NEHA-2004-183

September 30th, 2004

I am very pleased to provide you with a copy of our Region’s Community Health Assessment for 2003-2004.

This Assessment document is a valuable reference tool that provides a wealth of information in identifying the health needs of our Region and the services that we are currently providing. This information will be used extensively in the coming year as we prepare our strategic plans for the next five years.

I would like to acknowledge the following staff members who have worked diligently in conducting the Community Health Assessment and preparing the document:

Suzanne Dick, Research and Project Coordinator
Carol Orvis, Community Health Assessment Assistant
Judy Coleman, VP - Programs & Services

A tremendous working team of staff members from North Eastman facilitated or assisted in conducting the assessment activities through surveys, focus groups and other community meetings. Many community leaders provided support in identifying key contacts for the community consultation sessions and we wish to express our appreciation to them.

Thank you to everyone who had a part in the preparation of this excellent document.

Sincerely,

original signed by

James W. Hayes, MPA, CHE
Chief Executive Officer
TABLE OF CONTENTS

• Message from the Chief Executive Officer

1.0 EXECUTIVE SUMMARY

2.0 ACKNOWLEDGEMENTS

3.0 ABBREVIATIONS

4.0 INTRODUCTION

4.1 PURPOSE............................................................................................................. 4-1
4.2 WHAT IS A COMMUNITY HEALTH ASSESSMENT?................................. 4-1
4.3 NEHA RESPONDS TO PREVIOUS CHA REPORT 1998...................... 4-2
4.4 2003-2004 CHA PROCESS...........................................................................4-5
   4.4.1 STEERING COMMITTEE........................................................................ 4-7
   4.4.2 DATA COLLECTION TEAMS................................................................. 4-7
      4.4.2.1 Regional Health Authority Data Team........................................ 4-7
      4.4.2.2 Information Technology Team..................................................... 4-7
      4.4.2.3 Aboriginal Team........................................................................... 4-7
      4.4.2.4 Community Consultation Team .................................................. 4-8
   4.4.3 AWARENESS......................................................................................... 4-9
   4.4.4 CONSULTATION .............................................................................. 4-10

4.5 CHA FRAMEWORK – MANITOBA’S HEALTH PERFORMANCE MEASUREMENT FRAMEWORK................................. 4-11
   4.5.1 OVERVIEW.......................................................................................... 4-11

4.6 POPULATION HEALTH MODEL................................................................. 4-16

4.7 ETHICS......................................................................................................... 4-17
   4.7.1 PERSONAL HEALTH INFORMATION ACT...................................... 4-17
   4.7.2 NEHA POLICIES.................................................................................. 4-17
   4.7.3 GUIDELINES DEVELOPED BY CHAN............................................. 4-17
# Table of Contents

## 4.8 HOW TO USE THIS REPORT ................................................................. 4-19

4.8.1 GENERAL USE ..................................................................................... 4-19
4.8.2 INTRODUCTION – SECTION 4 ............................................................... 4-20
4.8.3 DATA COLLECTION & METHODOLOGY – SECTION 5 ....................... 4-20
4.8.4 REGIONAL INFORMATION – SECTION 6 ............................................... 4-20
4.8.5 HEALTH SERVICES – SECTION 7 ......................................................... 4-21
4.8.6 HEALTH DISTRICTS – SECTIONS 8 THROUGH 13 ............................ 4-21
4.8.7 CONCLUSION – SECTION 14 ............................................................... 4-21

## 4.9 PRIORITY SETTING .............................................................................. 4-22

## 4.10 SUMMARY/CONCLUSION ................................................................ 4-23

## 4.11 REFERENCES ..................................................................................... 4-24

### APPENDICES - SECTION 4

4-1 Community Health Assessment Network (CHAN) Terms of Reference
4-2 2003-2004 CHA Steering Committee Terms of Reference
4-3 Role of the Community Consultation Team
4-4 CHA Ethics Guidelines & CHAN Ethics Policy
4-5 Diagnostic Categories

## 5.0 DATA COLLECTION METHODOLOGY

### 5.1 OVERVIEW ....................................................................................... 5-1

### 5.2 LIST OF PRIMARY SOURCES OF INFORMATION ............................ 5-2

5.2.2 MARTENS, P. ET AL. (2003) THE MANITOBA RHA INDICATORS ATLAS: POPULATION-BASED COMPARISONS OF HEALTH & HEALTH CARE USES, MCHP, JUNE .......................................................... 5-4
5.2.3 STATISTICS CANADA WEB SITE: HTTP://WWW.STATCAN.CA .................. 5-5
5.2.4 ACUMEN RESEARCH (2004) COMMUNITY HEALTH SURVEY 2003 ........... 5-5
5.2.5 NORTH EASTMAN RHA DATA ............................................................... 5-10
5.2.6 MANITOBA HEALTH INJURIES OF MANITOBA – A TEN YEAR REVIEW, JANUARY 2004 .................................................................................................................. 5-10
TABLE OF CONTENTS

5.3 PRIMARY SOURCES OF QUALITATIVE INFORMATION....................... 5-11
  5.3.1 FOCUS GROUPS................................................................. 5-11
  5.3.2 COMMUNITY VALIDATION MEETINGS “AN OVERVIEW OF YOUR
       COMMUNITY’S HEALTH STATUS.” ........................................ 5-16
  5.3.3 NEHA HEALTH PROGRAM COMMUNITY CONSULTATIONS............. 5-19
  5.3.4 GLOSSARY OF STATISTICAL TERMS..................................... 5-19

5.4 SUMMARY/CONCLUSION ............................................................. 5-19

5.5 REFERENCES............................................................................. 5-20

APPENDICES – SECTION 5

5-1 North Eastman Provincial Survey Questions And Corresponding Responses-
    November/December 2003
5-2 Focus Group Correspondence Letters
5-3 Validation Workshop Collation Template
5-4 Glossary Of Common Statistical Terms

6.0 NORTH EASTMAN REGIONAL PROFILE

6.1 GEOGRAPHICAL OVERVIEW......................................................6-1
    Description / NE Map............................................................. 6-1
    Geographical Boundaries..................................................... 6-3

6.2 COMMUNITY SYSTEM CHARACTERISTICS.................................6-4
    Overview .................................................................................. 6-4
    • Population Demographics ............................................... 6-4
    • Aboriginal Population ..................................................... 6-6
    • First Nation Population .................................................... 6-6
    • Population & Growth Projections ................................. 6-7
    • Comparing the Number of People Projected in 2025.............. 6-8
    • Migration.............................................................................. 6-8
    • Other Population Indicators ............................................ 6-9
    • Language.............................................................................. 6-11
    Community Feedback: Characteristics That Support Healthy Living .......... 6-12
# TABLE OF CONTENTS

**Education as a Health Determinant** .......................................................... 6-17  
Overview ........................................................................................................... 6-17  
Attendance ....................................................................................................... 6-17  
Levels of Education.......................................................................................... 6-18  
Literacy............................................................................................................ 6-20  
Number of Children With Special Needs......................................................... 6-21  
Community Feedback on Schools ................................................................. 6-21  

## 6.3 HEALTH STATUS.................................................................................. 6-22  
Overview ........................................................................................................... 6-22  
Measuring Overall Health Status ................................................................. 6-23  
- Social Economic Factor Index [SEFI] ........................................................... 6-24  
- Premature Mortality Rates Region & Health Districts .................................. 6-25  
Deaths .............................................................................................................. 6-27  
- Life Expectancy ........................................................................................... 6-27  
- Total mortality ............................................................................................ 6-28  
- Potential Years of Life Lost (PYLL) ............................................................... 6-29  
- Causes of Death ......................................................................................... 6-31  

### Health Conditions ................................................................................. 6-32  
- Cancer ......................................................................................................... 6-33  
- Arthritis & Rheumatism .......................................................................... 6-36  
- Diabetes ..................................................................................................... 6-37  
- Respiratory Disease .................................................................................. 6-41  
- Hypertension .............................................................................................. 6-43  
- Myocardial Infarction ............................................................................... 6-44  
- Stroke ......................................................................................................... 6-45  
- Injuries ........................................................................................................ 6-46  
  Overview ..................................................................................................... 6-46  
  Unintentional and Intentional Injuries .......................................................... 6-47  
  Injury Morality Rates .................................................................................. 6-48  
  NE Unintentional Injury Deaths ................................................................ 6-50  
  NE Intentional Injury Deaths ...................................................................... 6-51  
  NE Undetermined ....................................................................................... 6-52  
  Injuries Requiring Hospitalization ............................................................... 6-53  
  Occupational Injuries ................................................................................ 6-54  
  Community Feedback - Injuries ................................................................. 6-57  

### Human Function ...................................................................................... 6-58  
- Functional Health ...................................................................................... 6-58  
  Community Feedback - Difficulties with Physical Health ......................... 6-59  

### Well-being .............................................................................................. 6-59  
- Self Rated Health ....................................................................................... 6-60  
  Community Feedback – Health & Meaning of Health .............................. 6-60
# TABLE OF CONTENTS

## 6.4 DETERMINANTS OF HEALTH ......................................................... 6-63

- **Culture & Gender** ................................................................. 6-64
  - Overview .............................................................................. 6-64
- **Visible minorities** .............................................................. 6-64

- **Environmental Factors as a Health Determinant** .................. 6-65
  - Overview .............................................................................. 6-65
  - **Water** ........................................................................... 6-65
    - Community Feedback on Environment Safety ...................... 6-67
  - **The Air We Breathe** ......................................................... 6-67
    - Staff Feedback on Smoking Within Facilities ...................... 6-67
  - **Safety** ............................................................................ 6-68
    - Community Feedback - Safety ............................................ 6-70
- **Housing** ............................................................................ 6-71
  - Community Feedback on Housing ........................................ 6-73

- **Biology & Genetic Endowment as a Health Determinant** ...... 6-74
  - Overview .............................................................................. 6-74

- **Personal Health Practices & Lifestyles as a Health Determinant** 6-75
  - Overview .............................................................................. 6-75
  - **Community Feedback on Life Style Changes Overall** ......... 6-76
  - **Dietary Practices** .......................................................... 6-77
    - Community Feedback on Dietary Practices and Behaviour .... 6-79
  - **Adult Immunizations** ...................................................... 6-81
    - Influenza Immunizations ................................................. 6-81
    - Pneumococcal Immunizations ....................................... 6-82
  - **Alcohol Consumption** ................................................... 6-84
    - Substance Use Among Manitoba Height School Students – Alcohol 6-85
  - **Gambling Practices** ....................................................... 6-87
  - **Substance Use Among Manitoba High School Students – Substance Use** 6-88
    - Community Feedback on Illicit Drug Use ......................... 6-89
  - **Addictions Foundation Programs** .................................... 6-90
    - AFM Youth Service Clients in North Eastman ..................... 6-90
    - Adults in AFM Programs in North Eastman ......................... 6-91
  - **Physical Activity** .......................................................... 6-91
    - Community Feedback on Exercise .................................... 6-92
  - **Smoking Practices** ........................................................ 6-94
    - Substance Use Among Manitoba High School Students – Smoking 6-95
      - Community Feedback on Smoking Practices ................. 6-97
  - **Risk Taking Behaviours** ................................................. 6-97
    - Community Feedback on Risk Taking Behaviours .............. 6-97
# TABLE OF CONTENTS

Medication Use

- Pharmaceutical Use in NE ................................................................. 6-98
- Antibiotic Use ..................................................................................... 6-99
- Antidepressant Use ........................................................................... 6-100

Modifying Lifestyles to Improve Health ........................................... 6-101

- Community Feedback of Lifestyle Changes ...................................... 6-101

## Healthy Child Development as a Health Determinant ..................... 6-102

- Overview .......................................................................................... 6-102

## Mortality Rates .................................................................................. 6-102

- Mortality Overview ........................................................................... 6-104
- Injury Hospitalization Overview ....................................................... 6-105

- Births ................................................................................................. 6-107

- Community Feedback on Obstetrical Practice ................................. 6-108

## Adolescent and Teenage Pregnancy ............................................... 6-109

- Overview .......................................................................................... 6-109

- Breastfeeding Practices ...................................................................... 6-112

- Birth Weights
  - High Birth Weight ........................................................................ 6-114
  - Low Birth Weight .......................................................................... 6-115
  - Pre-Term Birth Weight ................................................................. 6-116

- Childhood Immunizations ............................................................... 6-116

- Overview .......................................................................................... 6-116

- Childhood Immunization Rates – Completed Recommended Vaccines.... 6-118

## Living & Working Conditions as a Health Determinant ................. 6-123

- Overview .......................................................................................... 6-123

- Working Conditions
  - Unemployment ............................................................................... 6-125

- Community Feedback on Youth Employment ................................... 6-126

## Social Economic Status .................................................................... 6-126

- Household income ........................................................................... 6-126

- Income Inequality ............................................................................. 6-127

## Personal Resources (Social Support Network) as a Health Determinant 6-128

- Overview .......................................................................................... 6-128

- Mental Emotional Health
  - Stress ............................................................................................... 6-129

- Community Feedback on Stress & Mental Well-being ...................... 6-130

- Social Support ............................................................................... 6-131

- Community Feedback on Social Support ......................................... 6-134
TABLE OF CONTENTS

Other Community Supports .................................................................................................. 6-136
- Mental Health Support Group ....................................................................................... 6-136
- Rural Farmers ............................................................................................................... 6-137
- Crisis Services & Shelters ........................................................................................... 6-138
- Crisis Service ............................................................................................................... 6-139

6.5 SUMMARY & CONCLUSION ....................................................................................... 6-140

6.6 REFERENCES ............................................................................................................. 6-148

7.0 REGIONAL HEALTH SERVICES

7.1 NEHA REGIONAL HEALTH SERVICES ...................................................................... 7-1
Overview ......................................................................................................................... 7-1

7.2 HEALTH SYSTEM CHARACTERISTICS ....................................................................... 7-6
Health Service Utilization ............................................................................................... 7-6
Alternative Care .............................................................................................................. 7-6
Expenditures ................................................................................................................... 7-7

7.3 HEALTH SYSTEM PERFORMANCE ........................................................................... 7-8
Availability ....................................................................................................................... 7-8
Community Feedback on Availability of Services ......................................................... 7-8
Accessibility .................................................................................................................... 7-9
Community Feedback on Accessibility of Services and Information ......................... 7-9
System Competency ...................................................................................................... 7-13
Effectiveness .................................................................................................................. 7-13
Community Feedback on Information Seeking ........................................................... 7-13
Client / Community Focus ............................................................................................. 7-14
Communication .............................................................................................................. 7-14
Community Feedback on Communication .................................................................. 7-16
Confidentiality ................................................................................................................ 7-19
Participation & Partnership ............................................................................................ 7-20
Respect & Caring ............................................................................................................ 7-21
Community Feedback on Addressing Health Concerns and Interaction
with Health Providers ....................................................................................................... 7-22
Organization Responsibility & Involvement in the Community .................................. 7-25
# TABLE OF CONTENTS

**Work Life**.................................................................................................................. 7-26
- Open Communications Role Clarity.............................................................................. 7-26
- **Staff Satisfaction Survey**.......................................................................................... 7-27
- Role Clarity.................................................................................................................... 7-30
- Partnership in Decision Making.................................................................................. 7-32
- Learning Environment................................................................................................... 7-32
- Well being .................................................................................................................... 7-34
  - Workplace Injuries.................................................................................................... 7-35
  - Influenza Staff Immunizations................................................................................... 7-36

**7.4 HEALTH SYSTEM INFRASTRUCTURE**.............................................................. 7-38
- Finances......................................................................................................................... 7-38
- Comparing Acute and Community Care Expenditures.............................................. 7-38
- **Human Resources**.................................................................................................... 7-40
- **Leadership**............................................................................................................... 7-41
- **Information & Technology**....................................................................................... 7-42

**7.5 PHYSICIAN SERVICES**....................................................................................... 7-44
- 7.5.1 Health System Characteristics............................................................................. 7-44
- **Health Service Utilization**....................................................................................... 7-44
  - Community Feedback on Health Care Providers.................................................... 7-45
  - Community Feedback on Waiting Times................................................................. 7-46
  - **Health System Performance**.................................................................................. 7-52
  - Availability.................................................................................................................. 7-52
  - Community Feedback on Availability...................................................................... 7-52
  - **Accessibility**.......................................................................................................... 7-53
  - Community Feedback on Physician Access............................................................ 7-56
  - Community Feedback on Physician Related Services............................................ 7-59

**7.6 NEHA HEALTH CARE PROGRAMS**................................................................. 7-62
- 7.6.1 Facility Based Programs....................................................................................... 7-62
  - 7.6.1.1 Acute Care..................................................................................................... 7-62
  - Overview.................................................................................................................... 7-62
  - **Health System Characteristics**............................................................................. 7-63
  - Emergency Services................................................................................................... 7-63
    - Community Feedback on Emergency Services..................................................... 7-63
  - Admissions................................................................................................................ 7-66
    - Community Feedback on Utilization..................................................................... 7-69
  - High Profile Procedures............................................................................................ 7-70
# TABLE OF CONTENTS

- Community Feedback on Access ................................................................. 7-76
- Health System Performance ........................................................................ 7-77
- Availability ................................................................................................. 7-77
- Accessibility .............................................................................................. 7-77
- Appropriateness ......................................................................................... 7-78
- Effectiveness ............................................................................................. 7-80
- Participation & Partnerships ...................................................................... 7-84
  - Community Feedback on Rating, Acute Care, Acute Care Client Consultations... 7-84
  - Community Feedback – Other Comments on Acute Care ............................ 7-86
- Dialysis Program ....................................................................................... 7-87
  - Community Feedback on Dialysis .......................................................... 7-87
- Diagnostic Services .................................................................................... 7-88
  - Community Feedback on Diagnostic Services .......................................... 7-89
- 7.6.1.2 Long Term Care ............................................................................. 7-92
  - Overview ................................................................................................. 7-92
  - Community & Health System Characteristics ......................................... 7-93
  - Health Service Utilization ...................................................................... 7-93
  - Health System Performance .................................................................. 7-94
  - Availability .............................................................................................. 7-94
  - Accessibility ............................................................................................ 7-96
  - Community Feedback on Accessibility .................................................. 7-97
  - Appropriateness ....................................................................................... 7-100
  - Community Feedback on LTC ............................................................... 7-101
  - Participation & Partnership .................................................................... 7-102
  - Community Feedback on Rating Of Service And LTC Client Consultations .... 7-102
- 7.6.2 Community Based Programs ........................................................... 7-104
  - 7.6.2.1 Home Care .................................................................................. 7-104
    - Overview .............................................................................................. 7-104
    - Community & Health System Characteristics ...................................... 7-105
    - Utilization ............................................................................................ 7-105
    - Community Feedback on the Use of Community Services ................. 7-107
    - Health System Performance ............................................................... 7-108
    - Availability ............................................................................................ 7-108
    - Community Feedback on Availability ................................................. 7-108
    - Effectiveness ......................................................................................... 7-109
    - Community Feedback on Effectiveness ............................................... 7-109
    - Participation and Partnerships ............................................................ 7-110
      - Community Feedback On Rating Of Service And Home Care Client Consultations ................................................................................. 7-110
  - 7.6.2.2 Primary Health Care ................................................................. 7-112
    - Overview .............................................................................................. 7-112
    - Community & Health System Characteristics ...................................... 7-113
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization</td>
<td>7-113</td>
</tr>
<tr>
<td></td>
<td>Community Feedback On Utilization and Community Services</td>
</tr>
<tr>
<td>Health System Performance</td>
<td>7-115</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>7-116</td>
</tr>
<tr>
<td></td>
<td>Community Feedback On Importance Of Community Services and On Primary Health Care</td>
</tr>
<tr>
<td>Participation &amp; Partnership</td>
<td>7-117</td>
</tr>
<tr>
<td></td>
<td>Community Feedback On Rating, Importance And Client Consultations</td>
</tr>
<tr>
<td><strong>7.6.2.3 Mental Health</strong></td>
<td>7-118</td>
</tr>
<tr>
<td>Overview</td>
<td>7-118</td>
</tr>
<tr>
<td></td>
<td>Community &amp; Health System Characteristics</td>
</tr>
<tr>
<td>Utilization</td>
<td>7-119</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Utilization</td>
</tr>
<tr>
<td>Health System Performance</td>
<td>7-121</td>
</tr>
<tr>
<td>Availability</td>
<td>7-121</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Availability</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>7-122</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Effectiveness</td>
</tr>
<tr>
<td>Participation &amp; Partnerships</td>
<td>7-124</td>
</tr>
<tr>
<td></td>
<td>Community Feedback On Rating, Importance Of Service</td>
</tr>
<tr>
<td><strong>7.6.2.4 Emergency Medical Services</strong></td>
<td>7-125</td>
</tr>
<tr>
<td>Overview</td>
<td>7-125</td>
</tr>
<tr>
<td></td>
<td>Community &amp; Health System Characteristics</td>
</tr>
<tr>
<td>Utilization</td>
<td>7-126</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Utilization</td>
</tr>
<tr>
<td>Health System Performance</td>
<td>7-128</td>
</tr>
<tr>
<td>Effectiveness- Community Feedback on Effectiveness</td>
<td>7-128</td>
</tr>
<tr>
<td>Participation &amp; Partnerships- Community Feedback On Rating, Importance Of Service, EMS In General And Client Consultations</td>
<td>7-129</td>
</tr>
<tr>
<td><strong>7.6.2.5 Public Health</strong></td>
<td>7-131</td>
</tr>
<tr>
<td>Overview</td>
<td>7-131</td>
</tr>
<tr>
<td></td>
<td>Community &amp; Health System Characteristics</td>
</tr>
<tr>
<td>Utilization</td>
<td>7-132</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Utilization</td>
</tr>
<tr>
<td>Health System Performance</td>
<td>7-135</td>
</tr>
<tr>
<td>Accessibility- Community Feedback on Accessibility</td>
<td>7-135</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>7-136</td>
</tr>
<tr>
<td></td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on STD’s</td>
</tr>
<tr>
<td></td>
<td>Enteric, Food and Waterborne Illnesses</td>
</tr>
<tr>
<td></td>
<td>Community Feedback on Public Health</td>
</tr>
<tr>
<td>Participation &amp; Partnerships- Community Feedback On Rating, Importance Of Service.</td>
<td>7-143</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

and Client Consultations........................................................................................................ 7-144
Health System Infrastructure.................................................................................................. 7-147
  • Surveillance.................................................................................................................... 7-147
  • Breast Cancer Screening.............................................................................................. 7-147
  • Cervical Cancer Screening.......................................................................................... 7-149

7.6.3 Quality & Organizational Development Program.................................................... 7-151
Overview............................................................................................................................. 7-151
Risk Management................................................................................................................ 7-151
Accreditation......................................................................................................................... 7-151
  Community Feedback on Quality of Health System and Addressing Health
  Concerns ......................................................................................................................... 7-152

7.7 SUMMARY/CONCLUSION ............................................................................................ 7-153

7.8 REFERENCES .................................................................................................................. 7-161

8.0 SPRINGFIELD HEALTH DISTRICT

8.1 GEOGRAPHICAL OVERVIEW.................................................................................... 8-1
  Community Feedback On How Healthy Living Is Supported........................................ 8-3

8.2 COMMUNITY SYSTEM CHARACTERISTICS............................................................... 8-4
  Overview ........................................................................................................................ 8-4
  Population Demographics............................................................................................... 8-4
  Education as a Health Determinant................................................................................. 8-5
  Community Feedback on Schools................................................................................. 8-7

8.3 HEALTH STATUS ........................................................................................................... 8-9
  Overview........................................................................................................................ 8-9
  Significant Indicators Measuring Overall Health Status................................................. 8-10
    Community Feedback on the Meaning of Health....................................................... 8-12
  Deaths.............................................................................................................................. 8-13
    Total Mortality Rate.................................................................................................... 8-13
    Life Expectancy ......................................................................................................... 8-14
    Potential Years of Life Lost ....................................................................................... 8-15
  Health Conditions ......................................................................................................... 8-17
    Cancer........................................................................................................................ 8-17
    Community Feedback on Cancer............................................................................. 8-17
    Diabetes...................................................................................................................... 8-18
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Diseases</td>
<td>8-19</td>
</tr>
<tr>
<td>Hypertension</td>
<td>8-21</td>
</tr>
<tr>
<td>Community Feedback on Hypertension</td>
<td>8-21</td>
</tr>
<tr>
<td>Heart Attacks</td>
<td>8-22</td>
</tr>
<tr>
<td>Strokes</td>
<td>8-23</td>
</tr>
<tr>
<td>Injuries</td>
<td>8-24</td>
</tr>
<tr>
<td><strong>Human Function</strong></td>
<td>8-25</td>
</tr>
<tr>
<td>Overview</td>
<td>8-25</td>
</tr>
<tr>
<td><strong>Well-being</strong></td>
<td>8-25</td>
</tr>
<tr>
<td>Overview</td>
<td>8-25</td>
</tr>
<tr>
<td>Community Feedback from Youth “There’s Nothing to Do.”</td>
<td>8-25</td>
</tr>
<tr>
<td><strong>8.4 DETERMINANTS OF HEALTH</strong></td>
<td>8-26</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td>8-27</td>
</tr>
<tr>
<td>Water</td>
<td>8-27</td>
</tr>
<tr>
<td>Community Feedback on Water</td>
<td>8-28</td>
</tr>
<tr>
<td>Air</td>
<td>8-28</td>
</tr>
<tr>
<td>Community Feedback on Air Quality</td>
<td>8-28</td>
</tr>
<tr>
<td>Housing</td>
<td>8-29</td>
</tr>
<tr>
<td>Community Feedback on Housing</td>
<td>8-29</td>
</tr>
<tr>
<td>Safety</td>
<td>8-30</td>
</tr>
<tr>
<td>Community Feedback on Safety</td>
<td>8-31</td>
</tr>
<tr>
<td><strong>Biology &amp; Genetic Endowment</strong></td>
<td>8-32</td>
</tr>
<tr>
<td>Overview</td>
<td>8-32</td>
</tr>
<tr>
<td><strong>Personal Health Practices &amp; Lifestyle</strong></td>
<td>8-33</td>
</tr>
<tr>
<td>Overview</td>
<td>8-33</td>
</tr>
<tr>
<td>Community Feedback on Personal Health Practices and Coping Skills</td>
<td>8-33</td>
</tr>
<tr>
<td>Dietary Practices- Community Feedback on Dietary Practices</td>
<td>8-34</td>
</tr>
<tr>
<td>Alcohol Consumption- Community Feedback on Alcohol Consumption</td>
<td>8-35</td>
</tr>
<tr>
<td>Physical Activity- Community Feedback on Exercise</td>
<td>8-36</td>
</tr>
<tr>
<td>Smoking Practices- Community Feedback on Smoking</td>
<td>8-37</td>
</tr>
<tr>
<td>Medication Use</td>
<td>8-38</td>
</tr>
<tr>
<td>Pharmaceutical Use</td>
<td>8-38</td>
</tr>
<tr>
<td>Number of Different Drugs</td>
<td>8-38</td>
</tr>
<tr>
<td>Proportion of Residents Using Antibiotics</td>
<td>8-39</td>
</tr>
<tr>
<td>Proportion of Residents Using Antidepressants</td>
<td>8-40</td>
</tr>
<tr>
<td>Community Feedback on Prescriptions and Pharmacare</td>
<td>8-40</td>
</tr>
<tr>
<td><strong>Healthy Child Development</strong></td>
<td>8-41</td>
</tr>
<tr>
<td>Overview</td>
<td>8-41</td>
</tr>
<tr>
<td>Infant Mortality Rates</td>
<td>8-41</td>
</tr>
<tr>
<td>Births</td>
<td>8-41</td>
</tr>
<tr>
<td>Community Feedback on Obstetrical Practice</td>
<td>8-42</td>
</tr>
<tr>
<td>Adolescent and Teenage Pregnancy</td>
<td>8-43</td>
</tr>
<tr>
<td>Breastfeeding Practices</td>
<td>8-44</td>
</tr>
<tr>
<td>Birth Weights</td>
<td>8-45</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>8-47</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

Community Feedback on Healthy Child Development ........................................ 8-48
Living and Working Conditions .......................................................................... 8-49
Overview ............................................................................................................ 8-49
Employment and Unemployment ................................................................. 8-49
Social Economic Status ..................................................................................... 8-50
Community Feedback on Employment and Working Condition ............... 8-51
Personal Resources ............................................................................................ 8-52
Overview ............................................................................................................ 8-52
Mental Emotional Health .................................................................................... 8-53
Community Feedback on Mental Well-being .................................................. 8-53
Social Support ..................................................................................................... 8-54
Community Feedback on Social Support .......................................................... 8-55

8.5 SUMMARY/CONCLUSION ............................................................................. 8-57

8.6 REFERENCES ................................................................................................ 8-64

9.0 BROKENHEAD HEALTH DISTRICT

9.1 GEOGRAPHICAL OVERVIEW ................................................................. 9-1
Community Feedback On How Healthy Living Is Supported ....................... 9-3

9.2 COMMUNITY SYSTEM CHARACTERISTICS ........................................ 9-4
Overview ............................................................................................................ 9-4
Population Demographics .............................................................................. 9-4
Education as a Health Determinant ................................................................. 9-6
Community Feedback on Schools ................................................................. 9-8

9.3 HEALTH STATUS ....................................................................................... 9-9
Overview ............................................................................................................ 9-9
Significant Indicators Measuring Overall Health Status ................................. 9-10
Community Feedback on the Meaning of Health ......................................... 9-12
Deaths ................................................................................................................. 9-13
Total Mortality Rate .......................................................................................... 9-13
Life Expectancy .................................................................................................. 9-14
Potential Years of Life Lost .............................................................................. 9-15
Health Conditions .............................................................................................. 9-17
Cancer .................................................................................................................. 9-17
Diabetes ............................................................................................................... 9-18
Community Feedback on Diabetes ................................................................. 9-18
Respiratory Diseases .......................................................................................... 9-19
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>9-21</td>
</tr>
<tr>
<td>Heart Attacks</td>
<td>9-22</td>
</tr>
<tr>
<td>Strokes</td>
<td>9-23</td>
</tr>
<tr>
<td>Injuries</td>
<td>9-24</td>
</tr>
<tr>
<td>Human Function</td>
<td>9-25</td>
</tr>
<tr>
<td>Overview</td>
<td>9-25</td>
</tr>
<tr>
<td>Well-being</td>
<td>9-25</td>
</tr>
<tr>
<td>Overview</td>
<td>9-25</td>
</tr>
<tr>
<td>Community Feedback from Youth “There’s Nothing to Do.”</td>
<td>9-26</td>
</tr>
</tbody>
</table>

## 9.4 DETERMINANTS OF HEALTH ................................. 9-27

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Factors</td>
<td>9-28</td>
</tr>
<tr>
<td>Water</td>
<td>9-28</td>
</tr>
<tr>
<td>Air</td>
<td>9-29</td>
</tr>
<tr>
<td>Housing</td>
<td>9-29</td>
</tr>
<tr>
<td>Community Feedback on Housing</td>
<td>9-29</td>
</tr>
<tr>
<td>Safety</td>
<td>9-30</td>
</tr>
<tr>
<td>Community Feedback on Safety</td>
<td>9-32</td>
</tr>
<tr>
<td>Biology &amp; Genetic Endowment</td>
<td>9-33</td>
</tr>
<tr>
<td>Overview</td>
<td>9-33</td>
</tr>
<tr>
<td>Personal Health Practices &amp; Lifestyle</td>
<td>9-33</td>
</tr>
<tr>
<td>Overview</td>
<td>9-33</td>
</tr>
<tr>
<td>Dietary Practices - Community Feedback on Dietary Practices</td>
<td>9-34</td>
</tr>
<tr>
<td>Alcohol Consumption - Community Feedback on Alcohol and Illicit Drug Use</td>
<td>9-36</td>
</tr>
<tr>
<td>Physical Activity - Community Feedback on Exercise</td>
<td>9-37</td>
</tr>
<tr>
<td>Smoking Practices - Community Feedback on Smoking</td>
<td>9-38</td>
</tr>
<tr>
<td>Potential Risk Taking Behaviour – Community Feedback on Risk Taking Behaviour</td>
<td>9-38</td>
</tr>
<tr>
<td>Medication Use</td>
<td>9-39</td>
</tr>
<tr>
<td>Pharmaceutical Use</td>
<td>9-39</td>
</tr>
<tr>
<td>Number of Different Drugs</td>
<td>9-40</td>
</tr>
<tr>
<td>Proportion of Residents Using Antibiotics</td>
<td>9-41</td>
</tr>
<tr>
<td>Proportion of Residents Using Antidepressants</td>
<td>9-42</td>
</tr>
<tr>
<td>Community Feedback on Prescriptions and Pharmacare</td>
<td>9-42</td>
</tr>
<tr>
<td>Healthy Child Development</td>
<td>9-43</td>
</tr>
<tr>
<td>Overview</td>
<td>9-43</td>
</tr>
<tr>
<td>Community Feedback on Youth</td>
<td>9-43</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>9-44</td>
</tr>
<tr>
<td>Births</td>
<td>9-44</td>
</tr>
<tr>
<td>Community Feedback on Obstetrical Practice</td>
<td>9-44</td>
</tr>
<tr>
<td>Adolescent and Teenage Pregnancy</td>
<td>9-45</td>
</tr>
<tr>
<td>Community Feedback on Teen Pregnancy</td>
<td>9-45</td>
</tr>
<tr>
<td>Breastfeeding Practices</td>
<td>9-46</td>
</tr>
<tr>
<td>Birth Weights</td>
<td>9-47</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>9-48</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living and Working Conditions</td>
<td>9-50</td>
</tr>
<tr>
<td>Overview</td>
<td>9-50</td>
</tr>
<tr>
<td>Employment and Unemployment</td>
<td>9-50</td>
</tr>
<tr>
<td>Community Feedback on Employment and Job Satisfaction</td>
<td>9-50</td>
</tr>
<tr>
<td>Social Economic Status</td>
<td>9-51</td>
</tr>
<tr>
<td>Community Feedback on Income and Social Status</td>
<td>9-52</td>
</tr>
<tr>
<td>Personal Resources</td>
<td>9-53</td>
</tr>
<tr>
<td>Overview</td>
<td>9-53</td>
</tr>
<tr>
<td>Mental Emotional Health</td>
<td>9-53</td>
</tr>
<tr>
<td>Community Feedback on Mental Well-being</td>
<td>9-53</td>
</tr>
<tr>
<td>Social Support</td>
<td>9-54</td>
</tr>
<tr>
<td>Community Feedback on Social Support</td>
<td>9-55</td>
</tr>
<tr>
<td>9.5 SUMMARY/CONCLUSION</td>
<td>9-56</td>
</tr>
<tr>
<td>9.6 REFERENCES</td>
<td>9-63</td>
</tr>
</tbody>
</table>

## 10.0 IRON ROSE HEALTH DISTRICT

### 10.1 GEOGRAPHICAL OVERVIEW                                      | 10-1 |

*Community Feedback On How Healthy Living Is Promoted In Their Community* 10-3

### 10.2 COMMUNITY SYSTEM CHARACTERISTICS                             | 10-4 |

Overview 10-4
Population Demographics 10-4
Education as a Health Determinant 10-5
*Community Feedback on Schools* 10-6

### 10.3 HEALTH STATUS                                                 | 10-7 |

Overview 10-7
Significant Indicators Measuring Overall Health Status 10-7
*Community Feedback on the Meaning of Health* 10-10
Deaths 10-11
Total Mortality Rate 10-11
Life Expectancy 10-12
Potential Years of Life Lost 10-13
Health Conditions 10-15
Cancer 10-15
Diabetes 10-16
Respiratory Diseases 10-17
<table>
<thead>
<tr>
<th>Table Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>10-19</td>
</tr>
<tr>
<td>Community Feedback On High Blood Pressure</td>
<td>10-19</td>
</tr>
<tr>
<td>Heart Attacks</td>
<td>10-20</td>
</tr>
<tr>
<td>Strokes</td>
<td>10-21</td>
</tr>
<tr>
<td>Injuries</td>
<td>10-22</td>
</tr>
<tr>
<td>Human Function</td>
<td>10-23</td>
</tr>
<tr>
<td>Overview</td>
<td>10-23</td>
</tr>
<tr>
<td>Well-being</td>
<td>10-23</td>
</tr>
<tr>
<td>Overview</td>
<td>10-23</td>
</tr>
<tr>
<td>Community Feedback from Youth “There’s Nothing to Do.”</td>
<td>10-23</td>
</tr>
<tr>
<td>10.4 DETERMINANTS OF HEALTH</td>
<td>10-24</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>10-25</td>
</tr>
<tr>
<td>Water</td>
<td>10-25</td>
</tr>
<tr>
<td>Community Feedback on Water</td>
<td>10-25</td>
</tr>
<tr>
<td>Air</td>
<td>10-26</td>
</tr>
<tr>
<td>Housing</td>
<td>10-26</td>
</tr>
<tr>
<td>Community Feedback on Housing</td>
<td>10-26</td>
</tr>
<tr>
<td>Safety</td>
<td>10-27</td>
</tr>
<tr>
<td>Community Feedback on Safety</td>
<td>10-28</td>
</tr>
<tr>
<td>Biology &amp; Genetic Endowment</td>
<td>10-29</td>
</tr>
<tr>
<td>Overview</td>
<td>10-29</td>
</tr>
<tr>
<td>Community Feedback On Biology And Genetic Endowment</td>
<td>10-29</td>
</tr>
<tr>
<td>Personal Health Practices &amp; Lifestyle</td>
<td>10-29</td>
</tr>
<tr>
<td>Overview</td>
<td>10-29</td>
</tr>
<tr>
<td>Dietary Practices-Community Feedback on Dietary Practices</td>
<td>10-30</td>
</tr>
<tr>
<td>Alcohol Consumption - Community Feedback on Alcohol Use</td>
<td>10-30</td>
</tr>
<tr>
<td>Physical Activity - Community Feedback on Exercise</td>
<td>10-31</td>
</tr>
<tr>
<td>Smoking Practices-Community Feedback on Smoking</td>
<td>10-32</td>
</tr>
<tr>
<td>Medication Use</td>
<td>10-33</td>
</tr>
<tr>
<td>Pharmaceutical Use</td>
<td>10-33</td>
</tr>
<tr>
<td>Number of Different Drugs</td>
<td>10-33</td>
</tr>
<tr>
<td>Proportion of Residents Using Antibiotics</td>
<td>10-34</td>
</tr>
<tr>
<td>Proportion of Antidepressants Use</td>
<td>10-35</td>
</tr>
<tr>
<td>Community Feedback on Pharmacare</td>
<td>10-35</td>
</tr>
<tr>
<td>Healthy Child Development</td>
<td>10-36</td>
</tr>
<tr>
<td>Overview</td>
<td>10-36</td>
</tr>
<tr>
<td>Community Feedback on Youth</td>
<td>10-36</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>10-36</td>
</tr>
<tr>
<td>Births</td>
<td>10-36</td>
</tr>
<tr>
<td>Community Feedback on Obstetrical Practice</td>
<td>10-37</td>
</tr>
<tr>
<td>Adolescent and Teenage Pregnancy</td>
<td>10-38</td>
</tr>
<tr>
<td>Breastfeeding Practices</td>
<td>10-39</td>
</tr>
<tr>
<td>Birth Weights</td>
<td>10-40</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunizations ..................................................................</td>
<td>10-42</td>
</tr>
<tr>
<td>Community Feedback on One Year Immunizations</td>
<td>10-44</td>
</tr>
<tr>
<td>Living and Working Conditions</td>
<td>10-45</td>
</tr>
<tr>
<td>Overview</td>
<td>10-45</td>
</tr>
<tr>
<td>Employment and Unemployment</td>
<td>10-45</td>
</tr>
<tr>
<td>Community Feedback on Employment</td>
<td>10-45</td>
</tr>
<tr>
<td>Social Economic Status</td>
<td>10-46</td>
</tr>
<tr>
<td>Community Feedback on Income and Social Status</td>
<td>10-47</td>
</tr>
<tr>
<td>Personal Resources</td>
<td>10-48</td>
</tr>
<tr>
<td>Overview</td>
<td>10-48</td>
</tr>
<tr>
<td>Mental Emotional Health Community Feedback on Mental Well-being</td>
<td>10-48</td>
</tr>
<tr>
<td>Social Support</td>
<td>10-49</td>
</tr>
<tr>
<td>Community Feedback on Social Support</td>
<td>10-50</td>
</tr>
<tr>
<td>10.5 SUMMARY/CONCLUSION</td>
<td>10-52</td>
</tr>
<tr>
<td>10.6 REFERENCES</td>
<td>10-58</td>
</tr>
<tr>
<td>11.0 BLUE WATER HEALTH DISTRICT</td>
<td></td>
</tr>
<tr>
<td>11.1 GEOGRAPHICAL OVERVIEW</td>
<td>11-1</td>
</tr>
<tr>
<td>Community Feedback On How Healthy Living Is Promoted In Their Community</td>
<td>11-3</td>
</tr>
<tr>
<td>11.2 COMMUNITY SYSTEM CHARACTERISTICS</td>
<td>11-5</td>
</tr>
<tr>
<td>Overview</td>
<td>11-5</td>
</tr>
<tr>
<td>Population Demographics</td>
<td>11-5</td>
</tr>
<tr>
<td>Education as a Health Determinant</td>
<td>11-6</td>
</tr>
<tr>
<td>Community Feedback on Schools</td>
<td>11-9</td>
</tr>
<tr>
<td>11.3 HEALTH STATUS</td>
<td>11-10</td>
</tr>
<tr>
<td>Overview</td>
<td>11-10</td>
</tr>
<tr>
<td>Significant Indicators Measuring Overall Health Status</td>
<td>11-11</td>
</tr>
<tr>
<td>Community Feedback on the Meaning of Health</td>
<td>11-13</td>
</tr>
<tr>
<td>Deaths</td>
<td>11-14</td>
</tr>
<tr>
<td>Total Mortality Rate</td>
<td>11-14</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>11-15</td>
</tr>
<tr>
<td>Potential Years of Life Lost</td>
<td>11-16</td>
</tr>
<tr>
<td>Health Conditions</td>
<td>11-18</td>
</tr>
<tr>
<td>Cancer</td>
<td>11-18</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11-19</td>
</tr>
<tr>
<td>Community Feedback on Diabetes</td>
<td>11-20</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Diseases</td>
<td>11-21</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11-22</td>
</tr>
<tr>
<td>Heart Attacks</td>
<td>11-23</td>
</tr>
<tr>
<td>Strokes</td>
<td>11-24</td>
</tr>
<tr>
<td>Injuries</td>
<td>11-26</td>
</tr>
<tr>
<td><strong>Human Function</strong></td>
<td>11-26</td>
</tr>
<tr>
<td>Overview</td>
<td>11-26</td>
</tr>
<tr>
<td><strong>Well-being</strong></td>
<td>11-26</td>
</tr>
<tr>
<td>Overview</td>
<td>11-26</td>
</tr>
<tr>
<td><em>Community Feedback from Youth “There’s Nothing to Do.”</em></td>
<td>11-26</td>
</tr>
<tr>
<td>11.4 <strong>DETERMINANTS OF HEALTH</strong></td>
<td>11-27</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td>11-28</td>
</tr>
<tr>
<td>Overview</td>
<td>11-28</td>
</tr>
<tr>
<td>Water</td>
<td>11-28</td>
</tr>
<tr>
<td>Air We Breathe</td>
<td>11-29</td>
</tr>
<tr>
<td><em>Community Feedback on Water &amp; Air Quality</em></td>
<td>11-29</td>
</tr>
<tr>
<td>Housing</td>
<td>11-29</td>
</tr>
<tr>
<td><em>Community Feedback on Housing</em></td>
<td>11-30</td>
</tr>
<tr>
<td>Safety</td>
<td>11-31</td>
</tr>
<tr>
<td><em>Community Feedback on Traffic</em></td>
<td>11-32</td>
</tr>
<tr>
<td><strong>Biology &amp; Genetic Endowment</strong></td>
<td>11-33</td>
</tr>
<tr>
<td>Overview</td>
<td>11-33</td>
</tr>
<tr>
<td><strong>Personal Health Practices &amp; Lifestyle</strong></td>
<td>11-33</td>
</tr>
<tr>
<td>Overview</td>
<td>11-33</td>
</tr>
<tr>
<td>Dietary Practices - <em>Community Feedback on Dietary Practices</em></td>
<td>11-34</td>
</tr>
<tr>
<td>Alcohol Consumption - <em>Community Feedback on Alcohol &amp; Illicit Drug Use</em></td>
<td>11-35</td>
</tr>
<tr>
<td>Physical Activity - <em>Community Feedback on Exercise</em></td>
<td>11-36</td>
</tr>
<tr>
<td>Smoking Practices - <em>Community Feedback on Smoking</em></td>
<td>11-37</td>
</tr>
<tr>
<td>Medication Use</td>
<td>11-39</td>
</tr>
<tr>
<td>Pharmaceutical Use</td>
<td>11-39</td>
</tr>
<tr>
<td>Number of Different Drugs</td>
<td>11-40</td>
</tr>
<tr>
<td>Proportion of Residents Using Antibiotics</td>
<td>11-41</td>
</tr>
<tr>
<td>Proportion of Antidepressants Use</td>
<td>11-43</td>
</tr>
<tr>
<td><em>Community Feedback on Pharmacare</em></td>
<td>11-43</td>
</tr>
<tr>
<td><strong>Healthy Child Development</strong></td>
<td>11-44</td>
</tr>
<tr>
<td>Overview</td>
<td>11-44</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>11-44</td>
</tr>
<tr>
<td>Births</td>
<td>11-45</td>
</tr>
<tr>
<td><em>Community Feedback on Obstetrical Practice</em></td>
<td>11-46</td>
</tr>
<tr>
<td>Adolescent and Teenage Pregnancy</td>
<td>11-47</td>
</tr>
<tr>
<td><em>Community Feedback on Teen Pregnancy</em></td>
<td>11-47</td>
</tr>
<tr>
<td>Breastfeeding Practices</td>
<td>11-49</td>
</tr>
<tr>
<td>Birth Weights</td>
<td>11-52</td>
</tr>
</tbody>
</table>
### TABLE OF CONTENTS

- **Childhood Immunizations** ................................................................. 11-52
- **Living and Working Conditions** ....................................................... 11-54
  - Overview .................................................................................. 11-54
  - Employment and Unemployment .............................................. 11-54
    - Community Feedback on Employment .................................. 11-54
  - Social Economic Status ......................................................... 11-55
- **Personal Resources** ................................................................. 11-57
  - Overview .................................................................................. 11-57
  - Mental Emotional Health .................................................. 11-57
    - Community Feedback on Mental Well-being ..................... 11-57
  - Social Support ....................................................................... 11-58
    - Community Feedback on Social Support ......................... 11-58
- **Social Support** ........................................................................ 11-58
- **SUMMARY/CONCLUSION** .......................................................... 11-60
- **REFERENCES** ............................................................................ 11-67

---

### 12.0 WINNIPEG RIVER HEALTH DISTRICT

- **12.1 GEOGRAPHICAL OVERVIEW** ............................................. 12-1
  - Community Feedback On How Healthy Living Is Promoted/Supported In Their Community..12-3
- **12.2 COMMUNITY SYSTEM CHARACTERISTICS** ......................... 12-4
  - Overview .................................................................................. 12-4
  - Population Demographics ................................................... 12-4
  - Education as a Health Determinant ...................................... 12-5
    - Community Feedback on Schools .................................... 12-7
- **12.3 HEALTH STATUS** .............................................................. 12-8
  - Overview .................................................................................. 12-8
  - Significant Indicators Measuring Overall Health Status ........ 12-9
    - Community Feedback on the Meaning of Health ....... 12-11
  - Deaths ...................................................................................... 12-12
    - Total Mortality Rate ....................................................... 12-12
    - Life Expectancy ............................................................. 12-13
    - Potential Years of Life Lost ........................................... 12-14
  - Health Conditions ............................................................... 12-16
    - Cancer ................................................................................. 12-16
    - Diabetes .............................................................................. 12-17
      - Community Feedback on Diabetes ............................. 12-17
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Diseases</td>
<td>12-18</td>
</tr>
<tr>
<td>Hypertension</td>
<td>12-19</td>
</tr>
<tr>
<td>Heart Attacks</td>
<td>12-20</td>
</tr>
<tr>
<td>Strokes</td>
<td>12-21</td>
</tr>
<tr>
<td><strong>Community Feedback on Cardiac Disease</strong></td>
<td>12-21</td>
</tr>
<tr>
<td>Injuries</td>
<td>12-22</td>
</tr>
<tr>
<td><strong>Human Function</strong></td>
<td>12-23</td>
</tr>
<tr>
<td><strong>Well-being</strong></td>
<td>12-23</td>
</tr>
<tr>
<td><strong>12.4 DETERMINANTS OF HEALTH</strong></td>
<td>12-24</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td>12-25</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>12-25</td>
</tr>
<tr>
<td>Water</td>
<td>12-25</td>
</tr>
<tr>
<td>Air We Breathe</td>
<td>12-26</td>
</tr>
<tr>
<td><strong>Community Feedback on Air Quality</strong></td>
<td>12-26</td>
</tr>
<tr>
<td>Housing</td>
<td>12-26</td>
</tr>
<tr>
<td><strong>Community Feedback on Housing</strong></td>
<td>12-26</td>
</tr>
<tr>
<td>Safety</td>
<td>12-28</td>
</tr>
<tr>
<td><strong>Biology &amp; Genetic Endowment</strong></td>
<td>12-29</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>12-29</td>
</tr>
<tr>
<td><strong>Personal Health Practices &amp; Lifestyle</strong></td>
<td>12-29</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>12-29</td>
</tr>
<tr>
<td>Dietary Practices - <strong>Community Feedback on Dietary Practices</strong></td>
<td>12-30</td>
</tr>
<tr>
<td>Alcohol Consumption - <strong>Community Feedback on Alcohol &amp; Illicit Drug Use</strong></td>
<td>12-31</td>
</tr>
<tr>
<td>Physical Activity - <strong>Community Feedback on Exercise</strong></td>
<td>12-32</td>
</tr>
<tr>
<td>Smoking Practices - <strong>Community Feedback on Smoking</strong></td>
<td>12-33</td>
</tr>
<tr>
<td>Potential Risk Taking Behaviour - <strong>Community Feedback on Risk Taking Behaviour</strong></td>
<td>12-33</td>
</tr>
<tr>
<td>Medication Use</td>
<td>12-34</td>
</tr>
<tr>
<td>Pharmaceutical Use</td>
<td>12-34</td>
</tr>
<tr>
<td>Number of Different Drugs</td>
<td>12-34</td>
</tr>
<tr>
<td>Proportion of Residents Using Antibiotics</td>
<td>12-35</td>
</tr>
<tr>
<td>Proportion of Residents Using Antidepressants</td>
<td>12-37</td>
</tr>
<tr>
<td><strong>Community Feedback on Prescriptions</strong></td>
<td>12-37</td>
</tr>
<tr>
<td><strong>Healthy Child Development</strong></td>
<td>12-38</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>12-38</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>12-38</td>
</tr>
<tr>
<td>Births</td>
<td>12-39</td>
</tr>
<tr>
<td><strong>Community Feedback on Obstetrical Practice &amp; Midwifery Service</strong></td>
<td>12-40</td>
</tr>
<tr>
<td>Adolescent and Teenage Pregnancy</td>
<td>12-41</td>
</tr>
<tr>
<td><strong>Community Feedback on Teen Pregnancy</strong></td>
<td>12-41</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

Hypertension................................................................. 13-16
Heart Attacks.............................................................. 13-17
Strokes........................................................................ 13-18
Injuries...................................................................... 13-19

**Human Function**.......................................................... 13-20
  Overview.................................................................. 13-20

**Well-being**................................................................ 13-20
  Overview.................................................................. 13-20

## 13.4 Determinants of Health .............................................. 13-21

**Environmental Factors**.................................................. 13-22
  Water & Air Quality .................................................. 13-22
  Safety..................................................................... 13-23

**Biology & Genetic Endowment**....................................... 13-24
  Overview.................................................................. 13-24

**Personal Health Practices & Lifestyle**........................... 13-25
  Overview.................................................................. 13-25
  Medication Use........................................................ 13-25
  Pharmaceutical Use.................................................. 13-25
    Number of Different Drugs .................................... 13-26
    Proportion of Residents Using Antibiotics............... 13-27
    Proportion of Residents Using Antidepressants......... 13-28

**Healthy Child Development**.......................................... 13-29
  Overview.................................................................. 13-29
  Infant Mortality Rates............................................... 13-29
  Births..................................................................... 13-30
  Adolescent and Teenage Pregnancy............................. 13-31
  Breastfeeding Practices............................................ 13-32
  Birth Weights.......................................................... 13-33
  Childhood Immunizations.......................................... 13-36

**Living and Working Conditions**.................................... 13-38
  Overview.................................................................. 13-38
  Employment and Unemployment ................................ 13-38
  Social Economic Status............................................. 13-39

**Personal Resources**.................................................... 13-40
  Overview.................................................................. 13-40
  Mental Emotional Health.......................................... 13-41
  Social Support.......................................................... 13-41

## 13.5 Partnership Support.................................................. 13-42

## 13.6 Summary/Conclusion.................................................. 13-46

## 13.7 References................................................................ 13-52
# TABLE OF CONTENTS

## 14.0 CONCLUSION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1 OVERVIEW</td>
<td>14-1</td>
</tr>
<tr>
<td>14.2 SUMMARY OF SOME REGIONAL STRENGTHS</td>
<td>14-1</td>
</tr>
<tr>
<td>14.3 SUMMARY OF SOME HEALTH DISTRICT SPECIFIC STRENGTHS</td>
<td>14-2</td>
</tr>
<tr>
<td>14.3.1 SPRINGFIELD HEALTH DISTRICT</td>
<td>14-2</td>
</tr>
<tr>
<td>14.3.2 BROKENHEAD HEALTH DISTRICT</td>
<td>14-2</td>
</tr>
<tr>
<td>14.3.3 IRON ROSE HEALTH DISTRICT</td>
<td>14-2</td>
</tr>
<tr>
<td>14.3.4 WINNIPEG RIVER HEALTH DISTRICT</td>
<td>14-3</td>
</tr>
<tr>
<td>14.3.5 BLUE WATER HEALTH DISTRICT</td>
<td>14-3</td>
</tr>
<tr>
<td>14.3.6 NORTHERN REMOTE HEALTH DISTRICT</td>
<td>14-3</td>
</tr>
<tr>
<td>14.4 COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS ON HEALTH PLANNING AND DELIVERY</td>
<td>14-3</td>
</tr>
<tr>
<td>14.4.1 MANITOBA’S HEALTH PERFORMANCE MEASUREMENT FRAMEWORK</td>
<td>14-4</td>
</tr>
<tr>
<td>14.4.2 SOME SUGGESTIONS RAISED BY RESIDENTS DURING COMMUNITY CONSULTATIONS</td>
<td>14-8</td>
</tr>
<tr>
<td>14.5 FURTHER RESEARCH</td>
<td>14-9</td>
</tr>
<tr>
<td>14.6 CONCLUSION</td>
<td>14-10</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

## LIST OF TABLES

### Section 5.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Provincial Survey Report Demographics</td>
</tr>
<tr>
<td>5.2</td>
<td>3003 Focus Group Attendance</td>
</tr>
<tr>
<td>5.3</td>
<td>2004 Validation Workshop Attendance</td>
</tr>
</tbody>
</table>

### Section 6.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Communities Within NE Region's Health Districts</td>
</tr>
<tr>
<td>6.2</td>
<td>Population by Health Districts</td>
</tr>
<tr>
<td>6.3</td>
<td>Aboriginal Population 2001</td>
</tr>
<tr>
<td>6.4</td>
<td>2002/2003 NE Population Divided into Health Districts and FN People</td>
</tr>
<tr>
<td>6.5</td>
<td>Projected change in 2025 Compared with 1998</td>
</tr>
<tr>
<td>6.6</td>
<td>Percentage of the Population One Year Internal/External Migration into Manitoba</td>
</tr>
<tr>
<td>6.7</td>
<td>Internal Migration in NE and Manitoba</td>
</tr>
<tr>
<td>6.8</td>
<td>Languages Spoken at Home in NE - 2001</td>
</tr>
<tr>
<td>6.9</td>
<td>What would you like to see in your community that would improve health?</td>
</tr>
<tr>
<td>6.10</td>
<td>School Attendance-Summary of NE Schools and Adult Education Centres</td>
</tr>
<tr>
<td>6.11</td>
<td>Lung Cancer Incidence for Males and Females 2000 &amp; 2001</td>
</tr>
<tr>
<td>6.12</td>
<td>Causes of Cancer Deaths in NE</td>
</tr>
<tr>
<td>6.13</td>
<td>Number of Diabetes Cases</td>
</tr>
<tr>
<td>6.14</td>
<td>Number of Hypertension Treatment Cases in NE</td>
</tr>
<tr>
<td>6.15</td>
<td>Number of AMI Treatment in NE</td>
</tr>
<tr>
<td>6.16</td>
<td>Number of Stroke Treatment in NE</td>
</tr>
<tr>
<td>6.17</td>
<td>Unintentional and Intentional Injury Category ICD-9 Classification</td>
</tr>
<tr>
<td>6.19</td>
<td>Top Causes of Injury Deaths in NE 19992-1999</td>
</tr>
<tr>
<td>6.20</td>
<td>Total Unintentional Injury Deaths per 100,000-1992-1999 in NE</td>
</tr>
<tr>
<td>6.21</td>
<td>Top Four Causes of Unintentional Injury Mortalities in NE</td>
</tr>
<tr>
<td>6.22</td>
<td>Crude Rates/100,000 of Hospitalizations due to Injuries - Males 2001</td>
</tr>
<tr>
<td>6.23</td>
<td>Crude Rates/100,000 of Hospitalizations due to Injuries - Females 2001</td>
</tr>
<tr>
<td>6.24</td>
<td>Leading Cause of Injury Hospitalizations in NE from 1992-2001</td>
</tr>
<tr>
<td>Number of Table</td>
<td>Table Name</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6.25</td>
<td>Manitoba Workplace Injury Claims, NE</td>
</tr>
<tr>
<td>6.26</td>
<td>Manitoba Workplace Fatal Injuries 1983-2002</td>
</tr>
<tr>
<td>6.27</td>
<td>Major Causes of Workplace Deaths from 1983 to 2002 in Manitoba</td>
</tr>
<tr>
<td>6.28</td>
<td>Crime Report Regional Total</td>
</tr>
<tr>
<td>6.29</td>
<td>Elderly Person's Housing in NE</td>
</tr>
<tr>
<td>6.32</td>
<td>Percentage of Manitoba Hospitalizations Due to Injuries – 1992-2001</td>
</tr>
<tr>
<td>6.35</td>
<td>Number of Newborns in NE</td>
</tr>
<tr>
<td>6.36</td>
<td>Number of Teen Pregnancies in NE</td>
</tr>
<tr>
<td>6.37</td>
<td>Deliveries by Adolescents and Teens in NE Aged 10-19 Years 2001-2002</td>
</tr>
<tr>
<td>6.40</td>
<td>Number of High Births in NE</td>
</tr>
<tr>
<td>6.41</td>
<td>Number of Low Births in NE</td>
</tr>
<tr>
<td>6.42</td>
<td>Number of Pre-Term Births in NE</td>
</tr>
<tr>
<td>6.43</td>
<td>Vaccination Schedule</td>
</tr>
<tr>
<td>6.44</td>
<td>Diphtheria, Acellular Pertussis, Tetanus, Polio, Haemophilus Influenza B- Under One Year</td>
</tr>
<tr>
<td>6.45</td>
<td>Diphtheria, Acellular Pertussis, Tetanus, Polio, Haemophilus Influenza B- Two Years</td>
</tr>
<tr>
<td>6.46</td>
<td>Tetanus, Diphtheria – 15 Years</td>
</tr>
<tr>
<td>6.47</td>
<td>Tetanus, Diphtheria – 17 Years</td>
</tr>
<tr>
<td>6.48</td>
<td>MMR Immunization Coverage- Two years</td>
</tr>
<tr>
<td>6.49</td>
<td>MMR Immunization Coverage – Seven Years</td>
</tr>
<tr>
<td>6.50</td>
<td>Hepatitis B Immunization Coverage</td>
</tr>
<tr>
<td>6.51</td>
<td>Major Occupational Groups in NE</td>
</tr>
<tr>
<td>6.52</td>
<td>Mode of Transportation to Work Used in NE</td>
</tr>
<tr>
<td>6.53</td>
<td>Percentage of all Income Held by the Lower 50% of Households</td>
</tr>
<tr>
<td>6.54</td>
<td>Incidence of Low Income in the Year 2000 within NE Health Districts</td>
</tr>
<tr>
<td>6.55</td>
<td>Marital Status in NE</td>
</tr>
<tr>
<td>6.56</td>
<td>Manitoba Farm Rural Stress Line NE Region Clients Serviced</td>
</tr>
<tr>
<td>6.57</td>
<td>NE Region Clients Served by Nova House</td>
</tr>
<tr>
<td>6.58</td>
<td>NE Region Clients Served by Crisis Stabilization Unit and by the Mobile Crisis Unit</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

### Section 7.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Manitoba’s Health Performance Measurement Framework</td>
</tr>
<tr>
<td>7.2</td>
<td>NE Medical Utilization Rates and Costs of Services for Males and Females 2001/02</td>
</tr>
<tr>
<td>7.3</td>
<td>Top Three Suggestions Identified by NEHA Staff</td>
</tr>
<tr>
<td>7.4</td>
<td>Staff Turnover Rate</td>
</tr>
<tr>
<td>7.5</td>
<td>Areas of the Body Injured Most Frequently</td>
</tr>
<tr>
<td>7.6</td>
<td>Top Three Causes of Injury</td>
</tr>
<tr>
<td>7.7</td>
<td>Percentage of funding Allocated to Acute and Community Programs</td>
</tr>
<tr>
<td>7.8</td>
<td>RHA Budget &amp; Administration Costs</td>
</tr>
<tr>
<td>7.9</td>
<td>Position Vacancy Rate by Percentage from April to December 2003</td>
</tr>
<tr>
<td>7.10</td>
<td>Percentage of Budget Spent on IT Support</td>
</tr>
<tr>
<td>7.11</td>
<td>Top Ten Reasons Why NE Residents See a GP/FP or Specialist</td>
</tr>
<tr>
<td>7.12</td>
<td>Location of Visits to General Practitioner/Family Practitioner by Health District</td>
</tr>
<tr>
<td>7.13</td>
<td>Regional Location of Specialists</td>
</tr>
<tr>
<td>7.14</td>
<td>Location of Visits to Specialists by Health District</td>
</tr>
</tbody>
</table>

### Section 8.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Percentage of Population with Less than a High School Education by Years</td>
</tr>
<tr>
<td>8.2</td>
<td>Sunrise School Division – Springfield District</td>
</tr>
<tr>
<td>8.3</td>
<td>Elderly Person’s Housing in Springfield Health District</td>
</tr>
<tr>
<td>8.4</td>
<td>Crime Report in Springfield Health District</td>
</tr>
<tr>
<td>8.5</td>
<td>Number of Newborns in Springfield</td>
</tr>
<tr>
<td>8.6</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>8.7</td>
<td>Median Family Income of Couple Families</td>
</tr>
<tr>
<td>8.8</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>8.9</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>8.10</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

### Section 9.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Population Demographics Brokenhead</td>
</tr>
<tr>
<td>9.2</td>
<td>Percentage of Population with Less than a High School Education by Years</td>
</tr>
<tr>
<td>9.3</td>
<td>Sunrise School Division – Brokenhead Health District</td>
</tr>
<tr>
<td>9.4</td>
<td>Elderly Person's Housing in Brokenhead Health District</td>
</tr>
<tr>
<td>9.5</td>
<td>Crime Report in Brokenhead Health District</td>
</tr>
<tr>
<td>9.6</td>
<td>Number of Newborns in Brokenhead</td>
</tr>
<tr>
<td>9.7</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>9.8</td>
<td>Median Family Income of Couple Families</td>
</tr>
<tr>
<td>9.9</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>9.10</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>9.11</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>

### Section 10.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Percentage of Population with Less than a High School Education by Years</td>
</tr>
<tr>
<td>10.2</td>
<td>Sunrise School Division – Iron Rose Health District</td>
</tr>
<tr>
<td>10.3</td>
<td>Elderly Person’s Housing in Iron Rose Health District</td>
</tr>
<tr>
<td>10.4</td>
<td>Crime Report in Iron Rose Health District</td>
</tr>
<tr>
<td>10.5</td>
<td>Number of Newborns in Iron Rose</td>
</tr>
<tr>
<td>10.6</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>10.7</td>
<td>Median Family Income of Couple Families</td>
</tr>
<tr>
<td>10.8</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>10.9</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>10.10</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>

### Section 11.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Percentage of Population with Less than a High School Education by Years</td>
</tr>
<tr>
<td>11.2</td>
<td>Sunrise School Division – Blue Water Health District</td>
</tr>
<tr>
<td>11.3</td>
<td>Pine Falls School division- Blue Water Health District</td>
</tr>
<tr>
<td>11.4</td>
<td>Frontier School Division – Blue Water Health District</td>
</tr>
<tr>
<td>11.5</td>
<td>Elderly Person's Housing in Blue Water Health District</td>
</tr>
<tr>
<td>11.6</td>
<td>Crime Report in Blue Water Health District</td>
</tr>
<tr>
<td>11.7</td>
<td>Number of Newborns in Blue Water</td>
</tr>
<tr>
<td>11.8</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>11.9</td>
<td>Median Family Income of Couple Families</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.10</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>11.11</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>11.12</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>

### Section 12.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Percentage of Population with Less than a High School Education by Years</td>
</tr>
<tr>
<td>12.2</td>
<td>Sunrise School Division – Schools in Winnipeg River Health District</td>
</tr>
<tr>
<td>12.3</td>
<td>Whiteshell School division – Schools in Winnipeg River Health District</td>
</tr>
<tr>
<td>12.4</td>
<td>Elderly Person’s Housing in Winnipeg River Health District</td>
</tr>
<tr>
<td>12.5</td>
<td>Crime Report in Winnipeg River Health District</td>
</tr>
<tr>
<td>12.6</td>
<td>Number of Newborns in Winnipeg River</td>
</tr>
<tr>
<td>12.7</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>12.8</td>
<td>Median Family Income of Couple Families</td>
</tr>
<tr>
<td>12.9</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>12.10</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>12.11</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>

### Section 13.0

<table>
<thead>
<tr>
<th>Number of Table</th>
<th>Table Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>Population 2001 to 2003 by Health District</td>
</tr>
<tr>
<td>13.2</td>
<td>2002/2003 Northern Remote Health District Divided into Non First Nations and FN People</td>
</tr>
<tr>
<td>13.3</td>
<td>Frontier School Division, Northern Remote Health District</td>
</tr>
<tr>
<td>13.4</td>
<td>Crime Report in Northern Remote Health District</td>
</tr>
<tr>
<td>13.5</td>
<td>Number of Newborns in Northern Remote</td>
</tr>
<tr>
<td>13.6</td>
<td>Parentage of Population 15 Years and Over Employed and Unemployed – Males/Females</td>
</tr>
<tr>
<td>13.7</td>
<td>Median Family Income</td>
</tr>
<tr>
<td>13.8</td>
<td>Median Family Income of Lone Parents – Males and Females</td>
</tr>
<tr>
<td>13.9</td>
<td>Median Family Income of Lone Parent Families Male &amp; Female for NE</td>
</tr>
<tr>
<td>13.10</td>
<td>Total Number of Couple Families by Family Structure/ Total Lone Parent Families</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

LIST OF FIGURES

Section 4.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>CHA Assessment</td>
</tr>
<tr>
<td>4.2</td>
<td>2003-2004 CHA Structure</td>
</tr>
<tr>
<td>4.3</td>
<td>CHA Consultation</td>
</tr>
<tr>
<td>4.4</td>
<td>Manitoba’s Health Performance Measurement Framework</td>
</tr>
<tr>
<td>4.5</td>
<td>Manitoba’s Health Performance Measurement Framework Categories</td>
</tr>
<tr>
<td>4.6</td>
<td>Population Health Model Framework</td>
</tr>
</tbody>
</table>

Section 5.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Age of Respondents in Acumen Survey</td>
</tr>
</tbody>
</table>

Section 6.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>NE Health Districts Map</td>
</tr>
<tr>
<td>6.2</td>
<td>NE Population Pyramid 2001/02</td>
</tr>
<tr>
<td>6.3</td>
<td>Manitoba Population Pyramid 2001/02</td>
</tr>
<tr>
<td>6.4</td>
<td>Population and Project Growth NE Region</td>
</tr>
<tr>
<td>6.5</td>
<td>Percentage of Population with Less Than a High School Graduation Certificate in NE</td>
</tr>
<tr>
<td>6.6</td>
<td>Percentage of Population with a High School Graduation certificate and/or some Post Secondary</td>
</tr>
<tr>
<td>6.7</td>
<td>Percentage of Population With a College Certificate or Diploma</td>
</tr>
<tr>
<td>6.8</td>
<td>Percentage of Population With a University Certificate, Diploma or Degree</td>
</tr>
<tr>
<td>6.9</td>
<td>Social Economic Factor Index in NE</td>
</tr>
<tr>
<td>6.10</td>
<td>Social Economic Factor Index in NE Health Districts</td>
</tr>
<tr>
<td>6.11</td>
<td>Premature Mortality Rate in NE</td>
</tr>
<tr>
<td>6.12</td>
<td>Premature Mortality Rate by Health District</td>
</tr>
<tr>
<td>6.13</td>
<td>Life Expectancy NE</td>
</tr>
<tr>
<td>6.14</td>
<td>Total Mortality Rates in NE</td>
</tr>
<tr>
<td>6.15</td>
<td>Mortality Rates NE Health Districts</td>
</tr>
<tr>
<td>6.16</td>
<td>Potential Years of Life Lost All Causes both Males and Females</td>
</tr>
<tr>
<td>6.17</td>
<td>Potential Years of Life Lost Males and Females Separately</td>
</tr>
</tbody>
</table>
## Table of Contents

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.18</td>
<td>Average PYLL in NE for Deaths due to Circulatory, Cancer, Respiratory, Unintentional Injuries, and Suicide.</td>
</tr>
<tr>
<td>6.19</td>
<td>Causes of Death From all Causes in Manitoba 2001</td>
</tr>
<tr>
<td>6.20</td>
<td>Leading Cause of Deaths NE Males/Females 1992-2001</td>
</tr>
<tr>
<td>6.21</td>
<td>New Cancer Rates</td>
</tr>
<tr>
<td>6.22</td>
<td>Cancer Incidents NE compared with Manitoba</td>
</tr>
<tr>
<td>6.24</td>
<td>Number of NE Residents with Arthritis &amp; Rheumatism.</td>
</tr>
<tr>
<td>6.25</td>
<td>Projected Prevalence of Diabetes in Manitoba 1995 to 2025</td>
</tr>
<tr>
<td>6.26</td>
<td>Diabetes Treatment Prevalence in NE</td>
</tr>
<tr>
<td>6.27</td>
<td>Economic Cost of Diabetes</td>
</tr>
<tr>
<td>6.28</td>
<td>Projected Costs of Selected Health Care Services Among Persons with Diabetes in Manitoba</td>
</tr>
<tr>
<td>6.29</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>6.30</td>
<td>Asthma Diagnosis</td>
</tr>
<tr>
<td>6.31</td>
<td>Total Respiratory Morbidity</td>
</tr>
<tr>
<td>6.32</td>
<td>Hypertension Treatment Prevalence in NE</td>
</tr>
<tr>
<td>6.33</td>
<td>Acute Myocardial Infarction Treatment</td>
</tr>
<tr>
<td>6.34</td>
<td>Stroke Treatment in NE</td>
</tr>
<tr>
<td>6.35</td>
<td>Injury Mortality Rates NE Region</td>
</tr>
<tr>
<td>6.36</td>
<td>PYLL Due to Unintentional Injuries</td>
</tr>
<tr>
<td>6.37</td>
<td>PYLL Due to Suicide in NE</td>
</tr>
<tr>
<td>6.38</td>
<td>Number of Hospitalizations Due to Injuries</td>
</tr>
<tr>
<td>6.39</td>
<td>Workplace Injury Rate Resulting in Hospitalization in NE</td>
</tr>
<tr>
<td>6.40</td>
<td>Functional Health in NE Over 12 Years</td>
</tr>
<tr>
<td>6.41</td>
<td>Self – Rated Health in NE</td>
</tr>
<tr>
<td>6.42</td>
<td>Percentage of Households with Unaffordable Housing NE</td>
</tr>
<tr>
<td>6.43</td>
<td>Self Reported BMI in NE</td>
</tr>
<tr>
<td>6.44</td>
<td>Influenza Immunizations in NE Over 65 Years</td>
</tr>
<tr>
<td>6.45</td>
<td>NEHA Public Health Influenza Clinic Coverage</td>
</tr>
<tr>
<td>6.46</td>
<td>Pneumococcal Cumulative Immunization Coverage in NE</td>
</tr>
<tr>
<td>6.47</td>
<td>Self Reported Drinkers in NE</td>
</tr>
<tr>
<td>6.48</td>
<td>Alcohol Foundation of Manitoba Youth Services in NE</td>
</tr>
<tr>
<td>6.49</td>
<td>Adults in Alcohol Foundation of Manitoba Program in NE</td>
</tr>
<tr>
<td>6.50</td>
<td>Self Reported Leisure Time Physical Activity</td>
</tr>
<tr>
<td>6.51</td>
<td>Self Reported Smokers in NE</td>
</tr>
<tr>
<td>6.52</td>
<td>Proportion of Residents With at Least One Prescription</td>
</tr>
<tr>
<td>6.53</td>
<td>Average Number of Different Drugs per User in NE</td>
</tr>
<tr>
<td>6.54</td>
<td>Percentage of all Residents Receiving at Least One Prescription for antibiotics in NE</td>
</tr>
<tr>
<td>6.55</td>
<td>Average Number of Antibiotics Prescribed</td>
</tr>
<tr>
<td>6.56</td>
<td>Proportion of Residents Using Antidepressants</td>
</tr>
<tr>
<td>6.57</td>
<td>Infant Mortality Rates &lt; One Year- NE Region</td>
</tr>
<tr>
<td>6.58</td>
<td>Infant Mortality Rates &lt; One Year – NE Health Districts</td>
</tr>
</tbody>
</table>
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.59</td>
<td>Number of Births at Pine Falls Health Complex</td>
</tr>
<tr>
<td>6.60</td>
<td>Teen Pregnancy Rate in NE Region</td>
</tr>
<tr>
<td>6.61</td>
<td>Breastfeeding Initiation Rates in NE</td>
</tr>
<tr>
<td>6.62</td>
<td>Breastfeeding Initiation Rates in NE Health Districts</td>
</tr>
<tr>
<td>6.63</td>
<td>Percentage of High Birth Weight Babies in NE</td>
</tr>
<tr>
<td>6.64</td>
<td>Low Birth Weight Births in NE</td>
</tr>
<tr>
<td>6.65</td>
<td>Percentage of Pre-Term Babies in NE</td>
</tr>
<tr>
<td>6.66</td>
<td>Percentage of Children Immunized in NE</td>
</tr>
<tr>
<td>6.67</td>
<td>Unemployment Rate 15 Years and Older in NE</td>
</tr>
<tr>
<td>6.68</td>
<td>Youth Unemployment 15-24 Years in NE</td>
</tr>
<tr>
<td>6.69</td>
<td>Average and Median Household Income</td>
</tr>
<tr>
<td>6.70</td>
<td>Median Income of Individuals - 2000</td>
</tr>
<tr>
<td>6.71</td>
<td>Self Reported Levels of Chronic Stress in NE</td>
</tr>
<tr>
<td>6.72</td>
<td>Percentage of Households with Children Headed by Single Parents</td>
</tr>
</tbody>
</table>

#### Section 7.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Human Resources Profile</td>
</tr>
<tr>
<td>7.2</td>
<td>Use of Alternative Health Care</td>
</tr>
<tr>
<td>7.3</td>
<td>NEHA funding Allocation</td>
</tr>
<tr>
<td>7.4</td>
<td>North Eastman Health Association Inc. Organizational Chart</td>
</tr>
<tr>
<td>7.5</td>
<td>Number of Reported Accidents</td>
</tr>
<tr>
<td>7.6</td>
<td>NEHA Staff Immunized by Program for Influenza 2003</td>
</tr>
<tr>
<td>7.7</td>
<td>Staff Influenza Immunizations Increase</td>
</tr>
<tr>
<td>7.8</td>
<td>Contact With Health Professionals</td>
</tr>
<tr>
<td>7.9</td>
<td>NE Residents With At Least One Ambulatory Visit to a Physician</td>
</tr>
<tr>
<td>7.10</td>
<td>NE Health District Residents With at Least One Ambulatory Visit to a Physician</td>
</tr>
<tr>
<td>7.11</td>
<td>Regional Adjusted Annual Average Number of Visits per Resident to See a Physician</td>
</tr>
<tr>
<td>7.12</td>
<td>Health District Adjusted Annual Average Number of Visits per Resident to See a Physician</td>
</tr>
<tr>
<td>7.13</td>
<td>Regional Adjusted Average Ambulatory Consultation Rates to Physicians</td>
</tr>
<tr>
<td>7.14</td>
<td>Health District Adjusted Average Ambulatory Consultation Rates to Physicians by Health District</td>
</tr>
<tr>
<td>7.15</td>
<td>NE Regional Percentage of Total Ambulatory Visits Provided by General &amp; Family Practitioners</td>
</tr>
<tr>
<td>7.16</td>
<td>Health District Regional Percentage of Total Ambulatory Visits Provided by General &amp; Family Practitioners</td>
</tr>
<tr>
<td>7.17</td>
<td>Location of Visits to General Practitioner/Family Practitioner by NE Residents</td>
</tr>
<tr>
<td>7.18</td>
<td>Regional Emergency Room Visits</td>
</tr>
<tr>
<td>7.19</td>
<td>Number of Acute Care Admissions</td>
</tr>
<tr>
<td>Number of Figure</td>
<td>Figure Name</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7.20</td>
<td>Cardiac Catheterizations in NE</td>
</tr>
<tr>
<td>7.21</td>
<td>Cardiac Catheterizations in NE Health Districts</td>
</tr>
<tr>
<td>7.22</td>
<td>Cataract Surgery in NE</td>
</tr>
<tr>
<td>7.23</td>
<td>Cataract Surgery by Health District</td>
</tr>
<tr>
<td>7.24</td>
<td>CT Scans in NE</td>
</tr>
<tr>
<td>7.25</td>
<td>CT Scans in NE Health Districts</td>
</tr>
<tr>
<td>7.26</td>
<td>NE Ambulatory Care Sensitive Conditions</td>
</tr>
<tr>
<td>7.27</td>
<td>Hospital Separation Rates in NE</td>
</tr>
<tr>
<td>7.28</td>
<td>NE – Day Surgeries by Surgical Procedure as Percentage of total Surgeries</td>
</tr>
<tr>
<td>7.29</td>
<td>Dialysis Visits</td>
</tr>
<tr>
<td>7.30</td>
<td>Number of Pneumococcal Vaccines Given to LTC Residents</td>
</tr>
<tr>
<td>7.31</td>
<td>Number of Influenza Vaccines Given in LTC Facilities</td>
</tr>
<tr>
<td>7.32</td>
<td>Total Number of Residents Receiving Influenza Vaccines in LTC</td>
</tr>
<tr>
<td>7.33</td>
<td>PCH Admissions</td>
</tr>
<tr>
<td>7.34</td>
<td>PCH Respite Admissions</td>
</tr>
<tr>
<td>7.35</td>
<td>New Home Care Cases Opened</td>
</tr>
<tr>
<td>7.36</td>
<td>Open Home Care Cases in NE</td>
</tr>
<tr>
<td>7.37</td>
<td>Closing Home Care Cases in NE</td>
</tr>
<tr>
<td>7.38</td>
<td>Average Length of Time for Home Care</td>
</tr>
<tr>
<td>7.39</td>
<td>Mental Health Case Files Opened in NEHA</td>
</tr>
<tr>
<td>7.40</td>
<td>NEHA Mental Health Case Files Active</td>
</tr>
<tr>
<td>7.41</td>
<td>NEHA Ambulance Trips</td>
</tr>
<tr>
<td>7.42</td>
<td>Influenza Immunization Coverage</td>
</tr>
<tr>
<td>7.43</td>
<td>Public Health Consultation – Waiting Times During 2003 Flu Clinic</td>
</tr>
<tr>
<td>7.44</td>
<td>Public Health Survey – How Did You Learn About the Flu Clinic?</td>
</tr>
<tr>
<td>7.45</td>
<td>How was the Service?</td>
</tr>
<tr>
<td>7.46</td>
<td>Breast Screening Rates – NE Region</td>
</tr>
<tr>
<td>7.47</td>
<td>Breast Cancer Screening – NE Health Districts</td>
</tr>
<tr>
<td>7.48</td>
<td>Cervical Screening Rates - NE Region</td>
</tr>
<tr>
<td>7.49</td>
<td>Cervical Screening Rates - NE Health District</td>
</tr>
</tbody>
</table>

**Section 8.0**

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Age Profile of Springfield – 1995 &amp; 2000</td>
</tr>
<tr>
<td>8.2</td>
<td>SEFI Value by Health District 1991 &amp; 1996</td>
</tr>
<tr>
<td>8.3</td>
<td>Premature Mortality Rate NE Health District</td>
</tr>
<tr>
<td>8.4</td>
<td>Total Mortality Rate of Deaths in NE Health Districts</td>
</tr>
<tr>
<td>8.5</td>
<td>Life Expectancy – NE Health Districts for Males and Females</td>
</tr>
<tr>
<td>8.6</td>
<td>Potential Years of Life Lost for Males and Females – NE Health Districts</td>
</tr>
<tr>
<td>8.7</td>
<td>Potential Years of Life Lost Males &amp; Females Separately</td>
</tr>
<tr>
<td>8.8</td>
<td>New Cancer Rates NE Health Districts</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9</td>
<td>Diabetes Treatment Prevalence in NE Health Districts</td>
</tr>
<tr>
<td>8.10</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>8.11</td>
<td>Residents Treated for Respiratory Disease</td>
</tr>
<tr>
<td>8.12</td>
<td>Hypertension Treatment Prevalence</td>
</tr>
<tr>
<td>8.13</td>
<td>Acute Myocardial Infarctions or Heart attack Rates of Hospitalization</td>
</tr>
<tr>
<td>8.14</td>
<td>Stroke Treatment Prevalence in Hospital</td>
</tr>
<tr>
<td>8.15</td>
<td>Injury Hospitalization Rates in NE Health Districts</td>
</tr>
<tr>
<td>8.16</td>
<td>Pharmaceutical Use in Springfield</td>
</tr>
<tr>
<td>8.17</td>
<td>Average Number of Different Drugs Prescribed in NE Health Districts</td>
</tr>
<tr>
<td>8.18</td>
<td>Percentage of Residents Receiving at Least One Prescription for an Antibiotic</td>
</tr>
<tr>
<td>8.19</td>
<td>Average Number of Antibiotic Prescriptions Dispensed</td>
</tr>
<tr>
<td>8.20</td>
<td>Proportion of Residents Using Antidepressants</td>
</tr>
<tr>
<td>8.21</td>
<td>Teenage Pregnancy Rates</td>
</tr>
<tr>
<td>8.22</td>
<td>Breast Feeding</td>
</tr>
<tr>
<td>8.23</td>
<td>High Birth Weights</td>
</tr>
<tr>
<td>8.24</td>
<td>Low Birth Weights</td>
</tr>
<tr>
<td>8.25</td>
<td>Pre-Term Births</td>
</tr>
<tr>
<td>8.26</td>
<td>Completed Immunizations at One Year</td>
</tr>
<tr>
<td>8.27</td>
<td>Completed Immunizations at Two Years</td>
</tr>
<tr>
<td>8.28</td>
<td>Completed Immunizations at Seven Years</td>
</tr>
</tbody>
</table>

### Section 9.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Age Profile of Brokenhead – 1995 &amp; 2000</td>
</tr>
<tr>
<td>9.2</td>
<td>SEFI Value by Health District 1991 &amp; 1996</td>
</tr>
<tr>
<td>9.3</td>
<td>Premature Mortality Rate NE Health District</td>
</tr>
<tr>
<td>9.4</td>
<td>Total Mortality Rate</td>
</tr>
<tr>
<td>9.5</td>
<td>Life Expectancy – NE Health Districts</td>
</tr>
<tr>
<td>9.6</td>
<td>Potential Years of Life Lost – NE Health Districts</td>
</tr>
<tr>
<td>9.7</td>
<td>Potential Years of Life Lost Males &amp; Females Separately</td>
</tr>
<tr>
<td>9.8</td>
<td>New Cancer Rates NE Health Districts</td>
</tr>
<tr>
<td>9.9</td>
<td>Diabetes Treatment Prevalence</td>
</tr>
<tr>
<td>9.10</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>9.11</td>
<td>Residents Treated for Respiratory Disease</td>
</tr>
<tr>
<td>9.12</td>
<td>Hypertension Treatment Prevalence NE Health Districts</td>
</tr>
<tr>
<td>9.13</td>
<td>Acute Myocardial Infarctions or Heart attack Rates of Hospitalization</td>
</tr>
<tr>
<td>9.14</td>
<td>Stroke Treatment Prevalence in NE Health Districts</td>
</tr>
<tr>
<td>9.15</td>
<td>Injury Hospitalization Rates in NE Health Districts</td>
</tr>
<tr>
<td>9.16</td>
<td>Proportion of Residents with at Least One Prescription</td>
</tr>
<tr>
<td>9.17</td>
<td>Number of Different Drugs</td>
</tr>
<tr>
<td>9.18</td>
<td>Percentage of Residents Being Prescribed an Antibiotic</td>
</tr>
</tbody>
</table>
# Table of Contents

## Number of Figure | Figure Name
--- | ---
9.19 | Number of Antibiotics Prescribed
9.20 | Proportion of Residents Using Antidepressants
9.21 | Teenage Pregnancy Rates
9.22 | Breast Feeding Initiation Rates in NE Health Districts
9.23 | High Birth Weights
9.24 | Low Birth Weights
9.25 | Pre-Term Births
9.26 | Completed Immunizations at One Year
9.27 | Completed Immunizations at Two Years
9.28 | Completed Immunizations at Seven Years

### Section 10.0

## Number of Figure | Figure Name
--- | ---
10.1 | Age Profile of Iron Rose – 1995 & 2000
10.2 | SEFI Value by Health District 1991 & 1996
10.3 | Premature Mortality Rate NE Health District
10.4 | Total Mortality Rate
10.5 | Life Expectancy – NE Health Districts
10.6 | Potential Years of Life Lost – NE Health Districts
10.7 | Potential Years of Life Lost Males & Females Separately
10.8 | New Cancer Rates NE Health Districts
10.9 | Diabetes Treatment Prevalence
10.10 | Asthma Prevalence
10.11 | Residents Treated for Respiratory Disease
10.12 | Hypertension Treatment Prevalence NE Health Districts
10.13 | Acute Myocardial Infarctions or Heart Attack Rates of Hospitalization
10.14 | Stroke Treatment Prevalence in NE Health Districts
10.15 | Injury Hospitalization Rates in NE Health Districts
10.16 | Proportion of Residents with at Least One Prescription
10.17 | Average Number of Different Drugs
10.18 | Percentage of Residents Receiving at Least One Prescription Antibiotic
10.19 | Average Number of Antibiotics Prescribed
10.20 | Proportion of Residents Using Antidepressants
10.21 | Teenage Pregnancy Rates
10.22 | Breast Feeding Initiation Rates in NE Health Districts
10.23 | High Birth Weights
10.24 | Low Birth Weights
10.25 | Pre-Term Births
10.26 | Completed Immunizations at One Year
10.27 | Completed Immunizations at Two Years
10.28 | Completed Immunizations at Seven Years
# Section 11.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Age Profile of Blue Water – 1995 &amp; 2000</td>
</tr>
<tr>
<td>11.2</td>
<td>SEFI Value NE Health District 1991 &amp; 1996</td>
</tr>
<tr>
<td>11.3</td>
<td>Premature Mortality Rate NE Health District</td>
</tr>
<tr>
<td>11.4</td>
<td>Total Mortality Rates in NE Health Districts</td>
</tr>
<tr>
<td>11.5</td>
<td>Life Expectancy – NE Health Districts</td>
</tr>
<tr>
<td>11.6</td>
<td>Potential Years of Life Lost – NE Health Districts</td>
</tr>
<tr>
<td>11.7</td>
<td>Potential Years of Life Lost Males &amp; Females Separately</td>
</tr>
<tr>
<td>11.8</td>
<td>New Cancer Rates</td>
</tr>
<tr>
<td>11.9</td>
<td>Diabetes Prevalence Rate – NE Health Districts Treatment Prevalence</td>
</tr>
<tr>
<td>11.10</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>11.11</td>
<td>Residents Treated for Respiratory Disease</td>
</tr>
<tr>
<td>11.12</td>
<td>Hypertension Treatment Prevalence NE Health Districts</td>
</tr>
<tr>
<td>11.13</td>
<td>Acute Myocardial Infarctions or Heart Attack Rates of Hospitalization</td>
</tr>
<tr>
<td>11.14</td>
<td>Stroke Treatment Prevalence in Hospital</td>
</tr>
<tr>
<td>11.15</td>
<td>Injury Hospitalization Rates in NE Health Districts</td>
</tr>
<tr>
<td>11.16</td>
<td>Proportion of Residents with at Least One Prescription</td>
</tr>
<tr>
<td>11.17</td>
<td>Average Number of Different Drugs Prescribed</td>
</tr>
<tr>
<td>11.18</td>
<td>Percentage of Residents Receiving at Least One Prescription Antibiotic</td>
</tr>
<tr>
<td>11.19</td>
<td>Average Number of Antibiotics Prescribed</td>
</tr>
<tr>
<td>11.20</td>
<td>Proportion of Residents Using Antidepressants</td>
</tr>
<tr>
<td>11.21</td>
<td>Infant Mortality Rate NE Health Districts</td>
</tr>
<tr>
<td>11.22</td>
<td>Teenage Pregnancy Rates</td>
</tr>
<tr>
<td>11.23</td>
<td>Breast Feeding Initiation Rates in NE Health Districts</td>
</tr>
<tr>
<td>11.24</td>
<td>High Birth Weights</td>
</tr>
<tr>
<td>11.25</td>
<td>Low Birth Weights</td>
</tr>
<tr>
<td>11.26</td>
<td>Pre-Term Births</td>
</tr>
<tr>
<td>11.27</td>
<td>Completed Immunizations at One Year</td>
</tr>
<tr>
<td>11.28</td>
<td>Completed Immunizations at Two Years</td>
</tr>
<tr>
<td>11.29</td>
<td>Completed Immunizations at Seven Years</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

## Section 12.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Age Profile of Winnipeg River – 1995 &amp; 2000</td>
</tr>
<tr>
<td>12.2</td>
<td>Social Economic Factor Index in NE Health District 1991 &amp; 1996</td>
</tr>
<tr>
<td>12.3</td>
<td>Premature Mortality Rate NE Health District</td>
</tr>
<tr>
<td>12.4</td>
<td>Total Mortality Rates in NE Health District</td>
</tr>
<tr>
<td>12.5</td>
<td>Life Expectancy – NE Health District</td>
</tr>
<tr>
<td>12.6</td>
<td>Potential Years of Life Lost – NE Health District</td>
</tr>
<tr>
<td>12.7</td>
<td>Potential Years of Life Lost Males &amp; Females Separately</td>
</tr>
<tr>
<td>12.8</td>
<td>New Cancer Rates</td>
</tr>
<tr>
<td>12.9</td>
<td>Diabetes Treatment Prevalence in NE Health District</td>
</tr>
<tr>
<td>12.10</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>12.11</td>
<td>Residents Treated for Respiratory Disease</td>
</tr>
<tr>
<td>12.12</td>
<td>Hypertension Treatment Prevalence NE Health District</td>
</tr>
<tr>
<td>12.13</td>
<td>Acute Myocardial Infarctions or Heart Attack Rates of Hospitalization</td>
</tr>
<tr>
<td>12.14</td>
<td>Stroke Treatment Prevalence in Hospital NE Health District</td>
</tr>
<tr>
<td>12.15</td>
<td>Injury Hospitalization Rates in NE Health District</td>
</tr>
<tr>
<td>12.16</td>
<td>Proportion of Residents with at Least One Prescription</td>
</tr>
<tr>
<td>12.17</td>
<td>Average Number of Different Drugs Prescribed</td>
</tr>
<tr>
<td>12.18</td>
<td>Percentage of Residents Receiving at Least One Prescription for Antibiotic</td>
</tr>
<tr>
<td>12.19</td>
<td>Average Number of Antibiotics Prescribed</td>
</tr>
<tr>
<td>12.20</td>
<td>Proportion of Residents Using Antidepressants</td>
</tr>
<tr>
<td>12.21</td>
<td>Teenage Pregnancy Rates</td>
</tr>
<tr>
<td>12.22</td>
<td>Breast Feeding Initiation Rates in NE Health District</td>
</tr>
<tr>
<td>12.23</td>
<td>High Birth Weights</td>
</tr>
<tr>
<td>12.24</td>
<td>Low Birth Weights</td>
</tr>
<tr>
<td>12.25</td>
<td>Pre-Term Births</td>
</tr>
<tr>
<td>12.26</td>
<td>Completed Immunizations at One Year</td>
</tr>
<tr>
<td>12.27</td>
<td>Completed Immunizations at Two Years</td>
</tr>
<tr>
<td>12.28</td>
<td>Completed Immunizations at Seven Years</td>
</tr>
</tbody>
</table>

## Section 13.0

<table>
<thead>
<tr>
<th>Number of Figure</th>
<th>Figure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>Age Profile of Northern Remote – 1995 &amp; 2000</td>
</tr>
<tr>
<td>13.2</td>
<td>Social Economic Factor Index 1991 &amp; 1996</td>
</tr>
<tr>
<td>13.3</td>
<td>Premature Mortality Rate</td>
</tr>
<tr>
<td>13.4</td>
<td>Total Mortality Rates in NE Health District</td>
</tr>
<tr>
<td>13.5</td>
<td>Life Expectancy – NE Health District</td>
</tr>
<tr>
<td>13.6</td>
<td>Potential Years of Life Lost – NE Health District</td>
</tr>
<tr>
<td>13.7</td>
<td>Potential Years of Life Lost Males &amp; Females Separately</td>
</tr>
<tr>
<td>Number of</td>
<td>Figure Name</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13.8</td>
<td>New Cancer Rates</td>
</tr>
<tr>
<td>13.9</td>
<td>Diabetes Treatment Prevalence NE Health Districts</td>
</tr>
<tr>
<td>13.10</td>
<td>Asthma Prevalence</td>
</tr>
<tr>
<td>13.11</td>
<td>Residents Treated for Respiratory Disease</td>
</tr>
<tr>
<td>13.12</td>
<td>Hypertension Treatment Prevalence NE Health Districts</td>
</tr>
<tr>
<td>13.13</td>
<td>Acute Myocardial Infarctions or Heart Attack Rates of Hospitalization</td>
</tr>
<tr>
<td>13.14</td>
<td>Stroke Treatment Prevalence NE Health Districts</td>
</tr>
<tr>
<td>13.15</td>
<td>Injury Hospitalization Rates in NE Health Districts</td>
</tr>
<tr>
<td>13.16</td>
<td>Proportion of Residents with at Least One Prescription</td>
</tr>
<tr>
<td>13.17</td>
<td>Average Number of Different Drugs Prescribed NE Health Districts</td>
</tr>
<tr>
<td>13.18</td>
<td>Percentage of Residents Receiving at Least One Prescription Antibiotic NE Health Districts</td>
</tr>
<tr>
<td>13.19</td>
<td>Number of Antibiotics Prescribed</td>
</tr>
<tr>
<td>13.20</td>
<td>Proportion of Residents Using Antidepressants</td>
</tr>
<tr>
<td>13.21</td>
<td>Infant Mortality Rate NE Health Districts</td>
</tr>
<tr>
<td>13.22</td>
<td>Teenage Pregnancy Rates</td>
</tr>
<tr>
<td>13.23</td>
<td>Breast Feeding Initiation Rates in NE Health Districts</td>
</tr>
<tr>
<td>13.24</td>
<td>High Birth Weights</td>
</tr>
<tr>
<td>13.25</td>
<td>Low Birth Weights</td>
</tr>
<tr>
<td>13.26</td>
<td>Pre-Term Births</td>
</tr>
<tr>
<td>13.27</td>
<td>Completed Immunizations at One Year</td>
</tr>
<tr>
<td>13.28</td>
<td>Completed Immunizations at Year Two</td>
</tr>
<tr>
<td>13.29</td>
<td>Completed Immunizations at Year Seven</td>
</tr>
</tbody>
</table>
OVERVIEW

A community health assessment (CHA) is an exciting and dynamic project as it consistently reinforces the fact that communities are never static, and always evolving.

This report emphasizes the importance of North Eastman Health Association Inc. (NEHA) as a leader in providing health care services. It also reinforces the importance of our partnerships with community groups and other sectors as we work together to achieve a healthier population.

NEHA, as a regional health authority is in a unique position to implement integrated, multi-sectoral prevention and health promotion strategies in that we are able to examine the health impact, costs and benefits relative to their own policies, procedures and program planning as well as public policy. The leadership NEHA provides enables us to coordinate our efforts throughout a variety of community partnerships, communicating and collaborating with community leaders from all work sectors throughout North Eastman (NE) Region.

The findings of this report assist decision makers to plan for health services that will meet future health needs of North Eastman residents, as well as support and justify future health service plans.

Our residents place a great value on their physical and mental health. In order to understand the health status and burden of illness, information has been divided into geographic areas. With respect to NE, we can review information at the regional level and also at the health district level. As we will see, NE is a very diverse region economically, socially and culturally, all affecting health status. The information contained in this report clearly demonstrates that some of our health districts are not as healthy as others.

This report uses the Manitoba’s Health Performance Measurement Framework model to organize the information. This model provides a ‘common lens’ by which all Regional Health Authority’s (RHA’s) have viewed their community’s health, enabling a systematic assessment and reporting method. The Population Health Model is integrated within this framework. This ensures that the determinants of health: physical environment, biology and genetic endowment, healthy child development, personal health
practices and coping skills, social support, education, income and social status, employment and working conditions and health services tell a complete story about the health status of NE residents.

The following is a list of the primary quantitative data resources used:

- RHA Data – This is information generated within NE Regional Health Association (RHA).

Our residents had an opportunity to provide their input through Focus Groups held in the summer and fall of 2003, a survey held in November 2003 and Validation Workshops entitled: “An Overview of Your Community’s Health Status “ held in the spring of 2004.

The following provides an overview of results of our exploration into NE resident’s health status from the broadest of perspectives. It is important to note that there may be important differences in indicator results when NE is compared with our health districts.

**SUMMARY OF SOME REGIONAL STRENGTHS**

- Focus groups, 2003 Acumen survey and program surveys overall felt that NEHA health services were excellent / very good.
- Adult influenza vaccine coverage is increasing, an indicator of residents taking charge of their health, in order to prevent illness.
- Prescribed medications are increasing significantly in NE, but remain lower than the Manitoba average.
- Antibiotic prescriptions are unchanged and are significantly lower than the Manitoba average.
- High and low birth weights are not significantly different than the Manitoba average.
• Median income was slightly higher in NE as compared with Manitoba. We know that income has an effect on health status.

• Over 99% of residents surveyed had a regular health care provider. It is important for health consumers to have someone they can go to who are familiar with their care.

COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS ON HEALTH PLANNING & DELIVERY

The following information highlights some issues or trends that emerged consistently regionally, or within health districts from the quantitative data or through community consultations. This is not meant to be a comprehensive list.

Manitoba’s Health Performance Measurement Framework

COMMUNITY CHARACTERISTICS

There is a consistent increase in our elderly population in the region and within all health districts except for Northern Remote. Northern Remote has a very young population.

Thirty-six percent of our populations have less than a high school education.

HEALTH STATUS

Regionally, NE’s Social Economic Factor Index value appears to be better than Manitoba’s overall value, however there are clear health district differences, the poorest value occurring in Northern Remote Health District.

From an overall health status perspective with respect to premature mortality rate, life expectancy and premature years of life lost (PYLL) we see the disparity in health status among our health districts within North Eastman:

<table>
<thead>
<tr>
<th>Best Health Status</th>
<th>Poorer Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>Winnipeg River</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>Iron Rose</td>
</tr>
<tr>
<td>Blue Water</td>
<td>Northern Remote</td>
</tr>
</tbody>
</table>
Deaths

- Premature Mortality Rate (PMR) is the single best measure that reflects the health status of a population. PMR has increased regionally although not significantly, and is significantly higher than Manitoba.

- The leading causes of death are due to circulatory diseases and cancers. The third leading cause of death is due to injuries, which were significantly higher than the Manitoba average.

Health Conditions

- Diabetes is showing a significant increase in NE overall. Blue Water and Northern Remote Health Districts have a where diabetes prevalence that is significantly higher than the Manitoba average.

- Hypertension has increased significantly in NE compared with the Manitoba average.

- Types of injuries NE residents were being hospitalized for were due to: falls, motor vehicle traffic accidents, assaults and self inflicted injuries. Traffic injuries and deaths have increased especially in Springfield and Brokenhead. Injury hospitalizations in Blue Water and Northern Remote are both significantly higher than the Manitoba average.

DETERMINANTS OF HEALTH

Personal Health Practices

- Approximately one-quarter of our residents are still smoking.

- Antidepressant use is increasing in all NE health districts. This is a similar trend throughout Manitoba.

- Youth in all focus groups expressed concerns about alcohol use not only in their age group, but within the adult population as well.

- Illicit drug use was raised as a concern by youth in some focus groups.

- Obesity is a national concern. In NE, over half of males and females surveyed self-reported to be either overweight or obese.
**Healthy Child Development**

- Immunization coverage in NE overall appears to be decreasing, and is especially low in Northern Remote and Blue Water health districts.

- The main causes of injury hospitalizations in children are caused by falls in early childhood, while self inflicted and motor vehicle accidents are the major cause in older children.

- While teenage pregnancy rates have not changed significantly overall in NE, Blue Water and Northern Remote’s teen pregnancy rates are significantly higher than the Manitoba average.

- Breastfeeding initiation rates are lower than the Manitoba average in Northern Remote and Blue Water health districts.

- ‘Nothing to do’ say our youth in all health districts.

**Environmental**

- Water concerns were expressed in Springfield, Blue Water and Iron Rose. There are boil water advisories in some communities in Brokenhead and Springfield.

**Living & Working Conditions**

- Unemployment in NE is slightly higher than in Manitoba overall in 2001.
There has been a positive response from residents consulted regarding the overall health programs provided by NEHA.

- Two out of five residents surveyed did not know where to go to address a health concern.
- NE visits for ambulatory consultations have increased significantly overall. Residents would like to see more visiting specialists come to NE.
- Staff influenza immunization rates are increasing, but there is need for improvement.
- ER visits have been increasing consistently over the past few years. There were voiced concerns about accessing physicians and services at some emergency rooms.
- Many residents felt that there is a shortage of physicians in NE and that physician retention needs to be addressed.
- Accessibility was a concern raised by some focus group participants especially when some health services were not available here. Travelling to Winnipeg was often felt to be stressful.
- Overall, waiting times to get an appointment or while waiting in a clinic were seen as unacceptable. Thirty-three percent of those surveyed felt that they had difficult accessing a health care provider.
- Lack of access to health services after hours and on weekends was a consistent concern voiced.
- Timely access to some diagnostic services such as ultrasound and Magnetic Resonance Imaging (MRI's) was a concern raised.
Regionally breastfeeding initiation rates have increased to 69.1%, but are significantly lower than the Manitoba average. When we look at the health districts we find that Springfield and Winnipeg River were significantly higher than the provincial average.

Breast cancer screening rates in NE are increasing and achieved 54% between 2001 to 2003, in the 50-69 age group. The desired target is 70%.

Diabetes, Asthma, Essential Hypertension and Neurotic Disorders were treated in our hospitals where there was a possibility they could have been managed in a clinic setting.

The need for more personal care home (PCH) beds was raised as a need in Winnipeg River, Blue Water and Springfield.

Mental health concerns focused on the need for more community supports. The issue of stigma when accessing services and the need to identify members of the community who are at risk were also flagged as some areas focus group participants were concerned about.

Issues surrounding emergency medical services (EMS) by focus group participants and staff include long arrival times, cost of transport, rough ride, need for more staff and some confusion about 911.

Slight increases in some communicable reportable diseases in NE overall: Chlamydia, Gonorrhea, Salmonellosis, E. Coli and Tuberculosis.

More women in NE are going for Papanicolau (PAP) tests, however the rates in NE are significantly lower than the Manitoba average. This is particularly significant in Iron Rose and Blue Water health districts.

Youth and some adults would like to see a higher visibility of public health nurses in the schools.

Difficulty in getting to health services for people living in more isolated communities who had limited access to transportation, people without cars and travelling outside of the region for services often depending upon other family members, were access issues raised by some focus group participants.
CONCLUSION

The relationship between health determinants and health status is a complex one. It is important that the information is reviewed in its entirety and not isolated. In this way a more realistic measure of health status is obtained.

“The challenges to the region are broad, ranging from significant health issues of the residents of the region and the scarcity of both fiscal and human resources.”

Work undertaken since the 1998 CHA continues to be addressed, pursued further, as the updating of the information indicates many of the same issues and trends are still present today for example:

- The three population subgroups whose members are at particular risk for poor health outcomes – children and youth, seniors, and aboriginal people.
- Major themes that continue to emerge include:
  - Mental health and social issues for example: stigma associated with accessing mental health services, isolation and emotional wellbeing.
  - Housing in particular transitional housing and more PCH beds.
  - Rural disparity in service delivery and services.
  - Lack of access to after hours physician care resulting in high use of the emergency department for non-urgent issues.
  - Lack of sufficient health care providers and specialists.
  - Lack of structured recreational options for youth and adults.

We believe that careful consideration must be given when allocating resources for health care delivery. While our report shows that there are serious issues related to poor health status in segments of the North Eastman region, there are communities that are relatively healthy.

Appropriate resource allocation to meet the identified needs of our population is integral to improving health status. This report will assist planners to identify high needs issues and target our limited resources in the most effective way.

The evidence that has been gathered for this report will provide a basis from where we will continue to work with our communities.
Suzanne Dick, CHA Research and Project Coordinator and Carol Orvis, CHA Assistant wish to thank the following people who contributed to the 2003-2004 Community Health Assessment. Without their time and support this project could not have been accomplished. If we inadvertently left anyone out we sincerely apologize. It wasn’t intentional.

Jim Hayes – Chief Executive Officer for supporting and promoting the project among managers and staff.

Judy Coleman – VP Programs who provided the support and leadership for this project.

Lorraine Dent – Director of LTC who provided support and understanding for the period of time away from LTC.

CHA PRIMARY REVIEWERS- For their time, energy, enthusiasm, valuable comments and insight reviewing the CHA report.
- Judy Coleman- VP Programs and Services
- Pat Hayes- Program Assistant Quality & Risk Management
- Bonnie Frith – Director of Quality & Organizational Development
- Jim Hayes – CEO North Eastman Region
- Dr. Eilish Cleary- Medical Officer of Health

Program Specific- Lorraine Dent, Brenda Neufeld, Mary Power, Debbie Viel, Myrna Suski, Sharon Bissonnette, Jay Ferens, Greg Prokopchuk, and Sharlene Thompson, Val Orlick

CHA DOCUMENT FORMATTING
- Gertie Oliveira – Executive Assistant

CHA FOCUS GROUP CONSULTANT
- Lesley Ann Fuga

CHA PUBLIC PREVIEW OF THE RESULTS PAMPHLET
- Bonnie Frith
- Gisele Wilson
- Judy Coleman
CHA TEAMS

Steering Committee

- Core Members- Judy Coleman, Dr. Eilish Cleary, Debbie Viel, Carol Orvis & Suzanne Dick
- Ad Hoc Members- Jim Hayes, Bonnie Frith, Pat Hayes, Myrna Suski

CHA Consultation Team

Core Team
- Primary Health Care- Karen McDougall, Lillian Kuchar, Susan Spindler, Bonnie Stefansson
- Public Health – Vicky Pizzey
- Acute Care- May Fast
- LTC Care- Heather Frederick
- Mental Health- Melanie Shumilak
- Services to seniors- Grace Honke
- Home Care- Lucile Chay
- EMS- Jay Ferens

Ad Hoc Members- Debbie Viel (PHC), Myrna Suski (PH) and Greg Prokopchuk (Diagnostics)

RHA Data Team
- Bonnie Frith
- Pat Hayes
- Judy Coleman

IT Team
- Ron Drabyk
- Patty Charles
- Jeffrey Kong

Aboriginal Team
- Team Leaders: Myrna Suski, Debbie Viel
- Member- Pat Urrutia

Validation Team
- Team Leader: Elaine Heinl
- Assistant: Carol Orvis
- Members: Karen McDougall, Lillian Kuchar, Susan Spindler, Caroline McIntosh, Bonnie Stefansson, May Fast, Heather Frederick, Melanie Shumilak, Grace Honke, Lucille Chay, Brigette Budgell
Board Members [Inclusive from January 2003 to August 2004]

- Boonstra, Bill, (Chair)
- Kolton, Len, (Vice Chair)
- Aitken, Pat (Secretary)
- Barker, Furion
- Boznianin, Dorothy
- Dalrymple, Charlie (Treasurer)
- Ellison, Ken
- Frame, Lea
- Harvey, Kay
- Houghton, Doug
- Hartwich, Egon
- Kelly Diane
- Kozak, Jeanne
- Mathews, Virginia
- Mills, Margaret
- Thompson, Fran

District Health Advisory Council

- Aitken, Locklyn
- Degagne, Deirdre
- DuGray, Dorothy
- Goodall-George, Ian
- Gugenerheimer, Karl
- Hanushchak, Ron
- Neal, Lorraine
- Orvis, Martin

NEHA Managers and Staff [only if not mentioned earlier]

- Austman, Mary Ann, CTM EGL
- Best, Lorraine, Palliative Care Volunteer
- Brown, Anita, Baby First Coordinator
- DeMarco, Donna, Financial Services Manager
- Deveau, Kelly, Immunization Coordinator
- Dumas, Dianne, Services to Seniors
- Dowhaygo, Peggy, LTC Social Worker
- Fenez, Judy, Administrative Secretary Community Services
- Fischer, Merle, CTM LDPCH
- Hanna, Kathy, Financial Reporting Coordinator
- Hogue, Liz, CTM, Kin Place
- Hrynyk, Lisa, Public Health Nurse
- Kaye, Gord, Ambulance Coordinator
- Kerr, Lorraine, Community Resource Coordinator
• Klapprat, Marion, Clerk/Resource Coordinator
• Kroeker, Lisa, Nurse Practitioner
• Lange, Dennisem, Direct Care Worker, Acute Care
• Lidforis-Karklin, Cheryl, Human Resources Officer
• Magnusson, Brian, Director of Human Resources
• Malo, Bella, Aboriginal Interpreter
• Martin, Alva, Home Care Attendant
• Muellar, Debbie, Direct Care Worker Long Term Care
• Musey, Susan, Executive Assistant.
• Neurenburg, Tina, Community Resource Coordinator
• Oliveira, Gertie, Executive Assistant
• Pang, Raymond, VP of Support Services
• Popiel, Chris, Business Office Receptionist EGL
• Pavitt, Carol, Public Health Nurse
• Power, Mary, Home Care Manager
• Porth, Pat, Community Resource Coordinator
• Rickner, Dee, Community Resource Coordinator
• Sale, Donna, Home Care Coordinator
• Steinbart, Loretta, Community Mental Health Worker
• Tardiff, Wendy, Medical Records Technician
• Warbeck Joan, Public health Nurse
• Wilson, Gisele, Executive Assistant
• Zarecki, Gail, Regional Public Health Clerk/Administration Support

**Manitoba Centre for Health Policy**
- Randy Fransoo
- Elaine Burland Research Assistant

**Manitoba Health Information Management**
- Debbie Malazdrewicz and her staff
- Debbie Klassen nee Brown
- Rachel McPherson, Statistical Analyst, Decision Support Services

**Manitoba Health Regionalization Support Unit**
- Lorraine Dacombe Dewar
- Leslie Gillis
- Shirley Dzogan
- Shahin Shooshtari
- Radan Svitlica
- Healthier Sparling
CHA Network

- Fellow colleagues at the Community Health Assessment Network.

School Divisions
Brouwer, Glen, Principal, Agassiz Adult Education Centre/Empower Education Centre/New Directions
Candline, Gail, Area 3 Administrative Secretary, Frontier School Division, Winnipeg
Chisholm, Jeff, Principal, Reynolds Elementary School
Craig, Doug, Principal, Lac du Bonnet Centennial School
Currie, Heather, Principal, Heartland Colony School
Dougall, Gerry, Superintendent, Whiteshell School Division No. 2408
Firlotte, Denyse, Administration Lac du Bonnet Senior School
Fetterly, Christine, Principal, Hazelridge School
Fournier, Della, Principal, Greenwald Colony School, Sunrise School Division
Glavedoni, Cam, Area 3 Supervisor, Frontier School Division Hines Fred, Administrator, Sunrise Support Centre, Sunrise School Division
Hamilton William, Principal, Whitemouth School, Sunrise School Division
Ilchena, Pat, Principal, Springfield Middle School
Kendell, Lynn, Career Counselor, New Directions
Lackman, Carol, Sunrise School Division
MacFadye, Gwen, Principal, Oakbank Elementary School
Magnan, Paul, Principal, Ecole Powerview School, Sunrise School Division
Mayla, Michelle, Principal, Grafton Colony School
Margaretha, Janssen, Principal, Ecole Dugald School
Melnyk, Kathy, Principal, Lac du Bonnet Senior School, Sunrise School Division
Midford, Loa, Principal, Anola Elementary School
O'Hagan Se', CEO Asst. Superintendent – Programs, Sunrise School Division
Orest, Deneka, Principal, Springfield Collegiate Institute, Sunrise School Division
Pankratz, Robert, Principal, Whiteshell Colony School
Schroeder, Larry, Principal, Gillis School, Sunrise School Division
Thibault, Pat Principal, Beausejour Elementary School
Waldner, George, Principal, Springwell (Brightstone) Colony School
Whitehall, Donald, Principal, School District of Pine Falls No. 2155, Pine Falls School.

Around North Eastman Region
Adams Dennis, Beausejour Curling Club
Baxter, Bun Lions Club, Beausejour
Berg, Gilbert, Canadian Mental Health Association, Eastman, Oakbank
Besel, Anne, Seven Sisters Seniors Group
Betsill, Melanie, Manitoba Public Health
Brackenreed, Leanne, Counsellor, Manitoba Farm & Rural Stress Line.
Cheverfils, Andrea, Wings of Power, Pine Falls
Fillion, Leo, Winnipeg River Seniors
Good, Kathy, Child & Family Services
Hemminger, Christine, Manager, Sun Gro Recreational Facility, Beausejour
Hilderbrant, Kerryleigh, Yoga Buddies, Beausejour
Lacroix, Bonnie, Wellness Resource Coordinator, Oakbank
Larson, Cory, RCMP Detachment, Beausejour
Malazdrewicy, Deborah, Manager, Health Information Management, Manitoba Health
McInnis, Sharron, Rennie Moms & Tots Quilting Club
McKay, Judy, Eastman Regional Development Office, Beausejour
Olafon, Pat, Crisis Stabilization/Mobile Crisis Unit, Interlake Regional Health Authority
Ortel, Dianne, Manitoba Public Health Inspector, Lac du Bonnet
Pazdzierski, Anna, Nova House, Selkirk
Reynolds, Mike, Seniors Group
Saxler, Kim Seven Sisters Community Club
Simmons, Gary, 50+ Club Pinawa
Sitar, Marilyn, Whitemouth Adult Day Care Program
Stark, Jennifer, Early Children’s Development, Whitemouth
Stiener, Hanna, Whitemouth Happy Hours Senior Club
Tetrault, Carman, Pioneer Club Lac du Bonnet
Wiebe, Dr., Physician
Wilgosh, Glen, Beausejour

**Municipal Offices**
Bell, Rita, Chief Administrative Officer, RM of Whitemouth
Blanchette, Rose-Marie Chief Administrative Officer, RM of Alexander
Hanna, Gary, Chief Administrative Officer, LGD of Pinawa
Johnson, Colleen, Chief Administrative Officer, Town of Lac du Bonnet
Moreau, Raymond, Chief Administrative Officer, RM of Victoria Beach
Nylen, Janet, Chief Administrative Officer, RM of Springfield
Omichinski, Wayne, Chief Administrative Officer, RM of Brokenhead
Schwanki, Christine, Chief Administrative Officer, Town of Beausejour
Shandroski, Donna, Accounting Clerk, RM of Reynolds
Watson, Marlene, Chief Administrative Officer, RM of Lac du Bonnet

**Out of Region**
Alberg, Norma, Workers Compensation, Winnipeg
Barret, Shelly, Child & Family Services, Winnipeg
Dojack, Bob, Director of Adult Probation, Department of Justice, Winnipeg
Edmonds, Eric, Constable Road Safety Division 2010 Coordinator, RCMP Traffic Services, Winnipeg
Hanysh, Bill, CMB-Client Services, RCMP, “D” Division, Winnipeg
Parkinson, Ronald, Corrections Division, Department of Justice, Winnipeg
Young, Kevin, Vehicle Occupant Protection, Manitoba Public Insurance, Winnipeg
ABBREVIATIONS

Section 3.0

A
Acute Myocardial Infarction (AMI)
Acquired Immunodeficiency Syndrome (AIDS)
Admission, Discharge and Transfer (ADT)
Annual General Meetings (AGM)
Alcohol Foundation of Manitoba (AFM)
Anxiety Disorders Association of Manitoba (ADAM)

B
Blood Alcohol Level (MG)
Blood Pressure (B/P)
Bovine Spongiform Encephalopathy (BSE)
Body Mass Index (BMI)

C
Caesarian Section (C-Section)
Canadian Community Health Survey Cycle (CCHSC)
Canadian Council on Health Services Accreditation (CCHSA)
Canadian Mental Health Association (CMHA)
Canadian National Railway (CNR)
Canadian Prenatal Nutrition Program (CPNP)
Chief Executive Office (CEO)
Community Health Assessment (CHA)
Community Health Assessment Network (CHAN)
Canadian Institute for Health Information (CIHI)
Client Services Branch (CMB)
Community Therapy Services (CTS)
Computed Tomography (CT)
Computerized Radiography (CR)

D
Diphtheria, Acellular Pertusis, Tetanus, Polio, Haemophilus Influenza B (DaPTP/Hib)
Diabetes Education Program (DEP)
Diabetes Education Resource-Children and Adolescents (DER-CA)
Diabetes Education Resource (DER)
Diagnostic Services of Manitoba (DSM)
District Health Advisory Council (DHAC)

E
East-Gate Lodge (EGL)
Emergency Medical Services (EMS)
Emergency Room (ER)
Equivalent Full Time (EFT)
F
Family Physician (FP)
First Nation (FN)

G
General Physician (GP)

H
Hepatitis B Virus (HBV)
Haemophilus Influenzae B (Hib)
Human Immunodeficiency Virus (HIV)

I
International Classification of Disease (ICD)
Injection Drug Use (IDU)
Sudden Infant Death Syndrome (SIDS)
International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version)
Information & Technology (IT)

L
Licensed Practical Nurse (LPN)
Local Government District (LGD)
Long Term Care (LTC)

M
Manitoba (Mb.)
Manitoba Breast Screening Program (MBSP)
Manitoba Centre for Health Policy (MCHP)
Manitoba Health Performance Measurement Framework (MHPMF)
Manitoba Immunization Monitoring System (MIMS)
Measles, Mumps, Rubella (MMR)
Men having Sex with Men (MSM)
Meningococcal conjugate (MC)
Meningococcal polysaccharide (MP)
Metropolitan Area and Census Agglomeration Influenced Zones (MIZ)
Mood Disorders Association of Manitoba (MDAM)
Myocardial Infarction’s (MI’s)

N
National Population Health Survey (NPHS)
North Eastman – (NE)
New Democratic Party (NDP)
North Eastman Health Association Inc. - NEHA
Nurse Practitioners (NP)
P
Papanicolau (PAP)
Performance Indicators Reporting Committee (PIRC)
Personal Care Home – (PCH)
Personal Health Information Act (PHIA)
Personal Health Information Number (PHIN)
Pinawa Community Development Corporation (PCDC)
Public Health Nurse’s (PHN’s)
Pneumococcal Conjugate 7 Valant (PCV7)
Pneumococcal Polysaccharide 23 Valant (PPV23)
Potential Years of Life Lost (PYLL)
Pregnant Mare Urine (PMU)
Premature Mortality Rate (PMR)
Public Health (PH)
Quadrant Human Resources (QHR)

R
Random Digit Dial (RDD)
Recruitment and Retention (R&R)
Regional Health Authority (RHA)
Registered Nurse (RN)
Royal Canadian Mounted Police (RCMP)

S
Southeast Resource Development Council (SERDC)
Social Economic Factor Index (SEFI)
Sexually Transmitted Diseases (STD)
Sunrise Alternative Learning Program (SALP)

T
Tonsillectomy and Adenoidectomy’s (T&A’s)
Tuberculosis (TB)
Tetanus/Diptheria (Td)
Tetanus, diphtheria, acellular pertussis (Tdap)

V
Varicella (V)
Vertoxigenic E.Coli (VTEC)
Video Lottery Terminal (VLT)
Vice President (VP)

W
Wheelchair (w/c)
Workers Compensation Branch (WCB)
Working Indicators Group (WIG)
World Health Organization (WHO)
INTRODUCTION

4.1 PURPOSE ...................................................................................................................... 4-0

4.2 WHAT IS A COMMUNITY HEALTH ASSESSMENT? ......................................................... 4-1

4.3 NEHA RESPONDS TO PREVIOUS CHA REPORT 1998 .................................................. 4-2

4.4 2003 – 2004 CHA PROCESS .............................................................................................. 4-5

4.4.1 STEERING COMMITTEE ................................................................................................. 4-7

4.4.2 DATA COLLECTION TEAMS ............................................................................................ 4-7

4.4.2.1 Regional Health Authority (RHA) Data Team ................................................................. 4-7

4.4.2.2 Information Technology (IT) Team .................................................................................... 4-7

4.4.2.3 Aboriginal Team ............................................................................................................ 4-7

4.4.2.4 Community Consultation Team ...................................................................................... 4-8

4.4.3 AWARENESS ..................................................................................................................... 4-9

4.4.4 CONSULTATION ................................................................................................................. 4-10

4.5 CHA FRAMEWORK - MANITOBA'S HEALTH PERFORMANCE MEASUREMENT FRAMEWORK ............................................................ 4-11

4.5.1 OVERVIEW ....................................................................................................................... 4-11

4.6 POPULATION HEALTH MODEL .......................................................................................... 4-16

4.7 ETHICS ................................................................................................................................. 4-17

4.7.1 PERSONAL HEALTH INFORMATION ACT (PHIA) ......................................................... 4-17

4.7.2 NEHA POLICIES .............................................................................................................. 4-17

4.7.3 GUIDELINES DEVELOPED BY CHAN ............................................................................. 4-17

4.8 HOW TO USE THE REPORT ............................................................................................... 4-19

4.8.1 GENERAL USE .................................................................................................................. 4-19

4.8.2 INTRODUCTION – SECTION 4 ............................................................................................. 4-20

4.8.3 DATA COLLECTION & METHODOLOGY – SECTION 5 .................................................... 4-20

4.8.4 REGIONAL INFORMATION – SECTION 6 ......................................................................... 4-20

4.8.5 HEALTH SERVICES – SECTION 7 ....................................................................................... 4-21

4.8.6 HEALTH DISTRICTS – SECTIONS 8-13 ......................................................................... 4-21

4.8.7 CONCLUSION - SECTION 14 ............................................................................................ 4-21

4.9 PRIORITY SETTING ............................................................................................................. 4-22

4.10 SUMMARY / CONCLUSION ............................................................................................... 4-23

4.11 REFERENCES ..................................................................................................................... 4-24

APPENDICES
4-1 Community Health Assessment Network (CHAN) Terms of Reference
4-2 2003-2004 CHA Steering Committee Terms of Reference
4-3 Role of the Community Consultation Team
4-4 CHA Ethics Guidelines & CHAN Ethics Policy
4-5 Diagnostic Categories
4.1 PURPOSE

It is vital that regional health authorities have a fundamental knowledge of their communities.

This technical document: North Eastman Health Association (NEHA) Inc. Community Health Assessment 2003-2004 provides a comprehensive assessment of the health status of North Eastman (NE) residents during a particular time period. It includes consumer participation as well as other quantitative data providing evidence-based information. This will assist health planners in making decisions about health services in North Eastman.

A Community Health Assessment (CHA) can be used for several purposes:

- To provide baseline information and the ability to compare information over time about the health status of our residents and the clients we serve.
- To direct decisions for regional health plans and program planning to create programs and services specifically designed to improve the community health status and quality of life of residents of NE region.
- To support ongoing partnerships within the community and within NEHA.
- The CHA assists in ensuring that programs are developing optimum health care outcomes to meet the needs of (NE) population.
- Provides evidence-based information in order to justify funding requests.
- To help set priorities and assist in health planning.
- Offers insight into the effectiveness of programs when information is compared over time.

4.2 WHAT IS A COMMUNITY HEALTH ASSESSMENT?

The NEHA CHA project describes a community health assessment as follows:

“...a dynamic ongoing process undertaken to:

- identify the strengths and needs of the community,
- enable the community-wide establishment of health priorities, facilitate collaborative action planning directed at improving the community health status and quality of life.”

This definition serves to ground the CHA project, ensuring that the project operates within a very distinct and clear mandate.
4.3 NEHA RESPONDS TO PREVIOUS CHA IN 1997-98

“The North Eastman Health Association is a progressive health services organization that is committed to developing and maintaining health services that are responsive to the needs of the residents of the region. Wherever possible, the priority for health service delivery is focused community based care with an emphasis on supporting individual, families and communities to maintain a high level of wellness.”

All performance measurement templates used within NEHA align with the Manitoba’s Health Performance Measurement framework, the framework the CHA Report has used to report information.

Since the last CHA Report in 1998, NEHA has developed other performance measurements in order to comprehensively and clearly report on our health system’s performance in order to assess the progress made towards achieving the Board Ends and Strategic Priorities.

The board ends statements were also developed in response to the 1998 CHA Report:

1. Health Status
   a. North Eastman Health Association Inc. provides health care and services those enables all individuals, families and communities to pursue optimum health.
   b. Assistance is available to isolated and socio-economically disadvantaged communities to develop health programs and to improve health status.

2. Access to Services
   a. All residents have access to a full spectrum of integrated basic health services available within the region through a seamless single point of entry.
   b. Residents have timely access to services required, but not available in the Region.

3. Healthy Lifestyles
   a. North Eastman Health Association Inc., as an integrated health system, provides leadership in the development of healthy communities through health promotion and education and through partnership with other human services providers and community stakeholders.

4. Healthy and Productive Staff
   a. North Eastman Health Association Inc., as a health system, is a healthy and productive environment for people to work in.
   b. Trust, confidence, safe and supportive work places, a commitment to excellence, and effective, efficient service delivery characterize this environment.
The region then developed a strategic plan to achieve these ends through a series of regional strategies. These indicators are categorized as strategic indicators and operational indicators.\(^4\)

**Strategic Indicators**
- Defined as leading as they look at the progress towards fulfillment of Board Ends and Strategic Priorities
- Linked to actions
- Not stagnant and may change as strategies change
- A main component of our performance measurement system and NEHA Scorecard

**Operational Indicators**
- Generic data that we want to consistently measure and monitor
- They review past performance
- Able to highlight what the organization has accomplished over time

NEHA’s organizational measurement indicators and the indicators described in the CHA report create a comprehensive data base that allows evidence based decisions to be made from the organization's leadership and program teams. Continual measurement of the health status of NE residents as well as the organization is now functional.

The following summarizes some of the actions NEHA has completed, or are currently underway to the issues identified previously:\(^5\)

- Primary Health Care Centres developed in Oakbank, Whitemouth, and Beausejour.
- Adult Day Program and Services to Seniors program expansion to include a wider geographic area of the region.
- Emergency Medical Services – increased full-time and part-time positions for staff.
- Primary Health Care Nurse (Nurse Practitioner) located in Oakbank and Beausejour with outreach clinics held in our northern communities and Whitemouth.
- Increased PCH beds in region with the addition of a 40 bed PCH in Oakbank.
- Exploring the development of supportive housing services in Pine Falls, Pinawa and Lac du Bonnet.
- Focus on community wellness, health promotion and disease prevention has been enhanced with the addition of Wellness Facilitators Practitioners and Dietitians.
- Public Health program expansion to include: Immunization Coordination, Baby First Program and Travel Health Clinic.
- Injury prevention strategy is being developed. Strategies have been implemented such as bicycle helmet safety seminars, Child/Infant car seat safety inspections and education.
♦ Increase access to northern communities through a Telehealth site in Pine Falls.

♦ Mental Health Housing and Proctor Services are being further developed with the hiring of a Housing Coordinator (Nov 2003).

♦ Modest increase to Community Mental Health Worker positions to attempt to address increasing demands for these services.

♦ Telepsychiatry consultation services were piloted at the Pine Falls site (Dec – March 2004) to increase services primarily to northern and First Nation's communities.

♦ Services are being improved for persons with co-occurring mental illness and substance use disorders as part of a provincial strategy.

♦ A Regional Intersectoral Committee is currently conducting research to identify gaps in crisis services in North Eastman.

♦ A pediatric dental surgery program has been developed and will soon be implemented at Beausejour Hospital (Summer 2004).

♦ Palliative Care services has developed further through training of staff and volunteers.

♦ Developed and launched a diabetes management website to provide education for the public as well as other health care providers.

♦ Recently appointed Primary Health Care Manager to work with the Wellness Facilitators to further health promotion throughout the Region.

♦ Development of the Northern Health Planning Team, a forum for dialogue and health services planning with residents and other service providers in northern road accessible communities.

♦ Participation by the Regional Diabetes Team in a Telehealth research project with Berens River, one of five federally funded research projects across Canada.

♦ Development of the Regional Diabetes Program. The prevalence of diabetes is very high in the region, especially among persons of aboriginal heritage. The program includes development of a range of strategies including prevention, screening and treatment.

♦ Formation of the Regional Early Child Development Committee for development of parent-child supports through the region.

♦ Consultation with experts in care for persons with Alzheimer's Disease and other dementias for the enhancement of resident focused programs for the elderly.

♦ Efforts to recruit health care professionals to the region resulted in several medical, nursing and allied health vacancies being filled.
Since 2001, two NEHA representatives have been attending the Community Health Assessment Network (CHAN). CHAN is a provincial group, chaired by Manitoba Health staff which directs and coordinate the CHA process in Manitoba.

The current CHA process in NEHA officially began January 2003 when the CHA Research and Project Coordinator was hired. She began attending the CHAN meetings. With the hiring of the CHA coordinator, progress began in the development of teams within NEHA to assist with the project. Judy Coleman, Vice President of Programs and Services was responsible for overseeing the project.

The CHA project assistant was hired in June 2003.

Refer to Appendix 4-1 for a copy of the CHAN Terms of Reference.


Figure 4.1 CHA Assessment Guideline

The indicators required in the report were pre-determined by the Working Indicator Group (WIG) a subcommittee of CHAN. There are over one hundred and sixty indicators that were collected specific to North Eastman region.

The following provides an outline of the 2003-2004 CHA Team Structure

Figure 4.2 2003-2004 CHA STRUCTURE  [Revised July 2004]

DATA COLLECTION TEAMS

COMMUNITY CONSULTATION TEAM
(Brackets denote programs they are representing as well as the districts they work in)

IRON ROSE – Heather Frederick (Long Term Care) & Lillian Kuchar (Primary Health Care (PHC))
BROKENHEAD – Grace Honke (Services to Seniors) & Melanie Shumilak (Mental Health), Lucille Chay (Home Care)
SPRINGFIELD – Vicky Pizzey (Public Health) & Bonnie Stefansson (PHC)
BLUE WATER – Susan Spindler (PHC) & Pat Urmuta (Director of Nursing at George Guimond Care Centre Inc.)
WINNIPEG RIVER - Karen McDougall (PHC) & May Fast (Acute Care) & Jay Ferens (EMS)

ABORIGINAL TEAM
Myrna Suski
Debbie Viel

In Ad Hoc Members: Debbie Viel (PHC), Myrna Suski (PH), and Greg Propkochuk (Diagnostics)

INFORMATION DISSEMINATION

COMMUNITY VALIDATION MEETINGS
Team Leader: Elaine Heinl; Assistant: Carol Orvis
Members: Karen McDougall, Lillian Kuchar, Susan Spindler, Caroline McIntosh, Bonnie Stefansson, May Fast, Heather Frederick, Melanie Shumilak, Grace Honke, Lucille Chay, Brigette Budgell

REPORTS
- CHA Technical Report
- Process Reports for Focus Groups, CHA Project and Validation Workshops
- Community Report
- Manitoba Health Progress Reports

Note: All teams were chaired or directed by the CHA Research/Project Coordinator.
4.4.1  **Steering Committee**

The Core Steering committee's primary function was to make key decisions to steer the project. Members include the CHA Core Team, VP Programs and Services, Medical Officer of Health and the Manager of Primary Health Care. The initial meeting of the steering committee was held along with the ad hoc members. Discussion included the mobilizing NEHA staff resources, job descriptions, timelines, CHA structure, facilitation of Focus Groups, a review of the CHA indicators with special emphasis on the RHA indicators and budget.

Refer to Appendix 4-2 for a copy of the Steering Committee's Terms of Reference.

4.4.2  **Data Collection Teams**

4.4.2.1  **Regional Health Authority (RHA) Data Team**

The CHA Core team will help to coordinate the collection of this information. NEHA’s program indicators that measure outcomes were one source of collecting RHA specific information. Most NEHA program managers were asked to contribute information. The Quality and Organizational Development Program provided a leadership role for this team.

4.4.2.2  **Information Technology (IT) Team**

The IT program within NEHA provided software support throughout the project. They have been a tremendous help ensuring that the information was safe and always came to the rescue when computer glitches arose.

4.4.2.3  **Aboriginal Team**

It was felt to be important to continue to have staff that was already familiar with aboriginal communities to be the liaisons for the CHA project within these areas. To this end, the team leaders were the Managers of Primary Health Care and Public Health. Membership also included a First Nation representative.

The team leaders conducted two Focus Groups, one youth and one adult session in Seymourville using the same target ages and questions that were used in all the other health districts.
4.4.2.4 **Community Consultation Team**

This was a large and very active team consisting of representation from all program areas within NEHA.

It is the ultimate goal of this team to develop a template in which community consultation can continue within their respective programs once the CHA project has been completed. The need for the team to continue to meet as a resource for each other and their program is a question that the team and senior managers will need to answer.

Team members were offered education sessions in order to build consultation capacity within their respective programs. Some education sessions offered were:

**Internal**

a) October 14- Topic- Focus Groups and Surveys –Presented by Dr. E. Cleary
b) Gender Workshop- November 18. Presented by: Lissa Donner
c) Dec 9- Topic- In the Beginning…. there is Consultation. Presented by Suzanne Dick.
e) April 16- Validation Workshop Education Session for Validation Facilitators. Presented by Elaine Heinl, Suzanne Dick and Bonnie Frith.

**External** – Consultation team members were asked to volunteer if they wished to attend.

a) January 15 – *Manitoba Health Data Analysis and Interpretation Workshop* – Two members of the Steering Committee attended, two members of the Consultation Team attended and the CHA Coordinator attended.

b) February 10- *CIHI- Applying a Population Health Perspective to Health Planning and Decision Making*. Several NEHA staff members on various CHA Teams including the CHA Coordinator attended.

c) April 6 - CHAN workshop on *Report Writing*. Two members from the Consultation Team, three members from the Steering Committee and CHA coordinator attended.

Refer to Appendix 4-3 for a copy of the Teams Terms of Reference.
4.4.3 Awareness

It was important that both staff and members of the community knew about the role of the CHA project. Communication was coordinated through the Core Team. Any public documents were reviewed by the VP of Programs and the Director of Quality and Organizational Development.

Pamphlet

A CHA pamphlet was developed. The pamphlet was developed and distributed by the Consultation Team and the District Health Advisory Committee (DHAC) members and other staff. The pamphlet was featured on the NEHA web page.

Informational Meetings

The DHAC’s and the consultation team were asked specifically to talk about the CHA project whenever there was an opportunity.

Project updates to the NEHA Board, specifically the Communications and Community Development Committee of the Board, to the DHAC to NEHA Regional Management, and to the subcommittee of the North Eastman Intersectoral Agency Committee.

A presentation about the project was delivered at the 2003 NEHA Annual General Meeting held in June at Victoria Beach and Whitemouth.

Presentations

A power point presentation about the CHA project’s purpose and importance to residents and staff was created and circulated to program managers. The intent was that this be shared with their staff and within communities by programs who work in community outreach. For example: Public Health, Primary Health Care and Services to Seniors.

Articles

Generic articles were written for insertion in:

- The NEHA web site “Health Corner”
- The NEHA External Newsletter ‘The Pulse’
- The NEHA internal newsletter ‘The Breeze.’
- The ‘Annual Report 2003’ brochure
- Local newspapers
4.4 CONSULTATION

Community consultation increases the community’s awareness of health issues, and provides trust in the process that information is not only collected but shown to be utilized to the benefit of the population served.

Figure 4.3 CHA Consultation

The consultation team contributed to the development of ideas and assisted in the implementation of the focus groups and validation workshops.

Focus Groups

Planning for Focus Groups began in April 2003. Questions were initially developed by the consultation team focusing around:

- questions that they would like answered by the community from their program perspective,
- questions that were outstanding from the previous CHA project,
- any missing information that would lend itself to this type of consultation.

Once the questions were developed, they were reviewed by the Steering Committee. The consultation team was asked to provide any community contacts to begin generating a list of possible participants.

A private researcher, Lesley Anne Fuga, was hired to facilitate the Focus Groups. For consistency, the CHA Program Assistant transcribed the information generated by each of the groups. The facilitator reviewed the information and provided it to the CHA Research and Project Coordinator. This was then formatted, ready to use within the CHA Report. Both the facilitator and the CHA Program Assistant reviewed the report information to ensure that the information reflected the meaning and tone of the Focus Groups.

Please refer to Section 5 for more details about the focus groups.

Validation Workshops – The planning for these workshops began in December 2003. The team leader was Elaine Heinl.
Please refer to Section 5 for more details about the validation workshops.

NEHA staff were continuously consulted and given sections of the report for review as it was developed. Statistical expertise was provided by Dr. Eilish Cleary, our Medical Officer of Health.

There was many staff not listed within the CHA structure who contributed to this process.

Please refer to Acknowledgment Section 2.

4.5 CHA FRAMEWORK - Manitoba's Health Performance Measurement Framework

The CHA report used Manitoba's Health Performance Measurement Framework to provide a reference that guided the collection and interpretation of the information and identified key elements to be considered when assessing the health needs of our population. Within this framework is the Population Health Model.

4.5.1 Overview

“The purpose of the Manitoba's Health Performance Measurement Framework is to provide a common frame of reference within which expectations¹ and performance measurement indicators/measures will be organized and/or developed. This framework will provide a “common lens” through which health system performance and population health status can be articulated, enabling a systematic assessment of progress toward outcomes, goals and objectives. Another key function will be to facilitate performance reporting. The framework has been designed so that it is congruent with work that is being done regionally, nationally and internationally in this area², permitting health system performance measurement collaboratively with the RHAs.

“Manitoba’s Health Performance Measurement Framework” is a conceptual overview of the structure and process of performance measurement that links expectations, performance dimensions (broad categories within which performance measurement takes place), and performance measurement mechanisms to strategic outcomes and priorities.

Manitoba’s Health Performance Measurement Dimensions describes the four broad categories across which performance measurement takes place (health status & determinants; health system performance; health system infrastructure; and, community & health system characteristics). Each has associated sub-categories that will assist in the development, collection, or reporting of more detailed information. The dimensions reflect the complexity and broad scope of the health care system and facilitate the development of expectations, such as policy, as well as indicators/measures.”⁷

¹ Desired results as set out in expected outcomes, goals, legislation, policy, standards, targets, benchmarks, and guidelines.
² Performance Measurement dimensions are based on the review of the following sources: CIHI’s Health Indicators Framework, Australia’s Proposed National Performance Framework, Manitoba Health’s Report on the Health of Manitobans (in development), Health Canada’s Advisory Committee on Population Health, the Canadian Council on Health Services Accreditation AIM Standards, and the Manitoba Regional Health Authorities proposed framework for reporting indicators.
The framework’s many categories have used a variety of other concepts or models for example: the World Health Organization’s (WHO) International Classification of Functioning and disability (CHIDH-2, Beta 2 Version) and the Health System Performance category currently used by the Canadian Council on Health Services Accreditation (CCHSA).

For the purpose of this report, the order of some of the categories has been adjusted to enhance readability. The basic framework has not been changed.
The following is a table portraying the categories within the framework.

**Note:** The brackets with wording in italics are the population health determinants as described in the Population Health Model.

**Figure 4.5 Manitoba’s Health Performance Measurement Framework Categories**

<table>
<thead>
<tr>
<th>HEALTH STATUS</th>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.&quot; 8</td>
<td>&quot;Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)).&quot; 9</td>
<td>&quot;Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version)).&quot; 10</td>
<td>&quot;Broad measures of the physical, mental and social well-being of individuals.&quot; 11</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DETERMINANTS OF HEALTH</th>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.&quot; 16</td>
<td>&quot;Measures the prevalence of factors such as social support and life stress that epidemiological studies have shown to be related to health.&quot; 17</td>
<td>&quot;Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.&quot; 18</td>
<td>&quot;Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.&quot; 19</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.&quot; 20</td>
<td>&quot;The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.&quot; 21</td>
<td>&quot;Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.&quot; 22</td>
<td>&quot;Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.&quot; 23</td>
</tr>
</tbody>
</table>
**HEALTH SYSTEM PERFORMANCE**  
*Health Services as a Health Determinant*

“Health services, especially those designed to maintain and promote health, prevent disease and injury and restore health, contribute to population health.”

**RESPONSIVENESS** – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. Canadian Council on Health Services Accreditation (CCHSA).

<table>
<thead>
<tr>
<th>Availability</th>
<th>Accessibility</th>
<th>Timeliness</th>
<th>Continuity</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA)</td>
<td>“The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs.” (CCHSA)</td>
<td>“Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time.” (CCHSA)</td>
<td>“The ability to provide uninterrupted, coordinated care/service across programs, practitioners, organizations, and levels of care/service, over time.”(CCHSA)</td>
<td>“Decisions are made and services are delivered in a fair and just way.” (CCHSA)</td>
</tr>
</tbody>
</table>

**SYSTEM COMPETENCY** – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA).

<table>
<thead>
<tr>
<th>Appropriateness</th>
<th>Competence</th>
<th>Effectiveness</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Care/service provided is relevant to the clients'/ patients' needs and based on established standards.” (CCHSA)</td>
<td>“An individual's knowledge and skills are appropriate to the care/ service being provided.”(CCHSA)</td>
<td>“The care/ service, intervention or action achieves the desired results.” (CCHSA)</td>
<td>“Potential risks of an intervention or the environment are avoided or minimized.”(CCHSA)</td>
</tr>
</tbody>
</table>

**CLIENT /COMMUNITY FOCUS** – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

<table>
<thead>
<tr>
<th>Communication</th>
<th>Confidentiality</th>
<th>Participation and Partnership</th>
<th>Respect &amp; Caring</th>
<th>Organization Responsibility &amp; Involvement in the Community</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>“All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable, and useful.” (CCHSA)</td>
<td>“Information to be kept private is safeguarded.” (CCHSA)</td>
<td>“The client and/or community actively participate as a partner in decision making, and in service planning, delivery, and evaluation.”(CCHSA)</td>
<td>“Politeness, consideration, sensitivity, and respect are incorporated into all interactions with the client and/or community.” (CCHSA)</td>
<td>“The organization supports and strengthens the community and its development, and contributes to its overall health.”(CCHSA)</td>
<td>“All care/ service provided meets the expectations of the client, community, providers and paying organizations, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of the clients'/ patients' are paramount.” (CCHSA)</td>
</tr>
</tbody>
</table>
WORKLIFE – The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well being, and satisfaction. (CCHSA) 43

<table>
<thead>
<tr>
<th>Open Communication</th>
<th>Role Clarity</th>
<th>Participation in Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The organization fosters a climate of openness, free expression of ideas, and information sharing.” (CCHSA) 44</td>
<td>“Staff have a clearly defined job scope and objectives, and these are aligned with team and organization goals.” (CCHSA) 45</td>
<td>“Staff input is encouraged and used in decision making.” (CCHSA) 46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Environment</th>
<th>Well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Staff creativity, innovation, and initiative is encouraged. The necessary training and development to attain organizational goals and personal/professional development objectives, is provided.” (CCHSA). 47</td>
<td>“The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement activities.” (CCHSA) 48</td>
</tr>
</tbody>
</table>

Note: Health system Infrastructure and Community and Health System Characteristics may reflect expectations, indicators or measures or provide useful contextual information. 49

HEALTH SYSTEM INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Finances</th>
<th>Human Resources</th>
<th>Leadership</th>
<th>Information &amp; Technology</th>
<th>Physical Structure &amp; Equipment</th>
<th>Public Health Surveillance</th>
<th>Research</th>
</tr>
</thead>
</table>

COMMUNITY & HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Population Demographics</th>
<th>Health Service Utilization</th>
<th>Expenditures</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Education as a health determinate] 54</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.6 POPULATION HEALTH MODEL

Figure 4.6 Population Health Model Framework

The above framework provides an outline of the population health model and its nine determinants that influence the health of our population. Within these determinants i.e. physical environment, biology and genetic endowment, healthy child development, personal health practices and coping skills, social support networks, education, income and social status, employment and working conditions and health services are health status indicators that tell a story about each determinant of health. The definition for each determinant is incorporated into the earlier Manitoba’s Health Performance Measurement Framework table.

“The population health approach addresses the entire range of individual and collective factors that determine health with the overarching goal to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups.”

Population Health Goals

- To maintain & improve the health status of the entire population.
- To reduce inequities in health status between population groups.
As you read through the CHA you will clearly see disparities in health status between our health districts especially notable in Blue Water and Northern Remote health districts.

The following outcomes or benefits of a population health approach extend beyond health status outcomes:

a) “more product contribution to overall societal development,
b) …less support in the form of health care and social benefits, and
c) is better able to support and sustain itself over the long term.”  

4.7 ETICS

A CHA involves research that collects and retrieves information about people. In order to protect the rights of the individual there must be fundamental guidelines to direct the process. It was important to the team that the risks to the individual be clearly identified and communicated to them orally and/or in writing. This was particularly important during the focus groups and the validation workshops.

The following outlines the processes in place to protect the individual.

4.7.1 Personal Health Information Act (PHIA)

The principles of PHIA are fundamental to the protection of personal information. All members who actively participated in the CHA project were given a copy of the article entitled ‘A Brief summary for HEALTH RESEARCHERS’, an excerpt taken from PHIA.

4.7.2 NEHA Policies

There are NEHA regional policies which guided this project.

#12-4 Protection of Privacy During Use and Disclosure of Personal Health Information.
# 5-9 Research Access.
# 5-10 Research Committee – NEHA.

4.7.3 Guidelines Developed by CHAN

A CHAN Ethics Sub-committee was established to assist in ensuring alignment with the ethical issues of accessing and using information.

Refer to Appendix 4-4, CHAN Ethics Guidelines, August 25, 2003.
Focus Groups

A letter was given to every participant at the beginning of each of the Focus Group Workshops which explained how the information would be used. A concern that was discussed within the team was participants divulging personal information, as we would have no control as to how other participants might share this information outside the group. This issue was raised within each group, so they could evaluate for themselves exactly what information they were comfortable to share.

Please refer to Section 5 Appendix for a copy of the letter.

Validation Workshops

Validation workshop participants were informed during the presentation that information discussed would be used in the CHA Report and that this report would be public document. They were assured that no names would be used.

2003 Provincial Survey

The survey was completed by an external agency, which was responsible for ensuring that ethical standards for use of the data were adhered to.

4.8 HOW TO USE THE REPORT

4.8.1 General Use

Information in this report has been collected to correspond with the geographical boundaries of NE region and NE health districts. It is recommended when the document is first used that the Introduction and Data Collection and Methodology Sections 4 and 5 be read for a general understanding of the projects intent, scope and limitations.

This report is meant to be used as a working document primarily for NEHA staff and partners for planning purposes. A public document has been created and distributed to the general public throughout NE region in English and French. The completed document is available through NEHA Corporate Office.

An Executive Summary is provided at the beginning of the report. If a member of the general public requests a more detailed account of the CHA Report the executive summary will be provided.

Table of Contents provides details of the report contents. Each Section is numbered separately corresponding with the section number, for example: Section 4 –3 is page 3 within Section 4. If there are any appendices included within the section these will be located at the end of the section.

Acknowledgments include a list of people who supported the project. We are very grateful for the assistance given this project from staff, community leaders and participants in our consultations. If there are any names left out we apologize, it was not intentional.

A Summary & Conclusion ends each section. There is a table in which issues are divided into ‘Strengths and Issues having implications for health planning and delivery.’ It is meant to provide planners with a quick overview of items that have been identified as areas that either could be monitored or are a potential concern.

Example:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Issues Having Implications for Health Planning &amp; Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Terms:</td>
</tr>
<tr>
<td></td>
<td>• Partner: implies that if this is an action by NEHA it will require partnering with a community group/ agencies/ department.</td>
</tr>
<tr>
<td></td>
<td>• Monitor refers to an area of possible concern and monitoring will ensure it isn’t missed if it changes.</td>
</tr>
<tr>
<td></td>
<td>• NEHA if a program may or could have some responsibility for this issue.</td>
</tr>
</tbody>
</table>

As population health is all encompassing many issues are not the sole responsibility of NEHA. This is where partners play a major role. It is to the credit of NEHA programs that there are partnership groups already in place and fully functional within each health district.

References are provided at the end of each section. References allow the reader to source out additional information on a particular subject.
4.8.2  Introduction – Section 4

This provides an overview of the CHA process, structure/team, framework, ethics and use of the report.

4.8.3  Data Collection & Methodology – Section 5

This section discusses the major data sources used in this report including their strengths and weaknesses. It is recommended that this section be read before any interpretation of the data is made.

4.8.4  Regional Information – Section 6

This refers to information that has been obtained at a Regional level. This section includes the following components from the Manitoba's Health Performance Framework:

- Community System Characteristics
- Health Status
- Determinants of Health

Focus group information is divided up into ages and districts. The 2003 Acumen Research Survey - NE Findings information is also provided and may be cross-referenced to the earlier NE Survey done in 1997 if there is a similar question.

It is highly recommended that the reader review Section 6 as it provides the most detailed account as to why an indicator is used and its definition. This section contains the most indicators, as many sources of data did not generate information at the district level.

Because NE is a very diverse region, it is important that planners and staff working in a particular district also cross reference any regional health district information to ensure a more complete and accurate picture of the indicator being discussed.

In Appendix 4-5 a copy of the “Diagnostic Categories” has been provided. At times in the report a diagnostic statistic will have an International Classification of Disease (ICD) –9. This list provides more detail about the diagnostic classification. At the time of writing, Manitoba Health is in the process of updating its disease classification to ICD-10.
4.8.5 **Health Services – Section 7**

This section covers health service information that has been obtained from both a regional and health district level. It was a conscious decision to put health district information in this section. This allows for cohesiveness in reviewing health services overall without having to jump to another section.

This section includes components of the Manitoba’s Health Performance Framework:
- Health System Characteristics,
- Health System Performance – Responsiveness, System Competency, Client/Community Focus and Work Life.

Once more focus group information is divided up into ages and districts. The 2003 Acumen Research Survey - NE Finding information is also provided and may be cross-referenced to the earlier NE Survey done in 1997.

4.8.6 **Health Districts- Sections 8 through 13**

The health district section provides information related to a specific health district. You will see that in some graphs or tables other NE health district regions are included. This allows the reader to compare information to our other health districts, Manitoba and Rural South without having to go to another section. The narrative discusses only that health district.

Health district information is valuable for staff working exclusively in one health district, providing them with quick access to a variety of information. Information is more limited at the health district level; therefore it is advised to become familiar with what is available in the regional section.

This section includes the following components of the Manitoba’s Health Performance Framework:
- Community System Characteristics
- Health Status
- Determinants of Health

The focus group information is described by age, but only includes information that arose from that particular health district. The validation workshop information includes the top three key issues identified as well as some discussions that arose from that health district only.

The 2003 Acumen Research Survey - NE Finding information was not included as this was collated at the regional level.

4.8.7 **Conclusion – Section 15**

At the end of the report, the Conclusion focuses on summarizing regional and district strengths, and highlights issues or trends that emerged suing the Manitoba’s Performance Measurement Framework as a template. It also summarizes resident suggestions raised during the focus groups, Acumen survey and validation workshops. To conclude this section, some ideas for further research are provided for consideration.
4.9 PRIORITY SETTING

As indicated earlier this document describes many strengths as well as areas that have implications for health planning and delivery.

As planners, making decisions about determining priorities, many things need to be reviewed. A few of these include:

- Size of Problem
- Seriousness
- Effectiveness of Interventions

Specific questions to ask about a particular issue:

- How many people does it affect?
- Is it a growing and/or increasing problem?
- Can you measure it over time?
- Can something be done about it?
- Will there be a positive effect if something is done or a negative effect if nothing is done?
- Economic burden—cost to community?
- What will be the long term negative effect?
- What supports are needed for change?
- What will the impact be on current resources?
- Is it efficient use of resources?
- Severity of problem to person?
- Did the public raise this concern during consultations?
- What are the risks – legal & ethical?
4.10 SUMMARY / CONCLUSION

The goal of the CHA Report is to provide NEHA staff, first and foremost, with a way of obtaining comprehensive, insightful and the most up to date evidence based information. It will assist them with planning for future health programs and services to meet the needs of NE residents.

“Working together to create a healthy North Eastman”
4.11 REFERENCES

2. NEHA Strategic Plan 2002-2006 pg. 2.
3. NEHA Strategic Plan 2002-2006 pg. 6.
4. NEHA Strategic Plan 2002-2006 pg. 11.
5. NEHA Strategic Plan 2002-2006 pg. 5 and Judy Coleman, VP Programs and Services. August 2004.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1</td>
<td>Community Health Assessment Network (CHAN) Terms of Reference</td>
</tr>
<tr>
<td>4-2</td>
<td>2003-2004 CHA Steering Committee Terms of Reference</td>
</tr>
<tr>
<td>4-3</td>
<td>Role of the Community Consultation Team</td>
</tr>
<tr>
<td>4-4</td>
<td>CHA Ethics Guidelines &amp; CHAN Ethics Policy</td>
</tr>
<tr>
<td>4-5</td>
<td>Diagnostic Categories</td>
</tr>
</tbody>
</table>
APPENDIX 4-1
Community Health Assessment NETWORK (CHAN)
Terms of Reference

PURPOSE
To work with the final recommendations of the Community Health Assessment Indicators Working Group and in collaboration with the Funding Opportunities Group (FOG), the Community Consultation Working Group (CCWG) will focus on the process and content of the community consultation piece of the next comprehensive Community Health Assessment (CHA). The objectives of the Community Consultation Working Group are:

1. To define the scope of "community consultation" within the broader field of community (public) participation;
2. To review and discuss Manitoba RHAs’ previous experience with CHA community consultations (subject areas/mechanisms/success or fail/ reasons);
3. To explore potential sources of information in gap areas as identified by WIG and recommend a common consultation process for prioritization by CHAN
4. To recommend the most appropriate and if possible standardized methods to the RHAs (CHAN) for consulting with their communities in the identified subject areas;
5. To present common subject areas and mechanisms/methods for CHAN approval to use in the next comprehensive provincial Community Health Assessment (CHA) process.
6. To recommend appropriate educational opportunities for CHAN members and other key stakeholders.

MEMBERSHIP

Members - The number of members will be limited to facilitate discussion and decision making. Membership to include:
(a) Regional Health Authority representatives: Sue Crockett, Faye White, Doreen Fey and Val Austen-Wiebe
(b) Manitoba Health - Regionalization and Health Plan Process: Shahin Shooshtari

Representation - Working Group members will represent the RHA’s and Manitoba Health. Additional members may be appointed by the CHA Network, or invited as required in consideration for specific issues.

Terms of Appointment - Members are appointed until the Community Consultation Working Group (CCWG) objectives have been met.

Chair - There will be one chairperson representing Manitoba Health, as the group is small enough to manage without co-chairs. All members commit to supporting the chair during and in preparation for ongoing meetings of the working group.

DECISION MAKING
The Committee will make decisions using a consensus approach.

COMMITTEE MEETINGS

- The Working Group plans to meet on a regular basis until the objectives are met.
- The Working Group will determine where and how the meetings will take place and will use telecommunications for routine meetings when appropriate.
- The Working Group chairperson will circulate an agenda prior to each meeting. The Group may alter the agenda.
- Minutes will be kept of each meeting and circulated to each member. Minutes may be circulated to other interested non-committee members for information purposes.
- The Director of the Community Health Assessment Unit/Health Planning will receive all committee minutes.

ACCOUNTABILITY
The Community Consultation Working Group (CCWG) will report to the Community Health Assessment Network (CHAN). In addition, communication will occur with identified stakeholder groups. CHAN will advise and evaluate the subcommittee process.
APPENDIX 4-2
2003-2004 CHA Steering Committee
Terms of Reference

PURPOSE
The North Eastman Health Association Inc. is committed to the implementation of a community health assessment at least once every 4 years.

The CHA Core Team will be made up of the CHA Research & Project Coordinator, and CHA program assistant. The CHA Core Team reports directly to the VP of Programs. The VP of Programs ensures that all relevant correspondence from Manitoba Health is directed to the CHA research/project coordinator.

ROLES AND RESPONSIBILITIES
The CHA Steering Committee will act in an advisory role to the CHA Core Team by
- providing overall direction and guidance to the CHA Project in alignment with NEHA Board Ends, Mission, Vision and Policies.
- developing and supporting a plan for the utilization of staff resources.
- promoting awareness of the CHA project among NEHA staff and the community.
- collecting existing information from specific NEHA programs as requested.

MEMBERSHIP
- VP of Programs, CHA Core Team, Primary Health Care Manager, Medical Officer of Health, Physician.
- AD HOC- CEO, Public Health Manager, Director: Quality & Organizational Development, Quality & Organizational Development Program Assistant.

ORGANIZATION
- The CHA Research/Project Coordinator will serve as the chair of the Steering Committee.
- CHA program assistant will take minutes.

MEETING FREQUENCY
- At the call of the chair.

QUORUM
50% +1.
APPENDIX 4-3
Role of the Community Consultation Team

Community & Staff Awareness
- Development of strategies
- Assist in Implementation

Community Consultation
- Development of questions
- Prioritizing questions with Steering Committee
- Developing strategies
- Contacting community members
- Assisting with Implementation

Community & Staff Information & Validation
- Work with the team leader to implement these meetings.
APPENDIX 4-4
CHA Ethics Guidelines

1. Each RHA will ensure appropriate ethical considerations in the management of the ongoing Community Health Assessment (CHA) process.

2. Each RHA will utilize best practices regarding informed consent for participation in CHA activities.

3. Each RHA will ensure the appropriate handling of data obtained (i.e. storage and utilization of data collected), to ensure confidentiality as outlined under their existing policy. If such a policy does not currently exist, one must be developed.

4. Each RHA may obtain an independent/external review of their proposed activities.

5. Formal ethical approval must be obtained prior to embarking on activities, which may lead to publication in many academic journals.

Ethics Group - a Subcommittee of CHAN
August 25, 2003
COMMUNITY HEALTH ASSESSMENT NETWORK

ETHICS POLICY

POLICY STATEMENT

The RHA is committed to conducting a Community Health Assessment (CHA) that respects personal privacy and safeguards individual record confidentiality and system security in accordance with PHIA legislation. In addition efforts will be made to protect community confidentiality where appropriate. The Participation and Information Consent Form shall be used for activities involving the collection of personal information.

The Community Health Assessment process shall be consistent with the following ethical principles.

1. **Accountability**

   The RHA is accountable for compliance with the following principles when conducting CHA activities. Under the RHA Act Division 2 Section 23(2) (b) states each RHA shall "assess health needs in the health region on an ongoing basis".

2. **Limiting Collection**

   The RHA will only directly or indirectly collect person/community-identifiable information that is necessary to establish sound health policy, effectively manage the health system, support the ongoing CHA process and/or create public awareness. The information maybe allowed under guideline No. 5.

3. **Limiting Use**

   The RHA will only use personal/community information for purposes of establishing sound health policy, effectively manage the health system, support the ongoing CHA process and/or create public awareness.

   In addition aggregate information may be used under ethical guideline No. 5. The RHA will also ensure minimal risk in the use of information and clearly articulate the benefit to public interest.

4. **Limiting Disclosure**

   The RHA may disclose information to support provincial databases for epidemiological studies and policy analysis. The purpose is to be consistent with those for which it was originally collected or as allowed under ethical guideline No. 5.
5. **Consent**

The knowledge and consent of the individual or his/her guardian are required for the collection, use or disclosure of personal information except where the collection, use or disclosure is permitted by law.

6. **Integrity**

The RHA shall ensure the integrity (quality, accuracy and reliability) of records under its control, whether in written, electronic or other form.

7. **Security**

The RHA shall establish and retain the signed informed consent forms in a secure area for a minimum of 7 years.

8. **Openness**

Upon request, RHA will make available specific information about its policies and practices relating to its handling of personal information.

This policy and guiding principles are based on those contained in the Canadian Standards Association: Model Code for the Protection of Personal Information. A National Standard of Canada. CAN/CSA-Q830-96
APPENDIX 4-5
Diagnostic Categories

Source: ICDS-9 International Classification of Disease, 9th Revision.

REFERENCE TO 18 DIAGNOSTIC CATEGORIES
(referenced from the ICD-9 International Classification of Diseases, 9th Revision)

1. Infectious and Parasitic Diseases
   - includes diseases generally recognized as communicable or transmissible as well as a few diseases of unknown by possibly infectious origin.

2. Neoplasms
   - includes all cancers, whether or not functionally active

3. Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders
   - includes disorders of the thyroid gland, diabetes of other endocrine glands nutritional deficiencies and other metabolic and immunity disorders.

4. Diseases of the Blood and Blood-Forming Organs

5. Mental Disorders
   includes:
   - organic psychotic conditions, other psychoses,
   - includes neurotic disorders, personality disorders, and other nonpsychotic mental disorders
   - includes mental retardation

6. Diseases of the Nervous System and Sense Organs
   includes:
   - inflammatory diseases of the Central Nervous Systems
   - hereditary and degenerative diseases of the Central Nervous System
   - other disorders of the Central Nervous System
   - disorders of the Peripheral Nervous System
   - disorders of the eye and adnexa
   - diseases of the ear and mastoid process

7. Diseases of the Circulatory System
   includes:
   - acute rheumatic fever
   - chronic rheumatic heart disease
   - hypertensive disease
   - ischemic heart disease
   - diseases of pulmonary circulation
   - other forms of heart disease
   - cerebrovascular disease
   - diseases of arteries, arterioles, and capillaries
   - diseases of veins and lymphatics, and other diseases of the circulatory systems

8. Diseases of the Respiratory System
   includes:
   - acute respiratory infections
   - other diseases of the upper respiratory tract
   - pneumonia and influenza
   - chronic obstructive pulmonary disease
   - pneumoconioses and other lung diseases due to external agents
   - other diseases of the respiratory system
9. Diseases of the Digestive System
   includes:
   - diseases of the oral cavity, salivary glands, and jaws
   - diseases of the esophagus, stomach and duodenum
   - appendicitis
   - hernia of abdominal cavity
   - noninfectious enteritis and colitis
   - other diseases of intestines and peritoneum
   - other diseases of digestive system

10. Diseases of Genitourinary System
    includes:
    - nephritis, nephrotic syndrome, and nephrosis
    - other diseases of urinary system
    - diseases of male genital organs
    - disorders of breast
    - inflammatory disease of female pelvic organs
    - other disorders of female genital tract

11. Pregnancy, Childbirth, Puerperium

12. Diseases of Skin and Subcutaneous Tissue
    includes:
    - infections of skin and subcutaneous tissue
    - other inflammatory conditions of the skin
    - other diseases of the skin and subcutaneous tissue

13. Diseases of Musculoskeletal System and Connective Tissue

14. Congenital Anomalies

15. Certain Conditions Originating in the Perinatal Period
    includes conditions which have their origin in the perinatal period even though death or morbidity occurs later.

16. Symptoms, Signs and Ill-Defined Conditions
    includes:
    - symptoms
    - signs
    - abnormal results of laboratory or other investigative procedures, and
    - ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.

17. Injury and Poisoning

18. Supplementary Classification of Factors Influencing Health Status and Contact With Health Services

   This classification is provided to deal with occasions when circumstances other than a disease or injury classifiable to the above categories, are recorded as "diagnoses" or "problems". This can arise mainly in two ways:

   a) when a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.

   b) when some circumstance or problem is present which influences the person's health status but it is not in itself a current illness or injury.
Section 5.0 DATA COLLECTION METHODOLOGY

5.1 OVERVIEW

5.2 LIST OF PRIMARY SOURCES OF INFORMATION


5.2.3 STATISTICS CANADA WEB SITE: HTTP://WWW.STATCAN.CA


5.2.5 NORTH EASTMAN RHA DATA

5.2.6 MANITOBA HEALTH INJURIES OF MANITOBA - A TEN YEAR REVIEW

5.3 PRIMARY SOURCES OF QUALITATIVE INFORMATION

5.3.1 FOCUS GROUPS

5.3.2 COMMUNITY VALIDATION MEETINGS “AN OVERVIEW OF YOUR COMMUNITY’S HEALTH STATUS”

5.3.3 NEHA HEALTH PROGRAM COMMUNITY CONSULTATIONS

5.3.4 GLOSSARY OF STATISTICAL TERMS

5.4 SUMMARY / CONCLUSION

5.5 REFERENCES

APPENDICES

5-1 North Eastman Provincial Survey Questions and Corresponding Responses-November/December 2003

5-2 Focus Group Correspondence Letters

5-3 Validation Workshop Collation Template

5-4 Glossary of Common Statistical Terms
5.1 OVERVIEW

This section discusses the major data sources used in this report including their strengths and weaknesses.

The value of having a variety of information sources is that it has the ability to validate each other’s information. Having said this the most fundamental problem is that one must compare sources with extreme caution, due to differences in dates, geographic boundaries, collection methods, target group differences, and how information is collected, or even analyzed.

In this report definitions are provided at the beginning of the indicator in the regional sections six and seven and often are repeated at the health district level. The regional section provides a more detailed account of the indicator’s purpose. Understanding the indicator will assist in prioritizing areas of concern.

The information contained in this report focuses on the North Eastman (NE) region. Comparisons if available are made between NE, district level information, Manitoba and Rural South. When information comes from the Atlas, Rural South refers to “… an aggregate of all southern and mid-province RHA’s except the urban centres of Winnipeg and Brandon.” The primary information resource contains other valuable information. It is recommended that one review these documents for more detailed information.

Some research standardizes age and sex. If this has occurred it is mentioned either in the table, graph or notes. At times, crude numbers are given as this provides a “… realistic look at the effect of the population burden of illness on the region’s health care system.”

Each piece of information should be reviewed in the context of the whole to see if there are similar trends. As information is being reviewed, it important that the following be noted:

- Time period e.g. is it over one year, ten years etc.? Some information contained in this report may be felt to be ‘old’ already. It is important to review what has been achieved by NEHA and partners since the information was collected.
- Rate by which the population is being referenced to e.g. by 1,000, 10,000 or 100,000 population.
- Is the information by percentage of a particular population?
- Who is the population e.g. certain age category, gender, a region, health district or province?
- Is the research generalizable to the broader population?

Knowing this assists in the interpretation of the information. These factors will vary between sources.

Information has been categorized using the Manitoba’s Health Performance Measurement Framework (MHPMF). Most indicators were derived from a list of indicators developed by the Working Indicators Group (WIG), a subcommittee of the Community Health Assessment Network (CHAN). These indicators were grouped within the dimensions of the Performance Measurement Framework. As other information is collected, it is placed into the appropriate dimension or category.

Refer to Section 4 for an explanation of the MHPMF.

Indicators in this report are shaded in yellow. An example of how this is presented in the CHA report is: Asthma Prevalence.
5.2 LIST OF PRIMARY SOURCES OF INFORMATION

Quantitative Data
- RHA Data – This is information generated within NE Regional Health Association (RHA).
- Canadian Community Health Survey Cycle. Stats Canada 1.1 2001. (CCHSC 1.1] as analyzed in the PROFILE document.

Qualitative Data
- Health District Focus Groups (June to November 2003). Referred to as: 2003 Focus Groups
- Validation Workshops: “An Overview of Your Community’s Health Status Workshops” (April / May 2004). Referred to as: 2004 Validation Workshops

The strengths and limitations of each primary data source is discussed below.


The profile document was composed from a variety of information sources by the Health Information Management Branch of Manitoba Health.

- Manitoba Health : Medical Utilization Data
- Manitoba Vital Statistics
- Manitoba Health Hospital & Medical Claims Administrative Data
- Manitoba Health Information Monitoring System (MIMS)

The information from MIMS is from physician billing claims and from manual entry of immunization records by either MIMS clerks or Public Health Nurses (PHN’s). The population is based on the Decision Support Services Population Data of June 1 for each year. There may be gaps in the information due to delays in registering or due to individuals who are not eligible for Manitoba Health benefits e.g. non-Manitoba federal inmates and federal employees.

For the Profile report, data was extracted on April 15, 2002, and only active files were extracted which means people who had died, moved out of province or whose Personal Health Information Number (PHIN) was
changed were not included. Approximately 1% of immunization records cannot be accessed for these reasons.

Limitations to MIMS
Gaps in the information are due to
- Physicians not always billing for immunizations provided.
- Salaried physicians do not always “shadow bill.”
- Hospitals are not required to submit information on in-patients, out-patient clinics, emergency rooms, or occupational health immunizations provided.
- Private sector providers, correctional institutions, long term care facilities are not required to submit data to Manitoba Health.
- Human errors in inserting data.
- MIMS data entry is not funded for all immunizations provided.

- CancerCare Manitoba. These include all cancers using ICD-9CM codes: 140-208.
- Statistics Canada, Canadian Community Health Survey Cycle (CCHSC) 1.1

The CCHSC 1.1 is part of a “…federal initiative aimed at providing health information at the regional and provincial levels.” This project began in 2000. Cycle 1.1 is the first survey and was designed to provide information at the regional level. The survey targets individuals 12 years of age and older who live in private dwellings, covering approximately 98% of the Canadian population. The geographical boundaries correspond to the geography of the 1996 census. This is a potential limitation as our geographical boundaries have changed slightly. This must be taken into account when reviewing the information. Information was collected for one year beginning September 2000. Those surveyed in NE made up a total sample size of 522 people out of a total sample size of 131,535 surveyed across Canada.

Limitations
- The respondent represents a 0.7% stratified sample of Manitobans (stratified by age, gender, and RHA).
- Excludes persons living on First Nations reserves and on Crown lands, residents of institutions, full time members of the Canadian Armed Forces, and residents of certain remote regions of Manitoba.

- 1996 / 2001 Census of Canada, special purchase, Manitoba Statistics Canada Data Consortium. If Manitoba Health has done the analysis, the geographic information is accurate to our current geographic boundaries.

Limitations
- In some instances may exclude institutional residents.
- Unemployment rates can be misleading as they reflect only those people who are actively looking for jobs, not people who may have given up looking for work.

- Manitoba Health Annual Statistics
- Manitoba Health Communicable Disease Control Program.
Limitations

- Includes only laboratory-confirmed cases. There may be an underestimate of total incidence especially during years with outbreaks.
- Tuberculosis (TB) new cases represent episodes and not individuals, therefore one individual may have more than one symptomatic episode.
- Human Immunodeficiency Virus (HIV) cases may be under reported i.e. Health Canada estimates 30-40% not reported.
- Chlamydia may be under reported in men, causing misleading gender rate ratio.

- Manitoba Health, Population Registry.

Residents were assigned using municipality of residence. This information will not capture RCMP or inmates of a federal penitentiary.


Manitoba Centre for Health Policy (MCHP), Manitoba Health and non-Winnipeg RHA’s worked collaboratively to provide information to assist Manitoba RHA’s in planning appropriate services.

Most of the indicators are standardized rates to create a fair comparison among regions, unless specified otherwise, meaning that they are age and sex adjusted in order that a comparison can be made with other regions. Most indicators in the Atlas provide comparisons between the RHA’s and within each RHA at the district level. The district comparisons are valuable as they provide information for RHA’s to review health status and health needs within the RHA itself. As clearly articulated in this report, NE has considerable variation in health status and health care needs within the RHA. Rates are attributed to where a person lives, not where a person receives services.

Two time periods are reviewed: the first being pre-RHA and the second time period post RHA. With respect to the Atlas report, current geographical boundaries were used. The “assignment of unorganized territories and First Nations communities was based on six – digit postal codes in North Eastman.”

There is one change that Manitoba Health and MCHP are aware of and will be changing in future reports. This refers to Seddons Corner. In NE geographical boundaries, it is located in the Winnipeg River Health District, not in Brokenhead Health District as indicated in the Atlas on page 282.

The reason that Rural South [includes North and South Eastman, South Westman, Central, Marquette, Parkland and Interlake] is included in the Atlas figures is that “The Manitoba rate is heavily weighted toward the Winnipeg rate, since over half the population of the province resides in Winnipeg RHA. Therefore the other groupings of the Rural South and the North were considered extremely useful comparisons for the non Winnipeg RHA’s.”

Statistical significance was also calculated for Rural South using the Atlas ordered data. Where relevant this is mentioned in the discussion notes beside the figures.

A “1, 2, t or s” may be observed after the location of information on the graph. This refers to whether the rate is statistically significantly higher or lower when compared with Manitoba. Statistically significant refers to the
fact that “…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.” ⁸

“When you see a large difference that is NOT statistically significant, it is telling you that this rate is probably not different from the comparison rate, and that it could fluctuate greatly from year to year. This could be due to the rate being based on small numbers… so it could change from year to year and may be higher, similar or lower than the comparison the next time it is measured. Most graphs show the statistical significance testing in brackets. …” ⁹

1 = indicates the area’s rate is statistically different from Manitoba average in the first time period shown.
2 = indicates area’s rate is statistically different from the Manitoba average in the second time period shown.
t = indicates change over time is statistically significant.
s = indicates data suppressed due to small numbers. The Atlas reports rates if there are more than five cases.

5.2.3 Statistics Canada Web Site: http://www.statcan.ca.

Because of the boundary limitations especially in Blue Water and Northern Remote, this source had limited use.

Limitations
– Statistics Canada is using their definition of RHA so it will not give accurate representation of our current geographic boundary within NE Health Districts.


Acumen Research, 226-388 Donald Street, Winnipeg, Manitoba, R3B 2J4, Telephone: 204-989-8002 was contracted by eight of our eleven RHA’s in Manitoba to conduct a survey based on information that wasn’t readily available in the various sources already described. These areas were identified as:

• Health System Performance
• Quality of life
• Safety/injury prevention

Since not all RHA’s participated, this survey cannot represent results for Manitoba, “…reference in this report to findings for “all RHAs, "overall" findings or “combined” findings should be understood to refer to combined findings for all eight RHAs participating in this study.” ¹¹

Each RHA also had the opportunity to insert 1 to 2 questions. Consultation occurred with the NEHA Community Health Assessment Consultation Team and the Core Steering Committee members to determine the question submitted. NE ‘s question was number 34, related to whether the participant was knowledgeable about a variety of health services offered in their area.
Survey respondents were contacted through Random Digit Dialed (RDD) telephone numbers. The researchers felt that a telephone survey represented the most accurate, reliable and cost-effective means of conducting the survey. One limitation of a telephone survey is that it will not reach populations who don’t have a telephone.

Interviews began November 12 and were completed December 7, 2003. There were 400 residents (204 males and 196 females) 18 years and older interviewed in NE. To ensure residents were located in our geographic area, postal codes and community names were included in the survey questions. One error was made with respect to including Ostenfeld in NE. On discussing this with Acumen we were reassured that this would not compromise the integrity of the data, as it was only one survey. RHA employees were not excluded from the study.

All the data was weighted by age and gender. The quotas set initially were to reflect the gender of our population using Manitoba Health June 1, 2002 Population Report. The data was age and gender weighted to ensure that the information proportionally reflected our population. The other RHA’s were also weighted to their population.

Responses of “don’t know / refused” were excluded in the tables in the Acumen report. Percentages may not total exactly 100% due to rounding.

Table 5.1 Provincial Survey Report Demographics

<table>
<thead>
<tr>
<th>City, town, reserve, or community</th>
<th>Surveys (#)</th>
<th>City, town, reserve, or community</th>
<th>Surveys (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albert Beach</td>
<td>1</td>
<td>McMunn</td>
<td>1</td>
</tr>
<tr>
<td>Anola</td>
<td>29</td>
<td>Oakbank</td>
<td>40</td>
</tr>
<tr>
<td>Beausejour</td>
<td>83</td>
<td>Ostenfeld</td>
<td>1</td>
</tr>
<tr>
<td>Belair</td>
<td>4</td>
<td>Pinawa</td>
<td>38</td>
</tr>
<tr>
<td>Bloodvein River I.R. #12</td>
<td>1</td>
<td>Pine Falls</td>
<td>21</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>2</td>
<td>Pointe du Bois</td>
<td>2</td>
</tr>
<tr>
<td>Cloverleaf</td>
<td>2</td>
<td>Powerview</td>
<td>3</td>
</tr>
<tr>
<td>Cook's Creek</td>
<td>4</td>
<td>Prawda</td>
<td>2</td>
</tr>
<tr>
<td>Dugald</td>
<td>10</td>
<td>Rennie</td>
<td>1</td>
</tr>
<tr>
<td>East Braintree</td>
<td>2</td>
<td>Sapton</td>
<td>1</td>
</tr>
<tr>
<td>Elma</td>
<td>2</td>
<td>Seddon's Corner</td>
<td>1</td>
</tr>
<tr>
<td>Fort Alexander</td>
<td>1</td>
<td>Seven Sisters Falls</td>
<td>4</td>
</tr>
<tr>
<td>Fort Alexander I.R. #3</td>
<td>1</td>
<td>Springwell</td>
<td>1</td>
</tr>
<tr>
<td>Garson</td>
<td>7</td>
<td>St. George</td>
<td>4</td>
</tr>
<tr>
<td>Great Falls</td>
<td>6</td>
<td>Ste. Rita</td>
<td>3</td>
</tr>
<tr>
<td>Hadashville</td>
<td>7</td>
<td>Traverse Bay</td>
<td>6</td>
</tr>
<tr>
<td>Hazelglen</td>
<td>1</td>
<td>Tyndall</td>
<td>10</td>
</tr>
<tr>
<td>Hazeldridge</td>
<td>8</td>
<td>Victoria Beach</td>
<td>3</td>
</tr>
<tr>
<td>Hillside Beach</td>
<td>2</td>
<td>Vivian</td>
<td>1</td>
</tr>
<tr>
<td>Hollow Water I.R. #10</td>
<td>5</td>
<td>Wanipegow</td>
<td>1</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>60</td>
<td>Whitemouth</td>
<td>13</td>
</tr>
<tr>
<td>Little Black River I.R. #9</td>
<td>3</td>
<td>TOTAL</td>
<td>400</td>
</tr>
</tbody>
</table>
Sex

There were 50.9% males and 49.1% females, slightly more males than females surveyed. This is similar to NE’s total population as of June 2001, i.e. males 51% and females 49%. 12

Demographics as Discussed in Survey

- Seven out of ten respondents of First Nations/Aboriginal/Metis descent are in the 18 to 44 age brackets.
- Respondents in one-person households tend to be aged 65 or older, whereas those living in larger households (four or five to 10 people) tend to be between the ages of 35 to 44.
- Respondents aged 65 and over form a larger proportion than average of those with incomes under $20,000. Conversely, those with incomes $60,000 or over are more likely to be from 25 to 54 years in age.

Within the CHA report, the 2003 NE Provincial Survey information is presented in this format:

2003 Acumen Research Survey - NE Provincial Survey Findings on Hospital or Ambulance Utilization

Q- Have you used a hospital or an ambulance service in the past 12 months? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

The Q refers to the “question” asked within the survey. What may follow is a discussion about who answered the question.

Throughout the report there may be a reference to the 1997 NE Provincial Survey, if questions were similar. If this is available, it will follow the 2003 NE Provincial Survey and is presented as follows:

**NE Survey 1997**

Question Section B # 2: “Overall how would you rate the quality of health care services for people your age in your community?”

**Excellent** 250 (15%) **Good** 1,089 (67%) **Poor** 301 (18%)

*No responses were excluded from percentage*

No responses refer to respondents who did not answer the question.

The Acumen provincial survey provides more detailed information on the methodology and findings especially related to some of the verbatim responses. The CHA report does incorporate a few responses, but is not as comprehensive as the Acumen report.

**Provincial Survey Summary**

**Quality of Life Summary**

- More than half of all NE respondents said their health is “excellent” or “very good.” (56%).
- Self-reported health generally declines with age and improves with higher education.
- Three out of four respondents had not experienced any physical difficulties that limited their normal activities within the previous 30 days of the survey.
- Nine out of ten respondents (86%) had not experienced any similarly limiting emotional difficulties within the previous 30 days of the survey.
- Almost half of all respondents had someone who will listen to them when they are anxious or upset. One in 10 have no one to listen to him or her. Those over 65 years and those living in a single-person household were amongst those most likely to lack a confidant.
- Walking, running, and eating healthy foods are health improvement measures practiced most often by respondents.
- Thirty eight percent of respondents could suggest no community changes that would improve their own health. Of those who did make suggestions the most frequent was associated with recreational activities (31%). Another suggestion was improved access to health services (11%). Of this, 8% of respondents suggested better access to doctors.
Safety / Injury Prevention Summary

- Sixteen percent of respondents suffered an injury severe enough to limit normal activities.
- Males, First Nations/Aboriginal / Metis and French respondents were most frequently injured.
- The likelihood of injury declines with age.
- The most prevalent injury sites was a person’s home (43%), followed by a park or other place for recreation (14%), then a factory / warehouse/construction site (13%), followed by a farm (excluding farmhouse) at 11%.
- The most prevalent injury type reported was a sprain/strain (41%), followed by whiplash or spinal injury, then dislocation.
- Injuries were treated most often by alternative therapists (36%) followed by hospital emergency / urgent care (30%).
- More than half of injury sufferers required a one-day absence or less.

Health System Performance Summary

- Nine out of ten respondents have regular health care providers.
- Women are more likely then men to have a regular health care provider.
- Sixty-nine percent said it is either “somewhat easy” or “extremely easy” to get an appointment with a health care provider.
- Eight out of ten respondents were able to get the health care they needed, when they needed it.
- Fifty – eight percent knew “where to go” to get a concern addressed.
- A little more than eight out of ten respondents knew where to find information (85%).

Health Promotion

- One in three (34%) have used health promotion services in the past 12 months.
- Respondents over 65 years and those with less than a high school education assign extremely high importance to health promotion as well as being the main users.

Community Services

- One in five or 21% have used community services within the past 12 months.
- Respondents who are between the ages of 25 to 44 years and First Nations/Aboriginal/Metis were more likely to use community services.

Home Care / Personal Care Home (PCH)

- Two percent have used home care or PCH.
Hospitals and Emergency Medical Service (EMS)

- One in 3 have used a hospital or an ambulance service within the past 12 months of the survey.
- Users of the service were more likely to be between 25 to 34 years and either employed full time or not employed at all.
- With respect to the importance of services: hospitals and ambulance services ranked as the most important.

Refer to Appendix 5-1 for a copy of the survey and NE results.

5.2.5 North Eastman RHA Data

Information that was obtained internally from NEHA looks at the number of people receiving services within our RHA. It does not look at the utilization burden on our system when we care for residents from other RHA’s, for example, during the summer months when our population doubles and we care for many people outside our region and perhaps the province and/or country.

Most of the quantitative information comes from the statistical reports generated by the finance department. There are various measurements used depending upon the area being examined, for example:

- **Active cases**- refers to the total number of cases open including new cases and cases carried forward from previous months/years.
- **Open cases** refers to the number of cases opened.
- **Units of services** – diagnostic department and dietitians categorize one unit = one minute, however in other programs it may mean one unit = 1 hour of service.
- **Direct contacts** – may refer to contact with an individual, family, group or community. The specific contact is not usually specified.

As NEHA participates in this survey, another source used in relation to human resource indicators: staff turnover rates, length of time position is vacant and staff management ratio was the Annual Benchmarking Survey 2001 and 2002, conducted by the Human Resources Benchmarking Network. This document contains ‘benchmark’ statistics that are divided into the health care sector and municipal sector. The averages from the survey are taken from the health care sector.

5.2.6 Manitoba Health Injuries of Manitoba – A Ten Year Review. January 2004

This information comes from three sources:

a) Manitoba Vital Statistics Deaths Data Base.
b) Population data from Manitoba Health’s Registration System.
c) Data on injury hospitalization comes from Manitoba Health’s hospital discharge abstract database.

The information includes:

b) Deaths occurring from injury - This information includes all Manitobans who died in Manitoba during the calendar years 1992 to 1999.
The rates in the injury report are crude rates therefore, a direct comparison of North Eastman data to Manitoba overall is not possible. The crude rate does not take into account differences in distribution of the population by age or sex. You are able to compare a specific age group in North Eastman to the same age group in Manitoba. For all information, the residence of the injured person determines their RHA, not the location of their hospitalization or death.

5.3 PRIMARY SOURCES OF QUALITATIVE INFORMATION

During the current CHA project, we conducted two major qualitative studies, one being the Focus Groups and the other the Community Validation Workshops entitled: “An Overview of Your Community’s Health Status.”

5.3.1 Focus Groups

A Focus Group provides the ability to examine a specific topic from different perspectives in a safe environment. A Focus Group is meant to be informal in order to encourage open discussion among the participants. In NE the NEHA staff community consultation team designed several questions. A Focus Group generally involves 6-12 people that broadly represent a particular segment of the population. Our Focus Groups were made up of specific age groups located in five of our health districts.

Focus Group Strengths

a) Provides a venue for learning about the group’s needs.
b) Participants frequently feel good about the discussion, as there often is consensus about various topics.
c) The informal environment is less intimidating for participants.
d) It is one way to gauge the opinions of the public.

Focus Group Limitations

a) Recruitment criteria can create biases in the opinions. Refer to recruitment process below. Our selection criteria were not specific to a particular organized group. One exception was the youth groups (except Seymourville, Manigotagan, and Bissett) who were selected by the schools.
b) Limited number of participants, therefore it isn’t a representative sample from the community. It is felt however that when opinions were similar across or between ages and health districts, this was in all likelihood an important idea or concerns that may require some follow up.
c) There is always the potential for participants to be influenced by the interaction among group members. This limitation was minimized due to the fact that our facilitator was experienced.
d) Resource intensive. It was very time consuming, recruiting, setting up and conducting these workshops. Although participants were not paid they could claim mileage.
NEHA Focus Groups- June to November 2003

NEHA hired a professional researcher, Lesley Anne Fuga, to facilitate the Focus Groups. She was asked to conduct twenty community Focus Groups and one staff Focus Group. The CHA Assistant was assigned the role of assistant to the facilitator i.e. recruiting, organizing and documenting the discussions of the Focus Groups. This worked well as it ensured consistency between Focus Groups. Two additional Focus Groups were held with the aboriginal people in Seymourville, and were facilitated by NEHA staff members.

The CHA Consultation Team assisted in the development of questions for the Focus Groups.

**Purpose (developed by the CHA Core Team)**

To understand and explore the community's perception of health and health maintenance, its awareness of the health status of district communities, and its perceptions and feelings regarding accessibility of programs, services and supports. This information would then be used for program planning and ensuring appropriate delivery of services in order to meet the needs of our client population.

**Questions**

*Note: The questions asked of staff were the same as those asked of community members.*

The topic themes were broken down into four categories

1) Knowledge of health issues, which included questions such as what does good health mean and how does the community promote or support healthy living.

2) Knowledge of health services, which included questions on what health related programs people use, are the appropriate services available and knowledge on how the services can be accessed.

3) Barriers, which included questions on programs and services, which might be under utilized or not readily available, what NEHA could do to improve public awareness, acceptance, and participation to promote healthy lifestyles?

4) Communication which included questions on the awareness of articles like “Health Corner” and “Wellness Tips” that are in the local weekly newspapers, and how residents could be encouraged to participate in community consultation.
Community Focus Groups

a) Springfield, Brokenhead, Iron Rose, Blue Water, Winnipeg River

In total twenty community Focus Groups were held within North Eastman’s five districts. The initial two Focus Groups were held in June, providing valuable feedback influencing how future groups were conducted. The remaining 18 Focus Groups were scheduled from August to October 2003.

In each health district, Focus Groups were divided by age. We asked community leaders involved in various service clubs, organizations and recreational activities to provide names of possible participants.

The average number of participants in each Focus Group was seven. The total number of participants in all Focus Groups was 164 consisting of 56 males and 108 females.

b) Seymourville Focus Groups

Although Seymourville is in Blue Water Health District, it was felt to be valuable to hear from aboriginal people in our consultation process. Debbie Viel (Manager of Primary Health Care) and Myrna Suski (Manager of Public Health) facilitated two Focus Groups in Seymourville. The adult group consisted of two females and two males, whose ages were 65+ (1); 46-65 (1) and 18-45 (2). The youth group consisted of two females aged between 14 –17 years.

During the collation of the focus group information, the youth group was integrated into the other youth focus groups, and the adult group was integrated into the young adult group, as two out of the four participants were within this age group.

Staff Focus Groups

A staff Focus Group was held in November consisting of 12 staff, 10 females and two males. We had staff from the following job categories: Medical Records Technician, Community Mental Health Worker, Acute Care Licensed Practical Nurse (LPN), Diagnostics Technician, Public Health Nurse (PHN), Home Care Attendant, Personal Care Home (PCH) Recreation Worker, Office Assistant, Physician, Ambulance Coordinator, Volunteer from Palliative Care, and a Nurse Practitioner.
## Table 5.2 - 2003 Focus Group Attendance

<table>
<thead>
<tr>
<th>Gender</th>
<th>Youth Ages 14-17</th>
<th>Young Adult Ages 18-44</th>
<th>Middle Adult Ages 45-65</th>
<th>Seniors Ages 66+</th>
<th>Seymourville Youth</th>
<th>Seymourville Adults</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>17</td>
<td>7</td>
<td>13</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Females</td>
<td>25</td>
<td>19</td>
<td>25</td>
<td>25</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>26</td>
<td>38</td>
<td>40</td>
<td>2</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

### Discussion

The first Focus Group question was meant to be an icebreaker i.e. Why did you come? This discussion is not included elsewhere in the CHA Report.

**Responses:**
- They were asked and were curious.
- They were interested in health.
- They wanted to have input and saw it as an opportunity to participate and learn.
- The 66+ age group were also interested in being able to help, to meet people, enjoy themselves and to be mentally challenged. Some of them had parents or they required health care.
- The 45-65 age groups expressed some concern about future resources, family members were experiencing health challenges, or they wanted to help their community and hear each other’s points of view.
- The 18-44 age groups expressed interest in community participation. Some of them identified the event as an “evening out”.
- Some of the 14-17-age group viewed attending as a way to get out of class and there was nothing else to do anyway.
- Additional comments in the staff group included that it may be in their best interest to attend or they were volunteered to attend.

At the end of the group meetings, the general feeling overall was that people were pleased that they came, felt they had learned something and seemed to have a good time.

Recruiting participants and ensuring attendance was challenging. The 66+ age group consistently attended as they said they would. Of the 18-44 and 45-65 age groups, approximately one third of those who had previously agreed to attend cancelled during the confirmation call. However there was only one person from all the groups who confirmed at the confirmation call and did not show. The 14-17 age groups were recruited by the schools and therefore were a “captured” group, but even then there were a total of four who did not show up at the sessions.

The 14-17 year age groups were recruited through their respective schools. The first Focus Group Workshop in this age group was held in Iron Rose. Because of time restraints for this Group, the CHA Assistant phoned each of the parents and obtained permission for their child to attend. For the three remaining Groups, the Facilitator sent a ‘request for permission to attend letter’ to the schools. The schools then forwarded the letter, with a permission slip for signature attached, to the parent/guardian. The students returned the signed permission slip to the school before the Focus Group workshops were held.
Although Focus Group participants were not paid they were given the opportunity to claim mileage if they lived outside of the community where the Focus Group was being held.

At the beginning of each Focus Group meeting the facilitator spoke on confidentiality and the importance of what was said in the room remaining there. A form outlining the importance of confidentiality was prepared and given to each participant before the meeting began.

Refer to Appendix 5-2 for Focus Group Correspondence Letters

Handouts at all the Focus Group meetings included: the form outlining confidentiality, the Community Health Assessment 2003/04 pamphlet, the NEHA Directory of Health Services, November 2002, and the NEHA Health Services directory cards by district.

Within the CHA Report Focus Group information is inserted by:
1) Age and then linking the response by wherever the health district the focus group was conducted in. Sections 6 and 7.
2) By age and specific health district. Sections 8 through 12.

In this way one is able to get an understanding of the regional context or zoom in on the health district. If there is an age group missing, this implies that there was no information related to that topic raised / discussed in that particular Focus Group.

The Focus Group information is presented as follows in the CHA Report.

2003 Focus Groups

Focus Group information was either quoted or summarized to reflect participant’s perceptions. In some instances, their responses may not have always been factual, however it was felt that information, whether true or not, was an important indicator of the community’s knowledge and perceptions.

In order to have a detailed account of the process, there is a separate “process document” that includes the methodology and evaluation of this process.
5.3.2 Community Validation Meetings – “An Overview Of Your Community’s Health Status”

Members of the CHA Consultation Team volunteered to conduct two community workshops during April/May 2004 in each of our health districts: Springfield, Iron Rose, Brokenhead, Winnipeg River and Blue Water. The Validation Team was led by Elaine Heinl, Staff Development Coordinator for Acute Care.

An education session was held March 16, 2004 for the facilitators to ensure that the workshops were conducted and material collated in a consistent manner.

The purpose of the Community Validation Workshops is to:

1. Present to the community at a district level some key health status information gathered during the current CHA process [inform].
2. Provide community/staff participants an opportunity to identify “key issues” for their health district [consult].

GOALS:
- Increase community understanding of their district’s health status.
- Assist in identifying key issues affecting health at the district level.
- Continue to build a relationship with community members.
- Improve the quality of NEHA’s health projects and/or programs by better understanding the community’s view points.

A major limitation was the low attendance in every health district. The facilitators indicated that the discussions were good and the feedback from participants indicated the process was valuable and beneficial. Because of the low numbers, the information collected cannot be generalized to the broader community.

Table 5.3 - 2004 Validation Workshop Attendance

<table>
<thead>
<tr>
<th></th>
<th>Springfield</th>
<th>Winnipeg River</th>
<th>Iron Rose</th>
<th>Brokenhead</th>
<th>Blue Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance</td>
<td>12</td>
<td>8</td>
<td>15</td>
<td>11</td>
<td>22</td>
</tr>
</tbody>
</table>

The workshop consisted of two main components:

Presentation by Facilitators consisting of:

- An overview of the CHA process.
- Explanation of the Population Health Model and its determinants.
- A “snapshot” of some health status information organized under each determinant of health. The information was health district specific where possible. Due to time constraints only selected information was presented to the community.
Consultation Exercise

This was an important component of the workshop. To avoid personal ‘agendas’ the facilitators reinforced the point that each participant was speaking as a member of their community and to keep the health of the community (rather than the individual) foremost in their mind.

Note: Participants were informed that information from the issues they identified and general discussions may be included in the Community Health Assessment Report.

a) Participants were asked to review the issues under each of the health determinants. They were also asked to add any issues that they felt were important and not on the list i.e. ‘raised issues.’

b) The facilitators and participants added the “raised issues” to the list of existing issues under each health determinant. Participants were then asked to choose a limited number of issues under each determinant, that they felt were most important to the health of their community, and place a tick in the box beside the issue. The number of issues they could choose was dependent upon the number of issues under a particular determinant. For example, if a determinant had three issues or less then only one issue could be ticked.

Collation of Data

a) The facilitators added up the number of ticks under each determinant, identifying the issues that participants as a group felt were most important. This information was shared with the group.

b) When the two workshops within each health district were completed, facilitators collated the information into one record. The collated information was sent to the CHA Assistant.

c) The CHA Assistant identified the top three key issues in each health district. This was accomplished by counting the responses from the participants for each of the issues identified under all health determinants. Only the top three issues were reported in this report. In the case where there was a tie, there may have been more than three issues flagged within a particular determinant of health.
CHA Report Information Presentation

a) The key issues identified per health district were placed in the either the health district section or in Section 7 depending upon the determinant of health being discussed.

Validation meeting data is presented in the report as follows:

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Winnipeg River-Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in PCH Beds [Raised Issue]</td>
<td>50%</td>
</tr>
<tr>
<td>- Validation Workshop Participants felt that waiting time is too long. “Need more PCH beds”.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus groups - also mentioned the need for larger/more PCH beds (Blue Water, Springfield Seniors, and Winnipeg River).</td>
<td></td>
</tr>
</tbody>
</table>

The above example was an issue ‘raised’ by a participant i.e. it was not discussed during the formal presentation. Fifty percent of the participants stated that this was one of their key issues. Because this topic was related to health services it was placed in Section 7 of the report.

b) We didn’t want to lose information that was discussed during the workshops either about the other health issues or about raised issues. To limit repetitive information, the discussion information was presented only in the respective health district in which it was raised or in Section 7.

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>SPRINGFIELD GROUP DISCUSSIONS ON HEALTH SERVICES – COMMUNICATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>- Participants felt there is a need for more and better corporate communications.</td>
<td></td>
</tr>
</tbody>
</table>

This information represents other discussions that arose during the workshop that were a concern to participants and not presented during the formal presentation.

*Refer to Appendix 5-3 for the collation template used in the Validation Workshops by the facilitators.*
5.3.3 **NEHA Health Program Community Consultations**

All program managers from Home Care, Public Health, Acute Care, Primary Health Care, Long Term Care and Emergency Medical Services were asked to provide a summary of any consultations that had occurred within their program during the past several years. Consultations that took place at the regional level were also summarized.

5.3.4 **Glossary of Statistical Terms**

Statistical terms are not normally part of the daily vocabulary for most staff. A glossary of common statistical terms used in this report is provided.

*Refer to Appendix 5-4 for a glossary of statistical terms.*

5.4 **SUMMARY / CONCLUSION**

It is important that when a variety of data sources are used, that the strengths and limitations of the information are taken into account. Other factors should also be taken into consideration such as the variability between years, the research technique, and the ability to generalize to the broader population.

Variations such as dates of collection, collection methodology, information sources and how the information was collated are important factors to be considered when comparing data.

Focus group and Validation Workshop information, while valuable cannot be generalized to the broader communities.
5.5 REFERENCES


16. Ibid.
CONTENTS

5-1 North Eastman Provincial Survey Questions and Corresponding Responses – November/December 2003.

5-2 Focus Group Correspondence Letters

5-3 Validation Workshop Collation Template

5-4 Glossary of Common Statistical Terms
APPENDIX 5-1

North Eastman Provincial Survey Questions and Corresponding Responses
November/December 2003


Note: Ostenfeld is not geographically located in NE but we are reassured from Acumen that because it represents only one survey, it will not affect the total responses and interpretation of the information.

North Eastman Survey Questions and Corresponding Responses
(N=400)

GENDER: Male..................51% Female.................49%

Hello, I'm calling on behalf of the Regional Health Authorities of Manitoba. My name is and I'm from acumen research and we wish to speak to the person in your household who is 18 years of age or older and whose birthday will come next. Is that you? We wish to do a brief 15 minute survey about health. Do you have a few minutes now?
Q1 Can you please tell me the name of the city, town, or community you live in?

Albert Beach............................................. <1%
Anola .................................................... 7%
Beaujolais ........................................... 21%
Belair .................................................. 1%
Bloodvein River I.R. #12 ......................<1%
Brokenhead ......................................... 1%
Cloverleaf .......................................... 1%
Cook's Creek ....................................... 1%
Dugald .......................................... 3%
East Braintree ................................... 1%
Elma .................................................. 1%
Fort Alexander ......................................... <1%
Fort Alexander I.R. #3 ...................... <1%
Garson ........................................... 2%
Great Falls ......................................... 2%
Hadashville ........................................ 2%
Hazelglen ........................................ <1%
Hazelridge ........................................ 2%
Hillside Beach ................................... 1%
Hollow Water I.R. #10 ......................... 1%
Lac du Bonnet .................................... 15%
Little Black River I.R. #9 .................... 1%
Manigotagan ....................................... 1%
McMunn ........................................... <1%
Oakbank ........................................ 10%
Ostenfeld ........................................ <1%
Pinawa ........................................... 10%
Pine Falls ......................................... 5%
Pointe du Bois ................................... 1%
Powerview ........................................ 1%
Prawda ........................................... 1%
Rennie ........................................... <1%
Sapton ........................................... <1%
Seddon's Corner ..................................<1%
Seven Sisters Falls ............................. 1%
Springwell ........................................ <1%
St. George .......................................... 1%
Ste. Rita ........................................... 1%
Traverse Bay ...................................... 2%
Tyndall ........................................... 3%
Victoria Beach ................................... 1%
Vivian ............................................ <1%
Wanipigow ....................................... <1%
Whitemouth ...................................... 3%
Just before we begin, I would like to assure you that all the information gathered through this study is strictly confidential. We guarantee your anonymity – no names will be attached to the research findings. The information gathered in this study will be used for future health planning by your Regional Health Authority. Please also note that this call may be monitored for quality control purposes.

Q2 Would you say your health is generally… **READ LIST**

Excellent....................................................... 22%
Very good..................................................... 34%
Good............................................................. 34%
Fair ................................................................. 7%
Or, poor? ....................................................... 3%
Don’t know / refused................................. 0%

Q3 During the past 30 days, did you have any difficulties with your physical health that kept you from doing the things you usually do in a typical day? **IF YES ASK** … would you say it limited your normal activities a little, a lot or totally?

No................................................................. 78%
A little............................................................. 9%
A lot.............................................................. 10%
Totally............................................................. 3%
Don’t know / refused...................................... 0%

Q4 During the past 30 days, did you have any difficulties with your emotional health, like depression, stress or anxiety that kept you from doing the things you usually do in a typical day? **IF YES. ASK** … would you say it limited your normal activities a little, a lot or totally?

No................................................................. 86%
A little............................................................. 11%
A lot.............................................................. 3%
Totally............................................................. 1%
Don’t know / refused...................................... 0%

Q5 Compared to others your age, would you say your health is… **READ LIST**

Excellent....................................................... 18%
Very good..................................................... 35%
Good............................................................. 35%
Fair ................................................................. 9%
Or, poor? ....................................................... 2%
Don’t know / refused................................. <1%
Q6 What, if anything, is the main thing you do on a daily basis to improve your health?

**PROBE.**

**Exercise**
I walk/run/jog outside everyday for a certain distance/amount of time ....................... 22%
I walk outside several times a week for a certain distance/amount of time ..................... 9%
I regularly workout at home ....................... 8%
I have physically demanding work/lifestyle that gives me plenty of exercise ............. 6%
I engage in sports regularly (hockey, curling, volleyball, etc.) .................................. 5%
I go regularly to a fitness club/gym/ work out/pool/yoga class ......................... 4%
I ride/use an exercise bicycle/machine everyday for a certain distance/amount of time .... 3%
I ride/use an exercise bicycle/machine several times a week for a certain distance/ amount of time ............................................ 3%
I do housework that is physically demanding 2%
I walk my dog at least once a day ........... 1%
I am resting a lot because of my age/ doctor’s orders ............................................. 1%
I try to get a good/proper sleep ............. 1%

**Food**
I eat healthy foods/balanced diet/foods in moderation everyday .................................. 7%
I eat lots of fruits/vegetables/whole grains .... 3%
I follow the Canada/Manitoba Food guide 1%
I drink plenty of water ................................. <1%
I eat organic food ........................................ <1%

**Medications/supplements/vitamins**
I take vitamins/supplements/herbal remedies 3%
I take my daily-prescribed medications ...... 1%
I am on a diet/diet supplements ..................... 1%

**Avoidance**
I avoid eating foods with high fat content.... 3%
I avoid junk food/fast food ......................... 3%
I avoid eating foods high in sugar ............. 1%
I avoid eating foods high in fat and sugar .... 1%
I avoid fried foods ...................................... <1%

**Nothing/other/don’t know/refused**
I do nothing in particular to improve my health ......................................................... 8%
Other .......................................................... 3%
Don’t know/refused ........................................ 0%
Q7 What types of things would you like to see in your own community that you believe could help you to improve your health? **PROBE**

**Health Services**
- Better access to doctors..................................... 8%
- A regional/local hospital with emergency care......................... 3%
- More/better services/facilities in hospital. ...... 2%
- More/better health education................................. 2%
- More/better health services in community..... 1%
- More/better transportation to health services. 1%
- Better availability and affordability of prescription drugs................................. 1%
- Better home care services in my community.<1%
- More/better personnel working in the hospital. ..................<1%
- Access to a chiropractor.................................<1%
- More specialists for rural areas. ................<1%
- Keep the local/regional hospital open.........<1%

**Recreation facilities**
- Exercise gym/fitness studio/spa ...................... 12%
- A recreation facility offering swimming/aerobics/weight lifting/cycling/programs for seniors/ ............................................. 6%
- A swimming pool (indoor/outdoor) or longer pool hours................................................... 6%
- A wellness/community health centre that has exercise programs available in it.............. 3%
- More/better sports facilities............................. 3%
- Trails or paths for cross-country skiing/hiking/cycling/walking.................................... 1%
- Cheaper/free facilities........................................... 1%
- Indoor walking track and running track.........<1%

**Recreation programs**
- More/better exercise programs/recreational activities................................................. 6%

**Other/don’t know/refused**
- Other.................................................................. 7%
- Nothing I can think of............................................ 38%
- Refused............................................................. 0%
Q8  When you are feeling anxious or upset and you need to talk, do you have someone you can count on to listen to you? **IF YES ASK ...** Would that be a little of the time, some of the time, most of the time or all of the time?

- No................................................................. 10%
- A little.......................................................... 8%
- Some............................................................ 4%
- Most.............................................................. 33%
- All................................................................. 45%
- Don’t know / refused.................................... 1%

Q9  Applies to other RHA only.

Q10 In the past 12 months, did you have any injuries that were serious enough to limit normal activities, such as work, school, or regular activities outside of the home?

- Yes............................................................... 16%
- No............................................................... 84%  **GOTO Q16**
- Don’t know / refused.................................... <1%  **GOTO Q16**

Q11 Thinking back at your most recent injury, where did it happen? **(IF RESPONDENT SAYS ‘AT WORK’, PROBE FOR TYPE OF WORKPLACE) (N = 65)**

- In a home or the surrounding yard............ 41%
- Factory, warehouse, or construction site..... 13%
- In a park or other place for recreation...... 13%
- Farm (excluding farmhouse).................... 10%
- On a street, sidewalk, highway or in vehicle 6%
- In a workplace ............................................. 6%
- Other institution (e.g., church, hospital, theatre, civic building)......................... 3%
- Sports or athletics area (include school sports areas)............................................ 2%
- Commercial area (store, restaurant, bar, office, airport or other transport terminal).... 1%
- Other............................................................ 0%
- Don’t know / refused................................. 5%
Q12  What type of injury did you have? For example, was it a broken bone, or burn?  (N = 65)

Sprain or strain ............................................. 41%
Whiplash or spinal injury ................................. 13%
Dislocation................................................... 8%
Multiple injuries ........................................... 8%
Broken or fractured bones ............................... 5%
Injury to internal organs ................................. 3%
Cut, puncture, animal bite (open wound) ........ 2%
Scrape, bruise, blister .................................... 2%
Burn, scald, chemical burn ............................. 1%
Other .......................................................... 19%
Don’t know / refused ................................. 0%

Q13  And in the past 12 months, about how many days of school or work did you miss as a result
of this injury?  (N = 65)

No time lost ................................................. 46%
1 day .......................................................... 9%
2 days .......................................................... 5%
3 days .......................................................... 4%
4 to 7 days ................................................... 8%
8 to 14 days ............................................... 6%
15 to 30 days ............................................... 5%
31 to 60 days ............................................... 14%
61 to 90 days ............................................. 1%
91 to 180 days ............................................ 1%
Don’t know / refused .................................. 1%

Q14  And, if you went to see anyone about treatment for your injury, where did you go?  (N = 65)

Alternate therapies like massage, reflexology,
chiropractor, acupuncture, physiotherapist .... 36%
Hospital emergency or urgent care dept ...... 30%
Family doctor .............................................. 18%
Hospital non-emergency or outpatient
clinic (e.g., day surgery, cancer) ............. 6%
Community health centre or clinic .......... 6%
Other .......................................................... 2%
Did not seek medical treatment ............ 3%
Don’t know / refused ............................... 0%
Q15 What are you now doing, if anything, to prevent this kind of injury from happening again?  
CIRCLE ALL THAT APPLY (N = 65)

- Being more careful................................. 48%
- Using protective gear/safety equipment........ 7%
- Sought professional help.......................... 6%
- Took safety training................................. 5%
- Changing physical situation / moved out or away / ended relationship................. 4%
- Taking medication / had medical testing / had surgery to prevent further injury.............. 4%
- Gave up other activity (exclude alcohol or drug use).......................... 2%
- Gave up alcohol / drug use.......................... 0%
- Other.................................................... 24%
- Nothing can be done about it...................... 12%
- No precautions are being taken.................. 13%
- Don’t know / refused................................. 2%

Q16 Do you have a regular health care provider, such as a doctor or nurse that you can see about your health?

- Yes.................................................... 88%
- No.................................................... 12%
- Don’t know / refused................................. 1%

Q17 Please tell me how easy it is for you to get an appointment to see a health care provider, such as a doctor, nurse, public health or home care worker? Would you say it is extremely difficult, somewhat difficult, neither difficult nor easy, somewhat easy, or extremely easy to get such an appointment?

- Extremely difficult................................. 4%
- Somewhat difficult................................. 18%
- Neither difficult nor easy.......................... 9%
- Somewhat easy........................................ 42%
- Extremely easy........................................ 26%
- Don’t know / refused................................. 2%
Now I will read you a list of statements. Please tell me whether you agree, disagree, or do not feel strongly either way. Would that be strongly agree/disagree, or somewhat agree/disagree?

<table>
<thead>
<tr>
<th>Q18</th>
<th>“When I need a particular health care service, I am usually able to get it.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q19</th>
<th>“When I have a concern about the health care system in my region, I know where to go to get my concern addressed.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q20</th>
<th>“If I need specific information about my health or a particular treatment, I know where to go or who to call about it.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Now we would like to get your opinion about health care services in your region. Using a scale of 1 to 5 where 1 is not at all important and 5 is extremely important, please tell me how important to you are ...

<table>
<thead>
<tr>
<th>Q21</th>
<th>Health promotion, such as flu shots, blood pressure clinics, or health fairs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q22</th>
<th>Community services, such as public health or mental health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q23</th>
<th>Home care and personal care homes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q24</th>
<th>Hospitals and ambulance services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Q25  **IF RESPONDENT DOES NOT CLEARLY HAVE A “#1” AND “#2” CHOICE, ASK** … and which of {health promotion} or {hospitals and ambulance services} or {community services} or {home care and personal care homes} is **most** important to you? And which is second most important to you?

**MOST IMPORTANT**

- Hospitals and ambulance services ................ 69%
- Home care and personal care homes ............. 13%
- Community services .................................... 9%
- Health promotion ........................................ 8%
- Don’t know / refused .................................... 1%

**SECOND MOST IMPORTANT**

- Home care and personal care homes ............ 34%
- Health promotion ................................. 26%
- Community services ................................. 20%
- Hospitals and ambulance services ............ 18%
- Don’t know / refused ............................... 2%

Q26  Have you used a health promotion service, such as a flu shot, a blood pressure clinic, or a health fair, in the past 12 months?

- Yes .......................................................... 34%
- No ............................................................ 66% **GO TO Q28**
- Don’t know / refused ............................... 0% **GO TO Q28**

Q27  How would you rate your experience? Would you say it was… **READ LIST**  (N = 137)

- Excellent ................................................ 46%
- Very good ............................................... 26%
- Good ........................................................ 25%
- Fair .......................................................... 3%
- Or, poor? .................................................. 1%
- Don’t know / refused ............................... 0%

Q28  Have you used community services, such as public health or mental health services in the past 12 months?

- Yes .......................................................... 21%
- No ............................................................ 79% **GO TO Q30**
- Don’t know / refused ............................... <1% **GO TO Q30**
Q29  How would you rate your experience? Would you say it was…  READ LIST  (N = 83)

Excellent....................................................... 29%
Very good.................................................... 29%
Good............................................................ 27%
Fair ............................................................. 13%
Or, poor? ..................................................... 2%
Don’t know / refused................................. 0%

Q30  Have you personally used home care or a personal care home in the past 12 months?

Yes............................................................... 2%
No............................................................. 97%  GO TO Q32
Don’t know / refused................................. <1%  GO TO Q32

Q31  How would you rate your experience? Would you say it was…  READ LIST  (N = 10)

Excellent....................................................... 41%
Very good.................................................... 19%
Good............................................................ 0%
Fair ............................................................. 23%
Or, poor? ..................................................... 9%
Don’t know / refused................................. 9%

Q32  Have you used a hospital or an ambulance service in the past 12 months?

Yes............................................................... 33%
No............................................................. 67%  GO TO Q34
Don’t know / refused................................. 0%  GO TO Q34

Q33  How would you rate your experience? Would you say it was…  READ LIST  (N = 132)

Excellent....................................................... 30%
Very good.................................................... 26%
Good............................................................ 26%
Fair ............................................................. 9%
Or, poor? ..................................................... 7%
Don’t know / refused................................. 2%
Q34 Now I want to read you a list of health services. Please tell me if this health service is offered in your area? **READ LIST AND CIRCLE ALL THAT APPLY.**

- Doctors ........................................................ 90%
- Home care ..................................................... 88%
- Public health nurses ...................................... 88%
- Services to seniors ........................................ 87%
- Social workers .............................................. 77%
- Nurse practitioner ........................................ 60%
- Clinical dietitian.......................................... 53%
- Mental health services.................................. 53%
- Diabetes education ....................................... 52%
- Wellness facilitators .................................... 47%
- None of the above ......................................... 1%
- I don’t know about any services in my area. 1%
- Refused.......................................................... 0%

Q35 - 43 Applies to other RHA only.

Q44 What age category are you in – are you under 45 or are you 45 or older? **READ LIST**

- 18 to 19............................. 4%
- 20 to 24......................... 8%
- 25 to 29......................... 7%
- 30 to 34........................... 8%
- 35 to 39........................... 11%
- 40 to 44........................... 11%

- 45 to 49........................... 11%
- 50 to 54........................... 9%
- 55 to 59........................... 8%
- 60 to 64........................... 7%
- 65 to 69........................... 6%
- 70 to 74........................... 5%
- 75 or over ...................... 7%
- Don’t know / refused..... 0%
Q45  Please tell me which of the following best describes your level of schooling? **READ LIST, CHOOSE HIGHEST LEVEL ATTAINED**

- Less than high school.......................... 17%
- Graduated high school.......................... 29%
- Some college or university...................... 16%
- Completed college or technical school........ 21%
- University graduate.............................. 17%
- Don't know / refused.............................. <1%

Q46  To which ethnic or cultural groups did your ancestors belong?

- Canadian......................................... 9%
- English........................................... 10%
- German............................................ 10%
- Scottish.......................................... 3%
- Ukrainian........................................ 10%
- Irish.............................................. 1%
- French............................................ 5%
- First Nations / Aboriginal..................... 6%
- Polish............................................. 3%
- Metis............................................. 2%
- Dutch / Netherlands............................ 4%
- Filipino.......................................... 0%

- Russian.......................................... 0%
- Icelandic........................................ 1%
- Swedish.......................................... 1%
- Italian........................................... 1%
- Belgian.......................................... <1%
- Norwegian...................................... 0%
- Jewish........................................... 0%
- Welsh............................................ <1%
- Multiple origins............................... 23%
- Other............................................ 7%
- Don't know / refused......................... 4%
Q47  Which of the following best describes your current employment situation? **READ LIST, IF MORE THAN ONE, ASK…** Which do you consider to be your primary source of income?

- Employed full-time ......................... 39%
- Employed part-time .......................... 15%
- Self-employed / home-based business .... 12%
- Retired ........................................ 24%
- Not employed .................................. 10%
- Don’t know / refused ...................... <1%

Q48  And how many people, including both adults and children, are currently living in your household?

1 ...................................................... 10%
2 ...................................................... 36%
3 ...................................................... 25%
4 ...................................................... 16%
5 ...................................................... 9%
6 .....................................................  3%
7 .....................................................  1%
Don’t know / refused ....................... 0%

Q49  Please tell me which of the following categories best describes your yearly family income? Is it below $40,000 or $40,000 or over? **READ LIST**

- Under $10,000 ................................ 1%
- $10,000 to $19,999 ........................... 7%
- $20,000 to $29,999 ............................ 9%
- $30,000 to $39,999 ............................ 16%
- $40,000 to $49,999 ............................ 13%
- $50,000 to $59,999 ............................ 13%
- $60,000 to $69,999 ............................  7%
- $70,000 to $79,999 ............................  7%
- $80,000 to $89,999 ............................  4%
- $90,000 to $99,999 ............................  2%
- $100,000 or over .............................  5%
- Don’t know / refused ...................... 17%

Q50  Can you please tell me your postal code?

- R0C .............................................. <1%
- R0E ............................................. 100%

I'd like to thank you for taking the time to participate in this survey.

**MONITORED:** Yes 7%  No 93%
APPENDIX 5-2
Focus Group Correspondence Letters

It is important that all participants were aware of the purpose of the focus groups and that each participant voluntarily chose to participate.

Letters attached:

1. To community leaders to assist in recruiting focus group participants
2. To the parents or guardians of minors for the youth groups.
3. To all participants who requested a summary of the focus group meeting
4. Thank you to community leaders
DATE

COMMUNITY CONTACT

DEAR CONTACT,

I’m writing on behalf of the North Eastman Health Association (NEHA) Community Health Assessment (CHA) project. Last undertaken in 1997, the CHA is one means by which the Regional Health Authority puts its finger on the pulse of the community. The purpose of this process is to ensure that NEHA programs and services are appropriate to the health status of the community it serves. Today, NEHA is inviting your participation in the Community Consultation phase of the CHA.

I have been hired by NEHA as the Program Assistant for the Community Health Assessment and one of my tasks is to organize focus groups with residents of your health district. NEHA wants to hear their views on health, and things that affect health, in your community. We will be holding a series of 4 meetings within each district each comprised of community members within a specified age group. As a community leader, we are asking for your help in recruiting focus group participants.

As we discussed by telephone on DATE, a meeting will be held on TIME, DATE, PLACE. The meeting will last about an hour and a half to two hours. At each meeting about 8-10 people from the region will gather to share ideas, perspectives, and experiences focused on a topic identified by residents in the 1997 CHA, and selected by NEHA workers responsible for program planning and delivery. No specialized knowledge or background is required to participate. We want to hear the opinions of the people we serve.

Will you please refer to me # OF PEOPLE, #MEN / WOMEN, AGES who might be interested to attend the DATE, PLACE, TIME meeting? Once you have established the potential participant’s availability and interest in learning more, I will call that person to answer any questions they might have. You can call me at (204)367-8077 with names and phone numbers, or you can email me at morvis@mb.sympatico.ca.

It is important to assure people that your passing their number on to me does not obligate them to participate. Likewise, given the anticipated challenges we face in recruiting a group, we are casting our net wide and may not be able to invite everyone we speak with at this time. Also advise them that this research is being conducted within strict ethical guidelines and focus group participants will not be required to reveal any information they consider to be private. All discussion within a group is confidential. No report will contain any identifying information.

If you have other questions or concerns, please feel free to call me directly at (204)367-8077. If you need to verify any of the above, you can contact Suzanne Dick, CHA Project Coordinator for NEHA at (204)268-7406.

I sincerely hope you are willing to assist us as we embark on an important initiative to include the community in the health care planning process. Thank you in advance.

Yours truly,

Carol Orvis
CHA Program Assistant
Phone: 204-367-8077
morvis@mts.net
Date

Dear Parent or guardian,

I’m writing on behalf of the North Eastman Health Association (NEHA) Community Health Assessment (CHA) project. Last undertaken in 1997, the CHA is one means by which the Regional Health Authority puts its finger on the pulse of the community. The purpose of this process is to ensure that NEHA programs and services are appropriate to the health status of the community it serves. Today, NEHA is inviting youth participation in the Community Consultation phase of the CHA.

I am an independent researcher who has been contracted to undertake focus group interviews with students in your health district. NEHA wants to hear their views on health, and things that affect health, in your community. In total, we will be holding a series of 4 meetings within each NEHA district, each comprised of community members within a specified age group. We are asking for your permission to speak with your son or daughter who is between the ages of 14 and 17.

An average meeting will take about an hour and a half, and will be held in your local school. About 8-10 youth will gather to share ideas, perspectives, and experiences focused on questions developed by NEHA workers responsible for program planning and delivery. No specialized knowledge or background is required to participate. We want to hear the opinions of the people we serve.

The questions we ask are very general in nature, and are designed to learn how young people think about health, keeping healthy, and health care services. We cannot predict what people might choose to talk about during our discussions. The purpose of our project is to find out what is important to them. This research is being conducted within strict ethical guidelines and focus group participants will not be required to reveal any information they consider to be private. We will not reveal any identifying information about group members. No one is obligated to participate. If you would like to speak to the researcher before you decide, I would be happy to take your call.

Most focus group participants enjoy this opportunity to share their views and possibly have an influence on health care delivery. The discussions are usually lively and we all get a chance to hear other opinions on common themes. If you have other questions or concerns, please feel free to call me directly at (204) 444-7888. If you need to verify any of the above, contact Suzanne Dick, CHA Project Coordinator for NEHA at (204) 268-7406.

I sincerely hope you are willing to assist us as we embark on an important initiative to include the community in the health care planning process. Thank you in advance.

Yours truly,

Lesley Anne Fuga
April 13, 2004

Dear North Eastman Resident,

Several months ago you participated in a focus group as part of North Eastman Health Association’s (NEHA) Community Health Assessment (CHA) with Lesley Anne Fuga as the facilitator. I am writing this letter in follow up of your request for a written summary as indicated by the self addressed envelope you left with Lesley Anne. Please be assured that your names have not been kept on any record. The groups would not have been successful if community members such as you had not given of their time to participate. We appreciate the effort you made to come out to the focus group and share your thoughts and experiences.

We conducted 21 focus groups in total. Twenty groups represented community residents, and one group was made up of staff only. The focus groups were organized by age and NEHA health district, with four age groups being interviewed in each of the five NEHA health districts. All groups were asked the same series of questions, although groups chose to discuss topics which were of interest to them.

The enclosed report summarizes the comments of all groups in your age bracket. The CHA Technical Report will include much more detail from each focus group. There will also be a CHA Community Report that includes information gained from many sources in addition to the focus groups, and will be available later this year.

We would also like to invite you to attend the Community Validation meetings, which are a part of the CHA process. We have enclosed a poster, which lists the Validation Workshop schedule for your district. If you are interested please call Susan Musey at (204) 753-3106 to register.

Again, thank you for taking part in the Community Health Assessment.

Sincerely,

Suzanne Dick
CHA Research & Project Coordinator

Carol Orvis
CHA Project Assistant

Attachment: Validation Workshop schedule
DATE

ADDRESS

DEAR COMMUNITY LEADER,

I am writing on behalf of the North Eastman Health Association (NEHA) Community Health Assessment Project (CHA). I would like to thank you for assisting me with recruiting people within your community to attend our Focus Group Meetings. From feedback received at the end of the meetings, we concluded that most people who attended were happy to contribute, felt they had learned something and seemed to have enjoyed participating.

The next phase of the CHA Project is to hold Validation Workshops. The Workshops will be an opportunity for the public to hear an overview of the findings to date from the work done on the CHA Project.

I have enclosed a poster, which lists the Validation Workshops scheduled for your health district. You are invited to attend one of these workshops. Please call Susan Musey at (204)753-3106 to register. I would also ask if you would post this announcement in some visible location within your community for others to see.

Again, I sincerely thank you for your assistance as we continue our work in this important imitative to include our communities in the health care planning process.

Yours truly,

Carol Orvis
CHA Program Assistant

Attachment: Validation Workshop Schedule
APPENDIX 5-3
Validation Workshop Collation Template

This is the template by which the validation workshop facilitators used to collate the information presented by participants during the workshops.

North Eastman Health Association
Community Health Assessment – Validation Workshops

SUMMARY

**Summary Must be returned to Suzanne within 1 week of completion of last workshop**

FACILITATOR NAMES

________________________________________

________________________________________

WORKSHOP LOCATION – DATE – TIME

1. ______________________________________

2. ______________________________________

NUMBER OF PARTICIPANTS:

Workshop # 1. ______________

Workshop # 2. ______________

RESULTS OF KEY ISSUE EXERCISE
Please complete attached summary pages of the results of the Key Issue Exercise for each determinate of health.

COMMENT SUMMARY:
Record summary of comments around each key issue (on comment summary page)

PARKING LOT ISSUES (Use reverse of page if needed)
KEY ISSUE EXERCISE COMMENT SUMMARY:

1. Health Child Development

2. Personal Health Practices and Coping Skills

3. Health Services

4. Biology and Genetic Endowment
5. Social Support Networks

6. Income and Social Status

7. Education

8. Physical Environment

9. Employment and Working conditions
**APPENDIX 5-4**
**Glossary of Common Statistical Terms**

**Crude Number** – refers to the actual number of people with a particular condition. ¹

**Generalizability** – “That quality of a research finding that justifies the inference that it represents something more than the specific observations on which it was based.” ²

**Incidence**– Looks at new events or cases of disease that develop in a population of individuals at risk during a specified time interval. Cumulative incidence is defined as:

\[
\frac{\text{Number of new cases of a disease during a given period of time}}{\text{Total population at risk}}
\]

**Mean**- “An average, computed by summing the values of several observations and dividing the by the number of observations.” ⁴

**Median** - “The median or 50th percentile describes the literal “middle” of the data. It is defined as the value above or below which half the observations fall.” ⁵

**Prevalence**– Looks at individuals in a population who have the disease at a specific instant

\[
\frac{\text{Number of existing cases of a disease at a given point in time}}{\text{Total population}}
\]

**Proportion** – “…those who are included in the numerator must also be included in the denominator, such as the proportion of women over the age of 50 who have had a hysterectomy…and is often expressed as a percentage.” ⁷

**Qualitative analysis** - “The nonnumerical examination and interpretation of observations for the purpose of discovering underlying meanings and patterns of relationships.” ⁸

**Qualitative analysis** – “The numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect.” ⁹

---

³ Ibid pg. 58.
⁶ Ibid pg. 57.
⁷ Ibid pg. 56.
⁹ Ibid pg. G6
Rate - “is a ratio in which there is a distinct relationship between the numerator and the denominator and, most essentially, a measure of time is an intrinsic part of the denominator. “ Example: The number of colds per 1000 per elementary school students during a 21- month period.\(^\text{10}\)

Reliability – “ That quality of measurement method that suggests that the same data would have been collected each time in repeated observations of the same phenomenon.” \(^\text{11}\)

Standardized rates – Usually for age and gender. This mathematically removes the effects of different population structures that may influence overall rates of use of health care, thereby allowing for a fair comparison among regions with different age and sex population distribution.\(^\text{12}\)

Statistical Significance – “…describes how much confidence to put in the results. If a difference is “statistically significant, “then this difference is large enough that we are confident it’s not just due to chance. When you see a large difference that is NOT statistically significant, it is telling you that this rate is probably not different from the comparison rate, and that it could fluctuate greatly from year to year. ” \(^\text{13}\)

Validity - “ A descriptive term used of a measure that accurately reflects the concept that it is intended to measure.”\(^\text{14}\)

Weighting – “ procedure employed in connection with sampling whereby units selected with unequal probability are assigned weights in such a manner as to make the sample representative of the population from which it was selected.” \(^\text{15}\)


\(^{15}\) Ibid. Pg. G8.
6.1 GEOGRAPHICAL OVERVIEW

Description / NE Map

The North Eastman (NE) Region extends east to the Ontario border, north to the 53rd parallel, west to Lake Winnipeg and the Rural Municipality of St. Clements, and south slightly beyond the Trans-Canada Highway (p. 2).

North Eastman Health Association divides NE Region into six health districts. These districts correspond to how information is collected by Manitoba Health. These health districts include: Springfield, Brokenhead, Iron Rose, Winnipeg River, Blue Water and Northern Remote.

A map follows with a detailed description of communities and municipalities located in each health district. NE has a diverse geography, ranging from agricultural land in the southwest, to the eastern area which boasts an expanse of provincial parks and vacation resorts. Approximately one-third of our region is accessible only by air, water or a winter road system. Springfield and Brokenhead Health Districts are located in close proximity to Winnipeg.

This section of the report focuses on information at the regional level.
Geographical Boundaries

The North Eastman Health Association Inc. (NEHA) has broken up NE Region into 6 health districts. When we talk about districts in this report it is to these districts that we will be referring to. Information collected by Manitoba Health and Manitoba Centre for Health Policy has also used these districts for aggregating their information.

Table 6.1 Communities Within North Eastman Region’s Health Districts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lac du Bonnet RM (061)</td>
<td>Brokenhead RM (016)</td>
<td>RM Springfield (146)</td>
<td>Reynolds RM (186)</td>
<td>Powerview Village (100)</td>
<td>Unorganized Territories</td>
</tr>
<tr>
<td>-SEDDON’S CORNER-ROE1GO</td>
<td>-MISKWA-ROE1GO</td>
<td>-EAST BRAINTREE ROE1GO</td>
<td>-POWerview ROE1PO</td>
<td>-BERENS RIVER FN-ROBOAO</td>
<td></td>
</tr>
<tr>
<td>-Brightstone</td>
<td>-TYNDALE-ROE2BO</td>
<td>ROE OLO</td>
<td>-LITTLE GRAND RAPIDS FN-ROBOO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Brightstone Colony</td>
<td>-Allegro</td>
<td>-HADASVILLE-ROE1O</td>
<td>-NEGGINAN-ROBOZO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Lee River</td>
<td>-Cloverleaf</td>
<td>-RENNE-ROE1RO</td>
<td>-BLOODVEIN-ROE1O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-McArthur Falls</td>
<td>-Cromwell</td>
<td>-McMunn</td>
<td>-PRINCESS HARBOUR-ROE1O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Minster Ridge</td>
<td>-Denacross</td>
<td>-Medika</td>
<td>-ROE1RO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Moss Spur</td>
<td>-Ladywood</td>
<td>-Molson</td>
<td>-LOON STRAITS-ROE1XO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Spring Well</td>
<td>-Lydiatt</td>
<td>-Prawda</td>
<td>-POINAWA-ROE2G0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-St. Ouens</td>
<td>-Beausejour Town (017)</td>
<td>-West Hawk Lake</td>
<td>-ROE1XO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lac du Bonnet Village(062)</td>
<td></td>
<td></td>
<td></td>
<td>-UNORGANIZED TERRITORIES</td>
<td></td>
</tr>
<tr>
<td>-BERNIC LAKE -ROE1GO</td>
<td>-Pinawa Village(018)</td>
<td></td>
<td></td>
<td>-BERENS RIVER FN-ROBOAO</td>
<td></td>
</tr>
<tr>
<td>-LAC DU BONNET-ROE1AO</td>
<td></td>
<td></td>
<td></td>
<td>-LITTLE GRAND RAPIDS FN-ROBOO</td>
<td></td>
</tr>
<tr>
<td>Pinawa LGD (190)</td>
<td></td>
<td></td>
<td></td>
<td>-NEGGINAN-ROBOZO</td>
<td></td>
</tr>
<tr>
<td>-PINAWA-ROE1GO</td>
<td></td>
<td></td>
<td></td>
<td>-BLOODVEIN-ROE1O</td>
<td></td>
</tr>
<tr>
<td>-Otter Falls</td>
<td>Unorganized Territories</td>
<td>Unorganized Territories</td>
<td></td>
<td>-PRINCESS HARBOUR-ROE1O</td>
<td></td>
</tr>
<tr>
<td>(288)</td>
<td>POINTE DU BOIS-ROE1INO</td>
<td></td>
<td></td>
<td>-ROE2XO</td>
<td></td>
</tr>
<tr>
<td>Note: Aboriginal population may be under reported depending upon the criteria used by source.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There have been some significant geographical changes since the previous CHA report completed in January 1998.

Geographical Changes:
- Unorganized Territories previously was a separate geographic area. In this report depending upon the municipal code, communities have been re-located into Winnipeg River, Iron Rose, Blue Water and Northern Remote.
- Northern Remote is a separate health district.
- Springfield has had no geographical boundary changes since the previous report.
- Brokenhead has had Seddon’s Corner re-located into Winnipeg River.
6.0 - North Eastman Regional Profile

6.2 COMMUNITY SYSTEM CHARACTERISTICS

**Population Demographics**

[Education as a health determinate] 3

Overview

Providing a scan of the population is important as human populations live in the macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Where information is available the sex of the individual is provided. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women as well as gender influences affecting age, education, socio-economic status, culture and physical environment. 4

Population Demographics

**WE ARE GROWING & AGING!**

The population pyramid reviews the number of males and females within specific age groups in NE Region comparing 1995 and 2000.

There has been an increase in the population between 35 years and over, with fluctuations in increases /decreases between males and females between 4 to 34 years of age. There has been a decrease in the number of children in the 0-4 year age range.
Population of North Eastman and Manitoba 2001/2002

North Eastman represents approximately 3.4% of the total population of Manitoba. Of this, 22.6% are under the age of 15 (Manitoba 20.8%) and 65.1% are between the ages of 15 and 64 (Manitoba 65.5%) and 12.3% are aged 65 years and older (Manitoba 13.6%).

Figure 6.3 Manitoba Population Pyramid 2001/02

![Manitoba Population Pyramid 2001/02](image)


Table 6.2 Population By Health District

<table>
<thead>
<tr>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td>7,089</td>
<td>7,232</td>
<td>7,274</td>
</tr>
<tr>
<td>Blue Water</td>
<td>8,531</td>
<td>8,424</td>
<td>7,970</td>
</tr>
<tr>
<td>Springfield</td>
<td>11,967</td>
<td>11,976</td>
<td>12,099</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>5,590</td>
<td>5,635</td>
<td>5,673</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>2,662</td>
<td>2,668</td>
<td>3,237</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>3,481</td>
<td>3,454</td>
<td>3,391</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>39,320</strong></td>
<td><strong>39,389</strong></td>
<td><strong>39,644</strong></td>
</tr>
</tbody>
</table>


There has been little change in population variation when comparing the past three years. From discussions with community members in Winnipeg River Health District, they feel that there is and continue to be an increase in people moving to the area to retire and build all season homes.
Aboriginal Population

Depending upon the source used, there will be some variation in the reporting of Aboriginal population.

The 2001 census data includes anyone reporting as being “…with at least one Aboriginal group (North American Indian, Metis or Inuit) and/or who reported being a Treaty Indian or a Registered Indian as defined by the Indian Act and/or those who were members of an Indian Band or First Nation.”

Table 6.3 Aboriginal Population 2001

<table>
<thead>
<tr>
<th>Aboriginal Population in NE.</th>
<th>Aboriginal Population in Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>24%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Note: The NE percentage was affected by the incomplete enumeration of certain Indian reserves and Indian settlements.

First Nation Population

“Manitoba Health includes in its definition of First Nations (FN) people all those who, through self-declaration, have advised Manitoba Health that they are residents with Treaty Status. This system includes Manitobans living both on and off reserves. It is a voluntary system, which therefore does not include all FN people…. the Manitoba Health FN data set represents about 86% of the total FN population [in Manitoba] …Those without Treaty Status, Metis and Inuit people are not included.”

Table 6.4 2002/2003 North Eastman Population Divided into Health Districts and FN People

<table>
<thead>
<tr>
<th>District</th>
<th>Non First Nations</th>
<th>FN on Reserve</th>
<th>FN off Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>11,949</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Brokenhead</td>
<td>7,154</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Iron Rose</td>
<td>3,143</td>
<td>311</td>
<td></td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>5,622</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Blue Water</td>
<td>5,051</td>
<td>3,011</td>
<td>362</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>442</td>
<td>2,038</td>
<td>188</td>
</tr>
<tr>
<td>Total NE: 39,389 persons</td>
<td></td>
<td>5,049</td>
<td>979</td>
</tr>
</tbody>
</table>

From this information, FN people make up approximately 15.3% of our total population in 2002. There may be FN people who have not received provincial health services, therefore there may be more FN people than reported here.
Population & Growth Projections

Figure 6.4 Population and Project Growth North Eastman Region

When we break down the age groups in the projected populations for the years 2008 and 2013, we see that all age categories have increased with the exception of the 10-19 and the 40-49 year old age groups. In approximately six years the population in NE is projected to increase by 2,926 residents.
Comparing the Number of People Projected in 2025

The population in North Eastman, as within Manitoba, is projected to age. When we look at the information from 1998 to 2025 we see fewer children and adults under the age of 65 years and more seniors 65 years of age and older, than Manitoba as a whole.\(^8\) This information is based on net migration, total fertility and mortality rates.

It is projected that by 2025 there will be 18% of the population over the age of 65 as compared with 12% in 1998.\(^9\)

Table 6.5 Projected Change in 2025 Compared with 1998

<table>
<thead>
<tr>
<th>Age</th>
<th>Projected Change North Eastman</th>
<th>Projected Change Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 14 Years</td>
<td>-9.5%</td>
<td>-17.4%</td>
</tr>
<tr>
<td>15 to 64 Years</td>
<td>-6.2%</td>
<td>-4.1%</td>
</tr>
<tr>
<td>65 Years and Older</td>
<td>+52.6%</td>
<td>+46.9%</td>
</tr>
</tbody>
</table>


Migration

Migration refers to the “percentage of people who lived in a different Canadian municipality one year prior to the 2001 Census of Canada. Internal migrants are people who resided in a different Census Sub Division one year earlier. External migrants are people who resided outside of Canada one year earlier.”\(^{10}\)

Table 6.6 Percentage of the Population One Year Internal/External Migration into Manitoba

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>2001 Internal</th>
<th>1996 Internal</th>
<th>2001 External</th>
<th>2001 External</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>5%</td>
<td>5.8%</td>
<td>0</td>
<td>0.2%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>4%</td>
<td>4.2%</td>
<td>1%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Sources:

This refers to the percentage of the population one year of age and older, who had moved within one year of the 2001 or 1996 Census of Canada.

With respect to internal migration, NE had fewer people move into the region when 2001 and 1996 are compared. NE had a higher rate of internal migrants than Manitoba overall during 2001, albeit only by 1%.

With respect to external migration, based on the above table, there was only a slight difference. When compared to Manitoba, NE has a lower rate of external migrants.
Figure 6.7 Internal Migration in North Eastman and Manitoba

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>2001 1-year internal</th>
<th>2001 5-year internal</th>
<th>1996 1-year internal</th>
<th>1996 5-year internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>5%</td>
<td>17.7%</td>
<td>6%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>4%</td>
<td>12%</td>
<td>4.7%</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

Sources:

This refers to the “percentage of people who lived in a different Canadian municipality at the time of the 1996 Canadian Census (5-year internal migrants) or one year before the current 2001 Canadian Census (1-year internal migrants).” External migrants are excluded. 11

NE appeared to have a higher rate of mobility than Manitoba as a whole.

In NE 5% of the population moved within one year of the 2001 Canadian Census, compared to 4% of Manitobans combined. This was a decrease in internal migration in NE from the 1996 census.

In NE 19% of the population moved within five years of the 2001 Canadian Census, compared with 12% of Manitobans combined. This was an increase in internal migration in NE from the 1996 Census.

Other Population Indicators

Dependency Ratio

This ratio measures the percentage of people in the non-working age groups, 0-14 and aged 65 and older. This is an important measurement as this population is more likely to be socially and/or economically dependent on working age Canadians, and may place additional demands on health services. In 2001/02 NE experienced a slightly higher dependency ratio of 53.7 for people of non-working age for every 100 people of working age. This is slightly higher than Manitoba’s dependency ratio of 52.6. 12
Population Density

We know that in some urban areas and countries there is a problem with population density. This has implications on health, as often when people are living in close proximity some illnesses are more likely to flourish, for example, Tuberculosis. Population density is not a problem in NE Region. In fact in 2001 NE appeared to have fewer people per square kilometre than Manitoba as a whole and was the third least densely populated region.\(^{13}\)

Urban Population

In 1996, 14.5% of the NE population lived in what is considered an urban area. This increased in 2001 to 19%. Urban is defined as having a minimum population of 1,000 people and a density of 400 people per square kilometre. This is the lowest rate in all of Manitoba. This measurement allows regions to compare themselves and other urban/rural populations with similar proportions.\(^{14}\)

Communities With Strong Census Metropolitan Area and Census Agglomeration Influenced Zones (MIZ)

There is a geographic portion of NE Region that borders Winnipeg. As Winnipeg is a large urban area one might expect to see a high degree of economic and social integration especially for residents living in close proximity to Winnipeg. MIZ are based on measuring the proportion of the population that have at least 30% of the employed labour force commuting to a large urban population, such as Winnipeg.

It has been found that in 2001, 34% of the population of NE lived in communities where at least 30% of the employed labour force commuted to an urban area [compared with 31.7% in 1996]. Of the rural regions, excluding Winnipeg and Brandon, NE had the second highest percentage of people living in strong MIZ (34%), after Interlake with 53%."\(^{15}\) This means approximately 1/3 of our working population in NE commute to an urban centre to work.

Reference to mode of transportation to work is discussed later under the ‘Living and Working Conditions’ determinant.
Language

Canada is a culturally diverse nation, with individuals from a variety of languages, cultural and religious backgrounds.

Table 6.8 Languages Spoken at Home in North Eastman - 2001

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage of Population in NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>88%</td>
</tr>
<tr>
<td>French</td>
<td>0</td>
</tr>
<tr>
<td>Non-Official Language</td>
<td>3%</td>
</tr>
<tr>
<td>English &amp; French</td>
<td>1%</td>
</tr>
<tr>
<td>English &amp; Non-Official Language</td>
<td>8%</td>
</tr>
</tbody>
</table>


Language has an impact on how we deliver health services. With the knowledge of what languages dominate our population, we can ensure that translation services are representative of common languages.

As shown in this table, 88% of residents speak English at home and appears to be higher than that for all Manitobans combined (82%). “Fewer residents of NE appeared to speak French at home than all Manitobans combined (1%). Fewer residents of NE also appeared to speak a language other than English or French at home than all Manitobans combined (4%).”
Community Characteristics That Support Healthy Living

During the focus group discussions and survey responses, our residents provided us with information about how their communities supported healthy living.

### 2003 Focus Groups on How Communities Support Healthy Living

Focus Group participants provided feedback about their communities and what they felt was happening to promote or support a healthy community.

#### HOW DOES THE COMMUNITY PROMOTE OR SUPPORT HEALTHY LIVING?

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Springfield</th>
<th>Blue Water / Seymourville</th>
<th>Winnipeg River</th>
<th>Brokenhead</th>
<th>Iron Rose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>- Local restaurant menu &quot;has under 6 grams of fat.&quot;</td>
<td>- AFM Counselor at the school; Dentist; Counselors; Health Nurse; Chiropractor; Masseuse – Wings of Power (Students didn’t really know about the work of the agency, but perceived it as a good thing in regard to providing support for young moms.)</td>
<td>- Organized activities e.g. Terry Fox Run, yoga organized by the Recreation Commission for Pinawa and Lac du Bonnet. Hockey, AFM Counselor, Peer Support Team, Pinawa Rowing Club golfing, curling, roller blading, biking walking trails, and private weight watcher organization. Teen centre in Pinawa as it has a TV, pool table, fooz ball table, shuffleboard, basketball. A gym a Lac du Bonnet but there is an admission fee.</td>
<td>-Recreation: skateboard park, baseball diamonds, curling, swimming pool, hall, Sun-Gro Centre “...is the best thing so far that's come to Beausejour.”, private exercise establishment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seymourville</td>
<td>- Junk free food day at school (Tuesday and Thursday); team sports; caring week at school; School Counselors; leadership training opportunities.</td>
<td>Suggestions from Group</td>
<td></td>
<td>Suggestions from Group</td>
</tr>
<tr>
<td></td>
<td>- AFM Counselor at the school needs to be more visible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Adult</td>
<td>- Oakbank doctors generally liked, Oakbank Health Centre is open Wednesday evenings and Saturday “...absolutely fabulous…”, Nurse Practitioner is seen as very positive, Baby</td>
<td>- Audiologist in Beausejour, more personal and attentive service in small town hospitals, local Chiropractor is highly regarded, Physiotherapists good, Acupuncture available, Massage</td>
<td>-Evening clinic at the Health Centre, birth control is encouraged and paid for by Social Assistance, Recreational activities: hockey, baseball, curling, public skating, hall walking at elementary school, walking trails. Litter less lunches. Child and Family Services Counselor, nurses at Beausejour</td>
<td>-Recreational activities: hockey, baseball, curling, skating, roller blading. Breast feeding support, dietitian, First Place Program (out of Beausejour), Readiness Clinics,</td>
<td></td>
</tr>
<tr>
<td>Age Groups</td>
<td>Springfield</td>
<td>Blue Water / Seymourville</td>
<td>Winnipeg River</td>
<td>Brokenhead</td>
<td>Iron Rose</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Clinics, pre-school clinics, Mother Goose Program from Recreation Commission, Prevention services, Wellness Day, Sign board outside the Primary Health Care Centre, Physiotherapist, Chiropractor, having a lab in Oakbank.</td>
<td>Therapy, Family Psychologist in Lac du Bonnet appreciated, Recreational activities (gym in school well used), kick boxing, Badminton program, gymnastics and dance programs for children, hockey, Fort Alexander Gym, Wings of Power, Dietitian, Public Health nurse, palliative support (praised), Wellness Program at the Paper Mill. Seymourville - Community garden, no smoking policy in the Community Council and hall, Frontier school divisions “healthy nutrition policy”, playground improvement, being able to access the programs and services that come to the community, Moms N’ Tots group very popular, improvement noted in the availability of healthy foods in the local store.</td>
<td>Nurse practitioner, Mrs. Lucci’s Parenting Class, Public Health Nurse, Baby First Program, private weight watcher program, kindergarten orientation is good.</td>
<td>Hospital, quality of care at Beausejour Hospital, Palliative Care Program.</td>
<td>care in the Whitemouth PCH (excellent, nurses wonderful), Grief Counseling Support group is “excellent.”</td>
<td></td>
</tr>
<tr>
<td>Middle Adult</td>
<td>- Doctor, drugstore, Health Centre, PCH, school (provides a lot of emotional support for students, availability of counseling), Recreational: Women’s Fitness Centre, Skateboard Park). Recreation Newsletter. Wellness Resource Centre, Physiotherapist, Merry Makers raise funds for community and charities and Christmas hampers. Care by South African doctors. Seven Oaks Heart Program, Dietitian (seen for weight control, cholesterol reduction), Physiotherapist, Occupational Therapist, Medi-van good and drivers</td>
<td>A participant described an ideal healthy community as, “...everyone understands everyone’s needs and respects them...a good variety of organizations to support recreation and socio-emotional needs, including religion.” Massage Therapy,</td>
<td>-Recreational activities (private weight watcher program, Sun Gro Centre, hall walking at the school, aqua size at Super 8 pool, skating, paved walking trail for roller blading, cross country skiing, streets are good for biking, sidewalks paved for walking.</td>
<td>- Generally pleased with the quality of service in NEHA hospitals (aside from services not available) Follow up call by Health Links, Home Care, Pharmacy, Dietitian.</td>
<td></td>
</tr>
<tr>
<td>Age Groups</td>
<td>Springfield/Seymourville</td>
<td>Blue Water/Winnipeg River</td>
<td>Brokenhead</td>
<td>Iron Rose</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>massage, Acupuncturist, yoga, Chiropractor, Nurse Practitioner. Pain Management Program delivered by the Arthritis Society, Peer Support.</td>
<td>good. Health Centre Staff is caring, and viewed as aggressive in getting patients support they need e.g. specialists treatment in Winnipeg, ambulance drivers good.</td>
<td>NEHA information, Pinawa Paper, Pinawa Hospital.</td>
<td>skateboarding, curling. - Wellness Centre, Physiotherapist, Massage Therapist, various community groups and Church Organizations. Support Groups. Yoga classes, doctors are better now, home care, Diabetes clinic, Well Baby Clinic.</td>
<td>Loss to the Community - Homeopath and Naturopath used to be available now must go to Winnipeg.</td>
<td></td>
</tr>
<tr>
<td>Seniors - Oakbank Beautification Committee; Seniors Walk and Weight, hall walking. - Health care availability, trend toward prevention, positive experience with home care, personal care, Nurse Practitioner and meals program.</td>
<td>- Seniors Scene, health focus at Seniors Club, wheelchair accessibility makes your life fuller more functional, &quot;I like what hospitals and doctors are doing and hope they carry on.&quot;, Planned Wellness Center on Hwy. 59 and 11 is &quot;exciting&quot;. Described as, &quot;A healthy care facility with a swimming pool, curling rink. Like a community complex.&quot;</td>
<td>- Diabetes Clinic in Beausejour, Wellness Group. - Pinawa Support Group for widows/widowers. - Friends, Cancer Care visits. Pool and tennis courts, health facility, hall walking program at school in Lac du Bonnet, Tai chi in Pinawa, Dietitian, Physiotherapy, Massage Therapy Chiropractor, home care.</td>
<td>- Churches, Garson Senior's Club (expanded catchment to capture enough members), Children. &quot;With young children, it's a happy place.&quot;</td>
<td>- Home care, presentations by speakers. Availability of pamphlets at medical centres and doctors offices.</td>
<td></td>
</tr>
</tbody>
</table>

**STAFF (From across the Region)**

Staff clearly indicated the positive benefits to both themselves and clients they serve when living in a healthy community.

On the general topic of healthy communities, one participant pointed out that health care staff can do their best job if the community in which they live is meeting their personal needs. As the discussion progressed, the group talked about how health care can be enhanced or hindered by the community at large.

"If you work at a place which serves only burgers and fries, and (you) have an obesity problem, it's hard for you to make the changes I might suggest because I'm concerned about your weight."

Another pointed out that some populations will not be affected by what may or may not be going on in the community, specifically citing the case of elderly people who are already sick. "No matter what the community puts forward, it's not helping them any.” This participant noted one exception, that being programs that enable seniors to stay in their own homes. These programs are seen to enhance the health status of the elderly.
Positive

• High quality EMS training.
• Recreational facilities and programs.
• Health promotion: the visible presence of dietitians etc, disease prevention and management workshops.
• 911 service and civic addressing.
• Smoke free by-laws, and buildings, which go smoke free voluntarily.
• Churches: “We’re thinking about health care here, but it’s not just that if you’re looking at the whole person.”
• Pinawa school outdoor activity programs - teaches life skills, fitness, fun, team building.
• Nurse practitioners.

Discussion

From the information provided most participants have an intimate familiarity with their community and there are many positive things happening. Focus Group participants, especially youth felt that there could be more recreational activities.

2003 Acumen Research Survey – NE Findings

Q- Respondents were asked to suggest what types of things they would like to see in their own community that they believe could improve their health. A total of 38% of respondents could think of nothing, while the remainder provided the following suggestions. Consistent with the Focus Group’s responses, additional recreation activities topped the list.

The following table was adapted from pages 48-49 of the Acumen Provincial Survey Report.

Table 6.9  What would you like to see in your community that would improve health?

<table>
<thead>
<tr>
<th>Category / category total</th>
<th>Verbatim response</th>
<th>North Eastman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>Nothing I can think of</td>
<td>38%</td>
</tr>
<tr>
<td>North Eastman 38%</td>
<td>Exercise gym / fitness studio / spa</td>
<td>12%</td>
</tr>
<tr>
<td>Recreation facilities</td>
<td>A swimming pool (indoors / outdoor) or longer pool hours</td>
<td>6%</td>
</tr>
<tr>
<td>North Eastman 31%</td>
<td>A recreation facility offering swimming / aerobics / weight lifting / cycling / programs for seniors</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>More / better sports facilities</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>A wellness / community health centre that has exercise programs available in it</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Trails or paths for cross-country skiing / hiking / cycling / walking</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Cheaper / free facilities</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>An indoor walking track and running track</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>A bowling alley</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Open school gym so public can use</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A local health club</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A facility for socializing, such as a coffee shop, etc.</td>
<td>-</td>
</tr>
<tr>
<td>Category / category total</td>
<td>Verbatim response</td>
<td>North Eastman</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Improved access to health services</td>
<td>Better access to doctors</td>
<td>8%</td>
</tr>
<tr>
<td>North Eastman 9%</td>
<td>More / better transportation to health services</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Better availability and affordability of prescription drugs</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>More specialists in rural areas</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Improvements to hospitals</td>
<td>A regional / local hospital with emergency care</td>
<td>3%</td>
</tr>
<tr>
<td>North Eastman 6%</td>
<td>More / better services / facilities in hospital</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>More / better personnel working in the hospital</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>Keep the local / regional hospital open</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Recreation programs</td>
<td>More / better exercise programs / recreational activities</td>
<td>6%</td>
</tr>
<tr>
<td>North Eastman 6%</td>
<td>More / better programs for seniors</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Activities to encourage exercise in winter</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>More affordable exercise programs</td>
<td>-</td>
</tr>
<tr>
<td>Health education / nutrition / food labeling</td>
<td>More / better health education</td>
<td>2%</td>
</tr>
<tr>
<td>North Eastman 2%</td>
<td>More / better produce in stores</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Better food labelling / ingredient list</td>
<td>-</td>
</tr>
<tr>
<td>Improvements to other health services</td>
<td>More / better health services in community</td>
<td>1%</td>
</tr>
<tr>
<td>North Eastman 1%</td>
<td>Access to a chiropractor</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>Better home care services in my community</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>Alternative forms of health care like homeopathy</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A high-blood-pressure clinic</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A public-health nurse</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Radiation treatment facility</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>More mental health facilities / staff</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>7%</td>
</tr>
<tr>
<td>Overall 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Eastman 7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Note: Percentages may not equal 100% due to rounding. Figures of less than 0.5% are shown as “<1%.”

Discussion

Survey respondents under age 35 years were more likely to suggest more or improved recreational programs or facilities. Those 65 years or over were the most likely of any age group to suggest improvements to health services. 17

The 2003 focus groups also indicated that recreational activities and access issues to some health services were of concern to them.
Overview

There has been an association found that when education levels increase, the self-rated health status improves. The 2003 Acumen Research Survey validates this association when it has respondents rate their health status. This report found that “Respondents’ impressions of their own health generally improve as their level of education increases.” Education is also closely tied with socioeconomic status. Effective education for children and lifelong learning for adults contributes to the health and prosperity of individuals. We know those individuals “with less education are more likely to face low-paying and uncertain jobs higher risks of occupational injury and a less rewarding work life.” Education often provides the ability for people to increase their sense of control and mastery over life circumstances. An initiative for lifelong learning is an important component in effective population health strategy. Having an understanding our community’s education level provides us with an indication of the types of communication strategies we may be effective in our health districts.

It is suggested not to compare educational information across generations as the importance given to education, it’s cultural status, and an individual’s ability to access educational institutions varies considerably between age groups.

Attendance

Table 6.10 School Attendance- Summary of NE Schools and Adult Education Centres *

<table>
<thead>
<tr>
<th>School District</th>
<th># of High Schools</th>
<th># of Elementary Schools</th>
<th># of Colony Schools</th>
<th># of Adult Education Centres</th>
<th>Total # of Schools</th>
<th>Total Number Of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2001/02</td>
</tr>
<tr>
<td>Springfield</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>10</td>
<td>2040</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1339</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>980</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>1</td>
<td>1</td>
<td></td>
<td>0</td>
<td>3</td>
<td>347</td>
</tr>
<tr>
<td>Blue Water</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>1657</td>
</tr>
</tbody>
</table>

Sources: Principals of each Sunrise School Division School and Colony School, January-April 2004

* Not all numbers are available in every school. Refer to Health District information for more detail.
Levels of Education

Figure 6.5 Percentage of Population With Less Than a High School Graduation Certificate in North Eastman

Within NE we have a higher percentage of the population in all the age groups with less than a high school graduation certificate when compared with the Manitoba. When we add up all the representative age group percentages there is an average of 35.6% of our population who have less than a high school education certificate compared with Manitoba at 27.5%.

As one gets older the percentage of residents with less than a high school education increases.

Figure 6.6 Percentage of Population with a High School Graduation Certificate and/or some Post Secondary

There is only a slight difference in the percentage in NE and Manitoba overall who have a high school graduation certificate and/or some post secondary education.

An average of 22.3% of NE residents ages 20-64 years have a high school graduation certificate or some post secondary education.

35.6% of NE residents have less than a high school graduation certificate compared with Manitoba at 27.5%.
There is very little difference between NE and Manitoba overall in the percentage of residents with a college certificate or diploma.

An average of 15.8% of NE residents ages 20-64 years has a college certificate or diploma.

In the 20-34 year old age group 9.6% of residents have a university certificate, diploma or degree. This is 8.8% less than the Manitoba percentage of 18.4%.

Differences also occur in the other two age groups.

An average of 12.1% of NE residents ages 20-64 years have a university certificate, diploma or degree compared with Manitoba overall at 18.8%.
Literacy

Literacy is the basis for the well being of individuals, families, and the whole province. The ability to read, write and perform basic math has an impact well beyond those skills. Low literacy is, on the surface, an invisible handicap. Its effects, however, are not. Investing in literacy makes economic, social and political sense.

The following information is provided from a Manitoba Perspective:

**Education**
- Number of Manitoba adults aged 20-64 with less than grade 9 education: 39,200.
- Number of Manitoba adults aged 20-64 with less than a high school diploma: 180,380 (more than 1 in 4).
- The number of adults in many Manitoba's aboriginal communities with less than Grade 9 education ranges between 40% and 70%.

**Labour Force and Economics**
- Average annual salary for a Manitoba worker with a college or trade school certificate: $29,000.
- Average annual salary for a Manitoba worker with less than a high school education: $19,000.
- The estimated annual cost of low literacy to Manitoba society is $375 million.

**Access to Adult Literacy Programs**
- Number of Manitobans enrolled in the province’s 35 provincial funded adult literacy programs in 2002: 2,100.
- Number of Manitobans enrolled in the province’s 35 provincial funded adult literacy programs in 2003: 2,400 (13% increase from previous year).
- Amount budgeted by the provincial government for family and adult literacy programs in 2003: 1.3 million or an average of $37,000 per program. *

*Prime source of funding, to cover such costs as school supplies, materials, transportation, day care, teacher salaries, recruitment, rent and utilities.

Most literacy programs are part-time and have waiting lists of willing learners at the door.

The results of low literacy include:
- People with low literacy skills have difficulty understanding such vital information as prescriptions, food safety tips, and baby formula directions.
- People with low literacy smoke more, have poorer nutrition, and exercise less.
- Children whose parents are jobless and did not graduate high school are five times less likely to graduate than children with employed parents who completed Grade 12.
Number Of Children With Special Needs

*Please refer to Iron Rose, Springfield, Brokenhead and Blue Water for these numbers.*

Community Feedback on Schools

2003 Focus Groups on Schools

**YOUTH**
The topic of school was raised in almost every group but the specific topic of discussion varied. Issues included: school counselors need for more visibility, nurses in schools more often, use of school gym outside of school hours, relationships with teachers, how their school is perceived by others and personal safety.

**ADULT FOCUS GROUPS**
School issues were raised by various adult groups with respect to the lack of healthy food being distributed, bullying in schools, the need for more Public Health Nurse time in schools, and to using the school facilities after school hours.


### Overview

An individual's health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health” we find that there are many influencing factors. Some of these factors are controllable for example, the choices we make that is the use of seat belts or food we eat. There are other factors that we have less or no control over for example hereditary diseases.

Aside from those health factors we have no control over, it has been found that the more control a person has to make choices, the better their over all health status. This section will discuss a variety of indicators that influence health in some way.

The population health model focuses on strategies and interventions. These strategies prevent health problems from occurring or worsening, protecting people from disease and injury and promoting the health of individuals and communities, as it reviews these indicators using the determinants of health. The Health Service determinant is discussed in Section 7.0 of the report.
Measuring Overall Health Status

There are two robust indicators that measure the overall health status of a region or district and strongly influence the potential need for health services. These are Socioeconomic Factor Index (SEFI) and Premature Mortality Rate (PMR). Because these two indicators are important, district information will be provided here and repeated in the respective health districts.

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The source for the socioeconomic characteristics is from Statistics Canada 1991 and 1996 censuses. The variables that are included are: age dependency ratios, single parent households, female single parent households, labour force participation female, unemployment and education. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents who live in NE and also by Health District. Results less than 0 indicate LESS socioeconomic risk and values GREATER than 0 indicate greater socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services. The dates represented are pre RHA years.

Figure 6.9 Social Economic Factor Index in NE

NE standardized SEFI scores from 1991 and 1996 (based on corresponding census of that year) went from −0.20 to −0.37. As scores less than 0 indicate less socioeconomic risk (suggesting better health status) than NE appears to have gone from a higher risk score in 1991 to a lower risk score in 1996, a positive sign of improving socioeconomic risk.

When comparing the NE SEFI value provincially in 1996 it is a better value than the Manitoba value at -0.06. NE compares closely with Rural South at -0.39.
When we look at the SEFI score at the district level another picture is presented. We can clearly see disparities in socioeconomic risks identified in the Blue Water and Northern Remote Health Districts. Having said this, there has been some improvement in Blue Water’s value in 1996.

Except for Winnipeg River and Northern Remote, there has been an overall improvement in the SEFI index value in all the other districts when 1996 is compared with 1991.

All health districts except for Northern Remote and Blue Water have a better SEFI value than both Manitoba and Rural South. This suggests the likelihood of a greater need/usage of health services in these two health districts. As we review other indicators the reasons will become clearer as to the areas of possible concerns.

Note: In NE health districts the data could not be defined precisely to match district boundaries, so the closest approximations are presented. 28
**Premature Mortality Rate (PMR)**

PMR is defined as deaths when they occur before age 75. This indicator is often used as a measure of general health status and the need for health services and is considered the single best measure to reflect the health status of a region's population. If PMR is high, we can assume that this population requires the use of more health services including preventive services.  

*Figure 6.11 Premature Mortality Rate in NE*

<table>
<thead>
<tr>
<th>PMR per 1000 Aged 0-74 NE Region [age &amp; sex adjusted]</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMR per 1000 Aged 0-74 NE Region [age &amp; sex adjusted]</td>
</tr>
<tr>
<td>NE Region</td>
</tr>
<tr>
<td>Manitoba Average</td>
</tr>
<tr>
<td>Rural South</td>
</tr>
</tbody>
</table>


NE PMR (3.67/1000) is statistically significantly higher when compared with the Manitoba rate (3.32/1000) and Rural South (3.23/1000) during the second time period reviewed.

Two other RHA’s i.e. Norman and Burntwood have higher PMR percentages than NE.

Our Premature Mortality Rate is significantly higher when compared with Manitoba during the second time period.
We do not want to see this indicator increase. PMR’s in Blue Water and Northern Remote are statistically significantly higher than Manitoba and Rural South during the second time period.

Deaths

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” 30

Life Expectancy

“Life expectancy measures average expectation of life, and therefore reflects both changing lengths of life for the very old, and changes in mortality rates for the non-elderly.” 31

Figure 6.13 Life Expectancy NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>75.1</td>
<td>75.7</td>
<td>75.9</td>
<td>80.3</td>
</tr>
<tr>
<td>10</td>
<td>74.6</td>
<td>81.3</td>
<td>75.9</td>
<td>81.7</td>
</tr>
<tr>
<td>20</td>
<td>81.3</td>
<td>81.6</td>
<td>81.7</td>
<td>81.7</td>
</tr>
</tbody>
</table>


Life expectancy is defined as the expected length of life from birth, based on the mortality of the population. Life expectancy is a common indicator of population health status and is used for international comparisons. 32

There is little change in life expectancy between the sexes during the two time periods reviewed. In NE females live longer than males. This is consistent with the Manitoba and Rural South figures.

Currently in NE life expectancy for males in 1996-2000 is 74.6 years of age and for females is 79.9 years, both slightly less than Manitoba and Rural South. For males, life expectancy has shown a decrease during the two time periods.

Total Mortality

This indicator examines all deaths per 1000 from all causes and all ages.
It appears that there is an increase in the number of deaths in NE, but it is not significant.

NE does not show a significant difference from the Manitoba average or Rural South.

Springfield has a statistically significantly lower total mortality rate when compared with Manitoba and Rural South during both time periods.

Northern Remote has a statistically significantly higher total mortality rate than the Manitoba average and Rural South during the second time period.
**Potential Years of Life Lost (PYLL)**

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths.  

"PYLL reflects the levels of success in preventing premature (and therefore presumably preventable or postponable) loss of life, with its consequent loss of social and economic productivity. It is an overall indicator of population health and well being, and effectiveness of preventative programs."  

A large PYLL indicates that there is a high death rate among young or middle-aged persons, often associated with injury. If PYLL is small, most deaths are occurring in later life often from chronic health conditions.

Figure 6.16 Potential Years of Life Lost (PYLL) All Causes Both Males and Females

NE Region is statistically significantly higher when compared with the Manitoba average and Rural South during the second time period reviewed.

The question we need to examine is where and what is the cause of these deaths. When we examine some diseases that could lead to premature death, we find that NE has had an increase in these disease categories: diabetes, hypertension and injury mortality rates. The top causes of unintentional injury deaths in NE for males are motor vehicle traffic, drowning/submersion, transport other, fire/burn; and for females, motor vehicle traffic, falls, and fire/burn.

When we look at the sex differences we see that NE males have a higher PYLL than females.

NE females have a statistically significantly higher PYLL for the second time period when compared with Manitoba and Rural South. There is not significant difference between female PYLL value during the two time periods reviewed in NE.

We know our health regions are very diverse so it is important to review the health district information to determine where the premature deaths are occurring. Often “PYLL is large if there is a high death rate among young or middle-aged persons (often from injury), and small if most of the deaths in a population occur in later life (usually from conditions such as heart problems or chronic health problems).”

As shown, when we compare the average PYLL during the 10 years reviewed we see that cancer deaths leads the number of PYLL, followed by unintentional injury deaths.

PYLL appears to be higher for suicide than it is for respiratory deaths.
**Causes of Death**

Using another source we will review the leading causes of death in Manitoba. We are unable to compare accurately with NE Region because the years are different.

**Figure 6.19 Causes of Death From all Causes in Manitoba 2001**

Between 1990-1994, 1995-1999 and 2001 as shown above, the top three causes of death for Manitobans had not changed:

- Circulatory,
- Cancer (Neoplasms), and
- Other

During 2001 respiratory and external causes tied at seven percent. This was the first time that external causes reached fourth.

During the time period reviewed we find that both males and females have consistently the same five leading causes of death, however there is some variation in the number of deaths within each category.

The leading cause of death in females appears to be due to circulatory diseases and neoplasm. The leading cause of death in males appears to be due to external causes (injuries) and respiratory deaths. The percent of Endocrine deaths is 3.5% for both males and females.

It is possible that ‘external causes’ may be a contributing factor in increasing our PYLL value.

Illnesses of any kind place a burden on the health care system. This is one of the main reasons we review actual health conditions. Some conditions are chronic e.g. hypertension, diabetes, asthma, arthritis. Others are considered acute e.g. stroke, cancer, myocardial infarctions. Although there may be a genetic predisposition to disease that we cannot change, many chronic diseases we know can be controlled with diet, exercise, nutrition, stress modification, medication and regular monitoring. This is the area of secondary prevention. It is here we have some control to potentially decrease the cost of disease burden to the individual (disability, job loss, premature death) and to the health care system by emphasizing the risks associated with chronic diseases, thereby decreasing acute illness episodes.
Cancer

When we see an increase in the incidences of cancer, this “...could reflect either a deterioration in healthy lifestyle or an improvement in screening. However, this latter kind of ‘screening artifact’ is unlikely to carry on for a long period of time, so that generally a declining incidence of cancer suggests a positive change in population health.” 37

Figure 6.21 New Cancer Rates [includes non-invasive malignancies ]

It is important to note that the rate describes every new case. This means that if one person had two different cancers diagnosed it would be recorded as two separate diagnoses.

NE is not statistically significantly different than the Manitoba average or Rural South.

Figure 6.22 Cancer Incidents NE compared with Manitoba

Overall NE residents appeared to experience lower or similar incidences of all types of cancer than did Manitobans as a whole. This is a positive sign that could indicate that our residents are practicing preventative health strategies. It is necessary to continue to track these trends. With our aging population we could, however, see a rise in cancer rates, as we know that cancer incidence does increase with age.
The three top cancers incidences in NE between 1992 to 2001

- Prostate cancer at a total of 297
- Invasive Breast cancer at a total of 200 and
- Lung cancer at a total of 139 for males and 88 for females

When we look at Primary Sites of Cancer incidence

a) Melanoma (Skin) – 1996-2000
Females appear to have a higher incidence of skin cancer at 12.6 per 100,000 as compared with all Manitoba combined at 9.4 per 100,000. Male incidence is 10.8/100,000 compared with Manitoba males at 12.6/100,000

b) Colorectal – 1996-2000
Male residents appear to have a higher incidence at 80.7/100,000 than for all Manitoba males at 77.6/100,000. The female incidence is 44.3/100,000 as compared with Manitoba at 51.9/100,000.

c) Prostate – 1996-2000
Males appear to have a higher rate 142.3/100,000 than all Manitoba males combined 137.4/100,000. Incidence than Manitoba.

d) Breast – 1996-2000
Females have an incidence of 108.4/100,000 as compared to Manitoba at 117.1/100,000.

Females in NE have an incidence of 4.6/100,000 as compared with Manitoba at 9.5/100,000.
Lung cancer incidence for males appeared to fluctuate during this time with the highest incidence in 1999 where it has dropped. For females, we see a sudden rise in incidence during 1994 where it has remained fairly stable. The incidence is similar to males during the later years.

Table 6.11 Lung Cancer Incidence for Males and Females 2000 & 2001

<table>
<thead>
<tr>
<th>Sex</th>
<th>1999 Incidence Lung</th>
<th>2000 Incidence Lung</th>
<th>2001 Incidence Lung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>18</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>


Lung cancer treatment interventions have limited success. This underscores the need to emphasize preventive strategies. Many of the cancers discussed can be prevented or detected early through screening programs.

Refer to screening statistics, Section 7- Public Health Program.

Table 6.12 Causes of Cancer Deaths in North Eastman

<table>
<thead>
<tr>
<th>1999 – 2001 Males Total Actual Deaths</th>
<th>1999-2001 Female Total Actual Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung = 19</td>
<td>Lung = 19</td>
</tr>
<tr>
<td>Prostate = 13</td>
<td>Breast = 12</td>
</tr>
<tr>
<td>Colon = 11</td>
<td>Colon = 5</td>
</tr>
</tbody>
</table>


During 1999-2001 the leading cause of cancer deaths in NE for both males and females, at 19 deaths each. Lung cancer is also the leading cause of cancer death in Manitoba. Lung cancer is usually preventable.
**Arthritis and Rheumatism**

Arthritis and rheumatism are very debilitating diseases and depending upon the severity affects an individual’s mobility, and quality of life both at work and at home. Arthritis is a condition of pain and stiffness in any joint in the body. The two most common types of arthritis are osteoarthritis and rheumatoid arthritis.

**Osteoarthritis** is a gradual loss of the soft, smooth covering on the ends of bone called cartilage. This type is usually caused by wear and tear on the joints over time. It is known that osteoarthritis affects about three in ten people between the ages of 45 and 64 and more than six in ten people over the age of 65.

**Rheumatoid arthritis** is a condition of ongoing swelling and irritation of the inner lining of joints. The body's immune system mistakenly starts to attack the lining of a joint and causes it to become inflamed. Rheumatoid arthritis can also affect other organs such as the ears, lungs or eyes. People usually get rheumatoid arthritis in their thirties or forties. Approximately one in every 100 people are affected by rheumatoid arthritis. Women get it three times more often than men.

**Figure 6.24 Number of NE Residents with Arthritis & Rheumatism**

Both NE males at 16.8% and females at 28.3% appear to have a higher percentage of the population with arthritis than Manitoba males at 15% and females at 24.9%.

![Arthritis & Rheumatism - Population Aged 12 and over for 2001](image)
Diabetes

Diabetes is becoming an increasing concern for all health care providers. According to the diabetes treatment prevalence rate in 1998-2001 for ages 20-79 years, North Eastman had a 6.2% rate and is significantly higher than the Manitoba average at 5.6%. Other RHA’s that have a higher diabetes prevalence rate than NE include: Burntwood (12.9%), Churchill (11.2%), Norman (8.7%) and Parkland (6.7%).

North Eastman Region has a Diabetes treatment prevalence rate that is above the provincial average, with an increase in prevalence over the last ten years. In particular, the Blue Water and Northern Remote districts have an extremely high diabetes treatment prevalence, among the highest in the province.

Figure 6.25 Projected Prevalence of Diabetes in Manitoba 1995 to 2025

As shown in this diagram we can expect to see an ever increasing prevalence of diabetes in our population overall.
Children & Diabetes

The incidence of Type 1 diabetes in Manitoba children appears to be stable i.e. approximately 1 in 800 children under 15 years. There are approximately 40 children under 15 years of age newly diagnosed with Type 1 diabetes every year in Manitoba. 47

According to the Diabetes Education Resource-Children and Adolescents (DER-CA) annual report, June 2002, the number of children diagnosed with all types of diabetes has increased in every RHA except Interlake and Burntwood. There are currently 22 children in North Eastman receiving outreach services through the DER-CA program: 13 with Type 1 diabetes and 9 with Type 2 diabetes. 48

As the incidence of Type 2 diabetes continues to rise in the younger population, the North Eastman Regional Diabetes Program (DEP) encourages primary prevention initiatives through nutrition and physical activity programs in partnership with school divisions. 49

Seniors & Diabetes

There is concern with respect to seniors and diabetes and the prevalence among this age group is growing. “More than 1% of Manitobans aged 55 years and older develop diabetes each year [this increases to] more than 13% over the age of 55 and 15% over the age of 65 that have been diagnosed with Type 2 diabetes.” 50

First Nation People & Diabetes

The Aboriginal population suffers a higher prevalence of diabetes than the rest of the population, necessitating the need for collaborative partnerships with the First Nations Communities, while respecting the jurisdictional boundaries associated with service delivery. First Nation communities are represented on the Regional Diabetes Steering committee, providing valuable insight into the challenges facing these communities, such as poor housing, lack of accessible health services and transportation, to name only a few. Several partnerships with some integration of services are currently happening between First Nation communities and the Regional Health Association.

Treatment for Diabetes is on the increase in NE Region as it is across the province.

The incidence of diabetes in NE population in 1999, not including the Treaty Status population, was 49 per 10,000. The incidence of diabetes in the Treaty Status population in North Eastman was 87 per 10,000. It is important to note that the Treaty Status population is small in several age groups, so this may cause the rates to be unstable. The incidence of diabetes in the Treaty Status population in Manitoba was 74 cases per 10,000 population. 51
It has been determined that only about 10% of the people who are diagnosed with diabetes receive service from the diabetes educators. It is anticipated that only about 50% of people living with diabetes have been diagnosed. This poses a significant risk for complications from being undiagnosed and/or not accessing education for the self-management of diabetes. The burden of disease, directly or indirectly through complications has the potential to increase with the rising regional prevalence. For the residents of NE a website has been created by the Regional Diabetes Education Resource. It provides information about Type 2 diabetes including advice on monitoring, diet, medication, active living and complications. To access the site go to [www.neha-diabeteseducation.ca](http://www.neha-diabeteseducation.ca).

**Diabetes Treatment Prevalence**

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes at two or more physician visits or one hospitalization during the time period reviewed.

![Figure 6.26 Diabetes Treatment Prevalence in NE](image)

The rates of diabetes treatment has shown a statistically significant increase within NE.

NE has a significantly higher diabetes treatment prevalence during both time periods when compared with both Manitoba and Rural South.

Increase in diabetes treatment is a good news/bad news story. We know that “It has been estimated that up to 50% of persons with diabetes mellitus have not been diagnosed and ...approximately 35% of Treaty Status individuals are not appropriately identified.”

As more cases of diabetes get diagnosed, early treatment and careful monitoring can prevent the many complications associated with diabetes.
The data presented suggests an ever-increasing prevalence of diabetes in the population, indicating the need for a population approach as discussed in Section 4 under the Population Health Model. This includes activities that encompass prevention, education, care, research and support targeting the general population in every age category.

Crude numbers are provided for NE for ages 20-79 years in order to better understand the decease burden in our population.

**Table 6.13 Number of Diabetes Cases**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Observed</td>
<td>Crude Percent</td>
</tr>
<tr>
<td>1,268</td>
<td>5.1%</td>
</tr>
<tr>
<td>1,708</td>
<td>6.5%</td>
</tr>
</tbody>
</table>


During the year 1998/99, the prevalence of diabetes was greater in females at 38.66/10,000 than for males at 723.6/10,000 aged 20 and over. 54

**Economic Costs**

These per capita cost expenditures are for selected services in Manitoba during 1995-1996. As to be expected this will have increased in 2004. The costs in this table do not include drugs, home care, public health services, nor do they include indirect costs such as disability and lost productivity.

**Figure 6.27 Economic Cost of Diabetes**

<table>
<thead>
<tr>
<th>Selected Health Services</th>
<th>General Population</th>
<th>Status Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Diabetes</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>$479</td>
<td>$1196</td>
</tr>
<tr>
<td>Personal Care Home Services</td>
<td>$251</td>
<td>$340</td>
</tr>
<tr>
<td>Professional Services</td>
<td>$271</td>
<td>$519</td>
</tr>
<tr>
<td>Dialysis</td>
<td>$10</td>
<td>$114</td>
</tr>
</tbody>
</table>

**Total** | $1,011 | $2,169 | $1,359 | $3,656

Table 2. Per capita expenditures (standardized to the Status population) for selected health services, Manitoba 1995-96.

Respiratory Diseases

Figure 6.29 Asthma Prevalence

During the two years reviewed ages 1-4 appears to have the highest rate of asthma in our region.
The Manitoba rate appears to be higher than the NE rate during the April 2000 to March 2002 time period.

Asthma rate for NE between April 2001 and March 2003 is 52.6/1000.

The percentage of residents treated for respiratory diseases (this includes asthma, bronchitis & pneumonia) have experienced a statistically significant decrease over time in NE. In the later time period the NE percentage is not statistically different than the Manitoba average.

NE’s total respiratory morbidity is significantly higher than Rural South during the later time period.

This is a positive sign for our region overall. It is important to note that there may be some under reporting of respiratory diseases in the Northern Remote area of NE, which may skew the NE average.
Hypertension

Hypertension (high blood pressure) treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed, i.e. each resident is defined as either having been treated for hypertension or not.

Figure 6.32 Hypertension Treatment Prevalence in NE

During the time periods reviewed NE has experienced a statistically significant increase during the two time periods. NE is statistically significantly higher when compared with Manitoba and Rural South during the later time period.

A possible implication of this is that we are doing a good job in screening blood pressure (B/P). We know that in general B/P does increase with age and in NE we find that our population is increasing as we reach 35 years and over. As hypertension comes with associated risks for cardiovascular disease, the actual crude numbers are also provided to provide a better sense related to actual numbers. Hypertension affects a growing number of people, and like diabetes is under diagnosed.

It can be easily measured and controlled. This benefits the individual and the health system by ensuring that other chronic diseases do not occur from uncontrolled B/P.

Table 6.14 Number of Hypertension Treatment Cases in NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Observed</td>
<td>Crude Percent</td>
<td>Number Observed</td>
</tr>
<tr>
<td>4,681</td>
<td>20.2%</td>
<td>5,860</td>
</tr>
</tbody>
</table>

**Myocardial Infarction (Heart Attack)**

**Figure 6.33 Acute Myocardial Infarction (AMI) Treatment**

NE has shown a statistically significant decrease in the rate of hospitalizations for acute MI's during both time periods reviewed.

There is no significant difference between Manitoba and Rural South's AMI treatment during the later time period.

We know that prevention strategies help in decreasing the number of heart attacks especially in middle aged individuals. These strategies include controlling blood pressure and cholesterol and performing regular exercise, decreasing weight if overweight, and stress reduction.

Refer to personal health practices and lifestyle section to review what Focus Groups and 2003 Acumen Research Survey participants are doing in NE to modify their lifestyles.

### Table 6.15 Number of AMI Treatment in NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Observed</td>
<td>Crude Rate per 1000</td>
<td>Number Observed</td>
</tr>
<tr>
<td>60</td>
<td>2.41</td>
<td>55</td>
</tr>
</tbody>
</table>

Stroke

Stroke is an significant cause of death and disability. Although stroke treatment prevalence does not look at stroke deaths, there are many factors that influence stroke survival, that being: "emergency treatment, quality of care in hospitals, primary care and prevention, or socioeconomic factors." 56

“Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents in an area [NE] aged 20 or older, averaged over the five-year period. To give an annual rate…an individual may suffer more than one stroke,…each stroke is counted as a separate event.” 57

Figure 6.34 Stroke Treatment in NE

Although NE shows a statistically significant decline in the number of hospitalizations for strokes during the two time periods shown, we are statistically significantly higher when compared with Manitoba and Rural South during the second time period.

Table 6.16 Number of Stroke Treatment in NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Observed</td>
<td>54</td>
<td>51</td>
</tr>
<tr>
<td>Crude Rate Per 1000</td>
<td>2.602%</td>
<td>1.91</td>
</tr>
</tbody>
</table>

Injuries

Overview

Injury places a significant burden on individuals, families and the health system. Injuries are preventable. There are often predictable patterns associated with the most common types of injuries and who is injured. Understanding these patterns and creating resources to help prevent the injuries from occurring is critical to improving the health status of NE residents.

This section explores intentional and unintentional injuries in NE and Manitoba overall. By examining injury data we can identify key areas of regional concern, in order to determine priorities for prevention strategies. This information is vital in order to create strategies and set priorities under the evidence-based decision-making model. This model allows for a systematic approach to applying best available evidence (data) to evaluate options and decision-making in clinical, management and policy settings.

Injuries tend to follow the socioeconomic gradient i.e. higher injury rates occur in lower socioeconomic status populations.58

The primary source of information has come from the Manitoba Health Injuries in Manitoba. A 10-Year Review report released in January 2004. There was a change in classification systems used for recording data about deaths. Until December 31, 1999 Manitoba recorded deaths using the ICD-9 system. On January 1, 2000, deaths were recorded using the new ICD-10 system. There is no ability to allow for direct comparability of data between the two systems. This system change influences the dates used, therefore the data for 2000-01 is shown separately in this report. The other two sources of information came from the Marten, P. et al. (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use. Manitoba Centre for Health Policy. June and Manitoba Health NE Regional Profile Document 2003/2004.

In 2001 approximately seven percent of Manitoba deaths were the result of injuries. From 1992 to 2001, 5,702 Manitobans died as a result of injuries. From 1992-1999 injury deaths represented 125,619 years potential life lost (PYLL), an average of 28.4 years for each Manitoban who was fatally injured.59

Males & Females

We know as a province and certainly as a region, males are more likely to die as a result of injuries as compared with females. In 2001, Manitoba males aged 25 to 54 years injuries remained the most frequent cause of death. Females in this age group were most likely to die of cancers. Injuries were the second most frequent cause of death.60

Seniors

“Compared to other age groups seniors in Manitoba aged 75 years and over were at greatest risk of dying as the result of injuries, although injuries accounted for less than four per cent of deaths among those in this age group. As a group, seniors were also at greatest risk of hospitalization as the result of injuries, although injuries accounted for less than ten per cent of hospitalization among seniors.”61

In Manitoba the trend is an increase in death from injury. From 1992 to 1999, on average, injury deaths increased by 21.3 percent. Deaths among males increased 12.5 percent. Deaths among females increased
42.0 percent. Some of this increase is due to an aging population, as we know seniors are more likely to die from injuries. \(^{62}\)

**Unintentional and Intentional Injuries**

Injuries are grouped into the following categories using the World Health Organization’s International Classification of Diseases “E” codes, ICD-9 classification:

Table 6.17 Unintentional and Intentional Injury Category ICD-9 Classification

<table>
<thead>
<tr>
<th>Unintentional Injury Categories [there was no intent to do harm]</th>
<th>Intentional Injury Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cutting and Piercing</td>
<td>• Self-inflicted Injuries / Suicide [intent to harm one self]</td>
</tr>
<tr>
<td>• Drowning and Submersion</td>
<td>• Assault [intent is to harm another]</td>
</tr>
<tr>
<td>• Falls</td>
<td></td>
</tr>
<tr>
<td>• Fires and Burns</td>
<td></td>
</tr>
<tr>
<td>• Firearms</td>
<td></td>
</tr>
<tr>
<td>• Machinery</td>
<td></td>
</tr>
<tr>
<td>• Motor Vehicle Traffic</td>
<td></td>
</tr>
<tr>
<td>• Pedal Cyclist, Other (not involving motor vehicle traffic)</td>
<td></td>
</tr>
<tr>
<td>• Pedestrian, Other (not involving motor vehicle traffic)</td>
<td></td>
</tr>
<tr>
<td>• Transport, Other (not involving motor vehicle traffic)</td>
<td></td>
</tr>
<tr>
<td>• Natural and Environmental</td>
<td></td>
</tr>
<tr>
<td>• Overexertion</td>
<td></td>
</tr>
<tr>
<td>• Poisoning</td>
<td></td>
</tr>
<tr>
<td>• Struck By or Against</td>
<td></td>
</tr>
<tr>
<td>• Other Specified, Not Elsewhere Classified</td>
<td></td>
</tr>
<tr>
<td>• Unspecified</td>
<td></td>
</tr>
</tbody>
</table>

Injury Mortality Rates

Table 6.18 Leading Causes of Injury Deaths in Manitoba – 1992-1999

<table>
<thead>
<tr>
<th>Cause</th>
<th>Total Number</th>
<th>Rate/100,000</th>
<th>Total PYLL</th>
<th>Average PYLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>1,037</td>
<td>11.3</td>
<td>35,157</td>
<td>33.9</td>
</tr>
<tr>
<td>Motor Vehicle Traffic Accidents - Unintentional</td>
<td>888</td>
<td>9.7</td>
<td>31,326</td>
<td>35.3</td>
</tr>
<tr>
<td>Falls – Unintentional</td>
<td>659</td>
<td>7.2</td>
<td>3,273</td>
<td>5.0</td>
</tr>
<tr>
<td>Fractures Cause Unspecified – Unintentional</td>
<td>266</td>
<td>2.9</td>
<td>275</td>
<td>1.0</td>
</tr>
<tr>
<td>Suffocation and Choking – Unintentional equal to Assault</td>
<td>207</td>
<td>2.3</td>
<td>6,907</td>
<td>33.4</td>
</tr>
<tr>
<td>Assault</td>
<td>207</td>
<td>2.3</td>
<td>8,972</td>
<td>43.3</td>
</tr>
</tbody>
</table>


Males have a higher rate of injury deaths in all categories described above, except for unintentional fractures, where females had a rate of 3.6/100,000 and males 2.2 / 100,000. As shown, there has been a significant impact on PYLL in the areas of suicide and motor vehicle accidents.

NE Injury Mortality Rates

Injury mortality rates for NE are profiled for the years 1992 to 1999. Information for each specific year is not available. It is difficult to determine if the rate for the seven years is consistent, or if there are years where the rate is unusually high.

Clearly, males have more than double the injury mortalities than females. This is true for all categories: unintentional, self-inflicted, assault and undetermined.
Figure 6.35 Injury Mortality Rates NE Region

This is defined as the number of deaths per thousand residents that are due to any injury. There is no available health district information as the numbers were very small.

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Females</td>
</tr>
<tr>
<td>Suicide</td>
<td>55</td>
<td>9</td>
</tr>
<tr>
<td>Motor Vehicle Traffic Accidents-Unintentional</td>
<td>48</td>
<td>17</td>
</tr>
<tr>
<td>Drowning &amp; Submersion-Unintentional</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Assault</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Fire &amp; Burns-Unintentional</td>
<td>11</td>
<td>4</td>
</tr>
</tbody>
</table>


Note: We are unable to compare the rates with Manitoba as age and sex standardization was not done in this report. 63

From 1992 to 1999, 193 residents of NE died as a result of injuries. This represents a total of 7,024 PYLL or an average of 36.4 years per person. 64
**NE Unintentional Injury Deaths**

This refers to injuries where there is no intent to do harm.

**Table 6.20 Total Unintentional Injury Deaths per 100,000 - 1992-1999 in NE**

<table>
<thead>
<tr>
<th></th>
<th>Females /100,000</th>
<th>Males / 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>26</td>
<td>52</td>
</tr>
<tr>
<td>Manitoba</td>
<td>24</td>
<td>42</td>
</tr>
</tbody>
</table>


NE appears to have a higher rate of unintentional injuries for both females and males during the time period reviewed when compared with Manitoba. Males appear to have more than double the unintentional injury deaths than females.

**Table 6.21 Top Four Causes of Unintentional Injury Mortalities in NE**

<table>
<thead>
<tr>
<th>Males [all age groups]</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle Traffic</td>
<td>Motor Vehicle Traffic</td>
</tr>
<tr>
<td>Drowning / Submersion</td>
<td>Fall</td>
</tr>
<tr>
<td>Transport Other</td>
<td>Fire/burn</td>
</tr>
<tr>
<td>Fire / Burn</td>
<td></td>
</tr>
</tbody>
</table>


Mortalities related to motor vehicle traffic occur in all age groups, but affect more males than females until the females reach the age of 65 years, after which the female rates surpass males.

Consistent with the Manitoba data more males have injury mortalities than females in the majority of categories, however this changes in older age groups. Around the age of 85 years, there are more female injury mortalities than males with a higher incidence of deaths related to unintentional falls. 65

For females beginning at age 65 years and over, we see unintentional injury death rates increasing. By 85 years and older, we see the rate at its highest for any age group, at 341.7/100,000. The cause of deaths at 85 years and older is primarily due to falls then motor vehicle traffic.

For males we see unintentional injury death rates beginning to increase at 55 years and over. We see unintentional injury rates reaching there highest at 85 years and older with a rate of 226.2/100,000. The cause of these deaths at 85 years and older, are related to transport, other, natural/environmental and unspecified.
Figure 6.36 PYLL Due to Unintentional Injuries

The number of PYLL varies throughout the ten years reviewed. Females appear to have a lower PYLL than males.

NE Intentional Injury Deaths

Self-inflicted injuries refer to the intent to harm one's self. Assault refers to the intent to harm another.


For injuries that are self-inflicted, the total rate for males is 29.5/100,000 and for females it is 6.1/100,000. For both sexes it is 18.1/100,000.

For males in the 10-14 age group, this is the first time where self-inflicted injury resulted in death. The deaths were the result of suffocation and firearms.

For females, self-inflicted deaths begins to occur in the 15 to 19 year age group at 26.4/100,000.

The highest rate of self – inflicted injuries occurred between 15 to 19 years for both males (81.7/100,000) and females (26.4/100,000). The cause of these deaths is associated with suffocation.
Figure 6.37  PYLL Due to Suicide in NE

PYLL due to suicide is the number of years of life lost when a person dies “prematurely” from suicide before age 75. This was the main cause of injury death in Manitoba between 1992 and 1999. PYLL due to suicide fluctuates during the time periods reviewed. In 1995 and 1998 there was no female PYLL reported. During 2001 there was no male PYLL reported.

The average PYLL from suicide during 1992 to 2001 was 269 in NE. Unintentional injury deaths was 499 PYLL during the same number of years.


In terms of total assaults, males have about twice as many injuries as females at 5.1/100,000 and 2.7/100,000 respectively. When females reach the age of 25 years, the rates even out with female assault rates surpassing males in the 45-65 age groups.

The top two causes of assaults for males were firearms and fire/burn. For females the causes of assault death rates were: child maltreatment, cut/pierce and struck by, against.

NE Undetermined (1992-1999)

There is no intent known. The total undetermined rate for males was 3.8 / 100,000 and for females 2.3/100,000.
Injuries Requiring Hospitalization

Figure 6.38 Number of Hospitalizations Due to Injuries

This is where an injury code is listed as the primary diagnosis on the hospital discharge abstract.

In both time periods reviewed, NE injury hospitalization rate was statistically significantly higher when compared with Manitoba.

Injury hospitalizations in NE were not significantly different than Rural South during the second time period.

The good news is that this rate has had a statistically significant decrease in NE during the two time periods reviewed.

Table 6.22 Crude Rates/100,000 of Hospitalizations due to Injuries – Males 2001

<table>
<thead>
<tr>
<th>Area</th>
<th>15 to 19 years</th>
<th>20-24 years</th>
<th>25 to 34 Years</th>
<th>35-44 Years</th>
<th>85 years &gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>1,484</td>
<td>1,747</td>
<td>1,578</td>
<td>1,027</td>
<td>7,071</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1,234</td>
<td>1,278</td>
<td>1,007</td>
<td>829</td>
<td>5,540</td>
</tr>
</tbody>
</table>


In NE, boys and young men from birth to age 14 appeared to have a lower rate of hospitalization due to intentional and unintentional injuries than all Manitoba males combined. This changed, however, when we look at adult men aged 15 years and old, who appeared to be at higher risk for injury than all Manitoba men. An exception to this was men aged 55 –64 and 75 to 84 years.

Table 6.23 Crude Rates / 100,000 of Hospitalization due to Injuries – Females 2001

<table>
<thead>
<tr>
<th>Area</th>
<th>15 to 19 years</th>
<th>20-24 years</th>
<th>25 to 34 Years</th>
<th>85 years &gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>1,729</td>
<td>1,266</td>
<td>1,035</td>
<td>10,738</td>
</tr>
<tr>
<td>Manitoba</td>
<td>797</td>
<td>602</td>
<td>539</td>
<td>7,827</td>
</tr>
</tbody>
</table>


Females in NE were at higher risk for both intentional and unintentional injury hospitalizations in all age groups except for ages one to four and 45 to 74 years. Young people and people over 85 years are at highest risk for injury hospitalization in 2001.
Table 6.24 Leading Cause Of Injury Hospitalizations In NE From 1992-2001

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Females</td>
</tr>
<tr>
<td>Falls – unintentional</td>
<td>1,476</td>
<td>811</td>
</tr>
<tr>
<td>Motor Vehicle Traffic Accidents-Unintentional</td>
<td>483</td>
<td>211</td>
</tr>
<tr>
<td>Assault</td>
<td>387</td>
<td>108</td>
</tr>
<tr>
<td>Self-inflicted Injuries</td>
<td>371</td>
<td>238</td>
</tr>
<tr>
<td>Transport, Other-Unintentional</td>
<td>168</td>
<td>42</td>
</tr>
</tbody>
</table>


Note: We are unable to compare the rates with Manitoba as age and sex standardization was not done in this report.

Females in NE have more hospitalizations than males due to falls and self-inflicted injuries. The male rate exceeds females for motor vehicle injury, assaults and transport.

In Manitoba during 2001 to 2002, injuries were the leading cause of hospitalization among males aged 10-39 years of age (31%). Injuries were the fifth leading cause of hospitalization among females aged 15 to 39 years (4.2%). Injury hospitalizations showed a 17.3% decrease among males and a 9.3% decrease among females. This decrease may be in part, the result of changing hospital-admitting practices during this time.

Occupational Injuries

The Manitoba Workers Compensation Board (WCB) is a mutual accident and disability insurance agency governed by a Board of Directors representing employers, workers and the public interest and is funded by employer premiums.

“Every workplace and worker in Manitoba is under the jurisdiction of either provincial or federal workplace safety and health legislation... WCB Manitoba generally covers approximately 70 percent of the Manitoba workforce. Examples of industry sectors and groups that are excluded from compulsory WCB coverage include agriculture (farming), school teachers, landscaping, pilots or self-employed workers from any industry sector.”

Through close work with the Workplace Safety and Health Division of Manitoba Labour and Immigration, the WCB continued injury prevention efforts in 2003 to build a strong workplace safety and health culture in Manitoba. Priority areas are public awareness, training, prevention measures and responsibility.

“Manitoba’s time loss injury rate has decreased from a high of 5.8 injuries per 100 workers in 2000, to 4.8 in 2003. There is still work to be done, safety has to be everywhere for the rate to keep decreasing. That’s why Manitobans are being encouraged to think of reducing risks at home and at work.”
Injury prevention remains a priority for the WCB. The WCB and the Workplace Health and Safety Division are working together to build a culture of safety in Manitoba with a goal of reducing the time loss injury rate by 25% over five years.75

Table 6.25 Manitoba Workplace Injury Claims, North Eastman

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of firms reporting claims*</th>
<th>Number of workers in these firms</th>
<th>Number of firms with &lt;5 claims</th>
<th>Time loss claims (TL)</th>
<th>No time loss claims (NT)</th>
<th>Total number of claims (TL+NT)</th>
<th>Total number of compensation days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>106</td>
<td>3033</td>
<td>97</td>
<td>165</td>
<td>373</td>
<td>538</td>
<td>4941.4</td>
</tr>
<tr>
<td>2001</td>
<td>108</td>
<td>3095</td>
<td>99</td>
<td>147</td>
<td>357</td>
<td>504</td>
<td>5265</td>
</tr>
<tr>
<td>2002</td>
<td>126</td>
<td>2470</td>
<td>121</td>
<td>161</td>
<td>203</td>
<td>364</td>
<td>6446.5</td>
</tr>
<tr>
<td>2003</td>
<td>109</td>
<td>2507</td>
<td>101</td>
<td>144</td>
<td>168</td>
<td>312</td>
<td>4268.7</td>
</tr>
</tbody>
</table>


* The larger employers include those in the primary industries related to mining and forestry, as well as others, for example the health care sector, school divisions and small business located in our municipalities.

During the four years reviewed we can see a trend toward a decrease in the total number of time loss and no time loss claims from 538 in 2000 to 312 in 2003. Having said this, there appears to be the greatest decrease related to no time loss claims. When time loss claims are reviewed, there has been a fluctuation in the numbers, with only slight variations between the years.

One might conclude by this, that the number of more serious injuries that required time loss has not changed appreciatively during the four years. WCB was unable to be more specific, in providing us with the types of injuries that occurred.

Table 6.26 Manitoba Workplace Fatal Injuries 1983-2002

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mining</td>
<td>43</td>
</tr>
<tr>
<td>Construction</td>
<td>68</td>
</tr>
<tr>
<td>Farm related</td>
<td>151</td>
</tr>
</tbody>
</table>

Table 6.27 Major Causes of Workplace Deaths from 1983 to 2002 in Manitoba

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Percentage of Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle/mobile equipment</td>
<td>36.4%</td>
</tr>
<tr>
<td>Other</td>
<td>24.9%</td>
</tr>
<tr>
<td>Fall from height</td>
<td>12.4%</td>
</tr>
<tr>
<td>Explosion/fire</td>
<td>7.2%</td>
</tr>
<tr>
<td>Machinery contact</td>
<td>6.6%</td>
</tr>
<tr>
<td>Electrocution</td>
<td>4.6%</td>
</tr>
<tr>
<td>Structure failure</td>
<td>2.9%</td>
</tr>
<tr>
<td>Confined entry</td>
<td>2.6%</td>
</tr>
<tr>
<td>Excavation</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

Total number of deaths from all industries 346


Workplace Injuries Resulting in Hospitalization

In 2001, WCB recorded hospital payments for 506 claims or 2.7% of time loss claims. Of the 506 claims tracked, over 50% of those injured were hospitalized within 30 days of the injury.

Figure 6.39 Workplace Injury Rate Resulting in Hospitalization in NE

As noted NE males aged 45 to 54 years appeared to be at greatest risk for hospitalization due to a workplace injury at 210/100,000, compared with Manitoba in the same age group at 98/100,000.

When NE is compared with all of Manitoba males, we see NE hospitalizations appear to be higher than Manitoba in the following age groups: 15 to 19, 35 to 44 and 45 to 54 years during 2001.
Q10 – *In the past 12 months, did you have any injuries that were serious enough to limit normal activities, such as work, school, or regular activities outside of the home?*

Yes = 16% and No = 84%

First Nations/Aboriginal / Metis respondents were more than twice as likely as respondents in the region, generally to have suffered an injury limiting their normal activities in the past year.

It is known that FN Manitobans were more likely to die of their injuries and/or be hospitalized due to injuries than other Manitobans. The rate of injury deaths was almost twice that of other Manitobans. The rate of injury hospitalization among FN Manitobans was over three times that of other Manitobans. 78

Q11 *Looking back at your most recent injury, where did it happen?*

- The home or surrounding yard was by far the most prevalent place of injury at 43%.
- Park or recreational site 14%.
- Factory, warehouse/construction site at 13%.
- Farm at 11%.

Q12 *What type of injury did you have?*

The top three types of injury were

- Sprains or strains at 41%.
- Whiplash or spinal injury at 13%.
- Dislocations at 8%.

Q 13 *And in the past 12 months, about how many days of school, or work did you miss as a result of injury?*

Fifty-four percent of the respondents, who had an injury, indicated that if they did miss time the most frequent absence period was between 31-60 days. None indicated a period longer than six months.

CHA NE Survey - 1997

Q - Section A 11a: *In the past twelve months, did you or any member of your household have any injuries that were serious enough to limit normal activities?*

Yes 527 (31%)  No 1,197 (69%)  [No response numbers were excluded from percentage]

We would expect to see a higher percent, as the 1998 NE survey included other members of their household as well as the respondent.

Q- Section A 11e: “Where did the injury happen?"  

The top four places were:

a) In a home or its surrounding area.
b) Workplace.
c) Place of recreation.
d) Street or highway.

In the home was the consistent with the 2003 Acumen Research Survey.
2003 NE Acumen Research Survey – NE Findings

Q14 And, if you went to see anyone about treatment for your injury, where did you go?

<table>
<thead>
<tr>
<th>Alternative Therapies ex. Massage, Reflexology, Chiropractor, Acupuncture, Physiotherapist</th>
<th>Hospital emergency or urgent care department</th>
<th>Family Doctor</th>
<th>Hospital non-emergency or outpatient clinic</th>
<th>Community Health Centre or Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>36%</td>
<td>30%</td>
<td>18%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>


The majority of NE respondents indicated that they sought alternative therapies for their injuries. It should be noted that some alternative therapy examples provided are mainstream treatments i.e. Chiropractors and Physiotherapists.

Q 15 What are you now doing, if anything, to prevent this kind of injury from happening again?

Fifty percent of respondents indicated they are being more careful as a means of preventing the injury from re-occurring. About 26% indicated that nothing could have been done to prevent the injury.

Functional Health

In the CCHSC 1.1, this indicator captures eight dimensions of functioning in the population over age 12 years: vision, hearing, speech, mobility, dexterity, feelings, cognition and pain. Functional health is a good predictor of residents who may have ongoing health care needs. Both males and females reported slightly better functional health than Manitoba combined.

Figure 6.40 Functional Health in NE Over 12 Years

Note: The (c) for NE males represents a small sample size so should be interpreted with caution.

We know that there are health district disparities. This indicator is not available at the health district level.
Q 3 During the past 30 days, did you have any difficulties with your physical health that kept you from doing the things you usually do in a typical day?

Slightly more than three-quarters of respondents (78%) reported no physical difficulties within the previous 30 days. Of those that did respond yes, 3% reported physical difficulties that totally limited normal activities.

Respondents aged 35-44 years were more likely than the NE average to report physical health difficulties that impaired their normal activities. Given the age group, one might surmise that the physical limitations might be short lived and accidental in nature.

**Activity Limitations**

There is no information available for NE as the sample size is too small. (CCHSC 1.1)

**Well-Being**

“Broad measures of the physical, mental and social well-being of individuals.”

Health status of the population is not only measured by how often an individual visits or is diagnosed with an illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but is well controlled and they are functioning well, i.e. able to work and do various activities that other people their age are able to do who may not have an illness.

**Self-Rated Health**

Self-reported health is a general indicator of the overall health status of individuals. This is defined as the percent of the population age 12 and older that report that their health is very good or excellent. “Studies indicate that when individuals rate their health in response to this question, they tap into information that has important predictive power relating to chronic disease incidence, functional decline and ultimately survival.”

This measure lacks credibility by some groups because it is not verifiable.
We can see that there was a slightly smaller proportion of NE males reporting themselves in very good or excellent health (53.5%) when compared with Manitoba as a whole at 57.6%. Females in NE and Manitoba were comparable in their self-reporting of very good or excellent health at 56.6% and 56.0% respectively.

**2003 NE Acumen Research Survey – NE Findings**

**Q2 Would you say your health is generally...**

Excellent or good = 56%. This compares with the CCHSC 1.1 of 55% for both males and females in NE, validating these findings.

**Q5- Compared to others your age, would you say your health is:**

Excellent = 18% Very good = 35% Good = 35% Fair = 9% and Poor = 2%. Respondent’s perception of excellent and/or very good health peaked in 24-34-age bracket, closely followed by the 18-24 age group.

Question 2 and Question 5 reveal similar information.

a) Respondents’ impressions of their own health and or perceptions of enjoying health generally deteriorate with age.

b) Perception of health rises with education.

c) Respondents of First Nations, Aboriginal or Metis ancestry are more likely than average to rate their health as fair or poor (23%) compared to the NE average of 10% [Q2 only].

d) Respondents living in a household of one or two persons are much more likely than those in larger households to rate their health as fair or poor. In four-person or more households, respondents claimed to have very good or excellent health.

e) Respondents’ impressions of their own health generally improve as their family income increases with 28% of those in the under $20,000 category rating their health as fair or poor compared to just 4% of those in the $60,000 and over category. [Q2 only]. Similarly Q5 with highest incomes over $60,000 tended to say their health was very good/excellent while those in the under $20,000 were more likely to indicate fair or poor health.

These findings clearly support the population health model that the perception of good health is not only a response to illness, but to other factors such as age, education, employment, social support, and income.
CHA NE Survey 1997
Q- Section  B # 9: In general, compared to other people your age would you say your health is”

Excellent 204  (13 %) Very Good 576 (36 %) = Good 624  (39 %)
Fair  158  (10 %) Poor 39 ( 5 %) [No responses were excluded from percentage]

We can compare this question with the 2003 Acumen Research Survey – NE Findings as the questions are virtually identical, however the age groups surveyed were not identical which could skew the results. We note that there are fairly similar findings between the two surveys with a slight increase in the Excellent or Very Good from 49% to 53% respectively; in the Good from 36% to 35% and in the Fair or Poor from 15% to 11%.

Overall there seems to have been a slight improvement in the self reported health when we compare 1997 with 2003 survey respondents.

2003 Focus Groups – Meaning of Health

It was important for the CHA Consultation team to have an understanding of what health meant to people in our community and to ascertain if staff has a similar view. The following information provides an overview of participants’ thoughts on health.

YOUTH
Youth participants in all the focus groups had a good sense that health was not limited to only physical health, but did include social support and healthy lifestyle practices.

Overall, youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself, minimizing stress, and being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

YOUNG ADULTS
Overall the young adults had a clear sense of what health means to them and it wasn’t only about physical health, but included attitude. This group emphasized how work and child demands play an important part in their lives and had the ability to affect their health.

Some of the major themes that emerged in all focus groups included: absence of sickness, participating in life, humour, healthy eating, active lifestyle (exercise), good mental health, social support, good relationships especially for people who are alone, balance, work, no bad habits i.e. smoking, drinking to excess and ensuring one had a good night’s sleep.

MIDDLE ADULTS
This group indicated that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humour, weight management and the importance of social activity and connection, being mentally well, stress management, and balance. A participant in Blue Water felt that good health is relative to the health status of others. Use of the health system by them personally is mentioned for the first time. Caring for aging parents emerges more strongly here than in the Young Adult age group.
SENIORS
This age group seemed to have knowledge about what good health and healthy lifestyle meant to them. In general, most senior groups included aspects of mind, body, attitude, as well as keeping active and mobile, good nutrition, exercising, for example walking. Other activities that contributed to good health included socializing, being active in the community, friends and family. Religion and churches were seen as a positive thing seen in a healthy community.

STAFF
NEHA staff participants’ idea of health focused on many of the determinants of health.

Themes included: quality of life, lots of energy, enjoying life, no pain or fatigue, ability to participate in activities, happy at work and socially, exercise, healthy eating (Canada Food guide), no smoking, drugs, or alcohol, ability to handle stress, a personal well-being, contentment, moderation and balance. A whole person is bio-social-spiritual and health not just health care. Healthy lifestyle is different for different people.

- “any approach to living that allows one to maintain health.”


2003 Focus Group on There’s Nothing To Do

It was felt that the perception of ‘nothing to do’ has an effect on the overall well-being of an individual. Youth in every focus group mentioned this as an issue. Adults also raised this in their focus groups specifically related to recreational activities.

YOUTH
- There are few options other than walking around town. [Brokenhead]
- There are inadequate numbers and varieties of activities to keep them [youth] occupied. [Winnipeg River]
- In Springfield there was apparently a Drop-In Centre during the summer but it wasn’t well advertised and the hours of operation were not conducive to their lifestyle. Youth stay up late and get up late or work during the day making attendance at the centre prohibitive. [Springfield]
- Youth spend time “flipping loops” i.e. driving around town. [Brokenhead]
  “We’re not really the healthiest bunch here because there’s nothing to do in town…” [Blue Water]  “Smoke and drink, that’s what you have to do…” [Blue Water]
- The youth in the group did understand that these activities aren’t good for you [smoking and drinking], but would rather go to a party than stay at home. [Blue Water]  Refer to alcohol and smoking in the Health Practice Section.

Suggestions Raised by Youth
- Would like evening hours for drop in centres. [Springfield, Brokenhead, Blue Water]
- Drop in centre held at Sun Gro Centre. [Brokenhead]
- Would like a “rec centre” with games, stuff to do, maybe a fitness centre.  It was emphasized that the facility must be accessible at low cost, preferably free. [Springfield]
- Movie theatre. [Blue Water]
- Youth felt their communities are too small to offer much diversity of activity. They would like more organized sports, e.g. roller rink. [Blue Water]
- “Somewhere to go and have fun, like a rec hall.”[Blue Water]

Note: During the 1997 Focus Groups several similar need arose:
- Need for more recreation for teenagers. [Brokenhead]
- Youth problems seem to be escalating. Youth in general need more attention. [Springfield]
- Teenagers need more attention – recreational activities. [Winnipeg River]
- Need more guidance from school and home. [Winnipeg River & Blue Water]

At the time of writing this report, Springfield is in the planning stages for a youth drop in centre to be located in Oakbank.
### 6.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.&quot; 88</td>
<td>&quot;Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.&quot; 89</td>
<td>&quot;Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.&quot; 90</td>
<td>&quot;Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.&quot; 91</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.&quot; 92</td>
<td>&quot;The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predisposition influence the ways individuals are affected by particular diseases or health challenges,&quot; 93</td>
<td>&quot;Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.&quot; 94</td>
<td>&quot;Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.&quot; 95</td>
</tr>
</tbody>
</table>

Among the major health problems facing Canadians over the next 10 to 20 years will be: heart disease, cancer, mental health problems, AIDS, asthma, obesity and diabetes.

These problems are related to our diet, exercise, substance-use patterns and other health behaviours.

Overview

Men and women are different. We know that women do live longer than men, but in Canada over 4 million women compared with under 3 million men reported in 2000-2001 to have two or more chronic conditions.  

"It is acknowledged that culture and gender have a cross-cutting, influential effect on all the other health determinants ...Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors."  

Visible Minorities

This is defined as persons other than Aboriginal people who identified themselves a non-Caucasian in race, or non-white in colour, in the 2001 Census of Canada.

In NE less than one percent of residents identified themselves as belonging to any visible minority group.

In Manitoba, Filipino is the largest single visible minority group at 3% of the population.
Overview

We can’t expect to be healthy if our environment is not. Nor can we take for granted environmental health. It is something that we must be working on constantly and it involves other partners as it is so interrelated. It is known that a community where you can trust your neighbours and feel you belong promotes health and long life.

It is important that we “Live in quality housing, but not next to a busy street, in an urban ghetto, or near a polluted river: clean air water and soil are vital to…health, as are the human-made elements of our physical environment.”

Environmental factors encompass a wide range of issues and are often difficult to measure. We do have regulations in place, for example: food processing and other manufacturing, sewage disposal, water testing, air quality related to pollution, home building products and roads. Global environmental changes affect us. As global citizens, we have a duty to ensure that we assist in minimizing the pollution and waste in our environment.

A variety of illnesses arise from environmental issues including: respiratory diseases, skin or eye problems, gastro-intestinal, various infections, cancer, cardiovascular disease, mental disorders and poisoning.

Water

Most communities within NE have access to treated drinking water. There are also a number of independent water co-ops throughout the region. In many of the rural areas, private wells are used.

Water Quality

Since the outbreak of E.Coli in Walkerton, Ontario in 2001, residents of Manitoba are becoming increasingly aware of the fragility and importance of their water supply. In the summer of 2003, there were several swimming bans in our local lakes and there continues to be water boil recommendations in some of our communities.

With all these concerns, the New Democratic Party (NDP) in November 2003, created a new department called the Office of Drinking Water, Department of Water Stewardship. All public drinking water supplying the province is managed out of the central office in Winnipeg.

“The mandate of the Office of Drinking Water is to ensure that water suppliers provide safe, aesthetically pleasing water in quantities sufficient to meet public needs…. There are four officers located in the NE region... [they] monitor drinking water related activities with their geographical area of jurisdiction. Their
primary activities center on inspecting, monitoring, and providing technical support to public water supply systems …the regional Drinking Water Officers have been in place since the spring of 2003.”

The Drinking Water Safety Act was proclaimed in January 30, 2004… “The Drinking Water Safety Regulation deals with the permitting of new works and issuing renewable operating license for existing works. The Drinking Water Standards Regulation relates to the water quality standards that drinking water facilities will be required to meet. Enactment of these regulations is expected in the spring of 2004.”

“The water quality of the North Eastern Region is typical for rural, cottage country water systems. The majority of the North Eastern [district’s] water systems are small public and semi-public systems. In the 1970’s, Prairie Farm Rehabilitation Administration and Manitoba Water Services Board assisted residents in constructing most of the public systems.”

Manitoba has 400 public water systems. There are 73 registered public water supplies in NE.

“A number of public water systems in the North Eastern Region rely on a surface water source with minimal treatment. In the short-term, such systems may be more vulnerable to microbial contamination that more sophisticated water systems, so operators must be vigilant in their disinfectant applications and water quality monitoring. In the longer term, there is the potential for turbidity and Trihalomethane (THM) levels that exceed Canadian Drinking Water Guidelines. Potable water systems utilizing surface water as their source will require specific treatment for the removal of crypto/gardia and to reduce turbidity and THM levels. These variables are currently being monitored and the Office of Drinking Water is working cooperatively with the small system owners to try and address these chronic issues. However, due to costs of upgrading current systems, maintenance and operations, regional systems and/or linking of small water co-ops may be viable solution in providing potable water to a wider base of North Eastern residences.”

Boil Water Advisories in NE

“Boil Water Advisories are issued for microbiological outbreaks, system failure and operational deficiencies and are not intended to remain in perpetuity. Manitoba Health, Conservation and Water Stewardship work collectively to ensure that health and technical support are given to water systems that are issued boil water advisories. Ongoing discussions between government departments, communities and the public in general assures that all concerned is making every effort that notification and subsequent lifting of the Boil Water Advisory is timely.

Technical and operational support is provided to water system owners and operators by regional Drinking Water Officers; located in Gimili, Lac du Bonnet and Via Rail Regional Offices. Working cooperatively with owners of systems under boil water advisories, support is given for treatment upgrades and/or the acquisition of an alternate source of potable water in the interim.”

In NE, as of March 2004, there are three communities that have boil water advisories. These are Tyndall, issued July 21, 2000; Garson issued July 27, 2000 and Anola issued July 28, 2000.
There are also other boiling water advisories related to some campgrounds, treatment plants and co-operative water systems.

**Sewage Systems**

Sewer system services are provided to most communities, while the rural areas rely on septic fields and holding tanks. All areas are serviced with lagoons for waste disposal.

---

**Focus Groups on Environmental Safety**

**YOUTH**
- Water quality emerged in the Iron Rose group when talking about farm safety and whether they were concerned about bovine spongiform encephalopathy (BSE) and E-coli water contamination. They generally felt that more was being made of these concerns than warranted.
  “We get town water, so you think it should be good.” [Iron Rose]

**YOUNG ADULT**
- Access to safe water was raised as a concern around Elma. [Iron Rose]

**MIDDLE ADULT**
- One participant in Springfield felt pollution responsible for higher than average incidences of nervous system disorders e.g. Fibromyalgia, Multiple Sclerosis. [Springfield]
- Poor water quality in Cooks Creek, the creek is contaminated by pesticides, chemicals, sewage. [Springfield].

---

**The Air We Breathe**

**Second Hand Smoke**

“Smoke from cigarettes remains one of the most significant indoor pollutants.” In NE region, 31.6% of males and females over the age of 12 indicated that they were exposed to second hand tobacco smoke in public spaces and work places. The CCHSC 1.1 defined exposure as being within the month prior to the date of the survey (during September 2000 to November 2001). In Manitoba this percentage for both males and females was 30.4% and in Canada the percentage was 28.6.

**Note:** This percentage should be used with caution in our region, due to the small number of responses to this question.

---

**2003 NEHA Staff Focus Group on Smoking within facilities**

Within the staff focus group there were three former smokers and one participant who still smoked. Some participants felt that it is inappropriate to permit staff to smoke immediately outside the doors of health care facilities. Three reasons were cited:
- “…We are supposed to be role models…we have our own addictions…but should we be broadcasting that?”
- “…I feel bad for people that are coming in with severe breathing problems…and they have to walk through that haze at the door.”
- “…People complain about staff coming back from smoking and the poor person with asthma, they smell it…”

The group generally agreed that smoking areas should be designated spaces away from facility entrances. At Whitemouth District Health Centre and Beausejour Health Centre, smokers do not smoke at public entrances.

**Suggestions Raised by Staff about an anti-smoking campaign:**
- “…You have to respect both sides of it. It’s a process that will take time. If you can protect children and people with asthma or whatever, from second hand smoke, that’s a step in the right direction.”
## Safety

### Table 6.28 Crime Report Regional Total *

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Springfield</td>
<td>456</td>
<td>378</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle theft, theft over $5000/under $5000, fraud.</td>
<td>Brokenhead</td>
<td>556</td>
<td>431</td>
</tr>
<tr>
<td></td>
<td>Criminal Other - Offensive and restricted weapons.</td>
<td>Iron Rose</td>
<td>104</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace, arson, indecent acts, bail violations, breach of probation, harassing and stalking, kidnapping, prison unlawful at large.</td>
<td>Winnipeg River</td>
<td>448</td>
<td>337</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blue Water</td>
<td>321</td>
<td>278</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Northern Remote</td>
<td>2,596</td>
<td>2,669</td>
</tr>
<tr>
<td><strong>Total Criminal Code</strong></td>
<td></td>
<td></td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td>Brokenhead</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Iron Rose</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Winnipeg River</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blue Water</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Northern Remote</td>
<td>62</td>
<td>85</td>
</tr>
<tr>
<td><strong>Total Federal Code</strong></td>
<td></td>
<td></td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-moving traffic.</td>
<td>Iron Rose</td>
<td>459</td>
<td>142</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Winnipeg River</td>
<td>370</td>
<td>275</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blue Water</td>
<td>286</td>
<td>161</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Northern Remote</td>
<td>1023</td>
<td>1027</td>
</tr>
<tr>
<td><strong>Total Provincial Code</strong></td>
<td></td>
<td></td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Springfield</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Brokenhead</td>
<td>30</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron Rose</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Winnipeg River</td>
<td>27</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Water</td>
<td>17</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Remote</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Municipal Codes</strong></td>
<td></td>
<td></td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td><strong>Traffic Codes</strong></td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired driving, driving over 80 MG (blood alcohol level), driving a motor vehicle prohibited, property damage.</td>
<td>Springfield</td>
<td>92</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>Brokenhead</td>
<td>174</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron Rose</td>
<td>119</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Winnipeg River</td>
<td>166</td>
<td>154</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Water</td>
<td>135</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Remote</td>
<td>211</td>
<td>204</td>
<td></td>
</tr>
<tr>
<td><strong>Total Traffic</strong></td>
<td></td>
<td></td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Springfield</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Brokenhead</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron Rose</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Winnipeg River</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Water</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Remote</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Persons killed</strong></td>
<td></td>
<td></td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Springfield</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Brokenhead</td>
<td>27</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron Rose</td>
<td>24</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Winnipeg River</td>
<td>29</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Water</td>
<td>14</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Remote</td>
<td>25</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>Total Persons injured</strong></td>
<td></td>
<td></td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td><strong>GRAND TOTAL OF ALL OFFENSES</strong></td>
<td>Note: this does not include persons injured or killed in traffic related incidents.</td>
<td></td>
<td>8,714</td>
<td>7,481</td>
</tr>
</tbody>
</table>

Source: Bill Hanysh, Corporate Management Branch (CMB). Client Services, RCMP ‘D’ Division. Received August 8, 2003.
• * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may have been cleared.

• ** The number of persons injured and killed in traffic related incidents are not included in the numbers associated with the total traffic code category nor in the grand total of all offences. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or NE region.

There is some cause to celebrate with respect to the criminal code offenses as these have generally decreased overall. Federal Code violations is the only category that has shown an increase. Municipal code violations have stayed the same, at 83, for the two years reviewed.

There are substantial differences in the number of offenses when we compare Northern Remote with other health districts. The total reported cases in Northern Remote have increased slightly in 2002, as compared with 2001.

Of some concern is the increase in motor vehicle deaths and injuries.

Deaths – There has been a rise in all the health districts, especially Brokenhead and Springfield, where there were no deaths reported in 2001. In 2002 there were 3 deaths in Brokenhead and 4 in Springfield. Deaths in Iron Rose saw a decrease from one to zero in 2002. Northern Remote remained the same at two deaths in both years. Regionally, there has been an increase in total deaths with three deaths in 2001 compared with 11 in 2002.

Injuries – Injuries related to traffic incidents increased from 133 in 2001 to 154 in 2002 (a 15.8% increase). The highest number of injuries in a health district occurred in Springfield, where there were 14 injuries in 2001 as compared with 36 in 2002.

Note: We are not able to compare previous crime report information as the Corporate Management Branch (CMB) of the RCMP changed their system of reporting.
2003 Focus Groups - Safety

YOUTH

a) Personal Safety
- There is concern among half of the Springfield participants about their security and youth carrying weapons. There was a felt need that they had to protect themselves from becoming victims. There was no consensus on whether the targets are random. [Springfield]

b) SKIDS – The issue of skids (kids who hang around the streets) emerged in a compassionate and thoughtful way in Brokenhead youth focus group.
   Suggestion
   • Would like something for skids, activity centres are needed (Brokenhead).

As a follow-up, the CHA Assistant Carol Orvis talked to Cory Larson, Royal Canadian Mounted Police (RCMP) officer on February 6, 2004. He is the liaison with Edward Schreyer School. The following is a summary of this discussion:

Cory Larson indicates that right now there are not a lot of kids on the streets, its too cold, but come summer the kids will start to come out again. There is nothing for them to do. Cory has started a youth program, which he plans to run every Friday night at the old Elementary School. The first Friday night was February 6 and no one showed up. He plans to continue for a few more weeks and hopes that the kids will come once word gets around. The Pastor of the Beausejour Community Church holds a game night the last Friday of every month in the basement of the church. The Church is right on Park Avenue where the kids like to hang around, so it is convenient for them to drop in. The kids can come in and play pool, watch television, or just hang around. Refreshments are available. This initiative is going very well. The Town of Beausejour has recently implemented a loitering by-law, which states there will be no loitering at the front entrances to businesses.

YOUNG ADULT
Safety – There were two areas of concern i.e. vandalism and traffic issues.
   a) Vandalism
   Suggestion by Young Adults
   • In response to vandalism, having more people on the street in the evenings would reduce the incidences of vandalism. [Springfield]

b) Traffic
   - Participants were concerned about the speed of traffic in Seven Sisters and Whitemouth. [Iron Rose].
   - One person in Ironrose group felt there wasn’t enough police presence in Whitemouth. [Iron Rose].

Suggestion by Young Adults
- Promote bicycle use and safety.
Housing

Unaffordable Housing

Whether an individual or family rents or owns, it is valuable information to know what proportion of income is spent on housing. If it is more than 30% of their household income, it is considered to be unaffordable housing.

Figure 6.42 Percentage of Households With Unaffordable Housing NE

Twenty-eight percent of renters living in NE were considered to be living in unaffordable housing. Manitoba’s percentage was 37%.

For owners 11% in NE as well as Manitoba was considered living in unaffordable housing.

To put this into some perspective in 2001 there were 1,795 rented and 11,530 owned dwellings in NE.  

Elderly Persons’ Housing

The North Eastman Region has a total of twenty-three facilities dedicated to housing for seniors, a total of 362 units:

- eleven of these facilities are owned and operated by Manitoba Housing,
- seven are privately owned, two are owned and operated by the Rural Municipality in which they are located,
- one is owned and operated by Community Housing Managers of Manitoba,
- one is owned by Beausejour Lion's Lodge Inc., and
- one is owned by North Eastman Health Association.

The Manitoba Housing Units are full, with waiting lists, except for the Foyer Chateauguay in St. Georges and Bonnie Vista Lodge in Lac du Bonnet. The Foyer Chateauguay has a chronic vacancy problem and Manitoba Housing has had to cap the rent in this facility in order to keep the vacancy problem to a minimum.

All other Manitoba Housing operated facilities charge 27% of income. At Bonnie Vista there have been 3 vacancies since December 2003 that have not been filled, which is unusual as there had always been a waiting list.
## Table 6.29 Elderly Person’s Housing in NE

<table>
<thead>
<tr>
<th>District/Community</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brokenhead</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour Burgoyne Station</td>
<td>20</td>
<td>Private</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour Lions Lodge</td>
<td>20</td>
<td>Lion’s Lodge Inc. Beausejour Lion’s Club</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour Twin Maples</td>
<td>15</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour South Haven</td>
<td>18</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour Armstrong Manor</td>
<td>22</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Beausejour Stony Plains Terrace</td>
<td>30</td>
<td>East Gate Lodge Personal Care Home, NEHA</td>
</tr>
<tr>
<td>Tyndall</td>
<td>Tyndall Manor</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Garson</td>
<td>Limestone Villa</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td><strong>Springfield</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anola</td>
<td>Sunrise Lodge</td>
<td>12</td>
<td>Private</td>
</tr>
<tr>
<td>Dugald</td>
<td>Evergreen Lodge</td>
<td>10</td>
<td>RM of Springfield</td>
</tr>
<tr>
<td>Cooks Creek</td>
<td>Pleasant View Lodge</td>
<td>10</td>
<td>RM of Springfield</td>
</tr>
<tr>
<td>Oakbank</td>
<td>Kin Place</td>
<td>14</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Oakbank</td>
<td>Oaks North (seniors condominium)</td>
<td>14</td>
<td>Private</td>
</tr>
<tr>
<td><strong>Winnipeg River</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Bonny Vista Lodge</td>
<td>43</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Parkview Place</td>
<td>11</td>
<td>Private</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Park Manor</td>
<td>12</td>
<td>Private</td>
</tr>
<tr>
<td><strong>Blue Water</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Georges</td>
<td>Foyer Chateauguay</td>
<td>15</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>St. Georges</td>
<td>55+ Condominium</td>
<td>9</td>
<td>Private</td>
</tr>
<tr>
<td>Powerview</td>
<td>Winnipeg River Manor</td>
<td>16</td>
<td>Private</td>
</tr>
<tr>
<td>Pine Falls</td>
<td>Pineview Lodge</td>
<td>17</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td><strong>Iron Rose</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitemouth</td>
<td>Riverbend Manor</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Hadishville</td>
<td>4 of 8 units designated to seniors</td>
<td>4</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Prawda</td>
<td>2 of 8 units designated to seniors</td>
<td>2</td>
<td>Community Housing Managers of Manitoba</td>
</tr>
</tbody>
</table>

Source: Provided by Manitoba Health as cited to Grace Honke, Services to Seniors Specialist. February 2004.
Housing, especially the need for more Personal Care Home (PCH) beds, was an important concern raised in the previous 1997/98 CHA.

**MIDDLE ADULT**
- The need for PCH beds was identified in Pinawa. The need for transitional housing for people that are having difficulty in maintaining their own homes was identified in all health districts.

**SENIORS**
- More PCH beds were identified as a need by some participants in the Blue Water, Springfield, Winnipeg River groups. The need for more transitional housing is becoming more an issue in the seniors and middle years age focus groups.
- Pinawa has affordable townhouses for rent, there is no outside maintenance, but they are two-story dwellings. [Winnipeg River]

**Suggestion by Middle Adults**
- Condo complexes life leases “…run like a condo…on a non-profit basis…” [Blue Water]
  “We need a PCH in Pinawa more than anything. It’s very important to stay in your own community…Lac du Bonnet is nice, but you don’t know people.” [Winnipeg River]

**STAFF**
The group discussed the need for more varied senior’s housing. It was noted that Pinawa is lacking options for seniors.
Overview

The fundamental characteristics of this determinant include our genetic make up for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.”[116]

For information related to this determinant refer to the section on health status.
Overview

Health practices are linked with individual behaviours and values. “Healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life.” Lyons and Langille suggest that “…a healthy lifestyle is an adaptation of one’s social environment. Unless lifestyle is constructed (as a category of intervention) in concert with the way that lifestyle is experienced by target groups, interventions are unlikely to succeed.…Social environments are complex. Therefore, we must approach health issues and problems that recognize this complexity…”

Many health problems for example diabetes, cardiovascular disease, lung and other cancers, accidental injuries etc. can be associated to some degree with lifestyle practices, for example, eating habits, stress, lack of exercise or sleep.

It is important to recognize that that health status and the determinants of health although provided separately, are integrated to the degree that “One’s sociocultural environment is a very powerful determinant of lifestyle.” This refers to the multitude of influences i.e. economic, social, cultural and environmental that affect lifestyle choices.

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family’s pattern of life style and practice. Education alone is never enough. Other known influences on behaviour, either positive or negative, may include an individual’s peers, social / community norms and practices and the willingness on the part of the individual, family, or community to change.

Focus Group participants provide us with some clues about why they made changes to their life style. This is valuable information as to why changes were made and can be incorporated into health promotion programs, ensuring better success at achieving life-long sustained health practices.
Focus Groups on Life Style Changes Overall

Life style changes focused around what the individual did [if anything] to change their own lifestyle to promote better health and what the reason was. Participants told us that often a life style change, such as quitting smoking leads to other positive life style changes such as modifying diet and exercise.

YOUTH
- The common life style changes included dietary and exercise based primarily on the desire to lose / control weight.
  "I guess when you get older, like you never used to care about the clothes you wore or anything. As you get older you're more concerned about what people think." [Brokenhead]

YOUNG ADULTS
- The time and energy needed for lifestyle changes is a challenge in this age group due to the demands of young children.

MIDDLE ADULTS
- Family often focused on the children (other demands included parents and career), rather than on themselves. Making the time and energy needed for lifestyle changes for this group was a challenge. As the age increases and the family unit changes, the partner becomes an influencing factor and time becomes less of a barrier. A Springfield participant was that it was usually not a lack of information, rather it's the self-discipline required to break habits and make new choices.

SENIORS
- Partners / friends came up as a support when changes were made.
- In this age group often the motivator for a lifestyle change is a health concern.
Dietary Practices

Overview

Many things influence dietary practices, for example:

*Food Consumption* - Eating fruits and vegetables is one indicator of healthy eating. "Healthy foods often cost more than foods high in fat, sugar or starch." This becomes a challenge for low-income individuals and families.  

There is a trend to increasing consumption of soft drinks, which is linked to obesity. In 1976 the average Canadian consumed 56 litres of soft drinks annually. In 2002 this rose to 200 litres per person, an increase of nearly 80%. During the same period milk consumption declined, however lower fat milk products were consumed more.

*Availability of Food* – In the Canada Food Statistics 2002 report, the total amount of energy consumed per capita per day increased over 18% between 1991 and 2002, particularly in fat consumption. The availability of fresh produce in some isolated and remote communities not only increases the cost, but availability and choice become an issue.

*Income* - In Canada as a whole in 2000-2001, it was found that for men, rates of overweight and obesity increased with increasing income level. In contrast, women were less likely to be overweight or obese in high-income groups. Children aged 2 to 11 years in 1998-99 in low-income families were 1.5 times as likely to be obese as children living in non-low income families. From a wellness perspective weight is an area that often can be modified.

*Exposure to Food Advertising* – Research has shown that heavily advertised foods are generally over consumed and often these foods are high in fats, sugar, starch or lower in nutritional value.

*Lifestyle* - Eating is often associated with social times. When an individual lives alone, this may influence the food choices, as cooking for one is seen to be more challenging. If an individual or parent works, the fast and processed foods are often food choices, as they are quick and easy. These choices often are of less nutritional value.

*Obesity*

Obesity is becoming a public health concern in Canada and is “… identified with major risk factors contributing to a number of chronic illnesses such as diabetes and heart disease.”

“Over the past two decades rates of overweight and obesity have more than doubled for Canadian adults….and have tripled among Canadian children, although the latest data suggests that rates of obesity among children may have stabilized….nearly all provinces and territories [including Manitoba have] ...

[adults] obesity rates higher than the national average…rates of overweight and obesity appear to be much higher among Aboriginal peoples.”
**Intake of Fruit & Vegetables**

“There is general agreement among experts that increased consumption of fruits and vegetables is one of the indicators of healthy eating.”

The CCHSC 1.1 2001, indicated that according to self reported practices for the NE population over 12 years, 31.64% males and 41.47% of females consumed an average of five or more servings of fruits and vegetables per day. NE had a larger proportion of fruit and vegetable consumers than Manitoba at 25.11% for males and 36.69% for females.

**Body Mass Index (BMI)**

BMI is an international standard that is used to determine if an individual's weight is in a healthy ranged based on their height.

The information provided is self-reported e.g. the respondent's weight and height determines BMI. The prevalence of obesity may be under-represented, as respondents tend to underestimate their weight and overestimate their height.

**Figure 6.43 Self Reported BMI in NE**

In NE we have 40% of males and 35% of females whose BMI interpretation falls within the overweight category. Twenty percent of females and 24% of males report that they are obese according to the BMI calculations.

![BMI - Self Reported Percentage of Population Aged 20-64 Years - 2001](image)


Over half of both males and females reported a BMI interpretation of being overweight or obese. This is a significant portion of our adult population. We know that obesity is associated with increased prevalence of high blood pressure, diabetes, high cholesterol and certain cancers.
2003 Focus Groups – Dietary Practices

Dietary modifications were common among all focus groups in relation to lifestyle changes participants made. Often the reason for nutritional changes was to control weight. Here are some comments with respect to nutrition and diet from Focus Group participants.

YOUTH

Reasons to Change: previous illness and to control weight were the main reasons.

a) One youth stated illness was the motivator for changing eating habits [Seymourville]

Programs / Methods Used

• One participant made an effort not to eat “…too much junk food.” [Iron Rose]
• One youth in Brokenhead used portion control at meals to lose weight.

EMERGING TOPICS

a) Eating Disorders – this was raised only in Brokenhead group. The group in Brokenhead expressed concern that young people (not just girls) with eating disorders, evoked anger rather than understanding from their peers. They felt much of the reason for the disorder is to be more attractive. The group also indicated that there are more magazines that portray the perfect image aimed at young men now. Controlling food is seen as an easier fix, than for example, going to the gym. “They don’t want to work out and wait 6 months.” [Brokenhead]

Suggestion from Youth Focus Groups

• More education/information on eating disorders and how it affects the person’s body, how to support an affected individual toward recovery for grades 10, 11 students. They did mention they had information in earlier years but “I think we were too young to listen….I didn’t care to listen.” [Brokenhead]

b) Obesity – This issue was mentioned separately from lifestyle change and emerged in the Brokenhead group. “There is obesity everywhere in this town.” [Brokenhead]

- On a positive note, the Brokenhead group mentioned that the school is taking measures to reduce the amount of junk food sold by the canteen, and have disallowed junk food eating in class. [Brokenhead]

Barriers

- Junk food is easily accessible. Almost all goods sold in the canteen are junk food. [Brokenhead]
- Junk food tastes better. [Brokenhead]

YOUNG ADULTS

Two areas of concern arose.

a) Lifestyle pressures – difficulty in finding the time to cook healthy.

“Our lifestyles promote it because we are so busy and it’s so fast and easy to grab and eat and run…..” [Brokenhead]

b) Schools promoting unhealthy foods. There were mixed opinions whether early year schools were healthier than senior year schools. One participant mentioned that bad habits are forming and, if continued, will lead to health problems. [Brokenhead] The Brokenhead group also speculated that schools are subject to suppliers who provide needed materials e.g. computer paper, in exchange for being allowed to sell their product in the schools.
MIDDLE ADULTS

Often some or parts of the diet were changed, for example, drinking more water, decreasing caffeine intake, or diet changes related to reducing cholesterol.

Barriers
- Motivation and difficulty changing old habits.
- Difficult to make these changes with children at home…. One becomes used to cooking a certain way…. also once you’re feeling better, easy to slip into old habits. [Blue Water]

EMERGING TOPICS
- Food additives felt to be responsible for increasing number of allergies. [Springfield]
  “It’s a concern when you read the labels and you don’t know what they are, what are they feeding you?” [Blue Water]

SENIORS

There were several reasons given for a change of diet:
- prevent the pattern of parental obesity. [Brokenhead];
- health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water];
- decrease in meat consumption because of Mad Cow disease [Brokenhead];
- vegetarian family member influenced participant’s diet choices. [Brokenhead]

Barriers
- The ability to seek assistance or to know where assistance might be obtained can be a challenge in this age group where there might be more isolation occurring in the community.
- Difficulty when two persons in a household are on different diets “She can’t cook a hamburger. She can for herself, but not for me. It’s a problem.” [Winnipeg River]

Note: During the 1997 Focus Groups there were some similarities in dietary practices:
- People not eating property especially seniors. [Iron Rose]
- When eating out healthy choices are not always available [Springfield]
- Fresh fruit and vegetables can only be obtained by going out of town. [Seymourville]

Note:
At the time of writing this report there is a Diabetes Prevention Committee operating within NEHA that consists of nurses, dietitians, wellness facilitators and a school board member and a teacher. The committee has been working with the Sunrise School Division for the past 2 years. The role of this committee is to facilitate change and policy development in the area of nutrition.

The Prevention committee presented information regarding the rates of diabetes, obesity, and other chronic diseases to:

- the Agassiz Board of Trustees (May 2002)
- the Agassiz School Administrators (Dec 2002)
- the Sunrise School Division Board of Trustees (Oct 2003)
- the Regional Parent Advisory Committees (Feb 2004)

The Agassiz School Division extended “support in principal for the development of a healthy foods policy” after the meeting of May 7, 2002. The Diabetes Prevention Committee anticipates that this policy would likely be a guideline regarding what foods would be served in school cafeterias and what would be sold as fundraisers.
In the Canadian Institute for Health Information’s (CIHI) report “Improving the Health of Canadians” they indicate that “Comprehensive school health programs can be an effective approach for promoting physical activity and healthy eating and possibly reducing obesity.”  

In February 2004, NEHA has developed a regional policy on “Healthy Eating.” The purpose is to ensure that all functions within NEHA and/or supported by NEHA offer food choices consistent with Canada’s Guidelines for Healthy Eating. In this way, NEHA takes a leadership role in the promotion of health and prevention of disease, creating a healthier environment for the community, staff and volunteers. 

**Adult Immunizations**

**Influenza Immunizations**

“Influenza derives its importance from the rapidity with which epidemics evolve, the widespread morbidity and the seriousness of complications notably viral and bacterial pneumonia’s.”

Surveillance of influenza illness occurs by physicians and institutions reporting outbreaks to the Medical Officer of Health. Outbreaks in children often herald an outbreak in the general population. The health effects associated with influenza illness are, for example, pneumonia, hospitalization and potential death, which surpasses the cost of vaccination. The influenza virus changes yearly, so does the vaccine, requiring that it be offered to the at risk groups yearly.

a) **Community Members**

**Figure 6.44 Influenza Immunizations in NE Over 65 Years**

NE’s over 65 years population appears to be still under-immunized when it is compared with Manitoba as a whole.

The number of residents (there are no ages specified) receiving immunizations from public health clinics dramatically increased in 2003 when compared with other years. Resident influenza coverage overall is under-reported as these numbers do not include other places where residents may have received their vaccine, for example physician's office.

b) Residents in a PCH

During 2002, 149 residents were immunized against influenza. NE has a total of 191 beds. This crude number does not reflect the percentage of residents immunized, as the resident population is always changing due to deaths, regular and respite admissions.

Upon admission, the resident may have had their influenza vaccine already. Unless there is a contra indication, NEHA Long Term Care Program goal is to have 100% coverage.

Pneumococcal Immunizations

The pneumococcal bacteria, Streptococcus pneumoniae is a leading cause of pneumonia, meningitis, septicemia and death in Canada. It accounts for 30 to 50 percent of all community acquired pneumonia requiring hospitalization in adults.” Because of this, Manitoba began a program to provide the pneumococcal vaccine at no charge to targeted groups, such as all residents in a personal care home, all persons over 2 years of age with various chronic diseases or immunosuppressive disease or treatments, and all persons 65 years and over. The target coverage for those persons in the community is 80%. The pneumococcal vaccine is generally required only once. The figure reviews one of the target groups in the community, persons over the age of 65 years.
The number of community members being immunized appears to have increased in NE over the period reviewed. This is due in large part to the efforts of the public health team, nurse practitioners and physicians. The target coverage still remains to be reached. There may be some under-reporting as the information is dependent upon health care providers entering the data into the MIMS system in a timely way.

Residents in personal care homes receive the pneumococcal vaccine upon admission if they have not received the vaccine in the community. In a PCH the target coverage is 95%.

The information for PCH coverage by the profile document does not include those residents who were already immunized in the community, therefore it was felt that this would not portray accurately the actual number of residents immunized. In NEHA PCH’s all residents are asked if they have received the vaccine. If they have not they are offered the vaccine. Residents have the option to refuse. Due to this process, coverage is considered very good.

NEHA conducted an Influenza Immunization Satisfaction Survey in 2003 and opportunities for improvement were identified. Some strategies identified based on respondent’s feedback are:

- Saturday clinics.
- Extended clinic hours.
- Increase number of community clinics.\(^{138}\)
Alcohol Consumption

Heavy alcohol consumption has adverse effects on individuals, family and community with its subsequent damage to physical health. Five or more drinks measures the prevalence of a high level of alcohol potentially linked to personal, family and health problems.\(^\text{139}\)

The following is self-reported information from the CCHSC 1.1 survey in 2001.

**Figure 6.47 Self Reported Drinkers in NE**

We see from the CCHSC 1.1 survey 2001 that for those surveyed aged 12 and over there was a total of 48% of males and 31.3% of females who reported drinking 5 or more drinks on at least one occasion in the past 12 months.

*Once per Week to 2-3 Times per Month*

NE males and females appear to have been more likely to drink heavily once per week to three times per month than were all Manitobans combined.*\(^\text{140}\)

*Over Once/Week*

Due to small numbers of responses NE residents could not be compared with Manitobans in this category.
Substance Use Among Manitoba High School Students 141

A Manitoba research report on youth and substance use conducted a survey in 2001 sampling a cross-section of 32 Manitoba high schools, with a total attendance of approximately 14,000 students. The two schools surveyed in NE region were Edward Schreyer School (156 students) in Brokenhead Health District and Lac du Bonnet School (102 students) in Winnipeg River Health District. Five Winnipeg schools and 27 rural schools participated. A total of 4,680 students were surveyed.

The overall discussions in this report are similar to what the youth were telling us in the 2003 Focus Groups about smoking, alcohol use and illicit drug use.

The findings related to alcohol use:

- Over half the students considered alcohol and drug use to be a major problem at their school.
- About 15% of students report having experienced moderate or serious problems as a result of family members using alcohol.
- Nine percent of students reported experiencing serious problems as a result of a family member using other drugs.
- About 81% of the high school students drank alcohol in the past year, which showed an increase of about 2% over 1997. This rate is identical to the one estimated for Manitoba adults overall.
- About 33% of male students and 20% of female students reported drinking about once a week or more. The rate of drinking increases as students move up grade levels.
- The average first drink is at age 13.3 years.
- Males drink more often than females e.g. 13.5% males and 7.1% females reported drinking in the past year of the study.
- Consistent with what the Focus Group youth indicated the study found that alcohol and drugs were used at parties and friends’ homes. About 15% reported drinking at school during regular school hours. Thirty percent drank in cars.
- The research indicated that for the most part students did not condone drinking and driving, consistent once more with the focus group findings. Male attitudes toward drugs (including alcohol) are more likely to be influenced by their peers than female attitudes. Males were also much more likely than females to think that using drugs (including alcohol) is acceptable, as long as one is “in control of the use.”
2003 Focus Groups- Alcohol Use

**YOUTH**
Drinking as an emerging topic came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change. It must be noted that many youth in the Focus Groups did not consume alcohol. The youth clearly saw alcohol not only as something youth did, but even more as a behaviour of adults in their communities.

**Springfield**
Overall the participants didn’t perceive teen drinking as a health problem, other than concern over drinking and driving. They (Springfield) felt there was sufficient education about the consequences of drinking and believe that people won’t stop drinking until they suffer personally. [Springfield]

“...Everybody in Oakbank does it, because there’s nothing better to do.” “...Get one friend drunk, and there is your evening entertainment.” [Springfield]

**Brokenhead**
- Most participants claimed there is not much pressure to drink.
  “...Even if you go to a party, you don’t have to drink...Everybody goes and everybody knows each other. That’s the good thing about living in a small town.” [Brokenhead]
  “It’s a small town. There is nothing better to do (referring to drinking).” [Brokenhead]

**Blue Water**
“We’re not really the healthiest bunch here because there’s nothing to do in town.” “Smoke and drink, that’s what you have to do...” [Blue Water]
- There is a perception of getting drunk as having fun, and youth highlights the social aspect of drinking i.e. getting together with friends. In response to the question about having fun without drinking, some replied you can, but not in their home communities. In Winnipeg, for example, one can shop, walk around downtown, go to movies, “...even just to drive around, it’s fun. At least there’s stuff to look at...” [Blue Water]

**Winnipeg River**
- In the Winnipeg River youth group, participants implied that drinking is a problem among youth and adults.
  “...all the adults talk about how they are going to go get hammered.” [Winnipeg River].
- It is rare that a student will go to school drunk but some come with hangovers and occasionally leave school at lunch to drink and do drugs. Overall they feel that the problem is very similar in Pinawa as it is in Lac du Bonnet despite the differences in the two school’s reputations. [Winnipeg River].

**Suggestion by Youth Focus Groups**
- AFM Counselor should be around more. [Winnipeg River]

**ADULT FOCUS GROUPS**
- Alcohol consumption was not raised as a social problem in most of the adult Focus. There were several adults who mentioned on a personal note that they did give up drinking.

**YOUNG ADULT**
- Two participants in the Blue Water group mentioned that they had stopped drinking alcohol. The reasons were related to supporting a spouse, health problems and to improving performance in a physical activity.

**MIDDLE ADULT**
- Two participants in Iron Rose mentioned about the need for more programs to curb alcohol abuse and the need to support those who want to stop drinking. One participant indicated that:
  “Alcohol costs just as much if not a lot more money for disease, absenteeism from work, and yet the health care won’t touch it...”. [Iron Rose]

**SENIORS**
- One participant in the Springfield group mentioned stopping drinking.

**Note:** During the 1997 Focus Groups it was mentioned in Winnipeg River that drunk driving is a problem and alcohol is very accessible.
**CHA NE Survey 1997**

*Question Section A 13: In the past 3 months have you taken a drink of beer, wine or liquor.*

- **Yes** 1404 (81%)  
- **No** 334 (19%)

[No response numbers were excluded from this percentage]

*Question Section A 15: How many drinks do you normally drink at one time?*

- **1-2 drinks** = 1119 (80%)  
- **3-4 drinks** = 238 (17%)  
- **5 or more drinks** = 47 (3%)

[No response numbers were excluded from this percentage]

This is a self reported question and there are always reporting biases. Although the questions are phrased differently, and the time frames vary we do see that there are far less self reports of alcohol consumption over 5 drinks in the 1997 NE survey, when compared with the CCHSC data.

**Gambling Practices**

**Overview**

It is estimated that of the 18.9 million Canadians who gambled in 2002, 17.7 were non-problem gamblers while 1.2 million (5%) were problem gamblers i.e. Gamblers who have suffered adverse effects from their gambling behaviour.

As cited by Volberg in 1994, it has been shown that increased access to gambling does increase the prevalence of gambling related problems. Other risk factors include: “poverty, low socio-economic status, and substance abuse have been linked with problem gambling…” (p.7)

The CCHSC 1.2 found that “Men who gambled were significantly more likely than women to be at-risk or problem gamblers … At-risk and problem gamblers were also, on average, younger than non-problem gamblers, Off-reserve Aboriginal gamblers were significantly more likely to be at risk than non-Aboriginal gamblers –18% versus 6%…Manitoba and Saskatchewan had considerably higher proportions of at-risk gamblers (9.4% and 9.3% respectively) than other provinces….at-risk and problem gambling rates varied considerably by the type of game played, suggesting that some games are more alluring than others…confirming the much-reported notion that VLT’s are the ‘crack cocaine’ of gambling.” (p.9)

“Stress is the inevitable outcome of the financial and social pressures created by problem gambling…Persistent stress can be related to depression… Finding that one in five problem gamblers considered suicide in 2002 is startling and worrisome.” (p.11)
Substance Abuse / Use

Substance Use Among Manitoba High School Students – AFM

A Manitoba research report on youth and substance use conducted a survey in 2001 sampling a cross-section of 32 Manitoba high schools, with a total attendance of approximately 14,000 students. The two schools surveyed in NE region were Edward Schreyer School (156 students) in Brokenhead Health District and Lac du Bonnet School (102 students) in Winnipeg River Health District. Five Winnipeg schools and 27 rural schools participated. A total of 4,680 students were surveyed. The overall discussions are consistent with what our youth focus groups had to say about smoking, alcohol use and illicit drug use.

The following provides information about substance abuse (use of drugs other than tobacco and alcohol), and include licit substances (such as over the counter drugs and inhalants) as well as illicit substances that are restricted under the criminal code.

- Over half the students considered alcohol and drug use to be a major problem at their school.
- Six percent of students report moderate or serious problems with the use of other drugs.
- Nine percent of students reported experiencing serious problems as a result of a family member using other drugs.
- The use of drugs (other than alcohol or tobacco) has increased slightly, in 1995 about 37% comparable to 2001 at approximately 40%. Although the 2003 NE Focus Groups spoke little about the type of drugs this survey indicated that cannabis was the drug used most often. No other drug, except psilocybin (magic mushrooms) was used in the last years by more than 5% of students. It was mentioned that cocaine and ecstasy use is still not common, with less than 5% reporting use in the past year.
- More males (50%) than females (45.3%) had ever used drugs.
- The mean age at first drug use was 14 years for males and 14.2 years for females.
- Consistent with what the 2003 NE Focus Group youth indicated the study found that alcohol and drugs were used at parties and friends' homes. About 26% of males and 13% of females felt it was acceptable to use cannabis and drive. The use of cannabis and driving was not raised during the 2003 NE Focus Groups.
- The research indicated that for the most part students did not condone drinking and driving consistent once more with the 2003 NE Focus Group findings. Male attitudes toward drugs (including alcohol) are more likely to be influenced by their peers than female attitudes. Males were also much more likely than females to think that using drugs (including alcohol) is acceptable, as long as one is “in control of the use.”
2003 Focus Groups on Illicit Drug Use

YOUTH

The mention of using drugs such as marijuana and cocaine was raised in Blue Water, Brokenhead and Winnipeg River groups.

Brokenhead – There was general consensus that drinking and drugs in general was more a problem among the young adults than at the high school. [Brokenhead]

"You'd be surprised at how many kids do drugs in this town." [Brokenhead] They discussed here the importance of friends looking out for you and this helps deal with peer pressure. [Brokenhead]

- A participant noted that some young people are using cocaine, however it was considered "...not a big thing." [Brokenhead]

Winnipeg River – There was more concern expressed over the availability and use of cocaine as compared with marijuana as they likened marijuana to alcohol. All were aware of people who did drugs and felt in general, students divided themselves into groups of users and non-users. Having said this they did mention that socially people mix as the community is small and the choice of friends is limited. They felt there were concerns that younger and older children tend to hang out together, subjecting younger children to drug influences. They don't feel there is much pressure to use, as long as one is clear about their personal choice. [Winnipeg River]

- "...when you're younger, you get pressured more..." [Winnipeg River]

Suggestions from Youth Focus Groups

- When asked about identifying important issues which require attention one youth replied “Just things they can't put a stop to, like drugs and stuff.” [Blue Water]

- Another youth indicated if penalties were more harsh perhaps this would scare some youth from starting. [Blue Water]
Addictions Foundation of Manitoba (AFM) Programs

AFM provides a variety of services depending upon where one lives in Manitoba. The Winnipeg Region provides satellite services of varying intensity to Beausejour and surrounding areas. “Intervention and referral for persons requiring rehabilitation services. Individual counseling for persons requiring information or for persons who are involved with a self-help group but require some additional supportive counseling. ...a variety of prevention education programs.... Consultation and training are provided for specific communities or groups enabling them to develop a greater community action towards alcohol/drug abuse or misuse and its related problems.”

AFM Youth services vary depending upon where you live in the province. Certainly youth in NE are aware of the counseling services provided by AFM as this was mentioned during the Focus Group discussions with youth.

There is a Rural and Northern Youth Intervention Strategy (RNYIS) that provides “... information, early intervention and counseling services to students in selected schools... Counselors work with schools to establish alcohol/drug policies and to facilitate early intervention and assistance to students with alcohol/drug problems.” In NE the RNYIS program operates in Lac du Bonnet and Beausejour areas.

The following information from AFM includes in-patient and community services.

**AFM Youth (10-18+ years)**

The following graph looks at NE youth receiving AFM services from: RNYIS, the youth residential program at Southport (now called Compass), the community non-residential program at 200 Osborne and the community based Youth services in Western and Northern region offices.

There were a total of 69 youth; 38 males (55%) and 31 females (45%) serviced.

The youth in programs are primarily receiving services for their own alcohol and other drug use problems, although there is a small number receiving service due to family issues.
**Adults Aged 20 to 60+ Years**

The following graph depicts the number of adults over 20 years of age who resided in NE who received services from the AFM in a variety of programs: impaired drivers, gambling and family programs during 2002/03.

**Figure 6.49 Adults in Alcohol Foundation of Manitoba Program in NE**

There were 72% males (152) and 28% females (59) who received these services, a total of 204 adults. As shown, the 40-49 year old age group had the highest attendance.

There is a difference between gender and age counts as the “total count with gender includes everyone in adult services. In the total count with age chart, the data analyst selected only individuals 20 years of age and older for the age breakdown. Thus, the age breakdown chart excludes a couple of hundred between 17 and 20 who received adult services.”

There are other addiction programs operating in Manitoba. The information provided by the AFM is one source and does not present the full picture of people seeking help from other sources for addictions.

**Physical Activity**

In general Canadian adults are inactive. In 2000-2001, 56% of Canadians were physically inactive. We know that regular physical activity protects against being overweight or obese and several chronic illnesses.

The two top forms of exercise Canadians participate in are walking (69%) and gardening and yard work (48%). This is consistent to what our 2003 NE Focus Groups and 2003 Acumen Research Survey participants are telling us.

Children aged 12-19 years showed an increase in physical activity rates between 1994-1995 and 2000 and 2001 at 75% for boys and 61% for girls during the later time period. During 2000-20001, 82% of youth aged 12 to 19 years were “still not sufficiently active to meet international guidelines for optimal growth and development.”

It was found that for both adults and children, lower income family levels tended to be less active than higher income Canadians.
“A sedentary lifestyle has been associated with increased rates of mortality, as well as, increased risk of chronic disease including ischemic heart disease, hypertension, obesity, colorectal cancer, breast cancer, osteoarthritis and depression.”

Figure 6.50 Self Reported Leisure Time Physical Activity

As we look at this we will be able to see trends that will indicate whether the wellness strategies developed by NE and our partners have had an impact in increasing physical activity.

This information comes from the CCHSC 1.1 survey conducted September 2000 to November 2001. We see that 49% of males and 48.5% of females reported active or moderate physical activity. NE appears to be higher than the Manitoba percentage in the active category and have less inactive people than Manitoba as a whole. We still have a way to go at influencing our population to become even more active. Complicated and costly technical resources are not a necessity to be active. It is interesting to note the responses from the Focus Groups regarding some of the issues surrounding recreational opportunities and barriers to participating in exercise.

2003 Focus Groups on Exercise

Increasing the amount of exercise was the most common form of lifestyle change that the adults made with respect to changing their lifestyle to improve health.

YOUTH
The three main strategies youth used to improve their health were exercise improving nutrition and quitting smoking. These were undertaken primarily to manage weight and to be healthier. Most youth chose to exercise at home. Two barriers sited for not using a recreational facility were cost and inflexible scheduling.

YOUNG ADULTS
The two primary motivators for exercising were to decrease weight and improve body image.

Barriers
- “Used to do hall walking, but no longer able because one is not allowed to bring along children.” [Springfield].
- “No exercise programs for moms and kids.” [Brokenhead]
- Time, due to young children [Brokenhead]

MIDDLE ADULTS

Reasons to exercise include: to decrease weight, improve image, a health crisis in self or acquaintance, or mental health reasons.

Barriers - Exhaustion, time, family commitments were the main barriers expressed.

"...I never had time before. [I was] so busy raising kids, house, job, marriage, family. Who [had] time for this type of stuff?" [Winnipeg River]

- Proximity to a facility. "...if I lived closer I would be a member [at Seven Oaks] just to go walking on the track." [Blue Water]

SENIORS

Often the person was influenced by family or friends to exercise or there was a specific goal i.e. weight loss/gain were common reasons to exercise.

2003 NE Acumen Research Survey – NE Findings

The provincial survey respondents indicated that

- 61% or six out of ten NE respondents reported doing regular exercises to improve their health.

The provincial survey does not indicate the frequency, duration and intensity, as does the CCHSC 1.1 Survey. This may explain the higher response to this question. Walking was the main form of exercise, consistent with the Focus Group participant responses.
Smoking Practices

Figure 6.51 Self – Reported Smokers in NE

This indicator provides information about a lifestyle practice that is clearly a modifiable health risk. It is associated with increased morbidity and mortality. “Health Canada estimates that smoking is responsible for more than 45,000 deaths per year. Because of the addictive nature of nicotine, youth smoking is of particular concern. It is estimated that approximately eight out of every 10 people who try smoking become habitual smokers”\(^\text{155}\)

Self reported smoking habits from the CCHSC 1.1 indicates that in NE we have approximately
- 24% of females (to be interpreted with caution due to a small number of responses) and
- 29% of males who still smoke.

**CHA NE Survey 1997**

Question Section B 21b: At the present time do you smoke cigarettes, cigars, or a pipe?  
**Yes 371 (36%) No 648 (64%)**  
[No responses were excluded from percentage]

Smoking remains an area where prevention has a role to play. In early 2004, the Primary Health Care program in NE conducted a Smoking Cessation Program for women.

Don’t give up giving up.
Substance Use Among Manitoba High School Students – Smoking

A Manitoba research report on youth and substance use conducted a survey in 2001 sampling a cross-section of 32 Manitoba high schools, with a total attendance of approximately 14,000 students. The two schools surveyed in NE region were Edward Schreyer School (156 students) in Brokenhead Health District and Lac du Bonnet School (102 students) in Winnipeg River Health District. Five Winnipeg schools and 27 rural schools participated. A total of 4,680 students were surveyed. The overall findings that are consistent with what our youth focus groups had to say about smoking, alcohol use and illicit drug use.

This study found that:
- Over half of the students surveyed had smoked at some point in their lives, with females more likely to smoke than males (60% vs 54%).
- Smoking rates increase as one gets older. Slightly over 43% of all Senior 4 students smoked in the past year of the study compared with 34% of Senior 1 students.
- Average age of starting smoking is 13.2 years.
- Of those high school students who smoked, 52% smoke less than 20 cigarettes in a week.
- Heavier smokers are more likely to be males than females.

2003 Focus Groups on Smoking

The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This provides valuable information for staff working in smoking Cessation Programs. The most consistent message is that if the individual wants to quit, there are a variety of methods used to suit the individual. Success often depends upon support the individual receives. One of the biggest concerns that smokers indicate repeatedly, is the potential and real problem of weight gain that accompanies quitting.

YOUTH

Smoking emerged in the majority of groups as either a lifestyle change and/or emerging topic.

- **Brokenhead** - There is a perception that smoking among the youth group in Brokenhead is on the decline. They feel that smoking has declined, as there are so many public places where it is not allowed, it is bad for your health, and it is expensive. Some schools support non-smoking by banning smokers from certain activities e.g. Cheerleading Squad.

- **Blue Water** - There were several youth in the Blue Water group who smoke. All were aware of the health impacts of smoking. The reason a youth started smoking was because people they spent time with i.e. friends and/or family smoked.

**Quitting Smoking**

There were not many youth in the groups who actually quit smoking as a lifestyle change. Quitting 'cold turkey' was the most common way of quitting.
- Would not enter a stop smoking program because
  "...I don't feel comfortable with a lot of situations, cry on my shoulder sort of thing." [Springfield]
ADULTS

It was felt in the Winnipeg River young adult group that “… if there was a ban on smoking [rurally] like in Winnipeg, it would make a lot of people cut back or quit.” Support for public smoking ban by participants in Blue Water.

From the reasons given by some participants why they quit, there is evidence that public policy, peer and social pressure, health education strategies i.e. the effects of smoke on children and personal health, and costs are effective.

In the Seymourville young adult group they mentioned that there is a no smoking policy related to the community council and halls which the group felt influenced a healthy lifestyle in their community.

A multitude of programs were used i.e. pharmaceuticals, ‘cold turkey’, support from friends, hypnosis, and gradual reduction.

The NEHA Primary Health Program promotes various smoking cessation programs:

- ‘Kick Butt’ at Seven Oaks Wellness Centre
- ‘Not on Tobacco’ (NOT) a youth cessation program
- ‘Catching Our Breath’ a women’s cessation program
- The Self -Help ‘Quit 4 Life’ Books
- The use of the Smokers Help Line\(^{157}\)
Risk Taking Behaviours

These are behaviours, which could potentially cause an increase in morbidity and premature mortality. The following discusses some risk taking behaviours described by youth.

2003 Focus Groups on Risk Taking Behaviour

**YOUTH**

a) In general
   - “Teens care less than if you were older…they are invincible.” [Brokenhead]

b) Tattoos
   - There was knowledge about infection risks. “…could get really infected.” [Blue Water]
   - “You should be smart enough to go to a certified place.” [Brokenhead]
   - Tattoos are seen as a means of self-expression [Brokenhead]

c) Seat Belts
   - Students with drivers license gave mixed report about wearing seat belts. Some seeing it as a matter of choice and others it depends upon the situation. [Iron Rose]
   - “I wear my seat belt on long distance trips, but just driving around, I usually don’t.” [Iron Rose]
   - “If you don’t want to wear a seat belt, it’s your choice. It’s your life in your hands.” [Iron Rose]

d) Speed
   - With regard to safe driving and speed youth seemed to realize the consequences.
   - “When I get my license, I think when I see an open road in front of me, I’ll go fast…” [Iron Rose]
   - “People don’t drive fast to hurt people, people just enjoy it.” [Iron Rose]

**Note:** During the 1997 Focus Groups it was mentioned that drunk driving was a problem. [Winnipeg River]
Medication Use

There was some general overall concerns with respect to over-use prescription medications and multi-pharmacy use. NE medication use varies regionally and between health districts. In health districts where there is an overall positive health status, i.e. Springfield, we would expect to see lower use of prescription medications.

Pharmaceutical Use In NE

Definition of pharmaceutical use is the percent of residents is using at least one prescription medication.

Figure 6.52 Proportion of Residents With at Least One Prescription

![Proportion of Residents With at Least One Prescription](image)


NE has shown a statistically significant increase in the proportion of residents receiving at least one prescription during the two time periods. NE is statistically significantly lower than the Manitoba average and Rural South during the second time periods.

Figure 6.53 Average Number of Different Drugs per User in NE

![Average Number of Different Drugs per User in NE](image)


The average number of different drugs NE residents are prescribed is statistically significantly higher at 3.53 than Manitoba and Rural South both at 3.44 during the second period.

NE has experienced a statistically significant increase during the two time periods reviewed.
Antibiotic Use

There has been growing concern related to the over-prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason, it is important that antibiotics be used judiciously and not be unnecessarily prescribed. This indicator helps us understand the percentage of residents who have received at least one prescription for an antibiotic during the two time periods reviewed. Ideally we would like to see this percentage decrease.

Figure 6.54 Percentage of all Residents Receiving at Least One Prescription for Antibiotics in NE

When we look at NE as a whole, we see that our prescription antibiotic use did not change significantly during the two periods reviewed. NE is statistically significantly lower than the Manitoba average and Rural South during the time periods reviewed. This is good news. We expect to see differences in prescription drug use within the health district given the health status disparities.

Figure 6.55 Average Number of Antibiotics Prescribed

For those who received prescription antibiotics, the average number of prescriptions for NE was 2.1 in the first time period and 2.0 in the second time period.

NE has experienced a statistically significant drop in the number of prescriptions during the two time periods.

NE rates are not significantly different than Manitoba or Rural South.
**Antidepressant Use**

Because antidepressants are prescribed for depression are prescribed for other reasons as well as depression, one cannot make an assumption that depression has increased.

**Figure 6.56 Proportion of Residents using Antidepressants**

When reviewing the provincial information all RHA’s have appeared to show an increase in the number of prescriptions for antidepressants during the later time period reviewed.

In NE we have a statistically significant increase in the number of prescriptions during the two time periods. Despite this, we are statistically significantly lower than Manitoba average and Rural South for the second time period reviewed.

---

**2003 Focus Groups on Prescription Drugs**

In the young and middle aged Focus Groups there was some discussions about the dispensing of medication.

**YOUNG ADULT**
- Quickness to prescribe medication. [Winnipeg River, Blue Water]

**MIDDLE ADULT**
- The overriding concern was the question of whether prescription drugs should be the first treatment option explored. This came up in the young adult group as well. [Springfield, Brokenhead, Winnipeg River]
  - “You don’t have to take antibiotics for just anything…” [Springfield]
  - “I am offended by the pushing and peddling of drugs.” [Winnipeg River]
Modifying Lifestyles to Improve Health

The following provides an overview of personal health practices as discussed in the provincial survey conducted in NE during Nov/Dec 2003, and the Focus groups conducted in our region in the late summer and fall of 2003.

**2003 Acumen Research Survey – NE Findings**

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Food/ Nutrition</th>
<th>Do nothing</th>
<th>Medications / supplements</th>
<th>Dieting / avoidance of certain foods</th>
<th>Rest</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>61%</td>
<td>13%</td>
<td>8%</td>
<td>5%</td>
<td>9%</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>


**Focus Groups – Lifestyle Changes**

The Focus Group question discussed lifestyle changes i.e. What the participants did (if anything) to change their own lifestyle to promote better health and what was the reason behind the changes? Rarely did lifestyle changes occur in isolation and were often combined with other changes.

**YOUTH** – The emphasis on lifestyle change was not a major part of their thinking. The three main areas were: nutrition, quitting smoking and exercising, similar to most of the adult groups.

**YOUNG ADULT** - In this age group there was often little time to spend on lifestyle changes, rather their focus is spent on their children. Some common attempts at change included: exercising most often to decrease weight, nutrition to provide healthier meals and Smoking Cessation.

The challenge for health care providers in the area of health prevention and promotion in assisting this age group in balancing their dependent needs (children and parents) and their own health needs.

**MIDDLE ADULT** - The most common lifestyle change was increasing the amount of exercise. The main reason was due to a health crisis in self or acquaintance. Other changes occurred were improving nutrition and quitting smoking.

**SENIORS** - Changes in this age group were mostly exercising, nutritional changes, and smoking cessation. The most common reason for a lifestyle change was due to a health concern. Often partners and friends provided motivation.

**Discussion**

Exercise and eating more nutritiously emerged as common health practices in both the 2003 Acumen Research Survey and Focus Group participants. The reasons for the changes varied within the age groups and this is something to take into account when developing wellness programs.
Healthy Child Development
as a Health Determinant

"The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful."  

Overview

We know from the research that prenatal and early childhood care and development programs have a positive effect on future health status. It is not unexpected then, that NEHA has increased its preventive programs in these areas over the past several years for example: Health Baby, Baby First, Early Start, Bright Beginnings, Preschool Speech and Language called 1st P.L.A.C.E.

For youth health practices, please refer to the Personal Health Practices and Lifestyle for discussions about dietary, exercise, smoking, substance use and youth.

Mortality Rates

Infant Mortality Rates

The reason this indicator is placed here is that infant mortality rates are considered useful in determining the level of health within a community. " Infant mortality rate is a long-established measure of child health, as well as, the well-being of a society. It reflects not only the level of mortality, but also the health status and health care of a population, the effectiveness of preventive care and the attention paid to maternal and child health, as well as broader social factors such as, maternal education, smoking and relative deprivation."

We want to see a low infant mortality rate.

Over the past 35 years Canada has experienced the most dramatic decline in infant mortality of any developed country with the exception of Japan. Although we don't have the cause of infant deaths specific to our region, Manitoba data for 1994-1997 indicates that the leading cause of neonatal deaths (28 days and under) was congenital anomalies (26%) and low birth weight (18%). For post – neonates (29 days to less than 1 year) Sudden Infant Death Syndrome or "SIDS" was the leading cause of death at 29%, followed by congenital anomalies at 14%. Respiratory, infectious, and parasitic disease made up a total of 19%.  

158

159

160

161
Section 6.0 - North Eastman Regional Profile

Figure 6.57 Infant Mortality Rates < One Year - NE Region

NE infant mortality rates have shown a slight increase during the two years reviewed, but it was not a statistically significant increase.

Although NE infant mortality rates appear higher than both Manitoba and Rural South, it is not a statistically significant difference.

Figure 6.58 Infant Mortality Rates < One Year - NE Health Districts

We find that the infant mortality rates in all health districts during the later time period were low enough to be suppressed, except Blue Water.

Blue Water deaths appear to be higher than Manitoba average during the later time period at rate of 15.56/1000 as compared with Manitoba at 6.9/1000, but it is not a statistically significantly difference.
Injuries in Children

The number of injury deaths and hospitalizations progressively increases as age increases. The leading cause of deaths and injuries varies between ages.

Mortality Overview

There is a tendency an overall injury mortality where populations are found to be less healthy. Injury mortality rates for children in rural areas are almost two and half times higher in lower income neighborhoods than those higher income neighborhoods in Manitoba. 162

Between 1992 and 2001 injuries were responsible for about 49% of deaths among children aged one to 14 years and about 71% of deaths among young people aged 15 to 24 years. 163

It is known that children from Lower Social Economic Status (SES) families tend to experience more severe and often fatal injuries. Morrongeillo (1998) suggests that the reasons for this are that these children are likely to live and play in more hazardous environments and that their parents may have limited knowledge about parenting and child development and abilities leading to poor parental judgement.

It was found from Manitoba data from the National Longitudinal Study for Children in Youth (NLSCY) that 40.6% of children from low-income families (less than $20,000 per year) seldom or never wear seat belts while driving in a motor vehicle, compared with 14.5% of children from higher income families. In Manitoba it was found that helmet use was strongly related to income level. 164 “Children living in NE also have a higher mortality rate (43.6/100,000) as compared with the Manitoba average (23.4 /100,000) between 1994-1997.” 165


<table>
<thead>
<tr>
<th>Age</th>
<th>Deaths due to Injury</th>
<th>Top Three Leading Cause of Death - Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Rate / 100,000</td>
</tr>
<tr>
<td>0-1 years</td>
<td>29</td>
<td>22.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 years</td>
<td>96</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-9 years</td>
<td>64</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-14 years</td>
<td>85</td>
<td>13.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 years</td>
<td>325</td>
<td>50.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Manitoba overall, suicide begins to emerge for the first time in the 10-14 year old age group. Assault is the second leading cause of death in the 0-1 year olds. Motor vehicle deaths emerge in all age groups.

**Table 6.31 Injury Deaths External Causes by Age in North Eastman [Both sexes] – 1992-1999**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Rate / 100,000</td>
</tr>
<tr>
<td>0-1 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-4 years</td>
<td>8</td>
<td>43.1</td>
</tr>
<tr>
<td>5-9 years</td>
<td>6</td>
<td>24.4</td>
</tr>
<tr>
<td>10-14 years</td>
<td>6</td>
<td>24.3</td>
</tr>
<tr>
<td>15-19 years</td>
<td>27</td>
<td>114.4</td>
</tr>
</tbody>
</table>


In NE, in all age groups, drowning/submersion is a consistent cause of death. Motor vehicle accidents lead the cause of death in the 5-9 year olds. As children get older (between 10 to 19 years, self-inflicted death is one leading cause. Of particular note is in the 15-19 year old age group where there was 13 self-inflicted deaths at a rate of 55.1/100,000 during this time period.

**Injury Hospitalization Overview**

Higher injury rates are often associated with income levels. Children from lowest income rural areas experience injury hospitalizations two and half times higher than those from higher income rural areas. In NE as well as “Burntwood, Norman, Parkland, Interlake and Marquette children all had significantly higher overall rates of injury hospitalization than the Manitoba rate” between 1994-1997.

**Table 6.32 Percentage of Manitoba Hospitalizations Due to Injuries - 1992-2001**

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage of Hospitalizations due to Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 years</td>
<td>10%</td>
</tr>
<tr>
<td>5-9 years</td>
<td>18%</td>
</tr>
<tr>
<td>10-14 years</td>
<td>21%</td>
</tr>
<tr>
<td>15-19 years</td>
<td>9%</td>
</tr>
</tbody>
</table>

### Table 6.33 Injury Hospitalizations by Age in Manitoba [Both Sexes] – 1992-1999

<table>
<thead>
<tr>
<th>Age</th>
<th>Injury – Hospitalization</th>
<th>Leading Cause Injury/Hospitalization- Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 years</td>
<td>794</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fires &amp; Burns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assault</td>
</tr>
<tr>
<td>1-4 years</td>
<td>4,109</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poisoning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fires &amp; Burns</td>
</tr>
<tr>
<td>5-9 years</td>
<td>4,344</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle Traffic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Struck by/Against</td>
</tr>
<tr>
<td>10-14 years</td>
<td>5,747</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Struck by/against</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-inflicted injuries</td>
</tr>
<tr>
<td>15-19 years</td>
<td>9,613</td>
<td>Self-inflicted Injuries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle Traffic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assault</td>
</tr>
</tbody>
</table>


In Manitoba, self-inflicted injuries begin to emerge for the first time in the 10-14 year old age group as a cause for hospitalization. Assault is the third leading cause of hospitalizations in the 0-1 year old age group.

### Table 6.34 Injury Hospitalizations by Age in North Eastman [Both sexes] – 1992-1999

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 years</td>
<td>30</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unspecified</td>
</tr>
<tr>
<td>1-4 years</td>
<td>174</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unspecified &amp; Other specified, classifiable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fire/burn</td>
</tr>
<tr>
<td>5-9 years</td>
<td>167</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unspecified &amp; Other specified, classifiable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle Traffic</td>
</tr>
<tr>
<td>10-14 years</td>
<td>254</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-inflicted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle</td>
</tr>
<tr>
<td>15-19 years</td>
<td>466</td>
<td>Self-inflicted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle Traffic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Falls</td>
</tr>
</tbody>
</table>


Up to the age of 14 years the most frequent cause of hospitalization is due to falls. By 15-19 years the most frequent cause for hospitalization is due to self-inflicted injuries, then motor vehicle accidents and falls.
Births

At 40 weeks gestation, 50% of babies born, females weigh approximately 3500 grams and males weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. Often in disadvantaged groups, mothers have babies with higher birth weights. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.

Table 6.35 Number of Newborns in NE [Rate is in brackets]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Remote</td>
<td>63 [23.6/1000]</td>
<td>151 [29.8/1000]</td>
<td>158 [31.3/1000]</td>
<td>133 [28.0/1000]</td>
</tr>
<tr>
<td>Unorganized Territories</td>
<td>No longer separated into Iron Rose, Blue Water, Winnipeg River and Northern Remote.</td>
<td>42 [17.1/1000]</td>
<td>54 [22.1/1000]</td>
<td>48 [18.4/1000]</td>
</tr>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


* The geographic boundaries have changed for the 2002-2003 fiscal year. Most of the First nation Reserves are located within Northern Remote health district. Communities previously located in the Unorganized territories have been distributed within the various health districts. Three FN communities remain in Blue Water where previously they were located in Northern Remote or Unorganized Territories. This explains the sudden change in birth rates occurring between Blue Water and Northern Remote during 2002-2003.

During 2002-2003, we had a total of 431 births, a rate of 10.9 /1000 compared with the Manitoba rate of 11.7/1000. In our region Northern Remote had the highest rate at 23.6/1000 and Winnipeg River experienced the lowest rate at 5.7/1000.

Blue Water Health District had the highest number of births with 149 and Winnipeg River Health District had the fewest with 32.
Currently Pine Falls Health Complex is the only facility that accommodates planned deliveries however numbers are low (in 2002/03, 8 of the 149 births from Blue Water occurred in the Pine Falls Health Complex). When reviewing the hospital utilization rates for childbirth, it is important to note that most of the residents in NE have their babies delivered outside our NE.

2003 Focus Groups on Obstetrical Practices

The topic of obstetrical services emerged in several adult Focus Groups.

YOUNG ADULTS
- Like to see more surgeries and obstetrics in our hospitals. [Springfield, Iron Rose, Winnipeg River, Blue Water]
  “I’m disappointed that baby delivery has been shut down in rural hospitals.” [Springfield]

MIDDLE ADULTS
- If there is no birthing capability you “…lose something as a community. No one is born here.” [Winnipeg River]
- Disruptive to family, strain on other children. [Iron Rose]
  “... traffic, parking it’s a hassle” [Winnipeg River].
- Hospitals should have birthing capability. [Winnipeg River, Blue Water]
- Would like see midwife services. [Winnipeg River, Brokenhead]

Note: During the 1997 Focus Groups, it was mentioned that there should be obstetrical services for low risk deliveries. [Brokenhead]
Adolescent and Teenage Pregnancy

Overview

There are many factors that influence the health of the mother and baby, for example marital status, age, employment situation, socioeconomic status, religious and cultural beliefs, sexual behaviour and practices.

Once the birth has occurred, there are other potential risks. These include physical complications i.e. prematurity, low birth weight, psychosomatic problems, or psychological stress i.e. delay in speaking, under stimulation, behavioral problems, stress includes social stress i.e. poor education, isolation, poverty. \(^{171}\) Teenage pregnancy rates also provide an indirect way of measuring unplanned pregnancies due to the lack of use or incorrect use of contraceptive methods among teenagers.

Utilizing this data will enable health care providers to plan for programs that educate and support in family planning and other related health services.

Table 6.36 Number of Teen Pregnancies in NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen pregnancies in NE aged 15-19 years.</td>
<td>97 (68.5/1000)</td>
<td>95 (65.1/1000)</td>
</tr>
</tbody>
</table>


There has been little change in the overall number of teen pregnancies between 1991 and 2000.
As shown in this figure, NE’s pregnancy rate appears to be slightly higher than the Manitoba average during the two time periods shown but is not statistically significantly different. The rate has dropped slightly from 68 to 65 per 1000 in the later time period.

Teen pregnancy rates are significantly higher when compared with Rural South during both time periods.

The most current information from the 2000/2001 Profile Document indicates that NE appears to have a higher teenage pregnancy rate (66.4) than the Manitoba Rate (53.1). At the health district level Northern Remote had a teen pregnancy rate of 197/1000, one of the highest in the province.

Table 6.37 Deliveries by Adolescents and Teens in NE Aged 10-19 years 2001-2002
This refers to the percentage of females in NE aged 10-19 years who gave birth in 2001/2002

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent of Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years</td>
<td>0%</td>
</tr>
<tr>
<td>15-17 years</td>
<td>6.6%</td>
</tr>
<tr>
<td>18-19 years</td>
<td>8.6%</td>
</tr>
</tbody>
</table>


Table 6.38 Adolescent Pregnancy Rates in NE – 2001/2002
This includes deliveries, spontaneous and therapeutic abortions.

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years</td>
<td>0.0 Manitoba</td>
</tr>
<tr>
<td>15-19 years</td>
<td>66.4 Manitoba</td>
</tr>
</tbody>
</table>

2003 Focus Groups on Teen Pregnancies

Note: Teen pregnancy was not mentioned in the adult groups.

YOUTH

Teen pregnancy was discussed in the Brokenhead, Blue Water and Winnipeg River and Seymourville youth groups.

Brokenhead
- Teen pregnancy is not as great a concern as in past years, but still felt it needs to be addressed.

Blue Water
- In Blue Water the opposite was felt to be true compared to Brokenhead.
  
  "...a lot of people have babies out here." [Blue Water]

- In the Blue Water Focus Group participants were aware that they could get birth control information from their guidance counselor, public health nurse and doctor. No one was comfortable about approaching the health teacher. Generally felt contraception was well covered in school. One youth indicated that a teen pregnancy can have a beneficial effect, acting as a wake-up call for that new mother or father who sometimes now turns their life around due to the added responsibility. Most participants felt they wouldn't want children yet, without a reliable partner or job.

- When asked if birth control is a male issue the responses varied:
  
  Male Response
  "No" [Blue Water]
  "It kind of is, I guess. If you and your girlfriend plan on having sex you should like, ask her, are you on the pill so that you know."
  - "Sort of, I think so."
  - "Kind of."

  Female Response
  - They noted that an unplanned pregnancy will impact more on the young mother than on the father.

Winnipeg River
- Teen pregnancy is not seen to be a big issue in town, "...not as much as in Pine Falls."

Seymourville
- Afraid to ask about reproductive health issues –not private if you go to the clinic, everyone would know.

Suggestions from Youth
- Provide some way of providing reproductive health information especially in smaller communities. [Seymourville]
- Sex education begins in the early grades but one participant in Brokenhead mentioned that you’re not really listening at that early age, therefore factual information needs to be re-presented to older students. [Brokenhead]

Note: During the 1997 Focus Groups, it was mentioned that more birth control is needed. [Seymourville]
Breastfeeding Practices

Overview

Breastfeeding is highly recommended for its many benefits to baby, e.g. providing optimum nutritional requirements and protection against respiratory and gastrointestinal infections. Babies who have been breast fed tend to have a decreased incidence of asthma, eczema, and food allergies. Evidence shows that breast fed babies have a lower risk of becoming obese, relative to the length of exclusive breast-feeding. “Younger mothers, single mothers and mothers with lower levels of education and income tend to have lower rates of breastfeeding.” Health professionals and employers, both play an important role by creating environments that encourage and support breastfeeding.174

The year long maternity leave available in Canada is conducive to supporting breast feeding practices.

The National Population Health Survey (NPHS) indicates that 79% of all new mothers breast-feed. The 1994/95 NPHS and 1994/95 National Longitudinal Survey of Children and Youth, indicates that mothers in the prairie region of Canada stop breastfeeding by 3 months. The recommended time is the first 4 months of life. 175 A Manitoba Longitudinal Survey of Children and Youth is planned and will provide NE specific information over the next few years.

The following information illustrates the percentage of live born babies who were exclusively or partially breastfed at hospital discharge. The data excludes hospital-discharged babies with missing feeding information.

Figure 6.61 Breastfeeding Initiation Rates in NE

North Eastman has a statistically significantly lower percentage of hospital breastfeeding initiation rates than Manitoba and rural South during both time periods. The good news is that NE shows a significant improvement during the later time frame reviewed from 64.2% to 69.1%.

We are improving our breast feeding rates, but there are opportunities for more improvement especially in the Blue Water and Northern Remote health districts.

The success of breast feeding is not only dependent upon initiation in the hospital but also how long it is continued in the home. The Public Health Program is currently developing a survey to determine the duration of breast feeding in the home.

**Figure 6.62 Breastfeeding Initiation Rates in NE Health Districts**

When we look at the health districts, we find that Blue Water and Northern Remote have statistically significantly lower breastfeeding initiation rates than Manitoba and Rural South.

**Table 6.39 Postpartum Women Breastfeeding During Visit in NE – January to September 2003**

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Visits</th>
<th>Number Breastfeeding</th>
<th>Percentage Breastfeeding at Post Partum Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beausejour</td>
<td>55</td>
<td>42</td>
<td>75%</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>23</td>
<td>15</td>
<td>65.2%</td>
</tr>
<tr>
<td>Manigotagan</td>
<td>*s</td>
<td>*s</td>
<td>100%</td>
</tr>
<tr>
<td>Oakbank</td>
<td>81</td>
<td>72</td>
<td>88.8%</td>
</tr>
<tr>
<td>Pinawa</td>
<td>*s</td>
<td>*s</td>
<td>100%</td>
</tr>
<tr>
<td>Pine Falls</td>
<td>26</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>Whitemouth</td>
<td>27</td>
<td>26</td>
<td>96.2%</td>
</tr>
</tbody>
</table>


* * = number is under 5 and is suppressed

In the above table although not health district specific, it shows similar percentages when we compare this table to the Atlas data on breastfeeding by health district.

While breastfeeding initiation rates are documented in Canada, the rates and duration of exclusive breastfeeding are not known. This is a gap in information. There is no information that compares the length of time women continued to breast feed after hospital discharge. NEHA Public Health Program is currently conducting a breast feeding survey to determine the duration rates of breastfeeding.
In 2001 Blue Water began an outreach program called Canadian Prenatal Nutrition Program. In 2003, Healthy Baby started in Beausejour and Lac du Bonnet. There is an emphasis on promoting breastfeeding in both these programs. It will be interesting to see if breastfeeding rates increase.\(^\text{177}\)

**Birth Weights**

The average birth weight is between 2500 to 3999 grams. When a baby's birth weight is either lower or higher, there are potential health concerns associated with weight.

It is essential that a mother receive prenatal care as soon as she learns she is pregnant. The prenatal care provides information on nutrition, health practice, environmental or social issues for example: coping skills, alcohol and drug use, and smoking. Refer to NEHA’s Public Health and Primary Health Programs.

**High Birth Weight**

High birth weight babies may potentially have more birth-related complications, disabilities especially if the cause is due to maternal illness, for example diabetes that occurs before or occurring during pregnancy. We know in NE that we are higher than the Manitoba average for adult treatment prevalence for diabetes.

We are looking at the percentage of babies born weighing more than 4000 grams (8.8 lbs). “High birth weight infants may also be a concern due to increase probability of birth complications, and possible increases in adult health problems such as obesity and diabetes.”\(^\text{178}\)

**Table 6.40 Number of High Births in NE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of High Births in NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991-1995</td>
<td>Total 83 high birth weight babies born in NE.</td>
</tr>
<tr>
<td>1996-2000</td>
<td>Total 83 high birth weight babies born in NE.</td>
</tr>
</tbody>
</table>


**Figure 6.63 Percentage of High Birth Weight Babies in NE**

NE appears to have had an increase in the number of high birth weight babies during the two time periods reviewed, but it is not significant. NE’s birth rate is not statistically different than the Manitoba average or Rural South.
**Low Birth Weight**

We know that birth weight is an indicator of a baby’s survival, health and development. We are looking at the percentage of babies born weighing less than 2500 grams (5.5 pounds). This is “a key indicator when measuring progress towards attainment of overall population health. Low birth weight infants may be at greater risk for developmental problems, and tend to use high cost health services.”

Why low birth weights occur is a complex issue, but the most common reasons are: prematurity, fetal defects, multiple births, and acute or chronic disease in the mother. Environmental and social factors may be, income level, domestic violence or abuse, poor living conditions, lack of education, single mothers and age (less than 17 and greater than 35 years).

It is important to note there is “…some variations in the ethnic composition of the population since some ethnic groups tend to have babies of lower weight, even though these infants are otherwise healthy.”

**Table 6.41 Number of Low Births in NE**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total of 28 (5.1%) low birth weight babies born in NE.</td>
<td>Total of 23(4.8%) low birth weight babies born in NE.</td>
<td></td>
</tr>
</tbody>
</table>


The decrease in the number of low birth weight babies is a positive sign.

**Figure 6.64 Low Birth Weight Births in NE**

NE Region is not statistically significantly different than the Manitoba average or Rural South.

The rates are likely to fluctuate yearly because they are based on small numbers of births.
**Pre-Term Births**

Pre-term births are defined as live births, delivered before 37 weeks gestation.

**Table 6.42 Number of Pre-Term Births in NE**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 32 (5.73%) pre--term babies born in NE.</td>
<td>Total 36 (7.02%) pre--term babies born in NE</td>
</tr>
</tbody>
</table>


Note: There is a difference in the time period between the crude rate and the adjusted rates below in the graphs.

**Figure 6.65 Percentage of Pre-Term Babies in NE**

NE is not statistically significantly different than the Manitoba average or Rural South during the second time period.

The percentage of pre-term births remained fairly constant over the two time periods reviewed in NE.

**Childhood Immunizations**

**Overview**

“Vaccination programs are considered to be the most cost-beneficial health intervention and one of the few that systematically demonstrates far more benefits than costs.”

Preventing illness before it occurs is an important area of focus for NEHA’s Public Health Program.

A measure of illness prevention success is how many children at various ages have completed the recommended vaccines. There are many reasons why a child would not have received or have completed their vaccines. In the past several years, immunizations in general have been a controversial topic in the media. Parents are often confused at the many mixed messages they receive about the value and adverse effects of vaccines. This is understandable because often “the diseases that vaccines can prevent are so rarely seen by the general public today…safety concerns have such a high profile.”

This may have contributed to the general overall decline in vaccination rates in many RHA’s throughout the province. The
one vaccine exception is the Measles, Mumps, Rubella (MMR) vaccine that seems to have increased overall in our province from 1995 to 2002. In NE MMR coverage is exceeds the Manitoba average coverage.\textsuperscript{185}

Table 6.43 Vaccination Schedule\textsuperscript{186}

<table>
<thead>
<tr>
<th>Age</th>
<th>DaPTP*</th>
<th>Hib</th>
<th>MMR**</th>
<th>HBV</th>
<th>Tdap</th>
<th>PCV7</th>
<th>PPV23</th>
<th>MC</th>
<th>MP</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-6 years</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 years</td>
<td></td>
<td></td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-16 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-risk individuals only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

DaPTP* = Diphtheria, acellular Pertussis, Tetanus, Polio (given as "one needle with Hib")
Hib = Haemophilus Influenzae B
MMR** = Measles, Mumps, Rubella (given as "one needle" on or after the first birthday)
HBV = Hepatitis B (3-dose series)
Tdap = Tetanus, diphtheria, acellular Pertussis (given as "one needle")
PCV7 = Pneumococcal conjugate 7 valent
PPV23 = Pneumococcal polysaccharide 23 valent
MC = Meningococcal conjugate
MP = Meningococcal polysaccharide ACYW-135
V = Varicella

High-risk individuals are those who are at risk of infection or complications. For more information, speak with your doctor or public health nurse.

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib $\times$ 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total 4 doses.\textsuperscript{187}
For immunization rates to be counted they must be recorded into the Manitoba Immunization Monitoring System (MIMS) database. There may be some under-recording if health providers miss recording some immunizations they may have given.

**Childhood Immunization Rates – Completed Recommended Vaccines**

**Note:** The Manitoba Health NE Health Profile information was used for the regional profile. The Atlas was used for regional comparisons, as it is important to review because there are differences between each health district.

Age two is an important year, as it is an indication of service coverage for the pre-school immunization program. It also provides a proxy outcome measure for the immunizations.

**Figure 6.66 Percentage of Children Immunized in NE**

The percentage of immunization appears to have decreased slightly over time in every age group except for age seven where it remained constant. This is a similar finding throughout the province.

NEHA has targeted full immunization of all children by age seven. Baselines will be set in 2004 in order to monitor the progress.

Disease surveillance occurs for vaccine preventable diseases such as diphtheria, hepatitis, measles, mumps, pertussis, polio, rubella, tetanus, and tuberculosis. Surveillance is necessary to assess the effectiveness of the immunization programs in children and adults. If we are seeing more and more cases of vaccine preventable diseases, then it is important to review immunization rates.

NE as a region falls slightly below the Manitoba percentage at one and two years of age for DaPTP/Hib, but for MMR surpasses the Manitoba percentage.
Diphtheria, Acellular Pertussis, Tetanus, Polio, Haemophilus Influenza B (Daptp/Hib)

Diphtheria is a serious communicable disease with a case fatality rate of 5-10%, with the highest death rates occurring in the very young and elderly. Only one or two cases have been reported annually in Canada in recent years due to the success of the vaccine. 189

Pertussis or Whooping Cough “is a highly communicable infection of the respiratory tract…can affect individuals of any age…severity is greatest among young infants…during the last 50 years its incidence has decreased by >90%…the disease is less severe in older children, adolescents and adults…[however] pertussis in this group is an important source of infection for young infants.” 190

Tetanus “is an often a fatal disease…is rare in Canada…Tetanus immunization programs are highly effective, provide long-lasting protection and are recommended for the whole population.” 191

Polio “is a disease that may cause irreversible paralysis in a certain proportion of infected individuals. It is a highly infectious disease… and can remain viable in the environment for long periods of time…In 1994, the Pan American Health Organization certified that Canada was polio free.”192

“Haemophilus Influenza B was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in young children. Before the introduction of Hib vaccines….the case –fatality rate of meningitis was about 5%. Severe neurologic sequelae occurs in 10-15% of survivors and deafness in 15% to 20%.” 193 These outcomes can have serious detrimental effects not only on the health system but also on the child’s future quality of life.
Many of these diseases are no longer commonly diagnosed, but the virus or bacterial that causes these illnesses are still around. For this reason, it is important that we continue to vaccinate children and adults to ensure that we keep these illnesses from re-emerging in our communities.

DaPTP/Hib Immunization Coverage Rates for one and two years olds appears to be declining in NE and in Manitoba.
Measles, Mumps & Rubella (MMR)

Measles “or rubeola is the most contagious vaccine-preventable infection of humans...In Canada, sustained transmission has been eliminated by our current schedule and high vaccine coverage. However,...some clusters due to imported cases continue to occur...the great challenge for future years will be to continue achieving vaccine coverage rate of 95% or more as measles becomes increasingly unfamiliar to Canadian parents.” 194 “The Pan-American Health Organization adopted the goal of measles elimination by 2000; it is also the only national goal and objective that has been adopted by all provinces and territories....In the absence of global eradication, maintaining measles elimination requires ongoing, enhanced surveillance and continued high immunization coverage rates.” 195

Mumps “is an acute infectious disease caused by mumps virus. Subclinical infection is common. ...Before the widespread use of mumps vaccine, mumps was a major cause of viral meningitis...Mumps infection during the first trimester of pregnancy may increase the rate of spontaneous abortion...Outbreaks are rare [in Canada], but two localized outbreaks have been reported recently...in British Columbia in 1997, and the other occurred in Quebec in 1998.” 196

Rubella “is a viral disease...Serious complications are rare, and up to 50% of infections are subclinical. The main goal of immunization is the prevention of rubella infection in pregnancy.” 197

Table 6.48 MMR Immunization Coverage – Two Years

<table>
<thead>
<tr>
<th>Year</th>
<th>North Eastman</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>99 %</td>
<td>87 %</td>
</tr>
<tr>
<td>2000</td>
<td>89 %</td>
<td>87 %</td>
</tr>
<tr>
<td>2001</td>
<td>90 %</td>
<td>86 %</td>
</tr>
<tr>
<td>2002</td>
<td>90 %</td>
<td>87 %</td>
</tr>
</tbody>
</table>


Table 6.49 MMR Immunization Coverage – Seven Years

<table>
<thead>
<tr>
<th>Year</th>
<th>North Eastman</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>47 %</td>
<td>46 %</td>
</tr>
<tr>
<td>2000</td>
<td>80 %</td>
<td>78 %</td>
</tr>
<tr>
<td>2001</td>
<td>83 %</td>
<td>82 %</td>
</tr>
<tr>
<td>2002</td>
<td>84 %</td>
<td>82 %</td>
</tr>
</tbody>
</table>


In NE, MMR immunization coverage appears to be higher than Manitoba’s overall coverage.
**Hepatitis B (Hbv)**

*Hepatitis B virus* (HBV) is one of several viruses that cause hepatitis. Initial infections with HBV may be asymptomatic in up to 50% of adults and 90% of children. …case fatality rate of one to two percent which increases with age. Chronic carriers are likely the major source of infection, and all carriers should be considered infectious…Canada is considered an area of low endemicity…the overall incidence rate of clinically recognized acute HBV has been estimated to be…higher among males (3.0 per 100,000) than females (1.5 per 100,000). 198

In Manitoba a public funded school based immunization for HBV was introduced in 1998-99 for Grade 4 students. For complete coverage the vaccine is given in three doses. There has been considerable controversy in the media and through various advocacy groups about the safety of this vaccine. About a year ago, public health began funding any student who requested HBV vaccine. In NE the hepatitis vaccine is not offered outside of Grade 4. However, if the parents of older children contact a Public Health Program then a decision is made to provide the vaccine in the school or at the clinic. As noted in the table the coverage rate increased dramatically with age. An explanation of this is that parents are requesting to have their child immunized when they see that those previously vaccinated have had no serious side effects associated with this vaccine.

**Table 6.50 Hepatitis B Immunization Coverage**

<table>
<thead>
<tr>
<th>Age</th>
<th>North Eastman</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Years</td>
<td>22 %</td>
<td>21 %</td>
</tr>
<tr>
<td>10 Years</td>
<td>78 %</td>
<td>72 %</td>
</tr>
<tr>
<td>11 Years</td>
<td>77 %</td>
<td>73 %</td>
</tr>
<tr>
<td>12 Years</td>
<td>70 %</td>
<td>69 %</td>
</tr>
<tr>
<td>13 Years</td>
<td>51 %</td>
<td>49 %</td>
</tr>
</tbody>
</table>


The number of children vaccinated in NE is slightly higher in each age category when compared to all Manitoba children combined.
Living & Working Conditions as a Health Determinant

[Income, Income Distribution and Social Status and Employment and Working Conditions]

"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health."

Overview

Job rank, social status in the workplace and the amount of control over one’s work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under-employed.

In Canada, “… in 2001, almost three times as many people reported having job-related stress as in 1991.” Further, unemployed people may suffer from stress and isolation.

Working Conditions

Labour Force Participation Rate (brackets represent 1996)

In 2001 in NE region there were 58% (57.5%) of females and 70% (70.9%) of males aged 15 and over in the labour force. Although there is not a great deal of percentage difference when we compare our labour force participation rate with Manitoba’s at 61% females and 73% males. In comparison with the other RHA’s, NE did have a smaller proportion of individuals in the labour force during this time period.

When we look at 1996 and compare with the 2001 labour force participation data, there has been little change within NE. NE does have proportionately more males than females in the labour force.

In 2001, NE had a smaller proportion of individuals in the labour force than Manitoba as a whole.
Table 6.51 Major Occupational Groups in NE

<table>
<thead>
<tr>
<th>Top Three Occupations for Men in 2001 in NE Canada Census</th>
<th>Top Three Occupations for Women in 2001 in NE Canada Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trades, transport and equipment operations and related occupations.</td>
<td>1. Sales and Service</td>
</tr>
<tr>
<td>2. Occupations unique to primary industries</td>
<td>2. Business, finance and administration.</td>
</tr>
</tbody>
</table>


The occupations for men and women in NE were the same as those for all Manitobans.

Table 6.52 Mode of Transportation to Work Used in NE

<table>
<thead>
<tr>
<th>Gender</th>
<th>Blue Water</th>
<th>Brokenhead</th>
<th>Iron Rose</th>
<th>Northern Remote</th>
<th>Springfield</th>
<th>Winnipeg River</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
</tr>
<tr>
<td></td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
<td>Passenger</td>
<td>Passenger</td>
<td>Passenger</td>
</tr>
<tr>
<td></td>
<td>Passenger</td>
<td>Passenger</td>
<td>Passenger</td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
</tr>
<tr>
<td>Male</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
<td>Driver</td>
</tr>
<tr>
<td></td>
<td>Walk</td>
<td>Passenger</td>
<td>Walk</td>
<td>Passenger</td>
<td>Passenger</td>
<td>Passenger</td>
</tr>
<tr>
<td></td>
<td>Passenger</td>
<td>Walk</td>
<td>Passenger</td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
</tr>
</tbody>
</table>

Source: Community Data Network Basic tabulations Statistics Canada Census Population 2001. Received from: Rachel Mcpherson, Decision Support Services. Email to Suzanne Dick, April 7, 2004 entitled: Census Data Questions

Depending upon where you live and if you are male or female your top three modes of transportation may vary. Males are either drivers or passengers more frequently than females. After being the driver, females walk more than they are passengers.

2003 Focus Group and Employment

SENIORS - Quitting work for whatever reason is a lifestyle change and one that is never taken lightly. In Blue Water two participants discussed work related to the fact that their job was no longer a pleasure anymore and that the job was causing stress and boredom.
**Unemployment**

Employment rate refers to the number of persons working in the week prior to the census day expressed as a % of the total population 15 years and over. 204

Labour force includes people 15 years of age and over who did not have a job during the time period surveyed.

**Figure 6.67 Unemployment Rate 15 years and older in NE**

As shown the overall unemployment rate appears to be slightly higher in NE Region when compared with Manitoba.

Males have a higher unemployment rate than females.

**Figure 6.68 Youth Unemployment 15 to 24 Years in NE**

Unemployment rate refers to the unemployed expressed as a percentage of the labour force in the week prior to census day who are actively looking for work. Youth is defined as those aged 15-24. Unemployment rates can be misleading, as they reflect only those people who are actively looking for jobs, not people who may have given up looking for work. 205

Females for both NE and Manitoba had the same unemployment rate at 11%. Males appeared to have a higher unemployment rate at 14% in NE compared with Manitoba at 12%.
2003 Focus Groups on Youth Employment

MIDDLE ADULT

- young people “…who finish school go to University or Red River and don’t come back here because there’s nothing to come back to.” [Iron Rose]

Social Economic Status

Overview

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status, that is “rich people live longer than poor people and they’re healthier at every stage of life.” 206 Although the income indicators in this report look at individual and household/family income, the issue is broader and we must look to our society as a whole. “It is the inequality of distribution of wealth in a society which affects the health of the whole population, since the differences in health and illness exist across all socioeconomic levels and not just between the poor and the non-poor.” 207

“Single mothers who were not employed were more than twice as likely as all other groups of women to report a high level distress…” 208

Household Income

Average income is the weighted mean total household income (pre-tax, post transfer) for 2000. The median income is that amount which divided the income size distribution into two halves those below the median and that above the median. The median was calculated for all household units in the 2001 Census of Canada whether or not they reported an income.

Figure 6.69 Average and Median Household Income

Household average income in NE appears to be slightly lower than Manitoba. The median income in NE appears to be slightly higher than Manitoba.

Income has a positive influence on health status. It must be noted that when an average is used, it could be misinterpreted especially if there are incomes that are very high or very low.

With median, we see the distribution of incomes at the middle range. Although the advantage of median is that extremes are not affected, we have no information about the other income values.
In 2000 the median income for females is lower when compared with Manitoba females and considerably lower than the income for males both in NE and in Manitoba.

Males in NE ($26,226) and Manitoba ($26,265) appears to have a similar median income.

When the household is made up of a lone parent family we see that the income level drops considerably closer to the median individual level. For both males and females in the median family income for a lone parent family in NE in 2001 was $22,562, compared with the Manitoba median income of $26,469 for lone parent families.

**Income Inequality**

Income inequality refers to the proportion of income from all sources held by a household whose incomes fall below the median household income.

**Table 6.53 Percent of all Income Held by the Lower 50% of Households**

<table>
<thead>
<tr>
<th></th>
<th>North Eastman - 1996</th>
<th>Manitoba - 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23.4%</td>
<td>22.1%</td>
</tr>
</tbody>
</table>

This percentage shows that there are 23.4% of households who fall in the lower 50% of households. Household incomes are more equitably distributed in NE as compared to Manitoba as a whole.

**Note:** This information comes from Stats Canada and their definition of our RHA may be different than our current geographical boundaries.
### Table 6.54 Incidence of Low Income in the year 2000 within NE Health Districts

<table>
<thead>
<tr>
<th>District</th>
<th>Incidence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Water</td>
<td>10.3%</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>7.2%</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>8.4%</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>No data</td>
</tr>
<tr>
<td>Springfield</td>
<td>5.9%</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>9.6%</td>
</tr>
</tbody>
</table>


As shown, Blue Water has the highest percentage of low income followed by Winnipeg River. Springfield has the lowest.

---

**Personal Resources**

*Social Support Network*

“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.”

---

**Overview**

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included, as these all support a strong social network.

“Social relationships may have as great or even greater influence on health as do the more established lifestyle and risk factors. Social support provides a buffer against adverse life events and living conditions, and an emotional and practical resource for coping and for enhancing quality of life. Belonging to a social group makes people feel cared for, loved, and valued.”
Mental Emotional Health

Mental health was raised, in the 1997/98 CHA Report, as an important concern for many NE residents, particularly in the areas of mental health services, stress, unemployment, isolation, alcohol and drug abuse.

Stress

This was a self-reported level of chronic stress question asked of individuals aged 18 and over during the CCHSC 1.1.

Figure 6.71 Self Reported Levels of Chronic Stress in NE

NE residents reported a lower level of stress than Manitobans as a whole.

Note: Because of the small sample size, the information should be interpreted with caution in males for NE in these categories: ‘not at all’, ‘not very’ and ‘extremely’, and for females the ‘not at all’ category. The females ‘extremely’ category was suppressed due to extreme sampling variability.

2003 Acumen Research Survey- NE Findings

Q4- During the past 30 days, did you have any difficulties with your emotional health, like depression, stress or anxiety that kept you from doing the things you usually do in a typical day?

- Eighty – six percent of respondents indicated that they had no emotional difficulties in the time period asked. Respondents aged 18-24 years were more than twice as likely (33%) as the regional average (14%) to report being limited by a recent emotional difficulty.

- Those with less than high school education were twice as likely as the regional average to report an emotional difficulty. “Household size appears to be associated with emotional health, with respondents from three person household being more likely to say their activities were limited by an emotional difficulty recently.”

There are many factors such as, personal, family, work pressures, socioeconomic etc. that could be causing emotional difficulty.
Question Section B # 20: In the past 12 months, have you had any problems with your emotions or nerves?

Yes 650 (38%) No 1064 (62%)  [No responses were excluded from percentage]

The time periods are different so we would expect potentially a higher yes response in 1998. This is in fact what we see. It is impossible to determine if this was the influencing factor. In 1998, mental health issues were raised as a one of the top concerns during the CHA report.

2003 Focus Groups on Mental Well Being

Mental health issues emerged during various discussions with the community groups and the issues varied somewhat between the age groups.

YOUTH

Youth reinforced the importance of friends and social support and their influence both positively and negatively on them and on their mental wellbeing. Some of the stresses experienced by youth were related to school (in Springfield: teachers attitude and weapons) and family issues mostly related to siblings. Youth in all districts felt there was “nothing to do” and this may contribute to some negative behaviours such as alcohol and drug use.

a) Behaviour / Image

- “…everyone seems to judge on that [being overweight].” [Springfield]
- Another student mentioned that “It probably matters more to you than others, but you always have that self-conscious thing.” [Springfield]
- When one teen is acting out it pre-judges all teens. One youth indicated: “The thing is, we are just as annoyed and pissed off about it as anyone else.” Implying that not all teens act that way and shouldn’t be judged. [Springfield]
- The Brokenhead group seemed to understand the value of having strong self-esteem, some felt it was important that youth be aware of how and what they say can affect others because some people are more vulnerable to external influences. “Lots of people judge you.” [Blue Water]
- The focus on appearance sometimes motivates people to manage themselves in accordance with other’s impressions; for example piercing, tattoos, sports injuries by “…showing off.” Drinking and doing drugs. [Blue Water]

“Peer pressure was seen as a leading cause of untoward behaviours.” The youth who said this seemed to be very aware of how to handle awkward situations. [Iron Rose]

Suggestions by Youth

- Would like somewhere to go where they could talk, but not be pressured to talk about things they don’t want to discuss. Perceiving that adults don’t get it, they would prefer a young (20-25 year old) counselor. They want a counselor to listen, not to judge, not to give unsolicited advice, not to moralize and especially, not to impose the counselor’s views or morals on the student. [Springfield]
YOUNG ADULT

a) **Stigma** - The primary issues in this age group not only discussed the need for better awareness of the mental health programs, but also the stigma associated with accessing programs. One participant in Springfield mentioned the perceived public concern that if they did access a mental health service the possible negative repercussions for their family might involve “…taking my children away.” (Springfield)

b) **Aging Parents** - Only the Iron Rose focus group mentioned this area of concern, however it was a topic that came up in the older age focus groups.
- Difficulty driving seniors to city appointments, taking time off work, away from my family, a lot of services are not provided in small communities. “…one more layer of stress.....” [Iron Rose]
- There was a perception that there is difficulty finding placement in PCH of one’s choosing “…what you really have to do is put your name on that list before you’re ready for it, because otherwise you’re taking a chance you might end up in Beausejour or Pinawa…” [Iron Rose]

**Suggestions by Young Adults**

Participants had some good suggestions, for example, combining physical prevention clinics like blood pressure (B/P) readings with mental health discussions.

MIDDLE ADULTS

a) **Health Programs** - Felt that programs need to address other issues like managing stress as well as illness.

b) **Aging Parents** - This arose as an area of stress and concern in the Brokenhead and Winnipeg River Focus group only.
- There are differences among siblings on how to handle parents affairs and this can be stressful. There is concern for the safety of elderly parents living alone. [Brokenhead]
- Want to learn more about services and housing options on behalf of their parents. [Winnipeg River]

SENIORS

a) They were concerned about being able to identify vulnerable members in the community, in particular those who were more isolated and described as ‘lonely.’ Another big concern for this age group was living alone and being lonely.

STAFF

Lack of awareness of services by the community and by physicians. There are not enough supports and there is a need for consulting psychiatrists for geriatrics.

**Note:** The Manitoba Centre for Health Policy will be releasing a new research study in the fall 2004, entitled: *Pattern of Regional Mental Health Disorder Diagnosis and Service Use in Manitoba: A Population-Base Study.* “The goal of this project is to describe the use of mental health services by residents of each RHA in rural and northern Manitoba. This has been identified as a high priority by the rural and northern RHA’s...” 216

**Social Support**

We know that overall in Canada “…irrespective of a women’s employment status, single mothers are significantly more likely than partnered others to be poor, and to experience financial stress and food insecurity.” 217
Social support may come from families or non-family members. This information does not tell us whether non-family refers to the person living alone or in a group of two or more people who do not constitute a census family.\(^{218}\)

Marriage is a measure of social support.

**Table 6.55 Marital Status in NE**

<table>
<thead>
<tr>
<th>Marital Status [15 years and over]</th>
<th>North Eastman (%)</th>
<th>Manitoba (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married (single)</td>
<td>27</td>
<td>32</td>
</tr>
<tr>
<td>Legally married and separated</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td><strong>Sub-total of above categories</strong></td>
<td><strong>40</strong></td>
<td><strong>48</strong></td>
</tr>
<tr>
<td>Legally married (not separated)</td>
<td><strong>59</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>


When we look at the percentage of individuals possibly living alone or as a single parent family we observe that in NE there was 40% of the population over 15 within these categories, as compared with 48% in Manitoba as a whole. We know that there could be some lack of social support in these households.

It appears in NE that we have a greater percentage of married people (59%) as compared with Manitoba (52%).
2003 Acumen Research Survey – NE Findings

Q8 - When you are feeling anxious or upset and you need to talk, do you have someone you can count on to listen to you? This question looks at the social supports individuals have.

In NE, 90% of respondents indicated that they did have someone they could count on to listen to them. Ten percent said they did not. This is a positive finding in relation to social support.

- “Respondents 65 years and older are the most likely to report having nobody to listen to them.” (p. 54) This is raised in the Focus Groups as a concern in this age group.
- “Respondents with some college or university education, with family incomes of $20,000–$29,000, or from single–person households are also more likely than the average NE respondent to lack a confidant.
- Those most likely to have a sympathetic listener they can count on all of the time are those aged 25 to 54, graduates of a technical school/college/university, those employed full-time, those from four-person households, and those with family incomes of $60,000 or over.” (p.54)  

Social support was an area that was raised in all focus groups of all ages. It was something that was seen as positive with respect to an individual’s well being. We know that social support is a strong determinant of health status.

**YOUTH**

When talking about what it means to be healthy, youth mentioned the importance of friends and social supports.

a) **Support Network**
   - Influences of others around you – your peers. [Seymourville]
   - "They [youth] had changed just because they were told you ‘re an awesome kid." This comment was mentioned referring to youth who had been involved in supportive programming. [Brokenhead]

b) **Talking with Adults**
   - Some participants in Springfield and Winnipeg River discussed their experiences when talking with adults.
     "It’s hard to talk with adults because they don’t quite understand where you are coming from...It’s a new day and age." [Springfield] It’s different because “…everybody’s vandalizing, people are carrying weapons.” [Springfield]
     - It’s important that counselors and other adults maintain strict confidentiality. [Winnipeg River]

**YOUNG ADULTS**

Suggestions by Young Adults

This age group had some suggestions for improving support systems:

- Support for moms or single moms including a support group that meets during school hours rather than in the evening when children have to be brought along and it gets late. Shared baby-sitting for those who can’t afford to pay. [Springfield]
- ‘Someone to watch my kids if I was ill.’ [Springfield]
- ‘Neighbour’s program where someone would watch the kids while others participate. ‘ [Springfield]
- Lack of grieving support. [Springfield]
- Parent Support Group – There was a program in the community but when the health nurse left it was discontinued [Winnipeg River]
- Can’t get a Big Brother until children are 7. [Winnipeg River]
- ‘New Friends Mentorship Program’ should be expanded to allow children under age of seven. [Winnipeg River]
- “…next to no child care support available in Whitemouth. Any child care not just licensed.” [Iron Rose]

**MIDDLE ADULTS**

The concerns expressed in this group focuses around community supports rather than personal support. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group.

“If you talk about the seniors, I think we have a good service, but if you had a 35 year old...that needed more help than the family could provide, I haven’t got a clue what’s available. I honestly don’t think there’s anything.” [Brokenhead]

Suggestions by Middle Adults

- Would like to see volunteer transportation for appointments and treatments for all people, not only seniors. [Springfield]
- Expand programs to allow others (for example those with disabilities) to access. [Springfield, Iron Rose]
- “Make it a community program, versus a seniors’ program.”…..”the bulk of your participants would probably still be seniors but I’m sure there are other people that would benefit from it because they are either socially or physically isolated.” [Springfield]
- “When my father was on disability there was no help…”[Iron Rose]
- Use local newspapers to list various services and what they do.
SENIORS

a) Living Alone
Some of the concerns raised related to:
- Access to assistance in a health crisis, as often they can't get a hold of their family [Springfield, Winnipeg River]
- Some elderly people “…hardly ever see another soul.” [Brokenhead]
- May not eat properly [Iron Rose, Winnipeg River]
- Mental stimulation can be an issue especially in winter [Winnipeg River]
- Those living alone report a need for companionship. After being widowed, “It's a different life.” [Winnipeg River]
- Family concerns about the senior person living alone may contribute to their growing lack of self-confidence i.e. being told they “should or ‘shouldn’t ‘do this or that. [Winnipeg River]
- Lifeline “…it costs $40 a month but it’s worth the peace of mind.” [Winnipeg River]

b) Effects of Isolation
- There is a problem with the effects of isolation when living alone. [Springfield]
- Changing community demographics can leave the elderly feeling “…strange in my own town.” [Brokenhead]

c) Identification of Vulnerable Community Members - The middle adult focus group raised similar concerns about identifying vulnerable members of the community in relation to mental health issues. [Brokenhead]

d) Stereotyping Seniors
“Seniors are …dummies.” “People laugh.” [Iron Rose]
- Some people do not like to be identified as senior. The Golden Age Club accepts members aged 50 and older and is known by the community the ‘seniors club.’ [Brokenhead].
- The local seniors club doesn't attract the participation of men. [Blue Water]

Suggestion by Seniors
- Increase catchment area of clubs so there would be more men available. [Blue Water]

Note: During the 1997 Focus Groups several comments were made about social support:
- Teenagers need more attention [Winnipeg River, Blue Water]
- More self held groups required. [Blue Water]
- Need for safe house for children and adults during a social crisis. [Springfield]
- Many seniors are not aware of programs available. [Brokenhead]
- Need more assistance in developing better parent-child relationships. [Springfield]
- Youth need opportunities to volunteer and contribute to the community. [Iron Rose]
Females headed the majority of single parent households in both in NE and Manitoba. NE appears to have fewer female single parent households than Manitoba as a whole. Male single parents in NE and Manitoba were the same at 3%. The Canadian percentage for males was also 3%. Single parent families in general, are considered at higher risk for health problems due the potential effects associated with less income and support and isolation.

**Other Community Supports**

*Mental Health Support Group*  

The Canadian Mental Health Association (CMHA) along with the local chapter of the Alzheimer’s Society started two monthly support groups for persons providing care for a family member. One is held in Whitemouth and the other in Oakbank. An average of 14 people attends each month.

Educational sessions, mostly on the topic of Anger Management, have been held over the last year (April 2003 – March 2004). Approximately 200 people have attended. Most of the people who attend are referred either by the Community Mental Health Program or by Probation Services.

There has been a joint effort between the Anxiety Disorders Association of Manitoba (ADAM), Mood Disorder Association of Manitoba (MDAM), Schizophrenia Society and Canadian Mental Health Association (CMHA) Eastman to develop a strategy of mental health awareness in Eastman Health Regions. Letters were sent to all the schools and physicians, and were followed up by a visit which provided additional information.
Another example designed to create awareness was a celebration event held in Beausejour during Mental Illness Awareness Week (October 2003). The event featured various artistic abilities of people with a mental illness. Samples of artwork were on display and a consumer provided musical entertainment. The goal was to focus on the gifts and abilities of persons with a mental illness. Twenty to thirty people were in attendance.

A very important innovation in the NE Region has been the opening of a Drop In Centre in Beausejour (September, 2003) for persons with a mental illness. This center is open weekly on Monday from 1-3 p.m. The goal of this venture is to provide recreational and social interaction opportunities. Eight to ten people attend each week. A variety of special events are held monthly. These include things such as a fishing trip, bowling, a Valentine party and birthday celebrations. A community Task Force provides leadership for the Drop In Centre. Its members include consumers, family members, and representatives from NEHA, Manitoba Schizophrenia Society, MDAM, CMHA, Vocational Rehabilitation, Beausejour Community Church and Addictions Foundation of Manitoba.

Rural Farmers

In Manitoba there has been tremendous stress placed on farming households. Examples include: several years of drought, the decrease in the need for pharmaceutical hormone replacement therapy thus decreasing the number of contracts from pregnant mare urine (PMU) farms and the issues surrounding bovine spongiform encephalopathy (BSE).

The Manitoba Farm Rural Stress Line is a resource for rural families in crisis. The Manitoba Farm & Rural Stress Line provides confidential support, counseling, and information to farm and rural families. Trained counselors who have farming backgrounds and strong rural identities answer the Telephone Stress Line. The service also provides an e-mail help line, a rural resource directory web site, speaker's bureau and an information display.

Table 6.56 Manitoba Farm Rural Stress Line North Eastman Region Clients Served

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td><strong>No. of Calls</strong></td>
<td>unknown</td>
<td>unknown</td>
<td>6</td>
</tr>
<tr>
<td><strong>Issues Identified</strong></td>
<td>Anxiety, medical, family</td>
<td>Relationships, anger, suicide information, isolation</td>
<td>Addictions, relationships, isolation, housing, mental health, loss, anxiety</td>
</tr>
</tbody>
</table>

**Crisis Services & Shelters**

**Nova House (Selkirk)**

Nova House Inc. provides a 24 hour crisis line and a toll free number for anyone who is in need of crisis intervention, counseling, and information on or referrals to appropriate programs. The Shelter is staffed 24 hours a day, 7 days a week and provides temporary emergency shelter for up to about 30 days. It also provides individual and group counseling, advocacy, support groups and referrals to other community resources for women who have been abused and their children. Two interim housing units are available for women who are unable to access housing when they leave the Shelter. Trained staff provide presentations on the Shelter’s programs, abuse related issues and healthy relationships. All services are free of charge.

Nova House is a registered charity run by a volunteer board of directors who are representative of the areas in which the service is provided. There are 15 staff, 10 of which are full-time, and an active volunteer program. Nova House is dependent on donations and fundraising to provide the children’s services and programming. 221

**Table 6.57 North Eastman Region Clients Served by Nova House**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>2001/02</th>
<th>2002/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Line Calls</td>
<td>90</td>
<td>86</td>
</tr>
<tr>
<td>Residential – number of clients residing in the Shelter</td>
<td>21</td>
<td>31</td>
</tr>
<tr>
<td>Shelter Bed nights – bed nights used for residential clients including their children</td>
<td>835</td>
<td>507</td>
</tr>
<tr>
<td>Non Residential – number of clients obtaining counseling but not using Shelter</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>Follow up – to residents who have left the Shelter</td>
<td>25</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: Anna Pazdzierski, Nova House, Selkirk. Accessed by Carol Orvis January 2004

**Promises aren't the only things that get broken.**

**LEARN HOW YOU CAN STOP DOMESTIC VIOLENCE.**
## Crisis Service

### Table 6.58  North Eastman Region Clients Served by Crisis Stabilization Unit and by the Mobile Crisis Unit

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td><strong>Crisis Stabilization Unit</strong> – Provides short-term, intensive care and treatment to adults or older adolescents in psychosocial crisis, who require specialized services in the community, but do not require hospitalization.</td>
<td>40</td>
<td>11</td>
</tr>
<tr>
<td><strong>Mobile Crisis Unit</strong> – A community based after-hours service to assist adults and older adolescents experiencing a mental health crisis.</td>
<td>58</td>
<td>44</td>
</tr>
</tbody>
</table>


The number of persons seeking help from both the Crisis Stabilization Unit and the Mobile Crisis Unit has increased in 2002 when compared with 2001. More females than males accessed services.
6.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the previous CHA Report, completed in 1998, there have been boundary changes most prominently related to the northern areas. Unorganized Territories were originally separated and now are incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts. Northern Remote has recently been designated as a health district.

Population

NE adult population continues to grow. The implication of growth, especially as it relates to the elderly population, has the potential for added pressure on the health system. There is a need to plan for continued health services for this population group including preventative services. Our birth rate in NE is decreasing. During 2002/03 we had a newborn rate of 10.9/1000 as compared with Manitoba at 11.7/1000. Northern Remote health district has the highest rate at 23.6/1000.

Education

In NE we have an average of 35.6% of our population with less than a high school education. It is important to ensure that information provided is at a literacy level that most NE residents can comprehend.

HEALTH STATUS

Measuring Overall Health Status – SEFI, PMR

The Social Economic Factor Index or SEFI value and premature mortality rates or PMR both are important overall measurements of health status. It must be noted that the most current SEFI value available is from 1996. Many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern.

SEFI from a regional perspective shows good news in that we have improved our socioeconomic risk when compared to the two time periods reviewed. It appears NE has a better SEFI value than Manitoba as a whole.

When we look at the health districts a different picture emerges and indicates some concern, particularly in Blue Water and Northern Remote Health Districts.
When we examine the PMR, we find regionally that our PMR appears to have increased but not significantly. Our PMR is significantly higher than the Manitoba average during the second time period. It is possible that the regional rate is very much influenced by the high PMR of the Northern Remote Health District.

These two indicators emphasize the importance of looking at information; not only from a regional perspective but also at the health district level when health services are being planned and resources are allocated.

Deaths

Regionally we have seen an increase in mortality rates, but it is not significant.

NE has a significantly higher PYLL than the Manitoba average.

The leading causes of death for both males and females both in NE and in Manitoba overall are circulatory and cancer deaths. External causes (injuries) are the 3rd leading cause of death in NE. This is important, as injuries are preventable.

Life Expectancy

Data from 1996-2000 shows a life expectancy of 74.6 years for males and 79.9 for females, a 5.3 year difference.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Arthritis &amp; Rheumatism</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>-New cancer cases have declined but not significantly.</td>
<td>NE has a higher percentage of arthritis than Manitoba.</td>
<td>Diabetes treatment is on the increase in NE and is above the provincial average.</td>
<td>Respiratory diagnoses and asthma in particular are on the decline. Rates are most prevalent in the 1-4 year old age group.</td>
<td>Hypertension treatment has increased and is slightly more than Manitoba and Rural South</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury Deaths</th>
<th>Injury Hospitalization</th>
<th>Occupational Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI's have decreased.</td>
<td>Stroke treatment has declined, but we are higher than both Manitoba and Rural South.</td>
<td>Males have more than double the injury mortalities than females. NE mortality rates are higher than Manitoba and Rural South. Suicide is the leading cause of death, next to motor vehicle accidents and drowning.</td>
<td>-Injury hospitalization has a higher rate in NE compared with Manitoba. -Females over age 85 have the highest rate, due to falls.</td>
<td>-Males Ages 34-54 were the age group most frequently hospitalized because of a workplace injury in NE in 2001. -No females were hospitalized due to workplace injury in 2001</td>
</tr>
</tbody>
</table>
Cancer- Our incidence of skin and prostate cancers appear to be higher than Manitoba overall. The ability to screen and prevent many cancers this could be an area explored as a prevention and health promotion strategy.

Diabetes – With diabetes increasing and the ability to screen and manage diabetes effectively in the community, this is an area where a population health approach is known to be effective if services are in place i.e. prevention, education, care, research and support.

Hypertension – As our population is aging, increasing screening and increasing the ability to affectively manage hypertension in the community are strategies to consider.

Injury - Injuries are usually preventable. NE injury rates are significantly higher than the Manitoba average. This is an area of concern not only because of the loss of productivity that occurs in a community, but the high health care costs associated with hospitalization. Injury prevention requires strategies with our community partners.

Injury Deaths – Unintentional - We know the most frequent cause of unintentional injuries are due to motor vehicle traffic for males and females, and secondly drowning for males and falls for females. There is no data at the health district level.
Intentional – The highest number of suicides occur in the 15-19-year old age group for both males and females.

Injury Hospitalizations - The top causes were due to falls, motor vehicle traffic accidents, assault and self-inflicted. Elderly women could be one target population for a falls prevention program.

Occupational Injuries – Target population for workplace prevention could be males aged 35-54 years.

Human Function & Well Being

The most prominent comment from our youth in all health districts indicated that there was ‘nothing to do.’ This might be an area to explore with our community partners. Youth and adults in the Focus Group provided many good suggestions for improvement.

DETERMINANTS OF HEALTH

Environmental Factors

Water - There are three communities in NE with a boil water advisory; Tyndall, Garson and Anola. Water quality concerns arose in Focus Groups in Iron Rose, Springfield.

Another environmental issue that arose: secondhand smoke, and staff smoking on facility grounds in particular outside facility doors. NE, as an organization, may want to think about staff smoking policies and how to promote smoking cessation programs.
Safety – There was raised as a concern by some youth in Springfield associated with youth carrying weapons, by Brokenhead youth with respect to ‘skids’, and traffic speeds in Seven Sisters and Whitemouth. Traffic injuries and deaths are on the rise within NE, particularly in Brokenhead and Springfield.

Housing – The need for more PCH beds was raised in Blue Water, Springfield, Winnipeg River during Focus Group discussions. Adult Focus Groups mentioned the need for transitional/independent housing units.

Personal Heath Practices

From Focus Group discussions and the 2003 Acumen Research Survey comments there seems to be a readiness by the public toward healthier lifestyle choices.

Dietary – Obesity is a national concern. We see in NE that there is a substantial number of self-reported survey respondents indicating they are overweight or obese. During the Focus Groups, participants mentioned that this was one of the areas where they were making healthier choices. Thirteen percent of provincial survey respondents indicated they were working at improving their diet. NEHA is partnering with schools to improve the nutrition content of food in canteens and vending machines. Our dietitians have held workshops in various communities in order to promote healthy eating.

Adult Immunizations – Flu and pneumoccal immunizations appear to be increasing yearly. To better improve services, some ideas emerged from the Public Health survey conducted in 2003: extending Saturday clinics, extending clinic hours and increasing the number of community clinics.

Alcohol Consumption – Self-reported cases of adults consuming over five drinks needs to be reviewed with caution due to small number of responses in one category. During Focus Groups, youth felt alcohol consumption was an issue with both youth and adults in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners.

Illicit Drug Use – This was raised as a concern in the youth Focus Groups in Brokenhead and Winnipeg River.

Physical Activity – According to the 2003 Acumen Research Survey, approximately half of NE respondents were not physically active. Exercise was the top area that Focus Groups and provincial survey respondents indicated they did to achieve a healthier lifestyle.

Smoking Practice – Approximately one quarter of our residents in NE still smoke according to 1.1 CCHSC self-reports. Focus Group participants felt the success of smoking cessation programs often depended upon addressing the issue of weight gain. It appears that public policy e.g. the increasing cost of cigarettes, and limiting places where smoking can occur are working, as many participants indicated that these were the reasons why they chose to quit. Ongoing smoking cessation programs targeting community and staff could be considered. Addressing each age group’s issues surrounding barriers to quitting smoking will increase the success rate.
Medication Use –

Prescriptions - The number of prescriptions dispensed has shown a significant increase in NE, however we are significantly lower than the Manitoba average.

Antibiotics - There has been no significant change in the number of antibiotics prescribed in NE. We are significantly lower than the Manitoba average.

Antidepressants - Antidepressant prescriptions are increasing significantly in NE. It is difficult to know if the reason is due to diagnosis of depression, as antidepressants can be prescribed for other reasons.

There were concerns raised in the Focus Groups about the use of prescription drugs as the first choice of treatment. Pharmacare deductible was also felt to be too high.

Healthy Child

Mortality Rates - NE as a region appears to have experienced a slight increase in infant mortality rates but it is not significant.

Injury Deaths in Children (1-19 years) – Although the actual numbers are low, it is a concern that the primary causes of early and middle childhood deaths are due to drowning, motor vehicle traffic and fire. As children reach early and late adolescence, drowning and self inflicted injuries are the major causes of death.

Teenage Pregnancy - During 2001/2002 we see that NE has a higher teenage pregnancy rate than the Manitoba average although not significantly different. There has been no significant change in rates during the two time periods reviewed in NE.

Breastfeeding Initiation – NE breast feeding initiation rates have shown a significant increase, however we are significantly lower than the Manitoba average.

Injury Hospitalizations in Children (0-19 years) - In early childhood, up until age 14 years, the most frequent cause of hospitalization is due to falls. By 15-19 years, the most frequent cause for hospitalization is due to self-inflicted injuries, then motor vehicle accidents. NEHA is preparing an injury prevention strategy to address these concerns.

Birth Weights - As a region our low and high birth weights are not significantly different than the Manitoba average. It is important to continue to monitor birth weight as it may impact on the future health of our children and the potential burden on health services.

Immunizations - Immunization coverage appears to be declining throughout NE overall. Regional MMR coverage appears to be higher than in Manitoba. It would be a consideration to investigate why there is an overall decrease in vaccine coverage. Vaccination is a cost-effective way to prevent illnesses and decrease costs to the health system.
Living and Working Conditions

Work - During 2001, the unemployment rate in NE was slightly higher than in Manitoba overall. Youth unemployment is similar to Manitoba. Some Focus Group participants in Blue Water felt job satisfaction was important to well being.

Economic Status – The overall median income in 2000 was slightly higher in NE when compared with Manitoba. Female median income was lower when compared with Manitoba overall.

Personal Resources

Mental Emotional Health - Self reports from both the CCHSC 1.1 Survey and indicated that NE residents seem to have their personal stress under control. The 2003 Acumen Research Survey indicated that 90% of respondents indicated they had someone they could count on to listen to them. Respondents over 65 years were most likely to report that they had nobody to listen to them.

During the Focus Groups there was much discussion about mental well being.

- Youth stressed friends and social support as really important. When adults judged youth, it was felt to have a negative affect on their self-esteem.
- Young adults discussed how stigma affects how people access mental health services. Aging parents were a concern in Iron Rose where there was stress associated with their care.
- Middle adults felt that programs overall not just Mental Health Programs. Need to address issues like managing stress. Looking after aging parents arose as a concern once more.
- Seniors mentioned that they were concerned about many vulnerable people living out in the community especially those who were more isolated. They identified themselves as often living alone and being lonely and they had concerns they had about their ability to access help quickly.

Approximately 40% of our population in 2001 were either single, legally married and separated, divorced or widowed. Lack of social support and isolation may be potential concerns.
## Summary At A Glance

### KEY
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

### Strengths
- NE SEFI value appears to be better than Manitoba’s.
- Influenza adult immunization coverage appears to be increasing.
- Prescribed medications are increasing significantly in NE, but are lower than the Manitoba average.
- Antibiotic prescriptions are unchanged and are significantly lower than the Manitoba average.
- Median income was slightly higher in NE as compared with Manitoba.
- NE residents appear to have personal stress under control.
- High and low birth weights are not significantly different than the Manitoba average. [Monitor]
- PMR has increased but not significantly [NEHA, Monitor]

### Issues Having Implications for Health Planning & Delivery
- Increasing adult/elderly population. [NEHA, Partner]
- Unemployment is slightly higher than in Manitoba overall in 2001.
- There has been a regional increase in mortality rates, but it is not significant. [Monitor]
- Illicit drug use was raised as a concern by youth in Focus Groups. [Partner]
- Diabetes is showing a significant increase in NE. [NEHA, Partner]
- Hypertension treatment is increasing significantly. [NEHA, Partner]
- NE injury death rates show a significant increase compared with the Manitoba average.
- Intentional – highest suicide rates occur between 15-19 years in both males and females. [NEHA, Partner]
- NE Injury Hospitalizations experienced a significant decrease but remains significantly higher than the Manitoba average. Top causes of hospitalization were: due to falls, motor vehicle traffic, assault and self – inflicted [NEHA, Partner]
- Occupational Injuries occurred primarily in males aged 35-54 years. [NEHA, Partner]
- Focus group participants and validation participants expressed water concerns expressed in Iron Rose and Springfield. [NEHA, Partner]
- Need for more PCH and transitional housing units. [NEHA, Partner]
- Obesity is a local and national problem in youth and adults. [NEHA, Partner]
- Approximately one quarter of our residents are still smoking. [NEHA, Partner]
- The use of anti-depressant is increasing in NE. [NEHA, Partner]
- Injury Deaths (1-19 years) is a concern. [NEHA, Partner]
- Injury Hospitalization (0-19 years) most frequently due to falls in early childhood. In adolescents it is due to self-inflicted injuries and motor vehicle accidents. [NEHA, Partner]
- Teenage pregnancy rates have not changed significantly, but there is considerable variation among our health districts. [NEHA, Partner]
- NE breast feeding initiation rate has shown a significant increase, but we are significantly lower than the Manitoba average. [NEHA, Partner]
**KEY**
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

### Issues Having Implications for Health Planning & Delivery

<table>
<thead>
<tr>
<th>Mental Well-being &amp; Social Support concerns raised by focus group and validation participants included: [NEHA, Partner]</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Youth – negatively stereotyping youth by some adults.</td>
</tr>
<tr>
<td>- Young adults – stigma associated with accessing mental health services &amp; concern for aging parents.</td>
</tr>
<tr>
<td>- Middle adults- concern for aging parents</td>
</tr>
<tr>
<td>- Seniors- Need to be able to identifying people living alone in the community. Concern about their ability to access help if needed.</td>
</tr>
</tbody>
</table>

- Childhood immunization coverage appears to be decreasing overall in NE. [NEHA, Monitor, Partner]
6.6 REFERENCES

21 Stastcan. www.statcan.ca/english/profil01. Total population in all % of age groups = 7,833 divided by Total population in the age groups = 21, 960= 35.6% . Accessed: 08/01/04.

Federal, Provincial & Territorial Advisory Committee on Population Health (1994)


RM Municipal Offices, Town Offices, Web Page: communityprofiles.mb.ca/maps/regional/eastman.htm; Western Diversification Office in Beausejour, Lac du Bonnet.


Federal, Provincial & Territorial Advisory Committee on Population Health (1994)


140 Manitoba Health (2003) North Eastman Regional Health Profile. P. 71, 72, 73.


204 Statistics Canada Website. www.statscan.ca
205 Statistics Canada Website. www.statscan.ca
## 7.0 REGIONAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>NEHA REGIONAL HEALTH SERVICES</td>
<td>7-1</td>
</tr>
<tr>
<td>7.2</td>
<td>HEALTH SYSTEM CHARACTERISTICS</td>
<td>7-6</td>
</tr>
<tr>
<td></td>
<td>Health Service Utilization</td>
<td>7-6</td>
</tr>
<tr>
<td></td>
<td>Expenditures</td>
<td>7-7</td>
</tr>
<tr>
<td>7.3</td>
<td>HEALTH SYSTEM PERFORMANCE</td>
<td>7-8</td>
</tr>
<tr>
<td></td>
<td>Availability</td>
<td>7-8</td>
</tr>
<tr>
<td></td>
<td>Accessibility</td>
<td>7-9</td>
</tr>
<tr>
<td></td>
<td>System Competency</td>
<td>7-13</td>
</tr>
<tr>
<td></td>
<td>Client / Community Focus</td>
<td>7-14</td>
</tr>
<tr>
<td></td>
<td>Work Life</td>
<td>7-26</td>
</tr>
<tr>
<td>7.4</td>
<td>HEALTH SYSTEM INFRASTRUCTURE</td>
<td>7-38</td>
</tr>
<tr>
<td></td>
<td>Finances</td>
<td>7-38</td>
</tr>
<tr>
<td></td>
<td>Human Resources</td>
<td>7-40</td>
</tr>
<tr>
<td></td>
<td>Leadership</td>
<td>7-41</td>
</tr>
<tr>
<td></td>
<td>Information &amp; Technology</td>
<td>7-42</td>
</tr>
<tr>
<td></td>
<td>Research</td>
<td>7-43</td>
</tr>
<tr>
<td>7.5</td>
<td>PHYSICIAN SERVICES</td>
<td>7-44</td>
</tr>
<tr>
<td>7.5.1</td>
<td>Health System Characteristics</td>
<td>7-44</td>
</tr>
<tr>
<td>7.5.2</td>
<td>Health System Performance</td>
<td>7-52</td>
</tr>
<tr>
<td>7.6</td>
<td>NEHA HEALTH CARE PROGRAMS</td>
<td>7-62</td>
</tr>
<tr>
<td>7.6.1</td>
<td>Facility Based Programs</td>
<td>7-62</td>
</tr>
<tr>
<td>7.6.1.1</td>
<td>Acute Care</td>
<td>7-62</td>
</tr>
<tr>
<td>7.6.1.2</td>
<td>Long Term Care</td>
<td>7-92</td>
</tr>
<tr>
<td>7.6.2</td>
<td>Community Based Programs</td>
<td>7-104</td>
</tr>
<tr>
<td>7.6.2.1</td>
<td>Home Care</td>
<td>7-104</td>
</tr>
<tr>
<td>7.6.2.2</td>
<td>Primary Health Care</td>
<td>7-112</td>
</tr>
<tr>
<td>7.6.2.3</td>
<td>Mental Health</td>
<td>7-118</td>
</tr>
<tr>
<td>7.6.2.4</td>
<td>Emergency Medical Services</td>
<td>7-125</td>
</tr>
<tr>
<td>7.6.2.5</td>
<td>Public Health</td>
<td>7-131</td>
</tr>
<tr>
<td>7.6.3</td>
<td>Quality &amp; Organizational Development Program</td>
<td>7-151</td>
</tr>
<tr>
<td>7.7</td>
<td>SUMMARY/CONCLUSION</td>
<td>7-153</td>
</tr>
<tr>
<td>7.8</td>
<td>REFERENCES</td>
<td>7-161</td>
</tr>
</tbody>
</table>
7.1 NEHA REGIONAL HEALTH SERVICES

Overview

Section 7 reviews the NEHA Health Services at both the regional and health district level utilizing the Manitoba Health Performance Measurement Framework. If there is no information or indicators under a measurement component, then the category will not be mentioned.

Three broad categories are explored in this section:

- NEHA Regional Health Services
- Physician Services
- NEHA Health Care Programs
The North Eastman Health Association is a progressive health care organization. The regional health authority is responsible for the planning and delivery of all health services in the region. A full spectrum of health services is provided by NEHA including: Acute Care, Long Term Care, Public Health, Primary Health Care, Mental Health, Home Care, Diagnostic Services, and Emergency Medical Services. Support Services and Financial Services are not listed separately but provide support to the health-related programs.¹

**NEHA Human Resource Profile**

There are 1,070 staff members employed with NEHA. Support Service staff are integrated into the programs they work in.
Table 7.1 Manitoba’s Health Performance Measurement Framework

**HEALTH SYSTEM PERFORMANCE**

**Health Services as a Health Determinant**

“Health services, especially those designed to maintain and promote health, prevent disease and injury and restore health, contribute to population health.”

<table>
<thead>
<tr>
<th>RESPONSIVENESS</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Timeliness</th>
<th>Continuity</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA)</td>
<td>“The ability of client / patients to obtain care/service at the right place and the right time, based on respective needs.” (CCHSA)</td>
<td>“Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time.” (CCHSA)</td>
<td>“The ability to provide uninterrupted, coordinated care/service across programs, practitioners, organizations, and levels of care/service, over time.” (CCHSA)</td>
<td>“Decisions are made and services are delivered in a fair and just way.” (CCHSA)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEM COMPETENCY</th>
<th>Appropriateness</th>
<th>Competence</th>
<th>Effectiveness</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Care/service provided is relevant to the clients’/patients’ needs and based on established standards.” (CCHSA)</td>
<td>“An individual’s knowledge and skills are appropriate to the care/service being provided.” (CCHSA)</td>
<td>“The care/service, intervention or action achieves the desired results.” (CCHSA)</td>
<td>“Potential risks of an intervention or the environment are avoided or minimized.” (CCHSA)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLIENT/COMMUNITY FOCUS</th>
<th>Communication</th>
<th>Confidentiality</th>
<th>Participation and Partnership</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>“All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable, and useful.” (CCHSA)</td>
<td>“Information to be kept private is safeguarded.” (CCHSA)</td>
<td>“The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation.” (CCHSA)</td>
<td>“All care/service provided meets the expectations of the client, community, providers and paying organizations, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of the clients’/patients’ are paramount.” (CCHSA)</td>
<td></td>
</tr>
</tbody>
</table>
WORK LIFE – The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well-being, and satisfaction. (CCHSA) 21

<table>
<thead>
<tr>
<th>Open Communication</th>
<th>Role Clarity</th>
<th>Participation in Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The organization fosters a climate of openness, free expression of ideas, and information sharing.” (CCHSA) 22</td>
<td>“Staff have a clearly defined job scope and objectives, and these are aligned with team and organization goals.” (CCHSA) 23</td>
<td>“Staff input is encouraged and used in decision making.” (CCHSA) 24</td>
</tr>
</tbody>
</table>

Learning Environment

<table>
<thead>
<tr>
<th>Well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Staff creativity, innovation, and initiative is encouraged. The necessary training and development to attain organizational goals and personal/professional development objectives, is provided.” (CCHSA) 25</td>
</tr>
<tr>
<td>“The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement activities.” (CCHSA) 26</td>
</tr>
</tbody>
</table>

Note: Health System Infrastructure and Community and Health System Characteristics may reflect expectations, indicators or measures or provide useful contextual information. 27

HEALTH SYSTEM INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Finances</th>
<th>Human Resources</th>
<th>Leadership</th>
<th>Information &amp; Technology</th>
<th>Physical Structure &amp; Equipment</th>
<th>Public Health Surveillance</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Health workforce structure and distribution.” 28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Formal structure / processes of the organization.” 29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Mechanisms” 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Research funding and structures “ 31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMUNITY & HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Population Demographics [Education as a health determinate] 32</th>
<th>Health Service Utilization</th>
<th>Expenditures</th>
<th>Other</th>
</tr>
</thead>
</table>

North Eastman's Organizational Alignment: Board Ends-Strategic Priorities and Quality Dimensions

The North Eastman board has identified the following board ends: 33

1. Health Status
   a. North Eastman Health Association Inc. provides health care and services that enable all individuals, families and communities to pursue optimum health.
   b. Assistance is available to isolated and socio-economically disadvantaged communities to develop health programs and to improve health status.

2. Access to Services
   a. All residents have access to a full spectrum of integrated basic health services available within the region through a seamless single point of entry.
   b. Residents have timely access to services required, but not available in the Region.
3. Healthy Lifestyles
   a. North Eastman Health Association Inc., as an integrated health system, provides leadership in the development of healthy communities through health promotion and education and through partnership with other human services providers and community stakeholders.

4. Healthy and Productive Staff
   a. North Eastman Health Association Inc., as a health system, is a healthy and productive environment for people to work in.
   b. Trust, confidence, safe and supportive workplaces, a commitment to excellence, and effective, efficient service delivery characterize this environment.

The North Eastman Health Association's Performance Measurement System is based on organizational alignment of Board Ends, Regional Strategic Priorities and Quality Dimensions as follows:

- **Board End:** Health Status
  - **Regional Priority:** Optimum Health Care Outcomes
  - **Quality Dimension:** Responsiveness

- **Board End:** Access to Services
  - **Regional Strategic Priority:** Optimum Systems
  - **Quality Dimension:** System Competency

- **Board End:** Healthy Lifestyles
  - **Regional Strategic Priority:** Optimum Community Health
  - **Quality Dimension:** Client and Community Focus

- **Board End:** Healthy Productive Staff
  - **Regional Strategic Priority:** Optimum Workplace
  - **Quality Dimension:** Work life

This forms the framework for our Corporate Scorecard and Dashboard of Operational Indicators. It is full alignment with the Canadian Council on Health Services Accreditation quality dimensions of Responsiveness, System Competency, Client and Community Focus and Work life and Manitoba’s Health Performance Measurement Framework.  

---

34
7.2 HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Population Demographics</th>
<th>Health Service Utilization</th>
<th>Expenditures</th>
<th>Other</th>
</tr>
</thead>
</table>

**Health Service Utilization**

**Alternative Care**

There are a number of alternative health care services within North Eastman communities. They include Chiropractors, Physiotherapists, Acupuncture, Massage Therapy, Reflexology, Foot Care Services, Dentists, and Natural Foods stores.

**Figure 7.2 Use of Alternative Health Care**

![Use of Alternative Health Care Services - 12 Years and Older 2001](image)

From the information available, NE females appear to utilize alternative health care services more frequently than men.

**Note:** Information is not available for NE males because too few men responded.

36% of NE respondents utilized alternative therapies for their injury treatment.

**2003 Acumen Research Survey - NE Findings – Alternative Therapy for Injury Treatment**

Of the respondents who reported having injuries within the past year, 36% utilized alternative therapies for their injury treatment. 35
Expenditures

Funding Allocation

In 2003/2004 the funding allocation was $41,297,000.00, in 2002/2003 the funding allocation was $36,934,000 and in 2001/2002 the funding allocation was $32,272,096.00 for the delivery of health services for NE region.

Figure 7.2 NEHA Funding Allocation 2003/2004

The following table looks at the number of medical services per 1000 population in NE and the subsequent per capita cost of these services in 2001/02.

Figure 7.2 NE Medical Utilization Rates and Costs of Services for Males and Females 2001/02

<table>
<thead>
<tr>
<th>Service</th>
<th>NE Males</th>
<th>NE Females</th>
<th>Total Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Medical Services used, Rate per 1000 population</td>
<td>2,946</td>
<td>3,754</td>
<td>13,265</td>
</tr>
<tr>
<td>Cost of Services Per Capita</td>
<td>$67.00</td>
<td>$85.00</td>
<td>$305.00</td>
</tr>
</tbody>
</table>


Females appeared to have utilized more health care services and the per capita cost of these services was higher than for males.
### 7.3 HEALTH SYSTEM PERFORMANCE

**Responsiveness** – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. [Canadian Council on Health Services Accreditation (CCHSA).]

<table>
<thead>
<tr>
<th>Availability</th>
<th>Accessibility</th>
<th>Timeliness</th>
<th>Continuity</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” [CCHSA]</td>
<td>“The ability of client/patients to obtain care/service at the right place and the right time, based on respective needs.” [CCHSA]</td>
<td>“Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time.” [CCHSA]</td>
<td>“The ability to provide uninterrupted, coordinated care/service across programs, practitioners, organizations, and levels of care/service, over time.” [CCHSA]</td>
<td>“Decisions are made and services are delivered in a fair and just way.” [CCHSA]</td>
</tr>
</tbody>
</table>

#### Availability

“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” [CCHSA]

#### 2003 Acumen Research Survey – NE Findings - Ability to Get Health Services

**Q: When I need a particular health care service, I am usually able to get it.**

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neither agree or disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>44%</td>
<td>41%</td>
<td>4%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Almost half of NE survey respondents strongly agreed that if they needed a particular health care service they were usually able to get it.

#### 2003 Focus Group on Availability of Services

**Middle Adult**

- Suggestion by Middle Adult
  - Would like to see publicly insured dental care. [Winnipeg River]
**Accessibility**

“The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs.”

(CCHSA) 43

**2003 Focus Groups- Accessibility to Services & Information**

**YOUTH**

a) **Seeking health information** - Some ways they would seek health information are: internet, doctor, parents, Public Health Nurse, in school, from the Alcohol Foundation of Manitoba (AFM) Counselor. [Brokenhead]

- Would ask their parents or a friend. [Seymourville]

- Younger youth in the Iron Rose group seemed to have less knowledge of the health care coverage overall than older participants. [Iron Rose]

**YOUNG ADULT**

a) **Non-Medical Itinerant Services** - This arose in almost all focus groups as a need for itinerant specialists for example: more audiologist services. Audiologist in Beausejour cannot meet local demand. [Springfield, Brokenhead]  "He [audiologist] said ..6-8 month wait and it's already been a year." [Brokenhead]

- Need more speech language services.

b) **Lack of Transportation** - This barrier to service arose very strongly when talking with participants from more isolated communities e.g. Seymourville, from families who don't have a car, and from some others who are unable to drive because of concerns with weather, or their license was removed for health reasons or the fact that city driving is a real stressor.

- A lack of transportation is viewed as very important access issue in Seymourville. Some concerns are: Hollow Water Van not always available or willing to provide transportation for Seymourville residents. Very few people have vehicles in the community. Transportation warrants do not cover the costs to hire private drivers. Type of treatment prescribed is often a barrier to compliance, as they may be unable to go due to a lack of available transport.

- With children and no car, getting to the emergency room can be expensive unless approved by social assistance in advance. [Winnipeg River]. One example came from a participant who was transferred to Winnipeg via ambulance and when discharged did not have the transportation means to return to her community.

- In contrast, the Brokenhead group felt there was no problem travelling to see specialists in Winnipeg.

c) **Information Overload** - A lot of health information and difficulty knowing what is actually true [Blue Water].
d) Related to Staff

- One participant mentioned about spending more money on administration due to regionalization
  “...There is no money for more doctors and more nurses.” [Brokenhead]

- Some participants in the Brokenhead group mentioned the qualities expected of health care staff including doctors and receptionists “…you need someone who is personable and pleasant and will understand …” [Brokenhead]

- Need adequate follow up as instructions as not always clear…. Pamphlets are not always enough, sometimes need instructions too. [Winnipeg River].

- There can be an attitude toward single young mothers “…Just a young dumb single girl that had another baby that’s sick and nobody wanted to take me serious.” [Winnipeg River]

- Seymourville group indicated that they felt that the staff at the Pine Falls Health Complex to be excellent and the care, the treatment and the meals that they have received – have been very good!

**Suggestions Raised by Young Adults**

- Need to ensure people have awareness of services as this might be a reason for not accessing. [Seymourville]
- Use of the nurse practitioner is seen as an appropriate way to allocate resources to save doctor time. “It's great to have [nurse practitioner]...great to have female.” [Springfield]. Similar comments have been mentioned about nurse practitioners in every adult age Focus Group.

**MIDDLE ADULT**

a) Information Overload

- It was expressed that there is a lot of health information to sort through. Participants mentioned using family members educated in the health field, talking to other people, internet access. Some do what the doctor tells them to do. Others felt the doctor was too busy to discuss information. Stressed importance of finding reliable sources. [Brokenhead, Iron Rose, Winnipeg River]
  “…There’s no end to it [information]. Who do you believe?”[Iron Rose]

b) Seeking Information

- Concern over the power of the media.

- “We are made to feel we are always lacking... Everyone your age is doing this.” Especially in regard to youth: “...Magazines are telling my daughter her body isn’t that right.” [Winnipeg River]

c) Lack of Access to Non – Medical Specialist Services

- Audiology is perceived in all the adult Focus Groups as a valuable service, however the wait time is a barrier expressed in most health districts. Having an audiologists in Beausejour is “better than going to Winnipeg.” [Winnipeg River]

**Suggestions raised by Middle Adult**

- Expand Speech and Language Pathology for children. [Winnipeg River]
- Would like to see itinerant specialists. [Winnipeg River]
- Chemotherapy is a service that is requested in all the adult Focus Groups.
- Smaller more efficient vehicle for patient transfer. [Blue Water]
- More public awareness needed about many community and health-related programs, services and supports. [Springfield]
SENIORS

a) Information Overload –
- Lots of information can be contradictory. [Iron Rose, Brokenhead]
- Felt physician was possible source, others felt physicians are not paid for counseling. Most participants agreed that the physician often doesn’t have the time. [Brokenhead, Iron Rose]
- Abundance of information on nutrition and this was confusing. [Iron Rose]

“Sometimes the information is contrary… If different books contradict each other I use my own judgment and will usually go along with the one that says don’t eat it.” [Iron Rose]

Suggestion Raised by Seniors
• Volunteers need to come and talk to seniors about health and exercise. [Brokenhead]

b) Awareness of Health Services
- More information on services that are available needed. Felt this wasn’t NEHA’s fault as there are pamphlets but not everyone reads them. Further “People have to accept help.” [Iron Rose]

c) Transportation - There is a strong desire is to have services within the region in this age group.
- Much trepidation about driving in the city. [Springfield, Blue Water, Iron Rose]
- Some participants expressed fear if in an accident, license would be taken away and this would be very hard, living out in the country. [Springfield]
- It was felt that there is an impact not being able to drive and that there is discrimination against senior (drivers) in general. [Iron Rose]
- “A whole day spent in the city is traumatic, especially in winter.” [Iron Rose]
- “Do not like driving in the city… It’s hard when you’re not used to it. Parking. It’s confusing. You get lost. It frightens me… almost like a nightmare.” [Blue Water]
- Travel is difficult. People who don’t drive (or don’t drive in the city) need to find someone available to drive them to appointments. [Winnipeg River]
- Seniors facilities in Beausejour are a long distance from downtown…”We have 2 vans now…. I wonder if we couldn’t have a little taxi of some sort…” [Brokenhead]
- Physiotherapy in Kin Place. [Springfield]

STAFF

a) Distance is seen as a barrier to service delivery by community staff.

“...It may take me two hours to get where they [clients] are and two hours to get back. Sometimes that’s a barrier when I would like to see them and it’s 4:30 already. As opposed to someone who is just down the road and I can just pop in and see them on my way home.... When they phone I say, ‘No, you have to come and see me.’...Part of my area, you can’t get there, even with a good vehicle. There is a safety concern, when you go up there in the wintertime.... there are no places you can stop if you ran out of gas.” …“if it’s bad weather you can’t put yourself at risk but by the same token you want to go but you can’t.” “You say, ‘you should go see a doctor’...They look at you like, ‘I’ll never get there, I have no car, I have no money’...”

Note: During the CHA Focus groups conducted in 1998, the following issues were also raised:
- The need for dentist, physiotherapists, optometrists.
- Transportation to appointments.
- Needing more information, but not information overload.
- Awareness of health services.
In order to utilize services our residents must be aware of their existence. This question from the 2003 Acumen Research Survey was submitted by NE region only. It was important for the CHA consultation team to understand if our residents were aware of existing services. During the Focus Groups one of the areas that seemed to repeatedly be raised was a lack of awareness of mental health services.

**2003 Acumen Research Survey - NE – Identifying Services Offered**

Q- NE respondents were asked to identify which services were offered in their area.

The following table provides a list of services in order of respondents being most aware.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>90%</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>88%</td>
</tr>
<tr>
<td>Home care</td>
<td>88%</td>
</tr>
<tr>
<td>Services to seniors</td>
<td>87%</td>
</tr>
<tr>
<td>Social workers</td>
<td>77%</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>60%</td>
</tr>
<tr>
<td>Clinical Dieticians</td>
<td>53%</td>
</tr>
<tr>
<td>Mental health services</td>
<td>53%</td>
</tr>
<tr>
<td>Diabetes education</td>
<td>52%</td>
</tr>
<tr>
<td>Wellness Facilitators</td>
<td>47%</td>
</tr>
<tr>
<td>None of the above</td>
<td>1%</td>
</tr>
<tr>
<td>I don’t know about any services in my area</td>
<td>1%</td>
</tr>
</tbody>
</table>


Note: This question was put to the North Eastman sample only. Column percentages total greater than 100% because multiple responses were allowed.

- Respondents living alone (one-person households) are most likely to be unaware that Mental Health Services, Public Health Nurses or Services to Seniors exist in their area. 

- Respondents with a family income under $20,000 are least likely to know that Social Workers, Public Health Nurses, or doctors are available in their area.

Potentially high risk, vulnerable groups such as low-income families and residents living alone, may be unaware of certain services.

It is a positive finding to see that many of the respondents were aware of most services offered in our region. Given the concerns raised about the lack of awareness of Mental Health Services in many of the focus group sessions it is surprising to see 53% of the survey respondents acknowledging an awareness of this service. It is important to note that these potentially high risk, vulnerable groups may be unaware of certain services.
SYSTEM COMPETENCY

The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA) 46

<table>
<thead>
<tr>
<th>Appropriateness</th>
<th>Competence</th>
<th>Effectiveness</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Care/service provided is relevant to the clients'/patients' needs and based on established standards.” (CCHSA) 47</td>
<td>“An individual's knowledge and skills are appropriate to the care/service being provided.” (CCHSA) 48</td>
<td>“The care/service, intervention or action achieves the desired results.” (CCHSA) 49</td>
<td>“Potential risks of an intervention or the environment are avoided or minimized.” (CCHSA) 50</td>
</tr>
</tbody>
</table>

Effectiveness

“The care/service, intervention or action achieves the desired results.” (CCHSA) 51

2003 Acumen Research Survey - NE – Information Seeking

Q- If I need specific information about my health or a particular treatment, I know where to go or who to call about it.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neither agree or disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>48%</td>
<td>37%</td>
<td>3%</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>


Eighty-five percent of NE respondents either strongly or somewhat agreed that they knew where to find information about their health or a particular treatment. Retired respondents and those working full-time were more likely than the regional respondents generally to agree that they know where to find information about their health or a particular treatment.
CLIENT /COMMUNITY FOCUS

The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA) 82

<table>
<thead>
<tr>
<th>Communication</th>
<th>Confidentiality</th>
<th>Participation and Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable, and useful.</em> (CCHSA) 53</td>
<td><em>Information to be kept private is safeguarded.</em> (CCHSA) 54</td>
<td><em>The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation.</em> (CCHSA) 55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respect &amp; Caring</th>
<th>Organization Responsibility &amp; Involvement in the Community</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Politeness, consideration, sensitivity, and respect are incorporated into all interactions with the client and/or community.</em> (CCHSA) 56</td>
<td><em>The organization supports and strengthens the community and its development, and contributes to its overall health.</em> (CCHSA) 57</td>
<td><em>All care/service provided meets the expectations of the client, community, providers and paying organizations, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of the clients'/patients' are paramount.</em> (CCHSA) 58</td>
</tr>
</tbody>
</table>

The North Eastman Health Association is committed to ongoing development and enhancement of communication strategies to effectively involve stakeholders and to build strong community links and partnerships. Indicative of this commitment is the hosting of two annual General Meetings with locations being rotated throughout the region on an annual basis. Attendance at these meetings has steadily been increasing over the past four consecutive years.

Information is readily accessible to the communities we serve and include: a comprehensive Service Directory, Complaint Management processes, four issues of the “Pulse” an external newsletter published by NEHA, a NEHA Website, toll free number to the Corporate Office (1-877-753-2012), and multiple articles in local newspapers. Annual Reports are widely distributed including Municipal Offices and all local Libraries. There are also multiple opportunities for stakeholders to participate in focus groups, District Health Advisory Councils, wellness and health promotion activities, to name a few. 60

**Communications Methods**

There are a variety of methods NEHA uses to communicate with their staff and general public. These include: Web site: www.neha.mb.ca; internal newsletter (The Breeze) and external newspaper (The Pulse), annual general meetings, public consultations, memos, email and articles to local newspapers.
Web Site

The web site includes information about NEHA in general, facility description, programs and services, strategic plan, annual reports, newsletters, a calendar of events and health corner.

Annual General Meetings (AGM)

The annual general meetings over the last several years have shown an increase in participation from the general public.

2004
During June 2004 there were approximately 250 community members that attended meetings held at Beausejour Sun Gro Centre and the Seymourville Recreation Centre. Highlights were presentations of “Award Winning Long Term Care Program” in Beausejour and “Healthy Living - What Does it Mean?” presented by: Dale Kornelson (Clinical Dietitian) and Bonnie Stefansson (Wellness Facilitator) in both Beausejour and Seymourville. A celebration and signing of our Aboriginal Employment Partnership Agreement also occurred in Seymourville. 61

2003
During June 2003 there were approximately 100 community members that attended meetings held at Victoria Beach Senior Scene and the Whitemouth Community Hall. Highlights were an overview of the Community Health Assessment project and a presentation addressing Quality of Work Life presentation, which included a review of the recruitment video. 62

Current Inventory of Specific Health Programs in Place

Telephone Listing/Directory Card

This is a stiff double-sided card that contains health provider telephone numbers that are relevant to a specific health district. This card was distributed to every household in NE during January 2003.
Blue Directory

In November 2002, NEHA published a *NEHA Directory of Health Services* (referred to in this report as the ‘Blue Directory’). It was distributed broadly throughout the region.

Health Links

This is a provincial telephone service that provides confidential multilingual health advice by Registered Nurses as well as information for direction to the most appropriate care. Any resident can call at no charge 1-888-315-9257. Clients are encouraged to use this service for telephone advice.

At the time of the Focus Groups, participants were telling us that there was often a wait before the nurse would return a call. Since then, there has been a substantial increase in staffing and a news release from the Manitoba government indicated that expanded service means “quick access to the primary healthcare information and support services they need.”

### 2003 Focus Groups on Communication

Communication questions included awareness of the Blue Directory, Telephone Listing/Directory Card, of articles written by NEHA staff and placed in local newspapers e.g. Health Corner, Wellness Tips and Health Links. Another question that was asked of some groups was how as an organization we could increase community involvement in participation activities.

**Note:** Telephone Listing/Directory cards and Blue Directory’s were given out after the Focus Groups to interested participants.

The following information describes what the participants in the Focus Groups have to say about these communication strategies.

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Wellness Tips/ Health Corner / Local Newspaper Articles</th>
<th>NEHA Telephone Listing/Directory Card</th>
<th>NEHA Blue Directory</th>
<th>Health Links</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YOUTH</strong></td>
<td>-Some youth had no familiarity with the health service directory. [Iron Rose, Blue Water, Brokenhead]. -Others saw it at place of work and “believe its printed on the back of the Pinawa Paper.” [Winnipeg River]. -One student recognized it as coming in the mail and kept by their phone at home. [Springfield]</td>
<td>-Most youth had no familiarity with the Blue directory. [Iron Rose, Springfield, Brokenhead, Winnipeg River] One student had seen it because, “…my auntie works at home care.” (Blue Water)</td>
<td>-None of the students had heard of Health Links.</td>
<td></td>
</tr>
<tr>
<td><strong>YOUNG ADULT</strong></td>
<td>-Health Corner and Wellness Tips were recognized by most. [Blue Water] -NEHA information seen in local papers – questions and answers, dietary, ads for Healthy Baby. [Springfield]</td>
<td>-No one had seen the directory card [Winnipeg River, Blue Water] -In Springfield, all participants had copies of the directory card. -Only two participants had seen it, one keeps it in the phone book the other on</td>
<td>-Most had not seen the Blue Directory, [Winnipeg River, Blue Water, Iron Rose]. -Most of the participants had one. One of them remembers picking it up at the Health Centre. [Winnipeg River]</td>
<td>-Only one person had heard of it but hadn't used it. [Iron Rose] -Four of five knew what Health Links is and have used the service. -Found out about it from TV, doctor's answering machine, and information</td>
</tr>
</tbody>
</table>
### Focus Group

<table>
<thead>
<tr>
<th>Wellness Tips/ Health Corner / Local Newspaper Articles</th>
<th>NEHA Telephone Listing/Directory Card</th>
<th>NEHA Blue Directory</th>
<th>Health Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>- This Focus Group had limited awareness of the Wellness Tips or NEHA Health Corner. Regional newspapers are not readily available. [Seymourville]</td>
<td>the fridge. [Brokenhead]</td>
<td>-Only one participant had seen it. [Brokenhead]</td>
<td>given by St. Anne’s hospital when doctor was not available. [Springfield]</td>
</tr>
</tbody>
</table>

**Suggestion On What Could Be Done To Improve Communication / Participation?**

Have Focus Groups on individual topics – for example on diabetes, parenting. [Seymourville]

**Note:** Some of the participants in the Springfield group questioned if the EMS numbers were correct.

### MIDDLE ADULT

- Everyone had heard of Wellness Tips. The participants were unable to remember the Health Corner articles. [Winnipeg River]

- Half the group was familiar with the card, three of them remember receiving it in the mail, others kept it, one is not sure where it is. [Iron Rose]
  
  - Majority had not seen it, two of them picked it up at the Lac du Bonnet Health Centre. [Blue Water]
  
  - Most remember receiving it, one keeps it tucked inside the phone book, two participants indicated that they hadn’t received it. [Winnipeg River]
  
  - Most participants remembered receiving the card by mail. Keep in the phone book, drawer by phone. [Springfield]

**Note:** Some participants in Springfield felt that there was a large number of errors on the card.

- NEHA’s blue directory is “…a good tool to get to the public… it would be nice if it was published in the phone book…” [Brokenhead]
  
  - These things are important to have in places like the hotel! - Could be more inclusive, e.g. foot care.” These things aren’t NEHA but they are health care…” [Brokenhead]
  
  - None remember having seen it. [Winnipeg River]
  
  - Two had it, one received it from the clinic in Lac du Bonnet and one from Seniors’ Scene. There were none in the Pine Falls hospital on the day one person was there. [Blue Water]

- Three people in the group had seen it. [Iron Rose]
  
  - A couple of participants had seen it. One doesn’t remember how they got it. Another remembers picking it up at the Primary Health Centre. It was noted that people might not find physicians because they are listed under ‘Primary Health Centre’, not ‘Doctors’. [Springfield]

- Large majority of group is familiar with Health Links. One participant who uses the service reported difficulty getting through and that return call time had increased to 2-3 hours. [Springfield]
<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Wellness Tips/Health Corner / Local Newspaper Articles</th>
<th>NEHA Telephone Listing/Directory Card</th>
<th>NEHA Blue Directory</th>
<th>Health Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>SENIORS</td>
<td>- One participant recognized Health Corner and had called in a question, although hadn't seen a reply (is there a way by which the questioner could be alerted if an article is to be printed?) [Brokenhead]. - No recognition by name to Wellness Tips. [Blue Water] - NEHA corner, Wellness Tips: one participant replied, “Oh yes, there is a column isn’t there?” No one else was familiar although they all claim to read the local papers. [Iron Rose] - Someone recalled Health Corner from the Echo newspaper. [Blue Water] Suggestions on what could be done to improve communication / participation? - The group suggested NEHA could promote and disseminate information through existing community groups, doctors and hospital waiting rooms (even the healthy go to visit friends). [Winnipeg River] - The Directory card was familiar to about half the group. They had received it through the mail or from a wellness group. (Winnipeg River). - Most are familiar with the card [Blue Water]. - No one had previously seen the blue directory. [Winnipeg River] - A few seemed to recall seeing the Blue Directory. Some participants received a copy at NEHA’s annual general meeting, or at the health conference in Mitchell. Most felt that it was useful. One participant mentioned that handing out the information is necessary but perhaps not sufficient as people sometimes need to be told what you have given them or encouraged to examine it: “It would be useful if I took the time to read it.” [Iron Rose] - A few had seen the directory at the day program at Victoria Beach [Blue Water]. - Directory was seen by only one participant whose spouse had picked it up – upon review it was deemed a good resource. [Springfield] - More than half had not seen the directory. When everyone had a chance to review it, the group suggested delivering a short review of the directory when it is being distributed so recipients realize the value of the information. [Brokenhead] - Most of the group had not heard of Health Links. The program was described to the group. One participant who had called the service was pleased with the experience: “It’s a great thing. A fantastic thing. It will eliminate people going to the doctor for minor things.” Others were glad to be informed of the service. [Brokenhead] - While one participant recognized Health Links as a provincial service, no one else knew about it (Springfield) - “I heard of the name (Health Links) Is it a phone number?” After explanation response was very positive about the service. [Iron Rose] - One participant knew Health Links was a phone service. Other participants “had heard of it.” [Winnipeg River]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Often handing out health services directories isn’t enough. The information needs to be explained and its usefulness described.

2004 Validation Workshops

**SPRINGFIELD GROUP DISCUSSIONS ON HEALTH SERVICES – COMMUNICATION**

**Discussion**
- Participants felt there is a need for more and better corporate communications.
Management of Confidentiality

The North Eastman Health Association is committed to maintaining high standards of confidentiality at all times. All staff and volunteers sign an Oath of Confidentiality and are aware of the policies in regards to Personal Health Information.

Personal Health Information Act (PHIA) Training

NEHA is committed to ensuring that the rights of the individual to privacy of health information are adhered to by all staff as set out under the PHIA Act. Our regional privacy officer is the VP of Programs and Services.

Education

During Day 1 of Regional Orientation all new staff are presented with a review of the Act as well as given examples for group discussion of possible workplace breaches of PHIA. Nurses are provided with additional reading material entitled: The Personal Health Information Act. A Brief Summary for Health Professionals. Manitoba Health.

Policies

In the Regional Policy and Procedure binder there are four policies related to PHIA

   a) 12-2 Access to Personal Health Information
   b) 12-3 Criteria and Procedure for the Release of Information
   c) 12-4 Protection of Privacy during Use and Disclosure of Personal Health Information.
   d) 12-5 Correction of Personal Health Information.
### Participation and Partnership

*The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation. (CCHSA).*

### Community Partnerships

The North Eastman Health Association (NEHA) works with the community and other organizations to regularly assess the community's health status capacities and health needs. Some of our partners include: Municipalities, School Divisions, Red River College, Assiniboine Community College, University of Manitoba, Southeast Tribal Council, Senior’s Centres, various community organizations, Manitoba Housing, Addictions Foundation of Manitoba, CancerCare Manitoba, Facility Foundations and other Regional Health Authorities of Manitoba.

Linkages and partnerships exist through inter-agency groups that North Eastman Health Association participates in, such as, the North Eastman Intersectoral Agency Committee. This Inter-Agency committee consists of representation that crosses all human service jurisdictions such as Child and Family Services, Education and Training, Corrections, RCMP and Health Services.

NEHA has partners with several related locally initiated human service organizations such as the Winnipeg River Community Resource Centre (includes a second hand store, single Moms support group, child and youth activities and counseling), and ‘Wings of Power’ (includes a moms and tots program, nutrition counseling, family counseling and children’s activities).
**District Health Advisory Council**

The District Health Advisory Council (DHAC) provides a focal point for community participation in relation to providing feedback regarding our programs and services. The DHAC meets every second month. There is representation from the board and management at each meeting. Members represent five of our health districts. 68

The roles and responsibilities of the DHAC include, but are not exclusive of:

- To facilitate communications and distribution of information such as the AGM’s (Annual General Meetings), between communities they represent and the NEHA Board of Directors.
- To assist NEHA in the development of the Health Plan and Strategic Plan through identification of priorities to address health needs.
- To describe for NEHA the changing health needs and give suggestions for solutions.
- To provide access and assistance to the community for the initiation of health and community development projects.
- To carry out special projects at the request or as approved by the NEHA.
- To assist NEHA with the Community Health Assessment Project. 69

In regards to assisting with the CHA, the DHAC has:

- informing the public about the Focus Group projects (summer and fall 2003) and Validation Workshops (April/May 2004)
- helped the Validation Workshop facilitators in April/May 2004.

### Respect & Caring

“Politeness, consideration, sensitivity, and respect are incorporated into all interactions with the client and/or community.” (CCHSA) 70

The North Eastman Health Association supports the work of the Services to Seniors Boards and partners with several community foundations to support their work and initiatives. All NEHA Program and Service Teams have strong linkages and partnerships within their communities and utilize client satisfaction surveys to obtain feedback on their care and service delivery. We have partnered with several related locally initiated human service organizations such as: Winnipeg River Community Resource Council and Wings of Power.

We are proud of community partnerships that facilitated the development of a bilingual ‘Health Corner’ located within the community of St. Georges. The ‘Health Corner’ provides bilingual health information and internet access for health related sites. 71
Regional Consultations

Over the last few years there have been several issues that NEHA as an organization went to the public for consultation.

a) 2000 – Key stakeholders were invited to meetings to discuss the health planning process, to identify key health concerns and gaps in services, assist in developing a vision for health care and determining priorities for the immediate future. These consultations assisted NEHA in developing their strategic plan for 2001 to 2004. All key stakeholders in the five health districts were invited.

b) 2002 – Primary Health Care Development. Before the establishment of a formal Primary Health Care Program, Lori Clemente, Nurse Practitioner and Dr. B. Onoferson, Regional Chief of Staff conducted meetings to identify community needs. Seventy-seven people attended the meetings. A total of 71 people responded to a questionnaire that was distributed. Separate meetings were also held with the Regional Interagency group and with NEHA staff involved in health promotion.

c) 2003 – Management and the Board were busy with consultations in relation to a proposal for the redevelopment of the Pinawa Hospital. A discussion paper was developed. The public was asked to document their comments and/or attend community meetings that were held over several months. The public was informed of the consultation results by a newspaper article in all the local newspapers in February 2004.

Program Surveys Related to Client Satisfaction

Over the past few years various programs have made a considerable effort to consult with their clients with respect to how they perceive care. Client satisfaction survey results are located under ‘Participation and Partnership’ within ‘NEHA Health Care Program’ category, this section.

2003 Acumen Research Survey – NE Findings – Addressing Health Concerns

Q: When I have a concern about the health care system in my region, I know where to go to get my concern addressed.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neither agree or disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>26%</td>
<td>32%</td>
<td>6%</td>
<td>18%</td>
<td>20%</td>
</tr>
</tbody>
</table>


Almost three out of five NE respondents either strongly agreed or somewhat agreed that they knew where to go to address a health care concern. These respondents were more likely to be 18-24 or over 65 years of age. Two out of five NE respondents did not know where to go to address a health care concern.
2003 Focus Group- Interaction with Health Providers [not necessarily NEHA staff]

**YOUTH**

a) **Staff** - There was general agreement that they were always treated better when they had an adult with them e.g. staff more polite, showed more caring. [Springfield]
   "...don't like teens at all unless your parents are with you." [Springfield]
   "...judgmental." [Springfield]

**Suggestions Raised by Youth**

- "...You want to talk to someone who's supportive.....someone who is going to understand and listen and actually help you...you have to have the trust." [Brokenhead]
- It is important " That you can trust the people that are taking care of you and they won't hurt you or betray you." [Iron Rose]

**Evidence of Translation Services**

**Aboriginal Liaison/Interpreter**

This position has been in existence in the Region for many years now. Primarily the role of this position is to assist the care team in providing comprehensive health service to Aboriginal clients at the Pine Falls Health Complex. There is emphasis on assisting with the language, cultural differences, and client advocacy. There is also an outreach component to this position to facilitate communications between the facility and the community. 

**French Language Services and Other Translation Services**

Communication regarding services are available in French, at our designated facility (Pine Falls Health Complex). Written material regarding health promotion and services is available at the ‘Health Corner’ in the community of St. Georges.

The region maintains a list of staff members and volunteers to provide communication in as many languages as possible. When a specific need is identified, care providers make every effort to locate staff, a family member or volunteer to facilitate communication with the patient or client.

**Complaint Management Process In Place**

The North Eastman Health Association is committed to providing quality care and service to all clients in a safe and secure environment. A Complaint Management process is in place to provide for a systematic and coordinated approach to the processing and resolution of all concerns and complaints brought to our attention by our clients. It is designed to seek resolution to all concerns/complaints through effective investigation and management, and to provide an environment that will ultimately result in an amicable resolution of the concern/complaint for both the client and the organization.

The Complaint Management process is reviewed at a Senior Management level to identify factors that have contributed to complaints received and to make recommendations regarding changes in procedures, practices or corrective actions that can be expected to resolve identified problems or reduce them to an acceptable and manageable level.
**Spiritual Care**

NEHA is committed to a holistic approach to health care. The mission of the Spiritual Care Program is to “promote the holistic care and treatment of the person (spiritual, religious, cultural, psychosocial, emotional, physical). In collaboration with the health team, the providers of Spiritual Care integrate the spiritual and religious aspects of care into the delivery of services across the continuum of care.”

In June, 2000 NEHA staff and representatives from faith communities throughout the region came together to establish the first Spiritual Care Advisory Committee to the North Eastman Health Association. The purpose of this Advisory Committee is to assess the spiritual care delivery within NEHA and to propose creative “needs based” recommendations. It focuses on integrating spirituality into the health care system through recommending educational options, seeking to maintain a highly professional level of spiritual care in the institutions and community programs to persons, their families and staff; and to consult, advise and support NEHA on spiritual care and broad ethical issues. As well, it is there to foster communication and information sharing between the faith communities and NEHA and to work cooperatively with faith ministerials and encourage participation in delivery of spiritual care along the whole health care continuum.

One of the questions all new patients and residents are asked is whether they want to participate in this program. If they do, staff then ensures that their spiritual and religious needs are met in a more formal way. This includes visits from a spiritual care volunteer and access to religious services.

All patients and residents are cared for by mobilizing their own personal spiritual resources and are...“treated as unique individuals with particular beliefs, values and customs. All cultural preferences will be accommodated for as much as possible. Privacy, modesty and dignity is protected and respected.”

**Palliative Care Services**

“Palliative Care is the provision of skilled, compassionate interdisciplinary professional and volunteer care for people whose disease does not respond to curative treatment. Palliative care is presently provided throughout the region in hospitals, PCH’s and in the home... The goal is the best possible quality of life for clients and their families.”

Some components of the program are: pain and symptom management; interdisciplinary team approach, volunteer services, grief and bereavement counseling, support groups, information services, education, research, resource library, community care, acute care, care-giver support, links with other programs/services and resources for comfort care e.g. specialized equipment.
Linkages / Partnerships With Core Groups e.g. Women, Children, Aboriginal and Seniors.

The organization recognizes the importance of being connected to our communities, clients and stakeholders. These linkages occur at all levels of the organization and include interagency groups such as Wings of Power, District Health Advisory Council and provincial groups.

The Board is committed to community empowerment. This commitment has extended to putting additional resources into community wellness, and links to community programs, foundations, boards and First Nation communities.

Feedback from community partners indicates our success with our communication strategies. The partners indicated key strengths as being connected with the people, a true grass roots organization with a genuine respect for the people who work within it, as well as, those it serves.

The North Eastman Health Association encourages, supports and participates in ongoing community development by:

- Supporting activities that inform and educate the community about factors contributing to their health
- Helping members of the community develop skills and abilities they need to take responsibility for and make decisions about their health
- Giving the community opportunity to participate in decisions about the organizations' services
- Participating in activities that make other sectors and governments aware of how out policies, decisions and actions affect the population we serve
- Working with other organizations, groups, sectors and government to promote healthy communities.

Mechanism for Community Volunteers

NEHA is committed to provide opportunities for community members to volunteer their services within our programs. The region has a well-established volunteer program with approximately 1000 volunteers participating. Volunteer opportunities exist in acute, long term care, Palliative Care programs and other programs.

Each acute and long-term care site has an individual who volunteers to coordinate the volunteers. The Palliative Care Program has a part time volunteer coordinator who provides orientation and education to community members interested in volunteering.

There is an annual “Volunteer Appreciation” celebration where each site brings together their volunteers and extends NEHA’s appreciation to this group of people. A volunteer binder was created to ensure consistence expectations and orientation for all volunteers working within NEHA programs.
WORK LIFE

The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well being, and satisfaction. (CCHSA) 80

<table>
<thead>
<tr>
<th>Open Communication</th>
<th>Role Clarity</th>
<th>Participation in Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization fosters a climate of openness, free expression of ideas, and information sharing. “” (CCHSA) 81</td>
<td>Staff have a clearly defined job scope and objectives, and these are aligned with team and organization goals. “” (CCHSA) 82</td>
<td>Staff input is encouraged and used in decision making. “” (CCHSA) 83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Environment</th>
<th>Well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff creativity, innovation, and initiative is encouraged. The necessary training and development to attain organizational goals and personal/professional development objectives, is provided. “” (CCHSA) 84</td>
<td>The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement activities.” (CCHSA) 85</td>
</tr>
</tbody>
</table>

Overview

NEHA is committed to a workplace that is characterized by an environment that provides for healthy and productive staff. It is one of the organization's four board ends. During the last three years the organization provided a comprehensive opportunity for leaders within the organization to receive extensive training over an eighteen month period regarding how to encourage full participation and development of staff along with an inclusive approach to communication and decision making. This program was conducted by through the Director Of Quality And Organizational Development with the assistance of a consultant educator. Another major initiative was the partnering with the Nurses Recruitment And Retention Committee to provide for extensive education across the organization regarding performance excellence.

Communication Strategies

NEHA is committed to fostering open communication, for example there is an internal newsletter published quarterly and circulated to all staff called the “The North Eastman Breeze.”

On a regular basis all staff have an opportunity to participate in general staff meetings at all sites. The CEO or designate attends the site staff meetings on a regular basis to sustain two-way communication regarding where the organization is going and speak to questions and issues.
Staff Satisfaction Surveys

For the past three years NEHA has conducted staff satisfaction surveys annually. Broad categories included: communication, working conditions, organizational structure and orientation/training staff development. Staff participation in the survey has been very good (over 50% of full time and part time staff). The results of the survey are shared with the staff and NEHA has acted upon the feedback received. Results have been very favourable overall and ratings have increased in each of the last three years.

Total Number of Respondents [includes full time, part time, and causal staff]
- 2001= 319
- 2002= 244
- 2003= 246

Communication

Communication is an ongoing challenge especially in an organization that is so geographically spread out as NEHA is.

<table>
<thead>
<tr>
<th>2001 Survey Results</th>
<th>2002 Survey Results</th>
<th>2003 Survey Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Responses</td>
<td>Average Response</td>
<td>No. of Responses</td>
</tr>
<tr>
<td>317</td>
<td>2.71</td>
<td>243</td>
</tr>
<tr>
<td>317</td>
<td>4.26</td>
<td>244</td>
</tr>
</tbody>
</table>

A. COMMUNICATION
1. I find the NEHA staff newsletter (The Breeze) informative.
2. I check the bulletin boards regularly to update myself.
3. The person I report to
   a) asks me for my opinions or ideas,
   b) is a team player,
   c) fosters and promotes teamwork,
   d) treats employees fairly and equitably,
   e) explains changes in procedures and practices in a timely manner,
   f) is concerned about me as a person,
   g) promotes the concept of "client/resident" first,
   h) is open to discussion regarding my concerns / suggestions.
4. NEHA policies and procedures are accessible.
5. Regional information is communicated in a timely manner.
6. Staff meetings are meaningful and provide good information.
7. I read and understand those policies and procedures that affect my job.
8. I find the NEHA community newsletter (The Pulse) informative.
9. I receive information that affects my job in a timely manner.

Section "A" Overall Average 4.01 4.05 4.26

The overall average has improved in 2003 at 4.26 compared with 4.05 in 2002 and 4.01 in 2001. The two categories that scored less than four related to whether staff meetings are meaningful and whether “The Pulse” was informative.
Working Conditions

<table>
<thead>
<tr>
<th>Section</th>
<th>Working Conditions</th>
<th>2001 Survey Results</th>
<th>2002 Survey Results</th>
<th>2003 Survey Results</th>
<th>No. of Responses</th>
<th>Average Response</th>
<th>No. of Responses</th>
<th>Average Response</th>
<th>No. of Responses</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>In general, I enjoy my job.</td>
<td>321</td>
<td>5.12</td>
<td>253</td>
<td>5.14</td>
<td>251</td>
<td>5.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My job description accurately reflects the work I do.</td>
<td>321</td>
<td>4.24</td>
<td>248</td>
<td>4.43</td>
<td>250</td>
<td>4.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My position makes good use of my skills and abilities.</td>
<td>326</td>
<td>4.64</td>
<td>252</td>
<td>4.74</td>
<td>249</td>
<td>4.70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The physical space where I work contributes to a positive job experience.</td>
<td>323</td>
<td>4.04</td>
<td>250</td>
<td>4.42</td>
<td>250</td>
<td>4.23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The people I work with positively influence the way I feel about my job.</td>
<td>324</td>
<td>4.33</td>
<td>253</td>
<td>4.47</td>
<td>251</td>
<td>4.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is good working relations between departments / programs.</td>
<td>322</td>
<td>3.66</td>
<td>251</td>
<td>3.99</td>
<td>251</td>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have a good working relationship with my team.</td>
<td>322</td>
<td>4.79</td>
<td>249</td>
<td>4.76</td>
<td>251</td>
<td>4.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My workload is such that I cope adequately.</td>
<td>324</td>
<td>4.07</td>
<td>251</td>
<td>4.16</td>
<td>252</td>
<td>4.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I find my job challenging and interesting.</td>
<td>324</td>
<td>4.77</td>
<td>251</td>
<td>4.77</td>
<td>252</td>
<td>4.87</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>After a days work I feel I have accomplished something.</td>
<td>323</td>
<td>4.54</td>
<td>252</td>
<td>4.67</td>
<td>252</td>
<td>4.72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I believe that the workplace is a safe working environment.</td>
<td>325</td>
<td>4.38</td>
<td>252</td>
<td>4.58</td>
<td>252</td>
<td>4.72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section “B” Overall Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.42</td>
<td>4.56</td>
<td>4.56</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During both 2002 and 2003 an overall average of 4.56 was reported. ‘In general I enjoy my job’ was consistently rated at over five for three years in a row.

Organizational Structure & Climate

<table>
<thead>
<tr>
<th>Section</th>
<th>Organizational Structure &amp; Climate</th>
<th>2001 Survey Results</th>
<th>2002 Survey Results</th>
<th>2003 Survey Results</th>
<th>No. of Responses</th>
<th>Average Response</th>
<th>No. of Responses</th>
<th>Average Response</th>
<th>No. of Responses</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>NEHA policies are consistent with the organizations’ values, mission and vision.</td>
<td>317</td>
<td>3.75</td>
<td>247</td>
<td>4.05</td>
<td>247</td>
<td>4.40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management’s actions are consistent with their words. They “walk the talk.”</td>
<td>317</td>
<td>3.24</td>
<td>246</td>
<td>3.52</td>
<td>247</td>
<td>3.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management practices are consistent with NEHA’s values, mission, and vision.</td>
<td>317</td>
<td>3.45</td>
<td>248</td>
<td>3.85</td>
<td>245</td>
<td>4.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I feel management is approachable and open to suggestions.</td>
<td>321</td>
<td>3.69</td>
<td>251</td>
<td>3.85</td>
<td>248</td>
<td>4.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balance between work and personal life is respected by the organization.</td>
<td>319</td>
<td>3.64</td>
<td>249</td>
<td>3.78</td>
<td>248</td>
<td>4.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have confidence in the leadership of the person I report to.</td>
<td>320</td>
<td>4.26</td>
<td>250</td>
<td>4.38</td>
<td>247</td>
<td>4.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employees are recognized when they do high quality work.</td>
<td>320</td>
<td>3.38</td>
<td>251</td>
<td>3.56</td>
<td>247</td>
<td>3.94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section “C” Overall Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.63</td>
<td>3.83</td>
<td>4.18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall average for this area has improved consistently during the three years being 4.18 in 2003. The areas that were ranked at 3 were associated with whether ‘manager actions are consistent with their words’. It should be noted that this also improved during the three years and employees are recognized when they do...
high quality work. This is consistent with the written responses related to respecting, appreciating and recognizing staff.

**Orientation / Training Staff Development**

<table>
<thead>
<tr>
<th>2001 Survey Results</th>
<th>2002 Survey Results</th>
<th>2003 Survey Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Responses</td>
<td>Average Response</td>
<td>No. of Responses</td>
</tr>
</tbody>
</table>

**D. ORIENTATION / TRAINING STAFF DEVELOPMENT**

1. I feel performance appraisals are useful.

   - 2001: 317, 3.89
   - 2002: 246, 3.79
   - 2003: 246, 4.00

2. I believe NEHA provides education & training

   - a) that is accessible,
     - 2001: 320, 3.64
     - 2002: 251, 3.78
     - 2003: 249, 4.10
   
   - b) that is relevant to my area of work,
     - 2001: 321, 3.77
     - 2002: 250, 3.86
     - 2003: 248, 4.17
   
   - c) that enhances my current skills.
     - 2001: 321, 3.70
     - 2002: 249, 4.00
     - 2003: 250, 4.12

3. I am aware of inservices that are offered in the region.

   - 2001: 321, 4.30
   - 2002: 249, 4.12
   - 2003: 251, 4.14

4. There is an adequate amount of training in the region.

   - 2001: 310, 3.43
   - 2002: 246, 3.29
   - 2003: 248, 3.66

5. I believe my orientation was complete and of sufficient length.

   - 2001: 300, 3.46
   - 2002: 241, 3.82
   - 2003: 231, 3.74

6. I believe a regional orientation is useful for new staff.

   - 2001: 319, 4.15
   - 2002: 248, 4.25
   - 2003: 248, 4.67

*Section "D" Overall Average*: 3.79, 3.87, 4.08

Overall average responses were the highest in 2003 at 4.08% as compared with 3.87 (2002) and 3.79 (2001). In 2003, average responses were up in all categories when compared to 2002 except for the belief that orientation was complete and of sufficient length. Unfortunately there were no comments to indicate why.

Over the three years, the top three suggestions staff identified to improve staff satisfaction were:

**Table 7.3 Top Three Suggestions Identified by NEHA Staff**

<table>
<thead>
<tr>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Communication</td>
<td>Respect/Appreciation/Recognition</td>
</tr>
<tr>
<td>Communication</td>
<td>Respect/Appreciation/Recognition</td>
<td>Communication</td>
</tr>
<tr>
<td>Organizational</td>
<td>Team Building/Teamwork</td>
<td>Staffing</td>
</tr>
</tbody>
</table>

The placement rating has changed over the three years however the major themes remain consistent related to communication, staffing and respect/appreciation and recognition.

*Staffing issues were the top concern expressed by staff in 2001. In 2003 it dropped to third place.*
Role Clarity

“Staff have a clearly defined job scope and objectives, and these are aligned with team and organization goals.” (CCHSA)

Overview

Our regional organizational structure has not changed over the last few years, which has contributed to our staff’s clear understanding of reporting lines.

Figure 7.4 North Eastman Health Association Inc. Organizational Chart

Staff Orientation

“NEHA is committed to a comprehensive orientation program for all new employees, physicians and volunteers. Orientation forms the foundation of productive relationships and ensures each participant is equipped with the information needed to become a contributing member of the team.”

There is a regional orientation policy describing the three components to staff orientation.

a) Managers Component

Upon hiring the manager provides the new employee with an orientation package. There is a manager checklist that he/she reviews with the new employee. At this time the new employee is scheduled into the next regional orientation.

b) Department / Job Specific Component Site Orientation

Each department is responsible for ensuring that the employee has a job specific checklist. This includes the duties and responsibilities and orientation to the job the employee is being hired to do. A work buddy or mentor is assigned to the new employee.

c) Regional Orientation Component

Within 90 days of being hired the new employee will attend a regional orientation. In order to sustain staff’s familiarity with the organization’s strategic plan and organizational culture, the CEO and Director of Quality and Organizational Development attends each orientation session to provide an overview of the strategic plan and overview.

Other information provided at the orientation describes regional services, policies, safety and health, disaster plan and infection control. An employee that works directly with clients attends a second day of orientation to designed specifically to familiarize them with the charting system, feeding and swallowing management and a review of transfer techniques.

Performance Management Process

NEHA has a performance appraisal program that provides for performance appraisals to be conducted during the initial probationary period and on an annual basis thereafter. The organization is doing relatively well with timely compliance, but in order to facilitate further improvement the performance appraisal forms will be reviewed. NEHA is implementing a new Human Resource Information System (HRIS) which will provide additional information to managers to facilitate the completion of performance appraisals.

Job Descriptions

The organization has maintained current job descriptions. The most recent indictor shows that ninety eight percent of staff have current job descriptions.
Participation in Decision Making

“Staff input is encouraged and used in decision making.”
(CCHSA) \(^\text{93}\)

Staff Participation on Internal Committees, Staff/Management Committees, Teamwork Process and Staff Input \(^\text{94}\)

The North Eastman Health Association has a clearly defined and coordinated quality improvement system to continually monitor, evaluate and improve quality. Quality is imbedded in all process throughout the organization as we continuously strive to meet or exceed client expectations. Quality is one of our core values and is exemplified by all staff within the organization. Considerable resources, time and effort have been put into developing a culture of quality where teamwork is fostered.

The organization is committed to team based decision making and includes ongoing measuring and monitoring to continuously improve and enhance performance. This responsibility has been developed throughout all care and service delivery teams. The Board of Directors demonstrates commitment to this process through frequent meetings with teams where presentations are made on team activities. The Chief Executive Officer reports to the Board on the Performance Measurement Scorecard and Dashboard of Indicators.

A quality improvement culture is fostered and supported by:
- Clear expectations for performance measurement and improvement
- Quality improvement initiatives that are an integral part of our Strategic and Health Plans
- Coaching and mentoring
- Promotion of the measurement of results and making changes accordingly
- Taking away barriers to improving performance
- Recognizing staff and volunteers for their work
- Teams monitoring both Strategic and Operational Indicators
- Communicating the results of improvement activities to everyone in the organization and external to the organization.

Learning Environment

“Staff creativity, innovation, and initiative is encouraged. The necessary training and development to attain organizational goals and personal/professional development objectives, is provided.”
(CCHSA) \(^\text{95}\)

Information Resources

All programs have a budget to purchase educational resources that they fee are relevant to their program activities. Programs also have access to the Internet and email services.

A Nursing Recruitment and Retention Committee was established in September 2000 as a result of resources from Manitoba Health being provided through their Nursing Recruitment and Retention Fund. These resources are intended to enhance nursing education the goal being to recruit and retain nurses.
NEHA’s Nursing Recruitment and Retention Committee is responsible for the development of a creative and innovative education plan that includes priority setting, decision making and administration of the Manitoba Health Nursing Recruitment and Retention Fund. Members include nurse representation from all direct service programs. The amount of resources available for distribution varies from year to year and is dependent upon Manitoba Health.

**Staff Education Budget** 96

The total amount allocated to staff education in all programs and services in the 2002/2003 budget was $124,024.00. This represents 0.33% of our total budget of $37,238,572.

**Staff Education Activities** 97

NEHA recognizes the critical importance of professional development and is committed to supporting and promoting educational activities.

Various union contracts provide clauses related to educational opportunity. These vary depending upon the job description of the employee.

The regional policy and procedure manual has a policy entitled: 5-15- Professional Development, which guides staff in requesting continuing education funds. All staff has the opportunity to attend internal and external education sessions that are relevant to their job. The staff person fills out an education request form and their manager makes the decision about whether they are able to attend.

There is a regional education committee that coordinates the development and implementation of the education plan for the NEHA. This committee meets regularly and its roles & responsibilities are to:

1. To coordinate a regional education plan that will meet the priority learning needs of employees of the Association.

2. To develop policies and procedures to ensure consistency across the region in regard to employee education.

3. To communicate educational opportunities across the organization.

4. To develop cost-effective methods to meet learning priorities of the organization.

5. Evaluate the effectiveness of the plan, and modify the plan on an ongoing basis.
Well-being

“‘The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement activities.”’ (CCHSA) 96

**Family Friendly Workplace** 99

There are provisions for family friendly workplaces in employee contracts for example: banking of statutory holidays and overtime as well as job sharing. This is extended to non-union staff as well. Another example of this is the ability to accommodate flex hours within some job categories.

**Table 7.4 Staff Turnover Rate**100

<table>
<thead>
<tr>
<th></th>
<th>2003/04</th>
<th>2002/03</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEHA Rate</td>
<td>14.6%</td>
<td>12.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>National Health Care Average results are not yet available.</td>
<td>National Health Care Average = 12.0%</td>
<td>National Health Care Average = 12.0%</td>
<td></td>
</tr>
</tbody>
</table>

NEHA participates in a comprehensive human resources survey on an annual basis with the other RHA’s as part of a national benchmarking survey.

NEHA’s staff turnover rate corresponds with the national health care average during 2002/03. The region’s population is growing at the top quartile within Manitoba. This is resulting in an increase of people coming to the region, which is enabling recruitment of experienced workers.

**Workplace Wellness Initiatives**

NEHA has put on an annual fitness challenge in May for the past several years. This event encourages all staff to monitor their fitness activity. Prizes are awarded to the team that has scored highest in healthy lifestyles.

At Beausejour Health Centre staff are encouraged to use the physiotherapy room in off-hours. This contains equipment such as treadmill, stationary bike, and weights.

During March (Nutrition month) Dietitians distribute information on healthy eating. The Dietary Programs in our facilities make a special effort to provide extra nutritional meals in the cafeteria. During March 2004, a daily e-mail nutrition tip has been provided.

As mentioned in Section 6 under Dietary Practices NEHA has introduced a Regional Healthy Eating Policy in February 2004.

There are annual social events such as staff Christmas dinner and dance, an annual golf tournament open to NEHA staff, Board of Directors, DHAC members, NEHA physicians and guests and a Board picnic.
Workplace Injuries

Definitions

- **Time Loss** refers to the employee taking time off due to injury.
- **No Time Loss** refers to employees not having to take time off due to the injury.
- **Pension** refers to one-time payouts for permanent partial impairment or one time top-ups for those on long-term wage loss.
- **Other** refers to claims opened but not accepted by Workers Compensation Board. Usually refers to investigative costs. 101

Figure 7.5 Number of Reported Accidents

As shown there appears to be a decrease in the number of time loss and no time loss injuries. Though there has been a decrease in the number of workplace injuries, the goal is to further decrease this number.

Table 7.5 Areas of the Body Injured Most Frequently

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple injury</td>
<td>(15)</td>
<td>Multiple injury</td>
<td>(17)</td>
</tr>
<tr>
<td>Lower back</td>
<td>(9)</td>
<td>Lower back</td>
<td>(10)</td>
</tr>
<tr>
<td>Hand/fingers</td>
<td>(4)</td>
<td>Lower arm</td>
<td>(8)</td>
</tr>
</tbody>
</table>


There appears to have been a decrease in the number of workplace injuries in 2003.

The areas of the body injured most frequently are consistent during the three years reviewed.

In an effort to decrease the number of injuries due to transferring residents, the long term care program provided mandatory training for nursing staff on transferring techniques. This training was initially offered from January 2003 to March 31, 2004 and will now be provided on an as-needed basis.
Table 7.6 Top Three Causes of Injury

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overexertion in lifting</td>
<td>Overexertion in lifting</td>
<td>Overexertion in lifting</td>
<td></td>
</tr>
<tr>
<td>(14)</td>
<td>(12)</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td>Bending, climbing, crawling,</td>
<td>Bending, climbing, crawling,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reaching twisting (8)</td>
<td>reaching twisting (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall to floor, walkway, or other</td>
<td>Fall to floor, walkway, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surface (4)</td>
<td>other surface (10)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Note: The brackets ( ) refers to actual number of injuries.

The top three causes for the injuries remained consistent during the three years reviewed. The good news is the number of injuries associated with cause has declined in 2003.

Influenza Staff Immunizations

Previously there was inconsistent collecting of information regarding influenza coverage between programs, therefore only 2003 data has been provided. As shown, Mental Health and Public Health programs have the highest percentage of immunization coverage during the 2003 season.

There appears to have been an increase in the number of staff influenza vaccines throughout NE. These numbers represent staff immunized in our region and recorded to MIMS through Public Health Surveillance Sheets. This may be under reported if other providers did not report to MIMS or if the immunization was given outside the region.

7.4 HEALTH SYSTEM INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Finances</th>
<th>Human Resources</th>
<th>Leadership</th>
<th>Information &amp; Technology</th>
<th>Physical Structure &amp; Equipment</th>
<th>Public Health Surveillance</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Health workforce structure and distribution&quot;</td>
<td>&quot;Formal structure / processes of the organization.&quot;</td>
<td>&quot;Mechanisms&quot;</td>
<td>&quot;Research funding and structures&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Finances**

NEHA currently receives the lowest amount of funding on a per capita (population) basis of all the RHA’s in Manitoba. Although NEHA receives the least amount of funding on a population basis, the region allocates a proportionately high amount for community care.

The Manitoba Centre for Heath Policy (MCHP) will be providing a study on population needs and will make recommendations for funding the RHA’s based on population needs. Manitoba Health and NEHA will be undertaking a review of the current resource allocation for programs and services in NE compared to the other RHA’s in Manitoba.

Comparing Acute Care and Community Care Expenditures

Community care is defined as mental health, primary care, home care and public health. This includes free standing health clinics, outreach programs, regional Social Workers and some Community Therapy Services (CTS). Acute Care is defined as hospital services that includes dialysis and diagnostic services.

| Table 7.7 Percentage of Funding Allocated to Acute and Community Programs * |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Community        | 40%              | 20.7%            | 41.2%            | 20.2%            | 39.1%            | 18.9%            |
| Acute Care       | 59.9%            | 79.3%            | 58.9%            | 79.8%            | 60.8%            | 81.0%            |


*When acute care and community care expenditures were compared, the total percentages of costs in all program areas were not included.

Since NEHA receives the lowest funding on a population basis at the present time, the amount spent on community care is less than most other RHA’s, however on a percentage basis NE RHA reported a higher proportion of expenditures spent on community care than other Manitoba Health RHA’s. The rural Manitoba average for community care is approximately 30% as distinct from the urban average which is slightly under 20% which reflects acute referrals to urban centres.
Over the last few years there has been a paradigm shift in health programming with more emphasis on health promotion and prevention as well as community services in the desire to keep people healthier longer, and service their health care needs in the community. To this end there has been a push for streamlining primary health care clinics and ensuring that there is a one stop place for health care services for Mental Health, Home Care, Public Health, Physician and Primary Health Care services.

This is clearly showing up in the allocation of funding over the past three years. As we look at 2001/02 we see a 40/60 split of community/acute care funding, a considerable difference from Manitoba at 21/79.

Administration Costs

Open transparency and public accountability are important aspects of any organization's operation and communication.

During the past several years, NEHA has developed a regional management structure that also includes site leadership. NEHA has among the lowest actual costs for regional and site leadership in Manitoba.

Table 7.8 RHA Budgets & Administration Costs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Burntwood</td>
<td>44,734</td>
<td>41,714,172</td>
<td>2,532,875</td>
</tr>
<tr>
<td>Central</td>
<td>99,285</td>
<td>111,248,920</td>
<td>7,933,526</td>
</tr>
<tr>
<td>Interlake</td>
<td>75,342</td>
<td>60,384,021</td>
<td>4,005,010</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>69,852</td>
<td>94,918,794</td>
<td>7,062,929</td>
</tr>
<tr>
<td>Norman</td>
<td>24,883</td>
<td>43,326,040</td>
<td>2,957,149</td>
</tr>
<tr>
<td>North Eastman</td>
<td>39,644</td>
<td>29,668,444</td>
<td>2,885,756</td>
</tr>
<tr>
<td>Parkland</td>
<td>42,609</td>
<td>74,758,107</td>
<td>6,025,225</td>
</tr>
<tr>
<td>South Eastman</td>
<td>56,648</td>
<td>43,072,786</td>
<td>2,848,314</td>
</tr>
</tbody>
</table>


On a percentage basis, NEHA is slightly higher than the average RHA percent of administrative cost. For 2001/2002 the Manitoba average administration cost as a percentage of operating cost was 5.8% vs. NEHA at 7.9% and for 2000/2001 Manitoba cost was 5.7% vs. NEHA at 7.6%. The definition of administration as a percentage of operating cost is: General Administration, Human Resources, Information Technology and Communications costs. These costs are then divided by the total operation costs (less capital costs).

This is largely due to the fact that NEHA has less resource allocation on a population basis than any other Manitoba RHA to provide services. If additional resources are provided, based on population, compared to the other RHA's, NEHA's leadership cost on a percentage basis will become among the lowest of the RHA's within the province.
Human Resources Aboriginal Coordinator

In May 2004, the Human Resources Department added a Human Resource Aboriginal Coordinator in a term position. Their role will be to develop a NEHA Aboriginal Employment Plan with the ultimate goal of increasing aboriginal representation in our workforce. 112

Staff Education Needs Assessment

In acute care and long term care a formal staff education needs assessment was conducted during 2000.

When the Nursing Recruitment and Retention (R&R) Committee was established in 2000, results from the above assessment as well as other program needs were used to determine what inservices would be most appropriate for staff. It was felt that staff education needs that were identified during this time were addressed through the initiatives of specific programs and the R & R committee.

The Regional Education Committee is planning on developing and implementing an educational plan in 2004.

Table 7.9 Position Vacancy Rate by Percentage from April to December 2003

<table>
<thead>
<tr>
<th>Professional Title</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses (RN)</td>
<td>10.6%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0%</td>
</tr>
<tr>
<td>Home Care Case Coordinators</td>
<td>0%</td>
</tr>
<tr>
<td>Medical Technologists</td>
<td>6.6%</td>
</tr>
<tr>
<td>Management</td>
<td>0%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>100% [currently being filled with contracted services]</td>
</tr>
<tr>
<td>Dietitians</td>
<td>0%</td>
</tr>
</tbody>
</table>

Length Of Time Position is Vacant

The indicator is defined by NEHA as the average time it takes for an external hire to fill a posted vacant position from the date of posting to the date of offer of employment.

During 2003/04 in NEHA, positions were vacant an average of 35.2 days and for 2002/03 an average of 30 days. The Human Resources (HR) Benchmarking Network Survey, the national health care average for positions vacant for 2002/03 was 39.01 days. There are no figures available for 2003/04. The number of position vacancy days is lower within NEHA than averaged in the HR Benchmarking survey. 113
Subsidized Health Related Programs

Although we do not have funding for subsidizing health related programs for staff, the organization runs a health and fitness competition every spring to encourage staff health across the region. Staff are also encouraged to participate in community based wellness initiatives along with our external clients.

Leadership

"Formal structure/processes of the organization"

New Programs/Services With Impact Analysis and Evaluation Strategy

During the past year NEHA has undertaken the development of a “performance measurement reporting system.” This included the development of corporate and team score cards and dashboards to monitor and evaluate program and services through strategic and operational indictors. This is part of NEHA’s strategic planning process.

Staff/Management Ratio

The Human Resources Benchmarking Network Annual Survey defines management employees as “those employees with full responsibility for the management of a minimum of one formal organizational “functional” (‘cost’ or ‘expense’ ...Senior management positions (Present, VPs, Executive directors, Commissioners) should be counted as “management” employees.

<table>
<thead>
<tr>
<th></th>
<th>2003/04</th>
<th>2002/03</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Staff</td>
<td>1054</td>
<td>1020</td>
<td>1029</td>
</tr>
<tr>
<td>Management Staff</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Staff/Management Ratio</td>
<td>49.19 to 1</td>
<td>47.57 to 1</td>
<td>48 to 1</td>
</tr>
<tr>
<td>Note: The National Health Care average results are not available.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Health Care Average</td>
<td>32.39</td>
<td>32.04</td>
<td>32.39</td>
</tr>
</tbody>
</table>

NEHA’s staff / management ratio has increased in 2003/04. The number of staff to management is higher than the national health care average between 2001 and 2003.

Management and Leadership Training

During the past three years, the board endorsed the provision of training for the leaders of NEHA. Training included: evidence based analysis, strategic planning, team based implementation strategies, indicator development, monitoring and evaluation and research analysis.
A information needs assessment was undertaken and several information systems are in the process of being implemented including: an admission / discharge transfer system, a primary health care information system, ICD 10 system, human resource information system, performance measurement reporting system, Public Health information system, and a preventative maintenance system. In NEHA recently participated in a provincial survey to further develop the provincial strategic plan for the implementation of IT systems.

### Table 7.10 Percentage Of Budget Spent On ‘IT’ Support

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$290,000/$39,000,000</td>
<td>$290,000/ $36,450,000</td>
<td>$120,000 / $33,032,000</td>
</tr>
<tr>
<td></td>
<td>(Approximately .74% of total budget)</td>
<td>(Approximately .79% of total budget)</td>
<td>(Approximately .36% of total budget)</td>
</tr>
</tbody>
</table>


The IT budget has increased over the past three years.

Budget increase is due to:

- Hiring staff - IT services went from .9 EFT to 2.9 EFT since 2001, and have a contract position for another .6 EFT
- The Admission, Discharge and Transfer (ADT) system was purchased in 2003, and the licensing costs are included annually.
- The initial purchase payments, installation and annual licensing costs for the Quadrant Human Resources (QHR) project (Payroll, scheduling and Human Resources information system) are included in the budget.
- Some project management costs for the Primary Health Care IT Initiative (now known as 1st Health) are included.
Research

Research programs are essential to any dynamic health institution. NEHA has two policies that address research: 5-9 Research Access, which provides information for any research proposals that may involve NEHA and 5-10 Research Committee.

Over the past few years, many NEHA programs conduct client satisfaction surveys. Please refer to this section under a specific program.

Need To Know Team 124

The North Eastman Health Association participates in a collaborative research project known as “The Need to Know Team”. It is collaborative research with the Manitoba Center for Health Policy and Evaluation, the Rural and Northern Regional Health Authorities and Manitoba Health.

The project is built upon a model of collaborative research that will specifically addresses the critical need for research to support decision making. The projects three main goals are:

- To create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and the wider community
- To develop useful models for health information infrastructure, as well as, for training and interaction that will increase and improve capacity for collaborative research interaction
- To disseminate and apply health-related research so as to increase effectiveness of health services, and ultimately the health of RHA populations.

The project consists of three sets of activities related to the above goals – new knowledge creation, development of capacity to facilitate interaction and communication and dissemination activities to support active application of the research.
7.5 PHYSICIAN SERVICES

This section describes physician utilization responsiveness and accessibly. Both regional and health district information is located here.

7.5.1 HEALTH SYSTEM CHARACTERISTICS

Health Service Utilization

Figure 7.8 Contact with Health Professionals

NE Region residents aged 12 and over appear to be reporting more contact with health professionals when compared with both Manitoba and Canada. Note: The male NE percentage should be reviewed with caution due to the low number of respondents.

NE residents over 12 years appear to have had more contact with health professionals when compared with Manitoba and Canada as a whole.
2003 Acumen Research Survey – NE - Regular Health Care Provider

Q- Do you have a regular health care provider, such as a doctor, nurse, that you can see about your health?

Eighty – nine percent of NE respondents stated yes to this question. Females in NE are more likely than males to say they have a regular health care provider. Those aged 18-34 and those not employed are the least likely respondents in NE to have a regular health care provider.¹²⁻⁵

**CHA NE Survey 1997**

Question 7: Do you have a family doctor?

Yes 1,662 (95%)  No 92 (5%)  [No response numbers were excluded]

Note: This question asks about family doctors only, where the 2003 Acumen survey included other health care providers.

Use of Physicians in NE

The following information looks at the percentage of area residents who had a least one ambulatory (walk in) visit to a physician during two fiscal years (includes any type of physician, at office visits, home visits, Personal Care Home (PCH) visits), but excludes hospital in patients.

**Figure 7.9 North Eastman Residents with at Least One Ambulatory Visit to a Physician**

NE has a statistically significant decrease in the number of residents with at least one ambulatory visit during both time periods.

NE had statistically significantly lower number of residents with at least one ambulatory visit to a physician during both time periods when compared with Manitoba, however NE is not significantly different than Rural South for the second time period.

80% of NE residents saw a physician in an ambulatory setting during 2000/01.
Use of Physician Services by Health District

“This is the average number of ambulatory visits to all physicians including General Practitioners/Family Practitioners (GP/FP) and specialist per area resident in a fiscal year.”

**Figure 7.10 North Eastman Health District Residents with at Least One Ambulatory Visit to a Physician**

When we look at the health districts we need to keep in mind the overall health status of that district, assuming that a healthier population would require fewer visits to physicians.

For example we know the overall health status of Springfield Health District is good. We can assume that the reason for their slightly lower number of visits could be due to this factor.

However, we know that Northern Remote has a poorer health status than all of our other health districts. The statistically significantly lower physician visits when compared with Manitoba and Rural South may be due to a lack of physician access rather than assuming that their health has improved. We must also keep in mind that this information does not look at nurse practitioner visits. Residents in these communities may not see a physician, but may have access to alternate practitioners for care.

Overall the number of physician visits during the two time periods have statistically significantly decreased in all health districts except for Blue Water where the physician visits increased significantly.

**2003 Focus Groups Waiting Times**

Waiting times emerged as a topic of concern in almost all the adult Focus Groups. Refer to overall comments related to physician services at the end of this section.
Number of Visits per Resident Annually

This reflects the average number of ambulatory visits to all physicians including specialists.

Figure 7.10 Regional Adjusted Annual Average Number of Visits per Resident to See a Physician

When we look at the average number of physician visits per resident we see that NE has statistically significantly less visits than the Manitoba average, but NE has significantly higher visits than Rural South. When we compare the two years, the number of visits has shown a statistically significant decrease.

NE residents have significantly fewer physician consult visits than the Manitoba average.
This reflects the average number of ambulatory visits to all physicians including specialists.

**Figure 7.12 Health District Adjusted Annual Average Number of Visits per Resident to See a Physician**

Except for Northern Remote health district, Springfield has the lowest average number of physician visits. This may be due to the fact that Springfield overall has a population with good health status.

Springfield, Winnipeg River, Brokenhead and Northern Remote all had statistically significant decreases in physician visits. Iron Rose has a significantly lower number of visits when compared with the Manitoba average. Blue Water had the highest number of visits per resident surpassing other NE health districts, as well as a statistically significantly higher number of visits than the Manitoba average and Rural South.

Northern Remote as the lowest number of physician visits in NE and is likely due to access issues. Northern Remote is statistically significantly lower than the Manitoba average and Rural South for the second time period reviewed.
Ambulatory Consultations

This is the average number of ambulatory consults to physicians per resident during the years described. Consultations occur when one physician refers a patient to another physician. The referring physician is usually, but not always a specialist. “A consultation is only the first visit to a specialist and is considered the best overall measure of access to specialist care.”

Figure 7.13 Regional Adjusted Average Ambulatory Consultation Rates To Physicians

North Eastman’s consultation rate is statistically significantly lower than the Manitoba average during both years reviewed, but significantly higher than Rural South.

This could indicate that we do not have readily available access to specialist services.

Within NE, consultation rates have shown a statistically significant increase over the two time periods.

Figure 7.14 Health District Adjusted Average Ambulatory Consultation Rates To Physicians by Health District

The average number of consultations statistically significantly increased in Springfield, Iron Rose and Blue Water during the two time periods.

Winnipeg River appeared to have an increase but it wasn’t statistically significant. Brokenhead appeared to have a decrease but it wasn’t significant. Northern Remote had a significant decrease in the number of consultations.

If this is a measure of overall access to specialist care, we know that NE has a limited number of specialists who work in our region.
Visits to General and Family Practitioners

“This is the percentage of all ambulatory visits that were to a GP or FP as opposed to a specialist or surgeon.”

This includes all visits in NE, Manitoba, or out of province.

**Figure 7.15 NE Regional Percentage of Total Ambulatory Visits Provided by General & Family Practitioners**

NE has had a statistically significant decline in the percentage of resident physician visits to a general/family practitioner, from 82% to 78.7%.

The percentage is also statistically significantly higher than the provincial rate, but significantly lower than Rural South.

**Figure 7.16 Health District Regional Percentage of Total Ambulatory Visits Provided by General & Family Practitioners**

With the exception of Northern Remote, Springfield, when compared to NE’s other health districts had the lowest number of physician visits to GP’s or FP’s during both time periods reviewed.

Winnipeg River, Brokenhead, Iron Rose and Blue Water visits were statistically significantly higher that the Manitoba average during both time periods. Winnipeg River, Iron Rose and Blue Water were statistically significantly higher and Springfield and Northern Remote were statistically significantly lower than Rural South for the second time period.
Why do NE Residents See a GP/FP or Specialist?

The following describes what broad category of illness a patient went to see a general practitioner, family practitioner or specialist for during 1996 and 2000 in NE.

### Table 7.11 Top Ten Reasons why NE Residents See a GP/FP or Specialist

<table>
<thead>
<tr>
<th>ICD Category -1995</th>
<th>Number of Visits</th>
<th>ICD Category -2000</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>28,904</td>
<td>Respiratory</td>
<td>27,755</td>
</tr>
<tr>
<td>Nervous System</td>
<td>16,510</td>
<td>Circulatory</td>
<td>18,298</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>14,843</td>
<td>Musculoskeletal</td>
<td>16,999</td>
</tr>
<tr>
<td>Accidents</td>
<td>14,444</td>
<td>Nervous System</td>
<td>14,655</td>
</tr>
<tr>
<td>Circulatory</td>
<td>14,307</td>
<td>Ill Defined Conditions</td>
<td>13,375</td>
</tr>
<tr>
<td>Ill Defined Conditions</td>
<td>13,671</td>
<td>Accidents</td>
<td>11,964</td>
</tr>
<tr>
<td>V codes [supplementary classification of factors influencing health status and contact with health services]</td>
<td>12,640</td>
<td>Mental Disorders</td>
<td>11,088</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>12,282</td>
<td>Genitourinary</td>
<td>10,940</td>
</tr>
<tr>
<td>Skin</td>
<td>9,863</td>
<td>Skin</td>
<td>10,346</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>9,212</td>
<td>V codes [supplementary classification of factors influencing health status and contact with health services]</td>
<td>10,041</td>
</tr>
</tbody>
</table>


When compared with 1995, the year 2000 saw a considerable increase in the number of circulatory and mental disorders.

Winnipeg River, Brokenhead, Iron Rose and Blue Water visits were significantly higher than the Manitoba average during both time periods.
7.5.2 HEALTH SYSTEM PERFORMANCE

RESPONSIVENESS – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. [Canadian Council on Health Services Accreditation (CCHSA)]

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA)</td>
</tr>
</tbody>
</table>

Population per Physician - 2001-2002

This is defined as all fee for service doctors only who make over $50,000/annum. The information comes from payments billed to Manitoba Health.

**NE has 1 physician for approximately every 2,000 residents in 2003/2004.**

Using this definition, we have a ratio of one physician for every 3,575 residents. This is the second highest number of residents per physician in the province (Burntwood has 11,202 residents for every physician). The Manitoba average is 783 residents per one physician. It must be noted that this is a misleading number, as there are a number of physicians, especially in the rural areas that are paid by other means e.g. contracted / salaried services who are not represented in this number due to the fact that not all salaried physicians shadow bill.

Total Number of Physicians Working in NE 2003/2004

If we look at the number of physicians working in NE i.e. 20 and our population averaged out to 40,000 our physician/population ratio is approximately 1:2000. Focus Group participants raised concerns about the availability of physicians within their health districts.

2003 Acumen Research Survey – NE Findings – Ease at Getting an Appointment With Health Care Provider

Q- Please tell me how easy it is for you to get an appointment to see a health care provider, such as a doctor, nurse, public health or home care worker?

<table>
<thead>
<tr>
<th>Extremely easy</th>
<th>Somewhat easy</th>
<th>Neither difficult nor easy</th>
<th>Somewhat difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>26%</td>
<td>43%</td>
<td>9%</td>
<td>18%</td>
<td>5%</td>
</tr>
</tbody>
</table>


Respondents between the ages of 25 and 54 are less likely than the regional average to say getting an appointment is easy. Thirty-three percent of respondents indicated that it might be difficult to access a health care provider. This question includes more than just physician services.
CHA NE Survey 1997

Question Section B # 1: Overall how would you rate the availability of health care services for people your age in your community?

**Excellent 250 (15%)**  **Good 1,054 (62%)**  **Poor 384 (23%)**  [No responses were excluded from percentage]

This is not easily comparable to the 2003 Acumen Research survey as the question in 2003 looked at the availability of all health care services. It does reinforce the point that availability appeared to be a concern during the first CHA Report.

**Accessibility**

“The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs.” (CCHSA)

Location of General Practitioner (GP) and Family Practitioner (FP)

This information looks at where NE residents went for physician services. We know traditionally that residents located within a reasonable geographic distance of Winnipeg accessed services there.

**Note:** The KinPlace Health Centre had not opened yet. This could explain the increase in the number of residents going to Winnipeg for physician services.

**Figure 7.17 Location of Visits to General Practitioner /Family Practitioner by NE Residents**

In 2000/01 we see a higher percentage of residents going to other locations within NE, outside of their health district or going to Winnipeg. This could imply a shortage of physicians, or difficulty in accessing physicians in the residence’s respective health district.

When we review where most visits take place we know that residents are accessing NE GP’s and FP’s for the most part. There appears to be a slight increase during 2000/01 where residents were going elsewhere in NE, outside of their own health district, when accessing physician services.

Approximately one quarter of physician visits occur in Winnipeg. From information received from Focus Group participants, they would like to access services within our region, or within another close rural community, e.g. Selkirk rather than Winnipeg. The exception to this was Springfield Health District Focus Group participants. Those living in close proximity to Winnipeg, i.e. Oakbank, indicated they have no problem receiving services in Winnipeg, in particular specialist services.

We see this trend continuing in the following table. With the establishment of a health centre in Springfield, we would expect to see a decline in Winnipeg visits to a GP/FP.

Table 7.12 Location of visits to General Practitioner / Family Practitioner by Health District

<table>
<thead>
<tr>
<th>District</th>
<th>% In District</th>
<th>% Elsewhere in RHA</th>
<th>% To Other RHAs</th>
<th>% To Winnipeg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield 1995</td>
<td>16.7%</td>
<td>13.1%</td>
<td>6.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Springfield 2000</td>
<td>13.2%</td>
<td>12.8%</td>
<td>8.6%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Winnipeg River 1995</td>
<td>69.9%</td>
<td>12.4%</td>
<td>3.0%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Winnipeg River 2000</td>
<td>60.1%</td>
<td>23.9%</td>
<td>2.2%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Brokenhead 1995</td>
<td>79.7%</td>
<td>3.0%</td>
<td>5.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Brokenhead 2000</td>
<td>78.7%</td>
<td>1.2%</td>
<td>5.8%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Iron Rose 1995</td>
<td>42.4%</td>
<td>30.5%</td>
<td>11.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Iron Rose 2000</td>
<td>32.3%</td>
<td>35.4%</td>
<td>15.5%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Blue Water 1995</td>
<td>81.9%</td>
<td>3.7%</td>
<td>3.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Blue Water 2000</td>
<td>80.9%</td>
<td>3.4%</td>
<td>3.1%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Northern Remote 1995</td>
<td>56.3%</td>
<td>4.7%</td>
<td>9.3%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Northern Remote 2000</td>
<td>26.5%</td>
<td>3.6%</td>
<td>33.2%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>


Springfield residents traditionally sought health care services either in Winnipeg (because of its geographical convenience), Beausejour, Oakbank or Ste. Anne.

It is not surprising to see that over half of Springfield residents visited GP’s or FP’s in Winnipeg. With the opening of the Kin Place Health Centre in 2000, it will be interesting to see if this trend to Winnipeg declines.

Stability of physicians’ services may be one of the main reasons why we are seeing a fairly stable number of residents accessing services during the two years reviewed in Brokenhead and Blue Water. There has been some increase in physician access out of the district to other RHA’s in Iron Rose and Winnipeg River, but the majority is still accessing services within NE region.
There has been a shift in trends in the Northern Remote health district, with a considerable drop in the number of residents accessing services within their health district. It appears that they are going to another region, with only a slight increase in access to Winnipeg. This has potential implications in the services, as there has been a slight decrease from 4.7% to 3.6% by Northern Remote residents seeking health services within NE.

Table 7.13 Regional Location of Specialists

<table>
<thead>
<tr>
<th>RHA</th>
<th>% In District</th>
<th>% Elsewhere in RHA</th>
<th>% To Other RHA</th>
<th>% To Winnipeg</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman 2000</td>
<td>0.5%</td>
<td>0.1%</td>
<td>6.7%</td>
<td>92.6%</td>
</tr>
<tr>
<td>North Eastman 1995</td>
<td>0.7%</td>
<td>0.2%</td>
<td>6.4%</td>
<td>92.7%</td>
</tr>
</tbody>
</table>


We have few specialists in NE, so it is not surprising that residents access specialists in Winnipeg during the two years reviewed.

Table 7.14 Location of Visits to Specialists by Health District

<table>
<thead>
<tr>
<th>District</th>
<th>Per Cent in District</th>
<th>Per Cent Elsewhere in RHA</th>
<th>Per Cent to Other RHA</th>
<th>Per Cent to Winnipeg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield 1995</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.5%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Springfield 2000</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.4%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Winnipeg River 1995</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.9%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Winnipeg River 2000</td>
<td>0.0%</td>
<td>0.0%</td>
<td>7.3%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Brokenhead 1995</td>
<td>0.0%</td>
<td>0.0%</td>
<td>17.2%</td>
<td>82.8%</td>
</tr>
<tr>
<td>Brokenhead 2000</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.0%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Iron Rose 1995</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.2%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Iron Rose 2000</td>
<td>0.0%</td>
<td>1.5%</td>
<td>4.9%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Blue Water 1995</td>
<td>0.0%</td>
<td>0.2%</td>
<td>6.8%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Blue Water 2000</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.7%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Northern Remote 1995</td>
<td>8.9%</td>
<td>2.3%</td>
<td>4.9%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Northern Remote 2000</td>
<td>7.9%</td>
<td>0.5%</td>
<td>7.4%</td>
<td>84.3%</td>
</tr>
</tbody>
</table>


Many Focus Group participants would like to see more visiting specialists come to NE.

Access to specialist services was a consistent theme in various adult Focus Groups throughout the health districts.
2003 Focus Groups- Physician Access

Access was a concern in the previous CHA 1997-98. Access is also a NEHA board end. There were discussions related to accessing both local services and the difficulty in accessing services that were not available in NE. Often when there was the availability of a service, geographic location became the deciding factor on where participants would choose to receive health services. Going to Winnipeg is seen by many Focus Group participants as very stressful, particularly by seniors. While many young and middle participants drive to Winnipeg, they can perceive a problem about traveling to Winnipeg or Selkirk. It was raised that many people don’t drive or don’t have access to a car.

YOUNG ADULT

a) Lack of Access to Specialist Services
- Specialist services for children, especially a pediatrician [Iron Rose, Blue Water, Winnipeg River & Springfield], ear, eye specialists, oncology treatment “…Cancer is a very tiring illness on its own and so many people have to travel every day to the city for treatment. That cannot be helping their health…” [Iron Rose] and dental services especially in smaller communities. [Winnipeg River, Seymourville]
- Like to see more surgeries and obstetrics in hospitals. [Springfield, Iron Rose, Winnipeg River, Blue Water]
- When children have a chronic illness, repeat visits to Winnipeg are challenging, especially when you don’t have a car. [Winnipeg River]

b) Consistent Health Care Provider
- Although health services are good, we need more providers on a regular basis e.g. the health provider is not in the community on a regular consistent basis.
- Various health services say they are coming to the community and then don’t show. [Seymourville]

Suggestions raised by Young Adults
• Beausejour Health Centre – longer hours. [Springfield, Brokenhead]
  “Nobody’s lifestyle is 9-5 anymore. For those who commute to the city, a doctor’s appointment means significant time off work.” [Brokenhead]
• Would like to see Community Health Worker. [Seymourville].
• Bring more specialists to the rural area [Springfield, Iron Rose]
  “To go that distance (to Winnipeg), probably four times a month was draining. Just the drive alone.” [Springfield]

MIDDLE ADULT

- Local service was okay for my child, but specialist in the city was a long wait. [Iron Rose]
- Some felt treatment in Winnipeg was preferred as “…we’re going there anyway”. [Iron Rose]
- Others preferred Selkirk because it is closer and “my wife doesn’t drive in the city.” [Iron Rose]
- Going to Winnipeg under the duress of a disease or medical condition is seen as especially difficult. [Winnipeg River]
  “I think of the number of times I traveled in and out of the city to see a specialist for a number of years…and I was just a basket case just to go in and out.” [Winnipeg River]
- Would go to Selkirk if the services were as good as Winnipeg because it is closer. [Blue Water]
SENIORS
a) Specialist Services
- Found accessing an ophthalmologist in timely fashion for eye surgery was really hard. [Springfield]
- Pharmacare deductible is too high. [Iron Rose]

Suggestions raised by Seniors
• Would like to see visiting specialists. [Iron Rose, Winnipeg River]

- Most participants preferred to travel to a rural location i.e. Beausejour, Selkirk rather than Winnipeg. [Springfield, Iron Rose, Winnipeg River, Blue Water]
- Concentrating services (birthing, surgery) in city seen as contributing to hallway medicine by some participants. [Iron Rose]

Note: During the CHA Focus Groups conducted in 1998, the following issues were also raised:
- Bring more specialists to the rural area.
- More flexible clinic hours.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Issues Identified By Participants</th>
<th>% of participants choosing this issue as a priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Winnipeg River</strong></td>
<td></td>
</tr>
<tr>
<td>More Visiting Specialists in the Region</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups - Access to visiting Specialists was brought up in all Focus Groups other than youth.</td>
<td>62.5%</td>
</tr>
<tr>
<td>Would like Obstetrical Services in North Eastman Hospitals</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups - The desire to have Obstetrical Services in NE hospitals was brought up by the both the Young and Middle Adult Focus Groups.</td>
<td>62.5%</td>
</tr>
<tr>
<td><strong>Brokenhead</strong></td>
<td></td>
</tr>
<tr>
<td>Access to Family Doctors</td>
<td></td>
</tr>
<tr>
<td>Validation workshop participants brought up the difficulty of accessing their own doctors.</td>
<td>90.9%</td>
</tr>
<tr>
<td>2003 Focus Groups – Difficulty in accessing family doctors was brought up in all Focus Groups other than youth.</td>
<td></td>
</tr>
</tbody>
</table>

2004 Validation Workshops

IRON ROSE GROUP DISCUSSION ON HEALTH SERVICES- Access to Physicians

Suggestions by Validation Workshop participants
• Provide satellite doctor to Prawda Community on a regular basis.
• Provide a transportation bus from outer Perimeter of Winnipeg to city center for medical appointments for people that are able to drive to Perimeter but not in the city.
• Continue access to Prawda Health Office.
Survey respondents were asked to suggest what types of things they would like to see in their own community that they believe could improve their health.

<table>
<thead>
<tr>
<th>Category / category total</th>
<th>Verbatim response</th>
<th>North Eastman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access to health services North Eastman 9%</td>
<td>Better access to doctors</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>More / better transportation to health services</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Better availability and affordability of prescription drugs</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>More specialists in rural areas</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>


Some of the verbatim responses related to doctors were associated with:

- length of waiting time or difficulty getting an appointment (3);
- need for more, or lack of doctors in their community (22);
- better doctors (2);
- stability issues (3) and
- need for closer or better access (5). 134

**CHA NE Survey 1997**

**Question Section A # 6: Major problems in our health care system were (top three):**

- a) **Cut backs.**
- b) **Waiting period for surgeries, treatments testing and results, appointments and emergency service.**
- c) **Abuse – overuse of the system.**

All the above, except for cut backs, were raised in the 2003 Acumen Research Survey and Focus Groups.
YOUNG ADULT

a) Waiting Times in the Clinic and for Appointments

- Long wait times and difficulty getting timely appointments for acute health problems was emphasized in most Focus Groups. [Springfield, Winnipeg River, Blue Water]
  - The implications associated with long office waiting times were related to managing (bored) children and the risk of infection due to spending time in the presence of other sick people. [Springfield, Iron Rose, Blue Water]
  - Feeling of being rushed during the doctor’s appointment. [Springfield, Winnipeg River].

b) Physician Retention or Physician Not Accepting New Patients

- Implications associated with doctors who did not intend to stay in a community was to seek doctors in other communities who were felt to be more stable. For example, in Whitemouth one participant chose to go to Beausejour or Winnipeg to ensure continuity of services. Another was unable to get a family physician because they are full. [Iron Rose]
  “You can ask for the same one [doctor] but they switch around so often.” [Winnipeg River]

d) Prescriptions

- Felt doctors were too quick to prescribe medication. [Winnipeg River, Blue Water]

e) Referrals

- Physicians need to be knowledgeable of other resources and refer e.g. mental health. [Springfield]
  - Would like more referrals to alternative care. [Blue Water, Springfield]

f) Other

- Would like female physician. [Iron Rose]
- Long wait for “Child Development clinic and four months wait for child psychologist.” [Iron Rose]

MIDDLE ADULT

a) Waiting Times, Both when in the Clinic and for Appointments

Waiting times and timely appointments emerge as a concern for this age group as it did in the younger adult and senior Focus Groups.

- Appointments are hard to get, long waits. [Brokenhead, Blue Water]
  “When they are sick (children) you want to see the doctor that day, not a week later when they are better…” [Brokenhead]
- Felt waiting times in Beausejour “excessive” [Pinawa and Whitemouth] “not bad” [Iron Rose]

b) Physicians Not Taking New Patients

- Some participants would like to see a local physician but local doctors contacted are not taking new patients. [Springfield, Brokenhead]
  - Would like to see another female physician. [Brokenhead, Springfield]
  - More physicians. [Springfield]

Suggestion Raised by Middle Adult

- Nurse practitioners were viewed as a good option to improve the efficiency of physician’s time. [Brokenhead]
d) **Physician Retention** – The main issue here was related to physicians setting up practice and leaving the community shortly after.

- Changing doctors all the time is really difficult. [Iron Rose, Winnipeg River, Blue Water]

  "...My mom...hated it...It was just a steady flow of here and gone...very hard for older people." [Iron Rose]

  "Doctors can’t practice their craft, their art, their skill.” “The (new) doctor now doesn’t know me. Maybe that’s why I don’t go to the doctor.” [Winnipeg River]

- It bothers some, to the extent they will consider switching to a more stable physician in the city. [Blue Water]

e) **Privacy** – This issue also arose in the youth Focus Group where their concern related to seeing counselors or attending support groups where everyone knew who you were.

- One participant felt uncomfortable in a small community where their name was bellowed out in a physician’s waiting room. [Iron Rose]

### SENIORS

**Physician Services**

a) **Feeling Rushed**

- Feeling rushed and under served. [Springfield, Iron Rose]

  "Salaried doctors have time. A doctor with his own practice does not." [Springfield]

b) **Physician Retention**

- Would like more and better physician retention. Many physicians are not accepting new patients. [Springfield, Winnipeg River]

c) **Referrals**

- Physician’s need to make referrals to other services e.g. home care. [Iron Rose]

d) **Lack Of Information**

- Felt physician didn’t tell them any meaningful information e.g. would like actual B/P value or cholesterol value and not that it is okay. [Springfield, Brokenhead, Iron Rose]

e) **Other**

- Would prefer female physician. [Springfield, Winnipeg River]

- Would like to see a doctor in Hadashville, East Braintree, Prawda. [Iron Rose]

- General acceptance and trust of nurse practitioner. [Iron Rose]

  "We have no trouble getting into the hospital or seeing doctors in Pinawa, but, if you have major problems, you can’t seem to get out of our hospital to a Winnipeg hospital." [Winnipeg River]

- Concern expressed about doctor’s receptionist giving medical advice and triaging over the phone. [Brokenhead]

### STAFF

a) **Physician Shortage**

- Lack of doctors was a barrier to health care identified by this group. They discussed their observations that physicians are booked weeks in advance, patients have long waits for an appointments, and there (technically) are no walk-in clinics in the region. They see these concerns as some reasons people go to emergency rooms when an ER visit may not otherwise be called for (e.g. bladder infection).

- Nurse practitioners (NP) are seen as a valuable addition to the health care team, however NP’s do not address the physician shortage, since NP’s are focused on health promotion and provision of some services. However, awareness and use of female nurse practitioners may encourage clients who are otherwise avoiding doctor visits to engage in preventive measures, such as women who do not get regular pap smears because they are uncomfortable with the procedure being conducted by a male physician.
Suggestions Raised by Staff

- Nurse practitioner / physician ratio must be given due attention when adding NP’s to the complement. Since NP’s cannot be primary caregivers, staff recommended more attention be given to attracting and retaining physicians.
- Attention must be given to promoting acceptance of both men and women as physicians and nurses.

b) Physician Retention.
While coping with high turnover among physicians is better than having no doctors at all, some staff pointed to a need to keep doctors in the region. Some of the relevant factors identified include hours of work, compensation, choice of practice, and health care administration management styles.

Suggestion by Staff
- When interviewing physicians, identify what their sources of satisfaction and dissatisfaction are. Some surmised that a lack of challenge due to service constraints (e.g. delivering babies, doing surgeries) might dissuade some physicians from staying.

"People like to have options and do what they want to do...(but this is not) necessarily every physician’s stand...lots...don’t want to do any of that."

Note: During the CHA Focus Groups conducted in 1997, the following issues were also raised:
- Difficulty affording prescription drugs.
- More physicians especially female physicians.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>SPRINGFIELD GROUP DISCUSSIONS ON HEALTH SERVICES – PHYSICIAN SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discussion</strong></td>
</tr>
<tr>
<td>- The percentage of doctors in each district per population was discussed, participants felt that Springfield was sorely lacking.</td>
</tr>
<tr>
<td>- The continuity of service by the doctor, i.e. you may want to stay with your doctor but they move often.</td>
</tr>
<tr>
<td>- Discussion on admitting privilege in Winnipeg and Beausejour, local doctors do not admit.</td>
</tr>
</tbody>
</table>
7.6 NEHA HEALTH CARE PROGRAMS

7.6.1 Facility Based Programs

7.6.1.1 Acute Care

Overview

The Acute Care program in the North Eastman Region continues to develop as it provides a wide range of hospital based services. This includes 24-hour emergency care at the three facilities in Pine Falls, Pinawa and Beausejour. Inpatient services are available at all sites in the region and include a variety of patient services such as medical, surgical, palliative and rehabilitation. The dialysis and telehealth programs at the Pine Falls site continue to be active.

Table 7.15 Programs & Services

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Number of Beds / Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinawa Hospital, Winnipeg River Health District</td>
<td>17 beds, 24 hour emergency and diagnostic services. Rehabilitation services available five days a week. No obstetrical or surgical programs.</td>
</tr>
<tr>
<td>Beausejour District Hospital, Brokenhead Health District</td>
<td>30 beds, 2 bed observation unit, 24 hour emergency and diagnostic service. A surgical program operates one day/week with an itinerant surgeon and anesthetist. No obstetrical program. Rehabilitation services available 5 days/week. <strong>Note:</strong> in 2004 there will be pediatric dental surgery.</td>
</tr>
<tr>
<td>Pine Falls Health Complex, Blue Water Health District</td>
<td>27 beds, 2 bed observation unit, 24 hour emergency room and diagnostic services, and a low risk obstetrical program. No active surgical or obstetrical program. Rehabilitation services available five days a week. Also includes: <em>Six bed Dialysis Unit</em> - 3 days/week. Serves up to 12 clients. <em>Telehealth</em> – This is a service that videoconferences a patient with a specialist in another part of Manitoba for consultations as well as providing health professional education.</td>
</tr>
</tbody>
</table>
HEALTH SYSTEM CHARACTERISTICS

Health Service Utilization

Emergency Services

Figure 7.18 Regional Emergency Room (ER) VISITS

ER visits have increased at all our acute care sites during 2003/04.

Pine Falls has the highest number of ER visits during the six years reviewed.

Source: NEHA Statistical Report For 12 months ending March 31, 2004 & 2001
Focus Groups on Hospital Emergency Services

**YOUTH**

**Emergency Services**
- When describing the Pine Falls Emergency Room, some youth experienced long wait times and others indicated they received prompt service. [Blue Water]

**YOUNG ADULT**

a) **Hospital Emergency Rooms** - There is varying opinion about hospital emergency services depending upon the experience of the participant. A common theme was not being able to rely on the emergency services related to the fact that the physician was on-call only, and may or may not come in to see you. [Springfield, Brokenhead]

- The other common question that arose was about where is one to go when the clinics are not open and/or when the clinics are open it is difficult to get an appointment at the time one is ill?

- There were examples of both positive stories and others not so positive. In general, depending upon where a person lived, and if they had a negative experience they subsequently chose to go to Winnipeg Children’s Hospital or Selkirk Hospital where they knew there was a doctor available.

Some Issues Raised

"Why is this place (Beausejour Hospital) even here if they are not willing to take people in?…" [Brokenhead]

"…was told (over the phone) not to bring a baby in until the next morning…" [Brokenhead]

- One participant was told of using the ER when a doctor’s appointment may have been more appropriate. Received the required service and, on the way out, was handed a pamphlet about the appropriate use of the ER. [Brokenhead]

- Several participants wondered if there was actually a choice of where to go to receive care:

  "...We took one of the kids to Beausejour. We were told your doctor is in Whitemouth and...admitting is in Pinawa. That’s where you should have gone. In Beausejour, at least you’ve got a pharmacy. If it’s something more serious, you can go to Winnipeg…" [Iron Rose].

- Upset that Pinawa does not call in doctor in advance of patient arrival. [Winnipeg River]

  "If something ever happened (to my children)…emergency…there is just a little bit more for kids (in Beausejour)." [Iron Rose]

Some Positive Examples

- Some people who phoned in advance were advised to come in to the hospital. [Brokenhead]

  “received the best care ever…” [Brokenhead]

b) **Transportation** - All our hospitals are seen as capable of handling minor emergencies, but the group in general wasn’t pleased about attending a hospital off the main route to a major hospital, in case greater intervention was needed e.g. having to transfer to Winnipeg. [Iron Rose]

**MIDDLE ADULT**

a) **Hospital Emergency Rooms** - Depending upon what the emergency is and where the person lives is often the determining factor of where they would access emergency services, e.g. some would go directly to Winnipeg or to Selkirk. [Springfield] Residents in the Cooks Creek area seem more likely to use Beausejour or Selkirk. [Springfield]

- Lack of emergency service when lost the hospital. [Iron Rose]

- Some of participants felt that the fastest route is a straight line from Whitemouth to Beausejour. One participant mentioned calling Beausejour Hospital in advance on bringing in a child and being directed to go to Pinawa. They went to Winnipeg. [Iron Rose]
Hospital Emergency Services - The group was not united about the cause of difficulties in emergency rooms. Some described some emergency rooms as “not sufficiently staffed.” For example, in Beausejour, a nurse must be pulled away from ward duties to do triage in the ER. One participant suggested some clients leave the region to see physicians in other regions because of this. A few group members expressed the view that many clients who phone the Beausejour ER in advance of attending, proceed to Selkirk instead because they are told they may not be seen by a doctor if a nursing assessment determines their situation is not an emergency.

Not everyone perceived the lack of an ER physician per se as the problem “because sometimes a nursing assessment is good enough.” However, since nurses are reticent to call in an emergency physician, or to pull a doctor from another client during office hours to see someone presenting in the ER with an earache or sore throat, some group members feel patients head to Selkirk or Winnipeg for treatment, and that funding follows.

**Suggestion by Staff**
- They feel this situation highlights the need for a walk-in clinic in the region because, although a nursing assessment might determine a patient’s case is not an emergency, that patient still might not necessarily be able to wait 2 weeks for an appointment. One participant reported the Pine Falls Clinic takes approximately 29 walk-ins per day, over and above fully booked clinics: “If they don’t see them there they get seen at the ER. They get seen somewhere.”

---

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td></td>
</tr>
<tr>
<td>Lack of Clinics open during evenings or weekends that would offer an alternative to going to the Emergency Department</td>
<td>90.9%</td>
</tr>
<tr>
<td>Validation workshop participants expressed the need for a walk in clinic.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups – This was raised as a concern in all of the adult groups in relation to long waiting times to make appointments and the difficulty in obtaining care at hospital emergency rooms.</td>
<td></td>
</tr>
<tr>
<td>Springfield</td>
<td></td>
</tr>
<tr>
<td>Lack of Clinics open during evenings or weekends that would offer alternative to going to the Emergency Department. Participants felt they should not have to go to Selkirk or South Eastman for services.</td>
<td>66.6</td>
</tr>
<tr>
<td>2003 Focus Groups – This was raised as a concern in all of the adult groups in relation to long waiting times to make appointments and inappropriate use of Hospital Emergency Rooms.</td>
<td></td>
</tr>
</tbody>
</table>
Admissions

In April 2004 a new automated computer system entitled: Admitting Discharge and Transfer (ADT) was installed at Beausejour District Hospital. The ADT system builds the foundation for a patient/client information database, while also automating the admission process. The long-term plan is to implement this system in the other acute care sites by May 2005 and eventually into the long term sites as well.

Figure 7.19 Number of Acute Care Admissions

The number of admissions remained fairly consistent during the periods reviewed at the Beausejour and Pinawa Hospitals.

In Pine Falls admissions increased during the later time periods. It must be noted that Pine Falls experienced bed closures during 2001-2002 that would explain the decrease in the number of admissions during this time period. Pine Falls had the highest number of admissions for the past two years.

Whitemouth is no longer an acute care facility and this is reflected in the decreased number of admissions.
The top five reasons NE residents were hospitalized during 2001/02 were due to:

**Table 7.16 NE Age & Sex Standardized Hospital Utilization Cases 2001/2002**

<table>
<thead>
<tr>
<th>Cause</th>
<th>NE Rate /1000 (age and sex standardized)</th>
<th>Provincial Rate /1000 (age and sex standardized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy, Childbirth, Puerperium</td>
<td>21.8</td>
<td>19.6</td>
</tr>
<tr>
<td>Diseases of Circulatory System</td>
<td>14.4</td>
<td>13.2</td>
</tr>
<tr>
<td>Diseases of Digestive System</td>
<td>11.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Disease of Respiratory System</td>
<td>11.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Injury &amp; Poisoning</td>
<td>10.2</td>
<td>8.7</td>
</tr>
</tbody>
</table>


For the top causes of hospitalization, the NE rate appears to be consistently higher than the provincial rate.

This is hospital utilization for any hospitals by NE residents.

**Table 7.17 NE Age & Sex Standardized Hospital Utilization Days in Hospital 2001/ 2002**

<table>
<thead>
<tr>
<th>Hospital utilization days by highest rate</th>
<th>NE Rate / 1000 (age and sex standardized)</th>
<th>Provincial Rate / 1000 (age and sex standardized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease of Circulatory System</td>
<td>144.8</td>
<td>148.5</td>
</tr>
<tr>
<td>Factors influencing health status and contact health services</td>
<td>120.7</td>
<td>158.4</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>85.8</td>
<td>129.5</td>
</tr>
<tr>
<td>Injury &amp; Poisoning</td>
<td>82.1</td>
<td>64.7</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>72.7</td>
<td>79.0</td>
</tr>
</tbody>
</table>


NE hospital days for each of these disease categories appeared to be consistently less (except for injury and poisonings) than the provincial rate. In Manitoba “factors influencing health status and contact with health services” were responsible for the most days spent in hospital provincially.
Top Five Major Clinical Categories by Number of Actual Cases in NE Hospitals

Table 7.18 Clinical Categories & Number of Cases - Beausejour Hospital

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Number of Cases Both Typical and Atypical 2001-2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory Diseases</td>
<td>126</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>114</td>
</tr>
<tr>
<td>Digestive Diseases</td>
<td>112</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract</td>
<td>51</td>
</tr>
<tr>
<td>Mental Diseases &amp; Disorders</td>
<td>45</td>
</tr>
</tbody>
</table>


Table 7.19 Clinical Categories & Number of Cases - Pine Falls General Hospital

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Number of Cases Both Typical and Atypical 2001-2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Diseases</td>
<td>127</td>
</tr>
<tr>
<td>Circulatory Diseases</td>
<td>97</td>
</tr>
<tr>
<td>Digestive Diseases</td>
<td>68</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract</td>
<td>54</td>
</tr>
<tr>
<td>Other Reasons for Hospitalizations</td>
<td>45</td>
</tr>
</tbody>
</table>


Table 7.20 Clinical Categories & Number of Cases - Pinawa Hospital

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Number of Cases Both Typical and Atypical 2001-2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory Diseases</td>
<td>103</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>59</td>
</tr>
<tr>
<td>Digestive Diseases</td>
<td>46</td>
</tr>
<tr>
<td>Nervous System Diseases</td>
<td>31</td>
</tr>
<tr>
<td>Diseases of Blood and Blood Forming Organs</td>
<td>24</td>
</tr>
</tbody>
</table>


Diseases of the Circulatory, Respiratory and Digestive systems are the leading causes of admissions to all our hospitals during 2001/2002.
2003 NE Acumen Research Survey – NE Findings - on Hospital or Ambulance Utilization

Note: We do not know which services were utilized but might assume someone who utilized ambulance services may have also utilized hospital services.

Q- Have you used a hospital or an ambulance service in the past 12 months? [Don't know or refused excluded]

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Survey respondents who were more likely to utilize hospital or ambulance services were between the ages of 25 to 34 years, employed either full-time or not employed at all, and were from households of three or more people.

2003 Focus Groups on Appropriate Utilization of Services

STAFF

a) Hospital Beds: Staff feel that patients who are in hospital awaiting PCH placement, creates stress on the system because of the different needs between long term and acute care. Specifically, they reported many elements of service which are central to personal care, such as stimulation, recreation, and outings are missed when long term care is delivered in an acute care setting. “Both aren’t getting appropriate care, in my opinion.”

Current staff levels are reportedly the reason hospital staff can’t do both well.

The group also raised the issue of how/whether people are able to manipulate the timing and duration of their hospital stays, i.e. they receive care but are not placed in a PCH. The advantage to the patient does not have to pay for hospital care.

Suggestions
- It was suggested that with more home care (i.e. more than the current 8 hour ceiling), and/or supportive care (e.g. more at-home meal service, including encouragement to eat), some long term patients could still be at home.
- Programs such as Lifeline were seen to be of benefit for certain groups, for example those who are unsteady on their feet, but otherwise able to be at home with meal services. However, the cost of such programs is seen as a deterrent.
High Profile Procedures

“High profile procedures are those that are often talked about in the media.”\textsuperscript{137} Some of these procedures are associated with major improvements in quality of life for patients.

\textbf{Cardiac Catheterizations}

“ This is the number of cardiac catheterizations performed…. Cardiac catheterization is a diagnostic procedure that identifies the exact location and severity of coronary artery disease.”\textsuperscript{138}

\textbf{Figure 7.20 Cardiac Catheterizations in NE}

Within NE, the numbers of catheterizations have shown a statistically significant increase during the two time periods from 2.46/1000 to 3.04/1000. NE’s rate is not statistically different than the provincial average of 2.91/1000 or Rural South at 2.66/1000 during the second time period.

![Cardiac Catheterizations in NE](chart)

There has been a significant increase in Cardiac catheterizations.
Blue Water had the highest rate of cardiotubulations and experienced a statistically significant increase in the number of cardiotubulations from 2.92/1000 to 4.75/1000 during the time periods reviewed.

Blue Water’s rates are also statistically significantly higher than the Manitoba average of 2.91/1000 and Rural South Rate of 2.66/1000 during the later time period.

Except for Brokenhead, all other health districts appeared to experience an increase in cardiac cardiotubulations, but were not significantly different than the Manitoba average.

“This is the number of angioplasty procedures performed per thousand residents... Angioplasty is a procedure that uses a balloon-tipped catheter to enlarge a narrowing in a coronary artery.”

**Angioplasty NE**

In NE, we see a statistically significant increase overall from 0.44/1000 to 0.68/1000 respectively when we compare the two time periods. This is slightly higher than the Manitoba rate of 0.48/1000 and 0.65/1000 respectively, but not significantly higher.

**Angioplasty Health Districts**

Angioplasty procedures appear to have had increased in all health districts, but was not a significant increase. Information for Northern Remote was suppressed due to small numbers.


“This is the number of bypass surgeries performed per thousand residents... Coronary artery bypass graft surgery creates a new route around narrowed and blocked arteries (caused by coronary artery disease) so that more blood can flow to the heart.”

**Coronary Artery Bypass Graft Surgery – NE**

In NE we see an increase in the number of bypass surgeries from 0.59/1000 to 0.74/1000, but it wasn't a significant difference.

There was no significant difference with the Manitoba average of 0.71/1000 nor with Rural South at 0.65/1000 during the second time period.

**Coronary Artery Bypass Graft Surgery – Health District**

All health districts experienced a variable increase in the number of bypass surgeries, but none were significant. For example: Blue Water (0.66/1000 to 0.91/1000), Brokenhead (0.58/1000 to 0.72/1000) and Winnipeg River (0.51/1000 to 0.81/1000). Northern Remote rates were suppressed.

There was not significant difference between NE Health Districts and Manitoba or Rural South during the later time period.

“This is the number of total hip replacements performed per thousand residents... Total hip replacements is performed when hip joints have degraded (usually because of advanced arthritis), and have been shown to provide major improvements in mobility and quality of life.”

**Hip Replacements NE**

In NE we have seen an increase in the number of hip replacements from 0.67/1000 to 0.77/1000 as compared with the Manitoba rate of 0.55/1000 and 0.71/1000 respectively, but neither differences were statistically significant.

**Table 7.21 Rate of Hip Replacements per 1000 Residents in Health Districts**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>0.70/1000</td>
<td>0.89/1000</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>0.51/1000</td>
<td>0.87/1000</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>0.75/1000</td>
<td>0.69/1000</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>0.87/1000</td>
<td>0.53/1000</td>
</tr>
<tr>
<td>Blue Water</td>
<td>0.66/1000</td>
<td>0.91/1000</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
</tbody>
</table>


All health districts except for Brokenhead increased the number of hip replacements, but none were statistically significant when compared with Manitoba. This increase has generally occurred in all RHAs. The Manitoba average was 0.55/1000 to 0.71/1000. Northern Remote rates were suppressed.


“This is the number of total knee replacements performed per thousand residents.... Total knee replacement is performed when knee joints have degraded (usually because of advanced arthritis), and have been shown to provide major improvements in mobility and quality of life.”

**Knee Replacement NE**

In Manitoba, we see almost consistently an increase in the number of knee replacements throughout the RHAs. In NE we see a statistically significant increase during the two time periods reviewed from 0.57/1000 to 0.92/1000. There was no significant difference when Manitoba and Rural South were compared with NE.
Table 7.22 Rate of Knee Replacements per 1000 Residents in Health Districts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>0.66/1000</td>
<td>0.68/1000</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>0.58/1000</td>
<td>1.14/1000</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>0.65/1000</td>
<td>0.70/1000</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>suppressed</td>
<td>1.19/1000</td>
</tr>
<tr>
<td>Blue Water</td>
<td>0.55/1000</td>
<td>1.12/1000</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>suppressed</td>
<td>1.04/1000</td>
</tr>
</tbody>
</table>


As shown, Blue Water appears to have had an increase in the number of knee replacements during the two time periods, however it was not a significant increase. Iron Rose had the highest number of knee replacements, compared with our other health districts during the later time period.

Iron Rose had the highest number of knee replacements when compared to our other health districts.

Cataract Surgery

Major improvements in quality of life are often achieved when cataract surgery is done. “A cataract is when the lens of the eye becomes opaque, obscuring vision. In surgery this opaque lens is removed and replaced by a clear one, resulting in major improvements in vision and quality of life.”

NE has a lower rate of cataract surgery than the Manitoba average, but was not a significant difference.

Figure 7.22 Cataract Surgery in NE

There has been an increase in the number of cataract surgeries performed on NE residents during the two time periods reviewed although not significantly so.

NE rates are significantly lower than the Manitoba average during the second time period.

When we review the health districts, we find that the number of cataract surgeries increased in Winnipeg River, Brokenhead, Iron Rose and Blue Water, but not a significant increase. A decrease in cataract surgeries occurred in Springfield and Northern Remote, but was not statistically significant during the two time periods reviewed.

Winnipeg River had the highest number of cataract surgeries performed in NE between 1998 and 2001.

**Computed Tomography (CT) Scans**

This rate counts person visits to the CT suite. If there were multiple body parts scanned this would be considered one visit or episode. NE residents have to travel to Selkirk or Winnipeg to access CT Scan services.

There had been a statistically significant increase in the number of CT scans during the two time periods within NE from 40.94/1000 to 49.35/1000.

Compared with Manitoba, NE had a significantly lower number of CT scans performed during the later time period, but CT scans performed in NE were significantly higher than Rural South.
CT scans performed were significantly less than the Manitoba average of 53.72/1000 during the second time period.

Although Northern Remote appeared to show an increase in the number of CT scans performed during the two-time periods, 37.6/1000 to 51.5/1000, it was not significant.

Given that the Manitoba average represents a high proportion of Winnipeg’s population, where there is better geographic access to CT scans, this may explain why fewer CT scans are performed on NE residents.

Springfield and Blue Water had significantly higher CT scans performed than Rural South during the second time period.

**2003 NE Acumen Research Survey – NE Findings - On Access**

Survey respondents were asked to suggest what types of things they would like to see in their own community that they believe could improve their health.

<table>
<thead>
<tr>
<th>Category / category total</th>
<th>Verbatim response</th>
<th>North Eastman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvements to hospitals</td>
<td>A regional / local hospital with emergency care</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>More / better services / facilities in hospital</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>More / better personnel working in the hospital</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>Keep the local / regional hospital open</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>


Six percent of the survey respondents indicated they would like to see some type of hospital improvements. The responses were vague and are open to interpretation. Some generic ideas were consistent with the 2003 Focus Groups.

Residents in Blue Water had the highest rate of CT scans at 57.2/1000 residents in all health districts, with a significant increase during the two time periods.

Winnipeg River was the only health district that showed a decrease in the number of CT scans from 41.1/1000 to 40.4/1000, although not significant.

Blue Water has the highest number of CT scans performed within NE.
HEALTH SYSTEM PERFORMANCE

RESPONSIVENESS – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. [Canadian Council on Health Services Accreditation (CCHSA).] 143

Availability

“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA) 144

Hospital Beds per 1000 Residents in NE

In NE, in 1995 there were 2.88 beds per 1000 population compared with the Manitoba average of 4.26 beds/1000 and Rural South at 4.27 beds/1000. The number of beds per 1000 residents decreased slightly in 2000 at 2.44 beds per 1000 in NE region as compared with 3.82/1000 in Manitoba, and 3.76/1000 in Rural South. 145

Accessibility

“The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs.” (CCHSA) 146

Where did NE Residents Receive Hospitalization Services?

Table 7.23 Percentage of Residents Receiving Hospital Services in NE, Other RHA’s, Winnipeg or Out of Province

<table>
<thead>
<tr>
<th></th>
<th>North Eastman Hospital [within NE]</th>
<th>Other RHA Hospital</th>
<th>Winnipeg Hospital</th>
<th>Out of Province Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999/00-2000/01</td>
<td>37.6%</td>
<td>8.1%</td>
<td>53.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>1994/95-1995/96</td>
<td>38.1%</td>
<td>8.1%</td>
<td>52.8%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>


There has been very little change with respect to where NE residents went for hospital services. A slight decline in NE hospital utilization is shown from 38.1% to 37.6%.
SYSTEM COMPETENCY – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA).  

### Appropriateness

“Care/service provided is relevant to the clients’/ patients’ needs and based on established standards.” (CCHSA)

Tonsillectomy and/or Adenoidectomy, Hysterectomy, and Caesarian Section procedures are considered ‘discretionary’ surgical procedures, as there is a potential for overuse and wide variation in rates.

**Tonsillectomy/Adenoidectomy 1993/94 to 1995/96 and 1998/’99 to 2000/01**

This is the number of Tonsillectomy and/or Adenoidectomy’s (T& A’s) performed per thousand residents aged 0-14 years. This is age and sex adjusted.

In NE there was a statistically significant decline in the number of Tonsillectomy and / or Adenoidectomy’s in NE during the two time periods reviewed from 6.15/1000 to 4.88/1000. During the later time period NE’s rate per thousand appears to be less than the Manitoba rate at 5.52/1000 and Rural South rate at 6.03/1000, but neither were significantly different. There was also a decline in the number of procedures in all health districts except for Winnipeg River, where there was an increase from 4.85/1000 to 8.25/1000. None of the declines or increases was statistically significant except for Brokenhead and Northern Remote.

To put this in perspective NE’s crude number of Tonsillectomy and/or Adenoidectomy’s performed was:

**Table 7.24 Number of Tonsillectomy’s and Adenoidectomy’s Performed in NE**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsillectomy</td>
<td>54</td>
<td>45</td>
</tr>
</tbody>
</table>

Hysterectomy 1991/92 to 1995/96 and 1996/97 to 2000/01

This is the number of hysterectomies performed per thousand women aged 25 years and older. This is age adjusted. A hysterectomy is a surgical procedure to remove the woman's uterus (subtotal hysterectomy), or uterus and cervix (total hysterectomy).

There has been a decrease in the number of hysterectomies performed in NE from 6.18/1000 to 5.61/1000 during the two time periods reviewed, but it was not a significant decline. NE's hysterectomy rate and the Manitoba average (5.26/1000 and 4.96/1000 respectively) or Rural South's (5.68 and 5.62 respectively) are not significantly different.

Blue Water has the highest rate of hysterectomies when compared with our other health districts at 6.10/1000. The good news is that the rate has shown a statistically significant decline during the two time periods reviewed. Although the rate appears to be higher than both the Manitoba average and Rural South, it is not significantly different. Except for Iron Rose, all health districts have a higher rate of hysterectomies than Manitoba, but not significantly different, except for Brokenhead during the second time period.

Table 7.25 Number of Hysterectomies Performed in NE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1991/92-1995/96</td>
<td>70</td>
<td>71</td>
</tr>
</tbody>
</table>


Caesarian Section (C-section) 1991/92 to 1995/96 and 1996/97 to 2000/01

This is the percentage of all births delivered by Caesarian Section. The percentage is age adjusted. The chance of having a Caesarian Section is known to increase with maternal age.

In NE for both time periods the percentage of Caesarian Section's performed was 14%. NE was statistically significantly lower than the Manitoba average (17%) and Rural South (17%) during the second time period.

There has been a decrease in the number of Caesarian Section's performed, but not statistically significant in Springfield, (17% to 15%) Northern Remote (10% to 9%), no change in Brokenhead at 15%, and Iron Rose at 14%, with an increase in Winnipeg River from 14% to 15%, and in Blue Water from 13% to 15%.
Table 7.26 Number of Caesarian Sections Performed in NE

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991/92-1995/96</td>
<td>74</td>
</tr>
<tr>
<td>1996/97-2000/01</td>
<td>66</td>
</tr>
</tbody>
</table>


Vaginal Birth after Caesarian Section

There were no vaginal births after Caesarian Section reported in NE from 1998/99 to 2001/02.

Effectiveness

"The care/service, intervention or action achieves the desired results." (CCHSA)

Hospitalization for Ambulatory Care Sensitive Conditions

These are illnesses that can be treated effectively in an ambulatory setting thereby reducing the need for admission to a hospital. These are age standardized in patient acute care hospitalizations.

Figure 7.26 NE Ambulatory Care Sensitive Conditions

The ambulatory care sensitive conditions, which appear to have resulted in the highest rate per 100,000 of hospitalizations for both males and females were: Diabetes (173.1/100,000), followed by Asthma (99.1/100,000), Essential Hypertension (60.9/100,000), and Neurotic Disorders at 66/100,000.

With the increasing number of diabetic cases and subsequent workload for staff, this area could indicate the need for an increase in resources in the diabetes program in order to ensure that clients with diabetes are managed successfully in the community, and are not hospitalized.

Other areas, which could be investigated, include screening for hypertension and asthma management clinics.

**Hospital Separation Rates**

This is the number of hospitalizations per thousand residents in NE counting both inpatients and outpatients. If the person was admitted more than once, these are counted as separate events.

**Figure 7.27 Hospital Separation Rates in NE**

NE has a statistically significantly higher separation rate than the Manitoba average during both time periods and is statistically significantly lower than Rural South during the later time period.

NE experienced a statistical significant increase from 185/1000 to 188/1000 residents. This could reflect a higher acuity.

Within the health districts, only Springfield was significant lower in their separation rates when compared with the Manitoba average and Rural South. Iron Rose, Blue Water and Northern Remote had a statistically significant increase in their overall separation rates during the two time periods reviewed. Both Blue Water (241.1 to 165.36) and Northern Remote (236.46 to 237.12) are statistically significantly higher than Manitoba and Rural South. This could reflect the poorer health status overall of residents in these health districts. 155
Hospital Days Used for Short Stays – 1994/95 to 1999/00 and 2000/01

This is the number of days used per thousand residents for short stays of less than 30 days. It is age and sex adjusted. There is an overall decline in the number of short stay days in Manitoba.

NE showed a statistically significant decrease in short stay days from 672/1000 to 582.2/1000. Despite this decline, NE had a significantly higher number of residents that have short stay days than Manitoba at 513.9/1000 and significantly lower than Rural South at 625.55/1000 during the later time period.

Springfield, Blue Water and Northern Remote all had a significant decrease in short stay days. Blue Water at 831.1/1000 and Northern Remote at 817.4/1000 have the highest number of short stay days during the later time period when compared with our other health districts and are also statistically significantly higher than the Manitoba average. This may reflect the poorer health status in these health districts. Springfield’s short stay days are significantly lower than the Manitoba average.

The number of hospital short stay days were significantly higher in NE compared with the Manitoba average, and lower compared with Rural South during the later time period.

Hospital Days for Long Stays 1994/95 to 1999/00 and 2000/01

This is the number of days per thousand residents, for long stays i.e. 30 days or longer. This is age and sex adjusted.

In NE we see an increase in the number of long stay days from 437.7/1000 to 463.9/1000, but is not a significant increase. This appears to be higher than Rural South (387.68/1000) and lower than the Manitoba average at 482.8/1000 for the second time period, but neither difference is significant.

Springfield, Iron Rose, Blue Water and Northern Remote showed a decrease, but not significant, in the number of long stay days. Winnipeg River, Brokenhead, Blue Water and Northern Remote long stay days are not statistically significantly different than Manitoba or Rural South.

Brokenhead has the highest long stay days at 532.4/1000 than all of the health districts. Next is Winnipeg River at 532.4/1000.

This could reflect the need for personal care home beds, if patients paneled for PCH’s use these beds.

Brokenhead has the highest number of hospital long stay days when compared with our other health districts.

NE males had more day surgeries performed than females during 2000/02.

NE Day Surgeries as a Percentage of Total Surgeries

In NE, day surgeries accounted for 39.8% of surgeries on females and 51.5% of surgeries on males during 2001/02.
In NE, it appears that the most frequent day surgeries were for operations on the digestive system.

The top three-day surgeries performed on NE residents were:
- Digestive system
- Male genital organs
- Miscellaneous diagnosis and therapeutic procedures.
CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

Participation and Partnerships

"The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation." (CCHSA).

2003 Acumen Research Survey – NE Findings - on Rating Hospital and Ambulance

Q- How would you rate your hospital and/or ambulance experience in the past year? [Don't know or refused excluded]

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>31%</td>
<td>27%</td>
<td>27%</td>
<td>9%</td>
<td>7%</td>
</tr>
</tbody>
</table>


Eighty–five percent of respondents rated hospital and ambulance services as good to excellent.

NE Survey 1997

Question Section B # 2: Overall how would you rate the quality of health care services for people your age in your community?

Excellent 250 (15%) Good 1,089 (67%) Poor 301 (18%)

[No responses were excluded from percentage]

Although one can't accurately compare this question as it looks at all health care services, it provides some sense of quality overall. When we add fair and poor together in 2003 we see that 16% of respondents answered compared with 18% in 1997. Likewise, adding together good and excellent, we see that 85% responded in this category compared with 82% in 1997.
Acute Care Client Consultations

Surgical, outpatient, emergency, as well and dialysis surveys have recently been developed or are in the development process.

The type of inpatient consultation completed, consisted of a survey given to all patients at the time of admission. Two time periods were surveyed, the first being February/March of 2003 and November/December 2003. There was no identified target and the total number of surveys returned per site varied. The total number of surveys returned in March of 2003 were 38 and in December there were 30. This is a return rate of 10% and 8% of admissions respectively. There was an opportunity for narrative comments, which were added by many of those surveyed.

Five categories were rated:

1 – Excellent; 2 – Very Good; 3 – Good; 4 – Fair; 5 – Poor

The following reflects the overall rating given to acute care inpatient services during the two periods identified.

Note: If the results fell between 1 and 2 for example: 1.7, this means that the responses were between excellent and very good.

Table 7.27 Acute Care Consultation Rates

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Admission</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Your Care</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Your Discharge</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Environment (Room)</td>
<td>1.7</td>
<td>1.8</td>
</tr>
</tbody>
</table>

There were respondents of all ages, the majority of respondents were in the greater than 60 age group.

The next consultation was held in April 2004, but the data has not been compiled at the time of this report.

The results will assist in making improvements to the care that is given or to maintain excellent service in the Acute Care Program. The target is a 50 % return rate.
Focus Group – Other Comments About Acute Care

**YOUNG ADULT**
- Favourable comments about Beausejour Hospital’s quality and compassionate care in general. [Brokenhead]

**MIDDLE ADULT**
- Well-equipped hospitals. [Brokenhead]
- Generally felt more personal service in rural hospitals. [Iron Rose]

**Suggestion Raised by Middle Adults**
- Minor surgery should be available [Blue Water]

**SENIORS**
- Small hospitals are “…100% better than hospitals in Winnipeg. You know everybody. The care is very good….Knowing your doctor makes a difference to your mental health and comfort level.” [Winnipeg River]

---

2003 Acumen Research Survey – NE Findings - on the Importance of Hospital and Ambulance Services

**Q- How important: hospitals and ambulance services?**

<table>
<thead>
<tr>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>12%</td>
<td>7%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>


The overwhelming majority of NE respondents indicated that they assign high importance to hospitals and ambulance services: 78% to 90%.

Out of the four services inquired about (hospital, ambulance, home care, PCH, community services and health promotion, NE respondents rated hospitals and ambulance services as extremely important (70%), with home care and PCH’s rated second at 49 %. 161
**Dialysis Program**

Figure 7.29 Dialysis Visits

The numbers of dialysis visits have remained fairly stable during the four years reviewed. A slight decline occurred in 2003-2004 of 163 visits.

Of note, the program at the Pine Falls site does not treat children, or clients who are acutely ill. The dialysis program runs three days per week. During recent staffing shortages, patients have been referred to other Dialysis Centres for treatment.

![NEHA Dialysis Visits at Pine Falls Health Complex](chart)

Source: NEHA Statistical Report For 12 months ending March 31, 2004 & 2001

**2003 Focus Groups on Dialysis**

**MIDDLE ADULT**

-A question raised in the Blue Water Focus Group was why the Dialysis Unit is limited to 3 days/week when some local people have to go to Winnipeg for treatment because Pine Falls is fully booked.

**SENIORS**

-Suggestion raised by Seniors

- Suggest putting dialysis in Pinawa Hospital. Pine Falls is too far to travel. [Winnipeg River]
Diagnostic Services

Overview

Diagnostics services provide specimen collection and testing service that aids practitioners in the accurate diagnosis, treatment and monitoring of client illnesses.  

Our region provides the following diagnostic services:

a) Imaging, routine and fluoroscopy (Beausejour Health Centre)
b) Laboratory Services (hematology, chemistry)
c) Electrocardiography, routine and holter monitoring.

Services that are referred out of our region include:

- Ultrasound (Selkirk)
- Mammography (Winnipeg)
- Nuclear Medicine (Winnipeg)
- Computerized Tomography (CT) (Winnipeg)
- Magnetic Resonance Imaging (MRI) (Winnipeg)
- Echocardiography (Winnipeg)
- Specialized Radiography Testing e.g. Angiograms (Winnipeg)
- Chemistry, Drug Screening, Serology and Microbiology (Cadham Provincial and Westman Labs)
- Stress Test (Selkirk or Winnipeg)

Refer to Mammography screening under public health, this section.

During 2002-2003 there was a 20.3 % increase in tests and examinations. This is attributed to the increase in the number of practicing physicians, and improved utilization of primary health services.

What's New in Diagnostics?

Most recently, Computerized Radiography (CR) was introduced as a new diagnostic tool. The picture below shows Allan Borody, a Radiology Technologist using this technology in the imaging department at Pine Falls Health Complex. Shortly, the imaging department at the Beausejour Health Centre will employ the same technology. Radiographic images are digitized using a computer and printed on laser film. In the foreseeable future, these images will be sent via high speed Internet to a specialist in Winnipeg for interpretation.

Diagnostic Services are currently under transition. Diagnostic Services of Manitoba (DSM) is currently being organized to take over the provision of diagnostic services in Manitoba. The vision of DSM is to deliver a centrally managed diagnostic system for Manitoba that is sustainable, state-of-the-art, cost effective, and known for its high quality and exceptional customer service. The use of information technology in both imaging and laboratory is an important part of this vision.
Focus Groups on Diagnostic Services

**YOUNG ADULT**

Major concern expressed was that the turn around time is long for results. [Springfield, Brokenhead]

“Strep is usually positive within 24 hours...we ended up in emergency...To have to wait because of couriers is not acceptable...” [Springfield]

“... It will be 12 weeks before I can get it (ultrasound)...I don’t care where- Selkirk or Winnipeg, wherever I can get in...” [Iron Rose]

*Note*: Strep ID testing is done at all labs in the region.  

**MIDDLE ADULT**

- Felt length of time to receive lab and x-ray results was too long - “If you don’t hear from us everything is fine –I hate that.” “It’s kind of a void there sometimes. Things get lost.” . [Brokenhead] “People are reassured by a phone call once the results have been reviewed by the physician.” [Blue Water]

Suggestions raised by Middle Adults
- Expand Selkirk to include MRI, CT scan. [Winnipeg River] *Note*: Selkirk does have a CT scan now.
- Pinawa Hospital need diagnostic equipment [Winnipeg River]
- MRI needs to come beyond the perimeter. [Winnipeg River]
- Participants would like x-ray and other diagnostic services. Generally it was felt going to Winnipeg was more preferable than Beausejour. However those living north and east had connections to Beausejour and see it as a practical alternative. [Springfield]

*Note*: During the 1997 Focus Groups, Springfield participants mentioned not enough diagnostic equipment in Springfield.

**SENIORS**

Suggestion Raised by Seniors
- MRI and CT scan in Pine Falls would prefer to go to Selkirk rather than Winnipeg. [Blue Water]

**STAFF**

- Staff believes waiting periods for some tests, e.g. barium’s, are unacceptably long. Also, since lab staff is busy with appointments booked in advance, sometimes in-patient work is delayed longer than it should be. There are insufficient numbers of staff to address the increased demands related to the new Beausejour Primary Health Care Center. This has resulted in backlogs. Staff are optimistic that adoption of new technologies may improve turnaround time (for example transmission of images for reading by radiologists off-site).
Three Top Key Issues Identified By Participants

<table>
<thead>
<tr>
<th>Issue</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Diagnostics and Procedures [Raised Issue]**

The group discussed the concept of “Day Hospital” where people would go for simple procedures, i.e. stitching, casting, rather than travel for it. Participants were also concerned about a lack of x-ray services and kidney dialysis. Participants felt the public needs to know that Selkirk is a good quality option for CT scans, ultra-sounds, cancer treatment, etc. As a region we want to advocate for Selkirk to develop their services more. A link on NEHA website to Selkirk Hospital was suggested.

**2003 Focus Group** - The concern about a lack of diagnostic services was brought up in all but the youth group. Major concern for the Young and Middle Adults was the turn around time for results. Springfield would like to see x-ray and other diagnostic services. The Senior group in Blue Water would like MRI and CT scans in Pine Falls.

The following information discusses wait times with particular emphasis on diagnostic services. It was felt that this information is important, as many diagnostic services are accessed outside our region. Long waiting times for various diagnostic services arose as an issue from most of the adult Focus Groups conducted in 2003.

**Manitoba Wait Time Reduction Plan**

The Plan has five components:

- Improved information services, including expanding Health Links and the posting of wait lists on the Manitoba Health Web site – to allow patients to make choices that will reduce their wait times.
- Expansion of day surgery and outpatient diagnostics to free up hospital beds.
- Investments in new diagnostic equipment, for all regions of the province.
- Expanded use of rural diagnostic equipment and operating theatres.
- Stabilizing and renewing the nursing workforce to get nurses to where they are needed.

Compared to September 1999, the Winnipeg Regional Health Authority reports:

- 26% more CT Scans were performed in November 2003.
- 42% more MRI exams were performed in November 2003.
- 53% more Bone Density exams were performed in November 2003.
- 18% more Stress exams were performed in November 2003.

This year, funding is being added for 14,000 more ultrasound exams in Winnipeg. More than $5 million has been invested in new ultrasound equipment across Manitoba over the past four years.

The number of Manitobans waiting for elective cardiac surgery has been reduced by more than 30% since 1999, when wait list statistics were first compiled.

The wait time for life-saving cancer radiation therapy has been cut in half since 1999. This has ended the need to send Manitoba cancer patients to the United States for radiation therapy.
Eleven new and replacement CT scanners have been installed across Manitoba over the past four years. Many of them in rural and northern Manitoba locations that have never had a CT scanner before. Each new CT scanner outside Winnipeg will help keep about 2,600 patients off wait lists in Winnipeg.

In 2004, two new MRI machines will become operational, including one in Brandon – the first ever MRI machine outside of Winnipeg.

Over the past four years, health care training in Manitoba has been expanded by more than 500 training spaces. This expansion includes new training spaces for lab, x-ray and ultrasound technologists.
7.6.1.2 Long Term Care

Overview

The Long Term Care Program includes all facility based resident/client care. This continuum of services includes the following programs: Elderly Persons Housing, Supportive Housing, Personal Care Home (PCH), Respite, Interim Placement, End of Life Care, and Convalescent Care and a community bathing program accessed by home care.

The mission of the dynamic team is to create an environment that not only enables residents to live full and abundant lives, but to do so in an environment that supports independence and emphasizes dignity and personal choice. The team successfully cultivates quality in the residents and their families’ long-term care experience. Each site is continually working towards making the interior environment “home like” and comfortable for residents and their families.  

Table 7.28 Programs and Services

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>East-Gate Lodge, Beausejour Brokenhead Health District</td>
<td>80 beds including a 20 bed Regional Dementia Unit. Includes respite and community bathing.</td>
</tr>
<tr>
<td>Lac du Bonnet PCH, Lac du Bonnet Winnipeg River Health District</td>
<td>30 beds. Community bathing offered.</td>
</tr>
<tr>
<td>Kin Place PCH, Oakbank Springfield Health District</td>
<td>40 beds. Includes respite and community bathing.</td>
</tr>
<tr>
<td>Sunnywood Manor PCH, Pine Falls Blue Water Health District</td>
<td>20 beds. Community bathing offered.</td>
</tr>
<tr>
<td>Stony Plains Terrace. Elderly Persons Housing Brokenhead Health District</td>
<td>30 bed suites. Twelve are designed for supportive housing. This is a service for frail and/or cognitively impaired persons requiring supervision on a 24-hour basis. The remaining 18 suites are for independent seniors housing with a variety of services available for them to purchase, e.g. meals and housekeeping.</td>
</tr>
</tbody>
</table>
The following provide some regional demographics about the residents utilizing the LTC Program. All information is averaged from the five facilities and was collected in November 2003 by the Care Team managers and collated by the Director of LTC.

- There are 191 residents. 61 males (31%) and 130 females (68%)
- The average age for males is 82 years and for females is 85.4 years.
- The average length of stay for males is 3 years and for females 2.7 years. In 1994/95-1995/96 the average length of stay was 2.47 years. In 1999/00-2000/01 the average length of stay decreased to 2.01 years. The Manitoba average length was 2.55 years and 2.30 years respectively.\(^{170}\)
- There is a 72.7% incidence of some type of cognitive impairment.
- Thirty-percent of residents use nine or greater regularly scheduled medications. This doesn't include as needed medications unless administered on a regular basis.
- The number of residents with indwelling catheters averages about 8.4%.
- The number of residents that have bowel or bladder incontinence (requires the use of incontinence products) averages about 54.9%.
- The number of bedfast residents (residents who are not mobile and require a mechanical lift with two people for lifts and transfers) is 32%.
- The use of side rails is 46.5%. Other types of physical restraint use (lap belts, wheelchairs (w/c) or geriatric chairs with tables and thigh belts) average about 54%.

The following provides some demographics about the residents utilizing the Supportive Housing Program at Stony Plains Terrace.

- There are 12 clients, all of which are female.
- The average age of the clients is 82.6 years.
- The average length of stay is 2.05 years.
• There is a 67% incidence of some type of cognitive impairment.

• One third of the clients use nine or greater regularly scheduled medications.

• The number of residents that have bowel or bladder incontinence (requires the use of incontinence products) averages about 17%.

**HEALTH SYSTEM PERFORMANCE**

**RESPONSIVENESS** – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. [Canadian Council on Health Services Accreditation] (CCHSA).

![Availability](Availability)

“Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA)

Pneumococcal Immunization PCH Residents

Residents in personal care homes receive the pneumococcal vaccine if they have not received the vaccine in the community. In a PCH the target coverage is 95%.

It is important to note that this vaccine is generally administered once. There is a very active community push for this vaccine by public health. Often upon admission, residents have already been immunized in the community, therefore they would not be immunized by PCH nurses. These number reflect only those residents that were administered the vaccine by PCH nurses, therefore does not reflect the actual number of residents who have had the vaccine.

**Figure 7.30 Number of Pneumococcal Vaccines given to LTC Residents**

The pneumococcal vaccine program was initiated in 2000, explaining the high coverage during that year.
Influenza Vaccines – PCH Residents

Residents are offered the influenza vaccine yearly in the fall. Unless there is a contradiction in receiving the influenza vaccine, NE PCH goal is to have 100% of the residents immunized.

We have a population of 190 residents. These crude numbers may exceed 190 as our resident population is consistently changing due to discharges or deaths, regular and respite admissions. Upon admission a resident may have had their influenza vaccine administered in the community.

Figure 7.31 Number of Influenza Vaccines Given in LTC Facilities

PCH flu vaccine coverage is excellent. During the flu season 2003 the LTC Program had one unit at East-Gate Lodge (EGL) PCH closed due to Influenza A outbreak.

### Accessibility

"The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs."

(CCHSA) 173

Kin Place PCH opened in the fall of 2000.

According to the Atlas in 1994/95-1995/96 NE had 22.32 admissions per 1000 NE residents aged 75 and over. This is age and sex adjusted. During 1999/00-2000/01 NE had an admission rate of 28.76/1000. There is no significant difference between Manitoba’s rate of 30/1000 and the Rural South rate of 29.45/1000 during the later time period when compared with NE PCH admissions.
2003 Focus Group – Accessibility

YOUNG ADULTS
- There is a perception that there is difficulty finding placement in a PCH of one's choosing “...what you really have to do is put your name on that list before you're ready for it, because otherwise you’re taking a chance you might end up in Beausejour or Pinawa...” [Iron Rose]

SENIORS
- Larger / more PCH beds [Blue Water, Springfield]
  “It’s a stress on the services and community to have them (residents) in the hospital because they would not be patients if the (PCH) space was available.” [Blue Water]

Note: During the 1997 Focus Groups, participants in Winnipeg River mentioned the need for more PCH spaces.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Increase in PCH Beds [Raised Issue]</td>
<td>50%</td>
</tr>
<tr>
<td>Validation Workshop Participants felt that waiting time is too long. “Need more PCH beds”.</td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
</tr>
<tr>
<td>- “if they can’t find appropriate housing they move”. “Need more PCH beds.” Waiting time is too long.</td>
<td></td>
</tr>
<tr>
<td>- No “Safe House”, shelters or transitional housing within NEHA, “not only for women but able to be accessed by residents who need a safe environment, e.g. youth”.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups - also mentioned the need for more PCH beds (Blue Water, Springfield Seniors, Winnipeg River).</td>
<td></td>
</tr>
</tbody>
</table>

IRON ROSE GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT - Housing

Suggestions
- Need more housing for seniors like Supportive Housing
- Elderly Person Housing.
- There is a need for interim placement for individuals awaiting Personal Care Home placement.
Level of Care on Admission to PCH per RHA

Each year the residents of LTC are assessed for the level of care that is required based on the Provincial Dependency Assessment Guide. This assessment reviews the resident's needs under the categories of bathing, dressing, assistance with meals, ambulation/mobility/transfers, elimination, professional intervention, behaviour management/support and supervision. The level of care guide is an indicator utilized by the LTC program to determine the overall needs of their residents and plan in relation to allocation of resources.

Once assessment is done the resident is categorized into a level of care.
- Level 1 – Independent.
- Level 2 N & Y – Minimum to partial dependence.
- Level 3 N & Y and Level 4 N&Y- Maximum dependence.

Table 7.29 Comparing LTC Levels of Care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 1</td>
<td>Level 2</td>
</tr>
<tr>
<td>North Eastman</td>
<td>0.0%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1.8%</td>
<td>54.6%</td>
</tr>
<tr>
<td>Rural South</td>
<td>2.3%</td>
<td>56.5%</td>
</tr>
</tbody>
</table>


There has been a considerable increase in the percentage of residents who are admitted with higher care needs i.e. Level 3’s and 4’s. NE appears to show a higher percentage of Level 3’s and 4’s than Manitoba and Rural South during the later time period.

NE PCH residents appear to have a higher % of Levels 3 & 4 than Manitoba and Rural South.
Levels of Care- Site and Regional

Note: there were no levels of care conducted during 2002. Whitemouth District Health Center includes interim care.

N= does not require maximum support and supervision. Y= requires maximum support and supervision.

Table 7.30 Total Percentage of Resident Population According to Levels of Care- PCH Site

<table>
<thead>
<tr>
<th>Level</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004</td>
<td>2003</td>
</tr>
<tr>
<td>Site</td>
<td>Site</td>
<td>Site</td>
</tr>
<tr>
<td>KP</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EGL</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>WDHC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sun</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LDC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Level 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Y</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Level 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Y</td>
<td>7.5%</td>
<td>13%</td>
</tr>
<tr>
<td>Level 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Y</td>
<td>12.5%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Level 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>Y</td>
<td>30%</td>
<td>41%</td>
</tr>
</tbody>
</table>


Table 7.31 Total Percentage of Resident Population According to Levels of Care- NE Region

<table>
<thead>
<tr>
<th>Level</th>
<th>2004</th>
<th>2003</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Level 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>16%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Y</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Level 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>19%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Y</td>
<td>175</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Level 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>4%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Y</td>
<td>41%</td>
<td>44%</td>
<td>55%</td>
</tr>
</tbody>
</table>


Over the past 5 years the percentage of residents assessed at Level 3 / 4 have averaged 85%, with 15% being level 2. This trend is consistent throughout the province of Manitoba.
SYSTEM COMPETENCY – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost effective use of resources. (CCHSA). 175

<table>
<thead>
<tr>
<th>Appropriateness</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Care/service provided is relevant to the clients’/ patients’ needs and based on established standards. “(CCHSA) 176</td>
</tr>
</tbody>
</table>

Median Length Of Waiting Times Before Admission To PCH

The median waiting time for PCH admission is the amount of time it took for half of all residents to be admitted after being assessed as requiring PCH placement. This includes only provincial beds.

**Table 7.32 Median Waiting Time for PCH Admission in NE**

<table>
<thead>
<tr>
<th>1994/95-1995/96</th>
<th>1999/00-2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 weeks time [Manitoba = 14]</td>
<td>22.1 weeks [Manitoba = 8.86]</td>
</tr>
</tbody>
</table>


Half of all PCH residents admitted waited less than 16.1 weeks and less than 22.1 weeks from assessment to placement.

The PCH in Oakbank opened in the fall of 2000, adding 40 more beds in the region. NE has the highest waiting times for PCH beds in all of the RHA’s for the later time period.

**Table 7.33 Wait Times for PCH’s in NE – March 31, 2004**

<table>
<thead>
<tr>
<th>Kin Place-Springfield</th>
<th>East-Gate Lodge Brokenhead</th>
<th>Lac du Bonnet Winnipeg River</th>
<th>Whitemouth Iron Rose</th>
<th>Sunnywood PCH Blue Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>228 days</td>
<td>76 days</td>
<td>381 days</td>
<td>92 days</td>
<td>110 days</td>
</tr>
</tbody>
</table>


NE keeps its own information related to wait times. The LTC program defines waiting times as the time the application comes to LTC until the date the resident is admitted.

From NE statistics we can see that Winnipeg River and Kin Place PCHs’ have the highest wait time for admission into a PCH.

The LTC Program has recognized that there is a need for more PCH beds. A submission is being made to Manitoba Health to approve the construction of additional beds.
2003 Focus Groups –Additional Comments Related to Long Term Care

MIDDLE ADULTS
- Concern was expressed only in the Iron Rose Focus Group about priority spending in health care. “...People are angry about this when they see all this decorative stuff (referring to work done at the Health Centre) and you can’t get a CT scan in Winnipeg...This is all really nice and I’ll soon be in a care home myself so I hope it’s still so pretty. I may not get there if I can’t get the CT scan...” [Iron Rose]

SENIORS
  Suggestion Raised by Seniors
  - More staff and/or volunteers in PCH. [Springfield]
2003 Acumen Research Survey – NE Findings - Importance of Home Care and PCH’s

Q- How important: home care and personal care homes?

<table>
<thead>
<tr>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>49%</td>
<td>21%</td>
<td>16%</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>


It is unfortunate the two programs are included in one question as they are very different programs. Those who did rate home care and PCH’s as extremely important were respondents with less than high school education, those who completed college/ technical school and females more than males.

49% of NE survey respondents rated home care and PCH as extremely important.

CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

Participation and Partnership

"The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation. "(CCHSA)

2003 Acumen Research Survey - NE Findings - Rating Home Care and PCH Care

Q- How would you rate your home care, PCH in past year? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>21%</td>
<td>0%</td>
<td>25%</td>
<td>9%</td>
</tr>
</tbody>
</table>


Two thirds of NE respondents rated their experience with home care or PCH in the past year as excellent or very good.
Long Term Care Client Consultation

1999- Kin Place Health Centre Construction- During the construction of Kin Place Health Centre, a community action group, community and municipal representatives and Kinsmen met to discuss the plans and the ongoing development. For some groups there were monthly meetings to ensure their input to the project.179

2000-2001- Residents of Stoney Plains- Consultation with residents of Stony Plains regarding tenant concerns resulted in improved environment and service and programming: painting, floor covering, colours, decorations, sidewalk repairs and the availability of a gazebo were also enhanced or achieved.180

2001 Ongoing - Resident / Family Council Meetings – These meetings, held biannually at each PCH have been in place since the spring of 2001. The target audience is family members from the five health districts. Topics for discussion have been sharing of new policies, legislation, demographics, programming, environmental needs and the results of the client satisfaction surveys.181

2001- Client Satisfaction Survey – Conducted November 2002

The Long Term Care Program embarked on conducting their first regional survey.

Family Member Survey
There were 181 surveys mailed out to the family or contact person for each resident requesting information about environment, communication, and quality of service. Respondents were encouraged to complete the survey and add comments as desired. A self-addressed stamped envelope was enclosed for ease of returning the responses. Regionally, there was a 50% response rate.

Resident Survey
Concurrent with the family member survey was the resident survey. There were 57 residents who were individually interviewed by a volunteer. Each volunteer attended a learning workshop to ensure there was consistency in how the surveys were conducted.

Survey Process / Outcomes
The responses were collated specific to each site and then compared on a regional basis. There were many positive comments as well as some constructive suggestions. The responses were completely anonymous, unless the respondents chose to identify themselves. The Care Team Manager of the facility addressed all comments or suggestions requesting specific follow-up.

This was a very transparent process and family members seemed very positive about having the opportunity to provide feedback and chart the course for future planning and program direction.

The responses and the survey process were reviewed at resident / family council meetings in March 2003 and results were shared. The survey will be conducted annually. The next survey is planned for May 2004 and will follow a similar format.182
7.6.2 COMMUNITY BASED PROGRAMS

7.6.2.1 Home Care

Overview

The Home Care program is a comprehensive community based program that provides essential support to individuals, regardless of age. The program strives to offer accessible, timely assessment and service to eligible clients, while supporting families to remain actively involved in the plan of care. Home Care augments the resources of family and the community, emphasizing care be provided in the home for as long as is safely possible. The professional assessment, that includes an interdisciplinary approach, determines eligibility for Home Care Services, Adult Day program, Respite Care, Supportive Housing and Personal Care Home placement. In planning care for the client, family and community resources are explored. The Home Care Program augments these services by providing: nursing, personal care, therapy, meal preparation, supplies and equipment, and light housekeeping that ensures basic household safety and sanitation. The Home Care program partners with the Services to Seniors program to assist with services such as personal supports, house cleaning, transportation, home maintenance etc. that will assist the client to maintain their independence.  

Palliative care is a program under the umbrella of home care. “Palliative care is an approach which improves the quality of life of clients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment, treatment of pain and other problems, physical, psychosocial and spiritual.” Palliative Care is provided in the home, hospitals and personal care homes in North Eastman by a variety of caregivers and volunteers. Palliative Care is a broad term that encompasses caring for people with life threatening illness and improving the quality of their lives from the time of a diagnosis through treatment, at the end of life, and into the bereavement period.
New Home Care Cases

This is the number of new home care cases being opened per thousand residents.

Figure 7.35 New Home Care Cases Opened

NE has shown an increase in the number of new home care cases during the two time periods, but is not a significant increase.

The number of new cases in NE are significantly less than the Manitoba average and also appears to be less than Rural South, but not significantly less.

When comparing our other health districts, Brokenhead (10.28/1000), followed by Springfield (9.95/1000) and Winnipeg River (9.85/1000) have the highest number of new home care cases during the later time period.

Table 7.34 Number of New Home Care Cases in NE

<table>
<thead>
<tr>
<th>Year</th>
<th>1994/95-1995/96</th>
<th>1999/00-2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases/1000 residents</td>
<td>8.02</td>
<td>9.08</td>
</tr>
</tbody>
</table>
Open Home Care Cases

This is the total number of open cases of home care per thousand residents. A resident could have more than one 'episode' of home care in the two year period and these will be counted as separate cases.

Figure 7.36 Open Home Care Cases in NE

In NE the number of open cases have shown a statistically significant increase during the two time periods.

There is no significant difference in the number of open cases in NE when compared with the Manitoba average.

Springfield, Winnipeg River and Iron Rose had a statistically significant increase in the number of open home care cases.

Table 7.35 Number Observed Open Cases in NE

<table>
<thead>
<tr>
<th></th>
<th>1994/1995-95/96</th>
<th>1999/00-2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>607 number observed per year (16.2/1000)</td>
<td>882 number observed per year (22.5/1000)</td>
<td></td>
</tr>
</tbody>
</table>

Following 2001, a decline in open cases was experienced, that seemingly followed the opening of a new personal care home in Oakbank. More recently, there is indication of a 7.5% increase in open cases compared to a year ago.
Closing Home Care Cases

This is the number of home care cases closed per thousand residents.

**Figure 7.37 Closing Home Care Cases in NE**

There has been a significant increase in the number of closed home care cases in NE.

Despite this, NE has closed significantly fewer cases per 1000 residents than the Manitoba average during both time periods.

Brokenhead at 10.75/1000 and Springfield at 10.1/1000 had the highest number of home care cases closed during the later time period.

**2003 Acumen Research Survey – NE Findings - on Use of Community Services**

The likelihood of these responses being from a PCH is relatively low, so this information is placed in Home Care section only.

**Q- How would you rate your home care, PCH in past year? [Don’t know or refused excluded]**

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>21%</td>
<td>0%</td>
<td>25%</td>
<td>9%</td>
</tr>
</tbody>
</table>


Two thirds of NE respondents rated their experience with home care or PCH in the past year as excellent or very good.

In the client satisfaction survey conducted by Home Care in 2003, respondents rated their experience with home care services as:

**Table 7.36 Home Care Survey Rating Home Care Services**

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>No Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>14%</td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
<td>23%</td>
</tr>
</tbody>
</table>

HEALTH SYSTEM PERFORMANCE

RESPONSIVENESS – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment CCHSA (186)

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Services and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).” (CCHSA) (187)</td>
</tr>
</tbody>
</table>

2003 Focus Groups - Availability

MIDDLE ADULT

- The main issues were related to Winnipeg Hospitals not knowing that there were home care services available in North Eastman. [Springfield, Blue Water, Iron Rose]
  “I can’t have it [home care] because I live outside the city.” [Springfield, Iron Rose]
- Some participants felt that Concordia Hospital in Winnipeg does a great job referring residents to home care, [Springfield]
- Difficulty accessing respite services. [Blue Water]
- Seeing one family member getting care, for example, a meal prepared but not preparing meal for other members of the family e.g. their child [Blue Water] or not doing laundry [Springfield]
- Stoney Plains (Beausejour) - good support for a parent who had Alzheimer’s once she heard from a PCH employee about supportive housing as an option. [Brokenhead]
- With regard to a parent being able to remain at home “…just somebody being there…it’s a good feeling.” [Iron Rose]

Suggestions Raised by Middle Adult

- More flexibility to help seniors, and thereby enable them to stay in their homes longer. [Iron Rose, Winnipeg River]
- Participants felt a need in some cases for 24 hour care in the home which is reported as currently unavailable. [Blue Water]

SENIORS

- Concern that 24 hour care was not available. [Brokenhead]
- People need help with housekeeping and this is not a home care service. [Brokenhead]
- Felt rules too rigid. [Blue Water]
- Group knew there was community services support program, but thought it had stopped because of people having to negotiate a fee-for-service individually. [Iron Rose]

Suggestions Raised by Seniors

- More assistance in the home so one can stay there. [Blue Water]
- Would like help with heavy housework, windows, and laundry “home care won’t do.” [Iron Rose]

STAFF

- Not enough staff. The cap on maximum hours allocated per client is too low.
**SYSTEM COMPETENCY** – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost effective use of resources. (CCHSA).

**Effectiveness**

“The care/service, intervention or action achieves the desired results.” (CCHSA)

**Average Length Of Time For Home Care**

This is the average number of days of home care received per case. Researchers also analyzed the median number of cases and found that the values and trends were virtually identical.

**Figure 7.38 Average Number of Days of Home Care Received**

NE shows an increase in the number of average days per case, but was not statistically significant. This could reflect the increasing complexity and acuity of home care clients.

The average number of days of care is significantly higher in NE when compared with Manitoba and Rural South.

When we compare our other health districts it appears that Iron Rose has the highest average number of days per case at 247.73 days during the later time period. Blue Water is next at 240.72 days.

**2003 Focus Groups – Effectiveness**

**YOUNG ADULT**

- Lack of consistency in the quality of home care providers. [Blue Water]

**SENIORS**

- Meals on Wheels provides – “*only one meal a day. That’s not enough.*” [Brokenhead]

**Suggestion by Seniors**

- A meal on wheels program is needed. [Winnipeg River]
2003 Acumen Research Survey - NE Findings - on Importance of Home Care and PCH

Q: How important: home care and personal care homes?

<table>
<thead>
<tr>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>49%</td>
<td>21%</td>
<td>16%</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>

It is unfortunate the two programs are included in one question as they are very different programs. Those who did rate home care and PCH’s as extremely important were respondents with less than high school or who completed college / technical school and females more than males.

CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

Participation and Partnership

“The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation.” (CCHSA)

2003 Acumen Research Survey - NE Findings- Rating Home Care and PCH

Q: How would you rate your home care, PCH in past year? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>21%</td>
<td>0%</td>
<td>25%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Two thirds of NE respondents rated their experience with home care or PCH in the past year as excellent or very good.
Home Care Client Consultations

A Client Satisfaction Survey was conducted in the spring of 2003. There were 438 surveys mailed out to Home Care clients from all areas of the region. There was a 39% return rate. The survey ratings were: 1 (Disagree) to 5 (Agree) with a No Comment section.

The survey was broken down into four areas:

a) **Referral and Assessment**: Included seven different areas from promptness of response to the initial request, did service meet the needs; to involvement of the client/family in decision making. **68% of respondents agreed.**

b) **Implementation of Service**: Included four areas from services placed in a timely manner to concerns regarding worker’s performance was promptly dealt with. **70% of respondents agreed.**

c) **Performance of Staff**: Included four areas from workers arriving and leaving within appropriate times to staff are reliable, respectful and caring. **83% of respondents agreed.**

d) **Quality of Service**: Included a list of the services provided. **44% of respondents agreed** (51% had no comment).

Each site reviewed the findings for their area, evaluated the results and has tried to make changes to improve all categories. Quality of service is an area that staff is mindful to improve. A “Best Practice Manual for Direct Service Workers” has been developed to support continuity and best practice in scheduled tasks that will improve quality of service. All staff are encouraged to participate in continuing education as it becomes available to them.

Discussion has occurred as to when the survey is the more timely and meaningful for clients and staff. Is it following discharge from the program, or is it routinely once per year, or is it in combination with a regional survey? No decision has been made to date.
7.6.2 Primary Health Care

Overview

Primary Health Care is the first level of contact with the health system where services are mobilized to promote health, prevent illness, care for common illnesses and manage ongoing health problems. Primary health care extends beyond the traditional health sector and includes human services, which play a part in addressing the inter-related determinants of health.

The principles of primary health care are integrated into services and programs developed by an interdisciplinary team in response to the needs of the community. Service in Pinawa is provided by itinerant staff, Pine Falls is well integrated, Whitemouth and Seymourville have limited services.

There are four Primary Health Care Centres within the North Eastman Region: Beausejour, Oakbank, Lac du Bonnet, and Whitemouth. The spectrum of services provided include: health promotion; illness prevention; treatment; rehabilitation and supportive services.

The Primary Health Care Team includes Nurse Practitioners in Lac du Bonnet, Beausejour, Oakbank with outreach services to Seymourville and Whitemouth, five Wellness Facilitators (located in five of our health districts), Primary Care Physicians, Social Workers and other members from various programs: Audiologist (Beausejour), Clinical / community Dietitians, Mental Health Workers, Home Care Coordinators, Diagnostics, Public Health.

Wellness Facilitators act as the liaison between the community stakeholders and NEHA. Their focus is community development and community capacity building. They work with our partners to promote healthy lifestyles. They may do this through advocating for Healthy Public Policies such as Bill C-31 (the provincial smoking ban) to organizing wellness events. They are health promotion specialists that know the needs of the communities as they work with grassroots organizations and participate in wellness coalitions/ district inter-agency groups to enhance community wellness.

There is a full time EFT Primary Care Social worker, divided into two 0.5 EFT positions. The presenting issues consist of marital conflict, abuse issues, addictions, anger management and grief counseling.

Priorities of Primary Health Care are:

- Safety and injury prevention.
- Tobacco reduction.
- Health lifestyle promotion e.g. exercise, nutrition, coping skills.
Initiatives include (this is not an exhaustive list): 193

- Tobacco cessation programs i.e. Catching our Breath and NOT-Not on Tobacco.
- Wellness tips in local paper.
- Safe kids initiatives i.e. helmet fitting clinics and care seat checks.
- Sit and fit exercise program for seniors.
- Wellness fairs and displays.
- Stress reduction workshops.
- Menopause clinics and workshops.
- Women's Wellness Days
- Nutritional education.
- Advocating for healthy food choices within Sunrise School Division and the new SunGro Recreation Centre.
- Partnering with other interagency groups both regionally and in each health district through wellness coalitions.
- Three and Four Year old Pre-Kindergarten Screening clinics.
- Healthy Heart Information Nights
- Screening clinics are held for example: School readiness Clinics, Manitoba Breast Screening Program, and Pap smear clinics.

### COMMUNITY & HEALTH SYSTEM CHARACTERISTICS

#### Health Service Utilization

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 7.37 Primary Care Clinic Direct Contacts</td>
<td>2,868</td>
<td>2,632</td>
<td>1,992</td>
</tr>
</tbody>
</table>


The numbers of client contacts are increasing over the three years reviewed. This is not surprising, as the primary health care program has also grown.

#### Nurse Practitioner Visits

Nurse practitioners are located in three locations: Lac du Bonnet, Beusejour and Oakbank. The average number of clients seen by nurse practitioners per month is approximately 350. 194

#### Primary Health Care Social Worker Visits / Waiting Times

The monthly cases load of both social workers is approximately 20 clients. The wait time is approximately 3 weeks in length. 195
2003 Acumen Research Survey – NE Findings - on Utilization of Community Services

Q- Have you used community services, such as public health or mental health services, in the past 12 months? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>count</td>
<td>21%</td>
<td>79%</td>
</tr>
</tbody>
</table>


One in five respondents (21%) used community services in the past year. Those respondents who used the community services were more likely to be between the ages of 25-44 years, those of First Nations, Aboriginal or Metis ancestry; those who are not employed; and from households of three or more people.

2003 Focus Groups on Community Services

MIDDLE ADULT

Suggestion raised Middle Adults
- Expand Wellness Resource Centre- people who work days cannot use this resource. [Springfield]

STAFF

a) Springfield Health District – Comments suggested that the Social Worker position in Oakbank at the time of the Focus Group was underutilized by the community.
   Some participants thought this might be due to
   I. The office hours (people commuting to day jobs need evening and weekend access.
   II. Stigma. The community identified the need for a social worker, perhaps this population does not really accept this type of intervention.
   III. Lack of awareness of the position by community, as it is a relatively new position.

b) Blue Water District/Northern Remote – The Northern Diabetic Education staff was seen as being under utilized. Some of the possible causes discussed included
   I. Service population is seen to prefer drop-in service as compared with service by appointment.
   II. Cultural influences and cultural predisposition.
   III. The population is more inclined than other groups to wait until the need for service is more severe before accessing.

Suggestions Raised by Staff
- Advertising the acceptability of drop-in visits on the staff person’s office door (which is next to the waiting room).
- Finding ways to adapt the service to the community.
2003 Acumen Research Survey - NE Findings - on Utilization

Q: Have you used health promotion services such as flu shot, a blood pressure clinic, or a health fair, in the past 12 months? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>


Those respondents who indicated that they used a health promotion service in the past 12 months were more likely to be:

- Between 55-64 years and especially over 65 years and retired individuals.
- Those with less than high school education.
- Those living in one and two person households.

Note: Flu shot clinics may have triggered “yes” responses in this age group, as they are a target for this service.

34% of NE survey respondents used health promotion services in past 12 months.

HEALTH SYSTEM PERFORMANCE

SYSTEM COMPETENCY – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA)

Effectiveness

“The care/service, intervention or action achieves the desired results.” (CCHSA)

2003 Acumen Research Survey - NE Findings - on Importance of Health Promotion

Q: How important: health promotion, such as flu shots, blood pressure clinics, or health fairs?

<table>
<thead>
<tr>
<th>Extremely important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>42%</td>
<td>26%</td>
<td>20%</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>


In the survey the respondents who assigned extremely high importance to health promotion were over the age of 65 years, those with less than a high school education and those living in households of two people.

Those who were more likely to indicate low importance to health promotion were aged 18-24, university graduates or respondents with some college or university and those living in households of three or 5-10 people.
Additional Comments specific to Primary Health Care

2003 Focus Groups Additional Comments on Primary Health Care

YOUNG ADULT
-Oakbank Health Centre Drop in for Moms and Kids viewed positively. [Springfield]

Suggestions Raised by Young Adults
- Introduce topics e.g. when not to go to emergency room, feeding, introducing solids, knowing what is and isn't fever, symptoms of teething. [Springfield]
- Introducing everyone in group to try and eliminate cliques. [Springfield]
- More funding for the Wellness Centre in Oakbank. [Springfield]

SENIORS
-Lack of information about men’s health. Group felt men do not typically talk about these problems, nor share this type of information. There was an article in the local paper about prostate cancer and a comment from a participant was that “This fella put every thing on paper for all men to see, and it’s a great service to men.” [Brokenhead]

STAFF
- Health promotion is positively regarded for its perceived potential to help ease the burden on the health care system:
  “...If we start educating kids sooner about exercising, smoking and whatever, in the long term we would probably see a difference.”
  “It's a vicious circle. If we don't put money or time into health promotion we will continue to have sick people. Where do you start?...because you can’t cut any services.”
CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

Participation and Partnership

“The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation.” (CCHSA)

2003 Acumen Research Survey – NE Findings - Rating Health Promotion Services

Q- How would you rate your experience with health promotion services?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46%</td>
<td>26%</td>
<td>25%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>


2003 Acumen Research Survey – NE Findings - On Importance of Community Services

Q- How important: community services such as public health or mental health?

<table>
<thead>
<tr>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40%</td>
<td>28%</td>
<td>21%</td>
<td>7%</td>
</tr>
</tbody>
</table>


Females were almost 50% more likely than males to indicate that community services were highly important.

Program Surveys/ Consultations

a) A telephone survey was conducted during the past year asking residents about whether or not they read the ‘Health Corner’ news column placed in all the NE local newspapers. Of those residents telephoned, 98% indicated that they read the Health Corner news column.

b) Another aspect of community consultation occurs when Wellness Facilitators and other facilitators of workshops, conduct ongoing program evaluations for each health promotion program held in the community. These evaluations provide staff with information on the merit or worth of programs, as well as providing community input on future health promotion programming. An example of one program evaluated was the Stress Workshop held in October 2002. An overwhelming number of participants rated the workshop as excellent or very good (94%).
7.6.2.3 Mental Health

Overview

The NEHA Mental Health Team delivers comprehensive community based mental health services to individuals, families and groups affected by emotional and mental health concerns. Services include: assessment, consultation, counseling, treatment, psychosocial rehabilitation, 24-hour crisis intervention, health promotion and public awareness of mental health issues.

The Team consists of Mental Health Workers specializing in Child & Adolescent, Adult, Intensive Case Management and Elderly Services, Consultant Psychiatrists, Clinical Psychologist, Interlake/North Eastman Crisis Services (see below), Eastman Mental Health Self-Help (see below), Proctors (Support Workers) and the North Eastman Community Trauma Postvention Team.

Since the last CHA Report in 1998, Child and Adolescence, Adult, and Elderly Services were increased by 1.5 Equivalent Full Time (EFT) Community Mental Health Workers. Funding was made available for individuals who are unable to afford and require a private therapist to provide specialized services not provided within the scope of the Mental Health Program. A significant portion of these monies was used in 2002 to support the development of a regional Sexual Assault Response Team.

Two new services added in 2002 by North Eastman Health Association and now frequently utilized by the Mental Health Program are: an Employee Assistance Program for NEHA staff and two halftime Primary Health Care Social Workers. A Mental Health Resource Coordinator was added November 2003 to coordinate and further develop Housing and Proctor Services. The Clinical Psychologist position remains vacant since June 2003 due to a lack of funding. Ongoing training in Applied Suicide Skills Intervention and Community Trauma Postvention is provided to staff and communities and agencies. A Telehealth project for psychiatric consultation services at the Pine Falls site was completed between December 18, 2003 and March 31, 2004. This requires funding to proceed further.

Eastman Mental Self-Help Service is a shared initiative of Anxiety Disorders Association of Manitoba, Canadian Mental Health Association Manitoba Division, Manitoba Schizophrenia Society Inc. and Mood Disorders Association of Manitoba. They include consumer education, empowerment, peer support, public education, mental wellness, advocacy, current literature and information resources; individual support and education groups and referrals to appropriate professionals.

A drop in centre at the Beausejour Community Church was opened for adult residents who are coping with mental illness and addiction issues in September 2003. This is a shared initiative with the Manitoba Schizophrenia Society, Canadian Mental Health Association, Mood Disorder Association of Manitoba, Addictions Foundation of Manitoba, Vocational Rehabilitation Services and NEHA.
Crisis Services – Crisis Services is a partnership between NEHA and Interlake RHA.

Crisis Stabilization Unit – This is located in Selkirk and is an eight bed residential unit for adults or older adolescents in a psychiatric crisis.

Mobile Crisis Unit – This service consists of a multi-disciplinary team offering crisis intervention services of a voluntary nature to people 15 years of age or older who are experiencing an apparent mental health crisis.

COMMUNITY & HEALTH SYSTEM CHARACTERISTICS

Health Service Utilization

Mental Health Open Case Files

Open cases refers to the number of cases opened on the Mental Health Management Information system (MHMIS). It does not include clients who are referred but not opened.

Figure 7.39 Mental Health Case Files Opened in NEHA

The number of case files open appears to have fluctuated during the five years reviewed.
Mental Health Active Cases

Active cases refers to the total number of cases open, including new cases, and cases carried forward from previous months/years.

**Figure 7.40 NEHA Mental Health Case Files Active**

The number of active case files appear to have fluctuated during the period reviewed.

### 2003 Acumen Research Survey – NE: Findings - on Utilization

**Q- Have you used community services, such as public health or mental health services, in the past 12 months? [Don’t know or refused excluded]**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21%</td>
<td>79%</td>
</tr>
</tbody>
</table>


One in five respondents (21%) used community services in the past year. Those respondents who used the community services were more likely to be between the ages of 25-44 years, those of First Nations, Aboriginal or Metis ancestry; those who are not employed; and from households of three or more people. 203
HEALTH SYSTEM PERFORMANCE

RESPONSIVENESS – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. CCHSA.  

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s). &quot;(CCHSA)</td>
</tr>
</tbody>
</table>

**2003 Focus Groups on Availability**

**STAFF**

- Not enough mental health supports. Other issues: lack of community and physician awareness, consulting psychiatrist for geriatrics needs to be increased.

**Note:** During the 1997 Focus Groups, it was mentioned that there was not enough mental health services available, and the need for more education about mental health. [Blue Water and Winnipeg River]
SYSTEM COMPETENCY – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA).

Effectiveness

<table>
<thead>
<tr>
<th>“The care/ service, intervention or action achieves the desired results.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>(CCHSA) 207</td>
</tr>
</tbody>
</table>

2003 Focus Groups on Effectiveness

**YOUNG ADULT** - The primary issues in this age focus group discussed the need for better awareness of the mental health program and also the stigma associated with accessing programs.

a) Mental Health Service Awareness

- One participant in Springfield mentioned a concern that if a person did access a mental health service, the possible negative repercussions for their family might involve “...taking my children away.” [Springfield]
- There is felt to be some difficulty in accessing either community and/or school guidance support for children in situations, for example where there is a marital breakup, or other issues for youth for example anorexia, teen pregnancy. [Springfield]
  
  “For me, it’s just the mental health...how many others out there have no idea how to find resources to heal themselves, or don’t know they need it...It’s really good to see the walk in for mental health but the criteria to go is that you have been diagnosed with a mental illness...”
  [Springfield]

Suggestion Raised by Young Adults

- Combining physical prevention clinics like blood pressure (B/P) readings with mental health discussions.

b) Stigma Using Mental Health Program

- “It’s okay to ask for help...My first vision is, ‘She can’t handle it. Well just take her kids away’...A little more promotion that there is help out there without having to worry about stuff being taken away from you if you feel you need help.” [Springfield]
- “Some of us know we have it and have never been diagnosed. There’s a stigma attached to it and thank you but no thank you.” [Springfield]

Suggestion Raised by Young Adults

- The words mental health has a negative connotation and maybe ‘wellness’ is more positive.
- “It’s hard to have a location in a small town without people talking if it’s not something that anyone can drop in ... Drop in and check out your mental health... Make it somewhere fun...Get your blood pressure and mental health done at the same time.” [Springfield]
- Referral to Mental Health Worker by Public Health Nurse and feels that “The system gave me good service.” [Winnipeg River]
MIDDLE ADULT

a) Mental Health Services Awareness
- Not always clear what these services are and the availability. Would like to see more public awareness of mental health resources. [Brokenhead]

b) Support
- "...there is no support for the [persons with mental illness]..." [Iron Rose]
- An adult with mental health illness is placed in a foster home "...is this the best or only thing that is available? Is there an assisted living situation?" [Brokenhead]
- "...People with mental illness are tossed all over the place...Not one of the situations are very ideal, because it's hard to find good care givers..." [Brokenhead]

c) Identifying & Diagnosing
- Mental health is more than mental illness e.g. managing stress...rural people are more isolated ...those needing help are not always identified. [Springfield]
- Troubled youth may not be recognized. Suggested suicide rate is relatively high. [Springfield]

Suggestions Raised by Middle Adult
- It was identified that the drop in centre in Selkirk is well used, as well as the store front centres in Lundar and Arborg. Participants in Springfield would like to see a mental health drop in in Springfield, but not naming it as such, due to stigma in small town. [Springfield]
- Another participant felt "...you just battle on...I don't think we cover it up. I think that's been done too much." [Springfield]
- "...when I started attending the therapist I was so relieved that she was operating out of her home, 7 miles out of town." [Iron Rose]

STAFF
- One participant voiced concern there is a need to increase awareness among both the community and physicians that mental health services are available. Pine Falls was one example specifically cited.

Suggestions Raised by Staff
- Group members suggested perhaps services are not being accessed because mental health workers do not have a high profile in the community and perhaps physicians aren't referring because they are not aware of the level of service available.
**CLIENT /COMMUNITY FOCUS** – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA)

---

**Participation and Partnership**

“The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation.

“(CCHSA)”

---

**2003 Acumen Research Survey - NE Findings - on Rating Health Promotion**

**Q- How would you rate your experience with health promotion services?**

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>46%</td>
<td>26%</td>
<td>25%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>


---

**2003 Acumen Research Survey - NE Findings - on Importance of Community Services**

**Q- How important: community services such as public health or mental health?**

<table>
<thead>
<tr>
<th></th>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>40%</td>
<td>28%</td>
<td>21 %</td>
<td>7%</td>
<td>4%</td>
</tr>
</tbody>
</table>


Females were almost 50% more likely than males to indicate that community services were highly important.
7.6.2.4 Emergency Medical Services

Overview

The Emergency Medical Services team is responsible for the delivery of pre-hospital emergency care for North Eastman Region.

Pre-hospital care is provided with advanced life support and basic life support levels with Emergency Medical Technician, Emergency Medical Responder and a small number of Basic First Aid providers. There are 17 full time and part time staff as well as approximately 108 casual staff. Transport includes both emergency and non-emergency.

The Disaster Preparedness program is an integral part of all programs within NE Region. During 2003 a Regional Disaster Preparedness Plan was developed. All staff participated in a regional orientation to the Disaster Preparedness Program. A Regional Disaster Preparedness Program orientation is provided to new staff.

Northern Patient Transportation Program (NPTP) provides transportation services to persons located north of the 51st parallel within our region. It is administered by NEHA at the Pine Falls Health Complex. Transportation is by both land and air.

The total population more than doubles in the summer with vacationers and cottagers. The largest impact of the summer population is felt in the areas served by Pine Falls, Whitemouth, Lac du Bonnet and Pinawa. The variations in population impact significantly on Emergency Medical Services.

EMS is also involved in community safety programs.

EMS calls are categorized in 2 ways: transport & non-transport.

Transport

1. **Primary Responses** - These are any:
   a) emergent calls (lights & sirens) such as trauma, motor vehicle accidents, drownings, hazardous material incidents, cardiac arrest, etc; or
   b) non-emergent calls (no lights & sirens) such as general illness, minor injuries, any minor or insignificant incidents.

2. **Interfacility Patient Transports** - CT scans, MRI, ultrasound, any other non-emergent diagnostics.

3. **Interfacility Patient Transports** - Emergent: emergency transfers resulting from injuries, trauma, cardiac arrests, etc. that cannot be managed by the receiving facility within our region.
Non-Transport

1. **Agency Stand-by** - Backup support for the police or fire or another ambulance service.
2. **Cancelled Call** - The call is cancelled by the client resulting in no transport.
3. **Treat & Release** - Care is provided at the scene but a transport does not occur.
4. **Refusal of Services** - The crew arrives on scene but the client refuses actual transport.
5. **Special Events** - Snowmobile races, motocross, horse events, etc.
6. **Deceased at Scene** - The patient is deceased at the scene, no transport of the body occurs.
7. **No Patient** - A patient cannot be found (transported by a passer-by or family member prior to EMS arrival).
8. **Other Agency Handled the Call** - Another ambulance service has already transported the client.

**COMMUNITY & HEALTH SYSTEM CHARACTERISTICS**

**Health Service Utilization**

NEHA Ambulance Trips

'Total' use of the service includes primary use for calls from a resident's home, interfacility transfers and interfacility transfers considered emergent.

**Figure 7.42 NEHA Ambulance Trips**

Pine Falls ambulance service was private up until September 2003 when it transferred to NEHA.

The total calls made in Pine Falls between January 1, 2002 to December 31, 2002 was 863. Effective September 1, 2003 Pine Falls had a total of 366 trips.

Beausejour ambulance had the most number of trips compared with the other ambulance services. Approximately three years ago Beausejour was providing all the interfacility transports for the region, however this was not continued. According to Jay Ferens the EMS Manager, this service did not increase the call volumes for interfacility transports greatly for the Beausejour service.
Table 7.38 NPTP Number of Elective and Emergency Calls

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>1,343</td>
<td>1,471</td>
<td>1,177</td>
</tr>
<tr>
<td>Emergency</td>
<td>17</td>
<td>44</td>
<td>51</td>
</tr>
</tbody>
</table>


2003 Acumen Research Survey – NE Findings - on Utilization Of Hospital and Ambulance Services

We do not know which service was utilized but can assume someone who utilized ambulance services may also have a need for hospital services as well.

Q- Have you used a hospital or an ambulance service in the past 12 months? [Don’t know or refused excluded]

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>


Survey respondents who were more likely to utilize hospital or ambulance services were between the ages of 25 to 34 years, employed either full-time or not employed at all and were from households of three or more people.

33% of NE respondents surveyed had used either hospital or ambulance services within the last 12 months.
HEALTH SYSTEM PERFORMANCE

SYSTEM COMPETENCY – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost effective use of resources. (CCHSA) 214

Effectiveness

*The care/ service, intervention or action achieves the desired results.* (CCHSA) 215

---

2003 Focus Groups and Effectiveness of Service

YOUNG ADULT

- Concerns about ambulance time from Whitemouth to Central Whiteshell [Iron Rose]
  
  “...Took just over an hour to arrive. And that's good time. ... they take you to Pinawa, and that's taking you farther from Winnipeg....” “... they call [ambulance] the hearse, because by the time they get to the Whiteshell and back to wherever they're going, it's too late…” [Iron Rose]

- In Rennie “...We are an hour to Beausejour, Pinawa, Kenora. If someone is in serious trouble, that's a long way to go.” [Iron Rose]

MIDDLE ADULT

- If ambulance is already busy, wait time for next nearest ambulance is too long. [Springfield]

- Ambulance service in Blue Water was seen as ineffective in winter conditions due to its large vehicle, difficulty getting traction in snow, rough ride. [Blue Water]

SENIORS

- Ambulance reported to be a rough ride. [Springfield]

STAFF

- EMS is sometimes affected by general overloading in the system. For example, an ambulance may notify a hospital that a "red" is incoming, but hospital staff may be too busy to notice the code light and prepare appropriately. The ambulance arrives and the code light is still on, indicating emergency staff have not acknowledged the forewarning.

- Back up in Winnipeg emergency rooms means sometimes an ambulance attendant must leave a patient who still has not been seen. Staff expressed concern that, under mutual aid agreements, the system may start to back up as ambulances are called from their respective areas to cover for others who may be tied up in emergency.

- One group member speculated that it's possible a lack of proper facilities may contribute to high turnover of EMS staff. Also, primary care paramedics from Winnipeg have offered to come out and volunteer in the region on weekends so they might gain trauma experience, but they cannot be accepted because there is nowhere for them to stay.

Suggestion Raised by Staff

- EMS hall in Oakbank – need for storage, training facilities, office space.
2003 Focus Groups and ‘911’ Services

YOUTH
- Most youth were unaware as to whether they were served by 911. [Blue Water, Springfield]
- Some who knew about 911 found out through the newspaper, parents, sticker seen on their phone or through life guard training. [Brokenhead].
- Students from Pinawa say they do not have 911 while students from Lac du Bonnet are aware they have 911 services. [Winnipeg River].

Note: During the 1997 Focus Groups, it was raised about needing 911 services.

STAFF
- The group noted there is some confusion in the community as to which areas are serviced by 911. There are some difficulties for communities in transition i.e. communities that have two emergency phone numbers in place.
- One participant observed it is particularly difficult for older people to make the switch, "They just don't think of 911."
- From an administrative perspective, maintaining old emergency phone numbers is seen to be an issue because the lines need staffing and sometimes it's difficult to ensure the line is answered. Examples were given of situations where staff was busy and there was no one available to answer the phone.
- NEHA is seen as having done "...a good job in making everyone aware,"
- There were various community members in the Focus Groups that were unable to say whether they had 911 or not.

Suggestion Raised by Staff
- Continued awareness campaign was recommended for communities with 911 service.

CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA)

Participation and Partnership
"The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation. (CCHSA). "

2003 NE Acumen Research Survey - NE Findings - on Rating Hospital and Ambulance Service

Q- How would you rate your hospital and/or ambulance experience in the past year? [Don't know or refused excluded]

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>31%</td>
<td>27%</td>
<td>27%</td>
<td>9%</td>
<td>7%</td>
</tr>
</tbody>
</table>


Eighty-five percent of NE respondents surveyed rated hospital or ambulance services as good to excellent.
2003 Focus Group Additional Comments about EMS

YOUNG ADULTS

- "... ambulance in Whitemouth is very good" [Iron Rose].
- Access to emergency care / ambulance service to the area is good from Pine Falls [Seymourville]

Suggestion Raised by Young Adults

- Increase emergency care – First Aid/CPR training, which would improve services to the community. [Seymourville]

Program Consultations

Formal program consultations have not occurred, however, there are a number of items that staff and the public has brought to the attention of the program manager:

Many EMS staff expressed concern regarding

a) The lack of full-time and part-time positions within our region.
b) The new Provincial Fleet ambulances have been identified as being rough riding (Pinawa service).
c) Additional communications equipment (pagers) is required (Beausejour EMS) as they are always in short supply.
d) Require additional staff to maintain service. (Pine Falls EMS).

Public Concerns

The cost of an ambulance trip is quite high.
7.6.2.5 Public Health

Overview

Public Health exists to enhance the health and social well being of North Eastman residents. Programs and services focus on activities that promote health, prevent illness, and postpone disability and cope positively with existing disabilities.

The Public Health Team includes:
- Public Health Nurses – Northern and Community Health, Immunization Program, Travel Health, Reproductive Health
- Registered Dietitians
- Home visitors – Baby First and Healthy Baby Programs, Speech and Language Pathologists
- Audiologist
- Diabetes Education Resource Team
- Medical Officer of Health

Some of the programs offered include:
- Partnerships with agencies outside the health sector.
- Regional community based influenza / pneumoccal clinics.
- Grade 4 Hepatitis B and school-based immunization programs.
- Injury prevention for example, car seat safety checks and bicycle helmet safety.
- Travel Health program implemented in October 2002. This is provided on a fee-for-service basis.
- Nutrition Services – Registered dietitians provide services for community clients.
- Parent-Child Centre Coalition now called 'Bright Beginnings'', supporting nutrition, literacy, parenting and community capacity building.
- Prenatal and postnatal services.
- School health services for children with special health needs.
- Baby First/Early Start/Healthy Baby.

Diabetic Education Resource Program

“The purpose of the DER program is to enhance the health and social well-being of NE residents by enabling individuals, families and communities, through education to prevent diabetes, to recognize early symptoms of diabetes, to improve the quality of life of persons living with diabetes and to fully participate in the control of their own health care.

" Components of the program include: Healthy Lifestyle Awareness, Assessment of Personal Risk and Management, Screening, Education, Counseling, Support advocacy and interventions related to diabetes and lifestyle, for example nutrition, fitness, foot care, family support, self-monitoring, medical/nursing care and community networks."
The Diabetes Education Resource (DER) team is currently staffed with 1.0 EFT Nurse Educator and 1.0 EFT Registered Dietitian who are both Certified Diabetes Educators. Clinical/community Dietitians support the work of the DER team, but their work is not specifically nor solely related to diabetes. Physicians are key primary care providers in the care and treatment of diabetic clients. In some sites, Primary Care Nurse Practitioners provide diabetes care and the Wellness Facilitators facilitate many primary prevention activities related to the prevention of chronic disease, which includes diabetes. As of March 4, 2004, the DER program has 1,569 people on their current caseload. Files are not closed due to the chronic nature of diabetes. 221

Diabetes prevalence is located in Section 6.0.

Dietitian Services

Many of our dietitians work concurrently in both facilities and community. If they work in the communities, they work under the umbrella of public health. “The clinical/community Dietitians provide services to clients in hospitals, personal care homes, and in the community. Primary responsibilities include assessment, planning and implementation of nutritional care for clients, education and support for both individuals and groups, and for promoting healthy lifestyles through liaison with other health care professionals and the community.” 222

COMMUNITY & HEALTH SYSTEM CHARACTERISTICS

<table>
<thead>
<tr>
<th>Health Service Utilization</th>
</tr>
</thead>
</table>

Table 7.39 Diabetes Education Program Direct Contacts with Individuals /Families/Groups or Community

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,138</td>
<td>1,149</td>
<td>1,034</td>
</tr>
</tbody>
</table>


The number of direct contacts with clients by the DER Program remains stable over the three years reviewed. There was a slight decline of 11 contacts in 2003/04 compared with 2002/03.

Table 7.40 Clinical Nutrition Services- Number of Inpatient and Outpatient Referrals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Referrals</td>
<td>524</td>
<td>612</td>
<td>558</td>
</tr>
<tr>
<td>Outpatient Referrals</td>
<td>1,081</td>
<td>787</td>
<td>606</td>
</tr>
<tr>
<td>Total Referrals</td>
<td>1,605</td>
<td>1,399</td>
<td>1,164</td>
</tr>
</tbody>
</table>


Outpatient referrals have increased during the three years reviewed.
Table 7.41 Direct Contacts by Program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Health</td>
<td>346</td>
<td>128</td>
<td>13</td>
</tr>
<tr>
<td>Community Public Health</td>
<td>5,862</td>
<td>5,187</td>
<td>4,691</td>
</tr>
<tr>
<td>Immunization Program [clinics/groups]</td>
<td>31</td>
<td>58</td>
<td>44</td>
</tr>
<tr>
<td>Hepatitis B Program [clinics/groups]</td>
<td>46</td>
<td>68</td>
<td>88</td>
</tr>
<tr>
<td>Influenza Program [clinics/groups]</td>
<td>66</td>
<td>88</td>
<td>42</td>
</tr>
<tr>
<td>Travel Health</td>
<td>733</td>
<td>493</td>
<td>-</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>408</td>
<td>362</td>
<td>275</td>
</tr>
<tr>
<td>Healthy Baby Program</td>
<td>408</td>
<td>242</td>
<td>126</td>
</tr>
<tr>
<td>Baby First Program</td>
<td>1,461</td>
<td>1,664</td>
<td>1,638</td>
</tr>
<tr>
<td>Community Dietitians</td>
<td>979</td>
<td>366</td>
<td></td>
</tr>
</tbody>
</table>


All programs experienced an increase in contact hours, except for a slight drop in the Immunization, Influenza, Hepatitis, and Healthy Baby programs during 2003/04 when compared with 2002/03.

Figure 7.41 Influenza Immunization Coverage

As shown the number of residents receiving immunizations from public health clinics have increased in 2003 when compared with the other years. Resident influenza coverage overall is underreported as these numbers may not include other providers, for example physician’s offices.
2003 Acumen Research Survey - NE Findings - on Utilization of Community Services

Q- Have you used community services, such as public health or mental health services, in the past 12 months? [Don't know or refused excluded]

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>21%</td>
<td>79%</td>
</tr>
</tbody>
</table>


One in five respondents (21%) used community services in the past year. Those respondents who used the community services were more likely to be between the ages of 25-44 years, those of First Nations, Aboriginal or Metis ancestry; those who are not employed; and from households of three or more people.

2003 NE Provincial Survey Findings on Utilization of Health Promotion Services

Q- Have you used health promotion services such as flu shot, a blood pressure clinic, or a health fair, in the past 12 months? [Don't know or refused excluded]

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>


Those respondents who indicated that they used a health promotion service in the past 12 months were more likely to be:
- Between 55-64 years and especially over 65 years and retired. **Note:** Flu shot clinics may have triggered “yes” responses as those over 65 years are a target for this service.
- Those with less than high school education.
- Those living in one and two person households.

34% of NE survey respondents used health promotion services in past 12 months.
RESPONSIVENESS – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment. CCHSA.

Accessibility

“The ability of client / patients to obtain care / service at the right place and the right time, based on respective needs.” (CCHSA)

Focus Group on Accessibility

MIDDLE ADULT
- Breast-feeding support is seen as positive. [Brokenhead & Winnipeg River]
  “…Hope it’s still good and always improving…” [Brokenhead]
- Baby Program at the clinics is “very good.” [Blue Water]
**SYSTEM COMPETENCY** – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources. (CCHSA).

**Effectiveness**

*The care/ service, intervention or action achieves the desired results.* (CCHSA)

The following information pertains to reportable, communicable and/or sexually transmitted diseases. Surveillance is an important part of public health in order to ensure that populations remain healthy.

There is a list of reportable diseases that must be reported to the Manitoba Public Health Branch.

**Sexually Transmitted Diseases (STD)**

**Chlamydia**

Chlamydia remains the most commonly reported STD in Manitoba. The highest numbers occurred among females. In NE in 2001 the highest number of cases occurred between the ages of 15-24 years. This is of concern as “Chlamydia” is often asymptomatic in females and is a known cause of pelvic inflammatory disease, ectopic pregnancy and infertility.” Women are often tested for Chlamydia when screened during a Pap test, during prenatal visits and family planning visits. This may be the reason for higher rates among females. Males are tested less often and often only if they know they have been exposed by an infected partner, or if they have symptoms. The Provincial STD Strategy has established goals to reduce Chlamydia to 80 per 100,000.

**Table 7.42 Chlamydia: Age Standardized Rates (per 100,000)**

<table>
<thead>
<tr>
<th>Geographic</th>
<th>Gender</th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Age Standardized</td>
<td>Number</td>
</tr>
<tr>
<td>North Eastman</td>
<td>Females</td>
<td>83</td>
<td>449.4</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>27</td>
<td>148.2</td>
</tr>
<tr>
<td>Total NE</td>
<td></td>
<td>110</td>
<td>298.0</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Females</td>
<td>2,335</td>
<td>399.3</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>914</td>
<td>160.9</td>
</tr>
<tr>
<td>Total Manitoba</td>
<td></td>
<td>3,249</td>
<td>281.8</td>
</tr>
</tbody>
</table>

Sources:

In NE when comparing 2000 and 2001, the Manitoba rate appeared not to have changed, at 281.8/100,000. NE appears to have a higher rate of Chlamydia during both time periods when compared with Manitoba.
Table 7.43 Number of Chlamydia Cases in NE

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>Rate/100,000</th>
<th>Number</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman Total Cases</td>
<td>157</td>
<td>397.62</td>
<td>154</td>
<td>390.02</td>
</tr>
</tbody>
</table>


In NE the rates of Chlamydia appeared to increase during 2002 and 2003. Issues such as age, limited physician and public health nursing resources, social and economic vulnerability of communities and geographic isolation all play a part in our ability to control this disease.  

Gonorrhea

The overall Manitoba trend indicates that the rate of gonorrhea had leveled and then increased between 1999 and 2001. This is a concern given the downward trend that was evident in the mid-1990s.

Table 7.44 Gonorrhea: Age Standardized Rates (per 100,000)

<table>
<thead>
<tr>
<th>Geographic</th>
<th>Gender</th>
<th>Number</th>
<th>Age Standardized</th>
<th>Number</th>
<th>Age Standardized</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>Females</td>
<td>34</td>
<td>190.5</td>
<td>23</td>
<td>126.3</td>
</tr>
<tr>
<td>North Eastman</td>
<td>Males</td>
<td>25</td>
<td>138.7</td>
<td>18</td>
<td>102.1</td>
</tr>
<tr>
<td>Total NE</td>
<td>Females</td>
<td>59</td>
<td>164.1</td>
<td>41</td>
<td>113.9</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Females</td>
<td>335</td>
<td>57.3</td>
<td>302</td>
<td>51.8</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Males</td>
<td>358</td>
<td>63.0</td>
<td>342</td>
<td>60.3</td>
</tr>
<tr>
<td>Total Manitoba</td>
<td></td>
<td>693</td>
<td>60.1</td>
<td>644</td>
<td>56.0</td>
</tr>
</tbody>
</table>


During 2000 & 2001, NE appears to have had a considerably higher rate of gonorrhea than the Manitoba average. Females in NE have the highest number of cases of gonorrhea. Gonorrhea cases appear to have increased in both NE and in Manitoba overall when 2001 is compared with 2000.
**Table 7.45 Number of Gonorrhea Cases in NE**

<table>
<thead>
<tr>
<th>Gonorrhea</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Cases</td>
<td>Rate/100,000</td>
<td>Number Cases</td>
</tr>
<tr>
<td>North Eastman Total Cases</td>
<td>67</td>
<td>169.68</td>
</tr>
</tbody>
</table>


NE appears to have had an increase in Gonorrhea rates during 2003.

The Manitoba Health target goal is the elimination of gonorrhea by 2010. \(^{231}\) “Similar to Chlamydia, target control strategies are required to address a variety of demographic, social, cultural and geographic issues.”

**Human Immunodeficiency Virus (HIV) Infection**

**Overview of Cases in Manitoba**

From 1985 to June 30, 2002, there was a total of 1,028 individuals (822 males and 206 females) testing HIV antibody positive in Manitoba. At the time of testing 83% of cases were residents of Winnipeg, while 13% resided outside of Winnipeg; 3% from out of province and 1% missing or unknown geographic information. \(^{232}\)

**Ethnicity**

Ethnicity is self-reported when cases are newly diagnosed. The self reported ethnicity of newly diagnosed cases provides… “information is important as it further characterizes at –risk populations to support targeted HIV prevention and planning initiatives...[or] facilitate the allocation of resources for education and treatment programs within RHA’s...” \(^{233}\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>29% Unknown / Missing</td>
<td>38% Aboriginal</td>
<td>32% Caucasian</td>
</tr>
<tr>
<td>28% Aboriginal</td>
<td>24% African American</td>
<td>14% Unknown / Missing</td>
</tr>
<tr>
<td>19% Caucasian</td>
<td>0 Asian</td>
<td>4% Asian</td>
</tr>
<tr>
<td>2% Other</td>
<td></td>
<td>2% Other</td>
</tr>
</tbody>
</table>


**Transmission**

Roughly 90% of all HIV antibody positive individuals diagnosed between January 1985 and December 2002 (excluding cases with missing/unknown mode of transmission n=46), men having sex with men (MSM), injection drug use (IDU) and heterosexual activity with person(s) at risk of HIV are the causes of transmission of HIV. \(^{234}\)
Age of HIV Positive Cases Among MSM Risk Profile

In Manitoba, overall, there was an observed increase from 59% (1985-1994) to 79% (January 1995 to June 2003) in individuals 30 years and older. A decrease in cases aged 20 and younger from 39% during 1985 to 1994 to 20% for the period 1995 to June 2003.

Table 7.46  Number of Cases in North Eastman Testing HIV Antibody Positive

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>Males</td>
<td>0</td>
<td>suppressed</td>
<td>suppressed</td>
<td>Total: 4</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>0</td>
<td>0</td>
<td>suppressed</td>
<td></td>
</tr>
<tr>
<td>Total (includes some out of province tested in Manitoba)</td>
<td>Males</td>
<td>26</td>
<td>41</td>
<td>755</td>
<td>822</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>16</td>
<td>29</td>
<td>161</td>
<td>206</td>
</tr>
</tbody>
</table>


Acquired Immunodeficiency Syndrome (AIDS)

From 1985 and June 2003 there was a total of 218 cases of AIDS reported in Manitoba. Of those reported, 76% or 166 individuals have died. There is a delay in reporting deaths, so this number may be underreported for the time period.

There were no reported cases of AIDS in North Eastman during this time period.

2003 Focus Groups on STD's

YOUTH

Sexually Transmitted Diseases – This topic emerged only in Winnipeg River.

"...could be ...a health issue because more and more people are having sex at a younger age...people think it's not a big deal, or it can't happen to them." [Winnipeg River]
Enteric, Food and Waterborne Illnesses

Salmonellosis

This foodborne illness typically occurs in individuals who are more susceptible i.e. the very young and elderly, and often occur in familial clusters.

Salmonellosis is a bacterial disease that manifests itself with sudden onset of headache, abdominal pain, diarrhea, nausea and sometimes vomiting. The source is infected feces of animals, persons or food that is raw (eggs), undercooked meat or contaminated water. Oral transmission occurs from the fecal – oral route if diarrhea symptoms are present and handwashing is poor.238

In 2001, the overall rate of salmonellosis decreased in Manitoba to 15.1/100,000 from 16.6/100,000 in 2000. Cases were evenly distributed between males and females. Most cases peaked in June, although cases occur throughout the year. Food was the most common source reported at 43.1%. In the remaining cases the source of infection was unknown. Where the setting was known it was most frequently in the home at 27%, and travel 16.1%.239

Table 7.47 Salmonellosis Number and Age Standardized Rate per 100,000

<table>
<thead>
<tr>
<th>Geographic</th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases</td>
<td>Age Standardized</td>
</tr>
<tr>
<td>North Eastman Total</td>
<td>7</td>
<td>17.8</td>
</tr>
<tr>
<td>Manitoba Total</td>
<td>174</td>
<td>15.1</td>
</tr>
</tbody>
</table>


The number of cases appears to have increased in NE in 2001 when compared with 2000. For 2001 NE appears to have a higher rate of salmonellosis than Manitoba.

Table 7.48 Number of Salmonellosis Cases in NE

<table>
<thead>
<tr>
<th>Salmonellosis</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate / 100,000</td>
</tr>
<tr>
<td>North Eastman Total Cases</td>
<td>3</td>
<td>7.60</td>
</tr>
</tbody>
</table>


In NE the rate appears to have shown a slight increase during 2003.
Shigelloidalis

Shigella is an acute bacterial disease, characterized by diarrhea and fever, abdominal cramps, nausea and sometimes toxemia. Stools typically contain blood and mucus. The reservoir is humans and the source is usually feces of infected humans with diarrhea. Contaminated food, and water are also potential sources. Transmission is person to person or fecal-oral. 240

There appeared to be no reported cases of Shigelloidalis in NE between 2000 to 2003.

A total of 12 cases and 24 cases were reported in Manitoba in 2001 and 2000 respectively. 241

Verotoxigenic E. Coli (VTEC) Infection [includes 0157:H7]

Verotoxigenic E. Coli is a Gram-negative bacterium serotype. A patient will present with acute diarrhea, often bloody, abdominal pain and vomiting. Complications are most common in children under 14 years of age and the elderly. Most infections are foodborne, resulting from inadequate cooking of contaminated food or cross-contamination during food preparation. Transmission may occur through contaminated water or secondary fecal/oral route. Peak occurrences occur in Manitoba in July and August. 242

Table 7.49 Verotoxigenic E. Coli Number and Age Standardized Rate per 100,000

<table>
<thead>
<tr>
<th>Geographic</th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases</td>
<td>Age Standardized</td>
</tr>
<tr>
<td>North Eastman Total</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>Manitoba Total</td>
<td>63</td>
<td>5.5</td>
</tr>
</tbody>
</table>


The number of cases appeared not to have changed during both years reviewed. The rate in NE appeared to be similar to the Manitoba rate for 2002.

Table 7.50 Number of VP-E Coli VTEC Positive Cases in NE

<table>
<thead>
<tr>
<th>VP-E. Coli VTEC Positive</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate / 100,000</td>
</tr>
<tr>
<td>North Eastman Total Cases</td>
<td>2</td>
<td>5.07</td>
</tr>
</tbody>
</table>


There were no reported cases of VTEC during 2002 and two cases in 2003.
Tuberculosis (TB) [includes respiratory, non respiratory and primary]

TB is caused by the bacterium mycobacterium tuberculosis or M tuberculosis complex. More than 90% of cases are asymptomatic at the time of primary infection. Transmission of pulmonary TB is person to person via inhalation of bacteria.

In Manitoba there has been an increased incidence recently. Most cases of newly active TB arise from risk groups such as: Aboriginal persons, persons living with individuals diagnosed with active TB, persons who previously had active TB, persons with presumed inactive TB, immigrants from countries where TB is common, substance abusers, homeless people, residents of extended care homes and staff and inmates of correctional institutions, preschool children in high risk communities, health care workers, those with cellular immunosuppression.

The risk of infection is directly related to the degree of exposure. 243

Table 7.51 Tuberculosis Number and Age Standardized Rate per 100,000

<table>
<thead>
<tr>
<th>Geographic</th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases</td>
<td>Age Standardized</td>
</tr>
<tr>
<td>North Eastman Total</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Manitoba Total</td>
<td>111</td>
<td>9.6</td>
</tr>
</tbody>
</table>


In 2001 there were no reported cases of TB in NE. Despite this, the rate of TB increased in Manitoba from 8.5 in 2000 to 9.6 in 2001. In 2000 the rate of TB was similar in NE as it was in Manitoba.

Table 7.52 Number of TB Cases in NE

<table>
<thead>
<tr>
<th>Tuberculosis (TB) – Respiratory and Non Respiratory</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate/100,000</td>
</tr>
<tr>
<td>North Eastman Total Cases</td>
<td>4</td>
<td>10.13</td>
</tr>
</tbody>
</table>

Source: Beaudoin, Carole, Dr. (2004) Epidemiologist, Communicable Disease, Manitoba Health. Email to Carol Orvis June 21 entitled; cd and std data request.

During 2003 there were a total of four cases of TB reported in NE.
2003 Focus Group on Public Health Comments

**YOUTH**
- Public Health Nurse does presentations but, "...they are kind of boring...mostly about sex..."
  [Winnipeg River]
- In Seymourville the youth were able to describe some of the health services or supports available e.g. Public Health Nurse and the Diabetes Education Resource (DER) team, the clinic at Hollow Water First Nation if they "got sick", a youth group, Girls Group that the Family services and Outreach Worker and Counselor lead
- Afraid to ask about reproductive health issues as not private if one goes to the clinic, everyone would know.
  [Seymourville]

**Suggestions Raised by Youth**
- Would like more health promotion – more commercials, more health-related movies in schools, "Show us that being healthy, in your mind and body, is actually a better way to live than just doing whatever." [Blue Water]
- "Legalize marijuana for medical purposes. ...just for pain...for people who need it to survive another day." [Iron Rose]
- Often health services are not used because they come to the community during school hours. [Seymourville]
- A nurse coming to the school would increase the use of the service. [Seymourville]
  - Would like a social worker. [Seymourville]

**YOUNG ADULT**
- Public Health Nurse is often the main point of entry to the health care system and is often trusted and felt they often give better service than from local physicians. [Winnipeg River].
- Would like to see Public Health Nurse more visible... more preventive things. [Iron Rose]
  "...If she had a visible presence and they could feel comfortable with her, they would come to her...when you're 16, you're not listening to your parents..." [Iron Rose]
- Would like to see sex education discussions. [Seymourville]

**Note:** During the 1997 Focus Groups, it was mentioned also that Public Health Nurses (PHN) in schools would be good to have.
CLIENT /COMMUNITY FOCUS – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA).

<table>
<thead>
<tr>
<th>Participation and Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The client and/or community actively participates as a partner in decision making, and in service planning, delivery, and evaluation. (CCHSA)”</td>
</tr>
</tbody>
</table>

2003 Acumen Research Survey – NE Findings - on Rating Health Promotion Services

**Q- How would you rate your experience with health promotion services?**

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>46%</td>
<td>26%</td>
<td>25%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>


2003 Acumen Research Survey – NE Findings - on Importance of Community Services

**Q- How important: community services such as public health or mental health?**

<table>
<thead>
<tr>
<th>Extremely Important (5)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Not at all important (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>28%</td>
<td>21%</td>
<td>7%</td>
<td>4%</td>
</tr>
</tbody>
</table>


Females were almost 50% more likely than males to indicate that community services were highly important.
Program Consultations

a) Flu Clinic Season Survey – October – November 2003

During the flu clinic, 200 surveys were distributed to the public. The following provides information about the results:

*Figure 7.43 Public Health Consultation – Waiting Times During 2003 Flu Clinic*

![Waiting Period Bar Chart]

The survey results were very positive. Most people learned of the clinic through their local newspaper.

b) Post Partum Courses are evaluated by participants after each five week course.
c) **Post Partum Referral Surveys** In March 2003 100 surveys were distributed to Post Partum referral clients. Thirty-nine were returned.

- Ninety-seven percent of respondents felt the visit benefited them at the time. Those who did not mentioned it was a little early.

- The top three most helpful parts of the visit were:
  - the infant health assessment (22)
  - the ability to get questions answered (12) and
  - breastfeeding/lactation (10)

- All of the respondents felt the information met their needs.

- Ninety-five percent of respondents mentioned that the information package presented at the time of the visit was helpful. Reasons that it was not included: too much information, some outdated information, no time to read information and some of the information was a duplication of what was received in the hospital.

Overall the survey responses were positive about the post partum visit.
Public Health Surveillance

"Mechanisms."  

Disease surveillance is necessary to assess the effectiveness of these programs in preventing breast and cervical cancers. Although these are health practices by residents in NE, in the Manitoba’s Health Performance Measurement Framework, the category is placed under Public Health Surveillance.

Breast Cancer Screening

This is defined as the percentage of women ages 50 to 69 that had at least one mammogram in a two-year period.

“In order for a screening program to reduce mortality in a population, that population must participate in the program in sufficient numbers. A participation rate of 70% and over was achieved in trials reporting mortality reductions.”

In 1995 the Manitoba Breast Screening Program (MBSP) began offering breast screening to women between 50 and 69 years. Screening in other age groups is done through physician consultations. In NE, we have the ability to access screening through the mobile unit. The target-screening rate is 70% or over in the MBSP. From April 2001 to March 2003 the MBSP screened 49% of the population aged 50-69 years. The screening rate goal has not yet been achieved. In NE the screening rate was approximately 54% from 2001 to 2003.

Table 7.53 NE Participation Numbers for Three Years: 2001-2003

<table>
<thead>
<tr>
<th>Age Group</th>
<th>North Eastman</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>48</td>
</tr>
<tr>
<td>50-64</td>
<td>677</td>
</tr>
<tr>
<td>55-59</td>
<td>599</td>
</tr>
<tr>
<td>60-64</td>
<td>550</td>
</tr>
<tr>
<td>65-69</td>
<td>388</td>
</tr>
<tr>
<td>70+</td>
<td>65</td>
</tr>
<tr>
<td>All ages</td>
<td>2,327</td>
</tr>
</tbody>
</table>

50-69 – Targeted Group 2,214


NE Breast Screening Rate was 54% between 2001 and 2003. The program target is 70%.
### Table 7.54 Breast Screening Attendance at all NE sites from 1999 to 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NE</td>
<td>585</td>
<td>936</td>
<td>692</td>
<td>1001</td>
<td>629</td>
</tr>
<tr>
<td>Total</td>
<td>1,062</td>
<td>1,327</td>
<td>1,063</td>
<td>1,333</td>
<td>1,047</td>
</tr>
</tbody>
</table>


### Figure 7.46 Breast Screening Rates - NE Region

NE has shown a significant increase breast cancer screening during the two time periods.

NE is statistically significantly higher than the Manitoba average during both time periods.

When we look at April 1, 2000 to March 31, 2002, we see that NE had a rate of 527.9/1000 women screened aged 50-69 years, as compared to Manitoba at 476 / 1000. NE appears to have a higher screening rate when compared to Manitoba.

### Figure 7.47 Breast Cancer Screening - NE Health Districts

Except for Northern Remote, all our health districts have had a significant increase in the number of women screened for breast cancer.

Springfield, Winnipeg River, Brokenhead had significantly higher number of women screen when compared with the Manitoba average and Rural South during the later time period. This is a really positive finding.
Cervical Cancer Screening

The screening rate looks at the percentage of women ages 18 through 69 years who had at least one Papanicolau (PAP) smear within a three-year period.

Figure 7.48 Cervical Screening Rates - NE Region

The number of women who had Pap Tests statistically significantly increased during the two years reviewed, which is good news.

NE is statistically significantly lower than the Manitoba average during both time periods, but not significantly different than Rural South during the second time period.

During the time period, April 1 1999 to March 31, 2002, NE had a cervical cancer screening rate of 587.9 per 1000 women 15 years and older, as compared with Manitoba’s rate of 595/1000 during the same time period. 251

In the last few years, the Primary Health Care Program in NE has made a great effort to increase the number of PAP tests done on women in our region by holding clinics in the various health centres.

Over 200 women received Pap smears in 2002-2003 clinics held in NE region. 252
There has been a significant increase in the percentage of women who had Pap tests in Springfield and Brokenhead. Only Springfield’s screening rate is statistically significantly higher than the Manitoba average, whereas Iron Rose, Blue Water and Northern Remote percentage rate is significantly lower than the Manitoba average and Rural South during the later time period.

Northern Remote appears to have the lowest rate of Cervical screens when compared to our other health districts.

Springfield had the highest the percentage of Pap Test screens when compared with our other health districts and is significantly higher than Manitoba and Rural South during the later time period.

_Adult immunization information is located in Section 6 - Determinants of Health 6.5._
7.6.3 Quality & Organizational Development Program

Overview

In the North Eastman Health Association the commitment to excellence is of strategic importance and is part of how the organization is nurtured and sustained.

There has been a recent focus on integrated planning, regional strategies, actions and measurement in a region wide Performance Measurement Reporting System. This is the same measurement system being used by the CHA report.

This program implements the Corporate Scorecard and Dashboard indicators to assist in turning data and information into knowledge in order to enhance decisions.

Risk Management

The North Eastman Health Association is committed to providing quality care and service to all clients in a safe and secure environment. Through a systemic and coordinated approach to Risk Management we strive to ensure that efficient and effective processes and systems are in place to manage risk within the organization. Risk Management is an organization wide issue that does not exist in isolation, but as part of several regional coordinated activities. Integrated Risk Management requires looking across all aspects of care and service delivery to better manage risk.

The Board of Directors has governance responsibility for risk. We ensure there are mechanism in place to control, minimize and manage risk in a systemic way utilizing a quality improvement approach that encompasses the continuum of care.

Risk is managed to ensure desired outcomes are achieved and strengthen processes through sharing of analyses and actions implemented to minimize and manager risk. Development and promotion of a risk management culture is ongoing.

Accreditation

Another program that is coordinated through the Quality and Organizational Development Program is accreditation. NEHA went through another successful accreditation review in June 2002.
2003 Focus Group – Quality of Health System

YOUTH

- “It’s good in Canada because if you need it, you get it for free.” [Blue Water]
- Youth seemed to have formed opinions about the quality of the medical care.
  “...they really don’t have a lot of resources here to deal with some problems, depending on how severe they are.” [Iron Rose]
  “If you have a car accident you have to be rushed to Pinawa Hospital and that’s a good drive sometimes and it could be too late.” [Iron Rose]
- Others felt access to services was adequate, especially since, “…you can drive to Winnipeg. They have good services in Winnipeg.” [Iron Rose]

- When youth discussed what is important regarding health care they mentioned: “That you can trust the people that are taking care of you…” [Iron Rose]
- When asked if appropriate health programs are readily available in their community the Seymourville youth indicated that
  “No, the ambulance is too far away.” “There is no doctor available in the community and the Doctor’s office is only open during the day.” [Seymourville]

Suggestions Raised by Youth

- Often health services are not used because they come to the community during school hours. [Seymourville]
- Transportation is a barrier in accessing medical services. [Seymourville]
- “More homeopathy and less dependency on hospitals.” [Iron Rose]
- “Better facilities and more competent doctors...better equipment, not this 70’s stuff.” [Iron Rose]

MIDDLE ADULTS

Suggestions Raised by Middle Adults

- More compensation for volunteer drivers. [Iron Rose]
- Better compensation for foster parents. [Winnipeg River]
- A smaller handivan for one or two people. [Blue Water]
- Smaller more efficient vehicle for patient transfer. [Blue Water]

Note: During the 1997 Focus Groups in Seymourville it was mentioned about needing more parenting sessions, doctor visits to the community and transportation to medical services.

2003 Acumen Research Survey – NE Findings – Addressing Health Concerns

Q- When I have a concern about the health care system in my region, I know where to go to get my concern addressed.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neither agree or disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26%</td>
<td>32%</td>
<td>6%</td>
<td>18%</td>
<td>20%</td>
</tr>
</tbody>
</table>


Almost three out of five NE respondents either strongly agreed or somewhat agreed that they knew where to go to address a health care concern. These respondents were more likely to be 18-24 or over 65 years of age. 255

Two out of five NE respondents did not know where to go to address a health care concern.
7.7 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

Overview of NEHA Health Services

Overview

- NEHA is responsible for the delivery of a broad range of health services both in a facility and within our communities and also includes Spiritual Care, Palliative Care and Volunteer services.

- Health partners provide NEHA with essential linkages to other organizations and their work. Alternative care is also an option for NE residents, females appearing to utilize alternative care more than males in our region.

Health System Characteristics

- Females appear to utilize our health system more than males with a cost difference in 2001/2002 of $67.00 for males and $85.00 females.

Health System Performance

- Accessibility was an area that focus group participants raised as a concern especially in the area of transportation and the lack of availability of some non-medical itinerant services for example audiologists and speech language services. There was also concern raised about whether high-risk vulnerable groups in our community were aware of some health services.

- When two out of five NE surveyed respondents from the 2003 Acumen Research Survey did not know where to go to address a health care concern, it would appear that there is still some work to be done on our communication strategies.

- Staffing issues were identified as the top concern in 2001 dropping to third place as a concern in 2003.

- There appears to have been a decrease in the number of workplace injuries in 2003. Overexertions when lifting was the most frequent cause of injuries between 2001 and 2003.

- Staff influenza immunization rates appear to be on the rise for the last few years.
Health System Infrastructure

- Funding allocated to community programs have been increasing from 1999 to 2002 within NEHA. This reflects a paradigm shift in health programming with more emphasis on health promotion and prevention, and the desire to provided health care needs in communities.

Physician Services

- NE residents appear to have more contact with health professionals during 2001 than other Manitobans overall.
- Over 99% of Acumen 2003 Research Survey respondents have a regular health care provider.
- During 2000/01 there was a significant decrease in the number of residents who had a least one ambulatory visit to a physician.
- Many focus group participants in 2003 indicated that waiting times to either get an appointment, or waiting to see a physician in a clinic setting was unacceptable.
- Blue Water has the highest number of physician visits (including specialists) and Springfield has the least number of visits.
- NE ambulatory consultation (usually specialist) visits have increased significantly although we are significantly lower than the Manitoba average.
- During 2001/02 NE had a ratio of one physician for every 3,574 residents, the Manitoba average was one physician for every 783 residents.
- Approximately 33% of Acumen 2003 Research Survey respondents indicated that it may be difficult to access a health care provider.
- Approximately one quarter of physician visits occurred in Winnipeg by NE residents during 2000/01.
- Many focus group participants would like to see more visiting specialists hold clinics in NE region.
- Overall the number of consultations is increasing, this might be an ideal opportunity to investigate the possibility of having more visiting specialists come to our region. It was an area that many Focus Group participants would like to see increased.
NEHA Health Care Programs

Acute Care

- ER visits have increased from 1998 to 2004 in Pinawa and Beausejour. Pine Falls has seen an increase during 2003-2004 compared with 2002-2003. Pine Falls has the highest number of ER visits.

- Focus group concerns were raised about emergency services with respect to
  - At times residents are referred to other sites or services
  - Unable to see a physician.
  - No alternatives in the community during evenings, nights and weekends to receive care for non-emergency services.

- Admissions were consistent over the past several years.

- Numbers of beds in 2000 were 2.88 beds per 1000 residents compared with Manitoba at 3.82 beds/1000 residents.

- The top three reasons NE residents utilized hospital services was for:
  - Pregnancy, childbirth and puerperium
  - Disease of the Circulatory system
  - Disease of the Digestive system

- Focus groups, and 2003 Acumen Research Survey and the Acute Care Survey respondents indicated that they felt that overall hospital services were excellent to very good.

- Angioplasty and Coronary artery bypass graft surgery increases significantly in NE.

- Knee replacements have increased significantly in NE. Iron Rose had the highest number of knee replacements compared with our other health districts.

- CT scans increased significantly. Blue Water had the highest number of CT’s performed within NE.

- Diabetes, Asthma, Essential hypertension and Neurotic Disorders were illnesses that were treatment in hospital that potentially could have been managed in a clinic setting. This could be an area to investigate screening and clinics specific to these illnesses.

- The number of short stay days was significantly higher in NE compared with Manitoba. Long stay days was not significantly different than the Manitoba rate.

- Dialysis visits in Pine Falls have remained stable for the past four years.

- Diagnostic services have upgraded some of their equipment. Computerized radiography is now available. The number of laboratory and X-ray tests has increased over the past several years.
Focus group participants expressed some concern about the waiting time to receive some services e.g. CT, MRI, ultrasound and the turn around time of some tests. Most residents would like to access diagnostic services within NE or in a local rural centre for example Selkirk rather than going to Winnipeg.

Long Term Care

- There are 191 residents in NEHA PCH facilities. The majority is female.
- The average length of stay for males is 3 years and for females is 2.7 years.
- PCH resident immunization rates for pneumoccal and influenza are very good.
- Admissions vary depending upon the site, with East-Gate Lodge (EGL) consistently having the most number of admissions per year.
- As of March 2004, waiting times are the longest to get into Lac du Bonnet PCH at 381 days and the shortest to get into EGL at 76 days.
- Some Focus group participants in all the health districts expressed concerns either about long waiting times or the need for more PCH beds in our region.
- PCH residents appear to have a higher percentage of Levels 3 and 4 than Manitoba.
- Overall comments from the focus groups were favorable about PCH services.
- Family/Residents Surveys sent out during November 2002 had many positive comments about PCH services as well as some constructive suggestions.

Home Care

- The number of open cases has showed a significant increase between 1994 and 2000.
- Focus group participants overall felt that home care services were good, however there was concern expressed about: wanting more home care hours, extension of services i.e. housekeeping, not enough staff.
- The average number of days of care is significantly higher in NE compared with Manitoba.
- Home care survey conducted in the spring of 2003 had the following percents of positive responses about referral and assessment (68%), implementation of service (70%) Performance of staff (83%), and quality of service 44% with 51% having no response).
Primary Health Care

- Primary Care Clinic Direct contacts have increased over the past three years.

- The surveys and focus group participants have consistently had positive responses about the primary health program. The nurse practitioners were seen by many focus group participants as a valuable asset to the team, providing service especially when physicians could not be accessed.

- 34% of NE Acumen Survey respondents used health promotion services.

Mental Health

- Mental health open cases and active case files fluctuated in all programs: adult, child and adolescent and elderly over the last three years.

- Focus group comments about mental health consisted mainly of concerns around: awareness, not enough supports, stigma associated with accessing services, and identifying at risk people in the community.

Emergency Medical Services

- Beausejour site has the highest number of ambulance trips within NE.

- Overall ambulance trips have been increasing over the past five years.

- Focus group comments about EMS services centered around: arrival times especially in the Whitemouth/Whiteshell areas, some confusion over 911 usage.

- Other comments raised by EMS staff and public included: costs of transport, lack of positions, rough riding ambulances and need for additional communication equipment.
Public Health

Overall there has been an increase in direct contacts by all public health programs when comparing 2002/03 with 2003/04.

Influenza immunizations (public) have increased steadily from 1999 (1,431) to 2003 (3,707).

Sexually Transmitted, Communicable and Reportable Diseases in NE:

- Chlamydia cases have increased slightly in 2003 compared with 2002.
- Gonorrhea cases have increased slightly in 2003 compared with 2002.
- HIV cases have been suppressed in NE due to low numbers.
- Salmonellosis cases have increased slightly compared with 2002.
- There were no Shigellosis cases reported between 2000 and 2003.
- E. Coli cases increased in 2003 compared with 2002.
- TB cases have increased slightly in 2003 compared with 2002.

Focus group comments were overwhelmingly positive about public health services. One comment from youth was that they would like to see a nurse more in the schools.

Screening in NE:

- NE breast screening rate was 54%, the target being 70%.
- Women in NE are going for more PAP tests, but we are still significantly lower than the Provincial average. Only Springfield’s rate is significantly higher than Manitoba, whereas Iron Rose and Blue Water are significantly lower than the Manitoba average.

Quality Program

- Overall focus group participants and other consultations done by programs had many positive things to say about NEHA health services
- Some areas that seem to come up repeatedly were: transportation issues especially in Seymourville were raised, as well as the desire to access local services rather than travel to Winnipeg, lack of specialists and the need to ensure doctors once recruited remain in our area.
## Summary at A Glance

### KEY
- **Partner**: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor**: refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA**: a program or service could be enhanced or developed to address this issue.

### Strengths
- Focus group participants, resident's surveyed, program surveys all indicated that overall they felt that NEHA services were excellent / very good. [NEHA]
- Public influenza clinics saw an increase over the past 4 years. [NEHA]
- Over 99% of resident's surveyed had a regular health care provider. [NEHA, Partner, Monitor]

### Issues Having Implications for Health Planning & Delivery
- Two out of five respondents surveyed did not know where to go to address a health concern. [NEHA]
- Timely access to CT, MRI and ultrasound as well a timely turn around time for some lab tests were concerns raised by some focus group participants. [NEHA, Partner, Monitor]
- Accessibly was a concern raised by may focus group participant e.g. transportation wasn’t always available, nor were some services available locally. [NEHA, Monitor]
- ER visits are increasing. ER services is an area that some focus group participants felt were not acceptable in relation to accessing a physician, and receiving services. [NEHA, Partner, Monitor]
- Communicable / Reportable diseases have increased slightly in NE: Chlamydia, Gonorrhea, Salmonellosis, E. Coli and TB. [NEHA, Monitor]
- Workplace injuries have decreased, but remain an area of concern. [NEHA, Partner, Monitor]
- Staff Influenza rates are increasing, but need to increase further. [NEHA, Partner, Monitor]
- Many focus group participants and some survey respondents felt that waiting times to get a physician appointment or waiting to see a physician in the clinic were unacceptable [NEHA, Partner, Monitor]
- NE ambulatory consultation visits increased significantly, although were significantly lower than the Manitoba average. Focus group participants would like to see more visiting specialists. [NEHA, Partner, Monitor]
- Diabetes, Asthma, Essential Hypertension and Neurotic Disorders were often treated in our hospitals, where they could have potentially been managed in a clinic setting. [NEHA, Partner, Monitor]
- Long waiting times to see physicians and some other health related services raised by some focus group participants. [NEHA, Partner, Monitor]
- Some focus group participants felt that more PCH beds were needed. [NEHA, Partner, Monitor]
- Mental health concerns by focus group participants were about the need for more mental heath supports, concern over the stigma when accessing services and being able to identify people in the community at risk. [NEHA, Partner, Monitor]
- Issues surrounding EMS by focus group participants and staff include: long arrival times, cost of transport, rough ride, the need for more staff and some confusion about 911. [NEHA, Partner, Monitor]
**KEY**

- Partner: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- Monitor: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.
- NEHA: a program or service could be enhanced or developed to address this issue.

<table>
<thead>
<tr>
<th>Issues Having Implications for Health Planning &amp; Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast screening rate is 54%, the target being 70%. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Pap testing rates in NE continue to be significantly lower than the Manitoba average. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>More visible public health nurses in the schools was a request by focus group youth. [NEHA, Partner, Monitor]</td>
</tr>
</tbody>
</table>
7.8 REFERENCES

1. NEHA Annual Report (2002/03) p. 3.
68 NEHA Annual Report 2002/03. P. 44.
69 NEHA Board Policies, pg.50-51.
75 NEHA. Spiritual Care Pamphlet.
76 NEHA. Spiritual Care Pamphlet.
87 NEHA Staff Satisfaction Survey Results. Human Resources Department. (2003)
88 NEHA Staff Satisfaction Survey Results. Human Resources Department. (2003)
Section 7- Regional Health Services

100 Magnusson, Brian. (2004) Email sent to Suzanne Dick September 7 entitled: Staff Mgmt Ratio and Turnover Rates
117 Magnusson, Brian. (2004) Email sent to Suzanne Dick September 7 entitled: Staff Mgmt Ratio and Turnover Rates
120 Drabky, R. IT Coordinator. Email to Suzanne Dick. April 26, 2004 entitled: RE: CHA.
135 NEHA Annual Report 2002/03. P. 34.


Dent, L. (2003) Email Program Consultations With Clients , June

Dent, L. (2003) Email Program Consultations With Clients , June


8.1 GEOGRAPHICAL OVERVIEW ................................................. 8-1
8.2 COMMUNITY SYSTEM CHARACTERISTICS ............................... 8-4
8.3 HEALTH STATUS ..................................................................... 8-9
   Overview ............................................................................. 8-9
   Significant Indicators Measuring Overall Health Status .............. 8-10
   Deaths .............................................................................. 8-13
   Health Conditions .............................................................. 8-17
   Human Function ............................................................... 8-25
8.4 DETERMINANTS OF HEALTH ................................................. 8-26
   Environmental Factors .......................................................... 8-27
     Water .............................................................................. 8-27
     Air ................................................................................. 8-28
     Housing .......................................................................... 8-29
     Safety ............................................................................. 8-30
   Biology & Genetic Endowment ................................................. 8-32
   Personal Health Practices & Lifestyle ........................................ 8-33
     Overview .......................................................................... 8-33
     Dietary Practices .............................................................. 8-34
     Alcohol Consumption ....................................................... 8-35
     Physical Activity ............................................................. 8-36
     Smoking Practices ........................................................... 8-37
     Medication Use ............................................................... 8-38
   Healthy Child Development ..................................................... 8-41
     Overview .......................................................................... 8-41
     Infant Mortality Rates ........................................................ 8-41
     Births .............................................................................. 8-41
     Adolescent and Teenage Pregnancy ....................................... 8-43
     Breastfeeding Practices ....................................................... 8-44
     Birth Weights ................................................................... 8-45
     Childhood Immunizations .................................................... 8-46
     Community Feedback on Healthy Child Development ............. 8-48
   Living and Working Conditions ............................................... 8-49
     Overview .......................................................................... 8-49
     Social Economic Status ...................................................... 8-50
   Personal Resources ............................................................. 8-52
     Social Support ................................................................... 8-54
8.5 SUMMARY/CONCLUSION ........................................................ 8-57
8.6 REFERENCES ........................................................................... 8-64
8.1 GEOGRAPHICAL OVERVIEW

The Springfield District consists of the Rural Municipality of Springfield that borders Transcona, with Winnipeg on the east, by the municipalities of St. Clements and Brokenhead on the north, Reynolds Municipality on the west and Tache Municipality on the south. It is approximately 800 square miles, the largest rural municipality in Manitoba. It is also the first rural municipality in Manitoba, constituted in 1873.

The economic base of the health district is varied and includes livestock production, agricultural, timber harvesting, granite and aggregate extraction, small business and tourism.

Oakbank is located on Highway 206, 6 km. south of Birds Hill Provincial Park. It is the largest community in the district and is growing yearly. The country charm of Oakbank attracts a large number of residents who commute to the City of Winnipeg, a short twenty-minute drive away. Residential and commercial development is expanding at a vigorous pace.

Currently a new housing development is underway in the southwest corner of the community of Oakbank. Construction began in 2003. Stage 1 consists of 40 homes. The plan is that once 75% of Stage 1 homes are sold, Stage 2 and then 3 of the project will commence with a further 100 homes to be constructed.

The Kin Place Health Complex was constructed in Oakbank and opened in October 2000. The facility consists of a 40-bed Personal Care Home and attached Primary Health Care Centre which provides a “one stop shopping” for health care services.

Dugald is the second largest community in the municipality and its situated on Highway #15, 6 kilometers south of Oakbank. A new of 55+ condominium home development is in progress and currently there are 8 homes built, 2 of which are occupied. It is expected that 4-5 homes will be built each year and when complete there will be 27 self-contained units available.

Springfield Recreation Commission has one full time Recreation Director who works with the Anola, Zora, Hazelridge, and Oakbank Community Clubs and the Springfield Curling Rink to ensure there are year round recreational and sport programs for all ages and skill levels.
The following tables list the municipalities and communities that fall under the Springfield Health District.

<table>
<thead>
<tr>
<th>SPRINGFIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 12,099 in 2003</td>
</tr>
<tr>
<td>RM Springfield (146)</td>
</tr>
<tr>
<td>- ANOLA- ROEAO</td>
</tr>
<tr>
<td>- DUGALD- ROEOKO</td>
</tr>
<tr>
<td>- HAZELRIDGE – ROEOYO</td>
</tr>
<tr>
<td>- OAKBANK-ROE1JO &amp; ROE1J1&amp;ROE1J2 &amp; ROE1J3</td>
</tr>
<tr>
<td>- Cook’s Creek</td>
</tr>
<tr>
<td>- Deacon’s Corner</td>
</tr>
<tr>
<td>- Glass</td>
</tr>
<tr>
<td>- Heartland Colony</td>
</tr>
<tr>
<td>- Melrose</td>
</tr>
<tr>
<td>- Pine Ridge</td>
</tr>
<tr>
<td>- Prairie Glove</td>
</tr>
<tr>
<td>- Ridgeland Colony</td>
</tr>
<tr>
<td>- Sapton</td>
</tr>
<tr>
<td>- Springfield Colony</td>
</tr>
<tr>
<td>- Vivian</td>
</tr>
</tbody>
</table>

Source for Population – 2003
Sources for communities:
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA Report.

Geographical Changes:
- Unorganized Territories previously was a separate geographic area. In this report, depending upon the municipal code, communities have been re-allocated into the Winnipeg River, Iron Rose, Blue Water or Northern Remote districts.
- Northern Remote is a separate health district.
- Springfield has had no geographical boundary changes since the previous report.
- Brokenhead has had Seddon’s Corner re-allocated into the Winnipeg River district.
How Is Healthy Living Supported in Springfield?

Focus Groups On How The Community Promotes Or Supports Healthy Living

**Youth – Positive:** Local restaurant “under 6 grams of fat.” [Springfield]

**Young Adults** - Oakbank doctors generally liked. Oakbank Health Centre is open Wednesday evenings and Saturday “...absolutely fabulous...”. Nurse Practitioner is seen as very positive. Baby Clinics, Pre-school Clinics, Mother Goose Program from Recreation Commission, Prevention Services, and Wellness Day. Sign board outside the Primary Health Care Centre, Physiotherapist, and Chiropractor, having a lab in Oakbank.

**Seniors** - Oakbank Beautification Committee, Seniors Walk and Weight, hall walking, health care availability, trend toward prevention, positive experience with home care, personal care, nurse practitioner and meals program.

Kin Place Health Complex

Oakbank Wellness Coalition
Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Where information is available the sex of the individual is provided. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women. Gender influences affects age, education, socio-economic status, culture and physical environment.

Population Demographics

Figure 8.1 Age Profile of Springfield – 1995 & 2000

During the two time periods reviewed there has been a decline in the 1-9 and 30-39 age groups, with an overall increase in the 40-69 year olds and little change in the 70 to 90+ age groups.
Overview

There has been an association found that when education levels increase, the self-rated health status improves. Education is also closely linked with socioeconomic status. Effective education for children and life long learning for adults contribute to the health and prosperity of individuals.

Table 8.1 Percentage of Population with Less than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school age 20-34</th>
<th>% of population with less than high school age 35-44</th>
<th>% of population with less than high school age 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>19.6</td>
<td>22.5</td>
<td>30.2</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


In Springfield, there was more people aged 45 to 64 who had less than high school education. Overall, Springfield’s population with less than high school education was lower than both NE and Manitoba in all age categories.

Sunrise School Division

The Sunrise School Division was established in July 2002, a partnership of the former Agassiz School Division and the Springfield component of the former Transcona Springfield School Division. This re-structuring has affected staff and families due to boundary changes creating uncertainty in where some students will be attending school. This is especially prominent in the former Springfield / Transcona School Division affecting Springfield Health District.

The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counselors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have consultants in the following areas: Early/Middle Years, Senior Years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.

The Sunrise Support Centre is part of the Sunrise School Division and is located in Tyndall in the Brokenhead Health District. The Sunrise Support Center provides an alternative learning environment that readily meets individual student needs. It is a resource for community schools and agencies to assist with therapeutic...
intervention, behavioral change, substance abuse issues and ongoing academic success. One of the key elements of the program is a low student/teacher ratio. The focus is on the four core academic areas: Language Arts, Mathematics, Science and Social Studies. Programs are adjusted to each student’s individual need and reviewed on a regular basis. In addition to the academic instruction, there is a heavy emphasis on communication, anger management and direct teaching/intervention with respect to replacing negative behaviours.

The Sunrise Alternative Learning Program (SSLP) is another program in the Sunrise School Division and is also located in Tyndall. This is a self-directed academic program designed for students to work at their own pace in an alternative setting away from the regular school. Curriculum includes Work Experience, Life Skills, Woodworking, Music, Drama, Physical Education, Art and other core subjects. Students experience hands on learning, participate in a variety of field trips throughout the community and become involved within the community. Target groups are students not registered in the regular school system, drop-outs, young mothers, students on independent living, students with truancy problems, students involved with Justice and students who have been suspended from the regular school system. Students can be referred to SSLP by schools, Justice, Child & Family Services or parents and are required to be registered in their home school.

Table 8.2 Sunrise School Division – Springfield District

<table>
<thead>
<tr>
<th>SPRINGFIELD DISTRICT</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% graduate High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Anola Elementary</td>
<td>381</td>
<td>368</td>
<td>196</td>
<td>193</td>
</tr>
<tr>
<td>Ecole Dugald</td>
<td>no data</td>
<td>375</td>
<td>no data</td>
<td>169</td>
</tr>
<tr>
<td>Hazelridge School</td>
<td>55</td>
<td>44</td>
<td>no data</td>
<td>25</td>
</tr>
<tr>
<td>Oak Bank Elementary</td>
<td>523</td>
<td>501</td>
<td>268</td>
<td>262</td>
</tr>
<tr>
<td>Springfield Middle School</td>
<td>351</td>
<td>358</td>
<td>172</td>
<td>182</td>
</tr>
<tr>
<td>Springfield Collegiate Institute</td>
<td>671</td>
<td>672</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Grafton Colony</td>
<td>26</td>
<td>26</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Heartland Colony</td>
<td>20</td>
<td>23</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Richland Colony</td>
<td>15</td>
<td>15</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Springfield Adult Learning Centre *</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Sources: Principals of each Sunrise School Division School and Colony School, January – April 2004
Alison Vokey, Career Counselor, Springfield Adult Learning Centre, April 2004
• *Numbers are not available due to restructuring of administrative support for the facility
• Difference in Graduates from 2001/02 to 2002/03 is due to change in number of credits required
Children With Special Needs

In the 2003-2004 school year, Sunrise School Division has a population of 5180 children. There are a total of 221 children (4.2%) who are receiving support through a health services program. These health services are provided by NEHA through the Unified Referral & Intake System. These numbers do not capture the number of children with health care needs who do not have a “formal” health care plan developed by a nurse. These numbers are no longer kept, but two years ago there were over 600 children receiving medications. It is believed that now that number has increased. 5

Focus Groups - Schools

YOUTH

a) Safety - There is concern among some Springfield participants about their security and youth carrying weapons. They felt there was a need to protect themselves from becoming victims. There was no consensus on whether the targets were random. [Springfield]

b) About Teachers - Some youth indicated that the behaviour of teachers is not always appropriate. Ethical issues arose about disclosing information especially as it relates to teachers. [Springfield]

“ Well, something should be done about that [reporting a teacher] …sets a bad example for everyone else…” [Springfield]

c) School Activities

-Gym - There should be more options in gym class than just sports as everyone does not like sports e.g. fitness as opposed to sports i.e. aerobics, proper food and nutrition. Depending upon the age of the youth, there are some participants who felt gym was fine e.g. grade 9 and 10. [Springfield]

-Scheduling difficulties created problems for some youth from taking gym. There was mixed opinion about taking gym. The group liked the idea of having choices and the chance to switch streams after a certain period of time. [Springfield]

Suggestions Raised by Youth

- Full time school nurse. [Springfield]
- Bike racks at school although “nobody rides their bikes to school…cause they will just get trashed.” [Springfield]
- Greater staff involvement with students. [Springfield]

“We have teacher events and I’ve only seen one out of every 5 times a guidance counselor or somebody, like not a teacher, plays sports or gets involved with kids at all.” [Springfield]

YOUNG ADULT

Suggestions Raised by Young Adults

- Open the weight room at the high school for public use. [Springfield]
MIDDLE ADULT

a) Nutrition in Schools
   - Selling junk food in school canteen was not seen as a positive influence on youth. The schools found that it was not profitable selling healthier soups and sandwiches. [Springfield]
   - Parents not sending healthy lunches. [Springfield]
   - While some schools “take a stand” and send lists of acceptable foods home with students, others do not because some parents “…don’t appreciate the school meddling in their affairs.” [Springfield]

Suggestions Raised by Middle Adults
   - Lists [of healthy foods] were seen as advantageous because then parents were not as subject to pressure from the children. [Springfield]
   - Schools and community clubs need “incentives” to provide “less of the bad choices and more of the good choices.” for example the Milk Marketing Board milk draws. Fruit companies should use similar tactics. [Springfield]
   - Education is important, teachers should be informed and health care workers should visit schools with aids such as pamphlets, video education. [Springfield]

b) Health Education in School
   - Reported that health education is now part of the physical education curriculum rather than a class unto itself. There was uncertainty whether this would work out as well as having separate health classes. [Springfield]
   - One participant mentioned that they felt that government was not honoring their commitment to support special need students in the mainstream. [Springfield]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>SPRINGFIELD GROUP DISCUSSIONS ON EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestions</td>
</tr>
<tr>
<td>• Parents need more parenting classes/skills.</td>
</tr>
<tr>
<td>• Retain existing Wellness Resource Center and material.</td>
</tr>
<tr>
<td>• Expand library services.</td>
</tr>
</tbody>
</table>
### 8.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” ⁶</td>
<td>“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)”⁷</td>
<td>“Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).”⁸</td>
<td>“Broad measures of the physical, mental and social well-being of individuals.”⁹</td>
</tr>
</tbody>
</table>

### Overview

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health” we find that there are many influencing factors, some controllable, for example the choices we make i.e. using a seat belt and things we have less or no control, over, for example hereditary diseases.
**Significant Indicators Measuring Overall Health Status**

**Social Economic Factor Index (SEFI)**

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services.

**Figure 8.2 SEFI Value by Health District 1991 & 1996**

Looking at the NE Health Districts separately, we clearly see disparities in socioeconomic risks identified in the Blue Water and Northern Remote Health Districts. Having said this, there has been an improvement in Blue Water in 1996.

Except for Winnipeg River and Northern Remote there has been an overall improvement in the SEFI value in 1996 as compared with 1991.

**Springfield has the highest social economic factor value index in NE and surpasses both the Manitoba average and Rural South for both time periods.**

All health districts except for Northern Remote and Blue Water have a better SEFI value than both Manitoba and Rural South. Springfield showed an improvement in its SEFI value in 1996. Springfield has the best SEFI value when compared with all other health districts in NE.

As NE continues with its health prevention and promotion strategies, we anticipate the future SEFI values will continue to improve.
**Premature Mortality Rate**

PMR is defined as deaths that occur before age 75. This indicator is often used as a measure of general health status and the subsequent need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services. 10

**Figure 8.3 Premature Mortality Rate NE Health Districts**

We do not want to see this indicator increase. PMR appears to have decreased slightly when comparing the two time periods in Springfield, but is not statistically significant.

**Springfield has the lowest PMR in NE and is not significantly different than the Manitoba average.**

Focus Groups – On the Meaning of Health

YOUTH – Youth participants in all the Focus Groups had a good sense that health was not limited to only physical health.

YOUNG ADULT – Overall, the young adults who participated in the focus group had a clear sense of what health means to them. This group emphasized that work and child demands played an important part in their lives and had the ability to affect their health.
-Access to good health care and finding it quickly, especially for children, came up in Springfield and Iron Rose.

Gaps in Springfield
Recreational Activities
- Generally more sport and fitness [Springfield, Brokenhead, Bluewater]. It should be a family friendly exercise facility. [Springfield]
- “I haven’t found a facility that’s easy for me to go to and deal with children who are under 12.” [Springfield]
- Have activities in the arena other than hockey. [Springfield]
- Swimming pool. [Springfield]
- More opportunity for activities in Anola and Cooks Creek. [Springfield]

MIDDLE ADULT - This group did indicate clearly that health encompassed many more things than just physical health.
“Chronic pain can make people feel out of control.” [Springfield]
- Good attitude / outlook was raised in Iron Rose, Winnipeg River and Springfield.

Gaps in Springfield
Recreational Activities – This is a common theme mentioned in all Focus Groups.
- Swimming pool [Springfield, Iron Rose]
- Bowling alley [Springfield]

SENIORS- This age group seemed to have a really rounded knowledge about what good health and healthy lifestyle meant to them.
- For the first time accepting your limitations arose and volunteerism as a way of staying connected [Springfield].
  “….pleasure others take in the job you’ve done.” [Springfield]
- The other areas that were of particular importance included discussion about the use of the health system and again being pain free, which came up in the 44-65 year old Focus Groups. Attitude was stressed over and over again as a way of feeling good in all the senior groups.
  “In a sense I’m healthy, in a sense I’m not, but attitude is very important.” [Springfield]
- Spiritual health came up only in the Springfield group. One senior participant mentioned about church attendance contributing to good health.

Recreational activities are consistently commented on in the provincial survey as well. Refer to Section 6 this report.
Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

Figure 8.4 Total Mortality Rate of Deaths in NE Health Districts

Springfield’s mortality rate appears to have increased during the two time periods reviewed, but it is not a statistically significant increase.

Springfield’s mortality rate is statistically significantly less than the Manitoba average and Rural South during the later time period reviewed.


Springfield has the lowest total mortality rate when compared with our other health districts.
Life Expectancy

Life expectancy is defined as the expected length of life from birth, based on the mortality of the population. Life expectancy is a common indicator of population health status and is used for international comparisons.\(^\text{12}\)

**Figure 8.5 Life Expectancy – NE Health Districts for Males and Females**

In Springfield we see that females live longer than males by approximately 4 years. In Springfield, the life expectancy is higher than that of the Manitoba average and Rural South. When Springfield is examined with the other NE Health Districts, it has the highest life expectancy for both males and females.

**Springfield had the highest life expectancy during the later time period when compared with all other health districts in NE.**
Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths. 13

Figure 8.6 Potential Years of Life Lost for Males and Females – NE Health Districts

Compared with Manitoba and Rural South, Springfield has a statistically significantly lower PYLL value during the second time period. This is a very good sign, as we do not want to see early deaths.

When reviewing PYLL, it becomes noticeable that males have a higher PYLL value at 45.0/1000 than females at 31.1/1000.

In Springfield for both males and females life lost is lower than the Manitoba average, but not significantly lower.

Health Conditions

“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)”

Cancer

New Cancer Rates [includes non-invasive malignancies].

Figure 8.8 New Cancer Rates NE Health Districts

In Springfield there has been a statistical significant decrease in the overall cancer incidence in the time periods reviewed. This is a positive sign. Springfield has a statistically significantly lower rate than Manitoba and Rural South during the second time period.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>75%</td>
</tr>
<tr>
<td>Concern about Cancer [Raised Issue]</td>
<td>75%</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any other specific comments on this subject.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups- Chemotherapy in the NE region is a service that was requested by all the adult Focus Groups.</td>
<td></td>
</tr>
</tbody>
</table>

Diabetes

Figure 8.9 Diabetes Treatment Prevalence in NE Health Districts

Diabetes treatment prevalence in Springfield has shown an increase from 3.5% to 4.0% in the 20-79 year old age group during the time periods reviewed, but is not a significant increase. The prevalence rate is statistically significantly less than Manitoba and Rural South during the later time period.

Respiratory Diseases

Asthma

Figure 8.10 Asthma Prevalence

When we look at Springfield we see that its asthma rates are one of the lowest as a health district during the time period reviewed.

As mentioned in the regional section, both asthma and respiratory diseases in general, are showing a decline.

Springfield has the third lowest asthma rates when compared to our other health districts.
In Springfield, there has been a statistically significant decline in respiratory disease diagnoses during the two time periods reviewed.

Further, Springfield is statistically significantly lower when compared with Manitoba and Rural South for the later time period. This is good news.

Respiratory diagnoses are declining in Springfield.
Hypertension

Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 8.12 Hypertension Treatment Prevalence in NE Health Districts

During the second time period, Springfield had a lower prevalence of hypertension treatment when compared with Manitoba, but experienced a statistical significant increase during the two periods reviewed.

This could be related to a population increase in the 40 to 69 age group.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Springfield</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Concerns about Cardiovascular Disease</strong> [Raised Issue]</td>
<td></td>
</tr>
<tr>
<td>Participants questioned if 1 in 25 people were being treated for high blood pressure.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups- This topic was discussed in adult groups in relation to lifestyle changes, eating healthy and quitting smoking because of high blood pressure or cholesterol in self or others.</td>
<td>75%</td>
</tr>
</tbody>
</table>

Heart Attacks

Figure 8.13 Acute Myocardial Infarctions (MI’s) or Heart Attack Rates of Hospitalization

Sprinkfield appears to have experienced a drop in hospitalized cases for MI’s during the two time periods reviewed, but it is not a significant drop.

Sprinkfield’s appears to be lower than the Manitoba average and Rural South for the second time period, but it is not a significant difference.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

Figure 8.14 Stroke Treatment Prevalence in Hospital

There has been a statistically significant decrease in the number of residents being treated for stroke from 2.47/1000 to 1.71 / 1000.

Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999, compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to relatively small number of injury deaths, these rates are not reported at the district level. 15

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

Figure 8.15 Injury Hospitalization Rates in NE Health Districts

Compared with Manitoba and Rural South, Springfield’s rate of hospitalization is statistically significantly lower during the second time period reviewed.

As we noted earlier, the traffic accident deaths and injuries are showing an increase during 2002 and we will need to continue to monitor this.
**Human Function**

"Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation). International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version)."  

**Overview**

Human function is associated with the consequences of diseases, disorders, injury and other health conditions.

*Refer to Section 6 for regional information.*

**Well-Being**

"Broad measures of the physical, mental and social well-being of individuals."  

**Overview**

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but it is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age are able to do who may not have an illness.

**Focus Group on There’s Nothing To Do**

It was felt that the perception of ‘nothing to do’ will have an affect on the overall well being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their focus groups specifically related to recreational activities.

**YOUTH**

- In Springfield there was apparently a Drop In Centre during the summer but it wasn’t well advertised and the hours were not conducive to their lifestyle i.e. they would stay up late and get up late or were working during the day making attendance at the centre prohibitive. [Springfield].

  **Suggestions Raised by Youth**
  
  - Would like a “rec centre” with games, stuff to do, maybe a fitness centre. It was emphasized that the facility must be accessible at low cost, preferably free. [Springfield]

**Note:** This is follow up information about the new youth drop in centre:

*The Kinsmen are purchasing a former church located near the Springfield High School. My understanding is that it will be a Community Centre. The youth will be encouraged to use the facility. I understand the Kinsmen are planning to house some revenue creating offices (in order to help pay mortgage) for people such as the recreation director and the community constable (public safety officer). They envision community movie nights a few times per month. The purchasing is moving ahead and I believe there is a lot of construction that will take place before opening. As far as youth involvement, they may be discussing arrangements with the new youth subcommittee of the Springfield Community Wellness Coalition. This committee has members such as the town constable, the recreation director, school counselors, and students.*  

*Source: Caroline McIntosh (2004) NEHA Wellness Facilitator Primary Health Care, as Emailed to Suzanne Dick May 7 entitled: RE: Springfield Drop in Centre.*
### 8.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Health Practices &amp; Lifestyle</strong></td>
<td><em>Personal Health Practices &amp; Coping Skills</em> 18</td>
</tr>
<tr>
<td><strong>Personal Resources</strong></td>
<td><em>Social Support Network</em> 19</td>
</tr>
<tr>
<td><strong>Living &amp; Working Conditions</strong></td>
<td><em>Income, Income Distribution and Social Status and Employment and Working Conditions</em> 20</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td><em>Physical</em> 21</td>
</tr>
<tr>
<td></td>
<td>&quot;Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.&quot; 22</td>
</tr>
<tr>
<td></td>
<td>&quot;Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.&quot; 23</td>
</tr>
<tr>
<td></td>
<td>&quot;Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.&quot; 24</td>
</tr>
<tr>
<td></td>
<td>&quot;Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.&quot; 25</td>
</tr>
<tr>
<td><strong>Healthy Child Development</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Biology &amp; Genetic Endowment</strong></td>
<td>&quot;The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.&quot; 27</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>&quot;Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.&quot; 28</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>&quot;Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.&quot; 29</td>
</tr>
</tbody>
</table>

---

Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status. (22)

Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health. (23)

Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health. (24)

Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors. (25)

The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. (26)

The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges. (27)

Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors. (28)

Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue. (29)
Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment, however there are some concerns most specifically related to water quality.

**Water**

**Water Quality**

There are two wells in the municipality which supply water through the Oakbank water station plant. From there the water is transferred to Dugald where the water treatment plant is located. Chlorinated water is supplied to Dugald, and eventually will be supplied to the new development, which is planned for Oakbank. The remainder of the district, including the community of Oakbank has private wells supplying their water.

Dugald has recently been serviced by a single municipal water supply system, which has improved the water quality in the area. A municipal water supply system is now being made available to portions of the community of Oakbank.

**Boiled Water Advisories in NE**

In NE as of March 2004, there are 3 communities that have boiled water advisories. These are Tyndall, issued July 21, 2000, Garson issued July 27, 2000 and Anola issued July 28, 2000.
### 2004 Validation Workshops

### Three Top Key Issues Identified By Participants

<table>
<thead>
<tr>
<th>Issue</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Springfield</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Water Quality</strong></td>
<td>66.6%</td>
</tr>
</tbody>
</table>

Participants are concerned about the use of household chemicals and sewage. They commented that the lagoon is not properly enclosed. They say Manitoba aquifers are polluted. Anola continues to have a boil water notice.

**2003 Focus Groups** – Participants in Springfield raised concerns about poor water quality in Cooks Creek. The creek is contaminated by pesticides, chemicals and sewage. Iron Rose Middle Adults Group also raised a concern about access to safe water around Elma.

---

### Sewage Systems

Dugald and Oakbank are supplied with gravity sewer lines which run to lagoons. The remainder of the district has septic fields and holding tanks. A lagoon provides for waste disposal.

---

### The Air We Breathe

**Focus Groups – Pollution/ Water Quality**

**MIDDLE ADULT**

- One participant in Springfield felt pollution is responsible for higher than average incidences of nervous system disorders e.g. Fibromyalgia, Multiple Sclerosis. [Springfield]
- Poor water quality in Cooks Creek, the creek is contaminated by pesticides, chemicals, and sewage. [Springfield].
Housing

Table 8.3 Elderly Person’s Housing in Springfield Health District

<table>
<thead>
<tr>
<th>Springfield Communities</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anola</td>
<td>Sunrise Lodge</td>
<td>12</td>
<td>Private</td>
</tr>
<tr>
<td>Dugald</td>
<td>Evergreen Lodge</td>
<td>10</td>
<td>RM of Springfield</td>
</tr>
<tr>
<td>Cooks Creek</td>
<td>Pleasant View Lodge</td>
<td>10</td>
<td>RM of Springfield</td>
</tr>
<tr>
<td>Oakbank</td>
<td>Kin Place</td>
<td>14</td>
<td>Manitoba Housing</td>
</tr>
</tbody>
</table>

Source: Manitoba Housing to Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

Focus Group - Housing

This was an area of concern in the 1997-98 CHA. There has been less vocal issues surrounding housing during this CHA. Some participants mentioned needing more PCH beds, transitional housing (accommodation in your community, before a PCH) was raised as a need in the middle and seniors Focus Groups.

SENIORS
- More PCH beds. As well, [more] independent living units with shared facilities.
- “They are independent suites but you are part of the community.” [Springfield]
Table 8.4 Crime Report Springfield Health District *

* The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

** The number of persons injured and killed in traffic related incidents is not included in the numbers associated with the total traffic code category nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Springfield</td>
<td>456</td>
<td>378</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle theft,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Criminal Other- Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>arson, indecent acts, bail violations, breach of probation,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>harassing and stalking, kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td></td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td>Total Federal Code</td>
<td></td>
<td>NE</td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coroner’s Act, Mental Health Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trespass Act, Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquor- intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td></td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Springfield</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td></td>
<td>NE</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired</td>
<td>Springfield</td>
<td>92</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>driving, driving over 80 MG (blood alcohol level), driving a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>motor vehicle prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Traffic</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Springfield</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td></td>
<td>NE</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Springfield</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td></td>
<td>NE</td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td>GRAND TOTAL OF ALL OFFENSES</td>
<td>Note: this does not include persons injured or killed in traffic related</td>
<td>Springfield</td>
<td>1,106</td>
<td>729</td>
</tr>
<tr>
<td></td>
<td>incidents.</td>
<td>North Eastman</td>
<td>8,714</td>
<td>7,481</td>
</tr>
</tbody>
</table>

With the exception of federal code offenses where the number doubled, all other areas have decreased during the two years reviewed.

Major causes for concern are motor vehicle deaths and injuries.

**Deaths** – There has been a rise in deaths in many health districts. In Brokenhead and Springfield, where there were none reported in 2001, however the numbers have increased to 4 and 3 respectively. This is a 300% increase in Springfield.

**Injuries** – The highest number of injuries in a health district occurred in Springfield, where there was a 157% increase in 2002 when compared with 2001 data.

**Note**: We were not able to compare previous crime report information as the CMB had changed their system of reporting.

**Focus Groups - Safety**

**YOUTH**
- There is concern among some Springfield participants about their security and youth carrying weapons. They felt a need that they had to protect themselves from becoming victims. There was no consensus on whether the targets are random. [Springfield]
  “...I’ve actually been in a couple of fights. It’s like, well you fought back so you get suspended too…..” This was felt to be unfair. [Springfield]

**YOUNG ADULT**
- There were two areas of concern i.e. vandalism and traffic issues.
  a) **Vandalism**
    **Suggestion Raised by Young Adults**
    - In response to vandalism, having more people on the street should decrease the number of occurrences. [Springfield]
    “Instead of shutting things down, we should be opening it up.” [Springfield]
  b) **Traffic**
    **Suggestion Raised by Young Adults**
    - A program to encourage people to bike and to bike safely. [Springfield]

**2004 Validation Workshops**

**SPRINGFIELD GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT – Safety**

**Discussion**
- On road safety, graduated licensing may help. Different diseases, i.e. high blood pressure may affect ability to drive.
- Participant referred to a by-law to allow for RCMP to enforce curfew (send them home).
- Young Offenders Act ties the hands of justice officials (RCMP, by law officer)
Biology & Genetic Endowment

"The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges." \(^{35}\)

Overview

The fundamental characteristics of this determinant include our genetic make up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.” \(^{36}\)

*For information related to this determinant refer to the section on ‘health status.’*
Overview

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family's pattern of life style and practice. Education alone is never enough. Other known influences on behaviour either positively or negatively, may include an individual's peers, social / community norms and practices, and the willingness on the part of the individual, family, or community to change.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>SPRINGFIELD GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES AND COPING SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Discussion on parents being too busy and too tired, this is breaking up society, not neighborly anymore.</td>
</tr>
</tbody>
</table>

Suggestions

- Activities are too structured; need a safe place to do things (i.e. skate park vs. using the street or Kin Place ramp.)
- Need a place for swimming, recreation and social gatherings all in one building.
Dietary Practices

Focus Groups – Dietary Practices

Dietary modifications were common among all Focus Groups participants in relation to lifestyle changes to control or decrease weight in order to promote better health.

YOUNG ADULTS
- “It’s hard changing food…I went to see a nutritionist, I needed re-education…one of the nurses had mentioned…they see kids with coronary disease…it hit me like a ton of bricks.” [Springfield]
- Consulted with nutritionist because kids were gaining weight. “It’s been really interesting because my kids train and compete…and they’re having a problem losing weight.” [Springfield]

Programs / Methods Used
- Visit to nutritionist [Springfield]
- Barriers - Numerous activities and always on the run – therefore prepare fast foods [Springfield]

MIDDLE ADULTS - Often some or parts of the diet were changed, for example drinking more water, decreasing caffeine intake, or diet changes related to reducing cholesterol.
- The reasons why participants modified their diet included
  - Written food reports. “...reading a lot about what is harmful to us”. [Springfield]

Programs / Methods Used
- Nutritionist. “…taught me how to read...labels…” now recommends friends visit the nutritionist “...I know some of them have gone and have been pleasantly surprised.” [Springfield]

Barriers
- Motivation and difficulty changing old habits.
  - “…everything tastes good…” when cooked in familiar ways. [Springfield]

EMERGING TOPICS
- Food additives felt to be responsible for increasing number of allergies. [Springfield]
- Good and quick meals can still be cooked if people learned how to use their microwave ovens. [Springfield]

SENIORS
- Reasons to Modify Diet – There were several reasons given i.e. preventive measure as parents were obese. [Brokenhead], health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water].
Alcohol Consumption

Focus Group- Alcohol Use

YOUTH
Drinking as an emerging topic came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change recognizing that many youth in the Focus Groups did not consume alcohol.

a)  Behaviour- The youth clearly saw alcohol not only as something youth did, but even more as a behaviour of adults in their communities.

b) Drinking & Driving – Some participants in the Springfield Focus Group didn’t perceive teen drinking as a health problem, other than concern over drinking and driving. They (Springfield) felt there was sufficient education about the consequences of drinking and believe that people won’t stop drinking until they suffer personally. [Springfield]  
  “…Everybody in Oakbank does it, because there’s nothing better to do.” “…Get one friend drunk, and there is your evening entertainment.” [Springfield]

ADULT FOCUS GROUPS
Alcohol consumption was not raised as a social problem in most of the adult Focus Groups except by several participants in the middle adult Focus Group. There were several adults who mentioned on a personal note that they did give up drinking. As the youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

SENIORS
- One participant mentioned stopping drinking for health reasons. [Springfield]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Springfield</strong></td>
<td></td>
</tr>
<tr>
<td>Concerns About Illicit Drug Use By Youth</td>
<td>66.6%</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any other specific comments on this subject. However they did speak about needing a safe place to do things, e.g. skate park and the need for a recreation center.</td>
<td></td>
</tr>
</tbody>
</table>

2003 Focus Groups- Youth commented on marijuana and cocaine drug use in their communities in these health districts: Blue Water, Brokenhead and Winnipeg River.
Physical Activity

Focus Groups – Exercise

YOUTH

Reasons to Exercise - The two primary reasons were weight management and to be healthy.

• To manage weight but indicated that she gained more weight. She would consider a weight management program if it didn’t cost too much. [Springfield]

Programs/Methods Used

• Group Programs
• “You don’t want to be there by yourself with people looking at you.” [Springfield]
• “…if it didn’t cost too much…” [Springfield]
• Exercising at home -siblings may bother them.
• “…if I do anything different, they [siblings] criticize me.” [Springfield]

Barriers - Time slots need to fit in with youth schedules. [Springfield].

• Increasing the amount of exercise was the most common form of lifestyle change that the adults made to improve health.

MIDDLE ADULT

Reasons to Exercise - A health crisis in self or acquaintance was the most common reason. Other reasons included to decrease weight, or improve image, or mental health reasons.

a) Self Image - “Tired of being a couch potato” [Springfield]

b) For Mental Health Reasons

“…I find that if you are anxious about something, or worried, exercise, even just walking, can get me more relaxed.” [Springfield].

Programs / Methods Used

• Local weight loss group- An advantage with this program is that participants meet similarly motivated people. [Springfield, Iron Rose]
• Walking.
• Using friends as supports and motivators.

Barriers

“…if we could somehow take control and get out of the exhaustion by being more active and manage our time better and get home and have more time to do what needs to be done…” [Springfield]

- Need for self discipline and motivation. [Springfield]
- Lack of a health crisis which decreases motivation. [Springfield]
Focus Group on Smoking

The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This provides valuable information for staff working in smoking cessation programs. The most consistent message is that if the individual wants to quit, there are a variety of methods used to suit the individual. Success often depends upon support the individual receives and successfully addressing possible weight gain associated with quitting.

YOUTH

Smoking emerged in the majority of groups as either a lifestyle change and / or emerging topic for discussion.

Quitting Smoking
- There were not many youth in the groups who actually quit smoking as a lifestyle change.

Program /Method Used
- Cold Turkey – Occasional smoker was successful quitting about a year ago. [Springfield]

Barriers
- Would not enter a stop smoking program because “…I don’t feel comfortable with a lot of situations, cry on my shoulder sort of thing.” [Springfield]

YOUNG ADULTS

Quitting Smoking
One of the biggest concerns that smokers indicate time and time again is the potential and real problem of weight gain that accompanies quitting.

Reasons for Quitting – From the reasons given by some participants there is evidence that public policy, peer pressure, and health education strategies are working.

MIDDLE ADULTS

Quitting Smoking - Once more weight gain associated with quitting smoking emerged as a real challenge for some participants.

SENIORS

As in all adult groups, weight gain that may accompany smoking cessation was once more a topic of concern.
Pharmaceutical Use

Figure 8.16 Pharmaceutical Use in Springfield

There has been an increase in the proportion of residents in Springfield that were prescribed at least one prescription drug.

There has been a statistical increase in the percent of residents using at least one prescription medication during the time period reviewed. The increase could be due to an increase in the population from 40 years to 69 years in 2000 when compared with 1995. Springfield Health District has an overall good health status, therefore one would expect to see a lower health service use and in turn a lower pharmaceutical use. Springfield’s prescription use is statistically significantly lower than Manitoba during both time periods reviewed and is not significantly different than Rural South.

Number of Different Drugs per User

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

Figure 8.17 Average Number of Different Drugs Prescribed in NE Health Districts

When we look at Springfield we see that this health district has the lowest number of prescriptions per user than all of NE, despite the statistically significant increase between the two time periods. Springfield is statistically significantly lower than both Manitoba and Rural South during the second time period reviewed.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

**Figure 8.18 Percentage of Residents Receiving at Least One Prescription for An Antibiotic**

Springfield has a statistically significantly lower use of antibiotic prescriptions when compared with the Manitoba and Rural South for the second time period reviewed average.

**Figure 8.19 Average Number of Antibiotic Prescriptions Dispensed**

Springfield Health District did not change significantly during the two time periods reviewed. Springfield has the lowest average number of antibiotic prescriptions dispensed when compared to our other health districts.

When compared with Manitoba, Springfield is significantly lower than the Manitoba average and Rural South during the second time period.
Figure 8.20 Proportion of Residents Using Antidepressants

The numbers of prescriptions have shown a statistically significant increase in Springfield during the two time periods.

Springfield has a significantly lower antidepressant use than the Manitoba average during the second time period. Antidepressant use appears to have increased throughout Manitoba.

The number of antidepressants prescribed in Springfield has increased, a trend common in all Manitoba’s RHA’s.

Focus Groups - Prescriptions

MIDDLE ADULT

There were some discussions about the dispensing of medication in the middle aged Focus Group from Springfield.

The overriding concern is the question whether prescribed drugs should be the first treatment option explored. This came up in the young adult group as well. [Springfield, Brokenhead, Winnipeg River]

“You don’t have to take antibiotics for just anything…” [Springfield]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td></td>
</tr>
<tr>
<td>#2 Government Assisted Programs, (e.g. Pharmacare) Inadequate</td>
<td></td>
</tr>
<tr>
<td>Participants felt Pharmacare deductible was high by approximately 5%.</td>
<td>75%</td>
</tr>
<tr>
<td>2003 Focus Groups: A Winnipeg River participant suggested they would like to</td>
<td></td>
</tr>
</tbody>
</table>
Three Top Key Issues Identified By Participants

<table>
<thead>
<tr>
<th>Issue</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>see publicly insured dental care. A participant in Iron Rose commented that Pharmacare deductible is too high.</td>
<td></td>
</tr>
</tbody>
</table>

Healthy Child Development

"The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful." 38

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status. 40

Mortality Rates

Infant Mortality Rates

The infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

In Springfield between 1990 and 1999, the number of infant deaths has been suppressed because there were 5 or less. This is good news for Springfield Health District. 41

Births

At 40 weeks gestation 50% of females weigh approximately 3500 grams and males weigh approximately 3600 grams. 42 There is a strong correlation between birth weight and the income of the mother. We see that often in disadvantaged groups mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances. 43

Table 8.5 Number of Newborns in Springfield

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


The number of newborns born in Springfield have shown a consistent decline over the last 4 years.
HOW HAS SPRINGFIELD’S BIRTH RATES CHANGED OVER TIME?

Springfield is showing a continuous decline in newborn birth rates throughout all years reviewed. These rates have consistently been less than the Manitoba rate.

Focus Groups on Obstetrical Practices

Obstetrics as a service emerged in several adult Focus Groups.

YOUNG ADULTS

“I’m disappointed that baby delivery has been shut down in rural hospitals.” [Springfield]
Adolescent and Teenage Pregnancy

Figure 8.21 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability.

Springfield, Winnipeg River, Brokenhead and Iron Rose are significantly below the Manitoba average.

There has not been a significant change during the two time periods, 24/1000 to 29.2/1000 respectively. Springfield has a statistically significantly lower teen pregnancy rate than Manitoba (61.3/1000) and Rural South (45.3/1000) during the second time period.

Breastfeeding Practices

Figure 8.22 Breast Feeding

There is considerable variability within the health districts. The highest rates of hospital initiation of breastfeeding occurring in Springfield at 86% and 88.1% respectively. This is not a significant change. Springfield is statistically significantly higher than Manitoba and Rural South for the second time period.

Breastfeeding initiation rates are higher than the Manitoba average in Springfield.
Birth Weights

**Figure 8.23 High Birth Weights**

In Springfield, the percentage of high birth weight babies at 15.8% is close to the Manitoba average at 15.6%, but not significantly different. There has been no significant change in high birth weight babies between the two time periods.

**Figure 8.24 Low Birth Weights**

Within the region, we are noticing some variability in the percentage of low birth weight babies.

Springfield’s percentage of low births has decreased from 5.3% to 3.5%, respectively, but this was not a statistically significant difference.
Springfield’s percentage of pre-term babies has not significantly changed during the two time periods reviewed. Pre-term births in Springfield are the lowest during the second time period when compared with our other health districts.
Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses. 44

**Figure 8.26 Completed Immunizations at One Year**

Springfield has the highest number of completed immunizations when compared to all NE health districts at 92% during the second time period.

Springfield is statistically significantly higher than Manitoba and Rural South during the second time period.

**Figure 8.27 Completed Immunizations at Two Years**

Springfield immunization rates are the highest in NE during the second time period.

Springfield is statistically significantly higher than the Manitoba average for both time periods.

---

There has been a statistically significant decrease in completed immunizations at seven years from 85.7% to 79.2% respectively. It would be interesting to determine why the overall decrease from one, two and seven years has occurred. This is not a unique phenomena to NE but has occurred in all RHA’s. Is accessibility or negative media attention a cause? This would be an area to consider for further exploration.

**Overall Springfield's immunization rates are the highest when compared with our other health districts.**

### 2004 Validation Workshops

**SPRINGFIELD GROUP DISCUSSIONS ON HEALTHY CHILD DEVELOPMENT**

**Discussion**
- There are a large number of children on Ritalin. Many people cannot afford to pay for these services.
- “They” want to present abstinence as an option in sex education classes.
- Kids need time to be kids, they need to learn to play on their own, organize themselves in play. Too much computer and TV.
- Youth are disrespectful, there is vandalism and property damage.
- Parents are using community activities and organizations as babysitters. They are too busy or too tired to be parents. Social workers are busy because of this.
Living & Working Conditions
[Income, Income Distribution and Social Status and Employment and Working Conditions] 45
“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.” 46

Overview

Job rank, social status in the workplace, the amount of control over one’s work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed. 47

Employment and Unemployment

Table 8.6 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td><strong>Springfield</strong></td>
<td><strong>79.3</strong></td>
<td><strong>69.3</strong></td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Springfield has the highest employment rate when compared with our other health districts. Females have a lower percentage of employment than males. Males have a slightly lower unemployment rate than females.
Social Economic Status

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status.48

Median Family Income of Couple Families

The following tables describe the median family income of couple families and the median family income for lone parent families in Springfield District communities, North Eastman and Manitoba.

Table 8.7 Median Family Income of Couple Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Couple Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$64,031</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Springfield has a higher median family income than NE or Manitoba as a whole.

Table 8.8 Median Family Income of Lone Parents – Males and Females

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$40,087</td>
<td>$36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$23,892</td>
<td>$17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$45,361</td>
<td>$26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$35,698</td>
<td>$26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$9,248</td>
<td>$12,587</td>
</tr>
</tbody>
</table>


Lone parent male families have consistently higher incomes than lone parent female households. Springfield males have the second highest income and the highest income for females when compared to our other health districts.
Table 8.9 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$ 22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 26,469</td>
</tr>
</tbody>
</table>


This table looks at males and females combined as an example of NE and Manitoba incomes. It is more difficult to compare as the previous table separates males and females.

Total Low Income Incidence

The incidence of low income in 2000 in Springfield was 5.9%. 49

2004 Validation Workshops

SPRINGFIELD GROUP DISCUSSIONS ON EMPLOYMENT AND WORKING CONDITIONS

Discussion
- Employers need to empower their workers, workers would be healthier and more productive.
- Rural residents incur higher travel costs.
- When one parent lives/works in the community, travel is reduced, it keeps one parent in the community, there is less stress and better parenting.
Overview

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included as these all support a strong social network.  

Mental Emotional Health

Mental health was raised as an important concern for many NE residents, in particular in the area of mental health services, stress, unemployment, isolation, alcohol and drug abuse in the 1997-98 CHA Report. Mental Health Services continued to be a concern for 2003 Focus Group participants.

Focus Groups on Mental Well-being

Mental health issues emerged throughout the Focus Group discussion. The topics varied between the age groups.

YOUTH

Youth reinforced the importance of friends and social support and their influence both positive and negative on them and on their mental wellbeing. Some of the stresses experienced by youth were related to school (in Springfield: teachers’ attitude and weapons in the school) and family issues mostly related to siblings. Youth in all districts felt there was “nothing to do” and this may contribute to some negative behaviours such as alcohol and drug use. Youth felt they were often unfairly judged and stereotyped.

a) Behaviour / Image

“…everyone seems to judge on that [being overweight].”  Another student mentioned that “It probably matters more to you than others, but you always have that self-conscious thing.” [Springfield]

-When one teen is acting out it pre-judges all teen.

One youth indicted “The thing is, we are just as annoyed and pissed off about it as anyone else.” Implying that not all teens act that way and shouldn’t be judged. [Springfield]

Suggestion Raised by Youth

- Would like somewhere to go where they could talk, but not be pressured to talk about things they don’t want to discuss. Perceiving that adults don’t get it, they would prefer a young (20-25 year old) counselor. They want a counselor to listen, not to judge, not to give unsolicited advice, not to moralize and especially, not to impose the counselor’s views or morals on the student. [Springfield]

b) Stress

Areas of stress that emerged were school and family.

- Stress was seen as being unhealthy and managing stress is necessary to remain healthy. [Springfield]
- One participant equated stress leading to depression. [Springfield].
c) School - Teachers expectations are too high and not enough help given. [Springfield]

d) Family – Parents having problems with drugs, marriage, abuse, youth are affected mentally, affects their life in general. [Springfield]

“If you’re not as good as the other one [siblings] then you don’t deserve the same stuff they have had.” [Springfield]

Adult Focus Groups

- Lack of mental health support emerged in the middle adult and staff Focus Groups. Stress emerged as a common theme, but the cause of the stress varied among the age groups.

Young Adult

The primary issues raised in this age group: better awareness of the mental health programs (refer to Mental Health Program Section 7), but also the stigma associated with accessing programs.

Middle Adults

- Felt that programs need to address more than the illness, but also other issues like managing stress.
- Troubled youth may not be recognized. Suggested suicide rate is relatively high. [Springfield]

Suggestions Raised by Middle Adults

- Participants in Springfield would like to see a mental health drop-in centre in Springfield, but not naming it as such, due to stigma in small town. [Springfield]
- Another participant felt “…you just battle on… I don’t think we cover it up. I think that’s been done too much.” [Springfield]

Seniors

- Seniors were concerned about being able to identify vulnerable members in the community, in particular those who were more isolated and described as ‘lonely.’ Another big concern for this age group was living alone and being lonely. Two issues emerged:
  a) what they would do if something should happen to them and they were unable to access help.
  b) effects of isolation and living alone.

2004 Validation Workshops

Springfield Group Discussions On - Mental Well Being

Discussion

We should include mental illness with other physical illnesses so as not to perpetrate the stigma attached, “it is an illness”.

Mental Health Programming is discussed under the NEHA Mental Health Program- Section 7.
## Social Support

### Table 8.10 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and they may be more economically disadvantaged than two parent households.

There are approximately 255 lone parent families reported in Springfield during 2001 Canada Census.
Focus Group On Social Support

Social support was an area that was raised in all focus groups and all ages as something that was seen as positive with respect to an individual's well-being.

YOUTH

During the initial discussions when talking about what it means to be healthy, youth mentioned the importance of friends and social supports. We know that social support is a strong determinant of health status.

a) Talking with Adults
- As part of the discussion some participants in Springfield and Winnipeg River discussed their experiences when talking with adults.

  "It's hard to talk with adults because they don't quite understand where you are coming from...It's a new day and age." [Springfield] Its different because "...everybody's vandalizing, people are carrying weapons." [Springfield]

YOUNG ADULTS

Suggestions Raised by Young Adults
- Support for moms or single moms including a support group, parenting information that meets during school hours rather than in the evening when children have to be brought along and it gets late. Shared babysitting for those who can't afford to pay. [Springfield]
- "Someone to watch my kids if I was ill." [Springfield]
- "Neighbours program where someone would watch the kids while others participate." [Springfield]
- Lack of grieving support. [Springfield]
MIDDLE ADULTS

The concerns expressed in this age group focuses around community supports rather than personal support concerns. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group.

Suggestions Raised by Middle Adults

- Would like to see volunteer transportation for appointments and treatments for all people not only seniors. [Springfield]
- Expand programs to allow other (for example those with disabilities) to access. [Springfield, Iron Rose]
  “Make it a community program, versus a seniors’ program.” “…the bulk of your participants would probably still be seniors but I’m sure there are other people that would benefit from it because they are either socially or physically isolated.” [Springfield]  

SENIORS

a) Living Alone

- Concerned about access to assistance in a health crisis as often they can’t get a hold of their family as they are working. [Springfield, Winnipeg River]

b) Effects of Isolation

- There is a problem with the effects of isolation when living alone. [Springfield]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>SPRINGFIELD GROUP DISCUSSIONS ON - Social Support Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discussion</strong></td>
</tr>
<tr>
<td>- The ordinary family needs opportunities to interact with neighbors, two parent families are too busy to socialize with neighbors.</td>
</tr>
<tr>
<td>- Urban isolation, Oakbank is a bedroom community, there is no broad community ownership.</td>
</tr>
<tr>
<td>- Block parties would be a way to interact with neighbors, it depends on how much you want to invest in your community.</td>
</tr>
<tr>
<td><strong>Suggestions</strong></td>
</tr>
<tr>
<td>- Kids need someone to talk to before they are at risk. Respect/guidance programs are needed.</td>
</tr>
<tr>
<td>- Need a facility in their community.</td>
</tr>
</tbody>
</table>
8.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since 1998 CHA Report there have been boundary changes most prominently related to the northern areas. Springfield Health District was not affected by any boundary changes.

Population

During 1996 and 2000, there has been a decline in the 1-9 and 30-39 year olds, with an overall increase in the 40-69 year olds and little change in the 70 to 90+ age groups. Health services will likely be affected because of the increase in chronic illnesses occurring in the over 40 year old age group.

The number of babies born to Springfield residents has shown a consistent decline over the last 4 years.

Education

There was a re-structuring of the school divisions establishing the Sunrise School Division in July 2002, a partnership of the former Agassiz School Division and the Springfield component of the former Transcona Springfield School Division. This re-structuring has affected staff and families due to boundary changes creating uncertainty in where some students will be attending school. This is especially prominent in the former Springfield /Transcona School Division affecting Springfield Health District.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index (SEFI value) and premature mortality rates (PMR) both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indictors to determine areas of concern. For Springfield we see a SEFI value that not only has improved, but also is the best value compared with our other health districts.

Springfield has the lowest PMR in NE, but it is not significantly different that the Manitoba average.
Deaths

Springfield has the lowest total mortality rate when compared with our other health districts and is lower than the Manitoba average.

Life Expectancy

In Springfield, females outlive males by approximately four years. Springfield has the highest life expectancy in NE and also appears to be higher than Manitoba and Rural South.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>-New cancer cases are declining and are lower than Manitoba.</td>
<td>Diabetes treatment is significantly less than Manitoba.</td>
<td>Springfield has the third lowest asthma rate in NE. Overall respiratory diagnosis is declining in Springfield.</td>
<td>Hypertension treatment has increased, but is significantly lower than the Manitoba average.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI’s appear to have decreased, but not significantly.</td>
<td>Stroke treatment has decreased significantly.</td>
<td>Springfield has the lowest rate of hospitalization due to injuries in NE. Springfield has a significantly lower rate when compared with the Manitoba average.</td>
</tr>
</tbody>
</table>

Human Function & Wellbeing

The most prominent thing that arose was our youth in all health districts indicating that there was ‘nothing to do.’ This might be an area to explore with our community partners. Youth and adults during the 2003 Focus Groups provided many good suggestions. In Springfield the Kinsmen are working on providing a drop in centre for youth to be located in Oakbank.
DETERMINANTS OF HEALTH

Environmental Factors

Water - Anola is the only community in Springfield with a boil water advisory. Water quality concerns arose in Focus Groups in Iron Rose, Springfield and in Validation Workshops in Iron Rose and Springfield it was raised as a key issue.

Safety – Safety was raised as a concern by some Springfield youth in association with youth carrying weapons. Traffic injuries and deaths are on the rise within NE, in particular in Brokenhead and Springfield.

Housing – The need for more PCH beds was raised in Blue Water, Springfield and Winnipeg River.

Personal Health Practices

From focus group provincial survey comments there seems to be a readiness by the public in general toward healthier lifestyle choices.

Dietary – Obesity is a national concern. Dietary modifications were common among all focus groups in relation to lifestyle changes in order to control or decrease weight.

Alcohol Consumption – During Focus Groups youth felt it was an issue with both youth and adults in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners. Some participants in the adult Focus Groups mentioned that they quit drinking for health reasons.

Illicit Drug Use – Illicit drug use among youth was a concern raised during the Winnipeg River and Springfield Validation Workshops, and was raised as a key issue.

Physical Activity - Exercise was the top area that focus groups and NE provincial survey respondents indicated they did to achieve a healthier lifestyle. We know from the evidence that there are many people who still do not exercise.

Smoking Practice – Some Focus Group participants mentioned that they had or were thinking about quitting smoking. Ongoing smoking cessation programs targeting community and staff should be considered. The Focus Group discussions addressed issues surrounding barriers to quitting smoking. Using this information will assist in increasing the success rate of smoking cessation programs.

Medication Use –

Prescriptions - prescription usage is increasing in Springfield, but remains lower than Manitoba average.

Antibiotics - Springfield has the lowest average number of antibiotics dispensed in NE, and is significantly lower than the Manitoba average.
Antidepressants - Antidepressant prescriptions have significantly increased, but are significantly lower than the Manitoba average.

High Pharmacare deductible was raised in Brokenhead and Springfield validation workshops as a key issue.

Injuries - We don't have injury death data at the district level, however we know that traffic deaths and injuries have increased in 2002 compared with 2001. Springfield’s hospitalization rates are significantly less than Manitoba’s rates.

Healthy Child

Mortality Rates - Springfield’s infant deaths have been suppressed.

Adolescent & Teenage Pregnancy – Springfield’s teen pregnancy rate has not changed significantly and is lower than the Manitoba average.

Birth Weights - There has not been a significant change in the number of high or low birth weight babies in Springfield during the two time periods reviewed.

Hospital Breastfeeding Initiation – Springfield has the highest breastfeeding initiation rate in NE at 88.1%, and is significantly higher than the Manitoba average.

Immunizations – Immunization coverage is the highest when compared with our other health districts.

Living and Working Conditions

Work - During 2001, Springfield had the highest employment rate in NE.

Economic Status – In 2001, Springfield had a higher median family income overall when compared with NE and Manitoba as a whole. Springfield had the lowest incidence of low income as reported in the 2001 census at 5.9%.
Personal Resources

*Mental Emotional Health* – During the Focus Groups there was a lot of discussion about mental wellbeing.

- Youth stressed friends and social support as really important. When adults judged youth, it was felt to have a negative affect on their self-esteem. School and family were a source of stress.
- Young adults discussed how stigma affects how people access mental health services.
- Middle adults felt that programs overall, not particularly mental health specifically, need to address issues like managing stress. Some participants would like to see a mental health drop-in centre.
- Seniors mentioned that they were concerned about many vulnerable people living out in the community especially those who were more isolated. They identified themselves as often living alone and being lonely, and had concerns about their ability to access help quickly.

*Social Support* - There are approximately 255 lone parent families reported.
- In the middle age Focus Group a concern arose about community supports that should be all encompassing and not restricted to one age group. This is certainly worth investigating and pursuing especially with services that are not directly related to physical health, e.g. housekeeping, transportation, maintenance, and child care in an emergency are just some examples.
Summary At A Glance

**KEY**
- Partner: implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.
- Monitor: refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- NEHA: a program or service could be enhanced or developed to address this issue.

**Strengths**
- In 2001 Springfield had the highest median income when compared with our other health districts and surpasses Manitoba & Rural South.
- SEFI value is the best compared with our other health districts. [Monitor]
- Springfield has the lowest PMR in NE. [Monitor]
- Mortality rates are the lowest in NE and are lower than the Manitoba average. [Monitor]
- Infant deaths have been suppressed. [Monitor]
- In 2001 Springfield had the highest employment rate in NE. [Monitor]
- Antibiotic use is significantly lower than the Manitoba average. [Monitor]
- No significant change in high or low birth weights. [NEHA, Monitor]
- Teen pregnancy has not changed and is lower than the Manitoba average. [NEHA, Partner]
- The numbers of new cancer cases are declining. [NEHA, Partner, Monitor]
- Breastfeeding initiation rate is 88%. [NEHA, Partner, Monitor]
- Childhood immunization coverage is the highest in NE. [NEHA, Partner, Monitor]

**Issues Having Implications for Health Planning & Delivery**
- Population has increased in 40-69 year old age group, with little change in the 70-90+ years. This has the potential to affect health services needs in this population.
- Validation workshop participants felt that Pharmacare deductible were too high.
- Housing – More PCH beds needed. [NEHA]
- Prescription use is increasing but lower than Manitoba average. [Monitor]
- Antidepressant use is increasing in Springfield, but is significantly lower than the Manitoba average. [Monitor]
- Hospitalizations due to injuries are the lowest in NE. [Monitor]
- Youth have ‘nothing to do.’ [Partner]
- Safety: Some youth are saying that youth carry weapons. [Partner]
- Safety: Traffic injuries and deaths have increased. [Partner]
- Alcohol consumption was raised by youth in particular in focus groups as a concern for both youth and adults in their communities. [Partner]
- Illicit drug use by youth was raised as a concern in Springfield validation workshop. [Partner]
- Traffic deaths & injuries appear to have increased. [Partner]
- Water quality- boil water advisory in Anola. Local lagoons are said to be a pollutant. [NEHA, Partner]
- Diabetes treatment is significantly less than the Manitoba average. [NEHA, Partner]
- Dietary-Obesity is a national and local problem. [NEHA, Partner]
- More physical activity in order to improve health. [NEHA, Partner]
KEY
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

Mental Wellbeing as raised by some focus group participants. [NEHA, Partner]
- Youth stress- school & family.
- Middle adults suggested all programs address issues of managing stress not just mental health. Would like to see a mental health drop in centre.
- Seniors – Need to identify vulnerable people in community.

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
8.6 REFERENCES

1. RM of Springfield Office, Eastman Regional Development Inc., Beausejour Office; Manitoba Community Profiles Website
5. Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004
9.1 GEOGRAPHICAL OVERVIEW.................................................................9-1

9.2 COMMUNITY SYSTEM CHARACTERISTICS.........................................9-4

9.3 HEALTH STATUS..................................................................................9-9
  Overview.................................................................................................9-9
  Significant Indicators Measuring Overall Health Status..........................9-10
  Deaths......................................................................................................9-13
  Health Conditions....................................................................................9-17
  Human Function......................................................................................9-25

9.4 DETERMINANTS OF HEALTH ..............................................................9-27
  Environmental Factors .........................................................................9-28
    Water....................................................................................................9-28
    Air........................................................................................................9-29
    Housing...............................................................................................9-29
    Safety....................................................................................................9-30
  Biology & Genetic Endowment...............................................................9-33
  Personal Health Practices & Lifestyle ....................................................9-33
    Overview..............................................................................................9-33
    Dietary Practices...................................................................................9-34
    Alcohol Consumption..........................................................................9-36
    Physical Activity..................................................................................9-37
    Smoking Practices...............................................................................9-38
    Potential Risk Taking Behaviour.........................................................9-38
    Medication Use....................................................................................9-39
  Healthy Child Development .....................................................................9-43
    Overview..............................................................................................9-43
    Infant Mortality....................................................................................9-44
    Births....................................................................................................9-44
    Adolescent and Teenage Pregnancy.....................................................9-45
    Breastfeeding Practices.......................................................................9-46
    Birth Weights......................................................................................9-47
    Childhood Immunizations...................................................................9-48
  Living and Working Conditions..............................................................9-50
    Overview..............................................................................................9-51
    Social Economic Status........................................................................9-51
    Personal Resources...............................................................................9-53
    Social Support......................................................................................9-54

9.5 SUMMARY/CONCLUSION.................................................................9-56

9.6 REFERENCES .........................................................................................9-63
9.1 GEOGRAPHICAL OVERVIEW

The Brokenhead Health District consists of the Town of Beausejour and the Rural Municipality of Brokenhead, which comprises eight townships encircling the town of Beausejour. Provincial Hwy. 44 is the main highway through the District. The economy is based on business, tourism and agriculture, with grain production being the mainstay of the agricultural activities. The Town of Beausejour is the central grain handling facility for the region.

Tourism has become an important economic tool for the area with Beausejour boasting a new Super 8 Hotel.

There is a full time Recreational Director who services the district and coordinates programs and activities year round. Recreational opportunities in this district abound and include an ice arena, recreational hall, ball diamonds, curling rinks, swimming pool, recreational parks, nature and ski trails, snowmobile trails and golf courses. There is a state of the art racetrack in Beausejour which brings motocross and snowmobile racing to Eastern Manitoba. The Canada Power Toboggan Championships and Double B Rodeo are events that take place in the Town of Beausejour.

A multi-purpose, multi-use recreational facility was constructed and opened in 2002. This facility, located in Beausejour, whose slogan is “Where Families Play and Grow”, features an 85 x 200 foot regulation ice surface, six sheet curling rink, walking track, fitness/wellness center, multi purpose room, full service concession and lounge.

Two schools have recently been replaced within the district. The Gillis School in Tyndall opened in the fall of 2002. The new Beausejour Elementary School opened in the fall of 2003.

A fully serviced Industrial Park has recently been developed outside of Beausejour which is zoned as light industrial or ‘M1’. This along with rail line service, natural gas, hydro, a four-lane highway, and stable tax rate makes the Brokenhead District an attractive location for industrial growth. Residents are able to enjoy all the amenities and a high quality of lifestyle while living just a short drive from Winnipeg.
These are the municipalities and communities that fall under the Brokenhead Health District.

<table>
<thead>
<tr>
<th>BROKENHEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 7,274 in 2003</td>
</tr>
<tr>
<td>Brokenhead RM (016)</td>
</tr>
<tr>
<td>-MUSKWA-ROE1GO</td>
</tr>
<tr>
<td>-TYNDALL-ROE2BO</td>
</tr>
<tr>
<td>-Allegra</td>
</tr>
<tr>
<td>-Cloverleaf</td>
</tr>
<tr>
<td>-Cromwell</td>
</tr>
<tr>
<td>-Dencross</td>
</tr>
<tr>
<td>-Ladywood</td>
</tr>
<tr>
<td>-Lydiatt</td>
</tr>
<tr>
<td>-St. Ouens</td>
</tr>
<tr>
<td>Beausejour Town (017)</td>
</tr>
<tr>
<td>Garson Village (018)</td>
</tr>
</tbody>
</table>

Source for Population – 2003

Sources:
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA report.

Geographical Changes:

- Unorganized Territories previously was a separate geographic area. In this report, depending upon the municipal code, communities have been re-allocated into the Winnipeg River, Iron Rose, Blue Water or Northern Remote.

- Northern Remote is a separate health district.

- Springfield has had no geographical boundary changes since the previous report.

- Seddon’s Corner has been re-allocated from Brokenhead into the Winnipeg River District.
How is Healthy Living Supported in Brokenhead?

Focus Groups On How The Community Promotes Or Supports Healthy Living

YOUTH
Positive Comments
- Recreation: skateboard park, baseball diamonds, curling, swimming pool, hall, Sun-Gro Centre “...is the best thing so far that's come to Beausejour.”, private exercise establishment. [Brokenhead]

Suggestions Raised by Youth
- Could use a “successful” drop-in centre. The last one “…looked dirty….and …there was drug deals going on.” [Brokenhead]
- Something for ‘street kids.’ [Brokenhead]

YOUNG ADULT
Positive
- Recreational activities e.g. hockey, baseball, curling, public skating, hall walking at elementary school, walking trails, litter less lunches, Child and Family Services counselor, nurses at Beausejour Hospital, quality of care at Beausejour Hospital, Palliative Care Program. [Brokenhead]

MIDDLE ADULT
Positive
- Recreational activities, local weight loss group, Sun Gro Centre, hall waking at the school, aqua size at Super 8 pool, skating, curling, paved walking trail for roller blading, cross country skiing, streets are good for biking, sidewalks paved for walking, skateboarding). Wellness Centre, Physiotherapist, Massage Therapist, various community groups and church organizations. Yoga classes, doctors are better now, home care, diabetes clinic, Well Baby Clinic, Drugstore, Health Centre, PCH,
- School (provides a lot of emotional support for students, availability of counseling). [Brokenhead]
- Recreational (Women's Fitness Centre, Skateboard Park), Recreation newsletter, Wellness Resource Centre, Physiotherapist, massage, Acupuncturist, yoga, Chiropractor, Nurse Practitioner, Pain Management Program delivered by the Arthritis Society, Peer Support.
- Support Groups, however there was a provision “Do you want to be in a group where you know everyone else?” [Brokenhead]

Gaps
- Homeopath and naturopath used to be available but now must go to Winnipeg. [Brokenhead]

SENIORS
Positive
- Churches, Garson Senior’s Club (expanded catchment to capture enough members), Children “With young children, it's a happy place.” [Brokenhead]
Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Where information is available the sex of the individual is provided. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women as well as gender influences affecting age, education, socio-economic status, culture and physical environment.  

Population Demographics

Table 9.1 Population Demographics Brokenhead

<table>
<thead>
<tr>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td>7,089</td>
<td>7,232</td>
<td>7,274</td>
</tr>
</tbody>
</table>


There has been a 143 person increase in Brokenhead in 2002.
The pyramid indicates that there is an overall increase in population when comparing 1995 to 2000. The increase appears in most age groups for both males and females, especially notable between 40-69 year olds and males 70-74 years.

The exceptions are in the male category between the ages of 20-39 years. This is likely due to out migration of young adults seeking education or work outside of the community. We see this decline happening in females in the 25 to 29 year old age group.
Education as a Health Determinant

Overview

There has been an association found that when education levels increase, the self-rated health status improves. Education is closely tied with socioeconomic status. Effective education for children and lifelong learning for adults contribute to the health and prosperity of individuals.

Table 9.2 Percentage of Population with Less than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school</th>
<th>% of population with less than high school</th>
<th>% of population with less than high school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 20-34</td>
<td>Age 35-44</td>
<td>Age 45-64</td>
</tr>
<tr>
<td>RM Brokenhead</td>
<td>31</td>
<td>28.9</td>
<td>45.1</td>
</tr>
<tr>
<td>Town of Beausejour</td>
<td>24.3</td>
<td>22.7</td>
<td>36.7</td>
</tr>
<tr>
<td>Village of Garson</td>
<td>1.1</td>
<td>35.3</td>
<td>21.4</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


Sunrise School Division

The Sunrise School Division was established in July 2002, a partnership of the former Agassiz School Division and the Springfield component of the former Transcona Springfield School Division. The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counsellors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have Consultants in the following areas: Early/Middle Years, Senior years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.

The Sunrise Support Centre is part of the Sunrise School Division and is located in Tyndall in the Brokenhead District. The Sunrise Support Center provides an alternative learning environment that readily meets individual student needs. It is a resource for community schools and agencies to assist with therapeutic intervention, behavioral change, substance abuse issues and ongoing academic success. One of the key elements of the program is a low student/teacher ratio. The focus in on the four core academic areas: Language Arts, Mathematics, Science and Social Studies. Programs are adjusted to each student’s individual need and reviewed on a regular basis. In addition to the academic instruction, there is a heavy emphasis on communication, anger management and direct teaching/intervention with respect to replacing negative behaviours.
The Sunrise Alternative Learning Program (SALP) is a Sunrise School Division Program and is located in Tyndall. This is a self-directed academic program designed for students to work at their own pace in an alternative setting away from the regular school. Curriculum includes Work Experience, Life Skills, Woodworking, Music, Drama, Physical Education, Art and other core subjects. Students experience hands on learning, participate in a variety of field trips throughout the community and become involved within the community. Target groups are students not registered in the regular school system, dropouts, young mothers, students on independent living, with truancy problems, involved with Justice and students or who have been suspended from the regular school system. Students can be referred to SSLP by schools, Justice, Child & Family Services or parents and are required to be registered in their home school.

Table 9.3 Sunrise School Division – Brokenhead Health District

<table>
<thead>
<tr>
<th>BROKENHEAD HEALTH DISTRICT</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Beausejour Elementary School</td>
<td>449</td>
<td>427</td>
<td>247</td>
<td>221</td>
</tr>
<tr>
<td>Edward Schreyer School</td>
<td>704</td>
<td>694</td>
<td>334</td>
<td>351</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gillis School (Tyndall)</td>
<td>147</td>
<td>181</td>
<td>65</td>
<td>78</td>
</tr>
<tr>
<td>Greenwald Colony</td>
<td>31</td>
<td>29</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Agassiz Adult Education Centre</td>
<td>no data</td>
<td>194</td>
<td>no data</td>
<td>56</td>
</tr>
<tr>
<td>Agassiz Support Centre</td>
<td>8</td>
<td>16</td>
<td>8</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: Principals of each Sunrise School Division School and Colony School, January – April 2004
Children With Special Needs

In 2003-2004 school year, Sunrise School Division has a population of 5180 children. There is a total of 221 children (4.2%) who are receiving support through a health services program. These health services are provided by NEHA through the Unified Referral and Intake System. These numbers do not capture the number of children with health care needs who do not have a “formal” health care plan developed by a nurse. These numbers are no longer kept, but two years ago there were over 600 children receiving medications. It is believed that now that number has increased.

Focus Groups – Schools

YOUNG ADULTS

Two common topics emerged: 1) nutrition and 2) alternative uses of schools by the community.

a) Nutrition in Schools
- There was mixed opinions whether early year schools were healthier than seniors year schools. One participant mentioned that bad habits are forming and, if continued, will lead to health problems. [Brokenhead]
  - Tyndall school canteen...refuses to sell junk food. [Brokenhead]
- The Brokenhead group also speculated that schools are subject to suppliers who provide needed materials e.g. computer paper in exchange for being allowed to sell in the schools.

b) Bullying
- Bullying was mentioned in the Brokenhead group, both in school and on the bus. A Grade 5 child “bloomed” at Edward Schreyer, having been relocated there due to previous bullying elsewhere. [Brokenhead]

c) Physical Education
- Tyndall School does not have a physical education teacher. Generally the Brokenhead group felt that physical education should be mandatory and a daily part of the school day. [Brokenhead]

Suggestions Raised by Young Adults

- Hall walking at the elementary school [Brokenhead]
- Reward for litter less lunches [Brokenhead]

MIDDLE ADULTS

- School (provides a lot of emotional support for students, availability of counseling). [Brokenhead]
### 9.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” ⁵</td>
<td>“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition.” (World Health Organization (WHO)) ⁶</td>
<td>“Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).” ⁷</td>
<td>“Broad measures of the physical, mental and social well-being of individuals.” ⁸</td>
</tr>
</tbody>
</table>

#### Overview

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health” we find that there are many influencing factors, some controllable for example, the choices we make i.e. using a seat belt, and things we have less or no control over, for example hereditary diseases.
Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services.

Looking at the NE Health Districts separately, we clearly see disparities in socioeconomic risks identified in the Blue Water and Northern Remote Health Districts.

Brokenhead has experienced a positive improvement in the later time period reviewed which is a good sign.

It will be very interesting to note future SEFI values in our health districts. As NE to continues with health promotion and prevention strategies, we anticipate that future SEFI values will continue to improve.
Premature Mortality Rate

PMR is defined as deaths that occur before age 75. This indicator is often used as a measure of general health status and the subsequent need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services. 9

Figure 9.3 Premature Mortality Rate NE Health Districts

We do not want to see this indicator increase. PMR has increased slightly when comparing the two time periods in Brokenhead. Brokenhead rates are close to the Manitoba average, but are not significantly different.

PMR’s have increased slightly in Brokenhead, but not significantly and the rate is not significantly different than Manitoba.
Focus Groups — On the Meaning of Health

YOUTH
Youth participants in all the Focus Groups had a good sense that health was not limited to only physical health.

Overall, youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself, minimizing stress and being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

“...It's easier to take care of your body when you're a teenager than when you're 40. If you're doing good as a teenager the chances of you doing good when you're 40 is much higher.” [Brokenhead]

Barriers – Youth were able to identify factors such as lack of money (limited their ability to join recreational activities and purchase healthier foods) and a lack of transportation (limited them from attending recreational activities) as barriers to a healthier lifestyle.

- Living in a family where the disposable income was limited. One youth mentioned that a lack of money does not necessarily pre-determine the course of one’s life. [Brokenhead]
- “...If you grow up in a home that you don’t have a lot of money, so you can’t do a lot, you have to realize that you still can.” [Brokenhead].
- Costs money to eat properly. [Brokenhead]
- Lack of transportation was limiting e.g. ability to get to sporting events practices. [Brokenhead].

YOUNG ADULTS
Overall, the young adults who participated in the Focus Group had a clear sense of what health means to them. This group emphasized that work and child demands played an important part in their lives and had the ability to affect their health.

Other Gaps in Communities
a) Recreational Activities- Generally more sport and fitness. [Springfield, Brokenhead, Blue Water]

MIDDLE ADULTS
This group indicated clearly that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humor, weight management and the importance of social activity and connection, being mentally well, stress management, and balance.

a) Stress management and minimizing stress- Good attitude / outlook was raised in Iron Rose, Winnipeg River and Springfield. It was mentioned in Brokenhead that we didn’t know how stressed we were until we were retired.
- “...knowing what to do, getting yourself mentally in shape will help your physical well being…” [Brokenhead]

Other gaps in the community
a) Recreational Activities – This is a common theme mentioned in all Focus Groups.

SENIORS
In general, most groups included aspects of your mind (memory), body, attitude, keeping active and mobile, good nutrition, and other recreational activities that included exercise and socializing, being active in your community, friends and family.

-Brokenhead group mentioned specifically church attendance.

Other Gaps in the Community:
 a) Recreational Activities – This emerged in all Focus Groups.
Deaths
“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” 10

Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

Figure 9.4 Total Mortality Rate

Except for Northern Remote, Brokenhead has the highest total mortality rate in NE at 8.87/1000 during the later time period.

Brokenhead has shown an increase in the rate but it is not a significant change.

It appears to be higher than Manitoba’s mortality rate of 7.99/1000, but it is not significantly different.

Mortality rates increased slightly, but it was not a significant increase and is not significantly different than Manitoba.
Life Expectancy

Life expectancy is defined as the expected length of life from birth, based on the mortality of the population. Life expectancy is a common indicator of population health status and is used for international comparisons.\(^\text{11}\)

**Figure 9.5 Life Expectancy – NE Health Districts**

Females live almost four years longer than males. In Brokenhead, life expectancy appears to have decreased slightly for both males and females. Male life expectancy appears to be similar to Manitoba and Rural South. Female life expectancy is less than Manitoba and Rural South.

---

Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths. 12

Figure 9.6 Potential years of Life Lost – NE Health Districts

Brokenhead has experienced a slight increase in its PYLL value, but it is not significant. Brokenhead is close to the Manitoba average but is not significantly different.

When we separate males and females, males have an increased level of PYLL compared to females but neither is statistically significant. PYLL is close to the Manitoba average, but is not significantly different.
Health Conditions

*Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)*

Cancer

Figure 9.8 New Cancer Rates [includes non-invasive malignancies].

There has been no significant change in new cancer rates in Brokenhead during the two time periods reviewed.

Brokenhead’s new cancer rates are close to Manitoba’s and Rural South but is not significantly different.


New cancer rates have not changed significantly during 1991 to 2000.
Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

Diabetes treatment prevalence in Brokenhead has shown a slight increase during the time period reviewed, but is not a significant increase. The diabetes treatment is close to the Manitoba average and Rural South, but is not statistically significantly different.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td></td>
</tr>
<tr>
<td>Diabetes is on the Rise</td>
<td>63.6 %</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any other specific comments on this subject.</td>
<td></td>
</tr>
</tbody>
</table>
Respiratory Diseases

Figure 9.10 Asthma Prevalence

Brokenhead appears to have the highest prevalence of asthma when compared with our other health districts.

Despite this, as mentioned in the regional section both asthma and respiratory diseases in general are showing a decline.
Figure 9.11 Residents Treated for Respiratory Disease [includes asthma, bronchitis & pneumonia]

Brokenhead shows a statistically significant decrease in respiratory diseases diagnoses during the time periods reviewed.

Compared with Manitoba and Rural South, Brokenhead’s treatment for respiratory disease during the second time period was statistically significantly higher.

Respiratory diagnoses are declining significantly, but are significantly higher than Manitoba overall.
Hypertension

Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

**Figure 9.12 Hypertension Treatment Prevalence NE Health Districts**

Brokenhead has shown a slight increase in its treatment prevalence for hypertension treatment during the later time period, but it is not a significant change.

Brokenhead has the same treatment prevalence as Manitoba and Rural South for the second time period.

Hypertension has increased slightly, but not significantly.
Heart Attacks

Figure 9.13 Acute Myocardial Infarctions (MI's) or Heart Attack Rates of Hospitalization

Brokenhead has experienced a statistically significant decrease in the rate of hospitalizations due to heart attacks.

In fact, Brokenhead has the lowest rate when compared with our other health districts during the later time period.

Brokenhead’s rate of MI hospitalizations has significantly decreased. Brokenhead has the lowest MI hospitalization rate when compared with our other health districts.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

Figure 9.14 Stroke Treatment Prevalence in NE Health Districts

There appears to have been a slight increase in the number of hospitalized stroke treatments in Brokenhead during the later time period, but it is not a significant increase. This could be due to the population increase in the older age groups.

Brokenhead has the second highest prevalence of stroke treatment at 2.38/1000 when compared to our other health districts.
Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999 compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to relatively small number of injury deaths, these rates are not reported at the district level.¹⁴

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

Brokenhead has shown a statistically significant decrease in the number of hospitalizations due to injury during the later time period.

Brokenhead appears to be slightly lower than Manitoba average and is statistically significantly lower than Rural South. This is a positive finding.

Brokenhead has the second lowest injury hospitalization rate when compared to the other health districts in NE.

Human Function

"Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability." (ICIDH-2, Beta 2 Version)  

Overview

Human function is associated with the consequences of diseases, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Well-Being

"Broad measures of the physical, mental and social well-being of individuals."  

Overview

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age is able to do who may not have an illness.
Focus Group on There's Nothing To Do

It was felt that the perception of ‘nothing to do’ will have an affect on the overall well being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their Focus Groups specifically related to recreational activities.

**YOUTH**
- There are few options other than walking around town. [Brokenhead]
- Youth spends time “flipping loops” i.e. driving around town. [Brokenhead]

With regard to a future in their town
“*One would have to leave town to “..do good”…There is nothing…” “Beausejour is not going anywhere, you know.”* [Brokenhead]

**Suggestions Raised by Youth**
- Evening hours for drop in centres. [Springfield, Brokenhead, Blue Water]
- Drop in centre held at SunGro Centre. [Brokenhead]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td></td>
</tr>
<tr>
<td><strong>Nothing for Youth to do in Communities</strong></td>
<td>63.6%</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any other specific comments on this subject.</td>
<td></td>
</tr>
<tr>
<td><strong>2003 Focus Groups</strong> – This was a common concern mentioned in all Focus Groups.</td>
<td></td>
</tr>
</tbody>
</table>
### 9.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
</table>

- “Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.” 21
- “Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” 22
- “Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.” 23
- “Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.” 24

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.” 25</td>
<td>“The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.” 26</td>
<td>“Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.” 27</td>
<td>“Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.” 28</td>
</tr>
</tbody>
</table>
Overview

Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment, however there are some concerns, most specifically related to water quality.

Water

Water Quality

The Town of Beausejour has a well system, which supplies treated water to the residents. The RM of Brokenhead has private wells.

Boiled Water Advisories in NE

As of March 2004, there were two communities that have boiling water advisories: Tyndall, issued July 21, 2000 and Garson issued July 27, 2000.

Sewage Systems

Facultative lagoons service the Town of Beausejour. The RM of Brokenhead is serviced by septic fields and holding tanks, with the exception of Tyndall which has a low pressure sewage system going to a lagoon.
The Air We Breathe

There were no concerns raised in the Brokenhead Focus Groups or validation workshops about air quality.

Housing

Table 9.4 Elderly Person’s Housing in Brokenhead Health District

<table>
<thead>
<tr>
<th>Brokenhead</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beausejour</td>
<td>Burgoyne Station</td>
<td>20</td>
<td>Private</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Lion’s Lodge</td>
<td>20</td>
<td>Lion’s Lodge Inc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Beausejour Lion’s Club</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Twin Maples</td>
<td>15</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>South Haven</td>
<td>18</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Armstrong Manor</td>
<td>22</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Beausejour</td>
<td>Stony Plains Terrace</td>
<td>30</td>
<td>East Gate Lodge Personal Care Home, NEHA</td>
</tr>
<tr>
<td>Tyndall</td>
<td>Tyndall Manor</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Garson</td>
<td>Limestone Villa</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
</tbody>
</table>

Source: Manitoba Housing to Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

The Manitoba Housing Units in Brokenhead are full to capacity.

Focus Group - Housing

The need for more transitional housing was expressed in the middle and senior Focus Groups.

SENIORS

• More independent living units [Springfield, Brokenhead, Iron Rose]

More independent housing units are something the participants in Brokenhead mentioned as a need.
### Safety

**Table 9.5 Crime Report Brokenhead Health District**

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Brokenhead</td>
<td>556</td>
<td>431</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle theft,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Criminal Other - Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace , arson,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>indecent acts, bail violations, breach of probation, harassing and stalking,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Federal Code</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coroner’s Act, Mental Health Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trespass Act, Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquor- intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Brokenhead</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired</td>
<td>Brokenhead</td>
<td>174</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td>driving, driving over 80 MG (blood alcohol level), driving a motor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>vehicle prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Traffic</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Brokenhead</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td>Note: this does not include persons injured or killed in traffic</td>
<td>Brokenhead</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Brokenhead</td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td>Note: this does not include persons injured or killed in traffic related incidents.</td>
<td>Brokenhead</td>
<td>1,198</td>
<td>916</td>
</tr>
<tr>
<td>GRAND TOTAL OF ALL OFFENSES</td>
<td>Note: this does not include persons injured or killed in traffic related incidents.</td>
<td>North Eastman</td>
<td>8,714</td>
<td>7,481</td>
</tr>
</tbody>
</table>

Source: Bill Hanysh, Corporate Management Branch (CMB). Client Services, RCMP "D" Division. Received August 8, 2003.

- * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged of the offense may also have been cleared.

- ** The number of persons injured and killed in traffic related incidents is not included in the numbers associated with the total traffic code category nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.
Discussion

All categories have shown a decrease during in 2002 except for federal code violations, which increased slightly.

With respect to traffic deaths, there was a considerable increase, from 0 in 2001 to 4 in 2002. There is no information about how many accidents this represents. In order to determine prevention strategies, more information is needed. The RCMP was unable to tell us if seat belts were in use.

There was also an increase in traffic injuries, from 27 in 2001 to 34 in 2002. Brokenhead has the second highest number of injuries when compared with our other health districts.

Note: We are not able to compare previous crime report information as the CMB changed their system of reporting.
Focus Groups - Safety

YOUTH

a) Risk-taking
"Teens care less than if you were older...they are invincible." [Brokenhead]

b) SKIDS – The issue of skids, or kids that walk the streets, emerged in a compassionate and thoughtful way only in the Brokenhead youth Focus Group.

"They [skids] don't have any ambition." "Most come from broken homes." The group feels, "...We're not helping anybody. Like, get a speaker...There are so many hurting people in our school and you can’t help them..." [Brokenhead]

- The fact that the skids are outside, walking around, made one student declare
"...[It's] better than the kids that are sitting at home watching TV...People who can't afford to play sports...are just stereotyped as a lesser person in society." [Brokenhead]

Suggestion by Youth
- Would like something for street kids, such as an activity centre. [Brokenhead]

In follow-up, Carol Orvis the CHA Assistant, talked to Cory Larson, Royal Canadian Mounted Police (RCMP) officer on February 6, 2004. The following is a summary of this discussion: Right now there are not a lot of kids on the streets, it's too cold, but come summer the kids will start to come out again. There is nothing for them to do. Cory has started a youth program, which he plans to run every Friday night at the old Elementary School. The first Friday night was Feb. 6 and no one showed up. He plans to continue for a few more weeks and hopes that the kids will come once word gets around. The Beausejour Community Church Pastor holds a game night the last Friday of every month in the basement of the church. The church is right on Park Ave. where the kids like to hang around, so it is convenient for them to drop in. The kids can come in and play pool, watch television, just hang around, and refreshments are available. This initiative is going very well. The Town of Beausejour has recently created a Loitering by-law, which states there will be no loitering at the front entrances to businesses. The RCMP has discouraged loitering in the past and are now enforcing the by-law.
Biology & Genetic Endowment

“The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.”  

Overview

The fundamental characteristics of this determinant include our genetic make up for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought that “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.”

For information related to this determinant refer to the section on ‘health status.’

Personal Health Practices & Lifestyle

“Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.”

Overview

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family’s pattern of life style and practice. Education alone is never enough. Other known influences on behaviour either positive or negative, may include an individuals peer’s, social / community norms and practices, and the willingness on the part of the individual, family, or community to change.
Dietary Practices

Focus Groups – Dietary Practices

The participants mentioned dietary modifications as a way to improve their lifestyle. Often the reason for nutritional changes was to control weight. Additional nutritional issues emerged in the youth and middle aged adult group.

YOUTH

EMERGING TOPICS
- Eating Disorders – this was raised only in Brokenhead. The group in Brokenhead expressed concern that young people (not just girls) identified with eating disorders evoked anger rather than understanding from their peers. They felt much of the reason for the disorder is to be more attractive. The group also indicated that there are more magazines that portray the perfect image aimed at young men now. Controlling food is seen as an easier fix than for example going to the gym. “They don’t want to work out and wait 6 months.” [Brokenhead]

Suggestion Raised by Youth
- More education/information on eating disorders and how it affects the person’s body, how to support an affected individual toward recovery for Grades 10, 11 students. They mentioned they had information in their earlier years but, “I think we were too young to listen….I didn’t care to listen.” [Brokenhead]

b) Obesity – This issue, mentioned separately from life style change, was only brought up in Brokenhead. We know from the Health Canada reports that obesity in youth is at an alarming rate.
“There is obesity everywhere in this town.” [Brokenhead]
- On a positive note, the Brokenhead group mentioned that the school is taking measures to reduce the amount of junk food sold by the canteen, and have disallowed junk food eating during class. [Brokenhead]

Barriers
- Junk food is easily accessible. Almost all goods sold in the canteen are junk food. [Brokenhead]
  - Junk food tastes better. [Brokenhead]

YOUNG ADULTS
- Some stay at home moms indicate they put effort into preparing healthy meals [rather than exercise as there is no time]. “I eat pretty healthy…I want to be an example for [my child]…” [Brokenhead]
- The young adult group had a concern about concern about young people eating so much junk food. “…As you get older you’re more concerned about what people think.” [Brokenhead]

EMERGING TOPICS
a) Lifestyle pressures contributing to unhealthy eating
“Our lifestyles promote it because we are so busy and it’s so fast and easy to grab and eat and run…” [Brokenhead]

b) Schools promoting unhealthy foods.
- There were mixed opinions whether early year schools were more healthy than seniors year schools. One participant mentioned that bad habits are forming and, if continued, will lead to health problems. [Brokenhead]
  - Tyndall school canteen…refuses to sell junk food…”[Brokenhead]
- The Brokenhead group also speculated that schools are subject to suppliers who provide needed materials e.g. computer paper in exchange for being allowed to sell in the schools

MIDDLE ADULTS
Often some or parts of the diet were changed, for example drinking more water, decreasing caffeine intake, or diet changes related to reducing cholesterol.

The reasons why participants modified their diet included:
a) Health reasons e.g. borderline diabetic, cholesterol. [Winnipeg River, Blue Water, Iron Rose, Brokenhead]
 SENIORS

Reasons to Modify Diet – There were several reasons given;
- as preventative measures, as their parents were obese. [Brokenhead]
- health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water]
- decrease in meat consumption because of Mad Cow disease [Brokenhead]
- vegetarian adult child influenced participant’s diet choices. [Brokenhead]

Programs / Methods Used
- Cut down on sweets [Brokenhead]
  “evening ritual of coffee and desserts was symbol the family was doing well, and why it’s necessary to cheat on a diet some times. “When we couldn’t afford it, we could have eaten (these foods). Now we can afford it but we can’t have this, can’t have that.” [Brokenhead.]
- Self educated regarding dietary changes
  “…what you do as head of the family, everybody follows.” [Brokenhead];
  “…I notice these menus (but) I eat what I don’t eat at home, when I get a chance to go out for dinner.” [Brokenhead]
- Preferred smaller portions than that seniors meal offered. [Brokenhead]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td></td>
</tr>
<tr>
<td>Need for Improvement in Dietary Behaviours</td>
<td>63.6%</td>
</tr>
<tr>
<td>A Validation Group participant suggested the use of a more accurate measurement than BMI.</td>
<td></td>
</tr>
</tbody>
</table>

2003 Focus Groups – This was a topic in every Focus Group. Youth groups wanted to modify their diet in order to lose/control weight. Some adults felt that young people were eating too much junk food. Modifications in dietary behaviours were something many adult participants were doing.
Alcohol Consumption

Focus Group - Alcohol Use

YOUTH
Drinking, as an emerging topic, came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change, recognizing that many youth in the Focus Groups did not consume alcohol.

The youth clearly saw alcohol not only as something youth did, but even more as a behaviour of adults in their communities

“...Even if you go to a party, you don't have to drink...Everybody goes and everybody knows each other. That's the good thing about living in a small town.” [Brokenhead]

- In the Brokenhead group, most participants claimed there is not much pressure to drink.

“...people just razzing you a little bit.” [Brokenhead]

“It’s a small town. There is nothing better to do (referring to drinking).” [Brokenhead]

ADULT FOCUS GROUPS
- This was not raised as a social problem in most of the adult Focus Groups except for the example given in the middle adult Focus Group. There were several adults, who mentioned on a personal note, that they did give up drinking. As the youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

Focus Groups on Illicit Drug Use

YOUTH
The mention of using drugs such as marijuana and cocaine was raised in Blue Water, Brokenhead and Winnipeg River groups only.

- In Brokenhead there was general consensus that drinking and drugs was more a problem among the young adults than at the high school. [Brokenhead]

“You'd be surprised at how many kids do drugs in this town.” [Brokenhead] They discussed the importance of friends looking out for you and this helps deal with peer pressure. [Brokenhead]

- A participant noted that some young people are using cocaine, however it was considered

“...not a big thing.” [Brokenhead]
Physical Activity

Focus Groups on Exercise

Increasing the amount of exercise was the most common form of lifestyle change that the adults did with respect to changing their lifestyle to improve health.

YOUTH

Reasons to Exercise - The two primary reasons were weight management and to be healthy.

YOUNG ADULTS

Reasons to Exercise - The two primary motivators for exercising was to decrease weight and improve body image.

Examples of Focus Group responses varied greatly

- Children gaining weight. [Brokenhead]
- Walking with a friend was a good motivator. “weight management and ‘me’ time.” [Brokenhead]
- Another participant walks because of high blood pressure and cholesterol. [Brokenhead]
- Family fitness after supper such as walking and biking keep children from gaining weight. [Brokenhead]

Programs / Methods Used

• Recreation facility. [Brokenhead]

Barriers

- “No exercise programs for moms and kids.” [Brokenhead]
- Time, due to young children. [Brokenhead]

MIDDLE ADULTS

- Reasons to Exercise - A health crisis in self or acquaintance was the most common reason. Other reasons include: to decrease weight, improve image, a health crisis in self or acquaintance, or for mental health reasons.

Barriers - Exhaustion, time, family commitments were the main barriers expressed.
- Felt they were too old to make changes. [Brokenhead]

SENIORS

Reasons to Exercise - Often someone influenced the person or there was specific goals i.e. weight loss/gain.

Programs / Methods Used

• Walking was the main method of exercising in this age group.
Smoking Practices

Focus Group on Smoking

The Focus Group discussion provided insight into some of the reasons why a person quits smoking, methods used and barriers to quitting. The most consistent message is that the individual wants to quit and there are a variety of methods used to suit the individual. Success often depends upon support the individual receives, and if weight gain is addressed and managed.

YOUTH
Smoking emerged in the majority of groups as either a lifestyle change and /or emerging topic. There is a perception that smoking among the youth group in Brokenhead is on the decline. They feel that there are so many public places where it is not allowed, it is bad for your health, and is expensive which has contributed to the smoking decline. [Brokenhead]

“…it's useless and people are starting to realize that.” [Brokenhead]

-Some schools support non-smoking and in fact ban smokers from certain activities e.g. Cheerleading squad. [Brokenhead]

YOUNG ADULTS
Programs / Methods Used to Quit
-Cold turkey. [Brokenhead]

Middle Adults
Quitting Smoking Barrier- Weight gain associated with quitting smoking emerged as a real challenge for some participants.

SENIORS
Quitting Smoking
A topic of concern in all adult groups was weight gain that may accompany smoking cessation.

Reasons for Quitting
-“I got fed up having to go outside.” [Brokenhead];

Programs / Methods Used
-Cold turkey [Brokenhead]
-Gradual reduction of cigarettes [Brokenhead]

Potential Risk Taking Behaviour

Focus Groups on Risk Taking Behaviour

YOUTH
a) In general
- “Teens care less than if you were older…they are invincible.” [Brokenhead]

b) Tattoos
- “You should be smart enough to go to a certified place.” [Brokenhead]
- Tattoos are seen as a means of self-expression. [Brokenhead]
Pharmaceutical Use

Figure 9.16 Proportion of Residents With At Least One Prescription

In Brokenhead there has not been a significant change in the proportion of residents receiving at least one prescription during the two time periods reviewed.

Manitoba and Rural South’s percentage is not significantly different.


There has been no significant change in the proportion of residents receiving at least one prescription in Brokenhead.
Number of Different Drugs

Figure 9.17 Number of Different Drugs

Brokenhead’s average number of different medications is statistically significantly lower than the Manitoba and Rural South during the second time period.

There has been a statistically significant increase when comparing the two time periods.

There has been a significant increase in the average number of different medications prescribed in Brokenhead.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason, it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic during the time period. Ideally we would like to see the percentage decrease.

Figure 9.18 Percentage of Residents Being Prescribed an Antibiotic

Brokenhead has the second highest percentage of antibiotic use when compared with all other health districts during the later time period.

Although there has been a significant decrease in the percentage of residents receiving at least one prescription antibiotic, Brokenhead’s percentage of use is statistically significantly higher than both the Manitoba average and Rural South for the second period.

Figure 9.19 Number of Antibiotics Prescribed

Brokenhead has shown a statistically significant decrease in the average number of antibiotics dispensed. This is good news.

Proportion of Residents Using Antidepressants

**Figure 9.20 Proportion of Residents Using Antidepressants**

The number of prescriptions overall have statistically significantly increased in Brokenhead, as in all health districts, except for Northern Remote.

During the second time period, Brokenhead has the second highest proportion of residents receiving two or more prescriptions for antidepressants at 5.7% when compared with our other health districts.

There is no significant difference between Brokenhead and Manitoba or Rural South's use of antidepressants.

**Focus Groups- Prescriptions**

There were some discussions about the dispensing of medication in the young and middle aged Focus Groups.

**MIDDLE ADULT**

The overriding concern is the question whether prescribed drugs should be the first treatment option explored. This came up in the young adult group as well. [Springfield, Brokenhead, Winnipeg River]
2004 Validation Workshops

Three Top Key Issues Identified by Participants

<table>
<thead>
<tr>
<th>Brokenhead</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Assistance Programs (e.g. Pharmacare) Inadequate</td>
<td>72.7%</td>
</tr>
<tr>
<td>Validation Group participants commented on the minimum annual income assistance – a program with a top up for the working poor is needed.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups – This was not a topic which was discussed at any length in the Focus Groups. A participant in Iron Rose commented that the Pharmacare deductible is too high.</td>
<td></td>
</tr>
</tbody>
</table>

Healthy Child Development as a Health Determinant

“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.”

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status.

Focus Groups on Youth

SENIORS

- Important to educate youth about prevention

“...That's the health of our next generation.” [Brokenhead]
Infant Mortality

Infant Mortality Rates

The Infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

In Brokenhead between 1990 and 1999, the number of infant deaths has been suppressed because there were 5 or less. This is good news for Brokenhead. 40

Births

At 40 weeks gestation 50% of females weigh approximately 3500 grams and males weigh approximately 3600 grams. 41 There is a strong correlation between birth weight and the income of the mother. Often in disadvantaged groups, mothers have babies with average higher birth weights. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances. 42

Table 9.6 Number of Newborns in Brokenhead

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


During 2002-2003, NE had a total of 431 newborns a rate of 10.9 / 1000 compared with the Manitoba a rate of 11.7/ 1000.

HOW HAS BROKENHEAD'S BIRTH RATE CHANGED OVER TIME?

Brokenhead’s birth rate has been fairly consistent, however they are lower than the Manitoba rate during the four years reviewed.

Focus Groups on Obstetrical Practices

MIDDLE ADULTS

- Would like to see midwife services . [Winnipeg River, Brokenhead]
Adolescent and Teenage Pregnancy

Figure 9.21 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability.

Springfield, Winnipeg River, Brokenhead and Iron Rose health districts have statistically significantly lower teen pregnancy rates than Manitoba.

The youth Focus Groups in Brokenhead indicated that teen pregnancy was less of a concern than in previous years.

Focus Groups on Teen Pregnancy

**YOUTH**

Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. Teen pregnancy was not mentioned in the adult groups.

-Brokenhead youth felt that teen pregnancy is less of a concern than in past years, but felt it needs to be addressed. [Brokenhead]

**Suggestions Raised by Youth**

- Sex education begins in the early grades but one participant in Brokenhead mentioned that you’re not really listening at that early age therefore factual information needs to be re-presented to older students. [Brokenhead]
2004 Validation Workshops

### Three Top Key Issues Identified by Participants

<table>
<thead>
<tr>
<th>Brokenhead</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teen Pregnancy</strong></td>
<td>72.7%</td>
</tr>
</tbody>
</table>

Validation Workshop participants did not raise any other specific comments on this subject.

2003 Focus Groups – Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. It was not mentioned in the adult groups.

### Breastfeeding Practices

**Figure 9.22 Breast Feeding Initiation Rates in NE Health Districts**

There is considerable variability within the health districts. Brokenhead has the third lowest hospital initiation of breastfeeding at 76.3% and 76.6% respectively when compared with our other health districts. Brokenhead’s rates appear to be lower than both Manitoba average and Rural South, but not significantly different.

Hospital breastfeeding initiation rates have not significantly changed and are close to the Manitoba average.
Birth Weights

Figure 9.23 High Birth Weights

The number of high birth weights has decreased slightly during the later time period, but not significantly. This is a positive sign.

High birth weight babies appear to be slightly lower than those in Manitoba and Rural South.

Figure 9.24 Low Birth Weights

There is a decrease in the percentage of low birth weight babies in Springfield, Northern Remote and especially in Brokenhead, where there was a positive statistical significant change over the two time periods from 6.5% to 3.6%.

Brokenhead’s percentage appears to be lower than Manitoba and Rural South, but is not statistically significantly different.
Brokenhead has experienced a decline in pre-term births from 7.5% to 6.1% respectively, but not a significant decline.

The number of pre-term babies has decreased, but not significantly.

Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses.

Brokenhead has the third highest number of completed immunizations at 87.6% during the later time period.

This percentage appears to be higher than Manitoba and Rural South, but is not significantly different.
Figure 9.27 Completed Immunizations at Two Years

Brokenhead’s immunization coverage has decreased during the second time period, but not significantly.

The coverage appears to be close to Manitoba and Rural South, but is not significantly different.


Figure 9.28 Completed Immunizations at Seven Years

Brokenhead experienced a decrease in immunization coverage during Year 1, 2 and 7, but it was not a significant difference.

Brokenhead’s coverage has shown a decrease, but not significantly.

Coverage shows that Brokenhead is statistically significantly higher than the Manitoba average at seven years of age.

“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.”

Overview

Job rank, social status in the workplace, the amount of control over one’s work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes, or those who are under employed.

Employment & Unemployment

Table 9.7 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Brokenhead has the third highest employment rate for males and the second highest rate for females. Females have a lower employment rate than males, however males have a higher unemployment rate than females.

Focus Group and Employment

SENIORS

- Quitting work for whatever reason is a lifestyle change and one that is never taken lightly. It may be due to many reasons, however discussion emerged only in the Brokenhead seniors Focus Group. The reasons given for quitting work were related to stress and boredom.
2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brokenhead</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Job Satisfaction</strong></td>
<td>63.6 %</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any specific comments on this subject.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups – Blue Water Seniors commented on lack of job satisfaction. Lack of jobs for young people was mentioned in Iron Rose.</td>
<td></td>
</tr>
</tbody>
</table>

Social Economic Status

There is considerable research to support the relationship between an individual's health status and their socioeconomic status.47

Median Family Income of Couple Families

The following tables describe the median family income of couple families and the median family income for lone parent families in the Brokenhead Health District communities, North Eastman and Manitoba.

Table 9.8 Median Family Income of Couple Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Couple Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td>$ 49,624</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$ 52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 55,885</td>
</tr>
</tbody>
</table>

Sources:

Brokenhead has a slightly lower median couple family income than either NE or Manitoba.
Table 9.9 Median Family Income of Lone Parents – Males and Females

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$ 40,087</td>
<td>$ 36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$ 23,892</td>
<td>$ 17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$ 29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$ 45,361</td>
<td>$ 26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$ 35,698</td>
<td>$ 26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$ 9,248</td>
<td>$ 12,587</td>
</tr>
</tbody>
</table>


Lone parent male families have consistently higher incomes than lone parent female households do. Brokenhead males and females rank the third highest in income when compared with our other health districts. Both exceed NE and the Manitoba median income for lone parent families.

Table 9.10 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$ 22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 26,469</td>
</tr>
</tbody>
</table>


Total Low Income Incidence

The incidence of low income as reported in the 2001 census in Brokenhead was 7.2%. 48

2004 Validation Workshops

<table>
<thead>
<tr>
<th>BROKENHEAD GROUP DISCUSSION ON INCOME AND SOCIAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestion</td>
</tr>
<tr>
<td>• Minimum annual income assistance – program with a top up for the working poor is needed.</td>
</tr>
</tbody>
</table>
Overview

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities, that safety, tolerance and a place for social interaction are included, as these all support a strong social network.

Mental Emotional Health

Mental health was raised as an important concern for many NE residents in particular in the area of mental health services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report. Mental Health Services continued to be a concern for 2003 Focus Group participants.

Focus Groups on Mental Well-being

Mental health issues emerged throughout the Focus Groups discussion. The topics varied between the age groups.

YOUTH - Youth reinforced the importance of friends and social support and their influence both positively and negatively on their mental well being.
   a) Self-Esteem: The Brokenhead group understood the value of having strong self-esteem. Some felt it was important that youth are aware of how and what they say can affect others.

ADULT FOCUS GROUPS - Several common themes emerged in the adult and staff Focus Groups. These included stress and lack of mental health support for adults.

YOUNG ADULT - The primary issues identified were the need for better awareness of the mental health programs (refer to Mental Health Program Section 7) and the stigma associated with accessing programs.

Mental Health Programming is discussed under the NEHA Mental Health Program - Section 7.
2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokenhead</td>
<td></td>
</tr>
<tr>
<td>Stigma Associated with Accessing Mental Health Services</td>
<td>63.6 %</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any specific comments on this subject.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Groups – This was an area of concern in the Young and Middle Adult Focus Groups.</td>
<td></td>
</tr>
</tbody>
</table>

Social Support

Table 9.11 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td><strong>Brokenhead</strong></td>
<td><strong>1725</strong></td>
<td><strong>225</strong></td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support, and they may be more economically disadvantaged than two parent households.

There are approximately 225 lone parent families reported in Brokenhead during 2001 Canada Census.
Focus Group On Social Support

Social support was an area that was raised in all Focus Groups and all ages as something that was seen as positive with respect to an individual's wellbeing.

Youth

During the initial discussions when talking about what it means to be healthy, youth mentioned the importance of friends and social supports. We know that social support is a strong determinant of health status.

a) Support Network

"They (youth) had changed just because they were told 'you're an awesome kid." This comment was mentioned referring to youth who had been involved in supportive programming. [Brokenhead]

Middle Adults

The concerns expressed in this group focused around community supports rather than personal support. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group. "If you talk about the seniors, I think we have a good service, but if you had a 35 year old...that needed more help than the family could provide, I haven't got a clue what's available. I honestly don't think there's anything." [Brokenhead]

Seniors

a) Effects of Isolation

- With changing community demographics this can leave the elderly with a feeling of "...strange in my own town." [Brokenhead]

b) Identification of Vulnerable Community Members - The middle adult Focus Group raised similar concerns about identifying vulnerable members of the community in relation to mental health issues.

"People are also lonely. Everybody living alone gets lonely." [Brokenhead]

-Expressed concern at difficulty identifying "...the ones (who) are not visible...People have a lot of pride." [Brokenhead]

2004 Validation Workshops

BROKENHEAD DISCUSSION ON SOCIAL SUPPORT NETWORKS

Suggestion

- Community support services should be available, not just for specific groups but especially for rural youth, how do they get to town in the evenings?
9.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the previous 1998 CHA Report, there have been boundary changes most prominently related to the northern areas. For the current health district boundaries, Seddon’s Corner was re-allocated to the Winnipeg River District.

Population

In Brokenhead, comparing 1995 with 2000, there has been an overall growth in most ages groups for both males and females. This is especially prominent for 40-69 year olds and for males 70-74 years. The implication of growth, especially as it relates to the elderly population, is the potential for added pressure on the health system. This contributes to the need for creative and preventative health services planning for this population group.

Brokenhead’s birth rate has remained relatively stable between 1999 and 2003. In 2002-2003 the birth rate was 8.8/1000 compared with 11.7/1000 in Manitoba.

Education

In July 2002, the Sun Rise School Division was established as a result of a partnership between the former Agassiz School Division and the Springfield component of the Transcona Springfield School Division.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index (SEFI) value and premature mortality rates (PMR) both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern. Brokenhead experienced a positive improvement during 1996 in its SEFI value, and appears to have surpassed both Manitoba and Rural South.

PMR has increased slightly in Brokenhead, but not significantly. This needs to be monitored, as it is a measurement of general health status.
### Deaths

Brokenhead’s total mortality rate did increase slightly, but not significantly and is the second highest in NE after Northern Remote.

### Life Expectancy

Females live almost four years longer than males in Brokenhead.

### HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cancer cases have not changed significantly and is close to the Manitoba average.</td>
<td>- Diabetes treatment has increased, but not significantly and is close to the Manitoba average, but not statistically significantly different.</td>
<td>- Brokenhead appears to have the highest rate of asthma within NE region</td>
<td>- Hypertension treatment has increased, but not significantly, and is close to the Manitoba average, but is not significantly different.</td>
</tr>
<tr>
<td></td>
<td>- Sixty-three percent of Brokenhead validation workshop participants felt diabetes was a key issue.</td>
<td>- Respiratory treatment diagnoses have decreased significantly, but are significantly higher than Manitoba average.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI’s has significantly decreased.</td>
<td>Stroke treatment has increased slightly, but not significantly. Brokenhead has the second highest treatment rate in NE.</td>
<td>Injury hospitalizations have experienced a significant decrease, and are the second lowest rate when compared with our other health districts.</td>
</tr>
</tbody>
</table>
Human Function & Well-being

The most prominent issue that arose in all health districts indicating that there was ‘nothing to do.’ This is an area to explore with our community partners. Youth and adults in the Focus Group provided many good suggestions. Sixty-three percent of validation workshop participants in Brokenhead raised this as a key issue.

DETERMINANTS OF HEALTH

Environmental Factors

*Water* - There were no concerns raised in either the Focus Groups or the validation workshops about water concerns. There are two communities in Brokenhead with boiled water advisory: Tyndall and Garson.

Other environmental issues that arose related to: second hand smoke, and staff smoking on facility grounds in particular outside facility doors.

*Safety* – Brokenhead youth raised concerns about the safety of ‘SKIDs’ in Beausejour. Traffic injuries and deaths are on the rise within NE, in particular in Brokenhead and Springfield.

*Housing* – The Brokenhead Focus Groups identified a need for more independent units.

Personal Health Practices

There appears to be a general public readiness toward healthier lifestyle choices.

*Dietary* – Obesity is a national concern. Dietary modifications were common among all Focus Groups in relation to lifestyle changes in order to control or decrease weight. Youth in Brokenhead raised concerns about eating disorders. Other issues expressed by adults regarded lifestyle pressures making it difficult to make healthy meals for family and schools promoting unhealthy food. Sixty – three percent of Validation Workshop participants indicated that improvement in dietary behaviours was a key issue.

*Alcohol Consumption* – Youth Focus Groups identified this as an issue in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners.

*Illicit Drug Use* – This was raised as a concern in the youth Focus Groups in Blue Water, Brokenhead and Winnipeg River.

*Physical Activity* – Exercise was the top area that focus groups and NE provincial survey respondents indicated they did to achieve a healthier lifestyle. We know from the evidence that there are many people who still do not exercise.
Smoking Practice – Some focus group participants mentioned that they had or were thinking about quitting smoking. Ongoing smoking cessation programs targeting community and staff should be considered. The Focus Group discussions addressed issues surrounding barriers to quitting smoking. Using this information will assist in increasing the success rate of smoking cessation programs.

Medication Use

Prescriptions - The average number of drugs dispensed has increased in Brokenhead, but not significantly.

Antibiotics - there has been a statistically significant decline in the number of antibiotics prescribed, however during the later time period, Brokenhead’s antibiotic use is significantly higher than the Manitoba average.

Antidepressants - Antidepressant prescriptions have shown a statistically significant increase in Brokenhead, but is not significantly different than Manitoba. It is difficult to know if the reason is due to depression diagnosis, as antidepressants can be prescribed for other reasons.

There were concerns raised in the Focus Groups that the first choice of treatment may be prescription drugs. Seventy – two percent of validation participants felt that government assisted programs for example, Pharmacare was inadequate.

Healthy Child

Mortality Rates - Brokenhead’s infant deaths have been suppressed due to low numbers.

Adolescent & Teenage Pregnancy - Between 1991 and 2000 there has been no change in the teenage pregnancy rate and it is statistically significantly lower than the Manitoba average.

Brokenhead youth felt it is less of a concern now than in the past, however an issue that needs to be addressed. Seventy percent of validation participants raised teen pregnancy as a key issue and there is a need to continue to monitor this.

Hospital Breastfeeding Initiation - Brokenhead breastfeeding initiation rate is 76.3% and it is not significantly different than the Manitoba average.

Birth Weights - High weight and pre-term births have decreased in Brokenhead, but not significantly. The numbers of low birth weight have shown a significant decrease. There is a need to continue to monitor this, as there are potential implications associated with the future health of our children and potential burden on health services.

Immunizations – There has been a significant decline in Brokenhead’s rate of immunization for 1, 2 and 7 year olds. Immunization coverage at age seven is significantly higher than the Manitoba average. Vaccination is a cost effective way to prevent illnesses and decrease costs to the health system. It would be interesting to determine why the overall decrease in the two and seven years occurred. This is not a unique phenomena to
NE as it has happened in all RHA’s. Is accessibility or negative media attention a cause? This would be an area to explore further.

Living and Working Conditions

Work - During 2001, Brokenhead had the third highest employment rate for males and second highest for females in NE. Sixty-three percent of Brokenhead Validation Workshops participants indicated that job satisfaction was a key issue.

Economic Status – In 2001, Brokenhead had a lower median family income when compared with NE and Manitoba overall. The incidence of low income in Brokenhead as reported in the 2001 census was 7.2%.

Personal Resources

Mental Emotional Health – During the Focus Groups there was discussion about mental well being.

- Youth stressed friends and social support as really important. As well having self-esteem in face of external influences.
- Adults, in general discussed stress and the lack of mental health supports. Young adults focused on the need for better awareness of the mental health programs and stigma associate with accessing programs.

Sixty – three percent of Brokenhead validation workshop participants identified stigma associated with accessing mental health services as a key issue.

Social Support – There were approximately 225 lone parent families reported during the 2001 census.

In the middle age Focus Group a concern arose community supports should be all encompassing and not restricted to one age group or a specific group. This is certainly worth investigating and pursuing especially with services that are not directly related to physical health e.g. housekeeping, transportation, maintenance, and child care in an emergency.
### Summary At A Glance

#### KEY
- **Partner**: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor**: refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA**: a program or service could be enhanced or developed to address this issue.

#### Strengths

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive improvement in SEFI value and appears to have surpassed both Manitoba &amp; Rural South in 1996.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>PMR has increased slightly, but not significantly.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>New cancer cases have not changed significantly and are close to the Manitoba average.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Hypertension treatment has increased, but not significantly.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Hospital treatments for MI’s have decreased significantly.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Injury hospitalization has decreased significantly.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Infant mortality rates were suppressed.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Third highest employment rate in NE in 2001.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>High &amp; pre – term birth weights have declined, but not significantly. Low birth weight babies have shown a significant decline.</td>
<td>[NEHA, Monitor]</td>
</tr>
<tr>
<td>Teenage pregnancy has not changed, and the rate is significantly lower than Manitoba.</td>
<td>[NEHA, Partner]</td>
</tr>
</tbody>
</table>

#### Issues Having Implications for Health Planning & Delivery

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male and female population increased in 40-69 year old age group, and males in 70-74 years.</td>
<td>This has the potential to affect health services needs in this population.</td>
</tr>
<tr>
<td>Youth have ‘nothing to do.’</td>
<td>[Partner]</td>
</tr>
<tr>
<td>Diabetes treatment is increasing but not significantly, and is close to the Manitoba average but not significantly different.</td>
<td>[NEHA, Monitor, Partner]</td>
</tr>
<tr>
<td>Hypertension treatment has increased.</td>
<td>[NEHA, Partner]</td>
</tr>
<tr>
<td>Water quality- boiled water advisory in Garson and Tyndall.</td>
<td>[NEHA, Partner]</td>
</tr>
<tr>
<td>Safety: ‘SKIDS’ a concern for youth Focus Group participants</td>
<td>[NEHA, Partner]</td>
</tr>
<tr>
<td>Safety: Traffic injuries and deaths have increased.</td>
<td>[NEHA, Partner]</td>
</tr>
<tr>
<td>Respiratory treatment diagnoses have decreased significantly, but are significantly higher than the Manitoba average</td>
<td>[NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Stroke treatment has increased slightly, but not significantly, but is the second highest when compared with our other health districts.</td>
<td>[NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Average number of drugs dispensed increased.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Median income lower than NE and Manitoba overall.</td>
<td>[Monitor]</td>
</tr>
<tr>
<td>Some focus group participants expressed need for more independent housing units.</td>
<td>[Partner]</td>
</tr>
<tr>
<td>Alcohol consumption was raised by youth in Focus Groups.</td>
<td>[Partner]</td>
</tr>
<tr>
<td>Community supports should not be restricted to one age or group.</td>
<td>[Partner]</td>
</tr>
<tr>
<td>Illicit drug use raised as a concern in Focus Group.</td>
<td>[Partner]</td>
</tr>
</tbody>
</table>
**KEY**

- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

<table>
<thead>
<tr>
<th>Issues Having Implications for Health Planning &amp; Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Promotion of exercise in all age groups. [NEHA, Partner]</td>
</tr>
<tr>
<td>• Government assisted programs e.g. Pharmacare inadequate as raised in Validation Group. [Partner]</td>
</tr>
<tr>
<td>• Dietary- Obesity a national and local problem. Issues raised on eating disorders, schools promoting unhealthy foods. [NEHA, Partner]</td>
</tr>
<tr>
<td>• Smoking cessation programs. [NEHA, Partner]</td>
</tr>
<tr>
<td>• Breastfeeding initiation rate is the third lowest in our region, but not significantly different than the Manitoba average. [NEHA, Partner]</td>
</tr>
</tbody>
</table>

Mental Wellbeing as raised by some focus group participants:

- Lack of adult mental health supports, stress and the need for better awareness of mental health services. [NEHA, Partner]
- Significant increase in antidepressant use, but not significantly different than Manitoba average. [NEHA, Partner, Monitor]
- Significant decline in antibiotic use, but is significantly higher than Manitoba. [NEHA, Partner, Monitor]
- Childhood immunization coverage has declined, but not significantly. Only at seven years is the coverage significantly higher than the Manitoba average. [NEHA, Partner, Monitor]

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
9.6 REFERENCES

1. Town of Beausejour Office, RM of Brokenhead Office, Eastman Regional Development Inc., Beausejour Office, Manitoba Community Profiles Website


33 RM Municipal Offices, Town Offices, Web Page: community profiles.mb.ca/maps/regional/eastman.htm; Western Diversification Office in Beausejour, Lac du Bonnet.
10.1 GEOGRAPHICAL OVERVIEW .......................................................................... 10-1

10.2 COMMUNITY SYSTEM CHARACTERISTICS ............................................. 10-4

10.3 HEALTH STATUS ......................................................................................... 10-7
    Overview ........................................................................................................ 10-7
    Significant Indicators Measuring Overall Health Status .............................. 10-7
    Deaths ........................................................................................................... 10-11
    Health Conditions ......................................................................................... 10-15
    Human Function ............................................................................................. 10-23

10.4 DETERMINANTS OF HEALTH ................................................................. 10-24
    Environmental Factors .................................................................................. 10-25
        Water ......................................................................................................... 10-25
        Air ............................................................................................................. 10-26
        Housing ................................................................................................... 10-26
        Safety ....................................................................................................... 10-27
    Biology & Genetic Endowment ..................................................................... 10-29
    Personal Health Practices & Lifestyle ......................................................... 10-29
        Overview ................................................................................................ 10-29
        Dietary Practices ....................................................................................... 10-30
        Alcohol Consumption ............................................................................. 10-30
        Physical Activity ....................................................................................... 10-31
        Smoking Practices .................................................................................... 10-32
        Medication Use ......................................................................................... 10-33
    Healthy Child Development ......................................................................... 10-36
        Overview ................................................................................................ 10-36
        Infant Mortality Rates ............................................................................. 10-36
        Births ......................................................................................................... 10-36
        Adolescent and Teenage Pregnancy ....................................................... 10-38
        Breastfeeding Practices .......................................................................... 10-39
        Birth Weights ........................................................................................... 10-40
        Childhood Immunizations ....................................................................... 10-42
        Community Feedback on Healthy Child Development .......................... 10-44
    Living and Working Conditions ................................................................. 10-45
        Overview ................................................................................................ 10-45
        Social Economic Status ......................................................................... 10-46
    Personal Resources ..................................................................................... 10-48
        Mental Emotional Health ....................................................................... 10-48
        Social Support ......................................................................................... 10-49

10.5 SUMMARY/CONCLUSION ......................................................................... 10-51

10.6 REFERENCES .............................................................................................. 10-58
10.1 GEOGRAPHICAL OVERVIEW

The Iron Rose District includes the Rural Municipalities of Whitemouth and Reynolds and the Whiteshell. The Trans Canada Highway and Provincial Trunk Highways 15, 11 and 44 all pass through the health district.

The economy consists of agriculture and natural resources, as well as, retail and service businesses and tourism. The Reynolds municipality is attractive to new business as there is no business tax and it boasts one of the lowest municipal tax rates in all of Manitoba. The Rural Municipality of Reynolds is constantly working towards the fostering of new business and investment.

Recreational activities include waterway attractions such as kayaking, whitewater rafting and canoeing, as well as slow-pitch and baseball, snowmobiling, cross country skiing and curling. There are two curling rinks within the district, one in Whitemouth and the other in Seven Sisters. After two years of planning, the Whitemouth Curling Club was able to pour a concrete floor for the ice surface in the fall of 2002. With grants from Community Places and the RM of Whitemouth, the Club was able to finance the construction. The concrete floor means that the facility can now be used year round for a variety of functions.

The Whitemouth Municipal Museum is important to the area, with its motto being, “To preserve the past for future generations”. The museum includes an Anglican Church, which was built in 1906. With monetary assistance from the RM of Whitemouth, fundraising efforts from the Museum Board and private donations, the church was recently moved to the museum grounds and then renovated. A dedication ceremony for the church was held in 2003.

Because of the growth experienced in the Whitemouth area, the South Interlake Credit Union constructed a new branch building in the town of Whitemouth and had its grand opening in 2002.

The Town of Whitemouth was presented with a special mention award for Environmental Awareness from the Manitoba in Bloom 2002 Provincial Competition.
These are the municipalities and communities that fall under the Iron Rose Health District.

<table>
<thead>
<tr>
<th>IRON ROSE</th>
<th>3,391 in 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reynolds RM (186)</td>
<td></td>
</tr>
<tr>
<td>-EAST BRAINTREE ROE OLO</td>
<td></td>
</tr>
<tr>
<td>-HADASHVILLE ROEOXO</td>
<td></td>
</tr>
<tr>
<td>-RENNIE ROE1RO</td>
<td></td>
</tr>
<tr>
<td>-McMunn</td>
<td></td>
</tr>
<tr>
<td>-Medika</td>
<td></td>
</tr>
<tr>
<td>-Molson</td>
<td></td>
</tr>
<tr>
<td>-Prawda</td>
<td></td>
</tr>
<tr>
<td>-West Hawk Lake</td>
<td></td>
</tr>
<tr>
<td>-Ste. Rita</td>
<td></td>
</tr>
<tr>
<td>RM of Whitemouth (169)</td>
<td></td>
</tr>
<tr>
<td>WHITEMOUTH ROE2G0</td>
<td></td>
</tr>
<tr>
<td>SEVEN SISTERS ROE1YO</td>
<td></td>
</tr>
<tr>
<td>ELMA ROEOZO</td>
<td></td>
</tr>
<tr>
<td>RIVER HILLS ROE1TO</td>
<td></td>
</tr>
<tr>
<td>Unorganized Territories (288)</td>
<td></td>
</tr>
<tr>
<td>WHITESHELL ROE2HO</td>
<td></td>
</tr>
</tbody>
</table>

Source for Population – 2003

Sources:
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA report.

Geographical Changes:

- Unorganized Territories previously was a separate geographic area. In this report, depending upon the municipal code, communities have been re-allocated into Winnipeg River, Iron Rose, Blue Water and Northern Remote.

- Northern Remote is a separate health district.

- Springfield has had no geographical boundary changes since the previous report.

- Brokenhead has had Seddon’s Corner re-allocated into Winnipeg River.
Focus Groups On How The Community Promotes Or Supports Healthy Living

YOUNG ADULT
Positive
- Heart Health Project, recreational activities - skating rink, biking, walking, roller blading, breast feeding support, Dietitian,
First Place Program (out of Beausejour), Readiness Clinics, care in the Whitemouth PCH (excellent, nurses wonderful),
grief counseling support group is “excellent.” [Iron Rose]

MIDDLE ADULT
Positive
- Generally pleased with the quality of service in NEHA hospitals (aside from services not available) “…the doctors here
are pretty good.” Health Links, Home Care, pharmacy, dietitian. [Iron Rose]

SENIORS
Positive
- Home care, presentations by speakers (some felt that this was a good way to receive information and some felt that it
wasn’t), availability of pamphlets at medical centres and doctors’ offices. [Iron Rose]
10.2 COMMUNITY SYSTEM CHARACTERISTICS

**Overview**

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up communities’ specific characteristics. Where information is available the sex of the individual is provided. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women, as well as, gender influences affecting age, education, socio-economic status, culture and physical environment. 3

**Population Demographics**

**Figure 10.1 Age Profile of Iron Rose**

During the time period, an increase in population occurred in most of the age groups. Decreases occurred in the 30-34, and 65-70 year old age groups, and in males older than 80 years.

There is an association between education levels and an improvement in self rated health status. Education is also closely tied with socioeconomic status. Effective education for children and life long learning for adults contributes to the health and prosperity of individuals.

Table 10.1 Percentage of Population With Less Than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school age 20-34</th>
<th>% of population with less than high school age 35-44</th>
<th>% of population with less than high school age 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM Whitemouth</td>
<td>56.5</td>
<td>52.0</td>
<td>45.3</td>
</tr>
<tr>
<td>RM of Reynolds</td>
<td>44.4</td>
<td>34.8</td>
<td>67.5</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


In Iron Rose there is a higher percentage of the population with less than a high school education when compared to NE and Manitoba overall.

Sunrise School Division

In July 2002 the Sunrise School Division was established in partnership with the former Agassiz School Division and the Springfield component of the Transcona Springfield School Division. The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counsellors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have consultants in the following areas: Early/Middle Years, Senior years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.

Table 10.2 Sunrise School Division – Iron Rose Health District

<table>
<thead>
<tr>
<th>SUNRISE SCHOOL DIVISION</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Rose Health District</td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
</tr>
<tr>
<td>Reynolds Elementary School</td>
<td>45 53</td>
<td>19 27</td>
<td>26 26</td>
<td></td>
</tr>
<tr>
<td>Whitewmouth School</td>
<td>254 242</td>
<td>127 115</td>
<td>127 127</td>
<td>96% 94%</td>
</tr>
<tr>
<td>Whiteshell Colony</td>
<td>48 52</td>
<td>24 16</td>
<td>24 36</td>
<td></td>
</tr>
</tbody>
</table>

Source: Principals of each Sunrise School Division School and Colony School, January – April 2004
Children With Special Needs

The Sunrise School Division had a population of 5180 children in 2003-2004 school year. There were a total of 221 children (4.2%) who were receiving support through a health services program. These health services are provided by NEHA through the Unified Referral and Intake System. These numbers do not capture the number of children with health care needs who do not have a “formal” health care plan developed by a nurse. These numbers are no longer kept, but two years ago there were over 600 children receiving medications. It is believed that now that number has now increased.5

Focus Groups – Schools

Middle Adult

a) Health Education in School

- Need for a greater connection between school and health care providers “…hungry children at school was a concern…gap getting help at school…a public health nurse only comes in if there is a crisis.” [Iron Rose]

2004 Validation Workshops

<table>
<thead>
<tr>
<th><strong>IRON ROSE GROUP DISCUSSION ON EDUCATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- A participant commented on the fact that many children are pulled out of school to work, which affects education levels. However this may be changing now.</td>
</tr>
</tbody>
</table>

**Suggestion**

- Issue of respect should be addressed in schools in relation to harassment and peoples rights.
10.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” 6</td>
<td>“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)” 7</td>
<td>“Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).” 8</td>
<td>“Broad measures of the physical, mental and social well-being of individuals.” 9</td>
</tr>
</tbody>
</table>

Overview

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health”, we find that there are many influencing factors, some controllable, for example the choices we make i.e. using a seat belt, and things we have less or no control, over for example hereditary diseases.

Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services.
All health districts except for Northern Remote and Blue Water have a greater SEFI value than both Manitoba and Rural South. Except for Winnipeg River and Northern Remote there has been an overall improvement in the value in 1996 as compared with 1991. Iron Rose in particular has seen an improvement in their SEFI value in 1996 as compared with 1991.

Iron Rose has shown an improvement in SEFI value and appears to be greater than both Manitoba and Rural South in 1996.
Premature Mortality Rate

PMR is defined as deaths when that occurs before age 75. This indicator is often used as a measure of general health status and the subsequent need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services.  

Figure 10.3 Premature Mortality Rate in NE Health Districts

We do not want to see this indicator increase. Iron Rose has experienced a decrease in the PMR value in 1996-2000 as compared with 1991-1995, but it is not a significant decline. There is not a significant difference between Iron Rose’s PMR and Manitoba or Rural South.

PMR has decreased but not significantly.
Focus Groups – On the Meaning of Health

YOUTH - Overall, youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself and minimizing stress, being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

“...out here, it's a bit more natural to be healthy than in the city because everything's far away so you bike to get there and if you live on a farm, you naturally get fit.” [Iron Rose]

Barriers – Youth were able to identify factors such as lack of money (limited their ability to join recreational activities and purchase healthier foods) and a lack of transportation (limited them from attending recreational activities) as barriers to a healthier lifestyle.

YOUNG ADULTS

- Some of the major themes that emerged in all Focus Groups included: absence of sickness, participating in life, humour, healthy eating, sleeping well, active lifestyle (exercise), good mental health, social support, good relationships especially for people who are alone, balance, work, no bad habits (smoking, drinking) all supported a healthy lifestyle.

- Access to good health care and finding it quickly especially for children came up in Springfield and Iron Rose. The Iron Rose group mentioned prevention as it specifically relates to immunization, health promotion e.g. anti-smoking.

Barriers

- Distance to activities and work [Iron Rose]

“Small towns are wonderful places to raise children, but pretty much whatever you want to do with your child, you're going some place else...” [Iron Rose]

“...wouldn't say there are no employment opportunities, but not good ones...” [Iron Rose]

MIDDLE ADULTS

This group indicated clearly that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humor, weight management and the importance of social activity and connection, being mentally well, stress management and balance.

Gaps

a) Recreational Activities – This is a common theme mentioned in all Focus Groups.

- Swimming pool [Springfield, Iron Rose]

- Local community clubs are declining… those who can afford it are going elsewhere: “…to the city, to Beausejour, to Pinawa…Then we've got people who can't afford to run off and do some other stuff. They need services here. ” [Iron Rose]

b) Employment

- Jobs for young people “…who finish school they go to University or Red River College and don’t come back here because there’s nothing to come back to.” [Iron Rose]

c) Other

- Natural gas line. [Iron Rose]

- More compensation for volunteer drivers. [Iron Rose]

SENIORS

In general most groups included aspects of your mind (memory), body, attitude, keeping active and mobile, good nutrition, exercising for example, walking and other recreational activities that included exercise and socializing, being active in your community, friends and family.

“...as you age your health will change somewhat.”[Iron Rose]

Gaps

a) Recreational Activities – This emerged in all Focus Groups.

Recreational activities emerged as a consistent comment in the 2003 provincial survey as well.
Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

**Figure 10.4 Total Mortality Rate in NE Health Districts**

Iron Rose showed a slight decrease in the total mortality rate, but did not change significantly.

Iron Rose’s mortality rate appears to be less than Manitoba and Rural South, but it is not a significant difference.

---

**Deaths**

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.”

---

**Total Mortality Rate**

This indicator examines all deaths from all different causes and all ages.

**Figure 10.4 Total Mortality Rate in NE Health Districts**

Iron Rose showed a slight decrease in the total mortality rate, but did not change significantly.

Iron Rose’s mortality rate appears to be less than Manitoba and Rural South, but it is not a significant difference.

---

**Iron Rose’s total mortality rate has decreased, but not significantly.**
Life Expectancy

Figure 10.5 Life Expectancy in NE Health Districts

In Iron Rose we see that females live longer than males by approximately 6 years. The male life expectancy has changed little, however the female life expectancy rate has increased from 79.7 to 81 years. Both males and females appear to have similar life expectancies as when compared to Manitoba and Rural South.

Iron Rose females live approximately 6 years longer than their male counterparts.
Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths.\textsuperscript{12}

Figure 10.6 Potential Years of Life Lost in NE Health Districts

Iron Rose has had a decrease in its PYLL, but it was not a significant change.

We do not want to see premature deaths.

Iron Rose appears to have a higher PYLL than Manitoba, but it is not significantly different.

Iron Rose has shown a decrease, but not significantly. In its PYLL value and is not significantly different than the Manitoba value.
When we separate males and females, it becomes noticeable that males appear to have an increased level of PYLL (77.3) than females (52.4) during the later time period.

Male and female PYLL have shown a decrease in value, but it wasn't a significant change.
Health Conditions

*Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. * (World Health Organization (WHO))

Cancer

**Figure 10.8 New Cancer Rates** [includes non-invasive malignancies].

![New Cancer Rates NE Health District [age & sex adjusted]](image)

In Iron Rose we see a slight increase in the overall cancer incidence during the time periods reviewed, but it was not a significant change.

Iron Rose’s rate is not significantly different than the Manitoba average or Rural South.

**Cancer rates have increased, but not significantly during 1996-2000, and are not significantly different than the Manitoba average.**
Diabetes

Diabetes Treatment Prevalence

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

**Figure 10.9 Diabetes Treatment Prevalence in NE Health Districts**

There has been a statistically significant increase from 3.6% to 5.2 % during the two time periods reviewed. Iron Rose’s diabetes treatment appears to be lower than the Manitoba average (5.6%) and lower than Rural South (5.4%), but it is not a significantly difference.


*Diabetes has shown a significant increase, but it is not significantly different than the Manitoba average.*
Respiratory Diseases

Figure 10.10 Asthma Prevalence

Iron Rose appears to have the second highest asthma rate when compared with our other health districts.

As mentioned in the regional section, both asthma and respiratory diseases in general are showing a decline.

Iron Rose appears to have the second highest rate of asthma in NE.
In Iron Rose there has been a statistically significant decline in respiratory diseases diagnosed during the time periods reviewed.

There is also a statistically significant decrease in Iron Rose when compared with Manitoba and Rural South during the second time period.
Hypertension

Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 10.12 Hypertension Treatment Prevalence in NE Health Districts

Iron Rose residents are statistically significantly higher (23% and 25% respectively) in the prevalence of hypertension treatment when compared with the Manitoba average (20% and 22% respectively) and Rural South (22% and 22%) during both time periods reviewed.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Rose</td>
<td>86.6%</td>
</tr>
<tr>
<td><strong>High Blood Pressure</strong></td>
<td></td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any specific comments on this subject.</td>
<td></td>
</tr>
</tbody>
</table>

2003 Focus Groups – This was mentioned in the Focus Groups, particularly Middle Adult and Seniors, in relation to life style change due to health problems. In some cases the health problem being high blood pressure.
Heart Attacks

Figure 10.13 Acute Myocardial Infarctions (MI’s) or Heart Attack Rates of Hospitalization

Iron Rose’s rates are not significantly different during the two time periods reviewed.

Iron Rose’s rate (1.79 and 1.78 respectively) appears to be less than the Manitoba average of (2.35 and 2.22 respectively) and Rural South (2.45 and 2.22) but it is not statistically different.

There has not been significant change in the rate of hospitalizations for MIs in Iron Rose.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older, and is averaged over the five-year period to give an annual rate. The reason it is not expressed as a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

There has been a decline in residents in Iron Rose being treated for stroke from 2.76 / 1000 to 1.95/1000, but not a significant decrease. There is no significant difference between Iron Rose's rate and Manitoba or Rural South.

Iron Rose's stroke treatment has decreased, but not significantly.
Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999 compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to a relatively small number of injury deaths, these rates are not reported at the district level.¹⁴

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

**Figure 10.15 Injury Hospitalization Rates in NE Health Districts**

![Injury Hospitalization Rates in NE Health Districts](chart)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield (1,2)</td>
<td>6.92</td>
</tr>
<tr>
<td>Winnipeg River (t)</td>
<td>7.01</td>
</tr>
<tr>
<td>Brokenhead (t)</td>
<td>11.72</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>11.99</td>
</tr>
<tr>
<td>Blue Water (1,2)</td>
<td>9.25</td>
</tr>
<tr>
<td>Northern Remote (1,2)</td>
<td>11.69</td>
</tr>
<tr>
<td>Manitoba Average (t)</td>
<td>14.63</td>
</tr>
<tr>
<td>Rural South (1,2, t)</td>
<td>48.07</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>11.52</td>
</tr>
<tr>
<td>Manitoba Average (t)</td>
<td>10.29</td>
</tr>
<tr>
<td>Rural South (1,2, t)</td>
<td>13.49</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>10.52</td>
</tr>
<tr>
<td>Manitoba Average (t)</td>
<td>9.81</td>
</tr>
<tr>
<td>Rural South (1,2, t)</td>
<td>13.54</td>
</tr>
</tbody>
</table>


Iron Rose's hospitalization due to injury rate appears to have increased slightly during the two periods reviewed but not significantly.

Iron Rose appears to have a slightly higher injury hospitalization rate during the second time period when compared with the Manitoba average (9.88/1000) and Rural South (11.52), but it is not a significant difference.

Hospitalization due to injuries has increased, but not significantly, and there is no significant difference between Iron Rose and Manitoba or Rural South.

Injury deaths are on the rise in NE, and throughout Manitoba overall.
Human Function

“Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation). International Classification of Functioning and Disability.” (ICIDH-2, Beta 2 Version)

Overview

Human function is associated with the consequences of diseases, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Well Being

“Broad measures of the physical, mental and social well-being of individuals.”

Overview

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age can do who may not have an illness.

Focus Group on There’s Nothing To Do

It was felt that the perception of ‘nothing to do’ will have an effect on the overall well being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their focus groups specifically related to recreational activities.

2004 Validation Workshops

IRON ROSE GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES AND COPING SKILLS

- One participant commented that the community has tried to develop activities/programs for youth in the past, i.e. community hall was built for entire community and used to have a very active Curling Club but now youth don’t seem to engage in activities that may be planned. Not the same interest and commitment.
### 10.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Personal Health Practices &amp; Coping Skills]</td>
<td>[Social Support Network]</td>
<td>[Income, Income Distribution and Social Status and Employment and Working Conditions]</td>
<td>[Physical]</td>
</tr>
</tbody>
</table>

- **Personal Health Practices & Lifestyle**
  - Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status. *21

- **Personal Resources**
  - Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health. *22

- **Living & Working Conditions**
  - Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health. *23

- **Environmental Factors**
  - Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors. *24

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
</table>

- **Healthy Child Development**
  - The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. *25

- **Biology & Genetic Endowment**
  - The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges. *26

- **Culture**
  - Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors. *27

- **Gender**
  - Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue. *28
Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment, however there are some concerns most specifically related to water quality.

**Water**

**Water Quality**

The Whitemouth Water Co-op supplies both the RM and Town of Whitemouth with treated water. There is a Co-op Treatment Plant in Prawda, which serves approximately 20 houses. Other areas in the district utilize private wells.

**Focus Group**

**YOUTH**

- Water quality emerged in the Iron Rose group when talking about farm safety and about whether they were concerned about bovine spongiform encephalopathy (BSE) and E-coli water contamination. They generally felt that more was being made of these concerns than warranted, as the town water was treated.

  
  "We get town water, so you think it should be good." [Iron Rose]

**YOUNG ADULT**

a) Safe Water

- Access to safe water was raised as a concern around Elma. [Iron Rose]

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Rose Water Quality</td>
<td>72.7%</td>
</tr>
<tr>
<td>Validation Group participants voiced concern about the quality of the water.</td>
<td></td>
</tr>
</tbody>
</table>

2003 Focus Groups – The creek is contaminated by pesticides, chemicals and sewage. Iron Rose Middle Adults group also raised a concern about access to safe water around Elma.
Sewage Systems

A sewage system serves the communities of Whitemouth and Seven Sisters. Rural areas have holding tanks and septic fields. A lagoon provides for waste disposal.

The Air We Breathe

There were no comments related to air quality in this district from focus group or validation workshop participants.

Housing

Table 10.3 Elderly Person's Housing in Iron Rose Health District

<table>
<thead>
<tr>
<th>Ironrose Communities</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitemouth</td>
<td>Riverbend Manor</td>
<td>12</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Hadashville</td>
<td>4 of 8 units designated to seniors</td>
<td>4</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Prawda</td>
<td>2 of 8 units designated to seniors</td>
<td>2</td>
<td>Community Housing Managers of Manitoba</td>
</tr>
</tbody>
</table>

Source: Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

The Manitoba Housing Units in Iron Rose are full with a waiting list. All Manitoba Housing operated facilities charge 27% of income.

Focus Group - Housing

This was an area of concern in the 1997/98 CHA. The need for more transitional housing was expressed in the middle and seniors Focus Groups.

SENIORS

- More independent living units [Springfield, Brokenhead, Iron Rose]

2004 Validation Workshops

IRON ROSE GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT - Housing

Suggestions
- Need more housing for seniors like Supportive Housing - larger Elderly Person Housing.
- There is a need for interim placement for individuals awaiting Personal Care Home Placement.
## Safety

Table 10.4 Crime Report Iron Rose Health District *

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Iron Rose</td>
<td>104</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle theft,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Criminal Other - Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace, arson,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>indecent acts, bail violations, breach of probation, harassing and stalking,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td></td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Federal Code</td>
<td></td>
<td>NE</td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coronor’s Act, Mental Health Act, Trespass Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquor- intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td></td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Iron Rose</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td></td>
<td>NE</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired</td>
<td>Iron Rose</td>
<td>119</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>driving, driving over 80 MG (blood alcohol level), driving a motor vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Traffic</td>
<td></td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Iron Rose</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td></td>
<td>NE</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Iron Rose</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td></td>
<td>NE</td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td><strong>GRAND TOTAL OF ALL OFFENSES</strong></td>
<td>Note: this does not include persons injured or killed.</td>
<td>Iron Rose</td>
<td>687</td>
<td>355</td>
</tr>
<tr>
<td></td>
<td>Note: this does not include persons injured or killed in traffic related</td>
<td>North Eastman</td>
<td>8,714</td>
<td>7,481</td>
</tr>
<tr>
<td></td>
<td>incidents.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


- * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

- ** The number of person injured and killed in traffic related incidents is not included in the numbers associated with the total traffic code category nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.

The overall number of reported crimes have dropped by more than half when comparing 2001 with 2002. The only area of increase, which has more, than doubled is the federal code, which includes drugs and substances.
There were no motor vehicle deaths in 2002 as compared with one in 2001. The number of injured people has decreased by 2 in 2002.

Note: We are not able to compare previous crime report information as the CMB changed their system of reporting.

Focus Groups - Safety

YOUTH
a) Seat Belts
   - Students with drivers license gave mixed report about wearing seat belts, some seeing it as a matter of choice and some depending upon the situation. [Iron Rose]
   “I wear my seat belt on long distance trips, but just driving around, I usually don’t.” [Iron Rose]
   “If you don’t want to wear a seat belt, it’s your choice. It’s your life in your hands.” [Iron Rose]

b) Speed - With regard to safe driving and speed youth seemed to realize the consequences.
   “…when I get my license, I think when I see an open road in front of me, I’ll go fast…” [Iron Rose]
   “If an accident happened and I was behind the wheel, I would feel horrible about it and probably would wish I could take my life instead… I guess it would be better if you just drove carefully and wear a seat belt.”
   [Iron Rose] “…people don’t drive fast to hurt people, people just enjoy it.” [Iron Rose]

YOUNG ADULT
a) Traffic
   - There was a concern in Seven Sisters and Whitemouth about the speed of traffic through their towns. [Iron Rose].
   - One person in Iron Rose group felt there wasn’t enough police presence in Whitemouth. [Iron Rose]

2004 Validation Workshops

IRON ROSE GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT - Safety

- Concern was voiced about decreasing number of RCMP around the Whitemouth area and that they are not easily accessible. A participant mentioned that some youth drive unsafely in town, i.e. passing vehicles on the right side of the road and driving too fast.
- Concerns voiced that home invasions off #1 Highway will be happening more often.

Suggestion.
- Would like to see safety programs in place on the use of ATVs (3&4 wheelers) and dirt bikes.
**Biology & Genetic Endowment as a Health Determinant**

"The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges."  

**Overview**

The fundamental characteristics of this determinant include our genetic make-up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought that “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems."  

**2004 Validation Workshops**

**IRON ROSE GROUP DISCUSSIONS ON BIOLOGY AND GENETIC ENDOWMENT**

**Suggestion**

- Would like more information on how to cope with the crippling and pain of arthritis.

*For information related to this determinant refer to the section on ‘health status.’*

**Personal Health Practices & Lifestyle as a Health Determinant**

*[Personal Health Practices & Coping Skills]*

"Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status."  

**Overview**

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family's pattern of life style and practice. Education alone is never enough. Other known influences on behaviour either positively or negatively may include an individual's peers, social / community norms and practices and the willingness on the part of the individual, family, or community to change."
**Dietary Practices**

**Focus Groups – Dietary Practices**

**YOUTH**
- One participant made an effort not to eat “…too much junk food.” [Iron Rose]

**YOUNG ADULTS**
- **Reason to change:** Elevated cholesterol. [Iron Rose]
- **Programs / Methods Used**
  - Physician’s advise [Iron Rose]

**MIDDLE ADULTS**
- Often some or parts of the diet were changed, for example drinking more water, decreasing caffeine intake, or diet changes related to reducing cholesterol.

  The reasons why participants modified their diet included:
  - a) Health reasons e.g. borderline diabetic, cholesterol. [Winnipeg River, Blue Water, Iron Rose, Brokenhead]

- **Programs / Methods Used**
  - “…I don’t take it seriously enough to follow the diabetic rules…don’t worry about it.” [Iron Rose]

**SENIORS**
- **Reasons to modify diet** – health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water]
- **Programs / Methods Used**
  - Cut down on snacks in general and soft drinks. [Iron Rose]
- **Barriers**
  - “…I do know Health Canada rules…Perhaps I could use help with eating to gain weight.” [Iron Rose]

**Alcohol Consumption**

**Focus Group- Alcohol Use**

**YOUTH**
- Drinking, as an emerging topic, came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change recognizing that many youth in the focus groups did not consume alcohol.

  The youth clearly saw alcohol not only as something youth did, but even more as a behaviour of adults in their communities.

**ADULT FOCUS GROUPS**
- This was not raised as a social problem in most of the adult Focus Groups except for the example given in the middle adult Focus Group. There were several adults who mentioned on a personal note that they had given up drinking. The youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

**MIDDLE ADULT**
- Only one participant in Iron Rose mentioned about the need for more programs to curb alcohol abuse and the need to support those who want to stop drinking. [Iron Rose]. “Alcohol costs just as much, if not a lot more money, for disease, absenteeism from work, and yet the health care won’t touch it…” [Iron Rose]
Physical Activity

Focus Groups on Exercise

Increasing the amount of exercise was the most common form of lifestyle change that the adults made with respect to changing their lifestyle to improve health.

YOUTH

Emerging Issue
- Frustration experienced by some youth in the Iron Rose group about out of school activities.
  "I know in Hadashville there is a hall...then they wouldn't let any teens use it because teens are reckless and break it. They used to have a rec centre in Whitemouth and they shut it down too. I don't know why...We couldn't even have a chance to prove ourselves." [Iron Rose]

Suggestions Raised by Youth
  "More supervision" suggested one youth in Iron Rose. To this, another youth replied "...nobody has enough devotion to sit and watch a bunch of kids do stuff." [Iron Rose]

- Youth should get more involved. [Iron Rose]

YOUNG ADULTS

Reasons to Exercise - The two primary motivators for exercising were to decrease weight and improve body image. One example was to help with post partum blues. [Iron Rose]

Programs / Methods Used
- Biking. [Springfield, Iron Rose]

MIDDLE ADULTS

- Reasons to Exercise - A health crisis in self or acquaintance was the most common reason. Other reasons include decreasing weight, improving image, and mental health reasons.

- Barriers - Exhaustion, time, family commitments were the main barriers expressed.

SENIORS

a) To gain or lose weight
- In the Iron Rose group it was mentioned that weight gain comes naturally with aging due to the decrease in activity or a disability. Conversely, there is sometimes the need to gain weight due to the effects of an illness.

Programs / Methods Used - Walking was the main method of exercising in this age group.
Smoking Practices

Focus Group on Smoking

The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This information provides valuable information for staff working in smoking cessation programs. The most consistent message is that the individual wants to quit, there are a variety of methods used to suit the individual. Success often depends upon support the individual receives and if weight gain is addressed and managed.

YOUTH - Smoking emerged in the majority of groups as either a lifestyle change and/or emerging topic. There were no specific comments from the Iron Rose youth group.

YOUNG ADULTS

Reasons for Quitting - From the reasons given by some participants there is evidence that public policy, peer pressure, and health education strategies are working.

a) Peer pressure, partner who didn't smoke, pregnancy [Iron Rose, Winnipeg River]
   "...just wanted to...That it was right then and there..." [Iron Rose],

Programs / Methods Used

• Pharmaceuticals - There seems to be mixed messages about smoking aids for those who did quit. Some tried and liked. One participant had a "weird experience". [Iron Rose]

• Support of friends. [Iron Rose]

MIDDLE ADULTS

Quitting Smoking - Once more weight gain associated with quitting smoking emerged as a real challenge for some participants.

Reasons for Quitting

a) "...it was time. It was too expensive." [Iron Rose]. This is the first time this reason emerges.
b) "...I was out of place by smoking. [Iron Rose]
c) You felt like a criminal already...standing outside and shivering. [Iron Rose]

Programs / Methods Used

• Cold turkey [Blue Water & Iron Rose]

Barriers

- Weight gain. [Blue Water, Iron Rose]

SENIORS

Reasons for Quitting

"I don't need this...kind of sickly (in and out of hospital)." [Iron Rose]

Barriers

"I don't cough. I'm still smoking." [Iron Rose]

2004 Validation Workshops

IRON ROSE GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES AND COPING SKILLS

- It was felt that female teens smoke to control weight.
Pharmaceutical Use

Figure 10.16 Proportion of Residents with at Least One Prescription

When comparing both time periods, there has been a statistical increase from 62% to 66% in at least one prescription.

Iron Rose appears to be lower than the Manitoba average of 68% during the second time period, but it is not a significant difference.

Number of Different Drugs

Figure 10.17 Average Number of Different Drugs

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

There has been a significant increase in the percentage of residents in Iron Rose that were prescribed at least one prescription drug.

There has been a significant increase in the average number of different medications prescribed.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

Figure 10.18 Percentage of Residents Receiving at Least One Prescription Antibiotic

There appears to be a slight decrease in the number of prescribed antibiotics in Iron Rose, but it is not a significant decline.

Iron Rose’s percentage not significantly different from Manitoba or Rural South.

Figure 10.19 Average Number of Antibiotics Prescribed

Iron Rose showed a slight decrease, but it did not change significantly in the number of antibiotics prescribed during the two time periods and is the third lowest when compared with other health districts.

Iron Rose has the third lowest number of antibiotic prescriptions dispensed.
Iron Rose has shown a statistical significant increase from 3.7% to 4.9%, but the antidepressant usage is not statistically significantly different from Manitoba or Rural South during the second time period.

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Iron Rose</strong></td>
<td></td>
</tr>
<tr>
<td>Government Assistance Programs (e.g. Pharmacare) Inadequate</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

Validation Workshop participants did not raise any other specific comments on this subject.

**2003 Focus Groups** – This was not a topic, which was discussed at length in the Focus Groups. A participant in Iron Rose commented that Pharmacare deductible is too high.

Healthy Child Development
as a Health Determinant

“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.”

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status.

Focus Groups on Youth

This is what focus group participants said about youth in our region:

**MIDDLE ADULT**

a) **Youth / Teen Support**—Once more the lack of youth activities in a community is mentioned. Although this wasn’t mentioned specifically for teens in the young adult group it was mentioned generally for children and for adults as well.

[Iron Rose]

-Felt the teen support operating out of the community in Lac du Bonnet was not attracting youth, maybe a phone service would be better. [Iron Rose]

- A group of teens carpool to Lac du Bonnet five times a week to use the gym...doesn't appear to be an exercise facility at any of the schools. [Iron Rose]

Infant Mortality Rates

The Infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

In Iron Rose, during 1990 and 1999, the number of infant deaths was suppressed because there was less than five. This is good news for Iron Rose Health District.

Births

At 40 weeks gestation, 50% of female babies weigh approximately 3500 grams and male babies weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. Often in disadvantaged groups mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.
Table 10.5 Number of Newborns in Iron Rose [Rate is in brackets].

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


During 2002-2003 NE had a total of 431 newborns, at rate of 10.9 / 1000 compared with the Manitoba rate of 11.7/ 1000.

How Has Iron Rose’s Birth Rate Changed Over Time?

Iron Rose’s birth rate has been fairly consistent over the years reviewed and always lower than the Manitoba birth rate. The increase during 2002/2003 may reflect boundary changes associated with dividing unorganized territories among several health districts.

Focus Groups on Obstetrical Practices

- Obstetrics as a need to improve service emerged in several adult focus groups. In Iron Rose only the young adult focus group mentioned specifically about obstetrical services.

YOUNG ADULTS

- Like to see more surgeries and obstetrics in hospitals. [Springfield, Iron Rose, Winnipeg River, Blue Water]

  “… I was paranoid about that. I was planning to deliver in Winnipeg and lived an hour and a half away from the hospital…” [Iron Rose]
Adolescent and Teenage Pregnancy

Figure 10.21 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability.

There has been no significant change in rates during the time periods reviewed.

Iron Rose’s pregnancy rate is statistically significantly lower than the Manitoba rate for both time periods reviewed.

Iron Rose’s pregnancy rate has remained the same for both time periods and is significantly lower than Manitoba average.

Breastfeeding Practices

There is considerable variability within the health districts, with higher rates of hospital initiated breastfeeding in Springfield and Winnipeg River. Iron Rose has the third highest initiation rate at 82.9% when compared with our other health districts during the second time period.

Iron Rose appears to have had a 7.7% increase in breastfeeding initiation during the two time periods, but it was not a statistically significant change.

Breastfeeding initiation rates have increased, but not significantly.
Birth Weights

Figure 10.23 High Birth Weights

In Iron Rose the number of high birth weights increased from 14% to 16% respectively, but this was not a statistically significant increase.

The rate is not significantly different than Manitoba.

Iron Rose has the second highest percentage of low birth weight babies in NE.

Figure 10.24 Low Birth Weights

Iron Rose has the second highest percentage of low birth weight babies born when we compare with our other health districts at 5.6% and 5.7% respectively.

The rate is not significantly different than Manitoba.


Between 1991-1995, the numbers of pre-term births were suppressed due to low numbers.

For the second time period Iron Rose had the third highest percent (6.7%) of pre-term births after Blue Water and Northern Remote.

The rate is not significantly different than Manitoba’s (7.1%) for the second time period reviewed.


**Childhood Immunizations**

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses.\

**Figure 10.26 Completed Immunization at One Year**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>92</td>
<td>82</td>
</tr>
<tr>
<td>Winnipeg River (t)</td>
<td>91.1</td>
<td>82</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>87.6</td>
<td>82</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>85.4</td>
<td>83</td>
</tr>
<tr>
<td>Blue Water (1,2,t)</td>
<td>81.6</td>
<td>83</td>
</tr>
<tr>
<td>Northern Remote (1,2)</td>
<td>57.8</td>
<td>83</td>
</tr>
<tr>
<td>Manitoba Average (t)</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Rural South (1,1)</td>
<td>83.1</td>
<td>83</td>
</tr>
</tbody>
</table>


Iron Rose had the third highest immunization rate after Springfield and Brokenhead.

There was a slight decrease during the two time periods, but it was not significant.

This rate is close to the Manitoba average of 85.4%, and Rural South of 83.1%, but it was not significantly different, during the second time period reviewed.
Figure 10.27 Completed Immunization at Two Years

Iron Rose was the only health district to increase their immunization rates from 63.8 to 75.9% (a 12% increase) during the two time periods reviewed, but this increase was not statistically significant.

Figure 10.28 Completed Immunization at Seven Years

There is a general overall decrease in immunization rates by seven years.

Iron Rose’s coverage appears to be less than Manitoba average and Rural South, but it was not significantly different.

Iron Rose’s immunization rates was not significantly different than Manitoba and Rural South during the second time period for immunizations completed at one, two and seven years.
Three Top Key Issues Identified by Participants

<table>
<thead>
<tr>
<th>Issue</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Rose</td>
<td></td>
</tr>
<tr>
<td>One Year Immunizations</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

Validation Workshop participants did not raise any other specific comments on this subject.

2003 Focus Groups – Focus Group participants did not raise this as an issue.
Living & Working Conditions as a Health Determinant

[Income, Income Distribution and Social Status and Employment and Working Conditions] 42

"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health." 44

Overview

Job rank, social statuses in the workplace, the amount of control over one's work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed. 45.

Employment and Unemployment

Table 10.6 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Iron Rose had the second highest employment rate for males and third highest employment rate for females when comparing other health districts. Females have a lower employment rate than males. Males have a higher unemployment rate than females.

Focus Groups on Youth Employment

MIDDLE ADULT

"Jobs for young people "...who finish school they go to University or Red River and don't come back here because there's nothing to come back to." [Iron Rose]"
2004 Validation Workshops

IRON ROSE DISCUSSIONS ON EMPLOYMENT AND WORKING CONDITIONS

- A participant pointed out that there is a high employment rate in Whitemouth, but a lower income rate which will affect overall health status.

Suggestion
• Workshops for employees held locally to improve job relations and satisfaction.

Social Economic Status

There is considerable research to support the relationship between an individual health status and their socioeconomic status.46

Median Family Income

The following tables describe the median family income of couple families and the median family income for lone parent families in the Iron Rose Health District communities, North Eastman and Manitoba.

Table 10.7 Median Family Income of Couple Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Couple Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron Rose</td>
<td>$ 43,838</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$ 52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Iron Rose has a lower median family income than NE and Manitoba.
Table 10.8 Median Family Income of Lone Parents – Males and Females

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income</th>
<th>Median Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lone Male Parent</td>
<td>Lone Female Parent</td>
</tr>
<tr>
<td>Springfield</td>
<td>$ 40,087</td>
<td>$ 36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$ 23,892</td>
<td>$ 17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$ 29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$ 45,361</td>
<td>$ 26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$ 35,698</td>
<td>$ 26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$ 9,248</td>
<td>$ 12,587</td>
</tr>
</tbody>
</table>


Lone parent female median income in Iron Rose is the second highest in NE region after Springfield.

Table 10.9 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$ 22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 26,469</td>
</tr>
</tbody>
</table>


This table looks at males and females combined as an example of NE and Manitoba incomes. It is more difficult to compare as the previous table separates males and females.

Total Low Income Incidence

The incidence of low income in 2000 in Iron Rose was 8.4%, which was the third highest when compared with other health districts. There was no information for Northern Remote.

2004 Validation Workshops

IRON ROSE GROUP DISCUSSIONS ON INCOME AND SOCIAL STATUS

- A participant commented on the lower income in Iron Rose area as compared to the higher income in the Oakbank area due to their proximity to Winnipeg.
Overview

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included as these all support a strong social network.

Mental Emotional Health

Mental health was raised as an important concern for many NE residents particularly in the area of mental health services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report. Mental Health Services continued to be a concern for 2003 Focus Group participants.

Focus Groups on Mental Well-being

Mental health issues emerged throughout the Focus Groups discussion. The topics varied between the age groups.

YOUTH

“Peer pressure was seen as a leading cause of untoward behaviours. “The youth who said this seemed to be very aware of how to handle awkward situations. [Iron Rose]

ADULT FOCUS GROUPS: Several common themes emerged, two of which are the lack of mental health services and stress.

YOUNG ADULT

The primary issues in this age group not only discussed the need for better awareness of the mental health programs (refer to Mental Health Program Section 7), but also the stigma associated with accessing programs.

a) Aging Parents - Only Ironrose focus group mentioned this area of concern, however it was a topic that came up in the older age Focus Groups.

-Difficulty driving seniors to city appointments, taking time off work, away from my family, a lot of services are not provided in small communities. “…one more layer of stress…..” [Iron Rose]

-There was a perception that there is difficulty finding placement in PCH of one’s choosing “…what you really have to do is put your name on that list before you’re ready for it, because otherwise you’re taking a chance you might end up in Beausejour or Pinawa…” [Iron Rose]

SENIORS – Seniors were concerned about being able to identify vulnerable members in the community in particular those who were more isolated and described as ‘lonely.’ Another big concern for this age group was living alone and being lonely. Two issues emerged:

a) what they would do if something should happen to them and they were unable to access help.

b) effects of isolation and living alone.

Mental Health Programming is discussed under the NEHA Mental Health Program Section 7.
Social Support

Table 10.10 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and they may be more economically disadvantaged than two parent households.

There are approximately 55 lone parent families in Iron Rose as reported in the 2001 Canada Census.
Focus Group On Social Support

Social support was an area that was raised in all Focus Groups and all ages as something that was seen as positive with respect to an individual’s wellbeing.

YOUTH
During the initial discussions when talking about what it means to be healthy, youth mentioned the importance of friends and social supports. We know that social support is a strong determinant of health status.

YOUNG ADULTS
Suggestions Raised by Young Adults
- “…next to no child care support available in Whitemouth. Any child care not just licensed.” [Iron Rose]

MIDDLE ADULTS
The concerns expressed in this group focuses around community supports rather than personal support. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group.
- “When my father was on disability there was no help…” [Iron Rose]

SENIORS
a) Living Alone
- Would like to see help with heavy housework, windows, laundry “…things home care won’t do. They knew there was a community support services program, but it was stopped, thought because of people having to negotiate a fee for service individually.” [Iron Rose]
10.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the previous CHA Report, completed in 1998, there have been boundary changes most prominently related to the northern areas. Unorganized Territories were originally separated and now incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts.

Population

There has been an increase in most age groups. The implication of growth, especially as it relates to the elderly population, is the potential for added pressure on the health system. This contributes to the need for creative and preventative health services planning for this population group.

Birth rates for the past four years have been relatively stable. The rates are slightly lower than Manitoba overall.

Education

During the Focus Groups several participants expressed a need for a greater connection between school and health care providers.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index (SEFI) value and premature mortality rates (PMR) both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern. For Iron Rose, there has been an improvement in the SEFI value, and it appears to be better than Manitoba and Rural South.

PMR has decreased, but not significantly. PMR measures general health status of the population therefore needs to be measured.
Deaths

Iron Rose’s total mortality rate is not significantly different than the Manitoba average.

Iron Rose’s PYLL value is not significantly different than the Manitoba average.

Life Expectancy

Iron Rose females live approximately six years longer than males.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cancer cases have increased, but not significantly and are not significantly different than the Manitoba average.</td>
<td>- Diabetes treatment has shown a significant increase, but it is not significantly different that the Manitoba average.</td>
<td>-Iron Rose has the second highest rate of asthma within NE region</td>
<td>Hypertension treatment is significantly higher than the Manitoba average.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI’s has shown no significant change.</td>
<td>Stroke treatment has decreased but not significantly.</td>
<td>There is no significant difference in Injury hospitalization when Iron Rose is compared with Manitoba.</td>
</tr>
</tbody>
</table>

Diabetes – With diabetes increasing and the ability to screen and manage diabetes effectively in the community, this is an area where a population health approach is known to be effective if services are in place i.e. prevention, education, care, research and support.

Hypertension – This is a condition that can be treated in the community effectively if left untreated has many health risks associated with it. As our population is aging this may be an area to consider increasing screening and management. High blood pressure / cardiovascular concerns were given second priority in Iron Rose Validation Workshops.
Human Function & Well being

The most prominent thing that arose was our youth in all health districts indicating that there was ‘nothing to do.’ This might be an area to explore with our community partners. Youth and adults in the focus group provided many good suggestions or improvement. During validation workshop discussions participants commented that the community has tried to develop activities and programs, but felt youth do not have the same interest and commitment.

DETERMINANTS OF HEALTH

Environmental Factors

Water - Concerns about water arose during focus groups and by seventy-two percent of validation workshop participants as a third key issue.

Air Quality - There were no comments during either focus groups or validation workshops about air quality concerns.

Safety – Youth Focus groups felt seat belt use was a matter of choice. Speed was also discussed as something you did because you enjoy it. Some young adult participants and Validation Workshop participants felt that the speed of traffic through Seven Sisters and Whitemouth was a concern. Both Focus Groups and some Validation Workshop participants felt that the RCMP was not as accessible.

Housing – Some focus group participants felt there was a need for more independent housing units. Validation Workshop participants in Iron Rose felt there was a need for more PCH beds.

During Focus Group discussions there were many adult participants across the age groups who raised the need for transitional/ independent housing units.
**Personal Health Practices**

There appears to be a general public readiness for healthier lifestyle choices.

**Dietary** – Obesity is a national concern. We see in NE that there is a substantial number of self reported survey respondents indicating they are overweight or obese. During the Focus Groups, participants mentioned that this was one of the areas where they were making healthier choices.

**Alcohol Consumption** – Youth Focus Groups identified this as an issue in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners.

**Physical Activity** – According to the provincial survey, approximately half of respondents were not physically active. Exercise was the top area that Focus Groups and provincial survey respondents indicated they did to achieve a healthier lifestyle.

**Smoking Practice** – Approximately one quarter of our residents in NE still smoke according to CCHSC self reports. From Focus Group participants it was essential that when smoking cessation programs are initiated, success is often depended upon addressing weight gain. Ongoing smoking cessation programs targeting community and staff should be considered. Addressing each age group’s issues surrounding barriers to quitting smoking will increase the success rate.

**Medication Use** –

*Prescriptions* - There has been a statistically significant increase in residents prescribed at least one prescription drug.

*Antibiotics* - There is no significant difference between Iron Rose and Manitoba in the number of prescribed antibiotics.

*Antidepressants* - Antidepressant prescriptions have shown a statistically significant increase. It is difficult to know if the reason is due to depression diagnosis, as antidepressants can be prescribed for other reasons.

During the validation workshop, a top key issue in Iron Rose was that government assistance programs such as Pharmacare were inadequate. During the Focus Groups a participant mentioned that the Pharmacare deductible was too high.
Healthy Child

**Infant Mortality Rates** - Iron Rose infant deaths were suppressed due to low numbers.

**Adolescent & Teenage Pregnancy** - Pregnancy rates have not changed and are significantly lower than the Manitoba average.

**Hospital Breastfeeding Initiation** – Breast feeding initiation rates have increased, but not significantly.

**Birth Weights** - Iron Rose has experienced increases in high and low birth weight babies, but neither were significant. These are important areas to continue to monitor as they have potential implications associated for the future health of our children and potential burden on health services.

**Immunizations** – Iron Rose’s immunization rates were not significantly different than the Manitoba average. It would be interesting to determine why the overall decrease from one, two and seven years has occurred. Vaccination is a cost-effective way to prevent illnesses and decrease costs to the health system.

Living and Working Conditions

**Work** - Iron Rose had the second highest employment rate for males and third highest employment rate for females when comparing our other health districts. Focus Group and Validation Workshop participants felt that there was high unemployment and no meaningful work in the area for young people.

**Economic Status** – The incidence of low income in Iron Rose was 8.4%, which was the third highest when compared with other health districts. There was no information for Northern Remote.

Personal Resources

**Mental Emotional Health** – During the Focus Groups there was a lot of discussion about mental well-being.

- Youth stressed friends and social support as really important. Peer pressure often led to negative behaviours.
- Young adults discussed how stigma affects how people access mental health services. Aging parents were a concern in Iron Rose where there was stress associated with their care.
- Seniors mentioned that they were concerned about many vulnerable people living out in the community especially those who were more isolated. They identified themselves as often living alone and being lonely and they had concerns about their ability to access help quickly.
Social Support - There are approximately 55 single parent families in Iron Rose. It was mentioned in the Focus Groups by some participants that there was next to no child care support available. Community supports should also be more encompassing and not restricted to a specific age group. Further some participants felt that there should be some support to help with heavy housework, transportation, maintenance, childcare in an emergency and things home care can not provide.

Summary At A Glance

**KEY**
- Partner: implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.
- Monitor: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.
- NEHA: a program or service could be enhanced or developed to address this issue.

**Strengths**
- Infant mortality rates have been suppressed.
- Positive improvement in SEFI value and appears to have surpassed both Manitoba & Rural South in 1996. [Monitor]
- Decrease in antibiotics prescribed, but not significant. [Monitor]
- PMI has increased, but not significantly. [Monitor]
- Childhood immunization coverage was not significantly different than the Manitoba average. [Monitor]
- Employment rate is second highest, but there are concerns about youth not getting employed in the area. [Monitor]
- PYLL has decreased, but not significantly and is not significantly different than the Manitoba average. [Monitor]
- MI hospital treatment has shown no significant change. [NEHA, Partner, Monitor]
- New cancer cases have increased, but not significantly and are not significantly different than Manitoba. [NEHA, Partner, Monitor]
- Teen pregnancy rates have not changed and are significantly lower than Manitoba. [NEHA, Partner, Monitor]

**Issues Having Implications for Health Planning & Delivery**
- Breastfeeding rates have increased, but not significantly. [NEHA, Partner, Monitor]
- High and low weight babies have increased, but not significantly. [NEHA, Partner, Monitor]
- There has been an increase in population in most age groups. For older populations this has the potential to affect health services needs.
- Youth 'have nothing to do.' [Partner]
- Alcohol consumption was raised by youth in focus groups. [Partner]
- Significant increase in prescription use, but not significantly different from Manitoba. [Partner, Monitor]
- Significant increase in antidepressant prescriptions, but not significantly different than Manitoba or Rural South. [Partner, Monitor]
- Some middle adult focus group participants felt that community supports should be more encompassing, rather than restricted to one age group. [Partner, Monitor]
### KEY
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

### Issues Having Implications for Health Planning & Delivery

<table>
<thead>
<tr>
<th>Issue</th>
<th>NEHA, Partner, Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension treatment is significantly higher than the Manitoba average.</td>
<td></td>
</tr>
<tr>
<td>Stroke treatment has decreased but not significantly.</td>
<td></td>
</tr>
<tr>
<td>Injury hospitalization has increased, but not significantly and there is no significant difference when compared with Manitoba.</td>
<td></td>
</tr>
<tr>
<td>Water quality is a concern raised by some focus group participants.</td>
<td></td>
</tr>
<tr>
<td>Need for more PCH beds and independent housing units.</td>
<td></td>
</tr>
<tr>
<td>Obesity is a national concern.</td>
<td></td>
</tr>
<tr>
<td>Need to promote exercise.</td>
<td></td>
</tr>
<tr>
<td>Need for smoking cessation programs.</td>
<td></td>
</tr>
<tr>
<td>Adults lack of mental health supports and aging parents are causing stress as indicated by some focus group participants.</td>
<td></td>
</tr>
</tbody>
</table>

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
10.6 REFERENCES

5. Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004


11.1 GEOGRAPHICAL OVERVIEW

11.2 COMMUNITY SYSTEM CHARACTERISTICS

11.3 HEALTH STATUS

11.4 DETERMINANTS OF HEALTH

11.5 SUMMARY/CONCLUSION

11.6 REFERENCES
11.1 GEOGRAPHICAL OVERVIEW

The Blue Water District comprises the Rural Municipality of Alexander, the Town of Pine Falls, which is a private unincorporated community, the Town of Powerview and the Rural Municipality of Victoria Beach which includes Wanasing Beach and Victoria Beach. The health district borders the Municipalities of Lac du Bonnet and St. Clements and stretches from the eastern shores of Lake Winnipeg, into the Whiteshell and north into the Canadian Shield. The major highways that run through the District are highway #59 north, highway #11 and #304.

Hollow Water, Black River and Sagkeeng (Fort Alexander) First Nation Reserves are included geographically as part of the Blue Water planning district and are accessible by road year round.

The economy is a mix of agriculture, natural resources, hydro generation, business and tourism. Tembec, the Pulp and Paper Company in Pine Falls is one of the major employers of the area, as is Manitoba Hydro with three hydro generating plants in the health district.

Recreational activities consist of fishing, boating, canoeing, golf, snowmobiling, ice fishing, hunting, cross-country skiing and curling. There are three golf courses. There are bowling facilities in Pine Falls and Great Falls, and there is a 5 sheet curling rink in Pine Falls.

In 2003, St. Georges Parish celebrated the 100 years that have passed since the arrival of the first pioneers from Chateauguay Quebec. In celebration of this very special event, the community of St. Georges organized a variety of activities that were enjoyed by many throughout the year. A reunion weekend was held in August where St. Georges hosted a Wine & Cheese, Banquet & Entertainment and a BBQ supper.

The Blue Water Trail Association held their official opening of the Blue Water Trail from Old Pinawa Dam to Powerview in May of 2003. When complete, the Blue Water Trail will comprise the section of the Trans Canada Trail from Old Pinawa Dam to Grand Beach. These trails are designed for walking, mountain biking, cross-country skiing, and horseback riding. The Town and Municipality of Lac du Bonnet along with the Rural Municipality of Alexander co-sponsored the Blue Water Trail project. The Blue Water and Pinawa Trail Associations collaborated on the production of a promotional brochure highlighting the trails, and they co-hosted a booth at the Discover Manitoba Conference and Expo.

A bilingual Health Corner was opened in the Spring of 2004. The Health Corner was an initiative of St. George Business Development Centre. A NEHA representative sat on the committee during development. The goal of the Health Corner is for the communities in the Blue Water District to have access to bilingual services in the prevention, education and promotion of health issues. The services will include access to health related Internet sites, literature, pamphlets, videos, newsletters and workshops.
These are the municipalities and communities that fall under the Blue Water Health District.

<table>
<thead>
<tr>
<th>Municipalities</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLUE WATER</strong></td>
<td>7,970 in 2003</td>
</tr>
<tr>
<td>Powerview Village (100)</td>
<td></td>
</tr>
<tr>
<td>-POWERVIEW ROE1PO</td>
<td></td>
</tr>
<tr>
<td>Pine Falls Town (192)</td>
<td></td>
</tr>
<tr>
<td>-PINE FALLS-ROE1MO</td>
<td></td>
</tr>
<tr>
<td>Victoria Beach RM (162)</td>
<td></td>
</tr>
<tr>
<td>-VICTORIA BEACH – ROE2CO</td>
<td></td>
</tr>
<tr>
<td>Alexander LGD (175)</td>
<td></td>
</tr>
<tr>
<td>-BELAIR -ROEOEO</td>
<td></td>
</tr>
<tr>
<td>-GREAT FALLS-ROEVOO</td>
<td></td>
</tr>
<tr>
<td>-OHANLY –ROE1KO</td>
<td></td>
</tr>
<tr>
<td>-ST. GEORGE-ROEVOO</td>
<td></td>
</tr>
<tr>
<td>-STEAD -ROE1ZO</td>
<td></td>
</tr>
<tr>
<td>-Albert Beach</td>
<td></td>
</tr>
<tr>
<td>-Amanda</td>
<td></td>
</tr>
<tr>
<td>-Gull Lake, East of Hwy 59</td>
<td></td>
</tr>
<tr>
<td>-Hillside Beach</td>
<td></td>
</tr>
<tr>
<td>-Silver Falls-Bird River</td>
<td></td>
</tr>
<tr>
<td>-White Mud Falls</td>
<td></td>
</tr>
<tr>
<td><strong>First Nations (FN)</strong></td>
<td></td>
</tr>
<tr>
<td>-Sagkeeng (Fort Alexander) FN</td>
<td></td>
</tr>
<tr>
<td>-Black River FN</td>
<td></td>
</tr>
<tr>
<td>-Hollow Water FN</td>
<td></td>
</tr>
<tr>
<td><strong>Unorganized Territories (288)</strong></td>
<td></td>
</tr>
<tr>
<td>-BISSETT-ROEJO</td>
<td></td>
</tr>
<tr>
<td>-FORT ALEXANDER – ROEOPO</td>
<td></td>
</tr>
<tr>
<td>-MANIGOTAGAN-ROE1EO</td>
<td></td>
</tr>
<tr>
<td>-WANIPAGOW – ROE2E0</td>
<td></td>
</tr>
<tr>
<td>-TRAVERSE BAY – ROE2A0</td>
<td></td>
</tr>
<tr>
<td>-Black River – ROE1KO</td>
<td></td>
</tr>
<tr>
<td>-Seymourville</td>
<td></td>
</tr>
<tr>
<td>-Aghaming</td>
<td></td>
</tr>
</tbody>
</table>

**Source for Population – 2003**


**Sources:**
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA Report.
Geographical Changes:

- Unorganized Territories previously was a separate geographic area. In this report, depending upon the municipal code, communities have been re-allocated into Winnipeg River, Iron Rose, Blue Water and Northern Remote districts.

- Northern Remote is a separate health district.

How is Healthy Living Supported in Blue Water?

Focus Groups On How The Community Promotes Or Supports Healthy Living

YOUTH

- AFM Counselor at the school, dentist, counselors, Health Nurse, Chiropractor, Masseuse – Wings of Power (Students didn’t really know about the agency, but perceived it as a good thing in regard to providing support for young moms.)

  Seymourville
  - Junk free food day at school (Tuesday and Thursday); team sports; caring week at school; school counselors; leadership training opportunities.

Suggestions Raised by Youth

- AFM Counselor at the school: “…you have to go see him, he doesn’t come to you…so not a lot of people probably go…I don’t know if people do.” [Blue Water]

YOUNG ADULT

- Audiologist in Beausejour (referred by wellness groups for 3-4 year olds), happy that Manitoba Health will pay up to 80% and travel costs), more personal and attentive service in small town hospitals, local Chiropractor is highly regarded, Physiotherapists good, acupuncture available, massage therapy, family Psychologist in Lac du Bonnet appreciated. Recreational activities (gym in school well used, kick boxing, badminton program, gymnastics and dance programs for children, hockey, Fort Alexander Gym,) Wings of Power (valuable local service), dietitian, Public Health Nurse, palliative support (praised), Wellness Program at the paper mill [Blue Water].

  Seymourville
  - Community garden, no smoking policy in the community council and hall, Frontier school division’s “healthy nutrition policy”, playground improvement, being able to access the programs and services that come to the community, Moms N’ Tots group very popular, improvement noted in the availability of healthy foods in the local store.
**Middle Adult**

- Merry Makers raise funds for community and charities and Christmas hampers, care by South African doctors, Dietitian (seen for weight control, cholesterol reduction), Physiotherapist, Occupational Therapist, Medi-van good and drivers good.
- Health Centre Staff is caring, and viewed as aggressive in getting patients support they need e.g. specialists treatment in Winnipeg, ambulance drivers good.

**Seniors**

- Seniors Scene, Health Center at Seniors club, wheelchair accessibility makes your life fuller more functional, “I like what hospitals and doctors are doing and hope they carry on.”. Planned Wellness Center on Hwy. 59 and 11 is “exciting”. Described as, “A healthy care facility with a swimming pool, curling rink. Like a community complex.” [Blue Water]

**Suggestion Raised by Seniors**

- Seniors Help Centre has list of people who are willing to do home maintenance tasks, but it doesn’t work well because there are not enough contractors, and prices (which are negotiated individually) are too high. [Blue Water]
11.2 COMMUNITY SYSTEM CHARACTERISTICS

Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up community’s specific characteristics. Research demonstrates that there are unique risks factors and health problems that vary for men and women, as well as, gender influences affecting age, education, socio-economic status, culture and physical environment. Where information is available the sex of the individual is provided.

Population Demographics

**Figure 11.1 Age Profile of Blue Water – 1995 & 2000**

During the time period most age groups saw an increase in either males or females, with the exception of the 25 to 39 year old age groups, where there was a decrease in the population in both males and females. This could be contributed to this age group leaving the area for employment opportunities. Overall there has been a slight increase in population of 559 people from 1996 to 2000.
Education as a Health Determinant

Overview

There has been an association found that when the education levels increase so does the self-rated health status improve. Education is also closely tied with socioeconomic status. Effective education for children and life long learning for adults contributes to the health and prosperity of individuals.

Table 11.1 Percentage of Population With Less Than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school age 20-34</th>
<th>% of population with less than high school age 35-44</th>
<th>% of population with less than high school age 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village of Powerview</td>
<td>20.0</td>
<td>35.0</td>
<td>41.7</td>
</tr>
<tr>
<td>Town of Pine Falls</td>
<td>10.0</td>
<td>0.0</td>
<td>35.5</td>
</tr>
<tr>
<td>RM of Victoria Beach</td>
<td>50.0</td>
<td>33.3</td>
<td>46.7</td>
</tr>
<tr>
<td>LGD of Alexander</td>
<td>20.9</td>
<td>38.6</td>
<td>36.8</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


Note: Due to a variation in the geographic boundaries, some Blue Water communities are not represented in this table.

Sunrise School Division

In July 2002 the Sunrise School Division was established as a result of a partnership with the former Agassiz School Division and the Springfield component of the Transcona Springfield School Division. The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counsellors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have consultants in the following areas: Early/Middle Years, Senior years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.
Table 11.2 Sunrise School Division – Blue Water Health District

<table>
<thead>
<tr>
<th>SUNRISE SCHOOL DIVISION</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Ecole Powerview School</td>
<td>528</td>
<td>504</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Empower Education Center*</td>
<td>73</td>
<td>194</td>
<td>21</td>
<td>56</td>
</tr>
</tbody>
</table>


* Numbers are substantially different in the 2 years reported due to new guidelines and reporting procedures in 2003/04.

Children With Special Needs

Sunrise School Division has a population of 5180 children. In the 2003/04 school year there are a total of 221 children (4.2%) who are receiving support through a health services program. These health services are provided by NEHA though the Unified Referral and Intake System. These numbers do not capture the number of children with health care needs who do not have a “formal” health care plan developed by a nurse. These numbers are no longer kept, but two years ago there were over 600 children receiving medications. It is believed that now that number is probably somewhere in the neighborhood of 800.5

Pine Falls School Division No. 2155

There is one school in the Pine Falls School Division, located in Pine Falls and provides education for Kindergarten to Grade 8. One of the special programs offered is Early Literacy Intervention. In this program students in Grades 1 to 4, identified by their teachers as being in need of remediation in reading, are scheduled to attend one-on-one sessions with a teaching assistant trained in early literacy intervention. Other special programs include Precision Reading, Speech/Language and English as a second language (ESL). ESL is provided to children who move to the community and do not speak English. Currently there are three children who have come from Chinese (Cantonese and Mandarin) and Philippine dialects.

Table 11.3 Pine Falls School Division – Blue Water Health District

<table>
<thead>
<tr>
<th>PINE FALLS SCHOOL DIVISION NO. 2155</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Students</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>2001/02</td>
</tr>
<tr>
<td>Pine Falls School</td>
</tr>
</tbody>
</table>

The Frontier School Division was formed by the Department of Education in 1965 to provide better educational opportunities for northern Manitoba communities. The Division encompasses communities on or near Lake Winnipeg bordering on the west to the CNR Bay-Line, stretching hundreds of miles from Bissett and Wanipigow to South Indian Lake north to Brochet. The Division is broken down into 5 areas. The four schools in area are Berens River, Falcon Beach, San Antonio (Bissett) and Wanipigow.

Because the communities are small, the majority of schools do not offer senior high school programs. Therefore students must leave their home school to complete their schooling. They can then apply to the Division’s residential high school, Frontier College Institute in Cranberry Portage or to the Division’s Home Placement Program. The Home Placement Program began in 1970 as an alternative to Frontier Collegiate Institute, where children move from their home to a community where a high school is available. This placement does not have to be in the Frontier School Division. The students in the program identify a placement home e.g. a relative or friend, or the division will place them in a home. In 2004 there are 120 students in the Home Placement Program.

The Division has a Health and Wellness initiative which provides students with opportunities to:
- examine how they are presently conducting their lifestyles (awareness)
- explore options and resources to lead a healthier lifestyle (education)
- to promote lifelong healthy lifestyles (growth).

In September 2002 a Healthy Food Program was implemented in all Frontier Division Schools.

### Table 11.4 Frontier School Division

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berens River</td>
<td>397</td>
<td>371</td>
<td>192</td>
<td>180</td>
</tr>
<tr>
<td>Falcon Beach</td>
<td>70</td>
<td>59</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>San Antonio</td>
<td>36</td>
<td>23</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Wanipigow</td>
<td>383</td>
<td>346</td>
<td>191</td>
<td>176</td>
</tr>
</tbody>
</table>

Focus Groups- Schools

Youth

- Some healthy supports at school in Seymourville: junk free food day at school – Tuesday and Thursday; Caring Week at school; school counselors; leadership training and opportunities; team sports. [Seymourville]

Suggestions Raised by Youth

- Would like to see a nurse coming to the school [Seymourville]
- Would like more health promotion – more commercials, more health-related movies in schools, “Show us that being healthy, in your mind and body, is actually a better way to live than just doing whatever.” [Blue Water]
- Work out in gym. Kick-boxing is available in neighboring community but no way to get there.
- A youth drop in centre in the evening. [Seymourville]

2004 Validation Workshop

BLUE WATER GROUP DISCUSSIONS ON EDUCATION

- Discussion on transportation and time traveling as an issue for the completion of a high school education (Victoria Beach).
Overview

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health”, we find that there are many influencing factors, some controllable for example, the choices we make i.e. using a seat belt and things we have less or no control over for example hereditary diseases.
Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes “an overall composite socioeconomic “risk” of a population in a given geographical area.” The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status -- a potential need for more input from health services.

Figure 11.2 Social Economic Factor Index NE Health Districts 1991 & 1996

Looking at the NE Health Districts separately, we clearly see disparities in socioeconomic risks identified in the Blue Water and Northern Remote Health Districts. Having said this, there has been an improvement in Blue Water in 1996, but it remains the second poorest in our region.

All health districts except for Northern Remote and Blue Water have a better SEFI value when compared to Manitoba or Rural South, therefore more health care service needs may be required in these areas.

Blue Water has the second lowest SEFI value in 1996 in NE and its value is worse than both Manitoba and Rural South.
Premature Mortality Rate (PMR)

PMR is defined as deaths that occur before age 75. This indicator is often used as a measure of general health status and the subsequent need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services.\(^{12}\)

Figure 11.3 Premature Mortality Rate NE Health Districts

We do not want to see this indicator increase. PMR has increased slightly from 3.27 /1000 to 4.33/1000 respectively, but not significantly.

During the second time period Blue Water shows a statistically significantly higher PMR when compared with the Manitoba average (3.32/1000) and Rural South (3.23).

PMR has increased slightly but not significantly.
Focus Groups – On the Meaning of Health

Youth
Overall youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself and minimizing stress, being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

Young Adults
Some of the major themes that emerged in all Focus Groups included: absence of sickness, participating in life, humour, healthy eating, sleeping well, active lifestyle (exercise), mentally good health, social support, good relationships especially for people who are alone, balance, work, no bad habits – smoking, drinking, all supported a healthy lifestyle.

- “Live your life to the extent you feel like a complete and whole person… meet personal goals… challenge yourself.” [Blue Water]
- “Living longer.” [Seymourville]
- “Seeing the dentist” [Seymourville]
- “Family unity – important to spend time with family.” [Seymourville]
- “Role modeling as parents and as community leaders for the children.” [Seymourville]

Only Blue Water mentioned specifically that “no pain” is associated with good health.

Gaps
a) Recreational Activities
- Generally more sport and fitness [Springfield, Brokenhead, Blue Water]

Middle Adults
This group did indicate clearly that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humor, weight management and the importance of social activity and connection, being mentally well, stress management, balance. A participant in Bluewater felt that good health is relative to the health status of others.

“There is always somebody worse off than you.” [Blue Water]

Gaps
a) Recreational Activities – This is a common theme mentioned in all Focus Groups.
b) Other
- A smaller handivan when transporting one or two people. [Blue Water]
- Smaller more efficient vehicle for patient transfer. [Blue Water]

Seniors
In general most groups included aspects of your mind (memory), body, attitude, keeping active and mobile, good nutrition, exercising for example walking and other recreational activities that included exercise and socializing, being active in your community, friends and family.

-Sometimes staying healthy is motivated by habits picked up earlier in life. One respondent in Bluewater mentioned that for his job, he had to go through a very thorough health check and because of this, it generated life long habits that are still in place.

“The incentive is great and…. I still run a couple of miles every day.” [Blue Water]

-For the first time a participant from Blue Water equated being healthy with learning and working at it. This could be a barrier for some, if being healthy is associated with work.

Gaps
a) Recreational Activities – This emerged in all Focus Groups.

The need for recreational activities is a consistent comment in the provincial survey as well. Refer to Section 6 this report.
Deaths

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.”

Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

Figure 11.4 Total Mortality Rates in NE Health Districts

Blue Water has shown a decline in the number of deaths from 8.47/1000 to 7.47/1000, but not significantly. This is less than the Manitoba average at 7.99/1000 during the second time period reviewed. This is a positive finding.

Blue Water is not statistically significantly different than the Manitoba average or Rural South during the later time period.

Life Expectancy

Figure 11.5 Life Expectancy – NE Health Districts

In Blue Water we see that females live longer than males by approximately 4 years. Life expectancy for Blue Water residents appears to be less than Manitoba and Rural South. Blue Water has the second lowest life expectancy rate when compared to other health districts. Northern Remote has the lowest.

Blue Water has the second lowest life expectancy rate when compared with other health districts in North Eastman.
Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths.\textsuperscript{14}

**Figure 11.6 Potential Years of Life Lost – NE Health Districts**

Blue Water has had an increase in the number of PYLL from 64.81 to 88.94 per 1000, but not significantly.

During the second time period there was a statistically significantly higher PYLL when compared with Manitoba’s value of 52.8 and Rural South’s value of 52.25.

When we look at the chronic diseases, Blue Water is statistically significantly higher than Manitoba and Rural South rates for hospitalization injuries, diabetes and hypertension, which might suggest a possible cause for the increased PYLL.

Blue Water has significantly higher rates from hospitalization injuries, diabetes and hypertension than Manitoba or Rural South.
When we separate males and females, it becomes noticeable that males have an increased level of PYLL than females in Blue Water.

A noticeable change in Blue Water has occurred in the female PYLL during the second time period where there has been an increase from 43.99/1000 to 85.12 / 1000. This is statistically significantly higher than the Manitoba female PYLL at 40.10/1000 as well as Rural South at 37.28/1000.

Unfortunately, for chronic diseases we do not have a male/female breakdown.
Health Conditions

“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO) "

Cancer

Figure 11.8 New Cancer Rates [includes non-invasive malignancies].

There appears to be a decrease in new cancer rates, but it is not a significant decrease from 5.8 to 5.21.

New Cancer Rates have decreased but not significantly in Blue Water.
Diabetes Treatment Prevalence

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

Blue Water has shown a statistically significant increase, from 8.2% to 10.3% in the 20-79 year old age group during the time period reviewed. These prevalence rates are statistically significantly higher than the Manitoba average for both time periods i.e. 4.6% and 5.6% respectively and for Rural South 4.5% and 5.4% respectively.

We know that diabetes carries with it the risk of other chronic illnesses such as cardiac diseases, renal disease and neurological impairment. It is reassuring that the number of diabetes cases are being identified, as early treatment and careful monitoring may prevent the many complications associated with diabetes.
Diabetes Planning Strategies

The Diabetes Education Resource (DER) has provided outreach services to the community of Berens River via Tele-health for several years, as well as providing support to the community of Poplar River in the form of a workshop. The Registered Dietitian provides support to Sagkeeng First Nation community, which is reciprocated by the Diabetes Nurse from Sagkeeng providing support to clients in the Blue Water District. This partnership has had a significant positive impact on clients and communities in general. A Regional Diabetes Steering Committee was struck to review the document, “Diabetes: A Manitoba Strategy” and has continued to meet to develop a regional Diabetes Program framework. This committee has representation from Sagkeeng FN, Black River FN, Southeast Resource Development Council (SERDC), as well as non-aboriginal communities.

2004 Validation Workshop

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Water</td>
<td></td>
</tr>
<tr>
<td>Diabetes is on the Rise</td>
<td>81.8%</td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any specific comments on this subject.</td>
<td></td>
</tr>
</tbody>
</table>

Blue Water has the third highest asthma rate when compared with other health districts.
Respiratory Diseases

Figure 11.10 Asthma Prevalence

Blue Water appears to have the third highest rate of asthma when compared with other health districts.

As mentioned in the regional section, both asthma and respiratory diseases in general appear to be declining.

Figure 11.11 Residents Treated for Respiratory Disease [includes asthma, bronchitis & pneumonia]

Despite the fact that Blue Water has shown a slight decline in the number of respiratory diseases from 19.1% to 18.7%, it was not a significant decrease. Blue Water is statistically significantly higher than Manitoba and Rural South during both time periods.

Respiratory diagnoses in Blue Water are significantly higher than Manitoba and Rural South during both time periods.
Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 11.12 Hypertension Treatment Prevalence NE Health Districts

There has been a statistically significant rise in the treatment prevalence of hypertension in Blue Water during the two time periods reviewed, from 26% to 31%, an increase of 5%.

Blue Water’s treatment prevalence is also statistically significantly higher than the Manitoba average for both time periods at 20% and 22% respectively and Rural South’s at 19% and 22% respectively.

Hypertension treatment has shown a significant increase in Blue Water and is the highest when compared with other health districts.
Heart Attacks

Figure 11.13 Acute Myocardial Infarctions (MI’s) or Heart Attack Rates of Hospitalization

Most health districts have shown a decrease in the rates of hospitalization due to MI’s, but only Brokenhead’s decrease was statistically significant.

In Blue Water the rates decreased from 2.85 to 2.76 respectively, but it is not a significant decrease.

Although the rates appear to be higher than Manitoba and Rural South they are not significantly higher.

There has been a decrease in MI hospitalizations in Blue Water but not a significant decrease.
Strokes

Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

Figure 11.14 Stroke Treatment Prevalence in Hospital

There appears to be a decrease in the number of Stroke treatments in Blue Water, from 2.06/1000 to 1.72/1000, but it was not significant.

Strokes have declined in Blue Water, but not significantly.

Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999, compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to the relatively small number of injury deaths, these rates are not reported at the district level. 18

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

There has been a slight decline in the number of hospitalized injuries, from 14.63 / 1000 to 13.49/1000, but not a significant decrease. These rates are statistically significantly higher than the Manitoba rate at 11.24/1000 and 9.88 /1000 respectively.

Blue Water has the second highest hospitalization rate due to injuries in our region.
Overview

Human function is associated with the consequences of diseases, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Overview

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but it is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age are able to do who may not have an illness.

Focus Group on There’s Nothing To Do

It was felt that the perception of ‘nothing to do’ will have an effect on the overall well being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their focus groups specifically related to recreational activities.

YOUTH

“We’re not really the healthiest bunch here because there's nothing to do in town…” [Blue Water] “Smoke and drink, that's what you have to do…” [Blue Water]

- The youth in the group understood that these activities aren’t good for you [smoking and drinking] , but would rather go to a party than stay at home. [Blue Water]

Suggestions Raised by Youth

- Evening hours for drop in centres. [Springfield, Brokenhead, Blue Water ]
- Movie theatre. [Blue Water]
- In Blue Water, youth felt their communities are too small to offer much diversity of activity. They would like more organized sports, i.e. roller rink. [Blue Water]
- “Somewhere to go and have fun, like a rec hall.”[Blue Water]
### 11.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.” 25</td>
<td>“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” 26</td>
<td>“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.” 27</td>
<td>“Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.” 28</td>
</tr>
<tr>
<td>Healthy Child Development</td>
<td>Biology &amp; Genetic Endowment</td>
<td>Culture</td>
<td>Gender</td>
</tr>
<tr>
<td>“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.” 29</td>
<td>“The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.” 30</td>
<td>“Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.” 31</td>
<td>“Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.” 32</td>
</tr>
</tbody>
</table>
Environmental Factors as a Health Determinant

Physical

"Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors."  

Overview

Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment, however there are some concerns most specifically related to water quality.

Water

Water Quality

The RM of Alexander has a number of independent water systems that supply treated water to residents. Tembec Paper Group maintains the water systems that supply treated water to the residents of Pine Falls and Powerview. The RM of Victoria Beach is serviced by private wells. A municipal water system also supplies a seasonal (above ground) water supply to some areas of the RM of Victoria Beach.

Sewage Systems

The sewage system is maintained by Tembec Paper Group and services the communities of Pine Falls and Powerview. The remainder of the district is serviced by septic fields and holding tanks. A lagoon provides for waste disposal.
The Air We Breathe

There was no mention of air quality concerns from focus group.

2004 Validation Workshop

<table>
<thead>
<tr>
<th>BLUE WATER GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT – Water &amp; Air Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Concerns expressed regarding environmental standards- water and air quality - whether they are being checked from all big industries in the district, Manitoba Hydro, area farming, AECL, Tembec Paper Group, Pine Falls Health Complex incinerator.</td>
</tr>
<tr>
<td>- Concerns regarding the quality of air environment in the workplace in Pine Falls Health Complex regarding: no smoking issues have not been dealt with.</td>
</tr>
<tr>
<td>- Discussion on the enforcement of standards for effluents into air and water systems from industry discharges.</td>
</tr>
<tr>
<td>- Need more collaboration between NEHA and municipalities on major issues such as air and water quality and road improvements.</td>
</tr>
<tr>
<td>- Questioned if lake, well and environmental waters are considered to be under the auspices of water quality?</td>
</tr>
</tbody>
</table>

Housing

Figure 11.5 Elderly Persons’ Housing in Blue Water Health District

<table>
<thead>
<tr>
<th>Blue Water Communities</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Georges</td>
<td>Foyer Chateauguay</td>
<td>15</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>St. Georges</td>
<td>55+ Condominium</td>
<td>9</td>
<td>Private</td>
</tr>
<tr>
<td>Powerview</td>
<td>Winnipeg River Manor</td>
<td>16</td>
<td>Private</td>
</tr>
<tr>
<td>Pine Falls</td>
<td>Pineview Lodge</td>
<td>17</td>
<td>Manitoba Housing</td>
</tr>
</tbody>
</table>

Source: Manitoba Housing to Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

The Manitoba Housing Units are full and have waiting lists with the exception of the Foyer Chateauguay in St. Georges. The Foyer Chateauguay has a chronic vacancy problem and Manitoba Housing has had to cap the rent in this facility in order to keep the vacancy problem to a minimum. All Manitoba Housing operated facilities charge 27% of income.
Focus Group - Housing

This was an area of concern expressed in the 1998 CHA report. The need for more transitional housing is becoming more an issue in the middle and seniors Focus Groups.

Seniors

Suggestion Raised by Seniors.
- Condo complexes life leases “…run like a condo…on a non-profit basis…” [Blue Water]

2004 Validation Workshop

BLUE WATER GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT – Housing
- Concern about the inability for seniors to sell their homes in the Pine Falls area when they need to move on to other housing options.
### Table 11.6 Crime Report Blue Water Health District Total

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td><strong>Persons</strong> – Homicides, robberies, personal assaults and abductions.</td>
<td>Blue Water</td>
<td>321</td>
<td>278</td>
</tr>
<tr>
<td></td>
<td><strong>Property</strong> – Break and enter, shoplifting, stolen goods, motor vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft, theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Criminal Other</strong> - Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other Criminal</strong> – Property damage under $5000, disturbing the peace,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>arson, indecent acts, bail violations, breach of probation,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>harassing and stalking, kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Federal Code</td>
<td>NE</td>
<td>155</td>
<td>204</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coroner’s Act, Mental Health Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trespass Act, Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquor-intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
<td></td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Blue Water</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td>NE</td>
<td>83</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e.</td>
<td>Blue Water</td>
<td>135</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>impaired driving, driving over 80 MG (blood alcohol level), driving a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>motor vehicle prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Traffic</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Blue Water</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td>NE</td>
<td>3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Blue Water</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td>NE</td>
<td>133</td>
<td>154</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL OF ALL OFFENSES**

| Note: this does not include persons injured or killed. | Blue Water | 775 | 586 |
|                                                       | North Eastman | 8,714 | 7,481 |

* The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

** The number of persons injured and killed in traffic related incidents are not included in the numbers associated with the total traffic code category, nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.
Discussion

All criminal code categories of reported cases have decreased during the later time period reviewed. This is a positive finding.

There was one traffic accident death reported in 2002, there was none in 2001. The number of traffic related injuries also went up from 14 in 2001, to 17 in 2002.

2004 Validation Workshop

BLUE WATER GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT - Traffic
- Concern about Highway # 304, unsafe to travel to specialists and local services.
- Need more collaboration between NEHA and municipalities on major issues such as air and water quality and road improvements.

Note: We are not able to compare previous crime report information as the CMB changed their system of reporting.
Overview

The fundamental characteristics of this determinant include our genetic make up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought that “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.”

For information related to this determinant refer to the section on ‘health status’

Overview

Behaviour change is one of the most difficult areas to modify as it is so well integrated into a person or family’s pattern of life style and practice. Education alone is never enough. Other known influences on behaviour, either positively or negatively, may include an individual’s peers, social / community norms and practices, and the willingness on the part of the individual, family, or community to change.
Focus Groups – Dietary Practices

Youth

Reasons to Change: previous illness and to control weight were the main reasons.

a) One youth became ill and this was the motivator for changing eating habits [Seymourville]

Young Adults

Programs / Methods Used

• In Frontier School Division there is a ‘healthy nutrition policy’. [Seymourville]
• It was noticed that there is an improvement in the availability of healthy foods in the local store. [Seymourville]

Middle Adults

The reasons why participants modified their diet included:

a) Health reasons e.g. borderline diabetic, cholesterol. [Winnipeg River, Blue Water, Iron Rose, Brokenhead]
b) Wanted to fit into clothes. [Blue Water]

Programs / Methods Used

• Seven Oaks Heart Program [Blue Water]

Barriers

- Motivation and difficulty changing old habits
- Difficult to make these changes with children at home…. One becomes used to cooking a certain way…. also once you’re feeling better, easy to slip into old habits. [Blue Water]

“\textit{It’s a concern when you read the labels and you don’t know what they are, what are they feeding you?}” [Blue Water]

- General confidence expressed in the Canada Food Guide. [Blue Water]
Alcohol Consumption

Focus Group- Alcohol Use

**Youth**

Drinking was discussed as an emerging topic. No participants associated this with a personal lifestyle change recognizing that many youth in the Focus Groups did not consume alcohol.

The youth clearly saw alcohol not only as something youth did, but even more as a behaviour of adults in their communities.

“We’re not really the healthiest bunch here because there’s nothing to do in town…” “Smoke and drink, that’s what you have to do…” [Blue Water]

There is a perception that getting drunk is having fun, and youth highlights the social aspect of drinking i.e. getting together with friends. In response to the question about having fun without drinking, they replied you can, but not in their home communities. In Winnipeg, for example one can shop, walk around downtown, go to movies, “…even just to drive around, it’s fun. At least there’s stuff to look at…” [Blue Water]

**Adult Focus Groups**

Alcohol was not raised as a social problem in most of the adult Focus Groups except for the example given in the middle adult Focus Group. There were several adults who mentioned on a personal note that they did give up drinking. As the youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

**Young Adult**

Some participants from Blue Water had stopped drinking in order to support a spouse who had stopped, due to a serious health problem and to improve physical activity performance. [Blue Water]

---

**2004 Validation Workshop**

**BLUE WATER GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES AND COPING SKILLS- Alcohol Consumption**

- Concern was expressed about the excessive use of consumption of alcohol amongst seniors.
Focus Groups on Illicit Drug Use

YOUTH
The mention of using drugs such as marijuana and cocaine was raised in Blue Water, Brokenhead and Winnipeg River groups only.

Suggestion Raised by Youth
• When asked about identifying important issues which require attention one youth replied “Just things they can’t put a stop to, like drugs and stuff.” [Blue Water]
• Another youth indicated if penalties were more harsh perhaps it would scare some youth from starting. [Blue Water]

Physical Activity

Focus Groups on Exercise
Increasing the amount of exercise was the most common form of lifestyle change that the adults made to improve their health.

YOUTH
Reasons to Exercise - The two primary reasons were weight management and to be healthy.
A youth did start scheduled exercises to be healthy [Seymourville].

YOUNG ADULTS
Reasons to Exercise - The two primary motivators for exercising was to decrease weight and improve body image.
Examples of focus group responses varied greatly: overweight and out of shape [Blue Water], feeling good about oneself [Blue Water].

Programs / Methods Used
• Local weight program – Generally those who go or use the program’s point system indicate success. [Blue Water].
• Dietitian – “she was really good, but I just wasn’t ready.” [Blue Water]
• Walking - This was a popular way of exercising described in all focus groups. Other methods included stair stepping and kickboxing. [Blue Water]

MIDDLE ADULTS
- Reasons to Exercise- A health crisis in self or acquaintance was the most common reason. Other reasons include to decrease weight, improve image, or for mental health reasons.
  a) Partners provide motivation to be active. [Blue Water]

Programs / Methods Used
• Local weight program [Blue Water]

Barriers - Exhaustion, time, family commitments were the main barriers expressed.
  - If a routine is interrupted, it’s sometimes difficult to get back with it. [Blue Water].
  - Proximity to a facility. “…if I lived closer I would be a member [at Seven Oaks] just to go walking on the track.” [Blue Water]

SENIORS
Programs / Methods Used
• Walking was the main method of exercise in this age group.
Smoking Practices

Focus Group on Smoking

The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This information provides valuable information for staff working in smoking cessation programs. The most consistent message is that if the individual wants to quit, there are a variety of methods used. Success often depends upon support the individual receives and if weight gain is addressed and managed. For adults, one of the biggest concerns that smokers indicate time and time again is the potential and real problem of weight gain that accompanies quitting.

YOUTH

- There were several youth in the Blue Water group that smoked. All were aware of the health impacts of smoking. The reason a youth started smoking was because of people they spent time with i.e. friends and/or family smoked. [Blue Water]

  Reasons for Quitting
  a) A poster of a smoking related disease motivated one student to quit “…(the poster) grossed me out. I thought it was…making people rich just to ruin your body…” [Blue Water]

  Barriers
  - “Not easy to quit.” [Brokenhead, Blue Water] especially around smoking friends. [Blue Water]

YOUNG ADULTS

Quitting Smoking

- Support for public smoking ban by participants in Blue Water.

  Reasons for Quitting –
  Some participants there is evidence that public policy, peer pressure, and health education strategies are working.
  a) Health reasons for quitting:
     “I’m going to have to change a few things or I’m going to be dead soon.” [Blue Water];
  b) Small children in house. [Blue Water]
  c) In Seymourville there is a no smoking policy related to the community council and halls, which the group felt influenced a healthy lifestyle in their community.

MIDDLE ADULTS

  Reasons for Quitting: health reasons. [Blue Water]

Programs / Methods Used

- Hypnosis - Participant was successful but other two friends were not. [Blue Water]
- Cold turkey [Blue Water & Iron Rose] “…replaced smoking with knitting….” [Blue Water]

Barriers

- Misses the cigarettes. [Blue Water]
- Weight gain. [Blue Water, Iron Rose]
  “…how awful it is….sick for a whole year. I caught every sickness that came along…exactly a year… I’ve been feeling great ever since.” [Blue Water]

SENIORS

Programs / Methods Used

- Just decided [Iron Rose, Blue Water]
### 2004 Validation Workshop

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Water</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
</tr>
<tr>
<td>Validation Workshop participants did not raise any other specific comments on this subject.</td>
<td>72.7%</td>
</tr>
<tr>
<td>2003 Focus Groups- Smoking was discussed in all Focus Groups in relation to life style changes and quitting smoking.</td>
<td></td>
</tr>
</tbody>
</table>

#### Potential Risk Taking Behaviour

**Focus Groups on Risk Taking Behaviour**

**YOUTH**

a) **Tattoos**

- There was knowledge about infection risks. "...could get really infected." [Blue Water]
Medication Use

Pharmaceutical Use

Figure 11.16 Proportion of Residents With At Least One Prescription

There has been a statistically significant increase in the percentage of residents using at least one prescription medication during the time period reviewed, from 62% to 68%.

Blue Water’s percentage is not significantly different than the Manitoba average during the later time period.

There has been a significant increase in the proportion of residents in Blue Water that were prescribed at least one prescription drug.
Number of Different Drugs

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

**Figure 11.17 Average Number of Different Drugs Prescribed**

Blue Water had the highest reported number of prescriptions per user than any other NE health district.

When we compare the two time periods, there has been a statistically significant increase, from 4.5 to 4.97. Blue Water is statistically significantly higher than the Manitoba average of 3.17 and 3.44 respectively and Rural South of 3.12 and 3.44 respectively.

We know the overall health status in Blue Water is poorer than the other health districts. This may be a reason why there are a higher number of different drugs prescribed.

Blue Water has the highest reported number of different drugs prescribed compared with other health districts and is significantly higher than Manitoba and Rural South.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

Figure 11.18 Percentage of Residents Receiving At Least One Prescription Antibiotic

Blue Water health district has the second highest reported number of prescriptions per user in the NE Health Region.

When we compare the two time periods there has been a statistically significant increase, from 41% to 44%.

Blue Water is also statistically significantly higher than the Manitoba average of 39% and Rural South at 38% during both time periods.

The number of Blue Water residents who have received at least one antibiotic prescription has increased significantly, and is significantly higher than Manitoba and Rural South.
Blue Water’s average number of antibiotic prescriptions dispensed is not significantly different during the two time periods, at 2.51 and 2.42 respectively.

Blue Water has the highest average number of antibiotics prescribed when compared with our other health districts.

There is a statistically significant increase when compared with the Manitoba average of 2.06 and 2.02 respectively and Rural South of 2.07 and 2.06 respectively.

There was not significant change in the number of antibiotic prescriptions dispensed during the two time periods, however Blue Water's average number of antibiotic prescriptions is significantly higher than Manitoba and Rural South.
Proportion of Antidepressants Used

Figure 11.20 Proportion of Residents Using Antidepressants

Blue Water’s percentage of prescriptions dispensed has had a statistically significant increase, from 3.5% to 6.3%.

There has been a statistically significantly higher proportion of prescriptions dispensed in Blue Water when compared to the Manitoba average of 5.5% during the second time period.

Except for Northern Remote, the number of antidepressant prescriptions significantly increased in all health districts.

Blue Water’s antidepressant use has significantly increased and is the highest in NE.

Focus Groups- Prescriptions

YOUNG ADULT

-Quickness to prescribe medication. [Winnipeg River, Blue Water]
Healthy Child Development as a Health Determinant

"The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful." 41

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status.42

Infant Mortality

The infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

Figure 11.21 Infant Mortality Rate NE Health Districts

In Blue Water in 1990-1994, the numbers were suppressed because there were five or less infant deaths.

Although there appears to be a higher infant mortality rate than Manitoba and Rural South, it was not significantly higher.
Births

At 40 weeks gestation 50% of female babies weigh approximately 3500 grams and male babies weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. We see that often in disadvantaged groups, mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.

Table 11.7 Number of Newborns in Blue Water

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Remote</td>
<td>63 [23.6/1000]</td>
<td>151 ** [29.8/1000]</td>
<td>158 ** [31.3/1000]</td>
<td>133 ** [28.0/1000]</td>
</tr>
<tr>
<td>Unorganized Territories</td>
<td>No longer separated integrated into iron Rose, Blue Water, Winnipeg River and Northern Remote.</td>
<td>42 [17.1/1000]</td>
<td>54 [22.1/1000]</td>
<td>48 [18.4/1000]</td>
</tr>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


* The geographic boundaries have changed for the 2002-2003 fiscal year. Most of the First Nation Reserves are within the health district Northern Remote. Unorganized Territories are no longer geographically together, but re-located into various health district boundaries.

** Listed as First Nation Communities during these years. The 3 FN communities now in Blue Water are likely also represented here. When we look at the 2002-2003 newborns, we see a decrease in Northern Remote and an increase in Blue Water newborns reflecting these geographic changes.

During 2002-2003 NE had a total of 431 newborns, a rate of 10.9 / 1000 compared with the Manitoba rate of 11.7/ 1000. Due to geographic boundary changes, Blue Water Health District is now showing the highest number of births, but a lower rate of 17.7/1000 when compared with Northern Remote’s rate of 23.6/ 1000.
How Has Blue Water’s Birth Rate Changed Over Time?

Blue Water was showing a decrease until 2002/2003 when there was a significant increase in newborns. This appears to be an artificial increase due to the geographic health district boundary changes.

Northern Remote showed a substantial decline during 2002/03, but this appears to be an artificial decrease in the number of newborns due to geographic health district boundary changes. There has been a small decline during the former years.

Focus Groups on Obstetrical Practices

Obstetrics as a service emerged in several adult Focus Groups.

YOUNG ADULTS
- Like to see more surgeries and obstetrics in hospitals. [Springfield, Ironrose, Winnipeg River, Blue Water]

MIDDLE ADULTS
- Hospitals should have birthing capability. [Winnipeg River, Blue Water]
Figure 11.22 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability.

Blue Water had a statistically significant decrease in the number of teenage pregnancies from 141.03/1000 to 118.01/1000.

Blue Water’s teenage pregnancy rate is statistically significantly higher than Manitoba’s at 61.39/1000 and Rural South’s at 45.37/1000 during the second time period.


Blue Water’s teenage pregnancy rate has had a statistically significant decrease but remains significantly higher than Manitoba and Rural South.

Focus Groups on Teen Pregnancy

Youth - Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. Teen pregnancy was not mentioned in the adult groups.

“...a lot of people have babies out here.” [Blue Water]

- In the Blue Water Focus Group, participants were aware that they could get birth control information from their guidance counselor, public health nurse and doctor. No one was comfortable about approaching the health teacher. Generally felt the topic of contraception was well covered in school. [Blue Water]

- When asked if birth control is a guy issue, the responses varied between male participants:
  - “No” [Bluewater]
  - “It kind of is, I guess. If you and your girlfriend plan on having sex you should like, ask her, are you on the pill so that you know.” [Blue Water]
  - “Sort of.” “I think so.” [Bluewater]
  - “Kind of.” [Blue Water]

- When the females in the group spoke they noted that an unplanned pregnancy will impact more on the young mother than on the father. [Blue Water]

- One youth indicated that a teen pregnancy can have a beneficial effect, acting as a wake-up call for that new mother or father who sometimes now turns their life around due to the added responsibility. [Blue Water]

- Youth in general felt they wouldn’t want children yet, without a reliable partner or job. [Blue Water]

Suggestions Raised by Youth

- Provide some way of providing reproductive health especially in smaller communities. [Seymourville]

- Afraid to ask about reproductive health issues – not private if you go to the clinic, everyone would know. [Seymourville]
2004 Validation Workshop

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blue Water</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Teen Pregnancy</strong></td>
<td>72.7%</td>
</tr>
</tbody>
</table>

Validation Workshop participants did not raise any specific comments on this subject.

2003 Focus Groups – Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. It was not mentioned in the adult groups.

2004 Validation Workshop

**BLUE WATER GROUP DISCUSSIONS ON HEALTHY CHILD DEVELOPMENT**

- During participant discussions, there was concern expressed that parenting skills for teen moms and dads were lacking.
Breastfeeding Practices

Figure 11.23 Breast Feeding Initiation Rates in NE Health Districts

There is considerable variability within the health districts. There are significantly lower rates of hospital initiated breastfeeding in Blue Water (63%) when compared with Manitoba (79.7%) and Rural South (80.3%) during the second time period.

On a positive note, Blue Water experienced a statistically significant increase during the two time periods reviewed.

Breastfeeding initiation rates have significantly increased but remain significantly lower than Manitoba and Rural South and are the second lowest in NE.

In 2001 Blue Water began an outreach program called Canadian Prenatal Nutrition Program which has an emphasis in promoting breastfeeding. It will be interesting to see if breastfeeding rates increase.45
Birth Weights

The number of Blue Water’s high birth weight babies has increased slightly, from 18.1% to 19.1%, but it is not a significant increase.

Blue Water has the highest percentage of high birth weight babies when compared to other health districts.

Blue Water appears to have a higher percentage of high birth weight babies than the Manitoba average of 15.6% for the second time period, but it is not a significant difference.

We know that high birth weights occur if pregnant moms have diabetes. We also know that there has been a statistically significant increase in diabetes in Blue Water.
As we look around the region we are seeing some variability in the percentage of low birth weight babies.

Blue Water has the highest percentage at 5.9% of low birth weight babies during the second time period when compared with other health districts.

Blue Water's low birth weight rate is not statistically significantly different than the Manitoba rate of 5.1% or Rural South's at 4.6% during the later time period.

Blue Water has the highest percentage of low birth weight babies when compared to other health districts.

Pre-Term births have significantly increased in Blue Water and are the highest in NE.
Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses.

Figure 11.27 Completed Immunization at One Year

Blue Water is showing a statistical decrease from 75.8% to 61.6% in the number of completed immunizations at one year.

Blue Water is statistically significantly lower than the Manitoba average of 84.5% and 83.0% and Rural South of 886.5% and 83.1% during both time periods.

Figure 11.28 Completed Immunization at Two Years

Blue Water is showing a statistically significant decline, from 62.0% to 43.6% in the number completed of immunizations at two years.

This is statistically significantly lower than the Manitoba average of 71.5% and 70.7% and for Rural South 74.8% and 70.9% during the two time periods reviewed.
Figure 11.29 Completed Immunization at Seven Years

Blue Water shows a decrease, but not significant from 68.4% to 62.4% in the number of completed immunizations at seven years.

Blue Water is statistically significantly lower than the Manitoba average of 82.6% and 73.3% and Rural South of 83.3% and 77% respectively for the two time periods reviewed.

It would be interesting to determine why the overall decrease in immunization rates at one, two and seven years has occurred.

A decrease in overall immunizations completed is not a unique phenomenon to NE but has occurred in most RHA’s. Is accessibility or negative media attention a cause? This would be an area to consider for further exploration.

For Years 1 and 2, Blue Water’s immunization coverage showed a decline and is the second lowest in NE. Coverage is significantly less than and Rural South for both periods reviewed.
Overview

Job rank, social statuses in the workplace, the amount of control over one’s work, are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed.

Employment and Unemployment

Table 11.8 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Blue Water has the second lowest employment rate for both males and females when compared with our other health districts. Females have a lower percentage of employment than males. Males have a higher unemployment rate than females.

Focus Group and Employment

**SENIORS**

“...becoming angry, the job was not a pleasure anymore...” [Blue Water]
- Another participant mentioned how spouse was very depressed by a “very boring job”….and came home really upset “so many times.” After leaving the job the spouse was “...much happier...” [Blue Water]
2004 Validation Workshop

BLUE WATER GROUP DISCUSSIONS ON EMPLOYMENT AND WORKING CONDITIONS

- Comment on the lack of availability of job opportunities in the area.
  Job security is at risk with Tembec Paper Group leading to higher stress rates, possible higher alcohol consumption, marriage break-ups, etc.

Social Economic Status

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status.50

Median Family Income

The following tables describe the median family income and the median family income for lone parent families in Blue Water Health District communities, North Eastman and Manitoba.

Table 11.9 Median Family Income of Couple Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Water</td>
<td>$42,163</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Blue Water has a lower median family income than NE or Manitoba as a whole.
Table 11.10 Median Family Income of Lone Parents – Males and Females

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$40,087</td>
<td>$36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$23,892</td>
<td>$17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$45,361</td>
<td>$26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$35,698</td>
<td>$26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$9,248</td>
<td>$12,587</td>
</tr>
</tbody>
</table>


Lone parent male families appeared to have consistently higher incomes than lone parent female households. Blue Water males and females have the second lowest lone parent family income when compared to our other health districts.

Table 11.11 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$26,469</td>
</tr>
</tbody>
</table>


Total Low Income Incidence

The incidence of low income in 2000 in Blue Water was 10.3%.

Lone parent male families appeared to have consistently higher incomes than lone parent female households.
Overview

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included, as these all support a strong social network.

Mental Emotional Health

Mental health was raised as an important concern for many NE residents particularly in the area of services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report. Mental Health Services continued to be a concern for 2003 Focus Group participants.

Focus Groups on Mental Well-being

Mental health issues emerged throughout the Focus Groups discussion. The topics varied between the age groups. Adult Focus Groups- lack of mental health support emerged in the middle adult and staff Focus Groups. Stress emerged as a common theme, however the cause of the stress varied among the age groups.

YOUTH

a) Behaviour / Image

“Lots of people judge you.” [Blue Water]

- The focus on appearance sometimes motivates people to manage themselves in accordance with others’ impressions of you, for example piercing, tattoos “...could get really infected [tattoos]”, sports injuries by “…showing off.” Drinking and doing drugs.

[Blue Water]

YOUNG ADULT

The primary issues discussed were the need for better awareness of the mental health programs (refer to Mental Health Program Section 7), and the stigma associated with these programs.

SENIORS

- Seniors were concerned about being able to identify vulnerable members in the community in particular those who were more isolated and described as ‘lonely.’ Another concern for this age group was living alone and being lonely. Two issues emerged;

a) what they would do if something should happen to them and they were unable to access help.

b) effects of isolation and living alone.

Mental Health Programming is discussed under the NEHA Mental Health Program –Section 7.
Social Support

Table 11.12 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td><strong>Blue Water</strong></td>
<td><strong>1,970</strong></td>
<td><strong>505</strong></td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and they may be more economically disadvantaged than two parent households.

Focus Group On Social Support

Social support was an area that was raised in all Focus Groups and all ages as something that was seen as positive with respect to an individual's wellbeing.

YOUTH
When talking about what it means to be healthy, youth discussed the importance of friends and social supports. We know that social support is a strong determinant of health status.

a) Support Network
- Influences of other around you – your peers. [Seymourville]

SENIORS
a) Effects of Isolation
- A partner may not wish to accept help even when the spouse is stressed with their care. [Blue Water]
### 2004 Validation Workshop

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blue Water</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Identification of at Risk Individuals Who are Vulnerable</strong>&lt;br&gt;Validation Workshop participants did not raise any specific comments on this subject.</td>
<td>68.2%</td>
</tr>
<tr>
<td><strong>2003 Focus Groups</strong>&lt;br&gt;– This was raised as a concern by many participants especially in the middle and senior adult groups.</td>
<td></td>
</tr>
<tr>
<td><strong>Community Support Services Available Not just for Specific Groups</strong>&lt;br&gt;Validation Workshop participants did not raise any specific comments on this subject.</td>
<td>68.2%</td>
</tr>
<tr>
<td><strong>2003 Focus Groups</strong>&lt;br&gt;– This was specifically mentioned in the middle adult Focus Groups that community supports should be all encompassing and not restricted to one age group.</td>
<td></td>
</tr>
</tbody>
</table>
11.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the 1998 CHA Report there have been boundary changes most prominently related to the northern areas. Unorganized Territories were originally separated and now are incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts. Northern Remote is designated as a health district.

Population

Almost all age groups saw an increase in either males or females, except for the 25-39 year old age groups, which could be due to leaving the area for employment opportunities. The implication of growth especially as it relates to the elderly population is the potential for added pressure on the health system. This contributes to the need for creative and preventative health services planning for this population group. From 1999 to 2002 there has been a decline in the number of births. In 2002-2003 with boundary changes, we see an increase in births, at 17.7/1000 compared with Manitoba at 11.7/1000.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index (SEFI) value and premature mortality rates (PMR) both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern. Blue Water has the second worst SEFI value in NE and is lower than both Manitoba and Rural South, despite the fact that the value has shown an improvement. It will be interesting to note future SEFI values to ensure that this value continues to improve. This measurement is an indicator that socioeconomic factors are improving.

PMR has increased slightly, but not significantly. PMR is statistically significantly higher when compared with Manitoba between 1996 and 2000. This needs to be monitored as it is a measurement of overall general health status and implies that there may be a need for more health services including preventative services.
Deaths

Blue Water’s total mortality rate has decreased but not significantly. It is also not significantly different than the Manitoba average.

Blue Water has shown an increase in the PYLL value, but it is not a significant increase. This suggests that there are an increasing number of early deaths in the population.

Life Expectancy

Females live longer than males by approximately four years. Life expectancy, for both males and females appears to be less than Manitoba and Rural South.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cancer cases have</td>
<td>- Diabetes treatment is</td>
<td>-Blue Water has the 3rd</td>
<td>Hypertension treatment has increased</td>
</tr>
<tr>
<td>decreased, but not</td>
<td>had a significant</td>
<td>highest asthma rate when</td>
<td>significantly and is the highest</td>
</tr>
<tr>
<td>significantly.</td>
<td>increase. It is</td>
<td>compared with our other</td>
<td>within NE’s health districts.</td>
</tr>
<tr>
<td></td>
<td>significantly higher than</td>
<td>health districts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the Manitoba</td>
<td>- Respiratory diagnoses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>average, and is 2nd</td>
<td>are significantly higher</td>
<td></td>
</tr>
<tr>
<td></td>
<td>highest in our health</td>
<td>than Manitoba average.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>districts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>Stroke</td>
<td>Injury</td>
<td></td>
</tr>
<tr>
<td>Hospital treatment for</td>
<td>Stroke treatment has</td>
<td>Injury hospitalization is</td>
<td></td>
</tr>
<tr>
<td>MI’s have decreased,</td>
<td>declined, but not</td>
<td>the 2nd highest when</td>
<td></td>
</tr>
<tr>
<td>but not significantly.</td>
<td>significantly.</td>
<td>compared with our other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>health districts and is</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>significantly higher than</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>the Manitoba average.</td>
<td></td>
</tr>
</tbody>
</table>

Diabetes- Diabetes can significantly affect the individual’s quality of life and can be a considerable financial burden and therefore must be not only managed but also prevented. The Blue Water diabetes data suggests an ever-increasing prevalence of the decease. This indicates a need for a population approach that encompasses prevention, education, care, research and support targeting the general population. It also requires monitoring of clients with diabetes to ensure good control of the illness in order to prevent other risks. Diabetes was raised as a key issue by 81.8% of participants during the Validation Workshops.

Human Function & Well being

The most prominent issue raised by youth was ‘nothing to do’, therefore an area to explore with our community partners. Youth and adults in the Focus Group provided many good suggestions for improvement.
DETERMINANTS OF HEALTH

Environmental Factors

**Water & Air Quality** - There were no concerns raised about water or air quality during the Focus Groups; however during the validation workshop both water and air quality were discussed.

**Safety** – Traffic injuries have risen. During the validation workshops there was discussion about traffic safety with regard to unsafe travel with respect to highway 304.

**Housing** – The need for more PCH beds was raised in Blue Water, Springfield, and Winnipeg River. During Focus Group discussions, there were many adult participants across the age groups who raised the need for transitional/independent housing units. In Blue Water they felt maybe condo complexes on a non-profit basis would be beneficial.

**Personal Heath Practices**

From focus group provincial survey comments there seems to be a readiness by the public in general toward healthier lifestyle choices.

**Dietary** – Obesity is a national concern. We see in NE that there is a considerable number of self reported survey respondents indicating they are overweight or obese. During the Focus Groups participants mentioned that this was one of the area where they were making healthier choices.

**Alcohol Consumption** – During Focus Groups youth felt it was an issue with both youth and adults in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners. There was concern raised during the validation discussions about excessive use of alcohol by seniors.

**Illicit Drug Use** – This was raised as a concern in the youth focus groups in Blue Water, Brokenhead and Winnipeg River.

**Physical Activity** – According to the provincial survey, approximately half of respondents were not physically active. Exercise was the top area that Focus Groups and provincial survey respondents indicated they did to achieve a healthier lifestyle.

**Smoking Practice** – Approximately one quarter of our residents in NE still smoke according to CCHSC 1.1 self reports. From Focus Group participants, it was essential that when smoking cessation programs are initiated, success often is dependent upon addressing weight gain. As well, it appears that public policy e.g. increasing cost of cigarettes and limiting places where smoking can occur are working, as many participants indicated that these were the reasons why they chose to quit. Ongoing smoking cessation programs targeting community and staff should be considered. Addressing each age group’s issues surrounding barriers to
quitting smoking, will increase the success rate. Seventy-two percent of Validation Workshop participants raised smoking as a second key issue.

**Medication Use**

*Prescriptions* - The number of residents with at least one prescription use showed a statistically significant increase in Blue Water. Blue Water’s percentage is not statistically significantly different than the Manitoba average. Given the overall poorer health status in Blue Water, this is not unexpected.

*Antibiotics* - Blue Water residents receiving at least one antibiotic prescription use showed a statistically significant increase. It is also significantly higher than the Manitoba average. Given the overall poorer health status in Blue Water, this is not unexpected.

*Antidepressants* - Antidepressant prescriptions showed a statistically significant increase. It is the highest in NE and is significantly higher than the Manitoba average. It is difficult to know if the reason is due to depression diagnosis, as antidepressants can be prescribed for other reasons.

There were concerns raised in the Focus Groups about prescription drugs being used as the first choice of treatment.

**Healthy Child**

*Infant Mortality Rates* - Blue Water health district in particular showed an increase in infant mortality rates during 1995-1999 (15.5/1000 compared with Manitoba at 6.6/1000). This is a significant difference. This is a useful indicator in measuring the wellbeing of an area and should be monitored.
Adolescent & Teenage Pregnancy - Blue Water’s teen pregnancy rate has had a statistically significant decrease, but is second highest in NE, and significantly higher than the Manitoba average. The youth Focus Group in Blue Water recognized that “a lot of people have babies out here.” Concerns were raised about the privacy for youth going to clinics as ‘everyone would know’. This is an area that could be discussed with the community’s youth on how to improve delivery of reproductive health information. Seventy–two percent of Validation Workshop participants felt that teen pregnancy was a key issue.

Breastfeeding Initiation – Blue Water’s breast feeding initiation rates have increased which is positive, but they are the second lowest in NE, and are significantly lower than the Manitoba average. This may be an area that could be investigated and strategies developed to improve these rates.

Birth Weights - Blue Water has the highest percentage of both higher and low birth weights compared with other health districts. This is an important area to continue to monitor, as birth weight has potential implications associated with the future health of our children and may be potential burden on health services. Pre-term births have increased significantly.

Immunizations – There has been a significant decrease in coverage during years 1 and 2, and is the rate is the second lowest in NE. Blue Water would benefit from reviewing strategies on how to increase immunization, as they have an overall poorer health status than other health districts.

Living and Working Conditions

Work - During 2001, Blue Water had the second lowest employment rate for both males and females when compared with other health districts. Some Focus Group participants in Blue Water felt job satisfaction was important to well being. There appears to be a lack of available job opportunities in the area.

Economic Status – The overall median income in 2000 was lower in Blue Water than in NE and Manitoba overall. Blue Water had the highest incidence of low income in 2000, at 10.3% as compared with other health districts.
Personal Resources

Mental Emotional Health
- Youth stressed that friends and social support are really important. When adults judged youth, it was felt to have a negative affect on their self-esteem.
- Young adults discussed that there was a stigma associated with accessing mental health services.
- Middle adults felt that there is a need for programs to address issues such as managing stress. Looking after aging parents also arose as a concern.
- Seniors had concern about people living out in the community who were isolated. They identified themselves as often living alone and being lonely and had concerns they had about their ability to access help quickly. The need for identification of at risk individuals was raised this as a key issue Blue Water.

Social Support - There are approximately 505 lone parent families reported in Blue Water during the 2001 census. Community supports should be available to all people, not just specific groups was raised this as a key issue by sixty-eight percent of Validation Workshop participants in Blue Water.

Summary At A Glance

<table>
<thead>
<tr>
<th>KEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner: implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.</td>
</tr>
<tr>
<td>Monitor: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.</td>
</tr>
<tr>
<td>NEHA: a program or service could be enhanced or developed to address this issue.</td>
</tr>
</tbody>
</table>

Strengths
- Total mortality rate has decreased but not significantly, and is not significantly different than the Manitoba average. [Monitor]
- New cancer cases have decreased, but not significantly. [Monitor]
- Stroke treatment has declined significantly. [Monitor]

Issues Having Implications for Health Planning & Delivery
- Population increased in most age groups. Growth in the older population has the potential to affect health services needs. [NEHA, Monitor]
- Second worst SEFI value when compared with other health districts in NE and is worse than Manitoba and Rural South. [NEHA, Partner, Monitor]
- PMR is statistically significantly higher than Manitoba which is an indicator that suggests the need for health services. [NEHA, Partner, Monitor]
- PYLL value has increased, but not significantly. [NEHA, Partner, Monitor]
- Life expectancy for both males and females is less than Manitoba and Rural South. [NEHA, Partner, Monitor]
- Second lowest employment rate. [Monitor]
- Overall median income was lower than NE and Manitoba overall. [Monitor]
- Highest incidence of low income in 2000 compared with our other health districts. [Monitor]
- Illicit drug use a concern raised by youth focus groups. [Partner]
- Traffic injuries have increased. [Partner, Monitor]
**KEY**

- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

### Issues Having Implications for Health Planning & Delivery Continued

<table>
<thead>
<tr>
<th>Issue</th>
<th>Partner</th>
<th>Monitor</th>
<th>NEHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prescriptions has had a significant increase.</td>
<td>[Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of at least one antibiotic prescribed has had a significant increase.</td>
<td>[Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Groups expressed need for mental health supports and awareness of mental health services.</td>
<td>[NEHA, Partner]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension treatment has increased significantly.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury hospitalizations are the 2nd highest in NE and are significantly higher that the Manitoba average.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus groups would like to see more PCH beds and transitional housing units.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity a national concern.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation programs a need.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant prescription use is the highest in NE, and has significantly increased.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water and air quality concerns were expressed during the validation workshops.</td>
<td>[Partner, NEHA, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen pregnancy significantly decreased, but 2nd highest in NE.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast feeding initiation rate is significantly lower than the Manitoba average.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High, low birth weights are the highest in NE. Pre-term births have had a significant increase.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization coverage has declined and is 2nd lowest in NE.</td>
<td>[NEHA, Partner, Monitor]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
11.6 REFERENCES

5 Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004


12.1 GEOGRAPHICAL OVERVIEW

12.2 COMMUNITY SYSTEM CHARACTERISTICS

12.3 HEALTH STATUS
Overview
Significant Indicators Measuring Overall Health Status
Deaths
Health Conditions
Human Function

12.4 DETERMINANTS OF HEALTH
Environmental Factors
Water
Air
Housing
Safety
Biology & Genetic Endowment

Personal Health Practices & Lifestyle
Overview
Dietary Practices
Alcohol Consumption
Physical Activity
Smoking Practices
Risk Taking Behaviour
Medication Use

Healthy Child Development
Overview
Infant Mortality Rates
Births
Adolescent and Teenage Pregnancy
Breastfeeding Practices
Birth Weights
Childhood Immunizations
Community Feedback on Healthy Child Development

Living and Working Conditions
Overview
Social Economic Status

Personal Resources
Mental Emotional Health
Social Support

12.5 SUMMARY/CONCLUSION

12.6 REFERENCES
12.1 GEOGRAPHICAL OVERVIEW

The Winnipeg River District consists of the Town and the Rural Municipality of Lac du Bonnet, and the Local Government District of Pinawa. The Region is located approximately 100 km northeast of Winnipeg, on the edge of the Whiteshell Provincial Park and continues along the Winnipeg River. Provincial Hwy. # 11 leads to and through the District, with Hwy.# 211 leading into the town of Pinawa.

Economic activity is diverse with farming, forestry, mining, light industry, retail and service businesses, technology-based business and tourism all contributing to the economy.

The RM of Lac du Bonnet has a local airport with a 3600 foot paved runway which, among other things, is used by private pilots and local air carriers to fly fishermen to remote camps. Lac du Bonnet has a new community centre, opened in 1999 that houses a four sheet curling rink, four lane bowling alley and three hall facilities for community events.

Lac du Bonnet had a number of major construction projects that have recently been completed. The South Interlake Credit Union constructed a new branch building that opened in 2002. A major expansion was completed to a local grocery store which in 2003 and a new privately owned exercise facility was constructed and opened in 2003.

Pinawa is building on the advanced technical and scientific skills base that exists within the region to attract high-tech companies. The Economic Development Office manages the business development strategy and supports the marketing and promotion activities of the Pinawa Community Development Corporation (PCDC).

The Pinawa Heritage Sundial is a unique project that marks the new millennium through an expression of art, science and heritage. It is located in a park in the centre of Pinawa and creates a meeting place where paths, roads and waterways converge in the Eastman Region. The Pinawa Suspension Bridge had its grand opening on May 14, 1999. The bridge is 54 meters long, 1 meter wide and forms part of the Trans Canada Trail. It has opened up new areas for interpretive walks, casual fishing and cross-country skiing.

An active Recreation Commission serving all the area, coordinates many programs and activities year round. The entire district has an abundance of walking, cycling, cross-country skiing, and groomed snowmobile trails. Visitors and locals alike enjoy fishing and hunting, as well as hiking, skiing and camping. A water ski facility and Club are operated out of Lac du Bonnet. There is a swimming pool, marina, windsurfing/rowing clubhouse, and golf course and clubhouse in Pinawa.
These are the municipalities and communities that fall under the Winnipeg River Health District.

<table>
<thead>
<tr>
<th>WINNIPEG RIVER</th>
<th>5,673 in 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lac du Bonnet RM (061)</td>
<td></td>
</tr>
<tr>
<td>- SEDDON’S CORNER-ROE1X0</td>
<td></td>
</tr>
<tr>
<td>- Brightstone</td>
<td></td>
</tr>
<tr>
<td>- Brightsone Colony</td>
<td></td>
</tr>
<tr>
<td>- Lee River</td>
<td></td>
</tr>
<tr>
<td>- McArthur Falls</td>
<td></td>
</tr>
<tr>
<td>- Milner Ridge</td>
<td></td>
</tr>
<tr>
<td>- Moss Spur</td>
<td></td>
</tr>
<tr>
<td>- Spring Well</td>
<td></td>
</tr>
<tr>
<td>Lac du Bonnet Village(062)</td>
<td></td>
</tr>
<tr>
<td>- BERNIC LAKE - ROEOGO</td>
<td></td>
</tr>
<tr>
<td>- LAC DU BONNET ROE1AO</td>
<td></td>
</tr>
<tr>
<td>Pinawa LGD (199)</td>
<td></td>
</tr>
<tr>
<td>- PINAWA- ROE1LO</td>
<td></td>
</tr>
<tr>
<td>- Otter Falls</td>
<td></td>
</tr>
<tr>
<td>Unorganized Territories (288)</td>
<td></td>
</tr>
<tr>
<td>POINTE DU BOIS – ROE1NO</td>
<td></td>
</tr>
</tbody>
</table>

Source for Population – 2003

Sources:
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA report.

Geographical Changes:

- Unorganized Territories previously was a separate geographic area. In this report depending upon the municipal code, communities have been re-allocated into Winnipeg River, Iron Rose, Blue Water and Northern Remote districts.

- Northern Remote is a separate health district.

- Springfield has had no geographical boundary changes since the previous report.

- Brokenhead has had Seddon’s Corner re-allocated into Winnipeg River.
How Is Healthy Living Supported in Winnipeg River?

Focus Groups On How The Community Promotes Or Supports Healthy Living

YOUTH
Positive Comments
- Organized activities e.g. Terry Fox Run, yoga are organized by the Recreation Commission for Pinawa and Lac du Bonnet. Hockey, AFM counselor, Peer Support Team i.e. Students are “…trained for helping…people can come to us and talk about whatever, but they don’t come…” One participant suggests fear lack of confidentiality might be the deterrent. Pinawa rowing cub, golfing, curling, roller blading, biking, walking trails, local weight loss group, Teen centre in Pinawa as it has a TV, pool table, fooz ball table, shuffle board, basketball. There is a gym at Lac du Bonnet but there is an admission charge.

Suggestions Raised by Youth
- Have programs at Lac du Bonnet school gym. [Winnipeg River]

YOUNG ADULT
Positive
- Evening clinic at the health centre. Birth control is encouraged and paid for by social assistance. Recreational activities: bowling, parks, hall walking, Scouts, swimming lessons. Pharmacy, food bank, Nurse Practitioner, Mrs. Lucci’s parenting class, Public Health Nurse, Baby First Program, local weight loss group and kindergarten orientation.

MIDDLE ADULT
Positive
- An ideal community is one where “…everyone understands everyone’s needs and respects them…a good variety of organizations to support recreation and social and emotional needs, including religion.”
- In community- massage therapy, NEHA information, Pinawa Paper, Pinawa Hospital.

SENIORS
Positive
- Diabetes Clinic in Beausejour, Wellness Group (liked their stats card for people to record own blood sugar, blood pressure and weight), Pinawa Support Group for widows/widowers, friends, Cancer Care visits, pool and tennis courts and health facility. Hall walking program at school in Lac du Bonnet, Tai chi in Pinawa, Dietitian, physiotherapy, massage therapy Chiropractor, home care. [Winnipeg River]
Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women as well as gender influences affecting age, education, socio-economic status, culture and physical environment. Where information is available the sex of the individual is provided.

Population Demographics

Figure 12.1 Age Profile of Winnipeg River

During the time period there has been a decline in the population in both males and females in the lower age groups, from 0 to 54 years, with a slight increase occurring in the females 35 to 39 and 45 to 49 year age groups. From about 55 years onward, there is an increase in population in both males and females. We know that Winnipeg River is a popular geographic location for people looking for a place to retire.
Overview

There has been an association found that when the education level increases the self-rated health status improve. Education is also closely tied with socioeconomic status. Effective education for children and lifelong learning for adults contributes to the health and prosperity of individuals.

Table 12.1 Percentage of Population With Less Than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school age 20-34</th>
<th>% of population with less than high school age 35-44</th>
<th>% of population with less than high school age 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM of Lac du Bonnet (LDB)</td>
<td>37</td>
<td>38.8</td>
<td>48.1</td>
</tr>
<tr>
<td>Town of LDB</td>
<td>33.3</td>
<td>25.0</td>
<td>40.4</td>
</tr>
<tr>
<td>LGD Pinawa</td>
<td>9.1</td>
<td>0.0</td>
<td>15.0</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


In Winnipeg River there were more people aged 45-64 years who had less than high school education. There is considerable variability in the number of people with less than high school education depending upon where one lived. The RM of Lac du Bonnet had a higher percentage of people with less than high school than the other areas within Winnipeg River.

Sunrise School Division

In July, 2002 the Sunrise School Division was established as a result of a partnership of the former Agassiz School Division and the Springfield component of the Transcona Springfield School Division. The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counsellors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have consultants in the following areas: Early/Middle Years, Senior years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.

The Sunrise Support Centre is part of the Sunrise School Division and is located in Tyndall in the Brokenhead District. The Sunrise Support Center provides an alternative learning environment that readily meets individual student needs. It is a resource for community schools and agencies to assist with therapeutic intervention, behavioral change, substance abuse issues and ongoing academic success. One of the key elements of the program is a low student/teacher ratio. The focus in on the four core academic areas: Language Arts, mathematics, Science and Social Studies. Programs are adjusted to each student's individual need and reviewed on a regular basis. In addition to the academic instruction, there is a heavy emphasis on communication, anger management and direct teaching/intervention with respect to replacing negative behaviours.
Table 12.2 Sunrise School Division – Schools in Winnipeg River Health District

<table>
<thead>
<tr>
<th>WINNIPEG RIVER HEALTH DISTRICT</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Centennial School</td>
<td>314</td>
<td>294</td>
<td>155</td>
<td>151</td>
</tr>
<tr>
<td>Lac du Bonnet Senior School</td>
<td>250</td>
<td>233</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>New Directions</td>
<td>110</td>
<td>107</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Springwell (Brightstone) Colony</td>
<td>43</td>
<td>30</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Sources: Principals of each Sunrise School Division School and Colony School, January – April 2004
Lynn Kendel, Career Counselor, New Directions School, Lac du Bonnet, January 2004
Gerry Dougall, Superintendent, Whiteshell School Division No. 2408, Pinawa, January 2004

Whiteshell School Division No. 2408

Whiteshell School Division is located in Pinawa within the Winnipeg River District. There are two schools in this School Division: F.W. Gilbert School and Pinawa Secondary School.

F.W. Gilbert School consists of students from Kindergarten to Grade 6. Their experienced and dedicated staff provides quality curriculum programs with an emphasis on fundamentals. Programs include Computer Applications, Art, French, Music from Kindergarten to Grade 5, and a Band Program for Grade 6.

The Pinawa Secondary School provides education for Grade 7 to Senior 4 students. School initiated courses include Psychology, Media (Journalism, Video Editing and Movie Making), Outdoor Education, Physical Education Leadership and Fitness. The school athletics program includes: soccer, volleyball, basketball, badminton, baseball and track and field. A Guidance Program includes Study Skills Group meetings, Peer Tutoring, Friendship Groups, Game Clubs, Drug Awareness Week and Take Your Kid to Work Day.
Table 12.3 Whiteshell School Division - Schools in Winnipeg River Health District

<table>
<thead>
<tr>
<th>WHITESHELL SCHOOL DIVISION NO. 2408</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>F.W. Gilbert School</td>
<td>109</td>
<td>106</td>
<td>60</td>
<td>61</td>
</tr>
<tr>
<td>Pinawa Secondary School</td>
<td>154</td>
<td>171</td>
<td>82</td>
<td>86</td>
</tr>
</tbody>
</table>

Sources: Principals of each Sunrise School Division School and Colony School, January – April 2004
Lynn Kendel, Career Counselor, New Directions School, Lac du Bonnet, January 2004
Gerry Dougall, Superintendent, Whiteshell School Division No. 2408, Pinawa, January 2004

**Children With Special Needs**

Whiteshell School Division has a population of 288 children. There is a total of 22 children with identified health needs and 20 that are identified as having health problems that require support, for a total of 42 or 14.5%. These health services are provided by NEHA through the Unified Referral and Intake System.

**Focus Groups – Schools**

**YOUTH**

- More programs at the Lac du Bonnet school gym. [Winnipeg River]
- "...lots of times guidance counselors not in office or busy or something ...you can't find them." [Winnipeg River]

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>More Counseling in School</td>
<td>50%</td>
</tr>
</tbody>
</table>

**WINNIPEG RIVER GROUP DISCUSSIONS ON EDUCATION**

- Comment that when schools have to reduce costs often the programs that are cut are detrimental to health.

**Suggestion**

- More value should be placed in alternative education. Academia is not the route for all students. If the goal is to have all students succeed then the need for alternative education is crucial.
### 12.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.&quot;</td>
<td>&quot;Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO).&quot;</td>
<td>&quot;Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).&quot;</td>
<td>&quot;Broad measures of the physical, mental and social well-being of individuals.&quot;</td>
</tr>
</tbody>
</table>

**Overview**

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health”, we find that there are many influencing factors, some controllable for example, the choices we make i.e. using a seat belt, and things we have less or no control over for example, hereditary diseases.
Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services.

Figure 12.2 Social Economic Factor Index in NE Health Districts- 1991 & 1996

Winnipeg River appears to show a slight decline in the 1996 the SEFI value.

Winnipeg River's SEFI value appears to have declined in 1996.
**Premature Mortality Rate (PMR)**

PMR is defined as deaths that they occur before age 75. This indicator is often used as a measure of general health status and subsequent potential need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services. 11

**Figure 12.3 Premature Mortality Rate NE Health Districts**

We do not want to see this indicator increase. PMR has decreased, but not significantly when comparing the two time periods in Winnipeg River. PMR is not significantly different during the second time period than Manitoba and Rural South.

**PMR has decreased, but not significantly.**
Focus Groups – On the Meaning of Health

YOUTH
Overall, youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself and minimizing stress, being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

“if your friends are supportive, then you want to be healthy”. But if they’re not, if they “don’t care, then I don’t care. What’s the point of being healthy?” [Winnipeg River]

YOUNG ADULTS
Some of the major themes that emerged in all Focus Groups included: absence of sickness, participating in life, humour, healthy eating, sleeping well, active lifestyle (exercise), good mental health, social support, good relationships especially for people who are alone, balance, work, no bad habits – smoking, drinking, all supported a healthy lifestyle.

-Changes in children’s sleeping schedule, you’re tired the next day- don’t feel like exercising, feel guilty [Winnipeg River].

MIDDLE ADULTS
This group did indicated clearly that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humor, weight management and the importance of social activity and connection, being mentally well, stress management and balance.

a) Stress management and minimizing stress- Good attitude / outlook was raised in Iron Rose, Winnipeg River and Springfield. It is a challenge in early adulthood to devote time to maintaining a healthy lifestyle due to family and other responsibilities. [Winnipeg River]

Gaps
a) Recreational Activities – This emerged in all Focus Groups
b) Other- Better compensation for foster parents. [Winnipeg River]

SENIORS
In general most groups included aspects of your mind (memory), body, attitude, keeping active and mobile, good nutrition, exercising for example walking and other recreational activities that included exercise and socializing, being active in your community, friends and family.

“Have all your faculties.” [Winnipeg River]

- The other areas that were of particular importance included discussion about the use of the health system, and being pain free which came up in the 44-65 year old Focus Groups. Further, all groups stressed that attitude was a way of feeling good.

“Some people assess their state of health relative to their age. I’m as healthy as I can be at my age.” [Winnipeg River]

Gaps
a) Recreational Activities – This emerged in all focus groups.
   - Pool in Oakbank. [Springfield, Winnipeg River]
   - Indoor winter activities. “I miss the gym in Pinawa.” [Winnipeg River]
   - Would like book club, tai chi in Lac du Bonnet. [Winnipeg River]

The importance of recreational activities is a consistent comment in the provincial survey as well.
Deaths

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.”

Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

Figure 12.4 Total Mortality Rates NE Health Districts

Although Winnipeg River’s mortality rate has gone up slightly during the two time periods from 7.54 to 7.9 respectively, it was not a significant increase, and is similar to the Manitoba average rate of 7.99 and Rural South of 7.97 during the later time period.

Winnipeg River’s total mortality rate increased slightly but not significantly.

Life Expectancy

Figure 12.5 Life Expectancy NE Health Districts

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Springfield Males</th>
<th>Winnipeg River Males</th>
<th>Brokenhead Males</th>
<th>Iron Rose Males</th>
<th>Blue Water Males</th>
<th>Northern Remote Males</th>
<th>Manitoba Average Males</th>
<th>Rural South Males</th>
<th>Springfield Females</th>
<th>Winnipeg River Females</th>
<th>Brokenhead Females</th>
<th>Iron Rose Females</th>
<th>Blue Water Females</th>
<th>Northern Remote Females</th>
<th>Manitoba Average Females</th>
<th>Rural South Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>78.17</td>
<td>75.01</td>
<td>77.26</td>
<td>74.32</td>
<td>73.54</td>
<td>66.63</td>
<td>75.4</td>
<td>75.65</td>
<td>83.3</td>
<td>80.92</td>
<td>81.31</td>
<td>79.78</td>
<td>79.99</td>
<td>70.15</td>
<td>81.3</td>
<td>81.63</td>
</tr>
<tr>
<td>55-59</td>
<td>78.18</td>
<td>74.59</td>
<td>75</td>
<td>74.58</td>
<td>73.55</td>
<td>62.62</td>
<td>75.87</td>
<td>75.87</td>
<td>83.35</td>
<td>82.9</td>
<td>78.88</td>
<td>81.02</td>
<td>77.73</td>
<td>71.24</td>
<td>81.29</td>
<td>81.72</td>
</tr>
</tbody>
</table>


In Winnipeg River we see that females live longer than males by approximately 8 years during the later time period. Winnipeg River males have a life expectancy slightly lower than Manitoba rate, while females have a life expectancy slightly higher than Manitoba.

Winnipeg River females live approximately 8 years longer than males.
Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths.\textsuperscript{13}

Figure 12.6 Potential Years of Life Lost NE Health Districts

As shown, Winnipeg River also has a lower PYLL value but it wasn’t significantly different than the Manitoba average (52.8) and Rural South (52.25) for the second time period reviewed,

\textbf{Winnipeg River’s PYLL had decreased but not significantly.}
When we separate males and females it becomes noticeable that males have an increased level of PYLL than females. During the second time period, in Winnipeg River, female and male PYLL appears to be less than the Manitoba average, but neither were significantly different than the Manitoba average. The positive finding is that PYLL has declined for both males and females during the time periods reviewed.
Health Conditions

“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO) ”

Cancer

Figure 12.8 New Cancer Rates [includes non-invasive malignancies].

In Winnipeg River there has been an increase in new cancer rates during the two time periods reviewed, but it did not change significantly.

The rate in the later time period of 5.48 is similar to the Manitoba average of 5.61 and Rural South of 5.46.

New cancer rates have increased slightly between 1996–2000 in Winnipeg River, but not significantly.
Diabetes

Diabetes Treatment Prevalence

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

**Figure 12.9 Diabetes Treatment Prevalence in NE Health Districts**

Diabetes treatment prevalence in Winnipeg River is showing an increase over time, but did not change significantly. Winnipeg River’s diabetes treatment is statistically significantly lower at 4.1%, when compared with the Manitoba average (5.6%) and Rural South (5.4%) during the second time period.

Diabetes is on the rise in Winnipeg River, but not significantly, and is significantly lower than Manitoba and Rural South during the second time period.

**2004 Validation Workshop**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Diabetes is on the Rise</td>
<td>62.5%</td>
</tr>
</tbody>
</table>
Respiratory Diseases

Figure 12.10 Asthma Prevalence

Except for Northern Remote, we see that Winnipeg River has the lowest rates of asthma at 50.9/1000 population when compared to the other health districts.

As mentioned in the regional section, both asthma and respiratory diseases in general are showing a decline.

Figure 12.11 Residents Treated for Respiratory Disease [includes asthma, bronchitis & pneumonia]

In Winnipeg River as with NE Region in general, there has been a decline in respiratory disease diagnoses during the time periods reviewed, but it did not change significantly.

Winnipeg River has a statistical significant lower disease diagnoses than the Manitoba average for both time periods. This is good news.

Hypertension

Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 12.12 Hypertension Treatment Prevalence NE Health Districts

Winnipeg River experienced a statistical significant increase during the time periods reviewed from 19% to 22%.

This could be related to a population increase in the older age groups from 55 onwards.

Winnipeg River ’s prevalence for the second time period is not significantly different than Manitoba or Rural South.

Hypertension treatment has increased significantly in Winnipeg River, but it is not significantly different from Manitoba or Rural South.
Heart Attacks

Figure 12.13 Acute Myocardial Infarctions (MI’s) or Heart Attack Rates of Hospitalization

Winnipeg River has experienced a decrease in hospitalized cases for MI’s during the two time periods reviewed from 2.44/1000 to 2.22/1000, but it is not a significant decline.

The MI hospitalization rate is not statistically different than the Manitoba average or Rural South for the second time period reviewed.

There has been a drop in MI hospitalizations in Winnipeg River, but it is not a significant decline.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

Figure 12.14 Stroke Treatment Prevalence in Hospital NE Health Districts

There appears to have been a decrease in the number of residents being treated for stroke from 2.61/1000 to 2.20 / 1000 in Winnipeg River, but it was not a significant decrease.

Winnipeg Rivers’ Stroke treatment prevalence appears to be higher during the second time period than the Manitoba average (1.71) and Rural South (1.97), but it is not a significant difference.

A decrease in stroke treatment occurred in Winnipeg River during 1996/97 – 2000/01, but it wasn't a significant decrease.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTH CONDITIONS

- Comment that cardiac disease appears to be prevalent and access to service seems prolonged.
Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999 compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to relatively small number of injury deaths, these rates are not reported at the district level.\(^ {15}\)

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

Figure 12.15 Injury Hospitalization NE Health Districts

There has been a slight decline in the number of injuries requiring hospitalization in the Winnipeg River district from 11.72/1000 to 10.29/1000, but this was not a significant change.

Injury requiring hospitalization has decreased in Winnipeg River, but not significantly.

Winnipeg River has the third lowest rate of hospitalized injuries when compared to other health districts.

Injury deaths are on the rise in NE, and throughout Manitoba overall.
Overview

Human function is associated with the consequences of disease, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Overview

Well Being

“Broad measures of the physical, mental and social well-being of individuals.” 17

Focus Group on There’s Nothing To Do

It was felt that the perception of ‘nothing to do’ will have an effect on the overall well-being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their Focus Groups specifically related to recreational activities.

YOUTH

- There are inadequate numbers and varieties of activities to keep them [youth] occupied. [Winnipeg River]
### 12.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Personal Health Practices &amp; Coping Skills]</td>
<td>[Social Support Network]</td>
<td>[Income, Income Distribution and Social Status and Employment and Working Conditions]</td>
<td>[Physical]</td>
</tr>
</tbody>
</table>

- *Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.*
- *Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.*
- *Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.*
- *Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.*

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.</em></td>
<td><em>The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.</em></td>
<td><em>Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.</em></td>
<td><em>Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.</em></td>
</tr>
</tbody>
</table>

---

"Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.*

"Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.*

"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.*

"Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.*

"The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.*

"The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.*

"Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.*

"Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.*
Environmental Factors as a Health Determinant

Physical

"Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors."

Overview

Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment however, there are some concerns most specifically related to water quality.

Water

Water Quality

There is a water treatment plant in Lac du Bonnet, which services the town. The town upgraded their water treatment plant in 2003. This was made possible through infrastructure and water services grants. The RM is serviced by private wells and independent Water Co-ops. There is a water treatment plant in Pinawa, which services the LGD of Pinawa.

Sewage Systems

The Town of Lac du Bonnet is serviced by a sewage system and a lagoon provides for waste disposal. The RM of Lac du Bonnet has holding tanks and septic fields and a lagoon provides for waste disposal. Pinawa utilizes a community sewer/storm system complete with lagoon.
The Air We Breathe

There was nothing suggested in the 2003 Focus Groups about air quality.

**2004 Validation Workshop**

<table>
<thead>
<tr>
<th>WINNIPEG RIVER GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT – Air</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggestions</strong></td>
</tr>
<tr>
<td>• Need by-laws restricting the use of hazardous chemicals, e.g. spraying gardens.</td>
</tr>
<tr>
<td>• Need education on the ill effects of second hand smoke. Concern expressed that children are still being exposed at home and in cars.</td>
</tr>
</tbody>
</table>

**Housing**

Table 12.4 Elderly Persons’ Housing in Winnipeg River

<table>
<thead>
<tr>
<th>Winnipeg River Communities</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lac du Bonnet</td>
<td>Bonny Vista Lodge</td>
<td>43</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Parkview Place</td>
<td>11</td>
<td>Private</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Park Manor</td>
<td>12</td>
<td>Private</td>
</tr>
</tbody>
</table>

Source: Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

The Manitoba Housing Unit, Bonny Vista Lodge in Lac du Bonnet, has three vacancies since December 2003 that have not been filled. This is unusual, as there always had been a waiting list in the past.

**2003 Focus Group - Housing**

This was an area of concern in the 1997-98 CHA. The need for more transitional housing in the middle and seniors Focus Groups.

**MIDDLE ADULTS**
- Some participants felt that they needed to learn about services in order to assist parents. [Winnipeg River]
- Personal Care Home (PCH) and transitional housing in Pinawa for seniors [Winnipeg River].

**SENIORS**
- Pinawa has affordable townhouses for rent, there is no outside maintenance, but they are two-story dwellings. [Winnipeg River]

**Suggestion Raised by Seniors**
- Seniors housing complex in Pinawa. [Winnipeg River]
- “We need a PCH in Pinawa more than anything. It’s very important to stay in your own community...Lac du Bonnet is nice, but you don’t know people.” [Winnipeg River]
### Three Top Key Issues Identified By Participants

<table>
<thead>
<tr>
<th>Winnipeg River</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase in PCH Beds</strong> [Raised Issue]</td>
<td>50%</td>
</tr>
</tbody>
</table>

Validation Workshop participants felt that waiting time is too long in Pinawa.

**Discussion:**
- "If they can’t find appropriate housing they move". “Need more PCH beds.” Waiting time is too long.
- No “Safe House”, shelters or transitional housing within NEHA, “not only for women but able to be accessed by residents who need a safe environment, e.g. youth”.

2003 Focus Groups - also mentioned the need for more PCH beds (Blue Water, Springfield, Winnipeg River).
Safety

Table 12.5 Crime Report Winnipeg River Health District Total *

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Criminal Code</em></td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Winnipeg River</td>
<td>448</td>
<td>397</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft, theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Criminal Other</strong> - Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>arson, indecent acts, bail violations, breach of probation,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>harassing and stalking, kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Criminal Code</strong></td>
<td>NE</td>
<td></td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td><em>Federal Code</em></td>
<td>Parole violation, weights and measures and other Federal Acts.</td>
<td>Winnipeg River</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Federal Code</strong></td>
<td>NE</td>
<td></td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coronor's Act, Mental Health Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trespass Act, Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Liquor</strong> - intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Traffic</strong> - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Provincial Code</strong></td>
<td>NE</td>
<td></td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td><em>Municipal Codes</em></td>
<td>Municipal Acts/ By-Laws</td>
<td>Winnipeg River</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total Municipal Codes</strong></td>
<td>NE</td>
<td></td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td><em>Traffic Codes</em></td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e.</td>
<td>Winnipeg River</td>
<td>166</td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>impaired driving, driving over 80 MG (blood alcohol level), driving a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>motor vehicle prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Traffic</strong></td>
<td>NE</td>
<td></td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Winnipeg River</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Persons killed</strong></td>
<td>NE</td>
<td></td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Winnipeg River</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total Persons injured</strong></td>
<td>NE</td>
<td></td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td><strong>GRAND TOTAL OF ALL</strong></td>
<td><strong>OFFENSES</strong></td>
<td>Winnipeg River</td>
<td>8,714</td>
<td>7,481</td>
</tr>
<tr>
<td></td>
<td>Note: this does not include persons injured or killed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>North Eastman</td>
<td></td>
<td>8,714</td>
<td>7,481</td>
</tr>
</tbody>
</table>

Source: Bill Hanysh, Corporate Management Branch (CMB). Client Services, RCMP "D" Division. Received August 8, 2003.

- * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

- ** The number of persons injured and killed in traffic related incidents are not included in the numbers associated with the total traffic code category, nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.
The overall number of reported crimes has dropped slightly when comparing 2001 with 2002. The only area of increase is related to the municipal acts and bylaws that increased by 10 reported cases in 2002. There was one traffic accident death in 2002 where there was none in 2001. Traffic injuries decreased by one in 2002, from 29 in 2001. Winnipeg River has the third highest traffic accident injuries when compared with the other health districts.

**Note:** We are not able to compare previous crime report information as the CMB changed their system of reporting.

---

**Biology & Genetic Endowment as a Health Determinant**

*The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.*

**Overview**

The fundamental characteristics of this determinant include our genetic make up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.”

*For information related to this determinant refer to the section on ‘health status’*

---

**Personal Health Practices & Lifestyle as a Health Determinant**

*Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.*

**Overview**

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family’s pattern of life style and practice. Education alone is never enough. Other known influences on behaviour, either positively or negatively, may include an individual’s peers, social / community norms and practices, and the willingness on the part of the individual, family, or community to change.
Focus Groups – Dietary Practices

**MIDDLE ADULTS**

The reasons why participants modified their diet included

- Health Reasons e.g. borderline diabetic, cholesterol. [Winnipeg River, Blue Water, Iron Rose, Brokenhead]

**SENIORS**

Reasons to Modify Diet - Health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water]

**Programs / Methods Used**

- Reads books and received pamphlet from physician [Winnipeg River]
- Diabetes Clinic in Beausejour. [Winnipeg River]
- Decreased fat. [Winnipeg River]

**Barriers**

- Difficulty when two persons in a household are on different diets “She can’t cook a hamburger. She can for herself, but not for me. It’s a problem.” [Winnipeg River]

---

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need for Improvement in Dietary &amp; Exercise Behaviours</td>
<td>50%</td>
</tr>
</tbody>
</table>

2003 Focus Groups – These two behaviours were topics raised in every Focus Group.
Alcohol Consumption

Focus Group- Alcohol Use

YOUTH

Drinking as an emerging topic came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change recognizing that many youth in the Focus Groups did not consume alcohol.

The youth clearly saw alcohol not only as something youth did, but even more as a behaviour by adults in their communities.

-In the Winnipeg River youth group participants implied that drinking is a problem among youth and adults. “…all the adults talk about how they are going to go get hammered.” [Winnipeg River].

- It is rare that a student will go to school drunk but some come with hangovers and occasionally leave school at lunch to drink and do drugs. Overall, they feel that the problem is very similar in Pinawa as it is in Lac du Bonnet despite the differences in the two schools’ reputation. [Winnipeg River].

Suggestions Raised by Youth

- AFM Counselor should be around more. [Winnipeg River]

ADULT FOCUS GROUPS

- This was not raised as a social problem in most of the adult Focus Groups except for the example given in the middle adult Focus Group. There were several adults who mentioned on a personal note that they did give up drinking. As the youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

Focus Groups on Illicit Drug Use

YOUTH

The mention of using drugs such as marijuana and cocaine was raised in Blue Water, Brokenhead and Winnipeg River groups only.

- In Winnipeg River there was more concern expressed over the availability and use of cocaine as compared with marijuana as they likened marijuana to alcohol. All were aware of people who did drugs and felt in general students divided themselves into groups of users and non-users. Having said this they did mention that socially people mix, as the community is small and the choice of friends is limited. They felt there were concerns that younger and older children tend to hang out together, subjecting younger children to drug influences. They don’t feel there is much pressure to use, as long as one is clear about their personal choice. [Winnipeg River]

- “…when you’re younger, you get pressured more…” [Winnipeg River]

- There is also a worry about their friends turning to harder drugs. One youth mentioned that you do not see as many people out and about (families walking) in Lac du Bonnet as in Pinawa and another youth replied “That’s because half the adult in this town do drugs…” [Winnipeg River]
WINNIPEG RIVER GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES

- Illicit Drug Use

Regarding concerns about illicit drug use by youth, one participant commented: "We hear it’s an issue but have no personal experience."

Suggestion
• There is a need to focus on the prevention/intervention on Fetal Alcohol Syndrome Disorder.

Physical Activity

Focus Groups on Exercise

Increasing the amount of exercise was the most common form of lifestyle change that the adults made to improve health.

YOUTH

Programs/Methods Used
- One participant indicated that her sibling had a positive influence on her when she made some personal changes. [Winnipeg River]
- Parent insists on exercising at home. Feels exercise might be more appealing if there was a gym accessible. [Winnipeg River]

Barriers – Cost and when it is being held were two of the main barriers.
- In Pinawa "we have a little weight room (at the school), but you can only use it during gym class." It was mentioned that students who stayed for lunch could use the room. A year or two ago they indicated there was a sign up sheet for use after school but they don’t hear about its use now. [Winnipeg River]

YOUNG ADULTS

Reasons to Exercise- The two primary motivators for exercising was to decrease weight and improve body image. [Winnipeg River]

"Now that I’ve started losing weight, I feel a little better about myself, too. It’s kinda lifted my spirits a bit" [Winnipeg River].

MIDDLE ADULTS

- Reasons to Exercise- A health crisis in self or acquaintance was the most common reason. Other reasons include to decrease weight, image, or mental health reasons.
  a) Self image -
  "I am more active than ever in my life…I have time…I have the right attitude." [Winnipeg River]

Barriers - Exhaustion, time, family commitments were the main barriers expressed.
  "...I never had time before. [I was] so busy raising kids, house, job, marriage, family. Who [had] time for this type of stuff?" [Winnipeg River]
SENIORS

- Another participant felt exercise “is the most important thing.” [Winnipeg River]

Programs / Methods Used

- Walking was the main method of exercising in this age group.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need for Improvement in Dietary &amp; Exercise Behaviours</td>
<td>50%</td>
</tr>
</tbody>
</table>

2003 Focus Groups – These two behaviours were topics raised in every focus group.

Smoking Practices

Focus Group on Smoking

The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This information provides valuable information for staff working in smoking cessation programs. The most consistent message is that if the individual wants to quit, there are a variety of methods. Success often depends upon support the individual receives and if weight gain is addressed and managed.

Adult Focus Groups - One of the biggest concerns that smokers indicate time and time again is the potential and real problem of weight gain that accompanies quitting.

Young Adults

a) Quitting Smoking

It was felt in the Winnipeg River group that “…if there was a ban on smoking [rurally] like in Winnipeg, it would make a lot of people cut back or quit.”

Reasons for Quitting – From the reasons given by some participants there is evidence that public policy, peer pressure, and health education strategies are working.

a) Peer pressure, partner who didn’t smoke, pregnancy [Iron Rose, Winnipeg River]

b) One participant works in a smoke free environment, however still smokes at home in the evening because “I’m bored, so I watch TV and have coffee and cigarettes.” [Winnipeg River]

Potential Risk Taking Behaviour

Focus Groups on Risk Taking Behaviour

Youth

a) Sexually Transmitted Diseases – This topic emerged only in Winnipeg River.

“…could be …a health issue because more and more people are having sex at a younger age…people think it’s not a big deal, or it can’t happen to them.” [Winnipeg River]
Medication Use

Figure 12.16 Proportion of Residents With at Least One Prescription

There has been a slight decrease in the percent of residents using at least one prescription medication from 68% to 67% during the two time periods reviewed, but not a significant change.

The percentage of use is similar to Manitoba and Rural South.

Number of Different Drugs

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

Figure 12.17 Average Number of Different Drugs Prescribed

Winnipeg River shows a statistical significant increase from 3.09 to 3.24 in the average number of different medications dispensed.

Compared with Manitoba at 3.44 and Rural South at 3.44, during the second time period, Winnipeg River shows a statistically significantly lower average number of different drugs at 3.24.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason, it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

Figure 12.18 Percentage of Residents Receiving at Least One Prescription for Antibiotics

A significant decrease in the number of antibiotics prescribed occurred between 1999/00 and 2000/01.

We see a statistically significant decrease in the number of prescribed antibiotics for the two time periods from 41% to 37% in Winnipeg River.

This percentage is statistically significantly less than the Manitoba average (39%) for the second time period.

Winnipeg River had a statistically significant decrease (from 2.03 to 1.90) in prescriptions dispensed during the time period reviewed. It is also statistically significantly less than Manitoba at 2.02 and Rural South at 2.06 for the second time period. This is a positive finding.

A significant decrease in the average number of antibiotics dispensed occurred during the time periods reviewed.
Proportion of Residents Using Antidepressants

There has been a statistically significant increase in the proportion of residents receiving two or more prescription antidepressants, from 4.0% to 5.2% respectively during the two time periods reviewed.

Winnipeg River’s percentage is not significantly different than the Manitoba average or Rural South.

Focus Groups- Prescriptions

**YOUNG ADULT**
- Quickness to prescribe medication. [Winnipeg River, Blue Water]

**MIDDLE ADULT**
- The overriding concern is the question whether prescribed drugs should be the first treatment option explored. This came up in the young adult group as well. [Springfield, Brokenhead, Winnipeg River]
  - “I am offended by the pushing and peddling of drugs.” [Winnipeg River]

2004 Validation Workshop

**WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTH SERVICES- Prescription Drugs**
- Discussion on the price of prescription drugs, the buying power of large pharmacies within Winnipeg results in lower costs to the consumer than in rural areas.

The number of antidepressants prescribed in Winnipeg River has significantly increased, but is not significantly different than Manitoba or Rural South.
Healthy Child Development as a Health Determinant

*The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. * 38

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status. 39

Focus Groups on Youth

Middle Adult

a) Youth / Teen Support: Once more the lack of youth activities in a community is mentioned. Some participants expressed the importance of parents as role models so young adults are well-equipped to make physical, mental, and social choices. [Winnipeg River]

Infant Mortality

The infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

In Winnipeg River between 1990 and 1999, the number of infant deaths were suppressed because there were less than five. This is good news for Winnipeg River Health District. 40

*The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. * 38
Births

At 40 weeks gestation 50% of female babies weigh approximately 3500 grams and male babies weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. Often in disadvantaged groups, mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.

Table 12.6 Number of Newborns in Winnipeg River [Rate is expressed in brackets]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


During 2002-2003 NE had a total of 431 newborns a rate of 10.9 / 1000 compared as compared with the Manitoba rate of 11.7/1000.

Winnipeg River’s birth rate is considerably lower than both Manitoba and NE.

HOW HAS WINNIPEG RIVER’S BIRTH RATE CHANGED OVER TIME?

During 2000-2001 there was a substantial increase in the birth rate as compared to the other years reviewed. Otherwise the birth rate has remained consistent throughout, but remains the lowest in NE region and the rate is considerably lower than the Manitoba birth rate during all years reviewed.
Focus Groups on Obstetrical Practices

Obstetrics as a desired service emerged in several adult Focus Groups.

Young Adults
- Like to see more surgeries and obstetrics in hospitals. [Springfield, Iron Rose, Winnipeg River, Blue Water]

Middle Adults
The impact of no obstetrics in NE region for this age group is described as follows:
- If there is no birthing capability you "...lose something as a community. No one is born here." [Winnipeg River]
  - Disruptive to family, strain on other children. "... traffic, parking it's a hassle." [Winnipeg River].
- Hospitals should have birthing capability. [Winnipeg River, Blue Water]
- Midwife services. [Winnipeg River, Brokenhead]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Would like Obstetrical Services in North Eastman Hospitals</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

2004 Focus Groups - The desire to have Obstetrical Services in NE hospitals was brought up by the both the Young and Middle Adult Focus Groups.

WINNipeg River GROUP DISCUSSIONS ON HEALTH SERVICES – Midwifery Services

Discussion
- Access to midwifery services within NEHA, “I am traveling to Central Region to access a midwife.”
Adolescent and Teenage Pregnancy

Figure 12.21 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability. Winnipeg River has a statistically significantly lower teen pregnancy than the Manitoba average Rural South.

Focus Groups on Teen Pregnancy

Youth
Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. Teen pregnancy was not mentioned in the adult groups.

-Teen pregnancy is not seen to be a big issue in town, "...not as much as in Pine Falls." [Winnipeg River]

Teen pregnancies are significantly below Manitoba and Rural South.
Breastfeeding Practices

Figure 12.22 Breast Feeding Initiation Rates in NE Health Districts

There is considerable variability within the health districts, with highest rates of hospital initiated breastfeeding in Springfield and Winnipeg River, lower rates in Brokenhead and Iron Rose with substantially lower rates in Blue Water (63%) and Northern Remote (38%).

In Winnipeg River, we see that there has been a statistical significant increase in the number of breast feeding initiations from 77.4% to 87.3 %, a 10% increase. This is very positive. Winnipeg River has the second highest initiation of breastfeeding when compared to our other health districts. It is also statistically significantly higher than the Manitoba average of 79.7% and Rural South at 80.3% during the later time period.

Birth Weights

Figure 12.23 High Birth Weights

In Winnipeg River we are seeing a slight increase in the percentage of high birth weights (14.4% to 15.8%), but it is not a significant change.

Winnipeg River is but is not significantly different from Manitoba at 15.6% and Rural South at 16.9% during the later time period.

Figure 12.24 Low Birth Weights

Winnipeg River (3.3% to 4.2%) shows an increase in the percentage of low weight babies during the two time periods, but it is not a significant change.

Winnipeg River appears to be slightly lower than the Manitoba average of 5.1% and Rural South of 4.6% during the second time period, but it is not significantly different.

The number of pre-term births has increased in Winnipeg River, from 3.3% to 5.3%, but not significantly.

The rate appears lower than the Manitoba average of 5.3% and Rural South of 6.5% during the later time period, but it is not significantly different.

Pre-term births are on the rise in Winnipeg River, but it is not a significant increase.
Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses. ⁴³

Figure 12.26 Completed Immunization at One Year
Winnipeg River's vaccine coverage increased significantly during the two time periods reviewed. This is a positive finding.

Figure 12.27 Completed Immunization at Two Years
Winnipeg River once more showed a statistically significant increase in the number of completed immunizations during the two time periods reviewed.

Rate of Completed Immunization at One Year - NE Health District

Rate Of Completed Immunization at Two Years - NE Health District

There has been a statistically significant decrease in immunization rates in Winnipeg River, from 90.1% to 73.5% respectively, a drop of 16.6% during the two time periods reviewed.

Despite this significant decrease, Winnipeg River’s percentage is not significantly different than the Manitoba average or Rural South.

During years 1 and 2 coverage rates increased significantly, but by year 7 the coverage rates showed a significant decline, although similar to Manitoba and Rural South.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTHY CHILD DEVELOPMENT

- Comment that breast-feeding initiation in the hospital does not indicate whether breast-feeding was successful, “if initiated in hospital and discontinued within a few days of going home this is not successful breast feeding”. The need for breast feeding support was a concern.
- Concern about the lack of midwifery services.
- Comment that the decline indicated in teen pregnancy doesn’t seem to agree with what people are hearing.

Suggestions

- Comprehensive early childhood screening, hearing/vision, fine motor skills, etc.
- Preserve successful programs e.g. immunizations.
Living & Working Conditions as a Health Determinant

[Income, Income Distribution and Social Status and Employment and Working Conditions] 44

"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health." 45

Overview

Job rank, social statuses in the workplace, the amount of control over one’s work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed. 46.

Employment & Unemployment

Table 12.7 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Winnipeg River has the third lowest employment rate for males and females when compared with our other health districts. Females have a lower percentage of unemployment than males. Males have a slightly higher unemployment rate than females.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON EMPLOYMENT AND WORKING CONDITIONS

- Comment on the difficulty finding employment related to education.

Suggestion

- Federal and Provincial governments have to be more aggressive in promoting employment opportunities in rural Manitoba.
Social Economic Status

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status.\(^{47}\)

**Median Family Income of Couple Families**

The following tables describe the median family income of couple families and the median family income for lone parent families in Winnipeg River, North Eastman and Manitoba.

**Table 12.8 Median Family Income of Couple Families**

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Couple Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td>$ 55,426</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$ 52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Winnipeg River has a higher median family income than NE as a whole, but slightly lower than Manitoba.

**Table 12.9 Median Family Income of Lone Parents – Males and Females**

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$ 40,087</td>
<td>$ 36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$ 23,892</td>
<td>$ 17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$ 29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$ 45,361</td>
<td>$ 26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$ 35,698</td>
<td>$ 26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$ 9,248</td>
<td>$ 12,587</td>
</tr>
</tbody>
</table>


In Winnipeg River, male lone parent families have almost twice as much income than their female counterparts.

Lone parent male families have consistently higher incomes than lone parent female households.
**Table 12.10 Median Family Income Lone Parent Families Male & Female for NE**

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$26,469</td>
</tr>
</tbody>
</table>


**Total Low Income Incidence**

The incidence of low income in 2000 in Winnipeg River was 9.6%. 48

**2004 Validation Workshops**

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Low Income – Lone Parent Households Discussion</td>
<td>87.5%</td>
</tr>
<tr>
<td>- Some participants questioned the significance of the number of lone parent families being listed as an issue. They thought it may be an assumption that more problems exist in a lone parent family “not a given that more problems will exist”.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Group- This issue was raised in relation to the support and social issues surrounding lone parent families.</td>
<td></td>
</tr>
</tbody>
</table>

**Personal Resources as a Health Determinant**

“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” 50

**Overview**

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included as these all support a strong social network. 51
Mental Emotional Health

Mental health was raised as an important concern for many NE residents in particular in the area of services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report. Mental Health Services continued to be a concern for the 2003 Focus Group participants.

Focus Groups on Mental Well being

Mental health issues emerged throughout the Focus Groups discussion. The topics varied between the age groups.

ADULT FOCUS GROUPS - several common theme emerged between the adult and staff Focus Groups in regards to lack of mental health support. Stress emerged as a common theme, but the cause of the stress varied among the age groups.

YOUNG ADULT
The primary issues were the need for better awareness of the mental health programs and the stigma associated with accessing programs. (refer to Mental Health Program Section 7)

MIDDLE ADULTS
Felt that programs need to address more than the illness, but also other issues like managing stress.

SENIORS
Seniors they were concerned about being able to identify vulnerable members in the community, in particular those who were more isolated and described as ‘lonely.’ Another big concern for this age group was living along and being lonely. Two issues emerged;
  a) what they would do if something should happen to them and they were unable to access help.
  b) effects of isolation and living alone.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON SOCIAL SUPPORT NETWORKS
- Personal Resources

  Suggestion
  • Is there a way of preserving client's privacy? Some people are reluctant to access mental health services as they have to wait in a public waiting area and everyone else will know that they are seeing the mental health worker.

  Mental Health Programming is discussed under the NEHA Mental Health Program- Section 7.
Social Support

Table 12.11 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and may be more economically disadvantaged than two parent households.

There are approximately 165 lone parent families in Winnipeg River as reported in the 2001 Canada Census.
Focus Group On Social Support

Social support was an area that was raised in all Focus Groups and all ages as something that was seen as positive with respect to an individual’s well being.

YOUTH

During the initial discussions when talking about what it means to be healthy, youth mentioned the importance of friends and social supports. We know that social support is a strong determinant of health status.

a) Talking with Adults
   - As part of the discussion some participants in Springfield and Winnipeg River discussed their experiences when talking with adults. It’s important that counselors and other adults maintain strict confidentiality. [Winnipeg River]

YOUNG ADULTS

Suggestions Raised by Young Adults

- Parent Support Group – There was a program in the community but when the health nurse left it was discontinued. [Winnipeg River]
- Can’t get ‘Big Brother’ until children are 7. [Winnipeg River]
- ‘New Friends Mentorship Program’ should be expanded to allow children under the age of seven. [Winnipeg River]

MIDDLE ADULTS

-Seniors living alone need support. [Winnipeg River]
   “They just won’t eat properly.” [Winnipeg River]

SENIORS

a) Living Alone
   - Concerned about access to assistance in a health crisis as often they can’t get a hold of their family as they are working. [Springfield, Winnipeg River]
   - May not eat properly. Without a partner or family for whom to plan meals, singles may not devote enough attention to meal planning. [Iron Rose, Winnipeg River]
   - Mental stimulation can be an issue especially in winter. [Winnipeg River]
   - Those living alone report need for companionship. After being widowed, “It’s a different life.” [Winnipeg River]
   - With family concerned about the senior person living alone, they may contribute to growing lack of self-confidence i.e. being told they “should or shouldn’t” do this or that. [Winnipeg River]
   - Life line “...it costs $40 a month but it’s worth the piece of mind.” [Winnipeg River]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need to Identify at Risk Individuals who are Vulnerable in Community</td>
<td>62.5%</td>
</tr>
<tr>
<td>2003 Focus Groups – This was raised as a concern by many participants especially in the middle and senior adult groups</td>
<td></td>
</tr>
</tbody>
</table>
12.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the previous 1998 CHA Report there have been boundary changes most prominently related to the northern area. Unorganized Territories were originally separated and are incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts based on postal code.

Population

There has been an overall decline in ages 0-54 (with some variability) and an increase from approximately 55 years onward. The implication of growth especially as it relates to the elderly population is the potential for added pressure on the health system. This contributes to the need for creative and preventative health services planning for this population group.

Winnipeg River's birth rate is considerably lower than NE and Manitoba.

Education

During the Validation Workshop, 50% of participants felt that there should be more counseling in school. This was raised by some Focus Groups as well.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index or SEFI value and premature mortality rates or PMR both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern.

Winnipeg River experienced a slight decline in the SEFI value, but it is better than both Manitoba and Rural South. This value needs to be viewed in light of other health indicators in order to determine the reason. PMR has decreased slightly, but not significantly. This needs to be monitored, as this is a measurement of general health status.
Deaths

Total mortality rate has increased slightly, but not significantly. It is similar to the Manitoba average.

Life Expectancy

Females live approximately eight years longer than males.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cancer cases have</td>
<td>Diabetes treatment is on the increase, but not significantly. It is significantly lower than Manitoba.</td>
<td>Respiratory treatment diagnoses have decreased, but not significantly, but is significantly lower than the Manitoba average.</td>
<td>Hypertension treatment has increased significantly, but is similar to Manitoba.</td>
</tr>
<tr>
<td>increased, but not</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>significantly.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI's has decreased, but not significantly.</td>
<td>Stroke treatment has decreased, but not significantly, and it is not significantly different than Manitoba or Rural South.</td>
<td>Injury hospitalization has decreased, and is not significantly different than the Manitoba number.</td>
</tr>
</tbody>
</table>

Human Function & Well being

The most prominent thing that arose was our youth in all health districts indicated that there was ‘nothing to do.’ This might be an area to explore with our community partners. Youth and adults in the Focus Group provided many good suggestions for improvement.

DETERMINANTS OF HEALTH

Environmental Factors

Air Quality- During discussions at the Validation Workshop several participants had some suggestions with respect to chemicals and need for second hand smoke education.

Housing – The need for more PCH beds was raised in Blue Water, Springfield, and Winnipeg River. Fifty percent of Validation Workshop participants felt that there was a need for more PCH beds.
Personal Health Practices - From Focus Group and provincial survey comments there seems to be a readiness by the public in general toward healthier lifestyle choices.

Dietary – Obesity is a national and local concern. Dietary modifications were common among all Focus Groups in relation to lifestyle changes in order to control or decrease weight.

Alcohol Consumption – Youth Focus Groups felt it was an issue with both youth and adults in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners.

Illicit Drug Use – This was raised in the youth Focus Groups in Brokenhead and Winnipeg River as a concern. Youth and illicit drug use was a concern raised during the Winnipeg River Validation Workshops as a key issue.

Physical Activity – Exercise was the top area that focus groups and NE provincial survey respondents indicated they did to achieve a healthier lifestyle. We know from the evidence that there are many people who still do not exercise. Fifty percent of Winnipeg River Validation Workshop participants felt this was an area that required further attention.

Smoking Practice – Some Focus Group participants mentioned that they had or were thinking about quitting smoking. Ongoing smoking cessation programs targeting community and staff should be considered. The Focus Group discussions addressed issues surrounding barriers to quitting smoking. Using this information will assist in increasing the success rate of smoking cessation programs.

Risk Taking Behaviour- Youth mentioned STD’s could be a health concern because there is more sexual activity at a younger age.

Medication Use

Prescriptions - The average number of different prescriptions per user, has shown a statistical increase in Winnipeg River, but is significantly lower than Manitoba.

Antibiotics - There was a statistically significant decrease in the number of antibiotics prescribed in Winnipeg River.

Antidepressants - Antidepressant prescriptions show a statistically significant increase in Winnipeg River, but it is not significantly different than Manitoba. It is difficult to know if the reason is due to depression diagnosis, as antidepressants can be prescribed for other reasons.

There were concerns raised in the Focus Groups about being prescribed prescription drugs as the first choice of treatment. The price of prescription drugs was discussed during the Validation Workshops.
Healthy Child

**Mortality Rates** - Winnipeg River’s infant deaths have been suppressed due to low numbers.

**Adolescent & Teenage Pregnancy** - Teen pregnancies are statistically significantly lower when compared with Manitoba. It also appears to be lower than Rural South. Youth during the Focus Groups felt it wasn’t a big issue for them in their community.

**Hospital Breastfeeding Initiation** - Winnipeg River had a statistically significant increase of 10% in breastfeeding initiation rates. It is also significantly higher than Manitoba.

**Birth Weights** - There has been a slight increase in high and low birth weights, but the rates are not significantly different than the Manitoba average. These are important areas to continue to monitor as they have potential implications associated with the future health of our children and may be a potential burden on health services. Pre-term births are not significantly different than the Manitoba average.

**Immunizations** - Immunization coverage significantly increased during Years 1 and 2, and showed a statistically significant decline by Year 7. It would be interesting to determine why this substantial decrease occurred. Vaccination is a cost-effective way to prevent illnesses and decrease costs to the health system and validation workshop participants felt that the immunization program was a success and should be preserved.

Living and Working Conditions

**Work** - During 2001, Winnipeg River had the third lowest employment rate.

**Economic Status** – During 2001, Winnipeg River overall, had a higher median family income than NE. When we separate lone parent male and female families, they had higher median incomes when compared with lone parent families in NE and Manitoba overall. Eighty-seven percent of Winnipeg River Validation Group participants felt that low income – lone parents was a top key issue.

Personal Resources

**Mental Emotional Health** - During the validation workshop there was some discussion about trying to preserve a person’s privacy especially when accessing mental health services in a common waiting area.
Social Support - There are approximately 165 lone parent families reported in Winnipeg River.

The concerns expressed in this group focus around community supports rather than personal support. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group. This is certainly worth investigating and pursuing especially with services that are not directly related to physical health that home care may provide. Housekeeping, transportation, maintenance, and childcare in an emergency are just some examples.

Sixty two percent of Winnipeg River Validation Workshop participants felt that there is a need to identify at risk individuals who are vulnerable in the community. This was a key issue.

Summary At A Glance

<table>
<thead>
<tr>
<th>KEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.</td>
</tr>
<tr>
<td>Monitor: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.</td>
</tr>
<tr>
<td>NEHA: a program or service could be enhanced or developed to address this issue.</td>
</tr>
</tbody>
</table>

Strengths

- Slight worsening in SEFI value during 1996, but appears to be better than both Manitoba & Rural South in 1996. [Monitor]
- PMR has decreased, but not significantly. [Monitor]
- Total mortality has increased slightly, but not significantly. [Monitor]
- Birth rate is lower than NE and Manitoba. [Monitor]
- Respiratory treatment diagnoses is significantly lower than the Manitoba average. [Monitor]
- Significant decrease in antibiotic prescriptions. [Monitor]
- Number of infant deaths have been suppressed. [Monitor]
- Winnipeg River has a higher median family income than NE overall. [Monitor]
- Breastfeeding initiation rates have significantly increased and are significantly higher than Manitoba. [Monitor]
- Birth weights are not significantly different than Manitoba's. [Monitor]
- New cancer cases have increased, but not significantly. [NEHA, Partner, Monitor]
- Diabetes treatment has increased, but not significantly and is significantly lower than Manitoba and Rural South. [NEHA, Partner, Monitor]

Issues Having Implications for Health Planning & Delivery

- Population generally declined from 0-54 years with an increase from 55 years onward. This has the potential to affect health services needs in this population. [NEHA, Partner, Monitor]
- Youth have 'nothing to do'. [Partner]
- Illicit drug use raised by youth in Focus Groups. [Partner, Monitor]
- Number of different prescriptions significantly increased, but significantly less than Manitoba. [Partner, Monitor]
**KEY**
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

<table>
<thead>
<tr>
<th>Issues Having Implications for Health Planning &amp; Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants showed a statistical increase, but is not significantly different than Manitoba. [Partner, Monitor]</td>
</tr>
<tr>
<td>Smoking cessation programs a need. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Hypertension treatment has increased, but is similar to Manitoba. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Stroke treatment has decreased, but not significantly. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Injury hospitalization has decreased, but higher than Manitoba. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>More PCH beds raised as a need by Focus Groups and Validation Workshops. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Obesity is a national concern. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Alcohol consumption concerns were raised by youth in Focus Groups. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>STD's mentioned as a health concern by youth in Focus Groups. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Preserving privacy when accessing mental health was a concern expressed by some Focus Groups. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Focus Group and Validation Group participants identified the need to identify vulnerable members in the community. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>Third lowest employment rate. [Monitor]</td>
</tr>
<tr>
<td>Child Immunization coverage significantly declined in Year 7. [NEHA, Partner, Monitor]</td>
</tr>
</tbody>
</table>

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
12.6 REFERENCES


6. Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004


33 RM Municipal Offices, Town Offices, Web Page: community profiles.mb.ca/maps/regional/eastman.htm; Western Diversification Office in Beausejour, Lac du Bonnet.
Section 12.0

WINNIPEG RIVER HEALTH DISTRICT

12.1 GEOGRAPHICAL OVERVIEW.................................................................12-1

12.2 COMMUNITY SYSTEM CHARACTERISTICS...........................................12-4

12.3 HEALTH STATUS....................................................................................12-8
   Overview..................................................................................................12-8
   Significant Indicators Measuring Overall Health Status.........................12-9
   Deaths .....................................................................................................12-12
   Health Conditions..................................................................................12-16
   Human Function......................................................................................12-23

12.4 DETERMINANTS OF HEALTH ..............................................................12-24
   Environmental Factors ........................................................................12-24
      Water ....................................................................................................12-25
      Air .......................................................................................................12-26
      Housing ..............................................................................................12-26
      Safety ..................................................................................................12-29
   Biology & Genetic Endowment ...............................................................12-29
   Personal Health Practices & Lifestyle ...................................................12-29
      Overview..............................................................................................12-29
      Dietary Practices..................................................................................12-30
      Alcohol Consumption .......................................................................12-30
      Physical Activity ................................................................................12-31
      Smoking Practices ..............................................................................12-32
      Risk Taking Behaviour .....................................................................12-33
      Medication Use ..................................................................................12-34
   Healthy Child Development ..................................................................12-38
      Overview..............................................................................................12-38
      Infant Mortality Rates .......................................................................12-38
      Births ....................................................................................................12-39
      Adolescent and Teenage Pregnancy ..................................................12-41
      Breastfeeding Practices ....................................................................12-41
      Birth Weights ......................................................................................12-42
      Childhood Immunizations ..................................................................12-43
      Community Feedback on Healthy Child Development .......................12-46
   Living and Working Conditions ............................................................12-47
      Overview..............................................................................................12-47
      Social Economic Status .....................................................................12-48
   Personal Resources ...............................................................................12-49
      Mental Emotional Health ...................................................................12-50
      Social Support ....................................................................................12-51

12.5 SUMMARY/CONCLUSION....................................................................12-53

12.6 REFERENCES .........................................................................................12-59
12.1 GEOGRAPHICAL OVERVIEW

The Winnipeg River District consists of the Town and the Rural Municipality of Lac du Bonnet, and the Local Government District of Pinawa. The Region is located approximately 100 km northeast of Winnipeg, on the edge of the Whiteshell Provincial Park and continues along the Winnipeg River. Provincial Hwy. # 11 leads to and through the District, with Hwy.# 211 leading into the town of Pinawa.

Economic activity is diverse with farming, forestry, mining, light industry, retail and service businesses, technology-based business and tourism all contributing to the economy.

The RM of Lac du Bonnet has a local airport with a 3600 foot paved runway which, among other things, is used by private pilots and local air carriers to fly fishermen to remote camps. Lac du Bonnet has a new community centre, opened in 1999 that houses a four sheet curling rink, four lane bowling alley and three hall facilities for community events.

Lac du Bonnet had a number of major construction projects that have recently been completed. The South Interlake Credit Union constructed a new branch building that opened in 2002. A major expansion was completed to a local grocery store which in 2003 and a new privately owned exercise facility was constructed and opened in 2003.

Pinawa is building on the advanced technical and scientific skills base that exists within the region to attract high-tech companies. The Economic Development Office manages the business development strategy and supports the marketing and promotion activities of the Pinawa Community Development Corporation (PCDC).

The Pinawa Heritage Sundial is a unique project that marks the new millennium through an expression of art, science and heritage. It is located in a park in the centre of Pinawa and creates a meeting place where paths, roads and waterways converge in the Eastman Region. The Pinawa Suspension Bridge had its grand opening on May 14, 1999. The bridge is 54 meters long, 1 meter wide and forms part of the Trans Canada Trail. It has opened up new areas for interpretive walks, casual fishing and cross-country skiing.

An active Recreation Commission serving all the area, coordinates many programs and activities year round. The entire district has an abundance of walking, cycling, cross-country skiing, and groomed snowmobile trails. Visitors and locals alike enjoy fishing and hunting, as well as hiking, skiing and camping. A water ski facility and Club are operated out of Lac du Bonnet. There is a swimming pool, marina, windsurfing/rowing clubhouse, and golf course and clubhouse in Pinawa.
These are the municipalities and communities that fall under the Winnipeg River Health District.

### WINNIPEG RIVER

<table>
<thead>
<tr>
<th>Lac du Bonnet RM (061)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEDDON’S CORNER-ROE1X0</td>
</tr>
<tr>
<td>Brightstone</td>
</tr>
<tr>
<td>Brightsone Colony</td>
</tr>
<tr>
<td>Lee River</td>
</tr>
<tr>
<td>McArthur Falls</td>
</tr>
<tr>
<td>Milner Ridge</td>
</tr>
<tr>
<td>Moss Spur</td>
</tr>
<tr>
<td>Spring Wells</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lac du Bonnet Village(062)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BERNIC LAKE - ROE1GO</td>
</tr>
<tr>
<td>LAC DU BONNET ROE1AO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pinawa LGD (199)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PINAWA- ROE1LO</td>
</tr>
<tr>
<td>Otter Falls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unorganized Territories (288)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POINTE DU BOIS – ROE1NO</td>
</tr>
</tbody>
</table>

**Source for Population – 2003**

**Sources:**
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA report.

**Geographical Changes:**

- Unorganized Territories previously was a separate geographic area. In this report depending upon the municipal code, communities have been re-allocated into Winnipeg River, Iron Rose, Blue Water and Northern Remote districts.

- Northern Remote is a separate health district.

- Springfield has had no geographical boundary changes since the previous report.

- Brokenhead has had Seddon’s Corner re-allocated into Winnipeg River.
How Is Healthy Living Supported in Winnipeg River?

Focus Groups On How The Community Promotes Or Supports Healthy Living

YOUTH
Positive Comments
- Organized activities e.g. Terry Fox Run, yoga are organized by the Recreation Commission for Pinawa and Lac du Bonnet. Hockey, AFM counselor, Peer Support Team i.e. Students are "...trained for helping...people can come to us and talk about whatever, but they don't come...." One participant suggests fear lack of confidentiality might be the deterrent. Pinawa rowing cub, golfing, curling, roller blading, biking, walking trails, local weight loss group, Teen centre in Pinawa as it has a TV, pool table, fooz ball table, shuffle board, basketball. There is a gym at Lac du Bonnet but there is an admission charge.

Suggestions Raised by Youth
- Have programs at Lac du Bonnet school gym. [Winnipeg River]

YOUNG ADULT

Positive
- Evening clinic at the health centre. Birth control is encouraged and paid for by social assistance. Recreational activities: bowling, parks, hall walking, Scouts, swimming lessons. Pharmacy, food bank, Nurse Practitioner, Mrs. Lucci's parenting class, Public Health Nurse, Baby First Program, local weight loss group and kindergarten orientation.

MIDDLE ADULT

Positive
- An ideal community is one where "...everyone understands everyone's needs and respects them...a good variety of organizations to support recreation and social and emotional needs, including religion."
- In community- massage therapy, NEHA information, Pinawa Paper, Pinawa Hospital.

SENIORS

Positive
- Diabetes Clinic in Beausejour, Wellness Group (liked their stats card for people to record own blood sugar, blood pressure and weight), Pinawa Support Group for widows/widowers, friends, Cancer Care visits, pool and tennis courts and health facility. Hall walking program at school in Lac du Bonnet, Tai chi in Pinawa, Dietitian, physiotherapy, massage therapy, Chiropractor, home care. [Winnipeg River]
12.2 COMMUNITY SYSTEM CHARACTERISTICS

Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women as well as gender influences affecting age, education, socio-economic status, culture and physical environment. Where information is available the sex of the individual is provided.

Population Demographics

Figure 12.1 Age Profile of Winnipeg River

During the time period there has been a decline in the population in both males and females in the lower age groups, from 0 to 54 years, with a slight increase occurring in the females 35 to 39 and 45 to 49 year age groups. From about 55 years onward, there is an increase in population in both males and females. We know that Winnipeg River is a popular geographic location for people looking for a place to retire.

Overview

There has been an association found that when the education level increases the self-rated health status improve. Education is also closely tied with socioeconomic status. Effective education for children and life long learning for adults contributes to the health and prosperity of individuals.

Table 12.1 Percentage of Population With Less Than a High School Education by Years

<table>
<thead>
<tr>
<th></th>
<th>% of population with less than high school age 20-34</th>
<th>% of population with less than high school age 35-44</th>
<th>% of population with less than high school age 45-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM of Lac du Bonnet (LDB)</td>
<td>37</td>
<td>38.8</td>
<td>48.1</td>
</tr>
<tr>
<td>Town of LDB</td>
<td>33.3</td>
<td>25.0</td>
<td>40.4</td>
</tr>
<tr>
<td>LGD Pinawa</td>
<td>9.1</td>
<td>0.0</td>
<td>15.0</td>
</tr>
<tr>
<td>North Eastman</td>
<td>35.7</td>
<td>31.1</td>
<td>38.6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>22.5</td>
<td>25.6</td>
<td>34.3</td>
</tr>
</tbody>
</table>


In Winnipeg River there were more people aged 45-64 years who had less than high school education. There is considerable variability in the number of people with less than high school education depending upon where one lived. The RM of Lac du Bonnet had a higher percentage of people with less than high school than the other areas within Winnipeg River.

Sunrise School Division

In July, 2002 the Sunrise School Division was established as a result of a partnership of the former Agassiz School Division and the Springfield component of the Transcona Springfield School Division. The Division consists of 25 Schools/Support Centres throughout the North Eastman Region, and provides the following Educational Supports: Child Guidance Clinicians, Reading Clinician, Physiotherapist, Occupational Therapist, Resource Teachers, Special Education Teachers, Guidance Counsellors, Reading Recovery Trainer and Teachers, and Behaviour Intervention Teachers. They also have consultants in the following areas: Early/Middle Years, Senior years, Talent Development, Music, Information and Communication Technology, Special Education, French Immersion, and Physical Education.

The Sunrise Support Centre is part of the Sunrise School Division and is located in Tyndall in the Brokenhead District. The Sunrise Support Center provides an alternative learning environment that readily meets individual student needs. It is a resource for community schools and agencies to assist with therapeutic intervention, behavioral change, substance abuse issues and ongoing academic success. One of the key elements of the program is a low student/teacher ratio. The focus is on the four core academic areas: Language Arts, mathematics, Science and Social Studies. Programs are adjusted to each student's individual need and reviewed on a regular basis. In addition to the academic instruction, there is a heavy emphasis on communication, anger management and direct teaching/intervention with respect to replacing negative behaviours.
Table 12.2 Sunrise School Division – Schools in Winnipeg River Health District

<table>
<thead>
<tr>
<th>SUNRISE SCHOOL DIVISION</th>
<th>WINNIPEG RIVER HEALTH DISTRICT</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Centennial School</td>
<td></td>
<td>314</td>
<td>294</td>
<td>155</td>
<td>151</td>
</tr>
<tr>
<td>Lac du Bonnet Senior School</td>
<td></td>
<td>250</td>
<td>233</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>New Directions</td>
<td></td>
<td>110</td>
<td>107</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Springwell (Brightstone) Colony</td>
<td></td>
<td>43</td>
<td>30</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Sources Principals of each Sunrise School Division School and Colony School, January – April 2004
Lynn Kendel, Career Counselor, New Directions School, Lac du Bonnet, January 2004
Gerry Dougall, Superintendent, Whiteshell School Division No. 2408, Pinawa, January 2004

Whitesshool School Division No. 2408

Whitesshool School Division is located in Pinawa within the Winnipeg River District. There are two schools in this School Division: F.W. Gilbert School and Pinawa Secondary School.

F.W. Gilbert School consists of students from Kindergarten to Grade 6. Their experienced and dedicated staff provides quality curriculum programs with an emphasis on fundamentals. Programs include Computer Applications, Art, French, Music from Kindergarten to Grade 5, and a Band Program for Grade 6.

The Pinawa Secondary School provides education for Grade 7 to Senior 4 students. School initiated courses include Psychology, Media (Journalism, Video Editing and Movie Making), Outdoor Education, Physical Education Leadership and Fitness. The school athletics program includes: soccer, volleyball, basketball, badminton, baseball and track and field. A Guidance Program includes Study Skills Group meetings, Peer Tutoring, Friendship Groups, Game Clubs, Drug Awareness Week and Take Your Kid to Work Day.
### Table 12.3 Whiteshell School Division - Schools in Winnipeg River Health District

<table>
<thead>
<tr>
<th>WHITESHELL SCHOOL DIVISION NO. 2408</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
<td>2001/02 2002/03</td>
</tr>
<tr>
<td>F.W. Gilbert School</td>
<td>109 106</td>
<td>60</td>
<td>61</td>
<td>49 45</td>
</tr>
<tr>
<td>Pinawa Secondary School</td>
<td>154 171</td>
<td>82</td>
<td>86</td>
<td>72 85</td>
</tr>
</tbody>
</table>

Sources: Principals of each Sunrise School Division School and Colony School, January – April 2004
Lynn Kendel, Career Counselor, New Directions School, Lac du Bonnet, January 2004
Gerry Dougall, Superintendent, Whiteshell School Division No. 2408, Pinawa, January 2004

### Children With Special Needs

Whiteshell School Division has a population of 288 children. There is a total of 22 children with identified health needs and 20 that are identified as having health problems that require support, for a total of 42 or 14.5%. These health services are provided by NEHA through the Unified Referral and Intake System.

### Focus Groups – Schools

**YOUTH**

- More programs at the Lac du Bonnet school gym. [Winnipeg River]

  "...lots of times guidance counselors not in office or busy or something ...you can't find them." [Winnipeg River]

### 2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>More Counseling in School</td>
<td>50%</td>
</tr>
</tbody>
</table>

### WINNIPEG RIVER GROUP DISCUSSIONS ON EDUCATION

- Comment that when schools have to reduce costs often the programs that are cut are detrimental to health.

**Suggestion**

- More value should be placed in alternative education. Academia is not the route for all students. If the goal is to have all students succeed then the need for alternative education is crucial.
### 12.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.&quot; 7</td>
<td>&quot;Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO).&quot; 8</td>
<td>&quot;Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).&quot; 9</td>
<td>&quot;Broad measures of the physical, mental and social well-being of individuals.&quot; 10</td>
</tr>
</tbody>
</table>

**Overview**

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health”, we find that there are many influencing factors, some controllable for example, the choices we make i.e. using a seat belt, and things we have less or no control over for example, hereditary diseases.
Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic "risk" of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status --- a potential need for more input from health services.

Figure 12.2 Social Economic Factor Index in NE Health Districts- 1991 & 1996

Winnipeg River appears to show a slight decline in the 1996 the SEFI value.

Winnipeg River’s SEFI value appears to have declined in 1996.
Premature Mortality Rate (PMR)

PMR is defined as deaths that they occur before age 75. This indicator is often used as a measure of general health status and subsequent potential need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services.  

Figure 12.3 Premature Mortality Rate NE Health Districts

We do not want to see this indicator increase. PMR has decreased, but not significantly when comparing the two time periods in Winnipeg River. PMR is not significantly different during the second time period than Manitoba and Rural South.
Focus Groups – On the Meaning of Health

YOUTH
Overall, youth described health as: not being sick, eating right, maintaining healthy weight, exercising, sleeping well, not abusing drugs or alcohol, taking care of yourself and minimizing stress, being able to express yourself without being judged. Further, support strongly influenced health e.g. the importance of friends and how friends influenced your health.

“If your friends are supportive, then you want to be healthy. But if they’re not, if they don’t care, then I don’t care. What’s the point of being healthy?” [Winnipeg River]

YOUNG ADULTS
Some of the major themes that emerged in all Focus Groups included: absence of sickness, participating in life, humour, healthy eating, sleeping well, active lifestyle (exercise), good mental health, social support, good relationships especially for people who are alone, balance, work, no bad habits—smoking, drinking, all supported a healthy lifestyle.

“Changes in children’s sleeping schedule, you’re tired the next day, don’t feel like exercising, feel guilty [Winnipeg River].

MIDDLE ADULTS
This group did indicate clearly that health encompassed many more things than just physical health. They discussed energy, being pain free, good sleep, proper nutrition, exercise, humor, weight management and the importance of social activity and connection, being mentally well, stress management and balance.

a) Stress management and minimizing stress - Good attitude / outlook was raised in Iron Rose, Winnipeg River and Springfield. It is a challenge in early adulthood to devote time to maintaining a healthy lifestyle due to family and other responsibilities. [Winnipeg River]

Gaps
a) Recreational Activities – This emerged in all Focus Groups
b) Other- Better compensation for foster parents. [Winnipeg River]

SENIORS
In general most groups included aspects of your mind (memory), body, attitude, keeping active and mobile, good nutrition, exercising for example walking and other recreational activities that included exercise and socializing, being active in your community, friends and family.

“Have all your faculties.” [Winnipeg River]

“The other areas that were of particular importance included discussion about the use of the health system, and being pain free which came up in the 44-65 year old Focus Groups. Further, all groups stressed that attitude was a way of feeling good.

“Some people assess their state of health relative to their age. I’m as healthy as I can be at my age.” [Winnipeg River]

Gaps
a) Recreational Activities – This emerged in all focus groups.
   - Pool in Oakbank. [Springfield, Winnipeg River]
   - Indoor winter activities. “I miss the gym in Pinawa.” [Winnipeg River]
   - Would like book club, tai chi in Lac du Bonnet. [Winnipeg River]

The importance of recreational activities is a consistent comment in the provincial survey as well.
Deaths

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.”

Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

**Figure 12.4 Total Mortality Rates NE Health Districts**

Although Winnipeg River's mortality rate has gone up slightly during the two time periods from 7.54 to 7.9 respectively, it was not a significant increase, and is similar to the Manitoba average rate of 7.99 and Rural South of 7.97 during the later time period.

Winnipeg River's total mortality rate increased slightly but not significantly.
Life Expectancy

Figure 12.5 Life Expectancy NE Health Districts

In Winnipeg River we see that females live longer than males by approximately 8 years during the later time period. Winnipeg River males have a life expectancy slightly lower than Manitoba rate, while females have a life expectancy slightly higher than Manitoba.

Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths. \(^{13}\)

Figure 12.6 Potential Years of Life Lost NE Health Districts

Winnipeg River has shown a slight lowering of its PYLL during the two periods reviewed at 53.4 to 47.3, respectively, but it was not a significant decline.

As shown, Winnipeg River also has a lower PYLL value but it wasn't significantly different than the Manitoba average (52.8) and Rural South (52.25) for the second time period reviewed,

Winnipeg River's PYLL had decreased but not significantly.
When we separate males and females it becomes noticeable that males have an increased level of PYLL than females. During the second time period, in Winnipeg River, female and male PYLL appears to be less than the Manitoba average, but neither were significantly different than the Manitoba average. The positive finding is that PYLL has declined for both males and females during the time periods reviewed.
Health Conditions

"Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO)"

Cancer

Figure 12.8 New Cancer Rates [includes non-invasive malignancies].

In Winnipeg River there has been an increase in new cancer rates during the two time periods reviewed, but it did not change significantly.

The rate in the later time period of 5.48 is similar to the Manitoba average of 5.61 and Rural South of 5.46.

New cancer rates have increased slightly between 1996–2000 in Winnipeg River, but not significantly.
Diabetes

Diabetes Treatment Prevalence

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

**Figure 12.9 Diabetes Treatment Prevalence in NE Health Districts**

Diabetes treatment prevalence in Winnipeg River is showing an increase over time, but did not change significantly. Winnipeg River’s diabetes treatment is statistically significantly lower at 4.1 %, when compared with the Manitoba average (5.6%) and Rural South (5.4%) during the second time period.


---

**2004 Validation Workshop**

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified by Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Diabetes is on the Rise</td>
<td>62.5%</td>
</tr>
</tbody>
</table>
Respiratory Diseases

Figure 12.10 Asthma Prevalence

Except for Northern Remote, we see that Winnipeg River has the lowest rates of asthma at 50.9/1000 population when compared to the other health districts.

As mentioned in the regional section, both asthma and respiratory diseases in general are showing a decline.

Figure 12.11 Residents Treated for Respiratory Disease [includes asthma, bronchitis & pneumonia]

In Winnipeg River as with NE Region in general, there has been a decline in respiratory disease diagnoses during the time periods reviewed, but it did not change significantly.

Winnipeg River has a statistical significant lower disease diagnoses than the Manitoba average for both time periods. This is good news.
Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 12.12 Hypertension Treatment Prevalence NE Health Districts

Winnipeg River experienced a statistical significant increase during the time periods reviewed from 19% to 22%.

This could be related to a population increase in the older age groups from 55 onwards.

Winnipeg River’s prevalence for the second time period is not significantly different than Manitoba or Rural South.

Hypertension treatment has increased significantly in Winnipeg River, but it is not significantly different from Manitoba or Rural South.

Heart Attacks

Figure 12.13 Acute Myocardial Infarctions (MI's) or Heart Attack Rates of Hospitalization

Winnipeg River has experienced a decrease in hospitalized cases for MI's during the two time periods reviewed from 2.44/1000 to 2.22/1000, but it is not a significant decline.

The MI hospitalization rate is not statistically different than the Manitoba average or Rural South for the second time period reviewed.

There has been a drop in MI hospitalizations in Winnipeg River, but it is not a significant decline.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

There appears to have been a decrease in the number of residents being treated for stroke from 2.61/1000 to 2.20/1000 in Winnipeg River, but it was not a significant decrease.

Winnipeg Rivers' Stroke treatment prevalence appears to be higher during the second time period than the Manitoba average (1.71) and Rural South (1.97), but it is not a significant difference.

A decrease in stroke treatment occurred in Winnipeg River during 1996/97 - 2000/01, but it wasn't a significant decrease.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTH CONDITIONS

- Comment that cardiac disease appears to be prevalent and access to service seems prolonged.
Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999 compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to relatively small number of injury deaths, these rates are not reported at the district level.\(^\text{15}\)

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

**Figure 12.15 Injury Hospitalization NE Health Districts**

There has been a slight decline in the number of injuries requiring hospitalization in the Winnipeg River district from 11.72/1000 to 10.29/1000, but this was not a significant change.

Winnipeg River has the third lowest rate of hospitalized injuries when compared to other health districts.

Injury requiring hospitalization has decreased in Winnipeg River, but not significantly.
Human Function

"Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation). International Classification of Functioning and Disability.” (ICIDH-2, Beta 2 Version)

Overview

Human function is associated with the consequences of disease, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Well Being

"Broad measures of the physical, mental and social well-being of individuals.”

Overview

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age are able to do who may not have an illness.

Focus Group on There's Nothing To Do

It was felt that the perception of 'nothing to do' will have an effect on the overall well-being of an individual. Youth in every Focus Group mentioned this as an issue. Adults also raised this in their Focus Groups specifically related to recreational activities.

YOUTH

- There are inadequate numbers and varieties of activities to keep them [youth] occupied. [Winnipeg River]
### 12.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
</table>

*Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.* 22

*Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.* 23

*Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.* 24

*Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.* 25

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
</table>

*The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.* 26

*The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.* 27

*Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.* 28

*Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.* 29
Overview

Environmental factors influence our health and should not be taken for granted. We must work on this continuously in partnership with others. We are fortunate that we live in a healthy and safe environment however, there are some concerns most specifically related to water quality.

Water

Water Quality

There is a water treatment plant in Lac du Bonnet, which services the town. The town upgraded their water treatment plant in 2003. This was made possible through infrastructure and water services grants. The RM is serviced by private wells and independent Water Co-ops. There is a water treatment plant in Pinawa, which services the LGD of Pinawa.

Sewage Systems

The Town of Lac du Bonnet is serviced by a sewage system and a lagoon provides for waste disposal. The RM of Lac du Bonnet has holding tanks and septic fields and a lagoon provides for waste disposal. Pinawa utilizes a community sewer/storm system complete with lagoon.
The Air We Breathe

There was nothing suggested in the 2003 Focus Groups about air quality.

**2004 Validation Workshop**

<table>
<thead>
<tr>
<th>WINNIPEG RIVER GROUP DISCUSSIONS ON PHYSICAL ENVIRONMENT – Air</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggestions</strong></td>
</tr>
<tr>
<td>• Need by-laws restricting the use of hazardous chemicals, e.g. spraying gardens.</td>
</tr>
<tr>
<td>• Need education on the ill effects of second hand smoke. Concern expressed that children are still being exposed at home and in cars.</td>
</tr>
</tbody>
</table>

Housing

Table 12.4 Elderly Persons’ Housing in Winnipeg River

<table>
<thead>
<tr>
<th>Winnipeg River Communities</th>
<th>Name of Facility</th>
<th># of units</th>
<th>Owner / Operator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lac du Bonnet</td>
<td>Bonny Vista Lodge</td>
<td>43</td>
<td>Manitoba Housing</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Parkview Place</td>
<td>11</td>
<td>Private</td>
</tr>
<tr>
<td>Lac du Bonnet</td>
<td>Park Manor</td>
<td>12</td>
<td>Private</td>
</tr>
</tbody>
</table>

Source: Grace Honke, Services for Seniors Specialist as cited to Carol Orvis. February 2004.

The Manitoba Housing Unit, Bonny Vista Lodge in Lac du Bonnet, has three vacancies since December 2003 that have not been filled. This is unusual, as there always had been a waiting list in the past.

**2003 Focus Group - Housing**

This was an area of concern in the 1997-98 CHA. The need for more transitional housing in the middle and seniors Focus Groups.

**MIDDLE ADULTS**

- Some participants felt that they needed to learn about services in order to assist parents. [Winnipeg River]
- Personal Care Home (PCH) and transitional housing in Pinawa for seniors [Winnipeg River].

**SENIORS**

- Pinawa has affordable townhouses for rent, there is no outside maintenance, but they are two-story dwellings. [Winnipeg River]

**Suggestion Raised by Seniors**

- Seniors housing complex in Pinawa. [Winnipeg River]

“We need a PCH in Pinawa more than anything. It’s very important to stay in your own community…Lac du Bonnet is nice, but you don’t know people.” [Winnipeg River]
### Three Top Key Issues Identified By Participants

<table>
<thead>
<tr>
<th>Winnipeg River</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase in PCH Beds</strong> [Raised Issue]</td>
<td>50%</td>
</tr>
</tbody>
</table>

Validation Workshop participants felt that waiting time is too long in Pinawa.

**Discussion:**
- “If they can’t find appropriate housing they move.” “Need more PCH beds.” Waiting time is too long.
- No “Safe House”, shelters or transitional housing within NEHA, “not only for women but able to be accessed by residents who need a safe environment, e.g. youth”.

2003 Focus Groups - also mentioned the need for more PCH beds (Blue Water, Springfield, Winnipeg River).
# Safety

## Table 12.5 Crime Report Winnipeg River Health District Total *

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criminal Code</strong></td>
<td>Persons – Homicides, robberies, personal assaults and abductions.</td>
<td>Winnipeg River</td>
<td>448</td>
<td>397</td>
</tr>
<tr>
<td></td>
<td>Property – Break and enter, shoplifting, stolen goods, motor vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>theft, theft over $5000/under $5000, fraud.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Criminal Other - Offensive and restricted weapons.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Criminal – Property damage under $5000, disturbing the peace , arson,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>indecent acts, bail violations, breach of probation, harasing and stalking,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>kidnapping, prison unlawful at large.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td></td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td>Federal Code</td>
<td>Parole violation, weights and measures and other Federal Acts.</td>
<td>Winnipeg River</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Canadian Environmental Protection Act, drugs and substances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Federal Code</td>
<td></td>
<td>NE</td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Transporting danger goods, Coroner's Act, Mental Health Act,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trespass Act, Offensive road vehicle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquor - intoxicated persons, Liquor Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traffic - failing to stop dangerous driving, other moving and non-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>moving traffic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td></td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Winnipeg River</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td></td>
<td>NE</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired</td>
<td>Winnipeg River</td>
<td>166</td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>driving, driving over 80 MG (blood alcohol level), driving a motor vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>prohibited, property damage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Traffic</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Winnipeg River</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td></td>
<td>NE</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Winnipeg River</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td></td>
<td>NE</td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>OF ALL OFFENSES</strong></td>
<td>Winnipeg River</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: this does not include persons injured or killed in traffic related</td>
<td>North Eastman</td>
<td>8,714</td>
<td>7,481</td>
</tr>
<tr>
<td></td>
<td>incidents.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Bill Hanysh, Corporate Management Branch (CMB), Client Services, RCMP "D" Division. Received August 8, 2003.

- * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

- ** The number of persons injured and killed in traffic related incidents are not included in the numbers associated with the total traffic code category, nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.
The overall number of reported crimes has dropped slightly when comparing 2001 with 2002. The only area of increase is related to the municipal acts and by laws that increased by 10 reported cases in 2002. There was one traffic accident death in 2002 where there was none in 2001. Traffic injuries decreased by one in 2002, from 29 in 2001. Winnipeg River has the third highest traffic accident injuries when compared with the other health districts.

**Note:** We are not able to compare previous crime report information as the CMB changed their system of reporting.

---

### Biology & Genetic Endowment as a Health Determinant

"The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges."  

---

### Overview

The fundamental characteristics of this determinant include our genetic make up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought "...in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems."  

*For information related to this determinant refer to the section on 'health status'*

---

### Personal Health Practices & Lifestyle as a Health Determinant

"Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status."  

---

### Overview

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family's pattern of life style and practice. Education alone is never enough. Other known influences on behaviour, either positively or negatively, may include an individual's peers, social / community norms and practices, and the willingness on the part of the individual, family, or community to change.
Focus Groups – Dietary Practices

MIDDLE ADULTS

The reasons why participants modified their diet included

a) Health Reasons e.g. borderline diabetic, cholesterol. [Winnipeg River, Blue Water, Iron Rose, Brokenhead]

SENIORS

Reasons to Modify Diet - Health issues (especially cholesterol) [Brokenhead, Iron Rose, Winnipeg River, Springfield, Blue Water]

Programs / Methods Used

- Reads books and received pamphlet from physician [Winnipeg River]
- Diabetes Clinic in Beausejour. [Winnipeg River]
- Decreased fat. [Winnipeg River]

Barriers

-Difficulty when two persons in a household are on different diets “She can’t cook a hamburger. She can for herself, but not for me. It’s a problem.” [Winnipeg River]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need for Improvement in Dietary &amp; Exercise Behaviours</td>
<td>50%</td>
</tr>
</tbody>
</table>

2003 Focus Groups – These two behaviours were topics raised in every Focus Group.
Alcohol Consumption

Focus Group - Alcohol Use

YOUTH

Drinking as an emerging topic came up in all the youth Focus Groups except for Iron Rose. No participants associated this with a personal lifestyle change recognizing that many youth in the Focus Groups did not consume alcohol.

The youth clearly saw alcohol not only as something youth did, but even more as a behaviour by adults in their communities.

-In the Winnipeg River youth group participants implied that drinking is a problem among youth and adults. “...all the adults talk about how they are going to go get hammered.” [Winnipeg River].

- It is rare that a student will go to school drunk but some come with hangovers and occasionally leave school at lunch to drink and do drugs. Overall, they feel that the problem is very similar in Pinawa as it is in Lac du Bonnet despite the differences in the two schools’ reputation. [Winnipeg River].

Suggestions Raised by Youth
• AFM Counselor should be around more. [Winnipeg River]

ADULT FOCUS GROUPS

- This was not raised as a social problem in most of the adult Focus Groups except for the example given in the middle adult Focus Group. There were several adults who mentioned on a personal note that they did give up drinking. As the youth perceived that adults drink heavily, it is given some weight related to its absence as an emerging health topic in the adult groups.

Focus Groups on Illicit Drug Use

YOUTH

The mention of using drugs such as marijuana and cocaine was raised in Blue Water, Brokenhead and Winnipeg River groups only.

- In Winnipeg River there was more concern expressed over the availability and use of cocaine as compared with marijuana as they likened marijuana to alcohol. All were aware of people who did drugs and felt in general students divided themselves into groups of users and non-users. Having said this they did mention that socially people mix, as the community is small and the choice of friends is limited. They felt there were concerns that younger and older children tend to hang out together, subjecting younger children to drug influences. They don’t feel there is much pressure to use, as long as one is clear about their personal choice. [Winnipeg River]

- “...when you’re younger, you get pressured more...” [Winnipeg River]

- There is also a worry about their friends turning to harder drugs. One youth mentioned that you do not see as many people out and about (families walking) in Lac du Bonnet as in Pinawa and another youth replied “That’s because half the adult in this town do drugs...” [Winnipeg River]
WINNIPEG RIVER GROUP DISCUSSIONS ON PERSONAL HEALTH PRACTICES
– Illicit Drug Use

- Regarding concerns about illicit drug use by youth, one participant commented: “We hear it’s an issue but have no personal experience.”

Suggestion
- There is a need to focus on the prevention/intervention on Fetal Alcohol Syndrome Disorder.

Physical Activity

Focus Groups on Exercise

Increasing the amount of exercise was the most common form of lifestyle change that the adults made to improve health.

YOUTH

Programs/Methods Used
- One participant indicated that her sibling had a positive influence on her when she made some personal changes. [Winnipeg River]
- Parent insists on exercising at home. Feels exercise might be more appealing if there was a gym accessible. [Winnipeg River]

Barriers – Cost and when it is being held were two of the main barriers.

- “I think about it but I just don’t (do it).” [Winnipeg River]

- In Pinawa “we have a little weight room (at the school), but you can only use it during gym class.” It was mentioned that students who stayed for lunch could use the room. A year or two ago they indicated there was a sign up sheet for use after school but they don’t hear about its use now. [Winnipeg River]

YOUNG ADULTS

Reasons to Exercise- The two primary motivators for exercising was to decrease weight and improve body image. [Winnipeg River]

“Now that I’ve started losing weight, I feel a little better about myself, too. It’s kinda lifted my spirits a bit” [Winnipeg River].

MIDDLE ADULTS

- Reasons to Exercise- A health crisis in self or acquaintance was the most common reason. Other reasons include to decrease weight, image, or mental health reasons.

  a) Self image - “I am more active than ever in my life…I have time…I have the right attitude.” [Winnipeg River]

  Barriers - Exhaustion, time, family commitments were the main barriers expressed.

  “…I never had time before. [I was] so busy raising kids, house, job, marriage, family. Who [had] time for this type of stuff?” [Winnipeg River]
SENIORS
- Another participant felt exercise “...is the most important thing.” [Winnipeg River]

Programs / Methods Used
- Walking was the main method of exercising in this age group.

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need for Improvement in Dietary &amp; Exercise Behaviours</td>
<td>50%</td>
</tr>
</tbody>
</table>

2003 Focus Groups – These two behaviours were topics raised in every focus group.

Smoking Practices

Focus Group on Smoking
The Focus Group discussion provides insight into some of the reasons why a person quits, methods used and barriers to quitting. This information provides valuable information for staff working in smoking cessation programs. The most consistent message is that if the individual wants to quit, there are a variety of methods. Success often depends upon support the individual receives and if weight gain is addressed and managed.

Adult Focus Groups - One of the biggest concerns that smokers indicate time and time again is the potential and real problem of weight gain that accompanies quitting.

Young Adults
- Quitting Smoking
  It was felt in the Winnipeg River group that “… if there was a ban on smoking [rurally] like in Winnipeg, it would make a lot of people cut back or quit.”
  
  Reasons for Quitting – From the reasons given by some participants there is evidence that public policy, peer pressure, and health education strategies are working.
  a) Peer pressure, partner who didn’t smoke, pregnancy [Iron Rose, Winnipeg River]
  b) One participant works in a smoke free environment, however still smokes at home in the evening because “I’m bored, so I watch TV and have coffee and cigarettes.” [Winnipeg River]

Potential Risk Taking Behaviour

Focus Groups on Risk Taking Behaviour

Youth
- Sexually Transmitted Diseases – This topic emerged only in Winnipeg River.
  “…could be …a health issue because more and more people are having sex at a younger age...people think it's not a big deal, or it can’t happen to them.” [Winnipeg River]
**Pharmaceutical Use**

**Figure 12.16 Proportion of Residents With at Least One Prescription**

There has been a slight decrease in the percent of residents using at least one prescription medication from 68% to 67% during the two time periods reviewed, but not a significant change.

The percentage of use is similar to Manitoba and Rural South.

**Number of Different Drugs**

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

**Figure 12.17 Average Number of Different Drugs Prescribed**

Winnipeg River shows a statistical significant increase from 3.09 to 3.24 in the average number of different medications dispensed.

Compared with Manitoba at 3.44 and Rural South at 3.44, during the second time period, Winnipeg River shows a statistically significantly lower average number of different drugs at 3.24.
Proportion of Residents Using Antibiotics

There has been growing concern related to the over-prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason, it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

**Figure 12.18 Percentage of Residents Receiving at Least One Prescription for Antibiotics**

We see a statistically significant decrease in the number of prescribed antibiotics for the two time periods from 41% to 37% in Winnipeg River.

This percentage is statistically significantly less than the Manitoba average (39%) for the second time period.

A significant decrease in the number of antibiotics prescribed occurred between 1999/00 and 2000/01.

Figure 12.19 Average Number of Antibiotics Prescribed

Winnipeg River had a statistically significant decrease (from 2.03 to 1.90) in prescriptions dispensed during the time period reviewed. It is also statistically significantly less than Manitoba at 2.02 and Rural South at 2.06 for the second time period. This is a positive finding.

A significant decrease in the average number of antibiotics dispensed occurred during the time periods reviewed.
Proportion of Residents Using Antidepressants

Figure 12.20 Proportion of Residents Using Antidepressants

There has been a statistically significant increase in the proportion of residents receiving two or more prescription antidepressants, from 4.0% to 5.2% respectively during the two time periods reviewed.

Winnipeg River’s percentage is not significantly different than the Manitoba average or Rural South.

Focus Groups- Prescriptions

YOUNG ADULT
- Quickness to prescribe medication. [Winnipeg River, Blue Water]

MIDDLE ADULT
- The overriding concern is the question whether prescribed drugs should be the first treatment option explored. This came up in the young adult group as well. [Springfield, Brokenhead, Winnipeg River]
  "I am offended by the pushing and peddling of drugs." [Winnipeg River]

2004 Validation Workshop

WINNIEP RIVER GROUP DISCUSSIONS ON HEALTH SERVICES- Prescription Drugs
- Discussion on the price of prescription drugs, the buying power of large pharmacies within Winnipeg results in lower costs for the consumer than in rural areas.
Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status. 39

Focus Groups on Youth

Middle Adult

a) Youth / Teen Support – Once more the lack of youth activities in a community is mentioned.
- Some participants expressed the importance of parents as role models so young adults are well-equipped to make physical, mental, and social choices. [Winnipeg River]

Infant Mortality

The infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

In Winnipeg River between 1990 and 1999, the number of infant deaths were suppressed because there were less than five. This is good news for Winnipeg River Health District. 40
Births

At 40 weeks gestation 50% of female babies weigh approximately 3500 grams and male babies weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. Often in disadvantaged groups, mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.

Table 12.6 Number of Newborns in Winnipeg River [Rate is expressed in brackets]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


During 2002-2003 NE had a total of 431 newborns a rate of 10.9 / 1000 compared as compared with the Manitoba rate of 11.7/ 1000.

Winnipeg River’s birth rate is considerably lower than both Manitoba and NE.

HOW HAS WINNIPEG RIVER’S BIRTH RATE CHANGED OVER TIME?

During 2000-2001 there was a substantial increase in the birth rate as compared to the other years reviewed. Otherwise the birth rate has remained consistent throughout, but remains the lowest in NE region and the rate is considerably lower than the Manitoba birth rate during all years reviewed.
Focus Groups on Obstetrical Practices

Obstetrics as a desired service emerged in several adult Focus Groups.

Young Adults
- Like to see more surgeries and obstetrics in hospitals. [Springfield, Iron Rose, Winnipeg River, Blue Water]

Middle Adults
The impact of no obstetrics in NE region for this age group is described as follows:
- If there is no birthing capability you “…lose something as a community. No one is born here.” [Winnipeg River]
- Disruptive to family, strain on other children. “… traffic, parking it’s a hassle.” [Winnipeg River].
- Hospitals should have birthing capability. [Winnipeg River, Blue Water]
- Midwife services. [Winnipeg River, Brokenhead]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Would like Obstetrical Services in North Eastman Hospitals</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

2003 Focus Groups - The desire to have Obstetrical Services in NE hospitals was brought up by both the Young and Middle Adult Focus Groups.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTH SERVICES – Midwifery Services

Discussion
- Access to midwifery services within NEHA, “I am traveling to Central Region to access a midwife.”
Adolescent and Teenage Pregnancy

Figure 12.21 Teenage Pregnancy Rates

When we look at the pregnancy rates at the district level there is considerable variability. Winnipeg River has a statistically significantly lower teen pregnancy than the Manitoba average Rural South.

Focus Groups on Teen Pregnancy

Youth

Teen pregnancy was mentioned in Brokenhead, Blue Water and Winnipeg River youth groups. Teen pregnancy was not mentioned in the adult groups.

-Teen pregnancy is not seen to be a big issue in town, "...not as much as in Pine Falls." [Winnipeg River]
Breastfeeding Practices

Figure 12.22 Breast Feeding Initiation Rates in NE Health Districts

There is considerable variability within the health districts, with highest rates of hospital initiated breastfeeding in Springfield and Winnipeg River, lower rates in Brokenhead and Iron Rose with substantially lower rates in Blue Water (63%) and Northern Remote (38%).

In Winnipeg River, we see that there has been a statistical significant increase in the number of breast feeding initiations from 77.4% to 87.3 %, a 10% increase. This is very positive. Winnipeg River has the second highest initiation of breastfeeding when compared to our other health districts. It is also statistically significantly higher than the Manitoba average of 79.7% and Rural South at 80.3% during the later time period.

Birth Weights

Figure 12.23 High Birth Weights

In Winnipeg River we are seeing a slight increase in the percentage of high birth weights (14.4% to 15.8%), but it is not a significant change.

Winnipeg River is but is not significantly different from Manitoba at 15.6% and Rural South at 16.9% during the later time period.

There has been a slight increase in high birth weight babies, but it is not a significant increase.

Figure 12.24 Low Birth Weights

Winnipeg River (3.3% to 4.2%) shows an increase in the percentage of low weight babies during the two time periods, but it is not a significant change.

Winnipeg River appears to be slightly lower than the Manitoba average of 5.1% and Rural South of 4.6% during the second time period, but it is not significantly different.

There has been an increase in low birth weight babies, but it is not a significant change.

The number of pre-term births has increased in Winnipeg River, from 3.3% to 5.3%, but not significantly. The rate appears lower than the Manitoba average of 5.3% and Rural South of 6.5% during the later time period, but it is not significantly different.
Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses.

Winnipeg River's vaccine coverage increased significantly during the two time periods reviewed. This is a positive finding.

Winnipeg River once more showed a statistically significant increase in the number of completed immunizations during the two time periods reviewed.
Figure 12.28 Completed Immunization at Seven Years

There has been a statistically significant decrease in immunization rates in Winnipeg River, from 90.1% to 73.5% respectively, a drop of 16.6% during the two time periods reviewed.

Despite this significant decrease, Winnipeg River’s percentage is not significantly different than the Manitoba average or Rural South.

During years 1 and 2 coverage rates increased significantly, but by year 7 the coverage rates showed a significant decline, although similar to Manitoba and Rural South.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON HEALTHY CHILD DEVELOPMENT

- Comment that breast-feeding initiation in the hospital does not indicate whether breast-feeding was successful, “if initiated in hospital and discontinued within a few days of going home this is not successful breast feeding”. The need for breast feeding support was a concern.
- Concern about the lack of midwifery services.
- Comment that the decline indicated in teen pregnancy doesn’t seem to agree with what people are hearing.

Suggestions
  - Comprehensive early childhood screening, hearing/vision, fine motor skills, etc.
  - Preserve successful programs e.g. immunizations.
Living & Working Conditions as a Health Determinant
[Income, Income Distribution and Social Status and Employment and Working Conditions] 44

"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health." 45

Overview

Job rank, social statuses in the workplace, the amount of control over one’s work are all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed. 46.

Employment & Unemployment

Table 12.7 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>32.9</td>
<td>28.9</td>
</tr>
</tbody>
</table>


Winnipeg River has the third lowest employment rate for males and females when compared with our other health districts. Females have a lower percentage of unemployment than males. Males have a slightly higher unemployment rate than females.

2004 Validation Workshop

WINNIEP RIVER GROUP DISCUSSIONS ON EMPLOYMENT AND WORKING CONDITIONS

- Comment on the difficulty finding employment related to education.

Suggestion

• Federal and Provincial governments have to be more aggressive in promoting employment opportunities in rural Manitoba.
Social Economic Status

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status.\(^{47}\)

**Median Family Income of Couple Families**

The following tables describe the median family income of couple families and the median family income for lone parent families in Winnipeg River, North Eastman and Manitoba.

**Table 12.8 Median Family Income of Couple Families**

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Couple Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td>$ 55,426</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$ 52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Winnipeg River has a higher median family income than NE as a whole, but slightly lower than Manitoba.

**Table 12.9 Median Family Income of Lone Parents – Males and Females**

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$ 40,087</td>
<td>$ 36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$ 23,892</td>
<td>$ 17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$ 29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$ 45,361</td>
<td>$ 26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$ 35,698</td>
<td>$ 26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$ 9,248</td>
<td>$ 12,587</td>
</tr>
</tbody>
</table>


In Winnipeg River, male lone parent families have almost twice as much income than their female counter parts.
Table 12.10 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male and Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$26,469</td>
</tr>
</tbody>
</table>


Total Low Income Incidence

The incidence of low income in 2000 in Winnipeg River was 9.6 %.  

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Top Three Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Low Income – Lone Parent Households</td>
<td>87.5%</td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>- Some participants questioned the significance of the number of lone parent families being listed as an issue. They thought it may be an assumption that more problems exist in a lone parent family “not a given that more problems will exist”.</td>
<td></td>
</tr>
<tr>
<td>2003 Focus Group- This issue was raised in relation to the support and social issues surrounding lone parent families.</td>
<td></td>
</tr>
</tbody>
</table>

Personal Resources as a Health Determinant

"Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health."  

Overview

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities that safety, tolerance and a place for social interaction are included as these all support a strong social network."
Mental Emotional Health

Mental health was raised as an important concern for many NE residents in particular in the area of services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report. Mental Health Services continued to be a concern for the 2003 Focus Group participants.

Focus Groups on Mental Well being

Mental health issues emerged throughout the Focus Groups discussion. The topics varied between the age groups.

ADULT FOCUS GROUPS - several common theme emerged between the adult and staff Focus Groups in regards to lack of mental health support. Stress emerged as a common theme, but the cause of the stress varied among the age groups.

YOUNG ADULT

The primary issues were the need for better awareness of the mental health programs and the stigma associated with accessing programs. (refer to Mental Health Program Section 7)

MIDDLE ADULTS

Felt that programs need to address more than the illness, but also other issues like managing stress.

SENIORS

Seniors they were concerned about being able to identify vulnerable members in the community, in particular those who were more isolated and described as ‘lonely.’ Another big concern for this age group was living alone and being lonely. Two issues emerged;

a) what they would do if something should happen to them and they were unable to access help.
b) effects of isolation and living alone.

2004 Validation Workshop

WINNIPEG RIVER GROUP DISCUSSIONS ON SOCIAL SUPPORT NETWORKS
- Personal Resources

Suggestion

• Is there a way of preserving client's privacy? Some people are reluctant to access mental health services as they have to wait in a public waiting area and everyone else will know that they are seeing the mental health worker.

Mental Health Programming is discussed under the NEHA Mental Health Program- Section 7.
Social Support

Table 12.11 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and may be more economically disadvantaged than two parent households.

There are approximately 165 lone parent families in Winnipeg River as reported in the 2001 Canada Census.
Focus Group On Social Support

Social support was an area that was raised in all Focus Groups and all ages as something that was seen as positive with respect to an individual's well being.

YOUTH
During the initial discussions when talking about what it means to be healthy, youth mentioned the importance of friends and social supports. We know that social support is a strong determinant of health status.

a) Talking with Adults
- As part of the discussion some participants in Springfield and Winnipeg River discussed their experiences when talking with adults. It's important that counselors and other adults maintain strict confidentiality. [Winnipeg River]

YOUNG ADULTS
Suggestions Raised by Young Adults

- Parent Support Group – There was a program in the community but when the health nurse left it was discontinued. [Winnipeg River]
- Can't get 'Big Brother' until children are 7. [Winnipeg River]
- 'New Friends Mentorship Program' should be expanded to allow children under the age of seven. [Winnipeg River]

MIDDLE ADULTS
-Seniors living alone need support. [Winnipeg River]
- "They just won't eat properly." [Winnipeg River]

SENIORS
a) Living Alone
- Concerned about access to assistance in a health crisis as often they can't get a hold of their family as they are working. [Springfield, Winnipeg River]
- May not eat properly. Without a partner or family for whom to plan meals, singles may not devote enough attention to meal planning. [Iron Rose, Winnipeg River]
- Mental stimulation can be an issue especially in winter. [Winnipeg River]
- Those living alone report need for companionship. After being widowed, "it's a different life." [Winnipeg River]
- With family concerned about the senior person living alone, they may contribute to growing lack of self-confidence i.e. being told they "should or shouldn't" do this or that. [Winnipeg River]
- Life line "...it costs $40 a month but it's worth the piece of mind." [Winnipeg River]

2004 Validation Workshops

<table>
<thead>
<tr>
<th>Three Top Key Issues Identified By Participants</th>
<th>% of participants choosing this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnipeg River</td>
<td></td>
</tr>
<tr>
<td>Need to Identify at Risk Individuals who are Vulnerable in Community</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

2003 Focus Groups – This was raised as a concern by many participants especially in the middle and senior adult groups.
12.5 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Since the previous 1998 CHA Report there have been boundary changes most prominently related to the northern area. Unorganized Territories were originally separated and are incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts based on postal code.

Population

There has been an overall decline in ages 0-54 (with some variability) and an increase from approximately 55 years onward. The implication of growth especially as it relates to the elderly population is the potential for added pressure on the health system. This contributes to the need for creative and preventative health services planning for this population group.

Winnipeg River's birth rate is considerably lower than NE and Manitoba.

Education

During the Validation Workshop, 50% of participants felt that there should be more counseling in school. This was raised by some Focus Groups as well.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index or SEFI value and premature mortality rates or PMR both are important overall measurements of health status. It must be noted that the most current SEFI value is 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern.

Winnipeg River experienced a slight decline in the SEFI value, but it is better than both Manitoba and Rural South. This value needs to be viewed in light of other health indicators in order to determine the reason. PMR has decreased slightly, but not significantly. This needs to be monitored, as this is a measurement of general health status.
Deaths

Total mortality rate has increased slightly, but not significantly. It is similar to the Manitoba average.

Life Expectancy

Females live approximately eight years longer than males.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cancer cases have increased, but not significantly.</td>
<td>Diabetes treatment is on the increase, but not significantly. It is significantly lower than Manitoba.</td>
<td>Respiratory treatment diagnoses have decreased, but not significantly, but is significantly lower than the Manitoba average.</td>
<td>Hypertension treatment has increased significantly, but is similar to Manitoba.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital treatment for MI’s has decreased, but not significantly.</td>
<td>Stroke treatment has decreased, but not significantly, and it is not significantly different than Manitoba or Rural South.</td>
<td>Injury hospitalization has decreased, and is not significantly different than the Manitoba number.</td>
</tr>
</tbody>
</table>

Human Function & Well being

The most prominent thing that arose was our youth in all health districts indicated that there was ‘nothing to do.’ This might be an area to explore with our community partners. Youth and adults in the Focus Group provided many good suggestions for improvement.

DETERMINANTS OF HEALTH

Environmental Factors

Air Quality- During discussions at the Validation Workshop several participants had some suggestions with respect to chemicals and need for second hand smoke education.

Housing – The need for more PCH beds was raised in Blue Water, Springfield, and Winnipeg River. Fifty percent of Validation Workshop participants felt that there was a need for more PCH beds.
Personal Health Practices - From Focus Group and provincial survey comments there seems to be a readiness by the public in general toward healthier lifestyle choices.

Dietary – Obesity is a national and local concern. Dietary modifications were common among all Focus Groups in relation to lifestyle changes in order to control or decrease weight.

Alcohol Consumption – Youth Focus Groups felt it was an issue with both youth and adults in the community. Because of the potential negative social and personal consequences associated with heavy alcohol consumption, this may be an area that warrants further prevention strategies working with community partners.

Illicit Drug Use – This was raised in the youth Focus Groups in Brokenhead and Winnipeg River as a concern. Youth and illicit drug use was a concern raised during the Winnipeg River Validation Workshops as a key issue.

Physical Activity – Exercise was the top area that focus groups and NE provincial survey respondents indicated they did to achieve a healthier lifestyle. We know from the evidence that there are many people who still do not exercise. Fifty percent of Winnipeg River Validation Workshop participants felt this was an area that required further attention.

Smoking Practice – Some Focus Group participants mentioned that they had or were thinking about quitting smoking. Ongoing smoking cessation programs targeting community and staff should be considered. The Focus Group discussions addressed issues surrounding barriers to quitting smoking. Using this information will assist in increasing the success rate of smoking cessation programs.

Risk Taking Behaviour- Youth mentioned STD’s could be a health concern because there is more sexual activity at a younger age.

Medication Use

Prescriptions - The average number of different prescriptions per user, has shown a statistical increase in Winnipeg River, but is significantly lower than Manitoba.

Antibiotics - There was a statistically significant decrease in the number of antibiotics prescribed in Winnipeg River.

Antidepressants - Antidepressant prescriptions show a statistically significant increase in Winnipeg River, but it is not significantly different than Manitoba. It is difficult to know if the reason is due to depression diagnosis, as antidepressants can be prescribed for other reasons.

There were concerns raised in the Focus Groups about being prescribed prescription drugs as the first choice of treatment. The price of prescription drugs was discussed during the Validation Workshops.
Healthy Child

*Mortality Rates* - Winnipeg River’s infant deaths have been suppressed due to low numbers.

*Adolescent & Teenage Pregnancy* - Teen pregnancies are statistically significantly lower when compared with Manitoba. It also appears to be lower than Rural South. Youth during the Focus Groups felt it wasn’t a big issue for them in their community.

*Hospital Breastfeeding Initiation* - Winnipeg River had a statistically significant increase of 10% in breastfeeding initiation rates. It is also significantly higher than Manitoba.

*Birth Weights* - There has been a slight increase in high and low birth weights, but the rates are not significantly different than the Manitoba average. These are important areas to continue to monitor as they have potential implications associated with the future health of our children and may be a potential burden on health services. Pre-term births are not significantly different than the Manitoba average.

*Immunizations* - Immunization coverage significantly increased during Years 1 and 2, and showed a statistically significant decline by Year 7. It would be interesting to determine why this substantial decrease occurred. Vaccination is a cost-effective way to prevent illnesses and decrease costs to the health system and validation workshop participants felt that the immunization program was a success and should be preserved.

Living and Working Conditions

*Work* - During 2001, Winnipeg River had the third lowest employment rate.

*Economic Status* – During 2001, Winnipeg River overall, had a higher median family income than NE. When we separate lone parent male and female families, they had higher median incomes when compared with lone parent families in NE and Manitoba overall. Eighty-seven percent of Winnipeg River Validation Group participants felt that low income – lone parents was a top key issue.

Personal Resources

*Mental Emotional Health* - During the validation workshop there was some discussion about trying to preserve a person’s privacy especially when accessing mental health services in a common waiting area.
Social Support - There are approximately 165 lone parent families reported in Winnipeg River.

The concerns expressed in this group focus around community supports rather than personal support. This is the first time where it was identified that community supports should be all encompassing and not restricted to one age group. This is certainly worth investigating and pursuing especially with services that are not directly related to physical health that home care may provide. Housekeeping, transportation, maintenance, and childcare in an emergency are just some examples.

Sixty two percent of Winnipeg River Validation Workshop participants felt that there is a need to identify at risk individuals who are vulnerable in the community. This was a key issue.

Summary At A Glance

**KEY**
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.
- **NEHA:** a program or service could be enhanced or developed to address this issue.

**Strengths**
- Slight worsening in SEFI value during 1996, but appears to be better than both Manitoba & Rural South in 1996. [Monitor]
- PMR has decreased, but not significantly. [Monitor]
- Total mortality has increased slightly, but not significantly. [Monitor]
- Birth rate is lower than NE and Manitoba. [Monitor]
- Respiratory treatment diagnoses is significantly lower than the Manitoba average. [Monitor]
- Significant decrease in antibiotic prescriptions. [Monitor]
- Number of infant deaths have been suppressed. [Monitor]
- Winnipeg River has a higher median family income than NE overall. [Monitor]
- Breastfeeding initiation rates have significantly increased and are significantly higher than Manitoba. [Monitor]
- Birth weights are not significantly different than Manitoba's. [Monitor]
- New cancer cases have increased, but not significantly. [NEHA, Partner, Monitor]
- Diabetes treatment has increased, but not significantly and is significantly lower than Manitoba and Rural South. [NEHA, Partner, Monitor]

**Issues Having Implications for Health Planning & Delivery**
- Population generally declined from 0-54 years with an increase from 55 years onward. This has the potential to affect health services needs in this population. [NEHA, Partner, Monitor]
- Youth have 'nothing to do'. [Partner]
- Illicit drug use raised by youth in Focus Groups. [Partner, Monitor]
- Number of different prescriptions significantly increased, but significantly less than Manitoba. [Partner, Monitor]
**KEY**
- **Partner**: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor**: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes.
- **NEHA**: a program or service could be enhanced or developed to address this issue.

### Issues Having Implications for Health Planning & Delivery

- Antidepressants showed a statistical increase, but is not significantly different than Manitoba. [Partner, Monitor]
- Smoking cessation programs a need. [NEHA, Partner, Monitor]
- Hypertension treatment has increased, but is similar to Manitoba. [NEHA, Partner, Monitor]
- Stroke treatment has decreased, but not significantly. [NEHA, Partner, Monitor]
- Injury hospitalization has decreased, but higher than Manitoba. [NEHA, Partner, Monitor]
- More PCH beds raised as a need by Focus Groups and Validation Workshops. [NEHA, Partner, Monitor]
- Obesity is a national concern. [NEHA, Partner, Monitor]
- Alcohol consumption concerns were raised by youth in Focus Groups. [NEHA, Partner, Monitor]
- STD’s mentioned as a health concern by youth in Focus Groups. [NEHA, Partner, Monitor]
- Preserving privacy when accessing mental health was a concern expressed by some Focus Groups. [NEHA, Partner, Monitor]
- Focus Group and Validation Group participants identified the need to identify vulnerable members in the community. [NEHA, Partner, Monitor]
- Third lowest employment rate. [Monitor]
- Child Immunization coverage significantly declined in Year 7. [NEHA, Partner, Monitor]

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
12.6 REFERENCES

6 Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004
8 Myrna Suski, Public Health Manager, North Eastman Health Association, April 2004
13.1 GEOGRAPHICAL OVERVIEW ................................................................. 13-1
13.2 COMMUNITY SYSTEM CHARACTERISTICS ............................................. 13-3
13.3 HEALTH STATUS ...................................................................................... 13-6
   Overview .................................................................................................... 13-6
   Significant Indicators Measuring Overall Health Status ....................... 13-6
   Deaths ....................................................................................................... 13-7
   Health Conditions ...................................................................................... 13-9
   Human Function ........................................................................................ 13-13
   Wellbeing ................................................................................................. 13-20

13.4 DETERMINANTS OF HEALTH ................................................................. 13-21
   Environmental Factors ............................................................................... 13-22
      Water & Air Quality .............................................................................. 13-22
      Safety ................................................................................................... 13-23
   Biology & Genetic Endowment ................................................................. 13-24
   Personal Health Practices & Lifestyle ...................................................... 13-25
      Overview ................................................................................................ 13-25
      Medication Use .................................................................................... 13-25
   Healthy Child Development ..................................................................... 13-29
      Overview ................................................................................................ 13-29
      Infant Mortality Rates .......................................................................... 13-29
      Births ..................................................................................................... 13-30
      Adolescent and Teenage Pregnancy .................................................... 13-31
      Breastfeeding Practices ....................................................................... 13-32
      Birth Weights ....................................................................................... 13-33
      Childhood Immunizations .................................................................... 13-36
   Living and Working Conditions ............................................................... 13-38
      Overview ................................................................................................ 13-38
      Social Economic Status ....................................................................... 13-39
   Personal Resources ................................................................................... 13-40
      Mental Emotional Health .................................................................... 13-40
      Social Support ...................................................................................... 13-41

13.5 PARTNERSHIP SUPPORT ........................................................................... 13-42

13.6 SUMMARY/CONCLUSION ......................................................................... 13-46

13.7 REFERENCES ............................................................................................. 13-52
13.1 GEOGRAPHICAL OVERVIEW

There are eight First Nations communities within the North Eastman Region and seven are affiliated with the Southeast Resource Development Council (SERDC) and one community has no tribal council affiliation. Poplar River, Berens River, Bloodvein, Pauingassi and Little Grand Rapids are considered remote northern communities for planning purposes.

Note: Hollow Water, Black River and Sagkeeng (Fort Alexander) are included as part of the Blue Water planning district and are accessible year-round by road.

The federal government is responsible for the provision of health services for the majority of residents living in the Northern Remote Health District.
These are the municipalities and communities that fall under the Northern Remote Health District.

### NORTHERN REMOTE
3, 237 in 2003

- Unorganized Territories (288)
  - BERENS RIVER FN - ROBOAO
  - LITTLE GRAND RAPIDS FN - ROBOVO
  - NEGGinan - ROBOZO
  - BLOODVEIN FN - ROCOJO
  - PRINCESS HARBOUR - ROC2P0
  - LOON STRAITS - ROC1X0
  - PAUINGASSI - ROB2G0
  - POPULAR RIVER FN - ROBOZO

**UNORGANIZED TERRITORIES - MUN CODE-290 (prior to 1997)**
Source for Population – 2003

Sources:
- Penny Brown – June 27, 2003 – MUN & postal codes in caps [CAPS]. Note: This was the primary source. If a community is listed in this document and Martens & Black then it is placed in caps.

There have been some significant geographical changes since the 1998 CHA report.

**Geographical Changes:**

- Unorganized Territories previously was a separate geographic area. In this report, depending upon the municipal code, communities have been re-allocated into Winnipeg River, Iron Rose, Blue Water and Northern Remote districts.

- Northern Remote is a separate health district.

**Notes:**

a) Focus Groups or Validation Workshops were not held in this health district.

b) In order to obtain more community related information, a letter was written on behalf of the Community Health Assessment Project by Judy Coleman on October 6th to Chief John Thunder. The letter requested information from a Community Health Assessment recently completed at First Nation Communities within NE. To date we have not received a reply to this request.
13.2 COMMUNITY SYSTEM CHARACTERISTICS

Population Demographics

[Education as a health determinate]  

Overview

Providing a scan of the population is important as human populations live in a macro environment. The size of our region, population by age and sex, distribution, and diversity make up a community’s specific characteristics. Where information is available the sex of the individual is provided. Research continuously demonstrates that there are unique risk factors and health problems that are different for men and women as well as gender influences affecting age, education, socio-economic status, culture and physical environment.

Population Demographics

Figure 13.1 Age Profile of Northern Remote – 1995 & 2000

During the time period there has been an overall increase in population in almost all age groups with the exception of 0-4, 25-29, 55-69, and over 70 years. Young people, aged 25-29 years may be leaving the area to seek employment or further education. The decline in the over 70 population may reflect the life expectancy of this population in general. Life expectancy in 1996-2000 was 71 years for females, 62.6 years for males. This is a young population.
### Table 13.1 Population 2001 to 2003 By Health District

<table>
<thead>
<tr>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Remote</td>
<td>2,662</td>
<td>2,668</td>
<td>3,237</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>39,320</td>
<td>39,389</td>
<td>39,644</td>
</tr>
</tbody>
</table>


### Table 13.2 2002/2003 Northern Remote Health District Divided into Non First Nations and FN People

<table>
<thead>
<tr>
<th>District</th>
<th>Non First Nations</th>
<th>FN on Reserve</th>
<th>FN off Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Remote</td>
<td>442</td>
<td>2,038</td>
<td>188</td>
</tr>
<tr>
<td><strong>Total NE : 39,389 persons</strong></td>
<td>33,361</td>
<td>5,049</td>
<td>979</td>
</tr>
</tbody>
</table>

Education as a Health Determinant

Overview

There has been an association found that when education levels increase the self-rated health status improves. Education is also closely tied with socioeconomic status. Effective education for children and lifelong learning for adults contributes to the health and prosperity of individuals.

Frontier School Division

The Frontier School Division was formed by the Department of Education in 1965 to provide better educational opportunities for northern Manitoba communities. The Division encompasses communities on or near Lake Winnipeg up along the CNR Bay-Line, stretching hundreds of miles from Bissett and Wanipigow in the south to South Indian Lake and Brochet in the North. The Division is broken down into five areas. The four schools in the North Eastman Region, Berens River, Falcon Beach, San Antonio (Bissett) and Wanipigow are included in Area 3.

Because the communities are small, the majority of schools do not offer senior high school programs. Therefore, students must leave their home school to complete their schooling. They can then apply to the Division’s residential high school, Frontier College Institute in Cranberry Portage or to the Division’s Home Placement Program. The Home Placement Program began in 1970 as an alternative to Frontier Collegiate Institute, where children move from their home to a community where a high school is available. This placement does not have to be in the Frontier School division. The students in the program identify a placement home e.g. a relative or friend, or the division will place them in a home. In 2004 there are 120 students in the Home Placement Program.

The Division has a Health and Wellness initiative which provides students with opportunities:

a) to examine how they are presently conducting their lifestyles (awareness)

b) explore options and resources to lead a healthier lifestyle (education)

c) to promote lifelong healthy lifestyles (growth)

In September 2002 a Healthy Food Program was implemented in all Frontier Division Schools.

Table 13.3 Frontier School Division

<table>
<thead>
<tr>
<th>FRONTIER SCHOOL DIVISION</th>
<th># of Students</th>
<th>Male</th>
<th>Female</th>
<th>% Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2002/03</td>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>Berens River</td>
<td>397</td>
<td>371</td>
<td>192</td>
<td>180</td>
</tr>
<tr>
<td>Falcon Beach</td>
<td>70</td>
<td>59</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>San Antonio</td>
<td>36</td>
<td>23</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Wanipigow</td>
<td>383</td>
<td>346</td>
<td>191</td>
<td>176</td>
</tr>
</tbody>
</table>

### 13.3 HEALTH STATUS

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health Conditions</th>
<th>Human Function</th>
<th>Well Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.” 6</td>
<td>“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO))” 7</td>
<td>“Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version).” 8</td>
<td>“Broad measures of the physical, mental and social well-being of individuals.” 9</td>
</tr>
</tbody>
</table>

**Overview**

An individual’s health status is influenced by more than the delivery of health services. As we learn more about what constitutes “health”, we find that there are many influencing factors, some controllable for example the choices we make i.e. using a seat belt, and things we have less or no control over, for example hereditary diseases.

“The health of Aboriginal people in the region is a priority and is of significant concern. Publications such as, “The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-based Study” (MCHP 2002); “The Health of Manitoba’s Metis Population and Their Utilization of Medical Services: A Pilot Study” (Cancer Care Manitoba & Manitoba Health 2002), and “The Aboriginal Peoples Survey” (Statistics Canada 2001) identifies the disparity in health status between aboriginal and non-aboriginal residents. Increased incidence of diabetes and complications due to diabetes, higher premature mortality rates, increased incidence of hypertension and decreased length of life expectancy are some of the identified disparities.

Preventative practices such as immunization uptake, breast feeding initiation and participation in screening activities such as mammography and cervical screening, are also reported to be lower among our aboriginal population.

“The North Eastman Health Association Inc. is committed to working with Aboriginal groups to improve the health status of the aboriginal people. We recognize that culturally sensitive services have a positive impact on the health of aboriginal people and facilitate their willingness to access health services. We are committed to understanding and developing ways in which we can foster increased cultural awareness. We believe that through partnerships and sharing, the aboriginal groups will engage in illness and accident prevention and health promotion activities, make healthy lifestyle choices, access health information and ultimately improve their health status.” 10
Significant Indicators Measuring Overall Health Status

Social Economic Factor Index (SEFI)

This indicator describes an overall composite socioeconomic “risk” of a population in a given geographical area. The greater the risk, the poorer the overall health status and likely the need for more enhanced health services. The SEFI values described here represent averages for all residents by health district. Results less than 0 indicate LESS socioeconomic risk and values greater than 0 indicate GREATER socioeconomic risk, meaning a likelihood of poorer health status -- a potential need for more input from health services.

Figure 13.2 Social Economic Factor Index 1991 & 1996

Looking at the NE Health Districts we see disparities in socioeconomic risks identified in the Blue Water and Northern Remote Health Districts.

Northern Remote’s SEFI value declined slightly during the later time period. Northern Remote had the worst SEFI value when compared with our other health districts for 1991 and 1996.

We shouldn’t be surprised that more health care services may be required in Blue Water and Northern Remote health districts.

Northern Remote has the poorest SEFI value in 1996 when compared with our other health districts and appears to be a worse value than both Manitoba and Rural South.
Premature Mortality Rate (PMR)

PMR is defined as deaths that occur before age 75. This indicator is often used as a measure of general health status and the subsequent need for health services. It is considered the single best measure to reflect the health status of a region’s population. If PMR is high, we can assume that this population requires the use of more health services including preventive services.\textsuperscript{11}

Figure 13.3 Premature Mortality Rate

![PMR per 1000 Aged 0-74 NE Health Districts [age & sex adjusted]](chart.png)


We do not want to see this indicator increase. PMR has increased from 6.82 to 8.53 during the time periods reviewed, but this was not a significant difference. It is statistically higher than the Manitoba average of 3.49 and 3.32 respectively and Rural South at 3.38 and 3.23 respectively. This corresponds with the lower life expectancy and PYLL values we are seeing.

Northern Remote has the highest PMR rate in NE and is significantly higher than Manitoba and Rural South.
Deaths

“A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost.”

Total Mortality Rate

This indicator examines all deaths from all different causes and all ages.

Figure 13.4 Total Mortality Rate – NE Health Districts

Northern Remote’s mortality rate had increased from 9.84/1000 to 12.12/1000 during the two time periods reviewed, but this was not a significant difference.

It is the highest mortality rate in our region and is statistically significantly higher than Manitoba and Rural South during the second time period.
Life Expectancy

Life expectancy is defined as the expected length of life from birth, based on the mortality of the population. Life expectancy is a common indicator of population health status and is used for international comparisons.\textsuperscript{13}

Figure 13.5 Life Expectancy – NE Health Districts

In Northern Remote we see that females live longer than males by approximately 8 years. In Northern Remote, life expectancy is the lowest in the NE region and appears to be lower than Manitoba and Rural South. When we compare the two time periods, male life expectancy appears to have shown a decline during the later time period.

Northern Remote has the lowest life expectancy rate when compared with other health districts in North Eastman and appears to be lower than Manitoba and Rural South.
Potential Years of Life Lost (PYLL)

This is an indicator of premature mortality before age 75 (excluding infant deaths up to one year). This measure provides greater weight to a death occurring at a younger age when compared to all deaths.\(^\text{14}\)

**Figure 13.6 Potential Years of Life Lost – NE Health Districts**

The PYLL for both males and females has increased from 174.8/1000 to 203.4/1000 during the two periods reviewed, but it was not a significant difference.

PYLL in Northern Remote is the highest in our region.

Compared with Manitoba and Rural South, PYLL is statistically significantly higher during both time periods.

When we look at chronic diseases in Northern Remote, we see higher than Manitoba average rates from injury deaths, injury hospitalizations, diabetes, and strokes which might suggest possible causes for the increased PYLL.
In Northern Remote we see the PYLL for males has increased from 200.22 to 249.4/1000 during the two years reviewed and for females the PYLL has increased slightly from 149.4 to 157.4/1000, neither are significantly different.

PYLL was statistically higher than the Manitoba average and Rural South for both males and females during both time periods.
Health Conditions

“Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition.” (World Health Organization (WHO) 15

Cancer

Figure 13.8 New Cancer Rates [includes non-invasive malignancies].

New cancer rates were not significantly different during the two time periods reviewed.

Compared with Manitoba at 5.61/1000, Northern Remote’s new cancer rates were statistically significantly lower, at 4.9/1000 during the second time period.

We know that the occurrence of cancer increases with age. We also know that the life expectancy for this population is less than the Manitoba average.

There has been no significant change in new cancer rates between 1996-2000.
Diabetes

Diabetes Treatment Prevalence

Diabetes treatment prevalence is defined as the percentage of persons aged 20-79 years who had a diagnosis of diabetes in two or more physician visits or one hospitalization during the time period reviewed.

Figure 13.9 Diabetes Treatment Prevalence NE Health Districts

Diabetes treatment prevalence in Northern Remote appears to have shown an increase, but it is not a significant increase. Northern Remote is statistically significantly higher than Manitoba (5.6%) and Rural South (5.4%). Northern Remote has the highest prevalence in our entire region at 18.1% in this population group.

First Nation People & Diabetes

The Aboriginal population has a higher prevalence of diabetes than the rest of the population. This necessitates the need for collaborative partnerships with the First Nations communities, while respecting the jurisdictional boundaries associated with service delivery. First Nation communities are represented on the Regional Diabetes Steering committee, providing valuable insight into the challenges facing these communities, such as poor housing, lack of accessible health services and transportation. Several partnerships with some integration of services are currently happening between First Nation communities and the Regional Health Association.

The incidence of diabetes in the population in 1999 not including the Treaty Status population, was 49 per 10,000. The incidence of diabetes in the Treaty Status population in North Eastman was 87 per 10,000. The incidence of diabetes in the Treaty Status population in Manitoba was 74 cases per 10,000 population. 16 According to the diabetes treatment prevalence rate in 1998-2001, North Eastman had a 6.2% rate and is significantly higher than the Manitoba average at 5.6%. The other RHA’s in Manitoba who surpass NE include: Burntwood (12.9%), Churchill (11.2%), Norman (8.7%) and Parkland (6.7%). 17

Diabetes is significantly higher than both Manitoba and Rural South.
Diabetes treatment prevalence in Northern Remote has shown a statistical increase, from 16% to 18.1% during the two time periods. This is also statistically higher than the Manitoba average at 4.6% and 5.6% respectively. Northern Remote has the highest prevalence in our entire region.

**Respiratory Diseases**

**Figure 13.10 Asthma Prevalence**

When we look at Northern Remote we see that the asthma rates between April 2001 to March 2003 appear to be the lowest in our region. These rates may be under-diagnosed.

As mentioned in the regional section, both asthma and respiratory diseases in general are showing a decline.

**Figure 13.11 Residents Treated for Respiratory Disease** [includes asthma, bronchitis & pneumonia]

Northern Remote shows a statistically significant decrease in respiratory diseases diagnoses during the time periods reviewed.

Compared with Manitoba and Rural South, the Northern Remote rate is statistically significantly lower during both time periods. This could be due to under diagnosing of respiratory disease.
Hypertension

Hypertension Treatment Prevalence

Hypertension treatment prevalence is defined as the percentage of persons aged 25 years or older who had at least one physician visit for hypertension during the time period reviewed i.e. each resident is defined as either having been treated for hypertension or not.

Figure 13.12 Hypertension Treatment Prevalence NE Health Districts

Northern Remote’s prevalence for hypertension treatment is not significantly different for both time periods reviewed.

Hypertension treatment is close to the Manitoba average and Rural South, but it is not significantly different.

Hypertension treatment in Northern Remote is not significantly different than Manitoba or Rural South.
Heart Attacks

Figure 13.13 Acute Myocardial Infarctions (MI's) or Heart Attack Rates of Hospitalization

Despite this decrease, Northern Remote has the second highest rate when compared with our other health districts. Northern Remote is close to the provincial average, but is not significantly different.

MI hospitalization rates have decreased, but not significantly. Northern Remote has the second highest MI hospitalization rate when compared to other health districts.
Strokes

Stroke Treatment Prevalence

Stroke treatment prevalence is defined as the combined number of hospitalizations for strokes experienced per thousand residents, aged 20 years or older and is averaged over the five-year period to give an annual rate. The reason it is not a percentage is that an individual may suffer from more than one stroke. Each stroke is counted as a separate event.

Figure 13.14 Stroke Treatment Prevalence NE Health Districts

There has been a decrease in the prevalence treatment for strokes from 3.30/1000 to 3.02/1000, but not significantly different, during the time periods reviewed.

Northern Remote has the highest stroke treatment when compared to our other health districts.
Injuries

In NE, injury mortality rates have shown an increase from .55/1000 in 1990-1994 to .73/1000 during 1995-1999, compared to Manitoba at .44/1000 and .49/1000 and Rural South at .47/1000 and .54/1000.

Due to relatively small number of injury deaths, these rates are not reported at the district level.

Hospitalization Injuries

A hospitalization injury is defined as any injury that is coded on the hospital discharge abstract as the primary diagnosis.

Figure 13.15 Injury Hospitalization Rates in NE Health Districts

There has been a statistically significant decrease in the number of hospitalizations due to injuries, from 48.07/1000 to 37.8/1000 during the time periods reviewed.

However, Northern Remote had the highest injury hospitalization rate compared with our other health districts and is statistically significantly higher than the Manitoba average of 9.88/1000 and Rural South of 11.52 during the second time period.

Northern Remote has a significantly higher hospitalization injury rate at 37.8/1000 compared with Manitoba at 9.8/1000 and Rural South at 11.52.
Human Function

"Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation . International Classification of Functioning and Disability. " (ICIDH-2, Beta 2 Version)"

Overview

Human function is associated with the consequences of diseases, disorders, injury and other health conditions.

Refer to Section 6 for regional information.

Well Being

"Broad measures of the physical, mental and social well-being of individuals." 

Overview

Health status of the population is not only measured by how often an individual visits or is diagnosed with illness by a health professional, but also how they feel personally. An individual may have a chronic illness, but it is well controlled and they are functioning well i.e. able to work, and do various activities that other people their age are able to do who may not have an illness.

Refer to Section 6 for regional information.
### 13.4 DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Personal Health Practices &amp; Lifestyle</th>
<th>Personal Resources</th>
<th>Living &amp; Working Conditions</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Personal Health Practices &amp; Coping Skills]</td>
<td>[Social Support Network]</td>
<td>[Income, Income Distribution and Social Status and Employment and Working Conditions]</td>
<td>[Physical]</td>
</tr>
<tr>
<td>“Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.”</td>
<td>“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.”</td>
<td>“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health,”</td>
<td>“Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy Child Development</th>
<th>Biology &amp; Genetic Endowment</th>
<th>Culture</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.”</td>
<td>“The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges,”</td>
<td>“Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.”</td>
<td>“Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue.”</td>
</tr>
</tbody>
</table>
Overview

Environmental factors influence our health and should not be taken for granted. We must work on this constantly in partnership with others. We are fortunate that we live in a healthy and safe environment, however there are some concerns most specifically related to water quality.

**Water & Air Quality**

We have no reported concerns with respect to water or air quality.
## Safety

### Table 13.4 Crime Report Northern Remote Total *

Note: Total Numbers represent all of NE Region.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXPLANATION</th>
<th>Health District</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Code</td>
<td>Persons – Homicides, robberies, personal assaults and abductions. Property – Break and enter, shoplifting, stolen goods, motor vehicle theft, theft over $5000/under $5000, fraud. Criminal Other- Offensive and restricted weapons. Other Criminal – Property damage under $5000, disturbing the peace, arson, indecent acts, bail violations, breach of probation, harassing and stalking, kidnapping, prison unlawful at large.</td>
<td>Northern Remote</td>
<td>2,596</td>
<td>2,669</td>
</tr>
<tr>
<td>Total Criminal Code</td>
<td></td>
<td>NE</td>
<td>4,481</td>
<td>4,234</td>
</tr>
<tr>
<td>Total Federal Code</td>
<td></td>
<td>NE</td>
<td>155</td>
<td>204</td>
</tr>
<tr>
<td>Total Provincial Code</td>
<td></td>
<td>NE</td>
<td>3,098</td>
<td>2,117</td>
</tr>
<tr>
<td>Municipal Codes</td>
<td>Municipal Acts/ By-Laws</td>
<td>Northern Remote</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Municipal Codes</td>
<td></td>
<td>NE</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Traffic Codes</td>
<td>Collision – fatal and non-fatal, and Criminal Code Traffic i.e. impaired driving, driving over 80 MG (blood alcohol level), driving a motor vehicle prohibited, property damage.</td>
<td>Northern Remote</td>
<td>211</td>
<td>204</td>
</tr>
<tr>
<td>Total Traffic</td>
<td>Note: this does not include persons injured or killed.</td>
<td>NE</td>
<td>897</td>
<td>843</td>
</tr>
<tr>
<td>Persons **</td>
<td>Killed in traffic related incidents</td>
<td>Northern Remote</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total Persons killed</td>
<td></td>
<td>NE</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Persons **</td>
<td>Injured in traffic related incidents</td>
<td>Northern Remote</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Total Persons injured</td>
<td></td>
<td>NE</td>
<td>133</td>
<td>154</td>
</tr>
<tr>
<td>GRAND TOTAL OF ALL OFFENSES</td>
<td>Note: this does not include persons injured or killed in traffic related incidents.</td>
<td>Northern Remote</td>
<td>3,893</td>
<td>3,987</td>
</tr>
<tr>
<td></td>
<td></td>
<td>North Eastman</td>
<td>8,714</td>
<td>7,481</td>
</tr>
</tbody>
</table>


- * The figures used in this report are reported cases to the RCMP. This does not mean that for all the reported cases there was a person charged with the offense. Similarly some of the persons charged with the offense may also have been cleared.

- ** The number of persons injured and killed in traffic related incidents are not included in the numbers associated with the total traffic code category nor in the grand total of all offences calculated. The numbers reflect people injured and killed in the respective health district, not necessarily residents of that health district or of NE region.
Discussion

There is a substantial difference in offenses reported, when we compare Northern Remote with our other health districts. The total reported cases in Northern Remote have increased slightly in 2002 as compared with 2001. In all the criminal code categories there has been a reported increase in 2002.

With respect to traffic codes, this has declined slightly. There were the same numbers of persons killed during 2001 and 2002 i.e. 2 people. There was a slight decrease in the number of traffic injuries i.e. 25 in 2001 to 17 in 2002.

Note: We are not able to compare previous crime report information as the CMB changed their system of reporting.

Biology & Genetic Endowment as a Health Determinant

“The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges.” 35

Overview

The fundamental characteristics of this determinant include our genetic make up, for example gender, how our body systems function, developmental factors and aging. This area is highly complex due to the interrelationship between human biology and other determinants. It is thought “…in some circumstances genetic endowment appears to predispose certain individuals to particular disease or health problems.” 36

For information related to this determinant refer to the section on ‘health status’
Overview

Behaviour change is one of the most difficult areas to modify, as it is so well integrated in a person or family’s pattern of lifestyle and practice. Education alone is never enough. Other known influences on behaviour, either positive or negative may include an individual’s peers, social / community norms and practices and the willingness on the part of the individual, family, or community to change.

Medication Use

Pharmaceutical Use

Figure 13. 16 Proportion of Residents with at Least One Prescription

There has been a significant increase in the percentage of residents using at least one prescription medication from 31% to 41% during the time period reviewed.

The percentage is the lowest in our region and is significantly lower than Manitoba and Rural South. The reason for this may be due to incomplete recording of pharmaceuticals dispensed in nursing stations.  

Number of Different Drugs

This is the average number of different medications dispensed to those who received at least one prescription during the two-year period.

Figure 13. 17 Average Number of Different Drugs Prescribed NE Health Districts

For the second time period, we see a statistically lower number of drugs prescribed than Manitoba and Rural South.

Northern Remote has had a slight increase in the average number of different drugs prescribed, from 3.05 to 3.12, during the two time periods, but it was not a significant change.

For the second time period, we see a statistically lower number of drugs prescribed than the Manitoba average and Rural South both at 3.44.

The reason may be due to an incomplete recording of pharmaceuticals dispensed in nursing stations.40
Proportion of Residents Using Antibiotics

There has been growing concern related to the over prescribing of antibiotics due to the increasing number of antibiotic resistant organisms. For this reason, it is important that antibiotics be used judiciously and not be over prescribed. This indicator helps us understand the percentage of all residents who have received at least one prescription for an antibiotic. Ideally we would like to see the percentage decrease.

Figure 13.18 Percentage of Residents Receiving at Least One Prescription Antibiotic NE Health Districts

There has been a decrease in the number of residents receiving antibiotics, from 15% to 14%, but it was not a significant decline. The reason may be due to an incomplete recording of pharmaceutical dispensing in nursing stations.

Figure 13.19 Number of Antibiotics Prescribed

There has been a slight increase in the average number of antibiotic prescriptions dispensed, from 1.83 to 2.15, but not significantly different, during the two time periods. The number of antibiotics dispensed is close to the Manitoba average of 2.02 and Rural South of 2.06, neither is significantly different.

Proportion of Residents Using Antidepressants

Figure 13.20 Proportion of Residents Using Antidepressants

There has been a slight increase in the percentage of residents receiving two or more prescriptions for antidepressants from 1.1% to 2.2%, but this is not a significant change.

Northern Remote has the lowest use when compared with our other health districts and is significantly lower than Manitoba and Rural South during the second time period.

This may be due to incomplete recording of pharmaceutical dispensing in nursing stations.42

Northern Remote has shown an increase in antidepressant use, but it is not significant, and has the lowest percentage of use when compared to our other health districts.
Healthy Child Development as a Health Determinant

“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.”  [43]

Overview

We know from the research that pre-natal and early childhood care and development programs have a positive effect on future health status. [44]

Infant Mortality Rates

The infant mortality rate is a useful indicator in determining the level of health in a community. Maternal health plays an important role in ensuring healthy babies.

Figure 13.21 Infant Mortality Rate

The infant mortality rate was suppressed because there were five or less deaths during the second time period.

This is a positive trend as the number of deaths during the first time period was statistically significantly higher at 19.13/1000 than the Manitoba average at 6.7/1000.

Infant mortality rates have been suppressed during the second time period.

Births

At 40 weeks gestation 50% of female babies weigh approximately 3500 grams and male babies weigh approximately 3600 grams. There is a strong correlation between birth weight and the income of the mother. We see that often in disadvantaged groups, mothers have babies with higher birth weights on average. The problems are often not only poor maternal nutrition and poor health practices, but may also include factors such as coping skills, sense of control and mastery over life circumstances.

Table 13. 5 Number of Newborns in Northern Remote

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Remote</td>
<td>63 [23.6/1000]</td>
<td>151 ** [29.8/1000]</td>
<td>158 ** [31.3/1000]</td>
<td>133 ** [28.0/1000]</td>
</tr>
<tr>
<td>Unorganized Territories</td>
<td>No longer separated integrated into Iron Rose, Blue Water, Winnipeg River and Northern Remote.</td>
<td>42 [17.1/1000]</td>
<td>54 [22.1/1000]</td>
<td>48 [18.4/1000]</td>
</tr>
<tr>
<td>Manitoba Rate/1000</td>
<td>11.7/1000</td>
<td>12.0/1000</td>
<td>12.1/1000</td>
<td>12.5/1000</td>
</tr>
</tbody>
</table>


* The geographic boundaries have changed for the 2002-2003 fiscal year. Most of the First Nation Reserves are within the health district Northern Remote. Unorganized Territories are no longer geographically together, but re-located into various health district boundaries.

** Listed as First Nation Communities during these years. The 3 FN communities now in Blue Water are likely also represented here.

When we look at the 2002-2003 newborns, we see a decrease in Northern Remote and an increase in Blue Water newborns reflecting these geographic changes.

Bluwater, Northern Remote and Unorganized Territories are listed together because of the boundary changes that occurred in 2002/03 that had obvious implications in the birth rates and numbers.

During 2002/2003 Northern Remote had the highest newborn rate at 23.6/1000 while Winnipeg River experienced the lowest rate at 5.7/1000.
How Has Northern Remote’s Birth Rate Changed Over Time?

Northern Remote showed a substantial decline during 2002/03, but this appears to be an artificial decrease in the number of newborns due to health district boundary changes. There has been a small decline during the former years.

Adolescent and Teenage Pregnancy

![Figure 13.22 Teenage Pregnancy Rates](image)

When we look at the pregnancy rates at the district level there is considerable variability. During 1996-2000 Northern Remote, at 197/1000, has statistically significantly higher teen pregnancies compared with the Manitoba average at 61/1000 and Rural South at 45.37/1000.

Northern Remote has one of the highest teen pregnancy rates in the province.

![Image of a young woman with her hand on her face.](image)
Breastfeeding Practices

Figure 13.23 Breast Feeding Initiation Rates in NE Health Districts

There is considerable variability within the health districts, with high rates of hospital breastfeeding initiation in Springfield and Winnipeg River, with considerably lower rates in Blue Water (63%) and Northern Remote (38%) during the later time period. The good news for Northern Remote is that this percentage is increasing, although not significantly.

Northern Remote is statistically significantly lower than Manitoba and Rural South during the two time periods.

Breastfeeding rates are on the rise, but not significantly, and remain the lowest within NE and significantly lower than Manitoba and Rural South.

Birth Weights

Figure 13.24 High Birth Weights

In Northern Remote, we see a slight increase in the percentage of high birth weight rates, from 18.1% to 19.1% during the time period reviewed, but it was not a significant difference.

Although there appears to be a higher percentage of high birth weight babies in Northern Remote, there is not a significant difference with the Manitoba average at 15.65% and Rural South at 16.9% for the later time period. Because these rates are based upon relatively small numbers of people living in these districts, the rates could fluctuate from year to year.

Northern Remote has the second highest percentage of high birth weight babies when compared to our other health districts, but it is not significantly different than Manitoba or Rural South.
As we look around the region, we are seeing a decrease in the percentage of low birth weight babies.

Northern Remote experienced the third highest percentage of low birth weights when compared to our other health districts.

Although there appears to be a higher percentage of low birth weight babies in Northern Remote, 5.3%, there is not a significant difference with the Manitoba average at 5.1% or Rural South at 4.6% for the later time period. Because these rates are based upon relatively small numbers of people living in these districts, the rates could fluctuate from year to year.
Northern Remote’s percentage of pre-term babies did not change significantly during the two time periods reviewed and is the second highest in our region at 8.3% during the later time period.

Pre-term births were close to the Manitoba average of 7.1%, but were not significantly different during the later time period.

Because these rates are based upon relatively small numbers of people living in these districts, the rates could fluctuate from year to year.

The rate of pre-term babies did not change significantly during the two time periods reviewed and is the second highest in our region.
Childhood Immunizations

In order for a child to completely be protected from a disease, they need to be vaccinated a certain number of times. This number varies with the type of vaccine used.

Completed recommended immunizations as introduced in Manitoba in 1997 are:

- Less than Year One = DaPTP/Hib x 3 doses.
- Year Two = DaPTP/Hib - For a total of 4 doses.
- Year Seven = DaPTP/Hib – For a total of 4 doses.\(^7\)

**Figure 13.27 Completed Immunization at Year One**

Northern Remote’s coverage was statistically significantly less than the Manitoba average and Rural South for both time periods. This district has the lowest number of completed immunizations at one year when compared to other health districts.

**Figure 13.28 Completed Immunization at Year Two**

Northern Remote was statistically significantly less than the Manitoba average and Rural South for both time periods. This district has the lowest number of completed immunizations at two years of age when compared to other health districts.
Northern Remote saw an increase in rates during the second time period, but it wasn't a significant difference, and is statistically significantly lower than the Manitoba average and Rural South for both time periods.

This health district has the lowest number of completed immunizations at seven years of age when compared to other health districts.

Northern Remote has a very young population, yet has the lowest number of completed immunizations at Years 1, 2, and 7 within NE.
Overview

Job rank, social status in the workplace, the amount of control over one's work is all contributing factors that support a healthier population. Poor health is associated with those who are unemployed, people with lower incomes or those who are under employed.  

Employment & Unemployment

Table 13.6 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

<table>
<thead>
<tr>
<th>Districts</th>
<th>Employment Rate 15 Years and Over</th>
<th>Unemployment Rate 15 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blue Water</td>
<td>48.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>70.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>70.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Springfield</td>
<td>79.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td><strong>Northern Remote</strong></td>
<td><strong>32.9</strong></td>
<td><strong>28.9</strong></td>
</tr>
</tbody>
</table>


Northern Remote has the lowest employment rate when compared with our other health districts. Females have a lower percentage of employment than males. Males have a higher unemployment rate than females.
Social Economic Status

There is considerable research to support the relationship between an individual’s health status and their socioeconomic status.¹¹

Median Family Income

The following tables describe the median family income and the median family income for lone parent families in Northern Remote Health District communities, North Eastman and Manitoba.

Table 13.7 Median Family Income

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Remote</td>
<td>$ 23,104</td>
</tr>
<tr>
<td>North Eastman</td>
<td>$ 52,938</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 55,885</td>
</tr>
</tbody>
</table>

Sources:

It appears that Northern Remote families have a considerably lower income than NE families as a whole and Manitoba overall.

Table 13.8 Median Family Income of Lone Parents – Males and Females

<table>
<thead>
<tr>
<th>District</th>
<th>Median Family Income Lone Male Parent Family</th>
<th>Median Family Income Lone Female Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>$ 40,087</td>
<td>$ 36,865</td>
</tr>
<tr>
<td>Blue Water</td>
<td>$ 23,892</td>
<td>$ 17,058</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>no data</td>
<td>$ 29,378</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>$ 45,361</td>
<td>$ 26,118</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>$ 35,698</td>
<td>$ 26,280</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>$ 9,248</td>
<td>$ 12,587</td>
</tr>
</tbody>
</table>


Lone parent male families have a lower income than lone parent female families. This is a reversal of the other health districts, as usually males have the higher income. Both lone parent male and female families have the lowest income when compared with our other health districts.

Female lone parent families have a higher income than do male lone parent families.
Table 13.9 Median Family Income Lone Parent Families Male & Female for NE

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Family Income Lone Parent Families Male And Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastman</td>
<td>$ 22,562</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 26,469</td>
</tr>
</tbody>
</table>


This table looks at males and females combined as an example of NE and Manitoba incomes.

**Total Low Income Incidence**

There is no information for incidence of low income in 2000 in Northern Remote. 52

**Personal Resources as a Health Determinant**

[Social Support Network] 53

“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” 54

**Overview**

Support from families, friends and communities positively influence health status. It is important when planning programs and discussing healthy communities, that safety, tolerance and a place for social interaction are included, as these all support a strong social network. 55

**Mental Emotional Health**

Mental health was raised as an important concern for many NE residents, particularly in the area of services, stress, unemployment, isolation, alcohol and drug abuse in the 1998 CHA Report.

*Mental Health Programming is discussed under the NEHA Mental Health Program.- Section 7.*
Social Support

Table 13.10 Total Number of Couple Families by Family Structure / Total Lone Parent Families

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Number Of Couple Families [married and common law]</th>
<th>Number Of Lone Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>3,385</td>
<td>255</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>Iron Rose</td>
<td>840</td>
<td>55</td>
</tr>
<tr>
<td>Winnipeg River</td>
<td>1400</td>
<td>165</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>1725</td>
<td>225</td>
</tr>
<tr>
<td>Northern Remote</td>
<td>410</td>
<td>185</td>
</tr>
<tr>
<td>Blue Water</td>
<td>1,970</td>
<td>505</td>
</tr>
<tr>
<td>North Eastman</td>
<td>9,735</td>
<td>1,380</td>
</tr>
</tbody>
</table>

Sources:

All families need support, but we know that there is the potential for lone parent families to have less support and that they may be more economically disadvantaged than two parent households.
13.5 PARTNERSHIP SUPPORT

North Eastman Health Association Partnering Process with Aboriginal Communities

North Eastman Health Association (NEHA) has developed and sustained several processes to partner with Aboriginal communities. Our goal has been to better understand the needs of the population, identify gaps and barriers in providing service and develop ways in which to provide programming that is mutually agreed upon. Ultimately, our approach has been one of partnership. The following will briefly describe our existing processes.

Northern Communities Wellness Coalition (formerly Northern Health Planning Team)

This is a well-established group that meets on a regular basis. The group has planned and implemented some successful initiatives such as: planting a community garden; Moms, Dads and Tots group which is a partnership with the Blue Water Prenatal Team, The Canadian Prenatal Nutrition Program, Child and Family Services and a girls group which focuses on self-esteem and includes a babysitting course. The membership representatives from NEHA are typically front-line workers.

_Northern Communities Wellness Coalition- Terms of Reference_

**Purpose:** To develop a plan for northern community health in collaboration with area residents based on an understanding of the needs of the residents.

**Roles and Responsibilities:**

1. To develop an understanding of the strengths needs and opportunities related to the health and wellness of residents living in the northern areas of North Eastman Region.
2. To develop an understanding of the role that the 'determinants of health' plays in improving the health and wellness status of residents living in the northern areas of North Eastman Region.
3. To develop collaborative partnerships in the development of strategies to improve the health of the population.

**Membership:** may include but is not necessarily limited to the following:

- Community residents from surrounding area
- North Eastman Health Association
- Public Health
- Mental Health
- Diabetes Education Resource Team
- Aboriginal Interpreter
- Primary Health Care - Wellness Program
- Child and Family Services
- Recreation
- Education
- CPNP
- Representatives from community council/Baby First

**Review:** Yearly
Northern Health Steering Committee

This committee was established approximately two years ago. The purpose of the group has been to better understand service needs, share information about programs and organizational structure, identify gaps in services, discuss jurisdictional issues and develop ways in which we can work together to improve the health status of our northern and aboriginal population. Membership includes the Health Coordinator from Southeast Resource Development Council (SERDC), leaders from northern communities, including First Nations, and Program Managers/ Senior Management from NEHA.

Diabetes Planning Strategies

The Diabetes Education Resource (DER) has provided outreach services to the community of Berens River via Tele-health for several years, as well as providing support to the community of Poplar River in the form of a workshop. The Registered Dietitian provides support to Sagkeeng First Nation community, which is reciprocated by the Diabetes Nurse from Sagkeeng providing support to clients in the Northern Remote District. This partnership has had a significant positive impact on clients and communities in general.

A Regional Diabetes Steering Committee was struck to review the document, “Diabetes: A Manitoba Strategy” and has continued to meet to develop a regional Diabetes Program framework. This committee has representation from Sagkeeng FN, Black River FN, SERDC, as well as, non-aboriginal communities.

Board Membership and District Health Advisory Membership (DHAC)

The Board recognizes the importance of having Aboriginal representation and there is currently one Board member from Seymourville and one from Hollow Water FN. The Board continues to actively recruit Board and DHAC members from the Northern/Aboriginal communities.

The Northern Communities Wellness Coalition, the Northern Health Steering Committee and the Diabetes Steering Committee provide for excellent community consultation opportunities as well as advice to the Region. Information from these committees is shared with the Board, the District Health Advisory Councils and staff on a frequent basis.

Aboriginal Liaison/Interpreter

This position has been in existence in the Region for many years. Primarily, the role of this position is to assist the care team in providing comprehensive health service to Aboriginal clients at the Pine Falls Health Complex. There is emphasis on assisting with language, cultural differences, and client advocacy. There is also an outreach component to this position to facilitate communications between the facility and the community.
Aboriginal Liaison Worker/Co-ordinator

Currently there is not a dedicated position in NEHA for this purpose. Our previous Health Plan submissions to Manitoba Health have included a proposal for this new initiative. The proposal will be revisited once again as part of our Aboriginal Health Strategy. In order to initiate and sustain the proposed action under the direction of the Regional Steering Committee the Aboriginal Coordinator position will need to be filled in 2004-2005.

Communication with Southeast Resource Development Council (SERDC)

The CEO and VP Programs and Services have developed a good working relationship with the Health Coordinator for the SERDC. Meetings are held on a regular basis to keep each partner informed as to initiatives related to health and to plan for action.

Aboriginal Employment Coordinator

Consistent with our stated value of recognizing and respecting people’s ethnic and cultural heritage, NEHA has entered into a one year partnership agreement with the Aboriginal and Northern Affairs and Manitoba Advanced Education and Training (Employment and Training Services Branch). An Aboriginal Coordinator was hired to assist in developing an Aboriginal Employment Plan for the region.

The initial phase of this project requires that a portion of time be focused on initial research and the assessment of the research material. NEHA plans to focus on activities that will concentrate on recruitment, retention, education and awareness.

The outcome of this project will be a report on the Aboriginal Employment Strategy for NEHA. The report will include the initial plan recommendations, implemented components, and evaluation. It will also include the recommendations of a long-term plan beyond this project year. As a result of this initiative, it is anticipated that NEHA will improve the recruitment and retention of Aboriginal employees within the organization. The long-term initiative is to increase employment of Aboriginals in health care that is more representative of the population in our region.
Proposed Action

"To develop a Regional Steering Committee that will lead the process of developing/writing a Region-specific Aboriginal Health Strategy. This process will include:

- Identify key stakeholders that will partner with NEHA in the development of the Strategy.
- Develop Terms of Reference for the Steering Committee.
- Ensure that membership includes decision-makers/leaders from Aboriginal communities and the North Eastman Health Association Inc.
- Articulate the shared vision for Aboriginal Health.
- Develop protocols for working collaboratively with Aboriginal partners.
- Research and review all available data regarding the health status of Aboriginal people living in the North Eastman region as compared with other jurisdictions in Manitoba.
- Utilize Community Health Assessment information in relation to Aboriginal health status and services.
- Identify priorities for action and validating these priorities with Aboriginal groups.
- Identify the goals, objectives and proposed actions, including responsibilities.
- Develop a draft health strategy and circulate it to stakeholders for feedback.
- Finalize the North Eastman Region Aboriginal Health Strategy.
- Submit the strategy to Manitoba Health and stakeholders for approval and implementation.
- Develop performance measures to monitor and evaluate the quality and effectiveness of the strategy.

Potential Partners

- Southeast Resource Development Council
- Sagkeeng First Nations community (independent)
- Manitoba Metis Federation (regional office Grand Marais)
- Band Councils and/or Health portfolio designates
- First Nations and Inuit Health Branch representative
- Manitoba Health Aboriginal Unit representative."
13.6 SUMMARY / CONCLUSION

Summaries will be based on the most current year discussed in the report.

NE is partnering with the Northern Wellness Coalition in a collaborative partnership in the development of strategies to improve the health of the Aboriginal population.

COMMUNITY SYSTEM CHARACTERISTICS

Boundaries

Geographical - Since the 1998 CHA Report, there have been boundary changes most prominently related to the northern areas. Unorganized Territories were originally separated and are now incorporated into Northern Remote, Blue Water, Iron Rose and Winnipeg River health districts. Northern Remote is designated as a health district.

Health Services - Apart from geographical boundaries, there are also health service boundaries. The federal government is responsible for the majority of residents in Northern Remote health districts' health care.

Population

Northern Remote has is a very young population with growth occurring in almost all age groups up until 54 years.

From 1999 to 2002, there has been a fairly stable birth rate, with a decline occurring in 2002-2003 due to boundary changes.

HEALTH STATUS

Measuring Overall Health Status

The social economic factor index (SEFI) value and premature mortality rates (PMR) both are important overall measurements of health status. It must be noted that the most current SEFI value is from 1996 and many indicators have data more recent than this, so it is important to review all health indicators to determine areas of concern. Northern Remote appears to have the worst SEFI value in NE and appears worse than both Manitoba and Rural South. It will be interesting to note future SEFI values to ensure that this value continues to improve.
PMR is statistically significantly higher than the Manitoba rate. This needs to be monitored as it is a measurement of overall general health status and implies that there may be a need for more health services including preventative services.

Deaths

Northern Remote's total mortality rate is the highest in our region, and is significantly higher than Manitoba.

Northern Remote's PYLL value is statistically significantly higher than Manitoba and is also the highest within NE. This suggests that there are an increasing number of early deaths in the population.

Life Expectancy

Females live longer than males by approximately eight years. Life expectancy for both males and females appears to be less than Manitoba and Rural South.

HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>There has been no significant change in new cancer rates.</td>
<td>Diabetes prevalence is significantly higher than Manitoba and Rural South, and is the highest in NE.</td>
<td>Respiratory diagnoses have shown a significant decrease, and are significantly lower than Manitoba.</td>
<td>Hypertension treatment is not significantly different than Manitoba.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI</th>
<th>Stroke</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI treatment has decreased, but is not a significant difference, but is the second highest in NE.</td>
<td>Stroke treatment has declined, but not significantly, and is the highest in NE.</td>
<td>Injury hospitalization is the highest within NE and has shown a statistically significant decrease. When compared with Manitoba, hospitalization is significantly higher. Injury hospitalizations appear to be higher than Rural South.</td>
</tr>
</tbody>
</table>

Diabetes – Diabetes can affect an individual’s quality of life and can be a considerable financial burden, therefore, we must not only manage, but also prevent diabetes. The data presented suggests that diabetes is increasing, but not significantly, but it is significantly higher than both Manitoba and Rural South. This indicates the need for a population approach; that is activities that encompass prevention, education, care, research and support targeting the general population. It also requires monitoring of clients with diabetes to ensure good control of the illness in order to prevent other risks. An evaluation of current resources may also be considered.
Respiratory - There may be some under diagnosing of respiratory disease.

Injuries - Injuries are preventable, and with Northern Remote’s high rates of injury, this is an area of concern, not only because of the loss of productivity that occurs in a community but the high health care costs associated with hospitalization. Injury prevention requires strategies with other community partners.

DETERMINANTS OF HEALTH

Environmental Factors

Safety – The total reported crime rate has increased in 2002 as compared with 2001, and is considerably higher overall when compared with our other health districts. Traffic injuries have decreased slightly.

Personal Health Practices

Dietary – Obesity is a national concern.

Physical Activity – According to the provincial survey, approximately half of respondents were not physically active.

Medication Use

Prescriptions - The number of residents with at least one prescription use showed a significant increase in Northern Remote. There may be some incomplete recording of pharmaceuticals dispensed.

Antibiotics - Northern Remote residents receiving at least one antibiotic prescription showed a decrease, however the average number of prescriptions prescribed to residents who already had received at least one antibiotic had increased. These were not significant changes. Antibiotic use is significantly lower than both Manitoba and Rural South. This may be due to incomplete recording.

Antidepressants - Antidepressant prescriptions have increased, but not significantly and are the lowest in NE. This may be due to incomplete recording.
Healthy Child

**Infant Mortality Rates** - Rates were suppressed for the second time period in Northern Remote. This is an area to continue to monitor as this is a useful indicator overall in measuring the well being of an area.

**Adolescent & Teenage Pregnancy** - Northern Remote health district has one of the highest teen pregnancy rates in the province. It is significantly higher at 197/1000 compared with Manitoba at 61/1000.

**Breastfeeding Initiation** – Northern Remote breast feeding initiation rates are among the lowest in NE, and are significantly lower than Manitoba.

**Birth Weights** - Northern Remote’s high and low birth weights are not significantly different than the Manitoba average. This is an important area to continue to monitor as birth weights have potential implications associated with the future health of our children and potential burden on health services. Pre-term births have not changed significantly and are the second highest in NE.

**Immunizations** – Northern Remote has the lowest coverage of completed immunizations at Years 1,2, and 7 within NE and is statistically significantly lower than Manitoba. Vaccination is a cost-effective way to prevent illness and decrease costs to the health system. It would be interesting to determine the reasons for low immunization rates experienced in the Northern Remote health district. Blue Water and Northern Remote health districts would benefit from reviewing strategies on how to increase immunization rates, as we know, generally they have an overall poorer health status than other health districts.

Living and Working Conditions

**Work** - Northern Remote had the lowest employment rate for both males and females when compared with our other health districts.

**Economic Status** - The overall median income in 2000 was lower than NE and Manitoba overall. Northern Remote has the lowest lone parent median family income when compared with other health districts. Northern Remote is the only health district where lone parent female families have a higher income at $ 12,587 than males at $9,248.

Personal Resources

**Social Support** - There were approximately 185 lone parent families reported in Northern Remote during the 2001 census.
Summary At A Glance

The federal government is responsible for the provision of health services for the majority of residents living in Northern Remote Health District.

**KEY**
- **Partner:** implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department.
- **Monitor:** refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA:** is committed to addressing the issues identified below for those with in its jurisdiction and also committed to working collaboratively with the federal government in it delivery of health services.

### Strengths
- New cancer cases have remained the same. [Monitor]
- Respiratory disease has decreased significantly, and is significantly lower than Manitoba. This needs to be reviewed with caution, as there could be some under diagnosing. [Monitor]
- Traffic injuries have decreased slightly. [Monitor]
- Infant mortality rates were suppressed. [Monitor]
- High and low birth weights are not significantly different than the Manitoba average. [Monitor]

### Issues Having Implications for Health Planning & Delivery
- Appears to have the worst SEFI value in NE and is worse than Manitoba and Rural South.
- Life expectancy for both males and females appear to be less than Manitoba and Rural South.
- Diabetes treatment increased but not significantly however it is significantly higher than Manitoba and Rural South.
- Stroke treatment has declined and is the highest in NE.
- Teen pregnancy rate is one of the highest in the province and is significantly higher than Manitoba. [NEHA, Monitor]
- Breast feeding initiation rate is the lowest in NE and is significantly lower than Manitoba. [NEHA, Monitor]
- Pre-term births have not changed significantly, but are the second highest in NE. [NEHA, Monitor]
- Childhood immunization coverage is significantly lower than the Manitoba average and is the lowest in NE. [NEHA, Monitor]
- This is a young population. [NEHA, Partner]
- Lowest employment rate within NE. [Partner, Monitor]
- Overall median income was lower than NE and Manitoba overall. [Partner, Monitor]
- Lowest lone parent income in NE. [Partner, Monitor]
- PMR is statistically significantly higher than Manitoba. [NEHA, Partner, Monitor]
- Total mortality rates are the highest in NE and are significantly higher than Manitoba. [NEHA, Partner, Monitor]
- PYLL value is statistically higher than Manitoba. [NEHA, Partner, Monitor]
KEY

- **Partner**: implies that if this is an action by NEHA it will require partnering with a community group/agency/department.
- **Monitor**: refers to an area of possible concern. Monitoring will ensure it isn’t missed if it changes.
- **NEHA**: Is committed to addressing the issues identified below for those within its jurisdiction and also committed to working collaboratively with the federal government in the delivery of health services.

<table>
<thead>
<tr>
<th>Issues Having Implications for Health Planning &amp; Delivery Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypertension treatment is not significantly different than Manitoba, but is the highest in NE. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>• MI treatment has decreased, but is not a significant difference, but is second highest in NE. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>• Injury hospitalizations have shown a significant decrease but are the highest in NE and are statistically significantly higher than Manitoba. [NEHA, Partner, Monitor]</td>
</tr>
<tr>
<td>• Obesity is a national concern. [NEHA, Partner, Monitor]</td>
</tr>
</tbody>
</table>

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.
13.7 REFERENCES

14.1 OVERVIEW ................................................................. 14-1

14.2 SUMMARY OF SOME REGIONAL STRENGTHS ......................... 14-1

14.3 SUMMARY OF SOME HEALTH DISTRICT SPECIFIC STRENGTHS ...... 14-2

14.3.1 SPRINGFIELD HEALTH DISTRICT ..................................... 14-2
14.3.2 BROKENHEAD HEALTH DISTRICT .................................... 14-2
14.3.3 IRON ROSE HEALTH DISTRICT ......................................... 14-2
14.3.4 WINNIPEG RIVER HEALTH DISTRICT ............................... 14-3
14.3.5 BLUE WATER HEALTH DISTRICT ...................................... 14-3
14.3.6 NORTHERN REMOTE HEALTH DISTRICT ......................... 14-3

14.4 COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS
ON HEALTH PLANNING AND DELIVERY ..................................... 14-3

14.4.1 Issues and Trends .......................................................... 14-4
14.4.2 Suggestions Raised by Residents During Community
Consultations ............................................................................. 14-8

14.5 FURTHER RESEARCH .......................................................... 14-9

14.6 CONCLUSION ....................................................................... 14-10
14.1 OVERVIEW

North Eastman is a diverse region geographically, politically and demographically. Information is reported at the macro level i.e. regionally and at the micro level within our six health districts in order to reflect this diversity.

14.2 SUMMARY OF SOME REGIONAL STRENGTHS

- Focus groups, 2003 Acumen surveys and program surveys overall felt that NEHA services were excellent / very good.

- Public influenza immunization clinics saw an increase over the past 4 years, an indicator of residents taking charge of their health, in order to prevent illness.

- Prescribed medications are increasing significantly in NE, but are lower than the Manitoba average.

- Antibiotic prescriptions are unchanged and are significantly lower than the Manitoba average.

- High and low birth weights are not significantly different than the Manitoba average.

- Median income was slightly higher in NE as compared with Manitoba. We know that income has an effect on health status.

- Over 99% of residents surveyed had a regular health care provider. It is important for health consumers to have someone they can go to who is familiar with their care.
14.3 SUMMARY OF SOME HEALTH DISTRICT SPECIFIC STRENGTHS

14.3.1 Springfield Health District

- Premature Mortality Rate is the lowest in NE.
- Mortality rates are the lowest in NE and are lower than the Manitoba average.
- The number of new cancer cases is declining.
- Breastfeeding initiation rate is at 88%.
- Childhood immunization coverage is the highest in NE.
- In 2001 Springfield had the highest employment rate in NE.
- In 2001 Springfield had the highest median income when compared with our other health districts and surpasses Manitoba & Rural South.
- Antibiotic use is significantly lower than the Manitoba average.
- Teen pregnancy rates have not changed and are lower than the Manitoba average.

14.3.2 Brokenhead Health District

- Premature Mortality rate has increased slightly, but not significantly.
- New cancer cases have not changed significantly and are close to the Manitoba average.
- Diabetes treatment is increasing but not significantly, and is close to the Manitoba average, but not significantly different.
- Hypertension treatment has increased, but not significantly.
- Hospital treatment for MI's has decreased significantly.
- Injury hospitalization has decreased significantly.
- Teenage pregnancy rates have not changed, and the rate is significantly lower than Manitoba.

14.3.3 Iron Rose Health District

- Premature Mortality Rate has decreased, but not significantly.
- MI hospital treatment has shown no significant change.
- New cancer cases have increased, but not significantly and are not significantly different than Manitoba.
- Teen pregnancy rates have not changed and are significantly lower than Manitoba.
- Childhood immunization coverage was not significantly different than the Manitoba average.
- Employment rate is second highest in NE. There are concerns about youth not getting employed in the area.
14.3.4 Winnipeg River Health District

- Birth rate is lower than NE and Manitoba.
- Diabetes treatment has increased, but not significantly and is significantly lower than Manitoba and Rural South.
- Respiratory treatment diagnoses is significantly lower than the Manitoba average.
- There has been a significant decrease in antibiotic prescriptions.
- There is a higher median family income than NE overall.
- Breastfeeding initiation had significantly increased and is significantly higher than Manitoba.

14.3.5 Blue Water Health District

- Total mortality rate has decreased but not significantly, and is not significantly different than the Manitoba average.
- New cancer cases have decreased, but not significantly and appear to be similar to the Manitoba average.
- Stroke treatment has declined but not significantly and appears to be similar to the Manitoba average.

14.3.6 Northern Remote Health District

- New cancer cases have remained the same.
- Traffic injuries have decreased slightly.
- High and low birth weights are not significantly different than the Manitoba average.

14.4 COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS ON HEALTH PLANNING & DELIVERY

The following information highlights some issues or trends that emerged consistently regionally, or within health districts from the quantitative data or through community consultations. This is not meant to be a comprehensive list. The reader is asked to refer to each chapter for the details. It also includes a summary of suggestions generated from focus group and validation workshop participants and survey respondents.
14.4.1 Issues and Trends

Manitoba’s Health Performance Measurement Framework

**COMMUNITY CHARACTERISTICS**

There is a consistent increase in our elderly population in the region and within all health districts except for Northern Remote. Northern Remote has a very young population.

Thirty-six percent of our population have less than a high school education.

**HEALTH STATUS**

Regionally NE’s Social Economic Factor Index value appears to be better than Manitoba’s overall, however there are clear health district differences, the poorest value being in the Northern Remote Health District. Fifty – six percent of Acumen survey respondents told us that their health is excellent or very good.

From a health status perspective with respect to premature mortality rate, life expectancy and PYLL we see the disparity in health status among our health districts within North Eastman:

<table>
<thead>
<tr>
<th>Best Health Status</th>
<th>Poorest Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td>Winnipeg River</td>
</tr>
<tr>
<td>Brokenhead</td>
<td>Iron Rose</td>
</tr>
<tr>
<td>Blue Water</td>
<td>Northern Remote</td>
</tr>
</tbody>
</table>

**Deaths**

- Premature Mortality Rate (PMR) is the single best measure that reflects the health status of a population. PMR has increased regionally although not significantly, and is significantly higher than Manitoba and Rural South.

- The leading causes of death are due to circulatory disease and cancers. The third leading cause of death is due to injuries, which were significantly higher than the Manitoba average.
Health Conditions

- Diabetes is showing a significant increase in NE overall. This is especially significant in Blue Water and Northern Remote Health Districts where it is significantly higher than the Manitoba average and Rural South.

- Hypertension has increased in NE and is significantly higher than the Manitoba average.

- Types of injuries being hospitalized were due to: falls, motor vehicle traffic and assault and self inflicted. Traffic injuries and deaths have increased especially in Springfield and Brokenhead. Injury hospitalizations in Blue Water and Northern Remote are both significantly higher than the Manitoba average and Rural South.

DETERMINANTS OF HEALTH

Personal Health Practices

- Approximately one-quarter of our residents are still smoking.

- Antidepressant use is increasing in all NE health districts. This is a similar trend throughout Manitoba.

- Youth in all focus groups expressed concerns about alcohol use not only in their age group, but within the adult population as well.

- Illicit drug use was raised as a concern by youth in some focus groups.

- Obesity is a national concern. In NE, over half of males and females surveyed self-reported (using the body mass index (BMI) as a measure) to be either overweight or obese.

Healthy Child Development

- Immunization coverage in NE overall appears to be decreasing, and is especially low in Northern Remote and Blue Water health districts.

- Causes of hospitalization in children are falls in early childhood while self inflicted and motor vehicle accidents are the major cause in older children.
• While teenage pregnancy rates have not changed significantly overall in NE, Blue Water and Northern Remote's rate is significantly higher than the Manitoba average and Rural South.

• Breastfeeding initiation rates are lower than the Manitoba average in Northern Remote and Blue Water health districts.

• ‘Nothing to do’ say our youth in all health districts.

Environmental

• Water concerns were expressed in Springfield, Brokenhead, Winnipeg River, Blue Water and Iron Rose. There are boil water advisories in some communities in Brokenhead and Springfield.

Living & Working Conditions

• Unemployment in NE is slightly higher than in Manitoba overall in 2001.

**HEALTH SYSTEM CHARACTERISTICS, PERFORMANCE & INFRASTRUCTURE**

Overall there has been a positive response from those consulted regarding the overall health programs provided by NEHA.

• Two out of five residents surveyed did not know where to go to address a health concern.

• NE visits for ambulatory consultations have increased significantly overall. Residents would like to see more visiting specialists come to NE.

• Staff influenza immunization rates are increasing, but there is need for improvement.

• ER visits are increasing consistently over the past few years. There were voiced concerns about accessing physicians and services at some emergency rooms.

• Many residents felt that there is a lack of physicians and that physician retention needs to be addressed.
• Accessibility was a concern raised by some focus group participants especially when some health services were not available here. Travelling to Winnipeg was often felt to be stressful.

• Overall, waiting times to get an appointment or while in a clinic were seen as unacceptable. Thirty-three percent of those surveyed felt that they had difficult accessing a health care provider.

• Lack of access to health services after hours and on weekends was a consistent concern voiced.

• Timely access to some diagnostic services such as ultrasound and MRI's was a concern raised.

• Regionally breastfeeding initiation rates have increased to 69.1%, but are significantly lower than the Manitoba average. When we look at the health districts we find that Springfield and Winnipeg River were significantly higher than the provincial and Rural South rate.

• Breast cancer screening rates in NE are increasing and achieved 54% between 2001 to 2003, in the 50-69 age group. The desired target is 70%.

• Diabetes, Asthma, Essential Hypertension and Neurotic Disorders were treated in our hospitals where there was a possibility they could have been managed in a clinic setting.

• The need for more PCH beds was raised as a need in Winnipeg River, Blue Water and Springfield.

• Issues surrounding EMS by focus group participants and staff include: long arrival times, cost of transport, rough ride, need for more staff and some confusion about 911.

• Slight increases in some communicable reportable diseases in NE overall: Chlamydia, Gonorrhea, Salmonellosis, E. Coli and TB.

• More women in NE are going for PAP tests, however the rates in NE are significantly lower than the Manitoba average. This is particularly significant in Iron Rose and Blue Water.

• Youth and some adults would like to see a higher visibility of public health nurses in the schools.
14.4.2 Suggestions Raised By Residents During Community Consultation
(Survey, Focus Groups, and Validation Workshops).

- Standardize the cost to services (housecleaning, yard maintenance, driver/transportation) that seniors may require.
- Support services that are deemed for seniors should be available to other people who may need it regardless of age. “A community [service] program rather than a seniors program.”
- Promote bicycle use and safety.
- More independent living units.
- Youth in Brokenhead would like more education / information on eating disorders.
- Youth in Winnipeg River would like to see the AFM counselor around more.
- Youth in Blue Water would like to see more attention given to drug use.
- Youth in Seymourville and Brokenhead would like more reproductive information available in smaller communities and the information reviewed again when kids get older.
- Combine physical prevention clinics e.g. blood pressure clinic with mental health discussions.
- More child care in Whitemouth.
- Expand Speech and Language Pathology for children and audiologist services.
- Would like to see chemotherapy service in NE.
- More public awareness about community and health related programs, services and supports.
- Longer hours at health centres and/or walk in clinics.
- Nurse practitioners were viewed as a good option to improve the efficiency of physician’s time.
- More physicians.
- Minor surgery should be more available.
- Mental health concerns focused on the need for more community supports. The issue of stigma when accessing services and the need to identify members of the community who are at risk were also flagged as some areas focus group participants were concerned about.
- Services must be adapted to the community needs.
• Continue 911 awareness to communities who have this service.
• Difficulty in getting to health services for people living in more isolated communities who had limited access to transportation, people without cars and travelling outside of the region for services often depending upon other family members were access issues raised by some focus group participants.

14.5 FURTHER RESEARCH

Information is being generated continuously as communities are dynamic by nature. It is important that information is reviewed and distributed to appropriate programs for interpretation. NE is collecting its own indicator data from a strategic and operational perspective. The ability to access information allows programs to respond quickly to any arising need.

Collaboration empowers communities to seek better and alternative ways to improve the health of a population. To this end, seeking ways to increase community interest and subsequently participation in attending consultation meetings is an area that could be addressed.

A Few Specific Areas to be considered for further research / analysis

• Recreational facilities and opportunities especially by youth.
• Alcohol and drug use – what types of concerns need to be addressed by communities?
• Traffic accidents – how to ensure all preventive strategies and defensive practices are being utilized.
• Fall prevention particularly in young children and the elderly.
• Transportation issues – meeting the needs of isolated communities and those without access to a car.
• How to involve and reach at risk communities and people.
• Timely physician access and retention.
• Investigate concerns youth had about weapons in Springfield.
• Immunization rates – why they are decreasing especially at age 7.
14.6 CONCLUSION

A comprehensive multi-sectoral approach to health planning ensures success in achieving “better health for all.” It is anticipated that the information contained in this report will assist in justifying and supporting future health service plans.

Work undertaken since the 1998 CHA continues to be addressed, pursued further, as the updating of the information indicates many of the same issues and trends are still present today for example:

- The three population subgroups whose members are at particular risk for poor health outcomes – children and youth, seniors, and aboriginal people.

- Major themes that continue to emerge include:
  - Mental health and social issues for example: stigma associated with accessing mental health services, isolation and emotional wellbeing.
  - Housing in particular transitional housing and more PCH beds.
  - Rural disparity in service delivery and services.
  - Lack of access to after hours physician care resulting in high use of the emergency department for non-urgent issues.
  - Lack of sufficient health care providers and specialists.
  - Lack of structured recreational options for youth and adults.

The ability to address and/or sustain and enhance initiatives currently underway requires additional resources. This report has identified the needs brought forward by community consultation as well as evidence based data.

NE looks forward to the results of the Manitoba Centre for Health Policy deliverable that will look at our population needs and make subsequent recommendations for funding based on the identified needs.

“The challenges to the region are broad, ranging from significant health issues of the residents of the region and the scarcity of both fiscal and human resources.”

---

1 NEHA Strategic Plan 2002-2006 pg. 3.
14.1 OVERVIEW ................................................................. 14-1
14.2 SUMMARY OF SOME REGIONAL STRENGTHS .......... 14-1
14.3 SUMMARY OF SOME HEALTH DISTRICT SPECIFIC STRENGTHS .......... 14-2
   14.3.1 SPRINGFIELD HEALTH DISTRICT .................. 14-2
   14.3.2 BROKENHEAD HEALTH DISTRICT .................. 14-2
   14.3.3 IRON ROSE HEALTH DISTRICT ....................... 14-2
   14.3.4 WINNIPEG RIVER HEALTH DISTRICT ............... 14-3
   14.3.5 BLUE WATER HEALTH DISTRICT .................... 14-3
   14.3.6 NORTHERN REMOTE HEALTH DISTRICT .......... 14-3
14.4 COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS ON HEALTH PLANNING AND DELIVERY .......... 14-3
   14.4.1 Issues and Trends ........................................ 14-4
   14.4.2 Suggestions Raised by Residents During Community Consultations ........................................ 14-8
14.5 FURTHER RESEARCH .................................................. 14-9
14.6 CONCLUSION .......................................................... 14-10
14.1 OVERVIEW

North Eastman is a diverse region geographically, politically and demographically. Information is reported at the macro level i.e. regionally and at the micro level within our six health districts in order to reflect this diversity.

14.2 SUMMARY OF SOME REGIONAL STRENGTHS

- Focus groups, 2003 Acumen surveys and program surveys overall felt that NEHA services were excellent / very good.
- Public influenza immunization clinics saw an increase over the past 4 years, an indicator of residents taking charge of their health, in order to prevent illness.
- Prescribed medications are increasing significantly in NE, but are lower than the Manitoba average.
- Antibiotic prescriptions are unchanged and are significantly lower than the Manitoba average.
- High and low birth weights are not significantly different than the Manitoba average.
- Median income was slightly higher in NE as compared with Manitoba. We know that income has an effect on health status.
- Over 99% of residents surveyed had a regular health care provider. It is important for health consumers to have someone they can go to who is familiar with their care.
14.3 SUMMARY OF SOME HEALTH DISTRICT SPECIFIC STRENGTHS

14.3.1 Springfield Health District

- Premature Mortality Rate is the lowest in NE.
- Mortality rates are the lowest in NE and are lower than the Manitoba average.
- The number of new cancer cases is declining.
- Breastfeeding initiation rate is at 88%.
- Childhood immunization coverage is the highest in NE.
- In 2001 Springfield had the highest employment rate in NE.
- In 2001 Springfield had the highest median income when compared with our other health districts and surpasses Manitoba & Rural South.
- Antibiotic use is significantly lower than the Manitoba average.
- Teenage pregnancy rates have not changed and are lower than the Manitoba average.

14.3.2 Brokenhead Health District

- Premature Mortality rate has increased slightly, but not significantly.
- New cancer cases have not changed significantly and are close to the Manitoba average.
- Diabetes treatment is increasing but not significantly, and is close to the Manitoba average, but not significantly different.
- Hypertension treatment has increased, but not significantly.
- Hospital treatment for MI's has decreased significantly.
- Injury hospitalization has decreased significantly.
- Teenage pregnancy rates have not changed, and the rate is significantly lower than Manitoba.

14.3.3 Iron Rose Health District

- Premature Mortality Rate has decreased, but not significantly.
- MI hospital treatment has shown no significant change.
- New cancer cases have increased, but not significantly and are not significantly different than Manitoba.
- Teen pregnancy rates have not changed and are significantly lower than Manitoba.
- Childhood immunization coverage was not significantly different than the Manitoba average.
- Employment rate is second highest in NE. There are concerns about youth not getting employed in the area.
14.3.4 Winnipeg River Health District

- Birth rate is lower than NE and Manitoba.
- Diabetes treatment has increased, but not significantly and is significantly lower than Manitoba and Rural South.
- Respiratory treatment diagnoses is significantly lower than the Manitoba average.
- There has been a significant decrease in antibiotic prescriptions.
- There is a higher median family income than NE overall.
- Breastfeeding initiation had significantly increased and is significantly higher than Manitoba.

14.3.5 Blue Water Health District

- Total mortality rate has decreased but not significantly, and is not significantly different than the Manitoba average.
- New cancer cases have decreased, but not significantly and appear to be similar to the Manitoba average.
- Stroke treatment has declined but not significantly and appears to be similar to the Manitoba average.

14.3.6 Northern Remote Health District

- New cancer cases have remained the same.
- Traffic injuries have decreased slightly.
- High and low birth weights are not significantly different than the Manitoba average.

14.4 COMMONLY RAISED ISSUES OR TRENDS THAT HAVE IMPLICATIONS ON HEALTH PLANNING & DELIVERY

The following information highlights some issues or trends that emerged consistently regionally, or within health districts from the quantitative data or through community consultations. This is not meant to be a comprehensive list. The reader is asked to refer to each chapter for the details. It also includes a summary of suggestions generated from focus group and validation workshop participants and survey respondents.
14.4.1 Issues and Trends

Manitoba’s Health Performance Measurement Framework

COMMUNITY CHARACTERISTICS

There is a consistent increase in our elderly population in the region and within all health districts except for Northern Remote. Northern Remote has a very young population.

Thirty-six percent of our population have less than a high school education.

HEALTH STATUS

Regionally NE’s Social Economic Factor Index value appears to be better than Manitoba’s overall, however there are clear health district differences, the poorest value being in the Northern Remote Health District. Fifty – six percent of Acumen survey respondents told us that their health is excellent or very good.

From a health status perspective with respect to premature mortality rate, life expectancy and PYLL we see the disparity in health status among our health districts within North Eastman:

<table>
<thead>
<tr>
<th>Best Health Status</th>
<th>Winnipeg River</th>
<th>Brokenhead</th>
<th>Iron Rose</th>
<th>Blue Water</th>
<th>Poorest Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springfield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Northern Remote</td>
</tr>
</tbody>
</table>

Deaths

- Premature Mortality Rate (PMR) is the single best measure that reflects the health status of a population. PMR has increased regionally although not significantly, and is significantly higher than Manitoba and Rural South.

- The leading causes of death are due to circulatory disease and cancers. The third leading cause of death is due to injuries, which were significantly higher than the Manitoba average.
Health Conditions

- Diabetes is showing a significant increase in NE overall. This is especially significant in Blue Water and Northern Remote Health Districts where it is significantly higher than the Manitoba average and Rural South.

- Hypertension has increased in NE and is significantly higher than the Manitoba average.

- Types of injuries being hospitalized were due to: falls, motor vehicle traffic and assault and self inflicted. Traffic injuries and deaths have increased especially in Springfield and Brokenhead. Injury hospitalizations in Blue Water and Northern Remote are both significantly higher than the Manitoba average and Rural South.

Determinants of Health

Personal Health Practices

- Approximately one-quarter of our residents are still smoking.

- Antidepressant use is increasing in all NE health districts. This is a similar trend throughout Manitoba.

- Youth in all focus groups expressed concerns about alcohol use not only in their age group, but within the adult population as well.

- Illicit drug use was raised as a concern by youth in some focus groups.

- Obesity is a national concern. In NE, over half of males and females surveyed self-reported (using the body mass index (BMI) as a measure) to be either overweight or obese.

Healthy Child Development

- Immunization coverage in NE overall appears to be decreasing, and is especially low in Northern Remote and Blue Water health districts.

- Causes of hospitalization in children are falls in early childhood while self inflicted and motor vehicle accidents are the major cause in older children.
• While teenage pregnancy rates have not changed significantly overall in NE, Blue Water and Northern Remote's rate is significantly higher than the Manitoba average and Rural South.

• Breastfeeding initiation rates are lower than the Manitoba average in Northern Remote and Blue Water health districts.

• ‘Nothing to do’ say our youth in all health districts.

*Environmental*

• Water concerns were expressed in Springfield, Brokenhead, Winnipeg River, Blue Water and Iron Rose. There are boil water advisories in some communities in Brokenhead and Springfield.

*Living & Working Conditions*

• Unemployment in NE is slightly higher than in Manitoba overall in 2001.

**HEALTH SYSTEM CHARACTERISTICS, PERFORMANCE & INFRASTRUCTURE**

Overall there has been a positive response from those consulted regarding the overall health programs provided by NEHA.

• Two out of five residents surveyed did not know where to go to address a health concern.

• NE visits for ambulatory consultations have increased significantly overall. Residents would like to see more visiting specialists come to NE.

• Staff influenza immunization rates are increasing, but there is need for improvement.

• ER visits are increasing consistently over the past few years. There were voiced concerns about accessing physicians and services at some emergency rooms.

• Many residents felt that there is a lack of physicians and that physician retention needs to be addressed.
• Accessibility was a concern raised by some focus group participants especially when some health services were not available here. Travelling to Winnipeg was often felt to be stressful.

• Overall, waiting times to get an appointment or while in a clinic were seen as unacceptable. Thirty-three percent of those surveyed felt that they had difficult accessing a health care provider.

• Lack of access to health services after hours and on weekends was a consistent concern voiced.

• Timely access to some diagnostic services such as ultrasound and MRI's was a concern raised.

• Regionally breastfeeding initiation rates have increased to 69.1%, but are significantly lower than the Manitoba average. When we look at the health districts we find that Springfield and Winnipeg River were significantly higher than the provincial and Rural South rate.

• Breast cancer screening rates in NE are increasing and achieved 54% between 2001 to 2003, in the 50-69 age group. The desired target is 70%.

• Diabetes, Asthma, Essential Hypertension and Neurotic Disorders were treated in our hospitals where there was a possibility they could have been managed in a clinic setting.

• The need for more PCH beds was raised as a need in Winnipeg River, Blue Water and Springfield.

• Issues surrounding EMS by focus group participants and staff include: long arrival times, cost of transport, rough ride, need for more staff and some confusion about 911.

• Slight increases in some communicable reportable diseases in NE overall: Chlamydia, Gonorrhea, Salmonellosis, E. Coli and TB.

• More women in NE are going for PAP tests, however the rates in NE are significantly lower than the Manitoba average. This is particularly significant in Iron Rose and Blue Water.

• Youth and some adults would like to see a higher visibility of public health nurses in the schools.
14.4.2 Suggestions Raised By Residents During Community Consultation (Survey, Focus Groups, and Validation Workshops).

- Standardize the cost to services (housecleaning, yard maintenance, driver/transportation) that seniors may require.
- Support services that are deemed for seniors should be available to other people who may need it regardless of age. “A community [service] program rather than a seniors program.”
- Promote bicycle use and safety.
- More independent living units.
- Youth in Brokenhead would like more education / information on eating disorders.
- Youth in Winnipeg River would like to see the AFM counselor around more.
- Youth in Blue Water would like to see more attention given to drug use.
- Youth in Seymourville and Brokenhead would like more reproductive information available in smaller communities and the information reviewed again when kids get older.
- Combine physical prevention clinics e.g. blood pressure clinic with mental health discussions.
- More child care in Whitemouth.
- Expand Speech and Language Pathology for children and audiologist services.
- Would like to see chemotherapy service in NE.
- More public awareness about community and health related programs, services and supports.
- Longer hours at health centres and/or walk in clinics.
- Nurse practitioners were viewed as a good option to improve the efficiency of physician’s time.
- More physicians.
- Minor surgery should be more available.
- Mental health concerns focused on the need for more community supports. The issue of stigma when accessing services and the need to identify members of the community who are at risk were also flagged as some areas focus group participants were concerned about.
- Services must be adapted to the community needs.
• Continue 911 awareness to communities who have this service.

• Difficulty in getting to health services for people living in more isolated communities who had limited access to transportation, people without cars and travelling outside of the region for services often depending upon other family members were access issues raised by some focus group participants.

### 14.5 FURTHER RESEARCH

Information is being generated continuously as communities are dynamic by nature. It is important that information is reviewed and distributed to appropriate programs for interpretation. NE is collecting its own indicator data from a strategic and operational perspective. The ability to access information allows programs to respond quickly to any arising need.

Collaboration empowers communities to seek better and alternative ways to improve the health of a population. To this end, seeking ways to increase community interest and subsequently participation in attending consultation meetings is an area that could be addressed.

**A Few Specific Areas to be considered for further research / analysis**

• Recreational facilities and opportunities especially by youth.
• Alcohol and drug use – what types of concerns need to be addressed by communities?
• Traffic accidents – how to ensure all preventive strategies and defensive practices are being utilized.
• Fall prevention particularly in young children and the elderly.
• Transportation issues – meeting the needs of isolated communities and those without access to a car.
• How to involve and reach at risk communities and people.
• Timely physician access and retention.
• Investigate concerns youth had about weapons in Springfield.
• Immunization rates – why they are decreasing especially at age 7.
14.6 CONCLUSION

A comprehensive multi-sectoral approach to health planning ensures success in achieving “better health for all.” It is anticipated that the information contained in this report will assist in justifying and supporting future health service plans.

Work undertaken since the 1998 CHA continues to be addressed, pursued further, as the updating of the information indicates many of the same issues and trends are still present today for example:

- The three population subgroups whose members are at particular risk for poor health outcomes – children and youth, seniors, and aboriginal people.

- Major themes that continue to emerge include:
  - Mental health and social issues for example: stigma associated with accessing mental health services, isolation and emotional wellbeing.
  - Housing in particular transitional housing and more PCH beds.
  - Rural disparity in service delivery and services.
  - Lack of access to after hours physician care resulting in high use of the emergency department for non-urgent issues.
  - Lack of sufficient health care providers and specialists.
  - Lack of structured recreational options for youth and adults.

The ability to address and/or sustain and enhance initiatives currently underway requires additional resources. This report has identified the needs brought forward by community consultation as well as evidence based data.

NE looks forward to the results of the Manitoba Centre for Health Policy deliverable that will look at our population needs and make subsequent recommendations for funding based on the identified needs.

“The challenges to the region are broad, ranging from significant health issues of the residents of the region and the scarcity of both fiscal and human resources.”

---

1 NEHA Strategic Plan 2002-2006 pg. 3.