

Canadian Supplement to THE STATE OF THE WORLD'S CHILDREN 2009

Aboriginal children's health: Leaving no child behind



THE CONVENTION ON
THE RIGHTS OF THE CHILD





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ACKNOWLEDGEMENTS

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“States parties shall ensure that all children enjoy the highest attainable standard of health and have access to health care service. Indigenous children frequently suffer poorer health than non-indigenous children due to, inter alia, inferior or inaccessible health services. The Committee notes with concern, on the basis of its reviews of State parties’ reports, that this applies both to developing and developed countries.”

Committee on the Rights of the Child: General Comment No.11 (2009): Indigenous children and their rights under the Convention.

FOREWORD

‘Canada’ comes from the *Wendat* (Huronian-Iroquoian) word Kanata, meaning ‘village’ or ‘settlement’.¹ But what is Canada? Who are we? Are we willing to accept that in Canada, some children are seven times more likely to die in infancy than others? That some children are 50 times more likely to be hospitalized with preventable illnesses, such as chicken pox? The fact that these children are Aboriginal and live in one of the most affluent nations in the world ignites anger in some of us, and concern among many. But anger and concern are not enough.

We are truly on the cusp of a social renaissance in this country as Aboriginal peoples gather renewed strength. The legacy of residential school policy, which severed the last few generations of families from their children and sowed the seeds of our current malaise, is starting to lift. Parents who grew up without their own mothers and fathers are learning how to parent, and the children who survived and made it home from residential schools are reclaiming their heritage.

Canada has officially apologized to Aboriginal people, but do we truly honour the survivors? As a country, do we accept that only half of our Aboriginal children will complete high school? That twice the number of Inuit and Métis children live in poverty than do other Canadian children?² Is the Canada we want a country where we resist funding the 22 per cent³ gap in child welfare services between First Nations and Canadian children on average, funding that could strengthen families instead of removing children from them? Do we want to live in a country where the result of that disparity is that more Aboriginal children are in government care today than during the peak years of the residential schooling era?

Our country is being called to a greater consciousness. Even if there are more questions than answers, it’s time to ask them. What kind of Canada do you want?

In 2009, the world will commemorate the twentieth anniversary of the UN Convention on the Rights of the Child and take stock of how much progress has been made to provide for and protect children’s rights. UNICEF Canada marks the anniversary with this Canadian supplement to the annual UNICEF *The State of the World’s Children* report.

Every year, *The State of the World’s Children* focuses on a key theme related to the rights and well-being of children, and monitors a broad range of child development indicators across countries. By telling stories, documenting evidence and identifying successes, the report aims to advance discourse among those who seek to create a world more fit for children.

This year’s *The State of the World’s Children* examines maternal and child health around the world, and in developing countries in particular. It notes that a child born in a developing country is almost 14 times more likely to die during the first month of life than a child born in an industrialized nation. But within countries, the health of marginalized children is shaped by circumstances that have little

resemblance to the story told by national averages. Across Canadian First Nations reserve communities, for example, infant mortality rates are three to seven times the national average. In fact, in almost all health status indicators (measures of child health, such as diabetes and suicide rates) and in the determinants of health and well-being (influences such as poverty and access to clean water), Aboriginal children fall well below the national averages for Canadian children. Twenty years after the Convention on the Rights of the Child was adopted with the promise of providing the best we have to give as a nation for all our children, the health conditions of Canada's Aboriginal children are not what we would expect in one of the most affluent countries in the world. Such disparity is one of the most significant children's rights challenges Canada must address.

In a number of countries, UNICEF expands on *The State of the World's Children* with an additional supplement detailing the domestic status of the rights and well-being of children. This report, *Aboriginal children's health: Leaving no child behind*, explores the health of Aboriginal children in Canada through the perspectives of experts across the country. In partnership with the National Collaborating Centre for Aboriginal Health, University of Northern British Columbia, and consistent with the format of the global report, we present guest articles on the current health status of Aboriginal children and strategies for the way forward. The accounts provided by our guest contributors are not meant to be exhaustive technical reviews intended for health policy-makers and practitioners. The stories and the evidence they lay out are for the rest of us – Canadians who do not turn our attention on a regular or professional basis to the circumstances of the more than 1 million Aboriginal peoples who are an integral part of our country's past – and future. This report is for each of us who believes that Canada is only as strong as our most vulnerable children.

Canada has made progress over the last decade in lowering Aboriginal infant mortality rates, increasing educational attainment levels,⁴ and improving housing conditions.⁵ Nevertheless, while many Aboriginal children are doing well, an unacceptable number suffer a greater burden of poor health and mortality than other Canadian children. This is measurable against national averages in a range of health indicators, although there is a dearth of comparable data.

For example, the infant mortality rate (IMR) – a fundamental indicator of the health and human development of a country – has declined for Canadian children in recent decades. The rate decreased from more than 27 deaths per 1,000 live births in 1960, to five per 1,000 live births in 2004. In comparison with OECD⁶ countries such as Japan and Norway, an IMR of five is still too high. However, despite a long-term decline, Canadian Aboriginal peoples' IMR is even higher than in the general Canadian population. The infant mortality rate among First Nations people living on reserves is estimated at eight deaths per 1,000 live births,⁷ comparable with Chile and higher than Latvia and Lithuania. The estimated IMR in Nunavut (where approximately 85 per cent of the population is Inuit) is 16 deaths per 1,000 live births – more than three times the national rate and almost equal to that in Sri Lanka and Fiji.⁸

The infant mortality rate is more than a technical measure of the deaths of young

BY THE NUMBERS

48

The percentage of children and youth in the Aboriginal population.

31

The percentage of children and youth in the non-Aboriginal population.

Statistics Canada, 'Aboriginal peoples in Canada 2006: Inuit, Métis and First Nations, 2006 Census'.

“The Committee urges the Government to pursue its efforts to address the gap in life chances between Aboriginal and non-Aboriginal children.”

UN Committee on the Rights of the Child (CRC),
UN Committee on the Rights of the Child:
Concluding Observations: Canada, 27 October
2003. CRC/C/15/Add.215. Available at
www.unhcr.org/refworld/docid/403a22804.html.
(Accessed 2 May 2009).

“The Committee recognizes that the protection of Aboriginal children’s rights – and thus the protection of Aboriginal communities’ future – is an issue of primary importance for all Canadians and an issue of fundamental concern with respect to the Convention on the Rights of the Child. Aboriginal and non-Aboriginal communities are destined to co-exist ‘in perpetuity.’ For all the lives at stake, [t]he cost of doing nothing... is enormous.’ Cindy Blackstock reiterated this point, telling our Committee that [b]y doing nothing, I think we put our own moral credibility as a nation at risk.”

‘Children: The silenced citizens’. Final report of the Standing Senate Committee on Human Rights, Ottawa, April 2007, p. 170. Available at www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/huma-e/rep-e/rep10apr07-e.pdf. (Accessed 2 May 2009).

children. It is an indicator of seismic fault lines in the delivery of the best we have to offer in health services for mothers and children. It is a proxy measure of the compassion of a society for its most vulnerable, and the commitment of a government to all of its citizens.

We know that health status is directly linked to poverty and other social determinants of health. And most Canadians know that a large proportion of Aboriginal children live in poverty in low-income families, particularly in urban areas.⁹ In fact, one in four children in First Nations communities lives in poverty, a rate more than double that of Canadian children on average.¹⁰ Much of this is the result of decades of policies that dislocated children from families and perpetuated disparity, generation after generation. That is our history as a nation and our current situation, but it does not have to be our future.

As UNICEF has learned in more than 60 years of working to drive down infant mortality rates and improve child health across the developing world, extraordinary gains can be made for children even in the most impoverished, and politically, economically, geographically and environmentally challenging circumstances – as long as we believe that the preventable death or illness of even one child is one too many. As citizens of one of the most affluent nations, we must believe that we can and should achieve for all children – such as Jordan and Rosalie, whose stories are told here – what we have achieved for many.

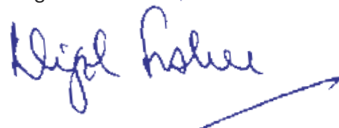
This year, 2009, is particularly important for children’s rights in Canada. Not only does it mark the twentieth anniversary of the Convention, Canada is due to report to the UN Committee on the Rights of the Child on its implementation of the Convention. In 2003, the UN Committee expressed deep concern about the health of Canadian Aboriginal children, including the lack of accessible health care, high rate of fetal alcohol spectrum disorder, and rate of youth suicide and diabetes that is among the highest in the world.

Where do we go from here? The experience and insights of our guest contributors in this supplement show us the way forward. The health of Aboriginal children is inextricably bound to the health of their mothers and their communities, and is tied to the ‘health’ of the different governance systems that affect them. Some paths require greater investment; some just ask for investment that is at least equal to that for other Canadians. Some cost nothing.

Just as UNICEF has shown that a continuum of health care has yielded huge gains elsewhere, here in Canada more community-based health services are required to ensure that Aboriginal families do not have to move far from home to find the services they need. Rather than removing children and families when they are in crisis, we need to expand the ability and early involvement of culturally appropriate health and social services to work with children and families in their homes and communities. We need to commit to funding the same level of services for all groups of Aboriginal children as we do for other Canadian children. We need to act on Jordan’s Principle – pending legislation that will ensure that First Nations children have equal health care treatment – so that no child languishes during disputes about who will provide or pay for what service, services that other Canadian children receive without question.

Aboriginal children are the fastest growing segment of the population of all Canadian children. The health of Canada's Aboriginal children is a bellwether of the health of our nation. Their health status is not a product of biological determinants, but of social conditions and access to societal resources. We have the knowledge, the technology and the resources to ensure the highest attainable standard of health for all of our children. Let's build a country fit for each of them.

Nigel Fisher



President and CEO
UNICEF Canada

ABORIGINAL PEOPLES IN CANADA – SOME TERMINOLOGY

Aboriginal is a collective name for all of the original peoples of Canada and their descendants. Most Aboriginal peoples in Canada identify themselves politically as belonging to one of three major groups: **First Nations, Métis and Inuit**.

The term **First Nations** came into common use in the 1970s to replace 'Indian', which some people found offensive. Despite its widespread use, there is no legal definition for this term in Canada.

Source: Adapted from 'Assembly of First Nations terminology fact sheet', www.afn.ca/article.asp?id=437.

A **Métis** is a person who self-identifies as Métis, is of historic Métis Nation ancestry, is distinct from other Aboriginal peoples and is accepted by the Métis Nation.

Source: Métis National Council, www.metisnation.ca/who/definition.html.

Inuit are a distinct group of Aboriginal people living in northern Canada, generally in Nunavut, the Northwest Territories, northern Quebec and northern Labrador.

Source: 'Indian and Northern Affairs Canada terminology list', www.aicn-inac.gc.ca/ap/tln-eng.asp.

These groupings reflect Section 35 of Canada's Constitution Act, as well as the federal Indian Act. From a cultural perspective, Aboriginal peoples in Canada comprise more than 50 distinct and diverse groups, each with its own language and traditional land base. Each of these groups represents a complex network of communities and kinship systems, often with distinct language dialects.

Source: 'Assembly of First Nations terminology fact sheet', www.afn.ca/article.asp?id=437.

Reserve refers to lands owned by the Crown and held in trust for the use and benefit of First Nations, for which they were set apart. The legal title to reserve land is vested in the federal government.

Source: 'Assembly of First Nations terminology fact sheet', www.afn.ca/article.asp?id=437.

BY THE NUMBERS

3

Canada's rank in applying the Human Development Index (HDI), out of 177 countries.

68

Canadian First Nations communities' rank in applying the HDI.

For First Nations: Assembly of First Nations. 'The First Nations plan for creating opportunity'. November 2006. www.turtleisland.org/news/fnplan.html. For Canada: 'Human development report 2007/2008'. hdr.undp.org/en/reports/global/hdr2007-2008.

ENDNOTES

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- 8 Canadian data from 'The chief health officer's report on the state of public health in Canada, 2008' and international comparisons from UNICEF's *The State of the World's Children*, 2009.
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- 10 '2008 report card on child and family poverty in Canada', Campaign 2000.



Executive summary:
**THE HEALTH OF FIRST NATIONS, INUIT AND
MÉTIS CHILDREN IN CANADA**
Margo Greenwood and Jessica Place



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“Our children are the hearts of our future, so let’s all take responsibility for the optimal health of our children and be confident that seven generations from now their hearts will be filled with love, peace and happiness!”

– Lindsay Jade Mainville,
Couchiching, Ontario

SOME CANADIANS MORE EQUAL THAN OTHERS

In Canada, there are major health disparities between Aboriginal¹ and non-Aboriginal people that are multi-faceted in origin and largely influenced by socio-economic and environmental factors. Canada’s long history of European colonization is at the root of the social inequalities and poor health that persist among Aboriginal peoples today. Aboriginal children suffer a greater burden of these inequities than all other children across the country.

Statistics show that a range of socio-economic factors, such as poverty, lower education attainment and substandard housing, challenge the health of Aboriginal people. As a result, they experience higher infant mortality rates, lower child immunization rates, poorer nutritional status and endemic rates of obesity, diabetes and other chronic diseases. Aboriginal people also suffer higher rates of suicide, depression, substance abuse and fetal alcohol spectrum disorder, and their representation in the welfare and justice systems is generally higher than in the non-Aboriginal population.

Socio-economic and environmental factors also manifest as chronic, non-communicable diseases in Aboriginal populations. Poor nutrition resulting from the deterioration of traditional foods and increased dependency on processed foods causes obesity and diabetes. These chronic diseases have reached epidemic proportions among children and youth.

Tackling the health inequalities experienced by First Nations, Inuit and Métis children requires the efforts of both Aboriginal and non-Aboriginal sectors and governments. The holistic nature of children’s health and well-being demands multi-level approaches designed to address individual and collective inequities. A social determinants approach provides a way to understand and address the interrelated context of environmental, social and historical factors underlying health disparities.

The individual articles in this Canadian supplement to the UNICEF’s *The State of the World’s Children 2009* report reveal the status of First Nations, Inuit and Métis children’s health in their communities, whether they reside in rural, remote or urban areas, and highlight jurisdictional hurdles facing these children. It should be noted that there are significant challenges around quality of data and the lack of disaggregated data that differentiates between First Nations, Inuit and Métis peoples, and between Aboriginal peoples and other Canadians. Given these data challenges, the five guest articles on the health of Aboriginal children only begin to touch on some of the health disparities and challenges. These papers also offer specific actions for addressing the health inequalities of First Nations, Inuit and Métis children.

HEALTH DISPARITIES IN CANADA: A focus on First Nations children

Rachel Eni

Rachel Eni examines some of the primary health indicators for First Nations children in Canada. On many indicators, First Nations children fare far worse than non-Aboriginal children. The First Nations population is the largest Aboriginal population in Canada, as well as the youngest. These demographics highlight a major health concern – the fertility rate of First Nations teenagers. Although declining, this rate is still seven times greater than that of other Canadian teenagers. Early parenting increases the vulnerability of individuals and communities because they are already disadvantaged socio-economically and have limited access to education, employment and formal child care.

A second major health concern for First Nations children is the high infant mortality rate. This rate, too, has been decreasing, from 27 (1979) to eight (1999) per 1,000 live births. Nonetheless, across Canadian reserve communities, infant mortality rates are three to seven times higher than the national average. The leading cause of infant mortality in First Nations populations is sudden infant death syndrome, which is linked to maternal smoking, climatic circumstances and socio-economic factors, such as sub-standard housing.

A third major health concern is the rate at which First Nations children are immunized. Immunization rates have been well below the acceptable target of 95 to 97 per cent set by the National Advisory Committee on Immunizations; on-reserve First Nations child immunization rates are 20 per cent lower than in the general population. First Nations children subsequently suffer from higher rates of vaccine-preventable diseases.

Eni's conclusion? We must understand the health status of First Nations children within the broader context of the socio-economic conditions they face. We must also be aware of the inherent inequality in the Canadian governance structure that places First Nations children and families at a disadvantage. Self-governance and the inclusion of First Nations voices in policy and programme development must be central to health programme delivery that addresses the needs of First Nations children and families.

ROSALIE'S STORY: Putting a face on Inuit maternal and child health issues

Selma Ford and Meghan McKenna

Selma Ford and Meghan McKenna provide a narrative from an Inuk mother and her child's perspectives, chronicling the teenage mother's pregnancy through the birth of her child and the growth of her daughter into adulthood. The story highlights their health challenges and emphasizes Inuit resiliency. This story is set against the backdrop of the environmental, social and geographic barriers for improving health that all Inuit face in Canada's northern regions.

Margo Greenwood, an associate professor in both the education and First Nations studies programmes, is an indigenous scholar of Cree ancestry with more than 20 years experience in the field of early childhood and indigenous education. She is also the director of a number of research institutes, including the National Collaborating Centre for Aboriginal Health, the Centre of Excellence for Children and Adolescents with Special Needs, and B.C. Initiatives, a Ministry of Health activity comprised of Aboriginal ActNow BC and the Preschool Vision Screening Initiative.

Jessica Place is a research associate with the Rural and Northern Practice Research Program at the University of Northern British Columbia and has worked as a consultant for the National Collaborating Centre for Aboriginal Health. She has undertaken a number of research projects related to Aboriginal health and well-being, including research on the various linkages between health and the environment, and research on early childhood as a social determinant of health.

The authors' story illustrates the connection between land and health for Inuit. They are tremendously reliant on hunting as a source of food, particularly because their geographic location makes it difficult for local stores to carry the same types of goods that most Canadians take for granted. The changing environment and food security are significant challenges faced by Inuit, and access to healthy food is inconsistent.

Inuit live in some of the worst conditions in Canada, which negatively affect the health of Inuit children. Respiratory virus and pneumonia infections are rampant and severe. Overcrowding can also lead to the transmission of other diseases, such as tuberculosis and hepatitis A.

Like other contributors to this Canadian supplement, Ford and McKenna illustrate the importance of considering all of the factors – such as poverty, inadequate housing, food insecurity, lack of education and lack of access to health services – that contribute to understanding the poor health outcomes for Inuit. They demonstrate that Inuit experience socio-economic and environmental conditions that result in chronic, non-communicable diseases. However, access to health care is particularly challenging for Inuit, given the remoteness of their communities. The first point of contact for medical services is usually a health centre staffed by at least one nurse; doctors rarely work in Inuit communities on a regular basis. It is essential to create strategies that focus on improving access to services and programmes targeted at children, youth and their parents.

IS CANADA FAILING MÉTIS CHILDREN? An examination of the challenges and barriers to improved health

Caroline L. Tait

Caroline Tait identifies the social, economic and historical factors that impact the health status of Métis children. When compared to non-Aboriginal children, Métis children share a similar disadvantaged socio-economic and health profile to other Aboriginal children. However, they face some unique challenges and barriers to improving their health status. These challenges are embedded in the historical dimension of European colonialism and the federal government's lack of will to afford the Métis the same status as on-reserve First Nations and Inuit.

The Métis represent approximately one-third of Canada's Aboriginal population. The Canadian census indicates that the Métis population is growing faster than both First Nations and Inuit; it nearly doubled between 1996 and 2006. Approximately 87 per cent of Métis live in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario. The Métis are a young population, with 25 per cent under the age of 14.

Tait draws attention to the conditions of living in poverty and in overcrowded housing that result in poor health for Métis children. These conditions can lead to a higher risk of injuries, an escalated risk of transmitting infectious diseases, mental health problems, family tension and violence. While these types of poor health outcomes are similar to those experienced by other groups of Aboriginal people,

Métis children are uniquely vulnerable to compounding health and social disparities because they lack access to the programmes and services that the federal government provides status First Nations and Inuit children through Health Canada's Non-Insured Health Benefits Program. Overall, Métis children are not provided with a similar local, provincial or federal health-care infrastructure to deliver the programmes and services that Inuit and First Nations children receive.

URBAN ABORIGINAL CHILDREN IN CANADA: Building a solid foundation for prosperity and change

Geraldine King

Illustrating the profound connection between parental and child health, Geraldine King writes from the perspective of a young, pregnant Aboriginal mother living in a large city. She highlights many alarming inequities in the socio-economic circumstances faced by urban Aboriginal mothers, which she argues are not conducive to the health of their children.

The Aboriginal population is becoming increasingly urban, with 54 per cent living in an urban centre in 2006, up from 50 per cent in 1996. Many urban Aboriginal children live in low-income households, and a substantial number live with one parent, usually the mother. The health of urban Aboriginal children depends on the socio-economic conditions of their mothers. Extreme poverty, low levels of education, low literacy rates and poor housing limit parents from building prosperous, healthy lives for themselves and their children.

Poverty is prevalent for Aboriginal families living in urban settings; in cities of more than 100,000 people, 50 per cent of Aboriginal children under the age of 15 live in low-income housing, compared to 21 per cent of non-Aboriginal children. Employment disparity and lower educational achievements are contributing factors, as is the higher rate of lone-parent families. Violence in the home is also a significant problem among the urban Aboriginal population.

Health in urban settings is inextricably linked to social determinants. The Aboriginal Friendship Centres that operate in urban centres across Canada are a powerful tool for addressing some of these social determinants. By providing a range of culturally appropriate programmes and services to empower individuals and enhance their economic, social, cultural and personal prospects, they are working to improve the lives of all urban Aboriginal parents and their children.

JORDAN'S STORY: How one boy inspired a world of change

Cindy Blackstock

Aboriginal people face many jurisdictional barriers to receiving appropriate access to social services. A critical factor in the delivery of health services to First Nations children in Canada is the prevalence of jurisdictional disputes over which level of

BY THE NUMBERS

1 in 4

The number of children in First Nations communities living in poverty.

1 in 9

The number of Canadian children on average living in poverty.

'2008 report card on child and family poverty in Canada', Campaign 2000.

government is financially responsible for the costs of providing services. Cindy Blackstock highlights this issue through the tragic story of the death of Jordan, a First Nations boy with multiple health problems. His story generated a public outcry and the creation of a movement in support of what has become known as 'Jordan's Principle'. Jordan's Principle puts the child's interests first in any jurisdictional dispute between federal and provincial/territorial governments. When a dispute arises about the provision or payment of a government service (such as health care, education, recreation or another service normally enjoyed by other Canadian children) for a status Indian or Inuit child, Jordan's Principle requires the government of first contact to pay the bill immediately – and then resolve the payment issue later.

The impact of this jurisdictional ambiguity is more common than one would think. Blackstock cites a study that reveals that, in one year alone, 393 children in 12 surveyed agencies were affected by jurisdictional disputes, and that the vast majority of these disputes were within, or between, the federal and provincial governments. Blackstock concludes that each year, thousands of Aboriginal children are denied government services on the basis of their race and residency.

Jordan's Principle is the most widely supported child policy movement in recent Canadian history. It is an example of what can be accomplished when a group of committed people leverage their networks and talents toward positive change. However, Jordan's Principle still has not been implemented and needs commitment from all levels of government to pass into law.

CONCLUSION:

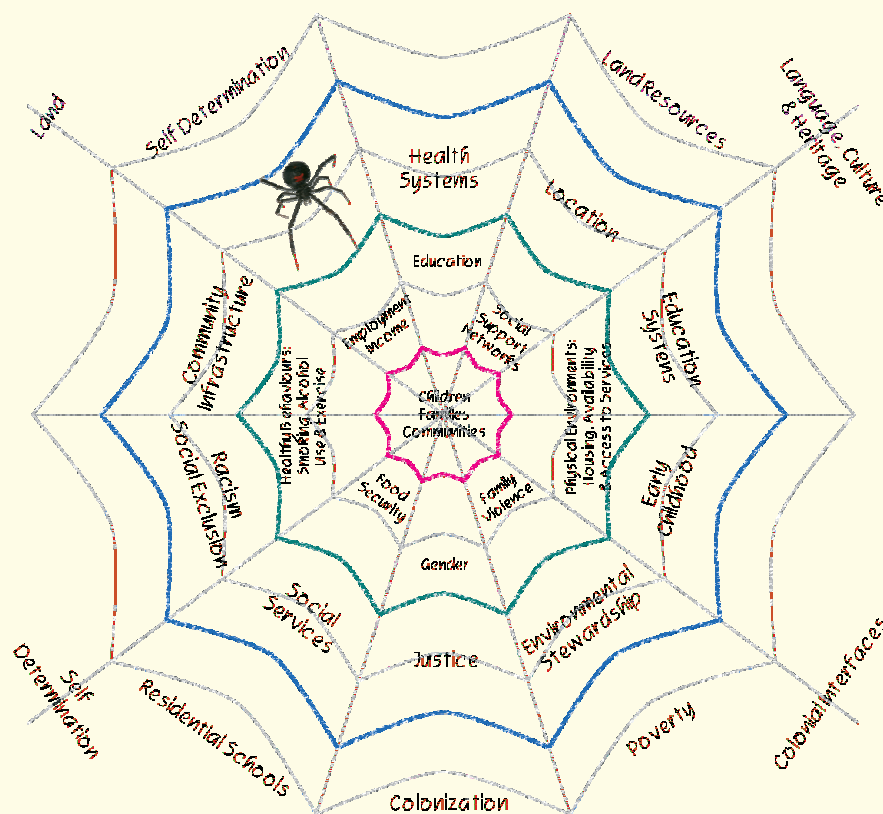
We need a collective Canadian effort

Addressing health disparities experienced by First Nations, Inuit and Métis children is a huge challenge and requires a collective Canadian effort to tackle them. These disparities will not be resolved by a single action or 'one size fits all' approach but, rather, by the concerted efforts of many.

The challenge will be determining the starting point in dealing with the pressing realities of the children's lives, while at the same time advocating for structural change that will create long-term transformation. We cannot be reticent on any of these fronts. Answers to these large questions and subsequent actions lie with the people of Canada. By focusing on local solutions, we will gain diverse and specific responses tailored to the needs of Aboriginal individuals and the communities in which they live.

At the same time, successful frameworks for transformation and change will need to occur at many levels and will need to address individual needs as well as the structural underpinnings of those needs. The authors of the articles in this supplement caution that whatever approaches are applied to addressing inequalities, Aboriginal peoples should not be viewed as victims. A starting place, then, for addressing social, economic and historical inequities begins with a holistic approach that builds on the attributes and strengths of First Nations, Inuit and Métis peoples.

WEB OF BEING: Social determinants and indigenous peoples' health



WHAT ARE SOCIAL DETERMINANTS OF HEALTH?

Over the last 50 years, health researchers and practitioners have changed the way we understand the factors that prevent chronic disease and those that lead to good health. Before that, we generally considered health as a matter of bio-medical cause and effect, coupled with poor lifestyle choices.

Health professionals began to see that good health and disease prevention are a lot more than that. In 1948, the World Health Organization declared that health is “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” And later, in 1986, the Ottawa Charter for Health Promotion declared that health is “created and lived by people within the settings of their everyday life; where they learn, work, play and love.” These declarations tell us that there are a large number of social factors and conditions, including income, employment, education, housing and others that lead to healthy people and communities. In 1998, Health Canada developed a comprehensive list of those factors, calling them the determinants of health. The list includes income; social support; education and literacy; employment and working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.

(www.healthnexus.ca/projects/primer.pdf.)



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WHY IS THIS MODEL IMPORTANT TO ABORIGINAL HEALTH?

A social determinants of health approach offers a holistic way to address social, economic and historical health inequities. For example, the Assembly of First Nations Public Health Framework² offers a model of public health that takes into account these determinants as well as those unique to Aboriginal peoples, such as self-determination, culture and heritage, and colonization. Indigenous scholar Charlotte Loppie developed a social determinants of health model, positioning determinants along the life course.³ The 'Web of being: Social determinants and indigenous peoples' health' model on page 7 demonstrates the interrelationships between determinants of health on the lives of Aboriginal children, their families and their communities.

This conceptualization of the social, economic and historical determinants of health is anchored in Aboriginal ways of knowing and being, particularly notions of interconnectivity and holism, which provide guidance for addressing health determinants. For example, access to health services is tied to larger health systems, which are, in turn, embedded in larger legislative, policy and historical contexts.

RECOMMENDATIONS FOR ACTION

The guest articles in this Canadian supplement to *The State of the World's Children 2009* report offer specific actions necessary to address health inequalities experienced by First Nations, Inuit and Métis children. These recommendations for action address the following key issues:

- There is insufficient data for many areas of Aboriginal health and well-being.⁴ For example, there is a serious lack of data regarding the prevalence of HIV and AIDS among First Nations peoples. As well, the lack of Métis-specific data indicates that an evidence-based foundation on which to build culturally sound and effective health-care and social-service policy and programming to directly address the needs of Métis children does not exist. **Collect more high-quality data on all areas of Aboriginal health and well-being** by and for Aboriginal peoples to meet their specific and various needs for evidence-based policy, practice and service.
- Inherent inequality in Canadian governance structures is a fundamental contributing factor to health disparities. **Remove jurisdictional boundaries** that block effective health care delivery.
- Moving toward equitable health status requires a greater understanding of Aboriginal contexts and health issues by health and social service providers. Efforts should be made to **provide training programmes aimed at increasing empathy and understanding among health and social service providers.**

- **Allocate greater resources and funding** for research, policy development and service provision.
- **Increase capacity-building initiatives** for Aboriginal peoples to actively and effectively govern their own social, health and education initiatives.

WHAT YOU CAN DO RIGHT NOW TO HELP IMPROVE THE HEALTH OF CANADA'S ABORIGINAL CHILDREN

Register your individual or organizational support for Jordan's Principle – a child-first principle to resolve inter-governmental jurisdictional disputes affecting the lives and health of Aboriginal children. www.fncfcs.com/more/jordansPrinciple.php.

Contact your elected federal (MP) and provincial (MPP) representatives to register your concern about the inequities that Canada's Aboriginal children face. Ask them what they are doing to raise the issues in Parliament and in provincial legislatures. Find out if they have acted on the recommendations made in Jordan's Principle and encourage others in your community to do the same. www.fncfcs.com/more/jordansPrinciple.php.

Support the Many Hands, One Dream principles to guide improvements that will result in healthier Aboriginal children and young people. www.manyhandsonedream.ca.

Learn about the United Nations Convention on the Rights of the Child and speak with others (friends, family, children, young people, and your government representatives) about children's rights and how important they are to all children in Canada. www.unicef.ca/portal/SmartDefault.aspx?at=2299.

When all is said and done – children remain our most precious gift, and it is everyone's responsibility to treasure and honour this gift.

ENDNOTES

- 1 The indigenous inhabitants of Canada including First Nations, Inuit and Métis peoples (as stated in section 35 (2) of the Constitution Act, 1982).
Note: The definitions in this footnote are from the 'Report of the Royal Commission on Aboriginal Peoples' (1996). Ottawa: Minister of Supply and Services.
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- 4 Although there is a lack of data for all Aboriginal groups, including Inuit, the work Inuit Tapiriit Kanatami (ITK) and the Inuit regions have done with Statistics Canada in the last two Aboriginal Peoples Surveys to ensure the relevance and appropriateness of questions, is a promising practice that has been a benefit to Inuit.



Health disparities in Canada: A FOCUS ON FIRST NATIONS CHILDREN

Rachel Eni

FIRST NATIONS CHILDREN SUFFER A GREATER BURDEN OF POOR HEALTH

There are major health disparities among children in Canada, with First Nations children suffering a greater burden of poor health than all other children across the country. By focusing on several primary health indicators for First Nations children from birth to 18 years of age who live both on- and off-reserve, we can draw a holistic picture of their health. Only then can we address the inequalities to improve the health – and the lives – of Canada’s First Nations children.

The causes of these health disparities are multi-faceted¹ and largely influenced by environmental and socio-economic factors, including the huge differences in income, education and occupation opportunities between First Nations peoples and other Canadians.² Geographic isolation, and the lack of access to physicians and medical specialists perpetuate the problem.³ A colonial history that includes residential schools and discriminatory child-welfare policies also underlies the inequities.⁴ This article concludes with a suggested focus on addressing the inequality to improve the health of First Nations children.



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“Our children are at the centre of our people – they are our value that ties our people together and centres our nations. Without our children we have no purpose.”

– Elaine M. Alec,
Penticton Indian Band

WHAT DO WE MEAN BY ‘HEALTH’?

We use the World Health Organization definition of health, which states: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”⁵ Health can also be seen as a resource for a well-lived life, “[t]he extent to which an individual or group is able on the one hand to realize aspirations and satisfy needs, and, on the other hand, to change and cope with the environment. Health is therefore seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities.”⁶

The First Nations concept of health encompasses more than physiology and is a complex, dynamic process that includes social relations, land and cultural identity.⁷ First Nations health is founded on wholeness, interconnection and harmony.⁸

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THE BIG PICTURE – A POPULATION OVERVIEW

The First Nations population is the largest Aboriginal population in Canada. Compared to the non-Aboriginal Canadian population in which 19 per cent is 14 years of age and younger,⁹ the First Nations population is very young, with 42.3 per cent of its on-reserve and 32.4 per cent of its off-reserve populations between

BY THE NUMBERS

63

The percentage of First Nations children on selected reserves who accessed a doctor in the past year.

85

The percentage of all children in Canada who accessed a doctor in the past year.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

zero and 19 years of age; 8.7 per cent and 6.1 per cent are between zero and four years of age, on- and off-reserve respectively.¹⁰

Teen fertility – seven times higher than other Canadian youth

Although declining in recent decades, the fertility of First Nations women across the country is currently 2.7 children per woman, almost double that of other Canadian women. Since 1986, fertility rates for First Nations teenage girls continue to be elevated, at approximately 100 births per 1,000 women. That translates into fertility rates seven times greater than that of other Canadian teenagers. If you look at rates for First Nations teenage girls under the age of 15, they are 18 times higher than that of other Canadians. Rates are highest in the prairie provinces; for example, in Manitoba in 2004, one in eight First Nations teenage girls had a child (128 births per 1,000 teenagers aged 15 to 19).¹¹

Youth fertility is a health matter. Generally speaking, early parenting increases the vulnerability of individuals and communities already socio-economically disadvantaged and with limited access to education, employment and formal child care.^{12,13}

Infant mortality rates – socio-economics play a role in children's deaths

As with the general Canadian population, infant mortality rates for on-reserve First Nations people have been steadily decreasing over the past three decades. For example, between 1979 and 1999, infant mortality rates declined from 27 to eight and from 10.9 to 5.3 deaths per 1,000 live births for First Nations and Canadian children, respectively.¹⁴ But when we take into account the specific ages of First Nations children upon death, we see another quite different picture that offers clues for the development of an explanatory framework. For instance, First Nations neonatal death rates, which reflect access to and quality of health care in the prenatal period during and immediately following labour, decreased significantly; they are now close to the national average. By contrast, although there were notable improvements, First Nations post-neonatal death rates (from one month to one year of age), which indicate socio-economic and environmental factors, remain about triple the national rate.¹⁵ In Manitoba, the 2003 perinatal mortality rate was 14.9 per 1,000 for First Nations children and 8.2 for other Canadian children.¹⁶ Across Canadian reserve communities, infant mortality rates are three to seven times the national average.¹⁷

Sudden infant death syndrome – one of the leading causes of infant mortality

The leading causes of infant mortality in First Nations populations are upper respiratory tract infections and sudden infant death syndrome (SIDS).¹⁸ Several environmental factors are known to contribute to SIDS, including maternal smoking; climatic circumstances, such as exposure to detrimental levels of fungi, bacteria and air particles common to northern climates; and socio-economic factors, including substandard housing.^{19,20} Mould and mildew are other contributing factors, and in a 2002-2003 national First Nations health survey, 40

per cent of respondents living in band-owned housing reported the presence of mould or mildew in their homes.²¹ Humid, damp conditions promote bacterial, mould and dust mite growth. These organisms then contribute to poor air quality and cause serious health problems. Higher rates of asthma and bronchitis among First Nations children are also prevalent.^{22,23}

Immunization rates – well below the rates for other Canadians

Few interventions surpass the positive impact that immunizations have made on the health of Canadian children. However, for First Nations children, immunization rates have been well below the acceptable target of 95 to 97 per cent set by Canada's National Advisory Committee on Immunization. For on-reserve First Nations children, immunization rates are 20 per cent lower than the general population, and these children suffer from higher rates of vaccine-preventable diseases. Some of the diseases result in higher hospitalization rates; for example, First Nations children under one year of age are hospitalized 50 times more frequently with streptococcal pneumonia and 80 times more frequently with chicken pox than non-Aboriginal children.^{24,25}

Chronic, non-communicable diseases – poor diets linked to diabetes, obesity and other health problems

A combination of socio-economic and environmental factors is responsible for many chronic health issues in northern First Nations children. Their diets are increasingly excessive and/or unbalanced, featuring many processed foods.²⁶ It is easy to understand the factors contributing to their poor-quality diets: the high cost of transporting fresh foods over significant distances (from city centres to the northern peripheries), the difficulties smaller communities have in selling fresh foods prior to food spoilage, and climates unfriendly to year-round crop growth.

The deterioration of traditional foods also contributes to insufficient diets, as fish and wild game have become tainted and sparse as a result of large-scale northern developments in oil, gas and hydroelectricity. Based on known or suspected impacts, First Nations people living close to the developments no longer trust the safety of traditional (country) foods. High levels of PCBs in the blood were measured in people from two First Nations communities in the Sioux Lookout area of Ontario.²⁷ Other studies in northwestern Canada indicate that toxic chemicals dumped into various waters and soils around the Great Lakes basin are absorbed into women's breast milk, a situation of grave concern to the Akwesasne women of the area.²⁸

Diabetes is another emerging health problem for First Nations children²⁹ and a major cause of morbidity and mortality. Research conducted in northern First Nations communities in British Columbia and Ontario concluded that diabetes has reached epidemic proportions among children and youth.³⁰ As well, the age of onset has been decreasing, so that not only are more First Nations people becoming affected by diabetes, they are becoming affected at a younger age. The appearance and increasing prevalence of Type 2 diabetes and impaired glucose tolerance among First Nations children are of particular concern.³¹

Childhood diabetes can be linked to a variety of factors, including limited access to

BY THE NUMBERS

42

The percentage of First Nations children on selected reserves breastfed for longer than six months.

43

The percentage of First Nations children off-reserve breastfed for longer than six months.

34

The percentage of all children in Canada breastfed for longer than six months.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

BY THE NUMBERS

38

The percentage of deaths attributable to suicide for First Nations youth aged 10 to 19. In 1999, the suicide rate among First Nations was 2.1 times higher than the overall Canadian rate.

Assembly of First Nations, 'The First Nations plan for creating opportunity', (November 2006), www.turtleisland.org/news/fnplan.html.

healthy foods, health beliefs, attitudes and environmental conditions. First Nations communities often attribute the increase in chronic diseases in general to decreased activity (loss of a lifestyle characterized as 'living off the land'); decreased intake of traditional foods; increased emotional stress from communal living; and the breakdown of traditional family, networking and governing structures over the past 50 to 60 years.³²

Studies of Swampy Cree women in James Bay^{33,34} and Ojibwa and Cree women in northwestern Ontario³⁵ found elevated rates of gestational diabetes. Gestational diabetes leads to a higher prevalence of high birth weights for First Nations infants, which, in turn, puts children at elevated risk of developing Type 2 diabetes. For instance, the national First Nations Regional Longitudinal Health Survey 2002/03 recorded high birth weights for 21 per cent of infants overall (24.6 per cent for males and 17.4 per cent for females). This rate is higher than the rate recorded only five years previously in the first round of the regional survey, when 17.8 per cent of infants were classified as having a high birth weight. These rates are markedly higher than the 13.1 per cent of high birth weights in the general Canadian population.³⁶

The number of children who are overweight has been rapidly increasing among First Nations across the country. Between 1981 and 1996, rates increased from 15 to 29 per cent in boys and 15 to 24 per cent in girls. Similarly, obesity has been on the rise, from 5 to 14 per cent in boys and from 5 to 12 per cent in girls.³⁷ Obesity is a prime risk factor for numerous related health problems, including high blood pressure; high levels of fat and insulin in the blood; joint problems; gallstones; menstrual abnormalities; neurological conditions; asthma and breathing problems during sleep; social exclusion; and depression. The greatest health problems, however, will become apparent in the next generation of adults as the present childhood obesity epidemic develops through to adulthood. It will show up in increased rates of heart disease, diabetes, certain cancers, gallbladder disease, osteoarthritis and endocrine disorders.³⁸ The result will be the potential loss of lives, a massive cost to the health care system, and a burden for both individuals and communities.

According to pediatric research, there are several interactive factors contributing to obesity, including metabolic and genetic, environmental and behavioural. The World Health Organization says:

Changes in the world food economy have contributed to shifting dietary patterns; for example, increased consumption of energy-dense diets high in fat, particularly saturated fat, and low in unrefined carbohydrates. These patterns are combined with a decline in energy expenditure that is associated with a sedentary lifestyle....³⁹

Other common chronic conditions – ear infections, tooth decay have far-reaching results

Studies reveal higher and more severe rates of otitis media (ear infections) for First Nations than for other Canadian children.⁴⁰ Consistent with previous research, a recent study of Mi'kmaq children at a First Nations elementary school in Nova Scotia found middle ear pathology and hearing loss in more than 20 per cent of children. Rates in some communities are as high as 40 times the national average.

Otitis media most likely develops in infancy, and susceptibility has been linked to immune defects and to environmental factors, such as diet, declining rates of starting and continuing breastfeeding, and exposure to cigarette smoke. Hearing loss is associated with language acquisition difficulties and subsequent developmental issues with literacy and school achievement, including learning disabilities and attention deficits. There is no doubt that the economic and social costs of otitis media are substantial.⁴¹

Nowhere is the health disparity between Aboriginal and non-Aboriginal children more evident than in dental health care. Although dental caries is declining in non-Aboriginal populations, the increasing severity and extent among young First Nations children is “alarming.”⁴² A devastating form of tooth decay, dental caries is the result of several factors,⁴³ including high sugar consumption and a lack of regular dental checkups. Studies in First Nations communities across Canada indicate high prevalence rates of dental caries – from 50 to 54 per cent overall.⁴⁴ Two Ontario First Nations studies reported one or more past carious lesions (tooth decay) in 74 per cent of children between three and five years of age, and in 96 per cent of children between seven and 13 years of age.⁴⁵ Associated risk factors are sugar being added to the baby bottle, late weaning, poor oral hygiene, low calcium and vitamin D during pregnancy,⁴⁶ and low family income.⁴⁷ The results of a study conducted in a First Nations community in the western James Bay region of northern Ontario suggest that lead in the environment may predispose First Nations children to high rates of dental caries.⁴⁸ Untreated dental caries in children has even been associated with failure to thrive, with significant consequences to physical and financial health.⁴⁹ What we need, in addition to medical treatment programmes, are community-based oral health promotion initiatives.⁵⁰

Fetal alcohol spectrum disorder – significantly higher rates

It is estimated that between one and three out of 1,000 babies born in Canada will suffer from fetal alcohol spectrum disorder (FASD), one of the major recognized preventable birth defects among children.⁵¹ A handful of studies carried out in the 1980s and 1990s suggest significantly higher rates in First Nations communities.⁵² The higher rates are replicated in more current studies, with roughly 55 to 101 cases per 1,000 babies born on one Manitoba reserve⁵³ and 7.2 per 1,000 on another.⁵⁴ FASD has devastating effects on First Nation communities. Alcohol damages the mind and body of the fetus, and can affect the child throughout life. Although children are valued implicitly in First Nations communities, regardless of their circumstances, alcohol has a negative effect on the health and wellness of individuals, families and whole communities.

Youth suicide – prevention starts in the community

Suicide is one of the most daunting public health issues facing Canadians and, in some First Nations communities, is occurring in ‘epidemic’ proportions. In 1999, First Nations youth lost between three and seven times as many potential years of life to suicide compared to Canadians overall.⁵⁵ There are wide variations in rates between First Nations communities.^{56,57}

The literature suggests that intervention and prevention can only be successful by taking into account the interconnected relationships between culture, community

BY THE NUMBERS

8

The rate of infant mortality per 1,000 live births among First Nations people living on a reserve.

Indian and Northern Affairs Canada Basic Departmental Data (2002), http://www.ainc-inac.gc.ca/pr/sts/bdd02/bdd02_e.pdf.

and environment.⁵⁸ We must also understand risk and protective factors to better inform suicide prevention policies and practices. These multi-level risk factors include psycho-biological, personal and community, historical, socio-economic and cultural influences. Important protective factors against suicide are trust, participation and public action within communities,⁵⁹ as well as self-governance and cultural continuity.^{60,61}

HIV and AIDS – very little information, but the outlook is grim

There is a serious lack of data regarding the prevalence of HIV and AIDS among First Nations. A University of Manitoba, Northern Medical Unit study on HIV and AIDS in Aboriginal people revealed that while Canadian incidences appear to be levelling off, there are many indications that HIV and AIDS are increasing among Aboriginal peoples. A Health Canada study on HIV among Aboriginal people suggested that First Nations youth may be more vulnerable to the disease since their rates of sexually transmitted diseases were five to 10 times the national average.⁶² The study identified other risk factors such as substance abuse, including injection drug use, and other health and social issues. Notwithstanding the dearth of information, the study authors referred to First Nations HIV and AIDS rates as “epidemic.”

UNDERSTANDING THE CAUSES OF INEQUALITY – ALL CANADIANS HAVE THE RIGHT TO HEALTH CARE

The relationship between health status and social factors has been well researched. First Nations children are the poorest in Canada⁶³ and come into the custody of child and family services more often than any other group of children across the country.⁶⁴ Moreover, the severe impacts of many of the diseases experienced by individuals living on-reserve reveal a serious lack of access to health services. In Canada, an industrialized nation with universal health care coverage, we place inordinate value on an accessible health care system. In fact, we consider it a basic determinant of health.⁶⁵ By that standard alone, we must address the barriers to health care for First Nations children, families and communities.

MOVING TOWARD EQUITY – COMBINED STRATEGIES CAN RESULT IN A SINGLE GOAL OF HEALTHIER CHILDREN

The health of First Nations children is affected by multiple factors at the individual, family, community, regional and national levels. But the root of health problems experienced by First Nations people stems from an inherent inequality in the Canadian health governance structure. Here, geographical remoteness, lack of service accessibility and jurisdictional issues are obstacles to effective health-care service delivery. Moving toward equitable health for First Nations communities

requires a multi-pronged approach.

We need to remove jurisdictional boundaries that block effective health care delivery, with a focus on the health needs of individuals and communities.

We must also increase resources and funding for a population that takes the brunt of the health discrepancies.

A greater understanding of First Nations contexts and health issues by health and social service providers is also crucial. For example, training programmes that provide opportunities for interns to work on reserves will improve understanding and empathy.

First Nations self-governance is crucial, too, for the development of a holistic health system that appreciates all of the multiple circumstances that affect health, as well as the opportunities for health that exist with social and economic developments. As well, self-governance should include participation in all levels of policy and practice, from community to national levels.

And we must not forget that the voices of children and their parents must be heard and respected in policy and programme development. These combined strategies will reshape health care for First Nations children and families, pointing the way toward a healthier future, not just for some Canadian children, but all Canadian children.

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METHODOLOGY FOR THE LITERATURE REVIEW

This chapter represents a summary of the available literature on the health status of First Nations children in Canada, in comparison with the mainstream Canadian population, and in consideration of the causes and impacts of disparity.

The literature search was conducted between April and June of 2008, using Netdoc, a standard academic search engine. Databases were searched, with priority given to papers published within the last 10 years (1998-2008). The search was updated in October 2008. This follow-up method is often implemented in systematic reviews to ensure inclusion of the latest research. Key words were *child, health, First Nation, inequalities, discrepancies, socio-economic, social factors* and the specific health issues covered in the review. Key databases searched include PubMed, Scopus, Social Sciences Abstracts, PsycInfo, Sociofile, Ebsco Host and CINAHL (Cumulative Index of Nursing and Allied Health Literature). Key websites reviewed are Indian and Northern Affairs Canada (www.ainc-inac.gc.ca), Health Canada – First Nations, Inuit and Aboriginal Health (www.hc-sc.gc.ca), Manitoba Centre for Health Policy (umanitoba.ca/faculties/medicine/units/mchp) and Assembly of First Nations (www.afn.ca).

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**Rosalie's story:
PUTTING A FACE ON INUIT MATERNAL AND
CHILD HEALTH ISSUES**

Selma Ford and Meghan McKenna



LIFE IN AN ARCTIC COMMUNITY

With its long, cold winters, life in a small, isolated Arctic community can be difficult, but also very appealing. Compared to the city, life runs at a much slower pace, without rush-hour traffic and long commutes. The Inuit who live here have a thriving culture and have made this land home for thousands of years. The land has sustained and nurtured them, yet the climate and challenging living conditions also contribute to major disparities in health compared to the rest of the Canadian population.

© Courtesy Inuit Tapiriit Kanatami/ M.Irwin

Miali, a young Inuit woman, lives in a community of about a thousand people, which is considered large by Inuit standards. For much of the year, her community is accessible only by air. During the short summers, the waterways open and the ferry season begins. For Miali, the closest major city is only an hour and half by plane, but the cost of travel makes it almost unreachable. The majority of Inuit make only \$13,600 annually (Statistics Canada, 2001d).

Since 2005, Selma Ford has been a senior project co-ordinator with Inuit Tapiriit Kanatami (ITK), the national organization representing Inuit of Canada. Born and raised in Nunatsiavut (northern Labrador), Ms. Ford has a community service worker diploma from the College of the North Atlantic in Goose Bay, Labrador, and has nine years' experience as a community health worker in her home community of Nain, Nunatsiavut.

BORN IN A TIME OF CHANGE

Miali will be giving birth to her first child in the fall. She eagerly awaits the day she will become a mother, and her partner, Jonathan, smiles as he begins his journey to fatherhood. Throughout her pregnancy, Miali receives advice and support from her family and community.

"Go outside first thing in the morning when you wake up so that the child will come out easily," her mother says.

Her grandmother encourages her by saying, "Eat lots of country food¹ because it is full of the nutrients that your baby needs. It has less fat and is better for your heart, muscles and blood. Also remember after your baby is born to eat lots of seal and caribou broth. This will help you produce lots of milk for your baby."

Jonathan works construction throughout the short Arctic summers. During this time, his ability to go hunting and fishing is curtailed, but he helps provide country food by giving money to family members to purchase gas and hunting supplies. Sharing country food with others is an important part of Inuit culture so, although Jonathan may not be able to go hunting himself, they will still have country food to eat.² Once winter comes and Jonathan is out of work, he will have more time to hunt and fish. Miali's uncle drops by with some fresh seal that he caught at the floe edge because he was worried that Miali hadn't had enough "good" (country) food to eat lately.

Local hunters have noticed subtle changes in the environment. The ice floe edge has moved farther from the town; the ice is thinner, and some of the animals are changing their migration patterns. Last year, the ice broke up so fast that some

hunters on snowmobiles were stranded on the land and had to be picked up by helicopter. This worries elders in the community because they have never seen the ice go out so quickly before. As well, some young people are nervous about these changes in the environment and wonder if it is safe to go hunting.³

WORRIES ABOUT FOOD AND HEALTH CARE

Inuit are tremendously reliant on hunting as a source of food, particularly because their geographic location makes it difficult for local stores to carry the same types of goods that other Canadians take for granted. There are times during the year when it is difficult to get fresh fruits and vegetables and, of course, if the weather is bad and the planes can't get in, there is also very little selection. Miali is glad when there is milk in the store; at times, there is no fresh milk in the community for several days. Miali and Jonathan work hard to make ends meet but the prices at the local store make it difficult. Sometimes they spend as much as \$450 a week on groceries, but occasionally they just can't afford to do that. It is frustrating because they know that Miali's cousin, who lives in Ottawa, will pay \$260 for the same amount of groceries (Lawn, 2007).⁴

Not only is good nutrition a major concern for Miali, access to proper health care also creates worries. Because there are few doctors, except in the larger centres, Miali receives prenatal care from the health centre in her community. She has seen four nurses over the course of her pregnancy, making it difficult to establish a continuing relationship. Miali isn't comfortable asking questions. She knows that most Inuit mothers breastfeed their babies and she wants to do that as well, but because she must leave her home community to give birth, she is worried that she won't have anyone to answer her questions when the baby is born.

With an infant mortality rate four times greater than the Canadian average (Wilkins et al., 2008), Miali has reason to worry. At present, midwifery services are not available in all regions, so Miali will need to leave her family and partner for four weeks before she is due to give birth. Miali is scared to stay in a boarding home in a big city where she may not know anyone, and expects to be very lonely.

THE IMPORTANCE OF COUNTRY FOOD IN INUIT DIETS

- Approximately 71 per cent of Inuit adults were involved in harvesting country food in 2000. In the Far North, nearly 50 per cent of all Inuit children ate wild meat five to seven days a week.
- Sharing harvested food is an important Inuit tradition, with 96 per cent of Inuit households participating in this activity.
- Country meats are higher in protein and lower in fat than non-country meats.

(Adapted from Statistics Canada, 2001a, pp. 6-8 and Statistics Canada, 2001c).

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WHERE INUIT LIVE

Of the approximately 50,000 Inuit, 19 per cent live in Nunavik (northern Quebec); 49 per cent live in Nunavut; 6 per cent live in Inuvialuit (Northwest Territories); and 4 per cent live in Nunatsiavut (northern Labrador). The remaining 22 per cent live in other rural areas outside of traditional Inuit lands or in urban centres.

(Statistics Canada 2006a, p. 21).

There are 53 Inuit communities located within Nunatsiavut, Nunavik, Inuvialuit and Nunavut, the largest of which had a population of 7,969 in 2001. The average population in these communities was 1,021.

(Statistics Canada 2001 Census, as cited in Senécal and O'Sullivan (2006), p. 3).

BY THE NUMBERS

33

The percentage of Inuit children with chronic health conditions.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

THE NON-INSURED HEALTH BENEFITS PROGRAM

Health Canada provides eligible First Nations people and Inuit with a specified range of medically necessary health-related goods and services when they are not covered through private insurance plans or provincial/territorial health and social programmes. Non-Insured Health Benefits (NIHB) include prescription drugs, over-the-counter medications, medical supplies and equipment, short-term crisis counselling, dental care, vision care and medical transportation.

(Health Canada, www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php).

She has heard that in some parts of the Arctic, there are midwives providing care to pregnant women, and that education of young Inuit women to become midwives is happening. Miali wishes there was a midwife in her community so all of her questions could be answered. Most important, she would then be able to stay at home to have her baby, with both her mother and Jonathan with her for the birth. According to the rules of Health Canada's Non-Insured Health Benefits for First Nations and Inuit Program, only the cost of Miali's travel will be covered, so she will be alone unless her family can find the money to join her.

INUIT ACCESS TO HEALTH CARE PROFESSIONALS

- The first point of contact for medical services is usually a health centre staffed by at least one nurse.
- Doctors rarely work in Inuit communities on a regular basis. In 2001, Inuit children were far less likely to have seen a doctor than non-Aboriginal children (45 per cent for Inuit children, compared with 85 per cent for non-Aboriginal children).
- Because most Inuit communities do not have a resident dentist, Inuit children receive dental treatment less often than non-Aboriginal children. Dental emergencies and dental specialists can only be accessed by trips to the south.

Statistics Canada, 2001b, pp. 6-7.

Miali gives birth to a healthy baby girl, Rosalie. According to Inuit custom, a baby is named after a family member or family friend. Aunt Rosalie was a much respected elder in the community, and Miali knows that naming the new baby after her will call forth many of the same traits in her little girl. Knowing the baby is named after such a respected elder, community members will treat little Rosalie with the same respect. On returning home, Miali and Rosalie are surrounded by caring, loving family and friends, but Rosalie will face many challenges that will affect her health as she grows into adulthood. These include living in overcrowded and inadequate housing, and experiencing food insecurity, high unemployment and a lack of education opportunities.

Miali, Jonathan and Rosalie live with Miali's parents, Miali's younger brother and two sisters in a three-bedroom house. Crowded living conditions are not unusual in Inuit communities.

Rosalie will be taken to the health centre many times during her first five years. Some visits will be for routine care, such as immunizations, but Rosalie will also have many ear infections. The nurses encourage Miali not to expose Rosalie to second-hand smoke, but Miali doesn't feel comfortable telling people in her parents' house not to smoke. Miali has made the decision to smoke outside of the house, but she would really like to quit; she just doesn't know how.

INUIT LIVE IN SOME OF THE WORST LIVING CONDITIONS IN CANADA

- 40 per cent of children under age 14 live in crowded homes, which is more than six times the rate for non-Aboriginal children.
- Approximately 28 per cent of Inuit reported living in homes requiring major repairs, compared to 7 per cent of non-Aboriginal people.
- There is a shortage of housing in Inuit communities, and Inuit are nearly five times more likely to live in households containing more than one family compared to non-Aboriginal people.

Statistics Canada, 2006a.

INADEQUATE LIVING CONDITIONS NEGATIVELY IMPACT HEALTH STATUS OF INUIT CHILDREN

- Respiratory syncytial virus (RSV) infection and streptococcus pneumonia infections are rampant and severe. In fact, one Inuit region in Canada has the highest rates of RSV infection hospitalization in the world. Many children have permanent chronic lung disease resulting from these infections.*
- Overcrowding can lead to many health concerns, such as the transmission of other diseases including tuberculosis and hepatitis A, and increased risk for “injuries, mental health problems, family tensions and violence.”**
- Between 2002 and 2006, the tuberculosis rate among the Inuit was 90 times higher than the non-Aboriginal population born in Canada.***

* Kovesi et al., 2007.

** Statistics Canada, 2003 as cited in Statistics Canada, 2006a, p. 24.

***Public Health Agency of Canada, 2006.

WILL ROSALIE KNOW HER OWN LANGUAGE?

Rosalie is told many stories in her native language of Inuktitut, but the community is growing and English is becoming more common. Some Inuit communities have significant native language loss, with just 50 per cent claiming Inuktitut as the language used at home (Statistics Canada, 2006a).⁵ As a preschooler, Rosalie will speak mostly Inuktitut. However, once she enters school, she will read and hear mainly English because there are few books in Inuktitut and even fewer Inuktitut immersion classes. Rosalie will have breakfast at school, taking part in the breakfast programme offered there. Miali knows that for Rosalie to learn at school

BY THE NUMBERS

53

The percentage of Inuit children rated as being in excellent health.

58

The percentage of all children in Canada rated as being in excellent health.

46

The percentage of Inuit children who accessed a doctor in the past year.

85

The percentage of all children in Canada who accessed a doctor in the past year.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

BY THE NUMBERS

45

The percentage of Inuit children in census metropolitan areas living in low-income families.

21

The percentage of non-Aboriginal children in census metropolitan areas living in low-income families.

'Aboriginal Children's Survey, 2006: Family, Community and Child Care', Statistics Canada, October 2008, Catalogue no. 89-634-X - No. 001.

INUIT EMPLOYMENT STATUS

In 2006, the unemployment rate was just over four times higher for Inuit men than non-Inuit men, and three times greater for Inuit women than for non-Inuit women. (Twenty-three per cent of Inuit men and 15 per cent of Inuit women were unemployed.)

Statistics Canada 2006 Census.

she needs to eat healthy foods, but that won't always be possible when, in a house of eight, there are only two adults working. Without country food, the family would go hungry more often.

CAN A LANGUAGE PROTECTION ACT SAVE THE INUIT LANGUAGE?

Inuktitut is one of only three Aboriginal languages in Canada to be spoken by enough people to ensure its survival. However, the 2006 Census revealed a 10 per cent decline in the use of this language at home. The Inuit Language Protection Act, assented to on September 18, 2008, aims to address this language loss issue through supporting Inuktitut as a working language of Nunavut Territory and ensuring the right to an education in that language.

Source: Inuit Language Protection Act and Background.

As Rosalie grows up, she will often go out on the land with her grandparents to learn survival, hunting and fishing skills. She will know that many of her friends are not as lucky. Residential schooling has left many adults without the skills or ability to parent their own children, and the result is a generation that can't cope with many day-to-day responsibilities. Between 1949 and 1960, there were 6,877 Inuit students attending residential schools (Department of Northern Affairs & National Resources, Northern Administration & Lands Branch: Education Division, as cited in King, 2006: p. 5). Around the same time, Inuit were forcibly relocated into permanent settlements. In order to support the movement of Inuit to settlements, dog teams were killed, children were forced to attend school, and family allowances were offered to those who remained in the settlements. Housing was also promised.

Although permanent settlement has resulted in some positive outcomes, the dramatic socio-cultural changes that Inuit have experienced and continue to experience affect their mental, physical, emotional and spiritual health in many ways. The movement from traditional forms of subsistence to a dependence on a wage economy radically disrupted Inuit social and environmental relationships, and is recognized as a major contributing factor to social marginalization, stress and higher incidences of suicide (O'Neil, 1994, Kirmayer et al., 1998 and Wexler, 2006). Not only were parenting skills lost, but many of the traditions and customs of Inuit were not passed on to the next generation. Consequently, in some regions, the younger generation has diminished survival and hunting skills. Youth are struggling, as many youth do, but young Inuit are struggling to find their way in two worlds: the traditional Inuit way of living off the land, and also the contemporary way of life. All this has happened very rapidly with little time for adjustment. This struggle often causes conflicts, and the result is a generation trying to map out a new place in which the traditional ways meet the new, modern ways. Because of this, Rosalie will see young people coping with this by drinking and engaging in other substance abuse. Unable to see their way out of their current situation, too many of her peers will even go so far as to take their own life. The rate of suicide for Inuit is 11 times higher than the overall rate of the Canadian population (Health Canada, 2005).

GROWING UP IS HARD TO DO

Rosalie will eventually graduate high school. Most of her friends will not be graduating with her because they have dropped out of school. Only 12 per cent of Inuit men and 14 per cent of Inuit women complete high school (Statistics Canada, 2006b). Rosalie wonders what will be in store for her next and what her friends will do. She considers her options: try to find work in her community, or go away to school and attain more education. Jobs are scarce in her small community, but the idea of going away to school is daunting. Continuing her education would mean attending a southern school, far from family, friends and everything she has ever known.⁶ Growing up in a small, isolated community, she has gone through school with the same people her whole life. She has lived in the same community and knows everybody; everything is so familiar, and she wonders if she could survive alone in a big city where everything will be new. The cost of travel is considerable, and her family won't be able to come for weekend visits, so Rosalie knows she will need to be dedicated should she decide to go. Busy city streets, no family close by ... it almost turns her away from continuing with her education.

Rosalie has a younger sister, Annie, who is 15. Annie confides to Rosalie that she is pregnant and scared and doesn't know what to do. Rosalie spends some time with her sister comforting her, and afterward realizes that she really does want to continue her education past high school so she can return home and help her family and her community. Rosalie sees the need for more health care workers and begins to consider the Inuit midwifery programme she heard about at a career fair. She thinks it might be the programme for her because it integrates both traditional Inuit ways and contemporary Western medicine.⁷ Rosalie will not have to travel as far from her home and is thankful to only have to go to the regional school, which is three hours away by plane. Rosalie is up for the challenge!

A BRIGHT AND PROMISING FUTURE

There are no easy solutions to the health-related issues described in this story, yet this scenario, while fictional, portrays the reality of many Inuit children, families and communities in the Arctic. There are no quick fixes or band-aid solutions that will bring about meaningful, long-term change; solutions must be multi-faceted and multi-jurisdictional. Inuit know that change is needed and that youth are the key. According to Statistics Canada's 2006 Census, 35 per cent of Inuit were under the age of 15. Improving access to services and programmes targeted at children and youth, and their parents, must be a priority in efforts to address the health inequities faced by Inuit. And these initiatives must be community driven to be viable for the unique contexts in which Inuit live.

BY THE NUMBERS

59

The percentage of Inuit children breastfed for longer than six months.

34

The percentage of all children in Canada breastfed for longer than six months.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

TEEN PREGNANCY

The median age of an Inuit mother at the birth of her first child is 19 years, compared to the national age of 26 years. While teen pregnancy rates have been declining, Nunavut still has the highest teen pregnancy rate in Canada at a rate of 161.3 children per 1,000 women.

Bjerregaard and Young, 1998, p. 87, as cited in Pauktuutit: Inuit Women of Canada & Archibald, 2004, p. 5.

ENDNOTES

- 1 "Country food includes such things as caribou, whales, seals, ducks, arctic char, shellfish and berries among others." (Statistics Canada, 2001c, p. 9.)
- 2 Sharing is an expectation for everyone in Inuit communities. One's status and value as a leader within the community is highly regarded. Self-interest and self-promotion are viewed as impediments to the family, community and social structure.
- 3 See, for example, Hassol (2004) for more information about the potential impacts of climate change on food security for Inuit peoples.
- 4 Food insecurity has been a major issue for Inuit (see, for example, results from an INAC survey addressing food security among Inuit households at http://www.ainc-inac.gc.ca/ps/nap/air/rep2003/hsr_e.html). One attempt to address the issue is the Government of Canada's Food Mail Project, a programme that pays part of the cost of shipping nutritious perishable food and other essential items to isolated northern communities. (For more information, visit http://www.ainc-inac.gc.ca/ps/nap/air/1brofoomai_e.html.)
- 5 Kirmayer, Brass and Tait (2000) argue that "language is a basic conveyor of culture" and that culture is intimately connected to the mental health and well-being of Aboriginal peoples.
- 6 For those who do graduate, the need to attend post-secondary institutions away from home imposes a financial burden that many cannot afford. Options for accessing financial assistance are limited.
- 7 There have been a number of recent initiatives to provide women with low-risk pregnancies more opportunities to deliver within their own communities or closer to home and in a familiar environment. These initiatives have utilized local health centres and midwives. See, for example, Couchie and Sanderson (2007).

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**Is Canada failing Métis children?
AN EXAMINATION OF THE CHALLENGES AND
BARRIERS TO IMPROVED HEALTH**

Caroline L. Tait

INTRODUCTION

In a country as affluent and stable as Canada, it is surprising that poverty and despair persist for some people at levels comparable to conditions in some of the poorest countries in the world. For a large number of Canadian Métis children, being vulnerable to endemic poverty, food insecurity, social marginalization and violence has been a way of life for their whole life. The European colonization of Canada led to some of the most destructive government policies anywhere in the world, policies that brought about the decimation of Métis as well as First Nations and Inuit populations by infectious disease, violence, and the active suppression of culture and identity (Kirmayer, Brass and Tait, 2000:608). These policies set the stage early in Métis history for a legacy of social inequities and poor health that persists even now and is most evident in the health and social status of Métis children.

Although we can identify some of the challenges to improving the health of Métis children, there is a lack of specific data on Métis people. Unfortunately, we do not have an evidence-based foundation on which to build culturally sound and effective health care and social-service policies and programming to directly address the needs of Métis children. From the research evidence that does exist, it is clear that on almost all quality-of-life indicators, Métis children do not fair well compared to non-Aboriginal children (National Council of Welfare, 2007:24). While some of the known disparities and their sources can be tackled through improved supports and services for Métis children and families, others, such as endemic poverty and structural inequities, present challenges that require broad-based changes to public policy at federal, provincial and territorial levels. Without political and social will that acknowledges and acts on the unique configuration of health determinants affecting the well-being of Métis children, it is unlikely that we can make real and sustained improvement.

MÉTIS DEMOGRAPHICS: A YOUNG AND GROWING POPULATION

Métis people represent approximately one-third of Canada's Aboriginal population. Results from the 2006 census indicate that in the past decade the Métis population has significantly increased, outpacing the growth of both First Nations and Inuit, as well as the non-Aboriginal population (Statistics Canada, 2006c). In 2006, an estimated 389,785 people reported they are Métis, almost double the number in 1996. While some of this increase can be attributed to high fertility rates, there has also been an increase in individuals reporting their Métis identity in census data. Approximately 87 per cent of Métis live in either the western provinces of British Columbia (59,445 or 15 per cent), Alberta (73,605 or 22 per cent), Saskatchewan (48,115 or 12 per cent) and Manitoba (71,805 or 18 per cent), or in Ontario (73,605 or 19 per cent). In the remaining provinces and territories, the number of Métis is smaller. Quebec's Métis population is 27,980, and the Atlantic provinces' is 18,805. Only 1 per cent of Métis live in the northern territories (4,515) (Statistics Canada, 2006d).



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 Liam Sharp

“Throughout our history, attacks on our identity as a people have been at the core of oppression, marginalization and social health problems that we have experienced. The legacy of the ‘half breed’ has often left our people confused about their identities, their own culture, lands and language. However, despite ongoing diversity, Métis people remain steadfast in their resilience and resolve as a distinct people. As a people, I know that it is our children and our future generations who will walk with pride declaring — I am Métis!”

– Kathie Pruden-Nansel
 Métis activist
 Saskatoon Indian Métis
 Friendship Centre
 Saskatoon, Saskatchewan

BY THE NUMBERS

39

The percentage of Métis children breastfed for longer than six months.

34

The percentage of all children in Canada breastfed for longer than six months.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

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The 2006 Canadian census (Statistics Canada, 2006a) found that compared to the non-Aboriginal population as a whole, Métis, are young; 25 per cent of the population is under 14 years of age. This is a significantly higher proportion of children than the non-Aboriginal population (17 per cent). Saskatchewan has the highest percentage of Métis children with children making up almost a third (29 per cent) of the Métis population (Statistics Canada, 2006a).

In 2006, the majority of Métis children aged 14 and under (65 per cent) lived with two parents, while 31 per cent lived with a lone parent. Two per cent lived with a grandparent (without a parent present in the home), and another 2 per cent lived with another relative. Fewer than 1 per cent lived with a non-relative. The likelihood of living with a lone parent was higher for Métis than for non-Aboriginal children but lower than for First Nations children. In 2006, the percentage of Métis children living with a single-parent mother was 27 per cent, similar to the 28 per cent in 2001 and double the figure for non-Aboriginal children (14 per cent in both 2001 and 2006). Only 4 per cent of Métis children lived with a single-parent father, similar to the proportion of 3 per cent among the non-Aboriginal population (Statistics Canada, 2006e). There is no doubt that, in terms of family income and poverty levels, family structure definitely has an impact.

Métis people are becoming increasingly more urbanized and, like urban First Nations and Inuit, are highly mobile compared to their non-Aboriginal counterparts. They are twice as likely as non-Aboriginal people to move in a given year (National Council of Welfare, 2007:17). The National Council of Welfare states that the implications of high mobility can have negative consequences for children. It can contribute to family instability and breakup, economic marginalization, and high victimization and crime rates. It can disrupt the delivery of health, social and education services. In urban areas, it can negatively impact cultural development, and weaken social cohesion in Métis and broader communities and neighbourhoods (National Council of Welfare, 2007:17-18). These factors are exacerbated when children live in lone-parent and/or low-income/high-need families.

CHALLENGES TO IMPROVING CHILDREN'S HEALTH

Métis children are uniquely vulnerable to compounding health and social disparities because they lack access to programmes and services that the federal government provides to status First Nations and Inuit children through Health Canada's Non-Insured Health Benefits Program. This jurisdictional limitation is historically embedded in the structural marginalization of the Métis by federal government policies that fail to fully recognize Métis identity and rights (Lamouche, 2002). Such exclusion contributes to health disparities among Métis children by adversely affecting how they and their families access health services, even though these individuals may live in the same families or communities as those who are eligible (National Council of Welfare, 2007:70). Métis children have access to mainstream services; however, little or no attention is paid to their specific cultural or geographical needs. This results in many Métis parents experiencing barriers to health care for their children, barriers that non-Aboriginal families or, in some instances, neighbouring First Nation reserve communities do not face. While the federal government has included Métis in recent Aboriginal

initiatives, equitable funding to that of First Nations and Inuit has not been forthcoming (National Aboriginal Health Organization, 2004e).

One of the challenges to understanding the health status of Métis children is the lack of specific health data on the Métis. Generally, health data collected on Métis people is included in the 'Aboriginal' category, with no disaggregation between Métis and First Nations or Inuit participants (Health Canada, 2006). General census data does provide some Métis-specific data; however, only limited information on health status is collected (Bourassa, 2005:9). Currently, there is no Métis-specific data for life expectancy at birth, infant mortality or deaths by suicide. Most of the current statistical data stems from Canada's Aboriginal Peoples Survey (Statistics Canada, 1991, 2001). What these studies reveal is that, when compared to non-Aboriginal children, Métis and other Aboriginal children share a similarly disadvantaged socio-economic and health profile (National Aboriginal Health Organization, 2004e).

In 2002, the National Aboriginal Health Organization (2004a) completed a 'snapshot' of Métis health information, initiatives and programmes. It found that, in general, programming for Aboriginal people in Canada considers "[the Métis] as an afterthought in their design and implementation" (p. 1). This stems directly from an increased use of the category 'Aboriginal' in the design of programmes and services for off-reserve Aboriginal peoples, as well as pointing to other structural challenges. For example, while the federal government provides health care funding, the implementation of health care programmes and services is a provincial responsibility. Under current federal transfer arrangements, the Métis do not have access to provincial health programme funding resulting from transfer funding. As well, Métis children do not receive similar local, provincial or federal health care infrastructure to Inuit and First Nations children in the delivery of programmes and services (National Aboriginal Health Organization, 2004a, b).

In a provincial review of Aboriginal health, Saskatchewan researchers found that while Métis communities report health issues similar to those of First Nations, they lack the infrastructure, skills and capacity to conduct research on the health of their people (Sinclair, Smith and Stevenson, 2006:43). A lack of research data documenting the health status of Métis children makes it extremely difficult for Métis organizations to argue for national or provincial funding to address the unique health needs of their children. Unfortunately, a lack of human and financial resources at all levels of government makes it difficult for Métis communities and organizations to participate in research. Research partnerships require a high level of commitment, and the participation of Métis communities and organizations would risk a further overburdening of their already heavy workloads.

ROOT CAUSES: SOCIAL DETERMINANTS OF MÉTIS CHILDREN'S HEALTH

Social disparities directly impact the health and well-being of any group of children. However, because of compounding social disparities, Métis children are at increased risk of experiencing poorer health than non-Aboriginal children. Household disparities – such as low socio-economic status, social exclusion, employment and job insecurity, low education levels, food insecurity and

BY THE NUMBERS

56

The percentage of Métis children rated as being in excellent health.

58

The percentage of all children in Canada rated as being in excellent health.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

BY THE NUMBERS

42

The percentage of Métis children in census metropolitan areas living in low-income families.

21

The percentage of non-Aboriginal children in census metropolitan areas living in low-income families.

'Aboriginal Children's Survey, 2006: Family, Community and Child Care', Statistics Canada, October 2008, Catalogue no. 89-634-X - No. 001.

inadequate housing – collectively contribute to poor health among Métis children (Statistics Canada, 2006b, d). For example, overcrowding escalates the risk of transmitting infectious diseases, such as tuberculosis and hepatitis A, and increases the risk of injuries, mental health problems, family tension and violence. Low-income Métis families are particularly prevalent in Quebec, Manitoba and Saskatchewan, where one-third of Métis children live in low-income households. Métis children are more likely than non-Aboriginal children to be living in homes below the Canada Mortgage and Housing Corporation's housing standards (National Council of Welfare, 2007:68).

Women's incomes are particularly important to Métis children's well-being because their families tend to be larger, and lone parenthood is relatively more common for Métis women than for non-Aboriginal women (National Council of Welfare, 2007:23). Social assistance payments that are grossly inadequate to address the needs of women and their children can be a barrier to the ability of Métis women to leave or avoid abusive relationships, and to assert themselves independently (National Council of Welfare, 2007:29). This barrier has a direct impact on the health and well-being of the children.

Similar to other young Aboriginal women, Métis women are particularly vulnerable to experiencing domestic violence, working in the sex trade and experiencing gang violence (National Council of Welfare, 2007). Along with this vulnerability comes the increased risk that their children will become victims of violent crimes or be apprehended by child welfare authorities (National Council of Welfare, 2007). Poverty also appears to be directly linked with the disproportionate number of Métis children who are taken into the care of child welfare agencies each year in Canada. Reporting on Métis children in care, Barkwell and colleagues (1989) conclude that many Métis children are taken into care "for no other reason than the real life Métis situation of living in poverty and overcrowded conditions. In effect Métis children are frequently being alienated from their families, their communities and their culture for economic reasons. Such children often are condemned to a succession of foster homes, thus creating a terrible instability in their lives which defeats the reasons for taking them into care in the first instance" (1989:34). Barkwell and colleagues (1989) point to a tragedy that has persisted through multiple generations of Métis children, and indeed with other Aboriginal children: unacceptably high rates of social ills.

There is also a link between poor childhood social and economic conditions and high rates of youth in custody. A 2004 one-day snapshot of Aboriginal youth in the justice system found that:

- 47 per cent of Aboriginal youth in custody came from families receiving social assistance
- 39 per cent were involved with child protection agencies at the time of their admission and of these, one in four was a ward of the state
- Grade 8 was the highest average grade completed at the time of the admission to custody; only 2 per cent of Aboriginal youth in custody aged 18 and older had a high school diploma
- 57 per cent had a confirmed drug problem, and 24 per cent had a suspected substance abuse problem

(National Council of Welfare, 2007:99)

The over-representation of Métis children and youth in the child welfare and justice systems is the result of a range of complex factors that contributes to current conditions. If we are to improve the lives of these children and youth, then we must address the social determinants that contribute to their vulnerability.

POLITICAL AND SOCIAL WILL MUST DRIVE CHANGE

There is no doubt that there is a clear gap in the research literature documenting the health and social status of Métis children. Along with existing structural gaps and barriers within federal and provincial/territorial health and social service sectors, this gap significantly hinders the development of culturally appropriate programmes and services to address the health and social needs of Métis children. The National Council of Welfare states that “existing problems related to Aboriginal child and youth poverty are only likely to increase in the future, if not adequately addressed in the present” (National Council of Welfare, 2007:7). For many Métis children, the reality of being born into a world of poverty and marginalization places their health and well-being at significant risk. In a country that prides itself on caring for its most vulnerable, it is clear that for Métis children, Canada’s commitment has fallen short. Without clear political and social will, improvements to the health status of Métis children will not be realized. Instead, current and future generations of children will suffer from poor health and despair.

We can make change and, while not exhaustive, the following recommendations begin to address the existing gaps in research, and health and social-service delivery to Métis children.

- 1) Enhance partnerships between federal, provincial and territorial governments as well as Métis leaders and stakeholders to increase involvement in the design, development and delivery of health and social services for Métis children.
- 2) Increase national and provincial/territorial research funding aimed at improving the health and social status of Métis children, including financial support for Métis communities and organizations to participate in building their own equitable and strong research/community partnerships.
- 3) Equalize health and social services for Métis, First Nations and Inuit children, as well as offer parity with those services available to other Canadian children.
- 4) Modify best and promising practices for health and social-service care to fit the cultural and social realities of Métis children.
- 5) Create an ethical framework to guide research, programme and service delivery that places the well-being of Métis children at its centre; at the same time, make sure there are evaluation mechanisms to gauge substantial, measurable improvement in the health and social outcomes for Métis children.

BY THE NUMBERS

45

The percentage of Métis children with chronic health conditions.

77

The percentage of Métis children who accessed a doctor in the past year.

85

The percentage of all children in Canada who accessed a doctor in the past year.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

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**Urban Aboriginal children in Canada:
BUILDING A SOLID FOUNDATION FOR
PROSPERITY AND CHANGE**

Geraldine King



In the early morning of January 30, 1980, in a downtown Toronto hospital, a 17-year-old Ojibwa girl is alone in a hospital bed experiencing the trauma, fear and the unknown associated with the birth of a first child. Despite her pregnancy occurring at a very young age, she vows to keep her baby and give the child the life she never had. She declares that the child will never go hungry, never spend a night in a homeless shelter and never experience domestic abuse. She swears that her child will not become a statistic.

© Courtesy "Val d'Or Native Friendship Centre/Centre d'amitié autochtone de Val-d'Or/Paul Brindamour

"Discover and embrace the gifts you have to offer. Have the courage to share and celebrate these gifts with the world around you."

– Carey Calder, Ojibwa youth

Geraldine King is an Ojibwa from Kiashke Zaaging Anishinabek (Gull Bay First Nation) in northwestern Ontario. Presently, Ms. King is the communications officer for the National Association of Friendship Centres. As an aspiring creative writer, she believes that nurturing expression through art and culture is integral to strengthening indigenous nations.

While the lives of urban Aboriginal children have been improving over the past decades, there are still many challenges that could prevent Aboriginal mothers from fulfilling such an oath. Most people probably do not think of Canada as a place where many urban Aboriginal children face extreme poverty, have low levels of education and poor literacy rates, and find themselves in abject homelessness. For many First Nations, Inuit and Métis children living in urban centres, these conditions are a reality. In a country that boasts one of the highest standards of living in the world, it is simply unacceptable for urban Aboriginal children to be living in extreme poverty.

One important factor in the equation is that the health of urban Aboriginal children depends on the socio-economic conditions of their mothers. How exactly does a 17-year-old with little education or skills, and a meagre support system raise a child? Not only did this young Aboriginal teen have to face systemic racism, poverty, unemployment and despair, she had to do it without access to the tools necessary to build a healthy and prosperous life. Facing the world in this unequipped state is much like a mason trying to lay bricks without a trowel. Despite the incalculable strength, resolve and determination of such young women, the foundation of their ambitions cannot be built without the proper tools. The challenges this young, pregnant, Ojibwa girl faced are the same challenges that many urban Aboriginal people face today. Statistics Canada census data (2006 and 2001) detail these challenges.

ALARMING INEQUITIES FOR ABORIGINAL PEOPLE

Statistics show that Aboriginal people face health challenges caused by a range of socio-economic factors. In 1996, the Royal Commission on Aboriginal Peoples conducted exhaustive research and analyses on the state of Canada's Aboriginal people. One of their key findings:

Aboriginal people are at the bottom of almost every available index of socio-economic well-being, whether [they] are measuring education 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.¹

Much has changed over the past decade since the Royal Commission report, including a clearer recognition of the link between socio-economic conditions and health status. We have made progress in lowering Aboriginal infant mortality rates, increasing educational attainment levels,² and improving housing conditions.³ Nevertheless, there are still stark inequities between urban Aboriginal and non-Aboriginal children and their families.

A GROWING, INCREASINGLY URBAN POPULATION

New data from the 2006 census show that the number of people who identified themselves as Aboriginal has surpassed the 1 million mark. Their share of Canada's total population is on the rise. Between 1996 and 2006, the Aboriginal population grew by 45 per cent, nearly six times faster than the 8 per cent rate increase for the non-Aboriginal population. Some of this growth is related to fertility rates, which are much higher for Aboriginal women than for other Canadian women. Between 1996 and 2001, the fertility rate of Aboriginal women was 2.6 children; that is, they could expect to have 2.6 children, on average, in their lifetime. This compares with 1.5 children among all women in Canada.⁴

The Aboriginal population is becoming increasingly urban. In 2006, for example, 54 per cent lived in an urban centre, a 4 per cent increase since 1996. Urban areas include large cities, or census metropolitan areas, and smaller urban centres. According to the 2006 census, children and youth make up a particularly large share of the Aboriginal population in several urban areas that are already home to a large number of Aboriginal people. In three urban areas, more than half of the Aboriginal population is aged 24 and under: Regina (56 per cent), Saskatoon (55 per cent) and Prince Albert (56 per cent).⁵

POVERTY

Poverty is prevalent for Aboriginal families living in urban settings. For example, in urban centres with fewer than 100,000 people, approximately 43 per cent of Aboriginal children under the age of 15 were found to be living in low-income families, compared to 17.4 per cent for non-Aboriginal children.⁶ For larger cities with more than 100,000 people, this contrast is even more evident, with 50 per cent of Aboriginal children under age 15 living in low-income housing, compared to

BY THE NUMBERS

57

The percentage of First Nations children in census metropolitan areas living in low-income families.

21

The percentage of non-Aboriginal children in census metropolitan areas living in low-income families.

¹Aboriginal Children's Survey, 2006: Family, Community and Child Care', Statistics Canada, October 2008, Catalogue no. 89-634-X - No. 001.

BY THE NUMBERS

78

The percentage of First Nations children off-reserve who accessed a doctor in the past year.

85

The percentage of all children in Canada who accessed a doctor in the past year.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

21 per cent of non-Aboriginal children.

Some of the poverty can be attributed to the incidence of Aboriginal children who live with a lone parent. Compared with their non-Aboriginal peers, Aboriginal children are much more likely to live with a lone parent of either sex, a grandparent (with no parent present) or with another relative. The 2006 census data indicates that 26 per cent of Aboriginal children under the age of 15 live with a lone mother, compared to 6 per cent who live with a lone father.⁷ This indicates one major disadvantage that many single Aboriginal mothers face over Aboriginal men – on average, being solely responsible for looking after more children.

LACK OF EDUCATION AND UNEMPLOYMENT

Data also frequently show that, in terms of participation in the labour force, urban Aboriginal women face striking disparities compared to the rest of the Canadian urban population. In 2001, the gap between the employment rates of Aboriginal and non-Aboriginal women was particularly high in the 15 to 24 age group, in which 35 per cent of Aboriginal women versus 57 per cent of non-Aboriginal women were employed.⁸

Lack of education for Aboriginal mothers – giving them access to higher paying jobs – is another impediment to the health of urban Aboriginal children. Results from the 2003 International Adult Literacy and Skills Survey (IALSS) show that well over half of urban Aboriginal women in Saskatchewan and Manitoba had reading literacy skills below the level generally regarded as necessary for full participation in social and economic life in Canada. The IALSS found that over 70 (71.7) per cent of urban First Nations women in Saskatchewan and almost 70 (68.9) per cent of urban First Nations women in Manitoba had low prose literacy scores. Among urban Métis women in Saskatchewan and Manitoba, the corresponding percentages were 52.4 and 51.7, respectively. In comparison, 35.6 per cent of urban non-Aboriginal women in Saskatchewan and 41.2 per cent in Manitoba had low literacy scores.⁹

INADEQUATE HOUSING AND VIOLENCE IN THE HOME

Further, an inability to access adequate housing has a significant impact on people's lives, including their health. According to 2006 census data, Aboriginal people are four times more likely to live in overcrowded housing than are non-Aboriginal Canadians. As well, Aboriginal people are three times more likely to live in housing that is in need of major repairs.¹⁰

In this regard, in 2007, the National Association of Friendship Centres (NAFC) produced a policy paper to present at the National Aboriginal Women's Summit (NAWS). Titled 'Urban Aboriginal women: Social determinants of health and well-Being', the policy paper states, in part:

*Aboriginal housing encompasses not only the building structure but also the environment in which the housing is situated. This includes provision of safe drinking water, disposal of sewage and garbage, dependable electrical supply, communications (telephone), transportation and other services. The number of people being housed and their socio-economic status is also part of housing, as the 'Regional Health Survey 2002/03 – Report on First Nations housing' determines that "there appears to be a link between crowding and lower socio-economic status.... Adequate housing, a fundamental human right, is a key link to education, health, economic opportunities and employment outcomes."*¹¹

The incidence of violence in the home also affects urban Aboriginal women and their ability to care for their children. According to Statistics Canada, 24 per cent of Aboriginal women said they had suffered violence from a current or previous spouse or common-law partner in the five-year period up to 2004.¹²

*"Research studies have demonstrated that, as the gap in income equality widens, the social environment deteriorates, trust decreases, involvement in the community declines, population health deteriorates, and the incidences of hostility and violence increase."*¹³

The nature of violence is multi-faceted, and a complex range of factors increase the risk of violence.¹⁴ Aboriginal women often move to urban centres to escape the violence and poverty occurring on-reserve, only to face the same conditions within urban settings.

A STRENGTH OF SPIRIT

As stated in NAFC's 'Urban Aboriginal women: Social determinants of health and well-being':

*There have been a number of national strategies undertaken to "close the gap" in health outcomes for all Aboriginal groups. Health Canada's 2005 Blueprint on Aboriginal Health, for example, includes 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."*¹⁵

Tackling these persistent health inequalities must involve identifying the roots of the social, physical and economic conditions in which urban Aboriginal women and children live. To the average urban Aboriginal mother with little education and few marketable skills, the census information collected about her does not translate into food, clothing or adequate housing. Data tables cannot be eaten, nor will an executive summary transport her children to dentist appointments.

BY THE NUMBERS

44

The percentage of First Nations children off-reserve with chronic health conditions.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

BY THE NUMBERS

54

The percentage of First Nations children off-reserve rated as being in excellent health.

58

The percentage of all children in Canada rated as being in excellent health.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

The question must be asked again: How exactly does a 17-year-old, with few employable skills, raise a child? Coming from a pedigree of strong-willed women and those who survived cultural genocide, she is no stranger to struggle and the historical subjugation of her spirit. Experiencing conditions that are highly inequitable compared to the rest of non-Aboriginal Canadians is her reality and the daily struggle faced by many urban Aboriginal children. Oftentimes, children share a room with other family members, regularly access soup kitchens, and sometimes receive clothes only when donations are available at the local church or Friendship Centre. Poverty and substandard housing have been linked to higher rates of child apprehension into the welfare system.¹⁶ This has led to the placement of many Aboriginal children into foster homes with non-Aboriginal families, leaving them cut off and disconnected from their roots and culture. While well-intentioned, many of these non-Aboriginal foster families have little sensitivity to Aboriginal issues or their unique cultural intricacies.

While our focus has been to shed light on the living conditions of urban Aboriginal families and their influence on children's health, much can be said about the Aboriginal strength of spirit and its ability to triumph over a litany of obstacles and challenges. Many urban Aboriginal people today enjoy a deep-rooted sense of family, community, culture and connection to their homes. This dedication to children and families, grounded in traditional values and customs, is a source of strength and resiliency that is integral to improving the lives of urban Aboriginal children. By preserving and enriching Aboriginal culture, language, teachings and customs, Aboriginal Friendship Centres across Canada are a key element of this resiliency.

FRIENDSHIP CENTRES: MAKING URBAN CONNECTIONS

Language and customs are integral to maintaining a sense of identity and pride, a key element in the health and well-being of Aboriginal peoples. For many urban Aboriginal youth and children, the Aboriginal Friendship Centre Program provides a key connection to Aboriginal culture, spirituality and communal nature, and a key foundation to improving their health and well-being. Aboriginal Friendship Centres "support and assist urban Aboriginal youth across Canada in enhancing their economic, social, cultural and personal prospects."¹⁷ Their doors are open to everyone.

Operating in more than 117 cities across Canada,¹⁸ Friendship Centres are the country's most significant off-reserve Aboriginal service infrastructure. They offer a "range of cultural, social, and recreational programming that strengthens Aboriginal families and communities, and empowers individuals to reach their goals."¹⁹ On any given day in a Friendship Centre, people enjoy free meals, receive clothing, obtain training, look for employment and participate in cultural events, just to name a few activities. The centres play a role in bettering the lives of many urban Aboriginal families. For children, some of the centres offer summer camps, play groups, and the opportunity to make traditional dance regalia and crafts. A range of programmes and services is offered to women, including programmes targeted at young mothers, victims of abuse and survivors of trauma. In essence,

Friendship Centres strive to provide the tools necessary for urban Aboriginal people to succeed in all areas of Canadian society and live healthier lives.

Education is extremely important in the Friendship Centre Movement. Fifty-eight Friendship Centres provide education-specific programming through 103 separate programmes. These include critical services such as headstart, tutoring, literacy, adult education, alternative high schools, legal education and bursaries. Through the component of education, Friendship Centres manage to leverage over \$11.5 million in revenues to provide educational services to more than 87,000 clients. In specific areas of adult education/alternative high schools, 16 Friendship Centres provide this service, which has approximately \$1.05 million in revenues and more than 7,000 clients every year.

Because of a critical need for 'gang reduction' strategies in urban areas, four Friendship Centres offer specific programmes to address the issue. Most of the programmes focus on Aboriginal youth and serve more than 11,000 clients, generating approximately \$300,000 in revenues.

In addition, 35 Friendship Centres offer 78 justice programmes, including a fine (rather than incarceration) option, restorative justice, advocacy, court worker assistance, diversion programmes and community circles. More than 30,000 clients are served and over \$4.4 million in total revenues is generated through Friendship Centre justice programmes.

TAKING IT GLOBAL

The international indigenous collective has long recognized the strength of its own communities to address specific issues such as discrimination, urbanization, drug and alcohol abuse, child trafficking and disease. As one of the most significant elaborations of contemporary Aboriginal self-determination in Canada, NAFC stresses the importance of asserting fundamental human rights. It is NAFC's intention to collaborate with indigenous people worldwide in the hope of strengthening the unique cultural identities of the world's urban indigenous communities.²⁰

Most recently, the final report of the United Nations Permanent Forum on Indigenous Issues, Seventh Session, states:

"... that the National Association of Friendship Centres in Canada is an example of a good practice model for developing indigenous peoples' centres in urban areas that should be replicated."²¹

In the global village that spans the earth, no child should worry about where they will sleep at night or go to bed hungry. No child should ever have to experience terror, or shame, or abuse. All children should be given the same opportunity to enjoy life, regardless of where they live.

ADVOCATING FOR CHANGE

Aboriginal families have many different reasons for leaving the reserve or settlement and migrating to urban areas, but for many, the realities are the same. Not only do many Aboriginal children live in physically abhorrent conditions, they suffer from a lack of outside sensitivity to their unique socio-economic issues.

Although a significant stride toward reconciliation has begun between the federal government and Canada's Aboriginal peoples, there are still critical gaps in funding to enhance programmes and services so they meet the unique cultural and holistic needs of Aboriginal people, particularly children. In 1989, the House of Commons voted unanimously to seek to end child poverty in Canada. Why is it that so many urban Aboriginal children have been left behind?

NAFC passionately believes that these unrelenting disparities between the quality of life for Aboriginal and non-Aboriginal Canadians must cease to exist. Friendship Centres play an important role in providing urban Aboriginal children and youth with the necessary tools to enhance the quality of their lives and better their life chances. Cultural, counselling, wellness and recreational programmes targeted at improving health and well-being, to programmes geared to enhancing educational prospects and steering urban Aboriginal youth away from destructive paths, all contribute to these goals. The centres also play an important role in advocating for the Aboriginal perspective in the highest level of policy and decision-making processes that affect the lives of Canada's urban Aboriginal population.

Ojibwa oral history²² tells us that when the Earth was young it had a family – Grandmother Moon, Grandfather Sun, Mother Earth, and the creator of this family is the Great Mystery. All living things come from our Mother Earth, and therefore we are all related. We all admire the same Grandfather (sun) as he awakens from his slumber. Everyone stares at the same Grandmother (moon) when she watches over us at night. All of the world's children gaze at the same stars hoping to shine just as brightly and bestow their own unique cosmic halos upon humanity. It's up to us to make sure this happens.

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- 16 Trocmé, N., Knoke, D., Shangreux, C., Fallon, B., and MacLaurin, B. (2005). 'The experience of First Nations children coming into contact with the child welfare system in Canada: The Canadian incidence study on reported child abuse and neglect'. In *Wen: de: We are coming to the light of day*. Ottawa: First Nations Child and Family Caring Society of Canada. Ch. 2. www.fnfcfs.com/docs/WendeReport.pdf.
- 17 British Columbia Association of Aboriginal Friendship Centres website, www.bcaafc.com.
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- 19 British Columbia Association of Aboriginal Friendship Centres website, www.bcaafc.com.
- 20 www.nafc.ca.
- 21 'Seventh Session of the United Nations Permanent Forum on Indigenous Issues'. Page 17, #107. www.un.org/esa/socdev/unpfii.
- 22 An account of the Ojibwa creation story can be found at: www.real-dream-catchers.com/Native_American_origins/ojibwe_creation_story.htm.



Jordan's story:
HOW ONE BOY INSPIRED A WORLD OF CHANGE
Cindy Blackstock



Jordan River Anderson travels with us. I know this is true because the skies are always blue when we work on Jordan's Principle, a 'child-first' principle to resolve government jurisdictional disputes that's named in the young boy's memory. Jordan's story is a message to all levels of governments to offer all children, irrespective of geography, jurisdiction, race and circumstance, "the right care, at the right place, at the right time" (MacDonald and Attaran, 2007).



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JURISDICTIONAL DISPUTES AND THE DENIAL OF GOVERNMENT SERVICES

Jordan was born in 1999 to a large family in Norway House Cree Nation, Manitoba. What's important to know about Jordan is that he was loved by his family, he enjoyed lining his room with teddy bears, and he liked to play on the computer and listen to music. He was born with complex medical needs and remained in a Winnipeg hospital for the first two years of his life while his medical condition stabilized. While Jordan's mother, Virginia, stayed with him in Winnipeg, his father, Ernest, returned to Norway House First Nation in northern Manitoba to look after the couple's other children. During the time Jordan was in hospital, Jordan's family, Norway House Cree Nation leaders and community members raised funds to ensure that Jordan's medical transportation needs could be met once he was discharged from hospital (Lavallee, 2005). Shortly after Jordan's second birthday, his doctors agreed that he was ready to go home. But Jordan never made it. As Noni MacDonald and Amir Attaran of the *CMAJ (Canadian Medical Association Journal)* (2007) noted, "Bureaucrats ruined it."

Provincial and federal governments do not always agree on which level of government is responsible for the payment of government services for First Nations children living on-reserve, services that are routinely available to other children. When one of these jurisdictional disputes occurred, the typical practice of both levels of government was to deny or delay the provision of services to the child until the payment issue could be sorted out. In this way, the needs of governments were prioritized over considerations for the child's safety or well-being.

For Jordan, this amounted to provincial and federal bureaucrats arguing over every item related to his at-home care – while he stayed in hospital at about twice the cost (Lavallee, 2005). It is important to underscore that the services that Jordan needed were available and would have been provided if he was non-Aboriginal. Because he was a First Nations child, the federal and provincial governments insisted that they sort out which level of government would pay before Jordan went home. Days turned into weeks, weeks turned into months, and as Jordan and his family celebrated his fifth birthday, he remained in hospital. While federal and

"The hardest but most important thing you will ever do is to fully live as the person you are."

– Ryan Queskepow,
Norway House Cree Nation youth

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BY THE NUMBERS

45

The percentage of First Nations children on selected reserves rated as being in excellent health.

58

The percentage of all children in Canada rated as being in excellent health.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

provincial bureaucrats expressed their concern about Jordan's situation, they steadfastly denied their respective government's responsibility to pick up the tab. Jordan died while waiting for a resolution. He was only five, and he had never spent a day in his family's home.

We can say that two lives were lost as a result of this jurisdictional dispute. Jordan's mother, Virginia, did not have a history of substance abuse prior to Jordan's hospitalization, but the heartbreak of seeing her young son remain needlessly in hospital, and enduring the long separation from her husband and other children, likely contributed to Virginia's subsequent slide into substance abuse. Just months after Jordan passed away, Virginia died in a Winnipeg bus shelter.

A GROUNDSWELL OF ADVOCACY FOR CHANGE

Trudy Lavallee, a courageous and effective advocate for children with the Assembly of Manitoba Chiefs, first introduced me to Jordan by sharing his story at a meeting in Winnipeg shortly before his death. From the moment I heard about him, I wanted to help and began advocacy work with Norway House Cree Nation leaders; the Assembly of Manitoba Chiefs; and the Assembly of First Nations (AFN), which represents First Nations governments across Canada. Buoyed by the strength of his son's spirit, Ernest Anderson vowed this type of discrimination would never happen to another First Nations child in Canada. Those touched by Jordan and the Anderson family were galvanized by the compelling need for change, but uncertain about how to address federal and provincial government policies to make Ernest's dream come true. There was no money and only a small group of Jordan's Principle supporters at the beginning, but all knew Ernest was right, and they were determined to succeed.

When Jordan passed away in 2005, the First Nations Child and Family Caring Society of Canada was conducting a research project on First Nations child welfare, which provided a platform to study the incidence rate of jurisdictional disputes affecting First Nations children (Blackstock et al., 2005). This study found that, during the previous year, within a sample of 12 of the 105 First Nations child welfare agencies, 393 children were affected by jurisdictional disputes. The vast majority of these disputes were within, or between, the federal and provincial governments. Extending these findings to the population of 105 First Nations child and family service agencies in Canada suggested that each year, thousands of First Nations children were being denied on the basis of their race and residency the government services that are routinely available to other children.

Just as these findings were coming to light in June 2005, UNICEF Canada hosted the North American consultation on violence against children, during which Jordan's Principle to resolve jurisdictional disputes was announced for the first time (UNICEF Canada, 2005). Simply put, Jordan's Principle puts the child's interests first in any jurisdictional dispute within and between federal and provincial/territorial governments. When a dispute arises around the provision or payment of government services (such as health care, education, child welfare, recreation and other services normally enjoyed by all Canadian children) to a status

Indian or Inuit child, Jordan's Principle requires that the government of first contact pays the bill immediately – and then resolves the payment issue later.

Four months later, Jordan's Principle was formally written into the text of the *Wen: de* series of reports developed to address funding shortfalls in federal First Nations child welfare (Assembly of First Nations, 2006; Blackstock et al., 2005). In 2005, all of the provinces/territories and the federal government were notified of Jordan's Principle and asked to take immediate steps to implement it. Unfortunately, the lack of action by the federal government to address the underfunding of child welfare services for First Nations children, or to act on Jordan's Principle, resulted in the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada filing a complaint with the Canadian Human Rights Commission. The complaint, filed in February 2007, alleged that Canada was consciously discriminating against First Nations children through its national child-welfare funding policy and the ongoing jurisdictional wrangling.

Although the federal government and provinces/territories were slow to act, hundreds of Canadians and Canadian organizations stepped forward to support an online declaration for Jordan's Principle, calling on governments to move quickly to adopt and implement the principle. Early supporters included First Nations leaders; the National Youth in Care Network; the Many Hands, One Dream movement; and the Canadian Paediatric Society. Although there were no financial resources to support the Jordan's Principle movement, the small collective of supporters leveraged their relationships and speaking opportunities to share Jordan's message with the Canadian public. One of our most influential contacts was *CMAJ*, which published a strong editorial in support of Jordan's Principle (MacDonald & Attaran, 2007) and that attracted coverage from more than 70 newspapers in Canada. In spring of 2007, Jean Crowder, an NDP member of Parliament, tabled Private Members' Motion-296 in support of Jordan's Principle. Despite these positive developments, by the summer of 2007 none of the provinces/territories nor the federal government had stepped forward to endorse and implement Jordan's Principle (Canadian Paediatric Society, 2007).

In the fall of 2007, debate commenced in the House of Commons on the private members' motion. All political parties, including the Conservative government, voiced support. By the time Jordan's Principle came for a vote in the House of Commons, more than 1,400 Canadians and organizations had officially registered their support.

Ernest Anderson and his daughter Jerlene, along with other families from Norway House Cree Nation who were also affected by jurisdictional disputes, flew to Ottawa to watch the vote take place. At 5:30 p.m. on December 12, 2007, members of Parliament stood in unanimous support of Private Members' Motion-296 supporting Jordan's Principle and followed with a standing ovation for the Anderson family and all those who supported Jordan's message. It was, by all accounts, a wonderful day, but, as Ernest Anderson warned, the good that was accomplished in Jordan's name that day would be little more than a victory in name only if Canada and the provinces/territories did not immediately move to implement Jordan's Principle. The result? The federal government decided to strike a working committee to discuss implementation.

BY THE NUMBERS

35

The percentage of First Nations children on selected reserves with chronic health conditions.

Guèvremont, Anne, and Kohen, Dafna, 'Inuit children's health: A report using the 2001 Aboriginal Peoples Survey (Children and Youth Component)', Statistics Canada, Ottawa, 28 September 2007, www.statcan.gc.ca/pub/89-627-x/89-627-x2007003-eng.htm.

BY THE NUMBERS

22

The percentage by which child welfare services are underfunded for First Nations children relative to Canadian children on average.

First Nations Child and Family Services Program – Indian and Northern Affairs Canada of the May 2008 Report of the Auditor General, Report of the Standing Committee on Public Accounts, March 2009, www.fnfcfs.ca/docs/402_PACP_Rpt07-e.pdf.

GATHERING PROVINCIAL/TERRITORIAL GOVERNMENT SUPPORT FOR JORDAN'S PRINCIPLE

On January 24, 2008, British Columbia Premier Gordon Campbell announced that B.C. could become the first province to endorse Jordan's Principle (Campbell, 2008). On May 20, 2008, Dr. Jon Gerrard, a Manitoba Liberal legislature member, introduced Bill 233 to force the provincial government to implement Jordan's Principle. Sadly, the government of Manitoba did not support Dr. Gerrard's proposal, which would have ensured that all children in Manitoba receive equal access to provincial government services. Instead, the Manitoba government chose to only partially implement Jordan's Principle for a small number of children experiencing complex medical needs. Jordan's legacy was meant to create equality for all children – not to be applied on a selective basis. In short, the Manitoba government still needs to ensure that race is not a criterion for the delivery of government services.

More recently, the government of Ontario announced its support for Jordan's Principle and although it plans to begin implementation for children with special needs, it has acknowledged the need to apply Jordan's Principle across health and social programmes in the province.

Meanwhile, jurisdictional disputes continue to negatively affect the lives and health of First Nations children. As of May 2008, as the governments of Manitoba and Canada engaged in a jurisdictional dispute concerning payment for children's special-needs care, 37 children in Norway House Cree Nation faced unnecessary placement in foster care. Norway House Cree Nation used their own revenue to provide the life-saving and wellness services these children needed, while the governments continued to argue that they lacked sufficient funds. The only remaining way to pay for the services was to place the children in foster care, even though there was no abuse or neglect. CTV News coverage of the story (CTV News, 2008a) resulted in federal Health Minister Tony Clement making a statement to CTV News on May 4, 2008, that services for the 37 families would not be interrupted and that he regretted the stress the dispute had caused them (CTV News, 2008b). Minister Clement went on to say that his department would undertake to identify other similar situations and intervene before a crisis was reached.

While the minister's announcement was an encouraging sign that the federal government might have been ready to fully implement Jordan's Principle, the government chose to rely on a case-by-case approach instead of systemically dealing with the problem so that every child could benefit. Only days later, in a statement made in the House of Commons, MP Jean Crowder pointed to another case of a critically ill First Nations child in Manitoba being deprived of basic medical care for years because of a jurisdictional dispute between the provincial and federal governments (Crowder, 2008). It appeared that, despite reassuring language, little progress had been made.

Only two days after Minister Clement's announcement, the auditor general of Canada, Sheila Fraser, released her report on the Department of Indian Affairs and Northern Development's funding for First Nations child welfare on reserves. Along with finding that the current funding formula and the government's proposal for a replacement formula were both inequitable, the auditor general suggested the

need for the federal government to resolve jurisdictional issues affecting service provision to First Nations children on reserves – and specifically cited Jordan's Principle (Office of the Auditor General of Canada, 2008).

JORDAN'S LASTING LEGACY

Jordan's Principle is now the most widely supported child policy movement in recent Canadian history. It is an example of what can be accomplished when a group of committed people stand up against injustice for the best interests of children, leveraging their networks and talents to bring about change, even without financial resources. However, the question remains: Why won't Canada vigorously and fully implement Jordan's Principle without delay? We must have an immediate answer: First Nations children are dying, and their best interests and safety are being jeopardized while waiting for governments to do the right thing.

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THE CONVENTION ON
THE RIGHTS OF THE CHILD

