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13.1 GEOGRAPHICAL OVERVIEW ¹

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 -POPLAR RIVER FN - ROBOZO
<u>UNORGANIZED TERRITORIES - MUN CODE-290 (prior to 1997)</u>
Source for Population – 2003 Kasper, Craig. (2004) Manitoba Health. Email to Suzanne Dick June 28 entitled: NE RHA Population Figures by District.
Sources: <ul style="list-style-type: none">• 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.• Martens, P. et al. (2003) <u>The Manitoba RHA Indicators Atlas: Population-Based Comparison of Health and Health Care Use</u>. Manitoba Centre for Health Policy. June. p. 280-281 [Normal print]• Public Health Nursing Offices Rural Directory 2000 – [italics] Revised Jan. 21, 2004

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

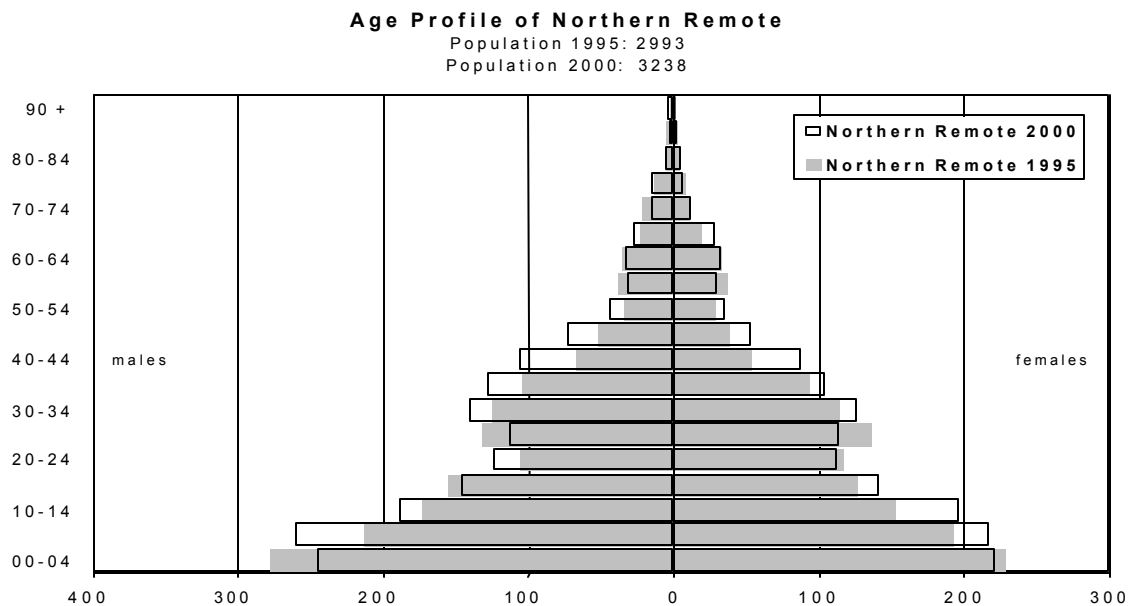
Population Demographics [Education as a health determinate] ²

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. ³

Population Demographics

Figure 13.1 Age Profile of Northern Remote – 1995 & 2000



Source: Burland, Elaine. (2003) Email to Suzanne Dick entitled: Population Pyramids. November 18. Martens, P. et al. (2003) The Manitoba RHA Indicators Atlas: Population -Based Comparisons of Health and Health Care Use. Manitoba Centre for Health Policy. June. P. 31. www.umanitoba.ca/centres/mchp/.

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. ⁴ This is a young population.

Table 13.1 Population 2001 to 2003 By Health District

Health District	2001	2002	2003
Northern Remote	2,662	2,668	3,237
TOTAL	39,320	39,389	39,644

Source: For 2001/2002 Penny Brown (2003) Manitoba Health. Health District Population. Email October 1. & for 2003: Kasper, Craig. (2004) Manitoba Health. Email to Suzanne Dick June 28 entitled: NE RHA Population Figures by District.

Table 13.2 2002/2003 Northern Remote Health District Divided into Non First Nations and FN People

District	Non First Nations	FN on Reserve	FN off Reserve
Northern Remote	442	2,038	188
Total NE : 39,389 persons <small>Manitoba Health Population Report 2002, June 1. Pg. 16.</small>	33,361	5,049	979

Source: Rachel McPherson, Statistical Analyst, Decision Support Services, Manitoba Health. (Email To Suzanne Dick. April 7, 2004 entitled Census Data Questions.)



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 life long learning for adults contributes to the health and prosperity of individuals.

Frontier School Division⁵

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

FRONTIER SCHOOL DIVISION								
	# of Students		Male		Female		% Graduate	
	2001/02	2002/03	2001/02	2002/03	2001/02	2002/03	2001/02	2002/03
Berens River	397	371	192	180	205	191		
Falcon Beach	70	59	37	30	33	29		
San Antonio	36	23	23	13	13	10		
Wanipigow	383	346	191	176	192	170	65%	92%

Sources: Glavedoni, Cam. (2004) Area 3 supervisor, Frontier School Division. January. Candline, Gail. (2004) Area 3 Administrative Secretary, April.

13.3 HEALTH STATUS

Deaths	Health Conditions	Human Function	Well Being
<p>“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</p>	<p>“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</p>	<p>“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</p>	<p>“Broad measures of the physical, mental and social well-being of individuals.”⁹</p>

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.

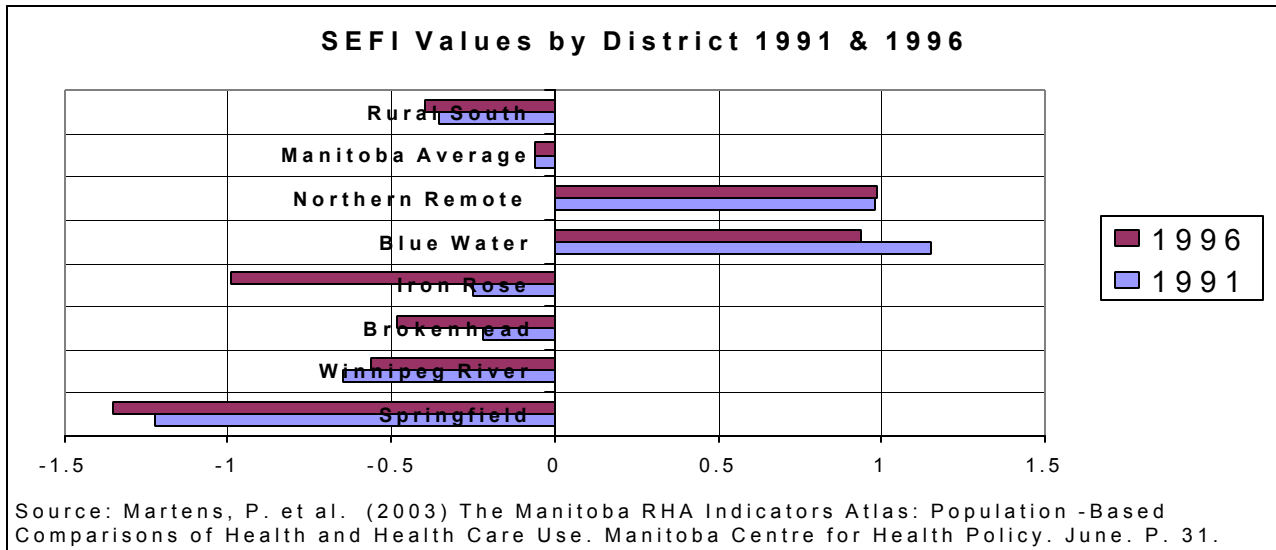
“The North Eastman Health Association Inc. is committed to working with Aboriginal groups to improve the health status of the aboriginal people. We recognize that culturally sensitive services have a positive impact on the health of aboriginal people and facilitate their willingness to access health 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.

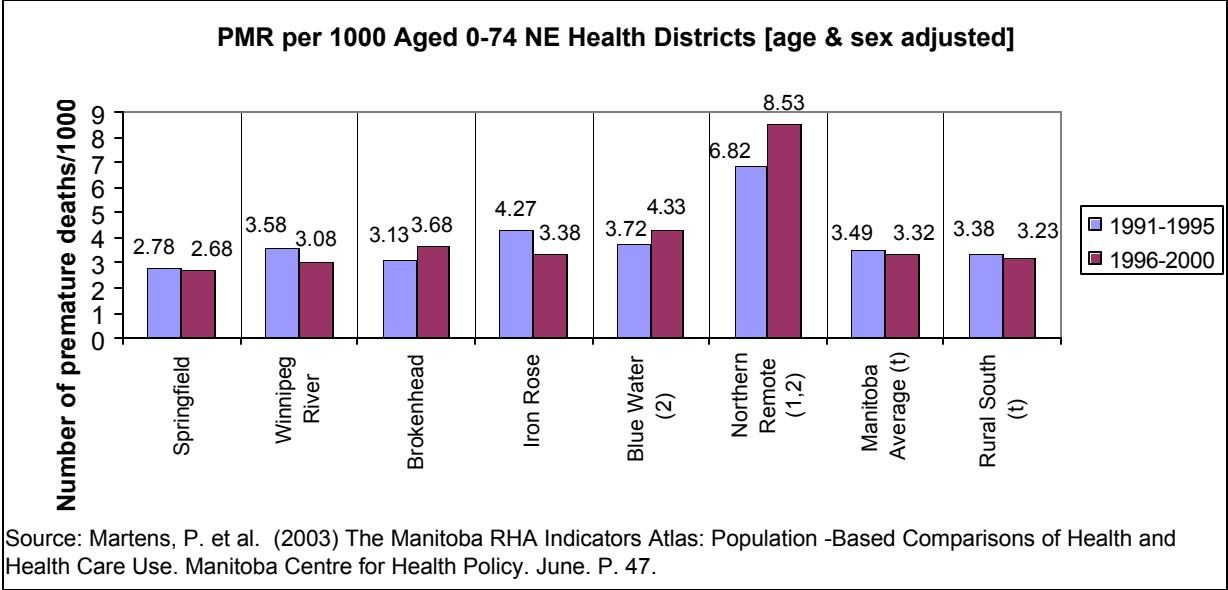
We shouldn’t be surprised that more health care services may be required in Blue Water and Northern Remote health districts.

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.¹¹

Figure 13.3 Premature Mortality Rate



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." ¹²

Total Mortality Rate

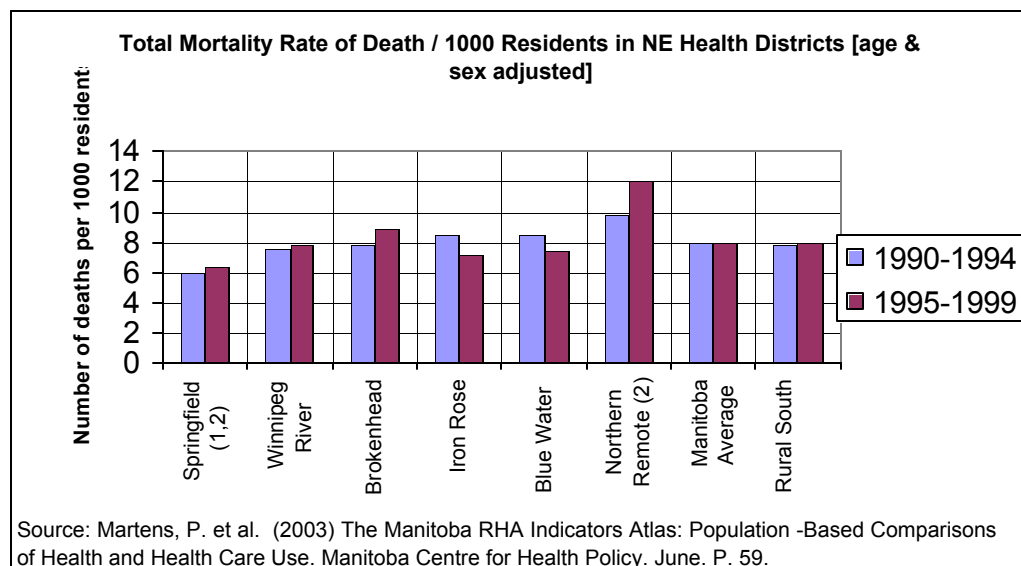
This indicator examines all deaths from all different causes and all ages.

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.

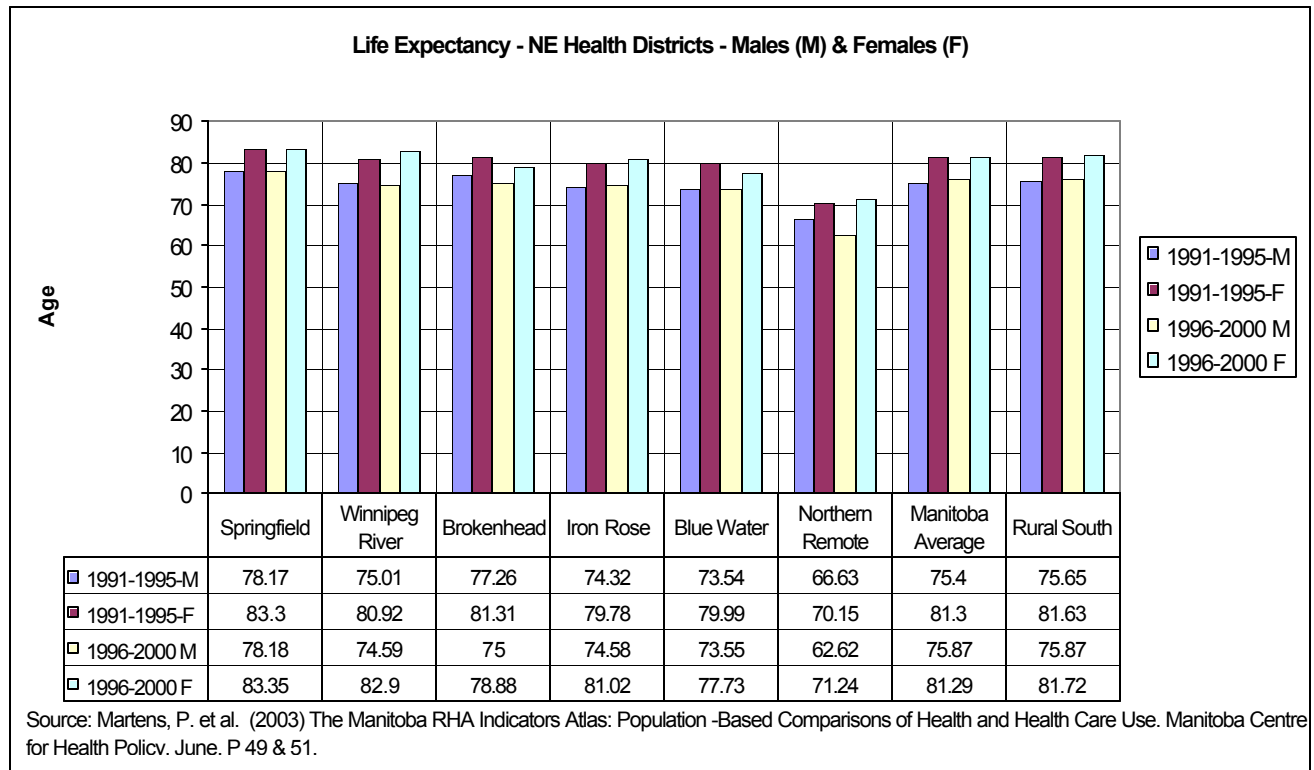


Total mortality rates are the highest in our region and significantly higher than Manitoba and Rural South.

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.¹³

Figure 13. 5 Life Expectancy – NE Health Districts



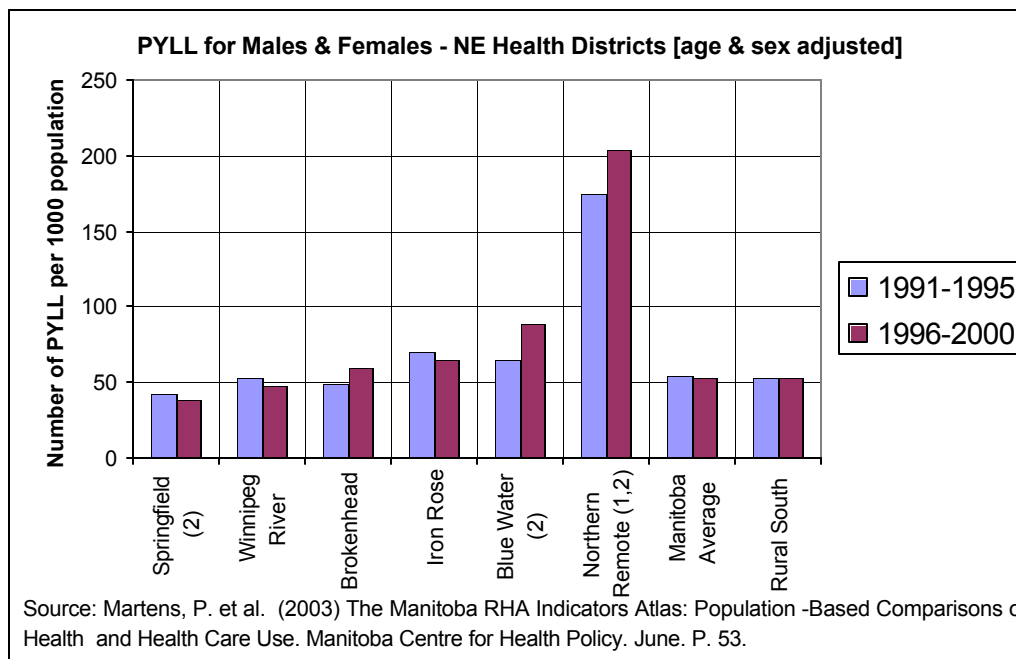
In Northern Remote we see that females live longer than males by approximately 8 years. In Northern Remote, life expectancy is the lowest in the NE region and appears to be lower than Manitoba and Rural South. When we compare the two time periods, male life expectancy appears to have shown a decline 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.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.

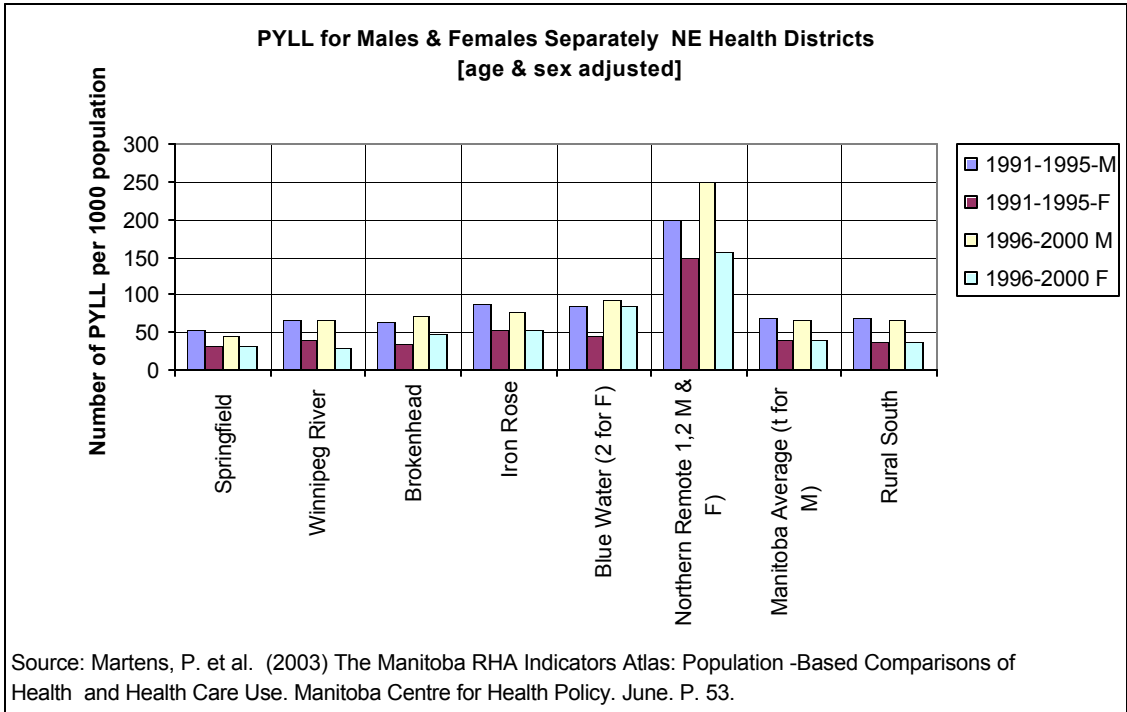
PYLL in Northern Remote is the highest in our region.

Compared with Manitoba and Rural South, PYLL is statistically significantly higher during both time periods.

In Northern Remote PYLL is significantly higher than Manitoba and Rural South.

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.

Figure 13. 7 Potential Years of Life Lost (PYLL) Males & Females Separately



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.

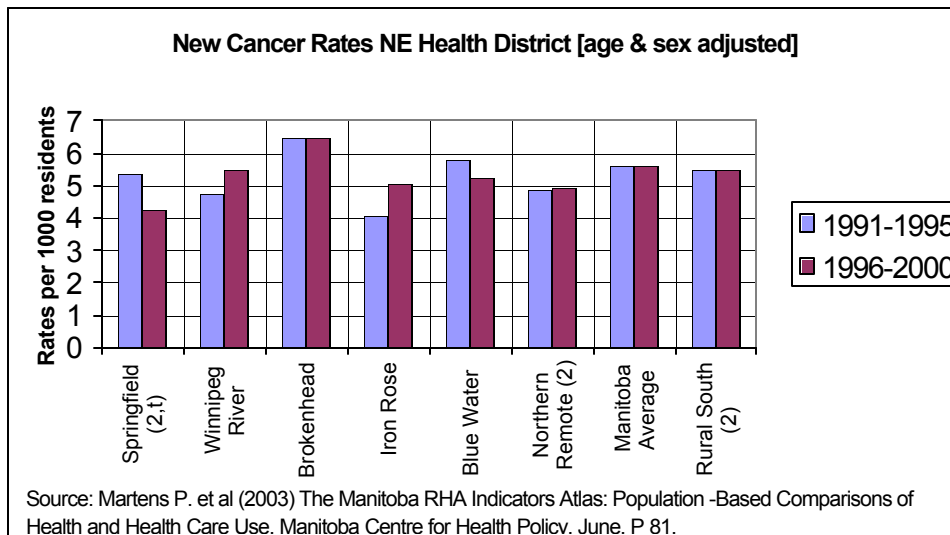
PYLL was statistically higher than the Manitoba average and Rural South for both males and females during both time periods.

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.

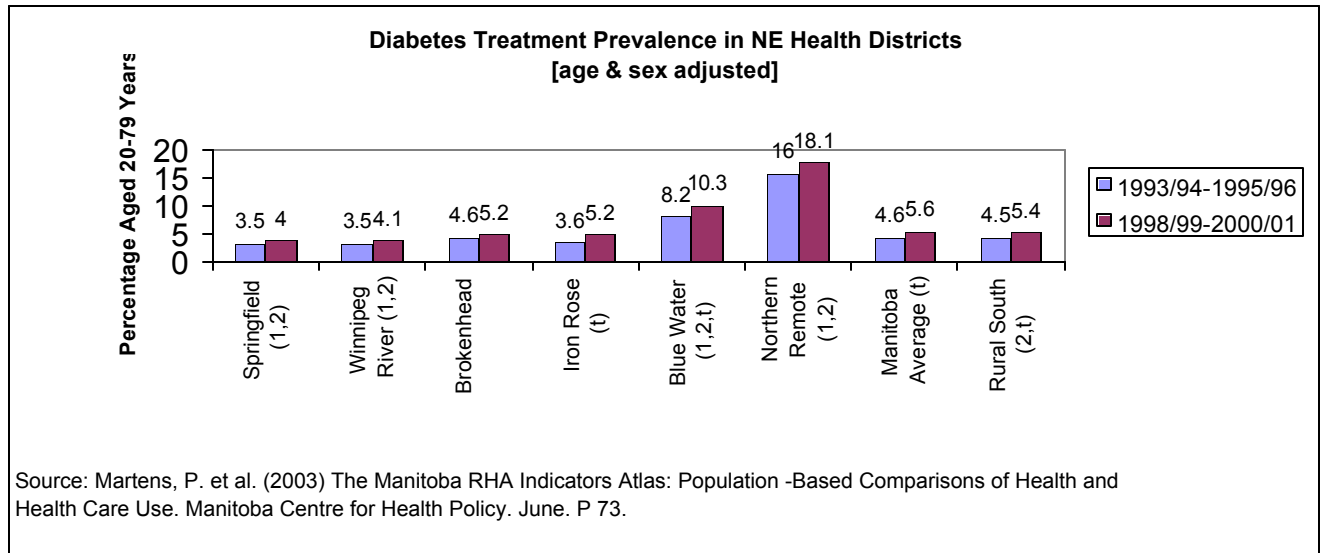
There has been no significant change in new cancer rates between 1996-2000.

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.

Diabetes is significantly higher than both Manitoba and Rural South.

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.

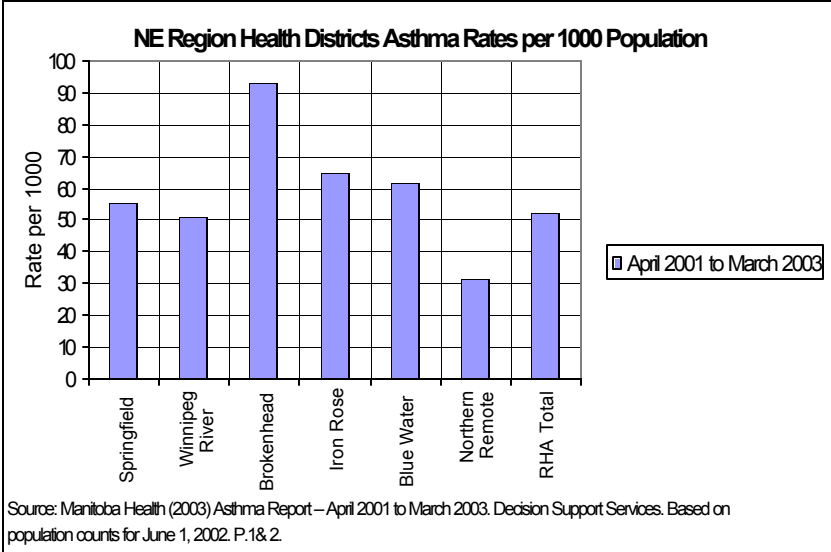
The incidence of diabetes in the population in 1999 not including the Treaty Status population, was 49 per 10,000. The incidence of diabetes in the Treaty Status population in North Eastman was 87 per 10,000. The incidence of diabetes in the Treaty Status population in Manitoba was 74 cases per 10,000 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 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.

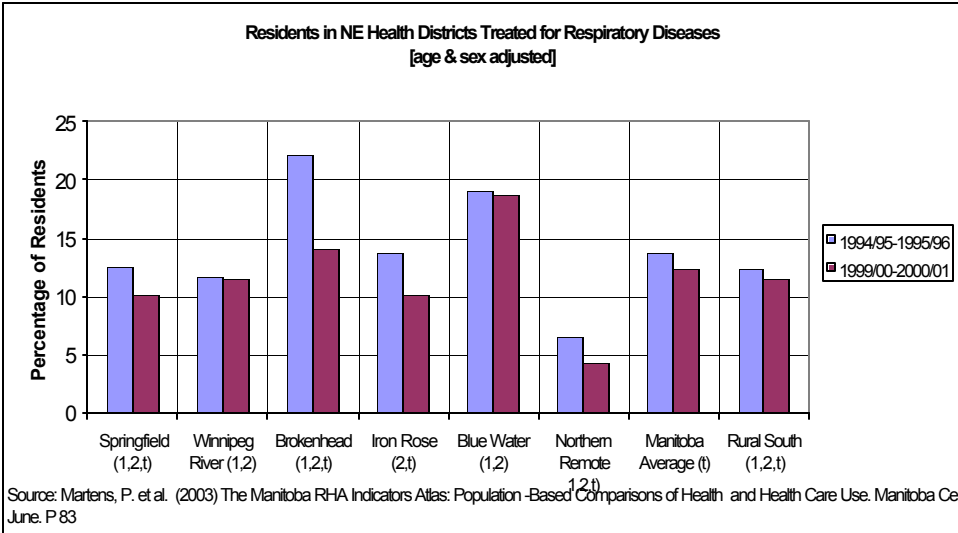
As mentioned in the regional section, both asthma and respiratory diseases in general are showing a decline.

Northern Remote had the lowest asthma rates in our region.

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.

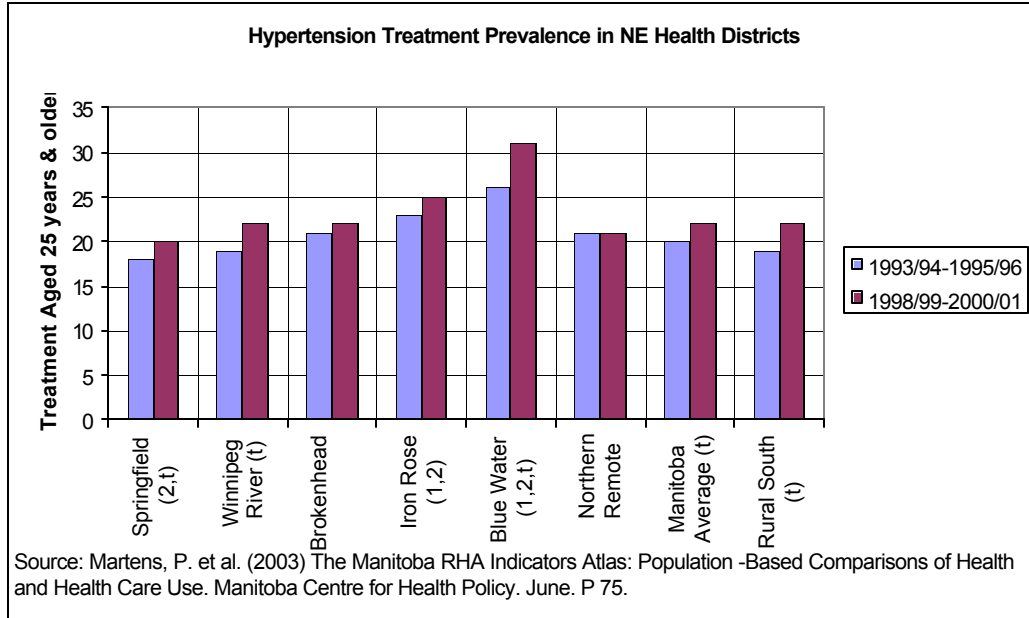


Hypertension

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 .

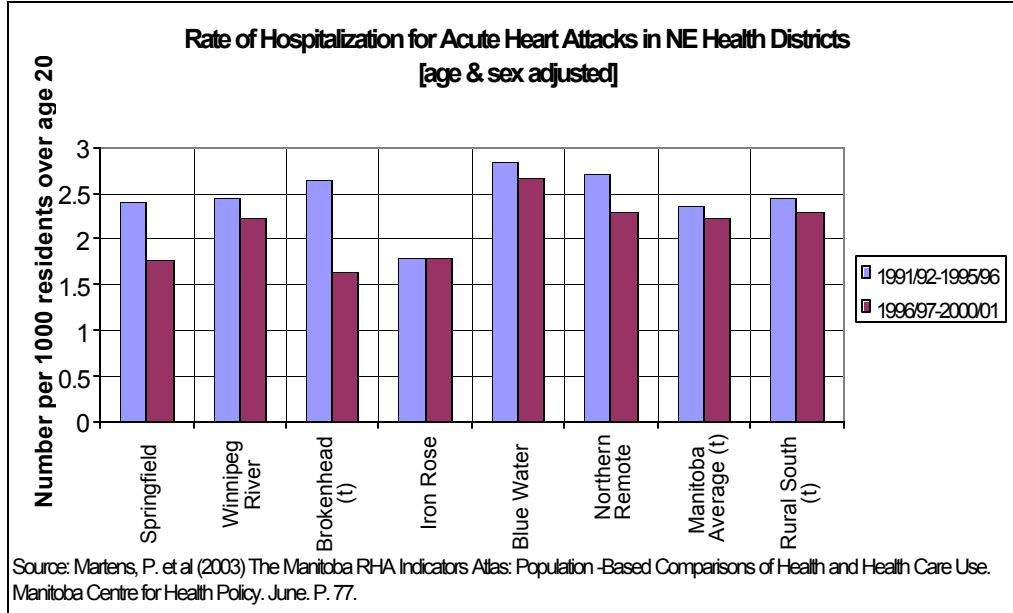
Hypertension treatment is close to the Manitoba average and Rural South, but it is not significantly different.



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



Northern Remote has experienced a drop in hospitalized cases for MI's from 2.72/1000 to 2.30/1000, but there was not a significant difference during the two time periods reviewed.

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.

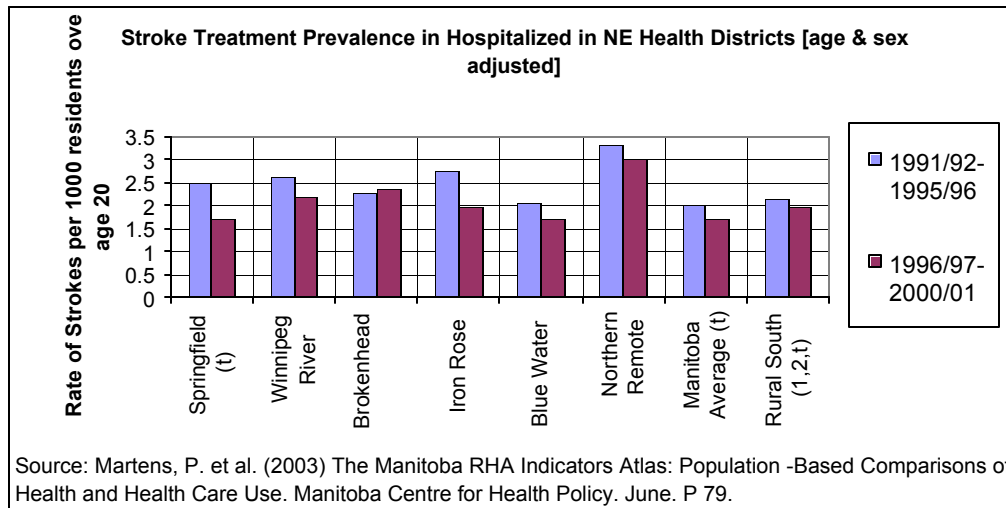
MI hospitalization rates have decreased, but not significantly. Northern Remote has the second highest MI hospitalization rate when compared to other health districts.

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.

Stroke treatment prevalence has declined, but not significantly and is the highest in NE.

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.

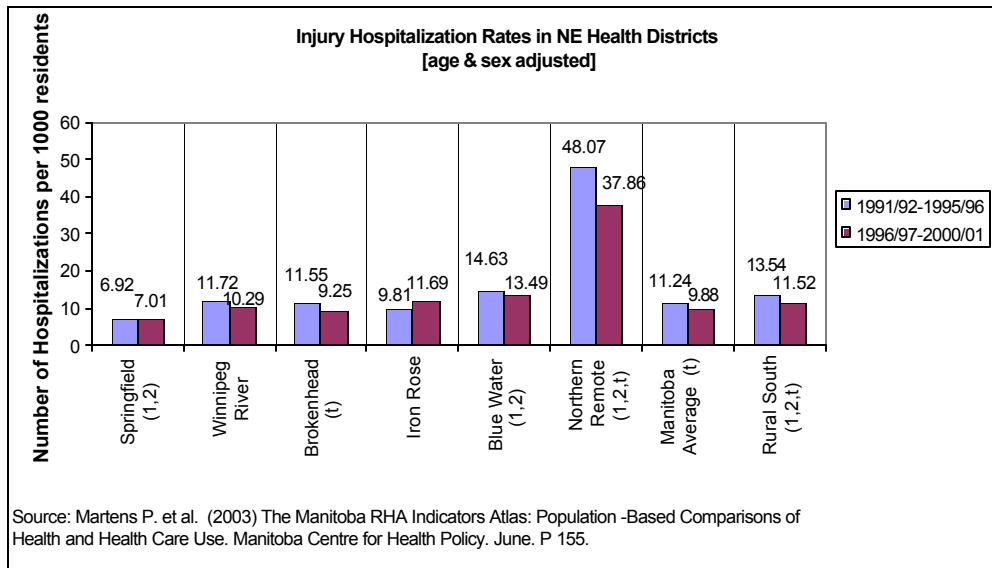
Due to relatively small number of injury deaths, these rates are not reported at the district level.¹⁸

Injury deaths are on the rise in NE, and throughout Manitoba overall.

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) ¹⁹

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.” ²⁰

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

Personal Health Practices & Lifestyle <i>[Personal Health Practices & Coping Skills]</i> ²¹	Personal Resources <i>[Social Support Network]</i> ²²	Living & Working Conditions <i>[Income, Income Distribution and Social Status and Employment and Working Conditions]</i> ²³	Environmental Factors <i>[Physical]</i> ²⁴
“Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.” ²⁵	“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” ²⁶	“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.” ²⁷	“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
Healthy Child Development	Biology & Genetic Endowment	Culture	Gender
“The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful.” ²⁹	“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	“Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors.” ³¹	“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



Environmental Factors as a Health Determinant

[Physical ³³

“ 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.” ³⁴

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.

CATEGORY	EXPLANATION	Health District	2001	2002
Criminal Code	<u>Persons</u> – Homicides, robberies, personal assaults and abductions. <u>Property</u> – Break and enter, shoplifting, stolen goods, motor vehicle theft, theft over \$5000/under \$5000, fraud. <u>Criminal Other</u> - Offensive and restricted weapons. <u>Other Criminal</u> – Property damage under \$5000, disturbing the peace, arson, indecent acts, bail violations, breach of probation, harassing and stalking, kidnapping, prison unlawful at large.	Northern Remote	2,596	2,669
Total Criminal Code		NE	4,481	4,234
Federal Code	Parole violation, weights and measures and other Federal Acts. Canadian Environmental Protection Act, drugs and substances.	Northern Remote	62	85
Total Federal Code		NE	155	204
Provincial Code	Child Welfare, Litter, Provincial Wild Life, Tobacco Tax Act, Transporting danger goods, Coroner's Act, Mental Health Act, Trespass Act, Offensive road vehicle. <u>Liquor</u> - intoxicated persons, Liquor Act. <u>Traffic</u> - failing to stop dangerous driving, other moving and non-moving traffic.	Northern Remote	1,023	1,027
Total Provincial Code		NE	3,098	2,117
Municipal Codes	Municipal Acts/ By-Laws	Northern Remote	1	2
Total Municipal Codes		NE	83	83
Traffic Codes	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.	Northern Remote	211	204
Total Traffic	Note: this does not include persons injured or killed.	NE	897	843
Persons **	Killed in traffic related incidents	Northern Remote	2	2
Total Persons killed		NE	3	11
Persons **	Injured in traffic related incidents	Northern Remote	25	17
Total Persons injured		NE	133	154
GRAND TOTAL OF ALL OFFENSES	Note: this does not include persons injured or killed in traffic related incidents.	Northern Remote	3,893	3,987
		North Eastman	8,714	7,481

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.

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’

Personal Health Practices & Lifestyle

[*Personal Health Practices & Coping Skills*]³⁷

“Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.”³⁸

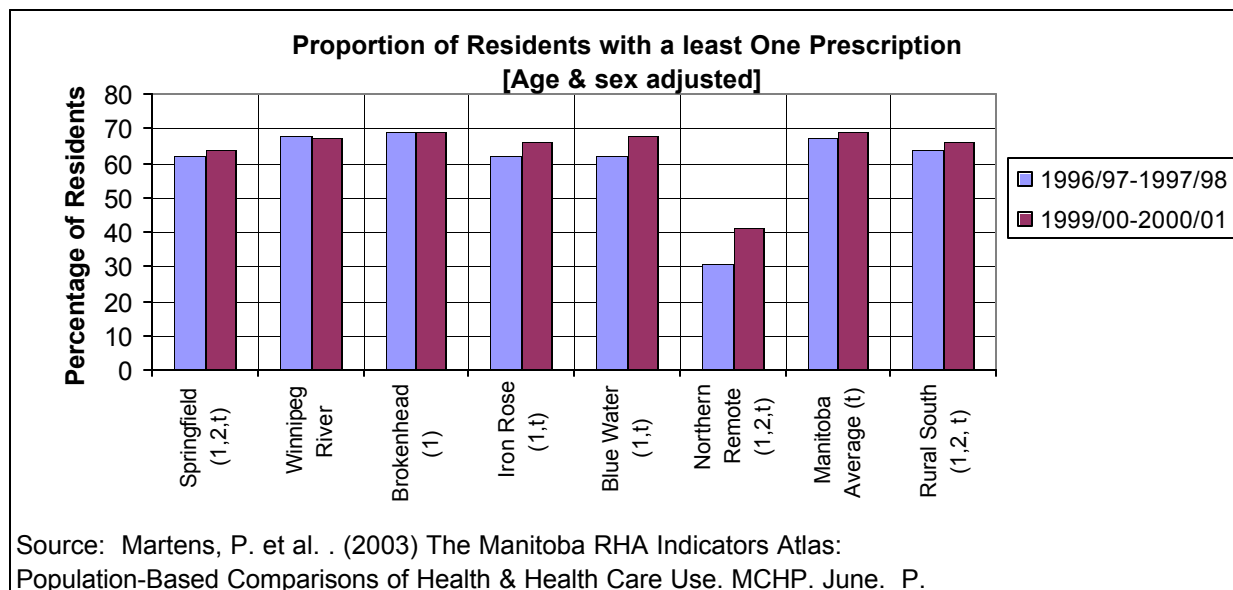
Overview

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 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.

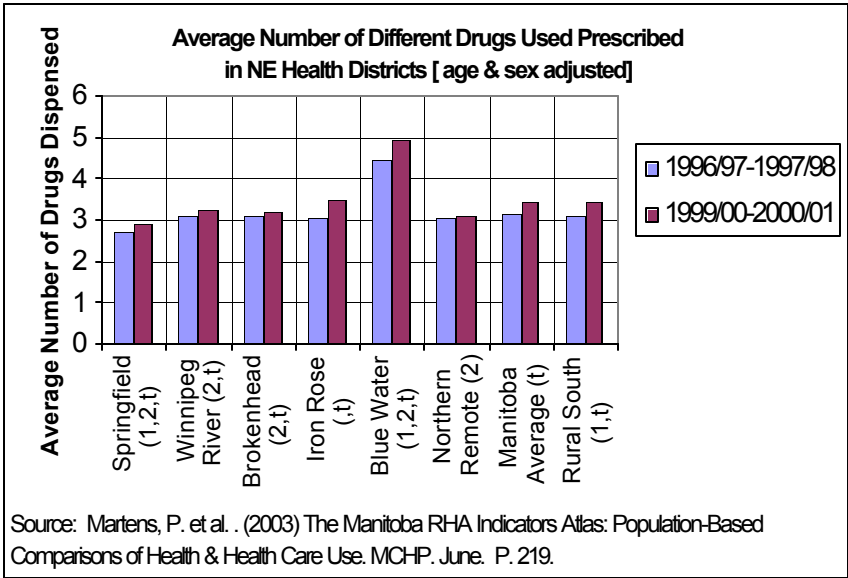
The percentage is the lowest in our region and is significantly lower than Manitoba and Rural South. The reason for this may be due to incomplete recording of pharmaceuticals dispensed in nursing stations.³⁹

There has been a significant increase in the proportion of residents in Northern Remote that was 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 13. 17 Average Number of Different Drugs Prescribed NE Health Districts



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

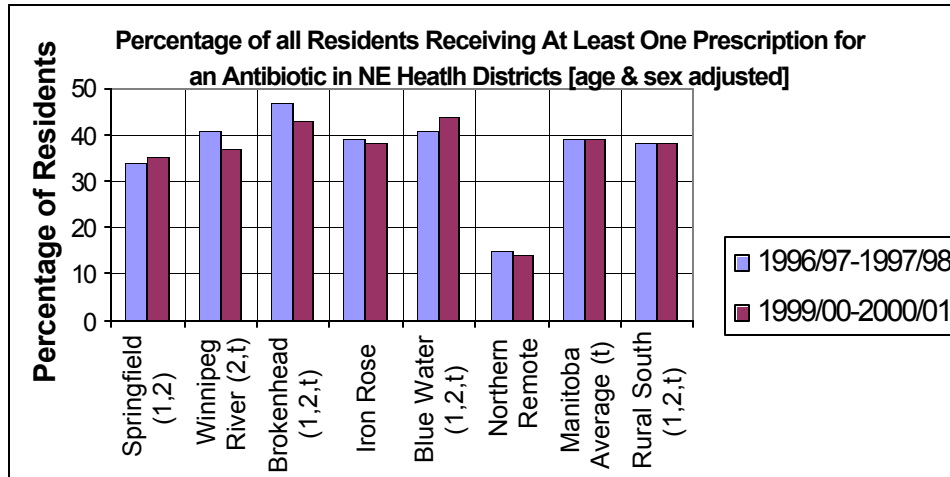
For the second time period, we see a statistically lower number of drugs prescribed than Manitoba and Rural South.



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 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.⁴¹

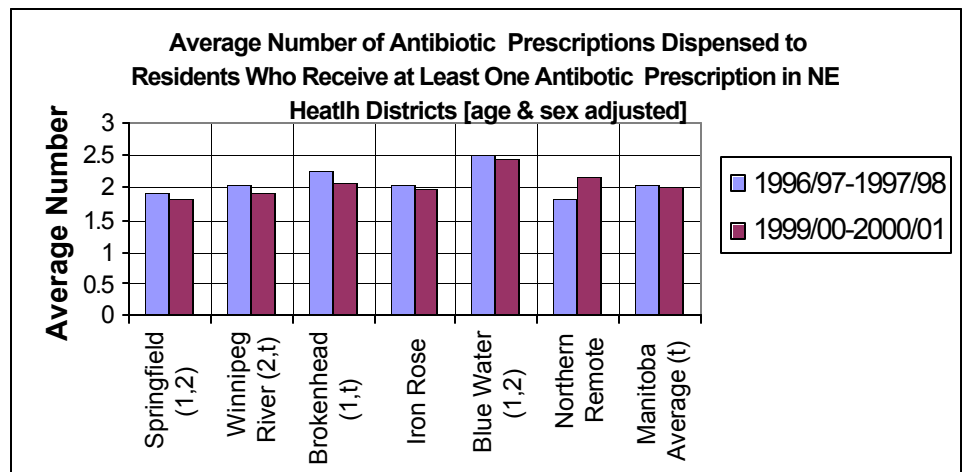
Source: Martens, P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. P. 221.

There has been a slight decrease, but not significant, in the number of residents receiving antibiotics.

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.



There has been a slight increase, but not significant in the average number of antibiotic prescriptions dispensed.

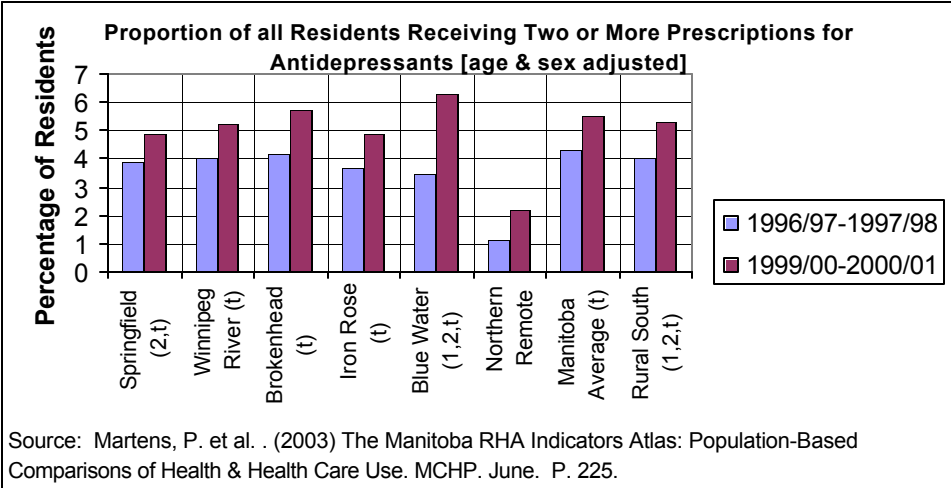
P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Health & Health Care Use. MCHP. June. P. 223.

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

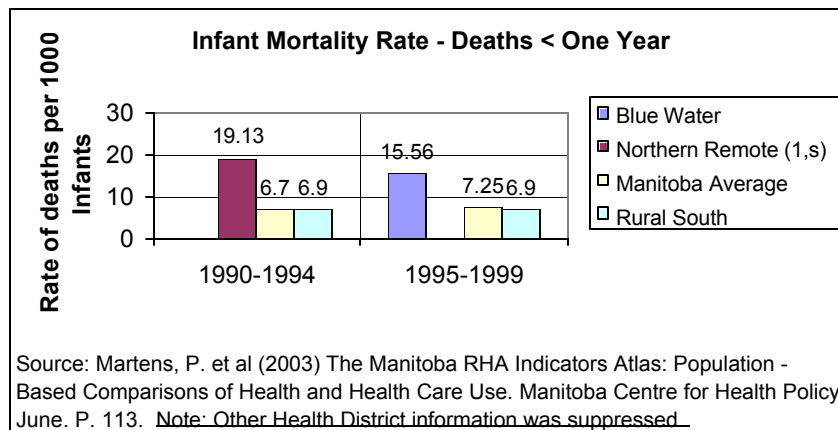
Overview

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. ⁴⁵ 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. ⁴⁶

Table 13.5 Number of Newborns in Northern Remote

Health District	2002-2003	2001-2002 *	2000-2001*	1999-2000 *
Blue Water	149 [17.7/1000]	44 [10.2/1000]	54 [12.4/1000]	62 [14.2/1000]
Northern Remote	63 [23.6/1000]	151 ** [29.8/1000]	158 ** [31.3/1000]	133 ** [28.0/1000]
Unorganized Territories	No longer separated integrated into Iron Rose, Blue Water, Winnipeg River and Northern Remote.	42 [17.1/1000]	54 [22.1/1000]	48 [18.4/1000]
Manitoba Rate/1000	11.7/1000	12.0/1000	12.1/1000	12.5/1000
TOTAL BIRTHS in NE	431 [10.9/1000]	464 [11.8/1000]	506 [12.9/1000]	501 [12.8/1000]

Source: 2002-2003 - Manitoba Health (2004) Decision Support Services April 1, 2004.
 1999-2000- Manitoba Health. (2000) Decision Support Services. October 20.
 2000-2001 Manitoba Health (2001) Decision Support Services. November 4.
 2001-2002 Manitoba Health (2001) Decision Support Services. November 4.

* 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.

Bluewater, 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.

Between 1999 & 2002 there appears to have been a slight decline in the number of newborns.



How Has Northern Remote's Birth Rate Changed Over Time?

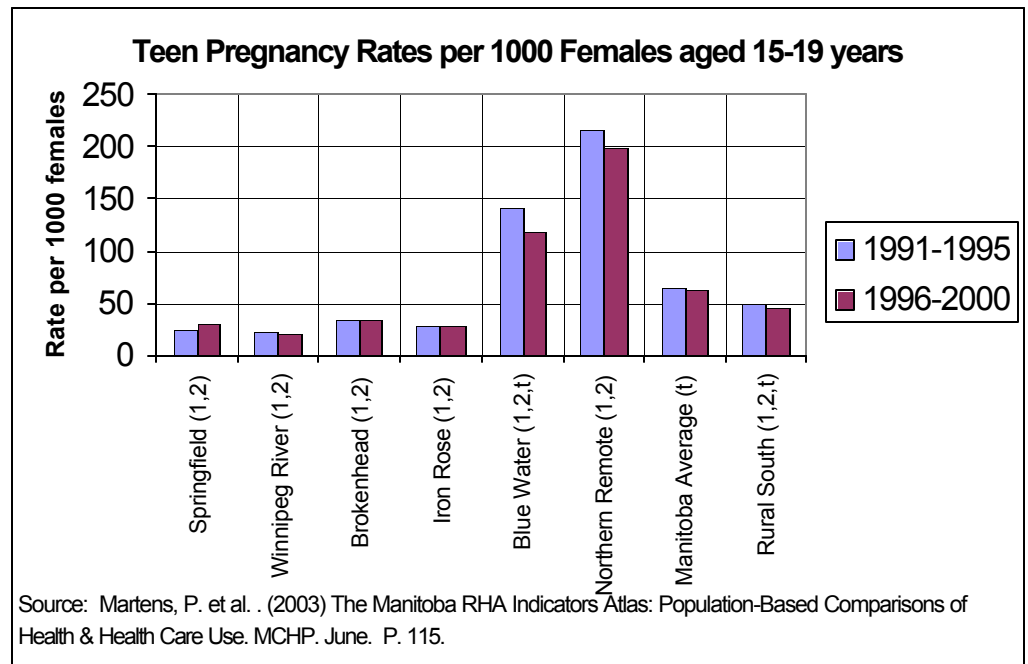
Northern Remote showed a substantial decline during 2002/03, but this appears to be an artificial decrease in the number of newborns due to health district boundary changes. There has been a small decline during the former years.

Adolescent and Teenage Pregnancy

Figure 13.22 Teenage Pregnancy Rates

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.



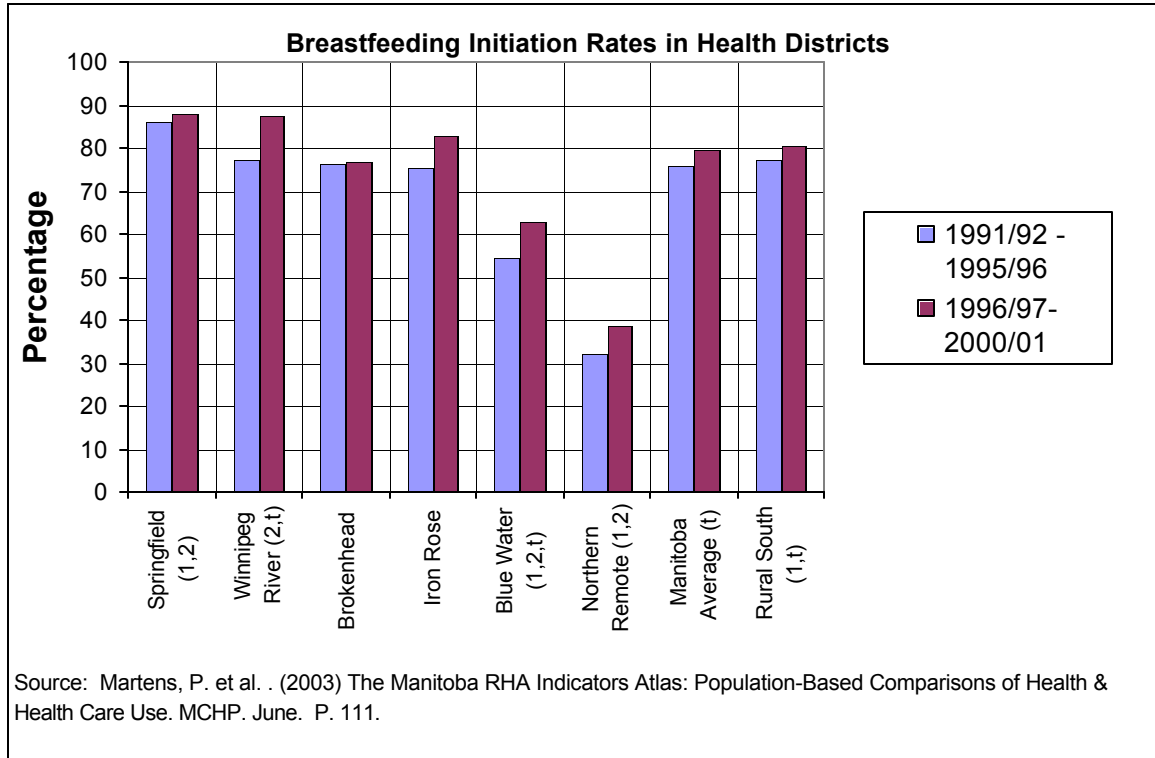
Northern Remote has one of the highest teen pregnancy rates in the province.

Northern Remote has one of the highest teen pregnancy rates in the province.



Breastfeeding Practices

Figure 13.23 Breast Feeding Initiation Rates in NE Health Districts



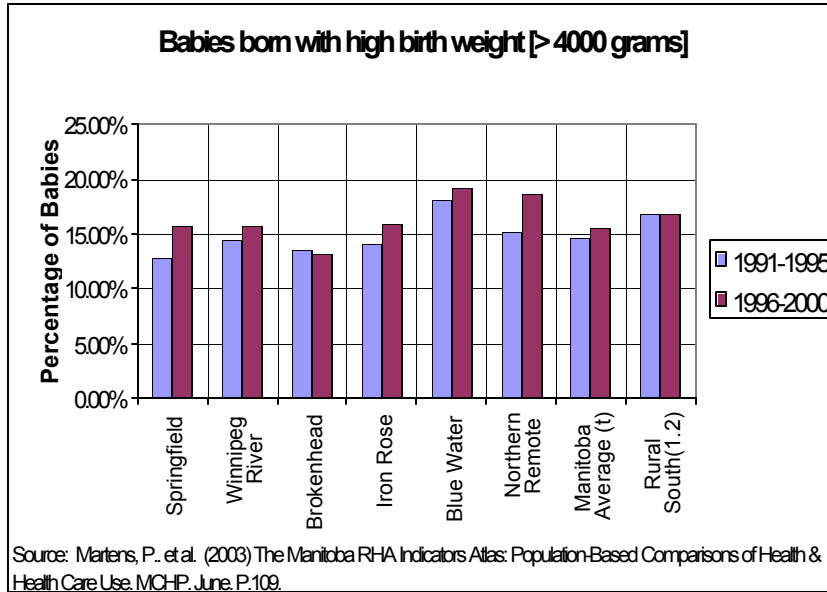
There is considerable variability within the health districts, with high rates of hospital breastfeeding initiation in Springfield and Winnipeg River, with considerably lower rates in Blue Water (63%) and Northern Remote (38%) during the later time period. The good news for Northern Remote is that this 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.

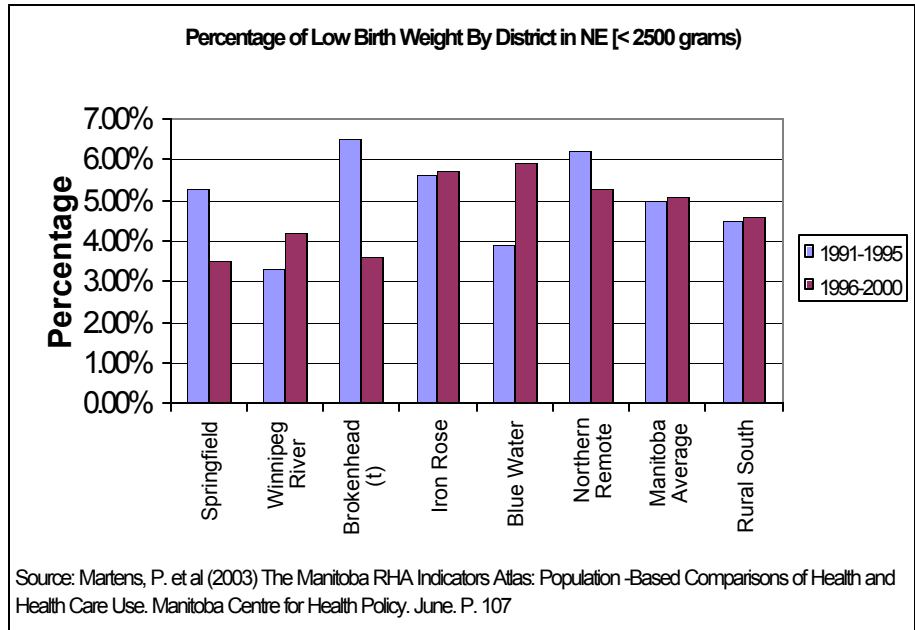


Northern Remote has the second highest percentage of high birth weight babies when compared to our other health districts, but it is not significantly different than Manitoba or Rural South.

Figure 13.25 Low Birth Weights

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.



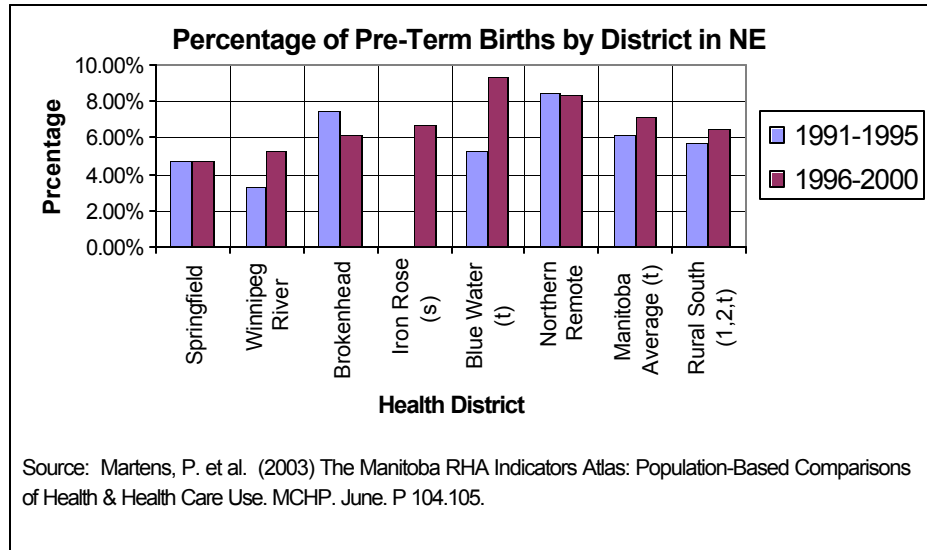
Although there appears to be a higher percentage of low birth weight babies in Northern Remote, 5.3%, there is not a significant difference with the Manitoba average at 5.1% or Rural South at 4.6% for the later time period. Because these rates are based upon relatively small numbers of people living in these districts, the rates could fluctuate from year to year.

Northern Remote experienced the third highest percentage of low birth weights when compared to other health districts.

Figure 13.26 Pre-Term Births

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.

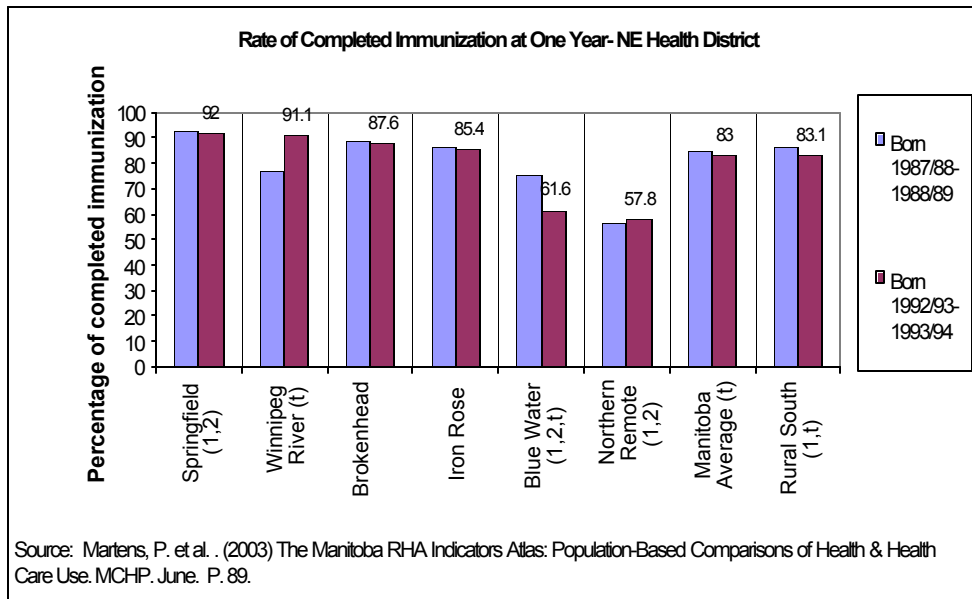
Childhood Immunizations

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.⁴⁷

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.

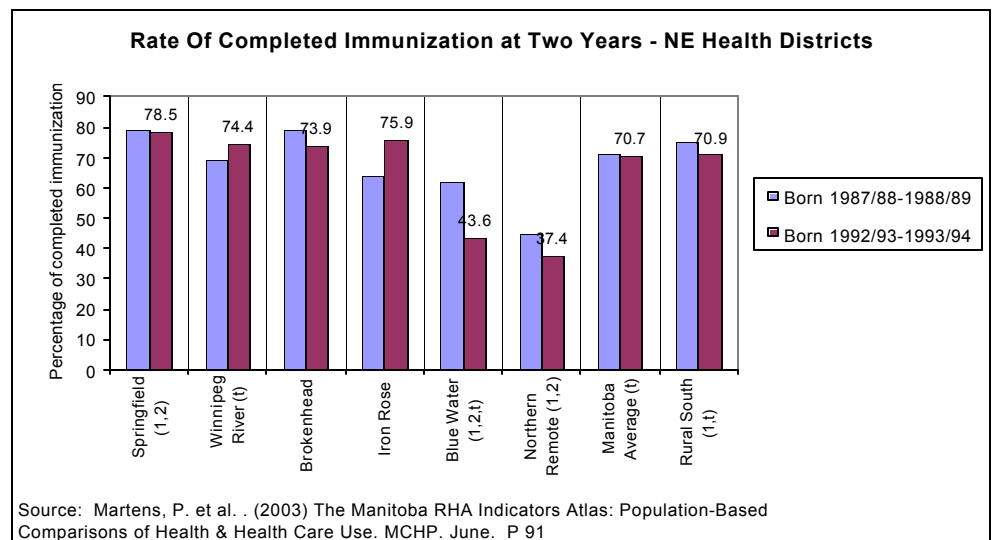
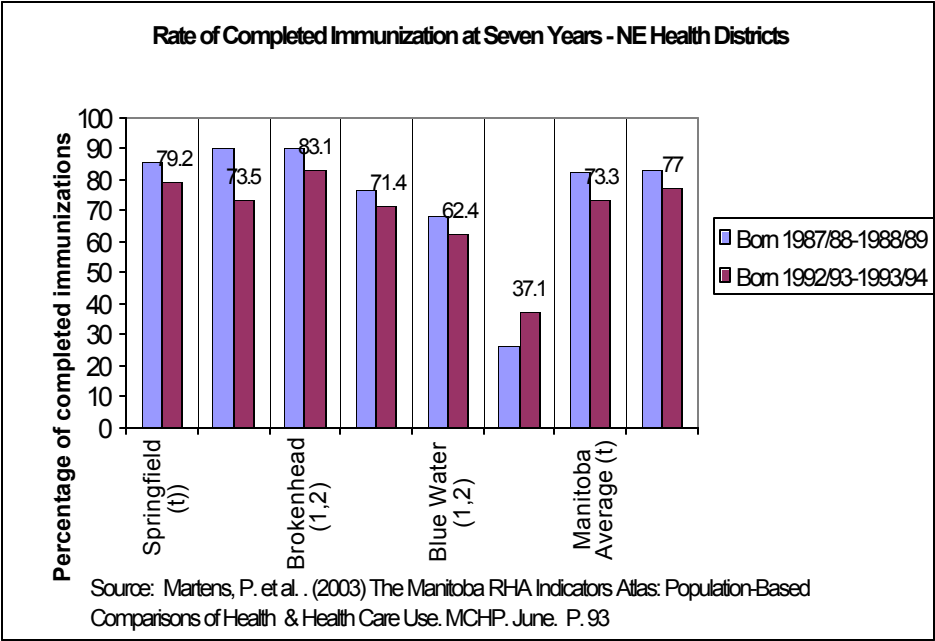


Figure 13.29 Completed Immunization at Year Seven

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.



Living & Working Conditions as a Health Determinant

*[Income, Income Distribution and Social Status
and Employment and Working Conditions]* ⁴⁸

“Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health.” ⁴⁹

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. ⁵⁰

Employment & Unemployment

Table 13.6 Percentage of Population 15 years and over Employed and Unemployed – Males/Females

Districts	Employment Rate 15 Years and Over		Unemployment Rate 15 Years and Over	
	Male	Female	Male	Female
Blue Water	48.5	42.8	21.4	12.1
Brokenhead	70.4	59.1	4.2	2.4
Iron Rose	70.9	51.7	4.6	1.6
Springfield	79.3	69.3	3.1	3.2
Winnipeg River	56.3	47.3	6.5	6.2
Northern Remote	32.9	28.9	25	16.3

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 .

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.

Northern Remote has the lowest
employment rate for both males and
females when compared with other
health districts.

Social Economic Status

There is considerable research to support the relationship between an individual's health status and their socioeconomic status .⁵¹

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

Area	Median Family Income
Northern Remote	\$ 23,104
North Eastman	\$ 52,938
Manitoba	\$ 55,885

Sources:

Northern Remote - 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.
NE and Manitoba- Census Canada 2001. www.statcan.ca. 2001 Community Profile. North Eastman Regional Health Authority. Accessed: April 10, 2004.

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

District	Median Family Income Lone Male Parent Family	Median Family Income Lone Female Parent Family
Springfield	\$ 40,087	\$ 36,865
Blue Water	\$ 23,892	\$ 17,058
Iron Rose	no data	\$ 29,378
Winnipeg River	\$ 45,361	\$ 26,118
Brokenhead	\$ 35,698	\$ 26,280
Northern Remote	\$ 9,248	\$ 12,587

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.

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

Area	Median Family Income Lone Parent Families Male And Female
North Eastman	\$ 22,562
Manitoba	\$ 26,469

Source: Census Canada 2001. www.statcan.ca. 2001 Community Profile. North Eastman Regional Health Authority. Accessed: April 10, 2004.

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

<p>Personal Resources as a Health Determinant [Social Support Network] ⁵³</p>
<p>“Measures the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health.” ⁵⁴</p>

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

Area	Total Number Of Couple Families [married and common law]	Number Of Lone Parent Families
Springfield	3,385	255
Blue Water	1,970	505
Iron Rose	840	55
Winnipeg River	1400	165
Brokenhead	1725	225
Northern Remote	410	185
Blue Water	1,970	505
North Eastman	9,735	1,380

Sources:

Northern Remote- 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.

NE - www.statcan.ca. 2001 Community Profile. North Eastman Regional Health Authority & Blue Water. Accessed: April 10, 2004.

There are approximately 185 lone parent families reported in Northern Remote during 2001 Canada Census.

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 Communities⁵⁶

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 ⁵⁷

“ 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

Cancer	Diabetes	Respiratory	Hypertension
There has been no significant change in new cancer rates.	Diabetes prevalence is significantly higher than Manitoba and Rural South, and is the highest in NE.	Respiratory diagnoses have shown a significant decrease, and are significantly lower than Manitoba.	Hypertension treatment is not significantly different than Manitoba.
MI	Stroke	Injury	
MI treatment has decreased, but is not a significant difference, but is the second highest in NE.	Stroke treatment has declined, but not significantly, and is the highest in NE.	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.	

Diabetes – Diabetes can effect 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.

<p>KEY</p> <ul style="list-style-type: none"> • <u>Partner</u>: implies that if this is an action by NEHA it will require partnering with a community group/ agency/ department. • <u>Monitor</u>: refers to an area of possible concern. Monitoring will ensure it isn't missed if it changes. • <u>NEHA</u>: 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
<ul style="list-style-type: none"> • New cancer cases have remained the same. [Monitor]
<ul style="list-style-type: none"> • 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]
<ul style="list-style-type: none"> • Traffic injuries have decreased slightly. [Monitor]
<ul style="list-style-type: none"> • Infant mortality rates were suppressed. [Monitor]
<ul style="list-style-type: none"> • High and low birth weights are not significantly different than the Manitoba average. [Monitor]
Issues Having Implications for Health Planning & Delivery
<ul style="list-style-type: none"> • Appears to have the worst SEFI value in NE and is worse than Manitoba and Rural South.
<ul style="list-style-type: none"> • Life expectancy for both males and females appear to be less than Manitoba and Rural South.
<ul style="list-style-type: none"> • Diabetes treatment increased but not significantly however it is significantly higher than Manitoba and Rural South.
<ul style="list-style-type: none"> • Stroke treatment has declined and is the highest in NE.
<ul style="list-style-type: none"> • Teen pregnancy rate is one of the highest in the province and is significantly higher than Manitoba. [NEHA, Monitor]
<ul style="list-style-type: none"> • Breast feeding initiation rate is the lowest in NE and is significantly lower than Manitoba. [NEHA, Monitor]
<ul style="list-style-type: none"> • Pre-term births have not changed significantly, but are the second highest in NE. [NEHA, Monitor]
<ul style="list-style-type: none"> • Childhood immunization coverage is significantly lower than the Manitoba average and is the lowest in NE. [NEHA, Monitor]
<ul style="list-style-type: none"> • This is a young population. [NEHA, Partner]
<ul style="list-style-type: none"> • Lowest employment rate within NE. [Partner, Monitor]
<ul style="list-style-type: none"> • Overall median income was lower than NE and Manitoba overall. [Partner, Monitor]
<ul style="list-style-type: none"> • Lowest lone parent income in NE. [Partner, Monitor]
<ul style="list-style-type: none"> • PMR is statistically significantly higher than Manitoba. [NEHA, Partner, Monitor]
<ul style="list-style-type: none"> • Total mortality rates are the highest in NE and are significantly higher than Manitoba. [NEHA, Partner, Monitor]
<ul style="list-style-type: none"> • PYLL value is statistically higher than Manitoba. [NEHA, Partner, Monitor]
<ul style="list-style-type: none"> •



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.

Issues Having Implications for Health Planning & Delivery Continued

- Hypertension treatment is not significantly different than Manitoba, but is the highest in NE. [NEHA, Partner, Monitor]
- MI treatment has decreased, but is not a significant difference, but is second highest in NE. [NEHA, Partner, Monitor]
- Injury hospitalizations have shown a significant decrease but are the highest in NE and are statistically significantly higher than Manitoba. [NEHA, Partner, Monitor]
- Obesity is a national concern. [NEHA, Partner, Monitor]

Please refer to Section 7 this report for health district information related to the Health Services a determinant of health.

13.7 REFERENCES

- ¹ NEHA (2004) Aboriginal-Specific Health Strategy. January 12, 2004.
- ² Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ³ Donner, L. (2003) Including Gender in Health Planning. A Guide for Regional Health Authorities. Prairie Women's Health Centre of Excellence. May. P. 3-6.
- ⁴ 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. P. 49.
- ⁵ Frontier School Division Website. Accessed April 2004 by C. Orvis www.frontiersd.mb.ca
- ⁶ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ⁷ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ⁸ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ⁹ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ¹⁰ NEHA (2004) Aboriginal-Specific health Strategy. January 12, 2004.
- ¹¹ 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. P. 43 & 46.
- ¹² Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ¹³ 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. P. 48.
- ¹⁴ 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. P. 52
- ¹⁵ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ¹⁶ Griffith, Jane (2003) North Eastman Regional Diabetes Profile: A statistical Summary. Manitoba Health. May. P. 10.
- ¹⁷ Marten, P. et al. (2003). As cited by Young 1998. The Manitoba RHA Indicators Atlas: Population -Based Comparisons of Health and Health Care Use. Manitoba Centre for Health Policy. June. P. 72.73.
- ¹⁸ 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. P.58.
- ¹⁹ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ²⁰ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ²¹ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ²² Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ²³ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 12.
- ²⁴ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ²⁵ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ²⁶ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ²⁷ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ²⁸ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 12.
- ²⁹ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P.13.

- ³⁰ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 13.
- ³¹ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 13.
- ³² Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 13.
- ³³ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ³⁴ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 12.
- ³⁵ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 13.
- ³⁶ Health Canada. (1994) Strategies for Population health. Investing in the Health of Canadians. Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health. September 14-15. P. 21.
- ³⁷ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ³⁸ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ³⁹ Martens, P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. P. 216.
- ⁴⁰ Martens, P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. P. 218.
- ⁴¹ Martens, P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. P. 220.
- ⁴² Martens, P. et al. . (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. P. 224.
- ⁴³ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P.13.
- ⁴⁴ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September. P.23- 23.
- ⁴⁵ Health Science Centre Intrauterine Growth Standards. Form # 80960. June 2002. Reprinted from: Pediatrics. Volume 108: 2e35. Table 1 & 2. 2001. Faxed to Suzanne Dick from Joan Warbeck. NE Public Health Nurse. April 5, 2004.
- ⁴⁶ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September. P.23
- ⁴⁷ Manitoba Health (2003) RHA Profile Technical Document 2003. Health Information Management. August 5. P 40
- ⁴⁸ Health Canada. (2001) The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Draft. Population and Public Health Branch Strategic Policy Directorate. July. P. 12.
- ⁴⁹ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ⁵⁰ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September. P 15.
- ⁵¹ Lissa Donner. (2000) Women, Income and Health in Manitoba: An Overview and Ideas for Action. Women's Health Clinic. July. P. 14-15
- ⁵² 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.
- ⁵³ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September.
- ⁵⁴ Canadian Institute for Health Information. (2000) Continuing Care (LTC Facilities): Review of Health Standards. July. P. A-1. Internet Access: October 22, 2003 www.cihi.ca.
- ⁵⁵ Federal, Provincial & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health. Investing in the Health of Canadians. September. P 16.
- ⁵⁶ NEHA (2004) Aboriginal-Specific health Strategy. January 12, 2004.
- ⁵⁷ NEHA (2004) Aboriginal-Specific health Strategy. January 12, 2004.