

# First Nations Regional Health Survey (RHS)



Phase 2 (2008-2010):  
Manitoba Regional Report

The Assembly of Manitoba Chiefs would like to thank your community and your community members for having participated in the First Nations Regional Health Survey. By participating, your members have contributed towards a better understanding of the health issues faced by First Nations people within your community and other First Nations communities in Manitoba as well as across Canada.

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How to Cite This Report:

Assembly of Manitoba Chiefs (AMC), *First Nations Regional Health Survey (RHS) Phase 2 (2008-2010): Manitoba Regional Report*. Winnipeg: Assembly of Manitoba Chiefs, June 2012 (Revised November 2012).

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Further information on RHS: [www.fnigc.ca](http://www.fnigc.ca)

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## FORWARD

### ASSEMBLY OF MANITOBA CHIEFS, Grand Chief Niibin Makwa, Derek Nepinak

On behalf of the Assembly of Manitoba Chiefs (AMC), I am very happy to present the Manitoba First Nations Regional Health Survey (RHS) Report. Undertaking our own holistic health survey of our own people, on an ongoing basis, is an essential part of renewal of self-determination in health and governance. Under First Nations Ownership, Control, Access and Possession (OCAP) principles, developed by and for First Nations, we recognize that when we have OCAP of our own data, it returns the power of our own information to our people.

We wish to thank the thirty-four (34) First Nations in Manitoba whose Chiefs and Councils agreed to participate, and the 3390 citizens of these First Nations who contributed their life experiences as it is lived in our First Nations from the years 2008-2010.

We also express our gratitude to the Manitoba First Nations RHS team, Leona Star, Leanne Gillis, and previous staff members, Jeff LaPlante and Kevin Beardy, as well as the members of the AMC Health Information and Research Governance Committee (HIRGC) and the Chiefs Task Force on Health (CTFoH) for their oversight of this project.

Following Chiefs Resolutions passed at various Chiefs Assemblies both regionally and nationally, the RHS is the First Nations survey of choice on reserve. We foresee that First Nations will soon be collecting data on our citizens who live off reserve.

It is our hope that our First Nation communities will utilize this information to design health programs and services and expand the health knowledge of the Nations thereby working to improve health outcomes for our First Nations peoples.

Miigwech. Ekosani, Wopida. Mahsi.

## **ASSEMBLY OF MANITOBA CHIEFS Health Information Governance Committee (AMC HIRGC): Co-Chairs, Lyna Hart (SERDC) & Garry Munro (SERDC)**

On behalf of the members of HIRGC, as co-chairs we are proud to present this report which provides an overview of the breadth of data available to all Manitoba First Nations in the MFNs RHS 2008-2010. This report is a First Nations review of the RHS collection and preliminary analysis of data given by free, prior, informed consent from 3390 surveys collected from adults (ages 18-54;55+), youth (ages 12-17, with parental consent) and caregivers of children (ages newborn to 11yrs).

This data is considered scientifically valid and reliable, and presents a “snapshot in time” of a wide array of indicators of health, including self-assessment of one’s own health (physical, mental, emotional spiritual), access to care in these spheres, as well as education (and whether the interviewee or parents or grandparents attended residential schools), income, housing, water. Importantly, we now have our own statistics on the daily usage of our own First Nations languages, involvement in traditional activities on our lands, and related culturally based indicators.

The HIRGC advocated to ensure that our 2008-2010 sample of MFNs included the 26 who were involved in the 2002-03 sample, so that First Nations can have some comparative data. We now have statistically valid data for at least one half the First Nations in 6 of the 7 Tribal Councils, and all of the large independent First Nations, and a representative sample of small, medium and large communities.

HIRGC also provided guidance to the MFNs RHS team at the Assembly of Manitoba Chiefs in preparation of the fieldworkers training and development, preliminary review and developing the plans to the return of the RHS data in community profiles and other means to the participating Manitoba First Nations.

We look forward to assisting all Manitoba First Nations in utilizing this data.

Ekosani. Mahsi. Wopida. Miigwech.

## **ASSEMBLY OF MANITOBA CHIEFS, Chiefs Task Force on Health (CTFoH) Member: Chief Norman Bone, Keeseekoowenin First Nation**

On behalf of the hard working Chiefs of the CTFoH, I am very pleased that the MFNs RHS 2008-2010 Regional Report is providing a preliminary descriptive analysis of the data available. The sample provided by the 34 Manitoba First Nations participating in the RHS 2008-2010 enables us to speak as leaders, supported by scientifically valid and reliable data, recognized as such across Canada and the world. We are appreciative of the leaders and citizens of these MFNs who participated!

The 2008-2010 RHS is the third wave (after 1996-97 and 2002-03) allowing us to capture some idea of trends in our region, and across the country, as each region contributes their sample data to be rollup and included in a national report.

Please be assured that any application for access to the RHS data is reviewed and approved by AMC HIRGC and the CTFoH, to ensure support and benefits are provided to the Manitoba First Nations through research partnerships, before any access or sharing of data is allowed. No individual First Nations or tribal area is disclosed, unless the Chief and Council of participating RHS First Nations authorize their approval in writing.

This Regional Report is another step in returning the data to MFNs. From January to October 2012, AMC distributed newsletters on the community level data provided by 34 Manitoba First Nations. The newsletters provided important information on water quality and infrastructure, mental health and resources, youth perspectives and experiences, and oral health. At the Chiefs Assembly in October 2012, the Chiefs received “MFNs RHS 2008-2010 Quick Facts”, in an easy-to-carry format, to enable leaders to use these statistics when advocating on behalf of our people. “MFNs RHS 2008-2010 newsletters and quick facts booklet have been distributed at meetings and assemblies. Online copies can be found at the AMC website at [www.manitobachiefs.com](http://www.manitobachiefs.com).

The MFNs RHS team at AMC is preparing the community profiles for all the MFNs who participated in the 2008-2010 RHS. The team will be notifying Chiefs and Councils this summer, regarding the process and protocols, which begins with a Band Council Resolution to the MFNs RHS Team.

We hope that you will make good use of the data, as we continue on the road to self-determination in research.

Miigwech. Mahsi. Wopida. Ekosani

## **OVERVIEW OF MFN RHS 2008-2010**

The First Nations Regional Health Survey (RHS) is the only national survey of its kind designed, developed and delivered by indigenous peoples for indigenous peoples. It is supported by Manitoba Chiefs-in-Assembly and within all regions across Canada as the First Nations survey of choice. The RHS asks questions about the health and well-being of First Nations in a holistic way, addressing physical, mental, spiritual and emotional aspects. In addition to specific health issues, there are questions about housing, employment, education, residential school, community development, services and other priority areas. The RHS plays a vital role in helping us to understand not only what makes First Nations people in Manitoba ill, but more importantly, what makes us well. There are separate questionnaires for children, adolescents and adults.

Within the Manitoba Region, the Assembly of Manitoba Chiefs (AMC) Health Information Governance Committee (HIRGC) is mandated to:

- provide oversight and guidance to RHS within the Manitoba region;
- promote the First Nations principles of OCAP, where First Nations have the right have Ownership, Control, Access and Possession of their own data; and
- work to ensure First Nations are partners in the research process from beginning to end.

The Manitoba First Nations (MFN) RHS team implemented the 2008-2010 RHS within the Manitoba region under the guidance and support of the AMC HIRGC and Chiefs Task Force on Health (CTFoH), with AMC Grand Chief as ex-officio member.

The RHS has been successful in collecting information about health, education, income, environment and other concerns from First Nations living on reserve across Canada every four to five years since 1997.

This Final Report on MFN RHS (2008/10) contains basic descriptive statistics and some analytical statistics about on-reserve Manitoba First Nations peoples. A sample size of 74.9% of the target number was achieved. In total, 3,390 surveys (Adult, Youth, and Children combined) were collected from the targeted sample of 4,527 surveys. Estimates derived from the sample are weighted to be representative of the general Manitoba First Nations population on-reserve. The locally updated community membership lists were used to select the participants. Making adjustments to the data set to better reflect the make-up of the community and province as a whole; this allows the results from the survey completed by some of the community members to estimate the health of everyone in the community.

Participants were randomly selected based within community size clusters (large, medium, small) and age and sex strata. The RHS provides a statistically valid overview of Manitoba First Nations holistic health and well being in 2008-2010.

## **ACKNOWLEDGEMENTS**

### **Assembly of Manitoba Chiefs Health Information Governance Committee (AMC-HIRGC)**

The Regional Health Survey within the Manitoba region was carried out under the governance, guidance and direction of the Assembly of Manitoba Chiefs Health Information Research Governance Committee (AMC HIRGC) who report to the Chiefs Task Force on Health (CTFoH). It was implemented by the RHS Regional Coordinators and RHS team members at the Assembly of Manitoba Chiefs.

The AMC Health Information Research Governance Committee (HIRGC) founded in 1996 and was mandated by the Manitoba Chiefs-in-Assembly to oversee the Regional Health Survey. Its mandate has since expanded to review academic proposals for research concerning Manitoba First Nations, ensuring benefits First Nations and to promote First Nations ethical and effective research, including partnerships based on (i) free, prior informed consent on an individual and collective basis; (ii) First Nations OCAP principles that First Nations have Ownership, Control, Access and Possession of their own data; and, (iii) First Nations ethical standards (AMC Constitution Article # 17).

The HIRGC is composed of: two Tribal Health Directors from the North, and two from the South; one Independent Health Director from the North, and one from the South; an Elder and a Youth Representative (appointed by and reports to the AMC Youth Council); and a First Nations academic advisor.

#### **Current Members:**

William Easter, Elder, Chemawawin Cree Nation

Lyna Hart, Co-Chair, Southeast Resource Development Council Health Services

Garry Munro, Co-Chair, Cree Nation Tribal Health Centre

Myrle Ballard, First Nations Academic Advisor

Doris Young, First Nations Academic Advisor

Wallace McDougall, Four Arrows Health Authority

Vacant, Independent First Nation

Howard Halcrow, Pimicikamak Cree Nation (Independent North)

Joelyn Foadi-Frenette, Dakota Ojibway Health Services (Independent South)



Clarence Flett, Youth Rep, St. Theresa Point First Nation

**HIRGC Committee Members (Past 2008-2012):**

Cindy Hart, Fisher River First Nation

Gloria Cook, Fisher River First Nation

Ryan Qeskekapow, Youth Representative, Norway House Cree Nation

Bernice Thorassie, Keewatin Tribal Council

Duke Beardy, Keewatin Tribal Council

Diane McDonald, West Region Tribal Health,

### **Participating Communities**

We would like to thank the following First Nations who participated in the Manitoba First Nations Regional Health Survey 2008-2010. There was involvement of the communities at various stages in the RHS process; the participants who gave their time to share the story of their own holistic well-being; the hard work and dedication of the Data Warriors who interviewed the participants, Health Directors who helped identify and provided support to the Data Warriors, Chief and Councils who signed the Statement of Participation inviting RHS into their communities, First Nations staff in the various departments who helped complete the RHS Community Surveys, and the AMC HIRGC members who provided support and oversight to the RHS process.

**DAKOTA OJIBWAY TRIBAL COUNCIL**

Canupawakpa\*

Long Plain

Roseau River

Sandy Bay

**ISLAND LAKE TRIBAL COUNCIL**

Garden Hill

Wasagamack\*

**INTERLAKE TRIBAL COUNCIL**

Kinonjeoshtegon\*

Peguis

Pinaymootang

**KEEWATIN TRIBAL COUNCIL**

Brochet

Barren Lands

Gods Lake\*

Sayisi Dene

Tataskweyak

War Lake

**SWAMPY CREE TRIBAL COUNCIL**

Mathias Colomb

Misipawistik

Opaskwayak

Wuskwi Sipihk

**SOUTH EAST REGION TRIBAL COUNCIL**

Berens River

Black River

Bloodvein

Brokenhead

Hollow Water\*

**WEST REGION TRIBAL COUNCIL**

Ebb and Flow

Keeseekoowenin

Pine Creek

Skownan

**NORTHERN INDEPENDANT**

Nisichawayasihk

Norway House

O-Pipon- Na Piwin

**SOUTHERN INDEPENDANT**

Fisher River

Sagkeeng

Waywayseecappo

\*Communities did not collect sufficient sample sizes to contribute to the regional or national RHS reports, although a RHS Community Survey was completed by their communities.

## RHS Data Warriors

Barren Lands First Nation  
Berens River First Nation  
Berens River First Nation  
Berens River First Nation  
Black River First Nation  
Bloodvein First Nation  
Bloodvein First Nation  
Brokenhead First Nation  
Brokenhead First Nation  
Brokenhead First Nation  
Bunibonibee First Nation  
Canupawakpa Dakota Nation  
Canupawakpa Dakota Nation  
Cross Lake Band of Indians  
Cross Lake Band of Indians  
Cross Lake Band of Indians  
Cross Lake Band of Indians  
Cross Lake Band of Indians  
Ebb & Flow First Nation  
Fisher River Cree Nation  
Fisher River Cree Nation  
Fisher River Cree Nation  
Fisher River Cree Nation  
Fisher River Cree Nation  
Fisher River Cree Nation  
Garden Hill First Nation  
Garden Hill First Nation  
Garden Hill First Nation  
God's Lake First Nation  
God's Lake First Nation  
God's Lake First Nation  
God's Lake First Nation  
Hollow Water First Nation  
Hollow Water First Nation  
Hollow Water First Nation  
Hollow Water First Nation  
Hollow Water First Nation  
Keeseekoowenin Ojibway Nation  
Keeseekoowenin Ojibway Nation  
Kinonjeoshtegon First Nation  
Kinonjeoshtegon First Nation  
Long Plain First Nation  
Long Plain First Nation  
Long Plain First Nation  
Long Plain First Nation

Trina Laponsee  
Donna Everette  
Ginger Green  
Stella McKay  
Lareen Johnston  
Annette Cook  
Barbara Fisher  
Jim Prince  
Emery Smith  
Marvin Smith  
Hazel Sinclair  
Wanda Sandy  
Kristen Paul  
Marlon McKay  
Nolan McKay  
William Miswagan  
Audrey Ross  
Charlene Umperville  
Paulette Malcolm  
Amy Crate  
Gary Hart  
Bernice McKay  
Wanda Murdock  
Rose McKay  
Stacey Murdock  
Ida Taylor  
Kevin Harper  
Amanda Harrison  
Mervin White  
Leona McKay  
Terrence Hill  
Fraser Spence  
Billy Barker  
Kristen Raven  
Gabrielle Boulette  
Furlon Barker  
Yvonne Michelle  
Martin Cowley  
Bella Bone  
Carolynn Brazeau  
Kimberley Ross  
Tony Traverse  
Ralph Francis  
Frank Hudson  
Tara Meeches  
Malleri Meeches

Mathias Colomb First Nation  
Misipawistik Cree Nation  
Misipawistik Cree Nation  
Nisichawayasihk Cree Nation  
Nisichawayasihk Cree Nation  
Northlands Denesuline First Nation  
Norway House Cree Nation  
Norway House Cree Nation  
Norway House Cree Nation  
Norway House Cree Nation  
Opaskwayak Cree Nation  
Opaskwayak Cree Nation  
Opaskwayak Cree Nation  
Opaskwayak Cree Nation  
O-Pipon-Na-Piwin Cree Nation  
O-Pipon-Na-Piwin Cree Nation  
Peguis First Nation  
Peguis First Nation  
Pinaymootang First Nation  
Pinaymootang First Nation  
Pine Creek First Nation  
Pine Creek First Nation  
Roseau River Anishinabe Nation  
Roseau River Anishinabe Nation  
Sagkeeng First Nation  
Sagkeeng First Nation  
Sagkeeng First Nation  
Sagkeeng First Nation  
Sandy Bay First Nation  
Sandy Bay First Nation  
Sayisi Dene First Nation  
Sioux Valley Dakota Nation  
Sioux Valley Dakota Nation  
Skownan First Nation  
St. Theresa Point First Nation  
St. Theresa Point First Nation  
Tataskweyak Cree Nation  
Tataskweyak Cree Nation  
Tataskweyak Cree Nation  
War Lake First Nation  
Wasagamack First Nation  
Wasagamack First Nation  
Wasagamack First Nation  
Wasagamack First Nation  
Waywayseecappo First Nation  
Waywayseecappo First Nation  
Waywayseecappo First Nation

Barbara Dumas  
Rhonda Cook  
Bernice Ross  
Clinton Hart  
Wilma McDonald  
Agnes Samuel  
Billie Jo Anderson  
Andrew Crate  
Harriet Cromarty  
Marion Juselius  
Jared Henderson  
Delores Lathlin  
Nicole Lathlin  
Kathleen Whitehead  
Valerie Dysert  
Lorette Stevens  
Clarence Cameron  
Anita Spence  
Shirley Cranford  
Phyllis Wood  
Lenora Nepinak  
Trina Chartrand  
Debra Henry  
April Sennie  
Lillian Cook  
Candice Daniels  
Anita Guimond  
Tania Twoheart  
Candice Gregory  
Cheryl Martin  
Jean Bussidor  
Brenda Smoke  
Leaha Tacan  
Mona Chartrand  
Gwen Flett  
Doreen Mason  
Jody Beardy  
Destiny Kitchekeesik  
Freda Spence  
Jennifer Iloomfield  
Ida Harper  
Connie Harper  
Joe Harper  
Phyllis Harper  
Nadia Brandon  
Bernalda Cloud  
Cody McKay

Waywayseecappo First Nation  
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Wuskwi Sipiik First Nation  
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Jeanette Mecas  
Myles Shingoose  
Erin Mecas  
Christine Spence  
Marina Mentuck  
Allison Wood  
Gloria Mentuck  
Johnathan Tanner  
Miranda Mecas  
Lyle Audy  
Patricia Leask

### **MFN RHS 2008-2010 team members (Current)**

Leona Star, Research Associate & RHS Coordinator  
Leanne Gillis, RHS & REEES Administrative Support  
Andrew Basham, Statistical Analyst  
Kathi Avery Kinew, Manager of Social Development & Research Initiatives

### **MFN RHS 2008-2010 team members (Past)**

Jeff LaPlante, RHS Regional Coordinator (2005-2009)  
Kevin Beardy, RHS Northern Liason / Acting Regional Coordinator (2008-2011)  
Sunday Lizu, MDP Intern, University of Winnipeg (May-July 2012)

## METHODOLOGY

### Study Design

The First Nations Regional Health Survey (RHS) is a cross-sectional survey designed to assess the wholistic health of First Nations individuals living in First Nations communities across Canada (on-reserve and in northern First Nations communities). Age-specific versions of the survey were developed to best represent the population; Child (0-11 years), Youth (12-17 years), Adult (18-54 years), Older Adults (55+).<sup>1</sup> First Nations community members were trained as fieldworkers to administer the surveys, typically in the respondent's home. The vast majority of surveys were completed on laptop computers utilizing customized software (CAPI: Computer Assisted Personal Interviewing) and a limited number were completed on paper. The MFN RHS team *worked closely with First Nations Health Directors to find and hire* Community Interviewers in their own communities to conduct the survey interviews, training them in using computer-assisted-personal-interviewing (CAPI) technology and the how-to of surveys. Data was collected between June 2008 and March 2010.

### Study Population and Sample Size

The RHS began as a pilot project in 1997 and included only nine regions. Subsequently, RHS Phase 1 was implemented in 2002/03 and included two new regions, the Yukon and the Northwest Territories. Overall, RHS Phase 1 reached 80% of the target sample with data collected from 22,602 participants in 238 First Nations communities. The Manitoba region has participated in each phase since the pilot phase in 1997 where 19 Manitoba First Nations participated; increasing to 27 First Nations in 2002-2003. In the most recent phase (2008-2010) 34 First Nations agreed to participate in the RHS.

The second and most recent phase of the RHS (Phase 2) was conducted between June 2008 and November 2010 across Canada within the 10 regions. In Phase 2, 72.5% of the target sample size was achieved for a total of 21,757 surveys from 216 First Nations communities across Canada. The RHS questionnaires were completed by 11,043 adults, 4,837 youth, and 5,877 children. Nationally the RHS accounted for 5.5% of those living in First Nations communities across Canada.

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<sup>1</sup> The 55+ age group marks a new addition to the sampling plan. In RHS Phase 1, within the adult group (18+), 10% of the sample was allocated to the over 55 subgroup even though this subgroup comprised on average only 5% of the over 18 population. The inclusion of this new age group in the Phase 2 sampling plan ensured sufficient numbers for statistically reliable results.

The sampling framework utilized the Aboriginal and Northern Affairs Development Canada (AANDC) Indian Status Registry, which is based on the band lists that Manitoba First Nations maintain and update according to the Indian Act and training received from AANDC. The sample design incorporated a two stage sampling strategy; the first stage involved the selection of communities to participate in the survey. First Nations communities were stratified by region, sub-region, and community size [large (1500+ people), medium (300-1499 people), and small (<300 people)]. Large communities were automatically included, while medium and small communities were randomly selected with equal probability within their respective strata.

AMC HIRGC ensured that the same Manitoba First Nations that participated in the 2002-2003 RHS were also included in the 2008-2010 RHS.

The 34 participating Manitoba First Nations reflected a wide range of communities north to south, isolated and accessible, at least 50% of each First Nations in each of the 7 Tribal Council<sup>2</sup> regions and Independent Manitoba First Nations and each of the 5 language territories (Cree, Ojibway, Dakota, Oji Cree and Dene) are represented within the sample.

The second stage of sampling pertained to the selection of individuals within each community sampled. Community members were selected using the official First Nations band membership lists. Data were gathered to represent eight categories of the community population (gender by four age-groups). The sampling rate within each community was determined as a function of the overall sub-region probability (within regions) and the probability of selection of the community (within sub-region).

Individual responses were weighted, to represent a proportion of the age group and Manitoba region, providing a greater representation of the First Nations population by the sample selected.

Within the Manitoba region, over 80% of the targeted regional sample of 4,527 surveys was collected. After cleaning the RHS data, a total of 3,390 surveys (74.9% of target) were found to be valid according to the sampling framework and methodology that was defined prior to collecting data. Based on a 2007 Manitoba First Nation on-reserve population of 78,160 the Manitoba First Nation RHS surveyed 4.38% of the on-reserve population.

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<sup>2</sup> Only includes 1 First Nations community that belong to the Island Lake Tribal Council. Due to unforeseen circumstances, data collection was not completed in the replacement community that was selected within the sampling framework.



## Data Preparation

Once the data collection phase was completed in May 2010, the MFN RHS team worked closely with the National RHS team to clean the data; ensuring each survey had a signed consent form (to ensure Free, Prior, Informed Consent of the participant), removing duplicates or incomplete surveys, and verifying/reclassifying gender and age categories. The MFN RHS team had the challenge of going back through the consent form database and hard copies of consent forms to identify missing categories in gender and/or age to ensure each community had at least one sex (male and female) in each of the four age categories (0-11yrs, 12-17yrs, 18-54yrs and 55yrs or more). Thus we followed the sampling framework that was defined in the beginning of the 2008-2010 RHS phase.

## Additional Data Sources for this Report

This report uses data from seven datasets, spanning Phases I (2002/03) and II (2008/10) of the RHS. Phase I provides three datasets from the adult, youth, and child survey questionnaires, and Phase II provides four datasets from the adult, youth, child, and community questionnaires. Each is drawn on in this report. Documentation relating to the 2002/03 RHS can be found at [www.fnigc.ca](http://www.fnigc.ca).

## Statistical Analysis

This report presents statistical results from the 2008/10 RHS (Phase II) and, where feasible, comparative statistics from the 2002/03 RHS (Phase I). All analyses were conducted using SPSS v.20 with the Complex Samples module, which adjusts estimates from the data collected through a stratified and clustered (i.e. complex) survey sample. It allows the design effect to be incorporated into weighted estimates of true population parameter as opposed to the sample alone. Results were entered into Excel to provide graphical presentation. The results of this analysis are representative only of First Nations people living on-reserve.

To compare groups, 95% confidence intervals are used. A 95% confidence interval (95% CI) displays the range where if we took the same size of sample repeatedly from population until everyone was surveyed, we would expect 95% of the intervals to include the true population value. When the 95%CI's of two groups overlap they are not statistically significantly different (i.e., any difference between them could be due to chance alone), and where the 95%CI's do *not* overlap, differences are considered statistically significant. Error bars in the charts display the 95%CI's calculated by the SPPS Complex Samples module. This is the same method used in the national RHS report developed by the First Nations Information Governance Centre (FNIGC).

The majority of results are frequency distributions, portraying the percentage of the population having certain characteristics (e.g., asthma prevalence, home repair status, etc). Other results are presented as averages or mean values for continuous variables (e.g., average Health Utilities Index Multi-Attribute Score). Cross-tabulations and grouped means were used to determine associations between variables. An example of a cross-tabulation would be the proportion of asthmatics by home repair status; and an example of a grouped mean would be the average Kessler Psychological Distress Score (K10) by sex.

Estimates that have a coefficient of variation (CV) ranging from 0.16-0.33 are marked with an “E” to represent high sampling variability. Estimates with a CV >0.33 are suppressed and marked with an “F”. Any estimate based on fewer than 5 cases is suppressed and also marked with an “F”, in order to preserve the anonymity of participants. Therefore, the data presented in this report is valid, reliable, and protects the confidentiality of each and every person interviewed; in keeping with the independent review of the 2002/03 RHS by researchers at Harvard University.

## INTRODUCTION

This report represents the lives of Manitoba First Nations people. A report on the health of Manitoba First Nations is not an easy thing to create. With so many potential questions and perspectives to consider, only a fraction of the possible can be studied and presented. It is a vital, living document that provides a snapshot of many facets of health, including the determinants of health and issues related to health services. Over time the report will expand to include further analyses and new data as future RHS phases are completed.

The primary focus of this report is the 2008/10 RHS (Phase II), however, for selected questions, comparisons with 2002/03 RHS (Phase I) are also presented in order to get an idea of trends, as well as to check the stability of estimates over time.

This report is divided into four chapters to reflect the four survey questionnaires that are part of the 2008/10 RHS: (1) Adults, (2) Youth, (3) Children, (4) Community. The first three chapters contain three sections each: determinants of health, health status, and health services. The contents of each chapter's sections will vary based on the different questionnaires for adults, youth, and children. The final chapter, community health, provides results from a survey of key individuals within each First Nation on a wide-range of community infrastructure, programs, and services.

## CHAPTER 1 - ADULTS

The following Adult section is based on responses of the 1,739 adults who were 18 years of age and over at the time of the survey. Fifty three (53%) percent of adults interviewed were female and 47% were male. Each adult was interviewed using the Adult questionnaire. The survey questionnaire can be found online at [www.fnigc.ca](http://www.fnigc.ca).

### Determinants of Health

Determinants of health are those things that determine a person or population's health and wellness. This section includes information about housing, education, employment, income, language, residential schools, food and nutrition, alcohol, non-prescription drug use, gambling, smoking, mobility, physical activity, and community issues.

#### Housing

- In Manitoba First Nations, there is an average of 4.7 persons per household (95%CI: 4.58, 4.89).
- There is an average of 5.18 rooms per household (95%CI: 5.06, 5.29) in Manitoba First Nations on-reserve households.
- There is an average of 1.16 people per room in Manitoba First Nations on-reserve households (95%CI: 1.10, 1.21).
- 42.5% of Manitoba First Nations households are overcrowded (have greater than 1 person per room).

Figure 1 Children per household

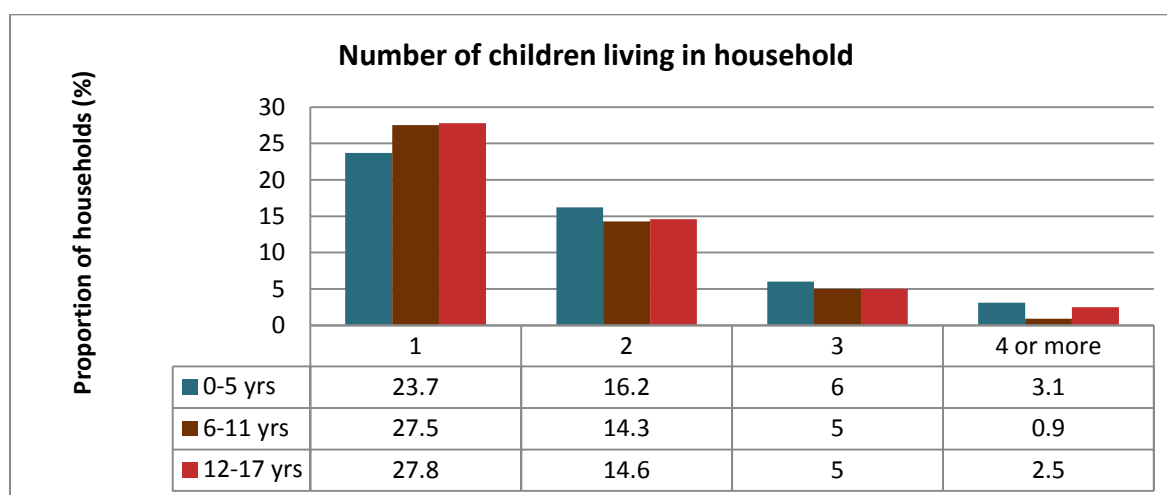


Figure 2 Adults per household

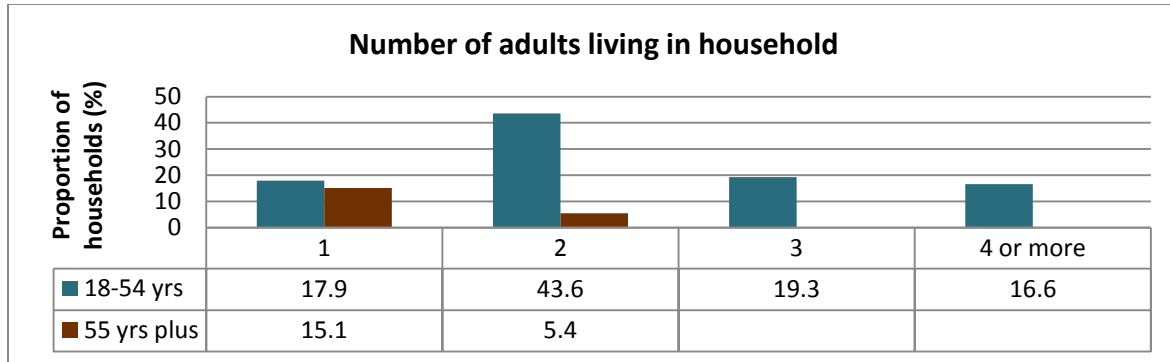


Figure 3 Rooms per household by age-group

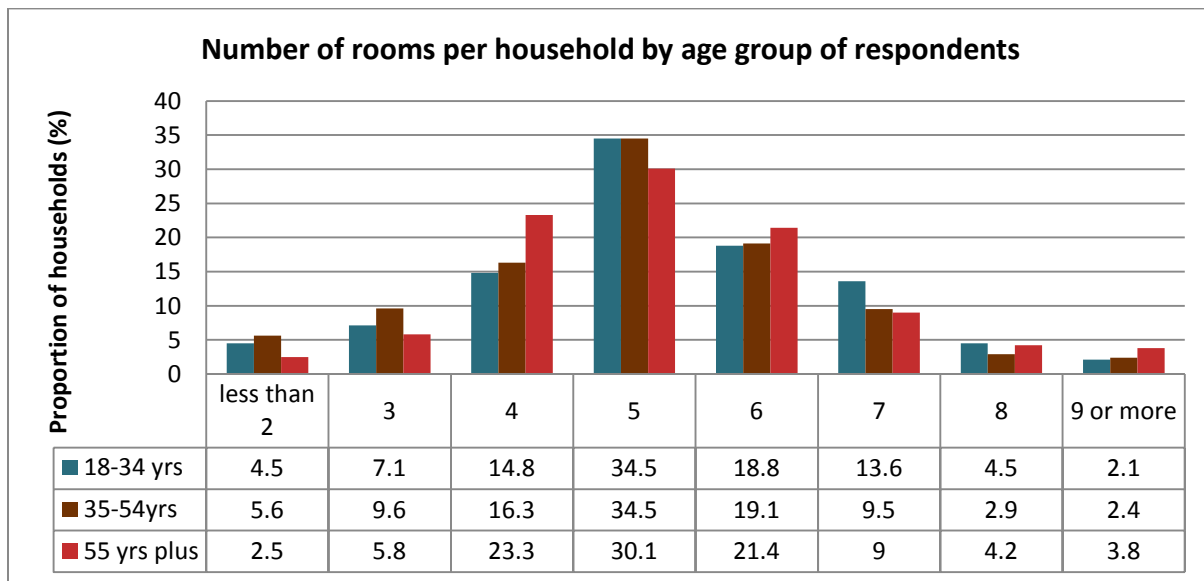
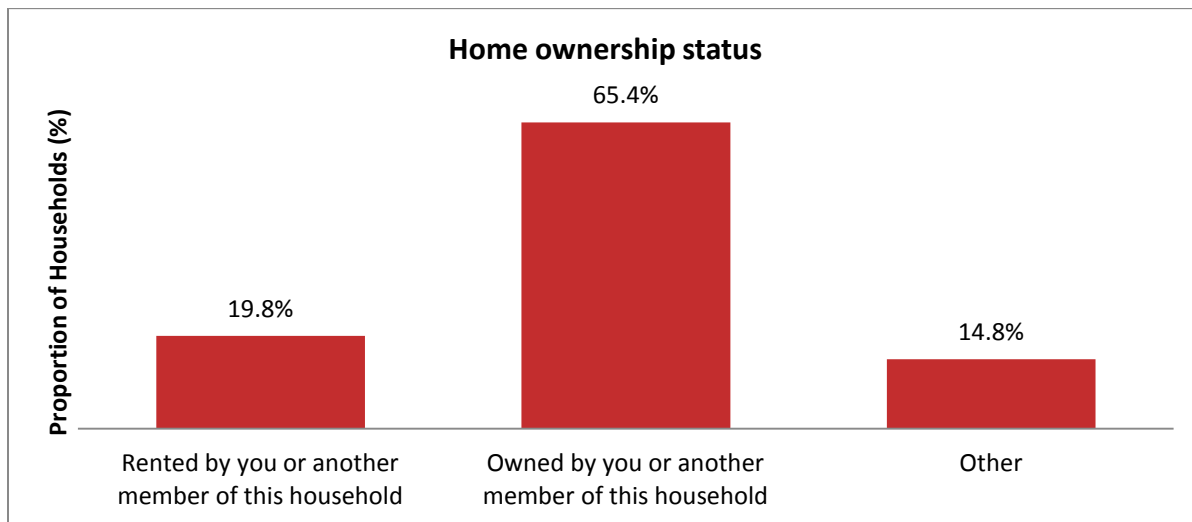


Figure 4 Home ownership



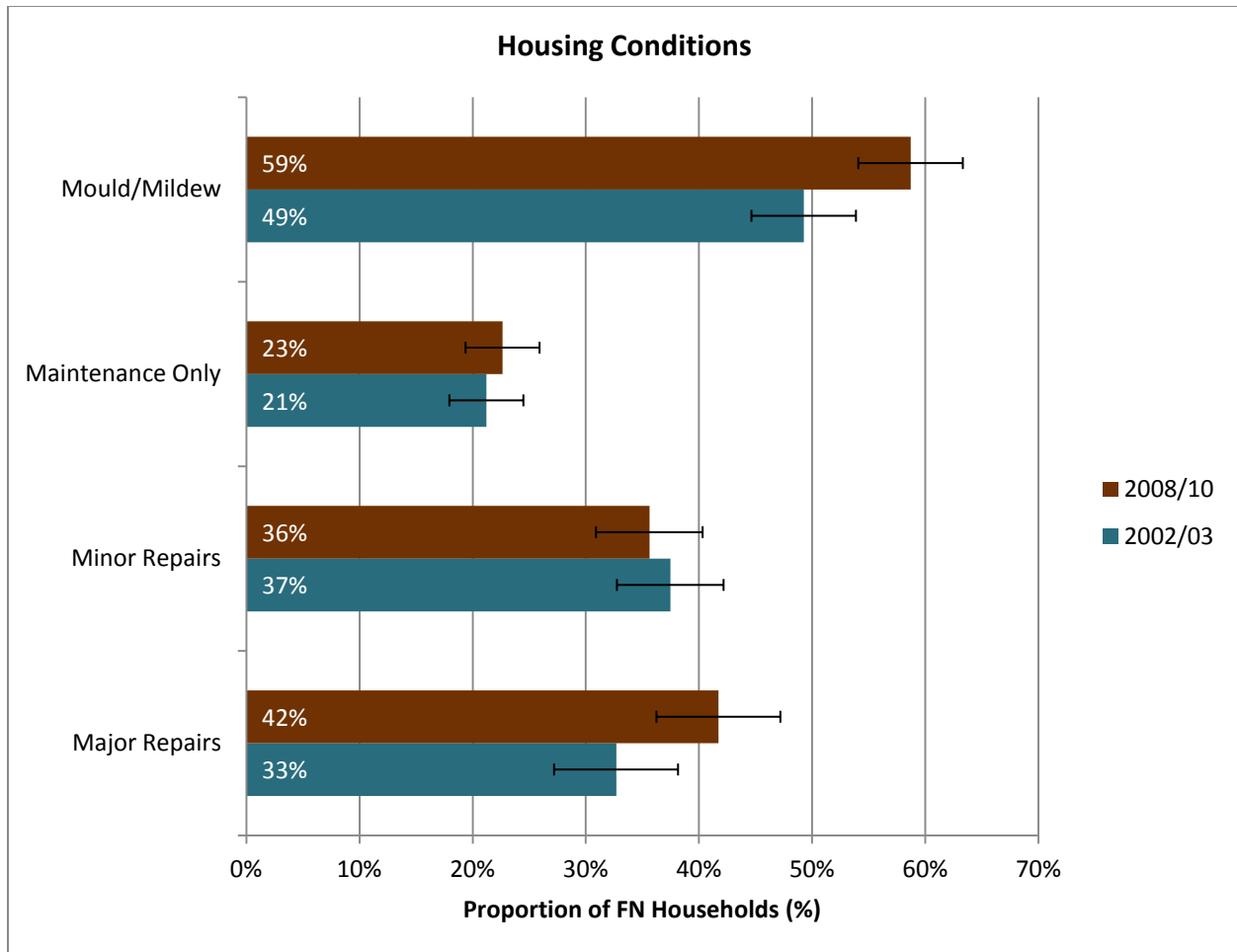
- 41.7% of houses were in need of major repairs and 35.7% of houses needed minor repairs
- 58.7% of houses had mould or mildew in the past 12 months

A significant increase in reports of mould/mildew in homes was observed between 2002/03 (49.3% [95%CI: 44.3%, 54.3%]) and 2008/10 (58.7% [95%CI: 55.4%, 62.0%]). It also appeared that reported major repair needs have increased, but this was not statistically significant.



Home in Wasagamack First Nation (Joe Bryksa / Winnipeg Free Press)

Figure 5 Housing conditions



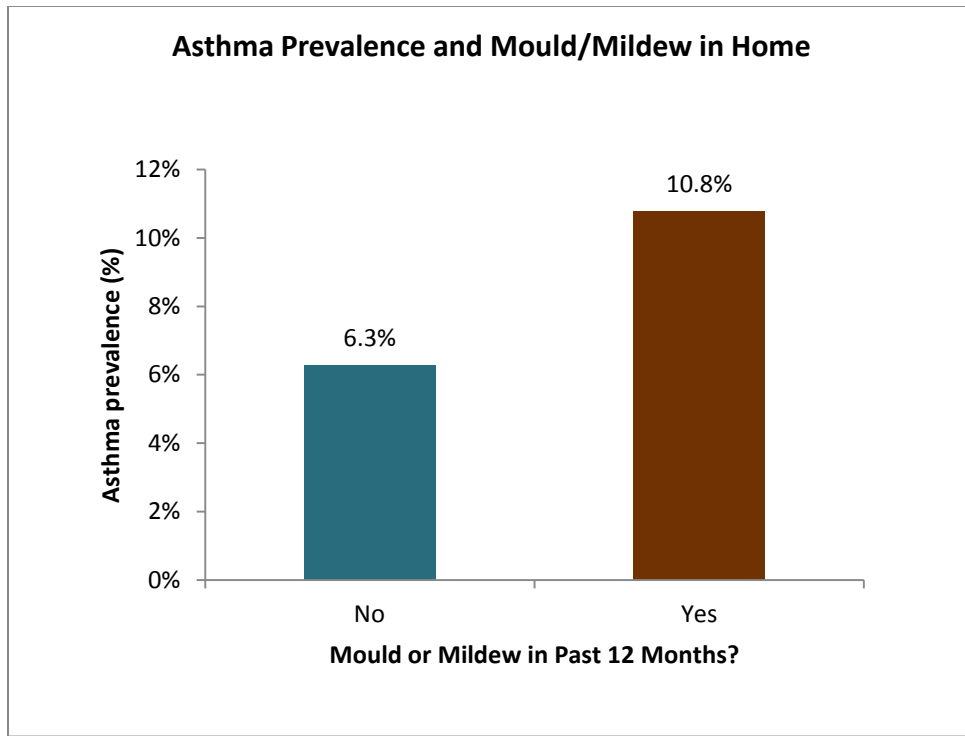
### Mould and Mildew

Mould can contribute to a number of respiratory illnesses, including asthma, allergies, and tuberculosis, to name a few. Mould is highly prevalent amongst Manitoba First Nations (43.7% of households had mould in last 12 months) compared to First Nations nationally (23.4% had mould in past 12 months).<sup>3</sup>

<sup>3</sup> First Nations Information Governance Centre (2012). First Nations Regional Health Survey 2008/10: National Report on Adults, Youth and Children living in First Nations Communities. Online: [http://www.fnigc.ca/sites/default/files/First%20Nations%20Regional%20Health%20Survey%20\(RHS\)%202008-10%20-%20National%20Report.pdf](http://www.fnigc.ca/sites/default/files/First%20Nations%20Regional%20Health%20Survey%20(RHS)%202008-10%20-%20National%20Report.pdf)



Figure 6 Asthma prevalence and mould/mildew in home



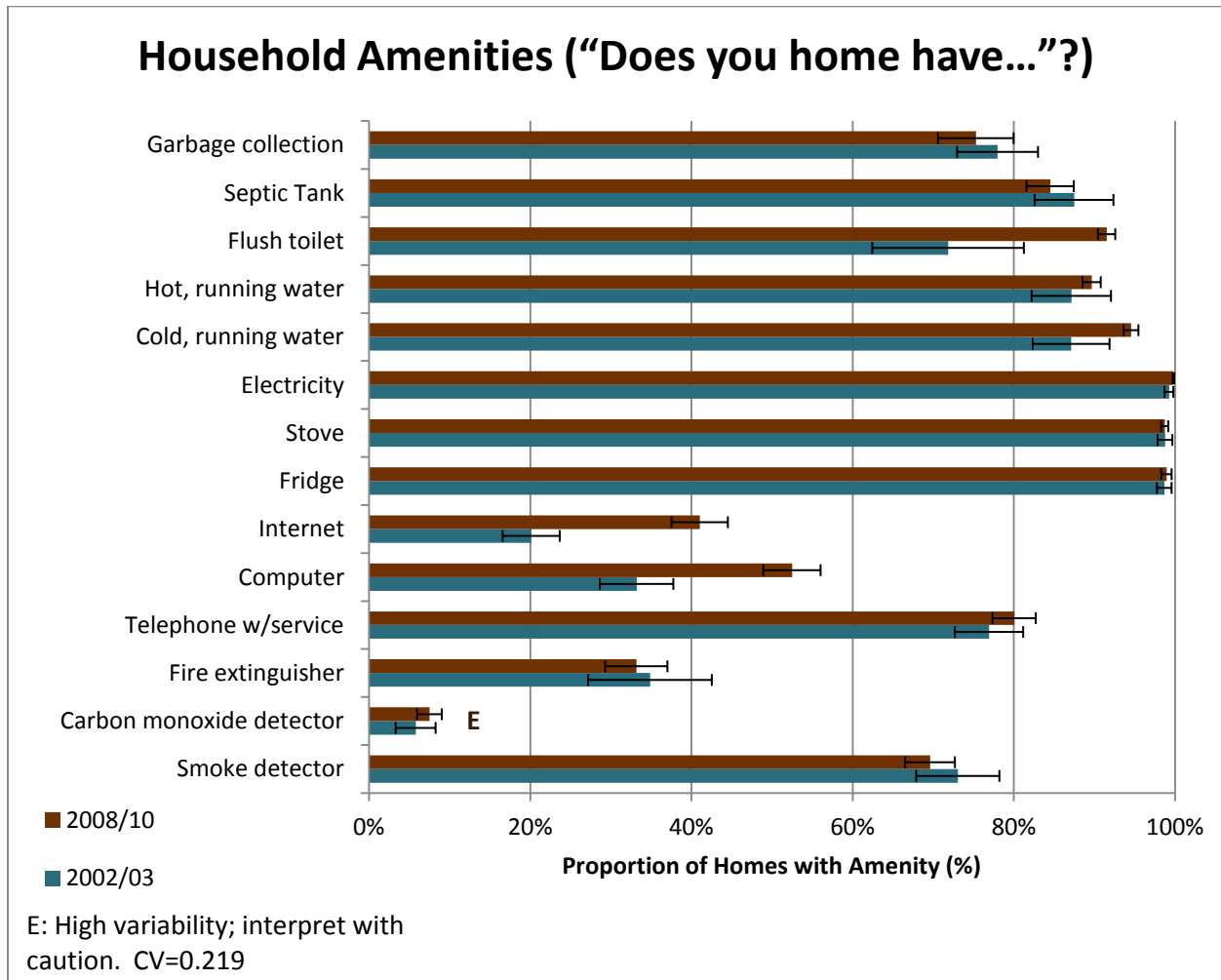
“Kids inside a [shelter] in [location]. The band needs about 450 more houses to alleviate chronic overcrowding” (Joe Bryksa / Winnipeg Free Press)

### Household Amenities

The proportion of households with flush toilets, cold running water, a computer, and Internet have all increased significantly between 2002/03 and 2008/10. However, there are still many gaps in household amenities:

- 30.4% of adults live in homes where they do not have a working smoke detector
- 19.9% of adults live in homes where they do not have a telephone and 47.5% do not have an internet connection
- 10.3% of adults live in homes where they do not have hot, running water and 5.4% are without cold, running water
- 8.5% of adults live in homes where they do not have a flushing toilet; 15.5% are without a septic tank or sewage services and 24.7% are without a garbage collection service

Figure 7 Household amenities





"Outhouses in Wasagamack First Nation are used year round" (Karen Pauls/CBC)

## Education

Figure 8 Highest grade completed (elementary and secondary school)

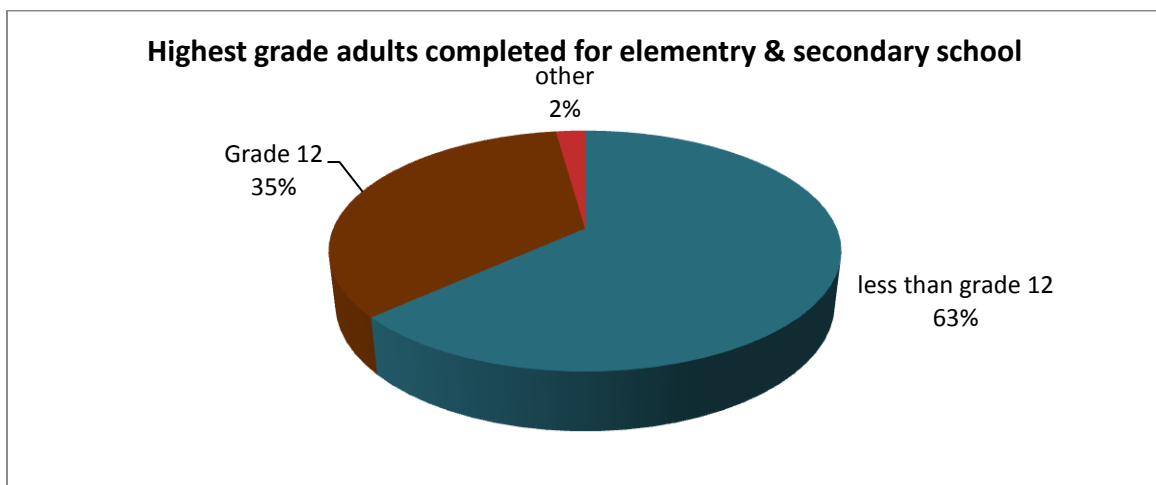
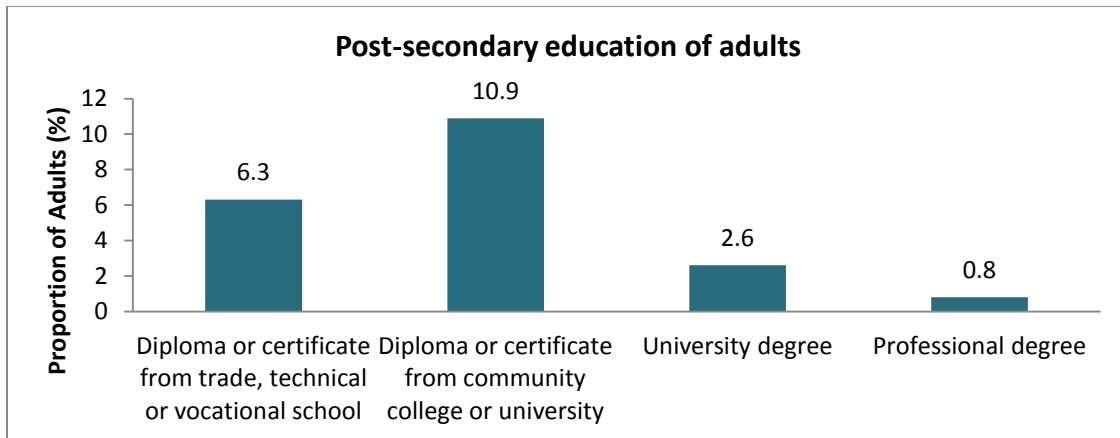


Figure 9 Post-secondary education



*Young Adults (18-34yrs old)*

- 58.9% had less than a high school diploma
- 9.7% had greater than a high school diploma (diploma/certificate from trade or vocational school, community college or university, university degree, Masters or Professional degree)

*Adults (35-54yrs old)*

- 60.9% had less than a high school diploma
- 27.1% had greater than a high school diploma (diploma/certificate from trade or vocational school, community college or university, university degree, Masters or Professional degree)

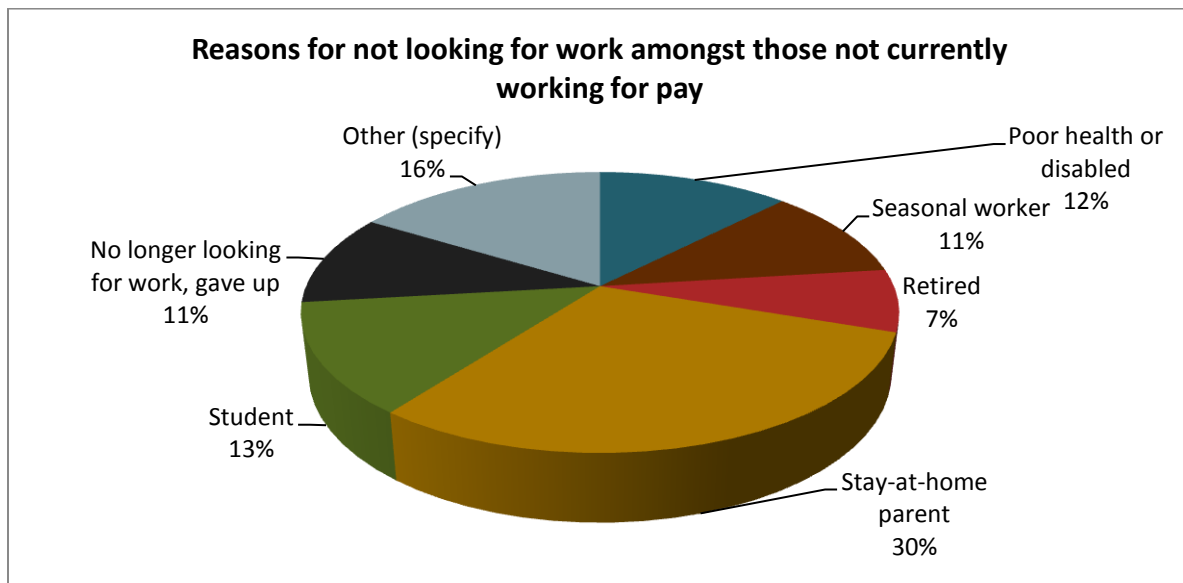
*Seniors (55yrs old plus)*

- 84.5% had less than a high school diploma
- 24.9% had greater than a high school diploma (diploma/certificate from trade or vocational school, community college or university, university degree, Masters or Professional degree)

**Employment**

- Over half (55.3%) of adults were not working for wages and 51.3% of these adults were not looking for work for a variety of reasons;
- 44.7% adults are currently working for pay, and 89.7% of those who work for pay work within their community;
- 51.7% were working a full time job for 40 hrs per week.

Figure 10 Reasons for not looking for work

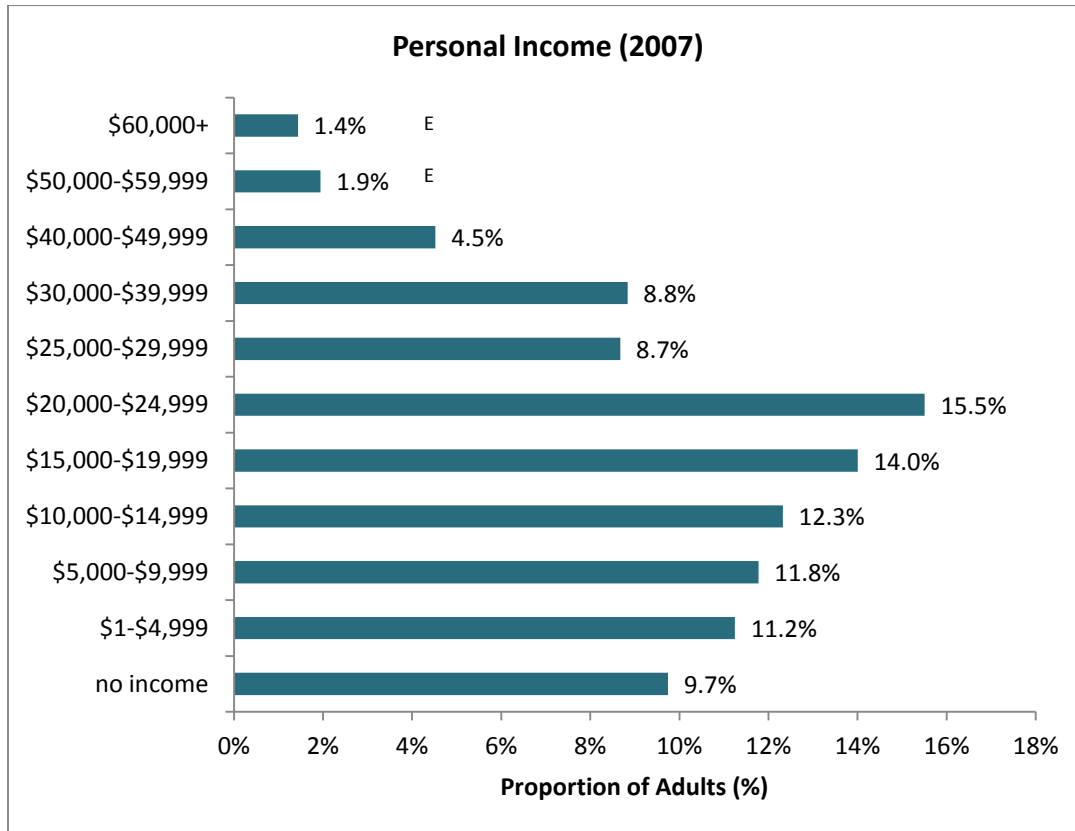


***“Not too many jobs available out here and no vehicle to travel outside community”***

***(MFN RHS 2008-2010 Adult respondent)***

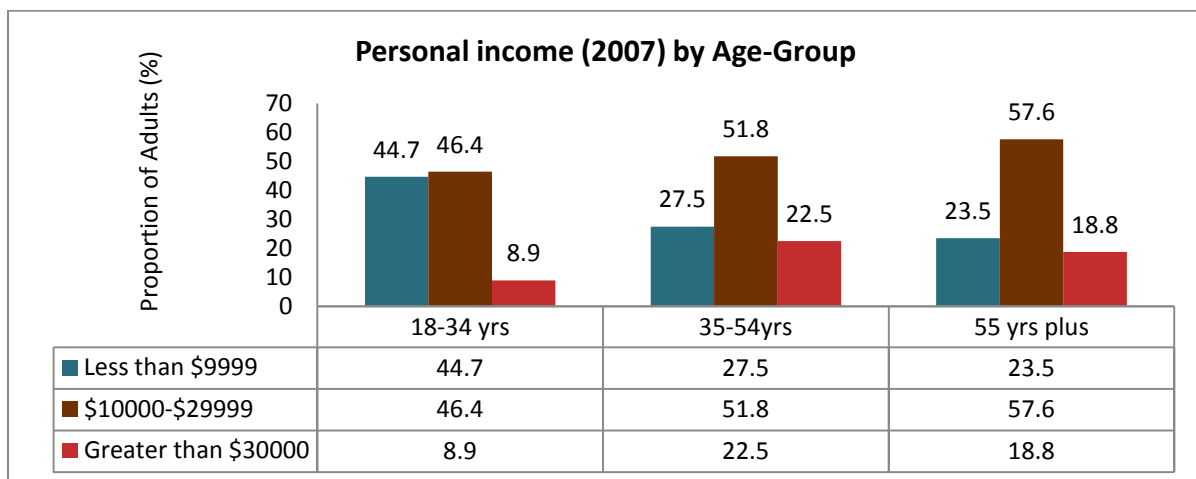
## Income

Figure 11 Personal income (2007)



- 51.8% of adults received income from paid employment
- 39.2% of adults received income from Child Tax Benefits
- 54.5% of adults received income from social assistance

Figure 12 Personal income (2007) by age-group



*Young Adults (18-34)*

- The top three sources of income were; 49.3% paid employment; 43.8% Child Tax Benefit and 31.1% Social Assistance<sup>4</sup>

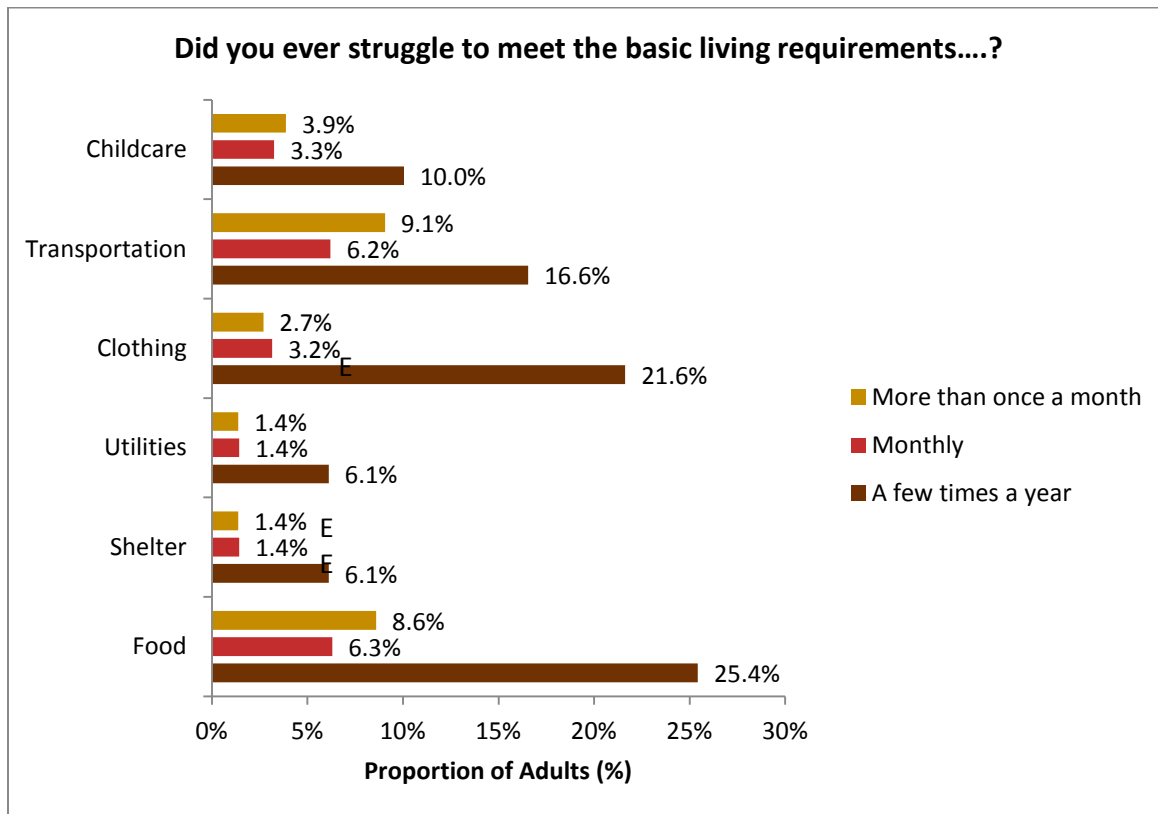
*Adults (35-54)*

- The top three sources of income were; 59.5% paid employment; 48.6% Social Assistance and 44.1% Child Tax Benefit

*Seniors (55yrs plus)*

- The top three sources of income for seniors were; 44.1% Old Age Security, 35% paid employment; and 29.9% Social Assistance

Figure 13 Meeting basic living requirements



<sup>4</sup> Note: these do not sum to 100% because people often have multiple sources of income.



## Language

### Understanding

- 10.1% of Adults said they could understand a few words of a First Nations language;
- 15.2% had a basic understanding of words in a First Nations language;
- 16.7% had an intermediate understanding of a First Nations language
- 57.9% were fluent in their understanding of a First Nations language.

### Speaking

- 15.1% of Adults said they could speak a few words of a First Nations language;
- 16.4% could speak basic words in a First Nations language;
- 14.9% could speak intermediately in a First Nations language;
- 53.7% were fluent speakers in a First Nations language.

### Young Adults (18-34yrs)

- When asked which language they use most often in daily life 94.4% said they use English in daily life.
- 61.9% understand or speak a First Nations language and 31.8% use a First Nations language in their daily life.

### Adults (35-54yrs)

- When asked which language they use most often in daily life 88.9% said they use English in daily life.
- 81.3% understand or speak a First Nations language and 52.2% of Adults use a First Nations language in their daily life.

### Seniors (55yrs plus)

- When asked which language they use most often in daily life 76% said they use English in daily life.
- 93.3% understand or speak a First Nations language and 74.6% use a First Nations language in their daily life.

### *Residential Schools*

Overall, 18.9% of Adults over the age of 18 years attended residential school. The negative impacts of residential school were most commonly reported amongst older adults. Younger adults were more likely to report no impact from residential school as less attended fewer schools. A small number of respondents reported positive impacts from residential school, with middle-aged adults reporting this most commonly compared to young adults and seniors.

#### *Young Adults (18-34yrs)*

- 5.3% attended residential school

#### *Adults (35-54yrs)*

- 22.9% attended residential school

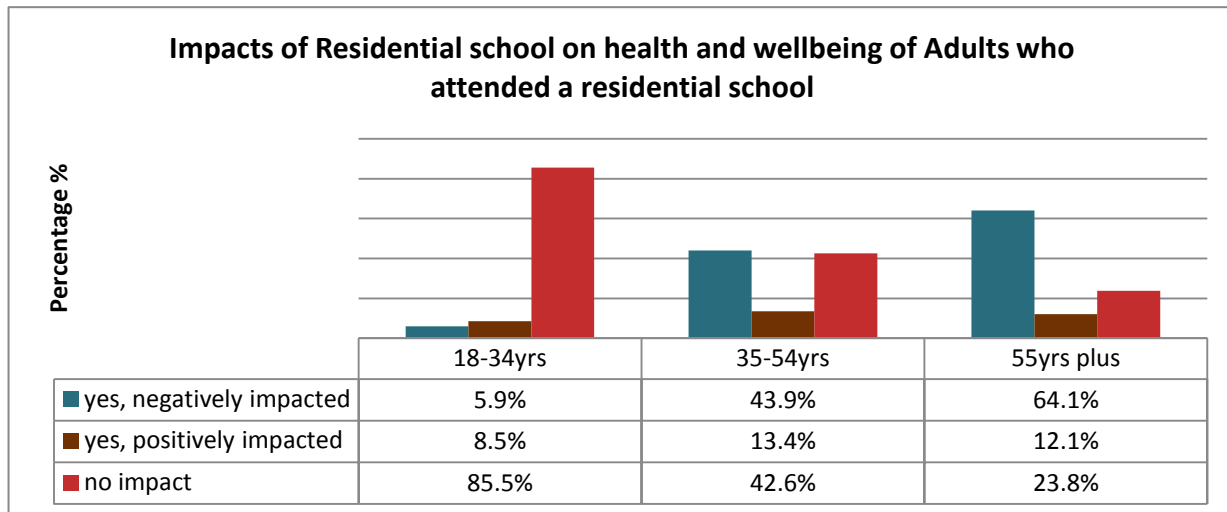
#### *Seniors (55yrs plus)*

- 44.1% attended residential school



Cross Lake Residential School, Manitoba Archives

Figure 14 Impact of residential school on health and wellbeing



*“They made another native girl cut off her hair for being late for supper, in front of everyone....”*

*(MFN RHS 2008-2010 Adult respondent)*

*“Being very lonely... sneaking the use of our language.”*

*(MFN RHS 2008-2010 Adult respondent)*

*“I didn't like residential school it had a very negative impact on my life. I will never be the same person that I was. I am glad I didn't stay that long.”*

*(MFN RHS 2008-2010 Adult respondent)*

Figure 15 Negative impacts of residential schools (ages 35-54 years)

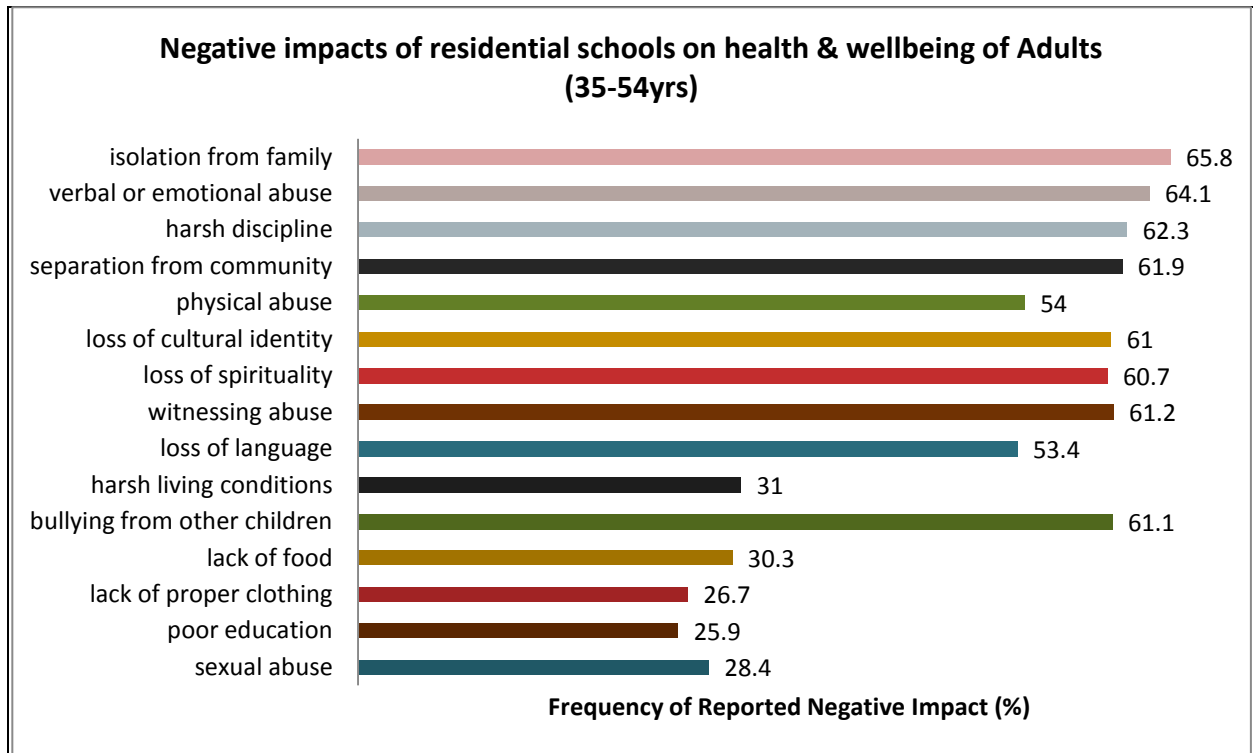
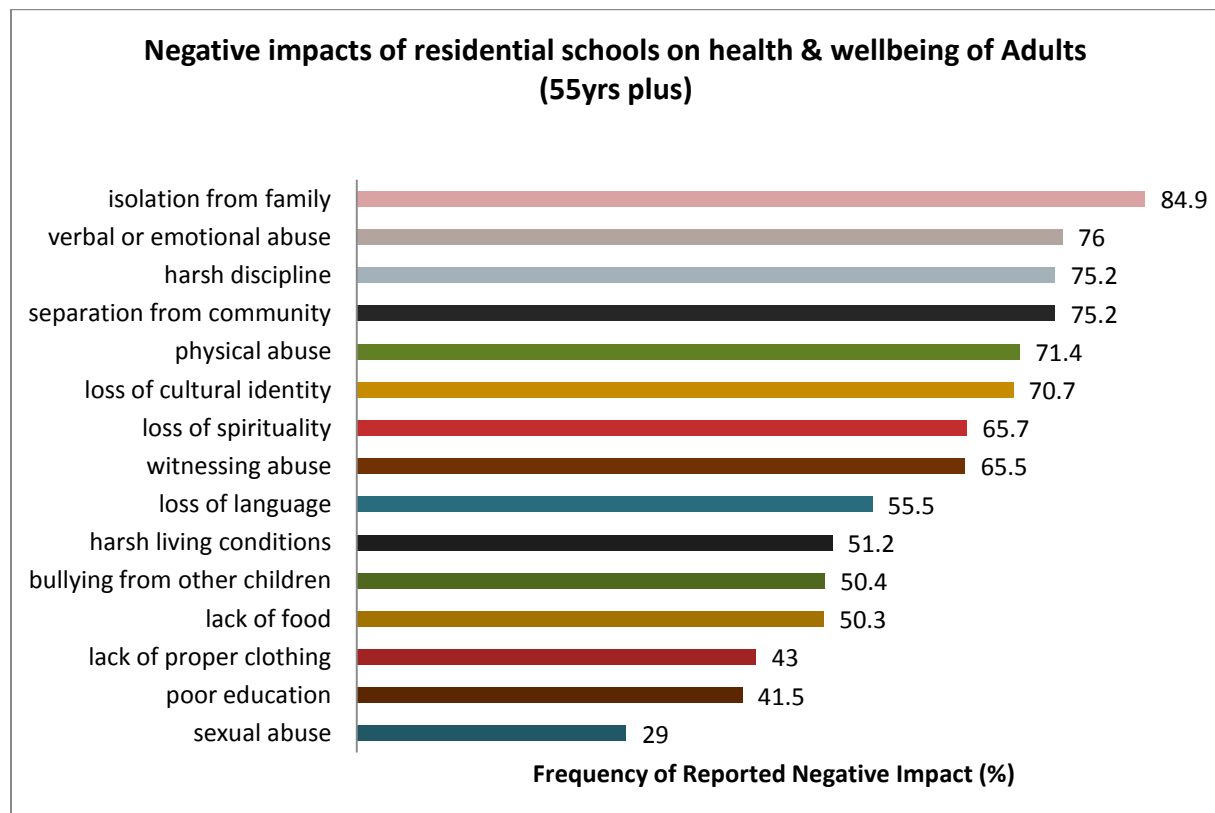


Figure 16 Negative impacts of residential schools (ages 55+ years)



## Water

Water is life. Without water, people cannot survive more than a day or two. It affects health in so many ways, from the ability to wash clothes to the potential transmission of illness. First Nations in Manitoba face significant challenges to water supply and safety, particularly in remote communities.

When asked what the main water supply was for their household:

- 57.3% had water “Piped in”
- 25.4% had water “Trucked in”
- 11.6% received water through a “Well”
- 3.1% “collected it themselves from water plant”
- 1.5% received water from “Other (River, Lake, Pond, bottled water, water plant)”
- 1% received water “From neighbour’s house”



“Elder Sam Harper retrieves water from Island Lake for his family- ” (Joe Bryksa / Winnipeg Free Press)

***“I get my water from a store about an hour out of my community and have to travel every other week to get water.”***

***(MFN RHS 2008-2010 Adult Respondent)***

***“Water delivery [is] not meeting [our] needs”***

***(MFN RHS 2008-2010 Adult Respondent)***

**[ 34.5% of adults feel their water supply is unsafe. ]**

## Food and Nutrition

### Young Adults (18-34yrs)

- 85.5% said they sometimes or often have someone who shares traditional food with their household
- 21.9% said in the past year they or other adults living in their home cut the size of their meals or skipped meals because there wasn't enough money for food, 28.9% of adults said this occurred almost every month
- 5.6% said in the past year they didn't eat because there wasn't enough money for food

### Adults (35-54yrs)

- 85.9% said they sometimes or often have someone who shares traditional food with their household
- 20.8% said in the past year they or other adults living in their home cut the size of their meals or skipped meals because there wasn't enough money for food, 25.2% of adults said this occurred almost every month
- 14% said in the past year they didn't eat because there wasn't enough money for food

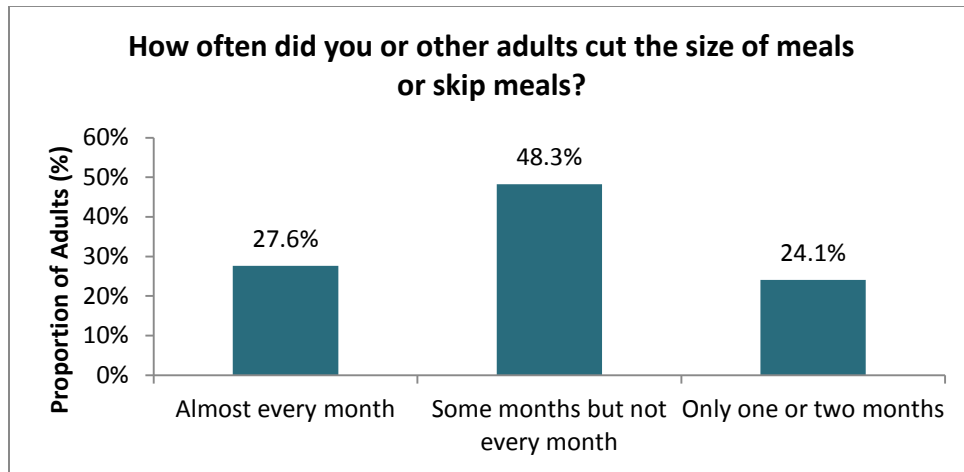


Moose meat hanging to dry.

### Seniors (55 plus)

- 87.2% said they sometimes or often have someone who shares traditional food with their household
- 12.3% said in the past year they or other adults living in their home cut the size of their meals or skipped meals because there wasn't enough money for food, 33.4% said this occurred almost every month
- 7% said in the past year they didn't eat because there wasn't enough money for food

Figure 17 Cut size or skipped meals



Northern Store in Nelson House First Nation.

Figure 18 Couldn't afford to feed children a balanced meal

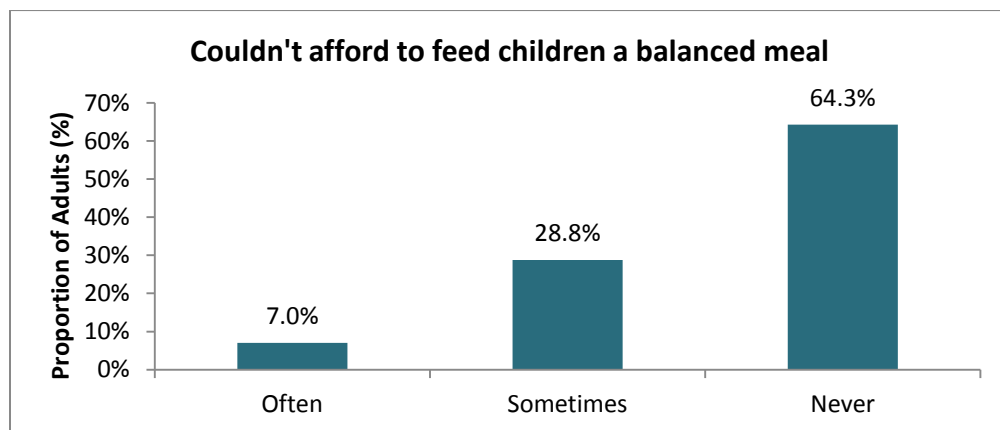
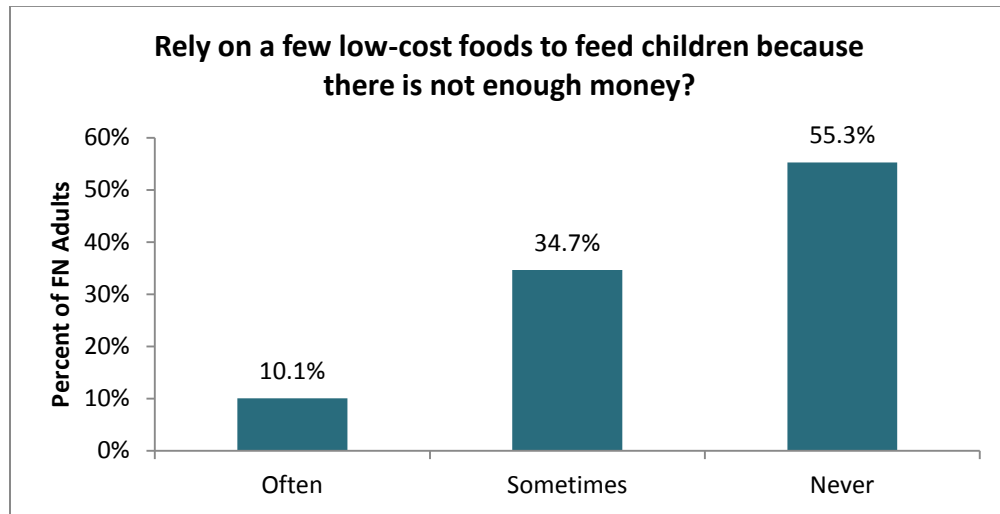




Figure 19 Rely on low-cost foods to feed children



*“As an ADI worker in my community we have a huge obstacle and that is the high costs associated with shipping vegetables, fruits and milk products.”*

*-Respondent*

*“I am a Trapper and I go trapping in the spring it's nice out there and it would be educational to have high school students come out there to learn about the outdoors and how to set snares, traps and skin the animals I have done this all my life and I never went to school but I always have food.”*

*-Respondent*



## Alcohol Consumption

The majority (67.4%) of adults have had at least one alcoholic drink (beer, wine, liquor) in the last 12 months. Over a third (33.6%) of adults does not drink alcohol at all. Amongst those who consume alcohol, 2% drink daily and 73% have 5 or more drinks in one occasion at least once a month.

Figure 20 Frequency of alcohol consumption

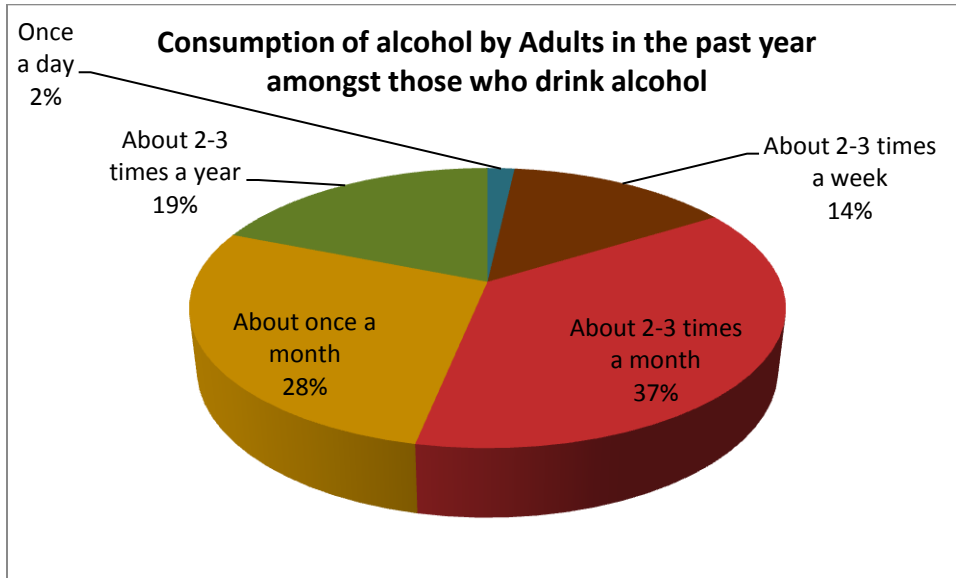


Figure 21 Frequency of alcohol consumption by age-group

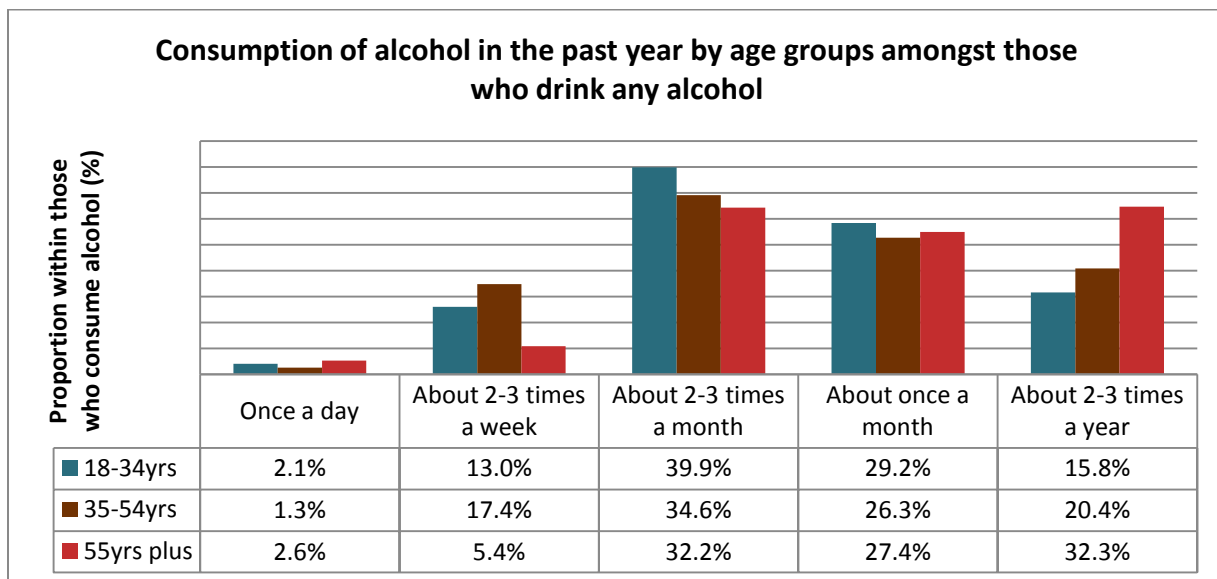


Figure 22 Consumption of 5 or more alcoholic beverages by adults in past year (amongst those who consumed any alcohol)

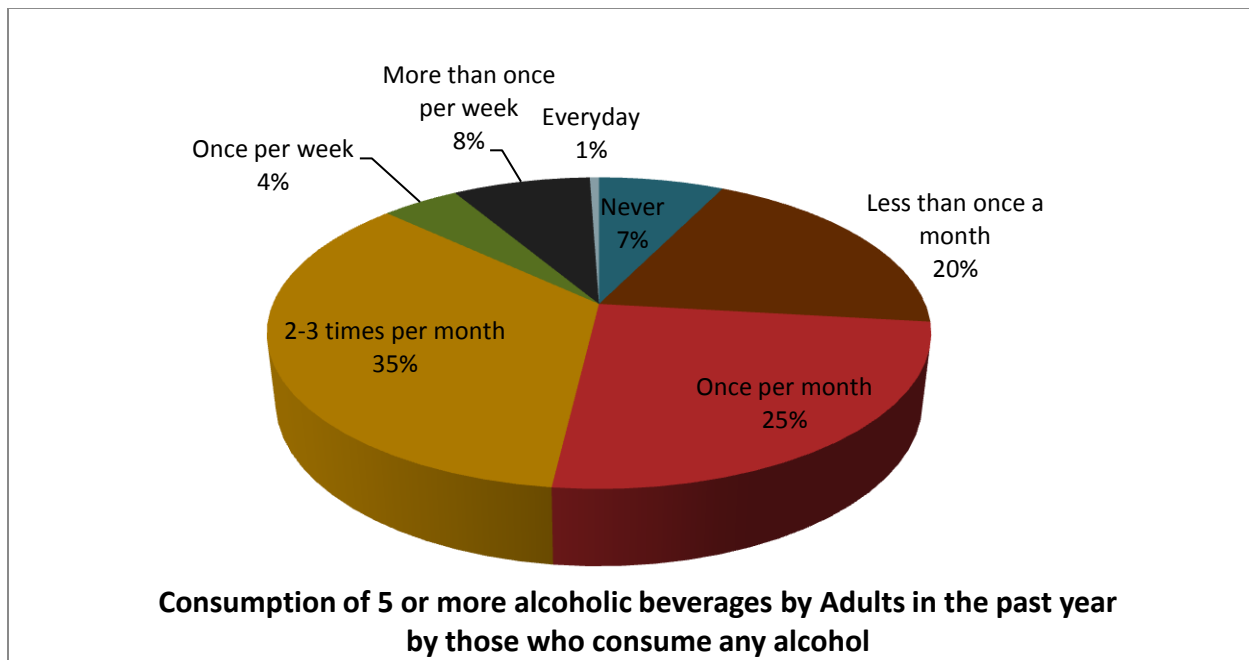


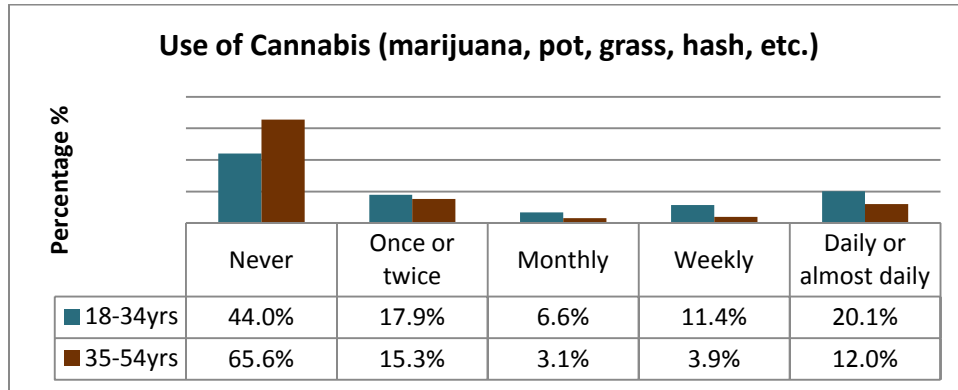
Figure 23 Consumption of 5 or more alcoholic drinks in past year by age group (amongst those who drink alcohol at all)



## Drug Use

Cannabis is the most frequently used non-prescription drug amongst First Nations, as well as the general population of Canada.

Figure 24 Use of cannabis by adults



***“We need a drug & alcohol treatment center here, so we don't have to leave the community and our children”***

***(MFN RHS 2008-2010 Adult Respondent***

### Young Adults (18-34yrs)

- 15.3% have sought treatment for substance abuse/addiction

### Adults (35-54yrs)

- 21% have sought treatment for substance abuse/addiction

### Seniors (55yrs plus)

- 95% have never used cannabis (marijuana, pot, grass, hash, etc)
- 10.4% have sought treatment for substance abuse/addiction

## Gambling

### Young Adults (18-34yrs)

- 73.2% of adults have gambled at least once in their lives;
- 40.6% have borrowed money to gamble;
- 27.4% have bet more money than they could afford to lose;
- 12.2% said their gambling has caused financial problems for their family.

*Adults (35-54yrs)*

- 75% of adults have gambled at least once in their lives;
- 40.2% have borrowed money to gamble;
- 34.1% have bet more money than they could afford to lose;
- 21.6% said their gambling has caused financial problems for their family.

*Seniors (55yrs plus)*

- 68% have gambled at least once in their lives;
- 29.4% have borrowed money to gamble;
- 26% have bet more money than they could afford to lose;
- 16% said their gambling has caused financial problems for their family.

**Smoking***Young Adults (18-34yrs)*

- 71.4% live in a smoke free home
- 49.9% smoke cigarettes daily
- 33.8% of adults have tried to quit smoking once or twice in the past year

*Adults (35-54yrs)*

- 53.4% live in a smoke free home
- 52.2% smoke cigarettes daily
- 17.3% of adults have tried to quit smoking once or twice in the past year

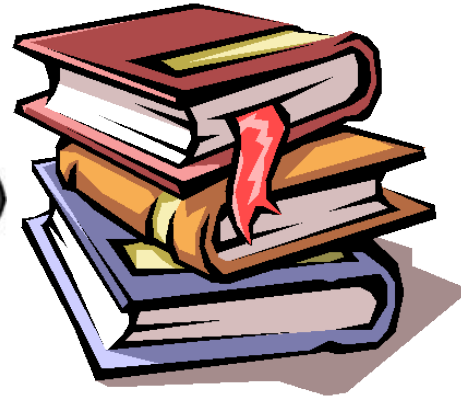
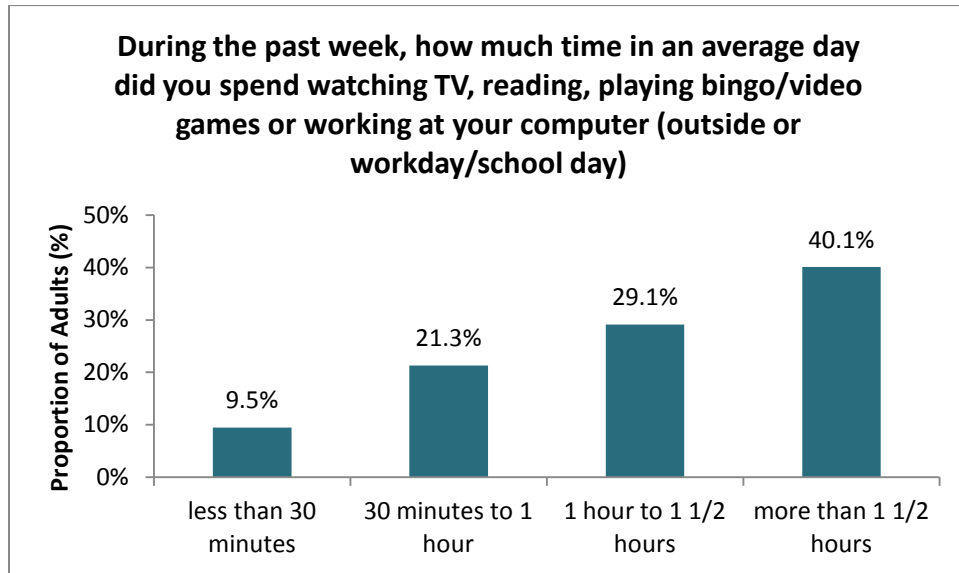
*Seniors (55yrs plus)*

- 35.9% live in a smoke free home
- 30.4% smoke cigarettes daily
- 14.5% of seniors have tried to quit smoking 5 or more times in the past year



## Physical Activity

Figure 25 Time spent in average day in sedentary activity



## Migration

56.9% of adults have lived outside of their community at some point in their lives, the main reason for leaving was education.

Figure 26 Reasons adults moved away from their community

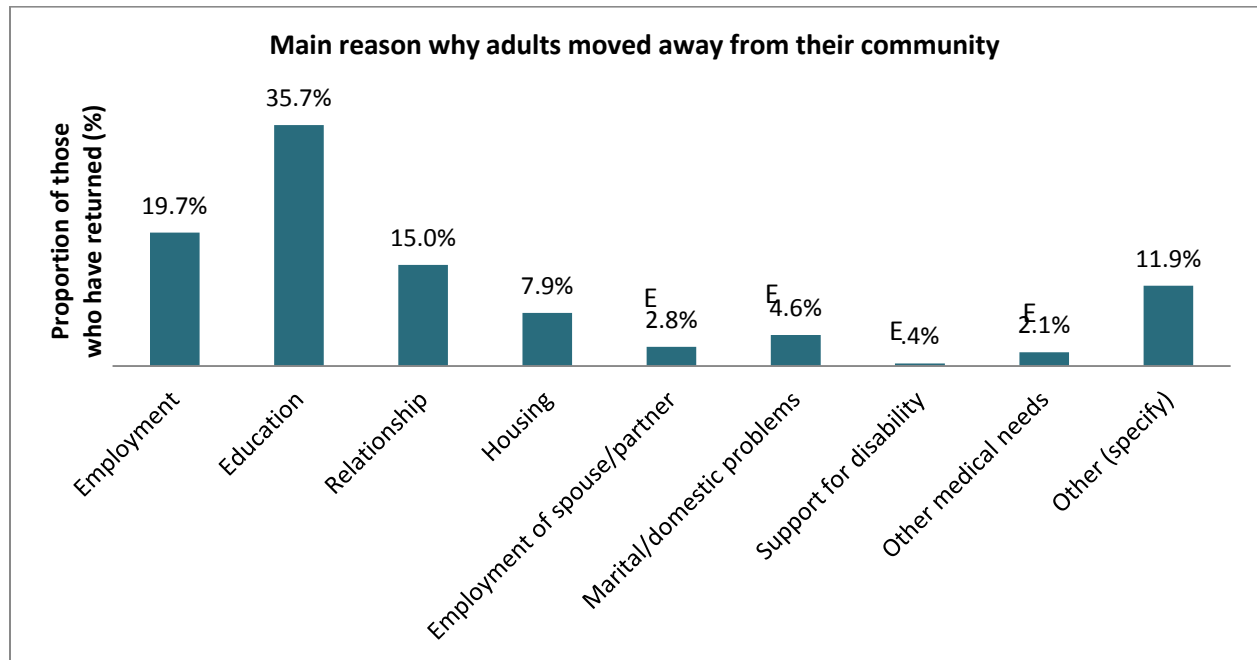
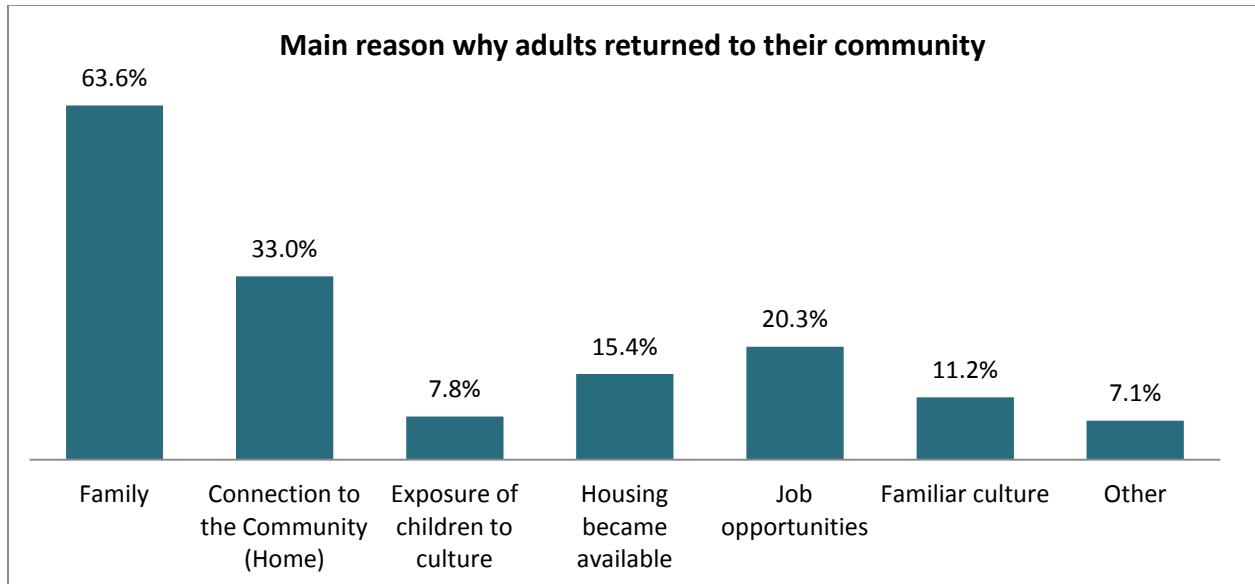


Figure 27 Reasons adults return to their community



Isaiah and his grandmother.

### Community Health

Alcohol and drugs are the most commonly reported community challenges for all adult age-groups, followed by housing and employment. Family values are the most commonly reported community strength by all adult age-groups followed by Elders and use of First Nations language.

Figure 28 Community challenges

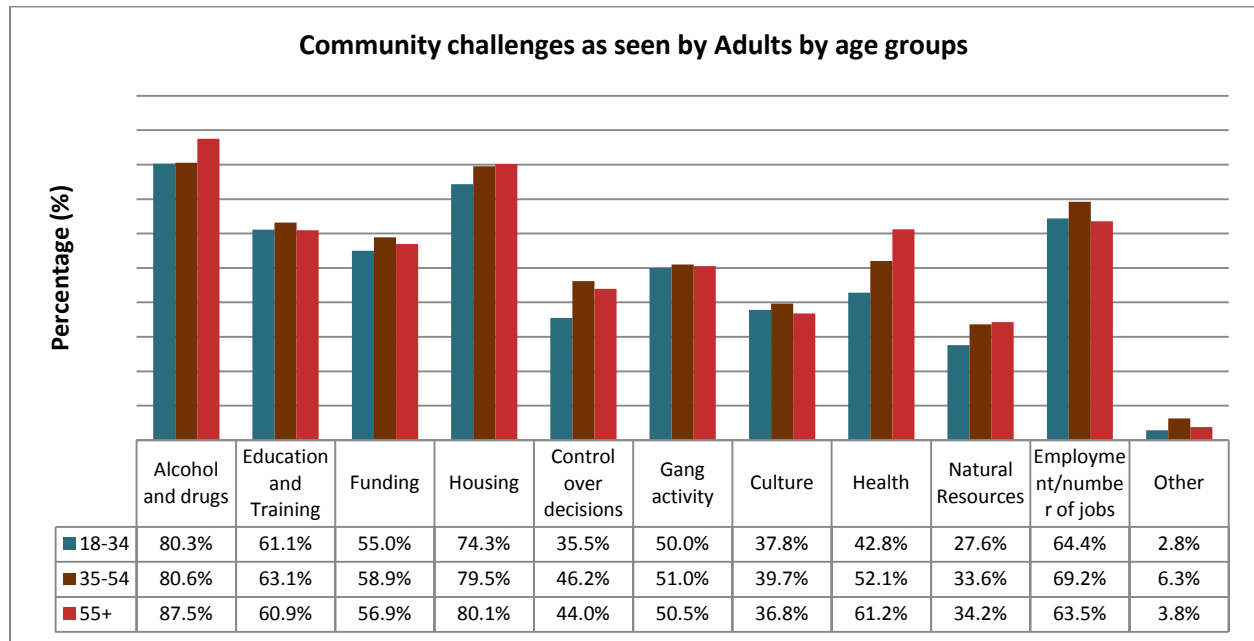
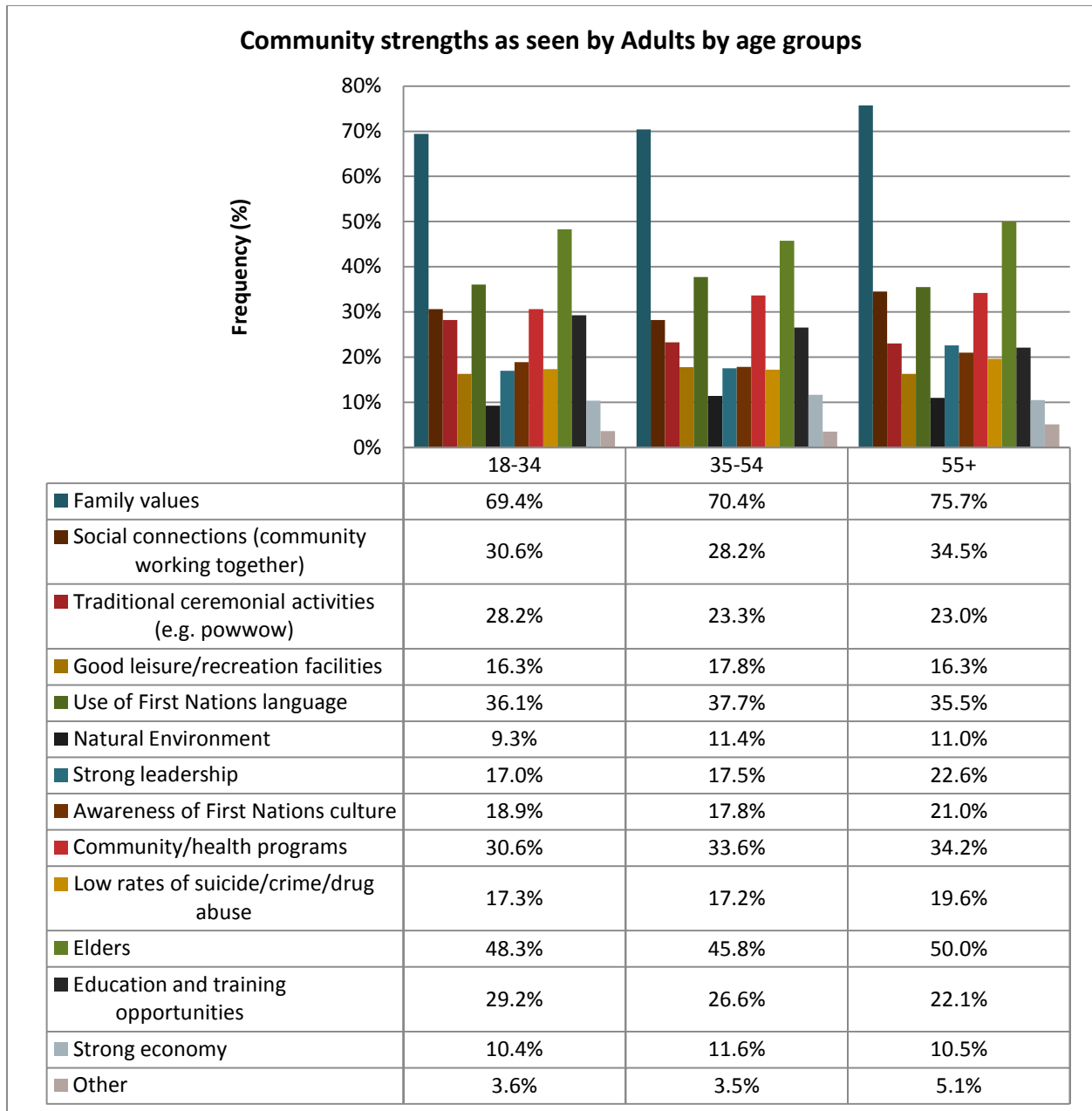




Figure 29 Community strengths



## Health Status

This section presents selected population health status indicators: self-rated health, chronic conditions, disabilities, injury, mental health, and sexual health.

### Self-Rated Health

There is a trend in self-rated (general) health with age: as age increases, self-rated health tends to decrease. The following chart displays the percentage of adults with excellent, very good, good, fair, and poor levels of self-rated health within each age-group.

Figure 30 Self-rated health by age-group

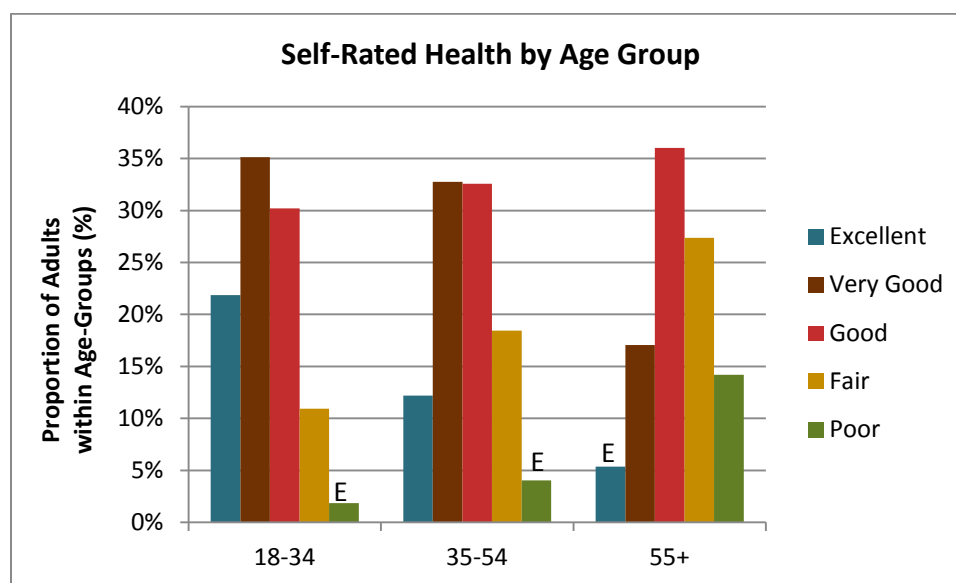
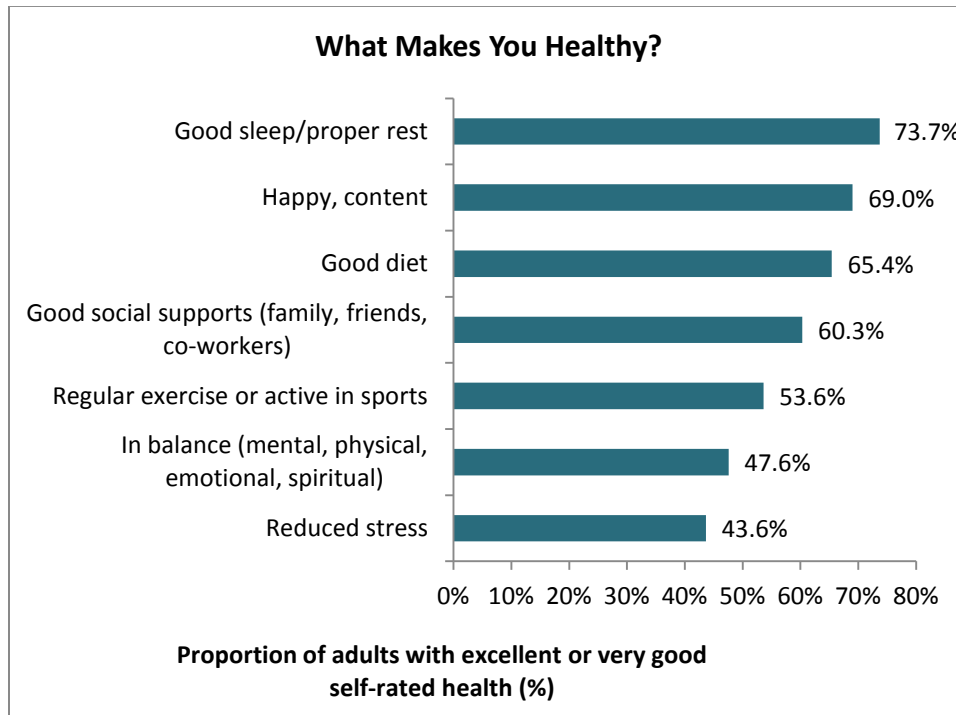


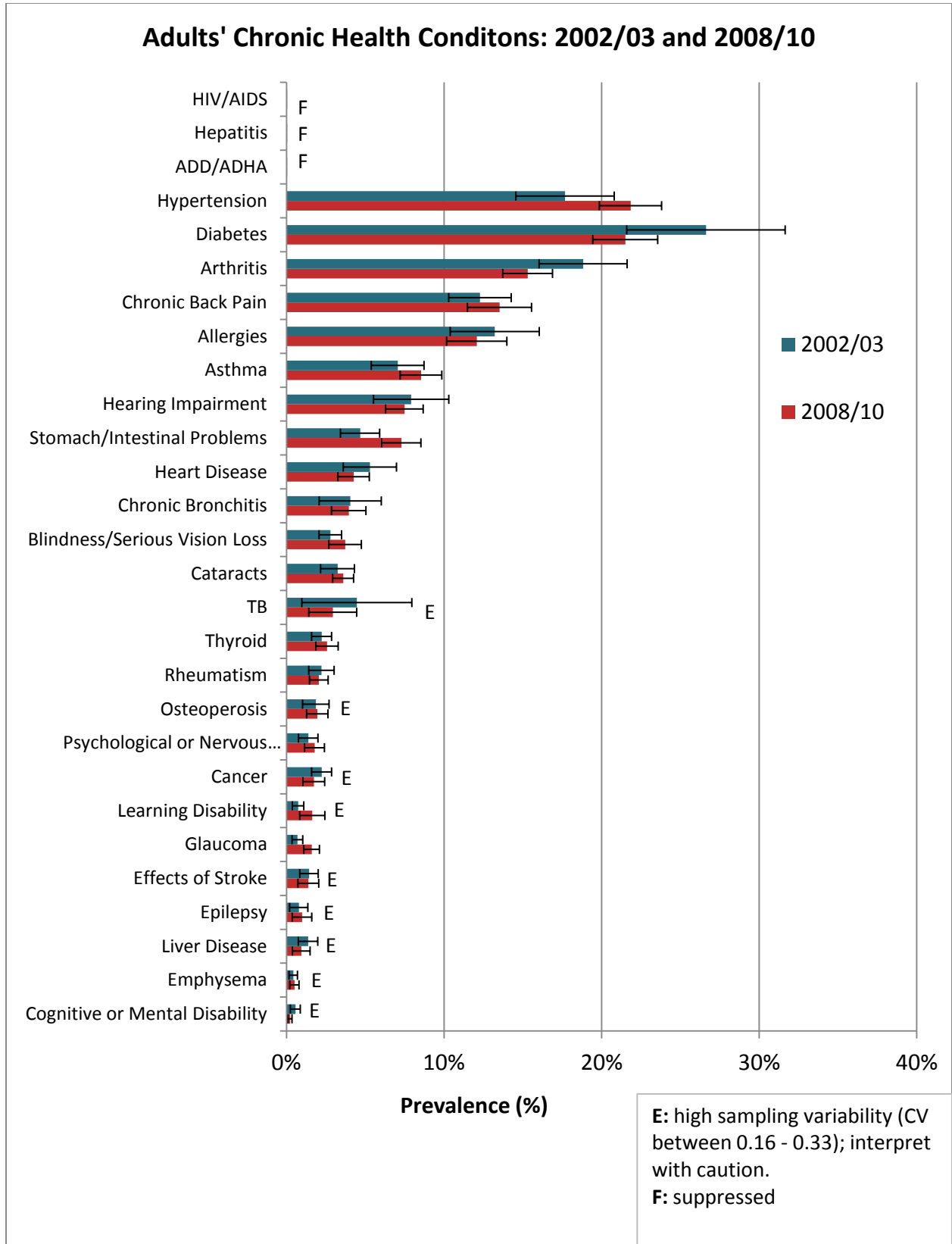
Figure 31 What makes you healthy?



### *Chronic Health Conditions*

Hypertension and diabetes remain the two most prevalent diseases amongst Manitoba First Nation adults. The prevalence of chronic conditions, generally, did not change significantly, except for glaucoma and stomach/intestinal problems, which both increased significantly between 2002/03 and 2008/10. Rates of human immunodeficiency virus / autoimmune deficiency syndrome (HIV/AIDS), Attention deficit disorder / attention deficit hyperactive disorder (ADD/ADHD), and hepatitis had either too few cases or too high sampling variability to be reported and were suppressed.

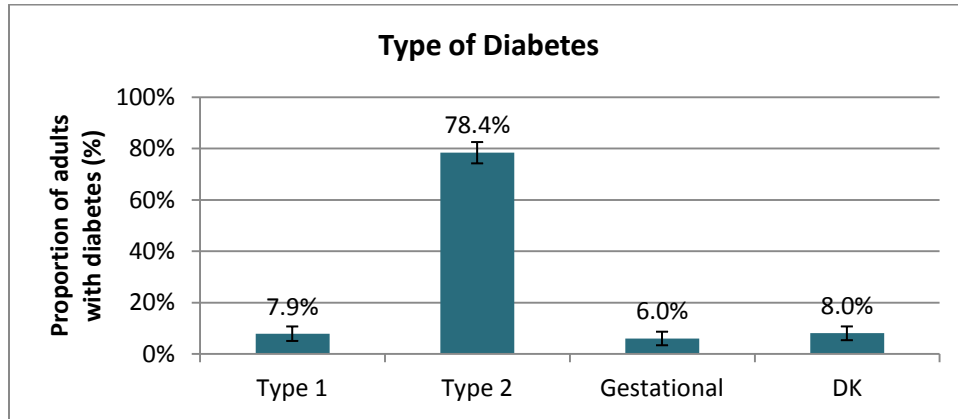
Figure 32 Chronic health conditions – Adults: 2002/03 and 2008/10



## Diabetes

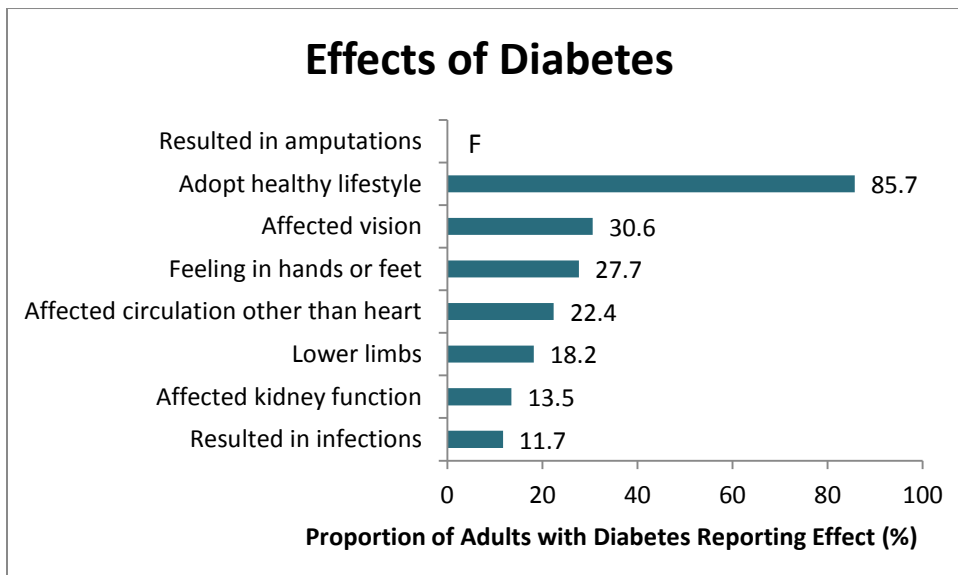
The vast majority of adults with diabetes have been diagnosed with type 2, which is the most common type in the general population.<sup>5</sup>

Figure 33 Type of diabetes



The effects of diabetes are varied, with over 85% of adults with diabetes reporting adopting a healthy lifestyle after being diagnosed. Many people have complications from diabetes, including vision problems, infections, loss of feeling in hands or feet, changes in blood circulation, lower limb amputations, and reduced kidney function.

Figure 34 Effects of diabetes



<sup>5</sup> Public Health Agency of Canada (2011). *Diabetes in Canada: Facts and Figures from a Public Health Perspective*. Ottawa: Government of Canada. Online: <http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/index-eng.php>

## Injury

### Young Adults (18-34yrs)

26% have been injured in the last year, when asked what type of injury they experienced,

- 43.8% had a major cut, scrape or bruise
- 35.4% had broken or fractured bones
- 29.6% had a major sprain or strain
- 18.1% had an “other” type of injury

Most injuries occurred on the hand (30%), arm (24.3%) or head (24.1%). Thirty two percent (32%) of the injuries occurred at home, 27.9% occurred on the street, highway or sidewalk, 13.2% occurred at a sports field or facilities of a school, and 30% somewhere else (“other”).

### Adults (35-54yrs)

15.3% have been injured in the last year, when asked what type of injury they experienced,

- 35% had a major sprain or strain
- 31.6% had broken or fractured bones
- 24.2% had a major cut, scrape or bruise
- 14.8% had an “other” type of injury

Most injuries occurred on the hand (21.8%), knee (17.5%) and ankle (16.3%). 42.1% of the injuries occurred at home, 21.5% occurred on the street, highway or sidewalk, 12.3% occurred in the countryside, forest, woodlot and 10.4% said “other”.

### Seniors (55yrs plus)

13.3% have been injured in the last year, when asked what type of injury they experienced,

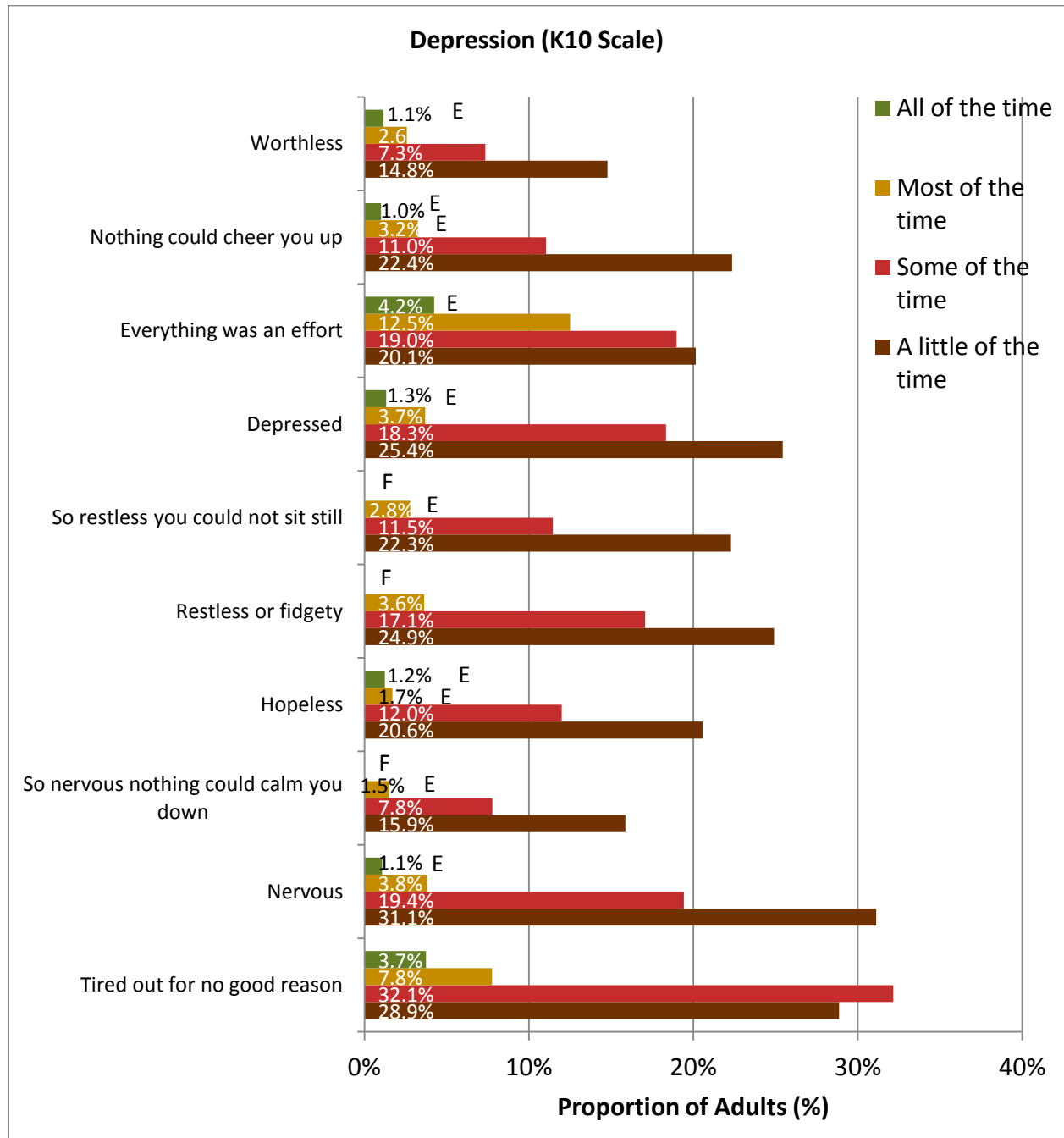
- 35.2% had broken or fractured bones
- 16.7% had a major sprain or strain
- 13% had a major cut, scrape or bruise
- 19.9% had an “other” type of injury

Most injuries occurred on the hand (16.4%), knee (41.9%) and other (20.3%). Fifty nine (59%) of the injuries occurred at home, 18.5% occurred on the street, highway or sidewalk and 16.9% elsewhere (“other”).

## Mental Health

The Kessler Symptom Scale (K10 Scale) is a set of 10 questions designed to assess general mental disorder and is primarily used in population health research rather than treating individuals. The 10 questions can be summarized into a score that provides an overall estimate of a person or population's mental health, which is known as the Kessler Psychological Distress Score (K10 Score).

Figure 35 Kessler Symptom Scale (Depression)



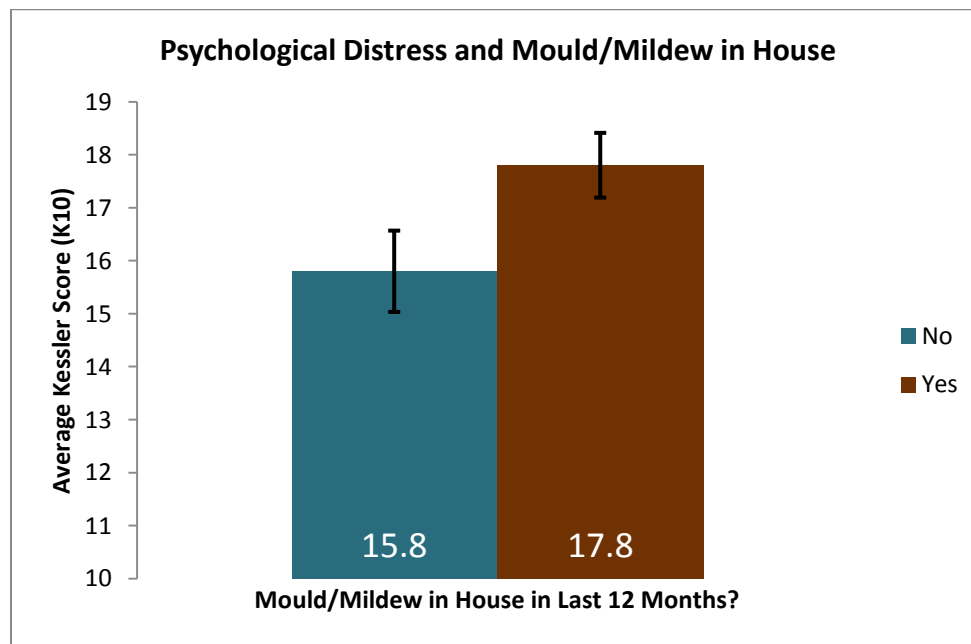
### Kessler Psychological Distress Score (K10 Score)

The Kessler Psychological Distress Score (K10 Score) is a measure of overall mental disorder. A K10 Score below 20 is considered normal, and over 20 is considered mental disorder, and the higher the more severe.

- The average K10 Score for Manitoba First Nations adults living on-reserve is 17 (95%CI: 16.4, 17.6).

Mental Health is associated with housing conditions, including mould/mildew in the house and repair status of the house. When comparing adults who live in mouldy housing to adults who do not, there is a significant difference in the average K-10 score, suggesting that housing conditions affect mental health.

Figure 36 Psychological distress and mould/mildew in house

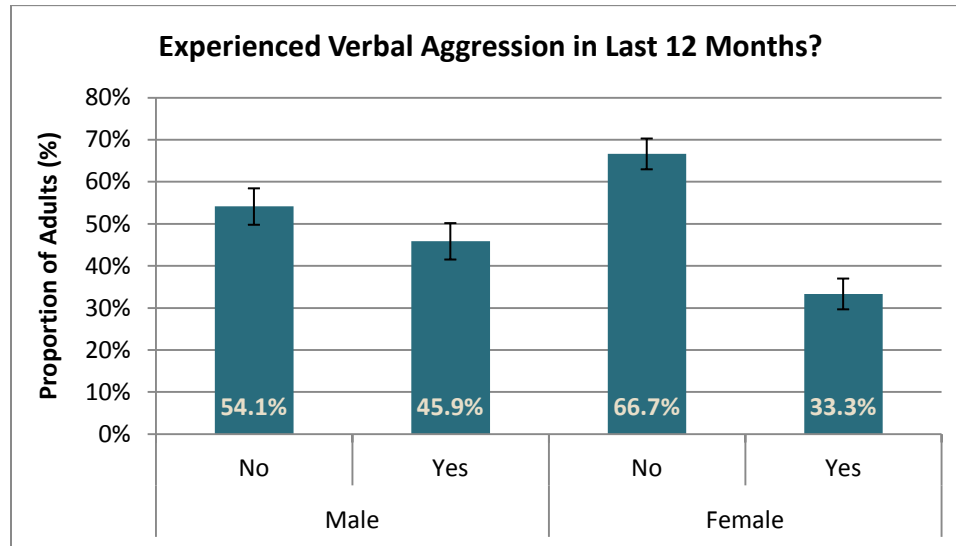




## Aggression

Males are significantly more likely to have experienced verbal aggression in the last year.

Figure 37 Experiencing verbal aggression in past year by sex



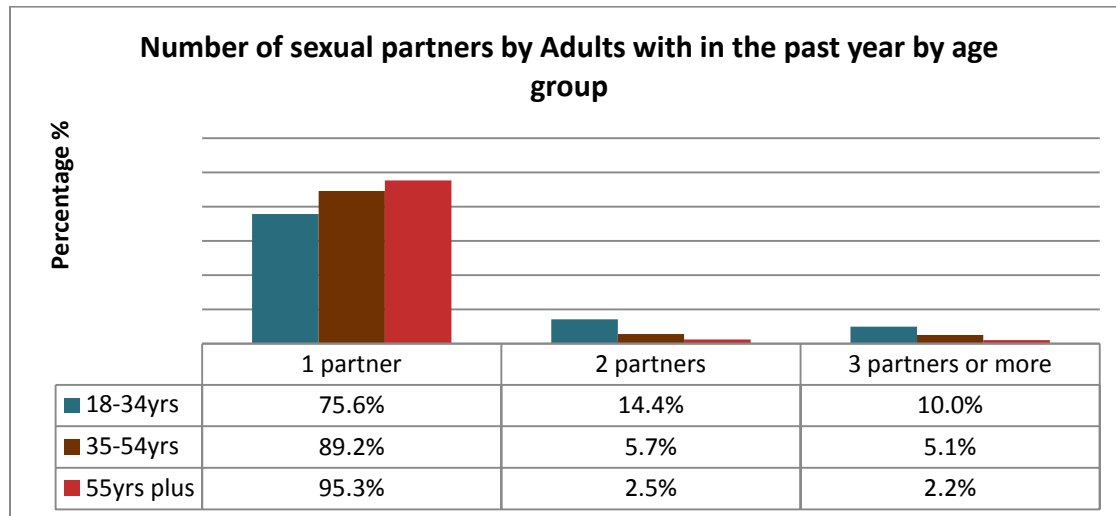
## Suicide

- 80.4% of adults have never thought about committing suicide, but 19.6% have thought about committing suicide and 19.5% thought about it during the past year.
- Within those adults who thought about committing suicide, 43.1% thought about as an adult (over the age of 18yrs old), 52.3% as an adolescent (12-17yrs of age) and 3.9% thought about it as a child (under the age of 12yrs of age).
- 86.8% of adults have never attempted suicide, but 13.2% have attempted suicide and 11.5% attempted suicide within the past year.
- Within those adults who attempted committing suicide, 48.5% attempted suicide as an adult (over the age of 18yrs old), 47.6% as an adolescent (12-17yrs of age) and 2.6% thought about it as a child (under 12yrs of age).

## Sexual Health

Young adults have more sexual partners than older adults; although older adults are less likely to use any form of protection (i.e., safe sex) or to be tested for STIs/STDs.

Figure 38 Number of sexual partners in last year by age-group



### Young Adults (18-34yrs)

Within the 85.6% that are sexually active,

- 97.5% of sexually active adults have had sex in the past year
- 21.2% do not use any birth control or protection methods
- 38.6% have never been tested for an STD or STI and 51.5% have never been tested for HIV/AIDS



### Adults (35-54yrs)

Within the 78.2% that are sexually active,

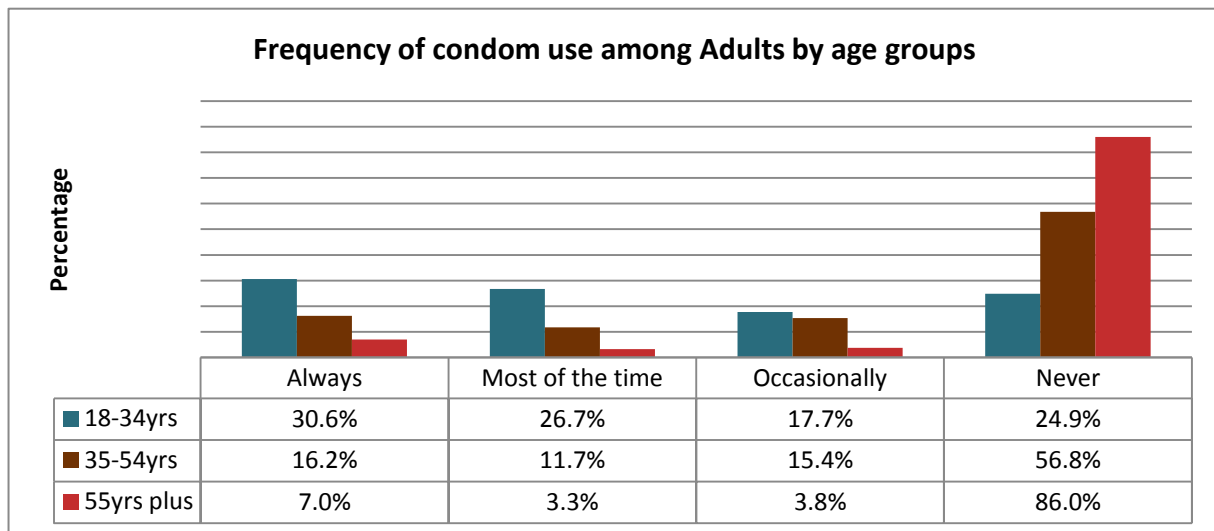
- 96.1% of sexually active adults have had sex in the past year
- 46.4% do not use any birth control or protection methods
- 55.9% have never been tested for an STD or STI and 69.8% have never been tested for HIV/AIDS

### Seniors (55yrs plus)

Within the 31.4% that are sexually active,

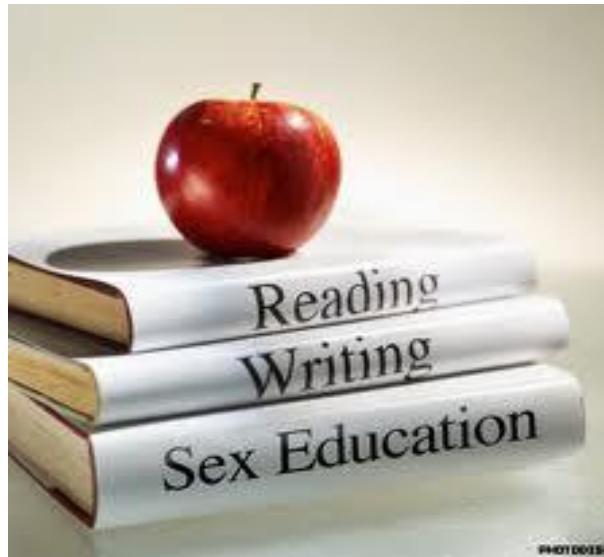
- 97.6% of sexually active adults have had sex in the past year
- 72.9% do not use any birth control or protection methods
- 80.6% have never been tested for an STD or STI and 88.8% have never been tested for HIV/AIDS

Figure 39 Condom use amongst adults



The main reason adults did not use condoms was that they were having sex with their steady partner (58.5%).





*“Sex education for Adults [is needed]. How many times a week is considered normal sexual relations? Men and women are in jail because of sexual deviance. They move south or urban cities where sexual autonomy is acceptable. There is lack of cultural teachings about sex to both the men and women. More education into the schools is needed and to openly talk about sex....”*

*(MFN RHS 2008-2010 Adult Respondent)*

## Health Services

This section presents results related to health services, including treatment of conditions, gaps in services, access to health services, diabetes treatment, dental care, mental health, and traditional medicine.

### Treatment

Many adults are not receiving treatment for chronic conditions.

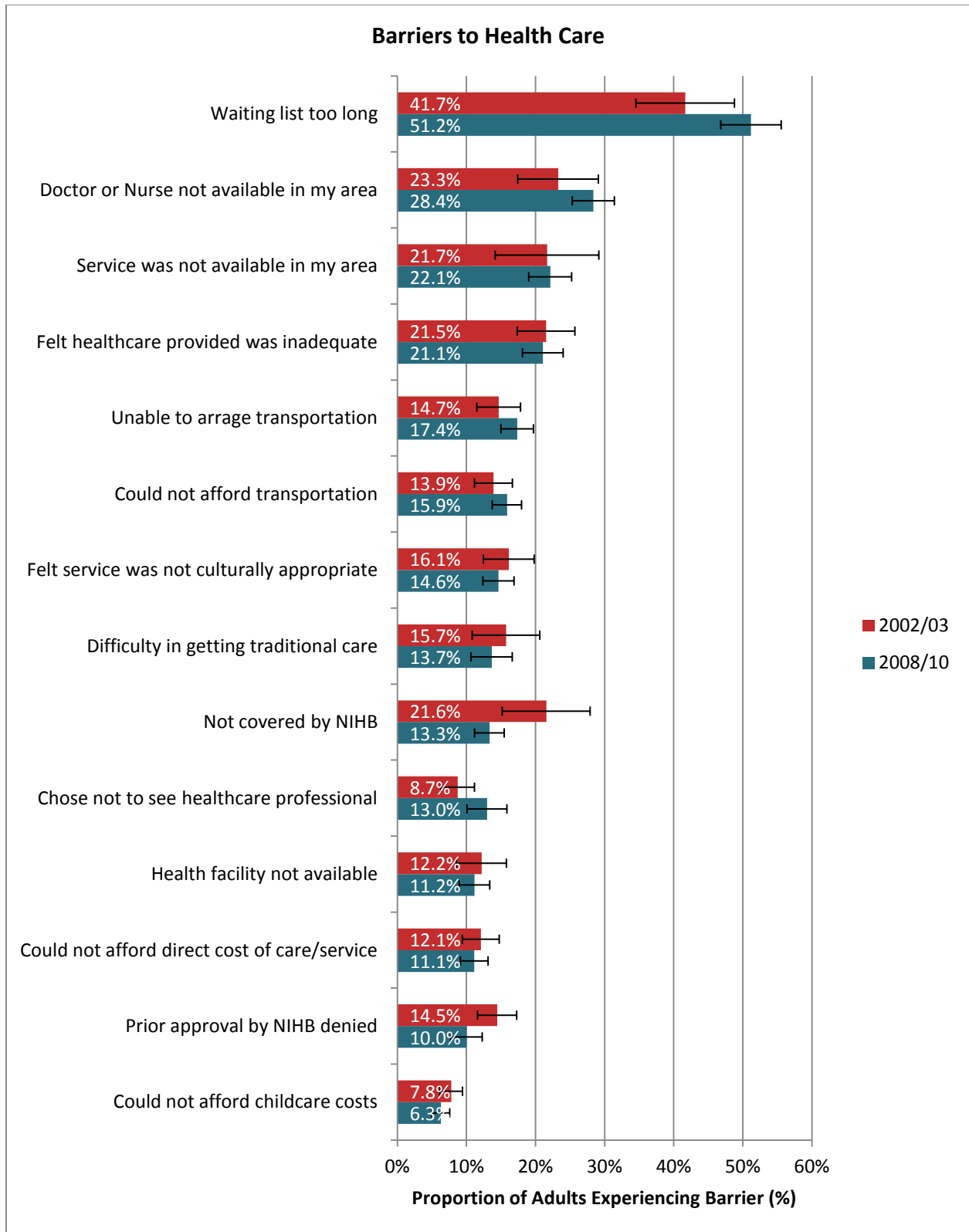
- Within the 21.8% of adults who have been diagnosed with high blood pressure, 75.3% are undergoing treatment.
- Within the 21.5% of adults who have been diagnosed with diabetes, 87.5% are undergoing treatment
- Within the 15.3% of adults who have been diagnosed with arthritis, 51.6% are undergoing treatment
- Within the 13.5% of adults who have been diagnosed with chronic back pain, 41% are undergoing treatment
- Within the 12% of adults who have been diagnosed with allergies, 36.5% are undergoing treatment
- Within the 8.4% of adults who have been diagnosed with asthma, 77.6% are undergoing treatment

### Access

Overall, 55.8% of Adults said they have less access to health services compared to the general Canadian population. The top three barriers to accessing health care among adults were:

- 51.3% said wait list is too long;
- 28.4% said Doctor or Nurse is not available in their area;
- 21.1% said the health care provided is inadequate

Figure 40 Barriers to Accessing Health Care: 2008/10 and 2002/03

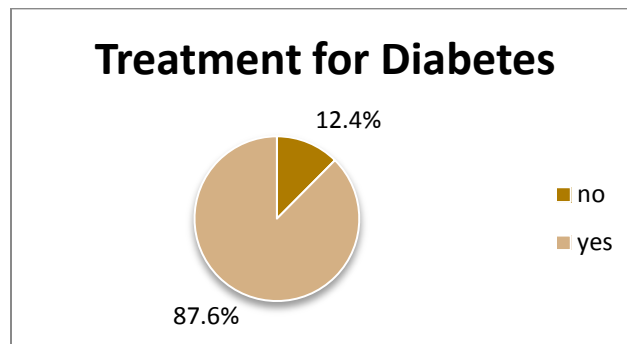


Some barriers appear to have changed between 2002/03 and 2008/10, with a higher proportion reporting long waiting lists as a key barrier, while fewer cited coverage by the Non-Insured Health Benefits (NIHB) program as a barrier; although no changes were statistically significant.

### Diabetes

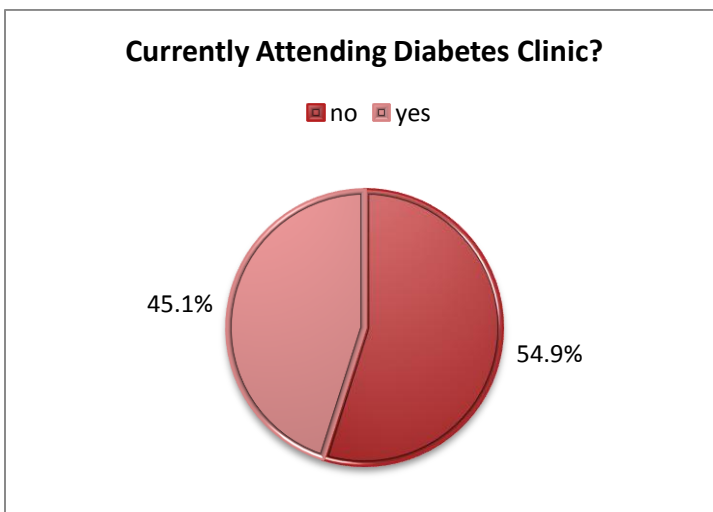
- 12.4% of adults with diabetes are not undergoing treatment.

Figure 41 Treatment fo Diabetes



The majority of adults with diabetes do not attend diabetes clinics, with the main reason being that they “have enough information already” (59.8%), followed by “chose not to attend” (31.6%).

Figure 42 Currently attending a diabetes clinic



*“I work during the day when the clinics are here and I cannot afford to miss a day of work.”*

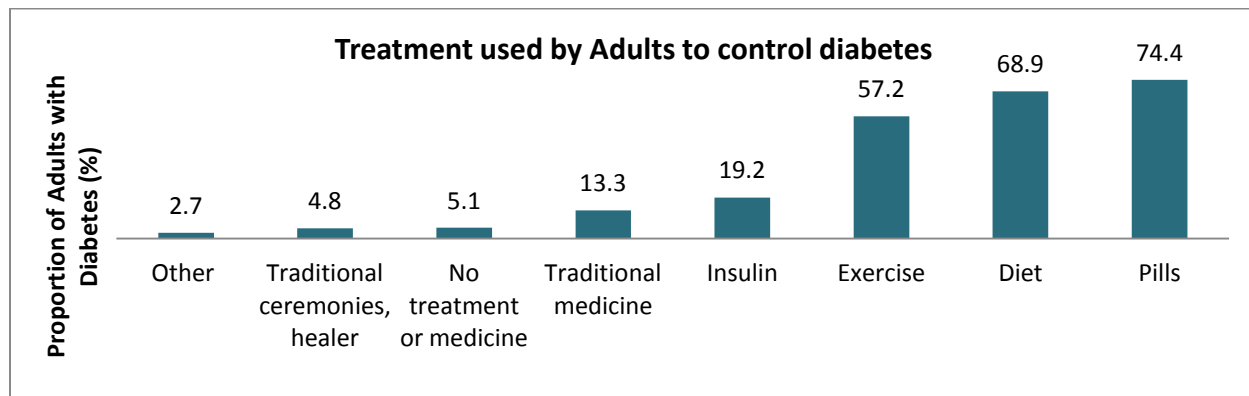
*-Respondent*

*“don’t want to bother anybody..”*

*-Respondent*

The primary forms of diabetes treatment used by adults are pills, diet, and exercise, followed by insulin and traditional medicine.

Figure 43 Treatment Types for Diabetes



*Dental Care*

Frequency of dental care follows a trend with age: Seniors are significantly less likely to have received dental care than young adults less than six months ago and between six months to a year ago (from time of survey). Seniors (55+) are also more likely to have last had dental care more than five years ago than both middle aged (34-54 years) and young adults (18-34 years).

Figure 44 Last time received dental care - adults

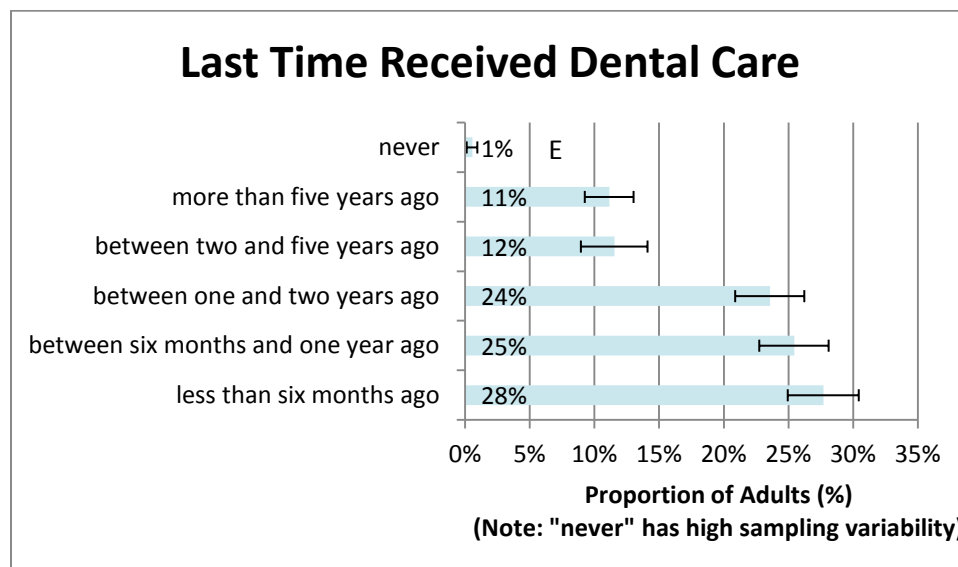
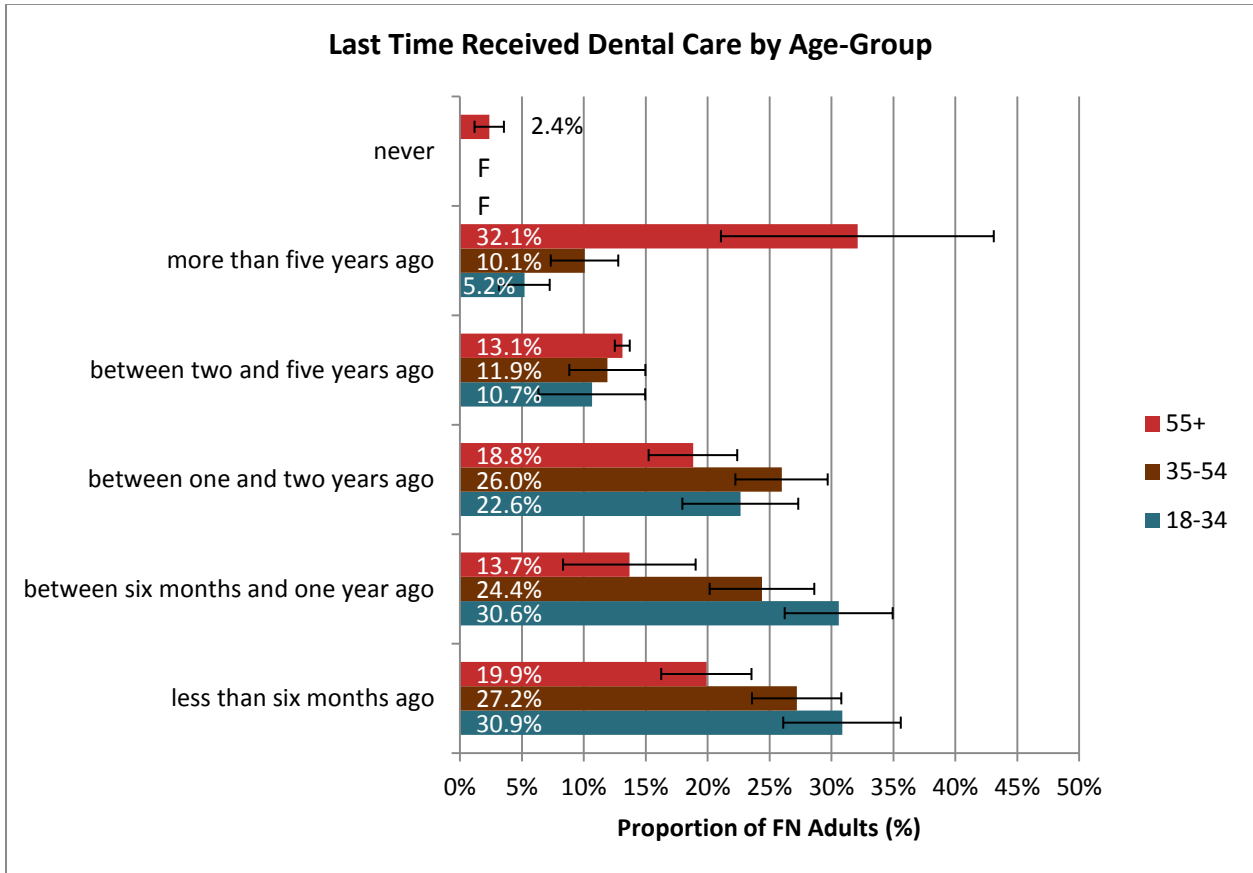


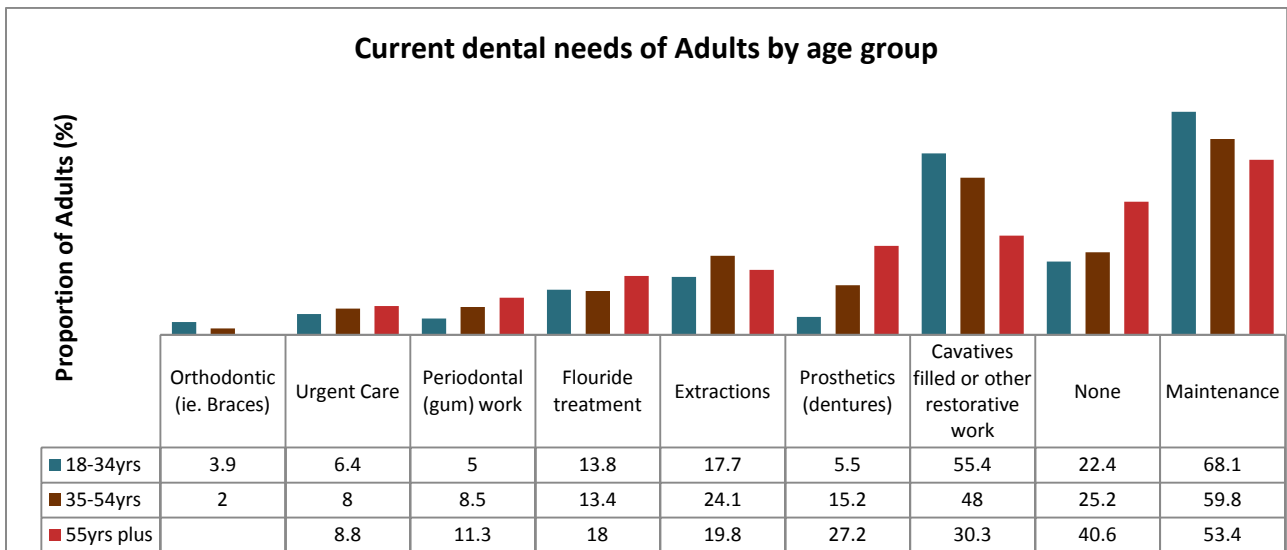


Figure 45 Last time received dental care by adult age-groups



Not surprisingly, seniors are more likely to require dental prosthetics (dentures) than either middle-aged or young adults. Almost a quarter of adults 18-34 years old require extractions.

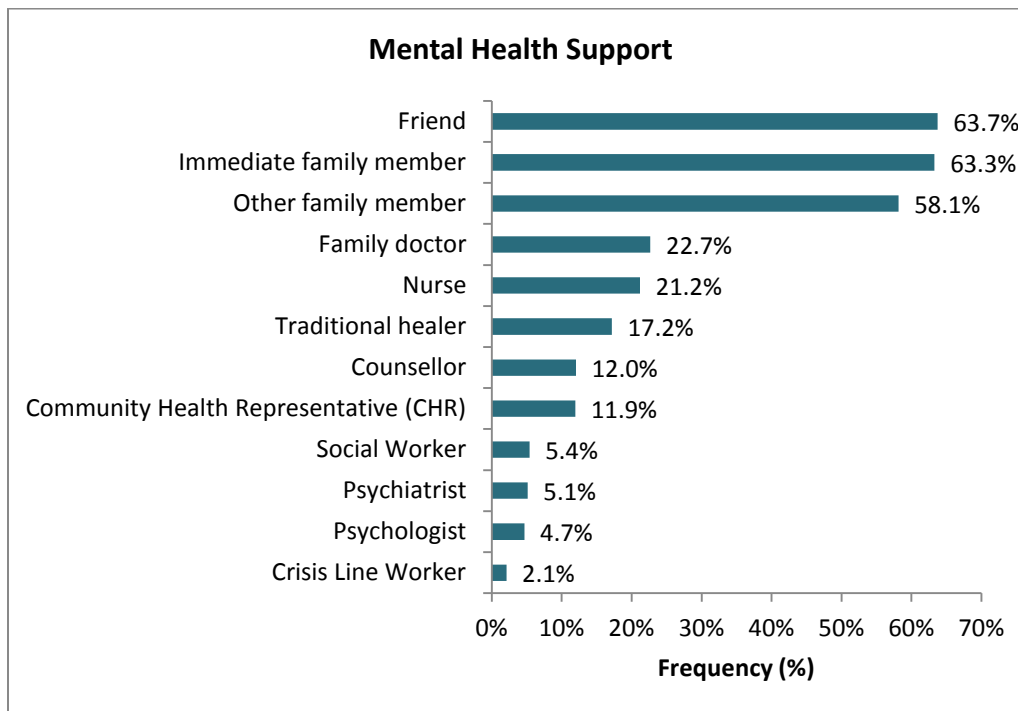
Figure 46 Current dental care needs of adults by age-group



### Mental Health

Family and friends are the most commonly reported people that adults receive mental health support from.

Figure 47 Mental health support - adults



### Traditional Medicine

Traditional medicine is more than simply health services, incorporating physical, mental, spiritual, and emotional health. For those who want to use traditional medicine, the vast majority report no difficulties in accessing it, although barriers still exist and those reporting any barrier will usually face multiple barriers. For example, not having a healer available through health centre and not being able to arrange transportation.

Figure 48 Use of traditional medicine - adults

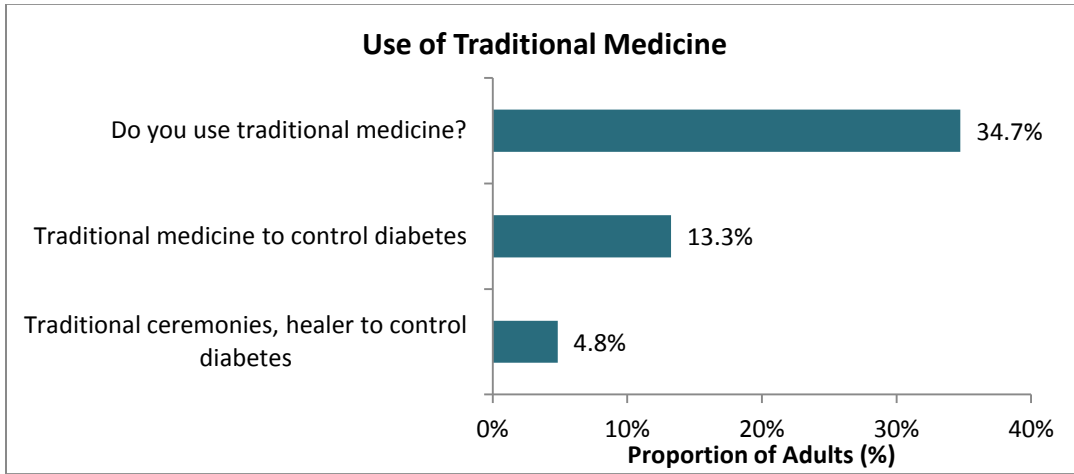
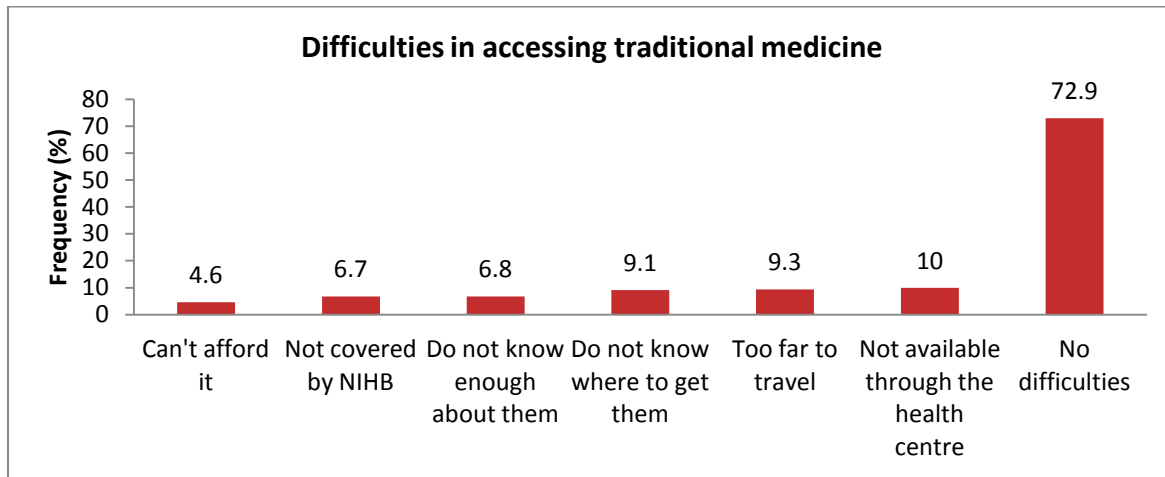


Figure 49 Difficulties in accessing traditional medicine



## CHAPTER 2 – YOUTH

This chapter is based on responses of the 757 youth (ages 12-17 years) to the youth-specific RHS questionnaire. Approximately half of respondents were male (47%) and half were female (53%).



Sagkeeng's Finest, winners of the first season of Canada's Got Talent: (L-R) Brandon Courchene Dallas Courchene and Vince O'Laney, perform on the Manitoba Legislative grounds (Sarah Swenson / Winnipeg Free Press)

## Determinants of Health

Determinants of health examined for this report include household structure, parental education, youths' education, language and culture, physical activity, smoking, alcohol consumption, and sexual health practices.

### Household Structure

When asked about the current relationship between their birth parents:

- 42.6% were living together and married
- 10.9% were living together but not married
- 35.5% not living together/separated
- 2.8% were divorced
- 8.2% one of their parents is deceased

Figure 50 Number of children in household - youth

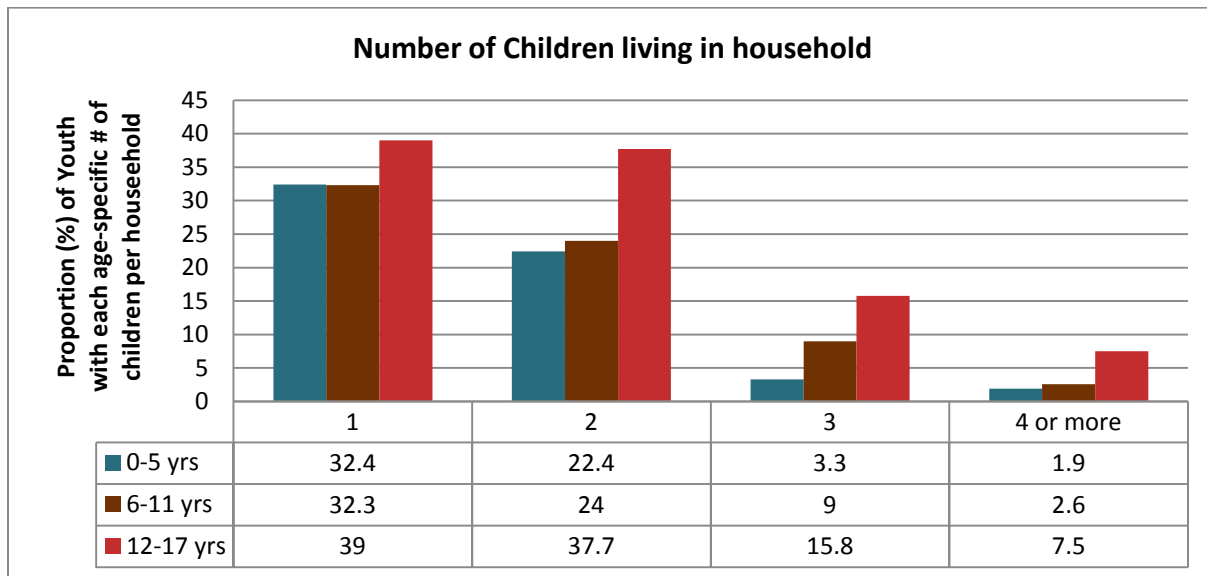
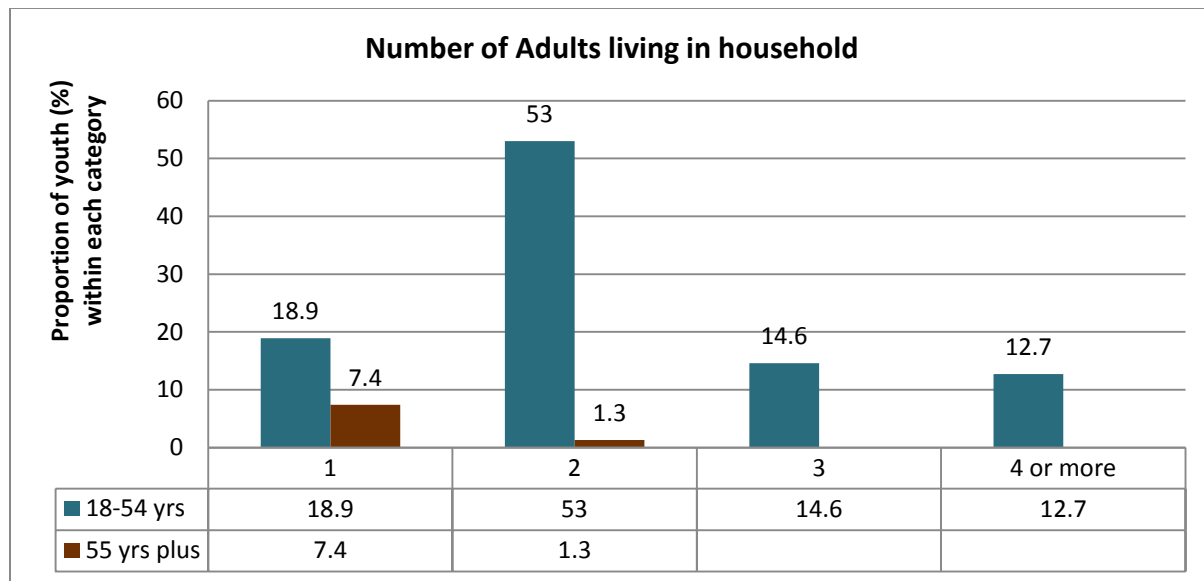


Figure 51 Number of adults living in household - youth



### Parental Education

Youth were asked what the highest level of education their *mother/guardian* has:

- 52.8% had less than a high school diploma
- 22.1% had a high school diploma
- 19.3% had greater than a high school diploma (diploma/certificate from trade or vocational school, community college or university, university degree, Masters or Professional degree)

Youth were asked what the highest level of education their *father/guardian* has:

- 53.8% had less than a high school diploma
- 18.1% had a high school diploma
- 9.1% had greater than a high school diploma (diploma/certificate from trade or vocational school, community college or university, university degree, Masters or Professional degree)

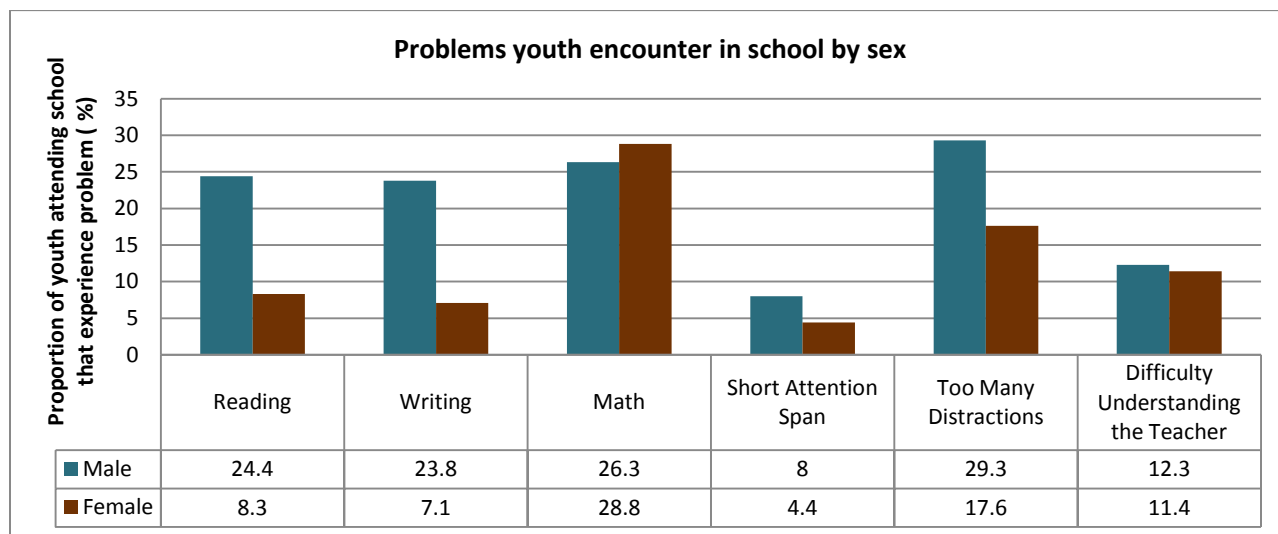
### Youth Education

- 87.5% of youth are currently attending school;
- 35.2% of youth have repeated a grade;
- Males experience more problems in school than females, particularly in reading and writing.

When asked what types of problems youth had in school their top four problems were:

- Math
- Too many distractions
- Reading
- Writing

Figure 52 Problems youth encountered in school by sex



When asked what the highest level of education they would like to complete youth said,

- A high school diploma 31.1%
- University degree 21.7%
- Unsure 15.1%
- A college diploma 12.4%
- Masters, PhD or professional degree 7.9%
- Trade or vocational certificate 3.4%

68.9% of Manitoba First Nations youth want to complete post-secondary education

### Language and Culture

Youth were asked which language they use on a daily basis and how well they understand and speak a First Nations language:

- 97% use English daily;
- One in two (51.8%) Youth understand or speak a First Nations language;
- Almost a third (29.5%) of youth speaks a First Nations language daily.

### Ability to understand of a First Nations Language

Among the Youth who use a First Nations language in their daily life,

- 33.5% could understand a few words of a First Nations language;
- 36.4% had a basic understanding of a First Nations language;
- 21.5% had an intermediate understanding of a First Nations language; and
- 8.7% were fluent in their understanding of a First Nations language.

### Ability to speak a First Nations Language

Among the Youth who use a First Nations language in their daily life,

- 40.4% could speak a few words of a First Nations language,
- 29.4% could speak basic words in a First Nations language,
- 17.5% could speak intermediately in a First Nations language and
- 8.6% were fluent speakers in a First Nations language.



Photo of syllabics chart taken in Cross Lake First Nation, Mikisew School (Leona Star/AMC).



Figure 53 Fluency in First Nations language amongst youth who use on a daily basis

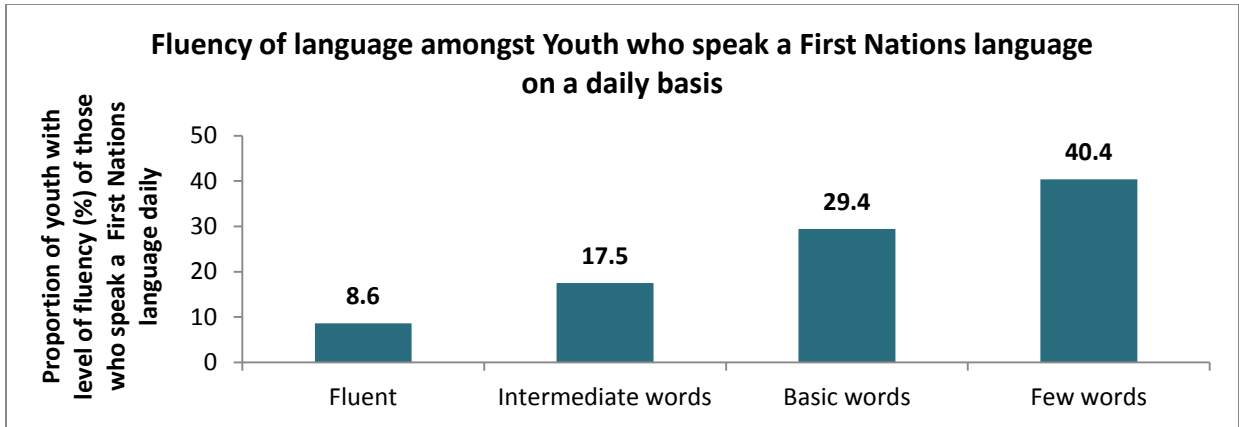
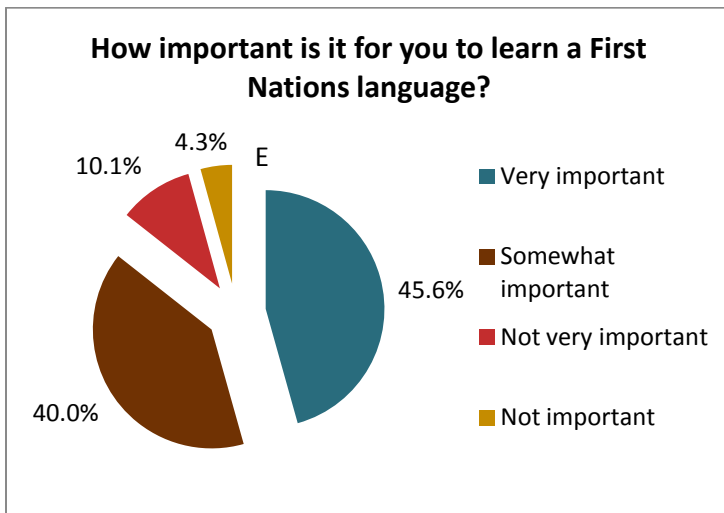


Figure 54 Importance of learning a First Nations language - youth

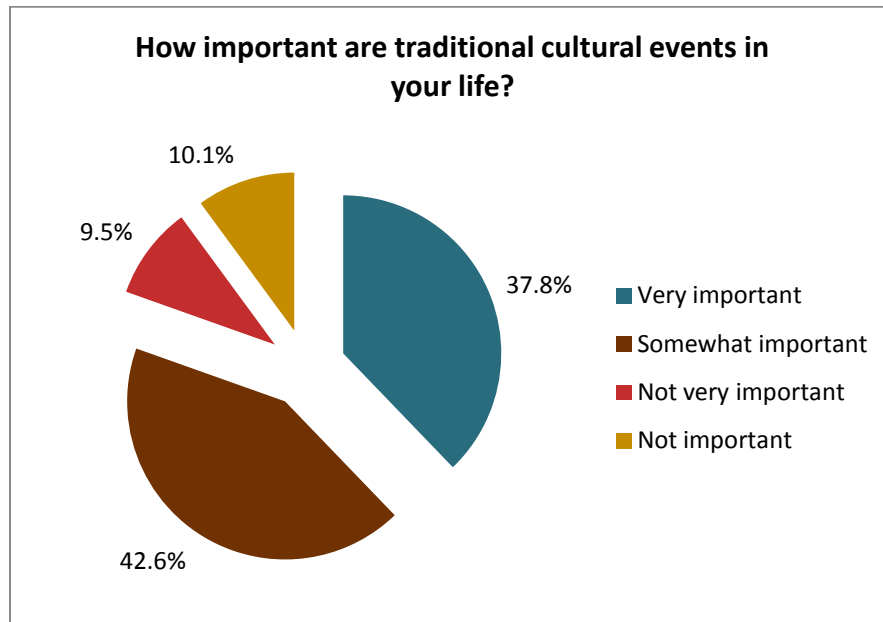


85.6% of First Nations youth feel that learning a First Nations language is either somewhat or very important

### Importance of Culture

When youth were asked how important traditional cultural events are in their life, over 80% said that it is somewhat or very important.

Figure 55 Importance of traditional cultural events - youth

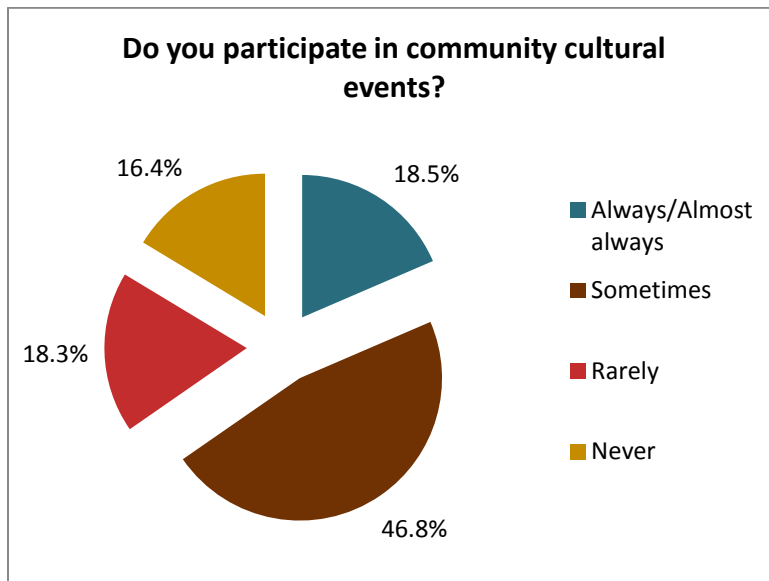


### Participation in Cultural Events

When asked how often they participated in cultural events within their community, 65.3% of First Nations youth stated that they participate sometimes or always.



Figure 56 Participation in community cultural events - youth

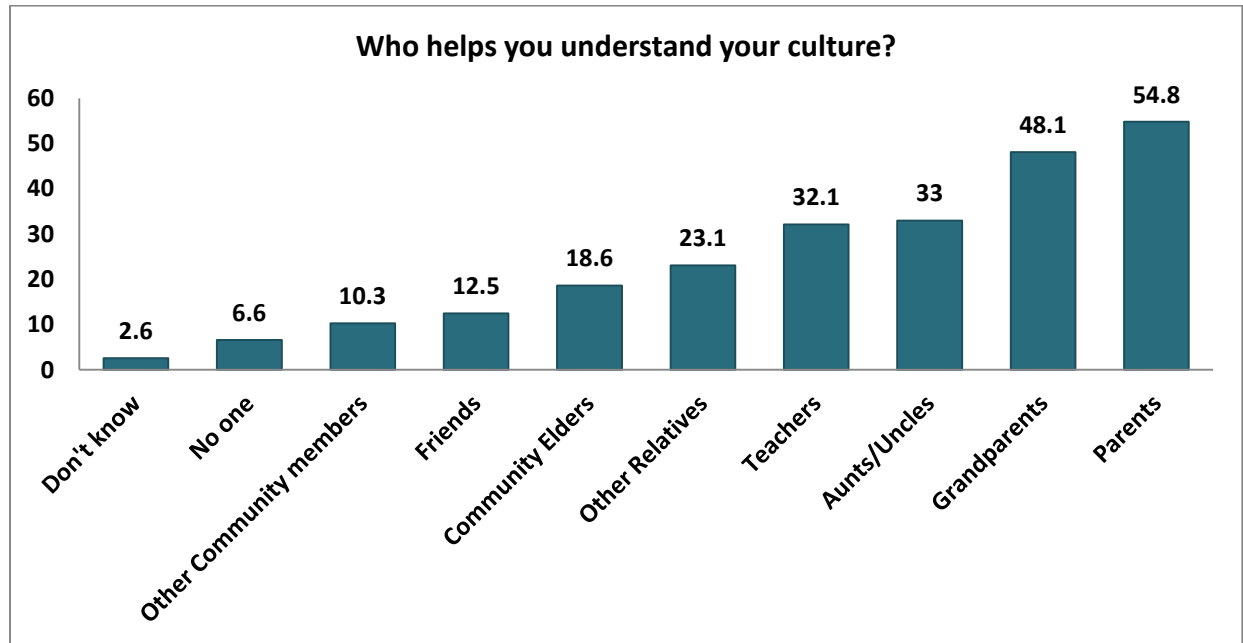


*Fancy shawl dancer, Amberae Wood from the Garden Hill First Nation*

### Learning the Culture

The top three people youth identified as helping them understand their culture were their parents (54.8%), grandparents (48.1%), and aunts/uncles (33%).

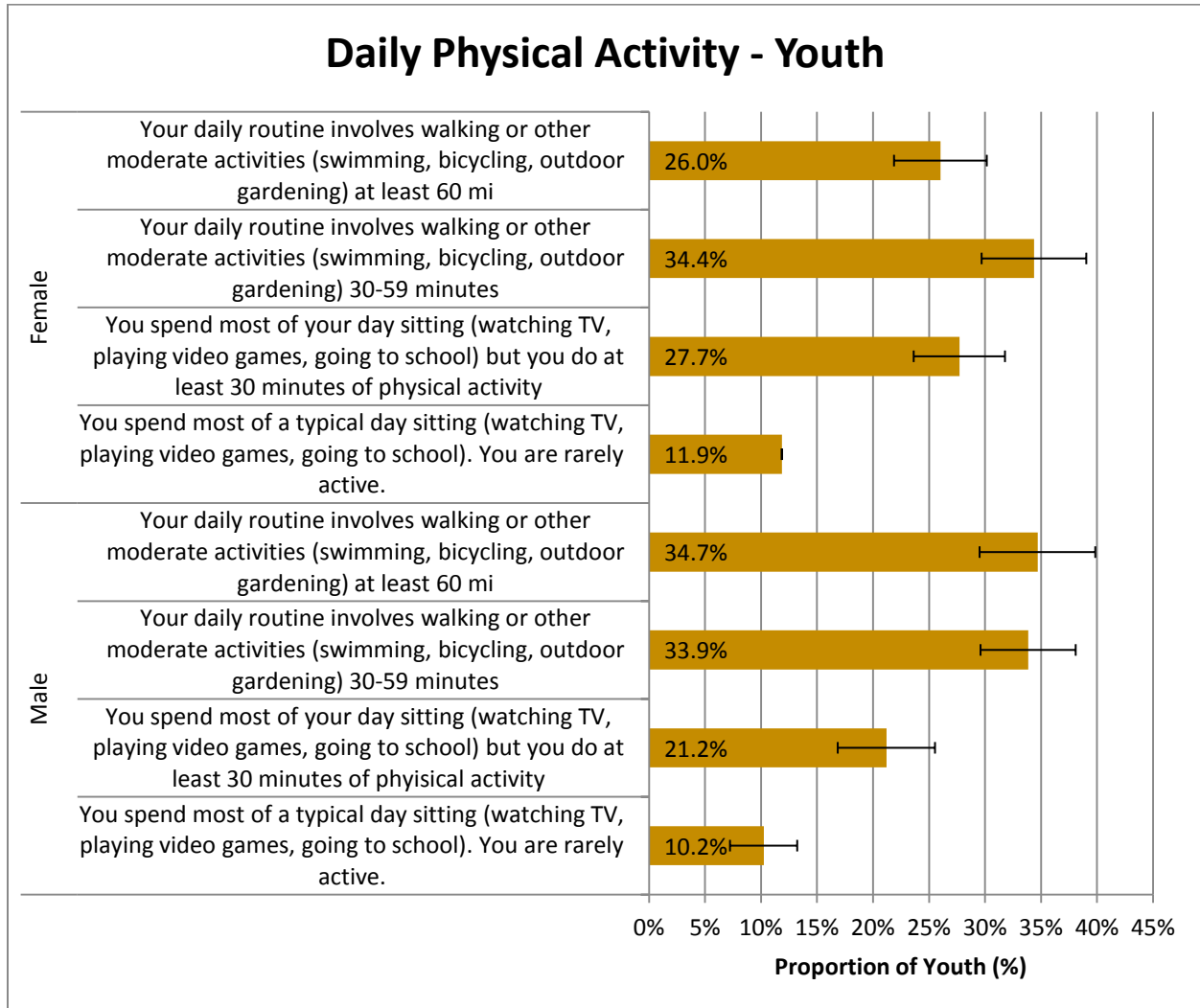
Figure 57 Who helps youth understand their culture



*Physical Activity*

Male and female youth tend to have similar daily physical activity routines, although males have a higher proportion reporting greater than 60 minutes of physical activity than females.

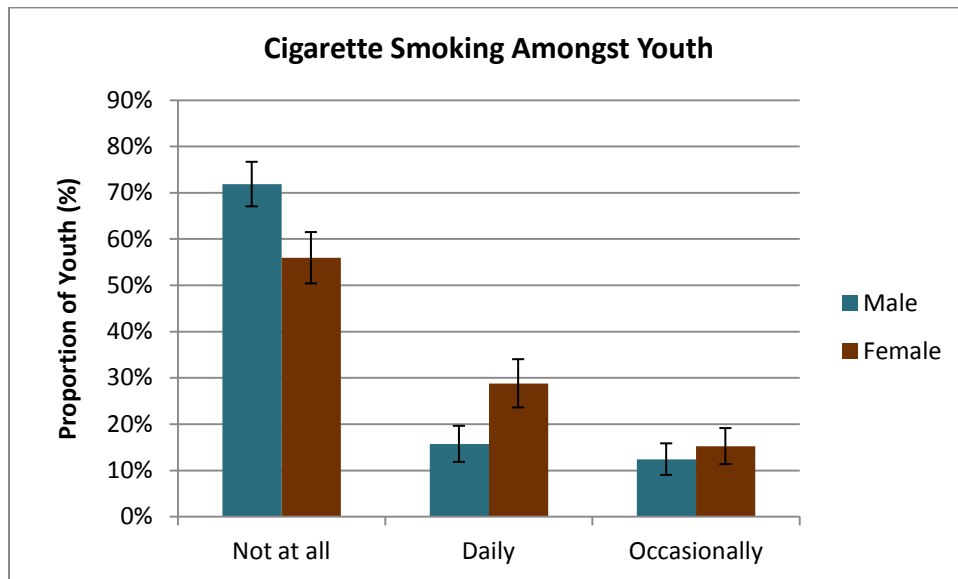
Figure 58 Daily physical activity - youth



### Smoking

Overall, 64.3% of First Nations youth in Manitoba do not smoke cigarettes while 22% smoke daily, and 13.8% smoke occasionally. Smoking is more common amongst female youth than male youth. A significantly higher proportion of males do not smoke [71.9% (95%CI: 66.8%, 68.1%)] compared to females [55.9% (95%CI: 50.3%, 61.4%)], and a significantly lower proportion of males smoke daily [15.7% (95%CI: 12.2%, 20.0%)] compared to females [28.8% (95%CI: 23.9%, 34.3%)]. On average, youth who have quit smoking ( $n = 52$ ) began smoking at 10.5 years of age (95%CI: 9.3, 11.7). The youth who have attempted to quit ( $n = 34$ ) have tried on average 1.3 times in the last year.

Figure 59 Cigarette smoking amongst youth



### Alcohol Consumption

Overall, 27.6% of youth have had at least one alcoholic drink in the past 12 months. Females were significantly more likely to report drinking in the last 12 months than males.

Figure 60 Any alcohol in past year - youth



### Sexual Health

- 29.4% of First Nations youth on-reserve are sexually active
  - Of those who are sexually active, 97% have had sexual intercourse in the last 12 months
  - Of those who are sexually active, 65.1% have had sex with one partner in the last 12 months, while 34.9% have had sex with two or more partners.
  - Condoms are the most widely used method of protection used, with 86.8% of sexually active youth reporting condom use.
  - Of those youth who use condoms, 62.5% use them all the time and 23.2% use them most of the time. The remaining 14.2% use them occasionally or never.
- Of all youth, 9.3% of youth have been tested for a sexually transmitted disease/sexually transmitted infection (STDs/STIs) and 6.4% have been tested for HIV/AIDS.
  - Of youth who are sexually active, 31.5% have been tested for STDs/STIs and 19.9%<sup>6</sup> have been tested for HIV/AIDS.

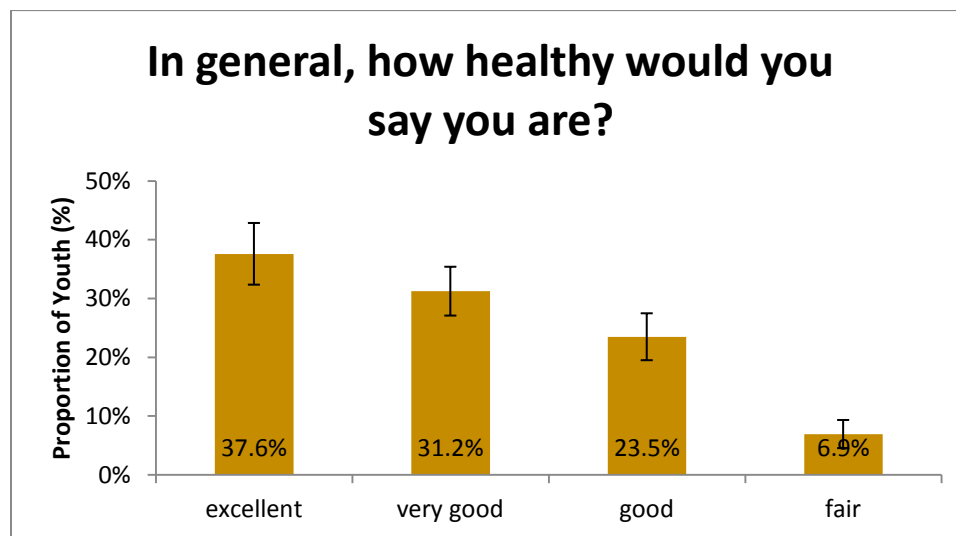
### Health Status

This section covers general (self-rated) health, chronic conditions, injury, and mental health.

### General Health

The majority of youth rate their own health as either excellent or very good. The proportion reporting “poor” health was too unstable to report (CV>0.33).

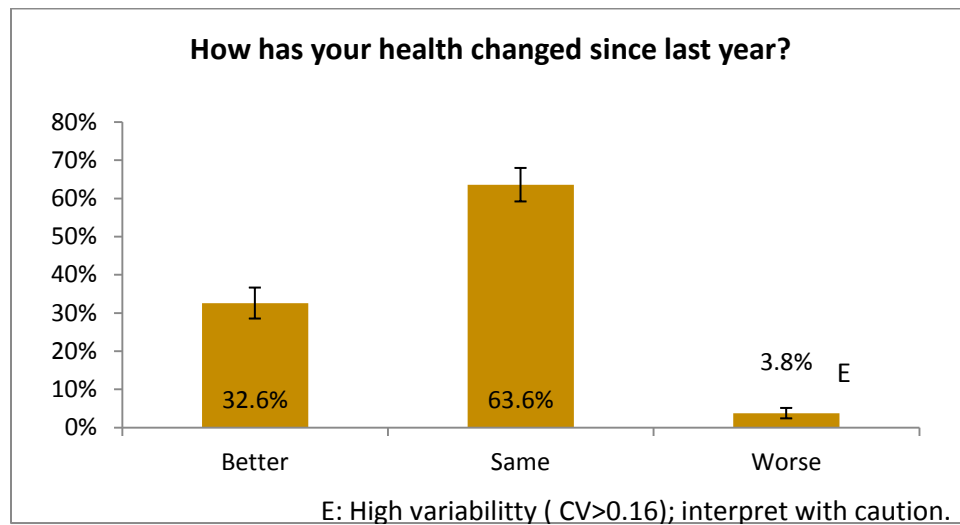
Figure 61 Self-rated health - youth



<sup>6</sup> Note: high sampling variability (CV>0.16); interpret with caution.

Most youth felt their health had stayed the same since the previous year, and a small percentage felt it had become worse.

Figure 62 How has your health changed since last year? Youth



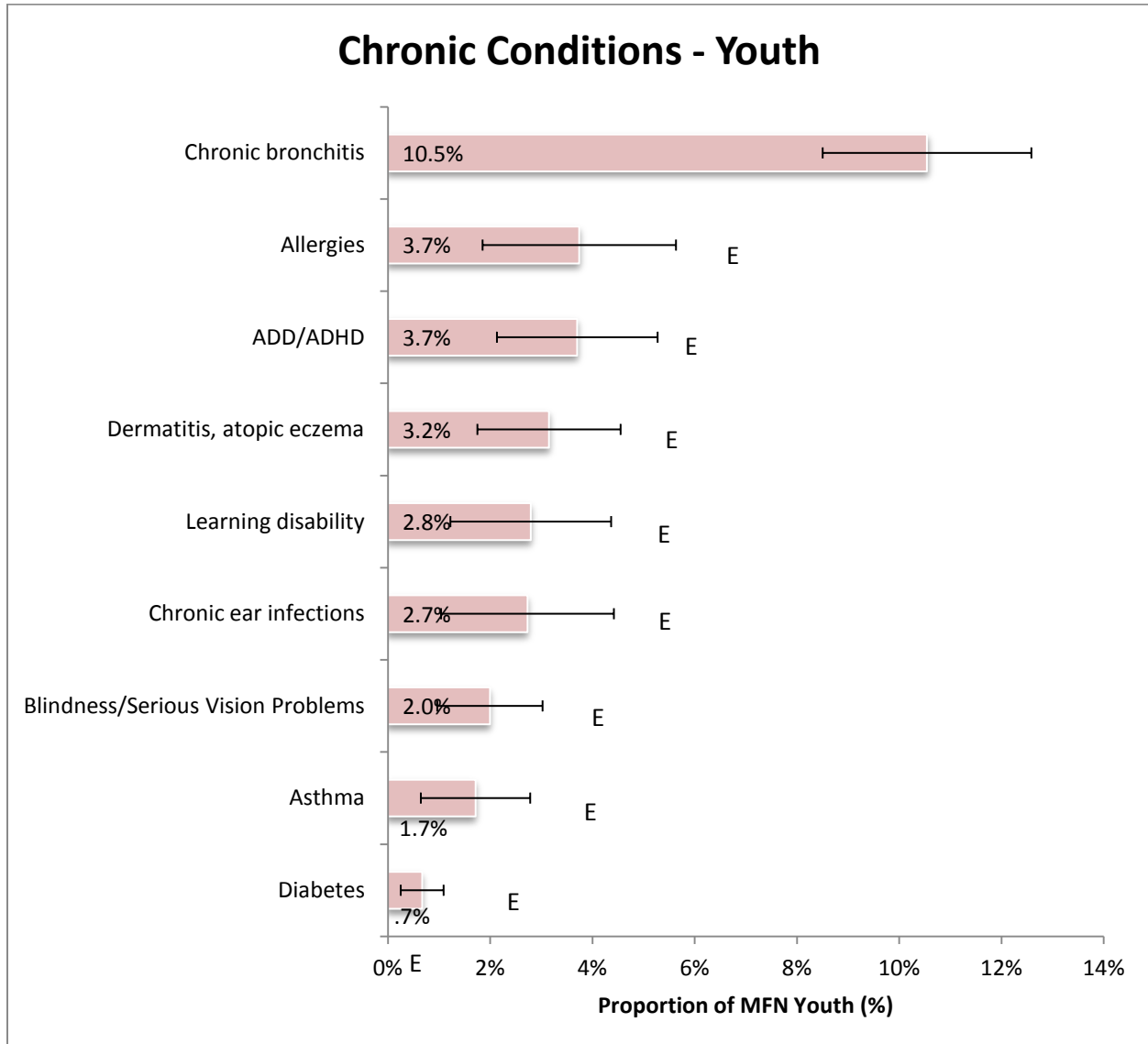
Isaiah with his cousins Tanner, Shalyane and brother Kisis.



### Chronic Conditions

Chronic bronchitis is the primary chronic condition affecting Manitoba First Nation youth on-reserve, with 10.5% having this condition.

Figure 63 Chronic conditions - youth



*Injury*

Injury is a leading cause of death amongst youth in Canada, and First Nations youth are no exception. In fact, injury rates amongst First Nations people are generally higher than non-First Nations.<sup>7</sup> Nearly a third (26.8%) of youth have been injured in the past 12 months.

Figure 64 Injured in Last 12 Months? - Youth

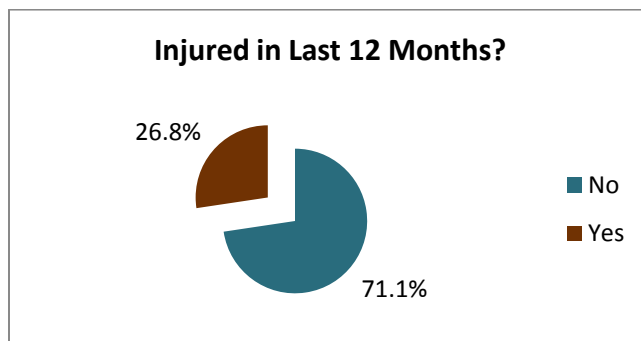
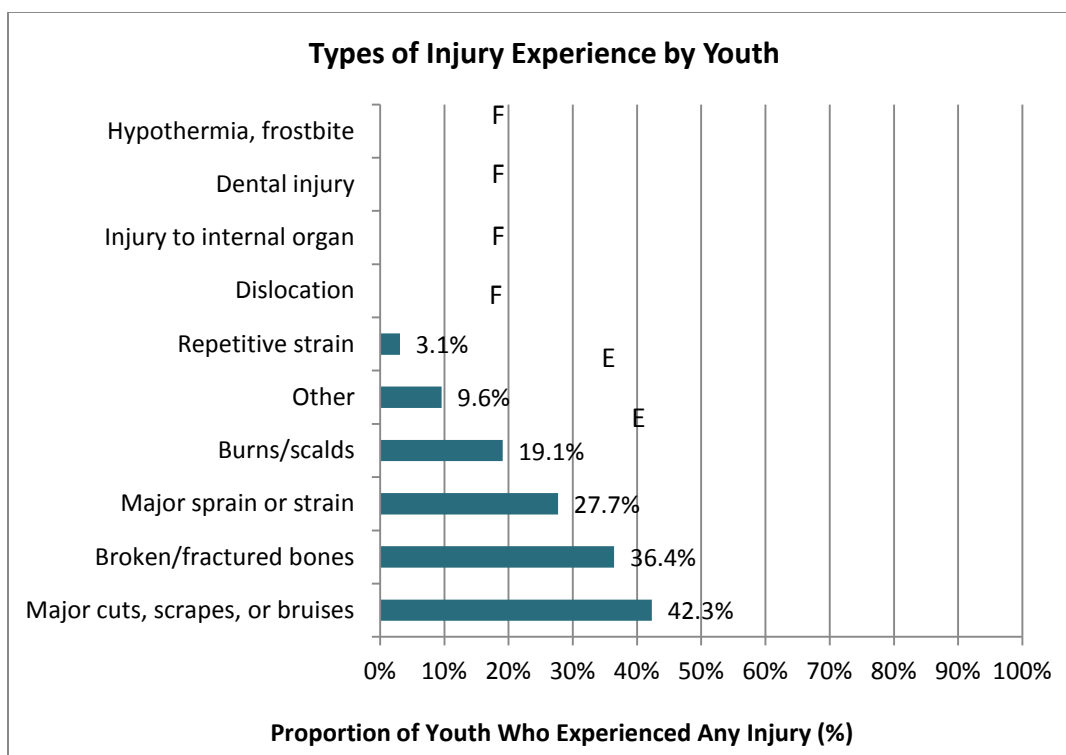


Figure 65 Types of Injury Experience by Youth (Amongst Injured)



<sup>7</sup>Fantus D, Shah BR, Qiu F, Hux J, Rochon P. (2006). Injury in First Nations communities in Ontario. *Canadian Journal of Public Health* 100(4): 258-262.

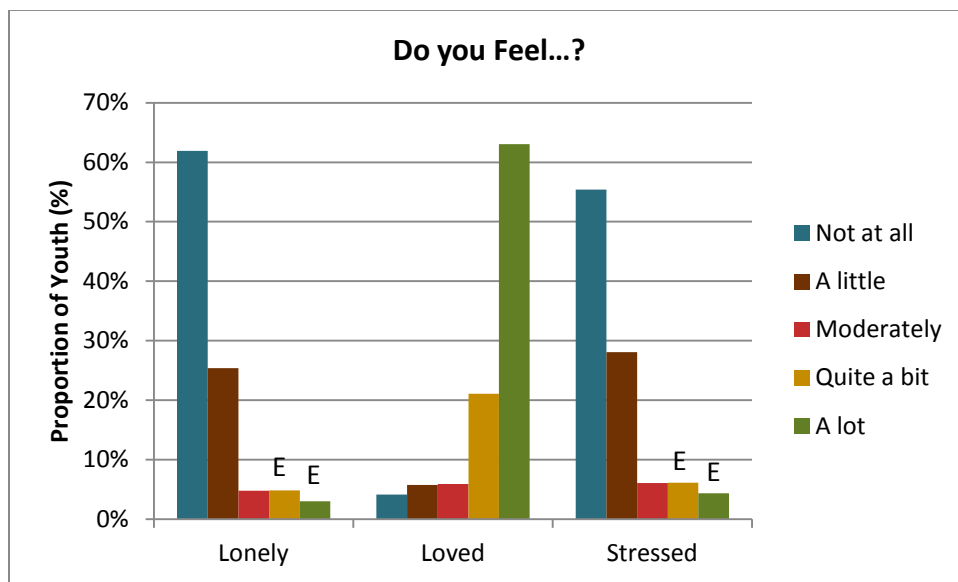
### Mental Health

When asked if in the past 12 months if there “was ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row”, 22.4% responded “yes”.

The majority of youth does not feel *lonely* or *stressed* and do feel *loved*. Conversely, 12.7% feel “moderately” to “quite a bit” *lonely*, and 16.5% feel “moderately” to “quite a bit” *stressed*.

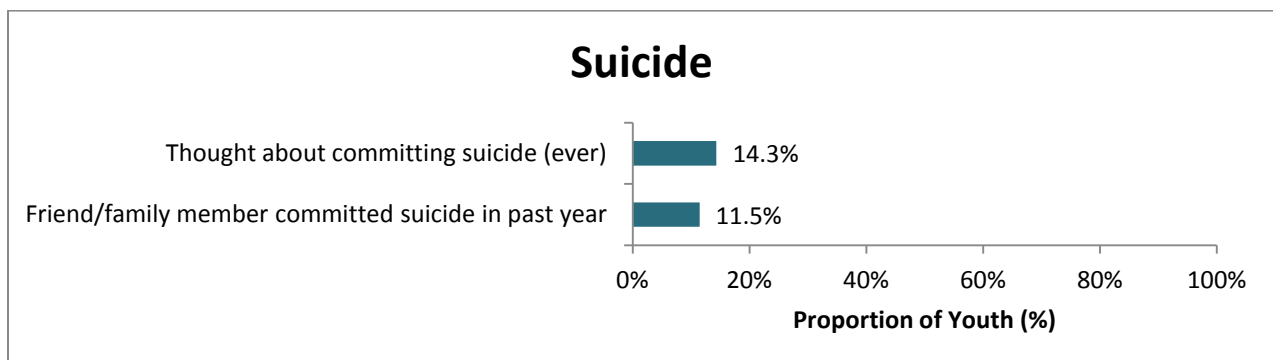
16% of Manitoba First Nations youth say they are being bullied

Figure 66 Do you feel lonely, loved, stressed? Youth



### Suicide

Figure 67 Suicide - Youth



## Health Services

This section covers visits to doctors or community health nurse, psychological/mental health counseling, preventive health measures, traditional medicine, and dental care.

Figure 68 Last visit to doctor or nurse - youth

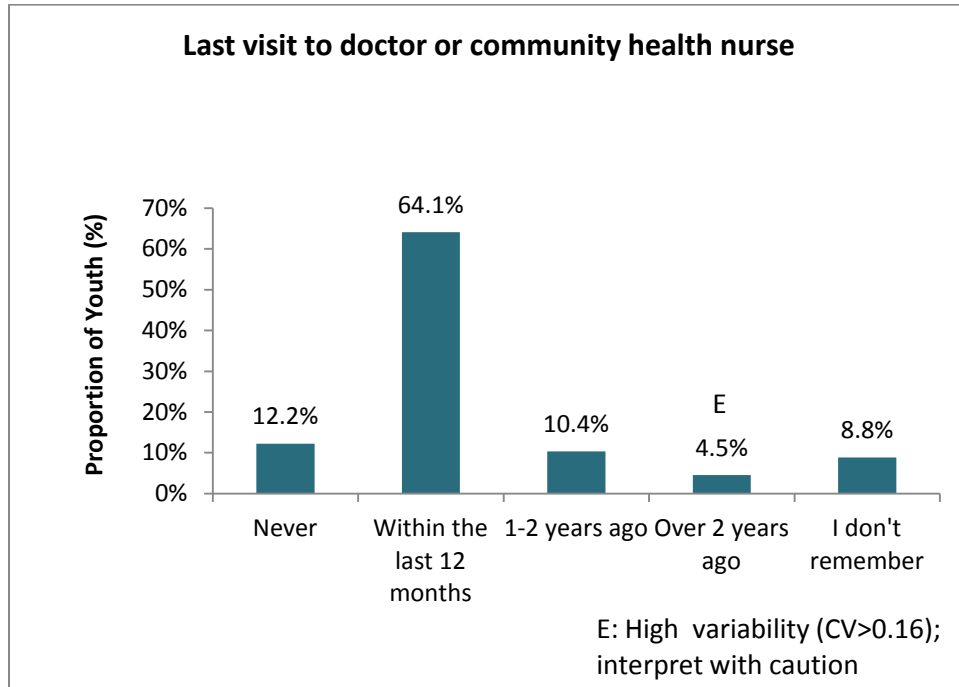


Figure 69 Last time accessed mental health service - youth

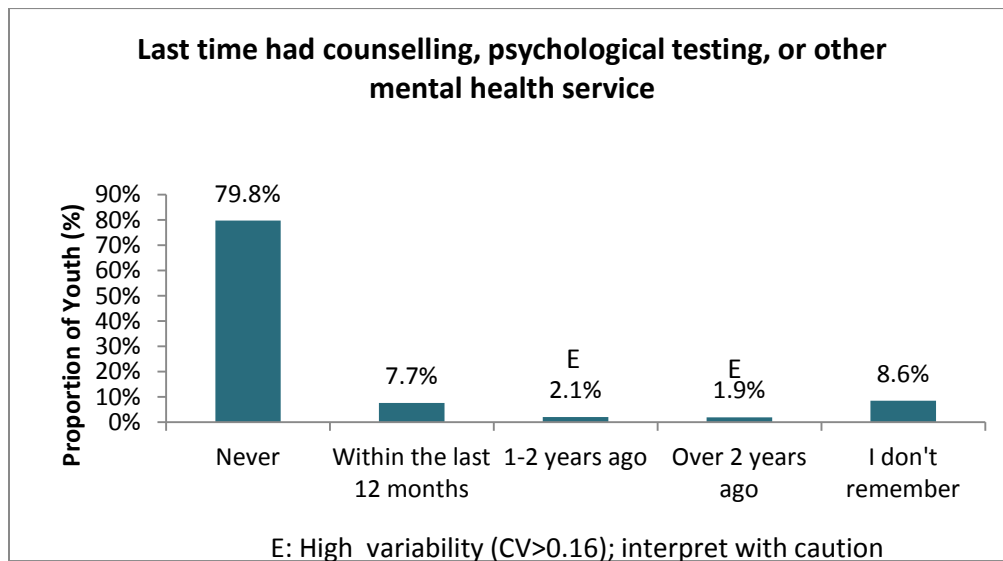


Figure 70 Health examinations - youth

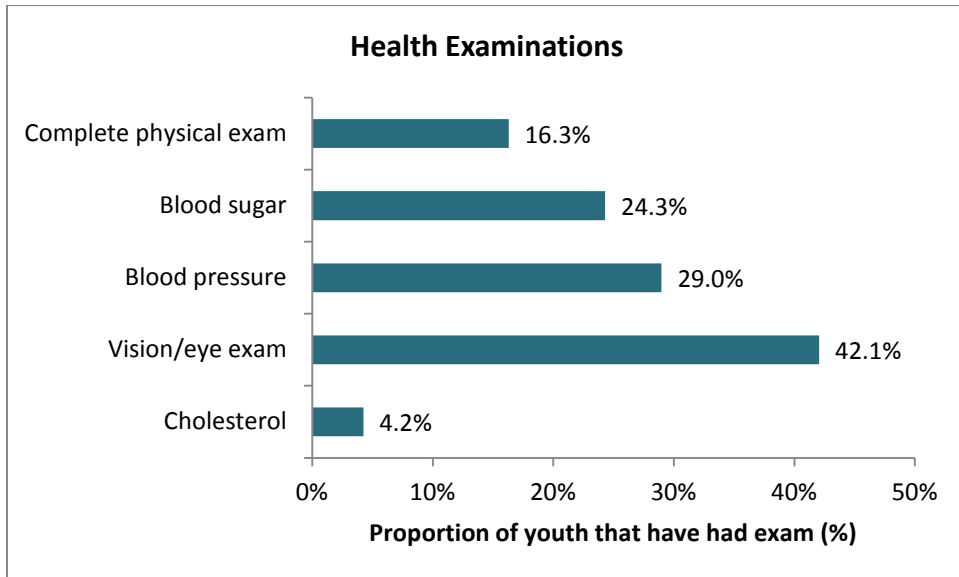
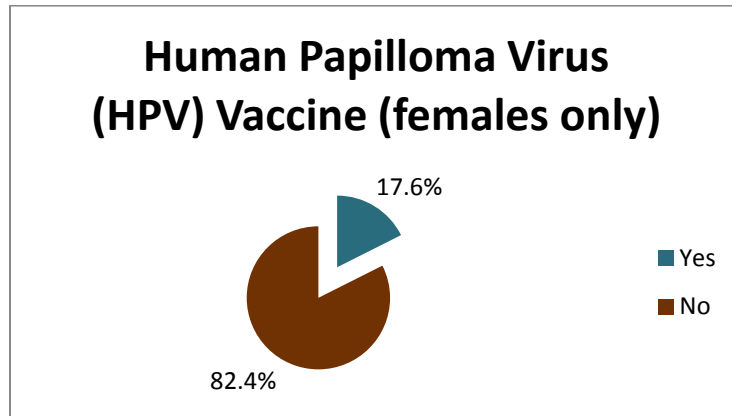


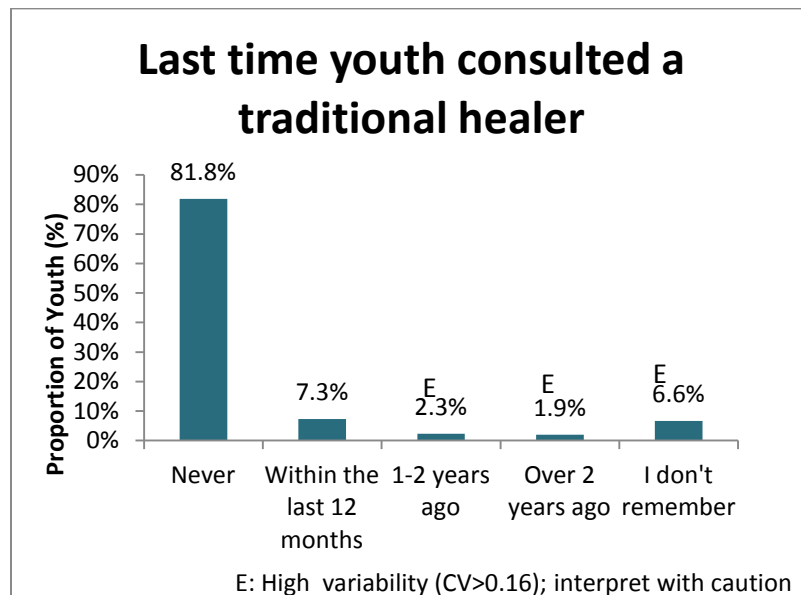
Figure 71 HPV Vaccine (female youth)



## Traditional Medicine

- 18.2% of First Nations youth on-reserve have seen a traditional healer.

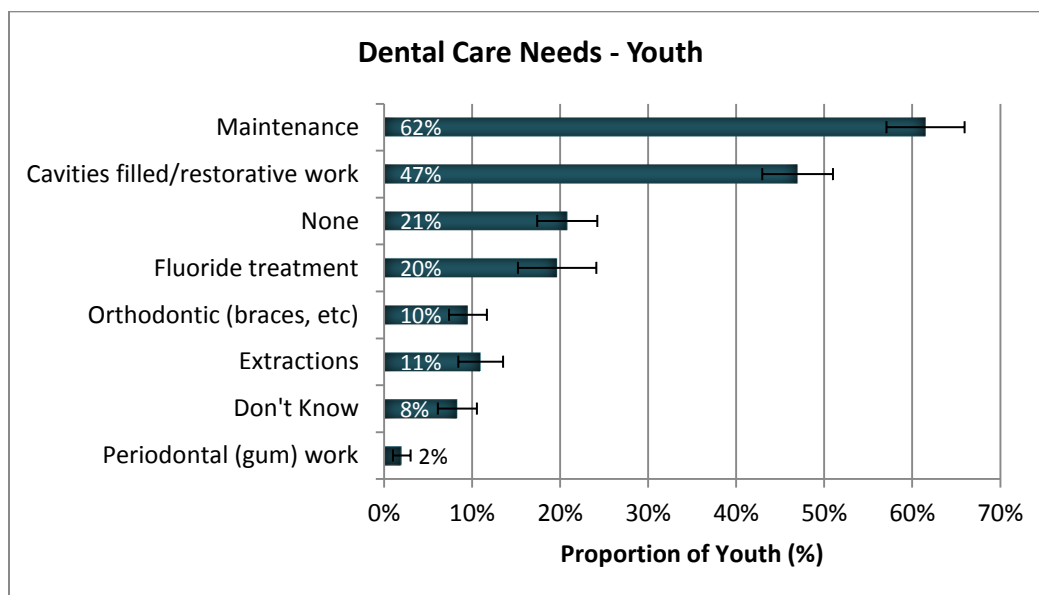
Figure 72 Last time youth consulted a traditional healer



## Dental Care

In the past 12 months, 18.7% [95% CI: 15.4%, 22.6%] of MFN youth on-reserve experienced problems with their teeth or dental pain. Only 21% of youth stated that they did not need any dental care, while 8% did not know whether they required dental care or not.

Figure 73 Dental care needs - youth



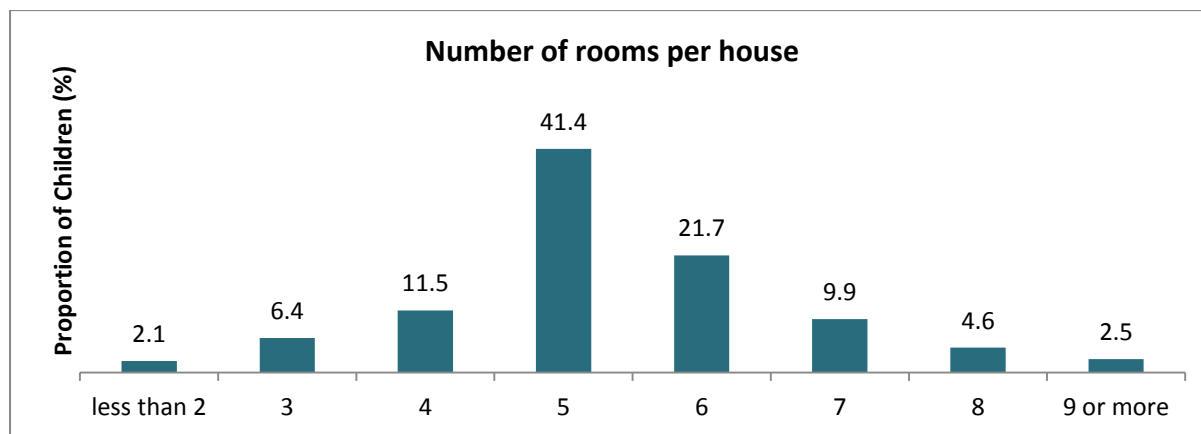
## CHAPTER 3 – CHILDREN

The following Child section is based on responses of the 894 parents or guardians who answered on behalf of their child. Each parent or guardian was interviewed using the age specific *Child Questionnaire*. Children were those between the ages of 0-11 years of age: 51% of the children interviewed were female and 49% were male. The majority of respondents were the child's birth mother (86.3%). The survey questionnaire can be found online at [www.fnigc.ca](http://www.fnigc.ca).



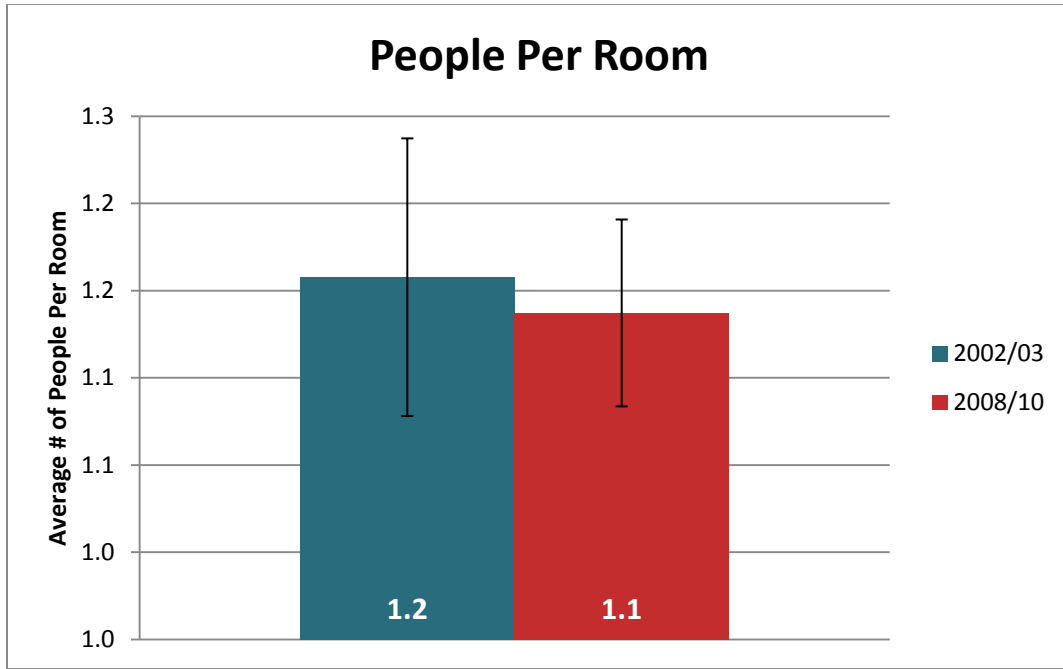
### Housing

Figure 74 Number of rooms per house - Children



The average child in Manitoba First Nations lives in a home that is overcrowded, according to the Canadian Mortgage and Housing Corporation (CMHC) guideline of 1 person per room. This did not change significantly between 2002/03 and 2008/10.

Figure 75 People per room - Children (2002/03 and 2008/10)



Food and Nutrition

Figure 76 Sharing of traditional food - Children

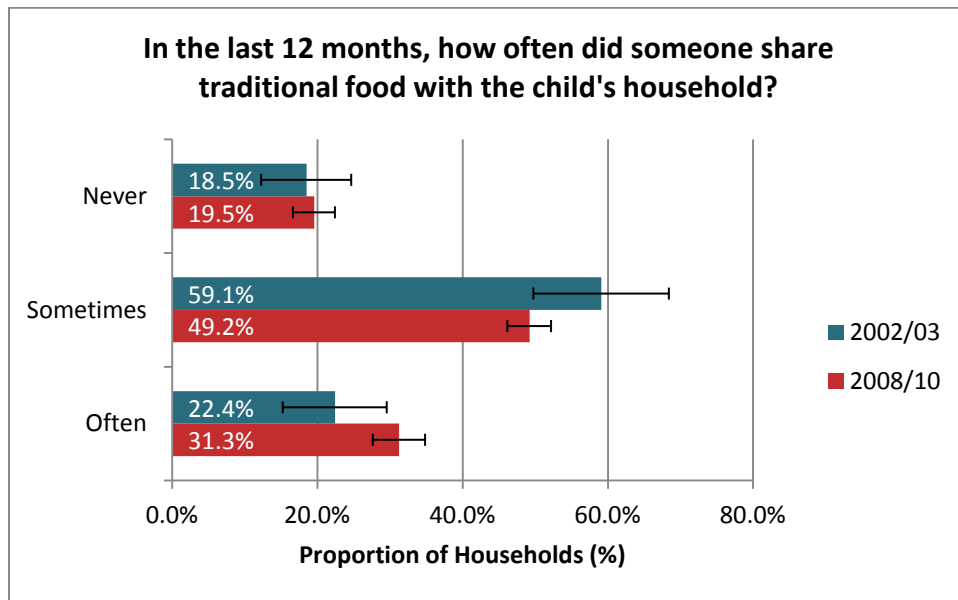
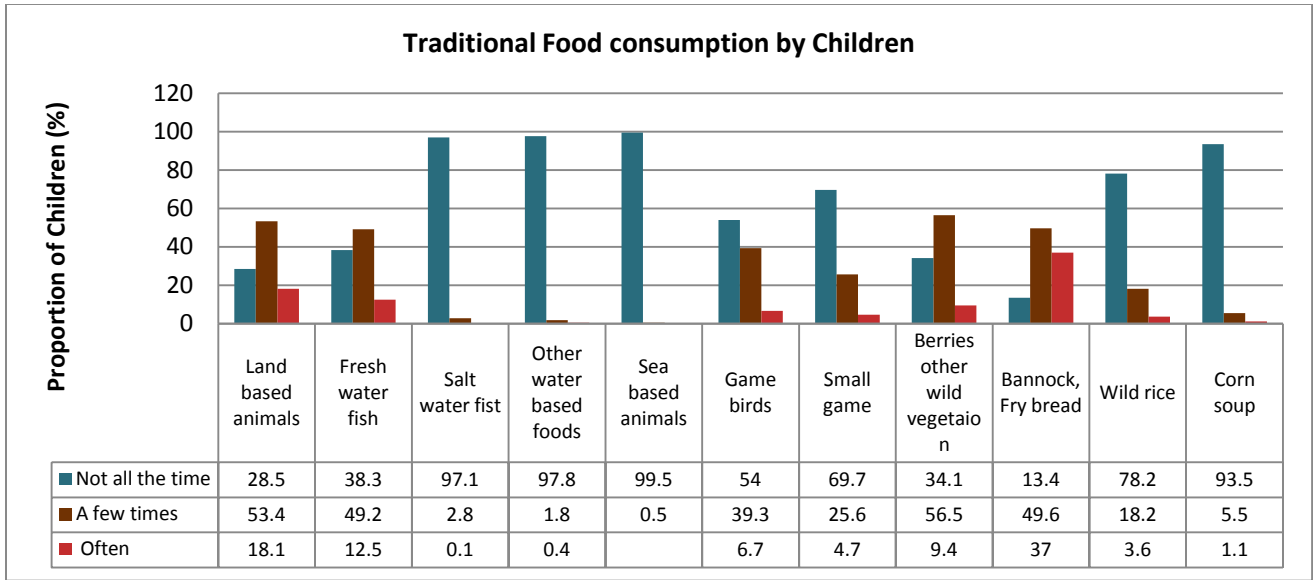


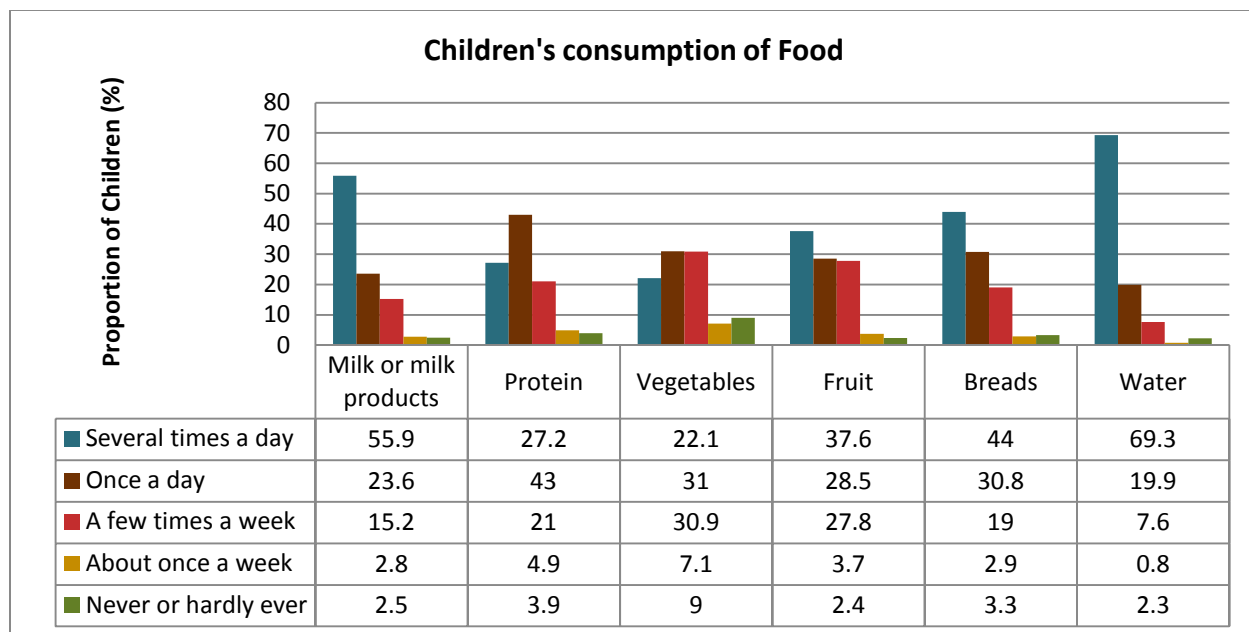


Figure 77 Traditional food consumption by Children



*Gracelyn celebrating her catch of fish for the day*

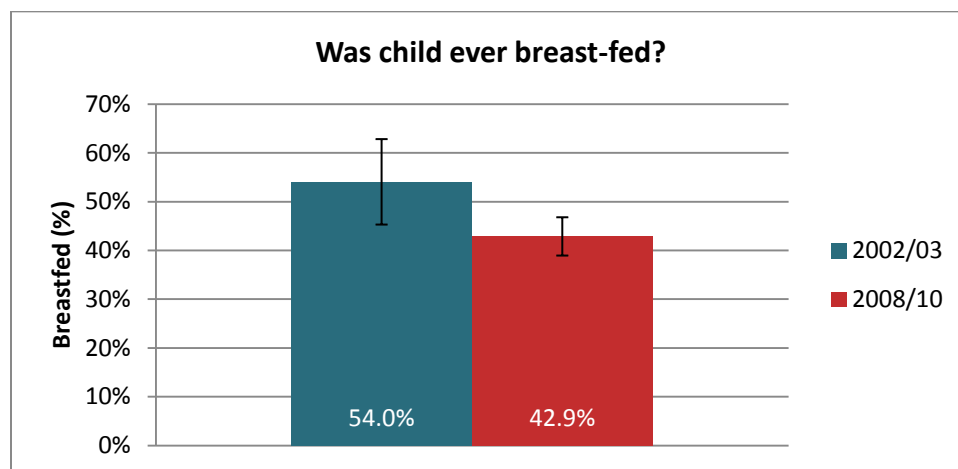
Figure 78 Consumption of Foods - Children



**Breastfeeding**

Breastfeeding has been shown to be associated with many positive health outcomes, and reduced risk of baby bottle tooth decay.<sup>8</sup> A decrease in breastfeeding between 2002/03 and 2008/10 is therefore cause for concern. 91.9% of children were bottle fed at one point during their childhood.

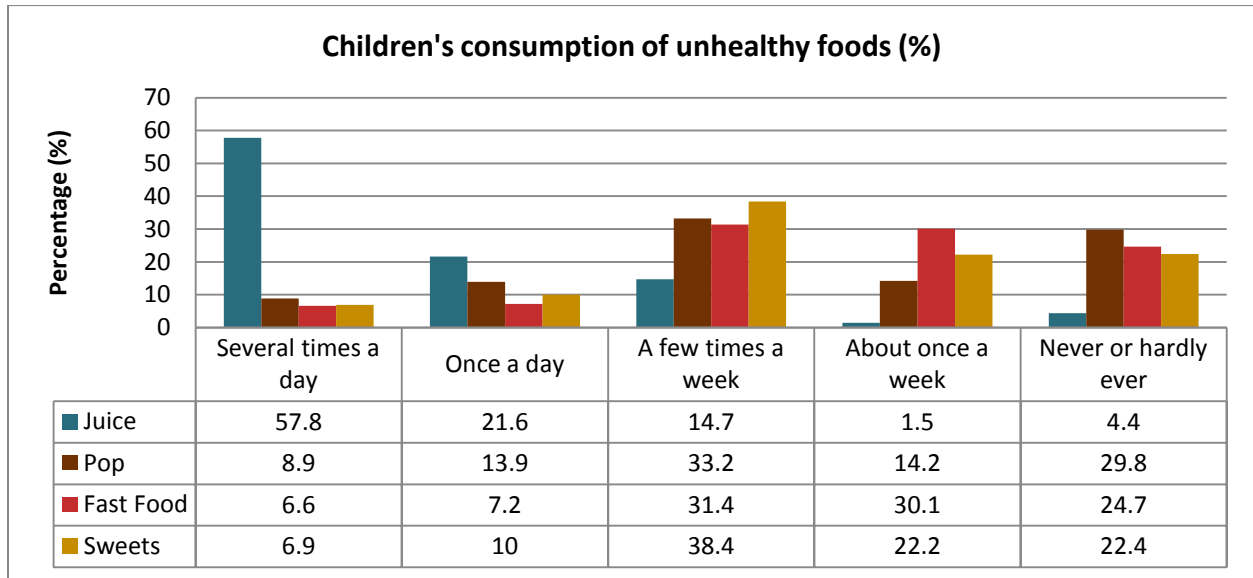
Figure 79 Breastfeeding



<sup>8</sup> National Women’s Health Information Center (2012). Why Breastfeeding is Important. Washington, DC: US Department of Health and Human Services. Online: <http://www.womenshealth.gov/breastfeeding/why-breastfeeding-is-important/index.html>

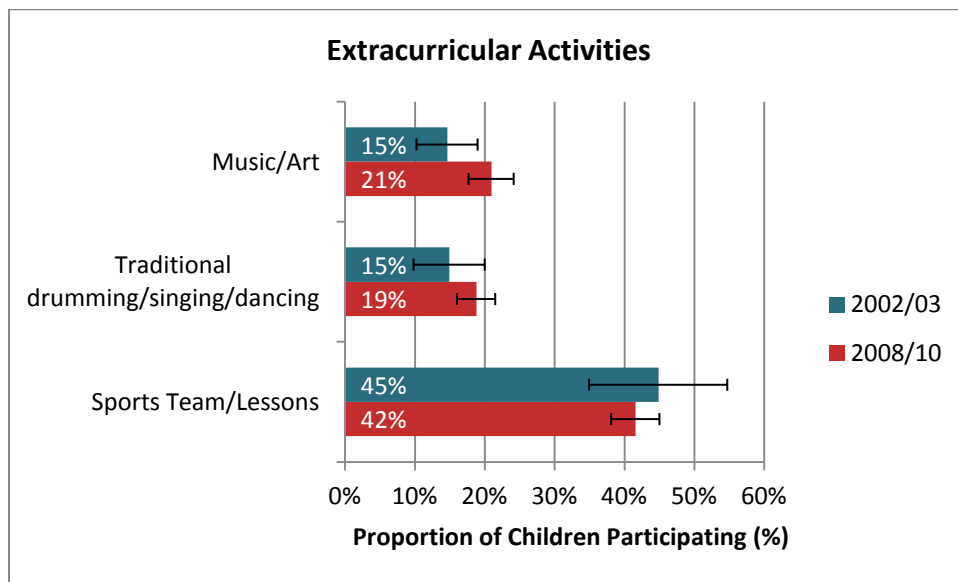
Unhealthy Foods

Figure 80 Children's consumption of unhealthy foods



Physical Activity

Figure 81 Extracurricular Activities



Smoke Exposure

Figure 82 Smoke exposure - children

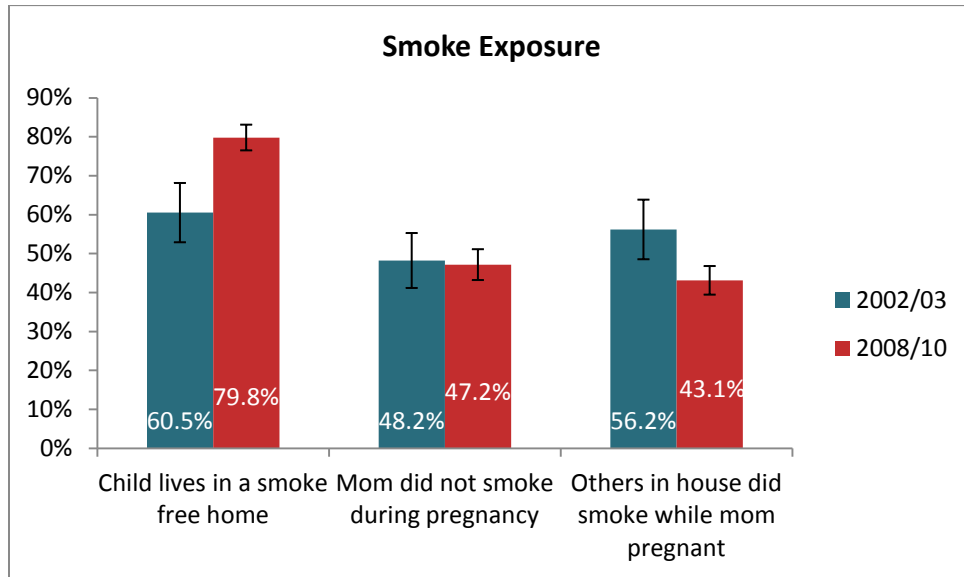
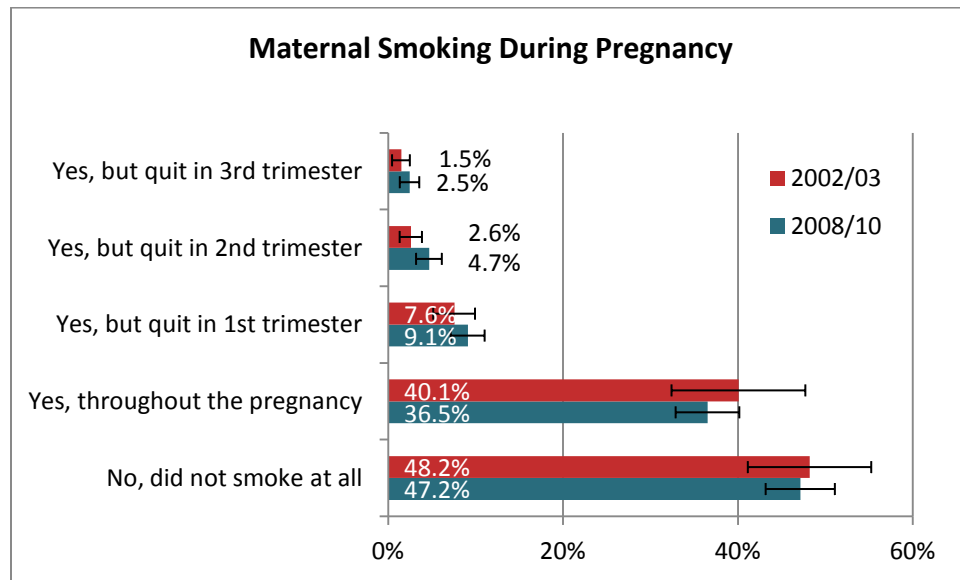


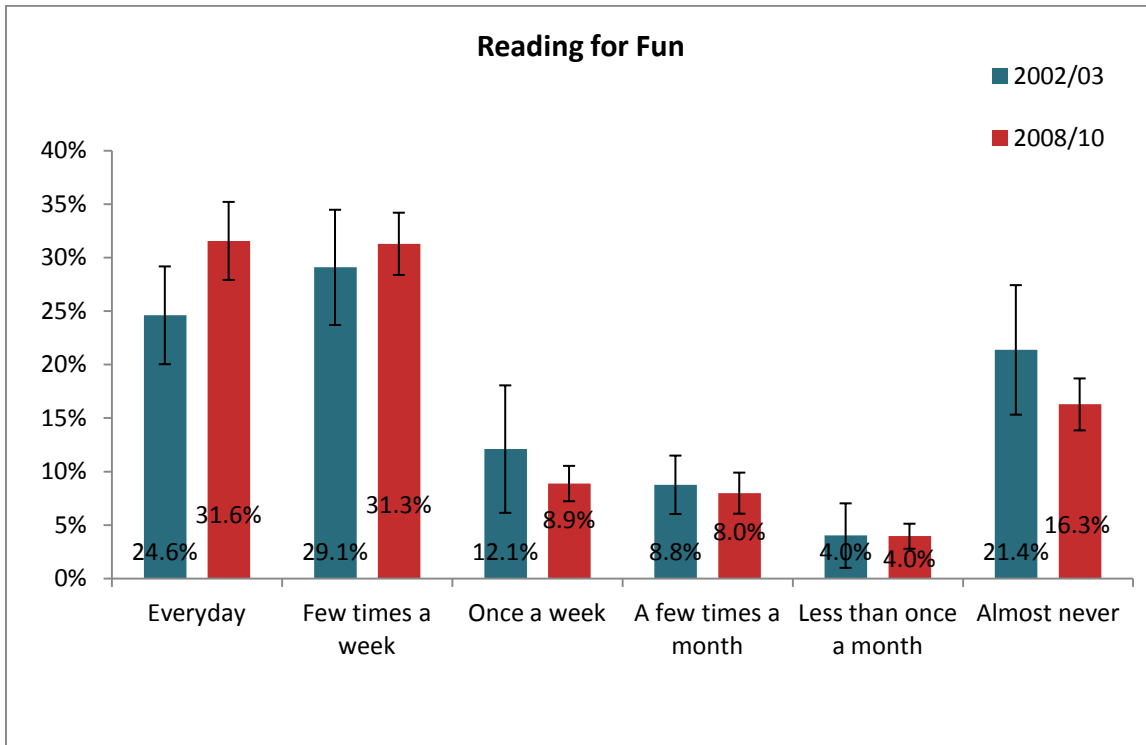
Figure 83 Maternal smoking



*Education and Learning*

- 67.6% of children were attending school
  - 98.8% of children 6-11 years are attending school.
- 27.5% of children attended an Aboriginal Head Start program during their early childhood education

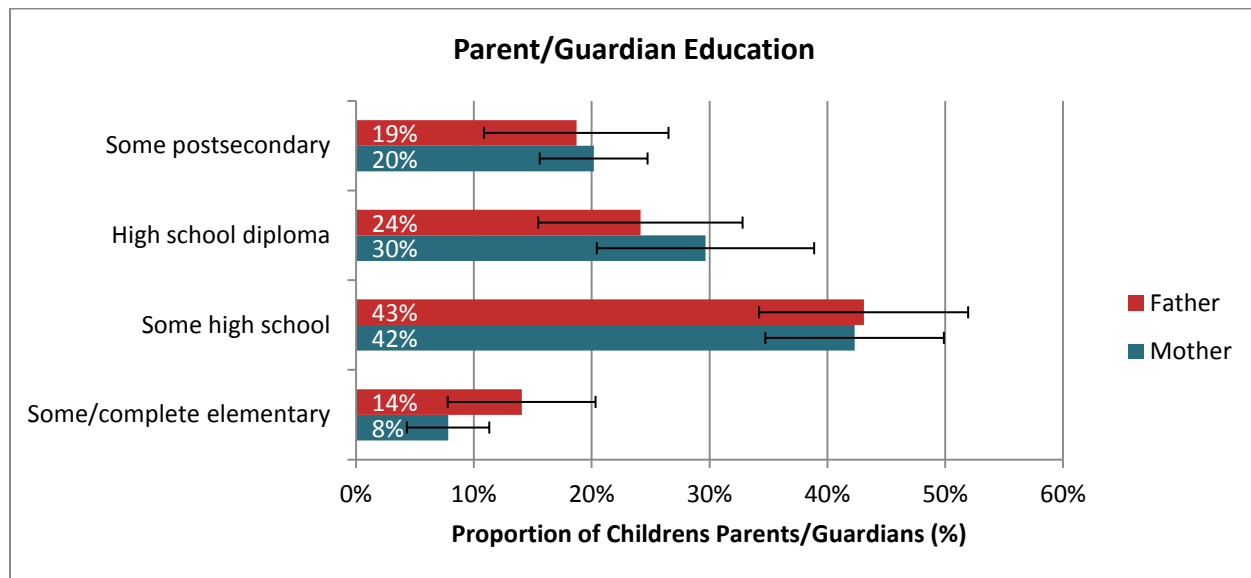
Figure 84 Reading for fun - children



Gracelyne reading a book.

Mothers and fathers have a similar distribution of educational attainment. The biggest difference is in the proportion that has some/complete elementary school education.

Figure 85 Mothers' and Fathers' Education - children



Dad helping son Blayne hold his new born sister Gracelyn.

*Language and Culture*

*Language*

Parents were asked which language the child uses on a daily basis and how well they understand and speak a First Nations language.

- 94.4% said English
- 44.6% Children understand or speak a First Nations language and
- Almost a third (28.6%) of Children speaks a First Nations language in their daily life.

### *Ability to understand of a First Nations Language*

Within the Children who speak a First Nations language in their daily life,

- 84.6% could understand a basic level of speech/a few words of a First Nations language,
- 15.4% had an intermediate/fluent understanding of a First Nations language

### *Ability to speak a First Nations Language*

Within the children who speak a First Nations language in their daily life,

- 86.4% could speak a basic level of speech/a few words of a First Nations language,
- 13.6% could speak a First Nations language intermediately/fluently

When parents or guardians were asked how important it is for their child to learn a First Nations language,

- 58.3% said very important
- 32.7% said somewhat important
- 5.8% said not very important
- 3.2% said not important

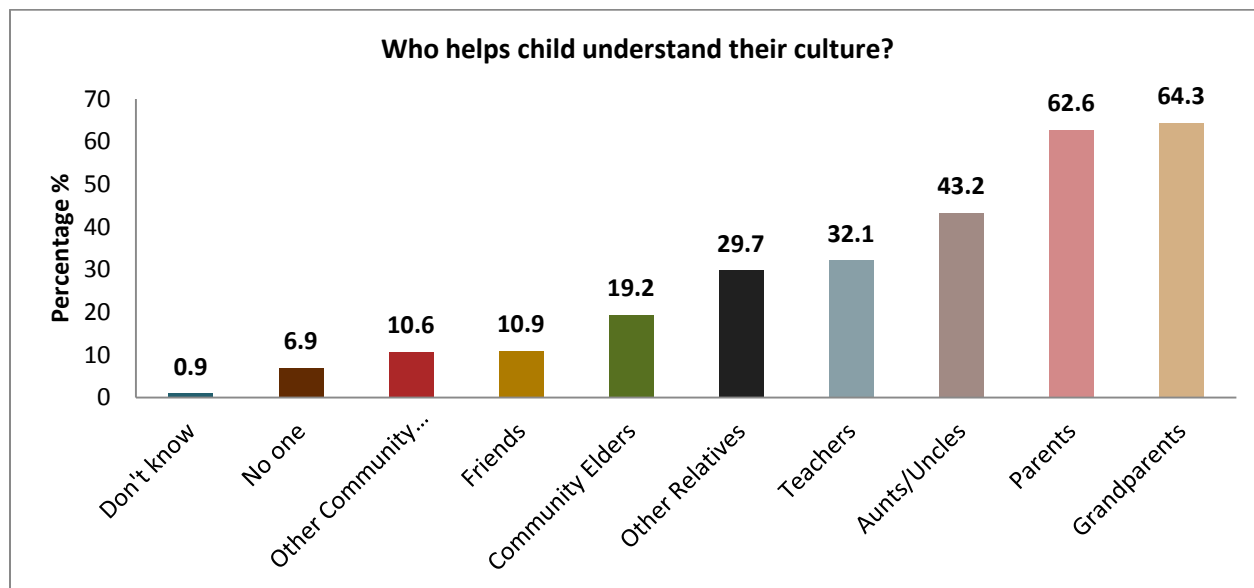
### *Culture*

When asked who helps the child understand their culture, the top three people caregivers identified as helping the child understand their culture were their grandparents (64.3%), parents (62.6%), and aunts/uncles (43.2%).



Gracelyne in a moss bag.

Figure 86 Who helps child understand their culture?

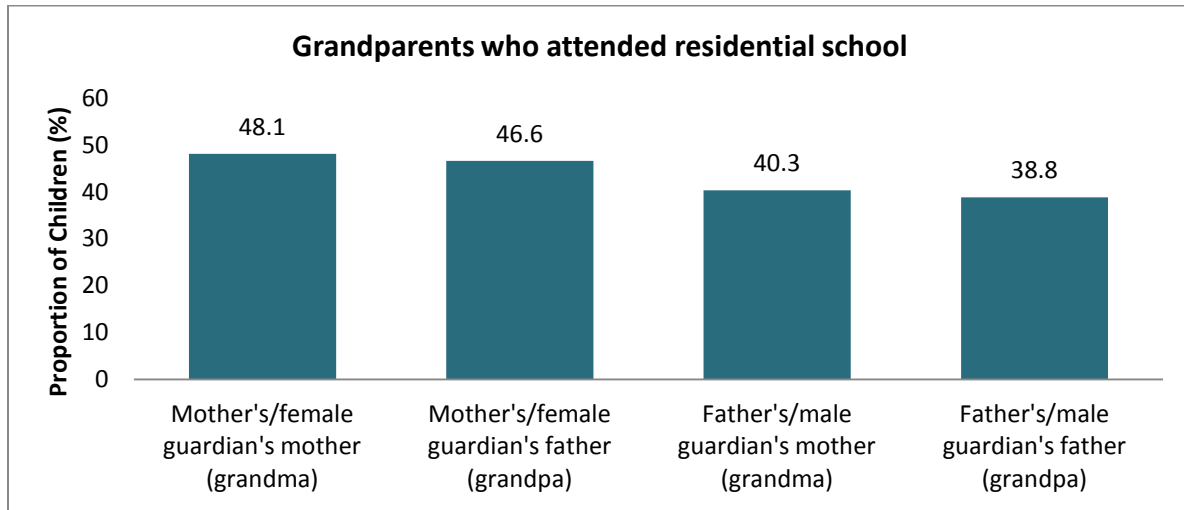


When asked how important traditional cultural events are in their child's life,

- 44.3% said very important
- 37% said somewhat important
- 10.6% said not very important
- 8.2% said not important



Figure 87 Grandparents' Residential School Attendance - children



Childcare

- 18.9% of children are currently receiving childcare

The top three childcare arrangements made for the child are:

- 37.5% received care through a daycare centre
- 21.8% were cared for in someone else's home by a family member/relative
- 20.1% were cared for within their own home by another relative other than their siblings



Isaiah blowing bubbles

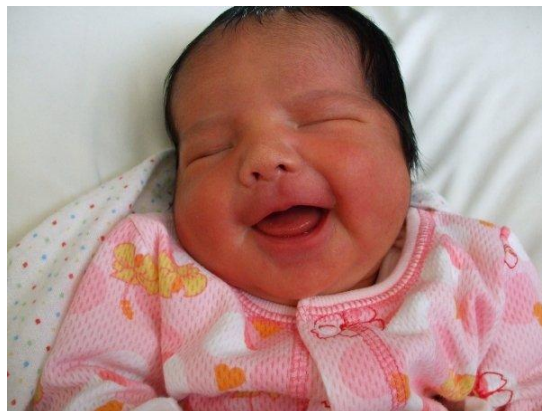
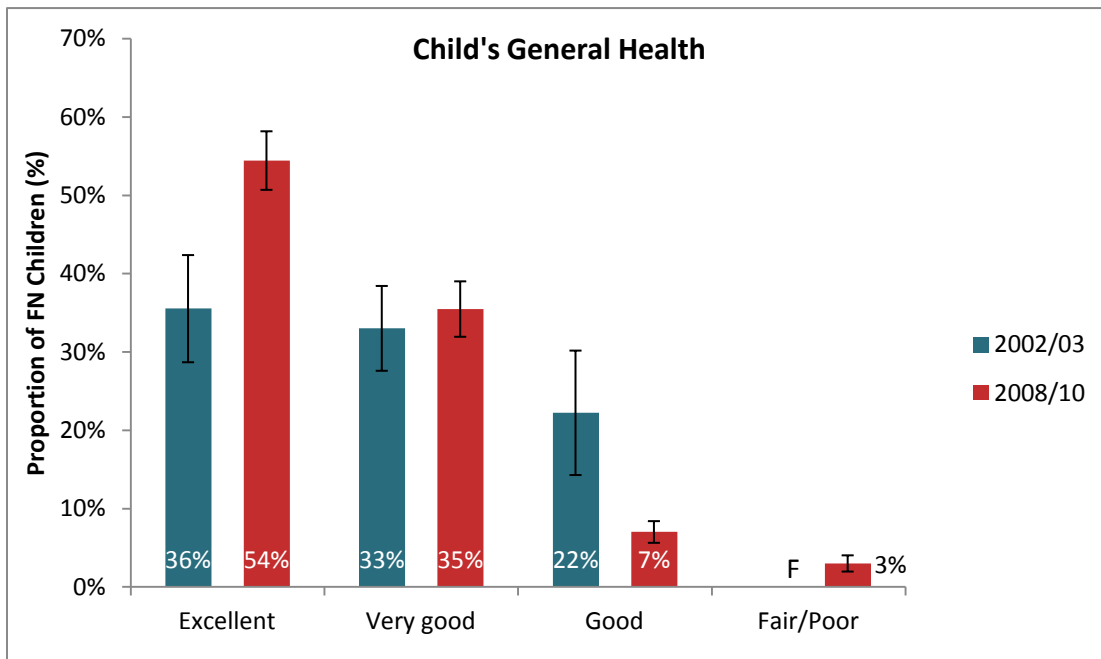
## Health Status

This section covers general health, chronic conditions, injury, and emotional health.

### General Health

A significant increase in the proportion of caregivers reporting their child to be in excellent health was observed. Also, a significant decline in the proportion of children with “good” health was also observed between 2002/03 and 2008/10, which is expected as more children were reported to have excellent health. A very small number of caregivers reported their child to be in fair/poor health, two categories that had to be combined to allow reporting.

Figure 88 Child's general health

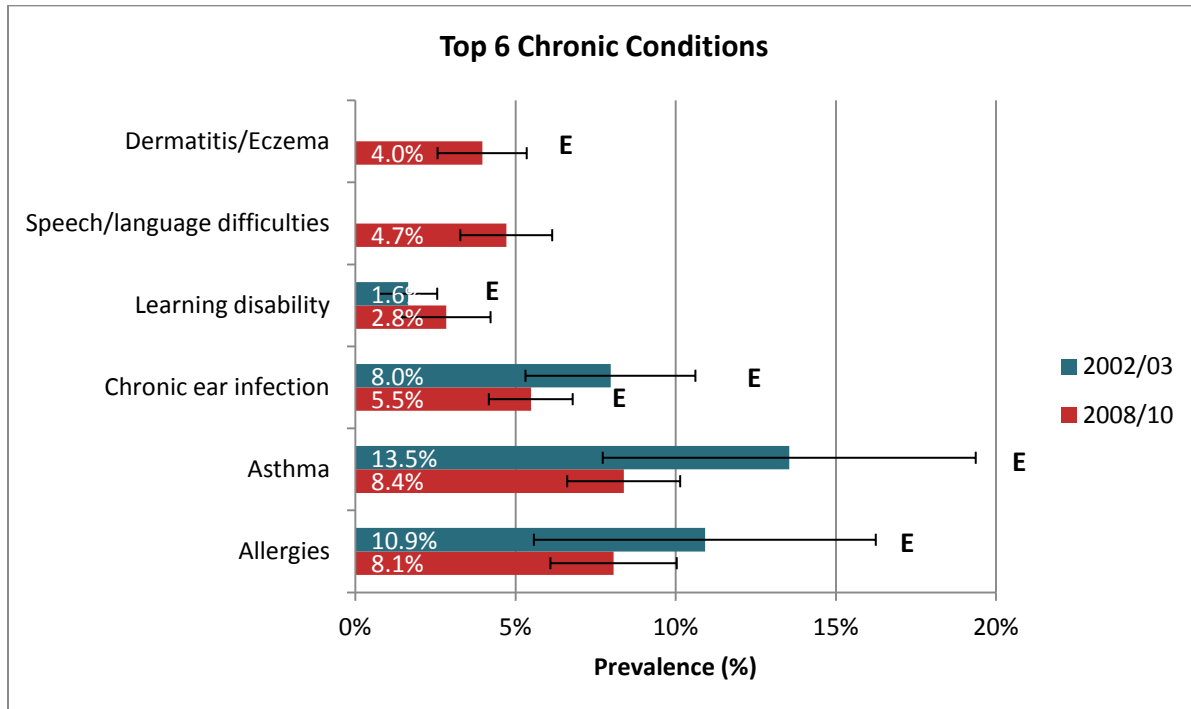


Gracelyn smiling.

### Chronic Conditions

Asthma and allergies are the two most common chronic conditions amongst Manitoba First Nation children living on-reserve.

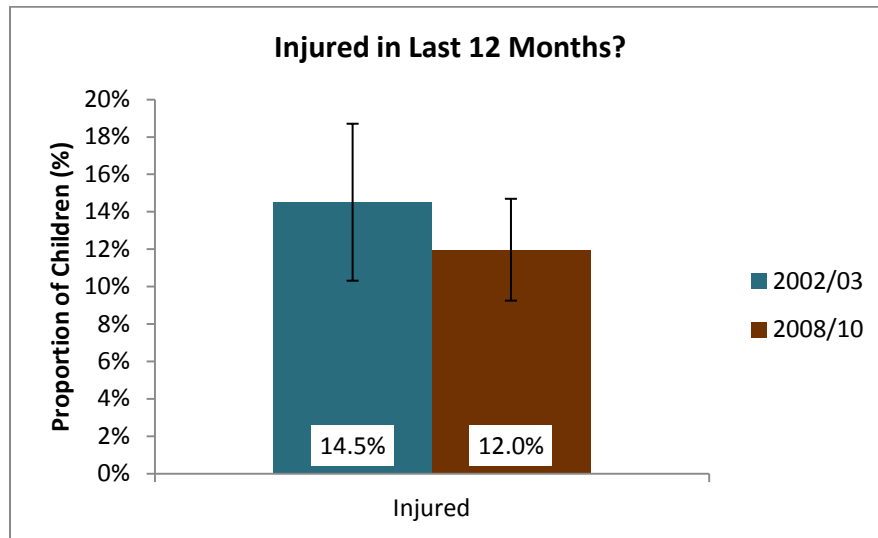
Figure 89 Top six chronic health conditions



### Injury

Injury is a leading cause of death amongst children and youth from age 1 to 19.<sup>9</sup> Approximately 12% of Manitoba First Nations children on-reserve were injured in the last year in 2008/10 and 14.5% in 2002/03; although the difference is not statistically significant. The most common type of injury sustained by children are minor (cuts, scrapes, bruises).

Figure 90 Injured in Last 12 Months? Children



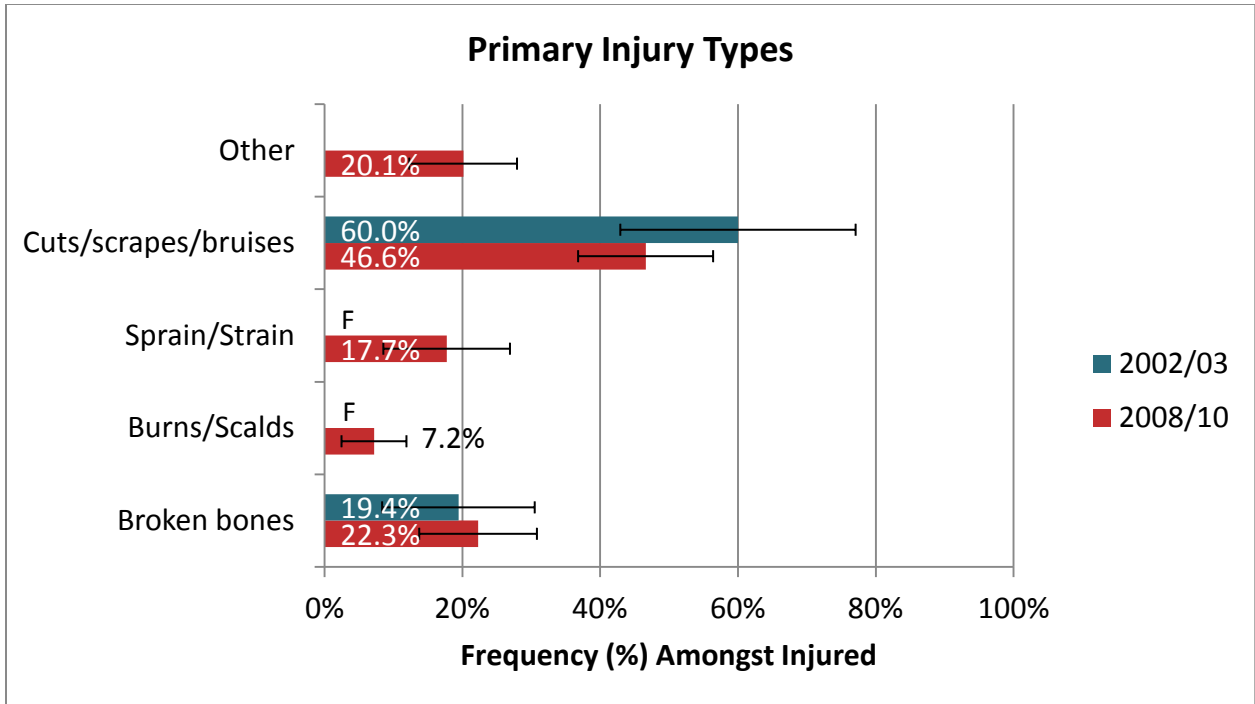
Over half (53.6%) of the injuries occurred at home, 16% occurred at school, college or university, 14.2% occurred at a sports field or facilities of a school and 20.4% said “other”.

When asked what the child was doing at the time of the injury,

- 31.9% said sports or physical injury
- 35% said leisure or hobby
- 38.2% said “other”

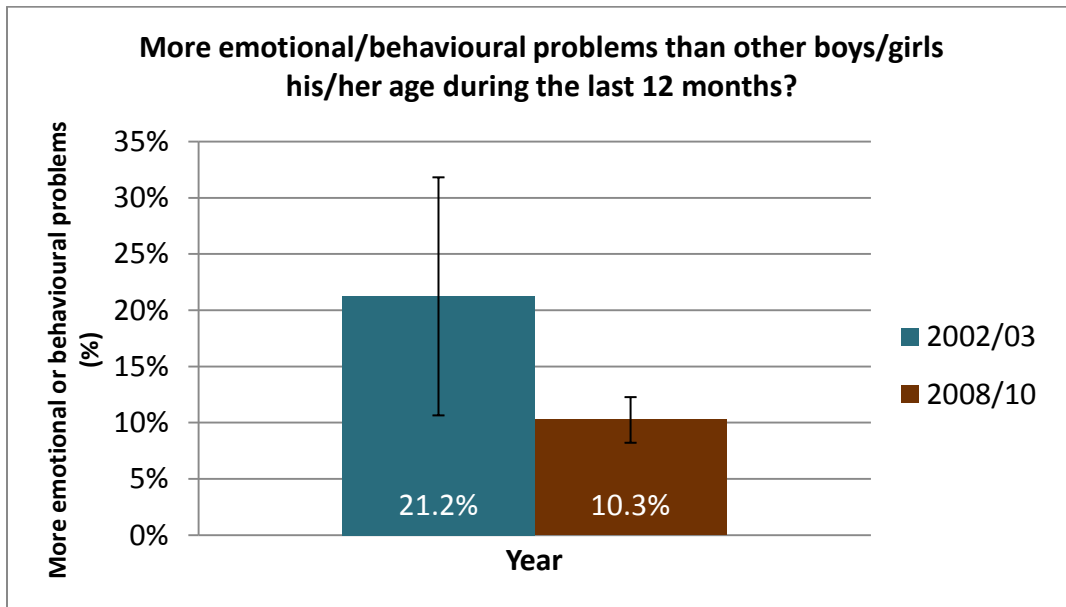
<sup>9</sup> Public Health Agency of Canada (PHAC) (2009). *Child and Youth Injury in Review, 2009 Edition*. Ottawa: Government of Canada. Online: [http://www.phac-aspc.gc.ca/publicat/cyi-bej/2009/pdf/inirep-rapbles2009\\_eng.pdf](http://www.phac-aspc.gc.ca/publicat/cyi-bej/2009/pdf/inirep-rapbles2009_eng.pdf)

Figure 91 Primary Injury Types - children



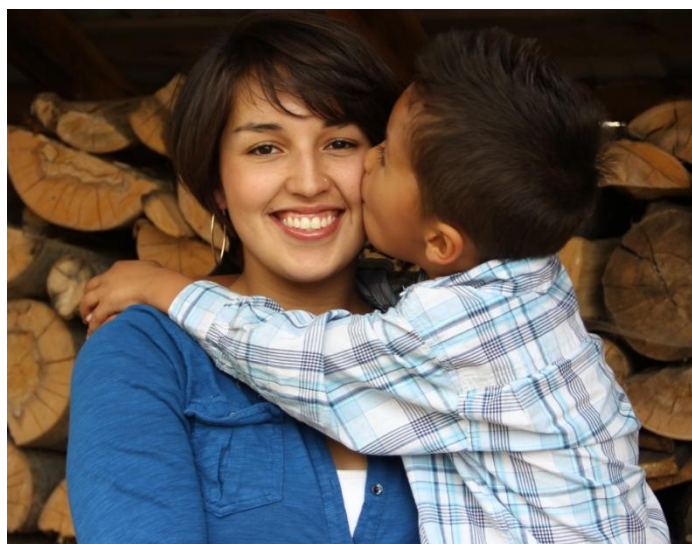
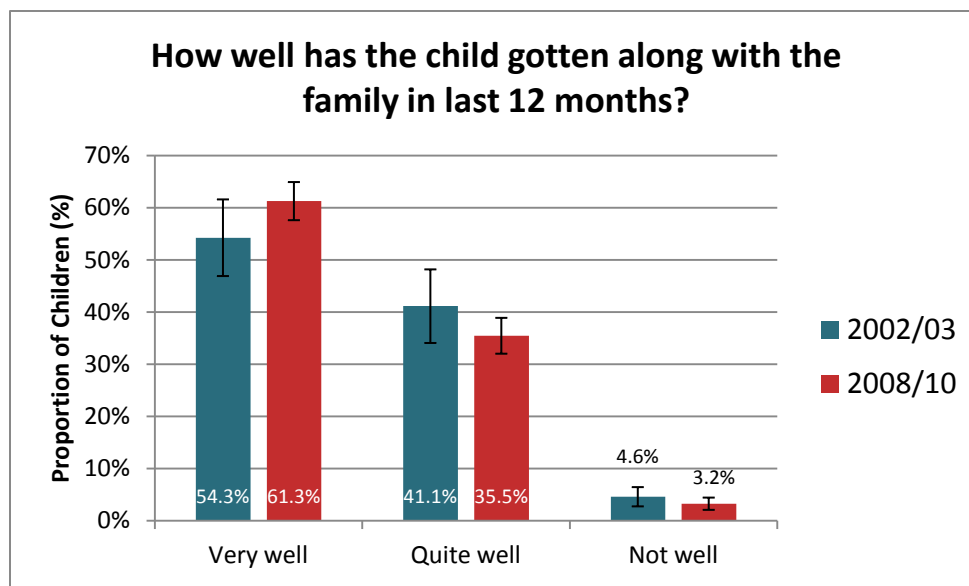
Emotional Health

Figure 92 More emotional/behavioural problems than other boys/girls his/her age during the last year - children



Most caregivers report that their child gets along with family very well or quite well. Only a small percentage (<5%) report that their child is not getting along with family. No significant change was observed between 2002/03 and 2008/10.

Figure 93 How well has the child gotten along with the family in the last 12 months?



Bethany and her son Colby.

## Health Services

This section covers immunizations, access to health care, dental care, and medication use. Due to the rarity of most paediatric conditions, children are often not receiving many health services, and thus few areas of health services could be reported on in the regional report alone. For more general information on First Nation children’s health care, the national RHS report produced by the FNIGC has much more information and is available at [www.fnigc.ca](http://www.fnigc.ca).

### Immunizations

Almost all children’s caregivers reported that their child had received all regular immunizations.

Figure 94 Immunizations - children

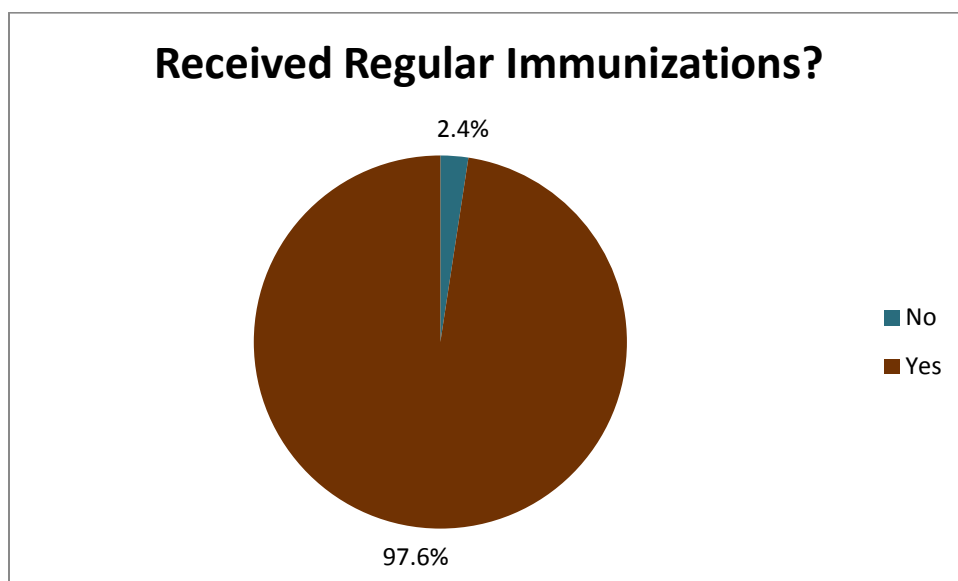


Figure 95 Reasons child not immunized

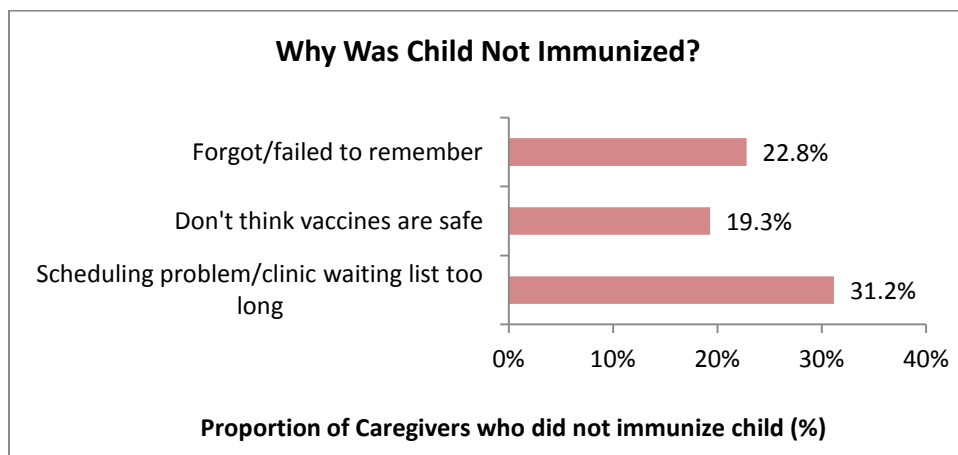
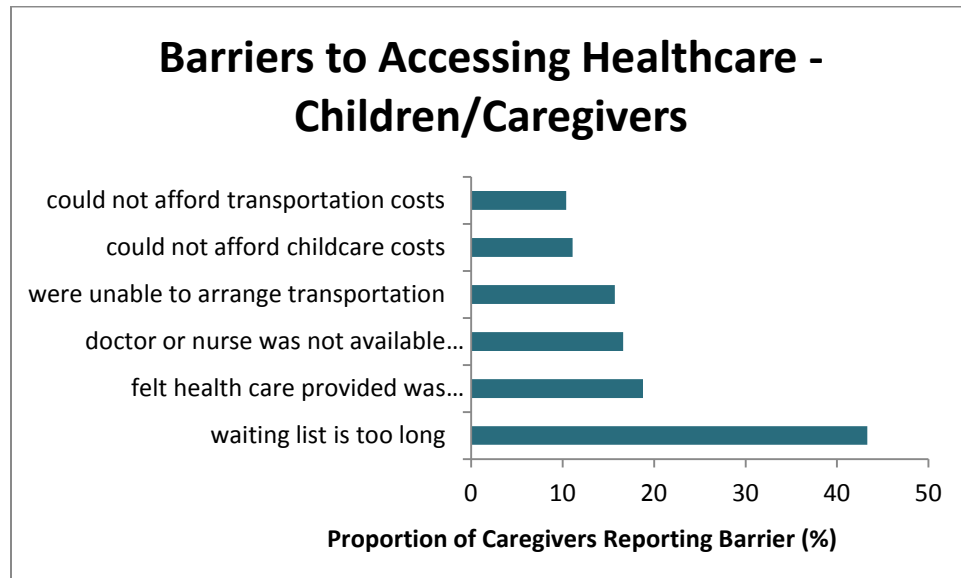


Figure 96 Barriers to accessing healthcare - children/caregivers



*“...slowly our treaties are being taken away, many medications and dental care are being taken away like orthodontic treatment. This should not be so as it is our right to receive them through the treaties that were signed”*

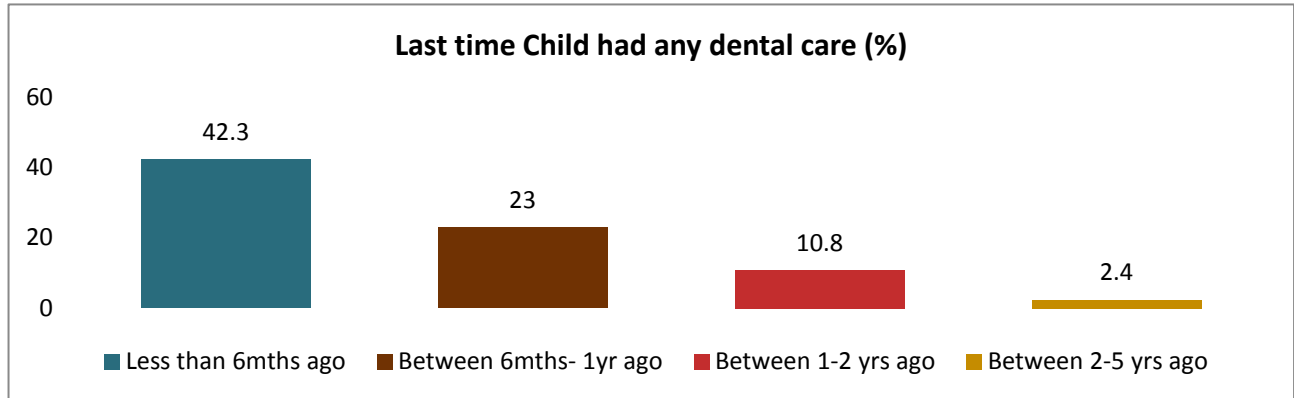
*(MFN RHS 2008-2010 Parent/Guardian of child)*



### Dental Care

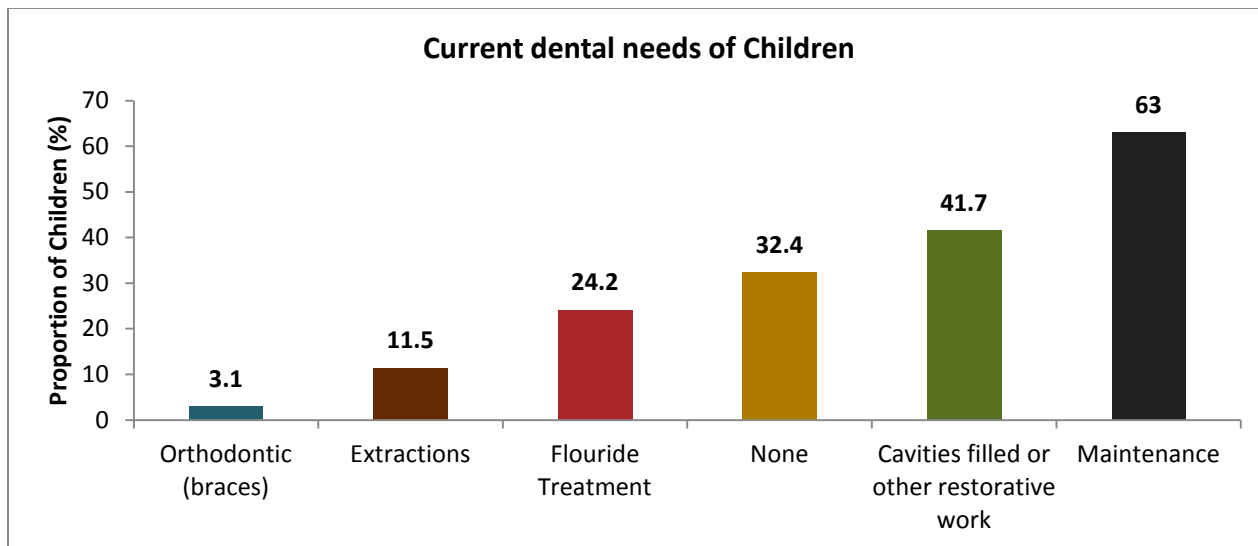
- 34.2% of children's teeth have been affected by Baby Bottle Tooth Decay (BBTD) and 83.4% of children affected by BBTD received treatment.

Figure 97 Last time child had dental care



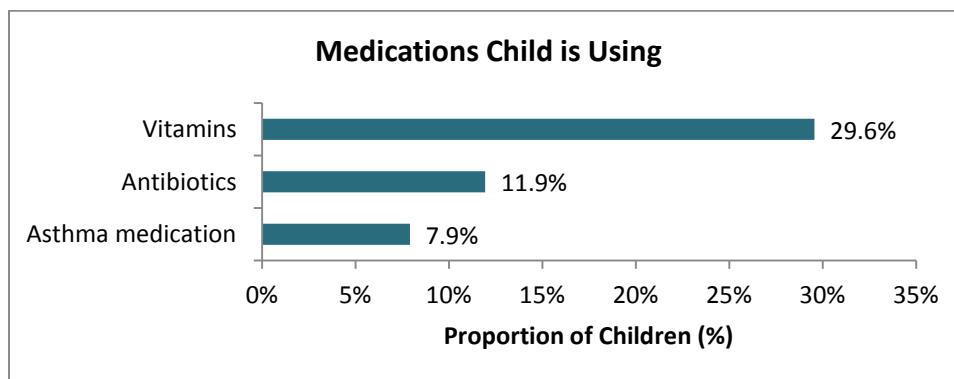
Gracelyn getting her teeth checked

Figure 98 Current dental needs of children



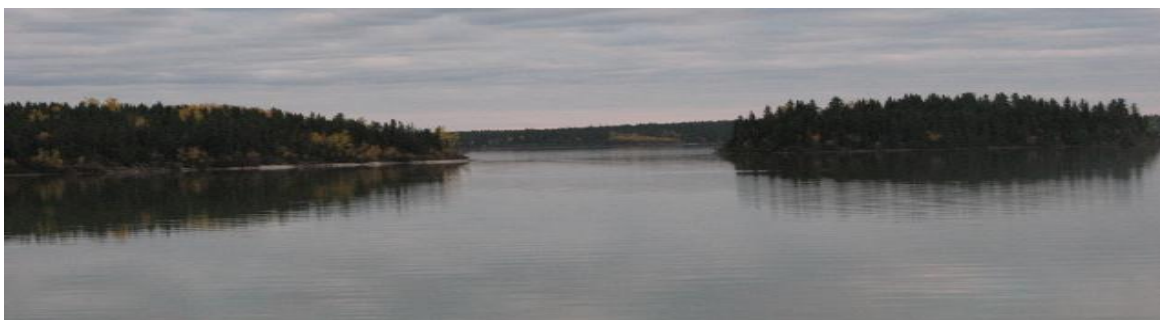
Medications

Figure 99 Medications child is using



## CHAPTER 4 – COMMUNITY SURVEY

The RHS Community Survey was conducted to gain a better understanding of the contextual, community-level factors that influence health and wellbeing of Manitoba First Nations. Thirty four (34) Manitoba First Nations participated in the community survey, with various individuals with different positions within the community completing the survey. Questions focus on: external environment; shelter and infrastructure; food; employment/economic development; education; justice, safety, and security; health services; social services; identity issues; and First Nations governance.



Taken at Nisichawayasihk Cree Nation (Nelson House)

### External Environment

Figure 100 Environmental disturbances near communities

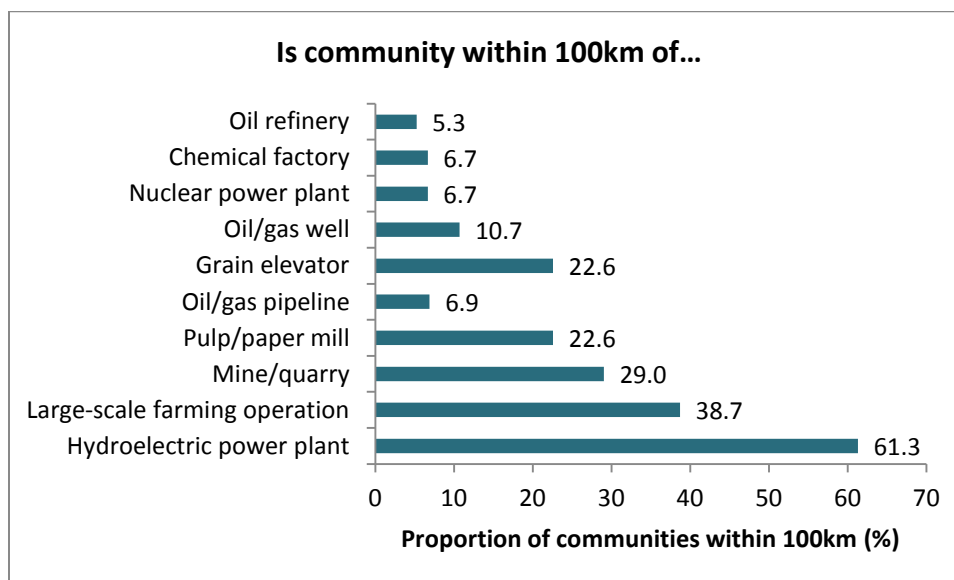
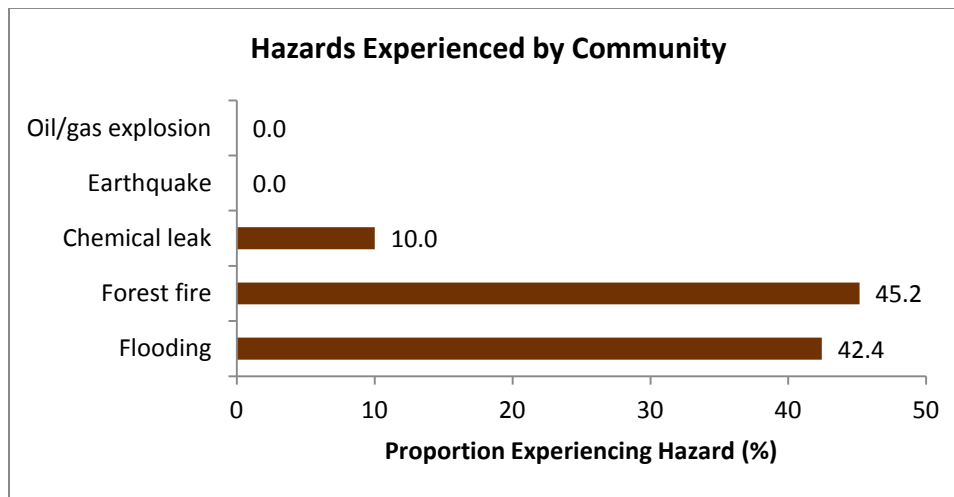


Figure 101 Environmental hazards experienced by communities



### Water

- 97.1% of communities surveyed tested for water contaminants
- 52.9% of communities surveyed have by-laws in place to protect water supplies; 20.6% stated they did not have a by-law to protect water; 26.4% did not know or did not answer the question.
- 87.1% of First Nations communities surveyed have a water treatment facility
- 55.9% of communities meet federal or provincial standards for water quality; 8.8% said they did not; 20.6% did not know; and 14.7% did not answer the question.
- 29.4% of communities were lobbying the federal government for a water treatment facility; 14.7% were not; 11.8% did not know; and 44.1% did not answer.
- 40% of communities had been under a boil water advisory in the last 5 years; of those that had been under a boil water advisory in the past 12 months, 63.6% lasted a few days while 36.4% lasted more than a month.

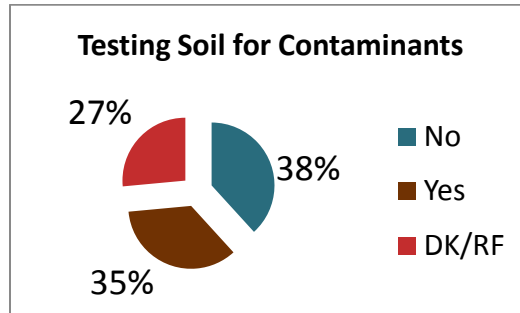
Figure 102 Agreements with local municipality concerning water



Soil

- 11.8% of communities have by-laws to protect soil; 50% do not; 32.4% did not know; and 5.9% refused the question.

Figure 103 Testing for soil contaminants



Shelter and Infrastructure

- 83.9% of communities have a community housing plan
- 63.9% receive funding for the construction of new homes
- 97% have construction crews
- 84.6% have suitable parcels of land for housing development
- 96.8% have access to technical expertise
- 77.4% have access to funds for repairs/maintenance of shelter/infrastructure
- 100% have waiting lists for housing
- 61.4% of communities have over half the population on the housing waiting list
- 93.7% of people on waiting lists will wait over 2 years to get housing

Figure 104 Proportion of community population on housing waiting list

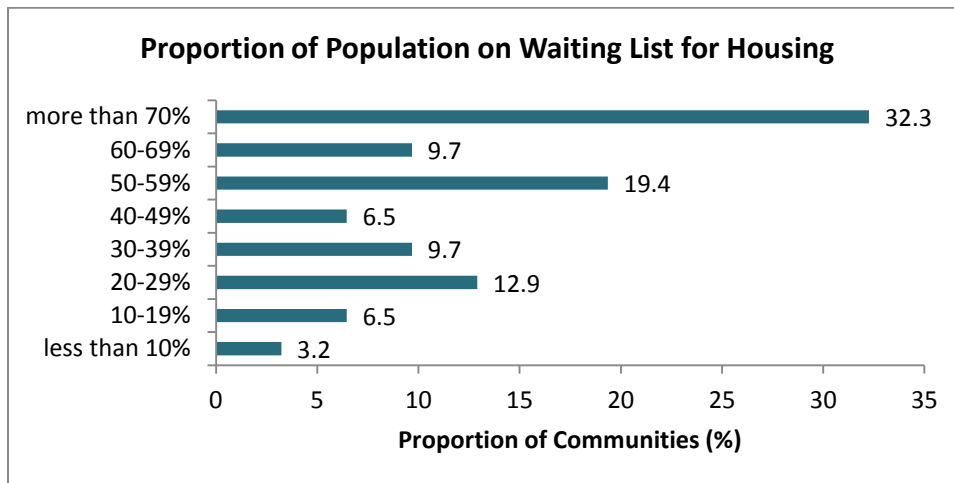
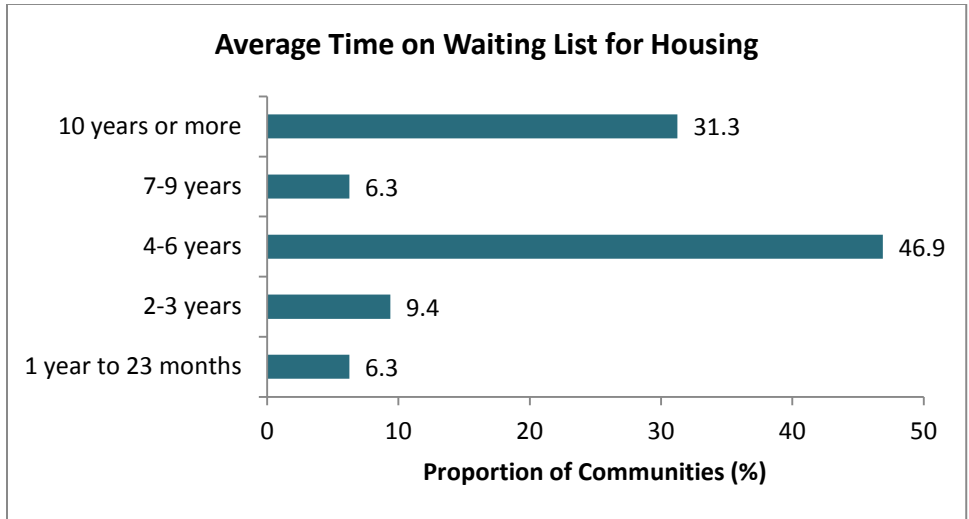
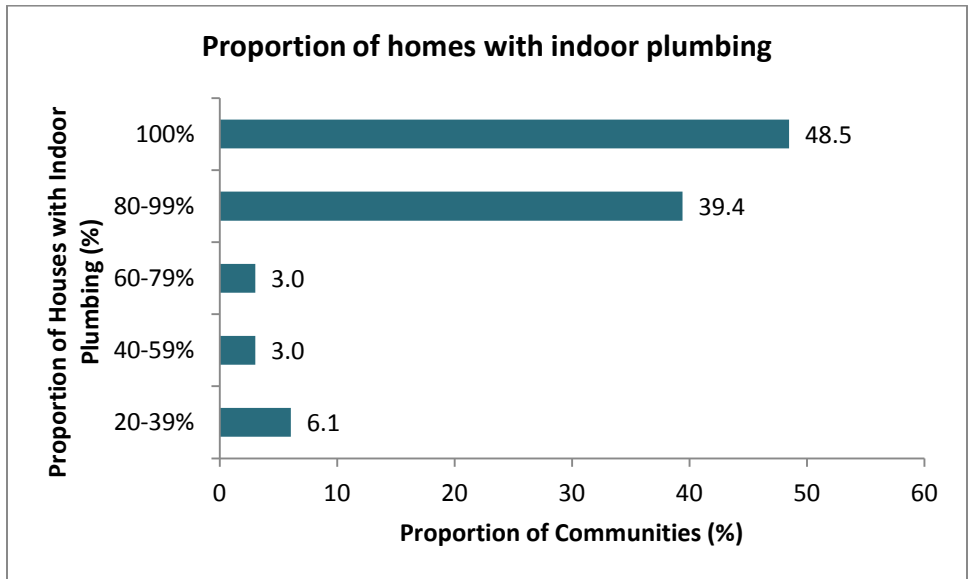


Figure 105 Average wait time for housing in communities



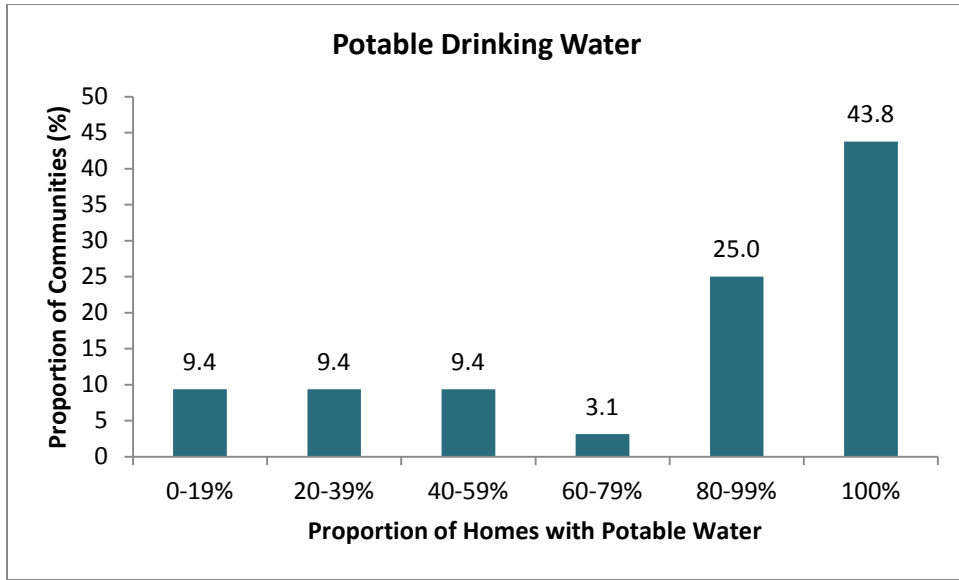
Home Water Supply

Figure 106 Proportion of homes with indoor plumbing



- 87.9% of communities have indoor plumbing in over 80% of their homes

Figure 107 Potable drinking water in homes



Energy

Figure 108 Proportion of community members with hydroelectricity

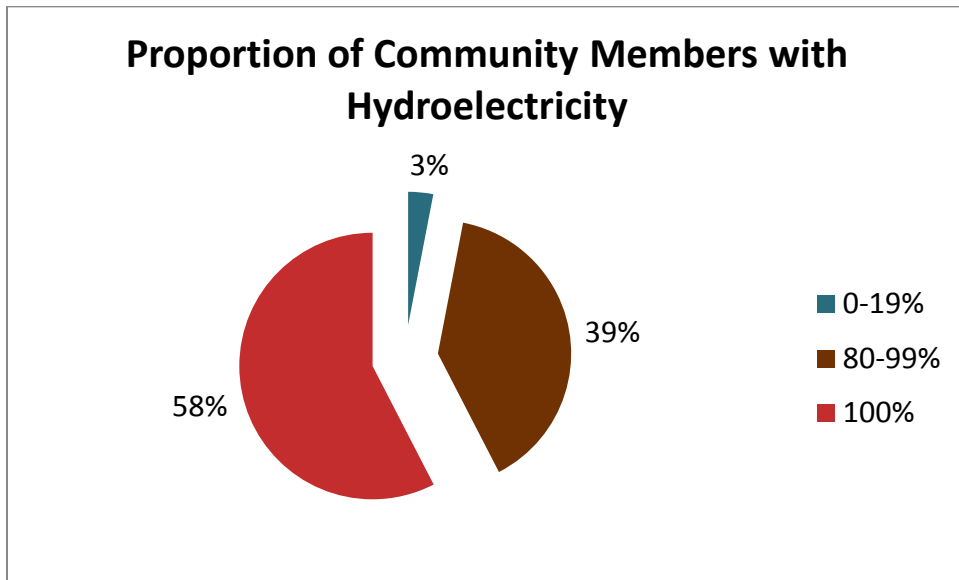
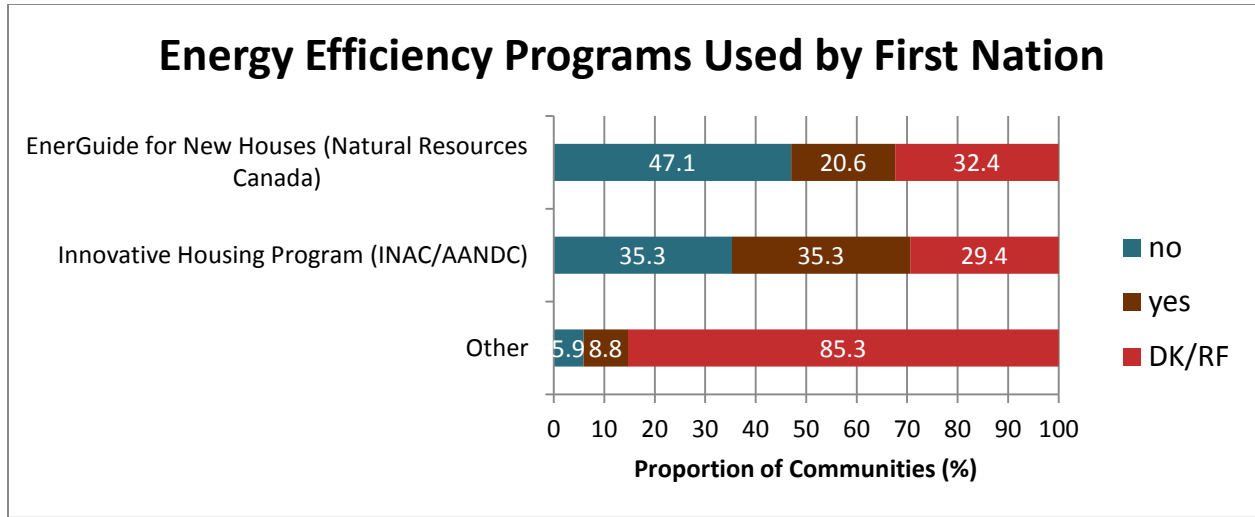


Figure 109 Energy efficiency programs used by First Nation communities



*Roads*

- 66.7% of communities have regularly maintained roads
- 71.9% of communities are accessible by all-weather road; 28.1% have winter roads only.

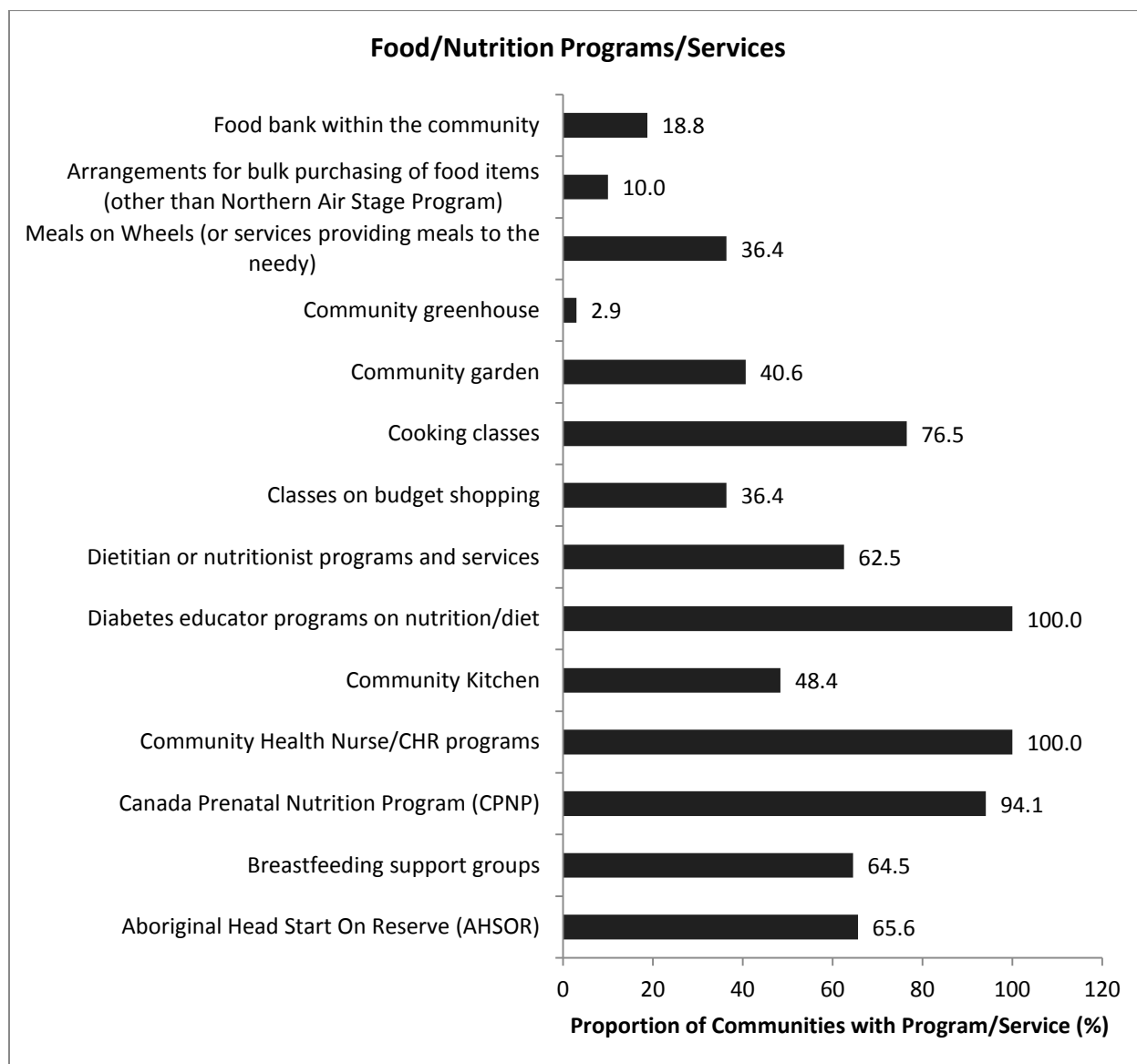


Winter road starting to thaw in Northern Manitoba coming out of Sayasi Dene First Nation



## Food

Figure 110 Food/Nutrition Programs/Services Available in Communities



- Diabetes educator, community health nurse/community health representative, and Canada Prenatal Nutrition Program (CPNP) are the three most common food/nutrition-related programs
- Community greenhouse, bulk food purchasing, and food banks inside community are the three least common food/nutrition-related programs.

Figure 111 Availability of fresh foods

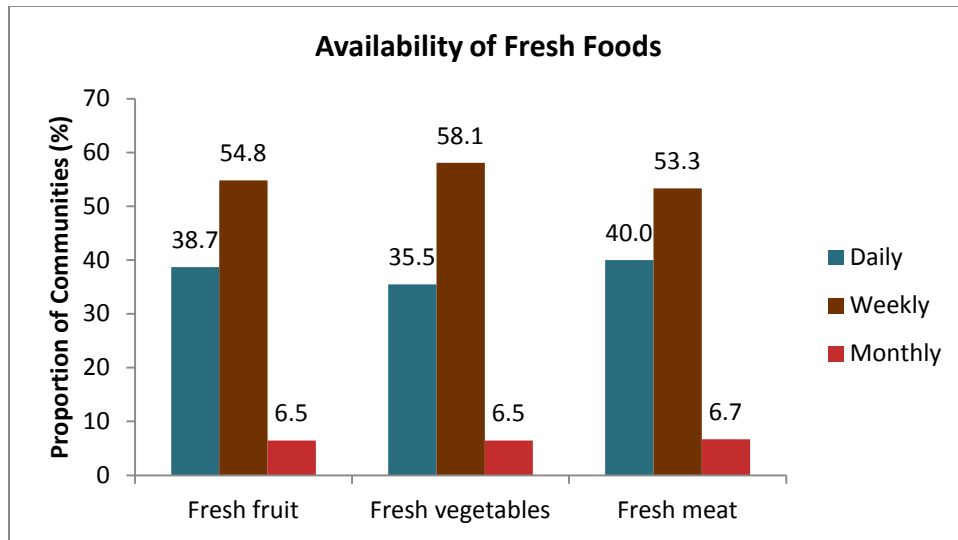
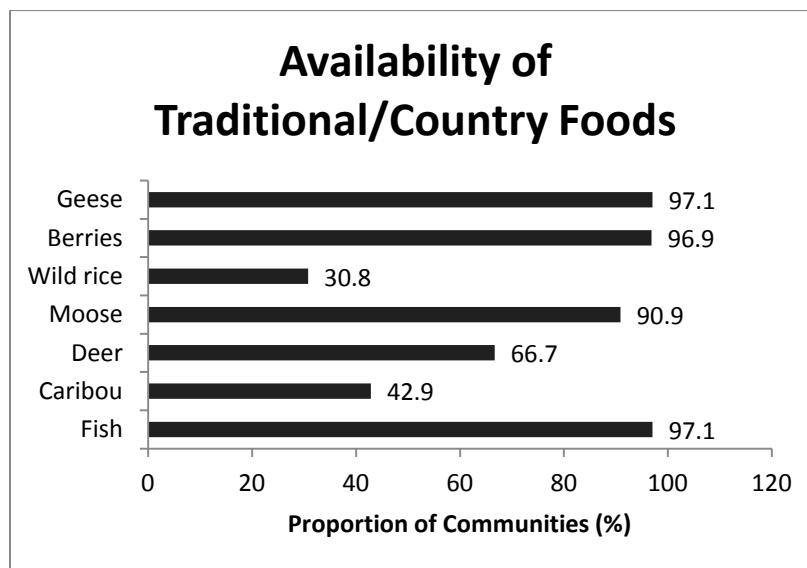


Figure 112 Availability of traditional/country foods



- 6.9% of communities have had advisories against the consumption of traditional foods (e.g., elk/deer for TB)

Employment and Economic Development

Figure 113 Jobs working for First Nation

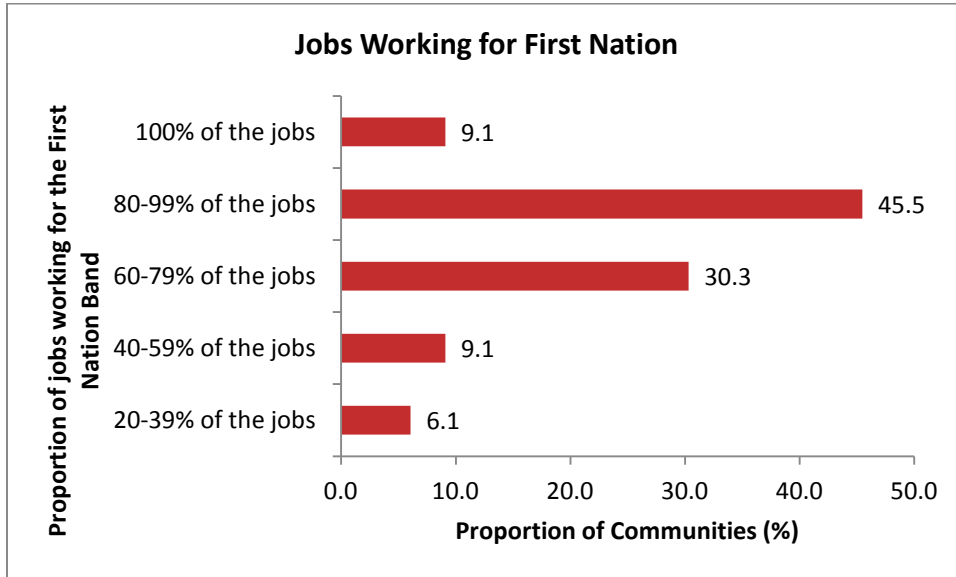


Figure 114 Proportion of community jobs filled by First Nations people

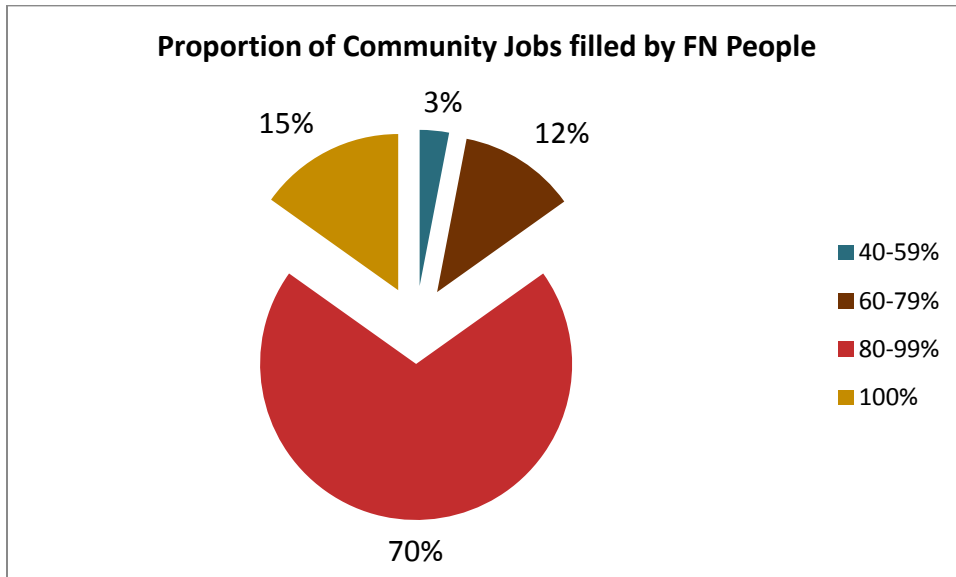


Figure 115 Proportion of university graduates from community working inside the community

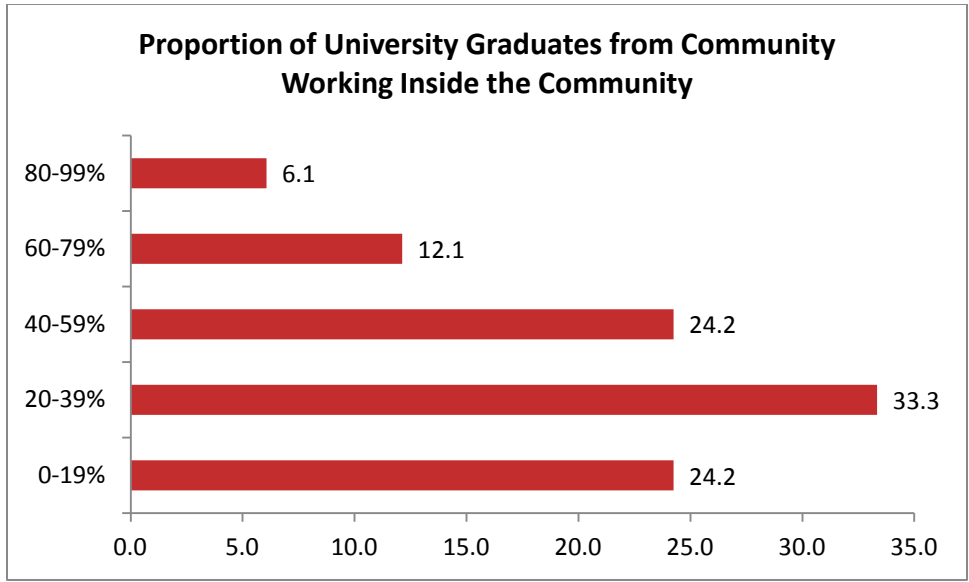


Figure 116 Proportion of university graduates from community working outside the community

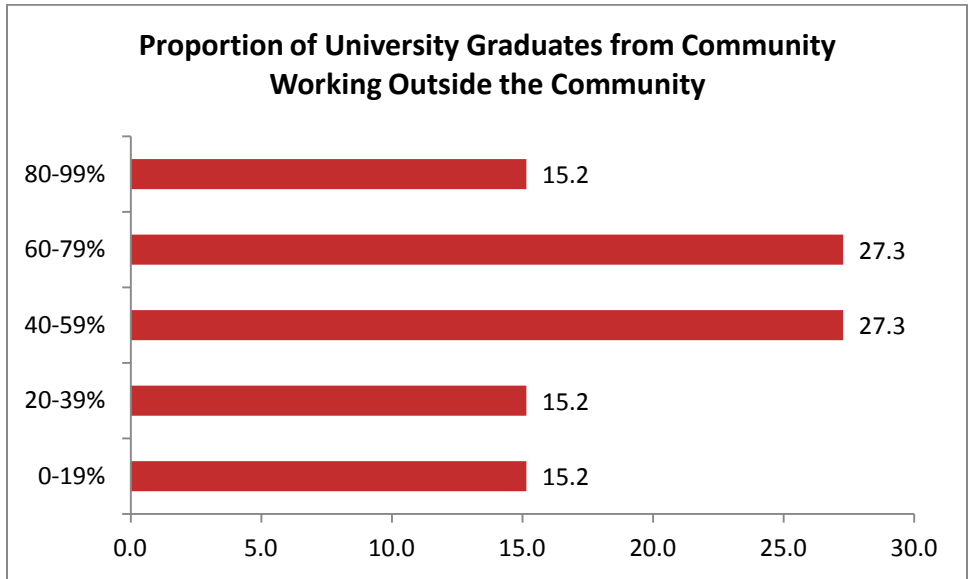
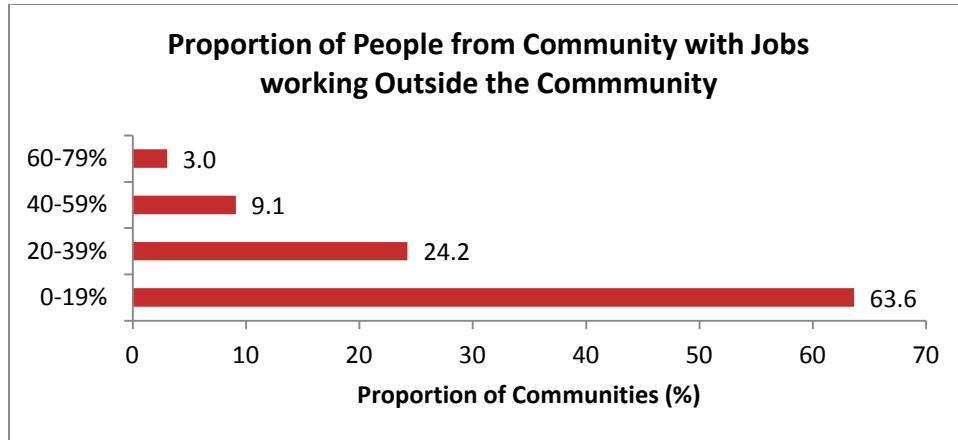


Figure 117 Proportion of people from community with jobs working outside the community



*81.8% of First Nations own at least one business*

Figure 118 Average commute (one-way) for those working outside community

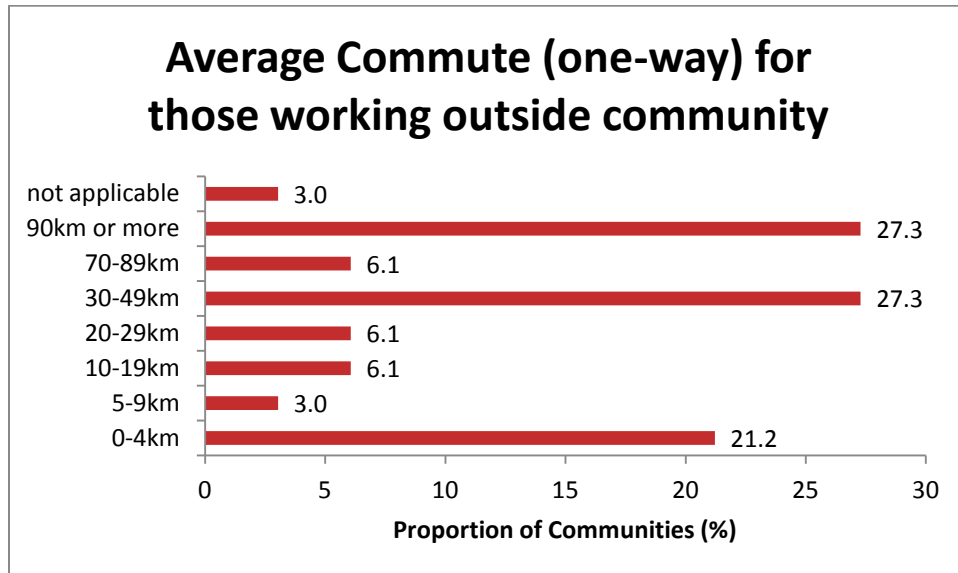


Figure 119 Proportion of businesses owned by community members or First Nation

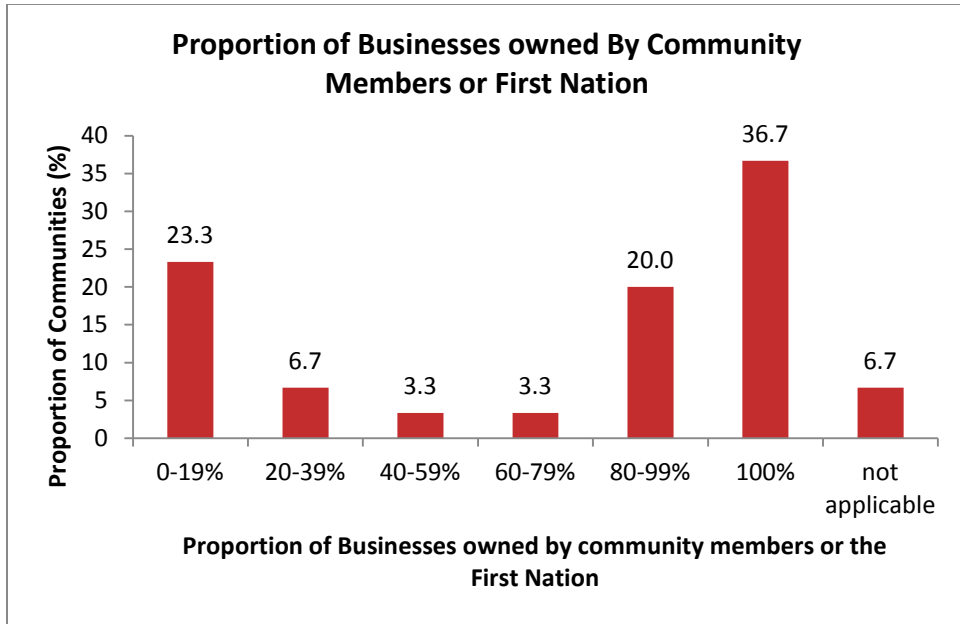
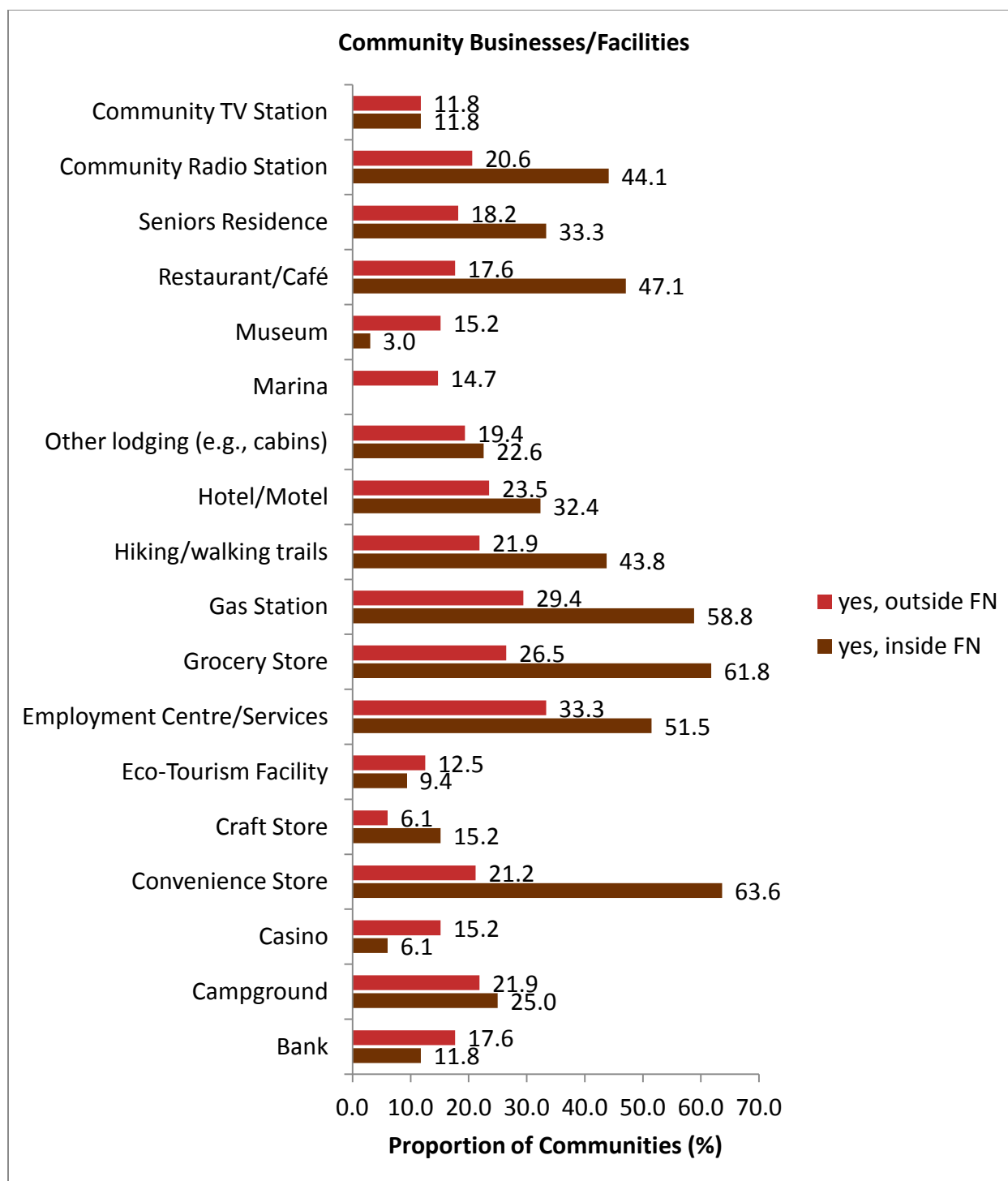


Figure 120 Community businesses/facilities



- Convenience store, grocery store, and gas station are the three most common businesses inside communities
- Employment centre, gas station, and hotel/motel are the three most common businesses outside communities

Education

Schools

Figure 121 Schools

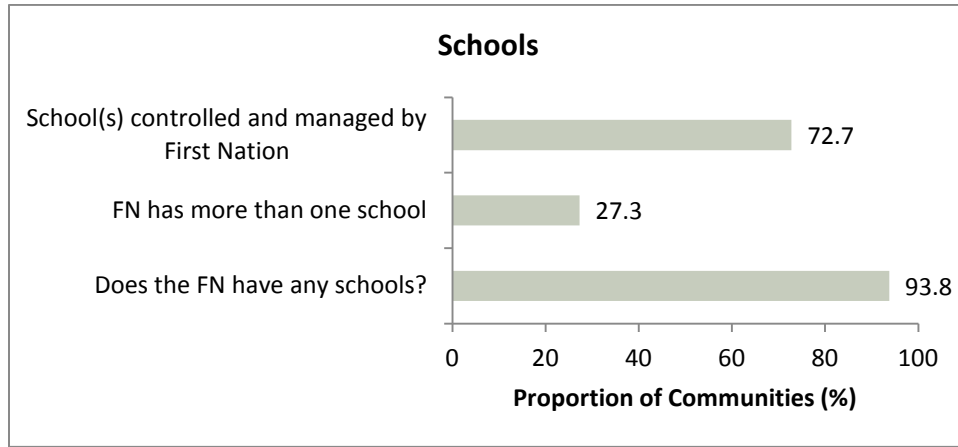


Figure 122 Highest grade offered by community school(s)

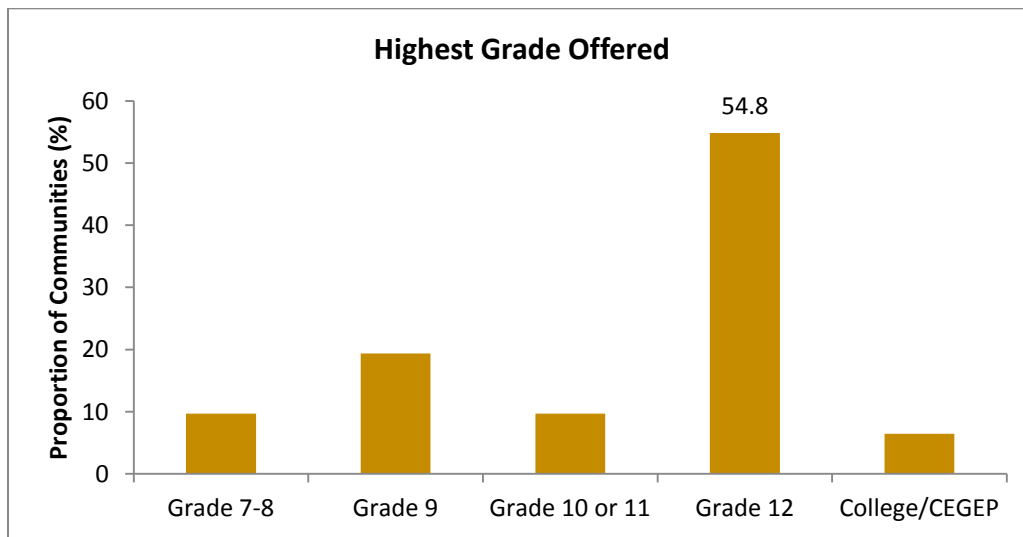




Figure 123 Proportion of children enrolled in community school(s)

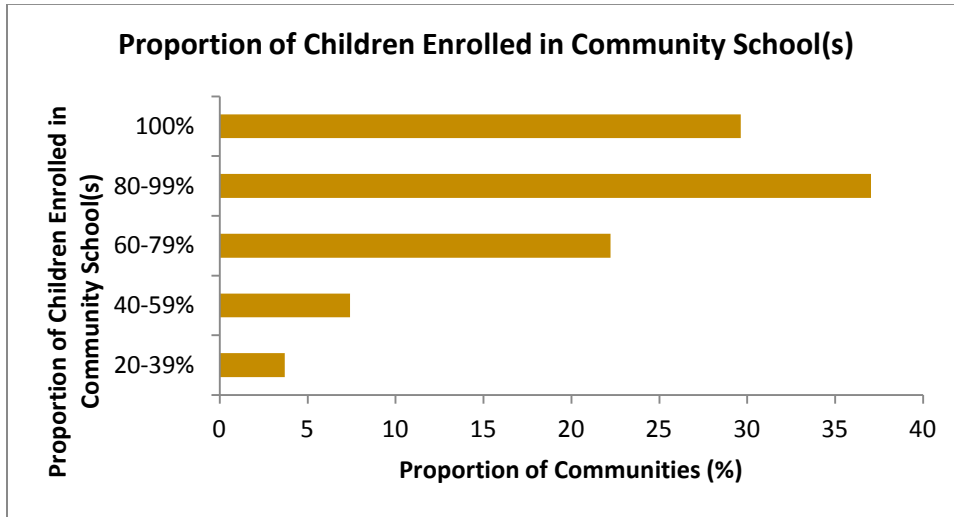
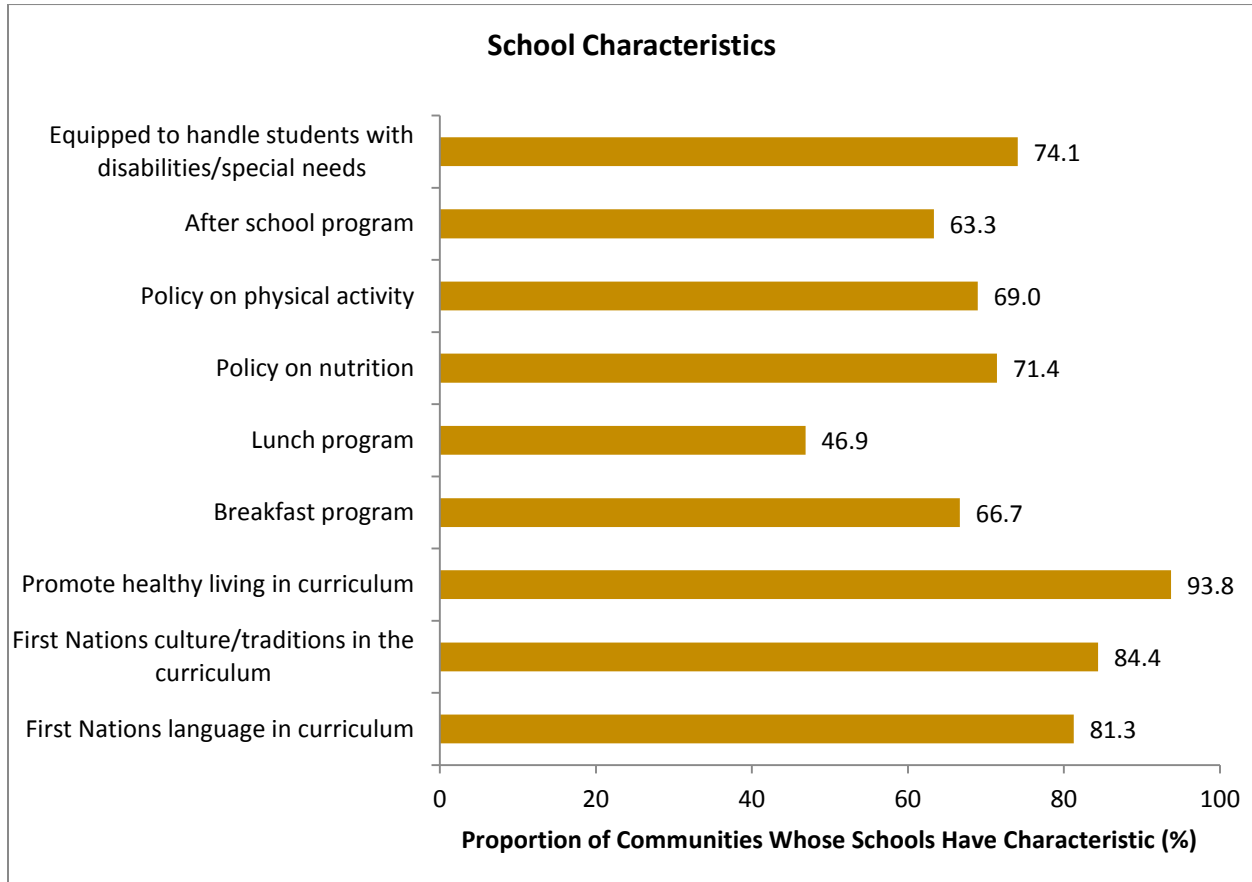
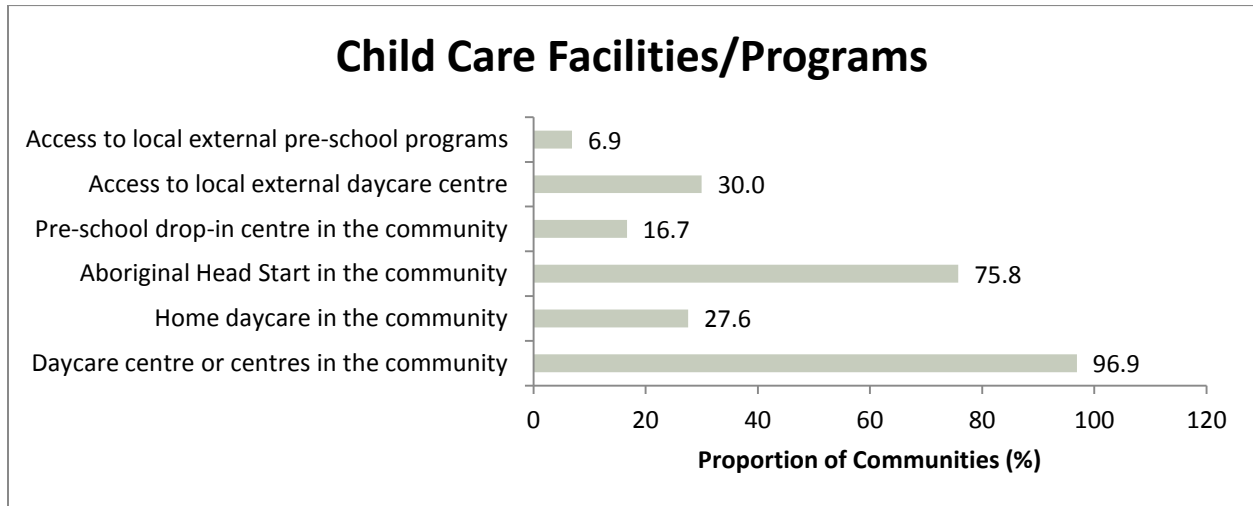


Figure 124 School characteristics



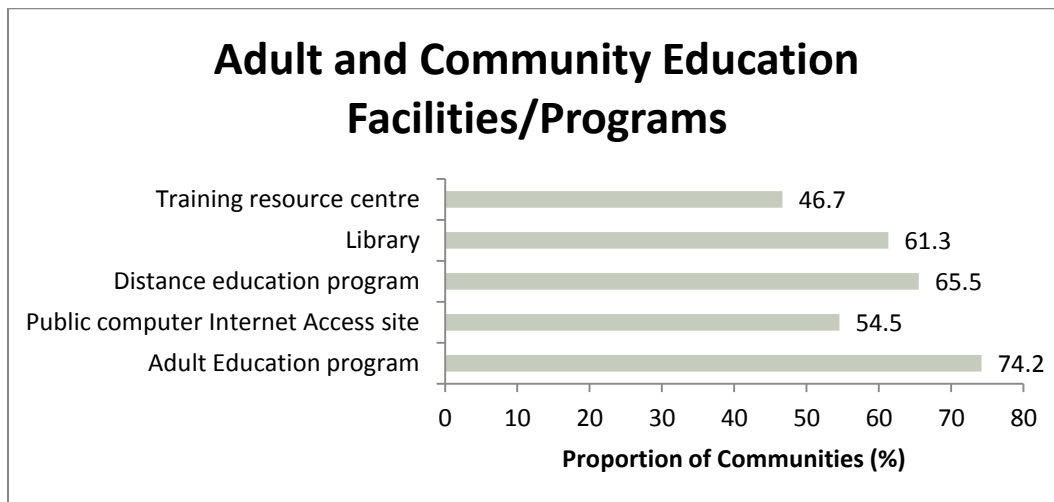
Child Care

Figure 125 Child care facilities/programs



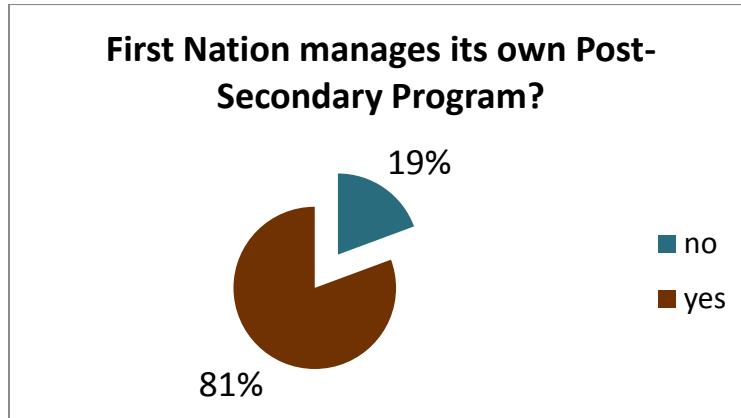
Adult and Community Education

Figure 126 Adults and community education facilities/programs



The Pimicikamak Regional Centre is located in the northern community of Cross Lake, Manitoba

Figure 127 First Nation management of Post-Secondary Support Program



Justice, Safety, and Security

Police Services

Figure 128 Primary police service provider

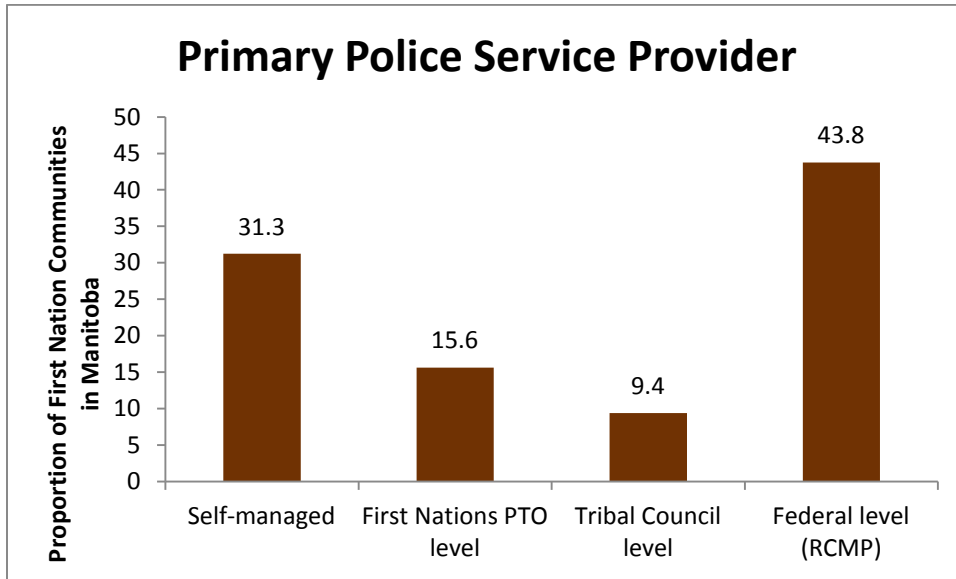


Figure 129 Type of police force

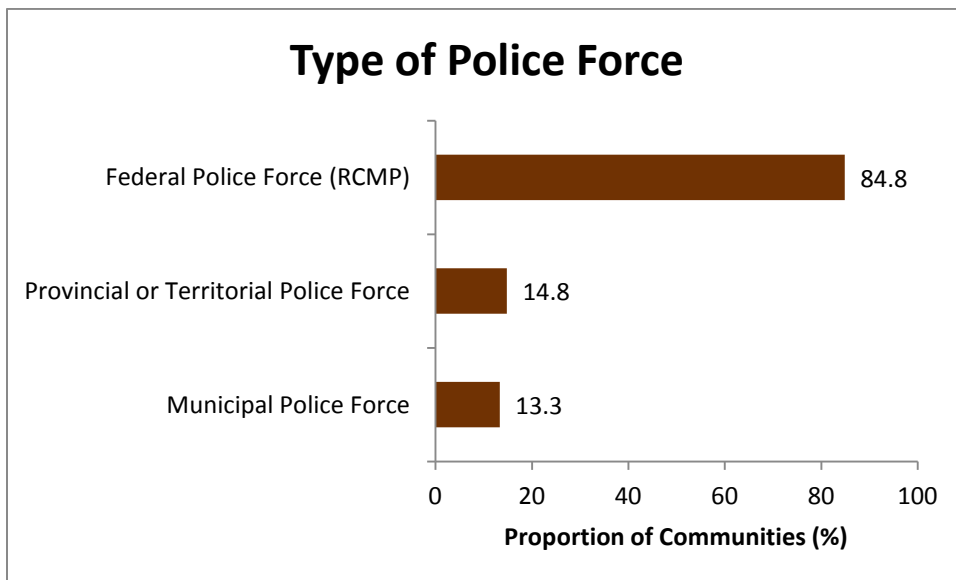
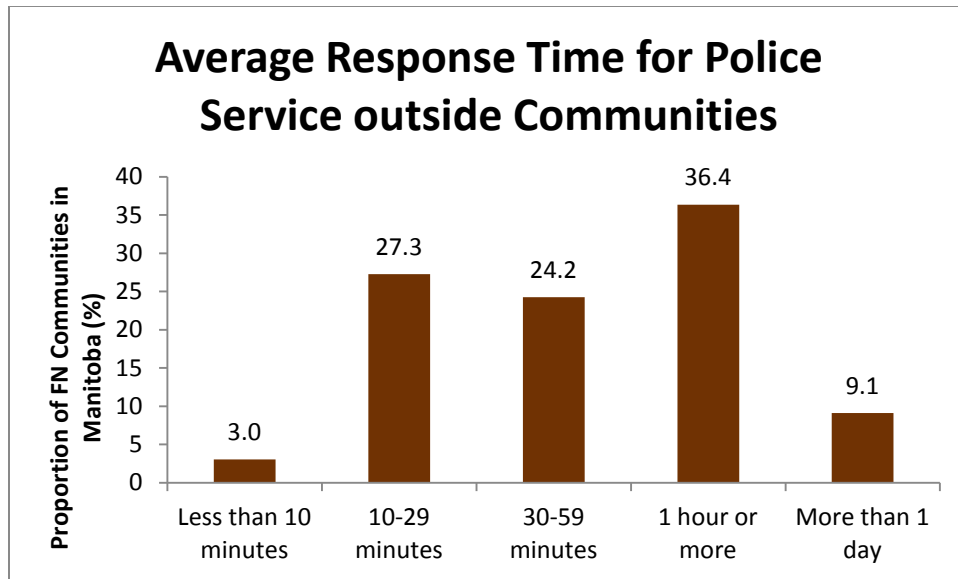


Figure 130 Average response time for police service outside communities



An unidentified man is seen handcuffed and chained in this undated handout photo taken inside a hockey arena dressing room in Lac Brochet, Police resources are so scarce on some reserves, people arrested for assault or liquor offences are being held in places such as this arena instead of an RCMP holding cell (The Canadian Press/ho-Manitoba Keewatinowi Okimakanak Inc.)

Figure 131 Average response time for police services inside communities

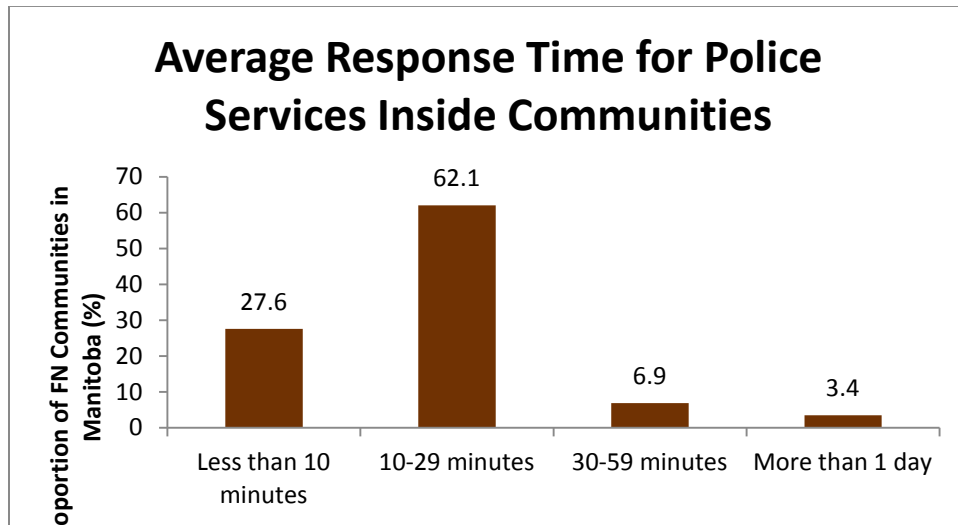


Figure 132 Emergency preparedness

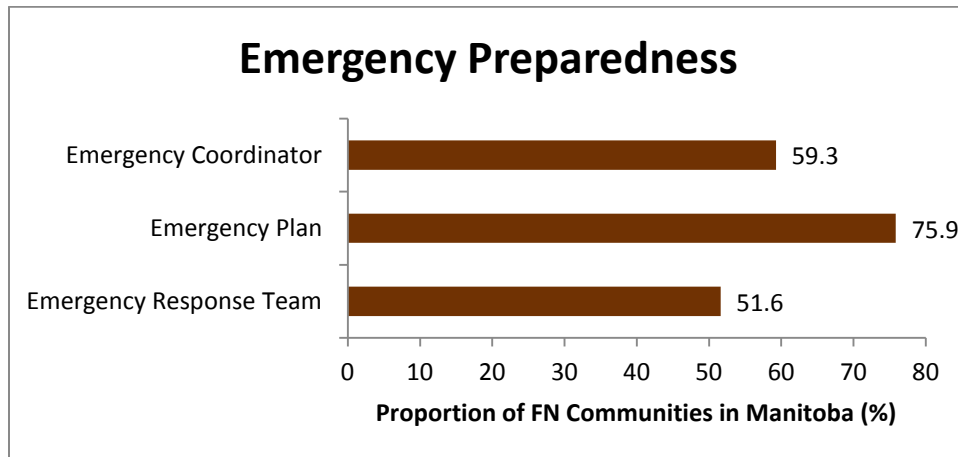


Figure 133 Collective police authority?

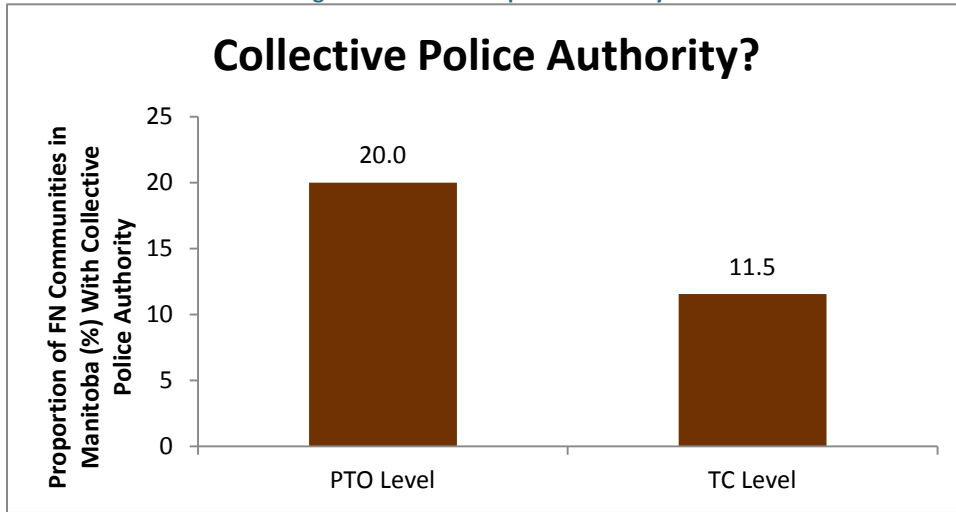
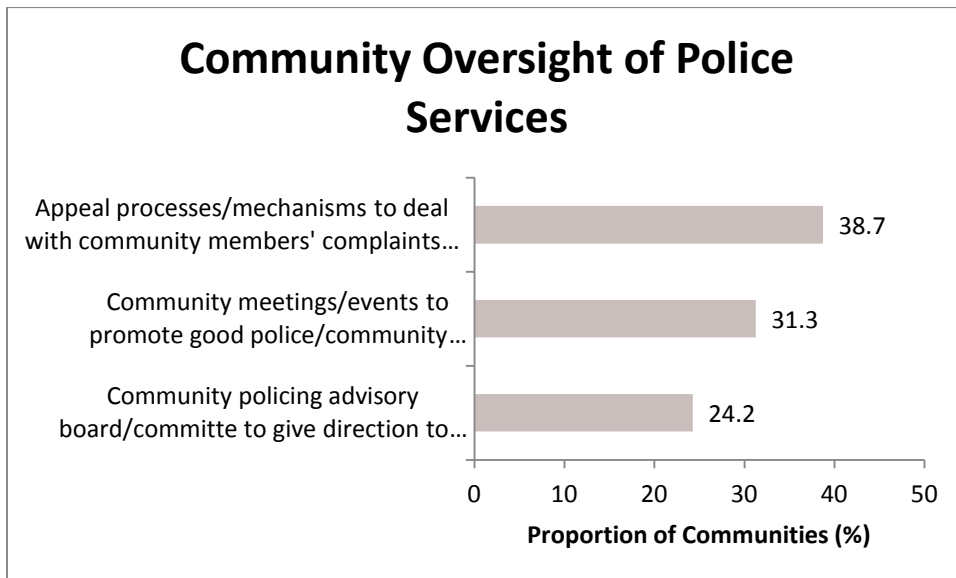
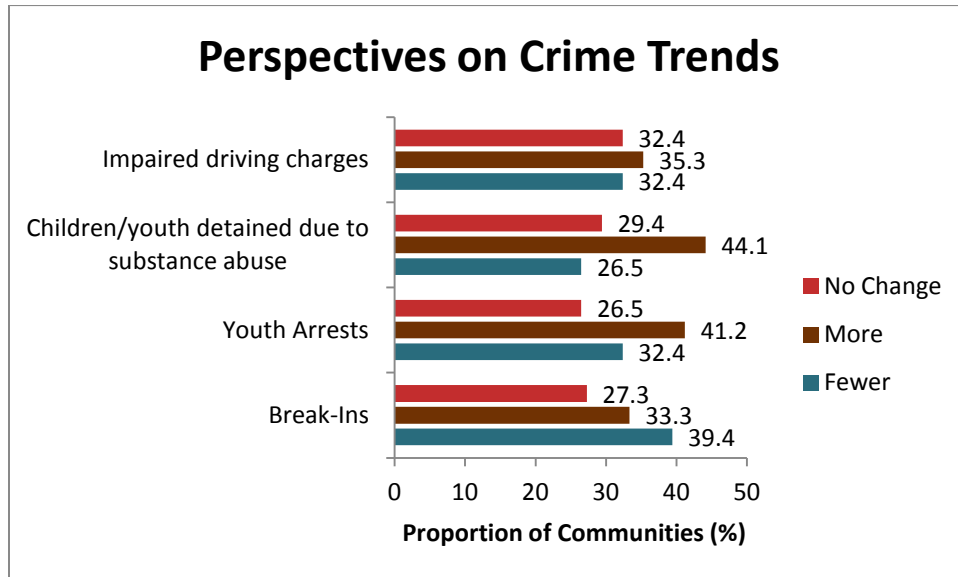


Figure 134 Community oversight of police services



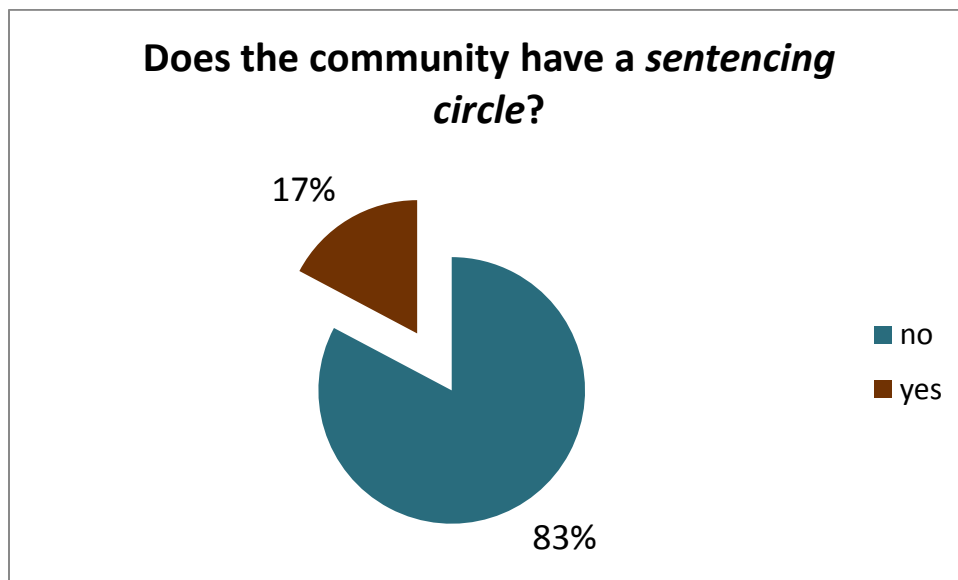
Crime Rate

Figure 135 Perspectives on crime trends



Restorative Justice

Figure 136 Sentencing circles





Fire and Paramedic Services

Figure 137 Fire/paramedic services

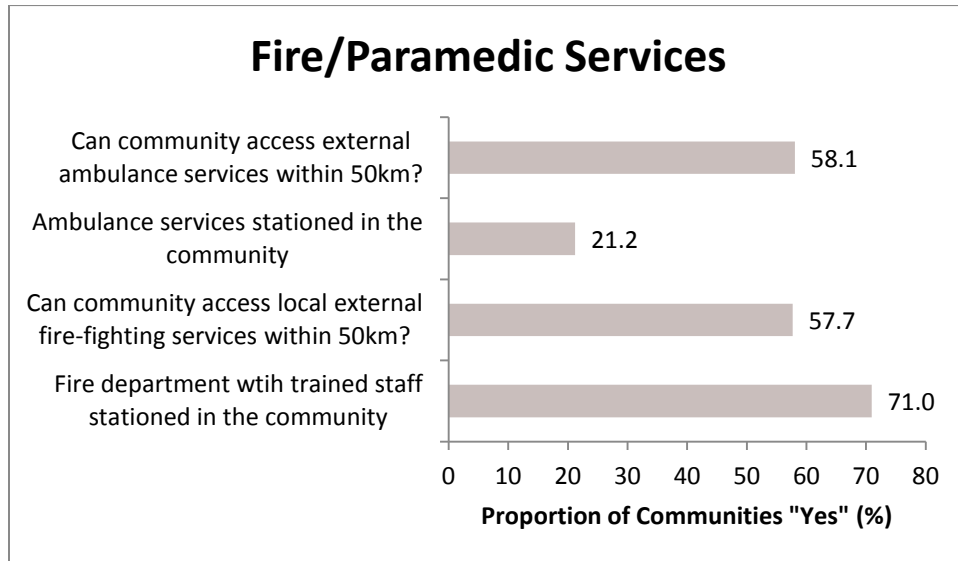


Figure 138 Average external ambulance services response time

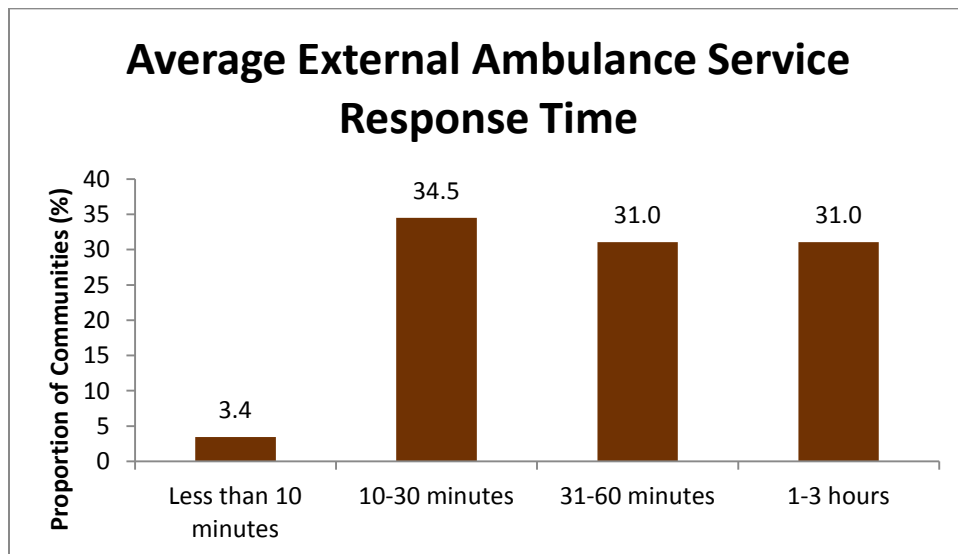
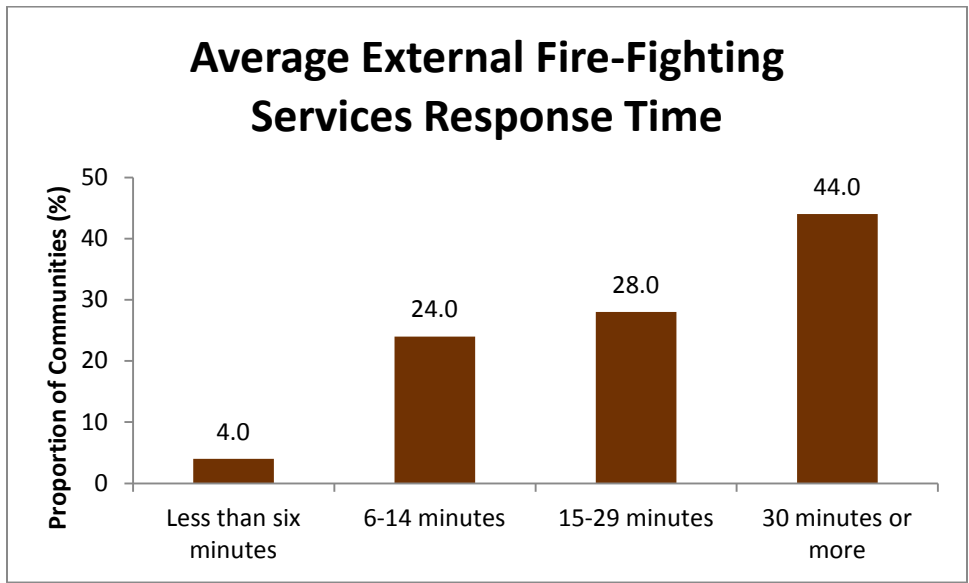


Figure 139 Average -fighting services response time



A house on God's Lake Narrows First Nation was reduced to rubble after a fire (CBC)

Figure 140 Health professionals

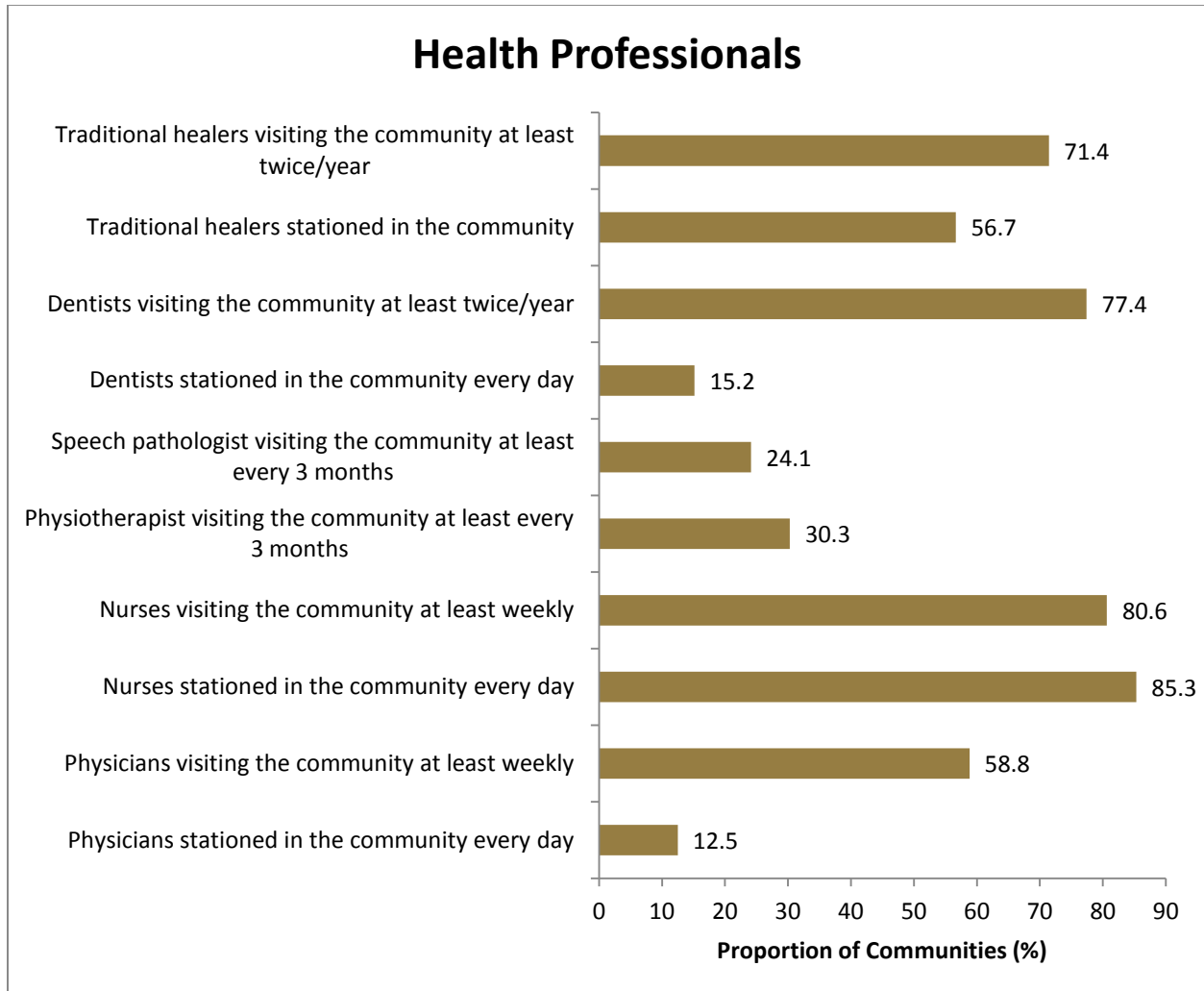


Figure 141 Health facilities

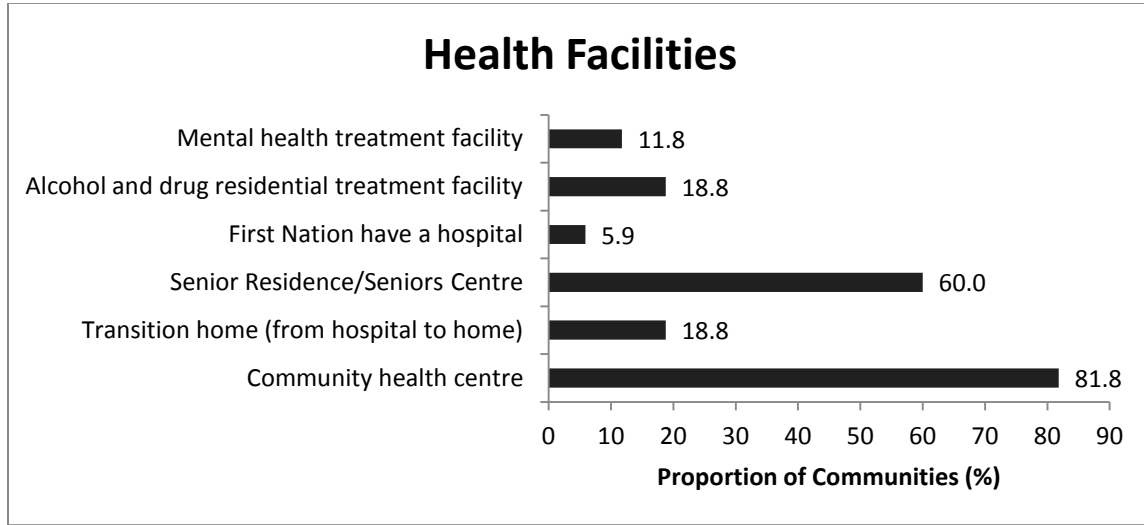


Figure 142 Nearest hospital

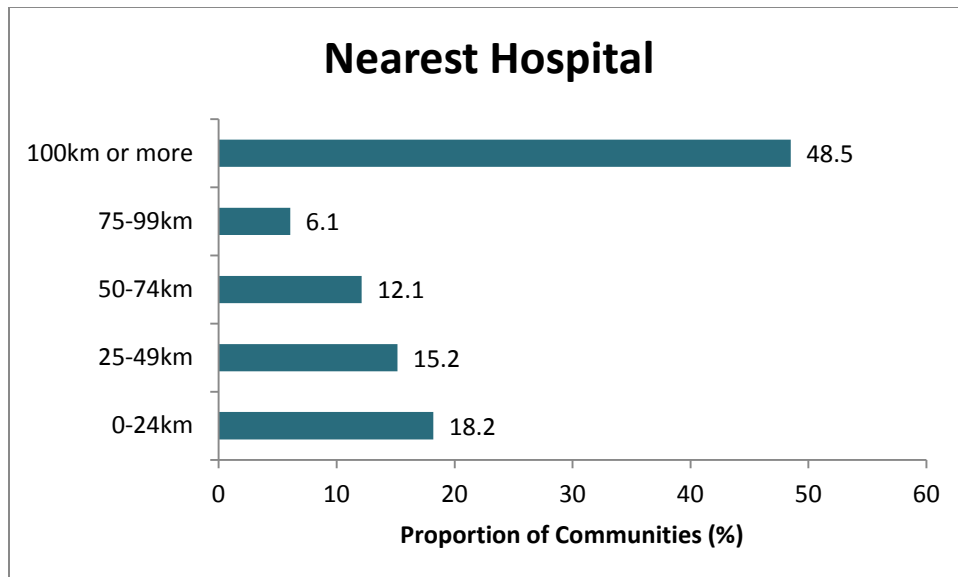


Figure 143 Hospital accessibility

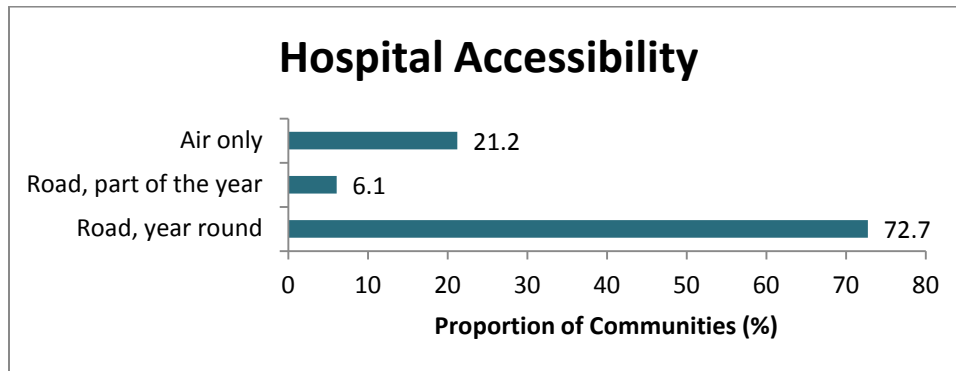


Figure 144 Proportion of health professionals that are First Nations people

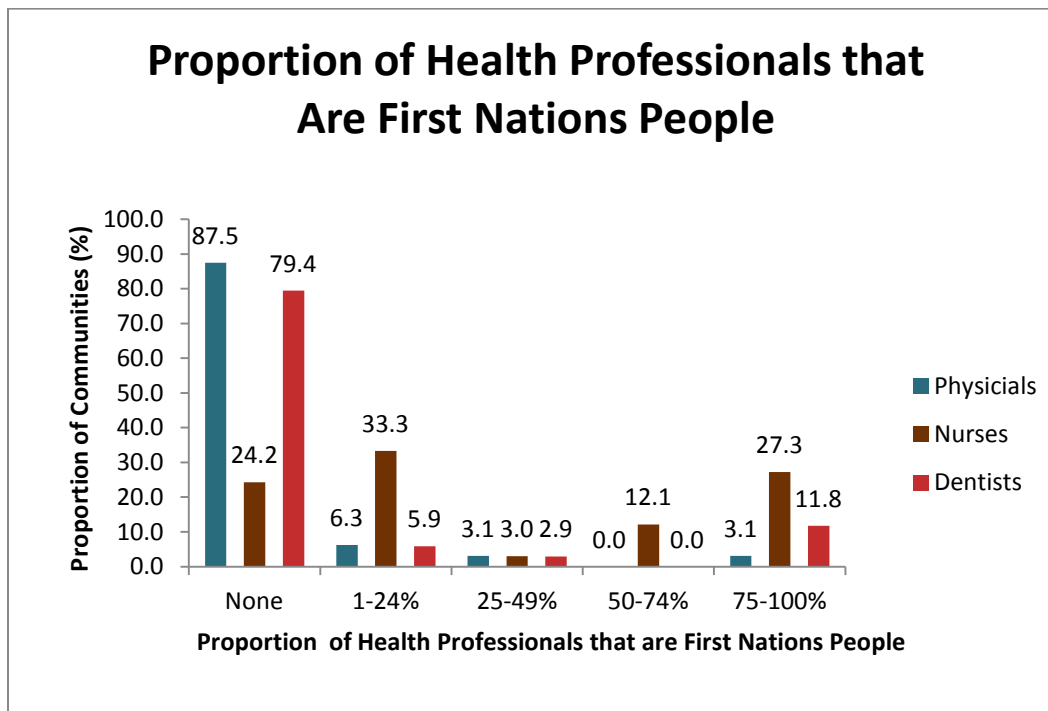


Figure 145 Health programs in communities

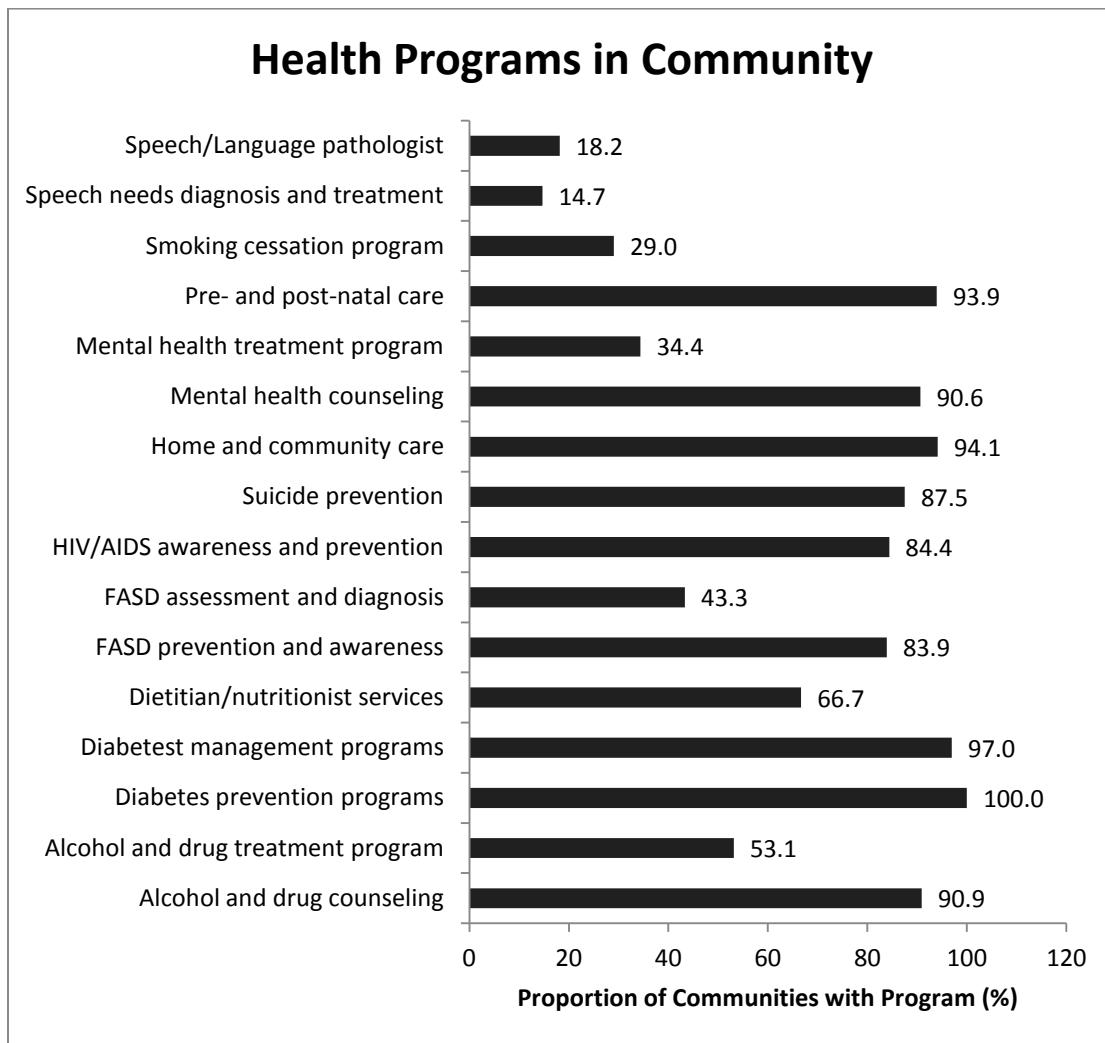
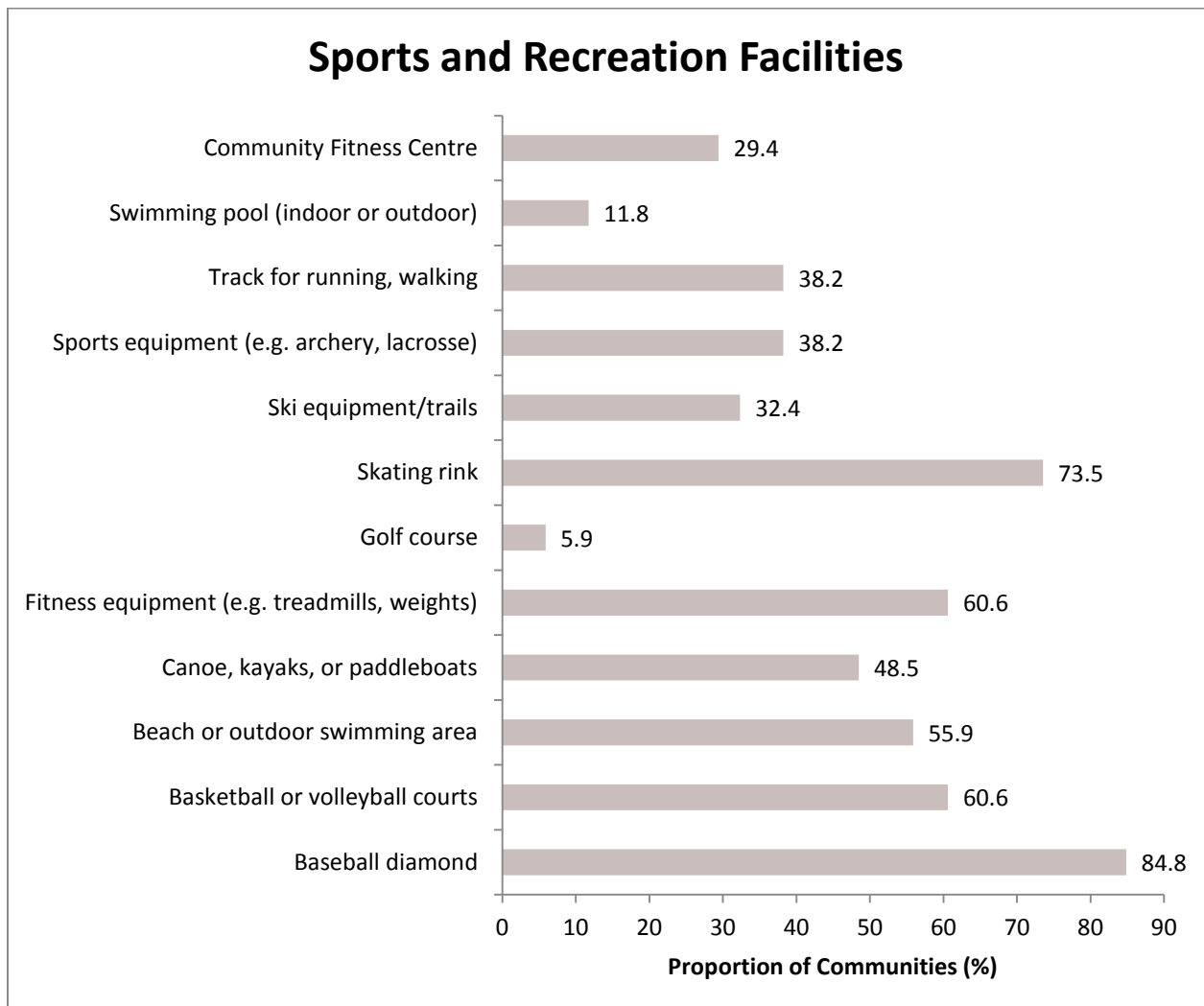


Figure 146 Sports and recreation facilities



## Social Services

This section covers social assistance, youth programs, and mental health workers.

- 93.8% of First Nations communities administer their own social assistance programs
- 28% of First Nations communities have developed their own policy related to income support

Figure 147 Average time people receive income assistance

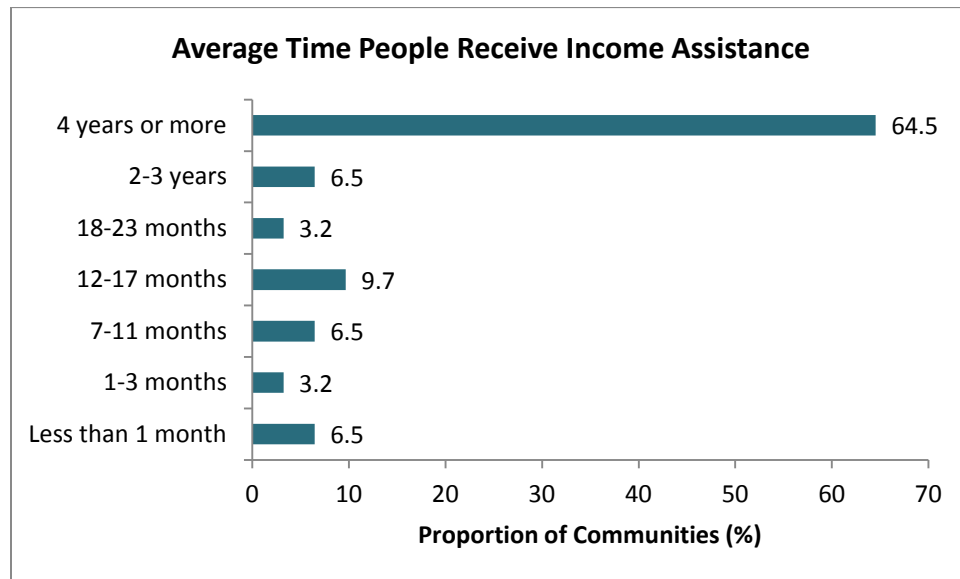




Figure 148 Youth programs

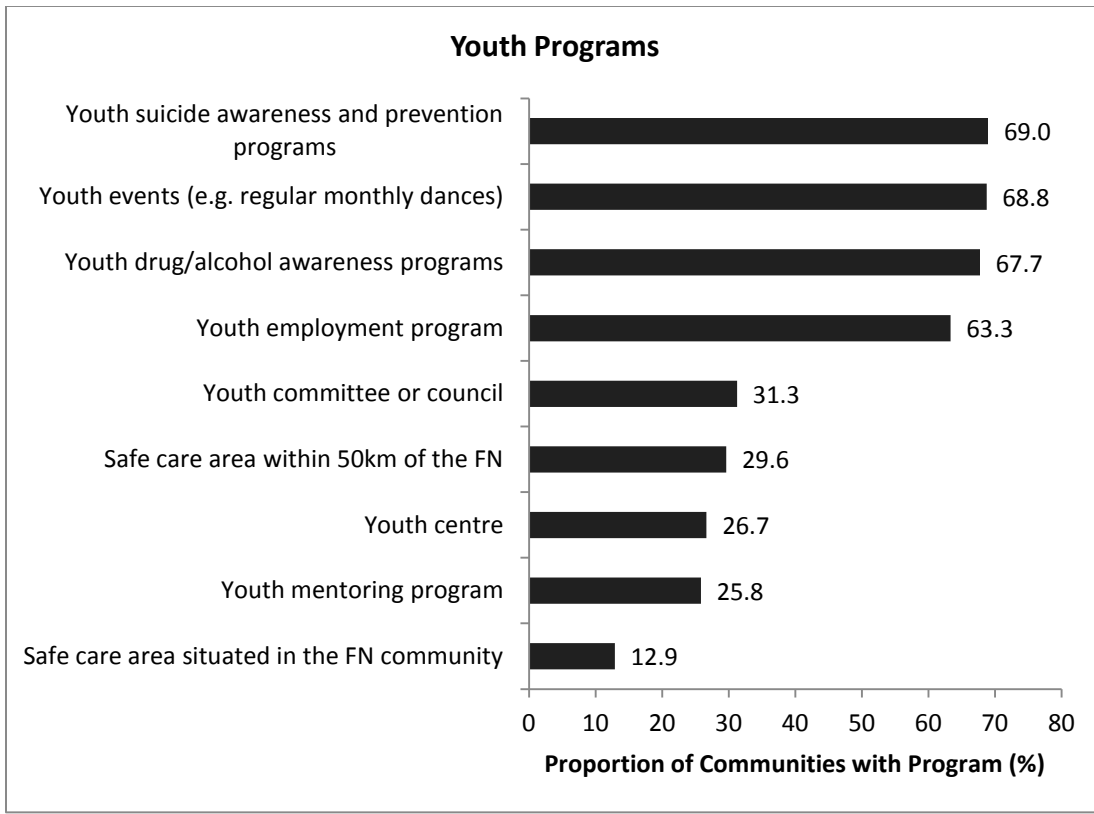
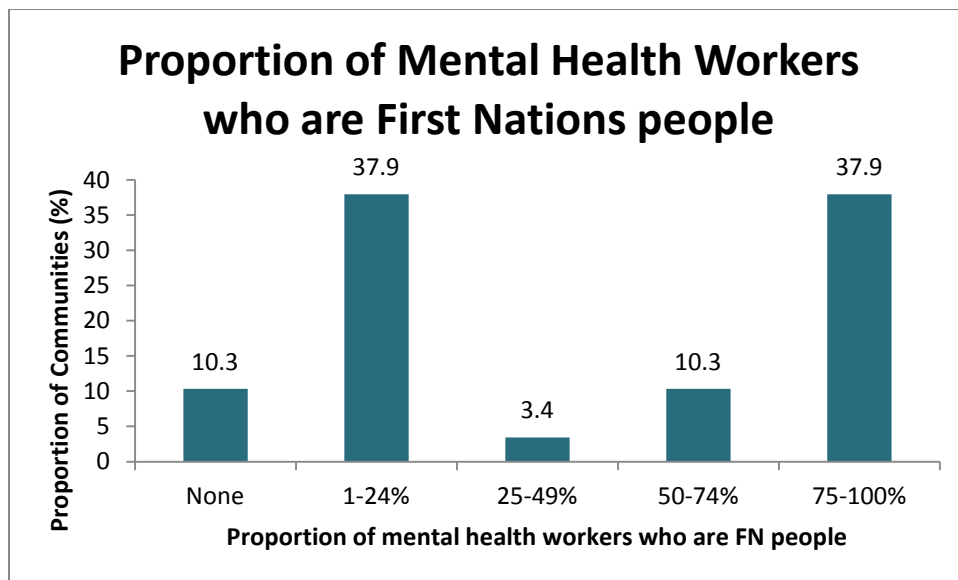


Figure 149 Proportion of mental health workers who are First Nations people



### Identity Issues

This section reviews language support, cultural activities, children and youth removed by Child and Family Services, children designated 6(2) under *Indian Act*, and membership management.

#### Language and Culture

Figure 150 Language support in communities

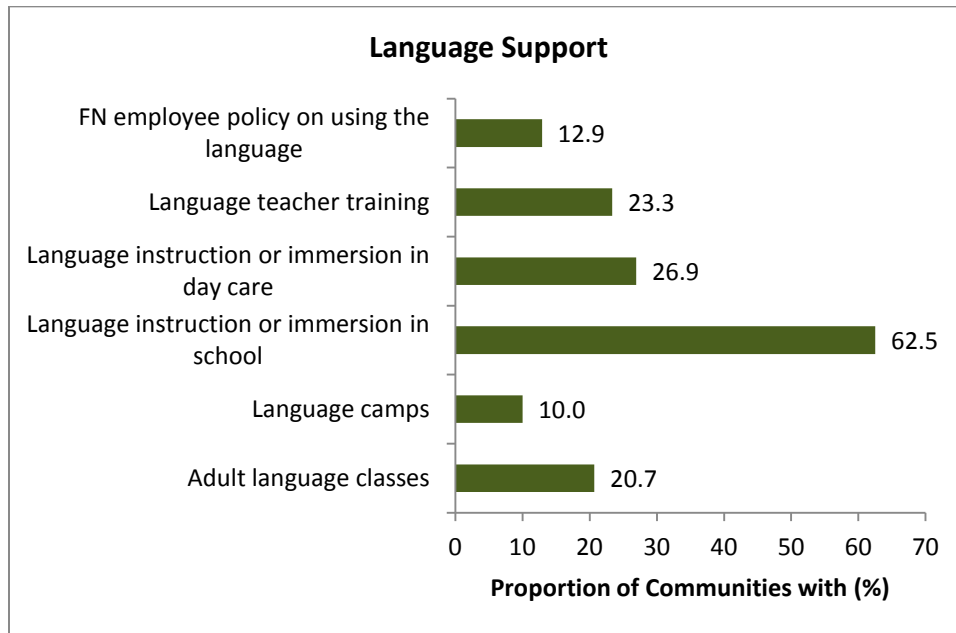


Figure 151 Cultural activities



*Children/Youth Removed by Child and Family Services*

- 48% of First Nations communities are involved in the repatriation of children and youth adopted-out/removed from the community by Child and Family Services

Figure 152 Number of children/youth repatriated in last 5 years

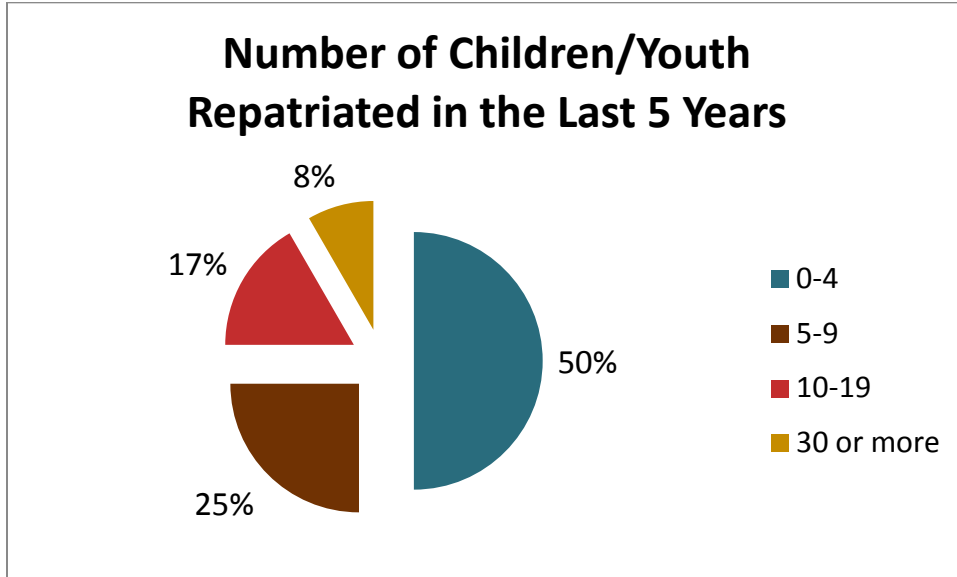
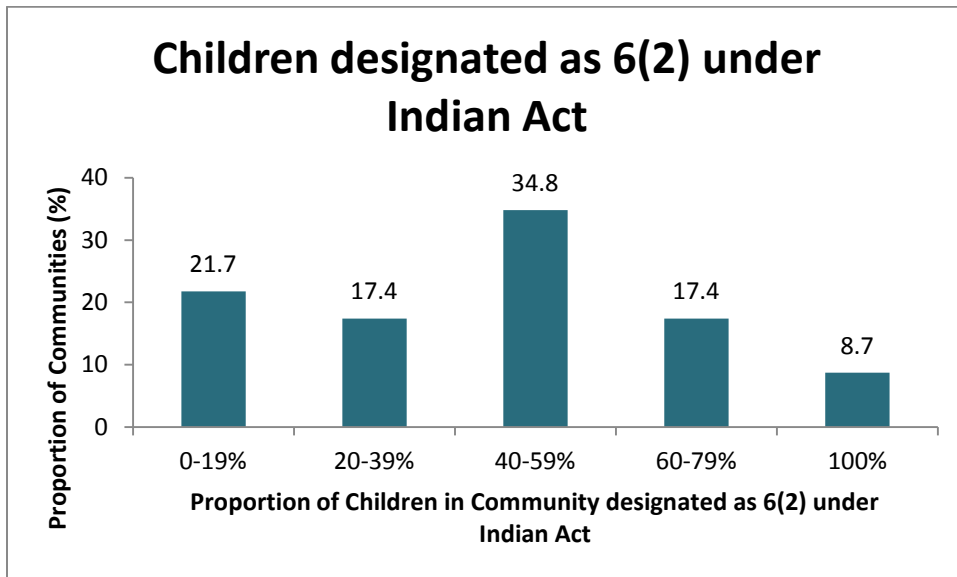
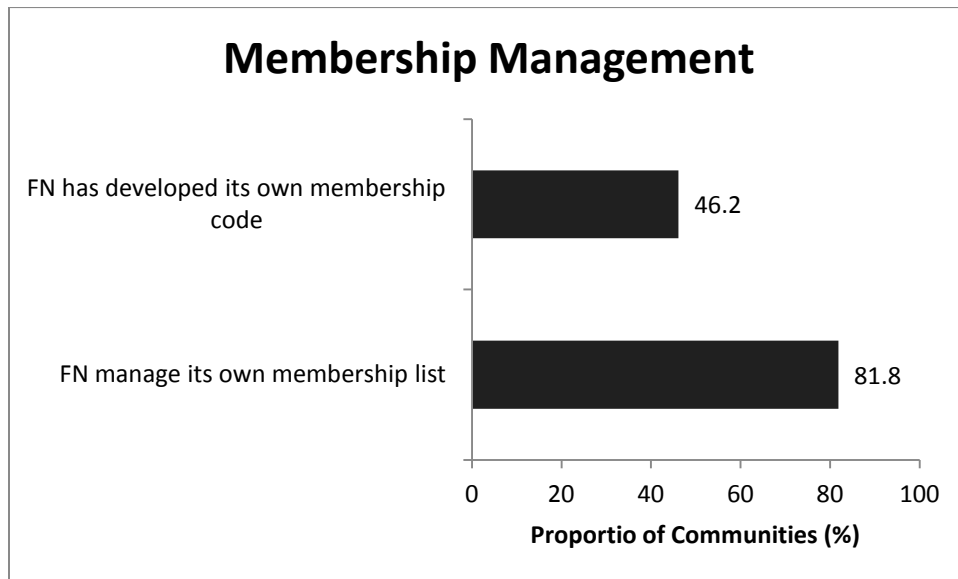


Figure 153 Children designated as 6(2) under Indian Act



Membership Management

Figure 154 Membership management



First Nations Governance

Funding and Management of Services

Figure 155 Type of funding agreement in place

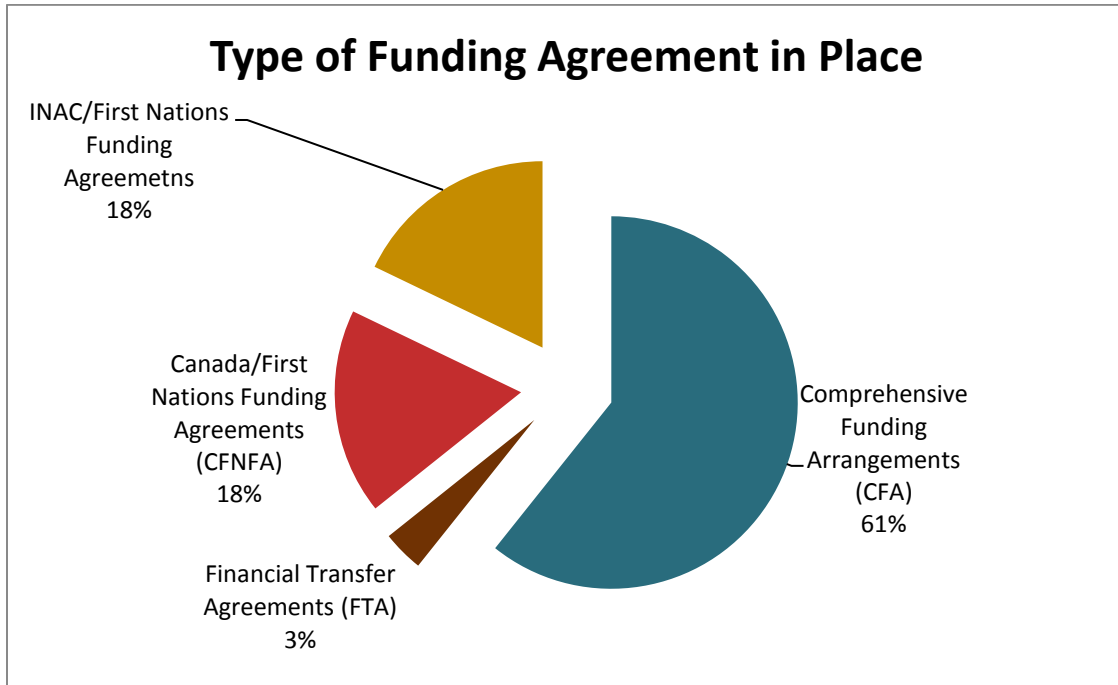


Figure 156 First Nation manages its health centre/nursing station

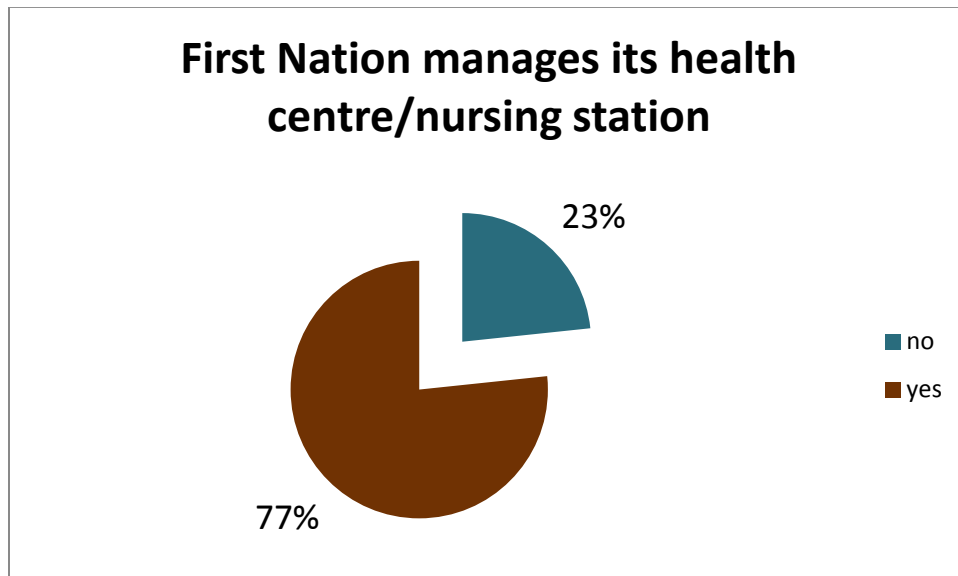


Figure 157 Health care funding agreement

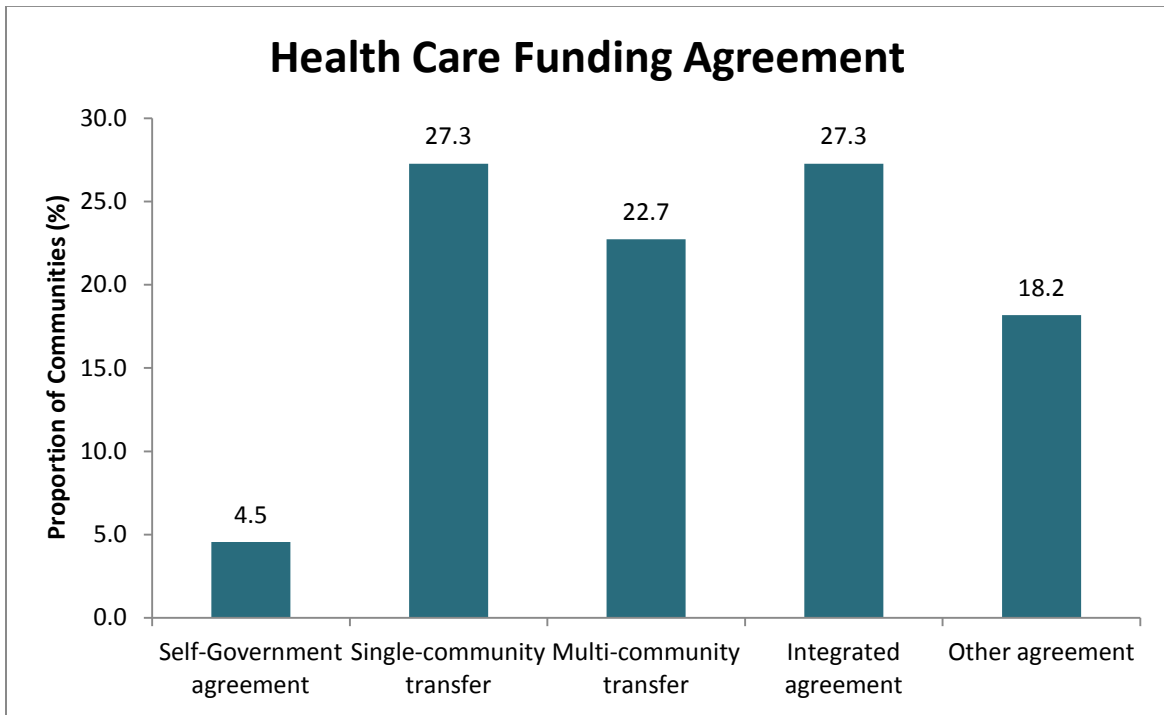
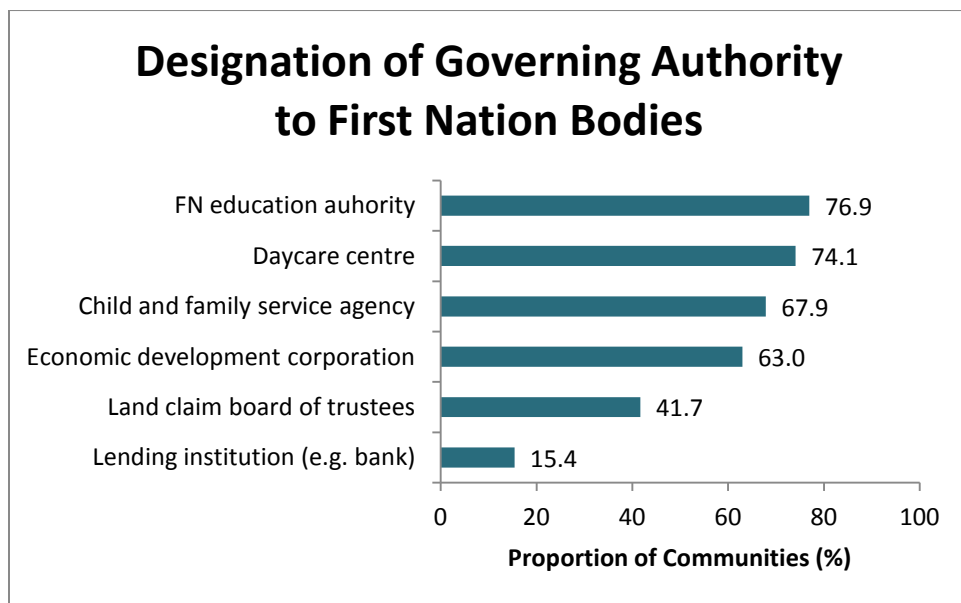


Figure 158 Designation of governing authority to First Nation bodies



*Chief and Council*

- 74.1% of First Nation councils provide members with regular updates on Chief and Council activity.

Figure 159 Frequency of Chief and Council Updates to Community Members

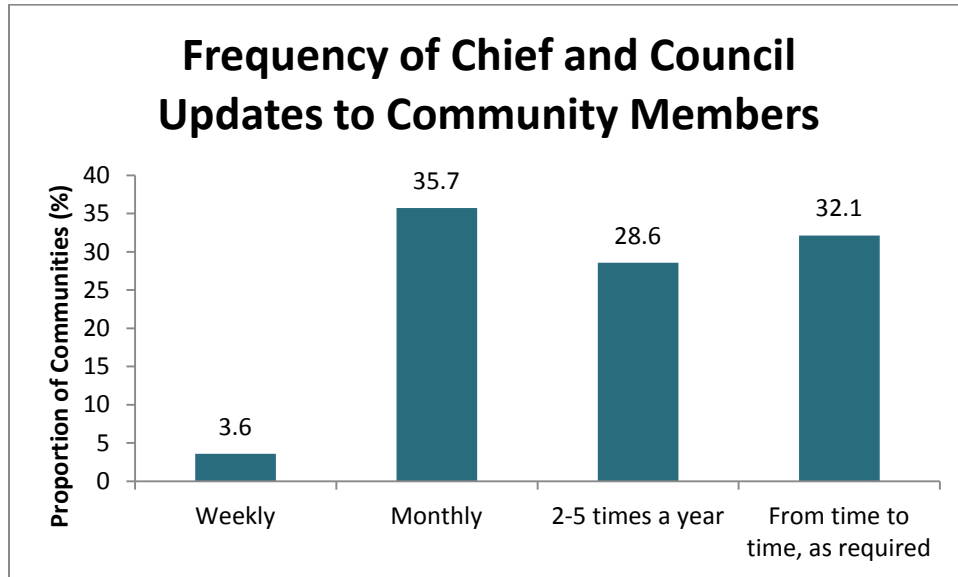
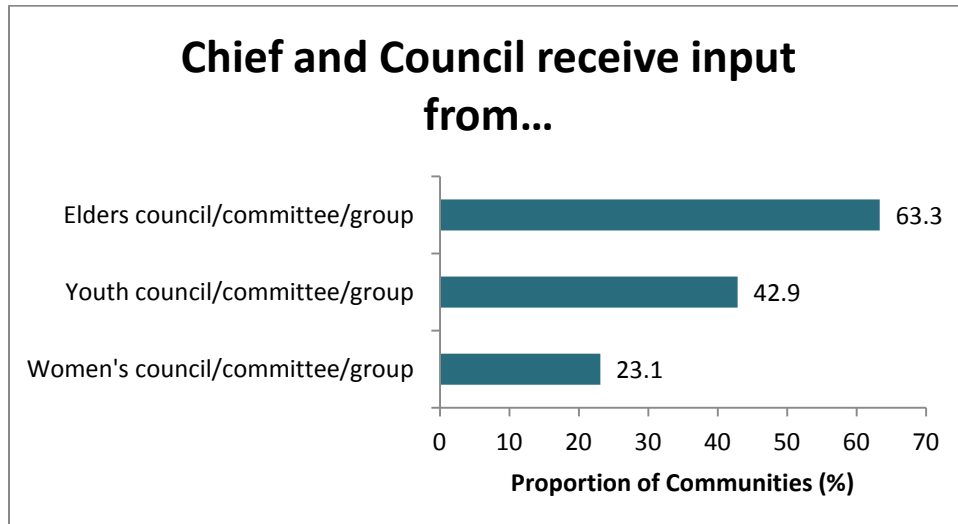


Figure 160 Chief and Council Receive Input from Elder, Youth, and Women



## APPENDIX A: RHS consent Form



### First Nations Regional Longitudinal Health Survey (RHS)

#### Information and Consent Form 2008/09

You are being asked to participate in a survey. In this study, we ask you a number of questions about your health and other factors linked to health. The survey will take approximately one hour for adults and about 30 minutes for youth and children. Please take your time to review this form and discuss any questions you may have with the interviewer.

**Research Team:** This survey is a joint initiative of the following organizations:

***First Nations Chiefs' Health Committee (B.C.)***

***Treaty 7 Management Corp.***

***Federation of Saskatchewan Indian Nations***

***Assembly of Manitoba Chiefs***

***Dene National Office***

***Council of Yukon First Nations***

***Chiefs of Ontario***

***First Nations of Quebec and Labrador Health and Social Service Commission***

***Union of New Brunswick Indians***

***Union of New Brunswick Indians***

***Union of Nova Scotia Indians***

***Assembly of First Nations***

#### **Purpose of the Study:**

The objective of this survey is to develop a better understanding of the many important factors that determine the health of First Nations children, youth and adults. The areas covered in the survey include health conditions, dental health, disabilities, general well-being, physical activity, health behaviors, use of health services, residential schooling, housing and other social factors related to health.

#### **Benefits and Risks:**

This research will help First Nation policy makers and program developers understand the factors that affect the health of our children, youth and adults. This information will be used to help improve wellness through the development of appropriate health and social programs and policies of the federal government such as Health Canada, Indian and Northern Affairs Canada, other federal departments, provincial and territorial governments, First Nations education institutions; and for research into the prevention, treatment and care of chronic diseases.

The RHS team has worked hard to make sure that all reasonable safeguards are in place to minimize the potential risks. The potential risk expected is discomfort talking about personal issues.

#### **Protecting your Privacy:**

Information gathered in this survey may be published or presented in public forums. However, your name or other identifying information will not be used or revealed in any way, since the survey results will be available only in the form of tables about everyone who participated in the survey.



As you complete your survey, your answers only (not your name) are entered directly into a computer database. In order to make sure that you cannot be identified in any way, your name, address, personal health information and contact information will be kept separate from your answers to other questions. No one will have access to your personal information other than the research investigators and research associates.

Your personal identifying information will be protected according to the First Nations Regional Longitudinal Health Survey Code of Research Ethics and the RHS privacy policies and protocols and the same privacy rules laid out in federal and provincial, and territorial privacy laws.

**RHS Longitudinal Component (surveys will be repeated over time):**

The first wave (Phase 1) of this study took place from July 2002 to March 2003. This is the second wave (Phase 2) of the study, and other phases are planned over the next 10 years. To assist us in contacting you at a later time to participate in the other phases of the RHS survey (Phases 3 and 4), we will ask you to provide the name of a contact person who may be able to help us reach you in case you move or your telephone number changes. At the conclusion of this longitudinal survey in 2026, we will destroy the record containing your consent form with personal identifying information.

**Voluntary Participation/Withdrawal from the study:**

Your decision to take part in this survey and to allow your information to be collected and used is voluntary. You may refuse to participate or you may withdraw from the study at any time. If you change your mind after agreeing to this survey your information can be removed from the database. Your decision not to participate or to withdraw from the survey will not affect the health care you receive.

**Questions:**

You are free to ask any questions that you may have about your rights as a survey participant. If questions come up at any time during or after the study, or if you wish to withdraw from the study, please contact your RHS Regional Coordinator or the RHS National team identified on the brochure provided.

**Statement of Consent:**

**Survey Participant:**

I have read this consent form. I have had the opportunity to discuss the survey with a member of the survey team. I have had my questions answered by them in a language I understand. The risks and benefits have been explained to me. I understand that information regarding my personal identity will be kept confidential. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. By signing this consent form, I have not waived any of the legal rights that I have as a participant in this survey.

**CHECK ONE**

	<p><b><u>Full Consent</u></b></p> <p>I hereby CONSENT to participate in the survey, and by providing my personal contact information, I also consent to be contacted at a later time for another wave (Phase 3 &amp; 4) of the study.</p>
--	---

	<p><b><u>Limited Consent</u></b></p> <p>I hereby CONSENT to participate in the survey. I do not wish to provide contact information and do not wish to be contacted at a later time for another wave of the study.</p>
--	--

**SIGNATURE:**

Survey Participant's Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Survey Participant's Printed Name \_\_\_\_\_

**Participation of Minors:** For participants under 18 years of age, parents and legal guardians will be advised of the survey and their rights in relation to their child's participation in the First Nations Regional Longitudinal Health Survey. No information will be collected from any child where the parent or legal guardian does not wish their child to participate.

Alternatively, parents or legal guardians may signify their consent for the participation of their child by signing below:

Parent/Legal Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Legal Guardian's Printed Name \_\_\_\_\_

*Member of the RHS Survey Team*

I, the undersigned, have fully explained the relevant details of this survey to the participant named above and believe that the participant has understood and knowingly given their consent.

Interviewer Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/08 (MM/DD/YY)

Interviewer Printed Name \_\_\_\_\_

**A. PERSONAL INFORMATION**

First Name  
 Middle Name  
 Last Name  
 Other Name Used  
*(If applicable)*

**Present Place of Residence (Mailing Address)**

Street/ Box #  
 Town/ City  
 Province  
 Postal Code  
 Phone number

**B. CONTACT INFORMATION**

In order for us to contact you for future surveys related to the First Nations Regional Longitudinal Health Survey, it would be helpful if you could give us the name and address of someone we can contact if we have trouble locating you. This person should not be living with you, not move frequently, and be most likely to know where you are. This information will remain strictly confidential and will not be stored with the completed survey questionnaire.

First Name

Last Name

**Present Place of Residence** (Mailing Address)

Street/ Box #

Town/ City

Province

Postal Code

Phone number

## APPENDIX B: Statement of Participation

### Statement of Participation

As a member of (*insert name of community*) Chief and Council, I have read this consent form and I freely agree that (*insert name of community*) can participate in this study. We have had the opportunity to discuss this research study with the Regional Coordinator.

We have had our questions answered by the Regional Coordinator in a language that we understand. The risk and benefits of the study have been explained to us.

We understand that the participation of (*insert name of community*) in this study is strictly voluntary and that we may choose to withdraw at any time.

We understand that information regarding the personal identity of community members will be kept confidential. Despite efforts to keep personal information confidential, absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organizations, such as the Assembly of Manitoba Chiefs, may also inspect and/or copy research records for quality assurance.

By signing this form, we have agreed to participate in the First Nations Longitudinal Health Survey.

**Chief or Council Member Printed Name** \_\_\_\_\_

**Chief or Council Member Signature** \_\_\_\_\_

**Date Signed** \_\_\_\_\_

Please answer the following as it applies to your community

Participation in this survey is formally acknowledged by way of a Band Resolution:

YES

NO

Submit signed copy of the form to:

RHS Regional Coordinator  
Assembly of Manitoba Chiefs  
200 - 260 St. Mary Avenue  
Winnipeg, Manitoba  
R3C 0M6  
Toll Free: 1-888-324-5483  
Main Reception: 204-956-0610  
Fax: 204-956-2109

If a band resolution was passed acknowledging participation in the survey, please fax it along with the form to the regional coordinator in your region.

## APPENDIX C: Protocol for Returning RHS to MFNs

### PROTOCOL FOR THE RETURN OF FIRST NATIONS REGIONAL LONGITUDINAL HEALTH SURVEY RESULTS TO PARTICIPATING FIRST NATIONS COMMUNITIES

Statistical tables containing FNRLHS community-level results will be returned to communities according to the following procedures:

1. The First Nation will submit a request addressed to the applicable region for return of community-level statistical tables.
2. Upon receipt of the request, the RHS will begin preparing the statistical tables for return to the First Nation. The RHS will only return **de-identified information**.
3. Once the statistical tables for that first nation are prepared, notice will be given and the First Nation will provide the applicable region with evidence of a duly executed First Nation Resolution (Band Council Resolution/BCR) in the format attached (or substantially the same). The BCR will contain undertakings and conditions regarding confidentiality of the information, as required by the respondents consent.
4. The statistical tables will be returned to the community, to the attention of the individual indicated in the BCR.

### QUESTIONS & ANSWERS

Regarding the procedures and principles for returning community-level survey results to First Nation communities.

### WHY DOES THE FIRST NATION HAVE TO REQUEST RETURN OF SURVEY RESULTS?

According to the consent form signed by the individual RHS respondents, information regarding the respondents personal identity will be kept confidential. This requires that all of the personal-identifying information be removed from the survey results before they are released to anyone. Moreover, RHS is ethically obligated to follow industry standards to ensure that information within the dataset cannot be used to re-identify any individual respondent.

Therefore, once the RHS team receives the request, they will commence the process of de-identifying the data set, in preparation for return of community-level statistical tables to the community. RHS will wait for the request to be made before beginning the process of de-identification.

### WHY CANT COMMUNITIES GET PERSONAL-LEVEL STATISTICAL TABLES?

Each respondent who participated in the RHS shared their personal information based upon a standard consent form (attached). This consent form prevents RHS from disclosing personal-identifying information about respondents to anyone. In other words, the respondents did not consent to the release of personal-identifying information about them to their communities. The RHS is legally and ethically bound to respect the limitations contained in the respondents consents. Therefore, communities will not receive statistical tables which have been de-identified to prevent any reasonable possibility of individual respondents being personally identified.

### **HOW ARE SURVEY RESULTS DE-IDENTIFIED?**

De-identifying means that personal health information will be modified so that the identity of the subject individual cannot be determined by a reasonably foreseeable method.

De-identification can involve:

- a. Ensuring removal of name and address, if present; and
- b. Removal of encryption of identifying numbers, such as personal health number or any other unique identification number.
- c. Converting date of birth to month and year of birth, age or age group;
- d. Reviewing the remaining data elements to ensure they do not permit identification of the subject individual by a reasonably foreseeable method, such as small cell sizes.

In the case of the RHS, because of small sample sizes within communities, in order to properly de-identify personal health information and to avoid the risk that the survey results can be re-identified, survey results will be returned to First Nations in statistical tables.

### **WHAT CAN THE COMMUNITY-LEVEL STATISTICAL TABLES BE USED FOR?**

Health Canada originally committed to provide \$30 million for the First Nations Regional Longitudinal Health Survey (RHS). During negotiations with Health Canada and planning and preparation for the RHS, Health Canada drastically reduced funding to approximately 20% of that amount. As a result, original plans for the comprehensive survey and samples within each community which would provide statistically useful information to all participating First Nation communities had to be changed. The limited funds forced a limited sample size. Rather than community-level sample sizes, the regions were forced to change sampling to regional level in some regions, and to sub-regional in others. This means that although the sample size within each community is not large enough to generate statistically useful analysis and conclusions at a community level, at a sub-regional and regional level, the sample sizes were significant and statistical analyses are definitely possible at a sub-regional and regional level.

What this means is that RHS surveys completed in most communities are too few to produce statistically meaningful results at the community-level. Any statistics based on the communities' responses alone would be unreliable and potentially misleading. No analysis should be attempted or reported on these community-level statistical tables. In order to have meaningful analyses, a larger sample size of respondents would have to be considered – namely, at the regional or sub-regional level. If communities

are interested in such analyses, they should contact their regional representative for further information.

### **WHY RETURN THE STATISTICAL TABLES TO THE FIRST NATION, IF THEY CANNOT BE USED FOR ANALYSIS?**

At the outset of the RHS process, First Nations were told that principles of OCAP (ownership, control, access and possession) would be honored and that consistent with OCAP, community survey results would be returned to the community. At the time, prior to funding cuts, RHS believed that in addition to OCAP principles, return of statistical tables to communities could be used for First Nation healthcare, health planning, policy and development. Although Health Canada funding cuts have negated the practical use of community-level survey results back to the community, RHS remains committed to honoring the principles of OCAP by returning community-level survey results back to the community.

By honoring OCAP principles in this way, regardless of the potential use of the community-level information, RHS hopes to provide a positive example to others who collect information for First Nation members in our communities, and to demonstrate that an RHS that is First Nation driven is capable of meeting individual privacy rights, together with First Nation community interests and self-governance.

Moreover, returning the community-level survey results to the First Nation represents a commitment by custodians of the RHS data (RHS National Team under the guidance of FNIGC at the Assembly of First Nations and the applicable Region) that community privacy interests and OCAP will continue to be respected by the RHS. What this means is that the neither the FNIGC, RHS National Team nor the region will release or disseminate any data or information from the RHS that identifies or could lead to the identification of a community without authorization from that community's recognized leadership.

### **WHY IS A BCR NEEDED?**

Legally, Chief and Council (Band Council/First Nation Council) are the only ones who are authorized to act on behalf of the community as a whole. Council derives its legal authority through the leadership selection process, through a First Nations inherent right of self-government and through the *Indian Act*. Any collective right or interest held by a First Nation is managed through Chief and Council, which is the only recognized entity with the legal authority to act on behalf of the First Nation as a whole {see *Blueberry River Indian Band v. Canada*, {2001} FCA 67}.

The acceptance of RHS community-level survey results is an acceptance of community property interests in the data and an acknowledgement of community privacy rights. In this respect it is no different than the acceptance of a settlement of a land claim or specific claim. Only Chief and Council then have authority to accept community property on behalf of the community. Chief and Council then have legal and fiduciary duties to manage that property in the best interest of the First Nation. No other individual or group within a First Nation has equivalent authority or duties.

Although it may seem practical to deliver the survey results to a First Nation's health director, that health director does not have the legal authority (and the coinciding legal duties) to accept this community property on behalf of the community as a whole. Only Chief and Council have this authority.

If the Chief and Council of a First Nation are not prepared to accept the return of survey results into the community, then their decision must be accepted as the decision of the First Nation. No individual within the community, whether they are employed by the First Nation or not, has legal authority to overrule Chief and Council in these circumstances.



## APPENDIX D: Band Council Resolution Sample

WHEREAS the First Nations Regional Longitudinal Health Survey (RHS) is a First Nation-driven survey which is aimed at collecting information regarding the health and wellness of First Nation communities across Canada;

WHEREAS the RHS was developed to respect and uphold the sovereign rights of First Nations and the authority conferred or mandated to their representative bodies.

WHEREAS the principles of Ownership, Control, Access and Possession (OCAP) which flow from those rights, mandate that First Nations have control over the collections, use and disclosure of information about their communities.

WHEREAS the RHS was invited into the \_\_\_\_ First Nation and information was collected about our community.

WHEREAS individual respondents who participated in the RHS within our First Nation consented to the release of the results of the survey, provided that their names and other personal-identifying information was removed from the results.

WHEREAS the RHS wishes to honor its OCAP commitments to the \_\_\_\_\_ First Nation, while honoring its obligation to protect the personal privacy of respondents.

WHEREAS the RHS and its partners have made contractual commitments and are bound by the RHS Code of Ethics that state there will be no release or dissemination of any data or information from the FNRLHS that identifies or could lead to the identification of a community without authorization from that community's recognized leadership.

THEREFORE BE IT RESOLVED that the \_\_\_\_ First Nation hereby accepts ownership, control and possession of all RHS statistical tables related to the \_\_\_\_ First Nation.

FURTHER BE IT RESOLVED that the \_\_\_\_ First Nation acknowledges:

- (a) The statistical tables accepted by the First Nation have been de-identified, as required by the respondent's consent.
- (b) Because of drastic funding cuts imposed by Health Canada there were not enough people surveyed within the community to produce reliable and valid statistical results at the community level. However, valid statistical analyses and results can be obtained by the First Nation by accessing larger sample sizes, such as sub-regional level data.

FURTHER BE IT RESOLVED that the \_\_\_\_ First Nation directs the RHS to release the community information to \_\_\_\_\_, to be held on behalf of the community at the direction of Chief and Council.

# Assembly of Manitoba Chiefs

