Health and Well-Being for Métis Women in Manitoba

Judith G. Bartlett, MD, CCFP, MScCH

ABSTRACT

Background: Continuing compromised Aboriginal health status and increasing opportunity for new Aboriginal health surveys require that Aboriginal understandings of health and well-being be documented. This research begins exploration of whether the Aboriginal Life Promotion Framework© may increase culturally pertinent planning, collection and analysis of health survey data.

Methods: A quasi-phenomenological tradition of enquiry was employed to gain understanding of the lived experience of participants. Data were collected through focus groups utilizing a 'talking circle' methodology. A participatory research approach involved three large Aboriginal organizations.

Results: Conceptions of health and of well-being are different entities for these Métis women. Health was most often more reflective of physical issues. Well-being was much broader, holistic and inclusive of the dimensions of spiritual, emotional, physical and mental/intellectual aspects of living, consistent with the first circle of the Aboriginal Life Promotion Framework.

Conclusions: The implications of this study should be important to health providers, and policy developers regardless of sector. Métis women in this study show significant strengths in the spiritual, emotional and intellectual/mental aspects of life, areas that could be incorporated into health promotion approaches. Physical health was focussed on ensuring a healthy diet and exercise, yet most adult women in the study experienced stress around goals that are seen as relatively unattainable. The data produced in this study should be utilized to develop and test survey questions that can be applied to a larger portion of the Métis population. The Aboriginal Life Promotion Framework is useful as an organizing tool for systematically exploring elements of living.

MeSH terms: Indians, North American; Aboriginal; Métis; Canada; participatory research; focus groups; holistic; health promotion

Aboriginal populations commonly describe life as holistic and use the terms *spiritual, emotional, physical, and mental (or intellectual)* to describe their perception of *health and well-being*.[1-3] Minimal academic exploration has been done to document this perception and the meaning of these terms with Aboriginal populations. Most health survey questions, even in Aboriginal-driven surveys,[4] have not been validated for congruency with Aboriginal culture. The purpose of this paper is to gain an understanding of the perception of health and well-being for a sample of Métis women in Manitoba and consider if this perception might be used to develop survey questions and to influence health promotion directed toward Métis women.

The study will also explore whether Métis women's perception is similar to the underlying conceptual framework used for the research – the *Aboriginal Life Promotion Framework*© (ALPF) (Figure 1).[5] During the 1994 development of an urban Aboriginal community health centre, this writer constructed the holistic ALPF by combining *medicine wheels*. Four wheels containing sixteen elements of living that I characterize as 'determinants of life' to reflect beyond the health sector, were brought together. Simply, the framework is a tool for reflecting on life by *organizing thought that already exists*. It can be used for individual, group or community assessment and planning, as well as program development. The ALPF supports understanding of individual and societal levels of existence and integration (or connectedness) within a single simple picture – through developing personal or community profiles and maintaining awareness of the relationships between and impact of all elements.

Is there need for the ALPF in research?

Generally focussed on risk factors, disease processes, and socio-economic problems, most health surveys lack context of contemporary Aboriginal understandings and lived experience. Corin states: "Concepts and methods attuned to this social and cultural heterogeneity must be developed for epidemiological and health research, along with more sophisticated methodological and analytical designs. Otherwise, strategies for action derived from epidemiological studies will remain disconnected

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

Centre for Aboriginal Health Research, Department of Community Health Science, Faculty of Medicine, University of Manitoba, Winnipeg, Manitoba

Correspondence and reprint requests: Dr. Judith G. Bartlett, Associate Professor, Centre for Aboriginal Health Research, Department of Community Health Science, University of Manitoba, Room 715, John Buhler Research Centre, 715 McDermot Avenue, Winnipeg, MB R3E 3P4, Tel: 204-975-7751, Fax: 204-975-7783, E-mail: bartlet0@ms.umanitoba.ca

Acknowledgements of Sources of Support: Special thanks are directed to the Aboriginal Health and Wellness Centre of Winnipeg, Mamawiwichiitata Centre, and the Manitoba Métis Federation for helping to make this research possible. Also thanks to Deborah Dyck of Leskiw and Associates, and my thesis committee Drs. John O'Neil, Jeff Reading and Sid Frankel.

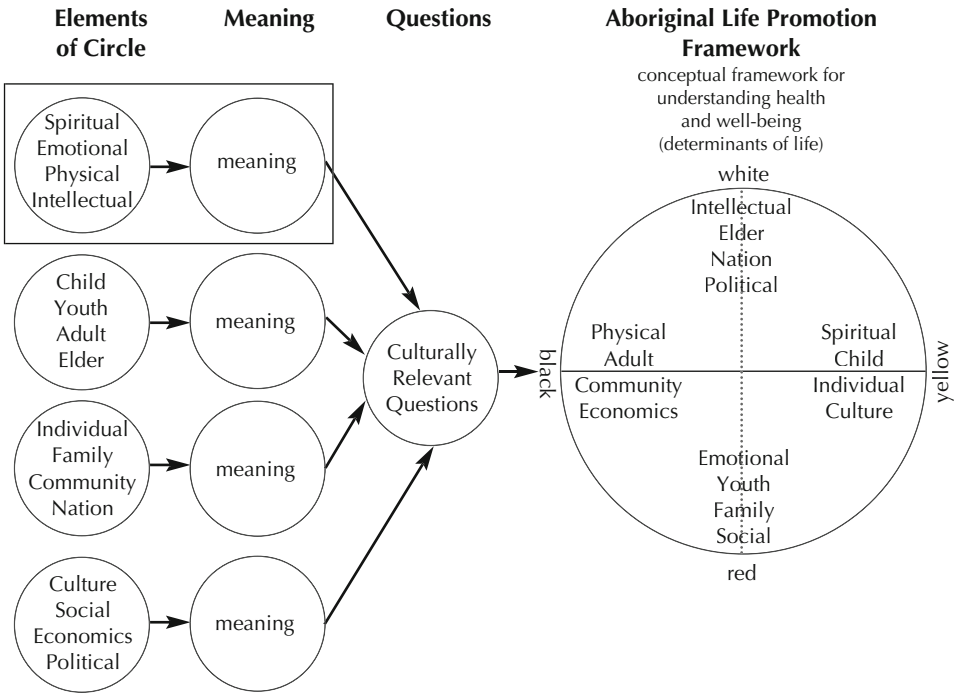

Figure 1. Using the Aboriginal Life Promotion Framework in Research

from the reality they are intended to influence."[6] Most research remains at best a poor fit for Aboriginal peoples because it is inherently rooted in Western cultural constructs and meaning.

The Aboriginal Life Promotion Framework, derived from and grounded within an Aboriginal construct of holism and connectedness, is consistent with the RCAP description of the Native concept of health,[7] and responds to Brant Castellano's call for "[h]olistic awareness and highly focused analysis [that] are complementary, not contradictory".[8] The ALPF embodies the call for a thorough integration of agency (the individual) and structure (the society) when choosing a new research methodology.[9]

Surveys ask a variety of questions that result in numerous variables to be considered for analysis. Logistic regression determines associations between variables, but less clear is the logic (conceptual framework) behind why any particular question is included at the outset. Corin argues for inclusion of the categories of culture, political, economic and social as part of a health measurement framework.[6] Hertzman outlines heterogeneities, inclusive of life stages, as important to health status measurement.[10] The ALPF includes these categories and heterogeneities, plus two additional layers of the complexity characterizing human life – one being the dimensions of well-being explored in this research, and the other the 'individual, family, community, and nation' levels at which health must be considered.

For this research, use of the ALPF was restricted to determining whether Métis women would describe health and or well-being in terms contained in its first circle (Figure 1 – upper left-hand box). The rationale for this use was to determine whether the ALPF might be congruent as a culturally appropriate conceptual framework for survey research.

METHODS

A *quasi-phenomenological tradition* of enquiry was employed to gain understanding of the lived experience of participants. Data were collected through focus groups rather than in-depth interviews, and the researcher began with a conceptual framework – not the usual phenomenology method.[11] An initial hypothesis was that Métis women would describe *health and well-being* as similar to popular holistic Aboriginal conceptions and the terms *spiritual, emotional, physical and intellectual/mental* would arise *'spontaneously'* in discussions.[7] Questions were constructed in a manner to ensure descriptions were not influenced – the ALPF was not presented, and terms of interest were not explored until they arose spontaneously. To reduce bias due to familiarity with the conceptual framework, an external Aboriginal firm recruited and facilitated the focus groups; the researcher attended all sessions to ensure retention of 'voice'.

A *participatory research approach* involved three large Aboriginal organizations. Two provided feedback on the research proposal and questions, and all allowed placement of recruitment posters in visible places at their sites. Posters were also placed in numerous other community sites. Interested individuals contacted the researcher or the contracted recruiter to get more information and determine whether they might participate in the study. Recruitment continued until enough individuals were available to implement the focus groups. Seventeen Métis women participated in three focus groups stratified into two age groups (25-54 and 55+) and length of residence in an urban setting (1st and 2nd or more generations). The 1st generation adult group consisted of rural residents who recently relocated to an urban environment, thus results will be shown in terms of rural and urban rather than by generations.

A *talking circle methodology* that uses symbolism grounded in Aboriginal cultural context was used for data collection. A general context of the research was set, and then the talking circle process and protocol were explained. Participants were asked if they would agree with holding a symbolic object when speaking. Upon posing the first question, the facilitator handed the object (a stone) to a participant who volunteered to start the circle. This begins the first 'round', and the focus question was repeated intermittently to encourage speakers to respond to the question rather than to the previous speaker. The passing of the object is a symbolic cultural gesture that provides a psychological space where there is freedom to reflect deeply and personally even in the presence of others. At the same time, the process facilitates active listening. The researcher must track speakers since it is unfair to ask the same speaker to begin with each new question. This can allow easier handling of data and tracking individual respondent statements that may be handled in a manner more similar to in-depth interviews used in phenomenology.

Data for each term and group *were processed in two stages*. First, synthesis resulted in descriptive narratives, and then analysis of narratives resulted in contextualization of Métis women's health and well-being. *Synthesis* consisted of coding transcribed data, grouping coded statements, creating a narrative for groups of coded statements, developing summary term statements and finally developing summary group narratives. Synthesized group narratives were sent to respective participants to obtain feedback, resulting in some minor edits. Summary group narratives were then analyzed for themes. *Analysis* consisted of developing code words until a saturation point was reached. A three-step analysis process ensured internal consistency in coding within and across groups. A coding mismatch resulted in review of the participant quotes to determine which code was most representative of the quote's intent. For this paper, only the synthesis results are presented.

RESULTS

Participant socio-demographics

Table I shows that urban and rural adult Métis women's mean ages were not significantly different, and elder Métis women's mean age was 59 years. A 2nd generation (urban born) elders group was unavailable – most elders were rural born but lived their adult years as urbanites. Elder and rural women had a higher median income range. All elder women were employed either full-time or casually. Urban adult women were more likely un/under-employed or homemakers. Elder and urban adult women appear to have significantly less education than rural women, although this may be an artifact (see limitations section). Rural adult and elder women were more likely to be divorced or separated. Despite apparent differences, much congruity in meaning of terms across groups was present.

TABLE I

Demographic Profile of Métis Women Participants

Demographic	Rural (1st Gen) Adult	Urban (≥2nd Gen) Adult	Elder
Age mean (standard deviation)	36 (4.2)	31 (3.6)	59 (2.7)
Education* mode	Some university/ college†	Grade 5-10	Grade 5-10
Marital Status* mode	Divorced/separated	Married/common law	Divorced/separated
Income median range	$20,001-$30,000	$10,001-$20,000	$20,001-$30,000
Occupational Status mode	Full-time student	Unemployed or under-employed	Full-time employed

* Categories collapsed due to small numbers
† As noted in the text, this mode may be falsely high

TABLE II

Conceptions of Health (Adult and Elder Métis Women)

All Groups	Good nutrition and physical activity Responsibility for others, especially healthy diet for children and family Understand and accept disadvantage and functional decline with age

TABLE III

Conceptions of Well-Being (Adult and Elder Métis Women)

All Groups	More holistic and differentiated from health; more than physical and disease processes Existence and action as part of collectivism rather than individualism Balancing of life aspects of physical, emotional, spiritual and intellectual; also body, mind and soul

TABLE IV

Differences Across Groups (Adult and Elder Métis Women)

Group	Health	Well-Being
Rural (1st Gen) Urban (≥2nd Gen)	• Optimum function of body/mind • Need to eliminate negative behaviours • Health impacted by lack of education/job	• Responsibility for others can impact on caring for one's own well-being
Elders	• Need to eliminate negative behaviours	• Having level of self-understanding and acceptance • Absence of physical limitations

Conceptions of health and well-being

Conceptions of health and of well-being are different entities for these Métis women. Health was most often more reflective of physical issues. Well-being was much broader and holistic. Meanings for 'health' and for 'well-being' that are common across age and residence are found in Tables II and III, respectively. Table IV outlines meanings that were different across groups.

Conceptions of Health for Métis women include: a need for *good function and sustenance of the body* such as exercise and a healthy diet; responsibility for others, especially ensuring a *healthy diet for children and families*; and an *understanding/acceptance of disadvantage and functional decline with age*. All groups expressed these themes as less related to personal health needs, and more a responsibility to stay healthy 'for' families. Only 3 of 17 women included the first circle ALPF terms as part of health. *Conceptions of Well-Being* for Métis women include: *holism and nurturance*; *balance of life aspects*; and *existence as part of a collectivity* rather than individualism. Most women voiced the terms spiritual, emotional, physical and mental/ intellectual as being the holistic aspects of well-being. A couple of women also saw well-being as balance of body, mind and spirit.

Dimensions of well-being

Dimensions include the terms *spiritual, emotional, physical and mental/intellectual* that clearly arose most consistently within discussion of the term "well-being". Table V shows a high consistency in meaning across groups, and a detailed description of each term is outlined below.

Description of ***spiritual*** revealed prayer as the primary method of practicing spirituality. Some adult women described alienation from spirituality due to early life religious experience, followed for some by initial confusion as to whether, as Métis, they could utilize indigenous historical ceremonial activities. Ultimately most came to understand that the method of spiritual practice

TABLE V

Dimensions of Well-Being for Adult and Elder Métis Women

	Spiritual	Emotional	Physical	Intellectual/Mental
Adult (25-54) Rural (1st Gen)	Belief in God or a 'higher power' with whom one may seek guidance	Feelings such as anger, sadness, and joy, and physical symptoms of nervousness, stress and anxiety	Good nutrition and physical activity, feeling good in your own body, having the energy to undertake basic daily activities, optimum functioning of the body, and having access to a clean and safe environment	Being about thinking, learning, reading and keeping one's mind active
Adult (25-54) Urban (≥2nd Gen)	Practice of spirituality through the Creator in order to gain strength	Feelings such as hurting, happiness, sadness, and anger	Healthy diet and physical activity, and being as active as possible	Being intelligent or smart; learning new things each day through education or life experience to accomplish goals and help others
Elder	Belief in a Creator or God who provides strength, courage and a sense of being looked after	Feelings such as anger, sadness, grieving, and 'feeling sorry for one's self'	Appropriate diet, being in good physical shape, getting regular exercise, caring for the body through rest and avoidance of stress, and orderly and clean physical environment	Being about maintenance of inquisitiveness or curiosity about life, and about learning new things on a regular basis

was not as important as becoming spiritually well – that no single approach is superior. Most adult women came to accept and practice traditional approaches as relevant to their lives. Elder Métis women did not express having experienced this confusion, and saw traditional spiritual practice as a powerful way to connect with one's inner peacefulness. Spiritually well individuals are described as having strength and resistance to adversity in difficult circumstances; being supportive, accepting, and non-judgemental; and caring for the spiritual needs of children, including choice.

Description of ***emotional*** revealed a reflection that no one is perfectly emotionally balanced, and quickly releasing negative emotions is essential. Emotionally well individuals are those who can identify feelings and understand their sources; accept emotions as part of the self; express feelings and keep others' feelings confidential; manage and control emotions in daily life; and understand that emotional well-being can only truly arise within one's self. For some Métis women, emotionally well individuals are also thought to be spiritually well, free of drugs and alcohol, practicing traditional activities, and acting as positive emotional role models.

Description of ***physical*** revealed this as a source of great stress and anxiety for most participants. Adult Métis women had feelings of discouragement and a general dissatisfaction with body image due to obesity and loss of youthful vitality. Most adult women did not consider themselves physically fit, and admitted to involvement in practices thought to be harmful, such as smoking. For elder women, motivation was considered an important aspect of maintaining physical well-being. Fear of loss of independence through progression of physical problems was a clear motivator to increase physical activity. Physically well individuals eat a proper diet; are physically active and fit; ensure their children have adequate diets and nutrients; and work hard.

Description of ***intellectual/mental*** revealed this as involving the mind, learning, and remaining curious about life. There was no perceived connection between age and intellectual well-being. Remaining intellectually active was seen as a lifelong activity, and increased age was not to be used as an excuse for allowing interest in life to lapse or for becoming intellectually inactive. Intellectually well individuals learn from reading and reflecting each day; have an attitude of openness to new ideas or 'out of the box thinking'; respect the views of others; are advanced and at ease in both their thinking and abilities; are rapidly adaptable to circumstances, responding with creative ideas; and attain higher education despite difficult life experiences. Some stated that elders who can teach and learn both old and new information are intellectually well.

DISCUSSION

A need to refocus health promotion and programs

Aboriginal populations in Canada continue to suffer the hardship of living in poverty conditions,[12] have disproportionate morbidity,[4,13] twice the infant mortality rate,[14] and still lag behind the general population in terms of life expectancy.[15] Because of the propensity to measure such statistics, researchers, policy-makers, program providers, and society in general identify Aboriginal populations mostly from the perspective of having poor health status. Even helpful intentions, unfortunately, can also personify Aboriginal peoples as victims with limited capacity to address problems.[16,17] Little effort has been put into understanding and describing the essential substance of Aboriginal populations – substance with which they remain vibrant and future-oriented despite many challenges.

Little academic effort has been expended for research on the meaning – conceptions and dimensions – of Aboriginal health and well-being for the purpose of program development. Most programs are boilerplate replicas of approaches developed for majority populations. For example, the mainstay for addressing diabetes mellitus has been counselling on physical aspects – diet and exercise, and screening and treatment for physical complications. This research shows that the physical area presents the most stress for Métis adult women. Spiritual, emotional and intellectual impacts of diabetes on individuals and their families have generally not been considered. Neither have resources that might be drawn from these areas of strength often been integrated or applied to addressing such disease entities.

This research clearly shows that for Métis women, a major motivating factor in

maintaining well-being is grounded within a sense of collectivism rather than individualism. Yet, most health promotion continues to focus on individualistic approaches that do not support Métis women's collectivist orientation to life. As well, it is clear that many systemic barriers, not usually considered in health promotion approaches, prevent Aboriginal prosperity.[7] Health promotion unfortunately remains embedded within an approach that can feel to some like a 'blame the victim' orientation. One woman, expressing her defiance and disgust at how poor people are judged by society, powerfully stated:

"Because we're on assistance or because we've had troubles in our life, don't begrudge us and look down on us – and think that we're no good, and we're never going to amount to anything. You know, like I'm always proud of my accomplishments. I don't care whether people like it or not. You have to be proud of what you're doing."

Limitations

The small number of women in the study cannot be considered a representative sample of Métis women in Manitoba. The demographic profile was intended only to determine whether there were significant differences between 1st/2nd (rural/urban) generation participants that might account for differences in perception between groups. Although the rural women participants appeared to have more education than the other groups, this may be an exaggerated difference since some of these women may have chosen '*some*' to the university/college category because of their current student status. Since so few differences in perception between groups appeared, it is questionable whether formal educational attainment alone has an independent influence on perception of health and well-being, which may also draw on understanding of general life experience and traditional learning. Although the small sample does not allow generalization of results, the latter should nevertheless be further explored through development and testing of survey questions that can be validated with a larger Métis population.

In considering the reporting of the dimensions of well-being, one should be cognizant that data were collected and reported on the basis of specific terms and an organizing framework, thus introducing what might be described as a '*coherence artifact*'. Coherence artifact can be thought of as '*falsely creating a perception of the existence of organized and structured thinking*'. Although the women did specifically voice the components of well-being as inclusive of the terms spiritual, emotional, physical and intellectual/mental, this arose because of having been asked a question to elicit such components. It is unlikely that the women's daily lives and reflections progress in this systematic manner. This statement about coherence artifact is not meant to imply that Métis women do not have critical thought about their lives (on the contrary, it was very apparent that they reflect deeply), and should not detract from utilizing the meanings of the terms to develop and validate survey questions.

It is important to understand that because this research was for an academic thesis, only one researcher completed the data synthesis and analysis. To ensure validity of the synthesis, the narratives were sent to participants for feedback. For the analysis, it is possible that other researchers might find different themes arising from the narratives. To mitigate this, a complex analysis process that required three separate coding stages was done. Analyzed narratives are not reported in this paper.

CONCLUSION

Considering Métis women's perspectives on health and well-being, alternatives to current health promotion and health education strategies must be considered.[18] Important critiques of such strategies have not resulted in a shift away from social marketing.[19] These approaches have had limited critical review and continue to be [poorly functioning] social marketing tools directed toward Aboriginal peoples as 'at risk' populations.[20,21] Options for policy and program framework development that are grounded in Aboriginal meaning and that draw on the strengths and culture of Aboriginal populations are critically needed.

Interestingly, the 'determinants of health' model with some prescience includes a box titled 'Well-Being', and thus appears to hold promise.[22] Despite the seemingly logarithmic increase in use of the term 'well-being' in health and other fields, the lack of literature on this subject reveals poor researcher engagement in defining the content of this Well-Being box. Systematic exploration of well-being and life is essential for Aboriginal peoples in order to develop appropriate responses to addressing compromised health status. Exploration of the 'well-being box', which no doubt involves elements beyond the health sector, is equally important to other populations in Canada.

Of particular importance in our disease-based health care system – except for physical disability that impacts on daily function and the perception of a need to follow a doctor's advice for a health problem, as mentioned by some elder women – most Métis women in this study did not articulate 'disease' as being a component of either health or well-being. This factor *must* be further explored.

Of note, health determinants[22] and population health[23] frameworks are now utilized in health service planning,[24] and it is clear that both *agency* and *structure* are important to health.[25] Yet, Aboriginal populations still live in poverty,[12] have high unemployment,[26] and few education opportunities[27] – the source of which is as often structure as it is agency. At the same time, our health service sector continues to focus primarily on agency and disease.[28] It will be important to explore the remaining elements contained in the Aboriginal Life Promotion Framework, from both the agency and structure perspectives, in order to best inform policy and programs for all sectors.

In summary, this research presents a synthesis of Métis women's perspectives on health and well-being that provides a counterbalance to sometimes overwhelming negative descriptions. Health is expressed as involving physical aspects of living, while well-being is holistic, integrated and includes the dimensions of spiritual, emotional, physical and intellectual/mental aspects of human life. It is clear that Métis women reflect deeply and understand the context of their own existence. Also discussed is the need to develop alternatives to current individualistic social marketing health promotion methods. The health sector, along with other important players such as education and employment, can play a role in advancing such alternatives through devel-

oping policies and programs that are based on context-appropriate and culturally grounded research. Certain limitations in the research were presented but this should not prevent use of the results to develop and validate survey research questions related to this first circle of the Aboriginal Life Promotion Framework. A continuation of a systematic exploration of meaning of all terms within the ALPF with Aboriginal populations is essential to increase culturally pertinent planning, collection and analysis of health survey data.

REFERENCES

1. Bopp J, Bopp M, Brown L, Lane P. *The Sacred Tree*. University of Lethbridge, Alberta: Four Worlds Development Press, Four Worlds Development Project, 1984.
2. The Ma Mawi Wi Chi Itata Centre Inc. *Considerations Relative to the Articulation of a Holistic Model of Health and Wellness for the Aboriginal Community of Winnipeg*. Presentation to The Royal Commission on Aboriginal Peoples, 1993.
3. National Aboriginal Health Organization. *Urban Aboriginal Health Centres Meeting, March 2002, Winnipeg, Manitoba*. Ottawa: NAHO, 2002.
4. Health Canada. *First Nations and Inuit Regional Health Survey (FNIRHS) National Report*, 1999.
5. Bartlett JG. *"UFO" in a Dream*. Term Paper on Medicine Wheel Life Promotion Framework (concept developed by author) submitted to Dexter Harvey P.E.D. for Health Promotion Course 93.739, University of Manitoba; December 1997.
6. Corin E. The social and cultural matrix of health and disease. In: Evans RG, Barer ML, Marmor TR (Eds.), *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Walter de Gruyter, Inc., 1994.
7. Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples*. Ottawa: Indian and Northern Affairs Canada, 1996.
8. Brant Castellano M. Ethics of Aboriginal Research. *J Aboriginal Health* 2004;1(1):98-114.
9. Poland BD. Learning to "walk our talk": The implications of sociological theory for research methodologies in health promotion. *Can J Public Health* 1992;83(Suppl 1):S31-S46.
10. Hertzman C, Frank J, Evans R. Heterogeneities in health status and the determinants of population health. In: Evans RG, Barer ML, Marmor TR (Eds.), *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* New York: Walter de Gruyter, Inc., 1994.
11. Creswell JW. *Qualitative Inquiry and Research Designing; Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications Inc., 1998.
12. Campaign 2000. *Child Poverty in Canada, Report Card 1988*. Toronto, ON, 2000.
13. Waldram JB, Herring DA, Young TK. *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*. Toronto: University of Toronto Press, 1995.
14. Hallett B, Nemeth M, Stevens H, Stewart D, Government of Canada, Government of Manitoba. *Aboriginal People in Manitoba 2000*. Winnipeg: Aboriginal Single Window or Manitoba Aboriginal Affairs Secretariat, 2000.
15. Health and Welfare Canada. *Aboriginal Health in Canada.* Ottawa: Minister of Supply and Services Canada, 1992.
16. Gerber LM. Multiple jeopardy: A socio-economic comparison of men and women among Indian, Métis and Inuit peoples of Canada. *Can Ethnic Studies* 1990;XXII(3):68-82.
17. McEvoy M, Daniluk J. Wounds to the soul: The experiences of aboriginal women survivors of sexual abuse. *Can Psychol* 1995;36(3):223-35.
18. McQueen D, Noack H. Health promotion indicators: Current status, issues and problems. *Health Promotion* 1988;3(1):117-25.
19. Labonte R, Penfold S. Canadian perspectives in health promotion: A critique. *Health Educ* 1981;19:4-9.
20. Allison K. Health education: Self-responsibility vs. blaming the victim. *Health Educ* 1992; 20(3-4):11-13,24.
21. Stevenson HM, Burke M. Bureaucratic logic in new social movement clothing: The limits of health promotion research. *Can J Public Health* 1992;83(Suppl 1):S47-S53.
22. Evans RG, Stoddart GL. Producing health, consuming health care. *Soc Sci Med* 1990;31(12):1347-63.
23. Federal/Provincial/Territorial Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians.* Ottawa, 1994.
24. Manitoba Health. *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*. Winnipeg: Government of Manitoba, 1997.
25. Bandura A. Ontological and epistemological terrains revisited. *J Behav Ther Exp Psych* 1996;27(4):323-45.
26. Canadian Medical Association. *Bridging the Gap, Promoting Health and Healing for Aboriginal Peoples in Canada.* Ottawa, 1994.
27. Young TK. *Health Care and Cultural Change: The Indian Experience in the Central Arctic*. Toronto: University of Toronto Press, 1988.
28. National Aboriginal Health Organization. *Final Report on Proceedings of Métis Health Policy Forum, April 2002 Saskatoon, Saskatchewan*. Ottawa: NAHO Métis Centre, 2002.

RÉSUMÉ

Contexte : Pour contrer l'affaiblissement de l'état de santé des Autochtones et accroître la possibilité d'entreprendre de nouvelles enquêtes sur la santé autochtone, il faut documenter la perception qu'ont les Autochtones de la santé et du bien-être. Notre étude est une première analyse visant à déterminer si l'outil Aboriginal Life Promotion Framework[MD] (« cadre de promotion de la vie autochtone ») peut rehausser la planification, la cueillette et l'analyse d'indicateurs de santé adaptés à la réalité culturelle autochtone.

Méthode : Nous avons eu recours à une tradition d'enquête quasi phénoménologique pour mieux comprendre le vécu des participantes. Les données ont été recueillies à l'occasion de « cercles de discussion » en groupe. Enfin, nous avons adopté une démarche de recherche participative en faisant appel à trois grands organismes autochtones.

Résultats : La santé et le bien-être étaient deux notions différentes pour les femmes métisses participantes. En général, la santé désigne pour elles tout ce qui a trait au corps. Le bien-être, une notion beaucoup plus vaste, englobe la dimension spirituelle, affective, physique et mentale de la vie et correspond au premier cercle de l'outil Aboriginal Life Promotion Framework.

Conclusions : Cette étude devrait avoir des répercussions importantes pour les dispensateurs de soins de santé et les décideurs, quel que soit leur secteur d'activité. Les Métisses ayant participé à l'étude ont manifesté des forces considérables sur le plan spirituel, affectif et mental – trois aspects qui pourraient être intégrés dans les démarches de promotion de la santé. Pour ces femmes, la santé physique était liée à une saine alimentation et à l'exercice, mais pour la plupart des femmes adultes de notre étude, ces objectifs étaient une source de stress, car ils leur semblaient hors d'atteinte. Les données de l'étude devraient servir à élaborer et à tester un questionnaire d'enquête, que l'on pourrait ensuite administrer à un plus grand pourcentage de la population métisse. Le cadre employé est un instrument d'organisation qui s'avérerait utile pour une analyse systématique des aspects du vécu.