to have opposite gender characteristics:

“So if you talk out loud [trying to defend yourself]… that is considered male aggression [by service provider staff]. Well it is okay for another woman to yell at you and throw things at you, but there is no gender identity towards that, but she is being more aggressive than you are, but when you voice something, oh that is male aggression? You know what I mean? So those are some things that I have experienced when I stood up for myself, I was distributing male aggression or male characteristics in the space. You know what I mean, and so, but that is just a way to, it is, you know, it is obviously a way to keep trans people in place.” (Cindy, >20 years)

Lauren also speaks about someone undermining her gender identity by trying to remove her from a washroom space, in which she also mentions that staff responded positively and accordingly. However, she recognizes that other transgendered people undermine her own gender identity and access to services by being disrespectful:

“[incident occurred in a women’s shelter] Well this one bully, “you fucking Trans get out, get out,” she basically chased me and my friend out of the washroom one morning, and she got my friend, and basically dragged her out of the washroom. That was taken care of immediately. So for that, they [shelter workers] are really respectful. The staff is, that is for sure. When they work for the city and they have to. But it goes both ways, like Trans girls that are accessing services as well, they need to be respectful. I have seen some Trans girls access services, and say to the women that are there, “suck my cock!”” (Lauren, <1 year)

In both Lauren and Cindy’s examples of their experiences, we see some evidence of broader societal discrimination against transgendered people, and how service providers and service users can reinforce it or undermine it. Cindy speaks to the fact that she is disgruntled with service
providers policing her gender identity by saying she possesses male characteristics, but Lauren describes how trans women do occasionally reinforce this by referencing male characteristics in a derogatory way. This was also apparent in Lauren’s description is talking about service providers; Lauren references that if the workers work for the City of Toronto, they have to be respectful and respond accordingly to discrimination. This is important to consider and highlights that some service providers are better than others at understanding and responding to discrimination. Moreover, the vast array of discrimination experienced as a result of identity reinforces the intersectional oppression and intersectional identities of participants.

This intersectional oppression appears again in discussions of another form of discrimination reported by participants – discrimination within the Aboriginal community (n=6). Specifically, participants discussed discrimination based on “not being Aboriginal enough” (n=4) or LGBTQ2S identity (n=2):

“Even in our own community, the whole community as a whole, you know two-spirited people need to be accepted, you know… how could a community heal when they are leaving a group of people out?” (Tim, >20 years)

It is interesting to note that belonging in the Aboriginal community was policed across two lines of colonialism – the colonization of gender and sexuality and therefore the marginalization of two-spirits and the legacies of the Indian Act, including status and reserves. As Tim indicates, the two-spirit community is still left out of the Aboriginal community. Similarly, participants spoke to the legacies of colonization (Indian status, adoption, reserves) as another avenue for discrimination within the Aboriginal community today:

“It is hard when people [in the Aboriginal community] mock that truth [your identity], or you are not you know 100 percent native, and people calling you greedy [for accessing programming or services]” (Tracy, <10 years)

“Like there is a screen saver at Council Fire, and it is of a like a cliff, with a whole bunch of natives along on their horses, right, and the caption underneath says, “have you ever gotten that ‘new on the rez’ feeling?” Right, that is kind of was the way it was [when I came here], because they were like … you are not a rez girl.” (Margaret, <10 years)

“Yea, when I first started coming here I was getting really dirty looks, and people [in the Aboriginal community] just [participant looked at me funny] right because I guess the
colour of my skin [white], they weren’t, they weren’t so accepting, but now that they know who I am, and were are talking, yea it is okay, and as time goes on, time heals everything.” (Sam, <20 years)

Even though seventeen people reported discrimination in Toronto, participants generally felt safe in Toronto. That said, participants did mention that some spaces they avoided because of previous trauma associated with the area (n=2), some mentioned one’s personal stake in staying safe (n=5), and others questioned the idea of safety for anyone (n=3). Ideas of safety for everyone was most often linked to gender and LGBTQ2S identity as opposed to Aboriginal identity:

“What is a safe place for women? You know what I mean, trans women, you know, they deal with some of the same systemic and societal stigma and oppressions and violence and discrimination that all women face.” (Cindy, >20 years)

“It is hard to change that mindset [discrimination towards LGBTQ2S people] once it has been instilled in generations of our people right, so [Toronto] a safer place [now]. I don’t believe that there is ever a safe place in any place you go. I think we can work to make it safer, but safe is not realistic, but there are definitely safer places, and all Trans programs, accept two-spirited people also.” (Jordan, <15 years)

Participants’ recollections of discrimination and safety varied tremendously but shared themes emerged. While some participants moved because of sexual discrimination but once they settled in to Toronto they found other forms of discrimination. Most often, this was reported because of Aboriginal identity (n=12), although participants acknowledged discrimination based on trans identity (n=6) and LGBTQ2S identities within the Aboriginal community (n=2). Participants also confirmed that safety was harder to experience if you are a woman or a member of the LGBTQ2S community. Trans participants reaffirmed this, as when discrimination occurred based on gender identity, it was an escalated and occasionally violent form of discrimination. This complicated relationship between LGBTQ2S, gender, and Aboriginal identity highlights the importance of intersectionality in this analysis, as these identities cannot be separated. Moreover, while some discrimination exists within the Aboriginal community (linked to the colonialism, either of gender and sexuality or status, reserves, and adoption), this occurred less frequently than within the broader Toronto community.
In summary, distal determinants of health, that is, factors that impact health from a distance such as colonialism and racism, influence migration, discrimination, and safety of participants. This situated knowledge reveals that distal determinants of health shape participants’ wellbeing as one’s gender, sexual, and Aboriginal identities occur within a sphere of colonization and racism. These intersections negotiate reasons for migration, incidences of discrimination, and feelings of personal safety. Finally, despite how distal determinants of health was only talked about explicitly in the contexts of migration and discrimination, the distal determinants of health continue to permeate participants’ narratives at many other intersections between housing, employment, culture, community, and service provision.

4.4 Intermediate Determinants of Health: Cultural Continuity and Service Delivery

Intermediate determinants of health are factors that impact one’s health indirectly. These include community resources and infrastructure, health and social services systems and delivery, and cultural continuity (Loppie Reading & Wien, 2009). As Loppie Reading & Wien (2009, p. 18) define, cultural continuity is “the degree of social and cultural cohesion within a community,” and includes intergenerational connectedness (elders, youth), control of education and facilities, and culturally-relevant health and social services. In combining community resources, services systems and delivery, and cultural continuity with what we know about Aboriginal services in Toronto (see Table 4.1), it is surprising that 50 different organizations were named by participants throughout the interviews, despite how listing different service providers was not a focus of the interview script. This suggests that participants use many services well beyond Aboriginal-specific or LGBTQ-specific services, even with a theoretical richness of Toronto’s Aboriginal service landscape. As a result, it is important to analyze service systems, service delivery, and cultural continuity together when thinking about participants’ experiences with service delivery.

4.4.1 Service Access and Availability as Determinants of Health

Of the 50 services mentioned, the majority were mainstream service providers (34 mainstream vs. 16 Aboriginal or LGBTQ). These included housing/shelter services providers (n=13), mixed housing/social services organizations (n=9), Aboriginal organizations (n=11),
youth programs (n=3, including 1 Aboriginal youth program), LGBTQ2S organizations (n=4), health services organizations/hospitals (n=6), and assorted other programs (n=4), including women’s organizations and community service organizations.

Participants combined to use 50 different services, across mainstream, LGBTQ, and Aboriginal services mandates. Participants were asked on if they preferred to access Aboriginal or mainstream services, and more than half (n=12) of participants mentioned that they would access any services. However, of all participants who had an opinion on preferring mainstream vs. Aboriginal-specific services (n=10), participants unanimously preferred to access Aboriginal organizations for employment, culture, and housing services (although one participant saying she might prefer to access LGBTQ-specific services, if they existed). Participants reported different motivations for preferring Aboriginal-specific services, although these reasons all aligned with cultural continuity and feeling a sense of belonging:

“I feel more connected to my people when I am at an Aboriginal community centre or drop in centre.” (Sam, <20 years)

“I access anyone’s [services], but I feel the treatment is better when it is our own people.” (Jordan, <15 years)

“Well because it is in [Aboriginal services’] mandates too, like you can’t discriminate, and I mean I am sure it is out there in the mainstream, but I have never really utilized them.” (Erin, >20 years)

Even though ten participants preferred accessing Aboriginal services, participants used both mainstream and Aboriginal-specific health services. Moreover, about half of all participants (n=12) preferred accessing mainstream **health** services. However, the reasoning for accessing mainstream health services instead of Aboriginal health services differed among participants, including a dearth of Aboriginal-specific services, better services at mainstream health facilities, and increased LGBTQ2S acceptance in the mainstream health system. One participant pointed to the general dearth of Aboriginal-specific health services, particularly as it relates to other services:
“Yes, the healthcare is lacking, but the services, yes there are [enough services], because you don’t ever have to go hungry.” (Heather, <10 years)

While it can be understood that some participants would use mainstream health services because of this shortage, participants also chose to utilize mainstream health services because of personal preference. Participants preferred mainstream services for two reasons, either because of their LGBTQ2S identity, or because of the traditional perspectives that Aboriginal health services use:

“I tried [Aboriginal] health services. It didn’t really work... I needed medication, I have panic attacks, bi-polar and I have mental issues, and I am on [bipolar medication] and stuff like that, but they [Anishnawbe Health] don’t go that way, you know what I mean, they don’t see it that way [needing medication]… but Sherbourne Health Centre they saved me. It is really, really good. So they saved me…You know what I mean. You get a doctor that you can talk to.” (Heather, <10 years)

“I just noticed that they have more programs provided for Trans females at Sherbourne … there are quite a few more programs… I find a lot of the staff there [Sherbourne Health] are Trans females, receptionists, one of the doctors is Trans, so visibly more welcoming.”

While all participants felt that mainstream service providers were more inclusive to their health needs (either because of being better services or more inclusive to LGBTQ2S people), six participants reported experiencing discrimination within the mainstream healthcare system. The reasons for discrimination ranged from LGBTQ2S identity, to being perceived as lower socioeconomic status, to perceived use of drugs or alcohol, although the most frequently discussed incidences related to Aboriginal identity:

“Like I went to [access mental health services] and they have an Aboriginal services unit there, but it was, I just went there for counselling, but I was told to go to detox. So I felt really being discriminated against in a really negative way… I said, well I ain’t doing that, so I am done if that is what you want me to do… If I go to detox, that means I am just another Indian in a frigging detox.” (Michael, <20 years)

“There was one [person of colour] guy sleeping in the corner with a security sitting beside him…the male nurse came to me and he is like, “oh so you are going to sit here and try and give me trouble too, right? I am like, “excuse me?” … He is like, “do you
want to be sleeping like him?” I am like, “why are you talking like that to me…I am here to get help. I am here because I am sick”… He…thought I was going to be all violent towards him. I was like “what do I look like? Do I look like all rough or something? Is that why you are thinking? ... Are you just like looking at me because I am native or because like I don’t have a smile on my face, because I am sick?” (Tammy, <5 years)

“[Discussing an experience at a walk-in clinic] I had a rash on my hands. “You are from the shelter?” [they asked] “Oh yea. Syphilis hands.” [participant didn’t have syphilis].” (Heather, <10 years)

As Tammy, Heather, and Michael illustrate, they were perceived as being difficult or sicker based on their appearance. While it is hard to separate why they were perceived that way, their stories came up in a discussion about accessing services as an Aboriginal person. However, Heather’s story is also tied to her housing situation at the time, linking to her intersectional identity. Participants also reported discrimination because of their LGBTQ2S identity. It is important to note here that discrimination does not always come directly from a service provider (as in the second example), but also occurs within the service space, such as in the first example:

“I went to [a health centre], and I waited for my doctor and this group of guys [other patients] asked “are you male or female?” and I said “I am Trans,” and as soon as I said I am Trans, their pronouns changed from she to he.”

“Because I had breasts and stuff and I had a lump in my breast, and she was like, “you have pretty natural looking breasts for a trans woman.” I don’t know what that is supposed to mean, and you know I am just like, “are you for real?” like you know what I mean? She was, “oh you are fine.” She didn’t even want to touch my breasts.”

Reconciling discrimination within services is particularly troubling. Of course, both Aboriginal and mainstream health and social service providers have anti-discrimination mandates. However, as the quotes above illustrates, it may not be about the service provider, but discrimination can occur within the space, and it could come from the doctor or nurse. Finally, as Tammy illustrated earlier, it may come from someone in between – like a security guard. This makes it hard to reconcile discrimination in these settings, as there are many different actors at play, especially given the size of mainstream health service providers (from a staff perspective; Aboriginal service providers, such as Native Women’s, are very small – NWRCT only employs
13 people). Heather reinforces this point after summarizing a similar incident to Tammy regarding a security guard who discriminated against her based on her Aboriginal identity:

“They [the security guards] can profile me, but when they are getting a job, who is profiling them?” (Tammy, <10 years).

The conversations about mainstream service organizations reveals that participants perceived the need for improvement. This is particularly important, since many participants did utilize mainstream health organizations, and – with cultural continuity as an intermediate determinant of health – it is important to have health services that are inclusive, which several participants did not experience. In fact, participants reported that finding culturally-relevant services is becoming harder and harder:

“Multiculturalism becomes very expensive, so the more we diversify, the more expensive and harder it is to deliver good services… services are becoming more diluted.” (Bev, <5 years)

“You know what? I am just grateful it is there for us [mainstream health services]. In a perfect world you know the province will say, you know you have your own agency, but there is nothing for us.” (Tim, >20 years)

Even with these negative experiences in mainstream organizations and a perceived lack of Aboriginal-specific health services, participants generally thought there were enough non-health services (e.g. employment, culture, and recreational programming) available to them. Moreover, even though Aboriginal health services were perceived as deficient, participants still reported a positive trajectory of service improvement throughout their time in Toronto:

“Accessing health care is now probably easier. I never found really like hard core like [racism], you know, like my doctors…I am not HIV, not Hep C, only one STI in my whole thirty somethin’ year career, you know, prostitution, sex work, hoe’ing, and I am lucky. See, what does that tell you?”

“This is good as it is going to get. I think. I think there are a lot of people putting in a lot of effort, and there is a lot of funding for Aboriginal and gay communities, so I am happy.” (Pamela, <5 years)
The idea that there are enough services available for participants became clearer throughout the interview process. This was especially apparent in conversations where participants acknowledged that people have a personal stake (n=11) in finding and accessing services:

“If you don’t [use the resources] then why bother [coming to Toronto], because you are only struggling. There is so much help here… There is so much help here. If people knew what kind of help there was. There can always be more services for sure. Is there enough? I can’t say that. There is. I don’t know, because some people are just so, are ignorant, and I don’t mean ignorant, but I mean ignorant where they just don’t know. There are people out there that aren’t given any information.” (Mary, <5 years)

“I would say bull shit [to people who say there aren’t enough services]. We have a lot of services especially in this area. So I am not lacking. Be honest. Find what you need. Yea, you really need to be honest with yourself.” (Pamela, <5 years)

“They say that there are not enough services? I say they are not looking hard enough.” (Linda, >20 years)

Despite a general perception that Toronto is well served when it comes to services, participants sympathized with those who were not able to walk in the door of a service agency or find it themselves, as many participants remembered experiencing the same when they initially moved to Toronto:

“People feel that they can be judged by using [so they won’t access services].” (Jordan, <15 years)

“[Back then,] I didn’t care about services. I didn’t care about staff or where I came from. I didn’t care. You kick me out, alright I will go to the other youth shelter. I will stay there for six weeks, and come back over here.” (Erin, >20 years)

One participant added another layer to why some LGBTQ2S people specifically would not want to access services, Yvonne mentions that it might be because of their gender identity and how it might be perceived by service providers:

“They [trans women] are so scared to go into agencies, because like we are looked at like oh my god, either we are looked at as we are there to, we want to suck your cock over there or to take you, or be more woman than you.” (Yvonne, >20 years)
While the majority of participants suggested there were enough services available to them, the idea that services were saturated was geographically rooted. Specifically, participants were more likely to feel there were enough services if they lived in close proximity to them:

“We have a lot of services especially in this area. So I am not lacking.” (Pamela, <5 years)

 “[all of the services are in] the downtown core…[it is] a bonus actually, because I live downtown…Everything is like right within walking distance, so it is a bonus” (Sam, <20 years)

This is in direct contrast to two participants who lived outside of the downtown core, who expressed difficulty accessing services:

“Yea, I live further away…so it is a little bit harder for me to get down here than anyone who lives downtown… Yea when I have to, yea if I absolutely need to access services, I will find my way to get here, because I know it is here and I know it’s available to me.” (Dawn, >20 years)

“Not all of us live downtown. I know some of the girls here that live out in North York or live out in Scarborough. There needs to be more native services outside of downtown.” (Lauren, <1 year)

In addition to an oversaturation of services in the downtown core area, participants also noted other strengths and weaknesses of service provision in Toronto. While acknowledging strengths and weaknesses of service provision was not explicit in the interview script, participants inferred one area of strength (youth services) and one area of weakness (mental health, discussed below). Youth services were seen as a strength of Aboriginal service provision by five participants (all adults), particularly as it relates to LGBTQ2S youth:

“There are more youth services than adult, from what I understand, because now youth are more open I find in that way [sexuality] right.” (Erin, >20 years)

“I think there are a lot more services to youth, but I think that is a good thing, but yea I don’t feel left out in the cold by any means.” (Pamela, <5 years)

Although five adults acknowledged youth services as a strength, the one youth interviewed had a different perspective:
“There are so little resources [for youth] and even if like there are like those one or two agencies [for youth], but they are so lack… I personally think there is not much going on, like it is not that popping honey.” (Brandy, <5 years)

Part of the reason some participants identified youth services as an area of strength for LGBTQ2S people is potentially because youth today can utilize more services because of the acceptance of LGBTQ2S identities by younger generations (as mentioned by Erin). However, in the context of Brandy’s comments from a youth perspective, there still needs to be more services and resources. Brandy mentions that there are one or two agencies specifically for youth, but that they are inadequate for her needs. She talks about this later, making a distinction between resources and opportunity, where she acknowledges that there are many resources for Aboriginal youth, but there needs to be more training and employment opportunities:

“There are a lot of resources for Aboriginal youth, but I just think that it is being able to, wanting to do it yourself, you know, and being able to take those opportunities and those trainings for those different things that are provided for you.” (Brandy, <5 years)

Brandy’s distinction is an important one since adult participants acknowledged that there were enough employment and training opportunities available to them. However, Brandy does not feel that way as a youth.

Meanwhile, mental health services were perceived as the weakest area in service delivery in Toronto, and a place where improvement was needed. This is especially important in the context of thinking about wellbeing holistically. Many of the positive descriptions of services provided above are related to physical health, yet mental health is experienced as completely opposite by participants:

“We have a dilapidated mental health system… We throw them all into cheap programs with low success rates… real, real treatment costs. What do we do about it? We’ve already made the decision. We’re not going to do anything.” (Bev, <5 years)

“What I really learned now is that the system there is nothing there. Mental health is the worst system. It is really bottom of the barrel in terms of what the options are. Like where I live, like they put me in supportive housing. It was horrible. It was ghetto, there is crack heads coming all night. It was awful.” (Michael, <20 years
The finding that mental health services are perceived to be the weakest services is particularly troubling, especially when factoring in what participants’ described as their ideal health system. When participants described their most positive services, there were common elements – most importantly, these services encompassing physical, mental, spiritual, and emotional dimensions of wellbeing. Specifically, participants perceived the best services to be those that are holistic, featured an Indigenous model of care, and were built on an anti-oppressive framework (n=15):

“[To improve services,] I would probably ask them to take into consideration our history as well. Like it is taking a holistic approach to our health, not just medical, looking at us in medical terms. So yea, I think that is what I would probably mention. Yea, because that is how we do our healing is just holistic way, spiritually, emotionally, mentally, and physically to form a circle, the four directions. That is how we approach it. So like a mainstream doctor wouldn’t know that. So I would probably suggest that, you know, approach it holistically.” (Dawn, <20 years)

“[Speaking about an organization she thinks is great] It is run by the youth for the youth, and like a lot of what we say goes…They also provide different trainings, and they provide services for employment. They also provide housing support, which is good, because like I think people need that to show that they care, you know what I mean. It is like, “Did you edit your resume?” and then I will be like, “oh shit we forgot,” and then it just reminded us, right. It is not that, it is not that they are nagging us, but it seems like they care about us too. Yea, so like when the organization, when the organization and service providers care, show that they care for you, obviously then you know [they are good], and keeping a balance to that caring with all of your clients, with all of your community members.” (Brandy, <5 years)

While Brandy explicitly refers to a pre-existing program, some participants (n=3) detailed how they constructed their own holistic healthcare. Of course, there were challenges associated with that, including Tracy, who mentions how she did not want to be learned from as an Aboriginal woman and survivor of the 60’s Scoop when accessing care:

“What I did was I got consents and asked if everybody would be in my life in this healing journey, would be a part of it. So my [doctor] is connected to my nurse. My [doctor] and my nurse is connected to my healers, so it is open, so everybody sees what I am doing, and if there is something else that can fit in that circle, that they see that I don’t see, we all come together, and we decide like on medicines, and healing, and healing medicine.
We come together, so one doesn’t know one without the other one knowing… So I have my native and I have my white nurse and my white doctor, and my white dentist, my white eye doctor, and I still have my circle of care with my native community for all those too…And everybody that comes into it, I have had to make sure that that person is coming in for me... Right, that is the real hard one that I have had. If having the helpers in my circle, that they are there to help me get better. Not to learn from me being an Aboriginal woman or learn from me from the 60’s Scoop” (Tracy, <10 years)

“When I quit smoking, I had 9 professionals helping me. Two at Sherbourne, 3 at CAMH, couple doctors, hypnotist… There are so many resources that you can come out with…but you have to know how to work the system.” (Bev, <5 years)

This idea of holistic health has been engrained within the literature on best practices in Aboriginal health for decades, yet it still has not translated into programming and policy for participants in Toronto (Martin-Hill, 2003). This is a point where distal and intermediate determinants of health intersect. As a result of colonization and racism, a lack of importance is placed on holistic health and wellbeing in favour of Western medicine, which is perpetuated in contemporary health systems. While some participants reported creating their own holistic healthcare, ultimately it requires extensive use of networks and an ability to navigate service landscapes, both of which are influenced by determinants of health, including education and literacy. Moreover, none of this is relevant if certain systems are inadequate – such as mental health, as indicated by participants.

4.4.2 Sense of Community and Culture as Intermediate Determinants of Health

In thinking about intermediate determinants of health, sense of community, culture, and identity must be examined. This is especially true in light of the migration literature, which suggests that cities – in contrast to reserve and rural communities – are places with more opportunity but less access to culture and community (King, Smith, & Gracie, 2009). Interestingly, the majority of participants reported that they had found a sense of community and culture in Toronto. Moreover, participants reported that Aboriginal culture was represented in a variety of ways in Toronto, including in public areas and also through programming and services. Participants found it somewhat surprising how easy it was to connect with their culture and see their culture around Toronto:
“Yea. Sometimes I am surprised, like I am surprised because I am not the only native person in my own area. I have noticed a few native people out there, oh wow, hi. Okay I’ll say “Aanii [hi]” in my language and they will be like, “Aanii!” I just know who they are, and that is, yea there are a lot of native people in Toronto. I was surprised when I first came to Toronto actually at the amount of native people that were here.” (Dawn, >20 years)

“There is in certain places there are like pictures of native art, like across the street. Even in actually College Park, there are like statues of native art… there are all cultures living here, and yea you have to share too. Other cultures put their things up… and [we need to] learn about them.” (Julie, <5 years)

As Dawn suggests, even though there are not many Aboriginal people in her area, it is easy to form a sense of community with them and say hi. Julie talks explicitly about the prevalence of Aboriginal art around the city, and how that contributes to her sense of belonging – but also she understands Toronto’s diversity and that many other groups need to be represented. Both narratives feed into a wider concept that it is easy to practice Aboriginal culture in Toronto:

“This [Toronto] is where the teachings are.” (Tracy, <10 years)

“I think living in the city has helped me identify more with native culture, because I had to access services out there and then I met people out there, that knew more about the culture than I did…I didn’t know these things until I came here. I just knew what smudging meant, like purification. I think I know what a dream catcher was, like I knew what it was. I thought it was decorative. I didn’t know its purpose.” (Lauren, <1 year)

“They have two-spirits sweats…I have been to those. Like they do women’s sweats, and male sweats, the two-spirit people are welcomed either.” (Jordan, <15 years)

Even though both Lauren and Jordan are from the reserve, they do not note that there is less culture in Toronto. In fact, Lauren notes the opposite, for example, she did not know about some aspects of culture before coming to Toronto. Tracy confirms this by specifying that there are many teachings in Toronto. This is particularly true to two-spiritedness, as Jordan reports that there are even two-spirited sweats. Yet, when thinking about ceremonies and culture, participants reported one main challenge of negotiating their LGBTQ2S identity with their Aboriginal identity. Specifically, participants experienced challenges accessing Elders. This is important given that a critical intermediate determinant of health is intergenerational culture sharing, where
Elders, youth, and adults are all engaging with each other. In discussing these challenges, participants note that it is hard to find allied elders, and generally speaking, many two-spirit teachings have been lost as a result of colonialism:

“As a group we lost a lot of two-spirit teachings. A lot of it, because it went underground, like they were really passionate, to them it was like witchcraft and stuff, right. So a lot of the Elders would take all that two-spirit stuff and buried it… there are thousands of teachings just without two-spirits, there has to be equal teachings [but] a lot of it is gone. I will never see it.” (Jordan, <15 years)

“Our two-spirited elders, our two-spirited grandmothers, you know. They are out there. I have seen them. I see them, you know. They are out there, but it is just not safe yet [for them to practice culture].” (Tim, >20 years)

“Finding an elder that is open to that [two-spiritedness], even better. [One] that doesn’t close that door, and there are elders here that come into this building, that do help the two-spirited gay and lesbian community.” (Mary, <5 years)

“I have been around Elders that didn’t tolerate it all, and I was asked to leave the circle because I was two-spirited. He didn’t understand it. He didn’t want to, but that just, I can’t change their thoughts.” (Jordan, <15 years)

As Mary suggests, there are Elders who are allies to LGBTQ2S people, but she does indirectly suggest that they are harder to find. Meanwhile, Jordan articulates that there are unsupportive Elders, but perhaps some of that can be attributed to the teachings that had been lost as a result of colonization. As a result, while culture is perceived as easily accessible in Toronto, ultimately finding truly relevant teachings to participants is a little more challenging. Participants pointed to this in other areas as well, particularly around language, whereby Toronto’s largest Aboriginal group dominates the majority of programming, Ojibway:

“Even our drop in here. I would say at least 90 percent coming in are Ojibway, and they all speak, most of us speak our language, which is great, because this is the only place I can really speak it.” (Jordan, <15 years)

“[It is easy to connect to the] the native culture. Yea, but not based on my, where I come from, what my tribe is. It is very hard to find, like even when I was asking Literacy to see if she could find stuff on like my language and that, and it is hard. So like when I do get
involved, [it is in] others languages… I consider myself as being Sioux...Ojibway and Cree are like here in Toronto, and like finding like Dakota is hard here. (Tammy, <5 years)

“I mean I didn’t even speak a word of Ojibway right or anything, right. I don’t even know [my original language]” (Margaret, <10 years)

Overall, participants explained that Toronto is a place where urban Aboriginal culture exists, in contrast to the migration literature. In total, the majority of participants (n=18) reported that their access to culture is the same or improved compared to where they lived before. Specifically, participants believe that there is good access to language programming (even though it is dominated by Ojibway), sweat lodges, and other healing ceremonies (many of which NWRCT offers). However, a key challenge reported by the participants is accessing Elders, which in turn is believed to disconnect them from the more spiritual aspects of their culture. This is particularly important because being two-spirited was suggested (and confirmed in the literature) as a very spiritual and cultural identity, which, as later discussed, that identity has been somewhat lost. Participants also had some critiques of Aboriginal culture in the city, particularly pan-Aboriginal programming, which most often manifests in language programming. Looking at access to culture holistically, it can be understood that there is enough access to culture in Toronto for some participants, but culture still does not always intersect with LGBTQ2S identities, a reality that is a product of colonization.

Access to culture feeds into examining the presence of a sense of community within the Aboriginal community. As discussed above, culture and LGBTQ2S identities do not always interact together. This became apparent in some participant narratives, where they indicated discrimination in home communities as a reason why Toronto was an easier place to form a sense of community. While we know this is a motivation for moving, it also connects migrants and helps them form their own communities:

“I already have said that [come to Toronto] to a couple of them [two-spirited people], because there is still shame you know back home [on reserve]. I said why don’t you come to Toronto, like it is more acceptable. You can get help. There are services now. Not like it was before where you were hushed, right.” (Erin, >20 years)
“When I had gone to the two-spirit community [in Toronto], like all the women that worked the streets at that time were all Aboriginal women. It is like, oh my God, so that connection came back, and that is where I was feeling more empowered and not only being two-spirited, but being native, and the connection, and all the stories were very much the same, you know we [two-spirited people] left the rez because it was just not a safe space, or a safe place or no opportunity or transphobia, you know all these things, right so all these women were coming from all over Canada or North America, and stand in the streets of Toronto. You know, so we shared a lot of same stuff that you know we were a community of our own, and it was a great community. It is still a good community.”

As the above quotes reveal, part of the reason that two-spirited identities are perceived to be more accepted in the city is because of Toronto’s identity as an LGBTQ2S-friendly city. Participants also acknowledged another reason for tolerance – the role of service providers:

“I got into some type of peer mentoring program. That is how I learned more about services for Two-Spirited people.” (Tracy, <10 years)

“When I first came to Toronto, I really didn’t know anything about Two-Spirited people. I didn’t even know any agencies or anything that would help us.” (Tim, >20 years)

“Native Women’s has gone long way in a sense of how trans women are being treated in those spaces. They are doing volunteer work here. They are more part of the agency, not just the clients, but also doing other things with them at the agency.” (Cindy, >20 years)

“This lady… she came in before me [to NWRCT], and she said, “oh, there’s no men allowed here,” I looked at her, “I am Two-spirited.” She laughed. She said, “I’m just teasing you, I’m just joking.” (Tim, >20 years)

As the quotes above demonstrate, participants perceived that service providers are going beyond their discrimination policy and embracing a role as educators for LGBTQ2S issues. For example, Tracy suggests that her peer mentoring program educated her about two-spirited people. Participants also reported that Native Women’s Resource Centre (where the interviews were held) was really doing their part in advancing LGBTQ2S wellbeing in Toronto, as Cindy acknowledges how LGBTQ2S people are included in actual programming. This is further illustrated in a story from Tim that happened on the day of our interview at NWRCT. Ultimately, service providers are perceived to be doing a good job to educate within their organizations and create safer spaces.
In addition to the tolerance of the Aboriginal community, participants often pointed to the broader benefits of finding the Aboriginal community. Most notably, many participants (n=10) said that finding the Aboriginal community played an integral part in changing their life for the better, confirming the importance of cultural continuity as an intermediate determinant of health as experienced by participants:

“[My life] has changed for the better. Yea. It has changed for the better. A lot better, because of my community actually, Aboriginal community… learning about my culture and stuff.” (Dawn, >20 years)

“It has just been me… until I started coming into the community and finding out you know different things that would advocate for me certain places that were, I would be able to speak and have that support… and then I found out there is healings and sweat lodges, and drumming and beading, and regalia and community drummings, so I started feeling part of that. That was my relationship with me for a long time, but the relationship I prefer was letting go of everything and getting out of there.” (Tracy, <10 years)

Participants’ intersectional identities were considered when discussing to which communities they felt most connected. When asked, most (n=18) participants identified with the Aboriginal community than the LGBTQ2S community, with nine participants identifying more with the Aboriginal community, nine participants identifying with both, three identifying more with the LGBTQ2S community, and one identifying with neither, because of the discrimination they experienced in both communities. For those who identified more with the Aboriginal community, they often spoke to the warmth they felt from the Aboriginal community:

“[I feel more connected to] the Aboriginal community, because everyone knows one another, so it is like everybody you know one person struggles, there are people who are willing to help them out. So it is like a real community and then there are children here, everybody seems to look after them, like their mother is there, but everyone will look after that child at the same time, keep an eye on them and so yea, one big family.” (Dawn, >20 years)

“I like coming here [NWRCT]. I feel welcome here. I feel like I am at home…I have lived my life on the streets, so that is why I feel like I am home here because of the women, two-spirits, are from the streets, and are still on the streets, and I can, I know where they are coming from. So that is why I feel, like that is why I feel home here, like I am home.” (Tammy, <5 years)
As Tammy and Dawn illustrate, they connect the sense of community that they feel in the Aboriginal community to feelings of home and family. This is in contrast to how participants described the sense of community in the LGBTQ2S community, if they felt more connected to the LGBTQ2S community:

“[I feel more connected to the] LGBTQ community, yeah, probably just because I was a part of the 60’s Scoop.” (Margaret, <10 years)

“I have always been connected to who I am [Aboriginal] but not the community… But I knew of where I came from, because I was adopted. I didn’t come in to community, it just wasn’t a belonging for me yet, because I had been adopted outside, but the first thing I did when I got off the bus, somebody was calling me from across the street and recognized me right away. So it was like, yea, so that made me feel welcome. I was always welcome here.” (Tracy, <10 years).

As demonstrated above, feeling a greater sense of community in the LGBTQ2S community is heavily influenced by historical trauma, colonialism, and racism, which disconnect participants from the Aboriginal community. This reflects participants’ intersectional identities, particularly when their appearance does not necessarily coincide with their identity. Participants also discussed this in the context of experiences of discrimination for participants who may not look Aboriginal. As a result, one participant identifies more with the LGBTQ2S community:

“I have just been more accepted [in the LGBTQ community]. I just sort of, it [the Aboriginal community] is more open [now than] when I came here, but I have just been accepted more [in the LGBTQ community]…I don’t look it [Aboriginal], right?” (Heather, <10 years)

Overall, participants described various communities to which they felt attached, although the majority (n=18) felt connected to the Aboriginal community in some way, and many people attribute that community to helping them find their path in Toronto. This is important, as all but one participant reported feeling some sense of community either in the Aboriginal or LGBTQ2S communities. For participants, having that sense of community represents an intermediate determinant of health, because it connects participants to each other, service providers, and other resources. However, it is important to note that where participants did not identify with the Aboriginal community, historical trauma often played a part in that – people did not feel like
they belonged because they were adopted or of mixed ancestry, which is another legacy of distal determinants of Aboriginal health.

4.4.3 LGBTQ2S Identity as Determinant of Health

Colonization has dramatically affected both Aboriginal and LGBTQ2S identities. As a result, these impacts trickle down and make feeling connected to your identity an intermediate determinant of health. One notion of identity that consistently came up in conversation was the term “two-spirited.” Six participants troubled the concept of two-spiritedness as a terminology and identity. They troubled the term because of when it was conceived – in the present day – and how, regardless of when the term was created, the term is so distant from Indigenous views of gender and sexuality. While I did not ask participants to label their gender or sexual identity, I noted that several participants (n=7) referred to their gender and sexual identity by Western terms instead of using the term two-spirited in conversation. Michael troubles this here, where he talks about how the term two-spirited was conceived in this Western mindset:

“The one thing that gets me really bad is like we don’t acknowledge this, but as young people in modern times almost everything we know about ourselves is based on the western concept. Everything. From the word gay to the word trans to the word two-spirit. It is all coming from that mainstream place and nobody challenges that. I mean I meet very few people that challenge that… and I think that threatens a lot of people, the ones that created that two-spirited thing.” (Michael, <20 years)

His language is strong here, where he talks about how no one challenges the term or the creation of the term. Later in the interview he talks about how he went on his own quest to find out more about what two-spiritedness meant – in theory and as a terminology – which contextualizes his point of view a little further:

“I went to see an elder a long, long time ago… and I said, you know, “can you teach me the two-spirit thing?” and he laughed at me, and he pretty much said, “you know this is an urban phenomenon…” and he taught me about like words like Obokwe and the true terminology and how it wasn’t even about gender or sexuality back then.” (Michael, <20 years)
When combining Michael’s words about the term being an “urban phenomenon” and stemming from Western ideas about gender and sexuality, Yvonne’s words are understood to reveal a misunderstanding between traditional (pre-contact) and present understandings of the term:

“Yea. Like the term two-spirit, I find is umbrella, their two-spirit to me equals funding, not an identity… I don’t like the term two-spirited. It erases our whole identity… like two-spirited is supposed to really be like the men and the women that use their identities as spiritual, not as like a token word… it is more spirit. Like to be who I am is to be a spiritual person, and like be my spirit and my health more than it is for a job, or for money. Money doesn’t mean anything. I want a real term. Not some two words put together at a conference, coined for cash.” (Yvonne, >20 years)

Tim further orients the term on the spirit, as opposed to gender and sexuality:

“We were, they were, our leaders, well respected leaders at one time. So I think that is where that needs to come forth, that is two-spirited people, and we have to start self identifying who we are in a spiritual sense.” (Tim, >20 years)

There are two narratives presented here, but both are rooted in the more traditional view of Indigenous gender and sexuality. The idea presented is that two-spirits should exist outside of a Western gender binary, but the term was conceived in that system. Furthermore, participants identify the “spirit” component of two-spirit, which has been forgotten through the Western mindset and colonialism. This is particularly troubling to Yvonne, because she sees the term as something that generates funding and money as opposed to a deeper, non-monetary engagement with Aboriginal culture. This results in a community that is more fragmented than it is jointed, as Michael explains:

“I was in the “two-spirit community” for a little while. I have always been I guess on the spectrum, right. I have never kind of labeled myself… Like I am fine with who I am, but people don’t understand it right, and because I am on the spectrum, I am not one way or the other… I don’t think people understand that. So in the two-spirit world I had a lot of problems, because I was, well I just don’t really relate to that community that much, so yea… and also I was doing my research and learning all the things over the years, I kind of learned about that word [two-spirit] and that term and where that came from, and then I learned it was kind of, not opposite, but it was different from like the two-spirited people were trying to put out there, right… and then I met other like-minded people that felt the same way, and there is a whole mess of people, like a whole community outside that, so yeah the two-spirit community is very split. It is very, very split.” (Michael, <20
Overall, the discussions around two-spirit identity can be challenging as it relates to sense of community and place. The perceived fragmentation of the two-spirit community coincides with the fact that no participants mentioned that they felt a sense of community among the two-spirited population. A few (n=4) participants acknowledged being friends with other two-spirited people, but their friendships did not align along spiritual lines, as depicted above as a crucial distinction of two-spirited identity. While it was expressed by participants that the two-spirited community is becoming more and more accepted within the Aboriginal community, in terms of the Indigenous view of two-spiritedness as leadership and spirituality, it seems most of that identity has been wrapped up in Western understandings and organizational funding. The result is a split community instead of a strong one, which influences the wellbeing of the community as a whole. Moreover, this undermines the strong sense of Aboriginal community and culture that other participants described. As Tim articulates:

“Two-spirited people need to be accepted, you know… how could a community heal when they are leaving a group of people out?” (Tim, >20 years)

Given how much importance participants placed on the community as a key determinant of their own wellbeing and sense of belonging within Toronto, the importance of being a part of any community becomes very clear. Moreover, in the absence of being able to reverse the distal determinants of health – improving Aboriginal wellbeing begins at further establishing this community, and – particular to the LGBTQ2S community – begins at reconnecting the community.

4.5 Proximal Determinants of Health: Housing and Employment

4.5.1 Educational Attainment and Housing

Proximal determinants of health are factors of health that are most often highlighted in the research – they are directly related to one’s health. As a result, they have a direct impact on physical, emotional, mental, and spiritual wellbeing (Loppie Reading & Wien, 2009). As Loppie Reading & Wien (2009) argue, these conditions often act as stressors, which can lead to substance abuse and other social problems among adults. Proximal determinants most often
include health behaviours (e.g. smoking, substance abuse), physical environments (housing), employment and income, and education. All of these factors directly impact wellbeing, and, particular to this research, housing and employment were both identified as a crucial issue facing the community in Phase I and by participants in Phase II.

While this research asked about educational attainment, it was not a focus of the interviews. That said, educational attainment was still polarized. As depicted in Table 3.4, five participants had less than a high school education, two participants had completed high school, two participants had taken some technical training or an apprenticeship, six participants had partial or completed college, and four participants had a university education. Three participants’ educational attainment was unknown. Among the participants, five people were employed (part-time or full-time), fifteen people were unemployed, and two were currently students. Of the fifteen people who were unemployed, the majority of people (n=12) mentioned that they were looking for a job, recently had a job, or wanted a job.

The numbers regarding education and employment were reflected in housing characteristics of participants. When participants first migrated to Toronto, only five participants had a home or a place to stay, and even then, two of those participants eventually lived in the shelter system. Three participants stayed in a hotel or hostel initially, with two specifying that they did not know about shelters, and ended up staying at a shelter after that. Fifteen participants stayed in a shelter their first night in Toronto.

While most participants (n=19) utilized the shelter system at some point during their time in Toronto, only three participants lived in the shelter system at the time of the interviews. Of those currently living in shelters, two people had been living in Toronto for less than 5 years and another had been living in Toronto for less than 20 years. This is congruent with Toronto Community Housing and other housing service providers wait times of approximately 6 years (Monsebraaten, 2014). At the time of the interviews, three participants were in transitional housing, three participants were living in the shelter, and four participants paid market rent. The remaining twelve participants were in subsidized or rent-geared-to-income housing. This is important to consider when interpreting these results, as participants now have adequate, safe, and private housing, but at the beginning of their time in Toronto, they did not. Moreover, this
speaks to broader socioeconomic trends of participants – upon moving to Toronto, many were in
the shelter system and unable to find housing or employment. Now, the majority of participants
are in adequate housing, and have or are looking for employment.

While these numbers above paint a picture of a successful migrant, the reasons for
migrating to Toronto continued to impact participants upon arrival, which shapes their wellbeing.
Upon moving to Toronto, only four participants had homes or places to stay (with family, for
example) arranged prior to when they arrived in Toronto. The majority of participants (n=15)
went into the shelter system, mostly because they were underprepared for life in Toronto – no
networks, friends, family, or support circles established. For those who did not enter the shelter
system, the lack of support system eventually caught up to them:

“I was at the bloody motel. I spent days oh my gosh, all my money is going; I was on
unemployment. I had money in the bank for an apartment, but I couldn’t find one. I don’t
know… They told me about the shelters. I never knew about shelters. I never knew
anything, right… I couldn’t find an apartment on my own. I didn’t have any job or
anything, you know. I had money, but that wasn’t enough. I couldn’t find any place.”
(Heather, <10 years).

“I just moved here, and got a room, and started looking for work… I had [that] room for a
little while, and then I was pretty much just comfortable just with a tent and with a
sleeping bag and winter would come and you would go inside to a shelter, and I lived like
that for quite a few years.” (Linda, >20 years)

As Linda and Heather illustrate, both of them did not initially live in the shelter system upon
migrating to Toronto. Heather, who was from a reserve, admitted that she did not know what
shelters were, and how if she did, she might not have ended up in that position after she spent her
savings on the motel. Meanwhile, Linda described how she moved to Toronto to find work and
had a room, but then ended up on the streets. This narrative was very common with participants.
When recounting the first few months of their life in Toronto, participants spoke to the
challenges of becoming successful in the city:

“The city has a lot of fucked up things… You have to have a healthy network before you
get here. You know I made that mistake of not doing that. You know led into so many
things, like sex work and drugs and drinking and all that kind of stuff until I realized what
I was doing. Right, so it is expensive living here, so yea, get networking, and get some
things set up before you get here.”
As a result of the challenges associated with being successful in the city, participants acknowledged that it was easy to get comfortable living in the shelters. This meant that shelters occasionally exasperated participants’ own struggles:

“[In the shelters] I could do what I want. You know I could sleep all day. I could go out at night, and so like yea, get anything done for you, you know, time to eat, your meals are done… You never had to buy anything, know what I mean, Donations, all the time, you know but then you have got, yea you get sort of like institutionalized…then when you live on your own, now we have to pay for this. You have to buy this.” (Heather, <10 years)

“I mean [the shelter] was better than the street, but it was hard to deal with, hard to stay sober, and hard to stay sane.” (Pamela, <5 years)

“I was homeless for most of my life… I did apply for housing, and they have waiting lists, like seven, eight years, so that kind of feeling, really kind of hopeless you know, so that kind of helped with pushing me into my addictions as well.” (Dawn, >20 years)

For the other participants who managed to find housing right away, the affordability of Toronto catches up to people quickly. Yvonne, for example, spoke to losing her home a few times (although she is now housed):

“I got housing kind of almost right away… I lost that. I moved out. I moved to Scarborough, and then I lost that, and I don’t know, I think the whole time I have been here since 2007 it has been a work in progress to get to where I am now.” (Yvonne, >20 years ago)

Here, I would like to reintroduce one participant’s story of losing their community housing to describe how housing is particularly important for the transgendered population. As a participant describes:

“I waited eight years to get into [social housing] to find out a week later I was attacked by two guys with a baseball bat, because I was transgendered… I asked about a transfer and they said I would have to stay there at least a year. I am not staying there another eight - nine months. Hell no.”

This story speaks to the inefficiency of one service provider to address and reconcile the
situation. While many social housing providers do have a transfer process – which includes priority transfers in incidences such as this – they acknowledge the wait time to transfer can be several years (such as Toronto Community Housing, see TCHC, 2015). Moreover, while many service providers acknowledge Aboriginal Canadians in their discrimination policy, but they do not mention LGBTQ2S people or gender identities (also in the case of TCHC, 2015). It seems that, as perceived by this participant, there is neither proactivity nor accommodation in the transfer process, despite how many providers have these policies in place. While some can be explained away with housing shortages (which leads to a long transfer process), it is unreasonable for someone to live for one full year in an unsafe environment. As a result, this participant is back in the shelter system, and their wellbeing is affected accordingly. This is especially important to consider in light of Lauren’s comment, which describes her experience nearly losing her home at the time of the interviews:

“I am behind on my rent… I don’t know how many Trans friends that have told me, “Don’t lose your place. Don’t lose your place. Take care of it. Take care of it” because I have Trans friends that have been homeless, like six, seven years, coach surfing, going to shelters, trying to get out of the housing program. [I’m] pretty close to almost losing it, but I can’t, because if I lose it, then what?” (Lauren, <1 year)

This participant intersects her losing her home with her own transgendered identity. This participant’s emphasis on how many people said for her to not lose her place is because of the cyclical homelessness facing transgendered people in Toronto. This is in addition to the violent incidents of discrimination depicted in the shelter and housing systems, particularly social housing story above, where she describes how she were victimized in her own home because of her identity, and how they ended up back at the shelter where they started.

While trans participants most powerfully tell this story, many participants echoed these stories. All participants pointed to housing as the main determinant of overall wellbeing, as housing was brought up by every participant (n=22) as either a challenge or area of improvement:

“[I would recommend Toronto] if they get housing right away, yes. If not, then no.” (Pamela, <5 years)

“Survival instincts kick in and like, okay, I am going to you know sit, or stand in a corner and make sure I will pull a trick so I can have a place to live… People do things due to
“I am so stuck right now. I was thinking about that last night, like what am I going to do? Just stay in Toronto, do I transfer my credits, do I go back home? My mom wants me to go back home. I don’t want to go back home and live with my mom. You know. I can’t do it. I just can’t. She is very, very good for short periods of time, but yea. I don’t know. I don’t know, I am very kind of on the fence. Yea, I need to figure it out soon though, the end of the month is coming. If I could find a place here, I will stay here.” (Kaitlyn, <1 year)

Pamela suggests housing as the key factor as to whether or not she would recommend Toronto to other people, speaking of the magnitude of her own challenges. Similarly, Cindy brings up the concept of “survival sex,” that is, to have sex in order for a place to stay or a meal. Kaitlyn also grapples with housing as a new migrant – she does not want to go home, but, without housing, she cannot stay in Toronto. Of course, with the majority of participants now housed (n=19), it is understandable why so much importance was placed on housing as a determinant of their health and wellbeing, and ultimately success in Toronto, especially in the early migration period. While the majority of the participants are now in subsidized housing, the average wait list time for Toronto Community Housing is six years (Monsebraaten, 2014). This leaves a 6-year gap between coming to Toronto and finally having affordable housing. I spoke to participants about this ‘flux time,’ or transitional time, and how it influenced them feeling settled:

“P: It took me about four years [to settle in] … As soon as I got up in this area [Sherbourne and Gerrard], it was a lot better. Someone brought me here. I was down at Bathurst and Queen there is not too much there either.

R: What were you doing that transitional period, those four years before you really felt connected?

P: Not too much. There was like, just going to different drop ins. Just hanging around the shelter. Getting into trouble really. I got into drugs, things… Just yea. Just nothing.”

(Heather, <10 years)

Through asking participants about this transitional time, it was also revealed that there is an extensive network for newcomers to Toronto, most often existing within the shelter system and on the streets:
“There is a code on this street, that kind of goes like “it is like one big family and everybody shares, what resources, whatever we find we share or they share or we share or I have shared”. It is just a code on the street, and I think it is still there… God, I hope it is still out there, because there are so many people out on the street, but I hope that it is still there, because sometimes that is the only family you have are the people on the street. Sometimes that is all they have. So I hope that that is still there. I hope that that, I mean I am sure it is. I am sure it is carried on, carried on, carried on. So I am sure it is passed down, passed down, passed down.” (Linda, >20 years ago)

“Once you find one place, it kind of ripples, like it is kind of a spiral, we are connected.” (Jordan, <15 years)

“If I actually like came here and didn’t know anybody, I probably would have been like down on the street, because it was so pretty lonely there, even though I had [family] here, it was still so lonely, and I just about gave up.” (Tammy, <5 years)

Jordan’s optimism suggests that once you find one place where you feel like you belong, you become connected to many people (which Linda reinforces). However, many participants above detail that it took them several years to find that belonging. As we know, seventeen participants lived in the shelter when they first migrated to Toronto because of an absence of family, friends, networks, or another place to stay. Ultimately, while there is a seemingly solid network that exists within the shelters and homeless community, it does take participants a few years to tap into this network – for participants, the number averaged out to be approximately three years. Moreover, supportive networks cannot replace having a safe, affordable, and private home. Ultimately, housing strongly influenced participants’ feelings of wellbeing in Toronto, and played an even bigger role in employment.

4.5.2 Employment

After securing housing, many participants spoke about finding employment as their next goal. Five participants were employed (part time or full time), fifteen people were unemployed, and two participants were currently in school. Of the fifteen people who were unemployed, the majority of people (n=12) mentioned that they were looking for a job, recently had a job, or wanted a job. The remaining three participants acknowledged that they were not ready for work yet:
“I am not at that point yet. I mean eventually I will get back to work, but had to do a lot of different things for myself, and my sanity, and just probably have to brush up on my skills by the time I get back to work, but yea it is an option.” (Pamela, <5 years)

Eight participants had recently (within the past year) worked, the majority of which worked in social services (n=6). Working in the social services presented challenges for participants. Ten participants mentioned taking some sort of social services training or peer mentorship program. While this is an excellent initiative, it presented challenges for those trying to obtain employment in the social services field:

“It is just hard to get that job…So many people are looking for the same job.” (Dawn, >20 years)

Similarly, nine participants expressed that they wanted to work within the Aboriginal community. One participant noted an outcome of the policy vacuum, that is, a surplus of unsteady employment, which impacts her wellbeing:

“They are not long term jobs… You are contract here, contract there, so I have been grateful with that, you know a lot of employers have taken me on, so I manage to work two part-time jobs to pay my rent, and to live, so you know I am surviving.” (Cindy, >20 years)

As Cindy describes, she has managed to make ends meet working two part time jobs, but ultimately she is only surviving instead of thriving. This is a key distinction – despite how she is one of the participants who is housed and paying market rent, she’s still not thriving in Toronto, in part because of the impermanence of jobs. Participants also reported to challenges affiliated with their migration narratives. As Brandy describes, she moved to Toronto from the reserve, and did not have any work experience:

“Employment was hard… I didn’t have any experience, because on the reserve like you don’t get no job, besides hustling, whatever, but how do you put that on your resume? “Hustler.” I did have like trainings…But yea I guess that wasn’t enough, because I didn’t have no experience, like I didn’t have like you know, like I didn’t really have anything to put on there. I didn’t have like waitress or anything, so yea I bullshitted. That was my strategy.” (Brandy, <5 years)
With six participants who came directly from the reserve included in this sample, as well as low levels of educational attainment and employment more generally, Brandy’s challenge is a challenge facing the community. In addition to a lack of experience, two participants who currently live in the shelter acknowledge their own current challenges of finding employment when living in the shelter, a challenge that faced many participants earlier on in their narratives:

“It is impossible to find a job when you are in a shelter.” (Bev, <5 years)

“It is frustrating for me [to find housing] because I was waiting to get a job first, right while I am in the shelter and then go from there, looking for a place because I can’t do both at the same time. There is no way in hell I could do that, so I am focusing on a place first, and then training.” (P, <5 years)

The migration, housing, and employment narrative is very similar for all participants. To generalize, participants initially moved to Toronto in pursuit of more opportunities, only to end up living in a shelter. From the shelter, it is challenging to find employment, so participants were in flux until they secured permanent housing. Now, participants who are housed are looking for employment, but many still remain unemployed because of a lack of training or education or contract jobs. For those that do become employed and housed, it is still challenging to fully thrive. This narrative is not linear – at many places in the narrative, participants can fall off the trajectory, and move back to the shelter, lose their employment, or a combination of the two factors. Finally, all of these factors exist within a policy vacuum, a shelter system that can perpetuate one’s challenges or undermine their progress, and a world where there is still Aboriginal and LGBTQ2S discrimination as experienced by participants.

There are many barriers to employment that affect participants, many of which are interconnected to other proximal determinants of health, including housing. Of all of the narratives presented throughout the interviews, the narrative surrounding employment and housing was the most consistent, perhaps because so many participants lived in the shelter system (n=19) and are unemployed and/or looking for work. More than that, the narrative surrounding housing is the strongest – it is the most proximal to participants’ current wellbeing.
A large part of wellbeing as it relates to housing and employment stems from self-esteem, which this quote encapsulates perfectly. Yvonne recently secured permanent housing:

“P: Last night I realized I am in my neighbourhood. Everybody smiles. Everybody is working, everybody is just regular people...And that is how they see me.
R: And that is you, yea?
P: Yea, and that is how I have to see myself.” (Yvonne, >20 years, bolding for emphasis)

As Yvonne illustrates, now that she is housed and has a sense of community within her neighbourhood, she needs to begin to see herself as a regular person. After years of impermanent housing and employment and ongoing discrimination, it can be challenging for participants to reverse their perception of themselves. Ultimately, this too must be considered in the context of housing, employment, and other proximal determinants of health.

4.6 Weaving It Together: Recommendations for Service Providers and LGBTQ2S Resurgence

As Loppie Reading & Wien (2009, p. 24-6) outline, “the complex interaction between various determinants [distal, intermediate, and proximal] appears to create a trajectory of health for individuals that must be addressed through a social determinants approach,” before concluding, “ultimately, assessment of social determinants could lead to individual, family and/or community interventions that improve health outcomes.” By taking a critical population health approach through looking at distal, intermediate, and proximal determinants of health, we now know some of the trajectory of wellbeing for LGBTQ2S Aboriginal migrants in Toronto. By assessing distal, intermediate, and proximal determinants as they relate to the LGBTQ2S Aboriginal migrant population in Toronto, we can now suggest community interventions to improve health outcomes. In this section, I will focus on two specific recommendations as discussed by the community: one, reducing the transition and flux time in between moving to Toronto and securing permanent housing and employment, and two, utilizing ongoing LGBTQ2S resurgence to create strong programs, partnerships, and new models of care.
4.6.1 Transition Time

It is important to remember that participants in this research were connected to and established within the Aboriginal and/or LGBTQ2S community. However, participants were not always established within these communities, as many had come to Toronto without existing networks, including friends and family. As was revealed when discussing proximal determinants of health, participants enter into a narrative of housing and employment that is often cyclical. This is the “trajectory,” that Loppie Reading & Wien (2009) describe, a trajectory heavily influenced by colonially influenced push and pull factors of migration that is accentuated by cultural continuity and service systems and delivery.

This trajectory that exists within this situated knowledge begins upon arrival to Toronto. Many participants described that they migrated to Toronto with only a backpack and spent their first night in a shelter. Upon staying at the shelter, participants entered into a period of flux, whereby they were both disconnected from their home community and disconnected from Toronto’s Aboriginal and LGBTQ2S communities. At some point, participants came out of this flux time, connected to their community, secured housing, searched for employment, and found culturally-relevant and sufficient services. This connection – this network – was the turning point in many narratives towards a life with better physical, mental, emotional, and spiritual wellbeing.

Yet, this flux time still exists in the community right now. While there is a perceived street code and sense of community, this code is separate from the Aboriginal community. About midway through my interview process, the time in between first settling in Toronto and finally feeling like a part of Toronto was noted as an early theme of the participants’ narratives. By the end of the interviews, this flux time was, on average, reported to be around three years, although it ranged from one to seven years for participants.

What we also know about this flux time is that participants were living in the shelter system during this time. It has been shown that 20 percent of youth in shelters are LGBTQ2S, however the estimates are much higher at 40 percent because of the stigma and safety concerns associated with being LGBTQ2S (Armstrong, 2015). Meanwhile, more than one-third of the homeless population in Toronto are Aboriginal (Shapcott, 2013). When combining these two statistics, they speak to the importance of outreach within the shelter systems to bring people to
both the Aboriginal and LGBTQ2S communities. Nine participants acknowledged the importance of outreach, and I think outreach truly begins here – the shelter system – to begin to mitigate that flux time gap.

I would also like to recognize and commend Fred Victor for recently opening a 24/7 drop-in space for women that is holistic in nature, and responds directly to Dawn’s request for a 24/7 space:

“I remember like being homeless, 3:00 o’clock in the morning, nowhere to go, if there had been a twenty-four hour drop in or something at that time, that would have been great, but there is nothing like that. So yea, they could improve on that.” (Dawn, >20 years)

The 24/7 space, which offers information on programs, referrals to healthcare and legal services, social and recreational programming, laundry, showers, and just a generally safe and warm space is an integral new component to Toronto’s services landscape. Spaces such as these function as 24/7 outreach, and will ultimately influence wellbeing for all newcomers to Toronto, as well as those who are at various other points of the trajectory.

4.6.2 LGBTQ2S Resurgence

The influence of colonialism, the impacts of racism, and the loss of many two-spirited teachings has impacted LGBTQ2S status within the Aboriginal community, and has created some discrimination and intolerance within Aboriginal and non-Aboriginal communities, as spoken about by participants. Yet, participants also spoke optimistically about the future for both LGBTQ2S and Aboriginal people in Toronto. Moreover, despite colonization of gender and sexuality, the understanding of two-spirited people as respected leaders is still very much alive among participants:

“We are two-spirit people. They’re the heart of our culture.” (Lauren, <1 year).

“We’re not just a fairy tale somewhere in some book… We existed, before contact. Thousands of years before that. We were the highest recognized, no Chief would take any shit unless we said something. That was what it was. We did both roles. We were doing so much work, I mean like male/female roles a lot of work to be going back and forth from. We were the warriors when someone would go into war, we were the first ones that were sent in. The mystic one. You know what I mean. Other people were scared of two-
spirited people, other tribes, like we were missionaries and seers and healers, and they thought we had all this power. We did. We still have our power.” (Jordan, <15 years).

As a result, despite years of colonization, two-spirited people and power is still very much alive. This coincides with the sentiment echoed by participants acknowledging the growing strength of the Aboriginal community, again, despite centuries of colonization:

“the Aboriginal community is starting to rise up and speak up, and they are becoming stronger.” (Mary, <5 years)

“There is a bigger voice out there, you know about mistreatment of just native people in general. You know what I mean, and all this, you know the price of you know Missing and Murdered Indigenous Women and just our land and all the stuff that is going on right now, I think we are in a good place…I think there is a lot of good empowerment going on right now…it is going to get better as our voice gets stronger.” (Cindy, >20 years)

Knowing this, participants really embraced the idea that two-spirited people – and Aboriginal people more generally – are permanent, and should be engrained permanently within spaces and in funding applications. This is especially important in light of the fact that two-spirited people have largely been missing in the policy, which was confirmed by the literature as well as participants:

“I just find that two spirited people and First Nations in general… We are not really recognized. We are just kind of tolerated… Just because the government didn’t want to fund, they said they were already funding too many programs, but whether or not it is First Nations, I am guessing that is kind of why they didn’t want to, be like First Nations, and two-spirit [programming]? now we are confused.” (Jordan, <15 years, bolding for emphasis)

“We are the most discriminated [LGBTQ2S Aboriginal people]. We need to reclaim a lot of our own history and power, like you know, to feel better about ourselves, to bring a voice. Yea, so it would be great to have more spaces available for two-spirit, and you know not just for seven to twelve weeks. We are a particular population in our community. There should be something that is permanent funding not just a year funding, just like you have permanent funding.” (Cindy, >20 years, bolding for emphasis)

“[Having a lot of services,] that is really important for people that are LGBTQ2S, because we need those services, and I think we access them the most in different ways.” (Lauren, <1 year, bolding for emphasis)
As these narratives came out about the need for two-spirit programs that are permanent, and more than tolerant of LGBTQ2S Aboriginal people, I asked participants to describe what those ideal programs would look like in particular spaces:

“I just feel like accessibility is a key word… if you are not accessible then it makes somebody feel so, it just makes them feel sad and upset, and like doing that [making things inaccessible] to people?” (Brandy, <5 years, bolding for emphasis)

“I would really like to see some kind of project put in place where like you come here or some place and like, oh yea, we are going to go learn about you know like how to save money. How to do like, just essential skills of natural people that have to survive in this society today, where the girls are empowered, and not ashamed, because they are so scared to go into agencies.” (Yvonne, >20 years, bolding for emphasis)

What we can glean here is that there needs to be an empowerment based model that is inclusive to many different people, including cultures, sexualities, and lifestyles. A model for doing this – creating culturally-relevant programming, more generally – continued to come up throughout the conversations: the harm reduction model (n=8). The initial support for the harm reduction model coincided with higher incidence rates of HIV/AIDS in the 1980s and early 1990s, and the model is largely responsible for the implementation of methadone clinics and safe injection sites, for example (James, 2007). While it has been predominantly affiliated with reducing harm for intravenous drug users, the model has gained significant implementation within the Aboriginal community in Toronto. Harm reduction, in a holistic sense, focuses on reducing the harms affiliated with drinking, using drugs, sex, and other health behaviours, and can take many forms – whether through large initiatives like needle exchanges or smaller projects like recreation and cultural programming. Instead of placing the blame on the victim for health behaviours, it focuses exclusively on mitigating risk. This is particularly important, especially in consideration of when someone does not have control over his or her own health (such as in the case of survival sex). As Michael discusses, the Aboriginal community has been employing this model for years:
“To me like that model [harm reduction] is like ‘90s I mean like it is a great model, like we were doing that way back in the day… We were doing our own harm reduction.”
(Michael, <20 years)

This begs the question – what does LGBTQ2S Aboriginal harm reduction look like? Moreover, what does LGBTQ2S Aboriginal harm reduction look like in the form of relevant programming and services? Consistently, harm reduction came up throughout the results – participants acknowledge that you could be using when in the shelters and that there was sufficient access to harm reduction supplies like condoms and drug kits from service providers. When intersecting harm reduction and distal, intermediate, and proximal determinants of health, it begins at LGBTQ2S empowerment and resurgence. These conversations begin at overturning the concepts of colonialism that have clouded Indigenous ideas of gender and sexuality, continue into overturning health systems and vying for culturally-appropriate care, and end with cultural continuity, outreach, and empowering each other. Finally, it is adding a critical next step to the narrative as Aboriginal people’s health as inferior to non-Aboriginal people’s health. As Cindy states:

“It is okay to say that we need to be saved and that, but I don’t see anyone really doing anything to empower our lives either.” (Cindy, >20 years)

4.6.3 Another Author’s Note on Terminology: From two-spirit to…

First and foremost, it becomes evident from both Chapter 2 and the research findings that gender and sexuality – in both Western and Indigenous constructs – are still highly colonized. The experiences of discrimination faced by LGBTQ2S migrants can, in part, be attributed to general insensitivity and prejudices. However, the discrimination that occurs within the Aboriginal community (with various instigators, including Elders, service providers, and other community members) can only be attributed to colonialism. As evidenced by participant narratives, we are still far from pre-colonial understandings of gender and sexuality. That said, there still is a vibrant collection of LGBTQ2S people who openly and willingly discuss the historical role and importance of two-spirited peoples, and those discussions need to be louder and in more public spaces.
Second, and related, I would like to further dwell on the term two-spirited. The term was questioned both by myself in Chapter 2 and by participants earlier in this chapter, and these conversations should merge. As Kehoe’s (1997, p. 270) states, “two-spirit is not a “traditional” term, and if it were it could be traditional only for one or a few nations. It is an example of the vitality of contemporary First Nations cultures, expressing for these persons a mode shared across the diversity of their native nations.” However, it seems that participants would only agree with the fact that two-spirit is not a traditional term. Kehoe (1997) emphasizes two-spirit as a term that is an example of vitality, but, for participants, the term was more divisive than it was uniting or bound in conceptions of resurgence or power. In completing this research, I felt the division within the two-spirited community is much greater than the gap between two-spiritedness and Aboriginal peoples in Toronto, even though the latter gap can occasionally feature discrimination. Moving forward, especially in light of the conversations presented above on two-spirit resurgence, these tensions will need to be discussed before true reconciliation of LGBTQ2S marginalization in Toronto’s Aboriginal community occurs. In the meantime, it is important to again acknowledge the many Aboriginal and non-Aboriginal service providers who are doing their part in minimizing all gaps within and between communities.

### 4.7 Summary

As this chapter explored, participants’ migration narratives can be explained via a critical population health lens utilizing distal, intermediate, and proximal determinants of health. Distal determinants of health are understood as factors that affect health from a distance, such as racism and colonialism. It was found that these factors – such as colonialism and racism – heavily influence reasons for mobility and experiences of discrimination prior to and following migrating to Toronto. As a result, these factors impact wellbeing and ultimately shape participant’s narratives.

Second, intermediate determinants of health, best understood as factors that indirectly impact wellbeing such as service systems and delivery, culture, and community, impact LGBTQ2S migrants’ wellbeing. Within that, migrants acknowledged that, while there were enough services, Aboriginal-specific health services that are tolerant to LGBTQ2S identities and needs are missing from the service landscape. Another weakness was in mental health, particularly as it applies to their Aboriginal identity. A critical point of migrant wellbeing was
associated with finding a sense of community and culture. While it was determined that Aboriginal culture is just as represented in the city as in other communities (including reserves), it is hard to find and become connected to the community. However, half of participants recognized that finding their community overturned their negative narrative of migration.

This negative narration of migration was constructed in discussing proximal determinants of health, which are factors that directly affect a person’s wellbeing such as housing and employment. Within that, it was found that LGBTQ2S migrants have a very common narrative stretched across all three categories of determinants of health. The narrative emphasized that one’s experience (positive or negative) moving to Toronto is intimately connected to reasons for moving and social networks established or previously existing during the migration process. From there, safe, stable, and affordable housing is the biggest barrier to employment, wellbeing, and sense of community for LGBTQ2S people. However, once these narratives coincide, there are still barriers to thriving within the community.

This chapter concluded by discussing the necessity to reduce this transition time in order to strengthen LGBTQ2S migration narratives. Moreover, it was discussed that LGBTQ2S resurgence is ongoing in both the Aboriginal community and the Toronto community, and is spoken about in a very optimistic way. Ideas to bring these two ideas together in policy and programming will be a focus of the following chapter.
Chapter 5
Conclusion

This thesis examined the links among migration, Aboriginal identity, and LGBTQ2S identity in Toronto by answering the following research questions: i) What are the migration experiences of LGBTQ2S Aboriginal peoples in Toronto?; and ii) How do these lived realities intersect with access to housing, employment, culture, community, and service provision? In addition to these two research questions, this thesis was guided by two research objectives: i) to understand the different reasons for migration and the migration experiences of LGBTQ2S Aboriginal people, how those experiences interact with wellbeing, and how these experiences may differ from other Aboriginal narratives of migration; and ii) to acknowledge LGBTQ2S Aboriginal peoples’ lived experiences, with a particular focus on providing knowledge to service providers and policymakers to create the most holistic and inclusive future policy and programming directions. To answer these questions and fulfill these objectives, qualitative research methods informed by Indigenous methodologies and community-based research were utilized. Furthermore, a theoretical framework that was rooted in critical population health was constructed. This framework was used in order to understand LGBTQ2S Aboriginal peoples’ wellbeing through distal, intermediate, and proximal determinants of health. The following chapter summarizes and expands upon those understandings, and also acts to fulfill the second research objective by intersecting LGBTQ2S and Aboriginal lived realities with future policy, programming, and research directions.

5.1 Summary and Discussion of Key Findings

The thesis began by contextualizing Aboriginal urbanization as a modern phenomenon. In 1901, only 5.1 percent of Aboriginal people lived in urban areas, and this number was steady for 50 years as by 1951 only 6.7 percent of Aboriginal people lived in urban areas (Kalbach, 1987). However, by 2001, 50 percent of Aboriginal people lived in urban areas (Statistics Canada, 2011). Most recently, the 2011 census revealed that the number has climbed to 56 percent of the population, and continues to climb today (Statistics Canada, 2014a). Combined with rapid Aboriginal urbanization, we are seeing the Aboriginal population grow at a rate much
higher than the non-Aboriginal population. From 2001 to 2006, the Aboriginal population grew by 20.1 percent compared to 5.2 percent in the non-Aboriginal population (Statistics Canada, 2014). We see these trends emerge in Toronto: from 2001 to 2011, Toronto’s Aboriginal population grew by 82 percent to 36,995 people (Statistics Canada, 2013). However, Aboriginal service providers estimated that high degrees of mobility, homelessness, and a growing refusal to participant in government surveys could mean that Toronto’s Aboriginal population is underestimated, and may be closer to 70,000 residents (McCaskill et al., 2011). When encompassing all these factors, we understand Toronto’s Aboriginal population as rapidly growing and highly mobile.

In considering Toronto’s Aboriginal population’s growth and mobility, as well as informed by Chapter 2’s critical literature review, one key group has emerged as underresearched, underfunded, and heavily marginalized. The Toronto Aboriginal Research Project (2011, p. 187) revealed that two-spirited people “constitute a forgotten group within the Toronto Aboriginal community.” Meanwhile Young (2003) acknowledges that both urban Aboriginal people and those who are most marginalized in this already marginalized community are often excluded in research (Young (2003) refers explicitly to women and children and does not mention two-spirits in his discussion). This notion led to the conclusion that exploratory research on two-spirited people in Toronto was needed, and formed the basis of the research questions and research objectives.

Chapter 4 presented the results of this exploratory study. In answering the research question “What are the migration experiences of LGBTQ2S Aboriginal peoples in Toronto?”, it was found that LGBTQ2S Aboriginal people have both diverse migration experiences and different migration experiences from other Aboriginal people. These differences orient around reasons for migrating, which lead to different housing characteristics during the migration process. Moreover, participants’ migration narratives occasionally led to instances of discrimination.

LGBTQ2S Aboriginal people’s reasons for moving to Toronto vary tremendously. While it was most often for work or other opportunities (n=10), five participants reported moving because of their LGBTQ2S identity and the discrimination or discomfort they experienced in
their previous communities as a result. This was particularly relevant to participants who were from the reserve (n=4). While some participants did not suggest that they moved to Toronto because of their LGBTQ2S identity, many participants acknowledged that LGBTQ2S identities were not as accepted on reserves or in small communities, and other participants admitted the benefit of moving to Toronto as an LGBTQ2S person, and the freedom associated with being able to be open about their identity. Finally, eight participants moved to Toronto because they had to – they moved not necessarily out of choice, most often to escape a previous life (n=5).

Migration experiences permeated the discussions surrounding housing, which ultimately meant that, for participants, their migration experiences influenced their access to housing upon migration and throughout their life in Toronto. In total, nineteen participants had lived in the shelter system at some point during their time in Toronto, while fifteen participants lived in the shelter system starting from their first night in Toronto. It was found that the factors of migration influence housing characteristics – if they knew about shelters, had money saved up for housing, or had other previously existing networks, then they all had different housing outcomes. It is theorized that part of the reason so many participants lived in the shelter system starting from their first night in Toronto is as a result of their reasons for migration. LGBTQ2S Aboriginal migrants come to Toronto with the hopes of escaping a lifestyle or discrimination or pursuing more opportunity, or some combination of the three. These factors for migration are bound in the desire to leave a community, which makes LGBTQ2S Aboriginal people vulnerable upon migration, and oftentimes underprepared, which results in them entering the shelter system. This theory is confirmed in the literature, where it is estimated that twenty to forty percent of youth in homeless shelters are LGBTQ2S11, while thirty percent of homeless people in Toronto are Aboriginal (Armstrong, 2015; Shapcott, 2013).

11 The number of LGBTQ2S homeless adults in Toronto is unknown. However, it has been speculated that there is a similarly disproportionate higher number of LGBTQ2S homeless adults – this has been most recently shown in San Francisco, where they recently opened an LGBT adult shelter for the 29 percent of the homeless population that identify as LGBT there (Green, 2015). Furthermore, as Gaetz (2014) argues, the current youth shelter system in Ontario is largely inadequate, which increases the chance of youth becoming chronically homeless as adults. Of course, this too would disproportionately affect LGBTQ2S adults.
Participants reported experiencing discrimination as new migrants, or new people to the Aboriginal community. Twenty people reported experiencing discrimination, however most instances were based on historical misconceptions or stereotypes of Aboriginal people. It was also revealed that discrimination also exists within the community, and occurs on lines of colonization, and often affects new migrants. Some participants reported feeling discriminated against because of their LGBTQ2S identities when they first moved to Toronto (associated with the legacies of colonization), while others mentioned they experienced discrimination because of their real or perceived lack of Indian status (being adopted, not growing up on the reserve, or looking white).

The summary presented above paints a somewhat gloomy picture that migrating to Toronto – and subsequently their migration narratives – are negative (in response to research question 1). However, all but three participants (n=19) reported that their life had improved since coming to Toronto. As a result, when combining these initial migration narratives, it is understood that LGBTQ2S migrant experiences are generally positive, however their reasons for moving vary tremendously from other Aboriginal people. Furthermore, participants in this research were likely to live in the shelter system at some point in their migration journey, which has been theorized as a result of their intersecting identities as both Aboriginal and LGBTQ2S and their reasons for moving. This intersectionality continued when discussing experiences of discrimination as new migrants, and eventually their intersectional identities interacts with access to housing, employment, culture, community, and service provision.

To answer the second question, “how do these lived realities intersect with access to housing, employment, culture, community, and service provision?,” participants reported sufficient access to culture, community, and services, but noted that employment and housing services needed improvement. It is particularly important here to acknowledge housing and employment as proximal determinants of health, meaning, they directly impact one’s wellbeing. As a result, while question 1 revealed that migrant experiences are generally positive, and question 2 determined that there are adequate services, culture, and community available to participants, the factors that are the most intimately connected to wellbeing (housing and employment) are reported as needing the most improvement.
While some research has acknowledged that culture is a pull factor to reserve communities and that cities are places where culture is not as prominent (see King, Smith, & Gracie, 2009), participants felt that there was enough culture available to them in Toronto. Participants described this in various ways, including specifying that Toronto was where all the teachings were, and how Aboriginal people are even represented in public spaces, such as through art. While participants highlighted that it was still challenging to access Elders that are supportive of LGBTQ2S people (because of the impacts of colonialism and the fact that many two-spirit teachings were lost), ultimately participants did specify that there were two-spirit inclusive spaces (such as sweat lodges) and Elders in Toronto. This refutes the idea that culture and the city do not overlap, and suggests that for LGBTQ2S people it is easier to access relevant and safe cultural programming in urban areas.

With regards to access to community, participants reported a high sense of community within the Aboriginal community. In total, eighteen participants identified that they felt connected to the Aboriginal community in some way. For those who associated more with the LGBTQ2S community (n=3), it was because of the distal determinants of health – historical trauma and colonialism, such as being adopted by a non-Aboriginal family. Finding the community was also attributed as a turning point for many LGBTQ2S migrants, and a place where their narrative changed for the better. Participants acknowledged many reasons for this, including feeling more connected to the culture, the power of the fact that many of their migration stories were similar, and the overall warmth of the community, as they take care of each other. It is important to note here that these narratives of community do not depict incidences of discrimination, and speak to the strength of the community today, as well as the strong progress made in reaccepting LGBTQ2S identities in the Aboriginal community.

Service provision was seen as another strength in the community. While there were some challenges accessing services, such as geographical clustering of services in the downtown core, services were reported as accessible. While participants agreed that there were enough services, they acknowledged that some people might not feel that way because of the stigma associated with accessing service providers (especially if you are transgendered or using drugs). This is an important consideration for service providers, who need to continue to advocate for and advertise their safe spaces. This – advocating for and advertising safe spaces – is an important
consideration when discussing migration narratives, as many participants reported experiencing a “transition time” upon migrating to Toronto, which averaged out to be approximately three years, where they were not fully utilizing services, in part because of these stigmas, but also because of not knowing where the services were located. Moreover, there are several spaces that are perceived as dichotomies – namely shelters – and it is important to remember, acknowledge, and continue to support spaces undergoing evolution towards more positive and inclusive places.

Participants noted one key shortcoming in accessing services – the lack of Aboriginal health services. Even though all of the participants who had an opinion on accessing Aboriginal services vs. mainstream services unanimously preferred Aboriginal services (n=10), it was found that more than half (n=12) of participants reported preferring mainstream health services. While some of this can be attributed to a general dearth of Aboriginal health services, it also relates to their LGBTQ2S identities and the traditional perspectives used in Aboriginal health. In reference to LGBTQ2S preference for mainstream health, participants justified their preference by discussing how it is more welcoming because there are more LGBTQ2S staff, and just the general perspective of the mainstream health system on LGBTQ2S people, which is not as affected by colonialism.

Access to housing was brought up as a challenge or area of improvement by all participants (n=22). This was best shown in discussing the significant transition time that occurs in between moving to Toronto and securing safe, affordable, and private housing. Participants acknowledged this time as created by a combination of factors including one’s personal stake in finding housing, a lack of affordable housing, and the difficulty associated with finding and affording housing (especially while living in a shelter). Participants also mentioned that it was easy to get comfortable in the shelter system, which undermined their goals to find or maintain employment or stay sober. Housing was seen as a particular area of need for Trans participants, as one participant reported a violent incident of discrimination that undermined their permanent housing. Moreover, another Trans participant – on the verge of losing her home – stated the importance of maintaining her home, especially as a Trans woman, because of the overrepresentation and mistreatment of Trans people in the shelter system. As a result, housing is seen as a truly integral piece to one’s migration narrative and ultimately their success story.
With the majority of participants now in permanent or transitional housing (n=19), access to employment is becoming more and more attainable for participants. The majority of participants (n=12) mentioned that they were looking for a job, recently employed, or wanted a job, while five participants were already employed and two were students. However, participants revealed that it was challenging to access permanent employment in their area of interest. Nine participants expressed wanting to work within the Aboriginal community to give back, especially because the community values lived experiences, however, the jobs that exist within the community are often temporary. Those who were currently working within the community acknowledged that they were only surviving instead of thriving. The result is that the work opportunities do not align with what participants want in a career. Migration narratives also impacted the work opportunities available to them – some participants said that because they were from a reserve, it was hard to get a job because they lacked skills. Finally, it is important to acknowledge the interdependency of a lack of safe, affordable, and private housing and unemployment – participants recognized the challenge of finding a job without a permanent home, meanwhile, finding a permanent home is hard to do without a job.

As a result, when thinking about how migration overlaps with access to culture, community, services, employment, and housing, it seems that there is a generally positive course for migrants as they come to and experience the city. Furthermore, cultural, community, services, employment, and housing supports do become available as one moves through their migration journey. However, this journey is long, and features about three years of transition time, which means that participants are coming to community, culture, housing, and employment later on in their migration journeys. This is especially apparent in housing, as one’s housing characteristics are influenced by their migration narratives, and perpetuated by employment, a lack of affordable housing, and occasionally, discrimination. These discrepancies (transition time, a lack of suitable housing) mean that the health and wellbeing of LGBTQ2S Aboriginal participants is directly affected. Moreover, while LGBTQ2S Aboriginal migrants’ narratives are positive at the present time, they have the potential to be undermined because of these glaring weaknesses.

5.2 Contributions to the Literature and Limitations

This research makes two key contributions to the Aboriginal mobility literature. First, it introduces a new population in the Aboriginal mobility literature by looking at LGBTQ2S
Aboriginal migrants across a variety of ages, genders, migration timeframes and places of origin. As a result, this research holistically examines LGBTQ2S Aboriginal migration narratives. This is especially apparent when discussing reasons for migration and experiences of discrimination. While the push and pull factors of migration coincide with what O’Brien-Teengs & Travers (2006) discussed (where reserves can be places of homophobia and cities places of acceptance), it was also found that other cities and small towns are places of discrimination as well. This is in contrast to the dichotomy of reserves as discriminatory and cities as inevitably accepting and reinforces the idea that many communities can still work towards LGBTQ2S acceptance.

Second, by interviewing primarily service users through a community-based research partnership, the findings revealed a significant transition time experienced by migrants. This transition time can be defined as the time in between migrating to Toronto and finding the Aboriginal community and/or adequate social, health, and community services, including sufficient housing. Within this, it was theorized that this transition time was influenced by factors related to participants’ intersectional identity, such as that participants’ reasons for migration were all bound in ideas to escape from another place – either their previous life or discrimination. As a result, participants are more vulnerable upon migration and potentially unprepared for life in Toronto, which results in them entering the shelter system. In thinking about life in the shelter system, participants acknowledged that it could undermine efforts to secure employment, housing, or to stay free of alcohol and drugs. This reinforces and extends the amount of transition time. Now that we know about this transition time experienced by LGBTQ2S Aboriginal migrants – and perhaps Aboriginal migrants more generally, as evidenced by the 30 percent of homeless people who are Aboriginal in Toronto – we have a better understanding of migration narratives, and more opportunity to improve these migration narratives in an era of increasing Aboriginal urbanization.

This research also makes a key contribution to the Aboriginal health literature. While it was understood that there are enough Aboriginal-specific social services, there was a reported dearth of Aboriginal health services. While this has been widely documented (see Allan & Smylie, 2015), LGBTQ2S migrants reported preferring mainstream health services. Despite how these mainstream health service spaces can be places of discrimination, participants liked how mainstream health services were outwardly open and accepting to LGBTQ2S identities. This was
particularly common amongst transgender participants, who recognized the amount of supportive programming available at mainstream health service providers around transgender health needs. As a result, it is important to consider LGBTQ2S health perspectives in conversations on Aboriginal health, as they have been largely absent from the literature (including in Allan & Smylie, 2015).

These contributions to the literature must be understood in unison with the limitations of the research. The Toronto Aboriginal Research Project (2011, p. 28) called for a:

“comprehensive research project [to] be undertaken focusing on gaining a greater understanding of the issues and concerns of the two-spirited community including the middle class, transgendered and HIV positive individuals. The study could include an examination of the relationship between First Nations and Métis communities and the city regarding two-spirit issues.”

While I think this project satisfies that call, this research is largely missing the “middle class” component of their request, in part because it primarily interviewed service users. As a result, it is important to recognize that this thesis represents situated knowledge. That said, in light of the widespread need for many service improvements across LGBTQ2S and Aboriginal communities, interviewing service users was the place to begin the conversation. In part, I think the reasoning for this is fair, because of the lengthy transition process to the city, and how that transition process is so intimately connected to distal, intermediate, and proximate determinants of health. Of these determinants, one of the major determinants that spans multiple scales is socioeconomic status. However, I do recognize that much can be learned from the middle class – particularly as it applies to overcoming that transition time. Nevertheless, this was a limitation.

Second, and related, a more holistic outlook on access to housing, employment, and services could have been obtained by formally interviewing service providers. While Phase I engaged many service providers, and this research did interview many dual providers-users, ultimately this research did not gain the explicit perspectives of service organizations and

12 This is not to say that middle class people do not use services. However, for example, Native Women’s Resource Centre is only open during the day – limiting the clientele that they could – and do – see.
agencies. While many scholars have interviewed service providers to gain perspective on Aboriginal health and social services (see DeVerteuil & Wilson, 2010; Yi, Landais, Kolahdooz, & Sharma, 2015), it is often in situations where service users might be hard to access or frontline perspectives are highly valued (in the case of DeVerteuil & Wilson (2010), in drug treatment centres, and in the case of Yi et al. (2015), Aboriginal youth). In this research, service user perspectives were valued because of the importance of gauging their unique migration narratives. However, with fifty service providers named by participants, it is important to gauge that frontline perspective on LGBTQ2S services and resources in the Aboriginal community and merger these perspectives. This is both a limitation of this research and a recommended next step in understanding LGBTQ2S Aboriginal services needs and availability.

This leads to several broader limitations of this research regarding participant recruitment. Since the Ethics protocol was limited to adults (18+), youth perspectives were largely missing. This is important to consider as several participants acknowledged that they first came to Toronto as a teenager, and meant that early migration perspectives could have been missed (especially important in light of the fact that 20-40% of the youth in shelters are LGBTQ2S). This exposes another limitation – the fact that there were not many recent (less than 1 year) migrants included in this research. In part, this can be explained by the transition time reported among participants, however, as a result, this is not an entirely comprehensive look at the experiences of all LGBTQ2S migrants. Lastly, since recruitment was through posters, recruitment was really limited to service users, and those who did not use services (including those in the transition time and perhaps those in the middle class) would not have been included in this research. This meant that participants had to be connected to services in order to access recruitment materials. Ultimately, youth, recent migrants, and non-service user perspectives were left out of this research, which means that we do not understand why some people do not use services, have a comprehensive picture of youth migration narratives, or can talk about early migration narratives in the moment they are occurring.

Lastly, I would like to acknowledge a final limitation – that colonization is ongoing. Colonization has and still occurs within service agencies, power imbalances between interviewer and researcher, and in discussions on Aboriginal health in particular (see Maar et al., 2011). While my conversations with participants were often rich, emotional, and prioritized narrative in
the discussions, ultimately we cannot separate the interviews from these external forces. In an effort to decolonize research, this research used Indigenous methods and will continue to use Indigenous methods in the Knowledge Translation process. Furthermore, by presenting some commentary on what decolonized narratives will look like, it is hoped that conversations on decolonizing research – particularly Aboriginal health research and Aboriginal mobilities – will continue to be had in the academy.

5.3 Rethinking Loppie Reading & Wien (2009)

In thinking about the limitations and contributions of this research, it is important here to acknowledge the limitations and contributions of Loppie Reading & Wien’s (2009) model. The model depicted by Loppie Reading & Wien (2009) and used extensively here is one way of conveying the many ways in which Aboriginal wellbeing is a product of many external forces – or that there are “causes of causes” of Aboriginal health (Marmot, 2007, p. 13). However, Loppie Reading & Wien’s (2009) model has some shortcomings, particularly around its intersection with Indigenous methods and methodologies.

de Leeuw et al. (2015, p. 13) indirectly challenge models such as Loppie Reading & Wien’s – interestingly, Charlotte [Loppie] Reading serves as an editor to Determinants of Indigenous Peoples’ Health, perhaps best indicating how thinking on social determinants has and continues to evolve – by suggesting that Indigenous peoples’ health “is not solely “socially” determined, nor is “adding colonialism” to a social determinants of health framework sufficient to fully analyze and understand the realities of Indigenous peoples’ health.” While Loppie Reading & Wien (2009) go slightly beyond both social determinants and adding colonialism, they fall short of what de Leeuw et al. (2015, p. 13) describes health as, where “health is multiply and complexly determined by a myriad of factors that, although they invariably unfold within a colonial reality, are always unique to a specific time and place.”

While Loppie Reading & Wien (2009) do expand our understandings of Aboriginal health – and attempt to bring the present into the conversation (recall how they mentioned that their model does connect to Indigenous understandings because of its temporal nature) – they also require us to simultaneously deconstruct and reconstruct narratives. For example, one must deconstruct them to detail how each story connects to these determinants, and reconstruct them...
as to make them fit back together as intersectional entities. This results in the occasional fragmentation of stories, which strongly differs from Indigenous methodologies. Relevant to this research, we have seen that migration is a product of both time and space, yet encapsulating that within the ILCSDAH can become challenging because stories are not presented in full. Certainly, with the social determinants of health framework as only a recent phenomena, particularly as it applies to Aboriginal peoples, it seems that thinking about models of Aboriginal health can extend beyond proximal, intermediate, and distal determinants of health and look to new conceptions of places, spaces, and identities that intersect across these three levels of determinants.

Though this research was highly exploratory in nature, many interviews captured well beyond what was expected from the interview script. While this was to be expected – the narrative, conversational approach to interviews, of course, produces strong personal narratives – ultimately it is was challenging to intersect models of Aboriginal health with qualitative research. This became particularly troubling because tremendously rich participant narratives were captured, which spanned well beyond health and wellbeing, yet these were hard to incorporate within the proximal, intermediate, and distal framework. This was particularly common amongst the trans population, where strong narratives of sex work, drug use, and trans-specific housing, employment, and service experiences emerged, but ultimately could not truly be encapsulated (also keeping in mind confidentiality and the small size of that community). When combined with the idea presented above that Loppie Reading & Wien (2009) both deconstruct and reconstruct narratives, it was challenging in this research context to present full – and truly representational – narratives.

One method gaining traction in academia and beyond – and a good way to integrate both Loppie Reading & Wien’s (2009) model and these full perspectives –is the composite narrative. As Thompson & Kreuter (2014) argue, using narratives have many benefits – they have the potential to target hard to reach populations, are powerful in disseminating information to policy and programming, and are engaging at their core. This results in “stronger emotional reactions, greater identification with the person sharing the messages, and increased engagement” (Thompson & Kreuter, 2014, p. 2). Composite narratives are created through joining together several stories and presenting them as one (Thomson & Kreuter, 2014). This not
only ensures anonymity, but also results in highly reflective stories, which often present stronger conclusions as they “draw a composite picture of the phenomenon emerging from the informants” (Wertz, Nosek, McNiesh, & Marlow, 2011, p. 5883). As a result – instead of deconstructing and reconstructing narratives through Loppie Reading & Wien (2009) – this method simply creates and expands upon existing narratives in order to create new and highly reflective understandings. This is particularly important as Aboriginal health continues to evolve, and offers the potential to recenter Aboriginal voices within Aboriginal health.

Knowing this, the composite narrative is much more than merely a method, but an Indigenous method as well. As we know, participants’ voices are intimately connected to Indigenous methodologies. Jackson, Debassige, Masching, & Whitebird (2014, p. 145) argue “composite narratives can act as mediators that trigger positive social transformation by resisting colonial practices.” In conceptualizing this resistance to colonial practices, Jackson et al. (2014) make the case to consider composite narratives as an innately Indigenous method. In articulating composite narratives as an Indigenous tool, Jackson et al. (2014) highlight three main points as to why – and how – composite narratives and Indigenous methodologies achieve the same goal. First, composite narratives reflect Indigenous knowledge in the stories of participants (Jackson et al., 2014). Second, composite narratives acknowledge Indigenous ways of sharing and learning through story (Jackson et al., 2014). Finally, dissemination and knowledge translation via story is congruent with traditional knowledge exchange, instead of the typical knowledge translation methods that often privilege Western dissemination methods (Jackson et al., 2014). As a result, composite narratives are one place where Indigenous methodologies and knowledge translation intersect. In essence, what Jackson et al. (2014, p. 157) are really arguing is that experiences “are best understood from the cultural perspectives of those who experiences it (McLeod, 2007), and thus, best expressed using their cultural practices of story telling.”

Looking forward, there is tremendous possibility to create and present findings in two ways – one, under Loppie Reading & Wien (2009) and similar models, and two, in Indigenous methodologies. Utilizing both together, we can see how determinants of health intersect and weave together when presented in narrative form. Moreover, we can understand how these determinants – in participants own words – are experienced, and at which point in time and space, since the composite narrative follows a story format. The result would be a much more
comprehensive and holistic understanding of participants’ experiences, which could be fully utilized by academic research, policy makers, community members, and community organizations. In doing so, we privilege both ways of knowing, which will inevitably lead to better ways of understanding and improving Aboriginal health and wellbeing outcomes.

5.4 Future Research and Recommendations for Policy and Programming

While there still is a large gap in understanding lived experiences of urban Aboriginal mobility, this research furthered the conversation on Aboriginal mobilities as they relate to intersectional identities. This conversation needs to be continued, whether that is looking at intersectionality within the LGBTQ2S community specifically or other specific communities within the Aboriginal community. I would particularly like to acknowledge that I had no Inuit participants, and while the Inuit are overrepresented in research, very few studies intersect Inuit identities with migration (Young, 2003). Moreover, while information saturation was achieved for this set of research questions, I think there are many other sets of research questions still left to be explored. As a result, a future research direction is intersecting LGBTQ2S identities with other intersectional identities (e.g. Inuit, First Nations, or Metis-specific research; transgender narratives). This will ultimately create more targeted future policy and programming recommendations.

Particular to understanding LGBTQ2S Aboriginal migration further, health does need to be further emphasized in research, albeit carefully. In still keeping a safe distance from the biomedical models of research, reincorporating Loppie Reading & Wien’s (2009) model with research questions bound more in access to health services, experiences of health and healthcare, or personal health would yield more in-depth conclusions on how distal, intermediate, and proximal determinants of health particularly affect LGBTQ2S Aboriginal people. Within that, while there has been a significant body of literature on culturally-relevant services and culturally-safe care (see Martin Hill, 2003; Smye & Browne, 2002), little has been said about age-appropriate care and services in Aboriginal research. This is in light of the fact that the Aboriginal population is the fastest growing in Canada and that 36.2 percent of the Aboriginal population is under the age of 25 (Statistics Canada, 2014a). For future research, there is tremendous potential to look at age-appropriate care and services, and extend the idea of
culturally-relevant services to other points of relevance (e.g. age-appropriate services, culturally-relevant services for LGBTQ2S peoples). When intersecting this with LGBTQ2S identities, there is tremendous possibility to look at health among LGBTQ2S Aboriginal peoples across varying ages as a particular focus of 2-Spirited People of the 1st Nations is palliative and end-of-life care, and O’Brien-Teengs & Travers (2006) acknowledged some shortcomings of youth services for LGBTQ2S people, as did one of my participants. Of course, in completing these proposed research projects, it is particularly important to blend Aboriginal health models and Indigenous methods, with the ultimate goal of satisfying and furthering both current understandings of Aboriginal health and Indigenous methodologies.

When thinking about this research’s implications for future programming and policy, it is important to highlight that this research confirms the existence of a “policy vacuum,” and reinforces the challenges that funding for Aboriginal services at many jurisdictional levels presents. To take this a step further, this research suggests that LGBTQ2S Aboriginal people are even more entrenched in the policy vacuum, because of the colonization of gender and sexuality, and the dominance of the Western gender binary in funding, programming, and research. Despite the existence of the policy vacuum, participants overwhelmingly reported that they – and their LGBTQ2S identity – are here to stay (both literally and metaphorically, as 17 participants planned to stay in Toronto forever), and that LGBTQ2S Aboriginal service needs are unique and warrant more attention in public policy.

In making policy and programming recommendations, it is important to again reinforce the migration narrative provided in Chapter 4, as it is a crucial starting point to improving LGBTQ2S Aboriginal experiences of the city. The narrative is that LGBTQ2S Aboriginal migrants come to Toronto to escape a lifestyle or discrimination or to pursue more opportunity, or some combination of the three. These reasons for migration are bound in the desire to leave a community, which makes LGBTQ2S Aboriginal people vulnerable and oftentimes underprepared upon migration, which results in them living in a shelter. This creates lasting problems in their migration narrative; from the shelter, it is hard to find employment (and housing), so participants are in transition until they secure permanent housing or employment. Yet, many still remain unemployed because of a lack of training or education, which is influenced by colonialism’s impact on the education system and the opportunities that reserves
offer. For those that do become employed and housed, it is still challenging to fully thrive. These factors exist within the policy vacuum illustrated above, which does not acknowledge LGBTQ2S Aboriginal peoples’ existence, as well a shelter system that can perpetuate one’s challenges or undermine their progress, and in a world where there is still Aboriginal and LGBTQ2S discrimination.

In thinking about the policy and programming recommendations to this narrative, there are many points at which this narrative can change, but reconciling this narrative starts with having an honest conversation in LGBTQ2S, Aboriginal, and mainstream service provision on intersectionality and intersecting identities. While many participants acknowledged that they did prefer Aboriginal specific services, there are no specific Aboriginal women’s shelters, for example (except for Anduhyaun, which is for women escaping violence), meaning that LGBTQ2S Aboriginal women do have to access mainstream shelters, where they were reports of discrimination. This coincides with more education – for all people, not just agencies – on both Aboriginal peoples and LGBTQ2S peoples and identities. This is especially important in health and social service provision, especially because of the intimate nature of LGBTQ2S identities and the necessity of culturally- and personally-relevant programming and services for all people.

Lastly, I would like to acknowledge the two turning points that participants acknowledged in their migration narrative as policy and programming directions: i) finding community; and ii) finding housing. While more affordable housing is a policy direction being sought by many organizations, advocates, and researchers, it was shown how this is particularly important to LGBTQ2S Aboriginal people. Second, the Aboriginal community is already fragmented by colonization, and the LGBTQ2S Aboriginal community is even further fragmented and marginalized within that. As a result, every effort needs to be made to reconnect the community, build on the current momentum of Aboriginal and two-spirit resurgence, and – most importantly – invite and welcome new migrants into Toronto’s Aboriginal community as soon as possible. By doing so, we take one critical step towards shortening an LGBTQ2S Aboriginal migrants’ time between surviving and thriving.
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Appendices

Appendix 1: Interview Guide

Mobility and Migration: On Moving to Toronto

How long have you lived in Toronto? Where did you move from? Why did you decide to move here? Do you go back and visit other places you have lived in? Why? Do you always plan to live in Toronto? Where else would you want to live? Why?

Finding Sense of Community and Place in Toronto

Do you like living in Toronto? Why or why not? Would you recommend Toronto as a place to live for other Aboriginal people? Why or why not? Would you recommend Toronto as a place to live for other two-spirit or LGBTQ people? Why or why not? What do you like about Toronto? Do you feel a sense of community here? Could you describe it? What community do you feel the most connected to? Are you involved in the Aboriginal community? Are you involved in the LGBTQ community? Why or why not? Do you feel that Toronto is a place where you can connect to your culture? Why or why not? Do you access your culture here? How? Do you think you are represented in Toronto? Do you think your experiences as a two-spirit man/woman are different from other Aboriginal people’s experiences? Why or why not? How does your experience of Toronto differ from the rest of Toronto’s experiences? Since moving to Toronto, has your life changed? For the good or bad? Why or why not? What factors contribute to this change?

Experiencing Toronto: Accessing Housing and Employment

How did you find a place to live in Toronto? Have you ever moved within Toronto? How often? Are you still looking for a place to live in Toronto? What are some challenges to finding housing in Toronto? Are you happy with where you live? Why or why not? If you could, how would you improve your living arrangements? Do you have a job in Toronto? If not, are you looking for a job in Toronto or would you want to have a job? How long did it take you to find a job after moving to Toronto? How did you find your job? Are you happy with your job? If you could, what would you change about your job? What other jobs would you consider doing in Toronto?

Experiencing Toronto: Discrimination and Safety

Where do you feel comfortable in the city? Why? Do you feel safe in Toronto? Why or why not? What places are safe for you in Toronto? Are there any places that are unsafe for you in the city? Why? What are some of the challenges you experience living in Toronto? How do they relate to you as an Aboriginal person? How do they relate to you as a two-spirit or LGBTQ person? Do you feel that Toronto is welcoming to you? What experiences have made you come to think this? Have you ever been discriminated against in Toronto? Can you describe it? How does this affect you? How does this affect your opinion of Toronto?

Experiencing Toronto: Accessing Services
What do you think of when I say social services in Toronto? Do you access services in Toronto (health, housing, employment, culture)? What services have you accessed in the past? Where are these services located? Do you prefer to access Aboriginal-specific services (Anishinaabe Health, Native Women’s Resource Centre, etc.)? Why or why not? Do you think there are adequate services available to you? Are there any challenges when you access Aboriginal services? Are there any challenges with using mainstream services? How do these challenges compare to other places you have lived? How are you treated when you access services? Does this ever change? Do you think Toronto offers enough services? Aboriginal-specific services? Why or why not? Compared to other places you have lived, what is Toronto better at? Worse at?

Recommendations

How do your service needs differ as an Aboriginal person? How do your service needs differ as a two-spirit or LGBTQ person? Where should social and community services be located? What services would you use if they were offered? What other services are missing from Toronto that may be in other cities? What services are needed for Aboriginal peoples in Toronto? What services are needed for two-spirit or LGBTQ people in Toronto? How could existing services improve in Toronto?

Demographic Information

Age – 18-25, 25-35, 35-45, 45-55, 55+
Family: Do you live with family? Are you single? Do you have kids?
Education: What is the last type of schooling that you did?

Conclusion

Anything else you would like to add? Any questions, comments, or concerns?

Recruitment

Can you think of anyone else who you think might be eligible and willing to participate in this study?
Appendix 2 – Recruitment Poster

Two-Spirit Discrimination and Service Provision Project
Improving Sense of Belonging and Services for the Two-Spirit Community

Interview participants needed for research on mobility, discrimination, and access to services in Toronto

We are looking to speak with LGBTQ or two-spirited people who:
• Identify as Aboriginal, First Nations, Inuit, Métis, or Indigenous
• Have not always lived in Toronto
• Are 18 years of age or older

What to expect?
• A 1-hour interview that asks you questions on your experiences moving to Toronto, accessing services and resources (including housing, employment, and culture), and instances of discrimination.
• Summary of the findings upon project completion.
• Compensation for your time.

For details, please contact:
Rachel Harris
MA Candidate, Geography & Aboriginal Health
Phone: 647-471-7317
E-mail: rachel.harris@mail.utoronto.ca
Appendix 3 – Letter of Information

Letter of Information

January 12, 2015

Thank you for your interest in Life on the Margins: The Two-Spirit Migrant Experience in Toronto. The purpose of this study is to understand the urban experiences of two-spirit or LGBTQ Aboriginal people in Toronto. This research is being conducted by Rachel Harris, a Masters student in Geography under the supervision of Dr. Kathi Wilson at the University of Toronto. This research is in partnership with the Native Women’s Resource Centre of Toronto.

I am requesting your voluntary participation in this study. Participation is limited to people who are 18 years of age or older, who self-identify as Aboriginal (including Inuit, First Nations, and Metis) and as either lesbian, gay, bisexual, trans*, queer, intersex or two-spirit. Should you participate, an interview will ask you a series of questions about your experiences with moving to Toronto, accessing Aboriginal and non-Aboriginal services, and ability to find employment, culture, and housing in Toronto. You will also be asked your ideas about service improvement in Toronto.

Interviews will last approximately 1 hour. With permission, your responses will be audio recorded. However, you may choose not to answer any question asked and have the right to withdraw from the study at any point without consequence. Your responses, personal information, and privacy are assured, as all responses are completely confidential and your information will be protected during and following the completion of the study. Should you agree to participate, you will be compensated for your time at a rate of $30. You will be provided with tokens to and from the interview location.

Aside from compensation, this is an opportunity to contribute to the understanding of sexuality and services in Toronto. This research will impact policy and provide guidance to service providers in the community. If you have any questions about the purpose or intent of the Life on the Margins research study, please feel free to contact my supervisor, Dr. Kathi Wilson or myself.

Sincerely,

Rachel Harris
MA Candidate
Department of Geography with
Collaboration in Aboriginal Health
University of Toronto
647-471-7317
rachel.harris@mail.utoronto.ca

Dr. Kathi Wilson
Professor and Chair
Department of Geography and
Programs in Environment
University of Toronto Mississauga
905-828-3864
kathi.wilson@utoronto.ca
Appendix 4 – Verbal Consent

Verbal Consent

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

The purpose of the study is to explore service provision and lived experiences of two-spirit or LGBTQ Aboriginal peoples who have not always lived in Toronto. Participation in this research study is limited to people who are 18 years of age or older and self-identify as Aboriginal (including Inuit, First Nations, and Metis) and as either lesbian, gay, bisexual, trans*, queer, intersex or two-spirit.

Participation is through an interview in which you'll be asked questions about your experiences with moving to Toronto, accessing Aboriginal and non-Aboriginal services, ability to find employment, culture, and housing in Toronto, and recommendations for service provision in the future. The interview will last approximately 1 hour. You will receive $30 for participating in the interview and TTC tokens for your travel costs.

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

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

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

____________________
Name of Participant

____________________
Signature of Interviewer

____________________
Date and Time
Appendix 5 – Written Consent

Consent Form

Study Information Overview

Project title: Life on the Margins: The Two-Spirit Migrant Experience in Toronto

Principal Investigator: Rachel Harris
MA Candidate
University of Toronto
705-931-7317
rachel.harris@mail.utoronto.ca

Purpose of Study:
The purpose of the study is to explore service provision and lived experiences of two-spirit or LGBTQ Aboriginal peoples who have not always lived in Toronto.

Potential Risks:
The potential risks to participating in this project are minimal. While some questions may bring up difficult memories, you can always choose not to answer any questions that are asked of you.

Potential Benefits:
The goal of this study is to better understand service provision, access to culture and community, and sense of belonging in Toronto. This study hopes to offer guidance to policy, service providers, and community advocacy agencies in the future.

Confidentiality:
Your personal information will be completely protected throughout the study. None of what you share during the interview will be attributable to you, and data will be stored in secured locations throughout the study. Codes will be used to protect your identity in any reports or presentations generated from the research study. All audio and data from the study will be destroyed following the completion of the study.

Participation
Your participation in this study is voluntary. Participation is limited to people who are 18 years of age or older and self-identify as Aboriginal (including Inuit, First Nations, and Metis) and as either lesbian, gay, bisexual, trans*, queer, intersex or two-spirit. Should you participate, your interview will ask you a series of questions about your experiences with moving to Toronto, accessing Aboriginal and non-Aboriginal services, and
ability to find employment, culture, and housing in Toronto. You will also be asked your ideas about service improvement in Toronto. If you would like a summary of the study findings, they will be mailed or emailed to you after completion of the study (approximately July 2015). You will be asked to provide your email or mailing address if you would like to receive a research summary, however you may choose not to.

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

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

Written Consent

I understand the purpose of the Life on the Margins: The Migrant Two-Spirit Experience in Toronto research study conducted by Rachel Harris at the University of Toronto. I understand that participation in this research study is limited to people who are 18 years of age or older and self-identify as Aboriginal (including Inuit, First Nations, and Metis) and as either lesbian, gay, bisexual, trans*, queer, intersex or two-spirit. I understand my rights as a participant in this study and my questions have been answered satisfactorily. I agree to participate in a research interview for this study. I have been given a copy of this form.

___________________
Name of Participant

___________________
Signature of Participant

____________________
Date

I agree to have this interview audio-recorded: ___________________________

Signature of Participant