SEXUAL HEALTH &
THE URBAN ABORIGINAL COMMUNITY:
a position paper

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INTRODUCTION

The path to positive sexual health requires the support, care and commitment of all community members, Aboriginal and non-Aboriginal. Sexual health is to be viewed as an important contributor to the overall health and well-being of Aboriginal individuals, families, and communities, no matter what stage in the life cycle. Affirmative and culturally appropriate notions of sexuality and sexual health that empowers Aboriginal people can be passed along throughout generations. When Aboriginal people embody and practice healthy sexuality, it will enrich their quality of life.

This document establishes the OFIFC’s position on sexual health as it pertains to urban Aboriginal people regardless of status. While defining and discussing various concepts of health and sexual health that are most relevant to urban Aboriginal communities, this paper will posit that holistic and culture-based approaches are the most effective and appropriate means to improving the sexual health of urban Aboriginal people. This paper is intended to stimulate critical discussion and action to ensure that urban Aboriginal people and organizations are appropriately supported in addressing their needs and issues in relation to sexual health. Improvement is necessary not only in sexual health, but also in the social determinants of health in order to equitably participate in Canadian society as distinct urban Aboriginal people.

This paper will explore historical and traditional notions of sex, gender and sexuality, including the acknowledgement of impact of colonization on cultural and social structure. An overview of contemporary issues, such as sexual behaviours, teenage pregnancy, sexual and gender identities, sexual assault and violence, racism and sexism, and mental health and addictions, is provided. The paper moves into culture-based approaches to sexual health, including increasing access to health and mental health services and increasing positive outcomes of the social determinants of health. Any initiatives, strategies or stakeholders seeking to address the state of Aboriginal sexual health must be informed of and understand the conditions that impact and share the health status of urban Aboriginal people.

THE ROLE OF THE FRIENDSHIP CENTRES

Ontario has the largest Aboriginal population in Canada with 301,425 First Nations, Métis and Inuit people living there.¹ Of the Ontario Aboriginal population, currently 84.1% live off-reserve in urban and rural locales.² The migration off-reserve has been growing over the last 40 years.³ Aboriginal people are choosing to build their lives in urban areas for a variety of reasons, many of which are influenced by education, employment, housing, health, and the overall perception that city life is more

² Ibid.
The promise of increased opportunity and access of urban living is not always fulfilled. The Urban Aboriginal Task Force (UATF) found that Aboriginal newcomers were often arriving in cities with little urban experience, low levels of education and few marketable skills. They often immediately ‘face major struggles of adjustment to the city including meeting such basic needs as housing, orientation to the city, transportation, lack of income and social support’. Despite challenges, many Aboriginal individuals and families are succeeding in making significant social and economic contributions to their urban locales in Ontario, creating support networks, and continuing to foster a strong Aboriginal cultural identity. And it is Ontario Friendship Centres who are playing a central role in supporting urban Aboriginal people in surmounting their obstacles to pursue and achieve their life goals.

The primary mandate of the Ontario Federation of Indigenous Friendship Centres (OFIFC) is to advocate on issues of collective concern for its twenty-eight member Friendship Centres located in towns and cities throughout Ontario. The vision of the Aboriginal Friendship Centre movement is to improve the quality of life of Aboriginal people living in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian Society and which respects Aboriginal cultural distinctiveness. The Friendship Centres represent the most significant off-reserve Aboriginal service infrastructure across Ontario and are dedicated to achieving greater participation of all urban Aboriginal peoples in all facets of society, inclusive of First Nation – Status/Non-Status, Métis, Inuit and all other people who identify as Aboriginal. This necessitates responding to the needs of thousands of Aboriginal people requiring culturally-sensitive and culturally-appropriate programs and services in urban communities.

The OFIFC administers and delivers several programs that are intended to improve the quality of life for urban Aboriginal individuals, families and communities throughout the lifecycle. These programs are culture-based and founded on the wholistic notion of wellbeing. Children and youth programs include Aboriginal Healthy Babies Healthy Children (0 to 6 year olds); Akwe:go – Urban Aboriginal Children’s Program (7 to 12 year olds); Wasa-Nabin – Urban Aboriginal Youth Program (13-18 year olds); Fetal Alcohol Spectrum Disorder and Child Nutrition; Children Who Witness Violence; Children’s Mental Health; and Alternative Secondary School Program (ASSP). The OFIFC administers promotion and prevention programs in the areas of health, healing, and wellness, including the Alcohol and Drug Program, Community Mental Health, Aboriginal Healing and Wellness, Health Outreach Workers, Kizhaay Anishnaabe Niin (“I Am A Kind Man”), Life Long Care, and Urban Aboriginal Healthy Living. These programs have proven to be very successful, and are addressing people’s immediate needs and increasing their capacity to fulfill long-term goals.

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5 UATF. (2007). p.186
6 Ibid. p. 18
The OFIFC offers Aboriginal Cultural Competency Training (ACCT) to individuals, groups and organizations who wish to deepen their knowledge of and strengthen their relationships with urban Aboriginal people. The training offers participants the opportunity to build a shared understanding of contemporary priorities, allied relationships, Aboriginal wholistic healing, and the importance of infusing ongoing Aboriginal cultural competencies throughout organizational practices through meaningful engagement with the urban Aboriginal community. The goal of the ACCT training is to advance cultural safety for Aboriginal people in all areas of society to ultimately improve the outcomes across the range of social determinants of health for urban Aboriginal people.

DEFINING SEXUAL HEALTH

The World Health Organization (WHO) defines sexual health as:

“a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

The WHO definition very much aligns with the OFIFC’s understanding of health, sexual health and healthy sexuality. Aboriginal worldviews of health incorporate the three interrelated concepts of the life cycle, wholistic health and the continuum of care. The life cycle relates to the passage of life stages – from infancy and childhood, youth, adulthood and senior years. Wholistic health incorporates the physical, mental, emotional, and spiritual needs of the individual, family and community. The continuum of care encapsulates health promotion, prevention, treatment and curative programs and services, and rehabilitation. People will have different and evolving needs over their lifetime, which must be addressed through appropriate health policies and programs. This approach forms a multi-dimensional matrix for Aboriginal health to ensure that the whole of the individual is addressed and all individuals are included.

The OFIFC refers to healthy sexuality as the positive perception of one’s own body and feelings which is impacted by cultural and social influences. Sexual health consists of being able to enjoy and control one’s sexual and reproductive behaviour, free from shame, fear, coercion, guilt, including freedom from sexually transmitted diseases and unintended pregnancies. In order to effect positive change among urban Aboriginal people throughout the life cycle as it relates to their perception of healthy sexuality, actions need to address their wholistic needs – providing a safe healthy environment;

empowering healthy choices; and freedom to be who they are without fear, guilt and shame.

**GENDER, SEX, AND SEXUALITY WITHIN AN ABORIGINAL CONTEXT**

Within the Indigenous worldview, the construction of gender and sexual identities is a fluid concept, where people embody certain roles and responsibilities in their clan, family, community, and nation, built upon the expression of their own personal gifts. Based on those gifts, individuals take up certain tasks and responsibilities within the community. At the centre of the conceptualization of traditional roles is the notion that individuals have dominion over the definition and execution of their community role. For example, men could not tell women what they should be doing and how they should be doing it, and vice versa. Individuals have the power of self-determination - the right to control their life and future, and the responsibility to contribute to the prosperity of the
community. This self-determination applied not only to men and women, but for Two-Spirit people within our communities.

Regarding gender and sexual diversity, Two-Spirit people have always existed in, and been an intrinsic part of, Indigenous communities. Prior to colonization, each Nation had their own unique understandings and language around Two-Spirit people and their roles in the community. For example, ‘agokwe-nini’ in Ojibwe described those who crossed gender roles and held special community status. A Two-Spirit person was seen as embodying both male and female characteristics, which the community recognized as giving them greater insight, knowledge, and responsibility. They were valued as visionaries, healers, caregivers, medicine people, warriors, and leaders, and they were respected as equal and vital members of Indigenous societies.

While each Nation expressed different interpretations, sex and sexuality were overall understood to be part the life cycle and viewed in a positive light. Sexuality was thought of as a life-creating force between men and women, with children being considered gifts from the Creator. Traditional notions of healthy sexuality were taught wholistically in Aboriginal cultures through the guidance of parents, extended family, Elders and select members of the community. Among the diverse Nations, there existed various rites of passage at puberty and acceptance of diverse gender roles. Teachings were facilitated to young people through oral storytelling to explain the physical changes, and their evolving responsibilities and roles within their community.

With the advent of colonization in North America, traditional Aboriginal cultural and societal norms were displaced and dismantled by European patriarchal values, policies, and systems. In their wake followed European social and cultural constructions of gender, where male performance and masculinity are valued as powerful and significant while female gender performance is viewed as submissive and marginal. It is both unbalanced and creates the supposition that there are two finite conceptualizations of gender: male and female. The dichotomous gender roles effectively removed Two-Spirit people from their place within the community, suppressed and persecuted them for their teachings and practices, and ultimately resulted in the emergence of homophobia and transphobia in Indigenous societies. This reconfiguration of Indigenous gender roles destroyed the foundations of Indigenous societies, ultimately aiding and allowing for Indigenous subjugation.

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The traditional transference of knowledge involving the broader Aboriginal community no longer existed to the same extent prior to contact. Children became adults who lost the capacity to engage in nurturing cultural and social interaction with their children, which promoted attachment and intimacy in developing children. Such interaction has been the primary means of instilling self-esteem, a positive cultural identity, and empathy for others – all aspects that contribute to the individual’s development of healthy sexuality.

Almost every contemporary social pathology or health issue in Aboriginal communities can be directly attributed to the legacy of colonialism. Contextual factors such as isolation, extreme poverty, economic deprivation, high rates of alcoholism, substance abuse and domestic violence, and the lack of appropriate parental role models have constructed contemporary Aboriginal people’s experiences – including negative or destructive behaviours around sexual health.

**SEXUAL HEALTH ISSUES IN THE URBAN ABORIGINAL COMMUNITY**

The historical experiences of trauma and dysfunction that has affected so many Aboriginal people and their communities continues to be transferred through generations. With respect to the notion of healthy sexuality and its development among Aboriginal children and youth, the main areas of concern are the negative linkages that attribute to poor sexual health attitudes, choices and consequences. The effects of family violence, child victimization, racism, sexism, early parenthood and early school dropout, mental health and substance abuse, and the ongoing lack of acceptance of sexual and gender diversity, including homophobia and transphobia, all contribute to the difficulties faced by Aboriginal children and youth in identifying notions of healthy sexuality. Protecting and promoting a healthy sexual and reproductive life cycle for urban Aboriginal people requires an awareness and understanding of the circumstances of their sexual health status and the barriers to health and wellbeing they encounter.

*Sexual Activity and Sexual Health*

Many Aboriginal people, especially youth, find themselves in situations that increase their risk for negative health and socio-economic outcomes due to their sexual activities and behaviours. Young Aboriginal men and women are more likely than other Canadian young people to report: first time sex at an earlier age; experience of sexual abuse and/or forced sex; higher numbers of lifetime sexual partners; and decreased condom usage. The OFIFC released *Tenuous Connections – Urban Aboriginal Youth Sexual Health & Pregnancy* in 2002, a study examining the views and experiences of urban Aboriginal youth on sex, sexuality, pregnancy, and sexual practices and behaviours. Of

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the Aboriginal youth interviewed, it was reported that 62% of youth were sexually active as young as eleven, and more than 50% reported little to no use of contraceptives.\textsuperscript{16} The study concluded that youth engagement in sexual activity is very much part of the broader youth culture for a number of reasons, some of which were peer pressure, pressure from a partner, substance abuse, the need for love, curiosity, and pleasure.

Deeply troubling is the fact that Aboriginal youth report inconsistent use of condoms.\textsuperscript{17} Along with increased possibility of pregnancy, this puts Aboriginal youth at high risk for a number of sexually transmitted infections (STI). Health research has confirmed the higher STI prevalence rates in the Aboriginal population.\textsuperscript{18} Chlamydia is estimated to be almost seven times higher among First Nations adults than in the broader Canadian population.\textsuperscript{19} The trend in the general Canadian population for reported HIV and AIDS cases has been declining since 1994; conversely, the annual number of reported HIV and AIDS cases among Aboriginal people has risen dramatically. In 2011, Aboriginal people made up 12.2% of new HIV infections and 8.9% of those living with HIV in Canada, despite only representing 4.3% of the total Canadian population.\textsuperscript{20} HIV prevalence rates unevenly impact Aboriginal youth with almost one-third (31.6%) of the positive HIV test reports from 1998 to 2012 being attributed to Aboriginal youth aged 15 to 29 years old.\textsuperscript{21}

The need for intervention is urgent given that the contraction of an STI can have serious long-term consequences beyond the immediate impact of the infection itself. Mother-to-child transmission of STIs can result in stillbirth, neonatal death, low-birth weight and prematurity, sepsis, pneumonia, neonatal conjunctivitis, and congenital deformities.\textsuperscript{22} The Society of Obstetricians and Gynaecologists (SOGC) estimates that 75% of Canadians will contract at least one Human Papilloma Virus (HPV) infection in their lifetime;\textsuperscript{23} this is particularly grave considering that all cervical cancers and an estimated 85% of anal cancers are caused by HPV.\textsuperscript{24} Some STIs can increase the risk of HIV acquisition by three times or more. HIV diminishes the body’s immunities making the body more susceptible to other conditions that may be life-threatening, and long term exposure to HIV treatment (such as highly active antiretroviral treatment or HAART) is

\textsuperscript{18} FNIGC. (2012)
\textsuperscript{19} FNIGC. (2012)
\textsuperscript{21} Ibid.
showing to have numerous associated side effects, including heart disease, obesity and comorbidities complications.  

Aboriginal Parenthood

Historically in Indigenous societies, the community was heavily invested in maternal, infant and child health as they understood that the prosperity of children was vital to cultural continuity and ongoing social wellbeing. Pregnancy and birth were celebrated community events that contributed towards a strong, interconnected Nation by strengthening relationships between extended families and the natural environment. Children were placed at the centre of the community, to be communally nurtured, protected and cared for by the parents, extended family, and Elders. Colonization and its legacies of residential schools, the “60s scoop” and the child welfare system have destabilized traditional social support structures and values around parenting and community child-rearing. This loss of community support has left many Aboriginal parents with the responsibility of raising their children on their own, often in conjunction with the residual trauma from colonization, residential schools and assimilationist child welfare policies.

The roles and responsibilities of parenthood are critical elements in the conceptualizations of sexual health. Aboriginal youth in the *Tenuous Connections* study stated that they are having children to escape dysfunctional family situations, to feel loved and needed, and to overcome their feelings of loneliness. It can be inferred that a lack of support, attention or care from the original family may be at the root of sexual activity and early parenthood among Aboriginal youth. This has resulted in teenage or young adult pregnancy and parenthood being something of a social norm in certain Aboriginal communities. Regardless, teenagers who became pregnant reported feeling further stigmatized and isolated from their communities, instead of achieving the sense of belonging they desired.

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27 *Tenuous Connections*, p. 44-45
28 Ibid. p. 11
Early parenthood increases the vulnerability of Aboriginal youth who are already at a socio-economic disadvantage. Long-term research has shown that early parenthood significantly made educational achievement much more difficult, which can have long-term repercussions of limiting both employment options and income levels over a life time.29 The repercussions of early parenthood are more acute for Aboriginal women than men because Aboriginal women are more likely to be the single and primary caregiver to their children. Aboriginal women who were mothers under the age of twenty have higher rates of unemployment, increased reliance on social assistance and experience greater levels of poverty. One study found that of off-reserve Aboriginal women aged 25 to 29 who were teenage mothers, 45.1% had less than a high school education - almost double the rate in comparison to Aboriginal women who were not teenage mothers (25.8%).30 Not unexpectedly, the same groupings of adult Aboriginal women who were teenage mothers were also more likely to be unemployed (13.4% versus 11.3%).31

The role of the father in Aboriginal families has been critically diminished, with high levels of Aboriginal children being raised in single-mother headed households. The positive involvement of fathers in their children’s lives is important to the wholistic development of healthy children, including the development of positive male role models, healthy relationships and sexual health. However, colonization and its legacies have eroded the roles of men in Aboriginal communities as providers, protectors and leaders, and diminished father-child relationships.32 Many Aboriginal men have had negative experiences with their own fathers or did not have a father present during their upbringing, leaving them with limited positive personal experience to draw upon. Furthermore, problems with substance abuse, mental health issues and difficulty sustaining relationships with partners can influence their ability to maintain involvement in their children’s lives.33 Aboriginal men are reporting that parenting programs and services are dominated by and geared towards mothers, creating exclusionary spaces and making invisible their roles in the care of their children. Finding the means to restore the positive role and involvement of fathers in urban Aboriginal communities is important because children who have had little to no contact with their fathers often experience considerable negative health, including sexual health, outcomes later in their life.34

Young Aboriginal parents garner the attention of child welfare agencies at increased levels, due to the greater perceived risk of neglect and abuse. The loss of traditional forms of child-rearing have left many urban Aboriginal parents without the necessary

30 Ibid.
31 Ibid.
32 Ball, Jessica. (March 2008). Policies and Practice reforms to promote positive transition to fatherhood among Aboriginal young men. Horizons. p. 53
33 Ibid.
34 Ibid.
knowledge, skills, resources and support networks needed to raise healthy children. This heightened involvement with the child welfare system has led to the portrayal of Aboriginal women and men as “bad mothers” and “dead beat dads”, which fails to consider the efforts that many Aboriginal parents are making to deal with the day-to-day realities created by the structural inequalities of the social determinants of Aboriginal health. The need for focused action is paramount as today, Aboriginal children are being apprehended and placed in out of home care at disproportional rates when compared to non-Aboriginal children. This is particularly disturbing given the statistical trend showing that adolescents who have been involved in the child welfare system are more likely to become pregnant teenagers, continuing the generational cycle of socio-economic disadvantage.

**Sexual and Gender Diversity**

Two-Spirit is a modern self-descriptor used to describe gender and sexually variant Aboriginal people in Canada and the United States that honours their ancestral past and reclaims their Aboriginal identity. While not all Aboriginal people identify as Two-Spirit, among those who do, Two-Spirit is an umbrella term that includes varying sexual identities (i.e. lesbian, gay, bisexual, queer, pansexual, questioning, asexual, etc.) as well as diverse gender identities (i.e. transgender, transsexual, intersex, genderless, androgyne, cisgender, genderqueer, etc.). For the purpose of this paper, Two-Spirit will be used to refer to Aboriginal people with diverse gender and sexual identities unless otherwise indicated.

Two-Spirit people are dealing with unique challenges that are shaped by their intertwining experiences of race, gender, and sexuality. Intersectionality is a concept that captures the idea of social identities being organizing features of social relationships, and that these social identities mutually constitute, reinforce, and naturalize one another, creating both oppression and opportunity for the individual. Intersections reproduce a complex operation of power relationships among social groups and can be experienced at the individual level right up to the socio-structural level. When discussing the construction of the identities of Two-Spirit people, gender, race, and sexuality have to be viewed as developing interdependently with one another, all equally and intricately contributing to an overall sense of self. In fact, this interconnection is inherent in the definition of term ‘Two-Spirit’.

This understanding of self for Two-Spirit people has meant having to experience multiple intersections of oppression and inequality, even from the very groups they identify with. Two-Spirit individuals recount experiencing homophobia, transphobia, and sexism from their own Aboriginal communities, forcing them to leave their families and

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36 Ordolois (2007).
37 For the purpose of this paper, the term “Two-Spirit” will be used to describe all Aboriginal people who identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual.

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homes. The modern re-emergence of Two-Spirit people in combination with their engagement in traditions and ceremonies has created friction with Indigenous traditionalists who do not recognize the Two-Spirit identity. On top of this, many Two-Spirit people also face racism and stereotypes within the LGBTQ community, rendering it quite difficult to find a positive community support system. All the while they are experiencing overarching racism, homophobia, transphobia and sexism from mainstream heteronormative and patriarchal society. Thus, when striving for increased positive outcomes for Two-Spirit people, culture, sexual and gender orientation and the impacts of colonization, including inter-generational trauma, must be dealt with concurrently.

Experiences and perceptions of homophobia, transphobia, sexism and racism within organizations, institutions and systems create barriers for Two-Spirit people, which inhibit their access to social networks and to needed health, social and cultural services and programs. If spaces are perceived to be unsafe by a Two-Spirit person, they may choose or be forced to hide their identity (racial, sexual, or gender) for fear of its potential consequences, such as violence, abuse, discrimination, exclusion, and harassment. For example, if they do not feel safe disclosing their transgender identity to their health professional, they will not be able to receive crucial health promotion and prevention information related to their sexual health.

This has led to adverse sexual health, health, and mental health outcomes for Two-Spirit people. The Two-Spirit, transgender and Aboriginal MSM (men who have sex with men) community continues to be disproportionately affected by STIs, HIV and AIDS. LGBTQ people have higher incidence rates of suicide, smoking, substance abuse, depression, low self-esteem, unemployment, and experiences of violence, homelessness, and HIV/AIDS than heterosexual people. As Two-Spirit people experience the same and increased types of exclusion, it can be expected that their levels are similar or worse. Suicide rates among Two-Spirit, and gay, lesbian, bisexual, or transgender Aboriginal people are not known, but the rates of related risk factors in these groups indicate that the suicide risk is greater than among heterosexual Aboriginal people.

Racism and Sexism

The gender roles of Aboriginal men and women have changed dramatically since European contact, with each gender experiencing different but equally destructive impacts of colonization. Sexism is prejudice or discrimination based on a person’s sex

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40 Lesbian, Gay, Bisexual, Transgender, Queer

41 Stirbys, Cynthia, “Gender Based Analysis and Differing Worldviews” Canadian Woman Studies. 26 (2008): 143


43 Ibid.
or gender. Racism is founded on the belief that all members of each race possess characteristics or abilities specific to that race, especially so as to distinguish it as inferior or superior to another race or races. Racism and sexism are alike in that “they operate via external power structures to contribute to poor health in certain disadvantaged groups”.44

Racism and sexism have been used as tools to subjugate and oppress Aboriginal people to enable Western colonial rule with detrimental effects on their sexual health. Colonialism has reshaped Aboriginal conceptualizations of gender roles while classifying Aboriginal people as inferior and subject to racial legislation (i.e. Indian Act, 1876).45 The Indian Act is the embodiment of structuralized racism and sexism by legislatively outlining Canadian government control over Indian bodies, identities, lands, resources, language and cultural practices.46 Aboriginal policies and departments were created to ‘get rid of the Indian problem’, which resulted in vast political, economic, health, social, and cultural inequities.

Not only was the role of men favoured over women in the home, community and broader society, but the Indian Act constrained Aboriginal women’s agency by making their livelihood dependent on Aboriginal men. Before 1985, section 12(1)(B) of the Act stated that Indian women would lose their legal Indian status if they married a non-Indian man.47 Section 6 of the Act removed the legal status of women’s children but not of Indian men who married non-Indian women; non-Indian women who married Indian men would gain status for themselves and their children.48 Aboriginal women’s and children’s identities were determined by their husbands and fathers.

Structural racism and sexism has translated into the relational racism and sexism Aboriginal people are currently experiencing in the health care system, including their access of sexual health care. When using mainstream health services, Aboriginal people are encountering racism, sexism and stereotyping, and find the western approach to health care to be alienating and intimidating. They are facing derision, condescension and dismissiveness by doctors, nurses, health and social workers for their illnesses. Because they are Aboriginal, they are at fault for their health outcomes, their symptoms are ignored and they are treated poorly in comparison to non-Aboriginal patients.49 A study found that Aboriginal women faced great difficulties when trying to communicate with health care providers, that health care providers did not listen to them. Aboriginal women are deterred from accessing sexual health care because of fear of judgement of their life and behaviours. For Aboriginal mothers, judgement could lead to child apprehension. Aboriginal males are often forgotten in sexual and

44 Ibid.
47 Ibid.
48 Ibid.
reproductive health care, making it an uncomfortable, unsafe and shameful experience for them. For these reasons, Aboriginal men and women report a significant lack of trust in health care providers and the Ontario health care system.

This results in Aboriginal people not seeking out needed care when symptoms arise, leading to later diagnosis and increased risk of complications. Aboriginal women and men end up losing out on important preventative care and screening, such as pap tests, breast screening, prostate exams, STI testing, and pregnancy tests. If they do seek care, they may drop out of treatment and not seek follow-up care. Moreover, Aboriginal women are usually the primary point of contact for health care for their families. They seek out treatment for their family, make the appointments and manage the aftercare. By making sexual health care a volatile environment for them, the health care system is removing a point of access for Aboriginal families. Due of the stigma attached to mainstream services, urban Aboriginal people prefer Aboriginal organizations, like Friendship Centres, because they provide a safe environment, where Aboriginal people can feel empowered in their health and life choices, to address their unique needs and goals.

**Sexual Assault and Family Violence**

Sexual assault is when someone is forced to have sexual activity without consent. Family violence is when someone uses abusive behaviour to control and/or harm a member of their family, or someone with whom they have an intimate relationship with. While both men and women are victims of assault and family violence, it is more often directed towards women. Sexual violence against Aboriginal women, including rape, mutilation and sexual abuse, is occurring at alarmingly high rates with long lasting impacts on their health and wellbeing. Women in abusive relationships have more difficulty negotiating safe-sex practices; consequently violence is a predisposing factor to pregnancies, HIV and AIDS and other STIs. The negative health associations of family violence include psychological trauma, acute physical injuries, chronic health problems, unwanted pregnancies, and miscarriages, all of which hinder the abilities of women to participate fully in society.

The effects of family violence on Aboriginal children are just as destructive. Children who experience or are exposed to violence are at heightened risk of being apprehended by the child welfare system with all the consequences that entails. Further to that, due to the impact that violence and abuse has on the physical and psychological health of the mothers, Aboriginal children are at greater risk for apprehension for reasons of neglect and parental substance use. Children who experience or witness violence are

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Aboriginal women are more likely to be sexually assaulted than non-Aboriginal women and are almost three times more likely than non-Aboriginal women to report having been a victim of violent crime.

(Statistics Canada, 2011)

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50 National Collaborative Centre For Aboriginal Health (2013). *Aboriginal and Non-Aboriginal Children in Child Protection Services*. Public Health Agency of Canada: Victoria, p. 2
more likely to repeat the cycle of violence as adults, as victims and victimizers. Violence and victimization have profound negative effects on the mental and physical development of children and youth’s identity and self-perception. The unstable and eruptive environment contributes to unhealthy feelings of stress, anxiety, anger and helplessness. It is reported that youth who experience or witness prolonged abuse often leave home at an early age, which increases their susceptibility to engagement in prostitution, homelessness, substance misuse, unprotected sex and gang activity for survival.51

*Mental Health and Addictions*

Issues of sex, sexuality and sexual health is relevant to any discussions on the mental health of Aboriginal people. Giving consideration that mental health and wellness encompasses both the emotional and mental aspects and influences how people think and feel, the mental health state of an individual will impact how they act and behave in regards to sex and sexuality. Aboriginal people displaying good mental health will take pride in themselves, be able to form and maintain satisfying relationships, will be able to cope with stress in positive ways, and will have personal control to make responsible choices.52 These behaviours are all contributors to positive sexual health, affirming sexualities and intimacies, and safe sex practices.

When suffering from mental illnesses, individuals may report concerns in regards to their sexual functions, their desires for sex, and their attitudes towards sex. For example, those suffering from severe depression may not have any interest in sex which can impact the health and stability of relationships with partners. This in turn can affect their treatment and support to regain or maintain their mental wellness. Alternatively, frequent and/or random sexual contact with multiple partners can been seen in various mental disorders, such as psychosis, manic episodes, substance abuse and dependence, dissociative identity disorder, as well as borderline, narcissistic and antisocial personalities.53

In terms of addictions and substance misuse, alcohol and drug use are major factors in the sexual practices of Aboriginal youth. It is reported that many youth are engaging in sexual activity when their ability to make choices and take responsibility is impaired. Impaired decision-making regarding sexual activity exposes them to increased risk for early pregnancy, unwanted sex, sexually transmitted infections, shame, and guilt. Many urban Aboriginal youth are sexually active before the age of 15 (70%) and do not have the knowledge, the means, or maturity to practice or negotiate for safe sex.54 In addition, youth are reporting that drug and alcohol impairment heavily influenced their decisions to use (or, in most cases, to not use) contraceptives during sexual activity.

54 Tenuous Connection. p. 11
Alcohol use with regards to sexual activity bears greatly in mind considering the devastating impact fetal alcohol spectrum disorder (FASD) can have on a person’s life and on their family. If people are unknowingly conceiving children during sexual activities while intoxicated, they may continue consuming alcohol long after the point of conception. Fetal alcohol exposure can alter brain metabolism, causing permanent brain damage, and is the primary cause of preventable developmental disability in Canada. Since FASD is completely avoidable, the most important factor towards preventing future cases lies in community awareness of the risks of alcohol consumption during pregnancy, treatment of existing alcohol abuse issues in women and communities, and reducing the risk factors associated with substance abuse.

Interventions are needed to address the critical mental health and addictions issues within the Two-Spirit community. Traumatic events, such as childhood bullying, family rejection, and homophobic and transphobic abuse or violence, can have lifetime consequences on a person’s mental and sexual health state and impair their ability to function well in society. Isolation, exclusion and rejection by families, communities and society have a substantial negative impact on a Two-Spirit person’s mental health and is suspected to be linked to self-hate, self-harm, risky sexual practices, and suicidal activities. Two-Spirit adolescent males were twice as likely as their heterosexual counterparts to have thought about or attempted suicide.

The 2013 Trans PULSE study found that all Aboriginal participants experienced trans-related discrimination as well as the ongoing impacts of colonization and systemic racism, which greatly impeded their health, social and economic opportunities. This ongoing social exclusion and discrimination for the Aboriginal trans and gender-diverse population produced and/or exacerbated high levels of mental health conditions, such as depression, mental distress, substance dependence, self-harm, and suicidality, while having to face systemic barriers to accessing respectful and competent health care. Almost half of the Aboriginal participants in the Trans PULSE study have attempted suicide at least once. The Aboriginal participants reported on the positive supports received by family and community for their gender identities, and high levels of spirituality, indicating that supportive Aboriginal communities and positive integration of Aboriginal identity and culture may buffer the impacts of life stressors, including impacts of colonialism.

57 Ibid.
59 Ibid.
60 Ibid.
CULTURE-BASED APPROACHES TO SEXUAL HEALTH

Approach to Access to Health Services

Health Services

Aboriginal people in Canada have a right to access culturally-appropriate supports and services as affirmed by Section 35 of the Constitution (1982). The health, including sexual health, of urban Aboriginal people is greatly impacted by their lack of or limited access to appropriate, timely, and equitable health care. Appropriate, timely and equitable health care is being defined here as health services, programs, providers and institutions that: are culturally appropriate, culturally safe and accessible; are provided in a suitable timeframe that does not cause undue hardship, suffering or escalated risk; and give equal opportunity to individual's to obtain health care based on their perceived need.

Culturally appropriate and culturally safe health care begins with the belief that urban Aboriginal people need to be treated with respect and dignity in the health care system, to feel that their issues are being heard and their needs are being met. Aboriginal people who live in urban settings are more exposed to health programs that provide services and support for the general public, that take a "pan-Canadian approach", but as stated, this has been shown to alienate Aboriginal people.

1. It is recommended that all health professionals in Ontario undergo Aboriginal Cultural Competency Training in order to understand their roles and responsibilities in reducing barriers, providing culturally appropriate and safe healthcare, and empowering Aboriginal people and communities to address their health and wellbeing. The training must be inclusive of Aboriginal health issues, Two-Spirit and gender teachings, and the social determinants of health.

The voices of Aboriginal organizations and communities must be central to the development of any sexual health strategies or approaches intended to affect change in the lives of Aboriginal people. The importance of self-determination in achieving health equity is articulated clearly by the WHO, which states that health equity depends on the empowerment of individuals and groups to represent their own needs and interests strongly and effectively. The Aboriginal Health Policy for Ontario, created in collaboration with the Ontario Ministry of Health, also recognises that Aboriginal people have the right to develop and determine policies, programs and services, allocation of resources, and the selection of representatives on planning bodies in relation to their own health concerns. Sexual health services and supports that are delivered to Aboriginal communities by mainstream agencies will continue to underperform as compared to services that are designed, developed, delivered and evaluated by Aboriginal organizations. Policies, programs and services designed and developed by Aboriginal organizations are built upon a foundation of culture and employ a

61 National Aboriginal Health Organization (2011). First Nations, Métis and Inuit: Respiratory Health Initiatives Environmental Scan. Ottawa: NAHO. p. 4
comprehensive and wholistic approach to improve the physical, mental, emotional, and spiritual wellbeing of urban Aboriginal individuals, families, and communities.

2. Access to and effectiveness of sexual health programs and services delivered in urban Aboriginal communities will be increased when Aboriginal people and organizations are involved in planning, consultation, delivery and evaluation. This should include equitable funding to support the sustainability of successful programs and services in Aboriginal organizations.

The concept of self-determination extends to Aboriginal individuals and communities and their choice of health care services. Sexual health empowerment is enabling individuals, families and communities to understand all factors which affect their health and to recognize their own responsibility. This in turn includes respecting their personal choices in determining their own course of treatment and care. Traditional health care providers, including healers, medicine people and elders, continue to have a central and respected role in Aboriginal societies as caregivers who use traditional healing knowledge and incorporate ceremonies and rites of passage for Aboriginal youth. Aboriginal and western approaches to health do not need to be seen as dichotomous, but instead should be viewed as complementary methods for achieving optimal health.

3. An Aboriginal person’s choice of services will be acknowledged and respected in regards to their sexual health and health needs.

Taking responsibility for one’s sexual health, including making informed decisions about one’s sexual activities, requires appropriate access to sexual and reproductive health information, services and resources. This includes uncomplicated access to condoms and contraceptives, culturally-safe sexual health clinics, abortions and reproductive services, and safe, comfortable and confidential sexual health testing (e.g. Pap tests, pregnancy tests, and HIV and STI tests).

4. Reduce the barriers to sexual and reproductive information, materials, resources, and services necessary for the realization of positive sexual health and healthy sexuality.

Urban Aboriginal people’s sexual health needs are best addressed through wholistic, preventative and culturally appropriate approaches that focus on the interrelated physical, mental, emotional and spiritual aspects of health. Friendship Centres have indicated that projects, programs and initiatives that fit into the local culture, reflect local values, and use appropriate methods (i.e. community-based) are the most effective.

5. Sexual health promotion, awareness and prevention, and disease detection and management initiatives must adopt a wholistic and community-based approach that applies to all stages of the life cycle. This includes the development of information and materials for public education, awareness campaigns, policies and programs, and population-based measures on sexual health.
Successful programs and services, which are addressing the health needs of urban Aboriginal people, should be made sustainable and expanded across the province. For instance, the Medicine Wheel Healthy Way Clinic, located in the North Bay Indian Friendship Centre, is offering primary care access through a nurse practitioner for Aboriginal people who do not have a primary care provider. It is currently operating at maximum capacity with a growing wait list. The clinic is treating and managing many health conditions, including sexual health. In a recent survey of clinic clients, the vast majority of respondents indicated that, prior to the clinic opening, they had utilized a hospital emergency department in the past year for non-urgent conditions that could have been handled in a family doctor’s office.\(^{62}\) Now clients are reporting high satisfaction in the care received, are better managing their health conditions, are in an environment they trust and feel safe in, and are surrounded by Friendship Centre programs that address their other health and social needs. This is an example of a successful health intervention for urban Aboriginal people that needs to be made sustainable and expanded to other locations.

6. Expand and sustainably support the development and delivery of primary health care in Ontario Friendship Centres.

**Mental Health and Addiction Services**

The propagation of mental wellness among Aboriginal people is paramount to positive outcomes in sexualities and sexual health. Wholistic sexual health for Aboriginal people includes bringing balance in mental and emotional health to make sexually affirming life choices. The current systems that are in place to respond to Aboriginal mental health issues are fragmented and often inconsistent with Aboriginal approaches to building and sustaining good mental health and responding to mental distress. While there are many mental health programs and services offered to the urban Aboriginal population in Ontario, these supports are largely uncoordinated and do not integrate with sexual health services and programs. As a result, many Aboriginal people are recipients of inadequate and/or inappropriate care and services for both mental health and sexual health needs, despite the fact that, due to adverse socioeconomic factors, Aboriginal people often have the highest incidences of mental distress, including suicide and depression, and sexually transmitted infections, including HIV.

The OFIFC supports an Aboriginal integrative system response to mental distress and crisis intervention. An Aboriginal integrative system response recognizes the opportunity to re-establish or build resiliency in the person. It understands the concurrent relationship of different diagnoses of mental health and addictions, requiring the need for wholistic mental wellness strategies, and incorporating supportive surrounding health and social service supports. It operates according to the Aboriginal Framework for Wholistic Health and Well-being which provides a continuum of care, through the lifecycle, in a wholistic fashion. Finally, the services are trauma-informed, respective of the history of colonization and contemporary issues.

\(^{62}\) From the Clinic Client Survey: 34% of respondents had used the ED 1-2 times in the past year, 25% had visited ED 3-5 times, 3.5% went to ER 6-10 times, and 3.5% had visited ED more than 10 times.
7. Invest in the development and delivery of mental distress services in accordance with the Aboriginal Integrated system response.

The linkages between sexual practices and addictions among Aboriginal people is leading to increased exposure to sexually transmitted infections, sexual violence and sex without consent, and limited or no condom and birth control usage. Reducing the prevalence of alcohol and drug misuse and increasing treatment options for Aboriginal people will allow them to regain their sexual autonomy and maintain body integrity. The OFIFC believes that an approach to substance abuse based on harm reduction will prove to be an effective way to encourage safer, reduced, or eliminated substance use while reconnecting individuals with their culture and communities. Through the use of cultural supports and resources and in correlation with addiction treatment programs and services, harm reduction strategies will address the root causes of substance abuse, resulting in long-term wholistic healing for urban Aboriginal communities and improved mental health and well-being. The future success of harm reduction-based programming relies on thoughtful and community-driven research, planning, and implementation.

As mentioned previously, Aboriginal youth are using alcohol while engaging in sexual activity, which reduces their usage of contraceptives and increased the risk of pregnancy. Youth participants in the *Tenuous Connections* study cited pregnancy and parenting as motivators to “straighten out” and “curb substance abuse”. By using pregnancy as a substance abuse treatment method, Aboriginal infants are at heightened risk of in utero health issues. Aboriginal youth require increased access to culturally-appropriate addictions treatment programs, services and centres to effectively and appropriately address their addictions and substance abuse issues.

The OFIFC is strongly committed to improving the health and well-being of urban Aboriginal people struggling with addictions and currently administers the Aboriginal Addictions and Mental Health Program (AAMHP). The AAMHP is comprised of three sub-programs: the Alcohol and Drug Worker Program (AADWP), the Aboriginal Community Mental Health Program (ACMHP), and the Aboriginal Responsible Gambling Program (ARGP). As part of the AAMHP, the AADWP aims to assist urban Aboriginal people with substance abuse issues while minimizing or eliminating the negative effects of addiction for the individual, family, and community. While the AADWP is reporting success and serving a large number of urban Aboriginal people, it is only delivered in eleven sites throughout Ontario.

8. Support the Friendship Centres in the exploration and establishment of their own harm reduction policies, strategies, approaches, and frameworks.

9. Expand the delivery of the AAMHP and its components to all Friendship Centre sites in Ontario.

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63 *Tenuous Connections*, p. 41
10. Expand the delivery of Aboriginal youth-specific addictions treatment programs, services in Friendship Centres across Ontario.

**Approach to Prevention and Promotion**

When discussing the interventions to address the status of the sexual health of urban Aboriginal people, they must include interventions that respond to the social determinants of Aboriginal health. The delivery of health care alone will have little discernable influence upon sexual health at the level of the Aboriginal population because health status is strongly related to income, education, poverty, and other social characteristics. The social determinants of health are the circumstances and environments as well as structures, systems and institutions that influence the development and maintenance of health along a continuum from excellent to poor. They are socio-economic, political conditions influencing the health vulnerabilities and capacities, and health behaviours and management of individuals, communities and peoples. For urban Aboriginal people, the roles of culture, colonization, racism, and self-determination must be taken into account as powerful areas of social influence on health status. Aboriginal individuals and communities that live with the inequalities of the social determinants of health experience a greater burden of negative sexual health and overall health outcomes while also experiencing greater limitations in their access to resources that would improve the situation.

**Access to Sexual and Reproductive Health Education**

In empowering urban Aboriginal youth to make healthy and informed decisions about sex, their sexual health, and their actions, they require access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education, which understands the interrelated and complex challenges of urban Aboriginal youth. As the Aboriginal population is a relatively young population, with 46% being under the age of 25, making interventions in the area of sexual health among Aboriginal youth can have widespread results. In OFIFC study, *Tenuous Connections*, youth participants explicitly stated that they wanted information concerning sexual health, healthy relationships, pregnancy and the realities of teen parenthood. By making sexual education interventions at earlier ages and consistently throughout their youth, Aboriginal youth will be better informed and empowered to understand their sexual rights, voice their needs and desires, and engage in healthy, supportive sexual practices.

Two-Spirit youth require increased access to appropriate, safe and accurate information and resources regarding sexual and reproductive health topics. At present, Two-Spirit youth have limited to no access to sexual and reproductive health education that is

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relevant to their bodies or identities. When sexual and reproductive health topics are discussed or materials and information are being distributed within schools, groups or organizations, it rarely includes or is relevant to Two-Spirit youth. If sexual education is being delivered to Aboriginal youth, it should include Two-Spirit and LGBT information and Two-Spirit teachings at all times, and be delivered in inclusive, informed and safe spaces.

11. Increase access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education to Aboriginal youth, which is informed of their historical and contemporary issues and inclusion of Two-Spirit people.

The unique needs, interests and behaviours of Aboriginal youth should be incorporated into any sexual health programs in order to fully engage youth in the content. The lives of Aboriginal people have been shaped by their experiences with colonialism, racism, sexism, homophobia, and transphobia, and Aboriginal youth want resources and services that are reflective and responsive to those experiences. This requires the involvement of Aboriginal youth and Aboriginal organizations in the development and delivery of programs, services and resources directed at Aboriginal and Two-Spirit youth.

12. Involve and engage Aboriginal youth and organizations in the development and delivery of sexual and reproductive health education.

As Friendship Centres have been delivering quality programs for urban Aboriginal children, youth, and families for years, they have the foundational knowledge of the issues of Aboriginal youth in the area of sexual and reproductive health. Furthermore, the infrastructure of Friendship Centre programming provides a mechanism to increase the delivery of sexual and reproductive health education in a culturally safe setting, if the Friendship Centres had increased capacity support. This can include funding support of Friendship Centre Aboriginal Youth Councils, and training for Friendship Centre staff in sexual health education.

13. Increase the capacity and funding support of Friendship Centres to effectively deliver sexual and reproductive health education to Aboriginal youth.

Investing in Aboriginal education will benefit all Canadians as education has an enormous role in determining sexual health status and sexual health behaviours. People with more years of schooling tend to have better overall health and wellbeing and report healthier sexual behaviours. It is a mechanism to promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community well-being, especially in the area of sex, sexuality and sexual intimacies. Education reduces the need for health care related to sexual health and the associated costs of dependence, lost earnings and

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67 Reading. (2009). p.15
human suffering. Inadequate education often includes poor literacy, which affects one’s ability to acquire information about sexual health and correct usage of materials. Schools are the means to provide sex education and inhibiting access reduces uptake of important sexual health knowledge.

Therefore it is necessary for the education system to be more reflective and responsive to the wholistic needs of Aboriginal students to ensure that Aboriginal students will be academically successful and that the education system is accessible to Aboriginal students. By creating learning environments that are culturally-appropriate and culturally-safe for Aboriginal people, the schools will be able to engage the Aboriginal students as well as their parents in the outcomes and success of their learning. For this to be achieved, teachers as well as professionals involved in the education system should undergo Aboriginal Cultural Competency Training delivered by Aboriginal organizations. The education system will then have a better understanding to the histories and current circumstances of Aboriginal people, allowing them to be more responsive to Aboriginal learning styles.

Currently, the OFIFC administers several programs that work together to support wholistic learning for Aboriginal students in Ontario’s public school system. Three programs in particular work closely with children and youth in their education: Akwe:go, Wasa-Nabin and the Alternative Secondary School Program (ASSP). Taken together, these programs provide wholistic support to Aboriginal students at any stage in the education system ensuring that they develop the necessary social, cognitive, and emotional skills to reproduce Indigenous identities and optimize learning in a school setting, leading to the development of healthy sexualities and self-images.

14. Teachers and education professionals should undergo Aboriginal Cultural Competency training to ensure that schools and the education system is accessible to Aboriginal students and responsive to their learning styles.

15. Explore current sexual health education curriculum to ensure appropriate inclusion and representation of Aboriginal people.

16. Increased programming and funding for educational opportunities within ASSP for urban Aboriginal youth and adults.

*Children and Youth*

Learning about human development and sexual health starts at birth making parents the first educators of children and youth. Parents create the foundation of children’s values, attitudes and behaviours on sex and sexual health; but not all parents are comfortable with having open and ongoing discussions with their children or are knowledgeable on sex education topics. By delivering supportive services, resources, and preventative programs that build on the strengths of Aboriginal parents by reinforcing their

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69 Ibid.
capabilities, abilities, and potential, we will be addressing the current and future sexual health and wellbeing of Aboriginal children.

The Aboriginal Healthy Babies Healthy Children (AHBHC) has made significant inroads in supporting parents, including fathers, in the neonatal, natal and early childhood stages of parenting. The AHBHC program aims to improve the long term prospects of children up to six years of age and includes pre and post-natal screening and assessment, breastfeeding skill development, postpartum support services, home visiting, service coordination and support for service integration. The program focuses on preparation for parenting, early childhood development, emphasizing family empowerment, healthy sexuality/relationships, nutrition and physical health, networking and referrals, and linking parents and families with traditional and cultural teachers.

Over the years there have been significant increases in the number of clients accessing the AHBHC program in Friendship Centres. The OFIFC maintains that the AHBHC program is vital and requires increased resources including administration support and expansion of services. The AHBHC program workers in 14 sites have all reached the recommended maximum of 20 clients and are often working over capacity due to high service demand. With a high fertility rate and a young population, it can be expected that this need will continue to rise in urban locations.

17. Support the expansion of the Aboriginal Health Babies Healthy Children program to all 28 Friendship Centres in Ontario.

Ending Violence Against Aboriginal Women and Children

Family violence involves an abuse of power and the violation of trust, and includes emotional or psychological abuse, economic abuse (limiting or controlling access to financial resources), physical abuse, sexual abuse and/or neglect. It removes sexual autonomy from the abused party and models unhealthy relationships to children and youth.

Programs and services successfully administered by the OFIFC and offered by local Friendship Centres throughout Ontario have been proven to have positive outcomes for urban Aboriginal communities and youth by espousing a deeper understanding of gender that includes men’s roles and responsibilities. Programs like Kizhaay Anishinaabe Niin: I Am a Kind Man Young Peoples’ Initiative is designed for Aboriginal men and youth to take responsibility for violence against Aboriginal women and girls, and to encourage them to adopt traditional and healthy lifestyle choices. Kizhaay accomplishes this by focusing more on rebalancing Aboriginal peoples through the seven grandfather teachings in order to eliminate the gendered understandings imposed through colonial discourse. The importance of programs like Kizhaay is the fact that they take away the focus from the victim as the problem and instead work towards

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wholistic community responses to violence against Aboriginal women and gender inequity.

18. Support the sustainable expansion of the Kizhaay Anishnaabe Niin program to all Friendship Centres.

CONCLUSION

Prior to colonization Aboriginal people had a robust understanding of gender, sexuality and sexual health, with interrelated methods for generational knowledge transmission and systems of community support. The OFIFC and Friendship Centres are seeking to restore those connections while repairing from the traumas and damages resulting from a history of cultural and gender assimilation, trauma, racism, homophobia, and transphobia. The challenge will be how to meaningfully incorporate the unique issues of urban Aboriginal sexual health into wholistic and collaborative solutions. Addressing the issues of Aboriginal sexual health requires actions, strategies and partnerships that extend beyond the realms of sexual or general health, because these are largely determined by individual and collective social determinants of health. Urban Aboriginal people, as a whole, experience widespread barriers to services and programs in health, education, employment, and social services, therefore advancing an agenda of healthy sexuality and sexual health will require the involvement of multiple, necessary stakeholders. Addressing negative sexual health outcomes presently will have the long-term results of producing happier and healthier urban Aboriginal children, youth, adults and elders.
APPENDIX 1

Recommendations

1. It is recommended that all health professionals in Ontario undergo Aboriginal Cultural Competency Training in order to understand their roles and responsibilities in reducing barriers, providing culturally appropriate and safe healthcare, and empowering Aboriginal people and communities to address their health and wellbeing. The training must be inclusive of Aboriginal health issues, Two-Spirit and gender teachings, and the social determinants of health.

2. Access to and effectiveness of sexual health programs and services delivered off-reserve will be increased when Aboriginal people and organizations are involved in planning, consultation, delivery and evaluation. This should include equitable funding to support the sustainability of successful programs and services in Aboriginal organizations.

3. An Aboriginal person’s choice of services will be acknowledged and respected in regards to their sexual health and health needs.

4. Reduce the barriers to sexual and reproductive information, materials, resources, and services necessary for the realization of positive sexual health and healthy sexuality.

5. Sexual health promotion, awareness and prevention, and disease detection and management initiatives must adopt a wholistic and community-based approach that applies to all stages of the life cycle. This includes the development of information and materials for public education, awareness campaigns, policies and programs, and population-based measures on sexual health.

6. Expand and sustainably support the development and delivery of primary health care in Ontario Friendship Centres.

7. Invest in the development and delivery of mental distress services in accordance with the Aboriginal Integrated system response.

8. Support the Friendship Centres in the exploration and establishment of their own harm reduction policies, strategies, approaches and frameworks.

9. Expand the delivery of the AAMHP and its components to all Friendship Centre sites in Ontario.

10. Expand the delivery of Aboriginal youth-specific addictions treatment programs, services in Friendship Centres across Ontario.
11. Increase access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education to Aboriginal youth, which is informed of their historical and contemporary issues and inclusion of Two-Spirit people.

12. Involve and engage Aboriginal youth and organizations in the development and delivery of sexual and reproductive health education.

13. Increase the capacity and funding support of Friendship Centres to effectively deliver sexual and reproductive health education to Aboriginal youth.

14. Teachers and education professionals should undergo Aboriginal Cultural Competency training to ensure that schools and the education system is accessible to Aboriginal students and responsive to their learning styles.

15. Explore current sexual health education curriculum to ensure appropriate inclusion of First Nations, Inuit and Métis representation and

16. Increased programming and funding for educational opportunities within ASSP for urban Aboriginal youth and adults.

17. Support the expansion of the Aboriginal Health Babies Healthy Children program to all 28 Friendship Centres in Ontario.

18. Support the sustainable expansion of the Kizhaay Anishnaabe Niin program to all Friendship Centres.