Community Health Assessment
Dedicated to the People of Central Region
so they can be

“As Healthy As Can Be!”
Community Health Assessment

Submitted to Manitoba Health September 2004

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Individuals
Families
Children
Elderly
Aboriginals
Women
Men
Central Region

"As Healthy As Can Be!"
Geography

The Regional Health Authority - Central Manitoba Inc. is located in the Southern portion of Manitoba, West of the Red River, South of Winnipeg and North of the United States, Canada border. The legal description as per the Regional Health Authorities Act (C.C.S.M.c.R34) Regulation 169/2002, Registered October 4, 2002 follows.

Legal Description:

Manitoba Regulation 207/97 amended.

1 The Regional Health Authorities Establishment Regulation, Manitoba Regulation, 207/97, is amended by this regulation.

Section 1, Schedule 3 states that “the East limit of Range 12 WPM, thence N’ly along the East limit of said Range 12 WPM to its intersection with the North limit of Township 19, thence E’ly along the North limit of said Township 19 to its intersection with the East limit of Range 11 WPM, thence N’ly along the East limit of said Range 11 WPM to its intersection with the North limit of Township 20, thence E’ly along the North limit of said Township 20 to its intersection with the Eastern shoreline of Lake Manitoba”.

Section 1, Schedule 9 states that “Township 20, thence W’ly along the North limit of said Township 20 to its intersection with the East limit of Range 11 WPM, thence S’ly along the East limit of said Range 11 WPM to its intersection with the North limit of Township 19 to its intersection with the East limit of Range 12 WPM, thence S’ly along the East limit of said Range 12 WPM to the most N’ly of the Northern limits of the R.M. of Glenella, thence W’ly along the North limit of the said R.M. of Glenella to its intersection with the East limit of the R. M. of McCreary”.


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District Health Advisory Council
Spiritual Care Advisory Team
Focus Group Participants
Key Informants
Telephone Survey Respondents

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Health Assessment Teams

The Regional Health Authority - Central Manitoba Inc had as their assessment teams, groups of individuals who were responsible for planning and leading the Community Health Assessment (CHA) process, teams of experts, and community representatives as advisors.

**LEADERSHIP AND PARTNERSHIP TEAM:** Provided ongoing guidance throughout the course of the project.

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Executive Summary

The Regional Health Authority - Central Manitoba Inc. (Central Region/RHA Central) is located in the southern portion of Manitoba, west of the Red River, south of Winnipeg and north of the United States/Canada border. The most recent estimate indicates a population of 98,778, slightly higher than the 93,980 reported by the 2001 Census. Central Region is second only to the Winnipeg Regional Health Authority in population. Projections show that we are expected to increase by 14.5 per cent between 1998-2025.

A Community Health Assessment (CHA) is a dynamic ongoing process undertaken to identify the strengths and needs of the community, enable the community-wide establishment of health priorities and facilitate collaborative action planning directed at improving community health status and quality of life. In 2003-2004 Central Region undertook a comprehensive CHA process. This document reports the information gathered and attempts to provide a picture of the health of people in Central Region while describing what influences this. The three primary measures of health status included are: mortality, morbidity and well-being.

Evidence suggests that the determinants of health have an effect on our health status and outcomes. By examining determinants of health indicators (such as smoking and obesity), in relation to health status outcomes in our population (such as rates of diabetes or deaths due to lung cancer), we can assess the major influences on the health of our population.

With advice from the Board of Directors’ Leadership and Partnership Committee and the Population Health Steering Committee, seven teams comprised of Board members, RHA Central staff, physicians and local experts were tasked with reviewing data for specific population groups. Known as Strategic Health Assessment, Planning and Evaluation (SHAPE) Teams, the groups each focused their research on one of the seven population groups designated in the Board ENDS. Data from administrative sources and national surveys was reviewed and in the context of this information, teams developed consultation strategies to obtain local information with the residents of Central Region. These consultations included a Telephone Survey, Focus Groups, and Key Informant...
Interviews. With guidance and input from Central Region’s Epidemiologist, teams then analyzed this data and reported on their findings at a regional level to the Board of Directors and other SHAPE teams. A reality check with the community provided a forum for further refinement of information gathered.

Key findings

The following key findings illustrate the relationship between the determinants of health and health status outcomes for population groups as defined by the Board ENDS. These include Individuals (the overall population of Central Region), Families, Children, Elderly, Aboriginal, Women and Men.

Individuals

The overall health status of Central Region’s population was reviewed in the context of the determinants of health. The following is what we found.

Key Points for Overall Health Status:

- The 2003 Canadian Community Health Survey (CCHS) reports that 59.3 per cent of residents believe their health status to be very good or excellent. This is slightly lower than in 2001 and is slightly lower than the provincial average.
  - We report rates of ‘no life stress’ from 6 per cent in 2001 to 10 per cent in 2003.
    - This is higher than the Manitoba average but lower than the Canadian average.
- Our standardized Premature Mortality Rate (PMR), lower than the provincial average, and improving, reflects overall good health status.
- Exceptions: Seven Regions and Portage la Prairie.
- Our total PYLL has declined between 1994 and 1998.
  - Deaths due to motor vehicle crashes\(^1\) continue to be the leading cause of PYLL.
  - Ischemic heart disease has remained the second leading cause of PYLL, despite a dramatic decline in the two time periods.
  - Cardiovascular disease is still a leading killer of Central Region residents.
  - There have been increases in PYLL due to both lung cancer and breast cancer.
- Lung cancer had increased to the fourth leading cause of PYLL and breast cancer was the sixth leading cause of PYLL among all residents of the Central Region.
- We report one of the lowest prevalence rates of diabetes in the province in 1998/99.
  - Given the risk factors identified, diabetes rates are expected to continue to rise.
  - There are population sub-groups for whom diabetes is a significant health issue.
- Mental health is a concern that has been raised by virtually every population group, assessment team, and consultation participant in this assessment.
  - The CCHS indicates that just under 5 per cent of regional residents are at probable risk for depression compared to approximately 7 per cent of Canadians.
- Hospitalizations and deaths due to injuries affect every sub-population in our region.

\(^1\) Accidents changed to crashes, or collisions, to reflect a growing ideology around events that can be prevented as not being truly accidental.
• Some groups are more affected by self-injury and others by injuries due to unintentional causes.
• The leading causes of injury are motor vehicle crashes and suicide.
• Falls were the leading cause of unintentional injury death, followed by Motor vehicle crashes.

**Key Points for Determinants of Health:**

**Personal Health Practices and Lifestyle:**
- Central Region ranked the fourth highest rate of physical inactivity in the province compared to the Manitoba average.
- Approximately one in five residents age 18 and older meets the criteria for obesity (BMI >30.0), slightly higher than the provincial average and much higher than the Canadian average.
- According to the 2003 CCHS, over 22 per cent of people in Central Region aged 12 or over are regular smokers. This is a slight decrease from 23 per cent in 2001.
- Immunization rates for adult influenza vary between areas within our region, with rates ranging from less than 35 per cent to just over 60 per cent.
  - 71 per cent of Central Region Telephone Survey respondents agreed that immunization is “the smart thing to do”.
  - A continuing trend of dropping rates of immunization could lead to pockets of unprotected individuals, leading to increasing prevalence of infectious disease.
- Spiritual well-being is seen as an important factor in health by our residents.

**Living and Working Conditions:**
- Our labour force is more reliant on agriculture than the rest of Canada.
- The total unemployment rate in Central Region (5.2%) is second lowest in the province, and lower than the Manitoba rate (8%).
  - Of those employed, the majority of new jobs created are in low paid and semi-skilled areas although they are helping to make Winkler, Morden, Altona and Carman among the top growing communities in Manitoba.
- In every age group rates of non-graduates is higher than the provincial average.
- Almost 50 per cent of the regional population may be exposed to the harmful effects of tobacco smoke on a regular basis.

**Culture:**
- We have significant numbers of Aboriginal peoples (see Aboriginal chapter). Key informants suggested that the population of Kanadier Mennonites (Low German speaking Mennonites from Mexico) in Central Region is also “significant”.
  - We know that we lack specific information and want to find ways to obtain evidence regarding the health and illness of these vulnerable populations.

**Health Services:**
- Most of our Community survey participants told us that they were very satisfied with health services generally in Central Region.
• Continuity of primary care provider, described as ‘any appropriate health service professional’ was important to residents who spoke of this factor.

Families

- The proportion of lone parent families in the Central Region is smaller than in the province overall (10.5% versus 16.0%).
  - Just over 81 per cent of lone parent families is headed by a female.
  - A dramatic drop in income was seen for lone parent families (median $25,067) compared to couple families (median $48,473). Both of these rates are lower than their Manitoba counterparts.
- The overall health of the family unit is crucial to its members.
  - Good communications can be both learned and enhanced.
  - Partnerships meant to ensure positive environments is most important.
  - Physically and mentally healthy family units will contribute to resilience for life.

Children

- Young children/adolescents suffer from mental disorders.
  - Approximately 270 children in Central Region utilize Mental Health Services.
  - Girls are most vulnerable to depression and boys are more vulnerable to ADHD.
- Between 1992 and 2001, there were 2,503 injury hospitalizations among our children.
  - 98 per cent of child injury deaths in 1997 were deemed preventable.
- Over half of current and former smokers started smoking between the ages of 15 and 19. This is an important factor to consider when we target programs for smoking prevention and cessation.
  - In 2002/03, we had one of the lowest teen pregnancy rates in the province.
- Youths must continually be made aware of the perils of lifestyle choices such as unprotected sex, smoking, unsafe driving and alcohol use.
  - A safe and supportive environment must be provided to youth who are engaging in, or at risk for, self-injurious behaviour.

Elderly

- Older seniors in the Central Region were much more likely to report activity limitation than were younger seniors. Activity limitation due to a chronic illness is higher among elderly females (44.5%) than males (39.5%).
- The elderly accounted for 42.1 per cent of all unintentional injury related hospitalizations in Central Region between 1992 and 2001.
  - Women accounted for just under two-thirds of these hospitalizations.
  - Falls accounted for 81 per cent of these hospitalizations.
  - Focusing energy to prevent serious injury, particularly resulting from falls, would be an important factor.
  - Self-inflicted deaths among elderly men accounted for 11 deaths.
Fifty percent of residents 65 or older in Central Region received the flu shot, compared to 55 per cent of residents 65 or older in Manitoba.

87-88 per cent of our 65+ generation have stress that affects their health.
- In this age group, rates of ‘life stress’ were higher among women than men.

Becoming a caregiver to your loved one is a significant life stress for people 65+.
- Services to both the well elderly and the frail, or vulnerable elderly is important.
- Although the frail elderly may have access to excellent acute care services, both will benefit from an on-going commitment to supporting an independent lifestyle with access to meaningful activities and social supports.

Aboriginals

- Between 1995 and 1999, the standardized PMR for Central Region First Nation residents was one of the highest in the province in this time period.
  - First Nations people living on-reserve can expect worse health outcomes from non-reserve First Nations as well as from the rest of the population in Manitoba.
  - Life expectancy of First Nations males is 66.71 years and 71.06 for females.

- Rates of our First Nations residents living with diabetes are significantly higher than for non-First Nations residents.
  - The difference between First Nations and non-First Nations rates in the Central Region was the largest in the province.
  - True rates of diabetes are likely much higher than reported.
  - Continued focus on diabetes prevention and management is clearly a priority.

- Mental health issues were identified as a major concern by many of our First Nations.
  - Mental health issues need to be addressed to improve health outcomes.
  - Supports for ongoing education and training as well as culturally appropriate mental health and wellness services are essential to this population.

- The injury hospitalization rate for Registered First Nations is 3.7 times higher than for the general population.
  - Injury mortality rate for First Nations children age 29 days to 14 years was over 9 times higher than for non-First Nations children in Manitoba.
  - Injury prevention, from both unintentional and intentional sources, would improve the PMR and quality of life for this vulnerable population.

Women

- Females accounted for 35 per cent of the total PYLL.
  - In the most recent time period, breast cancer was the leading cause of PYLL among females, an increase from previous reporting periods.
  - Lung cancer is now increased to the second leading cause of PYLL among females. It is interesting to reflect on the rising smoking rates among females that evidences ‘an alarming increase in young women who start to smoke’.
  - New causes of potential years of life lost among females include diabetes (sixth leading cause), leukaemias and cervical cancer (9th and 10th leading causes).
- In 2003, more women than men reported their health as “very good or excellent”.

Regional Health Authority – Central Manitoba Inc.
September 2004
Women are being hospitalized for self-inflicted injuries more frequently than men, (13% compared to 2%), providing us with an unique opportunity for intervention.

Overall, females accounted for 55 per cent of unintentional injury deaths.

Females were more likely than males to be physically inactive.

In 2001, fewer women than men reported having a BMI of great than 27.0.

In 2003, 17.3 per cent of females reported being a daily or occasional smoker.

Almost 60 per cent of women ages 50-69 years in Central Region receive at least one mammogram every 2 years, an improvement from the previous 53.1 per cent.
  • We will be interested to observe the rates of Breast Cancer deaths over time to determine whether there is a concurrent decrease.

Despite increased rates of cervical cancer screening, we are still below the provincial average. It is important that we adequately inform women regarding the need for screening for these diseases, the appropriate ages at which to start and how often they need to be screened.

Women in Central Region reported overall lower incomes.
  • The average income for women in 2001 in the Central Region was $18,244 compared to $21,480 in Manitoba overall.
  • Men who worked full time for a year earned an average of $34,200 while women earned nearly $8,000 less, at $26,257.

Suitable supports for pursuit of education and gainful employment would help improve women’s health.

Men

Males accounted for 65 per cent (or 81,253) of the total PYLL.
  • The patterns of premature mortality remain the same. The four leading causes of PYLL among men have not changed in the 19 year time period and PYLL due to lung cancer has increased.

Among males in the most recent time period, four of the ten leading causes of potential years of life lost are due to either unintentional or self inflicted injuries.
  • Two causes of PYLL for men are ischemic heart disease and lung cancer.
  • Some identified risk factors can be modified through lifestyle changes.

Self-rated ‘very good or excellent health’ has declined among men.

Between 1994 and 1998, diabetes mellitus was the ninth leading cause of death.

A high proportion of males (age 20-64) were classified as either overweight or somewhat overweight.

Just over 1 in 4 males reported being a daily or occasional smoker. (CCHS 2003).
  • Almost all current male smokers had started smoking by the age of 20.

In 2001, smoking rates were highest in Central Region males aged 20-24 with 21 per cent of our male population smoking by the age of 20 and 34 per cent by the age of 24.

Healthy public policy including messages about smoking, exercise and diet, safe driving practices as well as safety in work and leisure activity in general could benefit men’s health. A continued focus on mental well-being and suicide prevention must remain a priority in the Central Region.
Board Response

“As Healthy As Can Be!”

The CHA provided significant information to the community, staff and the Board of Directors. In particular, the Board used this information in refining its ENDS or statement of purpose and prioritizing outcomes.

The Regional Health Authority - Central Manitoba Inc. exists so that people in our region are as healthy as they can be at a reasonable cost to the community.

- We interpret people to be individuals who are as healthy as they can be.
- We further interpret individuals to include, in order of priority, the following groups: children, aboriginals, women, men and seniors.

Following the direction provided in the ENDS by the Board of Directors, the RHA Central staff will reasonably interpret the meaning of ENDS so that intervention and strategic planning will comply with the Board’s intention. This will lead the population of Central Region to be "As Healthy As Can Be!"
Introduction

MANDATE

In Manitoba, the Department of Health has a legislated requirement to “assess health needs in the health region on an ongoing basis”. The Community Health Assessment (CHA) provides the Regional Health Authorities (RHAs) with a great deal of information to support health planning in the regions.

The first comprehensive CHA was conducted in 1997 for the Central Region. The current report presents the findings from our regions’ second comprehensive CHA.

The CHA process in Manitoba is planned through the collaborative efforts of the Community Health Assessment Network (CHAN), through primary partnerships between: Regional Health Authorities of Manitoba, Manitoba Health, CancerCare Manitoba, and the Manitoba Center for Health Policy (MCHP). Central Region has representatives participating in the CHA Network.

In planning for the second comprehensive CHA, the Community Health Assessment Network has sought to pool resources and expertise, and where possible to adopt a common provincial approach based on lessons learned. For example, in 2001, the strategic health planning cycle and the CHA cycle were realigned to ensure a better match with data availability. A core set of baseline CHA indicators were developed through a subcommittee of CHAN, and approved by CHAN. Collaborative efforts between Manitoba Health, the RHAs, and MCHP, resulted in the timely provision of accurate and reliable information on the baseline CHA indicators. Further information was collected through a series of community consultations including a telephone survey conducted by Acumen Research Corporation. CHAN has provided some commonality, consistency, and comparison capacity between regions, where appropriate.

What you read in this report is an integration of all the information collected for the Central Region. This information is the evidence to distinguish between the actual health needs of our region versus wants, or perceived needs. A need is that which is required to ensure life and limb. In other words, it consists of those factors without which there would be severe consequences. A want is that which will make us more comfortable, add quality or convenience. Our conclusion is that if we are to plan health services and prioritize with consideration of need and want, we require evidence to do so; what is presented in this report is the evidence.
PREAMBLE

The 2004 comprehensive Community Health Assessment focused on health status and promotion, which is the process of enabling people to increase control over, and to improve, their health. As per the Ottawa International Conference on Health Promotion, “Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.” (Ottawa Charter for Health Promotion, 2004).

Determinants of Health

The fundamental conditions and resources for health are generally referred to as the Determinants of Health. They include such factors as:

- Personal health practices & lifestyle
- Personal resources
- Living and working conditions
- Environmental factors
- Healthy child development
- Gender
- Biology and genetic endowment
- Culture
- Health care system

All of these factors influence our health as a population and also as individuals. They can be further considered with respect to ‘risk factors’ or ‘indicators’ and include such concepts as shown below:

- Personal Health Practices & Lifestyle:
  - smoking
  - obesity
  - drinking alcohol
  - physical inactivity
  - immunization and health screening: eg. cervical, diabetes.
  - risk taking behavior: eg. impaired driving.
**Board ENDS**

What differences will the Regional Health Authority – Central Manitoba Inc. (RHA Central, Central Region) make in the world? Can we make it a better place? What impact do we intend to have? What outcomes do we seek?

In making decisions about the kind of future that RHA Central is to create, the RHA Central Board of Directors (the Board) spent considerable time doing future-oriented thinking and consulting with its owners, the community. From its early efforts in 2003, the Board began to define its expectations by setting itself a bold vision:

> The Regional Health Authority - Central Manitoba Inc. exists so that people in our region are as healthy as they can be at a reasonable cost to the community.
> This includes but may not be limited to healthy:

1. Individuals,
2. Families and
   3.1. Children
   3.2. Elderly
   3.3. Aboriginals
   3.4. Women
   3.5. Men

The development of the vision, or ENDS is an on-going process. The environment changes, new opportunities arise, population health priorities shift. This means that the Board must continually link with people in Central Region to assure that the range of opinions are heard, considered and formulated into a clear sense of purpose for the organization. The ENDS are a reflection of community ownership input and Board deliberation. While linking with owners, the Board seeks to understand what helps, or prevents, people from being as healthy as they can be. The Community Health Assessment is a proactive way of collecting information about people in Central Region but also assists in validating the prioritization of ENDS with the community.

ENDS describe three aims: what results, for which recipients, and at what worth. With the Board’s definition of success for the future, RHA Central staff further identified, or reasonably interpreted, more specific and succeeding outcomes to be achieved.

The Central Region is governed by Board ENDS. These ENDS, which ensure that the health of the entire population of Central Region is considered in all its assessment and planning, define the purpose for which RHA Central exists. Therefore, it seemed reasonable that the population served would form the outline for the health assessment. The health status that was observed was reviewed by the determinants of health within the population groups of Central Region and with a special look at some specific considerations of risk within the region.
PROCESS

Early in 2003, RHA Central established committees to plan the health assessment process. The Leadership and Partnership team guided RHA Central in key decisions regarding process for the health assessment. The Population Health Team hired a Coordinator and developed a process for the overall assessment format. Teams of experts were compiled from the RHA Central staff to assess population groups and consider data and gaps in data to determine the health status of the people of Central Region.

An Epidemiologist was contracted to seek data and assist in its interpretation. Workshops were held to introduce the teams to the research methods that were employed and to the available data. The teams examined the data in order to interpret it from a regional perspective. Gaps in the data were identified and further data sought through different forums.

The data was initially interpreted and provided through the Epidemiologist from sources such as the Manitoba Centre for Health Policy administrative databases including the Need To Know RHA Indicators Atlas, Manitoba Health, Canadian Community Health Surveys (CCHS), National Population Health Surveys, Statistics Canada, and other survey sources as required. The information led to questions that were considered through the team expertise regionally, literature reviews, and external partners or experts as appropriate. Data gaps that remained after team analysis were gathered from community sources.

Community consultation took three forms (see Appendix A). First, RHA Central collaborated with the RHA partners from the provincial Community Health Assessment Network (CHAN) involved in a Telephone Survey. Two region-specific questions were asked in addition to the overall survey questions. These two questions concerned perceptions about Spirituality and Health as well as Immunization. The second source of community consultation was through Focus Group sessions categorized by age, sex and culture. The third source of community data was gathered through Key Informants who spoke to us about their knowledge of specific groups with whom we could not gain full access in other ways.

Telephone Survey:

This survey, contracted by a sub-committee of CHAN, was conducted by Acumen Research in December of 2003 and reported to the RHAs in January of 2004. RHA Central sent out postcards to advise the residents of Central Region about the upcoming telephone survey. Following the mail out, the RHA Central newsletter informed residents of the upcoming consultation and opportunities for involvement in the health assessment. A radio spot added another layer of information to residents of Central Region regarding the health assessment, its purpose and opportunities for participation. The data from the telephone survey was analyzed by Acumen Research and further considered by the RHA Central health assessment teams.
Focus Groups:

Wildwood Consulting was contracted to conduct focus group sessions which were held in twenty-five different sites in Central Region. These twenty-five focus groups were segregated by age, sex and the specific cultures of Francophone, Aboriginal and Hutterite. Four core questions and sub-questions were asked of each group in addition to specific questions that were asked of the separate groups. These data were analyzed; quotes from the sessions added texture to the assessment and have been included throughout the report.

Key Informant Interviews:

There remained data gaps that could be filled by individuals who are knowledgeable regarding certain less reachable population groups. Assessment teams spoke to individuals who had knowledge to share regarding low German speaking Mennonites from Mexico who reside in Central Region. Some spoke to elders on Aboriginal reserves and other groups of people representing off-reserve Aboriginals. Staff members spoke to women who live in poverty and who have health struggles that they were willing to share with us. Together these Key Informants provided us with information we could not have obtained in other forums.

Once the preliminary research and analysis was available, the SHAPE teams and other health assessment contributors met with RHA Central’s Board of Directors during a two day workshop to review the findings and consider how they would guide planning in Central Region. The participants of that two day workshop collaborated together regarding how the Board ENDS might be revised in consideration of the health status of people in Central Region and how to improve that status. Decisions were subsequently made by the Board and the Board ENDS were changed to better reflect the priorities of RHA Central if we are to work toward the population becoming “As Healthy As Can Be!”

Population Groups:

The health status of Individuals as presented in Chapter 1 looks at the entire population with a review of the Determinants of Health in Central Region and those factors that are seen to be a risk for all categories of people within Central Region. The chapter forms the basis of information for the other population groups that follow and are more closely detailed within the following chapters.

Chapters 2-7 provide detailed information about special population groups within the region and comparative information with other health regions where appropriate and available. Health status encompasses far too many potential areas of inquiry to conduct an all-inclusive review, so the decision was to review all the information specifically about the health status of the population group assessed. The teams documented only
those areas of greatest concern, those that could be completed within the time period available, or those that indicated how healthy the people of Central Region are. Any considerable areas of concern that would entail a more in-depth review are deferred for consideration in upcoming assessment years for very focused health assessment. These include areas that require lengthy focused resources for assessment or perhaps awaiting data resources currently being gathered by external agencies such as the Manitoba Centre for Health policy or the Childhood Nutrition Survey.

After considering all the information from the available sources, the teams chose themes to review more closely, to consult the community regarding personal perceptions, or to recommend the Board of Directors pay special attention to through a revision of Board ENDS or by monitoring on a regular basis. The Board responded to the key assessment findings by revising the Board ENDS and choosing priority ENDS targeted at improving the health of the population in Central Region so that the residents might be “As Healthy As Can Be!”
“Individuals in Central Region are as healthy as can be!”

**INDIVIDUALS SHAPE TEAM:**

Debbie Nelson  
Kristine Svendsen  
Brad Street

Michelle Turnbull  
Cheryl Pearson  
Dr. Denis Fortier

Mary Smith  
Heather Dowling  
Jackie Haliburton
Jason’s Story

"Why is Jason in the hospital?
Because he has a bad infection in his leg.
But why does he have an infection?
Because he has a cut on his leg and it got infected.
But why does he have a cut on his leg?
Because he was playing in the junk yard next to his apartment building & there was some sharp, jagged steel there that he fell on.
But why was he playing in a junk yard?
Because his neighbourhood is kind of run down.
A lot of kids play there and there is no one to supervise them.
But why does he live in that neighbourhood?
Because his parents can't afford a nicer place to live.
But why can't his parents afford a nicer place to live?
Because his Dad is unemployed and his Mom is sick.
But why is his Dad unemployed?
Because he doesn't have much education and he can't find a job.
But why ...?" (Health Canada).
Chapter 1

SECTION I: ASSESSING RESIDENTS OF CENTRAL REGION

1.1 The Assessment Process

The Community Health Assessment (CHA) Individuals assessment team was one of seven teams established with a mandate from the RHA to gather and interpret data on the health of people overall in Central Region.

The team reviewed all sources of data with an overall population lens and within a ‘Determinants of Health’ framework considering what influences the health of the population in general in Central Region.

1.2 Demographic Overview

Central Region has the largest population of all rural and northern Manitoba RHAs and is second only to Winnipeg in population. The most recent population estimate available for the Central Region from Manitoba Health is for June of 2002 and it indicates that the population was 98,778. This figure is slightly higher than the population of 93,980 reported by the 2001 Census.
Figure 1-1: Central Region population pyramid, June 2002 population.

Source: Manitoba Health.

Figure 1-2: Manitoba population pyramid, June 2002 population.

Source: Manitoba Health.
Figures 1-1 and 1-2 illustrate that the population distribution in Central Region is very similar to the distribution in the provincial population. We have a higher proportion of youth (age <20 years) at 32 per cent of our population compared to 27 per cent of the provincial population. However, our population of residents aged 75 and older is very similar with both Central Region and the province being just under 7 per cent.

The population of Central Region has changed more than the province overall, with an increase of 2.6 per cent between the 1996 and 2001 census compared to a provincial increase of 0.5 per cent. This change is more significant than the rest of Manitoba. According to the Population Projections, our population is expected to increase by a total of 14.5 per cent between 1998 and 2025. The median age of the Central Region population was 35.0 years, slightly younger than the provincial 36.8 years. (Manitoba Bureau of Statistics)

Table 1-1 illustrates the marital status of residents aged 15 and over in Central Region and in Manitoba with just under 60 per cent of the Central Region cohort reporting a status of ‘married’ in 2001. This is higher than the provincial average of almost 52 per cent. Our reported divorce rate, at 3.8 per cent for Central Region residents, is lower compared to the average Manitoba rate of 6.4 per cent.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population 15+</td>
<td>72,500</td>
<td>885,865</td>
</tr>
<tr>
<td>Single</td>
<td>20,510 (28.3%)</td>
<td>281,545 (31.8%)</td>
</tr>
<tr>
<td>Married</td>
<td>42,890 (59.2%)</td>
<td>458,435 (51.7%)</td>
</tr>
<tr>
<td>Separated</td>
<td>1,395 (1.9%)</td>
<td>24,915 (2.8%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2,720 (3.8%)</td>
<td>57,125 (6.4%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>4,970 (6.9%)</td>
<td>63,845 (7.2%)</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

The Central Region has a fairly diverse population in terms of languages. Table 1-2 illustrates the proportion of residents by first language learned and still understood. Over one quarter (27.2%) of Central Region residents indicated a language other than English or French. This is higher than the provincial rate of 21 per cent of residents.

<table>
<thead>
<tr>
<th>Language first learned and still understood</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Only</td>
<td>67.6%</td>
<td>74.7%</td>
</tr>
<tr>
<td>French only</td>
<td>5.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Both English and French</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other languages</td>
<td>27.2%</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.
These indicators tell us general information about our population. The status of our health is described in the following sections on Health Status and Determinants of Health and will be summed up in Key Findings.
SECTION II: HEALTH STATUS OF CENTRAL REGION RESIDENTS

2.1 Overall Health Status

A measure of the health of a population can be demonstrated by a number of Health Status indicators. The Manitoba Centre for Health Policy used Mortality as one measure in the RHA Indicators Atlas (The Atlas) authored by Martens, Fransoo and Need to Know Team, 2003. Sources of information for ‘The Atlas’ included Manitoba Health and Vital Statistics.

The latter data source was used for mortality rates. Life expectancy, Premature Mortality Rate (PMR) and Potential Years of Life Lost (PYLL) were among them. “Five calendar years of data (1991-1995, 1996-2000) were used in order to obtain a more stable rate” (Martens et al, 2003, 257). Information for Central Region and, where appropriate, from other regions or provincial data for comparison, are used in this report.

A measure of how well or ill individuals are within a region can be measured by the ‘Morbidity Rate’. Overall morbidity is commonly defined as "departure from an overall state of health" (Health Canada, March 2004). Morbidity for Central Region is described through showing the incidence\(^1\) of particular diseases within our Region.

Measuring death and illness are not the only ways we can consider how healthy we are. This document includes indicators of well-being as measured by functional health, self-rated health and activity limitations as described in the Central Region Health Profile from Manitoba Health (2003).

\[\text{2.1.1 Mortality}\]

Mortality in Central Region is measured in a number of ways. We measured three for this assessment. The rate of death occurring prior to the age of 75 years is commonly referred to as Premature Mortality. We also measured the total number of years of life lost by death before the age of 75 years, which we refer to as the PYLL. The third measure we have included is that of life expectancy. This measure indicates for us the length of time, at birth, a person can be expected to live based on current projections. We have used the findings from The Atlas.

\[\text{2.1.1 (a) Premature Mortality Rate (PMR)}\]

In Central Region the overall average yearly PMR in the years of 1991-1995 was 3.26 per 1000 population and in the years 1996-2000 the average PMR per year was 2.942. This indicator reflects improving health in Central Region; our residents have improved in

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\(^1\) Incidence refers to the frequency we observe a particular indicator in a population in a given time period. For example, this might include how often we have had a diagnosis of breast cancer in 2003.

\(^2\) Age and sex-adjusted rates of death per 1000 population aged 0-74.
health status, as measured by PMR, in the two time periods measured. We are listed as fourth provincially overall in health status because in the first measure (1991-1995) our PMR was the fourth best in the province, next to Brandon. However, by the second time period our PMR had improved, surpassing that of Brandon (Martens et al, 2003, 46).

2.1.1 (b) Potential Years of Life Lost (PYLL)

Within our region, however, the story is somewhat different. While most of our areas are healthy as measured by this PMR indicator, the areas of Seven Regions and Portage la Prairie have higher premature mortality than the provincial average for both time periods shown (Martens et al, 2003). They have, however, shown some improvement over the two time periods. Altona and McDonald Cartier show significantly better health status both in comparison to the provincial average and over the two time periods. These rates have been sex and age adjusted to make comparisons possible.

The measurement of PYLL gives us some idea as to how much before the age of 75 that our population is dying. This measure “gives greater weight to a death occurring at a younger age than a death at a later age”. When the PYLL is high, it tells us that people are dying young, something about which we are concerned. (Martens et al, 2003). In Central Region, we have reduced PYLL over the two time periods (1991-1995 and 1996 – 2000) by almost three years from 51.37 potential years of life lost to 48.48 potential years of life lost. Although this change was not statistically significant, it is a move in the right direction and Central Region continues to have the fourth lowest rate of PYLL in the province. Within our region, it is important to note that there are differences with the North Area slightly above the provincial average.

Not surprisingly, the Northern Area3 story is once again similarly reflected in PYLL for Seven Regions and Portage la Prairie. Both of these areas are slightly above the provincial average and in the case of Seven Regions, there is an increase in PYLL from the first time period to the second (Martens et al, 2003). Because of small numbers and the influence of any major event in a small area, however, the difference between the two time periods was not considered significant. It is worthy of note insofar as we would much prefer to see a decline in PYLL to indicate improved health status.

Table 1-3 illustrates the leading causes of PYLL for residents over age 1.

Table 1-3: Leading causes of PYLL, 1994-1998.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle Accidents</td>
<td>Breast cancer</td>
<td></td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>Lung cancer</td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>Ischemic heart disease</td>
<td></td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>Motor vehicle accidents</td>
<td></td>
</tr>
<tr>
<td>Ill-defined causes</td>
<td>Diabetes</td>
<td></td>
</tr>
</tbody>
</table>

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.

3 Central Region is divided into four areas. They are North, South, East and West. The communities that are referred to within the area, as well as the area by direction are named in this document when appropriate.
2.1.1 (c) Life Expectancy

The last mortality measure we have considered is that of life expectancy. Figure 1-3 illustrates life expectancy at birth for people born in 1997. According to Statistics Canada, Central Region residents have the longest life expectancy in the province at 79.1 years.

Figure 1-3: Life expectancy at birth (1997), by region.

2.1.1 (d) Leading Causes of Death

Leading causes of death is an indicator identifying those problems that have the most visible and complete impact on individuals. The five leading causes of death for males and females in Central Region, while similar, are not identical for males and females, nor are they the same over the age span. For this reason, the leading causes of death will be


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4 Life Expectancy: According to Martens et al, 2003: the expected length of life from birth, based on the mortality of the population using provincial Vital Statistics records for a five-year period of time. Life expectancy values are the most commonly used indicator of population health status, especially for international comparisons. (48)
described in the relevant chapters. Overall, (based on 1994-1998 vital statistics data) they include:

- Ischemic heart disease
- Cerebrovascular disease
- Lung cancer
- Heart failure
- COPD
- Pneumonia and influenza.

2.1.2 Morbidity

Other indicators of the health status of a population can be measured by how ill a population is within the lifespan, and the causes of death. Studying the incidence and prevalence of diseases is one way to reflect on how healthy or ill that population is. This indicator might include the prevalence, incidence and deaths related to one disease such as cancer. It might include chronic diseases and incidence of certain treatable diseases that are seen frequently in our population. Injury rates are demonstrated in this section although for some specific injuries there is a separate discussion, where appropriate, in an area, for example, such as mental health for intentional injuries. Chronic diseases such as diabetes, cardiovascular disease, cancer, and respiratory illness dominate the illness burden within our health system.

2.1.2 (a) Cancer

Cancer is a disease that claims the health, quality of life, and life of many individuals. Cancer prevalence rates in Central Region appear to be lower than the rates for all Manitobans combined. Incidence of overall cancers is decreasing and is lower than the provincial average. However, some geographic areas are experiencing increases in incidence and/or are matching provincial rates. Lung cancer was the leading cause of cancer deaths 1999-2001. Of note is that among all rural Regional Health Authorities (RHAs), Central Region had the highest number of deaths attributed to breast cancer and prostate cancer from 1999-2001. (Manitoba Vital Statistics, analysis by Cancer Care Manitoba).

2.1.2 (b) Injuries

This indicator refers to behaviours leading to intentional and unintentional injuries, as evidenced by the categories below. Residents of Central Region appeared to be more likely to die as the result of unintentional injuries than were all Manitobans combined. (Manitoba Health, 2003, 6).

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5 Incidence refers to the frequency within which a disease is diagnosed in a given period of time. Prevalence refers to the total number of people living with a disease or condition within a given population.

Regional Health Authority – Central Manitoba Inc.
September 2004
In a study conducted by The Hygenia Group, the cost of unintentional injuries was calculated to be $8.7 Billion dollars annually in Canada. Falls accounted for $3.6 Billion and motor vehicle collisions accounted for $1.7 Billion. This is a significant, preventable cost to our economy.

To place this in perspective, “In 2001, Manitobans spent 143,423 days in hospital because of injuries, an average of 13.3 days per hospitalization. (Manitoba Health, 2004). Between 1992 and 2001, the average annual injury hospitalization rate in Central Region was 1,212 injury hospitalizations per 100,000 residents. In this time period there were a total of 11,627 hospitalizations due to injuries. Males accounted for 53 per cent of these hospitalizations with a rate of 1,287 per 100,000 (compared to females at 1,138 per 100,000). (Manitoba Health).

As Figure 1-4 illustrates, Central Region has a crude injury hospitalization rate⁶ that is about the mid-range for the province.

**Figure 1-4: Total injury hospitalization rates by region, 1992-2001.**

Source: Manitoba Health.

One source of standardized data is the Manitoba Centre for Health Policy (see Figure 1-5). These data are available for two five year time periods and illustrate that when taking into account our different population distributions, Central Region is still right in the middle of the RHAs (as with crude rates). Injury related hospitalizations showed a

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⁶ Crude Rate is a rate based on the actual numbers that have not been adjusted to account for population age and sex.

Regional Health Authority – Central Manitoba Inc.
September 2004
significant decrease from 13.18 per 1,000 in 1991/92-1995/96 to 11.26 per 1,000. In each time period, however, our rates were significantly higher than the provincial rates of 11.24 per 1,000 in the first time period and 9.88 per 1,000 in the second.

**Figure 1-5: Age and sex standardized injury hospitalization rates by region, 1991/92-1995/96-1996/97-2000/01.**

![Figure 1-5: Age and sex standardized injury hospitalization rates by region, 1991/92-1995/96-1996/97-2000/01.](image)

**Source: Manitoba Centre for Health Policy, Need to Know Project.**

Within Central Region, the top three areas, all higher than the provincial average for injury hospitalization rates, were, in descending order, Lorne/Louise/Pembina, similar in rates to Seven Regions and closely followed by Portage la Prairie. These rates alert us to the need for injury prevention in our region.

Injuries are classified both by the cause of the injury (for example, poisoning) as well as the “manner or intent”. The manner or intent is classified as follows:

- Unintentional
- Self-inflicted
- Assault
- Undetermined

In the Central Region, 90 per cent of injury hospitalizations between 1992 and 2001 were due to unintentional injuries (see Figure 1-6). This is higher than the provincial experience where just over 4 out of 5 (83%) hospitalizations were due to unintentional injuries. Figures 1-6 and 1-7 also illustrate that hospitalizations for self-inflicted injuries account for 5 per cent of hospitalizations in the Central Region and 8 per cent in Manitoba.
Figure 1-6: Central Region injury hospitalizations by manner or intent 1992-2001.

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.

Figure 1-7: Manitoba injury hospitalizations by manner or intent, 1992-2001.

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.
Gender analyzed data can be found in chapters for men and women respectively.

If we look at males and females in Central Region separately, we see that in both cases, about 90 per cent of injuries are unintentional (see Figures 1-8 and 1-9). The main differences that we see are among hospitalizations for self-inflicted injuries and for assault. Self-inflicted injuries account for a much higher proportion of females hospitalizations (7%) than males (4%). However for assault the opposite is true, accounting for a higher proportion of male hospitalizations (6%) than females (2%).

Figure 1-8: Central Region female injury hospitalizations by manner or intent, 1992-2001.

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.
Among the numbers of Central Region folks hospitalized for injuries, falls account for almost half. From 1992-2001, “each hospitalization for unintentional falls lasted for an average of 19.8 days. For Central Region, the result would mean the use of 29 hospital beds every day in Central Region due to falls alone. The second most common cause of injury hospitalization is motor vehicle traffic incidents followed by intentional injuries from self, then assault (Manitoba Health, 2004).

Unintentional injury deaths for Central Region from 1992 to 1999 resulted in an average of 29.9 PYLL per person. There were 419 people who died as a result of injuries for a rate of 41.9 deaths/100,000 residents compared to Manitoba at 51.0 deaths /100,000 residents.

The top 4 causes of unintentional injury/death in Central Region, in descending order, are: motor vehicle crashes, falls, poisoning, and drowning. Motor vehicle crashes are among the top 2 causes of death for men, women and children from infants to teens in Central Region. Most deaths occur between ages 15-24 years in both males/females. (See Children’s Chapter).

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.

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7 Motor vehicle crashes includes farm collisions, snowmobiles, all terrain vehicles.
Central Region is an agriculture community, so considering deaths and injuries on farms is important. Each year in Canada, farming injuries result in about 120 deaths and 1,200 medical interventions. Deaths to farmers and farm workers represent 13 per cent of all occupational fatalities in Canada. Among Central Region telephone respondents in 2003, the farm was the third most common locale for injury, after one’s home or factory/warehouse/construction. The farm ranked higher as a site of injury in Central Region than for overall provincial respondents.

In Canada, suicide is the top intentional injury, and among the leading causes of death. Similarly, suicide is one of the top 5 causes of death in Central Region and the second leading cause of injury death.

2.1.2 (c) Chronic Diseases

Chronic disease is another indicator of the health of a population. Some diseases that are considered in this category include Arthritis, Diabetes, Asthma, Cardiovascular Disease and Hypertension. While Cancer can be a chronic disease, it has been discussed separately in section 2.1.2 (a).

Central Region residents appear to have lower rates of arthritis, rheumatism, asthma and hypertension than all Manitobans combined. However, we have had a significant increase in prevalence of diagnosis and treatment for diabetes and hypertension, with little change in rates for heart attacks. Stroke rates for the region are decreasing but remain higher than the provincial average. Prevention and treatment programs can positively influence the outcomes for these chronic illnesses. Increased treatment rates may be the reason we have had improved stroke rates. Trend data may demonstrate this for us over time.

2.1.3 Well-Being

There are three measures of well-being that are described from data gathered in the Central Region Profile Document compiled by Manitoba Health in August of 2003. They are Functional Health, Self-Rated Health and Activity Limitations.

2.1.3 (a) Functional Health Status

This measure is useful to assess the numbers of residents who may have ongoing health needs. It is defined by the National Population Health Survey as:

Population aged 12 and over reporting measures of overall functional health, based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain). A score of 0.8 to 1.0 is considered to be very good or perfect health; scores below 0.8 are considered to indicate moderate or severe functional health problems. (Manitoba Health, 2003, 53).
This particular measure is available at the regional level only for Cycle 1.1 of the Canadian Community Health Survey (CCHS). In 2000-01 when the first cycle of the CCHS took place, Central Region had the highest proportion of residents (82.2%) who had very good or perfect functional health (see Figure 1-10).

**Figure 1-10: Proportion of residents with very good or perfect functional health.**

![Bar chart showing the proportion of residents with very good or perfect functional health by region.](chart)

*Source: CCHS Cycle 1.1, 2000-01.*

### 2.1.3 (b) Self-Rated Health Status

This measure shows the percent of the population aged 12 and over who report that their health is very good or excellent.

Self-reported health is a general indicator of the overall health status of individuals. It can include what other measures may miss, such as disease severity, some aspects of positive health status, physiological/psychological reserve, and social and mental function.(Manitoba Health, 2003, 53).

In our region, 59.3 per cent of residents reported that their health status was very good or excellent in 2003. This is slightly lower than 2001 when 60.3 per cent of residents reported their health status positively and we are still slightly lower than the provincial average of 60.8 per cent (see Figure 1-11).

In our Telephone Survey, 55 per cent of Central Region residents rated their health as excellent or very good. Although higher than overall survey results (53%), this is lower than reported in both the 2001 and 2003 CCHS. Central Region residents are slightly more likely than those overall to rate their health for their age as very good and slightly less likely to rate it as fair or poor. Those of German or Dutch background are the most likely to say their health is excellent or very good, while those of British or Irish
background are the least likely. Health comparisons tend to be most positive in respondents who have graduated from high school or university. (Acumen Research).

Figure 1-11: Self-reported health status by region, 2001-2003.


2.1.3 (c) Activity Limitations

Activity is one indicator used to demonstrate quality of life. While we often speak of PMR as an important indicator, the activity factor helps us to see that the number of years of disability free life is also important to one’s overall health. This concept will be found further illustrated in the chapter on ‘Elderly’.

Population aged 4 and over (or aged 12 and over for the data from the Canadian Community Health Survey and National Population Health Survey, North Component) who reported having a disability or being limited in certain activities on a continuing basis (or at least 6 months) because of a physical condition, mental condition, or health problem in 2001. Due to small sample size, Central [Region] residents cannot be compared to all Manitobans for this indicator (Manitoba Health, 2003, 54).

In both 2001 and 2003, Central Region residents reported the second lowest rates of activity limitation in the province. Our rates have increased slightly from 2001 where 18.1 per cent reported an activity limitation to 21.7 per cent in 2003. However, this is still lower than the provincial average of 24.2 per cent.
The above discussion has demonstrated that the overall health status of Central Region residents is rather good. There is room for improvement, however, and there are influences that affect our health status either for the better or the worse. The following factors, as discussed in the Determinants of Health section, play an important role in determining our health status.

SECTION III: DETERMINANTS OF HEALTH

Behind every health story in Central Region lays a complex set of factors or conditions that affect whether people are “as healthy as they can be.” This report attempts to capture the main influences in Central Region and to provide a picture of our health.

There is a growing body of evidence about what makes people healthy, and that increased spending in health care will not necessarily result in improved health. The evidence indicates that the key factors that influence health are: Personal Health Practices and Lifestyle, Personal Resources, Living and Working Conditions, Environmental Factors, Healthy Child Development, Gender; Biology and Genetic Endowment, Culture, and Health Services. Together these are referred to as determinants of health. There are several of ways to frame these determinants and the Population Health Committee for Central Region chose to use Manitoba’s Performance Measurement Framework as our approach.

We recognized that the modifiable determinants of health include those over which people or resources have some control or influence. Because Biology and Genetic Endowment are not among these, little assessment will be done on this particular determinant. However, the Individuals chapter provides overall information; specific gender-based analysis is to be found in the chapters for Men and Women respectively. While Culture is constant, health and illness beliefs can be influenced and practices altered for health promotion; for this reason culture will be considered both within chapters where applicable, and as a stand-alone chapter for our Aboriginal population.

Since Central Region scored significantly above the overall rating in the Telephone Survey with respect to accessing Health Services, and given that this is a health status review rather than a health services review, there is little comment on health services at this time.

The following framework for discussion is not meant to indicate any degree of importance for one determinant over the other. People with whom we spoke in Central Region made it clear to us that the determinant that they found most important to their health was very much dependent upon what stage of life they were in and the circumstances of health for themselves or their families at any given time.

3.1 Personal Health Practices and Lifestyle

Personal health practices and lifestyles refer to those actions by which individuals can prevent diseases and promote self-care, solve problems and make choices that enhance health. The choices we make are influenced by many factors, including our life circumstances and the social, economic and physical environments in which we live, work, learn and play. These choices involve decisions about amount and types of physical activity, what to eat, tobacco use, injury and risk taking behavior, as well as health practices such as screening for high blood pressure and breast cancer, influenza immunizations, and sun protection.
3.1.1 Weights

Obesity is a condition of abnormal or excessive fat accumulation to the extent that health may be impaired. Controllable factors such as dietary practice and activity level, and uncontrollable factors such as genetics affect it. International research indicates that increases in overweight and obesity are primarily due to societal and environmental changes that influence activity and eating patterns. Such changes include:

- Lifestyles that promote high-fat, high-energy diets
- More people working at sedentary jobs
- Increases in the use of automobiles and passive leisure activities

Healthy weights are an indicator of health status. International Standards use a measure of Body Mass Index (BMI)\(^9\) to report a measure of healthy weight in a common method of determining if an individual’s weight is in a healthy range based on their height.

According to the Provincial Health Indicators Report (1999), the proportion of obese persons is an indicator of the prevalence of problems of excess weight corresponding to the highest level of BMI and thus presenting potential health risks. High BMI is associated with increased prevalence of high blood pressure, diabetes, high cholesterol levels and certain cancers (Manitoba Health, 2003, 61).

BMI is calculated as follows: weight in kilograms divided by height in meters squared for persons aged 18 and older (In CCHS Cycle 1.1 it was for persons aged 20-64 only). Pregnant women are excluded from calculations. The index is: under 18.5 (underweight); 18.5-24.9 (normal weight); 25.0-29.9 (overweight); 30.0-34.9 (obese-Class I); 35.0-39.9 (obese-Class II); 40 or greater (obese - Class III). The index is calculated for those aged 18 and over excluding pregnant women and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).

While there is concern for those who are underweight as there is for those who are overweight, there is little evidence at this time regarding underweight rates in our Region. A National children’s nutrition survey, to be completed in 2005, will give us some idea of magnitude regarding this issue.

According to the Canadian Institute for Health Information, in Canada, rates of overweight and obesity are increasing, and are highest among men, Aboriginal people,

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\(^8\) This section is compiled from the references: Acumen Research, 2004; Romanow, 2002; Central Region Crisis Services Annual Stats 2002-3; Department of Public Health Sciences, University of Toronto.

\(^9\) Note: Definition change implemented in 2004 to conform with Health Canada guidelines for body weight classification. This means that comparisons to 2000/01 CCHS cannot be made.
and Canadians living in lower socio-economic circumstances. Rates of obesity in children are increasing faster than in adults. Within Central Region, approximately one in five residents age 18 and older meets the criteria for obesity (BMI >30.0), this is just slightly higher than the provincial average of 18 per cent (see Figure 1-13), and much higher than the Canadian average of 14.5 per cent.

**Figure 1-13: Proportion of residents who are obese (BMI > 30.0), 2003.**


Within our region we can see that as age increases, the likelihood that a resident is of “normal” body weight tends to decrease (although the trend is not consistently linear) (see Figure 1-14). For example, while almost two-thirds (64.2%) of residents age 18-19 are normal weight, this decreases to under half in the 20-24 year old age group and then to under 40 per cent in the 25-34 year old age group. The age group with the lowest proportion of residents having normal body weight is the 65-74 year old age group where just over one in five is of normal weight.
Healthy weights bear a close relationship to amount of daily intake of recommended five or more servings of fruit and vegetables per day. As Figure 1-15 illustrates, in every region except Brandon, the rate of consumption of five servings of fruits and vegetables daily has dropped. In Central Region it has dropped quite substantially from 71.7 per cent in Cycle 1.1 to 61.8 per cent in Cycle 2.1. In the first cycle we were below the provincial average but in the second cycle our region was higher than both the provincial (58.2%) and national (55.2%) averages.
Figure 1-15: Proportion of population who consumes fruits or vegetables less than 5 times per day, 2001-2003.


3.1.2 Alcohol Consumption

The CCHS examined rates of “heavy drinking” among the population. The CCHS defines heavy drinking as current drinkers who reported drinking 5 or more drinks on one occasion, 12 or more times a year. Although reported rates of heavy drinking have increased from 16.5 per cent of drinkers in 2001 to 20.7 per cent in 2003, we are still below the provincial average of 21.9 per cent and are among the lowest in the province (see Figure 1-16).
Figure 1-16: Changes in rates of heavy drinking by region, 2001 2003.

Note: In 2001 Assiniboine was still Marquette and South Westman. 2001 Assiniboine rate is an average of the 2001 rate of those two regions.

This indicator measures the prevalence of a high level of alcohol consumption potentially linked to personal, family and health problems. (Provincial Health Indicators Report, 1999).

### 3.1.3 Smoking

There is strong scientific evidence that smoking is related to more than two dozen diseases and conditions, yet individuals continue to smoke despite such evidence. In Canada, smoking is estimated to be responsible for at least one-quarter of all deaths for adults between 35 & 84 years of age.
In 2003, Manitobans reported the third lowest (after British Columbia and Ontario) rate of current smokers. According to the 2003 CCHS, over 22 per cent of people in Central Region aged 12 or over are regular smokers. This is a slight decrease from 2001 where 23 per cent of residents were current smokers (See Figure 1-17). Our rate is slightly lower than the provincial rate of 22.6 per cent and the Canadian rate of 22.9 per cent. Over half of current and former smokers started smoking between the ages of 15 and 19. This is an important factor to consider when we target programs for smoking prevention and cessation.

Figure 1-17: Changes in smoking rates by region 2000/01-2003.

Source: CCHS Cycle 1.1 and 2.1.
Note: In 2001 Assiniboine was still Marquette and South Westman. 2001 Assiniboine rate is an average of the 2001 rate of those two regions.

3.1.4 Physical Activity

Inactive leisure time, or sedentary lifestyle, has been associated with increased rates of mortality, as well as increased risk of several chronic diseases including ischemic heart disease, hypertension, obesity, colorectal cancer, breast cancer, osteoarthritis and depression. Monitoring the prevalence of this indicator will detect population trends and the impact of interventions. It will allow comparisons to other regions and provinces participating in the National Population Health Survey (NPHS) (Manitoba Health, 2003, 71).

Physical activity is one of the most important factors in improving and maintaining health for all ages. Physical inactivity has become a serious burden to health in Canada. Almost two-thirds (63%) of Canadians aged 12 and over are not sufficiently active to benefit their health, and three out of five children and youth aged 5 to 17 are not active enough for optimal growth and development. (Centers for Disease Control & Prevention, 2003).
Canadian data show that levels of physical activity decline with age. For all ages, rates of engaging in physical activity are higher for males, and for people with higher incomes and levels of education. Canadians say barriers to physical activity include:

- Lack of time and motivation
- Unsafe neighborhoods to exercise related to traffic, crime, poorly lit and maintained sidewalks
- Cost of sport and recreational activities

In the first CCHS, 2000-01, 52.3 per cent of Central Region residents (over age 12) were physically inactive, this increased very slightly in the second cycle to 53 per cent of residents. As in 2001, rates of physical inactivity are higher than the provincial rate (47.4%, a slight decrease from 48.4% in 2000-01) (see Figure 1-18).

**Figure 1-18: Rate of physical inactivity by region, 2001-2003.**

Source: CCHS Cycle 1.1 and 2.1.
Note: In 2001 Assiniboine was still Marquette and South Westman. 2001 Assiniboine rate is an average of the 2001 rate of those two regions (as they were almost identical).

As with weights, analysis of physical activity data by age group reveals a fairly consistent trend with age. Younger persons in Central Region are more likely than older to be active or moderately active (See Figure 1-19). For example, while almost three-quarters of residents age 12-14 are active or moderately active, this drops to just below 60 per cent in the 15-19 year age group and to just 23 per cent among residents age 75 and older.
When asked to name what they do on a daily basis to improve health, 60 per cent of Central Region Telephone Survey respondents cited a form of exercise. This was similar to overall provincial findings. These activities tend to be favoured by individuals less than 35 years old. Individuals of German/Dutch descent are more likely to feel that their occupation or lifestyle provides the necessary level of exercise needed to improve health. They are also more likely to state that they do nothing at all to improve their health.

It is interesting to note that the 2001 Census reports on the way in which employed individuals get to work. According to this data, 86.9% of Central Region residents get to work by car (includes truck and van). Only 11.8 per cent indicated that they walked or biked to work, with slightly more females (12.1% of females) biking or walking to work than males (10.3% of males). We wondered whether there is a relationship between distance to work in rural areas versus urban and propensity to drive to work.

### 3.1.5 Screening/Prevention

#### 3.1.5 (a) High Blood Pressure (Hypertension)

Individuals with elevated or high-normal blood pressure have been found to have a 1.5 to 2.5 times risk of heart attack, stroke, or heart failure than those with optimal blood pressure.

Central Region hypertension treatment prevalence rates do not differ significantly from the Manitoba average, with the highest rates for men ages 55-64, and for women between 65-74yrs. However, there are significant differences within Central Region itself. For example, Morris/Montcalm, Seven Regions, Altona and communities adjacent to...
Winnipeg have a hypertension prevalence rate higher than the provincial average, and Lorne, Morden/Winkler, Carman and Portage have rates lower than the provincial average. Appropriate treatment may reduce the risk of outcomes mentioned above.

3.1.5 (b) Diabetes

Diabetes as a health status indicator is reported by treatment prevalence.

This is the percentage of persons aged 20 to 79 years who, over a three-year period, had a diagnosis of diabetes in two or more physician visits or one hospitalization. It is expressed as a percentage because each resident is defined either as having been treated for diabetes, or not, in that period. This is age- and sex-adjusted to reflect the population of Manitoba for comparison purposes. (Martens et al, 2003, 72).

In Central Region, the diabetes treatment prevalence rate is significantly lower than the Manitoba average over the two time periods of both 1993-96 and 1998-2001. However, the rates increased in the second time period and it is expected they will continue to increase. If this meant that we had special programs in place that reflected a more accurate catchment of all, or the majority, of diabetics we could feel secure that the rates were appropriately increasing. For the study period, however, this has not been reported as a factor. This leads us to conclude that we actually have increasing rates of diabetes in Central Region.

3.1.5 (c) Immunization

There is a concern that rates of immunization are dropping in the Central Region and if this trend continues it could lead to pockets of unprotected individuals, which could lead to increasing preventable disease prevalence. A more in-depth analysis might lead us to further information and different conclusions, as these data are wholly dependent upon accuracy of individual reports through the provincial reporting structure. Given that some reports are compiled federally rather than provincially, this may reflect a gap in data rather than a gap in immunizations. Age specific immunization reports can be found in Chapters for Children and Elderly respectively.

Overall, personal health practices and lifestyle choices are factors over which we can exert a high degree of control and positively influence our health. Other factors have varying degrees of personal control.

3.2 Personal Resources

We have the ability to control some of the personal resources in our lives. We can, for example, make personal choices regarding interactions with others. Support from families, friends, and communities is associated with better health. Social support networks are very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances.
Indicators of social support networks include community participation, volunteering, charitable donations, children and youth in care, and the number of self help groups. Participation in social networks and the resulting sense of connectedness not only benefits the individual, but the entire community. There is ample evidence that the absence of social bonds or close networks of friends and relatives contributes to premature morbidity and mortality.

Social support networks influence the way individuals cope with stress and the challenges of life. The inability to deal with stress has significant health implications for individuals, and can be an indicator for self-injurious behaviour such as suicide.

Personal Resources can be measured by a number of indicators, some of which we have information about, and some not. Volunteer information, for example, is not readily available at the regional level. We have included measures such as life stress, spirituality, and support networks.

### 3.2.1 Life Stress

As the following Table 1-4 illustrates, most Canadians report some degree of life stress. In 2001 in Central Region, significantly fewer people report no stress than other Manitobans or Canadians. In that time period, only 6 per cent of our residents report no life stress, compared to 9.5 per cent of Manitobans and almost 13 per cent of Canadians. However in the 2003 CCHS 10.6 per cent of our residents reported “no life stress”. This was slightly higher than the provincial average (10.4%) but still lower than the Canadian (11.3%).

<table>
<thead>
<tr>
<th></th>
<th>No life stress</th>
<th>Some life stress</th>
<th>Quite a lot of life stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHA Central</td>
<td>6% 10.6%</td>
<td>69.8% 70.5%</td>
<td>23.8% 17.7%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>9.5% 10.4%</td>
<td>65.6% 68.7%</td>
<td>24.7% 20.3%</td>
</tr>
<tr>
<td>Canada</td>
<td>12.8% 11.3%</td>
<td>61% 63.8%</td>
<td>26.1% 24.4%</td>
</tr>
</tbody>
</table>


As Table 1-4 above illustrated, rates of “quite a lot of life stress” decreased in 2003 in our region. Although the decrease is small, the numbers were too small to break out by both sex and age group. We have chosen to look at 2001 data for a more detailed analysis of residents who report “quite a lot of life stress”. The highest rates of “quite a lot of life stress” are experienced by both men and women in the 35-44 year old age group (refer to Figure 1-20). This is not unexpected given that this is often a time that families struggle to balance the demands of parenthood with those of work life.
Life stress drops somewhat in the 45-64 year old age group and then dramatically in the 65+ age group. It is interesting to note that while life stress rates are low in the 65+ age group, this is the only age group where rates among women are higher than among men.

Stress levels can increase when social supports are lacking. Perceived social and emotional supports are shown to affect a person’s potential to attempt suicide. Suicide rates are measured by PYLL. The figures below show the most recent data in Manitoba and Central Region. Note that males are at significantly higher risk for completed suicide. (See Men’s Chapter)
Figure 1-21: Central Region PYLL due to suicide 1992 to 2001.


Figure 1-22: Manitoba PYLL due to suicide 1992 to 2001.

Stress levels, or self-reports of stress, can be influenced by our perception of available supports or where and how we seek external resources. One source of strength, for many people, is spiritual connectedness or spirituality.

### 3.2.2 Spiritual Resources

Central Region acknowledges spirituality as important to health and has a Spiritual Care Advisory Team to assist with consideration of related issues. We felt that it was important to know how the residents of Central Region felt about this issue.

In general, Central Region residents note a correlation between spirituality and their health. Over half of telephone respondents believe that their spiritual well being plays an extremely important role in their overall daily health, with another third saying its role is somewhat important (Acumen Research).

**Figure 1-23: How important is spirituality to the health of Central Region residents?**

![Bar chart showing the percentage of respondents who find spirituality extremely important, somewhat important, or unimportant to their health.]


In consultation with community members, some seemed to think there was a connection between spirituality and health. They were less sure when speaking of one particular segment of spirituality, that of religion. These individuals differentiated between religion, its family pressures, and the actual or potential support one gets to strengthen oneself in the concept of spirituality. These folks expressed that religion, not necessarily spirituality, actually adds stress to their lives while others felt it can relieve stress if used to express oneself and one’s emotions. Some felt they gained strength from their beliefs and values.

We were told that having someone of any faith to help when ill is important. One man said that he was unconcerned about the faith of a religious visitor.
while he was in hospital.

Overall the participants in the interviews expressed a nebulous need for some assistance with health and wellness outside of the scientific and verifiable. While some said they didn’t see any connection between spirituality and health, most felt there was a connection when ill and needing support more so than to maintain health.

Some folks seek support in addition to or separately from spiritual sources. In Central Region, residents have access to a number of crisis intervention telephone services.

### 3.2.3 Social Support Networks

The utilization of crisis lines is identified in the charts below. Figure 1-24 shows that the second highest number of calls to the Manitoba Farm and Rural Stress Line originated in Central Region. Since there is no documentation to indicate how many calls came from any one Individual, we were unable to determine number of callers separately from frequency of calls. However, it is important to note that 78 per cent of calls from Central Region to the Farm and Rural Stress Line occurred between August and December 2003. Issues some farmers faced at this time included Bovine Spongiform Encephalopathy (BSE) and drought-like conditions.

![Figure 1-24: Farm and Rural Stress Line utilization (2003). Total calls: 1470.](image)
As noted below, usage of the regional telephone crisis line increased between 2002 and 2003. Reasons for this are not determined. A review to assess this trend and qualitatively understand it would be helpful.

**Figure 1-25: Number of calls to Central Region Telephone Crisis Line by area 2002-2003.**

![Bar chart showing number of calls to Central Region Telephone Crisis Line by area from 2002 to 2003.](image)

Source: Central Region Crisis Services Annual Statistics 2002-03.

The provincial telephone survey indicated that slightly more than half of Central Region respondents have someone who will listen to them all of the time when they are anxious or upset, while 7 per cent have no one. This is slightly more positive than for overall provincial results. Those most likely to have no confidante are those 65 or over, have some college or university education or live alone.

### 3.3 Living and Working Conditions

Income, employment and social status are key determinants of health. Health status improves at each step up the income and social hierarchy. Unemployed or underemployed Individuals with lower social status experience more illness and have a shorter life expectancy. The healthiest societies are those that are prosperous and have an equitable distribution of wealth. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole.

Besides being a source of income, employment provides a sense of identity and purpose, social contacts, and opportunity for personal growth. This is especially true when people have more control over their working conditions and life situation.

#### 3.3.1 Income

Studies suggest that the distribution of income may be more important than the total amount of income earned. In Central Region 76 per cent of the population have annual net household income levels in the $0-$20,000 range, compared to 70 per cent for Manitoba. This means that only 24 per cent of households in Central Region have...
incomes greater than $20,000. Income levels in Central Region are below provincial averages. Note in Table 1-5 that the proportion of higher income earners within Central Region falsely raises the average reported household income.

Table 1-5: Earnings for Persons 15 Years of Age and Over.

<table>
<thead>
<tr>
<th>Income</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median total income</td>
<td>$18,206</td>
<td>$20,469</td>
</tr>
<tr>
<td>Average earnings</td>
<td>$23,277</td>
<td>$27,178</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Census.

The majority of Central Region residents earn their income in agricultural and related work. As Table 1-6 illustrates, we are disproportionately reliant on agriculture and other resource based industries compared to the province and the rest of Canada. Over 21 per cent of our experienced work force was employed in agriculture in 2001, compared to 8 per cent of Manitobans, and 5.5 per cent of Canadians. Factors that affect the agricultural industry such as flood, drought, and diseased herds (such as BSE) will have significant impact on our populations' ability to earn a living.

Table 1-6: Employment by Industry 2001.

<table>
<thead>
<tr>
<th>Type of Industry</th>
<th>Central Region</th>
<th>Manitoba</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture and other resource-based industries</td>
<td>21.1%</td>
<td>8.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Manufacturing and construction industries</td>
<td>18.1%</td>
<td>16.8%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Wholesale and retail trade</td>
<td>14.0%</td>
<td>14.6%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Finance and real estate</td>
<td>3.3%</td>
<td>5.0%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Health and education</td>
<td>19.1%</td>
<td>19.8%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Business services</td>
<td>9.7%</td>
<td>15.2%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Other services</td>
<td>14.8%</td>
<td>20.2%</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Census.

The total unemployment rate in Central Region (5.2%) is second lowest in the province, and lower than the Manitoba rate of 8 per cent. However, more Central Region respondents in the Telephone Survey were neither employed nor retired for a total of 39 per cent, more than other Manitobans at a total of 36 per cent in this category. The majority of new jobs created are in low and semi-skilled areas, helping to make Winkler, Morden, Altona and Carman among the top growing communities in Manitoba, yet with lower than average incomes.

Table 1-7: Employment Rates Central Region compared to Manitoba.

<table>
<thead>
<tr>
<th>Region</th>
<th>Unemployed</th>
<th>Not Employed</th>
<th>Not Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Region</td>
<td>5.2%</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>8%</td>
<td>23%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada
As Table 1-8 illustrates, over one third of residents of the Central Region over the age of 20 indicated in 2001 that they had not graduated from high school. The proportions increase as age increases; however, in every age group the rates in the Central Region are much higher than the rates in the province overall.

Table 1-8: Percent of population with less than high school certificate, 2001.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>34.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>36.0%</td>
<td>25.6%</td>
</tr>
<tr>
<td>45-64</td>
<td>45.9%</td>
<td>34.3%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

This determinant creates opportunities for income and job security, and control over one’s life. Research supports that health status tends to improve as educational level increases. Canadians with low literacy skills are more likely to be unemployed, poor, experience more health problems and die prematurely.

Impressions of one’s health generally improve as level of education increases. Only 19 per cent of Canadians with less than a high school education rate their health as "excellent" compared with 30 per cent of university graduates. This finding was generally supported in the Telephone Survey.

In the majority of rural communities, people have lower levels of formal education than those living in urban centres. In 2001 over one third of residents in Central Region over the age of 20 indicated that they had not graduated from high school. In every age group the rates of high school incompletion in the Central Region are much higher than the rates in the province overall. However, it is important to keep in mind that these data do not include informal education, knowledge and skills acquired outside the traditional education system. As indicated in the culture section, Central Region has a high ratio of Low German Speaking Mennonite population whose cultural beliefs include support of education only to around the Grade nine level, after which working support of the family is expected. This population is often highly skilled and fully employed in the trades although the education is not reflected by the high school completion rates.

Table 1-9: Percent of population with less than high school certificate, 2001.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>34.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>36.0%</td>
<td>25.6%</td>
</tr>
<tr>
<td>45-64</td>
<td>45.9%</td>
<td>34.3%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

The education factor may have implications regarding reported stress levels in Central Region (refer to Social Support Networks section). Employees with university degrees have been found to be more than twice as likely to experience stress from home and work as those with basic high school certification or less.
3.3.3 Work Life

Quality of work life can be measured, in part, by workplace injuries that result in hospitalization. Because this indicator is reported by gender, the measures are found in the Chapters for Men and Women respectively. School environment is discussed in section 3.3.2 in the Children’s Chapter.

3.4 Environmental Factors

3.4.1 Physical Environment

This determinant addresses the impact our external surroundings have on health. Clean air and water; safe, affordable housing; and healthy workplaces all contribute to good health. Conversely, exposure to contaminants in the environment can cause a variety of adverse health effects including cancer, respiratory illness and birth defects. Thoughtful community planning (green spaces, walking paths, safety) contributes to both physical and psychological well being (Romanow).

3.4.1 (a) Housing

Access to affordable and adequate housing is a recognized factor in personal health. As a general rule, households are considered to have affordability problems if more than 30 per cent of household income is spent on housing costs. In Central Region, 14.5 per cent of households experience housing affordability issues (less than the Manitoba average of 20.8%) (Statistics Canada, 1996). As expected, homeowners experience the biggest burden (31.3%) over renters (9.1%).

3.4.1 (b) Pollutants

There is mounting evidence that environmental exposure to herbicides, solvents and other environmental pollutants contribute to the development of some cancers and other illness. Children and pregnant women are particularly vulnerable. Health of individuals is also negatively impacted by increased incidence of mould and mildew in homes and buildings. This is related to our proximity to major waterways.

During the 1997 Health Needs Assessment for Central Region, our residents identified some environmental concerns including: Drinking water quality (40%), Second-hand smoke (31%), Aerial spraying (32%) and Traffic Safety (24%). This year we asked people which health determinant was most important to their health. Environment was among the possible responses. While comparisons cannot be made between the assessment years because the questions were different, there were few respondents who chose environmental factors as a top priority. A number of people chose it as the least important factor.

Air quality and water quality won't really affect me if it isn't clean. So what if I die at 80 instead of 85? I won't worry about that right now. There are way more important things to worry about.
Of those who chose environmental factors, they spoke of water quality, air quality and social environments such as safety.

There were some residents who expressed concern over the quality of air in their own communities, stating that it was hard to breathe sometimes due to asthma from mould in homes or diminished air quality as a result of increasing hog farms and crop spraying in their area.

Respiratory illness, as throughout Manitoba, is the third cause of death in Central Region. Fuel exhaust, emissions from crop residue, burning and aerial spraying all contribute pollutants to the air. There is a suspected link between environmental contaminants and asthma exacerbation. The prevalence of childhood asthma has increased sharply over the last two decades, especially among the very young (0 – 5yrs). The prevalence of asthma in Central Region is 5 – 7 per cent; this is lower than the provincial rate. (Abelsohn).

Most farm families depend on groundwater for their water source. Contamination of ground water occurs through agriculture run off, flooding or drought. The quality and quantity of our water impacts the health of our communities.

### 3.4.1 (c) Second Hand Smoke\(^{10}\)

Exposure to second-hand smoke can have a significant impact on health. Although below the Manitoba rate (28.5%), over 23 per cent of non-smoking Central Region residents over 11 years old report being exposed to cigarette smoke on most days of the week. Combined with the rates of daily smoking, this means that almost 50 per cent of the regional population may be exposed to the harmful effects of tobacco smoke on a regular basis.

During focus group consultation, some of our younger residents expressed concern over environmental tobacco smoke. Other respondents were less concerned because they were either seldom exposed to tobacco smoke, or didn’t find it important.

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\(^{10}\) Proportion of the non-smoking Canadian population exposed to environmental tobacco smoke in public spaces and work places on most days.

*Regional Health Authority – Central Manitoba Inc.*

*September 2004*
3.4.2 Social Environment

The values and norms of society influence the health and wellness of individuals. Issues such as a person’s perception of personal safety, racism, and family violence are measures of the social environment.

There were individuals who expressed concern over safety of surroundings, preferring rural communities over urban.

Social or community responses can add resources to an individual's own strategies to cope with changes and to foster health. Central Region has resources such as law enforcement agencies and women’s shelters to provide a level of safety in the community. Refer to the Women’s Chapter for further details.

During community consultation there were no references to racial problems despite the disparate mix in our population. We interviewed Aboriginal peoples of various ages, Hutterites, and low German speaking Mennonites, with only one individual commenting on the connection between racial/cultural concerns and health, in a strong and pride-filled way.

3.5 Healthy Child Development

Recent research demonstrates that the development of a child from conception until age 5 has a lifelong impact. Interventions targeted at this population will have a significant impact on the health of our region. These first years of life are the earliest opportunities to invest in the health of our region. Because of the high importance placed on the health of our children and their early development, a chapter has been dedicated to this aspect. Please see the Children’s Chapter for details on the health and development of children in Central Region.

3.6 Gender

Sex and gender influence health in two ways, through physiology (for example reproductive health, or effects of medications between men and women) and in conjunction with other determinants of health. It is important to know that sex and gender are two different concepts. Gender is not just a polite way of saying ‘sex’. Sex refers to the biological differences between females and males. Gender refers to the
socially constructed roles and relative power that society ascribes to the two sexes. (Donner, 2003). This topic will be dealt with in the chapters dedicated to men’s and women’s health.

3.7 Culture

Culture is the totality of shared ideas, beliefs, values, knowledge, norms, communication, and way of life of a group of individuals. It accounts for shared patterns of thought and action, and contributes to social and physical survival. (Department of Public Health Sciences).

One’s cultural background can affect health. Individuals who are not part of the predominant cultural group and not fluent in the language may be marginalized or stigmatized. Aspects of culture affect the ability to comprehend health measures, access services and respond to treatments.

More than 40 per cent of Central Region residents identify themselves as of “multiple ethnic origin” such as German and Ukrainian, while the other 60 per cent identify one single ethnic origin. (Statistics Canada, 1996).

The pie charts in Figures 1-26 and 1-27 illustrate the breakdown of ethnic origins among Central Region residents. The most commonly identified single-ethnicity in the region is German, followed by Canadian and English. Although not reflected in the pie graph, Central Region has approximately 49 Hutterite colonies (James Valley Address Book, 2000). There are 52 colony schools to which we deliver health services.

**Figure 1-26: Central Region residents by self-identified ethnicities, 1996 Census. "Aboriginal" includes North American Indian, Métis and Inuit.**

![Pie chart showing ethnic origins](image)

Source: Community Health Needs Assessment 1997, Central Region.
Central Region contains six First Nations reserves. The percentage of Aboriginal people has steadily increased since 1997, although there are discrepancies in reported numbers. According to 2001 Census data, approximately 9 to 10 per cent of residents (about 9,240) are registered as First Nations. The First Nations Report (March 2002) cites an approximate total of 6,000 registered First Nations peoples as of 1998. It is important to note that while Central Region ranks high within the province for overall health status, our Registered First Nations populations have the poorest health status. The PMR is approximately five times greater for Registered First Nations compared to all other Manitobans in Central Region. There are significant numbers of Aboriginals by other definitions as well. Our definition includes non-registered First Nations, Métis and Inuit who are not included in the above stated numbers. For further information refer to the chapter on Aboriginal Health.

Reports indicate that 68 per cent of residents in Central Region are fluent in English. Over a quarter (about 27%) of our residents’ first language is other than English or French. This rate is much higher than both the provincial (21%) and national (17%) rates. Francophones account for 4.5 per cent of Manitoba’s population. Similarly, about 5 per cent of Central Region residents’ first language is French. The socio-demographic profile of the French-speaking minority communities reveals that the health situation of the members of these communities can be more precarious (Health Canada, 2001).

Rates of immigration to Central Region were high between 1991 and 2001. Approximately 8 per cent of our population is foreign-born, with approximately a quarter of this population immigrating during this time period (Health Canada, 2001). Although
Central Region is diverse in terms of languages, there are very few visible minorities\textsuperscript{11} living in this region. Visible minorities account for less than 1 per cent compared to 7.9 per cent of Manitoba and 13.4 per cent of Canada. The largest numbers of ‘visible minorities’ living in the region are Chinese (.21%) followed by South East Asian (.15%), and Black (.13%).

The Kanadier Mennonites are a minority group based primarily in the southern portion of the region, but recently noted by health providers to be migrating north within Central Region in unspecified numbers. This population traditionally views health and illness from an acute and chronic perspective, rather than from a preventative focus. Providing health education in a spiritually sensitive manner is seen as a critical factor towards understanding of and compliance with health regimes (Kulig et al). In some cultural groups such as the Low German Speaking Mennonites, among whom are the Kanadiers in the region, education is limited by the cultural norms, which in turn can have an impact on the social and economic status of those individuals.

3.8 Biology and Genetic Endowment

In some circumstances, genetic endowment appears to predispose certain individuals and groups to particular diseases or health problems. While biological and genetic traits can’t be changed, recognizing the vulnerability of certain populations can assist in developing strategies for optimal health.

There are no indicators to measure this health determinant. It will not be assessed further in this chapter.

3.9 Health Services

Health Services include all components of the health care system; public health, mental health, hospital care, diagnostic procedures, home care, long term and end of life care. Whereas past focus has been on managing illness, greater emphasis is being placed, this assessment cycle, on aspects of primary health care including health promotion and disease prevention.

Evidence from Investing in the Health of Canadians indicates that Health Services is the determinant with the least likely impact on the health of communities. Yet the majority of health care funding is targeted towards delivery of these services (Romanow). Central Region Telephone Survey respondents felt that hospital and ambulance services were of high importance. Eighty-nine per cent of these same residents expressed satisfaction with accessibility and quality of health services and providers. However, 11 per cent feel that better access to health services would improve their health.

\textsuperscript{11} According to the Employment Equity Act (1986), visible minorities are persons other than Aboriginal persons who are non-Caucasian in race or non-white in colour.

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1: 43
Many focus group participants expressed concern with the lack of continuity of health practitioners within their communities, specifically physicians. They identified a need to be able to create and maintain consistent relationships with their physicians, and indicated that the lack of such relationships can be a deterrent to seeking healthcare. However, after stating that continuity of physician care was important, many participants commented that other appropriate health service providers would be beneficial and the real concern was continuity rather than whether a physician or nurse, for example, provided that link.

While overall use of physician services in Central Region has declined and is below the provincial average over the study years of 1995-1996 and 2000-2001, visits to General and Family Practitioners are above the provincial average. Ambulatory consultations, on the other hand, are lower than provincial averages but have increased over the two time periods (Martens et al, 2003, 122-7).

Hip and knee replacement procedures have been shown to provide major improvements in mobility and quality of life. Rates of these procedures performed outside of Central Region have increased significantly, as have angioplasty and coronary artery bypass rates, and they remain higher than provincial rates. Early diagnosis and interventions with diet, activity and treatment programs are recognized as necessary components to reduce the prevalence of these high-risk surgeries.

Within Central Region the top five reasons for hospital admissions, in descending order are: heart failure, respiratory, abdominal symptoms, general symptoms, and cardiac symptoms.

The five most common surgeries in Central Region, in descending order, are:

- Cholecystectomy
- Hernia repair
- Appendectomy
- Open reduction with internal fixation
- Hysterectomy

With advancements in medical technology and treatments, there has been a significant reduction in hospital length of stay for hospital clients. As length of stay decreases in hospitals, the demand for home care increases. In Central Region, use of Home Care services has increased by approximately 1000 cases per year since 1994.
SECTION IV: KEY FINDINGS

4.1 Observations

We concluded that there were some important areas for consideration when we look at improving the health of our population over time. With a population of almost 100,000 residents and growing, if we are to influence health outcomes in the future, we must make our decisions based on population health and health determinants. Projections show that we are expected to increase our population by 14.5 per cent between 1998-2025. This is important to consider when planning health service provision over time. Within these parameters, with respect to the entire population of Individuals in Central Region, we found that we might have the most impact on the modifiable determinants of health.

Our health status overall is one of the best in Manitoba, and improving as indicated by our PMR and PYLL, while our First Nation Dakota Ojibway Tribal Council (DOTC) population has the worst health status in the province. We identified that we have concerns over the health of immigrants and some other specific cultural groups, especially the low-German speaking Mennonites from Mexico. We know that we lack specific information and want to find ways to obtain evidence regarding the health and illness of these vulnerable populations.

In focus group consultation we were told that our residents are concerned about how they can have a personal effect on their health. They talked about how opportunities for exercise in their own neighbourhoods was somewhat dependent upon community design and condition of roads or pathways for walking, etc.

Folks in our region were concerned about the above conditions as well as telling us in virtually every focus group that they were concerned about stress and mental health. The percentage of Central Region residents who report “some” or “quite a lot” of life stress is higher than both the Manitoba and Canadian averages. Spiritual well-being is seen as an important factor in health by Central Region residents.

Some specific concerns identified include:

- Central Region has a higher proportion of individuals with less than a high school education as compared to the rest of Manitoba, a condition that can affect income.
- Central Region residents are at risk for poor health outcomes related to personal health and lifestyle practices; specifically there are concerns about obesity, smoking rates, and physical inactivity.
- Central Region residents are at risk for poor health outcomes related to stress and mental health.
- Central Region residents are at risk for hospitalization or death from injury.
- Chronic diseases such as cardiovascular disease, respiratory illness, cancer and diabetes dominate the illness burden within our health system.
- We have a significant proportion of our residents at risk for poor health outcomes related to cultural health beliefs and influences.
We have had a significant increase in prevalence of diagnosis and treatment for diabetes and hypertension. Stroke rates for the region are decreasing, perhaps because of the high treatment rates for these chronic diseases.

There is a concern that rates of immunization are dropping in the Central Region and if this trend continues it could lead to pockets of unprotected individuals, which could lead to increasing preventable disease prevalence.

We have low rates of cancer overall, although Central Region has the highest rate of both prostate and breast cancer deaths in the province. Lung cancer is the leading cause of cancer deaths in our region.

4.2 Considerations to aid our population to be ‘as health as can be!’

- Smoking cessation and early prevention of smoking in youth would be beneficial.
- Injury prevention would help reduce our use of hospital beds and our PYLL.
- Prevention and early detection programs can positively influence the outcomes for chronic illnesses, especially, in Central Region, for diabetes, and deaths from prostate and breast cancers.
- Follow-up assessment of the national children’s nutrition survey, to be completed in 2005, will give us some idea of nutritional status of our residents.
- Accurate accounting of our immunization rates could tell us whether, in fact, we have low immunization rates and therefore allow us to intervene if and where necessary.
- While we know that the use of crisis lines has increased, on-going, qualitative, time trend analysis would help us to understand the magnitude of this issue.
- Assessment of the health of specific cultures could help us to appropriately plan care for these populations.
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Families

“Families in Central Region are as healthy as can be!”

FAMILIES SHAPE TEAM:
Jan Marie Graham  Marnie Beninger  Diana Kissick
Debbie Bjarnason Sandra Dobson Grace Klassen
Dale Jamieson Dr. A. Loewen Al Schmidt
Ann’s Story

I had been in practice somewhat less than a year when I had my first patient diagnosed with gastric cancer. This difficult condition was complicated by a patient who was deaf and a system that did not include any home care or palliative care. A new doctor was joining forces with a large, loving family and only one daughter had adequate signing to communicate with the mother, everyone else lip-reading and gesturing.

An ethical dilemma, and even potentially a position of conflict, arose when the family wanted her diagnosis kept secret from ‘ma’. Although I did not agree, I was in no position to have my own way. We had our hands full in an effort to keep her comfortable at home till she died, as per her wishes - I didn’t need to look for additional battles to fight. I know that my patient had more than ten children and the kitchen was full of people every time I attended for a house call. It was through this family that I came to fully appreciate that I am family physician not because I am capable of being a doctor for all the members of the family, but because I am capable of being a doctor for the family itself. We worked together, as a rather loosely structured team, making decisions, holding meetings around the wood stove, crying as she slipped away. The Crash Test Dummies “Superman’s Song” was on the radio a lot around then. After the last house call I sat in my car listening to it, thinking how, rather than being Superman as a physician, swooping in to fight the forces of sickness and pain, we really are just the ordinary Clark Kent types. The real power lies with those people who surround the suffering and the dying with the strength of their collective selves.
Chapter 2

Families

SECTION I: ASSESSING FAMILIES OF CENTRAL REGION

1.1 The Assessment Process

The Community Health Assessment (CHA) Families assessment team was one of seven teams established with a mandate from RHA Central to gather and interpret data on the health of Families overall in Central Region.

The team reviewed all sources of data with a view considering what influences the health of the Families in Central Region.

Because Families do not fit into a single and commonly defined context, it is important to share the many ways we understand Family and its importance to health if we are to attempt to define the health of Families in Central Region. This chapter, unlike others in this health assessment, provides this defining context so the reader might better understand the frame within which the assessment took place.

Families are the building blocks of society. They tie individuals together and build relationships and bonds among individual Family members and the community that surrounds them. The family unit provides a sense of well-being and belonging, and a sense of emotional and biological connectedness. Every individual lives within the context of a family system and is affected by and shaped by family dynamics, emotional support provided by other family members, attitudes and behaviours, family economics, spirituality, culture, and the physical environment.

According to the Vanier Institute of the Family, if a child is to grow into adulthood with good health, a strong family is a critical element for full development.

Family can be defined in different ways. The RHA Central definition alludes to a particular understanding of family that is consistent with nursing literature. Family is whoever the client says it is. Family, then, for a particular individual, may include everyone living in a given household, including individuals who are not blood relatives.
Some may include grandparent/s in the understanding of family, even though they are not residing in the same household. Health care providers are most interested in who the client considers to be family.

Statistics Canada’s definition includes single parents living with never-married children and married couples\(^1\) living with or without never-married children. Statistics Canada refers to family as those who share a dwelling and are related by blood ties, marriage, or legal adoption. The Canadian government also uses the term household in gathering statistics concerning family and personal life. Household refers to people sharing a dwelling, whether or not they are related by blood ties, legal adoption, or marriage. We acknowledge Statistics Canada’s definition as used in data presented for comparative purposes within this chapter. However, the Families CHA Team prefers the Vanier Institute’s more conceptual definition of family. Their definition includes any combination of two or more persons bound together by mutual consent, birth and/or adoption or placement. In this definition of family, the members together are responsible for some physical maintenance, care of group members, addition of new members, social control of members and affective nurturance – love. (The Vanier Institute of the Family)

Major tasks of the family include the teaching of health maintenance and promotion, being a role model, providing care for members across their lifespan and during various family transitions. The family then, is a resource and an environment for the health and well-being of its members. This Team includes the concept that families are who they say they are, how they feel and what they do in our discussion of the health of families in Central Region. (Pogrebin).

In Central Region, families are whoever individuals claim they are. Within this context, the interpretation of how families demonstrate healthy characteristics include that:

- Families demonstrate responsible care-giving towards dependent members and
- Families ensure and/or have access to alternate safe environments

The Families Team struggled with the high degree of overlap between these two interpretations of family health. It was impossible to talk about ‘responsible caregiving’ without talking about safe environments (referring to physical, emotional, or environmental safety) since ensuring a safe environment is part of being a responsible caregiver. Likewise, we could not discuss ‘safe environments’ without concluding that ensuring the presence of a responsible caregiver is the key to creating and maintaining a safe environment. After some struggle to keep the two interpretations distinct, we concluded we could not, and thus, have addressed them jointly.

\(^1\) Married couples include cohabiting couples living together for longer than one year.
1.2 Demographic Overview

Canada’s most recent 2001 census clearly shows that the family, while in transition, endures as society’s oldest and most indestructible institution. (B.C. Council for Families). Although family is the fundamental social unit of society, its form and character vary greatly.

Family structure in Central Region, as in the rest of Canada, is diverse. In part this is because National, Provincial and Central Region families, are made up of Canadian-born descendants of immigrants, recent migrants and First Nations people.

Table 2-1 compares selected characteristics of families in the Central Region with those in the entire province of Manitoba.

Table 2-1: Selected characteristics of Central Region families, 2001.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Central Region</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of families</td>
<td>24,730</td>
<td>302,855</td>
</tr>
<tr>
<td>Married couple families</td>
<td>20,480 (82.8%)</td>
<td>224,055 (73.9%)</td>
</tr>
<tr>
<td>Common-law couple families</td>
<td>1,645 (6.6%)</td>
<td>29,635 (9.8%)</td>
</tr>
<tr>
<td>Lone parent families</td>
<td>2,605 (10.5%)</td>
<td>49,160 (16.0%)</td>
</tr>
<tr>
<td>Female lone parent</td>
<td>2,120 (81.4%)</td>
<td>40,100 (81.6%)</td>
</tr>
<tr>
<td>Male lone parent</td>
<td>485 (18.6%)</td>
<td>9,060 (18.4%)</td>
</tr>
<tr>
<td>Median family income - all</td>
<td>$46,199</td>
<td>$50,934</td>
</tr>
<tr>
<td>Couple families</td>
<td>$48,473</td>
<td>$55,885</td>
</tr>
<tr>
<td>Lone parent families</td>
<td>$25,067</td>
<td>$26,469</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

According to census data, there were 24,730 families living in the Central Region in 2001. Married couples comprised 82.8 per cent of these families, notably higher in Central Region than for families in the province of Manitoba overall. Like the rest of the province, women head the majority of lone-parent families at just over 81 per cent. We expect that our ethnic, cultural and religious mix is such that marriage is encouraged and divorce or extra-marital co-habitation is less socially acceptable than in some communities.
SECTION II: HEALTH STATUS OF CENTRAL REGION FAMILIES

2.1 Overall Health Status

As society’s most basic unit, the family provides the foundation for the health and well-being of its individual members. Health and illness behaviors are primarily learned and practised within the family. The term family health is a holistic term that encompasses the biological, psychological, sociological, spiritual, and cultural aspects of family life. Like health in general, family health is not static in nature. It is dynamic; family members adapting, interacting with one another and with their environment.

The Families Team asserts that family health is more than the absence of disease in a family member and more than the absence of dysfunction in family dynamics. Family health is considered to be a state of family well-being. While this chapter does not discuss overall health in the same way as other population groups, that is, using mortality and morbidity as frames of reference, the concepts are included in the ideas of marriage and divorce in the health of the family unit.

The Families team asserts that families have everything to do with health. It is within the family unit that young people develop and learn to interact. It is within the family that we learn health-related behaviours and lifestyles. Family networks play a part in health and illness and responses to illness including use of health care facilities and post-illness recovery. (Potvin & Eisner)

2.1.1 Characteristics of a Healthy Family

Just as family and family health have been variously defined, so have the criteria that make a family healthy. From Key Informants the Families Team heard that bonds are as key to “family”, as is love that is shared. Commitments to one another provide purpose. Close ties, relationships, and a desire to be the best family we can be, provides impetus for change.

From a sociological perspective, Pratt tells us that a healthy family responds to the needs and interests of all its members. Healthy families cope effectively with life transitions and problems, are flexible, distribute power equally and interact regularly among members as well as with the community. In this effective, encouraging environment, families practice health-promoting lifestyles as individual members and as family units.
Spradley & Allender discuss six important characteristics of healthy families. The RHA Central interpretation about what constitutes a healthy family is embedded in the following list of healthy family characteristics:

- Open and supportive communication. Ideas, feelings and concerns are shared, there is frequent verbal communication and nonverbal means are also used to transmit feelings, thoughts, love and affection.

- Support for, and responsiveness to the needs of individual members. The freedom and support necessary for the growth of each member is provided, including the fostering of growth and developmental needs of children.

- Adaptability and flexibility. Healthy families can alter their roles and tasks to meet needs that change over time and to fit the changing developmental needs of members.

- An active attempt to cope with problems. There is mutual involvement of family members in identifying problems and making decisions.

- A safe and healthy home environment and lifestyle. For example, healthy families advocate a nutritious diet, remove potential household hazards and maintain a positive and supportive emotional environment.

- Regular, open ties with the broader community. Healthy families are informed about events in the world around them and try to know and understand current social, economic and political issues that impact their lives.

**2.1.2 Family Trends**

Societal changes have influenced and continue to influence family form. The women’s movement, an escalating cost of living, rising separation and divorce rates, more mothers in the labour force, a rise in births outside of marriage and increased disclosure of sexual preference; all contribute to evolving family structures and the resulting diversity in family form. The current divorce rate in Canada, according to B.C. Council for Families, is approximately 31-36 per cent of marriages. While we do not have access to divorce rates in Central Region, we do know that we have 5.5 per cent fewer lone-parent families than Manitoba as a whole. Other identified trends include an increasing life expectancy,
declining fertility rates, increased cohabitation without marriage, and an increase in lone-parent and blended families. The changing family includes a large number of baby boomers set to retire from the workforce within the next 5 years and an increasing number of adult children who either choose to stay in the nest longer or return home to live with their parents.

Based on information from Statistics Canada, the Vanier Institute (2004) compiled a list of trends from 1990 to 2000 related to the contemporary family. The report concluded with some unexpected remarks, some for which we have supporting evidence:

- Young mothers who work full-time lose a significant number of paid days of work per year for family reasons.
- Among the different family types, male lone-parents were the fastest growing group in the last decade. In 1996, 1.3 per cent of all Central Region families were headed by male lone parents. This increased in 2001 to just under 2 per cent (1.96%) of all families.
- Over 40 per cent of wives with children who leave jobs on their own accord do so for family reasons.
- When there are two adult earners in a family, both partners are more likely to work overtime.
- Female lone-parents experienced the largest increase in employment rates between 1990 and 2000 and are now more likely to be in paid employment than are wives without children.
- Canadian family members who report that they are “severely stressed” jumped significantly between 1992 and 1998. Some data regarding stress in Central Region can be found in section 3.2.1.
- When there are two adult earners in a family with children, more wives are likely to feel that they have ‘insufficient time for family and friends’ while more husbands are likely to claim that they ‘have no time for fun’.

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2 ‘Wives’ and ‘husbands’ include those that are legally married and those living in common-law relationships.
2.1.3 Well-Being

RHA Central chose to inquire about what a healthy family means to residents in our region. The following powerful “word picture” is this Team’s attempt to compile Key Informants’ and/or Focus Group Participants’ images of healthy families. The appearance of a large majority of the characteristics of healthy/strong families identified in the literature is most remarkable, suggesting that families in Central Region have a positive attitude about family health. The eloquence of expression speaks to the depth of knowledge embedded in every person.

A healthy family is a happy family. They get along and enjoy one another. Family members relate to each other and enjoy working, playing, learning and being together. A healthy family spends time together...eat supper together...do stuff together...work together...getting out and being active together. (Compiled)

In a healthy family, members are interested in each other and cooperate with one another. They share a sense of responsibility for the achievement of individual and collective needs and goals...everybody pitching in together. (Compiled)

A sense of security, peace of mind...less stress, honesty, openness and understanding pervade the healthy family environment. While youth seek an understanding attitude, parents recommend knowing your kids, being sensitive to their needs and...listening to children. Mutual trust and respect are also essential to happiness and health. (Compiled)

2.1.3 (a) Functional Health Status

Once again the definition of the dimensions of health are different for families than for other population groups. Our residents felt that a functional family meant one in which the members supported one another, a concept embraced by RHA Central’s Board of Directors as noted in the Board Ends. In consultation, we learned what our family members thought about this dimension of a health family.

In a healthy family, members demonstrate support and caring. A healthy family means being there, helping out, encouraging. Family just helps you get through. A healthy family is communicative - members talk to each other frequently. Communication is considered to be a key element of family health. Parents of older children advise repeatedly, ‘keep in touch’. (Compiled)
SECTION III: DETERMINANTS OF HEALTH

Factors that influence the health of individuals also affect the health of family. The Team chose to look at several of the determinants of health through the lens of our Regional interpretation of ‘healthy family’. Not all determinants are addressed as not all factors influence the health of family units; rather they are dimensions affecting members within the unit. These factors affecting specific individuals are addressed in chapters specific to other population groups.

3.1. Personal Health Practices and Lifestyle

Lifestyle was one indication of whether a family was healthy or not. Enough healthy food, good eating habits, being active and energetic, participating in outdoor activities, physically taking care of oneself, no smoking, no alcohol, and no abuse were all identified by Focus Group Participants as indications of a healthy family. Influence has been identified as going both ways, though. Parents influence children’s choices but children effect parental use of leisure time and meal choices and planning. Family influence is clearly multi-directional. (Potvin & Eisner). Some of our younger residents spoke of healthy family environments.

Like a mum and dad that are in shape and with kids. They are role models for fitness. If they’re in shape and not sitting at home doing nothing all day, that motivates the kids to be like them. They’ll pass on their habits.  

People taking care of what they eat, how they treat their bodies.

Other folks spoke of the affects of income on Personal health practices and lifestyles.

Some of the children on the playground look horribly dressed for winter. Why can’t we feed our children in a small community? Seeing everyone being responsible for all children in the community.

Respondents from the telephone survey were asked to suggest what they would like to see in their own community to improve their health. Some responses included hospital improvements, access to health services, access to recreation, exercise, health education/food labeling/other. Clearly, there are individuals who feel that health services, contrary to evidence, play a leading role in how healthy we are. Others realize the importance of factors that keep us healthy rather than services to care for us when we become ill.
The physical and mental health of family members contributes significantly to happiness and family health. There were frequent references to “eating healthy”, “taking care of yourself” and “being physically active”. While parents consider themselves to be role models, “leaders”, “responsible for teaching the children” and “providing food and clothing”, one ‘voice’ reminds us that everyone also needs to remember to “look after” him/herself. 

Health practices include healthy weights, alcohol consumption, physical activity, smoking practices, injury and risk-taking behaviour, screening and immunization. All of these are clearly influenced either directly or indirectly by the family in which we live. Our residents made it clear to us, as demonstrated in some of the selected quotes above, that they understand the concept of healthy lifestyle and family influences.

3.2 Personal Resources

Family scientists, McCubbin & McCubbin, have defined healthy families as resilient. Family resiliency is the ability to cultivate strengths within a family that will help all members meet the challenges of life positively. Because families show resiliency in unique ways, there are no universal rules for success. Resiliency involves not only the ability to cope with everyday stress, it also requires confidence, hard work, cooperation and forgiveness to increase the family’s well-being. Strong families help children learn resilient behavior when they teach problem-solving skills and provide positive, non-critical support and a sense of togetherness.

Strong families, according to Goddard, exhibit ‘Caring And Appreciation’ even when a family member makes many mistakes. Finding quality time within quantity time spent together is one way for members of strong families to demonstrate commitment to the family. They value the things that make their family special and practice family traditions, talking and sharing amongst themselves, their feelings, hopes, dreams, fears, joys, sorrows, experiences, growth, and needs. Taking the time to listen and respond to what others have to say, strong families draw on other people and institutions for help and support. Although parents are the leaders, according to Goddard, children's opinions and efforts are invited, encouraged, and appreciated. Some circumstances of life add stress, yet strengthen the members as well as the family unit as they support one another and problem-solve together.

3.2.1 Life Stress

Circumstances of stress in a family were demonstrated by several informants who were providing care for, or had a family member with a physical or mental disability or illness such as autism or asthma. Literary sources spoke of the affects of disability on society as
well as on the individual. Because people with disabilities are living longer, more families are providing care and support for more years. (McCloskey). We noted that some long-term, chronic conditions such as Alzheimer’s Disease, epilepsy, or severe and persistent mental illness, and some more acute, life-threatening conditions such as cancer have major implications for families. The need to share was identified.

Sharing includes the physical, emotional and financial burden or blessing. Dependency ratio is indicated by the combined child population (aged 0 to 14) and elderly population (aged 65 and over) compared to the working age population (aged 15 to 64). This ratio is usually presented as the number of dependants for every 100 people in the working age population. This measure is important to consider in the context of Families as people aged 65 and over and those under age 15 are more likely to be socially and/or economically dependent on working age individuals. As Figure 2-1 illustrates, the dependency ratio in Central Region of 59.7 is the fourth highest in the province and is higher than the provincial average of 52.6.

Figure 2-1: Dependency ratio by region, 2001/2002.

Source: Statistics Canada, 2001 Census.
Etmanski & Cammack reported after consultation with parents who had a child with a disability\(^3\) that family views of a good life for their disabled member included having caring, loving relationships, living independently with security, contributing to their community and having choices. Families believe programs and services should supplement, not supplant, a good life.

Key Informants told us that parents of children with disabilities often have difficulty securing child care and pre-school education. Many of the existing settings/systems may not have the comfort level, knowledge/education, physical environment, and support to provide services.

### 3.2.2 Social Support Networks

It was apparent from the data that one of the expectations of a family is the mutual emotional and social support it should provide. Descriptors such as bonding, understanding, good communication, caring and respect, sharing responsibilities, trust and honesty prevailed when describing a healthy family. Forgiveness, interest in one another and respecting the need for private space, was important to many.

> Everyone gets along.

> You could have a healthy argument in a healthy family and not hold a grudge for the rest of your life...When you disagree about something but you still speak. (Compiled)

Emotional support was often closely related to the need for good communication. In a healthy family, the atmosphere is described as more joyful, very special.

> Once in a while I call just to talk to the grandchildren. I feel if the communication is good, it makes a healthier family. I tell them they always have to keep in touch. It is easier to get away and lose touch than it is to work the way back to get together again. You have to continue to work at relationships...Just knowing that if anything would happen to you, your parents would be there to back you up in a second. It is great to know that support. (Compiled)

Folks in our focus groups had poignant stories to describe emotional safety within a family. Safety for some included the security of unconditional love. Many young participants described the emotional security of home and family as a sanctuary.

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\(^3\) Disability refers to emotional, behavioural, or physical.
Safety was discussed in relation to family dynamics and was evident in comments regarding such things as how individuals are supported in a home environment or what effect negative behaviour might have on impressionable youth. One of the more poignant responses included physical security when a family member was alcohol impaired.

Being able to come home and not feel you have to walk on eggshells…There are times when I don’t feel my daughters are safe all the time or they’re in a place where they should be safe and secure. I don’t want the house to burn down or my kids to see [my husband drunk]…That is when I don’t feel my home is safe. It isn’t what I want for them.

A concern was raised about how a parent ensures the safety of children who no longer live solely with them.

It is harder to raise children now in circumstances when they are living in two different houses. Kids are very smart. They play one off the other. They know who allows what. They adjust to the environment they are in…Hard when the parent has no control over how they are cared for by the other parent. No control over who he lets them stay with, no control over who he has in his home. He can have a girlfriend you have never met or been introduced to and take them to a movie with questionable content. You can’t say anything about it because it is his weekend with them. Or you could, but what would be the point? There should be a support group for this. This is a whole area that is underdeveloped in Canada.

Social support and involvement in community were noted as important to family health and a safe environment.
However, there was a word of caution regarding balance from several sources as well.

Maybe this comes down to the lifestyle families have these days. It is always push and push. They push hockey or push basketball. There is too much for them to do. They go out and come home late at night. There is too much. They can't learn in school when they are tired.

I think sports help a lot for [children] not to smoke or do drugs because they want to be healthy…If you don’t want your kids to smoke or drink, this is a good place to be…I’d sooner see my grandchildren playing sports than being on the streets anytime.  (Compiled)

One indicator of effective personal resources is the rate of suicide and other self-inflicted injury in a population. In Central Region, suicide was the second leading cause of injury deaths from 1992-1999. Self-inflicted injuries were the third leading cause of injury hospitalization in Central Region in the study years of 1992-2001. (Manitoba Health, 2004). This glaring contrast between resident’s perception of what constitutes healthy family support and what might be the outcome of not enough appropriate support for all too many of our residents is an issue of concern. Somehow there needs to be enough support to prevent the risk-taking behaviour that leads to hospitalization and death from injuries.

According to Doherty, there are a number of health risks related to exposure to family violence. Some conditions identified include diabetes, heart disease, high blood pressure, sleep disorders, fibromyalgia, chronic pain/disability, cancer, osteoporosis, asthma, anaemia, hepatitis, lung, liver, and thyroid disease. Many of these are difficult, if not impossible, to link directly to violence or exposure to violence in Central Region. However, awareness of the health impacts together with knowledge of at risk populations will help us to consider these aspects when serving this population.

The rate of injury deaths from assault for Rural South Manitoba is lower than for Northern Manitoba, Winnipeg, or the Manitoba average. However, with similar patterns between jurisdictions for both males and females, males are notably higher in frequency for deaths from assault than are females. In the years “from 1992 to 1999, 419 residents of Central Region died as the result of injuries. These deaths represent a total of 12, 523 potential years of life lost, or an average of 29.9 years per person.” The fifth leading cause of hospitalization from injury between 1992-2001 was assault. (Manitoba Health 2004, 155).
3.3 Living and Working Conditions

Education and income are distinct determinants of health and the Team acknowledges their interconnectedness as does The Manitoba Women’s Institute (2001). Academic challenges have been noted in children who change schools frequently, demonstrated by such markers as math scores, grade failures and levels of behavioural problems. In Central Region there are children with frequent moves and with behavioural and mental health problems. These are specifically addressed in the Children’s Chapter.

Income and education are less easily divided regarding these influences on the health of families. Clearly the education of parents in a family has an impact on income as well as on the educational attainment of the children in a family. While these determinants are difficult to separate for individuals, they are more so for families. With this disclaimer in mind, we have tried to separate the two for the purpose of discussion.

3.3.1 Income

Canada’s National Longitudinal Study of Children and Youth has demonstrated the impact of income on families. Families who live in affluent neighbourhoods tend to have children with higher verbal abilities and less behavioural problems. Access to affluent neighbourhoods directly depends upon socio-economic status.

“Injuries also tend to follow this socio-economic status gradient – with injury rates experienced by those with lower socio-economic status, and generally decreasing rates of injuries as socio-economic status increases.” (Manitoba Health, 2004, 211). We have noted that the lowest socio-economic status in Central Region is among the First Nations population and as noted in the Aboriginal Chapter of this document, the injury rates for death and hospitalization are both 2-3X higher than for non First Nations or All Manitobans. This doesn’t confirm a direct link between socio-economic status and injuries, although it certainly supports the concept as described by Wilkens, Berthelot and Ng.

While “The experience of long-term poverty has negative impacts on children, causing poorer physical health, increased hyperactivity and worse performance in mathematics tests”, there is hope (Statistic Canada, 2002). Good neighbourhoods, positive parenting, and social support make a positive difference for families even when living in long-term poverty.

Of interest is the dramatic drop in income experienced by lone parent families. This is very important as extensive research illustrates the relationship between income and health. In communities where the discrepancy between the richest and poorest populations is the greatest, health is the worst. In populations with the least discrepancy in incomes across the population, health status is the best, regardless of the overall income level.
Statistics Canada (2003) found that family income and a mother’s educational level were important for children’s cognitive development. For example, the odds of being at risk for a child living in a family with $30,000 income was 7 per cent greater than for a child in a family with an income of $40,000. In Central Region the median income is significantly higher than this at-risk level. However, within Central Region there is disparity with many families being of significantly lower income. Of note are some of the specific ethnic groups, such as some First Nations families and, we suspect, ‘Low German speaking Mennonites from Mexico’ that are described in other chapters. The following Table 2-2 indicates family incomes in Central Region are lower than Manitoba telephone respondents overall.

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Central Region</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $10,000</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>$30,000 to $39,999</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>$40,000 to $49,999</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>$50,000 to $59,999</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>$60,000 to $69,999</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>$70,000 to $79,999</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>$80,000 to $89,999</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>$90,000 to $99,999</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>$100,000 or over</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Acumen Research.

Note: Percentages may not equal 100% due to rounding. Figures of less than 0.5% are shown as “<1%.” Respondents were asked which of the above categories best described their family income. Responses of “don’t know / refused” have been excluded. Statistical analysis indicates a significant difference in results for this question between Central Region and the overall sample. (Acumen Research)

3.3.2 Education

The significance of the educational level of parents has been noted in relation to childhood development and family health. There are implications of interaction between child and caregiver and resulting ‘readiness to learn’ at school entry. The ability of a family to cope with transitions and change is usually based on knowledge. Healthy families have an awareness of changes to be made and are able to develop strategies on how to go about making changes. Telephone survey results regarding education reveal that 41 per cent of Central Region’s respondents have at least some post-secondary education, although a relatively larger proportion than provincial respondents (31%) did not graduate from high school. These results suggest that respondents in Central Region are less educated than Manitoba respondents overall, a finding that is supported by Statistics Canada (see Individuals Chapter). In Central Region we have, on average,
around 12 per cent fewer high school graduates than the rest of Manitoba. Sources have indicated that with each additional year of educational attainment a parent has, the risk to child cognitive development decreases by 8-11 per cent. Statistics Canada suggests that overall maternal resources are important for behavioural development in children. (Statistics Canada, 2002). The following Figure 2-2 also indicates we have fewer high school graduates than Manitoba overall. Not surprisingly, respondents who report incomes of less than $30,000 are less likely than average to have completed high school, whereas those who report incomes of $60,000 and over are three times more likely to have graduated from university.

**Figure 2-2: Level of educational attainment Central Region compared to Manitoba overall.**

![Bar chart showing educational attainment levels](chart.png)

Please tell me which of the following best describes your level of schooling?

- Less than high school
- Graduated high school
- Some college or university
- Completed college/tech school
- University graduate

Source: Acumen Research.
3.4 Environmental Factors

3.4.1 Physical Environment

The Team identified a number of issues related to environment in Central Region. As demonstrated in the Romanow Report on Health Care, a rural physician identified that “geography is a determinant of health. People in rural and remote communities have poorer health status than Canadians who live in larger centres. Access to health care also is a problem, not only because of distances, but because these communities struggle to attract and keep nurses, doctors and other health care providers” (160). The CHA team for Families noted that where the family lives in relation to adequate housing, supports and services, availability of transportation, farm safety, access to good water and proper disposal, and crisis/disaster management all have an effect on the health of rural residents. “Information on disparities in health confirms that view – geography is, in fact, a determinant of health. “ (Romanow, 160).

Since we are predominantly an agricultural region, safety on the farm has been identified as important and a concern. There are two sources of information we used to understand injuries specifically in the home and on the farm, a work environment that is both a family and home environment. We sought information from the Acumen Telephone Survey and from the “Injuries in Manitoba – a 10-year Review” document from Manitoba Health. We have concluded that while there are a number of unspecified injuries about which we cannot know the source, there are enough injuries in the home and farm environment to comment on them.

The home and the workplace were identified as significant sites of injuries and with agriculture as a leading industry, farm safety was a common concern to our sources. In Manitoba, from 1992-1999 there was a rate of .5 deaths from machinery injuries while in Central Region the rate was 1.6 per 100,000. Agricultural machinery deaths during this same period had a Manitoba rate of 0.4 while Central Region’s rate was 1.2. The same pattern holds true for hospitalization rates for which Manitoba had 16.6 per 100,000 machinery with Central Region’s higher at 37.2/100,000. Agricultural machinery injury hospitalizations for Manitoba were 4.9/100,000 compared to 16.4/100,000 for Central Region. (Manitoba Health Injuries Report 11-2 and 155-6). This tells us that our rates of machinery injuries and specifically farm machinery injuries are approximately 3X higher than the provincial average, an issue about which we should be concerned.

We know from the Telephone Survey that injuries on the farm and in the home were identified by respondents as frequent injury sites. If we add the two sites together, we have a large number of injuries occurring in or around the home or farm.

There were folks who thought that disaster or emergency management was important to safety of our residents. For these folks, safety included the ability to take care of an injury or medical emergency. This is particularly important in farm country given the location of injuries as identified by the telephone survey.
3.4.1 (a) Housing

A safe environment was defined in a variety of ways by our sources. Some looked at the environment close to home and mentioned having a safe household with poisonous home products stored properly, a safe yard, a warm house, good water, and trees around their property. Others cited knowing one’s neighbours as important.

There was a sentiment that a smaller community is safer as there is less crime than a larger community or city. However, not all appeared to feel so safe. The benefits of having laws to address crime, alarm systems and guard dogs were also noted. Some informants viewed safety in the larger context of the world and current wars.

Natural disasters have a negative impact on families as witnessed by the Red River Flood in 1997. Some families had to move from their homes for a long period of time. Some people’s homes were destroyed, others had to spend many hours repairing and restoring their homes to make them safe and livable again. Some families had to separate some of their children to be housed elsewhere during the flood. Some of these children never returned home to live with their family after that. Some children never returned to school. This disaster had many implications beyond the high waters. People told us of ongoing stress and family health issues post flood. One voiced concern related to mould and resultant asthma in the Red River Valley, particularly on reserve. Our data does not support the claim that there is more asthma post-flood or that asthma is necessarily flood and mould related. In Central Region we have lower than Manitoba average rates of respiratory morbidity with a declining trend. Within Central Region the areas of highest respiratory morbidity are in Portage, MacDonald Cartier and Lorne/Louise/Pembina. These also follow the overall downward trend, with significantly fewer rates of asthma treatment post-flood than pre-flood. (Atlas 82-3). However, some folks shared a perception that the reverse was true and they doubted the evidence. Studies focusing on this issue would need to be conducted to be sure.

3.4.1 (b) Pollutants

There was an expressed sentiment that farming without chemicals, and banning large pig farms was important to the safety one feels in their home environment. These folks looked at a safe environment from a community perspective including good air quality, no pollution, and proper disposal of garbage.

Manitoba Women’s Institute reported that children from low-income households are almost twice as likely as children from high-income households to live with smokers. We know that in Central Region almost half of our population is regularly exposed to smoke either directly or indirectly through second-hand smoke. It has not been identified whether these people exposed to tobacco smoke are more often from lower SES\(^4\) or not.

\(^4\text{Socio-economic status}\)
3.4.2 Social Environment

Resources to support healthy neighbourhoods and safe community environments were noted in Central Region. They include block parenting, neighbourhood watch, Manitoba Hydro’s safety programs, fire department’s involvement in community, RCMP liaison for schools, and community recreation facilities.

3.5 Healthy Child Development

Parenting styles, parental emotional and physical health, and parental coping skills are important to healthy child development and the function of the family unit. The Team acknowledges that families are different but all parents want to be good parents.

Data reveals that one of the keys to developing resilient, well-adjusted children is a parent-child relationship that also supports the child’s early development. At the family level, children need a close relationship with a caring parent figure, a parenting style that promotes warmth, structure, and high expectations, socio-economic advantages and connections to extended supportive family networks. At an extra-familial context, children benefit from bonds to prosocial adults and organizations outside of the family and attendance at effective schools. Please see the Children’s Chapter for more details on the mental health and development of Central Region children.

Concern was raised about the moral compass that is available in society today.

It used to be the church that gave you moral background to live by…there has been nothing to take the place of that. There is no education for teens which will make them responsible adults and good mums and dads. There is no emotional training along the way or problem solving training, no financial training, how to be a good person training, values, life skills. Nothing took over when church lost its popularity. No work ethic. You have dysfunctional children turning into dysfunctional teens turning into dysfunctional children. They have nothing to look back on that is healthy. No one taught them when you have a baby, the baby takes precedence. How are you going to raise a healthy family when you only have dysfunction to look back on? 🙄 (Compiled)

5 Examples: Car seat safety, changing smoke detector batteries, recharging home fire extinguishers.
Parental role models were identified as an important part of a healthy life. Parents also model coping skills and anger management. There were several comments related to the need for parents to establish boundaries and set limits. Limit setting was regarded as creating a safe environment.

Understanding parents that if something happens they’re not going to get mad at you right away.

Parents who listen to their kids, if they have problems they listen and not just say ‘There’s been worse’.

I’ve seen certain families that feel they shouldn’t say what they think or there should be a strategic relationship so we’re all happy and there is some seven-step way to being a happy family. All these mothers read all these books. You just have to be open and honest and that contributes to a healthy family environment. Just be natural and normal. Don’t worry too much about having a super happy family. No family is perfect.

3.6 Culture

In Central Region we have a diverse ethnic mix that is addressed throughout the document in various ways and in specific chapters. The Families chapter discussed culture and its influence on family health. The health of Aboriginal peoples within Central Region is described in Chapter 5. Therefore there is no further comment in this chapter regarding this cultural group. Rather, the Families team pursued knowledge and understanding of Low German speaking Mennonite families from Mexico (LGMM - also known as Kanadier Mennonites). Key Informants (health care providers) suggested that the health needs of this cultural community were often difficult to meet in the context of the existing health care system. Since we know there are significant numbers of this population group in Central Region, and that there is some indication of health deficit specific to the population, we considered the LGMM health an important component of health and culture to explore.

There are no reliable data regarding population size of the LGMM either in Manitoba or in Central Region. However, from Key Informant interviews we have reason to believe that the majority of Manitoba LGMM live within the boundaries of Central Region. A representative of the Mennonite Central Committee (MCC) Family Services Office in Winkler, Manitoba (Mb) reports that, in 2003, 100 Kanadier families (with 240 children) who recently moved to Manitoba, contacted their office for some form of assistance. The MCC office estimated that 20-30 per cent of new LGMM families arriving in Manitoba would not contact their office. 81 of the 100 new LGMM families took up residence in Central Region. As this population tends to re-locate frequently, including living in Mexico for periods of time, the total numbers of LGMM families living in
Central Region is not known. Key Informants, however, suggest that the number is “considerable”.

This cultural group speaks ‘Low German’, a particular dialect of the German language. They are more likely to report their ethnic origin as ‘German’, rather than ‘Mexican’ or ‘Canadian’. Telephone survey data reveal that 15 per cent of Central Region households self-reported German ethnic origin, second only to multiple ethnic origin. This lends support to Key Informants’ views that the number of LGMM families in Central Region is significant.

Concerns observed by health care providers regarding this population were:

- Unpredictable use of the health care system
- Communication difficulties related to language
- Children less commonly attend school after age 14 years
- School-aged children carry major responsibilities for the care of younger siblings
- Infrequent use of preventative/screening practices

To better understand the impact of culture on the health of LGMM families, the Team undertook a search of recently published literature and conducted Key Informant interviews.

Key Informants agreed that this cultural group gives little attention to matters of health, considering health to be ‘the absence of illness’. Similarly, a 2002 report of health and illness beliefs of Kanadier Mennonites in southern Alberta reports that the majority of the participants did not view health holistically. Diet and cleanliness were seen as important aspects of health as was a link between spirituality and health. In the same study, “having a good and open relationship with one’s family and friends also meant, at least for some participants, that they were healthy. A few did mention health prevention activities such as physical check-ups at the physician or dentist’s office, but the majority of the participants do not invest time in health prevention. In fact, there was a sense from at least some of the participants that they did not see a formal role for health professionals to assist these Mennonites to stay healthy.” (Kulig et al, 50).

One Key Informant emphasized that personal health and lifestyle practices/choices were strongly influenced by “cultural beliefs and lack of education” [knowledge]. The same informant felt that personal health and lifestyle practices had a significant impact on the health status of this cultural group. Another Key Informant affirmed the 2002 study findings that, when seeking care in Canada, the LGMM population prefers “to receive… antibiotics, or at least some kind of medication, for many health problems” (Kulig et al, 55).

Key Informants agreed that a strong work ethic is a family strength in this population. This strength, however, must be considered in light of the lack of formal education; most 14 year olds would be considered old enough to take a job and contribute to the family income. While all of the above findings are reported under the heading of “culture”, it is
clear that the health of LGMM families is influenced by multiple factors/determinants, not the least of which gender plays a part for this population perhaps more than some others.

3.7 Gender

Gender and the perceived vulnerability of female family members was identified as a safety issue. Family violence, which encompasses physical, emotional, financial, and sexual abuse, and neglect, concerned the Family Team. Family violence occurs across the population and is not restricted to one gender, although Shelters are for women and children only. Family violence has a negative impact on all family members, having an effect on family relationships, and mental health. (Doherty).

One other way to consider a rate of risk in our population is through the use of and need for ‘alternative safe environments’ as in shelters for abused women and children. In Central Region there are two shelters with the Portage Women’s Shelter having 17 beds. There is no second stage housing in Portage for those people who are no longer in crisis, although there are some in Winkler.

Changes in family structure are associated with behaviour problems in children, particularly young boys. Problems include impulsive/hyperactive behaviour and school behaviour troubles. Girls seem to be less affected (Statistics Canada, May 2002). This topic is explored in more detail in the Children’s Chapter of this document.
SECTION IV: KEY FINDINGS

4.1 Observations

Families are the building blocks of society. Even though the family is in transition, from the Focus Group data it was apparent that participants still hold to the traditional concept of family. The literature regarding healthy families was strongly supported by the Focus Group data. The Families CHA Team found that:

- Intentionally caring for families as units is separate and distinct from caring for the individuals in the family as separate entities, and is important to the overall health of both the family unit and the individuals within the unit.
- Positive parenting, role modelling, and parental involvement are key to a healthy family.
- Effective communication, support and caring, and family togetherness are predominant characteristics of a healthy family.
- Financial and physical security contribute to family well-being.
- Level of education contributes to a family’s ability to learn and change.
- The physical and mental health of family members contributes significantly to happiness and family health.
- Healthy families spend time together, share activities and support each other.
- A safe family environment involves emotional security, physical safety, and concern for the broader world.

Clearly, in Central Region we have strong families overall, few indicators of health risk related to family environs, and strong support for families in our communities. It was also noted, however, that there are pockets of concern.

Some specific concerns identified include:

- Culture:
  - Some cultural groups have health practices that lead to poor health outcomes.
  - Specifically, we have concerns about injuries related to risk taking behaviour and to mental health as seen from the suicide and assault data, as well as poor health status for Aboriginal families and, it is suspected, for the Kanadier Mennonite families.
4.2 Considerations to aid our Families to be “as healthy as can be!”

- Supporting families is more than just supporting and caring for the individuals within the family. All the members of the family, and therefore the population of Central Region, are made healthier by strengthened family units.

Knowing more about the specific numbers of marginalized families and cultural groups as well as their health and illness beliefs would help us to help families in Central Region to be ‘as healthy as can be!’
SECTION V: CHAPTER REFERENCES

5.1 Books and Journals


5.2 Government Documents

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Canadian Community Health Survey Cycle 1.2

Canadian Community Health Survey Cycle 2.1

Canadian Vital Statistics


Manitoba Vital Statistics.


Statistics Canada/Canadian Institute for Health Information, 2000/01

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5.3 Internet Sources

www.smartrisk.ca

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www.phs.utoronto.ca/cultural_competence/glossary_1.htm

www.cape.ca

www.hc-sc.gc.ca/hppb/phdd/determinants/determinants.html


5.4 Personal Sources and Unpublished Documents

CancerCare Manitoba

Central Region Crisis Services Annual Statistics 2002-03


James Valley Address Book, 2000, Elie.
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Children

“Children in Central Region are as healthy as can be!”

CHILDREN’S SHAPE TEAM:

Jane Curtis
Diane Sloane
Kim Toews

Betty Loewen
Nancy Klassen
Dr. Deb Peabody

Jacquie Badiou
Marlo Miller
Bob McKenzie
Erik’s Story

I know that I’m not typical of all kids but I know there are lots like me. My mom was sixteen when I was born. I’m four now; here’s my story.

My mom tried to finish her grade eight but it’s hard when you are young and pregnant. She wants to finish but now there’s also my brother who is two and our new baby sister, and our dad is only here once in a while. My mom and dad fight, especially when he uses up her money. I heard my mom say that she ran away when she was fifteen, her mom and dad hit her and yelled at her and she never felt that anyone cared. She tried drugs and drank a lot and our dad went to jail, and then I came along. Sometimes it’s pretty noisy in our cramped, subsidized housing unit, and there’s no fence for me to go out to play.

My mom tries, but sometimes she gets stressed like when we ‘don't listen’ and there’s no one to give her a break for awhile; or when she has to go to the income assistance lady to tell her that she has no money but there are only two diapers and one can of formula left for my sister and there is hardly any food at our place. She has gone to the food bank even though she hates to, but there isn’t as much food any more because so many people use it. We walk with the stroller in the cold weather to get there, or take the taxi, which costs money. They paid for the taxi when my brother had an ear infection and had to go to the doctor. They said it might be from the secondhand smoke at our place. Mom tries to stop. It’s hard for my mom to see a doctor; sometimes the taxi just doesn’t come, sometimes there’s no one to take care of the rest of us when she has to take another appointment. We don’t have a phone to make or change an appointment.

There’s a visitor who comes to talk with my mom about how to spend time with us so that we are learning in our play and we feel good in our family. I heard one mom say her youngest child is smarter than all the rest, because - since her visitor came, the mom decided to spend more time playing with the baby. My mom is proud of how smart we are, although they said I should go to see a speech and language pathologist because I should be speaking more before I go to school. I will have to wait at least six months because they are so busy. I have to get my teeth pulled out too because they are all rotting. My mom didn’t know that breastfeeding is best, or that pop or kool-aid aren’t good in a bottle, but milk costs more.

We do have fun together; my mom is trying to make it better for us than when she was little. We are celebrating our own traditions and learning how to make good decisions for us. At the "group place" when we play, my mom learns about parenting. Mom is doing a pretty good job, but she is afraid of being reported to CFS and having us taken away from her. She gets discouraged sometimes and she just needs a bit of help to do this job.
Chapter 3

Children

SECTION I: ASSESSING CHILDREN IN CENTRAL REGION

1.1 The Assessment Process

The Community Health Assessment (CHA) began by establishing an in-house Children’s assessment team, one among seven assessment teams. We were charged with a mandate from RHA Central to gather and interpret data on the health of Children aged 1-19 in Central Region. We determined early on that because there was an overlap in the ages 15-19 with the Men’s and Women’s assessment teams, we would assess these ages in matters that are adolescent in nature. The gender specific matters that are more adult in nature, with respect to these ages, are found in the gender-based chapters.

In gathering data, the assessment team relied heavily on three sources of data. The first was from administrative sources as provided by our Epidemiologist and other documents described in the introduction of the overall document. One special document that was valuable to us was Assessing the Health of Children in Manitoba: A Population-Based Study. These data sources gave us an overview of the known health status of Central Region children and informed our inquiry for the assessment.

The second source was expert in nature and came from literature sources as well as interviews with people interested in the health of children.

The third source was Surveys that RHA Central had commissioned as a part of the larger regional assessment. Each contributed to the assessment of Children in Central Region.

1.2 Assessment Theme

Healthy child development is one of the determinants of health identified by Health Canada. This is based on the premise that good health in our childhood years increases our chances of becoming healthy adults. This connection between child and adult health has inspired a growing interest in childhood health and well-being.
Other determinants of health also have a significant influence on the health of our children. The assessment team looked most attentively at two determinants of health that have a powerful influence on the health of children:

- Personal Resources (Parenting Skills)
- Living and Working Conditions (Healthy Schools)

There are many areas of interest that could be discussed when one reviews the health of children. As the Children’s Health Assessment team reviewed the vast amount of information reflecting children’s health issues in our region, we noticed various themes arising through statistics, as well as through professional experiences of the experts on the team. We chose four main areas of focus for children’s health.

- Mental Health
- Reproductive Health
- Injury
- Obesity

The assessment that follows is the product of all the considerations regarding the health of children in Central Region. While it is comprehensive, it is not all-inclusive and we acknowledge that other factors affect the health of our children. These factors may be reviewed during future assessment cycles.
1.3 Demographic Overview

According to Manitoba Health, children under the age of 20 accounted for 32.03 per cent of the population of Central Region in 2002. This proportion is higher than Manitoba’s overall rate of 26.54 per cent. The population of children in Central Region surpasses the Manitoba average in every age group: Under 1, 1-4 years, 5-9 years, 10-14 years, and 15-19 years (see Figure 3-1).

Figure 3-1: Proportion of population by age group, 2002.

Source: Manitoba Health.
SECTION II: HEALTH STATUS OF CENTRAL REGION CHILDREN

2.1 Overall Health Status

2.1.1 Mortality

Since all childhood deaths lead to PYLL and PMR, and life expectancy has been addressed in the Individuals as well as the Men and Women’s chapters respectively, these factors are not addressed in this chapter for children. Rather, we have included infant and childhood mortality and causes of death in the following discussion.

2.1.1 (a) Infant Mortality

Between 1980 and 1998, there were 272 deaths in Central Region to children under the age of one year old. This is an average of 14 deaths per year. Of these, 150 (or 55%) were males and 122 (or 45%) were females.

As Figure 3-2 illustrates, in the period between 1994/95 and 1997/98, Central Region had the second highest rate of infant mortality in Manitoba. The rate of infant deaths in the region was 9.02 per 1,000 live births in comparison to the provincial average of 6.78 deaths per 1,000. In the second reporting period, the infant mortality rate decreased to 6.91 per 1,000, which was below the provincial rate of 6.94 per 1,000. Although the rate has decreased in the province, the rate is still among the higher end in the province and is above the reported Canadian rate of 6.1 per 1,000 (as of 1995, the most recent reported).

Figure 3-2: Changes in regional average annual infant mortality rates.

Source: Manitoba Health, Decision Support Services.
More recent data for the years 1999-2001 indicates that infant mortality rates in our region are dropping. For example in both 2000 and 2001 the rates were 4.26 and 4.32 per 1,000 live births. This sounds very positive and may be an indication of a decrease, however, the rate in 1999 was 11.58 per 1,000 live births. Using one year data for infant mortality, data can be misleading due to very small number and even four and five year averages can be misleading. Therefore it is suggested that a long term trend analysis of infant mortality rates be undertaken in Central Region.

The Manitoba Perinatal Health Surveillance Report, 1989-1998, contains an in-depth analysis of Feto-infant mortality by birth weight and time of death. According to this report, the Central Region has excessive Feto-infant mortality rates in categories related to maternal health as well as infant care. A review of this section of the Manitoba Perinatal Health Surveillance Report in conjunction with the current report will provide important and complimenting information to aid program planning and prevention campaigns.

2.1.1 (a-i) Causes of Infant Mortality in Central Region

Table 3-1 indicates the leading causes of infant mortality by broad ICD-9 classification.

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>ICD-9 Classification</th>
<th>Number of Deaths</th>
<th>Percent of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>760-779</td>
<td>15 – Conditions Originating in the Perinatal Period</td>
<td>106</td>
<td>39%</td>
</tr>
<tr>
<td>740-759</td>
<td>14 - Congenital Anomalies</td>
<td>76</td>
<td>28%</td>
</tr>
<tr>
<td>780-799</td>
<td>16 - Symptoms, Signs, Ill-defined Conditions</td>
<td>35</td>
<td>13%</td>
</tr>
<tr>
<td>460-519</td>
<td>6 - Diseases of the Respiratory System</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Other*</td>
<td></td>
<td>40</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Manitoba Health, Decision Support Services.
* All other classifications account for less than 10 deaths each.
Table 3-2 indicates the specific causes of death for some of the leading causes of deaths in infants under the age of 1. The leading specific cause of death is disorders related to short gestation and low birth weight followed by sudden infant death syndrome. Given the reported increases in very pre-term births and very low birth weights discussed in this report, it is clear that these adverse outcomes have had a negative effect on infant mortality.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Cause of Death</th>
<th>Number of Deaths</th>
<th>Percent of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>765</td>
<td>Disorders relating to short gestation and unspecified low birth weight</td>
<td>32</td>
<td>12%</td>
</tr>
<tr>
<td>798</td>
<td>Sudden infant death syndrome</td>
<td>26</td>
<td>10%</td>
</tr>
<tr>
<td>746</td>
<td>Congenital anomalies of the heart</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>748</td>
<td>Congenital anomalies of the respiratory system</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>770</td>
<td>Other respiratory conditions of fetus and newborn (example: pneumonia)</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>756</td>
<td>Congenital musculoskeletal anomalies</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>768</td>
<td>Intrauterine hypoxia and birth asphyxia</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>769</td>
<td>Respiratory distress syndrome</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>762</td>
<td>Complications of placenta, cord and membranes</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>799</td>
<td>Other ill-defined and unknown causes</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>Other*</td>
<td></td>
<td>119</td>
<td>44%</td>
</tr>
</tbody>
</table>

Source: Data: Manitoba Health Decision Support Services, Analysis: EPI Research & Data Management.
*Other – all other codes account for less than 10 deaths each.

2.1.1 (b) Mortality Among Children and Youth

Between 1980 and 1998, there were 333 deaths in Central Region to children and youth between the ages of 1 and 19. These deaths account for just over 2 per cent of all deaths in the region and is an average of 17-18 deaths per year. Of these, 230 (or 69%) were males and 103 (or 31%) were females.
Within this age group, males age 15-19 account for over one-third (36%) of all deaths (see Figure 3-3), followed by 1-4 year old males and females.

Figure 3-3: Distribution of child and youth deaths by sex and age group, 1980-1998.

![Distribution of child and youth deaths by sex and age group, 1980-1998.]

Source: Data: Manitoba Health, Decision Support Services, Analysis: EPI Research & Data Management.

2.1.1 (b-i) Causes of Child and Youth Mortality in Central Region

Table 3-3 indicates the leading causes of child and youth mortality by broad ICD-9 classification. Overall, injuries accounted for just under two-thirds of all deaths among our children and youth. For both males and females, in every age group, injury was the leading cause of death.

Table 3-3: Child and youth deaths by ICD-9 classification, 1980-1998.

<table>
<thead>
<tr>
<th>ICD-9 Classification</th>
<th>Number of Deaths</th>
<th>Percent of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 – Injury and Poisoning</td>
<td>208</td>
<td>62.5%</td>
</tr>
<tr>
<td>02 – Neoplasms (cancer)</td>
<td>34</td>
<td>10.2%</td>
</tr>
<tr>
<td>14- Congenital Anomalies</td>
<td>22</td>
<td>6.6%</td>
</tr>
<tr>
<td>06- Disease of Nervous System and Sense Organs</td>
<td>16</td>
<td>4.8%</td>
</tr>
<tr>
<td>16- Symptoms, Signs, Ill-Defined Conditions</td>
<td>14</td>
<td>4.2%</td>
</tr>
<tr>
<td>08- Disease of Respiratory System</td>
<td>11</td>
<td>3.3%</td>
</tr>
<tr>
<td>Other*</td>
<td>28</td>
<td>8.4%</td>
</tr>
</tbody>
</table>


* All other classifications account for less than 10 deaths each.
Figure 3-4 illustrates the burden of injuries in deaths among children by age group and gender. In our 15-19 year old youth, injuries accounted for just over three-quarters (76.6%) of all deaths that occurred between 1980 and 1998. Among 15-19 year old boys in particular, injury accounted for just over four out of every five deaths (82% of deaths). The good news is that these deaths are preventable; we need to examine further the causes of these injury deaths in order to determine appropriate programming, education campaigns and partnering.

**Figure 3-4: Injuries as a proportion of child deaths, 1980-1998.**

It is clear from looking at death classification alone, that injury and poisoning is the primary cause of death in children. However, if we look at the specific ICD-9 codes, as we did with infants, we can determine the specific causes of death. Table 3-4 illustrates that the primary cause of death among children and youth is motor vehicle collisions (accounting for just under one-third of all deaths) followed by suicide (6.9%) and accidental drowning (5.7%). In the case of accidental drowning, children aged 1-4 accounted for over half (10 of 19) of the deaths, it would be important to pursue further whether these are drowning deaths that occur in the home or in other locations. We look at injury hospitalizations and deaths further in the following section of this chapter.

---

1 Accident has been changed to Collision, crash or incident in this document to reflect the mostly preventable nature of these injury causes.
2.1.2 Morbidity

2.1.2 (a) Injuries

The word ‘accident’ suggests that injury incidents are ‘random’, and beyond our control. However, geographic and socio-economic patterns of childhood injuries demonstrate that they are NOT indiscriminate; they are strongly influenced by such factors as age, sex, urban or rural residence, socio-economic status and the interaction of all these factors. When a child’s life is lost due to injury, the loss to Canadian families and to society is uncountable. Lost potential cannot be described. The economic burden, however, can be, and is significant - $8.7 billion financial cost to Canadians.

As we’ve seen in this report, injuries are the leading cause of death among our children and youth. The same is true in Canada overall. In 1995, over 30 per cent of the deaths of Canadian children under 20 were the result of injuries (compared to over 60 per cent in our region). Of all hospitalizations for Canadian children, 17 per cent were due to injuries.

In Manitoba, as in our region, the relative picture is worse. Injuries account for over 50 per cent of all deaths to children between 1 and 9 years of age and 75 per cent of all deaths between 10 and 19 years of age. The highest injury death rate occurs in the 15-19 year olds, and the second highest in the less than 1 year olds. The Pediatric Death Review Committee (PDRC) of the College of Physicians and Surgeons of Manitoba deemed fifty-nine of sixty adolescent injury deaths in Manitoba in 1997, preventable. That equates to 98 per cent of injury deaths from that year as being preventable.

Table 3-4: Child and youth deaths by specific cause, 1980-1998.

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Number of Deaths</th>
<th>Proportion of all Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle traffic accidents</td>
<td>103</td>
<td>30.93%</td>
</tr>
<tr>
<td>Suicide</td>
<td>23</td>
<td>6.91%</td>
</tr>
<tr>
<td>Accidental Drowning</td>
<td>19</td>
<td>5.71%</td>
</tr>
<tr>
<td>Accident caused by Fire/Flames</td>
<td>16</td>
<td>4.80%</td>
</tr>
<tr>
<td>Other ill-defined and unknown</td>
<td>12</td>
<td>3.60%</td>
</tr>
<tr>
<td>Leukaemias</td>
<td>11</td>
<td>3.30%</td>
</tr>
<tr>
<td>Accidents caused by machinery</td>
<td>7</td>
<td>2.10%</td>
</tr>
<tr>
<td>Accidental Suffocation</td>
<td>7</td>
<td>2.10%</td>
</tr>
<tr>
<td>Homicide/Assault</td>
<td>6</td>
<td>1.80%</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>5</td>
<td>1.50%</td>
</tr>
<tr>
<td>Other*</td>
<td>124</td>
<td>37.24%</td>
</tr>
</tbody>
</table>

*Other – all other codes account for less than 5 deaths each.

Source: Data: Manitoba Health Decision Support Services, Analysis: EPI Research & Data Management.

2.1.2 Morbidity
Manitoba’s leading causes of death are the same as Canada’s. What is different is Manitoba’s very high injury mortality rate. For the years 1994-1997, Manitoba’s rate was almost 50 per cent higher than the 1996 national rate. Generally, the rates were highest in the North, followed by the Rural South, then Winnipeg. The Provincial PDRC found the injury mortality rate for First Nations children age 29 days to 14 years was over 9 times higher than for non-First Nations children in Manitoba. Central Region has many First Nations children within its borders.

As Figure 3-5 illustrates, Central Region has a slightly higher childhood injury mortality rate (2.28 per 100,000) than the provincial average (2.11 per 100,000).

**Figure 3-5: Injury mortality rates among children and youth, 1997-2001.**

<table>
<thead>
<tr>
<th>Region</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burntwood</td>
<td>2.45</td>
</tr>
<tr>
<td>North Eastman</td>
<td>4.03</td>
</tr>
<tr>
<td>Nor-Man</td>
<td>2.85</td>
</tr>
<tr>
<td>Parkland</td>
<td>2.19</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>2.28</td>
</tr>
<tr>
<td>Central</td>
<td>1.92</td>
</tr>
<tr>
<td>Brandon</td>
<td>2.11</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1.90</td>
</tr>
<tr>
<td>South Eastman</td>
<td>1.13</td>
</tr>
<tr>
<td>Interlake</td>
<td>1.03</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>2.35</td>
</tr>
</tbody>
</table>

Source: Manitoba Centre for Health Policy.

**2.1.2 (a-i) Injury Hospitalizations in Central Region**

In the ten-year period between 1992 and 2001, there were 2,503 hospitalizations due to injury among Central Region children. Of these, young females (age 19 and under) accounted for 922 (36.8%) hospitalizations and young males (age 19 and under) accounted for 1,581(63.2%) hospitalizations.

The pie charts in Figures 3-6 and 3-7 illustrate the breakdown of causes of hospitalizations among children in Central Region. Among both females and males, unintentional injury is by far the leading cause of hospitalizations. However, it is in self-inflicted injury where we see the biggest difference between the two groups (13% of female hospitalizations and 2% of male hospitalizations).
Figure 3-6: Female injury hospitalizations by type of injury, Central Region, 1992-2001.

Source: Manitoba Health.

Figure 3-7: Male injury hospitalizations by type of injury. Central Region, 1999-2001.

Source: Manitoba Health.

Figure 3-8 illustrates that among males, injury hospitalization rates elevate with increasing age. In addition, hospitalization rates are highest among males in every age group.
Although hospitalization rates are highest among males for injuries in general, Figure 3-9 illustrates that the opposite is true when we look at self-inflicted injuries only. In this case, hospitalization rates are significantly higher among females than males.

Table 3-5 illustrates the causes of injury hospitalization among children in our region. It is apparent that the leading cause is falls (26.81%) followed by motor vehicle crashes (14.26%) and being “struck” (10.91%). Children aged 5-9 account for the highest proportion of hospitalizations due to falls (33.2%). For motor vehicle collisions, youth aged 15-19 account for the highest proportion of hospitalizations (72.26%). What is also
of interest is that in the case of children aged 1-4, one-half of their hospitalizations due to motor vehicle traffic incidents actually involve the child as a pedestrian, not as an occupant of the vehicle. A large proportion of hospitalizations for 5-9 year olds were also due to being a pedestrian in a motor vehicle collision.


<table>
<thead>
<tr>
<th>Cause of Injury</th>
<th>Proportion of all Injury Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>26.81%</td>
</tr>
<tr>
<td>Motor vehicle traffic</td>
<td>14.26%</td>
</tr>
<tr>
<td>Struck by, against</td>
<td>10.91%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>10.75%</td>
</tr>
<tr>
<td>Transport, other</td>
<td>5.75%</td>
</tr>
<tr>
<td>Other specified, classifiable</td>
<td>5.63%</td>
</tr>
<tr>
<td>Cut/pierce</td>
<td>4.35%</td>
</tr>
<tr>
<td>Fire/burn</td>
<td>4.19%</td>
</tr>
<tr>
<td>Pedal cyclist, other</td>
<td>3.16%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>3.16%</td>
</tr>
<tr>
<td>Natural/environmental</td>
<td>2.96%</td>
</tr>
<tr>
<td>Other</td>
<td>8.07%</td>
</tr>
</tbody>
</table>

Source: Manitoba Health for data, Analysis by EPI Research & Data Management.

2.1.2 (a-ii) Injury Deaths

Further death data due to injury is available for an eight-year period between 1992 and 1999. In this analysis we include all children under age 19 (including those under age 1). In this time period, there were 80 injury related deaths among children living in the Central Region. Of these 80 deaths, 58 (or 72.5%) were among males and 22 (or 27.5%) were among females. Like hospitalizations, the primary type of injury death is classified as unintentional (a total of 57 or 83.8% of the total). Among males and females specifically, 86.2 per cent of injury deaths among young males were classified as unintentional, while a slightly lower proportion of injury deaths among young females (77%) were classified this way.

Table 3-6 illustrates the crude injury death rates by age group over the seven year period in the Central Region. As we saw in our mortality section of this chapter, death rates increase sharply in the 15-19 year old age group for both males and females. They are highest though, among 15-19 year old males for both unintentional and self-inflicted injury. Among both males and females, the second highest rate of deaths occurred in the 1-4 year old age group. The toddler years are known as “accident prone” years where children become increasingly mobile but are not old enough to understand the potentially dangerous outcomes of some of their actions.
For self-inflicted injury specifically, it is important to note that although historically data tends to show that males have a much higher suicide rate than females, this is not true in the 10-14 year old age group. In this young group of children, females have a slightly higher suicide rate than males. Fortunately, the total number of suicides among young people is very small. However, this data combined with the hospitalization rates for self-inflicted injuries among young girls demands our attention. No child, male or female, should die of suicide and it will be important for RHA Central to examine the causes and risk factors involved in self-inflicted injuries in order to develop successful counselling programs for our young residents.

According to the Manitoba College of Physicians and Surgeons of Manitoba ‘Pediatric Death Review Report for 2000’, injury accounted for 51 of 52 preventable deaths. When one looks at prevention programs, it is evident that injuries are not random. A high proportion of childhood injuries occur in the home (35%), especially for children under 4 years of age. Evidence-based Health Promotion Child Injury Prevention reviewed various ‘injuries’ and found that legislation is more effective than education campaigns especially related to the following:

- Poisonings - child resistant closures
- Immersion injuries – pool fencing requirements
- Burns/scalds - flame resistant materials, sleepwear designs, smoke alarms, lower hot tap water temperatures
- Motor Vehicle Crashes – Graduated Licensing Program (decreased collision rates in novice drivers in Ontario by 31 per cent after this legislation); car seats

Education is more likely to be associated with a reduction in injuries when:

- Coupled with enhanced access to safety devices – for example, helmet use in children riding bicycles is strongly related to income level - 30.5 per cent helmet use in highest income compared to 7.8 per cent in the lowest income groups.
- Coupled with regulation or enforcement and delivered over several occasions.
- Coupled with extended counselling.

<table>
<thead>
<tr>
<th>Age</th>
<th>All Deaths</th>
<th>Unintentional</th>
<th>Self-Inflicted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
</tr>
<tr>
<td>&lt;1</td>
<td>17.8</td>
<td>16.5</td>
<td>17.1</td>
</tr>
<tr>
<td>1-4</td>
<td>25.3</td>
<td>19.7</td>
<td>22.4</td>
</tr>
<tr>
<td>5-9</td>
<td>3.6</td>
<td>24.2</td>
<td>17.1</td>
</tr>
<tr>
<td>10-14</td>
<td>6.3</td>
<td>9</td>
<td>7.7</td>
</tr>
<tr>
<td>15-19</td>
<td>33.9</td>
<td>130.8</td>
<td>83.8</td>
</tr>
</tbody>
</table>

Source: Manitoba Health.

### Table 3-6: Crude death rates (per 100,000) due to injury in Central Region, 1992-1999.
Parenting attitudes and practices have a strong connection to the incidence of injury of children between the ages of 1-6 years. Current research related to childhood injury prevention indicates that parents may overestimate the capabilities of their children to act in safe ways and their children’s knowledge of how to handle emergency situations. The report on Parental Attitudes towards Unintentional Childhood Injuries states “knowledge of general risk is not sufficient to evoke a change in many adults' behaviours. In the present research, we considered that it could be the case that parents appreciate the scope of the problem and have sufficient knowledge about safety practices, but resist accepting that their child is personally vulnerable to injury and therefore do not consistently act on this knowledge.” (SAGE Research Corporation, 2).

2.1.2 (b) Health Conditions

2.1.2 (b-i) Low Birth Weight

Low birth weight (LBW) babies are defined as weighing less than 2500 grams at birth. Very low birth weight (VLBW) babies weigh less than 1500 grams at birth.

According to Health Canada, approximately 75 per cent of all newborn deaths and illnesses occur in LBW babies. LBW babies can also have more serious childhood problems like learning disorders, visual problems, respiratory illnesses and cerebral palsy.

Risk Factors for Low Birth Weight

According to the Perinatal Education Program of Eastern Ontario (1998), there are two categories of risk factors for low birth weight infants (see Table 3-7).

<table>
<thead>
<tr>
<th>Social Risk Factors</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty</td>
<td>• Smoking</td>
</tr>
<tr>
<td>• Single parent’Teenage parent</td>
<td>• Alcohol an other drug use</td>
</tr>
<tr>
<td>• Little or no prenatal care</td>
<td>• Poor nutrition before and during pregnancy</td>
</tr>
<tr>
<td>• Living with a violent partner</td>
<td>• Limited stress-relief strategies</td>
</tr>
<tr>
<td>• Generally stressful life</td>
<td></td>
</tr>
<tr>
<td>• Workplace Conditions</td>
<td></td>
</tr>
<tr>
<td>• Type and amount of work</td>
<td></td>
</tr>
</tbody>
</table>

Source: Perinatal Education Program of Eastern Ontario.

Post Partum Referral forms collect information pertaining to marital status, prenatal care, smoking and alcohol use. Data are entered for the years 1991 to 1998. Unfortunately, data entry of this information is not complete for any year. The most complete fiscal year of data is for the year 1997/98 with 1,125 entries versus the reported 1,498 live births in the region for that year (that is 75% of births are entered). Although data are not complete, there are currently 3,272 records entered for the Central Region. All but 94 of these records have information on smoking during pregnancy. Relative risk for low birth weight infant was calculated based on whether the mother smoked during pregnancy (see
Table 3-8). Infants weighing less than 2500 grams were born to women who smoked during pregnancy at the rate of 7.3 per cent compared to 4.5 per cent of infants born to women who did not smoke during pregnancy. The relative risk of giving birth to a low birth weight baby was 1.45 times greater for mothers who reported smoking during pregnancy than for those who did not smoke during pregnancy.

Table 3-8: Infant birth weight and smoking status.

<table>
<thead>
<tr>
<th></th>
<th>Smoked during pregnancy</th>
<th>Did not smoke during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant weighs &lt; 2500 grams</td>
<td>50</td>
<td>113</td>
</tr>
<tr>
<td>Infant weighs &gt; 2499 grams</td>
<td>637</td>
<td>2,374</td>
</tr>
</tbody>
</table>

Source: Post Partum Referral Forms.

Low Birth Weight Rates in Central Region

In 2002/03, 37.23 per 1,000 live born infants in our region weighted less than 2500 grams, this is lower than the provincial average of 50.17 per 1,000. As Figure 3-10 illustrates, Central Region has among the lowest rates of low birth weight (LBW) infants in the province. In the three years examined, Central Region was consistently lower than the provincial average and about the third lowest in the province in every time period.

Figure 3-10: Changes in low birth weight rates by region, 2000/01-2002/03.

Source: Manitoba Health, Decision Support Services.

A review of low birth weight rates over time indicates that Central Region has consistently been below the provincial average with the exception of 1999/2000. As Figure 3-11 illustrates, it appears that the year 1999/2000 was an anomaly as this year showed a dramatic increase in rates and was the only year where the Central Region had a higher LBW rate than the province. In general, in the past seven years, fewer than 5 per cent of live births have been less than 2500 grams. At this point, there does not appear to be a definite trend toward a decrease in rates, but as stated, we continue to be lower than the province.
According to the Manitoba Perinatal Health Surveillance Report, average annual rates of very low birth rate infants (weighing less than 1500 grams) increased substantially in the Central Region in 1994 to 1998 as compared to 1989 to 1993 (see Figure 3-12).

In the first reporting period, the average annual rate in Central Region was 8.7 per 1,000 live births, which was below the provincial rate of 9.5 per 1,000 live births. However, in the second reporting period the regional rate rose to 12.2 per 1,000, the second highest in the province and above the provincial rate of 10.2 per 1,000 live births. One possible influence on this increase is the reported increase in very pre-term infants (born before 34 weeks gestation) in this same period (1994-1998). A review of pre-term births and birth weights was undertaken in our region and most of these cases (and there are very few) appear to be related to multiple births.
High birth weight (HBW) infants are defined as weighing more than 4000 grams at birth. There is research that has shown an increased risk of developing Type 1 Diabetes for high birth weight infants (Stene, Magnus, Lie, Sovik and Joner). In addition, Health Canada advises that HBW infants are at greater risk of infant mortality than are normal weight infants.

**Risk Factors for High Birth Weight**

Women diagnosed with gestational diabetes during pregnancy are at increased risk of giving birth to a high birth weight infant.

In Central Region, older mothers were more likely than younger mothers to give birth to a HBW infant (see Figure 3-13). The average annual HBW rate for women aged 40-49 between 1994/95 and 2000/2001 was 27.2 per 1,000 live births as compared to 18.4 per 1,000 among women aged 15-19.
High Birth Weight Rates in the Central Region

The HBW rate in the Central region increased from 181 per 1,000 births in the 2000/01 fiscal year to 183 per 1,000 in 2002/03 (see Figure 3-14). Our rates are above the provincial average in each time period and rank about the middle of all regions.

Figure 3-14: Changes in high birth weight rates by region.

Source: Manitoba Health, Decision Support Services.
Long term trend analysis was again undertaken to review HBW for the region and the province over an extended period of time. Again, as Figure 3-15 illustrates, it appears that 1999/2000 was an anomaly as the Central Region appears to be consistently above the provincial average in HBW infants with the exception of this year (where we were lower).

**Figure 3-15: Rates of high birth weight infants, Central Region and Manitoba.**

![Graph showing rates of high birth weight infants](image)

Source: Manitoba Health, Decision Support Services.

**Pre-term Births**

Pre-term births are defined as births that occur prior to 37 weeks gestation. In Canada, pre-term births account for 70 per cent of fetal losses and neonatal disability (Society of Obstetricians and Gynecologists of Canada).

According to the Manitoba Perinatal Health Surveillance Report, between 1989 and 1993 Central Region had the lowest rate of pre-term births at 4.9 per cent of all births (see Figure 3-16). However, in the following five year period of 1994-1998, the rate of pre-term births increased to 5.7 per cent (although Central Region still had the lowest rate in the province).
While Central Region does have the lowest rate of pre-term births, the Manitoba Perinatal Health Surveillance Report indicates that the proportion of those births that occur at less than 34 weeks gestation has increased substantially. Between 1989 and 1993, 34 per cent of the pre-term births in Central Region occurred before 34 weeks. This proportion increased between 1994 and 1998 where 41 per cent of all pre-term births occurred before 34 weeks gestation (compared to the provincial average of 32 %)

In Canada, the Society of Obstetricians and Gynecologists of Canada (SOGC) reports that the rise in pre-term birth rates is primarily associated with the rise in multiple births. Because the Manitoba Perinatal Health Surveillance Report does not separate single from multiple births, it is unclear from this source, whether this is an influencing factor in the increase seen in Central Region. As stated earlier though, our analysis in Central Region confirms that association between pre-term rates and multiple births.

2.1.3 Well-Being

The indicator of self-reported health can tell us what some of the other indicators such as disease prevalence and causes of death may miss. The measures include functional health status, self-reported health status and activity limitations. However, for children, these indicators are not available because the studies that provide the information are not done on the under 18 age group. Therefore, with consideration to the health of children, the

following discussion regarding mental health was determined to be relevant to children’s well-being.

**2.1.3 (a) Mental Health Status**

The World Health Organization (WHO) advises that mental health is as important as physical health to the overall well-being of individuals. It is becoming increasingly apparent that young children/adolescents can and do suffer from mental health illnesses. There are approximately 270 children in Central Region utilizing programs offered through Mental Health Services.

Children/adolescents in Central Region suffer from many mental health disorders including the following:

- Schizophrenia
- Manic-Depression
- Depression
- Anxiety
- ADHD
- Asperger’s Syndrome
- Pervasive Developmental Disorder
- Post Traumatic Stress Disorder
- Personality Disorder
- Eating Disorder
- Other disorders not listed in the Diagnostic Statistical Manual of Mental Disorders (DSM-IV)

Girls in particular are vulnerable to depression. According to the 2000/01 Canadian Community Health Survey (CCHS), nearly 6 per cent of 12-14 year old girls had a high risk of having a major depressive episode in the year before the survey, compared with 2 per cent for boys the same age. Among 15-17 year olds, the proportion of girls who had such an episode was much higher (11%). Boys in the 15-17 year old age group were no more at risk for depression than those aged 12 to 14.

Boys, however, are more vulnerable to the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). It is estimated that 3-5 per cent of all boys suffer from ADHD (DSM-IV). Health care workers in Central Region have reported, anecdotally, an observed increase in anxiety-related illnesses in the past few years.
Figure 3-17: Rate of children aged 0-19 years with one or more prescriptions for antipsychotics and anxiolytics by region, 1998/99.

Statistical Significance:
*-Rate significantly different from Manitoba mean at p<0.05
N-Rate significantly different from mean for Northern Manitoba at p<0.05
S-Rate significantly different from mean for Rural South Manitoba at p<0.05
Source: Manitoba Centre for Health Policy.
Through discussions, the Children’s assessment team identified some unique factors that have seemingly influenced children/adolescents’ mental health in Central Region:

- Floods in the Red River Valley caused significant stress, both in 1996 and 1997. Major upheavals to the family unit/home were caused by evacuation, loss of homes, and lingering problems after the floods. There was significant impact on the most vulnerable, which includes the children. Education of the children suffered significantly after the flood, as some children did not return to school during that school year.

- High transient populations in several areas in Central Region make it difficult for children to continue accessing the help they need. Some of the areas where the population seems to be most transient are:
  - Morris – possibly related to proximity to Winnipeg, reflected by changing school population.
  - Portage – where the clients move on and off reserve.
  - There is a high population of immigrants in the Altona and Winkler area - Mexican, Paraguayan and Belize Mennonites. These low-German speaking Mennonites are a unique culture, with very strong work ethics and strong family commitments. Within these cultures the education and literacy rates are lower than average. There appears to be a higher than average need for Mental Health services, but there is often mistrust of authority figures that these families would see Children’s Mental Health workers representing. Of note, some “inroads” are being made through informal networks of Family Resource Centre programming and Baby First programming to meet the needs of this population.

- Limited access of children/adolescents to mental health resources. It is preferential to treat children closer to home, however, many rural hospitals are ill-equipped to deal with the unique challenges that the psychiatric population, especially children, present.

The Children’s team discussed the importance of a positive sense of self for our children. Although poor self-esteem is not defined as a mental disorder in the DSM-IV, it can significantly influence a child’s overall health and well-being and may eventually lead to more serious health problems. Programs that promote child/parental attachment, family resilience, and parenting skills will benefit children/adolescent’s mental health. These programs need to be available in a variety of places within the community such as family resource centres, schools and homes.
For children, the determinants of health that most affect them are somewhat different than for adults. For example, most children do not work, so work-life is not significant. However, the majority of their day is spent in school so school environment has been considered as a determinant as work-place would be for adults. The differences in these determinants are demonstrated in the following discussion.

3.1 Personal Health Practices and Lifestyle

3.1.1 Reproductive Health Practices

The World Health Organization released a report in October of 2002 identifying the top ten major health risks in the world. Having unprotected sex ranks second on the list. Two potential outcomes of unprotected sex for children are teen pregnancy and sexually transmitted disease. Similarly, the rates of these factors provide us with an indicator of how many children are placing themselves at risk through this lifestyle activity. Good education in the area of reproductive health can help to offset some of the negative outcomes. While we acknowledge there are others such as effect on self-esteem, we have addressed those for which data are available.

3.1.1. (a) Teen Pregnancy and Births

The Provincial Health Indicators Report (1999) advises that teenage pregnancy rates indicate the number of teenagers and their children who may experience difficult living conditions. While not a perfect indicator of unintentional pregnancy, it gives us some indirect information regarding risk from unprotected sex in our region. Teen pregnancies have many risks and associated problems, making it a concern when rates are higher than average. According to Health Canada, some risks and outcomes of unplanned pregnancy in teenage years include:

- delayed entry into prenatal care
- Lower rates of prenatal care
- Higher consumption of tobacco, alcohol and other substances
- Relatively higher proportion reported physical and sexual abuse
- Somewhat increased risk for delivering low birth weight babies
- Higher rate of adverse conditions such as pre-eclampsia, anemia, urinary tract infection, very low birth weight, pre-term birth and primary postpartum hemorrhage

According to Statistics Canada, in 1995 the Canadian teen pregnancy rate was 47/1000 for teens between the ages of 15-19 years. (Schaefer). We acknowledge that teen pregnancy is not always seen as undesirable, as it is normal in some cultures to bear children in the teenage years. As Figure 3-18 illustrates, in 2002/03 Central Region had one of the lowest pregnancy rates in the province among 15-19 year olds at 31.4 per 1,000. This is quite a bit lower than the provincial average of 50.2 per 1,000.
Over time, the teen pregnancy rate has decreased from 40.1 pregnancies per 1,000 among 15-19 year olds in 1996/97 to 31.4 per 1,000 in 2002/03. As Figure 3-19 shows, although the provincial rate has also declined (from 64.6 per 1,000 to 50.2 per 1,000), our region is consistently quite far below the provincial average.

**Figure 3-19: Changes in pregnancy rates among 15-19 year olds.**

Source: Manitoba Health.
Within our region there has been a decrease in teen pregnancy rates in all of our areas except Carman. In both 1991-1995 and 1996-2000, the highest teen pregnancy rates were in Seven Regions followed by Portage la Prairie (see Figure 3-20). The rates in these areas are higher than the provincial average, while all other areas are lower than the provincial average.

**Figure 3-20:** Teen pregnancy rates/1000 females aged 15-19 years in Central Region.

![Teen Pregnancy Rates](chart)

*Source: Manitoba Centre for Health Policy, Need to Know Project.*

We know from the Central Region Health Profile (2003) that Central Region teenage and adolescent girls appeared to have lower birth rates than other Manitoba peers. Of Central Region teenage girls aged 15-17 years, 2.7 per cent gave birth, compared to 3.7 per cent of all Manitoba girls this age. Of Central Region teens aged 18-19, 5.2 per cent gave birth compared to 6.5 per cent of all Manitoba peers.
Figure 3-21 illustrates, the birth rate for 15-19 year olds combined. As stated earlier, our birth rate is fairly low in the Central Region compared to the provincial average. In addition, the teen birth rates appear to be declining quite dramatically in our region (from 37.4 births per 1,000 in 1994/95 to 22.6 per 1,000 in 2002/03). (See Figure 3-22).

Figure 3-21: Teen birth rate by region, 2000/2001 to 2002/03.

Source: Manitoba Health, Decision Support Services.
Note: South Westman and Marquette amalgamated to Assiniboine Region in 2001/02.

Figure 3-22: Birth rate among 15-19 year olds, 1994/95-2002/03.

Source: Manitoba Health.
### 3.1.1 (b) Sexually Transmitted Diseases (STD)

STD infection rates are increasing over time. Looking at two STD’s (Gonorrhea and Chlamydia) over a 10 year period shows that although there was improvement in the late 1990’s, rates for both diseases are now on the rise. The same pattern is seen in the school aged population. It is difficult to extract those individuals residing in the correctional institutions, however verbal communication with the Communicable Disease Control Resource Nurse in our region indicates that those numbers have also risen.

#### Gonorrhea

![Gonorrhea Chart]

Series 1 = total cases over a ten year period all age groups;  
Series 2 = cases in 15-19 year age group over the same period.

#### Chlamydia

![Chlamydia Chart]

RHA Central has participated in a pilot project initiated by Manitoba Health as part of the Provincial STD strategy for Corrections. In Central Region, there are three correctional facilities giving us the opportunity to interface with male, female and youth offenders. The offender population in Central Region is approximately 600-700. We have valuable information from the 3 month time period (Jan-Mar 03) that we had a STD Nurse working with Headingley Correctional Center. The evaluations received on this initiative
have been very helpful for further refining the role of the STD Nurse employed by RHA Central in the Correctional facilities.

Aboriginal jurisdiction issues continue to be a challenge. We have persisted in our efforts to liaise with First Nation public health staff but these efforts have been hampered by significant staff turnover rates in our First Nation Communities.

Concurrent provincial requirements (Community Health Assessment process 03-04; Performance Deliverable agreements) along with regional initiatives (Corporate and Programmatic restructuring in RHA Central) compete for staff time. STD rates are rising in Central Region, including HIV and AIDS. Chlamydia and Gonorrhea rates are increasing in males and especially in females ages 15-19. Syphilis rates are also increasing. While this is not a conclusive indicator, it does suggest a possible rise in sexual activity among youth. The effect of an asymptomatic STD during the teenage years is a serious concern as untreated STDs can lead to sterility, trouble with pregnancies, and other health problems. The risk of other diseases such as infertility and HIV\(^2\) transmission is indicated by the rates of other STDs, an indicator of unprotected sex. (Smith and Buchan).

### 3.1.2 Reproductive Health Education

Children today are exposed to a variety of sexual information due to increased exposure to the Internet and other media sources. Public Health nurses, who are involved in teaching about reproductive health, report children/adolescents have many questions about healthy relationships, legal issues about sex, and making the decision to have a sexual relationship. There are many misconceptions about reproductive health. We brought together a sampling of teens for focus groups in Central Region and asked them where they get their information about sex. There were varied answers that included parents, school, friends, nurses, doctors, media and “the streets”. It was apparent that many teens are not aware of services in their communities that can offer reproductive health assistance. For example, reproductive information and birth control supplies are available from public health offices and/or clinics. However, even if teens are aware of these services, their desire to remain anonymous, especially in a small community, might deter them from seeking help.

As far as actual [reproductive health] education first hand from a teacher or parent, I don’t think I’ve learned anything useful…I know a lot more than the average teenagers only because I’ve gone to lengths to learn.  

Personally, I’ve never picked up anything from my parents…There haven’t been any programs in school to participate in. I wish it would have been different…I don’t necessarily wish I could talk more to an adult about it.  

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\(^2\) Human Immunoinsufficiency Virus
Sex education in class is pretty horrible. They teach the biology only. They don’t teach the why. There are more reasons to have sex than love or making kids. Sex isn’t just sex for fun or sex for kids. There are lots of reasons to have sex other than that.

It is important to know how it will affect your mental/emotional health. You need to know what will happen in your life if you have sex and have a kid. We need to know just how it will mess up your life if you do have a teen pregnancy…It is important to have younger people giving the information…Maybe people with that experience, a young woman who had a child at 15, coming in and talking about their experience would make it more real. That would give a lot more insight…There also needs to be education on what’s next – I’m 15 and pregnant, what’s next. They need to give more options. What about abortion, adoption or what if I keep it?…I think they need programs with a school with a day care…Have more support after the abortion or adoption. (Compiled)

Teens spoke at length about protection options.

I want it out in the open right in front of my face. I don’t want to have to go the guidance counsellor’s office and read the little pamphlets in the corner. I want big posters on ‘Use condoms’ in the middle of the school. We don’t get a condom machine in school because they think it promotes sex. It doesn’t. If you’re not having sex, you’re not going to see a condom machine and think, “I should be having sex”…You can go to the drug store and get condoms. To a certain extent it is promoting sex, even if it is safe sex. You still see this thing on the way and think ‘If the school is doing it, the school says it is ok. It is the school endorsing it.’ Even if it is indirectly. (Compiled)

Some teens were reflective about responsibility.

And what about the fathers? Where are they in this? I think we are talking too much about the women. Do they disappear? Child support? (Compiled)

Presently, Public Health nurses teach reproductive health education in some school divisions within the region. Until recently, the content of information taught to students varied between schools and school divisions. However, a provincial plan to implement standardized mandatory physical/health education for all students is underway. Course content will include personal health practices, active living, healthy nutritional practices, substance use and abuse, and human sexuality. The use of this new curriculum should
help ensure the information offered to students across the province is consistent and appropriate.

The information provided in schools will ensure an informed student body for the majority of our children who are in the public system. However, a growing percentage of children in the region are being home-schooled, or they attend private schools and little is known about the extent and content of their reproductive health education.

3.1.3 Weights

Obesity is becoming a major threat to the health of many Canadians, including children. The prevalence of obesity among children 7 – 13 years of age in Canada has more than doubled from 1981 – 1996. About 12 per cent of the children are obese, with the rates slightly higher for boys compared to girls. More than one third of Canadian children are overweight and more than one sixth are considered obese. According to the Manitoba Centre for Health Policy almost 29 per cent of Manitoba children are obese or at risk for obesity. The following charts show rates of overweight children and obese children in Canada. The numbers of obese children are included in the chart with overweight children. We know from other sources that data for Central Region often closely resemble that of the rest of Canada and Manitoba. We would be very interested in data regarding weight, eating disorders and nutrition for the children of Central Region.

Figure 3-23: Percentage of obese children in Canada.

![Bar chart showing percentage of obese children in Canada from 1981 to 1999](chart.png)

Source: National Longitudinal Study of Children and Youth.

Obesity is caused by an increase in energy intake or reduction in energy expenditure. One study noted that “in the past 30 years important changes have occurred in family eating patterns and in the consumption of fast food, pre-prepared meals and fizzy drinks. Likewise, the amount of physical activity that children engage in has been reduced by an increase in the use of cars, time spent watching television and decrease in opportunities in many communities for physical activity on the way to school or in school ” (Dietz, 314).
There are consequences to obesity in children. There is a high prevalence of faster growth, psychosocial concerns, persistence of obesity into adulthood, higher cholesterol, and elevated blood pressure. There are also other consequences seen less frequently, including abnormal glucose metabolism, sleep apnea, orthopedic complications, and more.

The Romanow Commission recognized the problem of obesity and refers to this in two of the recommendations:

- “Prevention of illness and injury, and promotion of good health should be strengthened with the initial objective of making Canada a world leader in reducing tobacco use and obesity.” Recommendation 22
- All governments should adopt and implement the strategy developed by the Federal, Provincial and Territorial Ministers Responsible, for Sport, Recreation and Fitness to improve physical activity in Canada. Recommendation 23

In the past, numerous interventions have been tried, focusing on education for behaviour change. This has had limited success. Current thinking is that there needs to be an increased focus on environmental factors. Healthy choices should be the easy choices, as opposed to difficult and more costly. Several comments were made by teens in the focus groups regarding the high cost and accessibility of healthy foods compared to “junk foods”.

Schools are making positive moves towards improving the health of children. One plan involves removing pop from many schools’ drink machines and replacing it with healthier options. Another positive step is the new Physical Education/Health Education curriculum that will have a greater focus on healthy lifestyle practices such as encouraging physical activity and good nutrition. Studies show that there is an economic cost attached to childhood obesity. People who are overweight use health care resources more than those who are not overweight. Obese persons are more likely to consult with physicians, be prescribed more medications and to require more disability days.
3.1.4 Alcohol Consumption

There is not a lot of information regarding the number of youth who drink alcohol in Central Region. What we do know, is that of the youth who sought help through Addictions Foundation of Manitoba (AFM), there were some in the 10-11 and 12-13 year age groups. That is alarming. The majority of youth who underwent programs through AFM were in the 14-15 year olds (41%) and 16-17 year olds (45.8%). According to the 2003 CCHS, 38.2 per cent of youth who currently drink state that they never drink five or more drinks on one occasion. However, 23 per cent indicated that they would drink this much less than 12 times per year (i.e. about once per month) and 34.2 per cent indicated that they would consume this much at least 12 or more times per year. Further research is necessary to adequately understand the extent of alcohol consumption and the extent of alcohol abuse in youth in Central Region.

3.1.5 Smoking

There is similarly little known about the extent of cigarette smoking among youth in Central Region. We do know, however, that most smokers start smoking before the age of 20. If we can prevent youth from smoking during the pre-20 age, there is every likelihood that these folks will never smoke. For this reason alone it is important that together we find ways to prevent youth from starting smoking.

Although numbers were too small to report rates of youths who are current smokers, we can report on the proportion of youth who indicated that they have never smoked. Overall, three-quarters of youth age 12-19 reported that they have never smoked in the 2003 CCHS. The rates are much lower among males (65.0%) than females (83.7%) and as Table 3-9 illustrates, rates of “never smoking” are much lower among the 15-19 year old group than the 12-14 year olds.

Table 3-9: Proportion of Central Region youth who have “NEVER SMOKED”.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-19 Years</td>
<td>65.0</td>
<td>83.7</td>
<td>74.2</td>
</tr>
<tr>
<td>12-14 Years</td>
<td>97.3</td>
<td>92.2</td>
<td>94.4</td>
</tr>
<tr>
<td>15-19 Years</td>
<td>54.2</td>
<td>79.3</td>
<td>65.7</td>
</tr>
</tbody>
</table>


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*Interpret CCHS alcohol data for this age group with caution due to small numbers.*
3.1.6 Physical Activity

Clearly there is a gap in health for children regarding physical activity. Some of this has been discussed in the section on obesity since the two are inter-related.

According to the Canadian Community Health Survey (CCHS, Cycle 2.1, 2003), 26 per cent of males (compared to 24.3% in Cycle 1.1) and 34.6 per cent of females (compared to 39.4% in Cycle 1.1) are physically inactive.5

3.1.7 Immunizations/Screening for preventable diseases

In Central Region, people told us that they support immunization. Only 7 per cent of Telephone Survey respondents did not support immunization on the grounds that they thought there could be some negative reactions. However, 14 per cent thought that only people who are weak or frail should be immunized. Those who thought immunization was a smart thing to do numbered 71 per cent of the respondents. (Acumen Research). Since adults decide for their children regarding immunization, adult responses are important to the choices about immunization for children in Central Region.

Our immunization rates for infants to two-year-olds are from 77 per cent to 89 per cent for childhood immunizations. While this rate is higher than the provincial average, there has been a decrease in rates even where, for the province, there has been a general increase. For example, 2 year old rates declined. In 2000 the rate was 80 per cent, dropping to 77 per cent in 2002. A similar decrease was seen for all Manitoba 2 year olds, dropping from 77 per cent to 75 per cent. Conversely, the Measles, Mumps, Rubella (MMR) vaccinations declined in Central Region from a high of 93 per cent in 1999 to 89 per cent in 2002. However, in Manitoba overall, the rates increased from 77 per cent in 1999 to 87 per cent in 2002.

For seven year olds the trend is different. In 2002, 85 per cent of our 7 year olds had their MMR immunizations, higher than the 82 per cent of other Manitoba 7 year olds. There was an increase from 47 per cent in 1999 to 85 per cent in 2002, while for Manitoba as a whole the rate increased from 46 per cent to 82 per cent. We did a Measles/Rubella catch up program in Central Region up to grade 6, this is what was captured in the data and accounts for our improved numbers. This indicates to us that these concentrated efforts are successful and worthwhile.

Immunization rates for tetanus and diphtheria (Td) is higher than the Manitoba average with 75 per cent of 15 year olds immunized with Td in 2002 compared to 62 per cent provincially.

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4 Physical Activity: Population aged 12 and over reporting level of physical activity, based on their response to questions about the frequency, duration and intensity of their participation in leisure-time physical activity. (Mb. Health Central Regional Health Profile 71).

5 Note: interpret all physical activity data for 12-19 year olds by sex with caution due to small numbers.
3.2 Personal Resources

3.2.1 Life Stress

Raising children in less than optimum conditions is likely to cause strain for both the parents and the children. For most chapters in this assessment, life stress is indicated by self-reports. For the adults caring for children, these rates are reported in the Men’s and Women’s chapters of this document. Since this mechanism of reporting is not available for the under 18 age groups, this measure is not demonstrated here. Rather, this section shows the outcome of stress for children of adults with whom they interact.

Research shows that as many as 70 per cent of shaken infants are shaken by men (fathers, boyfriends, and common laws). The average abusive parent is young, poorly educated, has often had personal experience with violence, has difficulty coping with stress and has little knowledge of normal child development or realistic expectations of children” (Lindsay, 1998, 160).

3.2.1 (a) Parenting Skills

We found that parenting skills have a profound influence on the overall health of children and are closely linked to the priority areas the team identified. For example, a safe, nurturing environment will help reduce the risk of injury and increase a child’s potential for better health. Nutritious and well-balanced meals help promote healthy bodies. Parental support and involvement were also seen to have a vital role in reproductive and mental health. A Canadian study by Charo and Willms (in Fine) found that parental child-rearing skills have a more pronounced effect on child development and well-being than parental income or social-class background.

Research in early childhood development has revealed startling new information regarding the way baby’s brains develop. “The brain matures in the world, not the womb” (Canadian Institute on Child Health, 7). The stimulation infants and young children receive from their environment influences neural development that in turn ultimately defines the outer limits of their capabilities. If the brain doesn’t receive the requisite stimulation from the environment at certain critical periods, the window of opportunity closes and development fails to occur. Interventions at a later period may not reverse the consequences (Corak). Therefore, a child’s environment from birth to three years is critical as it determines the ability to learn for a lifetime.

Healthy attachment is the relationship with the caregiver that makes the child feel safe, secure and protected. This relationship is best observed when the child is ill, hurt or afraid. Attachment systems are as necessary for survival as sleeping and eating. “Secure attachment to a significant adult is the best predictor for a child to become a healthy, productive adult.” (Working Group on Healthy Child Development 1999, 12). It is the most powerful predictor of future social outcomes. A child who is raised in a loving and nurturing environment will be better prepared for a lifetime of learning.
Research from the Childcare Education Foundation reveals it costs Canada $2.5 billion every year for remedial education because of delayed interventions or negative early experiences. Over time, if we front-load our investment on positive parenting supports and early child development, we may be able to reduce or delay expenditures in respect to learning, behavior concerns and health problems throughout the life cycle.

**Figure 3-24: Brain wiring and development, opportunity and investment.**

![Brain wiring and development, opportunity and investment.](image)

**Source:** Perry, 1996.

Children’s health is enhanced when families feel connected to community, however, the trend in society is one where people are not spending time together as was more customary in previous generations. Families also tend to be smaller, with fewer parents at home, and fewer grandmothers/grandfathers at home.

Programs within Central Region help ensure the best start for children in today’s environment. Baby First/Early Start, Healthy Baby, Family Resource Centres and the Healthy Child Coalition programs report that parents are asking for information on nutrition, child development, discipline, and how to provide for a child’s basic needs. These parents are also asking for support networks so they do not feel isolated. Experts state that the families who successfully survive crises are those who know how to access resources. The above mentioned programs provide supports and resources to families and help them through difficult situations.

It is recognized that there is little scientific data that specifically ties parenting skills to the healthy development of children. However, it is widely agreed that positive parenting does contribute to positive health of children and has even been shown to counteract and provide resilience when multiple risk factors threaten a child’s healthy development.

We spoke to many Key Informants and to each Focus Group Participant about parenting, family health and safe family environments. We heard a great deal of consensus both
among the folks interviewed and in the literature. All spoke of the need for strong parenting skills and the importance of relationships in the nurturing of children in families.

There is no education for teens which will make them responsible adults and good mums and dads. There is no emotional training along the way or problem solving training. No financial training, how to be a good person training, values, life skills. Nothing took over when church lost its popularity…You have dysfunctional children turning into dysfunctional teens turning into dysfunctional parents raising dysfunctional children. They have nothing to look back on that is healthy. No one taught them when you have a baby, the baby takes precedence. How are you going to raise a healthy family when you only have dysfunction to look back on?

If you have a dysfunctional family it will affect your emotional well being which would affect your motivation to do anything active.

Definitely a healthy family is good for your mental health in all those things. Just in everything. You can come home and feel like you are worth something; maybe that isn’t the best word to use. It helps you get through everyday.

I just think having a good relationship with your parents and siblings is really important. You avoid problems later on. If you can do jobs with someone in your family and you co-operate and get it done without arguing.

You made the kids, you’re responsible for them. You make sure he is healthy…You won’t be healthy if you don’t have food because the father is off drinking the money away.
3.2.2 Spiritual Resources

Adolescents in Central Region tended to express a variety of concepts and connections between spirituality and their health. Some felt there was no connection, some that spirituality is religion and the connection is related in that realm, while some understood spirituality to be much more than religion.

I want the most accurate information, the one with the least fallacy for choosing for my health. I’m not going to decide on a procedure based on whether some mythical father figure wants me to go and not do this or do that or whatever.

Very little…I don’t know…I’m not sure.
I’m unsure of what I think about it.
It doesn’t really affect my health.
My beliefs in that whole aspect are mixed.
It doesn’t affect my health all that much.

I know it’s a controversy and not everyone thinks the same thing. It has made me realise I don’t have time to waste my life in menial things. I want to live an upright and righteous life, which in turn helps you make good choices. It has made stress disappear.

If you go into different cultures you see different forms of spirituality. I took expressive dance and they showed you how to take all your emotions and express them through dance…For me it does affect me. I admire some cultures.

I’d definitely say it does affect physical health. I became a believer when I was four or something. So I didn’t really try anything or start smoking but think I definitely would have if I didn’t believe. I think it has kept me away from it. It has guided me.

3.2.3 Social Support Networks

Two indicators of social support are related to living in a family, and mental health supports. We know that Central Region residents appear more likely to live in a family household and to be married than other Manitobans combined. This places our children in family settings more frequently than on average in Manitoba. Since children’s social support is achieved primarily within family and schools, this indicator is addressed in the sections on parenting and on healthy schools.
3.3 Living and Working Conditions

3.3.1 Income

Income of parents plays an important role for children and what opportunities they have. Opportunities might include direct health benefits and might also mean indirect benefits such as access to education.

Table 3-10 demonstrates that Manitoba children are among the highest rates of child poverty in the country. A 2003 report found that Manitoba has the highest rate of child poverty in Canada. Seldom since 1990 have we rated above the lowest in the graphed years shown.

Table 3-10: Child poverty rates by Province, Canada, 1990-1996.

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<td>21.1</td>
</tr>
</tbody>
</table>

Source: Prepared by the Canadian Council on Social Development, using data from Statistics Canada, Cat. 13-569-XPB.

Note: Children under 18 years of age. Based on Statistics Canada’s Low-income Cutoffs, 1992-base.

While Manitoba has the highest rate of child poverty in the country, the graph does not specify which areas in Manitoba are impoverished. Given the below provincial average rates of income of Central Region residents, it is reasonable to assume that some of the children living in Central Region are among this population. We recognize, however, that income levels are not the only determinant of poverty. In a farming area such as Central Region, many families have access to foods that families without access to gardens might have. This factor may help to offset the effects of low income for some families.
3.3.2 Work Life

Most children are not employed, although some are.

I have to rush home from school to get ready for work. You work till eleven at night and then get home, go to bed and do it all the next day. There is no time for homework. It fits in on your days off.

Finding a balance between work and leisure time can affect you too. If you work too much your immunity goes down and you get sick pretty easily. Maintaining a balance between the two. I’m involved in a lot of stuff after school, and I have a big work load in school and have a part time job. So if someone asks me to do something I sometimes say no because I need time to myself to relax.

I work quite a bit at home a fair time and I think that if that is crap the rest of your life will be crap and that will stress you out. Or if you’re working a twelve-hour shift, which has happened before, it’s just not good because you’re up too long and it brings you down and throws your sleep patterns all out. At a young age it is good to have work experience. It teaches you a lot about respect. It just gives you the responsibility. It teaches you about that kind of thing. If you work hard when you’re young it will pay off when you’re older. It teaches you things you can’t learn at school.

From early development in the home situation, children move on to the school system where a majority of their day is spent. Whatever the preparation from home, the next most influential years will be during development in school.

3.3.2 (a) Healthy Schools

It is well known that there is a strong link between health and learning ability. Studies have shown that regular physical activity and good nutrition improves brain function and increases academic success. Research has also shown poor health and poverty are barriers to learning and literacy for children. Conversely, older children who have not
developed a solid literacy base are at risk for school failure and dropout, anti-social behavior, poverty and risky lifestyles” (Movement for Canadian Literacy).

The interdependency of health and learning has sparked an increased interest in the need for, and importance of, strong partnerships that include parents, student and community as well as service providers such as health and education.

To that end, an interagency task force has been created within Central Region composed of various partners including health, education, justice, and child and family services. Our mission is to create collaborative working relationships across all sectors to help ensure that all children have the resources they need to develop to their fullest potential. As well, the province of Manitoba has created the Healthy School Initiative that is a “comprehensive school initiative intended to promote the physical, emotional and social health of students, their families, school staff and school communities.” Active partnerships between students, teachers, parents, health professionals and the community are encouraged to achieve optimum health and well-being. (Manitoba Schools Initiative).

There are 16,781 students attending public schools within the Central Region. This number does not include private, home schooled or First Nations school students. Central Region has six First Nations school divisions. We also know there are over 60 Hutterite colonies with school systems.

There are eight public school divisions that are fully or partially within the boundaries of Central Region as follows:

- Western
- Portage la Prairie
- Prairie Spirit
- Prairie Rose
- Pine Creek
- Borderland
- Red River Valley
- Garden Valley

The provincial government spends $101.7 million dollars annually in Manitoba for Special Education. This includes spending on ‘Students at Risk’ Projects and funding for special needs students at levels 1-3. Approximately 2.6 per cent of all Canadian children have some sort of disability including learning, Attention Deficit Disorder (ADD), cardiac, cerebral palsy, autism. According to ‘A Profile of Disability in Canada, 2001’, 3.3 per cent of all Canadian children ages 0-14 years are disabled. The most common disabilities in children ages 0-14 years are those related to a chronic health condition such as Cerebral Palsy, asthma, allergies, cardiac conditions, Autism, ADD or ADHD. In children ages 0-4 years, developmental delay is the most common disability. In school aged children ages 5-14 years, learning disabilities and speech difficulties are the two most common disabilities.
Pre-school screening programs which involve a collaborative effort from health, education and other service areas have been successful at identifying children with disabilities before they enter the school system. However, to date there are only a few communities in the region that have access to these programs.

Experts in the region are aware of many children with disabilities who are accessing services. However, these same experts know that there are others who are not being identified, thus are likely “falling between the cracks”. Therapy services are currently delivered by a variety of providers including health, education and service agencies. This has led to inequities and fragmentation in services. In an attempt to improve therapy services to children, the province has created the Children’s Therapy Initiative. This initiative is a joint provincial project that has been set up to review the needs of children and create a therapy delivery system that would improve the co-ordination, access and equity of therapy services for children throughout Central Region and Manitoba.

The impact of poverty is far-reaching, especially in the areas of mental health. For example, a report by Ross and Roberts shows the link between income and child behaviour. The following chart (Figure 3-25) shows that nearly 40 per cent of children in low-income families demonstrate high levels of indirect aggression compared to 25 to 29 per cent of children in families whose incomes are $30,000 or higher.

**Figure 3-25**: Children with high levels of indirect aggression.

![Figure 3-25](chart.png)

Source: Prepared by the Canadian Council on Social Development using Statistics Canada National Longitudinal Survey on Children and Youth 1994-95m ICD-10 data.

Note: Two-parent families with children aged 4 to 11 years.
The report also links income and several other behaviours, such as emotional-disorder anxiety, hyperactivity, engaging in frequent delinquent behaviours, and hanging around with kids who frequently get into trouble. All of these behaviours are associated more frequently with lower income families than higher income families.

As noted previously, the Children’s team discussed the importance of a positive sense of self and the influence of self-esteem on a child’s overall health and well-being.

3.4 Environmental Factors

3.4.1 Physical Environment

…what if the air or water is polluted? I worry about air quality here in this community. Sometimes it is hard to breathe.

3.5 Healthy Child Development

This section is the focus of the entire Children’s chapter so little is distinguished in this particular area except breastfeeding, increasingly considered an essential to healthy childhood development.

Nothing is more important than the beginning and how a child develops (their brain and body). If a teen pregnancy is not done right and there is FAS it can really screw up a life from then on. So really just because it is the beginning and most important part.

3.5.1 Breastfeeding

Research shows that breastfeeding of infants provides advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases. There is strong evidence that breastfeeding decreases the incidence and/or severity of several diseases such as diarrhea, lower respiratory infection, and otitis media. (Dewey, Wright and Duncan). In addition, there are a number of studies that show a possible protective effect of breastfeeding against sudden infant death syndrome. (Ford, Taylor and Mitchell). Breastfeeding has also been related to possible enhancement of cognitive development.

Although we currently have no reliable data on duration of breastfeeding, information from Post Partum Referral forms was used in the Manitoba Perinatal Health Surveillance Report to identify women who at least initiated breastfeeding in the hospital. According to this report, between 1994 and 1998, 83.7 per cent of new mothers in the Central Region initiated breastfeeding in the hospital. This is a slight increase over the 1989-
1993 rate of 81.1 per cent. As Figure 3-26 illustrates, rates of breastfeeding initiation in the Central Region are among the highest in the province.

Because duration of breastfeeding has also been linked to health outcomes, a means of measuring breastfeeding duration would be a valuable tool. One suggestion might include a survey of Central Region mothers or an ongoing report that is filled out for all babies when they arrive at their vaccination appointments. One other benefit of this would be to facilitate the capture of data regarding those infants who begin breastfeeding after discharge from hospital. There were some indications from Key Informants in Central Region that there is a practice among some cultures to initiate breastfeeding only after lactation occurs, which may be after the mom and infant go home from hospital.

**Figure 3-26: Percent of women initiating breastfeeding in hospital, 1994-1998.**

![Figure 3-26: Percent of women initiating breastfeeding in hospital, 1994-1998.](image)

**Source: Manitoba Perinatal Health Surveillance Report, 1989-1998.**

A valuable source for data on breastfeeding initiation comes from hospitalization data. This data indicates whether the mother started breastfeeding in the hospital. According to this data (see Figure 3-27), over 80 per cent of Central Region mothers initiated breastfeeding in both time periods examined. This is very similar to the rates identified from the post partum referral forms.
Within our region, rates of breastfeeding initiation vary by area. Between 1996/97 and 2000/01 the highest rates were in Altona and Morden/Winkler – with both just over 90 percent. The lowest rates were in Seven Regions (69%) and Portage (77%). It is important to note that the Areas with the highest teen pregnancy rates also have the lowest breastfeeding initiation rates. It would be interesting to pursue if there is a relationship as some research indicates that young mothers are less likely to breastfeed.

Source: Manitoba Centre for Health Policy, Need to Know Project.

Figure 3-28: Breastfeeding initiation rates in Central Region by area.

Source: Manitoba Centre for Health Policy, Need to Know Project.
3.6 Culture

While we noted differences between cultures in the ways of rearing children and in the health and illness beliefs, the most noted issues have been addressed in previous sections.

3.7 Biology and Genetic Endowment

Inherited: – There is a lot of health troubles in my family. My dad is 45 and had two heart attacks. Grandpa and great Grandpa too. I thought the same thing as he did too. 

– Inherited health traits. It causes worry. There is nothing I do about it. I’m still young.

…there are a lot of health problems in my mum’s family. It affects me the worst. Sometimes it causes stress when I think about it. I know my mum, her brother, sister and her dad all have cancer. And my grandma and my aunt have diabetes. I don’t smoke and the diabetes thing, I don’t practice any not having sugar and stuff.
SECTION IV: KEY FINDINGS

4.1 Observations

As is evident in this chapter, the factors that influence children’s health and overall well-being are complex and interconnected. We have identified four priority areas that we feel have a significant effect on children’s health in our region. We acknowledge there are a multitude of other areas we have not mentioned. We find it critical to stress the health role parents and schools have in children’s daily lives and how important it is to encourage and support them in every way. The four identified priority areas include:

- Injuries
- Mental Health
- Obesity
- Reproductive Health

Children in Central Region are at unacceptable risk for injuries that lead to hospitalization and death. These injuries are, for the most part, predictable and preventable. Preventing these injuries is an urgent concern. Clearly, health practices can be most effectively influenced if we help our youth to develop good health habits and prevent bad habits from forming. For children, if we are to influence the determinants that affect their long-term health, we will be required to work closely with others. Some of the others include families, schools, recreation centres and jurisdictions such as the Dakota Ojibway Tribal Council.

Self-esteem has not been identified in the DSM-IV as a mental health diagnosis nor is it specifically set out as a determinant of health, yet we concluded that it plays an important role in health. The Mental Health, including self-esteem, of our youth is paramount in their lifelong health status. Children in Central Region suffer from many of the known DSM-IV conditions. Most notable is anxiety for females and ADHD for males.

Some specific concerns identified include:

- Personal Health and Lifestyle Practices:
  - Obesity and overweight places our children at risk for lifelong health concerns and should be addressed as soon as possible.
  - Targeting youth to prevent smoking starts prior to age 20 will have the most positive effect on smoking rates, and on the health of people in Central Region over time.
  - Children risk their current and future reproductive health status when becoming involved in unprotected sex at young ages. Central Region teen birth rates are higher than the Canadian average.
  - Risk Taking Behaviour results in:
    - Unacceptable hospitalization or death as a result of preventable injuries.
➢ Personal Resources:

- We identified some concerns regarding the mental health of our children in Central Region. Partnering with agencies that are closely connected with children will help us to address this concern. Two of these agencies would include schools and recreation facilities.
- Parents within Central Region’s early childhood development programs are asking for information on nutrition, child development, discipline, and how to provide for a child’s basic needs. These parents are also asking for support networks so they do not feel isolated.
- An interagency task force within Central Region is composed of various partners including health, education, justice, and child and family services to create collaborative working relationships across all sectors to help children develop to their fullest potential.
- We do not adequately understand the extent of alcohol consumption and the extent of abuse among youth in Central Region. There were youth in Central Region who underwent programs through AFM although we don’t know for what kinds of treatment, how many of our youth with addictions these numbers represent or where the majority of youth with addictions are located.
- We heard from some children that they don’t learn enough about the effects of early sexual activity for youth. They suggested having young people affected by teenage pregnancy, for example, come to talk to them about their personal experience; it might have more impact for them than hearing from adults. They want to hear about what to do if they should be faced with a pregnancy, for example, options regarding choices and options to continue to go to school if they should have a baby and choose to raise it.

➢ Healthy Child Development:

- In our adolescents, injuries accounted for over three-quarters of all deaths that occurred between 1980 and 1998. The good news is that these deaths are preventable.
  - In the case of accidental drowning, children aged 1-4 accounted for over half (10 of 19) of the deaths.
  - Hospitalization rates are highest among males for injuries in general, yet for self-inflicted injuries, rates are significantly higher among females than males.
  - Females in the 10-14 year old age group have a slightly higher suicide rate than males. This data combined with the hospitalization rates for self-inflicted injuries among young girls demands our attention.
- Central Region appears to have excessive Feto-infant mortality rates in categories related to maternal health as well as infant care.
  - It is important to note that the Areas with the highest teen pregnancy rates also have the lowest breastfeeding initiation rates.
  - There were some indications from Key Informants in Central Region that there is a practice among some cultures to initiate breastfeeding only after
lactation occurs, which may be after the mom and infant go home from hospital.

- Living and Working Conditions (Healthy Schools)
- Research from the Childcare Education Foundation reveals it costs Canada $2.5 billion every year for remedial education because of delayed interventions or negative early experiences.

4.2 Considerations to aid our children to be ‘as health as can be!’

- It is suggested that a long term trend analysis of infant mortality rates in Central Region could prove important to aid program planning and prevention campaigns.

- In our adolescents, injuries are preventable, but we need to examine the causes of these injuries in order to determine appropriate programming, education campaigns and partnering.

- In the case of accidental drowning, children aged 1-4 accounted for over half (10 of 19) of the deaths, it would be important to pursue further whether these are drownings that occur in the home or in other locations.

- Females in the 10-14 year old age group have a slightly higher suicide rate than males. This data combined with the hospitalization rates for self-inflicted injuries among young girls demands our attention.

- Little is known about the extent and content of reproductive health education for children being schooled outside of the public school system. We are interested in finding ways to reach these children.

- We would be very interested in data regarding weight, eating disorders and nutrition for the children of Central Region.

- More research would be necessary to adequately understand the extent of addictions and the extent of alcohol abuse in youth in Central Region.

- Over time, if we front-load our investment on positive parenting supports and early child development, we may be able to reduce or delay expenditures in respect to learning, behavior concerns and health problems throughout the life cycle.

- Ensuring continued support and resources to help less knowledgeable families through difficult situations would improve their resilience and their health outcomes.

- A means of measuring breastfeeding duration would be a valuable tool. One suggestion might include a survey of Central Region mothers or an ongoing report that is filled out for all babies when they arrive at their vaccination appointments. An
added benefit of this approach would be to facilitate the capture of data regarding those infants who begin breastfeeding after discharge from hospital.

- It would be interesting to know whether there is a relationship between age of a mother and breastfeeding choice.

Strong partnerships are essential to achieve the best possible outcomes for our children. Opportunities to engage service providers, communities, families and youth should be created and encouraged. By working together we can all help to ensure our children grow up safe, happy and “as healthy as can be!”
SECTION V: CHAPTER REFERENCES

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5.3 Personal Contacts and Unpublished Documents

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Elderly

“Elderly in Central Region are as healthy as can be!”

ELDERLY SHAPE TEAM:

Bev Boyd
Michelle Mansell
Auna Marie Brown
Clara Wiebe
Ralph Cibula
Heather Hilebrand
Mary Lou Schroeder
Chantelle D’Andrematteo
Valerie Emerson
Joanne Larson
Susan Mooney
Marcie Dupasquier
Dr. Murray Reimer
Rebecca’s Story

An 87-year old woman is brought into a geriatrician’s office by her daughter. The daughter is concerned about her mother’s health, ability to drive and to live alone. Since her husband’s death a few months ago, the patient has experienced a decline in her ability to care for herself. She has been behind in her bills, has been skipping meals, and recently had an automobile accident. She has been unsteady on her feet and reports having fallen several times over the last several months. Unwashed laundry in her home smells of urine.

She sees several physicians for her arthritis, heart and lung diseases and takes several prescription medications from each physician. The daughter is unsure about whether her mother is actually filling the prescriptions or taking the medications. The daughter senses that, through better-coordinated care, her mother may be able to stay in her home and improve her physical health.

(An excerpt from Geriatric Medicine: A Clinical Imperative For An Aging Population. American Geriatric Society)
Chapter 4

The Elderly

SECTION I: ASSESSING PEOPLE 65+ IN CENTRAL REGION

1.1 The Assessment Process

The assessment team was concerned with the terms “Elderly” and “Seniors”. Experience indicated that many people in this age group do not identify themselves as “Senior” or “Elderly”. In order to avoid a negative response and possible disinclination to participate in the Central Region Focus Groups with the elderly, we used alternate terminology. It was decided that we would refer to this population as “people 65+”.

Besides the “well 65+”, there is a population of “vulnerable1” and “frail2” elderly persons who are harder to connect with. Meeting with this group for direct health assessment was a limitation of this assessment and one that will be suggested for future assessment and consideration. To include this population, we had discussions with caregivers of these folks.

The Community Health Assessment (CHA) began by establishing an in-house Elderly assessment team, one among seven assessment teams. We were charged with a mandate from RHA Central to gather and interpret data on the health of Elderly persons aged 65 and over in Central Region.

In gathering data, the assessment team relied heavily on three sources of data. The first was a review of data from administrative sources as provided by our Epidemiologist and other documents described in the introduction of the overall document. These data sources gave us an overview of the known health status of Central Region Elders and informed our inquiry for the assessment.

---

1 A vulnerable person is one who is at risk of neglect, abuse, or exploitation due to their inherent verbal and physical capacity and/or their life circumstances which includes, but is not limited to, the person’s age, gender, race, education or social skills, or recent life experience (Hiltz, S. RHA Central). For more, see glossary.

2 See Glossary.
The second source was expert in nature and came from literature sources as well as interviews with people interested in the health of people 65+. Many of our sources were health professionals who serve the health needs of people in the 65+ age group.

The third source was surveys that RHA Central commissioned as a part of the larger regional assessment, particularly a Telephone Survey and Focus Group meetings. Each contributed to the assessment of Elders in Central Region.

1.2 Assessment Theme

Persons 65+ are one of the fastest growing population groups in Canada. The elderly population is expected to grow even more rapidly during the next several decades, particularly once people born during the baby boom years from 1946 to 1965 begin turning 65 in the second decade of the new century. Statistics Canada has projected that by 2041, 23 per cent of all Canadians will be aged 65 and over.

The Elderly health assessment team reviewed all available information. The evidence indicated that quality of life and disability free life, are very important to the lifestyle of people 65+ in Central Region. The conclusion was to focus the health assessment on the following questions:

1. What impacts the health of people 65+?
2. What is the health status of people 65+ in Central Region?
3. What do people 65+ think about their health and what most impacts their health?

1.3 Demographic Overview

According to Statistics Canada, between 1991 and 2001 in Manitoba overall, there were substantial increases in population among the elderly. The number of people aged 80 and over increased 30 per cent from 34,025 to 44,205. This latter age group is expected to gain another 20 per cent between 2001 and 2011. According to Manitoba Health, in 2001 there were 13,425 people in Central Region who were 65+ comprising 14 per cent of the regional population. Of those, there were 5,920 men and 7,500 women. Projections estimate that the 85+ age category will see the highest population growth rate over the next years (Lindsay). Age characteristics of this cohort, in our region, are seen in Table 4-1.

<table>
<thead>
<tr>
<th>Age Characteristics</th>
<th>Totals</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65-74</td>
<td>6,480</td>
<td>3,130</td>
<td>3,345</td>
</tr>
<tr>
<td>Age 75-84</td>
<td>5,045</td>
<td>2,095</td>
<td>2,950</td>
</tr>
<tr>
<td>Age 85 and over</td>
<td>1,900</td>
<td>695</td>
<td>1,205</td>
</tr>
<tr>
<td>Totals</td>
<td>13,425</td>
<td>5,920</td>
<td>7,500</td>
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Source: Manitoba Health.

Our statistics mirror those of Canada quite closely in that there are a larger number of females, 56 and 57 per cent respectively, than males in this age cohort. Comparison
differs from Canadian statistics in the 85 plus range. While the spread widens for both males and females, women 85+ in Central Region comprised 63% of the total population whereas overall, Canadian women 85+ made up 70 per cent of the population. From this we conclude that in our region, more men live to similar older ages as women than in the overall 85+ Canadian cohort. As Table 4-2 illustrates, life expectancy at birth in 1997, was slightly higher for both males and females of Central Region compared to Canada. The difference is the greatest among males who reach the age of 65; once reaching this age, Central Region males have, on average, one full year more of life expectancy (17.2 years vs. 16.2 years) than all Canadian men.

Table 4-2: Life expectancy at birth and at age 65 (1997).

<table>
<thead>
<tr>
<th>Canada</th>
<th>Females</th>
<th>Males</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth</td>
<td>81.3</td>
<td>75.7</td>
<td>78.5</td>
</tr>
<tr>
<td>At age 65</td>
<td>20.0</td>
<td>16.2</td>
<td>18.2</td>
</tr>
<tr>
<td>Central Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At birth</td>
<td>81.8</td>
<td>76.4</td>
<td>79.1</td>
</tr>
<tr>
<td>At age 65</td>
<td>20.4</td>
<td>17.2</td>
<td>18.9</td>
</tr>
</tbody>
</table>


In order to understand the complete demographic picture of those 65+, it is helpful to know their overall living arrangements. For many, there is a misconception that elderly people live in care homes. In fact, the opposite is true. The following description opposes this myth.

Of the 65+ in our region, 94 per cent are living in the community rather than in personal care homes. We know that 6 per cent live in Long Term Care (LTC) Facilities while the remainder live in other settings including independently, at home with assistance, with family or caregivers\(^3\) and in assisted living\(^4\) situations. Unfortunately, there are no specific data available regarding the percentage of people 65+ in specific settings outside of LTC. From reviewing numerous data sets, our Medical Officer of Health, Dr. Buchan, tells us that frequently Central Region closely resembles overall Canadian data. We assume this is approximately true for independent living among our elderly. The 1996 Canadian statistics for those 65+ living independently in their own homes are as follows:

- 92.8 per cent of all persons 65 years and older live in a private household.
- 97.9 per cent of those aged 65-74 live in private households.
- 66.2 per cent of persons 85+ live independently. (Lindsay, 30-31)

Of the above cohort living independently, we know that some live alone, with or without assistance, some live with family members including a spouse, a common law partner, children or extended family members, and others live with non-relatives. Table 4-3 demonstrates specific data for these arrangements. Of those living at home, according to

---

\(^3\) There are both formal and informal caregivers. See glossary for definitions of each.

\(^4\) Assisted living is a formal term describing facilities specifically set up to provide ongoing assistance within an otherwise independent living situation.
the 1996 Canada census, 84 per cent receive some sort of assistance, either from friends, family or outside agencies such as home care⁵.

Table 4-3: Living arrangements of 65+ who live in the community.

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Manitoba</th>
<th>Canada</th>
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</thead>
<tbody>
<tr>
<td>Live Alone</td>
<td>34.1%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Live with Family</td>
<td>64.7%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Live with Others</td>
<td>1.1%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, Lindsay, (42-3).

⁵ “Home care is an important component of health care services in Canada. It serves three main functions – to support individuals to stay in their homes and communities, to facilitate in home convalescence and care of postacute patients and to prevent institutionalization and/or hospitalization.” (Chappell and Hollander, 2001).
SECTION II: HEALTH STATUS OF CENTRAL REGION 65+

2.1 Overall Health Status

In Central Region, with one of the best PMR in the province, we expect our overall health to be similarly good. As demonstrated, older men perceive their health to be better although women live longer.

2.1.1 Mortality

Men rate their health better and seek medical intervention less frequently than women, yet they die younger than women, and in many cases, from largely preventable causes.

2.1.1 (a) Premature Mortality Rate (PMR)

We have no data regarding PMR for the 65+ age group. By definition, the only individuals who could be counted in this measure would be the 65-75 age group who tell us that they are more interested in how well and how independent they are during these years than in how many years of life they have left.

2.1.1 (b) Potential Years of Life Lost (PYLL)

This measure does not really apply to the seniors as it is more a measure of early death impact on our younger population.

2.1.1 (c) Life Expectancy

As discussed in our demographic overview of the elderly, in Central Region the life expectancy of males is 75.7, five years less than the female life expectancy of 80.7 years. While life expectancy is a measure of length of life, it does not give an indicator of quality of life. According to Statistics Canada, disability-free life expectancy in the Central Region is 68.9 years at birth. The importance of developing and maintaining good health and living habits over a lifetime is underscored by the disability-free life expectancy at age 65 years. As illustrated in Table 4-4 although disability-free life expectancy at birth is 68.9 years, those people who are disability-free at age 65 can expect, on average, an additional 12.1 years of disability free life.

Table 4-4: Disability-free life expectancy at birth and at 65, Central Region.

<table>
<thead>
<tr>
<th></th>
<th>All Residents</th>
<th>Female Residents</th>
<th>Male Residents</th>
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<tbody>
<tr>
<td>At Birth</td>
<td>68.9</td>
<td>70.3</td>
<td>67.5</td>
</tr>
<tr>
<td>At age 65</td>
<td>12.1</td>
<td>12.9</td>
<td>11.4</td>
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</table>

2.1.1 (d) Leading Causes of Death

Between 1980 and 1998, Central Region residents age 65 and older accounted for 11,820 of the 15,248 (77.5%) deaths among our residents. The leading causes of death among seniors in this time period are illustrated in Table 4-5.

Table 4-5: Leading causes of death among Central Region seniors (65+), 1980-1998.

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease</td>
<td>1206</td>
<td>1536</td>
<td>2742</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>603</td>
<td>509</td>
<td>1112</td>
</tr>
<tr>
<td>Pneumonia and Influenza</td>
<td>356</td>
<td>339</td>
<td>695</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>347</td>
<td>245</td>
<td>592</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>134</td>
<td>382</td>
<td>516</td>
</tr>
</tbody>
</table>

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.

From the consultants we spoke with, it was evident that people over 65 were less concerned about when and how they died than they were about the quality and independence they had within their remaining lifespan.

2.1.2 Morbidity

When we considered that as people age they are more likely to have health impaired in some manner, we chose to look closely at the factors that impaired the quality of life and independence of folks 65+. Injury data informed us how this factor impairs longevity, quality of life and independence. It was therefore found to be an important area to assess. While we reviewed other factors such as diabetes and hypertension, we found the factors that affected independence and quality of life included mental health diagnoses for the 65+. For this reason, we also assessed mental health in a more in-depth manner.

2.1.2 (a) Injuries

Immobility and decreased activity tend to put people at greater risk for falls and, in circular fashion, falls tend to put people at greater risk for injury. The outcome is a direct impact on independence and, predictably, on perceived quality of life for those with injuries from a fall. Injuries lead to hospitalization and mortality, both of which are significant outcomes for people 65+. As Figure 4-1 illustrates, hospitalization rates for unintentional injury increase tremendously after the age 65. Specifically, hospitalization rates increased from 1,542 per 100,000 at age 65-74 to 3,667 per 100,000 at 75-84 and then to 9,111 per 100,000 in the 85+ cohort.
Our 65+ residents accounted for 42.1 per cent of all unintentional injury related hospitalizations in Central Region between 1992 and 2001 (4,374 hospitalizations of a total of 10,400). Falls accounted for 81 per cent of the hospitalizations among our seniors. In this age group, women accounted for just under two-thirds (65.9%) of these hospitalizations. Table 4-6 illustrates the causes of injury related hospitalizations by gender and cause, however it is clear that falls are by far the most significant cause of hospitalizations in this age group. As indicated in Table 4-6, while falls accounted for just over 83 per cent of hospitalizations among elderly women in our region, they accounted for just over 72 per cent among men. Men were more likely than women to be hospitalized for poisoning, machinery injuries, burns or natural/environmental causes. It is interesting to note that among women, medication was by far the most common cause of unintentional poisoning, accounting for 83 per cent of poisoning hospitalizations. However, among men, medication accounted for just 37 per cent of poisoning hospitalizations.

Source: Manitoba Health.
Figure 4-2 illustrates the hospitalization rates by age group and gender for unintentional falls. Rates increase dramatically for both males and females at the age of 85 but rates are continuously higher in females in each age group.

Figure 4-2: Hospitalization rates due to unintentional falls, 1992-2001.

Fewer than 25 hospitalizations in the 65-74 year age group were due to self-inflicted injury (among both men and women). Men accounted for 54 per cent of these hospitalizations. Just over 62 per cent of the self-inflicted injury cases were due to poisoning with prescription medication. There were no hospitalizations for self-inflicted injury reported among residents aged 85 and older. There were fewer than 15 hospitalizations due to assault in the 65 and older age group. While some of these injury related hospitalizations results in death, not all deaths from injury are in hospital. Some individuals die without admission to hospital.

Table 4-6: Causes of hospitalizations for unintentional injuries in Central Region, 1992-2001 among the population age 65 and older.

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>2,460 (83.3%)</td>
<td>1,083 (72.6%)</td>
<td>3,543 (81.0%)</td>
</tr>
<tr>
<td>Motor Vehicle Accident</td>
<td>78 (2.7%)</td>
<td>95 (6.4%)</td>
<td>173 (4.0%)</td>
</tr>
<tr>
<td>Overexertion</td>
<td>52 (1.8%)</td>
<td>22 (1.5%)</td>
<td>74 (1.7%)</td>
</tr>
<tr>
<td>Poisoning</td>
<td>36 (1.3%)</td>
<td>43 (2.9%)</td>
<td>57 (1.3%)</td>
</tr>
<tr>
<td>Medication</td>
<td>30 (83.3%)</td>
<td>16 (37.2%)</td>
<td>46 (80.7%)</td>
</tr>
<tr>
<td>Machinery</td>
<td>&lt;5</td>
<td>39 (2.6%)</td>
<td>45 (1.0%)</td>
</tr>
<tr>
<td>Fire/Burn</td>
<td>20 (0.7%)</td>
<td>23 (1.5%)</td>
<td>43 (1.0%)</td>
</tr>
<tr>
<td>Struck by or against something</td>
<td>18 (0.6%)</td>
<td>25 (1.7%)</td>
<td>43 (1.0%)</td>
</tr>
<tr>
<td>Natural/Environmental</td>
<td>14 (0.5%)</td>
<td>19 (1.3%)</td>
<td>32 (0.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>171 (5.93%)</td>
<td>193 (12.94%)</td>
<td>364 (8.3%)</td>
</tr>
</tbody>
</table>

Source: Data: Manitoba Health, Analysis: EPI Research & Data Management.
Between 1992 and 1999, the 65+ in Central Region accounted for 123 (or 37.8%) of the 325 deaths due to unintentional injuries. Given that this age group accounts for just 14 per cent of the regional population, their over-representation in injury related deaths (and hospitalizations) is a concern.

A review of injury related deaths among the elderly in Central Region indicates that falls were the leading cause of death (39% of deaths), and that death rates due to falls increase dramatically over the age of 75. Motor vehicle traffic accidents were the second leading cause of unintentional injury death (22.7% of deaths). Overall, females accounted for 55 per cent of unintentional injury deaths. Fortunately, too few deaths among females in this time period were self-inflicted to report on, however there were 11 deaths among men that were classified in this manner. Fewer hospitalizations in the 65-74 year age group were due to self-inflicted injury among both men and women, and none were reported for those aged 85 and older.

In the 65+ group provincially, the leading causes of Injury deaths were: Unintentional Motor Vehicle Traffic, Unintentional Falls, Suicide, Unintentional Drowning and Submersion, and Unintentional Suffocation and Choking. Within the age categories, Unintentional Fractures, Cause Unspecified and Falls were in the top five. In Central Region, the story is similar as seen on Table 4-6 and Figure 4-2.

During consultation, participants agreed that increase in activity can and does impact a persons mental and physical health; telling us that inactivity and falls can interfere with independence and ability to live in the community of one’s choice. Crucial to the 65+ group is that many people choose to live at risk for falls rather than give up their independence. They choose independence despite that restricting mobility or using additional walking aids would decrease risk of falls and subsequent injury.

Some communities in Central Region are currently implementing Fall Prevention Programs. The Long Term Care continuous quality improvement team is in the process of developing a Regional Initiative on fall injury prevention. Targeting injuries rather than falls is a strategy meant to protect frail Personal Care Home (PCH) residents while limiting current activity levels as little as possible.

The impact of fall injuries alone on Central Region is significant, accounting for enough hospitalizations to fill a 40 bed hospital seven days a week, all year long. The cost to society is enormous and the fiscal cost, if spent on injury prevention alone would allow excess money to be deferred to other programs once the current hospitalization rates reduce over time. The quality of life for strengthened, well elderly living independently at home rather than in need of care after a disabling fall related injury is uncountable.
2.1.2 (b) Chronic Diseases

Among the chronic diseases reported, those considered to be of import to the 65+ in Central Region include Diabetes, Arthritis/Rheumatism and Hypertension. Mental Health is a condition in this age group that is important and will be discussed under Personal Resources, Section 3.2 in this Chapter. While not an exhaustive list, these chronic diseases were reviewed because of their negative impact on independence and quality of life for people who are 65+.

2.1.2 (b-i) Diabetes

Diabetes is a chronic disorder most prevalent in older Canadians and Aboriginal people (Health Canada, November 1999). Diabetes has been ranked as the 7th leading cause of death in Canada. Approximately 1.2 million Canadians have diabetes; it is suspected these numbers would bloom if more testing was done as it is thought that 1/3 of cases remain undiagnosed. It has been found that earlier diagnosis, lower blood glucose, lipid and cholesterol levels along with controlling blood pressure can and does reduce, or at least delay, the devastating complications that are associated with diabetes (CDA Clinical Practice Guidelines Expert Committee, 18-19 and 106-107).

Diabetes can lead to life threatening debilitating complications, such as blindness, kidney disease, nerve damage, cardiovascular disease or amputation. The burden of diabetes due to heath care costs, disability, work loss and premature death is estimated to be up to $9 billion annually. Quality of life issues for those living with diabetes, however, cannot be appraised. (Health Canada, November 1999, 1-2)

According to the 2003 CCHS, while 4.6 per cent of off-reserve Central Region residents have been diagnosed with diabetes, the rate is much higher among the elderly at 10.2 per cent. In 2001, among those age 65+, 15.9 per cent of men and 8.5 per cent of women indicated that they had been diagnosed with diabetes. Numbers in the 2003 CCHS were too small to be broken out for females in this age group; the rate among men was the same as in 2001 at 15.9 per cent. According to the 2003 CCHS, diagnosed rates of diabetes decrease slightly from 10.4 per cent among age 65-74 to 10.1 per cent among age 75+ (numbers were too small to break out by gender). As Figure 4-3 illustrates, these figures are slightly lower than identified in the 2001 CCHS. This is either due to good news – that is lower rates of NEW cases of diabetes, or bad news – mortality among those who in 2001 identified that they had been diagnosed with diabetes.
2.1.2 (b-ii) Arthritis/Rheumatism

A major cause of morbidity, disability and health care utilization, arthritis is one of the most prevalent chronic health conditions in Canada. Living with arthritis/rheumatism means living in pain and often reduced mobility. People living with arthritis/rheumatism have more than twice the number of disability days than those with other, or no, chronic conditions (Health Canada 2003, 7). The prevalence\(^6\) of arthritis/rheumatism rises with increasing age. In 2003, 18.9 per cent of all Central Region residents (age 12+) had been diagnosed with Arthritis/Rheumatism compared to 58.5 per cent of residents age 65 and older (see Table 4-7). Arthritis/Rheumatism is a chronic condition that has significant bearing on quality of life due to disability and pain impact.

Table 4-7: Proportion of 65+ residents with arthritis/rheumatism.

<table>
<thead>
<tr>
<th>Age</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>55</td>
<td>49.9</td>
<td>59.2</td>
</tr>
<tr>
<td>65+</td>
<td>58.5</td>
<td>51.4</td>
<td>64.4</td>
</tr>
<tr>
<td>75+</td>
<td>61.8</td>
<td>52.8</td>
<td>69.3</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey, Cycle 2.1, 2003.

\(^6\) Prevalence refers to the total number of people living with a disease or condition within a given population.
As Table 4-7 illustrates, self-reported rates of arthritis/rheumatism are much higher among females than males. We seem to have a high level of 65+ persons living with this disabling disease but remain unsure regarding how arthritis/rheumatism affects activity level, emotional or physiological state and ability to remain independent. Given the mobility-impairing impact of these diseases, and the reduced quality of life we postulate occurs, we are interested in seeking out further in-depth information regarding the correlation between arthritis/rheumatism, level of impairment and injuries.

2.1.2 (b-iii) Hypertension

The Heart and Stroke Foundation of Canada has reported that high blood pressure is a major risk factor in developing cardiovascular disease. The Canadian Community Health Survey (2003) identifies lower rates of hypertension for our residents (12.7% down from 14.7% in 2001), than all Manitobans combined (14.3% down from 15.6% in 2001). Rates of hypertension in residents 65+ are compared to those of Manitoba and Canada in Table 4-8. As shown, Central Region trends are similar for females 65+ who are at greater risk for developing this disease and that risk elevates with increasing age as seen when comparing the 65-74 year olds to the 75+ group.

Table 4-8: Proportion of 65+ residents with high blood pressure, 2003.

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Region</td>
<td>37.8</td>
<td>34.4</td>
<td>40.5</td>
</tr>
<tr>
<td>Manitoba</td>
<td>42.7</td>
<td>35.1</td>
<td>48.4</td>
</tr>
<tr>
<td>Canada</td>
<td>42.7</td>
<td>37.2</td>
<td>47</td>
</tr>
<tr>
<td>Central Age 65-74</td>
<td>35.3*</td>
<td>34.3*</td>
<td>36.1*</td>
</tr>
<tr>
<td>Central Age 75+</td>
<td>40.1</td>
<td>34.5*</td>
<td>44.7</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey, Cycle 2.1, 2003.
NOTE: *Interpret with caution due to small numbers leading to wide population estimates.

2.1.3 Well-Being

Health encompasses overall wellness including emotional, spiritual and physical components and how these aspects affect overall independence. The important factor for those 65+ was ‘quality of life’. People wanted life to be worth living. ‘Quality of life’ meant diverse things to different people, based on what we heard from consultation. Together the ideas seemed to be captured by the following definition:

‘Quality of Life’ – the parts of life that:
- make life worth living
- give a reason to get up in the morning
- make one feel like a worthwhile person in society
Focus Group participants were asked what gave their life purpose. Their responses included ideas encompassing:

- being involved in support groups
- helping others
- volunteering
- friends and family
- spirituality
- keeping physically active
- travelling
- having responsibility
- having control

I find that being able to work with the programs and helping others helps with my purpose in life…I need to feel I’m helping and doing something positive for other people.

I think the key word is control. How much control you have for your own situation. If you have control, life is good!

…I try to do what I can to make life better for my fellow man…We have to work together and do what you can to help others…I like it when the boys phone and ask me to go for this or that…It helps to be busy...

2.1.3 (a) Functional Health Status

Functional Health Status is a derived indicator obtained from the 2001 CCHS (2003 data is not yet available at the regional level). It measures overall functional health, based on 9 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition, memory and pain). A score of 0.8 to 1.0 is considered to be very good or perfect health; scores below 0.8 are considered to indicate moderate or severe functional health problems.

As Figure 4-4 illustrates, Central Region residents age 65+ exhibit the second highest rate of ‘very good or perfect health’ in the province. Overall, 63.4 per cent of the elderly report very good or perfect health. Within the region, a slightly higher proportion of women (65.2%) were in this positive category than men (61.1%). Just over one third of regional males (35.3%) were considered to have moderate or severe functional health problems compared to 31.9 per cent of females.
2.1.3 (b) Self-Rated Health Status

We found during our telephone consultations of Central Region residents, that 49 per cent of people 65+ rate their health as excellent or very good compared to the overall Manitoba response of 55 per cent and the overall Central Region response of 58 per cent. Analysis showed that “despite including the phrase ‘compared to others your age’ in the question wording, there is still a relationship between age and this question” (Acumen Research, 43-4). Generally, respondents’ impressions of their own health, compared to others their age, deteriorate as age advances (38). Retirees tended to see their own comparative health more pessimistically than other respondents and are less likely to characterize their health in the top ranges (38, 43).

The Canadian Community Health Survey (CCHS, 2003) also identified a trend of decreasing reports of positive health status with increasing age (see Table 4-9). For example, just over 41 per cent of residents age 65-74 report their health as “very good or excellent”. However, when we look at the total of 65 and older this reduces to just under 36 per cent and reduces further to 31 per cent for residents age 75 and older. It is interesting to note that in every age group, men were more likely to identify their health status as “very good or excellent” as compared to females (even though they have shorter life expectancy).

As Table 4-9 illustrates, there is a decrease in positive reported health status with increasing age. Rates of positive reported health status overall are just slightly lower in our region than in Manitoba overall. In both cases, slightly higher rates of males age 65+ self report their health as very good or excellent.

Source: Canadian Community Health Survey, 2000-01.
Of those responding to our Telephone Survey, we found that impressions of one’s own health deteriorated with advancing age and retirees tended to be less likely to rate their health in the top range. (Acumen Research)

2.1.3 (c) Activity Limitations

While the residents of Central Region with whom we spoke told us that activity improved their health status, even if they had chronic illnesses, the CCHS report on activity limitation due to chronic health problems indicates otherwise. Well over one-third (42.3%) of Central Region residents over the age of 65 report an activity limitation. The rates are higher among females (44.5%) than males (39.5%). These rates are just slightly lower than the provincial averages of 43.0 per cent overall and 38.7 per cent of males and 46.38 per cent of females specifically. Older seniors in the Central Region were much more likely to report activity limitation than were younger seniors. Overall, 38.7 per cent of seniors aged 65-74 reported activity limitation compared 45.9 per cent of those aged 75 and older. Supported by data in the telephone consultation, we found that in Central Region, people over 75 were more likely to have recent physical difficulties that has impacted on their normal activities of daily living than any other age group surveyed (Acumen Research).

During the telephone consultation on health, while only one-fourth of our population described having recent physical difficulties that impaired their daily activities, those aged 75+ were more likely to have had such difficulties (Acumen Research).

Table 4-9: Proportion of residents with very good or excellent self reported health.

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Region total</td>
<td>62.9</td>
<td>55.7</td>
<td>59.3</td>
</tr>
<tr>
<td>Central Region 65+</td>
<td>34.8</td>
<td>37.2</td>
<td>35.9</td>
</tr>
<tr>
<td>Manitoba total</td>
<td>60.4</td>
<td>61.1</td>
<td>60.8</td>
</tr>
<tr>
<td>Manitoba 65+</td>
<td>35.1</td>
<td>37.4</td>
<td>36.1</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey, Cycle 2.1 2003.
SECTION III: DETERMINANTS OF HEALTH

When speaking with the groups of people 65+ they rated:

- Personal Health Practices & Lifestyles and Health Services most important to their health and well being.
- Personal Resources/Living and Working Conditions and Environmental Factors also factored prominently in their answers.

‘Healthy Child Development’ is beyond the scope of this team’s assessment although many of our 65+ Focus Group Participants spoke of the importance of this factor and described their own health and happiness in relation to how well their children and grandchildren were. Culture and Gender are incorporated throughout the document where appropriate and Health Services are discussed more so than any other chapter due to their prominence in the interpretation of the Board End governing this chapter.

3.1 Personal Health Practices and Lifestyle

Many personal health practices and lifestyles have a direct impact on health and wellness. Below are a few areas that have been identified based on statistical data, population based information and professional and community input.

Our 65+ population felt that quality of life is improved by independence and living to one’s full capacity. Health promotion and lifestyle can have a significant impact on abilities and continued quality of life. It was exhilarating to discover in the recent consultations that people who were 55+ were more likely than other Central Region residents to identify health promotion as extremely high in importance, as were retirees. Females were 1/3 more likely than males to rate health promotion as extremely important (Acumen Research). Focus Group Participants supported this same finding.

3.1.1 Weights

BMI measures are available from the CCHS, which reports for the 20-64 year age group only. Therefore, measures of BMI for the 65+ are not available. Our report focuses on healthy eating rather than weights for our seniors in Central Region.
Ensuring a well balanced diet can help people maintain health. Ensuring a varied range of food intake will provide a person with all the nutrients required to remain as healthy as possible, decreasing the risks of disease. What you eat can also impact your emotional, physiological and psychological status. A well balanced diet includes five servings of fruit and vegetables per day.

Just over one-third (33.9%) of Central Region residents 65+ report consuming five or more servings of fruits or vegetables daily. However, a review of the rates by sex identifies a difference in dietary practices, with fewer men (29.2%) consuming these food groups than women (37.7%). When we look at the rates by age group, we find that 30.5 per cent of residents aged 65-74 compared to 37.1 per cent of residents age 75 and older eat the recommended five servings of fruits or vegetables daily. (Canadian Community Health Survey, 2003).

Professional Key Informants have identified dietary practices as a crucial component to overall health of people 65+. While we do not have a lot of specific data for Central Region on dietary practices, through consultation we identified the following concerns that may have a negative impact on healthy eating practices in this age cohort:

- Access or lack of access to grocery stores
- Adequate resources including income
- Living arrangements
- Loneliness
- Response to losses in life

A limitation in data that is focused on Central Region residents is recognized as a gap that we would like to assess further through a nutrition assessment. We need to look at what food choices people in this age cohort are making, and also what affects their choices both negatively and positively. We are interested, also, in the physical, personal, political and social components that affect nutrition choices for people who are 65+.

### 3.1.2 Alcohol Consumption

Over 88 per cent of Central Region seniors (age 65+) report that they never drink five or more drinks on any occasion; this is higher than the provincial rate of 81.2 per cent. More females in our region (94.1%) than males (83.1%) reported that they did not engage in “heavy drinking” on any occasion.

### 3.1.3 Smoking

According to the Canadian Community Health Survey (2003), 6.8 per cent of Central Region residents age 65 and older smoke compared to 10.0 per cent of Manitoba seniors. Please note that, due to small numbers, the rates could not be broken out by gender.

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7 This is the CCHS, 2000-01 definition for “heavy drinking”.
8 Interpret with caution due to small numbers.
3.1.4 Physical Activity

As we get older, remaining physically active is one of the most important things we can do to maintain our health and quality of life. Keeping our muscles in good condition will help us to maintain our independence. Health Canada recommends 30 – 60 minutes of moderate physical activity most days from a variety of activities for endurance, flexibility, strength and balance. The Minister of Public Works and Government Services has suggested that increasing activity, even in small amounts, can have a very positive effect on health status. Physical inactivity remains high in the 75-year old plus group according to Canadian statistics. Seniors in Central Region identified the importance of increased activity to their state of wellness.

In Central Region, the seniors concurred regarding activity; through consultations they told us that remaining active was very important to their health.

Physical activity is very important to our mental and physical health. Without physical activity I would probably just shut down. It is important to stay active. There is a definite connection between physical and mental health…I have Parkinson’s and have to keep going…The more I keep going the better…If you see some improvement in what you’ve done, it motivates you to do it more. I always feel better when I’ve done some exercise so I’m going to do it more. ⭐️⭐️

Despite knowing the benefits of activity, there are numerous reasons why people of any age might not be active. Activity limitations due to chronic health problems may be one. Yet even chronic illness is recognized by some as less disabling through participation in regular activity. Some participants told us that their health impedes their ability to choose their preferred activity, while others continue to exercise for reasons other than health.

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9 Physical Activity: Population aged 12 and over reporting level of physical activity, based on their response to questions about the frequency, duration and intensity of their participation in leisure-time physical activity. (Mb. Health Central Regional Health Profile, 71).
Data support the contention that seniors are improving their activity levels over time except in the over 75 age group, according to the ‘Interim Report Card’. Seniors aged 65 – 74 showed an improvement in their physical activity levels with 51.1 per cent reporting being physically inactive in 2000-01, compared to 54.7 per cent in 1998-99. Seniors 75+ lagged in this area and 64.3 per cent report being physically inactive in 2000-01, a little worse than the 62.5 per cent in 1998-99 (National Advisory Council on Aging, 2003).

According to the 2003 CCHS, although just over 40 per cent of elderly residents report having activity limitation, almost two-thirds (64.9%) are physically inactive. A much higher rate of females over age 65 report being physically inactive compared to males (70.5% of females vs. 58.1% of males). Figure 4-5 illustrates the changes in reported physical activity levels among the elderly between the two cycles of the Canadian Community Health Survey. Rates of physical inactivity have decreased slightly from 66.3 per cent to 64.9 per cent of elderly residents in the Central Region. Although there has been a decrease in physical inactivity, our rates remain higher than in Canada (54.2% of elderly). In addition, physical inactivity in Central Region is both higher than the Provincial and National average, and also higher than its peer group10 (60.5% of elderly in Peer Group G are physically inactive).

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10 Peer Groups are made up of regions throughout Canada with similar demographics, socio-economic conditions and working conditions.
Central Region service providers advise us that the well elderly report difficulty in finding a place to be comfortably active. Findings suggest that there are not sufficient places that are friendly and safe for the people in the 65+ age group. This idea was supported in consultation with community residents who spoke of safe places to be active. One individual suggested that with little effort some provisions could improve the situation for outdoor walkers, among whom are many of the seniors we spoke to.

For my part I find that since we’ve had…snow…walking on the street is difficult on the account it is slippery or the plows go by and there is a ridge. In summer time we have a walking path here. I’ve been using since it was done. It is really good. Since the snow, it hasn’t been opened up. I’m wondering if it could be opened up even in the wintertime. I think it would be safer to walk there. There is no traffic there. Plus there is black ice forming and I have to be very careful. If it was on a walking path there wouldn’t be those problems. To say it can’t be done, it can because the town hires up someone to clear the sidewalks; that same machine could be clearing the walking path too. If this was done I would be using it every day.
Many of the communities have seniors centres, however the well elderly didn’t feel that this was a place for them as they did not see themselves as ‘elderly’ or ‘senior’ and therefore did not access these facilities.

3.1.6 Immunizations/Screening for preventable diseases

For this population group, this indicator refers to the percentage of adults aged 65 or older who receive a flu shot. Certain groups are at increased risk for serious complications from the flu. These groups include people age 65 years and older, and people of any age with chronic medical conditions.

Fifty percent of residents 65 or older in Central Region receive the flu shot, compared to 55 per cent of residents 65 or older in Manitoba. There is a wide variation between areas within our region, with rates ranging from less than 35 per cent to just over 60 per cent. A more in-depth analysis might lead us to further information and different conclusions, as this data is wholly dependent upon accuracy of individual reports through the provincial reporting structure.

Immunization for diseases such as pneumonia or influenza is an important prevention measure and has a direct link with averting hospitalization and death in the 65+ age group. According to the ‘Manitoba Immunization Monitoring System’ (MIMS), in 2002, 27.8 per cent of Central Region residents age 65 and over have been immunized for Pneumococcal Disease. This is lower than the provincial rate of just over 38 per cent. There is some question surrounding these statistics as the recording process of those receiving pneumococcal vaccine had some flaws. The 2002 coverage for Influenza immunization is evidently higher at 53 per cent of elderly Central Region residents which is very close to the provincial rate of 54.7 per cent for the same cohort. (Martens et al, 2003).

We discovered during our Telephone Survey, that 71 per cent of Central Region respondents agreed that immunization is “the smart thing to do” (Acumen Research, 96). Evidently there is strong support for immunization in Central Region. Few (14 %) agreed that only people who are weak or frail should be immunized and 8 per cent subscribed to the view that people should only receive immunization after a doctor’s orders. Just 7 per cent think that people should not be immunized because of a possible negative reaction to the vaccine (Acumen Research, 96). The Province of Manitoba is implementing ongoing strategies to increase immunization rates in the 65+ age group.

Based on the rates of immunization in Central Region and conclusions from the Telephone Survey, our residents recognize the importance of immunization yet many 65+ do not practice this health promotion activity. Judging by views on immunization, Manitoba Health immunization programs are evidently successfully promoted, what we need to do now is find ways to ensure our residents are following through on those stated beliefs to avail themselves of immunization. We need to find out if they in fact are not, or whether they are and the data are not adequately captured. If people truly are not well immunized, we need to find ways to increase rates of immunization.
3.2 Personal Resources

3.2.1 Life Stress

Positive mental health is essential to the maintenance of quality of life and sense of well being for all individuals. Research suggests that supporting seniors to maintain their independence as long as possible is first and foremost in promoting mental wellness for them. As people become more dependent, support must to be provided in such a way that it strengthens the individual's dignity and self-respect.

Overall, 13.2 per cent of Central Region residents 65+ report experiencing ‘quite a lot’ of life stress. Among those age 65 – 74, 17.1 per cent report ‘quite a lot’ of life stress decreasing to 9.6* per cent of those aged 75+.

Table 4-10 illustrates life stress by gender. (Note: numbers were too small to break down further by age group or by gender/age group split).

Table 4-10: Life stress in Central Region residents 65+.

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>No life stress</td>
<td>23.3%</td>
<td>26.1%*</td>
<td>24.5%</td>
</tr>
<tr>
<td>Some life stress</td>
<td>55.1%</td>
<td>58.8</td>
<td>56.8%</td>
</tr>
<tr>
<td>Quite a lot of life stress</td>
<td>16.3%*</td>
<td>Not reported</td>
<td>13.2%*</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey, Cycle 2.1 2003.
Note*: Interpret with caution due to small numbers.

In reviewing statistics, 71 per cent of older women and at least 59 per cent of older men have stress that impacts their health, although we remain unsure regarding the causes of stress. RHA Central’s health professionals observe that some of the causes of stress in the older adult came from multiple losses. Examples of losses included:

- Loss of independence
- Loss of choice
- Loss of significant others
- Changes in health (mental and physical)
- Loss of life meaning and purpose
- Loss of social settings in which to belong and identify with

A look at self-inflicted injuries data helps us to see some of the impact of mental distress on some of our seniors. The ‘Injuries in Manitoba 10-year Review’ reports that men died from suicide in Central Region during the years 1992-99 at the rate of 16.5/100,000 versus 2.6/100,000 for women. However, it is very important to note that when we look at deaths from self-inflicted injuries for the elderly, the trend worsens. The rate per 100,000 for men after the age of 65 increases as it does for women. For men, 65-74 year olds died from suicide at the rate of 20.2/100,000, increasing to 27.7/100,000 for the 75-84 year olds and to 34/100,000 for 85+ year old males. This trend of increase holds true for women except in the 85+ year olds where the rate declines and where the rate is so low that it cannot be reported. It is very important to note that these rates reported are
based on very small numbers. Although self-inflicted injury is a very important issue, we must interpret this data with caution.

Reports from the United States indicate that nearly 20 per cent of those who are 55+ experience mental disorders that are not part of normal ageing. Most common disorders, in order of prevalence, are: anxiety, severe cognitive impairment, and mood disorders. Studies from the American Association for Geriatric Psychiatry suggest, however, that mental disorders in older adults are underreported.

Co-occurring mental illnesses have an impact on quality of life for seniors. We recognize that depression, anxiety, addictions, and schizophrenia of later life are highly disabling illnesses and should be considered in future assessments. A report on mental illness together with co-occurring diagnoses will be released in a Mental Health Report late in 2004. A review of what this upcoming report will and does mean for Central Region residents is recommended.

The following review of chronic mental health conditions have significant effect on the independence and quality of life of people who are 65+ including:

(a) Dementia
   (a-i) Alzheimer Disease
(b) Depression

3.2.2. (a) Dementia

“Dementia is common among elderly people, and costly to society” (Rockwood 9). As illustrated in Table 4-11, one in 50 Canadians aged 65 - 74 are affected by dementia, one in nine between ages 75 - 84, and one in three over age 85. Twice as many women as men have dementia. Half of those with dementia live in the community, half live in institutions; however, this balance varies from region to region across Canada.

While the rates of Dementia for Central Region are not yet reported outside of Personal Care Homes, we have included this issue so it is not overlooked. We have noted throughout this document that Central Region tends to be very much in line with both provincial and Canadian data for many of the findings and we intuit that the same holds true for dementia. There is one of the dementias that we felt it was particularly important to highlight in this discussion, that is, Alzheimer Disease. For example, with respect to Alzheimer Disease, Manitoba is similarly affected compared to the rest of Canada overall. The percentage of people afflicted with Alzheimer Disease in Canada versus all Related Dementias including Alzheimer is 66 per cent, while in Manitoba it is 67 per cent. Total Canadian numbers are 361,910 and 237,120 respectively.

3.2.2 (a-i) Alzheimer Disease

“Alzheimer Disease is the most common cause of dementia. It is age-associated (for example, it is rare below the age of 60, but is seen in about one person in three in those over the age of 85).…Alzheimer Disease is associated with functional dependence and
behavioural problems, the need for nursing home care is common…Alzheimer Disease is very costly, exceeding the costs for cancer and stroke combined” (Rockwood, 2001, 17).

Table 4-11: Canadians affected by Alzheimer Disease and related dementias.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cases of dementia in 2001</td>
<td>83,200</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>50,500</td>
<td>50.50%</td>
</tr>
<tr>
<td>Men</td>
<td>32,700</td>
<td>39.50%</td>
</tr>
<tr>
<td>Canadians over 65 with Alzheimer Disease and related dementias</td>
<td>364,000</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>247,520</td>
<td>67.8%</td>
</tr>
<tr>
<td>Men</td>
<td>116,480</td>
<td>32.2%</td>
</tr>
<tr>
<td>Canadians over 65 with Alzheimer Disease</td>
<td>238,000</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>194,000</td>
<td>81.3%</td>
</tr>
<tr>
<td>Men</td>
<td>44,000</td>
<td>18.7%</td>
</tr>
</tbody>
</table>

By 2011:
- New cases of dementia are expected to reach 111,600 per year.
- 67,600 will be women
- 44,000 will be men

By 2031:
- Over ¾ million Canadians are expected to have Alzheimer Disease and related dementias.

*Alzheimer Disease is the most common form of dementia; it accounts for 64% of all dementias. Over 52% of Canadians know someone with Alzheimer Disease.*

**Source:** Alzheimer Society – on line resource.

3.2.2 (b) Depression

Depression is not a normal part of ageing and tragically, depressed older adults are more likely to take their own lives. Depression is crippling for the young and middle aged adult but severe in the elderly and more often fatal. Depression kills not just through suicide; according to Health Canada. a strong association exists between various chronic medical conditions and an elevated prevalence of major depression. Several factors associated with physical illness may contribute to the onset or worsening of depression. These include psychological impact of disability, decline in quality of life, loss of valued social roles and relationships, or from medication side effects.

Recent studies indicate that by 2020, depression will be second only to heart disease as a cause of disability. This disabling disease is associated with greater losses of quality of life than many other chronic medical conditions including stroke, hypertension, diabetes, cancer, and emphysema/bronchitis (Unutzer).

Overall in Central Region, 95.4 per cent of older adults show ‘no risk’ for depression; 96.9 per cent of adults aged 65-74 and 93.6 per cent of adults aged 75+. These results were based on a question that establishes the probability of suffering a ‘major depressive episode’. This question may not have been the right one to ask, however. When speaking with health professionals regarding older adults, many felt that the risk for depression was actually quite high. When older adults were asked about depression, many people will not admit to this concern due to its negative connotations. "Older people will
basically agree they’re experiencing every symptom of depression except depression” (Gardner, 1).

Numerous literature reviews contain information on depression in older adults who are 65+. For example, it has been identified that the elderly are under-diagnosed for depression or are misdiagnosed with other disease processes such as dementia. Many (including health professionals) attribute being depressed as a normal part of ageing. Depression is very treatable in older adults. Preventive strategies are more effective and simpler than treatments and social supports are critical.

### 3.2.3 Spiritual Resources

Many of our 65+ Focus Group Participants felt that spirituality was essential to their overall health and well being. This was congruent with telephone consultation results indicating that retirees are more likely than average to say their spiritual well being plays an extremely important role in their overall daily health (Acumen Research, 55). Women expressed this more frequently than men. Men tended to be less vocal in their responses to this question.

> I absolutely believe spirituality helps your health. It relaxes you. If you meditate, you don’t think of all the other stuff. I know I have been blessed in many ways. If I didn’t have spirituality I wouldn’t be sitting here today. I find for myself if I need help I feel free to phone a friend to ask them to pray for me. To me it is helpful, it always has been. (Compiled)

> It is important to not have all the burden on our shoulders that we are responsible. I don’t see how people go through mourning and illness if people don’t have the faith to get them through. I don’t know if it [spirituality] is a guide, I just do what I do. (Compiled)

### 3.2.4 Social Support Networks

Social support information was not age disaggregated so there are no data to report for the 65+ population. However, it was noted in the mental health discussion that there is a gap in mental health supports for the 65+.
Many of our 65+ folks spoke of support when they spoke of spirituality. They spoke of support in relation to being there for their families, and they spoke of need for interaction with others as important.

During the Telephone Survey, people in our region identified the importance of having someone to talk to with 52 per cent (compared to 48% in Manitoba overall) reporting they had “someone who would listen to them all of the time”. While this is encouraging, respondents aged 65+ were almost twice as likely as the regional average to report having no one to talk to when in distress (Acumen Research, 54). This speaks once again to the well-being of our elders and how we ensure they have an environment in which they are able to feel secure and maintain their independence as much as possible.

There was a dimension to support for the 65+ population that is somewhat different than other populations. This dimension is related to needing help with daily life and the sometimes senior spouse or offspring whose life is affected by caring for the impaired loved one. Sometimes this caregiver was not a relative at all but was a loving friend who helped out as needed. Becoming a caregiver to your loved one can cause significant life

If you took the volunteer work out of this town, I don’t know what would happen.

I think some of the good things of life is having responsibilities for things important to you. Looking after your family, marrying the right girl to have a good marriage. I like to be able to have some personal satisfaction in that I’ve taken the challenges and met them fairly.

Less stress once retired. Only do so and so much every day. Don’t have to punch a time clock or report for work each morning. It is a different lifestyle that comes with age. More relaxed. Pressure is off altogether.

I find I get satisfaction from attending different church meetings or services.

Helping others helps with my purpose in life. I need to feel I’m helping and doing something positive for other people. Interacting with people gives me a boost. Interaction with others contributes to my health. We have to work together and do what you can to help others.
stress for people 65+. We learned of the concerns of elderly caregivers during our community consultations.

Evidence has demonstrated to us that caregivers\textsuperscript{11} in the community can be both rewarded and taxed. When the person cared for has dementia, it adds a layer of difficulty for the caregiver. Researchers in the Canadian Study of Health and Ageing (CSHA) interviewed more than 1,000 caregivers in 36 cities across Canada. CSHA gathered information about who these caregivers are, how they use community support services and what health problems they experience.

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“Caring for a patient with dementia at home is physically, emotionally, and financially taxing. The burden often falls on spouses or daughters, and in the middle and late stages of the disease is a full time job. Much research has demonstrated that the caregiver’s perception of the degree of burden, not the patient's actual requirement for care, is the better predictor of transfer to a nursing home. Interventions aimed at caregivers, not directly at the patient, have been successful in reducing the rate of institutionalization”. (Rockwood, 279)
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Approximately half of the people with dementia live at home, not in an institution. Of these people:

- 97% people have a caregiver
- 2.4% have no caregiver
- 29% live alone (34,800 in Canada), typically, these people have a daughter living close
- 8% have only one caregiver for support

Of the caregivers listed above some interesting statistics alert us to the burden they have: Surprisingly, only 3.4% of caregivers use respite care\textsuperscript{12}.

- 30% are employed
- 70%+ are women
- 50% are 60+
- 36% are 70+
- 24% most often are wives
- 29% are adult daughters
- Spouse-caregivers use fewer support services than sons and daughters
- The primary caregiver often receives assistance of two or more relatives or friends.

Not surprisingly, this loving investment has a cost for the caregiver. Caring for people with dementia is associated with chronic health problems among informal caregivers. Of

\textsuperscript{11} \textit{Informal caregivers-} those looking after someone with dementia, usually family or friends.
\textit{Formal caregivers-} paid caregivers, such as Home Care.

\textsuperscript{12} \textit{Respite Care:} care designed to give the caregiver a break from caregiving
informal caregivers who are helping someone with severe dementia in an institution, it has been suggested that there are a concerning number who suffer from some symptoms of depression. In Central Region we would expect to benefit from understanding more about formal, informal and respite care.

3.3 Living and Working Conditions

Where people live and what kinds of resources they have access to will shape the quality of life and health status of an individual. Focus Group participants told us that personal resources, which they saw as including access to appropriate health care resources, having family and friends around them and having a safe, comfortable place to live, were an important determinant to maintaining their overall health and independence. Many people stated didn’t they have to worry about working conditions any longer.

3.3.1 Income

Being poor, or living in financial conditions significantly different than those around you, has been identified as causing unfavourable health outcomes. There is no current specific data on income level of people 65+ although we have kept in mind that the statistics of our region often mimic Manitoba and Canada averages.

The average income of seniors in Canada has been rising since 1981. According to Unutzer, the average income of a 65+ Canadian was $17,275 in 1981 rising to $20,451 in 1997. Manitoba’s numbers were similar to Canadian statistics in 1997 with an average income being about $20,000 annually. Women and unattached seniors are more likely to have low incomes. In 1997, of all unattached 65+ individuals, 45 per cent were considered to have low incomes compared to only 6 per cent of the same cohort who were either with a spouse or an immediate family member. Women were more likely to be in low income situations than men with 49 per cent of women living in low income situations compared to 33 per cent of men (Lindsay, 101).
3.3.2 Work Life

Given that the population 65+ is, for the most part, retired, we have not further addressed this issue. Clearly, from the Focus Group information seen above, this population has not quit working. They have stopped paid work and now do unpaid work, either for a family business, or for organizations that need help. We were unable to find information regarding the health affects of unpaid work, since these people are not covered by workers compensation. We do know that mental health, from what our residents told us, is improved by continuing to give back to the community in a voluntary way.

3.3.3 Housing

Living at home with familiar people and surroundings is essential to one’s perception of independence and perceived quality of life. More than 90 per cent of the 65+ generation in Central Region do live at home. The Board of Directors of RHA Central has identified living in appropriate housing, in the community of one’s choice, as a Board End. At present there is no empirical data to support this as a concern of people in this age range, however there is personal and anecdotal information to support the importance of this Board End to the community. Living in a situation that is safe yet maintains independence close to the people you care most about is essential for ensuring quality of life in all age groups. For seniors, as they become more frail, we noted that having the supports at home to maintain independence as much as possible was likely to affect their ability to stay at home rather than to require Long Term Care.

Health service providers in our region identified concerns that they had for the clients they care for. They told us what kind of help was asked for by their clients, and where there were gaps in service and perceived need if they are to stay at home.

I needed help putting the bags in the fridge more than anything and one day a woman was there and I asked her to help put them in the fridge. She said she couldn’t because she wasn’t asked to. - The client needed more than medical help she needed help with her daily living. It isn’t health care we need help with. In the city they help clean the house and other things. They come to help me with the things I can do myself, but they don’t help me with what I need. §

The assessment team wondered about some issues surrounding the kinds of assistance our population needs in order to remain at home rather than going into an institution. While no answers were readily available at this time, the team identified the potential to review some of these issues in the future. Any further discussion regarding health services, for the ‘Elderly’ population is found at section 3.6, Health Services.
3.4 Environmental Factors

3.4.1 Physical Environment

People in the 65+ age group expressed concerns over the quality of water and air. While they didn’t express first hand knowledge of contamination so frequently, we heard of perceptions of poor health resulting from poor air or water quality. The perceptions are not born out by our regional statistics for cancer and asthma as some of our residents seemed to be concerned about. With perceptions such as those expressed here, it seems that an education session for the community regarding real information would benefit the health of some of our residents who lack a sense of security about this issue. This education could include a discussion about water and air quality, water sources, treatment and real cancer and asthma statistics such as are shown in this documents. For those who feel it is necessary to buy drinking water, there could be some benefit in proving the quality of their water through a sample testing of tap water.

We live near a waste dump and there was one day when the wind was coming and we had to close everything. I couldn’t breath from the smell. Everyone who has something contaminated in the area sends it there. My throat was burning from it. They said it wasn’t harmful, it would be better in a month. When everybody sprays it affects us. You smell it in the air. The farmers do that and there is nothing you can do about it.

The pig operation is near our place and sometimes we sniff some things that are not good for our health.
I am very concerned about our air and water quality. I don’t know how safe the water is but we buy distilled water just in case. I’m becoming very pessimistic about it. Our river in the fall, we walk over it every day but when you think the river water is what comes out of our taps, you wouldn’t think of drinking it when you look at it in the river. And the river is so low anyway. I know they treat it. You can smell it in the air after the plane has gone over. There has been an increase in cancer in this area, at least I feel there is an increase, and an increase in chemical use. I’m wondering if there isn’t a connection there.

Not everyone was worried about these environmental factors. Some expressed the need for more healthy living practices as compared to environmental concerns.

3.5 Healthy Child Development

Seniors in Central Region expressed more concern about the health of their children and grandchildren often than they did about themselves.

I received a newsletter, on health and nutrition today. They have done a survey and say this is everybody’s worry when they should be more concerned with eating the proper foods, not eating too much fat; because it has not been proven chemicals are harmful but it has been proven that fats are harmful. Yet people worry about this more.

There are a couple [of lifestyle choices] that really it is a lifestyle you take on yourself and no one can control but you, yourself. But if you have a healthy childhood it affects you later on. Like smoking.
3.6 Gender

While the seniors in focus groups did not raise gender as a particularly important factor, there was some concern regarding women’s breast health. In some ways the concern was related to culture. Most other aspects of gender related to this assessment have been discussed in the sections on injuries related to discrepancies in mental health or in the men and women chapters respectively.

3.7 Culture

There were some seniors who felt that culture was important to their health. They described anything from a culture of having Mom at home to look after the kids versus going out to work, to having the freedom and capability of speaking a given language other than English in the home. Others spoke of the culture of religious adherence as important in the culture realm for staying well.

The older you get, the more important it [culture] becomes.

To have the program in French when you go to the hospital different kinds of information like books or pamphlets in French. I had cancer one time and there was nothing in French. We made surveys and it seems they still don’t have information in French. It is a challenge and frustration.
3.8 Biology and Genetic Endowment

A surprising number of respondents in our focus groups answered the question regarding which determinant of health is most important to their health with a discussion regarding biology and genetic endowment. They most often referred to it as ‘Inherited health traits’.

My uncle had 12 children and they all died of the heart problem. 
…I took a seizure…It was then I found out my grandmother took seizures. 
I knew that but it never dawned on me it would affect me but I guess it did. 
…there is an inherited heart factor, rampant on one side of the family…People in the family have adjusted lifestyles as a result of this. (Compiled)

3.9 Health Services

Despite the focus of this health assessment on the health of the population rather than services, clearly this particular population felt very strongly about health services, and wanted to have a say. Some of their concerns are shared, as are the concerns of health service providers regarding specific services for this population group 65+. In addition to this factor, the RHA Central Board of Directors has, as a reasonable interpretation of the Board End for Seniors, some implication of service delivery. There is incorporated in the Board Ends, a statement regarding independence, housing choices, and support for care giving roles. For all of these reasons, the following discussion is appropriate despite health, rather than service focus, of this assessment.

As one ages, there increases a likelihood of gaps in one’s health. The group of 65+ seniors seemed to be in tune with this as, during our focus group conversations, they identified health service needs as the single most important determinant of health for them. These expressed needs were categorized as physician access, continuity of care and service provision.

3.9.1 Availability of physician

There were individuals who told us that having a physician available was the single most important health determinant for them. They spoke of how the factors they would choose have changed over time. Almost 88 per cent of our elderly residents told us that they had contact with a medical doctor in the past 12 months, not surprising since the likelihood of contact with a medical doctor does increase with age. In every age group except 75+, women were more likely than men to have contact with a medical doctor. Age 75+ is the only age group where likelihood of visiting a doctor decreased among women, while among men, the proportions increased with every age group (Canadian Community Health Survey). The following excerpts capture the ideas that were expressed by many 65+ folks.
There were others who spoke highly of the access to physicians that they do have, and how this is important to them.

I’m just realising how priorities change. I’ve always thought physical activity is right at the top. But once you can’t do it then something like availability of a physician comes into play. And to me, right now, that is quite important.

Last summer we wondered if we were going to have a doctor. If we didn’t, we would have to move. I need a doctor all the time...It is great to have doctors here now. At the time I made some phone calls and wondered if I should start packing my china but they said not yet. We were hopeful. We had a committee here working hard to get doctors and they did get doctors.

We have services just as well as they do in Winnipeg. I’m quite pleased with here.

We’ve got good service here. I feel satisfied with what we have here. It could be improved but it is good.

Here we can’t complain, it is very good. But if you have to go to Winnipeg for an operation, it takes six months before you can see anybody. You hear of stories sometimes when you have a bad disease and you have to wait months to see a specialist.

3.9.2 Continuity of Care

While having a physician was important to many people, having a care provider that one knows was seen as more important for some. They spoke of having a care provider who knew them well and in whom they could place their trust. For some this could be a nurse or other practitioner with a physician available for treating only the more difficult illnesses.

We here in this area are changing physicians all the time. You just start to get to know one doctor and then they are gone only to start over again. I do not have anything that demands a physicians attention at all times but my husband does. He needs to be in contact with the doctor. This is something really lacking, consistency.
Care providers agreed with the sentiment regarding continuity. When a local physician was interviewed regarding the high rates of preventive care in a particular area of practice, the response spoke to the quality of care provided in a stable, shared family practice, with respected colleagues. The result was access to continuity of care, periodic exams that follow the client through risk assessment and treatment, and resultant reduced risk for the client.

However, in the telephone consultation, folks told us that they know where to go to address their health concerns, and are able to access health care when needed (Acumen Research, 72). Quite a number of people felt that Community Services such as Public Health or Mental Health were extremely important with females attaching a higher importance to community services than did males. Clearly, while folks in Central Region feel that physician or other health profession services are important, they are quite secure in having that service in our region and know how to access it.

3.9.3 Service Provision

For people who have health gaps, and for those who are frailer, ability to stay home, despite challenges was important. Some identified that staying at home was where they remain the most well with respect to quality of life. Ability to stay home, we were told, is dependent upon supports available. The supports important to these individuals are Home Care and Personal Care Home (PCH) Supply and Wait Times.
In Central Region, three quarters of the Telephone Survey participants assigned high importance to Home Care and Personal Care Home and a high number of Home Care and Personal Care Home users reported a positive experience.

Although there has been a significant increase in both rates of open and of new Home Care cases in Central Region, the rates remain lower than the provincial averages. Approximately 2,948 people (2.3%) access Home Care in our population.

The supply of Personal Care Home beds decreased in Central Region from a total of 842 beds in 1996 to 813 beds in 2001. Evidently there is a connection between current supply and demand. Together with the decrease in beds, the median length of waiting in a hospital bed before admission to a PCH, has decreased in the Central Region. From a median wait time in 1994-1996 of 15 weeks with 842 beds, we have decreased to an average of 11.29 weeks by 1999-2001 with 813 beds. However, the current wait time is still higher than the provincial average (8.86 weeks) and was ranked as the third highest wait time among all Manitoba Regional Health Authorities (RHAs) from 1999-2001 (Martens, Fransoo, et al, 2003, 196-99).

The PCH admission rate increased from 23.66 admissions per 1,000 residents age 75+ from 1994-96 to 29.60 per 1,000 from 1999-2001. This increase represents a change in ranking among all 11 RHAs from eighth to fourth in PCH admission rates. RHA Central’s admission rate was almost identical to the provincial average rate of 30.00 per 1,000 in the second time period. Once admitted to a PCH, our residents stay about two and a half years (Martens, Fransoo, et al, 2003, 270).

| Table 4-12: Median length of stay (years) in Personal Care Home by level of care. |
|---------------------------------|---------|---------|---------|---------|---------|
|       | All levels | Level 1 | Level 2 | Level 3 | Level 4 |
| Central 94/95-95/96             | 2.69    | 7.52    | 2.98    | 1.99    | 1.22    |
| Central 99/00-00/01             | 2.49    | *       | 3.27    | 1.59    | 1.41    |
| Manitoba 94/95-95/96           | 2.55    | 8.09    | 2.75    | 1.92    | 1.29    |
| Manitoba 99/00-00/01           | 2.30    | 7.26    | 2.79    | 1.87    | 1.53    |

*No Level 1 cases reported.
SECTION IV: KEY FINDINGS

4.1 Observations

The team tasked with assessing the health of seniors in Central Region found the title 65+ to be more appropriate for this population of our residents. We acknowledged that health includes many aspects that may be different to different people, and that for our 65+ cohort, the most important aspect is ‘quality of life’.

The 65+ CHA Team found that:

- Quality of life has the most important impact on the health of people 65+.
- Injuries and chronic diseases impair the health status of people 65+ in Central Region.
- People 65+ think their health is quite good and is affected by health services, most importantly, continuity of caregiver.

Clearly, quality of life issues include independence and having meaning to life. Injury causes serious effect on the quality of life of many 65+ residents. Chronic diseases affect the life and health of our Elderly, including the effects of various mental health disorders.

Folks 65+ and some of their informal and formal health service providers have told us that appropriate social supports can help the elderly be the best they can be in this phase of their life. We’ve heard that Seniors would have better health care if they had continuity of care, regardless of whether the continuous caregiver was a nurse, doctor or perhaps other appropriate service provider. Seniors have told us quite strongly that alternative care professionals will give the community confidence in the service they receive.

Some specific concerns for the 65+ residents include:

- Injury from falls, especially in the 85+ elderly, has a high cost to Central Region residents, including direct effects of impaired mobility, independence, and overall cost of health care.
- Diabetes among the elderly is much higher than in other age groups and has a significant effect on quality of life and on independence.
- The well-being of their loved ones, particularly while responsible for helping to care for the seniors in their lives, is very important to our 65+ folks.
- Are the rates of immunization accurate for our 65+ population? If so they could be improved.

4.2 Considerations to aid our 65+ population to be “as health as can be!”

- Persons 65+ could benefit from community/RHA partnerships targeted at increasing opportunity for physical activity which in turn could strengthen seniors, reduce injuries from falls, and improve quality of life for this cohort.
Diabetes screening, education for prevention and stabilization would help keep the seniors ‘as health as can be’. Understanding the link between nutritional status and diabetes would help us to appropriately target interventions.

We could determine immunization programming for seniors with a better understanding regarding actual immunization rates as well as what prevents people from being immunized in this age cohort.

We wonder:

- How can we better support the caregivers of the elderly and frail population of this age group?
- Would improved nutrition lead to lower rates of diabetes?
- How we can prevent Disease and Injury to improve life and health for those 65+
- Would more information regarding nutritional status of Central Region residents help us to determine what, if any, programs might help to improve gaps in nutritional status? Knowing about individuals’ food choices, including what affects their choices could help us.
- What, if any, correlation there is between arthritis/rheumatism, impairment and injuries.

The 65+ Team noted that in Central Region, we have strong seniors who exhibit the second highest rate of ‘very good or perfect health’ in the province and are very supportive of families and youth. The seniors in Central Region are crucial to the quality of life and health of all individuals in Central Region. By keeping our seniors active and strong we can improve their daily quality of life and independence with a benefit of reduced cost to the health care system.
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Aboriginals

“Aboriginals in Central Region are as healthy as can be!”

ABORIGINAL SHAPE TEAM:

Claudette Lahaie  Sheldon Hiltz  Kristal McKitrick-Bazin
Dorothy Doell  Paulette Goosen  Kathryn Penner
Dr. Ken Parker  Jeannie Marion  Barb Cameron
Ivan’s Story

“Ivan’s Story” is a booklet written by Dr. Gilles Pinette, a Métis from Manitoba and a practising physician. He tells the story of Ivan Onespot, an Aboriginal person living with diabetes. In this excerpt Ivan is consulting his Uncle Terry, a well respected Elder in his community, about his diabetes. His Uncle Terry begins by saying:

For years our people have lived off the land. We only took what we needed to survive and did not waste anything. We also needed to work to get our food. All that has changed now. We can get a meal in less time than it takes to make toast. We no longer have to spend all our days hunting, fishing, and farming for food. We buy food that is made of ingredients that we can’t even spell. We need to take these traditional teachings and use them in modern day. We need to do this to control sugar. We need to do this to give hope and leadership to our children.

First, you must remember balance. Remember the teaching of the Medicine Wheel. You must find a balance between your own physical, emotional, intellectual, and spiritual health. Food and water are essential to maintaining the life within this circle. When people are out of balance in one of these ways, their health suffers. To heal ourselves, we must try to regain the balance in our lives. Food is not a bad thing. It is sacred. We must respect the power of the food and the life it helps us sustain. When we abuse that power and overeat or are careless with what we put into our body, we may suffer the effects of this.

Traditionally, our people ate a variety of foods that provided us with all the nutrients we required. Most foods that were prepared were made with lean wild meat and low in fat. Grains, berries, vegetables, corn, and beans were important parts of our diet. Our people were active daily. We laughed often. We did not regularly use salt, alcohol, or caffeine because these were not part of our way. We ate only what we needed. We did not sit down for three square meals per day, but instead ate smaller meals and snacks throughout the day as we hungered. Overeating was frowned upon. We cleansed our body by drinking lots of cool clean water.

Ivan, I know that you can find the balance in your life. You must start with one step at a time for your journey.
Chapter 5

Aboriginals

SECTION I: ASSESSING THE ABORIGINAL PEOPLE OF CENTRAL REGION

1.1 The Assessment Process

Ivan’s story demonstrates how traditional views, incorporating the Medicine Wheel along with the corresponding concept of balance, can be a natural and useful approach to teaching health concepts and addressing health issues among the Aboriginal people.

This excerpt is equally important in demonstrating the importance of Elders – respected people in the community who have the credibility to share their wisdom and knowledge, relating their message to familiar cultural traditions and practices to deal with current problems.

The Community Health Assessment (CHA) began by establishing an in-house Aboriginal assessment team, one among seven assessment teams. We were charged with a mandate from RHA Central to gather and interpret data on the health of the Aboriginal people in Central Region.

In gathering data, the assessment team relied heavily on three sources of data in addition to the sources listed in the introduction of this document. The first was a variety of research papers and studies undertaken in the relatively recent past which purported to assess the health of Aboriginal people. These studies, listed in the bibliography, were an invaluable source of information.

The second source was surveys that RHA Central commissioned as a part of the larger regional assessment, particularly a Telephone Survey and Focus Group meetings. Although these were done for the total population, Aboriginal-specific data were analyzed and have contributed to this report.
The third valued source of information was provided through Key Informants interviewed by the CHA team. A variety of individuals in each community extended themselves repeatedly to facilitate this assessment process. Although the individuals varied from one locale to the next, we had exceptional participation from Chiefs, Band Counsellors, Health Staff, Elders, local schools, Committee Members, and other interested individuals. Each contributed or confirmed a perspective of health that personalized and completed information available to the assessment team.

1.2 Demographic Overview

The Aboriginal population in Manitoba constitutes between 10-12% of the population, a proportion much higher than other Canadian provinces with the notable exception of Saskatchewan. In Central Region the population is spread across six First Nations communities as well as in various non-Aboriginal communities with Portage la Prairie housing a significant off-reserve and Métis population which comprise 18 per cent of the population (City of Portage la Prairie Strategic Planning).

One of the challenges in gathering demographic data on Aboriginal people is the variation in numbers from the various data sources. This is complicated by the fact that people move freely from reserve, to another community and back again depending on their personal circumstances.

Broadly speaking, a First Nations person may be registered with a given Band and counted in their census but may or may not be physically present in the community. Members living off-reserve can vary from one-third to one-half at any given time or given community. This results in a significant population of First Nations people living in town who have a health profile similar to on-reserve people but with differing issues, access to treatment, and follow up.

This environment is further complicated by people of Aboriginal ancestry who are non-status. They may live on reserve through marriage, or live off reserve in another community but, for some historical reason, do not have status with one of the Bands. Central Region has a significant registered Aboriginal population, many of whom have specific, and sometimes chronic, health issues. Almost 10 per cent of our population self-identifies as Aboriginal in surveys. This number appears to under-represent the true demographic. For example, our six Aboriginal communities comprise over ten-thousand (10,000) population as demonstrated in Table 5-1. In addition, there are 1,822 Métis registered with the Portage la Prairie Manitoba Métis Federation (MMF) and approximately 3,600 registered off-reserve First Nations people in urban Portage alone. These latter numbers do not count the previous populations outside of Portage in our many other off-reserve communities. Although at times considered a single group with common demographics, the Manitoba Aboriginal population is a large and diverse people with differing cultures, languages, traditions, and lifestyles, both in First Nations communities and in urban centres.

In Central Region, Aboriginal peoples with registered status who live in one of the six First Nations communities in the region share a bit of history. Three of our six communities, Swan Lake, Long Plain, and Sandy Bay all derived from a single band, the
Portage Band, which split into the present three communities following an unresolved debate over leadership in 1876. The Roseau River band, also Anishinabe, share a common language, Ojibway, and many customs with the descendants of the Portage Band.

The two remaining communities, Dakota Tipi and Dakota Plains, share some common traditions with each other and also share a common language, Dakota. The Tipi and Plains Dakota now occupy separate reserves within Central Region.

Manitoba Health provides a breakdown based solely on whether an individual lives on-reserve. There is no information captured about those people who are living off-reserve even if they are registered First Nations, Inuit or Métis. The 2001 census provides information about the number of Central Region resident who self-identify as “Aboriginal” (this is defined by Statistics Canada as “North American Indian”, “Inuit” or “Métis” and/or those who report being a Treaty Indian or Registered Indian). According to the 2001 census, 9,240 residents (9.8%) of the Central Region were identified as Aboriginal compared to just over 13% of residents of the province overall. It is likely that the Inuit population of the Central Region is very small as only 365 people in the entire province of Manitoba identified themselves as Inuit.

According to the Manitoba Centre for Health Policy (MCHP), in 1998, the population of Registered First Nations people living in Central Region was 5,919 which was just over 6 per cent of the total population. Just under 7 per cent of all Registered First Nations people in Manitoba live in this region.

Over half (52%) of the Registered First Nations population in the Central Region was under the age of 20 in 1998. For all other residents of the Central Region, the population under the age of 20 accounted for less than one third (29%) of the total population in 1998.

Just under 66 per cent of Registered First Nations residents in the Central Region lived on-reserve (total of 3,900) and 34 per cent lived off-reserve (total of 2,019).

For purposes of this Community Health Assessment, the Aboriginal population in Central Region is being viewed as large, with exact numbers clearly uncertain, and as three separate groups. There are Registered First Nations people who live on-reserve, Registered First Nations people who live off-reserve, and Métis people who have their own culture and traditions and see themselves as distinct from both the Registered First Nations people and from the rest of the population. We have had no self-identified Inuit people in our population at this time although we have been told that there are some Inuit living in our region. The data sources in some cases differentiate between the three groups we discuss, and in some cases do not. Where possible, the differentiation in information is made available and identified in this report. Each group of the three has health issues that need to be identified and addressed by the health care system. A brief sketch of the six reserves are summarized in the following Table 5-1:
Overall, when compiling the data from multiple sources, it appears that just under 66 per cent of Registered First Nations residents in Central Region lived on-reserve and 34 per cent lived off-reserve.

1.2.1 First Nations People

The population age grouping of First Nations people appears remarkably different from that of the rest of the population. The following population pyramids (Figure 5-1 and Figure 5-2) demonstrate in stark terms, the difference between all Manitobans and all First Nations, and then the differences between the population of Central Region and that of the Dakota Ojibway Tribal Council [DOTC] which incorporates the First Nations people of Central Region (Martens, 2002, 38-42). These charts demonstrate the claim that “RHAs having overall populations with the best health status also tend to have Registered First Nations populations with the poorest health” (52). Central Region off-reserve Premature Mortality Rate (PMR) is one of the best in the province while the PMR for the DOTC is the poorest in the province.1

While Manitoba, in general, has a central bulge moving through the population that is commonly referred to as the “Baby Boom”, the First Nations population lacks this bulge and is truly a pyramid. The bulk of the population is at the youngest ages, diminishing as the population ages. This is significant in that the service demands between these two peoples will vary according to age groups, whether the issue is health care, education, or other social services. This also graphically demonstrates that while Aboriginal people live into old age, they do so in much lower rates than the overall population.

Source: Compiled from a variety of sources including on-line and Band informants.

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1 Standardized rates.
Figure 5-1: Population profile of Central Region December 31, 1998 – Population 97,068.

Source: The Health and health Care use of Registered First Nations People living in Manitoba, Manitoba Centre for Health Policy.

Figure 5-2: Population profile of Dakota Ojibway Tribal Council December 31, 1998 – Population 5,227.

Source: The Health and Health Care use of Registered First Nations People living in Manitoba, Manitoba Centre for Health Policy.
1.2.2 Métis

The Métis are a people of mixed blood, white and Indian, who, over a period of several centuries, developed into a people with a culture and traditions separate from both of their founding peoples. A distinct language, called Michif, also developed based largely on a mixture of French and Cree.

In Central Region, most Métis trace their ancestry back to the fur trade, with their cultural practices well established long before the land was surveyed and settled by a wave of immigrants from Europe. Recent court decisions, along with inclusion as a people in the Canadian Constitution, have given renewed spirit and pride to the Métis in Central Region as reflected in the growing membership in the MMF. (Table 5-2)

Table 5-2: Manitoba Métis Federation membership statistics August, 2003.

<table>
<thead>
<tr>
<th></th>
<th>Amaranth</th>
<th>Portage</th>
<th>St. Ambroise</th>
<th>St. Eustache</th>
<th>St. Marks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>73</td>
<td>1227</td>
<td>192</td>
<td>300</td>
<td>30</td>
<td>1822</td>
</tr>
</tbody>
</table>

Source: Manitoba Métis Federation Portage la Prairie.
SECTION II: HEALTH STATUS OF CENTRAL REGION ABORIGINAL PEOPLES

2.1 Overall Health Status

In Central Region, First Nations people living on-reserve can expect health outcomes to differ from both their peers who have moved away, as well as from the rest of the population in Manitoba. It is relevant to note that life expectancy of the off-reserve group is different than that of those who remain in their First Nations community as noted in Table 5-3.

Studies by Kliewer, Mayer and Wajda have suggested that the health profile of the Métis people of Manitoba is closer to that of the First Nations people, than it is to the general Manitoba population.

2.1.1 Mortality

Research shows that there are several broad indicators that are accepted measures used to compare health status among populations. These indicators are the premature mortality rate (PMR), the potential years of life lost (PYLL) and life expectancy. These three indicators together help us measure health status and compare it with others, both within Central Region and from one region to the next.

2.1.1 (a) Premature Mortality Rates

Premature mortality rates count all deaths that occur prior to the age of 75. This is considered the best single indicator of the health status of a population. Populations with higher PMRs also have poorer health overall and higher need for, and utilization of, health services. (Martens, 2002, 52).

Between 1995 and 1999, the standardized PMR for First Nations residents of the Central Region was 8 deaths per 1,000 age 0-74, this is much higher than the rate of 3 deaths per 1,000 for all non-First Nations residents of the region. In fact, as Figure 5-3 and Figure 5-4 illustrate, the PMR for non-First Nations residents was one of the lowest in the province in this time period, but when we look at First Nations residents, the opposite is true.

Table 5-3: Life Expectancy of RHA Central First Nations versus Non-First Nations.

<table>
<thead>
<tr>
<th></th>
<th>First Nations</th>
<th>Non-First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>66.71</td>
<td>76.83</td>
</tr>
<tr>
<td>Female</td>
<td>71.06</td>
<td>81.92</td>
</tr>
</tbody>
</table>

Source: Martens: Manitoba Centre for Health Policy, 2002.
Figure 5-3: Standardized premature mortality rates, non-First Nations residents, 1995-99.

Source: Manitoba Centre for Health Policy: Health and Health Care: Manitoba First Nations.

Figure 5-4: Standardized premature mortality rates, First Nation residents, 1995-99.

Source: Manitoba Centre for Health Policy: Health and Health Care: Manitoba First Nations.

Note: South Eastman and Churchill RHAs are not included due to small numbers.
When we look at rates specifically for First Nations living on and off-reserve, it is apparent that First Nations living on-reserve in the Central Region experience a significantly higher PMR than those living off-reserve (8.51 per 1,000 versus 6.84 per 1,000). In fact, while the regional off-reserve PMR is almost identical to the provincial off-reserve rate of 6.82 deaths per 1,000; it is the on-reserve PMR (8.51) that is significantly higher than the provincial rate of 6.51 deaths per 1,000. (Martens, 2002, 53).

2.1.1 (b) Potential Years of Life Lost

Another indicator of health status measures the potential years of life lost by taking into account the age at which a person dies. It is a measure of how many years of life are lost in a population as a result of deaths prior to the age of 75 years. For Central Region overall, this number is low in comparison to our provincial counterparts. However, when we look at the PYLL of our First Nations, the opposite is true.

As Table 5-4 illustrates, the comparative rates of PYLL are much higher among the Central Region First Nations population than among the non-First Nations. That is, deaths prior to the age of 75 accounted for just under 178 years of potential life lost per 1,000 First Nations males compared to non-First Nations males at less than 59 PYLL. For women, the same pattern holds true with 94 years of potential life lost per 1,000 First Nations females compared to less than 34 PYLL for non-First Nations females.

<table>
<thead>
<tr>
<th></th>
<th>First Nations</th>
<th>Non-First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>94.33</td>
<td>33.35</td>
</tr>
<tr>
<td>Male</td>
<td>177.74</td>
<td>58.14</td>
</tr>
</tbody>
</table>

Source: Manitoba Centre for Health Policy: Health and Health Care: Manitoba First Nations.

2.1.1 (c) Life Expectancy

Life expectancy is a measure that projects the life expectancy of a person at birth. Life expectancy for a First Nations person living in Manitoba is eight years shorter than it is for other Manitobans. This figure, while dramatic, has been shown to be consistent with National studies of Aboriginal people, with the difference being smaller for urban Aboriginal people and greater for those who live on reserves. (Martens, 2002)

According to the Manitoba Centre for Health Policy, the life expectancy of First Nations males in Central Region, at birth, is 66.71 years (compared to 76.83 for all other RHA Central males) and 71.06 for First Nations females (compared to 81.92 for all other RHA Central females). As Table 5-3 illustrates, life expectancy is longer for First Nations living off-reserve in the Central Region than for those living on-reserve.

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2 Standardized
2.1.2 Morbidity

The Community Health Assessment Team identified a list of key health issues which were prevalent in literature reviews, our interviews with the Aboriginal population of Central Region, and confirmed by professional health providers as well as data sources.

Some sources of data refer to ‘disease burden’ rather than ‘illness’ as an indicator of health status in a population. The MCHP found three conditions to be causing a problem for the First Nations communities. These conditions are injuries, and such chronic diseases as diabetes, and hypertension. These conditions are included in the following discussion of ‘disease burden’ among the First Nations people. We have learned that there are similarities among the other Aboriginal populations with regard to ‘disease burden’. Although the rates may vary, we understand that the burden is higher throughout the whole Aboriginal population than for non-Aboriginal peoples.

2.1.2 (a) Leading Causes of Death

One of the leading causes of premature mortality among our Aboriginal peoples is injury. As Figure 5-5 illustrates, the standardized injury hospitalization rate among first Nations in the Central Region at 33.8 hospitalizations per 1,000 is one of the highest in the province. As with PMR, rates of injury hospitalizations are much higher among First Nations living on-reserve (37.1 per 1,000) than for those living off-reserve (27.7 per 1,000) in Central Region. Causes of injury hospitalization are available for the First Nations population as a provincial summary. On a provincial level, 31.6 per cent of First Nations injury hospitalizations between 1995 and 1999 were for “violence to self” or “violence by others”. This compares to 10.4 per cent of hospitalizations for non-First Nations residents of Manitoba.
2.1.2 (a-i) Injuries

The message regarding injuries among Registered First Nations (RFN) people in Central Region is sombre. Injury rates are significantly higher for Dakota Ojibway Tribal Council (DOTC) RFN than for other Manitobans in Central Region. The rate is 3.3 times higher for the RFN in Central Region.

The report on “Injuries in Manitoba: a 10-year review” provides us with a picture of the gravity of injuries for the RFN in our Region. We are unable to give a full picture of this ‘burden’ among all Aboriginal peoples, but the RFN data gives us a clue to the severity of the issue.

For example, RFN injury deaths from 1992-1999 are higher at a rate of 126.6 compared to 88.1 for all other Manitobans, with suicide topping all other forms of injury death, followed by Motor Vehicle traffic injuries. RFN suicide rates at 29.8 compare to 19.1 for all Manitobans. “First Nations Manitobans were about 1.7 times as likely to die as the result of suicide than were other Manitobans” (Manitoba Health, 2004, 180).

The story for injury hospitalizations is similar to deaths, with RFN more likely to be hospitalized for injuries than all Manitobans. There are concerns for these injuries and deaths within certain age categories that are discussed further within the chapters for males and for children. However, it is important to note that violence is the leading cause of injury hospitalization. According to Martens (2002), violence by others at 17.1 per cent together with violence to self at 14.5 per cent compares to main cause of injury falls at 48 per cent in the rest of the population. For all other Manitobans, violence by others...
rated at 4.1 per cent and injury to self at 6.3 per cent. This same report tells us that “RFN living “off-reserve” have higher rates of violence by others compared to those living “on-reserve” (20.6% versus 15.1%).” (78).

### 2.1.2 (b) Chronic Diseases

#### 2.1.2 (b-i) Diabetes

Diabetes is a major health issue for the First Nations population. Diabetes is 4.2 times more prevalent for Registered First Nations people compared to all other Manitobans. It is very important to note that Central Region has the highest\(^3\) Diabetes treatment prevalence in the province at 6 times that of all other Manitobans. According to the MCHP First Nations Report (2002, 64), this rate is highest for ‘on-reserve’ RFN and for some RHAs, the difference is as much as 50%”. Central Region is among these high rates. Upon review of the Manitoba First Nations Regional Health Survey, it is of particular interest that half of the First Nations people in Manitoba report diabetes as a major health condition.

In regards to the Métis population, the incidence of diabetes among males and the general population of Manitoba was similar, however, the incidence in women was higher. The incidence of diabetes among Métis 65-74 years of age was in epidemic proportions with 36.6 per cent of males and 40.0 per cent of females having the disease. However, the study done by Kliewer, Mayer and Wajda (2002) was limited predominantly to Interlake Métis and there is some question regarding the ability to apply the results to the Central Region population. Future studies linked to other regional data sources may further flush out the true diabetes rates among all our Aboriginal populations.

Diabetes is a largely preventable disease that is increasing in prevalence in Manitoba, and among First Nations populations in particular. The disease can be prevented or the outcomes improved through proper diet, adequate exercise and maintenance of appropriate body weight. Diabetes, if unmanaged, can have a significant impact on quality of life and can ultimately lead to serious disabilities and premature death. The MCHP uses a measure of diabetes treatment prevalence\(^4\) as a proxy measure for the disease prevalence in a population. Between 1996/97 and 1998/99, individuals were counted in the diabetes prevalence calculations if they had at least two ambulatory visits

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\(^3\) Standardized, age adjusted rate.

\(^4\) Numbers of individuals living with the disease
to a physician or one hospitalization with a primary diagnosis of diabetes. In Central Region, the crude diabetes treatment prevalence was 158.3 per 1,000 among First Nations residents, much higher than the rate of 40.3 per 1,000 among non-First Nations residents. This means that in the three year time period examined, greater than one out of every ten First Nations residents living in the region was living with diabetes. Given that many cases of diabetes are not diagnosed and many others may not be treated due to individuals not seeking treatment, true rates of diabetes are likely much higher.

In conjunction with increased incidence of diabetes there are a number of related illnesses associated with this disease, those being hypertension, amputation, heart disease, circulatory problems, loss of vision, and obesity. All of these are higher in the Aboriginal population than the general population.

2.1.2 (b-ii) Hypertension

The story for hypertension is the reverse of that for diabetes or injuries. In Central Region, the DOTC rate of hypertension prevalence is lower than the Manitoba ‘on-reserve’ average and lower than the rate for other Central Region residents (See Figure 5-6). However, since these rates are related to treatment of hypertension by a physician, it is unknown whether the actual rates of disease differ in the population for those who have neither been assessed nor treated for the disease.

Figure 5-6: Standardized hypertension treatment prevalence rates in First Nation populations age 25+, 1196/97-1998/99.

Source: Manitoba Centre for Health Policy: Health and Health Care: Manitoba First

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5 The crude rate is the true rate of an event in the population, before adjustments are made for age distributions in populations that allow for comparisons between populations.

6 Prevalence refers to the total number of people living with a disease or condition within a given population.
2.1.2 (b-iii) Amputation

Martens et al (2002) define amputation prevalence due to diabetes thus:

This is the number of lower limb amputations due to diabetes, per thousand persons in the region (including both diabetics and non-diabetics) ages 20 through 79 years old. It is adjusted for age and sex differences by region. This does not include all amputation, but rather only those for which there was an existing condition of diabetes coded along with the amputation. (153).

The amputation rate among the Aboriginal in Central Region is significantly higher compared to the general population of Manitoba. The Dakota Ojibway Tribal Council rate is 6.2 per thousand, and together with Brandon and Marquette (Since this study now incorporated in Assiniboine RHA) is among the highest rates in the province. Of particular importance to the health of diabetic Aboriginals is the amputation rate for the on-reserve population which is higher than the off-reserve population. (Figure 5-7) According to Martens (2002), while diabetes rates are higher for RFN than for Manitobans overall by 4.2 times, “amputation rates related to diabetes complications are sixteen times higher” (155). This factor is one that future study and reports might help us to better understand and address.

Figure 5-7: Direct adjusted population prevalence of amputation with diabetes co-morbidity per 1,000 population age 20-79 years for “On-Reserve” Registered First Nations 1994/95 – 1998/99.

Source: Manitoba Centre for Health Policy.
Figure 5-8: Direct adjusted population prevalence of amputation with diabetes co-morbidity per 1,000 population age 20-79 years for "On-Off Reserve" Registered First Nations 1994/95 – 1998/99.

Source: Manitoba Centre for Health Policy.
Note: South Eastman, South Westman, and Churchill have been removed due to no data available.
Figure 5-9: Direct adjusted population prevalence of amputation with diabetes co-morbidity per 1,000 population age 20-79 years 1994/95 – 1998/99.

Source: Manitoba Centre for Health Policy.

2.1.2 (b-iv) Cancer

According to Kliewer, Mayer and Wajda, for Métis men the average annual cancer incidence rate was much lower than that for all Manitoba men (Métis / Manitoba ratio .017), although for Métis women the incidence rate was slightly higher than for all Manitoba women (Métis / Manitoba ratio 1.07). Compared to all Manitoba women the rate for in-situ cervical cancer was substantially higher among the Métis women (Métis/Manitoba ratio 1.38).

Aboriginal women have a higher risk for cervical cancer, according to Young, Kliewer, Blanchard and Mayer (2000). In comparison with non-Aboriginal women, Aboriginal women have 1.8 times the in-situ cervical cancer rates and 3.6 times incidence rates of invasive cervical cancer.

2.1.3 Well-Being

During interviews with three of the First Nations communities within Central Region, mental health issues were identified as a major concern. There was a feeling that mental health issues needed to be addressed in order to improve the health outcomes of this population. Feelings of hopelessness and helplessness affect how the population values

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7 Age standardized
8 Age standardized
their overall health. These negative feelings, in some instances, have led to behaviours such as alcoholism, drug abuse and gambling.

Some Key Informants discussed root causes of these problems. For example it was suggested that current Mental Health problems stem from decisions made in the 1960s permitting “drinking in bars” and, secondly, as a result of the introduction of the welfare system during the same era.

It was stated that problems started in the 1960s when two significant events occurred: 1) Aboriginal people started drinking in bars, and 2) the welfare system came into existence. These events altered traditional ways and resulted in some of the health and social issues we see today.

Martens (2002) identified the Residential School System as a major source of health problems among the First Nations people. This data was consistent with what we found through interviews. A frequent sentiment was that issues with mental health have resulted from collective experiences such as the Residential School System.

Adding to these sources, data from the telephone survey of the Central Region population showed that those of First Nations/Aboriginal/Métis ancestry were more likely than the general population to report recent emotional difficulties. (Acumen Research, 42). The saga continues through yet another source. The Manitoba First Nations Regional Health Survey 1998, reported that 31 per cent of the population surveyed report having suicidal feelings, and 13 per cent indicated that they had actually attempted suicide. This topic is explored more fully in the personal resources section.

Finally, it was noted that perception of what constituted Mental Health services differed from what the RHA Central actually provided. A more holistic view of Mental Health seemed evident in that it referred to all aspects of emotional and mental well being as opposed to a more narrow view of significant psychiatric disturbance.

For this reason, mental health concerns have been included in this section on well-being as it reflects the concept of the Aboriginal view of ‘mental health’. There are no measures...
of well-being for this population that are in the categories of: Functional Health, Self-Rated Health and Activity Limitations.
SECTION III: DETERMINANTS OF HEALTH

It has been known for considerable time now that the factors that make a population healthy go far beyond those services offered by the health care system. These factors are known as health determinants and include a diversity of influences ranging from life style to genetics, from environmental issues to education and income in addition to services. As these factors improve, so does the health status of the population. Major studies have shown that prosperous societies that have an equitable distribution of wealth are the healthiest. This knowledge is critical to understanding the discrepancy that exists between the health of the Aboriginal population and that of the rest of Manitobans. It is equally true of the population of Central Region.

According to Martens (2002), some key determinants that affect the health of RFN people include educational levels, income, employment and housing issues. All of these are discussed within the Manitoba Performance Measurement Framework (PMF) together with other factors that were identified by such sources as the Key Informants and the individuals with whom we spoke in Focus Groups. The framework of ‘Determinants of Health’ includes PMF as well as select others generally accepted both nationally and internationally and described in the Individuals Chapter of this document.

3.1. Personal Health Practices and Lifestyle

Personal health practices and lifestyles were important factors to many of the Aboriginal people with whom we consulted. Folks were informed about actions by which individuals can prevent diseases and promote self-care, solve problems and make choices that enhance health. There were several lifestyle issues identified in the First Nations communities as barriers to favourable health outcomes. Personal Health Practices can adversely affect health and are often related to issues of lifestyle. This may include such things as failure to initiate breast feeding infants to the recommended age, immunization rates, compliance with medication regimes and other positive behaviours that can influence positive health outcomes. The Central Region Telephone Survey indicated that Aboriginal respondents were less likely to seek treatment from a family doctor or doctor at work when injured and twice as likely as the average to either treat their injury at home or get no treatment for it.

Focus Group Participants struggled with the issues of personal health practices, establishing home practices that they hoped would have a positive impact on their health.
3.1.1 Weights

Although there were no data available regarding weights of Aboriginal peoples as a population group, there were a number of references regarding healthy weights and good nutrition by Focus Group Participants. These folks clearly saw a link between good eating, healthy weight, and prevention of disease, diabetes in particular, as a repeated concern for the Aboriginal people. Obesity was identified as a problem among the population. Martens et al (1998) reported that ½ of survey interviewees reported being overweight and 36 per cent reported being significantly overweight.

Martens et al (1998) further identified that 46 per cent of the First Nations population surveyed indicated that running out of money for food was a household problem. The latter was confirmed by Key Informants who told us that the cost of adequate nutrition was a barrier to positive health practices related to diet. The First Nations people interviewed stated that it was much cheaper to “buy the starchy foods that are not good for you”.

Some Key Informants felt that there was a lack of teaching regarding proper nutrition. They felt this was important to prevent diabetes, to ensure healthy babies, and to improve overall health of the population.
3.1.2 Alcohol Consumption

A number of individuals spoke of the rates of alcoholism and its effect on the Aboriginal people. There is little data available specific to this population regarding rates of high use or abuse. Future studies might provide the opportunity for breakdowns in data that would allow us to explore this issue in a meaningful and useful way.

3.1.3 Physical Activity

Many people spoke of the need for adequate activity and their own personal interest in staying active. The Ginew Wellness Centre on the Roseau River Reserve has a weight room and a trainer employed to assist people in staying active. Folks spoke of activity in a variety of ways, from daily regimens to just staying busy. Others spoke of difficulty staying active in the long winter. Lack of regular exercise was identified by some as a problem among First Nations communities. The common theme identified was that there was a need for education on the importance of regular exercise programs and the positive impact that exercise would have on health outcomes.

3.1.4 Smoking

Tobacco plays a significant ceremonial role in the traditions of Aboriginal people but it is clear that cigarette smoking was identified as a health concern, unrelated to the ceremonial aspects of life. According to Martens et al (1998), 64 per cent of First Nations people in Manitoba currently smoke, 21 per cent began before age 14 years and 67 per cent before age 15 years (38). It seems evident that if we are to make a significant impact on the smoking rates, targeting the youth to delay smoking starts would potentially have the best outcomes.
3.1.5 Injury and Risk Taking Behaviour

See section 2.1.2 for information regarding the significant injuries reported in this population, many of which result from risk taking behaviour.

3.1.6 Screening/Prevention

Screening for disease and intentional disease prevention has been found to be less frequent than would be ideal for this population who have such poor health outcomes, as demonstrated below.

3.1.6 (a) High Blood Pressure (Hypertension)

Unfortunately, there are no data regarding either screening or treatment rates for Aboriginal people available. This data might be useful to track if it becomes available at a future date.

3.1.6 (b) Diabetes

There have been studies conducted on the Aboriginal people regarding diabetes rates and secondary diseases resulting from uncontrolled diabetes. One study recently conducted on the Sandy Bay Reserve within Central Region is due to be released in the near future. Those data are not available at this time. That report will be made available to Central Region staff once it is completed and published. These reports will inform RHA Central for planning purposes in the future.

3.1.6 (c) Immunization

The information on immunization rates for Aboriginals can only be selected for ‘on-reserve’ RFN and compared to ‘off-reserve’ Manitobans. The ‘on-reserve’ data “from federal health nurses and First Nations community health nurses may be incomplete” according to Martens et al (2002, 85). While the data indicate we are well below the Health Canada recommended target rates for immunization, it has been recognized there are variations in rates reported through the Manitoba Immunization Monitoring System (MIMS).

Taking the limitations of data into consideration, within Central Region there are gaps throughout the age span and geographically in immunization rates. The DOTC rates are consistently lower than the rest of the province, both on- and off-reserve. The rates for RFN are also consistently significantly lower than for other Manitobans in Central Region as in the other RHAs of Manitoba. Our rates of screening as reported in the RHA Indicator Atlas are consistently lower in Seven Regions suggesting that either the rates of immunization in Sandy Bay are below average or are consistently under-reported. Further research is required to satisfactorily answer this. Health professionals suggest that under-reporting is one cause of the low rates.
3.1.6 (d) Mammography

As with the immunization disease prevention program, mammography rates for ‘on-reserve’ and particularly for DOTC are significantly lower than for other Manitobans. The DOTC rates are the second lowest for ‘on-reserve’ comparisons and much lower than compared to all other residents of Central Region. This is not surprising given that Key Informants identified there were neither mammography nor cervical screening done on the reserves.

3.1.6 (e) Cervical Screening

With the exception of those aged 15 to 19 years, Aboriginal women were less likely to have had at least 1 Papanicolaou test (Pap test) in the preceding 3 years than non-Aboriginal women. The need for such a program among Aboriginal population is especially urgent. Beyond the clinical, technical, financial, and organizational proficiency required of Papanicolaou test screening programs, essential elements are an awareness and understanding of cultural concepts of cancer and its prevention and sensitivity to cultural barriers. (Young, Kliewer, Blanchard and Mayer, 2000).

3.2 Personal Resources

The Aboriginal people with whom we spoke felt that having a source of support was important to one’s health. For some, that source was family, to others it was spirituality, and others described support in terms of services that may or may not be available to them. They told us about people they could talk to and rely upon, and about the negative environment for someone who had nobody to depend on. For some this was family while for others it was counsellors, perhaps within the educational system.

People at home and at school who care and will listen.

I wish there were [Personal resources] available around here. How can it be important because it doesn’t exist?

3.2.1 Life Stress

Poignant stories from focus group participants told us a lot about life stresses. There was a story from one young man who described a spiral he had been in and has been fortunate enough to get out of. Others are less able to stop before it is too late. Many life stresses were described with unfavourable outcomes. This repeated theme of helplessness and hopelessness on reserve was heard loud and clear. Yet some described a positive outcome when they were able to stop the cycle and put their life back together.
3.2.2 Spiritual Resources

First Nations people, more than any others with whom we discussed spirituality, really spoke of this aspect of their lives in a holistic way. They spoke of the importance of having an external life force to guide oneself and be generally healthy. The following quotes describe the rich context of these people’s beliefs. Some other general, cultural beliefs are described in the Culture section of this chapter.

When I was younger, they didn’t have the resources they have now like Al-Anon and counselling. Now I’m starting to use what little resources we have but before I didn’t really take a second look at it. I thought it was too late, that was the sort of attitude I had. I sobered up. I was tired of going in a merry go round, go to jail, get out, drink, get in trouble, go to jail.

I get up every morning about six. I like to see the day start. And see where the day ends.

I’ve seen people ask for things especially when they’re on skid row, you see it in jail, you see it on the outside. Whether they think they’re solid or not, one day they’re gonna say “God help me”. One day you’re gonna question it yourself. I’ve done it and seen others do it too. Everybody’s gonna fall, whether somebody dies or somebody gets hurt. Then you don’t have that power to heal them so you’re going to start questioning your own belief and ask yourself if there is someone there to help you.

To me it is like self-discipline. I guess you need it to stay healthy and not make wrong decisions, make healthy decisions. To guide you.

I’m thinking about native spirituality. When I think about that I think, health wise, six or seven years ago I was into spirituality. I prayed to God or whatever to help me quit drinking. That was the only thing that could help. I haven’t had a drink since. It helped my health because I don’t drink anymore and I’m aware. Being sober is aware to me. I know better now and know more. It just helps my decision making and stuff like that.
3.2.3 Social Support Networks

While supports are important to the health of every individual, and equally so for the Aboriginal population, this subject has been addressed in previous sections of this chapter, including injuries data.

3.3 Living and Working Conditions

It is crucial to understand how all of the determinants, blended together, impact on the health of the First Nations people. Employment and education affects a person’s physical and emotional well being. It is difficult to secure good employment without education. Types of employment, again related to education, determine income. Poor income affects the health of the household. Income determines one’s ability to provide proper nutrition and proper housing. Education is key in understanding which factors promote health and wellness. It is not difficult to see the many difficulties faced by the First Nations people, in the promotion of their own health and wellness.

3.3.1 Income

According to the Manitoba First Nations Regional Health Survey, 80 per cent of the First Nations families have household incomes less than 25,000 dollars. Household is defined in section 3.3.3 – Housing.

The average Aboriginal income (1996) was substantially less than the Manitoba average. Social assistance, in the form of government transfer payments and old age pensions, supports 53 per cent of reserve households. Aboriginal unemployment rates are higher at every level of education; however, Aboriginal people with post-secondary education are more likely than non-Aboriginal people to participate in the labour market as opposed to professional employment. Status women on reserve have a much lower unemployment rate than men on reserve.

From 1981 – 1996 self-employment among Aboriginal Manitobans has increased much faster than the non-Aboriginal rate. Aboriginal households in Manitoba have incomes less than the “Low-income cut-offs” (see glossary). According to Martens (1998), income does not seem to be associated with health outcomes except for suicidal feelings, although income levels generally predict poor health. This information is in contradiction to what we see in other sources regarding the link between income and health. The region’s Telephone Survey (2004) confirmed Aboriginal respondents were less likely to be employed and more likely to have incomes under $20,000 than the rest of the respondents.

3.3.2 Education

Manitoba has the lowest rate of school attendance among Aboriginal youth of any province or territory in Canada. The MCHP indicates a lower than average education level among Aboriginal youth. Although 1996 data states that about half of Aboriginal adults aged 30 – 49 had completed high school, most of these had proceeded to some post-secondary education.
### 3.3.3 Housing

The “average persons per total housing unit” is the total number of “on-reserve” people in a Tribal Council area divided by the total number of housing units (including housing units categorized as adequate, requiring minor renovation, requiring major renovation, and requiring replacement). The “average persons per habitable housing unit” is the total “on-reserve” RFN population divided by the total number of habitable housing units (habitable housing units are those that are considered adequate or requiring minor renovation). (Martens, 2002, 158).

A household, according to Martens et al of the MCHP First Nations Survey (2002) consists of 84 per cent of First Nations living on reserve live in band housing. Housing conditions on reserve have been identified as being worse than in Winnipeg, with 41 per cent requiring major repairs. The average number of persons per housing unit for First Nations people is twice that of the overall population of Manitoba (4.8 versus 2.6). The data specific to the Central Region identifies 7 persons residing per housing unit. Problems with overcrowding exist. Crowding is partly a factor of family size, and partly of housing cost and supply. Ten per cent of Aboriginal people live in housing with two or more persons per bedroom. Although housing construction has increased on reserve, conditions and suitability remain serious concerns (171). About one-quarter (25.8%) of the housing units in Manitoba First Nations communities in 1998/99 were in need of either major revisions or in need of replacement. This is consistent throughout most Tribal Council areas (169).

The First Nations people live in crowded homes. According to the Manitoba First Nations Regional Health Survey, three quarters of the First Nations population live in households with four or more people. This can be positive in that no one is alone, however, it also speaks to a shortage of adequate housing and crowding that can lead to life stresses and other poor health outcomes.

### 3.4 Environmental Factors

There were environmental issues identified during our Key Informant interviews with the three First Nations communities. One concern expressed was regarding the incidence of mould in the homes, which has led to the incidence of respiratory infections, particularly in children.

There was also a concern identified regarding the safety of the water supply in some of the communities. The water is not regularly tested. The stakeholders wanted to avoid any future problems due to unsafe water.

#### 3.4.1 Physical Environment

There is a suspected link between environmental contaminants and asthma exacerbation. The prevalence of childhood asthma has increased sharply over the last two decades, especially among the very young (0 – 5yrs). The prevalence of asthma overall in Central Region is 5 – 7 per cent.
3.5 Healthy Child Development

One measure of the health practices of a population and care of the future health of the new generations is the indicator of breast feeding initiation rates. That is, the percentage of newborns who are breastfed before discharge from hospital after delivery. For these data shown in Figures 5-10, 5-11 and 5-12, unknown records have been excluded. We heard in our deliberation within Central Region, that this measure may not be the most accurate way to determine whether infants are in fact breast fed. We heard that there is a tradition within the Aboriginal community of initiating breast feeding after lactation has occurred. Therefore, unless we record who is breastfeeding at a standard date in the infants life, such as at Public Health Nurse visits, we cannot be sure that breast feeding rates are accurate. Within Aboriginal community comparisons, however, these data may give us more understanding of differences between reserves.

In Manitoba, breastfeeding initiation rates average 57.89 per cent. On-reserve rates compare at 55.20 per cent. However, when we look closer at comparisons between regions, and between on- and off-reserve RFN populations and non-RFN populations, the story is surprisingly different. It was found that, in general, the lowest breast feeding initiation rates correspond to the area with the worst PMR rates.

According to the First Nations Report, “Overall breastfeeding initiation rates for Registered First Nations newborns was 57.1%, with slightly lower rates for those living “on-reserve” (54.3%). These rates are substantially lower than for all other Manitoban newborns, at 80.5%.” (Martens, 2002, 83)

In Central Region, the discrepancy between the overall non-RFN population and the RFN population reflects that of the provincial rates. In addition, the discrepancy between the on- and off-reserve RFN is similarly reflected. As shown in Figures 5-10 to 5-12, the breastfeeding initiation rates for the population of Central Region from 1994-1998 was 87.24 per cent. This rate is the second highest in the province overall, as is the PMR for Central Region. However, the overall rate for RFN breastfeeding initiation drops to 58.03 per cent, slightly higher than the Manitoba RFN average of 57.89 per cent. This picture worsens when we examine the data more closely.

We find that the off-reserve breastfeeding initiation rate of 64.75 per cent has pulled up the RFN average. This rate is the fourth lowest in the province for the population and is comparable to the on-reserve difference of 54.59 per cent in Central Region versus the 55.20 per cent provincially. Once again, this difference, compared to other RHAs leaves our on-reserve rates at fourth lowest in the province. With a PMR for this population the lowest provincially, and demonstrated linkages between breastfeeding and health indicators, these rates are of concern.
Figure 5-10: Breastfeeding initiation rates of newborns (at hospital discharge).
All other Manitobans by RHA 1994-98

Source: The Health and Health Care Use of Registered First Nations People Living in Manitoba.

Figure 5-11: Breastfeeding initiation rates of newborns (at hospital discharge) by Tribal Council 1994-98.

Source: The Health and Health Care Use of Registered First Nations People Living in Manitoba.
3.6 Gender

Most conditions regarding gender are discussed in the respective chapters for men and women. However, specific issues regarding gender affect the Aboriginal population. For example, RFN males are at greater risk for injuries, including self and other inflicted injuries than other Manitobans while RFN females were at lesser risk.

Aboriginal women had issues they felt were important to them. They spoke of grounding, equalizing, keeping a person healthy physically, emotionally and spiritually. They linked spirituality, nature and connectedness in a wholesome way. Women talked about these issues and how important they are to Aboriginal choices and to health.
3.7 Culture

Aboriginal culture is advanced regarding their concept of the integration of determinants of health and spirituality. They view health in a very holistic way, believing all things to work together for their health and wellness.

I remember when our grandparents told us when you actually take the life of a wildlife to feed yourself, you don’t just leave it there after you’ve done what you needed. Everything is supposed to be put back together and put away. All these things are sacred. That is what our children are missing right now.

3.7.1 Traditional Views

Aboriginal people tend to be frequent users of the formal health care system, utilizing both insured services provided by the Province and the Regional Health Authority, as well as the non-insured services provided on-reserve which are funded through the Federal Government. What is less well understood by providers of health services are the traditional approaches to healing that may underscore the values, expectations, and beliefs of Aboriginal people seeking health services.

Associated with a traditional approach are various important ceremonies, which may include the ingestion or burning of plants, songs, drums, sweating or fasting. These traditions may be based on efforts to return natural balance within the circle of life.

Although scant attention has been paid to these processes in the past, present day health systems are increasingly recognizing the importance of the customs and beliefs of the people who practice them. As Aboriginal people rediscover their culture and take increasing pride in their traditions, the formal health care system is responding accordingly with strategies that accommodate local practices.
3.7.2 The Medicine Wheel

Traditional healing tends to take a more holistic approach and makes less distinction between physical and emotional healing than Western medicine does. Traditional beliefs hold that everything in life needs balance and that all aspects of a person’s being, physical, mental, emotional, and spiritual must be in order and balanced in order to maintain a healthy mind, spirit, and body. This is often demonstrated graphically by the Medicine Wheel.

Figure 5-13: The Aboriginal Medicine Wheel.

The Medicine Wheel is an ancient symbol used by almost all Aboriginal peoples in North and South America. The Wheel has many variations depending on how it is being used but in its essential nature it helps the user to envision a holistic approach. This example demonstrates the interconnectedness and balance one needs in life to function fully in a healthy environment.

Thus the Medicine Wheel is one of the most important teachings relative to traditional healing. It incorporates the wholeness and oneness concept of life and is a useful conceptual guide to a holistic Aboriginal approach to traditional healing.
3.8 Health Services

While health services have not been the focus of our health assessment, there were a number of folks who had concerns to share. The Aboriginal community shared a number of concerns related to accessibility and jurisdictional issues.

Transportation was identified as an issue for the communities interviewed. There is a funding formula for First Nations communities that includes money for some non-insured health services and for transportation to access health services. In most cases the cost for transportation to services was much higher than their budget would allow. As an example, within our First Nations communities there has been an increased incidence of clients requiring dialysis and the increased transportation costs associated with this is of great concern. In some communities the population has increased and Key Informants report to us that the funding costs for transportation to services has not. This creates challenges for the communities.

Common concerns around accessing services were often related to physician services. Specifically, folks spoke of difficulty in obtaining a permanent family physician and charges for missed appointments. While access to physician services is of concern in many areas, we heard a new concern related to cost. We were told of termination of services and waiting times to be seen in emergency. For example, if a person misses an appointment at the Portage clinic without prior notification, regardless of the reason, they have a charge for the missed appointment, with a consequence of discontinued services until the charge is paid. We were told that one exception to discontinued service is for prenatal care. We were told of many reasons for missed appointments without notification, not the least of which is that no transportation arrives to pick up a client who has no phone to notify the clinic of the issue. Another circumstance was if a client presents to the walk-in clinic and has a lengthy waiting time, leaves to go to the washroom or to get something to eat or drink, and their name is called. We are told that the client is then considered to have missed an appointment and have a resultant charge, with the above consequences coming into play.

During community consultation some of the population spoke of feeling isolated from service and would like access closer to home. Central Region, as the service provider, is a partner in this challenge.

One thing no one mentioned today is balance. There are three or four parts to each person. Each has to be in balance or the others are affected. Physical, spiritual, emotional, and intellectual. It has an affect on your family and community. To be a healthy person there needs to be a balance. If it affects one area, it is going to affect other areas like a stone on a pond creates a ripple. Just like you say eat a well balanced meal, you should live a well-balanced life.
SECTION IV: KEY FINDINGS

4.1 Observations

The health status of Aboriginal people in Central Region differs significantly from the rest of the population, with Aboriginal people carrying a disproportionately high burden of disease and premature mortality. It was apparent that our Aboriginal people are concerned about their health status and outcomes and that they are anxious to find ways to improve these outcomes. The administrative data available regarding our Aboriginal people was strongly supported by all the Key Informants and Focus Group Participants. It was clear to this team that there was a collective wish to improve the health of Aboriginal people in Central Region so their health would more closely resemble the health of other Central Region residents. The CHA Team for Aboriginal in Central Region found that:

- While Personal Health Practices and Lifestyles cause poor health outcomes for Aboriginal people, many of these practices result from an overwhelming sense of hopelessness and helplessness.

- Many of the lifestyle practices that negatively influence the health of Aboriginal people start at young ages, such as smoking.

- There is a gap in cultural awareness between the health services community and Aboriginal folks in Central Region that has a negative health effect on our Aboriginal population.

- Multiple jurisdictional issues have created barriers to good health that permeate all aspects of health and social services, including access, treatment, and ultimately, health outcomes.

Some specific concerns identified include:

- Seriously high intentional injury rates are reported with 31 per cent in Central Region purportedly having suicidal feelings, and 13 per cent having attempted suicide. Abuse from others was found to be seriously high in this population.

- Although there is little data regarding rates of substance use or abuse, there are enough anecdotal flags to concern us enough to suggest we study this factor more closely.

- Indicators suggest that health screening and immunization practices could be significantly improved for this population.

- Diabetes and its secondary affects are causing significant health issues for Aboriginal peoples. Of special concern is the seriously high amputation rate.
Some environmental issues have a detrimental affect on the health of Aboriginal communities. Some issues include housing, mould and poor infrastructure including road conditions.

4.2 Considerations to aid our Aboriginal Peoples to be “as health as can be!”

Reducing rates and severity of diabetes and its secondary affects would significantly improve the health of our Aboriginal population.

Partnering with the other jurisdictions of our Aboriginal folks could help to reduce barriers to good health and ultimately, health outcomes.
- If we are to collectively influence a change in unhealthy lifestyles, we would be best to intervene with the very young ages, perhaps partnering with schools.
- Improved cultural understanding and sensitivity would positively influence our ability to provide appropriate services and to collaborate with others for solutions to improve the health of Aboriginal people.

Mental Health issues in our Aboriginal peoples, especially on-reserve, could be better understood if we focused research on this category of chronic diseases to seek both knowledge and solutions.
- Specifically we need to know more about intentional injury and substance use.

Some specific screening improvements might include diabetes, hypertension, mammography and cervical. Providing better access to these kinds of screening by making it available on-reserve might help improve the rates of early detection and treatment.

Combining the above conclusions to plan health interventions for the Aboriginal population in Central Region could improve health outcomes, helping the Aboriginal population to be “as healthy as can be!”
SECTION V: CHAPTER REFERENCES

5.1 Books and Journals


5.2 Government Documents


5.3 Internet Sources


5.4 Personal Sources

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Women

“Women in Central Region are as healthy as can be!”

WOMEN’S SHAPE TEAM:

Mary Smith  Michelle Tully  Janice Madill
Roberta Moore  Karen Macloskie  Dr. M. Hesom
Celine Beaudette
Mary’s Story

A 45-year-old female patient in my care had breast cancer and underwent mastectomy. She described her chronic illness metaphorically as: “A stranger who knocks on my door one day and said, “From now on, I shall live in your house. You will have to feed and to finance me. I shall live in your house and meet with your friends. Wherever you are - I shall be. I’m not leaving you alone; I am not going anywhere and I shall stay in your house forever - as long as I like - whether you like it or not”. (Navon).
Chapter 6

Women

SECTION I: ASSESSING WOMEN IN CENTRAL REGION

1.1 The Assessment Process

The Community Health Assessment (CHA) Women’s assessment team is one among seven Central Region assessment teams. We were charged with a mandate from the RHA Central to gather and interpret data on the health of Women aged 15 and over in Central Region.

In gathering data, the assessment team relied heavily on four sources of data. The first was a review of data from administrative sources as provided by our Epidemiologist and other documents described in the introduction of the overall report. These data sources gave us an overview of the known health status of Central Region women and informed our inquiry for the assessment.

The second source was expert in nature and came from literature sources as well as from interviews with specialists in the field of women’s health. The Vancouver Richmond Health Board “Framework for Women-Centered Health” was an invaluable source of information to the team. The Winnipeg Women’s Health Clinic graciously sent a representative to describe the plight of women’s health in a general way, particularly with respect to income and health. Genesis House in Winkler was very generous in providing an employee to sit as a fully functioning member of our team and as an expert advisor to us regarding violence and women, especially in the southern part of our region. We are very grateful to these outside agencies for their collaboration and for the information shared in the process.

The third source was surveys that the RHA Central commissioned as a part of the larger regional assessment, particularly a telephone survey and Focus groups meetings. Although these were done for the total population, Female-specific data has contributed to this report. The fourth source of information was provided through Key Informants interviewed by the CHA team. Employees spoke with willing clients to discuss issues of concern within a context of income and its effects on their health. Although the individuals varied from one locale to the next, we had exceptional participation from interested folks. Each contributed to or confirmed a perspective of socio-economic impact on health that personalized and completed information available to the assessment team.
All of these sources are listed in the bibliography. The questions asked during interviews are provided in Appendix A.

1.2 Assessment Theme

Women's health involves women's emotional, social, cultural, spiritual and physical well-being and is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs and experiences of health.

When women talk about health, they talk about their whole lives, and differently than men. Women are clear that their health cannot be looked at in isolation. The determinants of health are recognized as integral parts of each woman’s life experience. (Vancouver-Richmond Health Board, 2001)

Manitoba Health’s ‘Women’s Health Strategy’ recognizes gender as one of the important determinants of population health. Women have both a different physical makeup from men and different life experiences, such as their roles as mothers and family caregivers. Because of her role as family caregiver, a woman’s health is important not only for her own sake but also for the sake of the family. Many of these differences are what is described as gender rather than sex. That is, gender refers to the sociological differences between the sexes.

Women are not a homogeneous group; they have very different experiences of health, and health care, and they different access to the conditions that contribute to and well-being. A male group participant commented on his perception of one difference service for women versus

When men go to the doctor I’m sure they are listened to more by the doctor than women. It is seen as more serious than complaints by women. The doctor takes their complaints more seriously. I think it works both ways, for some reason, they feel when a man complains about something it is more serious than when a woman does. Maybe it’s because you can’t get a man to the doctor in the first place. ☯

The Women’s Team felt very strongly that the experience of women and health is most affected by income. The lack of adequate resources were believed to be the one factor that permeates all other determinants from a sense of control over ones own life, to adequate housing, to ability to seek health services for prevention purposes or for illness care. As previously discussed in the Individuals’ Chapter, health status improves at each step up the income and social hierarchy. Living on low income creates uncertainly, insecurity, and lack of control over one’s life, all-powerful effects on health. Because of the growing evidence that income and social status seems to be the most important determinants of health, the Women’s Team believed it was critical that we focused on the dual factors of living and working conditions.

For the purpose of framing this chapter, the Women’s Team chose to adopt the Vancouver Richmond Health Board “Framework for Women-Centered Health”. (See Figure 6-1). It is interesting how closely the concept mirrors the ‘Aboriginal Medicine Wheel’. Within Manitoba’s
Performance Measurement Framework determinants of health are a number of more detailed determinants. While we reviewed the most relevant of these, we took a closer look at the following three specific determinants of health in relation to women in Manitoba and Central Region.

**Figure 6-1: Framework for Women Centered Health.**

Source: Vancouver Richmond Health Board.
They are:

1. Income: poverty, social status and single parenting
2. Personal Resources: Social support networks
3. Environment: Physical

### 1.3 Demographic Overview

According to the 2001 Census, the population of the Central Region is equally divided among males and females. There were 47,885 females reported in Central Region in this census year (just slightly over 50% of the population). However, in the 65 and over age group, women account for a higher proportion at 56 per cent of the population. Just over 58 per cent of women (age 15 and over) reported being married at the time of the 2001 census and almost 6 per cent of women reported being separated or divorced. (Carr)

The proportion of the population who has completed less than grade nine is considered an indicator for low socio-economic status. According to the 1996 census, 21 per cent of residents of the Central Region had completed less than nine years of schooling. This was the third highest of all the northern and rural RHAs (data for Winnipeg were not available). As Table 6-1 illustrates, a fairly large proportion of females living in the Central Region have not graduated from high school and less than 15 per cent have graduated from university.

**Table 6-1: Educational achievement, Central Region females, 2001.**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Less than high school graduation (% of population)</th>
<th>University certificate, diploma or degree (% of population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>31.2</td>
<td>13.7</td>
</tr>
<tr>
<td>35-44</td>
<td>31.5</td>
<td>12.1</td>
</tr>
<tr>
<td>45-64</td>
<td>42.8</td>
<td>14.1</td>
</tr>
</tbody>
</table>

*Source: Statistics Canada, 2001 Community Profiles.*
SECTION II: HEALTH STATUS OF WOMEN

2.1 Overall Health Status

Central Region telephone respondents reported they are slightly more likely than overall provincial respondents to rate their health, for their age, as very good, with identical rates of emotional difficulties reported. Women more frequently than men acknowledged such struggles and indicated more severe limitations to normal activities resulting from such emotional difficulty (Acumen Research).

According to Acumen Research, the Telephone Survey illustrated that income is related to perception of health. As will be demonstrated in the section on income, women in Central Region overall have lower incomes than do either men in Central Region or women in Manitoba overall.

2.1.1 Mortality

If we looked just at Premature Mortality Rate (PMR) and Potential Years of Life Lost (PYLL), it would appear that overall women are very healthy. However, the fact that they die later than men is not the sole indicator of health status. Clearly there is more to health than at what age a person dies. Quality of life and ability to function at one’s highest capacity are factors related to health. The health status of women in Central Region will describe some of these factors in addition to why and at what age women die.

2.1.1 (a) Premature Mortality Rates (PMR)

In the years 1996 - 2000, the crude rate of female PMR in Central Region was 2.27/100,000. This is lower than the Manitoba provincial rate of 2.57/100,000 and lower, too, than the 2.53/100,000 of the previous assessment years of 1991 – 1995. By this measure women in Central Region are healthier than other women in the province and getting healthier.

2.1.1 (b) Potential Years of Life Lost (PYLL)

In Central Region, women have fewer PYLL than men. While both rate below the provincial average for the time periods shown (1991-95 and 1996-2000), women have almost half the rate of PYLL as men. Women in Central Region lost 34.02 and 35.13 years of life per thousand respectively whereas men lost over 60/1000 PYLL in each of these time periods.

Overall PMR and PYLL for women is lower than men, as are each of the reported causes of PYLL. In a ten year period, from 1992 to 2001, Central females lost fewer years of life to cancer, respiratory diseases, circulatory diseases, unintentional injuries and suicides than did males in Central Region. For example, with respect to PYLL, women accounted for 47 per cent of cancers, 43 per cent of respiratory diseases, 31 per cent of circulatory diseases, 23 per cent of unintentional injuries and 17 per cent of suicide in Central Region. Clearly, men are consistently dying younger than women from all of these diseases. We also have information on specific causes of PYLL, however the data are only available until 1998. Between 1994 and 1998, the specific leading causes of PYLL were breast cancer, lung cancer, motor vehicle accidents (MVA, from here on referred to as ‘crash’ or ‘collision’), and ischemic heart disease. Although these data are somewhat dated, it is important to note that if we look at the ranking much earlier, between 1980 and 1984,
the top four causes of PYLL listed were the same as in the earlier time period. The only difference is that MVA was the second leading causes, and is now third, while lung cancer was third and is now second.

Within Central Region, female PYLL was higher, in descending order, for Seven Regions, Portage la Prairie, and Morris/Montcalm. While the PYLL for women in Manitoba overall and in Portage reduced in the second time period, for women in Morris/Montcalm and Seven Regions, the PYLL increased and remained higher than the provincial average. However, an increasing female PYLL was also identified in the second time period (1996-2000) in MacDonald/Cartier and Carman, with all other Central Region areas showing a decline over time.

2.1.1 (c) Life expectancy

On average, women in Central Region have a life expectancy five years longer than men. The life expectancy of men is 75.7 years while for women it is 80.7 years. The chapter on Elderly will describe other factors related to disability free life expectancy. As an overall health status indicator, though, women are likely to live longer in Central Region than men.

Within Central Region, while life expectancy is higher than the provincial average, in the areas of Seven Regions and Portage la Prairie the reverse is true. The life expectancy over the time periods reported (1991-1995 and 1996-2000) were both shorter for these two areas of Central Region.

2.1.1 (d) Leading Causes of Death

If we look at overall classifications of death, women in Central Region are dying from:

- Diseases of the Circulatory System
- Neoplasms
- Diseases of the Respiratory System
- Endocrine, Metabolic and Immunity Disorders
- External Causes

Each of the above leading causes of death has a number of specific disease categories within them. Of the cancer deaths, women died more frequently, in descending order, from cancers of: breast, lung, pancreas, colon and lymphoma. While cervical cancer is not one of the leading five, later in this chapter is a description of concern based on evidence of preventable death, making this disease important from this perspective.

In the only time period available, 1994-1998 data, the five leading causes of death for Central Region females were similar to men. One difference between men and women was that among the top five for men and not women was COPD and for women and not men was Heart Failure. Among women, the leading causes of death were:

1. Ischemic Heart Disease
2. Cerebrovascular Disease
3. Heart Failure
4. Pneumonia and Influenza
5. Lung Cancer
2.1.2 Morbidity

The rate of disease burden for Central Region women appears to be lower than for Manitoba women overall.

2.1.2 (a) Injuries

In Chapter 1, we have demonstrated that women are at a lower risk for injury deaths than men in Central Region. The same holds true for overall hospitalizations related to injuries with some exceptions. Women in Central Region had more hospitalizations for injury in the ages less than one year and over 65 years. Given that there are more women in the over 65-year bracket in Central, this is not surprising. See Elderly Chapter for more detail on this age group and the Children’s Chapter for the under 15 years age bracket. What is perhaps more surprising, is that compared to the average Manitoba woman, females in Central were at higher risk for hospitalization in these same age groups.

What is most alarming is that women were more likely to be hospitalized for self-inflicted injuries than for assault. While the hospitalization rate for assault on women was 21.5 hospitalizations per 100,000 women (compared to 65.1 per 100,000 among men) between 1992 and 2001, in this time period, the hospitalization rate for self-inflicted injuries was 71 per 100,000 women (compared to 46 per 100,000 among men). Overall, for women, there were three times as many hospitalizations for self-inflicted injuries as for assault. These data are congruent with suicide rates versus suicide attempts among men versus women. Women in Central Region are more likely to provide the opportunity to intervene and prevent a suicide than are men. With rates of attempts as well as hospitalization higher per completed suicide for women, there is an opportunity, with appropriate intervention, to prevent suicide in woman who may make several attempts prior to completing suicide. These opportunities must not be wasted.

2.1.2 (b) Chronic Diseases

Among the chronic diseases reported, those with increasing treatment prevalence1 over time in Central Region include diabetes, hypertension, and to a smaller degree, heart attack. Our rates of stroke, cancer and respiratory prevalence have decreased. We wonder whether the increasing prevalence of treated diabetes and hypertension have resulted in improved rates of stroke.

2.1.2 (b-i) Diabetes

Women in Central Region had higher prevalence of diabetes at 581.7/10,000 compared to men at 574.6/10,000 (Manitoba Health, 2003).

2.1.2 (b-ii) Hypertension

While prevalence of hypertension is lower in Central Region than the provincial average (12.7% versus 14.3% in 2003), women in Central Region report slightly higher rates of treatment for hypertension than do men (12.8% versus 12.6%).

---

1 Prevalence refers to the total number of people living with a disease or condition within a given population.
2.1.2 (b-iii) Cancer

Females in Central Region appeared to have had a lower incidence\(^2\) of cancer from the years 1996-2000 at 380.9/100,000 compared to Manitoban women, on average, at 529.8/100,000 (Manitoba Health, 2003, 35). Some specific cancers are exceptions to this overall picture.

For example, female residents of Central Region had similar rates of colorectal cancer than other Manitoba women while we had lower rates of breast and cervical cancers.

2.1.3 Well-Being

This indicator of self-reported health can tell us what some of the other indicators such as disease prevalence and causes of death may miss. The measures include functional health status, self-reported health status and activity limitations.

2.1.3 (a) Functional Health Status

Functional health status is based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain). A score of 0.8 to 1.0 is considered to be very good or perfect health; scores below 0.8 are considered to indicate moderate or severe functional health problems. At this time, 2003 CCHS data are not yet available at the regional level. However, in 2001, 84.3 per cent of Central Region women had scores putting them in the range of very good or perfect health. This is somewhat higher than the rate of 80 per cent for men. All of these dimensions of functional health status impact our quality of life.

2.1.3 (b) Self-Rated Health Status

According to the Central Region Profile Document, fewer of our female residents rate their health as good or excellent compared to both men in Central Region and Manitoba women combined. Central Region women rated their health by these parameters at 55.2 per cent while Manitoba women rated at 56 per cent and Central men at 58.6 per cent (Manitoba Health, 2003, 53). This is interesting given the highly rated functional health status of women in Central Region.

According to Canadian Community Health Survey, Cycle 2.1 (2003), more women than men (62.9% versus 55.7%) reported their health as “very good or excellent”. This is a change from the first cycle where women reported their health as very good or excellent less frequently than did men (55.20% versus 58.55). It is interesting to note that while women’s perception of their health has improved (with more women rating their health as “very good or excellent”) this time, men were less likely than they were two years earlier to rate their health positively. These comparisons are now more congruent with reports of functional health\(^3\). In the last cycle, although women were less likely to rate their health positively, their functional health status was clearly better than men’s. In this cycle, functional health status is still better, and the perception is more in line with this reality.

\(^2\) Age standardized

\(^3\) Population aged 12 and over reporting measures of overall functional health, based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain). Function is a useful indicator to assess the numbers of residents who may have ongoing health needs. (Manitoba Health,).
2.1.3 (c) Activity Limitations

Activity limitations include respondents to the CCHS who report being limited in selected activities (home, school, work and other) because of a physical condition, mental condition, or a health problem that has lasted or is expected to last six months or longer. According to the 2003 CCHS, slightly more Central Region females (23.1%) report an activity limitation compared to males (20.2%). This is an increase from the 2001 survey where just 18 per cent of both men and women reported an activity limitation. In our Telephone Survey women also reported that their activity is limited as a result of poor emotional health more frequently than for men (Acumen Research, 9)
SECTION III: DETERMINANTS OF HEALTH

The determinants of health that most affect women are demonstrated in the subsequent discussion. The determinant of gender is incorporated throughout this review and commented upon separately, while biology and genetic endowment, due to their non-modifiable nature is not discussed. Since Central Region scored significantly above the overall rating in the Telephone Survey with respect to accessing Health services, and given that this is a health status review rather than a health services review, no further comment on health services will be demonstrated at this time.

3.1 Personal Health Practices and Lifestyle

We know that there are a number of health practices and lifestyle issues that affect health. As described in the Individuals Chapter, weights, behaviors such as alcohol consumption, smoking, activity, and screening rates for treatable diseases, are some of the factors we considered.

3.1.1 Weights

High body mass index (BMI) is associated with an increased prevalence of high blood pressure, Type II diabetes, high cholesterol levels and certain cancers, according the Central Region Health Profile (Manitoba Health, 2003). Female residents of Central Region appeared to have been less likely than Manitoba women overall to have a healthy, or “normal” body weight\(^4\) (Central 43%; Manitoba 47%). In addition, more Central Region women meet the definition of obese\(^5\) (18.1 % versus 16.5% in Manitoba). Dietary intake plays one role in healthy weight. According to the Central Region Profile Document, “females are more likely than males to focus on diet, either through choosing healthy foods or avoiding foods considered unhealthy” (47). It appears that a smaller proportion of female residents of Central consume the recommended daily amount of fruits and vegetables than all Manitoba women combined. (Central females 36.9%, Manitoba females 38.9%) (CCHS, 2003).

In Central Region, the outcomes of high BMI have been seen with respect to diabetes and hypertension rates but not for other conditions such as cancer rates that are somewhat better in Central Region. Since the weight and disease outcome connection might be more pronounced for obesity than for overweight, it appears that the lower rates of obesity have been reflected more so than the higher rates of overweight, apart from the diabetes rates. We know that diabetes rates have many other factors of influence, such as genetics. With a high Aboriginal population in Central Region it is possible these diabetes rates are more reflective of this particular cultural group than of weight.

3.1.2 Alcohol Consumption

Central male and female residents appear to have been less likely to drink heavily once per month than Manitoba residents. In 2003, 10.2 per cent of Central Region female residents met the CCHS definition of “heavy drinking” versus 12.7 per cent of Manitoba females.

---

\(^4\) In the 2003 CCHS, “normal weight” is defined as BMI between 18.5-24.9.

\(^5\) In 2003 CCHS “obese” is defined as BMI greater than 30.0
3.1.3 Smoking

Over the past five years, rates of smoking have increased substantially among adolescents and youth, particularly among young women. While more men than women are regular smokers (27.1% vs. 17.3%), all research into youth smoking shows an alarming increase in young women who start to smoke. Approximately half of current and former smokers started smoking between the ages of 15 and 19 (53.7% of females and 49.5% of males). As seen in Figure 6-2 the highest rate for females is within the 35-44 years age group, with smoking rates just under 30 per cent. (CCHS, 2003).

The smoking rates among females in the peak child-bearing years of 20-34 year old age group are high, with just under 1 in 4 reporting being a current smoker. In 1997 and 1998, 22 per cent of women reported that they smoked during pregnancy. This is of particular concern because more babies of low birth weight are born to women who smoke during pregnancy. Low birth weight infants are at increased risk for health complications.6

Figure 6-2: Smoking rates among Central Region females.

<table>
<thead>
<tr>
<th>Age</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>23.9</td>
</tr>
<tr>
<td>35-44</td>
<td>29.9</td>
</tr>
<tr>
<td>45-64</td>
<td>19</td>
</tr>
<tr>
<td>65+</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Source: CCHS 2003, Cycle 2.1.
Note: Rates in 12-19 year old age group were suppressed by Statistics Canada. Rates in every other age group should be interpreted with caution due to wide population estimates.

3.1.4 Physical Activity

Figure 6-3 shows rates of physical inactivity7 for females in Manitoba RHAs with overall Manitoba and Canada rates for comparison. This graph demonstrates the degree to which inactivity is a problem for women of Central Region.

---

6 See Healthy Child Development Section
7 Physical Activity: Population aged 12 and over reporting level of physical activity, based on their response to questions about the frequency, duration and intensity of their participation in leisure-time physical activity. (Mb. Health Central Regional Health Profile 71).
According to the CCHS cycle 2.1, both males and females in Central (males 51; females 58) appear to be more likely to be physically inactive during their leisure time than all Manitobans combined (males 43.8; females 50.8).

### 3.1.5 Injury and Risk Taking Behaviour

Women are at significantly lower risk of injury as a result of risk taking behavior than are men. For example, in the years 1992-2001 females died from unintentional injuries at less than 30 per cent of the rates at which males died from unintentional injuries. Motor Vehicle Traffic collisions were responsible for the death of women at less than half the rate of men and intentional injuries for women caused less than half of the hospitalizations for intentional injuries. As demonstrated in section 3.2.1, life stress, women are at more risk for self inflicted injury than from injury by an external source.

### 3.1.6 Screening for Preventable or Treatable Diseases

#### 3.1.6 (a) Breast Screening

Breast Cancer was the leading cause of Cancer deaths in Central Region women from 1999-2001. Fifty women lost their lives during this time period from Breast cancer.

Early detection of breast cancer leads to more effective treatment and can save lives. Studies show that breast X-rays, taken on a regular basis, have the potential to reduce deaths from breast cancer for women by up to 40 percent.
Mammography screening rates\(^8\) (of women aged 50-69) have improved in the Central Region, from 53.1 per cent in 1995/96-1996/97 to 65.8 per cent in 1999/00-2000/01. These rates are higher than the provincial averages of 50 per cent in the first time period and 62.8 per cent in the second. (Martens, 2003, 96).

The target age group for mammography screening is age 50-69. Figure 6-4 illustrates screening rates by age group. Central Region has higher than provincial screening rates in every age group (including the non-target age groups). We will be interested to observe whether our death rates for breast cancer will reduce over time as a result of increased screening.

**Figure 6-4: Average annual mammography screening rates by age group, April 2001-March 2003.**

![Average annual mammography screening rates by age group, April 2001-March 2003.](image)

*Source: Manitoba Health, Decision Support Services.*

*Note: Diagnostic mammography is not included.*

Within Central Region, Lorne/Louise/Pembina had the highest rates of breast screening followed closely by McDonald Cartier with the area of Altona having the lowest rates in 1999-2001 although significantly higher than the preceding time period of 1995-1997. Seven Regions follows Altona in lowest rates, both of whom remain lower than the provincial average (Martens, 2003, 97). Figure 6-5 illustrates mammography screening rates in the target age groups by district. It is clear from this graph that Lorne/Louise/Pembina has the lowest screening rates in every age group while Carmen has the highest.

---

\(^8\) *Definition: This is the percentage of women ages 50 through 69 who had at least one mammogram in a two-year period, age-adjusted to reflect the female population of Manitoba aged 50-69 years.*

*Regional Health Authority – Central Manitoba Inc.*

*September 2004*
According to the Central Region Health Profile, Central Region has a low rate of breast cancer incidence with only Burntwood, Marquette and North Eastman having lower rates per 100,000 population. The rates for Central Region in the years 1996-2000 were 112.1 per 100,000 compared to 117.1 per 100,000 for Manitoba.

### 3.1.6 (b) Cervical Screening

While the leading causes of cancer deaths for females in Central Region during the years 1999-2001 were Breast (50 deaths), Lung (39 deaths) and Pancreas (21 deaths), with cervical cancer deaths much lower, cervical cancer is still very important as there should no longer be any deaths. This disease, when detected early, is highly treatable. Death rates from cervical cancer can be very nearly eradicated altogether.

Current Canadian guidelines, developed from the 1989 National Workshop on Screening for Cancer of the Cervix, suggest that all women age 18 and older who have ever had sexual intercourse should be screened. This screening should continue until the age of 69 for women who have had consistently normal smears. However, trends indicating a plateau in declining rates in screening suggest a possible complacency among women regarding cervical cancer screening resulting from decreased incidence of the disease.

Our cervical cancer incidence rates appear to be lower than many other regions, however, our death rates due to cervical cancer are among the highest in the province. This points to an issue around inadequate screening of women which may lead to late diagnosis.

---

9 Age-standardized
10 For more information on Cervical cancer risk factors, rates and mortality, see Cervical Cancer Screening in the Central Region, Cynthia Carr, 2002. 
Regional Health Authority – Central Manitoba Inc.
September 2004
According to Manitoba Health, just over half of the eligible population (15+) of Central Region has had a pap test between 2000 and 2003. The three year average screening rate of 520.5 is almost identical to the three year average of 517 per 1,000 between 1998-2001. Like 1999-01, the screening rate in Central Region continues to remain below the provincial average (and Brandon remains the highest) (see Figure 6-6).

**Figure 6-6: Average annual cervical cancer screening rates, April 2000-March 2003.**

Source: Manitoba Health, Decision Support Services.
As Figure 6-7 illustrates, not only does the Central Region have a lower than provincial average rate of screening, but this continues to hold true for every age group. A close look at the data reveals that the difference in rates escalates with increasing age groups. That is, older women in the Central Region are even less likely to be screened for cervical cancer in comparison to the rest of the province, than are younger women. This is of concern since deaths due to cervical cancer occur among women of all ages (deaths in Manitoba ranged from ages 26 to 96 between 1994 and 1998), and risk increases with increasing age.

Figure 6-7: Average annual cervical cancer screening rates by age group, April 2000-March 2003.

Source: Manitoba Health, Decision Support Services.

Key Informants in Central Region, people who provide screening services to women, commented on the effect of having few female service providers to screen women for intimate health promotion examinations. In the collective experience of these physicians and nurses, it was their impression that access to female screeners could improve screening rates for such exams as breast and cervical cancer.
A review of screening rates within the Central Region indicates that there are clear differences in coverage related to geography. As Figure 6-8 illustrates, the lowest screening rate was in the Lorne/Louise/Pembina (L/L/P) area with a screening rate of 480.8 per 1,000 women and the highest was in the MacDonald/Cartier (M/C) area with a rate of 551.4 per 1,000 women screened. It is important to note that none of our districts have screening rates higher than the provincial average.

**Figure 6-8: Average annual cervical cancer screening rates by district, April 2000 – March 2003.**

![Screening Rates Chart]

Source: Manitoba Health, Decision Support Services.

Early detection of cervical cancer is clearly the most important way to minimize the morbidity and mortality associated with the disease. When detected early, the five year survival rates for cervical cancer exceed 90 per cent. If the cancer remains undetected until the later stages of the disease, when symptoms become apparent, the five year survival rate drops to 10 per cent (Canadian Taskforce on the Periodic Health Examination).

In our 2002 cervical cancer screening report we noted the differences in patterns seen in the Central Region versus the Brandon Region. While the Central Region had a lower than average incidence rate of cervical cancer reported between 1990-98, Brandon actually had the highest incidence rate (at 129 cases per 100,000 women) in the province with the exception of Churchill. However, Brandon also reported the highest screening rates in the province and a death rate of 0, between 1994 and 1998. Central’s data is in contrast to this with low screening rates and higher than the provincial average death rates due to cervical cancer. This may indicate that cases of cervical cancer are being detected at a later stage in Central Region which results in more deaths, while cases in the Brandon region are being caught early enough to be successfully treated. The only way to ensure that cases, and potential cases – dysplasia, are caught at this early stage is through an organized screening program.

As we concluded in our 2002 report, “Unless a rigorous screening policy is developed and maintained, a rise in cases of invasive cancer and deaths may be expected. Thus, the implementation and ongoing evaluation of organized screening programs should be a priority in the Central Region.
3.2 Personal Resources

3.2.1 Life Stress

The focus of this chapter has been on determinants related to income and poverty, and it is important to mention Mental Health and mental illness. We have seen that women are at much lower risk for death from self-inflicted injury than men are. The Injuries in Manitoba 10 year Review reports that women died from suicide in Central Region during the years 1992-99 at the rate of 2.6/100,000 versus 16.5/100,000 for men. What is more important is that when we look at hospitalizations for self-inflicted injuries the reverse is true. Women in Central Region were hospitalized for self-inflicted injury at the rate of 77.7/100,000 compared to 48.3/100,000 for men. (Manitoba Health, 2004,156-7) This factor is important for health planners. We are given a unique opportunity for intervention regarding outcome for women versus men. During hospitalization, we have access to women who are at risk for future behavior that could result in death. Through appropriate and timely intervention, we can reduce the risk of self-injury to these women. By the act of suicide incompletion, women provide us with an opportunity for intervention that exists seldom for men, whose completion rates are much higher than for women.

Injury from an outside source, that is, violence or assault, is less common for women than injury from themselves or than assault upon men. However, women have died from assault in Central Region and they have been hospitalized, without death, at the rate of 25.9/100,000 versus 71/100,000 for men in the years from 1992-2001. There is a social and financial cost to this kind of life stress. Violence against women increases costs in health, social services, criminal justice (estimated around $1.5 billion) and in employment through lost working days. Although all women are vulnerable to violence in society, immigrant and refugee women, Aboriginal women, young and senior women are at particular risk (Deiter). Central Region has a significant population of women at risk for violence by this description. We have an elderly population of 14 per cent of our population, 56 per cent of whom are women. We have a high proportion of immigrants, particularly the Low German Speaking Mennonites from Mexico (Kanadier Mennonites) and we have a relatively high Aboriginal population, approximately 50 per cent of whom are female.

Being a victim of violence is linked with a number of health consequences for women: addictions, mental illness, migraine headaches, eating disorders, arthritis, irritable bowel syndrome, reproductive health problems like chronic pelvic pain, sexually transmitted disease and death. (Vancouver-Richmond Health Board) Rates for most of these specific disorders are not available at this time. Further study of this issue is needed to determine reliable data for Central Region.

Women who suffer from violence inflicted by others are only a small part of the picture. Central Region residents appeared to have higher levels of reported stress than Manitobans as a whole, and there is some concern regarding the levels of stress and the coping skills of women.

Having someone to talk to is thought to be one way to cope, to reduce the levels of stress one feels. Females reported in the phone survey that they are more likely than males to have someone to talk to (Acumen Research). Women in Central Region more frequently reported that their levels of stress were from not very, to extremely high compared to the Manitoba average while those who

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11 Level of chronic stress reported by the population aged 18 and over, based on their response to a series of 17 questions about their personal situation. These data should be interpreted with caution, because of small sample size. P. 79 Profile Doc.
thought their stress to be ‘not at all’ were fewer. However, due to small sample size, these data should be considered with caution (Manitoba Health, 2003, 79).

3.2.2 Spiritual Resources

For some, spiritual resources provide strength and make one feel confident in ability to cope with illness or stress. Over half (54%) of Central Region telephone survey respondents believe that their spiritual well-being plays an extremely important role in how they feel about their overall daily health, with another one-third (37%) saying its role is somewhat important. Only 9 per cent said that spiritual well-being plays an unimportant role in their overall health. Women tend more often to feel that their spiritual well-being plays an extremely important role in their overall daily health (Acumen Research).

Young females in Central Region tended to be rather confused about the aspect of spirituality and how it affects their health. They seemed to think there was a connection, but wavered between blaming or crediting religion, its family pressures, and the actual or potential support one gets to strengthen oneself in the concept of spirituality. Some felt, when asked whether spirituality had any affect on their health, that the stress of trying to live within strict confines was causing family problems and that integrity with respect to lifestyle was important to the family.

Some felt that religion, framed in the context of spirituality for these folks, adds stress to their lives. Others felt it can relieve stress if used to express oneself and one’s emotions. Some felt they gained strength from their beliefs and values.

Women in the ages of 20-35 told us that without values one would have stress that affects one’s ability to be emotionally strong, a requirement for taking care of oneself. Aboriginal women spoke of balance, inclusive of spirituality. Women 65+ spoke of spirituality as a value without which one would be less strong. Evidently, having these and other supportive networks are important to whether we feel stressed and how we cope with that stress.

The family needs to have reliability…to be honest with each other and to be open. ⭐️

If you have a peace inside of you it makes everything easier…It is easier to cope with things because you know it is happening for a reason. ⭐️

To be a healthy person there needs to be a balance. If it affects one area, it is going to affect other areas like a stone on a pond creates a ripple. Just like you say eat a well balance meal, you should live a well-balanced life. ⭐️

[Without spirituality…] I would be an unhappy/unhealthy person. ⭐️
3.2.3 Social Support Networks

Women told us that having a supportive environment helps with coping, strength and resilience against disease. Social support is evidenced in a number of ways. Two indicators are related to living in a family. We know that Central Region residents appear more likely to live in a family household and to be married than other Manitobans combined. For those who do not live in a family and/or are single, separated or divorced, women tend to have a higher burden with respect to single parenting and low incomes.

It is not simply that poor material circumstances are harmful to health; it is the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized that also matters. Women who are poor are more likely to be socially isolated. As social beings, we need not only good material conditions, but from early childhood onwards, we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful, and we need to exercise a significant degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness, which all rebound on physical health. (Wilkinson, 2003)

Mental health issues are often considered a consequence of women’s disadvantaged position in society. Women are more likely than men to experience emotional disturbances, like depression and anxiety disorders. They more often have borderline personality disorders, and eating disorders. The experience of physical and sexual abuse influences women’s mental health status while the current system focuses on illness rather than addressing the determinants of health. (Prairie Women’s Centre for Health Excellence)

Data are not available at time of printing regarding rates of mental health disorders for women in Central Region. This issue will be explored in more detail in coming assessment cycles and with data to reflect upon. While we do not anticipate being able to connect abuse to subsequent mental health disorders without willing study participants, we recognize the theoretical connection and note it for future reference.

Some women in Central Region told us some of the ways they cope with stress:

I feel down sometimes so I talk to my friends…they make me feel better. When I can tell I’m getting depressed I also know that I have to go see my doctor and go back on my medication. This works. My friends are also close enough to talk to and I can tell them anything. (§60 year old, female, income under $20,000.)
In Central Region, women told us they spend their spare time at a variety of social activities to enhance their sense of well-being. For example, they visit, volunteer, or join games. Some women spoke of participating in activities that could enhance their health.

Marriage is another measure of social support and is defined as the percentage of the population by conjugal status, as reported in the 1996 Census of Canada. Central Region data were supported by the telephone respondents who told us they have a support network. A slightly greater proportion of Central Region respondents than respondents overall (52% vs. 48%) said they had someone who would listen to them all of the time, and slightly fewer than overall (19% vs. 22%) reported having nobody or having someone only a little or some of the time (Acumen Research, 54).

### 3.3 Living and Working Conditions

In our region, respondents’ impressions of their own health generally improves as their family income increases, with one exception in the $30,000-$39,999 range. Those with family incomes under $20,000 or at $30,000-$39,999 are the most likely to describe their health, compared to others their age, as fair or poor (18% and 14% respectively). Those with incomes of at least $60,000 are the most likely to say their health is very good or excellent (71%, vs. 6% who describe it as fair or poor) (Acumen Research).

We wondered whether there is more financial and resource support to families with incomes less than $30,000 that contribute to a sense of security and health that those in the $30,000-$39,000 do not receive. This potential disparity is a question to which we may be able find answers in a future assessment.
3.3.1 Income, Poverty, Social Status and Single Parenting

Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned. It is this inequality of distribution of wealth in a society that affects the health of the whole population. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole. (Donner, 2002,15)

Poverty is associated with a number of conditions that adversely affect health and limit access to health care, including poor housing conditions, behavioural problems, isolation and depression. Research has shown that people who are living in conditions of lower socio-economic status as measured by income, education or occupational status, are more likely to:

- Experience disease, disability and early death
- Work in dangerous, stressful or unstable jobs
- Live in unsafe or unhealthy homes and neighbourhoods and spend relatively high proportions of their income on housing that may be temporary
- Have less social support and fewer social networks
- Engage in health damaging behaviours such as smoking or substance abuse
- Experience obstacles to obtaining basic health care services, such as lack of transportation, difficulty in arranging childcare or time off work to attend appointments and the expense of medication.

These conditions in turn are associated with an increased risk for disease as a result of high blood pressure, high cholesterol levels and the release of stress hormones. The following is a review of some data concerning some of these health indicators compared to socio-economic status.

While there are no retrievable data regarding release of stress hormones and a specific study would be required to get it, there are data regarding socio-economic status as well as for hypertension treatment. For example, in Central Region, the socio-economic factor index (SEFI)\(^{12}\) tells us that the communities at most risk for poor health by this measure are those of Seven Regions and Portage la Prairie. Both of these geographic areas fall at higher risk than either the provincial average or the rest of Central Region by average and by geographic areas of the region. Prevalence for treatment of hypertension may not be an accurate description of actual prevalence. However, it is the only one currently available. What we know is that in Central Region overall, we fall below the provincial average for prevalence of treatment of hypertension. Within Central Region, Seven Regions is somewhat higher than the provincial average, and the area of Morris/Montcalm is the highest in the region and significantly higher than the provincial average. What we don’t know is whether we have higher screening, and subsequently more appropriate treatment in these areas leading to well-managed hypertension, or whether we in fact have higher prevalence of hypertension, nor do we know whether this is male or female treatment. We also know that there is not a visible correlation between the SEFI scores and hypertension treatment in Central Region.

We know that some of the outcomes of high blood cholesterol levels are Heart Attack and Stroke. We know through the RHA Indicators Atlas that in the years of 1991-1996 Central Region was

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\(^{12}\) The SEFI is a composite index of several measures of social and economic conditions derived from Canadian Census data. Negative values indicate low risk, and positive values indicate high risk. (MCHP Atlas, 30).
well within the provincial average for both these indicators and within these time periods shown. We know that the rates, for the most part, have remained relatively steady or have lowered, and that there is no correlation between the highest rates in the region and the most at risk areas according to the SEFI. However, women in RHA Central are dying from heart related diseases. The three leading causes of death are heart related and the remaining of the top five are lung related. Whether this is associated with poverty or not is unknown at this time.

The link between income and health has a special importance for women. In Central Region, (as in Manitoba and the rest of Canada), poverty discriminates, striking women substantially more frequently and more severely than men.

The average income for a Canadian woman was $19,800 in 1997, compared with $32,100 for a man. Manitoba, at 18.5 per cent, has the country’s third highest rate of poverty among Canadian provinces, compared to 16.2 per cent for all of Canada. For women, the picture worsens; 19.9 per cent of Manitoba women aged 18 and over were poor in 1999.

Women in Central Region reported lower incomes than women, on average, in Manitoba. The average income for women in 2001 in the Central Region was $18,244 compared to $21,480 in Manitoba overall. A greater discrepancy in income was found between women and men. For example, men who worked full time for a year earned an average of $34,200 while women earned almost $8,000 less, at $26,257. (See Table 6-2).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Central Regional Health Authority</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>All persons with earnings (counts)</td>
<td>48,925</td>
<td>26,460</td>
</tr>
<tr>
<td>Average earnings (all persons with earnings ($))</td>
<td>23,277</td>
<td>27,513</td>
</tr>
<tr>
<td>Worked full year, full time (counts)</td>
<td>25,505</td>
<td>16,280</td>
</tr>
<tr>
<td>Average earnings (worked full year, full time ($))</td>
<td>31,327</td>
<td>34,200</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

According to the Central Regional Health Profile, household income appeared to have been more equitably distributed in Central Region than in Manitoba as a whole. Marriage does not protect women from poverty, though. In 1996, one in ten married couples were poor and married women’s

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13 Martens et al, 2003, 30, 709
14 See glossary for descriptors of poverty.
15 Income inequality measures the proportion of income (from all sources, pre-tax, post-transfer) held by the bottom half (based on median income) of all households within a geographic area. A proportion of 50% would represent no inequality.
earnings are vital to their families’ well-being; without them, that proportion would have risen to one in four.

Earnings of adults has an impact on the lives of children with Manitoba having the highest child poverty rate in Canada. The disparity between women and men is remarkable. In 1999, there were 29,000 more poor women in Manitoba than poor men, a difference of 54 per cent.

A single mother with one child working full-time and earning minimum wage in Manitoba lives 43.4 per cent below the poverty line. If she is married with two children, even when both spouses work full-time at minimum wage, their family will live 25 per cent below the poverty line.

During community consultation, the Women’s Team asked participants how income affects their health. We were told about limitations in healthy choices regarding food and medications.

Aboriginal women are more likely to live in poverty than non-Aboriginal women or Aboriginal men. In 1995, 42.7 per cent of off-reserve Aboriginal women (excluding those who lived in the Territories) lived in poverty, compared to 35.1 per cent of Aboriginal men, 20.3 per cent of non-Aboriginal women and 16.4 per cent of non-Aboriginal men.

In 1996, 31.8 per cent of visible minority women in Manitoba lived in poverty, yet they are more likely than other Canadian women to be employed full-time. Recent immigrant women have particularly low incomes. In 1995, the average Canadian income for these women was only $12,000, about 62 per cent of the amount earned by Canadian-born women that year. (Donner, 2002)

More than half (51.3%) of senior women who live alone are poor. This has remained virtually unchanged in the last thirty years. Poverty is also an important factor in the health of older women. Many factors compound this, including poor housing, higher heating costs, increased isolation, fear for personal safety and functional impairments that may make day-to-day life difficult and painful. The link between inequalities in income and health is strong, even for those over the age of 85.

Women with disabilities also face a higher risk of poverty. In 1997, 27 per cent of women aged 16 to 64 with disabilities, lived in poverty. Almost two-thirds of those lived more than 25 per cent below the Low Income Cut Off. (Donner, 2002, 1)

Many women must also deal with the stresses of having two jobs - one underpaid job at the shop, restaurant or office and one unpaid job at home doing the child care and housework.

More disparity is seen in labour force participation than income. Female residents of Central appear to have a lower participation rate in the labour force than all Manitoba females combined.
(Manitoba Health, 2003, 87). As Table 6-3 illustrates, labour force participation rates are much lower among Central Region females (59.8%) than males (76.0%).

### Table 6-3: Central Region labour force indicators by sex, 2001.

<table>
<thead>
<tr>
<th>Labour Force Indicators</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation rate</td>
<td>67.8</td>
<td>76.0</td>
<td>59.8</td>
</tr>
<tr>
<td>Employment rate</td>
<td>64.9</td>
<td>72.9</td>
<td>57.0</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>4.3</td>
<td>4.1</td>
<td>4.7</td>
</tr>
</tbody>
</table>

**Source: Statistics Canada, 2001 Community Profiles.**

However, Table 6-4 illustrates that higher numbers of females than males participate in unpaid work – particularly in the areas of looking after children and seniors.

### Table 6-4: Unpaid work characteristics, by Sex, RHA Central 2001.

<table>
<thead>
<tr>
<th>Persons reporting hours of unpaid work</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65,995</td>
<td>31,760</td>
<td>34,235</td>
</tr>
<tr>
<td>Persons reporting hours of unpaid housework</td>
<td>65,230</td>
<td>31,200</td>
<td>34,025</td>
</tr>
<tr>
<td>Persons reporting hours looking after children, without pay</td>
<td>31,200</td>
<td>13,905</td>
<td>17,300</td>
</tr>
<tr>
<td>Persons reporting hours of unpaid care or assistance to seniors</td>
<td>17,540</td>
<td>7,295</td>
<td>10,240</td>
</tr>
</tbody>
</table>

**Source: Statistics Canada, 2001 Community Profiles.**

In Central Region, females aged 55 to 64 appeared to be at greatest risk for hospitalization due to workplace injuries (49.1/100,000), higher than that for all Manitoba females in this age group (15.6/100,000). For all Manitoba females, those at greatest risk were females aged 45 to 54 (21.3/100,000). We wonder whether women in the latter age group, in Central Region, are re-entering the workforce on the farm as their children begin to leave home. We noted that this concept holds true for women in the 55-64 age group whose recorded hospitalization for injuries on the farm increased in these years more than any other recorded age group (Manitoba Health, 2004, 208).

**3.4 Environmental Factors**

**3.4.1 Physical Environment**

A new study by McCracken contributes to the mounting evidence that women with low incomes have acute housing needs. They lack access to safe, stable and affordable housing and this has detrimental effects on their health. They have to deal with health risks such as mould and rodent infestation, and risk eviction if their apartment is condemned. Women living on low incomes are vulnerable to homelessness and to living in sub-standard housing. This is no different for poor Central Region women.

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16 Rate per 100,000 of workplace injuries that resulted in hospitalization for all females where the location of injury was coded as “workplace”, by age, 2001. (Manitoba Health, 2003, 133).
3.5 Healthy Child Development

As was mentioned in the section on smoking, birth weights are affected when a pregnant mother smokes. Low birth weight has been identified as a principal risk factor associated with infant mortality. Other factors associated with low birth weight include poor maternal nutrition, low maternal weight prior to pregnancy, poverty and early or late age pregnancy.

Low birth weights\textsuperscript{17} in Central Region have been consistently lower than the Manitoba average between the years 1996-2002 with the exception of 1999-2000. When there are small numbers such as these data involved, we have to look at trends over longer time periods before we can draw any conclusions.

For high birth weights\textsuperscript{18} in Central Region in the same study years, the opposite is true. We consistently have more high birth weight infants than the Manitoba average, apart from the anomaly year mentioned above. This factor is consistent with the high rates of diabetes we have in females in Central Region. Maternal diabetes in pregnancy is known to predispose infants to higher birth weights.

The chapter on Families outlined the characteristics of a healthy family. Connectedness was among them. Clearly there is more stress on a family and time for connecting when there is one parent in a family with children. As shown in Table 6-5, in Central Region there are significantly more female lone parent families than male. This is an added challenge to health for both the female and for the children in that family.

\textsuperscript{17} The percentage of live infants weighing less than 2500 grams to the number of births where weight is known and greater than 500 grams.

\textsuperscript{18} The percentage of live infants born weighing more than 4000 grams to the number of births where weights are known and greater than 500 grams.
The rate of teenage pregnancy indicates the number of teenagers and their children who may experience difficult living conditions. Central Region teenage and adolescent girls appeared to have lower birth rates than other Manitoba teen and adolescents girls combined. Of Central Region teenage girls aged 15 to 17 years, 2.7 per cent gave birth, compared to 3.7 per cent of all Manitoba teenage girls of this age. Of Central Region teens aged 18 to 19, 5.2 per cent gave birth, compared to 6.5 per cent of all Manitoba teens combined between 2001-2002. There were no births reported in Central Region to adolescents aged 10 to 14 years. Adolescent girls aged 10 to 14 years in Central Region appeared to have a lower pregnancy rate (0.3/1,000) than all Manitoba adolescent girls combined (0.6/1,000). Teenage girls aged 15 to 19 years in Central Region appeared to have a lower pregnancy rate (36.9/1,000) than all Manitoba teenage girls combined (53.1/1,000). (Manitoba Health, 2003, 107-8).

Between 1996/97 and 2000/01, 17 per cent of women who delivered babies in hospital delivered by caesarean section, this rate is the same as the provincial rate. However, an elevated rate was noted in a sub-regional group. These data were analyzed and measures taken to improve practice reflective of current best practice models. The result has been a reducing trend not yet evidenced in our data.

Figure 6-9 illustrates the pre-term birth19 rates by region for two time periods. The average annual rates decreased from 5.7 per cent between 1989-1993 to 4.9 per cent of live births between 1994 and 1998. In this second time period, the Central Region exhibits the lowest pre-term birth rate in the province. During the study years of 1998-99 and 1999-2000, there was an increase in pre-term births. From a low of 4.4 per cent in 1998-99 to a high of 6.7 per cent in 1999-2000, there appears to be an increase in pre-term births however, with no evident trend over time. These elevated pre-term rates correspond to the aforementioned low birth weight anomalies. With small numbers of births in our region, the anomaly was more visible than would occur in large birth rates.

Table 6-5: Lone parent families Central Region.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Central</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lone parent families</td>
<td>2,605 (10.5%)</td>
<td>49,160 (16.0%)</td>
</tr>
<tr>
<td>Female lone parent</td>
<td>2,120 (81.4%)</td>
<td>40,100 (81.6%)</td>
</tr>
<tr>
<td>Male lone parent</td>
<td>485 (18.6%)</td>
<td>9,060 (18.4%)</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

19 Pre-term is defined as birth prior to 37 weeks gestation.
As Figure 6-10 illustrates, although there have been fluctuations in rates of pre-term births, the rate has consistently remained below the provincial rate in the past six years.

Figure 6-10: Pre-term birth rate, 1996/97 to 2001/02.

Source: Manitoba Health.
3.6 Gender

The thesis of this chapter is that gender has everything to do with income and income influences health and health practices. Women have lower PMR but their health issues can be linked to quality of life as imposed by income.

We wondered whether there was any difference in treatment access between men and women. We are particularly interested in examining the idea of disparate access to treatment for procedures such as Coronary Artery Bypass and what the outcome would be for chronic diseases. With future studies examining the differences between genders with respect to health, we are interested in follow up of outcomes between men and women in Central Region in future assessment cycles.

3.7 Culture

We have seen throughout this document that culture plays a part in health and health practices and this remains true for women in particular. The issue of ethnicity as demonstrated by Aboriginal and Kanadier evidence affects the health of women themselves, their children and their whole families.

If you go into different cultures you see different forms of spirituality. I took expressive dance and they showed you how to take all your emotions and express them through dance. It relieves stress and certain emotions. You take all your emotions and release them to a spiritual dance. For me it does affect me. I admire some cultures.

Some sexual abuse occurs where the mother knows about it. [Cultural groups] are very much against separation/divorce. It takes a great deal of courage for a woman to leave, as she would have no support from her family or friends. They would consider staying within the family unit to be safe. Physical safety would not be considered. Even if the minister knew physical abuse was happening a woman would not be encouraged to leave. (§)
Women did not understand or [were not] taught about childbirth. Sexuality, pregnancy is not talked about and therefore women are more ignorant about pregnancy and childbirth...this is mainly because of their culture and religion. (§)

I think in our community we used to dance and try to stay healthy. When I was growing up I danced powwow. In our grandparents, we ate the food they made us, bannock, tea, rice and things like that... 🌱
SECTION IV: KEY FINDINGS

4.1 Observations

The key theme that the Women’s CHA team concluded for women was that the connectedness between income and health could not be divided. Poverty affects women in every aspect of their lives. A direct link was not available because the research has not been done at the Central Region level. The Women’s team is interested in findings that would help us to better understand how income and social status affect the health of women of poverty in Central Region. Evidence suggests that perhaps these effects are within the areas of Mental Health and Nutrition rather than those of such available indicators as hypertension treatment prevalence. We acknowledge the current evidence that poverty makes women unhealthy by conditions in Central Region such as:

- Living in overcrowded and dilapidated conditions where diseases are easily spread;
- Lack of money to purchase nutritious food, medications, dental care.
- Lack of control within employment status, having to take time off without pay to attend to child care matters and doctor’s appointments.

Women in our region have lower incomes than other women in Manitoba and than their male counterparts in Central Region, with Aboriginal women the most severely disadvantaged with respect to income. The average earnings of women in Central Region are well below the provincial poverty line. Folks in Central Region with higher incomes rated their own health better than those with low incomes with the exception of the $30,000-$39,000 range. We wonder whether those below $30,000 income have more help than those above, leaving the aforementioned relatively disadvantaged financially.

Women identified to us that ‘personal health practices’ and ‘health system performance’ were most important to their health. They did not identify living and working conditions as particularly important to their health whereas they feel that spirituality plays an important role in their health status. The qualitative health of women in Central Region cannot be demonstrated by lifespan, PMR and PYLL. They are very healthy by these indicators. Quality of life and morbidity better describe the health gaps of women in Central Region.

Some health concerns noted regarding women include:

- **Income and Working Conditions:**
  - Low high school graduation rates resulting in:
    - Poverty
    - Poor housing conditions
  - Working conditions resulting in:
    - The workplace as the site of injury resulting in hospitalization for more women in Central Region than in Manitoba overall.
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Personal Health Practices and Lifestyle:

- Physical Inactivity that results in:
  - Obesity - Women in Central Region were less likely to have a health body weight than women in Manitoba overall.
  - Diabetes possibly related to high birth weights - Women are treated for diabetes at higher rates than men in Central Region
  - Hypertension - Women are treated for hypertension at higher rates than men in Central Region
  - Heart Attack
  - High rates of injury from falls, especially in women 65+

- Smoking results in:
  - Respiratory Diseases
  - Low birth weight infants

- Insufficient Health Screening that results in:
  - Death from Breast Cancer a leading cause of cancer deaths in Central Region
  - Death from Cervical Cancer

Personal Resources:

- Emotional Difficulties resulting in:
  - Activity limitations
  - Hospitalization for self-inflicted injuries (11% higher than for men in Central)

4.2 Considerations to aid our population to be ‘as healthy as can be!’

- It is clear that poverty affects women’s health and health outcomes for the poorest women in Central Region would be improved by increased incomes. We have some concern, however, regarding an increase in incomes that places women in the $30,000-$39,000 income bracket if the result is less access to sufficient resources. Because of the disparity in perceived health and security we found in this people of particular income level, we wondered about supports to families with incomes less than $30,000 that contribute to a sense of security and health that those in the $30,000-$39,000 do not receive. This potential disparity is a question to which we may be able find answers in a future assessment.

- The team acknowledges that, according to Morris, poverty makes you unhealthy by:
  - living in overcrowded and dilapidated conditions in which disease is easily spread;
  - the stresses of poverty and uncertainty lead to unhealthy coping mechanisms and addictions;
  - not having enough money for nutritious food;
  - having no health coverage for prescription drugs and dental care; having to take unpaid time off from a low-paying job to get to the doctor by public transit and then wait for hours because the doctor has overbooked; working at a high-stress, badly paid job in which you have very little control.
Improved activity levels could significantly improve health outcomes for women.

We are concerned with the proportion of women smoking and exposed to cigarette smoke on a regular basis. There are increasing rates of adolescent women starting to smoke with 22 per cent reporting smoking during pregnancy. Outcomes for infants could improve with decreased smoking during pregnancy. Targeting youth to prevent smoking seems appropriate.

The second leading cause of cancer deaths for women is breast cancer and too many cervical cancer deaths led us to conclude our rates of cervical screening are too low.
- With increased Mammography screening rates we will be interested to observe whether our death rates for breast cancer will reduce over time as a result of increased screening.
- As we concluded in our 2002 report, “Unless a rigorous screening policy is developed and maintained, a rise in cases of invasive cervical cancer and deaths may be expected. Thus, the implementation and ongoing evaluation of organized screening programs should be a priority in the Central Region.”

The rate of hospitalization for injury compared to men is alarming, but provides us with a unique opportunity for intervention that men do not provide. This opportunity must not be wasted.

We wonder:
- Whether people in general and women in particular would benefit from education regarding what affects their health.
- What can be done by folks to affect their health, how might they partner with health providers toward healthy public policy to improve the health of women, and through them, their children. We acknowledge that anti-poverty programs are health policies, affordable housing policies are health policies, education and income policies are health policies and policies meant to eliminate inequality are health policies.
- The Women’s team would be interested in knowing the proportion of women with diabetes who have Type II versus Type I. There are consistently more high birth weights in Central Region than the Manitoba average, a possible relationship to diabetes in our population.
- Our findings gave no indication of health service disparity between men and women, and we wondered whether there was any difference in treatment access. We are particularly interested in examining the idea of disparate access to treatment for procedures such as Coronary Artery Bypass and what the outcome would be for chronic diseases. With future studies examining the differences between genders with respect to health, we are interested in follow up of outcomes between men and women in Central Region in future assessment cycles.
- With low birth weights\(^{20}\) in Central Region being higher than the Manitoba average between the years 1999-2000, we wondered whether time trend analysis might help to verify or disprove our conclusions regarding this cycle as an anomaly.

\(^{20}\) The percentage of live infants weighing less than 2500 grams to the number of births where weight is known and greater than 500 grams.
SECTION V: CHAPTER REFERENCES

5.1 Books and Journals


5.2 Government Documents

5.3 Internet Sources


5.4 Personal Sources and Unpublished Documents

Carr, C. (2003). Epidemiological Profile for Community Health Assessment, Regional Health Assessment – Central Region. (Unpublished)
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Men

“Men in Central Region are as healthy as can be!”

MEN’S SHAPE TEAM:

Terry Hills
Pat Nodrick
Dr. Lazarus

Deb Wier
Florence Lepp
Connie Greetsinger

Dave Cook
Teri Wylde
SECTION I: ASSESSING MEN IN CENTRAL REGION

1.1 The Assessment Process

The Community Health Assessment (CHA) began by establishing an in-house Men’s assessment team, one among seven assessment teams. We were charged with a mandate from the RHA Central to gather and interpret data on the health of Men aged 15 and over in Central Region.

In gathering data, the assessment team relied heavily on three sources of data. The first was a review of data from administrative sources as provided by our Epidemiologist and other documents described in the introduction of this report. These data sources gave us an overview of the known health status of Central Region males and informed our inquiry for the assessment.

The second source was expert in nature and came from literature sources as well as interviews with people interested in the health of men. Some outside sources included the Canadian Cancer Society, Heart and Stroke Foundation, Manitoba Lung Association and Manitoba Health.

The third source was surveys that the RHA Central commissioned as a part of the larger regional assessment, particularly a Telephone Survey and Focus groups meetings. Each contributed to the assessment of males in Central Region.

1.2 Assessment Theme

The Men’s health assessment team reviewed all information provided by the epidemiologist. The evidence indicated that quality and longevity of life are directly related to lifestyle choices of men in Central Region. Clearly, there are many issues related to health status over which men could have control. We focused the health
assess on lifestyle issues that are having a negative effect on the health of men in our region, the modifiable determinants of health and outcomes.

Based on the information provided, the assessment priorities for Men’s Health Issues are:

- Personal Health Practices and Lifestyles
- Personal Resources

1.3 Demographic Overview

According to the 2001 Census, the population of the Central Region is equally divided among males and females. Men make up 50.16 per cent of our population with the largest population grouping occurring between the ages of 25 to 44. The median age of the population is 33.9 years. The language used most often at work is English. (Statistics Canada, 2001).

As can be seen in Table 7-1, a large proportion of men in Central Region have less than high school education, a factor that tends to limit employment choices and earning potential. We can see that a higher proportion of males appear to be completing high school than in the past since there is a trend toward more high school education in our younger aged men. However, the reverse trend appears to be true for post-secondary education with a higher proportion of our older generation of men having achieved this status. The problem with respect to interpretation is that young people, such as 20-year-olds etc, will still be in university so that older men will have had time to finish school and would be counted while the very young men have not. The men aged 35-44, however, are most likely to have completed their education and a lower percentage have post secondary education than the 65+ generation. We caution this understanding because these data don’t tell us anything about how many of these people are in university at the time of the survey. What it may tell us, is that proportionally, there is likelihood that more men 65+ with higher education are likely to be alive than those with lesser education. There is a known link between higher educational attainment, higher socio-economic status, and better health outcomes that these data appear to evidence.

Table 7-1: Educational achievement, Central Region Males, 2001.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt; high school graduation (% of population)</th>
<th>University degree, certificate or diploma (% or population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 19</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>20 – 34</td>
<td>37.7 %</td>
<td>11.5 %</td>
</tr>
<tr>
<td>35 – 44</td>
<td>40.7 %</td>
<td>11.2 %</td>
</tr>
<tr>
<td>45 – 64</td>
<td>48.8 %</td>
<td>15.5 %</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

While there are more female lone-parents than male lone-parents in Central Region, we have a similar percentage of lone-male parent families to the province overall. In Central Region, the percentage of male lone parent families is 18.6 per cent compared to the
provincial rate of 18.4 per cent. We vary from the provincial rates in that the rate of female lone-parent families in Central Region is lower than the provincial rate. Therefore, there is less disparity between male and female lone-parent families in Central Region than provincially.

Table 7-2: Selected Central Region family characteristics, 2001.

<table>
<thead>
<tr>
<th>Selected Family Characteristics</th>
<th>RHA Central</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of families</td>
<td>24,730</td>
<td>302,855</td>
</tr>
<tr>
<td>Number of married-couple families</td>
<td>20,480</td>
<td>224,055</td>
</tr>
<tr>
<td>Number of common-law families</td>
<td>1,645</td>
<td>29,635</td>
</tr>
<tr>
<td>Number of male lone-parent families</td>
<td>485</td>
<td>9,060</td>
</tr>
<tr>
<td>Number of female lone-parent families</td>
<td>2,120</td>
<td>40,100</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.
SECTION II: HEALTH STATUS OF CENTRAL REGION MEN

2.1 Overall Health Status

Central Region telephone respondents reported they are slightly more likely than overall provincial respondents to rate their health, for their age, as very good. Central, at 39 per cent compared to the overall provincial rate of 37 per cent, rated well for perception of health status. We were slightly less likely at 9 per cent to rate as fair or poor compared to the provincial respondent average at 13 per cent (Acumen Research, 44). Men indicated fewer struggles with normal activities being limited by emotional difficulties, with less severe effects than women (Acumen Research, 42).

During the Statistics Canada Community Health Survey, Cycle 1.1 (2001), men reported their health as very good or excellent more frequently than did women who self-reported this good health status at a rate of 55.20 per cent compared to men at 58.55 per cent. These data are incongruent with reported functional health status1. Central Region men rate their functional health as worse than all Manitoba males combined, and worse than Central Region females.

2.1.1 Mortality

The data for men are opposite than for women as we review deaths. For example, men rate their health better and seek medical intervention less frequently than women but live shorter lives than women. Moreover, men are dying from largely preventable causes compared to women.

2.1.1 (a) Premature Mortality Rate (PMR)

In the years 1996 - 2000, the crude rate of male PMR in Central Region was 3.51/100,000. This is lower than the Manitoba provincial rate of 3.98/100,000 and lower, too, than the 3.96/100,000 of the previous assessment years of 1991 – 1995. By this measure men in Central Region are healthier than other men in the province and getting healthier. Men are less healthy, however, than women in Central Region.

2.1.1 (b) Potential Years of Life Lost (PYLL)

In Central Region, men have a higher PYLL rate than women. While still below the provincial average for the time periods shown (1991-95 and 1996-2000), men have almost double the rate of PYLL as women. Men in Central Region lost 65.19 and 60.13 years of life per thousand respectively compared to an average of less than 35/1000 PYLL in these same years for women.

---

1 Functional health status is a self-reported measure taken from the National Population Health Survey that is based on 8 dimensions of functioning. They are: vision, hearing, speech, mobility, dexterity, feelings, cognition and pain.
Overall PMR and PYLL for men is higher than for women, as are each of the reported causes of PYLL. In a ten year period, from 1992-2001, Central Region males lost more years of life to cancer, respiratory diseases, circulatory diseases, unintentional injuries and suicides than did females in Central Region. For example, with respect to PYLL, men accounted for 53 per cent of cancers, 57 per cent of respiratory diseases, 69 per cent of circulatory diseases, 77 per cent of unintentional injuries and 83 per cent of suicide in Central Region. Clearly, men are consistently dying younger than women from all of these causes. (Manitoba Health, 2003).

We also have information on specific causes of PYLL; unfortunately, the data are only available until 1998. Between 1994 and 1998, the specific leading causes of PYLL were motor vehicle accidents, (from here on referred to as crashes or collisions) ischemic heart disease, suicide and lung cancer. Although these data are somewhat dated, it is important to note that if we look at the ranking much earlier, between 1980 and 1984, the top four causes of PYLL listed were the same as in the earlier time period, and remain in the same order. This is very important as it appears that very preventable causes of death (such as motor vehicle crashes, lung cancer and suicide) continue to be the reasons men die at early ages.

Within Central Region, male PYLL was higher, in descending order, for Portage la Prairie and Seven Regions. While PYLL for men in Manitoba overall reduced in the second time period, for men in Portage la Prairie, Lorne/Louise/Pembina, Carman and Morden/Winkler PYLL increased very slightly. (Martens et al, 2003, 59) While this increase was not considered statistically significant, we would prefer to see a clear decrease.

2.1.1 (c) Life Expectancy

On average, men in Central Region have a life expectancy of five years shorter than women. The life expectancy of men is 75.7 years while for women it is 80.7 years. The chapter on Elderly will describe other factors related to disability free life expectancy. As an overall health status indicator, though, men are likely to die younger in Central Region than women. (Martens et al, 2003, 262).
2.1.1 (d) Leading Causes of Death

Certain ‘risk behaviors‘ that affect the health status of men in Central Region have been identified through evidence based research. There exists a relationship between men’s health issues to the leading causes of death and potential years of life lost. For example, while most early years of life are lost due to motor vehicle collisions, there is a relationship between causes of death and years of life lost with respect to heart and lung diseases. As shown in Table 7-3, heart and lung diseases lead the top five causes of death and are among the top five causes of PYLL. It is widely known that both heart and lung disease can be either prevented, or at least moderated, by good personal health practices and lifestyles. Two of the remaining top 5 causes of PYLL are related to preventable injuries both self-inflicted and unintentional. These data support our concern that what is causing the men in Central Region to be less healthy than they can be are largely detrimental choices men make.

Table 7-3: Leading causes of death and PYLL, Central Region men, 1994-98.

<table>
<thead>
<tr>
<th>Causes of Death</th>
<th>Causes of PYLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease</td>
<td>Motor Vehicle Accidents</td>
</tr>
<tr>
<td>Cerebrovascular Diseases</td>
<td>Ischemic Heart Disease</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>Suicide</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>Lung Cancer</td>
</tr>
<tr>
<td>COPD</td>
<td>Short Gestation / Low Birth Weight</td>
</tr>
</tbody>
</table>

Source: Manitoba Health.

2.1.2 Morbidity

When we consider some specific diseases and compare to provincial rates and Central Region female rates, the rate of disease burden for men in Central Region appears to be generally lower than male provincial averages although higher than women both in Central and provincially. This is not surprising given the PMR and PYLL for males.

2.1.2 (a) Injuries

Men are at a significantly higher risk for injuries in Central Region, both for death and hospitalization overall. Two exceptions are the Elderly and self-inflicted injury hospitalization data.

For men, the rate of deaths and hospitalizations from motor vehicle collisions (MVC) is alarming in Central Region. A rate of 24.1 deaths and 147.3 hospitalizations per 100,000 population explains some of our PYLL for men. The rate of deaths from self-inflicted injury at 16.5/100,000 is much higher than for women at 2.6/100,000 whereas for hospitalization the reverse is true with 48.3/100,000 versus 77.7/100,000 for females.

Some social role theorists have attempted to explain how gender roles can influence risk-taking behaviour and, in turn, its effect on injury rates and health. One explanation,
linked to gender stereotypes, is that the female role is characterized by communal qualities such as kindness, compassion, and a concern for the welfare of others and the avoidance of harm to oneself. In contrast, the male role is characterized by more active qualities such as chivalrous or heroic helping, a resistance to being influenced by others and a willingness to take risks. As a result of their role as ‘risk taker’, it appears that men are more likely than women to experience adverse health consequences. (Thom).

From the most recent information we can see that, in Central Region, the ‘risk-taking theory’ is supported by injury data for men compared to women.

Central Region males accounted for 73.5 per cent of the total 29,452 PYLL between 1994 and 1998 (the most recent data available). The leading cause of PYLL among men was injury resulting from motor vehicle collisions. See Figure 7-1 for hospitalization due to injury.

**Figure 7-1: Central Region male injury hospitalizations by manner or intent, 1992-2001.**

![Pie chart showing hospitalization due to injury by manner or intent for Central Region males, 1992-2001.](image)

89%

4%

6%

1%

Unintentional
Self-Inflicted
Assault
Undetermined

Source: Manitoba Health for data, analysis by EPI Research & Data Management.

According to Manitoba Health, of 133 deaths due to MVC’s, just over 69 per cent (total of 92) were among men. Of the 92 deaths among men, 24 (just over 26%) were among men ages 15-19 and an additional 17 (18.4%) were among men age 20-24. Death in the young age group accounted for a total 44.5 per cent. We note that data regarding MVC’s and contributing factors (i.e. speed, substance abuse, seatbelts) were not readily available from either Manitoba Health or the department of Motor Vehicles.
In 2001, 2,433 people died in motor vehicle crashes in Canada. Of that total, approximately 35 per cent were attributed to alcohol. Alcohol is a significant cause of injury related death on the road. Despite advertising targeted at the most susceptible demographic group, many young males choose to consciously ignore the message. In Canada during 2000, a total of 981 persons died in confirmed alcohol-related crashes. (Transport Canada).

We were unable to link MVC’s and alcohol consumption in our region due to lack of data. However, we know that one indicator of alcohol abuse is the use of addictions treatment. For some, addictions treatment is mandatory following alcohol related conviction under the criminal code. In the future we anticipate access to information directly linking offences and addictions treatment. At this time it is not readily available. Figures 7-2 and 7-3 shows the rates of addictions treatment by one of Manitoba’s agencies. While there are other treatment agencies in Manitoba, these figures give us some perspective that in Central Region, males 20-29 are a highest risk. We also know that men in Central Region report heavy drinking, as noted earlier, more frequently than do women.

Figure 7-2: Central Region and Manitoba one-year gender based comparison for addictions treatment through Addictions Foundation of Manitoba.

Source: Addictions Foundation of Manitoba.
A Central Region analysis (April, 2002 – March, 2003) of male emergency room visits to RHA Central health centres revealed that injuries represented the main reason for seeking emergency room attention. This was true of all age categories, although the age groupings varied from the regional definitions as follows: 15-19; 20-24; 25-29; 30+.

Source: Addictions Foundation of Manitoba.
As Table 7-4 below illustrates, common injury complaint themes exist and remain consistent among the four age categories reviewed. It was noted that as the male population aged, the number of visits increased, although it is reasonable to assume this could be attributed to the large grouping of 30+ age category because these data are not adjusted to reflect the age groupings in our region.

### Table 7-4: Five most common injury reasons for male ER presentation by age.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Hospital 1</th>
<th>Hospital 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>Portage District General Hospital</td>
<td>Boundary Trails Health Centre</td>
</tr>
<tr>
<td></td>
<td>Injury – limbs, head/neck, body</td>
<td>Injury – limbs, head/neck, body</td>
</tr>
<tr>
<td></td>
<td>Lacerations/Cuts/Punctures</td>
<td>Lacerations/Cuts/Punctures</td>
</tr>
<tr>
<td></td>
<td>MVC</td>
<td>MVC</td>
</tr>
<tr>
<td></td>
<td>Foreign body</td>
<td>Foreign body</td>
</tr>
<tr>
<td></td>
<td>Alleged assault</td>
<td>Burns</td>
</tr>
<tr>
<td>20-24</td>
<td>Injury</td>
<td>Injury</td>
</tr>
<tr>
<td></td>
<td>Lacerations/Cuts/Punctures</td>
<td>Lacerations/Cuts/Punctures</td>
</tr>
<tr>
<td></td>
<td>Foreign body</td>
<td>Foreign body</td>
</tr>
<tr>
<td></td>
<td>MVC</td>
<td>MVC</td>
</tr>
<tr>
<td></td>
<td>Alleged assault</td>
<td>Burns</td>
</tr>
<tr>
<td>25-29</td>
<td>Injury</td>
<td>Lacerations/Cuts/Punctures</td>
</tr>
<tr>
<td></td>
<td>Lacerations/Cuts/Punctures</td>
<td>Foreign body</td>
</tr>
<tr>
<td></td>
<td>Foreign body</td>
<td>Injury</td>
</tr>
<tr>
<td></td>
<td>Burns</td>
<td>MVC</td>
</tr>
<tr>
<td></td>
<td>MVC</td>
<td>Burns</td>
</tr>
<tr>
<td>30+</td>
<td>Lacerations/Cuts/Punctures</td>
<td>Injury</td>
</tr>
<tr>
<td></td>
<td>Injury</td>
<td>Foreign body</td>
</tr>
<tr>
<td></td>
<td>Foreign body</td>
<td>Fall</td>
</tr>
<tr>
<td></td>
<td>Fall</td>
<td>Lacerations/Cuts/Punctures</td>
</tr>
<tr>
<td></td>
<td>MVC</td>
<td>MVC</td>
</tr>
</tbody>
</table>

**Source:** Central Region Emergency Room Visit Statistics.

The most prevalent injury type reported by Central Region telephone respondents (male and female) was a sprain/strain (34%), followed by broken/fractured bones (18%), then either cut/puncture/animal bite or scrape/bruise/blister (9% for each type) (Acumen Research, 58).

The home or surrounding yard (23%) was the most prevalent single-site injury location among Central Region respondents; followed by (in order of decreasing frequency) a
factory/warehouse/construction site, a farm, a sports/athletics area (including school sports areas), and a workplace (Acumen Research, 59). We remain uncertain about precise locations of injury as detailed by site-prevalence, because for many, the home and surrounding yard would be their farm, and the workplace would be the farm. Clearly there is more research required to fully articulate the location of injuries if we are to plan around location of injury for prevention.

While injury is not among the leading causes of death – it is among our leading causes of potential years of life lost. Therefore, our concern with respect to this particular issue is around the preventable loss of life and/or capacity. The unexpected loss of life of a young person seems so senseless. The unexpected death of a family member in whom one had one’s hopes for the future, was an expressed concern with males who had generations of a family business tradition that was lost due to injury.

2.1.2 (b) Chronic Diseases

Among the chronic diseases reported, those with increasing treatment prevalence over time in Central Region include diabetes, hypertension, and, to a smaller degree, heart attack. Our rates of stroke, cancer and respiratory prevalence have decreased. We wonder whether the increasing treatment of diabetes and hypertension have resulted in improved rates of stroke.

2.1.2 (b-i) Diabetes

Overall, in the two study periods of 1993-6 and 1998-2001, 20-79 year olds in Central Region were treated for diabetes at the rates of 4.0 per cent and 4.9 per cent respectively. Men in Central Region had lower prevalence of diabetes at 574.6/10,000 compared to women at 581.7/10,000. (Martens et al, 2003).

2.1.2 (b-ii) Hypertension

For hypertension in the same study periods, ages 25 plus, we had treatment rates increase from 19.4 per cent to 22.1 per cent. (Martens et al, 2003). The self-reported rates of hypertension in Central Region are lower than the provincial average (12.7% versus 14.3% in 2003). Women in Central report slightly higher rates of treatment for hypertension than do men (12.8% versus 12.6%). Self-reported data appears to indicate that men have lower rates of hypertension treatment than females in Central Region although we are to interpret these data with caution (Manitoba Health, 2003). As mentioned in the women’s chapter, it is entirely possible that we are appropriately

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2 Prevalence refers to the total number of people living with a disease or condition within a given population.
treating more hypertension with a positive outcome of reduced stroke rates, which have declined in these two periods from 2.28/1,000 to 1.97/1,000 (Martens et al, 2003).

2.1.2 (b-iii) Cancer

For cancer, the picture is somewhat encouraging. In the two time periods studied (1991-95 and 1995-2000), the rate has decreased from 5.28/1,000 to 5.13/1,000 (Martens et al, 2003). More specifically, in the years from 1996-2000, there appeared to be a lower rate of cancer for males at 450.0/100,000 than for Manitoba as a whole at 529.8/100,000. These lower rates are reflected in lower rates for some select cancers as shown in Table 7-5.

Table 7-5: Select cancer rates, Central Region compared to Manitoba, 1996-2000.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>RHA Central/100,000</th>
<th>Manitoba/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma</td>
<td>9.5</td>
<td>12.6</td>
</tr>
<tr>
<td>Colorectal</td>
<td>66.3</td>
<td>77.6</td>
</tr>
<tr>
<td>Prostate</td>
<td>101.3</td>
<td>137.4</td>
</tr>
</tbody>
</table>


2.1.3 Well-Being

This indicator of self-reported health can tell us what some of the other indicators such as disease prevalence and causes of death may miss. The measures include functional health status, self-reported health status and activity limitations.

2.1.3 (a) Functional Health Status

Men in Central Region report their functional health as about the same as all Manitoba males combined. Just over 80 per cent of Central Region males rate their health as very good or perfect compared to 79.4 per cent Provincially. This rating is lower than for Central Region women, where 84.5 per cent report very good or perfect functional health. (CCHS, 2003).

2.1.3 (b) Self-Rated Health Status

Ratings of self-rated very good or excellent health have declined among Central Region men, from 61.9 per cent in 2001 to 55.7 per cent in 2003. Rates among Manitoba men have also declined slightly (from 62.6% to 61.1%) but continue to be higher than Central Region rates. (CCHS 2001 and 2003).

2.1.3 (c) Activity Limitations

Activity limitations data include respondents to the CCHS who report being limited in selected activities (home, school, work and other) because of a physical condition, mental condition, or health problem which has lasted or is expected to last six months or longer. According to the 2003 CCHS, fewer Central Region males (20.2%) report an activity limitation compared to females. This is an increase from the 2001 survey where just 18
per cent of both men and women reported an activity limitation. These data support our survey where men also reported that their activity is limited as a result of poor emotional health less frequently than it is for women.
SECTION III: DETERMINANTS OF HEALTH

The determinants of health that most affect men are demonstrated in the subsequent discussion. The determinant of gender is incorporated throughout this review of men, while biology and genetic endowment, despite its non-modifiable nature is discussed separately. Since Central Region scored significantly above the overall rating in the Telephone Survey with respect to accessing health services, and given that this is a health status review rather than a health services review, little comment on health services is presented at this time.

3.1 Personal Health Practices and Lifestyle

We know that, for men, there are a number of health practices and lifestyle issues that affect their health. As described in the Individuals Chapter, weights, behaviors such as alcohol consumption, smoking and activity are some of the factors we considered.

3.1.1 Weights

Although a slightly smaller proportion of men in Central Region are overweight or obese than the provincial average, almost 60 per cent are considered somewhat or significantly overweight (39.1 % are overweight and an additional 20.9% are obese).

Being overweight – either excess weight or obesity, are well-documented risk factors for a variety of diseases, including coronary heart disease, hypertension, type 2 diabetes, osteoarthritis and some cancers. (WebMD) Individuals who are obese have a 50-100 per cent increased risk of premature death from all causes, compared to individuals with a healthy weight. High blood pressure is twice as common in adults who are obese than in those who are at a healthy weight. A weight gain of 5-8 kg increases a person’s risk of developing type 2 diabetes to twice that of individuals who have not gained weight. Over 80 per cent of people with diabetes are overweight or obese (United States Surgeon General).

3 Note: Definition change implemented in 2004 to conform with Health Canada guidelines for body weight classification.

Body Mass Index (BMI) is a method of classifying body weight according to health risk. According to World Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each of the following BMI categories: normal weight = least health risk; underweight and overweight = increased health risk; obese class I = high health risk; obese class II = very high health risk; obese class III = extremely high health risk.

BMI is calculated as follows: weight in kilograms divided by height in metres squared. The index is: under 18.5 (underweight); 18.5-24.9 (normal weight); 25.0-29.9 (overweight); 30.0-34.9 (obese-Class I); 35.0-39.9 (obese-Class II); 40 or greater (obese - Class III). The index is calculated for those aged 18 and over excluding pregnant women and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).
In the 2000-01 CCHS, a high proportion of Central Region males (age 20-64) were classified as either somewhat overweight (Body Mass Index (BMI), between 25.0-27.0) at 38.9 percent or overweight (BMI greater than 27.0) at 20.8 percent. Even with the definition changes for cycle 2.1, in 2003, we still have almost 60 per cent of our population meeting the criteria for being overweight or obese.

In 2001, more men than women self-reported having a BMI of greater than 27.0. (In 2003, with definition changes, rates were too small to break out by both sex and age group.) Rates in both of these categories are higher than seen among Central Region females. As Figure 7-4 illustrates, BMI ranges >27.0 among men are highest in the 45-64 year old age group. As illustrated with rates of physical inactivity, rates of high body mass indexes among young men aged 20-24 are high (40.9%).

**Figure 7-4: Overweight rates (BMI>27) in Central Region 2000-01.**

![Chart showing overweight rates by age group and sex]

Source: Canadian Community Health Survey, Cycle 1,1, 2000-01.
Note: Numbers suppressed for 20-24 females due to small numbers.

Dietary intake plays one role in this factor. According to the 2003 CCHS, just over one in five Central Region males (21.4%) consume the recommended daily amount of fruits and vegetables. This is much lower than the rate among females at about one in three.

My mom had diabetes. I can’t avoid it but I try to watch what I eat. I’m kind of scared of getting it too…I’ve been diabetic for over a year and a half. Sacrifices I’m making. It is difficult. But the benefit is a healthier life.  

(Compiled)

Some men who have seen health risks related to weight in family members told us about their own health promotion behaviors with respect to good dietary habits. Aboriginal males in general expressed a concern over their diet and how it affected their health in
particular with respect to diabetes. Young males cited appearance as being important with respect to healthy weight.

**Definitely your lifestyle you’re responsible for. People sitting in McDonald’s getting fat, that isn’t McDonald’s fault, it’s yours. Eating habits and activity levels…You don’t want to be a 300-pound guy because you wouldn’t feel very good about yourself. Even side comments from people, when they notice. They notice you look better after going to the gym. Encouragement. You feel good and want more comments like that. ![Compiled](image)

### 3.1.2 Alcohol Consumption

Central male and female residents appear to have been less likely to drink heavily once per month than Manitoba residents. In 2003, 29.1 per cent of Central Region male residents met the CCHS definition of “heavy drinking” versus 30.2 per cent of Manitoba males. Although our rates among males are slightly lower than among Manitoba overall, these rates are still much higher than seen among females (10.2%) and mean that almost one in three Central Region males meets the criteria for “heavy alcohol consumption”.

### 3.1.3 Smoking

Our assessment reveals that smoking has a significant impact on Men’s Health in Central Region. Smoking is one of the leading factors that is detrimental to health status and quality of life. Research shows significant rates of Cancers, Lung Disease, Heart Disease and Strokes, all of which are amplified by smoking. In our region, just over 1 in 4 (27.1%) males reported being a daily or occasional smoker (CCHS 2003). In addition, almost all current smokers had started smoking by the age of 20 (43.2% started between ages 5-14 and 49.5% started between ages 15-19). In 2001, smoking rates were highest in Central Region males aged 20-24 with 21 per cent of our male population smoking by the age of 20 and 34 per cent by the age of 24. Data from 2003 are more difficult to break out by both age group and sex due to smaller numbers participating in this survey. Men in Central Region expressed concern over smoking and its costs and risks.

**Smoking on my own just affects me but the truth is it affects the health care system. Money is tied up to treat people who are killing themselves with smoking…I smoked for 35 years and my father passed away from emphysema. I’ve seen the health affects of smoking…Smoke free house has to be a huge positive…When we moved into a new house I quit smoking in the house. The stress is primarily on [my wife] and not me. Finally when I quit, her life was a lot easier. ![Compiled](image)**

**The time came when I wanted to quit smoking. I told a friend in college and he said he would quit. He did quit, when he died of lung cancer. ![Compiled](image)**
Ischemic Heart Disease is the leading cause of death for men living in Central Region. Of men diagnosed with coronary heart disease, 45 per cent are related to smoking under the age of 65. It is clear that the prevention of heart disease would be significantly improved by reductions in smoking.

Lung Cancer is the third leading cause of death for men in Central Region and the fourth leading cause of potential years of life lost. Regrettably, the survival rate for those diagnosed is only 15 per cent. Smoking is estimated to be the cause of 85 per cent of all lung cancer making it one of the most preventable forms of cancer. Significant health care resources are dedicated to the treatment and management of this disease. (Canadian Cancer Society and Manitoba Lung Association)

Chronic Obstructive Pulmonary Disease (COPD), which includes Emphysema and Chronic bronchitis, is the 5th leading cause of death for Central Region men. These diseases often result in frequent use of acute care medical services. It is estimated that 80-90 per cent of COPD is related to long term smoking. Of those living with COPD, 51 per cent report significant limitation to daily activities. Long term hospitalization often occurs.

While our asthma rates (51.2/1,000) are lower than all Manitobans combined (65.8/1,000), a preliminary review of ER visits in our two regional centers reveals one of the top five reasons for presenting at ER was respiratory complaints.
3.1.4 Physical Activity

On average, physically active people outlive those who are inactive. Regular physical activity has been found to help maintain functional independence of older adults and enhances quality of life for people of all ages.

Physical inactivity is a risk factor for cardiovascular disease, which in Central Region is the leading cause of death among men and second leading cause of potential years of lost life.

According to the 2003 CCHS, 51 percent of Central Region males over the age of 12 are physically inactive (higher than the provincial rate of 43.87% of males). It is discouraging to note that rates of physical inactivity among men have increased from 46.4 per cent reported in 2001. Both males and females in Central Region appear to be more likely to be physically inactive during their leisure time than all Manitobans combined.

Manitoba was 1 of 5 provinces where the percentage of people who were physically inactive was higher than the rates for the Canadian population as a whole. (Heart & Stroke Foundation of Canada).

Males from 15-65 years of age with whom we consulted expressed agreement with the importance of physical activity for maintaining health.

Stay in shape and stay active. Important to stay fit. I play hockey and run once in a while. In the summer I work and ride my bicycle...I try to have physical activity everyday. I think it is one of the best solutions to have a healthy lifestyle. Have lots of exercise. This of course improves your digestion, appetite and keeps your blood flowing very freely in your system. # (Compiled)

As figure 7-6 illustrates, physical inactivity is prevalent in every age group. Even among young men aged 12-19, about one quarter (24.3% in 2001, and increasing to 25.9% in 2003) are physically inactive in Central Region. The highest rate of reported physical inactivity was in the 20-24 year old age group in the first CCHS cycle and in the 45-54 year old age group in the second cycle. The fact that the numbers in the 20-24 year old age were too small to report in this cycle must remind us that we must interpret data with caution as sometimes even “high rates” are based on small numbers of actual participants.

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4 Physical Activity: Population aged 12 and over reporting level of physical activity, based on their response to questions about the frequency, duration and intensity of their participation in leisure-time physical activity. (Manitoba Health, 2003, 71).
Perhaps life requirements at various age intervals affect abilities for physical activity. Men of various age groups identified some of the issues that prevent them from being physically active.

Males surveyed by telephone were almost twice as likely as females to cite a physically demanding occupation/lifestyle/housework as their main health improvement activity, while females were more than twice as likely to cite a healthy, well-balanced diet. Males are almost twice as likely as females to say they do nothing in particular to improve their health (Acumen Research, 46).
3.2 Personal Resources

3.2.1 Life Stress

The Injuries in Manitoba: a 10 year Review reports that men died from suicide in Central Region during the years 1992-99 at the rate of 16.5/100,000 versus 2.6/100,000 for women. However, it is very important to note that when we look at hospitalizations for self-inflicted injuries the reverse is true. Women in Central Region were hospitalized for self-inflicted injury at the rate of 77.7/100,000 compared to 48.3/100,000 for men (Manitoba Health, 2004). This factor is important in that we must target interventions for men differently than for women. For example, we are given a unique opportunity for intervention regarding outcome for women versus men. During hospitalization, we have access to women who are at risk for future behavior that could result in death. For men we must seek alternative methods to reach them prior to the one attempt during which they complete the act of suicide.

Depression is a common disabling condition that accounts for an important proportion of psychiatric hospitalization and, arguably, the majority of suicides. It is common and treatable; men in Manitoba have a ‘Probable Risk of Depression’ of 4.9 per cent (Statistics Canada, Health Indicators). The International Labour Organization, in a report on Mental Health in the Workforce, found that in the U.S., Clinical Depression has become one of the most common illnesses, affecting one in ten working age adults each year. Men account for only one in ten diagnosed cases of depression.

The lingering stereotype of depression as a female condition may prevent some men from recognizing its symptoms and seeking appropriate treatment. Several reasons have been given regarding why symptoms go unrecognized. Men tend to deny having problems because they are expected to be strong. North American culture suggests that expressing emotion is largely a feminine trait. Therefore, men with depression are more likely to talk about the physical symptoms of their depression, such as feeling tired, rather than those related to emotions. The observable symptoms of male depression are not as well understood as those in women. Men are less likely to show typical signs of depression, such as crying, sadness, loss of interest in previously enjoyed activities or verbally express thoughts of suicide. Instead, men are more likely to keep their feelings hidden, and rather, may become more irritable and aggressive. Rather than seek help, which means admitting to what they perceive as a weakness, men are more likely to deal with their depression by drinking heavily or suiciding. (Canadian Mental Health Association).

Depression appears to be on the increase. In this century, each succeeding generation has experienced major depressions at earlier and earlier ages, and each generation that follows the next has a higher lifetime risk of experiencing the mental disorder. (Canadian Mental Health Association).

According to the RHA Indicators Atlas, the Manitoba rate for Depression was 8 per cent (1994-95), with rates for males being lower than for females. In Central Region we have seen a rise in the prescribed use of Antidepressant Medication, from 4.2 per cent in
1996-98 to 5.5 per cent in 1999-01 (Martens et al, 2003). It is unclear, however, how much of this increase is attributable directly to depression and how much can be attributed to use as adjunctive therapy for analgesia. A future study is expected to reveal this level of detail more clearly, providing us with an opportunity to better understand depression treatment rates.

Suicide is the 3rd leading cause of Potential Years of Life Lost among Central Region men. At every age men are more likely than women to suicide. Males aged 20 – 24 were 4.6 times more likely and, in the over 75 year bracket, the suicide rate was 6.5 times greater than their female counterparts (Donner, 2003).

The most common triggers of suicide in men are:

- Unemployment or loss of career
- Divorce
- Permanent physical disability or chronic illness
- Alcohol abuse
- Depression
- Social isolation

Injury from an outside source, that is, violence or assault, is also more common for men than for women, with men dying from assault at the rate of 1.8/100,000 versus 0.8/100,000 for women. Men have also been hospitalized from assault in Central Region, without death, at the rate of 71/100,000 for men versus 25.9/100,000 for women in the years from 1992-2001.

Central Region residents appeared to have higher levels of reported stress than Manitobans as a whole, although these data are small and should be interpreted with caution. Of Central Region men counted in the 1996 Census of Canada, just under 29 per cent reported not very much, to no stress. That left over 71 per cent reporting anywhere from ‘a bit’ to ‘an extreme amount’ of stress, with the majority reporting “a bit” at 40.5 per cent. (Manitoba Health, 2003, 79-80).

### 3.2.2 Spiritual Resources

For some, spiritual resources provide strength and make one feel confident in ability to cope with illness or stress. Over half (54%) of Central Telephone Survey respondents believe that their spiritual well-being plays an extremely important role in how they feel about their overall daily health, with another one-third (37%) saying its role is somewhat important. Only 9 per cent said that spiritual well-being plays an unimportant role in their overall health. Women tend more often to feel that their spiritual well-being plays an extremely important role in their overall daily health than do men (Acumen Research).

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5 Level of chronic stress reported by the population aged 18 and over, based on their response to a series of 17 questions about their personal situation. These data should be interpreted with caution, because of small sample size. Manitoba Health, 2003, 79.
Adolescent males in Central Region tended to express that, for them, there was no connection between spirituality and their health.

Some males felt spirituality can relieve stress if used to express oneself and one’s emotions. Some felt they gained strength from their beliefs and values. Males in their middle years from 20-55 expressed a connection especially between spirituality and psychological health, having stability and good health.

Having someone of any faith to help when ill was important. One man expressed that he was unconcerned about the faith of a visitor while he was in hospital.

Aboriginal males in this age group felt that spirituality involved their connection with nature, their ability to stay clean, described by some as staying sober, substance free, and out of jail.

### 3.2.3 Social Support Networks

Social support is evidenced in a number of ways. Having someone to talk to is thought to be one way to cope, to reduce the levels of stress one feels. Females reported in the Telephone Survey that they are more likely than males to have someone to talk to. A slightly greater proportion of Central Region respondents than respondents overall (52% vs. 48%) said they had someone who would listen to them all of the time, and slightly fewer than overall (19% vs. 22%) reported having nobody or having someone only a little or some of the time. (Acumen Research, 53).

Two indicators of social support are related to living in a family. We know that Central Region residents appear more likely to live in a family household and to be married than other Manitobans combined.
Marriage is another measure of social support and is defined as the percentage of the population by conjugal status, as reported in the 1996 Census of Canada. Central Region data were supported by the telephone respondents who told us they have a support network. A slightly greater proportion of Central Region respondents than respondents overall (52% vs. 48%) said they had someone who would listen to them all of the time, and slightly fewer than overall (19% vs. 22%) reported having nobody or having someone only a little or some of the time (Acumen Research, 54).

For men, having a wife to talk to also meant having someone to validate their need for medical intervention. For others, having a mate was important for companionship. Most men spoke at some point in the interview about the significant role their wife or mate played in their life, health choices and outcomes. Research literature has indicated that men who are married live longer than those who are not, an idea that the men of Central Region seemed to support.

3.3 Living and Working Conditions

In our region, respondents’ impressions of their own health generally improves as their family income increases, with one exception in the $30,000-$39,999 range. (Acumen Research, 39). Those with family incomes under $20,000 or at $30,000-$39,999 are the most likely to describe their health, compared to others their age, as fair or poor (18% and 14% respectively). Those with incomes of at least $60,000 are the most likely to say their health is very good or excellent (71%, vs. 6% who describe it as fair or poor) (Acumen Research, 44). We wondered whether there is more financial and resource support to families with incomes less than $30,000 that contribute to a sense of security and health that those in the $30,000-$39,000 do not receive. This potential disparity is a question to which we may be able find answers in a future assessment.

As previously discussed in the Individuals’ Chapter, health status improves at each step up the income and social hierarchy. Living on low income creates uncertainty, insecurity, and lack of control over one’s life, all-powerful effects on health. Further, studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned. In Central Region, this claim is supported if we look at the PMR of Central Region compared to Manitoba as a whole. We have anywhere from 4th to 2nd best PMR in the province and according to the Central Region Profile Document, our household incomes appear to be more equitably distributed than in Manitoba as a whole (Manitoba Health, 2003). See Table 7-6.
The Men’s team has pointed out that while the chapter on Women has addressed financial inequities and the effects of poverty on health, ensuring the long term responsibility of men for their families could have a significant effect on the health of individuals in Central Region.

3.3.1 Work Life

As Table 7-7 illustrates, labour force participation rates are much higher among Central Region males (76.0 %) than females (59.8%).

<table>
<thead>
<tr>
<th>Labour Force Indicators</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation rate</td>
<td>67.8</td>
<td>76.0</td>
<td>59.8</td>
</tr>
<tr>
<td>Employment rate</td>
<td>64.9</td>
<td>72.9</td>
<td>57.0</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>4.3</td>
<td>4.1</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.

In Central Region, males aged 20 to 24 appeared to be at greatest risk for hospitalization due to workplace injuries (436.9/100,000), higher than that for all Manitoba males in this age group (91.1/100,000). For all Manitoba males, those at greatest risk were males aged 35 to 44 (117.4/100,000).6

Workplace injuries for men in Central Region would include farm injuries. According to the Injuries in Manitoba: a 10 year Review, of the provincial farm-related injuries, 151 ended in death from 1983-2002. Of these, 22 per cent were due to run-over and 18 per cent from rollover. This would imply injury by motorized farm vehicle. Of these, in Central Region, all were male. A closer look at age groupings shows that, depending upon age, the mechanism of injury differs. For example, of the farm deaths provincially, all males were more likely to be struck by a farm vehicle (either rollover or run-over) but

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6 Rate per 100,000 of workplace injuries that resulted in hospitalization for all females where the location of injury was coded as “workplace”, by age, 2001 (Manitoba Health, 2003, 133).

Table 7-6: Earning statistics, Central Region and Manitoba, 2001.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Central RHA</th>
<th></th>
<th>Manitoba</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Earnings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All persons with earnings (counts)</td>
<td>48,925</td>
<td>26,460</td>
<td>609,575</td>
<td>320,670</td>
</tr>
<tr>
<td>Average earnings (all persons with earnings ($))</td>
<td>23,277</td>
<td>27,513</td>
<td>27,178</td>
<td>32,312</td>
</tr>
<tr>
<td>Worked full year, full time (counts)</td>
<td>25,505</td>
<td>16,280</td>
<td>331,655</td>
<td>195,760</td>
</tr>
<tr>
<td>Average earnings (worked full year, full time ($))</td>
<td>31,327</td>
<td>34,200</td>
<td>36,549</td>
<td>41,027</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001 Community Profiles.
at significantly differing rates. Males from 0-14 were most likely to be run over, either because they fell off the machine, or they were not visible to the operator of the machine (approximately 71%). Males 15-59 were more likely to be killed from a rollover (approximately 21%) and males 60+ were more likely to be run-over (approximately 26%), the latter two ages at far fewer rates than the up to fourteen age group (Manitoba Health, 2004). While the rates of farm injury deaths and hospitalizations in Central Region are not extraordinarily high, any number is too high when we consider that none are necessary.

3.4 Healthy Child Development

The determinant of healthy child development has been addressed mostly in the Women’s Chapter and the Children’s Chapter. However, the men in Central Region had some things to say about this factor. They felt quite strongly that this alone is what leads to the health of our future generations and determines one’s health for a lifetime. Some men named other determinants as more important but when this determinant was raised as important to others, they agreed, for the most part, regarding its importance. Here is what the men of Central Region had to say.

Nothing is more important than the beginning and how a child develops (their brain and body). If a teen pregnancy is not done right and there is FAS it can really screw up a life from then on.

The Men’s Team added that if men in our region were free from addictions and mental health problems, did not die before their families were raised, if their overall health and relationships improved, it would have a significant effect on the health of their families. While this would involve few families, as the majority of men in fact are free from these indicators of poor health, for those that are affected, this is an issue one would find difficult to dispute. The men in Central Region, judging by the comments made by the men we interviewed, would agree.

We’re always fixing problems after we start them. We start them by living and eating improperly. I eat anything now. It isn’t going to affect me now. It needs to start at school age. We need more healthy child development.
3.5 Culture

We have seen throughout this document that culture plays a part in health and health practices and this remains true for men.

There are also predispositions to how you think about things. In some places some surgeries are considered unholy. Then you’re not pure. Taking blood transfusions are wrong because you’re taking something else in and you’re not pure. Lots of things can affect how you go about being treated for different illnesses.

It is difficult to engage some cultures in dialogue, particularly when there is both a cultural and language barrier. We felt that there was an important segment of our population missing in the story of our health status if we did not attempt to find out more about the Mennonite people of Central Region. We interviewed a knowledgeable member of the Kanadier Mennonite culture. He told us that culture was very important to the health of this low German Speaking Mennonite population. According to this informant, their culture and lack of education holds them back and keeps them in the dark. He feels education could motivate changes. He told us, for example, we would need to go to them with health education, that they would not come to us. He spoke about their need to know why to practice healthy lifestyles (eg. quit smoking) and what can happen if you don’t. He told us to try not to give out too much information at once. He also told us that the men are very important to these families in that they are the decision-makers and any health practices would need to be approved by the men.

3.6 Biology and Genetic Endowment

This particular determinant does not lend itself to changes or external influences.

...values lived by and beliefs held, influence everything you do, if you have poor values, it will reflect in health and social interaction. Influenced by activities in the church and working together with others. How you interact with others – it is very important.

Central Region. We interviewed a knowledgeable member of the Kanadier Mennonite culture. He told us that culture was very important to the health of this low German Speaking Mennonite population. According to this informant, their culture and lack of education holds them back and keeps them in the dark. He feels education could motivate changes. He told us, for example, we would need to go to them with health education, that they would not come to us. He spoke about their need to know why to practice healthy lifestyles (eg. quit smoking) and what can happen if you don’t. He told us to try not to give out too much information at once. He also told us that the men are very important to these families in that they are the decision-makers and any health practices would need to be approved by the men.

The father is the leader and is expected to rule. He makes all the decisions.

...there is a lot of health troubles in my family. My dad is 45 and had two heart attacks. Grandpa and great Grandpa too.

...my parents, my dad had inherited cancer and my mum has diabetes. My dad died from cancer a couple of years ago.

However, the men in Central Region spoke about the importance of this determinant to them. They told us about family predisposition to cancer, heart disease, diabetes, and
other diseases. They told us about young deaths of their loved ones from inherited
diseases and how important it is to reduce the probability of these diseases through health
practices. They told us about family members who have not followed good health
practices and how they watch and wait for those individuals to get sick or die as a result.
They told us about the effect this watching and worrying has on the family.

3.7 Health Services

This health report has not focused on health services because, for this cycle, we have
attended to health, and gaps in health. However, some of the men we interviewed wanted
to ensure that we would convey a message regarding health services. This message was
that, regardless of who provides service to them, men want to ensure that services are
available. They told us that the provider, for many conditions and for all but the most
serious examinations might appropriately be a nurse. They sometimes spoke about
services that have been described elsewhere as a component of Primary Health Care.

We should have clinics where nurses look after patients to a greater
degree. ER rooms are clogged around the province because more money
isn’t spent training nurses to look after things only doctors take care of.
That has always been my complaint about the system in Manitoba. They
should have clinics, not necessarily attached to the hospital but where the
nurses can handle 90% of the problems brought to them or direct people
with more serious conditions. Performance comes back to money and
planning for more nurses and training them properly.

We are going to see
the doctor when we
don’t need to.

It doesn’t have to be from doctors. I can
be from someone else with experience
and sharing that information. The nurses
can do a lot. In fact, they could do a lot
more sometimes than the doctor. They
have time for you.

In my opinion a well-trained nurse is an under-utilized resource to the
system. I’m always bothered by questions no one seems to have in the
health care system. Where can I go to get the information? Is there a
web site? Can I phone a toll free number? Finances for example.
Where can I get information about finances?
SECTION IV: KEY FINDINGS

4.1 Observations

The Key Themes that have been reviewed throughout this document for men are directly related to lifestyle choices. Each of the leading causes of death, disability and hospitalization can be linked either directly or indirectly to risk-taking behaviour, such as smoking, and operating machinery in an unsafe manner. These issues were shown to impact men, no matter what their age, throughout Central Region. They included:

- Smoking
- Inactivity/Obesity
- Injury
- Mental Health Issues (Suicide, Depression)

Clearly, in Central Region, men are dying from diseases over which they can exert some control. While not all deaths from heart disease and cancers are preventable, nor can all injury related deaths be prevented, most are either preventable or can be modified, or the impact reduced by changes in behavior. This is one area where differences can be demonstrated by positive lifestyle changes. This team focused on those areas over which changes can have an effect. We can, with the co-operation of men, make a difference to their health.

Men have told us quite clearly that they want to be able to access the continuous service of a health care provider. For men in Central Region this did not necessarily mean a physician, unless they were ill enough to need medical care. It meant, for them, perhaps a nurse or other appropriate provider of care that could ensure continuity and nearby access. Given the concerns for men regarding issues over which behaviour changes and social support could have a significant impact, it seems reasonable to conclude that men would more likely be as healthy as they could be if they had ongoing supportive care providers whom they knew and trusted.

Men are supportive of a long-term view for improving the health of Central Region residents. They spoke of using culturally appropriate approaches that are most likely to gain positive response for some population groups. They clearly told us that health promotion and multi-provider service options were important as was continuity of care provider. Men also told us that if we are to make a difference over the long term, healthy child development had to take priority.

Some specific concerns identified include:

- Personal Health and Lifestyle Practices:
  - Smoking results in
    - Ischemic Heart Disease
    - Lung Cancer
    - Chronic Obstructive Pulmonary Disease
• Almost all current smokers had started smoking by the age of 20.

• Risk Taking Behaviour results in
  • Hospitalization or death as a result of preventable injuries.

• Physical inactivity results in
  • Cardiovascular disease - leading to death and PYLL among men.
  • Overweight and obesity for a high proportion of Central Region males.

➢ Personal Resources:

  • Alcohol Consumption
  • Addictions
  • Suicide (males were significantly more likely to suicide than women).

4.2 Considerations to aid our population to be ‘as health as can be!’

➢ It is clear that health outcomes for men would be significantly improved by reductions in smoking.

➢ Having a more in-depth understanding about place of injury and types of injuries could help us to consider the interventions that might result in reduction of injury.

➢ Improved activity levels could significantly improve health outcomes for men.

➢ Alternative and pro-active methods are required to prevent suicide for men. Analysis of depression and use of antidepressants might be useful for understanding the significance of this disease in Central Region.

➢ We wonder:

  • What is the mental status of men in Central Region?
  • How can we reach men prior to the act that results in suicide?
  • We wonder whether the increasing treatment of diabetes and hypertension have resulted in improved rates of stroke
  • What is the magnitude of addictions and the significance with respect to mental health issues for men in Central Region.
SECTION V: CHAPTER REFERENCES

5.1 Books and Journals


5.2 Government Documents

Canadian Community Health Survey Cycle 1.2


5.3 Internet Sources


5.4 Personal Sources and Unpublished Documents

Addictions Foundation of Manitoba. Winnipeg.

Canadian Cancer Society


Manitoba Lung Association
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A Brief Review

“...as healthy as can be!”
A Brief Review

“As Healthy As Can Be!”

1.0 Introduction

The Regional Health Authority - Central Manitoba Inc. (RHA Central, Central Region) is located in the Southern portion of Manitoba, West of the Red River, South of Winnipeg and North of the United States, Canada border.

1.1 Demographic Overview

The most recent population estimate available from Manitoba Health for the Central Region (June 2002), indicates a population of 98,778, while the 2001 Census reports 93,980. Central Region has the largest population of all the rural and northern Regional Health Authorities (RHAs) and is second only to Winnipeg in population.

According to the 2001 census, the median age of the Central Region population was 35.0, slightly younger than 36.8 years old for the province. For males born in 1998 life expectancy was 75.7 and for females it was 80.7. (Manitoba Bureau of Statistics).

The population of the Central Region has changed more than the population of Manitoba overall. Our population increased 2.6 per cent between the 1996 and 2001 census while in the province overall, the population increased just 0.5 per cent. According to the Manitoba Bureau of Statistics (1999), the population of the Central Region is expected to increase by a total of 14.5 per cent between 1998 and 2025.

The Board of Directors (the Board) ‘Board ENDS’ guided the 2003-04 Health Assessment and accordingly the chapters of the technical document follow the ENDS population groupings. These consist of Individuals, Families, Children, Elderly, Aboriginals, Women and Men. Following the preliminary findings of the assessment, the Board revised the ‘Board ENDS’ the results of which can be seen at the conclusion of this document.

Every five years the government of Manitoba requires that RHAs in Manitoba conduct a comprehensive Community Health Assessment. This current assessment, conducted in the years of 2003-04, is meant to provide a template for future ongoing assessment that will allow us to track the health of our population over time as well as to provide the evidence needed to plan the necessary health services and priorities in our region.

1.2 Assessment Format
Behind every health story in Central Region lays a complex set of factors or conditions that influence whether people are “as healthy as they can be!” There is a growing body of evidence about what makes people healthy, and mounting evidence that increased spending in health care will not necessarily result in improved health.

The evidence indicates that the key factors that influence health are:

- Personal health practices and lifestyle
- Personal resources
- Living and working conditions
- Environmental factors
- Healthy child development
- Biology and genetic endowment
- Culture
- Gender
- Health services

Together these are referred to as determinants of health.

It is encouraging to note that in our Focus Groups, community members seemed to embrace the concept of determinants of health, even if they did not necessarily define the concepts they were articulating as “determinants”. For example, when asked what made a “healthy family”, the following was raised by Focus Group Participants:

“Enough food, healthy food, good eating habits, being active and energetic, participating in outdoor activities, physically taking care of oneself, no smoking, no alcohol, and no abuse.”

The determinants of health are the “risk factors” or, those things that have been found to be associated with outcome indicators: “Health Status Indicators”. We have four primary measures of health status: mortality, morbidity (health conditions), human function and well-being. Most of our data on health status indicators are related to deaths, illness and well-being (to a lesser extent).

In our Community Health Assessment (CHA), our groups attempted to look at the prevalence, or occurrence, of determinants of health indicators (such as smoking and obesity), and relate this information to health status outcomes we see in our population (such as rates of diabetes or deaths due to lung cancer). In this way, we can see the major influences on the health of our population and start to plan our services accordingly.

All of the teams have looked at issues most relevant to their populations. In this document we provide a summary of the key findings of the teams organized in a way that is meant to illustrate the relationship between the determinants of health and health status outcomes.
2.0 Overall Health Status – Key Findings

A measure of how well or ill individuals are in Central Region is indicated by Mortality and Morbidity rates, as well as by the determinants that affect our health. Overall morbidity is commonly defined as "departure from an overall state of health" (Population and Public Health Branch, Health Canada). Morbidity for Central Region is described through showing the incidence\(^1\) of particular diseases within our Region.

2.1 Deaths

Death is expected and acceptable. However, early and preventable deaths are important to note when we are attempting to ensure that people are “as healthy as they can be!” Therefore, in this report we have chosen to focus on the premature deaths.

2.1.1 Premature Mortality Rates (PMR)

Deaths are considered ‘premature’ when they occur before age 75. The Premature Mortality Rate indicates the number of premature deaths per thousand residents of the area. The PMR is often used as an indicator of general health status, and the need for health care services. This has been age and sex adjusted to reflect the population of Manitoba and allows us to compare ourselves to other RHAs.

According to the RHA Indicators Atlas, Central Region has the fourth best health status as per premature mortality rates in Manitoba, below the standardized provincial average for both time periods shown (1990-1994 and 1995-1999), except for Seven Regions and Portage la Prairie. Within the region, the PMR progressively improves as we look south. Morden/Winkler have the lowest, followed by Altona, Carman, Morris/Montcalm, Lorne/Louise/Pembina with Seven Regions significantly higher than the rest of the region and Portage significantly higher than both the rest of the region and the province.

Between 1995 and 1999, the standardized PMR for Registered First Nation (RFN) residents of the Central Region was 8 deaths per 1,000 age 0-74, this is much higher than the rate of 3 deaths per 1,000 for all non-First Nation residents of the region. In fact, the PMR for non-First Nation residents was one of the lowest in the province in this time period, but when we look at First Nation residents, the opposite is true (see Chapter 5).

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\(^1\) Incidence refers to the frequency we observe a particular indicator a population in a given time period. For example, this might include how often we have had a diagnosis of breast cancer in 2003.
2.1.2 Potential Years of Life Lost (PYLL)

One very useful measurement of premature mortality is ‘Potential Years of Life Lost’. The PYLL is calculated by subtracting age at death from age 75 (the standard ‘death age’) for each person who died, and then adding all these differences for a total PYLL. This information is usually grouped by cause of death for comparison with cause-specific death rates. This measure emphasizes causes of death that tend to be more predominant among younger persons, such as accidents, congenital anomalies, and AIDS.

Between 1980 and 1998\(^2\), the 6,486 premature deaths that occurred in the Central Region accounted for 125,955 PYLL. Males accounted for 65 per cent (or 81,253) of the total PYLL and females accounted for the remaining 35 per cent with 44,702 PYLL. While some sources recommend that only deaths aged 1-74 be included in the calculation of PYLL, others recommend including infant mortality. These numbers and subsequent analysis include all deaths from age 0-74.

The leading causes of PYLL for the Central Region overall and for males and for females specifically for the time periods 1980-1984 and 1994-1998 were:

<table>
<thead>
<tr>
<th>LEADING CAUSE OF PYLL IN THE CENTRAL REGION:</th>
</tr>
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<tbody>
<tr>
<td><strong>CAUSE OF PYLL 1980-1984:</strong></td>
</tr>
<tr>
<td>• Motor vehicle traffic accidents</td>
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<tr>
<td>• Ischemic heart disease</td>
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<tr>
<td>• Suicide</td>
</tr>
<tr>
<td>• Pneumonia and influenza</td>
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<tr>
<td>• Cerebrovascular diseases</td>
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<tr>
<td><strong>CAUSE OF PYLL 1994-1998:</strong></td>
</tr>
<tr>
<td>• Motor vehicle traffic accidents</td>
</tr>
<tr>
<td>• Ischemic heart disease</td>
</tr>
<tr>
<td>• Trachea, Bronchus and Lung Cancer</td>
</tr>
<tr>
<td>• Suicide</td>
</tr>
<tr>
<td>• Disorders relating to short gestation</td>
</tr>
<tr>
<td>• and low birth weight</td>
</tr>
</tbody>
</table>

\(^2\) 1998 is currently the most recent year for which specific cause (as opposed to broad category) and age (as opposed to overall age group) at death information is available.
The leading cause of PYLL among Central Region residents has not changed over the 19 year period examined. Deaths due to motor vehicle crashes were the leading cause of PYLL in both time periods. The good news is that the total PYLL has declined from 4,606 years of potential years of life lost in 1980-1984 to 3,483 potential years of life lost between 1994 and 1998.

In addition, although ischemic heart disease has remained as the second leading cause of PYLL, we noted a dramatic decline in PYLL in the two time periods.

On the down side, we saw increases in potential years of life lost due to both lung cancer and breast cancer. In the earlier time period, lung cancer was the sixth leading cause of PYLL accounting for 1,037 years of life lost. Between 1994 and 1998, lung cancer had increased to the fourth leading cause of PYLL accounting for 1,469 years of life lost. Although breast cancer affects primarily females, between 1994 and 1998 it was the sixth leading cause of PYLL among all residents of the Central Region.

Although potential years of life lost by cause have primarily decreased among men, the patterns of premature mortality remain the same. The four leading causes of PYLL among men have not changed in the 19 year time period and PYLL due to lung cancer has increased.

Among males in the most recent time period, four of the ten leading causes of PYLL are due to either unintentional or self inflicted injuries. Also, and by and large preventable, two other causes, ischemic heart disease and lung cancer, have some clearly identified risk factors that can be modified through lifestyle changes.

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**LEADING CAUSE OF PYLL AMONG CENTRAL REGION MALES:**

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<tbody>
<tr>
<td>• Motor vehicle traffic accidents</td>
<td>• Motor vehicle traffic accidents</td>
</tr>
<tr>
<td>• Ischemic heart disease</td>
<td>• Ischemic heart disease</td>
</tr>
<tr>
<td>• Suicide</td>
<td>• Suicide</td>
</tr>
<tr>
<td>• Trachea, Bronchus and Lung Cancer</td>
<td>• Trachea, Bronchus and Lung Cancer</td>
</tr>
<tr>
<td>• Air and Space Transport Accidents</td>
<td>• Short gestation and low birth weight</td>
</tr>
</tbody>
</table>

The leading causes of PYLL among Central Region females are:

---

3 Accidents changed to crashes, or collisions, to reflect a growing ideology around events that can be prevented as not being truly accidental.
LEADING CAUSE OF PYLL AMONG CENTRAL REGION FEMALES:

<table>
<thead>
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</thead>
<tbody>
<tr>
<td><strong>Motor vehicle traffic accidents</strong></td>
<td><strong>Breast cancer</strong></td>
</tr>
<tr>
<td><strong>Ischemic heart disease</strong></td>
<td><strong>Trachea, Bronchus and Lung Cancer</strong></td>
</tr>
<tr>
<td><strong>Cerebrovascular diseases</strong></td>
<td><strong>Motor vehicle traffic accidents</strong></td>
</tr>
<tr>
<td><strong>Pneumonia and influenza</strong></td>
<td><strong>Ischemic heart disease</strong></td>
</tr>
<tr>
<td><strong>Short gestation and low birth weight</strong></td>
<td><strong>Short gestation and low birth weight</strong></td>
</tr>
</tbody>
</table>

What is most striking is the increase in PYLL due to both breast cancer and lung cancer. In the most recent time period, breast cancer was the leading cause of PYLL among females accounting for 651 years of life lost in comparison to 433 years of life lost between 1980 and 1984. Lung cancer is now the second leading cause of PYLL among females when it was the tenth leading cause in the first part of the 1980’s. It is interesting to reflect, at this juncture, the rising smoking rates among females that evidences ‘an alarming increase in young women who start to smoke’.

New causes of PYLL among females include diabetes (sixth leading cause), leukaemias and cervical cancer (9th and 10th leading causes).

2.2 Well-Being

Indicators of well-being include self-rated health, functional health, and activity limitation.

2.2.1 Self-Rated Health

According to the Canadian Community Health Survey (CCHS) Cycle 2.1 (2003), in our region, 59.3 per cent of residents reported that their health status was very good or excellent in 2003. This is slightly lower than 2001 when 60.3 per cent of residents reported their health status positively and we are still slightly lower than the provincial average of 60.8 per cent. Ratings of self-rated very good or excellent health have declined among men, from 61.9 per cent in 2001 to 55.7 per cent in 2003. In 2003, more women than men (62.9% versus 55.7%) reported their health as “very good or excellent”. This is a change from the first cycle where women reported their health as very good or excellent less frequently than did men (55.20% versus 58.55). While women’s perception of their health has improved (with more women rating their health as “very good or excellent”) in 2003, men were less likely than they were two years earlier to rate their health positively.

In Cycle 1.1 we found that the largest difference in self reported health appears in the 20-34 year old age group where just under 81 per cent of males reported excellent or very
good health compared to just over 64 per cent of females. In general, positive reports of health decrease with increasing age, by the age of 65 and over just 36 per cent (an increase from 29% in Cycle 1.1) of the Central Region population report their health to be very good or excellent.

2.2.2 Functional Health

Functional Health Status is a derived indicator obtained from the 2000-01 CCHS (it is not yet available at the regional level for 2003). It measures overall functional health, based on 9 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition, memory and pain). A score of 0.8 to 1.0 is considered to be very good or perfect health; scores below 0.8 are considered to indicate moderate or severe functional health problems.

Central Region residents age 65 and older exhibit the second highest rate of “very good or perfect health” in the region. Overall, 63.4 per cent of the elderly are in very good or perfect health. Within the region, a slightly higher proportion of women (65.2%) were in this positive category than men (61.1%). Just over one third of regional males (35.3%) were considered to have moderate or severe functional health problems compared to 31.9 per cent of females.

2.2.3 Activity Limitation

The rates of activity limitation due to a chronic illness are higher among elderly females (44.5%) than males (39.5%). These rates are lower than the provincial averages of 43.0 per cent overall and 38.7 per cent of males and 46.4 per cent of females specifically. Older seniors in the Central Region were much more likely to report activity limitation than were younger seniors. Overall 38.7 per cent of seniors aged 65-74 reported activity limitation compared 45.9 per cent of those aged 75 and older. This was supported by the data found in a recent Telephone Survey, that in Central Region, people over 75 were more likely to have recent physical difficulties that has impacted on their normal activities of daily living than any other age group surveyed. (Acumen Research).

2.3 Health Conditions (Morbidity)

Some indicators of health conditions include rates of chronic diseases, mental health issues and injuries. For this report we have focused on one chronic disease due to its impact on our population – diabetes.

2.3.1 Chronic Diseases

2.3.1 (a) Diabetes

Diabetes is a largely preventable disease (through proper diet, adequate exercise and maintenance of appropriate body weight) that is increasing in prevalence in Manitoba, and among First Nations populations in particular. Diabetes, if unmanaged, can have a
significant impact on quality of life and can ultimately lead to serious disabilities and premature death.

Central Region had one of the lowest prevalence rates (that is, rates of people living with the disease) of diabetes in the province in 1998/99 (the most recent year for which data is available). The prevalence rates were almost identical among females (581.7 cases per 10,000 females) and males (574.6 per 10,000 males). However, given the risk factors identified in lifestyle of Central Region residents, diabetes incidence and prevalence rates may be expected to continue rising over the long term. In addition, there are specific populations among our residents for whom diabetes is a significant health issue. For example, in 1996 it was reported that 3 per cent of Central Region non-First Nations residents were living with diabetes compared to 17 per cent of Central Region First Nations residents.

In addition to the significant impact on quality of life that diabetes can impose, it is also important to note that between 1994 and 1998, diabetes mellitus was the seventh leading cause of death among women and the ninth leading cause of death among men in Central Region. Moreover, deaths due to diabetes occur, on average, at a relatively young age (77.4 years among women and 72.4 among men).

In the Central Region, the crude diabetes treatment prevalence was 158.3 per 1,000 among First Nations residents, much higher than the rate of 40.3 per 1,000 among non-First Nations residents.4 This means that in the three year time period examined, greater than one out of every ten first Nations residents living in the region was living with diabetes. Given that many cases of diabetes are not diagnosed and many others may not be treated due to non-compliance on the part of the patient, true rates of diabetes are likely much higher.

Standardized rates are useful in allowing us to compare different populations with different age distributions within those populations. The standardized diabetes prevalence rate among Central Region First Nations in this three year time period was 229.5 per 1,000 which was one of the highest rates in the province and much higher than the provincial standardized rate of 188.6 per 1,000 First Nations residents. The diabetes treatment prevalence rate of 299.5 per 1,000 is six times that of the Central Region non-First Nations standardized rate of 38.32 per 1,000 (which is below the provincial average of 45.4 per 1,000). In fact, the difference between First Nations and non-First Nations rates in the Central Region was the largest in the province.

### 2.3.1 (b) Mental Health

Mental health is a concern that has been raised by virtually every population group, assessment team, and consultation participant in this assessment. From children to adults, males and females and specific cultural and employment groups, mental health was identified as a health issue. The CCHS indicates that risk of depression in Central

\[4 \text{ The crude rate is the true rate of an event in the population, before adjustments are made for age distributions in populations that allow for comparisons between populations.}\]
Region is actually lower than that seen in the province and the rest of Canada. In total, just under 5 per cent of regional residents are at probable risk for depression compared to approximately 7 per cent of Canadians. Yet our population expresses concern about mental health directly to us. There is some concern about the usefulness and validity of this measure. As the Seniors Team noted: when older adults are asked about depression using the term "depression", many people will not admit to this concern due to its negative connotations.

"Older people will basically agree they're experiencing every symptom of depression except depression". (Key Informant)

It is becoming increasingly apparent that young children/adolescents can and do suffer from mental disorders. There are approximately 270 children in Central Region utilizing programs offered through Mental Health Services including: Schizophrenia, Depression, Anxiety, and Eating Disorders. Girls are most vulnerable to depression and boys are more vulnerable to ADHD.

During interviews with three of the First Nations communities within Central Region, mental health issues were identified as a major concern. There was a feeling that mental health issues needed to be addressed in order to improve the health outcomes of this population. Feelings of hopelessness and helplessness affect how the population values their overall health. These negative feelings, in some instances, have led to behaviours such as alcoholism, drug abuse and gambling. Depression kills not just through suicide: "elderly people can be so debilitated by depression that they are not managing their hypertension or diabetes or they are not eating right. People die from the sort of excess disability that is created by depression in the context of other diseases" (Gardner).

### 2.3.1 (c) Injuries

Although hospitalization rates for unintentional injury increase tremendously after the age 65, injuries impact every aspect of our population. Our analysis suggests that needless hospitalizations and deaths due to injuries affect every sub-population in our region. Some groups are more effected by self-injury and others by injuries due to unintentional causes. Below are some highlights from the teams’ work.

The elderly accounted for 42.1 per cent of all unintentional injury related hospitalizations in Central Region between 1992 and 2001 (4,375 hospitalizations of a total of 10,400). Among the elderly, women accounted for just under two-thirds (65.9%) of injury related hospitalizations. Falls accounted for 81 per cent of the hospitalizations among the elderly. Specifically, hospitalization rates increased from 1,033 per 100,000 at age 65-74 to 2,965 per 100,000 at 75-84 and then to 8,255 per 100,000 in the 85+.

A Central Region analysis (April 2002 – March 2003) of male emergency room visits to Regional Health Centres revealed that injuries represented the main reason for seeking medical attention. This was true of all age categories.
In the ten-year period between 1992 and 2001, there were 2,503 hospitalizations due to injury among Central Region children. Of these, young females (age 19 and under) accounted for 922 (36.8%) hospitalizations and young males (age 19 and under) accounted for 1,581 (63.2%) hospitalizations.

Among both females and males, unintentional injury is by far the leading cause of hospitalizations. However, it is in self-inflicted injury where we see the biggest difference between the two groups (13% of female hospitalizations and 2% of male hospitalizations). Although hospitalization rates are highest among males for injuries in general, the opposite is true when we look at self-inflicted injuries only. In this case, hospitalization rates are significantly higher among females than males.

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE:</th>
<th>FEMALE:</th>
<th>TOTAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>7.2</td>
<td>63.1</td>
<td>34.5</td>
</tr>
<tr>
<td>15-19</td>
<td>82.9</td>
<td>248.6</td>
<td>163.2</td>
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</tbody>
</table>

According to a report from the Manitoba Centre for Health Policy the hospitalization rate for Registered First Nations related to injury is 3.7 times higher than that of the general population. (30.4 versus 8.3 per thousand). Injuries resulting in hospitalization are often due to violence (17.1% from violence by others and 14.5% from violence to self). First Nations people living off reserve have a higher incidence of violence by others than those living on reserve. (Martens, 2002)
The following list highlights some of the findings with respect to deaths due to injuries:

- 98 per cent of child injury deaths in 1997 were deemed preventable by the Pediatric Death Review Committee.

- Injury mortality rate for First Nations children age 29 days to 14 years was over 9 times higher than for non-First Nations children in Manitoba. Central Region has many First Nations children within its borders.

- Among registered First Nations males up to 45 years of age, injury and poisoning are the leading causes of death. The leading causes of injury in this category are motor vehicle crashes and suicide.

- In Central Region between 1992 and 1999, the elderly (65+) accounted for 123 (or 37.8%) of the 325 deaths due to unintentional injuries. Given that this age group accounts for just 14 per cent of the regional population, their over-representation in injury related deaths (and hospitalizations) is a concern.

- Falls were the leading cause of death (39% of deaths), and death rates due to falls increase dramatically over the age of 75. Motor vehicle crashes were the second leading cause of unintentional injury death (22.7% of deaths). Overall, females accounted for 55 per cent of unintentional injury deaths. Self-inflicted deaths among elderly men accounted for 11 deaths.

3.0 Determinants of Health – Key Findings

Although all of the determinants of health are important, we have focused on some more than others for a couple of reasons. First, data are not currently available at a regional level (and sometimes not even provincial level) for all determinants of health. In addition, not all determinants of health are easily modifiable or can be reasonably addressed within the jurisdiction of a Regional Health Authority. For example, it will be noted that our Community Health Assessment was able to collect data and address, in great detail, indicators of personal health practices and coping skills, however, there may at this time be very little in our document specifically related to biology and genetic endowment. We addressed the determinants of culture and gender in specific chapters such as Aboriginal, Men, Women and Families. Health Services received little comment because, for this assessment cycle, we have focused on health status rather than health services.
3.1 Personal Health Practices & Lifestyle

Personal health practices and coping skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, develop self-reliance, solve problems and make choices that enhance health. The choices we make are influenced by many factors, including our life circumstances and the social, economic and physical environments in which we live, work, learn and play. Aboriginal Focus Group Participants struggled with the issues of personal health practices, establishing home practices that they hoped would have a positive impact on their health. One Focus Group Participant said:

“I believe children learn by example so my child will learn by my example. But my child will be taken to the doctor before I will. I will work through whatever cold I have but I take her right away. I try to practice teaching by example. Choosing healthy foods and cooking in healthy ways such as not using a lot of oils or grease and making the right selections, milk instead of Pepsi. Also trying to do some type of daily exercise, like walking. Negative influences? Watching TV. After work I go home and unwind by sitting and watching TV and taking a moment to get my head out of work and back into family. I can sit there for an hour or two and unwind. It is healthy to unwind, otherwise my stress level would be high all day long and I wouldn’t be able to get other things done.”

Personal health practices and lifestyle are affected by income (which is another determinant of health). Several sources noted that:

“Some of the children on the playground look horribly dressed for winter. Why can’t we feed our children in a small community? Seeing everyone being responsible for all children in the community.”

Indicators of personal health practices and lifestyle include:

- Physical activity
- Body mass index
- Dietary practices
- Smoking
- Heavy drinking and/or drug use
- Prescription medication use
- Immunizations
- Participation in health screening
Highlights of CHA findings for some of these indicators follow:

### 3.1.1 Physical Activity

Focus Group Participants described an active family lifestyle as one indication of a healthy family:

“Like a mum and dad that are in shape and with kids. They are role models for fitness. If they’re in shape and not sitting at home doing nothing all day, that motivates the kids to be like them. They’ll pass on their habits.”

Canadians say barriers to physical activity include:

- Lack of time and motivation
- Lack of neighbourhood safety for exercising related to traffic, crime, poorly lit and maintained sidewalks
- Cost of sport and recreational activities

Central Region has the fourth highest rate for physical inactivity in the province, at 53 per cent compared to the Manitoba average at 47.4 per cent. (CCHS 2003). In 2000-01, Central Region ranked lowest in the province in rates of leisure-time physical activity ages 20-64; 12.2 per cent compared to the provincial rate 17.5 per cent. Rates of physical activity decrease with increasing age. For example, in 2003, while almost three-quarters of residents age 12-14 were active or moderately active, just below 60 per cent in the 15-19 year age group and 23 per cent among residents age 75 and older are physically active.

In both cycles of the CCHS, females were more likely than males to be physically inactive. We are unsure why so many respondents (especially males) did not indicate their level of physical activity in the first CCHS cycle. This lack of response may have affected the validity of physical activity rates for our region in 2000/01.

<table>
<thead>
<tr>
<th>PHYSICAL INACTIVITY AMONG CENTRAL REGION RESIDENTS AGE 12+ (CCHS Cycle 1.1 and 2.1)</th>
<th>MALE:</th>
<th>FEMALE:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physically Active</strong></td>
<td>10.4%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Moderately Active</strong></td>
<td>16.1%</td>
<td>18.1%</td>
</tr>
<tr>
<td><strong>Physically Inactive</strong></td>
<td>46.4%</td>
<td>58.3%</td>
</tr>
<tr>
<td><strong>Physical Activity not stated</strong></td>
<td>27.2%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

When asked to name what they do on a daily basis to improve health, 60 per cent of Central Region telephone survey respondents cited a form of exercise. This was similar
to overall provincial findings. These activities tend to be favoured by individuals less than 35 years old. Individuals of German/Dutch descent were more likely to feel that their occupation or lifestyle provided the necessary level of exercise needed to improve health. They were also more likely to state that they do nothing at all to improve their health.

Males from 15-65 years of age with whom we consulted concurred with the importance of physical activity for maintaining health.

“Stay in shape and stay active. Important to stay fit. I play hockey and run once in a while. In the summer I work and ride my bicycle.”

“I try to have physical activity everyday. I think it is one of the best solutions to have a healthy lifestyle. Have lots of exercise. This of course improves your digestion, appetite and keeps your blood flowing very freely in your system.” (Focus Groups)

According to the 2003 CCHS, although just over 40 per cent of elderly residents report having activity limitation, almost two-thirds (64.9%) are physically inactive. A much higher rate of females over age 65 report being physically inactive compared to males (70.5% of females vs. 58.1% of males). Between Cycle 1.1 and 2.1 of the CCHS, rates of physical inactivity decreased slightly from 66.3 per cent to 64.9 per cent of elderly residents in the Central Region. Although there has been a decrease in physical inactivity, our rates remain higher than in Canada (54.2% of elderly). In addition, physical inactivity in Central Region is both higher than the provincial and National average, and also higher than its peer group5 (60.5% of elderly in Peer Group G are physically inactive).

Central Region service providers advise us that the well elderly report difficulty in finding a place to be comfortably active. Findings suggest that there are insufficient places that are friendly and safe for the people in the 65+ age group. This idea was supported in consultation with community residents who spoke of safe places to be active. One individual suggested that with little effort some provisions could improve the situation for outdoor walkers, among whom are many of the seniors we spoke to.

“For my part I find that...walking on the street is difficult on the account it is slippery or the ploughs go by and there is a ridge...In summer time we have a walking path here...Since the snow, it hasn’t been opened up...I’m wondering if it could be opened up even in the wintertime...To say it can’t be done, it can because the town hires up someone to clear the sidewalks; that same machine could be clearing the walking path too. If this was done I would be using it every day.” (Focus Group)

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5 Peer Groups are made up of regions throughout Canada with similar demographics, socio-economic conditions and working conditions.
Many of the communities have seniors centres, however the well elderly didn’t feel that this was a place for them as they did not see themselves as “elderly” or “senior” and therefore did not access these facilities.

### 3.1.2 Body Mass Index

In Canada, rates of overweight and obesity are increasing, and are highest among men, Aboriginal people, and Canadians living in lower socio-economic circumstances. Rates of obesity in children are increasing at even higher rates than in adults. Within Central Region, approximately one in five residents age 18 and older, meets the criteria for obesity (BMI >30.0), this is just slightly higher than the provincial average of 18 per cent and much higher than the Canadian average of 14.5 per cent.

In 2000-01 CCHS, a high proportion of Central Region males (age 20-64) were classified as either somewhat overweight (Body Mass Index (BMI), between 25.0-27.0) at 38.9 percent or overweight (BMI greater than 27.0) at 20.8 percent. Even with the definition changes for cycle 2.1, in 2003, we still have almost 60 per cent of our population meeting the criteria for being overweight or obese.

In 2001, more men than women self-reported having a BMI of greater than 27.0. (In 2003, rates were too small to break out by both sex and age group.) BMI ranges >27.0 among men are highest in the 45-64 year old age group. As illustrated with rates of physical inactivity, rates of high body mass indexes among men aged 20-24 are high (40.9%).

Some men who have observed the health risks related to being overweight in family members told us about their own health promotion behaviours with respect to good dietary habits. Aboriginal males in general expressed a concern over their diet and how it affected their health in particular with respect to diabetes.

Both male and female respondents in our regional telephone survey overwhelmingly stated that getting exercise is the most common way they believe that they can improve their health. The top four daily health improvement measures reported by respondents overall are walking/running/jogging outside every day (20%); walking outside several times per week (11%); participating in a physically demanding job or lifestyle (9%); and eating healthy foods (8%). ‘Doing nothing’ ranked fifth (9%). Dieting and food avoidance was named by relatively few (6%). (Acumen Research). Males were almost twice as likely as females to cite a physically demanding occupation/lifestyle/housework as their main health improvement activity, while females were more than twice as likely to cite a healthy, well-balanced diet.

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6Note: Definition change implemented in 2004 to conform with Health Canada guidelines for body weight classification. This means that comparisons to 2000/01 CCHS cannot be made.
3.1.3 Smoking

Smoking is one of the leading factors that is known to be detrimental to health status and quality of life. Research shows significant rates of cancers, lung disease, heart disease and strokes, all of which are amplified by smoking.

Manitoba Women’s Institute (August 2001) reported that children in low-income households were almost twice as likely as children in high-income households to live with smokers. Half of low-income households contain at least one adult who smokes regularly, while less than 30 per cent of high-income households have regular smokers.

According to the 2003 CCHS, over 22 per cent of people in Central Region aged 12 or over are regular smokers. This is a slight decrease from 2001 where 23 per cent of residents were current smokers. Our rate is slightly lower than the provincial rate of 22.6 per cent and the Canadian rate of 22.9 per cent. Over half of current and former smokers (53.7% of females and 49.5% of males) started smoking between the ages of 15 and 19. This is an important factor to consider when we target programs for smoking prevention and cessation.

The assessment of Men’s Health in Central Region revealed that smoking has a significant impact on Men’s Health. In our region, just over 1 in 4 (27.1%) males reported being a daily or occasional smoker compared to 17.3 per of females (CCHS 2003). In addition, almost all current male smokers had started smoking by the age of 20 (43.2% started between ages 5-14 and 49.5% started between ages 15-19). In 2001, smoking rates were highest in Central Region males aged 20-24 with 21 per cent of our male population smoking by the age of 20 and 34 per cent by the age of 24. 2003 data is more difficult to break out by both age group and sex due to smaller numbers participating in this survey.

Men in Central Region expressed concern over smoking and its costs and risks.

“Smoking on my own just affects me but the truth is it affects the health care system. Money is tied up to treat people who are killing themselves with smoking.”
“I smoked for 35 years and my father passed away from emphysema. I’ve seen the health affects of smoking.”
“Smoke free house has to be a huge positive.”
“When we moved into a new house I quit smoking in the house. The stress is primarily on [my wife] and not me. Finally when I quit, her life was a lot easier.”
“The time came when I wanted to quit smoking. I told a friend in college and he said he would quit. He did quit when he died of lung cancer.”
(Focus Groups)

In 2001-01 the smoking rates among females in the 20-34 year old age group (peak child-bearing years) were high, with over 1 in 4 reporting being a current smoker. In 1997 and 1998, 22 per cent of women reported that they smoked during pregnancy. This is of
particular concern because more babies of low birth weight are born to women who smoke during pregnancy. Low birth weight infants are at increased risk for health complications.

3.1.4 Immunization

Fifty percent of residents 65 or older in Central Region received the flu shot, compared to 55 per cent of residents 65 or older in Manitoba. There is a wide variation between areas within our region, with rates ranging from less than 35 per cent to just over 60 per cent. A more in-depth analysis might lead us to further information and different conclusions, as this data is wholly dependent upon compliance with the provincial reporting structure.

In a recent Telephone Survey, it was discovered that 71 per cent of Central Region respondents agreed that immunization is “the smart thing to do”. While 14 per cent agreed with the statement that the only people who should be immunized are those that are weak or frail, only eight per cent subscribed to the view that people should only receive immunization after a doctor’s orders. Just 7 per cent think that people should not be immunized because of a possible negative reaction to the vaccine. (Acumen Research).

3.1.5 Screening

Almost 60 per cent of women ages 50-69 years in Central Region receive at least one mammogram every 2 years. Rates of screening have significantly improved, from 53.1 per cent in 1995-97 to 65.8 per cent in 1999-2001, and are better than the provincial rate. (Acumen Research). We will be interested to observe the rates of Breast Cancer deaths over time to determine whether there is a concurrent decrease to reflect the increased screening.

Regular PAP smears can prevent or detect early cervical cancer. Although rates of screening are increasing in Central Region, we are still below the provincial average of 69.9 per cent, compared to 62.7 per cent.

“Cultural influences related to lack of access to female screeners among other beliefs may have a role in the lower rates.” (Key Informant)

3.2 Personal Resources

Social or community responses can add resources to an individual's own strategies to cope with changes and to foster health.

Indicators of personal resources include:

- Levels of life stress
- Marital status and living arrangements
- Emotional and social support
3.2.1 Life Stress

The inability to deal with stress can have health implications for individuals. Most people report some degree of life stress and personal resources can influence the way individuals deal with stress and the challenges of life. In 2001, only 6 per cent of our residents report no life stress, compared to 9.5 per cent of Manitobans and almost 13 per cent of Canadians. However in the 2003 CCHS over 10 per cent of our residents reported “no life stress”. This was slightly higher than the provincial average (10.4%) but still lower than the Canadian (11.3%).

In 2000-01, the highest rates of “quite a lot of life stress” were experienced by both men and women in the 35-44 year old age group. This is not unexpected given that this is often a time that families struggle to balance the demands of parenthood with those of work life. Life stress drops somewhat in the 45-64 year old age group and then dramatically in the 65+ age group. It is interesting to note that while life stress rates were lower in the 65+ age group, this is the only age group where rates among women were higher than among men.

Research suggests that supporting seniors to maintain their independence as long as possible is first and foremost in promoting mental wellness for them. As people become more dependent, support must to be provided in such a way that it strengthens the individual's dignity and self-respect.

Overall, 15.7 per cent of Central Region residents 65+ report experiencing "quite a lot” of life stress. Among those age 65 - 74, 14.4 per cent report "quite a lot" of life stress increasing to 17.2 per cent of those aged 75+.

In total, 87 per cent of older women and 88 per cent of older men have stress that affects their health. There was a sense that a more in-depth assessment might help us to understand what some of the stressors are. Subsequent planning for interventions could then be more appropriately targeted to the identified problem. Central Region health professionals observed that some of the stressors in the older adult came from multiple losses and from caring for ill or dying loved ones.

People in our region identified the importance of having someone to talk to with 52 per cent (compared to 48% in Manitoba overall) reporting they had “someone who would listen to them all of the time”. While this is encouraging, respondents aged 65+ were almost twice as likely as the regional average to report having no one to talk to when in distress. (Acumen Research). This information speaks once again to the well-being of our elders and how we ensure they have an environment in which they are able to feel secure and maintain their independence as much as possible.

Sometimes the strength is found within the community, or within the family. While this is a positive role to play in life, when the helper is a spouse of an ageing individual it may be less beneficial overall. Becoming a caregiver to your loved one is a significant life
stressor for people 65+. We learned of the concerns of elderly caregivers during our community consultations.

“When my husband was ill, what made things a lot more difficult for both of us was the lack of support in the local system here with home care. There was not support there that we needed. It put us through hell especially myself because I was the caregiver...I know it had an indirect affect on my own health...It was that type of support that was needed at that time. It ages you.”

“I too...looked after [my husband] at home for six months. It was hard to get home care.” (Focus Groups)

Other sources of strength and stress can originate in the work environment. With the major employment in our region being agriculture and agriculture related industry, it is important to note that the second most frequent calls to the Farm and Rural Stress Line originated from Central Region.

3.2.2 Marital Status

Some selected characteristics of families in the Central Region were compared to the province of Manitoba. The proportion of lone parent families in the Central Region is smaller than in the province overall (10.5% versus 16.0%). However, within those lone-parent families, the distribution is almost identical to provincial rates with just over 81 per cent of lone parent families being headed by a female. A dramatic drop in income was experienced by lone parent families compared to couple families.

SELECTED CHARACTERISTICS FOR CENTRAL REGION FAMILIES (COMMUNITY PROFILES 2001):

<table>
<thead>
<tr>
<th></th>
<th>CENTRAL REGION</th>
<th>MANITOBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median family income – all</td>
<td>$46,199</td>
<td>$50,934</td>
</tr>
<tr>
<td>Couple families</td>
<td>$48,473</td>
<td>$55,885</td>
</tr>
<tr>
<td>Lone parent families</td>
<td>$25,067</td>
<td>$26,469</td>
</tr>
</tbody>
</table>

3.3 Living and Working Conditions

Health status improves at each step up the income and social hierarchy. Unemployed or underemployed individuals, with lower social status, experience more illness and have a shorter life expectancy. The healthiest societies are those that are prosperous and have an equitable distribution of wealth.
Indicators of living and working conditions include:

- Income and income inequality;
- Labour force measurements (employment rates, participation rates etc.);
- Housing;
- Education – we are including education as a measure of living and working conditions due to the link between education and socio-economic status

### 3.3.1 Income and Income Inequality

Income levels in Central Region are below provincial levels.

#### EARNINGS FOR PERSONS 15 YEARS OF AGE AND OVER:

<table>
<thead>
<tr>
<th></th>
<th>CENTRAL REGION</th>
<th>MANITOBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median total income</td>
<td>$18,206</td>
<td>$20,469</td>
</tr>
<tr>
<td>Average earnings</td>
<td>$23,277</td>
<td>$27,178</td>
</tr>
</tbody>
</table>

Women in Central Region reported lower incomes than women, on average, in Manitoba. The average income for women in 2001 in the Central Region was $18,244 compared to $21,480 in Manitoba overall. An even bigger discrepancy in income is between women and men. For example, men who worked full time for a year earned an average of $34,200 while women earned nearly $8,000 less, at $26,257. Because the connection between poverty and poor health has continued to exist even as medicine has progressed, researchers believe that these factors are considered more important to women’s health status than lifestyle factors such as smoking, alcohol consumption and physical activity. (Donner, 2002).

When asked how income affects their health, Central Region consultation participants answered:

"You can’t afford the healthy foods you’re supposed to eat, and medication. You do without" (20-35 yr old Female Focus Group)

“Income affects health because it limits choices and social interaction”
(35 – 55 yr. old Female)

### 3.3.2 Labour Force

We are disproportionately reliant on agriculture and other resource based industries compared to the province and the rest of Canada. Over 21 per cent of our experienced work force was employed in agriculture in 2001, compared to 8 per cent of Manitobans, and 5.5 per cent of Canadians. Factors that affect the agricultural industry such as flood, drought, and diseased herds (such as Bovine Spongiform Encephalopathy- BSE) will have significant impact on our populations’ ability to earn a living.
Within Central Region’s labour force, males have a higher participation rate and females a lower participation rate than the Manitoba average. This finding was supported in the Telephone Survey, where compared to regional rates, male respondents were more likely than females to be full-time employees. Females were more likely than the regional average to not be employed. The survey also found that Central Region respondents who had graduated from at least high school were more likely to be employed full-time. (Acumen Research).

The total unemployment rate in Central Region (5.2%) is second lowest in the province, and lower than the Manitoba rate (8%). However, more Central Region respondents in the Telephone Survey were not employed or were retired (21% and 18% respectively for a total of 39%) compared to overall results (23% and 13% for a total of 36%). We learned during the Need to Know ‘Rural Health Day’ that for those employed, although the majority of new jobs created are in low paid and semi-skilled areas, they are helping to make Winkler, Morden, Altona and Carman among the top growing communities in Manitoba.

3.3.3 Education

Education creates opportunities for income and job security, and control over one’s life. Research supports that health status tends to improve as educational level increases. Canadians with low literacy skills are more likely to be unemployed, poor, experience more health problems and die prematurely.

In the majority of rural communities, people have lower levels of formal education than those living in urban centres. In 2001 over one third of residents in Central Region over the age of 20 indicated that they had not graduated from high school. In every age group the rates of non-graduates in the Central Region are much higher than the rates in the province overall.

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>CENTRAL REGION</th>
<th>MANITOBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>34.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>36.0%</td>
<td>25.6%</td>
</tr>
<tr>
<td>45-64</td>
<td>45.9%</td>
<td>34.4%</td>
</tr>
</tbody>
</table>

Men have quite low rates of high school completion, which tends to limit employment choices and earning potential.
EDUCATIONAL ACHIEVEMENT, CENTRAL REGION MALES % OF POPULATION (COMMUNITY PROFILES, 2001):

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>HIGH SCHOOL GRADUATION</th>
<th>POST-SECONDARY DEGREE, DIPLOMA OR CERTIFICATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-34</td>
<td>37.7%</td>
<td>11.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>40.7%</td>
<td>11.2%</td>
</tr>
<tr>
<td>45-64</td>
<td>48.8%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

3.3.4 Housing

Approximately 84 per cent of First Nations living on reserve live in band housing. Housing conditions on reserve have been identified as being worse than in Winnipeg, with 41 per cent requiring major repairs. The average number of persons per housing unit for first nations people is twice that of the overall population of Manitoba (4.8 versus 2.6). The data for RHA Central identifies 7 persons residing per housing unit. Problems with overcrowding exist. Crowding is partly a factor of family size, and partly of housing cost and supply. Ten per cent of Aboriginal people live in housing with two or more persons per bedroom. Although housing construction has increased on reserve, conditions and suitability remain serious concerns. (Martens, 2002).

Housing issues are not limited to on reserve. A key informant interview provided the following insight:

"The condition of my house affects my health...the apartment I lived in made me depressed. The pipes on the upstairs floor leaked into my apartment and the stairs were unsafe for my friends."
(60 year old, female, income under $20,000.)

3.4 Environmental Factors

Exposure to second-hand smoke can have a significant effect on health. Although Central Region is below the provincial smoking rate (28.5%), over 23 per cent of non-smoking Central Region residents over 11 years old report being exposed to cigarette smoke on most days of the week. Combined with the rates of daily smoking, this means that almost 50 per cent of the regional population may be exposed to the harmful effects of tobacco smoke on a regular basis.

"I am very concerned about our air and water quality. We are in an area where a lot of potatoes are grown and there is a lot of spraying...I don’t have asthma problems but others do. There has been an increase in cancer in this area, at least I feel there is an increase, and an increase in chemical use. I’m wondering if there isn’t a connection there." (Focus Groups)
Respiratory illness, as throughout Manitoba, is the third leading cause of death in Central Region. There is a suspected link between environmental contaminants and asthma exacerbation. The prevalence of asthma in Central Region is 5 – 7 per cent, lower than the provincial rate. (Abelshon).

### 3.5 Healthy Child Development

Children under the age of 20 accounted for 32.6 per cent of the population of Central Region in 2001. This proportion is slightly higher than Manitoba’s overall rate of 28.1 per cent.

Some indicators of healthy child development include:

- Teen pregnancy and birth rates
- Breastfeeding rates
- Childhood immunization rates
- Single parent families and parenting skills

Key findings related to some of these indicators include:

#### 3.5.1 Teen Pregnancy

In 2002/03, we had one of the lowest pregnancy rates in the province among 15-19 year olds at 31.4 per 1,000. This is quite a bit lower than the provincial average of 50.2 per 1,000. Over time, the teen pregnancy rate has decreased from 40.1 pregnancies per 1,000 15-19 year olds in 1996/97 to 31.4 per 1,000 in 2002/03. Although the provincial rate has also declined (from 64.6 per 1,000 to 50.2 per 1,000), our region is consistently quite far below the provincial average.

Within Central Region there has been a decrease in teen pregnancy rates in all of our Areas except Carman. In both 1991-1995 and 1996-2000, the highest teen pregnancy rates were in Seven Regions followed by Portage la Prairie. The rates in these Areas are higher than the provincial average, while all other areas are lower than the provincial average.

We brought together a sampling of teens for Focus Groups in Central Region and asked them where they get their information about sex education. There were varied answers that included parents, school, friends, nurses, doctors, media and “the streets”. It was apparent that many teens are not aware of services in their communities that can offer assistance. For example, reproductive information and birth control supplies are available from public health offices and/or clinics. However, even if teens are aware of these services, their desire to remain anonymous, especially in a small community, might further deter them from seeking help.
3.5.2 Parenting

Data reveals that one of the keys to developing resilient, well-adjusted children is a parent-child relationship that also supports the child’s early development. At the family level, children need: a close relationship with a caring parent figure; a parenting style that promotes warmth, structure, and high expectations; socio-economic advantages; connections to extended supportive family networks. At an extra-familial context, children benefit from bonds to prosocial adults and organizations outside of the family and attendance at effective schools.

The Children’s Assessment Team found that parenting skills have a profound influence on the overall health of children and are closely linked to the priority areas the team identified. For example, a safe, nurturing environment will help reduce the risk of injury and increase a child’s potential for better health. Nutritious and well-balanced meals help promote healthy bodies. Parental support and involvement were also seen to have a vital role in reproductive and mental health. Canadian studies have shown that parental child-rearing skills have a more pronounced effect on child development and well-being than parental income or social-class background.

3.6 Culture

According to the 2001 census, 9,240 residents (9.8%) of the Central Region self-identified as Aboriginal compared to over 13 per cent of residents of the province overall. We found that trying to accurately count the Aboriginal population in Central Region was, at best, a low approximation.

In Central Region, First Nations people living on-reserve can expect health outcomes to differ from both their peers who have moved away as well as from the rest of the population in Manitoba. For example, life expectancy of Registered First Nations people living in our region is longer for those living off-reserve than for those living on-reserve. The opposite is true for the province as a whole.

However, life expectancy overall is lower for all First Nations than for non-First Nations residents of our region. According to the First Nations report from the Manitoba Centre for Health Policy (MCHP), the life expectancy of First Nations males at birth is 66.71 years (compared to 76.83 for all other Central Region males) and 71.06 for First Nation females (compared to 81.92 for all other Central Region females). (Martens et al, 2002)

Low German speaking Mennonite families from Mexico (LGMM - also known as Kanadier Mennonites) were another cultural group that were examined. Key Informants suggested that the health needs of this population were often difficult to meet in the context of the existing health care system. As with the Aboriginal population, it was not possible to accurately count the population of LGMM in Central Region. However, Key Informants suggested that the numbers were “significant”.

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7 Defined by Statistics Canada as “North American Indian”, “Inuit” or “Metis” and/or those who report being a Treaty Indian or Registered Indian
In Manitoba, Key LGMM Informants advised us they believe that the majority of Manitoba LGMM live within the boundaries of the Central Region, making this an important factor for us when determining health status and determinants for health planning. Telephone survey data reveals that 15 per cent of Central Region households self-reported German ethnic origin, second only to multiple ethnic origin. This lends support to Key Informants’ views that the number of LGMM families in Central Region is significant.

Concerns observed by Key Informants (health care providers) regarding this population were:

- unpredictable use of the health care system
- communication difficulties related to language
- children less commonly attend school after age 14 years
- school-aged children carry major responsibilities for the care of younger siblings
- infrequent use of preventative/screening practices

Key Informants indicated that the LGMM give little attention to matters of health, considering health to be ‘the absence of illness’. Similarly, a 2002 study and report of health and illness beliefs of Kanadier Mennonites in southern Alberta reports that the majority of the participants did not view health holistically. A few did mention health prevention activities such as physical check-ups at the physician or dentist’s office, but the majority of the participants do not invest time in health prevention. In fact, there was a sense from at least some of the participants that they did not see a formal role for health professionals to assist these Mennonites to stay healthy.” (Kulig, Hall, Wall, Janzen, Campbell and Babcock, 2002).

### 3.7 Health Services

Most of our Community survey participants told us that they were very satisfied with health services generally in Central Region, but that access to continuity of care provider was a concern. Many spoke of their desire for local access and continuity of primary care provider in terms of any appropriate health service professional, not necessarily a physician unless complex illness was a factor in their care.
4.0 Overall Key Findings

We can attempt to further improve health and reduce premature mortality in our community through focusing our efforts on the main causes of premature death. Making a significant difference will take a long time – probably several generations, but we need to continue the good work already started, at the national and regional level, particularly in relation to cardiovascular disease (such as ischemic heart disease and cerebrovascular diseases), cancer, unintentional injuries and suicides.

For **Individuals** in Central Region, we see that premature mortality is decreasing, yet cardiovascular disease is still a leading killer of Central Region residents. We know the risk factors associated with cardiovascular disease – smoking, obesity, poor eating habits, stressful lifestyle, physical inactivity – to name a few. We identified the appropriateness of community programming to help our residents make and sustain healthier lifestyle choices. Focusing on healthier life style choices will also impact the premature death rates due to diabetes and lung cancer. Projections show that we are expected to increase our population by 14.5 per cent between 1998-2025. This is important to consider when planning health service provision over time. We identified that we have concerns over the health of immigrants and some other specific cultural groups, especially the low-German speaking Mennonites from Mexico. We know that we lack specific information and want to find ways to obtain evidence regarding the health and illness of these vulnerable populations. The percentage of Central Region residents who report “some” or “quite a lot” of life stress is higher than both the Manitoba and Canadian averages. Spiritual well-being is seen as an important factor in health by Central Region residents. We have had a significant increase in prevalence of diagnosis and treatment for diabetes and hypertension. There is a concern that rates of immunization are dropping in the Central Region and if this trend continues it could lead to pockets of unprotected individuals, which could lead to increasing preventable disease prevalence.

For **Families** in particular, we identified how crucial the overall health of the unit is to its members. Good communications can be both learned and enhanced. Partnerships and energies spent on ensuring an environment where each member can thrive is a significant inroad to helping all ages within families. When all members are physically and mentally healthy, the family unit will be most healthy and resilient to the on-going stressors of life, having a positive influence on each of the unit members.

For **Children** in particular, vigilance is important against the significant impact that poverty, stress and broken homes has on their health. Youths must continually be made aware of the perils of lifestyle choices such as unprotected sex, smoking, unsafe driving and alcohol use. A safe and supportive environment must be provided to youth who are engaging in, or at risk for, self-injurious behaviour.

For **Elderly** in particular, we must provide services for both the well elderly and the frail or vulnerable elderly. Although the frail elderly may have access to excellent acute care services, both will benefit from an on-going commitment to supporting an independent lifestyle with access to meaningful activities and social supports. Focusing energy to
prevent serious injury, particularly resulting from falls, would be an important factor in improving the quality of life for our 65+ residents and would result in significant health service savings over time.

For Aboriginal residents in particular, continued focus on diabetes prevention and management is a clearly identified priority. Culturally appropriate messages about healthy lifestyles—both physical and mental health will be key to improving the overall health of this population. Injury prevention, from both unintentional and intentional sources, would improve the PMR and quality of life for this vulnerable population. Supports for ongoing education and training as well as culturally appropriate mental health and wellness services are essential to this population.

For Women in particular, we noted that lives and health would be improved with suitable supports for pursuit of education and gainful employment so that women and children are not so severely impacted by poverty. We recognized also the effectiveness of screening programs for both breast and cervical cancer, and the difference in rates of screening perhaps related to access to female assessors. The women in our region will be best served when we provide excellent service in these areas and ensure that women are adequately informed of the need for screening for these diseases, the appropriate ages at which to start and how often they need to be screened. We assert that women are being hospitalized for self-induced injuries more frequently than men, providing us with an opportunity for intervention that men do not provide us.

For Men in particular, healthy public policy including messages about smoking, exercise and diet, safe driving practices as well as safety in work and leisure activity in general could benefit their health. A continued focus on mental well-being and suicide prevention must remain a priority in the Central Region.
Activity Limitation: Population aged 65 and over who report having a disability or being limited in certain activities on a continuing basis (at least 6 months) because of a physical condition, mental condition, or health problem. (CCHS)

Alcohol Consumption: Frequency of Heavy Drinking; Proportion of heavy drinkers by gender, age, ethnicity. Population aged 12 and over who are current drinkers and who reported drinking 5 or more drinks on at least one occasion in the past 12 months. (CCHS)

Arthritis/Rheumatism: Population aged 12 and over who report that they have been diagnosed by a health professional as having arthritis or rheumatism. (CCHS)

Asthma: All ages who have been diagnosed by a health professional as having asthma within a 2 year window.

Birth Weight:
- **High:** Ratio of infants born weighing more than 4000 grams to the number of live births for a given period of time.
- **Low:** The proportion of live births (birth weight known) with a birth weight less than 2500 grams.
- **Pre-term:** The number of live born infants prior to 37 weeks gestation expressed as a proportion of all live births (in a given place and time)

Body Mass Index: [BMI] is an internationally recognized measure of body weight in relation to height. A BMI between 18.5-24.9 is the zone associated with the lowest risk of illness. Underweight is under 18.5, 25-29.9 is overweight and 30 or higher is obese. The index is calculated for those aged 20-64 excluding pregnant women and those less than 3 feet tall or greater than 6 feet 11 inches. BMI is used as a measure of obesity, along with the waist-hip ratio. (CCHS 2003)

Breastfeeding Practices (initiation): Proportion of women who deliver in hospital and initiate breastfeeding (either breast only or breast and bottle) while in hospital. (MCHP)

Cancer Incidence: Age-standardized rate of new primary sites of cancer (malignant neoplasms) per 100,000 population, for all cancers (ICD-9 140-208) and for specific sites: colorectal (ICD-9 153-154), female breast (ICD-9 174), and
prostate cancer (ICD-9 185), melanoma (ICD-9 172), cervical (744.43 756.2) and skin cancer. (CancerCare Manitoba)

**Cancer Prevalence:** Number of individuals who have ever been diagnosed with cancer and living as of Dec. 31st of the report year.

**Cardiovascular Disease:** Disease that affect the heart and blood vessels.

**Caregiver:**
- **Formal:** Paid caregivers, such as Home Care.
- **Informal:** Those looking after someone with dementia, usually family or friends.

**Cervical Cancer Screening:** Proportion of women aged 18-69 screened at least once over a 3 year window of time. (MCHP)

**Chronic diseases:** This group of diseases has not been well defined. However, for the purpose of this report, we mean those diseases of long-lasting nature and in most, although not all cases, may be treated but are incurable. In this report we have included Diabetes, Cancer, Arthritis, Asthma, Cardiovascular Disease and Hypertension.

**Crude Rates:** Crude Rate is a rate based on the actual numbers that have not been adjusted to account for population age and sex.

**Determinants of Health:** The factors that influence our health have been framed by Health Canada and this document has re-framed the language to merge with the Manitoba Health Performance Measurement Framework. They are: Personal Health Practices and Lifestyles; Personal Resources; Living and working conditions; Environmental factors; Healthy child development; Biology and genetic endowment; Culture; Gender; and Health services.

**Diabetes:** Prevalence of diabetes in population aged 20-79 who have been diagnosed by a health professional as having diabetes. Data derived from a population based data base of individuals diagnosed with diabetes. Due to data sources, we have included both Type I and Type 2 diabetes together.

**Dietary Practices:** Proportion of the population aged 12 and over, by the average number of times per day that they consume fruits and vegetables. (CCHS)

**Exposure to Second-hand:** Proportion of the non-smoking population age 12 and over who are regularly exposed to environmental tobacco smoke in public spaces and work places. (CCHS)

**Gender:** Gender is not just a polite way of saying “sex”. Sex refers to the biological differences between females and males. Gender refers to the socially constructed roles and relative power that society ascribes to the two sexes. (Donner, 2003)
High Birth Weight: The proportion of live births (birth weight known) with a birth weight more than 4000 grams.

Hospitalization rates for injuries: Number of Central Region residents who stayed in hospital at least one day with a primary diagnosis of injury or poisoning (ICD code 800-999). (MCHP)

Hypertension: Percent (%) of persons aged 25 and over who had at least one physician visit for hypertension in a 3 year period

Immune System: A complex system that is responsible for distinguishing us from everything foreign to us, and for protecting us against infections and foreign substances. The system works to seek and kill invaders.

Immunization: A technique used to induce immune resistance to a specific disease in humans (or other mammals) by exposing the individual to an antigen in order to raise antibodies to that antigen.

Incidence: Refers to the frequency within which a disease is diagnosed in a given period of time.

Income Inequality: Median income of Individuals. Dollar amount that marks the midpoint of a distribution of individuals.

Income Status: Refers to the proportion of an economic family or an unattached individual 15 years of age and over in relation to Statistics Canada's low income cut-offs (LICOs). (Census Canada)

Indicator: An agreed upon data source or set that characterises an environment or situation to determine or aid in determining whether or not certain stated circumstances exist or criteria are satisfied, or whether they are changing over time.

Infant Mortality: Ratio of deaths among infants under 1 year old to the number of live births, for a given period of time. (excludes stillbirths). (MCHP, Manitoba Health)

Injuries: Intentional and Unintentional.(by gender and age groupings): Crude rates of acute care inpatient hospitalization due to injuries per 100,000 population. (Cause of injury is reported by the first-documented External Causes of Injury Code (E Code).

Labor Force Participation Rate: Refers to the labour force in the week (Sunday to Saturday) prior to Census Day (May 15, 2001), expressed as a percentage of the population 15 years of age and over.(Census Canada)
Life Expectancy: The number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), on the basis of the mortality statistics for a given observation period, typically a calendar year. Life expectancy, by sex.

Life Stress: Level of chronic stress reported by the population aged 18 and over, based on their responses to a series of 17 questions about their personal situation. (CCHS)

Low Birth Weight: The proportion of live births (birth weight known) with a birth weight less than 2500 grams.

Mammography: Is an imaging technique that uses X-rays to provide a picture of the internal structure of the breast. Mammography Rates: Age adjusted percent of women age 50-69 receiving at least one mammogram in two years. (MCHP)

Occupation: Refers to the kind of work persons were doing during the reference week, as determined by their kind of work and the description of the main activities in their job. The 2001 occupation data are classified according to the 2001 National Occupational Classification for Statistics (NOC-S 2001). This classification is composed of four levels of aggregation. There are 10 broad occupational categories containing 47 major groups that are further subdivided into 140 minor groups. (Census Canada)

Physical Activity (Leisure-time & physical activity): Population aged 12 and over reporting level of physical activity, based on their responses to questions about the frequency, duration and intensity of their participation in leisure-time physical activity

Physical Inactivity: The proportion of the population aged 12 and older whose average energy expenditure (E.E) on leisure time physical activities is less than 1.5 Kcal/kg/day.

Potential Years of Life Lost (PYLL): The total number of years of life lost by death before the age of 75 years in a given area (for us, Central Region) in a given period of time.

Poverty: According to Statistics Canada, when a family spends 20 percentage points more on basic necessities (food, shelter, clothing) than the average, then they are considered poor. The Fraser Institute’s definition reads: "People are poor if they cannot afford all basic physical necessities and items, the absence of which is likely to compromise long-term physical well-being."
Poverty Line (Poverty Level): According to Statistics Canada “Low Income Cut Offs” define poverty levels. These cut-offs depend on family size and size of community. For example poverty lines for rural and small urban centres that are located in Central Region are:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Urban Centres Less than 30,000</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$14,933</td>
<td>$13,021</td>
</tr>
<tr>
<td>2</td>
<td>$18,666</td>
<td>$16,275</td>
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<tr>
<td>3</td>
<td>$23,214</td>
<td>$20,242</td>
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<td>4</td>
<td>$28,101</td>
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<td>5</td>
<td>$31,412</td>
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<tr>
<td>6</td>
<td>$34,722</td>
<td>$30,278</td>
</tr>
<tr>
<td>7+</td>
<td>$38,033</td>
<td>$33,166</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2001

Pregnancy Rates:

Adolescent and Teenage: Proportion of the female population aged 15 to 19 years who become pregnant (includes in hospital rates for live births, spontaneous & planned abortions). (MCHP and Manitoba Health)

Premature Mortality Rate (PMR): Annual number of deaths occurring before the age of 75 per 100,000 population for individuals under age 75, which is adjusted to a reference (or standard) population of individuals under 75 years of age.

Preterm Birth Rate: The number of live born infants prior to 37 weeks gestation expressed as a proportion of all live births (in a given place and time). (MCHP)

Prevalence: Prevalence refers to the total number of people living with a disease or condition within a given population.

Qualitative Data: Concerned with quality rather than quantity; highlight rich, in-depth information gathered from individuals.

Quantitative Data: Measurable data: highlight overall statistical picture.

Self-rated Health: Percent of the population age 12+ who report that their health is very good or excellent. (CCHS)

Smoking Rates: Population aged 12 and over who reported being either a smoker (daily or occasional and always occasional) or a non-smoker (former, former daily, former occasional or never smoked). (CCHS)
Social Problem Approaches: (Jansson, 4)
Institutional approach to social problems:
• Narrow the cracks in the system rather than catch the people who fell through them.
Residual approach:
• Helping an individual with a specific problem rather than finding the problem.
  IE, catching the people who fall through the cracks.
Developmental approach:
• Instead of correcting one individual problem after another and another, community development can prevent problems by improving conditions that affect people.

Social Support:
Emotional Support: Level of perceived social support reported by population aged 12 and over, based on their responses to four questions about having someone to confide in, someone they can count on in a crisis, someone they can count on for advice, and someone who makes them feel loved and cared for. (CCHS Cycle 1.1)
Living Arrangements: Refers to the classification of persons in terms of whether they are members of a family household or a non-family household, whether they are family or non-family persons and can be identified as to sex, marital status, number of children and seniors. (Census Canada)
Marital Status: Refers to the conjugal status of a person e.g. Married (including common-law), separated, divorced widowed and never married (single). (Census Canada)

Socio-Economic Status (SEFI): A score that reflects the non-medical determinants of health, such as age, single parent status, female labour force participation, unemployment, and education. The lower the SEFI score, the more favourable the socio-economic conditions. (MCHP).

Standardized Rate: A statistical reporting of compared data that would be observed in the population if it had the same age and sex composition as the Manitoba population.
Standardized Rates: This means that the rate has been adjusted to create a fair comparison among regions with different age and sex population distributions. All rates are standardized to reflect what the rate would be if each area's population had the same age and sex distribution as the Manitoba population at December 31, 1996. (MCHP)

Standardized Mortality Rate: Annual number of deaths per 100,000 population, which would be observed in the population if it had the same age composition as the reference or (standard) population.
Statistically Significant: Statistical testing is done in such a way that when you say a difference is "statistically significant", you will be at least 95% sure that the difference was not due to chance alone. So you expect to see "statistically significant" differences occurring about 5% of the time merely through chance.

Unemployed: Persons aged 15 and over, excluding institutionalized residents, who were without work and were available for work.

Unemployment Rates: The labor force aged 15 and over who did not have a job during the reference week. The labor force consists of people who are currently employed and people who are unemployed but were available to work in the reference week and had looked for work in the past 4 weeks. (Census)

Youth Unemployment: The labor force aged 15-24 who did not have a job during the reference week. The labor force consists of people who are currently employed and people who are unemployed but were available to work in the reference week and had looked for work in the past 4 weeks. (Census Canada)

Inappropriate Employment: Employed part-time, unable to obtain full-time. (Census Canada)

Vulnerable: A vulnerable person is one who is at risk of neglect, abuse, or exploitation due to their inherent mental or physical incapacity or their life circumstances which includes, but is not limited to, the person’s age, gender, race, education or social skills, or recent life experience. Vulnerable people may have one or more of the following life circumstances rendering them vulnerable to neglect, abuse, or exploitation:
1) Age-related circumstance – the very young, youths, or the elderly.
2) Poverty-related circumstance – likely the most indicative factor of vulnerability and often combined with other factors.
3) Race-related circumstance – compounded by issues around language and culture; direct and indirect discrimination.
4) Ability/disability-related circumstance – people with special needs.
5) Gender-related vulnerability – women in various cultures around the world.
6) Social vulnerability – due to lack of social skills, poor literacy, unemployment, social exclusion, and geography.
7) The trauma vulnerability – those vulnerable due to illness, death, marital discord, job loss, financial problems.
8) Emerging vulnerability – people vulnerable due to lack of technological skills, opportunities and knowledge.

Well-being:

Self-rated Health: Percent of the population age 12+ who report that their health is very good or excellent. (CCHS Cycle 1.1)

Functional Health: Population aged 12 and over reporting measures of overall functional health, based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain). A score of 0.8 to 1.0 is considered to be very good or perfect health; scores below 0.8 are considered to indicate moderate or severe functional health problems. Otherwise known as the...
Health Utility Index (HUI), this index, developed at McMaster University’s Centre for Health Economics and Policy Analysis, is based on the Comprehensive Health Status Measurement System (CHSMS). (CCHS Cycle 1.1)

**Activity Limitation:** Population aged 12 and over who report having a disability or being limited in certain activities on a continuing basis (at least 6 months) because of a physical condition, mental condition, or health problem. (CCHS Cycle 1.1)
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“...as healthy as can be!”
The Community Perspective

“As Healthy As Can Be!”

Throughout the Community Health Assessment (CHA), various forums were provided for consultation with residents in Central Region:

- A Telephone Survey conducted by Acumen Research.
- Focus Group sessions with groups of individuals within our local communities.
- Key Informant interviews with people who have expert knowledge about specific groups of people within Central Region.

A core set of questions were developed and asked of every person or group consulted except the telephone respondents who participated in a broader provincial community survey and income specific Key Informants. Many of the findings are found within this report.

Telephone Survey:

In addition to the Manitoba overall telephone survey questions, in Central Region respondents were asked two separate questions.

1. Spirituality:

   Telephone Respondents were asked “Would you say your spiritual well being plays an extremely important, somewhat important or unimportant role in how you feel about your overall health every day?” Response choices included the following.

   1) Extremely important
   2) Somewhat important
   3) Unimportant
4) Don’t know/refused

2. Immunization:

There are many reasons why people do or do not immunize against things like infections, flu and pneumonia. Some people say they get immunized because their doctor told them to, OR that it protects them against illness and it’s the smart thing to do while others say they don’t do it because they are afraid of having a bad reaction to the vaccine OR they don’t need it anymore because immunization is only for those who are weak or frail. Which opinion is closest to your own?

1) Doctor’s orders
2) Smart thing to do
3) Fearful of reaction
4) Only for weak and frail
5) Don’t know / refused

Focus Groups:

Twenty-Five Focus Groups were held with 177 participants in all. Wildwood Consulting was the primary investigator for the Focus Groups, which were divided by sex, age and ethnicity.

- Males: 68
- Females: 109
- Francophone: 36
- Hutterite: 8
- Aboriginal: 25

Five core questions were asked. They were asked of every Focus Group, Key Informant, and Advisory Team with whom we consulted. These core questions were:

1. Core Question cycle:

   i) Determinants of Health Introduction. Viewing cards illustrated the nine determinants of health framed for our document.
      • Which of these is the most important to your health?
      • Which of these do you think is the least important to your health?
      • What affects the determinants in a positive or negative way?
      • What motivates a change in activities (behaviour) that affect your health?
   ii) Who is responsible for your health? In what ways are you responsible for your health?
   iii) What does a healthy family mean to you?
      • What makes a family environment safe?
   iv) What role does spirituality have in your health? Note: Asked as a core question after the first three Focus Group sessions.
   v) Do you have any final thoughts to share with us regarding health?

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1 All participant’s identifying information is protected for confidentiality. All participants were aware of their own exposure within the groups of their investigation, and were asked to keep confidential what was shared in the group sessions. Copies of all consents and letters can be found in the Appendix. They will be stored for seven years in RHA Central possession.
**Ethnic Groups (Aboriginal, French, Hutterite):**

How does spirituality affect your health?
Note: This question was moved into the core group after the first three Focus Groups due to the rich context of some answers to this question.

**Males:**

vi) Explain if and how an unexpected death from injury has affected your health. (eg. Self inflicted Suicide or other inflicted MVC).

vii) In what ways has your activity level changed in the last 5 years?

**Females:**

viii) How does environment affect your health?

ix) How does income affect your health?

**Youth:**

x) How does the way you get information about sex differ from the way you’d most like to get this information?

**65 years+:**

xi) In what ways does the life you currently live compare to the life you would like to live?

• What gives your life purpose?

An example of questions for a group with mixes as described would be:


Wildwood Consulting found it necessary to reframe the questions in some cases to address the spirit of the question. Sorting through the contextual meaning and quantifying the data will be a long-term project.

**Key Informants:**

Individuals and groups of experts who had specific knowledge about groups of people were consulted including people from Family Services, from Mennonite Services, Aboriginal Elders, and agencies who partner with RHA Central. Female clients of the Women’s SHAPE Team service providers were asked which questions related to how income affects their health. Advisory teams included the District Health Advisory Council and the Spiritual Care Advisory Team. All of the information shared is valuable and appreciated. It has been included in various ways within the report as quotes from Key Informants.

We asked the same core questions of these groups that we asked in Focus Groups with three exceptions. We did not ask any distinct questions as we did for the Focus Group
participants and we asked that all of these Key Informants answer, from their perspectives, on behalf of the people they serve. The income Key Informant groups were asked an entirely different set of questions found at the end of Appendix A.

These specific income questions were asked of clients who were known to have health challenges related to income and who agreed to participate in a general but completely confidential way through discussions with their care providers. Their responses are seen in the document where age and income of respondent is included. As well, Aboriginal SHAPE team members consulted with Aboriginal peoples both on and off reserve including a visit to the Friendship Centre in Portage la Prairie.

Together this qualitative data has added depth to our understanding of both the health status and health beliefs of our community. Over time we will further analyze the data for more in-depth comprehension of how it can better inform health planning in Central Region.

**Women’s Team Key Informant Interviews**

**Introduction**

The information you provide is strictly confidential. Participation is entirely voluntary, if you choose not to answer one or more of the questions that is okay. This will take about half an hour. We are members of the Women’s Community Health Assessment Team and encourage you to think of your answers in terms of your own health, and health needs as a woman, not as a mom.

**Personal data:**

1. Your AGE:________________________
2. Your INCOME – Above or Below $20,000 a year___________________

**Questions:**

1. How do you think that owning a car would make a difference to your health?
   PROMPTS – or, having enough money to afford a taxi when you need one…
   – or, knowing someone who has a car so you can travel when you need to

2. Tell me some ways that you think the condition of your house might affect your health?
   PROMPTS – can you afford to move, if you need to…
   – what are the reasons you would move if you felt you had to…insulation, security, storage capacity, mouldy basements, no fenced backyard…

3. When you have a problem or are feeling down, what do you do?
   PROMPTS – do you ever feel lonely…
   – do you have someone to talk to, who you trust, and who understands you?
   – how often do you talk to this person(s)…
   – are they in walking distance, do you talk by phone
4. What do you do in your spare (free) time?
   PROMPTS – how often do you do something you want to do, with or without children
     or your partner…
     – do you play bingo or cards, visit friends or family, attend community or
   church groups
     – or just step outside for a cigarette…

5. Do you sometimes feel like a single parent? What makes it difficult or easy?
   PROMPTS – having enough money…feeding your children…
     lack of child care…not able to find a job…

6. Have you ever been denied health services? And if so, how did you feel?
   PROMPTS – what did you do…
     – at the hospital ER, walk-in clinic, pharmacy, optometrist, dentist
Appendix B

Dear Focus Group Participant

Thank you for agreeing to participate in a discussion group for the 2004 Community Health Assessment conducted by the Regional Health Authority—Central Mb. Inc. The purpose of this assessment is to gather information about the health of the people in our community. There will be a number of discussion groups held throughout the RHA. The information we gather will be used for improving health services and for planning future programs.

Approximately 10 individuals have been invited to participate in this group discussion. The group leader will ask specific questions about your views and perceptions related to health in general and to your own special interest group in particular. This discussion will take approximately two hours and will begin with an introductory refreshment time.

Participation in this group discussion is optional. You may change your mind at any time and you may also choose not to answer specific questions. You do not have to give a reason and it will not affect the care you may require within the RHA-Central. Being involved in this discussion involves no known benefit or risk to you.

The information you provide will remain confidential. Only general information about you will be recorded, such as your year of birth, gender, and ethnicity. Only those individuals who are directly involved with the Community Health Assessment will have access to this information. Your responses will be grouped with those of others and it will not be possible to identify individual respondents. Group information will be included in a final report and future publications. The findings of the health assessment will be made available to the public and service providers throughout the region as well as Manitoba Health. In keeping with ethical standards, all recorded information will be stored in a locked cabinet in an office in Regional Administration for a period of seven years.

Refreshments will be provided to all participants and travel costs may be covered (if applicable). However you will not be paid for your participation.

Please call Donna Champagne at 204-746-4313 if you have any questions about the Community Health Assessment or this group discussion. If you would like to speak with someone who is not connected with this group discussion, please call Shirley Dzogan (Manitoba Health) at 204-786-7293.

Sincerely,

Donna Champagne
Regional Health Authority—Central Mb. Inc.
Director Community Health Assessment
Appendix B

Dear _____________

Thank you for agreeing to participate in a discussion group for the 2004 Community Health Assessment conducted by the Regional Health Authority—Central Mb. Inc. The purpose of this assessment is to gather information about the health of the people in our community. There will be a number of discussion groups held throughout the RHA. The information we gather will be used for improving Aboriginal health and for planning future programs and services.

We would be pleased if you could select 10-12 (Swan Lake: 20-35 year old females) (Roseau River: 20-35 year old males) (Sandy Bay: 15-16 year old males) (Urban: 15-16 year old females) (MMF: Barb will conduct groups) to participate in this group discussion. We recognize the importance of culturally relevant persons working within your community so we have asked Barb Cameron, Aboriginal Strategy Co-ordinator, RHA-Central to co-facilitate this undertaking together with the firm of David Church of Wildwood Consulting. Barb will follow-up with you regarding details of this process. If you have questions or concerns please call Barb Cameron at 239-1443.

The information you provide will remain confidential. Only general information about you will be recorded, such as your year of birth, gender, and ethnicity. Only those individuals who are directly involved with the Community Health Assessment will have access to this private information. Your responses will be grouped with those of others and it will not be possible to identify individual respondents. Group information will be included in a final report and future publications. The findings of the health assessment will be made available to the public and service providers throughout the region as well as Manitoba Health. In keeping with ethical standards, all recorded information will be stored in a locked cabinet in an office in Regional Administration for a period of seven years. Findings will be made available to the community through your contact and opportunities for discussing findings will be made available.

Refreshments will be provided to all participants.

Please call Donna Champagne at 204-746-4313 if you have any questions about the RHA-Central Community Health Assessment 2004. For this group discussion, if you would like to speak with someone directly, please feel free to contact Barb Cameron at 239-1443.

Sincerely,

Donna Champagne
Regional Health Authority—Central Mb. Inc.
Director Community Health Assessment
Participant Agreement:

Thank you for agreeing to participate in a discussion group for the 2004 Community Health Assessment conducted by the Regional Health Authority—Central Mb. Inc. The purpose of this assessment is to gather information about the health of the people in our community. The information we gather will be used for improving health services and for planning future programs.

Approximately _____ individuals have been invited to participate in this group discussion. The group leader will ask specific questions about your views and perceptions related to health in general and to your own special interest group in particular. This discussion will take approximately two hours.

Participation in this group discussion is optional. You may change your mind at any time and you may also choose not to answer specific questions. You do not have to give a reason and it will not affect the care you may require within the RHA-Central. Being involved in this discussion involves no known benefit or risk to you.

The information you provide will remain confidential. Only general information about you will be recorded, such as your year of birth, gender, and ethnicity. Only those individuals who are directly involved with the Community Health Assessment will have access to this information. Your responses will be grouped with those of others and it will not be possible to identify individual respondents. Group information will be included in a final report and future publications. The findings of the health assessment will be made available to the public and service providers throughout the region as well as Manitoba Health. In keeping with ethical standards, all recorded information will be stored in a locked cabinet in an office in Regional Administration for a period of seven years.

Your signature on this document indicates that you understand your participation to be confidential. You will keep any personal information, including the names of the other participants in confidence.

I have read, understood, and agree to the confidential non-disclosure required to participate in this focus group.

Name (print) ________________________________________________
Signature                                                                 ___________________________________________________
Signature of Parent or Guardian     __________________________________
Date         ______________________________________________________