Racism, Sexism, and Colonialism

The Impact on the Health of Aboriginal Women in Canada

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Cet article suggère que les pratiques et les politiques contemporaines qui affectent les femmes autochtones créent une menace pour leur santé. Il est démontré que la définition d' "Indien" imposée par la législation colonialiste au Canada constitue de multiples oppressions qui dépossèdent les femmes autochtones de leur pouvoir, augmentant les risques pour leur santé.

Aboriginal women in Canada carry a disproportionate burden of poor health. Aboriginal women have lower life expectancy, elevated morbidity rates, and elevated suicide rates in comparison to non-Aboriginal women (Prairie Women's Health Centre of Excellence, 2004). Aboriginal women living on reserves have significantly higher rates of coronary heart disease, cancer, cerebrovascular disease and other chronic illnesses than non-Aboriginal Canadian women (Waldram, Herring, and Young, 2000). A significantly greater percentage of Aboriginal women living off-reserve, in all age groups, report fair or poor health compared to non-Aboriginal women; 41 per cent of Aboriginal women aged 55–64 reported fair or poor health, compared to 19 per cent of women in the same age group among the total Canadian population (Statistics Canada). In addition, chronic disease disparities are more pronounced for Aboriginal women than Aboriginal men. For example, diseases such as diabetes are more prevalent among Aboriginal women than either the general population or Aboriginal men (Statistics Canada).

Epidemiologists suggest that many of these chronic health conditions are a result of the forced acculturation imposed on Aboriginal peoples (Young 1994). Yet, for Aboriginal women, low income, low social status, and exposure to violence also contribute to poor health. Aboriginal women face the highest poverty and violence rates in Canada. Joyce Green (2000) notes that in 1991 eight out of ten Aboriginal women reported victimization by physical, sexual, psychological, or ritual abuse; this rate is twice as high as that reported by non-Aboriginal women. These issues are evident in Saskatchewan where the Saskatchewan Women's Secretariat (1999) determined that at least 57 per cent of the women who used shelters in 1995 were of Aboriginal ancestry, yet they comprised only 11 per cent of the total female population. These numbers reflect the magnitude of the problem. Redressing these injustices requires awareness of the processes that create negative health consequences and mobilization of action to correct these processes. The Saskatchewan Women's Secretariat notes: "Studies have shown that health differences are reduced when economic and status differences between people, based on things such as culture, race, age, gender and disability are reduced" (44).

Gender and ethnicity have been shown to be influential determinants of health across populations. Conceptual distinctions between definitions of "gender" and "sex" have led to our understanding that the processes of sexism (such as increased exposure to violence) are more likely to contribute to women's poor health than biological or genetic differences between women and men. Similarly, conceptual distinctions between definitions of "ethnicity" and "race" in population health research suggests that "race" is used to describe natural units or populations that share distinct biological characteristics; whereas ethnic groups are seen as being culturally distinct (Polednak). In population health research, these two terms are used interchangeably, often leaving out a discussion of the processes by which racism creates conditions of poor health for certain ethnic groups (Young 1994). Racism is a biopsychosocial stressor that has severe negative health effects on racialized individuals (Clark, Anderson, Clark and Williams). Sexism is blatantly dangerous to women's health in many ways (Lips). Racism and sexism have this in common; they operate via external power structures to contribute to poor health in certain disadvantaged groups. Research suggests that culture and cultural differences also have an impact on health (Amaratunga; Wienert). However, little is written about how what we describe as culture

can be the outcome of colonial processes. Cultural groups that have lived under colonization experience a legacy of oppression that adds another level of threat to their health. Indigenous Peoples as distinct cultural groups have been exposed to genocide to further the interests of colonization (Chrisjohn and Young; Tuhiwhai Smith). We will illustrate that this colonization and its contemporary manifestations in the policies and practices that affect Aboriginal women create unique threats to their health status. Our analysis will demonstrate that the process by which the definition of "Indian" is imposed by colonial legislation in Canada constitutes a form of multiple oppressions that differentially disempower Aboriginal women, conferring particular risks to their health.

Women who bear their "otherness" in more than one way suffer from multiple oppressions, leaving them more vulnerable to assaults on their well-being.

Links between Sexism, Racism, Colonialism and Aboriginal Women's Health

Sexism, racism, and colonialism are dynamic processes rather than static, measurable determinants of health; they began historically and continue to cumulatively and negatively impact health status of Aboriginal women. Colonialism depends on the oppression of one group by another, beginning with a process described as "othering" (Gerrard and Javed). The process of "othering" occurs when society sorts people into two categories: the reference group and the "other." Women who bear their "otherness" in more than one way suffer from multiple oppressions, leaving them more vulnerable to assaults on their well-being than if they suffered from one form of oppression. The cumulative effects have painful material, social, and health consequences. We offer an example of the process of "othering" imposed on Aboriginal women through colonial legislation defining Indian identity between the years 1869–1985; these policies continue to influence women's health and well-being today. Using this example, we will deconstruct the process of colonialism and reveal its consequences for Aboriginal women and their health.

We describe ways in which the *Indian Act* differentially affects Aboriginal women and men in Canada; it is a case example of multiple oppressions. Colonial discourse has historically represented non-white populations as racially inferior. These assumptions have been used to justify social treatment of these populations that fosters inequality and social exclusion in all areas, ultimately contributing to poor health conditions in the oppressed group. Linda Tuhiwai Smith notes that racism, sexism, and colonialism (through the process of "othering") serve to describe, objectify, and represent Indigenous women in ways that have left a legacy of marginalization within Indigenous societies as much as within the colonizing society. She points out that racist and sexist notions about the role of women were imposed upon Indigenous communities by white, European settlers with patriarchal consciousness. "Colonization," she notes, "is recognized as having had a destructive effect on Indigenous gender relations which reached out across all spheres of Indigenous society." Sexism, racism, and colonialism have had a negative impact on Aboriginal women's identities, our sense of who we are, and where we belong. We argue that gender differences in the process of "othering" have forced Aboriginal women to challenge the racist, sexist, and colonial policies within and beyond our communities. We further suggest that accumulated disadvantage from past colonization and contemporary processes of ongoing colonization have a direct affect on Aboriginal women's access to social determinants of health and impedes their ability to develop a healthy sense of identity that can contribute to personal well-being.

Impact of Aboriginal Identity on Health and Well-being

An insidious result of colonialism has been the externally imposed definition of Indian identity through processes that create cultural ambiguity for Aboriginal women (Mihesuah). Bonita Lawrence (1999) argues that although Euro-Canadian legislation has affected what she terms "native identity" across gender lines, it has had greater impact on Aboriginal women. Consequently, significant gaps exist between material, social, and health outcomes for Aboriginal men and Aboriginal women. However, racist underpinnings of colonialism have also produced gaps *amongst and between* Aboriginal women themselves (Saskatchewan Women's Secretariat). For example, Métis women in Saskatchewan are more likely to be employed than status Indian women but less likely to be employed than non-Aboriginal women. Hence, sexism, racism and colonialism have converged to create a matrix of oppression that differentially affect specific Aboriginal groups and men and women within those groups.

Cultural identity evidently has implications for the status that women have in the external world and this has an impact on health. However, identity also has implications for feelings of self-worth and belonging, and this has an impact on health as well. A recent study conducted with Aboriginal women in Manitoba by the Prairie Women's Health Centre of Excellence found that Aboriginal women endorsed important links between health and wellness and their cultural identities. Cultural identities were inseparable from their family, history, community,

place, and spirituality and all of these elements were integrated into a broad and holistic understanding of health and well-being. The women acknowledged that many factors shaped their health and well-being including poverty, housing, violence, and addictive behaviours, however, cultural identity served as a potential anchor to help them deal with these issues and promote health. Accordingly, they made recommendations for health practices that integrated holistic solutions that included "traditional cultural practices and understandings with respect to health and wellness" (24). This suggests that women who are Aboriginal can look to cultural identity as a foundation on which they can build healthy lives, however, for women who cannot draw on a firm sense of cultural identity, maintaining and promoting health could be more difficult. Unfortunately, there are large numbers of women who are in the latter position. It is through this removal of cultural identity and status within Aboriginal groups that Canadian legislation has produced a significant threat to the health and well-being of many Aboriginal women.

Colonization as an Instrument of Multiple Oppressions for Aboriginal Women in Canada: *Indian Act* Legislation

The *Indian Act*, passed in Canada in 1876, defined Indian identity and prescribed what "Indianness" meant. Because of the sexist specification inherent in this legislation, ramifications of the *Indian Act* were more severe for Aboriginal women than men, ramifications that continue to have severe impacts on our life chances today. Lawrence (2000) notes that the *Act* ordered how Aboriginal people were to think of all things "Indian" and created classifications that have become normalized as "cultural differences". She argues that the differences between Métis (or mixed ancestry people), non-status Indians, Inuit, and status Indians were created by the *Act* and those differences became accepted in Canada as being cultural in nature when, in fact, they were social constructions imposed by legislation. It should be acknowledged that cultural distinctions did and do exist within and amongst Aboriginal people; however, those cultural distinctions were never categorized nor embedded in legislation prior to 1876 and did not have the same impact until commencement of the *Act*. Indigenous scholars agree that the *Indian Act* has controlled Aboriginal identity by creating legal and non-legal categories that have consequences for rights and privileges both within and beyond Aboriginal communities (Lawrence 2000; Mihesuah).

One important consequence of the *Indian Act* is that status Indian women (hereafter referred to as Indian women) who married non-Indian men lost their Indian status and their band membership under this *Act*. Prior to 1869, the definition of Indian was fairly broad and generally referred to "all persons of Indian blood, their spouses and their descendents" (Voyageur 88). After 1869, Indian women who married non-Indians were banished from their communities since non-Indians were not allowed on reserves; this was true even if a divorce occurred (McIvor). From the government's perspective, these women had assimilated and had no use for their Indian status. The goal of assimilation was a central element of the *Indian Act 1876* because it would advance the government's policy of genocide through the process of enfranchisement: the removal of Indian status from an individual. Section 12(1)(b) of the *Act* specified that

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Indian women would lose their status if they married a non-Indian man. Further, Indian women could not own property, and once a woman left the reserve to marry she could not return to her reserve so she lost all property rights. This legacy of disenfranchisement was passed on to her children (Wotherspoon and Satzewich). In contrast, an Indian man who married a non-Indian woman not only retained his Indian status, but the non-Indian woman would gain status under the *Act*, as would their children. Even upon divorce or the death of her husband, a non-Indian woman who gained status under the *Act* through marriage retained her status and band membership as did her children (Voyageur). Only the identity of Indian women was defined by their husband and could be taken away. The imposition of this Euro-centric, sexist ideology on Aboriginal families was a direct disruption of traditional Aboriginal definitions of family. Under *Indian Act* legislation, enfranchised Indians were to become Canadian citizens and, as a result, they relinquished their collective ties to their Indian communities (Lawrence 1999). However, Indian women were not granted the benefit of full Canadian citizenship. Lawrence notes that until 1884, Indian women who had lost their status could not inherit any portion of their husband's land or assets after his death. After 1884, widows were allowed to inherit one-third of their husband's land(s) and assets if "a widow was living with her husband at his time of death and was determined by the Indian Agent to be 'of good moral character'" (Lawrence 1999: 56). Furthermore, if a woman married an Indian from another reserve, the *Act* stated that she must follow her husband and relinquish her band membership in order to become a member of his band. If her husband died or if she divorced him, she could not return to her reserve, as she was no longer a member. These policies governing marriage and divorce were just one of

several ways that Aboriginal women were stripped of their rights and privileges. For example, from 1876 to 1951 women who married Indian men and remained on the reserve were denied the right to vote in band elections, to hold elected office, or to participate in public meetings. However, Indian men were eligible to take place in all of these activities (Voyageur). Therefore, colonization was an instrument by which sexism and racism were created and reinforced on and off reserve lands, converging in diminishing power and resources available to Aboriginal women in Canada.

participation in their communities. For example, the *Corbiere Decision in 1999 (John Corbiere et al. v. the Batchewana Indian Band and Her Majesty the Queen)* specified that Indian women living off-reserve could not vote in band elections because the *Indian Act* stated that Indian members must "ordinarily live on reserve" in order to vote. Thus, reinstated Indian women and their children were still at a disadvantage despite having legal recognition under the *Act.*[1]

In the end, the amendments did not repair the damage of previous legislation. Kinship ties, cultural ties, and participation in governance were significantly disrupted. Long term consequences for these women and their children would include the erosion of connections and rights that may have enabled them to work collectively to address social disparities.

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Passage of the *Charter of Rights and Freedoms* made gender discrimination illegal and opened the door for Aboriginal women to challenge the Indian Act. In 1967, Aboriginal women lobbied both the federal government and Indian bands for amendment to the *Act.* Sharon McIvor notes that in *Lavell v. Her Majesty (1974)* Aboriginal women challenged the government based on the argument that the government had been discriminating against Indian women for over 100 years via the *Indian Act.* The Supreme Court of Canada, however, ruled that since Canada had jurisdiction over Indians it could decide who was an Indian and that the *Act* was not discriminatory. Continual lobbying by Aboriginal women finally resulted in action and the *Act* was amended in 1985 through passage of *Bill C-31.*

However, despite the amendment, long-standing implications of the *Indian Act* for Aboriginal women in Canada are still evident. As Lawrence notes, the government's "social engineering process" (1999: 58) via the *Act* ensured that between 1876 and 1985 over 25,000 women lost their status and were forced to leave their communities. All of their descendants lost status and were "permanently alienated from Native culture, the scale of cultural genocide caused by gender discrimination becomes massive" (Lawrence 1999: 59). She notes that when *Bill C-31* was passed in 1985, there were only 350,000 female and male status Indians left in Canada. *Bill C-31* allowed individuals who had lost status and their children to apply for reinstatement. Approximately 100,000 individuals had regained status by 1995, but many individuals were unable to regain status. Under *Bill C-31,* grandchildren and great-grandchildren were not recognized as having Indian status and, in many cases, no longer identified as Indian (Lawrence 1999; Voyageur). In addition, legislative decision still blocked Aboriginal women from full

It is ironic that the only recourse Aboriginal women have is to appeal to the federal government and judicial system—the same government and system that instituted and upheld the sexist, discriminatory and oppressive legislation for over 100 years. This government holds different principles of justice than traditional Aboriginal government, leaving women once again vulnerable to multiple oppressions. As Jan Langford writes, "If First Nations governments are built on the traditional Aboriginal way of governing where equity is built into the system, there wouldn't be a need for the 'white' ways of protecting rights" (35). However, band governing bodies are not working according to the traditional Aboriginal way, instead using legislation to exclude women and protect male privilege.

After fighting for the recognition of Aboriginal rights, Aboriginal women have found themselves at odds with some of their own community leaders. Indian women and their children have not been welcomed back to their communities. Since the 1980s, when the federal government began the process of devolution of control to Indian bands, band governments have been able to refuse band membership. It should be noted that there has been an influx of status Indians going to their bands to seek membership. However, the government has consistently refused to increase funding to those bands. Cora Voyageur notes that some bands have not given band membership to people given status by the federal government because they do not have the resources or the land base to do so. Most reserves are already overcrowded, and many feel that

conditions will worsen if a rush of reinstated Indians want to return to the reserve. Some reinstated Indians are referred to as "C-31s," "paper Indians" or "new Indians" (Voyageur). In addition, many of these individuals may have previously been identifying with Métis or non-status Indian communities and were rejected not only by their Indian communities but also by the communities with which they had identified. As Lawrence (1999) reports that resistance to acknowledging the renewed status of those reinstated under Bill C-31 has been expressed throughout the Native press.

Furthermore, women have been formally excluded from constitutional negotiations as a result of patriarchal legislation that was applied in the federal government's decision to exclude them. The Native Women's Association of Canada (NWAC) has argued that the interests of individual Aboriginal women should not be overshadowed by collective social values and operational mandates that may be enshrined in customary law (Jackson 2000). However, Aboriginal women find themselves caught between bands who appeal to traditional practices to avoid action and a federal government that avoids involvement in deference to self-government (Green 2001).[2] In this way, government intrusion has succeeded in ensuring that divisions among Aboriginal people are maintained, if not more firmly entrenched.

Finally, as Lawrence (1999) argues, "Who am I?" and "Where do I belong?" are common questions among what she calls "people of mixed-race Native heritage." She examines the impact of the *Indian Act* and *Bill C-31* on Métis people in addition to Indian people and argues that the *Act* has externalised mixed-race Native people from Indianness and that this has implications for Native empowerment. What this discussion reveals is that other Aboriginal peoples have also been affected by these policies and this has likely had consequences for identity, empowerment, and quality of life of all Canada's indigenous peoples..

Implications for the Health of Aboriginal Women in Canada

A review of the post-contact history of indigenous peoples in Canada clearly demonstrates that direct practices of genocide have transformed into legislated control of Aboriginal identity and colonization-based economic, social and political disadvantage that disproportionately affects Aboriginal women. The government's definition of who can be called Indian, who cannot and who must exist in liminal spaces where they are outsiders both on and off reserve lands clearly has implications for citizenship, but it also has implications for access to health services and ability to maintain health and well-being. With this knowledge, we must re-examine data that suggests Aboriginal women are excessively vulnerable to cerebrovascular disease, coronary heart disease, diabetes, suicide cancer, depression, substance use, HIV/AIDS, and violence/abuse in light of how colonization and post-colonial processes have conferred risks to the health of Aboriginal women, and barriers to accessing quality health care. It is these risks and barriers that contribute to rates of morbidity and mortality that are well above those of the average Canadian woman.

At a fundamental level, we understand that the colonization processes that began many years ago and continue today have material and social consequences that diminish access to social determinants of health for both Aboriginal men and Aboriginal women. Yet, as we have discussed, women have been especially marginalized through these processes and their lower social status is reflected in diminished resources and poor health. Health consequences for women have been identified, but largely within a western model of equating health with the absence of disease or illness (Newbold). The wounds that result from the cultural ambiguity imposed on Aboriginal women are harder to catalogue. They are perhaps demonstrated to us in the plight of the Aboriginal women of Vancouver's Downtown Eastside. This neighbourhood is home to thousands of Aboriginal women who have been displaced from their reserve communities and extended families (Benoit, Carroll and Chaudhry). They are socially and culturally isolated, living in poverty, and often driven to substance use, violent relationships, and the street sex trade to survive and provide for their children (Benoit *et al.*). Their material circumstances force acts of desperation, but the damage that has been done to their cultural identities can leave them without the foundation to cultivate health and well-being in their lives. Recent initiatives that have arisen out of results from the First Nations and Inuit Regional Health Survey (National Steering Committee) may offer some hope for these women, but they are still disadvantaged in benefiting from them. First, the development of culturally-appropriate services will not be useful for women who have been excluded from the definition of that culture and excluded from the decision-making structures that will determine how Aboriginal health resources are to be designed and distributed (Benoit *et al.*; Grace). Second, the research that serves as the foundation of these initiatives has not included many Aboriginal women, both because women and children have been overlooked in the work (Young 2003), and because women who do not fit into research-defined categories of "Indian" (derived from Federal categories) have not been included in the data collections.

Conclusions

In conclusion, we reiterate the fact that in Canada, Aboriginal women have faced destruction in our communities, in our families as a result of multiple oppressions. Articulating the process by which the Indian Act differen-

tially marginalizes Indian women is important for our empowerment. Devon Mihesuah notes that there has never been a "monolithic essential Indian woman ... nor has there ever been a unitary world view among tribes" (37). She argues that this never created problems for people until after colonization and resulting genocide of Indian peoples (Chrisjohn and Young). Prior to the sexist specification of the *Indian Act* Aboriginal women were matriarchal in their families. Families thrived with their Aboriginal women's strength and support. Today, Aboriginal women suffer from poorer health than non-Aboriginal women in Canada; they suffer from more chronic diseases than Aboriginal men.

Our goal in writing this paper was to clarify our understanding of the externally-imposed oppressions facing Aboriginal women: to know where to focus our fight and our healing and to show the impact on the health of Aboriginal women. This paper has not examined the impact on Métis women specifically, but they too face similar challenges as a result of colonial policies. Today we find ourselves at peace with our identities, but vigilant against the ever-present social constructions of our identities. We can see the implications this has on our well-being and the well-being of our children. As long as we buy into the arbitrary, patriarchal, sexist, racist, socially constructed labels, we will continue to struggle not only as individuals but also as families and communities.

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[1]The *Indian Act* has had and continues to have implications for Aboriginal women in terms of identity. With the passage of *Bill C-31*, new divisions among Indian people were created. The bill limits the ability of women and their children to pass on their status beyond one generation. That is, grandchildren and great-grandchildren are generally not eligible to apply for status. In addition, while status can no longer be lost or gained through marriage, there are new restrictions on the ability to pass status on to children (Lawrence 1999). For example, the bill divides Indian people into categories by using sub-sections of the *Act*. A 6(1) Indian is defined as an Indian who had status in 1985. A 6(2) Indian is defined as a re-instated Indian under the *Act*. If a 6(1) Indian marries a non-status Indian (including a Métis) then any resulting child from that union will be considered a 6(2) Indian. If that 6(2) Indian child grows up and has a relationship with a non-status Indian the resulting child is a non-status Indian. Thus, once again, status can be eliminated in two generations and grandchildren and great-grandchildren are excluded. It should be pointed out that if a 6(1) has a relationship with a 6(2), the resulting child is a 6(1) Indian. Furthermore, if a 6(2) has a relationship with a 6(2) the resulting child is a 6(1). The message is, if you don't marry back into your race, you risk losing status for your children or grandchildren. Although assimilation policy was supposedly abandoned in 1973 (announced by the Minister of Indian Affairs, Jean Chretien), long-term effects of the *Indian Act* and *Bill C-31* still promotes assimilation. The federal government effectively controls the definition of "Indianness," but communities, families, and individuals live with the consequences and the confusion that arise from that control (Lawrence 1999).

[2]McIvor points out that these violations of civic and political rights of Aboriginal women are violations of their "existing Aboriginal and treaty rights" (35). She argues that the *Sparrow* decision *(Sparrow v. The Queen 1990)* was a landmark Supreme Court ruling that upheld the notion of existing Aboriginal and treaty rights and that this forms part of the inherent right to self-government protected under s. 35 of the *Constitution Act, 1982*. She maintains that self-government is central to Aboriginal nationhood, culture, and existence and, if it is central to the existence of Aboriginal nations, then the ability to determine civil and political rights of members must also be central. This right to self-government thus includes the right of women to define their roles in Aboriginal communities. She states:

> The right of women to establish and maintain their civic and political role has existed since time immemorial. These rights are part of customary laws of Aboriginal people and part of the right of self-government ... they [rights] are those which women have exercised since the formation of their indigenous societies. In some cases, these rights were suppressed or regulated by non-Aboriginal law, such as the *Indian Act*. (35)

References

Amaratunga, C. (2002). *Race, Ethnicity, and Women's Health.* Nova Scotia: Atlantic Centre of Excellence for Women's Health, 2002.

Benoit, C., D. Carroll and M. Chaudhry "In Search of a Healing Place: Aboriginal Women in Vancouver's Downtwon Eastside." *Social Science and Medicine* 56(2003): 821-833.

Chrisjohn, R. D. and S. L. Young. *The Circle Game: Shadows and Substance in the Indian Residential School Experience in Canada.* Penticton, BC: TheytusBooks Ltd., 1997.

Clark, R., N. B. Anderson, V. Clark and D. R. Williams. "Racism as a Stressor for African Americans: A Biopsychosocial Model." *American Psychologist* 54 (10) (1999): 805-816.

Gerrard, N. and N. Javed. (1998). "The Psychology of Women." *Feminist Issues: Race, Class, and Sexuality, 2nd ed.* Ed. N. Mandell. Scarborough, ON: Prentice Hall Allyn and Bacon Canada, 1998. 103-131.

Grace, Sherryl L. "A Review of Aboriginal Women's Physical and Mental Health Status in Ontario." *Canadian Journal of Public Health* 94 (3) (2003): 173-175.

Green J. A. "Canaries in the Mines of Citizenship: Indian Women in Canada." *Canadian Journal of Political Science/Revue Canadienne de Science Politique* 34 (4) (2001): 715-738.

Green, J. A. (2000). "Constitutionalizing the Patriarchy." *Expressions in Canadian Native Studies.* Eds. R. F. Laliberte, P. Settee, J. B. Waldram, R. Innes, B. Macdougall, L. McBain and F. L. Barron. Saskatoon: University of Saskatchewan Extension Press. 328-354.

Jackson, Margaret. (2000) "Aboriginal Women and Self-Government." *Expressions in Canadian Native Studies.* Eds. R. F. Laliberte, P. Settee, J. B. Waldram, R. Innes, B. Macdougall, L. McBain and F. L. Barron. Saskatoon: University of Saskatchewan Extension Press. 355-373.

Lawrence, B. *"Real" Indians and Others.* Unpublished Ph.D. Dissertation. Toronto: UMI Dissertation Services, 1999.

Lawrence, B. "Mixed-Race Urban Native People: Surviving a Legacy of Policies of Genocide." *Expressions in Canadian Native Studies.* Eds. R. F. Laliberte, P. Settee, J. B. Waldram, R. Innes, B. Macdougall, L. McBain and F. L. Barron. Saskatoon: University of Saskatchewan Extension Press. 69-94.

Langford, Jan. (1995) "First Nations Women: Leaders in Community Development." *Canadian Woman Studies/les cahiers de la femme* 14 (4): 34-36.

Lips, H. M. *A New Psychology of Women: Gender, Culture and Ethnicity, 2nd ed.* Toronto: McGraw Hill, 2003.

McIvor, S. D. "Aboriginal Women's Rights as Existing Rights." *Canadian Woman Studie/les cahiers de al femme* 14 (4) (1995): 34-38.

Mihesuah, D. A. Ed. *Natives and Academics: Researching and Writing About American Indians.* Lincoln: University of Nebraska Press, 1998.

National Steering Committee. *First Nations and Inuit Regional Health Survey: Final Report.* Akwesasne Mohawk Territory, 1999.

Newbold, K. B. Problems in search of solutions: Health and Canadian Aboriginals. *Journal of Community Health* 23 (1) (1998): 59-73.

Prairie Women's Health Centre of Excellence. Living Well: Aboriginal Women, Cultural Identity and Wellness – A Manitoba Community Project. Winnipeg: Prairie Women's Health Centre of Excellence, 2004.

Polednak, A. P. *Racial and Ethnic Differences in Disease.* New York: Oxford University Press, 1989.

Razack, S. *Race, Space and the Law: Unmapping a White Settler Society.* Toronto: Between the Lines, 2002.

Saskatchewan Women's Secretariat. *Profile of Aboriginal Women in Saskatchewan.* Regina: Saskatchewan Women's Secretariat, 1999.

Statistics Canada. *Aboriginal Peoples Survey 2001: Well-Being of the Non-Reserve Aboriginal Population.* Ottawa: Cat. no. 89-589-XIE, 2001

Tuhiwai Smith, Linda. *Decolonizing Methodologies: Research and Indigenous Peoples.* New York: Zed Books Ltd., 2002.

Voyageur, C. "Contemporary Aboriginal Women in Canada." *Visions of the Heart: Canadian Aboriginal Issues.* Eds. David Long and Olive P. Dickason. Toronto: Harcourt Canada, 2000. 93-115.

Wienert, D. *Preventing and Controlling Cancer in North America: A Cross-Cultural Perspective.* Westport, CT.: Praeger, 1999.

Waldram, J. B., D. A. Herring, and T. K. Young. *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives.* Toronto: University of Toronto Press, 2000.

Wotherspoon, T. and Satzewich, V. *First Nations: Race, Class and Gender Relations.* Regina: Canadian Plains Research Centre, 2000.

Young, I. M. *Inclusion and Democracy.* Oxford: Oxford University Press, 2000.

Young, T. K. "Review of Research on Aboriginal Populations in Canada: Relevance to their Health Needs." *British Medical Journal* 327 (2003): 419-422.

Young, T. K. *The Health of Native Americans: Toward a Biocultural Epidemiology.* New York: Oxford University Press, 1994.