Vol. 3 No. 12

Report Card, December 15, 2004

Aboriginal Women and Healthcare

Jan Hare

Healthcare is a major issue for Aboriginal people in British Columbia as elsewhere. In 2002, the Provincial Health Officer pointed out that

> If you are an Aboriginal person living in British Columbia, your standard of living is likely to be 20 per cent below the provincial average, based on measures such as income, employment, educational attainment, and housing adequacy. Think of any disease or health condition – from diabetes, pneumonia, or HIV/AIDS to injuries caused by a motor vehicle crash – and your chance of experiencing it will be greater than your non-Aboriginal counterpart.

This report card considers Aboriginal women's encounter with the healthcare system in British Columbia. Not only do such women face greater health burdens, created notably by high levels of poverty, than their non-Aboriginal counterparts, they also encounter major obstacles in accessing necessary and culturally-sensitive services. Research underscores how Aboriginal women are likely to confront ill-health, premature death and marginalization on a scale unimaginable to much of the country's population (Dion Stout, etal., 2001). Not only do they face numerous health challenges, their needs often differ from their mainstream counterparts. Aboriginal people receive healthcare through a complex combination of federal, provincial, and Aboriginal programs and services. Jurisdictional relationships, funding controversies, and the specific role of Aboriginal women in decision-making, research, and policy development need to be addressed before matters will improve.

Canada's Aboriginal population is growing, with 976,305 people self-identifying in 2001. In British Columbia, that number increased from 139,655 in 1996 to 170,025 in 2001, with still more people claiming ancestral roots. Aboriginal women make up about 469,255 of the general Canadian population. Aboriginal women and men are increasingly likely to reside in urban areas and two-thirds of them live in Western Canada. Winnipeg, Edmonton, and Vancouver are the cities with the largest urban Aboriginal populations. Aboriginal children are more likely than other youngsters to live in households headed by single-parents, and Aboriginal women and children's health determinants are more likely to include violence, poverty, and lack of education and social opportunity. While studies regularly point out health disparities between Aboriginal and non-Aboriginal peoples, many Canadians seem determinedly oblivious. Since the Aboriginal

population in B.C., as elsewhere in Canada, is growing faster than the non-Aboriginal and is much more youthful, health insecurity is likely to remain a major concern for years to come.

Aboriginal women speak frequently about barriers to good healthcare, identifying most often racism, lack of culturally relevant programs and materials, medicalized approaches to healing and wellness, and, especially in remote and northern areas, geography. (Benoit, Carroll, & Chaudhry, 2003; Brown, Fiske, & Thomas, 2000; Dion Stout, Kipling, & Stout, 2001; FAWHAS, 2000; Marshall, Charles, Hare, & Ponzetti, 2004; Poole, 2000). One examination of Carrier women's encounters with mainstream health providers and services in a reserve community in B.C.'s northern interior found that women felt dismissed or trivialized, judged in stereotypical negative ways, and their personal circumstances ignored. Researchers recommended integrating attention to cultural safety into policy-making in Aboriginal health, tackling jurisdictional issues that impede implementation of alternate approaches to on-reserve health care, and providing for meaningful input by Aboriginal women into local health care delivery (Brown, Fiske, & Thomas).

Urban women largely echo their northern sisters' identification of health barriers. Seventy percent of Vancouver's total Aboriginal population, about half of whom are women, lives in the Downtown Eastside (DTES), one of Canada's poorest neighbourhoods (Joseph, 1999). Yet, if single-room occupancies and drug use are common, so too are pockets of community vitality. The emerging Urban Aboriginal Health Centers (UAHCs) supply one sign of resilience. Two centres, the Vancouver Native Health Society and its sister organization, Sheway, (a Coast Salish word meaning 'growth'), work in the DTES. Sheway provides pre- and post-natal medical care, counseling, and advocacy to women dealing with drug and alcohol addictions. It encourages women to make their own choices and favours 'low barrier' service delivery. Strategies include drop-in appointments, Infant Development consultations, accompanying clients to appointments with other agencies, and general social supports (Marshall, Charles, Grant, & Hare, 2003).

Researchers speaking to clients of these agencies discovered that Aboriginal women contacting conventional health services very generally reported a lack of security and anonymity in the walk-in clinics, the dominance of culturally-foreign approaches to counseling, and the absence of staff who understood Aboriginal women's historical backgrounds. In sharp contrast, they rated the UAHCs as non-judgmental and supportive. Since federal and provincial governments are moving to change the governance of health delivery, there is fear that the authority and flexibility of such Aboriginal community services may be compromised. And as researchers remind us, "if policy-makers are serious about affecting real change, Aboriginal women, one of the most marginalized groups of all inner city populations must not be overlooked. The challenge will be how to address the inequities and ghettoization that exists in the DTES and at the same time work with urban Aboriginal women to help them effectively reclaim control over their health and social services" (Benoit, Carroll, & Chaudry p. 831).

Drawing on the positive aspects of Vancouver Native Health Society and Sheway, whose clientel is 70% Aboriginal, Vancouver's Aboriginal women have proposed an urban Healing Place, (Benoit et al.2003). They report that "the Sheway model is more akin to traditional Aboriginal health structures; it includes a fluid and informal service delivery, a collective, non-hierarchical staff structure, and horizontal relationships between staff and clients, all of which reflect the holistic values and structures of the more communal, traditional Aboriginal societies" (Benoit et al. p. 829). In response, Sheway has increased its Aboriginal staff and is considering how to build upon current services and programs to better meet the cultural needs of clients. While the agency has been spared many government cutbacks suffered by other programs, it faces growing demand from women who are losing assistance from other hard-hit agencies.

For Aboriginal people, on-going jurisdictional and funding controversies have worsened gaps and inadequacies in healthcare. The tendency of state policies and approaches to medicalize and fragment health and healing practices contradicts Aboriginal worldviews and cultural frameworks and adds to difficulties of every sort. As Sheway has discovered, women often bear the brunt of B.C. and Canada's failure to develop culturally and materially relevant healthcare services. Aboriginal women's health issues must be understood in the social, political, economic, and historical contexts of their lives. Aboriginal women view their own health as integrally linked to that of their families and communities. They wish to participate in the delivery of health services and the setting of priorities for research, policies, and programs. Aboriginal health reform depends on their success.

References

Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine*, 56, 821-833.

British Columbia. Provincial Health Officer. (2002). *Report on the Health of British Columbians. Provincial Health Officer's Annual Report 200*1. *The Health and Well-being of Aboriginal People in British Columbia.* Victoria, B.C.: Ministry of Health Planning.

Browne, A.J., Fiske, J.-A., & Thomas, G. (2000). *First Nations women's encounters with mainstream health care services & systems*. Vancouver, B.C.: British Columbia Centre of Excellence for Women's Health.

Dion Stout, M., Kipling, G., & Stout, R. (2001). *Aboriginal women's health research and synthesis paper: Final report*. Ottawa, ON: Women's Health Bureau.

Joseph, R. (1999). *Healing ways-Aboriginal health and service review*. Vancouver, BC: Vancouver/Richmond Health Board.

Marshall, S., Charles, G., Hare, J., & Ponzetti, J. (2003). *Evaluation of Sheway's infant services: Report to Vancouver Coastal Health Authority and BC Ministry of Children and Family Development*. Vancouver, BC: School of Social Work and Family Studies, University of British Columbia.

Poole, N. (2000). *Evaluation report of the Sheway project for high-risk pregnant and parenting women*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

Report on the Action Forum on Aboriginal Women's Health and Addictions Services (FAWHAS). (2000). Unpublished report, Vancouver, BC. Retrieved December 14, 2004 from http://www.healthservices.gov.bc.ca/aboriginal/pdf/aboriginal-addiction.pdf

Statistics Canada (2003). *2001 Census. Aboriginal peoples of Canada: A demographic profile.* Ottawa, ON: Author.