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First Nations Women in Northern Ontario: Health, Social, and Community Priorities

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First Nations Women in Northern Ontario: Health, Social, and Community Priorities

Abstract
This article reports on data from women dwelling in First Nations communities regarding (1) baseline statistics about women's circumstances, needs, interests, and opportunities for community engagement, and (2) information about women's present status, experience, interest, and other questions of social, economic, and health status. Two hundred twenty-six women from 35 First Nations communities completed the survey. This paper focuses on the main findings from the survey, which fall into 4 thematic areas. Theme 1 consists of demographic information as provided by participants. Theme 2 consists of social information such as housing and education. Theme 3 includes information about participants' top community health concerns. Theme 4 examines participants' community involvement. Use of the survey in directing women's social policy is discussed.

Keywords
First Nations; Women; Social determinants of health

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The health and socioeconomic conditions of Canadian First Nations peoples are of concern to health care workers, researchers, and policy makers. Regardless of the health outcome-mortality rates, self-rated health status or disease diagnosis-health disparities exist between First Nations peoples and the general Canadian population (Frohlich, Ross, & Richmond, 2006). Along with Indigenous populations in the United States and Australia, Canadian First Nations groups have a significant history of colonialism, and their position in society today is a direct result of the colonization process (Frideres & Gadacz, 2001). The colonization process included (but was not limited to) wardship through the 1876 Indian Act and related federal policy (Waldram, Herring, & Young, 2006), forced removal of children from their families and placement in residential schools and foster care (Kirmayer, Simpson, & Cargo, 2003), creation of the reserve system and forced relocation of communities (Adelson, 2005), and racism and discrimination towards First Nations peoples (Waldram et al., 2006). Discrimination frequently results in social and economic marginalization. Members of marginalized groups are often exposed to inadequate access to health care, environmental hazards and socially inflicted trauma, which can influence health directly or indirectly (Krieger, 1999). Compared to minority men, minority women are more likely to suffer ill health effects due to racism (Karlsen & Nazroo, 2002), making them a particularly vulnerable sub-group. This legacy of colonization continues to affect First Nations peoples' health, social, economic, cultural, and political status to this day (Spitzer, 2005; Waldram et al., 2006).

There exists a wealth of literature demonstrating how inequalities in social, economic, cultural, and political status are associated with health disparities (c.f. Adelson, 2005; Cooper, 2002; Frohlich et al., 2006; Krieger, 1999; Spitzer, 2005; Trovato, 2001). These social determinants of health must be addressed in order to reduce the health disparities experienced by First Nations peoples. This paper summarizes the unequal distribution of education, employment, income, and housing among Canada's Indigenous peoples. We use the term "Indigenous" to refer to First Nations, Métis, and Inuit peoples collectively. Whenever possible we specify the particular group represented. This paper has a particular focus on the First Nations population and demonstrates the lack of information specific to women's social and economic context. We conclude by describing a survey designed to collect data on the social and political status of First Nations women, reporting on the key information obtained. The main findings from the survey identify the intersection of health, social, and community priorities of First Nation women in Northern Ontario. The survey was implemented within the context of a large-scale women's development project under the direction of co-author C. Simard (Nishnawbe Aski Nation). Co-authors A. Maranzan (Lakehead University) and A. Sabourin (Beedaubin Resources) were project evaluators for the larger women's development project.

Education, Occupation, and Income

Socioeconomic status (SES) is traditionally defined by an individual or family's education, income, and occupation; several health problems including low birthweight, cardiovascular disease, diabetes, and cancer are linked to low SES (Adler & Newman, 2002). In general, the educational attainment of Canada's Indigenous peoples is lower than that of the general population (Bougie & Senécal, 2010; Health Canada, 2005). For example, the Canadian Community Health Survey indicated that 43.9% of Indigenous peoples (off-reserve) had less than a high school education compared to the general population at 23.1% (Tjepkema, 2002). The 2001 Canadian census indicated that on-reserve First Nations peoples also had lower rates of educational attainment across all levels including elementary, postsecondary, and college/university (Health Canada, 2005). In a sample of 301 on-reserve First Nations people only 10% had completed a university education, compared to 33% of people of European descent (Anand et al., 2001).

Rates of employment are similarly lower among the Indigenous population. The Canadian Community Health Survey asked respondents to indicate if they had worked the entire previous year; among those aged 15 to 75, only 38.1% of off-reserve Indigenous respondents had worked, compared to 53.2% of the general population (Tjepkema, 2002). This difference seems to be magnified for females; data from the 2006 Canadian census indicated that 20% of on-reserve First Nations females were unemployed, compared to 29% of their male counterparts (Quinless & Anderson, 2010).

Income is a key determinant of health in Canada and other countries around the world (Raphael et al., 2006) and is closely related to an individual's educational attainment and available employment opportunities. Higher income can promote health and well-being through supply of better nutrition, housing, schooling, and recreation (Adler & Newman, 2002). In general, Indigenous household incomes are significantly below that of the general population. For example, the Canadian Community Heath Survey indicated approximately 27% of off-reserve Indigenous peoples had a low income compared to 10% of the general population (low income was defined as less than $15,000 for 1-2 person households, less than $20,000 for 3-4 person households, and less than $30,000 for 5+ person households; Tjepkema, 2002). The 2006 Canadian census indicated that the average income for off-reserve First Nations females was $21,773, compared to $30,110 for First Nations men (Quinless & Anderson, 2010).

There is some data to suggest a relationship between income inequality and mortality. For example, data from the United States showed a strong relationship between income inequality and mortality for the working age population; as income inequality increased mortality also increased (Ross et al., 2000). In Canada, however, this relationship was not significant perhaps due to differences in social and economic resource distribution in Canada. Canadian provinces and metropolitan areas had lower income inequality and lower mortality compared to the United States (Ross et al., 2000). However, a separate Canadian study noted higher mortality rates in health regions characterized by high unemployment, low educational attainment, and low household income (Berthelot, Wilkins, & Allard, 2004). Education, employment, and income are inter-related and have a significant impact on health and well-being (Spitzer, 2005).

Housing

Socio-economic factors are also related to housing and are particularly important among the Indigenous population when coupled with the inequities in education, employment, and income described above (Dunn, Hayes, Hulchanski, Hwang, & Potvin, 2006). Several housing characteristics have the potential to influence health, such as physical hazards and crowded living conditions. Adelson (2005) summarized the available information about housing, which indicated that compared to the general population Indigenous peoples were twice as likely to live in homes requiring significant repairs (data included on- and off-reserve Indigenous peoples). Data from the 2006 Canadian census indicated that 28% of off-reserve First Nations people, 14% of Métis people, and 28% of Inuit people lived in homes in need of significant repairs, compared to only 7% of the general population (Statistics Canada, 2008). These figures increase on reserves. For example, in 2001 55.8% of homes on First Nations reserves were considered adequate (i.e., did not require major repairs and were large enough for the size of the household), while 36.0% were in need of major repairs (Health Canada, 2005).

Indigenous peoples (on- and off-reserve) are 2 to 8 times more likely to experience crowded living conditions compared to the Canadian general population (Adelson, 2005). For example, the 2006 Canadian Census indicated that off-reserve First Nations peoples were four times more likely to reside in crowded dwellings (i.e., more than one person per room) compared to the general population; three percent of Inuit and Métis people lived in crowded conditions. Crowding was especially common on First Nations reserves, where 26% of people lived in crowded conditions (Statistics Canada, 2008).

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Compared to the general population, Indigenous people are 90 times more likely to have no piped water, and 5 times more likely to have no bathroom facilities (Adelson, 2005; data included on- and off-reserve peoples). Many First Nations reserves lack basic sanitary infrastructure (Frohlich et al., 2006). Enteric, food, and waterborne diseases such as giardiasis, shigellosis, verotoxigenic *Escherichia coli* (E. coli) and hepatitis A are more easily spread in communities with substandard water and sewage systems.

Given the data presented, the picture that emerges is one of poor distribution of the social determinants of health among Indigenous peoples, including First Nations. First Nations peoples have lower educational attainment, employment, and income, and are more likely to live in crowded and sub-standard conditions. Data that are specific to the experiences and needs of First Nations women are difficult to come by, in part because most statistical reports focus on the First Nations or Indigenous groups as a whole, without conducting gender-based analyses. What little data are available suggest that these women experience an even greater amount of inequity compared to First Nations men (c.f. Adelson, 2005; Quinless & Anderson, 2010). In the next section we describe a survey that was designed to identify the social, economic, and political status of First Nations women in Northern Ontario, Canada; we report on statistical data collected by the survey in order to provide a snapshot of the women's current experience.

Nishnawbe Aski Nation Major Women's Development Project

Throughout the rest of this paper, we use the term "First Nations community" and "community" as synonymous with "reserve" in keeping with the terminology preferred by Nishnawbe Aski Nation and the people it represents. Nishnawbe Aski Nation (NAN) is a regional organization that represents the interests of approximately 45,000 First Nations peoples dwelling in 49 communities within the territories of James Bay Treaty 9 and Treaty 5 (Ontario portion). Members of NAN are individuals who are members of one of the 49 First Nations bands, regardless of their place of residence or treaty status. Located in Northern Ontario, Canada, NAN's territory occupies a land mass of approximately 210,000 square miles (Figure 1; Nishnawbe Aski Nation, 2011). In March 2007 a NAN Chiefs-In-Assembly Resolution (#07/33) recognized a need to facilitate the on-going involvement of women in leadership and called for the examination of how women could be included in NAN's leadership processes.

In response to this recognized need, approximately 100 NAN women attended a conference in Thunder Bay, Ontario. Participants discussed the potential use of workshops to address the social and economic concerns of women living on reserves, and the outcome of the conference was the development of a draft socio-wellness health plan from the perspective of the participants. This plan evolved into an initiative termed the Major Women's Development Project. A Director of Women's Development (co-author C. Simard) and Project Assistant (collectively the "Women's Development Team") were hired to further develop the project in consultation with key stakeholders. Input was obtained from women living on NAN reserves as well as women from the NAN Women's Council. The Women's Council consists of 8 women chosen through election, and one youth representative; its role is to bring forward issues that pertain to women within the context of Chiefs' meetings, and ensure the on-going involvement of women in decision-making processes.

The Major Women's Development Project developed through consultation with the stakeholders described above. In its final form, the Major Women's Development Project consisted of three elements: (1) four-day workshops on leadership and personal capacity development, to be delivered to women residing in each of the 49 NAN communities (results not described here), (2) curriculum and training to develop and support women's groups in the NAN communities (results not described here), and (3) development and implementation of a survey to collect statistical information

about the needs and experiences of NAN women. Thus, the focus of the Major Women's Development Project was on women dwelling in NAN's communities and not on urban-dwelling (off-reserve) women. The focus of this paper is on the survey's findings.

The NAN Women's Council and Women's Development Team designed the survey to determine the health, social, and community priorities of NAN women. The Women's Council wanted to collect this information for two purposes. The first purpose was to have more information with which to advocate for women's resources and services. The second purpose was to have a baseline measure of women's experiences and needs; a follow-up survey could then determine if allocation of resources had an impact on women living in the communities.

The three elements of the Major Women's Development Project were implemented simultaneously. Between 2008 and 2010, over 200 women residing in 43 of NAN's 49 communities attended the workshops. During the workshops the curriculum regarding women's groups was also delivered. Workshop participants completed the survey upon conclusion of the workshops.

The Present Study

As described above, NAN Chiefs-in-Assembly Resolution #07/33 called for the examination of how women could become involved in NAN's leadership process and was the impetus for development of the Major Women's Development Project. Given the lack of statistical information specific to First Nations women, development and delivery of a survey to collect such information was an important element of the Major Women's Development Project. We will now summarize the key findings from the survey, identifying the health, social, and community priorities of First Nations women residing in Northern Ontario. Our aim is to demonstrate that understanding and improving the social conditions and inequity experienced by First Nations women is necessary in order to promote the health and well-being of this group.

Methodology

Participants

All women who participated in the leadership and personal capacity development workshops were invited to complete the survey.

Measure

The survey included 33 items regarding demographic information (e.g., age, marital status, number of children), community health concerns (e.g., diabetes, doctor shortage, nutrition), social concerns (e.g., housing, income, education), and community involvement (e.g., volunteering, role models). It has become an accepted flexible data collection instrument within NAN that not only collects demographic information but allows women to express their top community health concerns, identify positive aspects of their communities, and identify challenges facing their communities with suggestions for change.

Procedure

Administered in hard copy format, participants completed the survey anonymously. Data were collected upon conclusion of the 4-day leadership and personal capacity development workshops.

Ethical Approval

The Major Women's Development Project was initiated by Nishnawbe Aski Nation and developed by NAN women, for NAN women, as described previously. Support and approval for the overall project, including development, administration, and analysis of the survey, was obtained from the NAN Executive. Each participating reserve's Chief and/or Council gave consent prior to implementation of the workshops and survey on their reserve. Additionally, the Lakehead University Research Ethics Board provided ethical approval to analyze the anonymous survey data.

Results

Data were obtained from 226 First Nations women residing in 35 First Nations communities throughout Northern Ontario, representing an average of 6.5 women per community. The number of women from each community ranged from 1 to 20. Data were analysed using SPSS 16.0 and are reported as frequency distribution tables. Using the data from the survey, we were able to report baseline statistics across four thematic areas. Theme 1 consists of demographic information. Theme 2 consists of social information such as housing and education. Theme 3 includes information about the participants' top community health concerns, separated by women's health concerns and men's health concerns. Theme 4 examines the participants' community involvement. Not all participants responded to each question; some categories include missing data.

Theme 1: Demographic Information

Table 1 displays the participants' age groups and current marital status. Fifty-two percent of the women were 40 years of age or less, with the 31-40 age bracket most represented. The majority of participants were common-law or married (58.0%) with the remainder single (25.2%), separated/divorced (11.1%) or widowed (4.4%). The average number of children for participants was 2.8 (SD = 2.03) and this number ranged from 0 to 12 children. The majority of these children were aged 18 years and older, followed by children aged newborn to 6 years.

English was the first language for the majority of participants (53.1%) followed by Oji-Cree (15.9%), Ojibway (15.0%) and Cree (7.1%). In addition to their first language, the women indicated they could also speak Ojibway (19.9%), Oji-Cree (13.3%), and Cree (5.3%) and a minority of women could write in Ojibway syllabics (9.7%), Oji-Cree syllabics (10.6%), and Cree syllabics (1.3%). We divided the participants into two groups based on age (15 to 40 years, and 41 years and older) to determine if first language differed by age group; there was no difference in first language for any age group.

The majority of participants had completed at least some high school (51.8%). An additional 19.9% had attended at least some college/university, while 12.8% indicated elementary school was the highest level of education received.

Theme 2: Social Information

Participants were asked if their home has enough bedrooms and living space to meet their family's needs. Seventy-four women (32.7%) indicated this was not the case; among these women the average number of people who live in the home was 5.4 (SD = 2.5) and ranged from 1 to 14 people. This same sub-group of women had an average of 3 rooms in their home (SD = 1.2, min = 1, max = 6). Fifty-eight percent of women (n = 130) indicated they do have enough bedrooms and living space to meet their family's needs (9.7% missing data).

One quarter of the women (26.1%) had a total personal annual income between $20,000 to $30,000 while an additional 40.7% made less than $20,000 per year. Approximately half of the women (56.6%) indicated that "work" was their current source of income. The next largest categories were social assistance (9.3%) followed by spouse's income (6.6%), disability (4.0%) and pension (2.7%).

Theme 3: Community Health Concerns

Participants were asked to identify the top 5 community health concerns from a list provided to them, developed by the Women's Development Team and NAN Women's Council, separated for men and women (see Table 2). The top concerns for women were diabetes (88.9%), addictions (75.7%), nutrition (60.2%), cancer (50.4%) and doctor shortage (50.0%). The top concerns for men were similar: diabetes (61.9%), addictions (57.1%), nutrition (37.6%), cancer (34.5%) and mental illness (33.2%). More participants endorsed concern about women's health issues compared to men's health issues.

Theme 4: Community Involvement

The women were also asked about the extent of their involvement in the community. Approximately one-third of the participants (38.5%) indicated that there are women's groups in their community. Twenty-three communities (65%) had women's groups but not all of the women from these communities were aware of the women's group(s) in their own community. In communities that have women's groups, an average of 11 reported participating in them.

The majority of women (76.1%) indicated that they volunteer for their community. The types of volunteer activities endorsed by the women are displayed in Table 3. The most common volunteer activities were helping at community events (50.0%), fundraising (46.0 %), and cooking (42.0%). Babysitting and helping with events for children/youth were additional examples of volunteer activities the women engaged in.

Finally, the women were asked if they had ever run for Chief and/or Council, or thought of running. Thirty-nine women (17.3%) had run for Chief and/or Council, while 65 women (28.8%) had thought about it. Potential barriers experienced by women who run for Chief and Council were family responsibility (48.7%), community pressure (44.7%), home responsibility (43.4%), lack of support (38.1%), self-esteem issues (26.5%), and financial concerns (18.1%).

Discussion

This study provided insights into some of the social and political realities of women residing in First Nations communities in Northern Ontario, Canada. A survey administered to women attending leadership development and personal capacity building workshops collected key statistical information.

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Findings from the survey highlight the demographic characteristics of the participants, social information, community health concerns, and women's involvement in their communities. Future research could focus on obtaining a representative sample in order to increase our understanding of women's context and experiences.

Taken together, the demographic, social, and health information collected by the survey are consistent with data reported elsewhere in the literature. Among the participants, approximately half obtained a high school education, a finding that was slightly higher than educational attainment rates reported elsewhere in the literature. It may be that self-selection to participate in the workshops (and hence completion of the survey) influenced this statistic, with women with lower educational attainment being less likely to participate. This selection bias may have occurred due to the method in which the workshops were advertised; promotional materials were posted mainly in the community's band office and other places of employment. Approximately one-third of the women indicated that their home did not have enough bedrooms and living space to meet their family's needs. On average, these women lived with 5 people in a home with three rooms. Previous research demonstrated that First Nations peoples are more likely to live in crowded living conditions compared to the general Canadian population, and our work is consistent with this finding.

Almost 60% of the participants were married or common-law, and the average number of children in the group was 2.8 (SD = 2.03). Thus, the majority of the women who participated in the survey carried significant responsibilities in terms of child-rearing and family. This finding corresponds with two of the frequently-endorsed barriers to leadership participation for these women: family responsibility and home responsibility. Several of the participants commented that, when a woman holds a position of leadership, she also retains responsibility for her children and family, and these priorities can be challenging to balance.

The survey also reported on new data about women's community involvement and leadership. Almost twenty percent of participants had run for Chief and/or Council, and over twenty-five percent of participants had thought about running for such a position. However, First Nations women continue to experience challenges which inhibit their full contribution (Castellano, 2009). The data from the present study certainly suggest that other responsibilities carried by women can act as barriers to their participation in the political arena, particularly those associated with child rearing and other family responsibilities. Community pressure and lack of support were additional often-cited barriers experienced by women who run for political office.

A major strength of the survey is that it was developed and delivered by First Nations women, for First Nations women. However, it is important to note that this study did not employ a representative sample, but rather a convenience sample. Therefore, the results do not generalize to the entire female population dwelling in First Nations communities. The Major Women's Development Project only targeted women living in First Nations communities; future research should consider the social context of women living off-reserve.

Conclusions

Taken together, the data from the current study indicate that First Nations women continue to experience inequities in social and economic status. Furthermore, the data indicate that women form the minority of political leadership. The other two elements of the Major Women's Development Project were implemented in order to begin to change women's political status by further developing the skills and strengths of NAN's women and facilitating their involvement in leadership. The survey from the present study will be used as one mechanism of measuring change in women's social, economic, and political status in the communities.

As previously described, the NAN Women's Council has input in the decision-making processes of the NAN Executive. The NAN Women's Council intends to use the survey data to advocate for resources and programs that will address women's current needs, with the ultimate goal of reducing inequities and improving the health of women, families, and communities. Castellano (2009) acknowledged the importance of women's voices in public dialogue about health and healing of First Nations communities. She also described the increasing influence women have in political forums. The present survey, therefore, is an important step forward for the NAN Women's Council. Survey information about the inequities experienced by women, as well as the strengths and resources identified by the survey, will be used to inform and direct policy regarding women's issues.

Table 1

Demographic characteristics of participants

Demographic	N	%
Age group		
15-20	16	7.1
21-25	19	8.4
26-30	21	9.3
31-35	27	11.9
36-40	35	15.5
41-45	21	9.3
46-50	25	11.1
51-55	22	9.7
56-60	13	5.8
61-65	8	3.5
66-70	7	3.1
70+	1	0.4
Unknown	11	4.9
Marital status		
Single	57	25.2
Common-law	47	20.8
Married	84	37.2
Separated	13	5.8
Divorced	12	5.3
Marital status		
Widowed	10	4.4
Unknown	3	1.3

Table 2

Top community health concerns for women and men, as endorsed by participants

	Health concern for women		Health concern for men	
Concern	N	%	N	%
Diabetes	201	88.9	140	61.9
Addictions	171	75.7	129	57.1
Nutrition	136	60.2	85	37.6
Cancer	114	50.4	78	34.5
Doctor shortage	113	50.0	74	32.7
Mental illness	84	37.2	75	33.2
Nursing shortage	83	36.7	54	23.9
Transportation	62	27.4	47	20.8
Health cards, Status cards	54	23.9	38	16.8
HIV/AIDS	46	20.4	39	17.3
Tuberculosis	25	11.1	23	10.2
Other	33	14.6	22	9.7

Table 3

Volunteer activities endorsed by participants

Activity	N	%	
Cleaning	69		30.5
Cooking	95	42.0	
Community events	113		50.0
Fundraising	104		46.0
Crisis response	67	29.6	
Visiting families in need	52	23.0	
Community hall	39	17.3	
Midwifery	5		2.2
Other	29		14.1

Figure 1. *Map of Ontario, Canada, showing Nishnawbe Aski Nations' territory, affiliated First Nations communities, and tribal councils.*

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