Resources:

Equity and Public Health and Recreation

A Sampling of Recent Canadian Research on Impact of Recreation on Addressing Economic and Racial Inequities

SOCIAL BENEFITS FROM RECREATION AND PHYSICAL ACTIVITY

The significant list of individual and societal benefits from public recreation go well beyond physical health according to public health and recreation experts. And, those benefits can be exponential for traditionally underserved populations based on age, income, gender, immigrant status, and race, etc. as the findings from numerous studies show.

"Sport participation benefits individuals and society overall through improved physical, psychological and social well-being, increased civic pride, engagement and cohesion, and increased economic development and prosperity. However, some women and girls, Indigenous Peoples, persons with a disability, recent immigrants, new Canadians, socio-economically disadvantaged Canadians, older adults, members of the LGBTQ community, and Canadians living in rural, remote and isolated regions do not participate at the same rates as their mainstream counterparts. Inclusive policies and programming benefit members of these groups and other Canadian residents who may feel excluded from sport"

"Sport is about more than training and performance, and participation is about more than just the number of participants who show up to a program. Sport participation includes experiential aspects related to inclusion and community integration including, belongingness, engagement, meaning, mastery and challenge."

Source: Policy and program considerations for increasing sport participation among members of underrepresented groups in Canada: A Literature Review, Cragg, S., C. Costas-Bradstreet, J. Arkell & K. Lofstrom. Interprovincial Sport and Recreation Council, Ottawa, 2016

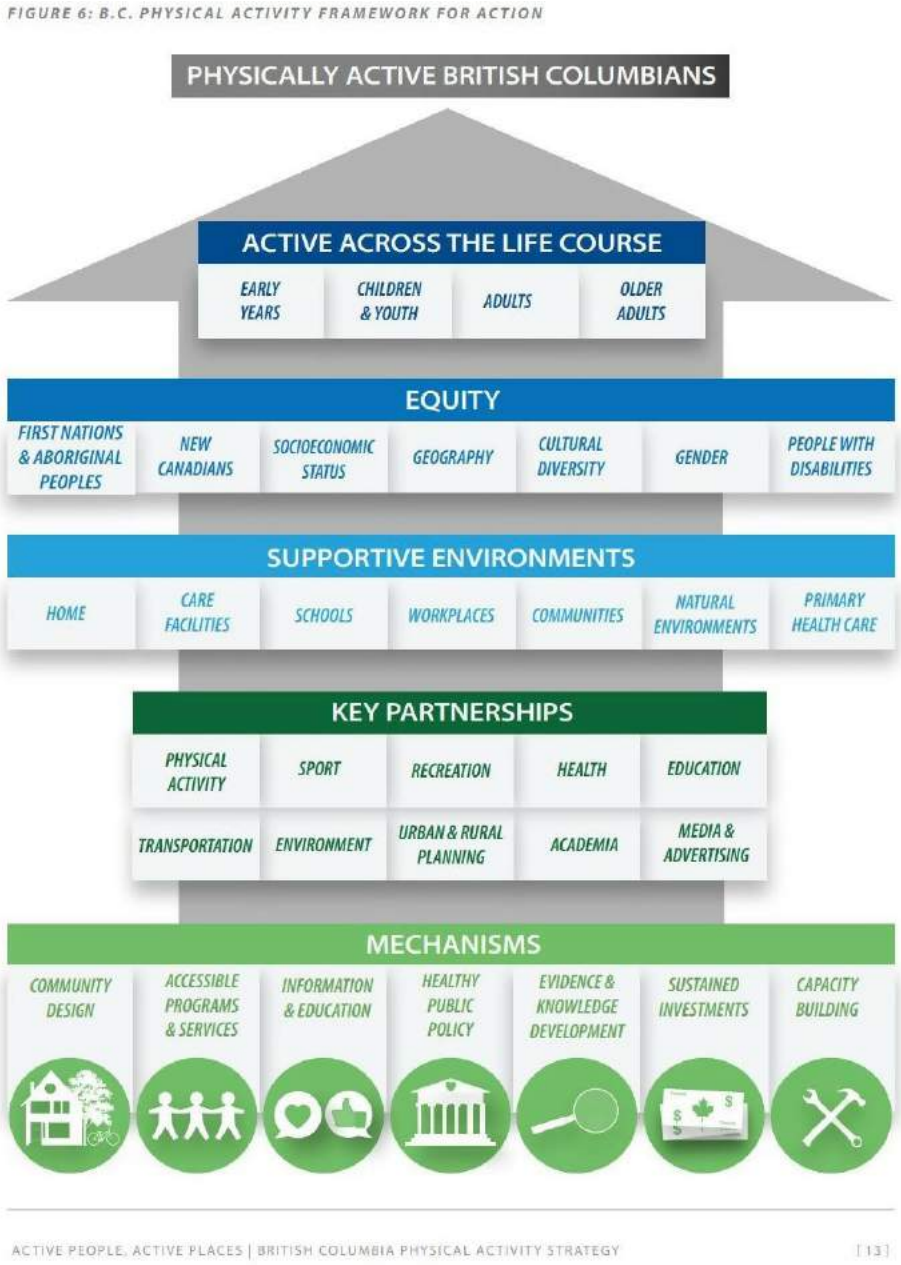
Listed below are other recent Canadian studies referencing the benefits of recreation to underserved groups, including seniors, immigrants, and indigenous peoples, in addition to the equalizing benefits of public recreation on households of low income.

Source: Active People, Active Places - BC Physical Activity Strategy, Ministry of Health 2015
Some people face barriers to participating in physical activity due to the unequal distribution of social and economic resources in some geographic locations, and among population groups. Often these factors are interrelated. Population groups in B.C. (individuals and families) who face constraints to participating in physical activity include First Nations and Aboriginal Peoples, new Canadians, people living in rural and remote areas, people with disabilities, and people with low incomes and low levels of education. This strategy applies an equity lens to address the barriers and inequities faced by these groups of people. The multiple benefits of physical activity are well documented. Physical activity is good for the health and well-being of individuals, families and communities, as well as for the environment and the economy.

The Healthy Families BC Policy Framework identifies the need to address health disparities in a comprehensive approach to improving health.

Mobility - To reduce inequities, physical activity strategies need to be universal and accessible to the whole population, but with an additional focus on those with lower levels of physical activity. The B.C. Physical Activity Strategy incorporates this approach by applying an equity lens to policies, programs, environments and practices in physical activity.

Socio-Economic - Participation in physical activity is affected by the unequal distribution of social and economic resources in some geographic locations, between men and women, and among population groups. Often these factors are interrelated. Several population groups in B.C. face barriers and constraints to participating in physical activity, including: First Nations and Aboriginal Peoples, people with low incomes and low levels of education, new Canadians, people living in rural and remote areas, and people with disabilities. Inequities are also related to gender. In some circumstances, girls and women face more constraints to participation than boys and men.



THE SPIRAL STAIRCASE OF PHYSICAL LITERACY – IMPROVED HEALTH AND QUALITY OF LIFE BEGINS WITH ACCESS

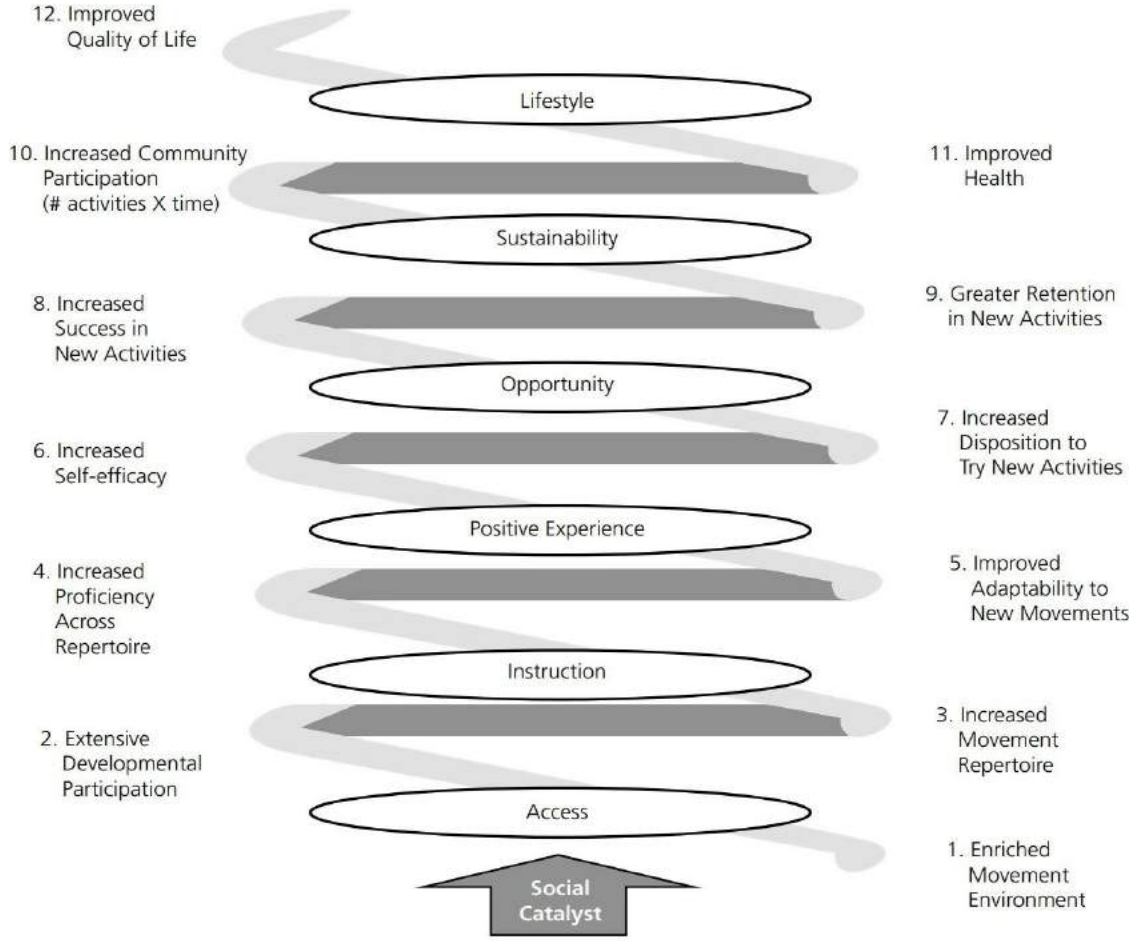


FIGURE 3
THE SPIRAL STAIRCASE OF PHYSICAL LITERACY
credit: Paul Jurbala

2018 ParticipACTION Report Card on Physical Activity for Children and Youth

While the physical health benefits of childhood physical activity are well known (e.g., improved heart, bone and muscle health; prevention of type 2 diabetes), a growing body of research has begun to examine the benefits of childhood physical activity in relation to brain health.

Emerging evidence suggests that physical activity in childhood and adolescence is associated with better cognition (i.e., thinking and learning), brain function (i.e., how the brain works) and mental health (i.e., emotional, psychological and social well-being). The landscape of preventable chronic disease among children and youth is changing—and not for the better. The prevalence of overweight and obesity, diabetes, and use of health services for mental illness is high. These issues are more prominent in children and youth with neurodevelopmental (brain-based) disabilities, where physical activity participation can be challenging, and social inclusion is limited due to the initial diagnosis, inaccessible facilities, and financial constraints.

Active for Life: Durable by Design, Sport for Life Canada, 2016

- The multistage Long-Term Athlete Development Framework is not only for athletes: it is also a Long-Term Participant Development Framework that describes developmental periods for individuals as they participate in sport and physical activity throughout their lifetime.

- In this document, a model is presented, Active for Life, and how it can be used to promote the inclusive design and delivery of programs and services for all Canadians from adolescence to mature adulthood.

- Large segments of society — including public institutions — still tend to view physical activity and sport as the domain of children, teens, and professional athletes.

- Too many Canadians face significant barriers to engagement in regular exercise or do not fully appreciate the life-changing benefits in health, social connection, and general wellness that can be derived from continued participation in physical activity and recreational sport.

- The dollars spent in support of community sport and physical activity represent a strategic investment in the health and wellness of Canadians. Having a more active population with relatively modest levels of physical fitness represents potentially billions of dollars in savings to our healthcare system. It has also been shown that active people are happier and healthier people (Blumenthal, 2007) and they suffer less depression and mental illness, and they are more resilient and resistant to disease. They are in effect “durable by design”.

Income and Social Determinants of Health

A Sampling of Recent Canadian Research on Impact of Income on Health Outcomes

INCOME AND OTHER SOCIAL DETERMINANTS OF HEALTH

FROM:

Summary Report http://www.bccdc.ca/pop-public-health/Documents/Priority%20health%20equity%20indicators%20for%20BC_selected%20indicators%20report%20EXEC%20SUMMARY_2016.pdf

Full Report http://www.bccdc.ca/pop-public-health/Documents/Priority%20health%20equity%20indicators%20for%20BC_selected%20indicators%20report_2016.pdf

British Columbia is one of the healthiest provinces in Canada, ranking favorably among provinces and territories on several population health indicators. Despite this overall success, there is considerable evidence that health status varies greatly depending on geography, demographics and socio-economic status (SES).

SOCIO-ECONOMIC INDEX

The Socio-economic status (SES) of each Local Health Area (LHA) is defined by the overall socioeconomic index score as developed by BC Stats.38 This index is a weighted summary of six individual indices including four basic indicators of regional hardship (human economic hardship, crime, health problems and education concerns) and two additional indicators of children and youth at risk. LHAs were categorized into three SES groups (low, medium, and high) using tertiles of the overall socio-economic index scores as cut off points. BC Stats regularly updates this index

By analyzing current data, 16 health equity indicators are examined across selected geographic, demographic and socio-economic dimensions. The selected indicators are organized into four chapters: life expectancy, early childhood development, adolescent health and general population health.

LIFE EXPECTANCY

Life expectancy at birth is used worldwide as a general measure of a population's health. Life expectancy of population groups can also indicate social conditions such as wealth, economic opportunity, healthcare and education.

KEY FINDINGS

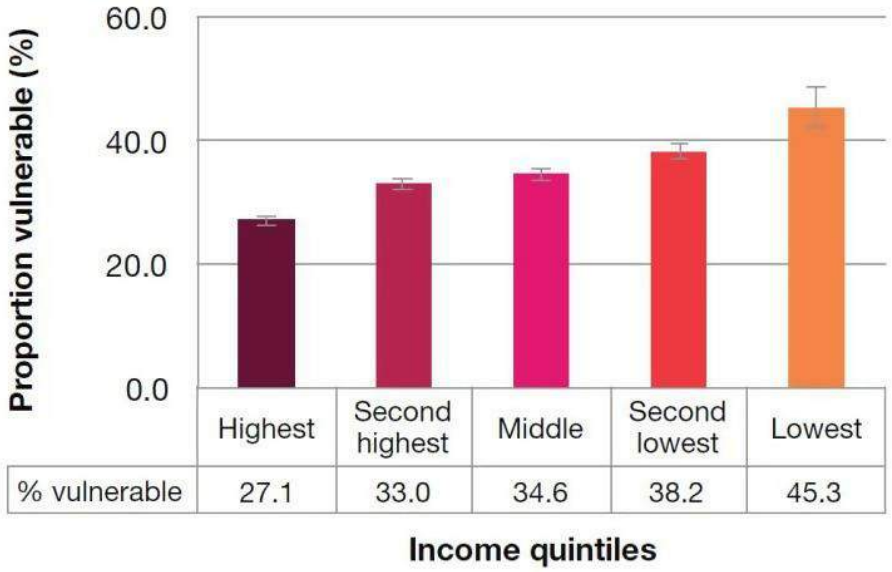
- Life expectancy in BC varies by sex, geographic region, and socio-economic status: People living in high SES local health areas are expected to live nearly four years longer than people living in low SES areas (82.2 vs. 78.6 years respectively).

"The true measure of a nation's standing is how well it attends to its children – their health and safety, their material security, their education and socialization, and their sense of being loved, valued, and included in the families and societies into which they are born." UNICEF, Innocenti Report Card 7, 2007 http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf

- The rate of BC children who are developmentally vulnerable during early childhood varies significantly by geographic region, sex, and neighborhood levels of unemployment and income:
- Rates of language and cognitive development vulnerability varied by Health Service Delivery Area (HSDA), ranging from a low of 5.8% to a high of 13.5%.
- The rate of vulnerability in one or more EDI areas was higher in boys (40.3%) than girls (24.5%), and was higher in regions with higher unemployment (35.4%) than lower unemployment (29.8%).
- The rate of vulnerability in one or more EDI areas was highest among children in regions with the lowest income (45.3%).

Income

Figure 5. Percentage of kindergarten children vulnerable in one or more EDI areas in BC, by neighbourhood income measure, EDI 2011/12 - 2012/13, NHS 2011



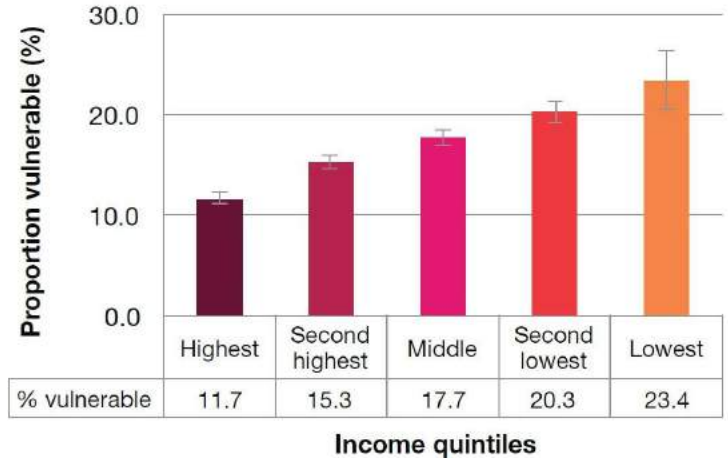
	Highest	Second highest	Middle	Second lowest	Lowest
% vulnerable	27.1	33.0	34.6	38.2	45.3

Regions with the lowest neighbourhood income had the highest rates of children vulnerable in one or more EDI areas (45.3%).

The rates of children vulnerable in one or more EDI areas decreased as neighbourhood income level increased: 18.2% fewer children were vulnerable in the highest income neighbourhoods (27.1%).

Income

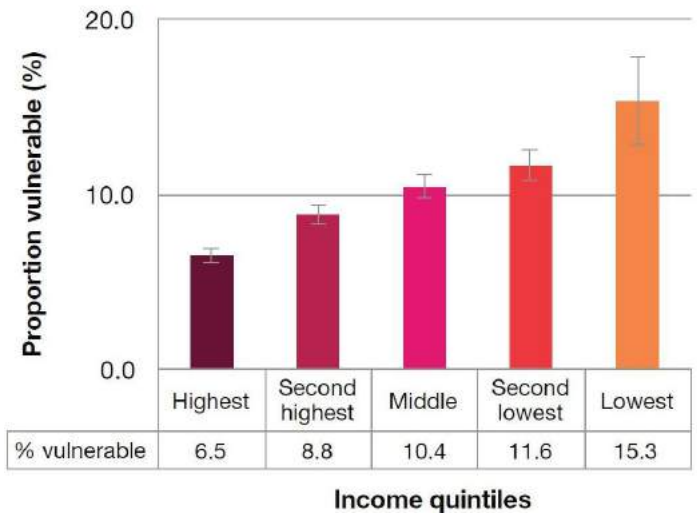
Figure 11. Percentage of kindergarten children vulnerable in physical health and well-being in BC, by neighbourhood income measure, EDI 2011/12 - 2012/13, NHS 2011



Regions with the lowest neighbourhood income had the highest rates of children vulnerable in physical and well-being (23.4%).

Smaller proportions of children were vulnerable as neighbourhood income levels increased: half as many children were vulnerable in highest income neighbourhoods (11.7%).

Figure 17. Percentage of kindergarten children vulnerable in language and cognitive development in BC, by neighbourhood income measure, EDI 2011/12 - 2012/13, NHS 2011



Regions with the lowest neighbourhood income showed the largest proportion of children vulnerable in language and cognitive development (15.3%). Smaller proportions of children were vulnerable in higher income regions.

Compared to the lowest income group, less than half as many children were vulnerable in the highest income neighbourhoods (6.5%).

ADOLESCENT HEALTH

Adolescence is an important stage of life for healthy human development. A recent overview of adolescent health by the World Health Organization stated that "promoting healthy practices during adolescence and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood."57

What happens in the early years of life can influence the health of adolescents, which in turn impacts adult health.58 Many of the current and projected leading causes of death, disease and disability can be significantly reduced by preventing or minimizing various behavioral risk factors. These behavioral risk factors include tobacco use, alcohol and substance use, and those that result in injury and violence.59

People tend to initiate many of these behaviors during adolescence, and socio-economic circumstances can influence the choices that people have or can make. Building resiliency and enhancing protective factors, such as family, school and cultural connectedness, can help youth overcome adversity and make healthier choices, thus increasing their likelihood to thrive in all aspects of life.

Adolescence is an important stage for healthy adult development. Promoting healthy practices and taking steps to better protect young people from health risks can prevent or reduce the impact of health problems in adulthood.8 Using BC's Adolescent Health Survey data collected in 2013, five priority health equity indicators for the BC youth in Grades 7 to 12 were examined across three equity dimensions, sex, geographic region, and neighborhood income level.

Five indicators that pertain to adolescent health that have short- and long-term consequences among BC youth in Grades 7 to 12 include:

- Teen current smoking rate
- Substance use before age 15
- Prevalence of discrimination
- Prevalence of physical and/or sexual abuse
- School connectedness

YOUTH AND SMOKING

Tobacco smoking is the leading cause of preventable death in Canada and has negative health impacts on people of all ages, including youth. Short-term health consequences of smoking among young people include respiratory and no respiratory health conditions, addiction to nicotine and risk of other drug use. Longer-term health consequences of regular teen smokers are lower rates of lung growth and poorer lung function than those who have never smoked.65 Most smokers begin smoking by age 19; if people have not started smoking by this age, they are less likely to smoke, while youth who smoke regularly typically continue to smoke throughout adulthood.66, 67

YOUTH AND SUBSTANCE USE

Substance use before age 15 is defined as the percentage of students who reported first trying alcohol, tobacco and/or marijuana before the age of 15.

Using alcohol or marijuana at a young age can affect cognitive development and can be associated with risky substance use behavior in adulthood. The younger an individual is when they first use substances, the more likely that they will engage in other risky behaviors, such as smoking, other substance use and driving under the influence.

Delaying the use of alcohol and other substances, even by one or two years, can significantly improve youths' short- and long-term health outcomes.71 BC AHS results show that some youth are more vulnerable to early substance abuse than others.72, 73 Protective factors (such as family, school and cultural connectedness) can help youth make healthier choices and improve their health outcomes.

YOUTH AND DISCRIMINATION (BASED ON RACE, PHYSICAL APPEARANCE, GENDER IDENTITY, OR SEXUAL ORIENTATION)

The prevalence of discrimination is defined as the percentage of students who reported experiencing any discrimination in the past year, based on their race or skin color, their physical appearance or their sexual orientation. Discrimination can affect youth in many ways and has been linked to emotional distress.

Youth who experience discrimination are also more likely to report mental health effects in the preceding month (feeling extremely sad, discouraged or hopeless), not to like school, and to have seriously considered suicide in the past year.[75]

Certain characteristics can make youth more vulnerable to discrimination. In BC overall, around one in five youth reported being discriminated against because of their physical appearance.[76] If youth are overweight or obese, discrimination rates can double. Research by the McCreary Centre Society has shown that Aboriginal youth report experiencing discrimination based on physical appearance at higher rates than non-Aboriginal youth.[77]

YOUTH AND PHYSICAL OR SEXUAL ABUSE

the prevalence of physical and/or sexual abuse is defined as the percentage of students who reported ever being physically or sexually abused. Sexual abuse included any indication of sexual abuse, forced sex, or being the younger sexual partner of someone who was not close in age at first sex. For the 2013 BC AHS, sex between youth who were both less than 12 years old was not considered abuse.

Physical and/or sexual abuse can affect youth emotionally, behaviorally and physically. These effects can be made worse when youth are victims of both types of abuse. The experience of physical or sexual abuse is strongly related to poor health outcomes, including lower self-perceived health and consideration of suicide.[79] Certain characteristics can make youth more vulnerable to physical or sexual abuse. In BC, youth with a limiting health condition or a disability report rates of abuse that are twice as high as those of other youth. Youth identifying as lesbian, gay or bisexual and Aboriginal youth also report higher rates of physical and sexual abuse compared to other youth.[80,81]

YOUTH AND SCHOOL CONNECTEDNESS

School connectedness is a combined measure created from the BC AHS questionnaire items asking youth:

- how much they felt being a part of their school,
- how well they got along with people at their school,
- how much they felt cared about at school by teachers and school staff,
- being happy at their school,
- school staff treating them fairly,
- getting along with teachers, and
- safety at school.

A higher score indicates higher connectedness to school. Connections to family, school, friends, and community are important contributors to good health. They are a valuable resource in times of stress or in reaction to difficult experiences or decisions. School connectedness is associated with positive academic and health-related outcomes,[82] and is linked to reduced risk-taking.[83] Previous McCreary reports showed that youth who report higher school connectedness were more likely to describe their mental health as good or excellent and were more likely to expect to continue their education beyond high school.[84]

KEY FINDINGS

Several key indicators of adolescent health (prevalence of physical and sexual abuse, discrimination, smoking, and substance use before age 15) vary significantly by geographic region and sex:

- Rates of substance use before the age of 15 differed by HSDA, ranging from the lowest (22%) to the highest (50%), a difference of 28%.

- Females reported higher rates of abuse (22%) and discrimination (41%), and slightly lower rates of smoking (9%) than males (13%, 30% and 11%, respectively).

GENERAL POPULATION HEALTH

Measuring general health and mental health can reveal a population's overall health and well-being, resiliency and social environments. Adult health and well-being are influenced by a complex set of social and environmental factors that include current living and working conditions, as well as early life experiences.

- Measuring behaviors related to nutrition, physical activity and smoking can give insight into current population health as well as the potential future chronic disease burden.[89, 90, 91, 92, 93]

- Measuring rates of adult health conditions can highlight important population and public health issues.[86, 87] For example, mood disorders can have significant economic costs, high risks of suicide and loss of quality of life; anxiety disorders can lead to more frequent use of costly emergency and primary care services.[88]

Adult health and well-being are influenced by a complex set of social and environmental factors that include current living and working conditions. Adult health can also be influenced by experiences in the early years that contribute to school success, and then by behavioral risk and protective factors during adolescence.
Past research and monitoring have shown that adult health status, health conditions and health behaviors can be significantly different between men and women, by geographic region and between socio-economic groups.[94, 95, 96, 97, 98, 99, 100]

Seven general health status and outcome indicators, all based on self-reported data from the Canadian Community Health Survey from 2007/08 to 2011/12, were examined across various geographic, demographic and socio-economic dimensions. These self-reported indicators generally coincide with health system data.[85]

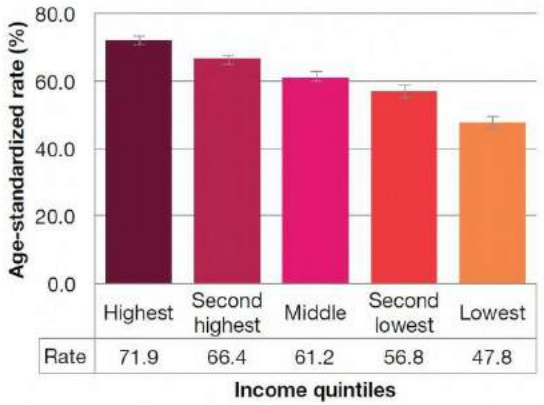
- Positive perceived health
- Positive perceived mental health
- Mood or anxiety disorder
- Adult obesity rate
- Fruit and vegetable consumption
- Leisure time physical activity
- Current smoking rate

PERCEIVED HEALTH

Perceived health can give insight into an individual's satisfaction with life and their overall well-being, which are measures identified in BC's Guiding Framework for Public Health. Additionally, perceived health is known to be a reliable and valid measure of health status associated with functional decline and morbidity.[104]

Income

Figure 32. Percentage of population (age 15+) with positive perceived health in BC, both sexes by income, CCHS 2007/08 - 2011/12



People (age 15+) with the lowest income reported the lowest rate of positive perceived health (47.8%).

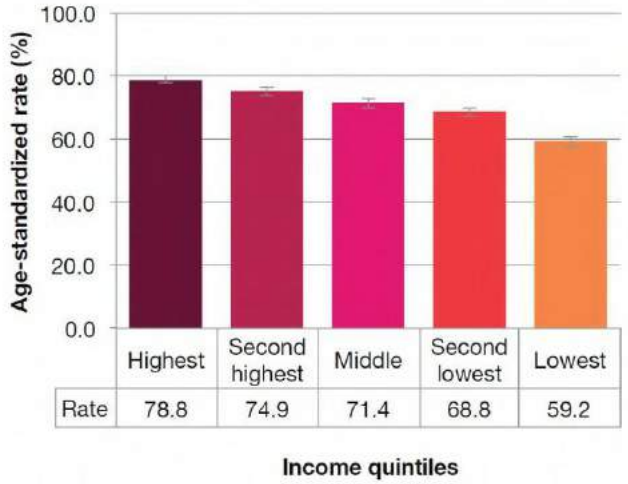
Rates of positive perceived health increased with income level, up to 71.9% among the highest income group.

PERCEIVED MENTAL HEALTH

Socio-economic disadvantages such as low levels of education, low income and poor housing are recognized risk factors for poor mental health.105

Income

Figure 37. Percentage of population (age 15+) with positive perceived mental health in BC, by income, CCHS 2007/08 - 2011/12



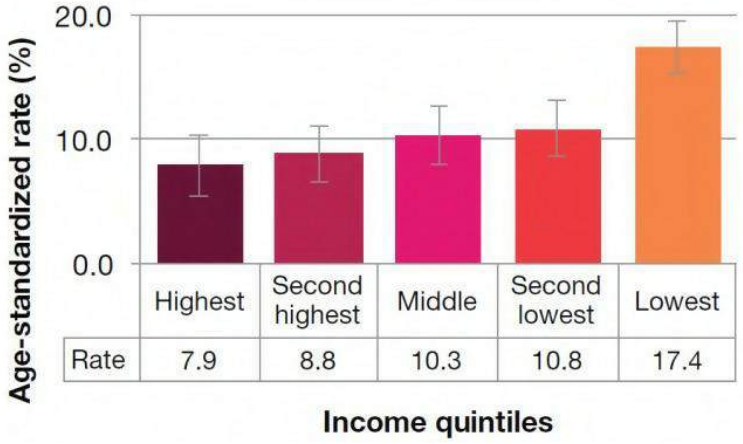
Rates of people (age 15+) who reported positive perceived mental health declined with decreasing levels of income; 78.8% of those in the highest income group reported positive perceived mental health, compared to 59.2% of those in the lowest income group.

MOOD/ANXIETY DISORDER

Anxiety disorders can be chronic and constitute a considerable social burden. A relatively small group of the Canadian population experiences anxiety disorders at serious and chronic levels that interfere significantly with quality of life and ability to function in academic, occupational and social contexts.106 The high rate of co-morbidity of mood/anxiety disorder with other conditions can be burdensome, as people with multiple diagnoses require greater access to medical services than those without such concurrent disorders.

Income

Figure 41. Mood/anxiety disorder prevalence of population (age 15+) in BC, by income, CCHS 2007/08 - 2011/12



People (age 15+) with the lowest income reported the highest rate of mood/anxiety disorder (17.4%), significantly higher than other income groups.

Rates of mood/anxiety disorders decreased as income level rose.

OBESITY RATES

Adult obesity rate is defined as the percentage of the BC population (aged 18+) that are classified as obese (BMI >30 kg/m2), based on self-reported height and weight data in the CCHS. Obesity increased significantly in Canada between 1985 and 2000.

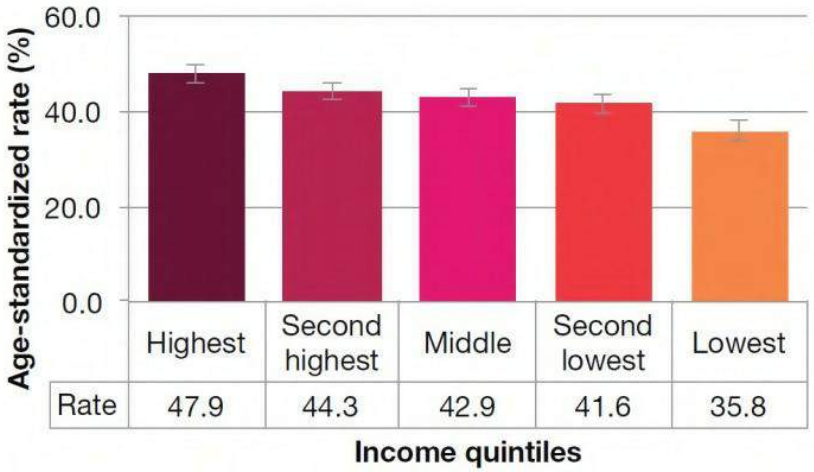
Being obese substantially increases the risk for many chronic conditions, such as diabetes, asthma, depression, and cardiovascular diseases. Obesity and other weight-related issues are shaped by social, cultural, economic, political and environmental factors, such as current trends in food production and marketing, recreation and physical activity opportunities, sedentary work and transportation.107

CONSUMPTION OF FRUITS AND VEGETABLES

Choosing and practicing healthy eating habits can promote and support social, physical and mental well-being for everyone, at all ages and stages of life.109 However, not everyone has access to or can afford nutritious, safe and personally acceptable food. How food is produced, processed, distributed and marketed as well as a person's income and area of residence can all impact food choices.110

Income

Figure 47. Adequate daily fruit and vegetable consumption (age 15+) in BC, by income, CCHS 2007/08 - 2011/12



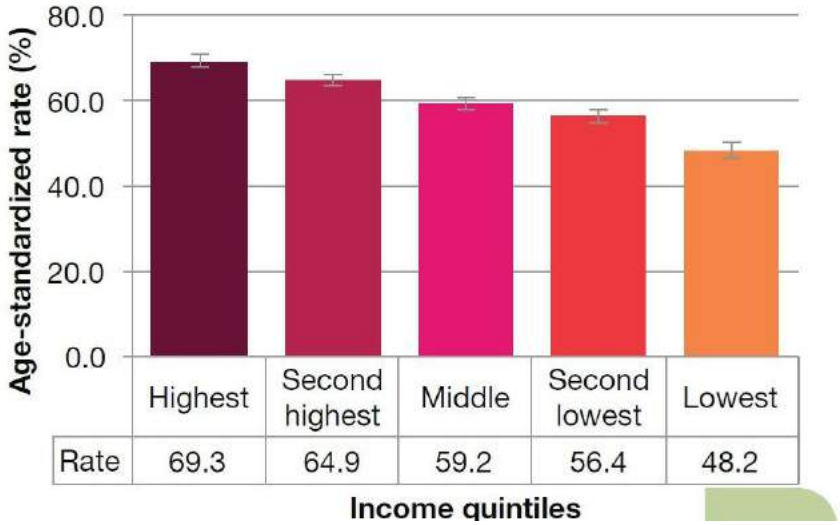
People (age 15+) with the lowest income reported significantly lower rate of adequate daily fruit and vegetable consumption (35.8%) than those in the highest income group (47.9%).

LEISURE TIME PHYSICAL ACTIVITY

The health benefits of physical activity include reduced risks of cardiovascular disease, some types of cancer, osteoporosis, diabetes, obesity, high blood pressure, depression, stress and anxiety. The economic impact of physical inactivity can be substantial to the healthcare system: the total cost of physical inactivity in BC in 2013 was estimated at $1 billion.111 Though physical activity is recognized as a key performance measure to monitor and promote healthy living in the province,112 leisure time physical activity accounts for only a portion of an individual's overall physical activity. Leisure time physical activity does not include daily living, commuting and occupational physical activity including household chores. Monitoring trends in the level of leisure time physical activity across equity dimensions in the province can help to provide some understanding of the health risks of vulnerable population groups.

Income

Figure 52. Percentage of population (age 15+) in BC that is active or moderately active during leisure time, by income, CCHS 2007/08 - 2011/12



Rates of people (age 15+) who reported as active or moderately active during leisure time declined with decreasing levels of income; 69.3% for those in the highest income group, significantly higher than those in the lowest income group (48.2%).

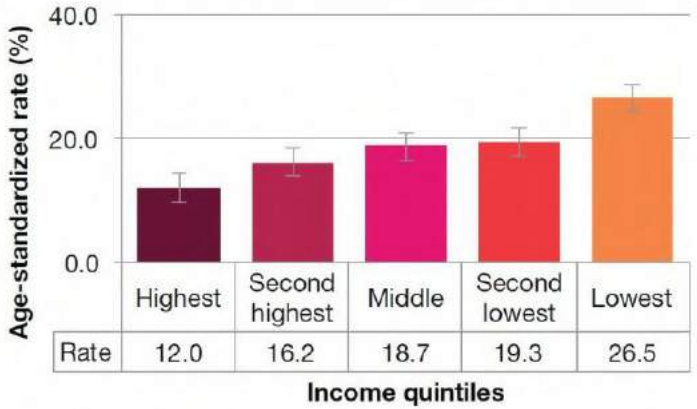
ADULT SMOKING RATES

Tobacco smoking has serious health and economic impacts on society. It is the most preventable cause of lung cancer (a leading cause of cancer death), accounting for about 85% of all new lung cancer cases in Canada.113 Smoking is estimated to increase the risk of coronary heart disease and stroke by 2 to 4 times; dying from chronic obstructive lung disease (such as bronchitis and emphysema) by 12 to 13 times; and the development of lung cancer in men by 23 times and in women by 13 times.114 The estimated annual economic burden of tobacco smoking in Canada, based on 2012 figures, is $21.3 billion.115 The annual economic burden attributable to smoking in BC is estimated at $2.0 billion in 2013.116

The profound negative consequences of tobacco smoking at the individual and societal levels and the evidence of geographic, sex, and socio-economic differences in smoking rates in BC, warrants continued monitoring of this indicator.

Income

Figure 57. Current smoking rate of population (age 20+) in BC, by income, CCHS 2007/08 - 2011/12



People (age 20+) with the lowest income reported the highest rate of smoking (26.5%).

Rates of current smoking decreased with income level.

KEY FINDINGS

Among the general BC population, the rates of different health and well-being indicators vary significantly by geographic region, sex, education and income:

- Obesity rates were more than three times higher in the HSDA with the highest rate (22.4%) compared to the one with the lowest rate (6.9%).
- Significantly higher rates of females reported mood/anxiety disorder (13.7%) and adequate fruit and vegetable consumption (48.6%) than males (7.7% and 36.4% respectively).
- People with at least a high school diploma reported significantly more favorable rates for a number of indicators than those with less than a high school education: positive perceived health (62.5% vs. 45.3%), positive perceived mental health (72.0% vs. 59.0%), adequate fruit and vegetable consumption (42.9% vs. 34.8%), leisure time physical activity (59.5% vs. 51.3%), mood/anxiety disorder (10.2% vs. 16.4%), adult obesity (12.2% vs. 17.3%) and current smoking (16.6% vs. 39.8%).
- People in the highest income group reported significantly more favorable rates than those in the lowest income group for a number of indicators: positive perceived health (71.9% vs. 47.8%), positive perceived mental health (78.8% vs. 59.2%), adequate fruit and vegetable consumption (47.9% vs. 35.8%), leisure time physical activity (69.3% vs. 48.2%), mood/anxiety disorder (7.9% vs. 17.4%) and current smoking (12.0% vs. 26.5%).

CONCLUSIONS AND NEXT STEPS

The results of analyzing 16 indicators from BC's priority health equity indicator suite demonstrate that some groups of British Columbians are doing noticeably better than others. The evidence provided here reveals some of the inequities various populations groups may face across geographic, demographic and socioeconomic dimensions. Application of similar approaches by others at the health system or program levels could reveal important health inequities in service delivery and utilization. This type of information can inform policies and programs to reduce inequitable gaps and improve opportunities for good health across all population groups. As a next step, PHSA PPH intends to engage our partners to explore how these findings can inform monitoring trends on health inequity. Additionally, working with a variety of partners, PPH also hopes to begin exploring how equity surveillance of the prioritized suite of equity indicators can inform action on promoting health equity.

Barriers to Recreation for Indigenous Peoples

A Sampling of Recent Canadian Research

SPORT AND RECREATION BARRIERS AND STRATEGIES FOR FIRST NATIONS

Aboriginal Long-term Development Pathway, Sport for Life Canada, 2016

This document presents a roadmap for developing sport and physical activity among Indigenous peoples. The Aboriginal Long-Term Participant Development Pathway is a reference for those who work with Indigenous participants in sport and recreation. It has grown out of the understanding that mainstream models for sport development do not necessarily align with Indigenous needs or experiences. As such, this document tries to address that gap by outlining the key elements that need to be considered when planning, developing, and implementing programs for and with Indigenous peoples and communities.

INDIGENOUS LONG-TERM PARTICIPANT DEVELOPMENT PATHWAY WORKSHOP (FULL DAY)

- The Indigenous Long-Term Participant Development Pathway resource and Supporting Indigenous Participation workshop is designed to help sport and physical activity leaders and organizations across Canada enhance their understanding about how to support Indigenous participants and athletes in their programming. The workshop will spend time developing an appreciation of Indigenous culture, and how that culture plays out in terms of engagement and sustained participation through the sport system. It will outline the key elements that need to be considered when planning, developing, and implementing programs for and with Indigenous peoples and communities, including a focus on supporting the physical, mental, spiritual, and cultural needs of the individual to maximize their experience in sport and physical activity. The workshop will focus on how we can adjust the competition pathway and some of the policies within the system to ensure that we create a clearer pathway for Indigenous participants and athletes.

- Upon completion of the workshop, participants will have:
  - Increased cultural awareness and understanding about our shared history as Indigenous and non-Indigenous peoples in Canada, through participation in the KAIROS Blanket Exercise
  - Increased understanding of the Indigenous and mainstream systems in Canada
  - Ideas to support participants' physical, mental (intellectual and emotional), spiritual, and cultural needs
  - Tools and an action plan to better support Indigenous participants in programs
  - A certificate of workshop completion and 3 National Coaching Certification Program (NCCP) Professional Development (PD) points (if applicable)

- To book a workshop, please fill out this form or contact us at events@sportforlife.ca.

Truth and Reconciliation Commission: Calls for Action - Sports and Reconciliation actions 87-91, page 10

CALLS FOR ACTION - SPORTS AND RECONCILIATION

87.We call upon all levels of government, in collaboration with Aboriginal peoples, sports halls of fame, and other relevant organizations, to provide public education that tells the national story of Aboriginal athletes in history.

88.We call upon all levels of government to take action to ensure long-term Aboriginal athlete development and growth, and continued support for the North American Indigenous Games, including funding to host the games and for provincial and territorial team preparation and travel.

89.We call upon the federal government to amend the Physical Activity and Sport Act to support reconciliation by ensuring that policies to promote physical activity as a fundamental element of health and well-being, reduce barriers to sports participation, increase the pursuit of excellence in sport, and build capacity in the Canadian sport system, are inclusive of Aboriginal peoples.

90.We call upon the federal government to ensure that national sports policies, programs, and initiatives are inclusive of Aboriginal peoples, including, but not limited to, establishing:

i. In collaboration with provincial and territorial governments, stable funding for, and access to, community sports programs that reflect the diverse cultures and traditional sporting activities of Aboriginal peoples.
ii. An elite athlete development program for Aboriginal athletes.
iii. Programs for coaches, trainers, and sports officials that are culturally relevant for Aboriginal peoples. iv. Anti-racism awareness and training programs.

91. We call upon the officials and host countries of international sporting events such as the Olympics, Pan Am, and Commonwealth games to ensure that Indigenous peoples' territorial protocols are respected, and local Indigenous communities are engaged in all aspects of planning and participating in such events.

Barriers to Recreation for Newcomers and Refugees

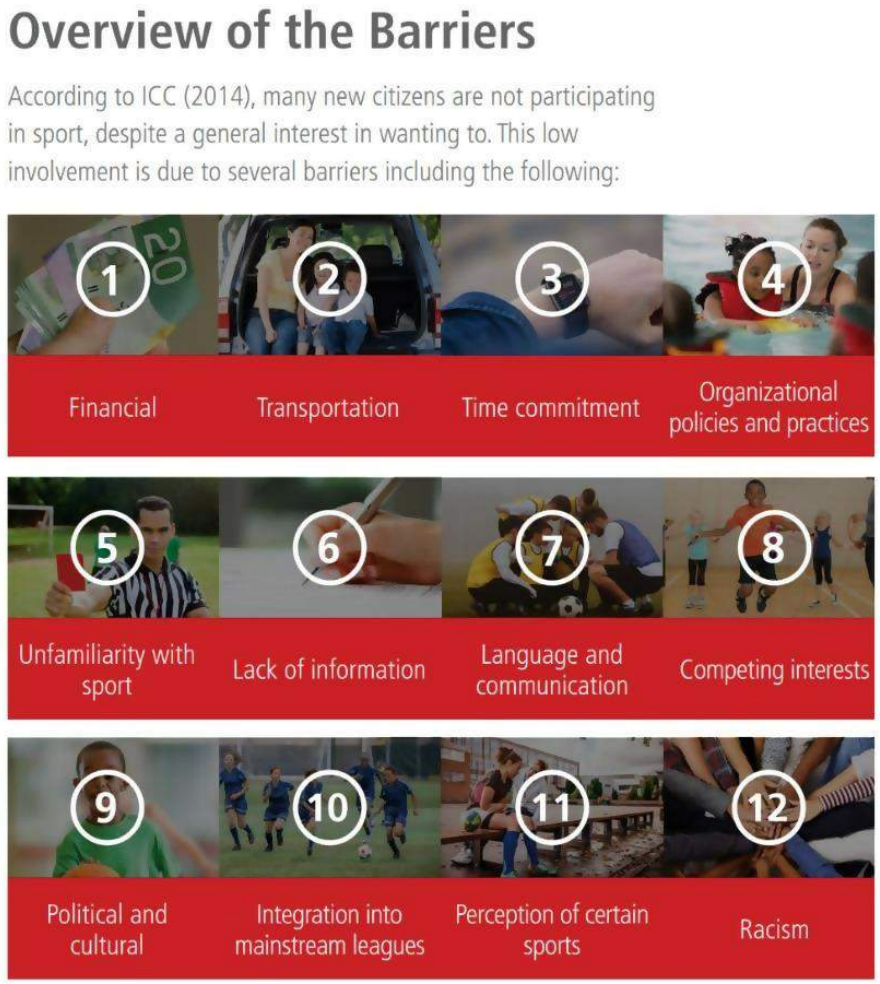
A Sampling of Recent Canadian Research on Barriers to Public Health which may be extrapolated to Recreation

SPORT AND RECREATION BARRIERS AND STRATEGIES FOR NEWCOMERS

Creating Inclusion of Newcomers in Sport and Physical Activity, Sport for Life Canada, 2014

Newcomers to Canada may have established their basic needs (e.g. a home, work, school for children) but they may not have integrated into their communities. Many may struggle to find a place in Canada well after they arrive, and sport and physical activity can be an important vehicle for helping them feel that they belong.

The ICC (2014) has affirmed the existence of several barriers that prevent the inclusion in sport. Although the report is specific to new citizens, some of the barriers identified may resonate with other populations as well, since we are still struggling to eliminate these barriers for all Canadians who wish to be physically active. The ICC (2014) report also provides an excellent compilation of information that can guide sport and physical activity leaders as they strive to meet the needs of newcomers. As the report confirms, "the good news is that the barriers cited by new citizens are mainly structural challenges, rather than cultural issues".



PUBLIC HEALTH SERVICES AND NEW CANADIANS/REFUGEES

The following barriers to access, availability, and applicability/appropriateness of public health facilities and services for newcomers more than likely corresponds to similar barriers in sport and recreation facilities and services for newcomers.

IMMIGRANT POPULATIONS/NEW CANADIANS

Source: http://www.bccdc.ca/pop-public-health/Documents/RHIImmigrantPopulationRecommendations1.pdf

IMMIGRANT POPULATION WORKING GROUP RECOMMENDATIONS

The Working Group used "A Framework for Conceptualizing Equity in Health Care"1 to organize recommendations. This framework is based on three dimensions for understanding equity in the delivery of health services:

- Availability,
- Accessibility,
- Acceptability.

Based on five meetings of the Immigrant Population Working Group and a Community Engagement meeting with various settlement and immigrant serving agencies, a number of Barriers and Opportunities for Action were identified. The following is a summary of the Working Group's findings.

1. AVAILABILITY OF SERVICES

Barrier

Immigrants can experience difficulties finding a family physician and accessing health care in their own language.

Opportunities for Action

- Increase capacity within the interpreting community to provide services to GPs.
- Provide the opportunity for foreign trained health care professionals to act as cultural health brokers. It can be challenging for some immigrant sub-groups (e.g. sponsored seniors) to obtain extended medical care.
- Improve the availability of extended health care services.

2. ACCESSIBILITY OF SERVICES

Barrier

Immigrants have challenges in navigating the complexity of the Canadian health care system.

Opportunities for Action

- Increase support for cultural health brokers.
- Hire foreign trained health care professionals as cultural health brokers.

Barrier

A lack of culturally responsive and (geographically) accessible health services means:

- Immigrants may travel long distances.
- Services may not be provided at suitable times for immigrants.
- Health care providers may not recognize

mental health issues of immigrants

Opportunities for Action

Partner with localized immigrant community organizations to provide:

- Health promotion programs,
- Medical outreach services,
- Mental health services.

Barrier

Discontinuity between settlement services and health services means that settlement workers often have limited knowledge about available health services.

Opportunities for Action

- Build health promotion capacity among settlement workers & immigrant serving agencies.
- Improve information support between health literacy coordinators and settlement agencies.
- Improve collaboration between community agencies and settlement workers. Information is provided in a way that does not enhance health literacy, such as using only English and using jargon or advanced vocabulary.
- Improve health literacy by utilizing: »» cultural health brokers and existing community programs, » media, such as radio and TV, and »» ESL classes.
- Promote awareness of interpreting services for health care providers.
- Develop partnerships between immigrant serving agencies and the BC Health Literacy Strategy.

Barrier

Waiting periods can delay access for new immigrants to access the publicly funded health care system.

Opportunities for Action

- Examine waiting period policies in BC, to ensure they meet the Accessibility Principle of the Canada Health Act. The Social Determinants of Health including poverty, transportation and housing affect health status of immigrants.
- Provide support within the health sector to address the social determinants of health.

3. ACCEPTABILITY OF SERVICES/PATIENT CENTERED CARE

Barrier

- Limited cultural competency means that health care is not always culturally responsive.
- Limited cultural safety means that immigrants don't always feel their cultural identity has been respected.

Opportunities for Action

Improve culturally competency and cultural safety by:

- providing education to health care providers, including how to work with cultural brokers and interpreters, as well as on the use of alternate therapies, and
- utilizing the knowledge and expertise of immigrant serving agencies to help train health care providers and/or improve health programs and services.

REFUGEES AND MIGRANT WORKERS TO CANADA

Source: http://www.bccdc.ca/pop-public-health/Documents/RHIRefugeePopulationRecommendations1.pdf

REFUGEE POPULATION WORKING GROUP RECOMMENDATIONS

The Working Group defined "refugee" to include government-assisted refugees (GAR), refugee claimants and migrant workers. Over the course of five meetings, the Refugee Population Working Group identified three main strategies for how the health care system can better meet the needs of refugee populations in British Columbia. The following is a summary of Barriers and Opportunities for Action for each strategy.

1. BUILD CAPACITY AND QUALITY IN THE HEALTH CARE SYSTEM

Barrier

Limited capacity of primary care providers to take on refugee clients, as:

- interpretation services are limited.
- practitioners are insufficiently reimbursed for working with refugees.
- there is a lack of knowledge about health issues that refugees face.

Opportunities for Action

- Add refugees to chronic disease group so GPs will receive extra remuneration.
- Create MSP fee code for interpreting services.
- Create a website that provides information to primary care teams.
- Ensure the availability of specialty clinics for refugees who require enhanced medical support.

Barrier

Limited resources available to address pre/post migration stressors may lead to higher rates of mental health and substance use issues.

Opportunities for Action

- Increase availability of trauma counselling.
- Train teachers and counsellors to identify mental health concerns in refugee children.
- The Interim Federal Health (IFH) program should fund counselling and interpretation for counselling for refugees.
- Create a website to help caregivers locate resources. Inadequate medical insurance coverage for refugees.
- Extend medical coverage to migrant workers.
- Simplify the IFH processes and improve timeliness of the payment system. Inadequate number of culturally competent health care providers.
- Provide cultural competency training to front line staff, health care providers and students.
- Implement a cultural health broker program.

2. IMPROVE PARTNERSHIPS BETWEEN HEALTH CARE SYSTEM AND SETTLEMENT/COMMUNITY-BASED ORGANIZATIONS

Barrier

Limited partnerships and linkages with organizations that work with refugees to raise the awareness about the range of services that are available to refugees.

Opportunities for Action

- Create new government position that could serve as a liaison between organizations.
- Create a list of community groups arranged geographically and by language.
- Promote communication and coordination between health services and settlement agencies. Inadequate legal representation for refugees.
- Provide free legal representation for refugees.
- Ensure that laws and regulations under Employment Standards and WorkSafe BC are complied with by employers of migrant workers. Refugees face difficulties navigating the complexity of the Canadian Health Care System.
- Implement a cultural health broker program, building on existing models.

3. ADDRESS THE SOCIAL DETERMINANTS OF HEALTH IN ORDER TO IMPROVE HEALTH CARE SYSTEM UTILIZATION

Barrier

Lack of safe, affordable and adequate housing, and difficulties in securing housing.

Opportunities for Action

- Increase the number of housing search workers.
- Eliminate wait period for BC Rental Assistance.
- Increase the transition time period out of Welcome House. Financial constraints affect access to health care.
- Enhance level of income assistance.
- Extend income assistance period for refugees, after they find employment.
- Abolish travel loan repayment.
- Provide childcare for two years post-arrival. Insufficient job training and employment opportunities for refugees.
- Develop job coaching, counselling and specialty training services for refugees. Miscommunication between health care providers and refugees.
- Increase diversity of types of English as a second language classes, including programs for illiterate people, different learning abilities, locations, rates of learning, etc.

Barrier

Difficulties with mobility and transportation to access health care.

Opportunities for Action

- Provide bus pass.
- Revise policy around the number of strollers permitted on the bus.
- Develop and fund mobile health clinic.
- Provide accompaniment (e.g. cultural health broker).