

**Métis concepts of health:**

**Placing health within a social-cultural context.**

**Social, Economic and Environmental (Ecological)**

**Determinants of Métis Health**

**By**

**Yvon E. Allard M.Sc.**

**Métis National Council MNC**

**National Collaborating Centre for Aboriginal Health**

**NCCA-H-PhAC**

**April 13, 2007**

# Table of Contents

## Executive Summary

- 1 Demographic characteristics of the Métis Peoples of Canada
- 2 Health Status of the Métis Peoples of Canada
- 3 Health Inequities in the Métis Peoples of Canada
- 4 Health Disparities in the Métis Peoples of Canada
- 5 Cultural aspects and cultural competency in the social-cultural determinants of the Métis Peoples of Canada
  - 5.1 Métis-specific aspects of population and public health
  - 5.2 Public Health in an Aboriginal Context
6. Métis Health Research (Research on the Roadside People)
7. Métis Nation Health Action Plan
8. Advocacy to address SDOH of Métis people.
  - 8.1 Political Advocacy to address SDOH of Métis people.
9. Summary and Conclusion

## Executive Summary

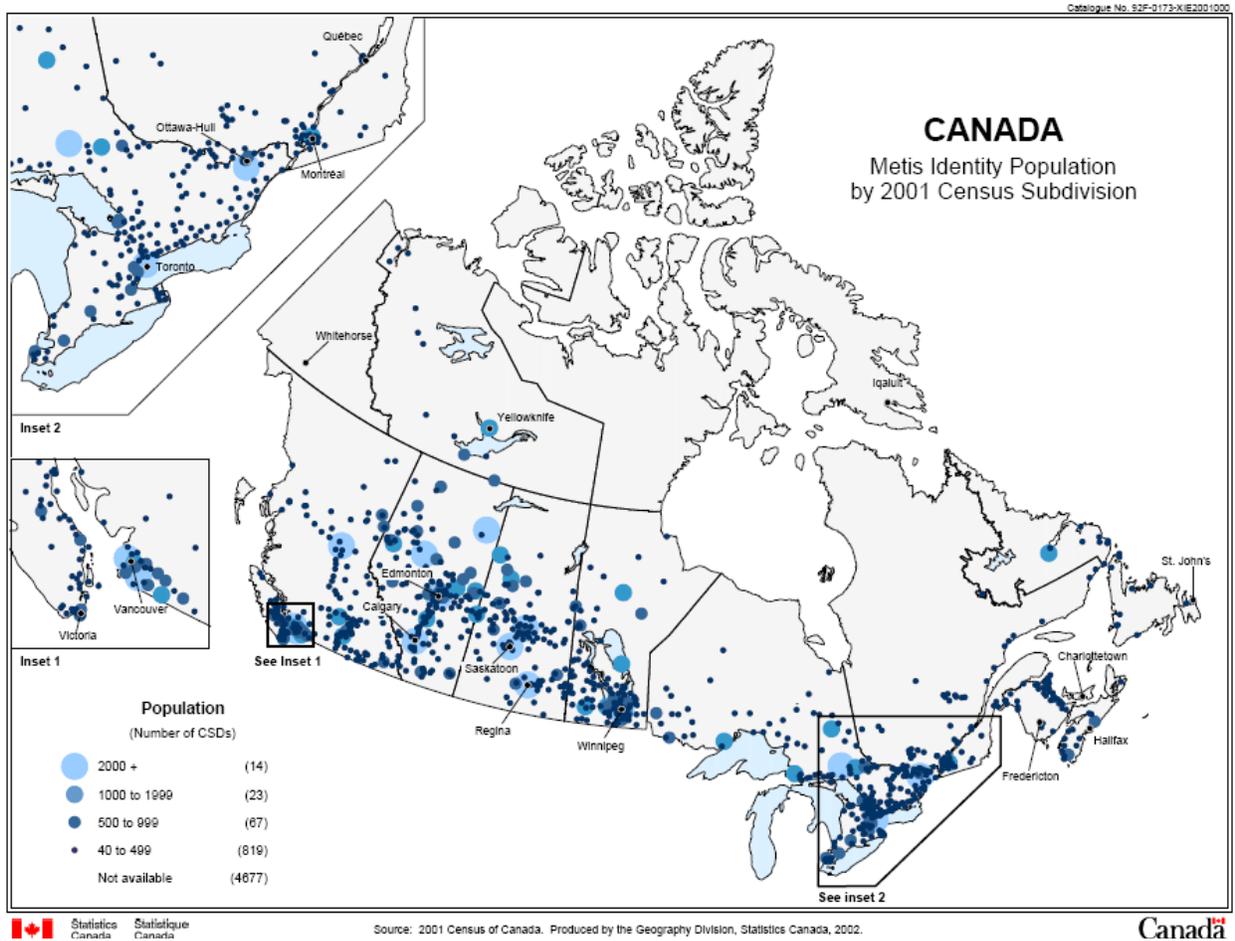
Métis health and well-being is not determined solely from health indicators, but health and well-being is shaped by the context of being Métis. The historical, socio-economic, cultural and epidemiologic context of health status must be viewed from an Indigenous worldview. The Métis need health information to design and implement effective, culturally appropriate health interventions. As well, the Métis must examine the underlying causes of health inequities and health disparities (MNC 2005), just as other Indigenous peoples worldwide have accomplished (Stephens 2006, Waldram et al. 2006).

In many ways, the Métis although they reside in a western first-world society, their health inequities and resulting health disparities reflect those of Indigenous in third world countries. The situation of the Métis in Canada is eloquently addressed in the paper by Stephens and colleagues (Lancet 2006) in which the Indigenous peoples of third world countries not only suffer health inequities, and resulting health disparities, they also lack the resources to take effective action to rectify their poor health status. (Stephens et al. Disappearing, displaced, and undervalued: a call to action for Indigenous health worldwide. Lancet 2006)

It is increasingly becoming clear that the socio-economic inequities and disparities in health status among the Métis in Canada arise from the disparities in wealth and power that have endured since Confederation. Being ‘poor’, ‘uneducated’, ‘illiterate’, and ‘lacking empowerment to make changes’ are risk factors for illness, just as well as viruses, bacteria and lifestyle risk factors (e.g. smoking, alcohol abuse). Research on housing, income, education, literacy, etc., as socio-economic determinants of health could be a strategy for improving our understanding of the effects of social environments on health and for reducing health disparities. The history of health disparity among the Aboriginal Peoples of Canada suggest that social, cultural and economic conditions have played a powerful role in generating “Aboriginal” vulnerability to disease, injuries and premature death. Such awareness must guide ongoing research and interventions if the disparities in health status between Aboriginal Canadians, including Métis, and the general population are ever to be eradicated (Stephens 2006, Boyer 2006, and Waldram et al. 2006).

# 1. Demographic characteristics of the Métis Peoples of Canada (Refer to Appendix A).

## Map of Métis Identity Population (2001 Census)



## 1. Aboriginal Peoples in Canada

This section highlights statistical data on the Métis population in comparison with other Aboriginal groups and the non-Aboriginal population. Specifically, the topics covered are population, age distribution, area of residence, mobility, life expectancy and fertility. The sources of data include the 1996 and 2001 Census, the 2001 Aboriginal Peoples Survey and Projections of the Aboriginal Populations, Canada, Provinces and Territories (2001-2017).

## 2. The Métis population experienced the largest increase in numbers and will continue to grow

Persons who reported Aboriginal identity in the 2001 Census of Population represented 3.4% of the total Canadian population or approximately 976,305 residents. Within this group, the census enumerated 292,310 Métis, who represented about 30% of the total Aboriginal population. This was up from 204,115 in 1996.<sup>1</sup> The majority of Aboriginal people, 608,850 or 62%, were North American Indians, and 5%, or 45,070, were Inuit. The remaining 3% were either persons who identified with more than one Aboriginal group or registered Indians or band members who did not identify as Aboriginal. The 2001 Census indicated that there were 292,310 Métis who live primarily in the western provinces of British Columbia (44,265), Alberta (66,055), Saskatchewan (43,695), Manitoba (56,795) and the province of Ontario (48,345).

Table 1. Size and growth of the population reporting Aboriginal ancestry and Aboriginal identity, Canada, 1996-2001

	2001	1996	Percentage growth 1996-2001
<b>Total: Aboriginal ancestry<sup>1</sup></b>	1,319,890	1,101,960	19.8
<b>Total: Aboriginal identity</b>	976,305	799,010	22.2
North American Indian <sup>2</sup>	608,850	529,040	15.1
Métis <sup>2</sup>	292,310	204,115	43.2
Inuit <sup>2</sup>	45,070	40,220	12.1
Multiple and other Aboriginal responses <sup>3</sup>	30,080	25,640	17.3

<sup>1</sup> Also known as Aboriginal origin.

<sup>2</sup> Includes persons who reported a North American Indian, Métis or Inuit identity only.

<sup>3</sup> Includes persons who reported more than one Aboriginal identity group (North American Indian, Métis or Inuit) and those who reported being a Registered Indian and/or Band member without reporting an Aboriginal identity.

Source: 2001 Census Analysis Series, Aboriginal peoples of Canada: a demographic profile, Demography Division, Statistics Canada, 2003, page 20.

Within the Métis population, the largest concentrations reside in the western provinces (72% of the Métis population) and in Ontario (16%). Of the three Aboriginal groups, the largest gain in population between 1996 and 2001 occurred among the Métis, whose numbers increased by 43%. This five-year growth was almost three times the 15% increase in the North American Indian population, and almost four times the 12% increase among the Inuit. Table 2 below shows the distribution of the Métis population by province and territory.

<sup>1</sup> In 2001, at least 266,020 persons reported Métis ancestry (This includes people who reported Métis as a single response and those who reported Métis ancestry along with non-Aboriginal ancestry. This figure is up from the 220,740 that reported a Métis ancestry in 1996.

**Table 2. Population reporting a Métis identity, Canada, provinces and territories, 2001**

	Number	%
Canada	292,310	100.0
Newfoundland and Labrador	5,480	1.9
Prince Edward Island	220	0.1
Nova Scotia	3,135	1.1
New Brunswick	4,290	1.5
Quebec	15,855	5.4
Ontario	48,345	16.5
Manitoba	56,795	19.4
Saskatchewan	43,695	14.9
Alberta	66,055	22.6
British Columbia	44,265	15.1
Yukon Territory	535	0.2
Northwest Territories	3,580	1.2
Nunavut	55	0.0

Source: 2001 Census Analysis Series, Aboriginal peoples of Canada: a demographic profile, Demography Division, Statistics Canada, 2003, page 25.

As noted above, the Métis population increased by 43% between 1996 and 2001—the largest increase among the three Aboriginal groups. During this period, there were important political and legal milestones for the Métis. Métis received significant recognition in the final report of the Royal Commission on Aboriginal Peoples (1996); Louis Riel was recognized as a “father of Confederation” and his conviction as a traitor due to his involvement in the Métis Rebellion was vigorously debated. Furthermore, discussion of a Métis enumeration process during the Meech Lake constitutional process (1992) was one of the political and jurisdictional issues affecting the Métis. In recent years, the Métis have won important court hunting rights cases (MLS Review 2006) and greater land rights recognition in some provinces such as Saskatchewan. The need for “Social Justice” programs and policies for the Métis of Canada needs to be addressed by Federal, provincial and territorial governments (MNC 2005). The Métis of Canada require “self-determination” through governance structures (Madden et al. 2005, MNC 2005, Boyer 2006).

## 2. Health Status of the Métis Peoples of Canada

### Métis Population Health Statistics Issues (Allard 2006)

-  Lack of Métis population-specific health data, information and knowledge.
-  Limited opportunity for Métis to self-identify as Métis.
-  Minimal Métis-specific health research.
-  Lack of infrastructure, resources and funding.
-  Similar socio-economic demographic profile as other Aboriginal groups.
-  Growing physical health problems in Métis communities.
-  Lack of access to culturally appropriate health programs / services and information.

Lack of Métis specific population health data due to (Allard 2006):

- Inaccurate / incomplete data sources, inability to access data, or no data
- Use of “Aboriginal” in literature when data applies to First Nations and Inuit only

Opportunity for Métis to self identify as Métis (Allard 2006):

- Differing opinions on how to identify and count Métis
- Lack of Métis identifier on health care records

While colonization, globalization, migration, cultural continuity, territory, access, poverty, and self-determination are cross-cutting determinants for Aboriginal Peoples, they need to be contextualized with the appropriate Lens (MNC 2005). For Métis peoples in Canada the only source for information on the social and economic determinants is the Canadian Census,

conducted every five years. The latest being in 2006 by Statistics Canada, with the accompanying Aboriginal Peoples Survey 2006.

In comparison with First Nations and Inuit, there is a scarcity of data on Métis demographics and conditions (i.e. health, lifestyle risk factors, education, employment, etc). Refer to the article by Smylie and Anderson (2006) on Aboriginal health indicators and data-sources.

### Health in an Aboriginal Context

The World Health Organization (WHO) defines health as more than the absence of disease. A traditional Aboriginal concept of health incorporates the mental, physical, spiritual, emotional, and social aspects of health. The health and well-being of individuals and communities are interdependent and equally important. This definition is consistent with the population health approach.

Health determinants in indigenous populations are being developed in full collaboration with Métis /Aboriginal communities and organizations. Researchers, health practitioners and policy makers are attempting to consider where and how health-determining conditions are affecting positive outcomes for Métis /Aboriginal communities, despite health-damaging historical and contemporary circumstances.

The Table below is from Raphael and Bryant (p. 237, 2006) on "political advocacy" on SDOH. It presents the different worldviews of what constitutes SDOH. Noted is that the SDOH National conference (Raphael et al. 2004) has “Aboriginal status” as a SDOH.

Table 1. Various conceptualizations of the social determinants of health

Ottawa Charter <sup>1</sup>	Health Canada <sup>2</sup>	World Health Organization <sup>3</sup>	SDOH National Conference <sup>4</sup>
peace	income and social status	social gradient	Aboriginal status
shelter social	support networks	stress	early life
education	education	early life	education
food	employment and working conditions	social exclusion	employment and working conditions
income	physical environments	work	food security
stable eco-system	social environments	unemployment	health care services
sustainable resources	healthy child development	social support	housing
social justice	health services	addictions	income and its distribution
equity	culture	food	social safety net
	gender	transport	social exclusion
			unemployment and employment security

1. World Health Organization, 1986 – 2. Health Canada, 1998 – 3. Wilkinson & Marmot, 2003 – 4. Raphael et al., 2004

### 3 Health Inequities in the Métis Peoples of Canada

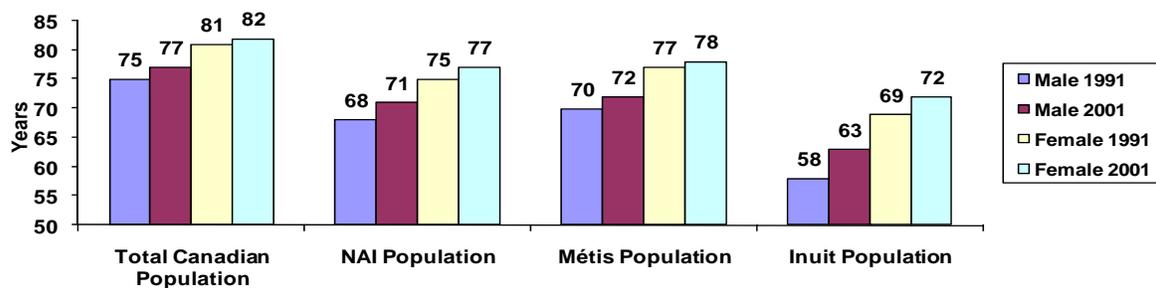
**The life expectancy of the Métis population is higher than other Aboriginal groups, but lower than the Canadian population.**

Improvements in Aboriginal life expectancy over the last 25 years have begun to affect the growth of the Aboriginal elderly population (aged 65 and over). Life expectancy at birth among the registered (status) Indian population, for example, has gone up for males from 59.2 years in 1975 to 68.9 years in 2000, and for females from 65.9 years to 76.3.

As indicated in Chart 6 below, the Métis life expectancy is higher than other Aboriginal groups and lower than the Canadian population. The male Métis population has a life expectancy of 72 years compared with the Canadian population at 77 years. The gap is narrower between the female Métis population at 78 years and the Canadian population at 82 years. The Métis and North American Indian populations possess similar life expectancy rates and they are both higher than those of the Inuit population (69 years for males and 72 years for females).

The gap between Metis-Canada is 4 years, which is a significant gap in life expectancy. The gap between Metis-FN is 1 year. There is a large gap between Metis-Inuit, but this is similar to FN-Inuit. Please note that it took 25 years to decrease the FN-Canada gap by 10 years, thus 4 years is a big gap.

**Chart 6: Life expectancy (in years) by sex, Aboriginal group and Canada, 1991 and 2001**



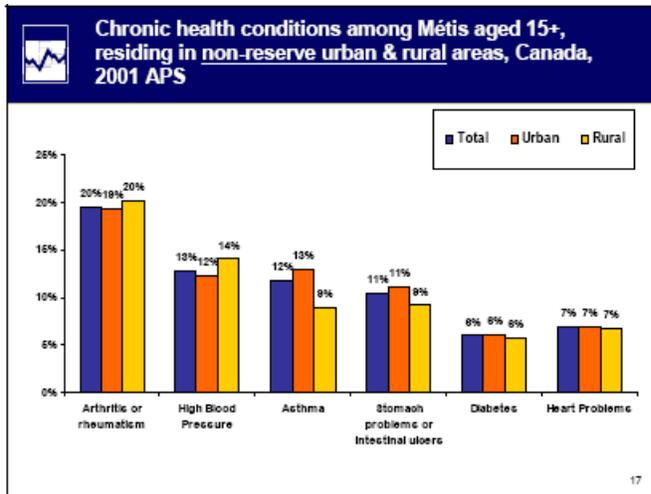
Source: 1991 and 2001 APS.

The life expectancy of the Métis population is expected to increase over time. By 2017, the male Métis population life expectancy rate will increase to 74 years while the rate of their female counterparts will increase to 80 years. The North American Indian population rates will increase at a similar rate. On the other hand, the life expectancy of the Inuit population will continue to be shorter than that of the Métis; 9 years shorter for Inuit men and 6 years shorter for Inuit women.

**Table 7. Life expectancy at birth by Aboriginal group and sex, Canada, 2001 and 2017**

Aboriginal group	Males		Females	
	2001	2017	2001	2017
	in years			
North American Indian	71.1	73.3	76.7	78.4
Métis	71.9	74.1	77.7	79.7
Inuit	62.6	63.9	71.7	72.9

Source: Projections of Aboriginal Populations: Canada, provinces and territories: 2001-2017, Demography Division, Statistics Canada, Text table 2.3, page 20. Statistics Canada 2005.



Source: Statistics Canada (November 2004) A Profile of Canada's Métis Population. Ottawa.

The Métis show very high rates of arthritis and rheumatism with one in five adults reporting this disease, with not much difference between those in urban or rural areas. The rate is only 1 in 10 in the general population. High blood pressure is the next highest reported disease for Métis with slightly higher shares in rural than in urban areas (12% vs. 14%), compared to 9% in the general population. Asthma is reported almost as much as high blood pressure and is higher in urban areas than in rural areas (13% vs. 9%) and about the same as in the general population (10%). Diabetes was reported at 6% among Métis, with no differences by area of residence. The comparable rate is 2% in the general population. About one in 15 Métis adults reported heart problems

#### 4 Health Disparities in the Métis Peoples of Canada

Racial, ethnic, and socioeconomic disparities in health care and health outcomes are well documented. Disparities research is evolving from documenting these disparities, to understanding their causes and mechanisms, and finally to conducting interventional research to reduce or eliminate disparities. Unfortunately, few studies to date have demonstrated substantial reductions in health outcomes disparities. Traditional experimental models of research that test a single intervention held constant throughout the study period may not have the power to impact complex clusters of comorbid health disparities in patients who receive care in under-resourced primary care safety net practice settings. New models of research will be required to test dynamic, multidimensional interventions that triangulate on patients, providers, and communities and are continuously improved with every radar-sweep of feedback from rapid-cycle measurement of population health outcomes on a community-wide basis.

Several decades of research have documented disparities in care and outcomes across a wide variety of clinical conditions. Health disparities have been documented between racial/ethnic groups, rural/urban and other geographic settings, as well as for socioeconomic status and for the uninsured. The most pervasive and deadly health disparities in Canada have been documented along racial lines. Racial and ethnic disparities have been found across all age/gender groups and geographic regions, in all health care settings, at all levels of care, and across all dimensions of quality. When poverty, non-white race, non-English language, lack of insurance, and underserved community all coexist, the inequities are compounded. This creates a continuum of disparities beyond just race, ranging from low-disparity populations (upper-income, white, suburban, well educated, and insured) to high-disparity populations (low-income, uninsured, minority race, and rural or inner-city community). Health disparities are pervasive and persistent among Aboriginal peoples in Canada (Adelson 2003, 2005) and among Native Americans (Jones 2006).

## **5. Cultural aspects and cultural competency in the social-cultural determinants of the Métis Peoples of Canada.**

The adoption of a holistic and population health approach to Métis health encourages us to consider indicators other than physical health that may contribute to our health and wellness as Métis.

Neither Health Canada nor Indian and Northern Affairs collect health information on the Métis population. Some provinces and territories collect health statistics on the Aboriginal population but their methods, including specific health indicators, differ. Those provinces and territories that have provided health statistics on the Aboriginal population indicate, in most instances, that the health status of the Aboriginal peoples in their respective jurisdictions is below their provincial and territorial counterparts.

In 2004 the Health Council of Canada released a major report on Aboriginal Health (The Health Status of Canada's First Nations, Métis and Inuit Peoples. Health Council of Canada. 2004). Cited below is an excerpt from that reports Executive Summary:

“The Health Council of Canada suggests that a population health approach be adopted to plan for improvements to the health status of Aboriginal peoples. The underlying philosophy of the population health approach takes the broader determinants of health into account. It is highly supportive of the Aboriginal belief that to be healthy one must achieve balance in all spheres – the spiritual, mental, emotional, physical and social. The approach is predicated on the principles that:

- Health is determined by the complex interactions between individual characteristics, social and economic factors and physical environments;
- The health of a population is closely linked to the distribution of wealth across the population;
- Strategies to improve the health of a population must address the entire range of factors that determine health;
- Important health gains can be achieved by focusing interventions on the health of the entire population (or significant sub-populations) rather than individuals; and,
- Improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional system.”

The Council also advises that systems be put into place to provide the necessary information to accurately assess the current health status of the First Nations, Inuit and Métis. The Council advocates the implementation of the following measures to overcome inter-jurisdictional and infrastructural challenges to address the health disparities that are common to First Nations, Inuit and Métis populations:

1. Enable, expect and respect First Nations, Inuit and Métis as full partners with federal, provincial and territorial jurisdictions in developing and implementing the Aboriginal Health Reporting Framework. Enable Aboriginal populations to collect health information which establishes an accurate baseline; permits the comparison and monitoring of their health status within and between their populations and with the rest of Canadians; meets the information needs of community leaders; and reflects the unique realities of Aboriginal peoples.
2. Adopt a population health model to address the health disparities of the First Nations, Inuit and Métis population. Enable and require all federal, provincial and territorial departments/agencies to work in partnership with Aboriginal organizations that oversee, manage or advise on programs and Health Council of Canada First Nations, Inuit and Métis. services, in order to address the determinants of health which have an impact the Inuit, Métis and First Nations populations.
3. In partnership with the various levels of government, identify the resource requirements to address the particular health needs of First Nations, Inuit and Métis who live in rural, remote or/and socio-economically challenged communities. Address, as a priority, the current and ongoing shortage of health care service providers available to these groups, especially nurses. Ensure that the necessary resources are devoted to implement educational programs that will increase the number of Inuit, Métis, and First Nations health care service providers – in the short, medium and longer terms. Recognize that resources have to be available and accessible. Barriers, such as those created through the use of standardized program or funding templates, should be avoided so that resources can be allocated and utilized.”

## 5.1 Métis-specific aspects of population and public health

### Métis Population Health Data and Information

#### Population Health

Good health is determined by much more than simply an absence of illness but also by a number of factors outside of the realm of doctors and health clinics. A population health approach, as defined by Health Canada, recognizes there are many contributors to a healthy population, including income and social status, education, employment, early childhood development, access to health services, and gender and cultural issues. This approach is more in step with Indigenous concepts of health and wellness, which are holistic in nature, viewing health as a balance of physical, mental, emotional, spiritual and social elements.

That 12% of Métis children aged 14 and under speak or understand an Aboriginal language, according to Statistics Canada's Aboriginal Peoples Survey (APS) 2001, exemplifies a population health issue. While not directly related to physical health, such as diabetes or accidental injuries, language is essential to culture and plays an important role in Aboriginal societies that are predominantly based on oral traditions and practices.

For another example, attendance at an early childhood development (ECD) or pre-school program facilitates a child's cognitive and social development, particularly those from economically disadvantaged families. The APS 2001 indicates 57% of Métis children aged 6-14 had attended an ECD program when they were younger.

The material presented within this section reflects key Métis health information, research, policy and public health issues. A great need exists to complete more research in order to appropriately determine the health status, well-being, and health needs of Métis. Unfortunately, there are several issues impacting the ability to provide Métis health information, namely:



#### Inaccurate or incomplete data sources

Uncertainty over identity and jurisdiction of Métis individuals and communities – i.e., who are the Métis, where do Métis people reside, and what level of government (federal, provincial or territorial) is responsible for delivering health services to this segment of the Canadian population — remain an impediment to research and data collection on Métis health status, issues and health outcomes. The inability to accurately survey the Métis population is an important reason why government health policies, legislation and services have generally overlooked Métis health issues. The inability to accurately identify and assess health issues and outcomes within the Métis population has led to the lack of recognition of Métis rights to health and health care. These factors have resulted in inaccurate or incomplete data sources and, for many specific health issues, a total absence of relevant or available data.



Inability to extrapolate or access data, or exclusion from data collection  
Given the reality of inaccurate and incomplete data sources due to issues surrounding Métis identity and rights to services, it remains extremely difficult to measure the health of Métis populations based on scant data. Despite recognition of Métis in the Constitution Act, 1982, as one of Canada's three Aboriginal peoples, federal Aboriginal health programs and services primarily focus on on-reserve First Nations populations and exclude Métis. Statistics Canada's Aboriginal Peoples Surveys 1991 and 2001 continue to be the most comprehensive and accurate data sources for Métis population health information. However, given the issues noted in identifying the Métis population, caution is advised regarding the accuracy of Statistics Canada's enumeration figures as these figures are essentially based on self-reported and identifying data.



Limited opportunity for Métis to self-identify as Métis

Métis health services are the responsibility of provincial and territorial governments, with few federal programs existing that include and/or outreach to Métis people or communities. Most provincial and territorial health programs and services offer the same services to Métis as for the overall, non-Aboriginal population. Such universal health programs often do not reflect the reality that Métis health overall lags behind the mainstream population for some health and disease indicators including socio-economic status, education levels, diabetes and arthritis. Given that Métis are only one segment of the broader population base within the provision of health services and that provincial health services generally do not have an identification process and do not keep statistics on the Métis population, there is limited opportunity for Métis to identify with their Aboriginal heritage for the betterment of health care service provision. (An exception is the Northwest Territories, where Métis are identified on health cards and receive health services and benefits on par with First Nations and Inuit.)



No uniform enumeration process for Métis in Canada

The enumeration of all Aboriginal peoples is a contentious issue. While provincial Métis organizations have membership lists of Métis within their jurisdiction, the federal government, through Statistics Canada, is the only source of national enumeration figures of Métis. This information is based on self-reporting of Métis ancestry. (In 2001, the self-reported Métis population had increased by 43% from the 1996 Census). Difficulties in reaching consensus on a nationally accepted definition of what it means to be Métis in Canada have exacerbated difficulties in establishing a verifiable and reliable registry to more accurately poll Métis on health information issues.

The Métis are not eligible for FNIHB health care programs and services. They must obtain health care services from provincial or territorial sources. However, Health Canada, through the Population and Public Health Branch (now the Public Health Agency of Canada), offers several programs targeted specifically for the three Aboriginal groups such as the Head Start Program, Community Action Program for Children and the Canada Prenatal Nutrition Program.

The only Métis health data available are from special surveys (e.g. Statistics Canada 1991, 2001, 2006 Aboriginal Peoples Survey) and sporadic university-based research conducted in communities. A major issue in health information is the lack of consistent identifiers across the regions for the collection of Métis health data.

The life expectancy of the Métis is unknown as are rates for infant mortality, low birth weight, and types of cancer that most commonly cause death in the Métis population. Other major mortality causes are unknown including suicide rates and potential years of life lost due to intentional or unintentional injuries. The rate and type of communicable diseases affecting the Métis are also unknown, with the exception of some data on HIV/AIDS (Vizina 2005, Barlow et al. 2006). Self-reported health and well-being and physical activity information is also unavailable. Thus, it is clear that there is an absence of reliable data and data sources to represent health indicators for the Métis population in Canada.

## 5.2 Public Health in an Aboriginal Context

- Largest gains in public health for Canadians are from “non-health” investments.
- Largest gaps in public health for Aboriginal Peoples are from limited or non-existent resources in these same areas (Determinants of Health).

Richmond and colleagues (2007a) have examined health disparities among the Métis in Canada. They have stated the following conclusions in their article (Richmond et al. 2007a):

“Indigenous health research has tended to examine the population as a relatively homogeneous one, with little recognition of its broad cultural and geographic variation. Because of sizeable disparities between Indigenous and non-Indigenous populations however, and also because of data limitations on Inuit and Métis populations, researchers have been more or less validated in this practice. Our paper moves beyond this paradigm, as it explores the dimensions of health for Canada’s Inuit and Métis populations, and considers the stability of these dimensions across and within cultural and geographical contexts. Informed by cultural frameworks of health and based on data from the 2001 APS, our analyses support *four dimensions of Métis health (social support, physical function, physical fitness and psychosocial wellness)*, and four dimensions of Inuit health (social support, personal wellness, physical function, and community wellness). Perhaps the greatest contribution of this work points to the significance of the dimension of **social support**, which consistently emerged as the principal health dimension among numerous analyses of Métis and Inuit.” (Richmond et al. 2007a)

“In terms of their health and social conditions, Canada’s Indigenous peoples continue to fare among the worst in Canada. Improving quality of life among Canada’s Indigenous population requires health policy and programs that are inclusive, community-based, and informed by holistic models that recognize the multiple, interacting dimensions of Indigenous people’s health. Piece-meal health policy that enables individuals, rather than communities, is just not sufficient, and our analyses provide some evidence to substantiate this. In all but one pattern of health dimensions, social support was the main dimension of health. Amidst the extreme social dysfunction we witness in Indigenous communities across Canada today, it is meaningful that our analyses should result in this finding. Despite a legacy of colonialism, it is remarkably hopeful that concepts and ideals central to Indigenous worldviews remain so strong today. Now is the time to put action behind words. Improving quality of life among Canadian Indigenous peoples requires more than the identification of health problems and risk factors. By working with and respecting the worldviews of Indigenous peoples, public policy can play a vital role in mobilizing Indigenous communities from suffering to equality and health.” (Richmond et al. 2007a)

The health disparities and inequities of the Métis can be addressed through improvements in health-care services and access, high-quality health data collection, and policy initiatives designed to provide sufficient resources and a more unified vision of the holistic health of Métis peoples. University- and community-based research and public health policy must address the contemporary realities of Métis health status and well-being, including the individual and community-based effects of health disparities and the direct and indirect sources of those disparities.

At minimum, achieving health equality for the Métis will require:

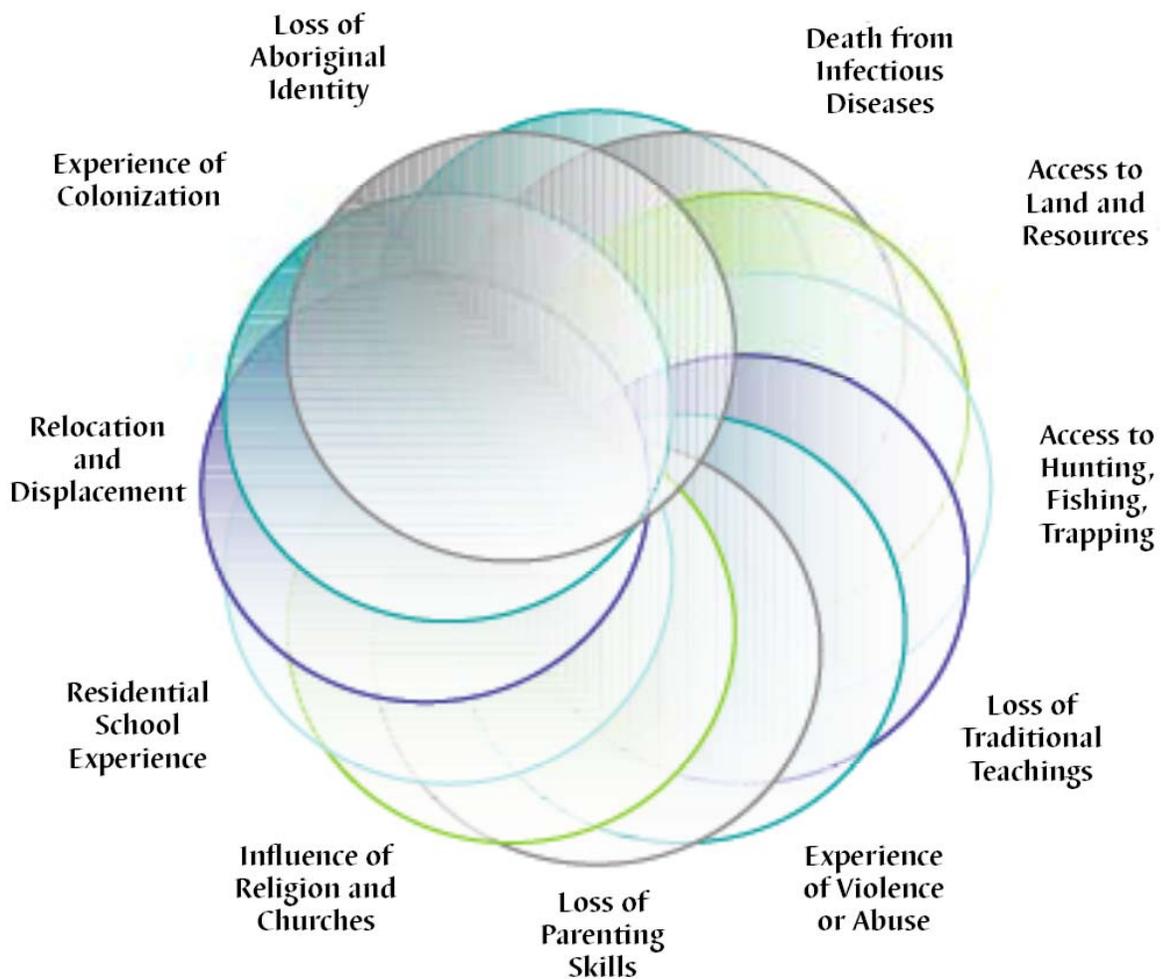
- ∞ measures to ensure equal access for Métis peoples to primary health care and health infrastructure.
- ∞ increased support for developing the Métis health workforce.
- ∞ a commitment to support and nurture Métis community controlled health services.
- ∞ a focus on improving the accessibility of mainstream health services for Métis peoples.
- ∞ an urgent focus on early childhood development, maternal health, chronic illness and diseases.
- ∞ supporting the building blocks of good health, such as awareness and availability of

nutrition, physical activity.

- ∞ fresh food, healthy lifestyles, adequate housing and the other social determinants of health.

The following figure presents some of the modern and historic sources for the health inequities and health disparities of Métis people. The figure below is from the recent article of Edge and McCallum (Pimatziwin: A Journal of Aboriginal and Indigenous Community Health 4(2), 83-115, 2006), that examines cultural determinants of health for Métis elders.

**Figure 2. Historical Factors Impacting Métis Identity and Health Status**



## **Métis Health and Human Resources Initiative Overview**

(Access at: <http://metisnation.ca/HHRI/default.html>)

This funding of \$10 million over four years will increase the number of Métis students pursuing careers in health sciences through bursaries and scholarships and build the capacity of Métis organizations to engage in health human resource planning. The program's objective is to reduce long-term wait times and address the shortage of personnel in the field, also providing a cultural context for non-Métis health personnel working in Métis communities. The HHRI is a part of Health Canada's new Aboriginal Health Human Resources Initiative which will develop health human resources strategies that respond to the unique needs and diversity among Métis, First Nations, and Inuit. This is a four year, \$10-Million health human resource development initiative (HHRI) aimed at laying the foundation for longer term systemic change in the supply and demand for Métis health human resources. Your Governing Members are offering scholarships and bursaries to students interested in pursuing a career in one of 26 health related fields. HHRI is based upon a Health Canada plan dealing with Aboriginal healthcare issues. Métis National Council took the lead roll on behalf of our Governing Members and the MNC is currently researching other opportunities for developing human resource components working with Health Canada and other Aboriginal groups. We hope this is the first of many projects aimed at improving Health Care Delivery across the Métis Nation Homeland.

## **Métis Nation Health/Well-Being Research Portal**

(Access at: <http://healthportal.metisnation.ca/home.html>)

The “**Métis Nation Health/Well-Being Research Portal**” (MNC 2006) has been established as a comprehensive site on health informaton for the Métis people throughout Canada. The site reflects the holistic understanding of the Métis Nation about what things are important when considering the health and well-being of our people and when designing policies and programs to address our population health needs.

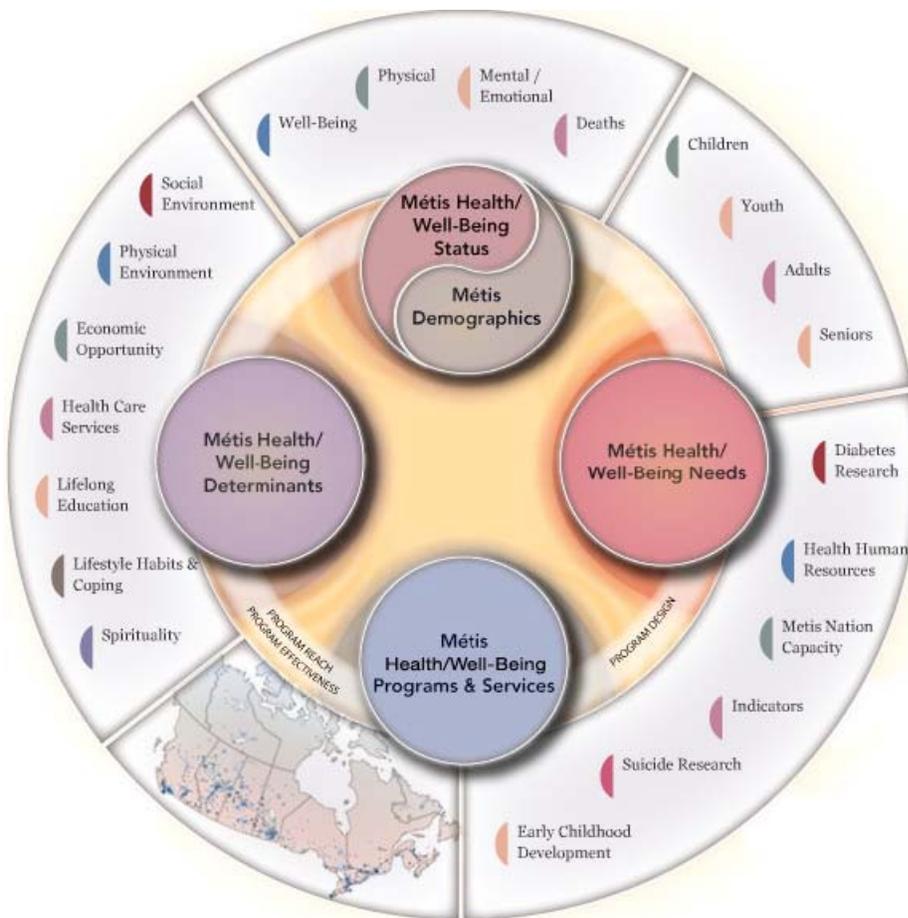
The Métis Nation Health/Well-Being Research Portal brings together in one source, information on:

- ∞ the health and well-being status of the Métis population,
- ∞ the broader health determinants that influence health and well-being of the Métis people,
- ∞ Métis Nation demographics which will play a major role in determining the type and amount of resources required to address the health and well-being needs of the Métis Nation , and
- ∞ programs that address those needs.

The Portal will ensure that what is known about the health of the Métis population is shared throughout the Métis Nation and with others that are interested in learning about the health and well-being of our people. Equally or more importantly, it will help ensure that others are able to understand and adopt the integrated, holistic view of population health and well-being that prevails among the Métis people.

Although the site will be further developed over a period of years, it now contains the most comprehensive information ever published about Métis health and well-being conditions and the factors that will influence how our population health need will evolve in the future. The health portal will provide updates and new research information as we continue to improve our understanding of Métis health and well-being.

The expanded view of the interactive Métis Health Portal (MNC 2006) is shown below <http://healthportal.metisnation.ca/framework.html>



Topics under the **Métis Health / Well-Being Determinants Icon** are:

-  **Social Environment**
-  **Physical Environment**
-  **Economic Opportunity**
-  **Health Care Services**
-  **Lifelong Learning**
-  **Lifestyle Habits & Coping**
-  **Spirituality**

### **A Métis Population Health Statistical Unit (MNC 2006).**

The MNC is proposing the development of a Métis Population Health Statistical Unit (MNC 2006) within the structure of the Métis National Council that could provide information on Métis population health. The Unit would ensure that all public policy stakeholders have access to reliable statistical data to ensure effective public policy development, research and analysis. It would fill the void in current public policy development processes at all levels of government by providing much needed information on Métis population health. The establishment of the unit is in accord with the Recommendation of the Royal Commission on Aboriginal Peoples (RCAP) and consistent with the approach in the Aboriginal Health Reporting Framework. The use of reliable statistics in public policy development is a hallmark of good governance practices ensuring effective planning, evaluation and results reporting.

The United Nations, in fact, measures statistical development indicators to determine the relative health of Nations and Canada's 2004 Performance Report now includes a chapter on the relative health of the Aboriginal community. This Report did not include data on Métis health conditions. Statistical data informs public policy in all Métis population health determinant areas (social, physical environment, economic opportunity, health care services, life-long education, lifestyle habits & coping and spirituality). They are also critically important in understanding Métis Health/Well-Being Status including the baskets of indicators that measure: Well-Being, Mental/Emotional Health, Physical Health and Mortality rates. All of these indicators are buttressed by demographic data that shows the composition of the Métis population and supports the trend analysis essential for long-term public policy planning.

Establishing a Métis Population Health Statistical Unit will (MNC 2006):

- ∞ Provide information to support analysis of social, economic, and cultural conditions of Métis providing for more effective planning, evaluation and results reporting;
- ∞ Provide for better targeted interventions by federal, provincial, municipal and Métis governments and other public policy providers;
- ∞ Promote the quality, coherence and comparability of statistical data with other Aboriginal and non-Aboriginal data sets;
- ∞ Promote the gathering, sharing and distribution of Statistics by all levels of government on Métis population health; and
- ∞ Facilitate increased Métis capacity in the statistical area at the national, regional and local areas.

## **6. Métis Health Research (Research on the Roadside People)**

This brings us to the discussion about the question, “Why Aboriginal health research?” As one can decipher from the description of Métis health status and the existing health disparities, there is a tremendous need to conduct research aimed at improving the health status of Métis through culturally appropriate and community-based approaches that actively involve the local communities (Masching et al. 2006). Disparity research includes examining how poverty, education, and the environment ultimately affect health status. In recent years, the Métis populations have embraced community-based participatory research (CBPR) (Fletcher 2003, Masching et al. 2006, Flicker et al. 2007) as the most acceptable as it actively engages local people in the research process to develop workable and culturally acceptable interventions. This process engages both researchers and local Métis people from the conception of research ideas to the application of research findings and publication.

Health challenges and disparities abound that require immediate attention by local tribal communities, leaders, policy makers, students, and researchers. Unfortunately, trained Aboriginal (especially Métis) researchers are few because of the low rate of college graduates and the severe shortage of Aboriginal (including Métis) doctorates that are trained in research (Indigenous studies, Anthropology, Public Health, etc.). Addressing health research needs includes planning approaches to increase local capacity by including Aboriginal students in

research projects, education about health issues, capturing the Indigenous perspectives, and designing culturally respectful projects that address disparity issues (Smylie et al. 2004).

Historically, much of health research was conducted by outside researchers who were not trained in Indigenous cultural ways nor did they seek the opinions of Aboriginal communities on how and what was researched. Often these researchers were given the title of “fly-in researchers” by local people as they seemingly “appeared on the scene, collected data, and were gone” without sharing the results. Aboriginal communities were bothered by the results of this type of research as they were treated as “subjects” rather than partners in research and frameworks were used that were not tested or adapted to the Aboriginal (including Métis) perspectives. Interventions were not identified to solve health problems, communities were not receiving the direct benefits of research, and the tools used were those that worked in other populations, not in Aboriginal (including Métis) communities. Thus, Aboriginal Peoples felt that they were “researched to death” or that they were tired of being “treated like guinea pigs.” Aboriginal communities want trained Aboriginal researchers who are involved in listening to their stories of how previous outside researchers treated them and their wishes to improve research to that which is respectful and practical.

The sparse data from the Census and APS provides a clear picture of the lack of effective governance, health workforce, policy, research and infrastructure in addressing the health of Métis and other Aboriginal peoples. Despite further research, Aboriginal health has remained unacceptably poor as many researchers have chosen to ignore the root causes of health problems, such as poor housing and lack of education, marginalisation, social exclusion, and racism. These cannot be considered in isolation to the disease or a specific health issue being researched. Aboriginal people, including Métis, are often considered formally and informally to be the source of their own problems. There has been a legacy of denial and white-washing of history that has failed to recognise the origins of the real problems. Smith (1999: 176) suggests:

*“Researchers are in receipt of privileged information. They may interpret it within a overt theoretical framework, but also in terms of a covert ideological framework. They have the power to distort, to make invisible, to overlook, to exaggerate and draw conclusions, based not on factual data, but on assumptions, hidden value judgements, and other often down right misunderstandings. They have the potential to extend knowledge or perpetuate ignorance.”*

The dominance of western worldviews in Canada relates to the tradition of knowledge constructs and intellectual paradigms considered to be Eurocentric that have colonised not just the landscape but also peoples. These worldviews are a cultural and value-based construct as are Aboriginal worldviews which differ because of the significant divergent cultural, historical experiences and learning frameworks. Incorporating knowledge of the past as experienced by Aboriginal Canadians, including Métis, will broaden their worldview.

As Aboriginal, including Métis, academics we 'have had to be masters of both our own worldviews and Euro-Western worldviews' (Absolon & Willett 2004:12). Despite this conditioning, the way we think about health is captured in the following statement:

*“Indigenous Peoples' concept of health and survival is both the collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, intellectual, physical, and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously (Durie 2004 :1139).”*

There is a legacy of distrust, harm and exploitation caused by researchers that must be recognized when undertaking research with Aboriginal Peoples in Canada (Smith, 1999; Smylie et al., 2004; Stephens et al. 2006). Significant shifts have taken place in recent history and increasingly Aboriginal communities are poised to take a leading role in research. This shift is captured in the notion of doing research “with” Aboriginal Peoples rather than “on” Aboriginal Peoples. Respect and awareness of the past helps to guide us in the present and into the future towards a vision of strong healthy communities. As an Aboriginal person engaged in research, the author of this paper values Knowledge Translation. It is our perspective that KT reinforces the relevance of research for Aboriginal communities, improves the results of research and engages more people in the research process creating opportunities for mutual learning and capacity building.

Attention to the legacy of research is necessary for all researchers, Aboriginal or not, who hope to pursue health research within Aboriginal communities. Smylie et al. (2004) point out the importance of a new research relationship: “Conducting health research with Aboriginal peoples entails tremendous responsibility. Researchers have a responsibility not to perpetuate existing inequalities, policies and attitudes. Information should be collected in a way that is consistent with Aboriginal worldviews, respects cultural differences, protects their traditions and cultural manifestations and also recognizes the moral, historic and legal rights of Aboriginal peoples to self-determination. (p. 34)” When research is respectful of the perceptions, needs, unique circumstances and traditional knowledge in Aboriginal communities (Smith, 1999) the outcomes have been demonstrated to be extraordinary.

Given a growing understanding of KT in practice and in literature the opportunity is emerging to reflect upon the impact of this concept in Aboriginal research forums (Masching et al. 2006). For example, Smylie et al. (2004) noted that until recently, the “two communities” theory put forward by Caplan in 1979 has been the dominant model of health research in Aboriginal communities. This theory presents the notion that research uptake is limited by a divide between the “two communities” - one of health researchers and one of policy makers. The divide is due to

differences in language, priorities and world view. Commenting further on this theory, Smylie et al. (2004) observe:

“ In the century following the Indian Act legislation, “official” health researchers and policy makers were clearly external to Aboriginal communities, and largely employed by the Federal government. While health researchers remain external to Aboriginal communities today, health policy makers are increasingly found within the community, as the communities take a larger role in the governance and management of their health care services. This shift has resulted in a widening gap in the worldview between the two groups. Further research regarding knowledge translation in Aboriginal communities can narrow this gap in two ways: by applying a health research methodology that is framed in the indigenous worldview of the community “policy makers”; and by involving Aboriginal academics and community members in the health research process. (p. 141-142)”

Finally, Kenny (2004) has presented an interesting Framework for Aboriginal Policy Research. Recognizing that sharing knowledge is a traditional norm, Kenny references, “sharing is a responsibility of research... For indigenous researchers sharing is about demystifying knowledge and information and speaking in plain terms to the community... Oral presentations conform to cultural protocols and expectations” (p. 13). Kenny emphasizes that research that is culturally relevant must honour “constant” communication with the community throughout the research process, “[a]fter all, lives will be affected by the changes the research may bring” (p. 13).

We believe it is critical that Indigenous knowledge be incorporated into the macro and micro Aboriginal health agenda to achieve health improvement. In saying this, the criticism we consider to be important is that current health policy and praxis approaches in Indigenous health remain linear (Absolon and Willett 2004, Smylie et al. 2004). This linear activity relates to western knowledge systems, which dissect knowledge and health into compartments and categories or boxes. This is in conflict with Indigenous knowledge systems that produce and transfer knowledge within a holistic model. As such health is not separated from any aspect of a person's life. This is in contrast with the approaches used by Western health systems that fund Aboriginal health projects according to body parts and diseases. The rhetoric of Indigenous health policy, funding, and praxis, is that policies acknowledge the Indigenous ways of defining health, but the reality is that policy and strategies target Aboriginal people using Western models of health.

Research has a bad name as lived from an Indigenous experience (Smith 1999, Smylie et al. 2004). It has been used as a tool to inform the government of ways to 'manage the problem' through the strategies it helps to develop and ratify. An attitude of superiority by researchers and policy makers has prevailed in respect to their status and the right to develop Aboriginal research policy and programs. Research has in essence become a critical tool for informing government

agencies about their Aboriginal subjects that they have had to manage. By and large, the interpretations of the results of this research have not always bid well for Indigenous peoples.

As Smith (1999:39) explains:

“Research has not been neutral in its objectification of the other. Objectification is a process of dehumanisation. In its clear links to Western knowledge research has generated a particular relationship to indigenous peoples which continues to be problematic.”

We argue that the current western epistemology related to research and specifically health is generally accepted as a positivist model that has not involved Aboriginal people in research about themselves (Absolon & Willett 2004; Ermine et al. 2004). We believe Aboriginal peoples' knowledge and experience is important in informing change around the Aboriginal health agenda, which remains in the domain of western knowledge power-brokers and bio-medical health regimes. It is not difficult to appreciate that 'Rarely, the topic of Indigenous knowledge is discussed in relation to Aboriginal health' (Smylie 2004:141).

Research is an important agent for change and can make a significant difference to Aboriginal health outcomes if and when Aboriginal peoples' voices, opinions and knowledge inform the process. As such, researchers need to expose societal structures that are responsible for disadvantaging Aboriginal Peoples in respect to their culture and status of health, instead of focusing on disease causation and remedial measures. Underlying structural inequalities have a major impact on health and wellbeing, and influence how health policy and services are determined. Health and culture need to be viewed and evaluated from the context of the historical and political consequences of this praxis (Absolon and Willett 2004, Smylie et al. 2004).

Indigenous health workers, nurses, doctors, allied health professionals, academics and researchers are concerned with the unrelenting approaches to health, which fail to hear Aboriginal voices. Smylie (2004: 139-140) rightly states:

*“Contests between indigenous peoples and states have been fought in a variety of sites, most obviously around territorial lands, waterways, and oceans. But increasingly the contests are shifting to intellectual and cultural sites and are about the terms under which there are effective interventions for many of the health conditions that impact on Aboriginal communities. However, there remains a paucity of health programming that enables widespread implementation of manoeuvres that could improve Aboriginal health outcomes. With few exceptions, knowledge translation activities that link health research to practice in Aboriginal communities have been overlooked. When knowledge translation does occur, there appears to be little adaptation of mainstream approaches to the Aboriginal community context.”*

This point is particularly relevant to western health care practice and training related to Aboriginal Peoples and communities. Indigenous health is observed as a critical health focus, but it is difficult to make an impact if health services and professions are to continue doing health the same old way.

### **Key research questions**

1. Under what conditions are some Métis /Aboriginal people/communities doing well?
2. How do people create meaningful and rewarding socio-cultural environments?
3. Which programs and policies on health determining conditions are facilitating positive health outcomes for Métis peoples?

Aboriginal health continues to be in crisis in Canada although expenditure has increased in service provision, strategic planning, research and policy development over the last few decades. This report recommends that a shift must occur to make Aboriginal health, especially Métis health, improvement a reality. This shift requires the decolonising of Aboriginal health so that the experts in Aboriginal health, namely Aboriginal people, can voice and action initiatives that address their health issues. This shift is from the current western dominant approach that continues to manage Aboriginal health in its linear spectrum of illness and disease. Aboriginal people view health differently; their contexts for health issues are also diverse requiring a more holistic and informed response. Health care in Canada has traditionally been informed by a dominant western worldview. This worldview is in direct conflict with the Indigenous worldview and the way health and well being are considered by Aboriginal people. This approach progresses a process for decolonising the ways in which health and illness are perceived and currently acted upon. Additionally, this report acknowledges the context under which poor Aboriginal health occurs and incorporates the historical circumstances and consequences arising from the colonial experience, the impact of which is often denied or underestimated.

Indigenous peoples worldwide share a commonality of the experience of imperialism and colonisation (Durie 2004; Ermine et al. 2004; Smith 1999). For Indigenous Australians, and other Indigenous people, this experience has led to the theft of sovereignty, land, health and wellbeing.

Durie (2004: 1139) asserts that:

*“By implication, concern about the health standards of indigenous peoples needs to take into account the broader perspectives of a world view that has been seriously fractured. Alienation of people from their environment - from the natural world- may be closely linked to the host of health problems that beset indigenous peoples as the more familiar life-style risks of modern living.”*

In order to undertake a process of decolonisation, it is imperative that Canadians acknowledge and comprehend the impact that invasion, imperialism, colonisation, research and policy have had on the Indigenous people of this country.

Smith (1999: 19) advocates:

*“Imperialism still hurts, still destroys and is reforming itself constantly. Indigenous peoples as an international group have had to challenge, understand and have a shared language for talking about their history, the sociology, psychology and the politics of imperialism and colonialism as an epic story telling of huge devastation, painful struggle and persistent survival.”*

Indigenous health workers, nurses, doctors, allied health professionals, academics and researchers are concerned with the unrelenting approaches to health, which fail to hear Aboriginal voices.

Smylie (2004: 139-140) rightly states:

*“Contests between indigenous peoples and states have been fought in a variety of sites, most obviously around territorial lands, waterways, and oceans. But increasingly the contests are shifting to intellectual and cultural sites and are about the terms under which there are effective interventions for many of the health conditions that impact on Aboriginal communities. However, there remains a paucity of health programming that enables widespread implementation of manoeuvres that could improve Aboriginal health outcomes. With few exceptions, knowledge translation activities that link health research to practice in Aboriginal communities have been overlooked. When knowledge translation does occur, there appears to be little adaptation of mainstream approaches to the Aboriginal community context.”*

Indigenous health is observed as a critical health focus, but it is difficult to make an impact if health services and professions are to continue doing health the same old way.

This praxis, research and writings remain critically ill-informed in relation to Indigenous peoples' concerns, expectations, and experience. Indigenous peoples are the experts in relation to their own health and health needs. Indigenous knowledge, local, traditional and ecological, provides essential ways of knowing related to Indigenous worldviews that are important for formulating health policy and praxis. According to Durie (2004: 1139):

*“Indigenous knowledge can prevail in modern times for the benefit of Indigenous peoples, if not all peoples. Much of the debate is between science and indigenous knowledge and takes three distinct forms; opposition to the promotion of science as the*

*only valid body of knowledge; the rejection of science in favour of indigenous knowledge; and the misinterpretation of knowledge by the use of system-bound criteria”.*

The silencing of Aboriginal voices and knowledge in relation to health research, policy, planning and praxis has been detrimental to Aboriginal people as the poor health outcomes demonstrate. Aboriginal voices have not just been silenced by researchers, they have also been silenced by the institution the researchers serve.

This praxis, research and writings remain critically ill-informed in relation to Indigenous peoples' concerns, expectations, and experience. Indigenous peoples are the experts in relation to their own health and health needs. Indigenous knowledge, local, traditional and ecological, provides essential ways of knowing related to Indigenous worldviews that are important for formulating health policy and praxis. According to Durie (2004: 1139):

*“Indigenous knowledge can prevail in modern times for the benefit of Indigenous peoples, if not all peoples. Much of the debate is between science and indigenous knowledge and takes three distinct forms; opposition to the promotion of science as the only valid body of knowledge; the rejection of science in favour of indigenous knowledge; and the misinterpretation of knowledge by the use of system-bound criteria”.*

The silencing of Aboriginal voices and knowledge in relation to health research, policy, planning and praxis has been detrimental to Aboriginal people as the poor health outcomes demonstrate. Aboriginal voices have not just been silenced by researchers, they have also been silenced by the institution the researchers serve.

The Métis people in Canada have tremendous needs to improve their health status. However, there are currently very few Métis researchers and health practitioners with knowledge and training in health research. In addition, there are few non-native health professionals with knowledge and training in Transcultural health care or expertise in disparity research. Collaborative and creative partnerships with Métis communities are needed to identify respectful and culturally competent research strategies and health interventions to decrease the current health disparities.

## **7. Métis Nation Health Action Plan (MNC 2005).**

In efforts to prepare for the new Aboriginal agenda, the Métis Nation has developed key components or areas of focus for its action plan for health. The overall goal of the plan will be to improve the health status of the Métis people to a comparable level with non-Aboriginal peoples in Canada. This will be no easy task and will require a variety of stakeholders working closely together in efforts to identify and fill the gaps within the current health care system.

The Métis National Council (MNC) has identified four priority areas of action;

1. building upon best practices in Métis health care;
2. developing a health career strategy for Métis people;
3. exploring new models to address jurisdictional barriers;
4. and, supporting Métis participation into health policies in Canada.

### **7.1 Best Practices in Métis Nation Healthcare**

The Métis Nation currently faces the reality where there are few to none federal best practices with respect to Métis health. This situation is only exacerbated by the fact that provincial governments largely ignore the unique needs of the Métis as well. The *Snapshot of the Nation* provides evidence of the stark void in the area of health that is the current state of affairs in the Métis Nation. However, within the Métis Nation there are two notable exceptions which demonstrate that positive results can be achieved when strategic investments are made. These include:

- **Métis Addictions Council of Saskatchewan Inc. (MACSI):** Supported by the Government of Saskatchewan's Community Health Care Branch, MACSI is a positive example of a culturally appropriate alcohol and drug recovery initiative that works. As an affiliate of the Métis Nation - Saskatchewan, MACSI provides detoxification services, inpatient recovery services, outpatient services and reintegration of offenders' initiatives to First Nation and Métis peoples in Saskatchewan. Its results and successes speak for themselves and are outlined in the *Snapshot of the Nation* at pp. 97-99.

- **Métis Nation of Ontario Long Term Care Initiative (MNO LTC):** Supported by the Province of Ontario, the MNO's LTC initiatives builds a much needed bridge between the Métis people and primary health care services, as well as, focuses on proactive and preventative interventions within the Métis community. The MNO's LTC initiative has 12 sites throughout the province and provides a range of services such as friendly visits to elders, security reassurance, care giver support, transportation to check ups and wheels to meals. The measurable results achieved to date through this initiative are outlined in the *Snapshot of the Nation* at pp. 49-50.

Despite the lack of federal best practices in Métis health, the Métis Nation advocates for federal health policy to follow the partnership approaches employed by other departments such as Human Resource Social Development (HRSD) or Canadian Heritage (DCH). For example, through the Aboriginal Human Resource Development Strategy (AHRDS) the Métis Nation has been able to make substantive gains in the area of labour market development in recent years. Through partnership, flexibility, and a Métis-specific allocation in an Aboriginal status-blind

initiative, the Métis Nation has made inroads in the employment sector. The Métis Nation is recommending that a similar nation-to-nation devolution model be employed in future federal health policy development and delivery.

## **7.2 Health Career Development for Métis People**

While the Métis Nation cannot point to any successful Métis health career development initiatives currently supported by any level of government in Canada, it can point to a Métis career development program that works in another sector.

The Gabriel Dumont Institute (GDI), an affiliate of the Métis Nation - Saskatchewan, provides Métis people in the province an accredited means of obtaining training and education. One of GDI's true success stories has been the Saskatchewan Urban Native Teachers Education Program (SUNTEP). The program was designed to meet the unique needs of Métis students, as well as, address the demand for Métis educators in the province. In 2001, SUNTEP had graduated 544 Métis teachers with Bachelors of Education degrees. Equally impressive is SUNTEP's extremely high success rates of employment (approximately 90% placement upon successful completion of the program) which is further detailed in the *Snapshot of the Nation* at pp. 89-93.

This model exemplifies the successes that can be achieved when a need is identified and a culturally-appropriate solution is developed. Building upon the successes of GDI could easily be expanded to other career areas, such as health, in efforts to improve Métis access to health care services and delivery.

## **7.3 New Models to Address Jurisdictional Issues**

In regards to jurisdictional issues, Métis people oftentimes find themselves limited to mainstream services which fail to meet their unique needs and realities. Through consultation processes and experience from best practices, the Métis Nation has discovered that Métis-specific approaches have proven the most beneficial. As a result, the Métis Nation's perspective is that rather than establishing new models, the solution lies in building upon models that have already proven successful for Aboriginal peoples and other federal departments.

There is no need to always "create" a new delivery structure when resources can be horizontally managed through infrastructures that are already accountable and results oriented. As outlined above, HRSD's AHRDS is a current best practice within the Métis Nation. This devolution model was implemented without jurisdiction wrangling or positioning with provinces and supported by the existing federal *Inherent Right Policy* with respect to the Métis. Further, this type of model in the health sector would provide Métis governments the opportunity to develop unique programming that meets the needs of their people. Central to this would be initiatives that would increase Métis access to primary health care services delivered by provincial

governments, as well as, initiatives tailored to the unique health realities faced by Métis people in urban, rural and remote areas. Rather than setting up new delivery structures, existing infrastructures could be built upon while ensuring accountability and results for jointly set health targets.

#### **7.4 Métis Participation in Health Policy**

The MNC is currently exploring a number of processes in efforts to support Métis participation in the development and implementation of health policies which affect Métis people. The initial impetus from this work stems from the April 19<sup>th</sup>, 2004 Canada-Aboriginal Peoples Roundtable and the corresponding follow-up. At the Roundtable, the Government of Canada committed to a renewed relationship with Aboriginal peoples and is hoping to make progress in key priority areas of action, one of which is health. In response, the MNC is hoping to develop its internal capacity to ensure effective and evidence-based input on Métis health issues in the health sector follow-up session to the Roundtable, which is to occur later this year. Further, the MNC is committed to increasing its influence over federal and provincial policies and/or initiatives that affect the health of Métis people by working more closely with all stakeholders.

The MNC recognizes that there will be a variety of levels of participation; nationally, provincially, regionally and at the community-level. In efforts to be inclusive and flexible, the MNC is recommending participation through a variety of bilateral and multilateral meetings and discussions that would focus on:

- Increasing awareness of the Métis Nation and its governing structures;
- Ensuring Métis access to current and future health initiatives;
- Engaging in dialogue on health policies and their affects on Métis people;
- Identifying and exploring current challenges, best practices and opportunities; and,
- Securing processes that support the Métis Nation’s ability to provide input and synthesize national positions relating to Métis health.

#### **8. Advocacy to address SDOH of Métis people.**

There is significant evidence confirming that Aboriginal health continues to be a major challenge to governments, its agencies, health professionals and Aboriginal communities. Despite the high level of expenditure and commitment to improving Aboriginal health outcomes through health policy, work force strategies that are inclusive of Aboriginal Cultural Awareness, research, and health infrastructure there has been only slight improvements (Census and APS 2001). We

believe the critical issues that underlie the lack of improvement in Aboriginal health are the continuation of colonisation, through the dominance of western worldviews in research, policy, planning, and praxis; the lack of Indigenous health models and the dominance of the bio-medical model; and everyday personal and institutional racism.

Achieving health equality for the Métis People will require:

- ∞ measures to ensure equal access for Métis peoples to primary health care and health infrastructure
- ∞ increased support for developing the Métis health workforce
- ∞ a commitment to support and nurture Métis community controlled health services
- ∞ a focus on improving the accessibility of mainstream health services for Métis peoples
- ∞ an urgent focus on early childhood development, maternal health, chronic illness and diseases
- ∞ supporting the building blocks of good health, such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, adequate housing and the other social determinants of health.

In many ways, the Métis although they reside in a western first-world society, their health inequities and resulting health disparities reflect those of Indigenous in third world countries. The situation of the Métis in Canada is eloquently addressed in the paper by Stephens and colleagues (Disappearing, displaced, and undervalued: a call to action for Indigenous health worldwide. *Lancet* 2006) in which the Indigenous peoples of third world countries not only suffer health inequities, and resulting health disparities, they also lack the resources to take effective action to rectify their poor health status. As stated in the recent paper by Frohlich and colleagues (2006):

“Improvement of Indigenous health does not mean only looking at underlying causes; it means taking a new approach, including Indigenous peoples in decision making at all levels of policy. Thus, the UN argues that a major focus must be on improved data related to Indigenous peoples’ health and living conditions, but this information can be obtained only with the full participation of Indigenous peoples. Additionally, access to comprehensive, community-based and culturally appropriate healthcare services, health education, adequate nutrition and housing should be ensured without discrimination. A key issue is the incorporation of Indigenous knowledge and values into all policies that affect Indigenous peoples. Participation of Indigenous peoples in these policies is a linchpin of all proposed strategies for the future.” (Frohlich and colleagues, 2006).

In a recent article on Knowledge Translation (KT) in regards to Aboriginal peoples (Masching, Allard and Prentice 2006), it is clear that KT is critical in making the link between poverty, social inequalities and resulting health disparities among Indigenous peoples. Métis health and well-being is not determined solely from health indicators, but health and well-being is shaped by the context of being Métis. The historical, socio-economic, cultural and epidemiologic context of health status must be viewed from an Indigenous worldview. The Métis need health information to design and implement effective, culturally appropriate health interventions. As well, the Métis must examine the underlying causes of health inequities and health disparities.

Major changes are afoot with respect to the Métis reality in Canada as evidenced by a number of developments, including the unanimous Supreme Court judgement affirming the constitutional rights of the Métis in *R. v. Powley*. However, despite the urgency of this issue and in contrast to First Nations governance, there has been relatively little written or researched on Métis Nation governance issues. The Institute of Governance (Ottawa: IOG), in partnership with JTM Consulting Inc., conducted an extensive research study to stimulate thinking among Métis and across governments. The paper (Madden and colleagues 2005) explores the historical, cultural and political factors affecting the Métis Nation; the fundamental governance issues that the Métis Nation and other levels of governments need to address; and options for future development. This is a crucial paper to examine self-determination for Métis people in Canada.

### **8.1 Political Advocacy to address SDOH of Métis people.**

The following are the 'Key Points' of the recent paper by Raphael and Bryant (2006) on "political advocacy" on SDOH in Canada.

- The primary determinants of health are the living conditions to which people are exposed.
- The quality of these living conditions are shaped by political and economic forces.
- The decline of support for the welfare state threatens these social determinants of health.
- Political action is required to strengthen the determinants of population health and to reduce health inequalities.

As stated in the recent paper by Raphael and Bryant (2006) on "political advocacy" on SDOH:

“Advocacy is about influencing governments to enact policies in support of health. This requires that health promoters and population health researchers be more explicit concerning their analysis of the role governments play in influencing the social determinants of health. It also requires explicit recognition of the role political and economic forces play in shaping these policies and the need to confront these sources of power and influence when they threaten health and well-being. Once these forces are

acknowledged, health promoters and population health researchers must go public with these conclusions to influence public policy.” (Raphael and Bryant 2006)

“The best means therefore of promoting health and improving population health involves Canadians –and others– being informed about the political and economic forces that shape the health of a society. Once so empowered, they can consider political and other means of influencing these forces. Health promoters and population health researchers need to “get political” and recognize the importance of political and social action in support of health. This seems a rather daunting task, but one that holds the best hope of promoting the health of citizens in Canada and elsewhere.” (Raphael and Bryant 2006)

Decolonising processes require all individuals to explore their own assumptions and beliefs so that they can be open to other ways of knowing, being, and doing. This change needs to be informed by Aboriginal people, the experts of their own health. Aboriginal health bodies and health professional associations have experience in effective ways of knowing about Aboriginal health and need to be heard, as do the communities they serve. Health agencies need to provide sustainable and adequate funding for comprehensive primary health care to be provided by culturally safe health professionals. This again requires the equitable guidance by and through the community.

Health literacy is an important determinant of health for Aboriginal peoples (Smylie et al. 2006). Mass media are very influential in shaping discourses about health and there is a need to examine the extent to which newspaper coverage of such stories reflect issues embedded in population and public health policy documents. Overall, the style of reporting for population health and public health for Aboriginal peoples in Canadian media is heavy, dry and critical, written in an academic style and fails to critically examine or challenge government initiatives. The potential for print media to educate the general public is poorly utilised (Hayes et al. 2007). Further exploration of how sensitive indigenous issues can be presented to avoid stereotyping, stigma and nihilism, while initiating more effective action, is needed. Canadian newspapers and media in general (Hayes et al. 2007) rarely report on socio-economic influences frequently cited in the research literature as being most influential in shaping population health outcomes.

The health research, policy and praxis focus requires a shift towards health and wellness, effectively accepting and acting upon the way Aboriginal people view health, rather than the mechanistic bio-medical approach currently in vogue. As such the health agenda needs to be deconstructed so that the focus is not just on disease and illness. It needs to acknowledge the inequities in society and how they really impact on peoples' health and wellbeing, and other determinants of health as prescribed by Aboriginal voices.

## 9. Summary and Conclusion

**Four main issues** need to be addressed to engage in the social determinants of health of the Métis of Canada. The underlying determinants of health of the Métis must be examined and efforts to ameliorate their socio-economic status, in order to improve the health status and well-being of the Métis.

### 1. 'A politics of whom'. Social Exclusion of the Métis of Canada. Human Rights and Constitutional Rights of the Métis of Canada.

Section 35 of the Constitution Act, 1982 provides:

1. The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.
2. In this Act, “aboriginal peoples of Canada” includes the Indian, Inuit and Métis peoples of Canada.

This constitutional protection was a victory for all Aboriginal peoples in Canada. For the Métis Nation, the explicit inclusion of the Métis in s. 35 was viewed as a new beginning after over 100 years of denial, avoidance and neglect by governments in Canada. The state recognizes in section 35 of the *Constitution Act, 1982*, three original peoples of Canada: First Nations, Inuit and **Métis** (Métis Law Society Review 2006). The state also has an obligation to honour treaty and Aboriginal rights for Aboriginal Peoples’ health (Barnsley 2006). Each group is distinct from the other and has a unique history, along with inter-group diversity.

Lack of Federal Government to fulfill their Fiduciary responsibility to deliver ‘health’ and ‘social’ services and programs to the Métis of Canada. The need for “Social Justice” programs and policies for the Métis of Canada needs to be addressed by Federal, provincial and territorial governments (MNC 2005). A “Social Justice” document and framework needs to be developed by the MNC on behalf of the Métis People of Canada (Boyer 2006). (Barnsley 2006).

**Self-determination** is an ‘ongoing process of choice’ to ensure that Métis People and communities are able to meet their social, cultural and economic needs. The right to self determination is based on the simple acknowledgment that Métis Peoples are one of Canada’s founding Aboriginal people, recognised by the Canadian Constitution. The loss of this right to live according to a set of common values and beliefs, and to have that right respected by others, is at the heart of the current disadvantage experienced by the Métis People. Without self-determination it is not possible for the Métis People to fully overcome the legacy of colonisation and dispossession

The Métis of Canada require “self-determination” through governance structures (Madden et al. 2005, MNC 2005). Major changes are afoot with respect to the Métis reality in Canada as evidenced by a number of developments including the unanimous Supreme Court judgement affirming the constitutional rights of the Métis in *R. v. Powley* (Métis Law Society Review 2006). It is a near certainty that the coming years will herald major advancements with respect to the Métis agenda. What is unclear, however, is what form these advancements will take – how will the process of registration of the Métis citizenry evolve? How will Métis choose to implement their rights? How will the Métis people relate to the Canadian state? How will the Métis people govern themselves? Métis people, the public, and governments at all levels have great interest in how these important questions are determined. In the shorter term, building upon the recently signed *Canada-Métis Nation Framework Agreement* provides a vehicle for making progress (MNC 2005).

## **2. Monitoring and Surveillance**

There is a need for the Monitoring and Surveillance of demographic, social and health status of the Métis of Canada.

There is a lack of Social and Health information, statistics and data on the Métis of Canada, concerning infectious diseases, chronic diseases, and injuries (Health Indicators).

There is a need for the creation of Métis-specific Health Indicators.

There is a need for the creation and monitoring of Métis-specific Social-economic determinants of health.

## **3. Health Promotion and Disease Prevention Services and Programs.**

Lack of ‘sustainable’ long-term Métis-specific Health Promotion and Disease prevention programs for the Métis of Canada.

Lack of both ‘Population Health’ and ‘Public Health’ Strategies for the Métis of Canada.

Need to develop Social and Health Financial resources for the Métis of Canada, in order to fund sustainable social and health programs.

Presently the Métis receive limited short-term social and health programs and funds through ‘Pan-Aboriginal’ federal and provincial programs.

## **4. Métis Health Research.**

There is a lack of Métis-specific ‘Research Capacity’. There are very few reports on Métis social determinants of health (Bartlett 2005, Richmond 2007a,b), and on Métis health status (Statistics Canada 2004). Based mainly on the Federal Census and accompanying Aboriginal Peoples

Survey (APS). (Young 2003, Sanson-Fisher et al. 2006). Knowledge Translation (KT) (Masching, Allard and Prentice 2006) is critical in making the link between poverty, social inequalities and resulting health disparities among Indigenous peoples.

As concluded by Richmond (and colleagues 2007b):

“In the years following the United Nation’s Decade of Indigenous Peoples (1995-2004), Indigenous health research that emphasizes thriving represents a positive and necessary turn in the discourse. Many of the health disparities borne by Indigenous peoples – from around the globe – represent systemic forces that sever Indigenous peoples’ connections to their traditional environments, while simultaneously disrupting social systems integral to maintenance of identity, culture and health. To better understand the determinants of thriving health, more intensive methods are needed to explore these relationships, with emphasis on mapping the mechanisms through which functions of our societal resources may be embodied as health outcomes. Among Canadian Indigenous peoples, richer exploration may illuminate the means by which one’s social ties mediate or exacerbate the effects of larger, structural forces on health (i.e., colonialism, racism). Such methods are critical for contextualizing health and social issues in terms of time and place, and for informing public health interventions and policy that makes sense to local people. Public programs may produce a greater health effect by supporting initiatives that build upon positive social interactions at the community level. By focusing on the strength and utility of societal resources for health, we set the stage for a paradigm that empowers Indigenous communities to focus less on disparities with non-Indigenous populations, and more on the spirit of the people to thrive, unified, well into the future.” (Richmond et al. 2007b)

Need to develop Social and Health Human Resource capacity for the Métis of Canada.

Need to develop ‘Aboriginal Masters of Public Health’ programs across Canada. This is already in use in the U.S.A and in Australia. Need to create Métis-specific Public Health Framework.

Need to fund a sustainable program of the Métis-specific data from both the Census and accompanying Aboriginal Peoples Survey (APS).

In **Conclusion**, it is increasingly becoming clear that the socio-economic inequities and disparities in health status among the Métis in Canada arise from the disparities in wealth and power that have endured since Confederation. Being ‘poor’, ‘uneducated’, ‘illiterate’, and ‘lacking empowerment to make changes’ are risk factors for illness, just as well as viruses, bacteria and lifestyle risk factors (e.g. smoking, alcohol abuse). Research on housing, income, education, literacy, etc., as socio-economic determinants of health could be a strategy for improving our understanding of the effects of social environments on health and for reducing health disparities. The history of health disparity among the Aboriginal Peoples of Canada suggest that social, cultural and economic conditions have played a powerful role in generating “Aboriginal” vulnerability to disease, injuries and premature death. Such awareness must guide ongoing research and interventions if the disparities in health status between Aboriginal Canadians, including Métis, and the general population are ever to be eradicated.

## References and Further Readings.

**Note: there are additional articles, documents and books listed in this section to add further readings on SDOH in general and SDOH among Indigenous peoples.**

Abele F. (April 2004) Urgent need, serious opportunity: Towards a new social model for Canada's Aboriginal peoples. Canadian Policy Research Networks (CPRN) Social Architecture Papers, Research Report F/39, Family Network. Ottawa, Ontario.

Absolon K. and Willett C. (2005). Putting ourselves forward: Location in aboriginal research. In L. Brown & S. Strega (Eds.) Research as resistance. Critical, Indigenous and Anti-Oppressive Approaches. Toronto: Canadian Scholars' Press, pp. 97-126.

Adelson N. (2003). Reducing health disparities and promoting equity for vulnerable populations: Aboriginal Canada, The Institute of Gender and Health, Canadian Institutes of Health Research, Ottawa.

Adelson N. The embodiment of inequality: Health disparities in Aboriginal Canada. *Can. J. Public Health*. 2005; 96:S45-S61.

Allard Y.E., Wilkins R., Berthelot J.M. Premature mortality in health regions with high aboriginal populations. *Health Reports* 2004 Jan;15(1):51-60.

Allard Y.E. 2006. Data to Guide Public Health Planning to Respond to Aboriginal Health Issues: The 'Trickster's Guide' to Aboriginal Health Data. Abstract. Canadian Public Health Association 97<sup>th</sup> Annual Conference, Vancouver, May 30, 2006.

Barlow K., Reimer G. and Stratton T. HIV/AIDS Issues affecting Métis in Canada. Ottawa: Canadian Aboriginal AIDS Network, CAAN, 2006.

Barnsley I. The right to health of indigenous peoples in the industrialized world: a research agenda. *Health Hum. Rights*. 2006;9(1):43-54.

Bartlett J.G. (2005). "Health and well-being for Métis women in Manitoba." *Can J Public Health* 2005; 96: S22-27.

Boyer, Y. (2006). Self Determination as a Social Determinant of Health. Discussion document for the Aboriginal Working Group of the Canadian Reference Group reporting to the WHO Commission on Social Determinants of Health, hosted by the National Collaborating Centre for Aboriginal Health and funded by the First Nations and Inuit Health Branch of Health Canada. Vancouver: June 29, 2006.

Bryant, T., Raphael, D., & Rioux, M. (2006) "Towards the future - Current themes in health research and practice in Canada." In Raphael, D. Bryant, T. & Rioux, M. (Eds.), *Staying alive: critical perspectives on health, illness, and health care*. Canadian Scholars' Press, Toronto.

Caledon Institute of Social Policy. (March 2004). Mendelson M. Aboriginal People in Canada's Labour Market: Work and Unemployment, Today and Tomorrow. Caledon Institute of Social Policy. Ottawa, Ontario.

Ciceri, Coryse and Katherine Scott. 2006. The Determinants of Employment Among Aboriginal Peoples. Paper submitted to the Policy and Research Coordination Directorate, Strategic Policy and Planning Branch, Human Resources and Social Development Canada.

[http://www.ssc.uwo.ca/sociology/aprc-crmpa/ciceri\\_and\\_scott-2.swf](http://www.ssc.uwo.ca/sociology/aprc-crmpa/ciceri_and_scott-2.swf)

CMHC. 2001 Census Housing Series Issue 6: Revised Aboriginal Households. Research Highlight, Socio-economic Series 04-036, August 2004.

CMHC. An Exploration of Housing Options for Aboriginal People in Edmonton, Alberta and Winnipeg, Manitoba. Research Highlight, Socio-economic Series 05-034, October 2005.

Dunn J.R., M.V. Hayes, J.D. Hulchanski, S.W. Hwang, Potvin L. Housing as a Socio-Economic Determinant of Health: Findings of a National Needs, Gaps and Opportunities Assessment. *Can. J. Public Health* 2006; 97(Supplement 3):S11-S15.

Durie M. Understanding health and illness: Research at the interface between science and indigenous knowledge. *Int. J. Epidemiol.* 2004; **33**:1138-43.

Edge L. and McCallum T. Métis Identity: Sharing Traditional Knowledge and Healing Practices at Métis Elders' Gatherings. *Pimatziwin: A Journal of Aboriginal and Indigenous Community Health* 4(2), 83-115, 2006.

Ermine, W., R. Sinclair, and B. Jeffery. 2004. *The Ethics of Research involving Indigenous Peoples: Report of the Indigenous People's Health Research Centre to the Interagency Advisory Panel on Research Ethics*. Saskatoon, SK: Indigenous Peoples' Health Research Centre.

Fletcher C. Community-Based Participatory Research in Northern Canadian Aboriginal Communities: An Overview of Context and Process. *Pimatziwin: Int. J. Aborig. Indig. Health* 2003; 1: 27-61.

Flicker S., Savan B., Kolenda B. and Mildemberger M. A snapshot of community-based research in Canada: Who? What? Why? How? *Health Education Research Advance Access* published February 25, 2007.

Frankish C.J., Moulton G.E., Quantz D., Carson A.J., Casebeer A.L., Eyles J.D., Labonte R., Evoy B.E. Addressing the non-medical determinants of health: A survey of Canada's health regions. *Can. J. Public Health* 2007; 98(1):41-47.

Frohlich K, Ross NA, Richmond C (2006). "Health disparities in Canada today: Evidence and pathways." *Health Policy*, Dec;79(2-3):132-43 .

Guimond, Eric, A/Director (Strategic Research and Analysis, Indian and Northern Affairs Canada). Education Indicators and Targets. Educational Attainment of Aboriginal Peoples. Aboriginal Policy Research Conference, March 2006. <http://www.ssc.uwo.ca/sociology/aprc-crmpa/E%20Guimond%20EducationIndicator%20FMM%20Session.swf>

Hayes M., Ross I.E., Gasher M., Gutstein D., Dunn J.R., Hackett R.A. Telling stories: News media, health literacy and public policy in Canada. *Social Science & Medicine*; In Press, 2007.

Heymann J., Hertzman C., Barer M.L. and Evans R.G. *Healthier Societies. From Analysis to Action*. Oxford University Press 2006.

Jones D.S. The Persistence of American Indian Health Disparities. *Am. J. Pub. Health*, 96 (12): 2122-2134, 2006.

Jeffrey B., Abonyi S., Labonte R. and Duncan K. Engaging numbers: Developing health indicators that matter for First Nation and Inuit People. *Journal of Aboriginal Health*. 44-52, September 2006.

Kenny, C. A Holistic Framework for Aboriginal Policy Research. 2004. [http://www.swc-cfc.gc.ca/pubs/pubspr/0662379594/200410\\_0662379594\\_e.pdf](http://www.swc-cfc.gc.ca/pubs/pubspr/0662379594/200410_0662379594_e.pdf)

Kindig D.A. Understanding Population Health Terminology. *The Milbank Quarterly*, Vol. 85, No. 1, 2007 (pp. 139–161).

Kirmayer LJ, Brass GM, Tait CL (2000). "The mental health of Aboriginal peoples: transformations of identity and community." *Can J Psychiatry* ; 45: 607-16

Little Bear, L (2000). *Jagged Worldviews Colliding*. In Marie Battiste (Ed). *Reclaiming Indigenous Voice and Vision*. Vancouver: UBC Press, pp 77-85.

Luffman J. and Sussman D. The Aboriginal labour force in Western Canada. January 2007 PERSPECTIVES. Ottawa, Statistics Canada — Catalogue no. 75-001-XIE; PP.13-27, 2007.

Masching R., Allard Y. and Prentice T. Knowledge Translation and Aboriginal HIV/AIDS Research: Methods at the Margins. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research*; Vol. 1:31-44, 2006.

Madden J., Graham H., Wilson J. Exploring Options for Métis Governance in the 21st Century. Ottawa; Institute On Governance (IOG). September 2005.  
[http://www.iog.ca/publications/2005\\_metis\\_gov.pdf](http://www.iog.ca/publications/2005_metis_gov.pdf)

Marmot, M. and Wilkinson, R. (2006). *Social determinants of health*. (2nd ed.) Oxford University Press, Oxford, UK.

McCallum-Mcleod L. and Willson K. Northwest Saskatchewan Métis Women's Health. Research discussion paper for the Northwest Métis Women's Health Research Committee. Project #88 Report. Centres of Excellence for Women's Health.

Métis National Council (MNC). (2005). Métis National Council Canada-Aboriginal Peoples Roundtable Sectoral Sessions Policy Papers. Ottawa, May 2005.  
[http://www.metisnation.ca/pres\\_pubs/MNC\\_Roundtable\\_Compilation.pdf](http://www.metisnation.ca/pres_pubs/MNC_Roundtable_Compilation.pdf)

Métis National Council (MNC). (2006). Proposals for Measuring Determinants and Population Health/Well-Being Status of Métis Peoples in Canada. Ottawa, March 2006.  
[http://healthportal.metisnation.ca/pdf/Metis\\_Indicators\\_Report.pdf](http://healthportal.metisnation.ca/pdf/Metis_Indicators_Report.pdf)

Métis Law Summary© 2006. Authored by Jean Teillet and Pape Salter Teillet (www.pstlaw.ca).  
<http://www.metisnation.ca/pdfs/MLS-2006.pdf>

Métis Health and Human Resources Initiative Overview 2007. Access at:  
<http://metisnation.ca/HHRI/default.html>

Métis Nation Health/Well-Being Research Portal 2007. Access at:  
<http://healthportal.metisnation.ca/home.html>

Navarro V. and Muntaner C. (Eds.) (2004). Political and economic determinants of population health and well-being: controversies and developments. Baywood Press, Amityville, NY.

Raphael D. (Ed.). (2004). Social determinants of health: Canadian perspectives. Book; Canadian Scholars' Press, Toronto.

Raphael D. (2006). "Social determinants of health: present status, unresolved questions, and future directions." *International Journal of Health Services* vol. 36, pp. 651-677.

Raphael D. and Bryant T. (2006). Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. *Promotion & Education*, 2006, XIII (4): pp 236-242.

Raphael D., R. Labonte, R. Colman, K. Hayward, R. Torgerson, Macdonald J. Income and Health in Canada: Research Gaps and Future Opportunities. *Can. J. Public Health* 2006;97(Supplement 3):S16-S23.

Researched to Life: The Métis Nation of Alberta on Health Research. Fran Hyndman. Health Research and Development Advisor. Métis Nation of Alberta Tripartite Process Agreement Unit. *Pimatziwin: A Journal of Aboriginal and Indigenous Community Health* 1(1), 171-175, 2003.

Richmond C, Ross NA, Bernier J. Exploring Indigenous concepts of health: The dimensions of Métis and Inuit Health. In White J, Beavon D, Wingert S, Maxim P (eds). *Aboriginal Policy Research: Directions and Outcomes Volume 4*. Toronto: Thompson Educational Publishing. Forthcoming Spring 2007a.

Richmond C., Ross N.A. and Egeland G.M. “Societal resources and thriving health: A new approach for understanding Indigenous Canadian health”. In Press in *American Journal of Public Health*, October 2007b.

Sanson-Fisher RW, Campbell EM, Perkins JJ, Blunden SV, Davis BB. Indigenous health research: a critical review of outputs over time. *Med J Aust*. 2006 May 15;184(10):502-5.

Shah P (2004). *The Health of Aboriginal Peoples*. In D. Raphael (ed.) *Social Determinants of Health: Canadian Perspectives*, Canada Scholars' Press Inc, Toronto.

Smith L.T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. Published by Zed Books (London and New York) and the University of Otago Press (Dunedin, New Zealand).

Smylie J., Kaplan-Myrth N., Tait C., Martin C.M., Chartrand L., Hogg W., Tugwell P., Valaskakis G., Macaulay A.C. Health sciences research and Aboriginal communities: pathway or pitfall? *J. Obstet. Gynaecol. Can*. 2004 Mar;26(3):211-6.

Smylie J., Martin C.M., Kaplan-Myrth N., Steele L., Tait C., Hogg W. Knowledge translation and indigenous knowledge. *Int. J. Circumpolar Health*. 2004;63 Suppl 2:139-43.

Smylie J., Williams L. and Cooper N. Culture-based Literacy and Aboriginal Health. *Canadian Journal of Public Health*; May/Jun 2006; 97, S21-S25.

Smylie J. and Anderson M. Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges. *C.M.A.J.* 175, 602-605, 2006.

Statistics Canada (November 2004) *A Profile of Canada's Métis Population*. Ottawa.

Statistics Canada. *Projections of the Aboriginal populations, Canada, provinces and territories 2001 to 2017*. Catalogue no. 91-547-XIE, Ottawa, 2005.

Stephens C., Porter J., Nettleton C., Willis R. Disappearing, displaced, and undervalued: a call to action for Indigenous health worldwide. *Lancet* 2006; 367: 2019–28.

The Health Status of Canada's First Nations, Métis and Inuit Peoples. Health Council of Canada. A background paper to accompany *Health Care Renewal in Canada: Accelerating Change*. January 2005.

Tjepkema M (2002). "The health of the off-Reserve Aboriginal population." *Health Rep*; 13: 73-88.

Vizina Y. Supporting Métis needs: Creating health individuals and communities in the context of HIV/AIDS. Ottawa: Canadian Aboriginal AIDS Network, CAAN, 2005.

Waldram J.B., Herring D.A. and Kue Young T. *Aboriginal Health in Canada. Historical, Cultural, and Epidemiological perspectives*. Second edition. University of Toronto Press Inc. 2006.

Wilson K, Rosenberg M (2003). "Exploring the determinants of health for First Nations peoples in Canada: can existing frameworks accommodate traditional activities?" *Soc Sci Med*; 55: 2017-31.

Wilson K. and Peters E. "You can make a place for it." Remapping urban Aboriginal spaces of identity. *Environment and Planning D: Society and Space* . In press. 2007.

Young T. Kue (2003). "Review of research on aboriginal populations in Canada: relevance to their health needs". *B.M.J.*; 327: 419–22.

Young T. Kue. *Population Health. Concepts and Methods*. Second Edition. Oxford University Press 2005.

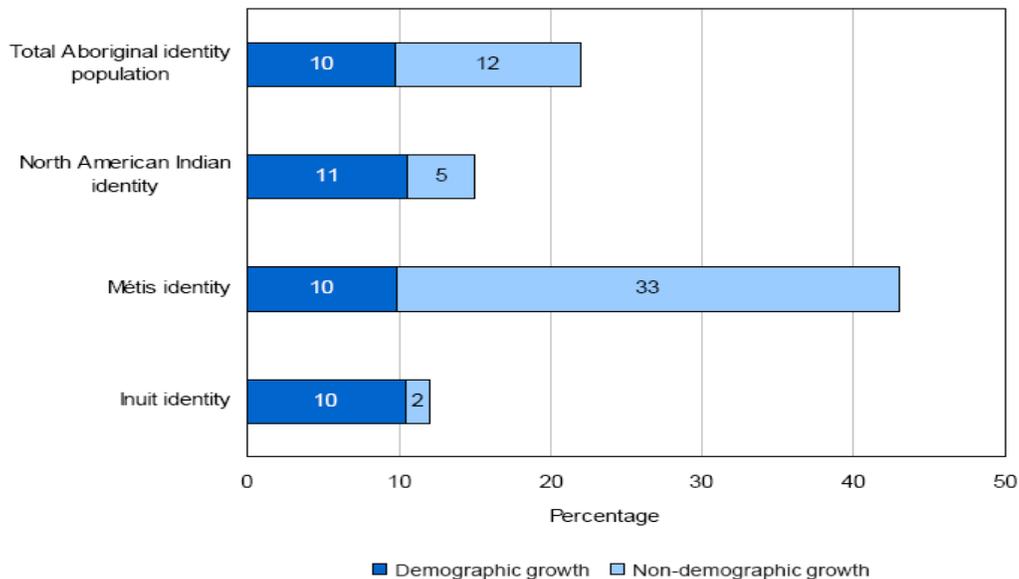
**For the connections between wealth disparities and health disparities**, see: "Health and Wealth," *Daedalus* 123 (Fall 1994), 1–216; Robert G. Evans, Morris L. Barer, and Theodore R. Marmor, ed., *Why are Some People Healthy and Others Not? The Determinants of Health of Populations* (New York: Aldine de Gruyter, 1994); Richard Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996); Norman Daniels, Bruce Kennedy, and Ichiro Kawachi, eds., *Is Inequality Bad for Our Health?* (Boston: Beacon Press, 2000).

## Appendix A

The Aboriginal population has grown dramatically in the past twenty years. While a portion of that growth has been due to natural increase (the difference between births and deaths) and to net migration, there have also been non-demographic factors. These include changes in the net undercoverage of the population by the census over time and “ethnic mobility”. The latter refers to people changing from reporting a non-Aboriginal identity in one census to an Aboriginal identity in another census.<sup>2</sup>

Of the 43% increase in the Métis population between 1996 and 2001, about three-quarters was likely due to ethnic mobility (and other non-demographic factors), while only about one-quarter was due to natural increase, as noted in Chart 1 below.

**Chart 1. Demographic and non-demographic factors affecting Aboriginal population growth, 1996-2001**



<sup>2</sup> As noted above, the Métis population increased by 43% between 1996 and 2001—the largest increase among the three Aboriginal groups. During this period, there were important political and legal milestones for the Métis. Métis received significant recognition in the final report of the Royal Commission on Aboriginal Peoples (1996);iv Louis Riel was recognized as a “father of Confederation” and his conviction as a traitor due to his involvement in the Métis Rebellion was vigorously debated. Furthermore, discussion of a Métis enumeration process during the Meech Lake constitutional process (1992)v was one of the political and jurisdictional issues affecting the Métis. In recent years, the Métis have won important court hunting rights cases (Powley, 2003) and greater land rights recognition in some provinces such as Saskatchewan.

Source: Siggner, A. and Costa, R. Trends and Conditions in Census Metropolitan Areas, Aboriginal Conditions in Census Metropolitan Areas, 1981-2001, Figure 2, page 30. Statistics Canada, 1996 and 2001 Census.

Based on projections for 2017, all three Aboriginal groups will continue to increase in population. As noted below, the Métis population will increase by 24% between 2001 and 2017 while the North American Indian population will increase by 36% and the Inuit by 30%. As a result of these increases, the total Aboriginal population is projected to increase from 3.4% of the total Canadian population to approximately 4.5% in 2017.

### **3. The Métis population is older than other Aboriginal groups, but younger than the non-Aboriginal population**

The Métis population is slightly older than the other Aboriginal groups and has aged slowly between 1996 and 2001. As noted in Table 3 below, 31% of the Métis population in 1996 was within the 0-14 age cohort compared with 29% in 2001. Additionally, 46% of the Métis population in 1996 was within the 25-64 age cohort compared with 49% in 2001. The senior cohort (65+) of the Métis population is virtually the same as the Aboriginal population at 4%.

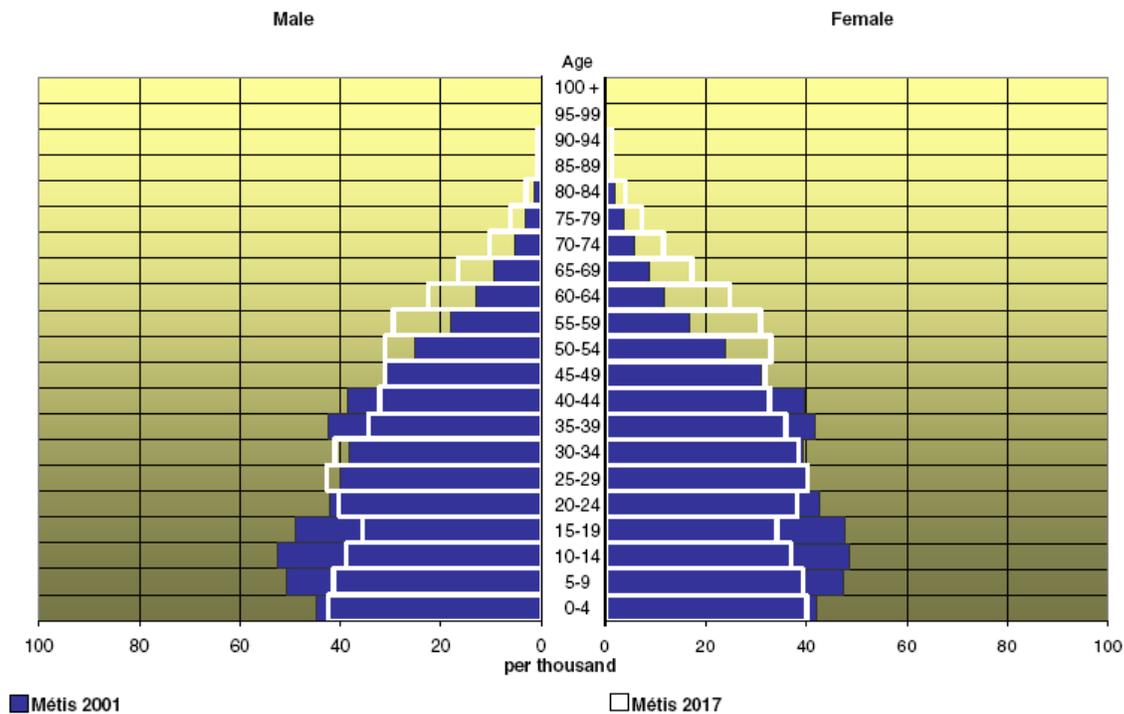
**Table 3: Population reporting a Métis identity, by age group, Canada, 1996 and 2001**

	2001		1996	
	Number	%	Number	%
Total	292,310	100.0	204,120	100.0
0-14 years	84,695	29.0	64,190	31.4
15-24 years	52,265	17.9	37,380	18.3
25-64 years	142,830	48.9	94,790	46.4
65 years and over	12,520	4.3	7,755	3.8

Source: 2001 Census Analysis Series, Aboriginal peoples of Canada: a demographic profile, Demographic Divisions, Statistics Canada, page 25.

Projections of age distribution in 2017 show a continued aging of the Métis population. Specifically, there will be a notable decrease in the cohort under 24 years of age coupled with an increase in the cohort over 50 years of age, as demonstrated in the age pyramid below (Chart 2).

**Chart 2 . Age pyramid for the Métis population, Canada 2001 and 2017**



Source: Projections of the Aboriginal populations, Canada, provinces and territories, 2001 to 2017, Statistics Canada, Demography Division, Figure 3.3, page 34.

Overall, the Aboriginal population, including the Métis, is younger than non-Aboriginal population in Canada. In 2001, 33% of the Aboriginal population were within the 0-14 year age group compared with 18% of the non-Aboriginal population. As well, 45% of the Aboriginal population were within the 25-64 age group compared with 55% of the non-Aboriginal population (Tables 4 and 5). Furthermore, seniors (aged 65+) made up only 4.1% of the Aboriginal population, versus 12% of the non-Aboriginal population.

**Table 4: Population reporting Aboriginal identity, by age groups, Canada, 1996 and 2001**

	2001		1996	
	Number	%	Number	%
Total	976,305	100.0	799,010	100.0
0-14 years	323,960	33.2	280,420	35.1
15-24 years	169,065	17.3	143,795	18.0
25-64 years	443,600	45.4	346,485	43.4
65 years and over	39,680	4.1	28,310	3.5

Source: 2001 Census Analysis Series, Aboriginal peoples of Canada: a demographic profile, Demography Division, Statistics Canada, page 20.

**Table 5 Non-Aboriginal population by age groups, Canada 1996 and 2001**

<b>Non-aboriginal population by age groups, 1996-2001</b>				
	<b>2001</b>		<b>1996</b>	
<b>Age groups and total</b>	<b>Total non-Aboriginal population</b>	<b>Percentage of population</b>	<b>Total non-aboriginal population</b>	<b>Percentage of population</b>
<b>0 - 14 years</b>	<b>5,413,715</b>	<b>18.8</b>	<b>5,618,780</b>	<b>20.3</b>
<b>15 - 24 years</b>	<b>3,819,135</b>	<b>13.4</b>	<b>3,705,230</b>	<b>13.3</b>
<b>25 - 64 years</b>	<b>15,844,710</b>	<b>55.3</b>	<b>15,153,640</b>	<b>54.7</b>
<b>65 years +</b>	<b>3,585,165</b>	<b>12.5</b>	<b>3,251,455</b>	<b>11.7</b>
<b>Total age groups</b>	<b>28,662,725</b>	<b>100</b>	<b>27,729,115</b>	<b>100</b>

Source: 1996 Census and 2001 Census

#### **4. Most of the Métis population live off-reserve and in cities**

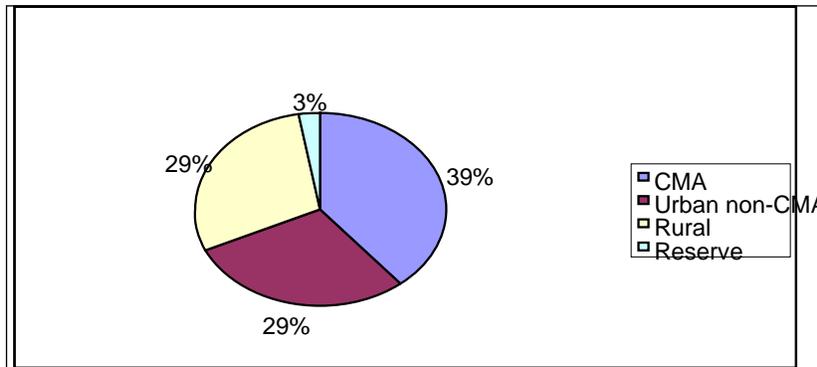
The Métis population represents a predominantly off-reserve, urban population with approximately 7,500 Métis living on reserve lands (2.5%) and 39% of Métis living in larger cities or Census Metropolitan Areas (CMA). By contrast, 29% of the Aboriginal population live on reserve and 28% of the off-reserve Aboriginal population live in CMAs. Moreover, over 45% of North American Indians lived on Indian reserves or settlements.

**Table 6 Adjusted Aboriginal population by group and place of residence, Canada, 2001**

Aboriginal group	Place of residence									
	Total		CMA		Urban non-CMA		Rural		Reserve	
	number ('000)	%	number ('000)	%	number ('000)	%	number ('000)	%	number ('000)	%
Total Aboriginal population	1,066.5	100.0	289.9	27.2	222.0	20.8	202.7	19.0	352.0	33.0
North American Indian	713.1	100.0	167.5	23.5	123.7	17.3	80.6	11.3	341.3	47.9
Métis	305.8	100.0	119.0	38.9	88.9	29.1	89.4	29.2	8.6	2.8
Inuit	47.6	100.0	3.3	7.0	9.4	19.8	32.6	68.6	2.2	4.6

**Source: Projections of the Aboriginal populations, Canada, provinces and territories, 2001 to 2017, Demography Division, Statistics Canada, Text table 2.1, page 18.**

**Chart 3. Percentage of Métis by Area of Residence, 2001**



Source: 2001 Census

The five census metropolitan areas with the largest Métis populations in 2001 were Winnipeg (31,395), Edmonton (21,065), Vancouver (12,505), Calgary (10,575) and Saskatoon (8,305). These five metropolitan areas combined were home to 29% of the total Métis population.

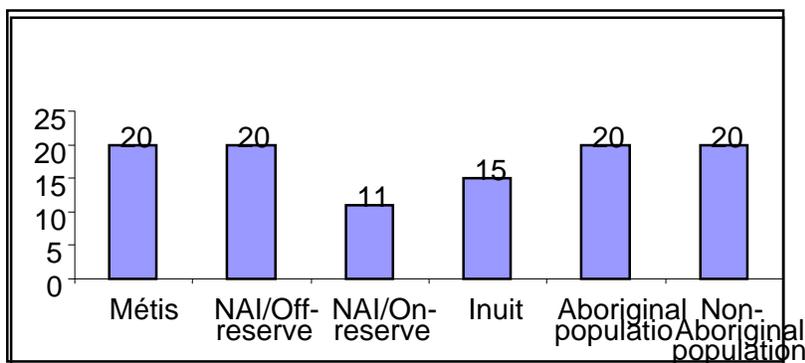
#### **5. The urban Métis population moves more frequently than the non-Aboriginal population.**



### *Movement outside of a municipality<sup>3</sup>*

In 2001, both the Aboriginal and non-Aboriginal populations moved outside of their municipality at a rate of 20%. With regards to the urban and rural Métis population, 20% also moved outside of their municipality which mirrors the total Aboriginal population's mobility as well as that of the North American Indian off-reserve population. The Inuit population had a slightly lower percentage of individuals (15%) who moved outside of their area.

**Chart 4. Percentage who moved outside of a municipality, by Aboriginal group, 2001**



**Source: 2001 Census**

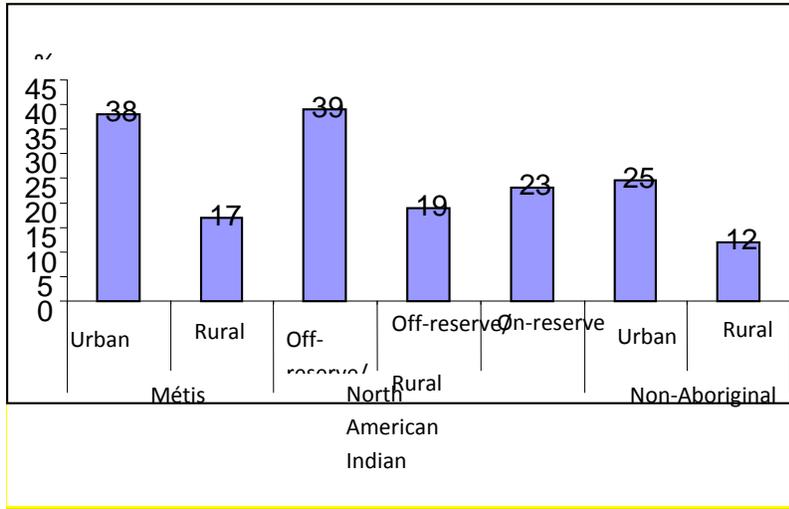
### *Movement within a municipality*

In 2001, less Aboriginal people (38%) changed addresses within the same municipality compared with 58% of the non-Aboriginal population. However, the total Aboriginal population does not reflect the movement within a municipality of each Aboriginal group depending on their area of residence. For instance, the table below reveals that off-reserve urban Métis and North American Indian groups have a 13% higher rate of movement within a municipality (38%) than the urban non-Aboriginal population (25%). As well, the off-reserve rural Métis and North American Indian groups have a 5 to 7% higher rate (17 and 19%, respectively) of movement within a municipality compared with the non-Aboriginal population (12%).

<sup>3</sup> The term municipality is used as a synonym for Statistics Canada's Census Sub Division. Please refer to Appendix A for the definitions of these terms.

Of note was the difference between Métis living in urban and rural municipalities. The Métis living in urban areas were twice as likely to move within their municipality (38%) than Métis living in rural areas (17%). In demonstrated in Chart 4 below, a similar trend existed with the urban (39%) and rural off-reserve (19%) North American Indian population.

**Chart 5: Percentage who changed addresses (over 5 years) within a municipality by Aboriginal group and area of residence, 2001**



Source: 2001 Census

**List of Definitions**

**Aboriginal Ancestry/Origin:** refers to those persons who reported at least one Aboriginal origin (North American Indian, Métis or Inuit) on the ethnic origin question in the Census. The question asks about the ethnic or cultural group(s) to which the respondent’s ancestors belong.

**Aboriginal Identity:** refers to those persons who reported identifying with at least one Aboriginal group, i.e., North American Indian, Métis or Inuit. Also included are individuals who did not report an Aboriginal identity, but did report themselves as a Registered or Treaty Indian, and/or did report Band or First Nation membership.

**Census Metropolitan Area:** City with a population of 100,000 or more inhabitants.



**Census Sub Division:** City or town where the enumerated person lived on Census Day.

**Mobility and migration:**

The concept of mobility concerns the movement of persons from one place to another. It includes persons who, in a specified reference period have not moved or have moved from one residence to another. The former are referred to as non-movers and the latter as movers. Movers include non-migrants and migrants. Non-migrants are persons who did move but remained in the same city, town, township, village or Indian Reserve. Migrants include internal migrants who moved to a different city, town, township, village or Indian Reserve within Canada. External migrants include persons who lived outside Canada at the earlier reference date. These external migrants include landed immigrants who moved to Canada but also Canadian-born persons who were out of the country but returned during the reference period.

**Municipality:** For the purposes of this document, municipality will be used as a synonym of Census Sub Division.

**On reserve population:** includes all people living in any of seven Census Sub Divisions types legally affiliated with First Nations or Indian Bands, as well as selected northern communities in Saskatchewan, the Northwest Territories and the Yukon Territory.

**Registered, status or treaty Indian** refers to those who reported they were registered under the *Indian Act of Canada*. Treaty Indians are persons who are registered under the *Indian Act of Canada* and can prove descent from a Band that signed a treaty. The term “treaty Indian” is more widely used in the Prairie provinces.

**Rural area:** Rural areas include all territory lying outside urban areas. Taken together, urban and rural areas cover all of Canada.

**Urban area:** Area with a population of at least 1,000 and no fewer than 400 persons per square kilometre.

