Oppression of first nation people

How is it that the indigenous of Canada transpire into the minority and oppressed? Specifically, how are First Nations women vulnerable to multiple prejudices? What are the origins of prejudice & oppression experienced by First Nations women in Canada, how has this prejudice been maintained, what is its impact and how can it best be addressed? Ever since the late 1400's when the European discovered North America they brought along with them a practice of domination leaving the first nation people with very little rights forcing them to stand defenceless.

Ever since the settlers arrived, the lives of the First Nation people have forever been damaged with the implementation of new ways of living. These changes have created an image of what First Nations people are prejudiced as. These prejudices have lead to stereotypes and even forms of discrimination and racism. Unfortunately, the majority of the beliefs are negative and have been widespread amongst non First Nations people. Some of the unfortunate cultural stereotypes that exist in today's society are that First Nations people are; poor, uneducated, dirty, bad parents, and alcoholics.

These beliefs and attitudes can all be rooted from practices that European settlers have indirectly instilled within Canada's institutional procedure. Systemic prejudice and oppression towards First Nations women can be best explained as the result of formal and informal colonial policies and so can be best addressed by changing the prejudiced individual. A chief illustration of prejudice that First Nations women experience is through the health care system.

The health care system has and continues to; discriminate, execute racism as well as permits structured inequalities that only hinders First Nations women. Health care is a direct reflection of the social, political, economic, and ideological relations that exist between patients and the dominant health care system (Browne and Fiske 2001). Internal colonial politics throughout the years has had a major influence on the dominant health care system in Canada; this has resulted in the marginalization of First Nations people. The colonial legacy of subordination of Aboriginal people has resulted in a ultiple jeopardy for Aboriginal women who face individual and institutional discrimination, and disadvantages on the basis of race, gender, and class (Gerber, 1990; Dion Stout, 1996; Voyageur, 1996). This political reality is alive in the structural and institutional level but most importantly originated from the individual level that has affected the health care experience by First Nations women. According to the 2006 Statistics Canada, First Nations people surpassed the one-million mark, reaching 1, 172, 790 (Stats Canada, 2006). As the population seems to increase, a linear relationship seems to arise with hopelessness in health.

Therefore, as First Nations people population increase so is the disparity in health. In comparison to non- First Nations people, there seems to be a large gap with health care service. It use to be assumed that the reason why First Nations people try to avoid conventional health care and instead prefer using healing and spiritual methods. According to a survey conducted, Waldram (1990) found that urban First Nations people continue to utilize traditional healing practices while living in the city, particularly as a complement to contemporary health.

This means that they do in fact use conventional health care but also take part in healing practices. According to the Department of Indian Affairs and Northern Development, statistics showed that: •The life expectancy of registered Indian women was 6. 9 years fewer than for women in the total population. •Mortality rates in were 10. 5 per 1, 000 compared to 6. 5 for all women. •Unemployment rates in for women on reserve (26. 1%) were more than 2. 5 times higher than for non-Aboriginal women (9. 9%), with overall unemployment on reserves estimated at 43%. In urban centers, 80% to 90% of Aboriginal female-led households were found to exist below the poverty line, resulting largely from dependence on meagre levels of social assistance (Department of Indian Affairs and Northern Development, n. d.). These inequities in health and social indicators are perfect examples of the affect of political and economic factors that influence access to health services (Browne and Fiske 2001). Health care for First Nations people, specifically for those who live in reserve communities receiving federally run services, has been founded on colonial ideology.

This allowed and influenced the beginning of dependency of the First Nations people upon the European policy makers (Browne and Fiske 2001). First Nations women have been exceptionally affected. A severe example of oppression in health care was the sterilization of First Nations women in the early 1970s, reportedly without their full consent. During the late 1960s and the early 1970s, a policy of involuntary surgical sterilization was imposed upon Native American women, usually without their knowledge or consent (First Nations).

This practice was a federally funded service . Such sterilization practices are clearly a blatant breach of the United Nations Genocide Convention, which declares it an international crime to impose “ measures intended to prevent births within [a national, ethnical, racial or religious] group (First Nations). Policies such as these allowed for the First Nations women to stay defenceless. Today there are still many examples of how systemically prejudice still exists.

Today, Canadian nurses and physicians often hold and maintain negative stereotypes about aboriginal men, women and children, in turn, provide health care that is not “ culturally sensitive” (Browne and Fiske 2001). For instance, nurses may ask more probing questions regarding domestic violence and make more referrals about suspected child abuse for aboriginal clients than for white clients. Studies with aboriginal Canadian women also reveal that some participant feel their health concerns are trivialized, dismissed or neglected due to stereotypic beliefs of nurses and physicians (Browne and Fiske 2001).

Some aboriginal women have even reported feeling like outsiders who are not entitled to health care services. This indicates that aboriginal people`s negative experience with health care professionals have compromised the quality of care they receive. This then reinforces their perception that aboriginal values are not respected by the western medical establishment and instilled feelings of mistrust toward care providers (Browne and Fiske 2001).

Marginalization from dominant political, economic, social, and health sectors arises from and reinforces racial stereotypes that contribute to views of

Aboriginal people as “ other” (Browne and Fiske 2001). For example, all those that are recognized as having “ Status Indians,” members of the First Nation community they are entitled to non-insured health benefits that no other Canadians receive. This has created bitterness and hatred from members of the dominant society with respect to “ free” health services and often is seen as an addition of welfare.

Members of the First Nation are acutely aware of the views commonly held by members of the dominant society and recognize that these perceptions contribute to negative stereotypes and the processes of “ othering” that further alienates them from the dominant health sector ” (Browne and Fiske 2001). In addition to having the Indian status card, residential school practices have had an influence on individuals. This again is an illustration of political power that had an influence on the mistreatment and abuse of children at these schools.

From 1917 to 1946, children of this First Nation were compelled to attend residential school to receive an education (Nelson, 2006). At these schools that are supposed to be a building of which education is suppose to be taught there were many instances of physical and sexual abuses that created a lifetime of fear, humiliation, and mistrust. These abuses and the shame expectancies taught by the very strict teachings of sexual modesty and morality are compounded by the lived experiences of maltreatment (Nelson, 2006).

The social harm of enforced residential schooling is enormous; this combined with economic and political relations shape women’s health care. Many First Nations women feel as though there are dismissed by their health care

providers. They believe their health concerns or symptoms were not taken seriously. They were either seen as inconsequential or simply dismissed by providers of which predominantly were doctors or Nurses (Nelson, 2006). The nurses and doctors assumed there was nothing wrong before assessing the patient’s condition. Individuals feel as though they have to transforming their image to gain credibility.

So they feel as though they have to dress up when going to the doctors. The risk of being dismissed was compounded by some women’s reluctance to admit to pain or to outwardly express suffering, which is what they had been taught by their Catholic teachers in residential school (Nelson, 2006). Therefore, they are more likely to wait until there condition is severe before seeking services, since past experiences cause them to fear that she will be dismissed by her provider. In addition, health care providers stereotype First Nations women as being very passive participants in health care.

But what they fail to realize is that they again were taught specific ways of expressing respect one of which was to act unassertive (Nelson, 2006). Another prejudice that First Nations encounter by health care providers are the judgments on the women as mothers. Extreme actions are usually taken by hospital staff based on assumptions. This is also another factor leading to individuals trying to transform themselves. They try to change their appearance so that they look like credible medical subjects to be treated equally as the every other patient.

Often a difficult task when First Nation people feel like outsiders. Systemic prejudice and oppression towards First Nations women can be best explained as the result of formal and informal colonial policies and so can be best

addressed by changing the prejudiced individual. A chief illustration of prejudice that First Nations women experience is through the health care system. The health care system has and continues to; discriminate, execute racism as well as permits structured inequalities that only hinders First Nations women.

The implications of providing health care to Aboriginal women must be critically analyzed to consider the unique social, political, economic, and historical factors influencing health care encounters at individual and institutional levels (Nelson, 2006). Women of First Nations are aware of the different ways in which racial and gendered stereotypes and economic privation can influence the health care they receive (Nelson, 2006). Health care is a basic necessity that many of us take for granted. This disadvantage is also a representation of a First Nations woman`s everyday social experience.

The tendency of Western nurses and doctors to bracket out the sociological and political context of health care encounters involving Aboriginal patients, however, stems from their professional socialization and predominantly middle-class values (O'Neil, 1989). It has been proven that there is in fact an institutional and colonial relationship with health care. Institutions are powerful symbols of Canada`s recent colonial past that currently affects Canadians. First Nations patient today are experiencing discriminatory behaviour from health care providers and as a result disempowering them.

The difficulty has been addressed and the time now is to solve this problem. Given the political and ideological context of relations between First Nations people and the Canadian state, power imbalances that give rise to the

women’s concerns regarding their health care are unlikely to be redressed without radical changes in the current sociological and political environment (Nelson, 2006). Health practitioners as well as policy makers would need to integrate their work to create health care policies, practices, and educational programs.

Moreover, since we are fully aware that systemic institutionalizations are originally rooted from individuals the approach to solve this problem would be by trying to reduce prejudice by changing the prejudiced individual (Morrison & Morrison, 2008). It seemed fairly obvious that because prejudice originated from the one who was doing the stereotyping that if society wants to reduce or eliminate such behaviour, it ought to direct its attention to changing that individual (Morrison & Morrison, 2008).

Thus reduction efforts using education, ad role playing, propaganda and confrontation techniques are examples of attempts to reduce prejudice (Morrison & Morrison, 2008). The shift in individual behaviours will in turn change mainstream health care. References Browne, A. J. , and Fiske, J. (2001). First Nations women’s encounters with mainstream health care services. Western Journal of Nursing, 23, 126- 147. Dion Stout, M. D. (1996). Aboriginal Canada: Women and health. Paper prepared for the Canada-U. S. A. Forum onWomen’s Health [Online]. Ottawa, Canada. Available: http://www. c-sc. gc. ca/canusa/papers/canada/english/indigen. htm Forced Sterilization of Native Americans. (n. d.). In Encyclopedia Net Industries online. Retrieved from http://encyclopedia. jrank. org/articles/pages/6242/Forced-Sterilization-of-Native-Americans. html Gerber, L. M. (1990). Multiple jeopardy: A socio-economic comparison of men

and women among the Indian, Metis and Inuit peoples of Canada. Canadian Ethnic Studies, 22(3), 69-84. Morrison, G. T. , & Morrison, A. M. (Eds.). (2008). The psychology of Modern Prejudice. New York, NY: Nova Science Publishers, Inc. Nelson, D.

T. (2006). The Psychology of Prejudice. Boston, MA: Pearson Education, Inc. O’Neil, J. D. (1989). The cultural and political context of patient dissatisfaction in cross-cultural clinical encounters: A Canadian Inuit study. Medical Anthropology Quarterly, 3(4), 325-344 Stats Canada. (2006). First Nations Health Care. Retrieved from http://www12. statcan. ca/census-recensement/2006/index-eng. cfm Voyageur, C. J. (1996). Contemporary Indian women. In D. A. Long & O. P. Dickason (Eds.), Visions of the heart: Canadian aboriginal issues (pp. 93-115). Toronto, Canada: Harcourt Brace