

SOCIAL EXCLUSION AS AN UNDERLYING DETERMINANT OF SEXUALLY TRANSMITTED INFECTIONS AMONG CANADIAN ABORIGINALS¹

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ABSTRACT

Aboriginal populations suffer a disproportionate burden of infectious disease in Canada; including high rates of sexually transmitted infections (STIs). These disparities cannot be adequately understood without a rooted focus on the social determinants of health. This paper examines the effects of social exclusion on STI rates in Aboriginal populations. Evidence suggests the social exclusion of Aboriginal peoples is rooted in the structures and norms of Canadian society and has substantial effects on risk taking behaviour, health seeking behaviour, and general life chances in this population. Interventions developed to counter social exclusion and STIs among Aboriginal peoples will be discussed, and what remains to be done.

Keywords: Aboriginal health, social determinants of health, racial discrimination, social exclusion, sexually transmitted infections

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Sexually transmitted infections are an important and increasing public health concern in Canada. Rates of chlamydia increased 74% and gonorrhea 124% between 1998–2007 (Public Health Agency of Canada, 2009). Syphilis infections increased 517% in this same time period (Public Health Agency of Canada, 2009). Although HIV incidence is dropping, an estimated 58,000 Canadians currently live with HIV/AIDS, a quarter of whom remain undiagnosed (Public Health Agency of Canada, 2008). Although the Canadian picture of STIs is not complete without the consideration of other viral infections such as herpes and human papilloma virus (HPV), these viruses are not reportable by law making national estimates difficult. Hepatitis B and C are also transmitted sexually, however these infections present a very different epidemiologic profile and are often excluded from the STI literature. This paper will primarily focus on HIV and the most prevalent bacterial STIs: chlamydia, gonorrhea, and syphilis.

Bacterial STIs are easily treated with antibiotics but prompt diagnosis and treatment are important. Largely asymptomatic in the beginning stages of infection, untreated chlamydia and gonorrhea can cause pelvic inflammatory disease, ectopic and other pregnancy complications, and infertility. Syphilis can cause blindness, heart disease, stroke, and is fatal if left untreated. All three infections increase the risk for HIV transmission (Public Health Agency of Canada, 2007). While no cure exists for HIV infection, highly active antiretroviral therapy is becoming increasingly effective and AIDS mortality is steadily dropping (Public Health Agency of Canada, 2008). Timely diagnosis, treatment, and prevention are key to reducing HIV transmission, making access to health services and public health messaging essential.

STIs disproportionately affect socioeconomically disadvantaged groups, including Aboriginal populations. Between 1998–2007 almost a quarter of all positive HIV tests in Canada were among those with Aboriginal ancestry (Public Health Agency of Canada, 2008). Official estimates for other STI infections in Aboriginal populations remain unreliable because ethnicity is not required when reporting these diagnoses to the Public Health Agency of Canada. However, the geographic distribution of infection rates provides some clues, with rates highest in provinces and territories that have the highest proportion of Aboriginal people. For example, the national rate of chlamydia is 224 per 100,000 Canadians, but the six regions with the highest Aboriginal populations have much higher rates per 100,000 (Alberta 318, Saskatchewan 440, Manitoba 471, Yukon 669, NWT 1727). Nunavut

has an even higher rate at 3,486 per 100,000, almost 16 times the national average (Public Health Agency of Canada, 2009). Rates for gonorrhoea follow these same geographic trends. Among Aboriginal street youth chlamydia prevalence is estimated to be 13% compared to 7% among non-Aboriginal peers (Shields et al., 2004). During an outbreak of syphilis between 1996-1999 in Vancouver's downtown east side 22% of cases were in Aboriginal individuals (Patrick et al., 2002). American sources offer a more complete picture, providing a rough analogue for Canadian conditions; a systematic review found Native Americans had STI rates that were 2 to 6 times those of non-Aboriginal populations. This gap appears to be widening, and in some populations such as those in the North Central Plains, the risk of STIs is more than six times that of Caucasians (Kaufman et al., 2007; Kaufman, Shelby et al., 2007).

THE SOCIAL DETERMINANTS OF STI DISPARITIES

To date we do not have a common understanding of the determinants underlying high STI rates in Aboriginal populations. Epidemiologic studies have shown that in established market economies STIs are higher among those living in poverty (Springer et al., 2010). Although it is well documented that Aboriginal Canadians are among the poorest and most socially excluded groups in the country, there is little information about the role social marginalization may play in these infections (Statistics Canada, 2010; Wilson and Macdonald, 2010). This is due in part to the continued belief that social inequalities in health are the result of "natural forces" or, more simply, that individuals get sick because of their own choices and behaviours (Lynch and Kaplan, 2000). This view is especially pervasive with regards to sexually transmitted infections: the mode of transmission facilitates blaming the individual since it can be linked to behaviour. Medical terminology has solidified and legitimized this perspective; homosexuality, homelessness, and Aboriginality are all viewed as "risk factors" for STIs without further clarification about the social and economic determinants that lie behind these observations.

Although the web of causation that links social factors to one another can make it difficult to tease out a single explanation for the high rates of STIs observed in Aboriginal populations, a common underlying theme appears to be social exclusion. Social exclusion is defined as the structures and processes that limit the full participation of certain groups or individuals in society due to inequalities in access to social, economic, political, and

cultural resources (Galabuzi and Labonte, 2002; Galabuzi, 2004). Negative attitudes and beliefs toward a racial outgroup can also lead to differential treatment of these individuals by both individuals and institutions in society (i.e., discrimination) (Williams and Mohammed, 2009). When the social marginalization of specific groups is deeply embedded in the norms and structures of a society it can lead to an “ideology of inferiority” that legitimizes the differential treatment of these groups (Williams and Mohammed, 2009). Social exclusion can occur at individual and institutional levels within society, and can also be internalized by members of racially stigmatized groups (Williams and Mohammed, 2009), all of which can have devastating impacts on emotional health, risk taking behaviour, and health seeking behaviour.

INDIVIDUAL AND INSTITUTIONAL SOCIAL EXCLUSION AND STIs

Emerging research suggests Aboriginal adults living in large metropolitan areas like Edmonton experience high levels of individual racial discrimination (e.g., while walking down the street, while shopping in stores) and engage in excessive gambling and other high risk activities to escape their emotional reactions to these experiences (Currie, 2011). There is also evidence of institutional discrimination against Aboriginal peoples in Canadian society; a history of colonialism, residential schools, forced migration, and other legislated policies such as the reserve system have systematically excluded Aboriginal peoples from Canadian society (King et al., 2009; Whitbeck et al., 2004). The health care system exists within the same discriminatory systematic and historical relations (Tang and Browne, 2008). A study of emergency room patients in a large city in Canada found that Aboriginal patients believed they were judged by their race and the negative societal stereotypes it invoked. For some, this meant they did not seek care unless it was absolutely necessary (Tang and Browne, 2008). These stereotypes begin with the training physicians receive, which often typecasts “Aboriginality” as a risk factor for disease rather than identifying the underlying social conditions they share in common. This medical training is combined with an ongoing media emphasis on negative Aboriginal stereotypes and anecdotes that bias physicians and the public alike into thinking that Aboriginal peoples experience a disproportionate burden of ill health because of their own choices, with little consideration given to the adverse social conditions that drive those choices. Aboriginal Canadians must struggle to negotiate health care

for themselves within this climate of judgements and assumptions about the lives they lead (Tang and Browne, 2008). It is not difficult to see how such an atmosphere might keep Aboriginal peoples from seeking sexual health services in particular given STIs are already stigmatized.

Institutional social exclusion is also evident in the disturbing levels of income inequality that persist no matter where Aboriginal peoples live in Canada. The structures in society that perpetuate what Weber terms unequal “life chances” result in the unequal and self-perpetuating distribution of wealth and opportunity (Lynch and Kaplan, 2000). Currently more than half of all Aboriginal peoples in Canada live below the poverty line (Wilson and Macdonald, 2010). In 2006, the median income of Aboriginal peoples who were employed was 30% lower than other employed Canadians. In addition, Aboriginal Canadians who are employed earn significantly less than non-Aboriginal Canadians with the same level of education, with the exception of those individuals who have earned a university education (Wilson and Macdonald, 2010). As argued by Wilson and Macdonald (2010) it remains unclear why Aboriginal people must earn a Bachelor’s degree before they can expect incomes similar to that of other Canadians with no greater qualifications. No group should be expected to consist entirely of university degree holders in an effort to avoid bias. Jobs in Canada must compensate Aboriginal peoples equivalently across sectors if poverty and its health consequences are to be reduced in Canada.

One of the most widely studied aspects of institutional social exclusion is residential segregation (Williams and Mohammed, 2009). Many Aboriginal Canadians live in socially isolated communities in rural and northern regions. Those who live in urban areas often live in areas designated as low income (Starchenko and Peters, 2008). For example, more than 60% of Aboriginal people who live in Edmonton, the second largest Aboriginal population in Canada, are concentrated in an area designated “inner city” by the City of Edmonton (Andersen, 2010). Residential segregation affects health by creating conditions that make it difficult to adhere to healthy practices, concentrating poverty and its resulting social problems in specific areas which can be extremely stressful for residents, weakening community and personal bonds, and allowing toxins to accumulate in these often deteriorated areas (Williams and Mohammed, 2009). Residential segregation and neighbourhood deterioration have been identified as fundamental determinants of STI rates (Cohen et al., 2000; Hogben and Leichter, 2008). The lack of health services in poor neighbourhoods and rural communities

is a key concern given prompt treatment and preventive information are essential to reduce incidence rates. High incarceration rates among residents in these areas can also lead to high STI transmission between prison systems and these areas. High levels of incarceration also result in disproportionate sex ratios, destabilized communities, and disrupted sexual networks, all of which contribute to infidelity and multiple partners, thus increasing the risk of STI infection (Hogben and Leichter, 2008).

Another important form of residential segregation that has likely contributed to higher levels of STIs among Aboriginal peoples is the legacy of the residential school system. More than 100,000 Aboriginal children were forcibly separated from their parents and communities and placed in residential schools between 1874–1986 in a systematic attempt to degrade the Aboriginal psyche and devalue Aboriginal identity (Royal Commission on Aboriginal Peoples, 1996). There is ample evidence that Aboriginal children experienced extremely high levels of emotional, physical, and sexual abuse in these schools and were also exposed to the violence experienced by others (Barlow, 2009; Barlow, 2003; Royal Commission on Aboriginal Peoples, 1996). Witnessing and experiencing abuse in childhood has been linked to a variety of health problems in adolescence and adulthood, including risky sexual behaviour and STIs (Devries et al., 2009; Felitti et al., 1998; Greenberg, 2001; Petrak et al., 2000). Analysis of sexual risk cognitions suggests that women who have experienced emotional, physical, or sexual abuse in childhood anticipate more negative reactions from partners to the suggestion of condom use and more psychological stress as a result of these negative reactions, which may partially account for the association between child abuse and STIs among women (Petrak et al., 2000).

INTERNALIZED RACISM

Internalized racism or self-stereotyping is another mechanism by which social exclusion may impact the health and well-being of Aboriginal peoples. Research has shown that racially stigmatized groups often internalize societal beliefs about their cultural inferiority, resulting in anxieties and reactions that adversely affect personal and cultural self-esteem and behaviour (Williams and Mohammed, 2009). A qualitative study of sexual risk taking among adolescents from a US Northern Plains tribe found that condom use was linked to self-respect and dignity, which was in turn linked to cultural pride (Kaufman et al., 2007). The authors concluded that a heightened awareness of one's minority status served as a daily reminder of their stig-

matized status, and led youth to distance themselves from their Aboriginal culture. A lack of cultural and self-esteem was also found to be an important predictor for sexual risk taking among Aboriginal women who were HIV positive in Alberta (Mill, 1997). The purposeful and systematic destruction of cultural worth in Canada's residential school system has also led to mental health problems and substance abuse amongst residential school survivors and their children (Barlow, 2003). The destruction of cultural worth and internalized racism have been linked to excessive alcohol use in other racial minorities, and a clear and consistent relationship has been established between alcohol problems and STI acquisition (Boden et al., 2011; Fortenberry, 1998; Taylor and Jackson, 1990). More research is needed to determine if these pathways similarly affect STI acquisition among Aboriginal peoples.

INTERVENTIONS TO ADDRESS THE PROBLEM

WHAT HAS BEEN DONE?

STI prevention and control interventions have received much less focus in the peer-reviewed literature compared to studies identifying the issues. Many interventions have likely been attempted to reduce the STI burden in Aboriginal populations, but comprehensive program assessments are virtually nonexistent. A systematic review of STI prevention programs has been conducted for Native Americans in the US but the effectiveness of the programs was not assessed (Kaufman, Shelby et al., 2007). The vast majority of available US programs for Native Americans focus on HIV/AIDS, particularly screening and treatment. Some offer training and technical support for health professionals, and a few developed care guidelines or curricula for HIV education in schools. Many were national programs that collaborated with Aboriginal communities or NGOs in specific communities (Kaufman, Shelby et al., 2007). Literature assessing the effectiveness of STI interventions is more common in Australia, for example one community screening program set up a mobile clinic as part of men's health week in a remote Aboriginal community. They screened all attendees at the event for chlamydia, gonorrhoea, and syphilis and treated all positive individuals (Bowden, Bastian, & Johnston, 1997). A similar program for Aboriginal women in Australia found that the use of Aboriginal nurses greatly improved participation rates (Panaretto et al., 2006), possibly because they perceived less judgement and stereotyping by these individuals.

The paucity of published articles evaluating Canadian interventions in this field does not necessarily reflect a lack of effort. Health Canada has in-

initiated numerous projects to address HIV/AIDS in First Nations, Inuit, and Métis populations, and is also developing a national HIV prevention strategy in partnership with Aboriginal communities. In conjunction with the assembly of First Nations, Health Canada has also developed a peer education program and there is an annual gathering to discuss holistic healing and sexuality in the country (Health Canada, 2005). Unfortunately program details and progress reports are not publicly available. The Public Health Agency of Canada also funds a variety of Aboriginal AIDS service organizations, Friendship Centres, and health centres with mandates to prevent and treat HIV/AIDS through its Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project (Public Health Agency of Canada, 2005).

While this focus on preventing HIV in Aboriginal populations in Canada is commendable, the lack of national funding and focus on preventing bacterial STIs in Aboriginal populations remains a serious public health concern. The rising incidence of chlamydia, gonorrhea, and syphilis in Canadian Aboriginal populations clearly indicates that more programs are needed, particularly those that assume an upstream focus on the underlying social and economic factors that lead to the observed disproportionate rates. Researchers in the field continue to recommend a holistic approach to STI prevention that includes addressing the social determinants of health, but these suggestions have not been translated into effective programs (Hogben and Leichter, 2008; Maticka-Tyndale, 2008; Steenbeek, 2004).

WHAT ELSE CAN BE DONE?

Interventions that address access to health care and the causes of high-risk behaviour are sorely needed in Canada. One approach is to change the administrative structure of health service delivery to improve access in underserved areas. Some success has been achieved in addressing HIV/AIDS by using interjudicial strategies and models developed at the regional, provincial, and territorial level in Alberta, BC, Québec, Ontario, and the Atlantic region (Lemchuk-Favel, 1999). The transfer of health care authority from federal and provincial governments to some Aboriginal communities is a recent trend that has also shown positive results. The Canadian Institute for Health Information presents two examples of successful authority transfer in the 2004 report *Improving the Health of Canadians* (Canadian Institute for Health Information, 2004). First is the Eskasoni First Nation in Nova Scotia, who assumed control over their health services in 1999. The resulting integration of health services translated into better access to health programs

for residents, and less perceived discrimination when accessing health services due to the high number of Aboriginal health care providers employed by the community. Since 1999, there have been improvements in a number of health outcomes in Eskasoni (e.g., pregnancy outcomes, diabetes outcomes). Expanding control to include sexual health services and prevention programs in Eskasoni and other Aboriginal communities would address access issues and may help reduce STI transmission in these communities. A second example in a Métis settlement in northern Alberta found that access to mental health, diabetes, and vaccination services improved once the community assumed leadership in directing these services (Canadian Institute for Health Information, 2004). Greater service integration may still prove useful in those communities in which the transfer of full authority over health services is not feasible. In remote communities access may be more efficiently streamlined by pooling personnel and resources from existing projects and by training health care professionals to integrate STI education and prevention into clinic visits for other services. Such novel service delivery models have been identified as a best practice for HIV/AIDS prevention (Barlow, 2003), and could easily be expanded to target bacterial STIs.

There is also a need for mandatory and ongoing training for health care practitioners to ensure they are aware of the ways in which social determinants affect health, particularly among Aboriginal Canadians, and how social factors like racism perpetuate risk taking behaviours, reduce treatment seeking and result in the health inequities they often see in this population. Health care providers have the opportunity to play a role in reducing these problems by creating a culture of respect for Aboriginal patients, developing a sense of reciprocity in the patient-provider dynamic, and by building relationships with these patients (Anderson, 2006). A greater understanding of Aboriginal holistic approaches to health grounded in the four quadrants of the medicine wheel (physical, emotional, intellectual, and spiritual wellbeing) would also be beneficial to practitioners (Macaulay, 2009). King and colleagues provide an excellent overview of how health care professionals can work to create culturally appropriate interactions with their Aboriginal patients (King et al., 2009). It is critical that health care providers work towards integrating these considerations into their daily interactions with patients to create an “ethical space” minimizing the health care system’s role in sustaining institutional racism (Ermine, 2007).

There is also a need for a more public discussion about racial discrimination in Canada, with particular attention paid to the extent of racial dis-

crimination directed at Aboriginal peoples. Public campaigns that educate Canadians about the effects of racial discrimination on physical and mental health may be an important first step. Such campaigns would address the negative stereotypes about Aboriginal people that remain deeply rooted in mainstream Canadian society. Such campaigns may also make Aboriginal peoples more aware of the degree to which they have internalized negative messages about their cultural group, and how these self-stereotypes may be influencing their health and behaviour.

Programs that educate youth about social exclusion and its impact on health may also have merit, particularly those that are combined with education about STI transmission and prevention. A holistic and multifaceted approach including cultural empowerment, participatory action research, and development of self advocacy has been recommended (Steenbeek, 2004). Ideally, such programs would empower Aboriginal youth to take lead roles, act as advocates for Aboriginal peoples, and lead discussion with other minority and nonminority youth on ways to increase awareness about the impacts of discrimination on individuals as well as tackling ways to reduce it among their peers. Once a nondiscriminatory ethical space is built, youth could work together to develop peer education STI programs.

Conditions for success of such programs would include prioritization of the collaborative process, maintenance of cultural standards specific to Aboriginal peoples and other minority groups, and inclusion of an evaluation component to measure effectiveness. The importance of program evaluation cannot be underestimated. This literature review highlights the paucity of published evidence on the effectiveness of programs addressing STIs in Aboriginal populations. Evaluating a program is important to ensure it is making an impact, to justify scaling it up to other communities, and critical for the development of best practices. Evaluations also allow other communities, health care workers, and program planners to learn and improve on previous experience without having to start from scratch.

CONCLUSION

Sexually transmitted infections present an important health challenge for Canada's Aboriginal populations. First Nations, Inuit, and Métis communities experience a disproportionate burden of chlamydia, gonorrhoea, syphilis, and HIV that is not being adequately addressed. A social determinants of health lens allows us to focus on the underlying causes of this disparity. Evidence suggests the social exclusion of Aboriginal peoples is rooted in the

structures and norms of Canadian society and has substantial effects on risk taking behaviour, health seeking behaviour, and the general life chances of Aboriginal peoples. Further research is needed to understand the cumulative and interactive effects of social exclusion on STIs and other health problems among Aboriginal peoples over the life course. Systematic evaluations of programs designed to address STIs among Aboriginal peoples in Canada are urgently needed so that best practices may be identified and expanded.

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