

# *Decolonizing Policy Discourse: Reframing the 'Problem' of Fetal Alcohol Spectrum Disorder*

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*In this paper, we examine how Canadian federal policy discourse on Fetal Alcohol Spectrum Disorder (FASD) frames the 'problem' of alcohol use and FASD in gendered and colonial ways that marginalize the needs of women. Applying a critical feminist lens to key policy documents, we show how Aboriginal women continue to be constructed as perpetrators of the 'problem' of FASD, while the structural, social, and historical processes (i.e., urbanization, racialization, and colonialism) that give rise to women's health and social inequities are obscured. Our aim is to contribute to the dialogue that feminist, indigenous, and women's health scholars have offered with respect to recognizing and problematizing the assumptions implicit within health policy. This analysis highlights the need to re-contextualize current policy discourses in ways that foreground women's health experiences within intersections of power and ongoing processes of discrimination.*

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*"FAS/FAE are serious concerns for First Nations and Inuit...You can prevent FAS/FAE by not drinking alcohol when pregnant or nursing."  
(Health Canada, 2002a)*

The term Fetal Alcohol Spectrum Disorder (FASD) is used to describe a range of physical and/or developmental disabilities experienced by children born to mothers who drink alcohol while pregnant (Poole, 2003). In Canadian health policy initiatives and FASD

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prevention campaigns, the link is often made between alcohol use<sup>2</sup> by Aboriginal<sup>3</sup> women and children who are diagnosed with FASD (Tait, 2009). As such, FASD is often identified in public discourses and popular conception as an 'Aboriginal problem'. Despite the growing argument among researchers that Aboriginal communities may be no more affected by FASD than non-Aboriginal communities (Pacey, 2009; Poole, 2003; Tait, 2009, 2008b), FASD continues to be identified as an Aboriginal 'issue' (Fiske & Browne, 2006; Greaves et. al., 2002). As a result, the dominant discourses about FASD divert attention away from local and systemic factors contributing to women's alcohol use, thereby perpetuating negative misperceptions about Aboriginal women, and Aboriginal health and social issues.

Understanding the multiple factors that may influence pregnant women to use alcohol often fails to be a priority within much research, media, and policy processes. The dominant discourses perpetuated within these processes inform and are informed by particular constructions of maternal alcohol use. It is through critical analysis of such discourses that the politics involved in the framing of a policy 'problem' can be understood (Codd, 1988; Fiske & Browne, 2006). In Canada, for example, health policies have been instrumental in constructing indigenous women's health and social issues in individualistic, racialized<sup>4</sup>, and often stigmatizing ways (Bourassa, McKay-McNabb & Hampton, 2004; Cull, 2006; Fiske & Browne, 2006). Examining how policy can contribute to obscuring the social, structural, and economic factors affecting health behaviour is integral to adequately address the growing gap in health inequities in Canada, a trend that impacts Aboriginal women and Aboriginal people in significant ways.

Despite this widening gap in health inequities across the country, Canada has reduced its program spending in all policy areas in ways that are unmatched in other developed nations, resulting in social inequities and conditions that have a detrimental impact on health,

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<sup>2</sup> Similar to Rutman et al., (2000), we adopt a "value-neutral stance" in relation to women and alcohol use. The terms "abuse" and "misuse" can imply judgment and divert attention from the complexities of women's lives (p. ix).

<sup>3</sup> The term "Aboriginal peoples" refers to the indigenous people of Canada including First Nations, Inuit, and Métis (Royal Commission on Aboriginal Peoples [RCAP], 1996, p. xii). These groupings refer to self-identified categories, rather than signify "racial" characteristics (RCAP, p. xii).

<sup>4</sup> Racialization refers to the process of attributing social, economic, and cultural differences to 'race,' and is often enacted through everyday actions and attitudes, and from institutionalized policies and practices that marginalize individuals and collectives on the basis of presumed biological, physical, or genetic differences. In Canada, racializing processes, policies, and practices have been central to the colonial project of defining, categorizing, and managing Aboriginal peoples (Browne, 2005).

particularly for women (Coburn, 2010; Varcoe, Hankivsky & Morrow, 2007). These cutbacks in policy spending have had an especially deleterious effect on Aboriginal women (Native Women's Association of Canada [NWAC], 2007; Tait, 2008a). Despite recent calls from various UN treaty bodies<sup>5</sup> to address the disadvantaged social conditions and racialized violence faced by many Aboriginal women, government responses have been minimal (BC CEDAW Group, 2010). It is against this backdrop that analyses of ongoing government policies and initiatives and their effects must be considered.

In this paper, we examine the ways in which a key policy document of the Public Health Agency of Canada (PHAC)<sup>6</sup> - *Fetal Alcohol Spectrum Disorder: A Framework for Action* (PHAC, 2005) (herein called the *Framework*) - fails to contextualize Aboriginal women's health within historical, social, and economic systems of power and structural disadvantage. Though FASD is not a health issue exclusive to Aboriginal people, an analysis of the *Framework* illustrates how dominant policy discourses can racialize and marginalize the experiences and needs of Aboriginal women. This analysis, informed by critical feminist perspectives, specifically addresses how Aboriginal women are constructed as perpetrators of the 'problem' of FASD, while the structural, social, and health inequities that give rise to women's alcohol use are obscured. In so doing, we show that policy discourses, while well intentioned, can inadvertently disadvantage indigenous people in Canada and internationally by racializing and stigmatizing women. In our analysis, we highlight how these constructions ultimately limit the development of meaningful policy responses that could be attentive to the inter-related social and structural conditions that shape health and influence substance use. Lastly, we argue for the need to reframe and redefine the 'problem' and in turn, the policy responses from an intersectional and women-centred perspective. Such a paradigm can serve to highlight the *interrelatedness* of 'race', gender, and class discrimination, as well as the co-constructed nature of racialized,

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<sup>5</sup> These include the Committee on the Elimination of Discrimination Against Women (CEDAW) in 2008, the Committee on Economic, Social and Cultural Rights in 2006, and the Committee on the Elimination of Racial Discrimination in 2007 (BC CEDAW Group, 2010).

<sup>6</sup> The Public Health Agency of Canada (PHAC) resides within Health Canada, the federal government department responsible for helping to maintain and improve the health of Canadians. PHAC was created in 2004 out of a federal commitment to strengthen the public health system in Canada, to achieve "better health and well-being" and to reduce health disparities among Canadians. PHAC's activities focus on health promotion, chronic disease and injury prevention, and infectious disease protection on a national level (PHAC, 2008).

gendered, and classist assumptions in shaping women's health and social experiences, and ensuing policy responses.

To foreground our analysis of the *Framework*, we will first outline some key contextual issues surrounding Aboriginal women and health and social inequities in Canada, and how these relate to dominant discourses of mothers who use substances. We will then underline the relevance of critical feminist analyses in problematizing and informing policy and the discourses surrounding policy. This is followed by a brief background of the *Framework* and a critical analysis of its discourses. We conclude with a discussion of the implications of our analysis on future research and policy directives in Canada and internationally in the area of substance use and FASD.

### *The Social & Political Context of Aboriginal Women's Health*

Current health and social status indicators for Canadian Aboriginal women are well documented and demonstrate major discrepancies in comparison to other Canadian women (Dion-Stout, 2005; NWAC, 2007). Compared to non-Aboriginal women in Canada, Aboriginal women experience higher rates of poverty, lack of access to safe and affordable housing, and lack of access to higher education, job training, employment, entrepreneurial loans and investments, and related socioeconomic opportunities (NWAC, 2007). On virtually all health status indicators, Aboriginal women in Canada show higher morbidity and mortality rates. These ongoing health and social inequities have been directly linked to the history of colonization, and to institutionalized discrimination enshrined in colonial policies and legislation in Canada (Bourassa, McKay-McNabb & Hampton, 2004). For instance, physical environments that are largely detrimental to health have been imposed through historic dispossession of traditional territories as well as current reserve or settlement structures, often resulting in unaffordable housing and homelessness for urban Aboriginal people (Browne, McDonald & Elliot, 2009). The inadequate response of the Canadian government to Aboriginal women's experiences of social dislocation and disadvantage continues to perpetuate patterns of institutionalized discrimination (Loppie-Reading & Wien, 2009).

In Canada, the "inferiorization" of Aboriginal mothers (Fiske, 1993, p. 20) has been a continuing colonial image, which has constructed Aboriginal women as irresponsible in relation to childcare and parenting (Browne, 2005; Fiske & Browne, 2006). These colonizing images have been instrumental in the 'policing' and surveillance of Aboriginal mothers by child welfare authorities. The magnitude of policing is evident in the high rates of Aboriginal children currently in out-of-home care (approximately 40% of all children) (Farris-Manning & Zandstra,

2003). The rates reflect a continuation of a process started in the 1960s when thousands of Aboriginal children were deemed to be in need of protection from their families and relocated by the state to non-Aboriginal families (Cull, 2006). In current times, surveillance of Aboriginal women also contributes to their overrepresentation in the justice system, and increased stigmatization and scrutiny within health and social settings (Browne, McDonald & Elliot, 2009). Colonial myths about genetic vulnerability of Aboriginal people to the effects of alcohol (which persist, despite evidence dispelling such theories) also work to discredit Aboriginal people (and mothers) as capable/self-governing citizens (Browne, 2005, 2007; Furniss, 1999).

*Increased Visibility of Aboriginal Women who use Substances*

The cumulative effects of colonization - intergenerational traumas, poverty, systemic discrimination, and displacement - have been directly connected to substance use and addiction issues for Aboriginal people in Canada (Adelson, 2005). Many women who experience substance use and addictions also experience racialization, discrimination, poverty, and interpersonal violence, which are often at the root of substance use issues (Rutman et. al., 2000; Shannon et. al., 2008; Tait, 2009; Varcoe & Dick, 2008). These social conditions - exacerbated in Canada by neoliberal policies that have brought about cutbacks to social housing, women's shelters, and mental health and addictions programs (Varcoe, Hankivsky & Morrow, 2007) - have contributed to the social dislocation and socioeconomic marginalization of many Aboriginal women and are critical factors contributing to substance use behaviours (Varcoe & Dick, 2008). Further, programs integral to health are often unavailable in rural areas, or inaccessible for Métis and non-status Aboriginal women in urban areas (where the majority of Aboriginal people live) due to legislative barriers. Yet, such contextual factors influencing and sustaining women's substance use are consistently ignored in policy discourses related to substance use (Wilson & Martell, 2003).

When the contexts of substance use are absent within social and health policy discourses, pregnant, substance-using women are often labelled with blame-based identifiers. In Canada, these have often included identifiers such as "indigent, welfare-dependent, possibly homeless, marginalized, and more than likely Aboriginal" (Rutman et. al., 2000, p. 85). When constructions of unhealthy Aboriginal women intersect with neoliberal discourses about peoples' ability to make 'healthy choices', Aboriginal women become stigmatized as being responsible for their own ill health (Tang & Browne, 2008; Browne, 2005; Furniss, 1999). These discourses also underpin discriminatory health practices. For instance, screening methods for substance use during

pregnancy have been criticized for an inherent racial and class bias in the ways they are designed and applied, especially contributing to the over-surveillance of Aboriginal mothers. These racialized and gendered associations between alcohol use and 'bad mothering' have perpetuated the hypervisibility of Aboriginal women in discourses of FASD (Tait, 2009). Overall, the continued surveillance of and discrimination toward Aboriginal mothers who use substances have resulted in their over-representation in FASD policy, while being under-represented as experts of their own health needs and experiences (Salmon, 2007).

### *Analyzing Policy Discourses: Critical Approaches*

Public policies can be considered guides to plans, frameworks, or courses of action or inaction constructed to deal with a problem (Pal, 2006). The discourses within policies are important intersections between language and power; power works through discourse to shape what one perceives as reality (Foucault, 2003) and frames the production and interpretation of policy texts (Ball, 1994 cited in Taylor et. al., 1997). The way health issues or 'problems' are framed in health policy discourse directly relates to how the issue is understood, thus the type of solutions that are considered to address it. Drawing on Codd's (1988) framing of critical policy analysis, we consider the *Framework* as constituting the "official discourse of the state", where language constructs "particular meanings and signs that work to mask social conflict and foster commitment to the notion of universal public interest" (p. 237). From this perspective, public policy discourses - and the action or inaction they perpetuate - are not removed from hegemonic values and the legitimation of authoritative interests (Bryant, 2009; Pal, 2006). As Bryant (2009) argues, such analysis "illustrates how health policy reflects ideological commitments - and action in support of such ideologies - of governments and various interests, sectors, and society" (p. 20). Thus the interests of individuals, systems and institutions in locations of power are often reflected in policy and its surrounding discourses.

In any analysis of current public policy discourses in Canada, it is important to discuss the dominant and interrelated ideologies that shape them. Over the last few decades in Canada, the dismantling of the welfare state has led to an increasing reliance on a free market economy, premised on the belief that citizens have equal freedom to access resources and can take personal responsibility for their well-being (Raphael, Curry-Stevens & Bryant, 2008). For instance, notions of 'public health' in Canada and its corresponding branches of 'health promotion' and 'health protection' are integral to the discursive shift towards the individualization of health and illness; this can be equated to what Orsini (2007) refers to as the "responsibilization paradigm" in health care (p. 349). The effect of this paradigm has been to hold individuals more

responsible for their situations, while simultaneously depriving them of access to the resources required for good health. This has contributed to the conflation of poor health as the inevitable result of poor 'lifestyle' choices.

Critical feminist analyses of discourses draw attention to the ways in which dominant discourses are imbued with gendered assumptions and ideologies. A critical feminist analysis highlights how discourses can create and perpetuate hegemonic power relations and how these create real-life consequences for men and women in specific contexts (Lazar, 2007). For instance, responsabilization discourses tend to stigmatize those who face barriers to health or healthcare as individual failures, overlooking the systemic barriers that shape peoples' experiences of inequity within social and health contexts. In the following analysis, we examine the *Framework* as a window onto dominant policy discourses about alcohol use, mothering, and Aboriginal women. As we argue, problematizing these discourses is needed to work towards more appropriate policy responses to alcohol use and FASD.

#### *Context of the FASD Framework for Action*

FASD is a life-long disability without a cure - but it is preventable. It is time for renewed efforts and a comprehensive approach to preventing the disorder and supporting those with it (PHAC, 2005, p. ii).

The *Framework for Action* was initiated by Health Canada as a starting point for action on FASD (PHAC, 2005, p. 2). The *Framework* stems from FASD policy initiatives that began in 1999, with the federal government allocating \$11 million in funding to "enhance activities related to FASD, including public awareness and education; training and capacity development; early identification and diagnosis and assessment; co-ordination and sharing of information and best practices; surveillance; and a strategic project fund" (Government of British Columbia, 2003, p. 3). The *Framework* was developed so that frontline workers and program and policy developers could "understand FASD better" as well as understand directions for collaborative action (PHAC, 2005, p. 2). As the most recent federal and national directive for FASD, the *Framework* is an important exemplar of dominant FASD discourse, since it serves as the basis for future policy and practice and was built from the input of organizations across Canada.

In our analysis of the *Framework*, we discuss three themes that represent limitations in the current approach to alcohol use and FASD prevention: 1) that alcohol using mothers require more health education on the benefits of abstinence; 2) that women must act individually to avoid harming their children through alcohol use; and 3) that women most impacted by FASD are most likely Aboriginal. These themes are organized according to dominant and interrelated discourses which

focus on: a) the positioning of 'health education' as the solution to FASD; b) the construction of individual mothers as dangerous; and c) the stigmatization of Aboriginal women.

***The Positioning of 'Health Education' as the Solution to FASD***

A key way in which current FASD policy discourse eclipses the experiences and contexts of women is its focus on health education as the primary prevention strategy. Messages within Health Canada's abstinence policy such as "don't drink" (Centre for Addiction and Mental Health, 2008) and messages urging people to follow a "sensible guide" (PHAC, 2007) or make "prudent choices" (Health Canada, 2002b) with respect to drinking while pregnant abound in public campaigns. The individualistic assumption underlying these discourses is that alcohol use during pregnancy is largely a result of inadequate knowledge or lack of awareness. Yet, it has been well documented that increased knowledge is not necessarily sufficient to bring about changes in alcohol or substance use for women (National Aboriginal Health Organization [NAHO], 2006). Reflecting the ideology of liberal individualism, the language of individuals as responsible for making the right 'choice' frames the solution to alcohol in terms of personal responsibility. Correspondingly, stigmatizing constructions of women who use alcohol illustrate how, within policy discourses, "it is a very short step from personal responsibility to blame" (Wolanski, 2005, p. 29).

The *Framework* overemphasizes health education's role in preventing alcohol use during pregnancy while failing to discuss the complex factors that intersect with alcohol use and addiction, including experiences of violence, mental health concerns, housing instability, and social isolation (Salmon et. al., 2006; Stout, 2010). Within the "aims" of the *Framework*, the first goal of FASD prevention involves enabling women who may use alcohol during pregnancy "to make *informed and positive decisions* about their health and the health of their family by *improving awareness* of the dangers and impacts of alcohol consumption during pregnancy" (PHAC, 2005, p. 9, emphasis ours). Though the *Framework* mentions that making these decisions can be aided through "a range of social and economic supports" (p. 9), what these supports are, and how they might fit with the lived social and economic realities and needs of women are not discussed.

Despite later acknowledging some "root causes" of alcohol use during pregnancy, these 'causes' remain largely individualistic and located within women's individual psychological characteristics (i.e. "low self-esteem", "poor knowledge", and "stress") or they are related to personal control (i.e. "lifestyle issues") (PHAC, 2005, p. 13). Though these factors are discussed in general terms that are assumed to apply to all women, they have particular salience when considered in relation to



the specific issues facing many Aboriginal women in Canada. The factors discussed in the *Framework* remain decontextualized from the social and structural forces of oppression that intersect with women's lives including gendered and racialized discrimination in the case of Aboriginal women in Canada. The wider social factors mentioned in this list of "root causes" - "family violence" and "poverty" (p. 13) - are also disassociated from the oppressive processes and systems that often perpetuate them, such as gender-based violence and the racialization of poverty. As factors that underlie substance use among women, such social and structural issues are unlikely to be alleviated through reliance on health education campaigns.

Further, though it is argued that FASD affects Canadians "in all walks of life", the *Framework* states that "in some First Nations and Inuit communities, given the history of colonization and devaluation of culture, rates of FASD may be higher than the national average" (PHAC, 2005, p. 8). While it is important that these historical issues are recognized as impacting Aboriginal health, statements such as this, in the context of the *Framework* as a whole, has the potential to stigmatize Aboriginal women in a number of ways. First, such statements position FASD as a particular problem within First Nations and Inuit communities without substantiating this 'fact' with evidence. To the contrary, current analyses reveal that much research has erroneously overrepresented the prevalence of FASD among Aboriginal communities largely due to a biased focus on Aboriginal people (particularly reserve communities) as sites of study (Tait, 2009). Secondly, substance use fails to be linked to *continuing* experiences of discrimination and racism that affect many Aboriginal women. Third, the focus on health education implicitly assumes that Aboriginal women are necessarily uneducated or ignorant about issues that affect their health. Decontextualizing alcohol use and emphasizing prevention through health 'education' further the surveillance and stigmatization of Aboriginal women who use alcohol, and fail to address the conditions of many women's lives that make women more vulnerable to alcohol use. These discourses conflict with the reality that, as Cull (2006) argues, "it is rare for a woman to knowingly and willingly harm her child" (p. 152).

#### *Constructions of Mothers as 'Dangerous'*

Closely related to the *Framework's* construction of risk-taking women who require health education is the construction of mothers as intentionally contributing to fetal or child neglect. Rather than highlighting women's substance use as complex and stemming from intersecting social and structural issues, dominant policy discourses in Canada often contribute to the construction of mothers who use substances as uncaring or dangerous to their children and society (Tait,

2009). Reaffirming this construction is the dominant image of the vulnerable fetus at risk of 'permanent disability'. For example, a Health Canada FASD leaflet points to the "significantly greater" occurrences of FASD among Aboriginal babies immediately before emphasizing that supporting those with "lifelong disability" is "a national public health, education, economic, and social concern" (Health Canada, 2006). Pathologizing Aboriginal people as having brain dysfunction results in the social and environmental factors that influence behaviour to be ignored or "rescripted as secondary disabilities" (Tait, 2009). These national level discourses intersect to construct a two-fold 'problem': 1) an increased burden of those with FASD on society's resources; and 2) a morally justifiable need to increase intervention and surveillance of inherently neglectful mothers.

Though understanding the needs and perspectives of those who have been affected by substance use is paramount, the tendency for dominant discourses to essentialize Aboriginal people as 'permanently disabled' or 'suffering', while stigmatizing Aboriginal populations as a whole, criticizes and blames mothers (Rutman et. al, 2000; Salmon, 2004). The discourse of the *Framework* underlines the notion that it is the responsibility of a pregnant woman to protect her unborn child from harm, while casting 'harm' as solely related to individual choice. In turn, potential 'harms' posed to the fetus via broader determinants such as inadequate housing or violence towards women fail to be addressed. This focus on protecting the fetus from the mother's behaviour is illustrated in a *Framework* strategy centred on expanding the knowledge base to "inform activities in prevention, treatment, support and protection of people with FASD" (PHAC, 2005, p. 13). Though the strategy points to some of the "root causes" of alcohol, including "stress" and "poverty", it finally emphasizes: "Clearly, women have an important role in preventing FASD" (p. 13). Here, a woman's "role" is reduced to protecting her child from 'preventable' harm by engaging in behaviours that are implicitly constructed as easily doable and straightforward to achieve: abstaining from alcohol by gaining knowledge of the harms. This tendency to focus on 'preventable' lifestyle factors influencing fetal development while ignoring social context (i.e. poor nutrition due to poverty) is a dominant trend within health policy processes (Rutman et. al, 2000).

Not surprisingly, the required supports discussed within the *Framework's* goals centre around the needs and diagnoses of alcohol-affected children, while the gaps in support for alcohol using women remain unacknowledged. Such discourse of fetal protection aligns itself with the argument that FASD has been largely framed within health and social campaigns and policy initiatives as a child health and welfare issue (Poole & Greaves, 2009; Poole, 2003). This has created challenges to

making health and social systems responsive to the needs of pregnant women; the provision of non-judgmental intervention, relevant information (beyond abstinence-based health education) and social support for women who use substances during pregnancy have been minimal (Greaves & Poole, 2004). Evidence of this lack of focus on women and the root causes of substance use is especially prevalent in policy making processes, exemplified by the fact that a document designed to solicit community input for the *Framework* failed to include a discussion of women's use of substances during pregnancy (Poole, 2003).<sup>7</sup> Overall, there remains a need for both national and provincial strategic plans that address FASD to push for a better balance between initiatives focusing on FASD diagnosis and interventions, and women-centred initiatives that provide non-judgmental support for both women and their babies (Poole & Dell, 2005).

### *Stigmatizing Constructions of Aboriginal Women*

The tendency toward blame-based and stigmatizing discourses in health policy can operate in ways that overlook the complexities of women's social locations and contexts, and health and social issues. Reflective of this is the tendency for FASD policy discourses in Canada to reinforce the construction of FASD as a "Native people's problem" requiring state intervention (Cull, 2006, p. 152). Such constructions of Aboriginal people are invoked in the *Framework*, beginning with a reference to the possibility of high FASD rates among "First Nations and Inuit communities" within the introductory description of FASD (PHAC, 2005, p. 8). Depicting FASD as especially prevalent among these communities and following with constructions of mothers as uneducated and dangerous further stigmatizes Aboriginal women. Failing to connect Aboriginal women's health experiences beyond "a history of colonization" and "devaluation of culture" reinforces the unidirectional link often made between colonization and individual conditions like mental distress and FASD – conditions that are often discussed as rooted in individual failure thus requiring individual intervention (Tait, 2009). Yet, this narrow discourse that assumes a linear and necessary relationship between the colonial 'past' and individual health and social 'problems' ignores present-day intersections of oppression that perpetuate poor health as well as how these intersections may vary between Aboriginal people.

Further, although the *Framework* states that information on FASD should be "gender appropriate and ethno-culturally sensitive", a

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<sup>7</sup> See Health Canada. (2002). *Developing a national Framework for action on Fetal Alcohol Syndrome/Fetal Alcohol Effects: National Framework for action workbook*. Ottawa (ON): Health Canada.

description of what that would entail is absent (PHAC, 2005, p.11). The emphasis on “Aboriginal people” as the only “ethnocultural group” discussed in the *Framework* (p. 11) links FASD to problems that are particular to Aboriginal women and suggests FASD is culturally-based. Failing to explain what “sensitivity” to ethnocultural groups entails risks reinforcing essentialist constructions of FASD as a product of, for example, Aboriginal ‘culture’ or ‘cultural difference’. In addition, Aboriginal people as a whole are essentialized in the discourse about FASD as a single “ethnocultural group”, assumed to share similar risk factors and needs for intervention. Although, in urban contexts, there is often a shortage of culturally appropriate support services for the rapidly growing urban Aboriginal population (Browne, McDonald & Elliott, 2009), the failure of the *Framework* to contextualize this need perpetuates perceptions in mainstream sectors that certain ‘cultural’ attributes contribute to Aboriginal women’s poor health status.

#### IMPLICATIONS FOR RESEARCH & POLICY DIRECTIVES

Though the *Framework for Action* highlights alcohol use and FASD as a topic warranting public discussion and investment nationwide, the discourses it promotes and reinforces are concerning in terms of knowledge translation and legislative action. Without consideration of the needs and contexts of women affected by alcohol use and FASD, ‘prevention’ messages and methods, such as those promoted within the *Framework*, will fail to be meaningful to those they target. The result is (a) a furthering of discriminatory assumptions of ‘risk’ and ‘prevention’ within health education, child-welfare, and substance use services, and (b) further marginalization of women. A starting point in resisting this discourse is the prioritization of an integrated women-centred approach to substance use and FASD management that respects and supports the health needs of both children and mothers (Poole, 2007). Providing this kind of support requires a shift from individualizing and essentializing notions of personal failure towards recognizing the effects of interrelated and marginalizing *processes* on women’s and children’s health.

Attention to the ways in which health intersects with social, historical, and structural processes has been emphasized as key to addressing health inequity in Canada (Hankivsky et. al., 2010). However, there remains a serious lack of systematic gender or equity-based analysis in the areas of substance use and addiction in Canada (“Ad Hoc”, 2006). In turn, this has resulted in a diminishing number of health programs and interventions for supporting women’s health and thus, their capacities as mothers (Greaves et. al., 2002; Rutman et. al., 2000). This lack of support within substance use policy initiatives is typified by Salmon (2007), who highlights the need for women-centred support in

relation to urban Aboriginal mothers whose lives have included substance use and FAS. She concludes, "Although women identified that public health education initiatives about the effects of substance use in pregnancy were important, they repeatedly emphasized that without accompanying structural and personal supports that made it possible to make change, such initiatives were not enough" (n.p.). Further research on the diverse social, structural, and spatial contexts of women's substance use - particularly in relation to urban Aboriginal women (Browne, Varcoe & Fridkin, 2011) - will be needed to ensure such supports are available and meaningful.

Despite these insights, women-centred and intersectional approaches in relation to women and substance use often fail to be taken up within government policy, reflecting the common disjuncture between knowledge and policy practices (Hankivsky et. al., 2010; Varcoe, Hankivsky & Morrow, 2007). In relation to Aboriginal women in Canada, Cull (2006) links this disjuncture to passivity of the state in providing help for women who use substances, and to the tendency for the state to invest resources in the aggressive criminalization of substance use. For example, it was estimated that of the \$454 million spent annually on Canada's substance use strategy in 2000, 94 percent was spent on enforcement initiatives while a mere six percent was shared between prevention and treatment programs (Office of the Auditor General of Canada, 2001). Though the need for a more balanced approach to investment has been acknowledged since then, law enforcement initiatives have continued to receive an overwhelming majority of national substance use strategy funding (DeBeck et. al., 2009).

Unless the current *Framework* - and the related policy discourses it can be considered to represent - shifts away from a "moralizing/medical model" (Rutman et. al., 2000, p. iv) that relies on health education as a solution, towards one that attends to the intersecting determinants of women's health, erroneous constructions of FASD will align poorly with the health and social needs of women. Doing this requires FASD initiatives to include representational consultation and increased dialogue across groups of women affected by substance use and FASD. In the case of Aboriginal people, a participatory process of taking back responsibility for health and defining models of well being is vital to restore individual and collective wellness (Native Mental Health Association, 2007). It is suggested within the *Framework's* appendix that future policy processes be "more inclusive and community driven", suggesting that "Aboriginal groups and community-based groups be at the centre of future consultations" (PHAC, 2005, p. 23). However, despite the opportunity for engagement called for in the *Framework*, a commitment or mandate to include the input of Aboriginal health stakeholders in future strategies is absent. Not

surprisingly, many Aboriginal women and Aboriginal communities remain sceptical as to the true commitment of government to provide continuous support for health initiatives that can address the wider context of Aboriginal women's health (Tait, 2008a).

It is clear that the current focus on diagnosing and treating FASD affected children must be expanded to include attending to women's health and social needs, otherwise current policy directives will only increase the surveillance and stigmatization of 'neglectful' mothers. Unfortunately, current discursive practices that identify maternal substance use as a consequence of 'bad mothering' continue to frame the issue as requiring education, treatment, or punishment (Rutman et. al., 2005), rather than requiring that systemic inequities be addressed. These dominant policy discourses have implications in Canada and internationally. It will, therefore, be important to foster collaborative community-based approaches to develop policies that address substance use in ways that are responsive to structural inequities and systemic oppressions. Importantly, critical feminist perspectives can continue to inform such approaches in understanding and attending to substance use and the intersections of women's health.

## CONCLUSIONS

In a recent study examining the impact of health policy on substance-using women in Canada, researchers found that both Aboriginal women and health and social service providers underlined the need for "a fundamental shift in the ideologies and societal attitudes relating to pregnant women's and mother's substance use" and a reconceptualization of maternal substance use in more "holistic and humanistic" ways (Rutman et. al., 2005, p. 243). Shifting the ideologies and discourses relating to pregnant women's alcohol use is clearly required to allow for policy and practice to be supportive of both women and their children. Though it has been argued that policy analysis alone may not influence the policy process directly (Pal, 2006), interrogating policy discourses and how they may be interpreted within wider political processes can shape political change and lead to new ways of thinking within public policy processes and programming (Bryant, 2009). This is especially relevant in the context of substance using women whose health and social experiences often fail to be seen as located within intersections of inequity, racialization, and disadvantage. There is also a pressing need to counter pathologizing discourses about Aboriginal women's health and social issues, which continue to locate problems in 'unhealthy' choices made by individual women and communities. Doing so will necessarily involve new and integrated approaches to FASD policy and practices in ways that move beyond

'raising awareness' - and instead, centre on the wider contexts and experiences of women's lives.

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