

**Community Based Participatory Project:  
Engaging Individuals/Families in the Development  
of Programs to Enhance Health and Well-being  
Métis Nation – Saskatchewan  
Final Report**

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**Community Based Participatory Project: Engaging  
Individuals/Families in the Development of Programs  
to Enhance Health and Well-being**

**Métis Nation – Saskatchewan**

**Executive Summary**

Because Métis citizens do not benefit from the numerous programs and services that First Nations and Inuit Health Branch provide to First Nations on-reserve and Inuit people, the social determinants of health have a greater impact on individuals, families and communities.

It was the desire of the Métis Nation to build a framework that would con-jointly engage the community and university partners in better understanding the social determinants of health within Métis communities. The information gleaned and the dialogue with the community was designed to illuminate the social, economic and cultural conditions that influence health and well-being within the communities of the Métis Nation - Saskatchewan.

Utilizing community-based participatory research methods and based on elements that were negotiated with the Métis Nation – Saskatchewan, 1669 individuals were invited to participate in this research project. The response rate was 90.77% (1515/1669). It was clear from the preliminary analysis that no one program would address the challenges identified in and by the community. Sex, age and social economic status were all important contributing factors found in the analysis. A more extensive sharing of this information within the communities will be undertaken; thus, ensuring that the voices of the community are more intimately integrated into the development of evidence-informed health promotion programs.

## **Background**

Traditionally, Métis put the well-being of the community before the well-being of any individual or smaller group. Their ancestors took pride in sharing resources and ensuring that the variety of talents within the community were brought forward; thus, reflecting the best interests of and for the community (NAHO, 2005). This was deemed to help people belong and respect the diversity in the community (NAHO, 2005).

Because Métis citizens do not benefit from the numerous programs and services that First Nations and Inuit Health Branch provide to First Nations On-reserve and Inuit people, the social determinants of health (WHO, 2003; Marmot & Wilkinson, 2006) may have a greater impact on individuals, families and Métis communities. Even in the most affluent countries, social determinants of health have a greater impact on those who are less well off (WHO, 2003). There is a paucity of current data regarding the health and well-being of Métis at the local, provincial or national levels; however, the data that are available would suggest that the Métis people suffer from similar rates of chronic, infectious and social illnesses as do First Nations and Inuit communities (Lamouche, 2002; Romanow, 2002; Statistics Canada, 2001).

Métis Nation - Saskatchewan represents approximately 80,000 Métis people in the province of Saskatchewan. The Nation is led by an elected Provincial Métis Council comprised of four executive members, 12 regional representatives; as well as, representation from Métis youth and Métis women. The President of the Métis Nation—Saskatchewan holds one seat on the Board of Governors of the Métis National Council.

The Métis Nation – Saskatchewan represents its citizens on political, social and community issues. Members of the Métis Nation – Saskatchewan’s Health/Addictions Portfolio worked together to design, articulate, plan, implement and evaluate the research agenda relevant to establishing a baseline related to the health and well-being of the communities by building on the strengths of individuals, families and the community to better understand the impact that the social determinants of health have within the community.

### **Methods**

Community-based participatory research methods (Israel et al, 1998; Macauley et al, 1999; Minkler et al, 2006; Ramsden et al, 2003; Wallerstein & Duran, 2006) integrated with the Needs Assessment Guide for Métis communities (NAHO, 2005) were used in the development of this research endeavour. The elements utilized were negotiated between citizens of Métis Nation – Saskatchewan, a researcher from First Nations University of Canada and a researcher from the University of Saskatchewan. Prior to embarking on this research endeavour, the Addendum for this research project was submitted and reviewed by the University of Saskatchewan’s Behavioural Research Ethics Board with a Certificate of Approval for BEH 07-100 (Appendices A & B) obtained. Given the nature of this research endeavour, approval was sought through the Northern Saskatchewan Population Health Unit and received from Mamawetan Churchill River Regional Health Authority and Keewatin Yatthé Regional Health Authority.

The Métis citizens were invited to participate in a community-based survey through purposeful sampling within each of the Regions of the Métis Nation – Saskatchewan. In addition to this, the data from the survey with Regina Métis Sports and Culture, Inc. were added to the data set to

ensure that all Regions were represented. Individuals invited to participate were 18 years of age and residing within the province of Saskatchewan at the time of the survey.

If the individuals invited to participate agreed to do so, a date and time for an interview with a member of the research team was established and oral consent obtained prior to commencing the interview. Consent was, however, viewed as an ongoing transactional process and as such the individuals were encouraged to answer only those questions that they felt comfortable with; thus, ensuring that the individuals played a collaborative role in the decision-making process regarding their participation.

A unique numeric code was assigned to each individual and subsequently to the surveys for the purposes of tracking and data entry. Documentation during the interview/survey was done using a pencil and paper so that reflection and dialogue could occur as a part of the process of data collection rather than as an outcome. This approach allowed the participants to reflect on the questions, identify the successes and consider the opportunities for change. At the conclusion of the interview/survey, any questions that the participants had were noted, answered whenever possible, and additional follow-up was provided as needed.

The data was entered into SPSS-X computer software (Version 17) for analysis. Double data entry was used to ensure accuracy of the entry, with the entries being crosschecked prior to final cleaning of the data. The quantitative (numerical) data such as demographics, risk factors, etc. were analyzed using descriptive statistics (frequencies and means) and for comparisons of categorical variables, the Chi-square test of independence was performed using a value of  $p < 0.05$

(two-tailed) for statistical significance. ANOVA (analysis of variance), at the same level of significance, was used to compare means.

The qualitative data was initially analyzed using inductive and thematic analysis; however, reflections on the analysis were undertaken using participatory approaches. The aggregate data was organized into themes that included elements that had been negotiated through the process. The emphasis of the qualitative data collected was on illumination and understanding rather than causal determination, prediction or generalization (Patton, 1990; Patton, 2002).

The data collected from the semi-structured interviews was returned to a number of communities of the Métis Nation – Saskatchewan that participated in the data collection for interpretation and decision-making. This took the form of sharing a meal and engaging in dialogue with the community about the results and their understanding of them. This was undertaken to give anyone who participated an opportunity to react and respond to the results/findings before completion of the Final Report. Matters of disagreement were carefully considered and accurately reported in the Final Report and will also be done in any subsequent publications.

## Results/Findings

### Response Rate:

The Response Rate was determined by:

$$\text{Response Rate} = \frac{\text{Number of Valid Responses}}{\text{Total Number of People Approached}}$$

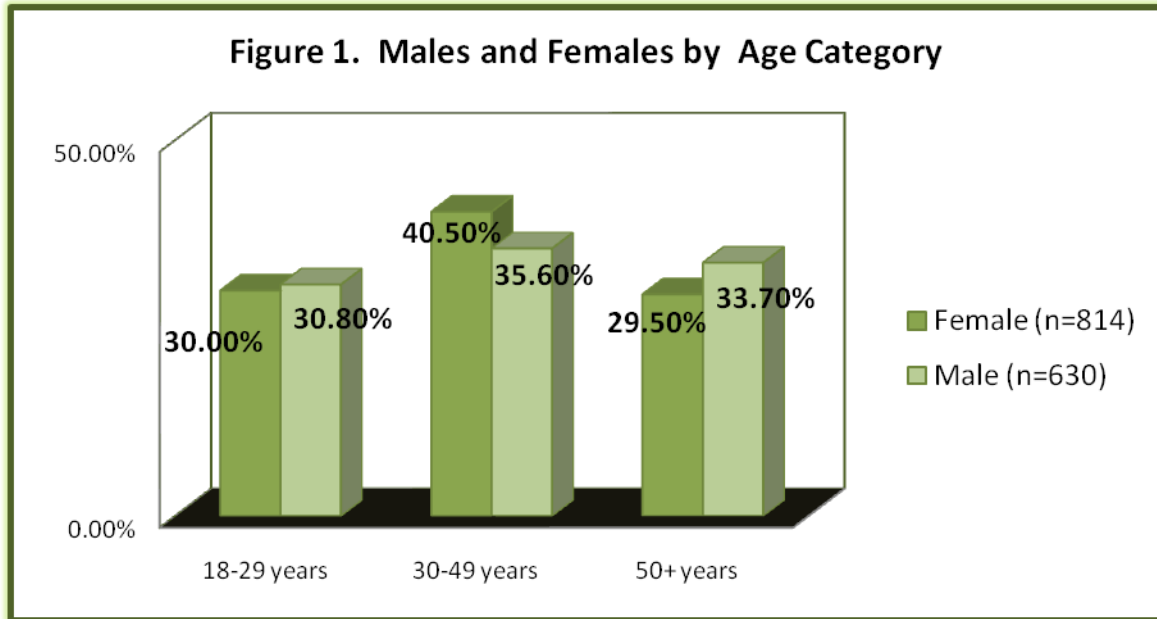
A Master List was compiled from all lists received from the Community Liaison Workers. The Master List was comprised of the total number approached. The valid responses were confirmed as the surveys were delivered. There were 1515 valid responses out of the 1669 individuals invited to participate; thus, the Response Rate was 90.77%. To ensure that the data set met the criteria originally delineated, surveys with: incomplete data (n=22); dates of birth that resulted in the participant being less than 18 years of age (n=10); or, those that lived outside of Saskatchewan (n=21), were removed. There were also: missing surveys (n=33); duplicates (n=7); surveys submitted without responses marked as refused (n=33); and, surveys for which the identity of the individual was unclear (n=28).

### Demographic Information:

Of those surveyed, 56.8% (861/1515) were female with an average age of 41.59 years (n=814) and 43.2% (654/1515) were male with an average age of 41.76 years (n=630). The age of the participants ranged from 18-109 years with a mean age of 41.66 years (n=1444) When age was collapsed into three categories, the sexes were represented fairly equally across the categories.

See Figure 1.

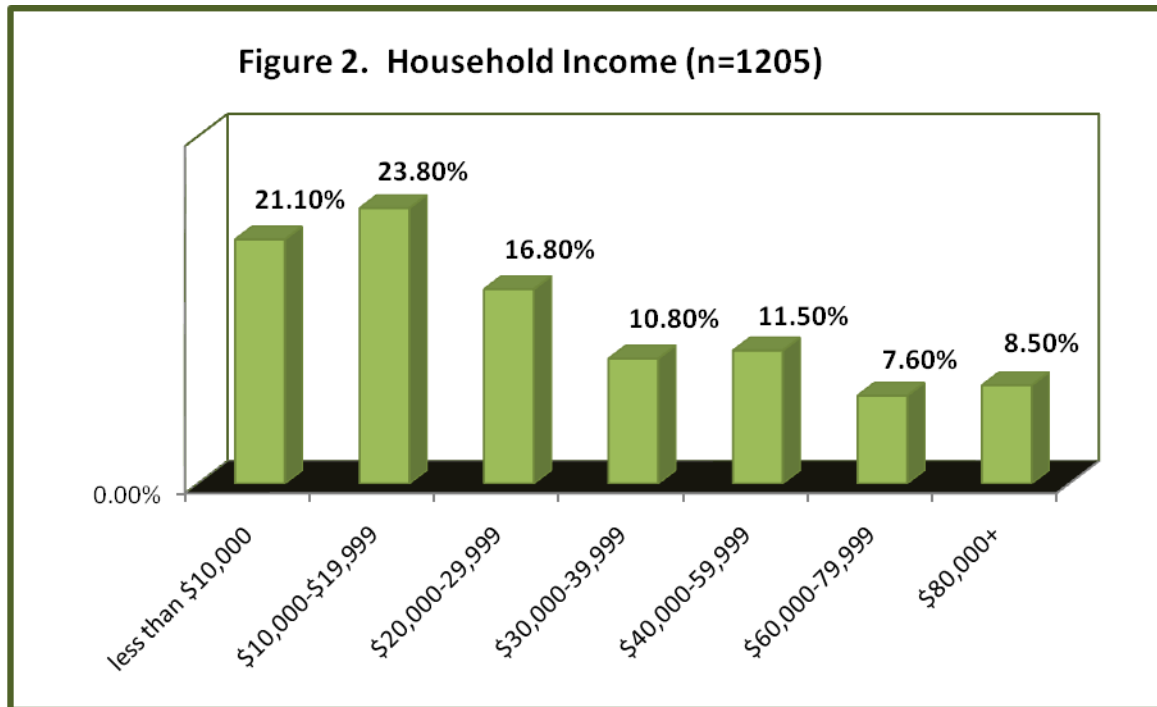




The employment participation rate for those who responded to the question “Are you currently employed?” was 57.0% (844/1481). The employment participation rate for those aged 18 to 65 was 62.1% (796/1282). Both rates were lower than both the Saskatchewan employment participation rate for October-December of 2009 which was 69.1% and the Saskatchewan employment participation rate for the Métis labour force reported at the same time which was 66.9% (Saskatchewan Bureau of Statistics, December, 2009).

Information on household income was collected using the categories seen in Figure 2. The median income for Saskatchewan (Saskatchewan Bureau of Statistics, May, 2008) was reported to be \$35,948.00 and the average income in 2006 was \$28,872.00. Thus, of those surveyed who responded to the question, 61.7% (744/1205) fall below the bracket which contains the median income for Saskatchewan, and 44.90% (541/1205) fall below the \$20,000.00-\$29,999.00 bracket which contains the average Saskatchewan income. From the Census, which reported a median earning for males of \$39,991.00 and females of \$32,097.00, the provincial earnings gap between

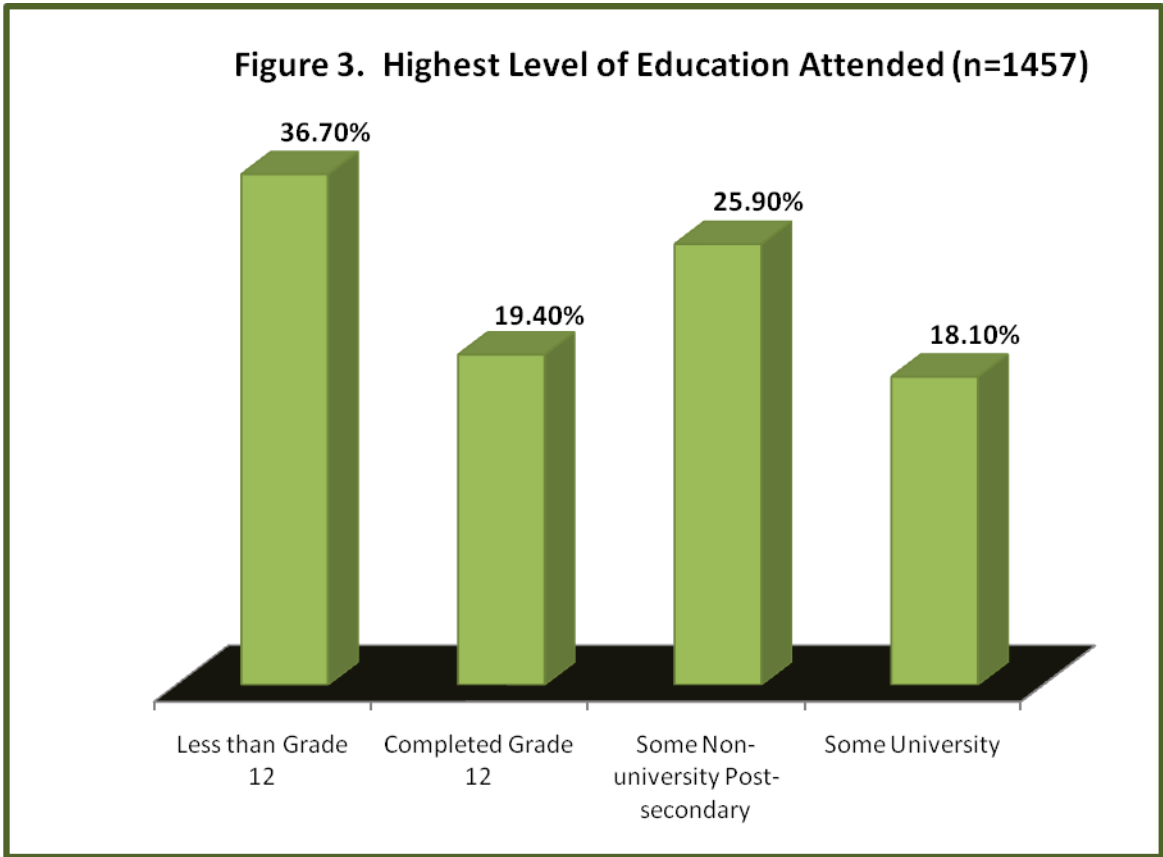
the sexes was 24.6%. In this study, 44.78% (300/670) of the females and 35.51% (190/535) of the males fall below the \$30,000.00-39,999.00 income bracket.



Of the 1441 participants who answered the questions relating to the highest grade of elementary or secondary school they attended, 52.7% (n=760) indicated they had attended Grade 12. Of these, 92.2% (701/760) reported having completed Grade 12 or equivalent. In the 2006 Census, 26.7% of the population reported having a high school certificate or equivalent as their highest level of education.

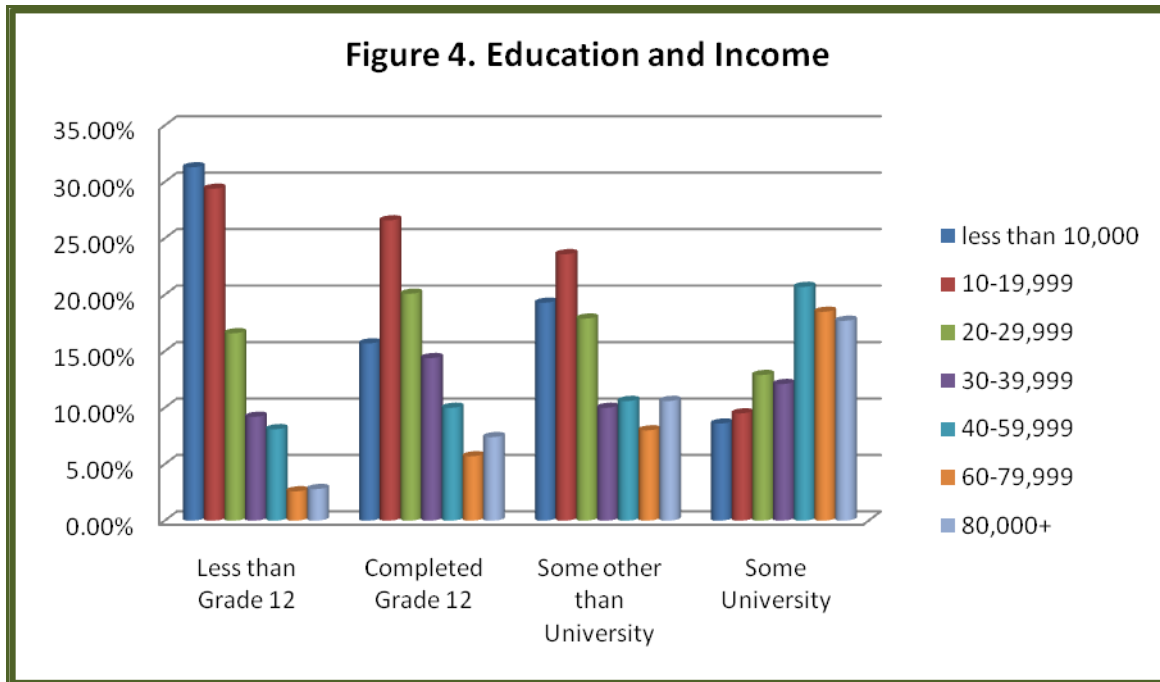
Of the participants, 39.5% (514/1301) reported attending some sort of post-secondary education other than university, ranging from 1 to 6+ years. With respect to university, 21.1% (264/1253) indicated that they had attended 1 to 6+ years. In the 2006 Census, 72.4% of the non-Aboriginal census population in Saskatchewan 15 years of age and over reported some type of post

secondary qualifications as did 50.6% of those self-identifying as Aboriginal (Statistics Canada, 2008). For the same time period, 28.6% of the Aboriginal population had some form of post-secondary education relative to 44.9% of the non-Aboriginal population. The survey did not include questions regarding the completion of post-secondary training or obtaining credentials. However, a composite variable was created from the education questions on the survey to approximate the highest level of education attended. See Figure 3.

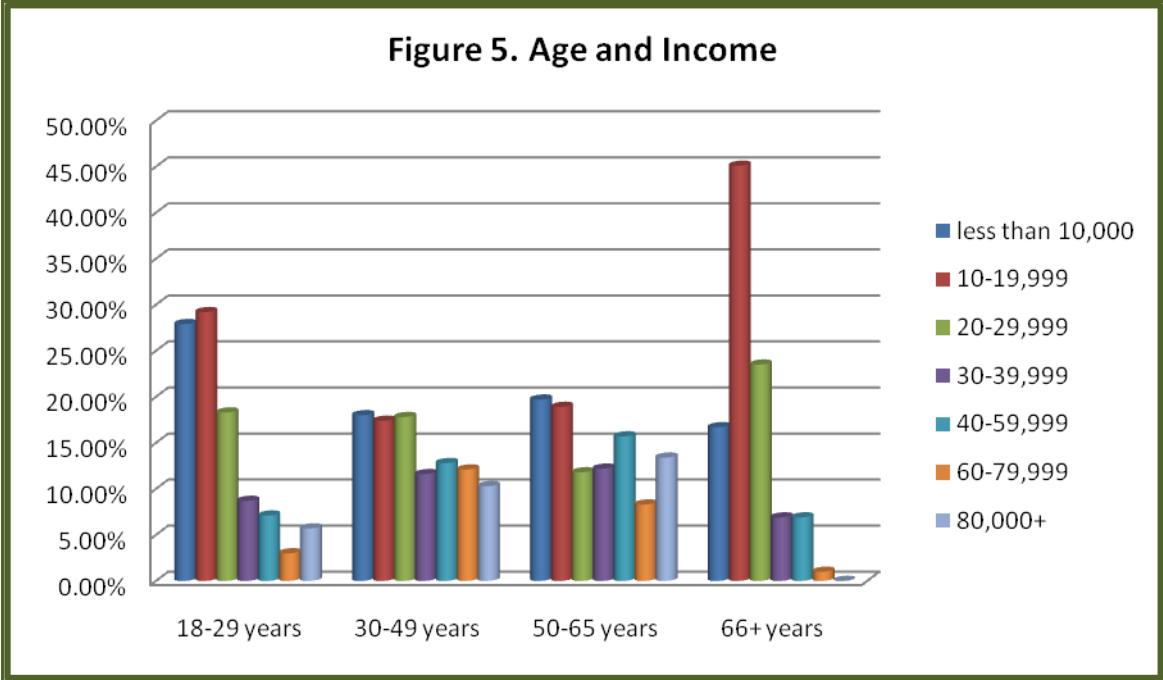


Education and income are certainly linked, as can be seen in Figure 4. With the completion of Grade 12 the proportion of those with a household income less than \$10,000.00 decreased. For those with some post-secondary education, the pattern of household incomes in the brackets under the median bracket was quite similar but proportionately more with some post-secondary/non-university had a household income above the median. For those with some

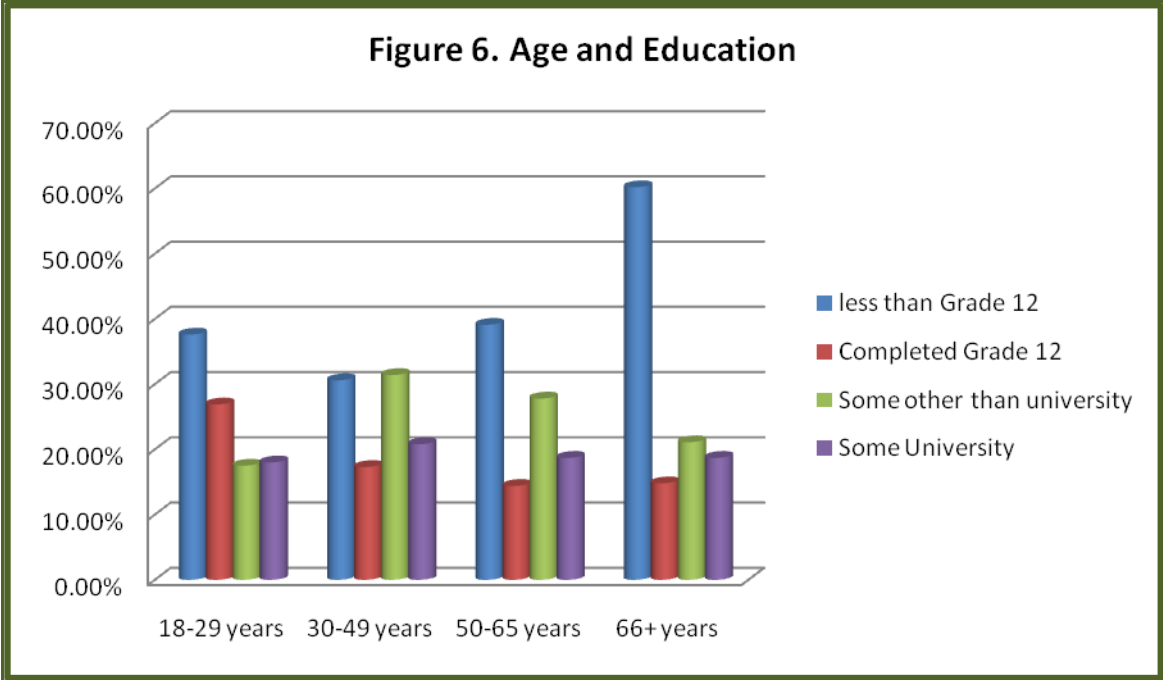
university, the income pattern shifted dramatically, with lower numbers in the lower income brackets and more earning higher incomes.



The relationship between household income and age of the participants can be seen in Figure 5. As expected, the household income of younger adults tended to be lower, in keeping with their lack of work experience and years in the workforce. However, older adults tended to earn less, which can be expected as people retire. The pattern of income earning was quite similar for the two middle age brackets.

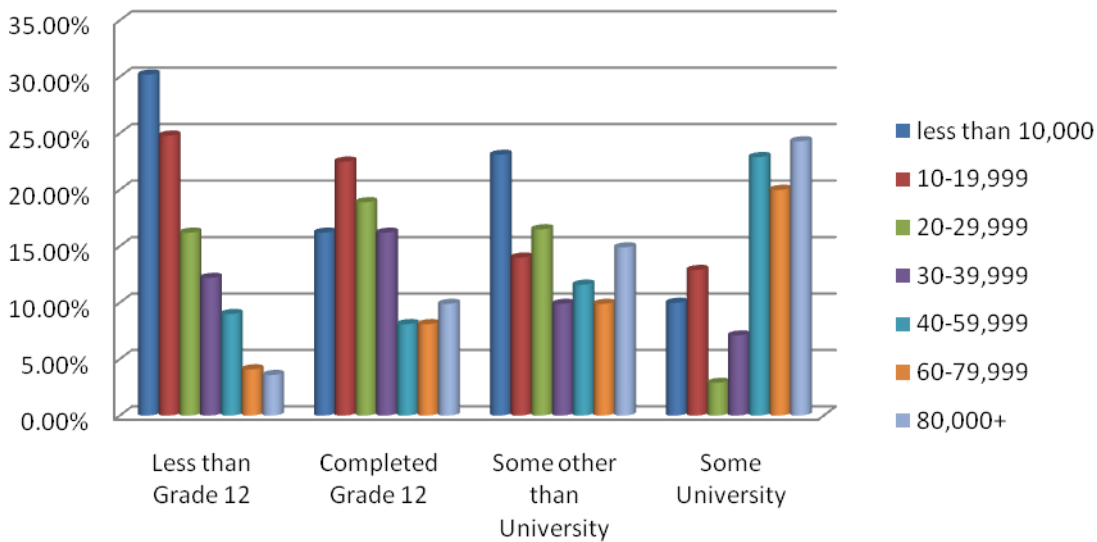


Further to this, the relationship between age and education is shown in Figure 6. Across the age groups, the proportion of those in each group with some university was quite similar. However, there was a substantive increase in the proportion of those in the middle aged groups with some post-secondary and a slightly higher proportion having completed Grade 12 in the 30-49 year old groups than the two older groups. Bearing in mind, the relationship between education and age, the very high proportion of those who did not complete Grade 12 in the oldest age bracket was reflected in their retirement income. Of some concern was the high proportion of young adults who had not completed Grade 12.

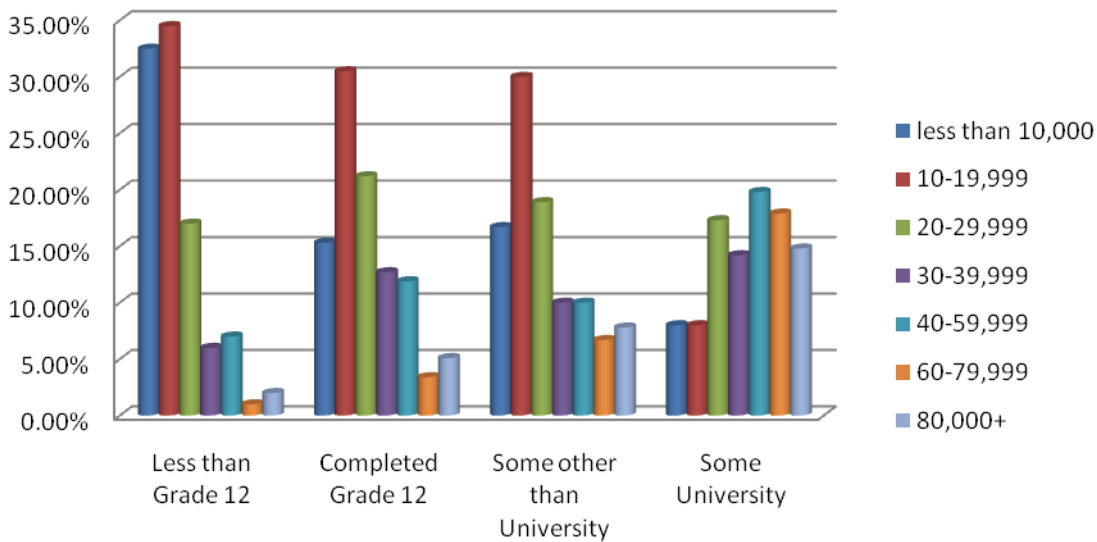


The patterns of education and household income for males and females are shown in Figures 7 and 8. The data demonstrated that males tend to earn more than females when they acquire some form of education. With the completion of Grade 12 or some post-secondary/non-university, proportionately fewer males were in the lowest income brackets and more were in the higher income brackets than were females. This was likely reflective of the types of employment typically selected by or open to each gender, with males earning more in trades and perhaps even unskilled heavy labour than females in pink collar and service industry employment. With respect to university, the data demonstrated that the effect of university education for men was different than for women. Proportionately more men with some university education were in the higher income brackets than women with some university education.

**Figure 7. Education and Income - Males (n=524)**

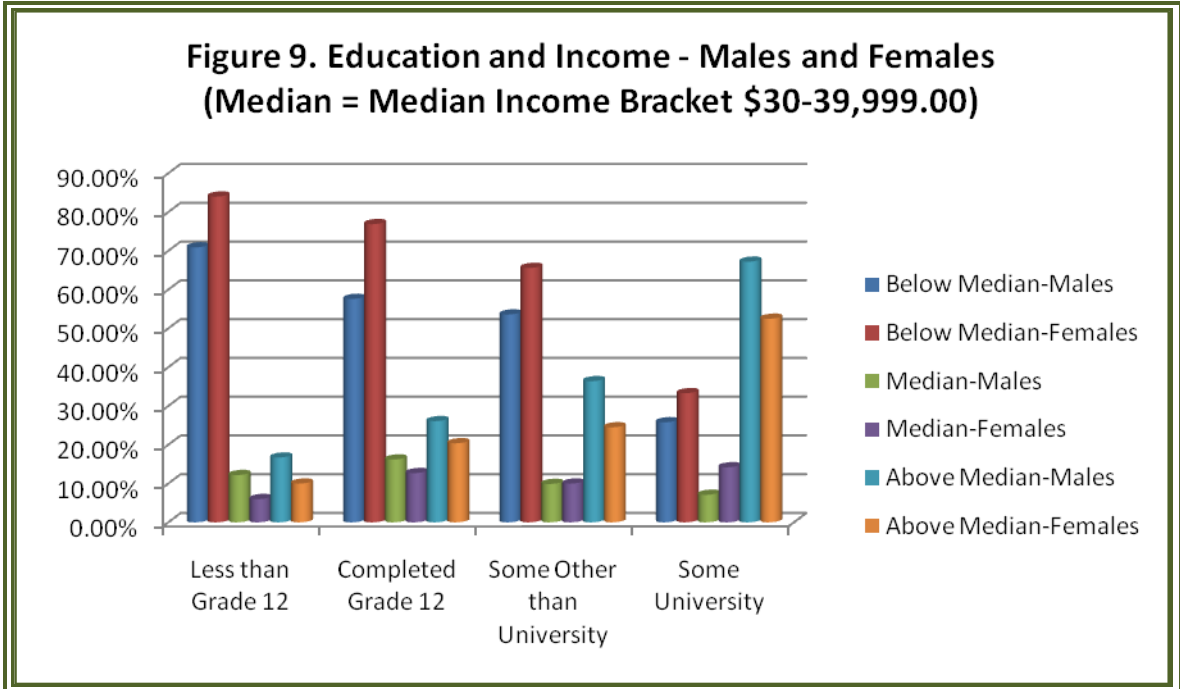


**Figure 8. Education and Income - Females (n=660)**



When the income brackets were grouped together, this further illustrated the pattern (below median bracket, \$0-\$29,999.00; median bracket, \$30-39,999.00; and, above the median bracket,

\$40,000.00+). This can be seen in Figure 9. For men, the trends were quite linear: as education increased, the proportion of men in households in the under median bracket decreased and the over median bracket increased. For women, the completion of Grade 12 or some post-secondary did not have the same dramatic effect on the reduction of females in households earning below the median or those earning above, although the effect was positive. However, some university education had a substantial effect on decreasing the proportion of women in households below the median income and increasing those above.

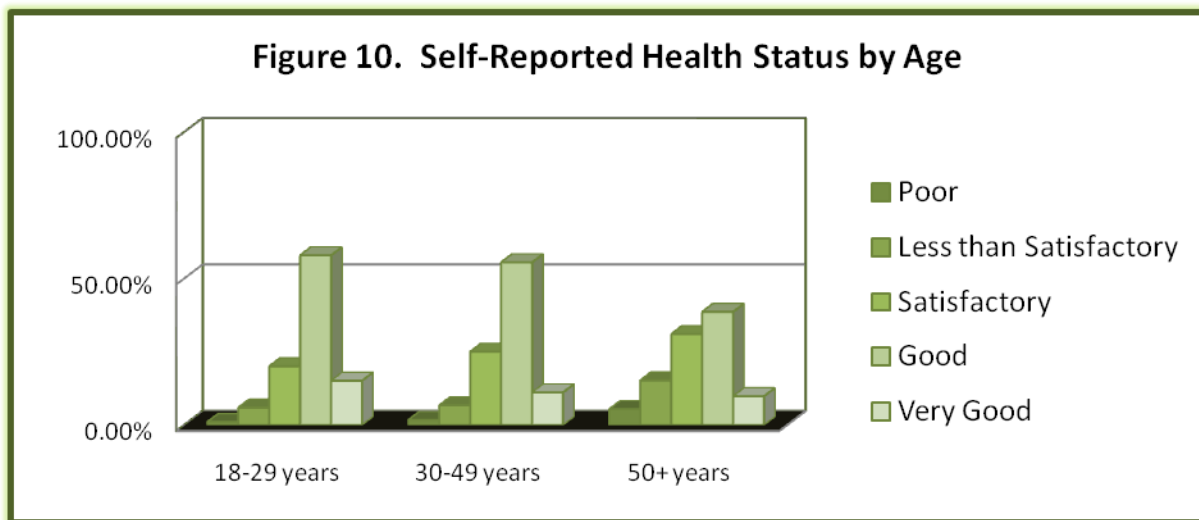


**Health Status:**

Participants were asked to self report their health status using the categories: poor; less than satisfactory; satisfactory; good; and, very good. Of the participants, 62.6% (820/1310) indicated their health was good or very good; 25.8% (338/1310) indicated their health was satisfactory; and, 11.6% (152/1310) indicated their health was less than satisfactory or poor. There was no



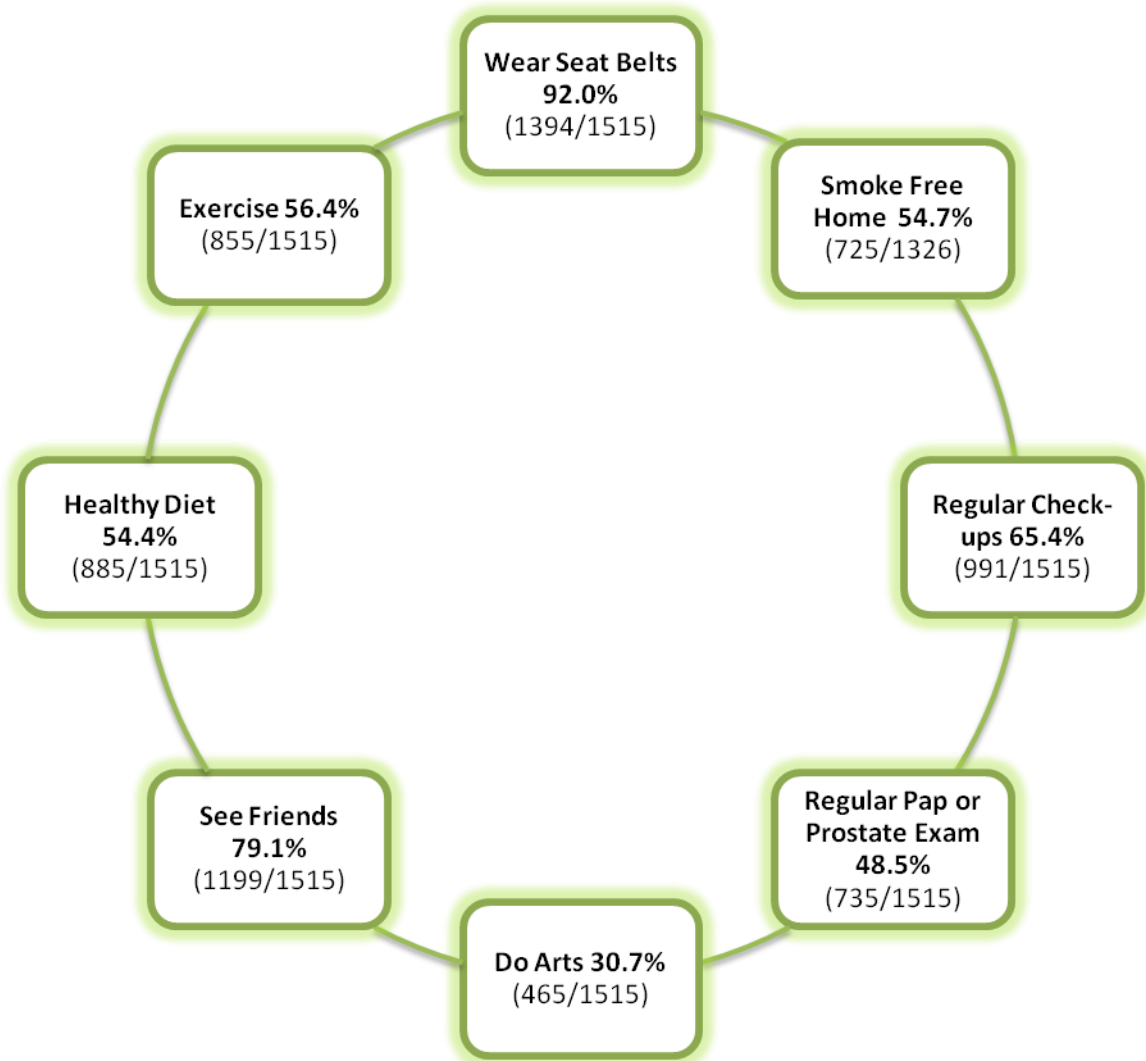
difference between men and women in their responses to this question: proportionately, men and women were represented equally in each category. Self-reported health status across the age groups is shown in Figure 10. As expected, health and the perception of health declines with age. Of the 1046 participants who responded to the same question with respect to the health of their children, 84.80% (n=887) indicated the health of their children was good or very good. Similarly 86.29% (453/525) participants indicated the health of their grandchildren was good or very good.



Out of 1483 participants who responded as to whether or not their immunizations were up to date, 79.4% (n=1177) indicated they were. With respect to their family, 82.3% (879/1069) of the participants indicated their immunizations were up to date.

Throughout the questionnaire, participants were asked various questions about their health related lifestyles. To what extent individuals were engaging in various healthy activities is described in Figure 11.

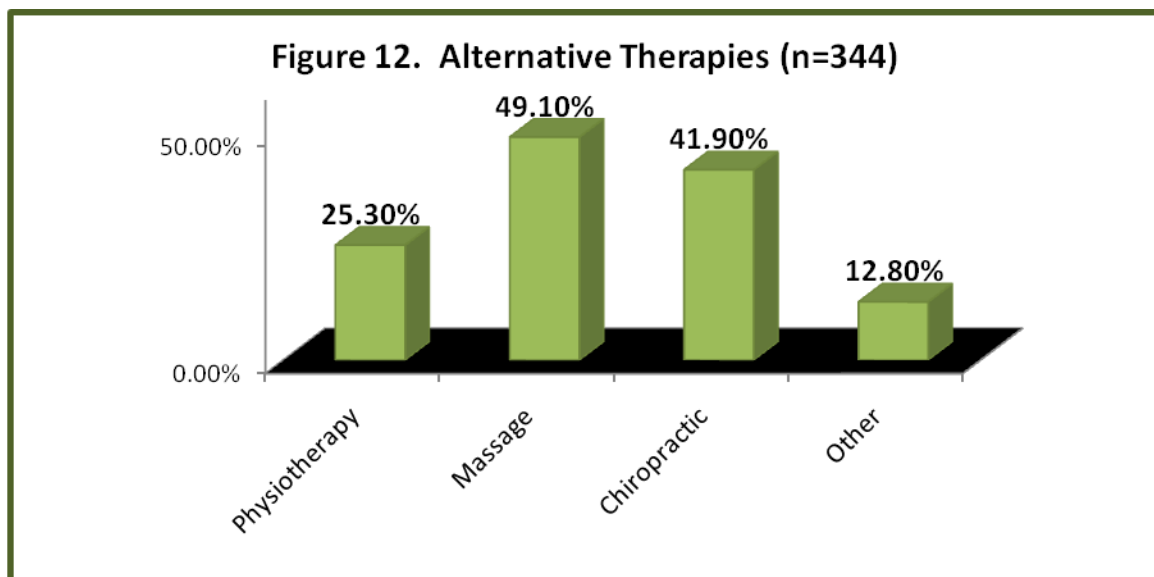
**Figure 11: Health Promoting Activities**



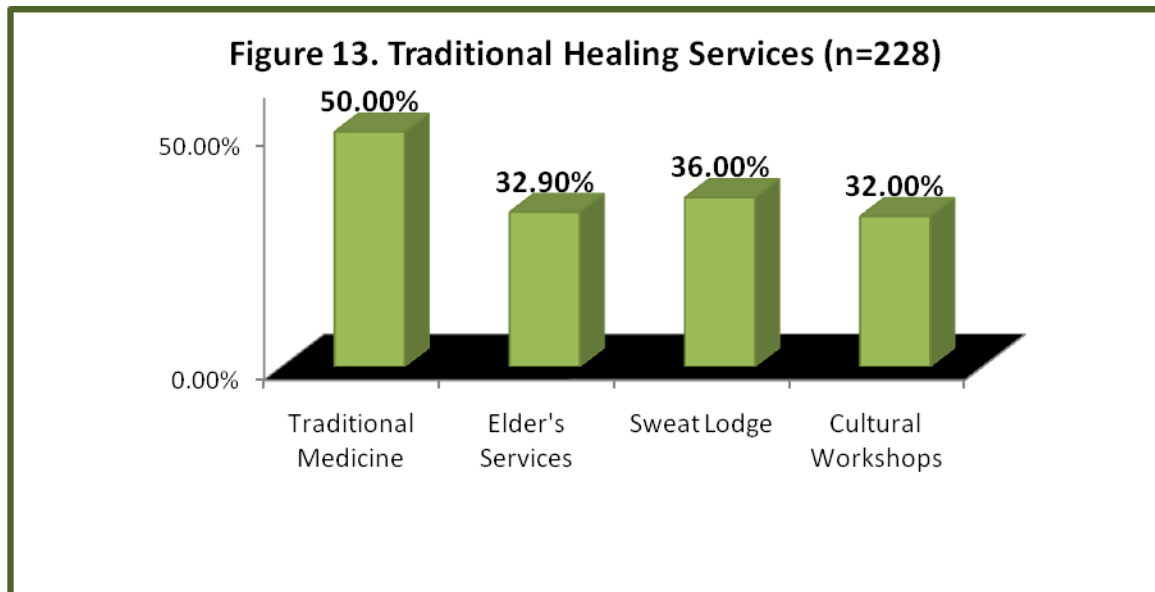
When asked to respond to what they did to help themselves stay healthy or prevent them from getting sick or injured, 58.4% (885/1515) indicated they ate a healthy diet. For specific health related diet behaviours: 47.9% (661/1379) said they ate foods low in fat; 46.6% (642/1379) indicated they limited the amount of salt in their diet; and, 41.3% (569/1379) said they ate foods low in sugar. When asked the question, “Do you feel you eat a healthy balanced diet?”, 66.4% (990/1491) indicated they did. In addition, 78.3% (1141/1457) stated they felt they had the information they needed to eat a healthy diet.

Out of 1481 participants who responded to the question about frequency of exercise: 23.3% (n=345) indicated they exercised 4-5 times per week; 23.2% (n=343) indicated they exercised 2-3 times per week; 36.0% (n=533) indicated they sometimes exercised but not regularly; and, 17.6% (260) indicated that in an average week, they did not exercise. Out of 1380 participants, 58.6% (n=809) indicated they felt like there was a place in their community where they could engage in exercise or physical activity.

Those surveyed were also asked about their participation in alternative therapies and traditional healing services. With respect to alternative therapies, 23.2% (344/1482) indicated they currently use alternative therapies on a regular basis. Their participation in various types of therapies is shown in Figure 12. Smaller numbers indicated participation in: Reiki (5.2%, 18/344); and, acupuncture (4.1%, 14/344). Those who said “other” reported involvement in: other therapies; prayer and meditation techniques; and, herbal remedies. Proportionately, females reported using alternative therapies more frequently than men (26.5% vs. 18.8%) as did those thirty years of age and older when compared to those 18-29 years (26.8% vs. 15.7%).



With respect to traditional medicine, 42.1% (565/1343) indicated that they were aware of traditional healing services in their community but only 19.2% (246/1281) indicated that they ever accessed those services. The types of traditional healing services in which they participated are shown in Figure 13. Smaller numbers indicated: participating in traditional parenting (14.0%, 32/228); attending a traditional health clinic with a healer (13.6%, 31/228); men’s and women’s support groups (19.7%, 45/228); and, accessing the Aboriginal Healing Foundation (7.0%, 16/228). Both awareness and use were similar for men and women. Awareness increased somewhat with age: 37.3% (140/375) of those 18-29 years of age; 42.2% (209/496) of those 30-49 years of age; and, 47.7% (196/411) of those 50 years of age and older. Use of traditional medicine increased with age: 13.2% (48/365) of 18-29 year olds; 39.4% (93/473) of those 30-49; and, 24.9% (95/382) of those 50 years of age and older.



**Primary Care:**

Of the participants, 69.5% (1010/1453) indicated they had a family doctor. Of those who did not have a family doctor, 64.8% (217/335) indicated they would like to have one. Females were more likely to have a family doctor, 76.8% (638/831) than males, 59.8% (372/622). Older adults (50 years of age and older) were more likely to have a family doctor, 78.6% (348/443); whereas, only 67.5% (360/533) of those 30-49 years and 63.7% (260/408) of those under 30 years of age indicated having a family doctor. Those with some university education were no more likely to have a family doctor, 71.8% (186/259) than those not having completed high school, 65.8% (332/507). Those with Grade 12 or some other post-secondary education had similar responses with, 74.1% (197/266) and 70.0% (259/370) respectively indicating they had a family doctor.

Accessing a medical doctor or clinic did not appear to be a problem, with 80.92% (1226/1515) indicating they drive their own car, borrow a car, or have someone else drive them. A small number of participants, 12.3% (182/1480) indicated they felt the medical services provided to them were not adequate, while 26.9% (398/1480) indicated the services were always adequate and 57.4% (849/1480) indicated that the medical services were sometimes adequate. In addition, 20.1% (81/403) of those without a family doctor said that medical services were not adequate while only 9.5% (94/987) of those with a family doctor said medical services were not adequate.

When asked had they ever had a complete physical or periodic exam, 80.4% (1208/1503) indicated they had. When asked did they have a regular complete physical or periodic health exam, 70.2% (684/975) indicated they did. Of those responding as to when their last complete physical or periodic exam occurred: 49.8% (586/1176) indicated that it had been within the last

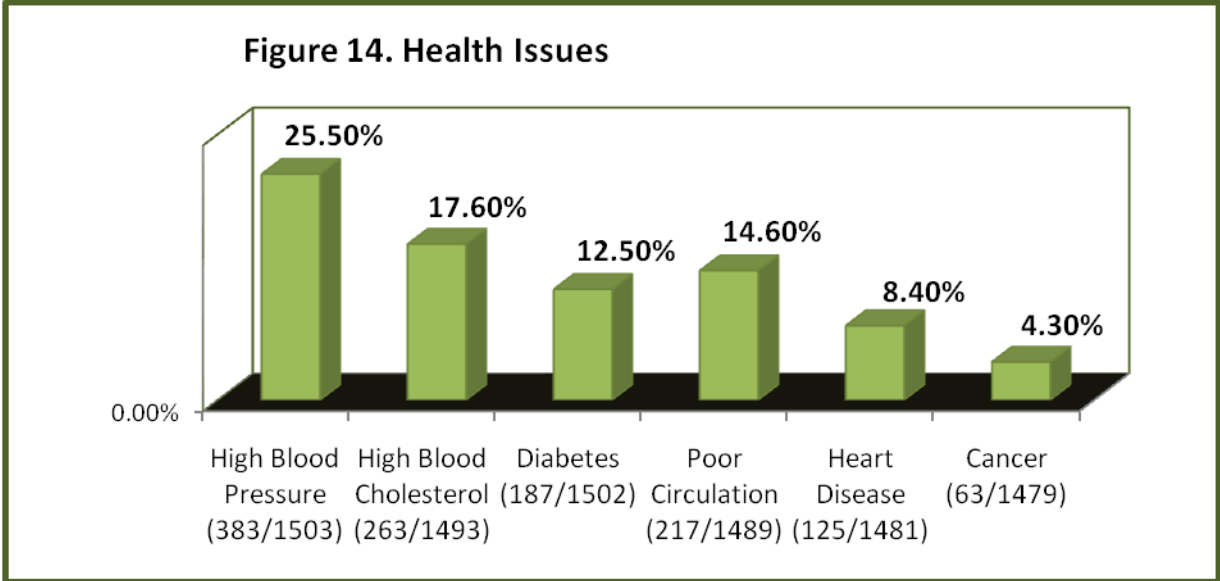
year; 28.3% (333/1176) within the last one to two years; 15.9% (187/1176) within the last three to five years; and, 6.0% (70/1176) more than five years ago. Females were more likely than males to have ever had a complete physical exam: 84.4% (721/854) of females; and, 75.0% (487/649) of males.

While 48.4% (308/637) of males indicated they have had a prostate exam, only 56.1% (152/271) indicated that they had one regularly. Of these, 68.1% (205/301) indicated they have had one within the last two years. Conversely, 90.8% (762/839) of the women indicated that they have had a PAP test done and 73.4% (527/718) indicated that they had one done regularly. Of these women, 77.9% (582/747) indicated that they have had a PAP test done within the last two years.

Of the participants who indicated they had been prescribed medications in the past two years, 94.9% (1011/1065) indicated that they had filled the prescription. Of these, 98.7% (991/1004) indicated they took the medication, while only 86.7% (841/970) said they had taken the medication as prescribed.

### **Health Issues:**

Participants were asked to indicate if a health care professional had ever told them they had high blood pressure, high cholesterol or diabetes. They were also asked to indicate if a doctor had ever told them they had poor circulation in their hands and feet, heart disease or cancer. Results are shown in Figure 14.



**Health concerns:**

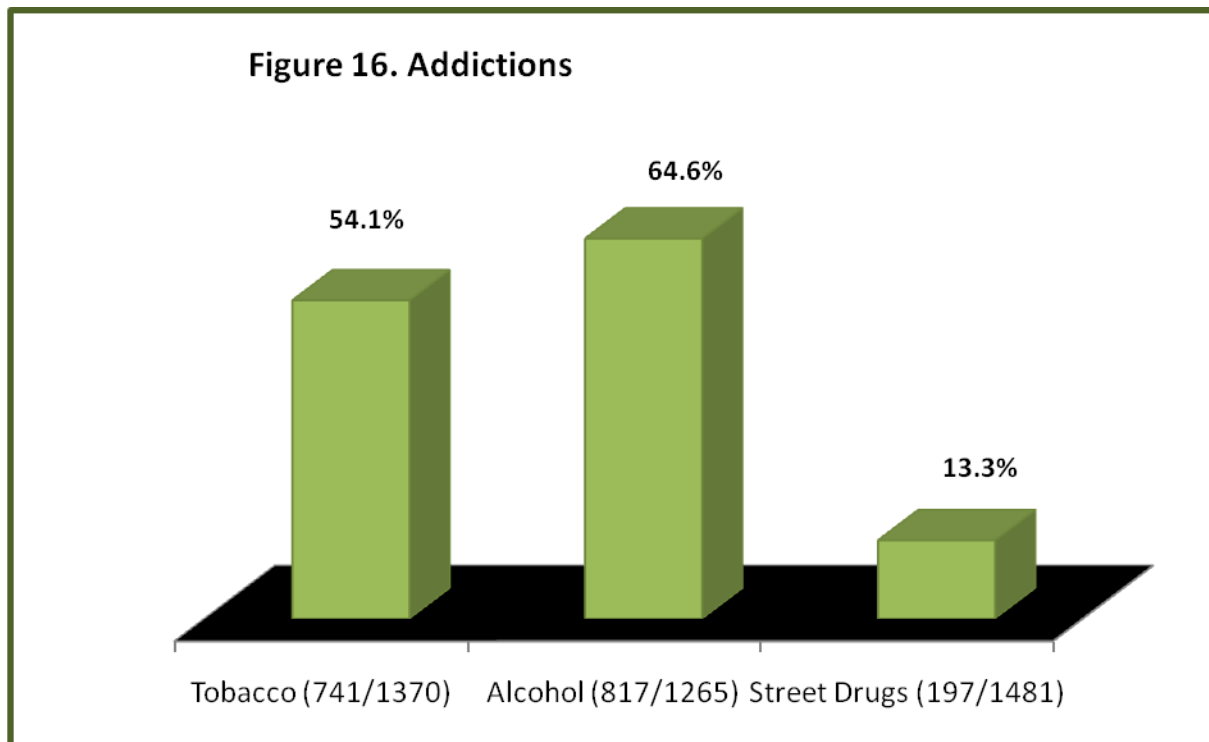
Participants were asked if they were concerned about specific health issues, and if they engaged in behaviours such as smoking/mis-use of tobacco, were they concerned about the amount of use/mis-use. Results are shown in Figure 15.

**Figure 15. Health Concerns**

High Blood Pressure	<ul style="list-style-type: none"> <li>• 56.0% (210/375) of those with HBP were concerned.</li> <li>• 22.9% (234/1020) of those without HBP were concerned.</li> </ul>
High Cholesterol	<ul style="list-style-type: none"> <li>• 57.6% (148/257) of those with high cholesterol were concerned.</li> <li>• 19.3% (215/1114) of those without high cholesterol were concerned.</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>• 71.6% (126/176) of those with diabetes were concerned.</li> <li>• 37.4% (455/1218) of those without diabetes were concerned.</li> </ul>
Smoking	<ul style="list-style-type: none"> <li>• 45.9% (347/756) were concerned about the amount of tobacco they mis-used.</li> </ul>
Drinking	<ul style="list-style-type: none"> <li>• 10.2% (84/820) were concerned about the amount of alcohol they used.</li> </ul>
Street Drugs	<ul style="list-style-type: none"> <li>• 26.0% (38/146) were concerned about the amount of street drugs they used.</li> </ul>

**Tobacco, Alcohol and Street Drug Use and Mis-use:**



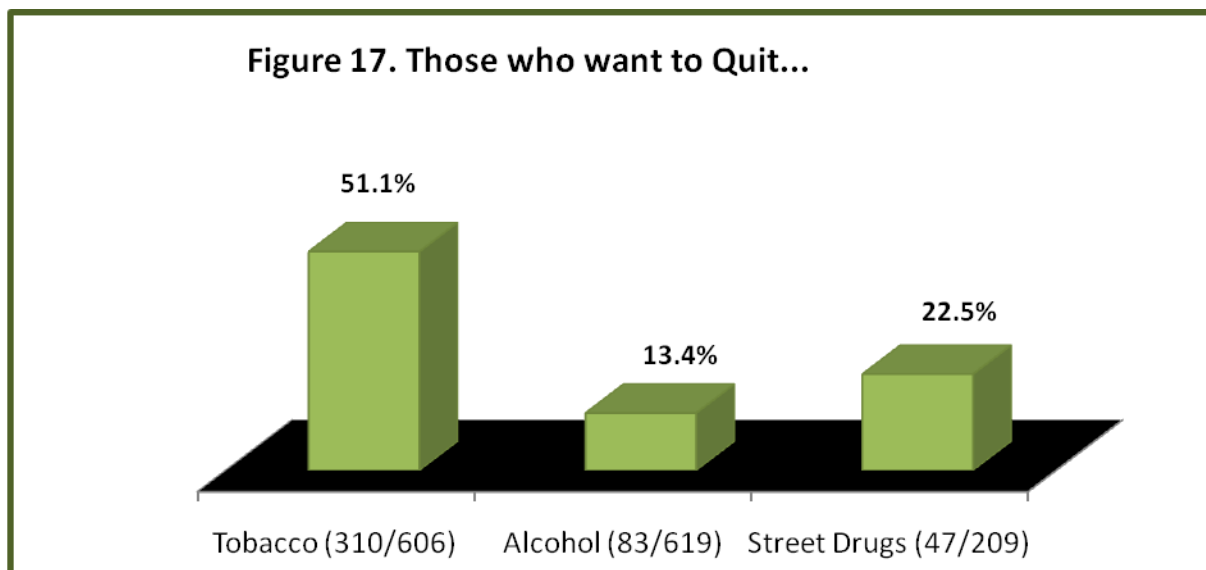


The overall rate of tobacco use/mis-use (smoking cigarettes, cigars or a pipe) was high at 58.00% (794/1370). Of those who indicated they currently use tobacco, 6.60% (53/802) indicated that they used tobacco for ceremonial purposes only, yielding a rate of mis-use of 54.1% (741/1370). The use of spit tobacco or chew was small but present at 5.1% (67/1310). Of those that indicated they currently smoke/mis-use tobacco: 21.3% (157/738) reported smoking more than one pack (25) per day; 68.7% (507/738) reported smoking less than a pack a day with the average being 11.9 cigarettes per day; and, 10.0% (74/738) reported that they only smoked socially, ranging from one to 75 cigarettes per week.

Of the 46.03% (348/756) concerned about the amount of tobacco they used/mis-used: 75.9% (264/348) indicated they were worried about getting cancer or lung disease; 56.6% (197/348) were concerned about their family being exposed to second-hand smoke; and, 59.2% (206/348)

were concerned about how they would manage their stress without it. For those who indicated they currently smoked/mis-used tobacco, 51.2% (310/606) indicated they wanted to stop the mis-use of tobacco or stop using spit tobacco/chew.

A large number of participants indicated they currently drink alcohol (64.6%; 817/1265). In terms of consumption, 26.7% (208/779) indicated they currently drink more than the recommended weekly maximum. Only 10.3% (84/820) of the participants that reported they currently drank alcohol indicated they were worried or concerned about the amount they drank. Of these, 67.1% (51/76) reported they drank more than the recommended weekly maximum. Of those concerned about the amount of alcohol they consumed: 35.3% (30/85) indicated they were worried about it affecting their ability to work; 62.4% (53/85) were concerned about the effect on their family or friends; and, 43.5% (37/85) were concerned about how they would manage their stress without it. Of those currently drinking, 13.4% (83/619) indicated they wanted to quit.



A small number of participants indicated they use street drugs on a regular basis, 13.3% (197/1481). Many of these participants indicated they regularly used marijuana, 86.9% (173/199). In addition to this, small numbers indicated regular use of: cocaine, 13.1% (26/199); heroin, 1.0% (2/199); morphine/dilaudid, 9.0% (18/199); ritalin/talwin, 6.0% (12/199); and, other street drugs, 4.5% (9/199). Of those who used marijuana, 78.5% (128/163) also reported mis-using tobacco. Worry over the amount of street drugs being used was identified by 26.02% (38/146). Of those concerned: 46.2% (18/39) worried about their ability to work; 56.4% (22/39) worried about the effect on their family and friends; and, 48/7 (19/39) worried about how they would manage their stress without it. Just over one fifth indicated they wanted to quit using street drugs (22.5%, 47/209). While the numbers who reported using street drugs were quite low, 62.6% (605/966) of the participants were concerned about the amount of street drugs available in the communities.

### **Demographics and Tobacco, Alcohol and Street Drug Use and Mis-use:**

Females and males reported similar rates of smoking at 53.27% (415/779) and 55.16% (326/591) respectively. Smoking declined with age: 61.8% (251/406) of those under the age of 30 years reported smoking; 59.1% (292/494) of those between the ages of 30 and 49 years; and, 50.4% (204/405) of those 50 years of age and older. However, almost half of those who indicated they smoked for ceremonial purposes only, were aged 50 years and over (25/53). Those with an income less than \$10,000.00 reported mis-using tobacco at a rate of 70.5% (167/237). However, those earning \$80,000.00+, also had a high rate of tobacco mis-use, 45.9% (45/98). Those with less than a Grade 12 education and those with some post-secondary education had the highest percentages of tobacco mis-use, 61.7% (292/473) and 60.4% (217/359) respectively; however,

those that had completed Grade 12 or had some university education still mis-used tobacco at a rate of 52.62% (261/496). The smoking rate for those who were unemployed was higher, 62.3% (362/581), than for those who were employed, 54.4% (415/763). A higher percentage of females, 56.3% (189/336), than males, 44.8% (121/270), indicated that they wanted to stop smoking/mis-using tobacco.

Reported use of alcohol was similar for males 66.9% (380/568) and females 62.7% (437/697). Use declined with age: 76.8% (288/375) of those less than 30 years of age reported drinking alcohol; 64.8% (306/472) of those aged 30 to 49 years; and, 50.4% (180/357) of those 50 years of age and over. Alcohol consumption across education levels was quite similar and ranged from 62.1% (265/427) for those with less than Grade 12 up to 72.3% (167/321) for those with Grade 12. Of those in the lowest income bracket, 56.7% (118/208) reported drinking alcohol; however, of those in the \$80,000.00+ income bracket, 81.1% (77/163) reported drinking alcohol. Reported alcohol use was higher for those employed (69.0%; 507/735) than those unemployed (58.7%; 298/508).

Across educational levels: 38.2% (91/238) of those with less than high school education indicated they drank more than the recommended levels; followed by those with high school education (28.4%; 46/162); some post-secondary education (20.6%, 42/204); and, some university education (14.9% 24/161). Of those that reported drinking more than the recommended weekly maximum: 60.1% (125/208) were males; and, 39.9% (83/208) were females. Of those that reported drinking more than the recommended weekly maximum: 39.2% (76/194) were under 30 years of age; 37.6% (73/194) were aged 30-49 years; and, 23.2%

(45/194) aged 50 years and over. Of those that reported drinking more than the recommended weekly maximum: those unemployed (36.1%, 101/280) reported a higher consumption of alcohol than those employed (21.4%, 105/490). However, reports of higher consumption declined as income increased: 38.6% (44/114) of those earning under \$10,000.00 per year compared to 15.8% (12/76) of those earning over \$80,000.00 per year.

Reported street drug use was higher for males (18.4%, 118/640) than for females (9.4%, 79/841). Street drug use was: highest for those aged 20-29 years at (20.4%, 87/427); less for those 30-49 years (14.1%, 77/547); and, lower still but present for those aged 50 years and older (4.8%, 21/437). While rates of street drug use were similar for the employed and unemployed, the majority of street drug users earned an income less than \$20,000.00 (67.5%, 108/160) and were more likely to have less than a Grade 12 education (45.9%, 89/194).

### **Demographics and Health Issues:**

Social determinants of health are the economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole (Raphael, 2009). In addition to this, social determinants are the quantity and quality of a variety of resources that a society makes available to its members (Raphael, 2009). Thus, the social determinants of health impact the health and well-being of individuals and communities (Marmot, 2005; Marmot & Wilkinson, 2006; WHO, 2003). These inequities in health arise frequently due to circumstances into which people were born, live, work and grow old. These conditions are shaped by the political, social and economic forces in which people live and subsequently die (Commission on Social Determinants of Health, 2008).

The Patient First Review examined the patient experience and the administration of the health system with attention to both strengths and concerns (Saskatchewan Health, 2009a). It identified that there were many positives to build upon; however, in order to achieve the vision of a patient- and family-centred health system, policy makers, health system leaders and health care providers would need to address the concerns identified. “Patients ask that health care workers and their respective leadership see beyond their declared interests so that the interest of patients takes precedence at every care interaction, every future contract negotiation and every policy debate” (Saskatchewan Health, 2009a).

Bourassa (2008) indicated that Métis with low education, income and employment report a lower health status; however, this study goes on to point out that the social determinants of health also impact the health and well-being of individuals, families and the community. Much of what was reflected by the participants and highlighted in this document focused on the social determinants of health which are: the social gradient (age, culture, social class); stress; early life (pre-natal care, nutrition, lifestyle choices); social exclusion (poverty, social exclusion, discrimination); work (people who have more control over their work have better health); unemployment (job security increases health); social support ; addiction; food security (healthy food is frequently a political issue); and, transportation (WHO, 2003). Thus, if the major determinants of health are social then so must be the remedies (Marmot, 2005).

Some of the social aspects that related specifically to health care and Métis people were identified in the Patient-First-Review’s Recommendations (Saskatchewan Health, 2009b).



**Figure 18. Demographics and Health Issues**

<p><b>High Blood Pressure</b></p>	<ul style="list-style-type: none"> <li>•25.5% (383/1503)</li> <li>•26.1% of Females, 24.7% of Males</li> <li>•29.5% of Unemployed; 22.4% of Employed</li> <li>•41.0%, income &lt; \$20,000</li> <li>•39.7% have &lt; grade 12</li> <li>•61.3% were age 50 and over</li> </ul>
<p><b>High Cholesterol</b></p>	<ul style="list-style-type: none"> <li>•17.6% (263/1493)</li> <li>•17.4% of Females; 17.9% of Males</li> <li>•18.9% of Unemployed; 16.1% of Employed</li> <li>•36.4%, income &lt; \$20,000</li> <li>•36.9% have &lt; grade 12</li> <li>•65.2% were age 50 and over</li> </ul>
<p><b>Diabetes</b></p>	<ul style="list-style-type: none"> <li>•12.5% (187/1502)</li> <li>•12.3% of Females; 12.6% of Males</li> <li>•16.8% of Unemployed; 8.7% of Employed</li> <li>•44.6%, income &lt; \$20,000</li> <li>•46.1% have &lt; grade 12</li> <li>•68.4% were age 50 and over</li> </ul>
<p><b>Poor Circulation in Hands or Feet</b></p>	<ul style="list-style-type: none"> <li>•14.6% (217/1489)</li> <li>•15.1% of Females; 13.9% of Males</li> <li>•19.6% of Unemployed; 10.1% of Employed</li> <li>•50.5%, income &lt; \$20,000</li> <li>•42.2% have &lt; grade 12</li> <li>•58.1% were age 50 and over</li> </ul>
<p><b>Heart Disease</b></p>	<ul style="list-style-type: none"> <li>•8.4% (125/1481)</li> <li>•7.5% of Females; 9.7% of Males</li> <li>•12.5% of Unemployed; 5.1% of Employed</li> <li>•51.4%, income &lt; \$20,000</li> <li>•47.5% have &lt; grade 12</li> <li>•71.2% were age 50 and over</li> </ul>
<p><b>Cancer</b></p>	<ul style="list-style-type: none"> <li>•4.3% (63/1479)</li> <li>•5.5% of Females; 2.7% of Males</li> <li>•5.7% of Unemployed; 3.3% of Employed</li> <li>•42.0%, income &lt; \$20,000</li> <li>•41.7% have &lt; grade 12</li> <li>•58.6% were age 50 and over</li> </ul>





## **Health and the Community:**

While returning the initial results to the Métis communities across Saskatchewan, it was noted that not only the statistics or quantitative aspects of the project were important but so were the stories collected by the Community Liaison Workers. The focus of the survey was to build on strengths and not completely focus on the deficits; thus, participants were asked questions such as “What keeps you healthy?”, “What things in your community keep you healthy?” and “What things they do you do for self-care and prevention?”

### What Keeps You Healthy?

The questions on the survey invited individuals to comment on what in their lives helped to make them healthy. For many, a combination of things contributed to good health. Participants commented on the importance of exercise and other forms of physical activity such as walking which many participants did to stay healthy. Outdoor activities including fishing and hunting were also identified as other ways of being active. Participants also mentioned the importance of fresh air and just “being outdoors”. Eating healthy was also considered important. Fresh fruits and vegetables; as well as, vitamins and wild meats were identified as part of a healthy diet. For some, quitting or cutting back on tobacco mis-use, alcohol consumption and/or drugs were cited as contributing to a healthier lifestyle.

*“I eat well. I am active. I don’t drink or smoke. I have hobbies. I have a good relationship at home. I am active in my community. Exercise. Good healthy meals. Traditional medicine. Prayer. Native spirituality.”*

Many gave credit to the relationships in their lives as contributing to their health. Family listed as being important included: children; grandchildren; partners; and, parents. In addition to this, other relationships with friends, support workers, community and church were identified as being important. Spirituality and a positive attitude or simply “being happy” were identified as contributing to health and well-being. These were identified by such comments as attending church and involvement in traditional gatherings such as sweats. For others, work was an important part of good health. Work met both physical and emotional needs by providing not only a source of physical exercise but also financial security and a sense of pride and accomplishment. A healthy work environment; as well as, relationships with co-workers were identified as valuable aspects of having a job. For others, education and learning were important. This was identified by such comments as attending school and having an education were valued. Small town and/or country living; as well as, adequate rest were acknowledged as also contributing to health. Travelling was also mentioned as part of what kept people healthy.

*“Family. Spouse. Being outdoors. Co-worker relationships.”*

#### What Things in the Community Keep you Healthy?

When invited to explore things in the community that helped to keep them healthy, participants provided a variety of answers. The community was identified as the source of essential health services and professionals. Access to recreational facilities including gyms and arenas were also identified as being important. Involvement in community activities for both physical exercise and socializing was a key to staying health. Family gatherings, entertainment, cultural camps, church, and programs for seniors and youth were all cited as part of what the community offered them. For some it was the physical environment of the community including fresh air and access

to the outdoors offering opportunities for recreational activities such as snowmobiling or fishing and hunting that was important. Those living in the country or a small town valued the open space and room to garden. The “sense of community” was notable for some. Being in a “close”, supportive community created a sense of security and belonging for participants which contributed to their health and well-being.

*“Lots of things to do here. Outdoor activities, clean air, water quality, fresh fish. Church/community events. Powwows/Round Dances and Lunch Box Socials. Hockey games. Our community is very supportive and tries to meet everybody's needs.”*

Housing and the housing environment were raised in a variety of contexts in response to a number of different questions. When asked to provide recommendations regarding programs to deal with chronic disease concerns several mentioned the need for housing to address the requirements of vulnerable populations including: assisted living; senior’s housing; and, the need for lodging when undergoing treatment similar to Ronald McDonald House. Community-based programming suggestions for dealing with addictions included: housing for treating recovering addicts in the community; and, youth facilities and half-way houses as an alternate to incarceration. The need for safe houses was mentioned as it pertained to community-based treatment for addictions. When asked about other program suggestions to address community needs in general, several suggested the need for social and affordable housing were mentioned. Homelessness was brought up as something that needed to be dealt with and access to crisis housing for those needing support or suffering from depression were also raised.

*“More social housing is needed here. (It would help with both addictions and chronic illness programs) – both on and off Reserve”.*  
*“Transitional housing from treatment to maintain recovery. Often return to previous dwelling. This places them at high risk for relapse.”*

When asked about the things in the community that made it difficult to be healthy, housing was again raised as a concern. The availability and quality of housing were issues. Participants referred to living in a “ghetto” and indicated the lack of safety limited their ability to walk about their community. For one individual, housing was stated as something that would help meet their family’s health concerns and for another not having a home was the thing that worried them.

*“I live in ghetto. Drug dealers live in every second house. Can’t get out.  
Poor housing. Bad area.”*

The environment in which they resided was identified as something in their community that made them healthy. Good, safe communities with friendly neighbours were contributors to people’s health. A clean neighbourhood and quiet environment were things that people valued. In some instances, living in the country or a small town where they had few or no neighbours was a positive aspect of the housing environment.

*“Clean environment. Friendly people. It’s a quiet and nice community to live in.  
Living in country and being able to enjoy pollution-free air.”*

Mental health issues were multifaceted and manifested in a variety of ways. Participants identified support and counselling as key elements for addressing their health concerns. Stress was felt to be both the cause of and result of many health concerns. Participants recognized the connection between mental health, addictions and chronic diseases. The survey invited participants to comment on community-based programs that would help to address addictions in their community. Many individuals commented on the need for assistance in the form of professional counsellors, peer support groups and other “support” programs. When asked about community-based programs to address chronic diseases and other identified needs, counselling and support groups were again mentioned.

*“Stress levels are high. My husband is an alcoholic.”*

*“I attended a Chronic Conditions workshop which allowed people with chronic conditions to talk to each other about the emotional, mental & physical strains. It was a good support system for people living with chronic conditions.”*

*“Suicide prevention. Mental health programs for young people. Young people who commit suicide are undiagnosed depressives. Youth have fewer programs than adults.”*

*“Expanded preventative mental health program, including a youth focus. Based on lifestyle. Mental health has lost money to addictions here.”*

*“More places for people who have depression, low self esteem. They should be as big or bigger than a hospital because the problem is this big.”*

Worry is defined in the Oxford Dictionary as thinking about a problem a lot and trying to find a solution (Oxford University Press, 2010). Worry can have a significant impact on mental health. Many of the participants described worrying about the stressors in their lives that came from a variety of sources. Stressors related to employment came from either the lack of a job or the workplace associated with workload or the work environment. Some identified experiencing family stressors including: parenting; relationships; and, the dependency or health of family members. Financial stressors were often connected to employment and participants were concerned about having sufficient money to address their daily needs and health issues. Anxiety over the environment in which people lived also generated stressors and individuals identified that they worried about: pollution; neighbourhood safety; as well as, physical and mental abuse. Other sources of worry identified were health issues such as smoking, addictions and being overweight. A number of participants were concerned about: depression; emotional issues; distress; and, the health implications resulting from these. Depression and emotional issues were also listed as things people worried about.

*“Stressful parents and job. Mental and physical abuse. Thus causing stress and emotional trauma.”*

When invited to further explore things that made it difficult to be healthy, a number of issues related to mental health were raised. Stressors associated with: money; work; chronic health conditions; addictions; being overweight; personal relationships; a busy lifestyle; losses; as well as, what was identified as “the stress of everyday life”, were obstacles to health. For some, lack of support or depression made it difficult to be healthy. Things in the community that made it difficult to be healthy and had an impact on mental health included stressors associated with: work; health; family; property; and, personal safety. When invited to explore what would help to address the family’s health concerns, counselling, support groups and mental health services were mentioned.

*“Relationship, stress, anxiety, my dad’s death. Stress because I worry about my children and their children. Stress. Need to change my lifestyle. Free from substance abuse. Have a high stress job with lots of responsibility. Finances. Household problems.”*

*“At present, she is able to be quite healthy as a student. When she was working she found it exhausting physically and mentally due to working shift work (mostly nights).”*

*“Drinking, depression, being unemployed.”*

Since mental health was an integral part of what people identified as facilitating their health and well-being, participants identified the following factors as contributing to their health: family; support groups; physical activity; and, a positive attitude. Access to professional help such as counselling and support workers was also identified as being important. A supportive community including family, friends and co-workers was mentioned as also contributing to health and well-being.

*“Family is close and keeps her mentally and emotionally healthy. My boyfriend and family keep me emotionally happy. I pray and meditate. Love my work. Peaceful, loving non-stressful home. I try to eat properly. Exercise. Try to live stress-free.”*

*“Working in a healthy environment. Supportive employers. Family contact. Healthy relationships. Access to services.”*

*“Healthy environment at my workplace (promote wellness, exercise, good nutrition, mental well-being).”*

*“A very spiritual community. Very good community support in everything.”*

Participants identified a number of ways in which employment contributed to health. When asked about the things in their lives and communities that contributed to being healthy, participants mentioned the importance of having a job. Meaningful employment met both physical and emotional needs by providing not only a source of physical exercise but also financial security and a sense of pride and accomplishment. Co-workers were mentioned as a resource for support and a healthy workplace was valued. For others, employment or the lack of it, was a source of stress. Participants identified work as one of the prime reasons they did not have time to exercise or to prepare and eat healthy meals. In some cases, the type of employment that had been secured did not provide sufficient monies to live a healthy lifestyle e.g. shift work, the stress of working two jobs. Those without employment felt financial pressures and as a result were less likely to be involved in daily physical activity. When asked what kinds of things could help meet the family’s health concerns, a number mentioned securing a better job.

*“Working - physical aspect and financial security. Working - takes away stress. Being able to work and enjoy the people I work with.”*

*“Healthy environment at my workplace (promote wellness, exercise, good nutrition, mental well-being). Working in a healthy environment. Supportive employers. Travel too much for the job. High risk job - oil patch.”*

*“Stress of no job.”*

*“Her job is wearing her down. She is in a lot of pain after her shift. We are still a*



*very work-oriented society. Life seems to be all about work, work, work, getting ahead, with little thought about the stress such a focus causes. Too much stress can cause illness & death. Time, shift work. Stressful job (work two jobs)."*

Information and education were also identified as an important contributor to health and well-being. When asked about community-based programs many talked about a desire for more information, awareness, workshops, education and programs that would support health and well-being. If the communities were to become healthy, participants felt more education on: parenting skills; teen pregnancy; health conditions and diseases; as well as, addictions would be beneficial. Educating the very young about preventing future drug and alcohol abuse was identified as being important. Some believed that the consequences of addictions were not well understood and that by providing youth and parents with this knowledge substance abuse may be prevented. When discussing chronic conditions participants felt they wanted more information about their condition; as well as, how to optimally manage it and where to obtain the services required when they were needed. General information on the components of a healthy lifestyle could also improve health. Education and access to information were identified as things that helped to make individuals and communities healthy.

*"Education support. Many of our people live in poverty as a direct result of poor education. I see how severe truancy is becoming. We need to work together to enforce our children attending school regularly so their future is healthier in all areas. Lack of education = poverty = poor health."*

*"She has someone that is going to come in and help her to feed the children nutritious meals and to set bed times for them. Feels this is a good program."*

*"Program to provide information about what's available here."*

*"Have speakers available, people who have gone clean and are drug-free, talk about their experiences."*

*"It has to be a community thing... teach the children when they're young."*

*More comprehensive, strenuous education process for very young children."*

*"I think we need to use our schools as community 'hubs' where parenting classes & support groups can be conducted, where nutrition information and ways of eating well can be shared, and where children are taught about lifestyle choices"*

*and strongly encouraged to live positive and healthy lives. FAMILY activities could also be emphasized.”*

*“Inform the public. Send Pamphlets. Have an open forum where the public can ask questions. Have a website.”*

*“Information about heart disease, diabetes and arthritis.”*

*“More education, especially what to do to help ourselves to be able to understand English better.”*

Participants valued their connections with other people and believed strengthening those relationships would improve their health and help to address health issues in the community. Many people mentioned getting together with family and friends; as well as, community support and activities as contributing to their health and well-being. There was a sense that community support was an important way that the community contributed to health with one individual stating “my community watches out for each other”. Participants understood the need to work on the addictions problems as a community, voicing a desire to get together and talk about the problems and then collectively develop a strategy to begin to address the issues. People valued volunteer opportunities and social activities such as those found in churches, clubs, group sports, family gatherings and community events. Community events and activities contributed to health by informing, involving and supporting people. Social gatherings that involved the youth had the potential to promote healthier living and gave young people a constructive way to spend their time.

*“Community puts on lots of outdoor events so getting out and being able to socialize with good people.”*

*“Getting together and helping each other be a better community (like functions).”*

*“The social connection she has with them (people in her community).”*

*“Community-based programs. This community / reserve is situated on an island and it always seems to be separated. Who makes it this way? People?”*

*Government? We should find ways to work together to have a healthier, happier island of people.”*

*“More (non-alcoholic) events for families and youth, with adequate budgets. More youth-focused community activities.”*

*“Youth centre for social, cultural and physical activities.”*

*“ There needs to be more activities to keep kids active and off the streets. ”*

*“ We need to work together to get all drugs out of our community.”*

*“ Get support groups together to talk about problems.”*

*“More alternatives for young people need to be available, especially social events.”*

In some cases, relationships were credited with helping participants stop the mis-use of tobacco or drinking. Encouragement or pressure from children and/or a spouse were identified as incentives to quit. Specific health events such as breaking bones and being hospitalized were also acknowledged as contributing to the decision to stopping the mis-use of tobacco. For individuals with an alcohol addiction, participating in a program or support group helped them quit. Others attributed their decision to quit to a pregnancy and/or their children. Family support was cited as something that helped a number of individuals to stop drinking.

*“Support from my brother. Kids' advice about quitting.”*

*“Prayer, will power, plus co-workers' support, and my kids'.”*

*“AA, family support, community support.”*

*“Counselling, Sweats, Women's group.”*

*“My wife and kids - didn't want them to see me like that.”*

### Self-Care and Prevention

Those surveyed were given the opportunity to comment on the things they did to stay healthy and prevent illness and injury. Responses included eating a proper diet in some

cases including traditional foods or wild meats. A number of participants mentioned prayer or going to church. Spiritual events, taking time for one's self and spending time with family and friends were other things that people did to stay healthy.

### **Reflections on the Results/Findings**

There is much to be gained from working through the data and the results with citizens of the Métis Nation - Saskatchewan over time. It will be from this process that evidence-informed health promotion and health education programs can be developed in and with the communities (The Four Winds International Institute for Human and Community Development, 1985). The initial findings from this Métis community-based survey that have the potential for developing evidence-informed health promotion and health education programs were:

1. Tobacco mis-use is a major public health issue and a leading cause of premature death.

Diseases related to tobacco mis-use are urgent issues in First Nations and Inuit communities where the rates of tobacco mis-use are more than double the rate in the rest of Canada (Health Canada, 2004). The First Nations and Inuit Health Branch reported that 60% of On-Reserve First Nations people currently mis-use tobacco (Health Canada, 2004). Whereas, the Canadian Tobacco Use Monitoring Survey (CTUMS) for the year 2007 indicated that the prevalence of tobacco mis-use was 19% (Health Canada, 2007). The rate of tobacco mis-use (smoking cigarettes, cigars or a pipe) found in this community-based survey was 54.1%. Although not quite as high, this rate aligns more closely with the rates reported by the First Nations and Inuit Health Branch. This provides an opportunity for the community to build an evidence-informed program around tobacco mis-use as it has the potential to prevent diseases related to tobacco mis-use such as heart disease, stroke, asthma, lung cancer, etc.

Based on the preliminary results, an Application for Contribution Funding was submitted to the Federal Tobacco Control Strategy in September, 2009. Subsequently, this was funded in May, 2010 and as a result a “Green Light Program” to celebrate the number of smoke-free homes will be implemented in the fall of 2010. Building on strengths and beginning to explore the opportunities for change specifically related to tobacco mis-use will be negotiated over the next several months.

2. A recent study conducted by the Heart and Stroke Foundation of Ontario indicated that there are ethnic differences in the rates of high blood pressure; however, the general Canadian population was 21% (Heart and Stroke Foundation of Ontario, 2008). Many individuals with high blood pressure are not being treated and/or effectively managed (Heart and Stroke Foundation of Ontario, 2008). Adequate treatment and control represents a significant and an important opportunity for improving the health of individuals that have been diagnosed with high blood pressure. This survey found that 25.5% of the participants had been told by a health care professional that they had high blood pressure and of these 61.3% were 50 years of age and older. The rate found in this survey and that of the Canadian population are not dis-similar; however, optimal treatment and management of high blood pressure can mitigate diabetes mellitus.
  
3. According to the 1991 APS, the prevalence of diabetes among the Métis was 5.5% (Health Canada, 2001); however, in this community-based survey, 12.5% of the participants indicated that they had been told by a health care professional that they had diabetes. This

rate is not dissimilar from the profile of First Nations (Health Canada, 2001). Of these, 12.3% were females and 12.7% were males with 68.4% being 50 years of age and older. This profile is similar to the Canadian population rather than the First Nations profile (Health Canada, 2001). There were higher rates in those that were unemployed (16.8%) as compared with those that were employed (8.7%).

4. According to the 2006 APS, health was self-rated by 58% of the participants as being good to very good (Statistics Canada, 2008); whereas, 62.6% (820/1310) of the participants in this survey indicated that their health was good or very good. Of the 1046 participants in this survey who responded to the same question with respect to the health of their children, 84.80% (n=887) indicated that the health of the children was good or very good; whereas, 84% of the participants in the 2006 APS indicated that the health of their children was good or very good (Statistics Canada, 2008).

This is important to note given the impact of the social determinants in the communities; however, there is something else at play that results in improved self-rated health status. We may be able to tease this out over time.

## **Conclusions**

Building on strengths builds capacity in and with the community. This research endeavour provided the Métis communities an opportunity to reflect upon their strengths and opportunities for change related to the impact of the social determinants of health on their health and well-being.

## **Next Steps**

Sharing this information more widely within the Métis Nation communities will be undertaken; thus, ensuring that the voices of the community are more intimately integrated into the interpretation of the results.

As this is the first known community-based provincial survey within Métis communities, these results will be used to secure additional funding to develop evidence-informed, health prevention and health education programs with the community. The tools and methods used could be the basis for work in other Métis communities in Canada. In addition to this, the Métis Nation – Saskatchewan in collaboration with the research team will work towards publishing this information in appropriate peer-reviewed journals; thus, illuminating the similarities and differences related to health and well-being.

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