INDIGENOUS KNOWLEDGE(S) AND PUBLIC HEALTH

AN OVERVIEW OF FIRST NATIONS, INUIT, AND MÉTIS HEALTH IN CANADA

First Nations peoples, Inuit, and Métis peoples, collectively referred to in Canada as Indigenous Peoples,[1] share distinct perspectives on health and wellness that are grounded in "place-based ancestral teachings and knowledge" (Stelkia et al., 2023, p. 2). At the same time, Indigenous Peoples generally share a holistic view of health that entails a balance between interconnected spiritual, emotional, mental, and physical dimensions. This balance has been disrupted by the adverse effects of colonization and ongoing colonialism, such as racism, discrimination, and loss of language, culture, identity, and land-based connections (Loppie & Wien, 2022). As a result, Indigenous Peoples are disproportionately represented in health statistics. The factors underlying these health disparities are multi-faceted and difficult to address, but strengths-based approaches grounded in self-determination, resiliency, capacity building, supportive environments, and culture-based practices are increasingly recognized as promising ways to improve health outcomes for Indigenous Peoples (Bryant et al., 2021; Kennedy et al., 2022; Paraschak, 2013).

This fact sheet provides a general introduction to Indigenous Peoples' health in Canada and the broad context in which Indigenous communities, health practitioners, policymakers, and researchers seek to improve the health and well-being of First Nations peoples, Inuit, and Métis peoples. The fact sheet provides an update to an earlier publication, *An overview of Aboriginal health in Canada* (National Collaborating Centre for Aboriginal Health, 2013).[2] The following sections include:

- an overview of data limitations in First Nations, Inuit, and Métis public health;
- demographic characteristics and health status of Indigenous Peoples;
- the appropriateness of population health measurement frameworks for use with Indigenous populations;
- and the jurisdictional context for Indigenous health policies and programs.

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[1] The term "Indigenous Peoples" is used throughout this fact sheet to describe First Nations peoples, Inuit, and Métis peoples collectively, and is capitalized as a sign of respect for the distinct First Nations, Inuit, and Métis societies. Wherever relevant, the terms "First Nations," "Inuit," and "Métis" will be used when referring to specific Indigenous populations.

[2] The National Collaborating Centre for Aboriginal Health (NCCAH) changed its name to National Collaborating Centre for Indigenous Health (NCCIH) in 2019.

National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

sharing knowledge · making a difference
partager les connaissances · faire une différence
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Data limitations in First Nations, Inuit and Métis public health

Having current, complete, and accurate statistical – and non-statistical – information available is fundamental to determining the health of populations and developing appropriate health interventions and policies for those populations. Access to such data for Indigenous Peoples is often a challenge, which can result in poor policy decisions, inequitable resource allocation, and a failure to meet the unique and diverse needs of Indigenous populations (Cascante et al., 2022).

Indigenous Peoples are often under-represented in health research and data collection efforts, especially non-status First Nations, Métis, and urban Indigenous peoples (Collier, 2020; Hayward et al., 2020). The reasons for this are diverse and can include:

- inconsistent use of Indigenous identifiers across public health assessment systems;[3]
- exclusion of some Indigenous populations in the design of specific surveys;
- challenges of collecting data in sparsely populated Indigenous communities and in rural and remote areas;
- high residential mobility[4] among First Nations, Inuit, and Métis individuals and families;
- and non-participation of individuals and/or communities in data collection efforts (Halseth, 2024).

The statistical information presented in this fact sheet reflects these current constraints.

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[3] In Canada, responsibility for public health assessment is shared across multiple jurisdictions operating at the national, provincial/territorial, and local level. Each of these jurisdictions uses their own definitions of key terms and defines their own indicators used to measure, track, and report on population health.

[4] Many push and pull factors have drawn Indigenous people to cities; including federal policies that stripped registered status from First Nations people and disposed Indigenous Peoples from their lands, and socio-economic influences such as food insecurity, violence and abuse, and access to health and social services. Nevertheless, despite the trend towards urbanization, Indigenous people are highly mobile between cities and rural/reserve lands.

Demographic characteristics of Indigenous Peoples in Canada

In 2021, just over 1.8 million people in Canada identified as Indigenous, representing 5% of the total population and an increase of 9.4% since 2016 (Statistics Canada, 2023). Table 1 presents the distribution of the Indigenous population, by Indigenous group. In 2021, the Indigenous population was reportedly younger than the non-Indigenous population, with average ages of 33.6 years and 41.8 years, respectively (Statistics Canada, 2022a).

In 2021, 41% of individuals identifying as First Nations reported residing on reserve and 59% reported residing off reserve (Statistics Canada, 2022a). Most Inuit (69%) resided in *Inuit Nunangat*, the Inuit homeland comprised of four Inuit land claim regions, including Nunatsiavut (Labrador), Nunavik (northern Quebec), Inuvialuit (Northwest Territories and the Yukon), and Nunavut (Statistics Canada, 2022a). Most Métis people resided in Ontario (21.6%), Alberta (20.4%), Manitoba (15.5%), or Saskatchewan (10.1%), mainly in urban centres. However, there are also eight Métis settlements in Alberta, established by the Government of Alberta as a registered Métis land base and self-government in Canada (Government of Alberta, 2024). Nationally, over 60% of all Indigenous people resided in urban areas (National Association of Friendship Centres, 2021). In 2021, 48% of status First Nations peoples, 75% of non-status First Nations peoples, 50.7% of Inuit, and 71.1% of Métis peoples resided in urban areas (Indigenous Services Canada [ISC], 2023a). Of the largest cities in Canada, referred to as Census Metropolitan Areas (CMAs), Winnipeg, Edmonton, Vancouver, and Calgary have the highest number of Indigenous residents; however, the largest concentrations of Indigenous people are found in Winnipeg (12.5% of the total CMA population), Saskatoon (11.2%), and Regina (10.0%) (Statistics Canada, 2022b).

TABLE 1: INDIGENOUS POPULATION IN CANADA, BY INDIGENOUS GROUP, 2021

	Total Population (n)	Percentage of Total Indigenous Population (%)
Indigenous	1,807,250	100.0
First Nations	1,048,405	58.0
Status	753,115	41.7
Non-Status	295,290	16.3
Métis	624,215	34.5
Inuit	70,540	3.9

Source: Statistics Canada (2022b).
Note: Statistics do not include those who reported more than one Indigenous identity or who were defined as having an Indigenous identity not included elsewhere

First Nations, Inuit, and Métis health status

Many First Nations, Inuit, and Métis communities exhibit resilience to the ongoing effects of colonialism, through the strength and capacity of their governance systems and assertion of Indigenous rights and treaty rights. Self-governance has enabled the creation of numerous Indigenous-led health system innovations that respond to the locally determined priorities of specific First Nations, Inuit, and Métis communities, with locally determined solutions that better meet the needs of the populations being served (Barnabe, 2021; Lavoie et al., 2016). Self-determination is considered a key factor affecting Indigenous Peoples' health and well-being, as it empowers communities and enables them to "build capacity and gain control over the wide-ranging forces that affect [their] health and well-being at individual and collective levels" (Halseth & Murdock, 2020, p. 4). These forces include the wide-ranging socio-economic impacts of colonialism that continue to contribute to a disproportionate burden of ill-health among Indigenous Peoples. This section examines some of the factors that impact health and well-being for Indigenous Peoples, often referred to as the determinants of health.

Determinants of health

Health is determined by many factors. For Indigenous Peoples, health inequities are directly and indirectly linked to historical and ongoing experiences of colonialism and related assimilation policies. These experiences and policies have contributed to socio-economic marginalization, inequitable allocation of services and resources, and intergenerational trauma, all of which are underlying determinants of poor health for many Indigenous people (Kim, 2019; Loppie & Wien, 2022).

Indigenous Peoples have experienced some improvements in these socio-economic determinants over time, including in relation to education, employment, income, housing, and access to culturally safe and appropriate health services and resources.[5] Nevertheless, as shown in Figure 1, persistent inequities continue to exist between and among Indigenous and non-Indigenous populations in key determinants. For example, there is a significant gap between the proportion of Indigenous and non-Indigenous people who are living in housing in need of major repairs, especially among status First Nations living on reserve, where the gap is over 28%. There is also a significant gap in relation to education, especially among Inuit who have received a high school diploma, where the gap is nearly 35% when compared to the non-Indigenous population. In contrast, the gap between Indigenous and non-Indigenous populations is lowest in relation to living in overcrowded housing conditions, with an almost non-existent gap for status First Nations living off reserve

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>
> (Halseth & Murdock, 2020, p. 4).

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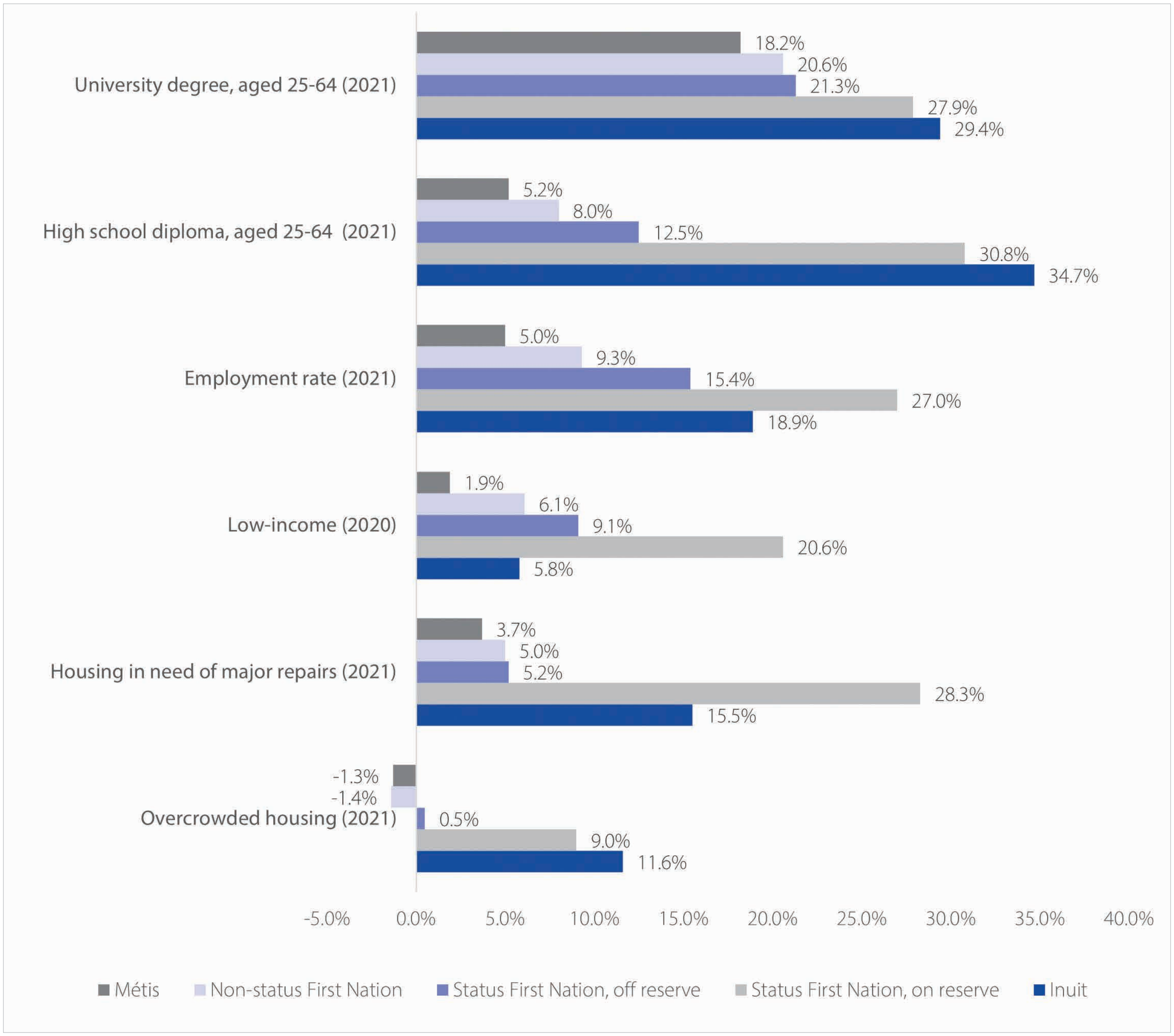
[5] See for example, the NCCIH's fact sheet series on the social determinants of health including education, employment, housing, access to health services, and economic development (NCCIH, 2017a, 2017b, 2017c, 2019, 2020), as well as ISC (2019, 2023a).

and living conditions that are even better for non-Status First Nations and Métis populations compared to their non-Indigenous counterparts (as reflected in a negative gap). It is important to acknowledge that there are socio-economic, political, and land-based differences and unique lived experiences between and among First Nations peoples, Inuit, and Métis peoples that affect these outcomes.

FIGURE 1. GAP BETWEEN INDIGENOUS VS. NON-INDIGENOUS POPULATIONS, BY SOCIO-ECONOMIC DETERMINANT



Source: ISC (2023a).

The federal government acknowledges that addressing these socio-economic disparities requires a holistic approach that considers social, cultural, and spiritual factors along with economic ones (ISC, 2023a). This includes the need to:

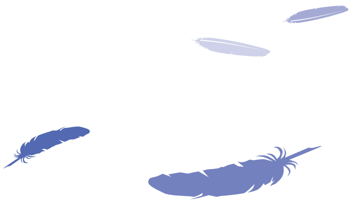
- support language and cultural revitalization,
- improve access to education and employment opportunities,
- promote community empowerment,
- address historical and ongoing injustices,
- and support Indigenous-led solutions and approaches.

Such a holistic approach is reflected in, for example, the federal government's first Poverty Reduction Strategy (2018) and strategy to prevent and address gender-based violence (2017).

There are also some social determinants that can promote health and wellness among First Nations, Inuit, and Métis populations. These include:

- strong connections to language, culture, and the lands and waters;
- social supports and positive peer and family relationships;
- positive personal identity, self-confidence, life skills, and resilience;
- access to health services and culturally safe health care;
- participation in school and community;
- and exercising self-determination, leadership skills, capacity building, and empowerment (Okpalauwaekwe et al., 2022; Schill et al., 2019; Shin et al., 2024; Tanner et al., 2022; Toombs et al., 2016).

For example, data from the *Healing Pathways* study found that community, culture, and a sense of connection were significantly correlated to positive self-rated physical, mental, and spiritual health outcomes among young Indigenous adults in Canada and the United States (Walls et al., 2022).



...data from the Healing Pathways study found that community, culture, and a sense of connection were significantly correlated to positive self-rated physical, mental, and spiritual health outcomes among young Indigenous adults in Canada and the United States

(Walls et al., 2022).

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Indigenous health disparities

Ongoing colonialism and continued socio-economic marginalization profoundly impact the health of Indigenous Peoples, individually and collectively (Henry et al., 2018; Loppie & Wien, 2022). For example, Indigenous Peoples are disproportionately challenged by a host of complex and multifaceted issues, including:

- a shorter life expectancy;
- inequities in maternal-child health;
- disproportionately high rates of child apprehension from families and placement in foster care;
- higher rates of mental illness and addictions, physical and cognitive disabilities, violence and abuse, chronic and communicable diseases, poor oral health, food insecurity, and health conditions associated with high-risk behaviours;
- as well as increased health impacts from natural disasters (ISC, 2024a; Inter-Agency Support Group on Indigenous Peoples' Issues, 2014; World Health Organization, 2023).

Indigenous Peoples also face greater barriers to accessing health care. Challenges are especially acute in rural, remote, and northern communities where access to health services is more limited due to small populations, difficulties in recruiting and retaining health professionals, and a lack of access to specialist health services (NCCIH, 2019). Residents are often required to travel to urban and southern-based hospitals for medical emergencies, hospitalization, appointments with medical specialists, and diagnosis and treatment, which can increase stress and pose personal hardships (NCCIH, 2019).

Barriers to care contribute to health inequities for First Nations peoples, Inuit, and Métis peoples. Some of the more pressing health issues – identified as health priorities in the most recent edition of the NCCIH's *Landscapes of First Nations, Inuit, and Métis health in Canada* (NCCIH, 2024e) – relate to:

- infectious diseases;
- chronic diseases;
- mental health, addictions, and violence;
- child welfare;
- and environmental health.

An overview of these health issues is presented on the following pages.

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> *While the rate of cardiovascular disease has been declining in the general Canadian population, it has been rising among Indigenous populations, especially Indigenous women, and is considered the leading cause of death in this population*
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> (Prince et al., 2018).

Infectious diseases

Indigenous Peoples in Canada have persistently experienced differential impacts from infectious diseases, including HIV infection, sexually transmitted infections (STIs), and respiratory illnesses. In 2020, Indigenous people accounted for 10.3% of all people living with HIV and 18.2% of all new HIV infections, despite comprising only 5% of the Canadian population (Challacombe, 2024). Indigenous Peoples have also experienced an elevated burden of STIs, including hepatitis C, Chlamydia, gonorrhea, and syphilis, especially First Nations people residing in the Prairie Provinces and Inuit residing in their traditional homelands (NCCIH, 2024f). In 2021, the proportion of active tuberculosis (TB) cases was almost five times greater among Indigenous Peoples compared to non-Indigenous people; however, some Indigenous groups are at greater risk than others (Public Health Agency of Canada [PHAC], 2024). In 2022, for instance, the rate of active TB was 26 times greater among Inuit and four times greater among First Nations peoples compared to the national population (ISC, 2024b). Indigenous Peoples are also more likely to be hospitalized and have greater mortality risk from infectious diseases such as COVID-19 and H1N1 influenza, in part due to increased comorbidity burden, and Indigenous infants have among the highest rates of hospitalization for respiratory syncytial virus (Lee et al., 2023).

Chronic diseases

Indigenous Peoples experience a disproportionate burden of many chronic diseases. The most significant of these disparities is in relation to diabetes. Diabetes Canada (2024) reports the age-standardized prevalence rate of diabetes (type 1 and 2) as 5% in the general population; in contrast, the comparative prevalence rate was 17.2% for First Nations peoples residing on reserve, 12.7% for First Nations peoples residing off reserve, 9.9% for Métis peoples, and 4.7% for Inuit. Despite limited data for Métis and Inuit populations, evidence has confirmed that diabetes rates continue to rise among all Indigenous populations, with First Nations peoples experiencing 'epidemic' levels (Cheran et al., 2023).

Indigenous Peoples also experience a disproportionate burden of other chronic diseases, including kidney disease and end-stage renal disease (Schiff et al., 2021), as well as increased rates and severity of rheumatic disease, especially First Nations peoples (Hurd & Barnabe, 2018). While the rate of cardiovascular disease has been declining in the general Canadian population, it has been rising among Indigenous populations, especially Indigenous women, and is considered the leading cause of death in this population (Prince et al., 2018). Disparities in chronic health outcomes among Indigenous Peoples can be attributed, in part, to:

- risk factors such as obesity, daily smoking, and regular and binge drinking (Batal & Decelles, 2019; Bruce et al., 2014);
- socioeconomic marginalization, especially food insecurity (Phillips-Beck et al., 2018);
- as well as inequitable access to health care, especially among Indigenous people residing in rural and remote areas (Disler et al., 2020; Vervoort et al., 2022).

Mental health, addictions, and violence

Indigenous Peoples continue to face significant health concerns due to intergenerational trauma, which has manifest in disproportionately high rates of violence, addictions, and mental health issues (Toombs et al., 2022). For example, in 2018, 63% of Indigenous women – including 65% of Métis women, 64% of First Nations women, and 45% of Inuit women – reported experiencing physical or sexual violence during their lifetime (Figure 2), compared with 45% of non-Indigenous women (Heidinger, 2022).

Canada has been experiencing an opioid crisis that has had a particularly heavy impact on First Nations peoples (Belzak & Halverson, 2018; Hatt, 2022). First Nations peoples in Alberta and British Columbia were five times more likely to experience an opioid-related overdose event and the mortality rate was three times higher compared to non-First Nations peoples (Belzak & Halverson, 2018). Hospital discharge data from 2011 to 2016 linked to the 2011 National Household Survey revealed that the age-standardized rate of hospitalizations due to opioid poisoning was 5.6 times greater

FIGURE 2: PHYSICAL OR SEXUAL VIOLENCE EXPERIENCED DURING LIFETIME, INDIGENOUS VS. NON-INDIGENOUS WOMEN, 2018

Source: Heidinger (2022).

among First Nations individuals residing on reserve and 3.2 times higher among Inuit and Métis populations than the non-Indigenous population (Carrière et al., 2018).

Indigenous Peoples also disproportionately experience mental health issues. Between 2011 and 2016, suicide rates were three times higher among First Nations peoples, two times higher among Métis peoples,[6] and nine times higher among Inuit compared to non-Indigenous people (Kumar & Tjepkema, 2019). Disparities are highest among First Nations and Inuit youth aged 15 to 24 years, especially males. Protective factors against suicide among Indigenous Peoples include:

- supportive peers, families, and communities;
- stable family environments;
- connectedness to others;
- sense of belonging;
- emotional health and personal resilience; and
- cultural continuity (Allen et al., 2021; Beaudoin et al., 2018; Hodgson et al., 2022).

Child welfare

Indigenous children have long been over-represented in the child welfare system due to the legacy of colonialism. Colonialism historically sought to separate Indigenous children from their families and communities through discriminatory policies and practices, including the residential school system and the Sixties Scoop,[7] and continues to foster conditions of socio-economic marginalization (Haight et al., 2018; Ma et al., 2019; Trocmé et al., 2004). Despite long-standing recognition of the need to address this over-representation, Indigenous children represented nearly 54% of all children under 14 years of age in foster care in 2021, while comprising only 7.7% of children in this age range (ISC, 2024a). In fact, the proportion of Indigenous children under 14 years of age in foster care has increased over time, from 47.8% in 2011 to 53.7% in 2021 (Hahman et al., 2024). This over-representation was especially evident among First Nations children, who comprised 42.5% of all children under 14 years of age in foster care, living in private households, while non-Indigenous, Métis, and Inuit children comprised 46.3%, 7.2%, and 2.8% respectively (Hahman et al., 2024). Indigenous children are often fostered in non-Indigenous households (Turner, 2016). This can impact their cultural identity and connection, and subsequently affect their well-being over time (Quinn, 2019).

In recognition of the need to improve child and family services for Indigenous children and families, in 2019 the federal government passed an *Act respecting First Nations, Inuit and Métis children, youth and families*. The Act – co-developed with Indigenous, provincial, and territorial partners – was enacted in 2020 and affirms First Nations peoples', Inuit, and Métis peoples' right to exercise jurisdiction over child and family services, enabling them to devise culturally appropriate approaches that better serve the needs of their children (ISC, 2024a).

Environmental health

Indigenous Peoples are uniquely – individually and collectively – affected by the health of the environment. Given their interconnectedness with the natural world, First Nations peoples, Inuit, and Métis peoples are disproportionately affected by climate change, natural disasters, and associated emergencies. They are also disproportionately affected by a host of other natural

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[6] Caution must be exercised in interpreting this data as the quality of estimates and confidence intervals is marginal due to high sampling variability.

[7] The Sixties Scoop refers to the mass apprehension of Indigenous children from their families and placement into the child welfare system, primarily in non-Indigenous households, that really began to accelerate during the 1960s.

and human-built influences that can adversely affect the lands and waters that are so inextricably connected to their health and well-being, both present and future generations. Indigenous Peoples are more likely than non-Indigenous people to reside in regions experiencing rapid climate change, potentially exacerbating socio-economic inequities and increasing risks for respiratory, cardiovascular, chronic, infectious, and water- and foodborne diseases (NCCIH, 2022). Populations in these areas are also vulnerable to environmental pollutants from resource extraction and construction initiatives such as hydro-electric developments, where many polluting infrastructures were built without the free, prior, and informed consent of affected Indigenous communities (Fernández-Llamazares et al., 2020). Inuit residing in Arctic regions have been particularly impacted by the accumulation of environmental toxins in their traditional food sources, raising concerns about food security, nutrition-related health conditions, and the potential impacts on infant and child development (Basu et al., 2022; Northern Contaminants Program Secretariat, 2017).

First Nations peoples, Inuit, and Métis peoples are rights-holders under Section 35 of the *Constitution Act, 1982*, including the inherent right to self-government over their lands, natural resources, and ways of life (NCCIH, 2022). These rights are further affirmed in national and international commitments made by the Government of Canada, such as the Truth and Reconciliation Commission (TRC) of Canada's (2015) Calls to Action for reconciliation and the passage of the *United Nations Declaration on the Rights of Indigenous Peoples Act* in 2021 (Crown-Indigenous Relations and Northern Affairs Canada, 2024; Government of Canada, 2021). Despite these expressed commitments, too often Indigenous rights and interests have been ignored, abrogated, or subject to court challenges (NCCIH, 2020). Given the deep connection between the health of the environment and health of Indigenous Peoples, it is imperative that Indigenous perspectives are incorporated not only in decision-making about resource development on traditional lands, but also in the development of policy on broader environmental health issues, such as climate change and resource development projects, that affect Indigenous Peoples' livelihoods and ways of living.


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Given their interconnectedness with the natural world, First Nations peoples, Inuit, and Métis peoples are disproportionately affected by climate change, natural disasters, and associated emergencies.

Appropriateness of population health measurement frameworks for use with Indigenous populations

Health indicators are used to measure, track, and report on population health, including health outcomes, access to services, and the socio-demographic factors that can influence health (Stelkia et al., 2023). Unfortunately, mainstream indicators of population health do not adequately capture key aspects of Indigenous Peoples' health. As such, they may not be appropriate for or useful to support health decision-making in Indigenous communities.

Indigenous Peoples' conceptions of health are holistic and balance physical, emotional, mental, and spiritual wellness (Mackean et al., 2022). For example, some First Nations use a Medicine Wheel to depict these interconnected dimensions of health and wellness and highlight the importance of maintaining balance between them (Indigenous Corporate Training, 2020). Métis people share similar conceptions of health and well-being based on their understanding that health is self-determined, holistic, multi-faceted, deeply connected to place, and inclusive of all Métis, regardless of age, background, or regions (Stewart & Panahi, n.d.). One Métis model conceptualizes the core components of Métis health and well-being as a Red River Cart, demonstrating the intimate connections between culture, identity, people, and lands (Atkinson et al., 2023). Inuit conceptions of health are also holistic and embedded within Inuit societal values – Inuit Qaujimajatuqangit (IQ) – which emphasize relationality with others and the natural world (Tagalik, 2018). IQ principles consider culturally appropriate determinants of health, such as community, family, identity, food, land, knowledge, economy, and services (Fletcher et al., 2024). Reclaiming and revitalizing cultural practices, languages, and traditional ways of knowing are seen as having a profound restorative impact on First Nations, Inuit, and Métis health and well-being at both individual and community levels (Kirmayer et al., 2003; Redvers, 2020).

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(Kirmayer et al., 2003; Redvers, 2020).

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In contrast, mainstream indicators of population health tend to fit within a Western biomedical paradigm that focuses on the prevalence of disease and health deficits, while overlooking the cultural, spiritual, and interconnected dimensions of First Nations, Inuit, and Métis health (Mackean et al., 2022; Stelkia et al., 2023). As such, there are often major gaps in Western-based indicator frameworks to support health decision-making in Indigenous communities. These gaps include a lack of strengths-based indicators that are inclusive of social, environmental, and behavioural determinants that provide context for Indigenous health outcomes, including the impacts of colonization; indicators that explore health resources and assets, what works in communities, and what can be built upon; as well as indicators that measure health system performance and health services utilization (Halseth, 2024). It is well acknowledged that Indigenous self-determination in data collection is critical for ensuring that data reflect the priorities, values, cultures, worldviews, and diversity of Indigenous Peoples (Halseth, 2024). As such, research with Indigenous Peoples is expected to be conducted in accordance with key standards that support First Nations, Inuit, and Métis data governance, as demonstrated in Indigenous-led governance initiatives such as the First Nations Information Governance Centre's (FNIGC) principles of ownership, control, access, and possession (OCAP®).

The federal government has committed to establishing measurable goals to identify and close gaps in health outcomes for Indigenous Peoples, as articulated in the TRC's (2015) Call to Action #19; yet progress on reconciliation has been limited to date (Yellowhead Institute, 2023). Some Indigenous-specific population health indicator frameworks have been developed and are now being used to measure aspects of Indigenous health, including the First Nations Regional Health Survey, implemented by the First Nations Information Governance Centre, and the Qaunuippitaa? National Inuit Health Survey, implemented by four Inuit Land Claims organizations in collaboration with Inuit Tapiriit Kanatami. These frameworks aim to affirm Indigenous self-determination regarding how data about Indigenous populations are collected and stored, who has access to that data, how it will be analyzed and interpreted, and how data are managed, disseminated, and used (Marsden et al., 2020). With these frameworks as leading examples, there is a need for further engagement with Indigenous Peoples and communities as equal partners in the development of population health frameworks to ensure that health data are relevant to Indigenous communities and aligned with their needs (Halseth, 2024; Walter & Suina, 2019).

Efforts are also underway to strengthen public health assessment in Canada through the federal government's *Vision 2030* initiative. The Government of Canada has engaged with numerous stakeholders, including First Nations, Inuit, and Métis health-related organizations and groups, to envision a public health assessment system for Canada in the future – one that is more inclusive, relevant, and responsive to public health needs (PHAC, 2023).

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(Halseth, 2024; Walter & Suina, 2019).

Jurisdictional context for Indigenous health legislation, policies, and programs

Indigenous health policy in Canada is made up of a complicated "patchwork" of policies, legislation, and agreements that delegate responsibility between federal, provincial, territorial, and Indigenous governments – in different ways across different parts of the country (Lavoie et al., 2021; Webb, 2022). All Canadians, including Indigenous Peoples, are entitled to receive insured services under the *Canada Health Act*, including hospital, physician, and surgical-dental services (Marchildon et al., 2020). These services are funded through the national insurance plan, *Medicare*, and administered by provincial and territorial governments.

The federal government funds or directly provides health services for First Nations peoples on reserve and Inuit residing in Inuit Nunangat. This includes

- clinical and client care services in approximately 138 remote and isolated First Nations communities;
- home and community care in 657 First Nations and Inuit communities;
- community-based mental health, health promotion, and healthy child development programs in approximately 650 First Nations and Inuit communities;
- and public health programs focused on communicable disease control and environmental public health in all First Nations communities (ISC, 2024c).

Additionally, extended health benefits – such as vision and oral care, medical supplies and equipment, prescription drugs, and transportation – are provided through the non-insured health benefits (NIHB) program to registered First Nations peoples and recognized Inuit, regardless of residence (ISC, 2024d). The federal government also offers funding for a number of health programs and services targeted at urban Indigenous people (ISC, 2024e); however, funding is often short term and woefully inadequate to meet the needs of targeted populations (Collier, 2020). This jurisdictional fragmentation continues to reinforce significant health disparities between Indigenous and non-Indigenous populations (Marchildon et al., 2020).

Jurisdictional fragmentation creates health care access barriers for non-status First Nations, Métis, and Indigenous peoples residing off reserve and outside of Inuit Nunangat. Individuals without registered status, such as First Nations status, do not receive access to NIHB. Meanwhile, those with access to NIHB but residing off reserve are unable to access specific services, such as mental health and addictions counselling, that are only available on First Nations reserves or in Inuit communities[8] (Hahmann & Kumar, 2022). This fragmentation results in disputes over which government – federal or provincial/territorial – should pay for services received by Indigenous clients who do not reside on reserve or in their traditional homelands, with potentially harmful health outcomes. Such a dispute involving a young boy from Norway House Cree Nation named Jordan River Anderson, who experienced tragic delays in services before his death in 2005, led to the creation of Jordan's Principle (Assembly of First Nations [AFN], 2015). Intended to ensure that First Nations children, regardless of where they live, do not experience denial, delay, or disruption of services as a result of jurisdictional disputes, Jordan's Principle was unanimously adopted by the House of Commons in 2007 and

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[8] While the Supreme Court of Canada ruled in 2016 that Métis and non-status First Nations peoples are included under s. 91(24) of the *Constitution Act* (1867), clarifying federal fiduciary responsibilities for these populations (Isaac & Hoekstra, 2017), implications of this ruling are yet to be seen in policy and practice (Boyer et al., 2021).

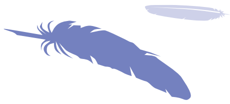
subsequently implemented (AFN, 2015). A similar initiative – the Inuit Child First Initiative – was implemented to ensure Inuit children, regardless of where they reside, have access to "essential health, social and educational products, services and supports they need, when they need them" (Inuit Tapiriit Kanatami, 2024, para. 1). However, no similar initiative exists for Métis children.

First Nations people, Inuit, and Métis people who access mainstream health services in urban hubs may experience challenges accessing culturally safe and appropriate health care (Browne et al., 2016; Naem et al., 2023). There are many reported cases of Indigenous clients experiencing difficulty communicating with health professionals due to linguistic or cultural barriers; racism, discrimination, and disregard by healthcare staff; and discomfort from an unfamiliar and intimidating health care environment (Graham et al., 2023). Lack of culturally safe and appropriate health care can be a significant barrier to health seeking behaviour, as well as timely diagnosis and treatment, which can result in poorer health outcomes (Wilkinson et al., 2022). In response, governments and health systems across Canada have been implementing policies, training programs, and practices aimed at enhancing cultural safety for Indigenous clients accessing mainstream health services. For example, a province-wide cultural safety and humility strategy was implemented in British Columbia, in collaboration with the federal and provincial governments, the First Nations Health Authority, regional health authorities, and various health organizations (NCCIH, 2024a). The multi-faceted strategy created and prompted:

- a tripartite cross-system framework of health care delivery and decision-making structures that achieve systemic change across multiple organizations;
- declarations of commitment to advance cultural humility and cultural safety from various professional and health organizations across the province;
- a provincial system-wide cultural safety policy;
- unique services designed to enhance Indigenous Peoples' access to culturally appropriate and safe care;
- cultural safety action plans and accountability measures across diverse health organizations;
- integration of Indigenous worldviews, knowledges, and approaches to health and wellness in health strategies; and
- cultural safety training programs at both provincial and regional levels.

Similar initiatives, though on a smaller scale, have been implemented in various health systems across Canada.[9]

> *Lack of culturally safe and appropriate health care can be a significant barrier to health seeking behaviour, as well as timely diagnosis and treatment, which can result in poorer health outcomes*
>
> (Wilkinson et al., 2022).



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[9] The NCCIH undertook an environmental scan of cultural safety initiatives implemented across Canada, with chapters for some provinces and territories already published (NCCIH, 2024a, 2024b, 2024c, 2024d), while others remain in press.

Indigenous control over health systems has increasingly been recognized as vital for improving health outcomes (Halseth & Murdock, 2020). These systems integrate Indigenous perspectives on health and wellness into health care and enable community-based responses and solutions to health challenges; thus, offering more holistic approaches to health care that better reflect the needs and priorities of clients and communities (Marchildon et al., 2020). Support for Indigenous-controlled health systems came in the 1980s with the implementation of the federal government's *Health Transfer Policy*, which enabled First Nations communities to assume varying levels of health care responsibility from the federal to the community or council level (Health Canada, 2005). Other mechanisms have facilitated a shift toward Indigenous-controlled health systems, such as comprehensive land claims and self-government agreements, the Primary Health Care Transition Fund Initiative,[10] and other partnership agreements involving Indigenous and non-Indigenous governments and representative organizations, such as the British Columbia Tripartite Framework Agreement on First Nation Health Governance (Health Canada, 2007; Webb, 2022). Such mechanisms have led to the creation of innovative models of shared governance in health care including, for example, the Northern Inter-Tribal Health Authority in Saskatchewan, Tajikeimɨk in Nova Scotia, and the First Nations Health Authority in British Columbia. These mechanisms have also led to greater integration of physical, mental, and behavioural health in Western-based medical care, supporting improved health outcomes for Indigenous people (Lewis & Myhra, 2017; Stefanon et al., 2023). Indigenous-controlled health services can help improve access to culturally appropriate health services and address health inequities often linked to systemic racism and discrimination (Marchildon et al., 2021).

Initiatives have also been implemented to support greater Indigenous participation within mainstream healthcare systems. Examples include formal Indigenous-led advisory boards, councils, or committees to represent and assert the health needs and priorities of Indigenous Peoples at local, regional, and provincial/territorial levels; as well as Indigenous-specific policies aimed at addressing gaps and coordinating cross-jurisdiction service provision (Webb, 2022). Ontario's Aboriginal Health Policy, for example, aims to improve Indigenous health by strengthening community involvement in all aspects of programs and services, from planning to design, to implementation and evaluation (Webb, 2022). Nevertheless, in the absence of a clear national and distinctions-based Indigenous health policy, jurisdictional ambiguities and gaps in health services and inequitable levels of funding will persist, especially for non-status First Nations, Métis, and urban Indigenous populations (Lavoie, 2013; Lavoie et al., 2007; Murdock, 2024; Webb, 2022).

The federal government has acknowledged the unique challenges faced by First Nations peoples, Inuit, and Métis peoples in accessing culturally safe health care (ISC, 2021a). It has also made specific commitments to address the social determinants of health for Indigenous Peoples (ISC, 2023b); advance reconciliation (TRC, 2015); renew its relationship with Indigenous Peoples based on a recognition of rights, respect, cooperation, and partnership (ISC, 2021b); and ensure Canadian laws align with the United Nations Declaration on the Rights of Indigenous Peoples, including their inherent right to self-determination (ISC, 2021a). To honour these commitments, the federal government has been working with First Nations, Inuit, and Métis organizations, leadership, health professionals, and subject matter experts to co-develop distinctions-based Indigenous health legislation. This legislation is intended to reflect the distinct cultures, needs, and aspirations of First Nations peoples, Inuit, and Métis peoples, and foster respect and a genuine effort to ensure the safety and well-being of all Indigenous Peoples (ISC, 2023b).

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[10] The Aboriginal Envelope of the Primary Health Care Transition Fund Initiative supported the integration of primary health care services by Indigenous populations, including Indigenous-led regional health authorities (Health Canada, 2007).

Conclusion

This fact sheet provides a general introduction to Indigenous health and the context within which First Nations, Inuit, and Métis communities – and health practitioners, policymakers, and researchers – seek to improve the health and well-being of Indigenous populations. This context includes a broad demographic and geographic overview of:

- Indigenous Peoples in Canada,
- the factors that determine and influence their health,
- current health disparities faced by Indigenous populations,
- Indigenous public health measurement frameworks,
- and the jurisdictional framework that underpins the delivery of health programs and services for First Nations peoples, Inuit, and Métis peoples.

This background information highlights the complex challenges Indigenous Peoples face in relation to their health and well-being, and how these challenges have not been adequately addressed by mainstream health services. Indigenous control over health services has increasingly been recognized as central to meeting these challenges. This has resulted in the creation of innovative and integrated health services that are holistic, culturally appropriate, and reflect the unique cultures, needs, and aspirations of First Nations peoples, Inuit, and Métis peoples.

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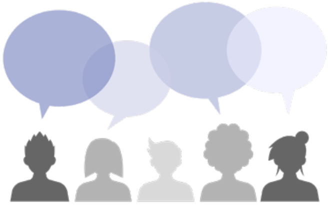
REFLECT

Talk to others in your community, reflect on the content of this fact sheet, and contemplate how you could make a difference in the health and well-being for yourself, your family or your community.



ENGAGE

Find local friendship centers, community organizations or groups where you can volunteer or participate in healthy positive actions. You too can share knowledge and make a difference in the health and well-being of First Nations, Inuit, and Métis Peoples' of Canada.

sharing knowledge · making a difference
partager les connaissances · faire une différence
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