

ONTARIO WOMEN'S HEALTH STATUS REPORT

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THE ONTARIO WOMEN'S HEALTH COUNCIL
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CHAPTER 26 – ABORIGINAL WOMEN

SHERRY L. GRACE

OVERVIEW

In traditional Aboriginal¹ cultures, women are considered to be the givers of life, and traditionally this role in the family was highly respected. However, many Aboriginal women face greater risks of complex health issues in a variety of areas than women in the general population (Statistics Canada, 1998), and this increased risk is partly attributable to their marginalized position in society and rapid change within their cultures (Indian and Northern Affairs Canada, 2000). For example, the life expectancy of Aboriginal women is significantly shorter than that of non-Aboriginal women (Statistics Canada, 1998). The suicide rate for Aboriginal adolescent girls is eight times the national average. The diabetes rate among Aboriginal peoples is ten times the Canadian rate, and is generally higher for women than men (Young, Reading, Elias, & O'Neil, 2000). Rates of cardiovascular (Anand & Tookenay, 2001) and respiratory diseases (Young, 1998), disability, infections, and mental health problems are all higher among Aboriginal women than in women in general. Aboriginal women suffer higher rates of cervical cancer (Marrett, 1998), sexually transmitted disease (Health Canada, 1999c), and cirrhosis of the liver than do their non-Aboriginal counterparts. A number of Aboriginal women and children are driven to relocate owing to domestic violence and lack of support, particularly in remote and isolated communities across the country (National Clearinghouse on Family Violence, 1997). The marginalized socioeconomic status of many Aboriginal women results in detrimental lifestyles, unsafe environments, and overcrowded housing. These conditions have an impact on the life chances and health status of many Aboriginal girls and women (Indian and Northern Affairs Canada, 2000).

METHODS AND INTERPRETIVE CAUTIONS

Since few data sources pertaining to the health of Aboriginal women in Ontario are available, the data presented here have been collected and compiled from data regarding urban and community women in Ontario; and when these are not available, national data are presented. The Ontario First Nations Regional Health Survey (OFNRHS) (MacMillan et al., 1998) presents representative data from Ontario First Nation women and children living in Aboriginal communities across the province. These rates were compared with those of Ontario respondents in general from the National Population Health Survey (NPHS; Statistics Canada, 1996). Statistics Canada has limited census data on Aboriginal women and children living in urban environments. The Aboriginal Peoples Survey (APS) (Statistics Canada, 1993) and the Royal Commission on Aboriginal Peoples Report (1996) also present some national data, but without comparison groups. The Ontario Federation of Indian Friendship Centres (2000) has recently published data on the health status of urban Aboriginal girls in Ontario. These data sources are reviewed, along with relevant published articles from the literature.

¹ Please see glossary for definition of terms (i.e., First Nation, Aboriginal).

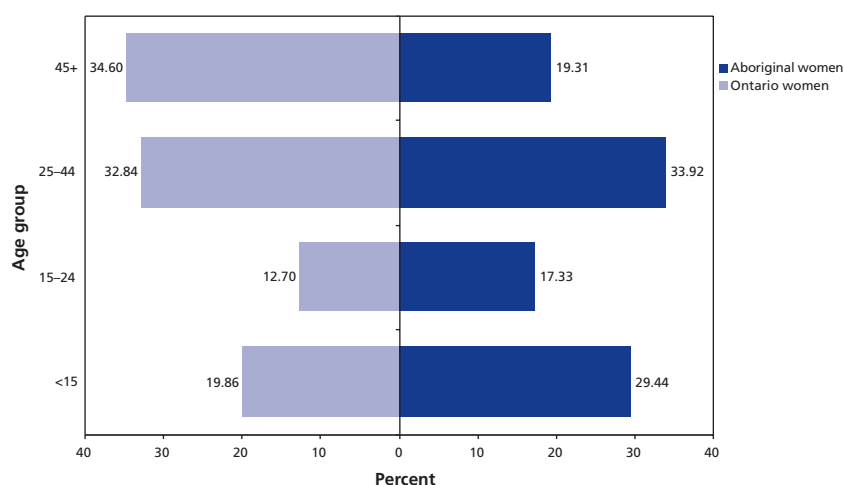
A few cautionary notes should be heeded. First, the definition of Aboriginal status is not very clear (for example, recognition of Métis status). Minimal data currently exist concerning Métis and Inuit women in Ontario. Therefore, the prevalence rates presented here are generally limited to First Nation (FN) women. Second, as a result of the review of limited secondary data related to Aboriginal women's health, the prevalence estimates may not be representative provincially owing to differing operational definitions and data collection methods. Moreover, First Nation communities have not been well represented in major Canadian longitudinal surveys: the National Population Health Survey (Statistics Canada, 1996), and the National Longitudinal Survey of Children and Youth (NLSCY). Even Canadian census data may not be accurate for Aboriginal groups for several reasons. The definition of "household" in Aboriginal communities is uncertain owing to the mobility of populations and household occupants. Moreover, 21 First Nation communities in Ontario declined to participate in Statistics Canada's 1991 enumeration process. Finally, the enumeration process excludes Aboriginals living in institutions, and yet statistics show that a high proportion of Aboriginal peoples are incarcerated (Ontario Native Women's Association, 1993) or living in psychiatric institutions in comparison to the general population (Kirmayer et al., 1994a).

FINDINGS AND DISCUSSION

SOCIODEMOGRAPHIC INFORMATION

In 2000 the Registered Aboriginal population in Ontario was reported to be 153,946, 51.6 percent of whom were female (Information Management Branch, 2001). Ontario has a larger population of Aboriginal people than any other province, and they make up 1.4 percent of Ontario's total population (Tait, 2001). In relation to the population of Canada as a whole, Ontario's Aboriginal population represents 21.7 percent of the First Nation population, 10.3 percent of the Métis, and 2.9 percent of the Inuit. Although data are not available specifically for Ontario, the majority of Aboriginal women in Canada (72.4 percent) live in rural or urban areas other than FN communities (Statistics Canada, 1998). Exhibit 26-1 portrays the Ontario and Aboriginal female population demographic by age.

Exhibit 26-1. Ontario Female Registered Indian Population and General Population, by Age



The Aboriginal population is much younger than the non-Aboriginal population in Ontario. Almost half (46.8%) of the Aboriginal population is under the age of 24 years, in comparison to one-third (32.6%) of the non-Aboriginal population. Furthermore, there are relatively fewer Aboriginal people in older age groups. Only 3.7 percent of the Aboriginal population are aged 65 and over, (vs. 11.7% of the general population of Ontario) (Statistics Canada, 1998).

Reports suggest that fertility rates are much higher among members of the Aboriginal population than they are among Canadian women as a whole (Indian and Northern Affairs Canada, 2000). The crude birth rate of registered Indians in 1996 was 25 per 1,000 (12.2 per 1,000 for the total population of Canada). The total fertility rate of registered Indians in 1996 was 2.7 (1.7 for the total population of Canada). Because the fertility rate of the Aboriginal population is about 69 percent higher than that of the population as a whole, the Aboriginal population is expected to increase significantly over the next two decades (Statistics Canada, 1998).

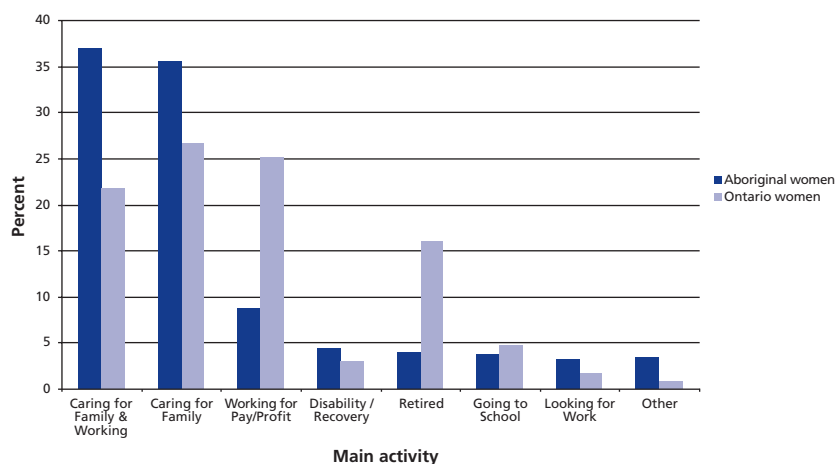
SOCIOECONOMIC ENVIRONMENT

Many Aboriginal women in Ontario suffer extreme poverty; most live on an average income of less than \$14,000 per year. Although data are not available for Ontario specifically, in 1995, 34.5 percent of Aboriginal people in Canada were living below the low-income cut-off, more than double the provincial rate of 14.8 percent. Low incomes are particularly prevalent among young Aboriginal women between the ages of 18 and 24 years. In 1990, 41 percent of Aboriginal women within this age range lived in low-income households (vs. 22 percent of the general population of Canadian women). Compared with their non-Aboriginal counterparts, Aboriginal women have less formal education, higher levels of unemployment, and lower earnings, and are less likely to be employed in professional positions (Statistics Canada, 1995; National Steering Committee for the First Nations and Inuit Regional Health Survey, 1999). These disparities are more fully outlined below.

Although Aboriginal women have made gains in their educational attainment in recent years, they have less education than Canadians as a whole (Tait, 2001). In 1996, over half (54 percent) of Aboriginal women had not completed their secondary education, compared to 36 percent of non-Aboriginal women (Statistics Canada, 1998).

According to the OFNRHS data on “main activity,” 36.9 percent of FN women in Ontario are caring for family as well as working for pay or profit; 35.5 percent are caring for family; 8.7 percent are working for pay or profit (see Exhibit 26-2 for comparative data) (MacMillan et al., 1998). Aboriginal women are much

Exhibit 26-2. Current Main Activity for First Nations and Ontario Women, Aged 20 and Over



Data source: Ontario First Nations Regional Health Survey, 1998.

less likely than their non-Aboriginal counterparts to be part of the paid workforce in Canada. In 1996, 41 percent of Aboriginal women aged 15 years and over were employed, in contrast to 53 percent of their non-Aboriginal counterparts. Aboriginal women were also less likely to be employed than Aboriginal men, 48 percent of whom had jobs (Statistics Canada, 1998).

Poverty and food insecurity are also prevalent (MacMillan et al., 1998; Tait, 2001). According to data from the NLSCY study, urban Aboriginal families were overrepresented among those experiencing hunger (McIntyre, Connor, & Warren, 2000). This was particularly true for lone-parent families. Many Aboriginal women in Toronto live in impoverished social and economic conditions, particularly non-partnered women with children (Williams, 1997).

MORTALITY INDICATORS

Only limited information is available on patterns of mortality among Aboriginal women in Ontario. Data from the Canadian Mortality Database suggest an increased risk of mortality from alcoholism/liver cirrhosis, homicide, suicide, and pneumonia among Aboriginals. For Aboriginals living in FN communities, the risks for mortality from environmental and social causes (see Determinants of Health below) are particularly high (Mao, Moloughney, Semenciw, & Morrison, 1992).

Aboriginal women have higher all-cause mortality rates than Canadian women. While the major causes of death are similar for both groups, Registered Aboriginal women are more likely than the general population of Canadian women to die as a result of injuries, respiratory disease (e.g., pneumonia, bronchitis), infection, and “other” causes, while death resulting from circulatory problems (e.g., heart disease, stroke) and cancer are proportionately less common (Janzen, 1998). This finding may be related to differences in the age distribution of the population.

The newborn babies of Aboriginal women also face a heightened risk of mortality and poorer health status. In 1996 the infant mortality rate among registered Indians was 11.6 per 1,000 and in the total population of Canada was 6.1 per 1,000 (Indian and Northern Affairs Canada, 2000).

Life expectancy

Aboriginal women live longer than men (as in the general population); however, they do not live as long as women in the general Canadian population. In 1995 the life expectancy at birth was 76.2 years for Aboriginal women, and 69.1 years for Aboriginal men. In that same year, the life expectancy in the general Canadian population was 81.3 years for women and 75.4 years for men. Thus, Canadian women in the general population live 5.1 years longer than Aboriginal women (Indian Affairs and Northern Development, 2000). This gap is projected to decrease considerably over the next two decades (First Nations and Northern Statistics Section, 2001).

Heart disease and stroke

Although heart disease is known to be the leading cause of death and illness in the Canadian population, there is limited information about cardiac-related deaths among Aboriginal people, particularly Aboriginal women. First Nations populations in Canada had, until recent decades, been thought to experience lower cardiovascular disease death rates than the general population (Mao et al., 1992). However, recent data show that First Nations women experience higher death rates than the general Canadian female population for both ischemic heart disease and stroke (Anand, 2001; Shah, Hux, & Zinman, 2000).

One of the major risk conditions associated with heart disease is hypertension. A survey among Aboriginal people living in three northwestern Ontario rural communities found that the incidence of high blood pressure was 12.3 percent, compared with 15 percent in the general population (McIntyre, Connor, & Warren, 2000).

However, its prevalence increases dramatically among obese Aboriginals, those with diabetes mellitus, and those who smoke.

Cancer

Data on the frequency of cancer in all persons registered as status Indians in Ontario between 1968 and 1991 were collected by Cancer Care Ontario (Marrett, 1998). Age-standardized incidence of all cancer types was found to be 28 percent lower in Aboriginal women than in the Ontario population as a whole. However, certain types of cancers were more prevalent in the Aboriginal population; cervical cancer occurred 73 percent more often in Aboriginal women, renal cancer was slightly more common, and gallbladder cancer was found to be more than twice as high in Aboriginal women. These elevated rates of cervical cancer may result from the fact that among Aboriginal women, its diagnosis tends to occur at a more advanced stage of the disease (Health Canada, 1999d). Aboriginal women were found to have a lower incidence of cancer of the colon, breast, and uterus, and lymphoma than the general population (Mahoney & Michalek, 1991).

Suicide

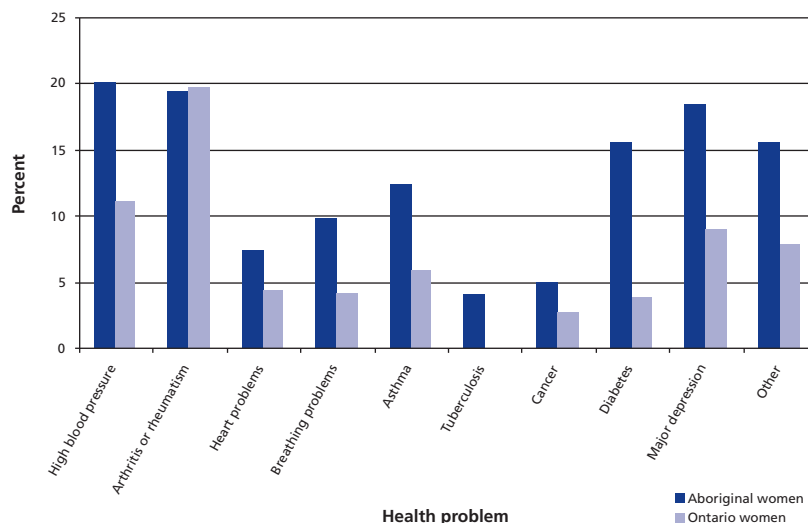
Data from a report prepared for the Royal Commission on Aboriginal Peoples indicate that suicide rates are consistently higher for the Aboriginal population than for the Canadian population as a whole (Kirmayer et al., 1994b; Spaulding, 1986). These rates vary over the lifespan, increasing in occurrence over the teenage years, and peaking around age 23 to 25. For instance, adolescent women who are status Indians are 7.5 times more likely to commit suicide than adolescent women in the total Canadian population. In the 20 to 29 year age range, the suicide rate for female status Indians is 3.6 times the rate for all Canadian women. Aboriginal women have higher suicide rates than all Canadian women up to 69 years of age, at which point the Aboriginal rate falls below that of all Canadian women (Medical Services Branch Steering Committee on Native Mental Health, 1991).

In both Aboriginal and non-Aboriginal populations, men may complete suicide more frequently than women, but women attempt suicide more frequently than men. Those who attempt suicide are more often single, separated, or divorced, and more apt to live in isolated regions. Suicide clusters pose a special problem in Aboriginal communities where many individuals are closely related and experience similar social problems; the impact of one suicide can be deeply felt within the whole community (Kirmayer et al., 1994b). Suicides most often occur in association with the abuse of substances such as solvents or alcohol (Kirmayer et al., 1994b).

MORBIDITY INDICATORS

Although health indicators paint a poor picture of Aboriginal women's health status, 77 percent of adult women in Aboriginal communities rate their health as good or better than average (National Steering Committee for the First Nations and Inuit Regional Health Survey, 1999). However, the rates of chronic health conditions (based on what respondents report being told by a health professional), are generally higher among First Nations than Ontario residents as a whole (see Exhibit 26-3) (MacMillan et al., 1998). Among Aboriginal persons living in Ontario FN communities, a higher proportion of women than men report health problems in the following areas: high blood pressure, back or spine, arthritis, digestive system, hay fever or allergies, mental health, emphysema or bronchitis, heart trouble, diabetes, and anemia; hepatitis and tuberculosis are the only exceptions (Myers, Calzavara, Cockerill, Marshall, & Bullock, 1993).

Exhibit 26-3. Percentage of Health Problems for First Nations and Ontario Women, Aged 20 and Over



Data source: Ontario First Nations Regional Health Survey, 1998.

Disability rates

Disability is defined as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (World Health Organization, 1980). Disability rates are higher among Aboriginal women than among Canadian women overall. According to the results of the Aboriginal Peoples Survey (Statistics Canada, 1993), approximately one-third of Aboriginal women reported some type of disability, in contrast to 13 percent of Canadian women. Age-standardized disability rates for Aboriginal women were also slightly higher than those of Aboriginal men, regardless of age. The high disability rates among Aboriginal youth may be associated with a higher incidence of accidents, violence, suicide attempts, inhalant abuse, and fetal alcohol syndrome (Ng, 1996).

Diabetes

Diabetes has reached epidemic proportions in Aboriginal communities, particularly in Northern Ontario. Among First Nations in northwestern Ontario, approximately seven percent have been diagnosed with Type 2 (or non-insulin dependent) diabetes (Morrison & Dooley, 1998). It is interesting to note that 65 percent of these cases were diagnosed in the last six years.

Gender differences in the prevalence of diabetes were examined in the First Nation and Inuit Regional Health Survey (FNIRHS) (National Steering Committee for the First Nations and Inuit Regional Health Survey, 1999). The prevalence of diabetes was 13 percent among women and eight percent among men. When age-adjusted to the Canadian population, the prevalence was 5.3 times higher among Aboriginal women than among Canadian women. Women are also diagnosed with diabetes at an earlier age than men (Fox, Harris, & Whalen-Brough, 1994). Aboriginal women who live in Aboriginal communities have five times greater risk of death from diabetes than Canadians nationally (Mao et al., 1992).

Additional information on diabetes in Aboriginal communities was obtained from a study in the remote community of Sandy Lake, where its prevalence reaches over 17 percent in residents over the age of ten. Through oral glucose tolerance surveys, the prevalence reaches as high as 25 percent among all adults in that community, and 80 percent among women aged 50 to 64 years (Harris, Caulfield, Sugamori, Whalen, & Henning, 1997). Diabetes is being diagnosed in very young children in Aboriginal communities in Northern Ontario. Having diabetes increases the likelihood of complications such as heart, foot, eye, kidney, and nerve problems at an early age, resulting in premature death, disability, and poor quality of life (DCCCT Research Group, 1993; Gafvels, Lithner, & Borjeson, 1993).

Diabetes during pregnancy poses a major risk for women. The prevalence of diabetes in pregnancy in North America is approximately four percent. However, surveys in northern Ontario have shown that diabetes may affect as many as 12 percent of pregnancies among Aboriginal women (Harris et al., 1997). This high incidence substantially increases the risk of diabetes in the next generation, and poses significant health risks to both the mother and fetus (Jovanovic, 1998; Roberts, 1998).

Tuberculosis (TB)

Tuberculosis (TB) remains a major public health problem for Aboriginal peoples in Ontario. Although there has been a decline in infectious diseases (including TB) among some Aboriginal groups, the prevalence of TB has stabilized at a level that remains higher than in the general Canadian population (Young, 1998). These rates tend to be highest in more northerly and remote areas where communities were exposed later to TB by European settlers (Fitzgerald, Wang, & Elwood, 2000). In 1996, the incidence of TB in Aboriginal communities was six times higher than the rates for non-Aboriginal populations (Statistics Canada, 1998). In that same year, Aboriginal women accounted for 16 percent of the total number of reported new active and relapsed tuberculosis cases among women in Canada, whereas these women made up only three percent of the total female population that year.

Health behaviours

Obesity, insufficient nutrition, lack of physical activity, and tobacco use are all closely tied to health status. In the past, Canadian surveys demonstrated that Aboriginal populations were deficient in nutrient intake. Currently, Aboriginal peoples are shown to have a higher weight-for-age compared to Canadians nationally. For instance, obesity has been estimated at 60 to 70 percent among Aboriginal women from Northern Ontario, and Aboriginal women are heavier in all age groups than Canadians of European ancestry (Katzmarzyk & Malina, 1999; McIntyre & Shah, 1986). Central distribution of fat has been thought to be an adaptation to the cold (Katzmarzyk & Malina, 1998). This type of fat distribution is linked to diabetes and related metabolic disorders.

The decreased ability of Aboriginal peoples to live off the land (owing to natural resource development and associated exploration, and to wildlife migration) has increased their dependence on store-bought foods and led to the transition from a traditional diet to a more refined, high-fat, low-fibre diet. An analysis of food consumption from Oji-Cree in northern Ontario indicated that diets were high in total fat (36 percent of total calories), high in simple sugars (22 percent of total calories), and low in dietary fibre (Wolever et al., 1997). Dietary choices are also linked to financial constraints and the cost of foods in remote communities.

The erosion of traditional ways of life among some Aboriginal people has also resulted in the reduction or elimination of fishing, hunting, and trapping, leading to a more sedentary lifestyle (Dion Stout, Kipling, & Stout, 2001).

Tobacco use is associated with increased risk for many diseases (Janzen, 1998). The prevalence of smoking is higher among Aboriginal peoples than all other groups in Canada (Millar, 1992). In 1997 adult smoking rates within the Aboriginal population were highest among young people aged 20–24 (72 percent), and those aged 25–29 (71 percent) (Federal Provincial and Territory Advisory Committee on Population Health, 1999). Among Aboriginal communities in northwestern Ontario, the prevalence of smoking is 56 percent, in contrast to a rate of 31 percent for Ontario as a whole (McIntyre & Shah, 1986). Approximately 60 percent of Aboriginal women in Ontario smoke daily, and 45 percent smoke more than half a pack of 25 cigarettes daily (Myers et al., 1993).

HIV/AIDS

Although Aboriginal persons represent 2.4 percent of all AIDS cases in Canada, they represent an increasing percentage of AIDS cases. In comparison to non-Aboriginals, Aboriginal persons with HIV/AIDS are more likely to be younger, injection-drug users (vs. male-to-male transmission), and female (Health Canada, 1999b). Aboriginal women represent a higher percentage of cases of HIV/AIDS than non-Aboriginal women (15.9 percent vs. 7.0 percent). Within Aboriginal AIDS cases among women, 50 percent are attributed to intravenous drug use, in comparison to 17 percent of all cases in women (Health Canada, 1999d). Among Aboriginal women, exposure categories include: injection-drug use (47.6 percent), heterosexual contact (35.7 percent), receiving blood-clotting factors (9.5 percent), and perinatal transmission (4.8 percent) (University of Manitoba Northern Health Research Unit, 1999). It is clear that some Aboriginal communities are at increased risk for HIV infection because of their low socioeconomic status and high rates of sexually transmitted diseases, as well as the movement of Aboriginal persons between urban centres and FN communities (Myers et al., 1993; University of Manitoba Northern Health Research Unit, 1999).

Reproductive issues

Aboriginal women's traditional role as givers of life is shadowed by poor reproductive health in the modern era. Canadian Aboriginal women have rates of sexually transmitted diseases (STDs) as much as four times higher than the general population (University of Manitoba Northern Health Research Unit, 1999). Five percent of FN women in Ontario report that they had an STD at least once in their lifetime (Myers et al., 1993).

In regard to health screening, findings from the OFNRHS show that 87.5 percent of Ontario FN women have had a Pap smear in their lifetime. Only 22.5 percent have had a mammogram, but this could be due to the young demographic of the FN population and a lack of regular access to such breast screening services (MacMillan et al., 1998).

There is a high rate of adolescent pregnancy in Aboriginal communities (Statistics Canada, 2000). The birth rate for Aboriginal women is twice that of the overall Canadian women. Aboriginal mothers are younger than those in the non-Aboriginal population: (about 55 percent vs. 28 percent under 25 years; about nine percent vs. one percent under 19) (Health Canada, 1999d). Iron deficiency and low intake of

vitamin D among pregnant Aboriginal women leads to greater health risks in Aboriginal infants (Moffatt, 1989).

Mental health

Depression, common in women in the general Canadian population, is also common among Aboriginal women. Paralleling the ratio of depression in women to men in non-Aboriginal communities, there is a higher ratio of major depression among Aboriginal women to men, and girls to boys (Kirmayer et al., 1994a). In the OFNRHS, approximately ten percent of FN women reported that they felt “everything was an effort” all or most of the time (MacMillan et al., 1998), a complaint that is an indicator of depressed mood. Almost 20 percent of FN women reported that they had talked to a health professional about their emotional or mental health in the past year, about twice the percentage of women in Ontario generally (MacMillan et al., 1998).

Anxiety is more difficult to measure because Aboriginal women’s conditions of disadvantage and oppression may justifiably make them fearful of their own safety and future prospects (Kirmayer et al., 1994a). However, a great deal of attention has been focused on the possibility that many Aboriginal people suffer from trauma-related disorders. In some communities, family violence and sexual and physical abuse may be common, as well as exposure to violent death. Native communities have also faced long-standing stress in many forms — suppression of traditional ways, gender and ethnocultural oppression, dislocation of communities, and childhood separation from families — all of which may lead to post-traumatic stress disorder (Kirmayer et al., 1994a).

Addiction

Alcohol and substance abuse are considered to be major problems in Aboriginal communities (Kirmayer et al., 1994a; MacMillan et al., 1998). Aboriginal youth are two to six times more likely to suffer alcohol-related problems than their non-Aboriginal counterparts in the Canadian population (Scott, 1994). According to the OFNRHS and NPHS, when respondents were asked if they had consumed an alcoholic beverage in the last 12 months, 54 percent of FN women responded yes, and 74 percent of Ontario women responded yes. Five percent of FN women, and 12.7 percent of Ontario women drink two to three times per week. In response to being asked whether they had ever regularly drunk more than 12 drinks a week, however, 28.7 percent of FN women said yes and 5.2 percent of Ontario women said yes (MacMillan et al., 1998). These findings reflect a polarization of drinking patterns among Aboriginal women in Ontario, where fewer Aboriginal women drink moderately than non-Aboriginal women, but some are more prone towards heavy consumption (or binge drinking). Aboriginal women report that alcohol is related to violence in their communities (Ontario Native Women’s Association, 1989).

Findings from the Ontario First Nations AIDS and Healthy Lifestyle Survey indicated that 14 percent of FN women in Ontario report having used either marijuana, cocaine, crack, LSD, glue, or gasoline in the previous month (Myers et al., 1993). Solvent use (i.e., inhalation of volatile substances such as gasoline, glue, and cleaning products) has been increasingly reported in isolated Aboriginal communities (Scott, 1994). One in five Aboriginal youth has used solvents and one-third of users are under the age of 15 years. Over half reported that they had begun to use solvents before reaching 11 years of age (Scott, 1994). Unfortunately, owing to the addictive potential of solvents and their tremendous toxicity, considerable permanent

brain damage and other organ damage may occur (Kirmayer et al., 1994a). The crisis in some communities has been attributed to feelings of hopelessness among Aboriginal youth (Kirmayer et al., 1994b).

Violence indicators

Data on family violence in Aboriginal communities were available from the National Clearinghouse on Family Violence. At least three-quarters of Aboriginal women in Canada have been the victims of family violence (The National Clearinghouse on Family Violence, 1997). Retrospective reports of rates of child physical abuse are very high among FN women in Ontario. Over 55 percent of FN women reported physical abuse, and 31.8 percent reported severe physical abuse (MacMillan et al., 1998).

Victims of sexual assault are mainly women (National Crime Prevention Centre, 2000). Reported rates of sexual abuse are also very high in FN communities, with 45.5 percent of Aboriginal women reporting sexual abuse, and 43.6 percent reporting severe sexual abuse (MacMillan et al., 1998). The prevalence of sexual abuse is significantly higher among Aboriginal women than among non-Aboriginal women (44.8 percent vs. 30.1 percent). Aboriginal women who had been sexually abused were more likely than those who had not been abused to have had an abnormal Pap smear (Young & Katz, 1998). (For further information, see Chapter 8.)

Health services

Comparative data from the OFNRHS and NPHS show that FN peoples have more contact with nurses but less contact with family physicians than does the general population of Ontario. For instance, over the past 12 months, 34.3 percent of FN women and 8.9 percent of women in Ontario had seen a nurse for care or advice. Seventeen percent of FN women had seen a social worker or counsellor, while 6.6 percent of Ontario women had done the same. When asked about using the services of an alternative health-care provider (such as elders and traditional healers), 21.8 percent of FN women, and 4.9 percent of women in Ontario reported using such services in 1994. However, more FN respondents perceive greater unmet health-care needs than the general population (Health Canada, 1999a).

DETERMINANTS OF HEALTH

Indigenous peoples around the world have experienced ongoing and evolutionary socialization that has resulted in their marginalization and integration into a global culture. Loss of cultural identity, language, and way of life has been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most dramatic impact on women and youth. This trend provides the backdrop for the health status of today's Aboriginal women in Ontario.

Aboriginal communities themselves are plagued by psychosocial and economic disadvantage. When asked which problems they were experiencing in their communities in Ontario, over 80 percent noted alcohol abuse, unemployment, tobacco and drug use, and diabetes as problems, and over 50 percent identified family violence, depression, cancer, and sexual abuse as problems (MacMillan et al., 1998). Overcrowded and dilapidated housing, unclean and limited supplies of water, and inadequate waste disposal systems all pose significant threats to the health of Aboriginal women in Ontario (Royal Commission on Aboriginal Peoples, 1996).

Overcrowded living conditions can lead to the transmission of infectious diseases, and increase the risk for injuries, mental health problems, family tensions, and violence (Indian Affairs and Northern Development, 1999).

High rates of many chronic diseases such as cancer, heart disease, and diabetes are likely related to the loss of the traditional ways. For instance, as populations undergo modernization, the prevalence of diabetes tends to increase. Thus, fattier diets with less fibre (owing to reliance on store-bought foods), lifestyles with less physical activity, and substantial stress are part of the problem. Before the 1950s, a diagnosis of Type 2 diabetes was rare in Aboriginal populations, and continues to be rare among the Inuit in the far North (Hegele, 1999).

CONCLUSIONS

Aboriginal women continue to experience poorer health status than the general provincial population. It is believed that this discrepancy in health is in part due to the widespread inequities that Aboriginal women face in the opportunities for health promotion, in their lack of a sense of control over their health, and most notably in socioeconomic conditions. The socioeconomic effects of poverty, isolation, limited access to sophisticated health-care systems, as well as language barriers and the diverse needs of Aboriginal women in this province may lead to the perpetuation of this detrimental health status in future generations of Aboriginal women. It has been suggested that traditional lifestyles prior to European contact may have been beneficial for Aboriginal women's health status.

Efforts to improve the situation of Aboriginal women in urban environments or in their communities should respect the cultural beliefs and values of their traditional ways. For instance, 58 percent of Aboriginals in Ontario want to learn more about Native spirituality (MacMillan et al., 1998). There is an obvious need for more culturally appropriate responses to care, incorporating traditional healers, the Medicine Wheel, the four directions (physical, spiritual, emotional, and mental health), elders (62 percent of FN seek assistance from elders), and the Sweat Lodge ceremony to ensure the cultural relevance of health services — and their greater success — among Aboriginal women in Ontario. With the transfer of control over health-care services to First Nations communities, and the growing acceptance of the value of traditional forms of medicine, it is hoped that the status of Aboriginal women's health in this province will improve significantly.

GLOSSARY

- *Aboriginal* — This term is used to refer to the indigenous inhabitants of Canada and their descendants. Aboriginal people are people of First Nation, Inuit, and Métis ancestry. In Canada, Aboriginal peoples may be classified as status Indians (people who are registered with the Federal Government as Indian), or non-status Indians (Aboriginal peoples who are not registered under the Indian Act).
- *First Nation* — This term came into common usage in the 1970s to replace the word “Indian,” which many people found offensive. Although the term “First Nation” is widely used, no legal definition of it exists. Among its uses, the term “First Nations” or “First Nations peoples” refers to the Indian people in Canada, both Status and non-Status Indians, and Treaty Indians.
- *Inuit* — Arctic-dwelling peoples of Canada.
- *Métis* — People of mixed Aboriginal and French origin.

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