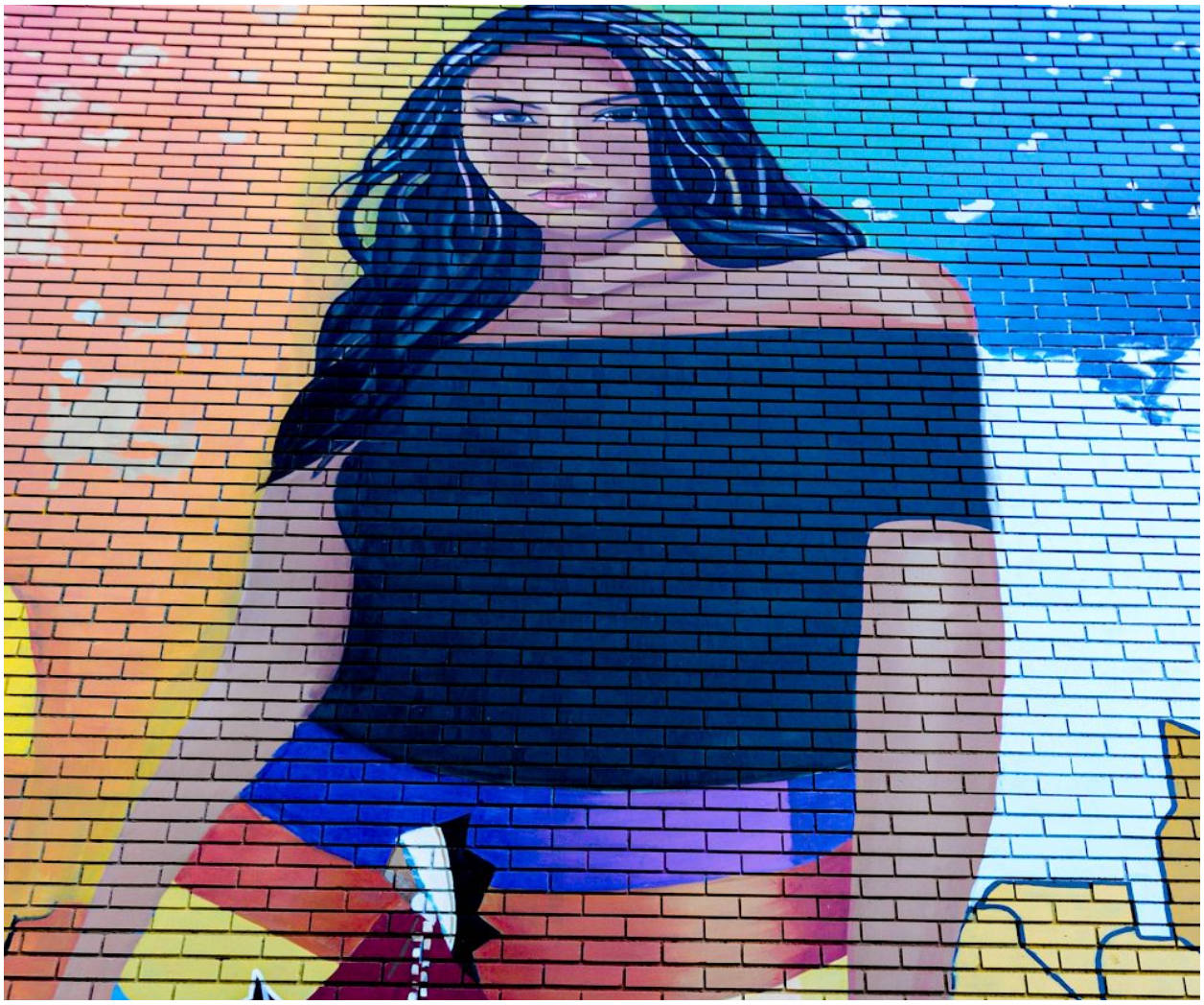

Keywords: Colonialism, Canada, Healthcare, Indigenous Women

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The Fatality of Bias

The Legacy of Colonialism on Indigenous Women and the Canadian Healthcare System

By Edith Denny

Systemic racism is a major problem within Canadian healthcare, which has been spotlighted by the livestreaming of an indigenous woman's mistreatment by hospital staff. This system was built from colonialist foundations in which the dispossession of indigenous rights and property, and the elimination and assimilation of indigenous cultures was an active part of State policy. The effect of this policy can still be felt to this day. Combined with the increased vulnerability of indigenous women to violence and mistreatment, policy makers must take action to disassemble the belief systems which continue to fuel biases against indigenous women in Canadian healthcare.

Quebec , 28 September 2020 - Joyce Echaquan, an indigenous woman admitted to hospital for stomach pains, live-streamed the abusive mistreatment she suffered at the hands of hospital staff on Facebook. Echaquan died just hours after the video was uploaded. The incident has been met with outcry across Canada, following similar cases of racial bias, mistreatment, abuse and misdiagnosis resulting in the numerous avoidable deaths of indigenous persons over the last twenty years. Systemic discrimination against indigenous women is evident throughout the Canadian health care system which this case only highlights.

COLONIALISM'S LEGACY

Healthcare was a popular policy tool of colonisers as a means of controlling and containing indigenous populations. The initial implementation of the Canadian health care infrastructure segregated indigenous communities into "Indian hospitals'' in the early 20th century. Policy was shaped on the fundamental belief that indigenous services were of less importance than non-indigenous, and therefore spending on Indian hospitals was purposefully kept to a minimum. Insufficient funding meant that most hospitals lacked the most basic features of modern hospital facilities - wards were understaffed and overcrowded, and staff were often insufficiently trained or unlicensed.

Government policy also encouraged the extended internment of patients. The "Indian Act" gave authorities the right to forcibly hospitalise, and treat, any indigenous person *suspected* of having an infectious disease. This allowed authorities to arbitrarily detain and hospitalise any indigenous person without their consent making the use of physical restraint commonplace. In addition, many Indian hospitals conducted experimental treatments on patients as new medical procedures were often trialled in these hospitals before their introduction into mainstream medicine thus creating a serious violation of human rights.

During this period, indigenous women were targeted by gender-specific measures aimed at their disenfranchisement in both their own and settler communities. The measures imposed by the Indian Act resulted in the direct removal of indigenous women's rights and the assimilation of indigenous culture and perceptions which increased indigenous women's vulnerability to abuse and mistreatment. For example, the Act tied indigenous women's "Indian Status" to her husband. This meant women lost their rights to land and marital property, were removed from leadership positions within their communities, and lost recourse for justice through the law. In Indian hospitals, indigenous women were subjected to coerced sterilisation and were forcibly removed from their new-born and young children to be adopted into non-indigenous families.

Indigenous women were also targeted and made vulnerable to violence and mistreatment through unjust stereotyping and harmful belief systems. Cultural assimilation enforced traditional Christian principles which reduced women to secondary citizens to men, and imposed homophobic and transphobic belief systems upon them. This devaluation left women, non-binary and two-spirit indigenous persons vulnerable to abuse and violence. Policing policies were also set in place by casting indigenous populations as "a menace", with false narratives stereotyping indigenous women as prostitutes, which within the context of Christian belief systems was dehumanising and a method of social devaluation and removal of status against women. This built the foundations for police misconduct and violence against indigenous women to go relatively unpunished, effectively laying the foundation of state abandonment of protection of indigenous women and girls.

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DISPARITIES IN HEALTHCARE PROVISION TO INDIGENOUS WOMEN TODAY

Colonialist policies have shaped Canada's current healthcare system as one which marginalises indigenous populations by design. Historically, medical practitioners were actively encouraged

to diagnose and treat indigenous people with disregard for cultural sensitivities or respect of personhood. In modern systems, the misconceptions of indigenous women and erasure of identity continues to fuel medical practitioner bias, leaving them vulnerable to racist practices. This is not purely historical as the lasting legacy of colonialism is still visible today.

Last year, a 700 page report issued by the National Inquiry into 'Missing and Murdered Indigenous Women and Girls' concluded that the culmination of violence against indigenous women, resulting from Canadian state policy, amounts to genocide. The report highlighted, amongst other areas, the massive health disparities between indigenous and non-indigenous women. In particular, Métis and First Nations populations' projected life expectancy is approximately five years less, while Inuit is a disturbing ten years less, than non-indigenous populations. The report concludes that poor health of indigenous women is a result of lack of access to quality healthcare, which is culturally sensitive and understanding of the historical colonial practices that targeted indigenous women.

Coerced sterilisation continues, with one hundred indigenous women recently launching a class action lawsuit for involuntary procedures being carried out as recently as 2018. In July 2018 an external review by the Saskatoon Health region processed accounts from sixteen indigenous women who reported they felt coerced into having tubal ligation during labour or immediately post delivery by nurses, social workers and physicians. These women stated they felt powerless, were not made aware of the irreversible effects of the procedure, and have suffered immensely as a result.

In addition, observers also noticed patterns in staff bias manifesting in the treatment of pregnant indigenous women compared to their non-indigenous counterparts. Pregnant indigenous women are more likely to be denied pain medication from staff, be put under the watch of social workers, and to be questioned as to their ability to provide a home for their new-born. Post-labour, indigenous mothers are more likely to automatically be given formula and do not receive any option or support for breastfeeding. In general, birth workers reported a general difference in staff body language, including being dismissive, quick and short to indigenous women. Staff were more likely to be less understanding to indigenous women and provide less information about their treatment and options.

Government response to the Covid-19 pandemic has also been unsympathetic to the challenges indigenous women face in healthcare. Newly implemented policies have seen a shift to appointments and consultations being held online. However only 24% of indigenous

households have sufficient internet connections to support even the most basic functions, such as image sending, let alone running appointment software. As a result, a staggering majority of new indigenous mothers have been left without any form of vital antenatal care. As many households are multi-generational, the fear of contracting and spreading coronavirus among community elders has led to indigenous women prolonging seeking medical assistance. This has seen an increased number of complications in indigenous pregnancies. Birth workers have observed that staff are less likely to explain stricter Covid-19 policies set in place in hospitals, resulting in confusion and fear of indigenous women in an already distressing environment. Furthermore, restrictions on hospitals have meant that traditional indigenous birthing ceremonies and practices have been made near impossible, removing a key support system and further alienating indigenous mothers in an already anti-indigenous environment.

Source: Unsplash

GOVERNMENT RESPONSE AND ACTION

The increasing research and pressure from indigenous advocacy groups has led the federal government to acknowledge the substantial evidence for systemic racism towards indigenous women in modern infrastructure and services, including the healthcare system. In response to

the National Inquiry into 'Missing and Murdered Indigenous Women and Girls', the Government formally recognised the historical role of the Canadian State in implementing and upholding colonialist policies.

Since the report's publication, the Government of Canada has stated it is working with provinces, territories, indigenous organizations and communities across the country to create a national action plan to stop violence against women. They are investing $425 million annually into community-based services to address the mental health wellness needs of First Nations and Inuit. A further $1.2 billion over three years has been pledged to support the implementation of Jordan's Principle, a programme delivering health support such medical equipment and mental health services to First Nations children. The delivery of this range of programmes, services and strategies has promised to be culturally appropriate and community-lead.

Focusing on women's protection within the care system, Ontario and Quebec have introduced "exemption midwives''. These are dedicated indigenous health practitioners who are regulated through community process rather than the state which enables them to deliver a wider scope of care to indigenous women, such as STI testing and pap smears, regardless of whether they are pregnant. This system means indigenous women are provided with a practitioner who shares the same cultural understanding and background, and therefore is able to give a more holistic and sensitive care experience.

LOOKING FORWARD

Investing into community-led programmes is a great first step in protecting indigenous women within healthcare systems, however policy makers and planners need to ensure that women are involved with the development of these programmes so that their needs are met. Measures should be implemented to ensure women are represented at every level of development, and feedback on plans should be sought from indigenous women to better understand their requirements.

Although investments into community-led programmes will allow indigenous women safe spaces which are culturally sensitive, policy-makers need to be more radical in addressing the systemic racism within state healthcare systems. Only investing in community-led systems and not reforming state healthcare will drive the re-segregation of indigenous healthcare, as the hostile environment in state healthcare will go unreformed, therefore discouraging indigenous

populations from accessing it. Therefore, it is imperative that policy is also developed to reform systemic racism in state infrastructure. It is here that the Canadian Government to date has fallen short.

The Government has recognised the role of colonialism in shaping current healthcare, however there has been no uniform acknowledgment by both state and federal governments that cases such as Joyce Echaquan are the manifestation of systemic racism, rather than isolated incidents. Furthermore, despite evidence and research, healthcare staff regularly deny that racism plays a role in determining the treatment of indigenous patients. Given the evidence to the contrary, it is crucial to illuminate and eliminate the implicit biases of healthcare workers which perpetuate indigenous marginalisation.

In New Zealand, where healthcare provision to indigenous populations faced similar challenges, healthcare staff were motivated to change their behaviour following interventions where they were educated on the history and evidence of racism and healthcare infrastructures. Given the success of similar initiatives, Canadian policy-makers should implement nation-wide anti-racism and cultural awareness initiatives for healthcare workers, to educate them on the colonialist principles which are woven into the fabric of the Canadian health care system. The failure to address these racial and gender biases will continue to facilitate the abusive mistreatment of indigenous women such as Joyce Echaquan.

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