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NWAC Submission: Aboriginal Women and Health Care in Canada

1. Introduction

*... the state of health of Aboriginal Canadians and the socio-economic condition in which they live remain deplorable.... In the view of the Committee the health of Aboriginal peoples is a national disgrace... We certainly need to do a better job. The federal government must take a leadership role in working to immediately redress this situation.*¹

We thank Commissioner Romanow for this important opportunity to present our issues and concerns, on behalf of the Native Women's Association of Canada, regarding the delivery of health care in Canada. The Native Women's Association of Canada (NWAC) has a long history of representing and advocating on behalf of the rights of Aboriginal women in Canada. We have been in existence since 1974, with the mandate from our national membership to:

Be the national voice for [Aboriginal] women.

Aboriginal women are doubly disadvantaged in Canadian society because of their race and gender. Aboriginal women are the poorest of the poor and because of this suffer unique health concerns that require immediate attention and need to be addressed by the federal, provincial, and Aboriginal governments. As Aboriginal scholar Madeline Dion Stout explains, it is important in addressing the health needs of Aboriginal women to understand our needs within a contextual framework:

Aboriginal women's relatively poor health status (when compared to that of non-Aboriginal Canadian women) can only be understood in the context of a range of health determinants, including socio-economic status, education and employment conditions, social support networks, physical environment, healthy child development and access to health services.²

¹ *Standing Committee on Social Affairs, Science and Technology, Interim Report: Health Issues and Options (September 2001) at chapter 13.*

² *Madeline Dion Stout, Aboriginal Canada: Women and Health A Canadian Perspective (July 1996) from "Abstract" (on web-site).*

It is therefore important, in assessing the needs and concerns of Aboriginal women's health to do so within a holistic framework which acknowledges our continued oppression, our gender, our race, and the continuing impact of colonization. It is also important to recognize that we make up a diverse population of Aboriginal peoples with different issues, concerns and cultural backgrounds. Finally, we underscore the importance of resolving the federal/provincial/territorial jurisdictional wrangling over responsibility for our health services - in order to best meet our growing and pressing needs.

2. Aboriginal Women and Health

The current health status of Aboriginal women has been chronicled in a number of reports. The Health Canada Women's Health Bureau, provides a concise and succinct summary of the current health realities of Aboriginal women:

- Life expectancy for Aboriginal women is 76.2 years vs. 81.0 for non-Aboriginal women.
- Aboriginal women experience higher rates of circulatory problems, respiratory problems, diabetes, hypertension and cancer of the cervix than the rest of the general female population.
- Current evidence shows that diabetes is three times as prevalent in Aboriginal communities than in the general population. Most Aboriginal diabetics are women (approximately 2 to 1).
- Aboriginal women represent a higher percentage of cases of HIV/AIDS than non-Aboriginal women (15.9% vs. 7%). Within female Aboriginal AIDS cases, 50% are attributed to IV drug use, in comparison to 17% of all female cases.
- The birth rate for Aboriginal women is twice that of the overall Canadian female population. Aboriginal mothers are younger – about 55% are under 25 years of age (vs. 28% for the non-Aboriginal population) and 9% are under 18 years of age (vs. 1% for the non-Aboriginal population).
- Mortality rate due to violence for Aboriginal women is three times the rate experienced by all other Canadian women. For Aboriginal women in the 25 to 44 age cohort, the rate is five times that for all other Canadian women.
- Women are often the victims of family dysfunction, which result from the alcohol or substance abuse. Hospital admissions for alcohol related accidents are three times higher among Aboriginal females than they are for the general Canadian population.

- Over 50% of Aboriginal people view alcohol abuse as a social problem in their communities. Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) have emerged as a health and social concern in some First Nations and Inuit communities.
- Suicide rates remain consistently higher for the Aboriginal population than the general Canadian population as a whole, in almost every age category. Over a five year span (1989-1993), Aboriginal women were more than three times as likely to commit suicide than were non-Aboriginal women.³

The current health status of Aboriginal women must be ameliorated within a holistic framework which acknowledges the impact of colonization and resultant socio-economic and health determinates, such as: poverty, violence, and substance abuse. Our needs must be addressed in ways which honour our right to self-government and our cultures.

a) Poverty

Most observers today believe that poor socio-economic conditions worsen the life chances and, by extension, the health status of Canadian Aboriginal peoples. Not only is poverty correlated with poor nutrition, smoking and other unhealthy practices, but it also serves to undermine one's self-esteem and sense of self-worth... Unfortunately, poverty is a condition which affects Aboriginal women disproportionately.⁴

One of the most profound impacts of colonization has been a denial of our traditional economic structures, loss of our land base, and traditional governing structures. This has resulted in a condition of poverty for many Aboriginal peoples and Aboriginal women, as articulated above, have been disproportionately affected. Statistics Canada, in a recent report found that:

A large percentage of Aboriginal women have low incomes. In 1996, 43% of Aboriginal women aged 15 and over had incomes below Statistics Canada's Low Income Cutoffs... The low-income situation for Aboriginal lone-mothers is even more serious. Among this group, 73% lived below the low-income cut-offs in 1996. This was substantially worse than the 45% figure for families headed by non-Aboriginal female lone parents.⁵

³ Health Canada, Women's Health Bureau: *The Health of Aboriginal Women* (web site).

⁴ M. Dion Stout, *supra* note 2.

⁵ Canada, Statistics Canada, *Women in Canada: 2000 A Gender-Based Statistical Report* (Ministry of Industry: 2000) at 259.

In order to address our over-whelming health needs our access to economic opportunities must be enhanced.

b) Violence

Violence against Aboriginal women has been identified as a health determinate which, as articulated by Dion Stout *et al*, can result in health consequences such as mental health problems, substance abuse, and suicidal thoughts⁶. Emma LaRoque, an eminent Aboriginal scholar, has identified violence as a serious health concern for Aboriginal women and notes that studies have shown that:

... this single most important group of health problems in terms of both mortality and morbidity is accidents and violence.⁷

Violence in the family home has been identified by some authors, including Judges Hamilton and Sinclair, as being in epidemic proportions in some Aboriginal communities⁸. A study prepared by the Ontario Native Women's Association found that 8 out of 10 Aboriginal women have been abused⁹. Similarly authors have identified the abuse of Aboriginal children as being in "epidemic proportions"¹⁰. Efforts must be made to address these pressing issues, in order to qualitatively improve the health of our women, children, and communities.

⁶ M. Dion Stout, G.D. Kipling, and R. Stout, *Aboriginal Women's Health Research: Synthesis Project, Final Report*. Prepared for the Centres of Excellence for Women's Health Research Synthesis Group (May, 2001) at 23.

⁷ E. LaRoque, *Royal Commission on Aboriginal Peoples, "Violence in Aboriginal Communities" in National Roundtable on Aboriginal Health and Social Issues (1994)* at 72.

⁸ Manitoba, *Public Inquiry into the Administration of Aboriginal Justice and Aboriginal Peoples, Report of the Aboriginal Justice Inquiry of Manitoba: The Justice System and Aboriginal Peoples. Vol. 2 (Winnipeg: Queens Printer, 1991)*.

⁹ Ontario Native Women's Association, *Breaking Free: A Proposal for Change to Aboriginal Family Violence*. (Thunder Bay, December 1989) at 19.

¹⁰ B. Hamilton and S. Longstaffe, *A New Justice for Indian Children. A final report of the Child Advocacy Project*. (Winnipeg: Ministry of the Solicitor General of Canada, 1987).

c) FAE/FAS

Another profound and pressing health concern in many of our communities is FAS and FAE (foetal alcohol syndrome and foetal alcohol effects). There is a crying need for pre-natal preventative services for alcohol and drug addiction. As articulated in the Royal Commission Report on Aboriginal Peoples (RCAP):

Aboriginal women who are pregnant need clear and accessible information about the potential effects of alcohol... This suggests to us that priority must be given to alcohol and drug programs for pregnant Aboriginal women.¹¹

However, as noted in RCAP, and in more recent reports¹² access to drug and alcohol treatment for Aboriginal women, especially pregnant women, remains difficult. Access to culturally appropriate and culturally sensitive services for pregnant women, must be a top priority on the governments agenda.

d) Sex Education

A number of scholars, including Aboriginal scholar Emma LaRoque, have argued for the need for better and more accessible sex education for Aboriginal children, youth and adults:

One of the biggest problems in Aboriginal homes and communities is the lack of qualitative sex education... Aboriginal children and youth are desperately in need of solid sex education.¹³

This is necessary for preventive measures against sexual abuse, sexually transmitted diseases and for planned parenthood. Of particular concern, is the susceptibility of Aboriginal women to sexually transmitted diseases, in particular, as identified by Dion Stout, to AIDS:

¹¹ *Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples: Gathering Strength. Vol. 3 (Ottawa: Supply and Services, 1996) at 133.*

¹² *See for instance, K.A. MacDonald, Missing Voices: Aboriginal Mothers Who Have Been at Risk of or Who Have Had Their Children Removed from Their Care (February, 2002) A Report prepared for NAC-BC; and M. Callahan, D. Rutman, A. Lundquist, S. Jackson, and B. Field, Substance Use and Pregnancy: Conceiving of Women in the Policy Making Process. (Ottawa: Status of Women Canada, 2000).*

¹³ *E. LaRoque, supra note 6 at 80.*

AIDS is expected to be a leading cause of death for Indians as we move into the next millennium, and women are particularly susceptible in light of high rates of sexually transmitted disease and inequitable gender relations (which make it more difficult for women to insist upon safe sex practices).¹⁴

Efforts to create and increase qualitative sex education programs must begin immediately.

e) Access to Health Services

*Within the Aboriginal health literature, numerous studies have highlighted the difficulties Aboriginal women face in gaining access to the mainstream system of health and social services system. Moreover, even if they do make use of such services, they must often contend with racism, cultural insensitivity and lack of Aboriginal personnel.*¹⁵

Much of the research, as identified by Dion Stout *et al*, highlights the lack of accessible services for Aboriginal women, as well as a lack of culturally appropriate and culturally sensitive services for women. This situation needs to be improved in order to adequately begin meeting the health needs of Aboriginal women.

f) Aboriginal Children: Our Future

Much, much more needs to be done on behalf of Aboriginal children. Our children are overly represented for rates of mortality, for example:

- The incidence of SIDS deaths among Aboriginal infants is approximately 6 times the non-Aboriginal population.
- The youth suicide rate for Aboriginal male youth aged 10-19 is over 8 times as high as that of their non-Aboriginal counterparts and for Aboriginal female youth the rate is 20 times greater than for the non-Aboriginal female youth;
- The death rate of Aboriginal children for all other causes of death is more than 3 times the death rate for children in the general population.¹⁶

¹⁴ M. Dion Stout, *supra* note 2.

¹⁵ M. Dion Stout, *supra* note 6 at 26.

¹⁶ British Columbia, Children's Commission, 1999 Annual Report. (Victoria: Queens Printer, 2000) at 28.

Improving the health of our children must be a top priority of governments to ensure the future survival of our Nations.

3. Jurisdiction

*...special status of Indian people has been used as a justification for providing them with services inferior to those available to Whites who established residence in this country, which was once theirs.*¹⁷

As cited in your *Interim Report*, the responsibility for Aboriginal health and health care programs demands resolution. The jurisdictional wrangling which underpins the dispute over which government, federal/provincial/territorial is responsible, was identified over 35 year ago by Hawthorne (above) and yet little has been done to rectify the situation. NWAC underscores what you state in your *Interim Report*, that responsibility for health care:

... is an area surrounded by uncertainties that have had serious consequences to the health and health care of Aboriginal peoples.¹⁸

This continual jurisdictional wrangling results in program fragmentation, problems with coordinating programs and reporting mechanisms, gaps in service delivery (etc.), thereby leaving Aboriginal peoples to fall through the cracks.

The Aboriginal Nurses Association of Canada poignantly illustrate how this impacts on their work with Aboriginal people:

Aboriginal nurses see the jurisdictional problems between the federal, provincial/territorial, and First Nations governments and agencies from a client's perspective. They spend many hours attempting to explain the complexity and the relevant policies and procedures to clients and their family members that require access to the wide array of programs and services offered at the various levels of government and non-government agencies.¹⁹

Clearly something needs to be done to resolve this situation.

¹⁷ H.B. Hawthorne, ed., *A Survey of the Contemporary Indians of Canada: A Report of the Economic, Political, Education Needs and Policies. Vol. 1 and 2* (Ottawa: Canadian Department of Indian Affairs and Northern Development, 1966) at 253.

¹⁸ R.J. Romanow (Commissioner), *Commission on the Future of Health Care in Canada, Interim Report: Shaping the Future of Health Care* (February 2002).

¹⁹ *Aboriginal Nurses Association of Canada, Submission: To the Romanow Commission on the Future of Health Care in Canada* (Nov. 1, 2001).

4. Research

*There is a lack of comprehensive health data on Canadian Aboriginal women...*²⁰

In order to address the over-whelming health needs of Aboriginal women research must be engaged in to determine what solutions best meet the needs of our diverse populations of Aboriginal women. Research which is controlled by and done on behalf of Aboriginal women. In Dion Stout, *et al's*, recently completed comprehensive review of health research on Aboriginal women, she provides a succinct and thorough analysis of the research needs of Aboriginal women and recommends that:

...steps must be taken to ensure that research methodologies are clearly articulated and respectful of Aboriginal women's multiple burdens, that attention be focused on groups of Aboriginal women whose needs and concerns have been under-represented in previous research; and that research initiatives be reflective of Aboriginal women's linguistic and cultural diversity. Other issues identified in the paper include the lack of sufficient funding to pursue Aboriginal women's health research, and the need to ensure adequate and appropriate follow-up. Also highlighted was the importance of giving Aboriginal women control over research that affects them, along with the need to enhance training and networking opportunities for Aboriginal women researchers, and to foster partnerships and collaboration with both Aboriginal and non-Aboriginal organizations.²¹

As argued by Madeline Dion Stout a "population health approach" needs to be utilized which considers the "total environment within which Aboriginal women's health is realized. Income and social status, social support networks, education, physical surroundings, biological and genetic makeup, child development and health services are key elements to this approach²². NWAC adds that this must be done within a contextual framework which acknowledges the continuing oppression of Aboriginal peoples and the impact of colonization.

²⁰ *M. Dion Stout, supra note 2.*

²¹ *M. Dion Stout, et al, supra note 6 at 3-4.*

²² *Madeline Dion Stout, supra note 2.*

5. Conclusion

Aboriginal women also emphasized the toxic role played by racism and sexism in undermining their health and well-being, together with the detrimental effects of poverty, unemployment and culturally inappropriate or inaccessible health services.²³

We have attempted in this submission to highlight some of our most pressing concerns regarding Aboriginal women's health in Canada, including:

- Amelioration of poverty and violence against Aboriginal women;
- FAE/FAS prevention;
- Qualitative sex education;
- Access to health services and development of services that are culturally appropriate and culturally sensitive;
- Resolution of the jurisdictional debate between the federal/provincial/territorial governments over responsibility for our health care services;
- Research specifically on Aboriginal women's health.

NWAC is interested in continuing to be consulted on and involved in Aboriginal women's health initiatives. The future of our communities, the well-being of ourselves and our children is reliant upon our continued and committed involvement on the pressing and urgent health needs of Aboriginal women.

²³ M. Dion Stout, *et al*, *supra* note 6 at 22.

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