HONOURING OUR CHILDREN: ABORIGINAL CHILDREN'S HEALTH IN BRITISH COLUMBIA

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Understanding Aboriginal Children's Health Measures in British Columbia

"We need to teach children how to be healthy in mind, body and spirit and to look after mother earth as in return she will look after us. The spirit is the whole base of our life. Take care of our spirit and teach our children how to respect that."
– Elder Sarah Modeste[1]

For Aboriginal peoples, health and wellness is often viewed as the holistic or whole result of the interconnection between individual, collective, and environmental elements. It is not simply the absence of illness; it is the inclusion and interbalancing of spiritual, cultural, community, mental, physical, emotional and environmental wellbeing.[2] Therefore, approaches to population health assessment for Aboriginal children and their families need to go beyond identifying physical symptoms of disease and also recognize the social determinants that have led to poor (or good) health status.[3]

Aboriginal peoples face a number of disadvantages in the underlying determinants of health, and Aboriginal children are particularly vulnerable. One approach that can be used to address these disparities is a population health approach. Population health approaches focus on the collective improvement of health and the reduction of health inequalities through actions targeting individual and community level conditions and the social systems that contribute to these conditions.[4]

Indigenous peoples throughout the world believe that the health and happiness of

their babies and children is the centre point of health for the whole community. As sacred gifts from the spirit world, children are an integral part of the family, the community and the culture of a people.[5] The health of the children, therefore, is a reflection of the health of the community.

Unfortunately the large majority of Aboriginal families living in Canada do not experience the relative prosperity that is enjoyed by the general Canadian population. The health of Aboriginal babies and children living in Canada is adversely impacted by significant and persistent challenges in the areas of food security, housing, employment, education and environmental exposures.[6] In almost any measure of health and wellbeing, Aboriginal children are worse off than other Canadian children. In its Canadian supplement to *State of the World's Children 2009*, the United Nations Children's Fund (UNICEF) called this disparity the most significant children's rights challenge facing Canada.[7]

A number of international initiatives have been undertaken to formally recognize and enshrine basic rights, including the right to health, children's rights, and the rights of Indigenous peoples, all of which are important for Aboriginal children in Canada. For example, Article 12 of the *United Nations' International Covenant on Economic, Social and Cultural Rights* recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The Covenant establishes a new vision of the child, with the recognition of the child as a holder of participatory rights and freedoms. It acknowledges the primary role of the family and parents in the care and protection of the child, while stressing the obligation of the State to help families in carrying out this task.[8]

The United Nations Declaration on the Rights of Indigenous Peoples sets out the individual and collective rights of Indigenous peoples, as well as their rights to culture, identity, language, employment, health, and education. With respect to children, the Declaration recognizes the right of Indigenous families and communities to retain shared responsibility for the upbringing, training, education and wellbeing of their children; consistent with the *United Nations Convention on the Rights of the Child*.[9] Canada was one of four countries that voted against the Declaration. In the 2010 Speech from the Throne, Canada's Governor General stated that the Federal Government would "take steps to endorse this aspirational document in a manner fully consistent with Canada's Constitution and laws."[10]

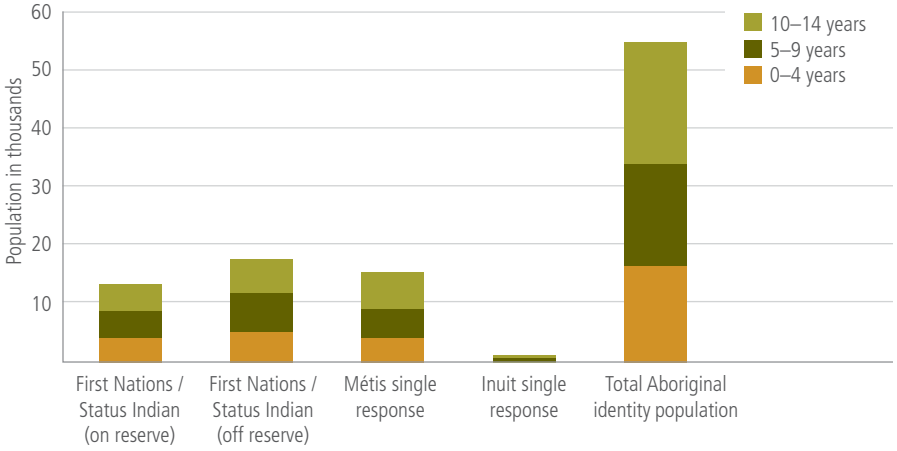
Demographics of Aboriginal Children in British Columbia

In BC, as in the rest of Canada, Aboriginal peoples represent a sizeable, youthful, and growing population group. According to the 2006 Census, 28.2% of the Aboriginal population in BC was under the age of 15 years, compared to 16.5% of the total BC population.[11] First Nations, including Registered Indians on and off reserve, Métis, and Inuit children 14 years of age and under, represented 23.9%, 30.6%, 28.0% and 0.4% respectively, of Aboriginal identity children 14 years of age and under in BC.[i] Figure 1 breaks down these Aboriginal identity groups by age group as follows: 0-4 years of age, 5-9 years of age, and 10-14 years of age.[12] For each of the age ranges described in Figure 1 (i.e. 0-4 years, 5-9 years, 10-14 years), Aboriginal children represent 8% of the total child population in BC.

The Social Determinants of Aboriginal Children's Health in British Columbia

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."[13] Social determinants of health are the economic, physical and social conditions that influence the health of individuals and communities.[14] These conditions are shaped by the distribution of money, power and resources at global,

Figure 1: First Nations, Métis, and Inuit child population compared to the overall Aboriginal identity child population in British Columbia



Source: Statistics Canada, Aboriginal Peoples of Canada, Census 2006 [CD Rom]

[i] Note that the percentages do not add up to 100 because specific population data are not available for non-Status Indians and some Aboriginal responses are not classified in census data reporting

national, and local levels. According to the WHO, the social determinants of health and the policy choices that influence them are mostly responsible for health inequities.[15]

Social determinants of health include income, employment, education, food security, social environments, and housing. In addition, Aboriginal peoples face a number of Indigenous-specific determinants, 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 understanding how health disparities have come to exist for Aboriginal peoples.[16] Aboriginal peoples in Canada continue to endure the effects of European colonization with direct impacts on health. Historic and ongoing government policies have resulted in the disruption of family networks, the forced dislocation of communities from traditional lands, and the degradation of natural resources.

Federal policies supported the abduction of Aboriginal children to residential schools, where language and culture were actively suppressed and child neglect and abuse were commonplace. The residential school experience is described in the following excerpt from the *First Nations Regional Health Survey Report*:

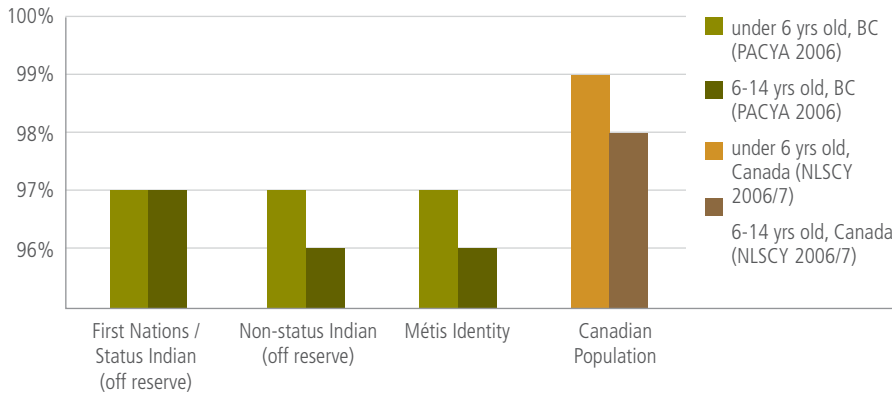
> *In some areas as many as five separate generations of children were removed from their homes, families, culture, and language...many of the children endured long years of isolation and loneliness.... Scores of children died from disease; others were emotionally and spiritually destroyed by the harsh discipline and living conditions.*[17]

The evidence suggests that health status, health service, and/or economic considerations themselves are not sufficient to describe the excess burden of health disparities experienced by Aboriginal children and their families, nor are they adequate to identify appropriate strategies for remediation. Key to the reversal of colonization is the restitution of the right of Indigenous peoples to self-determination, including the implementation of the standards in the *UN Declaration on the Rights of Indigenous Peoples*.[18]

Aboriginal children and their families in BC face a number of challenges that have the potential to impact their health status. Data shows that Aboriginal peoples encounter greater challenges than their non-Aboriginal counterparts in the areas of income, employment, education, adequate housing, food security and environmental exposures. For example, according to the 2006 Canadian Census, significant income disparity exists between Aboriginal and non-Aboriginal peoples in BC. In 2005, median annual individual income for the Aboriginal identity population was $15,836, or 36% lower than the $24,867 median annual income for non-Aboriginal individuals.[19]

Notwithstanding these challenges, Aboriginal children continue to learn their languages and benefit from extended family support systems. For example,

Figure 2: Children's self-rated health (good, very good, or excellent)



Source: 2006 Profile of Aboriginal Children, Youth and Adults (PACYA 2006), National Longitudinal Survey of Children and Youth cycle 7, 2006/2007 (NLSCY 2006-7), National Longitudinal Survey of Children and Youth cycle 4, 2000/2001 (NLSCY 2000/1)

24.7% of First Nations children living on-reserve between the ages of 0 and 11 years understand and 18.4% speak a First Nations language fluently or relatively well, and 71% of childcare arrangements for this same group of First Nations children living on-reserve involved a relative as caregiver.[20]

A growing body of literature continues to document the links between social determinants and Aboriginal child health status. A 2009 study entitled *Health Inequalities and Social Determinants of Aboriginal Peoples' Health* examined a wide range of determinants of health. The study noted that since health is experienced over the course of one's life, the circumstances of the physical and emotional environment impact not only children's current health but set the groundwork for future vulnerabilities and resiliencies. The study identified a number of determinants that are specific to child health status, including:

- crowded housing conditions, which can contribute to stress and behavioural and learning difficulties
- poor prenatal care as well as drinking and smoking during pregnancy, all of which have been linked to poor physical, emotional, and intellectual development among Aboriginal children
- lack of exercise and poor diet, which have been associated with increasing rates of Type II Diabetes among Aboriginal youth
- exposure to tobacco smoke, smog, and mould in the environment, which are linked to conditions such as asthma, allergies, ear infections and bronchitis.[21]

It is important to note that these determinants act within the context of the social and economic challenges described above.

The Canadian supplement to UNICEF's *State of the World's Children 2009* report identified the following as the most important factors affecting the health of Canada's Aboriginal children:

- poverty
- lack of education
- substandard housing
- poor nutrition
- lack of access to health care and other social services
- a legacy of family, community and cultural breakdown left by residential school policies.[22]

There is a shortage of studies examining the impact of positive predictors such as exposure to Aboriginal languages, culture and extended family support on child health outcomes.

Aboriginal Child Health Outcomes in BC

General Health

According to the 2006 Profile of Aboriginal Children, Youth and Adults, First Nations/Indian (off-reserve) and Métis children living in British Columbia were described as having good, very good, or excellent health, but at rates that were slightly lower than the Canadian population (Figure 2).[23] No data was available for First Nations children living on reserve. It should also be noted that the measure of self-rated health has yet to be validated in Aboriginal communities, and in general is considered problematic in the field of population health.[24] For example, individuals may rate their health in comparison to others and if the absolute level of health of a group is low, the perception will not accurately reflect a true measure of health.

Access to Health Care

Rates for accessing a family doctor, general practitioner, or paediatrician were comparable for young First Nations/Indian (off-reserve) and Métis children, and consistently lower than rates of access to care for the Canadian population (Figure 3). Rates of access to medical care for older (6-14 year old) First Nations/Indian (off-reserve) and Métis children were the same at 53%. No data was available for First Nations children living on-reserve.[25]

Dental Health

Rates of access to dental care for Aboriginal children in BC are comparable to those of the Canadian population. Among Aboriginal groups, rates of access to dental care are lowest for non-Status Indians, which may reflect the lack of dental care insurance (Figure 4). The higher rates of dental care for children under the age of six years may be related to higher rates of baby bottle tooth decay. According to the 2002/2003 RHS, 27% of First Nations children living on-reserve in

British Columbia were affected by baby bottle tooth decay.[26]

Obesity and Nutrition

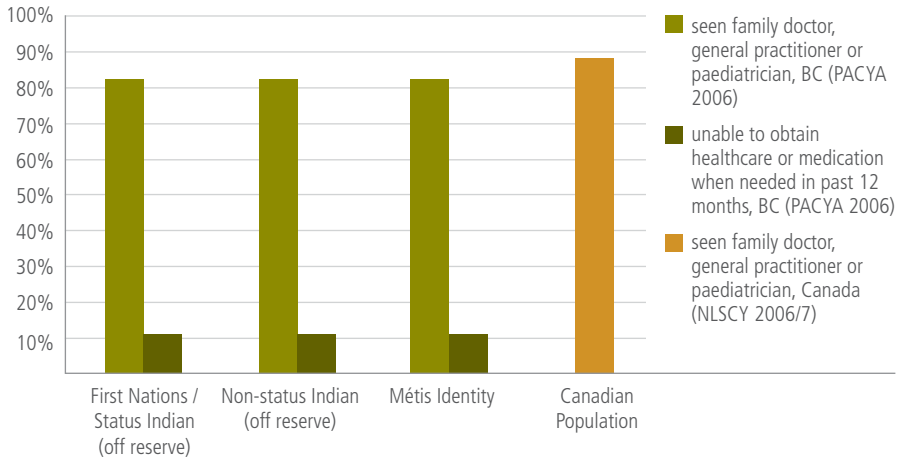
Fifty-two percent of First Nations children living on-reserve in British Columbia between the ages of 0 and 11 years are either overweight or obese. Particularly of concern is that among the First Nations on-reserve children, the overweight rate almost doubles from 18% in the range of 0 to 5 years old, to 33% of children ages 6 to 11.[27] Obesity in children has been linked to poor diet and lack of exercise. The First Nations Longitudinal Regional Health Survey (RHS) found that First Nations children living on-reserve in British Columbia consume fatty and starchy foods at very high rates—almost half of the participant children consumed sweets (48%), fried starch (44%) and soft drinks (43%) more than once a week, and almost one in five ate fast food more than once a week.[28] About one third of these children had eaten large land mammals, fresh water fish and berries often in the past 12 months. Data is not available regarding obesity rates and nutrition for other groups of Aboriginal children in British Columbia.

Activity and Activity Limitations

Sixty-three percent of First Nations children living on-reserve in British Columbia between the ages of 0 and 11 years participate in physical activity either almost every day or every day, and only 10% do not participate in any physical activity or undertake it less than once a week.[29] Physical activity rates are not available for other groups of Aboriginal children.

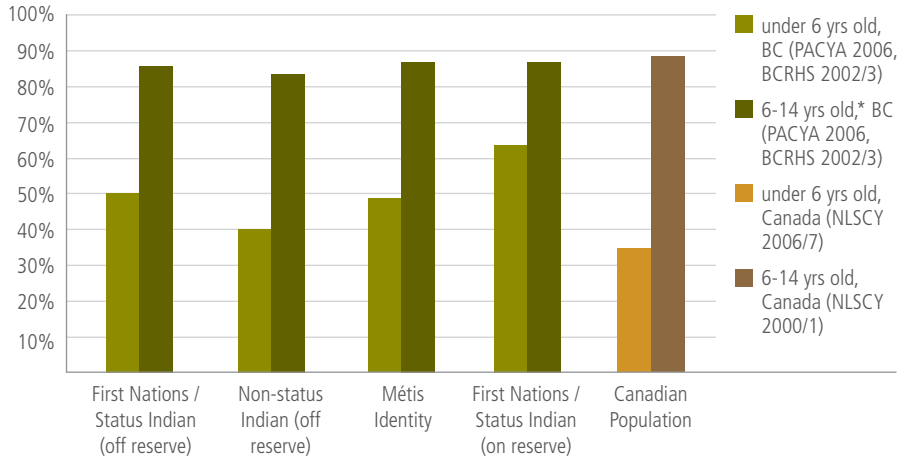
The rates of activity limitations for Aboriginal children from six to fourteen years of age were generally higher than the rate for Canadian children. The rates for First Nations/Status Indian children living off-reserve and Métis children were 19%, or more than twice as high as those of Canadian children.[30] Comparable activity limitation data was not available for First Nations children living on-reserve in British Columbia.

Figure 3: Has accessed medical care in past 12 months for children under 6 years old



Source: 2006 Profile of Aboriginal Children, Youth and Adults (PACYA 2006), National Longitudinal Survey of Children and Youth cycle 7, 2006/2007 (NLSCY 2006-7)

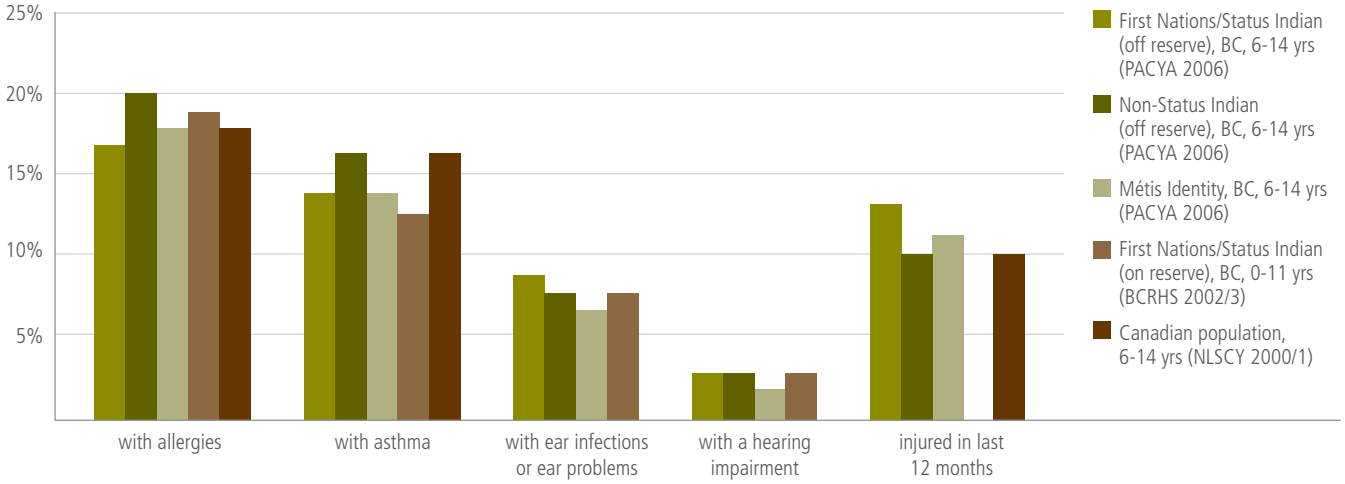
Figure 4: Has received dental care in the past 12 months



Source: 2006 Profile of Aboriginal Children, Youth and Adults (PACYA 2006), BC First Nations Regional Longitudinal Health Survey 2002/2003 (BCRHS 2002/3), National Longitudinal Survey of Children and Youth cycle 7, 2006/2007 (NLSCY 2006-7), National Longitudinal Survey of Children and Youth cycle 4, 2000/2001 (NLSCY 2000/1)

*6-11 years old for First Nations/Status Indian (on reserve)

Figure 5: Medical conditions



Source: 2006 Profile of Aboriginal Children, Youth and Adults (PACYA 2006), BC First Nations Regional Longitudinal Health Survey 2002/2003 (BCRHS 2002/3), National Longitudinal Survey of Children and Youth cycle 4, 2000/2001 (NLSCY 2000/1)

Medical Conditions

Figure 5 shows the rates (for children from six to 14 years of age) for specific medical conditions, including allergies, asthma, ear infections or ear problems, and hearing impairment. Rates for the Canadian child population are included where available. Allergies were the most common medical condition and rates were elevated for First Nations on-reserve and non-Status Indian children.[31] Asthma is also a common condition for Aboriginal children in British Columbia. Hearing impairment appears to be a problem as well across Aboriginal groups affecting 2-3% of children, and 7-9% of Aboriginal children reported ear infections or ear problems (see Figure 5). Caregivers of First Nations children living on reserve also reported conditions of mental disability (2%), ADD/ADHD (2%), and learning disability (5%). Another disturbing number among First Nations on reserve children is the incidence of heart condition (4%).[32] This is twice as likely among female children (6%) than male children (3%), and is extremely high in the Coastal Interior (10%).[33]

Between 40% and 41% of First Nations/Status Indian, non-Status Indian, and Métis children between the ages of 6 and 14 years reported one or more severe chronic health conditions.[34] Comparable data was not available for First Nations children living on-reserve.

School Attendance and Performance

The rates for both school attendance and performance for First Nations/Status Indian children living off-reserve, Inuit, and Métis in British Columbia were consistent across groups. The rate of school attendance ranged from 96% to 98%, while parents or guardians reported that between 67% and 72% of their children were doing well or very well in school.[35] Comparable data was not available for First Nations children living on-reserve.

Family, Emotions, and Behaviour

Of First Nations children living on reserve in British Columbia, 95% of the adults or guardians surveyed reported that their children had no difficulties (52%) or very few difficulties (43%) getting along with the rest of the family over the past six months.[36] For this same group of First Nations children, 12% were reported as having more emotional or behavioural problems than other children of the same age. Comparable data is not available for other Aboriginal groups.

Best and Promising Practices in Aboriginal Child Health Outcomes Assessment and Response

First Nations Regional Longitudinal Health Survey

The First Nations Regional Longitudinal Health Survey (RHS) is the only First Nations governed, national health survey in Canada. It is longitudinal in nature and collects information based on both Western and traditional understandings of health and well being over 30 topic areas, including demographics, language, housing, health status, culture, and community development.

The British Columbia report of the First Nations Regional Longitudinal Health Survey (RHS) 2002/2003 is called *Healthy Children, Healthy Families, Healthy Communities: The Road to Wellness* and was an important source of data for this fact sheet. It can be found on the First Nations Health Council website (link in additional

resources). The 2008/2009 RHS has been completed and data analysis is in process.

Aboriginal Children's Survey

The Aboriginal Children's Survey (ACS) was developed by Statistics Canada and Aboriginal advisors from across the country. ACS is designed to assess the gap in data about the health and development of Aboriginal children in Canada, thereby providing a picture of the early childhood development of First Nations/North American Indian, Inuit and Métis children under the age of six.

The survey was developed with the direct participation of parents, front-line workers, early childhood educators, researchers, Aboriginal organizations and others. The survey collected information on a wide range of topics, including child's health, sleep, nutrition, development, nurturing, child care, school, language, behaviour, and activities. To reflect the importance of the child's environment, some information was collected on the child's parents or guardians and their neighbourhood or community.[37]

First Nations Health Council

The First Nations Health Council (FNHC) was created in 2007 as a coordinating body mandated to implement the 10 year Tripartite First Nations Health Plan on behalf of BC First Nations. The role of the FNHC is to support and assist BC's 203 First Nations communities in realizing their health aspirations and priorities.

The Tripartite First Nation Health Plan, which builds on the *Transformative Change: First Nations Health Plan*, is designed to improve the health and wellbeing of First Nations and to close the health gap between First Nations and other British Columbians. The Plan includes an agreement to create and implement a new structure for the governance of First Nations health services in BC.

The Aboriginal Maternal and Child Health Committee was initiated by the First Nations Health Council as part of the implementation of the Tripartite First Nations Health Plan. It was established to ensure the implementation of the maternal and child health actions in the Tripartite and Transformative Change Accord First Nations Health Plans.[38]

Additional Resources

- Aboriginal Children's Survey www.statcan.gc.ca/aboriginal/acs/5801793-eng.htm
- Canadian Paediatric Society – Aboriginal Health Committee www.cps.ca/english/Advocacy/Aboriginal.htm
- First Nations Health Council www.fnhc.ca
- First Nations Regional Longitudinal Health Survey www.rhs-ers.ca/english
- Indigenous Children's Health Report www.stmichaelshospital.com/crich/indigenous_childrens_health_report.php
- National Aboriginal Health Organization (NAHO) www.naho.ca
- National Collaborating Centre for Aboriginal Health www.nccah.ca
- UNICEF: The State of the World's Children www.unicef.org/rightsite/sowc

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