



Saskatchewan



Notes

Volume 3 Issue 1 — January 2004

Aboriginal Women and Home Care in Saskatchewan

— by *Erika Haug and Shelley Thomas Prokop*

Aboriginal women have always played a central role as caregivers and healers within their families and communities. Over the course of their lives, many Aboriginal women will go back and forth between being care providers and requiring care themselves. As is the case with other Canadian women, providing care has been a taken for granted part of Aboriginal women's unpaid work in the home. While women in Canada provide 80 percent of caregiving which includes both paid and unpaid work, this gender discrepancy is arguably even higher in Aboriginal communities due to a number of factors including cultural values of caring for family and community members, lack of services, and lack of professional training opportunities.

The availability of home care services is particularly important to Aboriginal women for many reasons. First, many Aboriginal women with disabilities, activity limitations, and chronic health problems could benefit from home care services that enable them to remain at home and participate in their communities. Second, as the primary care providers, women are disproportionately affected by the care needs of others and access to appropriate health services. Third, home care is important to Aboriginal women because alternatives to home care, such as institutional care, may not exist in their communities, or may not be acceptable due to lack of cultural congruence.

As is the case with other Canadian women, providing care has been a taken for granted part of Aboriginal women's unpaid work in the home.

While home care providers and recipients have already been identified as being marginalized by the policy making process (Morris, 2002), Aboriginal women are one of the most politically, socially, and economically marginalized populations in Canada. They experience multiple barriers to participating in broader policy decisions that directly affect their lives. Aboriginal women experience chronic diseases, poverty, and systemic discrimination at a much higher level than the general Canadian population.

At the same time, Aboriginal women bring unique knowledge and expertise, based upon traditional holistic understandings of health, to the domain of home care. Therefore, it is extremely important that Aboriginal women become not just objects but subjects of home care policy and program development, so as to ensure that home care programming is shaped by their culture, values, aspirations, healing gifts, vision, and understandings of health.

To date, the literature on home care in Canada has failed to include any studies focused specifically on Aboriginal women's experiences as home care providers and recipients. There have been no studies conducted to explore their unique experiences as formal (paid) home care providers, informal (unpaid) caregivers, or care recipients. As well, there remains a major gap in terms of policies

(continued on page 2...)

and programs that specifically address home care training, employment, and service provision for Aboriginal women. It has been recognized that caregivers and care recipients in Aboriginal and other minority communities face racism and language and cultural barriers that make them more disadvantaged and less well served than others (Morris, 2002). However, there has been no further investigation of how these barriers affect Aboriginal women's experiences of home care. Aboriginal women are largely absent in the research on gender and home care, and home care is largely absent in the research on Aboriginal women's health.

The lack of studies on Aboriginal women and home care is due, in part, to the complex and problematic terrain of terminology used to refer to Aboriginal people, which is the inheritance of colonization. According to the *Canadian Oxford Dictionary*, the term Aboriginal refers to all people "inhabiting or existing in a land from the earliest times or from before the arrival of colonists". The *Indian Act* however, has sub-divided Aboriginal people into the categories Indian, Inuit, and Metis. Each of these groups has been further sub-divided into various categories. For example, Indian people are either status or non-status while status people are either treaty or non-treaty. The term "First Nations", which many view as politically, historically, and culturally more appropriate than the terms "Native" or "Indian", includes Indian and Inuit people, but not Metis people because Metis people did not sign treaties with the crown.¹

Thus, in view of the complex jurisdictional environment in which home care is conducted, it is very difficult to speak in blanket terms about the context of homecare service delivery for, and by, Aboriginal women because service provision varies so much depending on which category of Aboriginal women is being considered.

...Aboriginal women are one of the most politically, socially, and economically marginalized populations in Canada. They experience multiple barriers to participating in broader policy decisions that directly affect their lives.

Ideally, a truly "indigenized" home care program is founded on Aboriginal worldviews, knowledge, beliefs, and understandings of health and illness, and utilizes Aboriginal healing methodologies.

Depending upon their individual status with the federal government, Aboriginal people have very different access to services. For example, off-reserve First Nations and Metis people generally fall under provincial jurisdiction when it comes to home care services, and, in most cases, will not have access to Aboriginal homecare programs.

Aboriginal governments, in Saskatchewan particularly, have identified the importance of home care services to enable those who need care to remain in their own communities. A report prepared by the Federation of Saskatchewan Indian Nations (FSIN) entitled *Homecare on Reserve: A*

Framework noted:

The vision of the Elders, handicapped and chronically and acutely ill, is to continue to live productive, useful lives in their homes, close to their families, in their communities...and [to] help maintain culture, language and traditions....Their vision for home-care on-reserve is a guarantee that [First] Nations will have the authority and finances to help them live and contribute always to their communities. (1990, p. 7)

The Saskatchewan Indian Institute of Technology (SIIT) was the first site in Canada to offer the Home Health Aide Program that was designed specifically for Aboriginal students. The SIIT program is designed to provide students with the learning experiences required to function competently as health service workers in Aboriginal communities. This program, along with its sister programs across Canada, has been largely welcomed as a positive development, resulting in increased training and employment opportunities for women, financial compensation for home care previously done without pay, and increased quality of care.

(continued on page 3...)

¹ Therefore, in order to include Metis people in our discussion, we have used the term "Aboriginal".

A common challenge for home care training programs to resolve has been lower formal education levels of potential students vis a vis requirements based on Euro-Canadian contexts and standards. While many potential students bring a wealth of life experience and expertise as caregivers and healers in their communities, due to multiple interlinking factors of colonization, inferior formal education received from residential schools, and poverty, formal education levels for Aboriginal adult learners are often significantly lower than the general Canadian population.

Aboriginal home care can be seen as situated within the contested territory of two different ways of knowing and understanding health. Whose knowledge is represented and privileged in home care educational programs, and to what degree? What happens when there is a conflict between these two paradigms? While Aboriginal home care education programs seek to provide training that is culturally congruent, in some contexts this has meant only superficial adaptations, resulting in Aboriginal people delivering programs and services that are still based on non-Aboriginal models of health and healing. Ideally, a truly “indigenized” home care program is founded on Aboriginal worldviews, knowledge, beliefs, and understandings of health and illness, and utilizes Aboriginal healing methodologies.

While undoubtedly numerous benefits to the professionalization of home care services exist, the shift from informal to formal care provision cannot be naively assumed to be a unilateral good, and critical questions must be asked about its impact. The professionalization of care can represent a shift away from land based holistic paradigms to bio-medical paradigms founded in capitalist

market based systems and structures. When services and systems embedded within an Aboriginal cultural context are transformed according to European models of health care delivery, the impact on traditional healers, medicine people, and midwives, who have experienced centuries of colonial domination by Western medical, religious, and social institutions, must be carefully considered. As well, we must ask to what extent home care training actually re-inscribes gender oppression, taking Aboriginal women from unpaid to paid caregiving, but keeping them restricted in an occupation that offers little upward mobility, few professional development opportunities, and low salaries (Browne, 2000).

In sum, the ongoing development of culturally appropriate home care services that best reflect the needs, circumstances, and rich healing traditions of Saskatchewan Aboriginal women and

their communities, is critical. As the primary providers of home care, both formally and informally, Aboriginal women, and particularly, Elders, as traditional community leaders, must be

As the primary providers of home care, both formally and informally, Aboriginal women, and particularly, Elders, as traditional community leaders, must be at the forefront of envisioning, creating, and implementing Aboriginal home care research, policies, training, and services.

at the forefront of envisioning, creating, and implementing Aboriginal home care research, policies, training, and services. Addressing this need is of great concern as the demand for Aboriginal health care services continues to increase. Building community capacity to provide home care service to Aboriginal people must be done in a fashion that respects the diverse traditions and cultures of Aboriginal people. As an extension of Aboriginal culture, home care is a vital component to the well being of Aboriginal communities as a whole. ❖

REFERENCES

- Browne, P.L. (2000). *Unsafe practices: Restructuring and privatization in Ontario health care*. Ottawa: Canadian Centre for Policy Alternatives.
- Federation of Saskatchewan Indian Nations (FSIN). (1990). *Homecare on reserve: A framework*. Saskatoon, SK: FSIN.
- Morris, M. (2002). *Gender-sensitive home and community care and caregiving research: A synthesis paper*. Ottawa: Women's Health Bureau, Health Canada.

A fuller version of this paper will be published in *Caring For/Caring About: Women, Home Care and Unpaid Caregiving* (2004), Karen R. Grant, Carol Amaratunga, Pat Armstrong, Madeline Boscoe, Ann Pederson, and Kay Willson, (eds.). Aurora, ON: Garamond Press.

Erika Haug is a Saskatoon resident of Scandinavian descent who teaches in the Indian Social Work program at the First Nations University of Canada in Saskatoon, and is a Research Associate with the Saskatchewan Office of the Canadian Centre for Policy Alternatives.

Shelley Thomas Prokop is a member of Beardy's and Okemasis First Nation, currently teaches at the First Nations University of Canada, and formerly managed the home care program at the Saskatchewan Indian Institute of Technology (SIIT).

The Canadian Centre for Policy Alternatives—Saskatchewan (CCPA-SK) is an independent, non-partisan research organization. Studies undertaken by CCPA-SK will arise from a community, collective, and social concern.

CCPA-SK Saskatchewan Notes are produced and distributed electronically. They can be reproduced as an OpEd or opinion piece without obtaining further permission, provided they are not edited and credit is given.

If you would like to receive the **Saskatchewan Notes** please contact CCPA-SK to begin your free subscription.

Canadian Centre for Policy Alternatives – SK

2717 Wentz Ave., Saskatoon, SK S7K 4B6

Ph: 306-978-5308 — Fax: 306-922-9162

Email: ccpasask@sasktel.net / Website: www.policyalternatives.ca/sk