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
Aboriginal people encounter when they access mainstream health and social services in the Okanagan Valley, British Columbia. In their stories, the women describe multiple assumptions and injustices that they have faced when accessing these services. In particular, the women report experiences of marginalization and racism in their encounters with health care providers and recount how their voices are often silenced or disregarded. In order to begin to understand the injustices that they face, it is crucial to consider some of the ongoing impacts of colonization on the lives of Canadian Aboriginal people, especially women.

BACKGROUND

Colonization and Indigenous Peoples
Colonization has had tremendous negative effects on Indigenous populations (Smith, 1999). Mitchell and Maracle (2005) suggest that the gross differences in health between Aboriginal and non-Aboriginal people today are linked to the impacts of colonization and the historical and intergenerational trauma that has resulted from “systematic racism, policies of assimilation, and cultural genocide” (p. 14). Colonial policies and practices have impacted generation after generation, and have resulted in homelessness, addictions, poverty, domestic violence, family dysfunction, and a lower health status for many Aboriginal people, especially Aboriginal women (Boyer, 2006). For instance, Aboriginal people identify the legacy of residential schools, and the associated separation from their families, as an act that has significantly contributed to their poor health status today (Canadian Institute for Health Information, 2004; Heritage Community Foundation, 2002). Colonization broke down the family unit by destroying traditional cooperative structures that valued gender balance (Boyer, 2006). Aboriginal women, who once owned land and who had high political, social and economic status in their communities, were portrayed by colonizers as “drunken squaw[s], dirty Indian[s], easy and lazy” (Anderson, 2000, p. 99 in Moffitt, 2004). Boyer (2006) links these types of racist and discriminatory colonial perceptions of Aboriginal women to their continued oppression and low health status. She states, “Colonization, racism, the Indian Act, residential schools, laws, policies, and regulations that have subjugated Aboriginal women to a lifetime of violence, poverty, and degradation have created the crisis in Aboriginal women’s health today” (p. 19).

Colonization has also enforced a silencing of Aboriginal people’s voices through the suppression of their languages and disintegration of their cultures and social structures, resulting in ongoing oppression and disempowerment (Boyer, 2006; Royal Commission on Aboriginal Peoples, 1996). Structural violence is another outcome of colonial practices. It is enacted through political, economic and social structures that are ignorant of, or that disregard, certain values and beliefs. As a result, marginalized individuals and groups—including Indigenous Peoples—may encounter limited access to basic services due to discriminatory policies, limited economic resources and the rural or remote geographic locations in which they live (Farmer et al., 2004; Tester, 2007). Within this context, we consider the silencing of voice—when a person speaks and their concerns are ignored or disregarded—to be an act of structural violence. When individuals are prevented from speaking out about their health concerns, for example, they are pushed further to the margins of society, where they face additional racism and discrimination (Fiske & Browne, 2006; Tester, 2007).

Silencing of Aboriginal women’s voices as an act of structural violence
Ethnic minorities in Canada (Prodan-Bhalla, 2001; Dodgson & Struthers, 2005) and internationally (Farmer et al., 2004)—including Indigenous Peoples—have a long history of being marginalized within mainstream health care systems. When people are marginalized, it means that they are positioned on the margins of a dominant culture based on their gender, race and/or economic class (Hall, 1999). The little power that they have is often “constantly challenged and contested” (Meleis & Im, 2002, p. 219). Aboriginal women in particular are marginalized when accessing mainstream health care services (Benoit, Carroll & Chaudhry, 2003; Browne & Fiske, 2001; Brumen, 2000; Dion Stout, Kipling & Stout, 2001; Hare, 2004; Meleis & Im, 2002; Smye & Browne, 2002).

In past international studies, women from diverse ethnic groups have described how health care professionals have been prejudiced against them, judging them on their race, ethnicity or other factors, such as how they were dressed or their health insurance status (Alexander, 2004; Browne & Fiske, 2001; Caneals, 2004; Cassidy, Lord & Mandell, 1995; Dodgson & Struthers, 2005; Johnson et al., 2004). The women in these studies described feeling inferior, unimportant or stupid when voicing a particular health care concern. They often had little trust in the mainstream health care system, where they had felt unwelcome in the past.

Aboriginal women in Canada, who make the majority...
of health care decisions for themselves and their families, must negotiate health care services that are aimed at, and delivered by, the Western culture, where their “Nativeness” labels them as “Other” (Barrios & Egan, 2002). Unequal power relations can lead to oppressive interactions that silence women’s voices and can decrease their “self-esteem [and] autonomy and thereby restrict choice” (Wittmann-Price, 2004, p. 441). When Aboriginal women access health services, their concerns are often ignored or disregarded (Dodgson & Stuthers, 2005). This silencing—an act of structural violence—often causes women to set aside their health concerns or delay seeking health services to avoid racist interactions. These decisions subsequently endanger women’s personal health and—as women tend to be the household decision-makers—the health of their families. Research exploring and challenging current societal and political structures related to health care provision is therefore needed to help decrease the issues Aboriginal women face in accessing these services.

METHODOLOGY

The community-based participatory study profiled in this article is a partnership between three urban Okanagan Valley Friendship Centres (FCs) and various departments at the University of British Columbia Okanagan (e.g., Anthropology, Creative Arts, Geography, Indigenous Studies, Nursing, Psychology, Social Work, and Sociology). The study explores the barriers that urban Aboriginal people face when they access mainstream health and social services and the reasons why they are increasingly seeking out these services at FCs.

Participants in the study include individuals who access FCs for health and social services, urban Aboriginal and mainstream service providers, and policy makers. Currently, participant interviews and discussion forums are nearly complete, and the preliminary outcomes are being analyzed. Although both urban Aboriginal men and women have participated in the study, this article specifically highlights the experiences of some of the women. Participant insights are drawn from stories and narratives that have been documented thus far. A report, a community needs assessment tool and a documentary video will be developed for future use by the Aboriginal participants in their own communities. Each of these can be used to advocate for health and social program funding and to inform broader interactions with Aboriginal leaders, mainstream health professionals and policy makers.

RESULTS

Urban Aboriginal women speak out about their experiences with mainstream health care

The stories of the urban Aboriginal women from one of the three communities that have participated in the study highlight how colonial societal/political structures promote acts of structural violence, including racism, discrimination and silencing. These acts are evidenced in the women’s limited access to health services and the difficulties that arise when they try to communicate with health care providers. While a few of the women felt “comfortable” with their family physician—they found that he/she was “understanding”—or felt “supported” in their encounters with nurses, the majority of the women recounted more negative experiences with various health care providers. These experiences led some of the women to refuse treatment and helped to explain why others tended to wait until they were very ill before returning to seek help from particular health care providers.

RACISM: Some of the women in the study described encounters of outright racism, where the colour of their skin determined the type of treatment they received—the darker their skin, the worse their encounter or the more negative the assumptions made by their health care providers. As has been documented elsewhere, some health care and social service providers assume that Aboriginal women are unfit mothers based on racist stereotyping, and may remove Aboriginal children from their homes for unjust reasons (Browne & Fiske, 2001; Browne & Varcoe, 2006). This racist attitude resulted in one Aboriginal woman taking her grandchildren to their family physician each and every time they had an accidental injury—cuts and bruises from normal child play activities. She needed to have the children’s injuries examined, treated if necessary, and documented as proof of how they happened. This proof was required to prevent the woman from being accused of child abuse and having her grandchildren apprehended by the Ministry of Children and Families. She indicated that this was her way of protecting her family from doctors and social service providers who, together, had apprehended her own children. She stated, “I lost my children to doctors . . . because no one [was] believing how they got hurt, injured . . . . I’ve lost my little children to the Ministry three times in their growing up years” (personal communication, June 9, 2006).

DISCRIMINATION: Discrimination in the mainstream health care system was evident in the women’s
stories. The women talked about feeling judged and discriminated against simply because they are Aboriginal. One woman stated:

You can see by the way people look at you . . . a lot of nurses . . . when somebody is kinda looking through you . . . I think sometimes some of them think they are better than you are. And I just don't see why you should have to feel that way, especially in a hospital. (personal communication, May 11, 2006)

Assumptions of alcohol and drug addiction by some health care providers were also common throughout the women’s stories, even when the women had no history of substance misuse. One woman living with obvious physical health challenges as a result of a stroke was often asked by health care providers if she had been drinking. She explained how they assumed her physical challenges were due to alcohol rather than to her stroke, and how they would ask her questions like “How long have you been drinking?” and ‘How long have you been on drugs?’ or ‘What kind of drugs are you on?’ or ‘When was the last time [you] drank?’” (personal communication, July 28, 2006). Another woman, who had also had a stroke, described how her doctor doubted her when she told him that she did not drink:

[I] have not drank for many years . . . [even if you tell them] “Oh, I’ve been sober for 10, 12, 15 years,” [they will ask] “Are you sure? Are you sure you put your own pants on this morning?” That’s what he said to me. (personal communication, July 3, 2006)

COMMUNICATION BARRIERS: Many of the women described not feeling listened to by their physicians and not having opportunities to discuss the details of their health issues. They were often told that their health concerns and symptoms were “all in their heads.” One woman described her experience of being silenced in this manner when she was experiencing severe abdominal pain:

When I speak my truth and say “This is the way I’m feeling” or “This is the symptom I’m feeling,” I’m told that it’s different [than what I am experiencing] . . . . He [the doctor] told me . . . it was all in my head and it was “phantom pain.” And he said it was a “post-traumatic disorder from [my] sexual abuse from when [I was] a young child.” I’m sorry I can’t digest that, I can’t. And I’m having a hard time with it. I’m really angry right now. (personal communication, July 3, 2006)

After being told by health care professionals that her abdominal pain was “all in her head,” this woman’s health deteriorated until she was eventually diagnosed with cancer. Had she received treatment initially, the seriousness of her illness may have been less life threatening:

I’m being lined up for a hysterectomy now, all because it was “in my head” seven months ago, when this could have been looked after. But after sitting there for seven months . . . my uterus [is] inflamed [to] just two times its size now. It had to get to that point before [they would] do an internal and check to say “Oh, it’s not from sexual abuse from when you were three. Oh, it’s your uterus. It’s inflamed.” I don’t understand. (personal communication, July 3, 2006)

Another woman shared her frustration about not being heard in the mainstream health care system:

They’re just not hearing you, or they think you’re a woman. Of course, you know, that’s one disability, being a woman. When you’re fighting on your own, you’re fighting tooth and nail for your life. That’s for your family too, don’t forget. (personal communication, June 13, 2006)

Difficulties communicating with health care professionals surfaced in other women’s stories as well. One woman spoke about caring for her husband in the intensive care unit after he was accidentally electrocuted. She described her difficulty in accessing information about her husband’s condition and the barriers she faced as an Aboriginal woman trying to communicate with the health care team. She further indicated that in her communication with doctors, nurses and specialists, they were more directive and less sympathetic. Throughout the ordeal, she was given little or no details about her husband’s condition:

I was in that hospital for 20 to 22 hours a day, running back and forth by myself, and they didn’t have anyone there to talk with me, to help me. And it was like, “You have to get into the isolation unit. You have to go and help with the healing. You have to help clean” . . . . They told me I had to be part of that, part of the recovery . . . . I had to learn how to give him a different kind of physio. I didn’t have anyone there to talk to or anyone there to explain to me. It was just, “You have to . . . if you want to take your husband home. You have to learn . . . .” (personal communication, July 3, 2006)
This feeling of being ignored or silenced was evident in the voice of another woman:

He [non-Aboriginal family physician] doesn't tell me what's wrong with me. He doesn't listen. He'll sit there and start writing on the prescription pad. When I ask him something . . . he'll say, "I'll talk to you on the next visit." He never talks to me unless I bring [an advocate] with me. (personal communication, June 9, 2006)

All of these challenges faced by the women interviewed—racism, discrimination and communication barriers—have resulted in their hesitancy or outright refusal to seek out mainstream health care services. One woman shared her experience in this regard:

Sometimes I feel like I'm being belittled or being talked down to, and I've been fighting that all my life. For a very long time. So when I'm belittled I'd rather just cut it off and say "You know what? Thank you for your time, but I think I'll just move on." (personal communication, July 3, 2006)

To avoid negative encounters with mainstream health care providers, many of the women would discuss their health concerns with family members and friends to make sure that their concerns were valid enough to seek health care. Alternatively, some of the women would use home remedies, as stated by one of the participants:

I'd rather go out to Mother Earth and . . . make sweet grass tea, or maybe burn some fungus. Or you can boil fungus down and make it into a liquid and put that into your ear for ear infections . . . little things. Go cut down [a] rose bush so you can detoxify yourself and cleanse yourself out. These are things my grandmother taught me. I'd rather resort to that, and if that doesn't work . . . I don't know . . . then I will go to the doctor. If it's really bad I will go up to the hospital, but it's got to be really really bad before I go to the hospital—like to the point where I'm vomiting so bad because the pain is so intense. (personal communication, July 3, 2006)

As highlighted in the statements above, Aboriginal women living in urban communities in the Okanagan Valley face significant barriers, and have experienced numerous forms of structural violence, when accessing mainstream health care services. Many of these women therefore seek out Aboriginal-run health services, such as those offered by Bands, Tribal Councils and Friendship Centres.

Urban Aboriginal women speak out about their experiences with Aboriginal-run health services

The Assembly of First Nations (2006) recently awarded a “failing grade” to the federal government's response and actions over the last 10 years to reduce discrepancies in health between Aboriginal and non-Aboriginal communities, as promised in the 1996 Royal Commission on Aboriginal Peoples report. In addition, they found that "any major improvements in [the living conditions of] individual communities or regions have been led by those communities for those communities" (p. 2). FCs are an example of community-based, Aboriginal-controlled services aimed at improving the quality of life for Aboriginal people who live in, or are travelling through, urban areas in Canada. FCs provide culturally appropriate programs and referral services related to health and social well-being, housing, education, employment, recreation, and cultural preservation (National Association of Friendship Centres, 2006).

In the Okanagan Valley, FCs are increasingly mediating health and social service delivery for off-reserve Aboriginal people. Many of the programs provided by Okanagan FCs are aimed at addressing some of the problems that arise from inequities in health care access and services for Aboriginal people (Evans et al., 2006). When asked if they experienced differences in health care delivery between mainstream health care services and Aboriginal health services such as FCs, the women spoke about how FCs provide them with a “safe place,” “run by Aboriginals,” where they can trust the service providers. Many of the women described their more positive experiences accessing health services through FCs:

It feels like family . . . Everyone's nice and caring and willing to take that one step further . . . There's a lot more options here too . . . for your employment, or if you're pregnant, or if you have a child. (personal communication, May 10, 2006)

According to another participant, FCs are “more supportive. They actually look at people and they hear you . . . I think they listen a lot more than other people” (personal communication, July 16, 2006). Yet another claimed that FCs are “more personal. You can actually talk to somebody, without having to wait for them to call you back . . . I just noticed the difference in people” (personal communication, June 14, 2006).

FCs provide services for Aboriginal people who have emigrated from a multitude of different locations
across Canada. It is important to note, however, that the health and social services provided through FCs are not as comprehensive as those provided within the mainstream system, because they are not funded or mandated to provide such services. As ethnic and cultural diversity increases within Canadian urban communities, the development and implementation of an anti-racist approach to health and social service delivery become ever more critical (Reid, 2004).

**Urban Aboriginal women’s words of wisdom for improving health care services**

The participants provided some suggestions about how delivery of both mainstream and Aboriginal-run health care services could be improved. Their ideas included: making cultural education available to health care providers, allowing more time for patients to discuss their concerns with health care practitioners, and providing Aboriginal people with health care options other than walk-in clinics or emergency departments, such as Primary Care Centres. They wanted all people—Aboriginal and non-Aboriginal—to be treated equally by health professionals. As one woman commented:

> Everybody should be treated equal . . . . Doctors should wear coloured glasses so everybody looks the same. Maybe they should all wear yellow so everybody has yellow skin, or red so everybody has red skin—so everybody could be treated the same and so the individual is an individual, not categorized, not assumed. (personal communication, July 3, 2006)

One woman directed her comments specifically to health professionals:

> Listen with your ears and listen with your heart. Listen and be quiet . . . and don’t try to monopolize, but listen to what the patients have to say . . . . They are living with a disease, they are living with all these things, whether they be poor, whether [their problems] be financial, spiritual, emotional, or physical. Listening is an art. Listen and take it to heart and write it down. You learn a lot by listening, and maybe you can eliminate a lot of stress . . . . (personal communication, June 13, 2006)

> Overall, although the women described the occasional positive experience with mainstream health care providers, most of the participants in the study described instances where they received unequal or inadequate health care delivery. We have highlighted the challenges they encountered, as a way to increase awareness about the barriers that they face as urban Aboriginal women and to initiate change.

**DISCUSSION**

The narratives presented in this article show that the silencing of urban Aboriginal women’s voices regarding their health care needs persists in today’s mainstream health care system. This is problematic since Aboriginal women play a crucial role in the health and well-being of their families and communities. In addition, these experiences of racism and discrimination affect many women at times when they are most vulnerable and least able to protect themselves. This demonstrates a need for urgent action to stop the perpetual cycle that supports such structural violence. Health care professionals working with people from diverse ethnic backgrounds—including Aboriginal people—would benefit from an increased awareness of the lived experiences of these marginalized groups. With such an understanding, health care professionals would be more apt to listen to, and less likely to silence, their Aboriginal patients. This, in turn, could help to create safe spaces for people to share their voices. As stated by Hunter, Logan, Barton & Goulet (2004), “The understanding of cultural preferences can only enhance health outcomes” (p. 279).

Although many health care providers follow ethical standards and generally believe that their relationships with clients are culturally appropriate, many are unaware of how their practices may unintentionally demonstrate discriminatory attitudes (Browne, Fiske & Thomas, 2000; Hunter, Logan, Barton & Goulet, 2004; Johnson et al., 2004). For instance, health care professionals with a minimal understanding of historical colonial policies and practices—in particular the residential school system—are less able to contextualize how these experiences may have impacted the way Aboriginal people perceive health, well-being and health care structures (Smith, Varcoe & Edwards, 2005). This lack of awareness may be due to the fact that the concept of cultural safety—which acknowledges how issues of racism and discrimination can affect interactions between patients and health care professionals—is not generally considered a priority within the post-colonial health care education system (Smye, Rameka & Willis, 2006).

Making cultural education available to health care providers was one of the suggestions made by some of the Aboriginal women who participated in the Okanagan Valley study, as a way to improve health care provision for urban
Aboriginal populations. They recommended that cultural safety concepts be integrated into educational curricula across the professional health disciplines and throughout community organizations and agencies. The women also suggested that patients should be allowed more time to discuss their concerns with health care practitioners, and Aboriginal women should have health care options available to them other than walk-in clinics or emergency departments at hospitals. Further, the women suggested that Aboriginal people be actively involved in decision-making about changes to educational curricula and health policies to ensure that these changes are meaningful to Aboriginal people and reflect the realities of the environments in which they live.

CONCLUSIONS

This article has discussed the need to address the discrepancies in health between Aboriginal and non-Aboriginal populations, and between on-reserve and off-reserve Aboriginal populations. The ongoing and gendered impacts of colonization have also been highlighted to show how colonial practices and policies are linked to the current poor health status of many Aboriginal people and communities. By reviewing the literature and listening to the stories of urban Aboriginal women, we have learned about the types of challenges they face when accessing mainstream health and social services. Their stories show how colonial stereotypes and structures continue to be perpetuated within the current health care system, and how this affects their lives and health care decisions. The main elements of structural violence experienced by the women were racism, discrimination and the silencing of their voices. This resulted in poor communication experiences with their health care providers, which, in turn, prompted many of the women to refuse or delay accessing health services in order to avoid further acts of structural violence. The ultimate outcome of this cycle of violence and neglect was that the women's health and the health of their families was put at risk. As a result, more women started seeking out health services at FCs, where they felt more comfortable voicing their needs and priorities. Finally, the women provided recommendations about how to improve health and social service delivery, such as providing cultural education for health care practitioners and policy makers.

In conclusion, the voices of urban Aboriginal women and men must be the ones informing health care providers and policy makers about the health care gaps and inequities that exist within their communities. The inclusion of local Aboriginal people in decision-making can help to improve relationships between health care providers, policy makers and community members by having them work together to eliminate structural violence. Learning from the lived experiences, stories and insights of urban Aboriginal people will prompt new ideas about health care delivery, education, practice, and policy that will help to close the current gap in health status between Aboriginal and non-Aboriginal people.

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REFERENCES


**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.