

**Social Determinants of Health:
First Nations, Inuit and Métis Perspectives**

**For:
National Collaborating Centre for Aboriginal Health
University of Northern British Columbia**

A Note about Report Terminology:

The following terms are used throughout this report, but may differ from the definitions and understandings presented in the reports provided by each of the national Aboriginal groups. Where inconsistent perspectives and/or definitions exist, the information presented by the specific cultural groups should be considered correct and accurate.

The following definitions of terms are borrowed from the *Report of the Royal Commission on Aboriginal Peoples*.¹

Aboriginal people refers to the Indigenous inhabitants of Canada including First Nations, Inuit and Métis peoples (as stated in section 35(2) of the *Constitution Act, 1982*).

First Nations refers, generally, to peoples who identify as First Nations people. This term includes those First Nations peoples living on-reserve or off-reserve, those 'Indian' persons registered under the *Indian Act*, and non-Status First Nations.

Indian refers to persons (including, generally, First Nations and Inuit) registered, or entitled to be registered, under the *Indian Act*.

Indigenous people refers to the Aboriginal population of a nation (in this instance, Canada) or a geographical area.

Inuit refers to Indigenous inhabitants of various land-regions throughout the Canadian North.

Métis refers to a distinct Aboriginal peoples whose early ancestors were of mixed heritage, and who identify themselves as a nation with historical roots in the Canadian west.

¹ Report of the Royal Commission on Aboriginal Peoples (1996). Ottawa: Minister of Supply and Services.

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I. Introduction

There are gross disparities in health between countries around the world, as there are equally apparent health disparities within certain countries. In Canada, Aboriginal peoples, including First Nations, Inuit and Métis, experience both good and bad overall health, however, in general their health status is much worse than other Canadians.

In a global context, Indigenous peoples have been found to be “behind everyone, everywhere”.² Broad factors contributing to the poorer health status of Indigenous peoples globally include poor data collection and analysis, gaps in understandings about health and well-being, variances in demographic profiling in direct relation to existing problems in defining Indigenous populations in reference to their relationship to the local government as opposed to their own traditional understandings and identity. Other broad, global factors that have been recognized as contributing to the poorer health status of Indigenous peoples include poverty, human rights violations, issues related to the environment, lack of culturally-relevant education, community trauma related to development, and a lack of access to health care services.

The Public Health Agency of Canada established the Canadian Reference Group (CRG) to inform Canada's contributions to the World Health Organization (WHO) Commission on Social Determinants of Health by supporting Canadian Commissioners, various Knowledge Networks and Country Partner network involvement. In addition, the CRG has played a role in connecting with key initiatives within Canada and advancing action on social determinants of health (SDH). In Canada, Aboriginal peoples face many of the same challenges faced by Indigenous peoples around the world. There are, however, a number of key factors within the Canadian context that have given rise to gross health disparities experienced by many Aboriginal populations in Canada. It should also be noted that there are intra-group disparities in health status amongst Aboriginal groups in Canada. This overview paper is intended to highlight many of the broad issues and commonalities experienced by Aboriginal peoples within the context of social determinants of health. Critical factors recognized by all three Aboriginal groups, including self-determination, poverty, and colonization, are explored within a broader context in this overview paper and are highlighted as essential to understanding how health disparities have come to exist for Aboriginal peoples, and why these critical factors must be at the core of solutions to addressing health inequality.

² Stephens, C., Nettleton, C., Porter, J., Willis, R., and Clark, S. (2005). Indigenous People's Health – Why are they behind everyone, everywhere?. *The Lancet*, (2005), 366: 10-13.

As a result of broad variances amongst Aboriginal populations in Canada, many of the Canadian Aboriginal organizations and researchers who have contributed their expertise and knowledge to broadening the understanding of the social determinants of health within the context of the WHO Commission on Social Determinants of Health (hereinafter referred to as 'WHO Commission') have cited the importance of adopting a social determinants lens to understanding and addressing health inequalities that exist for Aboriginal peoples and communities. Their unique perspectives and analysis are shared within three research papers that have been prepared by each of the groups, First Nations, Inuit and Métis. These papers are intended to be 'stand alone' efforts from each of the three Aboriginal groups although, as discussed in the three papers, many of their experiences of colonization, social and economic marginalization, and poorer health status are common amongst all three groups.

II. Indigenous Peoples: International and Canadian Perspectives

To ignore the past would be to ignore the direct causes for Indigenous people's health inequities, in Canada and throughout the world that exist today. To ignore the past would be to ignore the critical factors that persist and have given rise to an ongoing struggle to achieve good health and well-being that reflects Indigenous people's holistic approaches to and understandings of health and well-being.

Research and dialogue at the international level has demonstrated a common element that exists for all Indigenous peoples and affects every issue confronting them as a collective: the history of colonization and the associated subjugation of Indigenous peoples.³

International Peoples: Common Experiences/Common Perspectives

Researchers from the London School of Hygiene and Tropical Medicine⁴ (hereinafter the 'London School'), in a Working Paper for the WHO Commission entitled *An Overview of Current Knowledge of the Social Determinants of Indigenous Health*, reflect on some of the common experiences of indigenous populations globally with respect to their marginalization and disenfranchisement from traditional lands and traditional approaches to health, to staying healthy. Discrepancy begins with a general inability globally to decide on how to

³ Rae, J. (2006). *Indigenous Children: Rights and Realty*. Report to the UN Sub-Group on Indigenous Children and Young People (ISG). Toronto: August, 2006.

⁴ Nettleton C., Napolitano D., Stephens C. (2007) *An Overview of Current Knowledge of the Social Determinants of Indigenous Health*. Working Paper for the *Symposium on the Social Determinants of Indigenous Health* Adelaide, Australia 29-30 April 2007.

determine or define indigeneity. Governments are largely unwilling to recognize Indigenous peoples at home and have stalled international recognition.⁵

Nettleton, et al. echoes the concerns of the WHO Commission with respect to the global lack of information and research specific to indigenous populations despite the “crisis situation” that exists with respect to disparities in health status that exist between indigenous populations and non-indigenous populations within many countries.⁶ Internationally, research specific to indigenous population’s health and well-being is piecemeal and fragmented which makes comparative analysis between indigenous populations difficult, if not impossible. There appears to be some consensus that even where an abundance of research and data do exist specific to a particular indigenous population or several indigenous groups within one geographical area, this information is rarely linked to specific health outcomes.⁷ There are broad discrepancies in international reporting of data concerning indigenous people’s health as there are vast differences in policy regarding how data is to be collected, organized and interpreted. In their Working Paper for the Adelaide Symposium, researchers from the London School include reports on a number of regions, countries/continents with differing sizes of indigenous populations including China, South Asia, Latin America, Indonesia and Philippines, Circumpolar and Russia, Africa, North America, and Australia/New Zealand. Structural determinants highlighted within the London School’s report reflect the importance of land and community to the overall health and well-being of Indigenous peoples. Other factors common to all indigenous peoples reflected in the London School’s report were ongoing experiences of marginalization, contemporary efforts to resist assimilation, low socio-economic status, poorer health status, and a patchwork of research and data reflecting increased incidences of malnutrition amongst indigenous children, higher rates of infant mortality, and a greater risk for victimization and violence against indigenous women.

Constitutional Status of Aboriginal Peoples in Canada:

In 1867, the Government of Canada received authority to legislate in relation to “Indians and Lands Reserved for Indians”, according to section 91 (24) of the *Constitution Act, 1867*. Since that time, the resultant *Indian Act* has established a comprehensive system for the Canadian government to determine who is entitled to be registered as an ‘Indian’ under the *Act*, to oversee the

⁵ Ibid.

⁶ WHO. Report by the Secretariat on the International Decade of the World's Indigenous People (A55/35), 55th WHA, 18 April 2002. 2002: WHO Geneva.

⁷ Ibid, note 4.

administration of Indian lands, and for the regulation of every aspect of Indian people's lives.

First Nations, Inuit and Métis peoples born in Canada possess rights that no other Canadians possess. These rights are found in the *Constitution Act, 1982* (hereinafter referred to as 'the Constitution'). The Constitution not only protects existing Aboriginal and treaty rights, but it should be noted that, by virtue of their entrenchment within the Constitution, these rights are recognized as part of the Supreme law of Canada. Aboriginal constitutional rights include the right to health and to self determination over knowledge, heritage, culture, and traditions that encompass all aspects of Aboriginal societies.⁸ The Constitution, however, is not the source of Aboriginal and treaty rights. Rather, Aboriginal and treaty rights, including the right to self-determination, are understood by Aboriginal peoples to be inherent to them by virtue of their existence as Aboriginal peoples.

The difficulty lies in the fact that the health status of Aboriginal people in Canada (who, at a minimum, are entitled to the same standard of health and delivery of health services as all other Canadians) continues to fall well below that of the general population. When properly understood, constitutional rights impose certain positive, social, fiscal and institutional obligations on federal, provincial and territorial governments. These obligations, in turn, permeate legislative and social policy development and place a positive duty on the Canadian government to fulfill its constitutional commitments.⁹

Residential Schools and Colonization:

Knowledge of the historic role of colonization in Canada is vital to any understanding of Aboriginal peoples current health status, and to the formulation of strategies, solutions and programs of change. Colonization as an overarching "root cause" of the poor human rights situation regarding the disparities in health that Aboriginal peoples in Canada experience in comparison to other Canadians points to an overarching fundamental declaration: decolonization through self-determination and group empowerment for Aboriginal peoples. Note that the principle of self-determination is explored further below.

⁸ M. Battiste & J.Y. Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich, 2000) at 212–213 [*Protecting*]. As cited by Yvonne Boyer in the Discussion Document for the Aboriginal Dialogue: *Self Determination as a Social Determinant of Health*. Vancouver: June, 2006.

⁹ See for example: Yvonne Boyer, Discussion Document for the Aboriginal Dialogue: *Self Determination as a Social Determinant of Health*. Vancouver: June, 2006.

In Canada, colonization is often referred to in the context of a historical process that devastated the traditional livelihood of Aboriginal peoples and resulted in their oppressed state within present-day Canadian society. Colonization is perceived as a 'past event'. However, the process of colonization must be recognized as a contemporary actuality:

Colonization is a process that includes geographic incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and ultimately, the creation of ideological formulations around race and skin colour which position the colonizers at a higher evolutionary level than the colonized.¹⁰

The broad, profound impact that colonization has on Aboriginal populations must be recognized:

The history of development is a history of trauma. Development that is not self-determined is predatory. Development that is not self-determined precipitates inter-generational trauma in individuals and communities. When this occurs people suffer loss and grieve over ways of life. Families divide and the rituals of celebration and healing lose meaning.

Development that does not occur as part of a nation's natural ebb and flow of creative change is traumatic. Development is traumatic when it is imposed by one group on another. Development that is not in the control of the communities is a form of socially condoned violence and leads to genocide.¹¹

It is well documented that federal assimilation policies and institutions created the crisis in Aboriginal health. The failure of 'Indian' health policies has always resided in the false assumptions that Aboriginal people were biologically predetermined to vanish, were inherently unhealthy and inferior, and that their culture caused them to pursue harmful lifestyles. The policies of the federal government were designed to implement the treaty promises of settlement, but actually diminished expectations for hunting, fishing, and trapping in traditional lands that had been transferred under treaty, and resulted in suffering, starvation, disease, and death. Residential schools, mandated by the federal

¹⁰ See Frideres, J. (1983). *Native people in Canada: Contemporary conflicts*. Cited in M. Kelm (1998) *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-1950* (pp.295-296). Vancouver: UBC Press.

¹¹ Korn, L.E. (2002). *Community Trauma and Development*. Fourth World Journal, Vol.5, Number 1, Center for World Indigenous Studies.

government and administered by the various churches, had inadequate health facilities and contributed to the spread of the settlers' diseases. Traditional medicines, healing ceremonies, access to family and traditional languages were discouraged and prohibited.¹²

Aboriginal Perspectives on Health and Well-Being:

First Nations, Inuit and Métis all have distinct conceptions of health and how to achieve and maintain good health. Their unique perspectives and understandings about health have been reflected in the discussion papers prepared by each respective cultural group. What is common amongst many Aboriginal peoples' understandings about health and well-being, however, is that good health involves both positive elements (energy, spiritual strength, etc.) as well as the absence of negative elements. Views about health also tend to be holistic, including not only physical well-being but also emotional, intellectual, spiritual and other components.

Aboriginal peoples human rights to life and to health services should be understood within the holistic and interrelated framework of well-being described above. Beyond this most proximate level of analysis, however, an individual's health, even broadly defined, cannot be understood in isolation of the collective well-being of their community and/or nation. As the "collective rights approach" demonstrates, Indigenous people's well-being is intimately linked to the well-being of their communities, society, and the world at large:

Everything in the world has life; all things breathe and live and have a spirit and power. Further, all of these beings are interrelated and influence the workings of the universe; each has a role and responsibility for maintaining order within the universe. When disruptions or imbalances occur – whether from unhealthy interactions amongst the beings, or from negative mental, physical, or spiritual activity – illness results.¹³

The poor health status of Aboriginal peoples "has to be seen in connection with the general marginalization that Indigenous peoples suffer from economically and politically."¹⁴ In addition, other abusive political and social interventions

¹² Lux, M. *Medicine That Walks: Disease, Medicine, and Canadian Plains Native Peoples: 1880-1940* (Toronto: University of Toronto Press, 2001). As cited by Yvonne Boyer in the Discussion Document for the Aboriginal Dialogue: *Self Determination as a Social Determinant of Health*. Vancouver: June, 2006.

¹³ Avery, C. (1991). Native American medicine: Traditional Healing. *Journal of the American Medical Association*, 265(17), 2271-2273.

¹⁴ See for example, African Commission on Human and Peoples' Rights (ACHPR). Report of the African Commission's Working Group of Experts on Indigenous Populations/Communities.

directed at the Aboriginal community as a whole – including displacement, cultural repression and assimilation, the forced removal of children, child abuse within state institutions, armed conflict, discrimination, and others – often leave deep emotional, mental, spiritual and physical traumas that affect generations to come.

Health Status and Poverty:

Health Status:

It has been well-known for a number of decades¹⁵, throughout the world, that poorer people have a lower overall health status than rich people. Determining the health status of marginalized populations includes such measures as life expectancy rates, infant mortality rates, access to health care services that support health and prevent health crisis within defined populations, chronic disease management and health promotion activities.

The health status of First Nations, Inuit and Métis peoples is substandard in comparison to the health status of other Canadians.¹⁶ Critical factors that broadly impact the reduced health status of Aboriginal peoples in Canada include poverty, violence, poor housing and deficient physical environments.¹⁷

Access to, and quality of, medical care services is not the main driver of people's health. The concept of social determinants is directed to the "factors which help people stay healthy, rather than the service that help people when they are ill".¹⁸ However, many Indigenous peoples do not have access to the holistic health and social services required to meet their basic needs and protect human rights:

- Programs are required that promote reconciliation and respect diversity. Many Indigenous communities and individuals experience alienation and marginalization from accessing services that meet their needs within this context;
- Less than 1% of Canadian health professionals are of Aboriginal ancestry.¹⁹ There is an ever-increasing need for culturally competent health care professionals;

Adopted by the ACHPR at its 28th ordinary session. Banjul and Copenhagen: ACHPR and IWGIA, 2005.

¹⁵ Chadwick, E., (1965). *Report on the Sanitary Condition of the Labouring Population of Great Britain, 1842*. Edinburgh: Edinburgh University Press.

¹⁶ See Appendix 1.

¹⁷ See for example Assembly of First Nations, *Royal Commission on Aboriginal People at 10 Years: A Report Card* (2006). www.afn.ca

¹⁸ London Health Observatory 2002 review of the London Health Strategy High-level Indicators.

¹⁹ Hunter, et al., (2004). *Linking Aboriginal Healing Traditions to Holistic Nursing Practice*. Journal of Holistic Nursing, vol.22,no.3: pg.267-285.

- Comprehensive research completed in 2005 demonstrated that many First Nations, Inuit and Métis children do not have access to the same range of health and social services within their community that their non-Aboriginal counterparts otherwise benefit from by virtue of where they live (on- or off-reserve, for example).²⁰ As a result, many children are placed in care of the state for the sole purpose of having their medical needs met. This is a violation of basic human rights;
- Inuit have experienced a decrease in life expectancy compared to other Canadians, who have experienced an increase between 1996-2001.²¹

Few programs and services designed to address the health circumstances of Aboriginal populations are designed to address their needs holistically and to take into account their worldviews. The National Aboriginal Health Organization (NAHO) has described First Nations, Inuit and Métis understandings of health and well-being to include both health promotion and disease prevention:

In a First Nations world view, healing (getting at the root cause, becoming whole) is synonymous with behaviour change and therefore is central to promotion and prevention. Inuit views of the body offer a holistic vision of the individual and his or her unity with his/her surroundings, a part of a whole that draws its meaning from the relationships that the human being entertains with whatever is living and whatever surrounds him or her... commenting on Métis health: Health is the whole person... we don't need to think that we have an addictions problem here, a problem with teens there, Elders who are lonely, women who are depressed. We have to think: People don't feel good. Why is that?²²

There is an absence of social supports within school and child care environments, nutritional capacity within Aboriginal communities is weak, the safety and security of children and families is compromised by the degree of violence that exists within many Aboriginal communities. All of these factors must be addressed in order to improve the health status of Aboriginal peoples.

²⁰ First Nations Child and Family Caring Society of Canada, *Wen'de: We are Coming to the Light of Day* (2005).

²¹ Department of Indian and Northern Affairs, *The Well-Being of Inuit Communities* (2006).

²² National Aboriginal Health Organization (NAHO), *Improving Population Health, Health Promotion, Disease Prevention and Health Protection Services and Programs for Aboriginal People* (2002).

The UN *Draft Declaration on the Rights of Indigenous Peoples*²³, first drafted in 1985 (with a number of redrafts since) by The Working Group on Indigenous Populations (WGIP)²⁴, includes five articles referring to the right to health²⁵:

Article 22:

Indigenous people have the right to special measures for immediate effective and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security.

Article 23:

Indigenous people have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous people have the right to determine and develop all health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions.

Article 24:

They [Indigenous people] also have the right to access, without any discrimination, to all medical institutions, health services and medical care.

Article 28:

States shall take effective measure to ensure, as needed, that programs for monitoring, maintaining and restoring health of Indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Article 31:

Indigenous peoples, as a specific form of exercising their right to self determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, including culture, religion, education, information, media, health, housing, employment, social welfare, economic activities, land and resource management, environment

²³ United Nations Human Rights Council (HRC). *Draft Declaration on the Rights of Indigenous Peoples*. A/HRC//L.10, Human Rights Council resolution 2006/2. Annex. 2006. www.ohchr.org

²⁴ Report of the Working Group on Indigenous Populations on its eleventh session, UN Doc. E/CN.4/ Sub.2.1993/29 (23 August 1993) at art. 22 [WGIP 1993].

²⁵ Cited by Yvonne Boyer in the Discussion Document for the Aboriginal Dialogue: *Self Determination as a Social Determinant of Health*. Vancouver: June, 2006.

and entry by non-members, as well as ways and means for financing these autonomous functions.

It should be noted that Canada was one of only two countries (along with Russia) to vote against adoption of the UN *Draft Declaration on the Rights of Indigenous Peoples*²⁶ (hereinafter referred to as the 'Draft Declaration'), in June 2006. Immediate adoption of the Draft Declaration, as a recommendation of the World Health Organization, would be a positive step towards supporting the aspirations of Indigenous peoples.

Suggested Strategies for Improving Aboriginal People's Health Status:

Social determinants of health can be understood as the social conditions in which people live and work, or "the social characteristics within which living takes place".²⁷ If the major determinants of health are social, so must be the solutions to addressing risk factors contributing to the poorer health status of Aboriginal peoples.

Holistic, Inclusive Strategy Development:

There have been a number of national strategies undertaken to 'close the gap' in health outcomes for all Aboriginal groups. In Canada, the *Blueprint on Aboriginal Health* represents a comprehensive process for negotiation and partnership with all Indigenous cultural groups (First Nations, Inuit and Métis) towards the development of a long-term "transformative plan...for improving access and quality of health services through comprehensive, holistic and coordinated service provision by all parties to the Blueprint, and through concerted efforts on determinants of health."²⁸ All parties to the *Blueprint* agreed to "adopt a population health approach that focuses on determinants of health, including those outside the formal health sector" through:

- a. concerted action, communications and collaboration with other sectors to address determinants such as housing, education, food security, violence

²⁶ At the United Nations Human Rights Council (UN HRC), out of 30 members only 2 voted against the adoption of the Draft Declaration on the Rights of Indigenous Peoples. The two countries voting against adoption were Canada and Russia. However, many other countries oppose the Draft Declaration. This coalition of opposing countries includes Canada, United States, Australia and New Zealand. Note that, as colonial and imperial powers, these countries recognize an increased pressure to respect the rights of Indigenous peoples within their borders if the Draft Declaration passes in the form adopted by the UN HRC.

²⁷ *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health*, World Health Organization: Commission on Social Determinants of Health (2005).

²⁸ See Health Canada, www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-blueprint-plan-abor-auto/index

- against Aboriginal women, children and elders and environment, including clean water and environmental contaminants;
- b. addressing regional realities in strategies to promote health and prevent disease; and,
 - c. identifying, sharing and implementing best practices that take a holistic approach when developing new programs or improving existing health programs including First Nations, Inuit and Métis health programs, promoting inter-community and inter-agency networking and learning.”

Cross-sectoral Collaboration and Integrative Approaches to Well-being:

Many Hands, One Dream: New Perspectives on the Health of First Nations, Inuit and Métis Children and Youth (MHOD) movement in Canada is “a long-term initiative to generate commitment, foster collaboration, and develop and implement solutions that will improve the health of Aboriginal children and youth in Canada”. International efforts between Indigenous peoples in Canada and the United States has given birth to the *Reconciliation in Child Welfare* movement, which is based on the declaration that “child welfare reconciliation with Indigenous peoples stems from the belief that North American child welfare systems can, and must, do better for Indigenous children, youth, and families.” Out of these two initiatives have evolved guiding principles²⁹ for a social movement committed to:

- eliminating the disproportionate risks currently faced by all Aboriginal children and youth through the active engagement of health and child welfare leaders who are guided by Aboriginal communities;
- identifying and implementing viable solutions that can be actively implemented by the range of stakeholders in Aboriginal child welfare and Aboriginal health as well as with the Canadian public; and,
- monitoring and evaluating progress of the movements.

Measuring Outcomes:

On the international landscape, research stresses how little has been done, even in wealthy countries, to develop an adequate system of measurement for determining the impact of public health policies on marginalized groups or to test approaches for closing the gap in health outcomes. “Knowledge sharing must be strengthened among countries working to promote health equity. New

²⁹ *Many Hands, One Dream: Principles for a new perspective on the health of First Nations, Inuit and Métis children and youth* (www.manyhandsonedream.ca), and *Touchstones of Hope for Indigenous Children, Youth and Families* (www.reconciliationmovement.org).

forms of collaboration between health experts and decision-makers should be explored, so as to turn evidence on social and environmental determinants into effective public policy.”³⁰ The issue of data collection and disaggregation was explored in some detail at a workshop of the *Permanent Forum on Data Collection and Disaggregation for Indigenous Peoples* in January 2004. The workshop recommended that the UN system use and further refine existing indicators such as the common country assessment indicators, the Millennium Development Goals (MDGs) indicators, country progress reports, other global monitoring instruments and the human development indices to measure the situation of indigenous peoples.³¹ Two main core themes have been recommended for grouping indicators with a view towards inviting United Nations organizations to involve indigenous peoples in the development of a more refined list of indicators and associated research initiatives:

- identity, land and ways of living;
- Indigenous rights to, and perspectives on, development.

Poverty:

Canada’s Report of the Royal Commission on Aboriginal Peoples concluded:

Aboriginal people are at the bottom of almost every available index of socio-economic well-being, whether [they] are measuring educational levels, employment opportunities, housing conditions, per capita incomes or any of the other conditions that give non-Aboriginal Canadians one of the highest standards of living in the world. There is no doubt in our minds that the economic and social deprivation is a major underlying cause of disproportionately high rates of criminality among Aboriginal people.³²

Income is thought to affect health in these ways:

- material deprivation removes the prerequisites for healthy development such as shelter, food, warmth, and the ability to participate in society;
- living on low income causes psychosocial stress, which damages people’s health; and,
- low income limits peoples’ choices and works against desirable changes in behaviour; and,

³⁰ Vega, J. & Irwin, A. (2004). Tackling health inequalities: new approaches in public policy. *Bulletin of the World Health Organization*, vol.82, no.7, pg.482.

³¹ See for example, www.un.org/esa/socdev/unpfii/news/news_workshop_doc.htm

³² RCAP, *Choosing Life, Special Report on Suicide among Aboriginal People* (Ottawa: Supply and Services, 1995), p.24.

- there is a graded relationship between household income and emotional and behavioural problems in childhood – the lower the household income, the higher the incidence of these problems.³³

Poverty is not only measured in reference to income levels. Just as the response to addressing poverty must be integrated and multi-faceted, understanding and defining poverty must be accomplished through a multi-dimensional methodology. According to the United Nations there are three aspects to poverty: ‘poverty of money’, ‘poverty of access’ and ‘poverty of power.’ “These make the working, living and social environments of the poor extremely insecure and severely limit the options available to them to improve their lives. Without choices and security, breaking the cycle of poverty becomes virtually impossible and leads to the marginalization and alienation of the poor from society.”³⁴

The Assembly of First Nations (AFN), in their report on First Nations peoples in Canada, has clearly outlined how the widening gap between government funding to [Aboriginal] peoples and other Canadians has been reflected in the Community Well-Being Index, the First Nations Regional Longitudinal Health Survey, and the United Nations Human Development Index.

Strategies for Alleviating and Preventing Poverty

International Focus:

The concept of health equity, or inequity, is foundational to international reflection. “Health equity can be defined as the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically. Inequity implies a failure to avoid or overcome inequalities in health that infringes human rights norms or is otherwise unfair. Health inequities have their roots in social stratification.”³⁵

Broad Canadian Approach:

In developing strategies to alleviate poverty, social gradient in health is a factor that must be taken into consideration. In Canada, for example, people enjoy a

³³ Canadian Institute of Child Health. (2004). *The health of Canada’s children – A CICH profile: Income inequity*. www.cich.ca/PDFFiles/ProfileFactSheets/English/Incomeinequity.pdf

³⁴ *Urban Poverty Alleviation*, unpublished paper presented at the Regional High-level Meeting in preparation for Istanbul+5 for Asia and the Pacific, 19 to 23 October 2000, Hangzhou, People’s Republic of China (2000). United Nations Economic and Social Commission for Asia and the Pacific. www.unescap.org/huset/hangzhou/urban_poverty.htm

³⁵ Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, World Health Organization: Commission on Social Determinants of Health (2005).

low level of material deprivation as a result of poverty. Most Canadians living in poverty, live in relative poverty. However, Aboriginal peoples experience a degree of poverty that includes both absolute poverty and relative poverty.³⁶ Understanding the social gradient in health changes the conceptual focus on absolute poverty to include relative poverty, and relates to a broader approach to social functioning and meeting human needs.³⁷

Indigenous Perspectives:

Developing strategies to alleviate and prevent poverty have been the focus of the United Nations Millennium Development Goals (MDGs). It should be noted, however, that Indigenous peoples (including Aboriginal peoples of Canada) did not participate in the development of the MDGs, nor did the United Nations consult with Indigenous peoples or representative organizations in the development of the MDGs. Aboriginal peoples must lead the discussions regarding how best to address health inequities resulting from a number of factors, including poverty.

The AFN has developed a plan for addressing poverty within First Nations communities in Canada. The *Make Poverty History* campaign, as presented more comprehensively in the AFN report on social determinants of health, highlights self-determination as a critical factor for alleviating First Nations poverty. Other critical factors include:

- Establishing self-government and long-term strategies towards self-sufficiency;
- Accountability on the part of the federal government with respect to the gap in spending on First Nations and other Canadians;
- Developing indicators that demonstrate inequities and inadequacies in state funding attributed to Indigenous peoples' programming and services are proposed; and,
- Fiscal data which is informative as links between funding levels to mandated areas of state government responsibility, assessing their accountability and projecting demand and other impacts into the future.

³⁶ Poverty is not only measured in reference to income levels. The United Nations *Urban Poverty Alleviation* describes two forms of poverty: 'absolute poverty' refers to the cost of the minimum necessities needed to sustain human life; 'relative poverty' refers to the minimum economic, social, political and cultural goods needed to maintain an acceptable way of life in a particular society. The circumstances of Aboriginal peoples in Canada varies between these two forms of poverty depending on where they live (on- or off- reserve, within a certain land-region of the North, or if their community is located near an urban center).

³⁷ Marmot, M., *Status Syndrome*. London: Bloomsbury, 2004.

Aboriginal Peoples within an Urban Context:

Extensive information and discussion regarding the circumstances of Aboriginal peoples living within an urban setting has been provided by the National Association of Friendship Centres (NAFC), which represents 117 Friendship Centres located throughout all regions of Canada and whose mission includes “improving the quality of life for Aboriginal peoples in an urban environment by supporting self-determined activities which encourage equal access to, and participation in, Canadian society”.

With an increasing Aboriginal population that is both rural and urban, young, vital and rapidly expanding, Canada must address the extremes of poverty that Aboriginal peoples face on a daily basis. This poverty is systemic and long-standing, and requires concerted attention from all levels.³⁸ Of the 150,000 Aboriginal children in Canada, nearly 100,000 do not live on-reserve but reside in urban, rural and remote communities. The poverty rate faced by urban Aboriginal peoples exceeds 50%. Forty percent of off-reserve Aboriginal children live in poverty³⁹, which is more than double the rate for non-Aboriginal children (18.4%). Nearly 16% of the total urban Aboriginal population experiences hunger. In urban centres, families with hungry children are 13 times more likely to be on social assistance and 4 times more likely to be of Aboriginal ancestry.

Poverty and Food Insecurity

Poverty in urban Aboriginal communities has become multi-generational. Experiences of poverty are aggravated by a number of factors such as racism, intergenerational trauma as a result of the residential schools experience, economic marginalization and both provincial and federal governments which are apathetic to the difficult realities of urban Aboriginal life. Both the root causes for poverty and solutions that Aboriginal peoples have posed to address issues of poverty and its impact on the lives of the urban Aboriginal population have been ignored. With record fiscal surpluses, there remain few resources allocated at both the provincial and federal level to addressing issues associated with long-term child poverty such as increased risk for deviant behaviour in adolescence and poorer educational attainment. Food insecurity is dynamic in nature and defined by a sequence of events and experiences. There are negative psychological, social and physical consequences across this continuum.⁴⁰ The

³⁸ Campaign 2000, Oh Canada! Too Many Children in Poverty for Too Long: 2006 Report Card on Child and Family Poverty in Canada.

³⁹ Ibid, Campaign 2000.

⁴⁰ Jarjoura, G., et al. (2002). Growing up poor: examining the link between persistent child poverty and delinquency. *Journal of Quantitative Criminology*, 18, 159-187.

evidence establishing a correlation between child hunger, food insecurity and health is substantive.

Early Childhood and Youth

Over the past few years, more urban Aboriginal children living in non-reserve areas were attending preschool programs with a culturally-specific focus. In eight years, the proportion of urban Aboriginal children attending such programs had increased almost four-fold. Just over half (53%) of Aboriginal children aged 6 to 14 living in urban areas had attended preschool programs, including those specifically designed for them. The scientific literature continues to demonstrate the considerable and sustained benefits to society when families and communities invest in the well-being of their children at the earliest stages of their young lives. Extensive evidence has demonstrated that education investments in the early years of life have the highest potential rates of return; conversely, failures to invest in children at these early stages are the most costly human capital policy failures.⁴¹ Children from disadvantaged backgrounds benefit particularly from such policies. Gaps in ability among children of different income groups emerge early on, widen slightly in the first few years of schooling, and stay constant after age eight. Over time, it becomes increasingly costly and difficult to narrow these gaps.

Helping young children from disadvantaged families get 'on the right track' has the highest potential returns of any education policy. Nobel Prize-winning economist, James Heckman, observes that:

“it is a rare public policy initiative that promotes fairness and social justice and at the same time promotes productivity in the economy and in society at large. Investing in disadvantaged young children is such a policy”.⁴²

Access to Affordable Housing

Canada remains one of the few countries in the world without a comprehensive affordable housing strategy and permanent funding.⁴³ In 1986, the Ottawa Charter for Health Promotion⁴⁴ recognized shelter⁴⁵ as a basic prerequisite for

⁴¹ Bendor et al. *An Education Strategy to Promote Opportunity, Prosperity, and Growth*, February 14, 2007. www1.hamiltonproject.org/views/papers/200702education.pdf

⁴² Heckman, James J. 2006. *Investing in disadvantaged young children is an economically efficient policy*. Presented at the Committee for Economic Development forum, “Building the Economic Case for Investments in Preschool,” New York (January 10, 2007).

⁴³ Ibid, Campaign 2000.

⁴⁴ WHO (1986) *Ottawa Charter for Health Promotion*. An International Conference on Health Promotion. WHO, Ottawa.

good health. It is only recently however, that researchers and policy-makers have focused on housing as an important determinant of health. Poor housing can be determined by various indicators, including the number of homeless people, the number of people who are forced to use temporary shelters, those who live in substandard dwellings, and those who spend more than 30% of their income on housing.

Nationally, 17% of urban Aboriginal populations live in over-crowded conditions, compared to 7% of other Canadians.⁴⁵ Urban Aboriginal children are particularly affected by these conditions – while 13% of non-Aboriginal children live in over-crowded conditions, 25% of urban Aboriginal children live in over-crowded conditions. Health experts maintain that over-crowding can lead to experiencing poorer health, including increased risk for injuries, higher risk for experiencing poorer mental health, heightened family tension and an increased risk for experiencing violence (Health Canada 1999).

There appears to be growing recognition of the need for all sectors to adapt program and policy changes that address the social determinants of health including; poverty, food insecurity, early learning and affordable housing in building healthy communities.

“We could prevent up to 60 or 70 percent of all cancers, up to 90 percent of all heart disease, up to 60 percent of all strokes, up to 90 percent of all cases of chronic lung disease, up to 90 percent of all diabetes – all the things that are filling up our hospitals and our doctor’s offices and our graveyards.”

- Dr. Andrew Larder, Medical Health Officer, East Kootenay Region

The depth and magnitude of our experience and resources is considerable and unmatched. Urban Aboriginal peoples continue to develop the skills and expertise required to deliver the unique “*basket of supports and services*” to the urban Aboriginal community that Friendship Centres provide. In addressing the social determinants of health, we seek means to improve the quality of life of Aboriginal peoples, to improve health status, and to achieve sustained and positive outcomes.

⁴⁵ Article 25(1) of the Universal Declaration of Human Rights says that “everyone has the right to a standard of living adequate for health and well-being including food clothing, housing”. The International Covenant on Economic, Social and Cultural Rights, to which Canada is a signatory, guarantees a right to housing.

⁴⁶ Canada Mortgage and Housing Corporation. (1996) “The Housing Conditions of Aboriginal People in Canada.” Research and Development Highlights. Issue 27 www.cmhc-schl.gc.ca/publications/en/rh-pr/socio/socio027.pdf.

Women's Perspectives:

The socio-economic realities of Aboriginal women today are directly linked to their historical experiences of colonization and racism. The process of colonization has resulted in the suppression of Aboriginal women to the extent that, according to the Native Women's Association of Canada in their submission to the Canada-Aboriginal Peoples Roundtable in 2004, "Aboriginal women face socio-economic challenges unlike those faced by any other woman in the country."⁴⁷

Poverty

In 1996, among the First Nation women with children living in urban Winnipeg, Regina and Saskatoon, 80-90% lived below the poverty line. These numbers remain relatively unchanged at present. Status of Women Canada has reported that the rates of poverty for Aboriginal women are more than double that of non-Aboriginal women, and are higher than rates of poverty experienced by immigrant women and visible minorities.

Unemployment

Aboriginal women are less likely than Aboriginal men, and non-Aboriginal women, to be employed. Among Registered Indian women the labour force participation rate was lower on reserves (47%) than off reserves (55%). The majority of Aboriginal women who are employed are in low-paying occupations, such as sales and service or administrative positions.

Education

Aboriginal women are more likely than Aboriginal men to have a university degree.⁴⁸ Inuit women and Registered Indian women on reserves have lower levels of attainment than Métis women, other Aboriginal women, or Registered Indian women living off reserves. Métis women have been especially successful, with 50% having some level of post-secondary attainment and only 10% having less than grade 9 attainment.

⁴⁷ The Native Women's Association of Canada Background Paper: Canada-Aboriginal Peoples Roundtable Economic Opportunities Sectoral Session, Native Women's Association of Canada, 2004.

⁴⁸ Aboriginal Women A Profile from the 2001 Census, DIAND, www.ina.gc.ca/pr/pub/abw_e.html

Housing

There are chronic housing shortages on-reserve, in the North, and for Aboriginal people in urban centres. Poverty and higher risk of violence due to involvement in the sex trade are intimately linked to homelessness. Aboriginal women often migrate to urban centers to escape violence and poverty occurring on-reserve, only to become victims of “Canada’s triple force of race, class and sex discrimination”.⁴⁹

Violence

Research has shown that at least three-quarters of Aboriginal women have been victims of family violence, and they are three times more likely than non-Aboriginal women to die as a result of that violence. According to Statistics Canada⁵⁰, 24% of Aboriginal women said that they had suffered violence from a current or previous spouse or common-law partner in the five-year period up to 2004. Aboriginal victims were also more likely to state that they were beaten, choked, threatened with or had a gun or knife used against them, or were sexually assaulted. Health Canada has reported that Aboriginal women aged 25-44 years are five times more likely to be killed by their abusive partner.⁵¹ As a result of the violence that Aboriginal women experience within their homes, they are at higher risk for alcohol and substance abuse, and are three times more likely to commit suicide.⁵² The challenges that Aboriginal women face in their lives are intimately inter-related.

Indigenous peoples in Canada have the inherent right to be self-determining. Traditionally, in most nations, Aboriginal women had significant roles in decision-making with regards to how best to ensure the health and well-being of their communities and nations. A contemporary accounting of the significance of women’s responsibility within their families and communities has been articulately explained by UNICEF:

“...gender equality furthers the cause of child survival and development. Because women are the primary caregivers for children, women’s well-being contributes to the well-being of their offspring. Healthy, educated and empowered women are more

⁴⁹ Farley, M. & Lynne, J. (2002) *Prostitution of Indigenous Women: Sex Inequality and the Colonization of Canada’s First Nations Women*, *Fourth World Journal*, vol.6, number1, pg.1-29.

⁵⁰ Statistics Canada, *Family Violence in Canada: A Statistical Profile* (2005), <http://www.statcan.ca/Daily/English/050714/d050714a.htm>

⁵¹ Health Canada, Women’s Health Bureau, *The Health of Aboriginal Women*, online: http://www.hc-sc.gc.ca/english/women/facts_issues/facts_aborig.htm, pg.1.

likely to have healthy, educated and confident daughters and sons. Women's autonomy, defined as the ability to control their own lives and to participate in making decisions that affect them and their families, is associated with improved child nutrition. Other aspects of gender equality, such as education levels among women, also correlate with improved outcomes for children's survival and development.

By upholding women's rights, societies also protect girl children and female adolescents. Gender equality means that girls and boys have equal access to food, health care, education and opportunities. Evidence has shown that women whose rights are fulfilled are more likely to ensure that girls have access to adequate nutrition, health care, education and protection from harm."⁵³

The following discussion focuses on the global call for recognition of the rights of indigenous peoples to be self-determining. However, there has been some caution stated from the perspectives of Aboriginal women. Defenders of indigenous rights to self-determination often fail to adequately account for the experiences of powerlessness that many Aboriginal women and children have that work to prevent their participation within their living environment. Stephanie Jarrett, in her paper to the Australian Bennelong Society⁵⁴, suggests that before the collective call for self-determination is answered some prioritization must occur with respect to addressing the violation of individual rights, human rights, that are experienced by Aboriginal women and children globally.

IV. Social Determinants of Health: A Broad Aboriginal Context

Self-determination

"The different types of human rights violations experienced by indigenous peoples all boil down to this fundamental issue: many marginalized indigenous peoples...are denied the right to exist as peoples and to determine their own development."⁵⁵

The need for states to recognize the right of Indigenous peoples to self-determination is without a doubt the most consistent, universal demand made

⁵³ *The State of the World's Children 2007*. UNICEF, (2007).

⁵⁴ Jarrett, S. (2006). *Minority Rights Harm Aboriginal Women and Children. The Bennelong Society: Occasional Paper*. September, 2006.

⁵⁵ *Ibid*, note 11.

by Indigenous peoples worldwide. Self-determination does not describe any single political or social arrangement; it can take different forms in different places, contexts, and cultures. Member states to the UN have argued that self-determination corresponded closely “to the will and desires of people everywhere.”⁵⁶

The right to self-determination for all peoples was one of the first principles enshrined by the United Nations, found among the first articles of both its founding *Charter of the United Nations*⁵⁷ and the *International Covenant on Civil and Political Rights*⁵⁸. However, the 1945 meeting of international delegates in San Francisco, which gave birth to both the United Nations and its Charter, interpreted self-determination within a certain, limited context:

When examining self-determination in the Charter of the United Nations, it is noteworthy that the Charter does not grant the Security Council the authority to redress breaches of the human rights cited in Article 1 or in Article 55. Human rights in the Charter, including self-determination, are included in the context of “developing friendly relations between countries” and are listed as one of the “appropriate measures to strengthen universal peace.” Equality and self-determination are mentioned *as elements important to peace*...⁵⁹

Marc Charfauros Chamorro, in speaking to the United Nations about the adoption of the Draft Declaration on the Rights of Indigenous Peoples, defined self-determination as “an inalienable right of a people to determine for themselves their relationship with their colonizer. It is a right that cannot be taken away nor given to someone else”.⁶⁰ However, Chief Ted Moses, of the James Bay Cree (Euyou Astchee), stated that:

By virtue of the right of self-determination, certain closely related rights flow; the right to freely determine our political status and freely pursue our economic, social and cultural development...it is by virtue of the right of self-determination that peoples may benefit from their own natural wealth and resources, and more

⁵⁶ Quoted in A. Rigo Sureda, *The Evolution of the Right of Self-Determination: A Study of United Nations Practice* (Leiden, Holland: A.W. Sijthoff, 1973).

⁵⁷ United Nations. *Charter of the United Nations*. 1945.

⁵⁸ United Nations. *International Covenant on Civil and Political Rights*. U.N. Doc. A/6316 (1966). 1966.

⁵⁹ Pomerance, M. *Self-Determination in Law and Practice* (Boston: Martinus Nijhoff Publishers, 1982), 9.

⁶⁰ *Dialogue Between Nations*, 1993. www.dialoguebetweennations.com

importantly, it is by virtue of the right of self-determination that our traditional economy and way of life is protected.⁶¹

Whereas Chamorro defines self-determination within the context of Indigenous peoples' relationship to their colonizers, to the state or government, Chief Moses considers self-determination within the context of a peoples' ability to determine their own means of subsistence. The entire context for interpretation has changed. Chief Moses' perspective is relational to the land and a way of life that is both meaningful to the people and tied to land on which they live. Understanding what it means to be self-determining now means understanding the relationship that a people have with the land, and includes their free choice of a way of life that meets their needs and ensures their rights upheld.

Aboriginal peoples have always maintained their ways of being, and pursued their means of subsistence through intricate relationships and interactions between individuals and the collective nation or community to which they belong. In this context, achieving self-determination cannot be done through understandings based on relationships with or to a government, or colonizer. Self-determination can only be achieved through restoring the intricate balance and relationship between Indigenous peoples individually and through their collective groupings. The relationship between the individual and collective is maintained through a balanced, full continuum of reciprocity between and amongst individuals and the collective.

As is often the experience of indigenous peoples' rights to be self-determining and other human rights in general, human rights evolve along with the understanding of the international community and are normally only identified when they are dramatically violated. For many Indigenous peoples, however, the right to *be* self-determining is an inherent right that exists within a people even if it is not recognized and realized in practice.

It is stated in Part I, Article 3 of the *Draft Declaration on the Rights of Indigenous Peoples*:

Indigenous people have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development;

The concept of self-determination is also infused throughout the entirety of the Draft Declaration document.

⁶¹ Ibid, note 59.

Chandler and Lalonde,⁶² through their research into understanding Aboriginal youth suicide, clearly set out the links between self-determination within First Nations communities (efforts towards cultural continuity) and a drastically reduced incidence of youth suicide within those communities. Chandler and Lalonde assert that governments have undermined the cultural life of Indigenous peoples to the extent that what remains in many instances is not a continuous cultural life, but efforts to reconstruct their culture from the remnants.

Research based on cultural continuity has concluded that communities that have either achieved self-determination through formal self-government agreements, or have initiated some degree of control over services within their community experience fewer to no incidences of suicide. In fact, those communities that have achieved some degree of self-determination, established efforts for cultural continuity, experience a reduction in youth suicides by 85%. Other markers for establishing a 'continuous cultural life' include control over traditional lands, education services, police and fire services, and community health services.

Self-Determination establishes 'health opportunity':

Research has supported Chandler and Lalonde's findings, and arguments in favour of self-determination within indigenous communities with respect to all aspects of decision-making weave throughout discussions regarding social determinants of health and well-being of Aboriginal peoples. In fact, some discussions echo the findings of Chandler and Lalonde and have indicated self-determination is a determinant of health itself. Other research has reflected self-determination as a critical component for ensuring well-being that impacts all other determinants of health, such as education, housing, health status and family violence.⁶³

The WHO Commission has recognized that focusing on health status alone will not fully account for existing health inequalities that exist between population groups:

Importantly, the factor to be equalized is not health status but *health opportunity*, since individuals may employ their positive freedom to choose a way of life that compromises health in the pursuit of other goods. This underscores that health inequalities per se are not

⁶² M.J. Chandler and C. Lalonde, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," *Transcultural Psychiatry* 35, 2 (1998):191–219.

⁶³ See for example *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health*, World Health Organization: Commission on Social Determinants of Health (2005).

inherently problematic, since such 'inequalities that are the result of free choices made by an individual are acceptable'. The principle of justice applied here 'does not require everyone to have the same level of health, but it demands such a distribution of determinants of health, to the extent they can be controlled, that every individual has the same possibilities to lead a long and healthy life'.⁶⁴

Approaching determinants from the perspective that individuals and groups must have the ability to self-determine their health choices will ensure the principle of justice within the context of overall health status. So long as an individual or collective has chosen poor health status, then no injustice can be said to exist. However, **where there is no choice available and poorer health status exists, a fundamental breach of human rights and justice occurs.** Hence, this argument describes the importance of self-determination for all aspects contributing to overall health and well-being.

Yvonne Boyer, in her paper *Self Determination as a Social Determinant of Health*⁶⁵, presents a discussion on self-determination as a critical factor in the development of health policy in Canada:

What self determination means, in practical terms, is as varied as the three constitutionally protected Aboriginal groups in Canada and the hundreds of culturally distinct groups within those groups. *The question of self determination can only be determined by the people to whom it affects.* However, certain evidence and data must be garnered and establish concrete ways to influence government decisions and move political will to create a plan that will highlight the importance of recognizing that self determination plays a fundamental role in determining the health of Aboriginal people in Canada. This includes:

- a) Examine and research Aboriginal developed and controlled knowledge networks in the areas of self determination;
- b) Discuss and research national linkages and how they can bridge the divide between government and Aboriginal peoples and address the fact that lack of self determination equals poor health; and,

⁶⁴ Ibid.

⁶⁵ Boyer, Y. (2005). *Self Determination as a Social Determinant of Health*. Discussion document for the Aboriginal Working Group of the Canadian Reference Group reporting to the WHO Commission on Social Determinants of Health, hosted by the National Collaborating Centre for Aboriginal Health and funded by the First Nations and Inuit Health Branch of Health Canada. Vancouver: June 29, 2006.

c) Examine other examples of effective self determination in the health realm, working either in areas of social determinants of health or other various capacities.

Social Exclusion

Social exclusion includes an array of definitions and constituent elements that reflect differing interpretations within different timeframes and contexts. What is consistent however, is that the concept of social exclusion is determined or defined using the conceptions and language of dominant culture. Rarely is this concept determined based on the understandings and language of Indigenous peoples who are, most often, the most 'excluded' group from dominant culture and society.

There are a few consistent aspects that weave throughout the various definitions and reflect social exclusion as the general denial of individuals to participate in the activities normally expected of members of their society:

Social exclusion occurs whenever the environments where people grow up, live and work, and the institutions that govern them, arbitrarily limit their opportunity to participate in society.⁶⁶

Social exclusion results from a number of inter-related factors that impact the ability of individuals to fully participate in society including poverty, lack of education, lack of employment, poor health and despair. Clyde Hertzman, in a series of working papers for the Laidlaw Foundation, includes two propositions within the concept of social exclusion: that social exclusion can occur in relation to processes where the environment is 'creating' the individual, and that social exclusion can be a factor in human development across the entire life course.⁶⁷

Graham Room⁶⁸ suggests that social exclusion has its roots deeply embedded within broad societal inequalities. He argues that inequality within society, and any subsequent response to inequality, affects the interests of both the disadvantaged and the advantaged in that social exclusion affects the ability of societies to be cohesive and economically prosperous. Social exclusion is multifaceted, relational and complex in that simply removing barriers that are understood to prevent full inclusion of all members of society is not enough – modification of wider social stratifications and

⁶⁶ Hertzman, C. (2002). *Leave no child behind: social inclusion and child development*. (Toronto: The Laidlaw Foundation).

⁶⁷ Ibid.

⁶⁸ Room, G. (1979) *The Sociology of Welfare: social policy, stratification, and political order*. (B. Blackwell & M Robertson Publishers: Oxford Press).

functioning is necessary. Room suggests three key areas for investigation with respect to understanding and responding to inequalities and instances of social exclusion:

- We must investigate the ways in which the various actors involved typically define their situations and their interests and goals;
- What are the processes of group formation and action that flow from these definitions of the situation; and,
- What are the typical outcomes of such actions by the various individuals and groups concerned.⁶⁹

An individual rights-based approach is not a realistic approach to understanding and addressing issues relating to social exclusion either. This type of approach focuses on the personal, systemic exclusion experienced by identifiable groups and fails to achieve the broader goals of social inclusion which should be understood to reflect proactive human development, health and well-being. Social inclusion incorporates both the removal of barriers to participation and investments that further valued recognition based on principles such as diversity and difference: social inclusion has value on its own as both a process and a goal.⁷⁰ Achieving a greater degree of social inclusion cannot be achieved through removing the social barriers to participation and productivity. For Aboriginal peoples in Canada, merely removing barriers and 'leveling the playing field' is not an acceptable approach to addressing the issue of social exclusion. In fact, several of the participants to the Aboriginal Sub-Committee indicated that casting the health disparities experienced by Aboriginal peoples in Canada within a social exclusion context ignores the unique status and history of Aboriginal peoples in Canada.

Based on the foregoing, one is moved to question: why should a unique Aboriginal discussion exist regarding the concept of social exclusion? Indigenous peoples' connection to the land not only distinguishes them ecologically and geographically, but a connection to land also makes these peoples spiritually unique. Aboriginal peoples' understandings of health and well-being are intimately related to the land which they occupy. It is these timeless and implicated relationships with the land that distinguish Indigenous peoples from others around the globe. These relationships are the essence of the individual and collective identities of Indigenous peoples. The relationship between Indigenous peoples and land, within the context of Indigenous peoples' social, economic, political, and cultural ties to land has been the focus of state policies and interference which may be characterized as state strategies toward cultural genocide:

⁶⁹ Ibid.

⁷⁰ Ibid, note 60.

Cultural genocide is a specific policy of destroying the culture of the marginalized ethnic group, especially material evidence (homes, cemeteries, churches, and other architectural monuments, manuscripts, and other artifacts) indicating *affiliation of a certain ethnic group with a certain territory*. In its pure form, cultural genocide is exercised after physical genocide has been accomplished, in order to destroy evidence which would allow the suffered group to appeal for retribution. A form of cultural genocide is renaming of the indigenous locations within the habitat of an ethnic group by the names of the dominant culture, and rewriting the history of the territory and of ethnic groups in order to cut off a historical connection between an ethnic group and a territory and to reinforce the historical connection of the dominant group with the territory.⁷¹[emphasis added]

Indigenous peoples are also unique in that, although there are individualized and territorially specific peoples and Nations, as a group all Indigenous peoples identify with certain collective identities and social markers. These can be (and are being) lost as languages and geographic locales fall prey to influences beyond the control of the collective through ongoing confrontation with the dominant groups in Canadian society. Historically and globally, examples of collective identities being lost included the forced relocation of Indigenous peoples from their traditional territories and the confinement of Indigenous peoples in residential schools or other state apparatuses designed to obliterate culture. There are examples of both deliberate state policy for assimilation of Indigenous peoples in Canada, as there are also examples where assimilation is achieved through structural inequality of the dominant group to a degree where indigenous groups would be apparently non-distinguishable from the dominant group⁷² - acculturation through blanket inclusion and disregard for both individual and collective identity. No other collective cultures have come under such forced attack.

Aboriginal peoples (along with other Indigenous peoples) share historical and social experiences unique to them. Colonization is an experience that Indigenous peoples around the world share. The practices of colonization have de-territorialized Indigenous peoples and have imposed social structures upon them without consultation or consent. In Canada, Aboriginal children are born into a colonial legacy: low socioeconomic status, intergenerational trauma associated with residential schooling, high rates of substance abuse, increased incidents of interaction with the criminal justice system and extensive loss of

⁷¹ Ter-Gabrielian, G. (1999). Strategies in "Ethnic" Conflict. *Fourth World Journal*, vol.4, no.1.

⁷² Ibid, note 68.

language and culture are but a few indicators of this legacy. For further evidence one has only to examine the fourth world health status of Indigenous peoples and note the obvious disparities between them and broader societies. The social marginalization of Indigenous peoples is likewise reflected in health disparities when one considers health from a social determinants perspective.

Politically, Indian peoples' lives continue to be governed by specific and particular regulations which apply to no other members of civil states. In Canada, the *Indian Act* means that Indians are accounted for in a way like no other peoples in Canada. Indian people continue to live on reserves or segregated and bounded lands and are placed at the heart of jurisdictional divides between the federal, provincial, and territorial governments, particularly in areas concerning access to programs and services.

In addition, the Declaration of Indigenous Peoples which was recently passed by the UN Human Rights Council states that "Indigenous people have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous people have the right to determine and develop all health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions". These realities implicate Indigenous rights to sovereignty and self-determination both of which are final aspects that differentiate Indigenous peoples from non-Indigenous peoples within discussions of social exclusion.

Culture and Language

Culture we understand to be the whole way of life of a people.⁷³ Therefore, culture includes understandings about the health and well-being of individuals and the collective, and how to achieve and maintain good health. "Culture" is one group or people's preferred way of meeting their basic human needs.

Language is the principal instrument by which culture is transmitted from one generation to another, by which members of a culture communicate meaning and make sense of their shared experience. Because language defines the world and experience in cultural terms, it literally shapes our way of perceiving – our world view.⁷⁴

Community knowledge is the essence of social capital of the poor and the source of their survival strategies. It is rooted in tradition, contemporary in nature and is constantly evolving as individual and community responses to the challenges

⁷³ Report of the Royal Commission on Aboriginal Peoples (1996). Ottawa: Minister of Supply and Services.

⁷⁴ Ibid.

posed by their environment.⁷⁵ Central to the findings of Chandler and Lalonde⁷⁶, in their research on suicide and First Nations, is the concept of cultural continuity and that “anyone whose identity is undermined by radical personal and cultural change is put at risk of suicide for the reason that they lose those future commitments that are necessary to guarantee appropriate care and concern for their own well-being.” Further measures of cultural continuity have been suggested, including use of traditional language, participation in traditional forms of spirituality or ritual, traditional use of lands and resources.⁷⁷

In developing strategies to improve health outcomes for Indigenous peoples, the strategy itself must not ignore the cultural factors that place Indigenous peoples at a lower health status in the first place. Cultural distinctions, and language, are foundational to improving health and well-being and have a profound impact on social determinants.

Justice

Aboriginal peoples have always had their own social structures for maintaining balance within their societies. Maintaining balance and peace within the community, within families and individually reflects some Aboriginal conceptions of ‘justice’. Justice was achieved, in most Aboriginal communities, by living in accordance with traditional teachings, through mutual respect, and healing fractures in relationships when they occurred. Elders played a key role in maintaining justice in many Aboriginal societies.

Through colonization practices and policies, however, displacement of social structures, practices, values and beliefs intended to achieve justice within Aboriginal communities has resulted in considerable disharmony. As discussed previously, according to Indigenous understandings, imbalance within the environment and in people’s interaction with their environment results in ill-health.

Western concepts of justice are based on social control and punishment for deviant behaviour. As a result, the appropriateness of the present legal and justice system with respect to Aboriginal peoples and the resolution of conflict,

⁷⁵ Prakash S, Nurturing traditional knowledge systems for development, *IK Notes NO. 61*, The World Bank, Washington D C, (2003) 1-4.

⁷⁶ M.J. Chandler and C. Lalonde, “Cultural Continuity as a Hedge Against Suicide in Canada’s First Nations,” *Transcultural Psychiatry* 35, 2 (1998):191–219.

⁷⁷ Lalonde, C.E. Creating an index of healthy Aboriginal communities. In *Developing a health communities Index: A collection of papers*. Ottawa, ON: Canadian Institute for Health Information, 2005. 21-25.

achieving reconciliation and the maintaining community harmony is starkly deficient.⁷⁸

Select Highlights/Issues from Aboriginal organization's papers:

First Nations:

- ❖ A vision for improving health involves partnership among First Nations communities to investigate the spectrum of local and world health issues that move beyond geo-political boundaries to involve governments, NGOs and the special interests of First Nations peoples, many of whom live in extreme poverty due to historic and present day socio-economic forces of colonization and globalization;
- ❖ First Nations peoples in North America are very critical of research as research systematically has failed to reveal a balance between community resiliencies demonstrated by First Nations peoples, as they endure many significant obstacles to achieve a reasonable standard of living. Faced with enormous hurdles, First Nations peoples have and continue to thrive despite profound lower levels of income and employment, lack of access to health care services and poor community infrastructure, often including substandard housing, lack of potable water and other essentials which determine optimal health and well being of any community. First Nations seek to create assurances from researchers and public health scientific investigators that their research and surveillance activities will lead to improved health, not the structural characterization of ill health which, in the long term, is thought to be a significant barrier to improved health and well being.
- ❖ The effects of the combination of poverty and social disadvantage in First Nations peoples are manifested in many diseases. For First Nations peoples, the path to community wellness is to be found within a holistic paradigm that includes the mental, physical, cultural and spiritual well being of both the individual and the community;
- ❖ The proposed *First Nations Holistic Policy and Planning Model* reinforces the need for a long-term process for building a better relationship between First Nations and the Government of Canada that is based on reconciliation and recognition;
- ❖ As the world pursues MDGs it becomes increasingly apparent that First Nations peoples, often deeply marginalized as minority populations undergoing rapid social and cultural change, may be left behind. The time

⁷⁸ *The Justice System and Aboriginal People*. Report of the Manitoba Justice Inquiry (1999).

is right for a global response to improve the health and well-being of Indigenous peoples in North America and Circumpolar northern countries and indeed, world wide.

Inuit:

- ❖ For Inuit in Canada, the links between socioeconomic conditions and health are glaringly clear. Inuit suffer much lower life expectancies than other Canadians, comparatively high rates of infant mortality, the highest suicide rates of any ethnic group in Canada, and disproportionate incidences of diabetes, respiratory illness, and violent crime;
- ❖ Although each social factor requires unique actions at the community level, there is a common need across all sectors for Inuit self-determination. Self-determination is the vital means by which Inuit can address the socioeconomic inequalities debilitating their health;
- ❖ Inuit have developed a strong voice and impressive organizational capacity, swiftly progressing toward self-determination through the signing of Land Claim Agreements, a Partnership Accord, and the election of Inuit governments;
- ❖ Future research activities and data collection are prerequisites for health improvements.

Métis:

- ❖ Neither Health Canada nor Indian and Northern Affairs collect health information on the Métis population. A great need exists to complete more research in order to appropriately determine the health status, well-being, and health needs of Métis;
- ❖ Topics under the Métis *Health/Well-Being Determinants Icon* include: Social Environment, Physical Environment, Economic Opportunity, Health Services, Lifelong Learning, Lifestyle, & Spirituality
- ❖ Indigenous knowledge must be incorporated into both the macro- and micro-Métis and Aboriginal health agenda to achieve health improvement. Health care in Canada has traditionally been informed by a dominant western worldview. This worldview is in direct conflict with the Indigenous worldview and the way health and well being are considered by Métis people;
- ❖ The history of health disparity among the Métis people of Canada suggest that social, cultural and economic conditions have played a powerful role in generating “Aboriginal” vulnerability to disease, injuries and premature death. Such awareness must guide ongoing research and interventions if the disparities in health status between Aboriginal

Canadians, including Métis, and the general population are ever to be eradicated.

V. Conclusion

In Canada, a number of activities are ongoing to address issues related to social determinants, health and well-being of Aboriginal peoples:

Senate Standing Committees

A number of standing committees have been mandated to examine issues related to Aboriginal peoples in Canada, including issues related to their well-being. The Senate Standing Committees on Aboriginal Peoples and the Committee on Human Rights have been mandated to examine legislation and general issues relating to Aboriginal peoples and related to human rights. The Standing Committee on Aboriginal Peoples is also completing a special study on economic development and Aboriginal peoples.

The Standing Committee on Health (SCOH) has recently focused much of its efforts on researching and reporting on Childhood Obesity. The SCOH released a report entitled *Healthy Weights for Healthy Kids*⁷⁹, in March, 2007. The final report included thirteen recommendations and cited income, education, social environment, physical environment/geographical location, culture, access and quality of health services, and food intake/security as key social determinants researched and discussed by the SCOH as factors for determining healthy weight in children, including Aboriginal children. The SCOH has also completed a comprehensive call to action on fetal alcohol spectrum disorder. *Even One is Too Many: A Call for a Comprehensive Action Plan on Fetal Alcohol Spectrum Disorder*⁸⁰ was tabled in September, 2006. This report includes four broad recommendations, with a number of associated action items for each recommendation. Key action items focus on national, culturally appropriate collaboration and cooperation amongst social and health professionals delivering services to individuals with FASD.

Kelowna Accord

In the November 2005 *Kelowna Accord* (hereinafter 'the Accord'), the Government of Canada undertook an unprecedented process of Aboriginal policy negotiation with key representatives from the Assembly of First Nations, Inuit Tapirriit Kanatami, Métis National Council, Congress of

⁷⁹ See for example, <http://cmte.parl.gc.ca/Content/HOC/committee/391/hesa/reports>

⁸⁰ Ibid.

Aboriginal Peoples (representing off-reserve Aboriginal peoples), and the Native Women's Association of Canada. Under the authority of the Prime Minister of Canada, the federal government pledged over \$5 billion over five years to bring the standard of living for Aboriginal peoples up to the standard enjoyed by other Canadians by 2016. The meeting in Kelowna, was not by any stretch a 'quick-fix' approach to alleviating poverty, but was preceded by 18 months of careful, thoughtful negotiation between provincial and territorial leaders, Aboriginal organizations and federal representatives. The priority issues addressed through the Accord included practical solutions to closing gaps in health, education, housing and economic development.

Aboriginal Organizations

The Assembly of First Nations (AFN) has focused much of its effort to support First Nations towards improved access to health services and programs that maintain good health. There is ongoing work within the AFN to ensure equitable funding for First Nations health. The AFN has also advocated for extensive support for the *Regional Health Survey*, which is a culturally-specific study to collect health data for First Nations peoples in Canada. Other efforts of the AFN include advocating on behalf of First Nations for access to culturally-appropriate health and social services, improving educational outcomes by advocating for the implementation of the Parliamentary Standing Committee's recent report on First Nations and post-secondary education, establishing opportunities for economic development, and resolving outstanding land claims and support First Nations governments. The AFN has also established a national campaign (*Make Poverty History*) to move the Canadian government to address crushing levels of poverty in a meaningful, sustainable way. These are some of the program and policy areas in which the AFN supports healthy First Nations individuals and communities. The AFN has also taken a lead role, in partnership with the First Nations Child and Family Caring Society of Canada, in the area of First Nations child welfare. In 2007, a human rights complaint was formally filed against the federal government for under-funding First Nations child welfare agencies in the delivery of essential social and support services to First Nations children and their families.

The Métis National Council (MNC) has taken a lead role in the Health and Human Resources Initiative. This is a four year, \$10-Million health human resource development initiative (HHRI) aimed at laying the foundation for longer term systemic change in the supply and demand for Métis health human resources. The MNC has also established a health portal as a comprehensive site on health information for the Métis people throughout Canada. The site reflects the holistic understanding of the Métis Nation about what things are important

when considering the health and well-being of Métis people and when designing policies and programs to address population health needs.

The Inuit Tapiriit Kanatami (ITK) has engaged in developing an Aboriginal component to Canada's *Integrated Pan-Canadian Healthy Living Strategy*, which is intended to improve the over-all health of Canadians and to reduce health disparities across Canada.

Understanding and improving Aboriginal people's health is an essential but complex challenge. In Canada, an extensive history of colonization and subjugation of First Nations, Inuit and Métis peoples has been addressed in each of the papers prepared by these groups to the WHO Commission on Social Determinants of Health. Included in each of these papers are solutions to begin to address the health disparities that each of the groups have discussed. These solutions are thoughtful and culturally-relevant for the individuals and communities for which they are intended.

The importance of self-determination and addressing issues related to social exclusion cannot be overlooked. These common themes have been weaved throughout the discussions of Canadian Aboriginal research papers, and the discussions of Indigenous populations globally within the context of social determinants of health. In contemplating solutions to addressing health disparities, these two critical elements cannot be ignored.