


Age-Friendly Cities and Older Indigenous People: An Exploratory Study in Prince George, Canada

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Article

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Résumé

À travers le monde, les villes cherchent à s'adapter au vieillissement de la population et aux préoccupations liées à l'équité envers les personnes âgées en élaborant des plans pour des communautés amies des aînés qui s'inspirent des orientations de l'Organisation mondiale de la Santé. Néanmoins, ces plans ne tiennent souvent pas compte de la grande diversité des personnes âgées, de sorte que certaines populations, notamment les Autochtones, ne voient pas leurs besoins reflétés dans les plans et politiques pour les aînés. Cet article présente une étude menée auprès de dix femmes âgées faisant partie des Premières nations et des Métis de la ville de Prince George, au Canada. Elle a comparé les besoins exprimés par ces femmes à deux plans d'action élaborés pour les personnes âgées : celui de la Ville de Prince George et celui de la Northern Health Authority. Quatre grandes catégories ont été soulevées lors d'une discussion de groupe et d'un entretien avec ces femmes au Native Friendship Centre de Prince George : la disponibilité des services de soins de santé, l'accessibilité et l'abordabilité des programmes et des services, les rôles spécifiques des aînés autochtones et les expériences de racisme et de discrimination. Il existe de nombreux domaines de synergie entre les besoins exprimés par ces femmes et les deux plans d'action considérés. Cependant, certains domaines clés sont absents des plans d'action, en particulier les stratégies spécifiques pour répondre aux besoins des populations autochtones et d'autres populations âgées qui se sentent souvent marginalisées dans les soins de santé et la planification “amie des aînés.”

Abstract

Cities around the world are responding to aging populations and equity concerns for older people by developing age-friendly communities plans, following the World Health Organization's guidelines. Such plans, however, often fail to account for the wide diversity of older people in cities, with the result that some older people, including Indigenous older people, do not see their needs reflected in age-friendly planning and policies. This article reports on a study involving 10 older First Nations and Métis women in the city of Prince George, Canada, comparing the expressed needs of these women with two age-friendly action plans: that of the city of Prince George, and that of the Northern Health Authority. Four main categories were raised in a group discussion and interview with these women at the Prince George Native Friendship Centre: availability of health care services, accessibility and affordability of programs and services, special roles of Indigenous Elders, and experiences of racism and discrimination. There are many areas of synergy between the needs expressed by the women and the two action plans; however, certain key areas are missing from the action plans; in particular, specific strategies for attending to the needs of Indigenous and other older populations who often feel marginalized in health care and in age-friendly planning.

Introduction

According to the World Health Organization (WHO), “age-friendliness” describes an orientation towards city and community planning that takes into account the inclusion of older people in society and community life and promotes the health and quality of life of people of all ages (World Health Organization, 2020). There is concern, however, among scholars and advocates that some populations, such as immigrant communities, racialized communities, LGBTQ2S+ communities, and Indigenous communities, have been overlooked in age-friendly cities planning, in Canada and beyond (Brooks-Cleator, Giles, & Flaherty, 2019; Kim, Jen, & Fredriksen-Goldsen, 2017).

Older Indigenous people in Canada – those 65 years of age and older – make up a small percentage of the overall Indigenous¹ population, which is young compared with non-Indigenous populations (Statistics Canada, 2017). However, the older segment of the population is also the fastest growing, changing from 4.8 per cent of the Indigenous population in 2006 to 7.3 per cent in 2016 (Statistics Canada, 2017). In the northern city of Prince George, British Columbia, although the population is younger than in the rest of the province, the proportion of older people living there is projected to grow substantially over the next 15 years (City of Prince George, 2017; Northern Health Authority, 2015). Prince George also has a high proportion of Indigenous people living there: approximately 15 per cent of the population, which is much more than in most other cities in Canada (Statistics Canada, 2017).

This article explores the perspectives of a small group of older Indigenous women in the city of Prince George, British Columbia, focusing on their views on the age-friendliness of health care and other services available to them. This is a small, exploratory study intended to bring to light how congruent age-friendly cities planning in Prince George is with some Indigenous community members' perspectives on aging in Prince George. The women's responses are analyzed in the context of two main action plans: the Northern Health Authority's *Healthy Aging in the North Action Plan*, and the city of Prince George's *Age-Friendly Action Plan*, in order to identify differences in perspective, and to gain insight into whether these age-friendly plans incorporate the topics that these women identified. This study forms a part of a larger project entitled "Age-Friendly For Whom?" that explored diverse perspectives on age-friendly cities from immigrant, racialized, Indigenous and LGBTQ2S+ communities (Herman et al., 2020).² The results of the present study are not intended to be authoritative, but rather to spark discussion on the ways in which the needs of older Indigenous people may be incorporated into age-friendly city planning.

The population of older Indigenous people in Canada is growing for several reasons, including growing numbers of Indigenous peoples of all ages, expanding life expectancy for Indigenous peoples in Canada, and increasing numbers of people of all ages who identify as Indigenous in the Census of Canada (Braun, Browne, Ka'Opua, Kim, & Mokuau, 2014; Tjepkema, Bushnik, & Bougie, 2019). Inequities persist with regard to older Indigenous peoples' health, linked to the impacts of colonialism and its associated policies and laws, such as the *Indian Act* in Canada, which negatively impact older Indigenous peoples' health (Braun et al., 2014).

¹"Indigenous peoples," in this article, refers to all of the original inhabitants of a land, who have a shared experience of colonization. The term is pluralized to signal that this broad generalization refers to a large number of distinct political, cultural, and linguistic groups. In Canada, Indigenous peoples include First Nations, Métis, and Inuit, although these three groups obscure a much larger number of diverse peoples and ignore the ways in which Indigenous peoples may prefer to self-identify. "Indigenous people" refers to individual people who identify as Indigenous.

²This larger project was undertaken between 2015 and 2020 to investigate the experiences of diverse older people living in Canada with respect to the perceived "age-friendliness" of their cities. As examples of some of the findings, Rosenberg, Walker, and Wilson (2016) showed that many of the basic services required for an age-friendly community (e.g., subsidized housing for low-income older people) had waiting times in excess of 12 months, or rules and regulations limiting the value of the services (e.g., the use of access vans). In a sub-study focusing on one ethnic group, Herman, Walker, and Rosenberg (2020) report on the challenges faced by older Chinese Canadians living in Saskatoon.

In spite of improvements in life expectancy, gaps between Indigenous and non-Indigenous life expectancies in Canada remain (Chief Public Health Officer, 2016; Tjepkema et al., 2019). Some studies have found that Indigenous older people report experiencing chronic illness and functional limitations at earlier ages than non-Indigenous people in Canada, and therefore live with the health impacts of these conditions for a longer period of time (Wilson & Cardwell, 2012), although living with chronic illness should not be interpreted unidimensionally. Scholars argue that elements of "successful aging" can be experienced along with chronic illness such as HIV/AIDS, and caution against ableist, classist, or culturally narrow understandings of aging well (Liang & Luo, 2012; Ryan et al., 2020). It is also important to note that older Indigenous peoples' experiences of health and illness vary by individual and by community, geography, and identity. Such experiences are far from homogeneous (Jacklin & Walker, 2020; Pace, 2020).

In this article, we refer to both "older (Indigenous) people" and "Elders." By older Indigenous people, we mean individuals over the age of 55. Although Statistics Canada uses a cut-off age of 65 to define older populations (Statistics Canada, 2017), in much of the literature older Indigenous people are defined as those 55 and older (Wilson, Rosenberg, & Abonyi, 2011). This number has been chosen because of inequities that persist between Indigenous and non-Indigenous populations in settler colonial contexts, in both life expectancy and the onset of diseases associated with growing older, as well as because of rising birth rates in Indigenous communities, leading to the "demographically younger age structure of the [Indigenous] population" (Wilson et al., 2011, p. 357). In order to align with existing literature, and to better take into account the experiences of older Indigenous people, in this study we included Indigenous women 55 years of age and older. In this article, then, "older people" includes those 55 and older unless otherwise specified.

The term "Elder", on the other hand, has a special meaning not fully associated with age. For many Indigenous communities, Elders are recognized by the community as knowledge holders, teachers, or healers, who work on behalf of the community to promote community health, cohesion, and deep understanding of traditional teachings, regardless of age (Hoffman, 2010; Rowe et al., 2019; Ryan et al., 2020). A group of Elders in Prince George pointed out that "not all old people are Elders, and not all Elders are old people" (Nelson et al., unpublished report, 2012).

A growing proportion of older Indigenous people in Canada live in cities and off-reserve areas (Wrathall, Wilson, Rosenberg, Snyder, & Barberstock, 2020). Research suggests that the numbers of Indigenous people living in cities may be more than twice what Census counts indicate, because of problems with mistrust of government surveillance that make it difficult for those conducting a Census to reach or identify many members of Indigenous communities (Rotondi et al., 2017). Methods of counting people developed through partnerships with Indigenous organizations and community leaders, which draw on the connectedness of urban Indigenous communities, have been shown to be much more effective at reaching people in urban areas (Rotondi et al., 2017; Smylie et al., 2011; Smylie, Firestone, Tagornak, Arngna'naaq, & Qitsualik, 2017). There may be many more Indigenous people living in cities in Canada, and perhaps in other countries as well, than Census numbers show.

Older Indigenous people have unique experiences in cities, a topic that is only beginning to be explored in research (Baskin & Davey, 2015; Beatty & Berdahl, 2011; Schill et al., 2019). Not only

do older Indigenous people have to navigate complex differences in rights and entitlements based on urban and non-reserve geographies as well as government-regulated Indigenous identities, as Indigenous people of all ages have to do (Nelson & Wilson, 2018; Senese & Wilson, 2015). Older Indigenous people also have been found to be excluded from age-friendly city planning in cities such as Ottawa (Brooks-Cleator et al., 2019). Cities form a part of Indigenous peoples' traditional territories, yet governments rarely acknowledge them as such, making it difficult to assert Indigenous governance in urban areas (Edmonds, 2010; Place, 2012). Research has found that Indigenous people of all ages report better health in urban areas than in rural areas, in large part because there is better access to services in cities (Wilson & Cardwell, 2012), although one study found that between 1991 and 2012, the self-reported health of Indigenous people who responded to the Aboriginal Peoples Survey, living in urban and off-reserve communities, declined, and the rate of chronic disease increased (Wrathall et al., 2020).

Many cities in Canada have developed age-friendly cities plans, supported and promoted by the provinces (Public Health Agency of Canada, 2016); however, the extent to which these age-friendly plans have taken the needs of older Indigenous people living in urban areas into account remains unclear (Rosenberg, Walker, & Wilson, 2016). In this article, we specifically engage with the two main action plans mentioned, which cover the city of Prince George, to see whether the topics covered in the action plans align with the issues that a group of older Indigenous women living in Prince George identified.

Prince George's *Age-Friendly Action Plan* incorporates an all-ages approach, guided by the vision: "Prince George is the ideal place to age, at any stage of life and for community members of all abilities and lifestyles" (City of Prince George, 2017, p. iv). The plan is based on many initiatives that align with age-friendly city principles and that are already taking place. The eight focus areas for this action plan align closely with the World Health Organization's eight domains of Age-Friendly Cities and Communities, which include the built environment, transport, housing, social participation, respect and social inclusion, civic participation and employment, communication, and community support and health services (World Health Organization, 2019).

The goal of the Northern Health Authority's *Healthy Aging in the North: Action Plan* is to improve the health, quality of life, and independence of seniors (people 65 years of age and older) who are engaged with the health care system at various levels (Northern Health Authority, 2015). The plan outlines three focus areas: "Healthy Aging in Community", "Frail Seniors Living in Community", and "Quality of Life in Facility-Based Care", in which the aim is to promote healthy aging at home and minimize or avoid hospital stays or, when institutional care is required, to maximize both quality of life and quality of care for seniors living in a long-term care facility (Northern Health Authority, 2015).

Study Setting, Methods, and Participants

Prince George is a small city of just over 85,000 people located in northern British Columbia (Statistics Canada, 2019). It is an important hub for many other communities in northern British Columbia, including at least 54 different First Nations served by the province's Northern Health Authority (Aboriginal Health, 2014). The most commonly reported Indigenous identities in Prince George from the 2016 Census are Métis, Cree, and Dakelh (also known as Carrier), followed by Gitksan, Salish, Mi'kmaq, Ojibway,

Nisga'a, Cherokee, Wetsu'wet'en, and Sekani (Statistics Canada, 2019). Prince George is located within the traditional territory of the Lheidli T'Enneh First Nation, one of the Dakelh peoples (Varcoe, Browne, & Einboden, 2014b). Almost 15 per cent of the population of Prince George identifies as Indigenous (Statistics Canada, 2019). Prince George also has a strong network of Indigenous-led services, including primary health care services, other peripheral health services, and the largest Aboriginal Friendship Centre in Canada (Prince George Native Friendship Centre, 2011; Varcoe, Browne, & Einboden, 2014a).

The authors of this article are both non-Indigenous health geographers who have worked extensively with Indigenous people and older populations in Canada, with a particular focus on those who experience barriers in relation to health care services. The first author completed her PhD in Prince George, and recruited the women for this study through existing contacts from previous research. Her research in Prince George has been ongoing since 2010. The second author has conducted research on Canada's older population in general and with Indigenous older people for many years. Both are committed to principles of decolonizing research in terms of prioritizing community needs and interpretations of research, for example through the inclusion of an advisory group, sharing the research at several stages on an ongoing basis with participants, and maintaining contact through community presentations and individual discussions about research outcomes.

The participants in this study were recruited through the Prince George Native Friendship Centre, a large and active community service centre where Indigenous and non-Indigenous community members access a wide variety of services (Prince George Native Friendship Centre, 2011). Participants were 10 women who all identified as First Nations or Métis and were all 55 years of age or older, who were convened as a group through the Friendship Centre's Cultural Advisor, Cree Elder Bertha Cardinal. All of the women had lived in Prince George for well over 30 years. The first author spoke with nine of the women as a group, and with one woman in an individual interview, in Prince George at the Friendship Centre, in February of 2019. The group interview format was chosen by the women themselves, who felt that this was a more comfortable and culturally appropriate format through which to engage with the research. Engaging in research in a group setting has been found in other studies to facilitate mutual sharing and to contribute to feelings of safety and community for many Indigenous participants (Loppie, 2007). Food was provided for everyone by the Friendship Centre following the discussion. The woman who participated individually did so because of time constraints that prevented her from being able to participate in the group.

Prior to our conducting the research, the ethics committee of the Prince George Native Friendship Centre as well as the General Research Ethics Board at the authors' home university reviewed the proposed research, protocols, and instruments used. All participants provided written informed consent. Interview questions were developed as part of the larger study (*Age-Friendly Cities: Age Friendly for Whom?*), and reviewed and edited by the Prince George Native Friendship Centre's research ethics team to determine their appropriateness for older Indigenous people in the community. The questions covered how age-friendly the women thought that Prince George was, how supported they felt by services available to them, what kinds of activities they participated in regularly, and whether they had experiences of discrimination that they felt were related to being older and/or Indigenous in the city. The purpose was to ascertain how age-friendly the women thought Prince George was, according to their own definitions and

categories; therefore, the World Health Organization criteria for age-friendly cities and the age-friendly action plans were not discussed during the group or individual interviews. The individual interview lasted just under 25 minutes, and the group interview spanned one and a half hours.

The information the women shared was audio recorded, transcribed by a research assistant and the first author, and coded iteratively by the first author, to highlight the most prominent themes. Themes were developed using the interview questions themselves as a starting point, and further refined through coding and re-coding as recordings were replayed and transcripts were read multiple times. These themes were then reviewed by the second author, and shared with Elder Bertha Cardinal as a way of verifying the analysis. A draft of this article was also shared with representatives from both Northern Health and the city of Prince George, for verification purposes as well as to facilitate dissemination of the results to those who have the ability to enact change in the future.

Results

This section presents the results of the qualitative interviews, grouped into four main categories through the analysis described. The first two categories, (1) health care and home care; and (2) accessibility and affordability, roughly correspond to areas addressed by the two age-friendly action plans. The final two categories, (3) special roles and responsibilities of Indigenous Elders; and (4) experiences of discrimination, are not addressed in either action plan and highlight areas that should be taken into account in age-friendly planning in Prince George going forward.

Health Care and Home Care

The first theme arising from the discussion with the women relates closely to the main categories in Northern Health's *Action Plan*, having to do with health care and home care services for older people. Participants expressed a desire for more services overall, including better access to primary health care, specialist services, and home care for older people. The women described a need in Prince George for more Indigenous-specific or culturally appropriate health care and home care services. For example, one participant described her ideal of having a residence for older Indigenous people who come to Prince George from smaller surrounding communities and need somewhere to stay in the city. Such a residence would provide traditional foods and generally make people feel at home. Home care, as well as care provided after people leave the hospital, was also described by participants as important, yet lacking in Prince George. One woman said that the current push in health care policy for people to age at home needs to be accompanied by better home support. Several women in the group discussion told stories of family members being sent home from the hospital before they felt they were ready, placing the burden of care on families. For example, as two women shared:

First woman: This town is really bad for putting you out of the hospital,
Second woman: Yeah.

First woman: After you've had an operation. My daughter-in-law's dad, a couple years ago had, had a knee replacement. He was in there for three days. After three days – they didn't even know if he could get up, and this is after he fell out of bed already, and pulled out all his IVs – the third day they told him, 'you're out of here.' And they... my daughter-in-law and her mom

refused, said 'no, we're not—' and they said, 'fine, leave him in here, he's just going to go in the hallway.' And that was it, and I mean, he [had] an infection, and everything else, and stuff like that....

Second woman: Same as my sister, like she went in the hospital, she was sick, and she was on life support. And after they took off life support and, like she—they got her up right away and everything, and all, and so she was walking, and just because she was walking, well, they moved her to a different floor, and then they wanted to kick her out the next day. And, like, she was only eating that much soup [indicates a small amount]. And then, plus, they wanted me to bring her in twice a day for her needles, and, oh, I was so mad I tell you.

Some participants in the group discussion also spoke of relatives being kept in the hospital for too long; essentially being confined there, which in one particular story was linked to the patient's lack of stable housing and history of problematic substance use. Participants in both the group discussion and the interview also felt that cuts to funding and services over the years had contributed to more frequent instances of care being inadequate, waiting lists being too long, and cleanliness at the hospital being of a lower standard than in previous years.

The women also described examples of culturally inappropriate care. Two participants had the following discussion about health care workers' disrespect for cultural symbols such as an eagle feather, as well as lack of knowledge of culturally appropriate gender norms:

First woman: You know, eagle feathers are very important to us... And they are a show of honour and respect. That should be common knowledge to anybody that would work with an Aboriginal person.... Mom's feather is hanging up in her room, and the worker comes in, and I had a braid of sweetgrass hanging there, and [the worker]... took my mom's eagle feather and her sweetgrass, and shoved it in her drawer. First of all, nobody is supposed to touch that feather but her. Second of all, my mom told her, 'no, leave it,' she didn't... there was no respect for that. You know, they couldn't understand why my mom was so upset that they had a male caregiver come in to give her a bath.

Second woman: Huh. That's not allowed [meaning, under facility rules].

First woman: That's—that is allowed.

Second woman: Is it?....

First woman: And they do, they're trained... [My mom] said, 'no, no, no.' And I told him, there's no way—

Researcher: That should be her choice. Yeah.

First woman: She's going to allow him, even if he is a caregiver, and he's trained, and all this sort of stuff.... For her, her own sons don't do that. They don't do that for her. So, a man shouldn't do that.

Putting older men and women in the same hospital room was also described as highly inappropriate for older Indigenous individuals. These examples were used to make the point that more Indigenous-focused health and home care services are needed. Participants suggested that partnering with local First Nations to provide services, and providing traditional Indigenous foods, both in hospital and long-term residential care settings, would help to make these places more welcoming and comfortable for older Indigenous people.

The women also mentioned that having to be assessed and meet certain criteria before being eligible for services such as home care, or before being referred to an appropriate health care support such

as a pain clinic, were experienced as a barrier for themselves and for other older people in the community. Finally, participants described family involvement as being an important part of an older person's care. As one woman put it:

It really has a lot to do with participation of the family once they're in [a long-term care facility], what kind of care they get. I've been going and seeing my mom just about every day. There are people in there that I don't think have family that are alive, because nobody comes and sees them. So they – nobody advocates for them.

Family involvement in the care of older relatives was described as a way of compensating for inadequate health care or home care, and of making sure that an older person's needs were heard and met. Therefore, those people without close family members were described as receiving less adequate care.

Accessibility and Affordability

We classified the second theme that participants discussed as accessibility and affordability, which ties in closely with many of the main categories identified in the City of Prince George's *Age-Friendly Action Plan*. Similarly to the *Age-Friendly Action Plan*'s focus on universally accessible indoor and outdoor spaces and transportation, as well as affordable, appropriate housing, participants reported finding retirement or primary care homes and home care difficult to afford. Participants also reported having difficulty with low-income cut-offs set by the city, which made some older Indigenous people ineligible for discounted services because of their having an income just above the cut-off amount. Participants also spoke about various barriers to physical accessibility, such as there not being enough accessible washrooms, that affect which activities older people can participate in. This was described as being a particular problem for those who may be experiencing mobility problems, or those of more advanced age. As one woman said in reference to the downtown swimming pool:

Unless you're swimming, you're not allowed to use the bathrooms in the change room. There's one bathroom in the change room that's big enough that a person could go into, but the public one that's accessible is down at the bottom of the stairs, and you need a key.... and the – even the ramp going into the public swimming pool is so frickin' long, that I could not push a wheelchair around there.... In all the months that I've been there, I've never seen a person on a wheelchair go in there.

This lack of accessible washrooms was described as a barrier that could prevent people from participating in activities offered at this particular pool, such as certain aerobics classes.

Advancing age was also described as partially limiting older people's ability to participate in programs or activities. As one woman said:

I do a lot of things. I help... in the Food Bank, and, oh, whenever [name of another participant] needs me I'm there, I phone wherever, and do what we have to do, and like I said, I was going to try their yoga there, but I still never got a chance to go and do it yet. And same with their other things like walking, I can't walk very good because of my hip and that eh, and my knee sometimes give out, but I do what I can. Then, at home, I do a lot of stuff at home too.

With respect to groups that these women are a part of, they described younger members of the group helping older members as they age, so that they remain able to participate in or contribute to the group.

Participants also discussed barriers to accessibility and affordability related to travel and transportation. For example, the cost of parking, the distance to services and amenities, inadequate snow removal, and over-booked accessible public transportation services were all mentioned as barriers that can make it difficult for older people to move around the city. Participants stated that older people do not always have or are able to afford a car, or may not feel comfortable driving at night, therefore relying on other people for rides. On a positive note, participants described ride sharing with one another, and mentioned that many organizations in town will help with arranging transportation for older people (for example to special events). In one exchange, the women said:

First woman: I do a lot of beading, crocheting, and knitting, and stuff like that.

Researcher: Yeah.

First woman: I do all that stuff, so.

Researcher: Nice.

First woman: I do my own hair yet, so, I can still do that. (laughter) But it's going to be changed, it's not going to be this red, it's going to go darker (laughter).

Second woman: I thought you were a (inaudible) when I came in the door (general laughter).

First woman: It's like Pippi Red—stockings, or whatever (general laughter). Yeah, but no, that's about it. And then like, sometimes if the Elders need a ride, like [name of another participant], if she needs a ride she lets me know, [a third participant] lets me know.

Participants gave examples of how their own mobility is becoming limited as a result of health problems, but also gave several examples of their ongoing independence, such as doing their own hair, shoveling their own driveway, or driving their own car.

Special Roles and Responsibilities of Indigenous Elders

A third important theme that participants spoke about was related to the special roles and responsibilities held by Indigenous Elders in their communities. This was a theme that was not specifically addressed as a category in either of the action plans, but was a prominent part of the women's group discussion. Participants described what makes a person an Elder in an Indigenous context, pointing out that it is based on more than a person's age. In the words of one participant, "the Aboriginal Elder is far different than the senior." This woman further explained:

I have a hard time calling myself an Elder, because these ladies here are my friends, and they are, to me, my Elders. So, how could I be an Elder to them? And then, one Elder answered it for me. She said, 'an Elder is not an old person. An Elder is an old person who shares her beliefs and her teachings.' That's what an Elder is.

In accordance with this idea, many of the participants in this study were active in teaching Indigenous languages or land-based teachings to young people in schools, summer camps, and community settings. One woman in the group discussion described a teaching program for school children that takes place in a small town outside of Prince George, and invited the other women present to come along if they were interested, to share their teachings with the children. The same woman also described participating in Indigenous language education locally, in a discussion that also indicates how busy someone recognized in the community as an Elder can become:

First woman: We have a language thing that we go to at [a postsecondary institution]... at the end of the month... And it's just a bunch of Elders that get together there, and they say how – they tell everybody how they might say 'hello' in their language... and they learned, actually those kids did really good, so we taught them to say, 'hello, how are you, my name is so and so,' and then after a while, we got them to say who their parents were, and how to say it in our language and stuff like that. They actually did really good, so I imagine probably we'll see a little bit more of that, so.

Researcher: That's cool.

First woman: It's interesting to sit there with all of the other Elders and listen to them, and—

Second woman: You also go to [another postsecondary institution] too.

First woman: Yeah, and there and [another postsecondary institution]—

Second woman: See, I know more about you than you do about you! (general laughter)

First woman: Just, I get called on. What's today? Today I have to go over to our own – at the new building... because the Assembly of First Nations are having meetings here. This is their last day today, so. Went there for supper last night, I had a good supper there last night, so. So that was—that's—

Second woman: We keep her as busy as we can. (general laughter)

Teaching about language, and about land-based knowledge, was described by participants as a very positive type of activity for Elders. Although not all participants were language or land-based teachers, all participants were active in giving to the community in a variety of volunteer roles, for example through volunteering at a food bank, collecting donations of needed supplies such as clothing and delivering them to a local reserve, driving each other to events, or volunteering to cook for people experiencing homelessness.

Experiences of Discrimination

Finally, participants were asked to describe any experiences of discrimination that they may have had, and the women shared several stories of being discriminated against or witnessing family members being discriminated against on the basis of being Indigenous, body size, or being older. The responses in this theme were also not reflected in either of the *Action Plans*. In particular, being perceived physically as Indigenous was described as leading to more, and worse, experiences of racism, including special vigilance in stores, at border crossings, and at the airport. Many participants described experiences of discrimination as happening to others, and felt very strongly about people insulting close family members. As one participant put it:

But for me, myself? The hurt really comes in when somebody insults me... I'm half [non-Indigenous] and half [Indigenous]. But when they insult me for being an Indian, it's because my mother is. And [crying], sorry ladies, nobody should disrespect my mom.

Participants described experiencing racism at work on such a regular basis that one woman said she had learned to “pick your battles, and make sure they're worthy of your fight.” Others described instances of older people or their family members having to “us[e] their outside voice” in order to be given appropriate services in health care settings. Describing a time when her niece was being sent home from the hospital without having someone at home to look after her, one woman said that she convinced the hospital, with some difficulty, to let her daughter stay:

My daughter had knee surgery, and they gave her too much of that stuff to put her to sleep, and they had a hard time to wake her up, eh, so she was in the Emerg—ah, well—after-recovery room or whatever, eh. But after she woke up and everything, because there was no bed, they wanted to send her home. And I said, 'I don't think so,' I said, 'you guys had a hard time waking her up,' I said, 'I ain't taking her home, I live out of town, and what if something happens, I have to bring her back in,' like, you know, I said, 'she can stay here.' So I—like I said, I had to get mad to do this, but I say my piece.

This woman described a need to “get mad” in order to convince people at the hospital to provide care that she felt was appropriate for her daughter. This ties in to concerns discussed by another woman in the group, that those who cannot speak up for themselves, or who are afraid to do so for fear of being labelled as a troublemaker, then suffer the consequences in terms of inadequate quality of services being offered. Participants described discrimination against Indigenous people in the media as well. Some of the women linked many of their experiences of racism to living in the city, in particular to living in Prince George, which they described as worse than other Canadian cities, such as Vancouver.

In addition to discrimination based on being (or appearing) Indigenous, participants described discrimination based on body size and on age. For example, participants described seeing older people in a store being pushed past or treated disrespectfully because they moved through the checkout area more slowly than others. It is important to note that a few participants stated that they had never experienced any issues of discrimination on any basis while living in Prince George. Overall, there was extensive discussion on the topic of experiences of discrimination and, although not every individual participant had personal experiences of discrimination, those instances when it is experienced form an important part of older Indigenous people's lives that should be acknowledged and addressed in age-friendly policy and planning.

Discussion: The Age-Friendly Action Plans

A detailed reading of the action plans reveals that they contain many areas of synergy with what the women discussed in this study, but that there were also several areas in which the action plans miss topics that were discussed by the study participants. It must be noted that the extremely small sample size, and the inclusion of only women in this study means that the results should not be generalized to all Indigenous people living in Prince George. Rather, in this discussion we aim to respectfully offer ideas for how to move forward as new age-friendly action plans are developed, based on what the women shared.

References to racism, as well as to the special roles and responsibilities of Indigenous Elders, were absent from both action plans. These two topics have been highlighted by other researchers as being key to improving Indigenous peoples' health in general; they are also fundamental to older Indigenous peoples' health (Loppie, 2007; Rowe et al., 2019). The role of racism, in health care settings in particular, is under investigation at the time of writing in British Columbia, following a series of tragic and dehumanizing events in hospitals across the country (Barrera, 2020; Lowrie & Malone, 2020). Supporting the special roles that Indigenous Elders play in their communities has the potential to combat racism. The age-friendly action plans should incorporate planning that acknowledges these experiences and offers a way forward.

Some of the items in Northern Health's action plan that align well with participants' concerns include ensuring timely access to

primary care; addressing long wait times for residential care; strengthening community-based services and supports; support to caregivers including respite care; education for health care staff to ensure respectful, responsive, and culturally safe care; and better-integrated planning for transitions from hospital or residential care back to the community. All of these areas were discussed by participants and the fact that they are included in the action plan is a sign that the health authority also has these concerns in mind. The action plan also includes a commitment to offer Northern Health resources and influence to help communities and organizations secure health-related supports that are outside the purview of Northern Health service delivery. This could be an area in which community groups could approach Northern Health for help in developing Indigenous-focused services, or further develop already-existing partnerships between the Northern Health Authority and Indigenous nations, groups, or organizations in Prince George.

In contrast, there are several areas in which the focus of Northern Health's action plan appears as though it may not be positioned to address the topics mentioned in this study. For example, the action plan is concerned with reducing the number of inpatient days when patients remain in acute care in the hospital while waiting to be placed in other levels of care. According to the action plan, "the admission of a senior to hospital should trigger an immediate, coordinated intervention with a rehabilitative focus, and attention to appropriate discharge planning with necessary community supports in place" (Northern Health Authority, 2015, p. 8). However, the women who participated in this study described a process of discharging older individuals into their relatives' care, which, the women reported, leads to problems when there is not enough physical capacity within the family to care for them at home. Participants in this study may be feeling negative effects from the hospital's desire to remove people from acute care beds more quickly. It is possible that in some instances the immediate advanced discharge planning is not taking place, or family support is assumed by hospital workers to be sufficient in the instances of older Indigenous people having close relatives who appear to be able to take charge of their care at home, when in fact such care may put unmanageable strain on family members. Close attention and focused resources to support community care and family caregivers, as mentioned in the action plan, could, over time, provide remedies for these problems described by the women.

Northern Health's action plan describes the importance of helping older people in the community to live at home, but the supports that they describe are generally outside of the purview of Northern Health-provided health care services. This is an area in which study participants felt that there was a gap; in the view of many of the women, there are not sufficient health care services and health-related supports for older people living in the city. Also, because of the regional focus of the Northern Health Authority, which has responsibility for health care services across the northern region of British Columbia, the action plan necessarily focuses on rural and remote communities, although it also addresses many aspects of hospital care. The major hospital serving the region is in Prince George itself; therefore, transportation to and from rural communities, as well as having supports available in communities without a hospital, are important issues to be examined in an age-friendly services plan. These types of supports, including transportation and housing or residential facilities for older Indigenous people visiting Prince George for medical care, were discussed by the women as areas in which services could be improved. However, it is also important not to overlook the many older Indigenous

people who live in Prince George, in the planning of age-friendly supports and services. Future planning that includes specific policies and plans aimed at older Indigenous people who live long term or permanently in the city of Prince George would be valuable.

Northern Health's action plan has a section that addresses First Nations and Indigenous peoples' health, which describes gaps in health outcomes that exist between Indigenous and non-Indigenous people in British Columbia; outlines how many Indigenous people live in British Columbia, highlighting that the Northern region has the highest proportion of Indigenous people living there; and mentions the importance of cultural safety. The action plan states that:

Northern Health is working alongside the First Nations Health Authority to understand what supports and resources exist in the First Nations communities that will allow aging in place and to facilitate supported and smooth transitions from hospital back to their communities. (p. 9)

This is an important and productive partnership; however, this statement is fairly cursory and lacking in detail. More information on what specific supports and resources for older Indigenous people have, or will, come out of this partnership would be a valuable addition to the plan. In addition, relying on partnerships without explicitly reflecting on what the partnership means and the concrete changes associated with the partnership leaves open the danger of pushing responsibility for improving services for older Indigenous people onto the First Nations Health Authority, without acknowledging the work that Northern Health is also responsible for. Northern Health has its own resources for Indigenous health, including a department of Indigenous Health, and having no reference to the extensive work that has been done in this regard is a significant omission from the action plan.

The city of Prince George did not undertake any new community consultations in producing the city's *Age-Friendly Action Plan*, instead making use of feedback that had been gathered from other action plans and consultation sessions in Prince George. There was engagement with key community stakeholders and city staff, in particular with staff in determining key priorities and the feasibility of the plan. Key domains of the plan were shared in a public consultation in 2016 as well as with additional key stakeholders, to verify that the main focus areas of the plan aligned with community needs. As with Northern Health's *Healthy Aging in the North: Action Plan (2015/16–2020/21)*, there are several areas of synergy between the city of Prince George's *Age-Friendly Action Plan* and the topics brought up by participants in this study. For example, in this action plan, as in conversations with study participants, the need for more affordable housing, in particular for seniors, has been identified. The city's action plan proposes encouraging the development of more multi-family housing through the Multi-Family Housing Incentives Program as one solution to this problem. This type of development, as long as it follows principles of universal accessibility, should result in more housing that is affordable and/or aimed at older people; although the action plan also recognizes that there is a lack of incentives or regulations requiring developers to follow specific accessibility principles and therefore not much that the city can do by way of enforcement. It should also be noted that some apartment complexes and retirement facilities specifically for older Indigenous people have been built or purchased in recent years through a partnership between the British Columbia Ministry of Housing and the Aboriginal Housing Society of Prince George (AHSPG) (Aboriginal Housing Society of Prince George, 2018), separately from the jurisdiction of

the city of Prince George. These additional housing options will help many, although not all, older Indigenous people in need of affordable housing.

Reduced handyDART (accessible public transportation) wait times are identified as a need in the action plan, and the plan also recommends increasing pedestrian crossing times and improving snow removal along pedestrian routes in the winter: both topics that the women in this study also identified. The action plan also recommends resources being devoted to intergenerational activities that involve both older and younger people, something that study participants also identified as important. Participants' calls for partnerships with First Nations and other Indigenous organizations are reflected in the city's collective impact approach, as described in the action plan, which involves working together with other organizations and agencies including the Northern Health Authority, the School District, and the Prince George Native Friendship Centre, among others, in order to address complex social issues, with a particular focus on health.

There are some important gaps in the City's action plan when analyzed in light of study participants' responses. For example, affordability of city-run facilities and programs was highlighted as an issue for participants, even when seniors' rates or low-income assistance programs are taken into account. The City of Prince George's Leisure Access Program, which provides free access to the pool and other city recreational facilities to people with low income, uses Statistics Canada's low income cut-off numbers. These cut-off numbers are extremely low, and as participants pointed out, they therefore exclude some low-income older people, whose family income is just above the cut-off but not high enough that they can easily afford passes or entrance fees. There are also some physical accessibility issues raised by participants that are not fully addressed in the action plan. For example, in the action plan, the relatively newly constructed Prince George Aquatic Centre is touted as a highly accessible facility, but study participants generally preferred using the other, downtown pool which is older and has several accessibility barriers. Part of the reason for this preference may be related to transportation: the older downtown pool is potentially more accessible by transit or for people without their own vehicle. It could also be because the older downtown pool is less crowded and has been there for much longer. This pool is scheduled to be replaced in the next few years by a new facility across the street from its current location, which is presumably going to be more barrier free.

There are no specific recommendations in the city's action plan that have to do with service delivery, beyond recommendations for organizations to partner with the city. Participants strongly identified health care and residential care as important needs, but the city's action plan leaves this to Northern Health, First Nations, and community organizations, delegating responsibility according to existing jurisdictional boundaries, but also leaving out many areas in which more specific plans for partnership or support could be developed. Having such specific plans, rather than focusing on each entity's separate jurisdiction, would aid in providing more seamless transitions between city and other supports and resources for older people in Prince George, in general, including older Indigenous people. Jurisdictional boundaries have been highlighted in the literature as an important barrier to Indigenous people's timely and equitable access to health care (Blackstock, 2009), and as contributing to the exclusion of Indigenous health policy from general discussions of health care services in Canada (Lavoie, 2018). In considering how best to serve older populations in Prince George, it is important to take into account ways of streamlining

services across jurisdictional boundaries as well as the particular ways in which these boundaries impact older Indigenous people.

Finally, the city's action plan is lacking in attention to diversity in general, including gender-specific barriers and attention to the needs of racialized, immigrant, and LGBTQ2S+ communities, and includes only minimal mention of Indigenous peoples. For example, it notes that the First Nations population in the city of Prince George is the fastest-growing segment of the population, but does not draw implications from this statement or indicate that this fact has influenced the development of the plan, other than expressing the intention to work together with the Lheidli T'Enneh First Nation to "understand barriers and opportunities" related to the action plan (City of Prince George, 2017, p. 19). The City of Prince George *Age-Friendly Action Plan* thus leaves the responsibility for developing solutions for older Indigenous community members to the Lheidli T'Enneh nation. Although the Lheidli T'Enneh are the appropriate first point of contact, there are other Indigenous populations in Prince George who also should be approached in an effort to determine everyone's needs and wants. Further, the city needs to commit to doing its own research and educating staff as well as the broader public with respect to the needs of older Indigenous people in the city, and incorporate appropriate actions into the action plan based on what are now well-established principles of cultural safety and equity (First Nations Health Authority, n.d.; Browne et al., 2016).

Concluding Thoughts

Participants in this study had concerns about the age-friendliness of Prince George, which we grouped under four main categories: (1) health care and home care, (2) accessibility and affordability, (3) special roles and responsibilities of Indigenous Elders, and (4) experiences of discrimination. The women who took part in this research described wanting to see more Indigenous-specific services, including residences with primary care for older Indigenous people. Family involvement and advocacy were described as important in order for older Indigenous people to receive an appropriate level of care and to fight discrimination and racism. Participants felt that barriers to access to health care services, home care, and other community activities needed to be removed. Participants described wanting to see more space and acknowledgment of the special roles that Indigenous older people can play within the community. Finally, experiences of racism and discrimination, although not universal among the women with whom we spoke, made a large impact on many women's experiences of living in the city, suggesting that any age-friendly planning should take into account these types of experiences and their potential impact on accessibility and quality of life for older Indigenous or other racialized people, or members of other marginalized communities as they age.

With respect to age-friendly planning in Prince George, a close reading of the Northern Health Authority's *Healthy Aging in the North: Action Plan* and the city of Prince George's *Age-Friendly Action Plan* reveals that although these plans take many of the participants' concerns into account – such as the need to provide support for caregivers of older relatives, or affordable and accessible housing for seniors – they miss the ways in which experiences of growing older intersect with experiences of racism or other forms of discrimination, and the need for culturally appropriate and culturally specific care, facilities, activities, and resources. Results from this exploratory study suggest that these plans, and actions

that have thus far resulted from them, have not yet succeeded in making some Indigenous older people feel that they are a part of age-friendly planning or services in Prince George. The two action plans acknowledge the pivotal roles to be played in this regard by entities such as the First Nations Health Authority and the Lheidli T'Enneh First Nation; however, in order for services to be seamlessly and equitably provided, it is necessary for these plans to include more reflection on specific measures that can be taken to provide a better, more age-friendly experience for people of all identities, subject positions, and backgrounds living in Prince George.

Although we cannot say that the experiences of 10 older Indigenous women are representative of a larger group of Indigenous women or Indigenous people in general or that Prince George is representative of a larger group of cities, certainly the experiences of the older Indigenous women in this study reflect what other marginalized older people from other communities in other parts of Canada have told us in other research. Their experiences return us to the question of “age-friendly for whom” and in their experiences, it urges us to ask this same question in communities everywhere that claim to be age friendly.

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