Improving the health of First Nations children in Australia

Regular monitoring and supportive federal and state public policy are critical to closing the gap in child health

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Health and wellbeing of children and young people are the keys to human capability of future generations. Human capability includes the capacity to participate in economic, social and civil activities and be a valued contributor to society;[1] it means that not only can you usefully live, work and vote, but you can be a good parent to your children. Thus there is no better investment that the state can make than to influence factors that will enhance the health and wellbeing of children and youth.

There were an estimated 200 245 First Nations[2] children aged 0–14 years in Australia in 2011, comprising 4.9% of the total child population and 35% of the total First Nations population.[3] With such a high proportion of children compared with the non-Aboriginal population, the First Nations population is much younger, with fewer adults per child to care for them. An Australian Research Alliance for Children and Youth report adds to evidence from the most recent Australian Institute of Health and Welfare report on the health of Australia's children to document the growing divide between the health of First Nations and other Australian children.[3,4]

Child health indicators include mortality rates (Box, A), prevalence of chronic conditions, indicators of early development (including rates of dental decay [Box, B]), promotion of early learning (eg, adults reading to children in preschool years) and school readiness assessed with the Australian Early Development Index (Box, C).[3] Risk factors for poor child health include: teenage pregnancies; smoking and alcohol exposure during pregnancy; pregnancy outcomes such as stillbirths, low birthweight and preterm births; the proportion of children aged 5–14 years who are overweight or obese; and the proportion of children aged 12–15 years who are current smokers. In addition, indicators of the level of safety and security of children — including rates of accidental injury, substantiated reports of child abuse and neglect, evidence of children as victims of violence, and indicators of homelessness and crime — further highlight how poorly Aboriginal children fare during childhood.

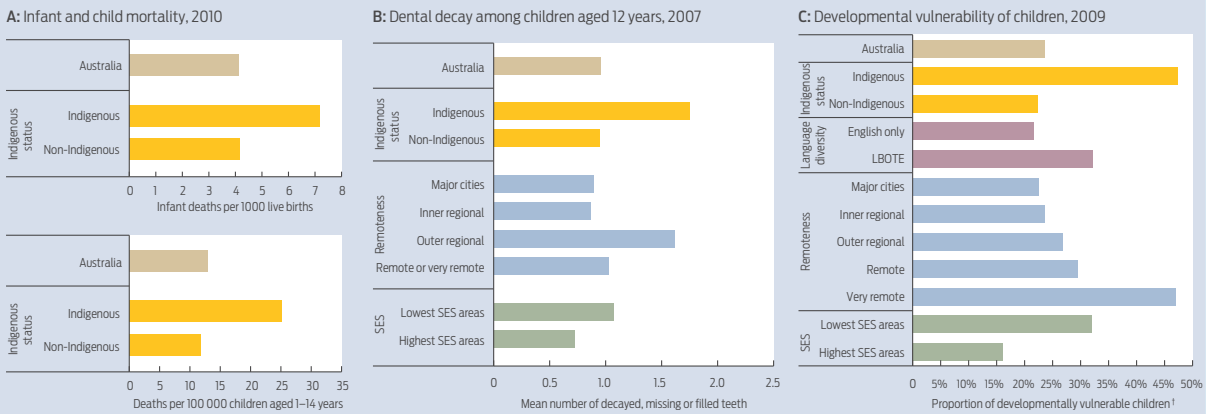
Owing to significant gaps in available data, Australia is not included in UNICEF reports relevant to First Nations children, including *The children left behind: a league table of inequality in child well-being in the world's rich countries*.[5] This report is important for many First Nations children who experience conditions near the bottom because it focuses on closing the gap between the bottom and the middle:

> We should focus on closing the gap between the bottom and the middle not because that is the easy thing to do, but because focusing on those who do not have the chance of a good life is the most important thing to do.[5]

While there has been progress, particularly in educational outcomes, the gap in healthy child development in safe and secure environments is disturbing. It has resulted from of a variety of complex social circumstances, due to colonisation, marginalisation and forced removals. To effectively and successfully interrupt and reverse these generational traumas on today's children, careful and sensitive First Nations-led programs are required. Programs in Canada and Australia have shown that the major protective and healing effects of strong culture are immensely powerful, even in urban situations, which highlights the value of strong government support for such programs in Australia. For example, putting First Nations children and youth into cultural programs is more effective than incarceration for preventing recidivism, and increased recognition of Aboriginal cultures in school curricula increases rates of high school completion by First Nations students.[6]

Drawing on our own and overseas data,[7] we believe that Australian services have failed to close the gap in child health because they have been developed without involving or engaging First Nations people. When participatory

Child health indicators that show a divide between First Nations and other Australian children*



SES = socioeconomic status. LBOTE = language background other than English. * Adapted with permission from *A picture of Australia's children 2012*.[3] † Developmentally vulnerable on one or more Australian Early Development Index domains. ◆

action research methods are used, as has been done with Inuit communities in Nunavut in Canada,[8] the use and success of services are dramatic. Such strategies lead to higher levels of local employment, higher self-esteem, and reduced mental illness and substance misuse among First Nations people. British Columbian data on First Nations youth suicide rates have shown that the lowest rates in Canada were in communities with strong culture and Aboriginal control of services (eg, health, education and community safety).[9] This means that a major rethink of services for First Nations people is needed, and that centralised policy applied to multiple diverse communities is unlikely to work. Although the policy content of what needs to be done can be developed centrally based on existing evidence (eg, alcohol in pregnancy causes brain damage, early childhood environments are vital to help children to be ready for school, complete immunisation prevents infections, and avoiding sweet drinks prevents obesity and dental decay), development and implementation of services need to be done locally and with community involvement. A great example of this is the strategy to overcome fetal alcohol spectrum disorders (FASD) that was developed by Aboriginal women June Oscar and Emily Carter and the First Nations people of Fitzroy Valley. This comprehensive and effective strategy has enabled the community to think and act beyond the stigma of FASD — community members drove the design and implementation of programs to prevent FASD, and they created opportunities and support mechanisms to enable the best possible treatment for children with FASD.[10]

Building on the Australian Research Alliance for Children and Youth report,[4] we need a consistent national framework for monitoring health status and an understanding of the impact of federal and state policies on First Nations children. Recent policies with the potential to affect First Nations children include: the Northern Territory intervention, the loosening of alcohol restrictions in the Northern Territory, policies aimed at addressing overrepresentation of Aboriginal children in child protection reporting, housing policies (including evictions and the transfer of public housing properties to ownership and management by non-government organisations), policies that have changed financial support for single parents, education policies aimed at assessing school readiness and other policies aimed at closing the gap in health. The effects of these policies on First Nations children need to be considered in regular assessments of public policy, with the needs of children prioritised over competing interests.

The exciting thing is that we now have a growing number of Aboriginal health care providers and other university-trained professionals to employ to make services effective. We have equity in medical student intakes which augurs well for future progress in this critical area. The dream of having appropriate, culturally safe policies, programs and services for our First Nations children can become a reality if it is supported and promoted by all levels of government.

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