



Assessing the Impact of Health Talks on Métis Elders Exercise and Nutrition Behaviour

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Abstract

Colonization has profoundly shaped Indigenous health in Canada, contributing to persistent inequities, high rates of chronic disease, and reduced life expectancy. Although Métis peoples represent a significant portion of the Indigenous population, they remain underrepresented in health-promotion and knowledge-translation research. This study explored culturally relevant, Métis-led approaches to sharing health information and supporting wellness. Using a community-based participatory research approach grounded in Métis worldviews and Wahkootowin (interconnectedness), we delivered 11 monthly Métis-led Health Talks (January 2024–January 2025) focused on physical activity, nutrition, and holistic health. Métis Elders ($n = 14$; ≥ 50 years) completed post-program surveys and participated in a semi-structured focus group. Survey data were analyzed descriptively, and qualitative data using inductive content analysis. Survey findings showed high satisfaction, engagement, and perceived cultural respect (mean scores $\geq 4.1/5$), alongside moderate

self-reported improvements in physical activity and nutrition. Qualitative analysis identified four themes: increased awareness and early behavioural shifts; strong program acceptability; logistical and structural barriers to participation; and the need for deeper Métis-specific cultural integration. Overall, Métis Elders valued the Health Talks as a culturally relevant and accessible health-promotion approach. Findings underscore the importance of Indigenous-led, community-based Knowledge Translation initiatives in supporting Métis wellness and addressing ongoing health inequities.

Keywords and Concepts Métis health, Indigenous health inequities, colonization and health, community-based participatory research, Indigenous knowledge translation, culturally safe health promotion, Elder-focused health interventions.

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Introduction

Indigenous health is a complicated issue in Canada. Indigenous peoples have faced systemic racism for generations. Due to policies like the Indian Act of 1876, they endured negative residential school experiences and live within a colonial system that has established a hierarchical distribution of power, control, and resources (Hurley & Gordon, 2009; Reading & Wien, 2009). It is well documented that the state of contemporary Indigenous health relates to colonialism (Kolahdooz et al., 2015; Paradies, 2016; Reading & Wien, 2009). Colonialism has been identified as a distal determinant of health. According to Reading and Wien (2009), distal determinants have the most impact on population health by creating systemic barriers that affect both individuals and communities. In colonized countries like Canada, the historical impacts of colonization on the health, social, economic and cultural experiences of Indigenous peoples are well documented (Paradies, 2016). Discrimination, segregation, and transgenerational trauma have led to health disparities. Colonialism has shaped the dominant understanding of health and influenced how care is delivered, while marginalizing Indigenous knowledge systems.

The disempowerment of Indigenous ways of knowing is shaped by fundamentally distinct epistemologies. European and Indigenous

worldviews provide two distinct perspectives on how the world works and how health is understood. Colonial perspectives are “linear and singular, static and objective” and all about progress (Bear, 2000, p. 82). This perspective results in “bigger, higher, newer, or faster being preferred over smaller, lower, older, or slower” (Bear, 2000, p.82). European perspectives cannot fully encompass the holistic ideas found in Indigenous ways of knowing. In contrast, Indigenous worldviews focus on “circular and cyclical aspects of the world” (Csaki, 2015, p. 51). This is best demonstrated by “the Wheel of Life” (George, 1991, p. 162). Also known as the medicine wheel, this symbol represents the interconnectedness of the world. It embodies a holistic framework of well-being that guided Indigenous understandings of health.

Many Indigenous Nations, including the Métis, are guided by the Medicine Wheel or similar holistic frameworks with differing interpretations across Nations. Within the Métis context, this underlying structure provides the foundation for relational principles such as Wahkohtowin—the interconnectedness of all relations. Wahkohtowin incorporates relationships among people, families, communities, the land, and future generations, while reflecting reciprocal responsibilities and collective wellbeing. It provides a relational framework that guides the creation and sharing of knowledge (Wildcat, 2018).

Indigenous peoples had a long and proud history of prioritizing health and well-being. According to Lipski (2010), Indigenous peoples living traditional lifestyles were largely exempt from modern diseases such as cancer, heart disease, and diabetes mellitus. Their pre-colonial way of being prioritized a balance among the various Medicine Wheel components of physical, emotional, mental, and spiritual health (Watts, 2016).

Today, Indigenous peoples lack access to health care services, experience high rates of chronic disease, and have a reduced life expectancy of more than a decade compared to non-Indigenous Canadians (Bethune et al., 2019; Kolahdooz et al., 2015; Turpel-Lafond & Johnson, 2021). Importantly, this is not a reflection of any intrinsic trait; these gaps result from systemic inequities. The comparisons made in this paper function only to illustrate the inequitable health

outcomes that result from unequal conditions, rather than to imply inherent group differences.

Recent attention has focused on the rapidly rising prevalence of chronic diseases—including hypertension, heart disease, and type 2 diabetes mellitus (T2DM) (British Columbia Provincial Health Officer, 2009; Health Council of Canada, 2012). For example, T2DM affects Indigenous peoples at up to three times the rate of the general Canadian population and carries a 30% greater lifetime risk (Crowshoe et al., 2018; Turin et al., 2016). Indigenous peoples are aging faster and have more chronic conditions early in life (Reading & Wien, 2009; Wilson & Young, 2008), leading Indigenous Elders to be one of Canada's most vulnerable populations (Health Council of Canada, 2013; Walker, 2020). Culturally appropriate solutions that can restore Indigenous health and wellbeing are needed.

The Métis are one of three constitutionally recognized Indigenous peoples in Canada, along with First Nations and Inuit (Crown-Indigenous Relations and Northern Affairs Canada [CIRNAC], 2026). They are a distinct Indigenous group with a unique history, culture, language and governance system that developed from the historic Métis Nation in the Canadian Prairies (Saunders & Dubois, 2019). The Métis people emerged from the fur trade in the late 1700s, as a result of intermingling between First Nations women and French voyageurs (Rivard, 2004). Métis identity was established in the early 1800s; governance structures were initially developed during buffalo hunts and Métis rights were later enshrined in Canadian legislature through the 1870 Manitoba Act (Saunders & Dubois, 2019).

Contemporary Métis governance is led by the Métis National Council, which is comprised of five Métis governments, including the Métis Nation British Columbia (MNBC) (Saunders & Dubois, 2019). MNBC is composed of regional Métis Chartered Communities, which function as local representative bodies and provide programs, services, and opportunities for community engagement (Métis Nation British Columbia, 2026). This study was conducted in partnership with a local MNBC Chartered Community, whose members are part of the broader provincial Métis governance structure.

In Canada, it is essential to distinguish between individuals who merely self-identify as Métis and

those who are registered citizens of a Métis government. Citizenship within Métis governments such as MNBC requires meeting established criteria, including: 1) self-identification, 2) being distinct from First Nations or Inuit, 3) evidence of genealogical ties to the historic Métis Nation, and 4) acceptance by the contemporary Métis community (Belcourt, 2013). Participants in this study were recruited through the partnering MNBC Chartered Community (the Kelowna Métis Community Services of BC Elders' Circle), reflecting engagement with an established Métis governance organization.

Gaps in the literature

Despite growth in Indigenous health research and the fact that Métis peoples represent over 30% of Indigenous people in Canada (Statistics Canada, 2018), there remains limited health promotion literature focused on Métis communities (Oosman et al., 2021). Research continues to prioritize First Nations and Inuit populations, leaving the Métis the least studied Indigenous group in Canada (Wilson & Young, 2008; Wilson et al., 2011; Young, 2003).

Although the Métis experience health challenges similar to other Indigenous peoples, there is no evidence that this has shifted, highlighting a persistent gap in literature specific to Métis health and wellness promotion (Bartlett et al., 2010; Gmitroski et al., 2023). Their underrepresentation underscores the need for dedicated Métis health promotion research.

Mainstream KT frameworks, such as knowledge-to-action and integrated KT, offer a useful structure (Graham et al., 2006) but lack the cultural sensitivity needed to reflect Métis history and worldviews. Community-specific approaches—such as co-designing resources with Métis Elders and leaders—remain largely unevaluated (Gmitroski et al., 2023). As a result, it is still unclear which KT strategies best support Métis communities in accessing and applying health information. Culturally relevant studies that address Métis Elders' wellness challenges, including barriers to physical activity and access to healthy food, are essential to closing this gap.

Research Purpose

Using a community-based participatory research (CBPR) approach grounded in Métis-centred knowledge translation (KT) and the principles of

community engagement, relationality, and Indigenous ways of knowing (Viswanathan et al., 2004). This study explored how health information can be shared and applied in meaningful, culturally relevant ways for Métis Elders and communities.

This work contributes to Indigenous health-promotion literature by piloting a Métis-centred KT framework that integrates CBPR principles with talking circles and Métis worldviews. Building on successful KT approaches in First Nations and Inuit communities (Campbell et al., 2020; Jernigan, 2010; Wilken & Nunn, 2017), we collaborated with Métis Elders, community leaders, and university professors to design and deliver iterative Health Talks workshops. The project aimed to a) identify perceived barriers to healthy PA and nutrition habits, b) assess the perceived impact of the Health Talks, and c) evaluate their cultural relevance, offering empirical insight into Métis-specific KT strategies for health promotion.

Methods

Project Background and Approach

The Health Talks project emerged through ongoing relationships with Métis community leaders and was grounded in culturally relevant health promotion. The talks were led by experts from the University of British Columbia Okanagan including Dr. Jonathan Little (Exercise and Metabolic Health), Dr. Mary Jung (Diabetes Prevention Program), and Dr. Kathleen Martin Ginis (Adapting Exercise for Individuals with Medical Conditions). A total of 11 Health Talks took place between January 2024 and January 2025 with Métis Elders, focusing on improving healthy habits through physical activity and nutrition. The talks supported holistic wellness, with topics addressing mental (exercise and cognitive health), physical (adapting exercise for injuries, medical conditions, and disabilities), emotional (Indigenous health and reconciliation), and spiritual aspects, including gratitude to the Creator and land acknowledgments.

The research component used mixed methods to explore Métis Elders' experiences with the program. Data collection included a survey and focus group to 1) evaluate program effectiveness through post-program changes in self-reported physical activity and nutrition habits, and

2) assess cultural relevance through content analysis of focus group feedback. The goal was to inform sustainable, culturally grounded health-promotion programming for Métis Elders that could be adapted by other Indigenous communities.

The research approach was through a constructivist paradigm, prioritizing meaning-making and participants' experiences over hypothesis testing. Consistent with a relativist ontology, we viewed knowledge as subjective, contextual, and co-created between researchers and participants. In line with constructivist principles, we acknowledge our positionality and its influence on data collection and interpretation (Tracy, 2010).

This research is particularly relevant because the Métis community, like many Indigenous peoples, has experienced the impacts of colonization, including the loss of traditional food systems and cultural practices that promoted physical activity. Many Elders in the community are living with chronic diseases such as Type 2 Diabetes Mellitus, and addressing these health issues through culturally relevant programming is crucial. The study explored how well these health talks were received, whether they led to changes in health behaviors, and how the program could be improved for future community-based health initiatives.

By incorporating feedback from the Elders and using qualitative and quantitative surveys, this study aimed to offer insights into how to better engage Indigenous communities in health programs. It will also consider the cultural relevance of the delivery format (e.g., talking circles) and how this can improve trust and health outcomes.

Relationship Researcher Positionality

The first author is a 31-year-old Canadian male with Indigenous and settler heritage, born in Penticton, BC, on the traditional, ancestral, and unceded territory of the Syilx Okanagan peoples. Although Métis, I grew up in a settler environment and view myself as an uninvited guest on Syilx territory. I am grateful for their stewardship of the land where this project took place. Positioning myself within this research is essential. As a member of the Métis Nation of British Columbia and the Kelowna Métis Association, a UBC medical student, and a

Health and Exercise Sciences graduate, I am well-situated to conduct this work. My lived experience shapes a holistic approach to health and PA, grounded in cultural humility and awareness of colonial power dynamics, and motivates my commitment to community-led, culturally safe research.

The second author is a 58-year-old Canadian woman of settler heritage (Irish, Scottish, and English). I was born and lived for many years in Southwestern Ontario on the traditional lands of the Wendat, Haudenosaunee, and Mississauga nations, within the Dish With One Spoon wampum territory. For the past decade, I have lived and worked as an uninvited guest on Syilx Okanagan territory. I am a professor in the Department of Medicine and the School of Health and Exercise Sciences at UBC Okanagan, leading a 25-year community-engaged research and KT program addressing health inequities among people with disabilities. In this project, my positionality is that of mentor and learner—supporting the research process while deepening my understanding of colonization’s impact on Métis Elders and pathways toward reconciliation and improved health equity.

Health Talks

Table 1 outlines the topics delivered through the Health Talks program. Early sessions were selected collaboratively with Métis community leadership, researchers, and university faculty, while mid-program surveys allowed Elders to guide later topics, ensuring cultural relevance and alignment with community priorities. This process reflects the Métis concept of Wahkohtowin—emphasizing reciprocity, shared responsibility—and CBPR principles that shaped session design and delivery (Viswanathan et al., 2004; Wildcat, 2018).

Each talk opened with a prayer and a land acknowledgement. Sessions were led by subject-matter experts and held at the Mamawapowin Métis Centre in Kelowna, BC, on Syilx Okanagan territory—a culturally meaningful setting for participants. For Indigenous peoples, land, culture, and health are deeply connected (Panelli & Tipa, 2007; Richmond & Ross, 2009; Wilson, 2003), and urban environments can strain this relationship. Although urban environments can present barriers related to colonial policies, they are also important sites of Indigenous resurgence,

community building, and cultural revitalization. Hosting the program at the Métis Centre grounded learning in a community-centered space. Traditions such as gratitude, shared meals, and mutual respect were embedded throughout, reflecting Métis values of reciprocity and relationality.

Table 1. Monthly Topics Covered in the Health Talks Program

Month	Title
January 2024	Exercise and Metabolic Health
February	Nutrition Tips and Tricks for Diabetes and Blood Sugar Control
March	Exercise and the Immune System
April	Exercise and Technology
May	Healing the Past: Indigenous Health and Reconciliation
June	Exercise and Glucose Control
July	Health Effects of Airborne Disease
August	Adapting Exercise for Individuals with Injuries, Medical Conditions, Disabilities
September	Health Benefits of Fasting
October	Exercise and Cognitive Health
November	Building Blocks of Health: The Crucial Role of Dietary Protein in Nutrition
January 2025	Small Steps for Big Change

Participants and participant recruitment

The protocol was approved by the UBC Behavioural Research Ethics Board (#H16-00044). The first author (JB) contacted Elders of the Kelowna Métis Association via email to recruit participants. Inclusion criteria were: 1) aged 50 years or older; 2) self-identified as Métis and/or Indigenous; 3) attended one or more Health Talks; and 4) resided in the Okanagan region as members of the Kelowna Métis Elders circle, with sufficient capacity to provide informed consent. Elders were excluded if they were unable or unwilling to consent due to cognitive impairment or unstable health. Fourteen of 66 (21%) Métis Elders (11 females, two males, one two-spirit individual) registered with the Kelowna Métis Community Services of BC Elders’ Circle were present on the day of data collection and participated in the study. In this study, the term Elder reflects a community-assigned role within the Elders’ Circle.

Procedure

Health Talks were held between January 2024 and January 2025. Data collection occurred on April 26th, 2025, at the Mamawapowin Métis Centre. Before data collection, participants provided written informed consent and completed a demographic questionnaire, followed by a survey and focus group. The pencil-and-paper questionnaire included 24 Likert-type items (1=Strongly Disagree to 5=Strongly Agree) assessing changes in health behaviours and program satisfaction. The first author (JB) was present to clarify questions. Immediately afterward, participants joined a ~90-minute focus group led by JB. A semi-structured interview guide, co-developed by JB and KMG, explored perceived barriers to healthy physical-activity and nutrition habits, and the perceived impact and cultural relevance of the program. The full guide is in Appendices A and B. Participants were remunerated with a \$25 gift card.

The Questionnaire and Interview Schedule are available on request.

Data management and analysis

Survey data were entered and analyzed in Microsoft Excel. Mean scores were calculated for each item to summarize trends and inform recommendations. The focus group was recorded on Zoom and transcribed; JB checked and corrected the transcript, which KMG then reviewed for completeness.

Qualitative content analysis with inductive coding (Erlingsson & Brysiewicz, 2017; Hsieh & Shannon, 2005) was used to analyze focus group data. JB and KMG read the transcript line-by-line, developed initial codes, and organized them into overarching themes through discussion, comparison, and memo writing. This iterative process ensured findings remained grounded in the data and aligned with project goals. To enhance trustworthiness, KMG acted as a critical friend (Rossman & Rallis, 2003), reviewing codes and categories, challenging assumptions, and confirming that topics reflected Elders' experiences. Consensus on final topics was reached through discussion, strengthening methodological rigour via a structured, step-by-step analytic approach (Hsieh & Shannon, 2005; Saldaña, 2016).

Results

Participant Characteristics

Fourteen community members (11 females, 2 males, 1 Two-Spirit) aged 50–80+ years (median age category: 70–79) participated in the Métis health talks. Nearly all (13/14) self-identified as Métis and resided in Kelowna or Westbank, BC. Although the study focused on Métis participants, one Indigenous participant who did not self-identify as Métis was included because they were a regular attendee of the Health Talks, and their inclusion did not meaningfully affect the thematic findings. Educational attainment ranged from high school (6/14) to postgraduate degrees (2/14). Half of the participants (7/14) lived with their family, while most rated their health as “good” or better (12/14). The frequency of reported physical activity varied: 9/14 engaged in physical activity daily, 4/14 engaged in physical activity a few times per week, and 1/14 was unable to participate due to a health condition. Attendance spanned 1–6+ sessions, with a median of 3–5 sessions.

Analysis of the Questionnaire Data.

Overall experience (Q1–Q5) scores were generally high. Average responses to the five overall experience questions ranged from 4.14 ± 0.77 to 4.50 ± 0.52 , with a mean of 4.28. All items fell within the “Agree”–“Strongly agree” range, indicating generally strong satisfaction with content and delivery of the Health Talks. Similarly, Impact on health behaviours (Q6–Q11) scores were predominantly high. Average responses ranged from 4.00 ± 1.04 to 4.40 ± 0.65 . The domain mean was 4.10, indicating moderate self-reported behaviour change and strengthened intent to act on the information provided.

Regarding Participation & engagement (Q12–Q17), scores indicated favourable ratings. Average responses ranged from 4.14 ± 0.86 to 4.36 ± 0.63 . The overall mean was 4.30 reflecting strong participant engagement and perceived benefit. Lastly, scores for Areas for improvement (Q18–Q21) suggest general agreement with proposed areas of improvement, with average responses ranging from 3.71 ± 1.27 to 4.07 ± 0.73 . The domain mean of 3.85 indicates opportunities to enhance interactivity and to provide more Métis-specific content in future iterations (See end Table 2. Mean Scores and Standard Deviations for Post-Program Survey Questions).

Analyses of the Focus Group Data

Content analysis led to the development of four themes reflecting Elders' experiences with the Health Talks program: 1) Awareness and Behavioural Shifts in Diet and Physical Activity; 2) Positive Experiences: Program Strengths; 3) Negative Experiences: Program Weaknesses; and 4) Cultural Relevance and Future Improvements. The themes, key findings and example statements are described in detail below.

1. Awareness and Behavioural Shifts in Diet and Physical Activity

Participants reported several positive behavioural changes following the Health Talks, alongside barriers and facilitators related to chronic illness, isolation, and daily living constraints. Elders reported increased awareness of diet, nutrition habits, and eating patterns following the Health Talks. Many described initiating small but meaningful changes such as eating breakfast, incorporating snacks, and reducing reliance on fast food. Intergenerational reflection on dietary habits (e.g., grandchildren, "treat" foods) was also noted.

You put me back on nutrition cause I was going the other way.

Now I try to grab a banana in the morning.

Junk food was a treat for us when we were kids.

Physical activity and chronic disease management. Participants described increased physical activity (walking, steps, yard work, resistance band exercises) and linked it to improved mood, confidence, and chronic disease management. Physical limitations (e.g., respiratory illness, cancer, musculoskeletal pain) were identified as barriers but also motivators for adapted activity.

I started walking 6,000 to 10,000 steps a day.

Yard work it helps a lot with my osteoporosis.

Barriers and facilitators to behaviour change. Chronic illness, pain, isolation, and living alone reduced ability to maintain healthy behaviours. Facilitators included improved weather, routine adaptation, and awareness of knowledge–practice gaps in diet.

I am a cancer patient. It's a disease called multiple myeloma, for me to exercise there is a potential of breaking bones, even walking is difficult.

I used to do a lot of walking, but last winter I started having problems with my lungs.

It's hard to cook for just one person.

2. Positive Experiences Program Strengths.

The Health Talks were perceived as a valuable addition to Elders Circle programming, with participants describing strong engagement, accessible information, and overall satisfaction with program delivery.

Program delivery and accessibility. Health Talks were perceived as a valuable addition to Elders Circle programming. Timing aligned well with existing gatherings, improving participation and engagement.

You did have some good speakers and good presentations.

When we come for the senior circle, that's the best time.

Knowledge sharing and content relevance. Participants valued practical, easy-to-understand information on nutrition and physical activity, viewing sessions as useful reminders and extensions of prior knowledge.

It was good to be reminded about my diet and exercise.

Presenter effectiveness. Presenters were described as respectful, well-prepared, and able to communicate in accessible language appropriate for Elders. Minor concerns included occasional speaking pace.

I think they knew their crowd, and I think they did pretty well here.

Overall program value. Overall experience was strongly positive, with participants expressing appreciation for learning opportunities and integration into Elders Circle.

Your feedback is good for us to add extra—we all need extra.

3. Negative Experiences- Program Weaknesses.

Participants identified several logistical and communication challenges, including unclear scheduling, inconsistent awareness of program components, and barriers to consistent participation.

Communication and scheduling. Lack of clear scheduling and advance communication limited participant awareness and engagement.

If we would have had an outline from the start.

Program implementation issues. Mid-program survey and co-design processes were not consistently remembered or clearly communicated.

Prior to doing it, maybe indicating what is available.

Participation barriers. Attendance was affected by illness, scheduling conflicts, forgetfulness, and transportation challenges.

Sometimes I couldn't make it because I wasn't feeling good.

Reduced exposure to program. Some Elders reported missing multiple sessions due to external barriers.

My negative experience was I didn't make it to enough sessions.

4. Cultural Relevance and Future Improvements.

Participants highlighted the importance of strengthening cultural integration, including incorporation of Indigenous protocols, holistic health frameworks, and broader program enhancements.

Cultural integration and protocols. Elders expressed desire for stronger incorporation of cultural teachings, including talking circle protocols and Medicine Wheel frameworks. Differences between Métis and First Nations traditions were noted.

In a traditional circle, there is usually a leader, and if you have the talking stick, the protocol is that you are never interrupted.

Holistic health expansion. Participants recommended integrating emotional, mental, spiritual, and trauma-informed approaches into programming.

I would like to see it balanced with a great health focus.

Program enhancements. Suggestions included pharmacist involvement, medication education, and more structured health programming.

Is it possible to bring someone in to speak about medicine?

Social and community-based physical activity. Interest in walking-based programs (e.g., "Walk and Talks") and structured community fitness models with measurement components.

Could it even be a walking tour? Like a walk and talk?"

Program continuation and expansion. Strong desire for continuation and expansion of programming, with suggestions for earlier and more frequent interventions, that provide a framework for future programming.

Where were you all this time?

Discussion

Health Talks is a knowledge-translation initiative designed to a) explore the perceived barriers to healthy PA and nutrition habits, as well as to b) assess the perceived impact and c) cultural relevance of program delivery, thereby offering empirical insight into Métis-specific KT strategies for health promotion. This paper reports on participants' experiences and evaluations of the Health Talks project.

Survey findings indicate high levels of satisfaction across domains such as: overall experience, impact on health behaviours, participation and engagement, and areas for improvement. Focus group findings support these results; indicating that for many participants, the Health Talks increased awareness of the role of diet and physical activity and several reported behavioural changes (e.g., adding breakfast, taking short walks, or adjusting activity levels). These outcomes suggest the program was successful in

moving some participants from knowledge acquisition to awareness and initial action.

Importantly, these findings may reflect not only the educational content itself but also the program's grounding in the Métis principle of *Wahkohtowin*. By emphasizing reciprocal relationships, shared learning, and community-guided decision-making, the Health Talks fostered an environment in which knowledge was co-created rather than unidirectionally transferred. This relational approach likely contributed to participants' engagement, perceived cultural relevance, and willingness to apply the health information within their daily lives. Participants also highlighted 1) barriers to sustaining change and 2) emphasized the integration of culturally relevant content, which is elaborated on in the following discussion.

Barriers to sustained behaviour change and participation

Despite an increase in awareness, participants also described an obvious knowledge-action gap; knowing what to do did not always translate to sustained behaviour change. Many Elders deal with health-related constraints (e.g., diabetes, respiratory problems, cancer-related pain) that enhance the perceived difficulty of physical activity. Practical realities such as living alone, difficulty cooking for one, social isolation, and transportation difficulties further impeded dietary and activity changes. Moreover, many Elders had difficulty accessing the online newsletter where the schedule was posted, and in some months, the “Health Talks” weren’t properly advertised in the newsletter.

Still, participants described pragmatic facilitators such as peer support, adapting activities to health status, and favourable weather that enabled modest adjustments to daily routines. Consistent with extensive research and theory on how people change their physical activity and eating habits (Michie et al., 2011), these results suggest that monthly KT events generate motivation, but are insufficient on their own to change behaviour.

KT programs, such as Health Talks, would be more successful when paired with more frequent ongoing supports, including skill-building workshops, peer support systems, and other community-based supports that align with specific behaviour-change techniques (Michie et

al., 2011). A program that is culturally relevant and set in Indigenous worldviews could impact systemic barriers experienced by Métis Elders and the Indigenous community.

Cultural relevance and community context

Holding the Health Talks at the Mamawapowin Métis Centre, within a trusted community setting and during regular Elder meeting times, resonated with participants. Survey responses regarding cultural respect and overall experience were positive, with participants finding the content useful; qualitatively, participants commented on the value of presenters using plain language and practical examples. In addition, the group discussion/talking-circle format appeared to facilitate trust, engagement, and a sense of belonging among Métis Elders.

The program was designed to minimize a purely didactic, presenter-led format by using a circle-based approach, in which participants and presenters could speak, ask questions, and share perspectives at any time. In some sessions, participant introductions further supported relational exchange; however, this was not consistently possible due to time constraints.

These findings align with existing literature on CBPR and KT (Campbell et al., 2020; Jernigan, 2010; Viswanathan et al., 2004), which stresses culturally safe delivery, community leadership and relational approaches as central to the relevance and effectiveness of health-promotion programming.

However, participants indicated a desire for deeper cultural integration and alignment with Métis-specific protocols. The incorporation of medicine wheel teachings, a more formal talking-circle structure led by an Elder or circle keeper, and content reflecting Métis traditions could have led to a more culturally relevant experience.

These insights suggest that, while the program was acceptable and culturally sensitive, there was room for improvement that would likely have enhanced outcomes and the perceived relevance of the Health Talks program.

Implications and future directions

The findings have practical implications for community organizations supporting healthy aging among urban Métis Elders. Monthly

expert-led sessions integrated into existing Elders programming were well received, but logistical barriers—scheduling, transportation, and reliance on online communication—limited participation. Clearer advance scheduling and multiple communication methods (printed schedules, phone calls, in-person reminders) may improve accessibility.

In addition to program-level implications, these findings also shed light on structural challenges related to the sustainability of community-based health promotion initiatives. There is evidence for the effectiveness of Indigenous-led health programming in supporting health behaviour change and culturally safe care, yet these are often underfunded within existing public health funding models. Métis Health Talks and similar initiatives require sustainable, long-term funding models grounded in community-driven priorities to support the ongoing delivery and scaling of these initiatives.

Future programming should incorporate true co-design with Métis Elders to ensure shared decision-making and alignment with community priorities, consistent with CBPR principles. Sustained delivery will likely require dedicated funding, as co-design is iterative and resource-intensive. Strengthening collaboration with healthcare professionals (e.g., pharmacists, physicians) could broaden topic relevance for Elders managing chronic conditions. Grounding sessions in Métis values—through medicine wheel teachings, trauma-informed approaches, and Elder-led talking circles—may enhance cultural relevance and long-term engagement.

Future research should include baseline and follow-up assessments of physical activity, dietary behaviours, anthropometrics, and self-efficacy to better evaluate program impact. Standardized measures of diet and physical activity (e.g., step counts, accelerometry) would strengthen evaluation. Mixed-methods approaches assessing both implementation and outcomes would provide a more robust understanding of program effectiveness for participants and programmers.

Limitations

This study has several limitations that we hope further work can address. Baseline health data were not collected, limiting the ability to objectively assess changes over time. The study relied on self-reported survey and focus group

data, which may be influenced by social desirability bias (Kaminska & Foulsham, 2013). The small convenience sample (n=14) limits generalizability and prevents causal inference, though it provided meaningful insights from Métis Elders. Additionally, the program occurred only once per month, and participants requested clearer scheduling and more consistent communication. Despite these limitations, the mixed-methods design generated valuable community-centred findings to guide future work.

Conclusion

Elders who participated in Health Talks found value in the program and several reported changes in their dietary and physical activity habits as a result of participation. Questionnaire and focus-group data suggested that the introduction and reinforcement of health benefits related to nutrition and physical activity behaviours fostered an environment that led participants to think and act differently about their health habits. Health disparities remain between Indigenous and non-Indigenous people; however, this project emphasizes the value of Indigenous leadership and community-led initiatives in providing health information to enhance Indigenous health and wellness in a post-colonial context.

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Table 2. Mean Scores and Standard Deviations for Post-Program Survey Questions

Question	Mean	SD
Overall Experience		
Q1. The health talks provided useful information about exercise and nutrition	4.43	0.65
Q2. I felt comfortable participating in the health talks	4.50	0.52
Q3. The content of the health talks was easy to understand	4.21	0.58
Q4. The format of the health talks (e.g., talking circles, group discussions) was engaging	4.21	0.69
Q5. I felt that my cultural values and experiences were respected during the talks	4.14	0.77
Impact on Health Behaviours		
Q6. After attending the health talks, I feel more motivated to engage in regular exercise	4.00	0.78
Q7. I feel more confident in making healthier food choices since attending the health talks	4.21	0.80
Q8. The health talks have helped me understand the importance of physical activity in managing my health	4.40	0.65
Q9. I am more aware of how my diet impacts my overall health after attending the health talks	4.21	1.12
Q10. I have made specific changes to my exercise routine based on what I learned in the health talks	4.00	0.88
Q11. I have made specific changes to my diet based on the health talks	4.00	1.04
Participation & Engagement		
Q12. I felt that the health talks were relevant to my personal life and health goals	4.21	0.69
Q13. I felt a sense of belonging and community during the health talks	4.21	0.89

Q14. The health talks were challenging in a way that encouraged me to think critically about my health	4.14	0.86
Q15. The health talks helped me feel more engaged with my physical and mental well-being	4.36	0.63
Q16. I feel that I have gained new skills or knowledge that have helped me improve my health	4.36	0.49
Q17. I felt that the health talks gave me a sense of purpose or helped me reflect on my values and goals	4.29	0.73
Areas for Improvement		
Q18. I would like more practical tips on how to apply the information from the health talks to my daily life	3.79	0.98
Q19. I would have preferred more opportunities for interaction or discussion with the speakers	3.71	1.20
Q20. I would have liked more discussions on traditional Metis foods and exercise during the health talks	4.07	0.73
Q21. The health talks should provide more information on managing specific health conditions (e.g., diabetes, arthritis)	3.71	1.27