

# Aen manaachihitooyaahk daan la pitaal Respecting One Another in Healthcare

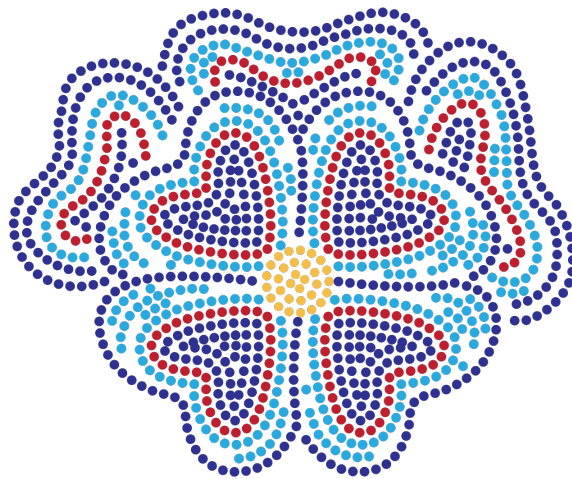


**Métis Approaches to Addressing  
Anti-Indigenous Racism in the Healthcare System:**  
A REVIEW OF MÉTIS RESOURCES AND NATIONAL PRIORITIES

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## Métis Approaches to Addressing Anti-Indigenous Racism in the Healthcare System: A REVIEW OF MÉTIS RESOURCES AND NATIONAL PRIORITIES

July 2024



### Cover art and in-text illustrations Addressing Anti-Indigenous Racism

When taking the time to imagine the art I am asked to create, I first think about the project's intention. For the Addressing Anti-Indigenous Racism report, I reflected on what addressing such a heavy topic like anti-Indigenous racism could look like. I thought about the cycle that creates the issue of anti-Indigenous racism. Some perpetuate the harm, those who experience it, and those who address it with the goal of action and change. I wanted to approach this project with honesty and humility. I used a young bison to represent our inner child. We are forever learning and unlearning the multifaceted layers of structural racism and the role we play within this system. However, learning and unlearning are a journey. It's okay not to know everything immediately; what is important is taking the journey. I put the young bison within a flower shape to show the opportunity for growth. The young bison within the flower and the MNC flower both sit on a sash, as if they are pins. I wanted to illustrate the sash as a symbol of the bravery one shows when facing anti-Indigenous racism. The sash also serves as a reminder not to shy away from being proud of our Métis culture and to remember the love found within community.

**Teagan Neufeld**

## Acknowledgements

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## Note on Representation

At the time this report was being developed, the Métis National Council's (MNC) Governing Members (GMs) comprised of the following Métis governments: Métis Nation-Saskatchewan (MN-S), Otipemisiwak Métis Government of the Métis Nation within Alberta (MNA), Métis Nation British Columbia (MNBC) and Métis Nation of Ontario (MNO). Engagements, contributions and language reflected in this report were informed by the perspectives and participation of these GMs during the drafting process.

## Translation

We respectfully acknowledge and deeply thank Michif Language Keeper, Reid Hala for the translated title in Heritage Michif.



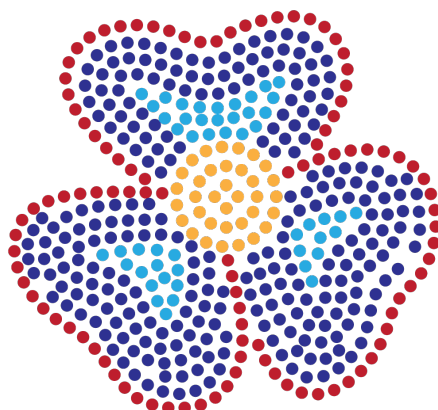
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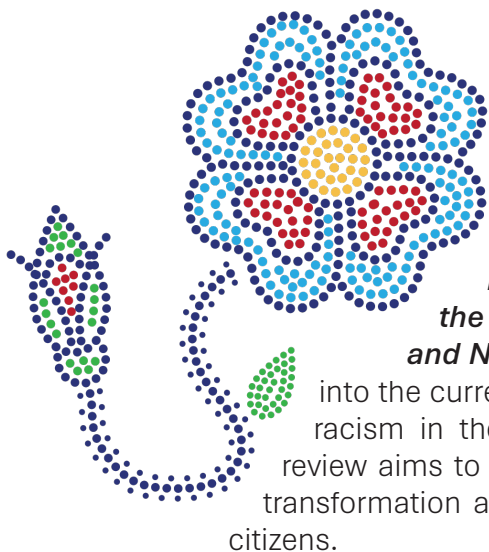
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## Introduction

### ***Métis Approaches to Addressing Anti-Indigenous Racism in the Healthcare System: A Review of Current Programs, Services, and National Priorities***

is the culmination of a five-month exploration into the current landscape of Métis-specific work to address anti-Indigenous racism in the healthcare system (AIR-HS) across the Métis Nation<sup>1</sup>. This review aims to support ongoing planning and advocacy for healthcare system transformation and Métis self-determination around the health needs of Métis citizens.

In September 2020, Joyce Echaquan, a First Nations woman, experienced fatal racist and discriminatory care while seeking critical medical treatment in a hospital outside of Montreal, Quebec. Joyce spent her last moments live-streaming the mistreatment she had received through public channels on social media. Following the tragic loss of Joyce Echaquan, and after public outcry, the Government of Canada publicly acknowledged the existence of systemic racism in Canada. Specifically, they highlighted it was embedded in the nature of Canada's health systems, with catastrophic effects for First Nations, Inuit, and Métis peoples (Native Women's Association of Canada, n.d.). The following summer of 2021, Indigenous Services Canada (ISC) and Health Canada announced \$126.7 million dollars in funding over three years to support efforts to respond to anti-Indigenous racism in health systems (AIR-HS) (Indigenous Services Canada [ISC], 2021). The AIR-HS funding program was divided to support efforts ranging from the development or expansion of culturally safe services, improving cultural and patient safety within health systems, additional Indigenous patient advocates, and undertaking meaningful engagement to develop policy and programs, including distinctions-based health legislation and participation in other national dialogues.

Under the Canada-Métis Nation Accord of 2017, Canada and MNC Governing Members<sup>2</sup> (GMs) are co-developing policies and programs to advance socio-economic development and self-determination for citizens of the Métis Nation. In accordance with this, the health of the Métis Nation has been identified as a joint commitment and key priority area. There are persistent disparities in health outcomes between Métis and non-Indigenous individuals (Statistics Canada, 2013). A primary source of disparity is anti-Indigenous racism targeted at Métis citizens in the mainstream healthcare system (Kitching et al., 2020; Loppie et al., 2014; Wylie & McConkey, 2019) information on their health is scarce. The objective of this study is to assess the association between experience of discrimination by healthcare providers and having unmet health needs within the Indigenous population of Toronto.

**METHODS:** The Our

<sup>1</sup> Distinct Métis communities developed along the routes of the fur trade and across the Northwest within the Métis Nation Homeland. This Homeland includes the Prairie provinces (Manitoba, Saskatchewan, Alberta), as well as parts of Ontario, British Columbia, the Northwest Territories, and the northern United States (MNC, n.d.a)

<sup>2</sup> The Governing Members are the democratically elected Métis governments in the provinces within the historic Métis homeland: Métis Nation-Saskatchewan, Métis Nation of Alberta, Métis Nation British Columbia and Métis Nation of Ontario. Collectively, they constitute the General Assembly of the Métis National Council and its Board of Governors

Health Counts Toronto (OHCT). Many Métis people have experienced discrimination and a lack of compassion or understanding from healthcare professionals, with consequent negative impacts to the health and well-being of Métis citizens (Métis National Council, 2022).

To advocate for fair and equal treatment of Métis people and their experiences within the healthcare system, the Métis National Council (MNC) and its Governing Members acquired approximately \$4.2 million dollars to address anti-Indigenous racism in the healthcare system (AIR-HS) from 2021-2023. Over the past several years, Governing Members of the MNC have developed diverse and innovative initiatives to address AIR-HS, with projects ranging from hiring Indigenous patient navigators or advocates, to resource creation, programming, and cultural supports for Métis citizens, among others.

To assess and understand the current landscape of Métis-specific approaches to addressing anti-Indigenous racism in the healthcare system, the Métis National Council contracted the Weaving Wellness Centre, a Métis-led private consulting and clinical practice, to complete the following project objectives from November 2023 to March 2024:

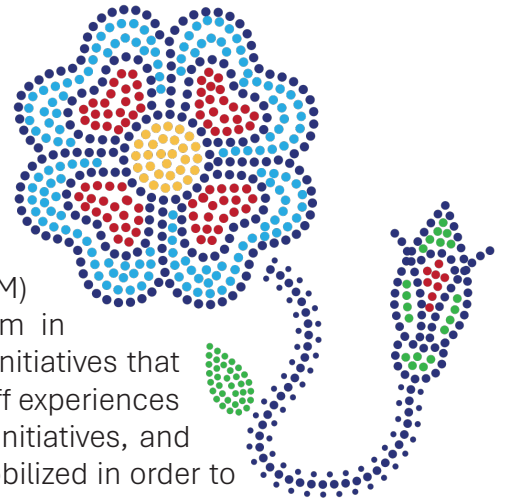
1. Review current resources, programs, and services developed by the Governing Members of the Métis National Council
2. Gather perspectives of key Métis Nation staff and stakeholders through engagement sessions and interviews
3. Summarize key findings in a final report

Based on the knowledge and experiences shared by the Métis National Council Governing Members, Métis Nation British Columbia (MNBC), Otipemisiwak Métis Government of the Métis Nation within Alberta (MNA), Métis Nation Saskatchewan (MN-S), and Métis Nation of Ontario (MNO), this report identifies:

1. Key successes and innovations in addressing anti-Indigenous racism in the healthcare system for Métis people
2. Current program and system gaps, challenges, and needs
3. National priorities and recommendations for further AIR-HS work

The Governing Members of the Métis National Council have worked arduously to create pathways of care for Métis individuals within mainstream healthcare systems and the programs and services offered by each Governing Member. Given the exemplary work done to date, and the aspirations of the Métis Nation moving forward, the perspectives summarized in this report will help inform next steps and ongoing work surrounding the healthcare needs of Métis citizens.

## Executive Summary



This report presents an overview of the Governing Members' (GM) efforts in preventing and responding to anti-Indigenous racism in health systems (AIR-HS). It provides a summary of the specific initiatives that were developed with allotted federal funding, followed by GM staff experiences in administering the funding, stories of success, the impact of initiatives, and concludes with an overview of gaps and efforts that must be mobilized in order to create a safer and equitable healthcare system.

Racism is a social determinant of health for Métis people (MNC, 2022a). Due to colonialism and ongoing systemic racism, Métis people continue to face disproportionate rates of illness (Loppie et al., 2014.; Wylie & McConkey, 2019). Further to that, racism within the healthcare system is evidenced by both micro interactions that Métis people have with healthcare providers, as well as macro level interactions in the form of systemic underfunding and the under-delivery of services and care for Métis people. When Métis people need to access care, they must often leave their home communities, travel far distances, and all too frequently encounter racism and discrimination while trying to address their health needs.

The GMs have developed a range of AIR-HS initiatives and programming that directly respond to Métis citizens' experiences and needs. Many of the initiatives entail creating accessible connections to GM program staff to support citizens when accessing care, training for non-Indigenous health staff and organizations, developing resources and supports for the AIR-HS complaints processes, information and toolkits to support citizens navigating the healthcare system, policy and systems advocacy, and research on Métis health and experiences of AIR-HS.

These initiatives have resulted in positive impacts throughout the Métis Nation and beyond. Citizens feel heard and supported, with increased knowledge and tools to advocate for themselves. Important conversations are being had with healthcare providers and governments to improve clinical practice. The GMs have raised the profile of Métis people and continue to push for their inclusion at important decision-making and governance tables to promote Métis health and wellness.

While the provided AIR-HS funding was instrumental to the creation of programming, the nature of the funding parameters and administration presented to be a key challenge for GMs. Given the short-term timing of the funding, delayed distribution of the funds, limited scope of eligible expenditures, the amount of funding provided and uncertainty around future funding, GMs have been under immense pressure to make meaningful, and measurable, impacts as they aspired to create systems level change within a truncated timeframe.

Resounding agreement was voiced by GMs around the need for the continuation of the AIR-HS funding to continue working toward system transformation. Additional funding is needed for more supports to address the needs of distinct Métis populations, such as Elders, youth and 2SLGBTQQIA+ peoples, as well as Métis healthcare providers and staff who experience AIR-HS in very unique ways. Key recommendations and priorities for AIR-HS work include:

### **1. Program needs:**

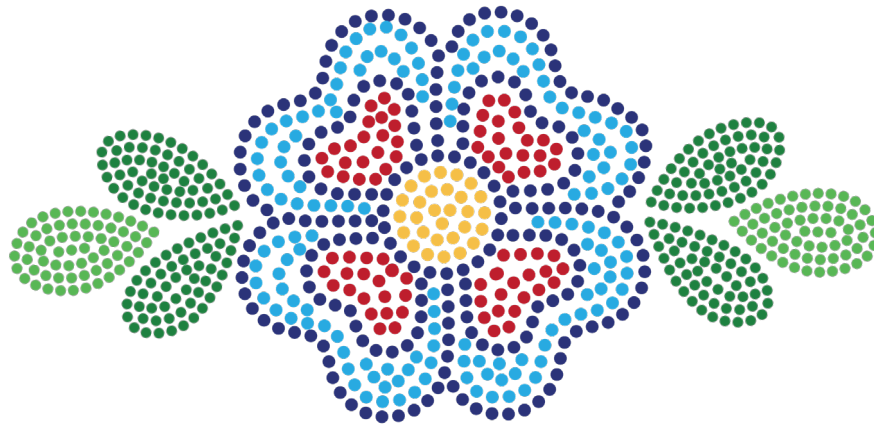
- a. Hiring more patient support workers to have one staff in each Métis Chartered Community or health region.
- b. Investing in supports for Métis healthcare providers and staff, including a mentorship program, lateral violence toolkit, and a worker peer support group.
- c. Resource development, including toolkits on specific health topics and treatments, practitioner guides for culturally safe care when working with Métis patients.
- d. Investing in data infrastructure and governance to support program evaluation and Métis health research, led by the Métis Nation.

### **2. System needs:**

- a. Guaranteed, long-term, sustainable funding.
- b. Accountability mechanisms for the inclusion and consultation with the Métis Nation and Governing Members in healthcare decision making.
- c. Integrate Métis-specific cultural safety training into standard clinical training with evaluative performance measures integrated to assess healthcare practitioners' knowledge and practice.

Within the engagement sessions, all GMs expressed high motivation, desire, capability, and readiness to implement all the described recommendations and needs. However, adequate and sustainable funding is required to continue to build upon the early outcomes and gains of the AIR-HS funding initially provided. The AIR-HS funding and initiatives have made significant progress and impact in improving healthcare services and promoting the health and wellness of Métis citizens.





## **Anti-Indigenous Racism in Healthcare Systems: LITERATURE REVIEW**

### ***Métis Health Status***

The Métis Nation is one of the three federally recognized Indigenous peoples of Canada. The Métis make up roughly one-third of the Indigenous population and two percent of the entire population of Canada. Despite this, Métis people, and Métis people's health, have been largely overlooked. Much of the data and research available either focuses primarily on First Nations people or places Métis into a homogenous group, virtually excluding or erasing them from health research (Anderson, 2016; Bourassa, 2008; Gmitroski et al., 2023; Jones et al., 2020; Kitching et al., 2020). However, the limited evidence that does exist suggests that Métis people experience a disproportionate burden of illness and poorer health outcomes. These poor health outcomes are rooted in past and present trauma, marginalization, stigma, and discrimination resulting from racist and colonial policies and practices (Browne et al., 2016; Loppie et al., 2014).

In 2017, the Métis National Council and the Government of Canada signed the Canada-Métis Nation Accord (Crown Indigenous Relations and Northern Affairs Canada, 2024). This was a critical step in Canada's recognition of the Métis Nation's right to self-governance, transforming Nation to Nation relations. In 2021, Indigenous Services Canada and the Métis National Council also signed a memorandum of understanding (MOU) to develop distinctions-based health legislation, which further served as a commitment to work together to establish principles that would guide the transformation and evaluation of healthcare systems to improve the health of Métis people. This was followed by the 2022 MOU between the Government of Canada and Métis National Council to develop a Métis health sub-accord to further support healthcare system transformation and improving health outcomes (MNC, 2022b). While the federal government has taken meaningful first steps toward acknowledging the Métis Nation's right to self-determination, the Métis Nation continues to lobby for the federal government's fiduciary obligation to be fully recognized and fulfilled (Les Femmes Michif Otipemisiwak, 2019). This is further echoed in the MNC's Métis Vision for Health, where "predictable and sustainable multi-year funding is essential" (MNC, 2022a, p.15). Additionally, both MOU's have since expired, with little to no progress or change. The current lack of predictable and sustainable funding and legislative recognition of the Métis Nation translates into tangible disparities as Métis people continue to be excluded from programs and services that address Indigenous health disparities. In addition, the ongoing lack of funding further impedes GMs' ability to participate in system transformation and health governance, such as sitting on AIR-HS committees or participating in

legislative processes. Without adequate support, Métis people remain at higher risk for negative health outcomes and further health disparities (Allan & Smylie, 2015). The 2021 United Nations Declarations Act (UNDA), followed by the 2023 UNDA Action Plan, are further promising tools and strategies supporting the work of the Métis Nation, as the Government of Canada is now legally obligated to “take all measures necessary in consultation and cooperation with First Nations, Inuit, and Métis to ensure all laws are consistent with the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) (MNC, n.d.b).

### ***AIR-HS in Canada***

Anti-Indigenous racism in the healthcare system occurs both at the micro and macro level – through racist interactions with healthcare providers, and ongoing colonial policies and practices within the healthcare system itself. Reports including but not limited to the Royal Commission on Aboriginal Peoples (1996), Out of Sight (2008), the Truth and Reconciliation Commission Final Report (2015), United Nations of the Special Rapporteur on the Rights of Indigenous Peoples (2014), National Inquiry into Missing and Murdered Indigenous Women, Girls, and 2SLGBTQIA (2019), Viens Commission (2019), and the In Plain Sight (2020) report, have all widely documented the evidence of anti-Indigenous racism within Canada’s health system for Indigenous peoples. In addition, at the MNC’s National Métis Health Forum (2022), Chief Public Health Officer (CHPO) of Canada, Dr. Theresea Tam stated “Canada must collaborate with [Métis] communities to incorporate Indigenous ways of knowing” to address health inequities.

At the micro level, Indigenous peoples report experiencing a wide range of negative interactions with healthcare providers. They commonly report experiencing longer wait times compared to non-Indigenous people in emergency departments and walk-in clinics, more frequent experiences of being turned away from care, and being under-referred to specialized services (Graham et al., 2023; Loppie et al., 2014.; Turpel-Lafond, 2020). When an Indigenous person’s health needs are assessed, Indigenous people report experiencing a lower quality of care. This includes reports of healthcare providers minimizing Indigenous peoples concerns, demonstrating a cold demeanour including negative body language and/or non-verbal communication, providing ‘rough care’, and sometimes directly using racial slurs toward the person (Kitching et al., 2020; Turpel-Lafond, 2020). Due to racialized stereotypes of Indigenous people being drug seeking, Indigenous people also report being denied pain medication for symptom management (Browne et al., 2016). Some evidence also suggests that due to provider racism and discrimination, more medical mistakes have been made, such as misdiagnosis of illnesses (Turpel-Lafond, 2020). At an organizational level, policies and routine practices such as forced sterilization and birth alerts, have harmed Indigenous women and children based on racist beliefs of Indigenous women and families (Allan & Smylie, 2015). AIR-HS is further embedded in legislation that creates unique jurisdictional challenges and barriers for Indigenous people. This includes less access to services through the geographic isolation of Indigenous communities, under-funding of programs and services, and restrictions associated with non-insured health benefits (NIHB), such as the exclusion of Métis people (Allan & Smylie, 2015).

## ***Métis-Specific Experiences of AIR-HS***

While there is a growing movement around cultural safety training for healthcare providers and culturally safe services, the inclusion of Métis specific content and understandings of cultural safety for Métis people has not been well-implemented within the healthcare system. As Smylie et al., (2009) stated, Métis people “find themselves caught betwixt and between, First Nations and mainstream services” (p. 35), with a clear gap around the provision of Métis specific healthcare services. Whether a Métis person is visibly Indigenous or “white-passing”, many reportedly do not identify as Métis because providers frequently “have no idea what to do with [Métis identity]” (Monchalin et al., 2020, p. 254). At times, non-Indigenous and Indigenous staff question Métis identity, with other providers not understanding the unique history or context of Métis people, and others commonly referring to Indigenous services and resources that are inaccessible to Métis people (e.g., NIHB, First Nations healers) (Monchalin et al., 2020). When one is identifiably Métis, individuals still experience the direct and indirect forms of racism described above. When one is not identifiably Métis, or misclassified as non-Indigenous, researchers have documented that racist comments about Indigenous people have been shared by healthcare providers (Monchalin et al., 2020; Paul et al., 2023). Sometimes ‘white-passing Métis’ are even denied services that are otherwise available to Métis and Indigenous people under the presumption they are trying to take advantage of the healthcare system (Paul et al., 2023).

Many rural and remote Métis communities experience further inequitable gaps in healthcare services, with many Métis people required to travel to urban centres for care. Although this is a reality for many other First Nations, Inuit, and non-Indigenous people, Métis people must do so without the financial assistance that is provided to First Nations and Inuit through the federal NIHB medical transportation program (Allan & Smylie, 2015; Gmitroski et al., 2023). Additionally, while Métis may access more specialized health services in urban centers, they, akin to First Nations and Inuit, are at further risk of experiencing racism and not necessarily better care due to the denser concentration of non-Indigenous people in urban centers (Graham et al., 2023; Kitching et al., 2020; Lawrence et al., 2016).

Legislation continues to be inherently racist and anti-Métis. As previously mentioned, the fiduciary obligation the federal government has to Métis people continues to be unacknowledged and unfulfilled (Les Femmes Michif Otipemisiwak, 2019). Thus, there is no Métis-specific legislation with accompanying long-term investments into Métis health programs and services. The majority of other ‘pan-Indigenous’ programs or funding opportunities are primarily utilized by First Nations and continue to be inaccessible to the Métis Nation (Auger, 2019; Gmitroski et al., 2023; Monchalin et al., 2019; Smylie et al., 2009). As a result, the Métis Nation has inequitable access to funding for programs to address the specific needs of Métis people.

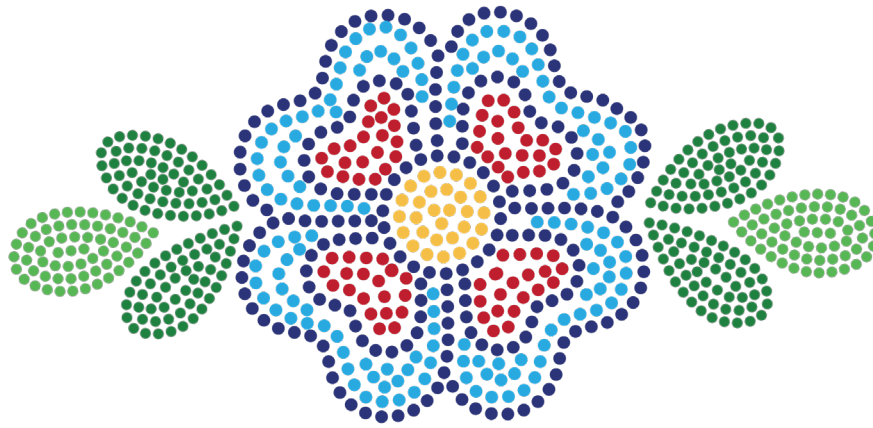
There is a paucity of research that has been conducted on Métis health, Métis traditional knowledge, and Métis ways of healing. Current health programming, services and healing centres are likely to be reflective of, and grounded within, First Nations culture (Auger, 2019; Monchalin et al., 2019). Métis knowledge, culture, and traditional ways of healing are often

excluded and de-legitimized in the current health system. As a result, many Métis people do not feel comfortable, or worse, unsafe, accessing such programs or services resulting in unmet healthcare needs.

In short, Métis people experience racism through healthcare provider interactions, limited opportunities for supports or culturally specific care, with less funding and resources for the Métis Nation to meet Métis people’s needs. Demonstrations of healthcare provider racism results in increased stress, trauma, social and emotional harm, and unmet needs of Métis people, all of which contribute to negative health outcomes in the long term (Gunn, 2008; Loppie et al., 2014.). In addition, such experiences may leave Métis individuals feeling fearful and avoidant of accessing healthcare altogether, contributing to compounding unmet needs and worsening health outcomes (Graham et al., 2023; Kitching et al., 2020). Moreover, avoidance of the healthcare system is a major contributor to the over-representation of Indigenous people in emergency departments, which further reinforces racist stereotypes and beliefs of First Nations, Inuit, and Métis ‘abusing the system’, thus increasing one’s chance of experiencing racism in healthcare settings (Browne et al., 2016; Dell et al., 2016). Presently, the healthcare system is deemed “culturally risky” and unsafe for Indigenous people (Loppie et al., 2014.).

Based on the growing literature, there is a clear need for structural changes to address AIR-HS. To address micro-level racism, the literature emphasizes the need for cultural safety training for healthcare providers (Kitching et al., 2020). There is also a strong call for better resourcing of the Métis Nation to lead their own work to respond to AIR-HS and Métis people’s needs (Allan & Smylie, 2015; Monchalain et al., 2019; Viens, 2019). This also includes Métis-specific health legislation and health funding to meet Métis social determinants of health to reduce illness, promote holistic health and wellness, and reduce opportunities for racism in healthcare settings. The MNC’s (2022) *Métis Vision for Health* report further illustrates the Métis Nation’s vision for health as including “Métis self-determined healthcare systems [where] Métis people are healthy, happy, resilient, grounded in their culture and language and thriving as individuals and as members of their Métis families and communities” (p. 2). The literature also suggests that adequate funding is needed to complete evaluations of AIR-HS work and initiatives, including cultural safety training, to ensure that such interventions are evidence-based and leading to improved healthcare user experiences and overarching health outcomes (Hardy et al., 2023; Smylie et al., 2024). In addition, accountability mechanisms such as culturally safe and accessible complaints processes are needed, in conjunction with Métis-specific health data, to effectively monitor progress in eliminating AIR-HS. Lastly, the Métis Nation must be supported so that participation at healthcare decision-making tables is achieved, with the ultimate aim centering on the Métis Nation’s self-determination around Métis health and healthcare needs (Turpel-Lafond, 2020).





## METHODOLOGY

This report aims to provide a high-level overview of how the MNC Governing Members used their AIR-HS funding, highlighting the key successes of initiatives, as well as the key challenges and ongoing needs with respect to AIR-HS.

This project consisted of the following phases:

- **Phase 1: Review of GM Resources** (November 2023 – February 2024)
- **Phase 2: Engagement with Métis Nation Staff and Stakeholders** (December 2023 – March 2024)
  - Session with GM Health Directors and key staff
  - Métis Nation British Columbia
  - Otipemisiwak Métis Government of the Métis Nation within Alberta
  - Métis Nation of Ontario
  - Métis Nation-Saskatchewan
- **Phase 3: Data Analysis** (February 2024 – March 2024)
- **Phase 4: Reporting Findings** (March 2024 – June 2024)
  - Draft resource review
  - Validation by Governing Members
  - Draft report
  - Validation by Governing Members and the MNC
- **Phase 5: Dissemination** (July 2024)
  - Presentation to the MNC and Federal Partners



## **Phase 1: Review of GM Resources (November 2023 – February 2024)**

This project was initiated with a request to the Governing Members for resources related to their respective AIR-HS initiatives. Resources included program descriptions, annual reports, examples of AIR-HS funded toolkits or guidebooks, videos, intake forms, and more were submitted by each GM. All the resources were reviewed by the project team and compiled in a master list. Additional resources were identified throughout engagement sessions and Governing Member websites. As information emerged and was made available regarding each resource, additional information was noted on the master list, such as the funding source of each resource, whether the resource was created in collaboration with external partners, and whether evaluation data was collected. Within this master list, all resources collected were coded based on resource form, including whether it was a source of information, a program for citizens, or the creation of a new staff role. Based on the materials collected and reviewed, a write up was produced for each Governing Member summarizing their AIR-HS funded initiatives, alongside additional initiatives related to AIR-HS that were funded by other sources. These reviews are included in Appendix A.

## **Phase 2: Engage Métis Nation Staff and Stakeholders (December 2023 – March 2024)**

To gather the insights and perspectives of Governing Members on the impact of their AIR-HS related work, engagement sessions were conducted virtually with staff from each Governing Member. Engagement sessions began with a roundtable session on December 1<sup>st</sup> with all the GM Health Directors, except for MNA due to scheduling conflicts. Each Health Director identified the staff best suited to participate in these sessions and included staff from the GM Health Departments or Ministries.

For each session, the following key research questions were asked to identify impact stories, needs and opportunities for AIR-HS work:

1. Please share 2-5 key successes in the application of AIR-HS funding
2. Is there an illustrative or powerful story of success that showcases how your AIR-HS funding and related work has had an impact?
3. What are the key challenges and gaps you have encountered in the application of your AIR-HS funding?
4. Is there any data (quantitative or qualitative) being collected to measure impact? (e.g., feedback from community members, access rates, monitoring, etc.)
5. Within these current projects, are there any areas of collaboration – with the province, regional health authority, hospital, or other partners – that you can highlight?
6. What are your GMs' remaining key needs regarding AIR-HS. Why should this program continue to be funded? Any key population needs or under-served areas of health? (e.g., women, birth, Elders, long-term care, etc.)
7. What is not currently being spoken to or addressed regarding AIR-HS?
8. Please share your recommendations for tools and resources to be created to address AIR-HS.

While most of the virtual sessions consisted of semi-structured dialogue with each group, additional tools such as a ‘jamboard’ were used to gather additional feedback in a written and conversational format.

### **Phase 3: Data Analysis (February 2024 – March 2024)**

Notes were taken by the project team during each engagement session. An MNC note taker also transcribed summary notes and key quotes from the recordings. After each session, the project team met to discuss and identify the key findings. All the notes were reviewed and thematically analyzed. Key notes and quotes were coded into a table organized by the themes of AIR-HS experiences, population needs, AIR-HS programs, services or resources, data, partners, success stories/impact, facilitators, challenges, AIR-HS program needs, AIR-plan/vision, and system needs. Further key findings and themes were then derived based on the coding table.

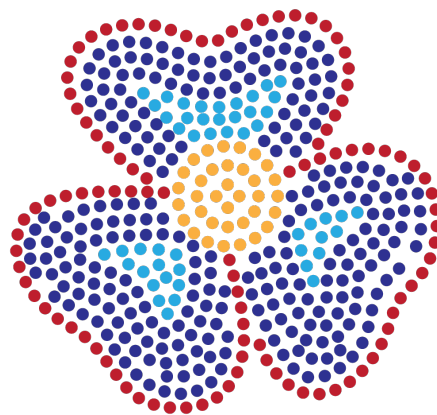
### **Phase 4: Reporting Findings (March 2024 – June 2024)**

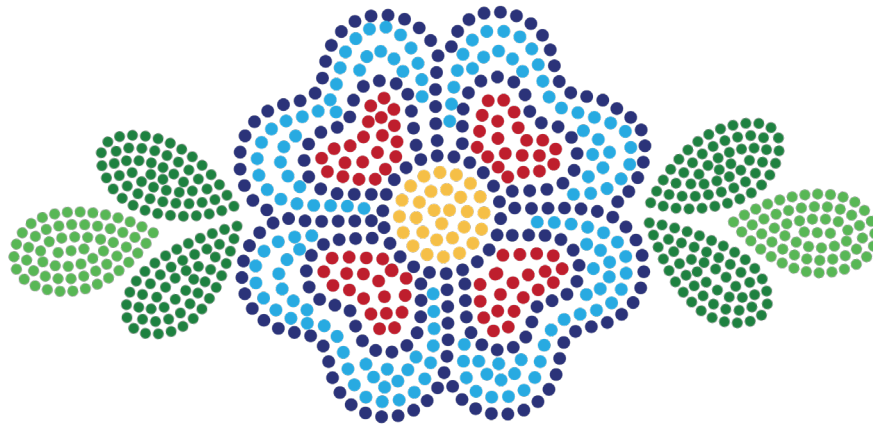
The project team reported the preliminary findings to the Governing Members during a MNC Technical Health Committee Meeting on February 5<sup>th</sup>, 2024. Feedback on the slides and preliminary findings was provided during the meeting and written feedback via email. This feedback was then integrated into the data analysis and report findings.

This summary report was prepared and presented to the MNC and the Governing Members for validation, and then revised into its final version. A summary presentation of the key findings has also been prepared and presented to the MNC and MNC’s Technical Health Committee.

### **Phase 5: Dissemination (June 2024 – July 2024)**

All project materials have been provided to the MNC for internal dissemination as they see fit. This includes the final report, resource review list, and powerpoint decks.





## RESULTS

In the following sections, key insights that arose from the engagement sessions will be presented. This includes a summary of how AIR-HS is experienced by Métis citizens and within Métis communities, a summary of the GMs' AIR-HS programs and initiatives and their impact on Métis citizens, and key challenges to implementing the AIR-HS funding program. This section ends with key recommendations, needs, and priorities as outlined by the GMs.

### **Métis Experiences of AIR-HS: Key Findings**

*“Racism is rampant in all areas, and we forget until we experience it ourselves”  
(MN-S, 2024).*

Even though the interview questions guiding the engagement sessions with the Governing Members did not include a specific question querying stories of anti-Indigenous racism among Métis citizens, illustrative examples and impactful stories were brought up in every session. It was necessary in every session to give space to GM staff to voice these stories, both to support the staff in their sharing, and to fully capture the need and impact of the AIR-HS work. Much of the experiences of AIR-HS described by the Governing Members ranged from direct experiences of verbal abuse by providers, misdiagnosis and judgemental treatment by practitioners, and the denial of care, resulting in further harm in spaces that were considered to be culturally safe. Rural and remote Métis communities further experience micro and macro-level AIR-HS through the underfunding and lack of healthcare infrastructure, as well as discriminatory interactions with rural providers. Finally, staff reflected on additional harm that was often experienced when attempts at reporting instances of anti-Indigenous racism occurred.

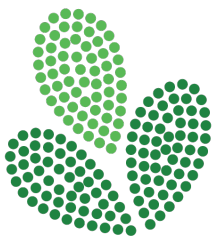
#### ***Misdiagnosis and Denial of Care***

Repeated stories of Métis people seeking healthcare, experiencing discrimination, and being denied care, were commonly shared by sharing circle participants. Some, particularly those who spoke with an accent, had a disability that delayed their speech, or were elderly, were often accused of ‘drug-seeking’. In some incidences, people were denied necessary pain medication or were never assessed or treated at all.

MN-S shared one story of the tragic, and preventable, death of one of their citizens that resulted from a provider assuming the individual was drug seeking in a local emergency department:

*“We had one of our citizens pass away at 46-years-old. It was a fellow complaining about pain in his leg. Some dialysis-related pain. He went to his doctor’s office, and his doctor sent him to the hospital, told him to go to the ER now. The doctor even provided a note detailing the man’s symptoms, concerns, and needs for assessment and treatment. The ER sent him away saying you are drug seeking, get lost. So, he goes home and then later that evening, dies. They figure it was a blood clot” (MN-S, 2024).*

Another story was shared by the MNO about a client who was repeatedly misdiagnosed as a result of a healthcare provider incorrectly assuming that she was not caring for herself properly:



*“A client who was 31 had gone to the emergency room with a lot of pain. She was female and Métis and was told it was a cracked rib, and simply to lose weight. She didn’t get better, went back again, they told her ‘no you pulled a muscle’. Finally, she said something was not right, she visited her mother down south, and then found out she had stage 4 ovarian cancer. The client came onto my case load because she didn’t know what to do, but she wanted to meet with the doctors to tell her story” (MNO, 2024).*

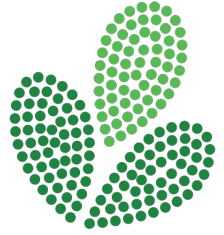
Both these stories are examples of the tragic and sometimes fatal impact that judgement and discrimination from providers and practitioners can result in for Métis citizens who are seeking care for critical health needs. There is a clear need for cultural safety training and accountability for providers and practitioners, as well as a strong need for advocacy supports, such as patient support workers, to support Métis citizens in accessing the care they need.

### **Healthcare System Harm**

In another incident, MNBC advocated for a Métis citizen named Naomie Gladue, to access necessary mental health and substance use recovery supports. While access to a private facility was obtained, Naomie experienced culturally unsafe and racist care, and as a result left the facility shortly after being admitted. The facility failed to notify Naomie’s family, care team, or MNBC about her withdrawal from the program. MNBC later discovered that Naomie had tragically died from a drug overdose within a short distance from the facility.

*“In October 2022, Naomie Gladue, a young Métis woman lost her life after seeking substance use recovery treatment. Naomie was determined to take these first steps in changing her life, in a way that was meaningful for her and with the*

*assistance of MNBC, attended a private treatment facility, as public beds were unavailable. After 10 days in treatment, Naomie died of an overdose at 22 years of age. Naomie was a vibrant, beautiful, fierce protector. Unfortunately, MNBC came to understand that Naomie had experienced culturally unsafe care and is seeking to share Naomie’s Story to advocate for safer care for Métis” (MNBC, 2024).*



MNA shared a story of a Métis woman who had experienced extreme physical intimate partner violence that required critical care and hospitalization. However, when the woman was in the hospital, the healthcare staff and police assumed she was drunk as a result of a speech impediment that was incurred from a significant brain injury. This woman was discharged from the hospital and placed into a transitional motel, only to experience repeated discrimination from victim services and the police, and shortly after, an arrest:

*“A woman’s partner abused her, and police assumed she was drunk because of the brain damage she experienced from a violent partner. When she dealt with victim services, they were very violent with her. She had to stay in a motel, and they arrested her because she didn’t want to testify, and she wanted to go back home to live with him” (MNA, 2024).*

GM patient advocates and navigators have helped protect Métis citizens from experiencing harm within healthcare settings. However, even when GM staff are present, providers may still demonstrate discriminatory care:

*“I am often requested to be there for and with a client and then the doctor will only talk to me. It is often disheartening. We finally built trust to support this client to see a doctor and then the doctor only talks to you, speaks to you in jargon, and the client is blank faced. I am not afraid because I won’t get fired but clients are afraid of being fired by their doctor” (MNO, 2024).*

Harm in healthcare spaces that are often deemed to be culturally safe can have a compounding impact on Métis people as a result of historical systems harms that have occurred within other systems (e.g., residential and day schools, forced sterilization). This has left many Métis people afraid to access healthcare:

*“I see it a lot in the healthcare system where people do not want to go see a doctor because of what their parents or grandparents have gone through ... The fear that they are not going to get treated well anyway, so why bother going” (MNO, 2024).*


Building relationships with citizens and healthcare providers to increase trust and safety for Métis people is of high value and a priority for the GMs. When AIR-HS still occurs, it causes

harm and jeopardizes the established relationship between citizens and GM staff. As MNA stated “you finally connect to folks and help them get support, and then they experience traumatizing care by the healthcare and justice system (police), and then they’re gone.” As a result, distrust of the healthcare system is further deepened with many Métis people electing to avoid accessing care entirely, which is an inherent right for all people. Other Métis folks who continue to engage with the healthcare system may become avoidant of asking questions about their care or diagnosis, or avoid advocating for themselves when needed, due to the fear of receiving more discriminatory care, being ‘fired’ by their providers, or being significantly harmed, including potential death.

### ***Inequitable Access to Care in Rural and Remote Communities***

According to the Governing Members, these direct experiences of AIR-HS are further amplified in rural and remote settings. As MN-S stated, “in rural hospitals they’re finding a lot of racial tension in the community and a large need for support.” These experiences of AIR-HS at a micro level are exacerbated by the systemic discrimination felt in rural communities. For those living in rural communities, Métis people have less access to critical care. MNA explained the additional strain felt by some of the staff who find themselves having to work in multiple roles to support Métis citizens in rural communities: “in rural areas you are 911, there is no one else, and when there is, they are not trusted by Métis citizens” (MNA, 2024).

Due to the lack of healthcare services available in rural communities, Governing Members such as MNA and MN-S repeatedly spoke of the additional gaps and challenges around supporting those needing to travel to urban centres to receive or continue critical medical treatment:



*“There are limited beds at rural health centers, so folks get sent to Edmonton and if folks have conditions like dialysis, they are basically told they have to move to Edmonton to continue receiving their treatment or stay with a death sentence. When they are sent to Edmonton, they do not receive any support navigating housing and such. There are no cultural, social, or emotional supports for them either” (MNA, 2024).*

It was conveyed that the decision to leave one’s home community for critical care is not made easily by Métis citizens and experiences of AIR-HS further complicate such transitions. As the literature suggested, and Governing Members further explained, travelling to an urban centre to access necessary care does not guarantee that a Métis citizen is any safer or healthier than if they were to access care in their home community. For many older Métis citizens, transitions to urban centres can be very challenging and distressing and are further worsened by racist and discriminatory providers and spaces.

## Challenges with Reporting AIR-HS

When incidences of AIR-HS do occur, Governing Members voiced challenges and concerns with reporting complaints. For one staff person from MN-S, it is often unclear whether their complaints are actually being reviewed or addressed by the healthcare institution:

*“I work frontline in the hospital and where do our complaints go to? For example, I complained about a nurse three times and I asked three times where does this information go? No response. How do we go back to our families who have complained about this, how do we address them and assist them with the health authority to let them know they have been heard and addressed? ... This elderly man put his coke on his counter and a nurse said make sure you pick up your cans here, this is not a reserve. His family came and found me and said we’d like to make a complaint. I made a complaint but where did it go? How are we going to address this? I’d like someone to be sitting at the table with someone looking at my complaint, and I’d prefer for them to be Indigenous” (MN-S, 2024).*



In another incident, one of MNO’s frontline staff worked with a Métis citizen to have her story of AIR-HS presented to her care team. While this was a courageous response from the citizen and staff, it was unclear whether her story was fully heard, or any meaningful action or change was implemented as a result:

*“The client came onto my case load because she didn’t know what to do but she wanted to meet with the doctors to tell her story. I supported her and sat at a table with about six males, we wrote out her story, we told her story from her first ER visit to the very end. It took a lot of strength to do. Some of the doctors were very understanding and some were very stand offish. I asked her ‘do you feel heard?’. She looked at every single individual and said, ‘I hope you take what happened to me and do better’” (MNO, 2024).*

Despite all the Governing Members working toward developing tools and resources to explain complaints processes to citizens and increase accessibility around it, it is still unclear when and how filed complaints are being addressed and what procedures may exist to ensure change is enacted.

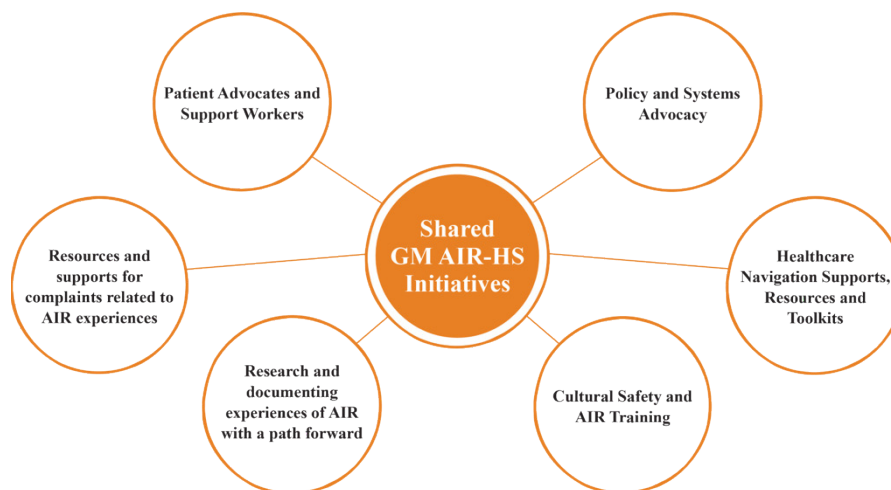
The Governing Members shared a plethora of tragic experiences of AIR-HS. These stories provide a clear need for ongoing action to effectively prevent and respond to AIR-HS. With the AIR-HS funding, Governing Members were able to support their citizens to access necessary care and treatment and worked towards increased protection from AIR-HS. They have also demonstrated clear leadership and innovation in response to ongoing systemic contributors to AIR-HS. Still, it is clear more work is needed across healthcare domains.

## AIR-HS Programs and Initiatives

This section provides a high-level summary of the key programs and initiatives developed by the GMs to address and respond to AIR-HS. During engagement sessions, the consulting team asked the GMs to share the ways in which the AIR-HS funding was used, as well as any stories of success or impact within their AIR-HS initiatives. Additional AIR-HS initiatives were also highlighted by the GMs and are further detailed in the resource review in Appendix A. The AIR-HS initiatives have been organized by overarching themes that cut across all GMs, with additional details describing the unique elements of each AIR-HS program included.

### Summary of the AIR-HS Initiatives across the Métis Nation

Figure 1: Summary of GMs AIR-HS Initiatives



With the AIR-HS funding received, the Governing Members developed a wide range of programs, resources, and initiatives to promote the health, wellness, and safety of Métis people across the Nation. This section provides a high-level summary of the key deliverables produced by each GM with the use of AIR-HS funding. Appendix A includes a full description of how the AIR-HS funding was used, as well as additional initiatives developed from other funding sources led by the GMs to combat AIR-HS. It is important to note that the initiatives highlighted in this report were gathered from what was shared with the consulting team in engagement sessions or via email, so the results may not be exhaustive. In addition, many of the programs and supports offered by the GMs overlap with other funding streams and projects, such as the trauma-informed care funding.

Each GM has demonstrated leadership and innovation in meeting their citizens' unique needs. Much of the AIR-HS work consisted of efforts to prevent AIR-HS through education, advocacy, system navigation, and relationship building within the healthcare system. Another key area of AIR-HS work centred on supporting Métis citizens in responding to incidences of AIR-HS through the use of resources, toolkits and other key supports developed by the GMs. All of the GM AIR-HS initiatives were primarily related to the key themes identified in Figure 1, including:

## 1) Patient Advocates and Support Workers:

- MNBC hired a Health Systems Advocate and a Métis Patient Experience Advocate (MPEA) to support Métis citizens in navigating the healthcare system, advocating for proper care and support through complaints processes when unsafe care and racism occurred. Currently, the roles are limited to two staff providing support to all MNBC citizens across the province. The MPEA is funded by the AIR-HS funding, while the Health Systems Advocate has been funded by the provincial BC health authorities.
- MNA hired a Supports and Services Navigator to connect Métis Albertans to the appropriate programs, services, and resources when needed. With other funding from Alberta Health, MNA also hired a Community Wellness Advocate (CWA) to support Métis Albertans on their medical and mental health care journeys, with a particular focus on those in rural communities. Supports included offering emotional support, liaising with other providers or agencies, and providing follow-up care. Although the CWA was not funded by the AIR-HS funding program, the staff position and role has played a critical part in combatting and responding to AIR-HS.
- MN-S hired Patient Navigators in multiple regions across Saskatchewan (North Battleford, Saskatoon, Prince Albert, and Regina), who help navigate the complex healthcare system to access necessary supports and resources for Métis citizens. This includes Patient Advocates who provide advocacy support when racism has occurred or is occurring in the hospitals, and Patient Support Workers who provide additional social, emotional, spiritual, and cultural supports (e.g., connecting to Elders and ceremony) to Métis citizens while in hospital. These three roles have been critical to MN-S citizens, however, there is a strong need for more capacity across all health centres in Saskatchewan.
- MNO hired two Patient Advocates who support other frontline staff by navigating various systems and referrals, and providing necessary advocacy, referral information, and guidance to staff who support clients and urgent requests.

## 2) Cultural Safety Training

- MNBC, with additional funding from the BC health authorities and other local agencies, developed a Métis 101 presentation to offer Ta Saantii Mamawapowuk Health Gatherings, one-day events for healthcare staff. The aim of these gatherings is to support providers in learning about the history of Métis people and the healthcare system, education on the social determinants of health model, and what mental health, wellness, and cultural safety means to the Métis.
- MNA developed and offered a Cultural Safety Training presentation for external organizations. Additionally, two courses for healthcare providers were developed, one in collaboration with the University of Alberta Rupertsland Centre for Métis Research and Faculty of Native Studies that focuses on Métis Health (still in development), and another on Métis and Cancer Care with SE Health (Métis Cancer Care Course). The Métis Cancer Care Course is provided directly through SE Health and the Alberta Health

Services learning portal for healthcare staff. All these MNA initiatives were not funded by the AIR-HS program.

- MN-S has worked on building relationships with the Saskatchewan Health Authority and local First Nations, educating partners on the cultural and historical context of Métis people, as well as advocating for Métis healthcare needs.
- MNO partnered with the First Peoples Group to develop training specifically for MNO frontline staff on AIR-HS.

### **3) Resources and Supports for Complaints related to AIR-HS Experiences**

- MNBC created the Métis Health Experience Program (MHEP), which offers a safe space for Métis-led story sharing and conversations about Métis citizens' health experiences, while also advocating for change. When AIR-HS occurs, the program offers support in navigating the healthcare feedback process. MNBC has also been developing a Complaints Process Guidebook to educate and support Métis citizens in understanding the processes for making a complaint in response to unsafe or discriminatory care in healthcare settings.
- MNA's Community Wellness Advocacy (CWA) framework and staff provide similar insight and support around complaints processes for Métis citizens in conjunction with other GMs' complaints resources.
- MN-S's Patient Advocates provide advocacy support when racism has occurred or is occurring in the hospital, including supporting Métis clients through the complaints and reporting processes.
- MNO reported that they had begun working with the Provincial Ontario Patient Ombudsman Office to plan and work towards shared goals. MNO has provided feedback to the Ombudsman Office on their resource documents around how best to work with patient relations in healthcare settings for Métis citizens.

### **4) Healthcare Navigation Supports, Resources, and Toolkits**

- MNBC's Ministry of Mental Health and Harm Reduction has created several tools and resources dedicated to raising Métis voices and perspectives and engaging Métis citizens on topics of mental health and wellness, such as a monthly magazine titled Resilient Roots: Métis Mental Health and Wellness. This work is funded by additional funding sources.
- MNA, with additional funding from Health Canada and the Canadian Partnership Against Cancer, have developed an Alberta Métis Cancer Care Strategy. Within this strategy, MNA has developed a guide for Métis Albertans to support them through their personal cancer journeys, including resources and information on each stage of the journey and supports for caretakers. MNA was also able to expand their medical travel program to provide financial support to those from rural communities travelling to urban centres for medical care beyond cancer, another critical resource for addressing AIR-HS which was funded by an alternative source. MNA has also developed a Tobacco Reduction Program with additional funds from Health Canada and Indigenous Services

Canada, providing information and financial support for nicotine replacement therapy and a peer-led tobacco specific support group. All these programs and initiatives address AIR-HS by responding to critical health gaps among Métis citizens through health promotion and increased access to care.

- MN-S's video series created in partnership with Healthcare Excellence Canada documents Métis experiences of AIR-HS, as well as Métis health and wellness teachings and practices. With other funding, MN-S also developed a Cancer Care Guidebook for Métis people navigating the healthcare system. The guidebook includes words of wisdom from other survivors and caregivers, a schedule and list to help prepare for appointments, how to speak with one's care team, how to care for one's holistic health during treatment and healing, and a list of other support services. MN-S also provides low-income citizens with financial support and accommodations to attend medical appointments outside their home community.
- MNO, with additional funding and in partnership with the Ontario Health's Indigenous Cancer Care Unit (ICCU), have developed a Cancer Care Strategy and Toolkit. With funding from the Ontario Ministry of Health and Long-Term Care, MNO has also developed an Aging at Home program and guide for seniors, as MNO defines, over 55 years of age to access home supports to be able to age and stay in their homes for as long as possible. It also includes resources for frontline staff to talk to Métis seniors on important healthcare decisions such as power of attorney, resuscitation, long-term care homes, and continuing care. MNO has also developed a Diabetes Awareness Strategy with the same provincial funds, providing financial support for necessary foot care services and transportation for dialysis appointments.

Notably, much of these healthcare navigation supports, resources, and toolkits are funded by additional or alternative funding to AIR-HS. However, these initiatives are imperative to preventing AIR-HS by providing Métis people with necessary information, tools, and support to care for one's health and wellness, navigate complex systems, and advocate for oneself.

## **5) Policy and Systems Advocacy**

- MNBC has been working on developing a cultural safety framework to honour the legacy of Naomie Gladue called Naomie's Principle, as well as successfully advocating to be involved in the accreditation of the Health Standards Organization (HSO) Cultural Safety and Humility Standard and the province of BC's Anti-Racism legislation to ensure it reflects and responds to the unique circumstances and needs of Métis people. MNBC has also been working with the provincial health authorities to review their workplans and ensure it is culturally safe and responsive to Métis health priorities. MNBC also hired a Health Equity Manager, a dedicated role for building relationships with external healthcare partners (e.g., health authorities) to both advocate for Métis priorities and hold partners accountable to their commitments. Some of this work has been supported by other funders, such as Healthcare Excellence Canada.
- MNA has developed a Community Wellness Advocacy Framework to support Métis Albertans with their mental wellness goals, guidance for system navigation, and self-

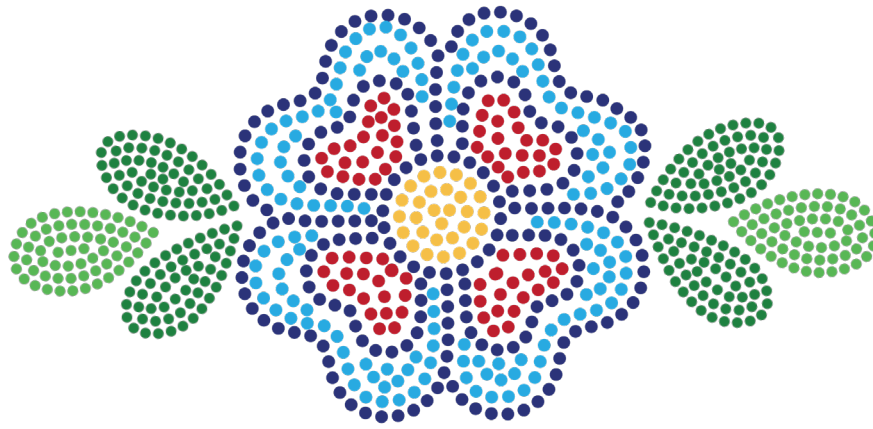
advocacy for safe and non-discriminatory care. This initiative was not funded by the AIR-HS program but is a critical resource for addressing AIR-HS.

- MN-S has held several consultations with Elders to inform the development of a Cultural Safety Framework, as well as advocating for Métis rights and needs with respect to culturally safe healthcare with the Saskatchewan Health Authority and First Nations groups.
- MNO participates at many provincial tables and a Circle of Knowledge with public health partners to raise the profile of Métis people and their needs, MNO's work, and to identify and create opportunities for collaboration with external partners for resource development and system transformation.

## **6) Health Research and Documentation of AIR-HS**

- MNBC has a Public Health Surveillance Program to track and monitor health outcomes for Métis people in BC that includes Métis specific indicators. MNBC is also currently working with the Office of the Attorney General to develop the Anti-Racist Data Act to collect data and monitor outcomes specifically related to AIR-HS. In partnership with University of British Columbia and with the support of other funding, MNBC has conducted research on a range of topics from cannabis, mental health and substance use, Métis wellness, environment, climate change, and food security.
- MNA is currently using AIR-HS funds directly to conduct research on Métis experiences in Alberta emergency departments. With the support of Alberta Health and academic partners at the University of Alberta, University of Calgary, and Queen's University, and additional funding unrelated to AIR-HS funding, MNA also conducts routine health research on a range of topics including chronic disease, cancer, mental health, maternal and perinatal health, long-term and continuing care, and life promotion.
- MN-S and Métis scholars, with funding from the University of Saskatchewan and Canadian Institute of Health Research (CIHR), have been conducting research and monitoring the rates of illness, disease, and wellness in Métis communities. This further includes the development of Métis-led models of care for mental health, substance use and addictions, and cancer.
- MNO has used the AIR-HS funds to conduct a scoping review exploring the current landscape of Métis health and wellness research in Canada. With other funding, the MNO Health and Wellness Branch has also undertaken several research initiatives and projects annually on topics such as chronic disease, cardiovascular disease, diabetes, cancer, and respiratory disease.

Although there are overarching areas of similarity with respect to GMs' AIR-HS work, each GM has identified distinct priorities and areas for focus. In summary, MNBC has used much of the AIR-HS funding for systems advocacy and transformation, MNA and MN-S have focused on expanding and/or continuing pre-existing direct supports for citizens, and MNO has focused on building internal capacity of staff and programs to support citizens.



## IMPACT OF GOVERNING MEMBER AIR-HS WORK

This section further showcases the unique AIR-HS initiatives led by each GM and the respective impacts of this work. During engagement sessions, each GM shared stories speaking to the positive impacts and changes their unique AIR-HS initiatives have had on their Métis citizens. The following will spotlight those initiatives with the provided stories and quotes from the GM staff.

### ***Métis Nation British Columbia (MNBC)***

A key aspect of MNBC’s AIR-HS work has included honouring the legacy of Naomie Gladue, a Métis woman who lost her life after experiencing discriminatory and harmful mental health and substance use care. In response to Naomie’s tragic passing, MNBC has been sharing her story to advocate for safer care for Métis people. This includes a community-led report documenting her story and the changes MNBC and citizens wish to see in response. To further honour Naomie’s legacy and advocate for system transformation, MNBC is also developing a policy to ensure all Métis people in BC have equitable access to culturally safe mental health supports and services that are free from discrimination; promote their cultural, mental, emotional, physical, financial, environmental, social, and spiritual wellness; and are available when and where they need them.

Furthermore, the AIR-HS funding expanded MNBC’s capacity to support Métis citizens in navigating the complex layers of the healthcare system to access necessary health services. The following quotes demonstrate the impact of MNBC’s programming and the increasing demand for AIR-HS related supports:

*“The Ministry of Health supported over 420 Citizen requests for support in navigating the system in some way, shape, or form last year. This does not include additional requests for the Ministry of Mental Health and Harm Reduction programs, but the Ministry of Health’s patient experience and support programs”  
(MNBC, 2024).*

The Métis Health Experiences Program particularly received positive feedback from Métis citizens who have been looking for a safe space to share their stories and hope for systems level change:

*“Patients often don’t feel safe accessing provincial complaint processes. We have seen huge success in providing invitations and information in our gatherings and circles. People have been very responsive and do want to share their experience ... While we have only just started this group, it has already had an impact on the members who are participating. The circle has created the space for connection with other Métis and the projects that the circle will be working on this year have been brought forward and decided by them” (MNBC, 2024).*

By introducing new roles such as the Health Equity Manager with the AIR-HS funding, MNBC has reportedly had more capacity to build relationships with health partners, hold them accountable, and work towards necessary systems change:

*“A hired Health Equity Manager and Patient Advocate has shown what we can do by having a manager role who is dedicated to holding those relationships for system change” (MNBC, 2024).*

### **Otipemisiwak Métis Government of the Métis Nation within Alberta (MNA)**

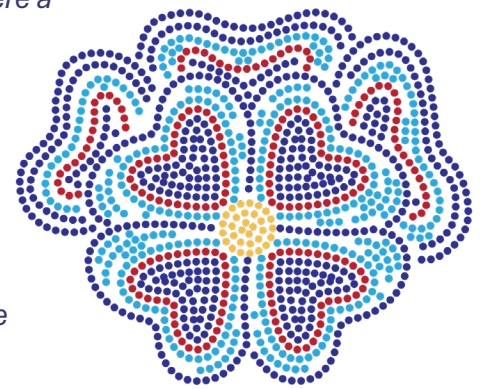
MNA has uniquely used their AIR-HS funding to promote maternal and perinatal health for Métis Albertans. Notably, MNA also put the funding toward supporting a local society of Indigenous birth workers, Kihew Awasis Awakamik, to expand their pre-existing programs and supports to meet the needs of Métis clients. Through both the MNA supported mentorship program and expansion support, Métis individuals received training and spent 150 hours supporting three families throughout their birth journeys. Nine of the seventeen participants in the Métis prenatal and parenting classes were Métis youth, and eight Métis families have received supports. These programs and supports have reduced risks around experiencing racism for pregnant people and new parents in spaces where they receive care. These programs further facilitate additional supports and continued care after birth, such as housing, food security, and transportation, as well as holistic health and wellness for young families through the revitalization of Métis birthing and wellness practices.

In addition, MNA has used their AIR-HS funding to conduct important research into Métis Albertan’s experiences in hospital emergency departments. This research seeks to understand Métis peoples’ experience in emergency departments, including factors that impact their decision to go to the emergency department (or not), if they experienced racism, what aftercare looked like, and how the experience impacts return rates to the emergency department. The results of this research will go toward the development of a Métis-specific definition of quality care and inform advocacy efforts for safer services led by MNA.

Although not funded by AIR-HS, MNA’s dental clinics further illustrate an innovative and important approach to bringing critical healthcare services to Métis Albertans in a safer and more accessible way, which helps to prevent experiences of AIR-HS. By integrating culture and trusted individuals (e.g., Elders, CWA) alongside specialized care, MNA has reduced barriers,

fear, and anxiety around such services. Both the role of the dental clinics and the CWA have demonstrated the wider impact that community-led and responsive approaches to healthcare can have, including a domino effect for broader health, healing, and wellness. The below quote summarizes a key story shared by the CWA about a vulnerable Métis citizen who previously struggled with mental health and needed necessary dental care, however, significantly mistrusted and feared the healthcare system:

*“I met this young man over a year and a half ago and we had a dental clinic in Cold Lake at the time. It included visiting with kokum’s, playing cards, dancing, all while there’s a dental clinic going on the in back room. I picked him up and invited him out for some free lunch, dancing, and cards and he said ‘okay I’ll come with you’ and we went ... He kept coming and on day two he was playing cards with one of the kokum’s there and he asked ‘what is going on back? Is there a clinic back there?’ I said ‘oh yeah, there’s a dental clinic back there and they’re taking walk-ins and such.’ I wasn’t sure if he’d be interested in that because of his fear and mistrust ... Eventually the kokum he was playing with just naturally brought it up [because of visible dental issues] and gave him a friendly kick and was teasing him asking him if he’d be going to the dentist. She said ‘if I beat you [in cards], you’re going to have to go to the dentist’ jokingly and he said ‘it’s on kokum.’ So he played her and he lost and he went in [to the dentist], they fixed his tooth ... Then after that initial interaction with the dental team, in a non-invasive safe space, he then came to me a week later to say he was ready to go into a see a psychiatrist and get into an injection program. Now we’ve got him into subsidized housing, and we got visitation set up with his son, and court dates now ... It was a complete 180 of a scared, angry, distrusting young man and now he has his family. It’s become a cascade of support. It started with just visiting and connecting him to a kokum” (MNA, 2024).*



This quote illustrates the powerful impact GM-led culturally appropriate care can have on Métis citizens health and wellness. MNA has also used their AIR-HS funding to hire a Supports and Services Navigator to further facilitate access to critical health and wellness services, resources, and programs.

### **Métis Nation-Saskatchewan (MN-S)**

While every GM has some form of a patient advocate or support worker, only MN-S has dedicated Patient Navigators, Advocates, and Support Workers that work directly in hospitals to support Métis citizens. This has been a critical support for Métis citizens, especially those in rural communities in Saskatchewan. Not only has MN-S staff protected Métis citizens from AIR-

HS experiences, but they have also helped to facilitate access to care and become a source of comfort in the hospital, promoting Métis citizens' holistic health and wellness during their stays:

*“What frontline workers are hearing is that patients are finding value in the Patient Advocates and Navigators, especially for folks travelling from far away. They provide support in accessing services, language supports, being a friendly face, helping to schedule appointments, etc. The value that patients feel will only grow more as time goes by” (MN-S, 2024).*

Furthermore, MN-S's video series, in collaboration with Healthcare Excellence Canada, enabled Métis citizens' stories and experiences around accessing healthcare in Saskatchewan to be shared and validated in a very impactful and accessible way. Six videos were produced documenting six unique citizen experiences, including two patients from Northern communities, one patient on dialysis, and one cancer patient, and featured patient support workers. The intent of these videos was to provide validation for other Indigenous peoples' experiences around AIR and promote more humanistic understandings of Métis people among non-Indigenous people and healthcare providers. The videos detail difficult and painful experiences but also showcase the strengths of Métis people and their persistent resilience, compassion, humour, and ways of being. Below is a quote by MN-S on the anticipated impact of these videos:

*“The benefit of these videos will be [for] two audiences. For one, it showcases and recognizes Métis people and their experiences. This will be validating for other Indigenous folks too. And then for non-Indigenous folks, it's a light bulb that goes off. They will see the videos and think ‘oh I think I understand a bit more’, and from a more humanistic perspective ... The videos are not just doom and gloom. These incidents should not have happened, but it still shows folks compassion and humour. Seeing that for non-Indigenous folks is both educational and hits them in the heart in a way that reading a report or infographic cannot” (MN-S, 2024).*

### **Métis Nation of Ontario (MNO)**

MNO's unique emphasis on building resources and capacity promotes long lasting impact and sustainability of the AIR-HS funding and initiatives. The role of their Patient Advocates and the development of a resource library will ensure that MNO can continue to respond to client needs in an urgent manner, particularly when/if funding further restricts their programming. It also increases the knowledge and understanding of supports available to Métis citizens among non-Métis staff. As one MNO staff explained about the unique role of the Patient Advocates:

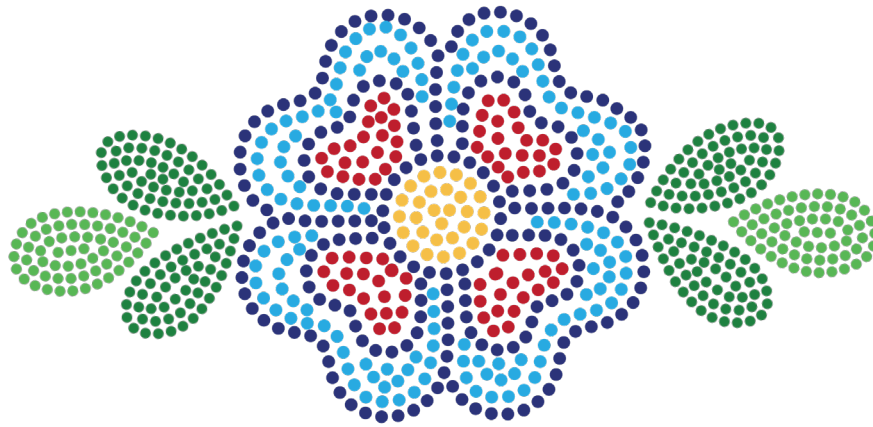
*“It can be difficult for staff on the ground who are providing direct support to clients to know about all the resources and agencies available to MNO clients. To have people [Patient Advocates] be the connecting link is helpful for expediting referrals and services and to promote smooth transitions. It takes a load off staff. You are connected to the province through one library of information” (MNO, 2024).*

In addition, through MNO’s increased capacity and participation at provincial tables, MNO has been able to establish relationships with external partners who have provided further funding and support for resource development. Below is a quote from an MNO staff person explaining the impact of the Circle of Knowledge group:

*“It’s nice to see organizations come to us to learn more about the history and culture of Métis people rather than just a pan-Indigenous view or lumping us in with First Nations. It’s a place for us to gather, talk to each other, figure out where to collaborate, what resources will be beneficial, etc. It is biweekly touch points and resources have come up out of these partnerships and collaborations” (MNO, 2024).*

Within a short period of time, the GMs’ AIR-HS initiatives have had a clear and undeniable impact on Métis citizens. The AIR-HS funding has created capacity to meet the needs of Métis citizens seeking culturally safe healthcare. Advocating for system transformation has allowed Métis people to voice their stories and for their stories to be heard and acted upon. Existing health programs and supports have been adapted to be Métis specific, increasing access and cultural safety. Roles for Métis people have been created to advocate, protect, and support Métis citizens in hospital settings and protect against AIR-HS. All the GMs spoke about frequently learning of the positive impacts the AIR-HS initiatives have had on Métis citizens’ health, wellness, healing, and access to critical health services. The demand for the AIR-HS initiatives was further evidenced by the number of requests from citizens for more services, and the often full or waitlisted programs and supports. GMs have significantly shown how impactful their work has been despite limited funding and truncated timelines, clearly demonstrating how much more could be possible with investments and appropriate administrative measures in place.





## PARTNERSHIPS AND COLLABORATIONS

The extent and role of partnerships and collaborations with respect to AIR-HS initiatives was an area of interest and inquiry. GMs were asked in the engagement sessions to reflect on partnerships or collaborations that had been established or strengthened, and what the nature of these relationships were like. Much of the GMs’ AIR-HS initiatives would not have been possible without the additional support of external partners. For the AIR-HS work specifically, partners commonly included local health authorities, provincial ministries, local offices of the Ombudspeople, First Nation communities, health organizations, and university and research institutions. Figure 2 is a summary of each GMs primary partners.

**Figure 2: AIR-HS Partnerships and Collaborations across the Métis Nation**

Governing Member	External Partner and Collaborator
<b>MNBC</b>	BC Health Authorities, BC Ministry of the Attorney General, Patient Quality Care Offices, BC Health Regulators, HSO Health Standards Organization, First Nations Health Authority
<b>MNA</b>	211 Alberta, Alberta Health Services, University of Alberta, Kihew Awasis Wakamik, SE Health, Rupertsland Centre for Métis Research, CANHelp Working Group, Canadian Partnership Against Cancer, Health Canada
<b>MN-S</b>	Saskatchewan Health Authority, Health Excellence Canada, University of Saskatchewan, Canadian Partnership Against Cancer, Federation of Sovereign Nations
<b>MNO</b>	Ontario Health, Ontario Ministry of Children, Community, and Social Services, Ontario Ministry of Health and Long-Term Care, Canadian Partnership Against Cancer, Ontario Native Women’s Association, Ontario Indigenous Friendship Centres, Cancer Care Ontario, Health Care Centres, Urban Indigenous Health Table, Joint Ontario Indigenous Health Committee, Southwestern Indigenous Health Strategy Engagement Table, First Nations, Inuit Health Branch, Anti Racism Advisory Circle, Heart and Stroke Foundation, Retinol Network  Renal Network, Home Hospice Association, First Peoples Group

As MNBC (2024) stated, and the other GMs echoed, “relationship capital is absolutely essential,” however, benefits and challenges exist within these relationships. Some beneficial aspects of these relationships included additional funding, opportunities for resource development, and/or increased capacity and wider reach of pre-existing GM work. Some of the identified challenges included competition that emerged with other Indigenous groups for the same resources and funding, and non-Indigenous partners who do not prioritize distinctions-based work. Although the GMs spoke highly about their partnerships and collaborations connected to the AIR-HS initiatives, staff also emphasized that these relationships are long overdue. For one staff from MNBC, many of the relationships that have developed over the past couple of years took over fifteen years to build. Similarly, MNO (2024) echoed that their experience of working with the Ontario Office of the Ombudsman was a good collaboration, however, slow to establish.

It was underscored that successful partnerships and collaborative work entail the provision of support and resources with GMs leading the work based on Métis community needs and priorities, and not simply the needs or priorities of the partner:

*“The partnerships are absolutely necessary for us to make any progress, and only in the last little while were we able to truly take the reins and steer them ourselves. This has been essential” (MNBC, 2024).*

After years-long efforts to raise the profile of Métis people across the Métis Nation homeland, GMs described more receptivity by partners around building positive and reciprocal relationships. Much of the collaborations described within the AIR-HS work consisted of co-learning and co-training, such as the Office of Ombudsman providing training to MNO staff on the complaint process, followed by MNO training the Office on the history and culture of Métis people. MNA further shared an example of characteristics that contribute to successful versus challenging partnerships with external partners, such as the University of Alberta:

*“In the Experiences of Care in the Emergency Department Research Project, the MNA partnered successfully with the University of Alberta. MNA leveraged the University’s expertise in the research process, while MNA provided community-based engagement and coordination ... Research projects and data suffer when a research partner comes to the table with pre-determined and prescriptive ideas about a research process. The result is often limited flexibility in decision-making and restrictions on the ability to respond to the results” (MNA, 2024).*

MN-S further spoke of the many times over the past several decades where MN-S was not invited to “Indigenous tables” or advisories, and that non-Indigenous partners still continue to exclude Métis people from their committees or programs. When asked about successful partnerships and collaborations, MN-S described that the onus is often on staff to build the relationships and have the skills and confidence to speak up or manage conflictual situations:



*“We are still fighting for the Métis to be acknowledged ... you have to participate and build relationships. And you have to know how to deal with situations when they come up, and deal with them professionally because it will arise all the time”  
(MN-S, 2024).*

Thus, these partnerships and collaborations, and the successes of the GMs’ AIR-HS work, has largely been a result of the GMs’ persistent advocacy and leadership. The AIR-HS funding has provided GMs with some increased capacity to build working relationships with important partners to train and educate non-Indigenous groups, as well as further the work of the GMs and the Métis Nation.

## **Data and Indicators**

The federal AIR-HS funding program emphasized the importance for funded programs and initiatives to collect data and report on key indicators of impact. Therefore, the GMs were asked specifically about the types of data they collected. In response, the GMs also shared some of the challenges they experienced with collected data as it related to the AIR-HS initiatives. The following section summarizes the GMs’ current data collection efforts and accompanying challenges.

### **GM Data Collected**

All the GMs track intake data from programs that directly support clients. They also track the number of clients on caseloads of staff like the Patient Navigators or Advocates. MNBC has been actively involved in the development of the province of BC’s Anti-Racist Data Act, ensuring it includes relevant indicators such as MNBC’s social determinants of cultural safety indicators. MNBC also has information sharing agreements with the Public Health Agency of Canada, Canadian Partnership Against Cancer, and Fraser Health Authority. MNA has an information sharing agreement with Alberta Health which uses anonymous Métis identifiers to collect administrative health data. A key aspect of MNA’s AIR-HS funding has focused on collecting more data to identify macro-level trends within the provincial health system. For other MNA AIR-HS initiatives, collected data includes intake data, post-participation surveys, and informal feedback from participants. MN-S holds an information sharing agreement with the Canadian Cancer Agency, and they are working towards an agreement with the Saskatchewan Health Authority. Within MN-S’s AIR-HS initiatives, they also collect patient stories and testimonies along with intake data. MNO reviews provincial health utilization statistics and relevant data from Canadian Institute for Health Information (CIHI), the province of Ontario, and MNO-led research projects. MNO also keeps track of distribution rates of resources and post-participation surveys from their training.

## Challenges with Data Collection

Without high quality data infrastructure or a national data strategy with Métis specific identifiers and indicators, the GMs are limited in their ability to collect data and quantify the impact of their programs. In addition, the short-term nature of the AIR-HS funding, including time and funding amount constraints, highly impeded the GMs' abilities to integrate data collection and evaluation into the design and implementation of their AIR-HS initiatives. GMs also do not have the required funding to build their internal human resource capacity to recruit and retain the necessary specialized and technical people to conduct data collection, analytics and program evaluation (e.g., data analysts, and evaluation specialists) (MNA, 2024). GMs further emphasized the clear need for sustainable funding to be able to gather data and evaluate their programs. As MNA (2024) stated, "there was hardly enough funding to run the program. There was not enough funding or time to evaluate the program too."

GMs also voiced concerns with the nature of quantitative data collection. Although they recognize the value of quantitative data and research, they find most quantitative indicators do not fully capture the nature or impact of their AIR-HS work. MN-S (2024) gave an example as to how certain indicators can have different meanings with respect to impact, such as reporting on number of complaints:

*"I don't want to see less complaints. I want to see more complaints of AIR-HS because then it shows that folks know we are out there and available to help, and they are utilizing us."*

For roles such as Patient Navigators or Advocates, it can be particularly challenging to find the right indicator. While number of patients is often used as an indicator, GMs further explained that this does not fully account for the extent or nature of the work a Patient Navigator or Advocate may complete. MN-S further explained how challenging it is to measure the impact of their work with aging or palliative community members:

*"Some of my patients die too, so my numbers are often off and not the best outcome measure. We helped them at their worst hour but that won't necessarily get documented" (MN-S, 2024).*



On the other hand, when GMs can collect their own data, with their own indicators, the data is often much more reflective of their community members' realities. MNBC has been working toward developing a set of Métis specific indicators on social determinants of health and cultural safety and gathering their own data on Métis people in BC. As MNBC explained:

*“When we apply a powerful Métis lens to Western data, it still doesn’t come close to what we know is true from what we gather through our own data systems. For example, the In Plain Sight report showed 50-60% reported experiencing racist harm in accessing the system, but from our question set, our rates are higher than other minority and non-Indigenous communities” (MNBC, 2024).*

Data that delineates impact in a Métis context may be more appropriately collected through sharing circles or informal story sharing, rather than a phone survey or an online survey. As MNBC expressed “a phone or internet survey does not produce the same quality of data as compared to speaking to someone in person, in a safe space” (MNBC, 2024).

When possible, GMs have collected data on their AIR-HS initiatives. Without appropriate data infrastructure or a national data strategy, GMs are limited in what they can collect, monitor, or access. The barriers experienced in data collection and program evaluation emphasize the need for data governance to be reflected and supported within funding initiatives.

## **Challenges of the AIR-HS Funding**

The challenges of the AIR-HS work were overwhelmingly tied to the nature of the funding. The timing of the release of funding, funding parameters, and the amount provided impeded the GMs’ ability to fully respond and meet Métis citizen needs. These themes are further explored in the following paragraphs.

### ***Timing of the Funding***

Due to delays in receiving the funding, all the GMs felt as though “the 3 years of funding have been squished into 2 years and there is pressure to show results” (MNC, 2024). This placed a lot of additional pressure and undo stress on the GMs to quickly design initiatives, hire and train new staff, and implement programs. For many of the GMs, hiring staff quickly was further complicated by the fact that the funding represented a pilot project, and therefore, many uncertainties existed as to whether newly created positions would continue past March 2024. Additionally, MN-S explained that certain roles, such as hiring language speakers, can take significant amounts of time. This means that certain programs took more time to organize and administer, with many of the programs only starting in 2023.

Due to the funding being short-term and representing a pilot program, all the GMs felt limited in what they could implement for community members. All the GMs were highly concerned about the impact of developing useful support for their communities only to have programming terminated once the funding window was closed. MN-S further explained the important relationship GMs have with their citizens and how careful they are to protect and maintain that

trust through demonstrations of listening, taking direction, and working toward change. They described how short-term and insecure funding frequently threatens trust between citizens and MN-S:

*“We are trying to build trust with citizens and if we are not getting funds from the government or if all the funds are engagement funds, and there’s a limitation of not being provided with service funds, then that’s where we are at ... We need to guard that trust, and that can be challenging when we are reliant on the scope of funds the federal government decides to provide us. With even this funding, to say we care about anti-Indigenous racism, we want to work on it, and then have it be only 3 years and it’s taken away, it’s not helpful. It’s the gaps to start a program up and start those relationships and then the funding doesn’t exist anymore. It harms the trust between us and the nation” (MN-S, 2024).*

In consideration of the potential non-renewal of funds, GMs made very deliberate choices in how the AIR-HS funding was to be used to minimize negative impacts if the funding was not renewed. This was illustrated in MNO’s careful decision-making around how their AIR-HS funds would be used in order to minimize harmful impacts to citizens:

*“A deliberate choice was made in using the AIR-HS funding to create patient advocate positions rather than navigator positions, in that sunseting funding often results in a withdrawal of services, and the withdrawal of advocates would result in less direct harm to communities than the withdrawal of navigators, who work one-on-one with clients” (MNO, 2023).*

*“[MNO] didn’t want boots on the ground frontline people who will only be there for two years and then they are cut. It can cause damage and harm. Advocates work virtually. So, they know that a direct community will not be hit hard when they lose that support” (MNO, 2024).*

Furthermore, GMs felt that there was an insufficient amount of time to collect data or measure results, as well as insufficient time to create significant system impact and change or demonstrate consequent results. As MNBC (2024) stated “without ongoing funding, we can’t implement bigger things because you don’t want to implement something and take it away”. Much of the GMs’ AIR-HS funding was used to build programs that built GM capacity and sustainability to continue to meet citizen needs with or without a renewal of AIR-HS funding. All GMs conveyed that significantly more could have been achieved with more time and funding commitments in place. As MNO (2024) further amplified, “you can’t fix racism in 17 months

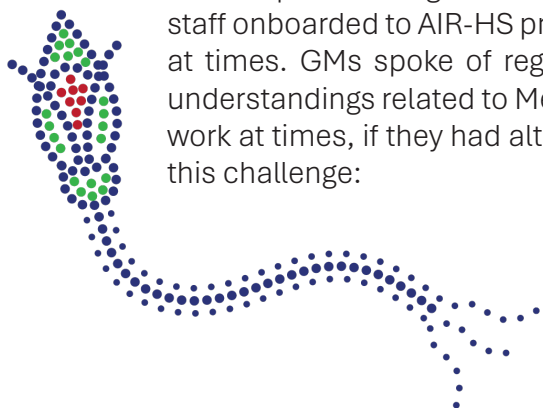
when it’s a historical, long standing, and widespread issue”. This was echoed by MNA (2024) who expressed that the funding was “moment-to-moment thinking versus long term thinking – which is the nature of grants.”

These limitations were coupled with insufficient amounts of funding as well. Some of the GMs were able to access additional funding to strengthen their AIR-HS initiatives, primarily through the Canadian Institute of Health Research (CIHR), the Canadian Partnership Against Cancer (CPAC), or other federal programs by the Public Health Agency of Canada (PHAC) and Substance Use and Abuse Program (SUAP). Still, this additional funding also comes with added administrative burdens. All of the GMs emphasized that the healthcare system is large and complex and that the nature of anti-Indigenous racism is long-standing and multi-layered, requiring more than 2-3 years of funding if systems-level change is to occur.

### ***Administrative Challenges***

The GMs were further challenged by the proposal-based nature of the AIR-HS funding. All the GMs spent a considerable amount of time and resources on applying, processing, managing, and reporting on the funding. The funding also confined GMs to specific and restrictive streams with no flexibility on expenditures. This further restricted the GMs’ ability to effectively meet citizens’ needs and to implement AIR-HS initiatives that appropriately reflected a Métis context. In addition, the GMs expressed challenges between the two different application processes instituted by Health Canada and Indigenous Services Canada that had to be navigated in order to access the AIR-HS funding. Both funding streams required different proposal templates and reporting, further adding to administrative burdens for GMs. Notably, GMs expressed that Indigenous Services Canada’s proposal template was easier to follow than Health Canada’s, which was deemed more labourious. All the GMs emphasized a need for a “set aside allocation” (MNBC, 2024) to minimize duplicate administrative labour that delays progress on the respective portfolios of work.

Staff turnover with provincial ministries and health authority staff, and other external partners, were also identified as key challenges in the GMs’ AIR-HS work. The GMs explained how much time and effort it frequently took to establish relationships with important partners to work together, or to receive funding. At times, the relationship would be developing well and unanticipated changes to staffing would occur, causing a redirection of work activity. When new staff onboarded to AIR-HS projects, GMs felt work progress was stalled or had to be re-initiated at times. GMs spoke of regularly having to re-educate and train new staff on foundational understandings related to Métis people. It was also felt that new staff attempted to redirect the work at times, if they had alternative ideas. The following quote from MN-S further exemplifies this challenge:

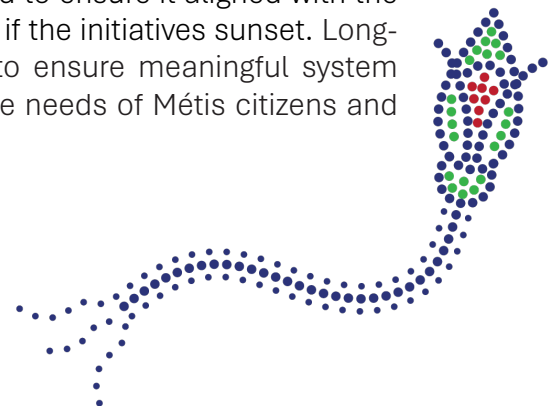


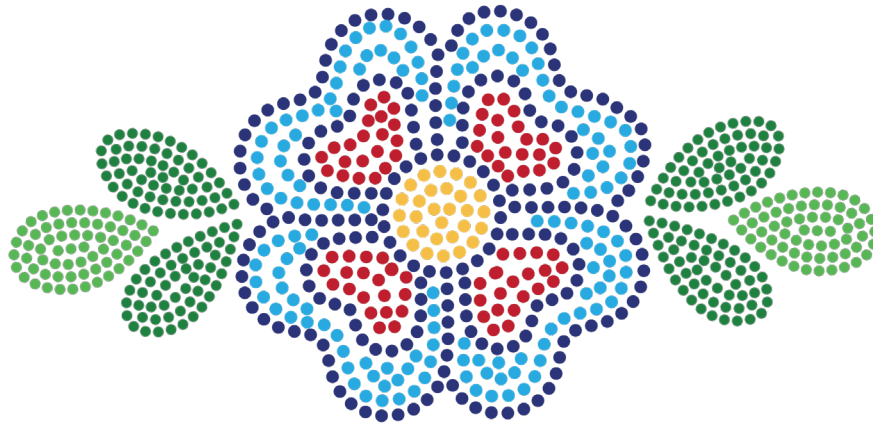
*“We were trying to establish a service agreement with the Saskatchewan Health Authority (SHA). We already had a MOU and a base commitment with cultural responsiveness embedded in the MOU. Then there was a transfer in the relationship within the SHA department. We had to bring a new Director up to speed. And then this new person wanted to do things differently ... So it’s like we were ready to go and then we were back to where we started” (MNO, 2024).*

MN-S shared another example where continuous changes within the Saskatchewan Health Authority (SHA) also impeded on MN-S work progress and programs. The constant change in staff meant MN-S had to continuously lend insight into their programming for new staff. If this knowledge sharing and insight was not completed, it was felt that there was greater risk around receiving fewer referrals and/or a potential decline in the utilization of their programs and services for Métis patients in the hospital. It also created lack of clarity for following up on complaints filed by patients and other critical communications with SHA:

*“Once we had our patient support worker lined up, each hospital, the way they work, is different and the visibility of their staff is different. There was also a revolving door with the managers that would connect us to the SHA staff. This made it really difficult to follow through or provide capacity to do our work. Between SHA departments, there was no understanding of the programs either. So we did have a knowledge sharing day at the end of January and we brought together the directors and managers” (MN-S, 2024).*

Although the GMs expressed gratitude for receiving AIR-HS funding, several challenges were identified with respect to the funding received. Since Health Canada and Indigenous Services Canada administered the funding as a proposal-based pilot initiative, the GMs felt constrained as a result. GMs spent much of their time on the administrative requirements of implementing the funding program. The short-term and uncertain nature of the piloted funds impeded on the GMs’ ability to respond to the needs and priorities of community members, and to make the significant the impact and system transformations GMs and Métis citizens envisioned. GMs had to be strategic in how the AIR-HS funds would be used to ensure it aligned with the funding requirements, and to mitigate any risk of harm when or if the initiatives sunset. Long-term, sustainable, and unencumbered funding is necessary to ensure meaningful system transformation can be achieved, and to adequately address the needs of Métis citizens and reduced instances of anti-Indigenous racism.





## RECOMMENDATIONS, NEEDS, AND PRIORITIES

A final area of inquiry centered on the remaining key needs and priorities surrounding AIR-HS work, including areas for expansion if the funding is renewed. This section provides a summary of the GMs’ visions for continuing and expanding their AIR-HS work. The priority areas and recommendations are organized by themes. This includes sub-population groups, program needs, and system transformation.

### Population Needs

**Figure 3: Summary of Population Gaps across the Métis Nation**



### **Question 5: Are there any key population needs or under-served areas of health?**

All of the GMs emphasized the need for ongoing support for the entire Métis population, with some trends around certain Métis sub-populations. Figure 3 shows the wide range of population gaps that remain and should be addressed if future funding is received. MNO (2024) stated, “the gaps are still there, we haven’t bridged those gaps yet and it is still very broad”, which was further echoed by MN-S (2024), “all Métis are very important.” The GMs were in agreement with all the identified sub-populations, including Elders and older adults, youth, 2SLGBTQQIA+, and Métis healthcare providers. When asked for more details around population gaps, each GM described a particular focus within each sub-population based on the unique demographics in their regions. For example, MNA and MN-S had particular interest in supporting those living in rural and remote communities and survivors of abuse. MNBC was particularly interested in supporting youth and 2SLGBTQQIA+ community members and MNO was interested in supporting those struggling with mental health and substance. In addition, the population gaps identified appear to coincide with health inequities, where certain populations are at higher risk for, or are already, experiencing ill health.

**Elders.** All the GMs voiced concerns around the gaps that continue to exist for those aged 65 and beyond. MN-S and MNA shared stories of seniors living with minimal financial resources due to the increased cost of living with no increases in their social assistance. They described scenarios where Métis seniors have shared prescription medication with others who cannot afford medication, skipping meals to pay for medication, or hitchhiking to be able to attend medical appointments. GMs further identified concerns with the nature of long-term care facilities, including the need for the older population to travel constantly between their home community and urban centres for care, and needing to leave their home community and their family entirely. The other key gap identified included the lack of culturally safe long-term care facilities. GMs echoed a clear need to better integrate culture into care facilities to make them safer and centered around healing for seniors and Elders. This would include hiring Métis staff, integrating traditional foods, offering cultural activities, and facilitating an ‘Elders in residence’ program where a Métis Knowledge Keeper would visit and support Métis residents. Funding that focuses on providing community-based long-term and home care supports was prioritized by GMs so that Métis seniors may be able to age at home and in community settings.

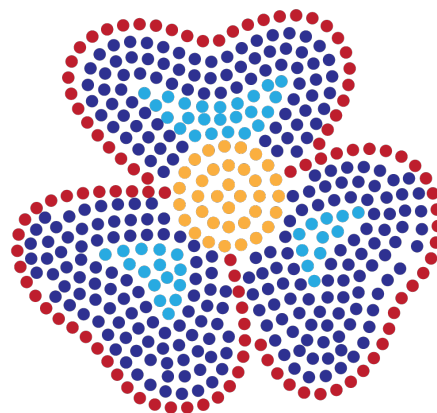
**Youth.** The Métis youth population was also identified as a subpopulation in need of support. MNBC is particularly concerned about the lack of supports for youth transitioning out of care, as well as the lack of supports available for emerging adults and early middle-aged adults (those aged 25-55) who do not appear to have the same funding or services available as older aged youth. MNO and MNBC further discussed the need for more Métis registry supports to help younger populations access Métis citizenship, followed by more available health and wellness supports. MNO and MN-S were further concerned about the rising rates of chronic illness and disease, disabilities, and complex medical issues among children and youth, with a clear need articulated around obtaining more funding to address these population specific health needs.

**2SLGBTQIA+.** The 2SLGBTQIA+ Métis population was further identified as a priority population that has not received adequate program funding and services to address key needs. GMs spoke about the lack of culturally safe supports available to 2SLGBTQIA+ community members, and the need for distinct 2SLGBTQIA+ centered services. MN-S and MNO have been implementing additional resources in community settings to increase community members understanding of 2SLGBTQIA+ identities. MNBC and MN-S have also been focused on creating more opportunities for Métis 2SLGBTQIA+ citizens to gather and connect to culture, community, and experience a sense of safety within a community setting. There was recognition by the GMs that the experiences of 2SLGBTQIA+ citizens are unique, and more work is needed to better understand and meet their needs, particularly as it relates to health and intersections with anti-Indigenous racism.

**Métis Healthcare Providers.** Métis healthcare providers and staff were another critical population identified by the GMs. All the GMs expressed concern about the impact of both experiencing racism directly as a Métis person, while also observing racist behaviours and commentary of other healthcare providers directed at Métis patients. GMs described how experiences of racism within personal and professional contexts can significantly and accumulatively impact Métis healthcare providers and staff. Comments were offered around how these experiences of racism can impact the nature of care a Métis healthcare provider may deliver, including their ability to advocate or file complaints within organizational and institutional settings. Further inquiry into experiences of Métis healthcare providers and workplace settings is needed, along with the implementation and evaluation of cultural safety standards for both Métis workers and patients.

## Program Needs

The GMs were eager to share their visions for continuing and expanding their AIR-HS initiatives. When asked where the current gaps exist for responding to AIR-HS, the GMs described in detail the next steps for this portfolio of work. The following section is organized by four key program areas, including expanding patient support workers, staff recruitment and retention, resource development, and evaluation and community-based research.



**Expand Patient Support Workers.** All the GMs articulated a strong need for additional and continuous funding to expand their current patient support worker roles, including MNBC’s Patient Advocates, MNA’s Community Wellness Advocate and Supports and Services Navigators, MN-S’s Patient Navigators, Advocates and Support Workers, and MNO’s Patient Navigators. Through the AIR-HS initiative, the GMs have observed positive impacts for Métis patients. For example, one MNO worker described higher quality of care for Métis patients as a result of provincial Patient Advocates:

*“They are like gold to me. As soon as I call them, I do not have to worry about my clients as much. It frees up my time to care for more folks and I know when my clients are in the hospital, they are covered” (MNO, 2024).*

However, there is a demonstrable gap in rural communities, with less staff and supports available to protect citizens from AIR-HS. In addition, the majority of the GMs only have one staff person in these roles to serve the citizens across the entire province. Therefore, a strong need was voiced around having one navigator and/or advocate in each health region or Métis community. GMs expressed interest in also expanding these roles into specialized care areas such as cancer care, cardiac care, etc. In addition, GMs would like to be able to hire cultural liaisons and/or Elders and Knowledge Keepers to support patients during their healthcare journeys. Overall, being able to have more Métis staff in advocacy roles within the hospitals would potentially reduce instances of AIR-HS according to GMs and improve overall quality of care. As the MNO described, which was further echoed by the other GMs:

*“I agree with getting more advocacy in the hospitals. In the hospital, we are working with a system that is huge. Beginning with doctors, we need to get the doctors to look at the client and talk to them. We need more advocacy within the hospitals” (MNO, 2024).*

**Staff Recruitment and Retention.** GMs discussed the need for funding and programs targeted at the recruitment and retention of Métis staff in healthcare settings. As MNBC (2024) explained “when you put people with lived experience in healthcare positions, then you are changing the culture from the inside out. And that is the most effective way we can address the racism within the system.” However, as noted previously, experiences of racism for Métis healthcare providers occurs according to GMs, compromising the safety of institutional healthcare spaces for Métis folks. The need for cultural safety training within healthcare settings was frequently articulated by GMs, alongside measures to evaluate healthcare provider and program practices. MNBC (2024) shared a story about the impact of their cultural safety trainings for Métis staff, identifying a clear need for health system change:

*“During sharing circles at the conclusion of MNBC’s cultural wellness sessions, there have been Métis nurses and healthcare service providers identifying*

*themselves as Métis to their colleagues for the first time. Which begs the question that, if the system is not safe enough for citizens to identify as Métis in their day-to-day work, then how is it safe enough for them to identify themselves to Métis patients and speak up in instances of racism?”*

GMs were also concerned about the impact of vicarious trauma for Métis healthcare providers, and intersections that exist across racism and trauma, identifying a need for more program supports to address the experiences of the Métis healthcare workforce specifically. Some suggested supports for staff included the development of a lateral violence toolkit, a worker peer support group, and a mentorship program.

**Resource Development.** The GMs identified a need for resource development across a number of areas. One area included client tools to support awareness, knowledge and self-advocacy when navigating the healthcare system. For instance, a self-advocacy toolkit could include information on scenarios or circumstances that may require self-advocacy or a complaint and the steps needing to be taken. The GMs suggested such a toolkit also include insight into what to expect when accessing services, and standard questions clients should expect to be asked and those they may wish to decline responding to. Additional resources on specific health issues, operations and treatments with Michif translations were also identified. A toolkit for healthcare practitioners was also identified as a need and should include principles of cultural safety, practice scenarios, and guidance around how to engage and speak with Métis patients in culturally appropriate ways. MN-S (2024) noted that this was something healthcare practitioners are specifically asking for: “there are good people out there. And when I talk to people that’s what they ask, they want a toolkit that applies to their clinical practices.”

**Evaluation and Community-Based Research.** GMs spoke pointedly about the need for additional funding to evaluate their AIR-HS initiatives. They expressed strong interests in measuring the impact of their programs, resources, and supports, and monitoring ongoing needs and gaps for their citizens. This funding should be in addition to AIR-HS program funding, not in replacement of it. The GMs also voiced a need for more community-based research on Métis experiences, knowledge, and cultural understandings of health and wellness. This would include research into the identification and development of culturally safe models of care that integrate Métis determinants of health and cultural knowledge, which should be reflective of the diverse Métis communities across the Métis Nation. Additional research should focus on Métis experiences in the healthcare system, including client experiences related to AIR-HS. GMs noted that when research institutions conduct research on or with Métis people, a mechanism that alerts the GMs of Métis research and requires GM approval, involvement, and review of the research should be established. These recommendations also echo earlier comments focused on Métis-specific data strategies and self-determination.

If AIR-HS funding is renewed, the GMs would be quick to prioritize expanding programs that have already shown promise, such as the patient support workers, into areas of critical need

(e.g., Northern, and remote communities). GMs also identified opportunities to support the recruitment and retention of Métis citizens into healthcare roles to further enhance cultural safety in healthcare spaces. Further resource development to build more client tools and support citizens in advocating for themselves were identified as needs, along with more Métis and community-led health research to better understand and monitor Métis peoples' health and experiences.

## System Needs

In order for the GMs to fulfill their visions for AIR-HS work, they further identified system level changes and needs. These system needs included ongoing funding to expand GMs' AIR-HS programs and initiatives, accountability mechanisms for non-Indigenous organizations, the implementation of Métis cultural safety training, and ongoing evaluations of healthcare providers' practice.

**Continued Funding.** Within the engagement sessions, all of the GMs expressed high motivation, desire, capability, and readiness to implement all the described recommendations and needs, however, adequate and sustainable funding is needed. For significant systems level change regarding AIR-HS for Métis people, dedicated funding for the Métis Nation is critical. This funding must be long-term, sustainable and unencumbered in nature to allow GMs to meet their citizens' needs. This report demonstrated the many challenges faced by GMs as a result of current funding structures. GMs further expressed challenges envisioning next steps for their AIR-HS work without knowing what future funding would look like, or if they would receive any at all. As MNO explained:

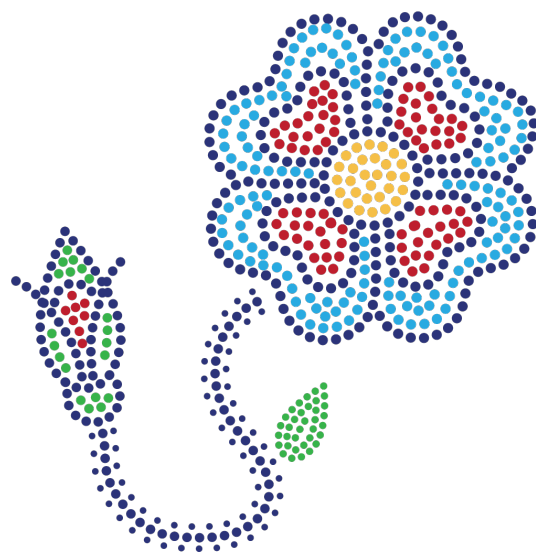
*“We are wanting to do community engagement to learn what citizens feel is needed and use that to build our actual application for funding. However, sustainable funding is necessary for this. It’s challenging to know where we want to go because we don’t know what the funding looks like or if it’s sustainable. That information will guide what kind of work we will do” (MNO, 2024).*

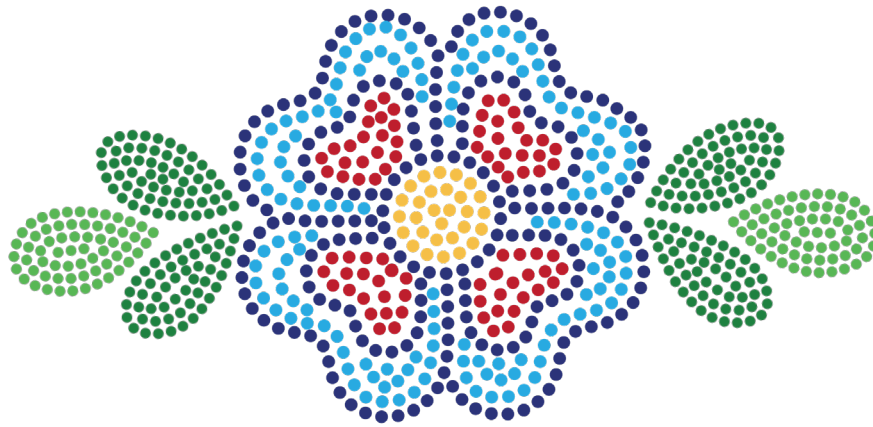
MN-S (2024) further expressed that the AIR-HS funding should be continued at least “until the health system is culturally safe for Métis citizens.” MNA (2024) also emphasized the critical importance of long-term funding to allow for GM's participation at advisory and policy decision-making tables and overall system transformation work within the healthcare system. These aspirations require significant commitments from local, provincial and federal partners who are working in the spirit of reconciliation.

**Mandatory Training and Evaluation of Healthcare Professionals.** GMs voiced the need for systems wide education and training initiatives within the healthcare system. All the GMs, as well

as the Métis National Council, have developed cultural safety trainings, tools, and resources, however, a key challenge they are reportedly having is around its utilization by non-Indigenous people and groups. GMs expressed a need for additional education and training offerings focused on Métis people, culture, health, and wellness, that equips healthcare providers with foundational understandings. Education and training offerings of this nature have the added benefit of reducing the arduous workloads of GM staff who must often repeatedly provide core trainings. This means that GM staff could alternatively dedicate their time to advancing other work projects and portfolios, such as those of AIR-HS. Given the results of GM engagement sessions, including well-documented experiences of racism and death of Métis people within the healthcare system, consideration should be given to the implementation of mandatory Métis cultural safety training for all healthcare professionals. Additionally, this should include the evaluation of healthcare professionals practice to ensure implementation and adherence to cultural safety practices.

The GMs have identified a number of areas for ongoing AIR-HS work. They are highly motivated to continue working toward system transformation and to create safer healthcare systems and experiences for Métis citizens. The GMs have identified critical opportunities for key population groups, including but not limited to, Elders and older adults, youth, 2SLGBTQQIA+ peoples, and Métis healthcare providers. More work is clearly needed to expand impactful programs such as the patient support workers, as well as to recruit and retain Métis healthcare providers. Additional areas for growth include the development of tools to support Métis citizens in self-advocacy and self-determination around their health, and to further document and monitor Métis health and healthcare experiences. More positive impacts and meaningful change could occur with additional system changes, including continued AIR-HS funding and mandatory cultural safety training and evaluation of healthcare organizations and professionals. This pilot initiative has demonstrated that the GMs are capable and best suited for ongoing initiatives and efforts to reduce anti-Indigenous racism in the healthcare system.

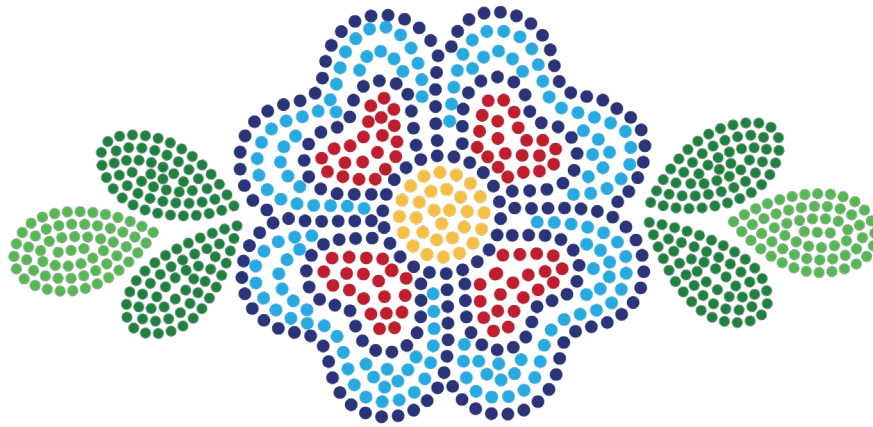




## CONCLUSION

The AIR-HS funding represented a critical portfolio of work for the GMs in supporting Métis citizens around their healthcare needs and experiences of racism within the healthcare system. As a result of the funding, the GMs were able to develop innovative initiatives that offered safe spaces for Métis citizens to share their stories and connect with each other, validate their experiences, and offer support through complaints processes. This ultimately facilitated increased trust between citizens and GMs, better access to healthcare services, and improved supportive care within healthcare settings. Significant resources that promoted Métis peoples' self-determination in their healthcare decision-making were created, along with other important materials that inform the day-to-day work of healthcare providers encountering Métis patients. Additionally, numerous relationships were formed with organizations, health authorities, hospitals, and levels of government. However, given time restrictions and funding restraints, the GMs and their staff were under considerable stress and pressure to rapidly develop initiatives that met citizens' needs thus impeding their ability to engage in wide-ranging healthcare system transformation. While the GMs certainly accomplished significant progress in combatting AIR-HS through their relationships with healthcare providers, organizations, and governments, offering trainings, and supporting Métis citizens through 1-1 interactions, GMs emphasized that there is still significant work to be done in order to effectively reduce and eliminate racism at all levels within the healthcare system. Métis experiences of racism within the healthcare system were manifold, with these stories just beginning to be shared. To continue building and growing from the good work that has already been completed to date, which includes improving healthcare services and promoting Métis health and wellness, ongoing investments that are streamlined and sustainable are needed so Governing Members and staff can focus on the work of reducing racism within the healthcare system for Métis people, in collaboration and unity with diverse partners and healthcare providers.

*“All the work is just beginning ... we can do so much more” (MNA, 2024).*



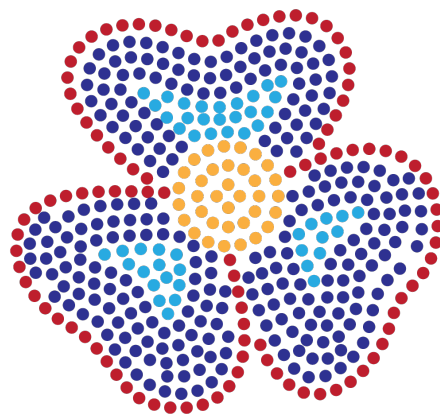
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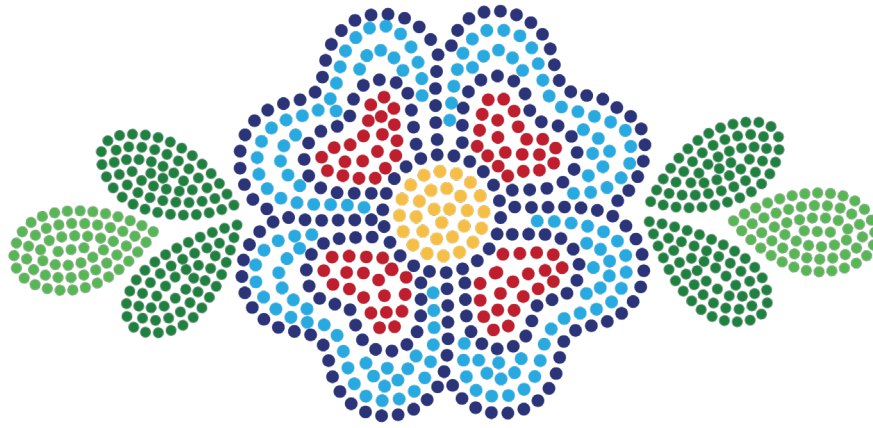
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## APPENDIX A

### **Anti-Indigenous Racism in Health System - Resource Review**

This resource review provides a summary of each Governing Member's Anti-Indigenous Racism in the Healthcare System (AIR-HS) resources and initiatives. It provides a detailed summary of the initiatives funded specifically by AIR-HS funding, as well as highlights additional initiatives related to AIR-HS that are funded by other sources.

### **Otipemisiwak Métis Government of the Métis Nation within Alberta**

The Otipemisiwak Métis Government of the Métis Nation within Alberta (MNA) has developed a wide range of innovative programs, resources, and initiatives to support Métis people within Alberta. MNA's Department of Health primarily leads the majority of MNA's AIR-HS initiatives. The Department of Health is structured around two key pillars: Community Wellness and Health Research and Advocacy. Community Wellness includes the Community Wellness Advocate, Wellness Program, dental clinics, cancer care resources and supports, opioid awareness and support, medical travel, and tobacco reduction programming. Health Research and Advocacy includes ongoing public health monitoring, strategies to promote health and wellness, infographics, and key research projects across health topics including, but not limited to, chronic disease, cancer, mental health, maternal and perinatal health, long-term and continuing care, and life promotion. There are also additional health and wellness promotion programs and services within the Department of Children and Family Services, Truth and Reconciliation, and Youth Programs and Services that are not captured within this document due to the scope of this review.

### **Anti-Indigenous Racism in the Healthcare System Funded Initiatives**

With the AIR-HS funding, MNA has been able to better protect their citizens from racist, discriminatory, and otherwise harmful healthcare experiences, while also working toward system transformation. The funding has been primarily used to 1) hire a Community Wellness Advocate to support Métis Albertans on their healthcare and mental health care journeys, 2) develop a cultural safety training program, 3) develop a mentorship program to train Métis midwives and doulas and 4) conduct research into Métis peoples' unique experiences when accessing emergency care within Alberta.

### **MNA/University of Alberta Emergency Care Research**

MNA, in partnership with the University of Alberta, is conducting research on emergency care of MNA citizens to better understand the emergency care characteristics and experiences of MNA citizens, and more specifically, the relationship between these experiences and anti-Indigenous racism and systemic barriers in the Alberta health system. The research also seeks to develop pilot interventions to strengthen cultural safety, address anti-Indigenous racism and systemic barriers, and build the capacity of existing system navigators and community advocates. The results will go toward a community report, academic publications, policy recommendations for health system leaders in Alberta, a literature review on navigation and advocacy best practices and programs, training sessions, and other capacity building.

### **13 Moons Mentorship Program**

In partnership with Kihew Awasis Wakamik, an Indigenous cultural society for Indigenous birth workers (e.g., midwives, doulas), MNA have co-developed AHAS invested funding in a Métis birth worker mentorship program. Within this program, Métis birth workers have the opportunity to combine their Western birth work knowledge and skills with Métis specific teachings around life transitions, health, wellness, as well as cultural safety. It also supports Métis birth workers in advocacy, providing culturally safe medical care, prenatal classes, transportation, housing, food security, and postpartum care of families. Basic participation rates and demographic information is collected through intake data.

### **Kihew Awasis Wakamik Cultural Society Expansion of Doula and Midwifery Services**

Kihew Awasis Wakamik Cultural Society is a collective of Indigenous birth workers, cultural helpers, Aunties, Elders, and knowledge keepers who support Indigenous parents and families through their prenatal, birth, and postpartum journeys. The MNA provides financial support to Kihew Awasis Wakamik to support the expansion of the collective to provide effective supports and culturally safe, and culturally grounded, care to Métis parents and families in major life transitions, including birth-work and end of life care. Data into these programs and services are collected through post-participation surveys and qualitative feedback from birth workers and families.

### **Supports and Services Navigator**

MNA hired a Support and Services Navigator with the AIR-HS funding. This role helps to direct and connect Métis Albertans to various programs, supports, and resources as it relates to their specific needs. The Navigator also provides advocacy and guidance to Métis Albertans to help ensure that appropriate supports and resources are accessed. Access rates are collected.

### ***Other Initiatives related to Anti-Indigenous Racism in the Healthcare System***

MNA works to educate citizens on self-advocacy, healthcare processes, and wellness while simultaneously working to advocate for systems-change within the healthcare system. Much of MNA's additional work related to AIR-HS ranges from training courses for healthcare providers

on working with Métis people, to courses, programs, or resources to support Métis Albertans in navigating the healthcare system and meeting their health and wellness needs. MNA also provides financial support for those traveling from rural areas to urban centres for healthcare. Their dental clinics showcase a key innovative approach to bringing critical healthcare services to Métis Albertans, by integrating culture and trusted individuals (e.g., Elders, CWA) alongside the specialized care to reduce barriers, fear, and anxiety surrounding services. MNA also conducts ongoing research to understand Métis Albertans' experiences and journeys within the healthcare system, and to advocate for necessary changes to better meet Métis needs and promote safe and anti-racist care. MNA collaborates with a number of partners within these initiatives, including SE Health, University of Alberta, Rupertsland Centre for Métis Research, CANHelp Working Group, Canadian Partnership Against Cancer, and Health Canada. Key additional funding sources include Health Canada, Canadian Partnership Against Cancer, and research grants through University of Alberta and the Canadian Institute of Health Information.

Other initiatives related to AIR-HS include:

- **Cultural Wellness Advocate (CWA):** a role that provides information, referrals, system navigation, appointment supports, and other supports to Métis Albertans accessing mental health care. This work is also supported and in partnership with 211 Alberta.
- **CWA Cultural Safety and the Métis:** a cultural safety education program that is provided to key organizations across Alberta on the history of Métis people in Canada, Métis cultural and definitions of wellness, and what culturally safe care is (and is not).
- **Métis cancer care course:** a course for healthcare providers working in cancer care to understand the Métis context and experiences, provided on MyLearningLink (the provincial health authority's internal training system). SE Health and Alberta Health Services have been key partners in this initiative. Survey data and feedback are collected.
- **Métis Health U of A course:** a series of learning modules on Métis health, developed in partnership with University of Alberta and Rupertsland Centre for Métis Research.
- **Medical travel program:** financial support for Métis citizen's medical travel across the province.
- **Dental clinics:** in partnership with the University of Alberta School of Dentistry, affordable emergency extractions and root canals are offered to Métis children and adults in a community setting with additional cultural and social supports.
- **Alberta Métis Cancer Care Strategy:** a guide for Métis Albertans on their cancer journeys, with resources and information on each stage of a cancer journey, and supports for caretakers. This strategy has been developed in collaboration with University of Alberta, CANHelp Working Group, Canadian Partnership Against Cancer, Health Canada, and additional funding from Health Canada and Canadian Partnership Against Cancer.
- **Tobacco reduction program:** peer-led tobacco specific support group, information and financial support for nicotine replacement therapy, a youth nicotine prevention program, and other intervention supports.
- **Health Research and Advocacy:** ongoing collection of Métis specific health data and documentation of Métis health experiences, including related to chronic disease, cancer, mental health, maternal and perinatal, long-term and continuing care, and life promotion.

## **Métis Nation British Columbia – Resources & Initiatives**

The Métis Nation British Columbia (MNBC) has developed a wide range of innovative programs, resources, and initiatives to support Métis people within British Columbia. Within MNBC, AIR-HS initiatives are primarily provided through either the Ministry of Health and/or the Ministry of Mental Health and Harm Reduction. The Ministry of Health primarily leads programs such as the Métis Health Experience Program (MHEP) and includes key staff such as the Health Equity Manager, regional health coordinators, advocates, navigators, and facilitates cultural safety training and gatherings. The Ministry of Mental Health and Harm Reduction primarily leads the wellness gatherings, a Métis mental health and wellness magazine, mental health-specific navigators, wellness workers, MNBC-led crisis-line, and other mental health, substance use, and life promotion-related programming. Both Ministries work together to provide programs such as the Métis Counselling Connection Program. In short, many of the AIR-HS initiatives are managed by the Ministry of Health, and many of the Trauma-Informed Care (TIC) initiatives are managed by the Ministry of Mental Health and Harm Reduction. However, there is often overlap between AIR-HS and TIC programs and services across both Ministries.

## **Anti-Indigenous Racism in the Healthcare System Funded Initiatives**

The majority of the AIR-HS funding has been allocated to recruit critical staff positions dedicated to advocating for Métis people and their right to self-determination, safety, respect, and high quality care within the healthcare system. This has included the hiring of a Health Equity Manager who is dedicated to building relationships with external healthcare partners (e.g., health authorities), a Health Systems Advocate, and a Métis Patient Experience Advocate to support Métis citizens in navigating the healthcare system, advocating for proper care, and supporting citizens through complaints processes when unsafe care and racism occurs. A regular sharing circle and a guidebook has also been developed to support those with harmful healthcare experiences to share their stories and advocate for change and accountability. MNBC's AIR-HS work has also included honouring the legacy of Naomie Gladue, a Métis woman who lost her life after experiencing discriminatory and harmful mental health and substance use care. MNBC has been sharing her story as well as developing 'Naomie's Principle', a policy to ensure all Métis people in BC have equitable access to culturally safe mental health and substance use supports, which are free of discrimination and racism. MNBC also advocated to be engaged around the accreditation of the Health Standards Organization (HSO) Cultural Safety and Humility Standard.

## **Naomie's Story and Principle**

In October 2022, Naomie Gladue, a young Métis woman lost her life after seeking substance use recovery treatment. Naomie was determined to take these first steps in changing her life, in a way that was meaningful for her and, with the assistance of MNBC, attended a private treatment facility as public beds were unavailable. After 10 days in treatment, Naomie died of an overdose at 22 years of age. Naomie was a vibrant, beautiful, fierce protector. Unfortunately, MNBC came to understand that Naomie had experienced culturally unsafe care and is seeking

to share Naomie’s story to advocate for safer care for Métis people. This includes a community-led report documenting her story and the changes MNBC and citizens wish to see in response.

To honour Naomie’s legacy and advocate for system transformation, MNBC is developing a policy to ensure all Métis people in BC have equitable access to culturally safe mental health supports and services that are free from discrimination; promote cultural, mental, emotional, physical, financial, environmental, social and spiritual wellness; and are available when and where they need them.

### **Métis Health Experience Program (MHEP)**

The MHEP is dedicated to assisting Métis individuals, families, and communities across BC to navigate the healthcare feedback process when complaints or negative experiences arise. It also provides a safe space to share one’s stories around healthcare experiences, as well as provide resources to support a citizen in advocating for systems change.

### **Health Equity Manager**

The Health Equity Manager is a dedicated position for working with external stakeholders, partners, and systems to advocate and propose system-level change in response to anti-Indigenous racism in healthcare.

### **Métis Patient Experience Advocate (MPEA)**

The MPEA supports patients and families at a local level to move through the provincial complaint processes to advocate for anti-racist healthcare. This role collaborates with the BC Health Authority’s Patient Quality Care Offices and BC Health Regulators.

### **Complaint Process Guidebook**

The complaint process guidebook is an MNBC-led tool created to educate and support Métis citizens in understanding the process for filing a complaint regarding unsafe or discriminatory care in healthcare settings. The guidebook includes an overview of the complaints process with the Patient Care Quality Office, the Ombudspersons Office, Human Rights Tribunal, and regulatory colleges.

### **Other Initiatives related to Anti-Indigenous Racism in Healthcare Systems**

MNBC has engaged in numerous efforts to advocate for systems-level change within the healthcare system to prevent and respond to anti-Indigenous racism. Additional initiatives related to AIR-HS range from offering Métis specific training to healthcare staff, to advocating and contributing to the proposal of anti-racist legislation, and calling for Métis priorities and culturally safe care within Health Authorities’ workplans. The key partners MNBC works with include the regional health authorities within BC and the Ministry of the Attorney General. Additional funding sources identified include Public Health Agency of Canada (PHAC) and Health Canada’s Substance Use Abuse Program (SUAP).

Other initiatives related to AIR-HS include:

- ***Ta Saantii Mamawapowuk Health Gathering***: one-day event for healthcare staff across the province of BC's regional health authorities to learn about Métis specific cultural safety education and training, and to discuss key health and wellness priorities.
- ***Anti-Racist Act***: a proposed new law that aims to address systemic racism within BC, led by the Ministry of the Attorney General, with engagement from MNBC. MNBC is also working towards an anti-racist data framework and strategy.
- ***Métis 101 Presentation***: a resource provided during the health gatherings that includes the history of the Métis and the healthcare system, as well as education on the social determinants of health model, and what mental health and wellness means to the Métis.
- ***Health and Wellness Workplans with each health authority***: MNBC has been creating health and wellness workplans with each of the Health Authorities to embed culturally safe and anti-racist practices into regional policies, programs, and plans. This work has been funded and supported by the provincial Health Authorities.
- ***Health Systems Advocate***: the Health Systems Advocate works closely with all six Métis Chartered Communities in the region to represent the needs and priorities of Métis people in BC, as well as inform the Fraser Health Authority's policies, programs, strategic planning, and vision. Funded by the provincial Health Authorities.
- ***HSO BC Cultural Safety and Humility Standard***: MNBC has become involved in guiding the implementation and accreditation of the HSO Cultural Safety and Humility Standard to promote and support quality and safety across health and social services. MNBC's involvement has been funded by Healthcare Excellence Canada.

## **Métis Nation – Saskatchewan – Resources & Initiatives**

The Métis Nation – Saskatchewan has created and implemented a range of programs, services, and resources to support citizens struggling with illness, disease, mental health, and substance use. They have also implemented several cultural programs and supports focused on life and wellness promotion. Much of the work related to anti-Indigenous racism in healthcare systems (AIR-HS) is provided through the MN-S Ministry of Health. The Ministry of Health also includes the Department of Health and the Department of Mental Health and Addiction. There is often overlap between the two departments, although the Department of Health provides the majority of the programs and resources related to AIR-HS and wholistic health, including things like medical transportation, cancer care guidebooks, patient navigators, support workers, etc. There is also some collaboration within the AIR-HS programs and resources provided through the Ministry of Early Learning and Childcare.

### **Anti-Indigenous Racism in the Healthcare System Funded Initiatives**

MN-S's AIR-HS funding has primarily gone toward hiring staff for hospital settings to support Métis citizens to receive safe and respectful healthcare. This includes the hiring of a patient navigator, who helps navigate the complex systems to access necessary supports and resources, the patient advocate who provides advocacy support when racism has occurred

in the hospital, as well as patient support workers who provide additional social, emotional, spiritual, and cultural supports (e.g., facilitating access to smudging, Elders, and ceremony) to Métis citizens while in hospital. MN-S has also been documenting Métis citizens' experiences in the healthcare system through a series of videos. These videos speak to both the trauma and racism they've experienced, as well as perspectives on Métis health and wellness practices and teachings. A cultural safety framework is also in development to inform how care is provided to MN-S citizens.

### **Patient Navigators and Support Workers**

Métis specific patient navigators provide support and facilitate safe and accessible primary and community-based healthcare services for Métis citizens. With the AIR-HS funds, MN-S was able to hire five Patient Navigators to support citizens when they attend appointments in hospitals and cancer clinics across four areas of the province (North Battleford, Prince Albert, Saskatoon, Regina). Data is collected through monthly reports from staff on the number of patients supported and their associated outcomes, as well as qualitative feedback from patients.

### **Patient Advocates**

MN-S has also hired patient advocates with their AIR-HS funds. The patient advocates provide support to those who have been treated poorly in a medical appointment or received substandard care due to racism or prejudice. The patient advocates provide supportive listening, system navigation, and advocacy to promote a culturally safe environment for citizens to address healthcare grievances. Data is collected through monthly reports from staff on the number of patients supported and their associated outcomes, as well as qualitative feedback from patients.

### **Cultural Safety Framework**

MN-S is in the process of developing a cultural safety framework that defines what culturally safe care is for Métis people. This document is being developed by and with community, with roughly 19 individual phone calls with Elders and Knowledge Keepers about cultural safety, and additional engagement sessions with communities.

### **Video series**

In partnership with Healthcare Excellence Canada, MN-S has developed a video series capturing MN-S citizens' experiences with the healthcare system. The videos consist of a mix of individual and group sharing around experiences of cancer journeys, substance use and addictions journeys, and the healthcare journeys of rural community members. It also includes stories detailing incidents of racism within healthcare settings as well as success stories of those accessing culturally safe care and the role MN-S programs and initiatives have played in those positive experiences. Additionally, some videos feature Métis teachings on wellness, such as cooking a traditional meal. These videos validate the experiences of Métis individuals and promote system transformation and safer care within the healthcare system.

## **Re-Integration Support Worker Program**

MN-S is working with the provincial health authority and Correctional Services Canada to support citizens in their transition from incarceration and other justice involvement into community settings. MN-S works to support citizens in accessing housing, employment, education, mental health, and physical supports. There is currently one staff in Saskatoon and one in Prince Albert.

## **Other Initiatives related to Anti-Indigenous Racism in the Healthcare System**

MN-S provides financial support to citizens who reside in rural communities to support their travel and accommodation costs when travelling to urban health centres for specialized care (e.g., cancer treatment). Financial support and public awareness initiatives are also promoted to support citizens to quit smoking. Lastly, MN-S works in partnership with the University of Saskatchewan and Métis scholars to conduct research monitoring the rates of illness, disease, and wellness within Métis communities, and developing Métis-led models of care for mental health, substance use and addictions, and cancer. Other partners involved include the Canadian Partnership Against Cancer and the Federation of Sovereign Nations. Additional funding sources include CIHR and the University of Saskatchewan research grants.

Other AIR-HS related initiatives:

- Medical travel assistance: financial support and accommodations for Métis citizens to attend medical appointments outside of their home community.
- You can quit smoking: financial support for a portion of nicotine replacement therapy.
- Health Research: MN-S led research projects on a variety of topics from mental health, substance use, and cancer. These projects are primarily funded by CIHR and the University of Saskatchewan research grants.

## **Métis Nation of Ontario – Resources and Initiatives**

The Métis Nation of Ontario has developed and implemented a wide variety of programs, services, and resources to support citizens holistic health and wellness. The MNO's AIR-HS work is primarily led by the Community Wellbeing branch and the Healing and Wellness branch. While there is some overlap with other branches across AIR-HS initiatives, the Healing and Wellness branch leads most of the AIR-HS initiatives. Many of the AIR-HS initiatives include resource development, supporting citizen's around self-advocacy, staff support for system navigation and advocacy, and building engaging relationships with external healthcare partners and leaders.

## **Anti-Indigenous Racism in the Healthcare System Funded Initiatives**

In consideration of the short-term nature of the AIR-HS funding, MNO has primarily sought to build capacity around their current staffing complement and programming to respond to AIR-HS. Therefore, much of the funding has gone towards AIR-HS training for staff and developing a resource library to equip staff to best support citizens' needs. MNO has also developed training

modules and guidebooks to support citizens in navigating health systems and building their legal literacy to self-advocate in incidences of AIR-HS. AIR-HS funding has also largely gone toward MNO's relationship building efforts, including beginning to work with the Ontario Patient Ombudsman Office, participating in many provincial advisory tables, and establishing a circle of knowledge with partners from across the province, all to discuss priorities, projects, and opportunities for MNO engagement and feedback.

### **Ontario Patient Ombudsman Office**

MNO has been working towards building a relationship with the Provincial Patient Ombudsman Office, a key organization who receives, responds to, and helps resolve complaints from patients, residents, and caregivers about experiences in public hospitals, long-term care homes, and home and community care. Thus far, MNO's Patient Advocate has met with the office leads to plan and work toward specific goals together. The Patient Ombudsman Office has since drafted a resource document on how to best work with patient relations, with MNO feedback. MNO is collecting data on distribution rates of their resources as well as collecting stories from community members on their healthcare experiences.

### **Regional Online Resource Library (in progress)**

MNO is currently developing a resource database for frontline staff to have better access to resources to support client services and referrals within their communities and regions. The library will showcase topics such as health (dental, hearing, medical, etc.), travel, accommodations, accessibility resources, legal services, and more.

### **Frontline AIR-HS training**

MNO's Patient Advocates have been working with First Peoples Group to develop a training session to build capacity of front-line coordinators on anti-Indigenous racism in healthcare. A post participation survey is provided and collected.

### **Compassionate Companionship Online Training Modules (in progress)**

MNO has been working with the Home Hospice Association to develop Métis-specific training modules on compassionate companionship. This training will be offered to frontline staff. The modules are currently in review with an MNO internal working group, and will also be reviewed by citizens. A post participation survey is provided and collected.

### **Exploring Métis Health and Wellness Research: A Scoping Review**

A scoping review was conducted looking at research across the Governing Members and public databases on Métis health and wellness. A scoping review will be published upon review.

### **Circle of Knowledge**

MNO hosts a Circle of Knowledge four times a year, bringing together representatives from various agencies and public health partners to collaborate on various knowledge translation

activities to promote health across the province and work collaboratively on shared goals. Key partners involved include the heart and stroke foundation, retinol network, renal network, CPAC, and other public health agencies.

### **Participating in Provincial Events and Tables**

MNO actively participates in various provincial events and tables to showcase their work, raise the profile of Métis people, and identify opportunities for collaboration with external partners. Key partners MNO collaborates with include CPAC, ONWA, OIFC, ICU Cancer Care, Health Care Centres, Urban Indigenous Health Table, Joint Ontario Indigenous Health Committee, Southwestern Indigenous Health Strategy Engagement Table, First Nations and Inuit Health Branch, Anti Racism Advisory Circle, Ministry of Children, Community, and Social Services Table.

### **Patient Advocates**

With the AIR-HS funding, MNO has hired two patient advocates. The role of the patient advocates is to liaise with front line coordinators to provide information and advice on navigating various health and social systems, provide MNO advice on areas of policy, research, and programming, support internal and external exchanges, and liaise with Ontario Health teams to improve service pathways and programs.

### **Transitioning from Home Guide**

This guide provides important information to consider and empower citizens in critical care decisions around aging, including home care and palliative care. The guidebook is intended to support citizen-informed decision making and prevent elder abuse in care settings.

### **Monthly Health Awareness Information**

Each month, a bulletin is provided to front line coordinators on select health topics. The bulletins often include current and relevant information on key health issues, as well as reminders about health and safety, and advocacy best practices. Topics have included breast cancer awareness, prostate cancer awareness, and more.

### **Sensitive Topics Guide**

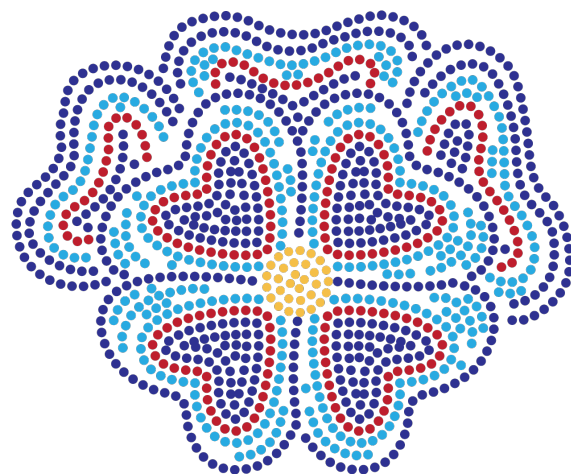
MNO has also developed a guide for front line coordinators around holding sensitive conversations with clients about their healthcare, including conversations around wills, power of attorneys, and do not resuscitate orders.

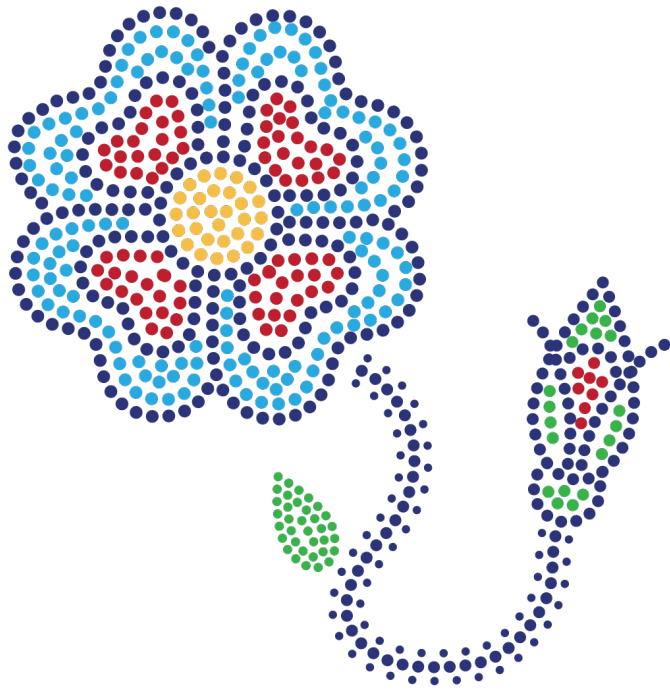
### **Other Initiatives related to Anti-Indigenous Racism in the Healthcare System**

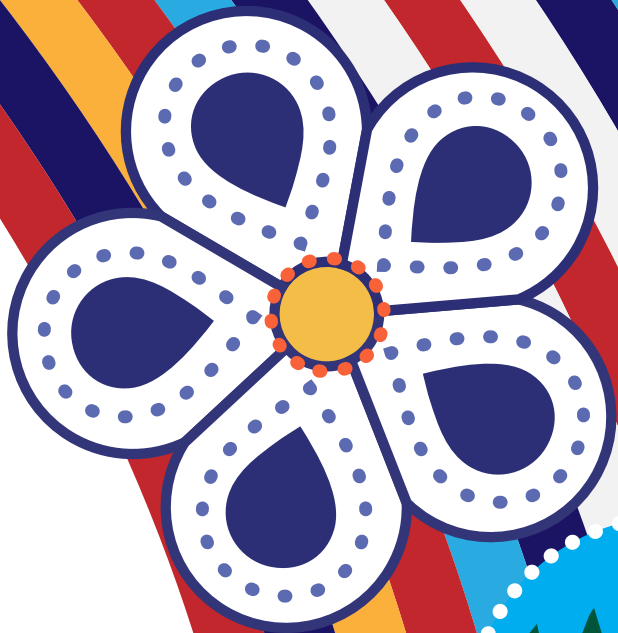
Additional AIR-HS initiatives delivered by MNO consist of a mix of health promotion initiatives, guides for navigating specific health journeys, and health research. Much of these initiatives have been in collaboration with the Ministry of Children, Community and Social Services, and

the Ministry of Health and Long-Term Care. Key health topics include cancer, diabetes, and overall family well-being.

- **Métis Family Wellbeing Program:** provides a variety of family specific programming to address the needs of families surrounding violence, child apprehension, and youth justice involvement. This work has been supplemented by funding from the Ministry of Children, Community, and Social Services.
- **Aging at Home:** support services specifically for Métis seniors over the age of 55, including home supports and contracted services to help individuals live safely and independently in their homes. This work has been supplemented by funding from funded by the Ministry of Health and Long-Term Care.
- **Diabetes Awareness Strategy:** provides resources and information about diabetes risk factors, as well as financial support for foot care, transportation, and other resources to help manage diabetes symptoms. This work has been supplemented by funding from Ministry of Health and Long-Term Care.
- **Cancer care:** a strategy to improve cancer care with and for Métis people in Ontario, in partnership with the Ontario Health Indigenous Cancer Care Unit (ICCU).
- **Health Research Initiatives and Projects:** several research initiatives and projects are undertaken each year to gain insight into the health needs of Métis people in Ontario. Current projects include chronic disease surveillance, cardiovascular disease, diabetes, cancer, respiratory disease, and other medical reports.







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