THE SOCIAL DETERMINANTS OF ABORIGINAL HEALTH: A LITERATURE REVIEW

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INTRODUCTION

The Assembly of First Nations has identified "the need to develop an integrated, holistic, inter-departmental and inter-organizational organism to address the inequities and gaps in health and social service delivery to First Nations" (AFN, 2002). However, there is much work to be done in efforts to reach this goal, as there are many factors that one must take into consideration when examining Aboriginal health from a holistic perspective. For example, it has been reported that in British Columbia (BC) that 20% of Aboriginal people are below the provincial average based on income, employment, and educational attainment and housing (Kendell and Hull, 2002).

In addition to national reports, the BC Ministry of Health advocates that there is the need to look at the broad spectrum of health and social determinants to come up with solutions that will improve the health and well being of Aboriginal people. These determinants are comprised of health, gender, biology, culture, coping skills, social environments, social support networks, income and social status, employment and working conditions, education, child development and physical environments. The determinants are interdependent, cannot be examined individually and a holistic approach needs to be utilized when dealing with Aboriginal health issues. It is important for non-aboriginals to observe the difference in fundamental viewpoints of Aboriginal people in their relationship with the natural surroundings, other races, flora and fauna (Driben and Simpson, 2000). The lack of control over one's life plays an important factor in their well-being.

HEALTH

Researchers have found that the lifespan rate of Aboriginals is 7 years less than the general BC population (Romaniuc, 2000; Williams and Guilmette; 2001, Driben and Simpson, 2000). The increasing age of baby boomers in the Aboriginal population has increased the need for health services (Kendall and Hull, 2002). The most common diseases are heart disease, cancer, diabetes and arthritis for Aboriginals in BC (Eng, Rimm, Fitzmaurice, and Kawachi, 2002; Kendell and Hull, 2002). The prevalence of chronic diseases is increasing and is higher then the national population (First Nation Inuit Regional Health Survey Committee, 1999). Broadly speaking, the poor health conditions are the result of historical disadvantages that Aboriginal people have experienced through racism, colonialism, and the onset of European diseases (Williams and Guilmette, 2001; Romaniuc, 2000; Kendell and Hull, 2002). The residential school experience has also greatly impacted the well-being of an entire generation of Aboriginal people (Hudson, 1997; Nelson, Allison, 2000; Williams and Guilmette, 2001; Romaniuc, 2000; Kendell and Hull, 2002). The systematic attempt to remove Aboriginal cultural and political systems has left this generation powerless and dependent, which can further contribute to ill health through the loss of traditional lifestyle and foods.

Similarly, diseases such as alcoholism, obesity and diabetes, introduced to Aboriginals as they have adopted a European lifestyle, have taken a significant toll. Diabetes was unknown to Aboriginal people 50 years ago, now it is the most common chronic illness observed in their communities (Young, 2000; Kendell and Hull, 2002). The rate of tuberculosis is three times the national average among Aboriginals (Young et al). Injury related deaths are seven times the national average and illicit drug deaths among Aboriginals are three times the provincial average (Young et al) One-third of Canadian Aboriginals have reported having a disability (Kendell and Hull, 2002).

Other factors affecting Aboriginal health include the delivery of medical health services, mental health services, and the uptake of health behaviours and skills (FNIRHS, 1999; Williams and Guilmette, 2001; Carstens, 2000 BC ministry of health, video 1996). Interactive communication between Aboriginal

communities, funders, and service providers appears to be poor, resulting in incongruence between community needs and the programs offered (FNIRHS, et al) thus, the community's ability to improve the delivery of health services has not been accomplished (BC ministry of health, video; 1996; Warf and McKenzie 1998; Kendell and Hull, 2002). The longer this gap exists between the needs of the community and the way programs are provided, the greater the health disparities for Aboriginal people will be (BC ministry of health, video, 1996).

The effects of lifestyle and health behaviours (nutrition, alcohol and drug abuse, sedentary lifestyle, and smoking) have a dramatic impact on Aboriginal lives. The chances of developing various cancers are modifiable with proper nutrition and abstinence from smoking (FNIRHS, 1999; Williams and Guilmette, 2001; Carstens, 2001; Kendell and Hull, 2002; Seipel, 1999). The effects of chronic malnutrition can also have long-term effects on health. Those who survive malnutrition are often unable to live normal lives and usually are unable to contribute to their family or community's development (Romaniuc, 2000; Seipel, 1999).

GENDER

The impact of racism and sexism has influenced the choices available to women in their utilization of health services. Negative stereotypes play a significant role in this issue. Negative factors that affect Aboriginal women's health are; low educational levels, multiple responsibities' of home and work, poverty, negative stereotypes of health professionals, language, underemployment, social and geographic isolation, physical, emotional, sexual violence, community dynamics and discrimination by gender, race and class (Brunen, 2000; Falconer, Swift, 1983; Health Canada, 2000). Consequently, Aboriginal women have a low rate of access the health system.

Women who are pregnant and live in poverty are at greater risk for health issues (Williams and Guilmette, 2001; Seipel, 1999). This is particularly true for teen pregnancy, as not only are the ten women at greater risk for poor health outcomes, their children will likely perpetuate the cycle of poverty Kendell and Hull, 2002). Sixty percent of single mothers in Canada live in poverty and this is likely higher in Aboriginal communities. The consequences include increased risk of infection, low birth

weight babies, and other prenatal health issues (Williams and Guilmette, 2001; Seipel, 1999). Obesity and asthma are two population health issues in Canadian women (Chen, Dales, and Tang and Krewski, 2002). Isolation, poor housing and unemployment are also contributors to the family disparities argues the conclusions of extensive research conducted by (Nelson, and Allison, 2000; Robson, 1993; Carstens, 2000; Tsuji, A. Iannucci, G. Iannucci, 2001; Kendell and Hull, 2002).

One in three Aboriginal women reported being abused by their partners, as compared to non-Aboriginal women who report wife abuse one in ten (Kendell and Hull, 2002). In addition the high rate of sexual exploitation among Aboriginal women is a serious risk factor for disease and violence related injury (BC Attorney, 2002). Acculturation and the impact of residential schools are hypothesized as being directly responsible for the high rates of domestic and other violence in Aboriginal communities (McClure, Boulanger, Kaufert, Forsyth, 2000; Falconer, Swift, 1983; Health Canada, 2000; Nelson, Allison, 2000, Kendell and Hull, 2002).

Employment opportunities for Aboriginal women hoping to break out of the cycle of poverty are also few. The fact that most managers are white males has perpetuated sexism and racism within the workforce (Creese, 1983). This is compounded by low educational attainment by Aboriginal women (Creese et al). As a result Aboriginal women are reluctant to search for employment.

Health professionals make racial *judgements* of Aboriginal women especially the marginalized women (lesbians, street workers, young women, elderly women, disabled women and the women who are chemically dependent). The service delivery is inadequate and the health professionals seem apathetic toward these groups of women.

In addition to the attitudes of some health professional's social and geographic isolation are determinants of Aboriginal women's health (BC provincial profile of women's health, a statistical overview 1999). These issues contribute to the lower health status of Aboriginal women, as the time and distance may negatively coerce women to seek out treatment that may benefit their well-being (BC et al).

BIOLOGY

The biological and genetic influences are one of the many precipitating factors that influence the well-being of Aboriginal people (FNIRHS, 1999; Romaniuc, 2000; BC ministry of health, video1996). Consequently, there is limited action that one can take to reduce the hereditary factor. However, if genetic predisposition exists, one can be proactive regarding screening for disease for maximizing a healthy lifestyle.

CULTURE

The lack of promotion of culture has been found to have devastating intergenerational effects that require a consistent integrated holistic approach to solving the problems that arise from its loss. For instance, the lack of promotion of culture increases the risk of suicide in communities (Connors, 1996; Kendell and Hull, 2002). The loss of social and kinship structures, including gender, parenting and social role models has had devastating intergenerational effects. This has resulted in a sense of anomie and nemesis for many Aboriginal peoples (Hudson, 1997; Romaniuc, 2000; as cited in Poonwassie and Charter, 1996). Systematic racism, in social, medical and educational systems continues to reinforce the assimilation of Aboriginal peoples into general Canadian population (Poonwassie and Charter, 1996). In residential schools children lost their culture, identity, self-respect and family bond. They had difficulties in adjusting upon returning back to their nations and experienced poor reintegration into their original social and political structures. This loss of traditional political governance and social structure has been found to be directly related to ill-health in those populations where large numbers of children were exposed to residential schools. (AFN cited in FNIRHS, 1999; Nelson, Allison, 2000; Tsuji, A. Iannucci, G. Iannucci, 2000; Kendell and Hull, 2002).

The residential school experience caused the affected generations to parent without the knowledge of Aboriginal ways of child rearing has contributed to the lack of parenting skills observed today and the high rate of aboriginal children in state based care. Traditional parenting skills have been lost; resulting in a lack of understanding of what the role of parent is (Blaine, 1995). The loss of culture has also had a direct negative impact on children's educational attainment (Blane, et al).

Further exacerbating the loss of culture, the main language in many Aboriginal communities is now English and many Aboriginal languages are in danger of being lost.

COPING SKILLS

Some mental health practitioners see substance abuse, alcohol abuse and petty theft as coping and survival mechanisms, however, they contribute to further ill health among the Aboriginal population (Foulks, 1980; Ben, 1991). Posttraumatic stress reactions are found in survivors who have had negative experiences in the residential school system (Cariboo Tribal Council; Bohn, Ertz, Mason, Beals, O'Nell, Piasecki, Bechtold, Keane, and Jones, 2000). This and other mental health issues that have occurred as a result of residential school exposure have had a negative intergenerational impact that still continues to threaten the well being of Aboriginal communities (Caribou et al). Thus, the impacts of the residential school system have left a legacy of mental health issues that in turn impact both social and health issues within Aboriginal communities.

SOCIAL ENVIRONMENTS

According to provincial statistics the Aboriginal population of BC lives under third world conditions (Provincial Health Office, 1999). The aging of the Aboriginal population has increased the stress on employment, housing, health and social services (Provincial Health Office, 1999). Measures used to gauge community security and stress includes: rates of crime, abuse and child apprehensions.

Seven times the adult population of incarcerated Aboriginal adults and 6% of all youth and children over represent the prison system. 70% of children who are in foster care are Aboriginal. The youth have a higher death rate than non-Aboriginal children do when they are wards of the social welfare system (Provincial Health Office, 1999). The high rate of assaults on women (usually spousal abuse) is an indicator that the social environment in Aboriginal communities is under significant stress (Provincial Health Office, 1999).

Researchers argue that the social environment plays a major factor in the determinants of the health and welfare of

individuals (Hudson, 1997; Tsuji, A. Iannucci, G. Iannucci, 2000; BC Ministry of Health, video, 1996; Chin, Monroe and Fiscella, 2000). Unhealthy behaviours are not randomly distributed throughout the population, but are strongly associated with lower social class (Tsuji, A. Iannucci, G. Iannucci, 2000; Chin, and Monroe and Fiscella, 2000). Lower income people are more often than not blamed for their health conditions (Tsuji et al). The total population is viewed as individualistic, self-sufficient and responsible, thus individuals are expected to make informed and proper choices regarding their health (Chin, Monroe and Fiscella, 2000). However, social scientists point out that to truly eliminate inequalities in health, we need to eliminate inequalities in socio-economic circumstances and community self-governance (Tsuji, A. Iannucci, G. Iannucci, 2000; Kendell and Hull, 2002).

SOCIAL SUPPORT NETWORKS

Communities that lack positive and safe support networks severely retard the healthy growth of people (BC Ministry of Health, video, 1996). Social support networks that are beneficial include survivors groups: Alcoholics Anonymous groups, parenting groups, healing circles and men's support groups. The lack of such adequate resources impedes the health of people (Tsuji, A. Iannucci, G. Iannucci, 2000; BC Ministry of Health, video, 1996). Stress combined with social isolation can also damage health (Carstens, 2000; Blane, 1995). Furthermore, a dysfunctional support network can have negative long-term and short-term effects on people in regards to education, criminality, employment and mid-life diseases (Kendell and Hull, 2002; Hertzman, 1998).

The Provincial Health Office (1999) discovered that Aboriginal people have access to a complex web of federal and provincial programs, however these programs designed by policy makers and senior bureaucrats who are usually non-Aboriginal middle aged white men. They often live in a comfortable middle-class, prosperous neighbourhoods and the people who receive the services and the front line workers lack these privileges (Warf and McKenzie, 1998). The knowledge and experience gap between the program policy makers and the people that must live with the consequences is enormous (Nelson, Allison, 2000; Warf and McKenzie, 1998). The policy

makers lack the cultural relevance and knowledge when designing and implementing programs to meet Aboriginal needs. This discordance between social networks needs and the social networks imposed can cause a lack of program uptake resulting in a squandering of scarce resources.

INCOME AND SOCIAL STATUS

Socio-economic circumstance affects the ability to make positive changes in people's lives (Hudson, 1997; Eng, Rimm, Fitzmaurice, Kawecki, 2002; FNIRHS, 1999; Williams and Guilmette; BC ministry of health, video, 1996). Lack of employment and education directly influences one's self-esteem and undermines the control one has over his/her life; consequently positive change may be difficult (Tsuji, A. Iannucci, G. Iannucci, 2000; BC Ministry of Health, video). Aboriginal income in BC is substantially lower than the provincial and national averages; however, this may be partially due to part-time or part-year work (Tsuji et al). Over two thirds of Aboriginal workers are part-time or part-year work. The average wage for an aboriginal working full-time is considerably lower than the provincial and national average. In BC an Aboriginal male earned $35,384, this is about 79% of a non-aboriginal male's wages [Provincial Health Office, 1999]. This is due to lower education levels and job achievement among Aboriginals [Provincial Health Office, 1999]. Fifty-nine percent of Aboriginals on reserves have jobs compared to 63% of Aboriginal population off reserve who are employed (Provincial et al) An income level under $10,000 per year for Aboriginals on reserve is 49% and the Aboriginal population off reserve is 42% [Provincial Health Office et al]. Forty percent of Aboriginal children live in households that are well below the $20, 000 per year poverty level [Provincial Health Office et al].

EMPLOYMENT AND WORKING CONDITIONS

Research findings indicate that employment is one of the most powerful predictors of good health among Aboriginals (Kawachi, Kennedy, 1997; FNIRHS, 1999; Tsuji, A. Iannucci, G. Iannucci, 2001; Blane, 1995). The more money one has, the more access one has to resources to enhance the quality of health. Further, chronic unemployment negatively affects the health of

individuals (Lavis and Payne, 2001; Kendell and Hull, 2002). However, occupations characterized by high demands and low control, low skills and wages or effort-reward imbalance are associated with poorer health, especially cardiovascular disease (Abella and Blane, 1995). Thus, employment in and of itself is not a panacea for the negative effects of low socio-economic status. Quality employment is necessary for the full achievement of individual potential.

EDUCATION

Forty-five percent of adult Aboriginals living on reserves have completed high while 53% of those off reserve have the same achievement level. About 15% of Aboriginal people have achieved some type of post-secondary qualification. Educational achievement has a direct impact on the well-being of people (FNIRHS, 1999). Aboriginal students do poorly on scholastic achievement measures when compared to other students have more learning or behavioural problems (Provincial Health Office, 1999). The reasons for poor performance can be attributed to: poverty, family dysfunction, exposure to drug and alcohol abuse, and the prevalence of fetal alcohol syndrome (Iceberg reprint, as cited Kendell and Hull, 2002; McBride and McKee, 2000). Another reason for poor academic achievement is the pedagogical approach in educational institutions and the ignorance of culturally relevant teaching and learning styles (Antone, 2000; Sterling, 1992). The consequences of the lack of formal education can bee seen through out First Nations in Canada (Antone et al).

CHILD DEVELOPMENT

Forty percent of Aboriginal children live well below the $20, 000 poverty line in BC (Provincial Health Office, 1999), thus child poverty is an issue that needs to be addressed. Nationally, 39% of Canadian children exist in poverty compared to 50% of Aboriginal children (Provincial et al) In general cuts, to environmental, social spending and healthcare are jeopardizing the future of Canadian children (Hechtman, and Hertzman, 1998). Child poverty is associated with a variety of negative outcomes in later life, including intentional violence, poor school performance, criminal activity, teen pregnancy and unemployment. In 1999 there were 4,027 Aboriginal children in

care in BC, which is more than a third of all children in care and this ratio has been consistent over the past several years (Provincial et al). However, Aboriginals only account for six percent of the population of BC. The lack of non-Aboriginal social workers compromises the care that the children receive, as non-Aboriginals may not be able to understand the cultural and community environment where the children come from.

The ministry of Health concludes that the first few years of an infant's life are greatly influenced by the parents with regard to optimal brain development. (BC Ministry of Health, Video, 1996). Poor stimulation and an emotionally and physically non-supportive environment in childhood and adolescence could result in low educational achievement and impaired adult health (Blane, 1995; Hertzman, 1998). The impact of biological embedding which is the rearing in the infant stage in an, unstimulating emotionally and physically unsupportive environment that affects brain development and has a dramatic effect on the child' immune system and impairs the long term functioning of organs that will create potential health hazards later in life (Hertzman, 1998). The risk of infectious diseases and allergies are higher Aboriginal children than for non-Aboriginal children (FNIRHS, 1999). The high death rate of Aboriginal children is the result of these deficits in childhood. (What is the death rate?)

Sudden infant death syndrome is a major contributor to higher death rates in Aboriginal infants (FNIRHS, 1999). Low birth weight births are associated with parental disadvantage that is further associated with social disadvantage during the parents own childhood. This cycle may be directly related to disease and poor health behavior in middle age (Davis, 1997; Kendell and Hull; 2002, Blane, 1995). Some contributors to low birth weight are tobacco use, alcohol and drug abuse, lack of good nutrition, multiple births and pregnancy-induced hypertension (FNIRHS, 1999; Kendell and Hull, 2002). Ongoing tobacco, alcohol and substance abuse problems play a significant role in the health of Aboriginal (Provincial Health Office, 1999; FNIRHS, 1999). Death from injuries in aboriginal children is four times greater than the national average (FNIRHS, 1999,). Additionally depressed Aboriginal mothers may have a direct negative impact on the development on their infants (Malphurs, Field, and Larraine, 1996).

PHYSICAL ENVIRONMENT

The homes and the community we live in can influence our health (Robson, 1993, BC Ministry of Health, Video, 1996). Isolation, poor housing, unemployment all contribute to family disparities and consequently poor health. (FNIRHS, 1999; Williams and Guilmette, 2000; Robson, 1993; Tsuji, A. Iannucci, G. Iannucci, 2001; Kendell and Hull, 2002). The physical environment is a significant determinant of the well being of Aboriginal people in particular (Ministry of Health Video).

The air we breathe (indoors and outdoors), the food we eat and the water we drink has a direct impact on our health (McColl, 1999; Williams and Guilmette, 2000; Robson, 1993; Tsuji, A. Iannucci, G. Iannucci, 2002; Kendell and Hull 2002; BC Ministry of Health, Video1996). The improper handling and storage of toxic waste can also have a devastating impact on a community's health. The environment needs to repair; otherwise the health of Aboriginal communities will continue to be hostage by a philosophy that does not respect the relationship between the people and the environment. Traditional diets consisting of fish, wild meat and marine mammals have been found to contain toxic contaminants that these researchers (Kendell and Hull 2002). Environmental contaminants can enter through food, water, soil, toxic wastes, water currents or rainfall and they have a direct impact on health (Robson, 1993; Kendell and Hull, 2002). Further, logging and agriculture have modified the natural habitat of many traditional food sources for Aboriginal people. For example Connel, Macbride and Alliance, 2002) found that juvenile pink salmon near fish farms had lethal doses of lice that may have been related to the close containment of large numbers of fish.

CONCLUSION

Lack of self-empowerment has a devastating impact on our health. Poor self-esteem originates from the external environment and it influences our actions, society's attitudes and social status. It also has a direct impact on our well being (BC Ministry of Health, Video, 1996). There is a striking consistency in the distribution between mortality, morbidity and social groups. The advantaged groups have higher income, social class, and education or of major ethnicity tend to have

better health than other members' do in their societies (Blane, 1995).

The picture is becoming quite clear how each determinant has an impact on each other and strengthens the argument for an integrated, holistic, inter-departmental and inter-organizational coordination to address these issues is based on community involvement and the equitable sharing of resources to enhance health and growth based on the Assembly of First Nations position for culturally appropriate health service delivery. Aboriginal health from a holistic perspective is the only way to address the types of social determinants that are interdependent of each other. When one of the determinants is not fully connected or non-functioning, the whole organism of health is jeopardized, thrown off balance and cannot function to its potential.

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SPECIAL EDITION

NATIVE SOCIAL WORK JOURNAL

Articulating Aboriginal Paradigms: Implications for Aboriginal Social Work Practice

The Native Social Work Journal is a member of the Canadian Association of Learned Societies

EDITOR (Special Edition)
Roger Spielmann, Ph.D.

Volume 5, November, 2003

Published by the Native Social Work Journal
Laurentian University
Sudbury, Ontario
www.laurentian.ca/www/nhs

Printed by the Laurentian University Press
Laurentian University
Sudbury, Ontario

Cover Artwork by Leland Bell

Journal Layout by Roger Spielmann

ISSN 1206-5323

NISHNAABE KINOOMAADWIN NAAMAADWIN