

The Embodiment of Inequity

Health Disparities in Aboriginal Canada

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ABSTRACT

Health disparities are, first and foremost, those indicators of a relative disproportionate burden of disease on a particular population. Health inequities point to the underlying causes of the disparities, many if not most of which sit largely outside of the typically constituted domain of “health”. The literature reviewed for this synthesis document indicates that time and again health disparities are directly and indirectly associated with social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering upon the Aboriginal populations of Canada. In analyses of health disparities, it is as important to navigate the interstices between the person and the wider social and historical contexts as it is to pay attention to the individual effects of inequity. Research and policy must address the contemporary realities of Aboriginal health and well-being, including the individual and community-based effects of health disparities and the direct and indirect sources of those disparities.

MeSH terms: Indians, North American; First Nations, Canada; Health Disparities; Social Sciences, Colonialism

La traduction du résumé se trouve à la fin de l'article.

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In a 2003 press release then-National Chief of the Assembly of First Nations, Matthew Coon Come said that the most recently published statistical profile of Aboriginal Canadians' health status confirmed “the already well-known disparities in our health compared to non-Aboriginal Canadians. Most importantly, it highlights the health determinants that are directly related to our Third World health status; those socio-economic determinants include infrastructure, housing, employment, income, environment, and education. So far, this government is more preoccupied on spending millions of dollars to impose unwanted colonial legislation on First Nations rather than investing in measures that will improve our quality of life.”¹ The health disparities outlined in this synthesis article reflect the present-day health effects of decades of inequity as Aboriginal peoples – First Nations, Inuit and Métis – continue to work toward economic, political, social, community and individual health. While there are tremendous successes and powerful indicators of triumph in many sectors, there remain far too many signs of the effects of a protracted history of inequity such that “irrespective of the indicator used, Canadian Aboriginal [peoples] tend to bear a disproportionate burden of illness.”²

Health *disparities* are, first and foremost, those indicators of a relative disproportionate burden of disease on a particular population. Health *inequities* point to the underlying causes of the disparities, many if not most of which sit largely outside the typically constituted domain of “health”. Specifically, the literature reviewed for this synthesis article indicates that time and again health disparities are directly and indirectly associated with or related to social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering on the Aboriginal populations of Canada. Scholars across all sectors of Aboriginal health studies concur that, despite inadequacies in the health care delivery system and regardless of peoples' relative access to or use of the biomedical system, the problems are entrenched in the history of relations between Aboriginal peoples and the nation-state. These health disparities are related to economic, political and social disparities – not to any inherent Aboriginal trait – and because of

the limited autonomy Aboriginal peoples have in determining and addressing their health needs.^{2,4} A history of colonialist and paternalistic wardship, including the creation of the reserve system; forced relocation of communities to new and unfamiliar lands; the forced removal and subsequent placement of children into institutions or far away from their families and communities; inadequate services to those living on reserves; inherently racist attitudes towards Aboriginal peoples; and a continued lack of vision in terms of the effects of these tortured relations – all of these factors underlie so many of the ills faced by Aboriginal peoples today.⁵⁻²⁴

Societal inequities exact a high personal toll in the form of disease, disability, violence and premature death. Thus, while we may talk about Aboriginal populations in general terms, we must appreciate the individual effects of the collective burden of a history of discriminatory practices, unjust laws and economic or political disadvantage. There are, in other words, far too many Aboriginal people in this country who suffer as a result of a shared history of inequality with non-Aboriginal Canadians. Thus, while some may continue to argue that there is a genetic basis for the disproportionate increase, for example, in chronic diseases such as non-insulin-dependent diabetes mellitus (NIDDM) among Aboriginal Canadians, we must equally examine the role of changing diets, changing or limited work options, poverty, access to resources, societal stressors, and the cultural valuations of foodstuffs as part of the more complex picture of disease in the contemporary context.

Political and economic disadvantage and marginalization are part and parcel of the felt effects of a history of internal colonization, which wear away not only at the individual but at the family, community and nation.²⁵ Internal colonization, succinctly defined by Emma LaRocque, is “that process of encroachment and subsequent subjugation of Aboriginal peoples since the arrival of the Europeans. From the Aboriginal perspective, it refers to loss of lands, resources, and self-direction and to the severe disturbance of cultural ways and values.”²⁶ Suicide, injuries, drug and alcohol abuse, sexual violence and even some chronic diseases – all occurring in disproportionate numbers across Aboriginal

Canada – are not just problems of the individual. In any analysis of health disparities, in other words, it is as crucial to navigate the interstices between the person and the wider social and historical contexts as it is to pay attention to the individual effects of inequity. The Assembly of First Nations’ (AFN) mission statement on health similarly reflects this relationship between health and equity:²⁷

We, as First Nations peoples accept our responsibility as keepers of Mother Earth to achieve the best quality of life and health for future generations based on our traditions, values, cultures and languages. We are responsible to protect, maintain, promote, support, and advocate for our inherent, treaty and constitutional rights, holistic health and the well being of our nations. This will be achieved through the development of health system models, research, policy analysis, and communication, and development of national strategies for health promotion, prevention, intervention and aftercare.

What, though, does health mean in the Aboriginal context? Too often programs and resources respond almost exclusively to an individual’s departure from health (i.e., disease) and thus neglect the underlying constituents of either health or ill-health. Cultural differences in how we come to understand what health means, economic conditions, living and social conditions, and one’s level of formal education are all elements that must be addressed in concert with public health priorities and initiatives if we are to understand and effectively take on the formidable task in reducing health disparities and promoting equity in Aboriginal Canadian populations.^{2,4,28-30} The *First Nations and Inuit Regional Health Survey*³¹ summarizes and highlights the disparate focus between Aboriginal and biomedical perspectives on health and healing. The biomedical model presumes, for example, a passive and compliant “patient” for whom treatments are prescribed (akin to other societal power imbalances, yet not always immediately perceived in this way). The Aboriginal wellness model, on the other hand, draws from a more comprehensive understanding of the individual and not just the healer/patient relationship and is often neglected in the formalized biomedical envi-

ronment. Wellness involves the physical, emotional, mental and spiritual aspects of a person and always in connection to his or her family and community.³² Unfortunately, this model of healing or concept of health priorities does not translate across the boundary of care in a typical biomedically based health-care centre, regardless of its location. If health-care workers are non-Aboriginal, they are at a particular disadvantage in that they are often only able to communicate through the language and culture of biomedicine. Thus, for example, there are many concepts, issues and practices that do not readily translate across linguistic, cultural, social or economic divides between the biomedical caregiver and his or her patient. Issues of time management or diet control, for example, may make little sense to an Aboriginal elder or, for that matter, a young mother with little income or social support. As Samson³³ found in his study in the Labrador Innu communities, non-Aboriginal health care workers talk of “naughty patients” or attribute blame for physical illness directly upon the behaviour of the patient. Doctors and nurses spoke of peoples’

...inability or unwillingness to teach their children basic safety requirements, their lack of coping skills, aversion to washing, their drinking, poor nutrition, and sexual promiscuity.... [Yet] few health workers stopped to question the many complexities that inevitably surround compliance to medications in places like Davis Inlet. Most Tshenut, even with coaching and translation are unable to follow complicated instructions dictated by the movements of the clock. Others, for example, young mothers in overcrowded households, will find it difficult to comply while there are numerous other crises in the household. Many people are not convinced of the efficacy of biomedicine, preferring to bear their pain alone or to seek an Innu remedy. Furthermore, there is no cultural basis among the Innu for them to adopt the customary deference towards physicians.³³

Mainstream biomedical health care, as it has evolved in relation to Aboriginal communities, has been shaped by a century of internal colonial politics that have effectively marginalized Aboriginal people from the

dominant system of care.^{34,35} Thus, despite the current (yet still problematic) thrust towards health transfer and improvements in health services,³⁰ there are numerous issues that may confound even the best efforts to negotiate the control and delivery of health care to Aboriginal people and communities. We must come to understand that conventional clinical approaches may not fit well with traditional indigenous values or with the realities of contemporary settlement or urban life. Kirmayer and colleagues suggest that there is a “need to rethink the applicability of different models of intervention from the perspective of local community values and aspirations.”³⁶ Indeed, if we are to understand “healing as the rebuilding of nations” and as a process of de-colonization, then we must find ways by which health can be effectively articulated at the levels of the individual, family, community and nation.^{5,30}

Included in this synthesis is an overview of the demographic profile and key indicators of the processes and effects of health inequities among the Aboriginal nations of Canada, offering a glimpse into a complex network of factors that impinge upon the health and well-being of Aboriginal Canadians. Demographic and statistical numbers – and synthesis papers that must rely on them – fail to provide a true or comprehensive picture of the Aboriginal peoples of Canada, however, and do little to reflect either the depth or diversity of experiences of First Nations Canada today. The diversity among and between Aboriginal populations can not be readily summarized and are thus diminished in the detached pall of statistical data. The profound cultural, linguistic and social differences between, for example, remote northern-dwelling Inuit, west-coast Haida, the Anishnabe and the Cree; between urban, rural and remote locations; between gender and age; employed or unemployed; poor or not; artist or rap singer; university-educated or full-time hunter; as well as differences in treaty-related rights and resources and nation-based differences in levels of political autonomy, all play a role in the relative (health) equity between Aboriginal populations and individuals. There is no way to adequately summarize these many differences among and between the men, women and children of Aboriginal Canada. The key element that

does bring them together as a group, however, is their autochthonous status on this land and the subsequent historical relationship since contact that each and every Aboriginal person continues to have to the nation-state.

While I have not focussed on the growing number of success stories of individuals, communities or nations, these achievements must be acknowledged. From the growth in the number of Aboriginal professionals, artists, musicians and scholars to the latest round of successful negotiations of title and compensation, there are optimistic signs of triumph throughout Aboriginal Canada. Unfortunately, these successes do not yet surpass the struggles faced by those who must continue to contend with the overwhelming disparities in health and social well-being.

Demographic profile

Overview

Aboriginal Canada constitutes all persons of Aboriginal origins, including First Nations, Métis and Inuit. While there are some basic demographic data on all three Aboriginal populations, there are considerably more data available on First Nations peoples. Most of the data presented here have been drawn from two key inter-related sources: Statistic Canada’s *Statistical Profile on the Health of First Nations in Canada* and the *Aboriginal Peoples Survey*³⁷ (APS) as well as the comprehensive findings of the Royal Commission on Aboriginal Peoples (RCAP).^{*} The 1997 Aboriginal Peoples Survey represents a weighted national survey of those 15 years of age or older who identify as Aboriginal (First Nation, Inuit, Métis) living both on- and off-reserve. Those who identified as Aboriginal and/or are registered under the *Indian Act* were randomly sampled from the total Aboriginal population and were selected from reserves, settlements and urban centres. The APS response rate was 75% and the total sample size was 25,122. Despite some presence of Métis in the Canadian census and APS, there remains, across the board, a dearth of demographic

* The 2002 Aboriginal Peoples Survey results were released shortly after the completion of the penultimate version of this paper. I have included some of the more significant statistics from this more recent APS in the sections on language and education.

and health status literature on the Métis population in Canada.³⁸

Census Canada indicates that in 2001 there were 976,310 individuals reporting Aboriginal identity in all of Canada’s provinces and territories. These numbers are incomplete, however, and should be viewed as such since they reflect only those individuals who reported to Statistics Canada and who self-identified as being of Aboriginal ancestry and are based solely on the ethnic origin question. As well, the census figures do not distinguish on- and off-reserve populations and do not reflect the total number of Aboriginal persons in Canada. In addition, some individuals may have identified themselves as having Aboriginal ancestry but did not associate with any of the three demographic groups (North American Indian, Métis, Inuit) or may have identified with more than one Aboriginal group. Thus, variances in the statistical data included here reflect the fact that Aboriginal persons who choose to self-identify and/or participate in various demographic exercises is not consistent.

Of that number of almost one million, 608,850 reported being of First Nations ancestry; 292,310 Métis; and 45,070 Inuit. The majority of First Nations persons live in Ontario (188,315), British Columbia (179,025), Alberta (156,220), Manitoba (150,040) and Saskatchewan (130,190). Similarly, the Métis people live primarily in the western provinces of Alberta (66,055), Manitoba (56,795), British Columbia (44,265), Saskatchewan (43,695) and the province of Ontario (48,345). The Inuit live predominantly in the north, with almost half of the entire Inuit population residing in Nunavut (22,560) (Table I). The absolute numbers must be compared to the relative distribution in the total population. For example, whereas Ontario has the highest absolute number of Aboriginal people, they account for only 2% of the total population of this province. In British Columbia, however, Aboriginal people account for 4.4% of the total population. The highest concentrations of Aboriginal people are in the North and the Prairies: 85% of the total population of Nunavut, 51% of Northwest Territories, and 23% of Yukon Territories. Gender distribution among First Nations peoples is reflected in the profile of the registered Indian population. According to

TABLE I

Population Reporting Various Forms of Aboriginal Identity, Canada, Provinces and Territories, 2001*

	Aboriginal Number	%	Indian Number	%	Métis Number	%	Inuit Number	%
Canada	976,310	100.0	608,850	100.0	292,310	100.0	45,070	100.0
Newfoundland and Labrador	18,780	1.9	7,040	1.2	5,480	1.9	4,555	10.1
Prince Edward Island	1,345	0.1	1,035	0.2	220	0.1		
Nova Scotia	17,015	1.7	12,920	2.1	3,135	1.1		
New Brunswick	16,990	1.7	11,490	1.9	4,290	1.5		
Quebec	79,400	8.1	51,125	8.4	15,855	5.4	9,532	21.2
Ontario	188,315	19.3	131,560	21.6	48,345	16.5	1,380	3.1
Manitoba	150,040	15.4	90,345	14.8	56,795	19.4		
Saskatchewan	130,190	13.3	83,745	13.8	43,695	14.9		
Alberta	156,220	16.0	84,990	14.0	66,055	22.6		
British Columbia	170,025	17.4	118,295	19.4	44,265	15.1		
Yukon Territory	6,540	0.7	5,600	0.9	535	0.2		
Northwest Territories	18,725	1.9	10,615	1.7	3,580	1.2	3,905	8.7
Nunavut	22,720	2.3	95	0.0	55	0.0	22,560	50.0
Rest of Canada (Inuit only)							3,145	7.0

* From Statistics Canada 2001 Census

Statistics Canada reports that of the total Aboriginal identity population, there were 6,665 "multiple Aboriginal responses" and 23,415 "Aboriginal responses not included elsewhere". This explains the discrepancy between the numbers reporting an Aboriginal Identity and the total of those reporting Indian, Métis and Inuit.

Adapted from the Statistics Canada Table entitled "Aboriginal Identity (8), Age Groups (11B) and Sex (3) for Population, for Canada, Provinces, Territories, Census Metropolitan Areas¹ and Census Agglomerations, 2001 Census - 20% Sample Data", Catalogue 97F0011, January 21, 2003.

the Department of Indian Affairs (DIA) Basic Departmental Data from 2001, of a total of 675,497 registered Indians, 330,883 (49%) are male and 344,614 (51%) are female (Table II). Overall, the data from the 2001 Census indicate that the Aboriginal peoples' total population is on the rise. Just over 1.3 million people reported having at least some Aboriginal ancestry in 2001, representing 4.4% of the total population. In 1996, people with Aboriginal ancestry represented 3.8% of the total population.

Language

While language retention and cultural continuity are not necessarily statistically correlated, we must consider the effect of the decline in Aboriginal languages in concert with the overwhelming media influences and educational priorities available to Aboriginal youth today. The 2001 APS

TABLE II

Registered Indian Population Distribution by Age and Gender

Age	Male - No.	%	Female - No.	%	Total
0-4	28,965	4.3	27,645	4.1	56,610
5-9	39,085	5.8	37,185	5.5	76,270
10-14	36,595	5.4	34,851	5.1	71,446
15-19	32,217	4.8	30,801	4.6	63,018
20-24	28,647	4.2	28,134	4.2	56,781
25-29	28,243	4.2	28,367	4.2	56,610
30-34	28,628	4.2	28,844	4.3	57,472
35-39	27,133	4.0	29,105	4.3	56,238
40-44	22,153	3.3	25,045	3.7	47,198
45-49	16,367	2.4	19,328	2.9	35,695
50-54	12,458	1.8	15,199	2.2	27,646
55-59	9,251	1.4	11,329	1.7	20,580
60-64	6,684	1.0	8,888	1.3	15,572
65-69	5,288	0.8	6,855	1.0	12,173
70-74	3,622	0.5	4,762	0.7	8,424
75-79	2,367	0.4	3,474	0.5	5,841
80+	3,140	0.5	4,783	0.7	7,923
Total	330,883	49	344,614	51	675,497

Source: Basic Departmental Data, 2001. Ottawa: Department of Indian and Northern Affairs Canada; p. 21. Reproduced with the Permission of the Minister of Public Works and Government Services Canada, 2005.

indicates that while there is considerable interest in learning one's Aboriginal language, only 15% of off-reserve Aboriginal

people indicated they could speak their language well or relatively well (Table III). By comparison, Inuit children (63%) and

TABLE III

Importance of Keeping, Learning or Relearning an Aboriginal Language by Age Group for the Aboriginal Identity Non-reserve Population 15 Years and Over for Canada, Aboriginal Peoples Survey 2001*†‡

	Total Population§		Very or Somewhat Important		Not Very or Not Important		No Opinion		Not Stated / Refused	
	Number	%	Number	%	Number	%	Number	%	Number	%
Total Aboriginal Identity Non-reserve Population										
Aged 15+	548,400	100.0	324,360	59.1	203,080	37.0	11,370	2.0	9,580	1.7
15-24	137,360	100.0	78,680	57.2	53,090	38.6	3,150	2.2	2,440	1.7
25-44	251,200	100.0	156,230	62.1	85,790	34.1	5,200	2.0	3,980	1.5
45-64	131,970	100.0	74,820	56.6	52,740	39.9	1,750	1.3	2,660	2.0
65 and over	27,870	100.0	14,640	52.5	11,450	41.0	1,270	4.5	510	1.8

* Excludes the population that did not answer the Language Section of the APS questionnaire and those with invalid or unstated ages.

† Aboriginal Identity population includes those people who reported on the APS at least one of the following: 1) Identification as North American Indian, Métis and/or Inuit; 2) Registered Indian status and/or; 3) Band membership.

‡ Non-reserve population includes Aboriginal people who do not live on Indian reserves, with the exception of the Northwest Territories, in which case the total (on and non-reserve) Aboriginal population is included.

§ The sum of the values of each category may differ from the total due to rounding.

Adapted from Statistics Canada, Aboriginal Peoples Survey, 2001.

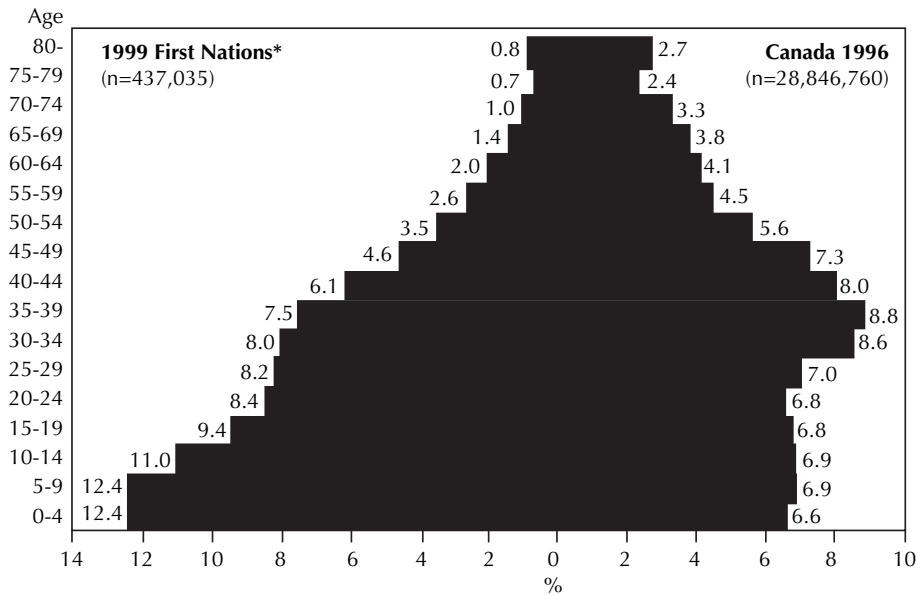


Figure 1. Distribution of the First Nations and Canadian population

* Includes on and off reserve for Alberta and British Columbia
n = size of population

Adapted in part from the Statistics Canada publication, "Age, Sex, Marital Status and Common-law Status (reference products: technical reports: 1996 Census of Population)", Catalogue 92-353, April 1, 1999.

Source: A Statistical Profile of the Health of First Nations in Canada, Figure 2.2, Health Canada (2003). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2005.

those over the age of 15 (80%) indicated they could speak Inuktitut at least relatively well.

Age Distribution and Life Expectancy

The median age for the Aboriginal population in 2001 was 24.7 years (versus a non-Aboriginal population high of 37.7 years). Of a total of 975,497 persons of all ages³⁹ 267,344 are between 0 and 19 years of age. Significantly, a full third of the total Aboriginal population is under the age of 14 (compared to the corresponding share of 19% in the non-Aboriginal population). There are 309,994 Aboriginal persons between 20 and 49 years of age and 98,159 are between 50 and 80+ years of age (Table II). The overall distribution by age of this population reflects both the new trend toward aging as well as an Aboriginal birth rate that is 1.5 times that of the non-Aboriginal birthrate in Canada.³⁷ The *Statistical Profile on the Health of First Nations in Canada* similarly reveals a steady and persistent age distribution difference between First Nations and the non-Aboriginal Canadian populations. Thus, while there is a trend towards aging in the Aboriginal population (the number of Aboriginal seniors increased by 40% between 1996 and 2001), there remains a far greater young Aboriginal population due to both the high birth rate and a lower overall life expectancy. By comparison, the non-Aboriginal Canadian population is distributed far more evenly up the age ranges with a single "baby boom" bulge (30-54 years of age) (Figure 1).

Tables IV and V indicate that while life expectancy is increasing overall for Aboriginal populations, it still falls well below the life expectancy for non-Aboriginal Canadians. As of 1990, Inuit men (57.6) and men living on-reserve (62) have the lowest life expectancy of all Aboriginal populations.³⁷

Registered Status

People of First Nations ancestry may or may not be registered under the *Indian Act*. The *Indian Act* of 1876, while formally recognizing First Nations ancestry, remains the legislative authority of internal colonization. Bringing the First Nations under federal control, the Act officially abolished the inherent authority of Aboriginal peoples to determine their own lives. The *Indian Act* was amended in 1939

TABLE IV

Registered Indians – Life Expectancy*

	Registered Indians	All Canadians	Gap
Male	68.9	76.3	7.4
Female	76.6	81.8	5.2

* Statistics from Department of Indian Affairs "Basic Departmental Data 2001"

Adapted in part from the Statistics Canada publication, "Report on the Demographic Situation in Canada", 1991, Catalogue 91-209, March 4, 1994.

TABLE V

Estimated Life Expectancy at Birth, Total and Aboriginal Populations, 1991*

Years	Male	Female
Total population	74.6	80.9
Total Aboriginal population	67.9	75.0
Total, North American Indians†	68.0	74.9
Registered North American Indians	66.9	74.0
On-reserve	62.0	69.6
Non-reserve, rural	68.5	75.0
Non-reserve, urban	72.5	79.0
Non-Registered North American Indians	71.4	77.9
Rural	69.0	75.5
Urban	72.5	79.0
Métis	70.4	76.9
Rural	68.5	75.0
Urban	71.5	78.0
Inuit	57.6	68.8

* From Report of the Royal Commission on Aboriginal People, Vol. 3, Table 3.2

† North American Indians includes all who self-identified as North American Indian on the 1991 Aboriginal Peoples Survey, whether or not they are registered under the *Indian Act*.

Adapted in part from the Statistics Canada publication, "Report on the Demographic Situation in Canada", 1991, Catalogue 91-209, March 4, 1994.

Adapted from "Health Indicators Derived from Vital Statistics for Status Indian and Canadian Populations, 1978-1986", Health Canada (September 1988). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2005.

TABLE VI

Adjusted Aboriginal Identity Population by Region and Aboriginal Group, 1991*

Region	Registered		Non-Registered		Métis		Inuit [§]		Total	
	No.†	%	No.	%	No.	%	No.	%	No.	%
Atlantic‡	15,800	3.6	4,800	4.3	2,500	1.8	4,800	12.7	27,700	3.8
Quebec	43,700	10.0	9,800	8.7	9,100	6.5	7,200	19.0	69,300	9.6
Ontario	91,500	20.9	39,600	35.2	12,800	9.2	900	2.2	143,100	19.9
Manitoba	65,100	14.9	8,500	7.5	34,100	24.5	500	1.3	107,100	14.9
Saskatchewan	59,900	13.7	6,500	5.8	27,500	19.7	200	0.4	93,200	12.9
Alberta	60,400	13.8	18,400	16.3	39,600	28.4	1,400	3.7	118,200	16.4
British Columbia	87,900	20.1	23,800	21.1	9,400	6.7	500	1.4	120,700	16.7
Yukon	4,400	1.0	500	0.4	200	0.1	—	0.25	100	0.7
Northwest Territories	9,300	2.1	800	0.74	200	3.0	22,200	58.7	36,200	5.0
Total	438,000	100.0	112,600	100.0	139,400	100.0	37,800	100.0	720,600	100.0

* From Report of the Royal Commission on Aboriginal People, Vol. 1, Table 2.4

Notes: - population count is less than 100.

† All counts are rounded to the nearest hundred.

‡ The Inuit count for the Atlantic region is actually for Labrador. The APS reported an unadjusted Inuit count of 55 in Nova Scotia and in New Brunswick. These counts were flagged to be used with caution because of sampling variability.

§ To obtain estimated counts for the Inuit population (3,560) in regions other than Labrador, Quebec and the Northwest Territories, the 1991 APS unadjusted counts were used to derive the shares of the adjusted Inuit population in each remaining region.

|| The adjusted count of non-registered North American Indian and Métis populations in the Yukon and Northwest Territories were derived using their respective percentage shares in each territory based on unadjusted 1991 APS data.

Source: "Report of the Royal Commission on Aboriginal Peoples" Royal Commission on Aboriginal Peoples, Volume One: Looking Forward, Looking Back, Chapter 2 titled: From Time Immemorial: A Demographic Profile, Section 2 titled: Current Population, Table 2.4 titled: "Projections of the Aboriginal Identity Population in Canada, 1991-2016" M.J. Norris, D. Kerr and F. Nault found on the following website:

http://www.ainc.inac.gc.ca/ch/rcap/sg/sg3_e.htm#11. The Commission c. 1996. Reproduced with the permission of the Minister of Public Works and Government Services, 2005, and Courtesy of the Privy Council Office.

Source: "Projections of the Aboriginal Identity Population in Canada, 1991-2016", prepared by Statistics Canada, Demography Division, for Royal Commission on Aboriginal People (February 1995).

to bring the Inuit under similar federal control. Being registered under the Indian Act confers the rights and privileges of Indian status in Canada yet remains one of the most contentious acts of colonial domination.* There is no commensurate recognition of status or required registration for the Métis people. According to the Royal Commission on Aboriginal Peoples (RCAP),⁴⁰ as of a decade ago there were 438,000 registered and 112,600 non-registered Indians across Canada (Table VI).

Geographic Distribution

Reserves are Crown lands that are set aside for the exclusive use of registered Indians. The creation of these reserves reflects a history of domination and early attempts to assimilate the indigenous peoples of Canada. Whereas they remain a reminder of assimilationist practices, they are also the family home to many, regardless of where one may now reside, and they constitute a base from which to negotiate political autonomy. Nonetheless, the number of registered Indians who are moving away from reserve lands (in particular, into urban centres) is on the rise and reflects a significant shift in the geographic distribution of First Nations peoples of

* Terminology is important as the word "Indian" is considered derogatory and insensitive in the Canadian context. However, the word "Indian" remains in the Indian Act and is the term used in distinguishing status according to the Indian Act.

TABLE VII

Registered Indian On- and Off-Reserve Population

Year		On Reserve	Off-Reserve	Total
2000	Male	199,815	131,068	330,883
	Female	192,178	152,438	344,616
	Total	391,993	283,506	675,499

Source: Basic Departmental Data, 2001. Ottawa: Department of Indian and Northern Affairs Canada; pp. 9, 13, 15. Reproduced with the Permission of the Minister of Public Works and Government Services Canada, 2005.

Canada. Specifically, of those registered as Indian, the Department of Indian Affairs notes that in 2000 a total of 391,993 lived on-reserve whereas 283,506 lived off-reserve (Table VII) with an overall decline from 33% to 31% in the proportion living on reserves or settlements. Stated differently, as of 2000, 25% of all Aboriginal people lived in 10 of Canada's 27 census metropolitan areas and almost half of the population who identify themselves as Aboriginal lived off-reserve. In Ontario, for example, 78,346 lived on-reserve and 75,600 lived off-reserve (Table VIII). Significantly, there are now more women than men living off-reserve (152,438 women versus 131,068 men). In addition, Aboriginal people are more mobile than other Canadians. This high level of mobility creates particular challenges for planning and implementing programs in Aboriginal-focussed education, social services, housing and health care, especially in urban areas.⁴¹

Housing and Home

In 1991, the RCAP compared the housing conditions of on-reserve and off-reserve First Nations, Métis and Inuit (Table IX). The findings indicate that far too many Aboriginal people are living in over-crowded and under-serviced homes.^{17,18,40-46} The on-reserve registered Indian population averages four persons per dwelling compared to less than three persons per dwelling for the non-Aboriginal population.⁴⁷ In reality, however, for most on-reserve registered Indian populations (Prairie provinces, NWT, Québec, and Newfoundland and Labrador), there are more than four persons living together. The 2001 APS indicates that 17% of off-reserve Aboriginal people and 53% of urban Inuit live in crowded conditions (defined as 1 or more people per room), compared to 7% of all Canadians. Off-reserve population and the Métis averaged approximately three persons per dwelling. Comparing Aboriginal and non-Aboriginal Canadian housing indicators

TABLE VIII

Registered Indian Population by Region (2000) – On and Off-Reserve

	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	BC	Yukon	NWT	Canada
On	17,075	44,274	78,346	70,094	54,093	56,545	56,801	3872	10,893	391,993
Off	9322	19,041	75,600	37,052	52,018	28,828	53,728	3761	4156	283,506
Total	26,397	63,315	153,946	107,146	106,111	85,373	110,529	7633	15,049	675,499

Source: Basic Departmental Data, 2001. Ottawa: Department of Indian and Northern Affairs Canada; pp. 9, 13, 15. Reproduced with the Permission of the Minister of Public Works and Government Services Canada, 2005.

TABLE IX

Housing Conditions of Aboriginal People, 1991*

	North American Indians		Métis	Inuit
	On-reserve†	Non-reserve		
Occupied dwellings	39,870	137,580	65,005	9,655
Average number of persons per dwelling	4.3	3.3	3.3	4.3
Average number of rooms per dwelling	5.5	5.9	5.9	5.4
Tenant-occupied dwellings	5,435 (13.6)	77,445 (56.3)	33,535 (51.6)	7,125 (73.8)
Average gross rent per month (\$)	362	517	505	318
Owner-occupied dwellings	10,755 (27.0)	60,025 (43.6)	30,893 (47.5)	2,510 (26.0)
Average owner's major payment per month	207	670	607	538
Band-owned dwellings	23,675 (59.4)	—	570	—
Available water not suitable for drinking	9,575 (24.0)	27,620 (20.1)	10,855 (16.7)	2,430 (25.2)
No electricity	2,585 (6.5)	9,645 (7.0)	3,682 (5.7)	445 (4.6)
No bathroom facilities	4,595 (11.5)	10,530 (7.7)	1,425 (2.2)	85 (0.9)
No flush toilet	7,715 (19.4)	2,880 (2.1)	2,230 (3.4)	496 (5.1)
In need of major repairs	15,445 (38.7)	21,420 (15.6)	10,965 (16.9)	1,770 (18.3)
Needs of residents not adequately met	15,610 (39.2)	22,905 (16.6)	12,090 (18.6)	3,175 (32.9)
Residents on waiting list for housing	5,545 (48.1)	10,065 (22.3)	15,200 (23.4)	2,760 (28.6)

* From Report of the Royal Commission on Aboriginal People, Vol. 3, Table 4.2

Data pertain to dwellings where at least one of the occupants identifies as a member of an Aboriginal group. Numbers in parentheses indicate percentage of total number of dwellings for that group.

† Data from the APS are deficient because of under-reporting but are the only data suitable for comparisons between Aboriginal groups.

— = not applicable.

Adapted from the Statistics Canada publication, "1-disability, 2-housing (The Aboriginal Peoples Survey 1991)", Catalogue 89-535, March 25, 1994.

TABLE X

Comparison of Canadian and Aboriginal Housing Indicators, 1991*

	Canada	Aboriginal†	Aboriginal Position
Occupied dwellings	10,018,265	239,240	2.4% of Canadian households‡
In need of major repairs	9.80%	19.60%	2 times as many in need of major repairs
Built before 1946	17.70%	13.60%	25% less than the Canada-wide proportion
No piped water supply	0.10%	9.40%	More than 90 times as many with no piped water
No bathroom facilities	0.60%	3.20%	More than 5 times as many
No flush toilet	0.50%	5.30%	More than 10 times as many
Average number of persons per dwelling	2.7	3.5	About 30% higher than the Canadian average
Average number of rooms per dwelling	6.1	5.8	Slightly smaller
Tenant-occupied dwellings	37.10%	48.70%	About 1/3 more tenants, not counting band-owned housing
Average gross rent per month	\$546.00	\$495.00	\$51 per month lower on average
Owner-occupied dwellings	62.60%	41.20%	About 34% fewer owners
Owner's major payment per month	\$682	\$603	\$79 per month lower on average

* From Report of the Royal Commission on Aboriginal People, Vol. 3, Table 4.1

† According to the 1991 Aboriginal Peoples Survey (APS).

‡ The actual figure is closer to 2.7 percent of Canadian households, owing to under counting in the APS. Canada data include only non-farm, non-reserve dwellings. The Aboriginal data include all non-farm dwellings, including those on reserves, where at least one of the occupants self-identifies as an Aboriginal person. Note that tenant-occupied dwellings do not include band-owned housing, which is treated as a separate category. Owner's major payment per month refers to the average monthly payments made by the owner to secure shelter.

Adapted from Statistics Canada, "Household Facilities and Equipment, 1995", Catalogue 64-202. (The estimate is based on the household income, facilities and equipment data base at Statistics Canada which contains data from several sources, including the household facilities and equipment survey, Aboriginal Peoples Survey).

(Table X), homes lived in by Aboriginal individuals/families are:

- 2 times more likely to be in need of major repair (19.6% versus 9.8%)
- 90 times more likely to have no piped water supply (9.4% versus 0.1%)
- 5 times more likely to have no bathroom facilities (3.2% versus 0.6%)
- 10 times more likely to have no flush toilet (5.3% versus 0.5%).

Adequate housing, both in terms of adequate basic facilities and the number required to adequately house both an aging and growing population are a high priority at all levels of Aboriginal government.

In addition to the toll that housing shortages and inadequate facilities take on populations, the actual place where people live also affects health status. The same colonialist interests that created the reserve

system have also controlled where Aboriginal people may or may not live. The relocation of entire communities, based on the whim or wishes of a government consumed with issues of northern sovereignty or resource management (not with the health or well-being of the First Nations, Inuit or Métis), has directly affected those communities' well-being. From the high Arctic Inuit relocations in

TABLE XI

On-reserve Students Remaining Until Grade 12 for Consecutive Years of Schooling, Canada, 1987/88 – 1996/97

School Year	Percent
1987/88	37.4
1988/89	38.6
1989/90	41.3
1990/91	47.0
1991/92	53.6
1992/93	62.6
1993/94	77.7
1994/95	73.3
1995/96	75.1
1996/97	70.8*

* The percentage for 1996/97 is obtained by dividing the number of students in grade 12 in 1996/97 by the number of students in grade 1 in 1985/86.

Source: Basic Departmental Data, 1997. Ottawa: Indian and Northern Affairs Canada; p. 31. Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2005.

the 1950s, to the forced relocation of the Innu of Labrador (and their subsequent recent second relocation and as yet unsuccessful attempt to quell the initial injurious effects), to the Anishnabe of Grassy Narrows who continue to suffer from methyl mercury poisoning as an indirect effect of relocation, the government mandate imposed upon Aboriginal people continues to resonate as social upheaval, as mental illness, as violence, as crime, as suicide, and as disease.^{33,48-51}

Many of those who have moved from reserves, but without adequate education, social support or skills, will likely find themselves outside of the mainstream in an urban centre. Those who move towards the illusory security of the city quickly discover a dearth of services (unlike those available on reserves) and a marginalized and compromised status. Among the many other services required, there is, as Mason⁵² has reported, a desperate need for adequate housing, and in particular, housing for women and children.

Education, Employment and Income

Education

According to the *Statistical Profile*, First Nations children are staying in school longer than in the recent past. Given that educational achievement is positively associated with health, this is good news. In 1997-98, significantly more First Nations' children remained in school until Grade 12 than in the previous decade (74% versus 37%) (Table XI). In addition, the

TABLE XII

Aboriginal and Canadian Populations Age 15+, Showing Percentage by Level of Education Attained, 1981 and 1991*

	1981 Aboriginal People 1	All Canadians 2	Gap 2-1	1991 Aboriginal People 1	All Canadians 2	Gap 2-1
Elementary school	63	80	17	76.1	86.1	10
High school	29.1	52.1	23	42.5	61.8	19.3
Post-secondary certificate	8.9	13.7	4.8	13.3	15.8	2.5
Some university	6.7	16	9.3	8.6	20.8	12.2
University degree	2	8	6	3	11.4	8.4

* From Report of the Royal Commission on Aboriginal People, Vol. 5, Table 2.6

Note: This table shows the number of individuals who have attained the level of education indicated, including individuals who have gone on to higher levels. Thus, in 1991, of the 76.1 percent of Aboriginal people who completed elementary school, many have completed high school and a number have also gone on to study at colleges and universities. The category 'post-secondary certificate' includes those who may not have completed elementary school or high school.

Source: Statistics Canada, "Canada's Aboriginal Population 1981-1991: A Summary Report", research study prepared for RCAP; and data from the Housing, Family and Social Statistics Division, Statistics Canada, January 1995.

Adapted from Statistics Canada, "Canada's Aboriginal Population, 1981-1991: A Summary Report", research study prepared for Royal Commission on Aboriginal People, and data from the Housing, Family and Social Statistics Division, Statistics Canada, January 1995.

TABLE XIII

Highest Level of Education, Aboriginal Identity and Canadian Populations Age 15-65 No Longer Attending School, 1991*

	North American Indian On-reserve %	Non-reserve %	Métis %	Inuit %	Total Aboriginal %	Total Pop. %
Less than grade 9	39.6	16.0	19.1	46.6	25.4	11.8
Secondary, no certificate	29.9	33.9	34.2	20.1	32.1	22.8
Secondary certificate	8.3	15.5	14.8	8.7	12.8	21.2
Non-university, no certificate	6.9	8.3	8.5	8.6	8.0	6.2
Non-university certificate	10.6	16.2	15.3	13.2	14.1	17.9
University, no degree	3.4	6.1	4.4	1.8	4.7	7.9
University degree	0.9	3.6	3.3	—	2.6	12.2

* From Report of the Royal Commission on Aboriginal People, Vol. 5, Table 5.7

Note: — = Figures suppressed because of small size; their coefficient of variation is higher than 33.3%. Adapted from Statistics Canada, 1991 Aboriginal Peoples Survey, and 1991 Census, Custom Tabulations.

TABLE XIV

Education and Employment Income, 1991*

Highest Level of Education Completed	Aboriginal People* (% of population age 15 to 64)	All Canadians† (% of population age 15 to 64)	Average Employment Income Per Aboriginal Person (\$000s)
Less than grade 9	25.4	11.8	12.7
Grades 9 to 13	32.2	22.8	15.3
High school diploma	12.9	21.3	19.4
College without certificate	8.0	6.2	15.8
College with certificate	14.2	17.9	20.5
University without degree	4.7	7.9	22.6
University with degree	2.6	12.2	33.6
Total	100.0	100.0	17.8

* From Report of the Royal Commission on Aboriginal People, Vol. 5, Table 2.3

† Population age 15 to 64 no longer attending school full-time.

Adapted from the Statistics Canada publication, "Education Attainment and School Attendance (data products: nation series: 1991 Census of Population)", Catalogue 93-328, May 11, 1993.

Profile optimistically points to an increase (by 54% between 1990 and 2000) in band-operated schools, an increase in federal funding for post-secondary education and a growth in Aboriginal studies programs at the university level. Despite these

encouraging accomplishments, however, there is an across-the-board lag in the completion rate of all levels of education when compared to the non-Aboriginal Canadian population. Indeed, as the 2002 APS points out, only 48% of off-reserve

TABLE XV

Participation and Unemployment Rates, Aboriginal and Non-Aboriginal Populations, 1981 and 1991*

	Participation Rate†		Unemployment Rate	
	% 1981	% 1991‡	% 1981	% 1991‡
Non-Aboriginal	65.0	68.1	7.2	9.9
Total Aboriginal	51.8	57.0	15.8	24.6
North American Indians				
Registered§				
On-reserve	37.4	45.3	19.3	30.1
Non-reserve	55.9	56	15.6	29.4
Non-registered	62.7	67.5	14.3	21.1
Métis	57	63.7	14.5	21.3
Inuit	48.2	57.2	15.2	24.1

* From Report of the Royal Commission on Aboriginal People, Vol. 3, Table 3.11

† Participation rate is the percentage of all persons aged 15 and older who are employed and unemployed, i.e., active in the labour force.

‡ For comparison purposes, the Aboriginal rates for 1981 exclude reserves that were enumerated incompletely in the Aboriginal Peoples Survey.

§ Data for registered North American Indians in 1991 exclude persons who regained Indian status after 1985 as a result of Bill C-31, which amended the Indian Act with regard to eligibility for Indian status. Such persons were added to the 1991 North American Indian non-registered population for purposes of comparing 1991 and 1981 data.

Adapted from Statistics Canada, "Canada's Aboriginal Population, 1981-1991: A Summary Report, research prepared for RCAP; and data from the Housing, Family and Social Statistics Division, Statistics Canada, January 1995.

Aboriginal children are completing Grade 12. Inuit peoples' educational attainment is either lower than or comparable to First Nations people, with proportionately fewer Inuit obtaining a university degree. As a recent study indicates, even with higher levels of post-secondary education, First Nations men and women continue to face barriers to employment (Tables XII-XIV).⁵³

Employment and Income

The RCAP reported that as of 1986 just under 45% of First Nations communities, at age 15+, were able to participate in the labour force (comparable communities: 60.3%; Canada: 66.9%). Of that total percentage, 33% of First Nations communities' members were unemployed compared to the national 1986 average of 12%. In a separate study commissioned by RCAP,⁴⁰ the total Aboriginal unemployment rate rose from 15.8% in 1981 to 24.6% in 1991 (Table XV).

Comparisons between registered on-reserve, off-reserve and non-Aboriginal Canadian populations indicate that, overall, Aboriginal household incomes are substantially lower than their non-Aboriginal counterparts. Registered on-reserve First Nations household incomes (per occupied private dwelling) are almost half that of the non-Aboriginal (reference) household incomes (\$25,040 versus \$46,606).⁴⁷ At \$32,177, registered off-reserve household

incomes are dramatically lower than the reference personal incomes. The average individual incomes are, in other words, substantially lower. The average income for the total registered (on- and off-reserve) Aboriginal population in 1991 was \$12,800. This is approximately one half of the reference population income of \$24,100.

An Assembly of First Nations (AFN) fact sheet of socio-economic exclusion indicators points to an even greater discrepancy between Aboriginal and non-Aboriginal earnings.⁵⁴ Their figures identify an unemployment rate of 28.7% among reserve-dwelling First Nations members (compared to a Canadian national average of 9.8%). Whereas 8.2% of non-Aboriginal Canadians earn less than \$2,000, 19% of those living on-reserve earn this meagre amount annually.⁵⁴ Kendall bluntly states that unemployment is the most immediate cause of poverty.⁵⁵ Yet it is the complex interplay of job market discrimination, lack of education, cultural genocide, and loss of land and sovereignty that affects employment status and, ultimately, the degree of poverty faced by those who are caught in a "circle of disadvantage". The income gap between indigenous and non-indigenous Canadians continues to grow, despite efforts at income assistance and community development. Poverty, and the resultant poor living conditions, continue to contribute

directly to poorer health status in both children and adults. Studies also continue to show that Aboriginal women face a disproportionate proportion of the burden of poverty and its concomitant social and health effects.⁵⁶⁻⁵⁸

The embodiment of inequity – Health status and health disparities

Perceived Health Status

According to the APS, only 13% of the overall Aboriginal population described their health status to be either "fair" or "poor" whereas 26% indicated that they considered their health status to be "excellent". These figures are significant, and even more so in contrast to the overall percentage of people with disability (30%) or who saw either a general practitioner (67%) or health-care professional (73%). Even more striking perhaps is that, by comparison, 23.1% of those living off-reserve rated their health as either fair or poor. In this same population 60% reported at least one chronic condition (e.g., arthritis, high blood pressure, diabetes), 16.2% reported a long-term activity restriction (more than 1.6 times higher than non-Aboriginal population) and 13.2% of those living off-reserve had experienced a major depressive episode in the year prior to the survey (1.8 times higher than the non-Aboriginal population).

Given the discrepancies between the stated health status profile both on- and off-reserve, we need to ask what "health" means for Aboriginal people. Health status and meanings of health are not adequately developed in the APS or other large scale survey instruments. Ethnographic data indicate that "health" means more than just the absence of disease in many cultural contexts and this avenue of health study must be more fully explored to develop a better sense of health equity for Aboriginal Canadians.^{25,29,32,59,60} If health is a statement of individual wellness, then the answer may be far less accurate than any statistical outcomes will show. If health is interpersonal, based on a socially driven model of well-being, then this will engender a far different set of answers in an assessment of health.^{29,33,61}

When asked what social problems were the most important for Aboriginal peoples,

the highest percentage of those who responded to the Aboriginal Peoples Survey indicated that unemployment (67.1%) and alcohol abuse (61.1%) were the greatest (social) health problems in their communities. Drug abuse (47.9%), family violence (39.2%), suicide (25.4%), sexual abuse (24.5%), and rape (15%) followed.⁶² These numbers are broken down according to on-/off-reserve First Nations, Métis and Inuit in Table XVI. While at best a broad sweep of the key social health concerns of communities, it is nonetheless a stark indicator of the individual and interpersonal results of social and societal disruption. Thus, while there are cultural differences in how health is understood, there are also social and historical factors that are impinging upon any sense of health and well-being that cannot be remedied with a simple invocation of a return to "culture".

Morbidity and Mortality

Infant mortality stands as one of the key indicators of the relative health of populations. Specifically, infant mortality decreases as mothers' health and nutrition improve and as they are better monitored throughout the prenatal period.

In 1999 the infant mortality rate in First Nations was 8 deaths per 1000 live births. This rate is 1.5 higher than the Canadian rate of 5.5. However, this is a significant improvement from the 1979 rate of 27.7 per 1,000 live births and reflects the increase in access to prenatal health-care services and better maternal nutrition overall.³⁷ Infant mortality should be assessed relative to birth weight as birth weight is normally a strong predictor of infant mortality and child well-being. Birth weight may be influenced by socio-economic conditions, maternal age and weight, previous births by mother, maternal nutrition, smoking or illness during pregnancy, diabetes, and length of the pregnancy. Both low and high birth weights place infants at risk for higher vulnerability to illness later in life and, in particular, to diabetes. In addition, high birth weights place the baby at risk during the delivery process. In 1999, of those First Nations births recorded, 22% were classified as high birth weight (almost twice the non-Aboriginal Canadian rate). Six percent of the recorded births were classified as low birth weight

TABLE XVI

Selected Social Problems Reported by Aboriginal Identity Population, 1991*

	Total Aboriginal %	North American Indian On-reserve %	North American Indian Non-reserve %	Métis %	Inuit %
Unemployment	67.1	78.3	60.2	66.9	74.5
Family violence	39.2	44.1	36.4	39.0	43.5
Suicide	25.4	34.4	20.4	21.6	41.2
Sexual abuse	24.5	29.0	21.8	23.0	35.1
Rape	15.0	16.4	13.3	14.6	25.0
Alcohol abuse	61.1	73.2	56.0	58.8	57.6
Drug abuse	47.9	58.8	43.2	45.2	49.0

* From Report of the Royal Commission on Aboriginal People, Vol. 5, Table 5.4

Note: Percentage of respondents reporting each phenomenon as a problem in their community. Adapted from the Statistics Canada publication, "Language, tradition, health, lifestyle and social issues", 1991, Catalogue 89-533, June 29, 1993.

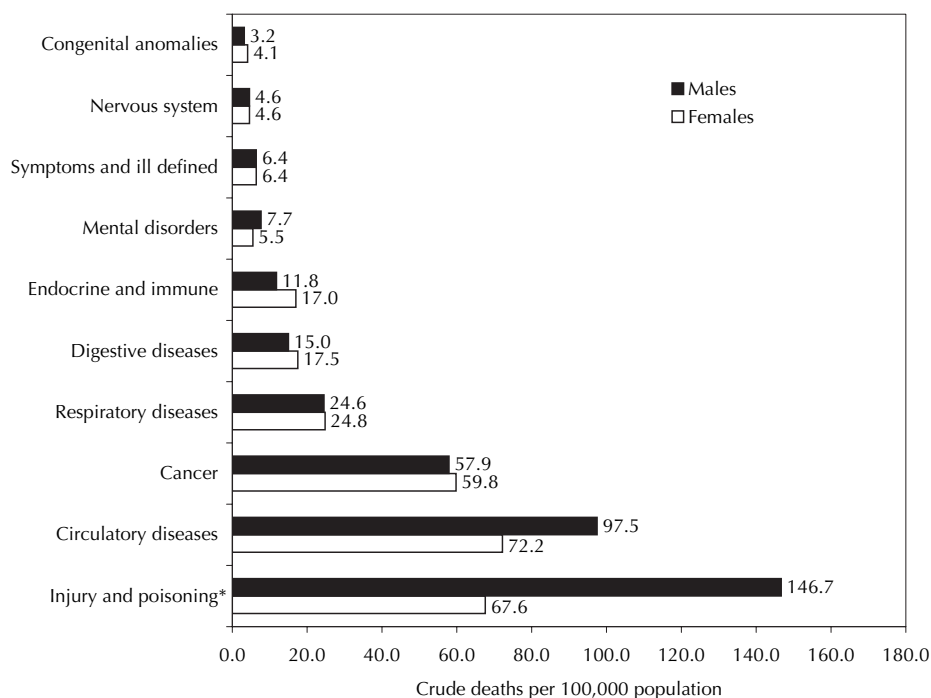


Figure 2. Leading causes of death in First Nations by sex, 1999

* Included in this rate are suicides with a rate of 12.4 per 100,000 for women and 43.3 per 100,000 for men
Ranking based on mortality (deaths per 100,000 population) for First Nations in 1999. Source: A Statistical Profile of the Health of First Nations in Canada, Fig. 3.4, Health Canada, (2003). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2005.

(compared with 5.6% among the non-Aboriginal Canadian population). Yet despite similar percentages, further research has shown that First Nations infants with lower birth weights have a higher mortality rate.³⁷

Injury, poisoning, circulatory disease, cancer and respiratory disease are the overall leading causes of death in all Aboriginal populations. Suicide and self-inflicted injury is the leading cause of death in those aged 10-19 and 20-44, followed by motor vehicle injuries and then accidental drown-

ing and homicide, respectively. For those aged 45-64, ischemic heart disease, lung cancer, motor vehicle injuries, diabetes, chronic liver disease, and other diseases (including breast cancer) are the leading causes of death.² For those aged 65 and over, heart disease, cerebrovascular disease, lung cancer, pneumonia and influenza are the leading causes of death. For those aged one to nine, the leading causes of death are injuries caused by fire and flames, motor vehicle and other injuries (Table XVII and Figure 2).

TABLE XVII

Deaths in First Nations, by Leading Causes and Age Group, 1999

Age group*	Rank	Cause of Death	Frequency	Rate†	%
01 to 09‡	1	Accidents caused by fire and flames (E890-898)§	9	11.2	26
	2	Motor vehicle accidents (E810-825)	8	10.0	24
	3	Other injuries (excludes motor vehicle accidents and fire)	8	10.0	24
	4	Other causes	9	11.2	26
			34		
10 to 19	1	Suicide and self inflicted injury (E950-959)	30	38.6	38
	2	Motor vehicle accidents (E810-825)	24	30.9	30
	3	Accidental drowning and submersion (E910-915)	8	10.3	10
	4	Other causes	18	23.2	23
			80		
20 to 44	1	Suicide and self inflicted injury (E950-959)	84	53.6	23
	2	Motor vehicle traffic accident (E810-819)	56	35.7	15
	3	Homicide (E960-969)	27	17.2	7
	4	Accidental poisoning by drugs (E850-858)	23	14.7	6
	5	Accidental drowning and submersion (E910-915)	20	12.8	5
	6	Other causes	157	100.1	43
			367		
45 to 64	1	Ischemic heart disease (410-414)	67	126.6	17
	2	Lung cancer (162)	23	43.4	6
	3	Motor vehicle traffic accident (E810-819)	20	37.8	5
	4	Diabetes (250)	16	30.2	4
	5	Chronic liver disease and cirrhosis (571)	15	28.3	4
	6	Other causes	249	470.4	64
			390		
65+	1	Ischemic heart disease (410-414)	117	755.7	20
	2	Other forms of heart disease (420-429)	51	329.4	9
	3	Cerebrovascular disease (430-438)	43	277.7	7
	4	Lung cancer (162)	40	258.3	7
	5	Pneumonia and influenza (480-487)	37	239.0	6
	6	Other causes	287	1853.6	50
			575		

* A total of 37 deaths were excluded because age at time of death was missing.

† Rate per 100,000 population.

‡ There were 65 deaths under the age of one.

§ Codes refer to the ICD-09 Classification System.

|| Breast cancer has been included in the "other" causes category for the 45 to 64 age group. There were 20 cases of breast cancer in this population.

Source: A Statistical Profile of the Health of First Nations in Canada, Appendix 4, Health Canada, (2003). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2005.

Violence and its Effects

Personal, interpersonal and family violence – including physical abuse, sexual assault and rape – continue to escalate in Aboriginal populations, and with dire effects. The RCAP found that 39% of the overall Aboriginal population reported family violence as a social problem (followed by suicide, sexual abuse and rape, which are all forms of violent interpersonal crimes). Violence, like suicide, does not occur in a vacuum, however, and factors leading to violent and abusive behaviours, including drug and alcohol consumption, must be taken into consideration when assessing the impacts of violence on individuals and communities. In an exploration of the relationship between substance abuse and physical/sexual abuse in an urban Aboriginal population, for example, Jacobs and Gill^{19,20} found that those who had experienced physical and/or sexual abuse were more likely to have a current substance abuse problem and that there

was a strong intergenerational transmission of violent behaviour and substance abuse. As well, substance abusers were more likely to have a history of legal problems, time spent in jail, and a high level of psychological distress (including depression, anxiety, suicide ideation and attempted suicide).^{19,20}

In her submission to the RCAP, LaRocque²⁶ specifically highlights the effects of family violence on Aboriginal women, teenagers and children. This focus on women is not inappropriate given that up to 75% of the victims of sex crimes in Aboriginal communities are women and girls under the age of 18 (50% of those are under age 14 and almost 25% are under the age of 7), that Aboriginal women are more likely to be living in a social environment in which substance abuse and spousal violence are widespread, and that they are more likely to be incarcerated and are at a greater risk of being homicide victims.⁶³⁻⁶⁵ Even with these dismal data, it is still alarming that eight in ten Aboriginal

women in Ontario reported having personally experienced violence.^{66,67}

Browne and Fiske argue that "the colonial legacy of subordination of Aboriginal people has resulted in a multiple jeopardy for Aboriginal women who face individual and institutional discrimination, and disadvantages on the basis of race, gender and class."^{60,68,69} LaRocque, too, is explicit in locating the underlying cause of violence within colonization and its concomitant damage to the cultural, political, economic and kinship systems of Aboriginal America. She moves one step further, however, in her piercing analysis of the effects of violence on Aboriginal women, stating that racism coupled with sexism leaves Aboriginal women in a highly vulnerable position vis à vis the wider society. This is exacerbated within communities when racism and sexism are internalized by Aboriginal people themselves. Internalization occurs when a colonized group begins to judge itself by the stan-

dards of the colonizing society, swallowing externally imposed negative valuations.⁷⁰ While many Aboriginal people today are far less inclined to judge themselves by these negative standards, LaRocque argues that internalization still exists and remains part of the problem of family and sexual violence. In addition, in small communities victims of violent and/or sexual assaults face further obstacles, including lack of privacy, humiliation through community gossip and fear of being ostracized and intimidated. Victims may also be confronted with disbelief, anger or denial by other family members. If the victim, most often a woman, chooses to go outside of the community, her claims may not be taken seriously or she may be viewed with indifference or disbelief. Yet LaRocque's solution is not just a turn to strong cultural or political re-assertion. "Political oppression," says LaRocque, "does not preclude the mandate to live with personal and moral responsibility within human communities."⁷¹ She calls for social, cultural and economic revitalization as crucial elements of change, but in concert with a strong, realistic and multi-level approach to youth development as the best and most effective defence against the perpetuation of sexual violence.⁷¹

Suicide

One wonders if the same approach might quell the disturbingly high rate of suicide in Aboriginal youth and young adults. In 1999, suicide accounted for 38% of all deaths in youth aged 10-19 and for 23% of all deaths in those aged 20-44. The total First Nations suicide rate in 1999 was – at 27.9 deaths per 100,000 – 2.1 times the Canadian populations' suicide rate.³⁷ Suicide is, bluntly put, the clearest indicator of the severity of social disruption in Aboriginal Canada and the rates are shockingly high by any standard. These suicides are the end result of a toxic mix of poverty, powerlessness, depression and, increasingly, young age^{72,73} and each individual suicide simultaneously attests to and hastens further community chaos. The crisis of suicide is set in motion by a series of factors including everything from the immediacy of abuse to the lack of services and local economic, social or cultural resources. Indeed, as Kral^{74,75} and Samson³³ both explore in rich ethnographic detail, a long

prior history of inequity combined with rapid and growing social and cultural changes, a lack of any political clout, a paucity of economic and social resources, and no apparent end to these inequities are leading to highly traumatic outcomes.

In one study, conducted in 1992, researchers found that of 100 Inuit youth (14-25 years of age) residing in a community on the Hudson Bay coast in Northern Québec, 34 reported a past suicide attempt and 20 had attempted suicide more than once. A full 43 of the 100 reported past thoughts of suicide (26 in the month before the survey) and over 40 had friends who had attempted or completed suicide in the past. The strongest risk factors for suicide attempts were male gender (although the number of young women attempting or completing suicide is on the rise), having a friend who had attempted suicide, experience of physical abuse, a history of solvent abuse, and having a parent with an alcohol or drug problem.⁷⁶

Compounding these stressors may be additional factors such as disorganized band administrations (patterned on the bureaucratic density of Department of Indian Affairs and Northern Development), the limitations on an individual's mobility either from or to a remote community, inadequate family and child services that are replete with jurisdictional disputes between prevention and protection services, and the absence of appropriate counseling.⁷³ And so, while the rate of suicide or suicide attempts continue to increase – and especially so among younger men and women – there remains a paucity of locally meaningful or effective intervention strategies.^{61,77}

Chronic and Infectious Disease Profile

It is widely accepted that the pre-contact period was not so much a halcyon time in terms of a disease-free state but rather a balance of functional health and an "ability to cope with challenges of the environment" including cyclical famines, parasitic infections, accidents and disease.³ The disease profile shifted, however, when Aboriginal populations – at times already compromised by famine – were in greater contact with Europeans and exposed for the first time to a series of deadly infections. Smallpox, measles, whooping cough, scarlet fever and influenza were among

those infectious diseases to take an incalculably high toll on the early contact populations.³ With the implementation of the reserve system and residential schooling in the early part of the twentieth century, infectious diseases such as tuberculosis plagued Aboriginal populations, especially those already compromised by inadequate reserve housing, poor sanitation and water, and limited food supplies.

While Aboriginal populations still have higher rates of infectious disease, chronic diseases such as diabetes and cancer are now taking a high toll on indigenous peoples. For example, NIDDM (non-insulin-dependent diabetes mellitus) was once unknown to Aboriginal populations. Over the last 25 years, this chronic disease has grown to become a major health concern of Aboriginal peoples around the world. Here in Canada, the prevalence of NIDDM in First Nations, Inuit and Métis peoples is between three to five times the national average, with rates higher in women and highest among those living on-reserve. The data also reveal that First Nations people develop NIDDM at a younger age and by the time they reach their 30s, 5% of First Nations people have developed the disease. The rate increases rapidly with age. The 1997 Regional Health Survey revealed that one third of those over 65 had been diagnosed with NIDDM.⁷⁸ Further, Aboriginal people with NIDDM tend to develop complications at a younger age than non-Aboriginal Canadians. Given these statistics, NIDDM has, not surprisingly, become a significant health funding and research priority for the Aboriginal leadership in Canada. The high prevalence of NIDDM has also had unanticipated positive outcomes as well. Stimulated by an attempt to reverse the trend, local research and community health initiatives in one Quebec Mohawk community have turned into some of the most innovative, inclusive, empowering – and emulated – public health projects and research protocols to date (see, for example, the Kahnawake School Diabetes Prevention Project⁷⁹).

Infectious diseases, while not as ubiquitous as in the early part of the last century, continue to impinge on First Nations communities in disproportionate numbers when compared to the rest of Canada. In 1999,

for example, the prevalence of tuberculosis was 8 to 10 times higher in First Nations than among non-Aboriginal Canadians. While the rate that year was due in part to large outbreaks in several regions (with just over 40% of the total cases occurring in 5 communities) infectious diseases occur disproportionately in First Nations communities.³⁷ For example, pertussis rates were three times the Canadian national rate in 1999, hepatitis rates were five times the national rate and chlamydia rates were just over five times the national rate.³⁷ One other infectious disease is noteworthy, given that it is highly preventable yet occurs at 19.3 times the national rate and was found to occur in one province in particular at 29 times the provincial rate: shigellosis is a bacterial infection that is the direct result of poor water quality, inadequate sewage disposal and, indirectly, poverty. As Rosenberg, Kendall and Blanchard⁸⁰ found in Manitoba, household crowding, poor access to clean water, and inadequate sewage disposal were significantly associated with increased incidence of shigellosis on reserves. Unsatisfactory – and unacceptable – living conditions, simply put, make people sick.

HIV/AIDS

In the last decade, the proportion of Canada's total HIV/AIDS cases contracted by Aboriginal people has risen sharply: from 1.0% in 1990 to 7.2% in 2001. The increase has been so dramatic that the Executive Director of the Canadian Aboriginal AIDS Network refers to it as an "epidemic".⁸¹ As in other communities and like many other health issues, HIV/AIDS is a problem of poverty, of under- and unemployment, unstable housing, homelessness, sexual/physical abuse and a concomitant lack of self-worth. HIV/AIDS is also a problem of injection drug use and all its attendant effects. A study sponsored by the Montreal Native Friendship Centre repeats the unsettling refrain that "unless [these] root causes of high risk behaviour are addressed...no amount of HIV/AIDS prevention will be effective."⁸¹ The same study found that when Aboriginal people test positive for HIV infection, they often do not access the available services: "As a consequence of multiple stigmas associated with HIV and AIDS, both within the Aboriginal and non-Aboriginal communi-

ties, most Aboriginal people living with HIV/AIDS prefer to remain invisible, silent and anonymous. Many aboriginal people [will] not seek out care, support or urgent treatment upon HIV diagnosis, but rather [do so] at later stages of the disease." The Montreal study indicates that service providers do not know enough about the "lived experience, needs, perspectives, cultures and traditions of First Nations, Inuit and Métis clients" and that there are significant barriers to establishing a trust-based relationship between service providers and HIV/AIDS clients. Here, like with other Aboriginal health-care concerns, there are cultural, linguistic and structural barriers, conflicting expectations and experiences about medical service delivery, financial and non-insured health benefits, or a lack of knowledge about existing services. A national Aboriginal AIDS strategy has been developed to begin to chip away at some of these barriers and is being linked to ongoing provincial urban strategies and community-based initiatives.⁸¹ While strategies like these deserve and require effective and long-term support, the underlying causes of HIV/AIDS (and drug dependency), including under- and unemployment, inadequate housing and abuse, must also be effectively resolved.

The institutionalization of inequity – Services and programs

Health-care services and provision have improved considerably since Aboriginal Canadians came into contact both with non-Aboriginal diseases and biomedicine. The earliest form of biomedical health care arrived in many communities with missionaries, who often saw the opportunity to heal a body as an investment in saving a soul. Nonetheless, the missionaries did provide rudimentary health service prior to any other medical attention to Aboriginal peoples in Canada.¹³ While some (meager) form of health-care services was federally instituted at the beginning of the 1900s, it was not until after World War II that health and social services were systematically provided to Aboriginal peoples, and this in part because of concerns regarding questions of the health and safety of non-Native population.^{3,82} Guided perhaps more by the need for a visible presence in the North and northern border security than by genuine concern for Aboriginal

peoples (as wards of the state), health and social services extended into the farthest reaches of northern Canada through the Cold War period. Hodgson⁸² describes the treatment for tuberculosis throughout the 1950s, for example, as interventions that showed only the most rudimentary concern for individual or community well-being. Anyone testing positive for the disease was physically removed from the reserve or residential school to a sanatorium far away from home. Hodgson explains that the government's priorities in caring for Aboriginal peoples with tuberculosis have been perceived as paternalistic, unnecessary, undesirable, and latently hostile, especially when removing people from their home community to southern, and wholly foreign, sanatoria. Treatment, says Hodgson, was imposed upon the people with little attention to the participation or needs of the recipient population who had little or no control over the quality or quantity of their medical care. The long-term effects of the disruption to family life from the long-term removal of family members had a profound impact across the country. To this day, for many Aboriginal peoples, there is a lingering fear of institutions that can be traced directly back to the insensitive treatment of those with tuberculosis.

To be sure, much has changed since initial contact with "western" diseases and biomedical practices and there have been many improvements in health-care services and delivery to Aboriginal peoples throughout Canada. Services alone, however, do not ensure health and what services are available remain largely inadequate and underestimate the link between the local control of health services and practices, meanings of health, and health disparities.

Health-care services are still provided to Aboriginal peoples living on-reserve or in remote communities through the federal government. Those services, a treaty-based federal responsibility, have been a struggle to maintain, regardless of their adequacy or sufficiency. While First Nations have requested an autonomous locally accountable system of health-care provision, the government does not admit that health is an Aboriginal or treaty right. An exception to this rule is if self-government in health care has been negotiated as part of a treaty

settlement, as in the case of the James Bay Cree of Québec; through this agreement, the Cree Regional Board of Health and Social Services took over the management of the health and social services needs of the Québec Cree. Outside of that kind of exception, the federal government only acknowledges a “special relationship” between the federal government and First Nations and, since 1989, has been instituting a Health Transfer Policy.

Initiated in 1974 as the “Indian Health Policy”, the current Health Transfer Policy emerges out of the federal government’s desire to integrate Aboriginal health care into the larger national health-care system. From the period of the late 1960s, when there was a federal push towards devolution of all “special services” first to provinces and then to Aboriginal peoples, to the 1989 government approval of the Health Transfer Policy to First Nations communities, representatives of the First Nations have fought to retain as much autonomy in health care delivery as possible, given the constraints inherent in the negotiation process.

The First Nations and Inuit Health Branch (FNIHB) of Health Canada, with regional offices in every province, supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It also provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence. Included within the FNIHB are the community programme directorate (which includes the children and youth division, mental health and addictions division, chronic disease prevention division, and other programs related to, for example, obesity and fitness, cancer, and cardiovascular disease), primary health care and public health directorate (which includes the divisions of primary health care, infectious disease control, environmental health, environmental research, and dental and pharmacy programs), non-insured health benefits directorate, the office of nursing services, the office of community medicine, the business planning and management directorate, the strategic policy, planning and analysis directorate, and the chief executive advisor of First Nations and Inuit relations. In addition, the Northern Secretariat was created in Fall 1998 to provide equitable program delivery to the First

Nations and Inuit living in the Yukon, the Northwest Territories and Nunavut (see for example: www.hc-sc.gc.ca/fnihb/, www.hc-sc.gc.ca/ns). The National Aboriginal Health Organization has a comprehensive review of Aboriginal health-related initiatives⁸³).

The Health Transfer Policy certainly does “achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves” and does acknowledge a “special relationship” between First Nations and the federal government. It does not, however, recognize health as an Aboriginal treaty right and hence summarily removes it from the realm of treaty negotiations.⁸⁴ This, fundamentally, is the fatal flaw of the Health Transfer Policy: while it transfers a range of services (including medical and hospital insurance, public health, and non-insured services such as drug and eyeglass prescriptions and dental care), it retains and reproduces the pre-existing dependent relationship. Thus, for example, First Nations proposals for community health plans must be approved by the federal government, there is a “non-enrichment” clause, which freezes funding from the time of transfer (and is calculated according to the number of registered members living on-reserve at the time of transfer); as well, the Transfer Policy does not formally recognize the role of traditional healers in the transfer agreement nor does it fund the training of First Nations health-care professionals.^{83,85} Ultimately, says Speck, the position taken by First Nations is that, “in the absence of recognition of title and treaty rights, control over economic resources, political autonomy, improved standards of living and changes in the attitudes of non-Native Canadians towards First Nations, health care services alone are unlikely to result in significant improvements in the health status within First Nations.”^{30,83,86}

First Nations, Inuit and Métis living in urban centres find themselves excluded from many of the services and benefits that arise from the FNIHB. Aboriginal people moving into or living in urban centres face a range of different health care provision challenges as they ostensibly exit their community’s health networks and enter into the provincially-funded public health care system. While those living on-

reserve have been, to be sure, “studied to death”, the health status of those living off-reserve remains to a large extent ignored.⁸⁷ As Goldenberg further summarizes: “Just as most demographic data are difficult to obtain for urban Natives, their health information is often inaccurate, inaccessible, or otherwise buried within the health information of the larger non-Aboriginal population or of the on-reserve Aboriginal population.... The lack of accurate information is compounded by a lack of political will, since the federal government mostly concerns itself with the [statistically and organizationally relevant] health needs and patterns of Indian people on reserve”.⁸⁸ Thus, while there are various successful, culturally-appropriate urban initiatives across urban Canada (such as Anishnabe Health in Toronto), there remains the problem of inadequate assessments of health-care needs, formidable barriers to timely and appropriate care, and scarce resources to offer appropriate services to the urban – and particularly the poor – Aboriginal women, men and children.²³ For example, Benoit found that Aboriginal women living in the downtown eastside of Vancouver, “expressed a strong desire for a ‘Healing Place’, where health concerns could be addressed in an integrated manner, where they [could be] respected and given the opportunity to shape and influence decision-making about services that impact their own healing.”^{89,90}

SUMMARY AND RECOMMENDATIONS FOR FUTURE POLICY AND RESEARCH

The theme repeated time and again in so many of the studies and reports reviewed here is this: those who are the poorest and the most disempowered are the sickest and the least likely to be able to change or remove themselves from their immediate circumstances. Referred to as an “endless circle of disadvantage”, too many Aboriginal people in Canada are caught in a seemingly never-ending cycle of poverty, violence, educational failure and ill health.⁵⁵ How far must we look and how deep must we dig in order to come to some understanding of these disparities? The context of this inequality emerges with and through a distress-

ing legacy of colonialism and is sustained by ineffective, inappropriate or under-funded programs or services for First Nations peoples in Canada. Thus, it is firmly believed that the ills and illnesses that have been reported here must be seen, at least in part, as the direct and indirect present-day symptoms of a history of loss of lands and autonomy and the results of the political, cultural, economic and social disenfranchisement that ensued.

The path towards a reduction in disparities in First Nations, Métis and Inuit health status is ultimately linked to a larger political will and attendant policy framework that will effectively acknowledge the relationship between inequality and ill-health. A fundamental first step towards the resolution of these disparities begins with an understanding that “[a]ny approach which fails to consider Aboriginal people as active in response to their colonial situation, rather than simply as passive victims, will fail to comprehend not only the past changes in health status and health care, but more importantly the future direction that will be taken in these areas”.⁴ Steps in that direction are now being taken at the community, regional and national levels and offer a good degree of optimism in among the persistent experience of disease, distress and social suffering for far too many Aboriginal peoples in Canada. The initiatives of, for example, the National Aboriginal Health Organization (NAHO), the National Native Alcohol and Drug Abuse Program, the First Nations Chiefs’ Health Committee of British Columbia, the Manitoba First Nations Centre for Aboriginal Health Research, the National Indian and Inuit Community Health Representatives Organization, the Aboriginal Healing Foundation (a direct but time-limited response to the RCAP and acknowledgement of the suffering incurred in residential schools), the Kahnawake School Diabetes Prevention Project,⁷⁹ the Native Mental Health Association, as well as the many local community- and nation-based initiatives and the CIHR Institute of Aboriginal Peoples’ Health (IAPH), all clearly resonate with promise of a better future for the health of Aboriginal peoples in Canada. Gaps still remain, however, in

both the researching and implementation of health initiatives for Aboriginal peoples in Canada. The most significant problem is the lack of control of a comprehensive health-care program. While there are many initiatives being created by and for the First Nations of Canada, there is inadequate control of the resources so that efforts can be stymied or ineffectively funded as a result of the bureaucratic maze of Aboriginal health-care management and policy in Canada.

In addition to this lack of control there remains a paucity of research that is inclusive, engaged and empowering. There is, appropriately, a growing call for “decolonizing methodologies” in Aboriginal research and program initiatives that engage in meaningful dialogue with communities, establish priorities and conduct research that is successfully collaborative.⁹¹ Dion Stout continues to call for research methods that are “just, sustainable and inclusive” as a crucial element in research that is as empowering as it is productive.^{65,92} For example, in syntheses such as this one, we assign greater authority to statistics than to case studies and the voices of individuals. Yet statistical data alone reduce individuals to subsets of specific populations and effectively is a methodology that can further colonize peoples into abstract entities. To be sure, there are many good uses for these data as they can expose inequalities in health and health care. Statistical data alone, however, only tell us the degree of health disparity and not enough about the causes and extent of the felt effects. What we now need are research initiatives that will lead toward a clearer understanding of – and emergence from – these disparities. That research must be conducted in concert with the needs and aspirations of First Nations, Inuit and Métis men and women.^{30,32,93} Organizations such as NAHO and research institutes such as the IAPH, committed to the overall health, well-being and empowerment of Aboriginal people across Canada through, in part, the advancement and sharing of Aboriginal health knowledge, are making tremendous headway in the shift towards equitable, empowering, culturally appropriate, inclusive and accessible high-quality research.^{30,94,95}

We must further be able to envision studies that examine differences within and between age groups, genders, levels

of socio-economic status, education, and other significant markers of both identity and inequity. Studies of “health” must be interpreted broadly enough to navigate the terrain between individuals and communities and include studies of housing, water, education, development and resource extraction in addition to the different social and cultural valuations of health and empowerment. We cannot presume an unchanged, single or uniform “Aboriginal” culture, whether people are of First Nation, Inuit or Métis heritage as culture can never be reduced to a variable in a contemporary world of urban Native artists, traditionalists, or poverty-weary young mothers. At the same time, though, we must remain cognizant of the very real cultural and social barriers that may exist between First Nations, Inuit and Métis individuals and health-service providers in communities and urban centres. It is only in this way that we will understand and be able to effectively reduce both the inequities and the disparities of health. Research and policy needs must, fundamentally, reflect the contemporary realities of Aboriginal health and well-being, including the individual and community-based effects of health disparities (including violence, suicide, HIV/AIDS and diabetes) and examine the contribution of direct (e.g., housing, education, employment, and adequate and appropriate health services) and indirect (e.g., colonization, racism) sources of those disparities.

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RÉSUMÉ

Les disparités sur le plan de la santé sont, d'abord et avant tout, les indicateurs d'un fardeau de maladie relatif disproportionné imposé à une population particulière. Les inégalités en matière de santé font ressortir les causes principales des disparités, dont un grand nombre – sinon la plupart – dépassent largement le domaine habituel que constitue la « santé ». Plus particulièrement, la documentation examinée en vue de rédiger le document de synthèse indique que maintes et maintes fois, les disparités sur le plan de la santé résultent directement et indirectement des inégalités sociales, économiques, culturelles et politiques, dont le résultat final est d'imposer un fardeau disproportionné de mauvaise santé et de souffrances sociales aux populations autochtones du Canada. Dans les analyses de ces disparités, il est important d'explorer tout le champ des relations entre les individus et les contextes sociaux et historiques plus larges, tout comme il convient de prêter attention aux effets individuels des iniquités. La recherche et les politiques doivent se pencher sur les réalités contemporaines de la santé et du bien-être des Autochtones, dont les effets individuels et communautaires des disparités sur le plan de la santé et leurs causes directes et indirectes.