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September 1998

MANITOBA FIRST NATIONS REGIONAL HEALTH SURVEY

FINAL REPORT SEPTEMBER 1998

The Vision of the Chiefs Health Committee (CHC) states:

"All life comes from our Creator.
Life is therefore sacred and must be preserved, protected and respected.
Paramount to life is HEALTH.
Thus, it is recognized and asserted that health is the total well-being and balance of our physical, mental, emotional and spiritual natures.
In a collective and cooperative spirit and respectful of each First Nations autonomy, it is our vision that total HEALTH be restored and maintained in the lives of all First Nations people of MANITOBA."

Certified Resolution – Assembly of Manitoba Chiefs Special Chiefs Health Committiee, February 7, 1996

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1 INTRODUCTION TO THE REPORT

This report was developed to provide First Nations communities and organizations in Manitoba with the results of the Regional Health Survey in a format that is useful for program planning and policy development purposes. Given this objective, we have been selective in the presentation of data and have purposefully avoided extensive documentation of raw data. As a result, this report is different from a typical survey final report in that we have not included statistical tables describing every question in the Survey. This information is available on request. Instead, we have described key variables in graphic form, with the intent of making the results of the Survey accessible to the widest possible audience in First Nations communities. We have also refrained from providing extensive interpretation of the results; our intent is to provide results in a format that can be incorporated into ongoing policy and program discussions in First Nations communities and organizations. Interpretation of these results should be a First Nations responsibility and reflect the particular issues and concerns of ongoing negotiations for improved health and health care in First Nations communities.

This Report reflects the efforts of many people, all of whom are listed in the Appendix . However, several people deserve particular recognition. Without their sustained effort, the survey would not be the success it is. Audrey Leader, Doreen Sanderson and Marilyn Tanner-Spence have worked tirelessly on behalf of the Assembly of Manitoba Chiefs and Mantitoba Keewatinowi Okimakanak to ensure that the survey is not only First Nations controlled, but implemented at a high standard throughout. John O'Neil, Brenda Elias, and Dawn Stewart at the Northern Health Research Unit at the University of Manitoba provided sustained technical and administrative assistance. Members of the Regional Steering Committee - Jennie Wastesicoot (MKO), Gary Munroe (SCTC), Pauline Wood Steiman (ILTC), Marge Roscelli (DOTC), Laura Sanderson (KTC), Larry Starr, (SERDC), Debra Wilde (IRTC), Marilyn Tanner Spence (NHFN), Joyce Cochrane (FRFN), Caroline Chartrand (WRTC) – directed this project throughout. The survey was approved by the Chiefs in Assembly (Resolution Feb-96:01).

The Regional Steering Committee would also like to thank everyone who responded to the Survey, the Chiefs Health Committee who have enthusiastically supported the Project, and the Chiefs and Councils of all participating communities for their willingness to participate in this important venture.

2 BACKGROUND TO THE REGIONAL HEALTH SURVEY

In 1994, Statistics Canada began three major national longitudinal surveys; National Population Health Survey (NPHS), National Longitudinal Survey of Children (NLSC), and the Survey of Labour and Income Dynamics (SLID). The NPHS and NLSC are collecting data on a two-year cycle on samples of approximately 22,000 and 25,000 Canadian households respectively. The SLID collects data annually on a sample of 15,000 households. The general objectives of each of the three surveys are to assist federal and provincial governments, researchers and non-governmental organizations to develop public policy by providing information as summarized below:

- to provide comprehensive information on the health status of the Canadian population
- to describe information on trends and changes in health status
- to examine the social determinants of health status including economic, social, demographic, occupational, and environmental correlates
- to better understand the relationship between health status and use of health services
- to determine the prevalence of various biological, social and economic characteristics and risk factors of Canadian children and youth.
- to monitor the impact of such factors, life events and protective factors on the development of these children.
- to provide information to policy and program officials for use in developing effective policies and strategies to help children live healthy, active and rewarding lives.
- to improve an understanding of links between demographics, labour market events and changes in family circumstances and income

Longitudinal studies are designed to follow a group of people over a long time period in an attempt to understand how changes in peoples well-being are linked to changes in their lifestyles and social environments. In the case of children, changes in growth and development can be linked to changes in home, school, and community environment. The results of these kinds of studies have more powerful policy implications than cross-sectional studies, which merely describe the presence of problems at one point in time.

The national sampling frame for these three longitudinal surveys specifically excludes First Nations people living on reserves, and Inuit communities in the provinces.

Recognising the need for comparable information on the First Nations population, Health Canada, Human Resources Development Canada and the Department of Indian and Northern Affairs contracted the Northern Health Research Unit at the University of Manitoba in January 1994 to conduct a Feasibility Study into the possibility of developing a National Longitudinal Aboriginal Survey.

The design of the Feasibility Study was to consult with First Nations technical staff working with Aboriginal organisations and communities. "Technical staff" included Aboriginal health, social service, child development, education and socio-economic development professionals active in service delivery, research and policy development with Aboriginal communities and organisations. Workshops were held in Ottawa, Halifax, Montreal, Toronto, Winnipeg, Saskatoon, Edmonton and Vancouver through the fall of 1994, where approximately 150 Aboriginal health technicians participated in discussions about the possibility of developing an Aboriginal longitudinal survey of health, children and social conditions.

The Feasibility Study asked the question "What kind of national longitudinal study would be acceptable to First Nations, Inuit and Métis people at the community level, while at the same time meeting the information needs of First Nations, Inuit and Métis organisations at the community, regional and national levels, and other levels of government?"

2.1 Recommendations of the Feasibility Study

The general framework for a longitudinal Aboriginal survey proposed by the Feasibility Study is summarized below:

1. Health Canada, Human Resources Development Canada, and the Department of Indian and Northern Affairs should commit funding to develop a framework of Regional Health Surveys for First Nations and Inuit people in the ten provinces to generate information on community health, the well-being of children, and the documentation of socio-economic conditions associated with community health and the well-being of children.

2. National First Nations and Inuit organizations, and the major funding departments should be invited to appoint members to First Nations and Inuit National Steering Committees. These Committees will be responsible for the general supervision of the development of the regional cohort studies for their respective communities.

3. Regional (usually provincial) First Nation and Inuit political organizations should be invited to submit letters of intent indicating their interest in developing the longitudinal survey on behalf of all communities in their respective regions.

4. Regional organizations should be asked to propose a Research Group with whom they wish to collaborate in the development of the survey. Research groups should be approved by the National Steering Committees.

5. National Steering Committees should appoint a Core Questions Research Group who which will be responsible for the development of comparative "core questions" for the longitudinal surveys.

6. A National Aboriginal Technical committee should be established consisting of members of the "core question" Research Group and one member from all other Research Groups involved in the longitudinal surveys.

7. National Steering Committees should approve grants to each regional organization/research group to develop and implement the survey.

8. This initiative should be developed at a pace that is suitable to Aboriginal organizations and communities. It is likely that the first wave of the survey in 1996 will be restricted to several pilot projects in different parts of the country. Other regions and communities may not be ready to participate until 1998.

Of the three original participating federal departments, only Health Canada was prepared to go forward with these recommendations. With funding from the Tobacco Demand Reduction Strategy, Medical Services Branch issued a “Call for Proposals” from each of the regional First Nations political organizations and Inuit organizations in Labrador and Quebec.

3 DEVELOPMENT OF THE MANITOBA FIRST NATIONS REGIONAL HEALTH SURVEY

3.1 Development of a First Nations/University of Manitoba Partnership

In response to the call for proposals from Medical Services Branch, both the Assembly of Manitoba Chiefs (AMC) and the Manitoba Okimakanak Keewatiniowi (MKO) contacted the Northern Health Research Unit at the University of Manitoba to solicit interest in providing technical assistance. After discussion AMC and MKO decided that one proposal would be submitted and that AMC and MKO would be jointly responsible for the Survey, although AMC would administer the contract for the Survey.

The contract between the University and the Assembly of Manitoba Chiefs (AMC) reflected the principle that ownership and control over the Project remains with First Nations. In our initial discussions, AMC representatives expressed concern over publication rights and copyright.

The University, on the other hand, refuses to enter into contract agreements, where the contracting agency has the right to suppress publication. The University insists on its traditional responsibility to disseminate scientifically valid research results in the public domain. Contract language which delays publication on sensitive issues is sometimes agreed to, but outright suppression of information for political reasons is not permitted in University research contracts.

Our task was to develop a contract, which would formalize the respective concerns of both AMC and the University but would also facilitate the kind of collaborative process that we envisioned. Although this contract contains standard language typical in university research contracts, the two clauses describing "Ownership of Project Deliverables" and "Use of Information for Publication in Learned Journals" are somewhat unique and benefit from previous work in this area by the Kahnawake Schools Diabetes Program (ref). Essentially, copyright is the property of AMC who also must provide written permission before any publication. Permission to publish is dependent on a satisfactory review of the publication by the AMC Survey Steering Committee. In the event that University authors and the Steering Committee cannot agree, papers may be submitted for publication as long as they are accompanied by a letter from AMC outlining their objections. It then becomes the responsibility of the journal editor (or conference organizer) to resolve this conflict.

Although the University contract is with the Assembly of Manitoba Chiefs, who control the funding provided by the federal government for the initiative, direction for the Project is provided by the Manitoba First Nations Regional Steering Committee (RSC) mandated by the AMC Chiefs Health Committee in a formal resolution.

The primary health authority of First Nations in Manitoba - the Chiefs Health Committee of the Assembly of Manitoba Chiefs - determined the RSC structure. The RSC consists of the Health Directors for each of the Tribal Councils in Manitoba plus the Health Advisors from AMC and MKO. The AMC and MKO Health Advisors also represent

Independent Bands. The RSC has met regularly by teleconference and in workshops since the Project beginning. These meetings have included both "training" as well as decision-making on all aspects of research methodology. One of the first tasks was to develop a "Code of Ethics" for the Project. This Code emphasizes both individual confidentiality and community ownership of data, as well as the responsibilities of the Northern Health Research Unit in terms of data storage and accessibility.

These principles draw first of all on the contractual language described above, but further clarify the respective rights and responsibilities of the various First Nations organizations and communities.

3.2 Development of the Regional Questionnaire

There are sixty-one distinct First Nations in Manitoba, many of which are accessible by air only. With a limited budget, we could not expect to include all communities in the survey, but the RSC felt that all communities must have an opportunity to participate in the development of the questionnaire if the results of the survey were to be relevant beyond participating communities. In early summer, 1996, we hired eight First Nation university students as research assistants to conduct exploratory interviews with key stakeholders in all First Nation communities in Manitoba on health issues and concerns.

Students underwent a one-week training program, which emphasized conceptual rather than technical skills. By this we mean that students were asked to develop their own interview schedules, methods for keeping notes, and approaches to soliciting interviews in their assigned communities. Our training emphasized the political context of the research, its significance for developing a First Nations controlled health information system, and general strategies for conducting community-based qualitative research. Frank Wesley, an elder who advises the Assembly of Manitoba Chiefs, also spoke to the students about their responsibility to the future of their communities.

Each student was affiliated with one of the Tribal Councils, and the second stage of training involved an orientation in the field at the Tribal Council office where appropriate contacts with community authorities were facilitated. Students developed their own approach to community consultations. In some instances, interviews were conducted mostly with health care workers and the political leadership in the community. In others, students visited schools or met with elders to discuss relevant issues. Informal meetings with a wide variety of community members in recreational and family settings supplemented these more direct consultations.

The results of this consultation phase were then summarized by each student for their respective communities, and further summarized in regional reports. Reports were distributed widely for comment and reviewed by the RSC. Issues raised in the reports ranged from the impact of health reform policy, to physicians' fly-in schedules, to road conditions, to family violence, to the status of elders. Together these topics describe a

wide range of health and social conditions as well as the macro and micro environmental determinants of well being in communities.

One of the students, Ms. Doreen Sanderson, was subsequently hired as the Survey Coordinator and she underwent an intensive apprentice training program at the Northern Health Research Unit.

3.3 The Sample

The RSC was responsible for determining an appropriate strategy for selecting communities. Considerable discussion occurred around stratification issues. Questions were posed as to whether communities should be grouped by size, by geographic "remoteness", by political affiliation, by health service administrative features, by tribal affiliation (i.e., Cree, Ojibway, Dene, Sioux, etc.), or by whether they were regarded as healthy progressive communities or not. The RSC was particularly concerned that whatever criteria were used, the communities must be confident that the selection was random and not biased by political interests in any way. Ultimately seventeen communities were selected for an invitation to participate in the survey according to the following criteria:

1. Political Affiliation: Each of the seven Tribal Councils would select two communities with one exception (see below). In addition, one Independent First Nation from the "north" and one from the "south" of the province were also selected.
2. Tribal Affiliation: The Dakota Ojibway Tribal Council selected one community from each of the two major Tribal groupings in their area. Other Tribal Councils did not have this problem.
3. Geographic Factors: The Keewatin Tribal Council selected three communities in order to adequately represent their large geographic region where communities are clustered in three distinct geographic areas. The Southeast Resource Development Council selected one community from among fly-in communities and one community from among road access communities.
4. Community Size: The RSC determined that a minimum sample of 100 adults was necessary in order to produce reliable and confidential community level data. Only communities with populations of at least 250 people were determined to be eligible for selection. Several Tribal Councils also insisted that at least one of the two selected communities in their regions should have a population of at least 1500 people.

Seventeen communities (and alternates) were randomly selected and the RSC extended an invitation to the Chiefs of these communities to participate in the survey. One community declined based on past involvements with other surveys.

Sampling considerations next involved a discussion of how individual respondents should be identified. Use of a list of residents for each community has many

problems as identified in previous research in northern communities. Resident lists are sometimes regarded as the confidential political property of the Band because they are contentious documents in negotiations for per-capita-based funding. Often lists do not accurately reflect Band members currently living in the community. Accessing respondents from a random list of names can be particularly difficult when people migrate back and forth to cities, or change residence on the reserve.

The RSC determined that a household-based approach to sampling would be more appropriate. Houses were randomly selected from a map of each community and all adults and one child or youth under eighteen years of age (by proxy) was interviewed for each house. The survey was completed in three months with an overall response rate of 81%, and a majority of communities reporting 100% completion of questionnaires. Sampling considerations and response rates are summarized in the Table below:

COMMUNITY	POPULATION	TARGET SAMPLE Adult/Children	INTERVIEWS COMPLETED Adult/Children	RESPONSE RATE Adult/Children (%)
Norway House	3490	200/100	154/81	77/81
Lac Brochet	640	100/50	55/17	55/34
Split Lake	1531	150/75	148/60	99/80
God's Lake	1147	150/75	102/32	68/43
Opaskwayak	2311	200/100	137/48	69/48
Chemawawin	747	100/50	99/36	99/72
Little Grand	928	100/50	95/47	95/94
Little Black	360	100/50	100/36	100/72
Waywayseecappo	1124	150/75	146/66	97/88
Wasaagamack	1064	150/75	150/89	100/119
Garden Hill	2605	200/100	100/39	50/39
Souix Valley	1086	150/75	112/51	75/68
Sandy Bay	2686	200/100	134/70	67/70
Fairford	1112	150/75	149/67	99/89
Little Sask	458	100/50	94/40	94/80
Pine Creek	807	100/50	73/43	73/86
Ebb & Flow	881	100/50	100/48	100/96
TOTAL	22,977	2400/1200	1948/870	81/73

3.4 Capacity-Building

Each participating community was asked to select up to three individuals for training as community interviewers. Communities were advised to select individuals who respected confidentiality and were considered trustworthy; research or health care experience was a secondary consideration. Three training workshops of three days duration were organized in different regions of the province for community interviewers. Training emphasized interviewing techniques, principles of random selection of respondents, and issues of confidentiality and ethics. Interviewers were encouraged to be flexible and creative in interviewer techniques, rather than expecting uniformity in approach. For example, interviewers were advised that joint interviewing of several respondents could occur if each respondent was able to complete a questionnaire independently while the interviewer acted as a guide. Interviewers were also encouraged to allow respondents to complete their own questionnaire in the interviewer's presence wherever possible in order to facilitate confidentiality.

This approach is somewhat at odds with standard survey methodology where consistency is emphasized in order to minimize interviewer bias. However, flexibility is essential in a First Nations community context to accommodate cultural differences and maximize participation rates.

Capacity-building of the Regional Steering Committee's data analysis skills was facilitated by an NHRDP grant to the Northern Health Research Unit to sponsor a Training initiative in applied population health research skills. This initiative was organized in partnership with AMC and formally offered as a one week long First Nations Summer Institute in Applied Population Health Research. In addition to skill development in the interpretation and analysis of community health surveys, participants gained familiarity with the use of other health information databases such as hospitalization and physician utilization records, and disease registries.

Data entry and database development for the RHS was undertaken by technicians at the Northern Health Research Unit. The Regional Steering Committee determined that data entry skills were not a priority at either the community or regional level, although an Aboriginal assistant at the NHRU has now assumed all data entry responsibilities. Analysis has been an iterative process with the Regional Steering Committee receiving data output at all levels. Raw frequencies on all variables were distributed as rapidly as possible and a Regional Steering Committee meeting was held to provide preliminary input into interpretation of these results. Graphic representations of key variables were next distributed to the RSC. Community reports describing key variables in graphic form compared to regional results were then distributed to all participating communities. One representative from each participating community was then invited to participate with RSC members in Workshops to discuss interpretation of findings and policy implications.

The Final Report for the Manitoba Survey is designed to reflect the content of discussions at these Workshops. The data is graphically reported in three sections. The first section will describe key variables from the survey. The second section compares

these results to national results, and to other relevant Surveys such as the Aboriginal Peoples Survey, the National Population Health Survey, and the National Longitudinal Study of Children and Youth. The final section of the Report provides a preliminary analysis of social determinants of health concerns including gender, age, income, and geographic location. Further in-depth analytical studies are planned.

Community reports are the property of participating communities and cannot be shared or distributed without their permission. Regional reports are the property of the Regional Steering Committee and will be distributed to all First Nations communities in Manitoba, all Tribal Councils and First Nations organizations, and to other interested parties approved by the RSC. A Summary Report of the regional health survey will be made available to interested members of all First Nations communities.

4 DESCRIPTION OF HEALTH IN MANITOBA FIRST NATIONS

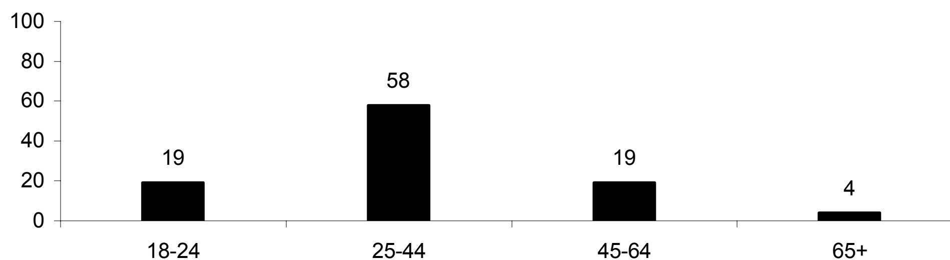
4.1 Introduction

This section of the report will provide a general description of the results of the Manitoba First Nations Regional Health Survey. Based on discussions with community representatives and the Regional Steering Committee Members, key variable were selected for descriptive presentation.

4.2 Sociodemographics

More than half of the sample of people interviewed were between the ages of 25 and 44. Nearly 60% of the sample were women. These results suggest a slight bias in the survey since the actual First Nation population in Manitoba is younger and consists of equal numbers of men and women.

Figure 1: Age Distribution



Slightly more than half of the people interviewed indicated an aboriginal language as their preference in day to day conversation. Only 19% of the sample have completed high school; 13% of the total sample have gone on to post secondary education. The vast majority (68%) have completed some secondary or high school education but 13% indicated only completing elementary education.

Figure 2: Gender %

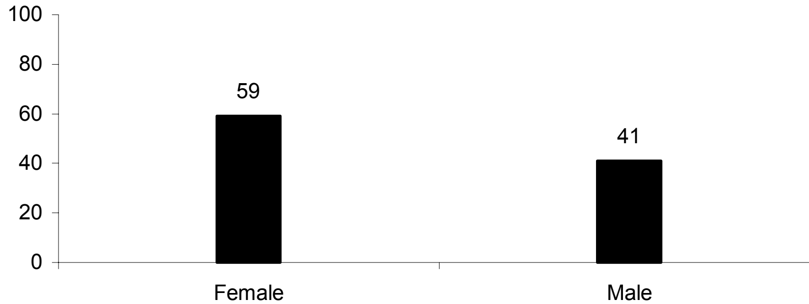


Figure 3: Language most comfortable speaking %

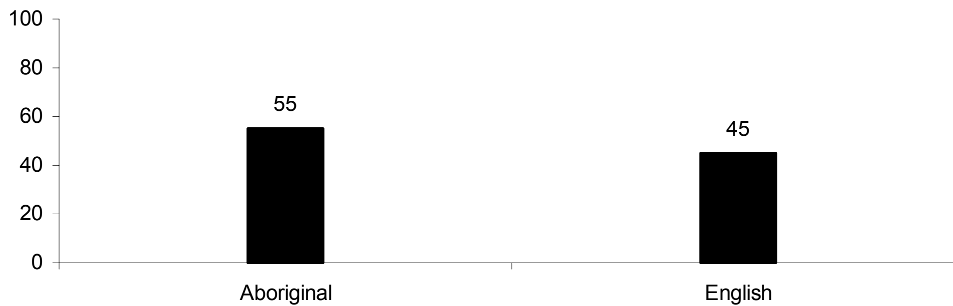
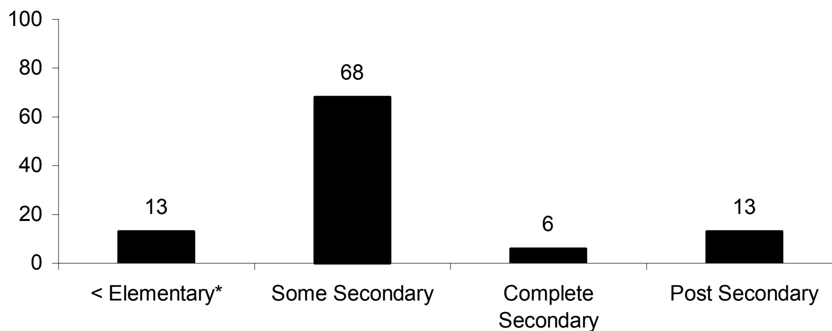


Figure 4: Highest education level attained %



Nearly half of the sample indicated that they did not work for wages in the previous year, with 50% of the sample reporting their primary source of income as a government transfer payment, such as Social Assistance, Old Age Pension, etc. Approximately half the people interviewed indicated their annual household income was less than $10,000 and nearly 80% reported household incomes of less than $25,000. Not surprisingly only 33% of the people interviewed indicated that their household income met all their basic needs.

Figure 5: Percentage of people who worked for income

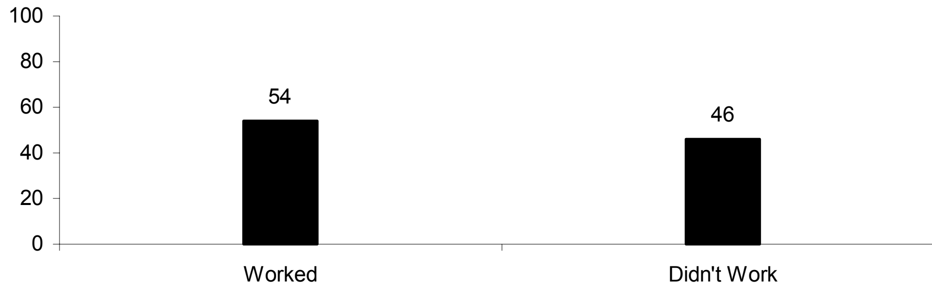


Figure 6: Primary source of income %

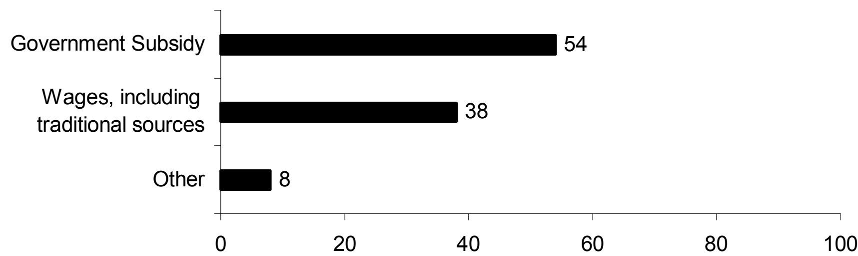


Figure 7: Total household income %

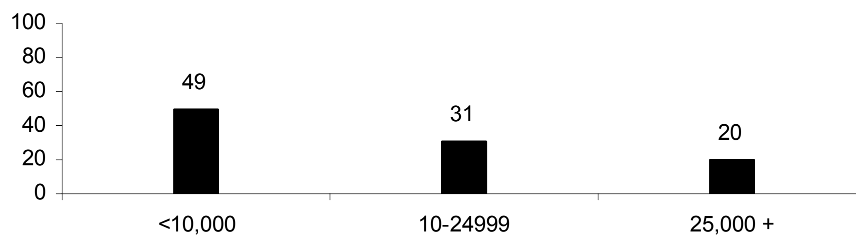
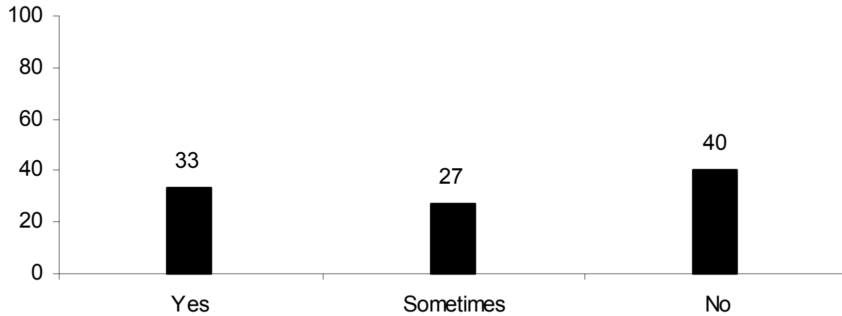


Figure 8: Percentage of people who indicated that their household income meets all basic needs



A large majority of the people interviewed (67%) indicated they were living with a partner, either married or common-law. Almost three-quarters of the people interviewed indicated that they were living in a household with four or more people. A surprisingly large number of the people interviewed (29%) indicated they were living in a single parent or guardian household. Only 5% of the people interviewed indicated they were living alone.

Figure 9: Marital Status %

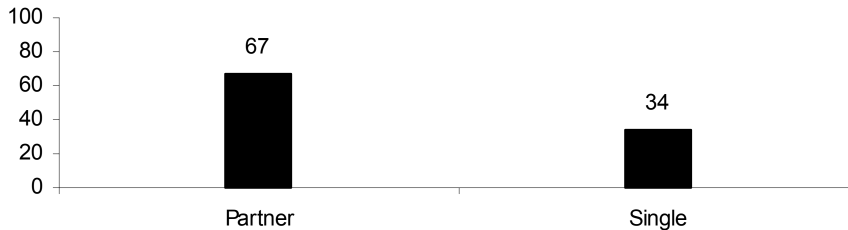


Figure 10: Number of people living in the household%

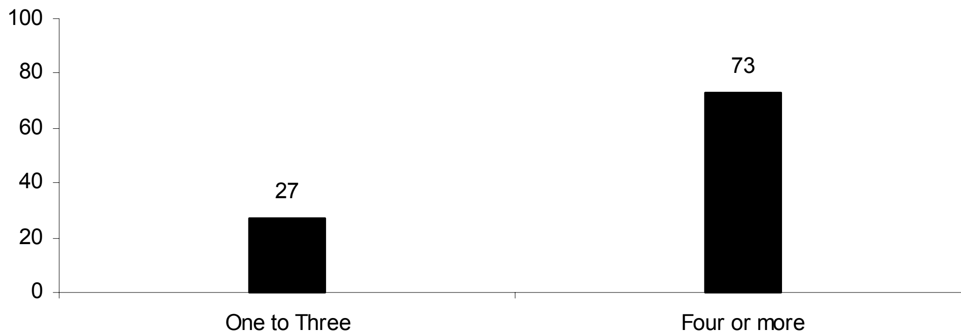


Figure 11: Single parent-guardian households %

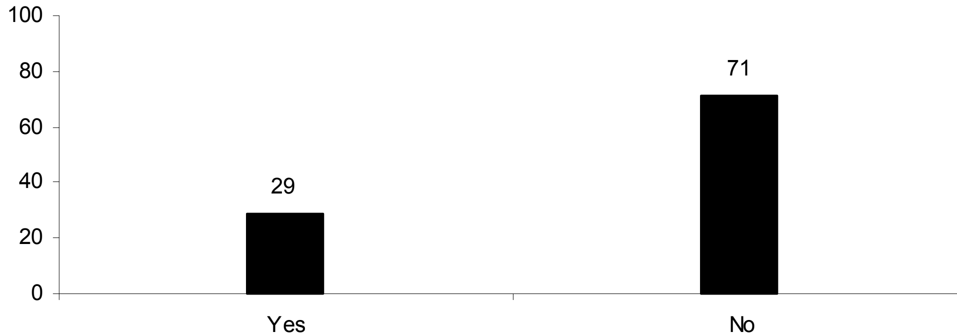
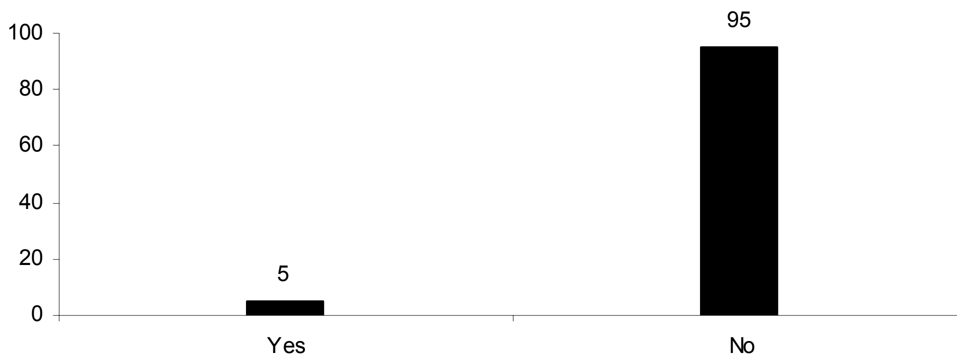


Figure 12: Percentage of people living alone



These results suggest several things. First, educational and employment opportunities continue to be restricted in Manitoba First Nation Communities. As will be discussed in a later section of this report, these constraints have a significant influence on the poor health status of the First Nation Communities. However, these results also suggest that the social and cultural strengths of First Nation Communities continue to be important. Aboriginal languages are alive and well. The majority of people live in family based households with very few people isolated and alone.

4.3 Health Status

4.3.1 Adults

Many studies have shown that people's perceptions of their health provide an excellent indication of their general state of health. Approximately half of the people interviewed reported their health as poor to fair. 25% of the people interviewed indicated their hearing ability was poor to fair, and approximately half of the people interviewed

indicated their eyesight without glasses was poor to fair. 53% of the people interviewed indicated they required dental treatment at this time.

Figure 13: Self reported health status%

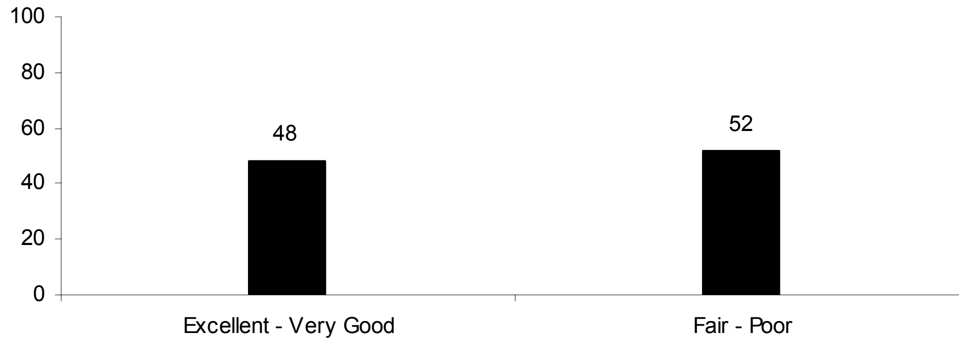


Figure 14: Self-rating of hearing ability %

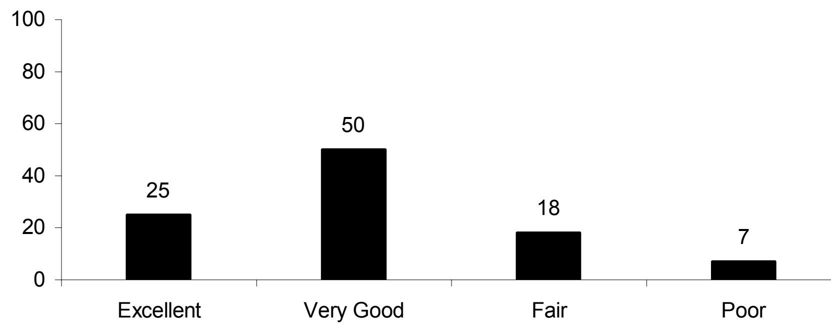


Figure 15: Self-rating of eyesight without glasses %

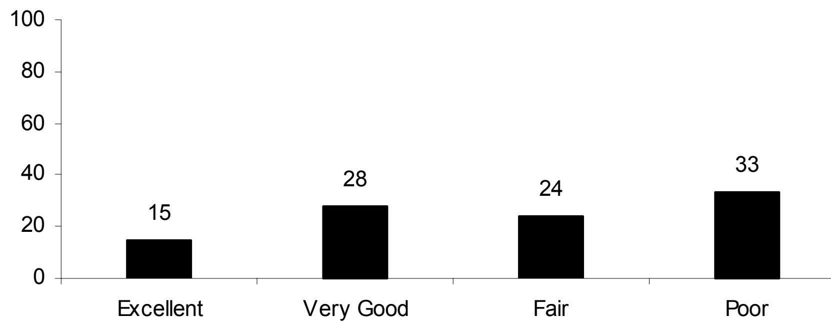
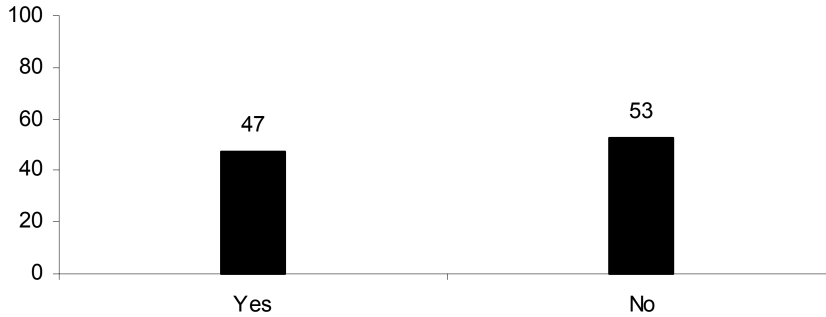
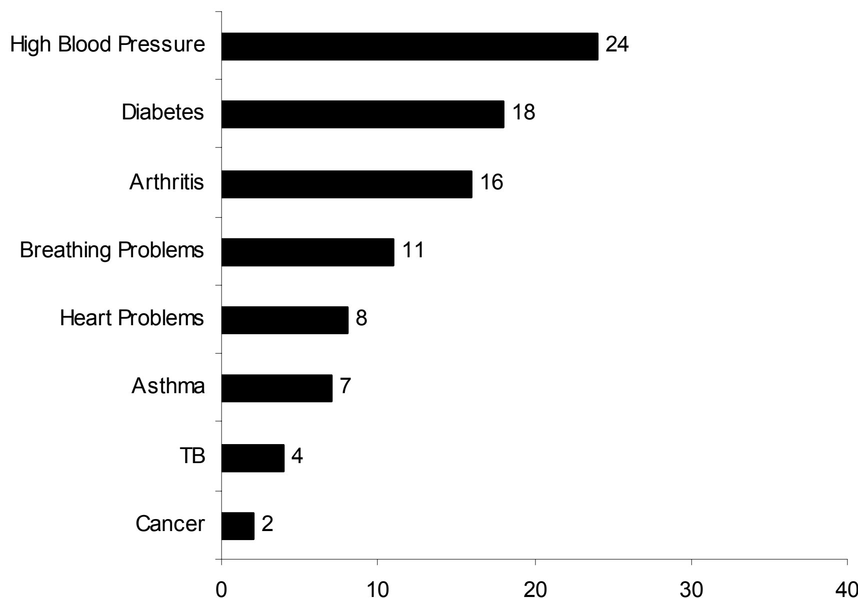


Figure 16: Percentage of people who require dental treatment at this time



People were also asked whether or not a physician had told them that they had a particular health problem. The response to this question suggests a high level of chronic illness in First Nation communities. One quarter of the people interviewed indicated that they had been told they had high blood pressure. 18% indicated they had diabetes. Other problems such as arthritis, breathing problems, heart problems, asthma, TB and cancer were reported at relatively high levels. Comparative analysis of these reports is provided in a later section.

Figure 17: Self reported health problems %



More than half of the women diagnosed with diabetes reported that they were diagnosed with gestational diabetes during one of their pregnancies.

Figure 18: Women reporting diabetes that have had gestational diabetes %

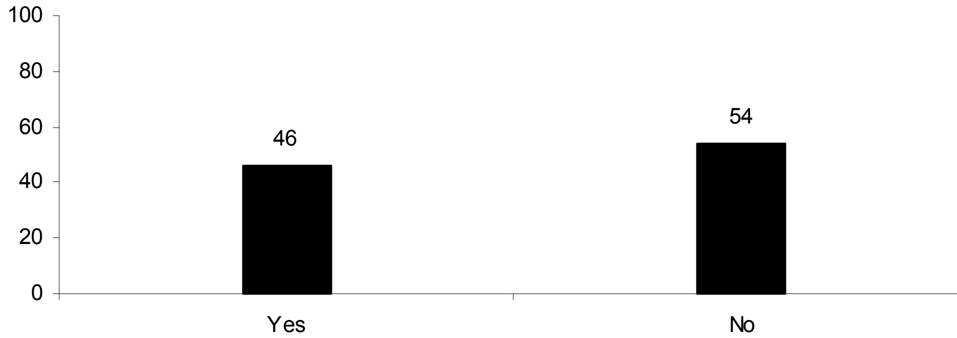
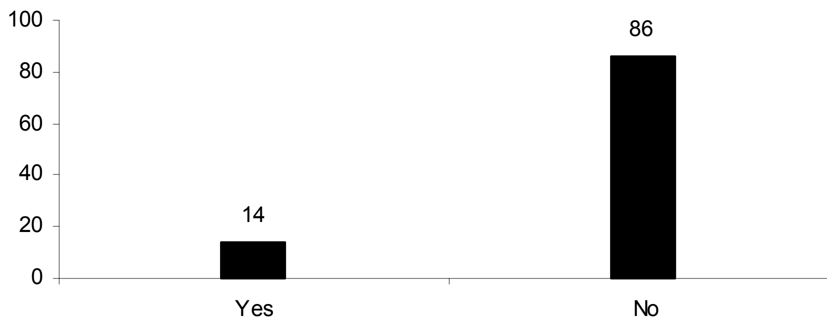
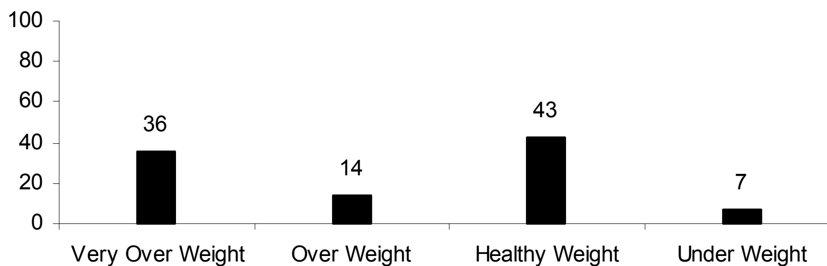


Figure 19: People disabled with a long term health problem or condition %



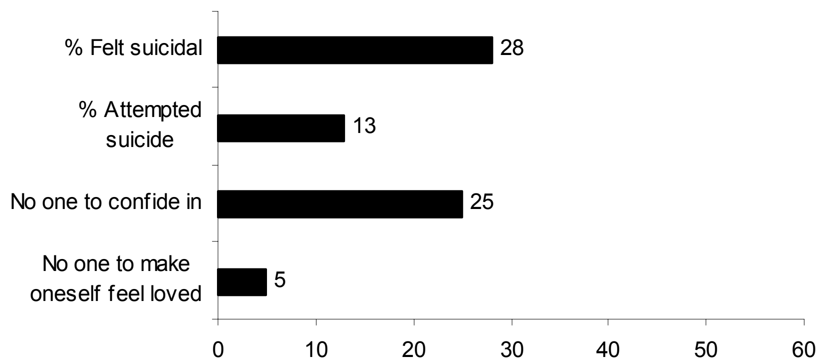
People were asked to report their height and weight, and calculations were done comparing these indicators to standard measures of healthy weights. One half of the people interviewed were overweight by these calculations and a very significant 36% of people were very overweight by these calculations.

Figure 20: People with weight problems %



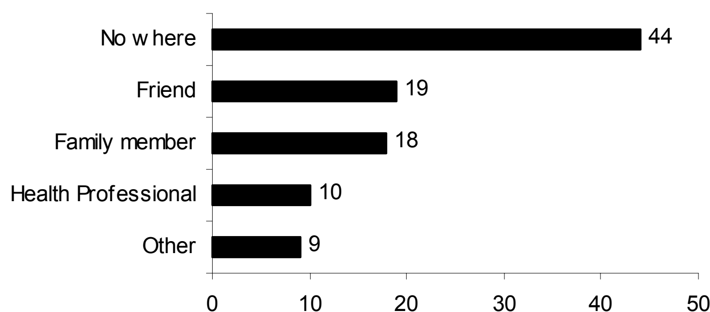
Mental health problems were assessed through questions about suicidal feelings and emotional concerns. A very high proportion of people interviewed (28%) indicated that they had felt suicidal at some point during their life and 13% indicated that they had actually attempted suicide.

Figure 21: People reporting mental health problems %



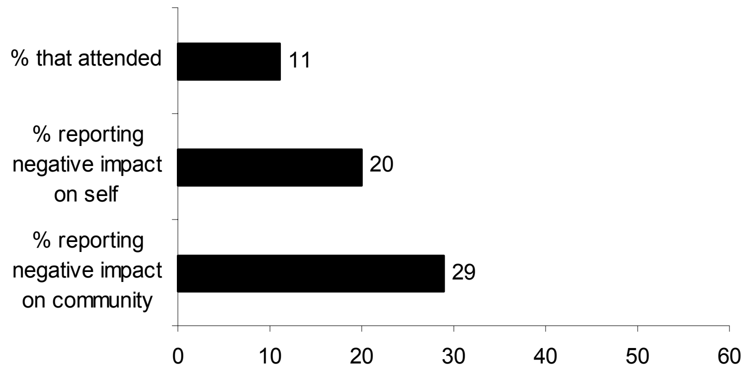
Although 25% of the sample indicated that they had no one to confide in, only 5% indicated that felt that no one cared for them or loved them. Of those people who indicated that they had felt suicidal, a large number (44%) indicated that they did not have anyone to turn to for help. 37% of people who felt suicidal turned to friends or family members, but only 10% of those people who felt suicidal went to a health professional for help.

Figure 22: Where help sought when feeling suicidal %



The residential school system has been identified as a major source of health problems for many First Nations people. In Manitoba 11% of the people interviewed indicated that they had attended a residential school. However 20% indicated that residential schools had a negative impact on their lives, and 30% of people interviewed indicated that the residential school system had a negative impact on the community as a whole.

Figure 23: Impact of residential school system %



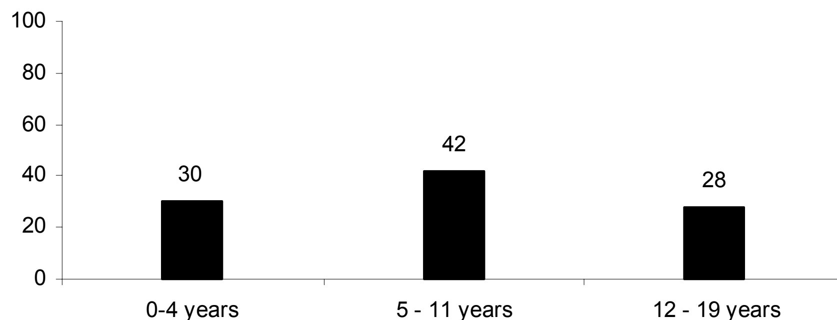
For a variety of reasons, including flooding of traditional camping, hunting and trapping areas, and to conform to government priorities, many First Nation's people have been relocated on a mandatory basis to new communities. Again it has been suggested that relocation has a negative impact on people's well being. 11% of the people interviewed indicated that they have been forced to relocate to their current community, and a further 12% reported that their parents or grandparents had been forced to relocate, and of those people reporting self or familial relocation, 62% indicated that relocation had a negative impact on themselves or their family.

Figure 24: Impact of relocation %

4.3.2 Children

An assessment of children's health status was provided by either the mother or father in the adult interviews. For the purposes of this survey, anyone under the age 18 was considered a "child". 42% of the children's sample were in the 5 to 11 year old age group. The remainder was equally distributed in the 0 to 4 and 12 to 19 year old age groups.

Figure 25: Age distribution of children %



Based on mother's reports 7% of children had low birth-weight.

Figure 26: Child's approximate birthweight %

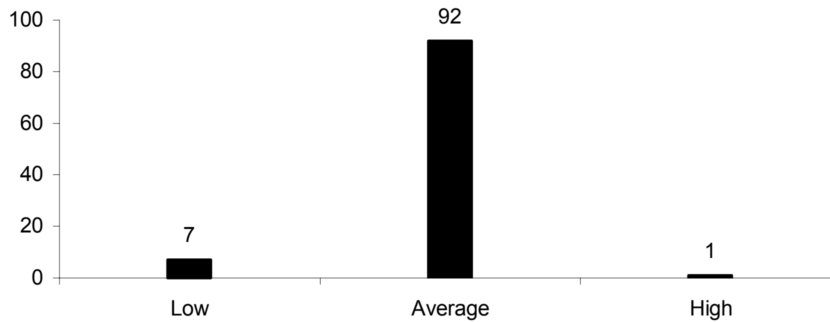
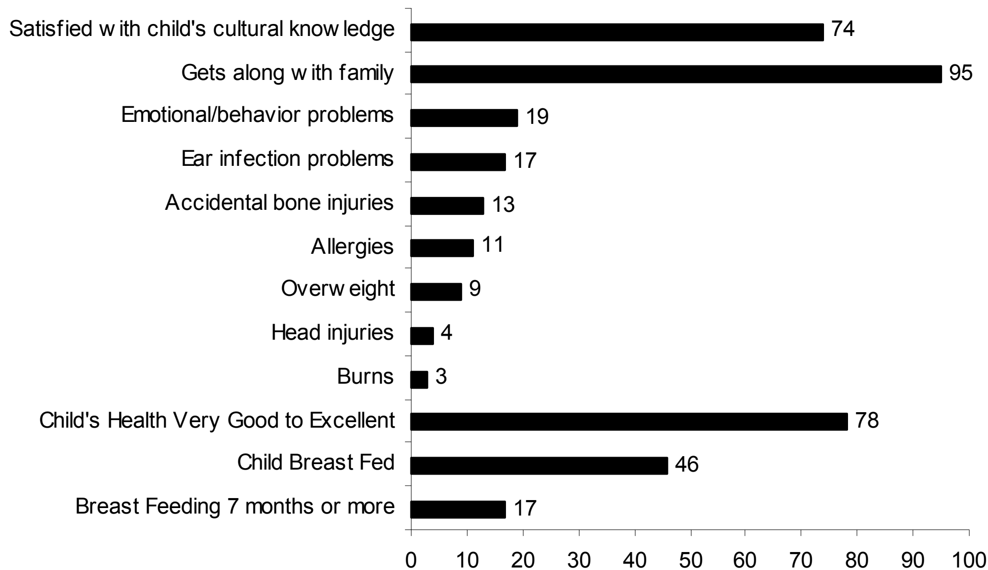


Figure 27 (Children's General Health) summarizes the results of the interview questions related to a range of children's health concerns. Almost everyone interviewed (95%) were happy with the relationship of the child to the family, but 19% indicated that their child was experiencing emotional or behavioral problems. 74% were satisfied with their child's cultural knowledge.

Other health problems identified included ear infections, injuries, allergies and weight problems. The number of children with accidental injuries is much higher than one would expect.

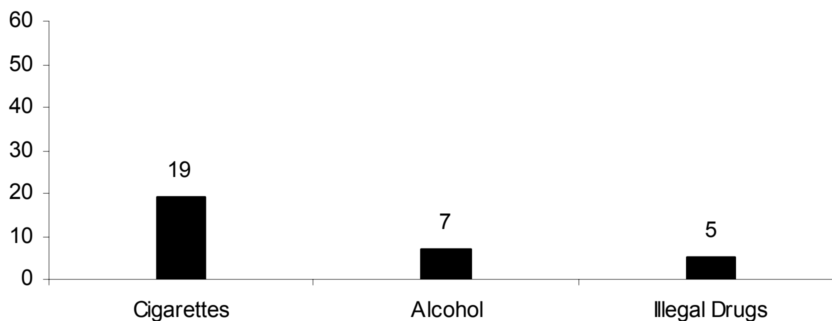
Almost half the parents reported that their child had been breast-fed, with 17% of parents reporting that their child had been breast-fed for more than six months.

Figure 27: Children's general health %



Cigarette smoking among children would appear to be a significant problem with 19% of parents indicating their knowledge of their children smoking. Alcohol and drugs appear to be a less serious problem, although these results are based on parent's knowledge.

Figure 28: Child's use of unhealthy sustances %



In summary, it appears that parents generally consider their children to be in good health and to have relatively few emotional or behavioral problems with the exception of cigarette smoking and accidental injuries.

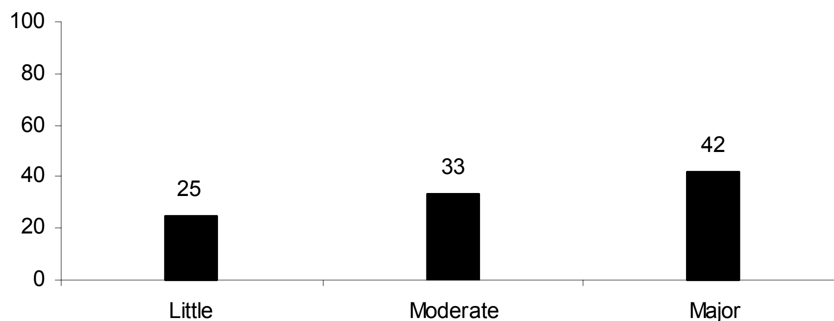
4.4 Health Behavior

The survey asked a series of questions about people's dietary practices, smoking patterns, use of alcohol and drugs, and behavior related to HIV/AIDS. These areas of behavior are all known to be related to health status.

4.4.1 Nutrition

People were asked a series of questions asking whether they had made dietary changes such as eating less salt, less fat, less sugar, and more fruits and vegetables. Responses were then calculated to indicate minor, moderate or major dietary changes. Almost half of the people interviewed (42%) indicated they had made major dietary changes.

Figure 29: People reporting that they have made positive dietary changes %



Virtually everyone interviewed (94%) indicated that at least a portion of their diet came from wild foods, including land animals, fish and water fowl. However, only 20% of people indicated that more than half of their diet was derived from wild foods and only 18% of people interviewed indicated that they ate wild food at least once a week. Obtaining wild food did not appear to be a significant problem, since 79% of people interviewed indicated they had no problem obtaining the wild food they wanted in the past year.

Figure 30: People who eat wild foods %

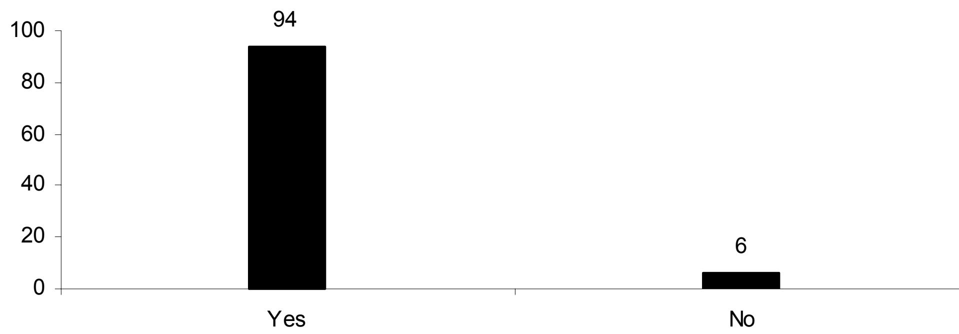


Figure 31: People who include wild meat as part of their daily diet %

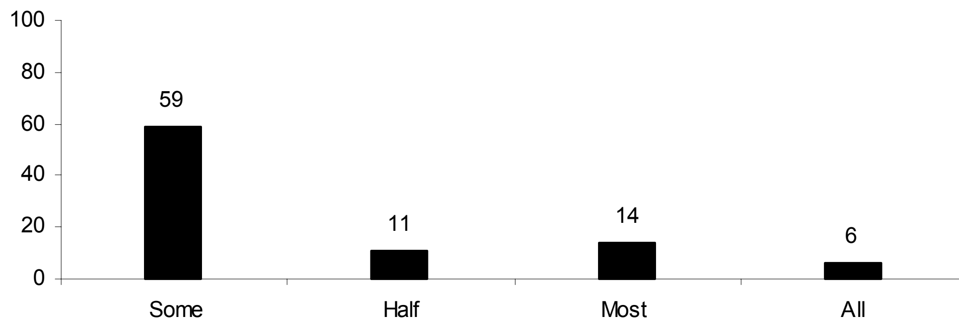


Figure 32: Number of times wild food eaten in the last year %

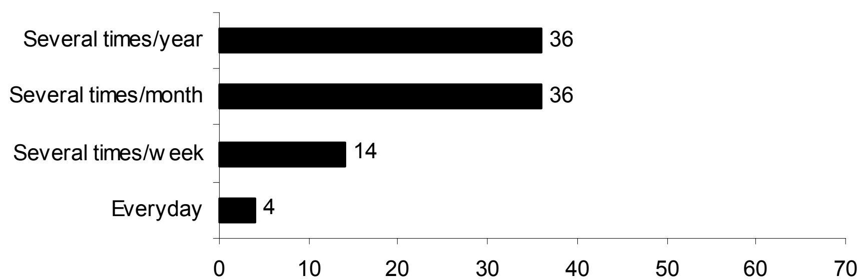
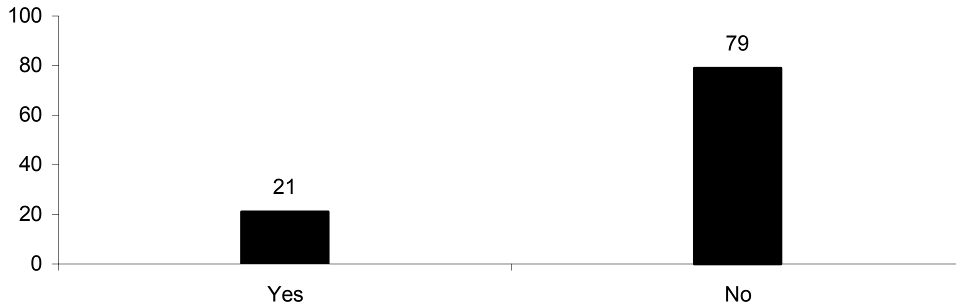


Figure 33: People report having problems obtaining wild meat in the last year %



Of more serious concern is the problem of having insufficient money in the household to purchase food necessary for the family diet. Almost half (46%) of the people interviewed indicated that running out money for food was a household problem. Almost one-third (31%) indicated that running out of money for food occurred at least once a month in their household.

Figure 34: Household run out of money for food %

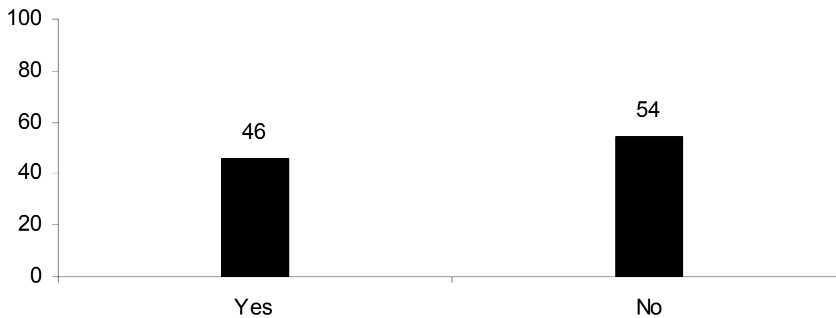
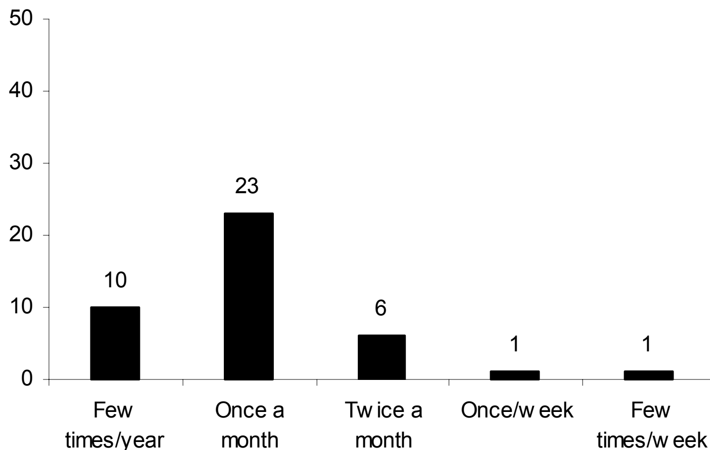


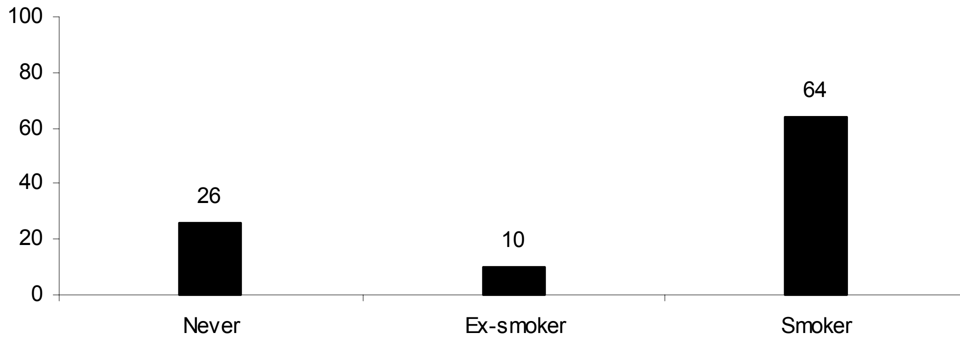
Figure 35: People reporting how often household runs out of money for food %



4.4.2 Smoking

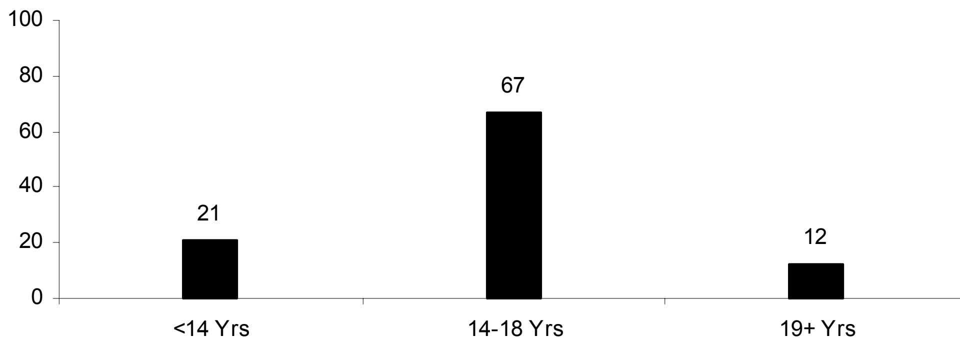
Cigarette smoking has been widely identified as a major risk factor in a variety of health problems including heart disease, cancer and other respiratory problems. Traditionally First Nation's people used tobacco for spiritual and ceremonial purposes. However, cigarette smoking is a major health concern in First Nation communities. Sixty-four percent of the people interviewed indicated they were currently smoking cigarettes with only 10% of the people interviewed indicating that they had quit smoking.

Figure 36: Smoking status %



Also of concern is the early age when children begin to smoke. Twenty-one percent of current smokers indicated they began smoking before the age of 14, and a further 67% of people interviewed indicated that they began smoking before the age of 18.

Figure 37: Age when started smoking %



On the positive side (55%) reported smoking fewer than 12 cigarettes per day and 35% of all people reported that no one smoked on a daily basis in the home. However, only 22% of the households where people were interviewed indicated that they were smoke free, despite the fact that 58% of people interviewed indicated that they had made an attempt to control smoking in the household.

Figure 38: Number of cigarettes smoked per day (daily smokers) %

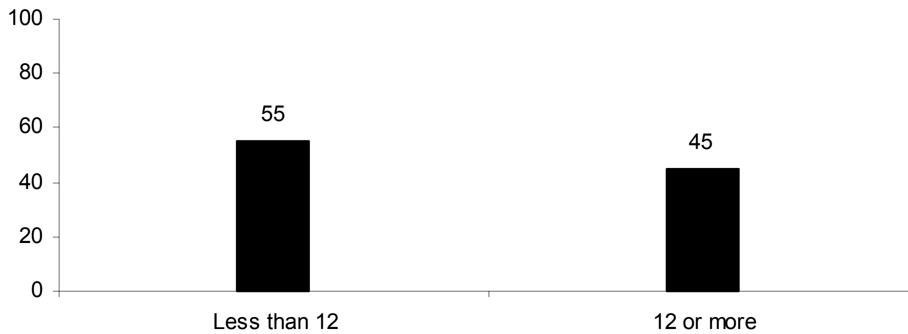


Figure 39: Percentage reporting daily smoking in the house

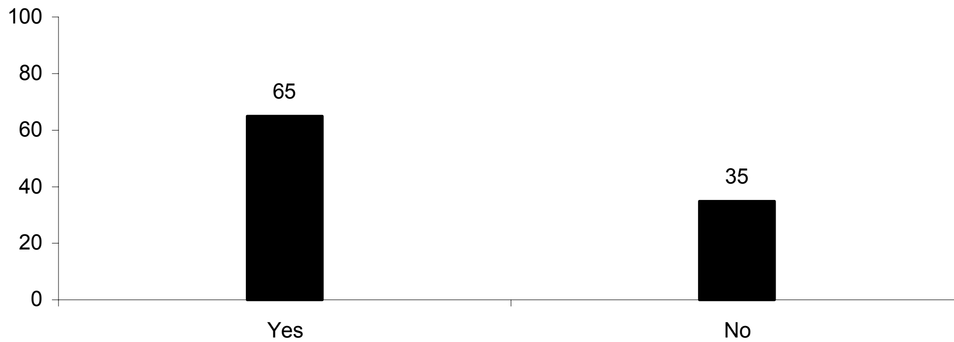


Figure 40: Number of daily smokers in house %

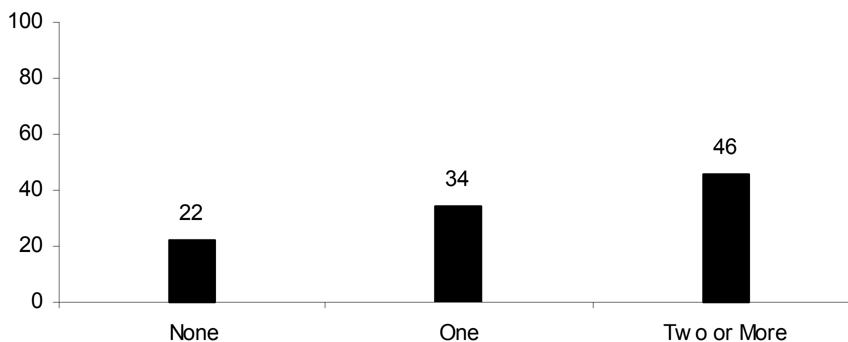


Figure 41: People who find the effects of second hand smoke unpleasant %

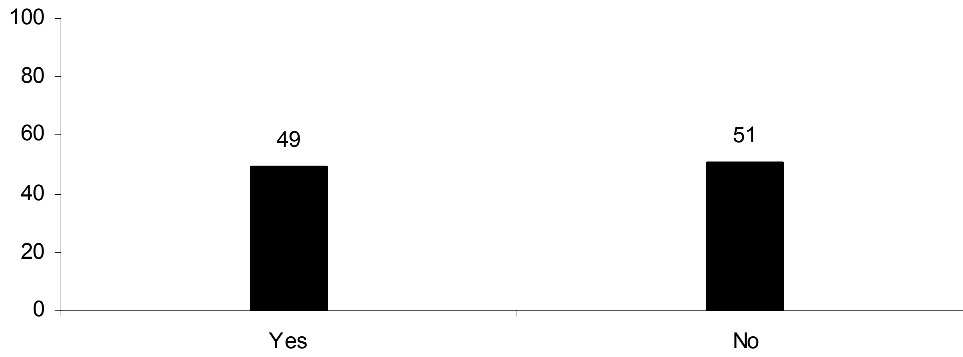
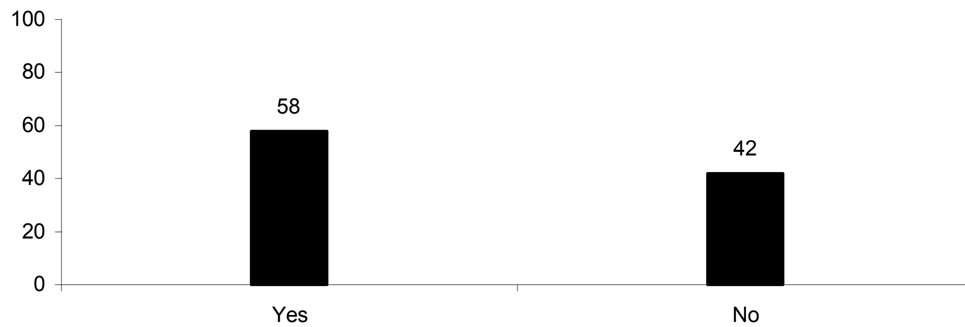


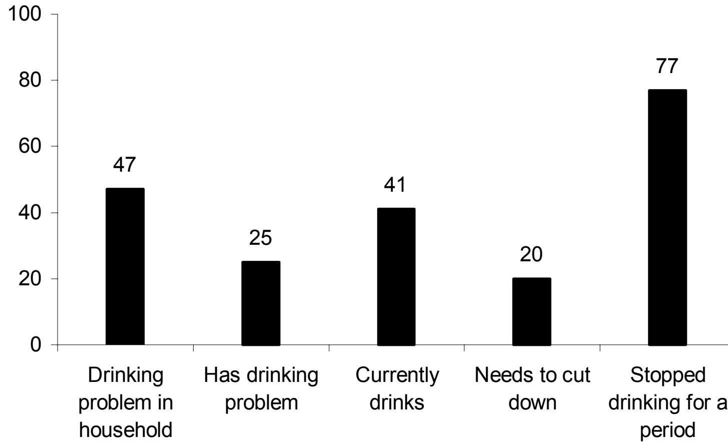
Figure 42: People who report attempts to control smoking in the households %



4.4.3 Substance Use

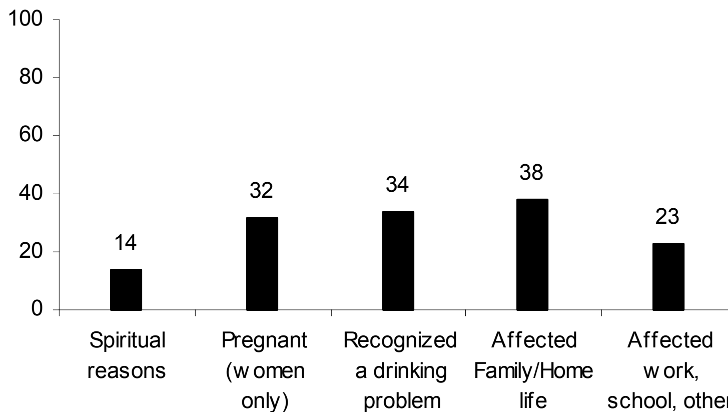
Alcohol abuse has been identified as a serious health concern in some First Nations communities. Nearly half of the people interviewed (47%) confirmed this by reporting that alcohol consumption was a problem in their household, and 25% of the respondents indicated that they felt they had a drinking problem themselves.

Figure 43: People indicating problems with alcohol %



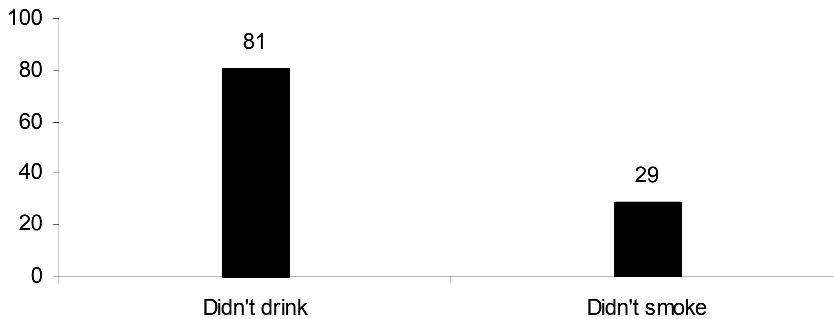
Awareness of this problem is high however, with 77% of the respondents reporting that they had stopped drinking for a period of time. Reasons given for cutting down or quitting drinking ranged from a recognition that alcohol consumption was affecting home life (38%) to spiritual reasons (14%).

Figure 44: Reasons given by people who have quit drinking alcohol %



A large proportion of women interviewed (81%) reported that they did not drink during their last pregnancy, but only 29% reported that they did not smoke.

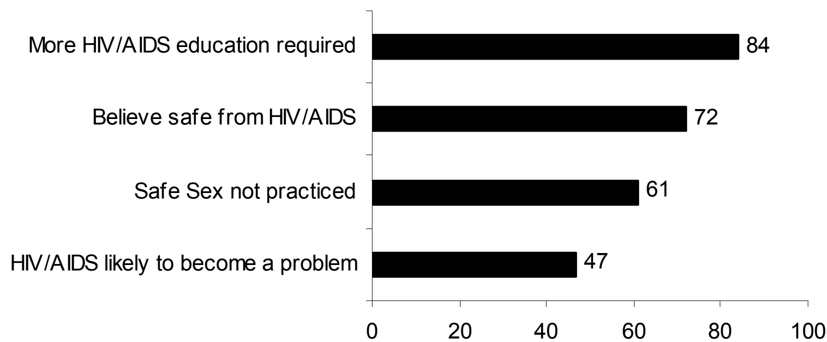
Figure 45: Lifestyle changes during last pregnancy %



4.4.4 HIV/AIDS

Although a large majority of people interviewed (84%) indicated that they felt more HIV/AIDS education was required in communities, nearly half of the people interviewed reported that they did not think that HIV/AIDS was likely to become a problem in First Nation communities in Manitoba. Again, although 72% of people reported they felt they were not at risk to contract HIV/AIDS, 61% of people reported that they rarely used condoms.

Figure 46: HIV/AIDS awareness%

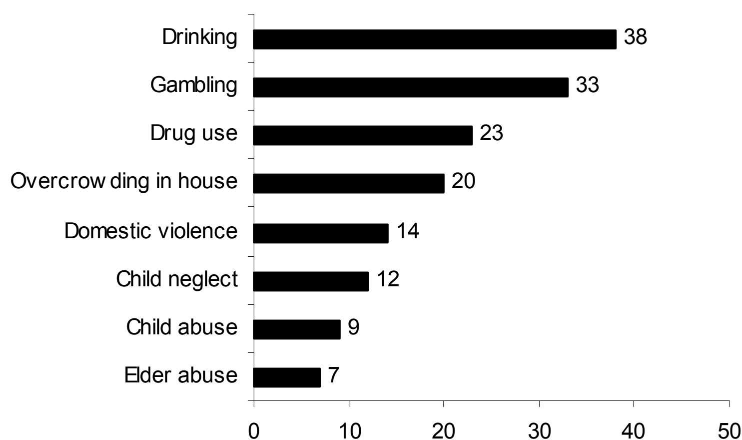


4.5 Community Health Concerns

In this section we describe people's responses to questions dealing with health issues and social problems in the community. These questions were designed specifically to increase the chances of an accurate response. Questions asked people to indicate whether they felt there was a particular problem in their household. The Regional Steering Committee felt people might be more comfortable answering a question about problems in the household rather than a question about personal problems.

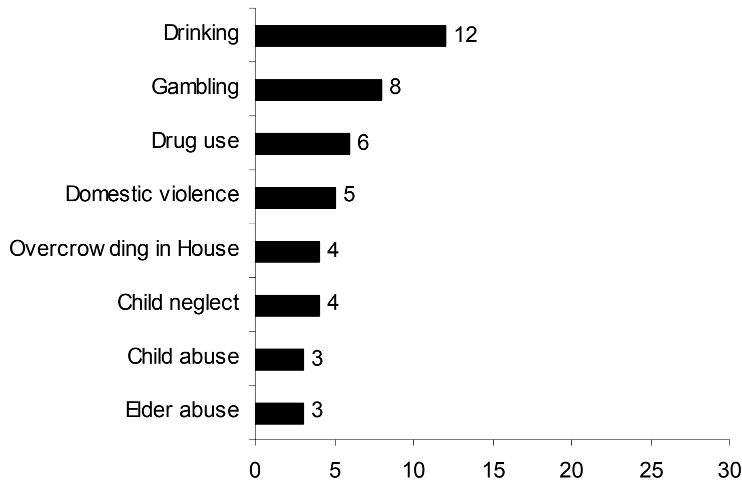
Figure 47 "Percentage of People Reporting Problems in the House" ranks the problems according to the proportion of people who indicated these were problems. Alcohol consumption, gambling, and drug use emerge as three most important problems as reported by approximately one-third of the people interviewed. The most significant problem, alcohol consumption, would appear to be a problem in nearly 40% of the households in First Nation communities. Equally important, the fact that 33% of First Nation households report gambling as a problem underlines the emerging significance of this issue. Although problems such as domestic violence, child neglect, child abuse, and elder abuse are reported less frequently, these problems are still significant in approximately 10% of First Nation households.

Figure 47: People reporting problems in the house %



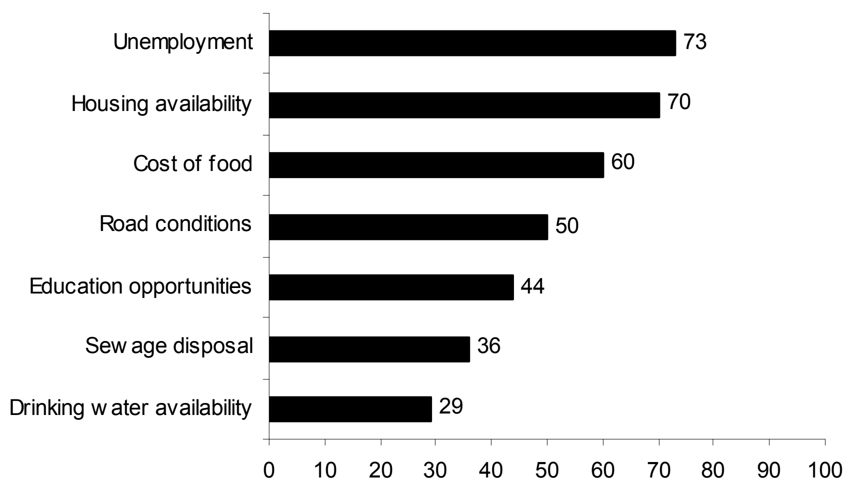
A subsequent question asked people whether any of these problems had improved in their household over the past two years. Twelve percent of people interviewed reported that alcohol consumption as a problem had decreased. For other problems less than 10% of the people interviewed indicated that these problems had improved.

Figure 48: People reporting that problems in the house have improved in the past two years %



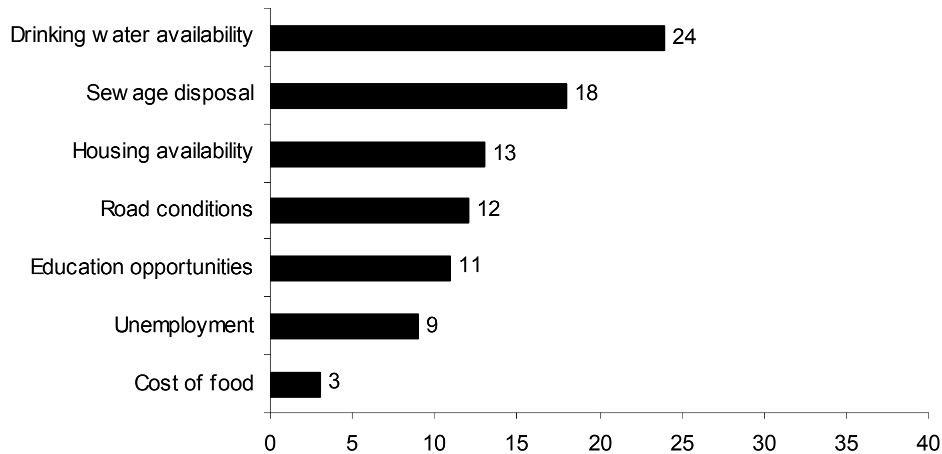
The next questions deal with what are broadly referred to as "Social Determinants" of health. These factors include such things as employment, housing, cost of food, road conditions, education opportunities, sewage disposal facilities, and the quality of drinking water. Nearly three-quarters of the people interviewed reported that unemployment and housing availability were major problems in their communities. Cost of food came third in the list of problems with 60% of people reporting this as a problem. A much smaller proportion of people reported sewage and drinking water availability as problems in their communities.

Figure 49: Percentage of people who indicate the following are major problems in their community



With the next question asking whether any of these problems had improved, people confirmed that drinking water and sewage disposal were two areas in which major improvements had occurred in their communities in the past two years, with nearly a quarter of all people interviewed reporting that these problems had improved. The problem where the least changes have occurred would appear to be the cost of food, where only 3% of people interviewed reported that this problem had improved.

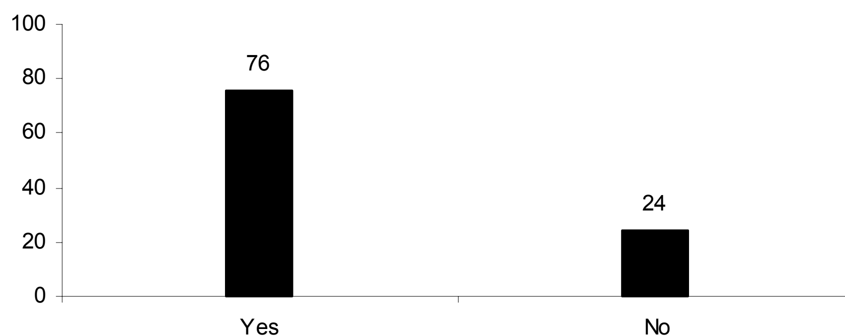
Figure 50: People who indicate the following community problems have improved in the past two years %



4.6 Healing and Wellness

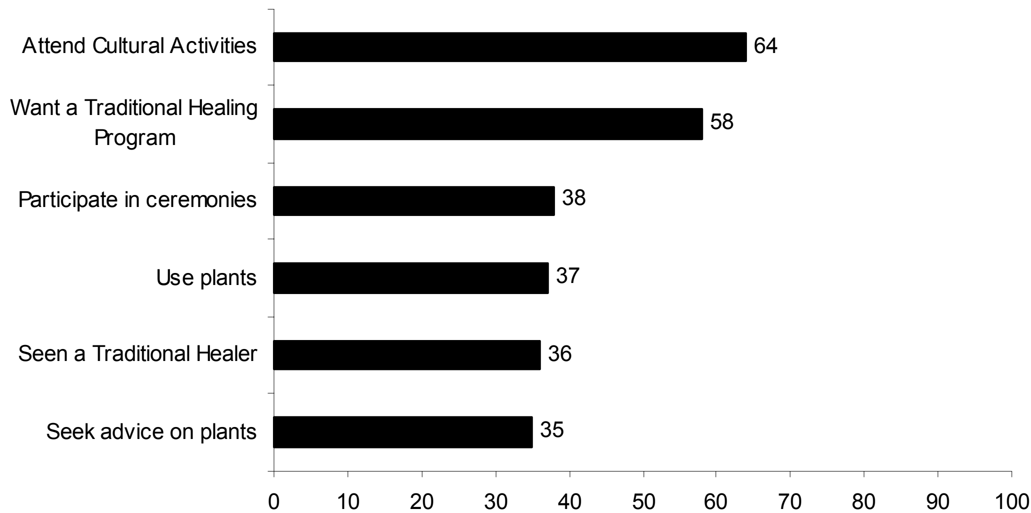
Traditional approaches to health and healing have become an important factor in First Nation approaches to community wellness over the past several years. This trend is reflected in the finding that 76% of people interviewed reported that they feel traditional ways are an important element of community wellness.

Figure 51: People who think traditional ways are a good idea %



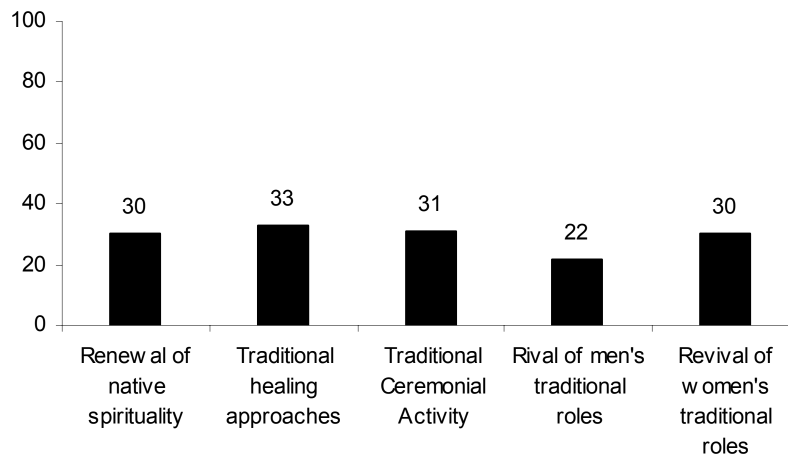
Individual participation in traditional activities is described in Figure 52. While 64% of people interviewed reported that they attend cultural activities, only about one-third of the people interviewed reported direct participation in traditional healing activities. Nonetheless, 58% of people indicated that they would like to have a traditional healing program available as part of a community wellness plan.

Figure 52: People who responded positively on traditional healing topics



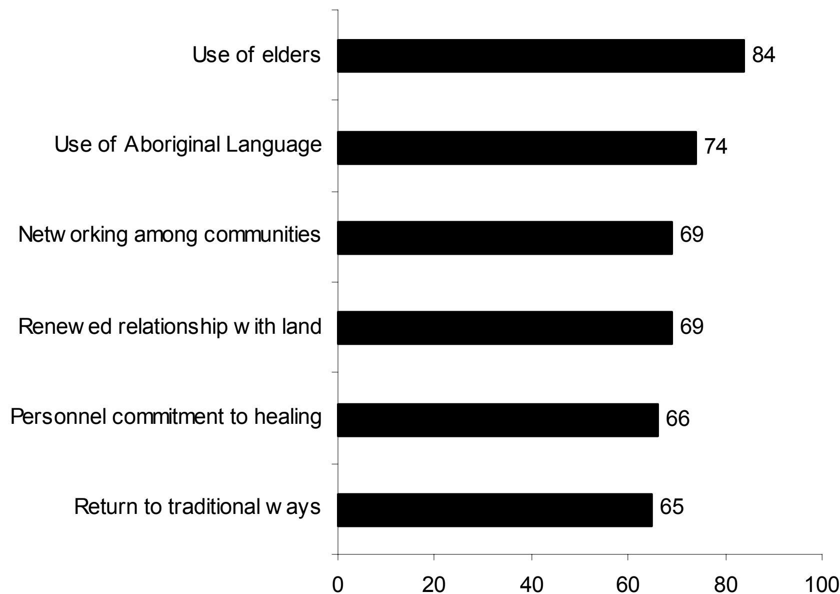
Again, approximately one-third of people interviewed indicated that progress has been made in areas such as native spirituality and ceremonial activity in the development of community wellness plans.

Figure 53: People who indicate progress in traditional community wellness indicators %



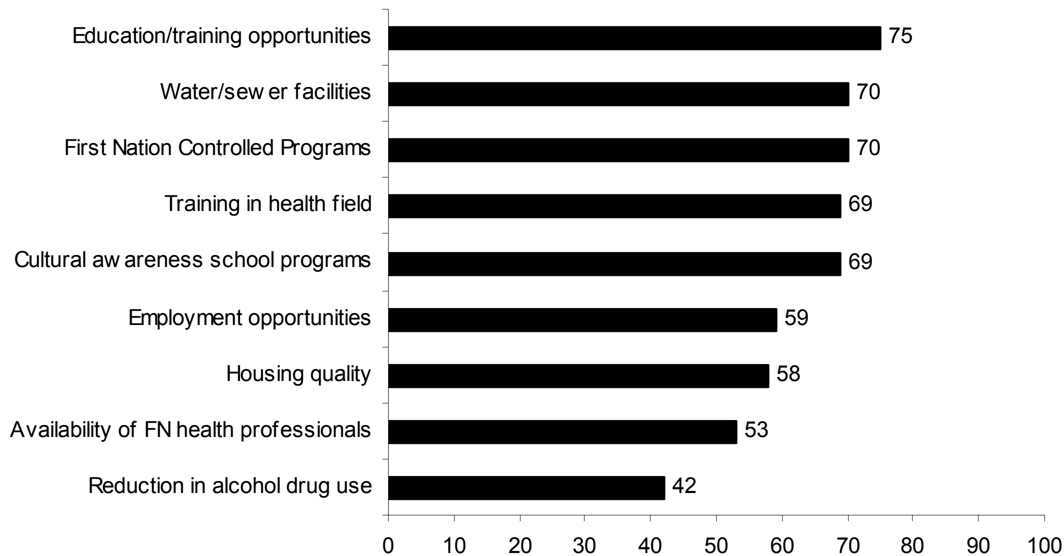
It would appear however, that people feel that tremendous progress had been made over the last several years in the area of traditional health and wellness. Approximately two-thirds of the people interviewed indicated that in areas such as personal commitment to healing, or a return to traditional ways, that progress had been made in their community.

Figure 54: People who indicate that there has been progress in areas important for community wellness %



The area where the most significant progress has been made would appear to be in the educational and infrastructure areas at the community level. More than 70% of the people interviewed reported that education training opportunities, water and sewer facilities, First Nation controlled programs and training in the health field, and cultural awareness as part as school programs had all made significant progress. Although nearly 60% reported progress in the area of employment opportunities and housing quality, reduction in alcohol and drug use was described as showing little progress by more than 50% of people interviewed.

Figure 55: People indicating progress in the following factors that are considered important for community wellness %



4.7 Health Service Utilization

Given the relatively higher prevalence of chronic health conditions and other health problems in First Nation communities, one would expect a correspondingly high level of health care utilization. This report is not able to describe health utilization empirically, instead we report on people's perceptions of the health care system and some general indicators of frequency of contact with the health care system.

Sixty-three percent of the people interviewed reported that they go for a regular check-up once a year, and 70% indicated they had their blood pressure checked within the previous year. This suggests a high frequency of contact with physicians or nurse practitioners (privacy care health professionals).

Figure 56: People who go for a regular check-up once a year %

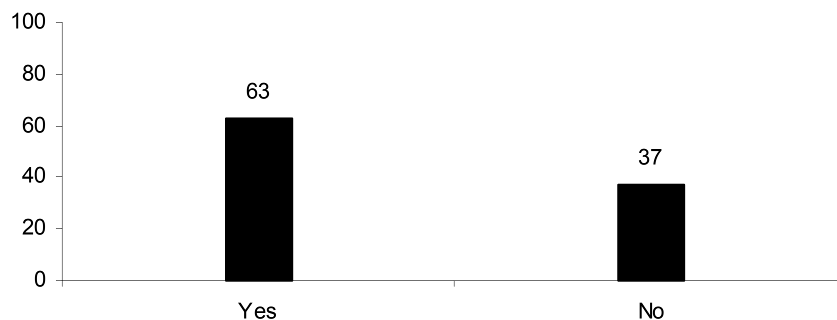
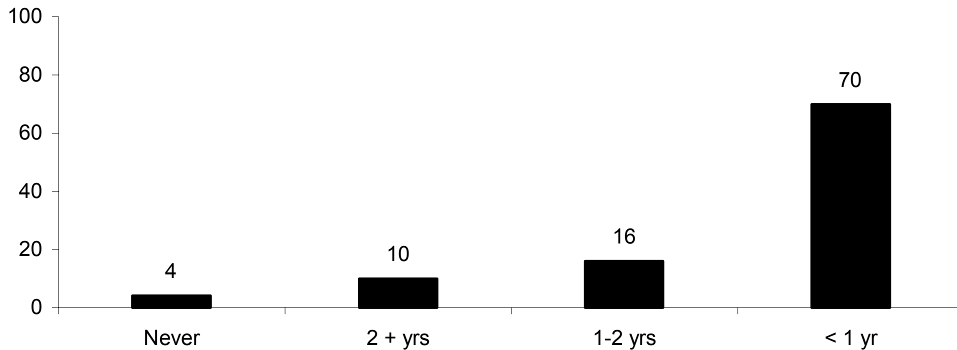
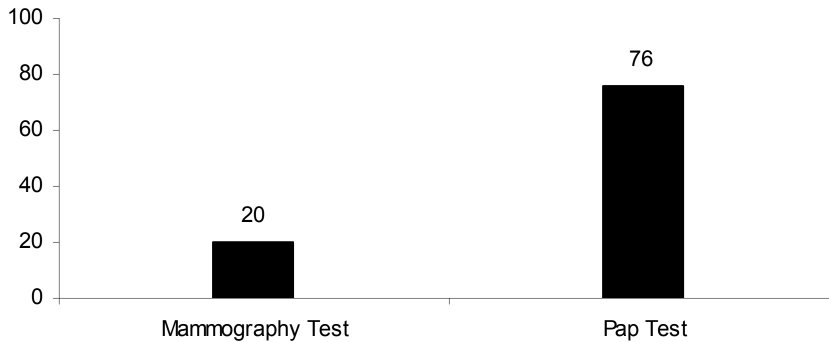


Figure 57: Last time blood pressure checked %



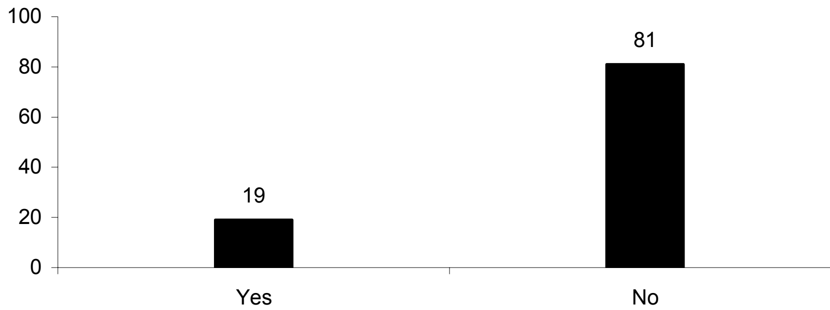
Seventy-six percent of women reported having received a Pap test, and 20% reported having had a mammogram test (breast x-ray). Since only 19% of the women interviewed were over the age of 45, this also suggests a high level of primary care utilization.

Figure 58: Women who have used prevention screening %



The Regional Steering Committee felt that men often have less frequent contact with primary care health professionals, which may sometimes lead to the late detection of serious health problems. The Steering Committee designed one question particularly for men, which asked whether they had ever had a rectal examination. Rectal examinations are usually routinely performed during a full physical assessment. Since only 19% of men reported having had a rectal examination (although a large number of men did not answer this question) either men are not having check-ups as frequently as they suggest or the check-ups are not as thorough as they might be.

Figure 59: Men who had a rectal examination %



Only 45% of people with diabetes reported attending a diabetes education clinic. This suggests that a high proportion of people with diabetes may not be receiving appropriate health education to manage their illness or that educational opportunities are not available to them. Only 18% of people interviewed reported having used NAADAP services. This is somewhat surprising given the large number of people who reported alcohol consumption as a problem in their household.

Figure 60: Diabetics attending Diabetes Education Clinic %

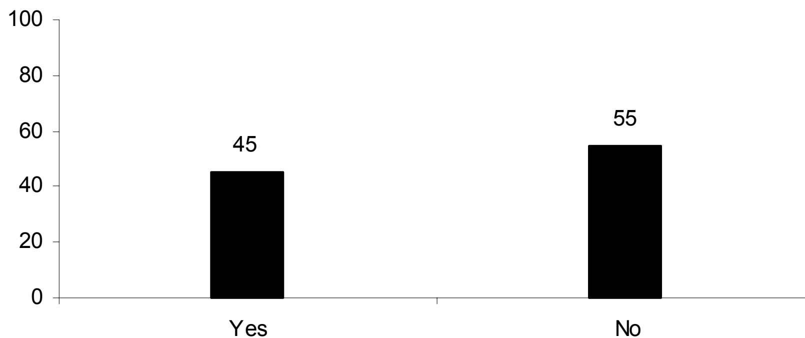
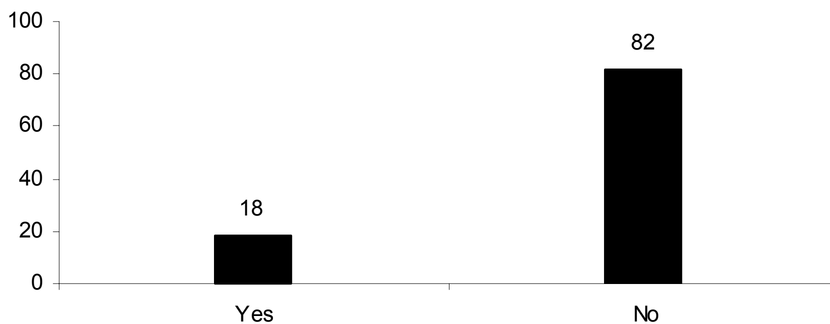


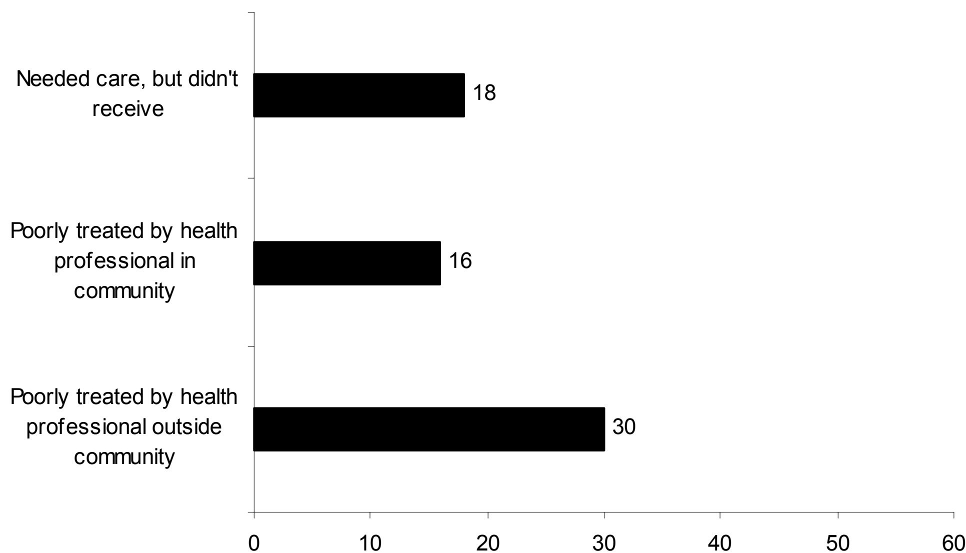
Figure 61: People who have used NNADAP services %



Several questions also asked about people's experience with the health care system and whether they were satisfied with the care or whether they felt the care was adequate to the needs of the community. A surprisingly large percentage of people interviewed (18%) reported that they had had an experience where they needed the health service but did not receive it. This likely reflects the remote nature of many communities and distance from health care facilities, although primary care is generally available in all but the smallest communities.

Racism in the health care system has been reported as a serious concern for many First Nation's people. In response to a question about whether people had experienced racism in their contact with health professionals inside their communities only 16% reported this as a problem. However, when asked the same question about health care contacts outside the community, 30% reported that they felt they had been treated in a discriminatory manner by health professional outside the community.

Figure 62: Satisfaction with health care delivery %

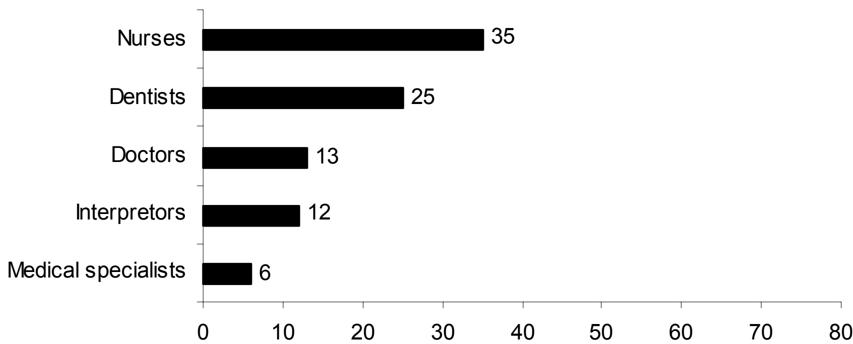


For most women, leaving the community for childbirth is now routine. Indeed 87% of women reported having had to leave their home community for childbirth. Leaving a community for childbirth is often described as a difficult experience for both women and the family; in this survey 50% of the women who had left the community for childbirth reported that this experience was stressful and 33% indicated that it had created problems for family members left behind.

Figure 63: Childbirth experiences of women %

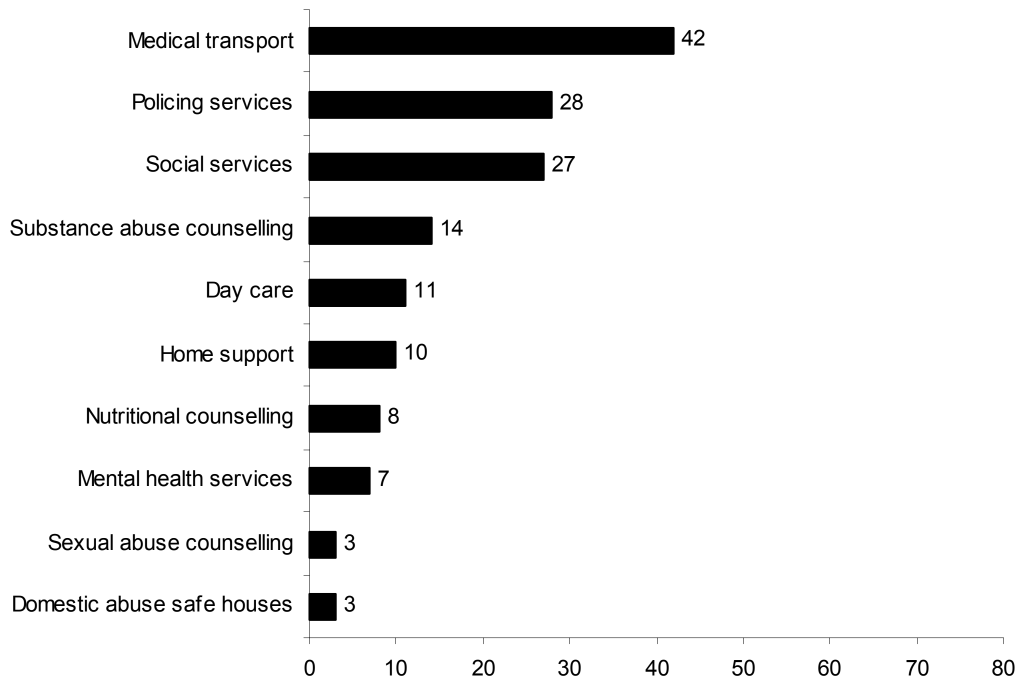
In general, health care and ancillary services are regarded as inadequate to the needs of First Nation communities. Only 35% of people interviewed indicated that there were sufficient nurses at the community level. The provision of other health professionals including dentists, doctors, and medical specialists was generally regarded as inadequate. Of particular interest, only 12% of people interviewed indicated that the availability of interpreters was adequate to the needs of the community.

Figure 64: People reporting availability of health care professionals as adequate %



In general most ancillary services such as sexual abuse counseling, mental health services, nutritional counseling, home support, daycare, and substance abuse counseling were regarded as very inadequate by the vast majority of people interviewed. In a few areas such as medical transport, approximately half the people interviewed felt this particular service was adequate.

Figure 65: People reporting the following health services as adequate %



Although, virtually all services were considered as requiring improvement, three areas stood out as the most significant services requiring improvement; pediatric care, home care, and senior citizens homes. This reflects the general First Nation concern with children and elders.

Figure 66: People who indicated that health education services are in need of improvement %

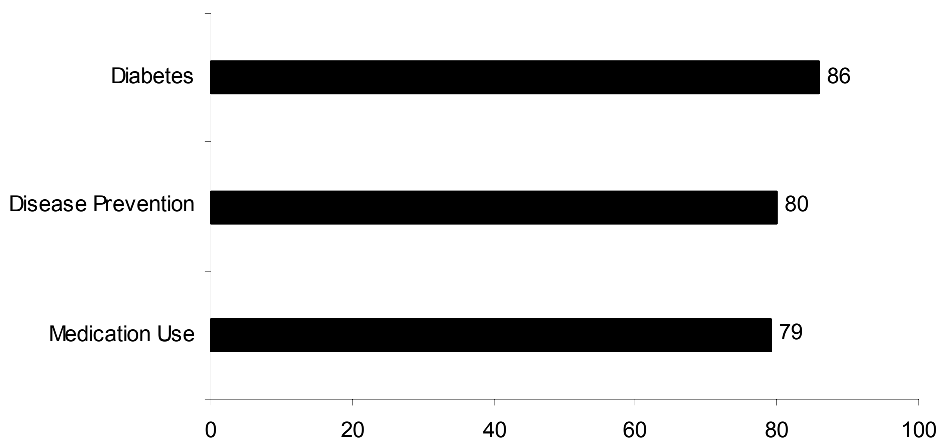
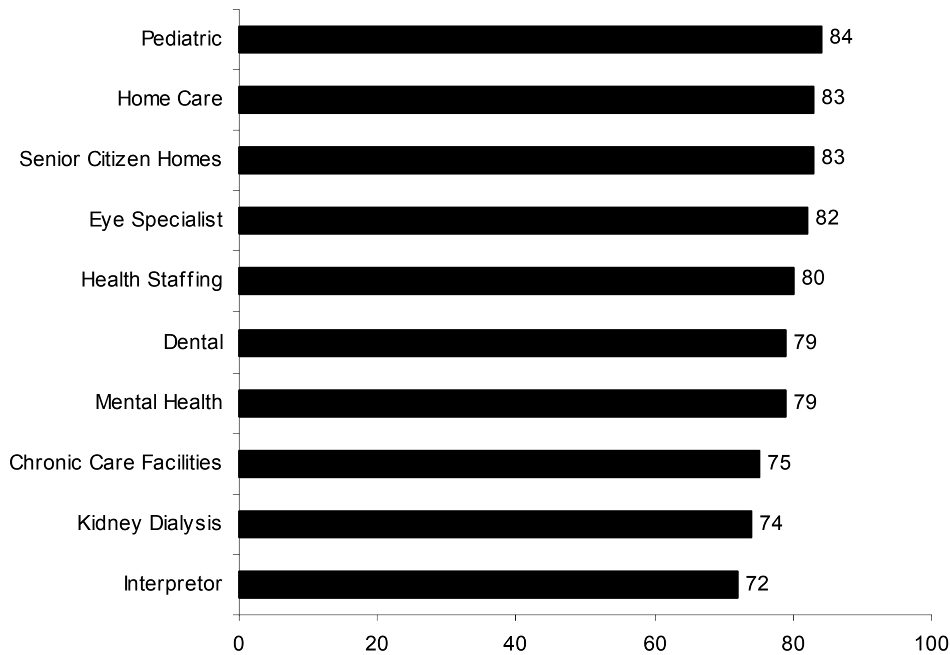


Figure 67: People who indicated that health servcies are in need of improvement %



Of particular significance was the finding that 35% of the people interviewed did not know whether health services had been transferred to the band in their community. This finding is very relevant since 25% of the communities involved in the survey have signed transfer agreements, and a further 50% are actively involved in pre-transfer projects. Clearly band councils and other First Nation organizations need to provide additional information on the transfer initiative to band members.

Figure 68: Proportion of people who reside in a community that has signed a Health Transfer Agreement %

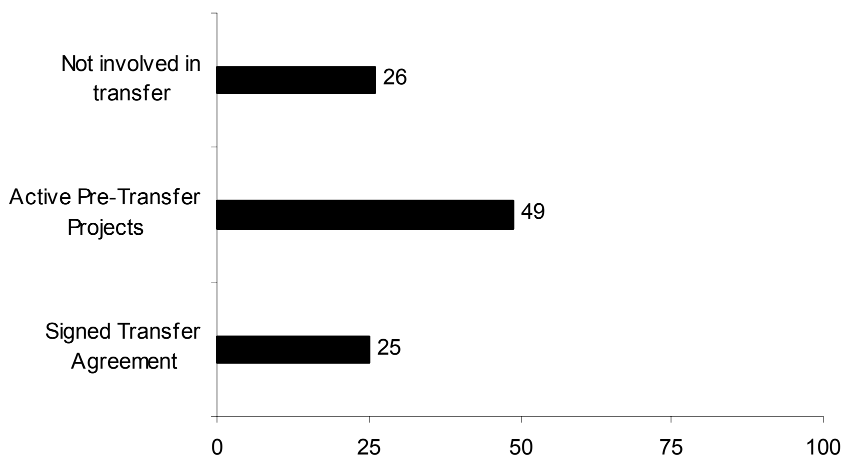
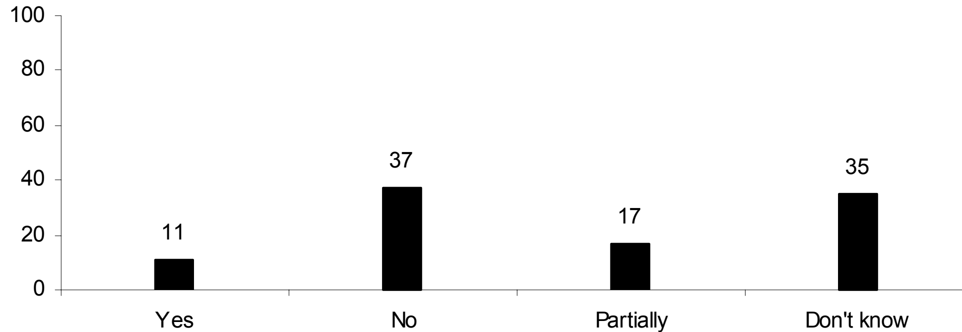


Figure 69: People who think health services have been transferred to Band %



4.8 Summary of Description of Manitoba First Nations Health

Highlights

Health Status

- The majority of First Nations people in Manitoba (80%) live in poverty.
- Only 19% of First Nations people in Manitoba report having completed high school.
- Only one half of First Nations people in Manitoba report good to excellent health status.
- High blood pressure and diabetes are epidemic in First Nations communities.
- Nearly one third (28%) of First Nations people in Manitoba report having thought about suicide.
- Eleven percent of First Nations people in Manitoba have attended residential schools and 20% reported this as a negative experience.
- Less than half of First Nations children in Manitoba are breastfed.

Health Behaviour

- Approximately one half of First Nations people in Manitoba indicate they are making major dietary changes to improve their health.
- Nearly one third of First Nations people in Manitoba report running out of money for food at least once per month.
- Cigarette smoking is a major public health problem in First Nations communities. Sixty-four percent of adults report regular cigarette smoking.
- Smoking in First Nations communities begins at an early age. Eighty-eight percent of smokers report starting to smoke before the age of 18.
- More than half of First Nations people in Manitoba have attempted to restrict smoking in their household.

Community Health Concerns

- Nearly half of First Nations people in Manitoba report alcohol consumption as a problem in their household.

- A majority of First Nations people in Manitoba (77%) have attempted to reduce alcohol consumption. Sixty-seven percent of women report not drinking during their last pregnancy.
- Alcohol abuse, gambling and drug use were identified as household problems by one third of First Nations people in Manitoba and only 10% report improvement in these problems.
- Only 10% of First Nations people in Manitoba report problems related to domestic violence and child abuse.
- Unemployment, housing availability and the cost of food are reported as community problems by 60-75% of First Nations people in Manitoba .
- Major improvements in water and sewage quality in the past two years are reported by the majority of First Nations people in Manitoba .
- The high cost of food is identified as the problem showing the least improvement.

Healing and Wellness

- Nearly everyone (75%) of First Nations people in Manitoba indicate support for traditional approaches to health and wellness and major progress in this area is indicated
- One third of First Nations people in Manitoba report participating in traditional healing activities.
- Major progress is also reported in areas of education, training and community infrastructure.

Health Service Utilization

- The majority of people have regular contact with a health care professional.
- Racism is a significant problem with 30% of First Nations people in Manitoba reporting a discriminatory encounter with the health care system.
- Childbirth away from the home community is not considered a problem for the majority of women.
- Children's health care, home care and senior citizen's homes are the health service issues requiring the greatest improvement.
- One third of First Nations people in Manitoba are unsure of the transfer status of health services in their communities.

Recommendations

1. Health conditions for First Nations people in Manitoba are in need of urgent attention. Policy development linking socioeconomic development to health outcomes should be a priority.

2. The survey reports a relatively high level of awareness of the health problems associated with risk behavior such as alcohol consumption, smoking, and diet with a very high proportion of people interviewed indicating they had made attempts to change these behaviors. Further programming effort to support people who wish to change risky health behavior is warranted.

3. Gambling as a problem requires attention by the First Nations leadership.

4. While community infrastructure such as sewage and water indicates improvement, unemployment, housing and particularly the cost of food require further attention.

5. Policy support for integrating traditional healing in community health planning is required.

6. More information on health service transfer is required at the community level.

7. Racism in the health care system requires urgent attention.

5 COMPARISON OF MANITOBA FIRST NATIONS HEALTH

In this section we compare the findings for Manitoba First Nations with the national results from the Regional Health Survey, as well as results from other major national surveys on both Aboriginal Peoples and the Canadian population. In particular, we compare the regional survey with national results from similar questions on the 1991 Aboriginal Peoples Survey and the National Population Health Survey, (the NPHS). Unfortunately, Statistics Canada has still not released health data from the Canadian Survey on Children and Youth (NLSCY).

5.1 Sociodemographics

In comparing the regional sample with both the national FNIRHS sample and the Canadian population, the Manitoba First Nations sample is consistent with demographic indicators. The Manitoba sample is a younger population than the Canadian population but fewer people under the age of 24 were interviewed in Manitoba than was the case for the National First Nations survey.

Figure 70: Age Distribution %

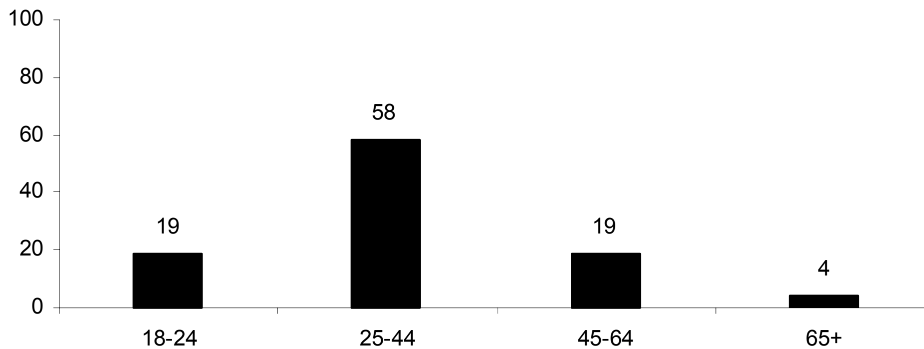
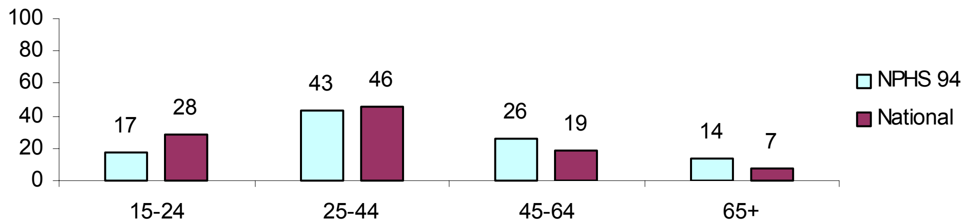
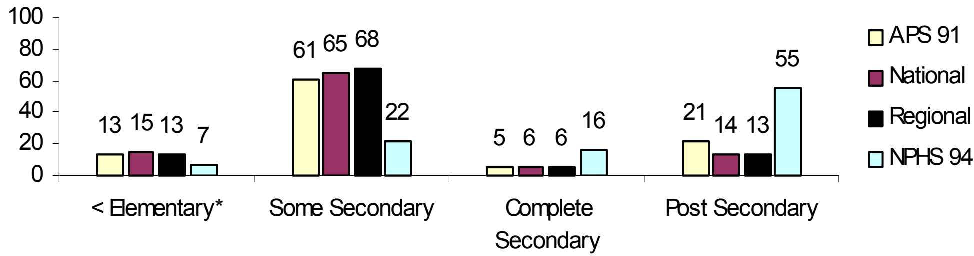


Figure 71: Age distribution %



The educational attainment of people interviewed in the Manitoba survey is consistent with the National First Nations results. The educational levels for First Nations people in Manitoba are significantly lower than educational levels for the Canadian population generally.

Figure 72: Highest education level attained %



Income levels for First Nations people in Manitoba are also significantly lower than for the Canadian population; whereas 32% of the Canadian population reported no wage related work in the previous year, 46% of Manitoba First Nations were in this situation. Similarly 49% of the Manitoba First Nation population reported household incomes of less than $10,000, whereas only 5% of Canadians reported similar income levels. In comparison to the 1991 Aboriginal People's Survey, there appears to be some slight improvement in First Nations incomes over the five-year interval.

Figure 73: Percentage of people who worked for income

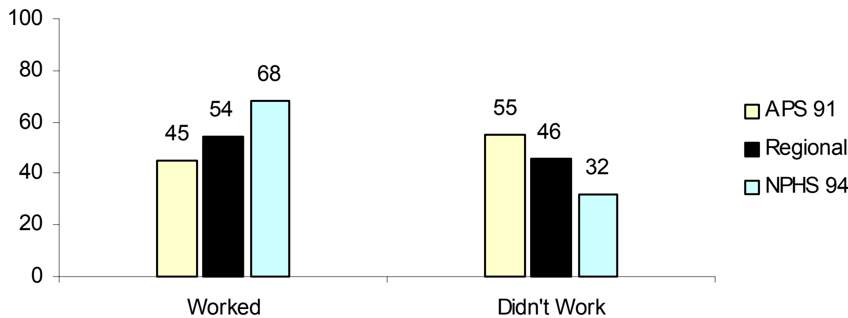


Figure 74: Total household income %

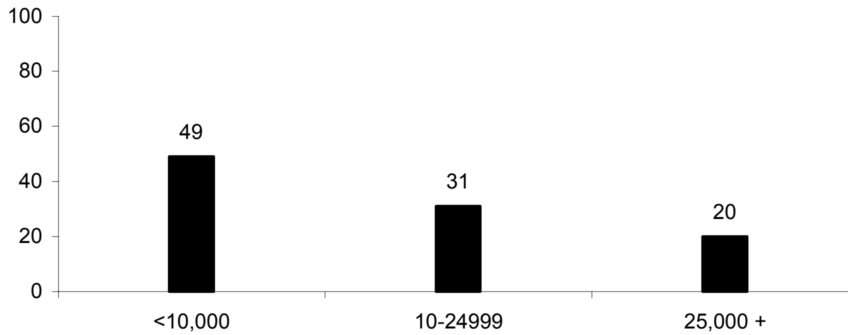
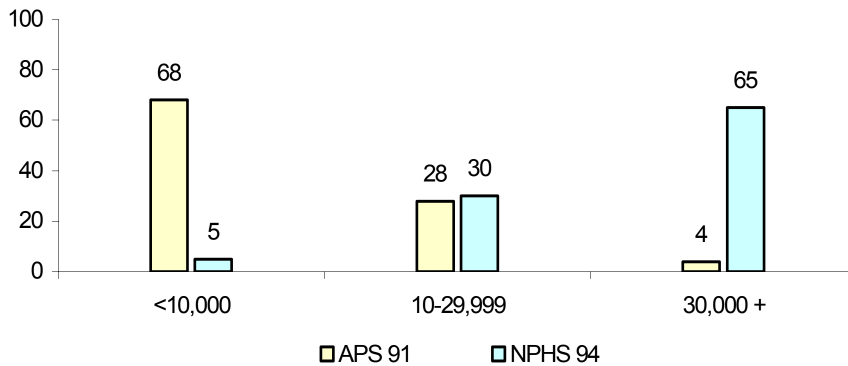
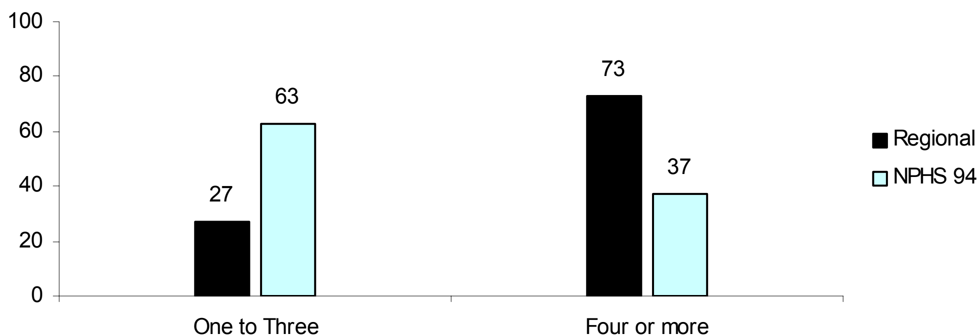


Figure 75: Total household income %



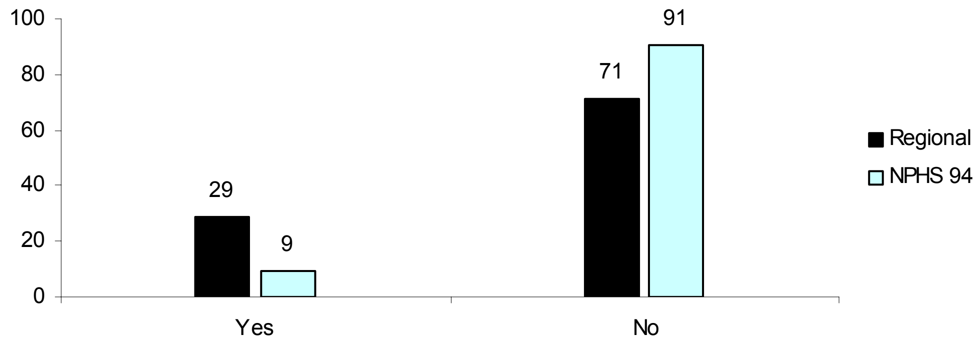
Household crowding is clearly indicated in the results described in Figure 76 (Number of people living in the household). Whereas 73% of Manitoba First Nations people indicated four or more people living in the house, only 37% of Canadians indicated this level of household crowding.

Figure 76: Number of people living in the household %



Twenty-nine percent of adults interviewed indicated that they lived in a single parent household, whereas only 9% of the people interviewed in the general Canadian sample indicated this as the case.

Figure 77: Single parent-guardian households %



5.2 Health Status and Behavior

Manitoba First Nations people reported very similar health status to the National First Nations results, with slightly more people reporting fair or poor health status. However, in comparison with the Canadian sample significant differences emerge. Only 11% of the Canadian sample reported fair or poor health status. One problem with this indicator is that in the First Nations Regional Health Survey, the question was worded slightly differently and one category of response was omitted. This may account for some of the difference between both the Canadian sample and the APS results.

Figure 78: Self reported health status %

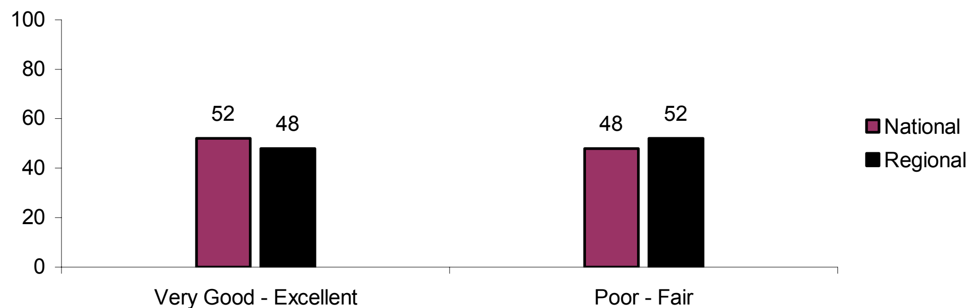
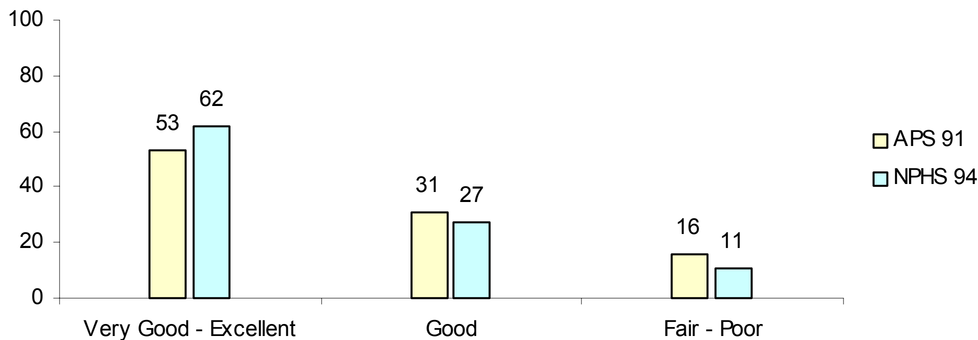
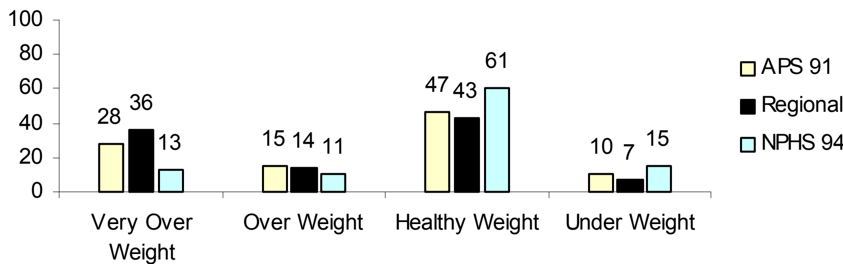


Figure 79: Self reported health status %



Weight is a general health problem for the entire Canadian population but it is a more significant problem in the Manitoba First Nation communities. Whereas 61% of the people in the Canadian sample have a healthy weight, only 43% of Manitoba First Nations people fall into this category.

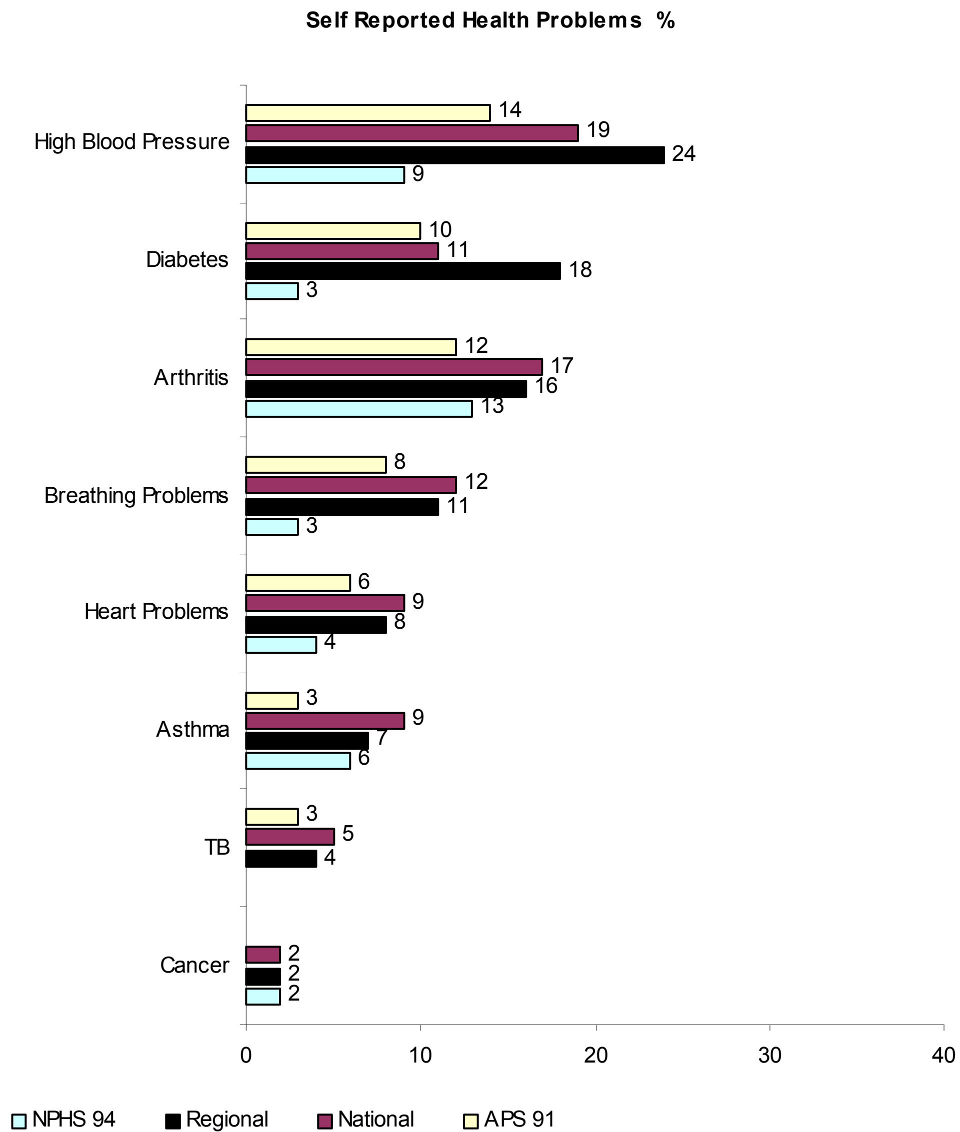
Figure 80: People with weight problems %



Self-reported medical conditions describe some serious inequities in the health status of Manitoba First Nations. Nearly three times as many First Nations people in the Manitoba survey reported high blood pressure as people in the Canadian survey. Six times as many Manitoba First Nations people reported diabetes as people in the Canadian survey. Nearly four times as many First Nations people reported breathing problems as people in the Canadian survey. Twice as many people reported heart problems, and for other conditions the Manitoba rate was slightly more than the Canadian rate. Equal numbers of Manitoba First Nations people reported cancer as in the Canadian survey.

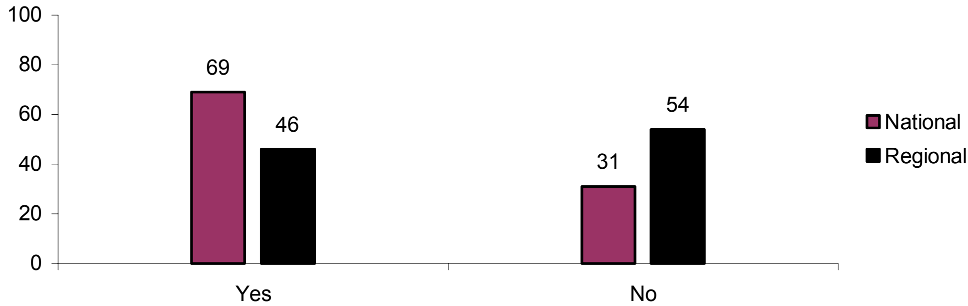
These findings are also disturbing when compared with the Aboriginal People's Survey, of 1991. Nearly twice as many people in the Manitoba First Nations survey report high blood pressure as was found in the 1991 Aboriginal People's Survey and nearly three times as many report diabetes as was found in the 1991 Aboriginal People's Survey

Figure 81: Self reported health problems %



Manitoba First Nations women appear to be slightly less at risk for gestational diabetes than First Nations women nationally. Only 46% of Manitoba women reported having had gestational diabetes compared with nearly 70% of First Nations women nationally.

Figure 82: Women reporting diabetes that have had gestational diabetes %



Manitoba First Nations people are much heavier smokers than the general Canadian population. More than twice as many people in the Manitoba survey report being a current smoker than in the general Canadian survey. The age at which people start smoking shows a more complex pattern. Approximately the same number of people indicate beginning to smoke under the age of 14 in the Manitoba and National First Nations community as in the Canadian population generally. However, twice as many Manitoba First Nations people started smoking in the 14-18 year old age group, as is the case in the general Canadian population where nearly half of current smokers began smoking after the age of 18. This suggests that the focus on youth in the First Nations community needed to be much more serious if cigarette smoking is to be prevented.

Figure 83: Smoking status %

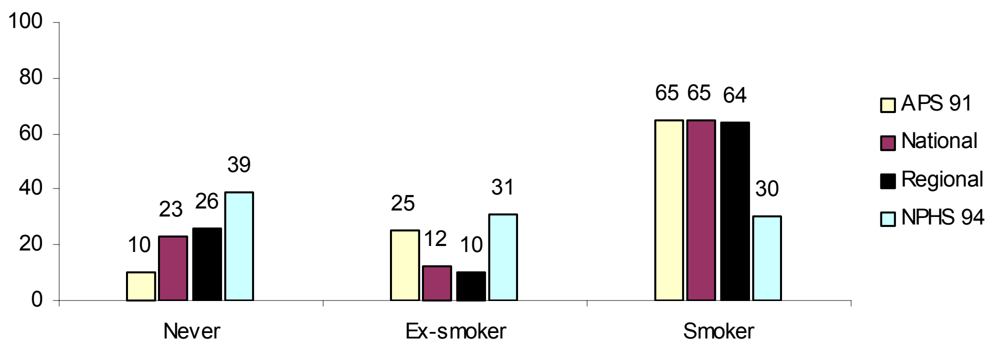


Figure 84: Age when started smoking %

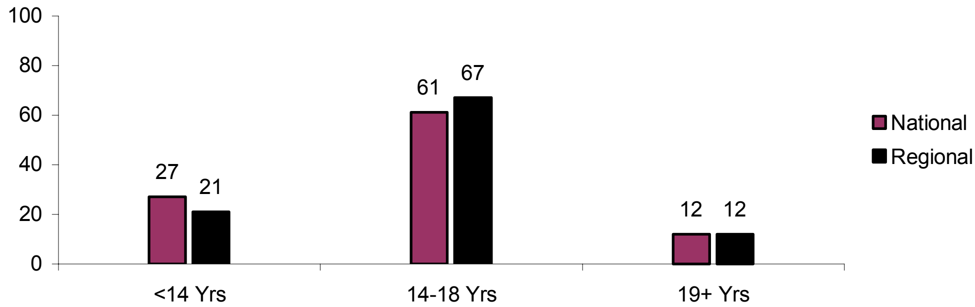
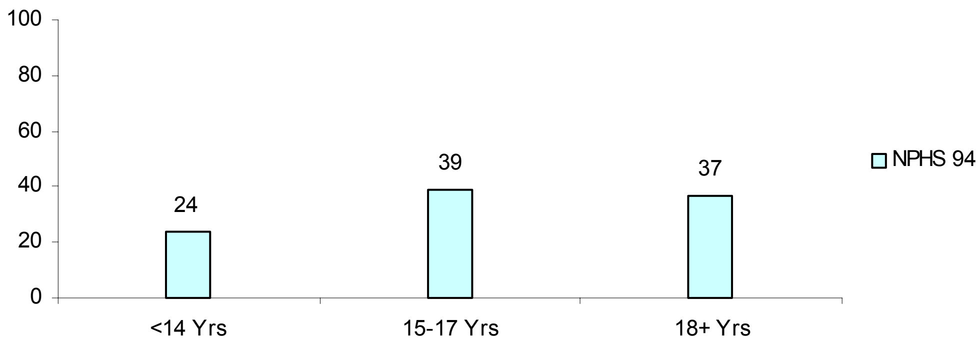
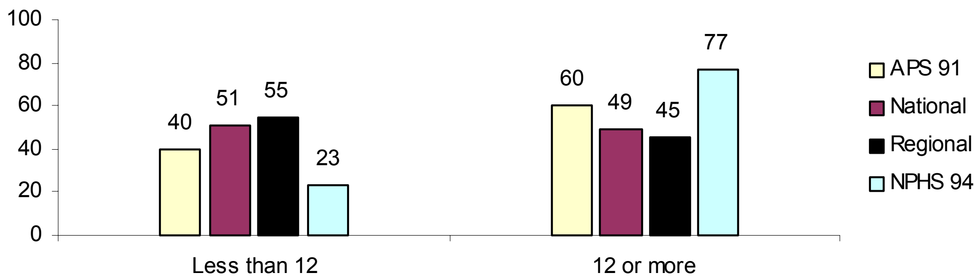


Figure 85: Age when started smoking %



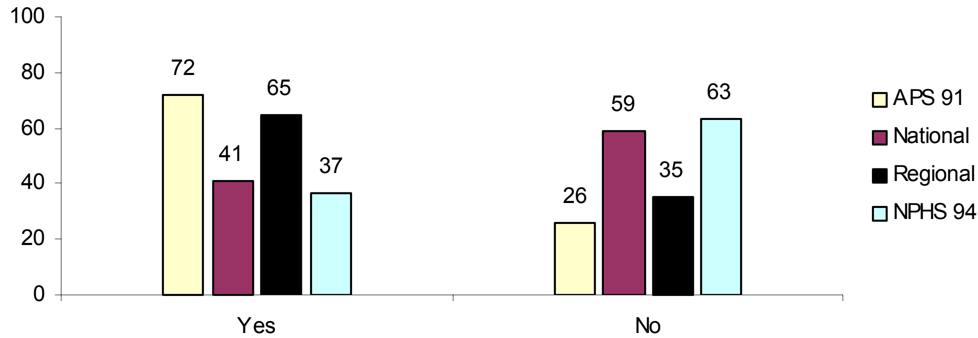
Manitoba First Nations people are similar to First Nations people nationally in terms of the number of cigarettes smoked daily, but significantly more people smoke fewer cigarettes than is the case for the Canadian population generally. Where 77% of the Canadian smoke more than 12 cigarettes a day, only 45% of the Manitoba First Nations population smoke a similar amount.

Figure 86: Number of cigarettes smoked per day (daily smokers) %



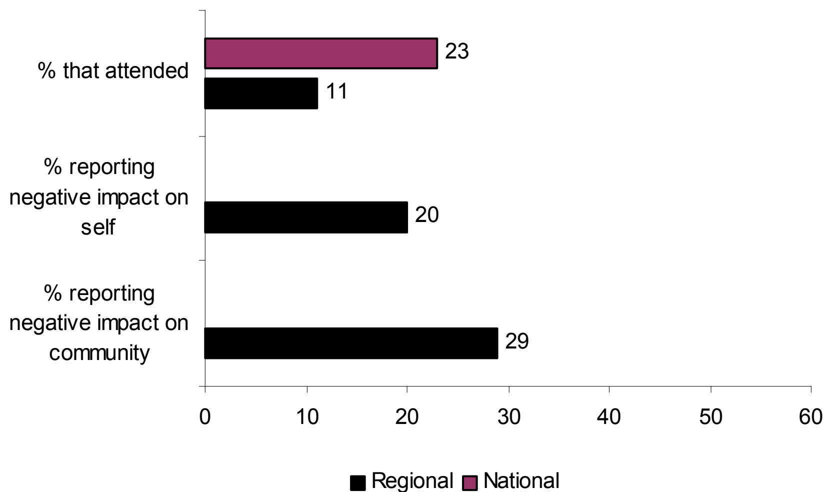
On the other hand, more Manitoba First Nations people smoke more frequently in the home, exposing others to second hand smoke, than is the case with either the Canadian population generally or the national First Nations population.

Figure 87: Percentage reporting daily smoking in the house



Finally it would appear that a lower proportion of people in Manitoba attended residential schools than was the case with national First Nations sample. Whereas 23% of First Nations people nationally attended residential schools, only 11% attended in Manitoba.

Figure 88: Impact of residential school system %



5.3 Children's Health

The health of Manitoba First Nations children is consistent with the health of all First Nations children nationally. Manitoba First Nations children experience similar rates of allergies and asthma as Canadian children generally, but report bronchitis twice as often and other conditions more frequently. However, First Nations parents in Manitoba report twice as many children in the poor to fair health status as Canadian parents generally. Manitoba First Nations babies are somewhat more likely to have high birthweights than Canadian children generally.

Figure 89: Children's general health %

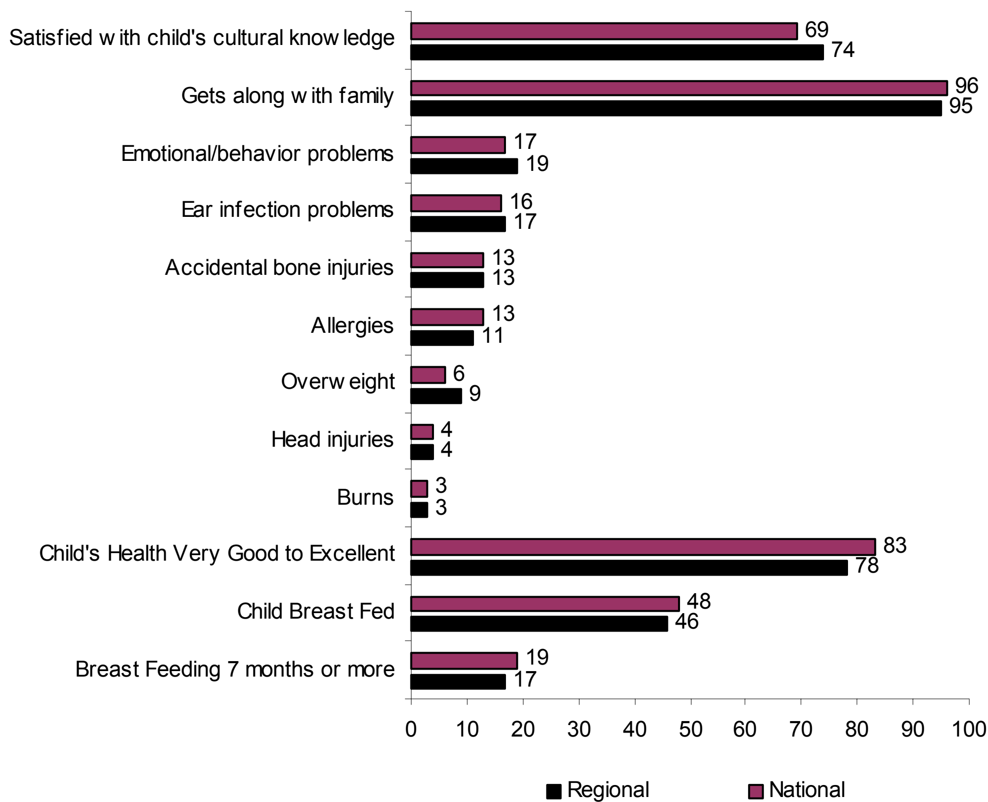


Figure 90: Children's chronic health conditions %

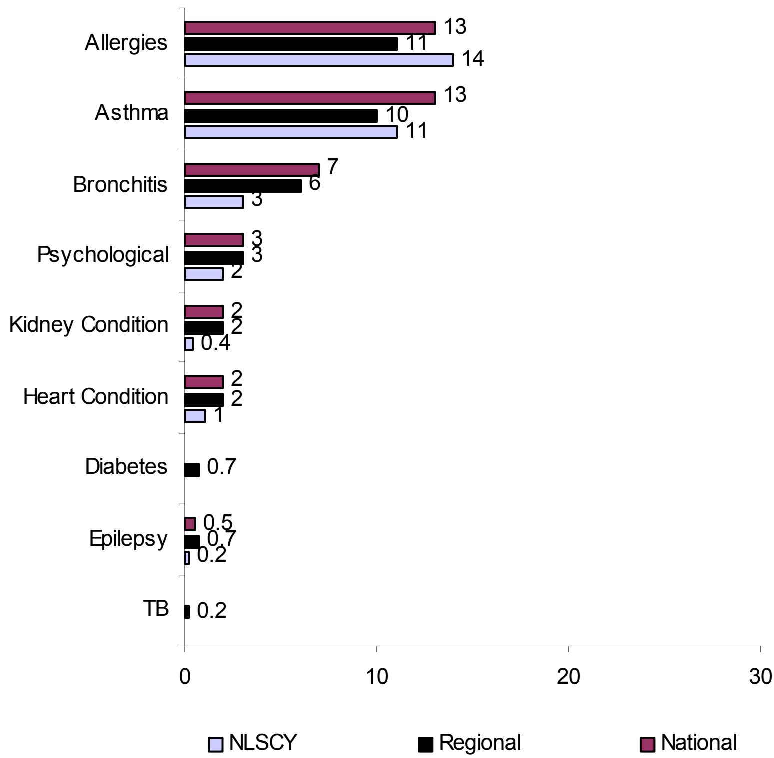


Figure 91: Child's health status Age 0-11 %

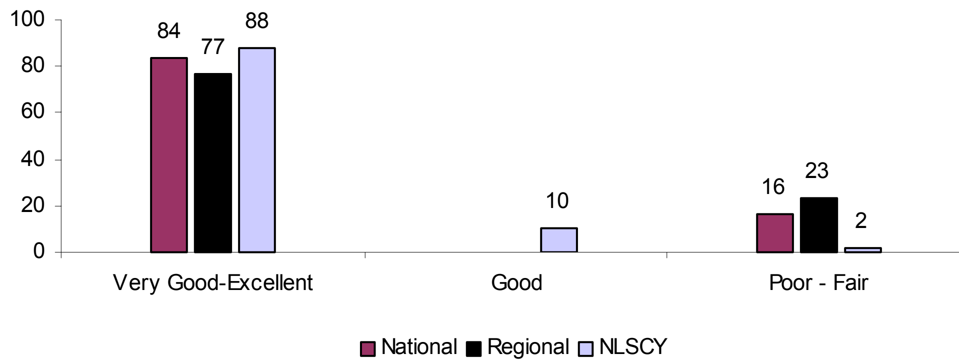
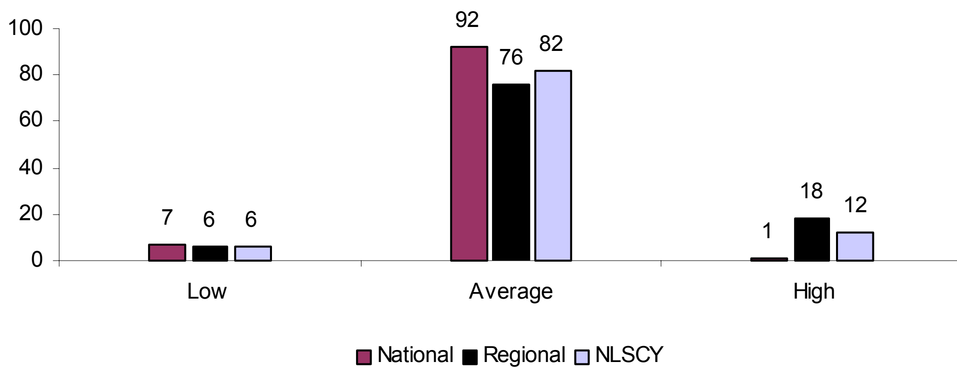


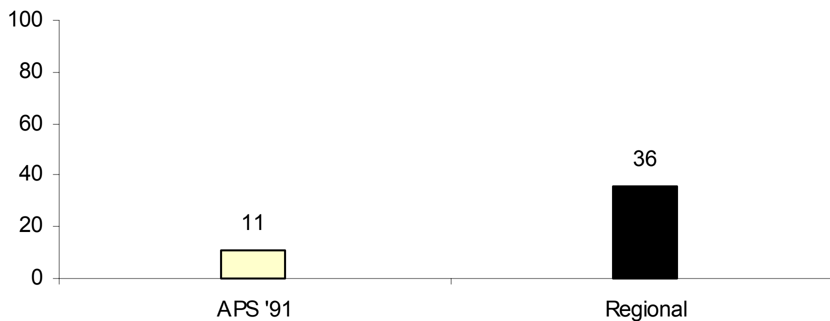
Figure 92: Child's birthweight Age 0-3 %



5.4 Healing and Health Services

There appears to be a significant increase in interest in traditional healing since the 1991 Aboriginal People's Survey. Whereas only 10% of Aboriginal people in 1991 indicated that they have seen a traditional healer, 36% of First Nations people in Manitoba in 1997 indicated that they had sought help from a traditional healer.

Figure 93: People who had seen a traditional healer %



Contacts with primary care health professionals appear similar from the surveys with approximately an equal proportion of the people from the Manitoba First Nations survey reporting having had their blood pressure checked in the past year as was found with the Canadian population generally.

Figure 94: Last time blood pressure checked %

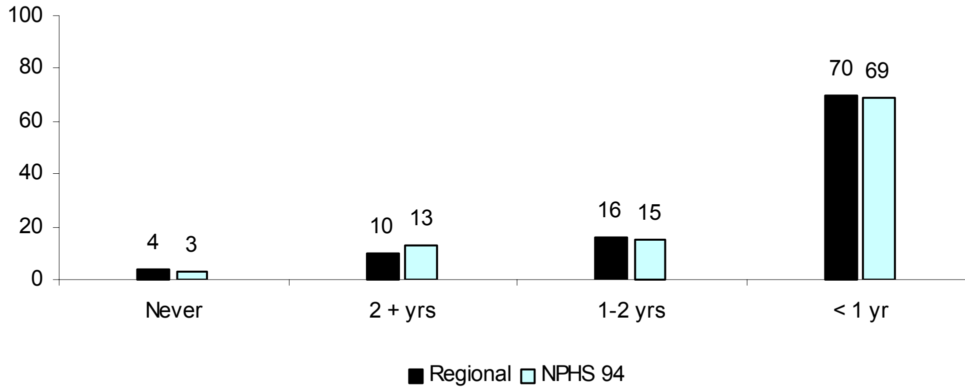
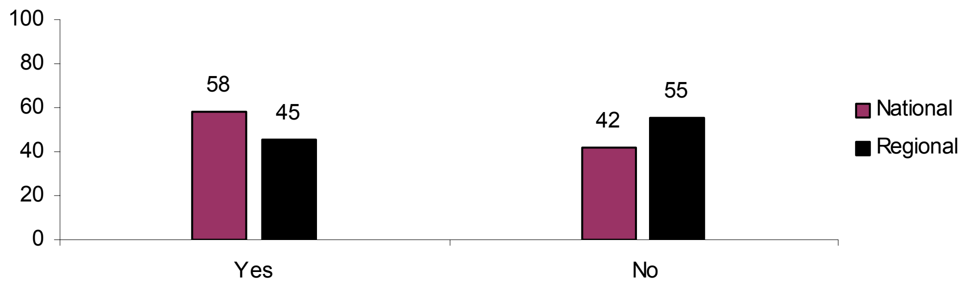
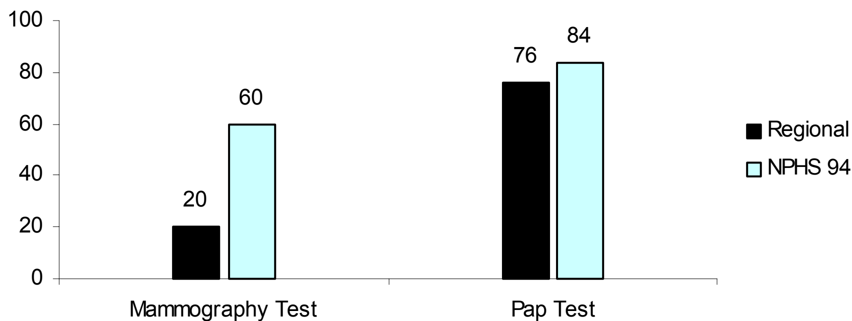


Figure 95: Diabetics attending Diabetes Education Clinic %



It would appear that smaller proportion of women have used prevention screening techniques such as Pap tests and mammography tests than the general Canadian population but this may reflect age since the Canadian population is generally older than the First Nation population in Manitoba.

Figure 96: Women who have used prevention screening %



5.5 *Summary of Comparison of Manitoba First Nations*

Highlights

- First Nations people in Manitoba are significantly poorer, less educated, live in more crowded housing and are more likely to live in single-parent households than Canadians generally.
- First Nations people in Manitoba suffer from high blood pressure and diabetes at 3 to 6 times the rate of Canadians generally and these rates have more than doubled since 1990.
- Twice as many First Nations people in Manitoba smoke as Canadians generally and twice as many began to smoke before the age of 18.
- Participation in traditional healing activities has more than tripled since 1990.
- Manitoba First Nations children appear to be similar in health status as Canadian children generally. However, methodological differences in comparing survey results may limit the validity of this interpretation.

Recommendations

1. Resources necessary to combat the escalating epidemic of high blood pressure and diabetes are urgently required.
2. Non-traditional use of tobacco is an urgent public health problem requiring a major policy initiative.
3. Support for integrating traditional healing in community health programs is warranted.

6 DETERMINANTS OF MANITOBA FIRST NATIONS HEALTH

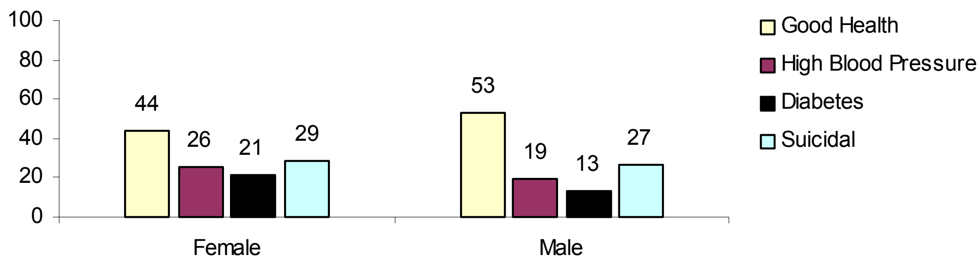
In this section we describe the association between several health indicators and some of the major social factors that are generally understood to be predictive of health status. For the purposes of this report we have selected key health indicators such as perception of general health status, reported high blood pressure and diabetes, and reported feelings of suicidal emotions. Together, these indicators provide a general indication of physical and emotional health. The primary social factors associated with health status include gender, age, income, and education.

6.1 Gender

Men generally report better health than women. More women report high blood pressure, and almost twice as many women report diabetes as men. However, as described in Section 4.3.1, women include gestational diabetes in these reports.

Men and women appear to have similar levels of mental health problems since equal proportions report suicidal feelings.

Figure 97: Gender and health %

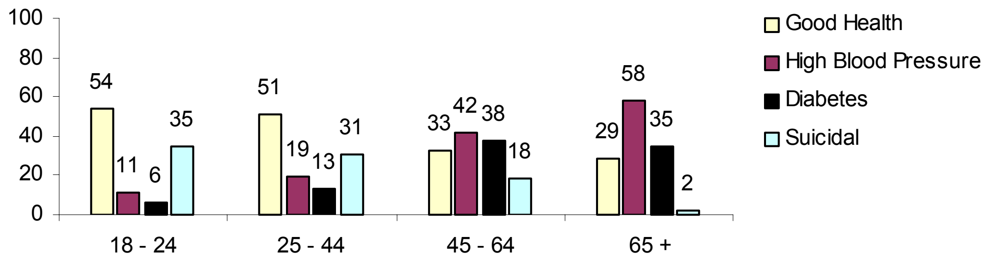


6.2 Age

Good health decreases with age, but surprizingly, only 54% of people in the 18-24 year old age group report good or excellent health. Blood pressure problems also increase with age but again, a surprizingly high proportion of people in the 25-44 year old age group (19%) report high blood pressure.

Diabetes also increases with age but the prevalence peak is reached in the 45-64 year old age group. Nearly half of First Nations people in Manitoba over the age of 45 report diabetes as a health condition! A surprizingly high proportion of people in the 25-44 year old age group (13%) also report diabetes as a problem.

Figure 98: Age and health %

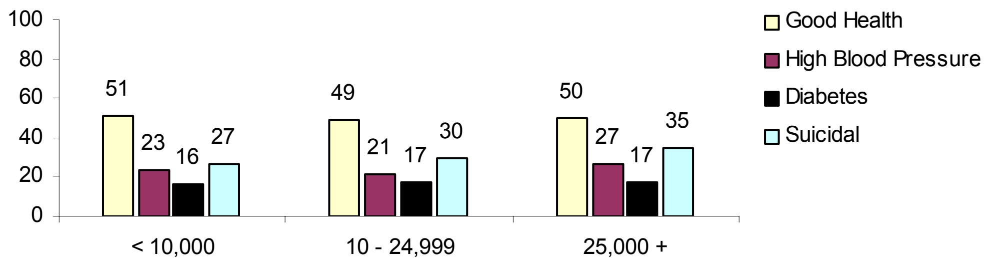


Suicidal feelings on the other hand decrease with age. More than one third of people in the 18-24 year old age group report suicidal feelings, and an almost equally large group in the 25-44 year old group reports the same problem.

6.3 Income

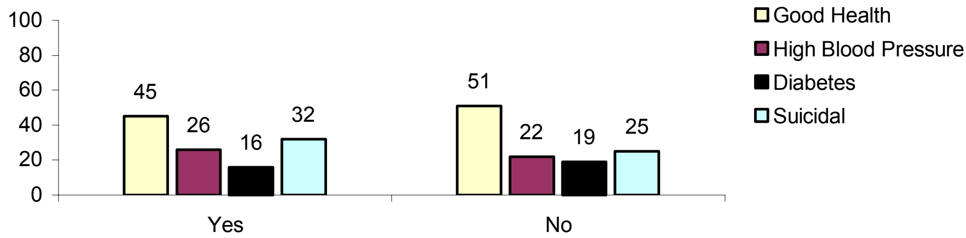
Contrary to expectations, income does not seem to be associated with health outcomes, except for suicidal feelings. Higher reported household income is associated with more people indicating suicidal feelings. However, these findings may reflect several methodological problems with the income variable. First, this question asked people to estimate their household income, but does not provide a measure of how many people are dependent on this income. Second, nearly 80 % of the people interviewed report household incomes of less than $25,000 (a nationally recognized indicator of poverty). Therefore income levels generally predict poor health.

Figure 99: Income and health %



However, we also asked people to indicate whether they ever ran out of money for food. This variable shows a stronger association with health outcomes. Self-reported health is somewhat better (51%) for people who do not run out of money for food than it is for those who do (45%).

Figure 100: Income insecurity and health %



6.4 Education

Education is generally thought to be a good measure of socioeconomic status (i.e., higher education generally leads to higher income), and is often associated with better health status. However, in First Nations communities, education is highly associated with age (i.e., older people generally have less formal education than younger people). When we examined the relationship between education and health within several age groups (18-24; 25-44;45-64, 65+) we found that education was only associated with good self-reported health in the 25-44 year old group. There was also a slight association between education and suicidal feelings in the 25-44 year old group. People with more education reported higher suicidal feelings (36%) than people with lesser education (30%).

Figure 101: Education and health %

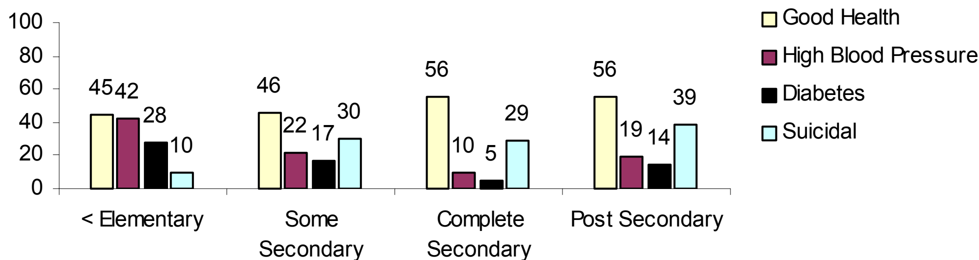
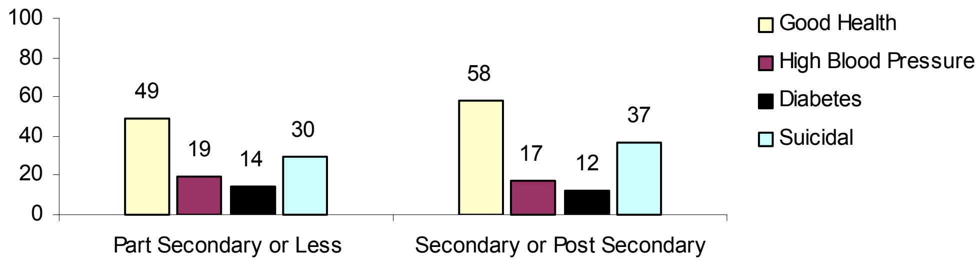


Figure 102: Education and health for agegroups 25 – 44 %

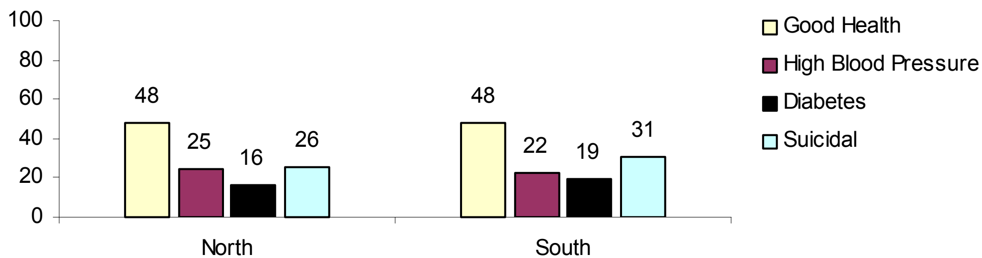


6.5 Geographic Region

We created a “region” variable to examine differences in health status between northern and southern communities. The “northern” region includes the communities of Norway House, Lac Brochet, Split Lake, Gods Lake, Opaskwayak, Chemawawin, Little Grand, Wasaagamack, and Garden Hill First Nations. All other communities are described as the "southern"”region.

No major differences were found in any of the health outcomes between the two regions, except for suicidal feelings. Thirty-one percent of people interviewed in the South reported suicidal feelings compared with 26% of people in the North.

Figure 103: Geographic region and health %



6.6 Summary of Social Determinants of Health

Highlights

- First Nations women report diabetes twice as often as men; although this higher rate may partially reflect gestational diabetes.
- Good health decreases with age but a surprizingly high proportion of adults in the 25-44 age group report poor health and chronic conditions.
- Nearly half of First Nations people in Manitoba over the age of 45 report diabetes as a health problem.
- One third of adults 18-24 report having experienced suicidal feelings.
- Higher household income and higher education are associated with a higher frequency of suicidal feelings.
- Higher education is associated with good health only in the 25-44 age group.
- No north/south regional differences were found except for suicidal feelings which were higher in the South.

Recommendations

1. First Nations women require diabetes prevention programs addressing their particular needs.
2. Suicide prevention programs should identify risks associated with higher socioeconomic status.
3. Improvements in socioeconomic conditions at the community level are required to improve the overall health status of all First Nations people living in Manitoba.

7 APPENDIX