HIV/AIDS and the Broader Determinants of Health in an Aboriginal Context

Introduction

This fact sheet introduces the reader to the broader determinants of health in an Aboriginal context. The broader determinants are intended to complement the social determinants of health and are reflective of the historical features that shape the contemporary health profile of Aboriginal Canadians.

Global concern for the gradual rise in rates of HIV in many countries around the world has allowed for innovative methodologies to uncover the multiple risk factors leading to vulnerability among certain populations within national boundaries. The broader determinants of health have been developed to add rigor to the social determinants of health that are widely appreciated as foremost attributes to health status and uncover the origins of health disparities.

Although not developed exclusively to address issues of HIV acquisition, the broader determinants offer important prompts that initiate disadvantage in the Aboriginal population.

HIV and Aboriginal Canadians

Epidemiological monitoring and surveillance regarding the prevalence and incidence of HIV acquisition within the First Nations, Inuit and Métis populations in Canada reveal a growing trend in the scope of HIV infection in this segment of the population. The Aboriginal population in Canada represents approximately 4% of the population in Canada, yet accounts for up to 7.5% of current HIV cases, making the HIV epidemic 2.8 times higher within this populace.

While it is difficult to obtain a precise accounting of all HIV cases in the Aboriginal population due to problems related to the accuracy and availability of ethnicity data, under-reporting and testing trends, it is clear that young Aboriginals and Aboriginal women are especially vulnerable to contracting HIV and represent the majority of HIV cases in the Aboriginal population in Canada. Increasingly, injecting drug use is a particularly important risk factor for HIV and AIDS transmission among Aboriginal persons and women in particular. In 2002, 64.9% of reported AIDS cases among Aboriginal women reported their exposure category as injection drug use, and 30.9% reported the mode of transmission as heterosexual contact. (CAAN 2006)

Although the route to contracting the infection is complex, several pathways to contracting HIV have been documented and include poverty, addictions, unsafe sexual practices and inadequate access to health services, all of which are relevant for Aboriginal people (CAAN 2006).

Demographic Profile

Highlights from the results of the Aboriginal Peoples Survey of 2006 provide snapshot information on the demographic profile of this population. Just over one million people in Canada identify as First Nation, Inuit or Métis accounting for approximately 4% of the total population. The Canadian constitution recognizes three distinct Aboriginal populations in Canada: First Nations, Inuit and Métis. Each population is distinct from one another and the diversity within each population reflects regional, historical and geographic realities.

The Aboriginal population is young with 48% of the population under the age of 24, compared with 31% of their non-Aboriginal counterparts being in that similar cohort. Increasingly, Aboriginal people are settling in urban centers such as Winnipeg, Edmonton, Calgary, Toronto, Saskatoon, Regina and Vancouver. Up to 54% of the total Aboriginal population lives in urban centers which is a 50% increase over ten years.

There is great diversity among the three Aboriginal populations and more detailed and specific population

information on their profiles, generated by the 2006 Aboriginal Peoples Survey, is available through Statistics Canada.

Social Determinants of Health

In 1947, the World Health Organization recognized a new way of defining health that included that health is a "...complete state of physical, mental and social well being." This shift in the definition of health advocates a broader understanding of what shapes health status in populations. The move from the individual based biomedical disease framework to include the multiple influences that mould the health status of individuals and populations led to the development of the social determinants of health.

The social determinants of health include: income; social support networks; education; employment and working conditions; social environment; physical environment; personal health practices and coping skills; healthy child development; genetic endowment; access to health services; gender; and culture.

These determinants are an effective lens to scrutinize the collective impact of these indicators on the health outcomes of individuals and populations. The social determinants of health are intended to be seen in combination as they release a synergy that generates the building blocks of optimal health. Deficits in various determinants can result in delicate foundations for favourable health and a closer examination reveals that Aboriginal peoples in Canada face barriers in achieving and maintaining a health status comparable to the rest of the Canadian population.

Broader Determinants of Health for Aboriginal Canadians

The National Aboriginal Health Organization introduced supplementary determinants that play a notable role in shaping the health profile of Aboriginal Canadians. These determinants were not developed with detailed attention to HIV acquisition in the Aboriginal population, but they are significant considerations when examining risk factors associated with contracting the infection.

The following are viewed as determinants particular to Aboriginal peoples in Canada as they incorporate both historical origins and contemporary patterns of poor health.

Colonization: The historical context of Aboriginal people in Canada includes legislation such as the Indian Act of 1867 and policies that frame practices such as residential schools. The intergenerational impacts of residential schools, if not remedied, can trigger detrimental coping mechanisms such as addictions and violence that impact on healthy choices and behaviours in the First Nations, Inuit and Métis populations.

Globalization: Decreased health budgets, health reform and decentralization all impact access to health services. First Nations, Inuit and Métis are the fastest growing population in Canada and their health needs exceed those of their Canadian counterparts. Increased health care costs and elevated levels of chronic conditions such as diabetes and HIV/AIDS, as well as hard to service locations, all require long term investments.

Migration: Increased urbanization of Aboriginal Canadians from reserves and home communities can result in a disconnection from lands and traditional practices that are tied to maintaining Indigenous knowledge systems. Complementary changes to regimes around nutrition and activity levels have translated into elevated levels of diabetes. The on-reserve/off-reserve migration applies only to First Nations, although relocation patterns in Inuit and Métis are similar in scope and rationale for moving to more urban locations.

Cultural Continuity: Aboriginal peoples come from rich traditions and ceremonial practices that strengthen mental and spiritual health and knowledge systems that maintain languages and cultures. Migration to urban locations detaches people from these systems that are intended to encourage a solid cultural compass for Aboriginal peoples.

Access: Many Aboriginal communities are located in remote and isolated settings. In some of the more remote communities, access to health services and health professionals are sporadic with access to specialized care being more complex requiring travel and time away from family and community.

Territory: For Indigenous peoples, the state of the land is a reflection of their own health and well being; when the land is not well, they are also not well. Indigenous knowledge is passed on through the intimate familiarity with traditional territories that are sustained through such activities as hunting, fishing and gathering berries. Today, many Aboriginal communities are isolated from their territories and therefore these traditional activities are at risk of vanishing through the lack of continuity to maintain these traditions into the next generation.

Poverty: The parallel between poverty and ill health is well established. Many Aboriginal people live in appalling conditions with inadequate housing, limited access to healthy foods, poor water quality and high unemployment. These conditions predetermine health status making poverty a strong pathway to ill health.

Self-determination: Control over decisions that impact individual and community health are important factors that facilitate the self-determination of Aboriginal communities. Developing capacity to address the cluster of health burdens in Aboriginal communities requires the best of both Indigenous and mainstream knowledge systems.

The broader determinants of health are a relatively new lens to examine the current health profile of Aboriginal Canadians. With regard to HIV acquisition, more concentrated research on how these determinants facilitate a higher rate of HIV acquisition within this population is required to fully establish the relationship of one to the other. It has been established that Aboriginal Canadians continue to account for disproportionate rates of HIV relative to the total population.

Residential Schools, Mobility and Traditional Practices

Perhaps the most visible colonial legacy in Canada is the residential school system that operated throughout the country in the 1900s. Although closed, the abuses and misguided attempts to assimilate First Nations, Inuit and Métis children have received significant attention in recent years. The Aboriginal Healing Foundation has done remarkable research into the lasting impacts of these schools with a particular emphasis on the intergenerational impacts that are evident in the social, emotional and spiritual landscape of Aboriginal communities. Addictions, poverty and mental health disorders have roots in the residential school legacy and can facilitate unhealthy coping behaviours that are pathways to HIV acquisition in this population.

In general the Aboriginal population is highly mobile. Reasons to relocate can include higher education and training opportunities, broader employment prospects, special education or health needs of family members, better-quality housing, and improved access to health services. Most who relocate move to cities. However, without appropriate tools to navigate urban and semi-urban environments, Aboriginal people often face limited choices for housing, reduced access to health services and barriers to employment, all conditions that can increase their risk and vulnerability to HIV and AIDS.

Indigenous knowledge is both tangible and abstract. Language, ceremonies and traditional activities form an important part of Indigenous knowledge and each provides a means for promoting long-term wellness and buoyancy within these populations. Traditional practices and activities link to teachings that increase an individual's ability to maintain strong family and community ties that foster resilience. Recognizing the pathways to wellness and understanding the origins of personal and community resilience among First Nations, Inuit and Métis are important foundations for building long-term physical, emotional and socio-cultural well-

being.

Conclusion

In Canada, the ***social*** determinants of health serve as an appropriate and effective lens from which to understand the origins of disparities in the health status of individuals and populations. Individual decisions and health seeking behaviours are influenced by the social, political and economic terrain generated by the social determinants of health. The ***broader*** determinants of health add a distinct layer of considerations that are specific to Aboriginal Canadians.

While HIV and AIDS are a global concern, in Canada specific vulnerable populations are at greater risk of contracting the HIV infection due to the intersecting determinants that paint a fragile socio-economic landscape resulting in risk factors that are largely avoidable. First Nations, Inuit and Métis face multiple challenges in achieving optimal health status comparable to their Canadian cohorts. While the origins of these disparities are rooted in the social determinants of health, these conditions are exacerbated by the broader determinants of health which in turn are rooted in historical and contemporary practices affecting the present health profiles of First Nations, Inuit and Métis communities.

References and Additional Information

Resources

- National Aboriginal Health Organization www.naho.ca
- Canadian Aboriginal AIDS Network www.caan.ca
- Public Health Agency of Canada www.phac-acsp.ca
- Aboriginal Healing Foundation Research Series http://www.ahf.ca/publications/research-series

International Indigenous HIV/AIDS Organizations

- Chile's Kelwo: Stitching Together a Better Future https://nacla.org/node/4784

References

- Canadian Aboriginal Aids Network (undated) Residential School and HIV/AIDS: Direct and Intergenerational Impacts, Fact Sheet
- National Aboriginal Health Organization (2006) Broader Determinants of Health in an Aboriginal Context
- O'Brien Teegs, D and Travers, R (2006) River of Life, Rapids of Change: Understanding HIV Vulnerability among Two-Spirit Youth who Migrate to Toronto *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research Volume 1,* Canadian Aboriginal AIDS Network, Ottawa
- Public Health Agency of Canada (2007) HIV/AIDS Epi-Updates, Government of Canada, Ottawa
- Statistics Canada (2008) Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census: Highlights_http://www12.statcan.ca/english/census06/analysis/aboriginal/highlights.cfm