

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH OF ABORIGINAL INFANTS, CHILDREN AND FAMILIES IN BRITISH COLUMBIA



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It has become well recognized that health is determined not only by the physical conditions of individuals, but also by the social, economic, and political environments in which they live. For Aboriginal¹ people, social, economic and political disparities underlie many of the health inequities that currently exist between Aboriginal and non-Aboriginal people. These disparities can challenge individual and group efforts to raise healthy children and develop strong families and communities. This fact sheet will define and discuss social determinants of health from both public health and Indigenous perspectives, and then review current information regarding the social

determinants of health for First Nations/ Indian, Inuit and Métis families in British Columbia. The fact sheet will then highlight several recent attempts to address disparities in the social determinants of health between Aboriginal and non-Aboriginal populations, including two examples of best/promising practices that are working in British Columbia.

What are social determinants and why do they matter in Aboriginal health?

The World Health Organization (WHO) defines the social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system.”¹ In other words, social determinants of health are the economic, physical and social conditions

that influence the health of individuals and communities.² Public health research shows that improvements in the social and economic determinants of health produce significant gains in life expectancy and quality of life.³

According to the WHO, the social determinants of health and the policy choices that influence them are mostly responsible for health inequities.⁴ Social determinants of health include income, employment, education, food security, social environments, and housing. In addition, Aboriginal people face a number of Indigenous-specific social determinants of health, including colonization, racism, and political marginalization. At the 2007 Symposium on the Social Determinants of Indigenous Health, delegates identified these Indigenous-specific social determinants of health as critical factors in

¹ Throughout this fact sheet, the term ‘Aboriginal’ is used to refer to all groups of First Nations/Indian, Inuit and Métis people collectively, regardless of status or location of residence.



understanding how health disparities have come to exist for Aboriginal peoples.⁵

Colonization: Symposium delegates highlighted two issues related to colonization. First, the history of colonization of Indigenous peoples was seen as a fundamental health determinant that continues to impact health and wellbeing. In particular, delegates referred to disruption of connections with the land, which weakened or destroyed closely associated economic and social practices, and to the degradation of the land on which Indigenous livelihoods depended.⁶ Second was the understanding that colonization cannot be viewed simply as an historical process that had a devastating effect on Aboriginal peoples. Instead, it must be recognized as a contemporary reality.⁷

Racism: Symposium delegates repeatedly identified the expression or experience of racism as a health determinant.

Racism may impact health through stress associated with disrespect, personal abuse and social exclusion, or through discrimination in access to services necessary to ensure equity in health outcomes.⁸

Political marginalization: Related to the ongoing effects of colonization and racism is the political marginalization that Aboriginal peoples have faced since colonial times. Symposium delegates also identified this political and economic marginalization as an upstream determinant of Aboriginal health.⁹

Efforts have been made to demonstrate the links between the social determinants of

health and Aboriginal health outcomes. An influential study conducted in 1998 showed that rates of suicide among First Nations people in B.C. were associated with a collection of characteristics the authors referred to as “cultural continuity,” which they described as the degree of social and cultural cohesion within a community.¹⁰ According to the study’s authors, low rates or an absence of suicide in a community appeared to be related to factors that tend to enhance cultural continuity, such as land title, self-government (particularly the involvement of women), control of education, security and cultural facilities, as well as control of the policies and practice of health and social programs.

Residential schools: an example of an Indigenous-specific social determinant of health

Years after the dismantling of the residential school system, the legacy of residential schools continues to weigh heavily on the lives and wellbeing of First Nations/Indian, Inuit, and Métis individuals and communities. The incredible damage suffered – loss of life, denigration of culture, destruction of self-respect and self-esteem, rupture of families – continues to impact succeeding generations.¹¹

The goals of the residential school system were to convert Aboriginal children to Christianity, to teach them to speak English, and to assimilate them into the dominant British culture — in other words to suppress the history, culture, and identity of First Nations/Indian, Inuit, and Métis children. Expressions of Aboriginal language, spirituality, or culture were punished and cases of physical and sexual abuse were common and well documented. In addition, overcrowding, poor sanitation, and lack of medical care resulted in high rates of tuberculosis and other diseases.¹²

The first residential schools were set up in the 1840s, while the last federally run residential school closed in Saskatchewan in 1996.¹³ In 1991, roughly 13% of Canada’s Aboriginal population self-identified as survivors of the residential school system.¹⁴

In 1996, the Royal Commission on Aboriginal Peoples recommended a public inquiry to investigate and document the origins and effects of residential school policies and abuses. This led to a number of subsequent actions to redress the damage caused by residential schools, including a Statement of Reconciliation, the establishment of the Aboriginal Healing Foundation (AHF) to address the legacy of physical and sexual abuse suffered by Aboriginal people in residential schools, and the launch of a dispute resolution (DR) plan to compensate survivors of Indian Residential Schools for abuses perpetrated on them while in attendance at the schools.

The Indian Residential Schools Settlement Agreement is a court-ordered settlement that was implemented as of September 2007. Among other things, it provided for a cash payment to survivors living in 2005 (or their estates if deceased), an individual assessment process for adjudication of cases of more serious abuse, and the establishment of a Truth and Reconciliation Commission with a five-year mandate consistent with many of the recommendations of RCAP.

ⁱⁱ North American Indian is the term employed by Statistics Canada to refer to the persons of First Nations and/or Indian (status and non-status) ancestry and identity.

The Aboriginal Peoples of British Columbia

According to the 2006 Census, just under 5% of the population of British Columbia is Aboriginal.¹⁵ Two thirds of this Aboriginal population identified as North American Indian,ⁱⁱ 30.3% identified as Métis, 0.4% identified as Inuit; and just under 1% identified as a member of multiple Aboriginal groups.¹⁶ The Aboriginal population in BC, like Canada, is a relatively youthful population. Close to one in five of Aboriginal persons living in BC is under the age of 15 years of age (17.4%), compared to one in ten for the non-Aboriginal population.¹⁷ Nearly 60% of BC's Aboriginal population lives in urban centres, compared with approximately 26% living on reserve and 14% in rural areas.¹⁸

What we know and don't know about the social determinants of First Nation/Indian, Inuit, and Métis health in British Columbia

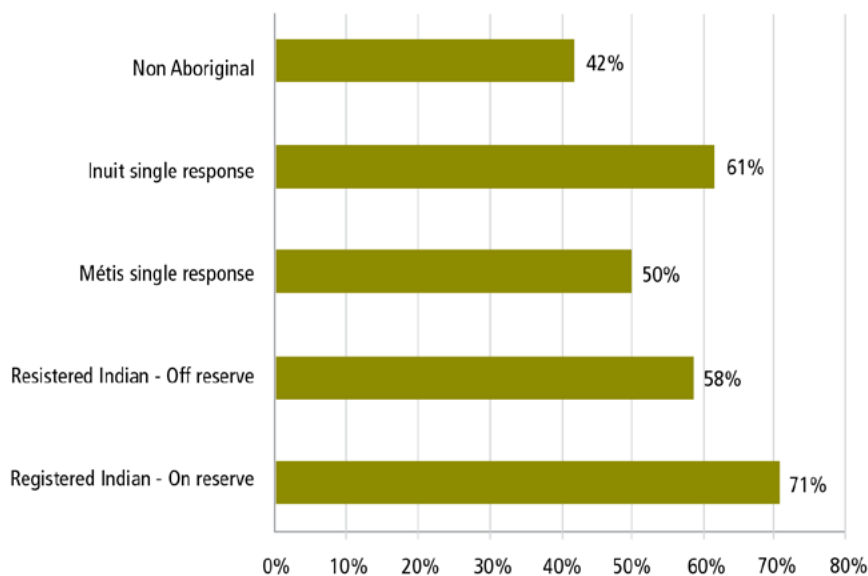
In a previous section, we identified both Indigenous-specific and general social determinants of health. This section will identify some disparities in the general social determinants of health that exist between BC's Aboriginal and non-Aboriginal population. Quantitative data relating to Indigenous-specific social determinants of health are limited, but data relating to the more general social determinants of health are readily available. As described below, the data consistently show that Aboriginal peoples are worse off than their non-Aboriginal counterparts on these measures.

Income

According to the 2006 Canadian census, significant income disparities exist between Aboriginal and non-Aboriginal peoples in B.C. In 2005, median annual individual incomeⁱⁱⁱ for the Aboriginal identity population was \$15,836, or 36% lower than the \$24,867 median annual income for non-Aboriginal individuals.¹⁹

With respect to the different Aboriginal identity populations that live in B.C., Figure 1 shows that only 42% of the non-Aboriginal population earned less than \$20,000 in 2005, while 61%, 50%, 58%, and 71%, respectively, of Inuit, Métis, Registered Indians – Off reserve, and Registered Indians – On reserve earned less than this amount.²⁰ Specific income data are not available for non-Status Indians in B.C. However, based on the available data we can state that their relative position is similar to that of other Aboriginal identity populations.

Figure 1: Percentage of labour force earning less than \$20,000



Source: Statistics Canada, 2006 Census.^{iv}

Employment

Unemployment rates for Aboriginal peoples in B.C. are more than twice as high as rates for the non-Aboriginal population. According to the 2006 Census, the unemployment rate for the Aboriginal identity population was 15.0%, while the rate for the non-Aboriginal population was 6.0%.²¹ Figure 2 shows that Inuit and Métis people fare only slightly worse than the non-Aboriginal population, with unemployment rates of 7% and 9%, respectively.²² The unemployment rate for Registered Indians – Off reserve was 15%, while Registered Indians – On reserve were the worst off, with an unemployment rate of 25%.²³

Specific employment data are not available for non-registered Indians in B.C. However, based on the available data we can state that their relative position is

ⁱⁱⁱ Based on the Statistics Canada of income, includes all income sources before tax for adults 15 years of age and over.

^{iv} The Canadian census distinguishes between "single response" and "multiple response" identity. "Single response" means that only one identity group was checked; for multiple response, a person would have checked off more than one identity group. For figures 1, 2, and 3 only single response data was available.

similar to that of other Aboriginal identity populations in B.C.

Education

Data from the 2006 Census show that Aboriginal peoples have received less formal education than the general population. For example, 39% of the B.C. Aboriginal identity population reported having no certificate, diploma or degree, while only 5% have a university certificate or degree.²⁴ For the general B.C. population, 20% have no certificate, diploma or degree and 19% have a university certificate or degree.²⁵ Figure 3 shows that 81% of the non-Aboriginal population in B.C. has earned a certificate, diploma, or degree, while 71%, 70%, 62%, and 48%, respectively, of Inuit, Métis, Registered Indians – Off reserve, and Registered Indians – On reserve have earned a certificate, diploma, or degree.²⁶

Housing

According to the 2006 Census, Aboriginal peoples tend to live in more crowded conditions and in homes of inferior quality than the general population. For example, in British Columbia 2.8% of Aboriginal peoples live in dwellings that average more than one person per room, while only 1.8% of the non-Aboriginal population live in these crowded conditions.²⁷ In addition, 17.7% of Aboriginal peoples live in homes requiring major repairs compared to 6.8% of the non-Aboriginal population.²⁸ Challenges with housing are intensified for First Nations reserve communities, where the rates of household crowding and houses in need of major repair are 5.8% and 36.5% respectively.²⁹

Food Security

One of the challenges in assessing rates of food insecurity in Aboriginal

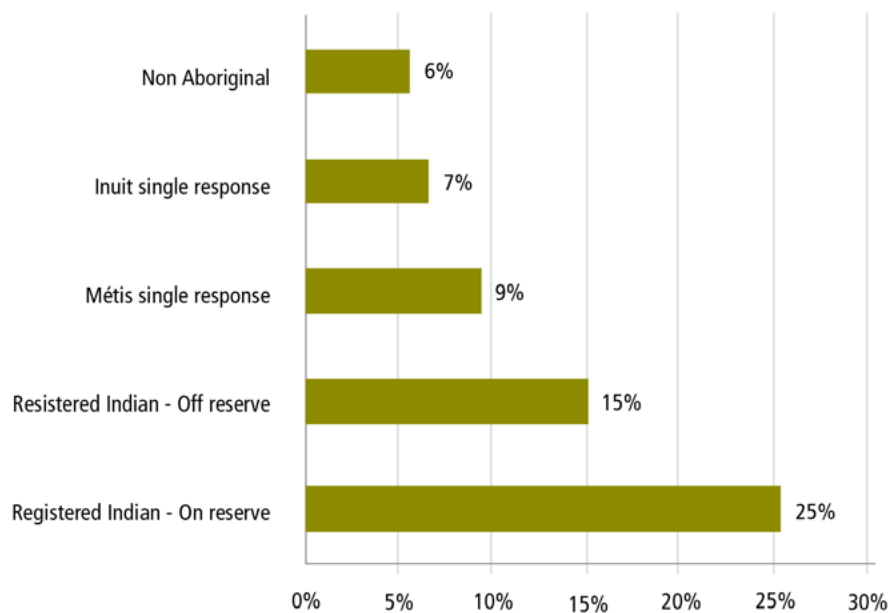
populations is that there are many different measurement tools in use, most of which have not been validated in Aboriginal settings. Food security is defined by the World Health Organization as existing “when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life.”³⁰ This definition includes both the physical and economic access to food that meets people’s dietary needs and food preferences.

Information regarding food security among First Nations, Inuit, and Métis children and their families is inconsistent and patchy, however the data that we do have as well as the strong links between food security, income, and employment indicate that food insecurity is a major concern. Results from the 2004 Canadian Community Health Survey, which excludes First Nations people living on reserve, indicated disproportionately high rates of food insecurity for the Aboriginal population when compared to the non-Aboriginal population. For example, at a national level 33% of Aboriginal respondents compared to 9% of non-Aboriginal respondents were experiencing moderate or severe food insecurity.³¹ Rates of food insecurity for First Nations populations living on-reserve vary from 21% to 83%.³²

Addressing Aboriginal/non-Aboriginal disparities in the social determinants of health

Over the past twenty years, a number of initiatives have been undertaken at the federal, provincial and local levels in an effort to address disparities in the social determinants of health, with varying degrees of success. These processes have evolved over time from the Royal Commission on Aboriginal Peoples

Figure 2 – Unemployment rates



Source: Statistics Canada. 2006 Census.^v

^v The Canadian census distinguishes between “single response” and “multiple response” identity. “Single response” means that only one identity group was checked; for multiple response, a person would have checked off more than one identity group. For figures 1, 2, and 3 only single response data was available.

investigation into the root causes of these disparities, to attempts from federal, provincial and territorial ministers to come to an agreement on how to address these disparities, to initiatives at the BC provincial and community level that are working to improve the standard of living and health care services for Aboriginal peoples. At the core of all of these initiatives is the recognition and support of Aboriginal rights to self-determination.

RCAP

In November 1996, the Government of Canada released *The Report of the Royal Commission on Aboriginal Peoples (RCAP)*. The report recognized Aboriginal peoples as self-governing nations with a unique place in Canada and acknowledged that “the main policy direction pursued for over 150 years, first by colonial then by Canadian governments, has been wrong.”³³ RCAP made 440 recommendations

and called for sweeping changes to the relationship between Aboriginal and non-Aboriginal peoples and governments in Canada. RCAP called for early action in four areas: healing, economic development, human resources development, and the building of Aboriginal institutions.³⁴ Ten years later, the Assembly of First Nations (AFN) issued an assessment of the Federal Government’s response and actions with respect to the findings and recommendations of RCAP. AFN’s ‘report card’ gave an overall grade of ‘F’, citing a lack of action on the key recommendations of RCAP and a resultant lack of progress on key socio-economic indicators.³⁵ The report card criticized the Federal Government for failing to make sustained investments to meet the basic needs of First Nations communities or address the key determinants of health and wellbeing. AFN also found that none of the structural

changes in the relationship between First Nations and the Canadian government recommended by RCAP had been achieved. In particular, the report card highlighted a lack of progress in improving the situation of First Nations children, the condition of First Nations homes, and the wellbeing of First Nations communities.

Kelowna Accord

The Kelowna Accord, which was announced in November 2005, was the culmination of a process called the Canada-Aboriginal Peoples Roundtable. It resulted in a series of agreements between the Government of Canada, the provincial and territorial governments, and five national Aboriginal organizations that sought to improve the quality of life and economic opportunities for Aboriginal peoples in Canada. The Accord included a 10-year commitment of \$5.1 billion and focused on four areas: health, education, housing and relationships.³⁶

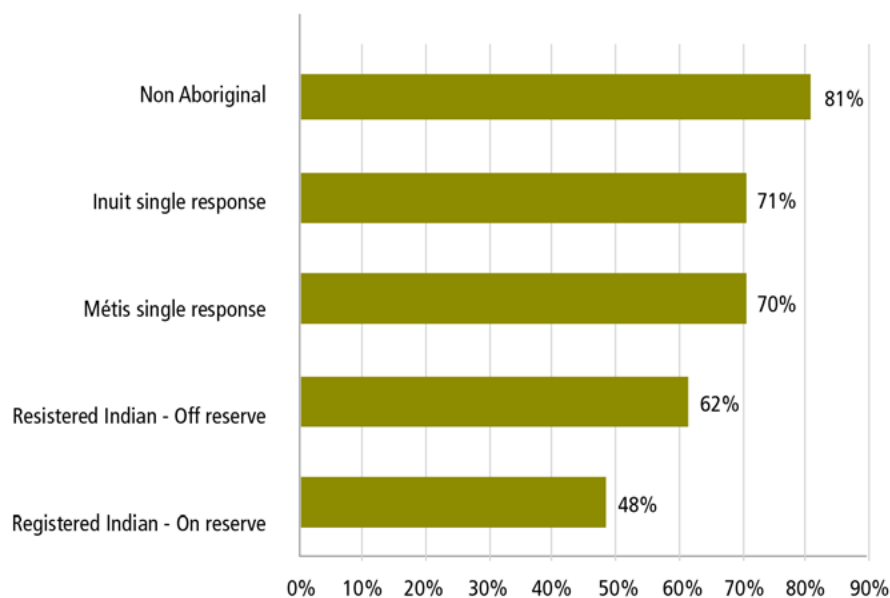
In June 2006, the Conservative Party formed the Government of Canada, replacing the Liberal government that negotiated the Kelowna Accord. Subsequent federal budgets have not included any provisions to meet the commitments of the Kelowna Accord.

Transformative Change in BC

In November 2005, the Province of British Columbia, the First Nations Leadership Council (FNLC), and the Government of Canada signed the Transformative Change Accord, under which all parties committed to:

- closing the gaps between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years;
- reconciling Aboriginal rights and title with those of the Crown, and;

Figure 3 - Earned a certificate, diploma, or degree



Source: Statistics Canada. 2006 Census.^{vi}

^{vi} The Canadian census distinguishes between “single response” and “multiple response” identity. “Single response” means that only one identity group was checked; for multiple response, a person would have checked off more than one identity group. For figures 1, 2, and 3 only single response data was available.

- establishing a new relationship based on mutual respect and recognition.³⁷

This was followed by a series of related agreements, including the Transformative Change Accord: First Nations Health Plan, which identified 29 actions intended to close the gaps in health status between First Nations people and other British Columbians, and the Tripartite First Nations Health Plan which, among other things, is designed to ensure that First Nations are involved in decision-making regarding their health. In addition, the First Nations Health Council (FNHC) was created in 2007 as a coordinating body mandated to implement the Tripartite First Nations Health Plan.³⁸

The Transformative Change Accord and its related agreements represent a promising step forward in addressing Aboriginal/non-Aboriginal disparities in the social determinants of health. It proposes systemic change by advocating for a collaborative partnership between government and First Nations in BC in improving the standard of living and health care services. While it is too early to point to tangible improvements in health outcomes or to assess the success of the implementation process, the commitments

embedded in the Accord and some early achievements provide hope that significant improvement in health outcomes is possible.

Tangible progress has already been made on a number of fronts. Some of the more noteworthy achievements include:

- The First Nations Health Council (FNHC) was formed in 2007.
- Also in 2007, an Aboriginal Physician Advisor was appointed in the Office of the Provincial Health Officer to provide expert advice, support and guidance regarding Aboriginal health.
- The tripartite partners are seeing early success in a number of areas, including vision and hearing screening for First Nations children and mental health and addictions programs.
- Considerable progress was also made in 2008-09 in implementing a fully integrated First Nations Tele-health / eHealth network.
- There was agreement to establish the First Nations Health Authority, and planning is underway.

Community Mobilization

The policy initiatives described above occurred at the national and provincial

level. It is important to keep in mind that at a more local level, communities may decide to mobilize for change and address disparities in the social determinants of health. Community initiated change contributes to community self-determination. It can also be extremely effective and efficient as it naturally adapts to each local community setting and draws on local community strengths. The Métis Nation of British Columbia's ActNow BC community projects are highlighted below as an example of communities mobilizing to address disparities in health and health determinants.

Aboriginal ActNow BC was an active living health promotion strategy initiated in 2006 that aimed to help address risk factors and reduce the chances of developing chronic diseases, such as high blood pressure or diabetes, through improving physical activity and nutrition levels, reducing tobacco use, and optimizing healthy choices in pregnancy. Hosted by the National Collaborating Centre for Aboriginal Health at the University of Northern British Columbia, the initiative incorporated Aboriginal knowledge and traditional approaches to healing, while supporting the role of communities in the health and well-being of their people.





Thirty-four ActNow Projects were held in Chartered Métis Communities throughout seven regions of British Columbia. The following were the five goals of the MNBC ActNow Project:

1. Promote wellness and support chronic disease prevention;
2. Promote physical activity in schools and communities;
3. Promote wellness and healthy lifestyles in BC;
4. Increase the capacity of Aboriginal communities to create and sustain health promoting policies, environments, programs and services; and
5. Enhance collaboration among local government, non-government and private sector organizations.³⁹

One project in particular focused on expectant mothers and their partners. The Métis Yoga Program in the Kelowna area provided weekly yoga classes along with transportation and a meal over a twenty week period. At the end of the projects, over 78% of project participants felt positive impacts with their increased physical activity. Other themes included learning more of and becoming proud of their Métis culture, increasing their

knowledge and skills in health related areas, living a healthier lifestyle, eating healthier, and just feeling good. One project participant gave the following insight into what the MNBC ActNow Projects provided for the community:

The activities and functions that our community took part in gave us a sense of purpose, allowed us to come together and share traditional knowledge and information, allowed us to include the Prince Rupert community in our exercise and healthy living planning and, very importantly allowed both our women and Elders to share their knowledge and make meaningful contributions.

Additional Resources

- **2006 Aboriginal Population Profile**
<http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-594/index.cfm?Lang=E>
- **First Nations Health Council**
<http://www.fnhc.ca/>
- **The Lowitja Institute**
<http://www.lowitja.org.au/>

- **Ministry of Aboriginal Relations and Reconciliation**
<http://www.gov.bc.ca/arr/>
- **Pathways to Health and Healing – Second Report on the Health and Wellbeing of Aboriginal Peoples in British Columbia, Public Health Officer’s Annual Report, 2007**
<http://www.health.gov.bc.ca/pho/pdf/abohlth11-var7.pdf>
- **National Aboriginal Health Organization (NAHO)**
<http://www.naho.ca/english/>
- **National Collaborating Centre for Aboriginal Health**
<http://www.nccah-ccnsa.ca/>
- **Canadian Reference Group on the Social Determinants of Health**
http://www.phac-aspc.gc.ca/media/nr-rp/2006/2006_06bk3-eng.php
- **World Health Organization Social determinants of health**
http://www.who.int/social_determinants/en/

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- ¹⁶ Ibid. Caution must be exercised when interpreting Census data as these numbers underestimate the actual Aboriginal population in B.C. Some First Nations reserves may choose to not participate in the census; while other Aboriginal groups and individuals may not have access to or may choose not to participate in the census (for example homeless Aboriginal persons and Aboriginal persons who do not accept the jurisdiction and/or mandate of the census).
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