

**Restricted Access: Aboriginal Women and Health Care in  
Canada**

by

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## **ABSTRACT**

“Restricted Access: Aboriginal Women and Health Care in Canada” addresses the barriers faced by indigenous women when accessing health care services in Canada. Using the distinction of practical (or needs-based) and strategic (or equity-based) barriers, it highlights the impact of physical isolation, cultural differences, and socio-economic disparities when using health services. However, the emphasis is placed on strategic challenges and more specifically on the impact of marginalization from the mainstream health system, using three different themes in the experience of marginalization: differences in conceptualization of health, the construction of aboriginal women as the “other” and racism. Following the discussion on marginalization, the research addresses some solutions, evaluating their potential to improve indigenous women’s access to Canadian health services.

**Keywords:** indigenous; women; health care; access; marginalization; Canada

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## GLOSSARY

Indigenous	Refers to people native to an area. Usually implies that the people considered indigenous were present before colonization. Though used in international texts, the term indigenous is seldom used in Canada.
Aboriginal	Name given in Canada to people native to the land and their descendants, who identify themselves as such. Includes First Nations, Inuit and Métis.
First Nations	Term used to replace the classification of Indian or North American Indian.
Indian	Used in the Constitution Act of 1982 and in the original Indian Act of Canada. Though still legally acceptable, the term has become obsolete due to its negative connotation. The term First Nations is more commonly used. It does not include Inuit and Métis.
Inuit	Aboriginal people who live in Arctic Canada.
Métis	People of mixed First Nations and European descent.
Reserve	Land set aside by the Crown for the benefit of a Band, or First Nation community. Only applies to First Nations as Inuit and Métis do not live on reserves. Though legally in use, many First Nations organizations prefer the term First Nation Community to reserve.
Native American	Commonly used term to refer to aboriginal people of the United States.
Health disparities	The differences in health experienced by different groups in society. They can be the result of genetic and biological factors, or choices made. However, they often result from differing income, education, social supports and employment.
Marginalization	To relegate to an unimportant or powerless position within a society, to be peripheralized on the basis of identities, associations, experiences, and environments.



**RESTRICTED ACCESS: ABORIGINAL WOMEN  
AND HEALTH CARE IN CANADA**

# 1: INTRODUCTION

The United Nations' most recent estimates place the number of people who identify themselves as 'indigenous' at roughly 370 million, living in 90 countries considered both economically developed and developing. (UN State of Indigenous People, 2009) Of these, 1.17 million live in Canada. Despite the wide variety of cultures, languages and ethnicities of the world's indigenous people, one characteristic seems to be common across countries, whether developed or developing: indigenous people have lower health indicators than non-indigenous people (UN, 2009; Gracey & King, 2009). Though socio-economic indicators, genetic predisposition, and environmental factors are important for understanding some of the reasons for these health disparities, part of the problem is also that indigenous people report having more difficulty accessing existing health care services than their non-indigenous counterparts. This situation occurs across the world, and countries with universal health care systems such as Canada, are not exempt from this trend.

Over the last two decades, the United Nations, the World Health Organization (WHO), and many national governments have recognized the importance of addressing the challenges faced by the world's indigenous populations by publishing reports and dedicating the decade of 1995 to 2004 as the "Decade of the World's Indigenous People". This attention has led countries such as Canada to adopt national strategies to improve indigenous people's access to health services. Yet, indigenous people still report problems.

Indigenous women are especially vulnerable to inequities in health because of their identity. Yet, when examining the various factors that prevent indigenous people from using health care services, official reports tend to ignore the intersection of gender and indigenusness, despite evidence that a gendered approach to health can be beneficial for understanding how men and women can have different health needs (Gender & Health, 2009). For this reason, this paper will explore the particular problems of indigenous women and their experience with health care services in Canada. It will, more specifically, answer the following two research questions:

1. What are some of the barriers faced by indigenous women when accessing health care services?
2. Once identified, how can these barriers be addressed to improve the experience of indigenous women when accessing health care services?

When answering the research questions, attention will be placed on the different types of barriers and their implications. By using a framework formulated by Caroline Moser that distinguishes practical (or needs-based) from strategic (or equity-based) barriers, I will argue that one of the greatest health challenges for indigenous women in Canada is marginalization. To argue this point, this paper will be divided into four chapters. The first chapter will provide a brief overview of the current health needs of indigenous people. It will provide a working definition of indigenesness, statistics to frame the scope of the issue, and provide a framework to understand the importance of looking at both gender and indigenous identities when studying health care. It will also detail the methodology and the reasons for selecting Canada as a case study. The second chapter will be dedicated to the problems faced by indigenous women in accessing health care services. In this section, a distinction will be made between practical and strategic problems, using Caroline Moser's gender needs framework. Practical problems will be explored before presenting strategic challenges and their implications for access to health resources. The third chapter will build on the second one and look at some of the ways the challenges identified previously have been addressed. Again, potential solutions will be assessed using the practical versus strategic framework, highlighting the point that strategic responses have typically been harder to address than practical ones. Finally, a closing chapter will offer some concluding thoughts on the state of indigenous women in Canada.

Though this paper will be assessing responses to identified challenges, the objective is not to provide an ideal model of health care, nor to come up with definitive solutions to the problems highlighted. As the methodology section will make clear, the paper is based on feminist method that emphasizes the importance of recognizing individuals' positionality. I am very aware that as a white, non-indigenous Canadian woman, my conclusions are likely to be influenced by my own background. In the context of this research, I wish to avoid reproducing power dynamics that have denied indigenous people a chance to make their own recommendations. This is why I will avoid making definitive conclusions on the best approaches to health reforms. Instead, I want to expose certain problems that have typically been ignored and evaluate what is being done in order to provide a starting point for future reforms.

## **2: OVERVIEW**

Though there are no universal definitions of the term 'indigenous', the one suggested by Jose R. Martinez Cobo, later adopted by the United Nations (UN), expresses a number of ideas useful to an understanding of what constitutes an indigenous identity (Figure 1). It highlights that countries with a history of colonization, and where colonizers established themselves and became the dominant population, are more likely to have identifiable indigenous populations than countries where colonization was not followed by large settlements of colonizers. For this reason, the Americas, Australia and New Zealand have more easily identified indigenous groups whereas Asia and Africa have contentious definitions of indigenesness. Though the terms used in the Americas, Australia and New Zealand to define indigenous people vary, this study will use the term

**Figure 1 UN Definition of Indigenous**

“Indigenous communities, people and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. [...]

Their historical continuity may consist of the continuation, for an extended period reaching into the present of one or more of the following factors:

- Occupation of ancestral lands, or at least of part of them
- Common ancestry with the original occupants of these lands
- Culture in general, or in specific manifestations (such as religion, living under a tribal system, membership of an indigenous community, dress, lifestyle, etc)
- Language (whether used as the only language, as mother-tongue, as the habitual means of communication at home or in the family, or as the main, preferred, habitual, general or normal language)
- Residence in certain parts of the country, or in certain regions of the world

On an individual basis, an indigenous person is one who belongs to these indigenous populations through self identification as indigenous (group consciousness) and is recognized and accepted by these populations as one of its members (acceptance by the group).”

Source : *UN State of Indigenous People, 2009. P.4-5*

‘indigenous’ when referring to the world’s indigenous people and ‘aboriginal’ when referring to Canada’s indigenous population<sup>1</sup>.

The Canadian definition of aboriginal people is similar to the one adopted by the United Nations. In its 2006 Census, the Canadian government defined aboriginal persons as “persons resident in

Canada who can trace their origins to the native people or First Nations people who inhabited the area of what is now Canada when the first Europeans arrived. In addition, some persons have gained aboriginal rights under legislation” (Statistics Canada, 2010). The government of Canada also makes the distinction between aboriginal ancestry and aboriginal identity. Aboriginal ancestry refers to “a person who can trace his or her ancestry to Aboriginal linguistic family whose

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<sup>1</sup> See the glossary for a more detailed definition of each term

traditional lands fell in total or in part in the geographic area that is now Canada” (Statistics Canada, 2010). Aboriginal identity, however, refers to “a person who reports that he or she identifies with, or is a member of, an organic political or cultural entity that stems historically from the original persons of North America” (Statistics Canada, 2010). As in the United Nations definition, the self-identification of an individual as ‘indigenous’ is an important part of the definition. For the purpose of this study, indigenous and aboriginal people will refer to those persons who identify themselves as indigenous rather than those who have an indigenous ancestry but do not identify themselves as such.

Canada’s aboriginal population is divided in three distinct sub-groups, as defined by the Constitution Act of 1982: North American Indian, Métis and Inuit (National Aboriginal Health Organization, 2003). The term Indian is still used in legal documents in Canada, although it is often seen as obsolete and people who are considered Indian by the government prefer using the term First Nations. Interestingly, the Canadian government in most of its publications also uses the term First Nations, despite the lack of a legal definition. Métis people are those of mixed First Nations and European ancestry, who identify themselves as such whereas Inuit are the aboriginal people of Arctic Canada, who usually live above the tree line and identify themselves as members of Inuit nations. Unlike First Nations, Inuit do not live on reserves but in Inuit settlements or communities. (NAHO, 2003)



According to the last general census of 2006, of the 31.241 million people living in Canada, 1.173 million identified themselves aboriginal which represents 3.75% of the total population (Statistics Canada, 2009). Of those 1.173 million, 698,025 were North American Indian (or First Nations), 389,780 identified themselves as Métis, and 50,480 as Inuit. Geographically, aboriginal people live primarily in Northern and Central Canada in terms of percentage of the population. In Nunavut and the Northwest Territories, aboriginal people make up over half of the population, followed by Yukon with 25%, Manitoba and Saskatchewan with 15.5% and 14.9% respectively. However, in absolute numbers, Ontario leads with 242,495 aboriginal people, followed by British Columbia with 196,075 and Alberta with 188,365 (Statistics Canada, 2009).

Though many aboriginal people live on reserves or in rural settlements, an increasingly large share resides in urban centres. In 2006, 54% of people who identified as aboriginal lived in metropolitan areas (compared to 50% in 1996). In comparison, 81% of non-aboriginal people in Canada lived in urban centres, which indicates that compared to the rest of the population, a significant share of the country's aboriginal people still lived in reserves or rural settlements. The majority of urban aboriginals were First Nations and Métis, whereas very few Inuit lived in urban centres. (Statistics Canada, 2009)

## **Indigenous People and Health**

In both developed and developing countries, indigenous people tend to be disadvantaged when it comes to their health. Internationally, the United Nations in the *State of the World's Indigenous Peoples Report* (2009) argues that indigenous people experience lower health status and are more likely to experience lower life expectancy, and higher rates of disabilities and diseases than non-indigenous people living in the same country. They are also more likely to suffer from high poverty rates, unemployment, illiteracy, marginalization and alteration of their traditional lifestyle which all contribute to poorer health (Pan American Health Organization, 2003 in UN, 2009). Additionally, indigenous people generally face higher risks of maternal and infant mortality, malnutrition, infectious diseases, cardiovascular problems, and HIV/AIDS.

One of the underlying causes of health disparities is the impact of colonization, which disproportionately affected indigenous people (Gracey & King, 2009). In addition to the introduction of infectious diseases such as tuberculosis and measles, colonization affected the traditional lifestyle of many indigenous groups. According to the authors, the erosion of the traditions, diets, and healing practices of indigenous people, accompanied by political and socioeconomic inequalities, has led to the current crisis in health experienced by these groups. The United Nations Organization (2009) argues similarly that their low health

indicators also reflect the high poverty rate and the lack of education and access to social services among indigenous people. Though the health situation of indigenous people mirrors that of the world's poorest, it is aggravated by their social and cultural marginalization (Stephens, Porter, Nettleton & Willis, 2006).<sup>2</sup>

The disparities between indigenous and non-indigenous people are also present in

richer countries such as Canada, the United States, Australia and New Zealand. The United Nations (2009), citing a study by Griew (2008), indicates that the life expectancies of indigenous people in industrialised countries are significantly worse than those of the rest of the population. Health Canada (in UN 2009) for example, reports that there is a seven-year gap in life expectancy between aboriginal people and the mainstream population.

The reasons that explain the health gap between indigenous and non-indigenous people are complex and varied. They include lifestyle choices, genetic pre-disposition, environmental constraints, nutrition, and socio-economic indicators to name only a few. All of these factors can vary from one group to another, or even

**Figure 2 Some persistent problems and factors affecting indigenous health**

Poverty, hunger, environmental degradation

- Malnutrition
- Maternal and infant ill-health
- Shorter life expectancy
- Chronic diseases
- Difficult access to health services
- Lack of recognition of traditional practices
- Mental disorders

Sources : UN, 2009 ; Stephens et al, 2006 ; Gracey & King, 2009.

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<sup>2</sup> The causes and effects of marginalization will be explored in greater detail in subsequent chapters of this study.

between individuals, making any attempts at closing the health gap difficult. Attempts made through official policies are often unsuccessful exactly because of the multiple angles of the problem. One factor that could potentially be addressed through government intervention, however, is access to existing health care services. The United Nations, the Pan American Health Organization (PAHO) and Health Canada, all recognize the importance of increasing access to health services for indigenous people, and generally agree that there are important barriers preventing indigenous people from fully accessing the services offered. These barriers result from various factors including, but not limited to, geographical isolation, low quality services, discrimination and lack of indigenous control in health care practices. These barriers create important challenges for policy makers and responses have been limited, slow and often unsuccessful.

## **Adding a variable: Bringing women in**

Indigenous women face some of the same challenges as their male counterparts when accessing health services, while simultaneously experiencing very different ones because of their gender. This is partly because of the gender specific health needs of women as well as the multiple layers of discrimination indigenous women experience as a result of their race, culture and gender. This concept of multiple layers of discrimination is known as intersectionality; a sociological theory holding that identities do not act independently from one another and, instead, interact to create an interlocking system of oppression.

Originally articulated by Kimberle Crenshaw in reference to the struggle of black women in the United States, the concept of intersectionality can be useful in understanding the difficulties of indigenous women when accessing health services. Indeed, Van der Hoogte and Kingma (2004) explain that indigenous women and the challenges they face cannot be understood uniquely through a cultural analysis. Unequal power relations, they argue, exist in all cultures and indigenous groups are not exempt from gender discriminatory practices. However, the authors warn that a narrow feminist analysis would be equally inappropriate because the identity of indigenous is of great importance for many women and affects the way they experience discrimination outside of the group.

Gender based inequities over control and access to resources can affect health outcomes by limiting the decision-making ability of women. Gender can also impact health status by influencing health seeking behaviour, ability to follow treatments, or access to health services (Gender and Health, 2009). Though the gender dimension of health has been recognized by multilateral and bilateral institutions through the creation of distinct gender units (see World Health Organization as an example), there is very little attention paid to indigenous women in official reports and policies. The United Nations report *State of the World's Indigenous Peoples* (2009) for example, devotes little more than a paragraph to women in its chapter on health, signalling that gender and indigenesness tend to be treated as separate identities.

The Canadian government, however, acknowledges the importance of including aboriginal women in health plan reforms and has addressed this issue in its *Blueprint on Aboriginal Health- A 10-year Transformative Plan* (2005). Despite this recognition, aboriginal women in Canada continue to face significant challenges and remain one of the most marginalized groups in Canadian society (Harell & Panagos, 2010). The challenges they face range from higher fertility rates to lower socio-economic indicators which contribute to the health disparities between groups in Canada. Though there are significant regional differences, national trends can nonetheless be identified regarding aboriginal women's health.

Overall, aboriginal women have a higher fertility rate than other Canadian women. According to the last Canadian general census (Statistics Canada, 2006), the aboriginal population grew by 45% between 1996 and 2006. In contrast, the growth of the rest of the population during the same period was 8%. Additionally, aboriginal mothers tend to be younger than their non-aboriginal counterparts. In 2002, 55% of aboriginal mothers were under 25 years old compared to 28% in the rest of the population (Health Canada 2000, in Dion Stout, Kipling & Stout, 2001). Of those 55%, 9% were under 18 years of age as opposed to the national average of 1%. The high fertility rate and the young age of aboriginal mothers can have significant impacts on health outcomes of both mother and child. Teenage pregnancies carry higher risks of low birth weight and potentially higher risks of infant mortality (Dion Stout et al, 2001; American College of Obstetricians and Gynaecologists, 2009). High fertility rates at a young age can also lead to lower socio-economic outcomes and a lower education level than in women who postpone childbearing (ACOG, 2009; Ministère de la Santé et des Services Sociaux, 2010).

Aboriginal women also face significant disparities in rates of substance-abuse, suicide, domestic violence and incarceration. For example, aboriginal women account for 32% of incarcerated women in federal prisons despite representing only 3% of the total Canadian population (Canadian Association of Elizabeth Fry Societies, 2010). Low socio-economic indicators, high unemployment rates and low levels of education are thought to be responsible for this overrepresentation

(Correctional Service of Canada in Elizabeth Fry, 2010). Though aboriginal women tend to have higher education levels and employment rates than aboriginal men, they fare significantly worse than non-aboriginal women. In 2001, 17% of aboriginal women in the labour force were unemployed, versus 7% in the rest of the female population. Additionally, incomes tended to be significantly lower for aboriginal women, with an income gap of roughly \$5,000 (Elizabeth Fry, 2010). Finally, in 2003, 35% of on-reserve First Nations were recipients of social assistance as opposed to the national average of 5.5% (Elizabeth Fry, 2010).

These disparities highlight the importance of understanding the disparities that contribute to ill-health in aboriginal women. Socio-economic disparities contribute to poorer access to health resources and can lead to health conditions such as diabetes or cardiovascular risks. It can also lead to late diagnoses of cancers and other fatal conditions (Figure 3). However, it is important to also examine disparities between aboriginal men and women to understand the importance of examining gender relations within aboriginal communities. For example, aboriginal women are three times more likely to have experienced sexual and physical abuse than non-aboriginal women and are also eight times more likely to be killed by a spouse (Amnesty International, 2004; Elizabeth Fry, 2010). Unequal gender relations also manifest in rates of sexually transmitted illnesses (STI) in aboriginal communities. In 2002, reported cases of genital Chlamydia in First Nations were 2.6 times higher in women than in men (Health Canada, 2005). HIV/AIDS cases also disproportionately affect aboriginal women. Whereas



non-aboriginal women account for 19.5% of new HIV cases, this number rises to 45.1% for aboriginal women (Public Health Agency, 2004). The gender disparities in STI cases can signal unequal gender relations within aboriginal communities (WHO, 2010). Gender norms related to masculinity can encourage men to engage in risky behaviour and to have multiple sexual partners, which can contribute to high

transmission rates. High rates of violence against women can also increase the rate of infection due to tears and laceration during intercourse. Finally, unequal gender relations can lead to lower decision making power, influencing women's ability to seek information or treatment for STIs (WHO, 2010).

The disparities mentioned highlight the importance of viewing gender and indigenouness as interlocking identities that influence women's health and experiences of health care services. Using the disparities between aboriginal

### **Figure 3 Aboriginal Women and Cancer**

#### *Breast Cancer*

- Breast cancer is the most frequently diagnosed type of cancer among Canadian women and is on the rise in aboriginal populations.
- Aboriginal women are more likely to be diagnosed at a later stage of the disease. The survival rate is lower in aboriginal women than non-aboriginal ones.

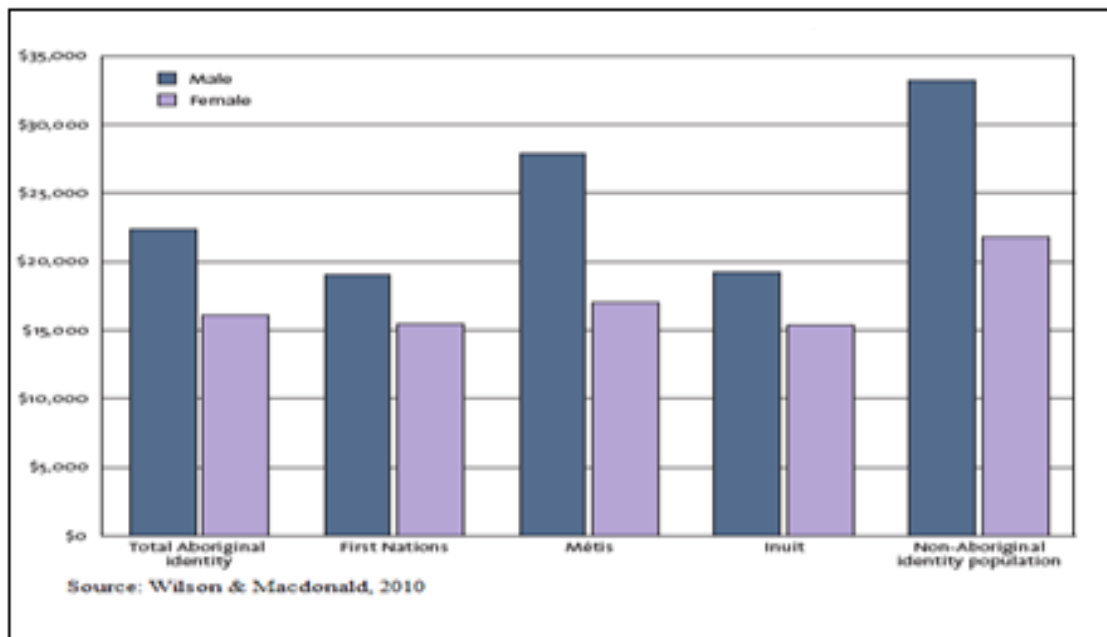
#### *Cervical Cancer*

- Cervical cancer is more prevalent in First Nations women than in the rest of the Canadian population. It ranks as the second most common site of cancer in aboriginal women, as opposed to the 6<sup>th</sup> most common site for non-aboriginal women.
- PAP smear test, which can detect cervical cancer, were less likely to have been conducted in aboriginal women than non-aboriginal women (despite significant regional and age differences). In British Colombia, 50% of First Nation women had gotten a PAP test in the past 3 years, compared to 85% of non-First Nation women.
- The low participation rate for PAP test was linked to a lack of awareness, shyness, discomfort and lack of culturally suitable services.

*Sources: NAHO, 2007; First Nations Centre, 2006.*

women and non-aboriginal women, it is possible to see that the identity of 'indigenous' influences socio-economic indicators and health outcomes. Additionally, by examining disparities between aboriginal men and women, it becomes evident that there are significant gender inequalities within aboriginal communities. These mirror the gender-based inequalities in the wider Canadian population, where the income gap is still significantly high (Figure 4) and where women are often overrepresented in short-term contracts or part-time work. While aboriginal women experience similar gender inequalities, they must also cope with the challenges related to their indigenous identity. The combination of these two identities affects health outcomes and demands that health policies consider the interaction of gender and indigenesness.

**Figure 4 Median Income by Gender and Identity (2004)**



## **Methodology**

This study will be using a feminist methodological approach to expose the challenges indigenous women face in accessing health care services in Canada. Though the label “feminist research methods” can be quite encompassing, it is usually concerned with issues of power relations, marginalization and exclusion (Ackerly, 2008 in Audie & Klotz, 2008). The aim of feminist theory is thus to explore silence, oppression and difference while focusing on women’s experiences, and avoiding the objectification of the research subjects by letting their lived experiences come at the forefront of the research project (Sprague, 2005; Burns & Walker, 2005). Furthermore, it encourages the researcher to pay attention to the power inequalities and hierarchies that have been rendered invisible or normalized (Ackerly, 2008).

By promoting the creation of knowledge that empowers the disadvantaged, a feminist method is particularly well suited for this project. As mentioned, indigenous women experience discrimination and marginalization that compromise their ability to access health care services. This inability, though mentioned in reports and government documents, does not seem to be leading to meaningful change that could improve the health status of indigenous women. By exposing some of the inequalities in the Canadian health system, this research project aims to bring some of the concerns articulated by indigenous

women to the forefront. To do so requires for indigenous women's voices to be put at the centre of the analysis. Due to time and resource constraints, field work is not possible and so I will be relying on interviews conducted by others, with the goal of highlighting the lived experiences of indigenous women and their perceived difficulties when dealing with the Canadian health system.

The choice of Canada for this study was justified by four factors. First, it has a large indigenous population that has been studied more extensively than in other parts of the world. As Stephens et al (2006) mention, data on indigenous people tends to be scarce and unreliable. This is partly due to geographical isolation or lack of disaggregated data collection by governments. Canada, however, has a large amount of reliable information that comes from various sources, such as the national, provincial and territorial governments, aboriginal groups, and scholars. Second, the identity of "indigenous" is less contentious in Canada than in other countries because of European colonization. Indeed, indigenous people in Canada are more easily identifiable than in other locations, where Europeans did not settle in large numbers. Furthermore, the Canadian statistical agency uses a definition of aboriginal based on identity, which is useful for a study on access to health services because it excludes people who might have an aboriginal ancestry but who do not identify with its culture and traditions. Third, Canada provides an interesting case because it is a developed country with a universal health care system, which legally guarantees care to all citizens. Yet there are still major disparities between the indigenous people of Canada and the

rest of the population in terms of health and health care services. If the cost of the actual visits to a clinic is not an important factor, there must be additional problems within the system that explain why indigenous women are reporting not being able to access the service. Finally, the government of Canada has taken many steps to improve the health status of its indigenous population, with sometimes limited success. In this context, it is interesting to see what barriers are being addressed and what solutions have been implemented.

The case of Canada can be relevant for other countries, both developed and developing, and some of the conclusions might be applicable in other locations. As mentioned previously, indigenous people generally have lower health indicators than their non-indigenous counterparts. Often, practical barriers such as geographical isolation are cited as the cause of such disparities. Yet studies conducted in Australia, New Zealand and the United States have reported that marginalization, understood as the exclusion of a group from mainstream society, is an important barrier to accessing health care services<sup>3</sup> (Wilson, 2008; Wilson & Neville, 2008; McMurray & Param, 2008; Dodgson & Struthers, 2005). However, the applicability of this research to other locations might be limited by difference between health care systems and legal definitions of indigenous identity. It is also possible that the conclusions of this study may be applicable to other minority groups in Canada. Feelings of marginalization and discrimination are not

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<sup>3</sup> The concept of marginalization and its effects will be discussed in greater detail in subsequent chapters.

exclusive to indigenous groups and it is possible that some of the solutions can apply to other cultural minorities.

The sources used to conduct this research come from various levels, disciplines and locations. Reports from international organizations such as the United Nations and the Pan American Health Organization provide valuable background information and are thus used as such. The core of the research however is based on reports from Canadian sources, scholarly journals and aboriginal groups. The reports and journals were selected so as to represent a wide variety of communities across Canada, both rural and urban- and because of their extensive use of interviews. The reproduction of parts of interviews was especially useful to allow for women's experiences to speak for themselves. Finally, scholarly articles from other locations than Canada are used as additional evidence and as possible solutions and alternatives to the barriers identified. The goal of comparing various communities in Canada, despite their different cultures and tradition, is to highlight the commonalities between these different groups. By doing so, it should be possible to compare and evaluate social phenomena and policies and then to generate appropriate responses to guide national strategies.

### **3: BARRIERS AND CHALLENGES**

Access to health care services is an important determinant of health and can seriously influence health outcomes. This conclusion is recognized in the literature and in official reports from the United Nations, the World Health Organization and the Canadian government. Yet, these reports tend to focus mainly on the physical inaccessibility of the services rather than examining the internalized barriers preventing aboriginal women from taking advantage of services offered to them. The following chapter will focus on these different barriers, categorizing them as either practical or strategic. The distinction between the two terms will be presented in the first part of the chapter, followed by the identification of some practical barriers, and finally, key strategic challenges. The distinction between the two types of problems will ultimately highlight the importance of considering internalized feelings and perceived difficulties as important barriers to fully accessing health services.

Before defining practical and strategic needs, it is important to understand what is meant by “access” to health resources. Though central to the analysis, the term “access” is rarely defined in official documents when discussing health care services. Yet, without a working definition, it is impossible to identify the barriers that prevent access and evaluate their effects. In fact, access can refer to such a range of conditions that under the most basic definition, most people in Canada could be understood as having full access to services. However, a definition of access that only includes physical entry to facilities or use of services would be insufficient to understand the experience of aboriginal women. Instead, a definition formulated by Penchansky and Thomas (1981), where access is evaluated by the degree of “fit” between the client and the system, can be used as it is more complete and reflective of aboriginal women’s experience. The authors argue that access can be divided into five dimensions: availability, (geographical) accessibility,

**Figure 5 The Five Dimensions of Access**

- *Availability*: the volume and type of existing services in relations to the volume of clients and types of needs
- *Accessibility*: the location of supply in relations with the location of clients
- *Accommodation*: the relationship between the manner in which the resources are organized and the client’s ability to accommodate to these factors and their appropriateness
- *Affordability*: the price of the services in relations to the client’s resources
- *Acceptability*: the relationship of clients’ attitudes about personal and practice characteristics of providers to the actual characteristics of providers, as well as to providers’ attitudes about acceptable characteristics of clients.

Source: Penchansky & Thomas, 1981

accommodation, affordability, and acceptability (Figure 5). Taken together, these areas of access can affect clients’ satisfaction as well as their use of health services. Using this definition of access, it is then possible to evaluate the



different barriers affecting aboriginal women's ability to benefit from health care resources in Canada.

### **Practical and strategic needs**

In her book *Gender Planning and Development: Theory, Practice and Training* (1993), Caroline Moser formulates such a distinction and categorizes needs as 'practical' or 'strategic'. Making this distinction, she argues, is essential for policy planning because it enables policies to be better targeted towards a specific goal. Originally formulated to guide gender analysis in development, Moser's framework can nonetheless be useful in understanding the different types of challenges that women experience in accessing health care services.

Moser defines practical needs as "a response to immediate perceived necessity, identified within a specific context" (p.40). They usually stem from a concrete problem or challenge experienced by women. Though there are exceptions, practical needs are usually easier to address than strategic needs because they do not require a change in power imbalances, but only a need-based intervention. Strategic needs are those that stem from socially constructed inequities and the subordinate position of certain groups. Unlike practical needs, strategic concerns cannot be easily addressed through practical interventions. To meet strategic needs, policies need to focus on changing power dynamics and socially constructed biases. Essentially, they require a change in mentalities and

attitudes, which can be much more difficult to achieve. For that reason, strategic needs, though acknowledged, are often left unmet because of their complexity.

The distinction between practical and strategic needs is crucial for understanding the challenges faced by aboriginal women when using health care services in Canada because it enables a different understanding of what is causing inequities in the system as well as what is required to improve the experience of aboriginal women. Though practical barriers are challenging for the day-to-day access to clinics and other health care resources, strategic barriers, if left unaddressed, have the potential to limit the success of practical interventions. For this reason, the following chapter will examine both practical and strategic barriers but will place the emphasis on the strategic ones.

## **Practical Barriers**

There are many practical problems that limit aboriginal women's access to the resources offered by health professionals. Though these barriers are often influenced by specific contexts and locations, it is possible to identify some national trends. The first major obstacle to obtaining quality health care services in a country as vast as Canada is geographical isolation. As noted, a significant proportion of First Nations people live on reserves that tend to be in isolated regions of the country. Similarly, Inuit tend to reside far from urban centres in areas where health services are not readily accessible. When a health centre is available near the aboriginal community, services tend to be limited and specialized care often needs to be received in the large urban centres.

A 2003 cross-country survey of aboriginal health and health care conducted for the National Aboriginal Health Organization of Canada (NAHO) indicated that distance greatly impacts the types of services available. Aboriginal people living in non-isolated communities (less than 90km away from a physician) and semi-isolated communities (more than 90km) have easier access to health care professionals than those living in isolated communities (no roads and infrequent air service). Nurses are the most easily accessible practitioners, followed by community health workers and social workers. Services that were geared toward women tend to be very difficult to access, regardless of the community's

geographical isolation. Thus, midwives and obstetrician/gynaecologists are the most difficult health professionals to access with 59% and 52% of respondents reporting them as “very or somewhat difficult to access” (First Nations Centre, 2003).

In a study on delivery of obstetric services at the Sioux Lookout Meno Ya Win Health Centre in Northern Ontario, the centralization of obstetric services in urban centres is seen as a major problem for the health of both mother and child (Dooley, St-Pierre-Hansen & Guilfoyle, 2009). The physical distance between the health centre and the reserves force many First Nations women to deliver in their home community or in the nearest rural centre that often lacks caesarean delivery capabilities. The Society of Obstetrics and Gynaecologists of Canada (SOGC), in a 2008 report on delivery services in Canada, notes the increasing shortage of skilled birth attendants in rural communities and the increasing need to transfer aboriginal women to regional hospitals for delivery. Similarly, a study on Inuit communities in Northern Canada conducted in 2001 (Pauktuuti Apr., 2001 cited in Dion Stout et al, 2001) highlights the lack of basic health services such as cancer screening and birthing services in isolated communities. Flying to southern centres or being transferred to regional hospitals is a practical barrier because it not only increases the risks of delivery but also removes expecting mothers from their social support systems and their families which negatively affects the birthing experience.

Another important practical barrier to using the provincial health care services is the language and cultural divide. Some aboriginal women do not speak French or English, making it difficult for them to use the services offered to them. In a study on interactions between health providers and Inuit, John O'Neil (1989) notes that language is a central component of a doctor-client relationship and that language barriers can severely affect one's ability to use health services. Though interpreters, or liaison workers, can bridge the gap, useful information can be lost in the process. For example, O'Neil notes that during a visit, one Inuit woman's concerns over a long-lasting cough were ignored by the interpreter and, consequently, the nurse. This resulted in frustrations on both sides and led the client to say: "I just knew this would happen. I didn't like to come to the Nursing Station anymore. I only came because I was feeling really sick before" (O'Neil, 1989, p. 339). In addition to the language barrier, health-related material can sometimes be culturally inappropriate, ignoring indigenous traditions or discussing health issues from a mainstream perspective, making it even less likely to be understood. In a study on cervical cancer screening in First Nation women (First Nations Centre, 2006), several problems were noted on the way information was presented. For example, it was noted that there is no word for 'cancer' in most native languages. Additionally, many women reported feeling as if cancer is part of life. By seeing life as a continuum where people must eventually die, many women feel that preventing or treating cancer is unnecessary. Pamphlets in clinics discussing the importance of receiving yearly PAP tests without considering the cultural understanding of cancer are thus less

likely to be effective for some aboriginal women. The problem of language and culture relates to another practical barrier: the low numbers of aboriginal health practitioners. In many studies (see Dion Stout et al, 2001; Browne & Fiske, 2000; Browne, 2007) and official reports by Health Canada and the National Aboriginal Health Organization, service delivery by aboriginal health providers is seen as a key component of effective service. However, lack of funding and training has left many health centres to operate without aboriginal staff, offering services adapted only to the needs of the dominant (usually non-aboriginal) community. For indigenous women, linguistic and cultural barriers can be obstacles to receiving effective treatment and can contribute to a feeling of alienation from the system (which will be discussed further as a strategic barrier).

An additional need-based challenge faced by aboriginal women relates to their generally lower socio-economic status. Aboriginal people in Canada are on average more likely to be poor than the rest of the Canadian population. In 2006, the median income for aboriginal people was \$18,692, a figure 30% lower than the rest of the population (Wilson & MacDonald, 2010). The income gap between aboriginal men and women worsens this condition for aboriginal women. Low income can impact a woman's ability to drive to a clinic or to pay for services that are not covered by the provincial health care plan. Additionally, some clinics charge a cancellation fee which can influence women's decision to use the services of that clinic, particularly if transportation is not guaranteed. (Browne et al, 2000) The alternative to the clinic, in this case, becomes the emergency

hospital where doctor-client relations are not guaranteed. These socio-economic constraints can thus influence women's ability to use existing services that are technically free but that can involve additional costs.

## **Strategic barriers**

The practical barriers identified can limit aboriginal women's ability to access the services offered by the health care system. However, they are insufficient explanations as to why many aboriginal women report not being able fully to enjoy the services offered to them. To understand these additional barriers, it is useful to look at them through the idea of strategic needs. As mentioned, Moser's framework for understanding strategic barriers calls for a closer examination of the power inequities that affect women's experience. In the case of health care, differentiating the need-based barriers from the equity-based barriers can highlight some of the deeper issues faced by aboriginal women when using the services, which can in turn lead to meaningful solutions for change.

Strategic barriers can often be invisible to outsiders as they are internalized and come out of lived experiences and perceived difficulties. Aboriginal women's accounts can highlight these problems, making their testimonies the starting point for understanding strategic needs. Dodgson and Struthers (2005) explain that it is important when studying perceived difficulties to assume that people are the most knowledgeable when it comes to their own experiences. Using this assumption, it becomes possible to use women's accounts as starting points to identify barriers common to many aboriginal women.



In a study conducted by Dodgson & Struthers (2005), Native American women discuss their experience with health services and spontaneously refer to the feeling of being outside of the mainstream culture. One woman explains this feeling of being on the outside by saying: “Living is hard and a lot of people don’t see that the Indian people are traditional but still have to survive and live and succeed in this world” (p.342). The feeling of being outside the mainstream system can be understood as marginalization which is “the process by which persons are peripheralized on the basis of their identities, associations, experiences, and environments” (Hall, Stevens & Meleis, 1994 cited in Dodgson & Struthers, 2005, p.339). The experience of marginalization, understood as being kept outside of the mainstream –in this case the health care system – is a recurring theme in many studies conducted with aboriginal women in Canada which affects the health outcomes of vulnerable populations. The interviews with these women highlight three different, but interrelated themes in the experience of marginalization: the clash between the Canadian mainstream health care system, the construction of aboriginal women as the “other”, and the discrimination and racism within the system. Combined, these themes create a situation where aboriginal women feel excluded, affecting their propensity to use the services, and inevitably influencing their health outcomes.

### **The clash between the Canadian and the indigenous health system**

The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

(WHO, 2010). This definition of health, however, is often more ideological than practical in relation to many western health systems where the body, the mind and society are treated as separate entities (WHO, 2010; Stephens et al, 2006). Yet, many studies and indigenous advocacy groups (see Martin Hill, 2003; WHO, 2010; Stephens et al, 2006) have concluded that, generally, indigenous people regard health in a more holistic way that “articulates physical, mental, spiritual and emotional elements, from both individual and communal points of view” (UN 2009, p.157). It is a way of thinking about health that relies on traditional knowledge passed down from one generation to the next and, whether explicable or not, contributes to the wellness and treatment of illnesses of a community (Crowshoe, 2005).

The clash between the western model of healing and the indigenous one can be seen as a consequence of colonization which led to a devaluation of traditional knowledge at the expense of ‘modern’ medicine. According to scholar Vandana Shiva (2000 in Hill, 2003), with colonization, knowledge plurality was replaced by knowledge hierarchy and traditional forms of healing were replaced by one hierarchical mainstream system. This system, because of its colonial origin, is still perceived by some aboriginal people of Canada as a tool for assimilation or as a foreign system of healing (Martin & Diotte, 2009). Faced with the clash between the two systems, aboriginal people might feel forced to choose between the two systems, often at the expense of their health.

The accounts of Canadian aboriginal women highlight this disconnect and the feeling of marginalization it creates. In their study on aboriginal women in Vancouver's Downtown Eastside neighbourhood, Benoit, Carroll & Chaudhry (2003) investigated the experience of aboriginal women living in this poor area of the city with regards to health care services. The interviews were conducted with women who used the Vancouver Native Health Society (VNHS), a clinic located in the heart of the urban ghetto that offers walk-in services to both aboriginal and non-aboriginal clients, as well as with users of Sheway, an adjacent service to the VNHS for substance-using pregnant women. Throughout the interviews, aboriginal women report feeling that the services offered do not adequately serve their needs and values. One woman stated her frustrations over the lack of spiritual and traditional values within the clinic, saying:

"If you're going to do something about Native people, I think you need to be like traditional and spiritual 'cause that's what Native people are about, you know? Do they have elders in the VNHS? Do they have Native healers? No, they have doctors! Gee, that's not my system, that's not where I come from." (Benoit et al, 2003. p.825)

This woman's narrative highlights the difficulty of dealing with a "white system" that does not represent her values. In another interview, one woman explains that the VNHS and Sheway would greatly benefit from using Healing Circles, as this form of healing is closer to her traditions: "A Healing Place is not only for your health, physical health, but also for your spiritual and mental health, It should be combined, not separated" (p.830). Users of Sheway, however, reported a higher satisfaction with the services offered because the model of care was more in line with aboriginal health care traditions, that is, the services

were seen as more fluid and informal, and the relationship between clients and providers was less hierarchical than in other clinics.

The interviews conducted with the women of the Downtown Eastside highlight the significance of culture when using health services. When services are seen as culturally irrelevant, some women may choose to avoid using them. As one woman explains:

“The reason I quit coming to counselling here [at the VHNS] is because the counselling is done very poorly... I’m a First Nations person, and I believe that a healing circle would help because that is our spirituality, that’s how we help each other” (p.826).

Dodgson and Struthers (2005) in a study on Native American women explain that the feeling of being torn between one value system and the other is a form of marginalization created by a forced biculturalism, which means that difficulties arise when native women try to negotiate mainstream culture while maintaining their own traditions. The authors explain that many of the women they interviewed chose to minimize contact with mainstream culture as a method of coping. One woman states:

“Because we walk two roads, it’s hard to lean toward one more than another one. Some Indian people see that to succeed in the White world, you have to be White, act White, do White, you know, everything. Only on your time, or at powwow time, you can be Indian. You can’t do both and survive and succeed.” (Dodgson & Struthers, 2005. p.342)

This biculturalism leads to feelings of alienation for many of the women interviewed who choose to limit their contact with mainstream health professionals. As in the VNHS case, aboriginal women who feel that their beliefs

are not integrated to health practices are less likely to report positive experiences. As one Cree medicine woman notes, “There is a growing need of other health professionals, non-Aboriginal health professionals, to understand what traditional healing is all about and be more respectful of it and be more open. Not allowing people to believe is disrespectful to our ways” (Dodgson & Struthers, 2005. p.343). By disregarding traditional practices, health professionals can contribute to marginalization by leaving women without a say in their own health care experience.

Baker et al (2000) in their study on the hospital experiences of Mi’kmaq clients in New-Brunswick reach similar conclusions and report that one recurring theme is the dichotomy of “our ways/their ways” which refers to the perceived differences between aboriginal traditions and the ‘white people’s way’. Clients reported feeling that their traditional customs were not welcomed in the hospital and that the hospital’s rules and norms were not in line with theirs. This created misunderstandings that affected the experience of clients within the hospital. For example, some clients reported feeling lost and lonely in the hospital because family visits were limited and that the staff as well as other patients did not understand the importance of family in Mi’kmaq culture:

“My family was here every day, but I have such a big family I think we drove everybody crazy... they tried so hard to not make any noise... the patients were the ones that were bothered by big crowds or “pow wows” as one of them called it. We were praying in our native language and I think they didn’t understand what we were doing” (Baker et al, 2000, p.17)

Others felt like complete strangers in the hospital setting saying “I had no clue about what was going on” (p.18). For the aboriginal women of the Downtown Eastside or the Mi’kmaq clients in New Brunswick, the difficulty of reconciling the two cultures within the health system creates a barrier that can potentially limit their access to health services by creating misunderstandings or reluctance to use these services.

### **Creating aboriginal women as the “other”**

The misunderstandings between aboriginal women and health care practitioners often result from the difficulty of reconciling cultural practices with mainstream health care. However, recognizing the difference in practices between diverse communities can lead to a perverse effect that ultimately increases the divide between the groups when it is used to create an inflexible dichotomy between aboriginal and non-aboriginal people. Fiske and Browne (2006; 2000) refer to this process as the construction of aboriginal women as the ‘other’, which occurs over presumed cultural differences.

The process of ‘othering’ occurs when groups are divided in an ‘us versus them’ way. In her study of clinical encounters between nurses and First Nation women, Annette Browne (2007) illustrates how this process occurs and its consequences on health care. She argues that often times, cultural differences are perceived as static traits, independent of social and political forces. Once acknowledged, these cultural differences become the basis for separating groups and creating

practices based on an 'us vs. them' dichotomy. The interviews the author conducts with nurses lead her to conclude that the construction of the 'other' occurs through generalizations and assumptions over the "native's way", meaning that the nurses were expecting certain behaviours to occur when dealing with aboriginal clients and adjusted their reactions accordingly. One nurse notes that she alters her behaviour when dealing with aboriginal patients.

"I think I am quieter with them. My approach is quieter because Natives tend to be quieter. Then there is the other, the type that are angry with white people so you do approach them differently in the fact that you don't talk to them as much probably" (p.2170).

Though recognizing the differences between aboriginal traditions and the "White people's way" could be seen as a positive step towards respecting aboriginal women's customs, it ultimately creates greater obstacles and leads to further misunderstandings. Browne argues that this is partly because cultural assumptions often hide power inequities and deeper problems in the client. For example, quietness and passivity were understood by nurses to be the "native way" of interacting with hospital staff. Yet, when asked about aboriginal people's perceived passivity, a First Nation nurse explains: "It stems from people being told how to live, how to speak, what language to speak, and that has gone on for so many years. And it is changing, but it is a process that we have to go through" (Browne, 2007 p.2169). A First Nation woman also notes that for many aboriginal women, speaking up in front of hospital staff is difficult and is the result of years

of being told not to speak up and not to react strongly by teachers in residential schools.<sup>4</sup>

Interestingly, the dichotomy of our way/their way can also be used by aboriginal women when discussing their clinical encounters. In the Mi'kmaq and Downtown Eastside studies, clients often referred to this disconnect between their traditional ways and the mainstream health system. Though recognizing the differences between the two systems and the need for services that respect aboriginal traditions is important, there is a danger in constantly focusing on cultural differences. Annette Browne (2007) argues that both aboriginal and non-aboriginal people risk creating further misunderstandings if they constantly analyze situations through a cultural lens. For example, one nurse, reflecting on her experience dealing with aboriginal clients, explains "some of them don't like us at all. You know, it's been inbred in them from a very young age. They resent us" (Browne, 2007 p.2171). By assuming that the differences are irreconcilable, both clients and providers risk feeling frustrated and misunderstood, negatively influencing health care experiences.

The creation of an inflexible barrier between aboriginal women and non-aboriginal practitioners can have severe consequences on health and on

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<sup>4</sup> Residential schools were institutions set up through the Canadian government between 1870 and 1996 to assimilate aboriginal children. Children were discouraged from speaking their native language and practicing their traditions. Over the years, many reports of physical and sexual abuse came to light. In May 2008, a formal apology was delivered by the government of Canada. (source: CBC News 2010: A history of residential school in Canada; Truth and Reconciliation Commission of Canada 2010)



women's ability to use health care services. In the example of the perceived passivity of First Nations women, the quietness was the result of historical forces and trauma that were likely to have lasting repercussions. Women interviewed by Browne et al (2000) explain that attending residential schools had left them feeling vulnerable, particularly when exposing their bodies - having been taught to be ashamed of doing so. One woman states:

“I don't know why, I didn't want anybody to look at my body. Because we were told not to show our bodies. Maybe it has to do with our upbringing and by the way we were taken out of our homes and told to be ashamed of our bodies.” (Browne et al, 2000 p.19)”

This shame can make the process of getting a physical or gynaecological exam difficult. In another interview, one woman explains that submissiveness and passivity could be signs of domestic abuse or sexual trauma. Yet, it is often interpreted by medical staff as a cultural trait, which makes identification of abuse and trauma more difficult.

Another consequence of the process of 'othering' is to reinforce marginalization by making aboriginal women feel as if they are left 'outside' of the system. Some First Nations women explain that they feel they are intruding on the 'white people's system' (Browne et al, 2000). Though some identified the lack of social cohesion between First Nations women and non-aboriginal women in rural clinics as the source of this discomfort, others felt that white people resented them for getting special treatment through federal transfer agreements regarding health

care.<sup>5</sup> The discomfort over special treatments was also identified by a First Nations nurse who explained that many of her colleagues would say: “they [First Nations people] can have all those medications because they get everything for free, paid for by the government” (Browne, 2007 p.2174).

Besides perpetuating stereotypes, the problem is that by distancing themselves, aboriginal women and non-aboriginal practitioners risk reinforcing the belief that the cultural divide is too wide to be addressed (Fiske and Browne, 2006). When this occurs, marginalization can be felt by aboriginal women who believe that mainstream providers cannot possibly understand them and are insensitive to their realities. This can lead to a distrust of mainstream practices and ultimately an avoidance of clinics and hospitals (Dodgson & Struthers, 2005; Wilson & Neville, 2008).

## **Racism and discrimination**

The categorization of aboriginal women as the ‘other’ is created by historical constructions of aboriginal people as different from non-aboriginal people and perpetuated through social interactions and policymaking. Though the recognition of cultural practices is essential, overemphasizing them can lead to stereotyping and further discrimination. In interviews conducted with First Nations

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<sup>5</sup> Health care in Canada is provided by provincial governments. However, the federal government provides services to aboriginal communities through additional services and financial transfers to aboriginal health centers. Federal transfers are sometimes perceived as being more generous than provincially funded services leading to possible resentment. (source: Fiske and Browne 2006; Government of Canada. Blueprint on aboriginal health, 2005)

women, racism and discrimination were recurring themes. Many women recalled experiencing prejudices and stereotypes when going to clinics and hospitals, which impacted their encounters with health professionals negatively. In an interview recounted by Browne et al (2000), one woman explained that she felt the need to dress well and to talk in an educated manner when she went to the local clinic because it was the only way to be taken seriously and to not be dismissed (p.15). In another interview, one woman expressed how uncomfortable she felt when having to present her Department of Indian Affairs status card when using health services because she felt judged by non-aboriginal people using the same services (p.16).

Discrimination and stereotypes were also felt by interviewees over their ability to be good mothers. In interviews by Browne et al (2000), aboriginal women felt their ability to raise their children was often questioned, and this they believed was due to negative perceptions of aboriginal people. In one interview, a young woman spoke of having had her child taken by child services upon arrival at the hospital because she (the mother) had a black eye from playing fastball. She explained how the experience had profoundly affected her and her ability to trust the services of the hospital staff:

“They wrote me a letter of apology and regretted the whole incident and I couldn’t believe it, and it just shows you, I said, just because I’m a Native person that came in with a black eye, that looked like I wasn’t, you know, because my child had a really bad severe rash, they just assumed the worse. ... I was so hurt. I’ve never trusted doctors after that because I was very reluctant to bring my daughter in. Anytime she was sick or anything, that incident always comes back to me and I think, I don’t want to ever go through that again. I don’t want to be

judged morally, that I'm a bad mom. I don't want to ever be judged like that again" (Browne et al, 2000 p.17)

Though racism exists in most social spheres, discrimination in the health care system has consequences on aboriginal women's ability to use the services by creating feelings of powerlessness and disempowerment (McMurray, 2008). Though racism can stem from health professionals' attitudes and actions, it is also embedded "in the history of relations between aboriginal people and the Canadian state, and the positioning of individuals within those relations" (Browne, 2007 p.2174). This means that discrimination and stereotyping are embedded in the way "the other" has historically been portrayed. This can affect both non-aboriginal and aboriginal people and can result in racialized encounters between practitioners who distance themselves from aboriginal clients who consider even innocuous acts as manifestation of racism (O'Neil, 1989). It also highlights the difficulty of addressing discrimination as a strategic barrier. Using the example of the mother and her child, one can see how the situation can become difficult for both the mother and the hospital staff. Indeed, one of the problems identified is that health care providers sometimes missed cases of abuse because of attitudes towards culture, yet, when they do suspect a situation of abuse, the gesture is understood as negative stereotyping.

## **Addressing strategic barriers**

The three themes discussed – the clash between aboriginal and mainstream systems, constructing the other, and racism and discrimination – all lead to marginalization by making aboriginal women feel themselves to be outsiders. Marginalization, in turn, can be understood as a strategic barrier because it involves power inequities and vertical hierarchies that ultimately prevent an equal access to health care. Marginalization is a difficult barrier to address because its different manifestations intersect to create “no-win” scenarios. For example, acknowledging the differences between the aboriginal traditions and the mainstream system is important and was seen as a necessity for the women of the Downtown Eastside and the Mi’kmaq clients. Yet, placing too much emphasis on cultural differences risks further alienating aboriginal clients by placing them in constant opposition to non-aboriginal practitioners. Assumptions over cultural preferences also have the potential to hide deep personal problems and power inequities. Finally, everyday acts of racism and discrimination, which limit aboriginal women’s ability to feel empowered in their encounters with medical professionals, can also impact some nurses who admit to feeling that they constantly have to walk on eggshells around aboriginal clients for fear of being labelled as racist (Browne, 2007).

Though some of the barriers identified can apply to both aboriginal men and women, the way they are experienced can vary between the two. It is easy to lose sight of the gender perspective when listening to aboriginal women’s

testimony because there is the possibility that faced with cultural discrimination they emphasize their indigenous needs over their gender needs (Van der Hoogte & Kingma, 2004). This translates into prioritizing collective rights over individual rights. Yet, the high rate of domestic violence in aboriginal populations – aboriginal women are three times more likely than non-aboriginal women to report spousal abuse (Statistics Canada, 2006) – is a sign that it is important to consider gender inequities within aboriginal communities. Unequal power relations within the household can influence who controls resources and who holds decision-making abilities. Without the ability to control economic resources, aboriginal women can be limited in the types of treatments they can seek. Faced with situations of abuse, women can also be wary of seeking health treatments that would increase their feeling of vulnerability. The vulnerability of those who experienced abuse and trauma, in both residential schools and in the community, is another problem specific to aboriginal women. One younger woman who did not attend residential school spoke of vulnerability saying:

“There’s a lot of sexual abuse too that happened, probably still happens in the community, and younger women, they hide their bodies. They don’t want to draw any attention to themselves or to their physical ailments or whatever because they’re afraid to let anybody touch them because of the sexual abuse that’s happening. Myself, I was sexually abused so I sort of know the feeling of being examined the first time by a doctor, I was ashamed. [The doctors] have these misinterpretations. ‘Is this part of their culture?’ ‘Is this why they’re so submissive?’” (Browne et al, 2000 p.19)

This woman’s account highlights how gender inequities in the community can affect aboriginal women’s ability to use gynaecological services or to interact with health practitioners. This in turn affects their health by limiting the number of

women who receive PAP tests or mammograms. It can also lead to negative encounters with health professionals.

Despite the difficulties of addressing the barriers that prevent aboriginal women's full access to health care services, some solutions can be conceived, though none are perfect. Ultimately, it is essential to understand how practical barriers and structural barriers demand different approaches, the former requiring needs-based solutions and the latter equity-based approaches. Through a commitment to change power dynamics, and by addressing racism and discrimination while acknowledging the needs of aboriginal people for a system that represents them, it might be possible to develop solutions that will ultimately empower aboriginal women, leading them to better experiences in the health care system.

## **4: SOLUTIONS**

Though both practical and strategic barriers have significant impacts on aboriginal women's ability to access health care services, they require different approaches and commitments. However, any reforms to the health care system are complicated by the multiple actors involved at different levels of jurisdiction, the limited funding available, and the current strains on the entire Canadian health care system. Given the complexities involved, and given that what works in one community might not work in the other, the solutions explored in this chapter should be understood as starting points or broad guidelines to address the barriers mentioned previously.

The solutions examined in this chapter are from a variety of sources –federal and provincial governments, aboriginal associations, and scholars – and are meant to address the problems exposed in the previous chapter. Given that the focus of this research is the strategic barriers, approaches to address these challenges will be given greater emphasis. However, it is important to note that the practical



barriers identified can be extremely challenging to address and should not be disregarded. Thus, some solutions to address these will be examined as well. To better frame the different responses, this chapter will be divided into two sections. The first one will present some of the steps taken by the government to improve access to health care services. Though many reports on aboriginal health have been written by and for the government, the one used is, at the time of writing, listed on top of Health Canada's web page concerning aboriginal health. This section will also offer some solutions provided by the government and some of their limitations. The second section will present two alternatives: self-governance and cultural competency training. These two methods were chosen because they are frequently referred to in reports and studies and their potential and limitations highlight some of the difficulties of addressing marginalization in health care.

## **Addressing barriers to health: the government response**

The federal and provincial governments have, over the years, developed a variety of reports and responses to some of the barriers preventing aboriginal people full access to health services. In the *Blueprint on Aboriginal Health- A 10-year transformative plan (2005)*, the Canadian federal, provincial and territorial governments outline a series of actions aimed at improving the experiences of aboriginal Canadians in health. The document recognizes the specific needs of aboriginal women and commits to a gender-based analysis when conducting research and implementing programs. It also recognizes the importance of indigenous knowledge and the participation of aboriginal leaders in the elaboration of health strategies. The Blueprint signifies a commitment from the governments to improve the health status of aboriginal people in the country. To do so, three areas of commitment are targeted and are presented in figure 6: National Directions for Actions.

**Figure 6 National Directions for Action**

Target areas	Priorities
1. Improved delivery of and access to health services through better integration and adaptation of health systems	<ul style="list-style-type: none"> <li>• strengthen environmental health activities and promote access to public health services</li> <li>• improve coordination of funding between federal and provincial governments</li> <li>• support culturally and linguistically-appropriate care through patient supports or client assistants</li> </ul>
2. Measures that will ensure that Aboriginal peoples benefit fully from improvements to the Canadian health system	<ul style="list-style-type: none"> <li>• acceleration of e-health and telehealth infrastructures</li> <li>• implement health human resource strategies (increased numbers of aboriginal health professionals, recognition and respect for traditional health practitioners, culturally appropriate health curriculum development)</li> </ul>
3. A forward looking agenda of prevention, health promotion and other upstream investments	<ul style="list-style-type: none"> <li>• facilitate engagement of communities in holistic health planning</li> <li>• acknowledge and respect traditional approaches to healing</li> <li>• engage aboriginal organizations in the development of health strategies</li> <li>• improve coordination and engagement within mainstream systems</li> </ul>

Source: Blueprint on Aboriginal Health. Government of Canada. 2005 p.21-22.

In their plan for action, the federal, provincial and territorial governments recognize the need to address some of the challenges identified in the previous chapter, such as the importance of respecting traditional approaches to healing, providing culturally relevant services and increasing the resources for aboriginal health centres. Though these measures are important for addressing the practical barriers identified, they only offer limited solutions to the problem of

empowering aboriginal women and decreasing their feelings of marginalization. The commitment of the governments to increase aboriginal participation in health planning is important and could signify a greater representation of aboriginal concerns in the health care system. However, it might not lead to significant improvements if it only serves to create a parallel system. Indeed, a parallel system would not address the discrimination in the mainstream system and could contribute to further alienation by overemphasizing the differences between aboriginal and non-aboriginal Canadians.

The Blueprint is not unique in that many other government reports have emphasized the need to improve aboriginal people's access to health care services. In a document entitled *The transformative Health Accord: First Nations Health Plan* (2005), the government of British Columbia (BC) commits to reducing the health gap between aboriginal and non-aboriginal people in the province by increasing the number of First Nations health professionals, increasing access to primary health care services, and developing a curriculum for cultural competency training in health care centres. As in the pan-Canadian blueprint, the BC Health Plan focuses on practical barriers while acknowledging the importance of culture and traditional healing practices. Yet, it does not address some of the deeper issues of racism and marginalization which are known to affect aboriginal women's ability to use the services.

Strategic barriers could theoretically be addressed through the recruitment of more aboriginal health professionals who would be more sensitive to the needs and concerns of aboriginal clients. The federal and provincial governments prioritize this solution as part of their human resources strategy. Though increasing aboriginal health professionals is an important step that needs to be prioritized, it is not a panacea and will not solve all the identified barriers. In 2003, aboriginal nurses represented approximately 0.47% of the total Canadian nursing staff, falling short of the 3% required for a proportional representation (Health Canada, 2008). The underrepresentation of aboriginal people in health care is due to a number of factors, but one significant contributor is the low education rate. In 2001, the graduation rate of aboriginal students enrolled in a high school was 29.6%, compared to the national average of 75.6% (Indian and Northern Affairs Canada, 2003; Statistics Canada, 2005). Though many eventually graduate through the adult education system, the proportion of aboriginal people without a high school diploma is twice as high as that among non-aboriginal Canadians -32% versus 15% (Wilson & Macdonald, 2010). Consequently, less aboriginal people complete a postsecondary education with a 15% gap between aboriginal and non-aboriginal students (INAC, 2003). Though aboriginal women are increasingly pursuing a postsecondary education, the number of women who choose to pursue a career in health is limited<sup>6</sup>. In this context, it might be difficult

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<sup>6</sup> In 2006, education was the biggest field of study for aboriginal women enrolled in undergraduate courses with 27%. This was followed by social sciences and law (23%) and business, management and administration (18%). Health received only 11% of aboriginal women (Wilson & Macdonald, 2010).

to increase the number of aboriginal health providers without addressing the severe problems facing the educational system.

Another limitation for aboriginal health professionals is that they might not be able to address the discrimination within the health system. Native Liaison workers and interpreters can help bridge the gap between aboriginal clients and non-aboriginal practitioners. However, they also risk being confronted by the same practices of 'othering' as the clients they assist if discrimination and stereotypes are not addressed, by representing the cultural difference between the two groups (Fiske & Browne, 2006). For those reasons, health sector human resources strategies are limited and must be understood as part of the solution but not as a panacea.

Despite the commitment of the governments to improving health care access for aboriginal people, critics argue that efforts have been limited and have not led to significant improvements, particularly for aboriginal women (Martin & Diotte, 2009; Fiske & Browne, 2006). In a critique of Canadian health care policies, Fiske and Browne (2006) explain that, too often, health care policies are framed in terms of cultural differences between aboriginal people and non-aboriginal people which contribute to the problem of 'othering'. By arguing for culturally sensitive services, the federal government continues to ignore power inequities that lead to health disparities. Additionally, the Blueprint and the BC Health Plan mention aboriginal women in the introduction of the document only then to leave

them out of the actual policies. For example, in the introduction to the BC Health Plan, the lack of appropriate medical services for aboriginal women living in rural communities is mentioned as a challenge and a health priority for the province yet, maternal health only gets mentioned briefly in the core of the document. The focus of the health promotion plan is on exercising more, better nutrition, substance abuse reduction, and HIV/AIDS control and advocacy. Though these are pressing issues for aboriginal communities, the lack of mention of cervical cancer screening, mammography and other women-specific services points to the lack of gender-specific spending as well as a construction of aboriginal people as victims of their unhealthy lifestyle choices (Fiske & Browne, 2006).

## **Self-governance as a solution?**

Since 1995, the Canadian government recognizes that the “Aboriginal people of Canada have the right to govern themselves in relation to matters that are internal to their communities, integral to their unique cultures, identities, traditions, languages and institutions, and with respect to their social relationship to their land and their resources” (Indian and Northern Affairs Canada, 2010). Under this agreement, aboriginal communities can negotiate for autonomy with the federal government over various matters, including health.

Self-governance can be seen as an interesting solution to the problems identified previously because it can address the specific needs of aboriginal people while engaging communities in decisions over their own health. Several examples of self-governed health centres in aboriginal communities across the country point to the success of community control over health resources. In a study on aboriginal health systems in Canada, Lemchuk-Favel and Jock (2004) identify a series of characteristics that contribute to the success of self-governed health systems in nine aboriginal communities. They argue that communities that have been successful at implementing their own health systems all shared some common characteristics such as self-empowerment, holistic approach, synergy of traditions and western philosophies, and primary care. These characteristics point to the potential of aboriginal health systems to address some of the barriers



identified. By respecting traditional values while recognizing some of the benefits of western medicine, community centres can limit the clash between traditions and mainstream currents. They can also limit feelings of marginalization often felt by people who feel on the outside of the mainstream system, by including them in the decision-making process. For example, in Kahnawake, Quebec, the vision of the health system is based on a holistic view of medicine and healing that emphasizes the importance of prevention and responsibility over one's health. Managed by the Mohawk-controlled Kahnawake Health and Social Service Commission, the health system benefits from the input of the community and enables the members of the community to better integrate aboriginal health practices (Lemchuk-Favel & Jock, 2004). Similarly, a study on midwifery practices in Nunavik (Northern Quebec) highlights the importance of the population's input in health decisions. Midwifery is a traditional practice in Inuit and Nunavik culture but was suppressed in the 1970s after the imposition of an evacuation policy to southern centres for all pregnant women. This policy negatively impacted Inuit women by removing them from their community during childbirth. The response of the community was gradually to increase the number of midwives and to promote their importance in the community. The Inuulitsivik Health Centre Maternity Program in Purvinituq is, since 1986, an example of a self-governed aboriginal health centre that successfully combines traditional and western practices. By offering services tailored to the needs of its target population, the program improved the birthing experience of Inuit women while

decreasing the risks related to unsupervised pregnancies (Lemchuk-Favel & Jock, 2004).

However, several problems can limit the ability of aboriginal communities to establish their own health care services. Besides having to deal with the same difficulties as the mainstream health system, such as limited funding, aboriginal communities have to deal with remoteness and community size, which can limit their ability to implement a viable health centre (Lemchuk-Favel & Jock, 2004). Additionally, aboriginal health centres can find it difficult to find aboriginal staff. The problem of human resources is a problem across Canada but it can be even more acute if a specific cultural background is required. Self-governance can also be extremely difficult to implement for aboriginal people living in urban centres (Martin & Diotte, 2009). Very often, the government, despite a written commitment, is hesitant to completely transfer control over services and spending to aboriginal centres in cities, particularly if jurisdictions are likely to intersect<sup>7</sup>. Yet, according to the last Canadian census, 56% of aboriginal people reside in urban centres (Statistics Canada, 2006). Thus, the impact of self-governance in reducing marginalization in health care can only be limited at the moment.

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<sup>7</sup> First Nations communities can gain autonomy for health services on reserves, since a reserve is for the specific use of a First Nation band. In urban centres however, provincial authorities provide delivery of health services for the benefit of the entire population. Since aboriginal health is partly regulated through the federal government, jurisdictions are likely to intersect outside of a reserve.

Finally, it is important to keep in mind that self-governance can only address aboriginal women's marginalization if they are included in the process. Currently, aboriginal women are often underrepresented in band councils and leadership positions which undermines their ability to participate in the creation of appropriate health services (NWAC, 2007). The concept of intersectionality in this case is crucial to understand the importance of examining self-governance through a gendered lens. As Van der Hoogte and Kingma (2004) explain, every culture is subject to unequal power relations, including those based on gender. Though self-governance might improve aboriginal people's ability to address health disparities, it might not translate into improvements for aboriginal women. Unless gender inequities are addressed and women in the community are involved in the process, it is unlikely that self-governance will be sufficient to address the strategic barriers preventing aboriginal women from accessing health care services in a positive way.

## **Cultural competency**

The concept of cultural sensitivity or cultural competency has gained attention over the last decades with the recognition that failure to provide culturally competent services can lead to negative health outcomes and dissatisfaction over the care received (Kongnetiman & Okafor, 2006). Given its potential to address some of the difficulties in working with clients from different cultural backgrounds, it has been part of many curricula and practical training sessions for health care workers. Cultural competency requires health professionals to a) examine their own beliefs and values and understand how these can affect their practice, and b) recognize and respect the beliefs of clients while incorporating them as much as possible into the treatment (Wilson, 2008).

Cultural competency can be an interesting solution to address some of the barriers experienced by aboriginal women when using the services of a health centre. Yet, it can also be insufficient if simply taken as a set of guidelines. In fact, universalizing differences and ignoring the diversity within groups can worsen feelings of marginalization by denying clients their identity (Wilson, 2008). Additionally, cultural sensitivity can worsen the process of 'othering' if too much emphasis is placed on cultural differences or if cultural sensitivity is used to ignore power inequities (Fiske & Brown, 2006). Thus, for cultural competency to

address the concerns of aboriginal women, a few key recommendations need to be adopted and put in practice by nurses, doctors and other health professionals.

McMurray and Param (2008), in a study on culture-specific care for indigenous people in Australia, offer some of these recommendations. The first point they argue is that cultural competency should be understood as a critical multicultural approach that entails developing alternative ways of thinking about aboriginal values and beliefs instead of regarding indigenous culture as a set of fixed characteristics. In this context, cultural competency becomes reflexive and is not used to engender or perpetuate stereotypes. They also argue that health professionals need to become resources for clients in order to create partnerships. McMurray and Param's recommendations, though formulated for the Australian context, can be relevant for the Canadian system. Indeed, indigenous communities in Australia, as in Canada, are diverse and heterogeneous. Thus, the idea of understanding aboriginal communities as diverse rather than considering all individuals as "native" can be useful and is desirable in a country as wide and diverse as Canada. Additionally, interviews with aboriginal women in Vancouver's Downtown Eastside and First Nations women in a BC community highlight the importance of developing meaningful relationships with the health care providers. Cultural competency training can help physicians and nurses go beyond cultural stereotypes and get to know the individual they are working with (Benoit et al, 2003; Browne et al, 2000).

Another recommendation articulated by several scholars is the importance of recognizing power inequities between aboriginal clients and non-aboriginal providers. Browne et al (2000) identify this process as 'cultural safety' which, they argue, goes beyond cultural sensitivity by understanding the impact of colonization, institutional discrimination and power inequities, while being aware of

#### **Figure 7 Cultural Safety Guidelines**

- Acknowledge that we are all bearers of culture
- Expose the social, political and historical contexts of health care
- Enable practitioners to consider difficult concepts such as racism, discrimination, and prejudice
- Acknowledge that cultural safety is determined by those to whom nurses provide care
- Understand the limitations of 'culture' in terms of having people access and safely move through health systems and encounters with care providers
- Challenge unequal power relations

*Source: Hart-Wasekeesikaw, F. Cultural Competence and Cultural Safety in Nursing Education, Aboriginal Nurses Association of Canada. 2009, p.2.*

the political, historical and social forces that have shaped the interactions of aboriginal people with health care providers. The principles of cultural safety are perhaps easier to understand and apply when contrasted with culturally unsafe practices:

“Any actions that demean or disempower the cultural identity and well-being of an individual. The crucial elements within cultural safety concepts are that unsafe practitioners diminish, demean and/or disempower those of other cultures, whilst safe practitioners recognize, respect and acknowledge the rights of others” (Browne et al, 2000 p.9)

McMurray and Param (2008) argue, similarly, that it is crucial to recognize the historical dispossession that has shaped the lives of aboriginal people and have contributed to unequal access to health care services. Finally, Dodgson and Struthers (2005) recommend that health care professionals develop an

understanding of the historical context of indigenous people and that they recognize the lasting impact of historical traumas on individuals, their families and their communities.

In practice, the concept of cultural competency and cultural safety training can be implemented into the learning curriculum through a series of guidelines. Through cultural safety training, nurses are meant to develop the following competencies when working with aboriginal clients:

<b>Competencies</b>	<b>Skills developed</b>
Postcolonial Understanding	<ol style="list-style-type: none"> <li>1. Understand the impact of historical and current government practices and their effects.</li> <li>2. Identify the determinants of health of aboriginal people and use this knowledge to promote the health of aboriginal people.</li> <li>3. Recognize historical trauma, socio-cultural and political factors as they apply to health outcomes.</li> </ol>
Communication	<ol style="list-style-type: none"> <li>1. Identify the centrality of communication in health care.</li> <li>2. Develop a positive therapeutic relationship with clients based on respect, empathy and understanding.</li> </ol>
Inclusivity	<ol style="list-style-type: none"> <li>1. Engage in dialogue and relationship building.</li> </ol>
Respect	<ol style="list-style-type: none"> <li>1. Identify culturally harmful practices and rectify behaviours causing harm</li> <li>2. Collaborate with aboriginal health providers.</li> </ol>
Indigenous Knowledge	<ol style="list-style-type: none"> <li>1. Demonstrate ways to value, include, and share Indigenous knowledge</li> <li>2. Recognize the diversity of Indigenous health knowledge and practices.</li> </ol>

Source: Aboriginal Nurses Association of Canada, 2009.

The concepts of cultural competency, cultural sensitivity or cultural safety all point to the importance of acknowledging and respecting cultural beliefs, without stereotyping, in order to provide more appropriate health services. Though the recommendations presented offer good starting points to improve relations between aboriginal clients and health providers, they can only have limited results if the practice does not follow on the theory. Officially, the Royal College of Physicians and Surgeons of Canada and the Canadian Nurses Association support culturally appropriate practices when working with aboriginal people. Yet, interviews with several aboriginal women refer to the insensitivity of many health professionals and the difficulty of integrating traditional practices to mainstream medicine (see Browne et al, 2000; Benoit et al, 2003). This is most likely due to the difficulty of putting into practice the theoretical concept of cultural competency. Interviews with aboriginal women or nurses in a regional hospital all highlight the disparity between various individual providers. As one nurse explains:

“People generalize all the time, and in nursing you have to be careful about that. I mean, I hate it when people say, “well, all Natives are drunk.” Well, no they are not. It is like saying, “all White people are drunks”. So, personally, I am very leery about categorizing people that way in groups” (Browne, 2007 p.2170)

However, another nurse mentions: “You try not to make a distinction but sometimes you do see, that is, the first thing you see is that they are Native” (Browne, 2007 p.2170). As the two interviews with nurses highlight, there are significant differences from one individual to the other. Since cultural



competency is a process that requires health professionals to investigate their own attitudes, it is likely that some will be more willing than others to put the concept into practice, which can severely limit its impact. Additionally, good intentions can sometimes be crushed by occupational stress or negative encounters. Thus, despite the theoretical promises of cultural competency, it is likely to be a long-term solution dependent on individual will.

## Further solutions

In addition to cultural competency training and self-governance, various solutions could be thought of to address feelings of marginalization felt by many aboriginal women when using health care services. In interviews with some of the women, recurring themes emerge pointing to important starting points for positive encounters with health providers. The first of these themes is the importance of actively participating in health decisions. Aboriginal women felt that a good relationship with the provider, where discussion was encouraged, contributed to their feeling empowered (Browne et al, 2000). This type of control over one's health concerns can offset what O'Neil (1989) refers to as a "paternal/maternal cast to clinical relationships", where the culturally distinct 'other' is treated in a child-like manner by health providers (p.340). By being able to make their own decisions regarding their health, aboriginal women felt validated and considered these encounters with health providers as being positive overall (Browne et al, 2000). The second recurring theme in the interviews is the importance of feeling cared for. Aboriginal women felt most comfortable when they could develop a long-term relationship with the provider and when they felt that their concerns were treated as important. Personal attentions from doctors and nurses were identified as having contributed to a good clinical experience by many First Nations women (in Browne et al, 2000), while horizontal relationships between counsellors and clients at Sheway in Vancouver's Downtown Eastside were seen

as positive aspects of the program (Benoit et al, 2003). These conclusions are consistent with those reached in New Zealand by Wilson & Neville (2008) who argue that developing a genuine and respectful relationship is an important aspect of building trust between clients and providers which results in reducing barriers to using health services.

Though meaningful and caring encounters with health providers could improve aboriginal women's access to Canadian health services, these solutions cannot realistically be implemented nationwide. The main problem is that creating a meaningful relationship with a client is up to the individual. Forcing a relationship to develop through policy would be near impossible and is unlikely to be adopted. Additionally, the Canadian health care system is characterized by high volumes of patients, limited funding and shortages of qualified providers. In 2008, health expenditures in Canada were \$171.9 billion and were foreseen to increase (Health Canada, 2008). Yet, 25% of the population that same year reported having difficulty obtaining immediate health care. In the province of Quebec alone, around 2 million people reported not having a family doctor, while the average waiting time for hospitalizations in 2009 was 17 hours (Federation des Medecins Omnipraticiens du Quebec, 2010; Champagne, 2010). In this context, aboriginal women are unlikely to be the only ones feeling the pressure of having to deal with a new doctor each time they visit a clinic, or having to deal with nurses under occupational stress. Though developing a meaningful relationship with a provider would be the first step towards improving access to health care

services it is unlikely to happen given the current constraints felt throughout the country.

Solutions to address the marginalization of aboriginal women in health care services will have to occur at the policy level as well as at the individual level in order for change to occur. Though none are perfect, the ideas presented in this chapter suggest that there can be no miracle solutions given the current limitations of the health care system and the social and gender inequities that still influence the way aboriginal women are perceived and treated. The most important solution then will be to create channels where aboriginal women can offer meaningful input into health policies. By using their concerns as starting points for dialogue, health care planners can develop appropriate policies while empowering aboriginal women over their own health.

## **5: CONCLUSION**

Aboriginal women in Canada continue to face health disparities vis-a-vis their non-aboriginal counterparts. In addition to socio-economic inequalities and the erosion of traditional lifestyles, aboriginal women face unequal access to governmental health care services, despite a legal right to universal and free health care. The difficulty of accessing these services stems from a variety of barriers that can be understood as practical and strategic, where practical barriers are defined as need-based problems and strategic ones are understood as equity-based. The distinction between the two types of barriers is essential to understanding the reasons why aboriginal women report unequal access in the Canadian system, as well as to formulating solutions for change.

Many barriers were identified through reports and interviews with aboriginal women. The main practical challenge for many aboriginal communities is thus geographical isolation and physical distance between communities and the nearest health centre. Physical isolation affects women's ability to access routine

services but also specialized ones, such as mammograms or obstetrics/gynaecological services. The lack of access to these health resources can severely affect health outcomes for both aboriginal women and their offspring. Addressing physical access is thus a priority for governments, that have recognized the need to invest in e-health and telehealth, increase the number of aboriginal health practitioners who will then return to their communities, and promote self-governance in terms of health services. However, none of these services are guaranteed to address the special needs of many aboriginal women whose gender and indigenous identity have left them vulnerable on both fronts.

Though the practical barriers are important challenges that need to be addressed in policies, the interviews used in this study with Canadian aboriginal women lead to the conclusion that marginalization is one of the biggest problems preventing full access to health care services. Marginalization can be understood as the vulnerability created through the exclusion of certain groups from the mainstream society. Three different aspects of marginalization were identified by aboriginal women and health practitioners during interviews: the clash between the mainstream and aboriginal health conceptualization of health, the construction of aboriginal women as the “other”, and the racism and discrimination within the health care system.

The clash between the two systems is a source of frustration for many of the women interviewed. It leads to dissatisfaction, misunderstandings and distrust. This in turn contributes to the feeling of marginalization by making aboriginal women feel they do not belong in the Canadian health care system. To address this problem, many aboriginal women and experts call for a greater respect for aboriginal traditions and for a greater inclusion of these traditions into the mainstream system. This, however, can only occur if aboriginal women are allowed to participate in decision-making and are given an opportunity to influence the system positively.

The second occurrence of marginalization is the creation of aboriginal women as a distinct category of people, in constant opposition with the rest of the population. By constantly erecting a wall between aboriginal women and non-aboriginal ones over perceived cultural differences, practitioners risk creating or reinforcing stereotypes that contribute to the peripheralization of aboriginal women. This problem can only be addressed through the recognition that perceptions over culture and differences are influenced by history, politics and society. As such, they are subject to distortions, stereotypes and racism. By avoiding a strict understanding of cultural differences as a set of fixed characteristics, health professionals can avoid the problem of 'othering' that causes aboriginal women to feel marginalized from the health care system.

Finally, marginalization needs to be understood as a consequence of historical racism and discrimination. Reinforced by a belief that aboriginal women are different than non-aboriginal ones, racism and discrimination can leave aboriginal women vulnerable and unwilling to use health care services because of the fear of being labelled as bad mothers or undeserving patients. Cultural competency training can be a tool to address the discrimination within the system but it cannot be sufficient if attitudes towards aboriginal people are not challenged on a wider scale, that is, if stereotypes and negative attitudes are not addressed in society as a whole.

Marginalization can be understood as a strategic barrier because it creates inequities that can only be rectified by changing power dynamics. By being made to feel isolated and peripheralized, aboriginal women lose their ability to participate in and control their health. This feeling of marginalization leads not only to involuntary exclusion from the system but also to voluntary withdrawal, negatively affecting health outcomes in the process. Addressing marginalization is essential if any improvements are to be made to health care services in Canada because it has the potential to limit future practical responses. Indeed, addressing geographical isolation and language difficulties is unlikely to improve aboriginal women's access to health care if negative encounters, discrimination and misunderstandings push women to avoid the health centres.



## **Implications and recommendations**

This research paper highlighted the importance of considering marginalization as an important barrier to full access to health care services by aboriginal women in Canada. By understanding the causes of this marginalization, it is possible to formulate solutions that can improve aboriginal women's experiences within the health care system. Though the solutions presented – self-governance and cultural competency – represent only a fraction of the possibilities, they highlight the difficulty of addressing gender needs at the policy level and the importance of individual commitments to eliminating stereotypes and discrimination. More importantly, they highlight the need to involve aboriginal women at every level of decision making in order to offer services that are responsive to their needs.

Though this paper should contribute to the literature on aboriginal women's marginalization from health care resources, it needs to be understood as a complement to aboriginal women's own research. It is essential for aboriginal women to be able to share their experiences and to be active participants in health decisions. Without this type of involvement, marginalization is likely to endure. Thus, any further research and policies will have to recognize the central role played by aboriginal women in health, as well as the intersectionality of gender and indigenusness. Without a commitment to address both aboriginal and gender needs, actions are unlikely to succeed. Additionally, policy makers need to put aboriginal women at the centre of any policy formulation. Their expertise and inclusion can offset the difficulty of formulating policies from an

outsider's point of view and can create a situation of empowerment, where women are in control of their own health.

Financial and time constraints made field research impossible but by using interviews, I hope to have included aboriginal women's voices to this research, and let their experiences be starting points for the analysis and recommendations. Their experience showed that strategic barriers will have to be addressed, along with practical ones, if aboriginal women are to access health services. They also highlighted the importance of listening to their concerns. By understanding marginalization as a strategic barrier to access, it becomes possible to formulate solutions based on addressing inequalities. Without such a commitment to change power dynamics, health disparities that currently plague aboriginal people in Canada are unlikely to change and aboriginal women are likely to continue reporting unequal access to the theoretically universal health care services.

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