



CHAPTER ONE

## Who Are the Women of Manitoba?

In this chapter we describe the basic demographics of the population of women in the province. In particular we describe the populations of First Nations, Métis and other Aboriginal women, including an overview of their health status and a description of the health data available.





## Who Are the Women of Manitoba?

Women comprise just over half of Manitoba's population. In 2006, Manitoba's population was estimated at 1,177,765 with 585,414 men and 592,351 women [1]. The median age of women in Manitoba was 39.2 years, with 81.3% of the population over the age of 15 [2].

Most female residents in Manitoba identify as Caucasian. Total visible minority populations in Manitoba are estimated at 87,110, with female (non-Aboriginal) visible minority populations at 43,770 [3]. The primary ethnicity of visible minority women in Manitoba is Filipino (pop. 16,225), Chinese (pop. 5,765), South Asian (pop. 6,305), and Black (6,125) [3]. Forecasts of immigration patterns from the Manitoba Bureau of Statistics show a 20% increase in Manitoba and Winnipeg's new immigrant population by 2026.

Canada's Prairie Provinces have a higher Aboriginal population than Canada as a whole. According to 2001 Census data, approximately 30% of Canada's Aboriginal population resides in Saskatchewan and Manitoba [4]. Current estimates of the total Canadian Aboriginal population are 976,305 with 179,682 Aboriginal people residing in Manitoba; 90,157 women and 89,525 men [1]. Of this population, 90,340 are First Nations, 56,800 are Métis and 340 are Inuit [5]. This means that Manitoba holds 11.7% of the entire female Aboriginal population in Canada [6].

Among First Nations in Manitoba, 46,930 are female, and 24,870 First Nations females live on reserve, 4,230 live off reserve in rural communities, and 17,830 live in urban centres [5]. There are 28,615 Métis females in Manitoba: 320 live on reserve, 8,035 live off reserve in rural communities and 20,260 live in urban centres [5].

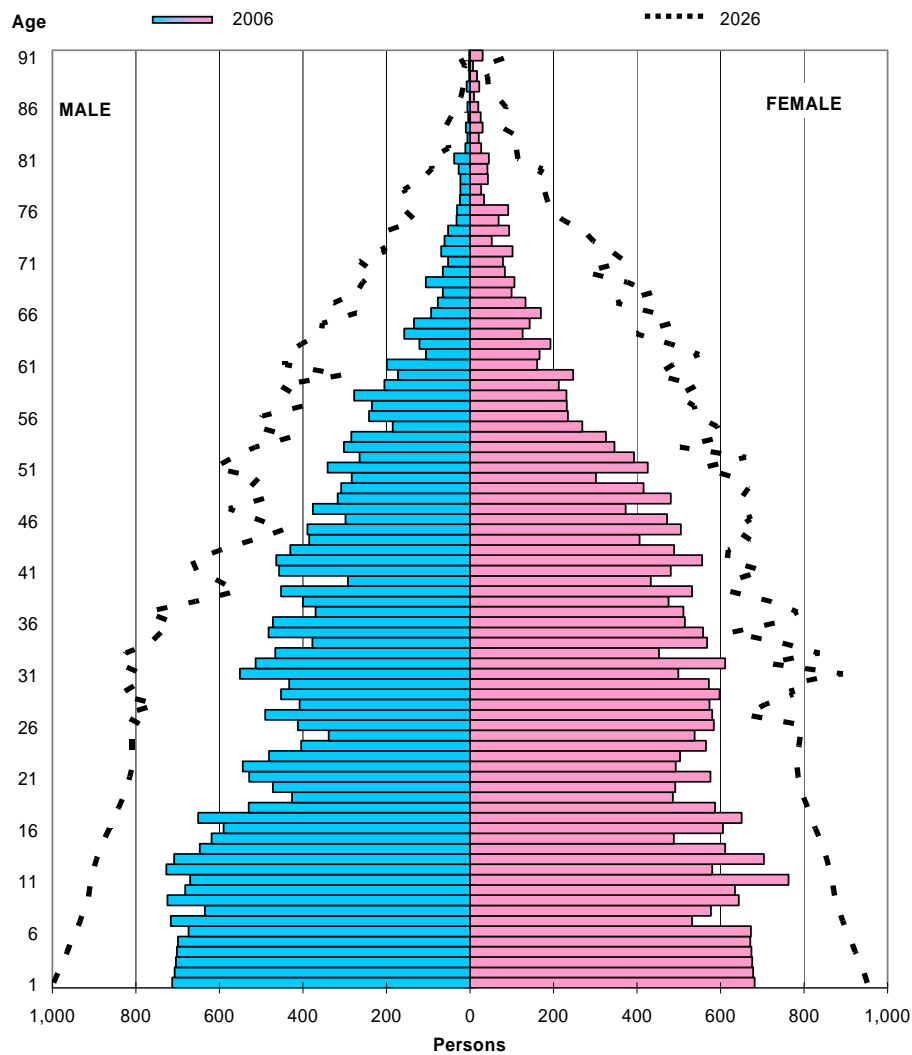
The Manitoba Bureau of Statistics estimates a 9.1% increase in Manitoba's entire female population by 2017 and an increase of 21.6% by 2026 [1]. However, estimates calculated by the Manitoba Bureau of Statistics project a 24% increase in Manitoba's female Aboriginal population by 2017 and a 45.2% increase by 2026 [1] (see Figures 1 & 2).

Given these estimates, and because it is often possible to identify Aboriginal Manitobans in health related data, we describe the health of Aboriginal women in Manitoba wherever possible. We hope that this will in some way rectify the lack of attention paid to Aboriginal women's health historically, but we acknowledge that ideally, we should be able to report and comment on the health of other sub-populations in the province as well.





**Figure 1**  
**Projected Population Pyramid**  
**Aboriginal People in Winnipeg 2006 and 2026**

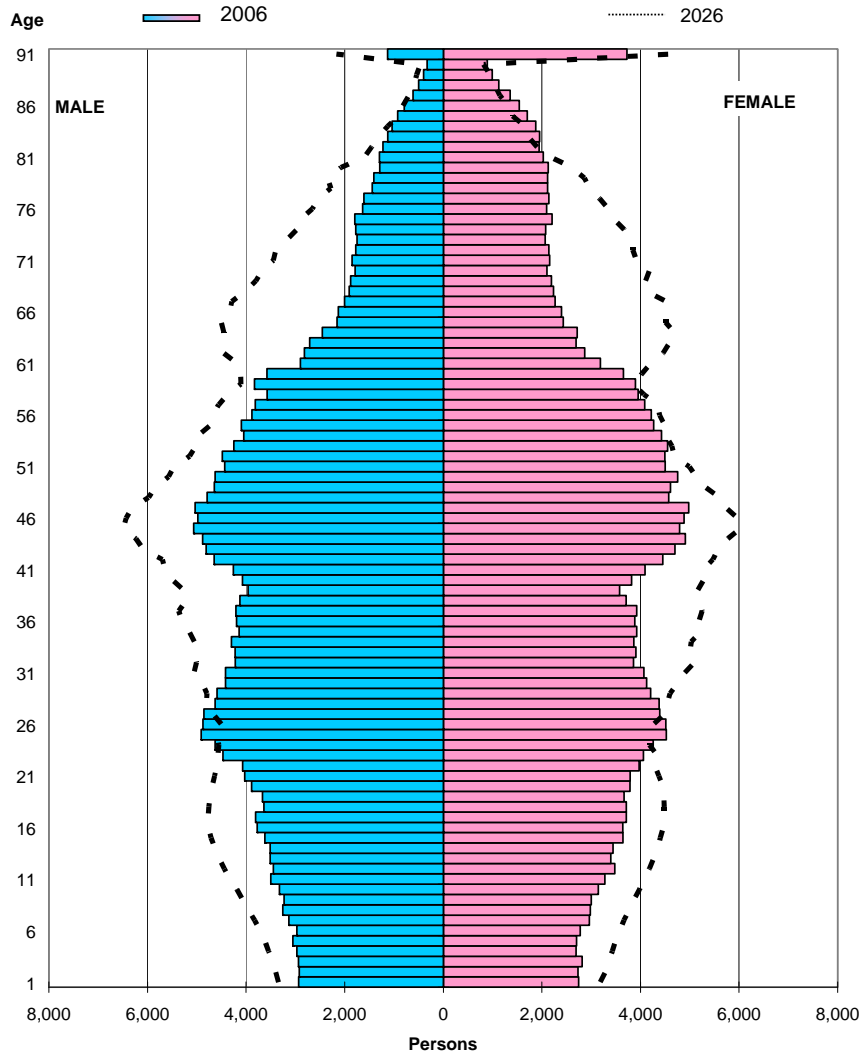


Source: Manitoba Bureau of Statistics. 2007





**Figure 2**  
**Projected Population Pyramid**  
**Non-Aboriginal People in Winnipeg 2006 and 2026**



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Source: Manitoba Bureau of Statistics. 2007





## Aboriginal Women's Health

There is very limited research and literature specific to the state of Aboriginal women's health in Manitoba. What information there is available, is further limited because often Aboriginal peoples are viewed as a homogenous group, making it difficult to know how gender, sex and geography, among other factors, contribute to the research and surveillance evidence. The term Aboriginal itself is problematic: it is an umbrella term that includes First Nations peoples (Status and non-Status, Status through Bill C-31) Métis and Inuit [7]. But in actual fact, research and statistics may very specifically refer to one group or sub-group of the population only. (Readers will find that throughout this *Profile*, different definitions of Aboriginal populations have been used in various ways when collecting and reporting health and health related data.)

Furthermore, much of the current literature examining health concerns of Aboriginal peoples are not sex-specific, which limits our understanding of how the research relates specifically to Aboriginal women [see 8, for example]. The need for greater gender-based analysis, research that is specific to Aboriginal women, and research and analysis that is also culturally appropriate (following OCAP<sup>1</sup>, for instance, and developed in consultation with, by and for Aboriginal women) are issues more Aboriginal women's groups are raising.

Despite the shortage of reliable, comprehensive and descriptive data and analyses, what we do know about the health of Aboriginal women is concerning. Aboriginal women's life expectancy is considerably lower at 76.6 years [11] compared to 81.1 years for non-Aboriginal women. Statistically, Aboriginal women have greater morbidity rates for circulatory and respiratory conditions, diabetes, cervical cancer, and HIV/AIDS in comparison to non-Aboriginal women [12]. Aboriginal women have mortality rates due to violence 2.8 times higher than non-Aboriginal women and suicide rates three times higher than Canadian women as a whole [13, 14, 15].

This *Profile* shows for instance that

- Hypertension is more prevalent among first Nations women than other Canadian women (23.2% versus 17.4%), as is heart disease (8% in First Nations women, 5.1% in other Canadian women)<sup>2</sup>
- First Nations women are 4 times as likely to be diagnosed with diabetes and non-First Nations women in Manitoba. First Nations women are also younger at the time of onset of type 2 diabetes. Diabetes among Manitoba Métis women has a prevalence of about 40%<sup>2</sup>
- Cancer rates have historically been lower in First Nations women, but incidence is now increasing at greater rates among First Nations women, than among non-First Nations women in the province<sup>2</sup>

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<sup>1</sup> OCAP stands for Ownership, Control, Access and Possession. It is a term coined and used by Aboriginal communities that highlights the need for local control of research and data. It is a call to be in control of research instead of being merely research subjects, as was historically the case [9, 10].

<sup>2</sup> See Chapter Five for full information and references.





- One-third of new HIV diagnoses occurred among Manitobans who self-identify as Aboriginal (220 of 676 cases), although they represented only 13.7% of the population. The rate of new HIV infection among Aboriginal women is nearly ten times the rate of new infection for non-Aboriginal women (40.1 per 100,000 versus 4.6 per 100,000)<sup>3</sup>

From the information gathered in this *Profile*, and from other recent studies, we find that Aboriginal women are marginalized or disadvantaged by many important social factors (income, social support, employment, etc) and these structural inequalities pose a major barrier to health and wellness [16, 17]. Overcrowded housing, unemployment and underemployment, poverty, addictions, intimate partner violence and limited supports are characteristic of the lived experience of Aboriginal women [16].

Although the poor health status of First Nation women has been documented to some extent, there are less data available about Métis women. There has been some research, however, done on the *positive* health practices women are taking. Aboriginal organizations are now taking more of a lead in guiding new health research that is culturally appropriate.

Bent [12] and Wilson [15], among other authors, point out that measures of health and wellness differ for Aboriginal and non-Aboriginal women and indicators currently used may be inappropriate for assessing Aboriginal peoples and communities [12]. Whereas non-Aboriginal definitions of health are typified as the absence of physical and mental disease, Aboriginal definitions of health view each person as a whole, equally influenced by interconnected spiritual, emotional, physical and mental aspects. Healthy functioning within the family, community and nation is essential to individual well-being [13, 15, 16], making community health and individual health inseparable in Aboriginal communities [6, 15]. Recognizing the essential connection between the strength of community and individual health, Aboriginal women note that community well-being is influenced by the quality and quantity of available community resources.

For example, standard treatments and methods used to address personal issues of violence and addictions require removal of the victim from the communities and consequently away from social supports, health care benefits and affordable housing [14, 16]. Aboriginal women understand that as their communities establish more responsibility and control of their own cultures, both the communities and the women will benefit [13].

Aboriginal women's groups now call more formally call for ensuring that research used to measure health status of Aboriginal women is inclusive of culturally appropriate and gender specific determinants of health.<sup>4</sup> The result is health definitions that are inclusive of voice and vision of Aboriginal women and that highlight this important connection between community and individual wellness [12].

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<sup>3</sup> See Chapter Four for full information and references

<sup>4</sup> See for example, Saskatoon Aboriginal Women's Health Research Committee, *Ethical guidelines for Aboriginal women's health research*, Prairie Women's Health Centre of Excellence, Saskatoon, Saskatchewan, 2004. <http://www.pwhce.ca>





## Summary

Manitoba's population is more than half female, and the demographics reflect the changing trends in immigration and population growth. In fewer than 20 years, the population will be more than 25% Aboriginal, with many more new immigrants as well.

Different sub-populations show different trends in health status, access to care and the influences of many health-related factors. In this *Profile*, we discuss these differences wherever possible, particularly by regional health authority, using urban and rural comparisons, and by reporting and commenting on what is known of the health of Aboriginal women, as identified in the data and related literature.

It is important to note that these opportunities to report on data are limited by how they are collected and that decision makers in policy, planning and programming will want to seek other means of becoming knowledgeable about the people they serve, including consulting with local women and girls about their health-related needs.

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