



Native Women's  
Association of Canada



L'Association des  
femmes autochtones  
du Canada

A report on the current status of the  
realization of the right to health in Canada  
for Indigenous women, girls and gender-  
diverse people

Prepared for submission to:  
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Special Rapporteur on the Right to Health

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The right to health of Indigenous women, girls, and gender-diverse people in Canada cannot be understood without first understanding the context of the marginalization and oppression experienced by Indigenous Peoples as a result of colonial policies and practices implemented by European colonizers.

Prior to first contact between Indigenous Peoples and European settlers, Indigenous nations were healthy and self-determining and their understanding of health and wellness was rooted in culture and community. Indigenous women, girls, two-spirit and gender-diverse people had important roles in their communities and were valued equally. Indigenous women were highly respected, playing important social, economic and political roles in communities and maintaining societal balance and harmony. They were involved in communal decision-making, including integral decisions about family, land, health, education, and governance and they made vital contributions to the cultural and physical wellbeing of their communities. Additionally, many Indigenous societies were matrilineal, with inheritance and clan membership passed down through the mother (1, 2).

#### *Colonization and Assimilation Efforts*

As colonization occurred, the dispossession of Indigenous nations and communities was crucial to the colonizer's goal of taking Indigenous lands. Indigenous women's and girl's bodies were seen as bodies that reproduce nations, and thus were specifically targeted by colonial policies. Two-Spirit and gender-diverse bodies were also viewed as a threat to the goals of assimilation. The gender binary was introduced and enforced through residential schools, Christian missions, and the Indian Act (3). With the introduction of the gender binary, women and gender non-conforming people were viewed as inferior to men. Additionally, diseases such as small pox and tuberculosis were introduced both intentionally and unintentionally respectively, to Indigenous populations with devastating effects, as a consequence, traditional lifestyles prior to colonization were violently altered.

Between the 1870s and 1990s over 150,000 First Nations, Métis and Inuit children were forcibly removed from their communities by the federal government and brought to residential schools across Canada with the intention of assimilation (4). Children were primarily taught to be ashamed of their culture: they were forbidden to speak their traditional languages, express their cultural customs and beliefs, wear traditional clothing, or eat traditional foods. Teachers were often poorly trained and many perceived Indigenous Peoples as inferior. Isolated from families and communities, family ties eroded, and within the schools, siblings were separated. Physical, sexual, emotional and spiritual abuse was rampant as was neglect and forced starvation; children were often beaten and humiliated as a form of discipline (5). The long-term effects of childhood sexual and physical abuse has increased Indigenous women, girls and gender-diverse people's vulnerability to violence, trafficking, addictions and poorer health outcomes as adults (6). Assimilation efforts continued with the Sixties Scoop where thousands of First Nations, Inuit and Métis children were taken by child-welfare agents between the 1960s to the 1980s and placed with non-Indigenous families. This continues today, as Indigenous children are taken away from



their families and communities at alarming rates and too many are being placed into non-Indigenous homes, this phenomena is known as the “Millennial Scoop”.

### *Indigenous women's health in Canada today*

The ongoing effects of colonization and assimilation efforts can be seen in the health inequities experienced by Indigenous women today. Within Canada, over 1 673 785 people, or approximately 5% of the population, identified themselves as Indigenous in 2016, and of those, 860,265 were girls and women, comprising 5% of the total female population in Canada (7). In 2011, the median Indigenous Canadian female age was 29.1; this is 12.4 years younger than the median Canadian female age (8). Despite the population size, Indigenous women are often over-represented in negative health statistics. Indigenous women experience numerous health inequities, due to the ongoing effects of colonization and assimilation as well as the current effects of systematic racism. In 2017, the life expectancy of Metis, First Nations and Inuit women was 80, 78, and 73 respectively, for Inuit women in comparison to 83 for non-Indigenous women (9). Many social determinants of health such as poverty, unstable housing and food insecurity are experienced at much higher rates than in non-Indigenous populations. Access to safe and potable water has been an ongoing issue for decades amongst Indigenous communities, with almost 3000 homes currently under boil water advisories (10).

Intergeneration trauma is a social determinant of health unique to Indigenous People. The long-term mental health impacts of colonization, residential school trauma and intergenerational trauma have been well-documented (11). Indigenous Peoples experience depression at higher rates than other Canadians (12) and women in general are more likely to suffer from mental illnesses such as anxiety and depression (13). Higher levels of mental distress have been linked to suicidal thoughts and higher rates of substance use and abuse. The youth suicide crisis is an urgent issue for First Nations and Inuit youth in Canada. Suicide rates are five to seven times higher for First Nations youth than for non-Indigenous youth and suicide rates among Inuit youth are among the highest in the world, and 11 times the national average (14). Intergenerational trauma is linked to increased likelihood of being affected by addiction and substance abuse. Alcohol and drug use have been identified as the leading causes hampering community wellness among First Nations on-reserve (15). In addition, the opioid crisis is affecting First Nations at much higher rates. First Nations people in the province of British Columbia are five times more likely than non-Indigenous people to experience an overdose event (16). Furthermore, First Nations women are even more overburdened by overdose events compared to non-Indigenous women. They are eight times more likely to overdose than non-Indigenous women, and five times more likely to die from it (17).

The social and economic marginalization of Indigenous women has impacts on maternal and child health, including higher risk for adverse pregnancy and infant health outcomes (18, 19). This includes 1.7 to over 4 times higher rates of infant mortality (IMR) (20) and Sudden Infant Death Syndrome (21). Higher IMR within Indigenous populations has been attributed to maternal risk factors such as previous preterm birth, two or more previous spontaneous abortions, low weight gain during pregnancy due to nutritional limitations, smoking while



pregnant, inadequate prenatal care and high levels of perceived stress for Indigenous women (22), as well as complications associated with violence during pregnancy (23). Violence during pregnancy is related to higher rates of postpartum depression (24), substance use (25), and suicide (26) with younger women, women with low income and education, and women who lack social support to be at highest risk (27).

Indigenous women are also disproportionately burdened by chronic diseases and are often affected at younger ages, and with worsening severity and outcomes. In 2012, 65% of Aboriginal women over the age of 15 reported having at least one chronic health condition and were more likely to have been diagnosed with a chronic health condition than non-Indigenous women. The most common chronic conditions afflicting Indigenous women are arthritis, high blood pressure, and asthma (28).

Similarly, Indigenous women are over-represented by infectious disease cases. Data indicates sexually transmitted and blood borne infections are more prevalent among Indigenous populations than the general population, with chlamydia rates 7 times higher and HIV rates 3.5 times higher than among non-Indigenous populations (29). Indigenous women and girls are acquiring HIV at a significantly higher rate than other Canadian women and girls, with rates steadily increasing in First Nations and Inuit populations over time. Between 1998 and 2012, Indigenous women represented 47.4% of all the HIV positive test reports within the Indigenous population, compared to 20.1% of reports among non-Indigenous women within the non-Indigenous population (30). Furthermore, in 2014 Indigenous women were the second highest group of reported HIV cases amongst all female reported cases in Canada, at 30.6% (31). Tuberculosis is another infectious disease that affects Indigenous People at higher rates than non-Indigenous people. Specifically tuberculosis rates among Inuit are over 300 times the rate of Canadian-born non-Indigenous people (32).

### *Inequitable Access to Health Care*

Several barriers to accessing health care intensify health inequities between Indigenous and non-Indigenous people in Canada. Many Indigenous People live away from urban centers where the majority of specialized health services are located, and many local health centers serving Indigenous communities have limited resources and services. Some areas do not have consistent services, relying instead on visiting health care workers, who are often non-Indigenous and who might not be culturally safe in their practice, which can lead to mistrust from patients as well as stigma and discrimination from the practitioners (33). When health services are available nearby, women may not have access to a vehicle or alternate transportation, either may be unable to afford the cost of transportation and time away from work, or may be unable to pay for the services. Indigenous women in particular are affected by lack of sexual and reproductive care and services in their area of residence. Many pregnant Indigenous women are forced to fly to southern cities to give birth, removing them from their families, social supports, and traditions, and increasing stress during pregnancy (34). Furthermore, racism in health care facilities in large urban centers is common and often leads to women not wanting to access care (35).



In addition, First Nations people living on-reserve<sup>1</sup> and Inuit living throughout Inuit Nunangat<sup>2</sup> are subject to distinct jurisdictional obstacles, which delay or outright prevent access of health care services. The federal government funds health care services on-reserve and in Inuit communities, whereas for most other Canadians, health care is provided by the provincial/territorial governments. Other health care services including hospital care and long-term care are a provincial responsibility and must be accessed off-reserve. This leads to major gaps in care within and between Indigenous groups and between Indigenous and non-Indigenous Canadians. Despite the fact that the federal government is responsible for funding health care in First Nations and Inuit communities, there are often severe financial constraints, which often result in delays, substandard equipment, and out-of-pocket expenses to make up the difference in cost (36).

### *Health Legislation and Policies*

The legislation that dictates the delivery of health care itself is confusing and overly complicated, which is an important factor contributing to the health inequities we see in Indigenous communities today. Health care is delivered through a division of powers between federal and provincial or territorial governments, which is outlined in Canada's Constitution. In 1984, the *Canada Health Act* was introduced and it outlined the responsibilities of provinces and territories for delivering health services, while the federal government is responsible for providing money transfers. However, according to the *Indian Act* (1876), health support for 'Indians' (status First Nations and Inuit) are a responsibility of the federal government. This responsibility was recognized and affirmed in Section 35 of The *Constitution Act* of 1982. The lack of clarity and overlap between these legislations and the lack of clear policies for providing Indigenous health services has historically been used by both the federal government and the provinces and territories as an excuse to ignore their responsibilities toward Indigenous health. As previously stated, it has created bureaucratic delays that leave Indigenous People waiting for care or medications that are readily available to non-Indigenous Canadians.

In recent years, efforts have been made on a legislative level to lessen the health inequities between Indigenous and non-Indigenous people. Jordan's Principle was passed in Parliament in 2007 after Jordan River Anderson, a First Nations child with complex health needs from Norway House Cree Nation in Manitoba died in hospital at age five, his discharge home delayed by two years because the federal and provincial governments couldn't agree on who would pay for his home care. The principle dictates that the government of first contact must pay for the services and resolve disputes later. It also applies to other public services, including education, early childhood learning and child welfare. However, since Jordan's Principle was passed in 2007, the Canadian Human Rights Tribunal has ruled on three occasions that the federal government is

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<sup>1</sup> First Nations people who live on a reserve. A Reserve is a tract of land set aside under the Indian Act and treaty agreements for the exclusive use of an Indian band.

<sup>2</sup> Inuit Nunangat refers to the homeland of Inuit of Canada. It includes the communities located in the four Inuit regions: Nunatsiavut (Northern coastal Labrador), Nunavik (Northern Quebec), the territory of Nunavut and the Inuvialuit region of the Northwest Territories. These regions collectively encompass the area traditionally occupied by Inuit in Canada.



applying the principle too narrowly. Furthermore, there are many gaps in the principle that still need to be addressed. The principle only applies to status First Nations, but does not apply to Inuit, Metis, or non-status First Nations people. It also doesn't apply to First Nations people over the age of 18, which means that jurisdictional disputes can still affect proper care provision to many Indigenous People.

### *Violence and MMIWG*

The health issues faced by many Indigenous women are intrinsically linked with the excessive amount of violence they experience. According to the 2014 Statistics Canada General Social Survey on Victimization (37), Indigenous women had an overall rate of violent victimization that was double that of Indigenous men and close to triple that of non-Indigenous women. The Survey also reported Indigenous women were more likely to report experiencing both physical and sexual maltreatment as a child than Indigenous men (14% versus 5%). Indigenous People (9%) more likely than non-Indigenous people (4%) to have been a victim of spousal violence in the past five years. Specifically, Indigenous women were about three times as likely to report being a victim of spousal violence as non-Indigenous women. The survey found that the high victimization rates among Indigenous women, could not be fully explained by an increased presence of other risk factors among this population. Even when controlling for other risk factors, Indigenous identity itself remained a risk factor for violent victimization of women but not for men.

The Native Women's Association of Canada (NWAC) has worked for more than four decades to document the systematic violence impacting Indigenous women, girls, their families, and their communities. From 2005-2010, NWAC's Sisters in Spirit (SIS) initiative confirmed 582 cases of missing and/or murdered Indigenous women and girls over a span of twenty years and worked to raise awareness of this human rights issue. NWAC believed the violence against Indigenous women to be much more pervasive than publicly available data would indicate. This suspicion was confirmed in 2013 when the RCMP released a report revealing 1,181 cases of missing and/or murdered Indigenous women and girls. As a result, the Government of Canada launched the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) in December of 2015.

### *Conclusion and Recommendations*

While many of the health inequities between Indigenous and non-Indigenous Canadians are beginning to lessen, others are steadily increasing. Indigenous women will not be able to experience the enjoyment of the highest attainable standard of physical and mental health until these gaps are closed. Indigenous women, girls and gender-diverse people in Canada continue to experience disproportionate burdens of poor health in comparison to their non-Indigenous counterparts, including higher rates of chronic and infectious diseases, higher rates of infant mortality and higher rates of physical and sexual violence. Significant strides will not be made until Indigenous women's health and wellness is understood in the context of colonization and systemic gendered racism. NWAC continues to advocate for Indigenous women's human rights



including their right to the enjoyment of the highest attainable standard of physical and mental health. The World Health Organization advocates that the highest attainable standard of health is a fundamental right of every human being, and Canada has a long way to go to ensure Indigenous women, girls, and gender-diverse people are also included in being able to attain this right. In order to fulfill this fundamental right, NWAC calls on international governing bodies to ensure that the Canadian government enacts the following recommendations:

1. Improve jurisdictional coordination and provide equitable funding for health services

Greater coordination between the federal, provincial and territorial governments and equitable funding is needed to ensure that jurisdictional ambiguities do not continue to result in health inequities.

2. Restore communities' control over health services

The right for communities to control how health care services are designed, delivered and implemented must be restored. Indigenous communities must have self-determination over their right to health.

3. Fully implement the TRC calls to action, particularly those pertaining to health<sup>3</sup>

The TRC calls to action numbers 18-24 are specifically linked to health and must be enacted to ensure Indigenous women, girls and gender-diverse people are able to attain the highest standard of health and wellness.

4. Ensure Indigenous data sovereignty

Indigenous Peoples must be involved in the collection of Indigenous health data, govern data that are collected and held about them and they must have access and supports to use the data.

5. Develop Indigenous driven health indicators

The social determinants of health are not the same as determinants of health of Indigenous People, particularly of Indigenous women, girls and gender-diverse people. There are major gaps in health data for the Indigenous population and the data that does exist are not always the most accurate indicators of Indigenous People's health.

6. Implement a trauma-informed, culturally safe and gender-based approach

While there is growing recognition of the legacy of trauma from colonization within the Indigenous population, there is a continued need to advocate for trauma-informed approaches, which include cultural safety, and a gender-based approach to health interventions.

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<sup>3</sup> The Truth and Reconciliation Commission (TRC) was established in 2008 with the purpose of documenting the history and impacts of the Residential School system. In 2015, the TRC released an Executive Summary of its findings along with 94 "calls to action" regarding reconciliation between Canadians and Indigenous Peoples. The TRC made several health-related recommendations, acknowledging that historical trauma has led to mistrust of the health care system, which has in turn left Indigenous People less likely to seek timely care and less likely to trust or access prevention programming, diagnostic tools or treatment options.



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**7. Address the underlying causes of the health inequities**

The health of Indigenous women and girls is intimately linked to a variety of determinants of health including poverty, housing insecurity, mental health and addictions, adverse childhood experiences, racism and unresolved intergenerational trauma as a result of colonialism and the legacy of the residential school system. Until the social determinants of health are addressed, health outcomes will not improve.



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