

GENDER, EQUITY AND INDIGENOUS WOMEN'S HEALTH IN THE AMERICAS

How are Ethnicity, Gender and Health Related?

Indigenous women's gender roles and their relationships with men, their communities and society as a whole shape both their ability to achieve good health and their quality of life. Indigenous women are triply disadvantaged throughout most of the Region due to their i) ethnicity, ii) sex, and iii) predominantly rural residency patterns.

A **gender-based analysis of indigenous women's health** looks at men and women's distinct social roles, the balance of power between them, and how these affect their physical and mental health profiles, including: determinants of health; health outcomes; and access to health care and other resources. The analysis also highlights how a dominant culture's beliefs about indigenous people can shape the cultural, economic, social and political causes behind indigenous women's consistently poor health profiles. The practical needs/strategic interests framework allows us to analyze indigenous women's health status, while also allowing them to express their own health needs.

Women's Practical Needs are those which must be met for survival – water, food, clothing, shelter, basic health care, and are determined primarily by their status as indigenous people; often poorer and more marginalized than the general population.

Women's Strategic Interests are related to the quality of their lives, their status within the community, and their sense of self-esteem. Indigenous women's strategic interests are more likely to be determined by their gender roles and relations within the indigenous community.

Indigenous women themselves may not identify gender inequities as a concern, focusing instead on their status as indigenous people within a larger population and placing the needs of their whole community above their own.

Determining Indigenous Women's Health Status

Health status is influenced by the interaction of health determinants (socio-economic status, health-seeking behaviour, etc.) and the availability or accessibility of health services.

1. Health Determinants

Indigenous women's social status - Indigenous communities, like the general population, define specific cultural roles and norms of behavior for both men and women, some of which pre-date colonization and some of which have been integrated into indigenous societies as a result of colonization. Indigenous women's social status is generally subordinate to men's, and is primarily characterized by their **triple burden of** productive, reproductive and domestic labour.

Women are responsible for childcare and household domestic

Quick Facts

- There are approximately 42 million indigenous people living in the Americas from 400 different ethnic groups¹
- They comprise 6% of the total population of the American continent and almost 10% of the population of LAC
- 80% live in Central America and the central Andes.
- The majority of indigenous people live in Mexico, Guatemala, Peru, Bolivia and Ecuador
- The high concentration of indigenous people in many of these countries suggests that their health concerns should be a national priority. However, as a group indigenous peoples often have the highest rates of morbidity and mortality, and the least access to health services among their national populations.

labour, but they also participate in "male" tasks such as community farming and other economically productive activities such as street vending. Women's heavy workload is both time-consuming and arduous, making it less likely that they will have time for other activities such as education, participation in community decision-making and seeking healthcare for themselves or their children, which also has a significant effect on their health status.

Young girls start assisting their mothers very early on, often resulting in the indefinite postponement of their education, and in many cases preference is given to boys' attending school. Indigenous women's exclusion from education, low educational achievement, lower rates of bilingualism negatively impact their ability to obtain higher incomes, access health care services, practice safe reproductive health strategies and organize themselves effectively.

Men are primarily responsible for heavy farming activities, and because of the higher value placed on this type of labor they tend to dominate the public sphere, where **community decisions** are made. Mayan women are subordinated to the authority of their husbands and fathers, who decide how many children the family will have, how the household income will be spent, and whether women may leave the house or not.⁵ The Kichwa women of Ecuador on the other hand have equal rights of inheritance and more influence within the public sphere.⁶ Despite these variations in their status and level of autonomy, as a group indigenous women are often deprived of both the right and the means (financial, transportation etc.) to seek medical attention.

Violence against Women (sexual, physical and psychological) constitutes a major health risk for indigenous women and has increased along with growing rates of alcohol abuse, poverty, and unemployment among indigenous men. Violence inflicts not only physical but psychological trauma on women and is associated with high rates of mental health disorders among indigenous women including anxiety, trauma and, in the case of the U.S. and Canada, suicide.

Indigenous Women's Health Status

- 70% of Kichwa women devote as much time as men to the marketing of their farm products
- In Ecuador, 53% of indigenous women are illiterate compared to 35% of indigenous men.² In the Sierra region, more than a quarter of women cannot read or write, compared to 14% of men.
- In Nicaragua, 32% of rural women say it is acceptable for a husband to beat his wife if he even *suspects* that she has been cheating on him. 75% of married Nicaraguan women have been beaten, coerced into sex or abused in some way.³
- In Guatemala, coverage of health services reached only 54%⁴ of the total population and only 25% of people in rural areas had access.

2. Availability and Accessibility of Health Services

- **Community Infrastructure:** Most indigenous communities lack access to clean water, adequate sewage systems, electricity and paved roads. The high incidence of diarrhea and other intestinal problems among indigenous communities is related to the poor quality of their water supply.⁷
- **Social Instability:** Recent civil wars, natural disasters and population migration have led to increases in unemployment, poverty, civil and military violence, environmental degradation, and STD/HIV prevalence. On the other hand, they have served to increase women's active political participation and female employment, and have often provided a valuable space for challenging existing gender roles.
- Indigenous women's increasing employment in the **informal labor market** exposes them to many work-related health hazards, and excludes them from worker's unions and health insurance benefits.
- **Coverage of health services** is low in rural areas, where most indigenous people live. Curative rather than preventive health services tend to focus on reproductive health to the exclusion of other illnesses. Most indigenous communities are remote and lack the means of transportation to access urban or peri-urban medical centers.
- Indigenous women state that the technical **quality of health services** is in itself not a problem, but rather the way the personnel administer care. Personnel often do not explain treatments or respect the rights of indigenous women to informed consent. Many providers also ignore traditional / indigenous medicinal concepts such as the need to health the mind, body and spirit together.

Health Outcomes

- High fertility rates and shortly-spaced births: Guatemalan indigenous women marry at a young age and have on average 6.8 children
 - Low use of contraception: 41.3% of Shipibo (Peru) do not use any form of contraception, most men do not use condoms⁸
 - High maternal mortality rates: In Peru, 489 deaths per 100,000 live births due to lack of medical care during delivery, also causing anemia, urinary incontinence, uterine prolapse, genital infections and vaginal fissures
 - High alcohol, drug and smoking rates: Native American women's binge drinking often leads to Fetal Alcohol Syndrome, cirrhosis and liver problems, drug abuse contributes to the high suicide rate
 - Neurological/Reproductive complications from contamination in hazardous work conditions
 - High rate of cervical cancer: American Indian women's rate is 1.5 times the national rate (3.8 deaths/ 100,000)
 - High HIV/AIDS/STI rate: Native American women make up 15% of all female AIDS cases, White women: 7%.
- Women are **unwilling to access health services** because a) they are more comfortable with their communities' traditional medical knowledge and midwives, b) they are not understood or are poorly treated by modern health providers, and c) cultural beliefs about modesty and sexuality prevent health providers (especially males) from examining them.

Improving Indigenous Women's Health

1. Improve data collection and research on indigenous communities
2. Increase indigenous women's economic capacity and ensure their equal participation in the labor market
3. Promote agrarian reform that includes women's participation in decisions on land distribution and titling
4. Ensure that all indigenous communities have access to affordable, quality, culturally sensitive health services
5. Incorporate a gender perspective into all programs and services that target the health of indigenous communities
6. Adopt a holistic, life-cycle approach to indigenous women's health care
7. Involve indigenous men in health initiatives for women and families
8. Involve indigenous women in all attempts to address their health and social status

Notes

1. PAHO, 1998a, *Salud en las Americas*, Volume I. Washington, D.C.: PAHO: p. 95
2. World Bank 2000, Ecuador Gender Review: Issues and Recommendations, Washington, D.C.: World Bank: p. 24.
3. Guerra, 2001, "Beating women is a way of life here" In *Jane Magazine* February 2001 <http://www.unfpa.org/focus/nicaragua.msomagazine.htm>
4. Hedlund, 1996, Indigenous women's health in Guatemala: A case study on the interrelations between indigenous women and local health workers in four selected municipalities. Bachelor's Thesis in Public Health . Stockholm: Karolinska Institutet: p. 5.
5. Meentzen, 2000, *Estrategias de desarrollo culturalmente adecuadas para mujeres indígenas* (primer borrador). Unidad de Pueblo Indígenas y Desarrollo Comunitario, Departamento de Desarrollo Sostenible. Washington, D.C.: Banco Interamericano de Desarrollo: Pp: 35-36.
6. Vallejo Real, 2002, "Estudio de Caso en el Pueblo Kichwa de Toacazo-Cotopaxi" in *Proyecto Estudios de Caso Sobre Identidades y Roles de Género en Pueblos y Nacionalidades del Ecuador* Programa de Género y Patrimonio Cultural de PRODEPINE, World Bank: p. 22
7. PAHO 1998c, *Situación de Salud de los Pueblos Indígenas de Perú* of the Iniciativa de Salud de los Pueblos Indígenas de OPS. Washington, D.C.: PAHO: p. 38
8. Alcock, 2001, Socio-cultural Aspects of Health: Women of childbearing age. Results from Missions in Ucayali, Peru. A Medecins Sans Frontieres Report. <http://www.msf.org>