



Environmental Scan of Métis Health Information, Initiatives and Programs

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National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
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1. Introduction

1.1 Brief Overview of the Métis Centre Environmental Scan

This document is intended to assist Métis organizations, communities and individuals in their work toward improving the health outcomes of Métis. The primary focus is to begin the development of a comprehensive picture of the programs, services, information, and policy work being performed in the area of health for Métis across the country. This is only a preliminary iteration of what will hopefully be a dynamic and continually evolving document. As partnerships are established and strengthened between the National Aboriginal Health Organization and groups such as the Métis National Council, provincial Métis organizations, academia, and most importantly, Métis communities, new information will be incorporated.

This document is divided into the following parts:

- 1) A brief introduction with examination of the historical, political, and social issues that continue to affect the health outcomes of Métis;
- 2) An examination of Métis organizations directly involved in the areas of health policy, programs, or services;
- 3) Federal and provincial initiatives that deal with the health issues of Métis; and
- 4) Summary of initiatives with some analysis of the strengths, weaknesses, and opportunities with respect to current practices.

This environmental scan is not intended to validate or support governments or institutions with respect to the health system as it now services, or fails to serve, Métis. There is near unanimous agreement that the health system, as it exists now, is failing Aboriginal Peoples in this country. If improvements are to be made, however, an examination of initiatives that have been attempted and the reasons for their successes or failures must be considered. The call for change is made repeatedly when individuals, communities, and organizations are given an opportunity to voice their opinions. For that change to be significant and effective, there needs to be an identification of what exists now and what changes are necessary. Without this step, the result would be change for the sake of change with little or no real improvement for the people this work is intended to benefit. This document is intended to provide a view of the situation with respect to the health of Métis People and to provide information and insight that can be used by Métis to make the changes necessary to improve their health outcomes.

1.2 Methodology

The process for gathering information for this scan included telephone interviews with stakeholders, the review of annual reports and other key documents, a number of Internet searches, and small scale review of pertinent literature. While there are numerous programs for Aboriginal people that Métis people access, the majority of these programs consider Métis as an afterthought in their design or implementation. Every effort has been made to ensure that programs listed or cited were in some way specific to Métis, i.e. designed and/or delivered by and for Métis. The end result is an overview of those organizations that have a stake in the provision of health and health services to Métis as well as a guide to sources of information that would prove useful for those individuals and organizations that are currently working in the field.

1.3 A Profile of the Métis

Métis have been part of the cultural, historical, and political landscape of Canada, since before Confederation. They have had significant impact on the history and national identity of English and French-speaking Canadians as well as their relationships with other Aboriginal Peoples in

Canada. Their participation in the formation and development of this country is a matter of historical record. Despite these facts, Métis have been, and continue to be, one of the most marginalized populations within Canadian society. This marginalization is especially evident when dealing with issues such as health.

Information, initiatives, services, and programs directed to, or designed for, the Métis have been insufficient for their needs and, as a result, their health outcomes continue to be significantly lower than those of the majority of Canadians. While an understanding of the social, historical and political forces that have had a hand in creating this disparity is necessary, any effort to improve the health outcomes experienced by Métis also requires the identification and analysis of the information, initiatives, services, and programs currently available. From this snapshot of what exists, we can begin to make judgements on what is missing, what is working, what needs improvement, and what is needed in order for Métis to improve their health and health outcomes as a People. To this end, this Environmental Scan is an attempt to provide that snapshot of the information, initiatives, services, and programs that currently exist and hopefully serve as an aid to Métis in the continuing struggle for good health.

While Métis have been referred to by a number of names throughout their history – Gens Libres, Black Scots, Bois Brulé, Half-breeds, Apihtaw'kosian, Coureurs de Bois, Otipeyimsowak – there has been little agreement on the question of Métis identity. With this impediment, questions about where they live, their population figures, or their needs and aspirations as a People become increasingly complex. Due, in part, to the inability of governments to adequately recognize Métis, policies, legislation, programs and services have tended to overlook this part of the Canadian population. In response, significant amounts of time and resources have been expended by Métis organizations and leaders in the struggle for recognition as a People at both the provincial and federal level. One result of these issues around the definition and identity of Métis is that statistical information for this population and research in the area of demographics and population health are consistently impeded by the issues of inaccurate or incomplete data sources, inability to extrapolate from sample data, and in some cases a complete absence of data of any sort.

For Métis, recognition in the *Constitution Act* 1982 was a major victory. There is still much to be done, however, in terms of full recognition of Métis identity and rights. The federal government, through Statistics Canada, is responsible for the enumeration of all citizens. The enumeration of Aboriginal citizens has been a contentious issue for all of the constitutionally recognized Aboriginal Peoples (Métis, First Nations and Inuit). An example of this is the lack of agreement on the accuracy of the census conducted by Statistics Canada when considering Aboriginal Peoples. This issue is particularly evident when considering Métis. The Aboriginal Peoples Survey (APS) I states that: "...over 135,000 individuals reported that they identified with Métis People. Together, they accounted for 22 per cent of the Aboriginal people identified by the survey."¹ The census for the same year reports that 210,000 individuals were of Métis ancestry. Many have called these numbers into question. The change in the terms used by Statistics Canada in reference to identity verses ancestry is also called into question, as highlighted by the following:

This is nevertheless a very low number that probably indicates more about the unsatisfactory nature of the census question or about the current usefulness of the term than about how many people it could properly be applied to. ...Depending on the criteria employed, estimates of the non-status and Métis population for the country as a whole range from a low of some 400,000 to over two million.²

1 Canada. *A Profile of the Métis: Target Groups Project*. Statistics Canada. 1996. Pg. 6.

2 Morrison and Wilson ed. *Native Peoples: The Canadian Experience*. 2nd Edition. Toronto. Oxford University Press. 1995. Pg. 610.

While there may not, at first, seem to be significant political issues in the enumeration of a group of people, serious issues are raised when the group is defined externally. A proposed solution to this problem is the creation of a registry for Métis People that would be under the control of the Métis and as such would require a definition developed and approved by Métis themselves.

The Royal Commission on Aboriginal Peoples defines Métis as follows:

Every person who (a) identifies himself or herself as Métis and (b) is accepted as such by the nation of Métis people with which that person wishes to be associated, on the basis of criteria and procedures determined by that nation be recognized as a member of that nation for the purposes of nation-to-nation negotiations and as Métis for that purpose.³

The legal, practical, and economic viability of this definition with respect to the development of the registry is under consideration by Métis organizations and the final implementation will require much further discussion and development.⁴

The further examination of the issues surrounding the identity and recognition of Métis are beyond the scope of this paper. These issues must, however, be considered when discussing the factors that determine their health and health outcomes. Issues of identity have direct effects upon matters such as membership, resource allocation, research, political representation, epidemiology, and identification of other health determinants. Identity will be a source of pride for some, a source of confusion for others, and will pervade the discussion of any policy or programmatic matters for organizations and governments that seek to provide services for Métis.

Available Health Statistics

While the questions discussed earlier in this paper do not recommend the Census or the Aboriginal Peoples Survey (APS) as definitive sources of information for Aboriginal Peoples, these sources may be used to provide some insight into the issues that face the Métis with respect to health. A caveat for all discussion must be that while this is not the most ideal source of data, it is the best, and in some instances, the only source that is available.

As stated above, in the 1991 APS there were over 135,000 individuals who identified themselves as Métis. The majority of these, 65 per cent, resided in urban areas, which is significantly less than the 85 per cent of non-Aboriginal people who lived in cities.⁵ Three out of four Métis people identified by the APS lived in the Prairie provinces with the largest populations being in the cities of Winnipeg and Edmonton.⁶ The Métis population was also younger and experiencing faster growth than the general Canadian population with over half of the Métis population being under the age of 25.⁷ The picture that begins to develop from this information is that of a population which is predominantly young, increasingly urban, and concentrated in the provinces of Alberta, Saskatchewan, and Manitoba. This geographical area, with some additional territory in northern Ontario, eastern British Columbia, the southern portions of the Northwest Territories and Nunavut, and the northern United States is considered to be the Homeland of the Métis.

The APS reveals little information with respect to health issues specifically. Of those who responded to the questions pertaining to health in the survey, almost 43 per cent reported at least

3 Canada. *Perspectives and Realities, Volume 4*. Royal Commission on Aboriginal Peoples. Canada Communication Group. 1996. Pg. 203.

4 As of Sept. 27, 2002, the Métis National Council adopted a national definition, which reads, "Métis means a person who self identifies as Métis, is of historic Métis Nation ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation."

5 Canada. *A Profile of the Métis*. Pg. 6.

6 Ibid. Pg. 14.

7 Ibid. Pg. 12.

one health problem.⁸ This was the highest rate of the three groups in the APS. The most common problem reported was arthritis (40 per cent) followed by high blood pressure (27 per cent) and bronchitis (25 per cent).⁹ A slight majority of Métis respondents (54 per cent) smoked at least occasionally with the highest prevalence of smokers being in the 25 to 44 age category. This represents a rate that is more than double that of the most recent data for Canadians, which reveals a smoking rate of 23 per cent.¹⁰ The overall trend reveals a population with a significant number of smokers, which has a proven impact on the health outcomes not only of the smokers but on the health of the entire population.

One of the most striking health statistics revealed in the APS was that of the incidence of disabilities in Aboriginal populations. For Métis, the incidence of disability reported was 32 per cent and was roughly equivalent to that of the First Nations and Inuit populations. This was almost twice the incidence reported by the Canadian population as a whole, which was 18 per cent.¹¹

The paucity of data at the national level prevents much in-depth analysis of health indicators for the Métis. Data for some indicators are available in some provinces and in some regions but as stated previously, the issues around identity and recognition makes comparisons between regions or provinces tenuous at best. There are other issues, however, that the APS does report which are not considered health indicators in the conventional sense. Some of these do have an impact upon the health of a population and include housing, education level, and income levels. Examination of these determinants of health will provide additional insight into the state of health for Métis people.

1.4 Determinants of Health

For most of those individuals, institutions, and organizations who are a part of the modern medical establishment, ideas of health and medicine have tended to be considered synonymous. Health is considered from the point of view of absence of disease or defect; and medicine is the manner in which this is achieved. Medical science has been able to provide impressive improvements in the areas of diagnosis and treatment of disease. These successes combined with the tendency to equate medicine with health have resulted in a focus on physical health only. As a result medical models for health and health care have been overemphasized with a corresponding under-emphasis of alternative approaches or viewpoints.

Recently, however, there has been a growing recognition of what has been called a population health or a health determinants approach. In these views, other non-medical determinants of health are considered when analyzing the health of individuals and populations. In these models, other forces and factors in the lives and environments of individuals may have as much, or more, impact on their health than the access to or provision of medical services. These would include such determinants as socio-economic status, education level, geography, cultural identity, spirituality, social inclusion and integration, community and infrastructure. This viewpoint can be considered to be more agreeable to Métis views of individual, family, community and their roles in the provision of health for each. In this viewpoint, health is not a separate and distinct part of an individual. It is the result of all of the factors that constitute the individual at all levels – spiritually, mentally, physically, emotionally, and socially. Health services and programs, while important and necessary, will not in and of themselves provide Métis with good health. Healthy individuals are those who are able to participate fully in their society, community, and family. In all too many instances, there are barriers to this participation, which remain unaddressed.

The issue of ensuring a sustained and substantial effort toward the improvement of the health status of Aboriginal people in Canada was highlighted in the Royal Commission on Aboriginal

8 Ibid. Pg. 61.

9 Ibid

10 *Globe and Mail*. [Toronto], January 22, 2002

11 Canada. *A Profile of the Métis*. Pg. 59.

Peoples (RCAP). Throughout the Commission's hearings, Aboriginal people questioned the current piecemeal approach to health care and the report stated:

It is not working. Indeed, we have concluded that the business-as-usual approach to services perpetuates ill health and social distress among Aboriginal people. However much good a particular health or social program may do in the narrow sphere it addresses, it does not shift the overall picture of Aboriginal disadvantage – the pattern of poverty, powerlessness and despair – that determines health and illness.¹²

The RCAP continues to conclude that:

The weight of the evidence in this chapter is clear: substantial improvements in the health and welfare of Aboriginal people will not be accomplished by tinkering with existing programs and services. Commissioners believe that to restore well-being to Aboriginal people – and their communities and nations – a major departure from current practice is needed.¹³

One of the manners in which this major departure may be implemented or fostered is through the use of health and policy research on Métis, by Métis, and for Métis in a manner that is more consistent with the vision and principles of the National Aboriginal Health Organization (NAHO), member organizations, other Métis organizations, and the recommendations found in the RCAP report. Those recommendations are as follows:

The Commission recommends that:

Fundamental Principles 3.3.1

Aboriginal, federal, provincial and territorial governments, in developing policy to support health, acknowledge the common understanding of the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of:

- holism, that is, attention to whole persons in their total environment;
- equity, that is, equitable access to the means of achieving health and rough equality of outcomes in health status;
- control by Aboriginal people of the lifestyle choices, institutional services and environmental conditions that support health; and
- diversity, that is, accommodation of the cultures and histories of First Nations, Inuit, and Métis people that make them distinctive within Canadian society and that distinguish them from one another.¹⁴

12 Canada. *Gathering Strength, Volume 3*. Royal Commission on Aboriginal Peoples. Canada Communication Group. 1996. Pg. 223.

13 Ibid.

14 Ibid. Pg. 229.

2. Métis Involvement in Health Policy, Research and Programs

2.1 National Métis Organizations

2.1.1 Métis National Council

Recent developments at the Métis National Council (MNC) include the appointment of a Director of Health Initiatives and Minister of Health for the Métis Nation.

The Métis National Council's report from the 17th Annual General Assembly identifies three main areas of focus for the MNC in the field of health. These are:

Diabetes: Of significance to the MNC are the differences in both policy and practice regarding programming to Métis. Case in point is the proportion of funding under the Aboriginal Diabetes Initiative (ADI), with only 25 per cent of the allocation assigned to all Aboriginal people off reserve. The funding mechanism for the off-reserve component was also different, with the monies allocated through a proposal call. With delays in developing and approving a program framework, guidelines and application forms, only \$400,000 was allocated. As a result, \$1.7 million of the 2000-2001 budget was lapsed. The MNC hopes to seek reinstatement of the lapsed funding, as well as a process for future phases of ADI that is more equitable.

HIV/AIDS: The MNC actively participated in the National Aboriginal Interim Working Group in March 2000. A year later, the Canadian Aboriginal Aids Network (CAAN), MNC, Inuit Tapiriit Kanatami, and Assembly of First Nations came together to discuss a draft framework and selection process to form the National Aboriginal Council on HIV/AIDS. Of significance to the MNC is the equal representation of all working group organizations, with six seats designated to each of the four members. As a partnership, the National Aboriginal Council on HIV/AIDS represents the beginning of a national, collaborative effort to address a disease that impacts all Aboriginal people, regardless of status under the *Indian Act*.

National Children's Agenda: A major policy initiative identified by Métis organizations is the National Children's Agenda, aimed at improving the conditions of children throughout Canada. Using Statistics Canada's Low-Income Cut-Offs measure (LICO), the MNC's report noted that significantly more Métis children were living in households at or below LICO than was the norm in all provinces, with the largest gap occurring in Manitoba and Saskatchewan. The MNC is urging all provinces to follow Manitoba's lead in transferring responsibilities for child/family services to Métis representative organizations.

2.1.2 Métis Women's Secretariat

Established in 1998, the mission of the Métis Women's Secretariat (MWS) is identified as the following: "To promote, empower, and enhance the social, economic and political well-being of all Métis women."¹⁵ The objectives and goals that will support this mission include:

To promote the spiritual, mental, emotional, and physical wellness of all Métis women. To promote the history, culture, languages, values and traditions of the Métis Nation. To promote and foster grassroots Métis women initiatives throughout the Métis Nation. To promote an effective means of communication for Métis women within the Métis Nation.¹⁶

¹⁵ www.Metisnation.ca, fully acknowledging the source Web site and reproduced solely for research purposes.

¹⁶ www.Metisnation.ca, fully acknowledging the source Web site and reproduced solely for research purposes.

Specific areas of interest for the MWS include: economic development, education, health, social services, and environment, among others. In the area of health, facilities for Métis and the integration of “Aboriginal healing knowledge and skill with the wellness model”¹⁷ were identified in the MWS report to the MNC Annual General Assembly.

2.1.3 Métis National Youth Advisory Council

The Métis National Youth Advisory Council (MNYAC) was conceived as a youth secretariat at the 1995 Annual General Assembly and developed over the course of the following year to be formalized during the 1996 Annual General Assembly.

The MNYAC has worked diligently to ensure Métis youth have a voice and participation in the numerous governmental and non-governmental initiatives. Too often, an initiative is described as involving Aboriginal youth, yet Métis youth are excluded or “token” within the process. The MNYAC has concentrated on ensuring equitable and respectful participation of Métis young people in these initiatives.¹⁸

The MNYAC is involved with initiatives that include the Urban Multipurpose Aboriginal Youth Centres program, national Métis youth conferences, National Métis Youth Role Model Program, the National Aboriginal Youth Strategy, and participation in the Canadian Public Health Association’s Aboriginal Youth Health Career Committee.

2.1.4 Métis National Council Office of Ability Issues

As part of a three-year capacity building strategy to address barriers to equal citizenship for Métis people with disabilities, the MNC Office of Ability Issues (OAI) has just completed its first year of operation. With assistance from the Aboriginal Healing Foundation, the MNC implemented the capacity building project entitled “Empowerment: Métis People with Disabilities and the Capacity to Heal.”¹⁹ The project goals are:

- 1) to initiate capacity building consultations with Métis persons with disabilities who attended residential school and/or alternative institutions, and those living with the legacy of physical or sexual abuse;
- 2) to increase the amount of information about the Métis experience with healing issues as a direct result of such institutionalization, or as a result of living with the legacy of residential/institutional schools; and
- 3) to increase the capacity of Métis persons with disabilities to design, develop, and deliver healing opportunities to other Métis persons with disabilities.²⁰

2.1.5 Other Initiatives – Métis National Council

Other program areas or initiatives, which may affect broad determinants of health for the Métis include Métis Human Resources Development, MNC Environment/Natural Resources, Aboriginal Peoples Survey (APS 2), housing/homelessness, culture and heritage, and economic development initiatives.

17 Métis National Council. 17th Annual General Assembly Report. Vancouver. 2001. Pg. 47.

18 Ibid. Pg. 55.

19 Ibid. Pg. 77.

20 Ibid.

2.2 Provincial Métis Organizations

2.2.1 Métis Nation of Ontario

The Health Program is a permanent program of the Métis Nation of Ontario (MNO). The program was put in place to facilitate and co-ordinate effective activities to address the holistic needs of the Métis Nation in Ontario at the provincial, regional and local levels.²¹ Health initiatives co-ordinated by the MNO include: long-term care, Aboriginal Diabetes Initiative, Healthy Babies/Healthy Children, and a gambling strategy. It was noted during discussion with MNO representatives that some regional or local councils might provide further programs, which are funded or directed, by local health authorities or boards. For example, the Thunder Bay Métis Council delivers a pre-natal care program to members of its community as well as others under the mandate of the Community Action Plan for Children (CAP-C) program through Health Canada.

Other portfolios of the MNO that may impact health include: MNO Economic Development initiative, MNO Housing, MNO Scholarship and Bursary Fund, and training and development initiatives.

2.2.2 Manitoba Métis Federation

The Manitoba Métis Federation (MMF) established a Health Committee, which oversees Aboriginal Community Continuing Care and the Breast Cancer Support Project. It also participates in the following initiatives: Diabetes: A Manitoba Strategy; consultations on the Manitoba Aboriginal AIDS Strategy; the Minister's Advisory Committee on Diabetes; and the Manitoba Aboriginal AIDS Task Force. In addition, a recent submission to the Aboriginal Healing Foundation for a Métis Survivor Wellness Project has been approved.

The project seeks to address the legacy of physical and sexual abuse in residential schools through a healing strategy focused at meeting the needs of residential school survivors and their families. Funding has been secured for one year of proposed three-year project. The first year focus is primarily to identify MMF membership residential school survivors and their descendents and then to work with them to develop processes to meet their healing needs. Currently this project is in a start-up phase.²²

Other initiatives of the MMF that may affect health include: Community Housing Managers of Manitoba, Youth Initiatives, Métis Child and Family Services, and the Manitoba Aboriginal Sports and Recreation Council Inc.

2.2.3 Métis Nation - Saskatchewan

The governance structure of the Métis Nation - Saskatchewan is designed to reflect existing relationships and a need for future relationships as the voice of the Métis within the province of Saskatchewan. A number of portfolios and/or ministries are set up to accommodate discussions with provincial and federal government departments. Housing, justice, and employment and training are examples.²³

²¹ www.Métisnation.org/home.html, fully acknowledging the source Web site and reproduced solely for research purposes.

²² www.mmf.mb.ca, fully acknowledging the source Web site and reproduced solely for research purposes.

²³ www.Métisnation-sask.com/index.html, fully acknowledging the source Web site and reproduced solely for research purposes.

The delivery of programming, however, is performed by the various affiliates that have been established by the Métis Nation - Saskatchewan (MNS) for that purpose.

Métis Nation - Saskatchewan affiliates are MNS owned and operated institutions. They are governed by Boards of Directors under the Non-Profit Corporations Act, with their respective Ministers acting as chairpersons. Collectively, the MNS institutions and their administration spend approximately \$16 million annually to deliver programs and services to Métis people and communities in Saskatchewan.²⁴

The Métis Addictions Council of Saskatchewan Inc. (MACSI) provides inpatient addictions services at three locations in Saskatoon, Prince Albert, and Regina. These facilities provide accommodations, treatment, and support services for 12 to 15 patients for programs of 28 days in duration. Outpatient counselling, workshops, and education are also provided in smaller communities. MACSI is also currently working with the Aboriginal Healing Foundation on developing a program for Métis survivors of residential schools in Saskatchewan.

Other affiliates of the MNS that provide programs and services, which may impact health include: Métis Sports, Culture, Recreation, and Youth, Métis Family and Community Justice Services, Provincial Métis Housing Corporation, and Métis Employment and Training of Saskatchewan Inc.

2.2.4 Métis Nation of Alberta

Information not available.

2.2.5 Métis Provincial Council of British Columbia

Health and wellness is a priority for the Métis Provincial Council of British Columbia (MPCBC) but the lack of equitable resources, along with federal and provincial issues of jurisdiction, has limited its participation in health programming and/or service delivery. A funding proposal submitted to the Ministry of Health was approved for funding to enable the MPCBC to support the Ministry's efforts in the development of the Provincial Aboriginal Health Services Strategy. In 2001-2002, the MPCBC received \$52,000.

The MPCBC is represented and participates on the Provincial Aboriginal Health Services Strategy Steering Committee. The MPCBC has worked with provincial Aboriginal Health Division staff to plan and develop community focus group sessions on information sharing to gather information about:

- Gaps in programs and services;
- Barriers to access of existing provincial health services to Métis; and
- Recommendations for improvements to the above-mentioned gaps and barriers to access existing provincial health services for Métis.

In addition, the MPCBC has been working with Provincial Health Officer Dr. Perry Kendal to ensure Métis input for the development of the Provincial Health Officer Report, an important document that the provincial government relies on for direction on health policy development.

The MPCBC maintains one of four provincial policy tables with the Ministry of Health Planning. Through this policy table, the MPCBC is negotiating a Health Framework Agreement that recognizes the MPCBC authority to advocate and negotiate health policy and direction for Métis people with the provincial government.

²⁴ Ibid.

The MPCBC also is represented on the NAHO Métis Centre Governing Committee.

2.2.6 Métis Settlements' General Council

The Métis Settlements' General Council (MSGC) is the political representative for the Métis Settlements of Alberta, the only land-based Métis in Canada. The MSGC represents the eight Alberta Métis Settlements of Buffalo Lake, Kikino, Gift Lake, Peavine, Paddle Prairie, Elizabeth, Fishing Lake, and East Prairie, which have a population of approximately 5,000 members. Together they control over 400,000 hectares of land and manage their affairs with quasi-municipal powers.²⁵ The Métis Settlements of Alberta are not represented by the Métis National Council or the Métis Nation of Alberta. (See 3.3.2)

2.3 Métis Specific Institutions/Infrastructure

Métis Settlements Child & Family Services Authorities Region 18 (Government of Alberta)

Each Child and Family Services Authority oversees a range of services, including child welfare, day care, family violence prevention services, services for children with disabilities, early intervention programs, court services, and mediation. Each Authority assesses needs, sets priorities, plans, allocates resources, and manages the provision of services to children, families and other community members in the region; ensures that children and families have reasonable access to quality services; ensures that provincial policies and standards are followed in the region; monitors and assesses the provision of child and family services; and works with other authorities, public and private bodies, and government to co-ordinate services for children and families.

This community-based system will allow services and programs to be planned on the basis of local needs. The province is divided into 17 geographical regions with a corresponding authority for each. Region 18 is not a geographical region but is comprised of the eight Métis settlements of Buffalo Lake Métis Settlement, East Prairie Métis Settlement, Elizabeth Métis Settlement, Fishing Lake Métis Settlement, Gift Lake Métis Settlement, Kikino Métis Settlement, Paddle Prairie Métis Settlement, and Peavine Métis Settlement

Métis Addictions Council of Saskatchewan Inc.

The Métis Addictions Council of Saskatchewan Inc. (MACSI) has been operating as a non-profit organization for over 30 years. The mandate of the organization is "to reduce and eventually eliminate the harmful effects of alcohol and drug abuse among Aboriginal people and to assist communities in restoring a balanced and harmonious lifestyle. The key to overcoming the addiction is to restore harmony – to become WHOLE."²⁶ The MACSI offers a variety services, primarily to Métis clients, including field educator programs, youth services, treatment programs, detox centres, and a recent project funded by the Aboriginal Healing Foundation. More information can be found in section 2.2.3.

2.4 Summary

Due, in large part, to policy and legislative actions by the various levels of government in Canada, national and provincial Métis organizations have focused on the issue of recognition of Métis identity and rights.

Currently, Métis organizations can be found at differing levels of capacity. This is a result of a number of factors in each of their histories and development. The Métis Nation of Alberta was

²⁵ www.Metis-settlements.org, fully acknowledging the source Web site and reproduced solely for research purposes.

²⁶ Métis Addictions Council of Saskatchewan Inc. *Annual Report 2001*. Saskatoon. 2001.

one of the first provincial organizations established and it has had a hand in the development of a number of initiatives. The Métis Provincial Council of British Columbia was established in 1996 and has recently begun its work in representing Métis living in B.C. As the situation exists today, there are a number of successful activities, initiatives, and programs, which address health issues and which can be found throughout the Métis Homeland.

3. Federal/Provincial/Territorial Health Initiatives

3.1 Federal Departments Involved in Health Research or Programs Reflecting Policy

3.1.1 Health Canada

3.1.1.1 Population Health Initiative

In 1974, the federal government's White Paper, *A New Perspective on the Health of Canadians*, proposed that changes in lifestyles could lead to greater improvements in health than could be achieved by spending more money on existing health care delivery systems. Twelve years later in 1986, *The Ottawa Charter for Health Promotion and Achieving Health for All: A Framework for Health Promotion* focused on the broader social, economic and environmental factors that affect health. In 1994, following a population health concept put forward by the Canadian Institute for Advanced Research (CIAR), the federal, provincial and territorial Ministers of Health officially endorsed the population health approach. The report entitled *Strategies for Population Health: Investing in the Health of Canadians*, summarized the broad determinants of health, and presented a framework to guide the development of policies and strategies to improve population health.²⁷

Population health is an approach that aims to improve the health of the entire population, by reducing health inequities among population groups such as Aboriginal Peoples, and by acting on a broad range of factors that influence health. These factors, referred to as determinants of health, include income and social factors, social support networks, education, employment, working and living conditions, physical environments, social environments, biology and genetic endowment, personal health practices, coping skills, healthy child development, health services, gender, and culture. Critical to this definition is that these determinants do not act in isolation of each other, but involve complex interactions.

It is important to note that because many determinants of health fall outside the health sector, it necessitates forging new relationships between various ministries of provincial governments, and departments of federal government, as well as involving those organizations working in the health sector. For Métis, the population health approach represents a way of defining health with broad implications. It is especially relevant given the importance of encouraging consistency in government legislation, policies and practices impacting the socio-economic environment of Métis. The policy significance of a population health approach is that it could serve to support policy changes impacting the overall "determinants of health" of Métis. This relates to housing, quality of education, opportunities for economic development, etc., as well as legislative and policy reform with greater collaboration between departments/ministries at all levels of government, in collaboration with Métis governing structures. From Health Canada's perspective, additional justification includes:

- that reductions in health inequities require reductions in material and social inequities;
- investments are directed at root causes to increase potential for health outcomes;
- uses evidence-based decision making;
- promotes multiple strategies both across government sectors and with sectors outside the traditional health system;

²⁷ www.hc-sc.gc.ca/hppb/phdd, fully acknowledging the source Web site and reproduced solely for research purposes.

- promotes target group participation in developing strategies to improve health; and
- increases accountability for health outcomes, as opposed to inputs, processes and products.

3.1.1.2 Aboriginal Diabetes Initiative

The Aboriginal Diabetes Initiative (ADI) program is one of four main components of the Canadian Diabetes Strategy (CDS) announced by the Government of Canada in 1999. ADI has been allocated \$58 million over five years to assist in meeting the needs of Aboriginal people dealing with type 2 diabetes in their communities. The ADI consists of an on-reserve portion of the program, which includes treatment aspects, and the off-reserve portion, which is focused on prevention and promotion activities. The framework, purpose and objectives of the program targeting the First Nations/Inuit and the Métis are described below:

ADI for Métis, off-reserve Aboriginal people and urban Inuit

Framework: The Métis, Off-reserve Aboriginal and Urban Inuit Prevention and Promotion component (MOAUIPP), administered through Health Canada's Public and Population Health Branch, delivers culturally-appropriate diabetes primary prevention and health promotion programs to Métis, off-reserve Aboriginal people and urban Inuit. The program is delivered on a national basis. A national-level sub-committee of the ADI has been created to guide its development.

Purpose and Objectives: As noted above, the ADI - MOAUIPP program provides culturally-appropriate diabetes primary prevention and health promotion programs, generally defined as programs that protect the health of people by personal and community efforts to promote and preserve good nutritional status, physical fitness and emotional well-being, and make the environment safe. In the context of the ADI - MOAUIPP program, diabetes primary prevention programs are those that will:

- raise awareness of diabetes, its risk factors, and the value of healthy lifestyle practices;
- promote Aboriginal ownership of diabetes primary prevention and health promotion programs; ensure the fair and equitable allocation of available resources among Métis, off-reserve Aboriginal people and urban Inuit; ensure that programming is delivered as equitably as possible across the country; and promote innovative approaches to diabetes primary prevention and health promotion projects.²⁸

From a policy perspective, a significant feature of ADI is the Branch's recognition that diabetes is not a disease that differentiates between Aboriginal groups, whether they are First Nations, Inuit, or Métis. With two separate frameworks, one for First Nations on reserve and Inuit in Inuit communities and one for Métis/off-reserve Aboriginal people, this represents a proactive change in First Nations and Inuit Health Branch policy, recognizing the diversity of Aboriginal Peoples. The limits of this change, however, come to light when comparing the scope and resource allocation of the two frameworks, as highlighted in section 2.1.1.

3.1.1.3 National Native Alcohol and Drug Abuse Program

Established in the mid-80s, the National Native Alcohol and Drug Abuse Program (NNADAP) has evolved into a model treatment program, represented by 59 centres nationwide. The addition of the National Youth Solvent Abuse Program (NYSAP) complements its mandate. In recognition of its success, the Health Programs Support Division has developed its fifth edition Treatment Centre Directory, summarizing basic information on all Native in-patient treatment centres funded by NNADAP.

²⁸ www.hc-sc.gc.ca/fnihb/cp/adi, fully acknowledging the source Web site and reproduced solely for research purposes.

As a dynamic program responding to the changing socio-economic issues faced by Aboriginal people, as well as the recent coming to terms with the legacy of residential school abuse, new programs are continuously being developed, with two new National Youth Solvent Abuse Treatment Programs (Alberta and Atlantic), being funded through NYSAP. Services delivered through NNADAP Treatment Centres include intake screening and orientation, case management, alcohol and drug education, crisis intervention, follow up, and aftercare.²⁹ Group counselling, life skills development, and recreation therapy can also be facets of the program. Outpatient/referral services ensures that programs remain linked with other treatment options in the area. Key to NNADAP's success is the attention paid to reporting and record keeping, so that program accountability can be measured and evaluated without fail.

From a policy perspective, NNADAP remains one of the few government initiatives that has a proven track record, due mostly to the dedication of government and organizations joined in a common cause. NNADAP has also undergone the rigors of a two national evaluations to ensure that the program remains accountable to both government and the clients it serves. In keeping with the 1998 NNADAP review findings, partnership committees were developed at the national and regional levels, and their recommendations resulted in the incorporation of the National Native Addictions Partnership Foundation on Jan. 31, 2000. The foundation status has allowed its Board of Directors to actively pursue funding and other resources to assist in moving forward with the recommendations arising from the NNADAP review. NNADAP serves as a model of Aboriginal programming that can be referenced by NAHO when seeking examples of best practices that have been developed and remain true to their original mandate.

3.1.1.4 Aboriginal Head Start

In 1995, the Government of Canada established Aboriginal Head Start (AHS) to help enhance child development and school readiness of First Nations, Métis and Inuit children living in urban centres and large northern communities. An expansion component of the AHS program for First Nations communities was announced on Oct. 19, 1998, as a result of commitments made in *Gathering Strength: Canada's Aboriginal Action Plan, Securing our Future Together* and the September 1997 speech from the throne. Funding for the AHS On-Reserve program was set at \$100 million over four years beginning in 1998/99.

Both components of the AHS initiative are designed to prepare young Aboriginal children for their school years by meeting their emotional, social, health, nutritional, and psychological needs. The program encourages the development of locally-controlled projects in Aboriginal communities that: strive to instill a sense of pride and a desire to learn; provide parenting skills and improve family relationships; foster emotional and social development and increase confidence; and enhance parenting skills that contribute to the child's healthy development.

A National Evaluation Framework was completed and submitted to the Treasury Board on July 30, 1999. Individual project evaluations must be completed during the third year of operation as a funding requirement. A comprehensive national program evaluation must be completed by March 31, 2003. Of significance from both a research and policy perspective will be the outcomes of this evaluation, given the priority that AHS has been given by Prime Minister Jean Chretien in his Jan. 31, 2001, address to the speech from the throne.³⁰ In this case, Métis participation in this program is "allowed" by government policies and represents one of few federal Aboriginal programs that truly attempt to consider all Aboriginal groups.

²⁹ www.hc-sc.gc.ca/fnihb/cp/nnadap, fully acknowledging the source Web site and reproduced solely for research purposes.

³⁰ www.hc-sc.gc.ca/fnihb-dgspni/fnihb/chp/ahf, fully acknowledging the source Web site and reproduced solely for research purposes.

3.1.1.5 Health Careers Scholarship and Bursary Program

The National Aboriginal Achievement Foundation (NAAF) is a nationally-registered charity with a mandate to provide financial support to Aboriginal youth who are pursuing education and training. NAAF was selected by Health Canada to administer its health careers scholarship and bursary program to assist students of Aboriginal ancestry who wish to pursue education opportunities leading to professional health careers. Aboriginal Peoples – Status and Non-Status Indians, Inuit and Métis – are eligible to apply to this program. Funding is provided to students training in accredited health care professions such as medicine, nursing, hospital administration, pharmacology, radiology, nutrition, lab technology, clinical psychology, psychiatry, dentistry and chiropractics.

3.2 Federal Initiatives that may impact Métis Health

3.2.1 Health Transition Fund

The Health Transition Fund (HTF) is a \$150-million fund supporting projects across Canada to test and evaluate innovative ways to deliver health care services. The HTF was announced in the 1997 federal budget as part of the federal government's initial response to the final report of the National Forum on Health recommending a multi-year Transition Fund to support innovations leading to a more integrated health system. Of the \$150 million, \$120 million was allocated to support provincial/territorial (P/T) projects, collaboratively determined with input of 12 P/T governments initially, and all 13 P/T governments as of April 1999 when Nunavut was created. From the onset, federal, provincial and territorial Ministers of Health agreed to fund projects in four priority areas related to:

- home care;
- pharmacare/pharmaceutical issues;
- primary care/primary health care; and
- integrated service delivery.

These four priority areas were chosen because they reflect the broadest range of parties involved in health care at the federal, provincial and territorial levels. With changes occurring across Canada in these health areas, policy program work was already underway.

With respect to Métis, the work in these priority areas are of significance in that they represent the cutting-edge interests of the P/T that are constitutionally responsible for health delivery within their respective borders. The resulting information on best practices should also prove useful in improving health delivery with respect to the needs of Métis.

To support this process, a national dissemination strategy has been prepared to guide the analysis and communication of what is learned through HTF projects. Projects in the area of home care and primary care may be of particular interest to Métis organizations and service providers given the evidence supporting the benefits of more holistic health care delivery models. These will also have impact upon the continuing issues of jurisdiction and the resulting ad hoc methods of delivery that tend to be prevalent in any discussion of the provision of services to the Métis.

3.2.2 Commission on the Future of Health Care in Canada

On May 1, 2001, the Commission on the Future of Health Care (also known as the Romanow Commission) was launched as a fully independent body, mandated to recommend policies and measures to ensure the long-term sustainability of a universal, publicly-funded health system, while striking a balance between investments in prevention, and investments directed to care and treatment. The work of the Commission is divided into two phases. Phase I is the fact-finding

phase aimed at determining the central issues and challenges facing the public health care system. A public consultation phase, or Phase II, began in early 2002 aimed at determining the views of interested stakeholders and the public on both priorities and preferences on key issues and challenges.

Of significance to Métis interests is the Commission's request of health stakeholders throughout the country to send formal submissions to the attention of the Commissioner. An interim report entitled a Framework for Public Discussion will guide the formal consultation process planned for the spring of 2002. The Commission's final recommendations, incorporating both its research and consultation findings, are due to the Prime Minister of Canada in November 2002.³¹

The Commission's areas of inquiry fall within four broad themes concerning Canadian values, sustainability, managing change and co-operative relations. The NAHO submission to the Commission, available for public viewing at www.naho.ca, addressed each of the four broad themes.³² It was supported by analysis that recommended attention to:

- 1) Aboriginal values, respecting the differences that exist between the Métis, First Nations, and Inuit;
- 2) effective service delivery models;
- 3) encouraging consistency in government policies, practices and standards; and,
- 4) the removal of barriers to inter-jurisdictional co-operation on, and access to, Aboriginal health information.

3.2.3 Aboriginal Health Infostructure

Health Infostructure (HI) is a national health information highway utilizing the latest in communications technologies to develop innovative applications such as electronic health records, telehealth and Internet-based health information. The expectation is that a national health information highway will improve communications among health care providers, professionals, and the general public by allowing individuals and communities to make informed choices about their health and Canada's health care system. With the end goal of increasing accountability for how health dollars are spent, the intent is that an evidence-based health system will ensure continuous improvement to health care as well as a better understanding of determinants of health.³³

As a component of HI, the Aboriginal Health Infostructure (AHI) exists to support Aboriginal Peoples and organizations to strategize on building capacity, linkages and access to information and technology in a manner that is both responsible and flexible. Similar to NAHO's own vision of knowledge transfer, the overall intent of AHI is to:

- ensure access to up-to-date, quality health information and services;
- develop both the capacity and range of skills to use AHI;
- support existing and emerging Aboriginal health organizations;
- ensure linkages with other health information systems and the pan-Canadian HI;
- integrate traditional and Western knowledge into a holistic perspective of health; and
- ensure its sustainability through appropriate jurisdictions.

31 www.healthcarecommission.ca, fully acknowledging the source Web site and reproduced solely for research purposes.

32 The Commission on the Future of Health Care in Canada and the National Aboriginal Health Organization (NAHO) jointly hosted an Aboriginal Health Forum entitled Dialogue on Aboriginal Health: Sharing our Challenges and Successes in June 2002. Forum Proceedings are available on the NAHO Web site.

33 www.hc-sc.gc.ca/ohih-bsi, fully acknowledging the source Web site and reproduced solely for research purposes.

The principles guiding the implementation of the AHI are inclusive and useful at the community level, respecting both the contribution of Métis, Inuit and First Nations and Aboriginal decisions relating to ownership, control, access and possession (OCAP) of health information. The AHI also provides insight into those common priorities in Aboriginal health that have been identified by Aboriginal political organizations, and include:

- increased Aboriginal participation in decision making at all levels of the health system;
- Aboriginal-controlled health research and information;
- human resources development and community capacity building; and
- sustainable and effective health care services and program, with emphasis on mental health, health promotion (i.e. smoking cessation), housing and environmental health.

3.2.4 Senate Standing Committee on Social Affairs, Science and Technology

The Senate Standing Senate on Social Affairs, Science and Technology, (SSCSAST) traces its origins back to 1908 when a Committee on Public Health and Inspection of Food was first established. The Committee received its present name in 1983. It has a mandate to examine legislation and matters relating to social affairs, science, and technology in general, including Indian and Inuit affairs, labour matters, health and welfare, housing, and other areas. Consistent with the original study work plan approved by the Committee in March 2000, the SSCSAST is producing a report that will present a set of options and recommendations on the potential role for the federal government to ensure the long-term sustainability of Canada's health care system.

The Phase One Report entitled *The Story So Far* was released March 2001 and provides a historical background and overview of the federal government's role in helping the provinces to fund hospital and physician care. It focuses in particular on the initial objectives of the federal government's involvement in health care and raises some questions in light of the changing health care environment (e.g. increased recourse to drug therapy, hospital out-patient services, home care and community care). This first report also traces the evolution of health care spending and health indicators over the past several decades, and is intended to provide factual information as well as to clarify the major current misconceptions that recur in Canada's ongoing health care debate.

Volume Two was released in January 2002 and reviewed major trends impacting the cost and method of delivering health services, and the implications for public funding. In particular, it focused on the pressures associated with changing demographics of the Canadian population (including the Aboriginal population), the increasing cost and utilization of drugs and technology, human resource planning issues, increased public expectations about health care and the evolving means of delivering health care services (i.e. the increased use of out-patient, home care, pharmacology, telehealth, etc.).

Volume Three described and compared the way health care is financed and delivered in several other countries, and the objectives of national government health care policy in those countries, highlighting policies and reforms that have been successful elsewhere. Finally, the Committee's fifth report will summarize the public debate brought about by the options presented in the fourth report and present the Committee's recommendations for changes to federal health care policy.

Volume Four: Issues/Options for the Aboriginal Health Service Delivery Role, which NAHO and a number of national Aboriginal organizations contributed evidence, was released on September 17, 2001. *Volume Four* presents a series of policy options that, in the Committee's opinion, requires the consideration of the Canadian public, as well as federal and provincial policy makers. When evidence was presented in May 2001, NAHO's recommendations in particular focused on:

- examining effective service delivery models and point of control;

- encouraging consistency in government legislation, policies, and practices impacting the socio-economic environment of Aboriginal people;
- removing barriers that prevent Aboriginal organizations from fully accessing Aboriginal health information collected by Statistics Canada and others; and
- developing mechanisms to systematically collect and analyze longitudinal health information.³⁴

Like the RCAP Report of 1996, observations reflected in Chapter 13 of *Volume Four* reiterate that the health of Aboriginal Peoples is a “national disgrace” and that the federal government must take a leadership role to redress this situation. Paramount to this redress is the task of making sense of the array of federal, provincial and Aboriginal-run programs and services. This is further complicated by such factors as an Aboriginal person’s status under the *Indian Act*, place of residence, the location of one’s community, and in the case of Métis, issues around the lack of recognition by governments that reinforces barriers to accessing services and resources.

Overall, the SSCSAST notes that jurisdictional barriers to the provision of health services to Aboriginal people exist on two levels. The first barrier arises from the division of powers between the federal and provincial governments, and the second barrier stems from the divisions among Aboriginal Peoples as a result of the *Indian Act*. The second barrier relates specifically to Métis and Non-Status Indians because they are excluded from the legislation and are not eligible for most federal programs. As a solution, the SSCSAST proposes the federal government undertake, in collaboration with the provinces, territories and Aboriginal representatives of all groups, the development of a National Action Plan on Aboriginal Health, to improve inter-jurisdictional co-ordination of health care delivery. Such a plan would include ways to:

- ensure adequate access to culturally-appropriate health services for Aboriginal people;
- increase the number of Aboriginal health care providers;
- address training, recruitment and retention issues of emerging health career categories such as home care workers, diabetes prevention workers, and systems technicians;
- improve access to health services in Aboriginal communities through tele-medicine;
- implement a population health strategy designed specifically for Aboriginal people;
- establish a mechanism for reporting on Aboriginal health policies/programs;
- undertake health research activities that explores models to obtain evidence-based information on how to design and deliver programs that affect Aboriginal health; and lastly,
- ensure a process to involve Aboriginal people in designing, developing, implementing and assessing federal programs and policies aimed at Aboriginal health.

From the perspective of Métis, the resulting impact of these recommendations would hinge on the true inclusion of Métis organizations and individuals when using the term Aboriginal. The use of the term Aboriginal when Métis are not considered, included or excluded continues to be a barrier to the effective development of services and programs for Métis.

3.2.5 Senate Standing Committee on Aboriginal Peoples

In the fall of 1997, as a follow up to the RCAP Report, Senator Charlie Watt, then Chairman of the Senate Standing Committee on Aboriginal Peoples (SSCAP), presented a motion proposing that the Committee examine the recommendations of the RCAP report regarding Aboriginal governance, in particular, the structural relationships required between Aboriginal Peoples and various levels of government and the means of implementing these relationships. In January 1998, with the federal government release of *Gathering Strength* as its response to the RCAP report, the SSCAP’s *Special Study on Governance* supported this process with the intent of

³⁴ www.parl.gc.ca/common/Committee_Sen, fully acknowledging the source Web site and reproduced solely for research purposes.

assisting Aboriginal and other governments of Canada as they work to develop new relationships.³⁵

While First Nations, Inuit and Métis share some common objectives, they also have differing goals and visions on how to achieve these objectives. From a health governance perspective as reflected in federal health policy, this is important to Aboriginal political organizations in determining health policy priorities. At present, the SSCAP is in the process of finalizing a report concerning economic development. Just as Métis, Inuit and First Nations have distinct histories and governing traditions, future opportunities may present themselves for the SSCAP to examine opportunities for equity in health legislation/policies, so that health programs/services that can be equally provided to and accessed by all Aboriginal Peoples.

3.2.6 Aboriginal Peoples Survey I and II

Sprouting from a 1996 RCAP Report recommendation, information collected from the 1991 Aboriginal Peoples Survey (APS I) was used to build profiles of more than 600 Aboriginal communities. Given the potential of this survey tool, the second Aboriginal Peoples Survey II (APS II) is being performed by Statistics Canada at this time. The rationale for continuing with the APS approach is simple. For the first time, a concerted effort is being made by government to further their understanding of all Aboriginal Peoples, with data from the APS supporting the planning and development of programs and services for and by Aboriginal people.

A major goal of APS II is to help create opportunities to develop statistical capacity in Aboriginal communities. A concerted effort has also been made by Statistics Canada to consult with regional and national Métis, Inuit and First Nations organizations, as well as provincial and federal government departments on the content to ensure information proposed for inclusion met the needs of all stakeholders. Statistics Canada is proposing that the survey be administered to a sample of people from all Aboriginal groups, Métis, Inuit and First Nations, both on and off-reserve, children and adults. Questions used in APS I pertaining to ethnicity would also be used to identify Aboriginal participants in APS II.³⁶ So far, the consultation process has resulted in a draft list of health-related survey questions specific to both the Métis and Inuit, with First Nations also being targeted for the survey.

Ultimately, the policy decision needs to be addressed from both Statistics Canada and Aboriginal political organizations concerning the issue of access, utilization and stewardship for this and other information collected on Aboriginal people. NAHO would be ideally positioned to fulfill that role to help guide future data collection initiatives.

3.2.7 Summary

While the current system with respect to influencing policy and programming decisions is in need of improvement, there are avenues available for Métis organizations to engage and possibly influence current and developing policies and legislation. While the end goal would generally be for Métis to have the direct autonomy and control over the decisions that affect their lives, a more pragmatic view and engagement of these processes must be taken in the short term as this goal is being attained. Key to these processes are windows of opportunities where recommendations could better inform and influence decision-makers or decision-making processes. Such is the case with the several federal initiatives presently underway. National Aboriginal political organizations are taking a leadership role with their participation in systems renewal, while governments demonstrate opportunities for primary care reform through the HTF.

³⁵ Ibid.

³⁶ www.ainc-inac.gc.ca/nr/nwltr/sts, fully acknowledging the source Web site and reproduced solely for research purposes.

Standing Senate Committees and the Romanow Commission are also unique opportunities for organizations to present working solutions to health care issues. Finally, just as information is power, so is the future of information management, with both the establishment of protocols and ethics guiding what information is collected by whom and for whom.

Despite these unique windows of opportunities, there remains a gap in how government policies can be made more accountable, through a system of controls and checks where remedies can occur. For example, the Auditor General of Canada supports a Triple-E approach to audits to ensure that government programming is effective, efficient and economical, yet processes or mechanisms do not currently exist for amending policy (or legislation) to ensure that policy/decision makers become more accountable for policy outcomes.

Sustainability, co-operative relationships, social cohesion/capital, and point of control are terms in use today that emphasize increased ownership and accountability for a populations' health, however it is in the communities that these concepts must be put into action.

3.3 Select Provincial Government Métis Health Initiatives

3.3.1 British Columbia

No evidence of Métis-specific programming was found. Aboriginal services are provided through a number of different ministries and departments, but almost no mention is made of the Métis in any of the program or initiative descriptions surveyed for this scan.

3.3.2 Alberta

The Métis Settlements in Northern Alberta represent the only land-based Métis communities recognized by any level of government in Canada. As stated in section 2.2.6, these communities govern themselves with quasi-municipal powers, which allows for some control by the community over services. The provision of health services and programs, however, remains a provincial responsibility and, as such, issues continue to exist around the provision of, and access to, programming that could be considered Métis specific. Health programs are, for the most part, provided by the Regional Health Authority. For example, the Lakeland Regional Health Authority provides services to the four eastern settlements of Kikino, Buffalo Lake, Elizabeth, and Fishing Lake. This is also true for the majority of Métis in the province, who are neither affiliated with, nor live in the settlements.

The stated intent of the government of Alberta with respect to the Métis may be found in the mission statement of the Aboriginal Affairs and Northern Development division.

“...the mission of the Aboriginal Affairs area is to lead the development of government-wide strategies and policies to improve the well-being and self-reliance of Aboriginal people, and to guide Alberta's relations with Aboriginal governments, communities, organizations and other partners.”³⁷

The Government of Alberta published an Aboriginal policy framework in September 2000, which is titled Strengthening Relationships and is available on the Government of Alberta Web site. Métis issues are recognized in this document, but it remains to be seen how this framework will be implemented as policies and programs are developed.

Despite the unique official recognition of Métis by the Government of Alberta, current programs and services for Métis in the area of health are few in number. There are, however, a number of

³⁷ www.aand.gov.ab.ca/pages.home.html, fully acknowledging the source Web site and reproduced solely for research purposes.

programs in other areas that will have an impact on health and that are either designed or delivered by Métis organizations and individuals, such as Métis Child and Family Services and Métis Urban Housing both operating in Edmonton. The Region 18 Métis Settlements Child and Family Services Authority is another example, as described in Section 2.3.

3.3.3 Saskatchewan

The Government of Saskatchewan, through its Aboriginal Affairs division, "...promotes Aboriginal peoples, communities and organizations through its grants to provincial Aboriginal women's organizations and urban-based Aboriginal agencies."³⁸ Under the Aboriginal Women's Program, Aboriginal Affairs facilitates provincial Aboriginal women's organizations to undertake special projects and policy development activities of benefit to their respective memberships.

The Aboriginal Affairs Division works with the Saskatchewan First Nations Women's Secretariat, Métis Women of Saskatchewan Inc., and Aboriginal Women's Council of Saskatchewan Inc. to administer the program. Funding for provincial organizations enables Aboriginal women to address priority issues such as family violence, child abuse, health care, education, housing, justice, and social development.

Of particular interest to Métis in Saskatchewan is the Aboriginal Community Management Authorities Program that promotes Aboriginal community development, enabling Indian and Métis people to develop their own service delivery systems in urban settings.³⁹ The Program provides financial assistance to facilitate the development of Aboriginal service delivery institutions at the community level. Systems developed can be Indian-specific, Métis-specific, or a cooperative arrangement where Indian and Métis people form a joint partnership, each responsible for decisions affecting services to their own constituency. As models for special community-based approaches, these systems are based on the following key components: community-based and community-paced, provides for integrated services, and potential for community management and control.⁴⁰

3.3.4 Manitoba

The vision of the Aboriginal and Northern Affairs Department of the Government of Manitoba is identified as: "To facilitate the removal of barriers and the development of better relations between government and the Aboriginal community, leading to successful outcomes for northern and Aboriginal people, based on a common understanding of goals and issues."⁴¹ Specific goals that are identified by this department are for the most part focused on development, employment, and governance issues. There is little in the way of direct programming identified by the Government of Manitoba and almost no mention is made of Métis in any of the program or initiative descriptions surveyed for this scan.

3.3.5 Ontario

The Ontario Native Affairs Secretariat is described as supporting the Minister of Native Affairs as follows:

"...works and partners with Aboriginal businesses and organizations, corporate Ontario, the private sector, provincial ministries and the federal government to promote Aboriginal self-reliance and economic development. The Secretariat also

38 www.iaa.gov.sk.ca/Aboriginal, fully acknowledging the source Web site and reproduced solely for research purposes.

39 Ibid.

40 Ibid.

41 www.gov.mb.ca/ana, fully acknowledging the source Web site and reproduced solely for research purposes.

develops provincial policy and works with other ministries to co-ordinate the government's overall approach to Aboriginal matters, and maintains relations with First Nations, Métis, Inuit, and Aboriginal organizations such as Friendship Centres, the federal government, stakeholders and the public."⁴²

An Aboriginal Policy Framework was established in March 1996 but the focus of that framework is revealed upon reading the subtitle: Supporting Aboriginal Self-Reliance Through Economic Development.⁴³ Further examination of this Aboriginal policy also reveals a focus upon issues and relationship between the province, the federal government, and First Nations.

Little or no mention of Métis was found elsewhere during this survey and no evidence of Métis-specific programming was identified as provided by the Government of Ontario.

3.3.6 Northwest Territories

The Ministry of Aboriginal Affairs of the Government of the Northwest Territories leads participation in negotiations on lands, resources and self-government; co-ordinates the implementation of Final Agreements; and contributes to the territorial government's political and constitutional development, and national Aboriginal affairs.⁴⁴ Self-government negotiations in the NWT are distinct in negotiating community and regional-based Aboriginal governments.

At present, the South Slave Métis are negotiating lands, resources and self-government with the federal and territorial governments on behalf of the South Slave Métis who are descendants of the Dene who signed Treaty 8 and who traditionally used and occupied land in the South Slave region.⁴⁵ The process provides for the negotiation of two agreements: a lands and resources agreement and a self-government agreement. Elsewhere in the NWT, Métis who meet ancestral and residency criteria become eligible as beneficiaries to negotiated regional land claims and self-government agreements.

The Government of the NWT provides health benefits assistance, similar to those available to chronic and extended care individuals, to eligible residents of a Métis Health Benefits Program, as payer of last resort.⁴⁶ All residents in the NWT are covered for health benefits under the NWT Health Care Plan.

3.3.7 Summary

Few instances of Métis-specific or directed initiatives were found in the investigation of provincial departments and programs. Throughout the materials searched and the programs identified, Métis were usually mentioned apparently as an afterthought in the description of Aboriginal programs, if they were mentioned at all. This highlights the pressing need for the support of Métis involvement directly in the programs, policies, and initiatives that seek to address the issues that they continue to face.

42 www.nativeaffairs.jus.gov.on.ca/english/onas.htm, fully acknowledging the source Web site and reproduced solely for research purposes.

43 Ibid.

44 www.gov.nt.ca/research/departments/index.html, fully acknowledging the source Web site and reproduced solely for research purposes.

45 www.gov.nt.ca/MAA/index.html, fully acknowledging the source Web site and reproduced solely for research purposes.

46 www.hlthss.gov.nt.ca/Features/Special_Activity/special_activities.htm, fully acknowledging the source Web site and reproduced solely for research purposes.

4. Conclusion

This document is intended to be of use to Métis organizations, communities, and individuals as they perform their work toward improving the health of Métis. As a knowledge-based organization, the National Aboriginal Health Organization (NAHO) has the opportunity to facilitate the sharing of information and knowledge between these organizations, communities, and individuals in an attempt to provide the best information possible to assist in the decisions and actions that need to be made now for the future of Métis. This snapshot of current programs, services, information, and policy work that are being performed in the area of health for Métis across the country was intended to provide a starting point for discussion. It is expected that much will be added through the development and strengthening of relationships between the many organizations involved. It would also be expected that this document would also assist in the identification of next steps for NAHO in general and NAHO's Métis Centre specifically.

In the analysis of the gathered information, a number of issues came to light. Of primary importance with respect to policy were issues of definition and identity. Identity permeates any discussion of programs, policies, and services for Métis. On the ground and in the communities, reports of "jurisdictional ping-pong" abound. Individuals in search of services are sent back and forth between provincial and federal departments as each declares Métis to be the responsibility of the other. This is also the case for organizations and communities that seek resources for programs and initiatives for their constituents. In certain situations, being defined as Aboriginal by a particular department may be enough justification for the allocation of resources or the provision of service to Métis. But as the definition of the word Aboriginal changes between governments, departments, ministries, and sometimes, even branches within these, Métis tend to get defined out of the discussion.

A subsequent result from the issue of identity is the absence of comparable data, which can be used in the forming or influencing of policy decisions. The Aboriginal Peoples Survey II is yet to be released and there remain many issues around the ownership, control, access, and possession of data and information for any group, but especially so with Métis. The Métis National Council has participated with Statistics Canada to some extent with the planning and implementation of the APS II. How this will affect the responses to the survey or the census will remain to be seen. Data collection and stewardship are controversial issues for government due to the fact that budget allocations are influenced to a great degree by census and other Statistics Canada reports. The perception of most is that the consistent under estimation of the population of Métis by these reports is yet another way to bypass responsibility to Métis. The possibility of more Métis involvement in the collection, analysis, and use of data on and for Métis needs to be explored more fully. Another benefit of this would likely be to make the above-mentioned issues around identity somewhat easier to manage.

A particularly salient issue, which did arise from the examination of the available data, was the absence of response to the issues that were identified. This is highlighted by the fact that one in three Métis respondents reported a disability. This did not initiate a significant response from policy makers or legislators. This result was simply reported in the APS and no subsequent research into the accuracy of this number or the possible causes was apparently initiated. Programs for all Aboriginal People with disabilities continues to be insufficient for the needs of these populations with Métis people being particularly ill served. The lack of action on behalf of governments in either the area of services for Métis people with disabilities or in the area of injury prevention highlights the amount of institutional inertia that Métis organizations and individuals have to deal with on most issues.

The capacity and resources necessary to provide services and to control and manage those services was also an issue, which was brought up a number of times in discussions. As stated previously, a great deal of resources and energy has been utilized by Métis organizations in the struggle for recognition of Métis as a People. There is also a concern for governments at all levels

downloading their responsibilities for programs and services without providing adequate funding or resources for the task. Issues of accountability also arise from any discussion of the provision of services or programs. In the cases where organizations have been able to provide the services directly, the results have been programming that is more culturally appropriate and specific to Métis. The low number of these initiatives with significant Métis involvement in all phases of the development and delivery of services prevents their use, however, in comparisons from a statistical point of view. More in-depth analysis of the programs that do exist should be considered as case studies or best practices so that other organizations can benefit from those who have gone before them.

While scholarships and bursaries are necessary to foster and support the development of Métis health care professionals, they tend to serve those individuals who have already achieved a measure of academic success. If the intent is to increase the number of health care professionals as directed in the RCAP, then other more proactive measures must be considered as well. These would need to focus on the recruitment and retention of Métis students, at earlier ages, to ensure that there are more Métis high school graduates. This would result in a larger pool of individuals who could choose to pursue post-secondary education and subsequently lead to an increase in the number who become involved in science and health-related disciplines.

With reference to the jurisdictional issues that Métis programming and services face, this was spoken to directly by the RCAP as seen in recommendation 3.3.3, which states:

“Governments act promptly to

- (a) conclude agreements recognizing their respective jurisdictions in the areas touching on Aboriginal health;
- (b) agree on appropriate arrangements for funding health services under Aboriginal jurisdiction; and
- (c) establish a framework, until institutions of Aboriginal self-government exist, whereby agencies mandated by Aboriginal governments or identified by Aboriginal organizations or communities can deliver health and social services operating under provincial or territorial jurisdiction.”⁴⁷

While most of the recommendations to the government through RCAP have yet to be seen, it is necessary to look into the shape and manner in which Métis organizations and government will take the roles necessary to fulfill the needs of Métis People.

Roles that can be, and are being, filled immediately by the existing Métis organizations are those of political representation, lobbying, and advocacy, thus, fulfilling the roles for which they were created in a large number of cases. Through the collection, sharing, and dissemination of information and knowledge in the area of health and health systems analysis NAHO could also play a valuable role in assisting those organizations in gathering and sharing the information that they would identify as being useful in their work.

In this short look into the programs, initiatives, and services, which attempt to better the health of Métis, a number of issues have been brought to the forefront. These are for the most part not new ideas or insights. The goal of this exercise is to provide a tool for all parties interested in promoting and improving the health of Métis in their work. For some, this may simply be the opportunity to see what else is being done in regards to Métis health. For others, it may be the first step in analysis of current programming or identification of current gaps in that programming.

47 Canada. *Gathering Strength. Volume 3.* Royal Commission on Aboriginal Peoples. Pg. 234.

In any case, it is hoped that the spirit of this endeavour is accepted, fostered and improved upon so that it will continue to develop into a truly useful tool for the user.

5. Directory/Index

Métis Organizations

Manitoba Métis Federation 150 Henry Avenue Winnipeg, MB R3B 0J7	Tel: (204) 586-8474 Toll Free: 1-800-665-8474 Fax: (204) 947-1816 www.mmf.mb.ca
Métis Addictions Council of Saskatchewan 100-219 Robin Crescent Saskatoon, SK S7L 6M8	Tel: (306) 343-8285 Toll Free: 1-888-343-6667 Fax: (306) 343-0171 www.Métisnation-sask.com/affiliates/macsi.html
Métis Nation of Alberta 100-11738 Kingsway Avenue Edmonton, AB T5G 0X5	Tel: (780) 455-2200 Toll Free: 1-800-252-7553 Fax: (780) 452-8946/8948
Métis National Council 350 Sparks Street, Suite 201 Ottawa, ON K1R 7S8	Tel: (613) 232-3216 Toll Free: 1-800-928-6330 Fax: (613) 232-4262
Métis Nation of Ontario 500 Old St. Patrick Street Ottawa, ON K1N 9G4	Tel: (613) 798-1488 Toll Free: 1-800-263-4889 Fax: (613) 722-4225
Métis Nation - Saskatchewan 219 Robin Crescent, 2 nd Floor Saskatoon, SK S7L 6M8	Tel: (306) 343-8285 Toll Free: 1-888-343-6667 www.Métisnation-sask.com
Métis Provincial Council of British Columbia Suite 1128-789 West Pender Street Vancouver, BC V6C 1H2	Tel: (604) 801-5853 Toll Free: 1-800-940-1150 Fax: (604) 801-5097 www.mpcbc.bc.ca
Métis Settlements General Council 3 rd Floor, Mayfield Business Centre 10525-170 th Street Edmonton, AB T5P 4W2	Tel: (780) 427-1122 Fax: (780) 489-9558 www.Métis-settlements.org
Métis Settlements Child and Family Services Region 18 3 rd Floor, Mayfield Business Centre 10525-170 th Street Edmonton, AB T5P 4W2	Tel: (780) 427-1033 Fax: (780) 415-0177 www.Métis-settlements.org/region%2018/index.html

Provincial Governments

Aboriginal Affairs and Northern Development (Alberta) 13 th Floor Commerce Place 10155-102 Street Edmonton, AB T5J 4G8	Tel: (780) 427-8407 Fax: (780) 427-4014
Aboriginal & Northern Affairs (Manitoba) 344-450 Broadway Winnipeg, MB R3C 0V8	Tel: (204) 945-3719 Fax: (204) 945-8374 www.gov.mb.ca/ana E-mail: bqudmundso@gov.mb.ca
Intergovernmental & Aboriginal Affairs (Sask.) 9 th Floor, 1919 Saskatchewan Drive Regina, SK S4P 3V7	Tel: (306) 787-6253 Fax: (306) 787-5832 www.iaa.gov.sk.ca/aboriginal
Ontario Native Affairs Secretariat 720 Bay St., 4 th Floor Toronto, ON M5G 2K1	Tel: 416) 326-4740 Fax: (416) 326-4017 www.nativeaffairs.jus.gov.on.ca/english/onas.html E-mail: merike.nurming@jus.gov.on.ca

Federal Government

Aboriginal Diabetes Initiative
Community Health Programs Directorate
First Nations and Inuit Health Branch
20th Floor, Jeanne Mance Building
Postal Locator 1920B
Tunney's Pasture
Ottawa, ON K1A 0K9

Tel: (613) 954-5810
www.hc-sc.gc.ca/fnihb/cp/adi
E-mail: fnihb-dqspni@hc-sc.gc.ca

Aboriginal Head Start
Division of Children and Adolescence
Health Canada
Jeanne Mance Building
Postal Locator 1909C2
Ottawa, ON K1A 1B4

Tel: (613) 952-1220
Fax: (613) 952-1556
www.hc-sc.gc.ca/childhood-youth
E-mail: children@www.hc-sc.gc.ca

Aboriginal Health Infostructure
Health Canada
Jeanne Mance Building, 4th Floor
Tunney's Pasture
Postal Locator 190A
Ottawa, ON K1A 0K9

Tel: (613) 954-5810
Fax: (613) 952-3226
www.hc-sc.gc.ca/ohih-bsi/
e-mail: ohih-bsi@www.hc-sc.gc.ca

National Native Alcohol and Drug Abuse Program
Community Health Programs Directorate
First Nations and Inuit Health Branch
20th Floor, Jeanne Mance Building
Postal Locator 1920B
Tunney's Pasture
Ottawa, ON K1A 0K9

Tel: (613) 954-5810
www.hc-sc.gc.ca/fnihb/cp

Population Health Approach
(Formerly Population Health Initiative)
Health Canada
Tunney's Pasture, PL 1910A1
Ottawa, ON K1A 1B4

Fax: (613) 952-6032
www.hc-sc.gc.ca/hppb/phdd

Other Sources

Commission on the Future of
Health Care in Canada (Romanow Commission)
P.O. Box 160, Station Main
Saskatoon, SK S7K 3K4

Toll Free: 1-800-793-6161
www.healthcarecommission.ca/

National Aboriginal Achievement Foundation
Suite 33A, 70 Yorkville Avenue
Toronto, ON M5R 1B9

Tel: (416) 926-0775
Toll free: 1-800-329-9780
Fax: (416) 926-7554
www.naaf.ca
E-mail: naaf@istar.ca

The Standing Senate Committee on
Aboriginal Peoples
The Senate
Ottawa, ON K1A 0A4

Tel: (613) 990-0088
www.parl.gc.ca

The Standing Senate Committee on
Social Affairs, Science and Technology
The Senate
Ottawa, ON K1A 0A4

Tel: (613) 990-0088
www.parl.gc.ca

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