TAANISHI KIIYA?

MIIYAYOW MÉTIS SAANTII PI MIYOOAYAAN DIDAAN BC*

Métis Public Health Surveillance Program—
Baseline Report, 2021

*How are you?
Improving Métis health and wellness in BC

MÉTIS NATION BRITISH COLUMBIA

BRITISH COLUMBIA | Office of the Provincial Health Officer

"A hundred and twenty four years ago our patriots, our men and our women, and even our children, stood their ground to ensure that we will exist forever and our flag shows that. Infinity. We will survive as a people. We will continue to work to overcome the obstacles that face us and we will have small victories, sometimes symbolic victories, but nevertheless with each victory that we have, whether it's something concrete, something that we can hold in our hands, or see with our eyes, or whether it's symbolic we will have these victories."

– Métis Informant, Métis Maternal and Child Health Project[1(p.26)]

Taanishi kiiya? Miiyayow Métis saantii pi miyooayaan didaan BC

Métis Public Health Surveillance Program – Baseline Report, 2021

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Front cover photo by Eden Jager. Back cover photo: Métis Nation British Columbia.

Ministry of Health

Victoria, BC

February 2022

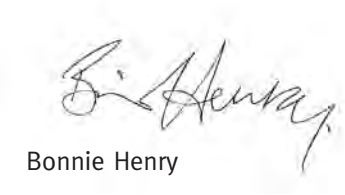
The Honourable Adrian Dix

Minister of Health

Sir:

I have the honour of submitting this Provincial Health Officer's Annual Report.

Sincerely,



Bonnie Henry

MD, MPH, FRCPC

Provincial Health Officer

Kaa-Wiichihitoyaahk
"We take care of each other"

MESSAGE FROM MÉTIS NATION BRITISH COLUMBIA'S MINISTER AND SENIOR DIRECTOR OF HEALTH, BC'S PROVINCIAL HEALTH OFFICER, AND BC'S DEPUTY PROVINCIAL HEALTH OFFICER–INDIGENOUS HEALTH

As this report demonstrates, Métis people and communities live and thrive in every region of British Columbia. The Métis Nation represents the largest Indigenous Nation in BC, with nearly 90,000 self-identified Métis people in the province. Of these, more than 22,000 are registered as Métis Citizens with Métis Nation BC. Despite this size, Métis people in BC are a population that is often marginalized and overlooked. Even where programs and policies are intended to benefit Indigenous peoples in general, they don't always consider the unique needs of Métis people.

We need good data to identify the specific strengths and challenges of Métis people and communities, and this report is a first step. It is the result of a partnership based on trust, mutual respect, collaboration, and reconciliation. Together, Métis Nation BC and the BC Office of the Provincial Health Officer, along with the BC Ministry of Health, have developed a plan to monitor and report on the health and wellness of Métis people in BC over the next decade. This initiative will include releasing interim reports every three years to assess our progress toward achieving the 10-year health and wellness targets outlined in Chapter 6 of this report.

Métis people know that health and wellness is rooted in community, culture, self-determination, language, spirituality, and connection to the land. Wherever possible, data presented in this report are grounded in Métis tradition, culture, and ways of seeing the world. Métis voices and imagery are integrated throughout this report to connect the numbers shown with the individuals and lived experiences they represent. We will continue to work together to improve our data collection and reporting processes with the goal of making this work as meaningful as possible to the Métis people of today and tomorrow, while honouring the memory of those who came before.

Our sincere thanks to the many people who shared their data and who have supported this project in other ways.

Aahkamayimo avik la bonn oovraazh ("keep up the good work").

Paulette Flamond
Minister of Health
Chair, Métis Data Governance Committee
Métis Nation British Columbia

Dr. Bonnie Henry
BC Provincial Health Officer
BC Ministry of Health

Tanya Davoren
Senior Director of Heath,
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The Métis Public Health Surveillance Program Steering Committee

We acknowledge with respect the territories on which much of this work took place, including those of the Esquimalt and Songhees Nations (Lekwungen) and W̱SÁNEĆ (Saanich) peoples in Victoria, BC, and the Katzie, SEMYOME (Semiahmoo), Kwantlen, and other Coast Salish Peoples in Surrey, BC. We also gratefully recognize the Métis Chartered Communities of Greater Victoria and Nova Métis Heritage Association in Surrey.

Executive Sponsors

Paulette Flamond, Minister of Health and Chair, Métis Data Governance Committee, Métis Nation British Columbia

Grew up Métis on squatted Crown land outside Battleford, SK, with roots in the Red River Settlement in Manitoba. Spent the last 25 years in the Treaty 8 territories in Northeast BC, where she is a medicine gatherer and Métis farmer, growing organic food.

Dr. Bonnie Henry, BC Provincial Health Officer, Office of the Provincial Health Officer, BC Ministry of Health

5th generation Canadian settler, Scottish Highland and Welsh ancestry. Born and raised on Mi'kmaq territory, PEI and NB.

Steering Committee Members

Dr. Danièle Behn Smith, Deputy Provincial Health Officer–Indigenous Health, Office of the Provincial Health Officer, BC Ministry of Health

Eh Cho Dene, Fort Nelson First Nation. Métis/French Canadian, Red River Valley, MB. Born in Fort Nelson, BC, on her paternal Eh Cho Dene territory. Raised in the territories of the Cree, Anishnaabe, Dene, Dakota, Oji-Cree, and her maternal Métis territory in Winnipeg, MB.

Tanya Davoren, Senior Director of Heath, Mental Health & Addictions, Métis Nation British Columbia

Métis Citizen, born and raised on Sylix Territory, which is also the home of her Community, the Vernon & District Métis Association (one of the 39 Métis Chartered Communities of Métis Nation British Columbia). Tanya's Métis lineage comes from Findlater and Lebret in the Qu'Appelle Valley in Southern Saskatchewan.

Adrienne Bonfonti, Project Director,
Office of the Provincial Health Officer,
BC Ministry of Health

2nd generation Canadian settler, Irish, Italian, and British ancestry. Born and raised on the territories of the Lekwungen and W̱SÁNEĆ peoples and the Métis Chartered Community of Greater Victoria.

Mike Pennock, Population Health
Epidemiologist, Métis Nation British Columbia

8th generation Canadian settler, descendant of British loyalists who became settlers in the Ottawa Valley following the American Revolutionary War. Grew up on the traditional lands of the Ojibway First Nation in the Niagara Peninsula.

Xibiao Ye, Provincial Epidemiologist and
Director of Epidemiology, Population Health
Surveillance and Epidemiology,
Office of the Provincial Health Officer,
BC Ministry of Health

Recent Canadian settler on the territories of the Lekwungen peoples and the Métis Chartered Community of Greater Victoria. Born and raised in China. Immigrated to Canada in 2009.

Acknowledgements

This report was developed through a partnership between Métis Nation British Columbia, the BC Office of the Provincial Health Officer, and the BC Ministry of Health. This important work could not have been accomplished without the contributions of the many organizations and individuals listed below, who provided expertise, critical cultural knowledge, data, insights, and feedback to the project team during the development of this report. We raise our hands and express our deepest gratitude to these contributors. *Marsee/Maarsii*.

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The project partners would also like to acknowledge the contributions of the following people:

- Susie Hooper, former Minister of Health, Métis Nation British Columbia, who supported this project and whose commitment helped move it forward.
- Former BC Provincial Health Officer Dr. Perry Kendall, whose expertise and leadership assisted in the advancement of Indigenous health in BC from 1999 to 2018.
- All those who supported the report wrap-up and launch, including Julia Wagner, Associate Director of Health, and Nick Hosseinzadeh, Senior Director of Communications, Métis Nation British Columbia; Lara Miramontes and Emerald UnRuh, Indigenous Health and Reconciliation, BC Ministry of Health; and Maya Nakajima and Sonora Godfrey, Office of the Provincial Health Officer, BC Ministry of Health.

A special thanks to the Citizens of the Métis Nation—especially those of you who helped make this report possible by sharing your health information, your voices, and your photographs. Many of the images in this report were submitted to Métis Nation British Columbia through a photo contest. These photos and the quotes that appear throughout this report help to connect the data and charts presented here to the actual lives, faces, and experiences of Métis people and communities.

Table of Contents

Executive Summary

"Wellness for Métis people includes the holistic connectedness of physical, mental, emotional, spiritual, and cultural aspects of life. Health and well-being for Métis is focused on Métis Community, family, and individuals."

– Improving Indigenous Cancer Journeys in BC: A Road Map[1(p.2)]

As the recognized government for **Métis** people in British Columbia, Métis Nation British Columbia (MNBC) is committed to advancing Métis health and wellness in the province. As part of this work, MNBC initiated the Métis Public Health Surveillance (MPHS) program to monitor the health and wellness of registered **Métis citizens** in BC. The MPHS program involves a data-sharing partnership and collaboration between MNBC, the Office of the Provincial Health Officer (PHO), and the BC Ministry of Health (BC MoH). The MPHS program and the related MNBC-Office of the PHO-BC MoH partnership include a commitment to data governance and **self-determination** for Métis people, as well as reporting in a manner that honours and privileges Métis stories, voices, and perspectives on health and wellness.

Source: Métis Nation British Columbia. Photo by Emerald UnRuh.

While Métis people in BC and across Canada have been adversely impacted by both historic and ongoing colonial violence, including systemic racism, the residential school system, discriminatory child welfare policies, and other injustices, many Métis people and communities are thriving. This is shown by the Métis Nation's ongoing strength and dedication to promoting Métis culture, nationhood, and self-determination, and by a number of milestone achievements and agreements, as outlined in Chapter 2 of this report.

The MPHS program builds on earlier work by MNBC, including a report released in 2015 titled *Métis Public Health Surveillance Project: Sharing Community Health Information*.[2] That report focused on chronic conditions such as diabetes, cardiovascular disease, and chronic respiratory diseases. As much as possible, this report follows the outline of the 2015 MNBC report. It includes many of the same indicators, uses a **strengths-based** approach, and expands the scope to include additional indicators. The longer-term goal of the MPHS program is to continue to shift health monitoring toward more strengths-based, **wholistic** reporting rooted in Métis tradition, culture, and understandings of health and wellness.

Summary of Key Findings

> *"Only the Métis Nation knows the history of the Métis people; we need to educate the public, the government, and the family coming home. Further, in addressing the wrongs of our past, we also want to look to the future. We feel the consequences of intergenerational trauma and we want that to end."*
>
> – Métis Sixties Scoop Survivor[3(p.12)]

Demographics and Socio-Economic Determinants of Health

Demographics (e.g., age, geographic distribution) and socio-economic determinants of health (e.g., income, education, employment, housing) are deeply connected to and help to shape the health and wellness of Métis and other populations.

- The Métis population in BC is substantially younger than the **non-Indigenous** population, with higher proportions of people between the ages of 0 and 34, and lower proportions in age groups 35 and up.
- Métis people are more frequently represented in lower income brackets and have a **median** pre-tax income lower than that of non-Indigenous people in BC.
- In 2016, Métis people in BC were less likely to have a post-secondary education, but more likely to have completed an apprenticeship, trades certificate, or diploma than non-Indigenous residents.
- Métis people in BC are more likely to be active in the **labour force** (either working or looking for work) compared to non-Indigenous people.

NOTE ON DATA SOURCES:
This report presents data from several different sources. The data highlighted in these pages may compare self-identified Métis people or registered **Métis citizens** in BC to **non-Métis, non-Indigenous,** or **"Other Resident"** populations (these and other bolded terms are defined in the glossary, Appendix A). Data sources are discussed more fully in Chapter 1 and Appendix B of this report, and specific data sources are identified in each figure and table where data are presented. "Non-Métis" and "Other Resident" comparison groups include First Nations and Inuit, as well as other populations.

- In 2016, Métis people in BC were more likely to live in the Northeast Health Service Delivery Area (HSDA) and the Northern Interior HSDA, compared to non-Indigenous people. Métis people were also less likely to live in more urban HSDAs such as Vancouver and Richmond.
- In 2016, 10.0 per cent of Métis people in BC reported that their home needed major repairs, which was substantially higher than for non-Indigenous respondents (5.7 per cent).
- Métis people are more likely to be renters (38.2 per cent of Métis compared to 27.3 per cent of **non-Métis** in BC).

Source: Métis Nation British Columbia.

Cultural Safety and Cultural Wellness

> *"As the keepers of Métis worldviews and as those responsible for passing along these worldviews to future generations,* kihteyayak/lii viyeu *['the mature ones,' 'the older people'] are the first and best source of information about Métis. They carry our histories in their stories, our visions for the future, they are caretakers of the ways of knowing of how Métis are Métis."*
>
> – Jennifer Adese[5(p.50)]

The Métis are a distinct **Indigenous** people with inherent rights, including the right to **cultural safety** and **cultural wellness.** Recognition of Métis identity promotes self-acceptance and pride for Métis people, which contributes to **reconciliation**, healthier communities, and Métis cultural wellness.[6]

- For Métis people, determinants of health and **health inequity** must be understood within both the broader context of historical, structural, and systemic inequities and protective factors such as cultural continuity, identity, self-determination, and connection to the land.
- **Distinctions-based** approaches that recognize the unique experiences, perspectives, rights, and needs of Métis and other Indigenous peoples are key to improving Métis cultural wellness.
- Increasing the number of Métis in health care professions is an important component of cultural safety. Although 2.0 per cent of the overall population of BC self-identified as Métis in 2016, only 0.4 per cent of registered physicians in BC self-identified as Métis in 2019.
- Métis women, girls, and **LGBTQ+/Two-Spirit (2SLGBTQQIA+)** people are integral to Métis communities and culture, yet face additional barriers to cultural safety, health, and wellness.
- Métis youth surveyed in 2018 who reported that they participated in cultural activities were more likely to feel connected to their community.

Youth Health and Wellness

"We must cherish our inheritance. We must preserve our nationality for the youth of our future. The story should be written down to pass on."

– Louis Riel[8]

The health and wellness of Métis youth is critical to the health and wellness of Métis communities. Métis youth have a vital role as those who carry on Métis culture, tradition, and leadership.

- In 2018, 76 per cent of Métis youth in BC rated their overall health as *good* or *excellent*, compared to 81 per cent of non-Métis youth.
- Male Métis youth were more likely than female Métis youth to rate their health as *good* or *excellent* (82 per cent of males compared to 71 per cent of females).
- In 2018, 35 per cent of Métis youth said that spirituality was *somewhat* or *very important* to them. Those for whom spirituality was *very important* were more likely to report positively on wellness indicators such as feeling connected to the land and nature.
- Métis youth were less likely than non-Métis youth to eat three meals a day. Métis youth were also more likely to report going to bed hungry at least some of the time because of a lack of money at home to buy food.
- Métis youth reported overall higher rates of physical activity than non-Métis youth.

> *Western society is about self, 'I' instead of 'we.' Feeling the community again would help a lot of people feel safe and happy and comfortable.*
>
> – Métis Youth Consultation Participant, McCreary Centre Society[7(p.48)]

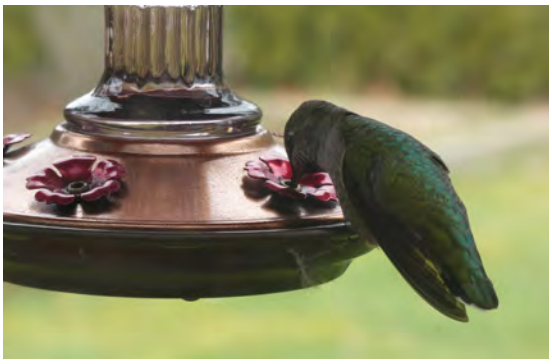
Source: Métis Nation British Columbia. Photo by Cassandra Gordon.

Mental Health and Substance Use

"I am very fortunate to have such great support through the Métis community… The medicine wheel teachings help me learn what real self care and self awareness [are] and made life more manageable. The music and prayer give me a sense of connection and community."

– Caty, Métis Substance Use Survivor[9]

As the data in this report show, mental health is a critical area of concern for Métis youth and adults in BC, and for Métis females and **non-binary** youth in particular. Substance use is also an issue of note. However, it is important to contextualize these findings in terms of experiences of systemic racism, social exclusion, and other factors linked to colonialism and **colonial trauma**.



Source: Métis Nation British Columbia. Photo by Natalie Robertson.

- Métis youth with a family member who attended residential school were more likely to report a range of negative experiences and risk factors, including substance use and mental health problems such as anxiety/panic attacks and depression.
- Mental and emotional health and well-being are a particular challenge for female and non-binary Métis youth.
- Between 2013 and 2018, the proportion of female Métis youth reporting positive mental health dropped from 65 to 49 per cent.
- The **prevalence** of mood and anxiety disorders among Métis females age 18 and up (20.7 per cent) was much higher than among **Other Resident** adult females and both Métis and Other Resident adult males.
- Métis youth were more likely than non-Métis youth to report having considered or attempted suicide or having self-harmed. The proportion of female Métis youth who had ever self-harmed increased from 27 per cent in 2008 to 36 per cent in 2013 and 42 per cent in 2018.
- A higher proportion of Métis youth reported use of substances, including tobacco, alcohol, and cannabis, than non-Métis youth.

Chronic Conditions among Adults

> *"The report* [In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care] *is an important first step in recognizing that change needs to happen so that Métis people in BC can have equity in treatment within our health care system and receive the same level of care other British Columbians are afforded."*
>
> – Paulette Flamond, Minister of Health, Métis Nation British Columbia[10(p.42)]

Métis people in BC bear a disproportionate burden of disease compared to Other Residents, including higher **age-standardized** rates of the following chronic conditions in 2017/18, as examined in this report:

- At 12.2 per 100 population, diabetes prevalence was higher for Métis than for Other Residents of BC (10.1 per 100 population)
- Rheumatoid arthritis prevalence among Métis females in BC (2.6 per cent) was higher than among all other groups (Métis males and Other Resident females and males).
- Osteoarthritis prevalence for Métis adults (14.2 per cent) was higher than for Other Residents (10.8 per cent).
- Hypertension prevalence among the **Métis cohort** overall was 26.5 per cent, compared to 23.0 per cent for the rest of the population.

> *Métis Elders… help communities and Indigenous peoples understand who they are, where they came from, the contributions of Indigenous women to this history and unfolding story, and the ways that their lives are extensions of history.*
>
> – Judy Iseke-Barnes[11(p.25)]

- Ischaemic heart disease prevalence (9.1 per cent) for the Métis cohort was **significantly** higher than the prevalence for Other Residents (7.1 per cent).
- Chronic obstructive pulmonary disease (COPD) prevalence among Métis people age 35 and up was 7.3 per 100 population—compared to a rate of 5.2 per 100 for Other Residents. Métis rates were higher among both females and males.
- Asthma prevalence for Métis was almost 1.5 times the rate for Other Residents (7.5 per cent compared to 5.2 per cent). This gap existed between Métis and Other Resident females as well as males, but the rate was far higher for Métis females (9.0 per cent).

Future Directions and Next Steps

"Cultural wellness is a key factor in promoting health and well-being. For many years, the Métis had to hide aspects of their culture and identity in order to stay physically safe, progress economically, and be respected in mainstream society. Even today, many Métis people experience that sharing their Métis identity can cause them to be subject to racism and misunderstanding. Cultural wellness is about promoting a world in which Métis people can express and celebrate their identity with pride."

– Métis Nation British Columbia, *Kaa-wiichihitoyaahk: Métis Perspectives on Cultural Wellness*[6(p.116)]

Source: Métis Nation British Columbia. Photo by Nadine Gagne.

While the MPHS program will continue to monitor many indicators over the next 10 years, several measures are identified in Chapter 6 of this report that will help MNBC and the project partners understand and monitor changes in the overall health and wellness of Métis in BC. Each of these measures has an established target to reach by 2030. To help advance the health and wellness of Métis people in BC, and support progress toward these targets, this baseline report identifies four priorities and makes four specific recommendations for action (see Chapter 6). Interim reports will identify actions underway to support the recommendations and assess whether there has been progress toward the targets. The final report in 2030 will identify whether targets were met and what next steps will be taken by the partners to continue to support Métis individuals and communities in BC to thrive.

> *Métis people understand the issues in their communities and should play an active role in designing the research projects and translating them into program implementation, policy development, and social change.*
>
> – Monique D. Auger[12(p.93)]

"Despite direct assimilation attempts

Despite the Residential School Systems

Despite the strong influences of the Church in Metis communities to ignore and deny our Aboriginal heritage

Despite not having a land base

And despite our own diversity in heritage

We are still able to say we are proud to be Metis

We are resilient as a weed, and beautiful as a wildflower

We have much to celebrate and be proud of"

– Christi Belcourt[4(p.1)]

Note: Quotations in this report are considered an additional form of data; therefore, quotations in the Executive Summary also appear in the body of this report.

Source: Métis Nation British Columbia. Photo by Brian Lavallee.

TAANISHI KIIYA?

MIIYAYOW MÉTIS SAANTII PI MIYOOAYAAN DIDAAN BC

Source: Métis Nation British Columbia. Photo by Megan Shannon.

Chapter 1:

Introduction

"Metis identities are nurtured and sustained by the stories, traditions and cultural practices taught by our grandmothers, grandfathers, and ancestors."

– Brenda Macdougall [a,1(p.5)]

The goal of this report is to provide a baseline assessment of the health and wellness of **Métis**[b] people in BC and to identify opportunities to improve health outcomes. This chapter provides contextual information about the report, gives a brief overview of Métis health and wellness, and introduces the Métis Public Health Surveillance (MPHS) program. The development of this report included a data-sharing partnership and collaborative processes that represent progress in how the health and wellness of Métis in BC are monitored and analyzed. In this way, it reflects the guiding principles of the MPHS program, including strong data governance and **self-determination** for Métis people.

Métis People

Métis people have their own distinct **Indigenous** identity and occupy a unique place in North American history and culture, with roots in both pre-contact[c] Indigenous communities and European settler society. Métis people are recognized under section 35 of the *Constitution Act, 1982*, along with **First Nations** (**"Indians"**) and **Inuit**, as one of the three Indigenous (**"Aboriginal"**) peoples of Canada.[d,3]

> *The Métis... view the 1885 Batoche uprising as a political 'resistance' rather than a rebellion (as it is commonly labeled), identify as 'the people who own themselves,' and embrace the infinity symbol on their flag to assert 'the existence of a people forever.'*
>
> – "Towards an Architecture of Métis Resistance"[2]

While a number of people and groups in Canada identify as Métis, this report focuses specifically on the Métis Nation, a distinct Indigenous nation descended from the Red River Métis settlement in what is now known

[a] Some writers (including Macdougall) omit the accent in "Metis" because they believe it emphasizes French identity over the Indigenous and other European identities that have also contributed to Métis heritage. The accent is used in this report to align with the usage preferred by Métis Nation British Columbia and the **Métis National Council**.

[b] Bolded terms in this report are defined in the glossary (Appendix A).

[c] "Pre-contact" refers to the time prior to the arrival of Europeans; in BC, this means any time before the late 1700s.

[d] Although the Constitution and law tend to use terms such as "Aboriginal" and "[Status] Indian," this report seeks to reflect the preferences of many Indigenous peoples by using the term "Indigenous" to refer collectively and inclusively to Métis (registered and unregistered), First Nations (Status and non-Status), Inuit, and others who self-identify as Indigenous.

as Manitoba.[4] The Métis Nation is known for its music (distinctive fiddle playing and dancing the Red River Jig), beautiful and artistic beadwork, and recognizable symbols such as the Métis flag and the Métis sash.[5] Members of the Métis Nation are now dispersed throughout—and beyond—the **Métis Nation Homeland,** which covers all of Alberta, Saskatchewan, and Manitoba, and parts of BC, the Northwest Territories, Ontario, and the northern United States.[1] Métis identity is discussed further in Chapter 2 of this report.

MÉTIS FLAG

This Métis flag can be blue or red and is a symbol of cultural identity. The infinity symbol, which resembles two circles coming together, represents the combination of European and Indigenous peoples to form a new nation. It also means the Métis Nation will live forever.[5]

Monitoring the Health of Métis People in BC

Métis people in Canada and BC have been, and continue to be, adversely impacted by the legacy of colonial policies like the residential school system. Current colonial practices fail to recognize the distinct Indigenous identity of Métis people or to provide accessible, culturally safe and appropriate health and social services. Despite these and other injustices, including systemic racism and discrimination, Métis communities and cultures remain vibrant and strong. The ongoing and concerted efforts of Métis people and governments have led to several landmark legal decisions, relationship agreements, and commitments over the past several years (see Chapter 2). These achievements support **reconciliation** and a more active voice for Métis in their own health and wellness. One key example is the evolving government-to-government relationship between Métis Nation British Columbia (MNBC) and the Province of BC, as evidenced by the October 2021 Letter of Intent discussed in the following chapter. The Office of the Provincial Health Officer (PHO), the BC Ministry of Health (BC MoH), and MNBC have entered into a formal partnership to support the health and wellness journeys of Métis people in BC. This report is a product of that partnership,

Source: Métis Nation British Columbia.

MÉTIS SASH

The distinctive Red Voyageur Sash has been a symbol of Métis identity since the fur trade. Traditionally, Métis sashes were woven by hand, and you could often identify a Métis person's family or their origin based on the unique pattern of their sash. Sashes are still worn today as symbols of Métis pride and heritage.[5]

Source: Métis Nation British Columbia. Photo by Benjamin Wilson.

which has also been supported by the BC Ministry of Mental Health and Addictions. MNBC is the recognized government for Métis people in BC and represents 39 **Métis Chartered Communities** across the province (Appendix C). MNBC was first established in 1996 as the Métis Provincial Council of BC and is one of four provincial governing members of the **Métis National Council** (MNC), which represents the Métis Nation nationally and internationally. MNBC's mandate is to develop and enhance opportunities for Métis communities in BC by implementing culturally relevant social and economic programs and services.[6] According to the 2016 Census, there were 89,405 self-identified Métis people living in BC.[7] As of 2021, there were more than 22,000 **Métis citizens** registered provincially with MNBC (see sidebar). In this report, a Métis citizen is a person who self-identifies as Métis, is registered with MNBC, is of **Historic Métis Nation ancestry**, and is accepted by the Métis Nation.

The MPHS program is a joint initiative of MNBC, the Office of the PHO, and the BC MoH. Its purpose is to better understand, as well as promote and improve the health and wellness of Métis people in BC. The PHO is required by the *Public Health Act* to report annually to the BC Minister of Health on the health status of British Columbians and on the need for policies and programs that will improve their health. This includes monitoring and reporting on the health and wellness of Indigenous peoples in BC, including Métis people. The BC MoH is responsible for ensuring that culturally safe, high quality, appropriate, cost-effective, and timely health services are available for all British Columbians. This includes BC MoH's commitment to working with Indigenous partners such as MNBC to promote **cultural safety** and humility in provincial health and wellness systems. Both the Office of the PHO and the BC MoH are dedicated to upholding the provincial government's commitment to true and

MÉTIS NATION BRITISH COLUMBIA WAHKOHTOWIN (REGISTRY RENEWAL) PROJECT

Métis Nation British Columbia (MNBC) provides services to more than 22,000 registered Métis citizens and is recognized by the provincial and federal governments as the official political representative of Métis people in the province of BC.

In 2021, MNBC launched the Wahkohtowin (Registry Renewal) Project. The project enhances services to Métis citizens in BC by digitizing citizenship files, reducing application processing times, and providing new, culturally designed citizenship cards. To recognize this achievement, MNBC proclaimed April 23, 2021, *Wahkohtowin Day. Wahkohtowin* is the Cree word for "kinship," but it also describes Cree law, codes of conduct, and "the interconnected nature of relationships, communities, and natural systems."[8]

lasting reconciliation with Indigenous peoples. This commitment includes implementation of BC's *Declaration on the Rights of Indigenous Peoples Act*, the Truth and Reconciliation Commission (TRC) Calls to Action, and the 2021 Letter of Intent, which are discussed in Chapter 2.

This report is meant to be **strengths-based** as much as possible, but it is important that it also recognizes where inequities exist and where improvements are needed. Despite considerable progress achieved through years of dedication, hard work, and advocacy by Métis people for the right to be self-determining, colonial governments have not yet achieved full understanding or recognition of Métis identity and Métis rights. This is an ongoing process.

> *Wellness for Métis people includes the holistic connectedness of physical, mental, emotional, spiritual, and cultural aspects of life. Health and well-being for Métis is focused on Métis Community, family, and individuals.*
>
> *– Improving Indigenous Cancer Journeys in BC: A Road Map*[9(p.2)]

Métis Perspectives on Health and Wellness

A sense of identity, community, and belonging is an integral component of health and wellness.[10,11,12] This has been a challenge for many Métis people, who have experienced systemic and interpersonal discrimination because of their mixed Indigenous and European heritage.[13,14] MNC's *Public Health 2018* forum identified the Métis Nation's interest in working with government and other partners to address the health and wellness needs of Métis people and communities using a **wholistic**,[e] evidence-based approach "…rooted in culture and history to promote health and wellness and reduce the burden of illness."[15]

The MNC and its governing members, including MNBC, are working to develop a Métis National Health Policy based on the "Métis Framework for Action" outlined in the 2005 *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*.[16,17] Among other things, this framework focuses on increasing Métis capacity and involvement in health policy and planning, and in the delivery of health promotion activities and health care services that are culturally appropriate and responsive to the needs of the Métis population.[17]

MNBC health officials have highlighted the importance of distinguishing Métis health needs, programs, and services from those of other Indigenous peoples, as well as the need for Métis-specific cultural safety and **cultural wellness** training.[15] To better integrate Métis perspectives into health services across BC, MNBC has signed Letters of

Source: Métis Nation British Columbia. Photo by June Graham.

[e] The term "wholistic" is used in this report rather than "holistic," except where the latter spelling appears in a quotation. The "w" in "wholistic" better recognizes the perspectives of Métis and other Indigenous peoples in focusing on strengths, connectedness, and "wholeness."

> *Connection to our heritage is so strongly imbedded in our landscape and we have to reconnect with that. . . . I think [that's what] health is and for me, I think it's tied to that connection and knowing that you can hopefully have a healthy lifestyle by making your relationships with the land.*
>
> – Métis Parenting Research Participant[12 (p.20)]

Understanding with Interior Health (September 2018), Island Health (March 2019), Fraser Health (June 2019), and Northern Health (June 2020).[20] A Letter of Understanding with Vancouver Coastal Health and a Letter of Commitment with the Provincial Health Services Authority are currently in development.

The Office of the PHO and the BC MoH have also entered into a formal partnership with MNBC with three main components to date. First, the PHO and MNBC signed a Letter of Understanding in 2018. In June 2019, MNBC, the BC MoH, and the PHO signed an Information Sharing Agreement to support enhanced monitoring of Métis health and wellness in the province through the MPHS program. In October 2019, these partners also signed a program charter for the MPHS program, thereby entering into a 10-year commitment to monitor and report on Métis health and wellness.

The Métis Public Health Surveillance Program

MNBC, the Office of the PHO, and the BC MoH are committed to working together to develop an ongoing surveillance and reporting relationship to monitor the health and wellness of Métis citizens in BC. The purpose of the 10-year commitment is to enter a new phase of monitoring and reporting focused on guiding efforts to advance the health and wellness of Métis people. This work was preceded by a related report released in 2015, titled *Métis Public Health Surveillance Project: Sharing Community Health Information*.[18] That report focused on chronic conditions such as cardiovascular disease, respiratory illness, and diabetes, and represented a very small cohort of Métis citizens. The current report builds on that work by revisiting indicators presented in the 2015 report, expanding the scope of analyses, and providing **baseline data** for a new suite of indicators that will be monitored and reported on over the next 10 years.

The Evolving Approach to the Métis Public Health Surveillance Program

The partnership initiatives between MNBC, the Office of the PHO, and the BC MoH described earlier in this chapter include a commitment to respect Métis data governance and self-determination and to report in a way that honours and privileges Métis stories, voices, and perspectives on health and wellness. For example, this report upholds principles of Métis data governance and defers to Métis teachings and tradition as appropriate. Partners also recognize that storytelling has an important place for Métis people and that stories are a necessary part of understanding lived experience and of connecting data to real Métis people and communities.

Source: Métis Nation British Columbia.

The partners anticipate that MPHS program reporting will be an evolving process that improves with each report. Data available for this baseline report are primarily clinical and deficit-based or illness-focused. The partners recognize that many of the indicators presented in this report therefore emphasize what is "wrong" rather than what is going well. One of the goals of this work is to complement these measures with a strengths-based approach that is more strongly rooted in Métis tradition, culture, and accepted ways of understanding health and wellness. This includes shifting from the term "cultural safety," which is potentially triggering, to an increased focus on "cultural wellness" for Métis people and communities.

> *Only the Métis Nation knows the history of the Métis people; we need to educate the public, the government, and the family coming home. Further, in addressing the wrongs of our past, we also want to look to the future. We feel the consequences of intergenerational trauma and we want that to end.*
>
> – Métis Sixties Scoop Survivor [19(p.12)]

Where possible, strengths-based indicators from additional sources are included in this report to allow for more wholistic analyses of Métis people's health and wellness in BC. Similarly, data available within the health system currently focus more on health outcomes, so another longer-term goal of the project will be to look at broader socio-cultural and structural determinants that lead to health and wellness outcomes. Data related to social and other determinants of health have also been included in this report, and initiatives are underway to explore access to other sources of data for future reports.

Source: Métis Nation British Columbia. Photo by Jackie Maurer.

Métis Public Health Surveillance Program Reporting

Working collaboratively, MNBC, the Office of the PHO, and the BC MoH will produce a series of four reports over the next 10 years (2021-2030) based on a Métis Nation cohort established for this purpose. These reports will be produced jointly and released every three years. They will monitor a core suite of indicators and provide surveillance for understanding and improving Métis population health and wellness.

This is the first of the four reports and it provides a baseline for the next 10 years of reporting. It includes targets to be achieved by 2030 for a selection of key indicators, as well as recommendations for improving the health and wellness of Métis people in BC. Two interim reports, scheduled for release in 2024 and 2027, will measure progress in moving

> *[B]oth my parents are Métis, so I grew up from a very young age [knowing] that I was Métis, and knowing the history of it and the ancestry of it, and I remember all the culture of it. I always remember my parents speaking the language but I didn't really understand it. I could pick up some words, but unfortunately, I don't know the language which is something I would like to work on because I think that's a really important thing to pass on.*
>
> – Métis Parenting Research Participant[12(p.21)]

toward the targets identified in this report. The final report will be released in 2030 and will identify whether targets were met, and what next steps will be taken by the partners.

Data Sources and Methodology

Many of the data included in this report are derived from a Métis-controlled data source developed to support the MPHS program. Since the 2015 report referenced earlier, there has been substantial advancement in growing the data cohort to reflect a larger proportion of Métis citizens in BC, as well as a robust data governance structure to uphold principles of Métis governance and self-determination in health monitoring and reporting. These advancements allowed for the creation of the **Métis cohort** of 14,515 citizens[f] represented by the data in this report.

The current report also incorporates data from the McCreary Centre Society's BC Adolescent Health Survey (BC AHS) on the health and wellness of Métis youth. Additional publicly available sources of data have been included to help make this report more strengths-based and comprehensive, such as Statistics Canada's Canadian Community Health Survey (CCHS) and census data, as well as pertinent literature. Quotes and anecdotes were derived from existing literature and published sources.

Since this report brings together a variety of sources, there is some variation in the years and types of data presented. The BC AHS, CCHS, and several other sources are based on Métis self-identification among survey sample populations, and so may capture Métis people who are not registered with MNBC and will likely not capture all registered MNBC citizens. The Métis cohort used in this report reflects only Métis people who are registered citizens of MNBC and have not opted out of the MPHS program dataset. Métis cohort data are compared to all other British Columbians, which includes **non-Indigenous** people as well as First Nations, Inuit, and non-registered Métis. Therefore, not all data in this report are strictly comparable.

For more information about the data sources and methodology used in this report, including the development of the Métis cohort, please see Appendix B.

[f] The Métis cohort consists of 14,515 registered Métis citizens age 18 and up and still living in 2018 who consented to have their data included in the Métis Public Health Surveillance program.

Organization of this Report

This chapter helps to set the context for the commitments to monitoring and supporting the health and wellness of Métis people in BC. The following chapter will provide an overview of Métis in BC, including a brief history of colonization and some key legal and policy advancements and commitments. Chapter 3 examines social, structural, and **Indigenous determinants of health** and presents relevant data to illustrate the impacts of living and working conditions on Métis health and wellness. Chapter 4 explores the health and wellness of Métis youth, and Chapter 5 establishes baseline data for selected chronic disease indicators to provide an overview of the health and wellness of Métis citizens in BC, based on the Métis cohort. Chapter 6 summarizes key findings, presents recommendations, and sets 10-year targets for improving Métis health and wellness. Subsequent reports will compare future MPHS program data to the baseline and targets established in this report to measure progress in improving health and wellness outcomes for Métis people in BC.

Source: Métis Nation British Columbia. Photo by Nicole Sutherland.

Chapter 2:

Brief History of the Métis in Canada and BC

"As a post-contact Indigenous people, the Metis, over a short period of time, developed a distinct society, with its own distinct cultural, economic, and social orientation."

– Brenda Macdougall[1(p.5)]

This chapter provides a brief overview of some key social, structural, and legal aspects of the history of Métis people in Canada and British Columbia. While a thorough review of this history is beyond the scope of this report, this chapter provides a necessary context for understanding the current health and wellness of Métis people in BC. It includes a discussion of the development of a unique post-contact Indigenous way of life; challenges faced by Métis communities; Métis **resilience** in times of adversity; progress toward formal recognition of a distinct Métis identity; and the impact of historical and ongoing challenges on the overall health and wellness of Métis people in BC.

> *Family [to our old people] meant sharing all things—wealth, knowledge, happiness and pain. It meant... loving and caring enough about each other to be honest, and from that honesty, gathering strength to change those things which would hurt us all.*
>
> – Maria Campbell, Métis Author and Elder[1(p.8)]

Colonialism, Discrimination, and Resilience

At the time of European contact on the west coast, Métis populations were not yet established in the territory now known as British Columbia. Métis people established families and communities in the Canadian prairies and further east by the 18th century,[3,4] and in BC by around the turn of the 19th century (late 1700s[3] and early 1800s[5,6]).

Understandings of Métis identity vary across Canada, and within and between Métis communities.[5,6,7] Métis people have been, and continue to be, subjected to racism and discrimination, were historically known as "half-breeds," and are still sometimes characterized as "the forgotten people."[1,7,8] The very status of the Métis as an Indigenous people has sometimes been questioned.[1] These questions of identity have important implications for the health and wellness of Métis people.[1] While a lack of comprehensive data on Métis populations is an ongoing challenge, there is sufficient evidence to demonstrate that gaps exist in areas such as health, education, and income between Métis and other populations in BC and Canada.[1,9,10]

Although Métis communities arose partially as a result of colonization, Métis people have experienced—and continue to experience—many of the same forms of colonial violence and oppression as other Indigenous peoples in Canada. These build on settler-colonial ideologies of **white supremacy**, and include the ongoing harmful impacts and legacy of residential schools and the child welfare system,[1,11,12] losses of language and culture, as well as the erosion of respect for the important roles of women,[13,14,15] seniors and Elders,[16,17] and **LGBTQ+**[g,18]**/Two-Spirit**[h] people[19,20] in Indigenous societies. Métis people also face unique challenges, including the lack of a formal land base, resulting in part from the historic **"scrip"** system,[i,1,6] and the historic and ongoing lack of recognition by colonial governments and institutions.

> *That's where the Métis come from; they were the new Nation, the new shoots that come up from the ground from Mother Earth.*
>
> — Tom McCallum, Métis Elder[2(p.15)]

Source: Métis Nation British Columbia. Photo by Jessica Harnett.

> *The Priest told his mother and grandparents that they did not have the ability to raise him, and so they took him away. He never had access to the wisdom of his grandparents. To those who knew their grandparents and grew up with their parents, he envied them for their knowledge.*
>
> *– Nobody's Children: A Métis Nation Residential School Dialogue*[21(p.2)]

One way that colonialism and lack of understanding of distinct Indigenous identities persists today is the way governments engage differently with distinct Indigenous groups. The report *A Tale of Two Nations: Highlighting the Inequities of the Treatment of the Métis in BC* (2020)[56] outlines some of the ways that Métis people have not been appropriately understood or recognized. For example, the report describes how Métis people have been excluded from reconciliation work pursued with other Indigenous groups. It also highlights the ongoing challenge of inequitable funding for health services for Métis people in BC.[56]

[g] LGBTQ+ is an acronym for lesbian, gay, bisexual, **trans/transgender**, queer or questioning, and others with fluid or **non-binary** sex or gender identities and sexualities. This acronym continues to evolve and has recently appeared as **2SLGBTQQIA+** (Two-Spirit, lesbian, gay, bisexual, trans/transgender, queer, questioning, intersex, asexual, and/or **gender diverse** or non-binary).

[h] The term "Two-Spirit" reflects the concept of the female and male principles coexisting within a single being. "Two-Spirit" is mainly used by Indigenous peoples to describe non-heterosexual and/or non-binary sexual and/or gender identities; however, Indigenous individuals of varying sexual and/or gender identities may prefer to identify as LGBTQ+ or use different terminology altogether.

[i] "Scrip" refers to a fraudulent system of land vouchers in the late 19th and early 20th centuries, whereby Métis community groups were dispossessed of their lands and small parcels were given to individuals, many of whom were later defrauded. More than a century later, the unfairness of the scrip system was acknowledged in the Supreme Court's 2013 *Manitoba Métis Federation Inc. v. Canada* decision.

THIS REPORT CONTAINS CONTENT THAT MAY TRIGGER READERS.

> "Residential schooling and its longterm effects on families and communities is an example of the cumulative and compounding impact of colonial trauma. Residential schools were undoubtedly one of the most pernicious and powerful practices of cultural genocide; through the removal of children from their cultures, their communities and their families. The impact of this personal, family and community level trauma has proven to be cumulative."
>
> – "Colonial Trauma: Complex, Continuous, Collective, Cumulative and Compounding Effects on the Health of Indigenous Peoples in Canada and Beyond"[57(p.84)]

Residential Schools and the Child Welfare System

One of the most damaging aspects of colonization for Métis people was Canada's **Indian Residential School system**. Through this system, many Métis children were forcibly separated from their families to assimilate them into Euro-Canadian society.[7,22] Residential schools have been recognized by the Truth and Reconciliation Commission (TRC) of Canada as a form of cultural genocide.[23] Many Métis children also attended day schools,[22] which were similarly used to assimilate Indigenous children under the guise of providing education. The ongoing impacts of this history for residential and day school survivors and their families and communities are well documented. These impacts include **intergenerational trauma**, **colonial trauma**, anger, depression, problematic substance use, self-harm, loss of language, loss of connection to traditional teachings, and other losses of culture.[24,25]

In 2000, the Manitoba Métis Federation instituted a program to promote healing for Métis residential school survivors and their families, to "...ensure that the Métis students are not the 'Forgotten People' that attended the 'Forgotten Schools.'"[26] Although the TRC made an effort to reflect the experiences of Métis children and communities in its work to respond to the legacy of residential schools and promote reconciliation and healing,[27] concerns remain about the lack of Métis inclusion and recognition in the process.[28,29,30]

Some have suggested that child welfare policies picked up where the residential school system left off in attempts to assimilate Métis and other Indigenous children.[59,82] Historically, Métis children and youth were raised by their parents, extended family, and the whole community; when problems or challenges arose, family and community members were there to provide support.[58] The child welfare system breaks up Métis families and communities.[59] The "Sixties Scoop," for example, refers to a time—actually beginning in the 1950s and lasting into the 1990s—when many Indigenous babies and children were removed from their families and brought up in Euro-Canadian homes.[31] Métis survivors of the Sixties Scoop have reported many of the same experiences of loss and trauma as residential school survivors.[11,12,31] Similar but more recent apprehensions of Indigenous children by

> *If we do not stand for our Métis Children and have them in our Métis homes and communities learning our history, culture and language, they are not going to be strong and proud of who they are. As survivors, we want you to realize that we are no longer invisible and hidden children of the child welfare system, no longer alone.*
>
> — Métis Nation Elder[31(p.15)]

If you need emotional support, please call the **Métis Crisis Line, 24/7 toll-free: 1-833-638-4722 / 1-833-MÉTISBC**

NATIONAL DAY FOR TRUTH AND RECONCILIATION

KAHKIYAW LII ZAAÑFAAÑ I SOOÑ SHEER – EVERY CHILD MATTERS

On September 30, 2021, Métis, First Nations, Inuit, and non-Indigenous peoples and Nations across Canada commemorated the first National Day for Truth and Reconciliation. This day honours residential school survivors and remembers the children who did not come home. September 30 is also Orange Shirt Day, an Indigenous-led day to recognize those who attended residential schools, as well as their families and communities.[49]

government agencies have come to be known as the "Millennium Scoop." Métis children and families continue to experience high rates of interaction with the child welfare system.[55]

In BC in 2016, Métis children and youth under age 15 were more than ten times as likely as non-Indigenous children and youth under age 15 to be living in a foster home.[60] Métis children and youth involved in the child welfare system are more likely to experience a range of poor health outcomes, including mental health issues.[9,60] Female children and youth are particularly at risk.[60] Provincial government data indicate that the number of Métis children and youth in the child welfare system in BC decreased from 597 in December 2017 to 479 in May 2020.[60]

Source: Métis Nation British Columbia. Photo by Jet Robertson.

> *I realize how difficult it is to open up and share. I also realize all the obstacles, and barriers that many of us faced when we got out of the convents and residential schools. I was listening and feeling like I was back there 65 years ago, feeling lonely, abandoned and like I did not belong—because that was taught to me. We were taught that what our parents taught us we needed to forget and that it was pagan. But those values from my parents, I never lost them.*
>
> – Angie Carrier, Métis Residential School Survivor[21(p.16)]

The child welfare system does not address intergenerational and colonial trauma, systemic racism and marginalization, or disparities in the social determinants of health for Indigenous peoples.[59] The Métis Commission for Children and Families of BC (MCCFBC) is the legislated representative for Métis children, youth, and families involved with the child welfare system in BC. Part of MCCFBC's work is to make sure that a cultural safety agreement is in place for every Métis child and youth in the child welfare system, to connect them with their family, culture, and community.[61] Still, Métis children and youth in the system are not always identified as Métis or placed with Métis families.[60]

THIS REPORT CONTAINS CONTENT THAT MAY TRIGGER READERS.

Source: Métis Nation British Columbia. Artwork by June Graham.

CHILDREN'S UNMARKED GRAVES AT FORMER RESIDENTIAL SCHOOLS

"Indigenous Nations have always known the truth of what happened at these schools, and it is only now that the rest of Canada is beginning to understand."

– Patrick Harriott, Director, Vancouver Island and Powell River Region, Métis Nation British Columbia[68]

On May 27, 2021, Tk'emlúps te Secwépemc shared the news of a loss "that was spoken about but never documented by the Kamloops Indian Residential School": the remains of 215 children had been buried in unmarked graves at the site of a former residential school in Kamloops.[69]

The news was shocking but not unexpected for Indigenous communities. Indigenous peoples have always known there were many missing children who did not return home from residential school, and whose deaths and burials had not been officially recorded by those who ran the schools. Many families never knew what happened to their children.[70] In Canada, the news has had a profound effect on Indigenous communities and beyond.

As more Indigenous communities launch investigations, more unmarked graves have been located at other former residential school sites in BC and across Canada.[71] Residential school survivors, bereaved families, and Indigenous and non-Indigenous people and communities have joined in mourning these children. Survivors and families continue to share stories of the horrific human rights violations and acts of genocide perpetrated against Indigenous children.

The Métis Nation grieves alongside other Nations and communities for these stolen children.[68,72,73] At the same time, Métis Nation British Columbia, like other Nations, is looking to the future, working toward true self-determination, and supporting culturally appropriate child care, education, and family programming to help create better lives for Métis children and families in the days ahead.[74,75]

If you need emotional support, please call the **Métis Crisis Line, 24/7 toll-free: 1-833-638-4722 / 1-833-MÉTISBC**

NATIONAL ACTION PLAN: ENDING VIOLENCE AGAINST INDIGENOUS WOMEN, GIRLS, AND 2SLGBTQQIA+ PEOPLE

"I am grateful for the bravery and heart that was put into the National Action Plan. ...It is imperative that we keep the momentum of this work going so that we can demonstrate our commitment to supporting our women and girls, and 2SLGBTQQIA+ [people]."

– Dr. Kate Elliott,
Minister of Women and Gender Equity,
Métis Nation British Columbia[76]

Source: Métis Nation British Columbia. Photo by Anne Duex.

On June 3, 2021, the Government of Canada released its long-awaited *National Action Plan: Ending Violence against Indigenous Women, Girls, and 2SLGBTQQIA+ People.*[77] Métis Nation British Columbia (MNBC) welcomed the plan, which takes an inclusive and distinctions-based approach that acknowledges the diversity of First Nations, Métis, Inuit, and Urban Indigenous peoples, and recognizes different provincial and territorial contexts across Canada.

MNBC and Métis Women British Columbia (MWBC) continue to remember and honour the missing and murdered Indigenous women and girls, and commemorate Red Dress Day on May 5. Red Dress Day is a National Day of Awareness for Missing and Murdered Indigenous Women, Girls, and Two-Spirit people. On May 5, 2021, MNBC and MWBC committed to the calls for justice—including the Métis-specific calls for justice—identified by the National Inquiry into Missing and Murdered Indigenous Women and Girls.[78]

"I use my voice daily to challenge systems that continue to increase risk and harm to our women, girls and 2SLGBTQQIA+ people."

– Jana Schulz, Kootenay Region
Women's Representative,
Métis Women British Columbia[78]

MNBC and MWBC work to promote health, wellness, and safety for Métis women, girls, and 2SLGBTQQIA+ people through initiatives like the anti-violence campaign *Sashing Our Warriors*[79] and a new 2SLGBTQQIA+ advisory committee.[80]

THIS REPORT CONTAINS CONTENT THAT MAY TRIGGER READERS.

Source: Métis Nation British Columbia. Photo by Shannon Tapley.

Métis and colonial governments are working together to reduce the number of Métis children and youth involved in the child welfare system, and to create a more positive, more equitable future for Métis children, youth, and families in BC and Canada.

In July 2020, BC's Representative for Children and Youth (RCY) released the report *Invisible Children: A Descriptive Analysis of Injury and Death Reports for Métis Children and Youth in British Columbia, 2015 to 2017*. This is the first RCY publication with a specific focus on Métis children and youth. It was produced in consultation with both MNBC and the MCCFBC. The report provides a baseline for measuring the success of efforts to improve services and outcomes for Métis children, youth, and families in BC.[60] The report identifies several systemic issues, including the vast overrepresentation of Métis children and youth in the child welfare system, inconsistency in identifying children and youth as Métis and providing appropriate cultural supports, and the risks of sexualized violence, attempted suicide, and mental health concerns, especially for females.[60] The report also suggests some positive changes are happening, including a decrease in the number of Métis children and youth in the child welfare system in recent years.[60]

Sterilization

In addition to attempts to assimilate children through the residential school system, Indigenous peoples in Canada faced forced sterilization in an attempt by colonial governments to eliminate them. In 1933, BC passed *An Act Respecting Sexual Sterilization*, which was not repealed until 40 years later. This Act allowed BC's Eugenics Board to sterilize, without consent, anyone in a provincial institution whom the Board felt might give birth to children with "serious mental disease or mental deficiency."[63] Although few records remain, there is evidence

> *The criminalization of Indigenous women and the policing of their sexuality contributed to their being labelled 'bad mothers,' unfit to care for their children. They were also subjected to coerced or forced sterilization.*
>
> – "Sterilization of Indigenous Women in Canada"[62]

that Indigenous women were sterilized under this legislation.[62] Recent accounts indicate that forced or coerced sterilization of Métis and other Indigenous women has occurred as recently as 2018.[62,64,81]

Residential schools, child welfare policies, and forced sterilization have had a substantial and lasting impact, but it is important to remember that these are just a few examples of the racist, oppressive, and unjust colonial policies and practices that continue to shape the experiences of Métis and other Indigenous peoples in Canada. Although an exhaustive review is beyond the scope of this report, other factors that have negatively affected the health and wellness of Métis people, past and present, include scrip, outlawing cultural practices, Indian hospitals, the lack of a land base, overrepresentation in the criminal justice system, and exclusion from federal funding streams dedicated to Indigenous peoples.

Despite these historic and ongoing issues, Métis people continue to demonstrate resilience, finding strength in shared family, community, history, traditions, spirituality, and connectedness to the natural world.[1,32,33] As Métis people across Canada continue to challenge discriminatory laws and policies, court decisions and nation-building efforts are slowly affirming Métis rights and fostering self-determination.

Timeline of Key Legal and Policy Milestones

Métis people in BC and Canada have advocated for their rights within social, structural, and legal systems, making headway particularly in recent decades. The following is a timeline of key legal and policy challenges, decisions, agreements, and milestones regarding Métis rights and status since the early 2000s.

In 2003, the Supreme Court of Canada decision known as *R. v. Powley* affirmed that Métis people have an "Aboriginal right" under Section 35 of the *Constitution Act, 1982* to hunt for food. This decision also set out legal criteria (the "Powley test") by which Métis people and communities in Canada can demonstrate eligibility for Indigenous (Aboriginal) rights.[34,35]

In 2006, MNBC and the Province of BC signed the historic Métis Nation Relationship Accord to strengthen the relationship between the Province and MNBC and to close the gaps in quality of life between Métis people and other BC residents. The Accord focused on health, housing, education, economic opportunities, and Métis identification and data collection.[50]

In 2007, the United Nations General Assembly adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which includes 46 articles that outline the individual and collective rights of all Indigenous peoples. They include rights to cultural and ceremonial expression, language, identity, education, employment, health, and justice, among others. UNDRIP affirms the right of Indigenous peoples to be free of discrimination. It promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their visions of economic and social development.[36,37] Despite issuing a statement of support for UNDRIP in 2010, Canada maintained "objector" status to the declaration until 2016, when it announced its endorsement of UNDRIP as a full supporter, without qualification.[38,39]

The Off-Reserve Aboriginal Action Plan (ORAAP) was announced in 2011, as a collaborative initiative between the BC Ministry of Indigenous Relations and Reconciliation and the BC Association of Aboriginal Friendship Centres (BCAAFC). Its stated aim was to

> *Despite direct assimilation attempts*
> *Despite the Residential School Systems*
> *Despite the strong influences of the Church in Metis communities to ignore and deny our Aboriginal heritage*
> *Despite not having a land base*
> *And despite our own diversity in heritage*
> *We are still able to say we are proud to be Metis*
> *We are resilient as a weed, and beautiful as a wildflower*
> *We have much to celebrate and be proud of*
>
> – Christi Belcourt [22(p.1)]

"...achieve better education and job training, healthier family life and strengthened cultures and traditions" for Indigenous peoples in BC.[42] This was strengthened in October 2014, when the same partners signed the ORAAP Protocol Agreement, committing to advance reconciliation efforts and improve employment outcomes for off-reserve Indigenous peoples through activities such as Indigenous community capacity building, social and economic development, and reducing systemic educational and employment barriers for Indigenous peoples in BC.[43] MNBC and Métis Chartered Communities in BC have received support for various capacity-building initiatives through the ORAAP.[44]

In the 2013 *Manitoba Métis Federation Inc. v. Canada* ruling, the Supreme Court of Canada found that Canada had failed to implement an 1870 commitment to allocate lands for the benefit of Métis children in a manner that upheld "the honour of the Crown."[40] This decision, which led to land claim negotiations between the Government of Canada and the Manitoba Métis Federation (MMF),[41] has been deemed "a significant victory for the MMF and Métis elsewhere in Canada."[40]

In 2015, the TRC of Canada released its final report. This report identified 94 calls to action in areas such as child welfare, education, language and culture, health, and justice, to help "redress the legacy of residential schools" and promote reconciliation between Indigenous peoples and other Canadians.[45(p.1)] For example, TRC Call to Action #20 states, "We call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples."[45(p.3)] The Government of BC has stated its commitment to "...working collaboratively with Indigenous organizations, communities, and stakeholder groups to ensure all parties undertake comprehensive and meaningful actions on all the TRC calls to action."[46]

In 2016, in a legal case referred to as *Daniels v. Canada*, the Supreme Court of Canada ruled that the term "Indian" in subsection 91(24) of the *Constitution Act, 1867* includes all Indigenous peoples, including Métis and non-Status Indians.[47] The full implications of this ruling (the "Daniels decision") are not yet known, but the Congress of Aboriginal Peoples, who participated as an appellant in the case, characterizes the Daniels decision as "...the beginning of a new era for Indigenous peoples..., which finally has made it clear that the Federal Government is legally accountable for Métis and Non-Status Indian interests."[48] In response to the Daniels decision, the Government of Canada has committed to "...working in genuine partnership with Métis and non-Status Indians—based on recognition of rights, respect, and partnership—in order to meaningfully advance the work of reconciliation."[47]

Source: Métis Nation British Columbia. Photo by Kristin Kronebusch.

> *It is vitally important that Métis in British Columbia are included in reconciliation efforts at all levels, and in implementing the principles in the* Declaration on the Rights of Indigenous Peoples Act. *The Métis can only be represented by our own people.*
>
> *Recognizing this, the BC Government has made recent steps in ensuring inclusion of Métis voices and perspectives through increased consultation with the Ministry of Indigenous Relations and Reconciliation. We are also optimistic that we will be able to construct an updated, fulsome government-to-government agreement with British Columbia in the near future.*
>
> – Lissa Smith, Acting President, Métis Nation British Columbia[85]

In BC in 2016, a review of the 2006 Métis Nation Relationship Accord (MNRA) led to the development of the MNRA II. The MNRA II updated the original agreement to include a focus on children, families, justice, and wildlife stewardship, as well as the requirement for annual public reporting, information sharing, and engagement.[50]

In April 2017, the Canada-Métis Nation Accord came into force between the Government of Canada and the Métis Nation (represented by the Métis National Council and its governing members, including MNBC).[51] This Accord establishes a nation-to-nation, government-to-government relationship between Canada and the Métis Nation. It reaffirms the special constitutional relationship that the Métis Nation has with the Crown as partners in Confederation. It also commits these bodies to ending the ongoing impacts of colonialism, while advancing the rights, recognition, and socio-economic status of Métis peoples.[51]

In 2017, MNBC, the First Nations Health Authority, the BCAAFC, and BC Cancer produced *Improving Indigenous Cancer Journeys in BC: A Road Map*. The partnership

that developed this strategy adopted a **distinctions-based** approach to ensuring that the unique needs of patients and families from differing Indigenous communities are recognized and addressed.[52]

On June 7, 2018, MNBC and the provincial government signed the MNBC and British Columbia Joint Commitment to transfer authority for Métis child welfare to MNBC by 2021.[60] The agreement also aims to reduce the number of Métis children and youth in government care and support the preservation

Source: Métis Nation British Columbia.

of families.[65] Debra Fisher, MNBC Minister of Children and Families and Minister of Education, explained that "This commitment between the province and Métis Nation BC allows for the first steps to move forward as a self-governing Nation, honouring our own policies, laws, and traditional values. We must be given the resources and opportunity to re-establish a strong foundation that begins with our children, their families, the close ties between our Chartered Communities and Métis Nation BC. It is time… it is the Métis people's time… to be able to reconnect and re-establish our healthy past to build our future."

In June 2019, the Province of BC released *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* ("the Roadmap"). MNBC was a key partner in the development of the Roadmap. In this document, the Province committed to enhancing capacity for MNBC for priority setting and planning in the context of mental health and wellness, to build on commitments made in the MNRA II and in the spirit of implementing UNDRIP.[53]

In September 2019, BC announced an end to the "birth alert" system, which notified social services—without parental consent—when a baby deemed to be at risk was born. Birth alerts were disproportionately issued against Indigenous and marginalized women.[66]

On November 26, 2019, BC enacted new landmark legislation, the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) and became the first jurisdiction in Canada to confirm its commitment to UNDRIP through provincial legislation. DRIPA requires the Government of BC, in consultation and cooperation with Indigenous peoples, to ensure provincial laws align with UNDRIP, to produce an annual action plan for meeting UNDRIP objectives, and to table an annual report to monitor progress.[54] Additionally, the mandate letters for provincial ministers include direction to review policies, programs, and legislation to determine how to bring the principles of UNDRIP into action in BC. It is not yet clear what this new legislation means for Métis people in BC and how far it may go to redress the history and ongoing legacy of injustice in the province. However, as

outlined in Chapter 6 of this report, this series of Métis Public Health Surveillance program reports will monitor and include data on how many BC government ministries are actively working with MNBC to implement actions under DRIPA.

A new federal law was brought into force on January 1, 2020: *An Act respecting First Nations, Inuit and Métis children, youth and families*. This legislation affirms the inherent right of Métis and other Indigenous peoples to control their own child and family services.[67]

On October 27, 2021, MNBC and the Province of BC signed a Letter of Intent signaling their intention to co-create a collaborative, accountable, "whole of government" approach to Métis—BC government relations. This initiative, which respects Métis self-determination and commits to the development of an Assistant Deputy Minister's committee and a Métis Relations Working Table, is intended to replace the MNRA II.[83]

Source: Métis Nation British Columbia. Photo by Laura Chan.

> *This historic achievement is a tremendous step forward for our Nation and our citizens. It honours the evolution of Métis self-government structures in Canada over the past 300 years and affirms the rights of Métis people as declared in Canada's* Constitution Act, 1982, *the* United Nations Declaration on the Rights of Indigenous Peoples, *the Canada-Métis Nation Accord, and B.C.* Declaration on the Rights of Indigenous Peoples Act. *An exciting new chapter in our history has begun!*
>
> – Lissa Smith, Acting President, Métis Nation British Columbia, on the September 2021 passage of a resolution affirming MNBC as the official Métis Government of the self-governing Métis community in BC[84]

Conclusion

Despite the ongoing legacy of colonialism and oppression based on persistent ideologies of white supremacy, as outlined in this chapter, Métis people have sustained a vibrant culture and communities. The Métis continue to hold a unique place in the history and ongoing development of BC and Canada. The laws and agreements made in the last 20 years demonstrate movement toward reconciliation and increased relationship-building between MNBC and the Government of BC, particularly with the commitments embedded in DRIPA and the 2021 Letter of Intent described above. The next chapter examines broad socio-economic determinants of health and wellness for Métis in BC.

Chapter 3:

Determinants of Métis Health and Wellness

"For many Indigenous populations, health is a communal concept, which has clear implications for understanding determinants of health. For instance, spirituality, relation to the land, and identity are often connected within ideas of overall health, meaning all would have to be incorporated into a framework for determinants of health."

– Miranda Dyck[1(p.7)]

This chapter provides demographic information about Métis people in BC, such as geographic and age distribution. It also examines social determinants of health, including income, education, employment, and housing, and identifies disparities that Métis people face that have broader implications for their health and wellness. Analyses presented in this chapter include data from the Métis Public Health Surveillance (MPHS) program (Métis cohort) and sources such as Canada's Census of Population (for more information on data sources, see Chapter 1 and Appendix B).

Understanding Métis Health and Wellness

In addition to biology and genetics, a person's health and wellness are a result of their social, cultural, economic, physical, and spiritual environments. According to the Public Health Agency of Canada and the Canadian Medical Association, as many as 75 per cent of the factors that influence health and wellness exist outside of the health system.[2(p.xii)] These factors are referred to as "social determinants of health": the conditions that shape people's everyday lives and ability to access resources. These determinants include literacy and access to education, income, food security, social status, employment, and working conditions.[3]

> *To have wellness, it means having access to your culture and to resources and support, and not having to do it alone.*
>
> – Métis Research Participant[6(p.94)]

Structural determinants of health refer to historical, political, societal, and economic factors that have contributed to systemic inequities between groups of people.[j,4,5] These can include inequitable access to housing, green space, safe water, adequate infrastructure, and health care services. In the lives of individuals and broader populations, these determinants overlap and intersect with one another.

Some frameworks include Indigenous identity or status as a determinant of health.[1] However,

[j] There are important differences between health (in)equalities and (in)equities. Health inequalities (or disparities) refer to differences in health status between populations. Health inequities refer to such differences when they are—or are seen to be—unfair and avoidable. Health equity is achieved when the factors (e.g., social, economic, environmental) that lead to these unfair differences are addressed and eliminated.

> *The Red River Cart has become, like the fur trade sash, a passionate and powerful symbol of Métis nationhood in Western Canada.*
>
> *– The Métis: Our People, Our Story*[11(p.119)]

being Indigenous does not lead to poorer health outcomes. Factors linked to colonialism are the actual determinants that place an undue burden of poorer health on some Indigenous peoples. Cultural continuity, language, identity, self-determination, and connection with the land are health determinants of particular relevance to many Indigenous populations.[7,8,9]

For Métis and other Indigenous peoples, the wholistic nature of health determinant frameworks aligns with traditional perspectives on health and wellness, where health is understood as communal and interconnected, and root causes of health or illness are not only social, but also political and historical.[1] For example, both the historic and contemporary denial of Métis identity and Indigeneity have had negative health consequences for Métis people.[1,33] The Métis Wellness Promotion Wheel (Figure 3.1)[10] highlights the importance of identity, unity, and inclusion for Métis wellness. It is based on the Red River Cart, an important symbol of identity for the Métis Nation.[11]

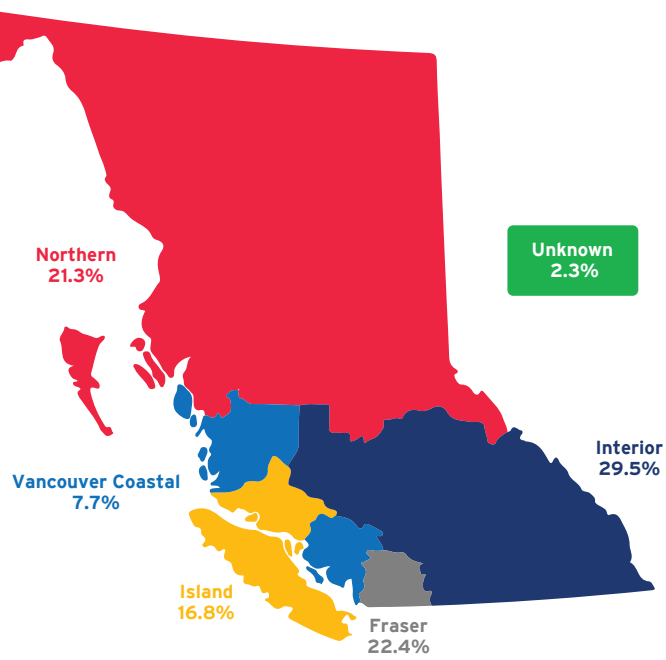
Source: Métis Nation British Columbia. Photo by Colleen Devlin.

This image is part of a poster series created by Michif / Métis Girls, Boys, Youth, Women, and Elders at the Sîhtoskâtowîn (working together. supporting each other) Symposium: Exploring Métis Cultural and Family Values for Métis-specific Violence Prevention, hosted by MNBC and MWBC in 2008.

FIGURE 3.1
MÉTIS WELLNESS PROMOTION WHEEL

When structural and systemic inequities in determinants of health exist, such as social exclusion, discrimination, and colonialism, the downstream effect is **health inequity**, or unjust and preventable disparities in health outcomes for different populations.[12] Gaps in health status between Métis and non-Indigenous people in BC need to be understood within this context of structural and systemic inequities.

FIG 3.2 Geographical Distribution of Métis Population, Age 18+, by Health Authority, BC, 2019



Note: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program.

Source: Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

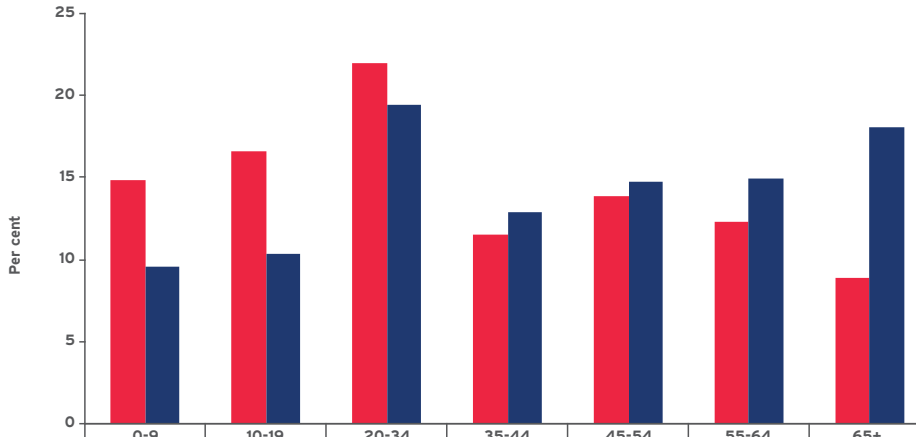
The Métis Population

Geographical Distribution

The geography where people live can affect health in various ways. For example, urban environments typically offer a greater number and variety of services and supports, including access to employment, child care, transportation, health care, and specialists. Accessing these services can be more challenging and costly for people living in rural and remote areas.[13] However, northern and rural/remote areas may offer other benefits, such as increased physical activity, access to green space, and opportunities to connect with the land and nature. In BC, **life expectancy** at birth is lowest in northern and rural/remote regions.[12] Populations of rural/remote residents also generally have poorer overall health and socio-economic status than their urban counterparts.[14] Therefore, geographic distribution can help identify areas that may be underserved and require further support.

These patterns are important for understanding the health of Métis residents in BC, many of whom live in rural/remote areas. Analyses of 2016 census data conducted for this report suggest that people who self-identified as Métis were 3.5 times more likely to live in the Northeast Health Service Delivery Area (HSDA) and 3.0 times more likely to live in the Northern Interior HSDA, compared to non-Indigenous people. Conversely, self-identified Métis people were substantially less likely to live in more urban HSDAs such as Vancouver and Richmond.

FIG 3.3 **Age Distribution of Métis and Non-Indigenous Populations, by Age Group, BC, 2016**



	0-9	10-19	20-34	35-44	45-54	55-64	65+
Métis - Per cent	14.8	16.6	22.0	11.5	13.8	12.3	8.9
Non-Indigenous - Per cent	9.6	10.3	19.5	12.8	14.8	14.9	18.1
Métis - Count	13,240	14,880	19,670	10,275	12,370	11,030	7,940
Non-Indigenous - Count	410,520	443,475	835,715	550,930	633,365	641,025	774,625

Age Group

Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. To ensure confidentiality, the counts presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. As a result of this rounding, when these data are summed, the total counts may vary slightly. Similarly, percentages calculated on rounded data may not add up to 100.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016155, accessed February 25, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

As shown in Figure 3.2, approximately half (51.9 per cent) of the MPHS program cohort live in the Interior and Fraser Health regions. Taken together, the census and Métis cohort data suggest that many Métis people live in rural and remote areas.

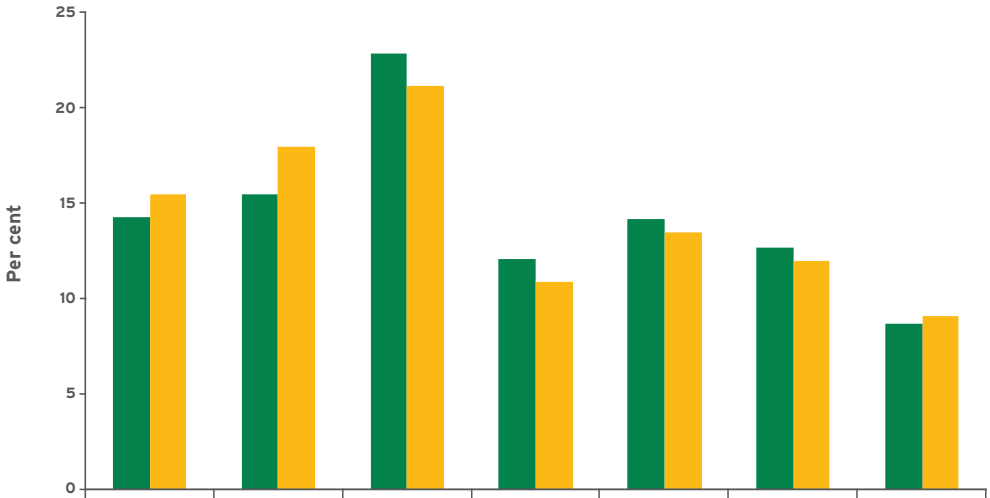
Source: Métis Nation British Columbia. Photo by Isaiah Kervin and Chad Kervin.

Age Distribution

Some health conditions and diseases are more common in specific age groups or have different effects among different age groups; for example, some conditions are more prevalent among older adults. Therefore, it is important to consider the age distribution of a population to understand its health needs. As shown in Figure 3.3, census data from 2016 indicate that the Métis population in BC is substantially younger than the non-Indigenous population, with higher proportions of people between the ages of 0 and 34, and lower proportions in age groups 35 and up. The most marked differences are in the youngest (age 0 to 19) and oldest (age 65 and up) populations.

Due to this age distribution, the Métis population would be expected to have lower rates for chronic diseases that primarily affect the elderly and higher rates for measures

FIG 3.4 Age Distribution of Métis Population, by Age Group and Sex, BC, 2016



	0-9	10-19	20-34	35-44	45-54	55-64	65+
Females - Per cent	14.2	15.4	22.8	12.1	14.1	12.7	8.7
Males - Per cent	15.5	18.0	21.2	10.9	13.5	12.0	9.0
Females - Count	6,635	7,195	10,635	5,640	6,605	5,915	4,070
Males - Count	6,610	7,675	9,035	4,640	5,765	5,120	3,865

Age Group

Notes: "Métis" includes people who self-identify as Métis. To ensure confidentiality, the counts presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. As a result of this rounding, when these data are summed, the total counts may vary slightly. Similarly, percentages calculated on rounded data may not add up to 100.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016170, accessed February 24, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

like injuries, which are more prevalent among younger age groups. The difference in age distribution underscores the importance of using **age-standardized** rates to provide comparable data and to allow for meaningful examination of the effects of preventable underlying issues on Métis health.

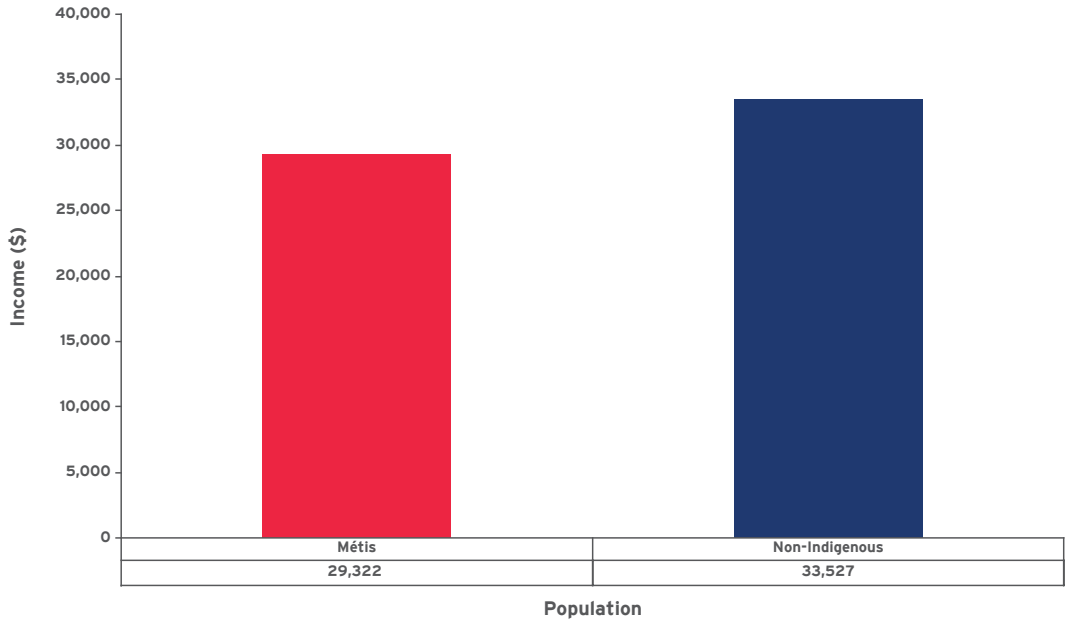
Census data from 2016 also illustrate differences in age distribution between Métis females and males in BC. As Figure 3.4 shows, the proportions of females and males across the life course by age group vary, with a higher percentage of males in the younger age groups (0–19), a higher percentage of females among those age 20 to 64, and a slightly higher proportion of males age 65+. The lower proportion of Métis males in most adult age groups may be partially explained by higher **mortality** rates for males. This is not unique to the Métis population. The lower proportion of females under age 20 reflects a broader national phenomenon of young females in the overall population, and warrants further investigation.

Social Determinants of Health

Income

In early subsistence economies, Indigenous peoples, families, and communities tended to rely on themselves and one another for basic material needs such as food, clothing, and shelter.[16] For the Métis, this reflected traditional values such as independence, autonomy, self-reliance, and resourcefulness or *débrouillardise*.[17] Increased engagement in mainstream market economies such as the fur trade ultimately disrupted traditional subsistence activities and has made many Métis and other Indigenous communities dependent on wage labour and the "formal" (settler) economy.[16]

FIG 3.5 Median Pre-tax Income of Métis and Non-Indigenous Populations, BC, 2016



Note: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016170, accessed February 24, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Data show income disparities between Métis and non-Indigenous residents of BC and Canada. In 2011, 20 per cent of Métis people in Canada lived with low income, compared to just 15 per cent of non-Indigenous Canadians.[37] Figure 3.5 illustrates that Métis people are more likely to be represented in lower income brackets, while non-Indigenous people are more likely to have higher incomes. As shown here, the **median** pre-tax income of self-identified Métis people in BC in 2016 was $29,322, compared to the $33,527 reported by the non-Indigenous population.

This analysis is important because most health conditions have a strong inverse relationship with income. Lower-income individuals tend to have higher rates of health issues than those with a higher income.[9] Therefore, the lower median income among Métis people can be expected to be linked to higher disease rates. Poverty, which disproportionately affects Indigenous peoples, as well as women and children, is associated with poorer physical health (e.g., higher risk of chronic disease, injury, and infant development problems), poorer mental health (e.g., anxiety, stress, depression, low **self-esteem**), and even premature death.[38] Lower income can also exacerbate problems by restricting a person's ability to access sufficient healthy food and pursue a healthy lifestyle,[9] to travel for tests and health care services,[13] or to purchase required medications.[18] Low income is also linked to substandard housing, which—as discussed in the following pages—is associated with additional risks to health and wellness.[9]

Educational Attainment

Education in traditional Métis communities included a focus on the practical skills needed to survive and raise families (e.g., harvesting, healing, sewing), and these skills were typically passed from parents to

THE FLOWER BEADWORK PEOPLE

"By the 1830s, increasingly naturalistic and colourful floral designs became evident on Métis products from the Red River region. Beadwork was found on almost every item of traditional Métis clothing and functional hide and cloth work. The glass beads they used were procured from the trading companies. Beaded clothes included moccasins, coats, vests, belts, bags and mittens. Beadwork was also done on tablecloths, wall pockets and cloth frames for religious pictures.

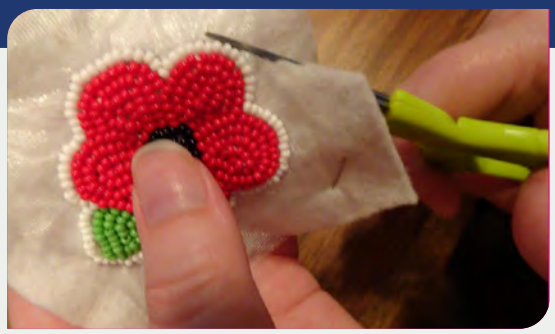
Beaded creations were, and still are, an important source of income for many Métis women and families. Generations of Métis women have produced countless *objets d'art* for loved ones and for sale. Many contemporary Métis artisans... continue to bead pieces such as moccasins, coats and mittens that are housed in museum collections across the Métis Nation Homeland."

– Indigenous Peoples Atlas of Canada[15]

Source: Métis Nation British Columbia. Photo by Emerald UnRuh.

Source: Métis Nation British Columbia. Photo by Margaret Biagioni.

Source: Métis Nation British Columbia. Photo by June Graham.



Source: Métis Nation British Columbia.

Source: Métis Nation British Columbia. Photo by Debbie Terlesky.

Source: Métis Nation British Columbia. Photo by Sherry Leigh Williams.

Source: Métis Nation British Columbia. Photo by June Graham.

Source: Métis Nation British Columbia. Photo by Natalie Robertson.

> *Mainstream institutions of higher education must recognize the level of cultural conflict that is still present and develop programs to bridge the gap for Indigenous youth that are attempting to navigate both worlds.*
>
> – "First Nation and Métis Youth Perspectives of Health: An Indigenous Qualitative Inquiry"[19(p.2)]

their children.[23] However, Métis education also encompasses more wholistic teachings with respect to Métis cultural and spiritual values and ways of being, such as living in harmony with the land and respecting the plants and animals that live there.[20,24] These types of education were—and still are—often passed on to younger generations through stories told by Elders and Knowledge Keepers.[20] Learning **Michif** and/or other Indigenous languages is another essential element of Métis education, facilitating communication in a way that honours Métis identity, history, traditions, and ways of seeing the world.[24,25] Delivering education in Indigenous languages has been associated with improved academic performance for Indigenous children.[25]

INCREASED SUPPORT FOR MÉTIS STUDENTS

In March 2019, the Government of Canada announced an investment of $362 million over 10 years, and $40 million ongoing, for the ***Métis Nation Post-Secondary Education Strategy,*** developed in partnership with the Métis National Council and its governing members. The strategy is intended to promote Métis self-determination and reconciliation, help provide Métis students with the same opportunities for success as other post-secondary students in Canada, and reduce labour market gaps between Métis and non-Indigenous Canadians.[21,22]

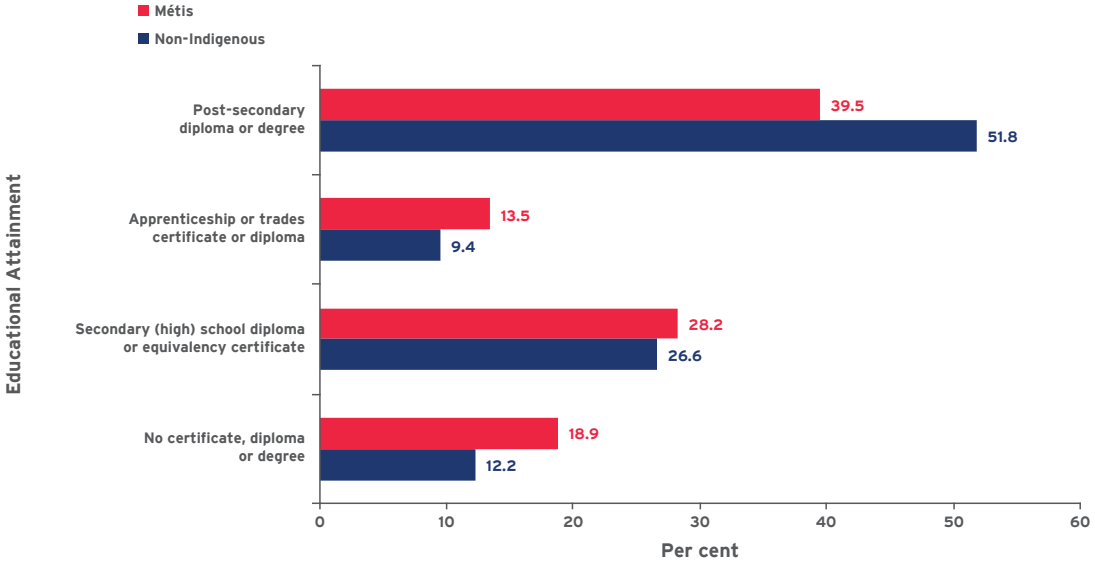
Métis people are resilient, and many thrive in the mainstream education system; however, as discussed below, there are gaps in educational attainment between Métis and non-Indigenous BC residents. The Métis Nation Post-Secondary Education Strategy (see sidebar) is intended to help address these gaps.

Similar to income, most health challenges follow an educational gradient, with the highest rates of disease among people with lower levels of education.[9] Generally, lower levels of education are associated with lower income levels as well as lower levels of **health literacy**,[26] which makes navigating the health system and health resources more challenging for individuals. From a health services perspective, lower health literacy can also pose challenges for health promotion activities intended to prevent poor health outcomes.

Figure 3.6 shows the highest level of education reported by Métis and non-Indigenous residents of BC, age 25 and up, in the 2016 Census. Overall, these data show that Métis people had lower levels of educational attainment.

Source: Métis Nation British Columbia. Photo by Carmen Olson.

FIG 3.6 **Educational Attainment of Métis and Non-Indigenous Populations, Age 25+, BC, 2016**



Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. To ensure confidentiality, the counts used to calculate the percentages presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. Percentages calculated on rounded data may not add up to 100.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016264, accessed April 2, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, April 2020.

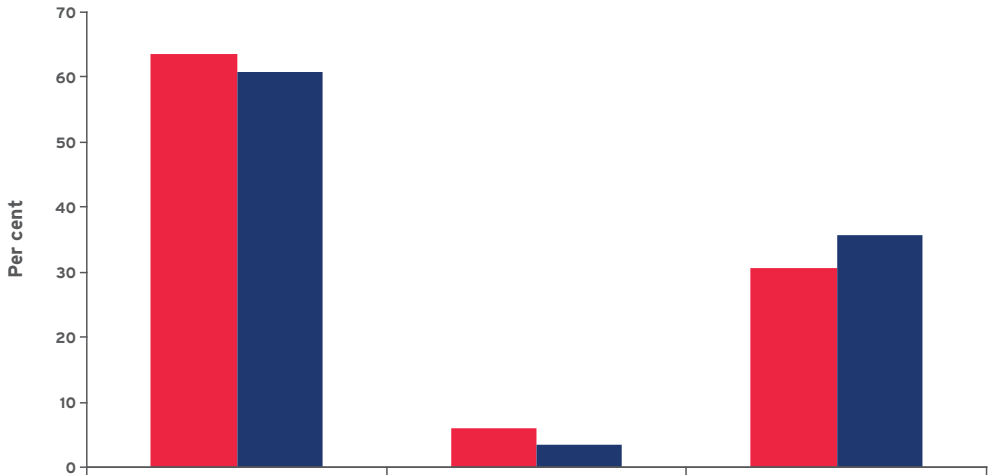
For example, Métis people were substantially less likely to have a post-secondary education (39.5 per cent of Métis compared to 51.8 per cent of non-Indigenous people) and were slightly more likely to report that a high school diploma or equivalency certificate was the highest level of education they had completed. Métis people were also more likely to report having no certificate, degree, or diploma (18.9 per cent of Métis compared to 12.2 per cent of non-Indigenous people). However, Figure 3.6 also shows that Métis people were more likely to have completed an apprenticeship or trades certificate or diploma (13.5 per cent of Métis compared to 9.4 per cent of non-Indigenous residents).

Employment and Labour Force Participation

Métis people in BC and Canada have engaged in diverse forms of employment, both historically and now. Métis are frequently linked to the historic fur trade, and traditionally acted as guides, farmers, hunters, traders, and artisans known for their elaborate beadwork.[15,28] Today, for Métis citizens in BC requiring employment support, Métis Nation British Columbia offers the Métis Employment & Training Program to improve their employment potential, earning capacity, and self-sufficiency.[29]

Participating in the **labour force** through employment can provide important mental and emotional benefits (e.g., having a sense of purpose, feeling good about oneself, social connectedness), in addition to the benefit of having an income that helps one access food, shelter, and other necessities. The labour force includes those who are currently employed and those who are currently unemployed but seeking employment. It does not include those who are neither employed nor seeking employment (e.g., students, retired people).

FIG 3.7 Employment Status of Métis and Non-Indigenous Populations, Age 25+, BC, 2016



	Employed	Unemployed	Not in Labour Force
Métis	63.5	5.9	30.6
Non-Indigenous	60.8	3.5	35.7

Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. To ensure confidentiality, the counts used to calculate the percentages presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. Percentages calculated on rounded data may not add up to 100.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016176, accessed March 9, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

> *Historically, the Métis were the lifeblood of the west. Our ability to communicate in so many languages was incredibly useful in many traditional occupations: voyageurs, bison hunters, boatmen, fishermen, traders, small-business owners, lumbermen, farmers, cattlemen, and certainly highly regarded interpreters. To this day, many Métis people still speak or understand multiple languages, an important part of our cultural legacy.*
>
> – Métis Youth British Columbia[27]

In 2016, the proportion of Métis in BC age 25 and up who were active in the labour force was higher than the proportion in the non-Indigenous population. As shown in Figure 3.7, Métis adults were more likely to be employed than non-Indigenous adults in this age group (63.5 per cent compared to 60.8 per cent). They also had greater rates of unemployment: 5.9 per cent of Métis reported being unemployed, compared to 3.5 per cent of non-Indigenous people. Chronic unemployment can have important physical and mental health consequences and has been associated with anxiety and depression.[26,30] The proportion of people who were not in the labour force (for example, retired people and students, who are neither employed nor looking for work) was lower among Métis, with 30.6 per cent of Métis not being in the labour force, compared to 35.7 per cent of non-Indigenous people.

Additional analyses conducted for this report (see Appendix D) show that the greatest proportion of working-age Métis people in BC are employed in retail (12.9 per cent), health care and social assistance (11.4 per cent), construction (10.4 per cent), and accommodation and food services (10.4 per cent). These are four of the five industries with the highest numbers of reported workplace injuries in BC,[31] which may partially explain why Métis males have the highest rates of **unintentional injury** hospitalizations (see Chapter 5 for more information). With the exception of construction, these are also among the lowest-paying employment sectors in BC,[32] which aligns with the finding of a lower median income among Métis people in BC, as presented in Figure 3.5.

When compared to non-Indigenous people in BC, Métis people are twice as likely to be employed in industries such as forestry and logging, mining and quarrying, and oil and gas extraction. While these are among the highest-paying industries in BC,[32] they are also linked to relatively high rates of employment-related injury and fatality.[31] Métis individuals are substantially less likely than non-Indigenous people to be employed in fishing, hunting, and trapping; professional, scientific and technical services; and finance and insurance (Appendix D).

According to the 2017 Aboriginal Peoples Survey, 14 per cent of employed Métis people in Canada were self-employed. This was highest in BC, at 18 per cent. The top reason given for choosing to be self-employed was freedom/independence (37 per cent). Flexible work hours and the possibility of greater income were noted as additional incentives.[34]

Housing

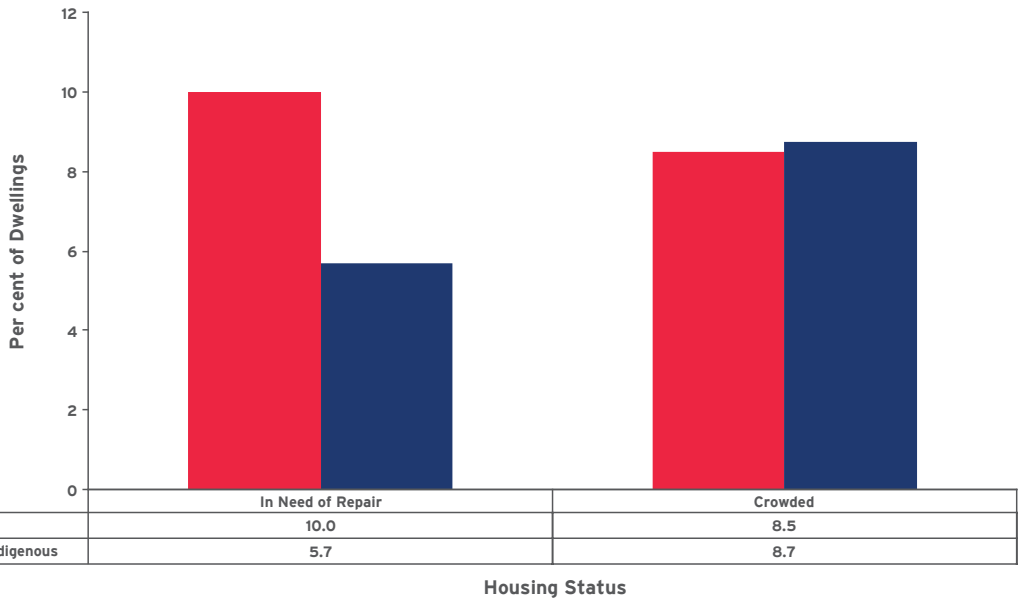
Historically, Métis used a wide variety of building and housing styles, ranging from mobile shelters suited to relatively nomadic lifestyles, to temporary winter houses *(maisons d'hiver)*, and to more permanent log cabins, some of which housed multiple families.[35] Analysis of the more recent "Métis folk houses," which were constructed into the 1930s, suggests that Métis principles and values such as egalitarianism, consensus, communalism, and connectedness to nature were reflected in the design and spatial arrangement of these homes.[36]

> *I think the end goal is a healthy space for Aboriginal people in this society where they are recognized, respected and honoured as a people, as the founding peoples of this country. And where there are opportunities for them to grow and become productive, healthy, participating members of society.*
>
> – Jean Teillet, Métis Lawyer[33(p.27)]

Then as now, adequate, suitable, and affordable housing can provide an environment for living active and healthy lives. Conversely, substandard housing can be associated with

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

FIG 3.8 Housing Status of Métis and Non-Indigenous Populations, BC, 2016



Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. "In Need of Repair" refers to need for major repairs. "Crowded" refers to one or more bedroom(s) shortfall. To ensure confidentiality, the counts used to calculate the percentages presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016164, accessed February 24, 2020. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

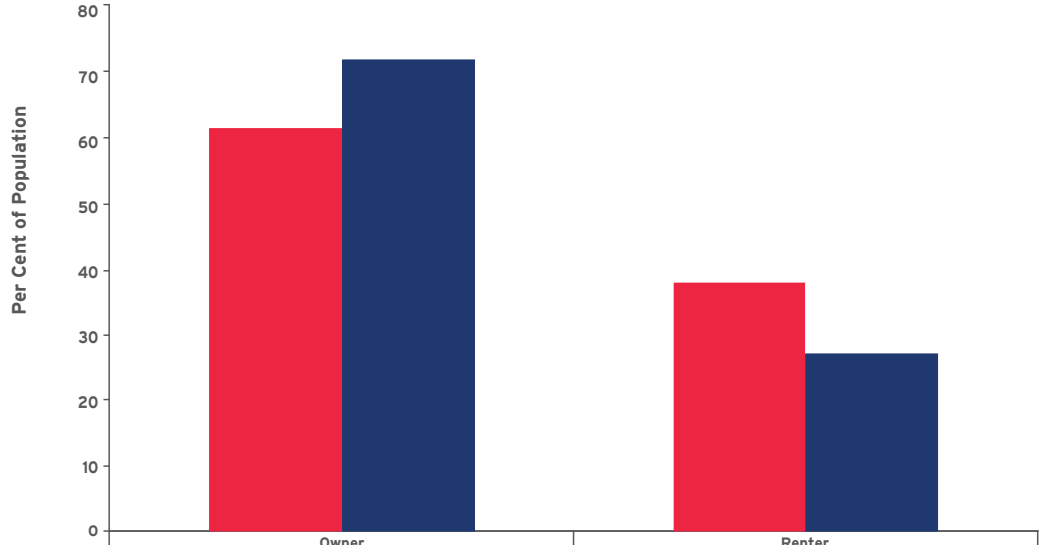
a variety of health consequences, particularly with respect to respiratory conditions linked to mold or other toxic substances.[9] Unsafe housing features (e.g., poor lighting, poorly installed flooring, poorly designed stairs) may contribute to falls and related injuries.[9] As a further illustration of the deep connections between the social determinants of health and actual health and wellness outcomes, inadequate housing has been identified as a risk factor for issues ranging from poor mental health to **infant mortality**.[9]

> *No matter how they lived, the Métis had the artistic ability to decorate their homes with their handicrafts, thus making the most Spartan living quarters livable. Copper kettles, pots, and plates were hung from the walls to keep them from being broken and to minimize clutter*
>
> *– Traditional Métis Housing and Shelter*[35(p.6)]

As illustrated in Figure 3.8, according to the 2016 Census, 10.0 per cent of Métis people in BC reported that their home was in need of major repairs. This was substantially higher than the 5.7 per cent of non-Indigenous respondents who rated their homes as in need of repair; however, this also means that approximately nine out of ten Métis households reported that their home was not in need of major repair. Fewer than one in ten Métis households reported that their household was crowded, which is similar to the percentage reported by non-Indigenous households.

As Figure 3.9 shows, Métis people are more likely to be renters and less likely to own their own homes than **non-Métis** people in BC. The higher concentration of renters in the Métis population may

FIG 3.9 Housing Tenure of Métis and Non-Métis Populations, BC, 2016



	Owner	Renter
Métis	61.8	38.2
Non-Métis	72.5	27.3

Housing Tenure

Notes: "Métis" includes people who self-identify as Métis; "Non-Métis" includes people who do not self-identify as Métis. Includes individuals of all ages living in private households. To ensure confidentiality, the counts used to calculate the percentages presented in this chart are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. Percentages calculated on rounded data may not add up to 100.

Source: Statistics Canada – 2016 Census. Tenure and Aboriginal Identity for Population in Private Households of Canada, Provinces and Territories. Special tabulation. Prepared by Métis Nation BC, October 2020.

Source: Métis Nation British Columbia.
Photo by Métis Nation Columbia River Society.

reflect both the younger age and generally lower incomes of the Métis population.

Conclusion

This chapter provides demographic information about Métis people in BC, including the geographic and age distribution of the Métis population, and explores a range of key socio-economic determinants of health. It shows that the Métis population is spread across all health regions in BC but has considerable proportions in rural/remote areas. It also illustrates that the Métis population is younger than the non-Indigenous population of BC. Data presented in this chapter show that Métis people had a lower median pre-tax income than non-Indigenous people and were less likely to have a post-secondary degree, but were more likely to have an apprenticeship or trades certificate or diploma. Métis also had a slightly higher proportion of labour force participation than non-Indigenous people, but were more likely to report that their home was in need of repair. These disparities in determinant factors are likely to contribute to disparities in health and wellness outcomes between Métis and other populations. The next chapter examines the health and wellness of Métis youth in BC.

Chapter 4:

Métis Youth Health and Wellness

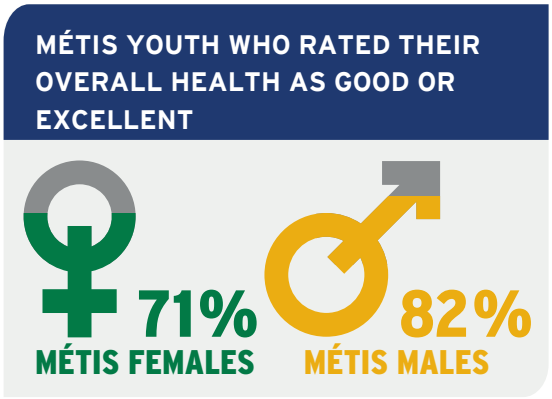
"We must cherish our inheritance. We must preserve our nationality for the youth of our future. The story should be written down to pass on."

– Louis Riel [1]

Source: Métis Nation British Columbia. Photo by Justin Turner.

Métis youth have unique needs and should be supported to achieve their best health and wellness. They also have an important cultural role as those who will carry on Métis culture and traditions and become future leaders. As one Métis educator explains, the youth are "…where the hope lies."[2] This chapter explores the social, cultural, spiritual, mental, emotional, and physical health and wellness of Métis youth in BC.

Since data within the Métis Public Health Surveillance (MPHS) program focus on Métis citizens age 18 and up, this chapter focuses on data derived from the BC Adolescent Health Survey (BC AHS). The BC AHS is an anonymous survey conducted by the McCreary Centre Society that is completed by students in grades 7 to 12 (age 12–19) in schools across the province (see Appendix B for more information).



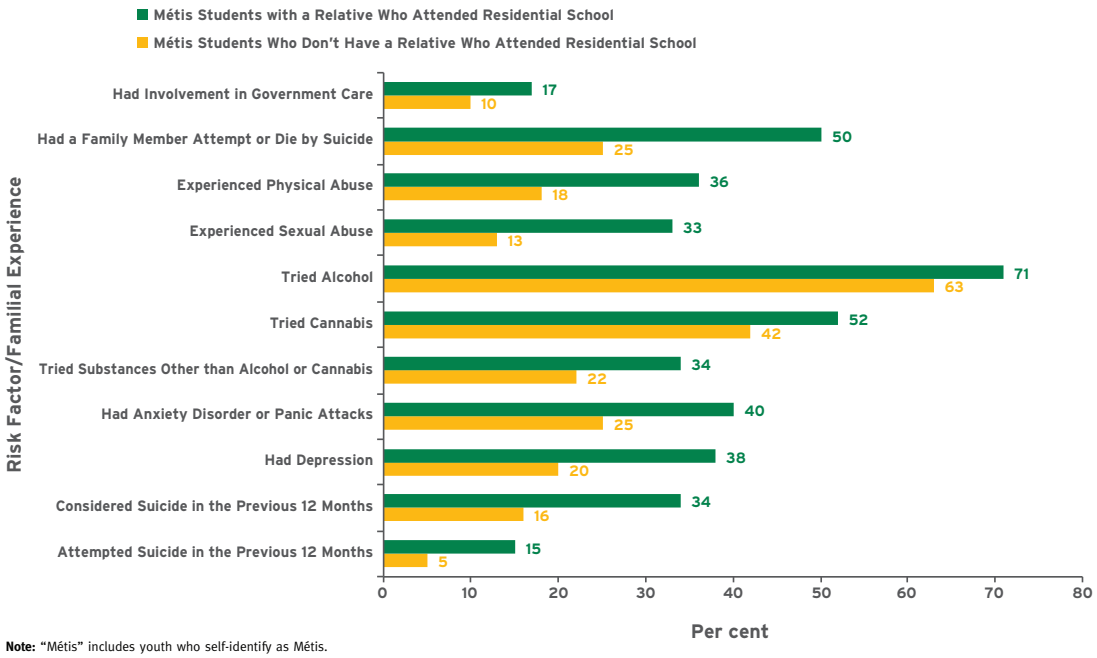
Source: BC Adolescent Health Survey, 2018

The information presented in this chapter is intended to supplement the MPHS program data presented in Chapter 5. BC AHS data in this chapter help to identify areas of strength as well as potential opportunities and areas of focus to improve Métis youth health and wellness in BC.

Overall Health and Wellness

Overall, findings from the BC AHS show high levels of positive *(good* or *excellent)* health reported among Métis youth. However, analyses also reveal inequities between Métis and non-Métis youth as well as sex- and gender-

FIG 4.1 **Risk Factors and Familial Experience of Residential School Among Métis Youth, Age 12-19, BC, 2018**



Note: "Métis" includes youth who self-identify as Métis.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

based inequities. For example, 76 per cent of Métis youth rated their overall health as *good* or *excellent,* compared to 81 per cent of their non-Métis counterparts.[3] Among Métis youth, males were more likely than females to rate their health as *good* or *excellent* (82 per cent of males compared to 71 per cent of females).

About two-thirds (67 per cent) of Métis students and 73 per cent of non-Métis students reported feeling safe at school. Métis males (73 per cent) were more likely than Métis females (64 per cent) to feel safe at school, and both of these groups were more likely to feel safe at school than **non-binary**[k,3] Métis youth (40 per cent, although this number should be interpreted with caution due to a higher than expected standard error).[3]

> *I didn't go to residential school but my dad was affected; he never said 'I love you' but I know he loved me; I express to my children and grandchild 'kisakihitin' – 'I love you.'*
>
> – Participant, Métis Nation Residential School Dialogue[4(p.19)]

The Impact of Residential Schools

Among Métis youth surveyed in the 2018 BC AHS, 24 per cent reported that a family member had attended residential school. This included 1 per cent of youth with a parent who attended, 10 per cent with a grandparent who attended, and 16 per cent with another family member who attended.[3] Findings from the study demonstrate that the ongoing and intergenerational impacts of the residential school system (as discussed in Chapter 2) continue to have repercussions for the health and wellness of Métis youth.

As shown in Figure 4.1, students with a family member who attended residential school were more likely to report a number of risk factors and

[k] McCreary Centre Society defines *non-binary* youth as those whose gender identity is neither female nor male, or who are not yet sure of their gender identity.

> *In our communities... we can see the connection between unresolved trauma, fractured identity, fractured parenting and the socio-economic effects.*
>
> — Victoria Pruden, former Vice President, Métis Nation of Greater Victoria[5(p.23)]

harms associated with poorer health and wellness outcomes. For example, youth with a family member who attended residential school were substantially more likely to have been involved in government care; to have a family member who attempted or died by suicide; and to have tried alcohol, cannabis, and/or other substances. They also were more likely to have experienced anxiety/panic attacks or depression; to have considered and/or attempted suicide in the previous 12 months; and to have been physically and/or sexually abused in their lifetime.

The remainder of this chapter examines different dimensions of Métis youth health and wellness outcomes, and outlines disparities identified between Métis and non-Métis youth, and/or differences by sex and gender.

Source: Métis Nation British Columbia. Photo by Ashley Turner.

Cultural and Spiritual Health and Wellness

Cultural Connectedness

Cultural connectedness offers Métis youth opportunities to explore Métis identity, engage in Métis traditions, and feel a sense of belonging. In the 2018 BC AHS, one in five Métis youth reported participating in traditional or cultural activities in the previous year, and 5 per cent reported participating in these activities at least once per week. Survey results showed that youth who participated in cultural activities were more likely to volunteer and to feel connected to their community.[3]

Connectedness to the land and nature is another important aspect of Métis culture. In 2018, half (50 per cent) of Métis youth reported that they *often* or *always* felt connected to the land and nature. Youth who felt this connection were more likely to report *good* or *excellent* mental health (64 per cent). In comparison, 53 per cent of those who *rarely* or *never* felt connected to the land reported *good* or *excellent* mental health. Connection to land was also linked to stress management: 20 per cent of youth who felt connected to the land reported that they managed stress very well, compared to 11 per cent of those who *rarely* or *never* felt connected to the land.[3]

> *The Métis are well known as speakers of many languages. In the past, Métis spoke up to five or six languages, including Michif, French, English, Cree, Ojibway, and Bungee.*
>
> – Métis Youth British Columbia[7]

> *Western society is about self, 'I' instead of 'we.' Feeling the community again would help a lot of people feel safe and happy and comfortable.*
>
> — Métis Youth Consultation Participant, McCreary Centre Society[6(p.48)]

Language

Indigenous language learning is an important part of Métis identity, tradition, and cultural connectedness. Among 2018 BC AHS respondents, when asked if they spoke an Indigenous language, 13 per cent of Métis youth reported that they did, including 2 per cent who could hold a conversation or were fluent in an Indigenous language. Youth in the Vancouver Coastal Health Region were about twice as likely as those in the Fraser and Island Health Regions to speak an Indigenous language.[3] In 2016, McCreary Centre Society reported that "Métis youth… talked about wanting more opportunities to learn the Michif language, and felt the language was important to their sense of culture and identity."[6(p.52)] Youth who could hold a conversation or were fluent in an Indigenous language were more likely to report

> *I have one Elder who speaks Cree but that's it. It has to be self-taught or online.*
>
> – Métis Youth Consultation Participant, McCreary Centre Society[6(p.52)]

that they planned to finish high school (97 per cent, compared to 87 per cent of those who spoke a few words or less).[3]

In the 2016 Census, 0.6 per cent of Métis people in BC indicated that they were able to conduct a conversation in an Indigenous ("Aboriginal") language.[8] The higher rate of

LEARNING MICHIF

To help promote Michif language learning and revitalization, Métis Youth BC and Métis Nation BC developed the www.LearnMichif.com website, which includes language lessons, videos, information on Métis culture and identity, and storytelling by Métis youth.[10]

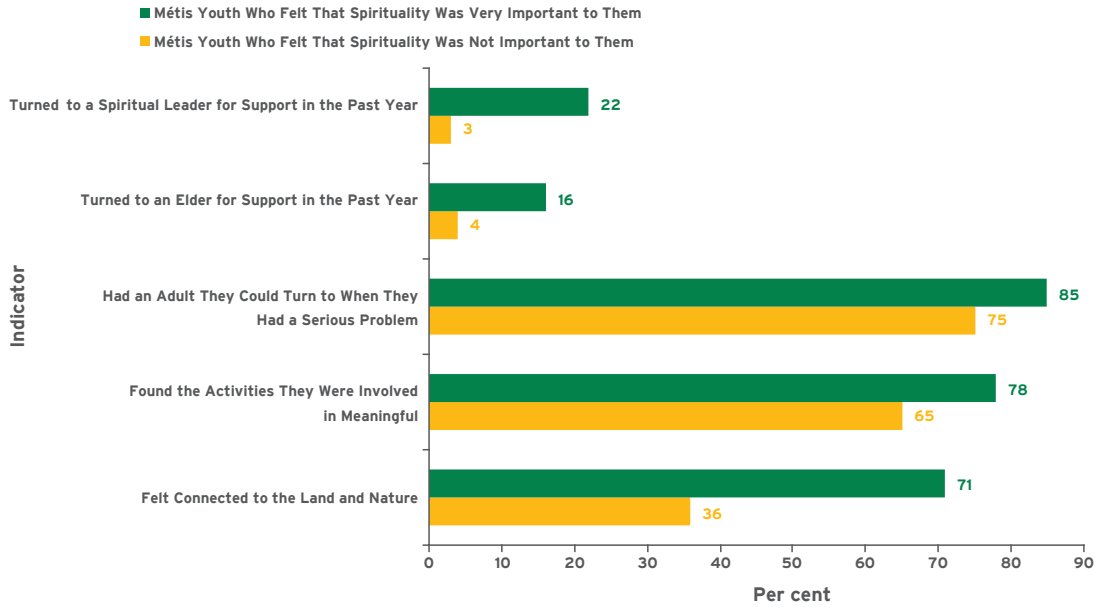
In addition, the Gabriel Dumont Institute offers an online Michif Dictionary, available at http://www.metismuseum.ca/michif_dictionary.php .[11]

2 per cent reported among Métis youth in the 2018 BC AHS may suggest a resurgence of Indigenous language-learning among Métis people in BC.

In 2018, the Province of BC committed $50 million over three years to support the revitalization of Indigenous languages in BC, noting the "…strong link between linguistic and cultural identity and social, mental and physical well-being."[9]

Source: Métis Nation British Columbia. Photo by Jackie Maurer.

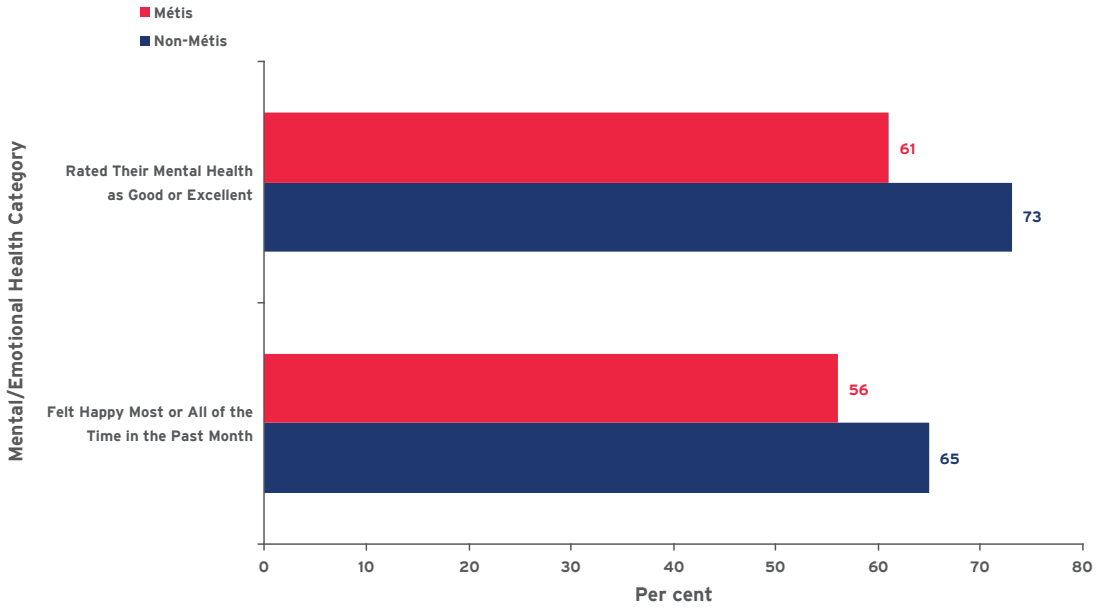
FIG 4.2 Wellness Indicators of Métis Youth, Age 12-19, by Importance of Spirituality, BC, 2018



Note: "Métis" includes youth who self-identify as Métis.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 4.3 Positive Mental/Emotional Health of Métis and Non-Métis Youth, Age 12-19, by Mental/Emotional Health Category, BC, 2018



Note: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

> *The more supports youth have around them, the more likely they are to succeed.*
>
> – Adult Consultation Participant, McCreary Centre Society[6(p.49)]

Spiritual Health

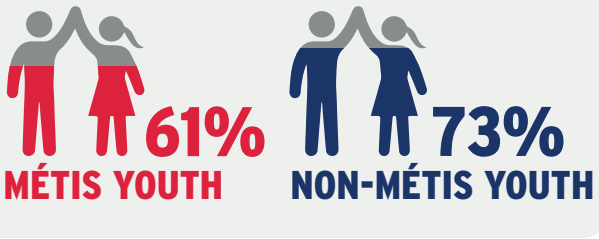
Spirituality is seen as a source of strength and cultural connection for Métis youth and their communities.[13,14] In 2018, more than one-third (35 per cent) of Métis youth who responded to the BC AHS said that spirituality was *somewhat* or *very important* to them. As shown in Figure 4.2, those for whom spirituality was *very important* (13 per cent) were more likely to report positively on several wellness indicators than those for whom spirituality was not important.

Mental and Emotional Health

Mental health is a key component of overall health and wellness and has been identified as a priority for Métis people and communities in BC.[12] The 2018 BC AHS revealed pronounced differences between the mental health status of Métis youth compared to non-Métis youth. As shown in Figure 4.3, Métis youth were less likely than non-Métis youth to rate their mental health as good or excellent (61 per cent of Métis youth compared to 73 per cent of non-Métis youth). Métis youth were also less likely to report feeling happy most or all of the time in the past month (56 per cent of Métis youth compared to 65 per cent of non-Métis youth). The 2018 BC AHS also showed that Métis youth were substantially more likely than their non-Métis counterparts to report a variety

> *Being Métis is something kind of cool, it's becoming more popular. I think more youth will identify [as Métis] in the future.*
>
> – Respondent, 2013 BC Adolescent Health Survey[31(p.9)]

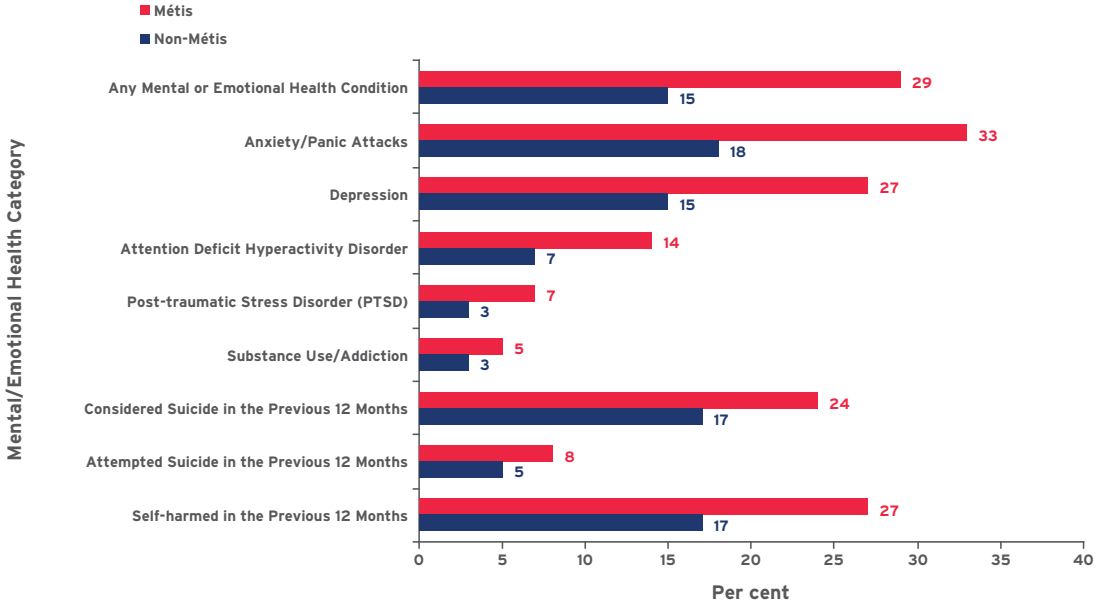
YOUTH WHO RATED THEIR MENTAL HEALTH AS GOOD OR EXCELLENT



See Figure 4.3. Source: BC Adolescent Health Survey, 2018

Source: Métis Nation British Columbia. Photo by June Graham.

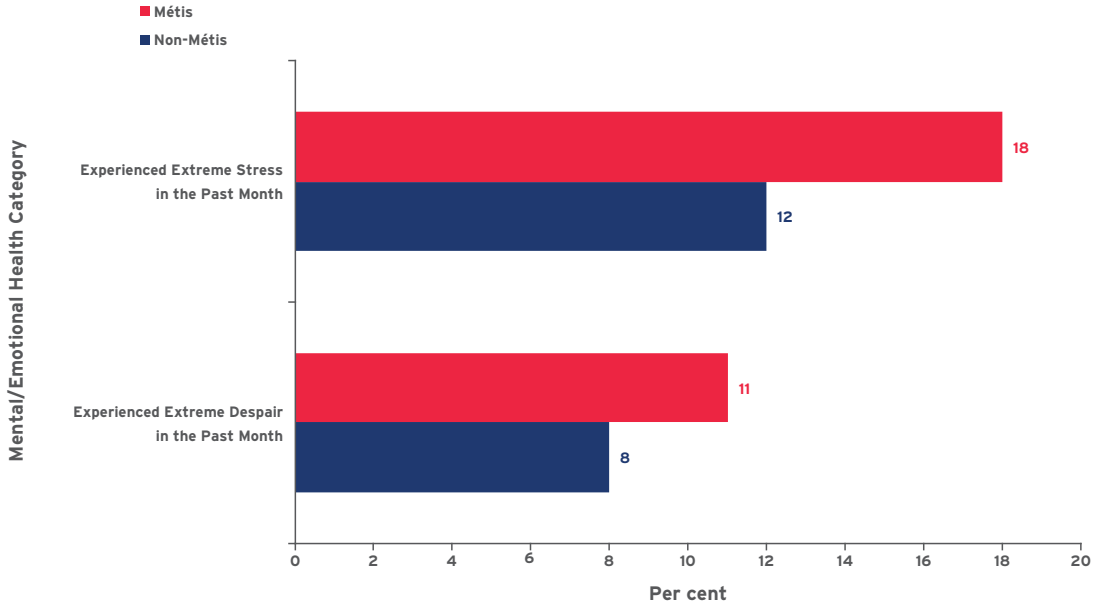
FIG 4.4 Mental/Emotional Health of Métis and Non-Métis Youth, Age 12-19, by Mental/Emotional Health Category, BC, 2018



Notes: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis. Youth could choose more than one mental health category.

Sources: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020. Smith A. Personal communication. McCreary Centre Society; May 2020.

FIG 4.5 Negative Mental/Emotional Health of Métis and Non-Métis Youth, Age 12-19, by Mental/Emotional Health Category, BC, 2018



Note: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis.

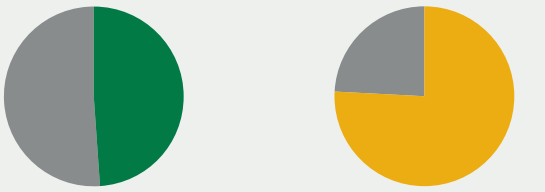
Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

of mental health conditions and problems (see Figure 4.4). This includes higher proportions of Métis youth who reported anxiety/panic attacks, depression, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and substance use/addiction. Métis youth were also much more likely than non-Métis youth to have considered suicide, to have attempted suicide, and to have self-harmed in the 12 months before the survey. As Figure 4.5 shows, Métis youth were also more likely to report experiencing extreme stress and/or extreme despair in the month before the survey.

> *We have to put ourselves back together. So mental health isn't just mental health, it's spiritual health, physical health, and emotional health as well.*
>
> – Métis Research Participant[12(p.94)]

These results highlight a need for additional mental health supports for youth. While all Métis youth may benefit from such enhanced support, as discussed earlier in this report, those living in more rural and remote areas may have greater difficulty accessing quality health services, including counseling.[14] Although the data on mental and emotional health and wellness among Métis youth are a cause for concern and highlight the need for additional supports, they also demonstrate areas of strength and resilience. The 2018 BC AHS found that 81 per cent of Métis youth were able to name something they were really good at (such as sports, school work, or art), up from 75 per cent in 2013.[3] This indicator may be linked to self-esteem, which is an important component of mental health (see text box).[16] However, female Métis youth were less likely to be able to name something they were really good at (78 per cent of Métis females compared to 84 per cent of Métis males).[3] Additional sex and gender differences are discussed in the following section.

MÉTIS YOUTH WHO RATED THEIR MENTAL HEALTH AS GOOD OR EXCELLENT



49% MÉTIS FEMALES

76% MÉTIS MALES

Source: BC Adolescent Health Survey, 2018

SELF-ESTEEM

"When you have good self-esteem, you value yourself, and you know that you deserve good care and respect—from yourself and from others. You can appreciate and celebrate your strengths and your abilities, and you don't put yourself down if you make a mistake. Good self-esteem means that you still feel like you're good enough even when you're dealing with difficult feelings or situations."

– Canadian Mental Health Association, British Columbia Division[15]

Disparities based on Sex, Gender, and Identity

Among Métis youth, two populations were particularly at risk for mental health issues: female and non-binary youth. Female Métis youth were much less likely than their male counterparts to report positive (*good* or *excellent*) mental health. In fact, only 49 per cent of young Métis females

reported positive mental health, compared to 76 per cent of young Métis males.[3]

From 2013 to 2018, negative changes in self-reported mental health were apparent among all youth respondents to the BC AHS.[3] Among Métis youth, the percentage of males reporting positive mental health remained relatively stable during this time, whereas a notable decline was reported among Métis females. The percentage of female Métis youth reporting positive mental health dropped from 65 per cent in 2013 to 49 per cent in 2018.

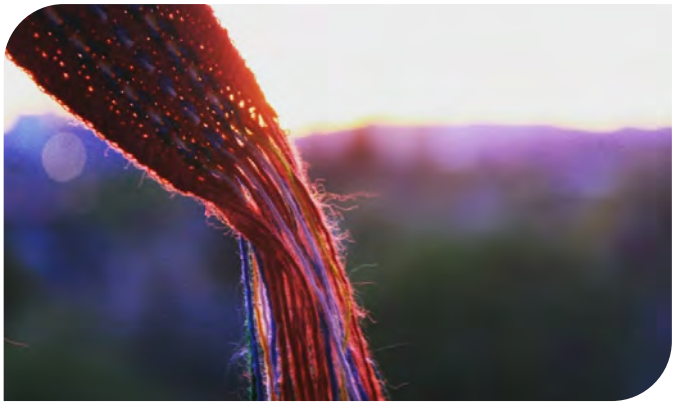
> *Depression is a big deal for me. I'm not open with it at all and have little idea on where to go to get help.*
>
> – Respondent, 2013 BC Adolescent Health Survey[6(p.20)]

The mental and emotional health of non-binary Métis youth has also emerged as an area of considerable concern. In the 2018 BC AHS, 4 per cent of Métis youth identified as non-binary, and 1 per cent identified as **transgender**.[1,3] Among all BC AHS respondents, 2 per cent identified as non-binary and 0.5 per cent as transgender.[32] The BC AHS also found that non-binary youth were more likely than other youth to identify as Two-Spirit, lesbian, gay, or bisexual. This is important

> *[There should be] more workshops specific to Métis students, such as self-esteem, managing anxiety and depression, and more support systems and groups.*
>
> – Métis Youth Consultation Participant, McCreary Centre Society[6(p.26)]

because, as researchers in both Canada and the United States have pointed out, these identities are associated with a range of challenges such as poorer mental health outcomes and increased levels of problematic substance use.[17]

However, because the numbers of BC AHS respondents who identified as non-binary and/or transgender (as well as Métis) are relatively



Source: Métis Nation British Columbia. Photo by Tanya Garneau.

small, the differences may not be statistically **significant** and should be interpreted with caution. Nonetheless, findings do show that Métis youth who identified as non-binary were less likely than Métis male or female youth to rate their mental health as *good* or *excellent*.

Non-binary Métis youth were also much less likely to report feeling happy most or all of the time in the previous month, to report that they usually felt good about themselves, and to report feeling connected to their family. These youth

TRANS CARE BC

Trans Care BC, a program of the Provincial Health Services Authority, coordinates and promotes access to *gender-affirming health care and supports* for people who identify as trans, Two-Spirit, and **gender diverse**.

See www.phsa.ca/transcarebc for further information and resources.[18]

[1] McCreary Centre Society defines *transgender* youth as those whose gender identity is different from the sex they were assigned at birth (e.g., their birth certificate lists female but they currently identify as male, or vice versa).

Source: Métis Nation British Columbia. Photo by Colleen Devlin.

reported substantially higher rates of anxiety disorders/panic attacks, depression, ADHD/attention deficit disorder, and PTSD than other respondents. Non-binary students were also more likely to have experienced extreme stress or extreme despair in the past month and to have considered suicide in the previous year.[3]

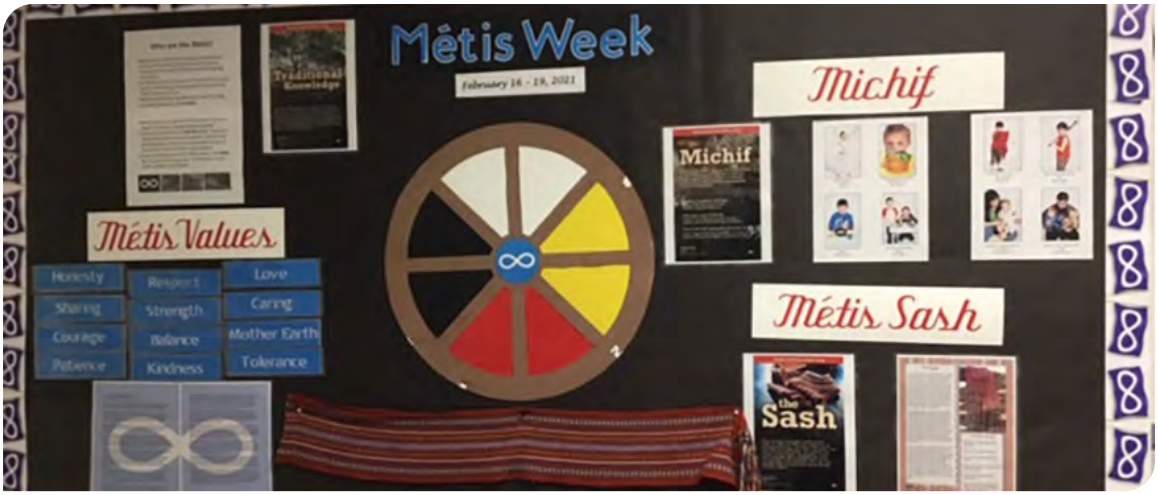
Self-harm (cutting or injuring oneself without intending to commit suicide) also disproportionately affects female and non-binary youth. The proportion of male Métis youth who reported having ever self-harmed (17 per cent in 2018) was relatively consistent over the past decade, while the proportion of female Métis youth who had ever self-harmed increased from 27 per cent in 2008 to 36 per cent in 2013 and 42 per cent in 2018. Non-binary Métis youth were substantially more likely than male or female Métis youth to have self-harmed in the past year.[3]

> *If we talk about intergenerational trauma, we also need to talk about intergenerational healing, and we should also talk about reproductive justice as intergenerational.*
>
> – Jannica, Métis Two-Spirit Woman[33(p.9)]

Sexual and Reproductive Health and Justice

Sexual and reproductive health and justice means having sovereignty over one's own body and sexual and gender identity, as well as having access to culturally safe, culturally appropriate sexual and reproductive health information and services. This includes the freedom to express oneself as female, male, non-binary, LGBTQ+, Two-Spirit, heterosexual, or anywhere else along these spectrums; to decide whether or not to engage in sexual activity, and with whom; and to choose whether or not to have children, with whom, and the circumstances of birthing.[33,34]

Many Indigenous peoples view sex and sexuality as a healthy, natural part of life.[35] Customs and traditions around sexuality and fertility may include open discussion, sex education, and ceremonies to mark the physical and social changes associated with life stages such as puberty, pregnancy, birth, and parenthood.[35,36] Research demonstrates that "coming of age" ceremonies support mental health and self-awareness for Métis and other Indigenous youth, promoting feelings of empowerment, connectedness, and belonging.[37,38] Colonization brought with it a legacy of racism, sexism, **heteronormativity**, and sexual shame (for females and people with non-mainstream sexual and gender identities in particular).[17,35] This legacy continues to undermine Indigenous peoples' rights and self-determination with respect to their bodies, fertility, sexual and gender expression, and sexual and reproductive health and wellness.[33,35]



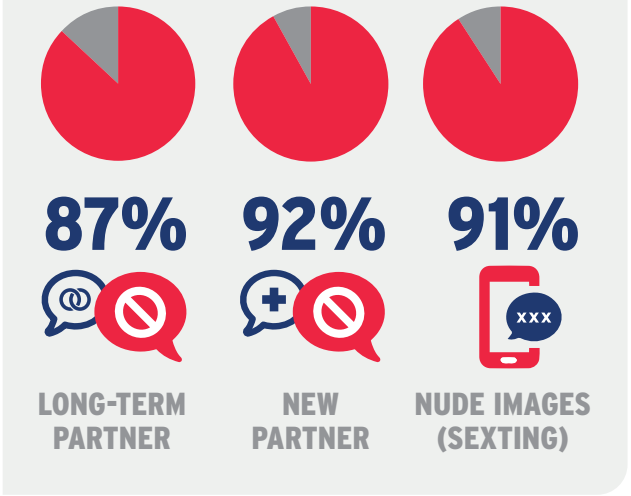
Source: Métis Nation British Columbia. Photo by Sandi Phye and Shannon Campbell.

Sovereignty over one's own body, sexuality, and gender identity is also known as sexual autonomy. One measure of sexual autonomy is in terms of "refusal skills": whether or not one feels empowered enough to say no to unwanted sexual activity. In the 2018 AHS, 87 per cent of Métis youth felt they could say no to sex with a long-term partner, 92 per cent felt they could say no to sex with a new partner; and 91 per cent felt they could say no to sending nude images or sexual texts ("sexting").[3] Although there were no notable age differences in terms of saying no to sex, 96 per cent of older youth (age 17 and up) felt they could say no to sexting compared to 87 per cent of 13- and 14-year-olds.[3]

According to the 2018 BC AHS, 33 per cent of Métis youth age 12-19 have engaged in sexual intercourse, which is higher than their non-Métis peers (19 per cent). Additionally, 34 per cent of Métis youth reported engaging in oral sex, which is also higher than non-Métis youth

Métis Nation British Columbia has partnered with Options for Sexual Health to promote condom use and awareness of the Sex Sense information and resource line among Métis youth.[39]

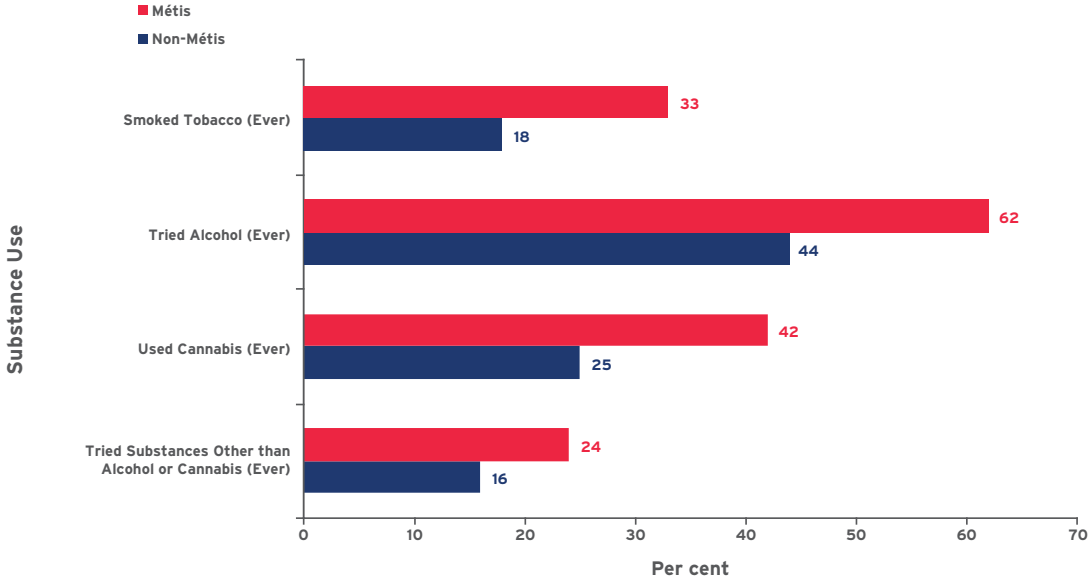
MÉTIS YOUTH WHO FELT THEY COULD SAY NO TO SEX WITH A LONG-TERM PARTNER



Source: BC Adolescent Health Survey, 2018

> *Most students in my school look physically healthy, but are not mentally healthy, as there are a lot of alcohol and drugs, and no spiritual health promotion.*
>
> – Métis Youth Research Participant[14(p.7)]

FIG 4.6 **Substance Use Among Métis and Non-Métis Youth, Age 12-19, BC, 2018**



Notes: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis. "Other Substances" includes prescription drugs without a doctor's consent, mushrooms, hallucinogens (excluding ecstasy/MDMA and ketamine), ecstasy/MDMA, cocaine, inhalants, amphetamines (excluding ecstasy/MDMA and crystal meth), ketamine, GHB, crystal meth, and heroine. Youth could choose more than one substance.

Sources: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020. Smith A. Personal communication. McCreary Centre Society; May 2020.

(21 per cent). These rates have remained relatively consistent among Métis youth since 2008, with no notable gender differences.

Métis and non-Métis youth were equally likely to have used some form of protection the last time they engaged in sexual activity.[3] Among Métis youth who had ever had intercourse, 55 per cent reported having used a condom and 50 per cent reported having used birth control pills or another prescription method of birth control the last time they had intercourse.[m,3]

Reported condom use among Métis youth in 2018 (55 per cent) was lower than it was five years earlier (65 per cent).[3] Despite this, only 1 per cent of Métis youth reported ever being medically diagnosed with a sexually transmitted infection (STI). It is not known whether this reflects low community rates of STIs among Métis youth, or low engagement with health services and STI testing. Two per cent of Métis youth who responded to the 2018 BC AHS reported that they had been involved in a pregnancy, which is similar to percentages reported in 2008 and 2013.[3]

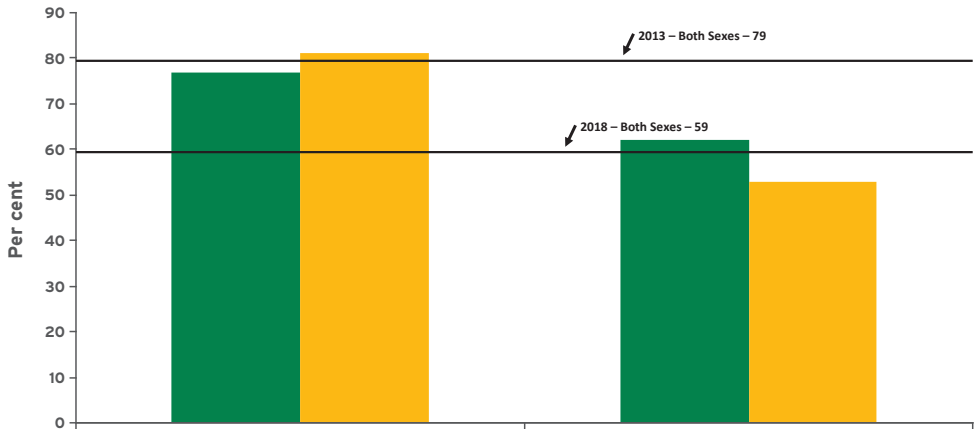
Substance Use

The BC AHS found more substance use among Métis youth than among their non-Métis counterparts. As shown in Figure 4.6, Métis youth reported higher rates of having ever used tobacco (33 per cent), alcohol (62 per cent), cannabis (42 per cent), and substances other than alcohol or cannabis (24 per cent). However, there was no difference between Métis and non-Métis youth for proportions who reported that they consumed alcohol the previous Saturday.[3]

The majority (70 per cent) of Métis youth who reported that they had used alcohol or other

[m] These numbers do not add up to 100 per cent because youth could choose more than one option. Therefore, some used prescription birth control in addition to a condom (and/or other methods) the last time they had sex.

FIG 4.7 **Percentage Who Engaged in Binge Drinking, Among Those Who Drank Alcohol on the Saturday Before the Survey, Métis Youth, Age 12-19, by Sex, BC, 2013 and 2018**



	2013	2018
Females	77	62
Males	81	53

Survey Year

Notes: "Métis" includes youth who self-identify as Métis. "Binge drinking" refers to females who consume three or more alcoholic drinks and males who consume four or more, within a couple of hours.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Vaping with nicotine poses particular risks to children and youth. In addition to respiratory illness, vaping with nicotine can have negative effects on brain development, memory, and concentration, and can lead to the use of other tobacco products. It is against the law in BC to sell vaping products to anyone under the age of 19.[23]

substances indicated that they did so for fun. A large proportion also reported problematic substance use behaviours in response to mental or emotional health issues: 30 per cent reported using substances because of stress and 25 per cent reported using them because they were feeling down or sad. Additionally, 56 per cent of Métis youth who had used alcohol or other substances in the past year reported negative consequences as a result (e.g., doing something they could not remember, passing out, getting injured, or arguing with family members). Eight per cent thought or had been told in the previous 12 months that they needed help for their substance use.[3]

Tobacco Use

It is important to examine tobacco use among Métis youth because Métis adults—especially females—experience very high rates of respiratory illnesses such as chronic obstructive pulmonary disease (COPD) and asthma (see Chapter 5). As shown earlier (Figure 4.6), Métis youth were much more likely than non-Métis youth to have smoked tobacco; however, the 33 per cent rate among Métis youth in 2018 represents a sizeable decrease from the 42 per cent of Métis youth who reported having smoked tobacco in 2008.[19] Among Métis youth who reported in 2018 that they had ever smoked tobacco, 46 per cent had smoked in the month before the survey. Seven per cent of those who had ever smoked tobacco were daily smokers, which is down from 15 per cent in 2008. Similar to other youth in BC and

Canada, Métis youth reported increased rates of electronic cigarette (e-cigarette) use, also known as ***vaping***.[3,6,20]

Vaping

Health Canada advises that vaping may be less harmful than smoking,[21] but it is still dangerous.[20,22] Although vaping can be used as a tool to help quit smoking,[21] research shows that it can also have the opposite effect and make users more likely to start smoking or to smoke more heavily, especially if they vape with nicotine.[20] Vaping exposes users to harmful chemicals and contaminants that have been linked to chronic respiratory conditions such as *bronchiolitis obliterans* ("popcorn lung")[22] and other severe and potentially fatal lung illnesses.[23]

According to the 2018 BC AHS, "vape" pens or sticks, with or without nicotine, were the smoking products most commonly used among all Métis youth in the month before the survey. Both Métis and non-Métis youth who felt connected to their community were less likely to vape than those who did not feel connected to their community.[20] More Métis than non-Métis youth reported having used any kind of vape product (40 per cent of Métis youth and 27 per cent of non-Métis youth). Métis youth were also more likely to have vaped with nicotine in the month before the survey (32 per cent of Métis youth compared to 21 per cent of non-Métis youth).[3]

Alcohol Use

There were no meaningful differences between Métis and non-Métis youth with respect to several alcohol use measures examined in the BC AHS. Métis and non-Métis youth were similar in the percentage who reported drinking alcohol on the previous Saturday. Métis and non-Métis youth who drank the previous Saturday were also similar in the percentages who reported **binge drinking**.[n,3]

Among Métis youth who had consumed alcohol on the previous Saturday, the proportion who reported binge drinking decreased dramatically from 2013 (79 per cent) to 2018 (59 per cent).[3] As depicted in Figure 4.7, this decrease was apparent among both Métis males and

MÉTIS CRISIS LINE

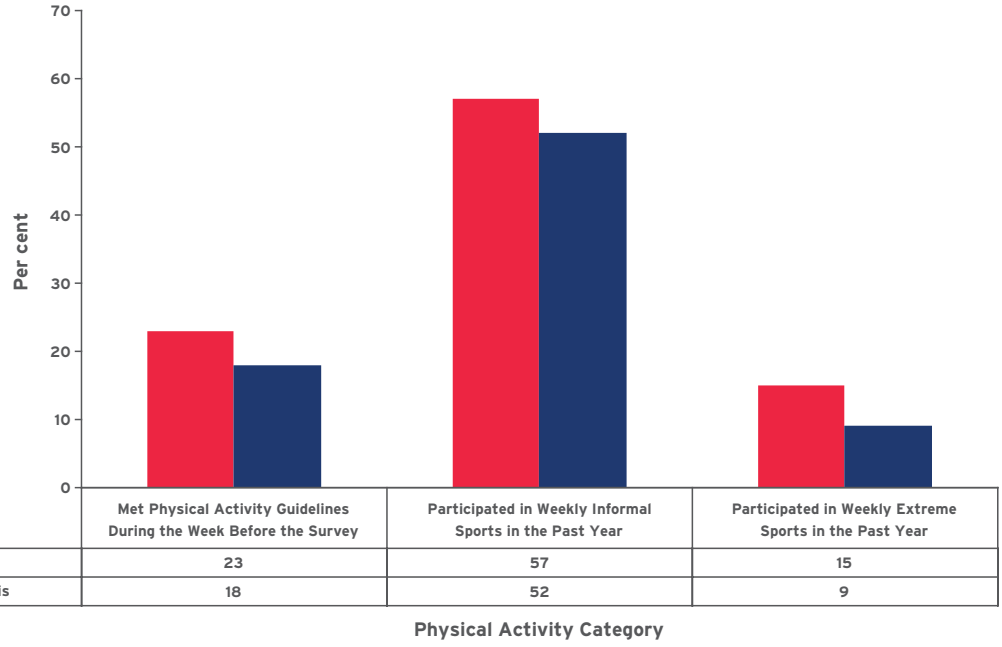
On February 14, 2020, Métis Nation BC and KUU-US Crisis Services announced the launch of the new Métis Crisis Line. The toll-free line is available 24 hours a day, seven days a week, providing Métis people across BC with culturally safe access to crisis support services for a range of issues, including mental health concerns, financial problems, and bullying.[24]

*"Now, more than ever, it is essential that Métis people of **all ages** have the opportunity to access appropriate and timely mental health support. Feedback from the Perceptions of Alcohol and Illicit Drug Use survey clearly demonstrated a need for Métis specific mental health resources."*

– Susie Hooper, Former Minister of Health, Métis Nation British Columbia[24]

[n] "Binge drinking" here refers to female youth who consume three or more alcoholic drinks and male youth who consume four or more, within a couple of hours. For an overview of Canada's low-risk drinking guidelines, please visit https://www.healthlinkbc.ca/health-topics/abj7553.

FIG 4.8 Physical Activity of Métis and Non-Métis Youth, Age 12-19, BC, 2018



	Met Physical Activity Guidelines During the Week Before the Survey	Participated in Weekly Informal Sports in the Past Year	Participated in Weekly Extreme Sports in the Past Year
Métis	23	57	15
Non-Metis	18	52	9

Physical Activity Category

Note: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

females. Métis males showed a decrease from 81 per cent in 2013 to 53 per cent in 2018, while Métis females showed a decrease from 77 per cent in 2013 to 62 per cent in 2018.

Cannabis Use

The 2018 BC AHS was completed shortly before cannabis was legalized for adults in Canada; however, it remains illegal for minors. At the time of the survey, 42 per cent of Métis youth reported having ever used cannabis, compared to 25 per cent of non-Métis youth. The proportion of Métis youth who reported cannabis use in 2018 had decreased from 48 per cent in 2008. There were no notable sex/gender differences in cannabis use identified among Métis youth.[3,6]

Other Substances

As shown earlier in Figure 4.6, Métis youth were more likely to use substances other than alcohol or cannabis, with 24 per cent of Métis youth reporting having tried at least one other substance, compared to 16 per cent of non-Métis youth. For both Métis and non-Métis youth, this was most often the misuse of prescription medications. Notably, there have been decreases in the misuse of prescription medications and the use of almost all other substances among Métis youth over the past decade.[3]

> *Recreational sports are also a great stress reliever from school and work. Recreational sports are not only an important part of my life, but I believe [they] should be an important aspect in everyone's life.*
>
> – Jamie, Métis Youth Research Participant[14(p.9)]

Seeking Help

Seeking help from others shows resilience and the initiative to take control of one's own life. In 2018, Métis youth reported reaching out to a variety of people for support, including family, friends, teachers, mental health counselors, school counselors, Aboriginal Education Workers, Indigenous Elders, and community members. Students who asked for help and received assistance that they found helpful were more likely to feel connected to their community and to report positive health outcomes, including better self-reported mental health.[3]

Physical Health

Physical health is the last component of health and wellness that will be explored in this chapter. Healthy eating and physical activity can help to reduce obesity and related ill health and disease while supporting improved mental health and wellness.[25] Researchers have found that, to be effective, promoting healthy eating and physical activity in Indigenous communities must recognize Indigenous histories and contexts, including ongoing inequities and intergenerational trauma. Health promotion strategies that incorporate traditional foods and forms of physical activity also tend to be better received at the community level.[25]

Physical Activity

BC AHS findings from 2018 show that Métis youth have higher levels of physical activity than non-Métis youth in several categories. According to Canadian physical activity guidelines, children and youth between 5 and 17 years of age should have at least 60 minutes of moderate to vigorous exercise every day.[26] As shown in Figure 4.8, 23 per cent of Métis youth reported that they met these guidelines in the previous week, compared to 18 per cent of their non-Métis counterparts. More Métis than non-Métis youth also reported participating in weekly informal sports and extreme sports in the past year.

Source: Métis Nation British Columbia.

Healthy Eating

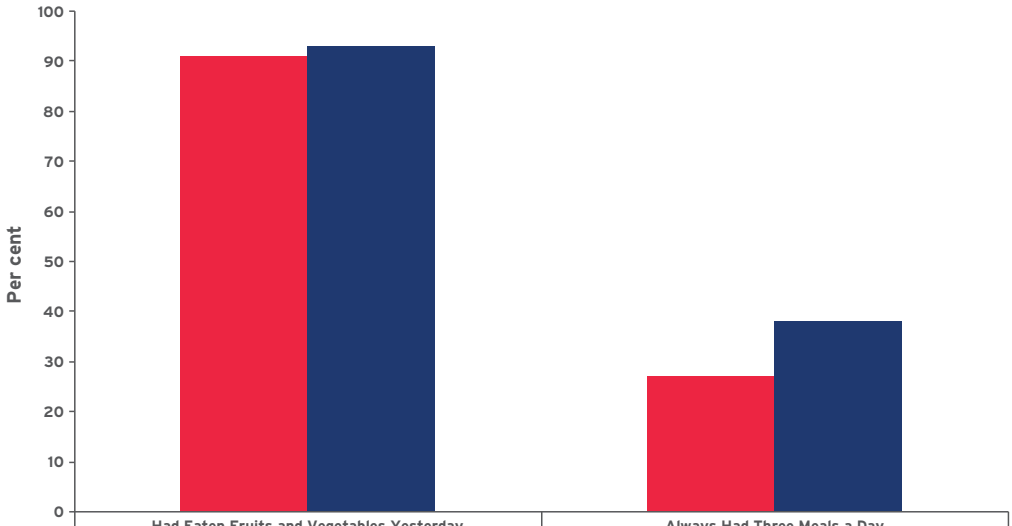
Canada's Food Guide provides advice on healthy food choices and healthy eating habits.[27] In addition to a version of Canada's Food Guide developed specifically for Indigenous peoples, which incorporates traditional foods such as bannock, berries, and wild game,[28] Canada's Food Guide Snapshot is available in Michif.[29]

As demonstrated in Figure 4.9, rates of fruit and vegetable consumption were similarly high among Métis and non-Métis youth. However, Métis youth were less likely to report that they always had three meals a day (27 per cent of Métis youth compared to 38 per cent of non-Métis youth). Métis youth were also more likely than their non-Métis counterparts to report going to bed hungry at least some of the time because of a lack of money at home to buy food (15 per cent of Métis youth compared to 10 per cent of non-Métis youth).[3] Métis youth were slightly more likely to have eaten food grown or caught by themselves or their family (19 per cent of Métis youth and 16 per cent of non-Métis), but were less likely to eat foods traditional to their background (15 per cent of Métis compared to 43 per cent of non-Métis youth).[3]

Linking Mental and Physical Health

Analyses of responses to the 2018 BC AHS identified a number of positive associations between healthy eating, other healthy behaviours, and positive mental health among Métis youth. While data examined here do not enable an analysis of causation (which variables are causing the impact or change in another variable), they do clearly show the interconnections between mental and physical health among Métis youth. Métis youth who reported eating fruit or vegetables the day before the survey were more likely than those who did not to have exercised every day in

FIG 4.9 Nutrition Status of Métis and Non-Métis Youth, Age 12-19, BC, 2018



	Had Eaten Fruits and Vegetables Yesterday	Always Had Three Meals a Day
Métis	91	27
Non-Métis	93	38

Nutrition Status

Note: "Métis" includes youth who self-identify as Métis; "Non-Métis" includes youth who do not self-identify as Métis.

Source: Smith A, Poon C, Martin-Ferris S, Beggs MK, McCreary Centre Society. *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC*; 2019.[3] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

> *My favourite cultural activity was the canoe trip. I felt it was really therapeutic just to go through the water and connect with nature and have some Elders around.*
>
> – Métis Youth Delegate,
> *Revitalizing Our Culture – Métis Youth Forum*[30]

Source: Métis Nation British Columbia. Photo by Jessica Nash.

the previous week (23 per cent compared to 10 per cent), to rate their mental health positively (63 per cent compared to 47 per cent), and to report that they usually feel good about themselves (52 per cent compared to 36 per cent). Those who reported eating fruit or vegetables three or more times the day before were also more likely to have slept for at least eight hours that night (52 per cent compared to 40 per cent).[3] These relationships reflect Métis perspectives of health and wellness as wholistic and interconnected.

Conclusion

This chapter presented analyses of Métis youth health derived primarily from data from the McCreary Centre Society's BC Adolescent Health Survey, and included a focus on social, cultural, spiritual, mental, emotional, and physical health and wellness. It identified areas in which Métis youth are doing well, such as comparatively higher rates of physical activity, and highlighted the importance of community and cultural connectedness for Métis youth. It also identified several concerning gaps between Métis and non-Métis youth in BC, such as in the areas of mental and emotional health and substance use. Further, this chapter showed inequities based on sex and gender identity, particularly with respect to mental health outcomes. The data also showed a strong link between family experiences of residential school and a number of risk factors and harms, including poorer health and wellness outcomes in areas such as depression, suicide, and experiences of physical and sexual abuse. Rates of tobacco and alcohol use among Métis youth are of concern because of the probable links to several health conditions later in life, which will be examined further in the following chapter. Nonetheless, this chapter also illustrates the courage and resilience of Métis youth and the strength they find in Métis culture and identity.

Chapter 5:

Health and Wellness of Métis Adults and Communities

"Cultural wellness is a key factor in promoting health and well-being. For many years, the Métis had to hide aspects of their culture and identity in order to stay physically safe, progress economically and be respected in mainstream society. Even today, many Métis people experience that sharing their Métis identity can cause them to be subject to racism and misunderstanding. Cultural wellness is about promoting a world in which Métis people can express and celebrate their identity with pride."

– Métis Nation British Columbia[1(p.116)]

Most of the data in this report chapter are from the Métis Public Health Surveillance (MPHS) program. MPHS data in this chapter are specific to Métis citizens age 18 and up who were registered with Métis Nation British Columbia (MNBC), still living as of 2018, and who consented to have their data included in the MPHS program. This group of 14,515 people is referred to as the "Métis cohort."[o] Future MPHS data will be compared to the baseline data presented here to measure progress in improving Métis health outcomes in BC. Wherever possible, MPHS data are supplemented by information from published Métis health literature to provide a more wholistic picture of Métis health and wellness in BC and Canada.

MNBC and the Office of the Provincial Health Officer worked together to select the indicators included in this chapter of the report. This process was overseen by MNBC's Métis Data Governance Committee. As much as possible, this report follows the outline of the 2015 MNBC report, *Métis Public Health Surveillance Project: Sharing Community Health Information*.[2] The present report includes many of the indicators from the 2015 report, and adds several new indicators based on the data available and the priorities identified by MNBC.

The indicators originally selected for this report include standard population and public health measures (e.g., birth, **morbidity**, and mortality) that are used to monitor the health of people all over the world. Three other provinces (Alberta,[3] Manitoba,[4] and Ontario[5,6]) have published reports on Métis health and wellness using similar indicators. Some BC data can be compared to data from these provinces and, in many cases, to Statistics Canada data at the national level; however, the birth and mortality indicators require more robust data collected over a longer period than are currently available from the MPHS program in BC.[p] Therefore, this chapter focuses on indicators that describe chronic diseases, access to **primary care**, and injuries among Métis adults in BC. Before presenting

[o] For more detail on the Métis cohort and how it was created, please refer to Appendix B.

[p] The following birth and mortality outcome indicators cannot yet be reported on using BC MPHS program data: life expectancy at birth, infant mortality, preterm birth, infants born at a healthy weight for gestational age, potential years of life lost (PYLL), and **age-standardized mortality rate** (ASMR).

the MPHS data, this chapter provides a brief overview of national-level birth data and discusses lifestyle and behavioural risk factors and the importance of access to culturally safe care. The chapter concludes with a summary of Métis mortality data from published literature and a discussion of the health of Métis Elders.

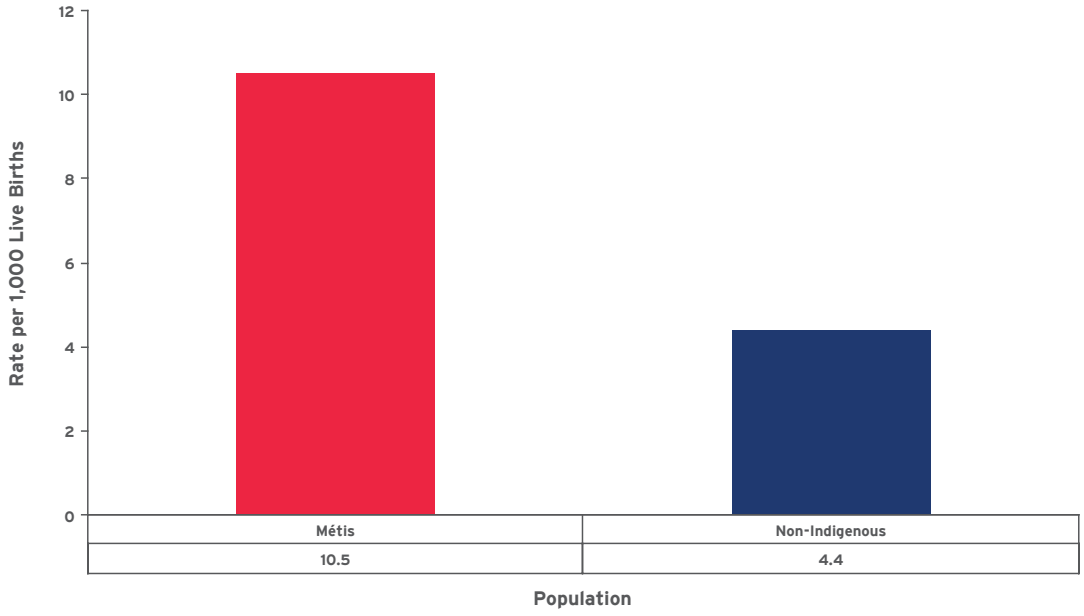
Birth Outcomes

Birth outcomes are an important indicator of the health of a population and are linked to social and other determinants of health,[8] as discussed in Chapter 3. Métis/Cree physician Dr. Janet Smylie explains that babies in Indigenous communities are often seen as "sacred gifts from the spirit world," and are central to the health of families, communities, and culture.[8]

A comprehensive literature review published in 2010 concluded that Métis infant mortality rates were not available from the published literature.[9] In 2017, a Statistics Canada report was published that helped fill this knowledge gap. That report found that, from 2004 to 2006, the infant mortality rate among Métis in Canada was 10.5 per 1,000 live births, which was 2.4 times higher than the infant mortality rate of 4.4 per 1,000 live births among the non-Indigenous population (see Figure 5.1). This mortality rate was higher for Métis in both the **neonatal** (7.5/1,000 versus 3.4/1,000) and **post-neonatal** (3.1/1,000 versus 1.1/1,000) periods.[10]

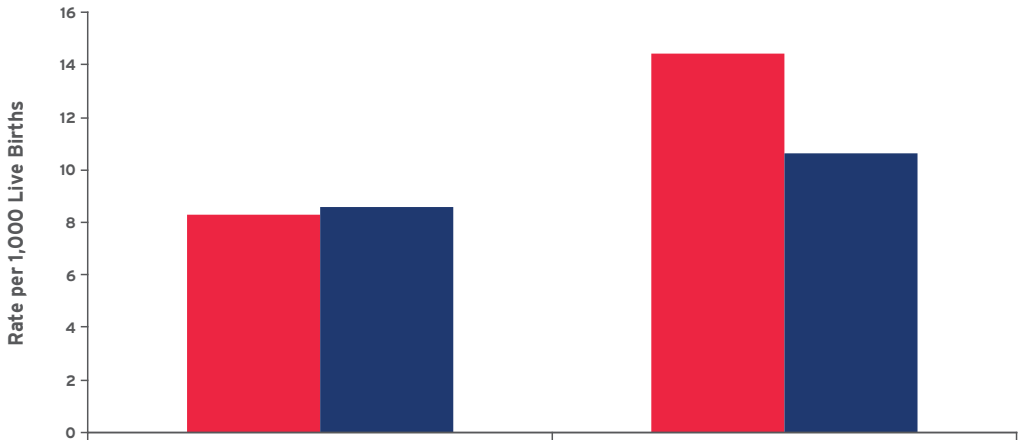
> *As a midwife you always talk about woman as the first environment and so... if I'm able to provide good care to a client... simultaneously my work needs to be caring for the land and making sure that there's something for this person, and this baby, to be able to eat and a safe place for them to be. I think that is a big piece.*
>
> – Kâ-Wâpiscikwâniyâsiki, Métis Midwife [7(p.219)]

FIG 5.1 Infant Mortality Rate, Métis and Non-Indigenous Populations, Canada, 2004-06



Note: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous.
Source: Sheppard A, Shapiro G, Bushnik T, Wilkins R, Serenity P, Kramer M, et al. *Birth outcomes among First Nations, Inuit and Métis populations*. Health Reports; 2020.[6] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

FIG 5.2 **Rate of Singleton Births That Are Small-for-Gestational-Age and Large-for-Gestational-Age, Métis and Non-Indigenous Populations, Canada, 2004-06**



	Small-for-Gestational-Age	Large-for-Gestational-Age
Métis	8.3	14.4
Non-Indigenous	8.6	10.6

Relative Size for Gestational Age

Note: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous.

Source: Sheppard A, Shapiro G, Bushnik T, Wilkins R, Serenity P, Kramer M, et al. *Birth outcomes among First Nations, Inuit and Métis populations*. Health Reports; 2020.[6] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

Source: Métis Nation British Columbia. Photo by Jolene van Wieringen.

A baby's birth weight and gestational age are important indicators of newborn health.[11] A baby who is **large-for-gestational-age** is heavier than average, weighing about 4 kilograms (8.8 pounds) or more at birth.[12] In terms of weight, babies who are large-for-gestational-age are usually in the top 10 per cent of live births of the same sex and gestational age.[13] Women with diabetes, women who are obese, and women who gain a lot of weight during pregnancy are at increased risk of having babies who are large-for-gestational-age.[12] Women carrying babies who are large-for-gestational-age are more likely to require a Caesarean section.[12] Babies who are large-for-gestational-age may be born with low blood sugar and may have trouble breathing.[12] Those babies who are delivered vaginally are also at risk of birth-related injury.[12]

A baby who is **small-for-gestational-age** is smaller and lighter than average, with a birth weight in the lowest 10 per cent of live births of the same sex and gestational age.[13] Babies who are small-for-gestational-age are at increased risk of disability and death, possibly (but not conclusively) associated with factors such

as smoking, nutrition, and insufficient or inadequate prenatal care.[14] Research has shown that pregnant women experiencing socio-economic disadvantage—specifically, those with lower levels of education and/or lower incomes—are at increased risk of giving birth to babies who are small-for-gestational-age.[14]

As shown in Figure 5.2, the percentage of **singleton births** that were large-for-gestational-age was significantly[q] higher in the Métis group (14.4 versus 10.6), while there was virtually no difference in terms of singleton births that were small-for-gestational-age. There were also no statistically significant differences between the two groups in the rates of preterm birth or stillbirth.[10] As with most areas in which Métis and other Indigenous peoples experience poorer health outcomes, many factors associated with higher-risk pregnancies and births can be linked back to Canada's colonial history and resulting colonial and intergenerational trauma.[10,16] These factors include institutional racism; reduced access to quality, culturally appropriate prenatal care (particularly for women in small, rural, and remote communities); pre-existing medical conditions; and generally younger maternal age.[10,17]

> *The fact that I walked pretty much daily, showed, when I broke my hip at age 80. My recovery time in hospital was relatively short, home in 4 days and pretty much shortened my recovery time to less than a month. Proving that being physically active helps to decrease recovery time from injury and illness.*
>
> – Region 3 Senator, Métis Nation British Columbia[2(p.40)]

> *Future research exploring Métis-specific birthing traditions, midwifery practices, and maternal and child health needs is necessary to inform and guide Métis-specific and Aboriginal programs, services and strategies.*
>
> – *Métis Maternal and Child Health: A Discussion Paper*[15(p.7)]

Lifestyle and Behavioural Factors

In any discussion of lifestyle and behavioural factors among Métis and other Indigenous peoples, it is important to acknowledge the ways in which Indigenous peoples' lifestyles and behaviours are influenced by historical and contemporary colonial practices and policies. Many interrelated structural and systemic inequalities, inequities, and other factors—such as colonialism, racism and discrimination, entrenched poverty, intergenerational and colonial trauma,[16,18] and associated mental health challenges—limit the options for many people to "choose" healthier lifestyles. Therefore, it is critical to root any discussion of lifestyle factors that impact Métis health in the context of broader structural determinants of health and an understanding of the strength and resilience of Métis people.

Statistics Canada's Canadian Community Health Survey (CCHS) provides some Métis-specific data on lifestyle factors that impact health. Given the relatively low numbers of Métis and other Indigenous respondents to the CCHS, these data can only support limited analyses, and the conclusions drawn may not be fully representative. However, Statistics Canada has combined Indigenous CCHS

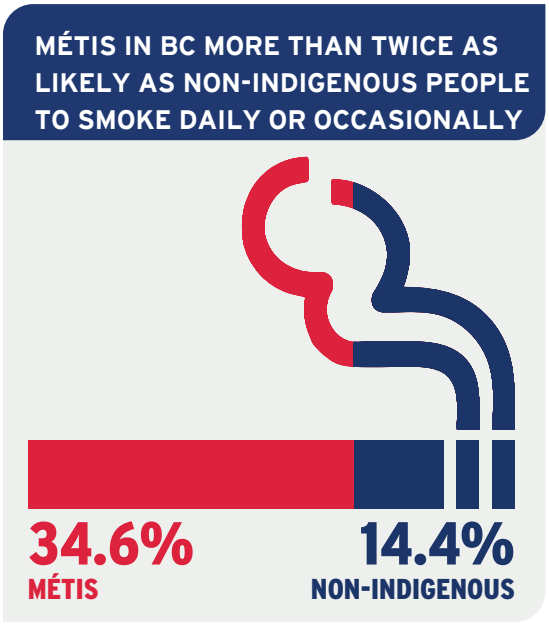
[q] Use of the term "significant" in this chapter refers to "statistical significance"; in other words, a difference between data points (statistics) that is likely due to specific factors (e.g., income), rather than being accidental or random. See Appendix B for more information.

data for two four-year periods (2007-2010 and 2011–2014), which has allowed for additional analyses at the national and provincial levels.

Figure 5.3 compares smoking rates among Métis and non-Indigenous CCHS respondents in BC. Métis respondents were more than twice as likely to report being a current smoker, with 34.6 per cent reporting smoking daily or occasionally, compared to only 14.4 per cent of the non-Indigenous population.

As shown in Figure 5.4, Métis respondents in BC were also more likely to report heavy drinking (also known as binge drinking). These data are based on the former Statistics Canada definition of heavy drinking as having five or more drinks on one occasion at least once a month in the past year.[r,19]

Research suggests that Indigenous people in Canada are less likely than non-Indigenous people to drink alcohol, but that Indigenous



See Figure 5.3. Source: Canadian Community Health Survey, 2011 to 2014.

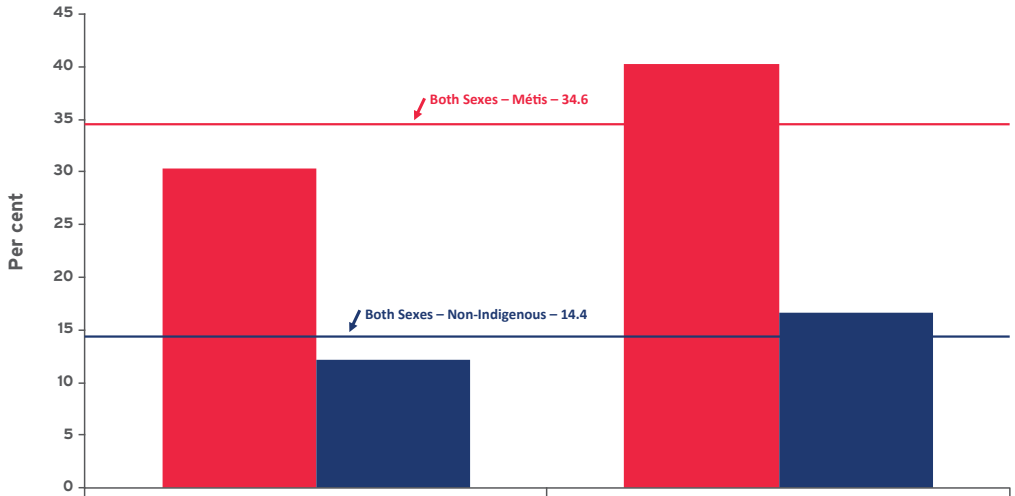
Source: Métis Nation British Columbia. Photo by Mireille Kessler.

people who do drink are more likely to drink heavily and to experience related harms.[20,21,22] Data from the 2011–14 CCHS indicate that Métis people age 12 and up in BC were almost as likely to report not drinking alcoholic beverages at all in the past 12 months (22.5 per cent) as they were to report heavy drinking (26.7 per cent). A slightly higher proportion of non-Indigenous respondents (24.6 per cent) reported not drinking in the year before the survey.[23] Patterns of alcohol use are important because heavy alcohol consumption is associated with a wide range of negative health effects and behaviours, including loss of coordination, violence, brain damage, and increased risk of cancer, cardiovascular disease, and stroke.[21,24]

Physical activity is another important lifestyle and behavioural indicator. As discussed

[r] Definitions of heavy/binge drinking vary between sources and have changed over time. In 2013, Statistics Canada changed its definition of "heavy drinking" to align with guidelines used by the World Health Organization and Health Canada. Heavy drinking now refers to females who have four or more drinks, and males who have five or more, on one occasion, at least once a month in the past year. Data in Chapter 4 for binge drinking among youth are based on a different definition.

FIG 5.3 Current Smoker, Daily or Occasional, Métis and Non-Indigenous Populations, Age 12+, by Sex, BC, 2011-14



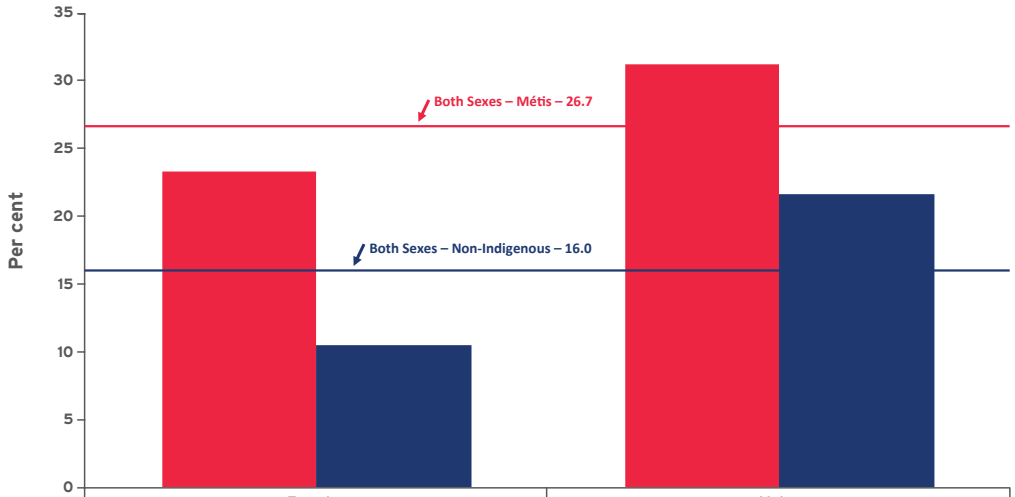
	Females	Males
Métis	30.4	40.2
Non-Indigenous	12.2	16.7

Sex

Note: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous.

Source: Statistics Canada – Combined samples from the Canadian Community Health Survey, 2011 to 2014. Table 13-10-0457-01, Health Indicators by Aboriginal Identity, four-year period estimates. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2021.

FIG 5.4 Heavy Drinking, Métis and Non-Indigenous Populations, Age 12+, by Sex, BC, 2011-14



	Females	Males
Métis	23.3	31.2*
Non-Indigenous	10.5	21.6

Sex

Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. *Percentage for Métis males should be interpreted with caution due to high co-efficient of variation and small sample size.

Source: Statistics Canada – Combined samples from the Canadian Community Health Survey, 2011 to 2014. Table 13-10-0457-01, Health Indicators by Aboriginal Identity, four-year period estimates. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2021.

> *I explored activities like singing, dance, music, art and sport that had always interested me but I had been too afraid or too drunk to try. All of these things were whispers of my soul that were there all along. Now that I could hear and respond, my spirit soared. Opportunities, friendships and growth poured in.*
>
> – Vicki Lynn Rae, Métis Substance Use Survivor[99(p.12)]

Cultural Wellness

Métis Elders and Youth provided input into this statement about what it means to be culturally well:

Cultural wellness is a sense of belonging and pride we feel when we are connected to our Métis families, Communities, traditions and the land. It feels like home.

We express cultural wellness by honouring the strength, determination, and traditions of our ancestors. We do this by telling our stories, using the Michif language, being on the land, and practising and passing on traditions such as our music, jigging, and art.

Métis culture is a beautiful continuation of the strength and resiliency of our ancestors, the joy of family connection and the passing on of the teachings and traditions of our Elders to future generations.

Cultural wellness fosters balance in physical, emotional, mental, and spiritual health for our Métis individuals, families, and Communities.

Embracing Métis heritage and culture honours each Métis person's unique story and our distinct identity as Métis people in BC today.

– Métis Nation British Columbia. *Kaa-wiichihitoyaahk: Métis Perspectives on Cultural Wellness*[1(p.10)]

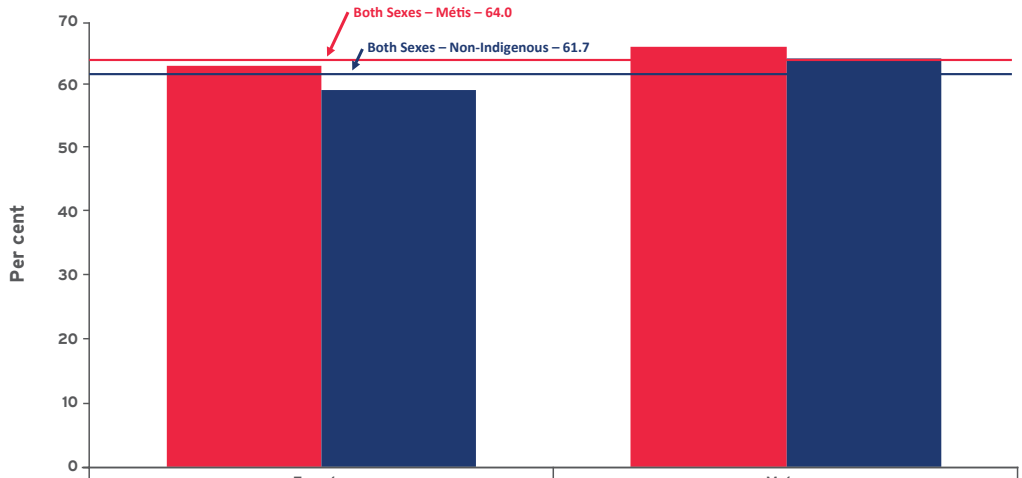
previously, physical activity helps reduce obesity and related ill health and disease and supports improved mental health and wellness.[28] Figure 5.5 shows that the percentage of Métis who reported being moderately active or active during leisure time (64.0 per cent) was higher than for non-Indigenous respondents (61.7 per cent). However, among adults age 18 and up, Métis respondents were significantly more likely to report a body mass index (BMI) of overweight or obese: 54.9 per cent of Métis respondents, compared to 46.5 per cent of non-Indigenous respondents.[23]

Results shown here are generally consistent with findings from other research. Other studies have shown that overweight and obesity are more common among Métis than the rest of the population,[29,30,31] as are non-traditional tobacco use[32,33] and problematic alcohol use.[21] However, Métis people have also continued to report higher levels of leisure-based physical activity,[34,35] which aligns with the higher levels of physical activity among Métis youth in BC discussed in the previous chapter.

Cultural Wellness and Culturally Safe Care

Métis are a distinct Indigenous people with inherent rights, including the right to cultural wellness, which includes having access to culturally safe and equitable health care. Equity in health care is achieved when a given population receives health services and resources proportionate to its need, and in a manner that is culturally and linguistically appropriate.[38] The same may be said of social services, which are also critical to health and wellness. In order to be truly accessible to Métis people, health care and social services and facilities must be culturally safe and promote cultural wellness (see sidebar). Cultural safety includes the "building blocks" of cultural awareness, cultural sensitivity, and cultural competency,[39] along with cultural

FIG 5.5 Physically Active During Leisure Time, Moderately Active or Active, Métis and Non-Indigenous Populations, Age 12+, by Sex, BC, 2011-14



	Females	Males
Métis	62.8	65.5
Non-Indigenous	59.6	63.7

Sex

Note: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous.

Source: Statistics Canada – Combined samples from the Canadian Community Health Survey, 2011 to 2014. Table 13-10-0457-01, Health Indicators by Aboriginal Identity, four-year period estimates. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2021.

Source: Métis Nation British Columbia. Photo by Leslie Mitchell.

> *Creating a culturally safe and humble healthcare system means taking action to support cultural humility approaches at multiple levels in the system. Recognizing that colonization and oppression continues today throughout our health system, it is important to review and revise structures and policies that support cultural safety.*
>
> *System-wide change begins with every individual that works in health. Health leaders in BC have committed to hardwire cultural safety and humility in the health system by signing the declaration of commitment to advance cultural safety and humility in health services delivery for First Nations and Aboriginal people in BC.*
>
> *– Improving Indigenous Cancer Journeys in BC: A Road Map*[37(p.6)]

humility and cultural intelligence.[40] Creating cultural safety and cultural wellness requires a focus on the beliefs and behaviours of non-Indigenous people and practitioners, and an honest assessment of the ways these may negatively affect Indigenous people. This includes the need for honest self-reflection, an understanding of the unequal distribution of power and privilege in our society, and an appreciation of who benefits and who is disadvantaged as a result.[40,41]

Culturally unsafe care is experienced by Indigenous peoples when the care they receive is disrespectful, demeaning, or of lesser quality. Métis and other Indigenous peoples have reported avoiding both mainstream and Indigenous health and social services

Source: Métis Nation British Columbia. Photo by Stella Johnson.

due to fear of or previous experiences of "racism, discrimination, stigma, sexism and bias."[42(p.6),7,43,44,45,46] Métis women and girls face particular barriers to accessing culturally safe care. Researchers have noted that the patriarchal and colonial nature of the health care system puts Métis women and girls at heightened risk of sexism, sexual exploitation, and sexualized violence.[42,46,47] Lack of cultural safety contributes to inequity in the health care system, and in health and wellness outcomes.

Other issues also limit Métis access to health services. For example, the federal government's First Nations and Inuit Health Branch provides Non-Insured Health Benefits (NIHB) to First Nations and Inuit, including coverage for items such as eyeglasses and medications, but Métis people are excluded from the NIHB program.[s,48,49,50] To address this gap, the Government of the Northwest Territories has created its own Métis Health Benefits program to provide registered Métis residents with access to benefits similar to the NIHB.[51] No comparable program is currently available for Métis citizens in BC.

[s] In BC, the First Nations Health Authority provides health benefits to Status First Nations peoples. The federal government continues to provide Non-Insured Health Benefits (NIHB) to Inuit in BC. Métis people in BC are currently ineligible for NIHB.

SUPPORTING THE CULTURAL WELLNESS OF MÉTIS PATIENTS

Understand the kinship structure of Métis families. Métis family structure is based on a kinship system and may not fit within Euro-Canadian expectations about family structure. It is important to take into account the patient's family structure and needs, and let them define who their family is. This is particularly important in terms of hospital policies around visitation. Working with the patient and their family to ensure their needs are being heard and respected can take a bit of effort, but ultimately this will create positive impacts for the Métis patient and their family.

This and other tips for supporting the cultural wellness of Métis patients can be found in *Kaa-wiichihitoyaahk: Métis Perspectives on Cultural Wellness*[1(p.137)]

Delivering care that respects diverse worldviews and belief systems is an important part of integrating cultural safety into the BC health care system. In 2020, MNBC produced *Kaa-wiichihitoyaahk: Métis Perspectives on Cultural Wellness*, a guide developed for both Métis and non-Métis audiences, to help "[address] the need for increased awareness of Métis culture, identity and resilience amongst the general public in order to promote cultural wellness for Métis people."[1(p.5)]

Urban Métis women in Toronto identified several factors that made them feel more comfortable and facilitated access to health care and social services. These included "Métis presence" (which could include Métis staff, Métis service providers, and/or Métis cultural symbols), Métis-specific or Métis-informed

> *A common narrative about Indigenous people [is] that colonization is in the past and Indigenous people need to move on. This narrative and others are prevalent in the health care system, and Indigenous people experience harm on a regular basis as a result of them. For example, the idea that Indigenous people are 'stuck' in the past can lead to the stereotype that Indigenous people are unwilling or unable to 'get better.' This stereotype can foster prejudice, such as the feeling that treating Indigenous people is a 'waste of time,' which can result in discriminatory treatment, such as Indigenous people receiving a reduced quality of care. Being aware of how these narratives lead to stereotypes, and then to prejudice and discrimination—and harm—is an important step in fostering a safer and more effective health care system. This awareness is part of the journey towards increased cultural safety and increased equity in health and health care.*
>
> – "What is Indigenous Cultural Safety—and Why Should I Care About It?"[41]

> *Racism serves as a serious barrier to health care access that can lead to delayed treatment or a lack of treatment altogether, either of which can have devastating effects on Indigenous people, their families, and communities.*
>
> *– First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada*[43(p.27)]

ADDRESSING INDIGENOUS-SPECIFIC RACISM AND DISCRIMINATION IN BC HEALTH CARE

On March 12, 2019, the Provincial Health Services Authority's (PHSA) Indigenous Health Department convened a group to discuss how to dismantle the known epidemic of anti-Indigenous racism and lack of cultural safety in the BC health care system. The group's two reports include numerous examples of health care workers failing in their duty to provide care to Indigenous people seeking treatment. The reports also catalog the many resulting harms to Indigenous patients, which range from emotional, psychological, and spiritual harm to family and/or community disruption, prolonged pain and suffering, and premature death.[52,53] While this work was undertaken to address systemic injustices, the reports were not made public at that time.[54]

On June 19, 2020, in response to recommendations from Métis Nation British Columbia and the BC Association of Aboriginal Friendship Centres,[54] BC's Minister of Health launched an independent investigation into complaints of discrimination against Indigenous people in BC's health care system. The investigation was conducted by Mary Ellen Turpel-Lafond (Aki-Kwe), an Indigenous lawyer and law professor, Director of the Indian Residential School Centre for History and Dialogue at the University of British Columbia, and BC's Representative for Children and Youth from 2006 to 2016.[55] The resulting report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, was released on November 30, 2020.[56] It identifies numerous issues of racism and discrimination within BC's health care system, and makes related recommendations to better uphold Indigenous cultural safety.

> *It was disheartening to read so many stories of mistreatment that Métis and other Indigenous people experienced in the health care system. Emergency Rooms and hospitals are places people go as a last resort. Hearing that Métis people were reluctant or afraid to seek out care when they needed it most shows deep-rooted problems in the system. The report* [Addressing Indigenous-specific Racism and Discrimination in BC Health Care] *is an important first step in recognizing that change needs to happen so that Métis people in BC can have equity in treatment within our health care system and receive the same level of care other British Columbians are afforded.*
>
> – Paulette Flamond, Minister of Health, Métis Nation British Columbia[56(p.42)]

services, and staff and service providers who had an understanding of the complexities of Indigenous identities and histories.[7] Métis health care providers may be more likely to provide these types of culturally safe care and foster cultural wellness for Métis patients.

As Figure 5.6 demonstrates, 56 self-identified Métis physicians were registered with the College of Physicians and Surgeons of BC in 2019. This represents 0.4 per cent of the provincial total of 13,263 registered physicians in BC. In comparison, 2.0 per cent of the overall population of BC self-identified as Métis in 2016.[58] This suggests that Métis people in BC are less likely than other British Columbians to be registered physicians, and that the health care system is not reflective of the population it serves.

KAA-WIICHIHITOYAAHK – WE TAKE CARE OF EACH OTHER: MÉTIS PERSPECTIVES ON CULTURAL WELLNESS

Métis Nation British Columbia produced the *Kaa-wiichihitoyaahk* cultural wellness guide to promote cultural wellness for Métis people. The guide furthers the goals of reconciliation and cultural wellness by meeting the need for a public resource to raise awareness of Métis culture and identity, and the impacts of colonization.[1]

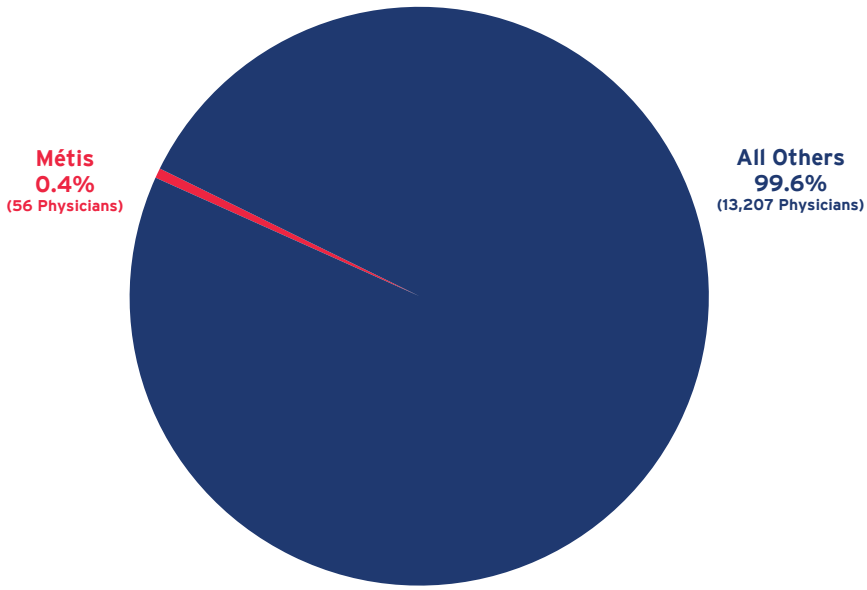
For more information, visit www.mnbc.ca

Source: Métis Nation British Columbia.

> *Despite good intentions, enforcing one university course or a pan-Indigenous cultural competency training, often completed online, will not be sufficient in improving service access for Métis Peoples.*
>
> – R. Monchalin et al., "I would prefer to have my health care provided over a cup of tea any day"[7(p.222)]

> *Increased Métis involvement in the health and wellness area will ensure the provision of culturally grounded and 'holistic well-being' approaches to health.*
>
> *– Blueprint on Aboriginal Health: A 10-year Transformative Plan*[57(p.20)]

FIG 5.6 Percentage of Registered Physicians, Métis and All Others, BC, 2019



Note: "Métis" includes registered physicians who self-identify as Métis. "All Others" includes registered physicians who do not self-identify as Métis, including registered physicians who self-identify as First Nations, Inuit, or non-Indigenous.

Sources: College of Physicians and Surgeons of British Columbia, 2019 Annual Licensure Renewal Form (number of registered physicians); Statistics Canada – 2016 Census, Catalogue Number 98-510-X2016001, Aboriginal Population Profile, released July 18, 2018. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2019.

> *Asking Métis individuals to engage a doctor to get personal health information, like blood pressure, glucose testing, etcetera is not [a] reasonable strategy considering many Métis individuals do not have a family doctor.*
>
> – Métis Nation British Columbia, *Métis Community Health Indicators Capacity and Need*[59(p.9)]

> *Cultural safety is an on-going and evolving process that will require health care providers to revisit and adjust modes of services in order to meet the needs of Métis.*
>
> *– Towards Cultural Safety for Métis: An Introduction for Health Care Providers*[39(p.1)]

Ambulatory Care Sensitive Conditions

The rate of hospitalization for **ambulatory care sensitive conditions** (ACSCs, also called **avoidable hospitalizations**) is an important measure of the accessibility and quality of primary care services, as well as the effectiveness of chronic disease self-management. Where effective, appropriate, and accessible primary care exists, ACSCs such as diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), depression, hypertension, and asthma can be successfully managed without the need for hospital care. Therefore, hospital admissions for ACSCs are avoidable, and indicate where there are challenges with primary care meeting population health needs.[60,61]

In 2017, there were 34 admissions of Métis people in BC for these conditions—13 females and 21 males. These numbers yielded age-standardized ACSC hospital admission rates for Métis (261.1 per 100,000 population) that were much lower than the rates for Other

Source: Métis Nation British Columbia. Photo by Dean Wilson.

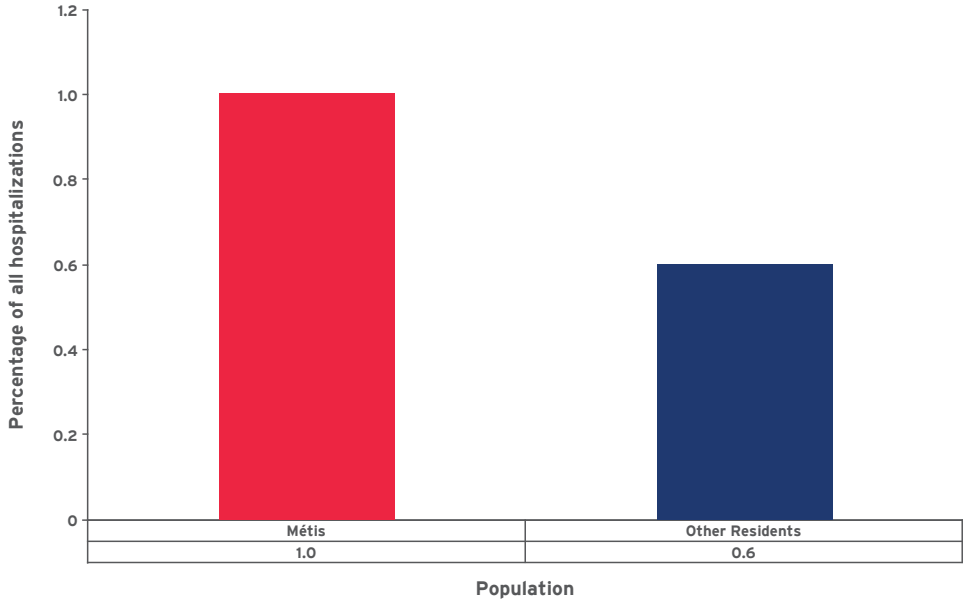
Residents (324.2 per 100,000 population).[66] Although substantial, the differences were not statistically significant.

These results differ considerably from those of a national study (excluding Quebec) of ACSC admissions among urban Métis age 18 to 74, which reported Métis rates that were much higher than the rates for the non-Indigenous urban population.[62] This study identified ACSC hospitalization rates of 1.0 per cent for Métis people in BC, compared to 0.6 per cent for non-Indigenous British Columbians (Figure 5.7).

In BC, males within the Métis cohort were more likely than females to be admitted for ACSCs, but the difference was not statistically significant. Although the numbers were very small, Métis rates varied dramatically across the province, from lower rates in Island Health and Vancouver Coastal Health to a much higher rate in Northern Health.[66]

> *Métis people believe that in order to properly meet their unique health care needs, major structural changes must be made to the design and delivery of existing health care approaches. Redressing the poor health conditions of Métis will require attitudinal, behavioral and systemic changes. It will also take the establishment of an effective and sustainable partnership between Métis and [federal, provincial, and territorial] governments. Failure to act quickly will lead to continued inter-generational negative health consequences, which can only exacerbate Métis health conditions.*
>
> *– Blueprint on Aboriginal Health: A 10-year Transformative Plan*[57(p.20)]

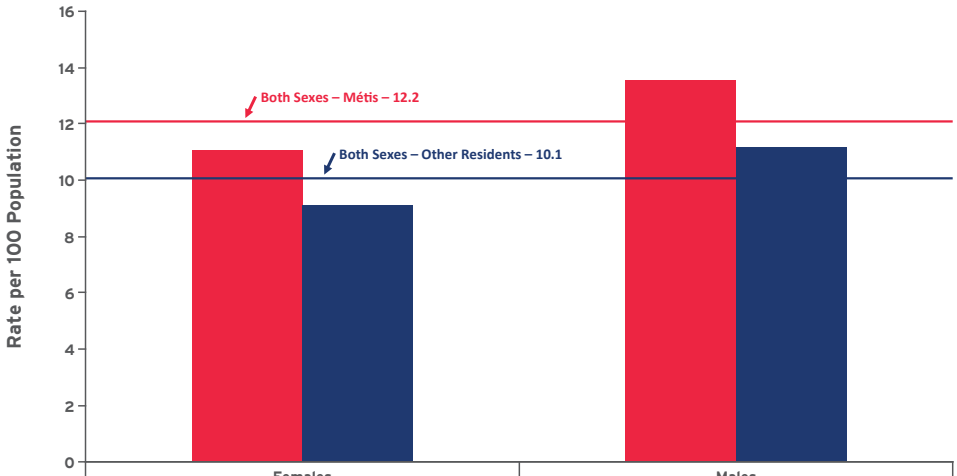
FIG 5.7 **Hospitalizations for Ambulatory Care Sensitive Conditions, Métis and Non-Indigenous Urban Populations, Age 18-74, BC, 2006/07-2008/09**



Notes: "Métis" includes people who self-identify as Métis; "Non-Indigenous" includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous. Ambulatory care sensitive conditions are chronic conditions that can often be managed with timely and effective treatment in the community, without hospitalization. Percentages are based on population counts that have been rounded to the nearest 100.

Sources: Statistics Canada, Linked 2006 Census-2006/2007-to-2008/2009 Discharge Abstract (https://www150.statcan.gc.ca/n1/pub/82-003-x/2017012/article/54891/tbl/tbl03-eng.htm). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, October 2021.

FIG 5.8 Age-standardized Diabetes Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



	Females	Males
Métis	11.1	13.6
Other Residents	9.1	11.2
Métis - Number of Cases	716	785

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Chronic Conditions

Diabetes

Diabetes mellitus (diabetes) is a chronic condition in which blood sugar (glucose) levels are elevated because an individual's body cannot produce or use the insulin it needs.[63] Causes of diabetes can include lifestyle, environmental, and genetic factors.[64] As illustrated in Figure 5.8, age-standardized diabetes **prevalence**[t] for the population age 18 and up in the Métis cohort was 12.2 per 100 population in 2017/18, which was higher than the proportion for Other Residents of BC (10.1 per 100 population). The prevalence of 13.6 per 100 for Métis males and 11.1 per 100 for Métis females were also higher than the corresponding proportions for Other Resident males and females. All these differences were statistically significant.

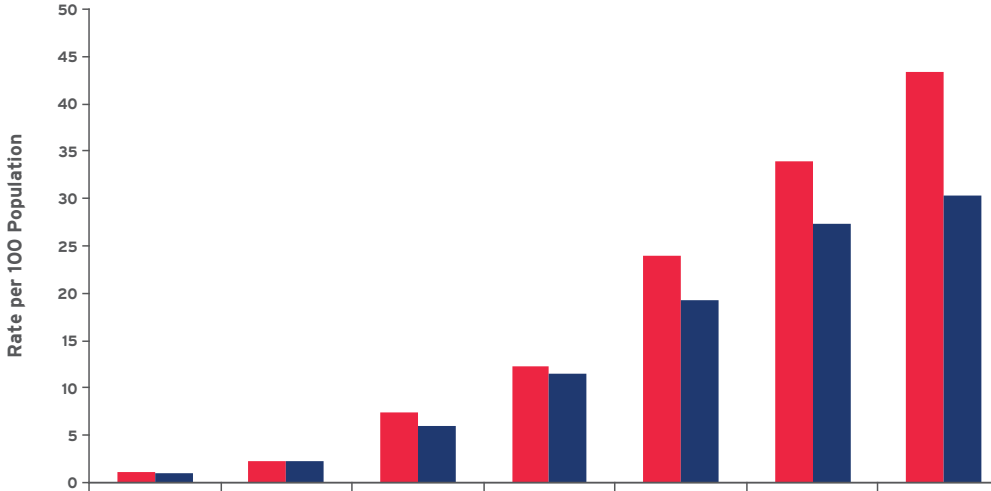
Significantly higher diabetes prevalence has also been reported among Métis populations in Alberta,[65] Manitoba,[4] and Ontario.[5]

BC data from 2017/18 indicate that, at that time, about 1,500 people in the BC Métis cohort had received treatment for diabetes. This number was sufficiently large to permit comparison across age groups. As shown in Figure 5.9, prevalence was higher among Métis in all age groups, but the difference was statistically significant only among those age 40–49, 60–69, 70–79, and 80+.

Figure 5.10 demonstrates that there is some variation between health authorities in age-standardized diabetes prevalence for the Métis population in BC. Prevalence was highest in

[t] Diabetes prevalence is the proportion of known/diagnosed cases of people living with diabetes. In this report, prevalence is reported as the number of known cases for every 100 people in a population, unless otherwise specified. Prevalence is an indicator of disease burden. It represents all known cases of a particular condition in a population (both new and existing cases). Prevalence can increase due to increased **incidence** (newly diagnosed cases) of a condition but can also be elevated due to advances in care that extend how long someone can live with a given disease. Given the historical and contemporary factors examined and the literature cited in this report, higher prevalence among the Métis population is interpreted in this report as a sign of inequity in disease burden.

FIG 5.9 Diabetes Prevalence, Métis and Other Residents, Age 18+, by Age Group, BC, 2017/18



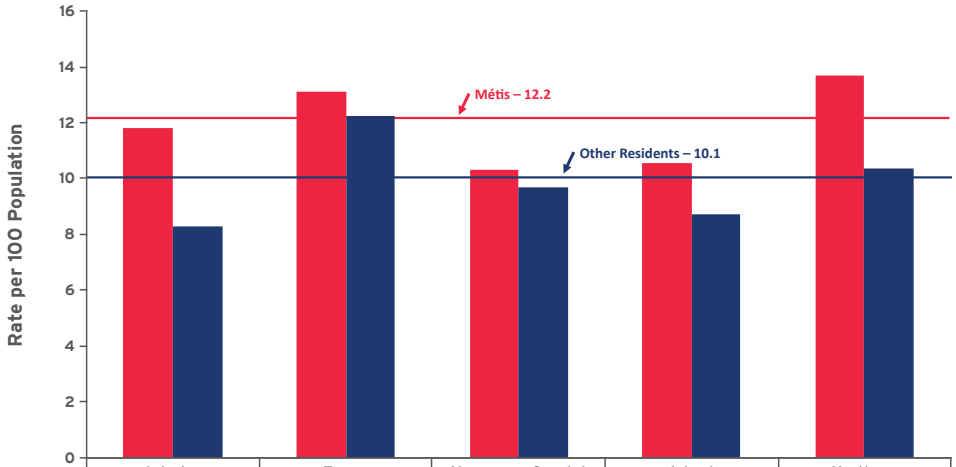
	18-29	30-39	40-49	50-59	60-69	70-79	80+
Métis	1.2	2.3	7.3	12.2	23.9	33.9	43.2
Other Residents	0.9	2.3	5.9	11.5	19.3	27.4	30.3

Age Group

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.10 Age-standardized Diabetes Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18



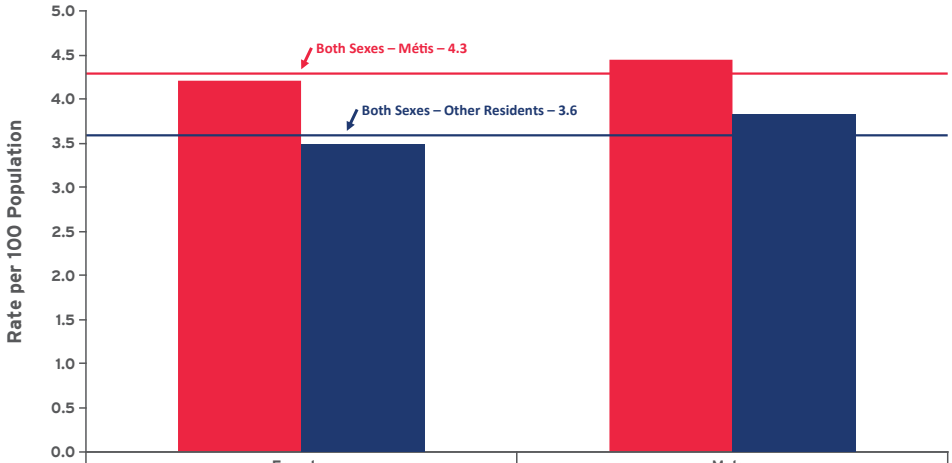
	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	11.8	13.1	10.3	10.6	13.7
Other Residents	8.3	12.2	9.7	8.7	10.4
Métis - Number of Cases	451	357	83	247	359

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.11 Age-standardized Chronic Kidney Disease Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



	Females	Males
Métis	4.2	4.4
Other Residents	3.5	3.8
Métis - Number of Cases	250	221

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Northern Health and Fraser Health (for Métis as well as for Other Residents). Differences in prevalence between Métis and Other Residents were statistically significant in three health authorities: Interior Health, Island Health, and Northern Health.

Source: Métis Nation British Columbia. Photo by Nora Lande.

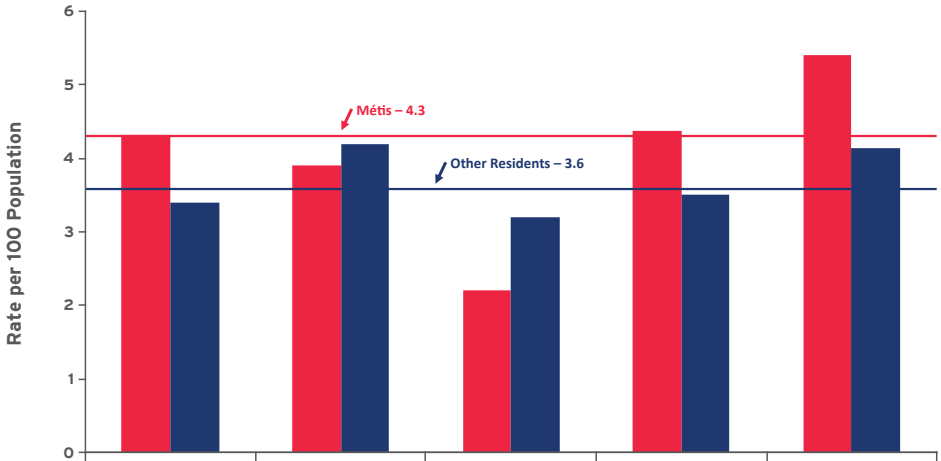
The age-standardized diabetes **incidence** rate within the Métis cohort was 8.9 per 1,000 population. This was higher than the age-standardized rate of 8.0 per 1,000 among Other Residents; however, this difference was not statistically significant.[66]

Chronic Kidney Disease

Chronic kidney disease may refer to kidney damage, reduced kidney function, or kidney failure.[2] Severe cases require dialysis and/or kidney transplant.[2]

Figure 5.11 shows the age-standardized prevalence of chronic kidney disease among Métis and other BC residents age 18 and up in 2017/18. The prevalence of 4.3 per 100 population for the Métis cohort was higher than the 3.6 per 100 reported for the rest of the population. The difference in prevalence between males and females within the Métis cohort was not statistically significant.

FIG 5.12 **Age-standardized Chronic Kidney Disease Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18**



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	4.3	3.9	2.2	4.4	5.4
Other Residents	3.4	4.2	3.2	3.5	4.1
Métis - Number of Cases	152	95	17	88	117

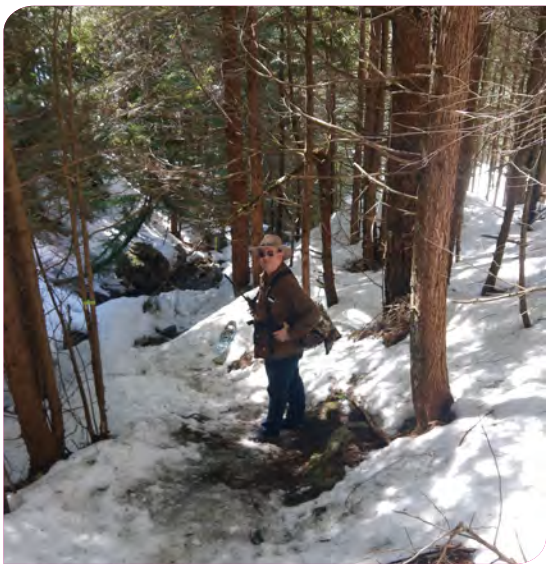
Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Figure 5.12 presents age-standardized chronic kidney disease prevalence among Métis and other BC residents age 18 and up by health authority. In Fraser Health and Vancouver Coastal Health, prevalence was lower for Métis than for the rest of the population, although these differences were not statistically significant. Interior Health and Northern Health both reported prevalence among Métis residents that was significantly higher than that of Other Residents (the difference in Island Health was not statistically significant).

The age-standardized incidence rate of chronic kidney disease for Métis people in BC (6.4 per 1,000) was not significantly different than the rate of 6.1 per 1,000 for the rest of the population.[66] This is unexpected, because Métis have a significantly higher prevalence than Other Residents of both diabetes and hypertension. Because diabetes and hypertension are known to be the leading causes of chronic kidney disease,[67] higher prevalence of these conditions would be expected to link to increased incidence of chronic kidney disease among Métis. This finding will be monitored and explored further in future reports in this series.



Source: Métis Nation British Columbia. Photo by April Kornitsky.

Musculoskeletal Diseases

Rheumatoid Arthritis

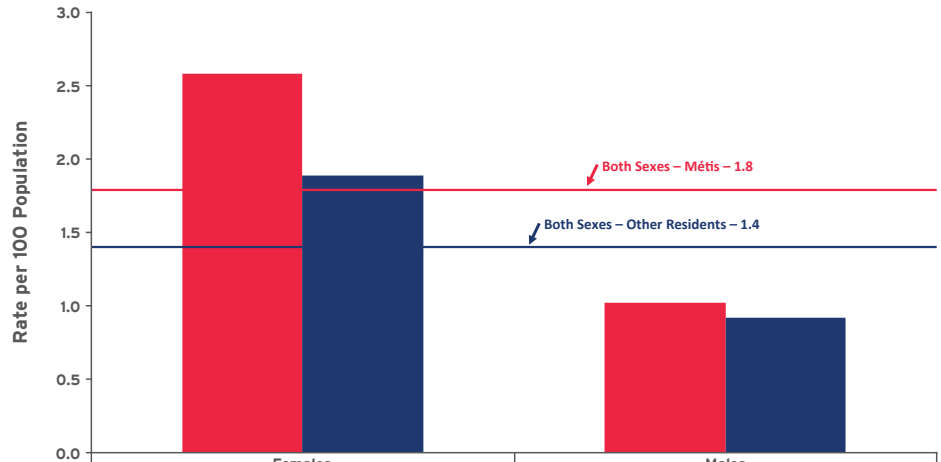
Rheumatoid arthritis is an inflammatory autoimmune disease that causes pain, stiffness, and swelling in one or more joints in the body.[2,68] The inflammation can eventually damage joints and affect other organs (e.g., nerves, eyes, skin, lungs, and heart).[68] Although there is no cure, rheumatoid arthritis can be treated effectively, especially when diagnosed at an early stage.[68]

The age-standardized prevalence of rheumatoid arthritis among Métis people in BC (1.8 per cent) was higher than the prevalence of 1.4 per cent among Other Residents (see Figure 5.13). This reflects the much higher prevalence among Métis females (2.6 per cent) compared to Other Resident females (1.9 per cent). The difference in prevalence between Métis and Other Resident males was not statistically significant. Within

> *Musculoskeletal diseases, including osteoarthritis and rheumatoid arthritis, are the most often mentioned health problem for Métis physical health.*
>
> – Métis Nation British Columbia, *Métis Public Health Surveillance Project: Sharing Community Health Information*[2(p.39)]

Source: Métis Nation British Columbia.

FIG 5.13 Age-standardized Rheumatoid Arthritis Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



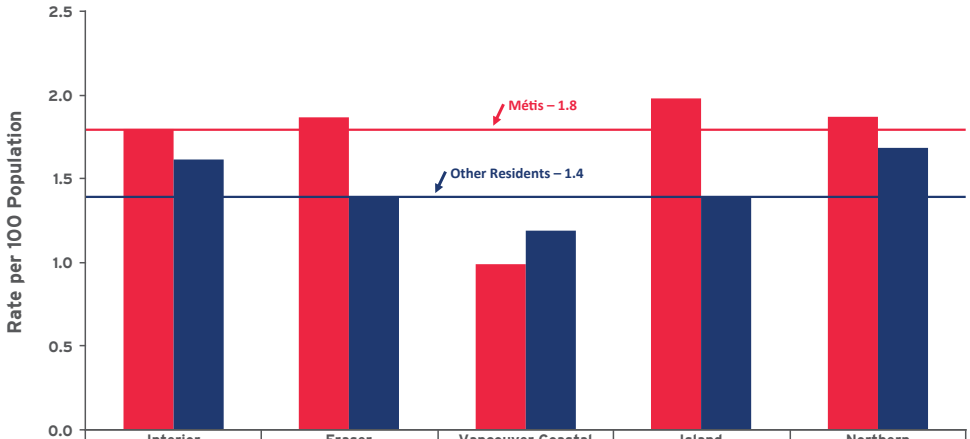
	Females	Males
Métis	2.6	1.0
Other Residents	1.9	0.9
Métis - Number of Cases	171	56

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.14 **Age-standardized Rheumatoid Arthritis Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18**



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	1.8	1.9	1.0	2.0	1.9
Other Residents	1.6	1.4	1.2	1.4	1.7
Métis - Number of Cases	70	49	9	47	51

Health Authority

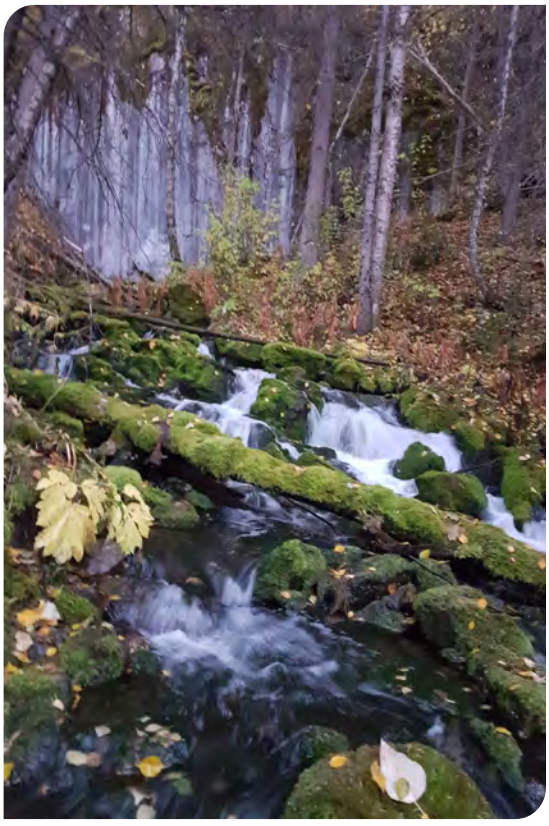
Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

the Métis population, prevalence among females was higher than among males; this difference was statistically significant.

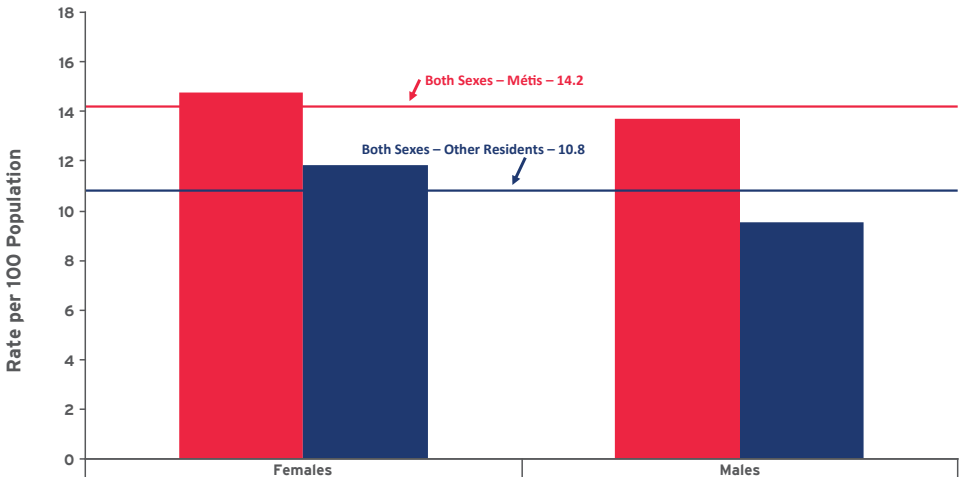
As illustrated in Figure 5.14, the higher prevalence of rheumatoid arthritis among the Métis cohort in BC reflects the elevated levels found in Island Health and Fraser Health, although only in Island Health was the prevalence among Métis significantly higher than among Other Residents. In Vancouver Coastal Health, the Métis prevalence of 1.0 per 100 population was slightly lower than the 1.2 per 100 reported for Other Residents.

The age-standardized incidence rate for rheumatoid arthritis was higher among Métis (1.4 per 1,000 population) than among Other Residents (1.0 per 1,000), but the difference was not statistically significant. This was at least partly due to the number of incident cases (N=18), which was too small to support a meaningful test of statistical significance.[66]



Source: Métis Nation British Columbia. Photo by Kendra Morrow.

FIG 5.15 Age-standardized Osteoarthritis Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



	Females	Males
Métis	14.8	13.7
Other Residents	11.9	9.6
Métis - Number of Cases	955	774

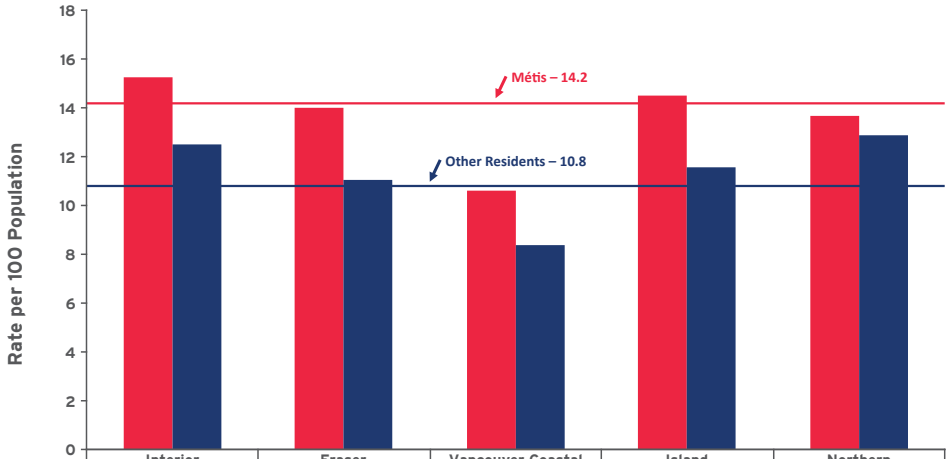
Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Louis Riel Day, 2021. Source: Province of British Columbia.

FIG 5.16 Age-standardized Osteoarthritis Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	15.3	14.0	10.7	14.5	13.7
Other Residents	12.5	10.9	8.4	11.5	12.9
Métis - Number of Cases	566	371	86	334	368

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Osteoarthritis

Osteoarthritis is joint damage caused by the deterioration of cartilage, which results in bone-on-bone contact.[69] This may cause pain, swelling, stiffness, and reduced range of motion.[69] Osteoarthritis affects more Canadians than all other forms of arthritis combined.[69] It can occur due to factors such as age, injury, obesity, and repetitive movements related to certain occupations.[69]

Figure 5.15 presents age-standardized osteoarthritis prevalence for Métis and Other Residents of BC age 18 and up for 2017/18. The prevalence of 14.2 per 100 population for the Métis cohort overall was significantly higher than the 10.8 per 100 among Other Residents. The gaps in prevalence between Métis and Other Resident males (13.7 compared to 9.6) and Métis and Other Resident females (14.8 compared to 11.9) were also statistically significant. Osteoarthritis prevalence was higher for females than males for both Métis and Other Residents, although the difference between males and females within the Métis cohort was not statistically significant.

As shown in Figure 5.16, the higher provincial prevalence of osteoarthritis among Métis reflects significantly higher prevalence in Interior Health, Fraser Health, and Island Health. The age-standardized incidence rate of 12.0 per 1,000 among the Métis cohort was significantly higher than the rate of 8.2 per 1,000 among Other Residents.[66] This elevated incidence rate for the Métis cohort suggests that the gap in prevalence between Métis and Other Residents will continue to grow.

Cardiovascular Disease

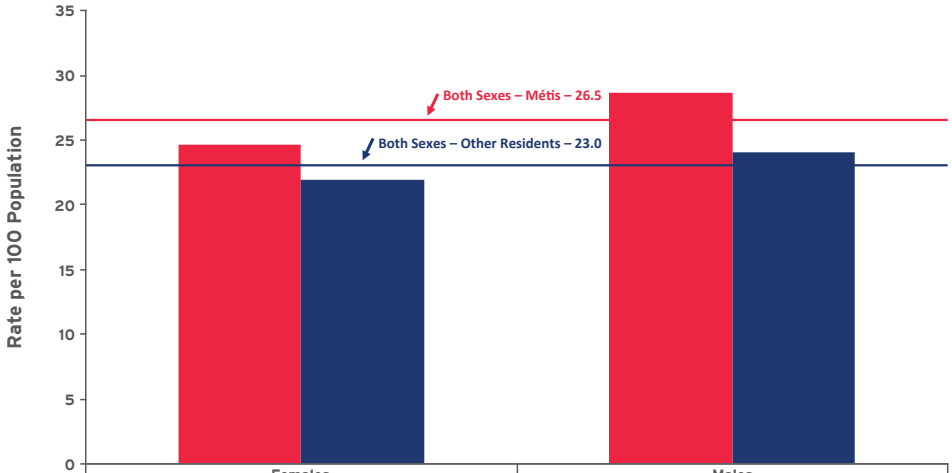
Cardiovascular disease includes heart disease and diseases of the circulatory system, such as hypertension. Cardiovascular disease is the leading cause of death for both females and males in Canada.[70] Risk factors include smoking, being overweight/obese, a high-fat diet, high cholesterol, physical inactivity, diabetes, stress, and family history; risk increases with age.[70] Disproportionately high rates of cardiovascular disease have been reported among Métis and other Indigenous peoples in Canada.[2,71,72]

Hypertension

Hypertension is the medical term for high blood pressure. Although hypertension is presented as a chronic disease in this report, it is also a risk factor for several other chronic diseases. High blood pressure can damage blood vessels and increase the risk of stroke, heart attack, or heart failure.[73] Hypertension is well established as a risk factor for ischaemic heart disease and renal dysfunction (kidney disease), and may also play a role in the development of non-cardiovascular diseases such as dementia, oral health diseases, osteoporosis, eye problems, and erectile dysfunction.[73,74] Hypertension is more common among older adults but can occur at any age.[73]

As Figure 5.17 illustrates, in 2017/18 the age-standardized prevalence of hypertension among the Métis cohort overall was 26.5 per cent, higher than the prevalence of 23.0 per cent for the rest of the population. The gap between Métis and Other Resident males was considerably larger than the gap between Métis and Other Resident females. All these differences are statistically significant. The prevalence of 28.6 per cent among Métis males was significantly higher than the 24.6 per cent among Métis females. Higher

FIG 5.17 **Age-standardized Hypertension Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18**



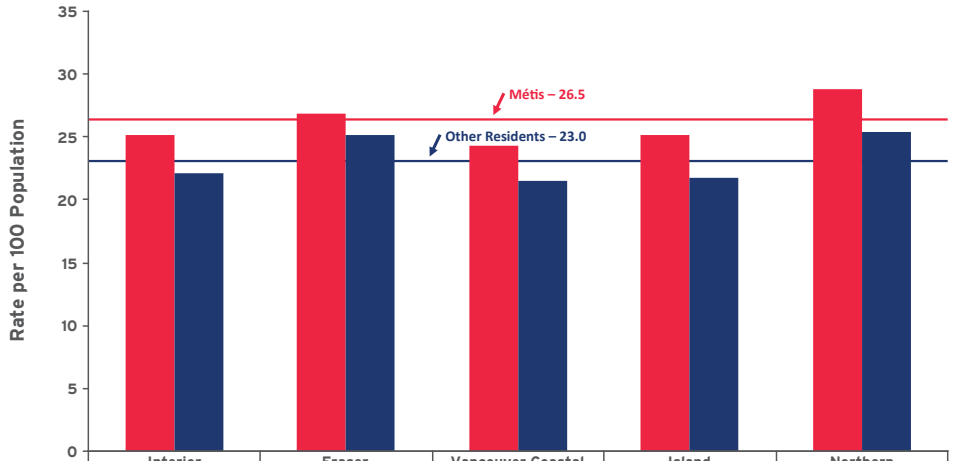
	Females	Males
Métis	24.6	28.6
Other Residents	22.0	24.1
Métis - Number of Cases	1,522	1,601

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.18 **Age-standardized Hypertension Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18**



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	25.1	26.9	24.3	25.2	28.8
Other Residents	22.1	25.2	21.5	21.7	25.4
Métis - Number of Cases	933	699	186	553	745

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Source: Métis Nation British Columbia. Photo by Mackenzie Bouchard.

prevalence of hypertension among Métis has widespread implications for the longer-term population health of Métis people because of its contribution to the development of other diseases.

Figure 5.18 shows age-standardized hypertension prevalence for Métis and other BC residents by health authority. As this demonstrates, the Métis cohort had higher overall prevalence as well as higher prevalence within each health authority. The differentials between Métis and Other Residents were statistically significant for BC overall, and in Interior Health, Island Health, and Northern Health.

The age-standardized hypertension incidence rate of 18.4 per 1,000 for the Métis cohort in BC was not significantly different from the age-standardized incidence rate of 20.6 per 1,000 for Other Residents.[66]

Ischaemic Heart Disease

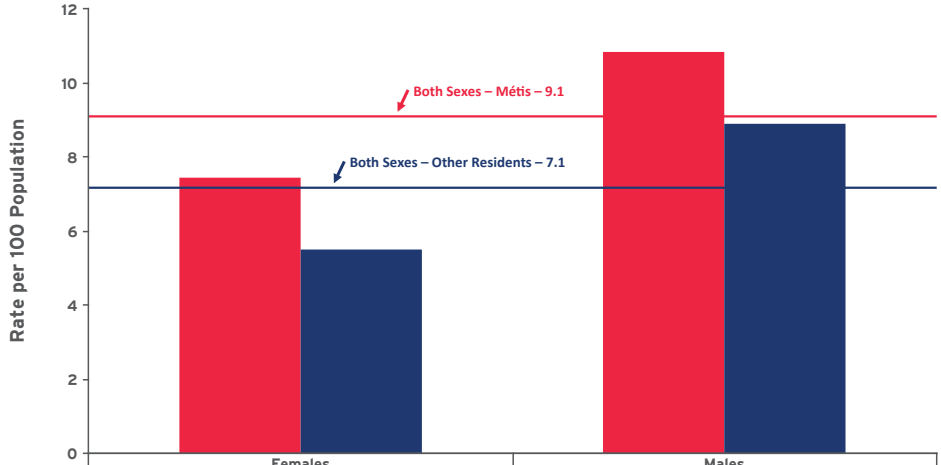
Ischaemic heart disease (IHD) is also called *coronary heart disease*, or simply *heart disease*. It is the result of plaque that builds up in the coronary arteries, which can lead to a heart attack, heart failure, or death. IHD is the second most common cause of death in Canada.[75] Healthy eating, physical activity, a healthy body weight, not smoking, and limiting alcohol consumption can all help reduce the risk of heart disease. The risk can also be reduced through early detection and management of conditions such as hypertension (high blood pressure), diabetes, and high cholesterol.[75]

As Figure 5.19 shows, age-standardized prevalence of IHD was higher for the Métis cohort than for Other Residents of BC. Prevalence of IHD was also higher for Métis females and males than for their Other Resident counterparts. Within the Métis cohort, prevalence among males was higher than among females. All these differences were statistically significant.

Source: Métis Nation British Columbia. Photo by Brad Hepworth.

Age-standardized prevalence of IHD for Métis was higher in all BC health authorities, as shown in Figure 5.20. These differences were statistically significant in all health authorities except Interior Health.

FIG 5.19 **Age-standardized Ischaemic Heart Disease Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18**



	Females	Males
Métis	7.5	10.8
Other Residents	5.5	8.9
Métis - Number of Cases	424	572

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

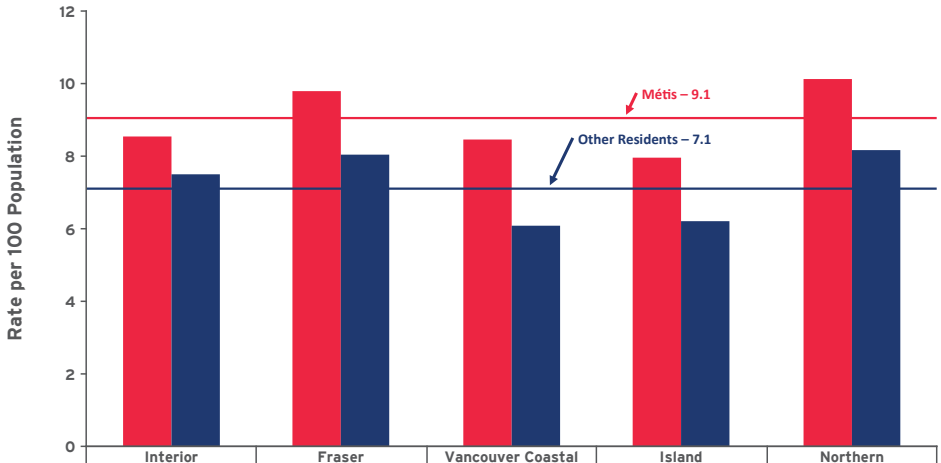
Higher overall prevalence of hypertension and IHD among the BC Métis population is consistent with higher prevalence reported among Métis populations in Alberta[3,76] and Manitoba.[4]

The significantly higher prevalence of hypertension among the Métis cohort in BC would be expected to lead to higher IHD incidence. However, age-standardized IHD incidence rates in BC were almost identical for Métis (6.9 per 1,000 population) and Other Residents (6.5 per 1,000).[66] The reasons for this unexpected result are unknown, and this issue will be revisited in future reports.

Since the age-standardized incidence rate of IHD among Métis was not significantly higher than the rest of the population, the gap in prevalence between these groups may persist but should not widen unless substantial changes occur in the respective mortality rates within the two groups.

Source: Métis Nation British Columbia. Photo by Bernard Hughes.

FIG 5.20 Age-standardized Ischaemic Heart Disease Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	8.5	9.8	8.4	8.0	10.1
Other Residents	7.5	8.1	6.1	6.2	8.2
Métis - Number of Cases	294	233	57	168	243

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Source: Métis Nation British Columbia. Photo by Tanya Garneau.

Chronic Respiratory Diseases

As discussed in Chapter 4, a focus on respiratory health is particularly important for Métis people, who experience high rates of chronic respiratory diseases.[2] In a 2006 MNBC survey of Métis households in BC, 25 per cent reported that at least one person in their household had a respiratory illness.[77] Respiratory illnesses may be associated with factors such as smoking and socio-economic status[78]—for example, substandard housing may expose residents to mold and toxic chemicals such as lead or carbon monoxide.[79] Respiratory health has become increasingly important in light of the global Coronavirus (COVID-19) pandemic, which puts people with existing respiratory diseases at increased risk if they are infected. Since COVID-19 affects the respiratory system, people with lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma may be more likely to require hospitalization or intensive care intervention if they contract the virus. COVID-19 is also likely to aggravate existing respiratory symptoms and air flow obstructions.[80]

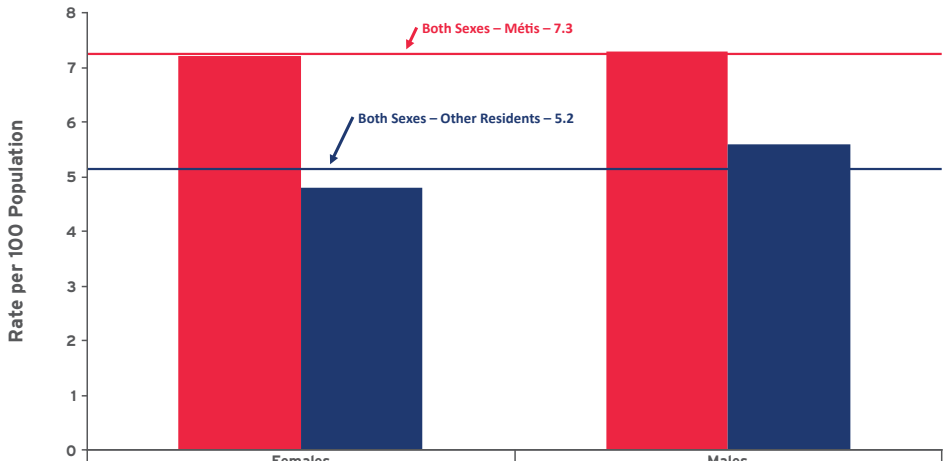
Chronic Obstructive Pulmonary Disease

COPD refers to two chronic respiratory diseases (emphysema and chronic bronchitis) that cause swelling and blockage (obstruction) of the airways, making it difficult to breathe.[81] Smoking is the main cause of COPD. COPD may also be caused by factors such as exposure to second-hand smoke or air pollution (dust or chemicals), asthma, and lung infections during childhood.[81] Although COPD can be treated, there is no cure, and it generally gets worse over time.[81]

As illustrated in Figure 5.21, the age-standardized prevalence of COPD among

> *For over thirty years respiratory diseases have been some of the most prevalent chronic conditions amongst the Métis population of Canada.*
>
> – Métis Nation British Columbia, *Métis Public Health Surveillance Project: Sharing Community Health Information* [2(pp.33-4)]

FIG 5.21 **Age-standardized Chronic Obstructive Pulmonary Disease Prevalence, Métis and Other Residents, Age 35+, by Sex, BC, 2017/18**



	Females	Males
Métis	7.2	7.3
Other Residents	4.8	5.6
Métis - Number of Cases	315	299

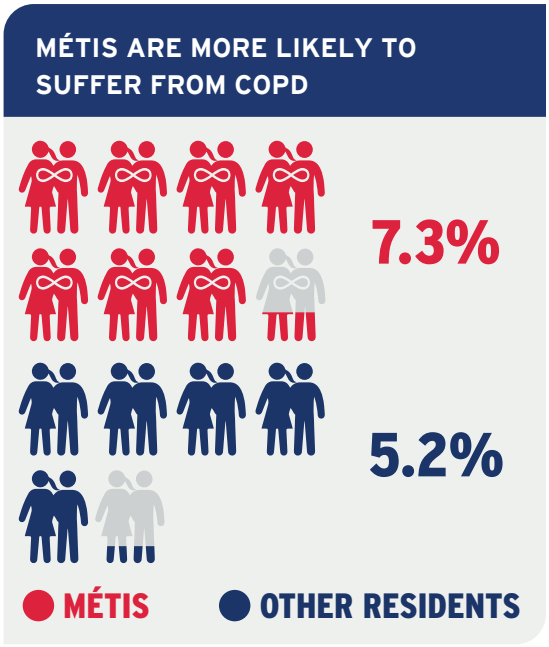
Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

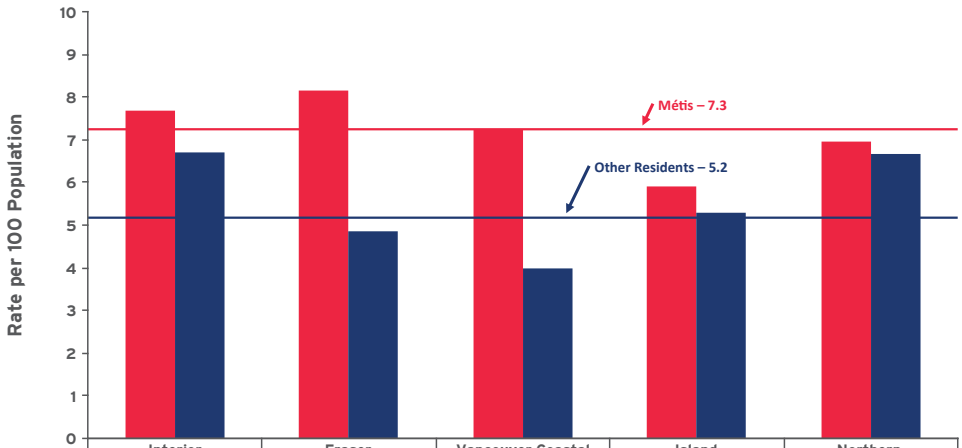
members of the Métis cohort age 35 and up was 7.3 per 100 population—significantly higher than the rate for other BC residents (5.2 per 100). Métis rates were higher among both males (7.3 per 100 for Métis males compared to 5.6 per 100 for Other Resident males) and females (7.2 per 100 for Métis females compared to 4.8 per 100 for Other Resident females). All these differences were statistically significant. However, there was no statistically significant difference between female and male prevalence within the Métis cohort.

Additional data analysis demonstrated that higher COPD prevalence was observable among those age 50 and up in the Métis cohort.[66] This included higher prevalence rates for Métis than for Other Residents among those age 50–59, 60–69, and 70–79, and these differences were all statistically significant.[66]



See Figure 5.21. Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019.

FIG 5.22 Age-standardized Chronic Obstructive Pulmonary Disease Prevalence, Métis and Other Residents, Age 35+, by Health Authority, BC, 2017/18



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	7.7	8.1	7.3	5.9	7.0
Other Residents	6.7	4.8	4.0	5.3	6.7
Métis - Number of Cases	206	147	38	92	131

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Geographically, COPD prevalence among Métis ranged from a high of 8.1 per 100 population in Fraser Health to a low of 5.9 per 100 population in Island Health (see Figure 5.22). Relative to Other Residents, Métis COPD prevalence was significantly higher in Fraser Health and Vancouver Coastal Health.

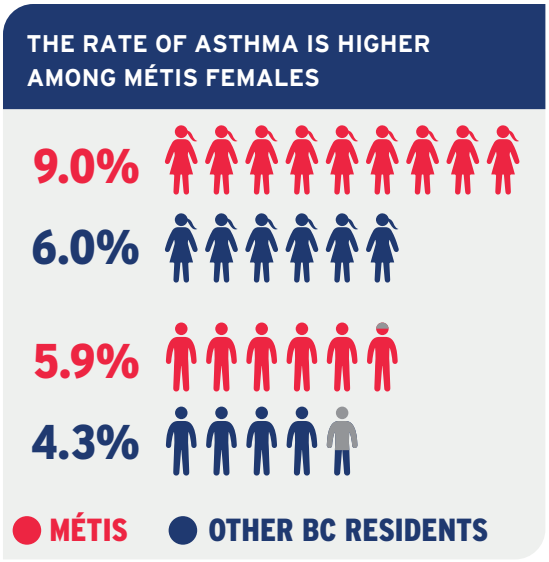
The greater burden of COPD among Métis in BC is consistent with higher levels of COPD and/or other respiratory illnesses (e.g., asthma) reported among Métis populations at the national level[82] and in Alberta,[83] Manitoba,[4] and Ontario.[6] The Ontario study found notably higher COPD incidence rates for both Métis females and males than for females and males in the general population. The same study recorded an incidence rate of asthma among Métis females that was approximately double the rate among Métis males.[6]

In BC, age-standardized COPD incidence rates were significantly higher for Métis people overall (7.8 per 1,000 population compared to 5.6 per 1,000 for Other Residents) and for Métis females, but the difference between Métis and Other Resident males was not significant.[66] Given these higher incidence rates among Métis, the gap in prevalence between Métis and Other Residents is unlikely to decrease as long as the gap in incidence rates remains and current differentials in mortality rates are unchanged.

Asthma

Asthma is a chronic condition that makes breathing difficult. When irritated, the sensitive tissues surrounding the breathing passages swell, and the airway constricts and fills with mucus.[84] Like COPD, asthma has no cure, but can be managed effectively.[84] Asthma is among the chronic diseases most frequently reported by Métis people in Canada.[2]

Although asthma was not included in the original list of indicators for this report, it was added because the results were very similar



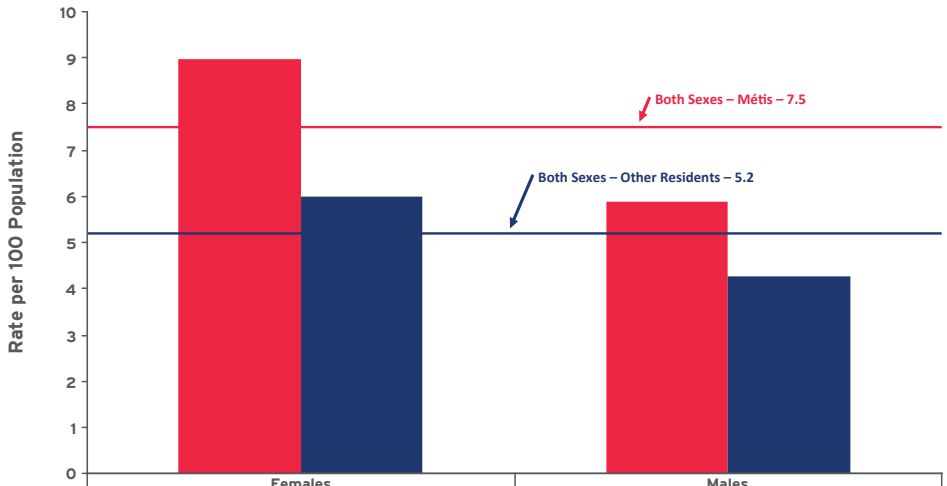
See Figure 5.23. Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019.

to those for COPD, including significantly higher prevalence and incidence among Métis people in BC than among Other Residents.[66] This suggests that there may be a broader respiratory issue among Métis residents of BC.

As noted earlier in this report (this chapter and Chapter 3), this broader respiratory issue could be associated with behavioural factors such as higher smoking rates among Métis people in BC, especially females. In addition, as discussed in Chapter 3, poorer respiratory health may be linked to environmental factors (e.g., mold and other toxic substances) related to socio-economic status and substandard housing.[85]

As Figure 5.23 shows, at 7.5 per 100 population, the age-standardized prevalence of asthma within the Métis cohort was almost 1.5 times that of the rate for Other Residents of BC (5.2 per 100). Gaps also existed between Métis and Other Resident males as well as females, but the gap was greater between Métis and Other Resident females. The prevalence of asthma among Métis females was also substantially higher than among Métis males. All of these differences were statistically significant.

FIG 5.23 **Age-standardized Asthma Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18**

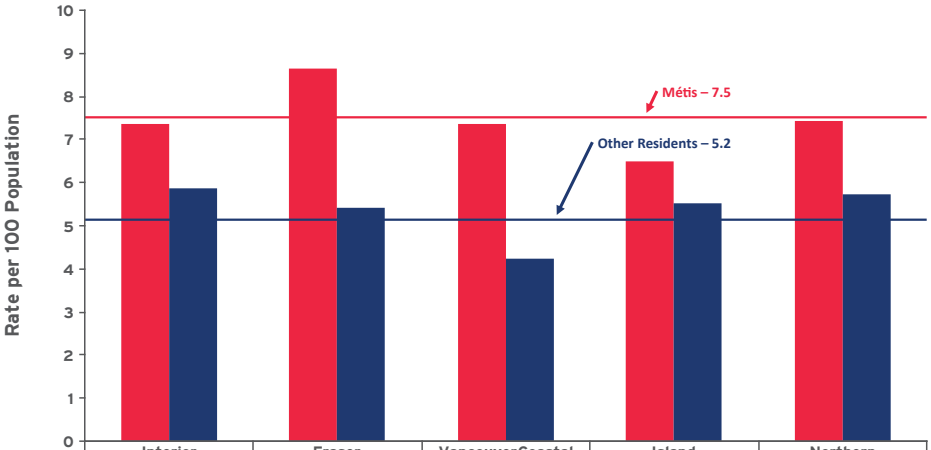


	Females	Males
Métis	9.0	5.9
Other Residents	6.0	4.3
Métis - Number of Cases	632	377

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.24 Age-standardized Asthma Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18



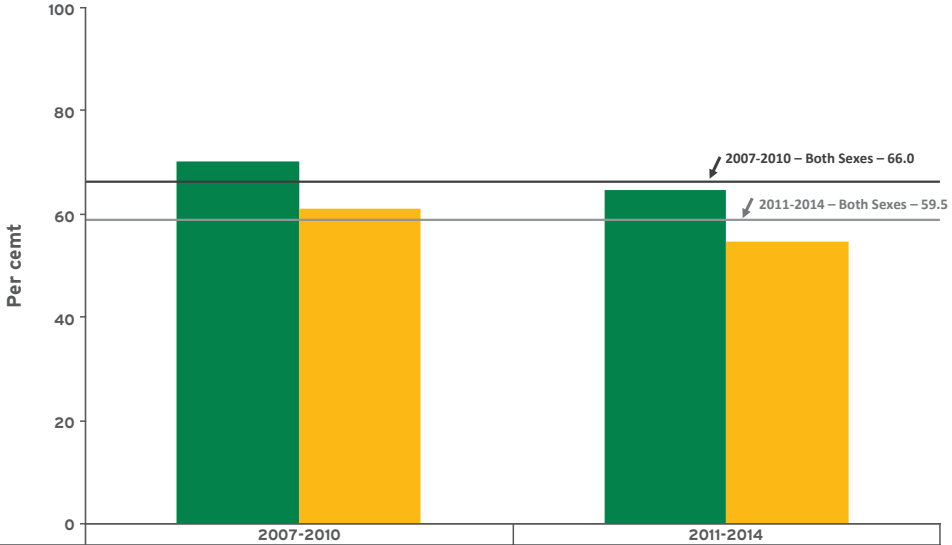
	Interior	Fraser	VancouverCoastal	Island	Northern
Métis	7.4	8.6	7.4	6.5	7.4
Other Residents	5.9	5.4	4.3	5.5	5.7
Métis - Number of Cases	302	258	77	151	219

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.25 Self-perceived Mental Health, Very Good or Excellent, Métis, Age 12+, by Sex, BC, 2007-2010 and 2011-2014



	2007-2010	2011-2014
Females	70.4	63.0
Males	61.4	54.8

Survey Period

Note: "Métis" includes people who self-identify as Métis.

Sources: Statistics Canada – Combined samples from the Canadian Community Health Survey, 2007-2010 and 2011-2014. Table 13-10-0457-01, Health Indicators by Aboriginal Identity, four-year period estimates. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, July 2021.

> *Considering that physical, emotional, and mental health information is sporadically available on Métis people and slowly increasing, the lack of the other elements of health including spiritual well-being needs to be addressed.*
>
> – Métis Nation British Columbia, *Métis Community Health Indicators Capacity and Need* [59(p.11)]

In March 2020, Métis Nation British Columbia launched *Resilient Roots: Métis Mental Health and Wellness Magazine*. The magazine was developed by the Métis Youth Mental Health and Wellness Initiative to explore mental health and wellness from Métis perspectives. *Resilient Roots* showcases the voices of Métis community members through photos, articles, stories, and poetry.[86]

Source: Métis Nation British Columbia.

Age-standardized asthma prevalence was significantly higher for those in the Métis cohort in all health authorities except Island Health (Figure 5.24), with the largest gaps apparent in Fraser Health and Vancouver Coastal Health.

Further analysis found that the age-standardized asthma incidence rate of 6.6 per 1,000 within the Métis cohort was significantly higher than the rate of 4.7 per 1,000 among Other Residents.[66]

Mental Health

As discussed throughout this report, mental health is an integral component of overall health and wellness for Métis people. As the data in this report show, mental health is a critical area of concern for Métis youth and adults in BC, and for Métis females in particular. This section of the report explores self-perceived mental health as well as mental illness (mood and anxiety disorders and substance use disorders) among Métis people in BC. These are important aspects of mental health and wellness.

> *The term colonial trauma… is a far more fitting term that helps indicate this is an ongoing issue and a continual struggle for all First Nations, Métis, and Inuit people… People often think of intergenerational trauma as something that has an 'end' date, something we're close to reaching. My hope is that colonial trauma starts to link it to the TRC and MMIWG investigations and helps solidify the understanding that this is truly an ongoing and growing concern… [rather than] an artifact of history. Colonial trauma also succinctly ties historical and contemporary sources of harm to Indigenous culture, language, and land to the source: colonialism.*
>
> – Stephen Thomson, former Provincial Harm Reduction Coordinator, Métis Nation British Columbia[36]

As shown in Figure 5.25, 59.5 per cent of Métis people age 12 and up in BC in 2011-2014 reported that their mental health was *very good* or *excellent*. This is down from 66.0 per cent in 2007-2010. It is also lower than the 68.9 per cent of non-Indigenous people in BC who reported *very good* or *excellent* mental health in 2011-2014.[23] Unlike with other mental health indicators presented in this report, Figure 5.25 also shows that Métis females were more likely than Métis males to report positive mental health.

- MENTAL WELLNESS
- ABUSE
- RELATIONSHIPS
- BULLYING
- ADDICTIONS
- SUICIDE & IDEATION
- DEPRESSION
- GRIEF & LOSS
- SELF-HARM
- PEER PRESSURE
- ANXIETY
- FINANCIAL ISSUES
- CULTURE

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Risk assessment
Safety monitoring
Community engagement

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(1-833-638-4722)

24 hour access to Crisis Programs

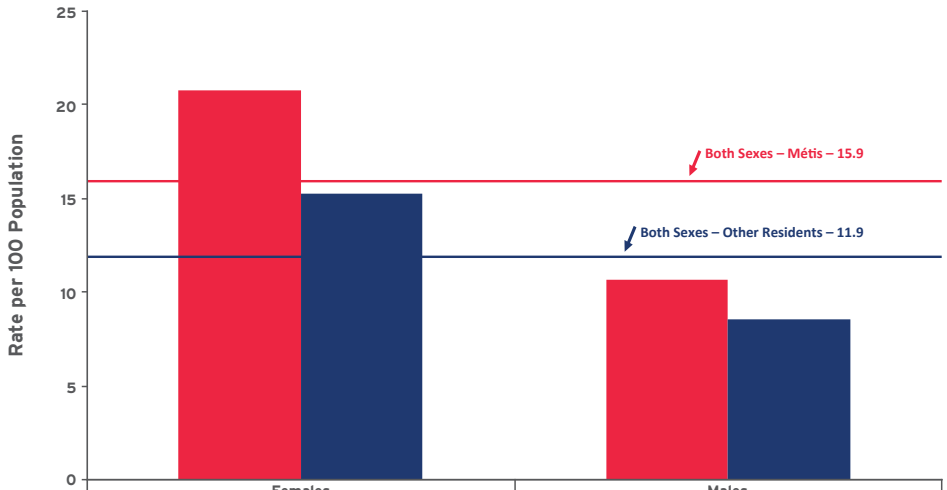
1-833-MÉTISBC

(1-833-638-4722)

MÉTIS NATION BRITISH COLUMBIA

in collaboration with KUU-US Crisis Services

FIG 5.26 Age-standardized Mood and Anxiety Disorder Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



	Females	Males
Métis	20.7	10.7
Other Residents	15.3	8.5
Métis - Number of Cases	1,522	709

Sex

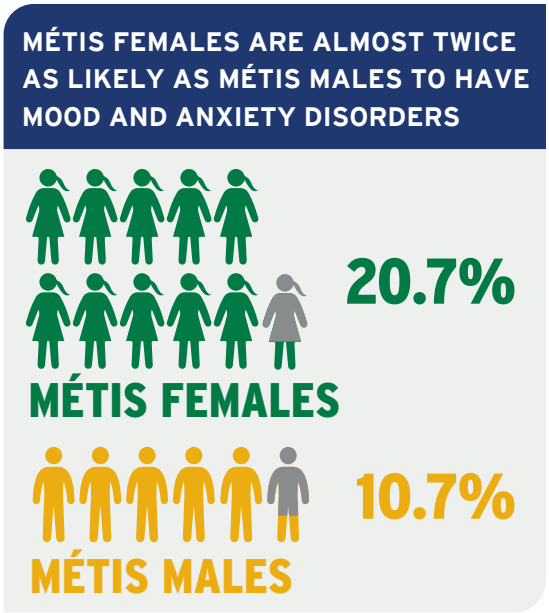
Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Mood and Anxiety Disorders

Mood and anxiety disorders are mental or emotional issues that may be temporary or longer-lasting. People with these disorders may experience emotional "highs" (feeling manic) and/or "lows" (feelings of despair); these and other symptoms may cause sufferers to withdraw from their regular activities. Mood and anxiety disorders include generalized anxiety, panic attacks, depression, bipolar disorder, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), postpartum depression, and many others.[87] The Department of Psychiatry at the University of British Columbia describes mood and anxiety disorders as "the most common and most burdensome disorders in all of medicine."[88] It is likely that colonial trauma has an ongoing impact on the mental health and wellness of Métis and other Indigenous peoples.[16]

As shown in Figure 5.26, the age-standardized prevalence of mood and anxiety disorders among the Métis cohort in 2017/18 was 15.9 per cent. This was substantially higher than the rate for Other Residents (11.9 per cent). Gaps exist between Métis and Other Resident males as well as females,



See Figure 5.26. Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019.

MENTAL ILLNESS: Raising Awareness, Reducing Stigma

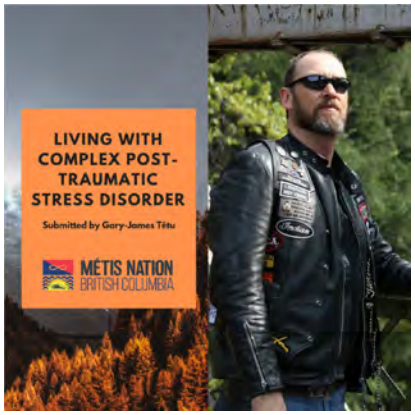
In recognition of Mental Illness Awareness Week, October 5-9, 2020, Métis Nation British Columbia featured stories from five courageous Métis citizens living with mental illness to help illuminate their day-to-day struggles and the ways they work to overcome them. Excerpts from their stories are shared here.

"In speaking your words of resilience, you have fostered hope and understanding. Though this campaign has come to an end, know that this is a dialogue that must continue year-round."

– Métis Nation British Columbia[89]

Learn more at www.mnbc.ca

Has culture played a role in your mental health journey?



Culture and community are massive factors for good emotional health, mental health, physical health and especially our spiritual health. So many of us deny our spirituality due to confusing it with religion. Any community that supports, understands and appreciates us without judgement, or expectations is crucial. This can come in the form of sports teams, music, food, sweatlodge, ethnic groups, hobbies, volunteer work, etc. I believe we all need to truly understand and implement this to fully balance our medicine wheel and keep it rolling smoothly. I wish there were more opportunities locally for Métis culture to be incorporated into peoples' lives and routines.

- Gary-James Têtu[93]

When you tell someone you live with **Borderline Personality Disorder** (BPD), it can be scary to accept and can change how they look at you. As a person living with BPD, after telling people about my disorder, sometimes people will become afraid of me. This is the stigma around mental illness that can be very challenging to deal with on top of everything else you are going through.

Living with BPD has been a challenge, as with all mental illnesses. It does not have a cure, but can be manageable. At the time of diagnosis it felt like a life sentence to suicidal ideation, sadness, and a guarantee of a really horrible existence. I now know that is not the case. You can live with mental illness; you don't have to just survive but you can thrive.

- Ava[91]

What words of hope would you share with someone who has been newly diagnosed with your particular mental illness(es)?

You are not your illness. You are not broken. It's extremely hard to believe that life will get better but the tears you shed will eventually begin lowering the weight that sits on your shoulders. Use your voice. Please ask for help, even if all you do is call a crisis line and say 'I need help.' Those words are the most important words you will ever say in your life. Taking that massive first step shows you how much strength you have inside you.

- Lisa Melton[92]

Have you felt stigma because of your illness?

Yes, and I feel it comes from the classic "Man's Man" approach to life that is so often portrayed. It is OKAY for men to have mental health issues. Men CAN cry. These are things that I think a lot of people need to know and respect.

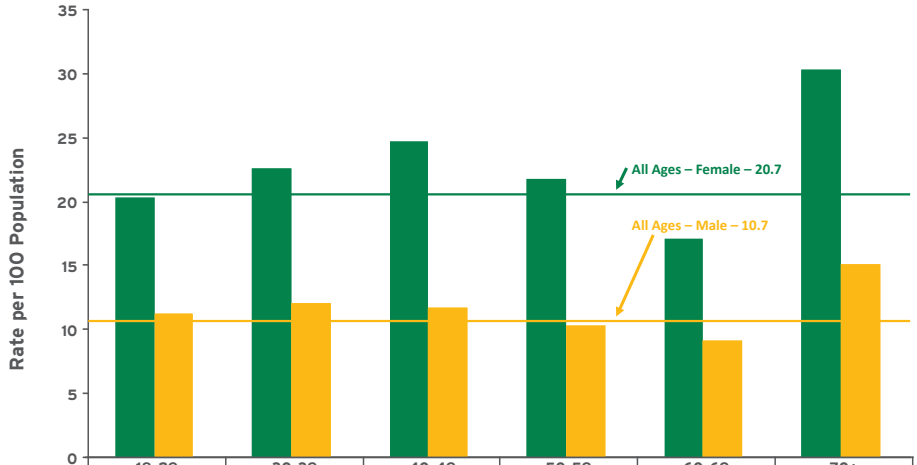
- Shaughn Davoren[90]

Are there any cultural teachings that have helped you during your journey?

An Elder taught me to visualize sending healing light energy through Mother Earth up to myself or anyone else who is struggling. In addition, they emphasized that one can find strength in connecting to nature and expressing gratitude for our environment, planet, and universe. In my experience, doing this can help me snap out of a bad head space when I am able to realize how small my problems are in comparison to the vastness and wonderment found within our world.

- Elle[94]

FIG 5.27 Mood and Anxiety Disorder Prevalence, Métis, Age 18+, by Sex and Age Group, BC, 2017/18



	18-29	30-39	40-49	50-59	60-69	70+
Females - Rate	20.6	22.5	24.6	21.7	17.0	30.3
Males - Rate	11.2	12.0	11.6	10.5	9.1	15.1
Females - Number of Cases	413	236	285	311	174	103
Males - Number of Cases	218	126	116	124	83	42

Age Group

Note: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Cohort 2019 from Métis Nation BC. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2021.

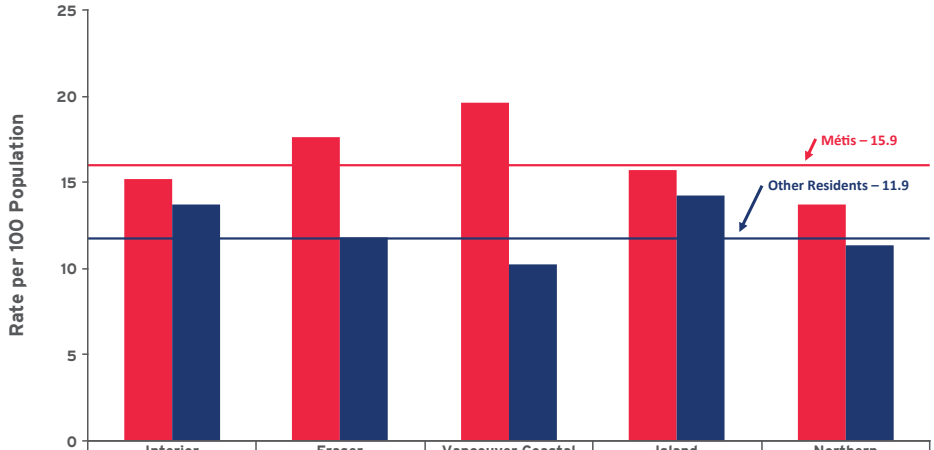
although the gap was particularly large between Métis and Other Resident females. Within the Métis cohort, prevalence among females was nearly double the prevalence among males. All these differences were statistically significant.

As illustrated in Figure 5.27, the prevalence of mood and anxiety disorders among Métis females was much higher across all age groups 18 and up compared to Métis males. For Métis females under age 60, the prevalence of mood and anxiety disorders was consistently between 20 and 25 per cent. It declined to 17 per cent among those age 60–69, then increased substantially to 30.3 per cent for Métis females age 70 and up. Although mood and anxiety disorder prevalence among males is much lower, it follows a similar pattern, hovering at between 10 and 12 per cent for Métis males in all age categories from 18–29 to 50–59, going down to 9.1 per cent in the 60–69 age group, then rising substantially to 15.1 per cent among those age 70 and up.

The elevated prevalence of mood and anxiety disorders within the Métis cohort is consistent

Source: Métis Nation British Columbia. Artwork by Nevada Christianson.

FIG 5.28 **Age-standardized Mood and Anxiety Disorder Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18**



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	15.2	17.6	19.6	15.7	13.7
Other Residents	13.7	11.8	10.2	14.3	11.6
Métis - Number of Cases	639	565	219	374	429

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

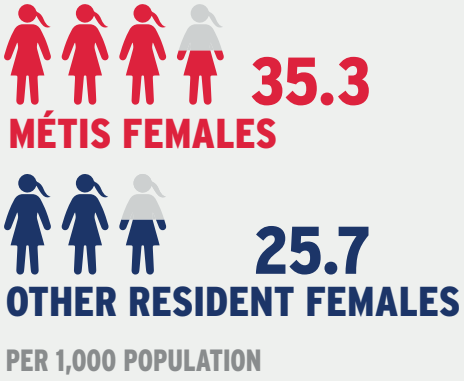
with the higher proportions of Métis youth in BC reporting mental health challenges, as discussed in Chapter 4. This is also consistent with an Alberta study that found the prevalence of mood disorders (including depression) among Métis to be much higher than the prevalence among the non-Indigenous population.[3] The Alberta study also noted that the prevalence of disorders such as anxiety was higher among Métis than among the non-Indigenous population.[3]

As Figure 5.28 shows, mood and anxiety disorder prevalence among Métis was higher than for Other Residents in all BC health authorities. The difference was only statistically significant in Vancouver Coastal Health, although the difference in Fraser Health bordered on significance. The higher prevalence among Métis at the provincial level reflects elevated prevalence for Métis residents in those two health authorities.

The age standardized incidence rate of mood and anxiety disorders for the Métis cohort in BC was 26.2 per 1,000 population, compared

Source: Métis Nation British Columbia. Photo by June Graham.

INCIDENCE OF MOOD AND ANXIETY DISORDER IS HIGHER FOR MÉTIS FEMALES IN BC



Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019.

to 21.0 per 1,000 for Other Residents. Among females, the gap was more substantial: the rate for Métis females (35.3 per 1,000) was much higher than the rate for Other Resident females (25.7 per 1,000).[66]

The differences between Métis and Other Residents overall and between Métis and Other Resident females were statistically significant. Although the incidence of mood and anxiety disorders among Métis males was higher than for Other Resident males, this difference was not statistically significant.[66] The significant gap in incidence rates between Métis and Other Resident females in BC suggests that the gap in prevalence for mood and anxiety disorders will continue to grow. This finding corresponds to several factors discussed in this report, such as colonial trauma and the intergenerational effects of the residential school system. In addition, the greater burden of mental health issues (along with various other health problems) experienced by Métis females throughout the life course may be linked to the intersections and compounding effects of racism and sexism[95] and experiences or fear of violence.[96] It may also be exacerbated by the epidemic of missing and murdered Indigenous women and girls in Canada.[97,98]

Substance Use Disorders

Figures 5.29 and 5.30 present data on individuals who saw a physician for or were hospitalized with a diagnosis of a substance use disorder in 2017/18.[u,100,101] The prevalence of substance use disorders within the Métis cohort (Figure 5.29) was slightly lower than for Other Residents overall, and for both males and females. The differences were statistically significant. Within the Métis cohort, prevalence was significantly higher among males than females.

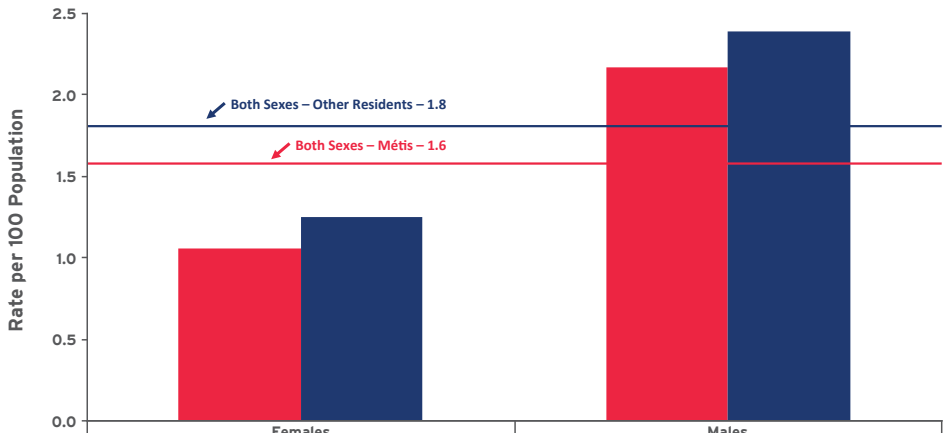
An exception to this general pattern was found in Vancouver Coastal Health, which reported a much higher and statistically significant prevalence of substance use disorders for the Métis cohort, relative to the rest of the population (see Figure 5.30). Fraser Health showed a slightly higher prevalence for the Métis population, although the results for Métis and Other Residents in this region were comparable. The reasons

ALCOHOL USE AND COVID-19

In response to both increased alcohol consumption and misinformation about alcohol use during the COVID-19 pandemic,[25,26] the World Health Organization Europe has suggested that alcohol use may make a person more susceptible to contracting COVID-19. This is because drinking alcohol is associated with a variety of communicable and non-communicable diseases, mental health disorders, and risk-taking behaviours. Alcohol use can also compromise the immune system.[27]

[u] Substance use disorders include alcohol use disorder, tobacco use disorder, cannabis use disorder, opioid use disorder, and several others. Alcohol use disorder is different from self-reported heavy drinking, as examined in Figure 5.4.

FIG 5.29 Age-standardized Substance Use Disorder Prevalence, Métis and Other Residents, Age 18+, by Sex, BC, 2017/18



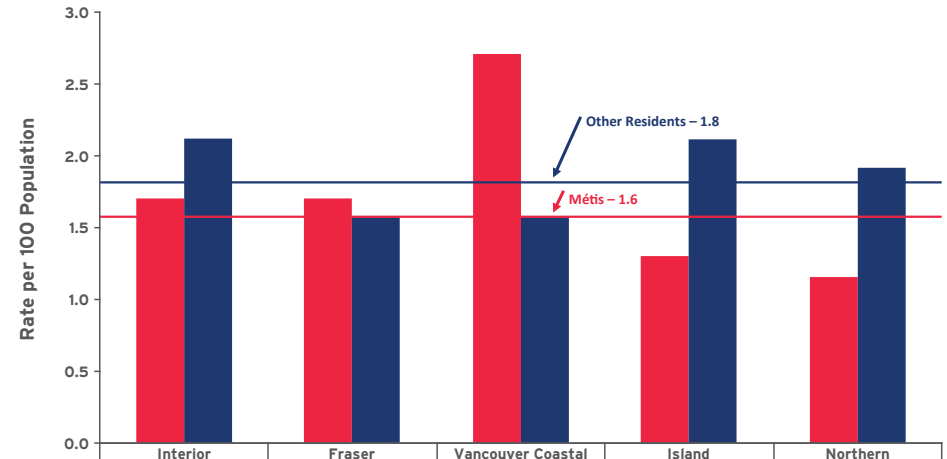
	Females	Males
Métis	1.1	2.2
Other Residents	1.2	2.4
Métis - Number of Cases	77	145

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG 5.30 Age-standardized Substance Use Disorder Prevalence, Métis and Other Residents, Age 18+, by Health Authority, BC, 2017/18



	Interior	Fraser	Vancouver Coastal	Island	Northern
Métis	1.7	1.7	2.7	1.3	1.2
Other Residents	2.1	1.6	1.6	2.1	1.9
Métis - Number of Cases	72	55	29	30	36

Health Authority

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. Health authority is based on the postal code of residence of the individual.

Sources: BC Ministry of Health, Chronic Disease Registries and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

> *I have felt stigma because of my substance use. I think the worst stigma was from the police and people in positions of authority, who were in control of my life. I often was reminded that I have less rights than others and that I should be appreciative of what they do for me because they can take it all away and there's nothing I can do about it.*
> *...I didn't believe I was suffering from addiction because I was still able to complete school, hold a job, go to college. My addiction definitely structured my life for a long time before it became unmanageable.*
> *...I am very fortunate to have such great support through the Métis community... The medicine wheel teachings help me learn what real self care and self awareness [are] and made life more manageable. The music and prayer give me a sense of connection and community.*
>
> – Caty, Métis Substance Use Survivor[102]

for this regional variation are unknown. The availability of substance use treatment beds and programs may influence the breakdown of these numbers by health authority.

In November/December 2020, Métis Nation BC hosted a series of four online dialogues on alcohol and community health. These dialogues focused on connection, relationship, and honouring the deep wisdom of Métis culture. The dialogues also supported Métis participants to connect, to share their own stories and experiences, and to learn from one another in a safe and respectful environment. The dialogue series culminated in the development of a graphic recording (Figure 5.31), which reflects the voices of the participants, the themes that emerged, and new possibilities for Métis community health and resilience in terms of the underlying issues related to alcohol use.

In 2016, BC's Provincial Health Officer declared a state of emergency in response to the surge in overdoses and overdose deaths in BC.[104] These were linked to increased toxicity in the illegal drug supply. Most of the overdoses and related deaths involved the opioid fentanyl.[105,106] Even more toxic opioids such as carfentanil and W-18 are increasingly appearing

Source: Métis Nation British Columbia. Photo by Chris Cathers.

FIG 5.31

Alcohol and Community Health Dialogue: Session Four, December 12th, 2020

Please see Appendix E for a close-up of this image.

> *I have struggled with opiate addiction since I was 21 years old, almost half my life. ...I started to get better when I stopped blaming myself... I felt, for the first time, compassion for myself. I started to do things that brought me joy, learned new creative passions like pottery and started to learn to bead. I learned so much through the beads, perseverance, patience, and connection to my ancestors. Beadings can help me find my centre and for a time I feel at ease, in balance and harmony. Creativity and connection can heal addiction, this has been my experience. Connection to safe, reliable, consistent, and kind people, can help heal addiction.*
>
> –Karen, Métis Substance Use Survivor[103]

in the illegal drug supply as well.[107] Work has been underway in the province to respond to this overdose emergency, but there has been limited success in curbing the rising overdoses. This has been further complicated by the COVID-19 pandemic and related response measures introduced in 2020. In fact, illicit drug toxicity monthly deaths in BC increased from 80 in January 2020 to 201 in October 2021—the highest monthly total reported since the overdose emergency began.[108] While MNBC health leadership is concerned about the impacts of the opioid crisis on Métis people in BC,[109] they have been unable to quantitatively track the impacts on their citizens because these data were not available.[56] Building on

the MPHS program partnership, MNBC and the Office of the Provincial Health Officer linked provincial overdose data to the Métis cohort to create Métis-specific overdose data. MNBC is now able to work with the BC Ministry of Health, BC Coroners Office, BC Centre for Disease Control, and Métis communities to monitor and respond to this crisis.

> *While preliminary work has been undertaken to explore the burden of cancer in Métis people, overall the data is limited and does not permit general conclusions.*
>
> – Lynda Earle[110(p.3)]

Cancer

The Métis National Council included cancer incidence as a priority indicator in its *Proposals for Measuring Determinants and Population Health/Well-Being Status of Métis in Canada* (2006).[111] Cancer data for the BC Métis cohort are not presented here as sufficient data were not available at the time this report was developed. A Canadian study published in 2009 found that cancer (all cancers combined) was the leading cause of death among Métis females (33 per cent of deaths) and caused 23 per cent of deaths among Métis males, second only to circulatory system diseases.[71]

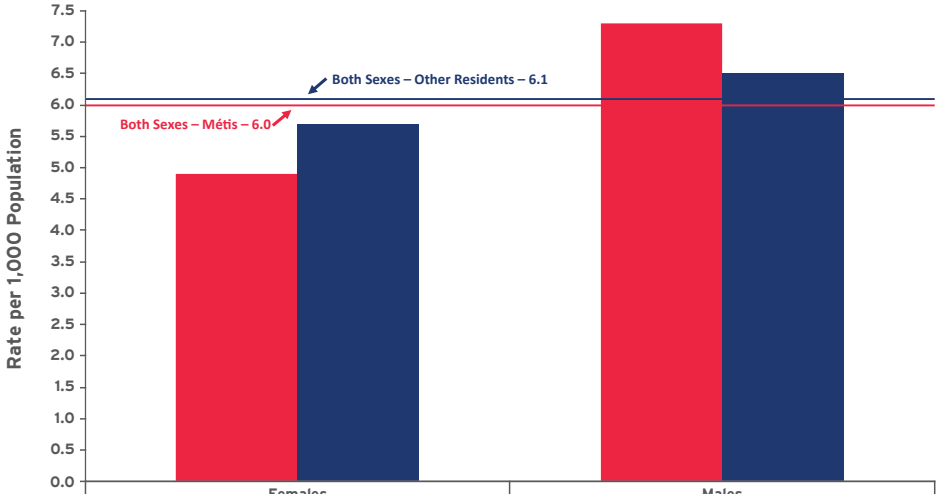
Source: Métis Nation British Columbia. Photo by Jackie Maurer.

Source: Métis Nation British Columbia. Photo by Dean Wilson.

In BC, MNBC has collaborated with First Nations Health Authority, BC Association of Aboriginal

> *MNBC recognizes the significance of working in a Métis-specific way to achieve improved health outcomes for Métis people throughout the cancer journey. Through enhanced prevention, screening, health education, and knowledge development in our Métis communities, we anticipate earlier detection and improved access to treatment.*
>
> – Susie Hooper, former Minister of Health, Métis Nation British Columbia[37(p.14)]

FIG 5.32 Age-standardized Rate of Unintentional Injuries Requiring Hospitalization, Métis and Other Residents, by Sex, BC, 2017



	Females	Males
Métis	4.9	7.3
Other Residents	5.7	6.5

Sex

Notes: "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. "Other Residents" includes Métis people who are not registered with Métis Nation BC, First Nations, Inuit, and non-Indigenous people. Standardized to the Canada 2011 population. "Injuries requiring hospitalization" are defined as injuries requiring overnight stay, excluding day surgeries. Patients who die of their injury are not included.

Sources: BC Ministry of Health, Hospital Discharge Records and Client Roster (Release V2017); Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Friendship Centres, and BC Cancer on *Improving Indigenous Cancer Journeys in BC: A Road Map*[37]—a strategy developed to support all Indigenous peoples in BC, including Métis (citizens and self-identified), First Nations (Status and non-Status), and Inuit, based on their distinct needs. An overarching principle in this strategy is the need for cultural safety and humility to be embedded in the health care system throughout the cancer care journey for patients and their families.

Unintentional Injury Hospitalizations

As Figure 5.32 shows, in 2017, Métis residents of BC were about as likely as Other Residents to be hospitalized for unintentional injuries (6.0 per 1,000 population compared to 6.1 per 1,000 population). There were relatively few Métis hospitalizations for unintentional injuries in this timeframe: only 39 unintentional injury hospitalizations among Métis males and 13 among Métis females in BC in 2017.

Source: Métis Nation British Columbia. Photo by Dennis Conrad Cronk.

> *There remains a lack of will to address systemic and specific racism towards Métis, First Nation and Inuit people… We know that our people avoid hospitals because we are afraid of having a discriminatory encounter. This happens to the point where Indigenous people end up in emergency with extreme diagnosis…*
>
> – Leslie Varley, Executive Director, BC Association of Aboriginal Friendship Centres[54]

Despite the overall similarities, this figure also shows that the hospital admission rate for unintentional injuries among Métis males (7.3 per 1,000 population) was slightly higher than for Other Resident males (6.5 per 1,000). Conversely, the admission rate for Métis females (4.9 per 1,000 population) was slightly lower than the rate for Other Resident females (5.7 per 1,000). These differences were not statistically significant, likely because of the relatively small numbers involved.

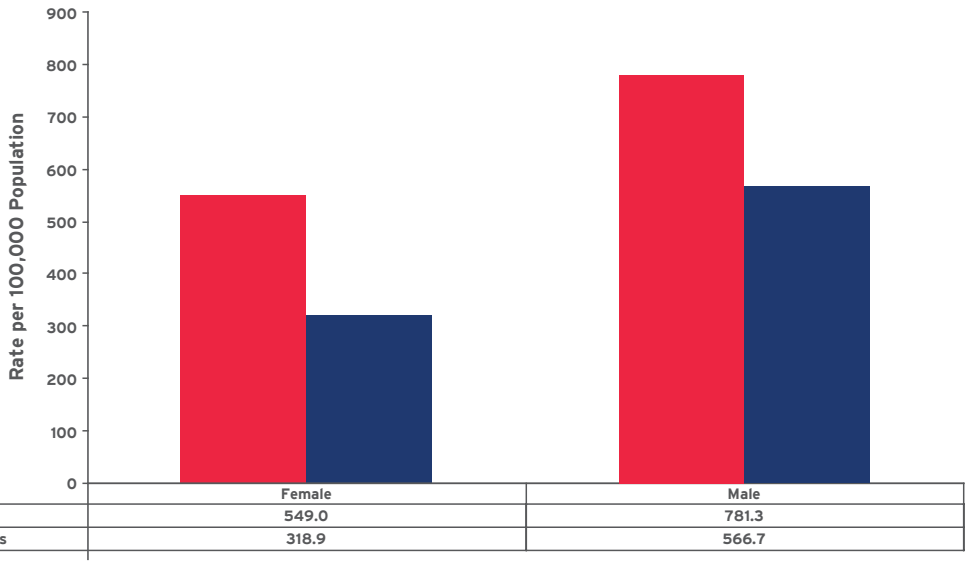
Mortality and Life Expectancy

Research demonstrates that life expectancy at birth for Métis and other Indigenous peoples in Canada is generally lower than for non-Indigenous Canadians.[35] Canada-wide, life expectancy at birth in areas with higher concentrations of Métis people is 74.8 years. This is 6.9 years below that of Canadians living in areas with lower concentrations of Indigenous people.[85]

Among Canadians who self-identified as Métis in the 1991 Census, one study (Tjepkema *et al.*) followed the same Métis cohort over an 11-year period (1991–2001). This study found that the life expectancy at age 25 for Métis males was an additional 49.5 years (i.e., they could expect to live to age 74 or 75), which was 3.3 years less than for non-Indigenous 25-year-old males, who could expect to live to

Source: Métis Nation British Columbia. Photo by Jackie Maurer.

FIG 5.33 **Age-standardized Mortality Rates, Métis and Non-Indigenous Populations, by Sex, Canada, 1991-2001**



	Female	Male
Métis	549.0	781.3
Non-Indigenous	318.9	566.7

Sex

Notes: "Métis" includes people who self-identified as having Métis ancestry. "Non-Indigenous" includes people who did not self-identify as having Métis, First Nations, or Inuit ancestry or status. Includes individuals who were 25 years or older as of June 4, 1991. Standardized to the Canada 2011 population.

Source: Tjepkema M, Wilkins R, Senecal S, Guimond E, Penny C. *Mortality of Métis and Registered Indian adults in Canada: An 11-year follow-up study.* Health Reports; 2009.[71] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

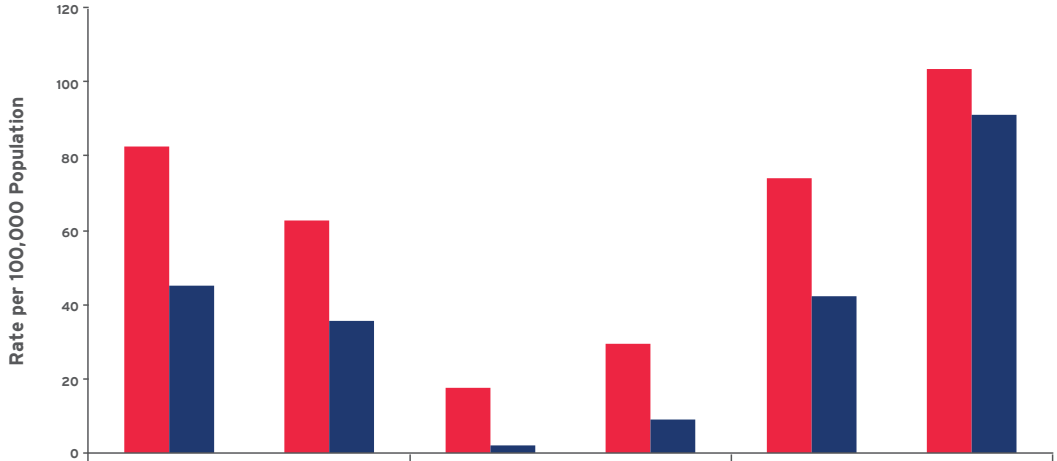
age 77 or 78.[71] The gap was larger for females: remaining life expectancy at age 25 for Métis females was 53.7 years (to age 78 or 79), which was 5.5 years less than for non-Indigenous 25-year-old females, who could expect to live to age 84 or 85.[71]

When the same study examined life expectancy based on the probability of surviving to age 75, there was a similar pattern. At age 25, 56.7 per cent of Métis males in the study were expected to survive to age 75, compared to 64.3 per cent of non-Indigenous males. While this is a sizeable gap, once again, the gap was much larger among females: at age 25, 63.3 per cent of Métis females were expected to survive to age 75, compared to 79.4 per cent of non-Indigenous females.[71]

> *Life expectancy at birth reflects the overall mortality level of a population. It summarizes the mortality pattern that prevails across all age groups in a given year—children and adolescents, adults and the elderly. Global life expectancy at birth in 2016 was 72.0 years (74.2 years for females and 69.8 years for males).*
>
> – World Health Organization[132]

The Tjepkema *et al.* study also found that the **age-standardized mortality rate** (ASMR) for Métis males in Canada was much higher than the corresponding rate for non-Indigenous males (see Figure 5.33).[71] As with the life expectancy results, the gap for females was larger: 549.0 per 100,000 population for Métis females compared to 318.9 per 100,000 for non-Indigenous females. Overall, mortality rates among Métis people were substantially higher even after controlling for differences in the age structure of the two populations.

FIG 5.34 **Age-standardized Mortality Rates, Métis and Non-Indigenous Populations, by Cause and Sex, Canada, 1991-2001**



	Deaths Preventable Through Medical Treatment		Alcohol-related Deaths		Smoking-related Deaths	
	Female	Male	Female	Male	Female	Male
Métis	82.5	62.8	17.7	29.4	73.8	103.3
Non-Indigenous	45.0	35.6	2.8	9.1	42.2	90.9

Cause of Death

Notes: "Métis" includes people who self-identified as having Métis ancestry. "Non-Indigenous" includes people who did not self-identify as having Métis, First Nations, or Inuit ancestry or status. Includes individuals who were 25 years or older as of June 4, 1991. Standardized to the Canada 2011 population.

Source: Tjepkema M, Wilkins R, Senecal S, Guimond E, Penny C. *Mortality of Métis and Registered Indian adults in Canada: An 11-year follow-up study*. Health Reports; 2009.[71] Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

Figure 5.34 shows the ASMR for Métis and non-Indigenous Canadians by cause for 1991–2001. The ASMR for smoking-related deaths was substantially higher among Métis males than non-Indigenous males; the difference was even more dramatic between Métis females (73.8 per 100,000) and non-Indigenous females (42.2 per 100,000). Differences pertaining to alcohol-related causes of death were even larger: the Métis male rate was more than three times higher than the rate for non-Indigenous males, while the Métis female rate was more than six times higher than the rate for non-Indigenous females.

The much higher ASMRs for Métis females compared to non-Indigenous females with respect to alcohol- and smoking-related causes of death are issues that warrant considerable attention. Since all deaths represented in this figure are ultimately *preventable*, these are all valid areas for focused work to reduce the inequitable burden of premature death experienced by Métis in BC.

Tjepkema *et al.'s* study concluded that factors such as income, education, and occupational skill, as well as urban residence, explained approximately two-thirds (68 per cent) of the excess mortality among Métis males but only 28 per cent of the excess mortality among Métis females.[71] A study of Métis health in Manitoba found smaller disparities in life expectancy (a reduction of 1.8 years in the life expectancy of Métis males and a nine-to-ten-month reduction in the life expectancy of Métis females). This study did, however, find significant differences in a variety of mortality indicators, with Métis people experiencing significantly higher rates of total mortality, premature mortality, injury mortality, and potential years of life lost.[4]

Source: Métis Nation British Columbia. Photo by Sherri Lund.

Métis Elders' Health

Métis communities place a high value on Elders, many of whom are also cherished Kokums/Nohkums (grandmothers), Moushoums/Moshooms (grandfathers), and Knowledge Keepers.[113] Elders and Knowledge Keepers are treasured for their experience and expertise, their knowledge of traditional cultural practices, protocols, medicines, and ceremonies, and their roles as mentors who pass this vital knowledge on to future generations.[114,115] While terms such as *senior* and *older adult* are generally used to refer to life stages or age in years, "Elder" is a term of honour used to recognize a community member who is deeply respected for their wisdom, teachings, and/or achievements.[116,117,118]

> *Métis Elders… help communities and Indigenous peoples understand who they are, where they came from, the contributions of Indigenous women to this history and unfolding story, and the ways that their lives are extensions of history.*
>
> – Judy Iseke-Barnes[130(p.25)]

> *Elders are the heartbeat of our community. They're our link to our ancestors, our teachings, and we need them to ensure cultural continuity.*
>
> –Danièle Behn Smith, Métis & Eh Cho Dene, BC Deputy Provincial Health Officer–Indigenous Health[112]

The number of Métis people age 65 and up in BC more than doubled between 2006 and 2016, increasing from 3,015 to 7,935.[v,123,124] Many health conditions are more common among older adults, making a focus on healthy aging for Métis people increasingly important. For example, as presented in Figure 5.9, diabetes prevalence increases sharply with age, among both Métis and non-Indigenous populations. Métis and other Indigenous communities know that the health and wellness of seniors and Elders is critical, both for the good of families and communities and for cultural survival.[112] Intergenerational connections promote both cultural and individual wellness.[116,119] As discussed in Chapter 4 of this report, Métis youth who have positive relationships with Elders and other adults more often report feeling connected to their community.[120] In some cases, the position of Métis Elders has been undermined by the ongoing effects of colonialism, the residential school system, and the influence of ageism.[121,122]

For many Indigenous seniors and Elders, healing from colonial trauma, including the loss of land, language, and traditions, is an important part of the process of being and

[v] Numbers are based on 2016 Census responses of Métis single origin (excluding multiple Aboriginal identity responses).

Source: Métis Nation British Columbia. Photo by June Graham.

> *I've been living as Michif, all my life. I talk Michif day in and day out, at home. My kids, my oldest daughter talks Michif. My other kids understand it very good. My grandchildren are starting to speak it… [When] this English came in, people kind of forgot their Michif language. I mean they didn't forget, but we're using English lots. At home, it was Michif. We lived Michif. We [ate] Michif, Métis foods. We live[d] the Métis life.*
>
> –Grace Zoldy, Métis Elder[131(p.29)]

> *I see that I have moved through the medicine wheel; that my pursuit of more education and experience has taken me through all four quadrants as a teacher (mental & emotional), as a religious educator and sweat leader (spiritual), and in community health education (physical).*
>
> – Marie Favel, Métis Community Elder[129]

> *As the keepers of Métis worldviews and as those responsible for passing along these worldviews to future generations,* kihteyayak/lii viyeu *['the mature ones,' 'the older people'] are the first and best source of information about Métis. They carry our histories in their stories, our visions for the future, they are caretakers of the ways of knowing of how Métis are Métis.*
>
> – Jennifer Adese[115(p.50)]

becoming well. Connectedness to culture and community, spirituality, opportunities to pass on cultural knowledge to younger generations, and re-establishing the honoured and respected place of Elders in Indigenous society are all critical to the health and wellness of Métis older adults.[119,129] At a series of Métis Elders Gatherings, Elders from across the Métis Nation identified several foundational themes to support Métis identity, health, healing, and wellness. These included a focus on and appreciation for ancestral voices and approaches to health and healing; the central role of women and family in Métis community health; the importance of the relationship between Métis people and the environment; and a return to the Michif language and the unique worldview and culture it represents.[116]

MNBC promotes senior and Elder health and wellness through initiatives such as a seniors' housing renovation program;[125] Elder abuse awareness resources,[126] and recognition and support for Métis Veterans[127] and their spouses.[128] In addition, MNBC announced a six-month Health Benefit program for low-income Métis seniors and Elders in 2021. The program will support access to medical devices such as dentures, hearing aids, walkers, and glasses.[133]

Conclusion

As this chapter demonstrates, age-standardized prevalence is significantly higher among the Métis cohort than other BC residents across the majority of conditions included in this analysis. The higher prevalence of disease among the Métis population is consistent with elevated risk due to a variety of socio-economic, occupational, and lifestyle factors such as overweight/obesity, smoking, and alcohol consumption. Among the chronic diseases, both prevalence and incidence were substantially higher among Métis for chronic obstructive pulmonary disease, asthma, and mood and anxiety disorders. With respect to mood and anxiety disorders, the incidence and prevalence among females was particularly high, which is consistent with BC Adolescent Health Survey data discussed in Chapter 4, and reinforces the serious issues pertaining to the early emergence and persistence of mental and emotional health concerns among Métis females. The greater share of variance in mortality rates between Métis and non-Métis females that could not be explained by standard socio-economic factors may reflect the intergenerational impact of residential schools upon females that was highlighted in the results of the BC Adolescent Health Survey, as discussed in Chapter 4. The data in this chapter also speak to the importance of cultural wellness for Métis people, including accessible, culturally safe health services for Métis residents and the critical role of Elders in maintaining cultural health and wellness. The following chapter provides a summary of key findings from this report and sets out recommendations and targets for improving Métis health and wellness outcomes in BC over the next decade.

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

Chapter 6:

Future Directions

"Métis people understand the issues in their communities and should play an active role in designing the research projects and translating them into program implementation, policy development and social change."

– Monique D. Auger[1(p.93)]

As this report demonstrates, the current health and wellness status of Métis people in BC must be understood in the context of the strength and resilience of Métis people, culture, and communities, as well as the underlying political, historical, and structural factors that contribute to health inequities. This report builds on other key documents, such as the Representative for Children and Youth's *Invisible Children* report on Métis children and youth in the BC child welfare system (discussed in Chapter 2);[2] the McCreary Centre Society's reports on the health of Métis youth in BC (discussed in Chapter 4);[3,4,5] the *In Plain Sight* report on Indigenous-specific racism in the BC health care system (discussed in Chapter 5);[6] and Métis Nation British Columbia's (MNBC) own report, *A Tale of Two Nations*,[7] documenting the absence of meaningful recognition of the Métis as a distinct and rights-bearing Indigenous Nation. Collectively, these reports show how mainstream systems and structures lack understanding of Métis identity, culture, and rights. The result is compromised cultural safety and cultural wellness, inequitable treatment and funding, limited Métis programs and services, and poorer outcomes for Métis people.[7]

> *Racism has inserted non-Indigenous peoples as the authors of not only who we are, but also how we are.*
>
> – Dr. Billie Allan and Dr. Janet Smylie[10]

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

Nonetheless, many Métis people and communities continue to thrive, demonstrating the pride, spirit, and resilience that have been attributed to Métis people and cultures throughout their history.[8,9] Given the

> *Now that I am back in touch with my culture… that's what grounds me. You know, I have to be honest; there's still a little tiny piece, I think, of living so many years with loss of identity and cultural loss…. There's still a piece missing. I haven't come full circle yet….*
>
> – Métis Interviewee, Fort St. John[11(p.192)]

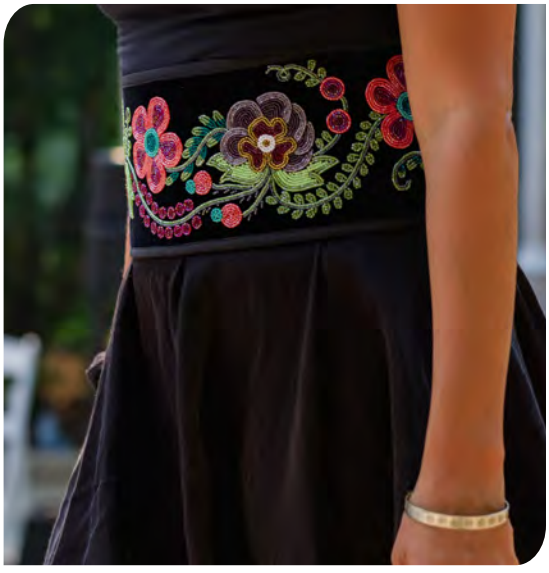
systemic discrimination and social exclusion experienced by Métis people, including assimilation attempts by colonial governments (e.g., residential schools, child welfare policies), Métis cultural continuity and progress toward true self-determination are remarkable achievements that signify the strength and vitality of Métis culture and identity.

The data and analyses presented in this report illuminate the impacts of persistent ideologies of white supremacy, which, through systemic racism and social exclusion, create and sustain gaps in health and wellness outcomes between Métis people and other British Columbians. Several of the data sources and health and wellness indicators chosen for this report are rooted in a deficit-based mainstream biomedical approach. Although these indicators are important, it is equally important to recognize that they tell only part of the story of Métis health and wellness. The quotes and images from Métis people throughout this report provide additional perspectives. This chapter summarizes the report's findings and identifies four priorities for future work. It also identifies targets for a selection of core indicators for the Métis Public Health Surveillance (MPHS) program, to be achieved by 2030, and offers four recommendations to help advance the health and wellness of Métis people in BC.

Summary and Discussion of Findings

This report emphasizes the urgent need to privilege Métis perspectives on health and wellness and disrupt status quo colonial policies and practices that negatively impact Métis wellness. For example, data presented in Chapter 4 of this report highlight that connectedness to the land and to their families, communities, and cultural teachings is linked to better health outcomes for Métis youth. The negative impacts of colonization and colonialism are also reflected in the data, including evidence of poorer health and wellness outcomes among Métis youth with a family history of residential school attendance. These associations underscore the importance of Métis self-determination and of taking a wholistic, strengths-based approach that encompasses the spiritual, emotional, mental, and physical components of health and wellness.

Strategies to improve Métis health and wellness must address not only downstream outcomes such as "disease" and "disability," but also important and interrelated health



Source: Métis Nation British Columbia. Photo by Derek Robitaille.

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

determinants, including income, education, employment and working conditions, sex and gender, and access to adequate, suitable, and affordable housing. To support Métis health and wellness, individuals and governments alike must work to root out pervasive racism, colonialism, and related attitudes and actions that lead to systemic and structural inequities, rather than merely focusing on behaviours such as physical activity or smoking.

Findings presented in this report align with Métis community perspectives that indicate the most immediate priorities for advancing Métis health and wellness in BC are mental and emotional health, overall disease prevention, and promotion of healthy behaviours (including lifestyle factors such as substance use and healthy eating), respiratory and heart health, and healthy weights. Findings related to emotional and mental health are similar for Métis youth and adults. These include elevated incidence rates of mood/anxiety disorders compared to other BC residents and the early emergence of mental health concerns, particularly among young females and non-binary youth.

Significantly higher incidence rates of chronic obstructive pulmonary disease (COPD) and asthma among Métis people, along with higher prevalence of hypertension, ischaemic heart disease, and diabetes, suggest that these conditions also need to be prioritized in health planning to support Métis people. Sex-based differences include a much higher risk of chronic non-communicable respiratory diseases among females. Respect for Métis rights requires targeted, Métis-focused actions, such as those recommended in this report, to address the systemic disadvantage highlighted by these findings. This includes programming with a specific focus on supporting Métis females.

In addition to these findings, potentially important patterns of geographical variation emerged that may support different priorities within different health authorities. For example, COPD prevalence was higher for Métis than for Other Residents in all BC health authorities, but the differences appeared particularly large in Vancouver Coastal and Fraser Health. Chronic kidney disease prevalence was significantly higher for Métis than for Other Residents in Interior Health and Northern Health, and rheumatoid arthritis prevalence was significantly higher for Métis people only in Island Health. In terms of prevalence of mood and anxiety disorders, Vancouver Coastal Health registered both the highest prevalence among Métis and the greatest differential, with prevalence among Métis almost twice that of Other Residents. Vancouver Coastal Health was also the only health authority in which substance use disorder prevalence was significantly higher among Métis than Other Residents.

The MPHS data presented in this report focus on Métis citizens age 18 and up; however, this report also explores the health and wellness of Métis youth (age 12–19) using data from the McCreary Centre Society's BC Adolescent Health Survey (BC AHS). In addition to emphasizing the importance of community and cultural connectedness, results from the BC AHS identify other areas of strength for Métis youth, such as higher rates of physical activity. However, the data also show areas of concern, such as poorer mental and emotional health and higher rates of tobacco and alcohol use observable among Métis youth.

Supporting Métis people to meet their full wellness potential requires upholding Métis people's inherent rights, including the rights to self-determination, cultural wellness, and recognition of the Métis as a distinct Indigenous Nation. Upholding these rights can help improve the health and wellness of Métis people and communities. Structural and systemic factors such as racism, white supremacy, and social exclusion cause harms and disadvantage Métis people, as reflected in the health inequities explored in this report. Therefore, optimizing Métis health and wellness must include working to address root causes such as colonial and intergenerational trauma and patriarchal attitudes; providing Métis-specific health and wellness programs and services; and promoting cultural safety and wellness for Métis people in the mainstream health care system. Attention to inequities based on age, sex, gender, and geography will help to target programming to the areas of greatest potential impact. The recommendations offered below respond to the immediate health and wellness needs of Métis people while also promoting longer-term systemic change.

Recommendations

The recommendations in this chapter are intended to inform the efforts of MNBC, the provincial and federal governments, and other parties to meet the health and wellness needs of Métis people in BC and to respond to the issues highlighted in this report. To truly advance Métis health in BC, efforts must be made inside and outside of government and by partners across all sectors. Therefore, for each recommendation, a lead organization and key support organizations are proposed. These lists are not exhaustive, and further engagement and partnerships will be needed to successfully advance this work.

On October 27, 2021, MNBC and the Province of British Columbia signed a Letter of Intent formalizing their intention to co-create a collaborative, accountable, "whole of government" approach to Métis-Provincial Government relations in BC, including the development of an Assistant Deputy Minister's Committee and a new Métis Relations Working Table.[12] This work supports priorities such as equity and anti-racism, implementation of the *Declaration on the Rights of Indigenous Peoples Act*, and lasting and meaningful reconciliation, which are embedded in the November 26, 2020, mandate letters to each BC government minister, minister of state, and parliamentary secretary.[13,14] These commitments affirm that addressing the recommendations outlined below is a shared responsibility. Nonetheless, specific ministries and organizations are identified based on how closely the focus of their work supports each recommendation. This is an invitation to these organizations to collaborate on this work.

PRIORITY #1:

IMPROVED MÉTIS HEALTH AND WELLNESS THROUGH UPHOLDING MÉTIS SELF-DETERMINATION

Métis self-determination is a fundamental determinant of health. For Métis people to optimize their health and wellness, their inherent rights must be upheld; for example, through recognition of MNBC governance, distinctions-based programs and policies, and a commitment to enhance cultural safety and promote cultural wellness across mainstream systems. One longstanding challenge is a lack of recognition of the unique Indigenous identity of Métis people and of the governance role of MNBC. Programs and policies are frequently implemented in BC that are intended to include all Indigenous peoples, but which fail to adequately involve or recognize Métis people and Métis governance. The Letter of Intent signed by MNBC and the Province of British Columbia in October 2021 is a promising next step. Actions must now be taken to advance its commitments, recognize the mandate and responsibility of MNBC within the province, and increase the involvement of Métis people in program and policy decisions that impact them. Implementing BC's *Declaration on the Rights of Indigenous Peoples Act* across government in a consistent and coordinated way that reflects Indigenous rights and reconciliation is another immediate opportunity to catalyze meaningful change for Métis people in BC.

Source: Métis Nation British Columbia. Photo by Zoe Edgar-Wilson.

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

RECOMMENDATION 1

Create accountabilities to Métis health and wellness within the MNBC—Province of British Columbia Métis Relations Working Table by establishing a Health and Wellness sub-Working Table that includes leadership from MNBC, BC Ministry of Health, BC Ministry of Mental Health and Addictions, the Office of the Provincial Health Officer, and regional health authorities.

a) The Health and Wellness sub-Working Table should report regularly to the Métis Relations Working Table on progress related to co-development and implementation of strategies, programs, policies, and services to support the following:

   i. Enhancing cultural safety and cultural wellness for Métis people;

   ii. Ensuring that provincial health systems are responsive to and inclusive of the unique needs and cultural traditions of Métis people;

   iii. Developing Métis-specific cultural safety and cultural wellness training; and

   iv. Increasing the numbers of Métis health care providers (physicians, nurses, etc.).

This approach aligns with the BC Minister of Health's mandate to "draw from the work of the independent investigation into systemic Indigenous-specific racism in health care in BC to address systemic racism in the health care system, including by leading work with health employers and unions to prioritize the hiring of a health care workforce that better represents the diverse communities it serves."[15(p.5)] This work has included the establishment of the In Plain Sight Task Team in September 2021 to eliminate Indigenous-specific racism and promote cultural safety in the BC health care system.[16]

b) Use the MPHS program report findings as indicators of the Métis Relations Working Table's progress on improving determinants of health and health outcomes for Métis people.

PROPOSED CO-LEADS:

Métis Nation British Columbia

BC Ministry of Health

PROPOSED SUPPORT:

BC Ministry of Indigenous Relations and Reconciliation

BC Ministry of Mental Health and Addictions

Office of the Provincial Health Officer

Post-secondary institutions offering health-profession-related education and training

Provincial Health Services Authority

Regional health authorities

PRIORITY #2:

FULLY REALIZED MENTAL HEALTH AND WELLNESS FOR MÉTIS PEOPLE

This report demonstrates a clear disparity in mental health status for Métis people compared to other British Columbians. Such disparities are a reminder that the imposition of settler-colonial laws, violations of Indigenous rights, and uneven distribution of health services and resources continue to cause harm, including negative mental health outcomes. These and other legacies of colonization and ongoing colonialism—including residential schools, child welfare policies, and systemic racism and sexism—continue to actively undermine Métis health and wellness. Immediate action is needed to curb the downward trend in mental health outcomes. Data indicate that young Métis females carry a disproportionate burden of colonial harms, as indicated by lower rates of positive mental health and higher rates of self-harm and binge drinking. The health system and all levels of government have a responsibility to respect the rights of Métis people and work to address disparities in mental health and wellness—which includes working to dismantle harmful systems, beliefs, and behaviours.

To uphold Metis rights and be effective, mental health programs and policies need to reflect Métis cultural identity, acknowledge the legacy of the residential school system and other assimilation attempts, and be grounded in Métis teachings. Initiatives such as the Métis Crisis Line discussed in Chapters 4 and 5 of this report provide an excellent foundation, but much more work, including preventative approaches, is needed to improve Métis mental health and wellness outcomes in BC. Efforts in this area can build on current work and a commitment from the BC Ministry of Mental Health and Addictions to collaborate with MNBC and the BC Ministry of Health on "a long-term health and wellness partnership that recognizes the unique priorities, interests, and perspectives" of Métis people in BC.[20(p.23)]

In 2019, Les Femmes Michif Otipemisiwak (LFMO; Women of the Métis Nation) released *Métis Perspectives of Missing and Murdered Indigenous Women, Girls and LGBTQ2S+ People,* a Métis-specific report in response to the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls ("the Inquiry"). Although the Inquiry's report included 29 Métis-specific Calls for Justice,[17] LFMO felt it did not adequately represent Métis perspectives.[18] LFMO's report concluded with 62 Calls for *Miskotahâ* (change), such as #53: *Action is required of the federal and provincial governments to recognize, respect and address the distinct health needs of Métis women and girls and to ensure there is equal access to services related to Métis health and healing, including but not limited to disability services, treatment for trauma, mental health services, addictions, and supportive recovery programs.*[19]

Louis Riel Day, 2021. Source: Province of British Columbia.

RECOMMENDATION 2

Develop a Métis Mental Health and Wellness Action Plan to improve mental wellness, reduce problematic substance use, and address the harmful effects of colonialism, assimilation attempts, and the residential school system.

PROPOSED CO-LEADS:

Métis Nation British Columbia
BC Ministry of Health
BC Ministry of Mental Health and Addictions

PROPOSED SUPPORT:

BC Ministry of Advanced Education and Skills Training
BC Ministry of Children and Family Development
BC Ministry of Education
BC Ministry of Tourism, Arts, Culture and Sport
Provincial Health Services Authority
Regional health authorities

PRIORITY #3:
LIFESTYLE AS MEDICINE FOR MÉTIS PEOPLE

Métis culture and traditions include long histories of active living and healthy eating. Disruption from homelands and traditional livelihoods has led to new ways of living Métis culture and traditions, while also introducing behaviours that are harmful to health. Smoking, sedentary living, and unhealthy diets negatively impact health and wellness.

These behaviours are shaped by systemic and structural factors that limit opportunities for many Métis people to "choose" healthier lifestyles. Supportive programs and initiatives that strengthen Métis traditions of "lifestyle as medicine" can help empower Métis people to live longer, healthier lives free from chronic disease.

RECOMMENDATION 3

Develop and action a Métis "Lifestyle as Medicine" Health and Wellness Strategy that recognizes and reflects Métis cultural traditions and values.

PROPOSED CO-LEADS:

Métis Nation British Columbia

BC Ministry of Health

PROPOSED SUPPORT:

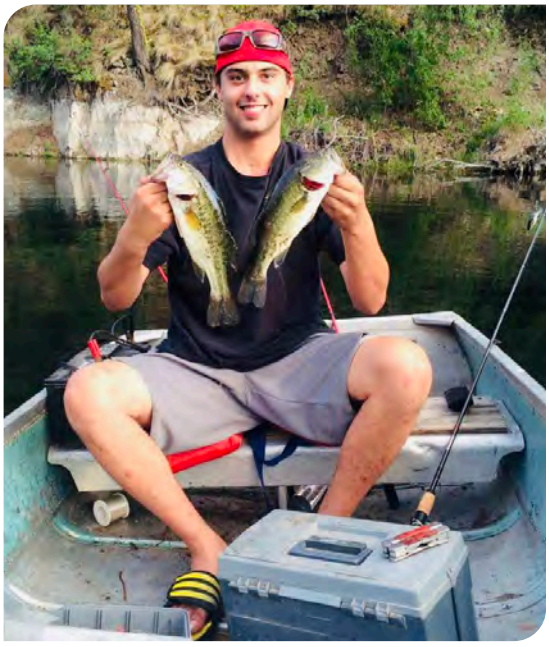
BC Ministry of Mental Health and Addictions

BC Ministry of Social Development and Poverty Reduction

BC Ministry of Tourism, Arts, Culture and Sport

Regional health authorities

Source: Métis Nation British Columbia. Photo by Marion Gonneville.



Source: Métis Nation British Columbia. Photo by Charleen Lowe.

PRIORITY #4:

COLLABORATIVE, ROBUST, SELF-DETERMINED MÉTIS HEALTH INFORMATION SYSTEMS

Understandings of the health of Métis people are limited by the relatively small amount of data currently available. Expanding the availability of Métis-specific data on a broad range of health and wellness indicators, including indicators linked to social and structural determinants of health, would facilitate improved assessment and monitoring of, and responses to, the health and wellness needs of Métis people in BC. While longer-term work will require revisiting how data are collected, stored, and governed, shorter-term work could include initiatives such as linking birth data with parental data to incorporate newborns into the Métis cohort. Developing a robust provincial cohort within government datasets—including fast-tracking and improving MNBC access to overdose, cancer, and perinatal data—would support the initiatives identified in this report's recommendations, enable analyses of birth/perinatal health and death measures, assist in further identifying specific Métis sub-populations and communities in BC that require enhanced supports, and better facilitate meaningful multi-year analyses.

› RECOMMENDATION 4

Develop and implement culturally safe, self-determined processes that facilitate robust data collection to monitor the health and wellness of all Métis people living in BC. This must include upholding Métis data governance standards, and accurate identification of registered Métis citizens and self-identified Métis people within provincially held datasets.

PROPOSED CO-LEADS:

Métis Nation British Columbia
BC Ministry of Citizens' Services
BC Ministry of Health

PROPOSED SUPPORT:

BC Centre for Disease Control
BC Ministry of Advanced Education and Skills Training
BC Ministry of Education
BC Ministry of Indigenous Relations and Reconciliation
BC Ministry of Mental Health and Addictions
BC Ministry of Public Safety and Solicitor General
Provincial Health Services Authority
Regional health authorities

Source: Métis Nation British Columbia. Photo by Malana Murray.

Source: Métis Nation British Columbia.

> *Our vision is for all Métis children throughout BC to experience a state of well-being that allows them to live healthy and happy lives, and fulfill their full potential as individuals, as members of their family and community, and as citizens of Métis Nation British Columbia and [as] British Columbians.*
>
> – Debra Fisher, Minister of Children and Families and Minister of Education, Métis Nation British Columbia[21]

Métis Public Health Surveillance Targets

The goal of the MPHS program is to monitor and advance the health and wellness of Métis people in BC. While achieving that goal cannot be reduced to a suite of health indicators, particularly with the current constraints on available data, monitoring a suite of core indicators through the MPHS program enables MNBC and its partners to identify important information about broader Métis population health status and trends. These indicators will also help monitor the effectiveness of action taken in response to the recommendations presented in this report. The targets identified here by the MPHS project team are intended to be ambitious, but are feasible if recommendations are implemented and Métis people are adequately and appropriately supported. The MPHS program will continue to report on the following indicators and their respective targets over the next 10 years.

INDICATOR	BASELINE	TARGET % Change	TARGET 2030
Cultural Wellness and Lifestyle Factors			
Métis youth who speak an Indigenous language	13% (2018)	⬆ 50%	20%
Métis youth who eat foods traditional to their background	15% (2018)	⬆ 50%	23%
Moderately active or active during leisure time (age 12+)	64.0% (2011-2014)	⬆ 10%	70.4%
Current smoker, daily or occasional (age 12+)	34.6% (2011-2014)	⬇ 25%	26.0%
Supportive Health Systems			
Diabetes prevalence	12.2% (2017/18)	⬇ 10%	11.0%
COPD incidence (age 35+)	7.8 per 1,000 (2017/18)	⬇ 10%	7.0 per 1,000
Hypertension prevalence	26.5% (2017/18)	⬇ 10%	23.9%
Ambulatory care sensitive conditions	261.1 per 100,000 (2017)	⬇ 10%	235.0 per 100,000
Number of registered physicians in BC who identify as Métis	56 (2019)	⬆ 100%	112
Mental Health and Wellness			
Adults who rate their mental health as "very good" or "excellent"	59.5% (2011-2014)	⬆ 25%	74.4%
Female youth who rate their mental health as "very good" or "excellent"	49% (2018)	⬆ 25%	61%
Female youth who report having ever self-harmed	42% (2018)	⬇ 25%	32%
Métis Rights and Governance			
BC government ministries working with Métis Nation British Columbia (MNBC) to implement Métis data standard policies and procedures		Target: 100%	
BC government ministries working with MNBC through the Assistant Deputy Minister's Committee identified in the October 2021 Letter of Intent		Target: 100%	
BC government ministries working with MNBC to implement Métis-specific actions under the BC *Declaration on the Rights of Indigenous Peoples Act*		Target: 100%	

Notes: The number of decimal places shown in the baselines and targets identified above may vary based on the data source. At the time of this report, there were 20 BC government ministries, though this number may change over time. Future reporting on the three indicators listed under "Métis Rights and Governance" will be calculated as a percentage of the number of ministries in existence at that time. The project partners will measure these indicators based on MNBC's assessment of whether each ministry has engaged meaningfully with MNBC in each of these three areas.

Conclusion

The analyses presented in this report are only one step in better understanding the health status and unique needs of Métis people in BC. Under the MPHS program, Métis Nation British Columbia and the Office of the Provincial Health Officer will continue to monitor the indicators presented in this report over the next 10 years. The recommendations offered here present a pathway both to address the systemic inequities experienced by Métis in BC and to better support Métis health and wellness. Colonial trauma, systemic racism, the residential school system, and other attempts to extinguish Métis culture, rights, and title have created many challenges for Métis people. Through the Letter of Intent signed in October 2021, Métis Nation British Columbia and the Province of British Columbia have committed to support Métis people and communities by working toward meaningful, substantial, and lasting positive change.

It is important to recognize that the development of this report has come at a time that is painful and challenging for Métis and other Indigenous peoples in BC. As discussed in Chapter 2, the unmarked graves of Indigenous children at the sites of former residential schools and the *National Action Plan: Ending Violence Against Indigenous Women, Girls, and 2SLGBTQQIA+ People* are reminders of the genocide perpetrated against Indigenous peoples in the name of white supremacy, systemic racism, and colonial oppression—and the fact that these harms persist. At the same time, the ongoing COVID-19 pandemic poses its own health and wellness challenges. These compounding stressors may well interfere with the achievement of several of the targets set out in this report.

However, this is also a time of promise. A renewed focus on reconciliation and the implementation of the *Declaration on the Rights of Indigenous Peoples Act* has engendered newfound understanding among non-Indigenous people of both the importance of and the legal imperative to uphold Indigenous self-determination. The growth in distinctions-based initiatives and reporting, including the October 2021 Letter of Intent between Métis Nation British Columbia and the Province of British Columbia, is increasing recognition of the Métis as a distinct Indigenous Nation. The next three MPHS program reports over the coming decade will help track progress toward lasting improvements in Métis health and wellness in BC.

Source: Métis Nation British Columbia.

Appendix A: Glossary

2SLGBTQQIA+ is an acronym that builds on the term LGBTQ+. Like that term, 2SLGBTQQIA+ includes a variety of gender, sexual, and affectional identities and orientations. 2SLGBTQQIA+ privileges Two-Spirit (2S) identity by listing it first; the letters after 2S stand for Lesbian, Gay, Bisexual, Trans, Queer, Questioning, Intersex, and Asexual. The "+" indicates the inclusion of other identities (e.g., gender diverse, non-binary) as this acronym continues to evolve.[1,2]

Also see *Two-Spirit, LGBTQ+, Trans*.

Aboriginal (Peoples) is a collective term used internationally to describe the original inhabitants of a given land or region and their descendants. The Canadian Constitution recognizes three distinct Aboriginal Peoples: Indians (more respectfully known as First Nations), Métis, and Inuit. According to the 2016 Census, there were 270,585 Aboriginal people in British Columbia, making up 5.9 per cent of the population. In Canada, *Aboriginal* is a legally defined term imposed by the federal government, and the term *Indigenous* is often preferred.[4,5,6]

Also see *Indigenous*.

Age-standardized / Age standardization is a step in analytical methodology for quantitative data that adjusts for differences in the age distribution of the populations being compared, making comparisons between groups, across geographical areas, and over time more meaningful. For example, the Métis population is a younger population than the rest of Canada, which can obscure rates of age-related conditions such as chronic diseases.

Age-standardized mortality rate is a weighted average of the age-specific mortality rates, which is the number of deaths from all causes in an age group, divided by the number of people in that age group, expressed as a rate per population (typically per 100,000 people), and where the 'weights' are the proportions of persons in the corresponding age groups of a standard population.[7,8,9] Mortality rates are age-standardized so that rates can be usefully compared between populations with different age distributions. Age-standardization adjusts for the effects of age differences in different populations.[7]

Ambulatory care sensitive conditions (also called *avoidable hospitalizations*) are hospital admissions related to conditions where appropriate ambulatory care (care outside of a hospital setting; i.e., *primary care*) could prevent or reduce the need for hospital admissions among persons under age 75 (e.g., complications due to diabetes, asthma, hypertension, neurosis, depression, and problematic substance use).[10]

Avoidable hospitalizations See *ambulatory care sensitive conditions*.

Baseline data are the data collected at the beginning of a study or intervention. These data serve as the starting point and can be compared to data collected at a later point in time to monitor progress toward project goals and targets.[11]

Binge drinking is having several drinks in a short period of time, typically with the goal of getting drunk. The Centre for Addiction and Mental Health defines binge drinking as having five or more drinks on one occasion for a male, or four or more drinks on one occasion for a female.[12] The McCreary Centre Society defines binge drinking among youth as having four or more drinks within a couple of hours for a male, or three or more drinks within a couple of hours for a female.[13]

Colonial trauma is a broad concept that includes intergenerational and historical trauma, but also explicitly recognizes that oppressive and traumatizing colonial forces are still at work and continue to undermine the health and wellness of Indigenous peoples on a daily basis. Mitchell et al. (2019) define colonial trauma as "a complex, continuous, collective, cumulative and compounding interaction of impacts related to the imposition of colonial policies and practices which continue to separate Indigenous Peoples from their land, languages, cultural practices, and one another."[14]

Cultural safety is the result of environments and interactions that respect diversity and recognize and challenge systemic inequalities and power imbalances. Lack of cultural safety is the result of health care, educational, and social systems based on settler-colonial worldviews that, whether overtly or unwittingly, incorporate and promote ideologies of white supremacy and systemic racism. A culturally safe health care system is free of racism and discrimination, empowers patients to be partners in their own health care, and makes people from all personal and cultural backgrounds feel safe and comfortable receiving care and treatment.[15,16]

Cultural wellness (Métis) is a sense of belonging and pride Métis people feel when they are connected to Métis families, Communities, traditions, and the land. It feels like home.[17]

Deterministic matching describes a method of linking datasets by matching individual records. In a deterministic linkage, two records are linked only where the fields in question (e.g., first name, last name, date of birth) are present and match completely.[18]

Distinctions-based describes an approach that explicitly recognizes and affirms the unique histories, cultures, rights, priorities, and interests of Métis and other Indigenous peoples and communities.[19,20]

First Nations is the preferred term for Indigenous peoples in Canada who are neither Métis nor Inuit. The term *First Nations* has largely replaced the term *Indian*, which is generally considered offensive. First Nations people may be "Status" (registered) or "non-Status," as defined by the *Indian Act*.[6,21] According to the 2016 Census, 63.8 per cent of the Indigenous ("Aboriginal") population in British Columbia (172,520 people) identified as First Nations.[3]

Also see *Indian*.

Gender diverse describes gender roles or forms of gender expression that do not coincide with social and cultural assumptions about binary gender categories. Gender diversity may also be described as gender non-conforming, gender variant, or non-binary gender identity.[22,23]

Also see *non-binary*.

Health inequity describes unjust and preventable disparities in health status between different populations. Health inequities are the result of unfair systemic and/or structural barriers and processes such as colonialism, social exclusion, racism, and other forms of discrimination.[24] Health inequity is related to but distinct from health inequality, which describes measurable differences in health status between individuals or groups.[25,26]

Health literacy is the ability to access and understand the information needed to maintain and support one's own good health, as well as the health of one's family and community. Being able to navigate the health care system and having appropriate support are also components of health literacy.[27,28] Health care systems and providers can promote health literacy through equitable access to information and services, such as culturally safe spaces and language that is appropriate and easily understood by the health system client.[29]

Heteronormativity is the belief that heterosexuality, the male/female binary, and associated gender roles are the "normal" and/or "natural" modes of sex and gender expression and identity. Within a heteronormative perspective, other sexual orientations and gender identities (e.g., LGBTQ+, non-binary, Two-Spirit) are stigmatized and seen as abnormal and problematic.[30]

Also see *gender diverse, LGBTQ+, non-binary, Two-Spirit*.

Historic Métis Nation ancestry means an ancestral (familial) connection to the historic Métis Nation community.[31]

Also see *Métis Nation Homeland*.

Incidence is the number of new cases of a given disease or chronic condition diagnosed during a specific time period (e.g., one year) per population.[32] In this report it is presented as a rate (e.g., rate per 1,000 population).

Indian is an outdated and inappropriate term used to refer to First Nations people in North America. In Canada, this term is retained in part due to legislation such as the *Indian Act*.[33] This term is appropriately used to refer to a citizen of India.

Also see *First Nations*.

Indian Residential School system was a devastating system of government-funded and church-operated schools created to assimilate Indigenous children into colonial society. In Canada this system emerged in the 1870s and continued to operate into the 1990s. Despite the term "Indian Residential School," Métis and Inuit children as well as First Nations children were forced to attend these schools. This system and the workers in the schools inflicted a range of horrific abuses, sometimes resulting in death, on more than 150,000 Indigenous children across Canada. The residential school system is also responsible for losses of Indigenous cultural and linguistic knowledge and has created a legacy of intergenerational trauma among Indigenous families and communities that continues to this day.[34,35,36] At the time of publication, thousands of unmarked children's graves had been detected using ground-penetrating radar at former residential school sites across Canada and the United States, and investigations are ongoing.

Indigenous is a collective term used internationally to describe the original inhabitants of a given land or region and their descendants. There are three constitutionally recognized Indigenous ("Aboriginal") peoples in Canada: First Nations ("Indians"), Métis, and Inuit. Because *Indigenous* is neither a legally defined nor government-imposed term, it is often seen as more respectful and inclusive.[6,37]

Also see *Aboriginal*.

Indigenous determinants of health are the interrelated social, economic, and political factors that influence health and wellness outcomes for Indigenous peoples. These determinants and their outcomes are shaped by the legacy of colonization that has produced health inequities between Indigenous and non-Indigenous people.[38,39]

Infant mortality is the death of a child due to any cause during the first year of life (less than 365 days old). Infant mortality is expressed as a rate of the number of deaths per 1,000 live births from a given period and is a core measure of the health status of a population.[40,41]

Intergenerational trauma is a concept that explains how experiences of collective historical trauma are passed down within families and communities and impact the following generations (e.g., trauma associated with the residential school attendance of one's parent, grandparent, or other community member).[42]

Inuit are an Indigenous people who traditionally live across the circumpolar coastal regions of what is now known as Canada and other Northern Arctic territories. The word *Inuit* is plural (singular: Inuk) and means *the people* in Inuktitut, one of several Inuit languages.[43,44] According to the 2016 Census, 0.6 per cent of the Indigenous ("Aboriginal") population in British Columbia (1,615 people) identified as Inuit (Inuk).[3]

LGBTQ+ is a collective term referring to a variety of gender, sexual, and affectional identities and orientations. The acronym (Lesbian, Gay, Bisexual, Trans, Queer/Questioning) continues to evolve, as denoted here by the "+" sign at the end. 2 or 2S is often included in the acronym to encompass Two-Spirit identities, as in 2SLGBTQQIA+.[1,45]

Also see *Two-Spirit, 2SLGBTQQIA+*.

Labour force is the combined total of Canadians age 15 and up who are employed (those who have a job or a business) and unemployed (those who are not working but are actively looking for work). Excluded from this definition are those living in institutions (e.g., prisons) and those who are not in the labour force (e.g., retirees, full-time students, and anyone who is unavailable for work).[46]

Large-for-gestational-age describes a singleton birth where the infant's birth weight is greater than the 90th percentile among live births of the same sex and gestational age.[47]

Life expectancy is the expected number of years of life of a population at a certain age, most commonly reported as life expectancy at birth.[48]

Median is the number in the middle of a dataset that has been arranged in numerical order, where half the data are above the median and half are below it.[49]

Métis refers to a distinct Indigenous Nation whose unique culture and identity emerged during the 18th and 19th centuries from unions between Indigenous people and Europeans in the territories that are now south-central Canada and the north-central United States.[50] The Métis National Council defines a Métis person as someone "who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation."[51] According to the 2016 Census, 33.0 per cent of the Indigenous ("Aboriginal") population in British Columbia (89,405 people) identified as Métis.[3]

Métis Chartered Community is a Métis Community in BC that has entered into a Community Governance Charter agreement with Métis Nation British Columbia (MNBC). MNBC represents 39 Métis Chartered Communities across the province. An executive member of each Chartered Community represents its members as part of the Métis Nation Governing Assembly.[52,53]

Métis Citizen	is a person who self-identifies as Métis, is of Historic Métis Nation ancestry, and is accepted by the Métis Nation.[54] In the BC context, Métis Citizenship is demonstrated by registration with Métis Nation British Columbia.
Métis cohort	is the group of Métis citizens registered with Métis Nation British Columbia who were age 18 and up and still living as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance program (14,515 people).
Métis Nation Homeland	is the geographic region historically occupied by the Métis Nation, which encompasses the territories now known as Manitoba, Saskatchewan, and Alberta, along with contiguous regions of northeastern British Columbia, the Northwest Territories, northwestern Ontario, and the northern United States.[55]
Métis National Council (MNC)	is the governing body that represents the Métis Nation, both nationally and internationally. MNC is directed by its four Governing Members: Métis Nation British Columbia, Métis Nation of Alberta, the Métis Nation—Saskatchewan, and Métis Nation of Ontario.[56]
Michif	is the unique language of the Métis and is a mixture of French and Plains Cree.[57] However, there are several variations of Michif, reflecting the diversity of Métis people and communities.[77]
Morbidity	describes the state of having symptoms or being in poor health because of a disease or health condition.[58]
Mortality (measures of)	is the number of deaths resulting from a particular cause or health event. It may be presented as a rate (e.g., mortality per 1,000 population) or as an absolute number.[58]
Neonatal	is the period of infancy from birth to 28 days of age.[59]
Non-binary	describes people whose gender identity is not solely girl/woman or boy/man; they may identify as neither gender, as both, or be undecided.[45,60] Also see *gender diverse*.
Non-Indigenous	includes people who do not self-identify as Métis, First Nations, Inuit, or Indigenous/Aboriginal. In this report, "Non-Indigenous" is used as a comparison group in some datasets.
Non-Métis	includes people who self-identify as First Nations, Inuit, or non-Indigenous. It also includes people who self-identify as Indigenous/Aboriginal, but who do not self-identify as Métis. In this report, "Non-Métis" is used as a comparison group in some datasets.
Other Residents	(as used in this report) includes people who self-identify as First Nations, Inuit, or non-Indigenous. It also includes people who self-identify as Métis and/or Indigenous/Aboriginal, but who are not registered Métis citizens included in the Métis cohort. In this report, "Other Residents" is used as a comparison group when presenting Métis cohort data. Also see *Métis cohort*.
Post-neonatal	is the period of infancy between 28 days and one year of age.[59]

Prevalence	is the total number of known cases (previously diagnosed and newly reported cases) in a population during a period or at a point in time.[61] It is usually reported as a percentage (e.g., 5 per cent or 5 per 100 population). For chronic conditions in this report, "known cases" are known as a result of interaction with the BC health care system.
Primary care	is essential health care that is often the first level of contact with the health system, and includes health promotion, prevention, curative, and rehabilitative services.[62,63]
Reconciliation	is establishing relationships based on mutual trust and respect between Indigenous and non-Indigenous peoples throughout Canadian society. It is an ongoing process that includes recognizing the injustices and harms of the past, providing support for Indigenous peoples to heal from colonization and its ongoing legacy, as well as action and commitment to create a future of equality, dignity, and peace.[64]
Resilience	is the ability to continue to live and to thrive in the face of hardship and adversity. For Métis, resilience is demonstrated by an ongoing commitment to achieving nationhood and self-determination, despite enduring both historical and contemporary injustice and oppression.[65,66]
Scrip	refers to a system of land vouchers given to Métis people in the late 19th and early 20th centuries to dispossess them of their lands. Scrip gave small parcels of land to individuals rather than providing for a communal land base, and it required that the owner clear and cultivate the land like any other settler. Many Métis families sold or were defrauded of their scrip lands.[67,68]
Self-determination	means that Métis and other Indigenous peoples are involved in and able to make decisions that affect their lives, including being free to determine their political status; pursue economic, social, and cultural development; and practice, develop, and teach their own spiritual and religious traditions, customs, and ceremonies.[69,70]
Self-esteem	is the value one accords oneself. Having good self-esteem means knowing you deserve to be treated with care and respect by yourself and by other people, no matter what the situation.[71]
Significant	(as used in this report) refers to *statistical significance*. A statistically significant difference is one that is likely to be the result of a specific factor or factors (e.g., income level), rather than being the result of chance.[72]
Singleton birth	describes a single child carried in pregnancy and born (rather than twins or multiples).[73]
Small-for-gestational-age	describes a singleton birth where the infant's birth weight is below the 10th percentile among live births of the same sex and gestational age.[47]
Strengths-based	describes an approach that recognizes and promotes the inherent strengths, skills, capacity, knowledge, resilience, and potential of individuals, families, and communities, and considers how these can be used and built on.[26]

Trans/Transgender	refers to a range of identities for people whose gender identity differs from the sex they were assigned at birth.[45,60]
Two-Spirit (2-Spirit)	is a term that reflects the concept of the feminine and masculine principles coexisting within a single being. "Two-Spirit" is mainly used by Indigenous people to describe non-heterosexual sexuality and/or non-binary gender identity. Some Indigenous people may prefer to identify as LGBTQ+ or other terminology. In some Indigenous communities, Two-Spirit people have traditionally held esteemed roles and been treated with great respect.[1,74]
Unintentional injuries	are injuries that are not caused on purpose or with intent to harm (e.g., accidental falls, motor vehicle crashes).[75]
White supremacy	is the set of conditions, practices, and ideologies that supports the dominion of whiteness and white political, social, cultural, and economic systems. White supremacy creates space for structural racism to continue in various forms, such as the overrepresentation of Indigenous and other non-white peoples in prisons and the child welfare system.[78] It is important to understand white supremacy as systemic rather than simply as a set of individually-held beliefs.[79]
Wholistic	describes a way of seeing and understanding the world as whole and balanced, interconnected, and circular.[76]

Source: Métis Nation British Columbia. Photo by Jessica Nash.

Source: Métis Nation British Columbia. Photo by Lisa Schnitzler.

Appendix B: Data Sources and Methodology

In 2015, Métis Nation British Columbia (MNBC) published *Métis Public Health Surveillance Project: Sharing Community Health Information*.[1] That report presented chronic disease statistics for a cohort of 1,507 persons in the MNBC Citizenship Registry. This was accomplished through linking the Registry data for consenting persons to the Chronic Disease Registries of the BC Ministry of Health (BC MoH).

With the goal of providing a more wholistic picture of the health and wellness of Métis citizens, MNBC consulted with key stakeholders to expand the indicator framework beyond chronic diseases. This was supported by the results of four focus groups of 36 Métis people using the Métis Community Readiness Model. This process included examining the priorities of different stakeholders and determining their interest and capacity to address health and wellness issues within the unique social and cultural contexts of their communities.

This appendix provides an overview of the methodology used to produce the Métis cohort, as well as a summary of the data sources used to examine the indicators presented in this report.

The Métis Population Cohort 2019

Methodology and Cohort Creation

Generation of data for some of the indicators included in this report required the identification of Métis citizens (Métis persons registered with MNBC) within BC MoH and Vital Statistics databases. This was accomplished by linking MNBC's Métis Registry to these data sources for consenting registrants, who are collectively referred to in this report as the "Métis cohort." The sharing and linking of the data were based on an Information Sharing Agreement between MNBC and BC MoH.

For an individual's data to be included in the Métis cohort for the purposes of the Métis Public Health Surveillance (MPHS) program, they must be a registered citizen of MNBC and have provided consent for inclusion. In the past, MNBC included an opt-out letter with every Métis citizenship card sent out. Citizens who wished to remove themselves or their minor children from the MPHS program were required to return this opt-out letter to MNBC. The consent process changed in 2020 with the revised MNBC citizenship application form, which includes check boxes for those who wish to opt out and/or opt out on behalf of their minor children; that process will be reflected in future reports for this program.

The name, sex, and birth date of each consenting Métis citizen were provided in a secure file transfer to the BC MoH. This information was linked to the BC MoH Client Registry, which contains the name, sex, birth date, and personal health number (PHN) of every BC resident registered with

BC Medical Services Plan (MSP). The MSP PHNs for the Métis cohort were thereby identified and used for the analysis of BC MoH and Vital Statistics data for the generation of the indicators. The result was a dataset that did not contain any names but reflected health and vital statistics data for Métis citizens.

The number of people in BC who self-identified as Métis in the 2016 Census was 89,405. In 2019, when the current project began, there were a total of 19,000 people listed in the Métis Registry, of whom 18,728 consented to the use of their health data in the generation of these indicators. Using a **deterministic matching** protocol, a total of 17,895 records were successfully matched to PHNs in the Client Registry. This represented a matching rate of 95.5 per cent.

The linkage to Vital Statistics data revealed that 156 cohort members had died after registration. All mortality-related indicators that were planned for analyses were to be calculated on the basis of these deaths, and it was agreed that this number was insufficient to produce robust measures of life expectancy, premature mortality, and total mortality. This decision was consistent with related Canadian research that indicates that at least 10 years of mortality data are required to produce meaningful mortality measures.[2,3] Similarly, the underrepresentation of children in the cohort and uncertainties about the registration of newborns resulted in the elimination of the birth-related indicators and the decision to focus on cohort members age 18 and up in the current analysis. This resulted in a final number of 14,515 Métis people included in cohort data analyses in this report.

In analyses done for the current report using BC administrative health data, most rate comparisons were between Métis and Other Residents. "Other Residents" includes people who self-identify as First Nations, Inuit, or non-Indigenous. It also includes people who self-identify as Métis and/or Indigenous/Aboriginal, but who are not registered Métis citizens included in the Métis cohort.

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

Métis Population Comparison, 2016 Census and 2019 Cohort

One way to assess how representative the Métis cohort is of the broader Métis population in BC is to compare the sex and age of the cohort to that of the population captured in BC census data. As presented in Figure B.1, the age distribution of the matched Métis cohort contained fewer children than the Métis population in the 2016 Census. Above the age of 14, however, the age distribution of the two populations was very similar, although there was a slightly higher proportion of persons age 20 to 30 in the study cohort.

Another way to determine how representative the Métis cohort is of the self-identified Métis population in BC is to compare the geographic distribution of the cohort and the BC census population across BC. As shown in Figure B.2, a larger proportion of cohort members reside in Northern Health, and a smaller proportion reside in Island and Fraser Health regions. The relative proportions of population in Interior Health and Vancouver Coastal Health are similar between the two groups.

The BC Adolescent Health Survey

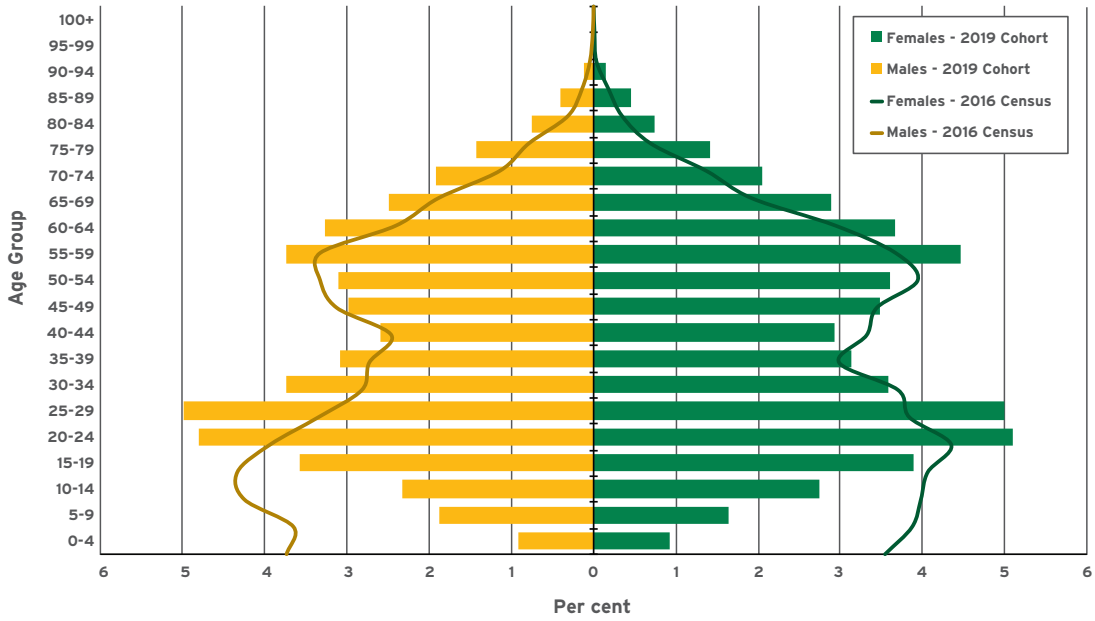
Data from the BC Adolescent Health Survey (BC AHS) are included in Chapter 4 of this report to examine youth health. The BC AHS is an anonymous questionnaire given every five years to BC students in grades 7–12 (age 12–19) attending public schools across the province. Since 1992, the McCreary Centre Society ("McCreary") has been using the BC AHS to gather information about the health and wellness of youth in BC. Since 1998, McCreary has been working with Indigenous communities to create specialized reports on the health and wellness of Indigenous youth based on BC AHS data.[4]

Since 2008, McCreary has also worked with Métis Nation British Columbia (MNBC) and other partners to produce a series of reports focused specifically on the health and wellness of Métis youth across the province: *Métis Youth Health in BC* (based on the 2008 survey), *Ta Saantii: A Profile of Métis Youth Health in BC* (based on the 2013 survey), and *Ta Saantii Deu/Neso: A Profile of Métis Youth Health in BC* (based on the 2018 survey).[5] In 2018, more than 38,000 students in 58 of 60 BC school districts participated in the BC AHS,[6,7] including approximately 1,300 students (3 per cent) who self-identified as Métis.[8]

The Canadian Community Health Survey

The Canadian Community Health Survey (CCHS) is an annual survey of the Canadian population, excluding First Nations living on reserve, the military, and people in institutions. The relatively small size of the Indigenous population responding to the CCHS limits the analyses that can be supported by the data. However, Statistics Canada has released health indicators for Indigenous populations based on combined four-year samples of CCHS data (2007–2010 and 2011–2014). The expanded sample size allows for the generation of several indicators for First Nations, Métis, and Inuit respondents at the national and provincial/territorial levels.

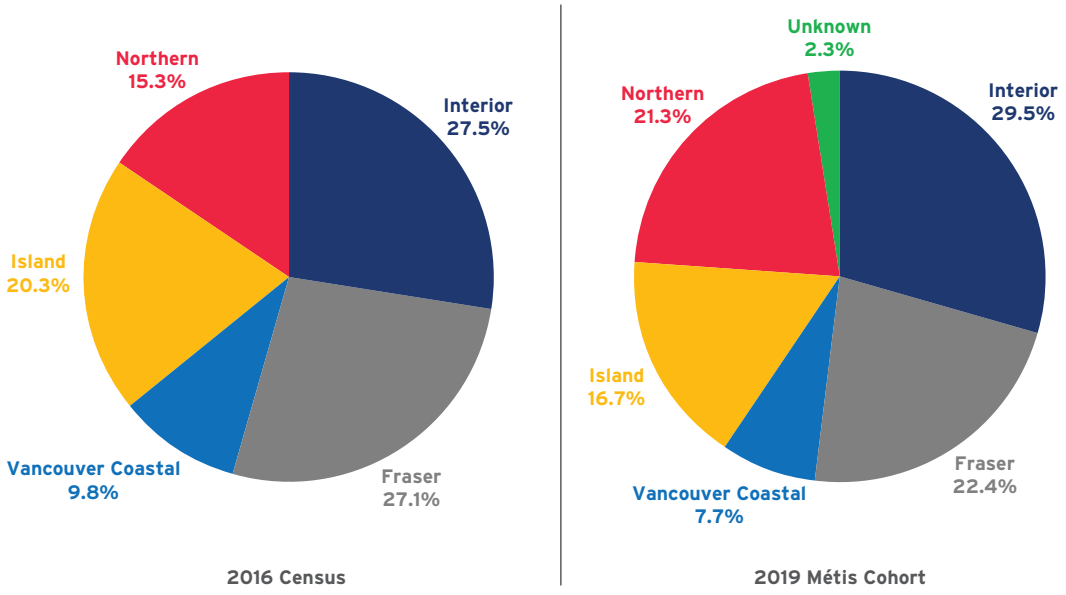
FIG B.1 Métis Population Proportion Comparison, by Sex and Age Group, BC, 2016 Census and 2019 Cohort



Note: 2016 census population includes people who self-identify as Métis. 2019 cohort population includes Métis citizens registered with Métis Nation BC who consented to have their data included in the Métis Public Health Surveillance Program.

Source: Statistics Canada – 2016 Census; Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

FIG B.2 Métis Population Proportion Comparison, Age 18+, by Health Authority, BC, 2016 Census and 2019 Cohort



Notes: The 2016 census population includes people 18 years or older who self-identify as Métis (N=64,325). The 2019 Métis cohort includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program (N=14,515). Due to rounding, percentages may not add up to 100.

Sources: Statistics Canada, 2016 census data, provided by BC Stats. BC Ministry of Health, Client Roster (Release V2017), Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020 and December 2021.

Canadian Census

Canada's Census Program conducts a census every five years to create a detailed statistical profile of the country. Only one-quarter (25 per cent) of the population receives the long-form census with additional questions that allow the respondent to self-identity as Métis, so all analyses in this report involving Métis-specific census data are based on this 25 per cent sample. The most recent census was conducted in 2021, although the data collected are not yet publicly available. This report therefore uses 2016 census figures for the self-identified Métis population of BC, which totals 89,405 people (25,080 under age 18 and 64,325 age 18 and up). Some of the analyses in this report compare Métis-specific census data to data for the non-Indigenous population. These analyses were typically done by other groups, such as Statistics Canada, and were part of larger analyses that presented results for First Nations, Métis, Inuit, and non-Indigenous populations.

Statistical Significance

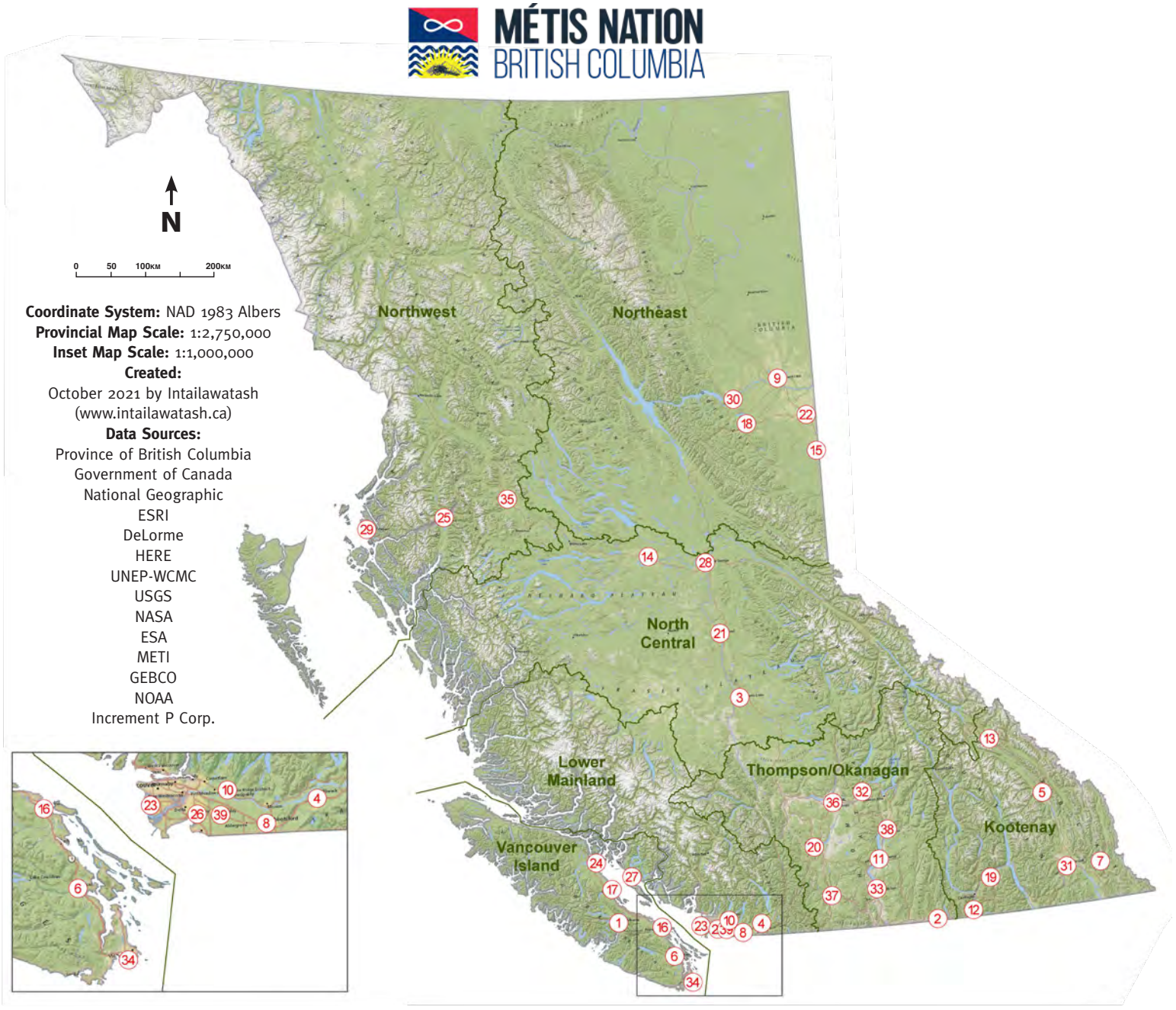
The result of a statistical analysis is "statistically significant" if it is very unlikely that the result is due to random variation in the data used for the analysis. That is, the result likely reflects something that is true in the real world, not a chance variation in data. Care has been taken to assess the statistical significance of the results presented in this report to avoid presenting results that are likely only due to chance. The data used in this report are complex, necessitating a variety of approaches to assessing statistical significance.

Confidence intervals (CIs) represents a level of confidence that a measure is within the range, with 95 per cent CI indicating 95 per cent certainty. CIs of 95 per cent were estimated for indicators whenever possible (e.g., chronic disease indicators). However, 95 per cent CI overlap is not the same as the statistical significance test of differences between two groups. For each pairwise comparison, we calculated rate ratio and rate difference and their 95 per cent CIs (i.e., 95 per cent CIs for rate ratios and rate differences). In this report, differences between two rates were identified as "significant" when the rate difference or rate ratio 95 per cent CI excluded the possibility of the rates being the same (i.e., differences of zero or ratios of 1). For example, diabetes prevalence for Métis and Other Residents were 12.3 per cent and 10.1 per cent, respectively. The difference between the two is 2.17 percentage points with a 95 per cent CI 1.51~2.84. Because the lower limit value (1.51) is above 0, this suggests the difference is statistically significant. When rate differences or ratios were not calculated, differences between the two rates were judged to be statistically significant if the 95 per cent CIs for the two rates did not overlap.

Confidence intervals were not available for the rates calculated from the combined samples of the CCHS by Statistics Canada. This report utilized the Sampling Variability Guidelines provided with the indicators whereby only those values that fell into the category "acceptable for general release" were used. Indicators classified as "marginal" and "use with caution" were not included. This rating means that each indicator probably had sufficient reliability, based on their coefficients of variation, that meaningful comparisons of "policy significance" could be deduced, particularly if these differences were consistent with the results of other studies.

Source: Métis Nation British Columbia. Photo by Derek Robitaille.

Appendix C: Métis Chartered Communities in British Columbia



This map is a living document and is intended to be amended and refined over time.
This map is the property of Métis Nation British Columbia and may not be reproduced without written permission.
Source: Métis Nation British Columbia

1. Alberni Clayoquot Métis Society, Port Alberni
2. Boundary Métis Community Association, Grand Forks
3. Cariboo Chilcotin Métis Association, Williams Lake
4. Chilliwack Métis Association
5. Columbia Valley Métis Association, Invermere
6. Cowichan Valley Métis Association, Duncan
7. Elk Valley Métis Association, Fernie
8. Fraser Valley Métis Association, Abbotsford
9. Fort St. John Métis Society
10. Golden Ears Métis Society, Pitt Meadows
11. Kelowna Métis Association
12. Kootenay South Métis Society, Trail
13. Métis Nation Columbia River Society, Golden
14. Métis Nation New Caledonia Society, Vanderhoof
15. Métis Community Society of Kelly Lake
16. Mid-Island Métis Nation Association, Nanaimo
17. MIKI'SIW Métis Association, Courtenay
18. Moccasin Flat's Métis Society, Chetwynd
19. Nelson & Area Métis Society (West Kootenay Métis Society)
20. Nicola Valley & District Métis Society, Merritt
21. North Cariboo Métis Association, Quesnel
22. North East Métis Association, Dawson Creek
23. North Fraser Métis Association, New Westminster
24. North Island Métis Association, Campbell River
25. Northwest BC Métis Association, Terrace
26. Nova Métis Heritage Association, Surrey
27. Powell River Métis Society (Métis Nation Powell River)
28. Prince George Métis Community Association
29. Prince Rupert & District Métis Society
30. River of the Peace Métis Society, Hudson's Hope
31. Rocky Mountain Métis Association, Cranbrook
32. Salmon Arm Métis Association
33. South Okanagan Similkameen Métis Association, Penticton
34. The Métis Nation of Greater Victoria Association
35. Tri-River Métis Association, Smithers
36. Two Rivers Métis Society, Kamloops
37. Vermilion Forks Métis Association, Princeton
38. Vernon & District Métis Association
39. Waceya Métis Society, Langley

Appendix D: Additional Data

This appendix includes data not presented in the body of the report that may be helpful in understanding Métis health and wellness in BC.

Table D.1 supplements the data presented in Chapter 3 and Appendix B of this report on the geographical distribution of the Métis population in BC. This table illustrates the regional distribution of the Métis population by health authority (HA) and health service delivery area (HSDA), including the distribution of the 89,405 self-identified Métis residents of BC (all ages) according to the 2016 Census and of the 14,515 Métis citizens (age 18 and up as of March 31, 2018) who form the Métis cohort examined in this report. This table demonstrates that self-identified Métis people and Métis citizens reside in all HSDAs in BC.

Table D.1 Geographical Distribution of Métis Population, by Health Service Delivery Area (HSDA) and Health Authority (HA), BC, 2016 Census and 2019 Cohort

Region (HA/HSDA)	2016 Métis Census Population		2019 Métis Cohort Population	
	Number	Per cent	Number	Per cent
Interior HA				
East Kootenay	3,335	3.7	672	4.6
Kootenay Boundary	2,540	2.8	471	3.2
Okanagan	10,995	12.3	1,586	10.9
Thompson Cariboo Shuswap	8,280	9.3	1,554	10.7
Total (Interior HA)	**25,155**	**28.1**	**4,283**	**29.5**
Fraser HA				
Fraser East	7,785	8.7	997	6.9
Fraser North	6,795	7.6	935	6.4
Fraser South	10,480	11.7	1,314	9.1
Total (Fraser HA)	**25,055**	**28.0**	**3,246**	**22.4**
Vancouver Coastal HA				
Richmond	615	0.7	95	0.7
Vancouver	4,450	5.0	617	4.3
North Shore / Coast Garibaldi	2,650	3.0	410	2.8
Total (Vancouver Coastal HA)	**7,720**	**8.6**	**1,122**	**7.7**
Island HA				
South Vancouver Island	6,830	7.6	881	6.1
Central Vancouver Island	7,275	8.1	1,034	7.1
North Vancouver Island	3,170	3.5	517	3.6
Total (Island HA)	**17,280**	**19.3**	**2,432**	**16.8**
Northern HA				
Northwest	2,130	2.4	1,924	13.3
Northern Interior	7,740	8.7	687	4.7
Northeast	4,325	4.8	335	2.3
Total (Northern HA)	**14,200**	**15.9**	**3,097**	**21.3**

Notes: For the 2016 Métis census population, "Métis" includes people of all ages who self-identify as Métis. To ensure confidentiality, the 2016 census counts presented in this table are randomly rounded either up or down: counts greater than 10 are rounded up or down to a multiple of 5; counts less than 10 are rounded to either 0 or 10. As a result, when these data are summed, the total counts may vary slightly. Similarly, percentages calculated on rounded data may not add up to 100. For the 2019 Métis cohort, "Métis" includes Métis citizens registered with Métis Nation BC who were 18 years or older as of March 31, 2018, and who consented to have their data included in the Métis Public Health Surveillance Program. Totals for the 2019 Métis cohort include unknown HA and HSDA; therefore, the sum of HSDAs will not equal HA totals, the sum of HAs will not equal the BC total, and the percentages will not add up to 100.

Source: BC Stats 2016 Census Data by Health Geography, March 13, 2018 and Métis Nation BC, Métis Cohort 2019. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, March 2020.

Table D.2 Employment by Industry for Métis and Non-Métis Populations, Age 15+, BC, 2016

Industry	Métis	Non-Métis	Ratio
Forestry and Logging	1.4	0.7	2.0
Mining, Quarrying, and Oil and Gas Extraction	2.1	1.1	1.9
Support Activities for Agriculture and Forestry	0.4	0.3	1.5
Construction	10.4	8.0	1.3
Accommodation and Food Services	10.4	8.6	1.2
Other Services (except public administration)	5.2	4.5	1.1
Administrative and Support, Waste Management, and Remediation Services	4.9	4.4	1.1
Retail Trade	12.9	11.8	1.1
Public Administration	5.7	5.4	1.1
Manufacturing	6.8	6.5	1.0
Transportation and Warehousing	5.4	5.3	1.0
Health Care and Social Assistance	11.4	11.2	1.0
Arts, Entertainment, and Recreation	2.3	2.4	0.9
Educational Services	6.1	7.3	0.8
Utilities	0.4	0.5	0.8
Wholesale Trade	2.7	3.4	0.8
Farms	1.2	1.5	0.8
Information and Cultural Industries	2.1	2.8	0.7
Real Estate and Rental and Leasing	1.5	2.2	0.7
Management of Companies and Enterprises	0.1	0.2	0.7
Fishing, Hunting, and Trapping	0.1	0.2	0.6
Professional, Scientific, and Technical Services	4.4	7.9	0.6
Finance and Insurance	2.0	3.9	0.5
Total	**100**	**100**	

Notes: Employment by industry for Métis and non-Métis are the percentage of people in each group who reported employment income during 2015. Employment income includes all income received as wages, salaries, and commissions from paid employment and net self-employment income from farm or non-farm unincorporated business and/or professional practice. Industry is categorized as per the North American Industry Classification System (NAICS) 2012. The "Farms" industry is not a category within NAICS but was created to combine all subcategories within NAICS codes 111 and 112.

Source: Statistics Canada – 2016 Census. Catalogue Number 98-400-X2016359. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2020.

One key difference between the Métis census and cohort populations is that a much higher proportion of citizens in the Métis cohort (13.3 per cent) reside in the Northwest HSDA, compared to only 2.4 per cent of the self-identified Métis census population. Relatively high proportions of both populations live in the Okanagan, Fraser South, and Thompson Cariboo Shuswap HSDAs. Overall, these areas have high proportions of rural and remote communities, but include urban centres as well, which makes it difficult to draw conclusions about the likelihood of Métis people to live in more urban or more rural areas.

Table D.2 compares employment by industry for Métis and non-Métis populations in BC in 2016. The data in this table supplement the discussion of employment and labour force participation in Chapter 3 of this report.

Appendix E

MÉTIS NATION BRITISH COLUMBIA

Alcohol and Community Health Dialogue:

Session Four, December 12th, 2020

LIVE GRAPHIC RECORDING
Tiaré Jung | Drawing Change

Appendix F: List of Figures and Tables

Chapter 3: Determinants of Métis Health and Wellness

Chapter 4: Métis Youth Health and Wellness

Chapter 5: Health and Wellness of Métis Adults and Communities

Source: Métis Nation British Columbia. Photo by Dean Wilson.

Source: Métis Nation British Columbia. Photo by Andrea MacDermott.

Appendix B: Data Sources and Methodology

Appendix D: Additional Data

Appendix G: References

Introductory Quote (Epigraph) - Reference

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