



ABORIGINAL WOMEN IN CANADA

Gender, Socio-Economic Determinants of Health, and Initiatives to Close the Wellness Gap

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The circumstances in which people are born, grow, live, work and age are responsible for most of the health inequities that have persisted and widened within and between countries.¹ These circumstances are commonly referred to as determinants of health. While a number of agencies and organizations have identified different determinants as contributing to ill health and inequities, they typically include: early child development, education, income, employment and the nature of employment, social and physical environments, personal health practices and coping skills, access to health services, racism, and gender.² Within the context of Aboriginal peoples in Canada, these determinants have worked in concert with Aboriginal-specific determinants such as culture, self-determination, and colonialism to produce significant health disparities compared to non-Aboriginal Canadians.³ These disparities are felt by many Aboriginal women who may experience accumulated disadvantage from the interaction of gender with other determinants. This paper explores the role that gender plays, alone and in concert with other determinants, to affect the health status of Aboriginal women across Canada, and highlights some initiatives aimed at improving their health and well-being.

The paper begins by exploring the historical and socio-economic context of Aboriginal women's lives that have so profoundly impacted their health and wellbeing. It then examines the influence of gender on the health of women generally, and on Aboriginal women specifically. This is followed by an overview of some of the health disparities between First Nations, Inuit and Métis women compared with non-Aboriginal women today, and of the barriers that must be overcome to

address these disparities. In considering health disparities, it is important to remember that Aboriginal individuals, families and communities exhibit tremendous strength and resiliency in overcoming challenges and barriers to health; this is reflected in improvements in many socio-economic and health indicators in recent decades. That said, however, ongoing health disparities highlight the need for further action on the part of Aboriginal and non-Aboriginal governments and organizations to work together to foster a more equitable environment in which Aboriginal women's health and well-being can be improved. The paper concludes by highlighting some promising examples of legal, policy and program initiatives that have been implemented to address some of these pressing health issues.

This paper builds on a discussion about gender as part of a social determinants of health framework developed for the National Collaborating Centre for Aboriginal Health's (2011) report, *The State of the Knowledge on Aboriginal Health: A Review of Public Health in Canada*.ⁱⁱ While the report highlighted some gender differences with respect to a range of social determinants (including education, income, family status, among others), as well as with respect to some health issues, it did not adopt a gendered perspective and the information is dispersed across a lengthy report. This paper aims to provide a gendered perspective and to compile the available information on gender and Aboriginal women's health. The published and unpublished literature utilized in *The State of the Knowledge* report helped narrow the focus of this paper to the issues considered most critical to the health and well-being of Aboriginal women. Additional supporting literature was

identified through a search of both Google and Google Scholar, using terms that included: "Aboriginal/First Nations/Inuit/Métis," "women," and "health," as well as terms that related to the specific health issue identified (i.e. HIV/AIDS, cancer, violence, etc.). This paper is not systematic or comprehensive, nor does it attempt to critically appraise the literature.

The Relationship Between Social Determinants and Aboriginal Peoples' Health

In recent years, health disparities have increasingly been explained through a conceptual framework which links social determinants with the health and lives of Aboriginal peoples. Aboriginal peoples generally view health holistically as encompassing physical, spiritual, emotional and mental dimensions.⁴ These dimensions have been influenced by a broad range of circumstances, environments, structures, systems and institutions that have "influenced the development and maintenance of [Aboriginal peoples'] health" and led to generally burdensome health disparities compared with non-Aboriginal people.⁵ However, just as the contexts in which First Nations, Inuit and Métis peoples live reflect diversity, so too do disparities in health. While Aboriginal peoples may share common experiences such as loss of land, language, and socio-cultural resources, as well as racism, discrimination and social exclusion, differences in the origin, form and impact of these experiences have shaped the health and well-being of individuals, families, communities and nations differently.⁶

Loppie-Reading and Wien (2009) provide an Integrated Life Course and Social Determinants Model of Aboriginal Health as a framework for understanding

ⁱ The term 'Aboriginal' is used throughout this paper to denote the First Nations (both status/non-status and on/off reserve), Inuit and Métis peoples of Canada collectively. In Referring to the literature, it must be noted that other writers may not use the term in such an inclusive way. Their use of the term remains their own. Wherever possible, the terms First Nations, Inuit and Métis are used to denote specific groups of Aboriginal People.

ⁱⁱ Please refer to the state of knowledge report regarding the initial search strategy for relevant literature.



social determinants as either proximal, intermediate, or distal. Proximal determinants are conditions that have a direct impact on physical, emotional, mental or spiritual health, and can include housing quality, rural residency, living conditions, family violence, health behaviours, employment, income, education, and food insecurity.⁷ These determinants influence health by affecting the capacity of individuals to meet their basic survival needs, and by contributing to stressors that in turn generate or exacerbate health problems. Intermediate determinants are those conditions that are thought to be the origins of proximal determinants and can include: health care systems, educational systems, community infrastructure, resources and capacities, environmental stewardship, and cultural continuity. Loppie-Reading and Wien highlight that differential access to health care, education, and community resources can create barriers that impact health and well-being. In addition, traditional ties to the natural environment and the degree of social and cultural cohesion within

communities (including a strong sense of identity, spirituality, self-determination, and intergenerational connectedness) are important in Aboriginal peoples' lives and are a strong determinant of their health and well-being. Finally, distal determinants are those which have the most profound influence on the health of populations because "they represent political, economic, and social contexts that construct both intermediate and proximal determinants."⁸ These determinants include the differential experiences Aboriginal peoples have had with colonialism, racism, social exclusion, and self-determination.

While this framework does not specifically address gender as a social determinant, it can be considered as a distal determinant because of the way it interacts with other determinants at all three levels to "create conditions and problems that are unique, more prevalent, more serious or different with respect to risk factors or effective interventions for men and women."⁹ It can be the basis for discrimination, leading to

material, social and health inequities that can marginalize women.

Gender as a Social Determinant

This section will explore the role of gender as a social determinant of women's health generally, and for Aboriginal women specifically. However, it is first necessary to define the term 'gender.'

'Gender' and 'sex' are often confused and used interchangeably in the literature, however, they are two distinct concepts that impact health through different mechanisms. 'Gender' refers to the socially constructed perceptions of feminine and masculine, while 'sex' refers to the biological differences between men and women.¹⁰ As defined by Johnson, Greaves, and Repta (2009), "gender is a multidimensional social construct that is culturally based and historically specific, and thus constantly changing," while "sex is a multidimensional biological construct that encompasses anatomy, physiology, genes, and hormones, which together

affect how we are labeled and treated in the world.”¹¹ While the two concepts are distinct, they are closely related and influence each other in complex ways. Social factors and biological differences do not operate in isolation: biology may condition behavior but biology is in turn conditioned by the social environment.¹²

Both sex and gender can have differential impacts in terms of health risks, symptom expression, and health outcomes.¹³ Women experience some unique health risks, such as those associated with reproduction. They are more likely to suffer from mental health issues (e.g. depression or anxiety) and from a wider range of cancers than men, while men are more likely to die prematurely.¹⁴ Women have also reported unique symptoms from men on certain illnesses or diseases, such as those associated with stroke.¹⁵ As a result, women may not recognize the symptoms and may delay in seeking care.¹⁶

There are powerful, pervasive values and attitudes about “gender-based social roles

and behaviours that are deeply embedded in social structures. ... [These] norms are perpetuated by social traditions that govern and constrain behaviours of both women and men, and by social institutions that produce laws and codes of conduct that maintain gender inequities.”¹⁷ These values and attitudes can form the basis upon which women face discrimination, creating income, employment and education inequities that have long-ranging impacts on the health of women and the type of health care they receive. These inequities affect the level of power and resources available to women. In many parts of the world, considerable gender inequities continue to exist because “women continue to have fewer rights, lower education and health status, less income, and less access to resources and decision-making than men.”¹⁸ Even in places where there have been considerable improvements in the socio-economic status of women, gender inequities in terms of opportunities for employment, quality of employment, and wages continue to exist.¹⁹

Many Aboriginal women face discrimination not only on the basis of gender, but also on class and race. Aboriginal women are more likely to experience lower quality housing, poorer physical environment, lower educational levels, lower socio-economic status, and fewer employment opportunities compared with non-Aboriginal women.²⁰ These determinants of health are often cyclical; that is, inequalities in one determinant of health (i.e. income) can stem from inequalities in another (i.e. level of education), perpetuating a cycle of inequalities that many Aboriginal women in Canada face on a daily basis. In addition, the health inequalities faced by Aboriginal women are deeply connected to a history of colonization, which will be discussed in greater detail in the following section.

The Historical and Socio-Economic Context of Aboriginal Women’s Health

Historical circumstances have shaped the current social, political and economic realities of Aboriginal women’s lives, which in turn impact their physical, emotional and mental health. This section provides an overview of how gender has interacted with historical and socio-economic determinants to impact the health and well-being of Aboriginal women, and the jurisdictional barriers that may limit their access to health services.

Historical determinants

Aboriginal women’s health in Canada must be understood within the context of the marginalization and oppression experienced by Aboriginal peoples generally as a result of colonial policies and practices implemented by European colonizers.²¹ Traditionally, women played a strong and central role in Aboriginal societies, and family breakdown was rare.²² While differences existed according to culture and tribal traditions, most Aboriginal societies were matriarchal



and matrilineal;²³ that is, women were the head of their household and descent was traced through the maternal line. Women played an essential economic role, their work was generally considered complementary to men, they possessed and wielded power and control over the distribution of resources, and they made a vital contribution to the cultural and physical survival of their communities.²⁴ Women were also respected because they were viewed as being closest to Mother Earth and Creation, and the foundation of the nation.²⁵ The importance of women in traditional Aboriginal societies is highlighted in the example of the Iroquois, where women played a crucial role in determining leadership, were involved in conflict resolution and making major decisions like declaring war, had supreme authority in the household, had the right to own land and other assets, and had the freedom to divorce and remarry.²⁶

In contrast, colonial authorities imposed a patriarchal social structure which eroded Aboriginal cultural values and gender roles. Within this imposed structure, not only were Aboriginal people considered an inferior class of people, but Aboriginal women were considered an inferior gender within that inferior class.²⁷ This discrimination against women was ultimately reflected in the 1876 *Indian Act* which replaced the matrilineal system with a patriarchal system, elevating the power and authority of men at the expense of women.²⁸ Under the Act, the federal government gave itself the power to define Indian identity, and their definition clearly discriminated against First Nations women.²⁹ Women became disenfranchised from Indian status and rights if they married non-status men,³⁰ they became largely excluded from the decision-making process,³¹ and their authority was undermined by a denial of household and property rights.³²

A central feature of this imposed patriarchal societal structure is the belief in

the inferiority of women by many men.³³ This belief began to infiltrate First Nations communities. A large number of First Nations women lost status or membership as a result of provisions contained in the *Indian Act*.³⁴ Not only did this have a direct impact on their access to health services, it also resulted in an erosion of cultural identity and feelings of self-worth and belonging.³⁵ Cultural identity promotes good health in that it acts as an anchor that helps women deal with the many factors that shape their health and well-being.³⁶ First Nations women have successfully fought to remove some of the more discriminatory aspects of the *Indian Act* and have their membership reinstated. Nevertheless, challenges remain with respect to regaining their property and civil rights.³⁷

Other colonial policies continue to be damaging to Aboriginal peoples' health and well-being generally, including imposition of the residential school system and past and current child welfare policies. Impacts of the residential school system, including an erosion of Aboriginal culture and values, widespread socio-economic marginalization, loss of self-esteem, and subsequent social problems within many Aboriginal communities, have been well-documented.³⁸ The impacts of this enduring trauma are reflected in past and continuing over-representation of Aboriginal children receiving child protection services.³⁹ The resulting conflicts and trauma from the imposition of such colonial policies are difficult to resolve in the context of impoverished living conditions that prevent adequate support for psychological and emotional needs.⁴⁰ They are also difficult to resolve in the context of ongoing federal and provincial government policies that continue to restrict the ability of Aboriginal peoples to shape their life opportunities and their social and health status.⁴¹ These challenges differentially affect the health and well-being of Aboriginal women as they are more likely

to experience poverty and disadvantage compared to Aboriginal men, to experience violence and trauma in their homes compared with both Aboriginal men and non-Aboriginal women, and to be the sole caregiver for their children.⁴²

Despite these challenges, Aboriginal women have demonstrated strength and resiliency in fighting to improve their quality of life in both the political sphere and within their communities. Individually and through organized Aboriginal women's groups such as the Native Women's Association of Canada, they have pushed to be part of the policy and legislative processes that are being used to develop forms of Aboriginal government, and to have their civil and political rights be reinstated.⁴³ Within their communities, Aboriginal women are beginning to take meaningful roles in the advancement and empowerment of their people as mothers and grandmothers, and as community leaders and activists.⁴⁴

Socio-economic determinants

The burden of poverty falls most heavily on certain groups (women, children, ethnic and minority groups, and the disabled) and in specific geographic regions.⁴⁵ For Aboriginal women in Canada, rates of poverty are double that of other Canadian women.⁴⁶ This can be attributed, in large part, to inequities in educational attainment, employment and income, and to family status (that is, family size and number of wage earners living in a household).

In terms of education, Aboriginal women are more likely to graduate from high school or complete a Bachelor's degree compared to their male counterparts, but less likely compared to non-Aboriginal women.⁴⁷ According to the 2006 Census, high school graduation rates for women aged 25 and older were 7-33% lower for Aboriginal women compared to non-Aboriginal women (Table 1).⁴⁸ The 2006 Census also showed that among women

Table 1: Educational attainment summary of Aboriginal women and non-Aboriginal women 25 years and older

	First Nations	Métis	Inuit	Non-Aboriginal
Highschool graduation	61%	73%	47%	80%
Bachelor's degree or higher	8.4%	9.4%	4.6%	20.3%

Table 2: Median income, Aboriginal women (age 15 and older) compared with Aboriginal men and non-Aboriginal men and women, 2006 Census⁵⁷

	Median Income
Aboriginal women	\$15,654
First Nations	\$14,490
Métis	\$17,520
Inuit	\$16,599
Aboriginal men	\$18,714
Non-Aboriginal women	\$20,640
Non-Aboriginal men	\$32,639

aged 25 and older, more than twice as many non-Aboriginal women achieved a bachelor's degree or higher compared to Aboriginal women (Table 1). Despite these disparities, there have been considerable improvements in both high school and post-secondary school completion rates for First Nations, Inuit and Métis women since the 2001 Census. This demonstrates the resiliency, strength and determination of Aboriginal women, many of whom are overcoming multiple barriers (i.e. raising a child alone and living in poverty) to improve their socio-economic circumstances through higher education.

Educational attainment is associated with employment status, affecting both the level of employment and the nature of that employment. Statistics Canada Census 2006 reports that Aboriginal women are slightly more likely to be employed compared with Aboriginal men, but less likely compared with non-Aboriginal women.⁵⁰ In 2006, Aboriginal women had an unemployment rate of 13.5% compared to 16.1% for Aboriginal men and only

6.4% for other Canadian women.⁵¹ Unemployment rates were highest among First Nations women living on reserve (20.6%), followed by Inuit women living within Inuit Nunangat⁵² (17.5%) and outside Inuit Nunangat (14.1%), First Nations women living off reserve (13.8%), and Métis women (9.5%).⁵³ Of Aboriginal women who are employed, more are likely to be employed in lower-paying jobs such as sales or administration.⁵⁴

In terms of income, according to Statistics Canada 2006 Census, Aboriginal women have lower median incomes than both Aboriginal men and non-Aboriginal women (Table 2). However, the gender gap between the median incomes of Aboriginal men and women is narrower than it is for non-Aboriginal men and women, suggesting a greater degree of gender income equality (albeit at lower income levels).⁵⁵ Median income levels were highest among Métis women, followed by Inuit, and First Nations women. The benefits of post-secondary education are demonstrated by the finding that Aboriginal women with

a university degree have higher median incomes than non-Aboriginal women with equivalent education.⁵⁶

Poverty is also exacerbated by family status. While most Aboriginal people lived in two-parent households (58%) in 2006, Aboriginal households were more likely to be headed by a single parent compared with non-Aboriginal households, and Aboriginal women were nearly five times more likely to be that single parent.⁵⁸ The percentage of two parent households was highest among Inuit families (70%), followed by Métis (65%) and First Nations (54%) families compared with 82% of non-Aboriginal families.⁵⁹ These percentages remained virtually unchanged from Statistics Canada's 2001 Census. Living in single parent households can place additional financial, as well as mental and emotional strains, on families.

Socio-economic determinants such as these may impact Aboriginal women's ability to access health care services equitably. They may not be able to afford additional health services not covered under Canada's comprehensive health insurance system, or they may lack the knowledge they need to understand the nature of their health concerns, their options for treating them, and the services they may have access to. In addition, the demands of single parenthood may impose additional barriers to accessing health care such as the financial costs associated with childcare and transportation to attend appointments.

Jurisdictional context

Aboriginal women's health is also affected by inequitable access to health services and benefits resulting from the fragmented and complex nature of the health care system for Aboriginal people generally. This fragmented health care system has differential impacts on First Nations, Métis and Inuit. The federal government provides limited primary health services to registered First Nations

people living on reserve and Inuit living within their traditional territories, as well as supplementary health benefits (through the Non-Insured Health Benefits [NIHB] program) to all registered Indians and Inuit.⁶⁰ In addition, they provide funding for a range of community-based programs targeted at addressing specific health issues; most of this funding is targeted at registered First Nations living on reserve and Inuit living within their traditional territories.⁶¹ All other Aboriginal people, including Métis, receive their medical care primarily from provincial and territorial governments which deliver universal health services to all residents within their jurisdiction. Within this framework, little attention is paid to specific cultural needs. In addition, since the late 1980s, the federal government has been encouraging the devolution of responsibility for health care to Aboriginal health boards and other authorities, which in turn has resulted in unequal provision of health services between provinces/territories and between communities.⁶²

Health Status of Aboriginal Women

As a result of the historical and socio-economic context of Aboriginal women's lives, they carry a disproportionate burden of poor health. It is well known that:

[L]ife expectancy is shorter and most diseases are more common further down the social ladder in each society. ... The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age.⁶³

Despite improvements in recent decades, Aboriginal women still have lower life expectancies and poorer conceptions of their health compared to non-Aboriginal women.⁶⁴ Increases in the prevalence of diabetes, cancer, and HIV/AIDS among Aboriginal women have emerged as public health concerns. In addition, the mental

health and well-being of many Aboriginal women continues to be a concern as a result of alcohol, drug abuse and domestic violence. This section will summarize current knowledge about these pressing health issues, which have been organized here into two categories: physical health and social/emotional well-being. While it is recognized that high fertility rates among Aboriginal women is an important gender-related health issue, this topic will not be a focus here because it has health implications extending beyond mothers to their infants, and the topic has been covered in other National Collaborating Centre for Aboriginal Health publications.⁶⁵

Physical health

Over the past few decades, prevalence rates for Type 2 diabetes, for which obesity, inactivity, poor diet and aging are considered risk factors, have been increasing rapidly. This global epidemic is considered to affect Indigenous populations disproportionately,⁶⁶ however rates vary widely. Rates of diabetes among Aboriginal people have been found to be highest in Saskatchewan, Manitoba, and Ontario, and lowest in BC.⁶⁷ They have also been found to be much higher for First Nations communities than for Métis and Inuit.⁶⁸ Prevalence rates have been particularly alarming among First Nations women, especially during their reproductive years.⁶⁹ A cross-Saskatchewan study by Dyck et al. (2010) showed incidence and prevalence of diabetes among First Nations women that were four times higher than for non-Aboriginal women, compared to rates among First Nations men that were 2.5 times higher than for non-Aboriginal men.⁷⁰ However, while overall prevalence rates were found to be considerably higher among the First Nations population, the rate of growth among First Nations women was in fact lower than for First Nations men and for non-Aboriginal men and women.⁷¹ The study also showed a tremendous increase in prevalence of diabetes over the 1980 to

2005 study period, and that Aboriginal Canadians are being diagnosed with the disease at a much younger age than non-Aboriginal Canadians. While diabetes tends to strike non-Aboriginal people in their 70s, members of First Nations are developing this illness by their 40s.⁷² Contributing to the high rates of diabetes are high rates of overweight and obesity among Aboriginal peoples, particularly among women.⁷³ Over time, diabetes can lead to a number of health complications including increasing risk of cardiovascular (heart) disease, hypertension (high blood pressure), stroke, kidney disease, and eye disease.⁷⁴

While not all provincial/territorial cancer registries collect data on ethnicity, there is also evidence to suggest that cancer, particularly cervical cancer, has become an important health issue among Aboriginal women. While there is no national data on cervical cancer among Aboriginal women, regional studies have shown that they are disproportionately affected by cervical cancer. A study by Young et al. (2000) found that compared to non-Aboriginal women, "Aboriginal women had 1.8 and 3.6 times the age-standardized incidence rates of in situ and invasive cervical cancer, respectively."⁷⁵ Separate studies have shown high cervical cancer rates among Aboriginal women in the Northwest Territories and Nunavut,⁷⁶ and among Status Indian women in Saskatchewan.⁷⁷ One of the risk factors in cervical cancer is tobacco smoking,⁷⁸ and Aboriginal women aged 15 and over are nearly twice as likely to report smoking daily (39% compared to 20%).⁷⁹

While Papanicolaou (Pap) screening programs have helped reduce the incidence of cervical cancer and mortality over the past 50 years, mortality rates for cervical cancer are still higher for Aboriginal women compared to non-Aboriginal women.⁸⁰ For example, a study on cervical cancer among First Nations women in BC found they had a mortality rate that was nearly six times that of the national

average.⁸¹ A key factor in these higher mortality rates is the lower levels of participation by Aboriginal women in screening processes, particularly among women living in rural and remote areas.⁸² Data from a cervical cancer screening program conducted by Manitoba Health from April 2002 to March 2005 showed overall cervical cancer screening rates were similar among on-reserve and off-reserve women in the Ste. Rose du Lac area of Manitoba (both groups had lower rates of participation than the provincial average, reflecting common barriers to accessing health services, such as lack of proximity).⁸³ However, this data also revealed significantly higher screening rates among off-reserve women in the 30-39 and 40-49 age groups compared to their on-reserve counterparts, suggesting that on-reserve women faced additional social and cultural barriers that may limit their access to screening services. Possible additional barriers suggested by the authors included perceptions of ostracization from the non-Aboriginal community, being uncomfortable with screening procedures, and chronic social crises that may prevent them from seeking Pap tests.⁸⁴ As a result, Pap tests may not be occurring on a regular basis and their timing may not be early enough for effective treatment.⁸⁵ In addition, the socio-economic circumstances in which women live can impact their survival rates.⁸⁶

HIV/AIDS has also been identified as a pressing health issue among Aboriginal women, who have been shown to be twice as vulnerable to HIV infection compared to their male counterparts and nearly three times more likely to contract AIDS than non-Aboriginal women.⁸⁷ This health issue is having the greatest impact among the First Nations population. Of 605 Aboriginal AIDS cases reported up to December 31, 2006, 73.1% were First Nations, 7.3% were Métis, and 3.6% were Inuit (Table 3).⁸⁸ With 61% of the Aboriginal population reporting First Nations identity, this

Table 3: Comparison of First Nations, Inuit and Métis AIDS cases reported to December 31, 2006 to their representation as a proportion of the total Aboriginal population⁹¹

	First Nations	Métis	Inuit
AIDS cases reported to December 31, 2006 (n=605)	73.1%	7.3%	3.6%
Representation within the total Aboriginal population	61.3%	34.2%	4.4%

finding reveals an over-representation of First Nations in AIDS cases. The biggest cause for concern is how quickly these rates are increasing, particularly for First Nations and Inuit women.⁸⁹ The most common mode of transmission of HIV/AIDS in the Aboriginal community is injection drug use.⁹⁰

The advent of antiretroviral treatment (ART) in 1996 has resulted in significantly prolonging and improving the quality of life for people living with HIV/AIDS. Despite these medical advances, recent studies have shown that Aboriginal women die of AIDS sooner than the general population and have a lower utilization of antiretroviral treatment (ART).⁹² McCall et al. (2009) identified several barriers that prevent Aboriginal women from seeking timely treatment for HIV infection, including fear of rejection from family, friends and health care providers; a sense of futility and inevitability; social support systems that impede access to treatment and care; and the fact that HIV was just one of many competing problems Aboriginal women face daily.⁹³ Rates of adherence to HIV medications are also reported to be lower for Aboriginal people compared with non-Aboriginal people.⁹⁴ Risk factors impacting suboptimal adherence can include: cognitive and psychological function (e.g. depression, mental health issues), substance use, disease progression and degree of symptoms, health care environment and material factors (e.g. access to care, financial concerns), treatment experiences (e.g. side effects), support from providers and others, and

informational resources (e.g. knowledge about HIV and need for adherence).⁹⁵ The Canadian Aboriginal AIDS Network (2004) notes further that despite Aboriginal women's overrepresentation in HIV/AIDS statistics, there is a lack of gender/Aboriginal specific resources, programs and services to support them.⁹⁶

Researchers have attributed the high rates of HIV/AIDS among Aboriginal people to both the intergenerational trauma of the residential school era, which has resulted in individuals resorting to negative coping mechanisms such as alcohol, drug abuse and violence, and to the impoverished living conditions in many Aboriginal communities that prevent adequate support for a person's psychological and emotional needs.⁹⁷ Aboriginal women are vulnerable in this regard as they are significantly more likely than non-Aboriginal women to have experienced physical and sexual violence.⁹⁸ Women who have been coerced into having sex against their will are more likely to contract HIV and other sexually transmitted diseases.⁹⁹ As noted by McCall et al. (2009), the current crisis of the high rates of HIV/AIDS among Aboriginal women must be understood as "one of the most devastating consequences of poverty, dispossession, violence and racialization, and ultimately, colonization."¹⁰⁰

Social/emotional well-being

While data documenting the state of Aboriginal mental health generally, and among Aboriginal women in particular, is extremely limited, it has been generally

accepted that they have poorer mental health compared with non-Aboriginal people.¹⁰¹ Mental health research focusing on this population group has tended to treat Aboriginal people as a single homogenous entity, and focus primarily on social problems such as substance abuse, violence, and suicide rather than on psychiatric disorders which stem from these social problems and in turn aggravate them.¹⁰² Generally, studies have shown that women are nearly twice as likely to experience depression compared with men.¹⁰³ Among Aboriginal women, certain groups, such as young First Nations women, are particularly vulnerable.¹⁰⁴ The role that social, economic and historical determinants play in the mental health of Aboriginal women cannot be understated. These determinants have often led to socio-economic marginalization and intergenerational trauma, resulting in depression and other psychiatric disorders, and engagement in self-destructive behaviours.¹⁰⁵

A serious threat to the well-being of many Aboriginal women is the violence they experience in their homes, their communities, and Canadian society at large. Such violence can “engender a pervasive sense of helplessness, futility and personal vulnerability.”¹⁰⁶ Aboriginal women are 3.5 times more likely to experience violence compared to their non-Aboriginal counterparts, and they are more likely to suffer from severe forms of spousal violence.¹⁰⁷ The high rates of violence Aboriginal women experience are related not only to lower socio-economic status, but also to the legacy of colonial policies like the residential school system, where many experienced sexual, physical and emotional abuse.¹⁰⁸ For some women, a legacy of these abuses has been a loss of self-esteem, alcohol and drug abuse, and the perpetuation of an existence where violence and abuse are the ‘norm.’¹⁰⁹ Prolonged exposure to abuse and neglect has been associated with complex post-traumatic stress disorder, a psychiatric

ailment characterized by impaired impulse management; chronic self-destructive behaviors; episodes of disassociation or depersonalization; alterations in self-perception manifested by a chronic sense of guilt or shame; alterations in relationships with others; and alterations in one’s belief system or the value and meaning of one’s unique life.¹¹⁰

Given the crucial problem of violence, support services need to be strengthened. Aboriginal women survivors of violence have described a lack of support from police authorities, the justice system, and from male chiefs and council members.¹¹¹ There are few services across Canada that consider the unique cultural and social context of Aboriginal women.¹¹² Inadequate funding to support new and existing Aboriginal women’s shelters is a significant challenge.¹¹³ Women’s groups in Quebec, for example, highlighted that the federal funding formula for Aboriginal women’s shelters has remained unchanged since 1995 and that these shelters receive less than one-third (on average) the funding that provincially funded

women’s shelters receive.¹¹⁴ In northern communities, the problem is exacerbated by a lack of ‘safe’ housing for victims of abuse and lengthy delays awaiting the arrival of police.¹¹⁵

A lack of support has led some Aboriginal women to move out of their reserves into urban centres to escape the violence. In fact, “a larger proportion of women leave [their] communities than men.”¹¹⁶ In cities, they may become vulnerable to risks associated with economic and social marginalization such as sexual exploitation and violence. Culane reports, for example, that Aboriginal women account for approximately one-third of the population of Vancouver’s Downtown Eastside, the poorest neighbourhood in Canada.¹¹⁷

Living in these types of conditions can contribute to harmful coping mechanisms such as substance use and addiction, which in turn can result in higher rates of suicide.¹¹⁸ While the data on the prevalence of suicide attempts among Aboriginal people is sparse, research has shown that Aboriginal women are three



times more likely to commit suicide than other Canadian women.¹¹⁹ The suicide rate, however, varies considerably among Aboriginal communities (even within the same geographical region), across Aboriginal groups, and over the lifespan.¹²⁰ In some communities, rates of suicide can be exceptionally high, while in others, the rates fall below the Canadian average. Some studies have found rates of suicide to be particularly high among adolescent Status Indian women¹²¹ and among Inuit women, particularly in Nunavut.¹²² Like other Canadian women, Aboriginal women are more likely to attempt suicide compared to their male counterparts, while Aboriginal men are more likely to commit suicide.¹²³ Cultural continuity and the development of a strong sense of identity and belonging have been identified as protective features for communities with low suicide rates.¹²⁴

Strategies and Initiatives for Improving Aboriginal Women's Health

Improving the health of Aboriginal women is critical not only for individual women, but also for the revitalization of families and communities. Women's role as mothers and primary caregivers extends their influence to the next generation. A number of promising initiatives to improve Aboriginal women's health and well-being will be highlighted in this section to demonstrate the diversity of approaches taken across the country. The examples range from the grass-roots level to federal government policy and address some of the key challenges to improving Aboriginal women's health, including achieving gender equity and improving access to culturally appropriate health care and health information. The examples also highlight initiatives that are targeted at addressing some of the pressing health issues affecting Aboriginal women identified in this paper. This section is not meant to be comprehensive.

Improving access to health care is an important step in addressing some of the health care needs of Aboriginal women. They have, to date, not been well served by the health care system. Petten (2002), for example, identifies the health care system's lack of understanding about how some diseases affect different ethnic groups; the lack of culturally appropriate treatment alternatives available; language and communication barriers that inhibit Aboriginal women's understanding of health and the types of services that are available to them; and the ability for the health care system to be sensitive to Aboriginal women's specific cultural needs as major obstacles in accessing health care.¹²⁵ In addition, Hare (2004) identifies racism, medicalized approaches to healing and wellness, and particularly in the north, geographical barriers.¹²⁶ She highlights one study by Browne et al. (2000) where Aboriginal women voiced their concerns about health care providers and services in a mainstream setting, indicating they felt "dismissed or trivialized, judged in stereotypical negative ways, and their personal circumstances ignored."¹²⁷ These types of sentiments are not unique to the study's geographic context and have been echoed by other Aboriginal women across Canada. Overcoming these barriers is essential if Aboriginal women are to be encouraged to seek health care, testing and treatment in a timely manner. Clearly there is a need to develop more culturally-sensitive service delivery models targeted to Aboriginal women.

One example of a model program for improving access to culturally-appropriate health care is the Sheway Project. A partner of the Vancouver Native Health Society (VNHS), Sheway promotes a harm reduction approach, holistic health care, and a 'homey' atmosphere for substance-using pregnant women.¹²⁸ While not specifically targeted at Aboriginal women, 70% of Sheway's clientele is Aboriginal.¹²⁹ The Sheway Project emphasizes Aboriginal women's resiliency by supporting

their self-determination, choices and empowerment.¹³⁰ Research assessing the appropriateness and suitability of the VNHS and Sheway service delivery models undertaken by Benoit et al. (2003) highlights several features of the project that are considered integral to its success, including: 1) a fluid and informal service delivery; 2) a collective, non-hierarchical staff structure; and 3) horizontal relationships between staff and clients, which the authors argue reflect the "holistic values and structures of the more communal, traditional Aboriginal societies."¹³¹ Nevertheless, research respondents identified several challenges with the Sheway model and indicated their desire to see the creation of a Healing Place in the Downtown Eastside, one that would build on the positive features of Sheway while providing for a "more holistic and integrated system of health services for Aboriginal families across the lifespan."¹³²

Some programs across Canada are dedicated to improving the health of Aboriginal women through enhancing access to cervical cancer screening. For example, the Aboriginal Health Program at BC Women's Hospital and Health Centre provides outreach, health education, and cervical cancer screening in remote areas.¹³³ A study by Black (2009) offered several suggestions for increasing Aboriginal women's participation in cervical cancer screening that could be grouped into seven categories: 1) building partnerships in the community of women you are trying to reach; 2) educating women from an early age about the importance of cervical cancer screening and the HPV vaccine's role in preventing this disease; 3) creating educational material that reflects Aboriginal women's lives; 4) organizing dedicated Pap screening days; 5) bringing services to the women who live in remote communities; 6) offering drop-in appointments; and 7) utilizing creative technology for harder to reach populations.¹³⁴ In addition,

alternative approaches to Pap testing are being explored by some researchers in an effort to improve screening rates. For example, Zehbe et al. (2011) tested a vaginal self-sampling approach among a group of First Nation women in Ontario and found that this approach was well received and viable.¹³⁵

The health of Aboriginal women may also be improved through the development of more culturally appropriate health information, education and resources. Alberta Health Services has developed an Aboriginal Cervical Cancer Screening Resource Toolkit with input from Aboriginal health care leaders, Alberta Cancer Board staff, Aboriginal community members, and First Nations and Inuit Health. The Toolkit is designed for use by healthcare workers to provide information to Aboriginal women about cervical cancer and screening. It includes background, presentation, resource and healthcare worker materials; as well as stories from Aboriginal women and hands-on tools. The toolkit has been pilot tested in several First Nations and Métis communities to ensure it meets the needs of these women.¹³⁶

In addition, researchers at the University of Western Ontario have been working in partnership with the Southern Ontario Aboriginal Diabetes Initiative (SOADI) to adapt the Ribbon of Life program so that it includes gestational diabetes as part of its awareness campaign. The Ribbon of Life was adopted in 2006 by the National Aboriginal Diabetes Association as its national symbol of diabetes awareness among Aboriginal people. It is a health promotion program that incorporates cultural elements into a holistic framework that emphasizes the necessity of balancing spiritual, emotional, physical and mental aspects of health in order to sustain healthy minds and bodies across the life span and through the generations. This is done through the symbolism associated with the Ribbon of Life's four ribbons (one in each of four



colours – white, black, yellow and red), and its seven blue beads. The modified Ribbon of Life for gestational diabetes consists of one ribbon and three beads (the original blue bead, along with a red bead representing the pregnant mother and symbolizing mother Earth, and a smaller green bead representing the baby and symbolizing new life and renewal). These researchers argue that pregnancy is an opportune time for the initiation of community-based intervention programs since pregnant women can be motivated to adopt healthier lifestyles to benefit fetal health.¹³⁷

Efforts are also underway to develop a coordinated response for addressing the impacts of HIV and AIDS in the lives of Aboriginal women. The Canadian Aboriginal AIDS Network has developed a five year strategy (2010-2015) that aims to create “environments of nurturing safety”

through the removal of barriers that affect quality of life for women with HIV/AIDS, increasing support systems for women with HIV/AIDS, and preventing new infections through positive prevention messaging directed at all Aboriginal women.¹³⁸ The strategy identifies key activities that should take place to meet five intersecting objectives: 1) strengthen the network and support for Positive Aboriginal Women (PAW) and their children in every region; 2) increase the availability and accessibility of culturally appropriate care, treatment and support services for PAW in every region; 3) lobby for policy shifts to remove and/or alleviate existing systemic barriers for PAW and their children in every region; 4) increase prevention, education and awareness on HIV and AIDS for ‘at risk’ populations of Aboriginal women in every region; and 5) increase Aboriginal women-specific community-based research.

The Government of Canada and its various departments and agencies have implemented several legislative and policy initiatives aimed at ensuring gender equity, for women generally and for Aboriginal women specifically. These include legal changes that are designed to eliminate gender discrimination embedded in the *Indian Act*, as well as initiatives aimed at ensuring future legislation and policies are viewed through a 'gender lens' that considers not only social and economic differences between the genders, but differential impacts in policy and program development as well. In 1985, the federal government adopted Bill C-31, an amendment to the *Indian Act* which: provides for the return of Indian status to women who had lost it under section 12(1) and their children; introduces new rules governing entitlement to Indian registration for children born after April 16, 1985; and provides for the ability of First Nations to develop and apply their own rules regarding band membership.¹³⁹

This bill has served to eliminate some aspects of gender discrimination in the *Indian Act* by ensuring women maintain their status if they marry a non-status man. The bill, however, still contained a discriminatory provision in the form of a 'second generation cut-off rule,' whereby grandchildren of Aboriginal grandfathers were entitled to receive status but grandchildren of Aboriginal mothers were not. Recent passage of *Bill C-3: Gender Equity and the Indian Registration Act* in December 2010 advances gender equity further by removing this discriminatory provision.¹⁴⁰ Nevertheless, controversy still surrounds both these bills,¹⁴¹ and Aboriginal women continue to lobby for the application of their civil and political rights.

The federal government has also worked to promote gender equity through encouraging the consideration of gender in the development of legislation and policies. In 1995, Cabinet approved its Federal Plan for Gender Equality which compels departments to establish "a

systematic process to inform and guide future legislation and policies at the federal level by assessing any potential differential impact on women and men."¹⁴² In response to the Federal Plan, in 1998 the Minister of Indian and Northern Affairs Canada created the Office of the Senior Advisor on Women's Issues and Gender Equality (renamed Women's Issues and Gender Equality Directorate in 1999) to develop and implement a Gender-Based Analysis Policy for the department to address gender equality issues as they relate to First Nations and northern partners.¹⁴³ This includes the development and implementation of all departmental policies, programs, communication plans, regulations and legislation; consultations and negotiations (such as self-government, land claims, treaty entitlements, and devolution); and instructions and strategies on research, dispute-resolution and litigation.¹⁴⁴

Similar initiatives have been developed by Health Canada to promote gender equity within its department. In 1999, Health Canada adopted the Women's Health Strategy as a framework to guide them in fully integrating gender-based analysis in departmental programs and policies.¹⁴⁵ The Bureau of Women's Health and Gender Analysis was given responsibility for promoting and advancing the strategy within Health Canada.¹⁴⁶ Key successes of the strategy have included establishing a Women's Health Contribution Program to support several women's health research groups and national working groups, as well as the Canadian Women's Health Network; initiating a Women's Health Indicators Project which aims to improve the ways in which women's health is measured and monitored; and coordinating, monitoring, and evaluating the implementation of a gender-based analysis process throughout Canada.¹⁴⁷ The strategy is, however, currently under review. The recognition of 'gender' as one of its dozen determinants of health by Health Canada is also a major advance in

the movement towards gender equity.¹⁴⁸ While these federal initiatives show promise in advancing the notion of gender equity and improving the lives of Aboriginal women, their families and communities, the challenge of achieving gender equity in practice will remain without sustained financial support and commitment on the part of all parties involved.

In addition to these initiatives, the federal government also provides funding for numerous community-based initiatives designed to improve the health of Aboriginal peoples generally. Many of these are targeted specifically for initiatives to address the most pressing health issues faced by Aboriginal women including obesity and diabetes; mental health, substance misuse, family violence and other intergenerational impacts from the trauma of residential school experience and other colonial policies; and HIV/AIDS.¹⁴⁹ Many of these initiatives allow Aboriginal communities to design and run programs and services that are culturally appropriate and adapted to meet the specific needs of each community. However, a common criticism of many of these types of programs is that they must often rely on short term funding allocated on the basis of community organizations' abilities to write successful grant applications, an activity that consumes considerable time and effort on the part of staff that could otherwise be directed at providing a valuable service.¹⁵⁰

Conclusion

Health is an important part of, and prerequisite for, both personal and community development. In looking at questions of Aboriginal health, gender is a key social determinant of health status. The health issues mentioned here illustrate "the intersecting issues of racialization and gender, the continuation of multiple forms of systemic discrimination, and

the extent to which health and social inequities shape the lives of many.”¹⁵¹

Research indicates that Aboriginal women across Canada face considerable barriers to health and wellness, including gendered racism, violence, poverty, single motherhood, and low rates of educational attainment and employment. This paper has reviewed some of the factors that intersect with gender to impact health and well-being of Aboriginal women, as well as recent evidence regarding their health status. It has also provided some examples of promising initiatives designed to improve the health of Aboriginal women. These examples occur at a range of scales, from federal government initiatives, to those of Aboriginal organizations, to community-based organizations, to those that are developed in partnership with multiple levels of governments and Aboriginal organizations.

The many challenges associated with health status among Aboriginal women in Canada can be largely attributed to historical precedents and the resulting socio-economic circumstances. Addressing these challenges is complex within a multi-jurisdictional framework of health care provision and within the diverse contexts of Aboriginal women’s lives. Despite this, Aboriginal women have demonstrated their strength and resiliency in coping with the challenges they face on a daily basis. They have pushed for legal and policy changes to address the underlying roots of the health inequities that exist and have shown that it is possible to overcome the considerable barriers they face in improving their health and well-being and that of their families and communities.

Resources

- Native Women’s Association of Canada
www.nwac.ca
- National Aboriginal Circle against Violence
nacafv.ca/en/mandate
- Aboriginal Justice Implementation Committee, Manitoba
www.ajic.mb.ca
- National Aboriginal Law Section, Canadian Bar Association
www.cba.org/CBA/sections_abor/
- Aboriginal Affairs and Northern Development Canada, Gender-based Analysis Policy
www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/plc_1100100028538_eng.pdf
- Health Canada, Sex and Gender-Based Analysis
www.hc-sc.gc.ca/hl-vs/gender-genre/analys/index-eng.php
- Canadian Women’s Health Network
www.cwhn.ca/en
- BC Centre of Excellence for Women’s Health,
www.bcccewh.bc.ca/about-us/
- Institute for the Advancement of Aboriginal Women
www.iaaw.ca
- Métis National Council of Women
www.metiswomen.ca
- Pauktuutit Inuit Women of Canada
www.pauktuutit.ca
- Vancouver Native Health Society
www.vnhs.net
- Aboriginal Health, BC Women’s Hospital and Health Centre
www.bcwomens.ca/services/aboriginalhealth
- Southern Ontario Aboriginal Diabetes Initiative
www.soadi.ca/resources.html
- National Aboriginal Diabetes Association
www.nada.ca
- Canadian Aboriginal AIDS Network
www.caan.ca

Endnotes

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