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# Silencing of Voice: An Act of Structural Violence

## Urban Aboriginal Women Speak Out About Their Experiences with Health Care

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### ABSTRACT

This article reports some of the preliminary findings of an ongoing participatory research study exploring the provision of health and social services for urban Aboriginal communities in the Okanagan Valley. In particular, the article examines how colonial structures and systems have worked to silence Aboriginal women's voices and how this has affected the ways in which urban Aboriginal women seek out health services. The article addresses these issues through the voices of the Aboriginal women in the study. The women's stories reveal the many assumptions and inequities that contribute to their marginalization. They describe how their voices are often silenced when they access health services and how this can cause them to either delay seeking needed health advice or accept the status quo. The women's stories are used to stress the importance and power of voice. This is most evident in their experiences accessing the health services offered through community-based Friendship Centres, where many felt they had more control over the care they received. In the context of this article, the impacts of colonization and the silencing of women's voices are viewed as acts of structural violence. The women's stories provide crucial insights into how health care provision can be changed to help prevent these acts of violence, thus leading the way to improved health for all urban Aboriginal populations.

### KEYWORDS

Urban Aboriginal women, health care, silencing, racism, colonization, marginalization, discrimination, structural violence, participatory research, Okanagan Valley



## INTRODUCTION

In the past several years, there has been an increased interest in researching and promoting the health and well-being of Canadians and, in particular, Aboriginal people. The emphasis has been on reducing inequities in the socio-economic conditions that determine the health of individuals and communities (Health Canada, 2007; Health Council of Canada, 2007; Royal Commission on Aboriginal Peoples, 1996). Determinants of health—such as early life experiences, personal health practices, coping skills, gender, cultural heritage, and Aboriginal status—are influenced by the “quality and quantity of a variety of resources that a society makes available to its members” (Raphael, 2004, p. 1). These resources can range from housing, education and employment opportunities, to the accessibility and quality of health care services. When economic and social challenges exist—such as poverty, unemployment, low education levels, discrimination, and racism—poor health is more common (Benoit & Nuernberger, 2006; Brunen, 2000; Cass, 2004; Flaskerud & Winslow, 1998; Glouberman & Millar, 2003; Smye, Rameka & Willis, 2006).

Major discrepancies in health status, morbidity and mortality rates, and access to health services exist between Aboriginal and non-Aboriginal Canadians (Dion Stout & Downey, 2006; Wardman, Clement & Quantz, 2005). In 2000, for example, infant mortality rates were 16 per cent higher among the First Nations population, while life expectancy at birth—68.9 years for First Nations males and 76.6 years for First Nations females—was 7.4 years less for men and 5.2 years less for women as compared to the Canadian average (Health Canada, 2000). More recent statistics show that chronic diseases, such as heart disease, among Canadian First Nations and Inuit populations are 1.5 times higher than the national average, while the prevalence of type 2 diabetes is three to five times higher (Health Canada, 2006). Aboriginal women in particular have substantially higher rates of mortality, injury, suicide, obesity, and chronic disease relative to other Canadian women (Dion Stout, Kipling & Stout, 2001). These differences are in part due to the social and economic inequities faced by many Aboriginal people—poor and crowded housing, poverty, and the legacy of colonialism (Canadian Institute for Health Information, 2004).

Inequities also exist within the Aboriginal population: off-reserve Aboriginal people have lower socio-economic status and higher rates of smoking, diabetes, arthritis, and obesity, as compared to those who live on a reserve (Statistics Canada, 2006; Tjepkema, 2002; Young, 2003).

Off-reserve communities are among the largest and fastest growing Aboriginal communities in Canada—with over 70 per cent of Aboriginal people living in urban areas (Statistics Canada, 2006)—yet much of the research and health promotion initiatives are aimed at improving the health of Aboriginal Canadians living on a reserve (Royal Commission on Aboriginal Peoples, 1996; Tjepkema, 2002; Young, 2003). Evans, Sookraj, Berg & the Okanagan Urban Aboriginal Health Research Collective (2006) contend that “the provision of services for urban Aboriginal people is impeded by the continuing rural/reservation orientation of many Euro-Canadian and Aboriginal policy makers” (p. 2). Several health programs and initiatives therefore fail to deal with the root causes and structural issues that contribute to socio-economic gaps among the Aboriginal population (Health Canada, 2007). This may be due to the fact that the health challenges faced by Aboriginal people are not commonly known or understood by non-Aboriginal people, especially those relating to urban Aboriginal populations (Dion Stout & Downey, 2006; Wardman, Clement & Quantz, 2005).

In response to these inequities, several health initiatives have been implemented to try and improve the health of Aboriginal people in Canada (National Aboriginal Health Organization, 2002; Romanow, 2002; Royal Commission on Aboriginal Peoples, 1996). Recently, for example, the federal, provincial and territorial governments developed a national agreement to reduce barriers to health and social service provision and to address the determinants of health that are negatively impacting Aboriginal communities (Patterson, 2006). At a more local level, the Interior Health authority of British Columbia has developed a regional plan for the provision of culturally appropriate and holistic services for Aboriginal people (Interior Health, 2006).

Despite the fact that these and other similar initiatives have been developed and implemented over the last several years, major social and economic inequities remain for Aboriginal people in Canada. To what extent can the lower health status of Aboriginal people be attributed to cultural insensitivities and racism that exist within the current health care system? What are the challenges for urban Aboriginal people with regard to mainstream health programs and services, and how can they be addressed?

This article answers some of these questions by drawing on the stories of 13 urban Aboriginal women. Their stories are part of the initial findings of an ongoing participatory research study aimed at uncovering the barriers that urban

















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## END NOTES

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2. The term “Aboriginal” is used to refer to First Nations, Métis and Inuit in Canada (RCAP, 1996), whereas the term “Indigenous” refers to Aboriginal Peoples globally. These terms are used in references according to the language used by the author cited.

