



Native Women's Association of Canada

Social Determinants of Health and Canada's Aboriginal Women

NWAC's Submission to the World Health Organization's
Commission on the Social Determinants of Health

June 4, 2007

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1. Introduction and Purpose of this Paper

This paper has been prepared as a result of the Native Women's Association of Canada's belief that the specific views of Aboriginal women in Canada about the social determinants of our health, and their potential solutions, need to be heard by the World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH). Notwithstanding what will certainly be the valuable contributions of the Canadian Reference Group on the Social Determinants of Health which will incorporate the input of its Aboriginal Working Group, that will be made to the June 2007 meeting of the CSDH respecting social determinants of health generally for First Nations, Inuit, and Métis peoples in Canada, Aboriginal women know it is not the whole story. The CSDH also needs to know this.

The Native Women's Association of Canada (NWAC) asserts that the unique situation of Aboriginal women in Canada – our story, our lives – must necessarily be specifically told, and specifically addressed, by the CSDH. To *not* hear or to *not* specifically address our story, the CSDH would miss a pressing need and valuable opportunity, and risk further institutionalizing and perpetuating the current health inequities which Aboriginal women in Canada, and consequently their children and their families, experience. Instead, the NWAC hopes by preparation and submission of this paper to the CSDH, to foster comprehension of, and catalyze proactive, transformative change potential with respect to, Aboriginal women's present marginalization and inequitable health status in Canada.

The purpose of this paper is therefore to provide an overview of Aboriginal women's key understanding and experience of the main social determinants of health (SDH) affecting them. First, we provide basic background information about the Aboriginal women of Canada and the NWAC. Following, is a section which relates to the social determinants of health and the specific CSDH setting, with respect to Canadian processes and NWAC involvement in them, as well as philosophies and approaches to the SDH generally and with respect to policy making and effecting policy change. Thirdly, we take a look at Aboriginal women's health status and our human rights in this policy context. Fourthly, from the perspective of Aboriginal identity as a given SDH of enormous import, we identify and describe three other main social determinants of health for which we highly recommend the CSDH considers and embraces inclusion thereof in its interim statement and final report. Finally, we conclude by posing several further questions the CSDH.

¹ The NWAC acknowledges and is grateful for the support of the First Nations and Inuit Health Branch of Health Canada to permit the preparation of this paper. However, it must simultaneously be noted that our substantive inclusion and this support came at "the eleventh hour."

2. Background: Who are the Aboriginal Women in Canada and What is the NWAC?

Aboriginal women in Canada are those women who identify themselves as one of the three constitutionally recognized Aboriginal peoples of Canada: Indian (commonly now, and in this paper, referred to as First Nations), Inuit and Métis. According to census data from 2001, Aboriginal women in Canada number 499,605² with 65,920 of us being single parents.^{3 4}

The Native Women's Association of Canada (NWAC) is founded on the collective goal to enhance, promote, and foster the social, economic, cultural and political well-being of First Nations and Métis women within First Nation and Canadian societies.

NWAC is an aggregate of 13 provincially- and territorially-based native women's organizations, and was incorporated as a non-profit organization in 1974. Much like a "Grandmothers' Lodge," we as Aunties, Mothers, Sisters, Daughters, Granddaughters, and Relatives collectively recognize, respect, promote, defend and enhance our native ancestral laws, spiritual beliefs, language and traditions given to us by the Creator.

The NWAC has over 30 years of experience working on behalf of Aboriginal women in Canada and bringing important issues to the attention of law and policy makers. Over the years, we have advocated, as we continue to do today, inclusion and accommodation of Aboriginal women's, their children's and families' rights, interests, and needs in multiple Aboriginal-specific and Canadian federal and provincial government contexts.

3. Social Determinants of Health and CSDH Setting

3.1. Canadian Processes, NWAC Involvement

The NWAC came to the present CSDH discussion via insertion into domestic and international processes already well under way. Canada's Public Health Agency (PHAC) had established the Canadian Reference Group (CRG) "to inform Canada's contributions to the WHO CSDH by supporting Canadian Commissioners, Knowledge Networks and Country Partner network

² Statistics Canada, *Census 2001*, Data Table: Aboriginal Identity (8), Age Groups (11B), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census - 20% Sample Data - Cat. No. 97F0011XCB2001001, online: Aboriginal Peoples, <http://www12.statcan.ca/english/census01/products/standard/themes/index.cfm>.

³ Statistics Canada, *Census 2001*, Data Table: Family Income Groups (21), Sex (3) and Aboriginal Group of Lone Parent (11) for Lone-parent Census Families in Private Households, for Canada, Provinces and Territories, 2000 - 20% Sample Data - Cat. No. 97F0020XCB2001065, online: Aboriginal Peoples, <http://www12.statcan.ca/english/census01/products/standard/themes/index.cfm>.

⁴ Because most data and information presently available in Canada reference Aboriginal women in aggregate terms, unless otherwise stated, it commonly includes First Nations, Métis and Inuit women. While the NWAC does not represent Inuit women in Canada – the Pauktuutit Inuit Women's Association of Canada does – and we have no official capacity to speak for Inuit women in this paper, it is our understanding and belief that most, if not all, of the content in this paper which uses the terminology "Aboriginal" or "native" coupled with "women" is equally applicable to First Nations, Métis and Inuit women.

involvement.”⁵ The CRG action plan includes “working with Aboriginal stakeholders and international leaders in Indigenous health to better understand self determination and health.”⁶ The latter was pursued in an Aboriginal Dialogue convened in Vancouver in June 2006,⁷ which resulted in a number of thematic areas and recommendations to the CRG, including among others:

- The need for an Indigenous-specific knowledge network additional to the existing knowledge networks of the CSDH;
- Definition from a spectrum of Indigenous perspectives on, and inclusion of, self-determination as a cross-cutting and interdependent issue through all social determinants of health; and,
- Respect as well as further and broader opportunities for Aboriginal peoples to engage with the CRG and CSDH, including within the Canadian legal duty to consult and accommodate Aboriginal peoples.⁸

Canada had already identified by May 2006, four key areas of health disparities in Canada: income, Aboriginal status, geographic location, and gender.⁹ Additionally, initiatives and challenges of intersectoral action and interjurisdictional approaches had been identified. Notably, from the NWAC’s perspective, PHAC had also observed that at the federal level, “equity is more commonly an implicit than [an] explicit goal.”¹⁰

The NWAC only became a resourced participant in the CRG’s Aboriginal Working Group, and obtained modest resources from the First Nations and Inuit Health Branch (FNIHB) of Health Canada to support its participation and preparation of this paper during the few weeks prior to this written submission’s date of June 4, 2007.

The NWAC views our participation as in keeping not only with our own mission and mandate, but also highly compatible with the aims and objectives of the CSDH generally and the preliminary recommendations of the CSDH knowledge networks as well as discussion at the CSDH’s seventh meeting in January 2007. This includes the recommendation of the *Women and Gender Equality* network, that the CSDH “pay attention to the interaction of biological and social determinants of health” and that “structural determinants of gender inequality such as gender norms developed in childhood should be discussed...”¹¹ Also, notably, that “gender equality and women’s empowerment is likely to underlie many of the CSDH recommendations

⁵ Public Health Agency of Canada, *Canada’s Response to WHO Commission on Social Determinant of Health: Canadian Reference Group*, online: http://www.phac-aspc.gc.ca/sdh-dss/crg-grc_e.html.

⁶ *Ibid.*

⁷ The NWAC was not invited nor represented at this dialogue.

⁸ *Aboriginal Dialogue June 2006, Executive Summary* (unpublished; shared with NWAC by Health Canada).

⁹ Public Health Agency of Canada, *Addressing Health Disparities in Canada Through Intersectoral Action on the Social Determinants of Health*, Presentation to Global Partner Country Consultation Workshop, May 18/19, 2006 in Geneva, Switzerland, online: www.who.int/social-determinants/presentations/Canada.pdf.

¹⁰ *Ibid.*

¹¹ *Report of the Seventh Meeting of the Commission on Social Determinants of Health, January 17-19, 2007, WHO Geneva*, p. 2, online: http://www.who.int/social_determinants/resources/report.pdf.

of [social determinants of health], as it does the Millennium Development Goals, and should be a major theme of the report.”¹²

3.2. Philosophies and Approaches to the Social Determinants of Health

A significant volume of material exists documenting history, philosophies and approaches to social determinants of health (SDH), including the substantial composite contained in the CSDH’s own background document, *Action on the Social Determinants of Health: Learning from Previous Experiences*.¹³ While they may not have been labelled with this particular moniker until the 1990s, the interaction of social and economic factors on human health has long been recognized, studied and documented under various titles, for well over one hundred years. Indeed, these facts have been central in the development of population health approaches which seek to go beyond the 20th century’s focus on primary health care delivery to address the root causes of the cause of illness and disease, as well as life expectancy, and include health prevention and promotion.¹⁴

While Canadian federal, provincial and territorial ministers of health officially endorsed a population health approach in 1994,¹⁵ this has not meant adoption of a universal Canadian approach to research and policy implementation on SDH. Nonetheless, significant research and study on the social determinants of health has taken place in Canada and other countries, which “are concerned with the organization and distribution of economic and social resources.”¹⁶ In Canada, key social determinants of health have been identified by authorities in the field, to include “Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security.”¹⁷

Despite the considerable body of knowledge available on SDH, its categorization into various frameworks, analyses by various epidemiological, structural, mechanistic, disciplinary, political, power, ideological, public policy and other perspectives, in 2007 none of these has been translated into effective government policy and action.¹⁸ The vulnerable and marginalized in Canadian society, particularly Aboriginal women, are suffering for this lack of action, continuing to endure the poorest socioeconomic and health status of all Canadians.

¹² Furthermore, the NWAC agrees that “emphasis needs to be put on addressing the gap...” and that the upcoming CSDH interim statement scheduled for July 2007 should include “focus on redistribution, rights, and regulation to be more responsive to civil society,” provided gender equitable processes and outcomes for Indigenous women are integral components of this approach.

¹³ Secretariat of the Commission on Social Determinants of Health, *Action on the Social Determinants of Health: Learning from Previous Experiences* (World Health Organization: Geneva, 2005), online: http://www.who.int/social_determinants/resources/action_sd.pdf.

¹⁴ Dennis Raphael, *Social Determinants of Health: Present Status, Unanswered Questions, and Future Directions*, *International Journal of Health Services*, Vol. 36, No. 4, 2006, 651, at pp. 651-652.

¹⁵ Health Canada, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health: Executive Summary*, (Ottawa, 1996), online, <http://www.phac-aspc.gc.ca/ph-sp/phdd/docs/common/execsumm.html>.

¹⁶ *Supra*, note 14, at p. 653.

¹⁷ *Ibid.*

¹⁸ See Dennis Raphael’s article, *ibid.*, synthesizing and referencing numerous other sources, for a comprehensive overview of the various frameworks and perspectives on social determinants of health, including those noted here.

The NWAC takes the position that labelling a particular philosophy and approach to SDH as definitive is not what the CSDH needs to do; while such understandings and categorization are helpful in underpinning discussion and challenging presumptions of equitable health care and health status, CSDH must primarily investigate why progress has not generally been made in ameliorating this Aboriginal-women-specific subset of the Canadian population's health. In respect to the CSDH's interim statement and final report, the NWAC also takes the position that the CSDH must provide compelling links with domestic and international human rights instruments, using legal and moral bases as the foundation for Canadian policy makers to undertake meaningful consultation with Aboriginal women on SDH followed by implementation in a timely fashion, and insist that WHO and United Nations state members, including Canada, proceed with the important work of translating knowledge into effective policy and action.

4. Health Status and Human Rights of Aboriginal Women in Canada

Previous reference thus far in this paper regarding the health status of Aboriginal women in Canada requires being elaborated, as it forms a crucial basis for outlining priority social determinants of health which the NWAC has identified to date. It is as or more important for our present purposes to also look briefly at our human rights and policy inclusion.

4.1. Health Status of Aboriginal Women in Canada

The role of development in nations such as Canada has not meant the erasure of inequalities between citizens.¹⁹ Nowhere is this more clear, than in the poor health status of Aboriginal peoples relative to the general Canadian population. Within Aboriginal peoples, women are significantly worse off than men. The situation of Canadian Aboriginal women thus aptly illustrates the intersection of race and gender – a double disadvantage which presently contributes exponentially to negative life and work experiences, the continuation of multiple forms of systemic discrimination, and the size of the gap in health to be closed for Aboriginal women in Canada.

The poor health status of the Aboriginal women due to inequities in SDH in Canada is quite well documented. For example, in 2001 the Society of Obstetricians and Gynaecologists of Canada noted these include, “lower quality housing, poorer physical environment, lower educational levels, lower socioeconomic status, fewer employment opportunities and weaker community infrastructure.”²⁰ Aboriginal women are at higher risk for alcohol and substance abuse, mental illness, suicide, diabetes (including gestational diabetes), cervical cancer, as well as more

¹⁹ Remedying these disadvantages will impact and improve not only the health of Aboriginal women, but contribute to raising the health status of the whole population. Expert authorities report that “it is well known that disparities – the size of the gap or inequality in social and economic status between groups within a given population – greatly affect the health status of the whole. The larger the gap, the lower the health status of the overall population.” (Health Canada, *The Social Determinants of Health: An Overview of the Implications for Policy and the Role of the Health Sector*, based on papers and presentations at York University's 2002 conference entitled, “Social Determinants of Health Across the Life-Span”, online: http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/overview_implications/01_overview_e.pdf.)

²⁰ Society of Obstetricians and Gynecologists of Canada (SOGC), “SOGC Policy Statement: A Guide for Health Care Professionals Working With Aboriginal Peoples”, *Journal SOGC*, Vol. 2, April 2001, p. 3.

frequently experience deleterious circumstances such as poverty, alarmingly high rates of spousal, sexual and other violence, inability to access safe, secure, affordable, non-discriminatory housing for themselves and their families (on- and off-reserve, in rural, remote and urban settings), and barriers and lack of access to higher education, job training, employment, entrepreneurial loans and investments, and related socioeconomic opportunities.²¹

The collection of the data and information which informs these statements resides in numerous sources. Qualitative and quantitative research, employing various instruments and methodologies are used by Canadian governments, non-governmental organizations, academics and health professional associations, and are supplemented by an array of anecdotal evidence and case studies. Combined, this body of accumulated work provides irrefutable evidence about the unacceptably poor health status of Aboriginal women in Canada.²²

4.2. Aboriginal Women's Human Rights and Policy Inclusion

The conditions in which Canada's Aboriginal peoples, and in particular Canada's Aboriginal women, live, have frequently not garnered as much focused attention in domestic as they have in international forums over the last two to three decades. Given that the above-referenced present Aboriginal women's health status and life course conditions are frequently referenced as "third-world" immediately suggests the serious scope and magnitude of the challenges which need to be addressed and surmounted with effective, gender equitable, culturally appropriate policy and law interventions, as well as coordinated, gender equitable, culturally appropriate program support and implementation by Aboriginal and federal, provincial and territorial governments and agencies, that are inclusive of Aboriginal women, and undertaken with the input and participation of Aboriginal women in order to directly address, benefit and redress Aboriginal women's health status.

An example of the ongoing Canadian challenges to include and address gender-based issues in health matters resides in the present Canadian CSDH support processes noted earlier in this paper: the CRG identified gender and Aboriginal disparities as key SDH areas by at least May 2006, yet financial resources facilitating capacity for and substantive inclusion for the NWAC's participation in these important CSDH matters came late, a matter of nearly one year from the start of CRG engagement of other Aboriginal representative organizations and individual experts. As one of the five federally recognized representative Aboriginal organizations, our participation in this important work from the 'get-go' should have been a given; however, the manner in which we have been engaged and finally supported is significantly attributable to our

²¹ For a more complete overview of these health matters relative to Aboriginal women in Canada, we suggest that the CSDH review our issue discussion and position papers which the NWAC prepared for the 2003-2004 Canada-Aboriginal Peoples Roundtable Sectoral Sessions, in particular those on the subjects of health, economic opportunities, and housing; they are available online, at the Canada-Aboriginal Peoples Roundtable website: http://www.aboriginalroundtable.ca/sect/index_e.html.

²² Notable instruments employed by Statistics Canada which have been particularly illuminating of SDH and health-related issues affecting Aboriginal women include: Censuses, Aboriginal Peoples' Surveys, and the General Social Survey. The latter has two primary objectives, "a) to gather data on social trends in order to monitor changes in the living conditions and wellbeing of Canadians over time; and b) to provide immediate information on specific social policy issues of current or emerging interest." (Statistics Canada, Social and Aboriginal Statistics Division, *The General Social Survey: An Overview* (Ottawa, 2006)).

own, and certain dedicated FNIHB officials', sustained efforts toward our inclusion. Unfortunately this fits the larger pattern of endemic systemic discrimination and frequent failure to be included, which we experience across a number of domains and which perpetuates Aboriginal women's disadvantages in Canada.

A recent briefing note entitled "Gender and Indigenous Peoples' Human Rights" prepared in May 2007 by the United Nation's (UN) Division for Social Policy and Development, Secretariat of the Permanent Forum of Indigenous People²³ articulates a number of important understandings and principles related to gender issues, women's and Indigenous peoples' rights with which the NWAC agrees. Among these, is that Indigenous women have made strides in, and continue to pursue their rights as women, using a human rights framework. We believe it is important, however, and continue to foster awareness and wider understanding and acceptance, that the intersection of our human rights and our collective Aboriginal rights and responsibilities are not mutually exclusive:

Positing Indigenous rights and women's rights as inextricably linked, Indigenous women ... conceive of women's human rights and collective rights as two parts of a coherent whole, [while] conventional interpretations and applications of human rights often compartmentalize sets of rights, sometimes even setting them in opposition to one another. The ways in which Indigenous women claim and use human rights at times departs from the conventional human rights framework. Yet, that difference need not be a source of discord. Rather, it can provide a point of vibrant engagement, strengthening an intercultural, gendered understanding and application of human rights that both promotes the rights of Indigenous women and enhances the human rights framework itself.²⁴

It is within this understanding that the NWAC is able to champion both the necessity for our protection by and use of rights guaranteed us in the Canadian *Charter of Rights and Freedoms*, and application of the Canadian *Human Rights Act* to matters affecting us in the *Indian Act* and under Aboriginal self-government regimes, simultaneously with promoting our Aboriginal collective and community Aboriginal rights and traditions.

The NWAC therefore also agrees that incorporating Aboriginal women's perspectives in any policy initiative must include an:

intersectional approach [which] recognizes that people's experience of human rights is mediated by multiple identities, including race, class, ethnicity, religion, sexual orientation, gender, age, disability, citizenship, national identity, geopolitical context, and health.²⁵

²³ In collaboration with The Office of the Special Adviser on Gender Issues and the Advancement of Women and the Division for the Advancement of Women - Department of Economic and Social Affairs. The briefing note is available online at: http://www.un.org/womenwatch/osagi/briefing_notes/BN6%20-%20Gender%20and%20Indigenous%20Peoples%20Human%20Rights.pdf.

²⁴ *Ibid.*, p. 1.

²⁵ *Ibid.*, p. 3.

It is both logical and incumbent on us to address Aboriginal women's exclusion and marginalization in Canadian policy making contexts. The federal example is cited here, however, similar issues apply in many if not all of the provincial and territorial settings.

Governments, Aboriginal women have said, including their politicians and policy making officials, must "recognize that 'sameness' does not mean equality and that Aboriginal cultural and gender differences must be considered in all policies and programs devised for Aboriginal people."²⁶ While we make the leap of faith in this paper that explaining the concepts and principles of health equity and equality of health outcomes is not required as it is well understood by readers as a premise to our discourse here, we know from long experience that this presumption does not apply as a norm within the public service setting.

Although some progress has been made, few Aboriginal women are employed in government policy areas affecting them and substantive consultation with Aboriginal women's groups "to ensure greater transparency of federal programs and services and improved access by Aboriginal women"²⁷ is still deficient. Moreover, despite the theoretical implementation of gender-based analysis (GBA) in all federal government policies and programs since 1995, the widespread application of non-Aboriginal Canadians' values and approaches (devoid of a GBA) continues to be the norm.

A legacy of policies and programs predating the GBA policy perpetuates numerous inequalities between men and women. For Aboriginal women, a GBA requires that the gendered racism facing Aboriginal women be particularly carefully examined. Combined with the implementation of more recent policies and programs that, despite the GBA policy, have still not incorporated the requisite gender and cultural factors to ensure substantively equal outcomes for Aboriginal women, this means that First Nation, Métis and Inuit women in Canada continue to be at least doubly disadvantaged, as Aboriginal women. The reality is that gendered racism does affect Aboriginal women in relation to many areas of federal governance, and health is one of the most important.²⁸

The inclusion of Aboriginal women via the NWAC's representation in the cooperative federal, provincial-territorial and Aboriginal peoples' consultation process during 2004-2005 which resulted in an Aboriginal health blueprint (with the caveat of its being a work in progress) providing national directions and health policy and program strategy and content tailored under the rubric of each of the three constitutionally recognized Aboriginal peoples.²⁹ The process

²⁶ *Aboriginal Women's Justice Consultation Final Report*, September 26-29, 2001 (Ottawa: Native Women's Association of Canada, Métis National Council of Women, Inc. & Pauktuutit Inuit Women's Association, 2002), p. 28.

²⁷ *Ibid.*

²⁸ Though federal programs related to pregnancy, maternal and child health have been in existence for some time, health program delivery encompassing a broad spectrum of health concerns specific to Aboriginal women has been slow to emerge. Certain initiatives in substance abuse prevention and mental health, for example, are now including Aboriginal women or being devised specifically for Aboriginal women; however, much more remains to be done on these and other health matters, to incorporate the requisite intersectoral perspective and approach to make them really effective.

²⁹ *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*, available online at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-blueprint-plan-abor-auto/index_e.html.

represented a significant step forward in equality of opportunity regarding policy development, by allowing NWAC the opportunity to ensure that gender and specific priority health matters of primary concern to Aboriginal women, such as violence against them, retained focus and inclusion during engagement by all the parties for this cooperative work.

While encouraged by this example of participation in the Aboriginal health blueprint experience, and we remain hopeful that the process instilled in the other parties a recognition and acceptance for the sustained efforts required to follow through during implementation of related policy and programs contemplated in the blueprint by policy makers, such follow-through is far from certain. This is in part because of the blueprint's vulnerability to political whim by the federal government for aspects of the plan which have yet to be financed with 'booked' (committed budget) monies. For example, beyond existing budget commitments already in place when this document was unanimously accepted by first ministers and Aboriginal leaders at their meeting on Aboriginal Issues in Kelowna, B.C. in November 2005, further work and implementation of the blueprint has stalled, calling into question if in fact real progress in Aboriginal women's equitable health outcomes will eventually, retrospectively, in fact be an appropriate association with and conclusion to draw from the Aboriginal blueprint process and document.

5. Highlighting Social Determinants of Aboriginal Women's Health

The population health approach which is predominant today in Canada and internationally, recognizes that primary health care is a limited actor in human health outcomes. The population health approach is thus compatible with native ancestral laws and spiritual beliefs, in which interconnectedness and holism as keys to healing and health are central tenets. For Aboriginal women in particular, addressing health status and remedying illness and disease means proceeding via a holistic approach: one which incorporates physical, mental, emotional and spiritual factors with her personal situation, nature and the environment, as well as her family, community and other relationships and societal settings and interactions. However, the lived experiences of Aboriginal women in the 21st century often impose disconnection on Aboriginal women, isolation and marginalization in and from their own communities, and in the broader micro- and macrocosms of Canadian communities and society, due to a number of factors the population health approach now commonly labels the social determinants of health.

While the scope and length of this paper are necessarily to provide a summary of some of the issues and experience of Aboriginal women in SDH, rather than provide all-encompassing explicit detail, this treatment should not be construed to detract from the importance of the factors and determinants noted here, and the fact of and their interaction with, other important SDH which are not reviewed here. The main SDH about which the NWAC has a comprehensive knowledge base, works towards amelioration for, and that our membership experiences in frequency many times other Canadian women's averages, are outlined. These arise as a fact of being, or in conjunction with, being an Aboriginal woman, among other reasons. In addition to the SDH subtitles below, we presuppose that the CSDH already understands and its comprehension of the fact of being Aboriginal is in itself a SDH. We trust from previous meeting and background materials by the CSDH there is no need to repeat the detail of this particular

SDH, for which a substantial academic and other authority literature already exists, and which we understand will be addressed in the CRG and its Aboriginal working group submission(s).

5.1. Gender

Being male or female is determined by physiological/biological difference. Gender is a more complex and less precise category, as it implies and includes “the economic, social and cultural attributes and opportunities associated with being male or female in a particular social setting at a particular point in time.”³⁰ For Aboriginal women, like other women and men, gender roles are taught and learned in society from a very young age. Additionally, in many cases, “gender-based inequality is systematically legitimized and institutionalized through laws and policies. This makes the task of challenging and breaking out of gender roles extremely difficult.”³¹

Aboriginal women in Canada know a great deal about this. Not the least of this is a result of the sustained legacy of colonization and the interference in Aboriginal society and governance by non-Aboriginal settlers and their successive governments, taking paternalistic control over and/or promoting assimilation of First Nations, Métis and Inuit peoples in their own territories over more than two hundred years. Though specific tasks and activities in the social fabric of their communities may have been primarily assigned to men or women, historically, pre-contact gender roles in Aboriginal nations and communities were based on equality. Equity was thus not in issue; it was a natural, fundamental principle and lived reality in terms of social processes and outcomes. Indeed, in many Aboriginal peoples’ traditions, women held highly respected and valued roles relating to governance and decision-making issues, which in the Euro-Canadian tradition had long been vested solely, and presently continue to vest mostly, in men.

Both the Crown in right of Canada via federal and provincial governments and Aboriginal men must now take responsibility for the change in ways which was forced on Aboriginal peoples, particularly First Nations who fell under the jurisdiction and control of the *Indian Act* since contact, and disproportionately put power and control into the hands of men.³² Significant accompanying factors are well documented in this, such as the effects on Aboriginal society, and especially Aboriginal women, by relegation to reserve lands, the imposition of an elected band council structure, disqualification of women from holding council positions, forced removal of children from their families and communities to attend residential schools, and until 1985, women’s loss of Indian status if she married a non-Indian, to name but a few. The point here, is that gender became an issue for Aboriginal peoples where it had not previously been, and many dysfunctional through outright abusive to catastrophic results have ensued. Though many of these circumstances have begun to evolve once again into the realm of the positive and

³⁰ Jane Cottingham, Sharon Fonn, Claudia Garcia-Moreno et al., *Transforming Health Systems: Gender and Rights in Reproductive Health. A Training Curriculum for Health Programme Managers*, edited by TK Sundari Ravindran, (Geneva: World Health Organization, 2001) WHO/RHR/01.29, p. 43.

³¹ *Ibid.*, p. 48.

³² The consequent the lowering of respect for and failure over time to substantively include Aboriginal women in community, governance and other important matters concerning them are well documented in numerous sources, including our own publications. Strategies and examples of rebalancing efforts by and in Aboriginal communities also exist. See for example, the comprehensive reports of the Royal Commission on Aboriginal Peoples, available online at: http://www.ainc-inac.gc.ca/ch/rcap/sg/cg_e.html.

significant healing, particularly in the last two decades as women have more overtly asserted their equality and human rights and some Aboriginal men and leaders have stepped up to the challenge, today the negative effects and prevalence of that legacy are still inequitably experienced and result in the highly compromised status of Aboriginal women's health in Canada.

Gender intersects with numerous other SDH factors, such as income, employment and occupational hierarchy, housing and living circumstances, personal safety and security, age and life cycle stage, including maternity and parental responsibilities, to produce and exacerbate poor health status results.³³ Furthermore, what are labelled "risk behaviours" by some authorities are, as other authorities cite and the NWAC also agrees, in fact directly related to the original experience itself of compromised social determinants of health.³⁴ In either case, the role of gender in arriving at risk behaviours, adds a dimension to the SDH context which should factor into the CSDH's present work.

5.2. Violence Against Aboriginal Women (VAAW)

One of the most crucial social determinants of health which intersects with gender to such a magnitude, that it commands its own treatment, is violence against Aboriginal women. No other issue has had – and continues to have – such an impact in such significant ways as this experience affecting so many Aboriginal women, their children and families in Canada has. As already noted earlier in this paper, Canadian Aboriginal women experience alarmingly high rates of spousal, sexual and other violence. This reality is distressing enough in and of itself; however, the consequent effects on our individual and collective health status, and even mortality rates, at times can become almost completely overwhelming.

In Canada, in 2004, Statistics Canada's General Social Survey (GSS) returned reporting rates of spousal assault against Aboriginal women in the previous five years by a current or ex-spouse, consistent with 1999 GSS findings, at more than three times higher (at 24%) than that of spousal assault reported by non-Aboriginal women.³⁵ Given that the GSS methodology has not taken account of cultural differences which Statistics Canada notes specifically that likely mean this incidence level is under-reported (e.g., barriers to GSS participation include lack of a telephone, non-fluency in English or French),³⁶ this is an even more troubling statistic, which needs more urgent attention to reversal than ever. Furthermore, the GSS results reported in Statistics Canada's document *Measuring Violence Against Women, Statistical Trends 2006*, indicates that:

³³ For more information on the specifics and intersection of gender and SDH in Canada, the work and writings of two Canadian university academics are thought-provoking and instructive. See Patricia Kaufert, "Gender as a Determinant of Health – A Canadian Perspective", undated article (no page numbers), available online at: http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/gender_e.pdf and Vivienne Walters, "The Social Context of Women's Health" in Farah Ahmad, Lori Anderson, Donna Ansara et al., *Women's Health Surveillance Report, A Multi-Dimensional Look at the Health of Canadian Women*, eds. Marie DesMeules, Donna Stewart et al. (Ottawa: Canadian Institute for Health Information, 2003).

³⁴ *Supra*, note 14, p. 654.

³⁵ Statistics Canada, "The Daily: Thursday, July 14, 2005: Family violence in Canada: A statistical profile", available online at: <http://www.statcan.ca/Daily/English/050714/d050714a.htm>.

³⁶ Statistics Canada, *Measuring Violence Against Women Statistical Trends 2006* (Ottawa, 2006), p. 64, Cat. No. 85-570-XIE, available online at: <http://www.statcan.ca/english/research/85-570-XIE/85-570-XIE2006001.pdf>.

Not only did Aboriginal women report higher rates of spousal violence in 2004, they were also significantly more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence, including being beaten or choked, having had a gun or knife used against them, or being sexually assaulted (54% of Aboriginal women compared with 37% of non-Aboriginal women). These percentages for Aboriginal women remained unchanged since 1999; however, for non-Aboriginal women, the percentage that experienced the most serious forms of violence declined from 43% in 1999 to 37% in 2004.

As a result of the more serious types of violence suffered by Aboriginal women, the consequences of spousal violence are also more severe. Aboriginal women were more likely than their non-Aboriginal counterparts to have suffered physical injury, received medical attention, taken time off daily activities as a consequence of the assaults, experienced 10 or more separate episodes of violence from the same perpetrator, and were more likely to fear their lives were in danger.³⁷ [Accompanying figure references omitted.]

For years, the NWAC has been speaking out about the prevalent incidence of VAAW, in and around their own homes and communities on and off reserves, and particularly in large urban areas, including disappearance and death of literally hundreds of Canadian Aboriginal women. The NWAC's own research and evidence collected over the course of our organization's history, plus that of Amnesty International in its seminal 2004 report *Stolen Sisters, A Human Rights Response to Discrimination And Violence Against Indigenous Women In Canada*³⁸ reinforce the quantified findings of the GSS, Aboriginal Peoples Survey and Censuses.

Progress with respect to remedying both the causes and effects of violence against all women globally is so slow, and the issue so serious, that it warranted appointment by the UN of a Special Rapporteur on Violence against Women. At the most recent meeting of the UN Permanent Forum on Indigenous Issues in May 2007, Special Rapporteur Yakin Erturk said that:

...progress lagged in the recognition of gender-specific discrimination encountered by indigenous women within and outside their communities, stressing that indigenous women faced at least five layers of discrimination on the basis of sex, ethnicity, poverty, often being rural and increasingly being migrant. As a result, they faced a dual task of defending their rights as members of an excluded group within a dominant society and resisting the static patriarchal perceptions of culture and tradition within their own communities.

In addressing the status of indigenous women, she continued, it was essential to identify the racial elements of gender discrimination, and the gendered elements of

³⁷ *Ibid.*, p. 65.

³⁸ Amnesty International, *Stolen Sisters, A Human Rights Response to Discrimination And Violence Against Indigenous Women In Canada* (London: Amnesty International's International Secretariat, 2004) AMR 20/003/2004, available online at: <http://www.amnesty.ca/campaigns/resources/amr2000304.pdf>.

racial discrimination, as violence against indigenous women was rooted in the traditional patriarchal gender hierarchies.³⁹

Since VAAW intersects with so many other factors and issues – Aboriginal-specific and non-Aboriginal – and so deeply affects the social determinants of Aboriginal women’s health and health outcomes and status, including premature mortality, that the NWAC takes the position that it is imperative for the CSDH to address VAAW in their upcoming interim statement and final report.

5.3. Income

The ability to provide basic needs – shelter, food and clothing – for herself and her family, particularly if she is the sole support parent of children, is a fundamental concern for a majority of Aboriginal women in Canada. Poverty is in fact the reality which attaches to most Aboriginal women, as their average income in 2000 amounted to just \$16,519; their median income was \$12,311.⁴⁰ These figures are the lowest of all Canadians’ income; Aboriginal men’s average income was \$21,958,⁴¹ and that of Canadian women and men was respectively \$22,885 and \$36,865.⁴²

The NWAC sees the intersection of a number of factors and SDH associated specifically with income and health. These include VAAW, education levels and job training, affordability and availability of quality child care and safe, secure housing, secure employment, as well as entrepreneurship and economic advancement supports such as business start-up loans.

Because we know that these factors and their relationships in, to and depending on income are fairly well understood and documented generally, we rely at this point on the information already provided in this paper to this point, the CSDH’s knowledge and ability to relate Aboriginal identity with such issues to situate the issues we have highlighted here, to allow Commissioners to draw relevant conclusions with respect to income and Aboriginal women, and the policy decision making and implementation required to redress Aboriginal women’s great income disadvantage.

³⁹ UN Department of Public Information News and Media Division, “Indigenous Face Poverty – Even Extinction – at Hands of Indifferent Governments, Profit-Hungry Corporations, United Nations Forum Told”, May 18, 2007, available online at: <http://www.un.org/News/Press/docs/2007/hr4921.doc.htm>.

⁴⁰ Statistics Canada, *Census 2001*, Data Table: Selected Income Characteristics (35A), Aboriginal Identity (8), Age Groups (6), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census - 20% Sample Data, Cat. No. 97F0011XCB2001046, online: Aboriginal Peoples of Canada, <http://www12.statcan.ca/english/census01/products/standard/themes/index.cfm>.

⁴¹ *Ibid.*

⁴² Statistics Canada, *Census 2001*, Data Table: Total Income Groups (22) in Constant (2000) Dollars, Sex (3), Age Groups (9A) and Marital Status (6) for Population 15 Years and Over, for Canada, Provinces and Territories, 1995 and 2000 - 20% Sample Data, Cat. No. 97F0020XCB2001040, online: Income of Individuals, Families and Households, <http://www12.statcan.ca/english/census01/products/standard/themes/index.cfm>.

6. Conclusion and Supplementary Questions for the CSDH to Consider

The NWAC believes that we, as duly mandated representatives of the Aboriginal women of Canada, have the capacity, the knowledge, and requisite abilities, when respectfully and appropriately consulted and supported as other segments of the population already are, to meaningfully participate in policy and program development and decision-making, and jointly foster innovation and change with Aboriginal, federal, and provincial/territorial government partners in Canada, as well as with international policy partners. Not only do we assert that we possess these valuable attributes, we take the position that it is within our human rights and incumbent on governmental actors of all types domestically and internationally to ensure our inclusion in such processes, and the substantive pursuit of equality of outcomes for Canada's Aboriginal women.

Accordingly, we end this submission with a few key questions for the CSDH to supplement the thoughts, assertions and questions already raised in this paper for your consideration:

- How will the CSDH deal with and represent gender in its deliberations, findings, and conclusions?
- More specifically, what will the CSDH do to ensure that Indigenous-specific concerns, including those of Canadian Aboriginal women, are treated in its deliberations and conclusions such that governmental actors will have no choice but to recognize the fact, and no longer require persuasion, that our equitable inclusion in policy processes and decision making specifically concerning and generally affecting Aboriginal women is required?
- Will the CSDH, as an exercise of its responsibility in world health matters and as both learned and effective policy advisors and in the pursuit of equitable outcomes for all the world's peoples, include a gender-based analysis in the findings, advice and recommendations of its final report?

We Aboriginal women of Canada have a collective history and intimate ongoing knowledge of our health determinants and needs, and the relationship of these with those of Aboriginal men – our fathers and grandfathers, sons, brothers, uncles and husbands – and our children, as well as our communities. We depend on the CSDH to receive the data and information we have submitted here, and ensure that it in turn, contributes to furthering the health, healing and overall well-being of Aboriginal women in Canada. We also remain ready to answer and respond to the best of our ability, with further participation and input that the CSDH may see fit to request of and/or involve us in during the remainder of its mandate.

Appendix A: Additional Information about the NWAC

Mission Statement

To help empower women by being involved in developing and changing legislation which affects them, and by involving them in the development and delivery of programs promoting equal opportunity for Aboriginal women.

Objectives

- to be the national voice for Native women;
- to address issues in a manner which reflects the changing needs of Native women in Canada;
- to assist and promote common goals towards self-determination and self-sufficiency for Native peoples in our role as mothers and leaders;
- to promote equal opportunities for Native women in programs and activities;
- to serve as a resource among our constituency and Native communities;
- to cultivate and teach the characteristics that are unique aspects of our cultural and historical traditions;
- to assist Native women's organizations, as well as community initiatives in the development of their local projects;
- to advance issues and concerns of Native women; and to link with other Native organizations with common goals.

Vision

We have a vision of Aboriginal communities where all individuals have an opportunity to develop their talents in order to achieve their full potential. We see communities where all people can lead healthy lifestyles by maintaining balance in their spiritual, emotional, mental and physical health.

We see Aboriginal communities where our children grow up with a strong identification of and pride in who they are and constantly seek to broaden their knowledge of the things that affect them and their relationship with the environment and the land. We see communities where all our people have an opportunity to learn our history and traditional ways while attaining a high level of academic education with the broader society.

In order to accomplish this we see strong Aboriginal families where the responsibility of education begins in the home and families nurture their children to be proud of who they are, and to be comfortable in a predominantly non-Aboriginal environment. We see a community where all Aboriginal people accept and exercise their responsibilities to contribute to a strong community.

We also envision an Aboriginal community which understands and respects the diversity and uniqueness of all Aboriginal Nations—a community which communicates with each other and

works in unity with all Aboriginal organizations to ensure a strong voice in maintaining and enhancing the exercise of our Aboriginal and treaty rights. This is a community which assumes responsibility in selecting leaders who will be role models for our youth and the following generations.

Finally we see an Aboriginal community which determines how our natural resources are utilized and can co-exist in co-operation with society—free of racism and discrimination.

Beliefs and Principles

We believe that every individual has a talent and has the responsibility and opportunity to develop that talent. The education, knowledge and confidence to develop and exercise that talent begins in the home. The family has a responsibility to nurture their children in a way which helps their child to develop his or her talents.

To achieve her/his full potential an individual must achieve a balance between understanding traditional ways and values and mastering academic disciplines. This will help the child to function equally well within the Aboriginal and the predominantly non-Aboriginal community. In order to be of help to our communities, we must strive for Aboriginal unity. To do this we have to recognize our diversities while we focus on our commonalities. Since we are part of the environment we must have respect for that environment and consistently use a holistic approach in all our endeavours.

We require a stronger and more consistent voice if we are to implement change and work towards the common goal of the advancement of Aboriginal peoples. We must work at entrenching and protecting the rights of Aboriginal women and families.

We recognize that the gains and advancements accomplished by Aboriginal women benefit everyone.