



Canada. Within this population there exist many distinct cultural groups or nations, including 630 distinct communities (Assembly of First Nations, n.d.) and approximately 60 different languages (Statistics Canada, 2013a). Based on the 2011 National Household Survey, there are an estimated 851,560 First Nations people living in Canada. About 49% of First Nations people reported living on-reserves, while 51% live off-reserve. The majority (approximately 75%) of First Nations people residing off-reserve live in urban areas (Statistics Canada, 2008).

Inuit

Inuit peoples are original inhabitants of the Arctic regions of the area now known as Canada. The majority of the 59,445 Inuit people in Canada live in their traditional territories in four regions collectively known as *Inuit Nunangat* (Statistics Canada, 2013a). These regions are: Nunatsiavut (Labrador), Nunavik (northern Quebec), Nunavut, and the Inuvialut Settlement Region in the Northwest Territories (Inuit Tapiritt Kanatami, n.d.). Close to 70% of the Inuit people speak Inuktitut, although the number of people reporting it as their first language is declining (Statistics Canada, 2008).

Métis

In French, the word “Métis” translates as “mixed.” There exists some debate over who is considered Métis, with some taking a broader definition than outlined by the Métis National Council (MNC). The MNC defines Métis people as individuals who self-identify as Métis, are of historic Métis origin (mixed First Nations and European heritage, descendants primarily of 18th century fur traders and First Nations in the area known as the Métis Homeland), and are recognized by the Métis Nation (Métis National Council, n.d.). Métis people have a distinct culture, traditions and language (Michif) which contribute to their collective consciousness and nationhood (ibid). The 2011 National Household Survey reports that there are approximately 451,795 Métis people in Canada (Statistics Canada, 2013a).

Non-Status and Urban Aboriginal Peoples

Many people who self-identify as Aboriginal are not registered under Canada’s 1876 *Indian Act*, which defines who is considered a “status Indian” and thus eligible for a range of programs and services offered by federal and provincial agencies. People who identify as First Nations but who are not a “Registered

Indian” according to the federal government are considered “non-status.” Based on the 2011 National Household Survey, Statistics Canada reported that there were 213,900 First Nations people who were not Registered Indians in Canada, representing 25.1% of the total Aboriginal population (Statistics Canada, 2013a). Three-quarters of this population reside in urban areas, with the largest numbers in metro Toronto, Vancouver, Montreal, Ottawa-Gatineau and Edmonton, respectively (Indian and Northern Affairs, 2009).

The Daniels Decision

In early 2013, the Federal Court of Canada ruled in a decision known as the “Daniels Decision” that Métis and non-status Indian peoples be considered “Indians” under section 91(24) of the *Canadian Constitution Act, 1867* (CBC News, 2013). Although the full implications of the Daniels Decision are not yet clear, this decision potentially doubles the number of people considered status Indians under the 1876 *Indian Act*. The federal government appealed the decision and is unlikely to implement it while the case is under appeal, a process that could take several years.



Aboriginal Health in Canada

Prior to European contact, Indigenous peoples of Canada had fully functional systems of health knowledge that were practiced within the contexts of their specific ways of knowing and being. However, the diseases and conflicts of colonization devastated Indigenous populations and their systems of Indigenous health knowledge. Although the health of Aboriginal populations in Canada has been improving in recent years, First Nations, Inuit, and Métis peoples continue to experience considerably lower health outcomes than non-Aboriginal Canadians. On many health indicators, First Nations, Inuit, and Métis peoples continue to show a disproportionate burden of disease or health disparities. These disparities are often rooted in health inequities, which are the “underlying causes of the disparities, many if not most of which sit largely outside the typically constituted domain of ‘health’” (Adelson, 2005, p. S45). These are referred to as determinants of health.

Determinants of Health

Health is determined by many different factors affecting individuals, communities and populations. Health research focused on Aboriginal populations in Canada shows that “health disparities are directly and indirectly associated with or related to social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering on the Aboriginal populations of Canada” (Adelson, 2005, p. S45).

The social, economic, cultural and political inequities that impact the health of individuals and communities are often referred to as “social determinants of health.”² It is important to acknowledge there are differences in the socio-economic circumstances and lived world experiences of First Nations, Inuit, and Métis peoples, between status and non-status, on-reserve and off-reserve, as well as urban and rural Aboriginal populations. Nevertheless, several decades of census data and other research show a persistent gap in socio-

Data Limitations in Aboriginal Public Health

Public health assessments and interventions, including those targeting Aboriginal populations, depend on complete and accurate statistical information about the health and well-being of groups of people in order to be effective. Unfortunately, in Canada there exists a serious deficit in the availability of accurate, complete, and up-to-date statistical information about the health of certain sub-populations of First Nations, Inuit, and Métis peoples (Smylie, 2010). Many Aboriginal health data initiatives, for example, have not collected data on non-registered First Nations people, or on Métis or Inuit people living in urban areas (Ibid.). Further, inconsistencies in First Nations, Inuit, and Métis ethnic identifiers in provincial health data collected through vital registration systems, hospital administrative datasets, and acute and chronic disease surveillance systems means that these populations are often invisible in health statistics (Ibid.). Although work is underway to improve data regarding the health of First Nations, Inuit, and Métis populations, these initiatives are isolated. The lack of statistical information in this fact sheet is a reflection of the limited availability of complete, accurate, and up-to-date data on Aboriginal health that is disaggregated by sub-population and geographical location.

economic status and well-being between Aboriginal and non-Aboriginal people in Canada (Reading & Wien, 2009).

² For more information on how social determinants can impact health, please refer to the NCCAH's Social Determinants of Health fact sheets, which can be found at www.nccah-cnca.ca/en/publications.aspx?sortcode=2.8.10&searchCat=2&searchType=0 and Wilkinson, R. and M. Marmot, eds. (1998). *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization.

Despite a modest improvement in the socio-economic status of Aboriginal peoples in Canada over recent decades, many of the underlying social determinants of poor health remain. Canada's 2006 Census data shows that fewer Aboriginal people between the ages of 25 and 34 obtained high school diplomas (68.1%) than non-Aboriginal people (90.0%) (Indian and Northern Affairs Canada, 2009). The 2005 median income for Aboriginal people was almost \$10,000 lower (\$16,752) than for non-Aboriginal people (\$25,955), and despite a 10% increase in Aboriginal employment between 1996 and 2000 (compared to a 4.1% increase in non-Aboriginal employment during the same time period), the unemployment rate for Aboriginal people in 2006 was still more than twice that for non-Aboriginal people (13.0% compared to 5.2%) (Ibid.). The First Nations Regional Health Survey (RHS) in 2008/10 showed no improvements in household income from 2002/03, and in fact observed an increase in low income levels for First Nations communities (First Nations Information Governance Centre, 2011).

Household overcrowding and poor housing conditions (dwellings in need of major repair) in Aboriginal communities are also improving, but regional statistics show that they are still major problems in some areas. While the rates of household overcrowding remained steady in Canada's non-Aboriginal population at 1.4% and have decreased in the total Aboriginal population from 7.6% in 1996 to 4.3% in 2006, overcrowding rates reached 23% in Nunavut and 8% in Saskatchewan (Indian and Northern Affairs Canada, 2009). Similarly, Aboriginal people were three times as likely as non-Aboriginal people to live in houses in need of major repair, and over 22% of dwellings in Aboriginal communities in 5 provinces and territories (Saskatchewan, Northwest Territories, Manitoba, Yukon, and Nunavut) were in need of major repair in 2006, compared with an average of 7.0% in non-Aboriginal communities in Canada (Ibid.).

Aboriginal Health Status

A common history of colonialism and resulting economic, social and cultural marginalization has had profound health impacts on Indigenous peoples not only

in Canada but also around the world (Gracey & King, 2009; King, Smith, & Gracey, 2009). In Canada and elsewhere, Indigenous peoples are affected by major health problems at rates much higher than non-Indigenous populations. These health issues include high infant and young child mortality; high maternal morbidity and mortality; heavy infectious disease burdens; malnutrition and stunted growth; shortened life expectancy; diseases and death associated with cigarette smoking; social problems, illnesses and deaths linked to misuse of alcohol and other drugs; accidents, poisonings, interpersonal violence, homicide and suicide; obesity, diabetes, hypertension, cardiovascular, and chronic renal disease (lifestyle diseases); and diseases caused by environmental contamination (for example, heavy metals, industrial gases and effluent wastes) (ibid).

Although accurate, complete and current data on Aboriginal health status in Canada is lacking, a general picture of Aboriginal health status is pieced together in a document published in 2012 by the National Collaborating Centre for Aboriginal Health (NCCA) entitled





The State of Knowledge of Aboriginal Health. This document draws together existing research focused on maternal, fetal and infant health; child health; communicable disease; non-communicable disease; mental health and wellness; violence, abuse, injury and disability; environmental health; and food security and nutrition.

Despite variations between different First Nations, Inuit, and Métis groups, Aboriginal populations in Canada face many urgent health issues. Aboriginal people are over-represented in HIV infection rates. While they comprised only 3.8% of the population in 2006, they accounted for 8% of people living with HIV and 12.5% of new infections in 2008 (Monette, et al., 2011). They also experience disproportionate rates of tuberculosis at 26.4 times the rate of Canadian-born non-Aboriginal people (Public Health Agency of Canada, 2007). Although limited data exists about rates of diabetes in Métis and Inuit populations, Type 2 diabetes is now

considered to have reached “epidemic” levels in First Nations communities, where adults are four times as likely to suffer from Type 2 diabetes and are more likely to experience health complications related to the disease than are non-Aboriginal Canadians (Thommasen, Patenaude, Anderson, McArthur, & Tildesley, 2004). In some First Nations communities, youth suicides occur at a rate 800 times the national average, while in others, suicides are virtually unheard of (Chandler and Lalonde, 1998). The suicide rate among Inuit communities in Arctic Canada is ten times that of the general Canadian population (Kral, 2012). Violence against Aboriginal women is also considered to have reached epidemic proportions in many parts of the country, with Aboriginal women 3.5 times more likely to experience violence than other Canadian women (Native Women’s Association of Canada, 2009). As of 2010, the Native Women’s Association of Canada had documented 582 cases of missing or murdered Aboriginal women (Native Women’s Association of Canada,

2010). Aboriginal peoples in Canada are also disproportionately affected by environmental contamination, particularly in Arctic regions where the traditional food sources of Inuit populations have accumulated environmental toxins, leading to a variety of health problems (Fontaine, et al., 2008).

Wellness and Resilience

In spite of the considerable health issues and challenges outlined above, Aboriginal peoples continue to demonstrate resilience and strive for wellness based in Indigenous ways of knowing and being. Aboriginal approaches to health are often rooted in a holistic conception of well-being involving a healthy balance of four elements or aspects of wellness: physical, emotional, mental and spiritual. These four elements are sometimes represented in the image of the medicine wheel (King et al., 2009). Many Aboriginal people in Canada have suffered the loss of connections to their land, cultures, languages and traditional ways of life through colonial practices such as forced relocations, the Indian

reservation system and the residential schooling system, which removed several generations of children from their families and communities. In this context, the revitalization and recovery of Aboriginal cultures, traditions and ways of knowing can have profound restorative impacts on health and well-being at both the individual and the community levels (Kirmayer, Simpson, & Cargo, 2003).

Aboriginal Health Policy and Programs

Aboriginal health policy in Canada is made up of a complicated “patchwork” of policies, legislation and agreements that delegate responsibility between federal, provincial, municipal and Aboriginal governments in different ways in different parts of the country (NCCA, 2011). Although in some cases, the administration of Aboriginal health services is adequate, in other cases the gaps and ambiguities created by a complicated policy

environment and jurisdictional confusions have created barriers to equitable access to health care and services (ibid).

For the majority of Canadians, including Métis, off-reserve status and non-status Indians, health services are financed through the national health insurance plan and administered at the provincial or territorial level. For on-reserve First Nations and Inuit communities, the federal government finances and administers health services through the First Nations and Inuit Health Branch (FNIHB). FNIHB administers several programs, including community-based programming for health promotion and disease prevention; primary health care centres and nursing stations in about 200 remote communities; public health programs focused on prevention of communicable disease, safe drinking water, and other public health issues; and non-insured health benefits, which covers expenses not typically covered by provincial health care plans, including dental and vision

care, prescription drugs, medical supplies and equipment, transportation and other services (FNIHB, 2008).

The provision of health care services to Aboriginal peoples in Canada is in a constant state of flux. In recent years, FNIHB has been working with communities to transfer responsibility for provision of on-reserve health care services to communities and tribal councils. Under the Health Transfer Policy initiated in 1989, individual communities have negotiated with FNIHB to transfer varying levels of health care responsibility to the community or council level (Health Canada, 2005). Legislation regarding provision of health services also exists in varying degrees at the provincial/territorial level, and this is largely focused on defining areas of jurisdiction and setting parameters for agreements regarding delivery of services between provincial, federal and Aboriginal government entities. However, most provinces have transferred authority for health service planning and delivery



to regional health authorities, and several provinces also have Aboriginal-specific policies to address gaps and coordinate cross-jurisdiction service provision. In short, multiple levels of authority and responsibility are involved in the provision of services to Aboriginal communities, with a general tendency towards delegating responsibility to local levels (NCCAH, 2011). In the absence of a clear national Aboriginal health policy, jurisdictional gaps and inconsistent levels of funding continue to create barriers for many Aboriginal communities (Lavoie, Forget, & O'Neil, 2007).

Conclusion

This fact sheet has provided a general introduction to Aboriginal health and an overview of the broad context within which First Nations, Inuit, and Métis communities, along with health practitioners, policy-makers and researchers, seek to improve the health and well-being of Aboriginal populations in Canada. Although the challenges faced by Aboriginal communities are complex and varied, there is increasing recognition that First Nations, Inuit, and Métis peoples possess the knowledge, determination and resilience rooted in their varied traditions and cultures to meet those challenges, particularly if they are aided by culturally-appropriate care in the maintenance and enhancement of their health and well-being.

For more Information

- **Assembly of First Nations**
www.afn.ca/index.php/en/policy-areas/health-and-social-secretariat
- **Inuit Tapiriit Kanatami**
www.itk.ca
- **Métis National Council**
www.metisnation.ca
- **National Collaborating Center for Aboriginal Health**
www.nccah-cnca.ca



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