Social determinants of health and the future well-being of Aboriginal children in Canada

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Aboriginal children's well-being is vital to the health and success of our future nations. Addressing persistent and current Aboriginal health inequities requires considering both the contexts in which disparities exist and innovative and culturally appropriate means of rectifying those inequities. The present article contextualizes Aboriginal children's health disparities, considers 'determinants' of health as opposed to biomedical explanations of ill health and concludes with ways to intervene in health inequities. Aboriginal children experience a greater burden of ill health compared with other children in Canada, and these health inequities have persisted for too long. A change that will impact individuals, communities and nations, a change that will last beyond seven generations, is required. Applying a social determinants of health framework to health inequities experienced by Aboriginal children can create that change.

Key Words: *Aboriginal health (area of specialization); Children and youth; Health inequities; Social determinants*

Les déterminants sociaux de la santé et le futur bien-être des enfants autochtones au Canada

Le bien-être des enfants autochtones est essentiel pour la santé et la réussite de l'avenir des nations. Pour se pencher sur les inégalités persistantes sur le plan de la santé des Autochtones, il faut réfléchir à la fois aux contextes de ces inégalités et aux moyens novateurs et adaptés à la culture de les rectifier. Le présent article met en contexte les disparités en santé des enfants autochtones, tient compte des « déterminants » de la santé par rapport aux explications biomédicales d'une mauvaise santé et conclut par des moyens d'intervenir en matière d'inégalités en santé. Les enfants autochtones subissent un plus lourd fardeau de maladie que les autres enfants du Canada, et ces inégalités persistent depuis bien trop longtemps. Un changement s'impose, qui aura des répercussions sur les individus, les communautés et les nations et se perpétuera pendant plus de sept générations. La mise en œuvre d'un cadre de déterminants sociaux de la santé aux inégalités en santé dont sont victimes les enfants autochtones peut provoquer ce changement.

Aboriginal (throughout this article, the term 'Aboriginal is used exclusively to describe Canada's first peoples and this includes First Nations, Inuit and Métis peoples) people agree, 'children are our future': they are our next generation of parents and leaders. Understood this way, Aboriginal children's health today is a vital precursor to the health and well-being of our future nations (First Nations – like Inuit and Métis people – were sovereign and self-governing 'nations' before containment within what are now the national boundaries and borders of Canada. We gesture toward this by recognizing future 'nations' from an Indigenous perspective). Addressing Aboriginal health inequities, which are lived by our children, requires considering both the contexts in which disparities exist and the most innovative and culturally appropriate means of rectifying those inequities. That is the aim of the present article – it contextualizes Aboriginal children's health disparities, considers 'determinants' as opposed to biomedical explanations of ill health and concludes with ways to intervene in those inequities.

Discussions concerning the health status of First Nations, Inuit and Métis children are always limited by a lack of data, particularly disaggregated data. This lack of data impedes the ability to derive accurate and reliable understandings regarding health inequities, an issue unto itself that requires remedying (1). Some First Nations, Inuit and Métis children's health data exist within the First Nations Regional Health Survey, the Inuit Regional Health Survey, surveys targeted to Aboriginal children residing in urban locales, vital registration data, health care utilization data and census data, along with a limited number of research projects and government reports. These data, however, are weak because they often do not account for the social determinants of health.

Social determinants of health increasingly explain the most pressing global inequities. They are defined as "the conditions in which people are born, grow, live, work and age – conditions that together provide the freedom people need to live lives they value" (2). These determinants, among others, include peace, income, shelter, education, food, a stable ecosystem, sustainable resources, and social justice and equity (3). They are shaped by the distribution of money, power and resources at the global, national and local levels, and their relationship to health; for example, "the lower an individual's socioeconomic status, the worse their health" (4). Essentially, a social determinant of health lens considers both the causes of the causes of disparities (5) and the causes that underlie the causes of the causes (6). Such a framework is imperative to understanding the enduring health inequities between Indigenous and non-Indigenous peoples.

UNICEF reports that Aboriginal children fall well below national health averages for Canadian children (7). In Canada, Aboriginal children experience higher rates of infant mortality (8), tuberculosis (9), injuries and deaths (10), youth suicide (11), middle ear infections (12-14), childhood obesity and diabetes (15), dental caries (16) and increased exposure to environmental contaminants including tobacco smoke (12,14,17). Immunization rates for Aboriginal children are lower than those of non-Aboriginal children (18,19), as are rates of accessing a doctor (20). These health inequities can only be understood and intervened upon if understood as holistic challenges. Such an understanding requires moving beyond the physical realm,

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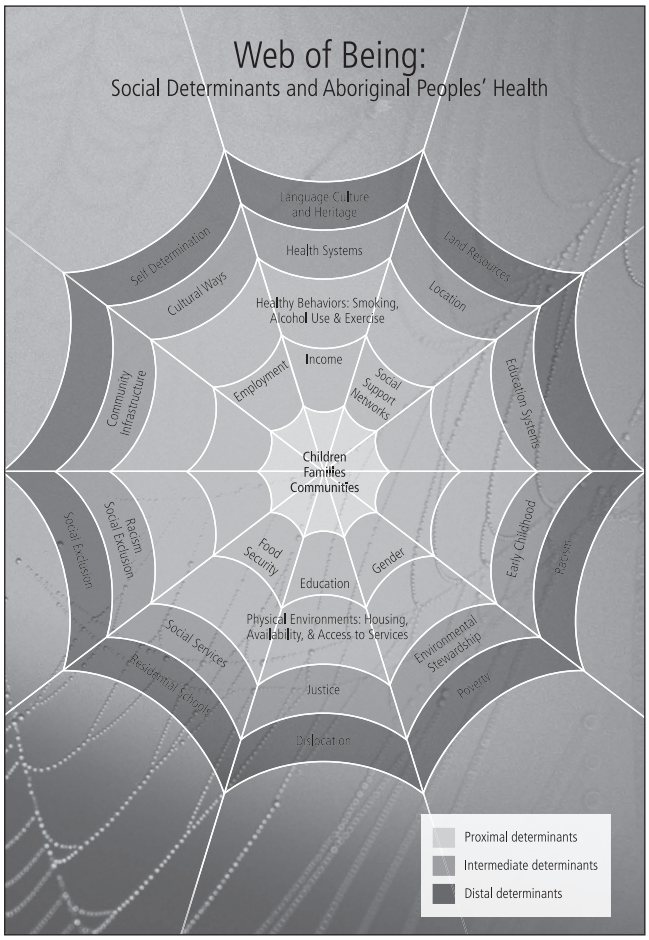

Figure 1) *Web of being: Social determinants and Aboriginal peoples' well-being. Adapted from reference 28*

or the absence of disease, to include the social, spiritual and emotional realms. Addressing Aboriginal children's health inequities must thus account for complex interplays between individual and collective determinants, in addition to addressing the challenging and often shifting systems that impact or influence the determinants, both of which might more easily be achieved through a social determinants of health orientation.

Aboriginal children are born into a colonial legacy that results in low socioeconomic status (21), high rates of substance abuse (22) and increased incidents of interaction with the criminal justice system (23). These are linked with intergenerational trauma associated with residential schooling (24) and the extensive loss of language and culture (25). Colonial legacies are, thus, determinants impacting Aboriginal children's lives and can only be accounted for by applying a social determinants of health lens that is inclusive of multiple realities and considerate of Aboriginal peoples' distinct sociopolitical, historical and geographical contexts. Aboriginal children's health continues to deteriorate after birth, influenced by distal, intermediate and proximal determinants (26) (Figure 1). The basis of adult health and health inequity begin in early childhood (27). Aboriginal children's health, then, necessitates understanding three interrelated dimensions. First, there are proximal determinants of health. These have a direct impact on the physical, emotional, mental and or spiritual health of an individual, and include employment, income and education. Second are intermediate determinants, the origin of proximal determinants, inclusive of community infrastructure, cultural continuity and health care systems. Third are the distal determinants, which include colonialism, racism, social exclusion and self-determination; these comprise the context in which intermediate and proximal determinants are constructed and are the most difficult to change. However, if transformed, distal determinants may yield the greatest health impacts and, thus, long-term change to Aboriginal child health inequities (Figure 1).

Distal determinants that require attention, including potentially by paediatricians, include ongoing colonial structures, racism, and the lack of Aboriginal peoples' sociocultural and political sovereignty. Colonialism, as a distal determinant of Aboriginal peoples' health, is complex and far from over. As a discursive structure, colonialism is enacted as colonization, including physical and colonially legitimated or 'legal' processes of invasion, dislocation and confinement, all of which accompanied European settler expansion into lands occupied by Indigenous peoples (28). Colonial legislation and policies continue to influence the health of Aboriginal children and their families, explicit, for instance, in Indian reserves that have unique jurisdictional complexities that result in disparities of service access and ongoing dislocation of people from traditional lands, fishing and hunting sites, and water rights. The reserve system precipitated great and sudden changes in lifestyle and patterns of settlement (29). The Indian Act continues to define who has or does not have 'status' as an Indian person, and it delimits services provided by the federal government (30). The Indian Act also governed the Indian Residential Schools, institutions that operated for more than 150 years, with the last school in Canada closing in 1996. These schools were explicitly designed to "kill the Indian in the child" (31) to assimilate Indian people into Canadian-European society:

> … many generations of Indigenous children were sent to residential schools. This experience resulted in collective trauma, consisting of… the structural effects of disrupting families and communities; the loss of parenting skills as a result of institutionalization; patterns of emotional response resulting from the absence of warmth and intimacy in childhood; the carryover of physical and sexual abuse; the loss of Indigenous knowledges, languages, and traditions; and the systematic devaluing of Indigenous identity (32).

Child welfare systems continue to intervene in the lives of Aboriginal families in Canada at a rate greater than any other population in the country (33), and currently more Aboriginal children live as governmental wards than were ever in residential schools.

Both colonization and colonialism are more than economic or material structures. They are unique sociohistorical determinants that anchor transformations of sense of self and one's view of one's place in the universe (34). Colonialism results in multiple forms of discrimination. Discrimination in the form of racism impacts equity and health outcomes whether it is individual or institutional racism; "often, institutional racism is covert or even unrecognized by the agents involved in it. Racism can affect diagnosis and treatment and therefore health outcomes" (35). Stemming from racism are microaggressions, which are often very subtle. They too impact health in a myriad of ways, including limiting choices and increasing stress through negative stereotypes in the media, learning histories that misrepresent Aboriginal people, having one's identity questioned or conforming to a narrow view of identity to be validated, or having to change one's appearance to be accepted in, for example, certain health care situations (36-38). Racism, along with these microaggressions, is evidence of advanced colonization (39) and has become entrenched in society. Taken together, these realities can be considered Aboriginal-specific determinants of

health in that they result in a disproportionate experience with socioeconomic inequities that are rooted in a particular socio-historical context.

A sense of cultural continuity for First Nations individuals and communities, and likely for Indigenous peoples more broadly, builds resiliency and reduces negative health outcomes, particularly youth suicide (40). Children's right to cultural continuity is affirmed in the Canadian Constitution, as well as at the international level by the UN Convention on the Rights of the Child that highlights the fact that "traditional cultural values are essential for the protection and harmonious development of children" (41). For Aboriginal people, the right to identify as an Indigenous person, the right to practice Indigenous ceremonies, and the right to speak an Indigenous language, are all crucial to identity and health, both of which are also especially linked to spirituality (42). Language and cultural revitalization are viewed as health promotion strategies (43). If Aboriginal children are provided opportunity for growth and development that fosters and promotes cultural strengths and citizenship, health disparities resulting from the impacts of colonialism may be lessened. This may, in turn, lead to self-determination, which is a distal determinant of Aboriginal children's health.

Interventions and practices designed to foster and enhance the health and well-being of Aboriginal children require holistic concepts of health that move beyond biomedical realms and, instead, address and focus upon social determinants. Approaches must be flexible, while also addressing historical and contemporary determinants and should include decolonizing strategies. These approaches must underpin all medical and psychosocial interventions aimed at bettering Aboriginal children's health and well-being. Interventions should not target individual behavioural change or focus solely on proximal determinants of child health. Instead, interventions should account for broader contexts and distal determinants that continue to influence the context and, thus, the health of the child. These broad contexts require collaborations across and between sectors and disciplines; medical or even health sectors alone cannot address or influence these determinants of health and must work in concert with other sectors such as education, child welfare, housing and justice, among others.

A critical starting point is to create awareness of the social and historical context in which Aboriginal peoples find themselves. This begins with the education and training of professionals that interact with Aboriginal people on a daily basis. For example, development of a curriculum for the training of health professionals should go beyond presenting Canada's Aboriginal peoples as having poor health status and experiencing substandard social and economic conditions – particularly if those poor health statuses are attributed only to biomedical or physiological failings. Students in the health professions who are not trained to understand socioeconomic and historical contexts may be vulnerable to adopting common, social stereotypes about Indigenous peoples (44). Concentrated effort is required to include the knowledge and strengths held by Aboriginal peoples into the curriculum. Specific cultural competency/safety training should be put into place for health practitioners who are working with or are intending to work with Aboriginal children and their families. Elliott and de Leeuw (44) write that:

> developing relationships with other patients involves social cues, cues that might differ between physicians' and Aboriginal patients' cultures.…physicians…can struggle to elicit a chief complaint and have difficulty developing a management plan that is relevant to the patient.…The solution might lie in how we use knowledge and curiosity in our relationships with Aboriginal patients.

This type of education opens opportunities for transmission of knowledge to other disciplines and even broader society.

Employing advocates and cultural translators in all health care facilities is vitally important to Aboriginal children's health and well-being. These individuals provide relational bridges of understanding between the health care system and the Aboriginal children and their families interfacing with it. While much baseline data about Indigenous peoples are needed, intervention research aimed at improving the lives of Aboriginal children is also necessary. This type of research demands collaborative partnerships with Aboriginal communities based on respectful, equitable relationships. Recognizing multiple ways of knowing and being in the world is fundamental to effective research and effective health care practice, with and for Aboriginal peoples. Understanding that this knowledge exists within Aboriginal communities, and engaging with the community from the onset of research and practice processes will be the basis for understanding and ensuring relevant, meaningful work. Principles of ownership, control, access and possession are also necessary to research endeavours involving Aboriginal peoples (45). Effective programs are characterized by vision and leadership, holism, active community participation, strengths-based orientation, and reinvigoration and revitalization of Aboriginal cultures aimed at realizing self-determination.

Little doubt exists that Aboriginal children experience a greater burden of ill health compared with other children in Canada. Aboriginal children's health inequities have persisted for too long. It is time for a change – a change that will impact individuals, families, communities and, ultimately, future nations. This change must last beyond seven generations. Applying a social determinants of health framework to health inequities experienced by Aboriginal children can create that change.

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