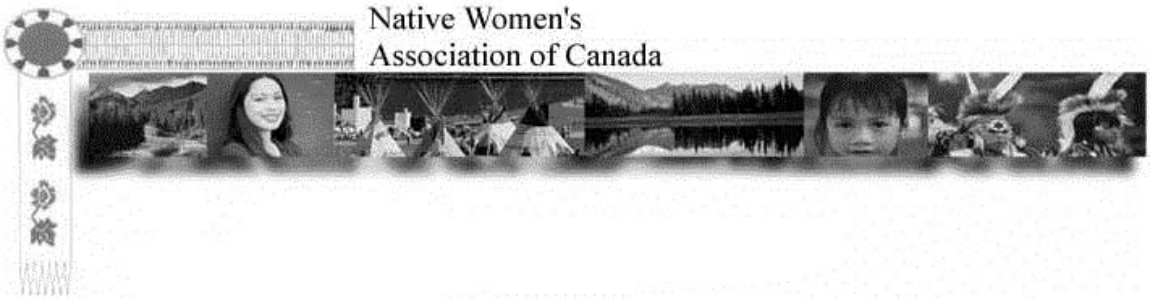

The Native Women's Association of Canada

Background Paper

Aboriginal Women's Health

Canada - Aboriginal Peoples Roundtable

Health Sectoral Session

October 2004

Introduction

> *"Indigenous women in many areas of the world are suffering from the alarming deterioration of health conditions within their communities. Inadequate and limited access to health services, lack of culturally appropriate approaches to health care, lack of outreach clinics in remote areas, deteriorating quality of air, water and land due to unchecked industrial development are just a few of the factors contributing to this downward trend. Other socio-economic factors, such as the alarming number of indigenous women, (especially in Asia) being trafficked and sold into prostitution, have led to the rapid spread of the HIV/AIDS epidemic and other sexually transmitted diseases into indigenous communities, destroying their social fabric. Changes in the traditional social, cultural and political institutions have led to an erosion or loss of practices and culturally appropriate health rules and codes of behaviour which have been instrumental in ensuring gender-sensitive approaches to health"*[1]

Unfortunately, in many areas, this is the reality for Indigenous women in Canada. Their health status is reflective of the poor health conditions of Indigenous women globally. This background document focuses on the health of Aboriginal women in Canada - a critical perspective that must be considered by all as Aboriginal leaders and First Ministers of Canada work together to develop a blueprint to improve the health status of Aboriginal peoples and health services in Canada.

The Government of Canada's announcement in September 2004 of $700 million in new Aboriginal health funding represents a solid commitment to improving the health status of Aboriginal peoples. This funding is to be spent on three areas: an Aboriginal Health Transition Fund ($200 Million), Aboriginal Health Human Resources ($100 million) and critical areas, including diabetes, youth suicide, maternal and child care ($400 million). Attention will need to be considered in each of these areas in how to best meet the needs of Aboriginal women. The Native Women's Association of Canada (NWAC) hopes to provide insight into Aboriginal women's health needs in this context.

Statistical information on key areas of concern related to the health status and needs of Aboriginal women is provided as well as a brief summary of the position of the NWAC in relation to the four priority policy areas to be addressed at the Health Sectoral Session from an Aboriginal women's perspective. These four priority policy areas are: addressing issues of jurisdiction and control, improving access and integration, building capacity and sustainability and broad determinants of health. The following is not an exhaustive discussion of the issues, but rather provides a framework for further discussion.

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[1] *Permanent Forum on Indigenous Issues, Report of the Third Session (10-21 May 2004), UN Doc. No. E/C.19/2004/23, p. 23.*

Statistical Information on Aboriginal Women and Health in Canada

General Health Concerns of Aboriginal Women

The well-documented poorer health status of Aboriginal peoples is linked to inequities in health determinants, including "lower quality housing, poorer physical environment, lower educational levels, lower socioeconomic status, fewer employment opportunities and weaker community infrastructure."[2] Aboriginal women are at higher risk for alcohol and substance abuse, yet only represent 40% of the Aboriginal treatment population in alcohol treatment centres. This is related to factors including lack of access to appropriate, women-centred treatment services, the impact of violence against Aboriginal women and lack of access to child care services.[3] Over-medicalization and over-prescription of anti-depressants to Aboriginal women are also health concerns.

A recent study by the Canadian Human Rights Commission on the Canadian prison system indicates that one key difference between male and female offenders is the higher prevalence rates of mental illness, self-abuse (such as slashing and cutting) and suicide attempts in women.[4] Given the disproportionate number of Aboriginal women in federal prisons (they make up 29% of the prison population, although they make up only 3% of the general Canadian female population), these high suicide, mental illness and self-harm rates are alarming.[5]

Particular health concerns of Aboriginal women include higher rates of diabetes among Aboriginal women compared to Aboriginal men, higher rates of gestational diabetes compared to non-Aboriginal women and higher rates of death caused by cervical cancer (for example, six times the national average for First Nations women in British Columbia, and three times as common among Inuit women in Nunavik compared to the general population)[6].

Violence and its Impact on the Health of Aboriginal Women

Violence against Aboriginal women is experienced at alarmingly high rates – leading to severely negative health impacts[7] and death. Health Canada reports that at least three-quarters of Aboriginal women have been the victims of family violence, and the overall mortality rate due to violence is three times higher for Aboriginal women than non-

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2 *Society of Obstetricians and Gynecologists of Canada (SOGC), "SOGC Policy Statement: A Guide for Health Care Professionals Working With Aboriginal Peoples", Journal SOGC, Vol. 2, April 2001, p. 3.*

3 *Aboriginal Women with Disabilities, "Alcohol Abuse", online: <http://www.schoolnet.ca/aboriginal/disable6/alcoh-e.html.>*

4 *Canadian Human Rights Commission, Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women. (Ottawa: Canadian Human Rights, Commission, 2003), p. 8. See also: Fillmore et al., "Prairie Women, Violence and Self-Harm" (The Elizabeth Fry Society of Manitoba, 2000).*

5 *Ibid, p. 6.*

6 *Ibid, p. 8.*

7 *Ibid, p. 23.*

Aboriginal women, a rate that rises to five times higher for Aboriginal women aged 25 to 44, compared to non-Aboriginal women.[8] Chronic housing shortages on-reserve, and a lack of affordable housing off-reserve, leave Aboriginal women at increased risk of violence due to a lack of practical options.[9] Lack of access to available resources further compounds this issue in northern and remote communities.[10] The rate of suicide for Aboriginal women is three times the national average for women.[11]

Sexual abuse rates are higher among Aboriginal groups. A Statistics Canada study found that 25% of Aboriginal people identified sexual abuse as a problem in their community (23% for Métis peoples, 22% for off-reserve First Nations, 29% for on-reserve First Nations and 35% for Inuit peoples).[12] Sexual abuse can lead to "psychiatric illnesses, sexual dysfunction, interpersonal difficulties and psychosomatic illnesses."[13] It is well-recognized that those who experience violence and sexual abuse as children are much more likely to suffer from emotional and behavioural problems as children.[14] Violence leads to further victimization and addictions, including involvement in the sex trade which makes Aboriginal women vulnerable to extreme forms of racialized, sexualized violence leading in turn to their disappearance and death at alarmingly high rates.[15]

Sexually Transmitted Infections, Including HIV/AIDS Among Aboriginal Women

Canadian Aboriginal women are almost three times more likely to have AIDS than non-Aboriginal women (23.1% versus 8.2%).[16] New HIV infections among Aboriginal women have increased over the past twenty years, making up 50% of new HIV cases, compared to only 16% of the non-Aboriginal population.[17] Increasingly, young Aboriginal women between the ages of 15-29 years of age are contracting HIV.[18] The two main modes of transmission of HIV for Aboriginal women are: injection drug use (64.9%) and

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[8] *Health Canada, Women's Health Bureau, "The Health of Aboriginal Women", online: <http://www.hc-sc.gc.ca/english/women/facts_issues/facts_aborig.htm>, p.1.*

[9] *Wendy Cornet and Allison Lender, Discussion Paper: Matrimonial Real Property On Reserve. (Ottawa: Cornet Consulting and Mediation, 2002) at 71 referring to Mavis A. Erickson, "Where are the Women?: Report of the Special Representative on the Protection of First Nations Women's Rights," January 12, 2001, p. 65.*

[10] *Ibid, p. 71-72.*

[11] *Supra, note 8, p. 2.*

[12] *T. Kue Young and Alan Katz, "Survivors of sexual abuse: clinical, lifestyle and reproductive consequences" (1998) 159 (4) Canadian Medical Association Journal 329 at 329.*

[13] *Ibid.*

[14] *Supra, note 8, p.1.*

[15] *See for example, C. Kingsley and M. Mark, Sacred lives: Canadian Aboriginal Children & Youth Speak out about Sexual Exploitation: Save the Children Canada. (Toronto: Save the Children Canada, 2000), p. 8, 12 which links the disproportionately high percentage (approximately 90%, 75 to 80% of whom are Aboriginal women youth) of commercially sexually exploited Aboriginal youth to childhood experiences of violence and abuse. See also Ian Brown "Main Problem Areas in Aboriginal Mental Health", online: <http://www.niichro.com/mental%20health/men_2.html>, p.3.*

[16] *Kevin Barlow, Canadian Aboriginal AIDS Network, Media Release March 5 2004, "Aboriginal Women Continue to Face Major Challenges, as International Women's Day Approaches" March 5, 2004."*

[17] *Tracey Prentice, HIV/AIDS and Aboriginal Women, Children and Families, (Ottawa: The Canadian Aboriginal AIDS Network, 2004), p. 3.*

[18] *Ibid.*

heterosexual contact (30.9%).[19] The alarming growth in HIV/AIDS among Aboriginal women calls for gender-specifically, culturally appropriate responses. Aboriginal women also suffer from higher rates of other Sexually Transmitted Infections (STIs) such as Chlamydia and gonorrhea, sometimes up to 10 times higher than the national average.[20]

Aboriginal women are likely to become mothers at a young age - 55% of Aboriginal mothers are under 25 years of age, compared to 28% for non-Aboriginal mothers.[21] The high rates of STIs, including growing rates of HIV in young Aboriginal women, coupled with high rates of reproduction at an early age, underscore the need to focus greater attention of the sexual and reproductive health and rights of Aboriginal women in Canada, particularly young Aboriginal women.[22] It has been suggested that the high rate of adolescent pregnancy contributes to the high Aboriginal infant mortality rates.[23] However, this has been challenged by Aboriginal women, who note that it is "the breakdown in traditional support structures and values, rather than teenage pregnancy *per se*, which is responsible for the health and social problems teenage parents and their families often face."[24]

Sexual and Reproductive Health Services

Sexual and reproductive health services are not adequately accessible to Aboriginal young women, particularly those who live in rural and northern areas.[25] In particular, studies assessing youth's perceptions of sexual and reproductive health services, found that youth perceive a lack of confidentiality and lack of privacy, particularly in rural communities.[26] Furthermore, access to Emergency Contraception and to abortion services is not as great for Aboriginal women, including youth, living in rural or northern areas.[27]

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[19] *Ibid referring to Marene Gatali and Chris Archibald, "Women and HIV" in Women's Health Surveillance Report (Ottawa: Minister of Health Canada, 2003).*

[20] *Audrey Steenbeek, "Empowering Health Promotion: A holistic Approach in Preventing Sexually Transmitted Infections Among First Nations and Inuit Adolescents in Canada", 22 (3) Journal of Holistic Nursing, 2004, p. 255.*

[21] *Madeleine Dion Stout et al. , Aboriginal Women's Health Research Synthesis Project: Final Report, (Winnipeg: Centres of Excellence for Women's Health, 2001), p. 11.*

[22] *Ibid.*

[23] *Ibid.*

[24] *Madeleine Dion Stout and Gregory D. Kipling, "Aboriginal Roundtable on Sexual and Reproductive Health in Preparation for the Five Year Review of the International Conference on Population and Development (CAIRO+5)" (Ottawa: Aboriginal Nurses Association of Canada, 1999), p. 3-4.*

[25] *Health and Welfare Canada, Report on Adolescent Reproductive Health (Report) (Ottawa: Health and Welfare Canada, 1990); Eleanor M. Maticka-Tyndale "Sexual Health and Canadian Youth: How Do We Measure Up?" (2001) 10 Canadian Journal of Human Sexuality 2.*

[26] *For example, see the findings of British Columbia Task Force on Access to Contraception and Abortion Services, "Realizing Choices: The Report of the British Columbia Task Force on Access to Contraception and Abortion Services" (1994) at 10-11 and DiCenso et al, "Completing the Picture: Adolescents Talk About What's Missing in Sexual Health Services" (2001) 92 Canadian Journal of Public Health 35 at 36.*

[27] *Action Canada for Population and Development (ACPD) and Planned Parenthood Federation of Canada (PPFC), Report on Canada's Compliance with the Convention on the Rights of the Child in Response to Canada's Second Periodic Report to the Committee on the Rights of the Child. (Ottawa: ACPD and PPFC, 2003)*

Traditional midwives played a key role in Aboriginal birthing services, a role that has been eroded over the years and replaced with medical services that are often accessible only outside of women's communities.[28]

Addressing Issues of Jurisdiction and Control

NWAC supports and recognizes the need for increased jurisdictional control over health care services by Métis, First Nations and Inuit governance structures. However, in order to protect the health rights and needs of Aboriginal women, these structures must be developed and implemented in accordance with a gender equality analysis. This model of analysis is described by Indian and Northern Affairs Canada as follows:

> *Gender-equality analysis is part of the policy development process. It is an analytical tool that assesses the differential impact of proposed and existing policies, programs and legislation on women and men by considering the different life situations (different socio-economic realities) of women and men.*
>
> …
>
> *Gender-equality analysis recognizes that the realities of women's and men's lives are different and that equal opportunity does not necessarily mean equal results. The challenge is to anticipate the results of policies, programs and legislation and ensure they are as equitable as possible for all women and all men.*[29]

Aboriginal women in Canada face a multitude of barriers to full and equal participation in their communities – high rates of discrimination based on gendered racism, violence, poverty, single motherhood, disability, low rates of employment, to name a few. All of these factors negatively impact the realization of their right to health and other human rights.

Aboriginal women have been marginalized within their own communities, as demonstrated by the high levels of violence facing Aboriginal women, the low representation of women in leadership positions and the fact that Aboriginal women live in greater poverty than Aboriginal men. The imposition of sexist values, the objectification of women, and de-valuing of motherhood are also factors in Aboriginal women's marginalization.[30] As jurisdictional control over health is transferred to First Nations, Métis and Inuit communities, measures will be required to ensure that health and social conditions that perpetuate Aboriginal women's inequalities will be eradicated rather than exacerbated. These measures must ensure the unique health needs and rights of Aboriginal women are respected, protected and fulfilled.

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[28] *Supra, note 2, p. 17.*

[29] *Indian and Northern Affairs Canada, "A Guide to Gender Equality Analysis" available online at: <http://www.ainc-inac.gc.ca/pr/pub/eql/gend_e.pdf>, p.4.*

[30] *Supra, note 24, p. 4.*

It will be imperative that health models for increased control over the administration, funding and delivery of health services for First Nations, Métis and Inuit peoples all involve participation of independent First Nations, Métis and Inuit women's groups to ensure adequate attention is paid to the particular health needs and rights of Aboriginal women. Policies and protocols based on non-discrimination on the basis of gender should be established, along with adequate representation of Aboriginal women at all levels from service delivery to management of health services.

Improving Access and Integration

There are many barriers to adequate access to and integration in health facilities, goods and services for Métis, First Nations and Inuit people. The right to health under international law:

> *"…clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health."*[31]

This right includes the right to access to comprehensive, available, accessible, acceptable and good quality health facilities, goods and services.[32]

Aboriginal women do not enjoy the same level of realization of the right to health as Aboriginal men or the rest of the Canadian population, as the statistical profile provided above demonstrates. The development of a blueprint, in partnership with Aboriginal leaders (including representation from an Aboriginal women's group), to improve the health status of Aboriginal peoples and health services in Canada is a positive step in achieving the highest attainable standard of health for Indigenous women.

For Aboriginal women, achieving an equitable level of the realization of the right to health requires increased accessibility to acceptable, comprehensive, high quality health services, including sexual and reproductive health services. Examples include local birthing centres, culturally appropriate midwifery services and facilities, culturally appropriate, gender-specific sexual health education and the provision of a comprehensive range of reproductive health supplies and services, particularly to young Aboriginal women. It requires increased representation of Aboriginal women in all aspects of the health delivery system, including policy development; this can be achieved by increased training of Aboriginal women nurses, doctors and other health professionals.

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[31] *The right to the highest attainable standard of health, CESCR General Comment 14 (General Comments), Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights General Comment No. 14. U.N. Doc. No. E/C.12/2000/4 (2000) at para. 53*

[32] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr. Paul Hunt, Commission on Human Rights, 59th Sess., UN Doc. No. E/CN.4/2003/58 (2003), para. 33.*

Building Capacity and Sustainability

Aboriginal women have a key role to play in building capacity and sustainability, as patients, caregivers, and health practitioners. As mentioned earlier, there is a recognized need for gender equality analysis in the area of Aboriginal women's health, promoting:

> *"…new research sensitive to the diversity within and between First Nations, Métis and Inuit women in order to develop accurate indicators of Aboriginal women's health and to serve as the basis for setting priorities for future health research, policies and programs."*[33]

In order to build capacity and sustainability beyond the five-year commitment of $700 million, a longer-term commitment will be necessary. In particular, it will be imperative through the five-year period to monitor and evaluate the improvements made in relation to the health of Aboriginal women. There is a growing awareness of the importance of mainstreaming a gender equality or gender-based analysis in the area of health and Aboriginal women. The Permanent Forum on Indigenous Issues highlighted the need to pay particular attention to the health needs of "Aboriginal women and girls and the role of women in health care, indigenous knowledge and service provisions."[34]

The development of this Blueprint in improving Aboriginal health provides the perfect opportunity to improve the sexual and reproductive health and rights of Aboriginal women, as well as other health needs, through new sustainability and capacity building plans. The sexual and reproductive health of Aboriginal women can be improved through gender-specific, linguistically and culturally appropriate sexual health education materials as well as improved health delivery services (such as assessment and screening facilities) related to diabetes, breast and cervical cancer, reducing geographical disparities in service provision, increased Aboriginal control over reproductive and maternal health programs, increased incorporation of Indigenous health knowledge and practices and increased training (such as cultural sensitivity and communications skills) and support to health professionals.[35] Current health delivery shortages, such as the need for more Aboriginal nurses (the shortage is estimated at 800 by the Aboriginal Nurses Association of Canada) must be addressed.[36] The need to recognize the diversity of Aboriginal women from different communities when designing health programming is critical. This can only be done once gaps in health research for some Aboriginal women's populations, such as Métis women, are filled.

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[33] *Health Canada, "Strengthening the Policy-Research Connection: Closing the Gaps in Aboriginal Health", in 5 Health Policy Research Bulletin 2003, p. 26.*

[34] *Supra, note 1, p. 24.*

[35] *Supra, note 24, p. 4-6. See also: Aboriginal Nurses Association of Canada and Planned Parenthood Federation of Canada, Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities, (Ottawa: Aboriginal Nurses Association of Canada, 2002), p. 117.*

[36] *Aboriginal Nurses Association of Canada Media Release, "Aboriginal nurses demand a more inclusive approach" (September 20, 2004), online <http://www.turtleisland.org/discussion/viewtopic.php?p=4021>.*

Broad Determinants of Health

Broad determinants of health identified by Aboriginal women in Canada include "strong families, supportive structures, safe homes and communities and healthy child development".[37] Reducing violence against Aboriginal women is one of the key gendered elements of the broad determinants of Aboriginal health. Amnesty International, in its recently released report, *Stolen Sisters: A Human Rights Response to Discrimination and Violence against Indigenous Women in Canada* highlights the tragic impact of violence against Aboriginal women in Canada, in the form of extreme violence causing death.[38] A holistic plan developed and implemented by Aboriginal women to address this issue must be an integral part of the Blueprint, in order to stop the suffering of these individual women and their families who live with the consequences of violence and other underlying social and economic conditions leading to ill health and death. One such example is NWAC's Sisters in Spirit Campaign, which is focused on addressing the impacts of racialized, sexualized violence against Aboriginal women.[39]

Health determinant accounting for Aboriginal women's poor health status include "socio-economic status, education and employment conditions, social support networks, physical environment, healthy child development and access to health services."[40] Socio-economic marginalization is a key broad determinant of health for Aboriginal women, described as interrelated with:

> *Most observers today believe that poor socio-economic conditions worsen the life chances and, by extension, the health status of Canadian Aboriginal peoples. Not only is poverty correlated with poor nutrition, smoking and other unhealthy practices, but it also serves to undermine one's self-esteem and sense of self-worth…Unfortunately, poverty is a condition which affects Aboriginal women disproportionately.*[41]

Efforts to improve Aboriginal women's health status within the current partnership between Aboriginal leaders and First Ministers will only be successful if these systemic barriers to Aboriginal women's equal enjoyment to the right to health are overcome. This will require adequate resources to decrease the gap between Aboriginal women and their families and the rest of Canadian society as well as ameliorative programs, in health and related areas that will remedy the long term effects of gendered racism and discrimination experienced by Aboriginal women.

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[37] *Supra, note 33 at p. 23.*

[38] *Amnesty International, Stolen Sisters: A Human Rights Response to Discrimination and Violence against Indigenous Women in Canada, (Ottawa: Amnesty International Canada, 2004), p. 11.*

[39] *See www.sistersinspirit.ca for more details.*

[40] *Madeleine Dion Stout, Aboriginal Canada: Women and Health: A Canadian Perspective (July 1996).*

[41] *Ibid.*

Conclusion

NWAC has outlined some of its key concerns related to improving the health status of Aboriginal women and the health services that they receive for consideration at the upcoming Health Sectoral Session. Below, a summary of NWAC's conclusions and recommendations in the four priority areas of discussion are set out.

1. Addressing Issues of Jurisdiction and Control

Inequalities between Aboriginal women and men in terms of social relationships (and high levels of violence against Aboriginal women) and overall socio-economic status must be addressed through policy and protocol development, if the health needs and rights of Aboriginal women are to be respected, protected and fulfilled in the context of increased jurisdictional control over health care services.

2. Improving Access and Integration

Taking a "right to health approach" in determining the success of the Blueprint in terms of Aboriginal women's health status will require First Ministers and Aboriginal leaders to identify whether access to health facilities, goods and services has improved, resulting in comprehensive, available, accessible, acceptable and good quality health facilities, goods and services. Reaching success in this area will require a change in approach, particularly with respect to sexual and reproductive health and rights, to greater provision of culturally appropriate, gender specific sexual health education, provision of reproductive health supplies and services and increased training and representation of Aboriginal women in all aspects of the health delivery system.

3. Building Capacity and Sustainability

In order to identify an effective capacity building and sustainability plan, a gender equality analysis should be applied, addressing gaps in Aboriginal women's health research and existing health service delivery and administration models.

4. Broad Determinants of Health

Broad determinants of health, such as socio-economic marginalization and violence, facing Aboriginal women must be must be addressed holistically for real change in Aboriginal women's health status to be realized.