



“They treated me like crap and I know it was because I was Native”: The healthcare experiences of Aboriginal peoples living in Vancouver's inner city



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ABSTRACT

There is growing evidence that Aboriginal peoples often experience healthcare inequalities due to racism. However, research exploring the healthcare experiences of Aboriginal peoples who use illicit substances is limited, and research rarely accounts for how multiple accounts of stigma intersect and contribute to the experiences of marginalized populations. Our research aimed to explore the healthcare experiences of Aboriginal peoples who use illicit drugs and or illicit alcohol (APWUID/A) living in Vancouver's inner city. Using Indigenous methodologies, a community research team comprised of APWUID/A led the study design, data collection and analysis. Peer-facilitated talking circles explored community members' experiences accessing healthcare services and patient-provider encounters. Using an intersectionality framework, our research demonstrated how healthcare inequalities among Aboriginal peoples are perpetuated by systemic racism and discrimination. Stigmatizing racial stereotypes were perceived to negatively influence individual attitudes and clinical practice. Participants' experiences of medical dismissal often resulted in disengagement from care or delay in care. The findings suggest healthcare providers must understand the structural and historical forces that influence racial disparities in healthcare and personal attitudes in clinical practice. Adequate clinical protocols for pain management within the context of illicit substance use are urgently needed. The valuation of Aboriginal peoples and cultures within healthcare is paramount to addressing the health gap between Aboriginal and non-Aboriginal Canadians.

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1. Introduction

Significant disparities in health and access to healthcare persist in a range of settings globally regardless of levels of income or development (Beiser and Stewart, 2005; Boutain, 2005). This is true of Canada, which despite being praised for its universal healthcare system, still fails in meeting the healthcare needs of many of its most vulnerable citizens. Such inequalities in care are concerning given healthcare access is an important determinant of health status (Marmot et al., 2008).

Studies have revealed that access to healthcare, including ability to obtain required services and quality of care delivered, is not equal across populations; for example, marginalized groups such as racial and ethnic minorities, substance users, the homeless, and the poor have less access to and utilization of healthcare services (Knowlton et al., 2001; Chitwood et al., 1999, 2001). Due to an overburden of health and social disparities (Adelson, 2005; Reading and Wien, 2009; Frohlich et al., 2006; MacMillan et al., 1996; Allard et al., 2004), Canada's Aboriginal groups, who refer to the Indigenous people of Canada including First Nations, Métis, and Inuit peoples, represent a population that is particularly vulnerable to healthcare inequities (Adelson, 2005). Aboriginal peoples experience significant disparities in health status, morbidity and mortality rates, and healthcare access compared to their non-Aboriginal counterparts (Adelson, 2005; MacMillan et al., 1996; Shah et al.,

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2003; Waldram et al., 2006; Marrett and Chaudhry, 2003). Moreover, these inequities are not evenly distributed within the Aboriginal population with urban populations experiencing greater disparities than those living on-reserve (Tjepkema, 2002; Young, 2003). With comparatively higher rates of homelessness, suicide, tuberculosis, HIV/AIDS, and diabetes, and an increased risk of substance abuse (Public Health Agency of Canada, 2014), urban Aboriginal peoples are likely to experience immense vulnerability to health-related harms. This is of concern for two reasons: firstly, off-reserve communities are of the largest and fastest growing Aboriginal communities in Canada with more than half of the total Aboriginal population living in urban areas (Statistics Canada, 2011); and secondly, improved access to healthcare is one of many reasons why Aboriginal peoples choose to relocate to urban centres (Peters and Newhouse, 2003).

Vancouver is home to the largest urban Aboriginal population in British Columbia, as well as Canada's poorest urban postal code - the Downtown Eastside (DTES) (Cardinal and Adin, 2005). The DTES is a neighbourhood characterized by high rates of poverty, homelessness, substance use, mental health issues, and violence, as well as immense social and economic marginalization (Werb et al., 2010; Kazempiur and Halli, 2000; Miller et al., 2002; Spittal et al., 2002; Wood and Kerr, 2006; Shannon et al., 2008). Such chronic inequalities can be understood as a manifestation of "multiple historical and interlocking mechanisms of poverty and exclusion" (Schatz, 2010), which are revealed in the overrepresentation of Aboriginal peoples in the DTES with at least one-third of the city's total Aboriginal population residing in or near the impoverished area (Cardinal and Adin, 2005). For Aboriginal peoples, these mechanics are controlled and maintained by ongoing colonial processes inherently racist by nature. These grave inequities signal the ways in which the colonial legacy has perpetuated the devaluation of Aboriginal peoples as Canadian citizens, undeserving of equal human rights.

The Canadian Health Act stipulates that all citizens should have access to timely and medically necessary care based on need rather than income (Health Canada, 2012). Access to appropriate healthcare services is essential to addressing the health disparities facing Aboriginal peoples (Adelson, 2005). For Aboriginal peoples, access to healthcare is not only defined by physical access, but is mediated by wider social and historical contexts, and clinical practice (O'Neil, 1989; Browne, 1995; Cameron et al., 2014a). Mainstream healthcare services, medical services relying on western medicine and conventional public health approaches, tend not to address the social and economic determinants that greatly affect individual health, and rarely do services accommodate for cultural differences. Without understanding the social and historical contexts of the current health status of Aboriginal peoples, racialized stereotypes (e.g., 'drunken Indian') prevail. Internalizing negative assumptions about Aboriginal peoples has allowed for systemic racism and discrimination to permeate many facets of society, including the healthcare system (Elliott and de Leeuw, 2009).

In the emerging literature, racism and stigmatization are identified as being at the forefront of Aboriginal peoples' healthcare experiences (Browne and Fiske, 2001; Browne et al., 2011; Anne Van Herk et al., 2011). Much of the current research focuses on First Nations, and in particular First Nations women (Elliott and de Leeuw, 2009; Browne et al., 2011; Benoit et al., 2003; Fiske and Browne, 2006; Denison et al., 2014), while primarily examining hospital care (Shah et al., 2003; Wood and Kerr, 2006; Browne and Fiske, 2001). In doing so, there is limited understanding of encounters with other actors within the healthcare system and alternate important points of care such as general physicians, walk-in clinics, medical laboratories, and pharmacies, and the experiences of the Métis and Inuit or those who identify more broadly

under the Aboriginal umbrella.

Despite the mass evidence of Aboriginal health disparities and the growing indication of healthcare inequalities in North America, and among other colonized Indigenous groups (e.g., Australia and New Zealand) (Marrone, 2007), research exploring the healthcare experiences of Indigenous peoples who use illicit substances is limited. Furthermore, to the best of our knowledge, no other group of Indigenous peoples who use substances has ever executed a similar study as the one presented here. As is being increasingly recognized, it is important to understand how multiple accounts of stigma (e.g., illicit substance use, homelessness, poverty) intersect and contribute to the experiences of marginalized populations. As Bowleg (2012) notes, such intersecting social identities are typically examined as independent systems opposed to interlocking mechanisms that work together to shape individual health, and policy and research often do not acknowledge "how the intersection of multiple interlocking identities at the micro level reflects multiple and interlocking structural-level inequality at the macro-levels of society" (p. 1267). This is a pressing issue given the immense disparities affecting Aboriginal peoples. The dearth of public health research that uses intersectionality as a framework may partially account for why efforts to address these appalling health and social inequities have failed. Using an intersectionality framework, this article seeks to explore how multiple forms of discrimination and oppression shape the healthcare experiences of Aboriginal peoples living in a marginalized community.

2. Method

In response to a critique of the appropriateness of traditional research methods typically used in the DTES, the Western Aboriginal Harm Reduction Society (WAHRS) partnered with the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE) to conduct the research presented here. WAHRS is an Aboriginal organization who represent Aboriginal peoples who use illicit drugs and or illicit alcohol (APWUID/A), current and former users, dedicated to harm reduction. Illicit alcohol is defined as alcohol that is not intended for human consumption (e.g., mouthwash) or is illegally produced (e.g., homemade alcohol). In an effort to further counter the historical power imbalance between research institutions and community partners, the community organization determined the research topics, the methods used, and led all data collection and analysis using approaches that drew upon Indigenous ways of knowing and sharing. The BC-CfE researchers provided academic and research support, which included a designated research coordinator for the project.

Talking circles were chosen as a culturally appropriate research method, and represent a common form of intragroup communication among many North American Indigenous groups and are intended for collaborative learning and decision-making (Hodge et al., 1996; Strickland, 1999). A total of three talking circles took place in the DTES at the Vancouver Area Network of Drug Users, each averaging 60 min in length. Convenience sampling was used to recruit participants, which was undertaken during the organizations' weekly membership meetings. During the meetings, members were invited to participate in the talking circles. As each talking circle was limited to ten participants, the names of those who were interested in participating were entered into a draw to be selected. This selection process is an approach adopted by the organization regularly to provide equal opportunity to their membership for involvement in research and various other activities, and was employed in this research to accommodate the group's regular practices and avoid intragroup conflict. In total, 30 individuals ranging from 19 to 70 years of age participated in the talking circles. With the exception of the first talking circle, which

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