

Commentary

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Aboriginal Communities in Canada*

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aboriginal policy studies Vol. 3, no. 1&2, 2014, pp. 198-213

This article can be found at:

<http://ejournals.library.ualberta.ca/index.php/aps/article/view/21706>

ISSN: 1923-3299

Article DOI: <http://dx.doi.org/10.5663/aps.v3i1-2.21706>

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Drowning in the Social Determinants of Health: Understanding Policy's Role in High Rates of Drowning in Aboriginal Communities in Canada

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Within Canada, Aboriginal peoples drown at much higher rates than non-Aboriginal peoples (Health Canada, 2001).² Drowning is commonly understood as a problem that has its roots in individuals' failure to learn to swim, a failure of adults to supervise children properly, or a failure to engage with safety practices (such as wearing a lifejacket or boating only when sober). This understanding of aquatic-related injury reflects the neo-liberal tendency to assign individual blame for poor health, rather than viewing health as being produced within particular socio-historico-politico environments. In this paper we use Bacchi's (2007) "What's the problem" approach to policy analysis to argue that it is misguided to understand high rates of drowning in Aboriginal communities as being caused primarily by the aforementioned factors, as they fail to account for the ways in which social determinants influence Aboriginal peoples' health.

Rates of Injuries in Aboriginal Communities

Unintentional injuries are a significant issue in Aboriginal populations in Canada. Finès, Bougie, Oliver, and Kohen noted that it is important to study unintentional injuries for multiple reasons: "they are considered largely preventable, are a leading cause of death and morbidity, have long-term health effects and are associated with large health care costs" (2013, 204). Studying unintentional injuries in Aboriginal populations can be difficult, however, because national hospitalization or mortality databases, where injury information could be found, tend to lack Aboriginal identifiers; as a result, quantitative studies in this area

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² Comprehensive overviews of drowning statistics in this paper are unfortunately somewhat dated due to the lack of up-to-date statistics that show changes over time (i.e., ten year intervals).

often use provincial databases, which do contain this type of information, or a geographical approach (Finès et al. 2013). Because it is so difficult to obtain data regarding unintentional injuries in Aboriginal populations, only a handful of studies have been conducted on this topic in recent years, and most have focused on children.

Injury Rates for Aboriginal Peoples

While injuries are known to be one of the leading causes of death in Canada, Aboriginal populations are especially at risk; however, as mentioned previously, there are few studies that have explored this trend (Karmali et al. 2005). Waldram, Herring, and Young (2006) noted that injuries are responsible for 25 percent of deaths in First Nations populations, while injuries account for less than 10 percent of deaths in non-Aboriginal populations. Finès et al. (2013) found that, in comparison to non-Aboriginal populations, First Nations populations had high rates of unintentional injury from motor vehicle accidents, poisoning, being “struck,” drowning/suffocation, fire/hot substance, and firearm injuries. As injuries are one of the most common causes of morbidity and mortality in children and adolescents in North America, it is especially important to examine injury rates for this group in Aboriginal populations. Alaghebandan, Sikdar, MacDonald, Collins, and Rossignol (2010) found that the hospital discharge rate of unintentional injuries, for each age category, was higher among Aboriginal children and youth populations in comparison to non-Aboriginal children and youth populations in Newfoundland and Labrador. Thus, while unintentional injuries are a concern in any population, they are of particular concern in Aboriginal populations. For the purposes of this paper, we will focus on drowning, which—as we will show—is a particularly grave problem for Aboriginal peoples.

Aboriginal Peoples and Drowning in Canada

In a country with a tremendous wealth of waterways, it is perhaps not surprising that people in Canada spend a great deal of time in, on, or close to bodies of water. While bodies of water provide individuals with opportunities for recreation, subsistence activities, and travel, activities in, on, or around water and ice are not without their risks. Though rates of drowning and near drowning have decreased considerably in the last ten years (Canadian Red Cross Society [CRC] 2003), there continue to be many water-related injuries and deaths within Canada each year. These injuries and deaths are not evenly distributed throughout Canada. The Canadian Institute of Health Information (2010) noted that drowning rates in rural and remote northern, predominantly Aboriginal, populations are incredibly high. Drowning rates amongst Aboriginal populations are up to 10 times higher than for non-Aboriginal populations (Health Canada 2001; CRC 2003). Alarmingly, Aboriginal children drown at a rate that is fifteen times the national average (Health Canada 2001). According to the National Household Survey (Statistics Canada 2011), 4.3 percent of the Canadian population identified as having Aboriginal identity. Throughout Canada, Aboriginal peoples are over-represented in drowning statistics, accounting for 26 percent of all snowmobile drowning incidences, 16 percent of all drowning incidences, and

9 percent of all boating drowning incidences (Health Canada 2001). Drownings are not, however, evenly distributed amongst Aboriginal peoples. Rates of drowning are highest in the Yukon, Northwest Territories, and Nunavut, and Aboriginal boys and men are at much greater risk than Aboriginal girls and women (CRC 2003).

There are several hypotheses for why Aboriginal peoples are overrepresented in drowning statistics. Amongst the most popular is one theory pointed out by the CRC, indicating that Aboriginal adults “often travel by boat and snowmobile both as part of daily life and for recreation ... Not wearing a flotation device or hypothermia garment and alcohol were frequent risk factors for boating and snowmobile drownings” (2003, 6). The CRC noted that Aboriginal toddlers in particular were at high risk, and attributed this to living near “natural bodies of water” and a “lack of continuous supervision and construction of family homes close to open water” (6). Other frequently cited factors have included low water temperatures in northern communities and low levels of access to swimming lessons (Health Canada 2001).

In its position statement on “preventing unintentional injuries in Indigenous children and youth in Canada,” the Canadian Paediatric Society (CPS) produced a more complex understanding of the reasons for disproportionately high rates of childhood injury amongst Aboriginal children:

Historical inequities, cultural alienation and loss of connectedness with the environment, as well as the grim legacy of residential schools, have contributed to depression, to alcohol and substance abuse and associated risk-taking behaviours, and to inadequate parenting skills for some ... The lack of culturally appropriate or targeted IP [injury prevention] programs continues to be a barrier (Banerji 2012, para. 8).

Certainly, this understanding differs significantly from that offered by Health Canada and the CRC. In this article, building on the CPS’s statement, we complicate understandings of reasons for disproportionately high rates of drowning in Aboriginal populations by focusing on public policy and the social determinants of health. We draw on Bacchi’s (2007) approach to policy analysis to argue that more nuanced understandings of high drowning rates amongst Aboriginal peoples must be taken into account and used as the foundation for new approaches to drowning prevention.

Bacchi’s “What’s the Problem” Approach to Policy Analysis

Public policy is often understood to be what governments do, why they should do it, and what difference it will make, but it should also be understood as what governments do not do and how they represent certain problems (Bacchi 2007). Public policies are generally developed to “address” certain political problems and to identify solutions to these problems (Bacchi 1999b); however, by doing this, the policies actually create certain understandings of what the “problems” are represented to be (Bacchi 2007). Representing certain things as problems affects the positioning in society of certain groups and problematizes these groups

and their practices. When discussing problems in relation to these groups, specifically marginalized groups, it is often the case that certain groups are seen as being responsible for their own problems (Bacchi 2007), which ignores the broader social contexts that may be affecting and creating the problems. By representing certain groups, in this case Aboriginal peoples, as the problem, governments and other organizations give themselves permission to attempt to “fix” the problem and find solutions within a narrow focus that is in line with how they define the problem and that protects certain interests. Since all policies include an identification of a problem, Bacchi (1999a) argues that all policy analyses need to look at how the problem is represented, which is the premise for her “What’s the problem” approach to policy analysis.

The purpose of Bacchi’s “What’s the problem” approach to policy analysis is “to create a space to consider competing constructions of issues addressed in the policy process, and the ways in which these constructions leave other issues untouched” (1999a, 7). An important aspect of this approach is that it offers a framework for looking at what is silenced in policy work and examining what is unproblematized in certain cases (Bacchi 1999a). The use of this approach helps to identify the representations of problems that are a part of every policy and policy proposal, and to analyze these representations critically. This approach takes the responsibility for the problem away from marginalized groups and looks at the broader social factors involved in the problem. In order to understand the root causes of drowning in Aboriginal populations, it is necessary to examine the social determinants of health, and Aboriginal social determinants of health more specifically, and the policies that affect these determinants. Brooks, Darroch, and Giles (2013) employed Bacchi’s (1999) approach to problematize the federal government’s Aboriginal Diabetes Strategy. As such, it has a history of being used to understand issues pertaining to Aboriginal health and public policy. We turn now to the social determinants of health.

Social Determinants of Health

The World Health Organization (WHO) defined the social determinants of health as “the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choice” (2012, para. 1). Though there are various iterations, the Public Health Agency of Canada (PHAC 2011) identified twelve key social determinants of health: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture. Due to the lack of success that mainstream approaches have had in successfully addressing inequities in health between non-Aboriginal and Aboriginal populations in Canada, researchers have proposed the need to identify Aboriginal social determinants of health.

Aboriginal Social Determinants of Health

Several authors have identified key social determinants of health for Aboriginal people: colonialism, dispossession of land, loss of traditional health practices, discrimination, education systems, access to health care, food insecurity, and lack of adequate housing (Earle 2011; Loppie, Reading, Wein 2009). These social determinants of health vary considerably from those proposed by PHAC (2011). According to Czyzewski (2011), the social determinants of health between non-Aboriginal peoples and Aboriginal peoples differ due to colonization and the ensuing subjugation of Aboriginal peoples.

Through assimilative policies and marginalization of economic benefits from lands and resources, colonialism established and continues to establish the pervasive promotion of poverty and resulting dependency. Loppie-Reading and Wein have provided examples of how colonialism often exacerbates health issues for Aboriginal peoples, noting, for instance, that “living conditions of low income have been linked to increased illness and disability, which in turn represents a social determinant, which is linked to diminished opportunities to engage in gainful employment, thereby aggravating poverty” (2009, 2). Another example relates to physical environments and the effects on educational achievements: “Physical environments such as crowded housing conditions cause stress [that] can indirectly contribute to substance overuse and parenting difficulties, which may result in poor school performance among youth and children” (3). These examples illustrate how, for Aboriginal peoples, experiences with the effects of colonialism correspond to the broader well-being for individuals and communities. As Czyzewski succinctly explained, the social determinants of health for Aboriginal peoples are vastly exacerbated, due to colonial relations that have “produced and reproduce unfavourable conditions and environments. These conditions and environments determine healthy behaviours, or lack thereof, physical environments, employment and income, education and food security” (2011, 4). As such, the social determinants of health play a large role in understanding unintentional injury.

Social Determinants of Health and Unintentional Injury

Peden et al. (2008) acknowledged there are a number of social and economic factors that may increase individual risk of injury: lower educational attainment, low socio-economic status, and being an ethnic or racial minority. We argue that these factors are created and sustained by colonialism embedded within policies in Canada and, hence, they must be taken into consideration when addressing high rates of drowning in Aboriginal communities.

Low Levels of Education Attainment

According to the World Health Organization (2012), in many countries, a lack of higher education is associated with drowning. According to the 2006 Canadian Census, 53 percent of Aboriginal men and 42 percent of Aboriginal women have less than a high-school education, while the numbers for non-Aboriginal men and women are much lower

at 29 percent and 24 percent, respectively. Likewise, only 5 percent of Aboriginal men and 9 percent of Aboriginal women have earned a bachelor's degree or higher. Comparatively, 19 percent of non-Aboriginal men and 22 percent of non-Aboriginal women have earned degrees. This trend is not abating. The 2011 National Household Survey (Statistics Canada 2011) showed that among Aboriginal people aged 25 to 64, 28.9 percent had no certificate, diploma, or degree while the proportion for non-Aboriginal people in the same age group was 12.1 percent. For First Nations people living on reserve, the situation is even more urgent: 60 percent of young adults living on reserve lack a high school diploma (Richards, 2008).

Aboriginal people experience lower education attainment levels as a result of the history of assimilative policies pertaining to education. For over one hundred years, education was used as an assimilative tool. Aboriginal children were forced to attend residential schools where they not only suffered immeasurable violence, but also received an absurdly substandard education. The type of education received in these institutions was more to do with labour indoctrination (i.e., preparing boys to till the fields and girls for domestic duties), than typical western education such as reading, writing, and math (Armitage 1995).

In the last thirty years, however, many Aboriginal people have sought out western education as a means to transcend the effects of colonialism. Chief Atleo of the Assembly of First Nations explained, "If education was once a tool of disconnection and suppression of First Nations' languages and cultures, it must now be a tool of reconnection and reconciliation" (Germain and Dyck 2011, 65). Education has become a means to attain better employment opportunities, greater income levels, and greater stability for many Aboriginal families.

In 2010, the Environics Institute reported that education is among the top priorities for Aboriginal peoples living in urban settings. The Assembly of First Nations has reiterated the importance of youth obtaining an education to the overall well-being of First Nations communities. Yet, current funding pressures make it harder and harder for Aboriginal peoples, especially for First Nations peoples on reserve, to obtain an education. In 1996 there was a 2 percent cap placed on the Post-Secondary Student Support Program (PSSSP) operated by what is now Aboriginal Affairs and Northern Development Canada. The impact of the funding cap is seen in the number of students able to receive funding. In 2008, the PSSSP supported an estimated 22,303 students at the 300 million dollar cap level, when 724 million was needed to support the actual need (Assembly of First Nations, n.d.). Low levels of Aboriginal educational attainment are a direct reflection of policies that create and sustain low levels of funding for Aboriginal education, which in turn put Aboriginal peoples at risk for unintentional injury.

In many studies, low levels of parental education, and particularly maternal education, have been found to negatively impact child survival, particularly in impoverished areas (Gakido, Cowling, Lozana, and Murray 2010). Several pathways have been hypothesized to explain this effect (for a review, see Hobcraft 1993). The pathway of most relevance to injury is likely that low levels of education in parents/caregivers could result in them lacking knowledge about preventative measures that could reduce drowning.

Aboriginal Peoples and Low Income in Canada

Like low levels of education, low household income is also tied to an increase in unintentional injury. In Canada, poverty is measured based on the low-income cut-off, which is an income level at which a family is required to spend more than 20 percent of the average family income in Canada on the necessities of food, shelter, and clothing (Statistics Canada 2013). In relation to Aboriginal peoples, they are

at the bottom of almost every available index of socioeconomic well-being, whether they are measuring educational levels, employment opportunities, housing conditions, per capita incomes or any of the other conditions that give non-Aboriginal Canadians one of the highest standards of living in the world. (National Collaborating Centre on Aboriginal Health [NCCAH] 2009, 2)

In comparison to non-Aboriginal peoples in Canada, Aboriginal peoples suffer from much greater levels of poverty. One in four First Nations children live in poverty, for example, in comparison to one in six for non-Aboriginal children; Aboriginal women experience poverty at double the rates of non-Aboriginal women; and Aboriginal peoples in Canada experience hunger due to poverty four times more than non-Aboriginal peoples in Canada (NCCAH 2009). Unemployment rates are also much higher for Aboriginal peoples than for non-Aboriginal peoples, which can be attributed not just to lower levels of educational attainment, but also to job market discrimination (Kendall 2001) and, more broadly, colonialism (Wilson and Macdonald 2010).

Health status and poverty are inextricably linked. As you move up on the income and social status ladder, health status also improves (Public Health Agency of Canada 2013). One of the most significant issues with poverty is the lack of access to material resources, which directly impacts health. For example, without access to nutrient dense food, education on proper nutrition, adequate and safe housing, or proper sanitation, residents of impoverished communities have much greater physical health risks, such as tuberculosis, diabetes, and cardiovascular disease, but also to great mental health risks, such as depression, low social cohesion, and an increased risk of suicide (Reading and Wien 2009). These health risks also extend to injury.

Laflamme, Burrows, and Hasselberg (2009) reported that those who experience material deprivation are more likely to experience injury. Laflamme et al. (2009) further demonstrated that “[a]mong mortality studies, the empirical evidence at hand very often shows strong associations with individual- and area-based material deprivation. People from low socioeconomic status and from less affluent areas tend to die by injury to a greater extent than others” (3). The Canadian Institute of Health Information (CIHI) reported that the rate of injuries among the poorest Canadians is 1.3 times greater than the wealthiest (CIHI 2010).

There are numerous ways to explain why lower SES is associated with higher rates of unintentional injury. In their review of twenty years of research on socioeconomic inequality and unintentional injury in children, Laflamme et al. note that two mechanisms

dominate explanations of poverty and material deprivation's link to injuries in children. The first is that children who live in poverty are exposed to a wider variety of hazards in their everyday lives. The second is the child's caregiver or the child him/herself lacks "the means to protect themselves in their home or in their community (e.g., the means to afford safe equipments [sic] or devices)" (2010, 19).

Interestingly, however, Bougie, Finès, Oliver, and Kohen examined variations in unintentional injury-hospitalization rates based on area socioeconomic conditions and location relative to an urban core in Canada found that even when comparing neighbourhoods that were similar in terms of SES socio-economic status and location, "the relative risk for unintentional injury hospitalization was greater in those [areas] with a high percentage of First Nations identity residents than in DAs [areas] with a low percentage of Aboriginal identity residents" (2014, 9).

As a result, SES and location account for only a portion of the explanation for high rates of unintentional injury in areas with high First Nations populations. As a result, First Nations status—or something tightly tied to it—appears to make individuals more vulnerable to unintentional injury hospitalizations.

As we have shown above, education and poverty, two of the mainstream social determinants of health, have been found to make significant (though by no means exclusive) contributions to high rates of unintentional injury and more specifically to drowning, in Aboriginal communities. If viewed more critically, it becomes clear that colonialism—an Aboriginal social determinant of health—makes a strong contribution to both low rates of education and high rates of poverty in Aboriginal communities. Taken all together, then, colonialism must be considered as one of the key determinants of drowning in Aboriginal communities.

Reframing the Problem—Or Why Swimming Lessons Are Not the Answer

Despite overwhelming evidence that drowning is linked to a number of socio-politico-historico factors, many continue to insist that swimming lessons are the best ways in which to prevent drowning. Before providing alternative approaches to preventing drowning, we will tackle this belief first. Many assume that swimming lessons will "drown-proof" children and that these skills will track into adulthood. Thus, given high rates of drowning in Aboriginal communities, it might seem as though the best possible solution would be to enhance access to swimming lessons for Aboriginal peoples in Canada. This is the very approach that is currently being taken by organizations such as Right To Play Canada and Alberta's Future Leaders Program, both of which have recently introduced swimming lessons into their programming in Aboriginal communities.. The protective role of swimming lessons in preventing drowning is controversial, however. In 2003, Brenner, Saluja, and Smith argued that "a clear protective relationship between increased swimming ability and the risk of drowning has never been limited ... [A]vailable evidence suggests that many drowning victims are able to swim" (2003, 211). These authors have argued that swimming lessons could actually *increase* drowning as they increase children's exposure to

the hazard (water), may result in children becoming more curious about/attracted to the water, and may result in children and adults feeling confident enough to swim in riskier situations. In their study of parents' perceptions of their toddlers' swimming ability, Moran and Stanley found that parents who enrolled their toddlers in swimming lessons were more likely to be overly optimistic in their beliefs about the swimming lessons' protective role in toddler drowning prevention. The authors went so far as to argue that it is "incumbent on all swim schools to de-emphasize the safety aspect of toddler swimming lessons in order to dispel any parental perception of enhanced water safety as a consequence of improved swimming proficiency in this [toddler] age group" (2006, 142).

Conversely, however, based on their case-control study in the United States, Brenner et al. (2009) argued that formal swimming lessons significantly reduced the risk of drowning in children aged 1 to 4 years of age. Interestingly, however, a statistically significant association between formal swimming lessons and drowning risk was not found in older children. In fact, they found that of the older children who drowned, many were "relatively" skilled swimmers. Brenner et al.'s findings have resulted in the American Pediatric Society's reversal of its previous stance against swimming lessons for children under the age of four, which was based on the argument that they were not developmentally ready (Brenner et al. 2003). Given that Aboriginal men are the most likely to drown and given that swimming lessons appear to serve as a (controversial) protective factor for only those 1 to 4 years of age, it seems that approaches to drowning prevention in Canada needs to be profoundly re-evaluated. We argue that they need to be re-evaluated in light of the Aboriginal social determinants of health.

Using Bacchi's (1999) approach, we can see that the problem of high rates of drowning in Aboriginal communities is represented as a result of individual failures to engage with safety practices. Such a representation of the problem disguises the public policies that create and sustain Aboriginal peoples' marginalization in terms of education and income—and, in particular, the ways in which these policies are rooted in colonialism. Certainly, producing posters that promote individual behaviour change (i.e., "wear a lifejacket!") and training teenagers as swimming instructors and lifeguards is much easier than attempting to rid public policies of their longstanding ties to colonial beliefs and their associated practices. However, failing to understand that individual behaviours are shaped by the social determinants of health, we argue, results in an inability to target significant contributors to the root causes of drowning.

Addressing the Aboriginal Social Determinants of Health in Drowning Prevention

It is beyond the scope of this paper—and the authors' expertise—to suggest ways in which the Canadian government should fundamentally re-structure its relationships with Aboriginal peoples in order to end inequities in education and income between Aboriginal and non-Aboriginal peoples. Certainly, there is a significant body of literature pertaining to self-determination and other best/promising practices in those areas with which readers are likely familiar. What we provide here, however, are examples of drowning prevention

initiatives that attend to the consequences of colonization (particularly as they pertain to education and poverty) and that serve as strong examples of ways in which such approaches can promote Aboriginal health.

Poverty and Drowning

Within Canada, low levels of income have been tied to an inability to purchase safety equipment. For example, Inuvialuit residents of Tuktoyaktuk, Northwest Territories (Giles et al. 2009) and Inuit residents of Pangnirtung, Nunavut (Giles et al. 2013) identified lifejackets and survival suits as being prohibitively expensive, which was one of the main reasons why residents reported failing to wear flotation devices. Initiatives that offer flotation devices free of charge reduce these barriers. An observational study of the impacts of Alaska's "Kids Don't Float" program found that children were more likely to wear lifejackets when they were made available free of charge on "loaner boards" provided beside bodies of water where children swim (Office of Boating Safety 2011). In partnership with the Lifesaving Society, the Government of Alberta recently adopted the "Kids Don't Float" strategy in provincial parks.³ Further, Hunters and Trappers Organizations in Nunavut sell safety equipment to harvesters at a reduced price through Nunavut Tunngavik Incorporated's Small Equipment Program (Aarluk Consulting Inc., n.d.). Thus, the provision of flotation devices free of charge or at reduced rates may enhance drowning prevention efforts by eliminating or reducing barriers that stem from low income.

Education and Drowning

Specific efforts to promote water safety education to/with Aboriginal peoples—as opposed to focusing on swimming lessons—might be one approach to ensuring that water safety messages meet those who are apparently most in need. The idea, however, that it is merely a *lack* of water safety education is problematic in that it fails to take into account the *kind* of information that is communicated and the ways in which it is tied to colonialism. In their work with communities in the Northwest Territories and Nunavut, Giles and colleagues identified that water safety programs in Canada's North, which are created in southern Canada and typically taught in the North by seasonally employed southerners with little to no experience in or on northern waterways (Giles, Baker, Rousell 2007), do not include traditional knowledge. Consequently, the information is perceived by many residents as culturally irrelevant, ineffective, and even dangerous (Giles, Castleden, and Baker 2010). In particular, they have pointed to the ways in which colonial legacies impact trust and power—two key components of risk communication (Giles, Strachan, Stadig, and Baker, 2010).

Successful injury prevention education strategies account for culture and are community-based (or "constituent involving") in nature (Kreuter et al. 2003). In their

³ See <http://www.albertaparks.ca/albertaparksca/advisories-public-safety/outdoor-safety/kids-don't-float.aspx>.

well-known example of the effectiveness of accounting for culture in drowning prevention, Zaloshnja et al. described a public safety campaign message designed by Alaskan Tribal Elders: “Wear a float jacket so that if you drown, people will not have to drag the river for your body” (2003, 632). The authors reported that this message, in addition to the sale of float jackets (which are essentially the top half of a survival suit) at a reduced price, resulted in a 53 percent decrease in drowning and the savings of \$1.2 million (USD) in recovery operations.

In another example from Alaska, The Alaska Eskimo Whaling Commission, the United States Coast Guard, the Alaska Native Tribal Health Consortium, and Mustang Survival (a flotation device manufacturer) designed a custom float coat for Native Alaskan whalers who wanted flotation devices that were white. Typical flotation devices are yellow, orange, or red, to stand out against snow, ice, and water. The desire for white flotation devices stemmed from the Alaskan whalers’ belief that coloured flotation devices scare the whales they hunt. The subsequently manufactured white float coat meets the target population’s cultural needs and beliefs and has had strong up-take (Barber 2010). This example is particularly interesting in that it was the flotation device manufacturer that had to re-think its way of thinking about what was, in fact, an appropriate piece of clothing to sell. In a similar example, Giles et al. (2013) described their research’s team community-based efforts to improve drowning prevention in Pangnirtung, Nunavut. They worked with community members to design thermoses that not only had Transport Canada’s (2010) “Minimum Safety Equipment Requirements” printed on them, but also key pieces of equipment that community members identified that were not on Transport Canada’s list: ammunition, rifles, knives, and harpoons. Importantly, the information appeared in both English and Inuktitut. In this example, community members taught the research team about community members’ own identified safety needs. Education concerning drowning prevention need not be a one-way street.

Conclusions

In this paper, we have argued that current approaches to drowning prevention fail to attend to Aboriginal social determinants of health. This failure is particularly startling given Aboriginal peoples’ overrepresentation in drowning statistics. Using Bacchi’s (1999) approach to policy analysis, we showed that the current focus on individual behaviour change misses the proverbial boat. Individual behaviour is influenced by the environment in which people live. By failing to address colonialism, drowning prevention strategies will continue to be of limited benefit to Aboriginal peoples. Successful approaches to drowning prevention within Aboriginal populations are those that employ messages that are respectful and understanding of community members’ beliefs, attitudes, and cultural practices and account for the historico-socio-politico realities that Aboriginal peoples face.

We do not deny that Aboriginal peoples, like all individuals, have the ability to exercise agency: they are not passive victims of their social circumstances. Nevertheless, the failure to acknowledge colonization’s profound impacts on areas as seemingly benign as

water safety promotion is short-sighted and results in victim blaming. Drowning rates in Aboriginal populations in Canada represent a serious public health problem; if changes are to be made, we must examine their root causes so that Aboriginal peoples can stop drowning in the social determinants of health.

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