First Nations Wholistic Policy and Planning

A Transitional Discussion Document on the Social Determinants of Health

September 2013
Production of this material has been made possible through a financial contribution from the Public Health Agency of Canada through the National Collaborating Centre for Aboriginal Health.

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1. Executive Summary

The statistics are unconscionable. First Nations people suffer a disproportionately higher rate of morbidity across most diseases including, but not limited to, diabetes, heart disease, tuberculosis and HIV/AIDS. Despite the staggering statistics, numerous examples from across the country can be found of individuals, families, Nations, tribal councils and regional organizations demonstrating resiliency and building healthier First Nations individuals and communities.

Improving First Nations health and overall wellbeing requires the development of meaningful partnerships between First Nations communities, non-First Nations governments and non-governmental organizations both domestically and internationally. These partnerships must be grounded in an understanding of wellness that moves beyond biomedical and epidemiological understandings of illness to address the unique historical, economic, political and social factors impacting the wellness of First Nations.

The mandate of the Assembly of First Nations (AFN) includes working to protect, maintain, promote, support and advocate for the inherent, treaty and constitutional rights of First Nations, including sustainable and equitable funding, as well as First Nations’ control over the development and delivery of all health and wellness services and programs. Consequently, the First Nations Wholistic Policy and Planning Model (FNWPPM) was developed by the AFN in 2005 as an initial step towards a First Nations controlled and sustainable health system that adopts a wholistic and culturally appropriate approach to wellness. This model, originally based on the World Health Organizations (WHO) approach to social determinants of health (SDOH), identified numerous determinants of First Nations health that extended far beyond issues of health care and service delivery. The WHO’s definitions of SDOH provided a foundation for the AFN to identify determinants that were First Nations specific.

Although the model was a positive initial step, AFN Public Health Experts, in March 2013, decided that the FNWPPM needed to be reviewed and updated, as the model lacked certain features important to First Nations cultures. The experts agreed to achieve a wholistic model to be used on a national scale changes, including the altering of definitions, adaptations to the models structure, and additional wording more appropriate to First Nations worldviews, was
required. These changes would support the development of a more inclusive and wholistic “wellness” approach taking into consideration various relationships as reflected by First Nations communities and governments.

1.1 Alignment with First Nations Health Plan

The AFN’s First Nations Health Plan (FNHP), developed in 2011 and approved by the AFN Executive, provides a comprehensive plan to achieve transformative change in the longer term, as well as immediate improvement in the health of First Nations. To realize sustained improvement in health, the FNHP states that a transformative change is required that focuses not just on provision of health services, but also on the underlying economic and social framework that perpetuates historical and social injustices. Given that the overall vision of the FNHP is a First Nations controlled and sustainable health system that adopts a wholistic and culturally appropriate approach, the FNWPPM will be well aligned with the FNHP.

The FNHP’s policy statement on a Public Health Framework underlines the need to incorporate SDOH into policy analysis and development. It states, “collective action must be mobilized to address these underlying causes of inequities in First Nations health… Opportunities will be identified and pursued which will strengthen public health efforts to incorporate a social determinant of health perspective, with particular emphasis on influencing those that have an immediate impact on health (i.e. water, sanitation and housing). These efforts will include working with other key partners (e.g. Aboriginal Affairs and Northern Development Canada) to establish formalized mechanisms (e.g. senior interdepartmental committee, joint authorities, and/or secretariats) to analyze and discuss action to improve the social determinants of health” (FNHP 2011).

The FNWPPM is a policy development approach that begins with the imperative that all policy development be First Nations driven and consistent with First Nations’ rights, interests, knowledge, traditions and beliefs. The wholistic model will be integrated in health services and programs across jurisdictions to support a new wholistic framework for First Nations wellness as defined through the FNHP.
2. Introduction

Rising costs and demand for Canadian health care has presented an unprecedented challenge for health care policy makers at all levels of government. Despite strong evidence supporting greater effectiveness of an integrated population health versus an individual biomedical approach, Canada lags behind other nations in matching theory to practice. Adopting a SDOH lens for the Canadian health care system further exemplifies the gap between First Nations and non-First Nations well-being in Canada. The examination of SDOH of First Nations can assist in identifying root causes of illness that fall outside the traditional health realm, leading to more wholistic and sustainable approaches to wellness, ultimately improving the health of First Nations in Canada.

The AFN is the national representative organization of First Nations in Canada. There are over 630 First Nations communities in Canada. The AFN Secretariat is designed to present the views of the various First Nations through their leaders in areas including, but not limited to, Treaty Rights, Economic Development, Education, Languages and Literacy, Health, Housing, Social Development, Justice, Taxation, Land Claims, and Environment. First Nations communities fall under roughly 50 culturally and linguistically distinct groups dispersed across Canada. There are a number of political entities that represent First Nations populations at different levels, including local band councils, tribal councils, and provincial organizations.

To improve the health and well-being of First Nations, geopolitical and cultural diversity must be reflected in all approaches used. “Given their diversity, it may be best to emphasize regional or local solutions than can focus on communities or community needs rather than searching for broad solutions that are unlikely to address the unique needs of different communities across the country” (Romanow Commission, p.222).

2.1 Historical and Social Context

The current state of First Nations health cannot be viewed outside of the historical context of settler colonialism, whose primary features include dislocation from land, imposition of western patriarchy, banning of cultural and spiritual practices, and the undermining of traditional governance, legal, economic and social systems and structures. Perhaps the most
abhorrent feature of Canadian colonialism was the establishment of Indian Residential Schools. The trauma experienced by many Indian Residential School survivors and their families has been cited as a significant contributing factor to First Nations peoples’ experience of poor mental health, personal wellness, and access to supports, with the intergenerational effects of this trauma still being felt today.

3. First Nations Wholistic Policy and Planning Model

As stated in the FNHP (AFN 2011), First Nations people’s health is in crisis. “When compared with the Canadian public, First Nations populations face much higher rates of chronic and communicable diseases and they are exposed to greater health risks associated with poor housing, contaminated water and limited access to healthy foods and employment opportunities” (AFN 2011). Adopting a SDOH lens for the Canadian federal, provincial and territorial systems highlights even more dramatically the gap between Canadian and First Nations well-being.

While a SDOH approach is necessary to policy discussions regarding First Nations well-being, it is not sufficient on its own and must be implemented in accordance with the values, attitudes and aspirations of First Nations peoples. Given the wholistic nature of many First Nations teachings, traditional knowledge and healing practices dovetail well with a SDOH approach. This reiterates the necessity of blending traditional and Western practices in program and services delivery aimed at First Nations.

Incorporating traditional knowledge and unique health perspectives of First Nations in non-First Nations government policies, programs, and services is a rare and daunting challenge. Notwithstanding, the AFN has outlined a successful policy development approach that begins with the imperative that the approach must be First Nations driven and consistent with First Nations’ rights, interests, knowledge, traditions and beliefs.

The AFN is taking a lead role in identifying social determinants of First Nations health in order to address issues beyond health care and service delivery. In reviewing international and national models and building on its previous model, the AFN proposes an updated FNWPPM intended to be used by communities and other First Nations and/or non-First Nations
organisations to inform policy and program development. This model is meant to be an organic document open to the incorporation of new developments and understandings as they emerge.

The model places community at its core. In a study of various healing modalities utilized by First Nations, a common thread was pinpointed as the positioning of the individual in the context of the community, with all modalities evolving from this premise (McCormick 1995/6). The model also incorporates the four components of well-being, with the understanding that “from a health promotion perspective, health is understood to be a state of unity or balance across the physical, mental, social, and spiritual components of a person’s well-being, rather than merely the presence or absence of disease” (Dell et al. 2011). Further to this, health and well-being are experienced over the life course, thus the model incorporates the four cycles of the lifespan allowing for variations in determinants in each stage of life (Loppie 2009).

The FNWPPM is unique to the extent that it emphasizes the significance of self-government as the underpinning framework for First Nations social determinants of health. As expressed in the FNHP, a flexible First Nations economic and social governance structure embraced by all levels of First Nations and non-First Nations governments will enable a First Nations controlled and sustainable health system which will accordingly address and improve the underlying determinants of health.

The exterior circle of the model comprises of the three components of social capital, which is a key health determinant for First Nations. Mignone and O’Neil (2005) propose using social capital as a means of characterizing First Nations communities according to the degree to which resources are socially invested, analyzing social capital on a scale that incorporates the concepts of bonding (relations within the community), bridging (relations with other communities), and linkage (relations with formal institutions). The social capital model resonates with the National Forum on Health’s recommendations with respect to First Nations communities in that the Forum acknowledged that the lack of a flexible, accepting, and responsive external environment was a significant barrier to achieving a wholistic approach to First Nations well-being.
In summary, the FNWPPM has the following key characteristics:

- Community at its core;
- Four components of well-being (spiritual, physical, emotional and mental);
- Four cycles of the lifespan (child, youth, adult, elder);
- Five key dimensions of First Nations self-government (self-government/jurisdiction, fiscal relationships/accountability, collective and individual rights, capacity/negotiations, nation-to-nation relationship);
- Social determinants of health;
- Three components of social capital (bonding, bridging, and linkage).
3.1 Figure: First Nations Wholistic Policy and Planning Model
4. **Social Determinants of Health**

Health determinants are intrinsically connected to health, but cannot be addressed by health care system interventions alone. Often referred to as the “root causes” of ill health, these root causes include social, economic and political factors, such as housing, employment, social services, and legal status. In addition, First Nations health is equally affected by a range of historical and culturally-specific factors which include aspects of colonization, loss of language, historical conditions, and cultural identity (NNADAP, 2011). Failing to address these First Nation specific determinants of health will stall any efforts working towards First Nations health promotion, health protection, and disease prevention.

The question of how to operationalize a SDOH approach is still in its infancy. Some experts, such as Michael Marmot, support a focus on disease prevention that moves away from specific individual risk factors, such as smoking, high-blood pressure, and substance abuse, to community and social forces that act at structural barriers to individuals in the society. Marmot (2005) refers to these social forces as the “causes of causes” and argues for their inclusion in all investigations of disease. According to Marmot, “if the major determinants of health are social, so must be the remedies”. Therefore, to maintain a wholistic view of health, it is important to understand and incorporate the various determinants of health. The following paragraphs outline various determinants from a First Nations perspective.

4.1 **Community Readiness**

The health of an individual and their family is substantially influenced by the community in which they live. Community readiness is the ability of a community to implement initiatives, such as emergency action plans and prevention strategies, to limit the negative impact of crisis or disaster and increase the capacity of the community to address such occurrences, specifically in relation to the health and wellbeing of its members. The goal of community readiness is to drive sustainable solutions that build long-term capacity to halt the perpetual cycle of reacting to crisis. Community readiness can be attained through capacity building opportunities which focus on human resources and organisational development, as well as institutional and legal framework development. As such, community readiness is a key determinant of health for First Nations.
4.2  Economic Development

Broadly speaking, First Nations in Canada support economic development that respects First Nations rights and is environmentally responsible. This can include resource revenue sharing, energy development, infrastructure, and skills development. According to the principles and relationships set out in the Treaties and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), First Nations must be full partners in designing a way forward with industry.

Unfortunately, there continues to be significant obstacles that impede First Nations economic development including deficits in skilled labour, lack of industry-specific job training, capacity, infrastructure, and financing options. When First Nations communities experience limited economic development it further hinders the communities overall health status.

4.3  Employment

Employment has a substantial impact on a person’s well-being. Research has not only shown the undeniable connection between income, SES, and health, but also the impact employment has on self-worth and well-being measured through quality of life indicators. Numerous studies have shown a positive correlation between income level and health status; that lower incomes result in worse health outcomes. These health outcomes are not only acute but, as stated by the WHO (2003), “the longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age”, result in higher rates of overall morbidity. Outcomes from the First Nations Regional Longitudinal Health Survey (RHS) (2008/2010) found “satisfactory employment and income are important elements in achieving individual well-being; similarly, a healthy economy plays an important part in achieving a strong and healthy community”, making a strong argument for the inclusion of employment as a determinant of health in the FNWPPM.

Unfortunately, First Nations are less likely than other Canadians to participate in the labour force, with 52.8% of First Nations adults reporting being currently unemployed. A lack of regional employment opportunities is driving this figure, with over 20% of First Nations adults reporting being currently without work but actively in search of employment. In the instances
where employment is secured, First Nations adults earn less than other Canadians, with 6 out of 10 First Nations adults reporting an annual income of less than $20,000 (RHS 2008/2010). The result of this large percentage of First Nations who find themselves unemployed unfortunately results in a comparable percentage who finds themselves in ill health.

4.4 Environmental Stewardship

First Nations are defined by their unique relationship to the land and are powerful observers of changes to ways of life that are presently in jeopardy. Although First Nations are a minority population in Canada, Indigenous peoples collectively represent an important part of global human biodiversity environmental stewardship. Defined as the responsible use and protection of the natural environment, environmental stewardship is considered an important social determinant for First Nations due to the vital role of the environment in First Nations cultures. Environmental degradation results in First Nations no longer being able to develop healthy relations to the land, including limiting their access to traditional foods and the ability to sustain and profit from resources of the land. Because of this close relationship to the land, First Nations have been directly affected by the ravages of poor environmental stewardship through contaminated lands, air, water, traditional foods and medicines.

4.5 Gender

Gender plays a primary role in determining the health of populations and is evident beyond disease patterns which follow biological pathways. In understanding First Nations health, gender disparities in access to health services and health systems responses demonstrate how First Nations women are at increased risk for multiple levels of disadvantage, including gender bias and discrimination. Narratives of First Nations women’s experiences reveal that women’s encounters with the health system are often shaped by racism, discrimination, and structural inequities (Browne and Fiske 2001).

The impacts of this gender divide are particularly concerning considering results from the 2008/2010 RHS reported that only 21% of First Nation men sought medical attention when they were in need of emotional or mental health support, whereas 34% of First Nation women sought help in these same circumstances. “Regarding illness/disease prevention behaviours, First Nations women reported more screening activities than men. For example, fewer than half
(48.3%) of men reported that they had undergone blood sugar screening, compared to 60.4% of women” (RHS 2008/2010).

The need to address this concern is echoed by the WHO (2010) stating, “addressing gender norms and roles leads to a better understanding of how the social construction of identity and unbalanced power relations between men and women affect the risks, health-seeking behaviour and health outcomes of men and women in different age and social groups”. Inequalities and discrimination continue to violate First Nations women’s human rights creating unsafe environments for them and their children, impacting their overall well-being.

4.6 Historical Conditions & Colonialism

Although First Nations are diverse, all share similar historical injustices as a result of colonialism, Indian Residential Schools, and government-based policies aimed at assimilation. These shared injustices have left many First Nations struggling against the intergenerational trauma caused by colonialism, which continues to negatively impact their well-being through loss of culture and language, racism, environmental destruction, marginalisation, exclusion, alienation and loss of connection to the land.

The residential school system is a major factor in the intergenerational trauma faced by many First Nations communities. Residential schools resulted in five generations of First Nations children being denied the opportunity for safe and secure physical, emotional, and mental development, creating cumulative trauma which continued to impact their lives as adolescents and adults. It is only recently that the Canadian government, authorities and the general Canadian population have begun responding to the physical, emotional, psychological and sexual abuse experienced in these schools. However, the legacy of the residential school system, assimilation policies, and legislation in Canada continue to negatively influence the health of many First Nations today.

4.7 Housing

The lack of healthy and secure housing, specifically the “lack of adequate, affordable housing conditions” (British Columbia 2001) is a primary determinant of health inequalities for First Nations communities. Severe shortages, overcrowding, lack of basic amenities such as running
water and heat, and deplorable construction are only some of the issues impeding healthy housing for First Nations. Jurisdictional issues further complicate the issue of housing, as First Nations lack jurisdictional authority and often ownership of their own housing, compounding issues of poor construction.

Housing quality on reserves has improved, but conditions are still poor. 37.3% of First Nations adults report their home is in need of major repairs and half of First Nations adults live in homes with mould or mildew (RHS 2008/2010). According to the 2008/2010 RHS report, approximately one-quarter of First Nations adults live in over-crowded housing. Overcrowding and lack of basic amenities has direct health implications, including increased risk of respiratory illness, communicable disease, and violence. The increasing demand for and lack of affordable housing disproportionately affects First Nations woman who often cannot access housing in communities. Without a secure place to live, First Nations women are in situations of increased risk of violence, social deprivation, and family breakdown.

Poor economic status and geographic isolation further exacerbate the inadequate housing conditions of First Nations by reducing access to facilities, supplies, and support services. Although housing traditional falls outside the health sector, the undeniable connection between housing and overall health and well-being reasserts the need to include broader determinants in the wholistic understanding of First Nations health.

4.8 Lands & Resources

First Nations are profoundly connected to the land and the natural environment, and both have an undeniable influence on health. Culturally specific beliefs, traditions, and activities are often expressed or enacted in association with the land, with indicators of community wellness measured through knowledge of the land (RHS 2002/2003). However, First Nations have endured historic dispossession of traditional territories, including reserve and settlement structures, including the destruction and unsustainable use of land for industrial purposes. “The past 500 years have witnessed a rapid transition from a healthy relationship with the natural world to one of dispossession and disempowerment. Aboriginal people are no longer stewards of their traditional territories, nor are they permitted to share in the profits from the extraction and manipulation of natural resources” (Loppie 2009).
This dispossession of land and its resources results in compounding negative effects on First Nations health, well-being, and way of life.

4.9 Language, Heritage & Strong Cultural Identity

Culture has been identified as an important determinant of health particularly within First Nations communities. A positive and balanced state of well-being cannot be achieved unless individuals, families, and communities are supported to openly express their cultural identity. Many First Nations communities in Canada are reconnecting with traditional knowledge and values, restoring the transmission of culture, and affirming their cultural identity in an effort to cope with the centuries of systemic abuse and intergenerational trauma. Strong cultural identity has become an important component of individual and community wholistic healing, often through cultural activities and interventions such as Elders teachings, language programs, and land-based activities. According to the RHS (2008/2010), “First Nations adults who frequently participated in community cultural events were less likely to be depressed, more likely to perceive control over their lives, more likely to perceive greater social support, and less likely to use licit and illicit substances than those who infrequently participated in community cultural events”.

Therefore, First Nations traditional knowledge and healing practices must be included in a SDOH approach. Although incorporating culture and traditional knowledge into polices, programs, and services can be challenging it is necessary that program and service delivery aimed at First Nations blends traditional and Western practices.

Culture is expressed by and embedded in language. Language transmits traditional knowledge, stories, and ceremonies and connects individuals and communities to values, traditions and beliefs (McIvor & Dickie, 2009). First Nations individuals and communities stress the link between health and wellness to language and/or reclaiming language. Activities and efforts aimed at preserving, promoting, and reviving traditional languages contribute directly to individual and community healing and resilience. As such, the language in which health services are delivered impacts wellness through the quality and accessibility of services. Considering that 36.2% First Nations adults use a First Nations language daily, and more than
69% of all First Nations adults are able to understand or speak a First Nations language, this is an important determinant to First Nations health (RHS 2008/2010).

4.10 Legal & Political Equity

Legal equity refers to the law being applied to everyone, and if legal action is required, the legal system will apply each law based on the considerations involved. The Universal Declaration of Human Rights (UDHR) states that “all are equal before the law and are entitled without any discrimination to equal protection of the law”. Consequently, it is important to consider the principal of legal equity for groups that are in the minority, such as First Nations people, especially amid the overrepresentation of First Nations in prison. “Over recent decades, legal systems throughout the world have come to recognise that both access to, and the delivery of, justice requires understanding of and sensitivity to the special requirements and disabilities of particular sections of the community” (Judicial Commission of New South Wales, 2006).

Governments are also responsible for the fair and equitable treatment of citizens with respect to the distribution of public goods and services. In regards to First Nations people, legal and political equity are one of the main gateways to improving health. Political equity would persuade the government to adequately allocate resources so First Nations people have fair access to health care, and improve the Canadian populations’ overall health. Sustainable First Nations communities should be provided services and resources to compensate for historical and social injustices and outcomes achieved should be in line with those available for other Canadians.

4.11 Life Long Learning

Access to education plays a significant role in determining the health status of both children and adults (WHO 2003). However, the WHO’s definition of education tends to focus on formal education, and does not include traditional knowledge First Nations gain throughout their lives. “Life Long Learning” encompasses formal education and traditional knowledge into one concept, providing knowledge as well as social support systems and self-esteem opportunities promoting healthy individuals and communities. Life long learning is more inclusive and connotes continual and endless learning.
In regards to formal education, more than one-third of First Nations adults living in First Nations communities had less than a high school education (RHS 2008/2010). This has a direct impact on health as research indicates increasing the general level of education and providing equal opportunity of access to education improves the health of adults and children (WHO 2003). This is supported from results of the 2008/2010 RHS which found that “among First Nations adults who had less than a high school education, 65.7% were likely to be well, 16.1% were likely to have a mild mental disorder, 9.8% were likely to have a moderate mental disorder, and 8.4% were likely to have a severe mental disorder”.

Acquiring traditional knowledge through life long learning is an essential determinant of First Nations health, equally as important as formal education. Traditional knowledge provides a set of beliefs and life skills complimentary to First Nations worldview which is wholistic, cyclical, and dependent upon relationships and connections to living and non-living beings and entities. Castellano (2000) described the characteristics of traditional knowledge as personal, oral, experiential, wholistic, and conveyed in narrative or metaphorical language through storytelling, talk story and remembering.

Traditional knowledge leads to increased wellbeing, as well as intergenerational connections and social supports. As such, life long learning, that encompasses both formal education and traditional knowledge, must be considered a determinant of First Nations health.

4.12 On/Off Reserve

Whether a First Nations person is on-reserve or off-reserve has important implications in terms of access to health services. Nearly one half (49.3%) of the total registered First Nations population lived on reserve in 2011. Although many acute health factors result from the location of the community (see Urban/Rural), the cultural and social support components which influence health are unique to the on/off-reserve determinant of health.

4.13 Racism & Discrimination

An important factor impacting First Nations health is experiencing racism and exclusion, both systemically and interpersonally. According to the RHS 2008/2010, 32.6% of First Nations had experienced racism in the past 12 months. Systemic forms of racism in health care, such as
“[l]inguistic and cultural barriers, as well as [interpersonal] racism and stereotypes, lead not only to misunderstandings and frustrations, but can result in inferior diagnosis, care, and outcomes” (RHS 2002/2003) for First Nations health. Experiencing any form of racism when accessing services often results in individuals feeling socially excluded, and significantly lessens the likelihood of the individual accessing services again. Thus, racialised inequities in quality and access of health care, as well as interpersonal and subjective experiences of discrimination in accessing care result in negative health outcomes for First Nations. Discrimination has been shown to be positively correlated to poor mental health, including increased levels of anxiety and depression. Results from RHS 2008/2010 found that First Nations adults who reported higher incidences of racism also reported being more psychologically distressed than those who did not. Furthermore, links between racism and physical health have been documented in increased cortisol levels, unquestionably linking negative emotional and mental states with decreased physical health (Hyman 2009).

4.14 Self Determination & Non-Dominance

The UNDRIP, endorsed by the Parliament of Canada, states that Indigenous peoples have the right to self-determination; meaning they are free to determine their own political status and pursue their own economic, social and cultural development. Unfortunately, the UNDRIP is not legally binding and the Canadian “colonial agenda has enforced unequal access to and control over property, economic assets and health services” (Loppie 2009) of First Nations. According to the FNHP (2011), a First Nations economic and social governance structure can be created once self-determination is acknowledged by all levels of First Nations and non-First Nations governments. This will subsequently address and improve First Nations health, in addition to positively influencing other determinants of health, such as housing and education. First Nations who participate equally in political decision-making, and possess direct control over their own lives have better health outcomes than those who have less control. Accordingly, there is a connection at the individual level. People who believe that they are in control of their lives are less likely to feel depressed (Loppie 2009). Chandler and Lalonde (1998) have also demonstrated the link between self-determination and dramatically decreased youth suicide rates among First Nations.
4.15 Social Services & Supports

Social services refer to the services provided to aid individuals or communities wellbeing. Some of the services are targeted towards specific determinants of health, which aim to improve targeted aspects of well-being. Social services also include the concept of social support, which are resources provided by support from family, friends, and community members. Such support can “include[e] tangible support, such as direct assistance or material aid; affective support, which provides intimacy, nurturance, and belonging; emotional or informational support, such as having a sense of being able to confide in and rely on another; and positive social interactions, such as having someone to spend time with” (RHS 2008/2010).

4.16 Urban/Rural

First Nations are an incredibly diverse, with over 630 communities in Canada and over 60 reported languages. With a population nearing one million, more than half of First Nations live in urban areas (Statistics Canada 2008). Where First Nations live is directly related to individual and community health through factors such as community size, environmental access, socio-economic factors, and culture. All the factors play a role in urban First Nations health, and their access to health facilities.

According to a 2006 study by the Canadian Institute for Health Information (CIHI 2006), rural or remote residence can increase risk factors of health for individuals including reduced access to knowledge and foods for a healthy diet, lower leisure time, lack of physical activity, and higher smoking rates. Because many First Nations live in rural and remote communities, they may be disproportionately affected by these risk factors. However, many of these risk factors are exacerbated for First Nations due to the impact of colonialism on the traditional lifestyles.

5. Conclusion

Nearly every health indicator reveals that First Nations peoples in Canada disproportionately suffer from poor health as compared to the general Canadian population. As outlined in this document, the health status of First Nations is impacted by multiple factors, many which fall outside the health sector and are considered SDOH. Similar health statistics are observed globally among Indigenous populations, with many vulnerable to higher rates of preventable
disability, disease, and premature death as a result of generations of discrimination and marginalization.

There is no single answer to addressing the health and wellbeing of First Nations, but it is clear that respect for community autonomy, support for self-determination, respect for inherent rights of self-government and Treaties, recognition of First Nations knowledge systems, and respect for First Nations ways of knowing must be included in all health policy. First Nations communities have much to offer in terms of their unique cultures and traditions. Traditional knowledge systems must be integrated into advanced health policy development and research in an effort to combine scientific excellence with community relevance. Proper forms of engagement with First Nations is crucial to policy development. Interpretation of research results and translation of knowledge to policy makers must be done in tandem with First Nations. First Nations specific SDOH must be addressed in a wholistic and culturally appropriate way in order for just and sustainable improvements to be made for First Nations wellbeing.
### 6. Acronyms

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<td>AFN</td>
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