First Nations Regional Health Survey Report

Manitoba Region

2015-2016

FIRST NATIONS HEALTH AND SOCIAL SECRETARIAT OF MANITOBA

The First Nations Health and Social Secretariat of Manitoba would like to thank your community and your community members for having participated in the First Nations Regional Health Survey 2015-2016. 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.

How to cite this report:

First Nations Health and Social Secretariat of Manitoba (FNHSSM) First Nations Regional Health Survey (RHS) Phase 3 (2015-2016): Manitoba Regional Report (Winnipeg: First Nations Health and Social Secretariat of Manitoba, September 2018).

Report written by: Marcie Snyder, PhD

For information or questions on this report please contact:

Manitoba First Nations RHS Team

Leona Star
Director of Research
204.946.9739
lstar@fnhssm.com

Venkata Ramayanam
Statistical Analyst
204.946.9746
vramayanam@fnhssm.com

Carla Cochrane
Regional Research Coordinator
204.946.9747
ccochrane@fnhssm.com

Leanne Gillis
RHS & REEES Administrative Assistant/Community Liaison
204.946.9730
lgillis@fnhssm.com

For further information or to obtain additional copies, please contact:
First Nations Health and Social Secretariat of Manitoba
6th floor -275 Portage Avenue
Winnipeg, MB R3B 2B3
204.942.9400
www.fnhssm.com

This report is available electronically at:
www.fnhssm.com

Table of Contents

ACKNOWLEDGEMENTS

The Regional Health Survey within the Manitoba region is carried out under the governance, guidance and direction of the Health Information Research Governance Committee (HIRGC).

Since 1996, the **Assembly of Manitoba Chiefs (AMC)** Chiefs-in-Assembly mandated the **Manitoba First Nations Health Information Research Committee (HIRGC)** to be the Manitoba Regional Ethics Board, reviewing proposals, and encouraging First Nations leadership and partnership in research according to First Nations priorities and values.

In 2007, the AMC Chiefs-in-Assembly provided further guidance for Respectful Research Relationships with and led by First Nations:

Free Prior Informed Consent (on collective and individual basis);
First Nations OCAP principles that First Nations have Ownership, Control, Access, and Possession of their own data;
First Nations ethical standards (whether Cree, Dakota, Dene, Anishinaabe or Oji-Cree). Benefits to First Nations within and after research is undertaken.

In 2013, AMC Chiefs-in-Assembly established the **First Nations Health and Social Secretariat of Manitoba**, **Nanaandawewigamig**, with the vision to restore holistic health of First Nations people, communities, and Nations.

HIRGC has broaden its mandate to holistic health research other than health care determining our health - including all that impacts our lives:

The health of Mother Earth and all the gifts of the Creator.
The four spheres of physical, mental, emotional, and spiritual health.
Social determinants such as housing, education, income, etc.Impacts of colonization and ongoing colonialism, racism, oppression, etc

Current Committee Members:

Doris Young, Opaskwayak Cree Nation
Patricia Dorion, Swampy Cree Tribal Council
Rene Linklater, O-Pipon-Na-Piwin Cree Nation
Guy Gosselin, Roseau River Anishinabe First Nation Gloria Rach, Dakota Ojibway Tribal Council Elvin Flett, St. Theresa Point First Nation
Sarah Samuel, Northlands Denesuline First Nation Vanessa Tait, Academic Youth Representative, Vacant

PARTICIPATING COMMUNITIES

We would like to thank the following First Nations who participated in the Manitoba First Nations Regional Health Survey 2015-2016: The leadership and guidance of the communities at various stages throughout 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 HIRGC members who provided support and oversight to the RHS process.

Birdtail Sioux Dakota Nation
Bloodvein First Nation
Bunibonibee Cree Nation
Canupawakpa Dakota First Nation Ebb and Flow First Nation Fisher River Cree Nation
Fox Lake Cree Nation
Garden Hill First Nation Hollow Water First Nation
Keeseekoowenin Ojibway Nation Kinonjeoshtegon First Nation Long Plain First Nation
Manto Sipi Cree Nation Mathias Colomb Cree Nation
Misipawistik Cree Nation
Mosakahiken Cree Nation
Nisichawayasihk Cree Nation
Northlands Denesuline First Nation
Norway House Cree Nation
O-Chi-Chak-Ko-Sipi First Nation
Opaskwayak Cree Nation
O-Pipon-Na-Piwin Cree Nation
Peguis First Nation
Pimicikamak Cree Nation (Cross Lake) Pinaymootang First Nation
Roseau River Anishinabe First Nation Sagkeeng First Nation (Fort Alexander) Sandy Bay First Nation
Sapotaweyak Cree Nation
St. Theresa Point First Nation
Swan Lake First Nation
Wasagamack First Nation
Waywayseecappo First Nation
Wuskwi Sipihk First Nation
York Factory First Nation

Community Data Collectors

Birdtail Sioux Dakota Nation
Andrea Eashappi
Bloodvein First Nation
Mobile Team Member
Bunibonibee Cree Nation
Alyssa Lundquist
Lauren Bradburn
Canupawakpa Dakota Nation
Kristin Eastman
Ebb and Flow First Nation
Paulette Malcolm
Fisher River Cree Nation
Delmer Sinclair
Wanda Murdock
Fox Lake Cree Nation
Mobile Team Member
Garden Hill First Nation
Maggie Flett
Hollow Water First Nation
Joy Phillips
Keeseekoowenin Ojibway Nation
Justin Bone
Kinonjeoshtegon First Nation
Kitty Keeper
Long Plain First Nation
Cheryl Meeches
Renee Francis
Tamara Clearsky
Manto Sipi Cree Nation
Muriel Scott
Mathias Colomb Cree Nation
Muriel Scott
Misipawistik Cree Nation
Rhonda Cook
Mosakahiken Cree Nation
Cindy Martin
Conrad Martin
Nisichawayasihk Cree Nation
Natalie Linklater
Muriel Scott
Northlands Denesuline First Nation
Glen Tssessaze
Norway House Cree Nation
Shanae Paupanekis
Muriel Scott
O-Chi-Chak-Ko-Sipi First Nation
Mary Eastman
Sky Eastman
Opaskwayak Cree Nation
Muriel Scott
O-Pipon-Na-Piwin Cree Nation
Della Mason
Matilda Dysart
Peguis First Nation
Della Mason
Rachelle Beauchamp
Samantha McPherson
Pimicikamak Cree Nation (Cross Lake)
Muriel Scott
Christie Scott
Pinaymootang First Nation
Vanessa Sanderson
Roseau River Anishinabe First Nation
Lois Thomas
Kitty Keeper
Sagkeeng First Nation
Reinie Courchene
Sandy Bay First Nation
Lionel Roulette Richard Roulette
Sapotaweyak Cree Nation
Muriel Scott
St. Theresa Point
Mobile Team Member
Swan Lake First Nation
Candace Mousseau
Cynthia McKinney
Wasagamack First Nation
Mobile Team Member
Waywayseecappo First Nation
Arlene Griffiths
Erin Cloud
Lena Clearsky
Stanley Clearsky
Marisa Murdock
Wuskwi Sipihk First Nation
Cynthia Munro
York Factory First Nation
Muriel Scott

Miigwech • Masi • Wopida • Ekosani

INTRODUCTION

First Nations people face a disproportionate burden of health and socioeconomic inequities across the life course, compared to the general population (King, Smith, & Gracey, 2009). These disparities are shaped by, and rooted in, the inseparable relationship between health, racism, and colonization – which is a globally recognized determinant of Indigenous health (Cunningham 2009, see: Allan and Smylie 2015, p. 6). The effect of colonization as a determinant of health has resulted in a legacy of environmental dispossession and degradation of the land, substandard housing and water conditions, inadequate access to health services, loss of language, and disrupted ties to family, community, land, and cultural traditions (King et al. 2009, NCCH, 2018, Richmond and Ross 2009). These policies have been clearly linked to adverse holistic health consequences (King et al., 2009).

Despite these devastating challenges, First Nation individuals, families and communities are demonstrating vitality and resilience (REEES, 2017). Countering this colonial legacy, and (re)forming cultural connections, have become integral to strengthening identity, positive health outcomes, and forms of resilience (FNIGC, 2018a). One example is the learning and revitalization of language and culture, which research indicates has become a source of resilience, health, and healing in "individuals, families, communities, and nations" (see NCCAH, 2016).

This report analyzes and reflects on these strengths and challenges using data from the Manitoba Region of the First Nations Regional Health Survey (RHS), a cross-sectional survey of First Nations adults, youth, and children living on First Nation reserves and in northern communities across Canada. The RHS is the only First Nations health survey in Canada, and recently completed its third phase. It is implemented in keeping with the principles of OCAP, and has been developed by First Nation, for First Nations(see Background & Methodology section for more information).

Following the path of previous RHS analyses conducted in Manitoba, this analysis of the RHS Phase 3 represents a "snapshot in time." It provides a summary analysis of various indicators of health and well-being among First Nations individuals, families, and communities, and provides conclusions and recommendations in moving forward. The knowledge gained from this data can also be seen as a source of resilience and strength: The intent of this report is that it be a living document that over time will serve to support further analyses, health promotion strategies, and assist in cultivating the wellness that *already exists* in Manitoba First Nation communities. Although we discuss health challenges and ill health, this report works to move away from deficit-based research, so that we can better measure First Nations' indicators of success, health, and wellness.

This analysis is also informed by a holistic health framework that emphasizes the larger social system, or environment, in which individuals live. Here, interconnectedness, family, community, culture, and the land are key elements of physical, mental, emotional, and spiritual

health (see Richmond and Ross, 2008, p. 1424). This approach frames health as part of a complex interaction between people, environment, and history across the life course. From this perspective, we understand that while an individual's actions shape their well-being, so too is their well-being influenced by the health of their surroundings (i.e., material or resource inequities), and those surrounding them (Bird, 1993; Casken, 2001).

This report is divided into five sections, or themes:

1. The first section focuses on **Community Wellness**. Here, we examine RHS data related to Language and Culture, Community Strengths, Challenges, and Progress, as well as Relationships (i.e., experiences with bullying).

2. The second section focuses on **Holistic Well-being**. Here, we examine the overall physical, mental, emotional, and spiritual health of adults, youth, and children. To do so, we consider relationships of support (i.e., who helps contribute to emotional and mental well-being), experiences with suicide, and measures of resilience.

3. The third section moves to focus on **Physical Well-being**. Here, physical aspects of health and wellness are considered, including the prevalence of Chronic Health Conditions among adults (including a focus on diabetes), youth, and children. Bodily injury across all age groups is also considered. The final portion of this section focuses on Health Care Access (e.g., access to western/ conventional, traditional, and dental health care).

4. The fourth section focuses on **Healthy Behaviours and Lifestyle.** This includes sexual health, and health challenges such as smoking, substance use, and gambling. We also examine food and nutrition, food security, and extracurricular/ physical activities among adults, youth, and children.

5. The fifth section focuses on **Mobility: Movement.** Here we examine movement to and from reserve communities. We also examine socio-economic determinants of health such as housing, education, employment, and income which are often primary motivators of migration.

BACKGROUND & METHODOLOGY

The First Nations Regional Health Survey (RHS) is a cross-sectional survey of First Nations adults (≥18 years of age), youth (12-17 years), and children (0-11 years) living on First Nation communities across Canada. It is the only First Nations health survey in Canada; and it is implemented explicitly in keeping with the principles of OCAP. It has been developed by First Nations, for First Nations, and focuses on physical, mental, emotional, and spiritual aspects of health, well-being, and the social determinants of health. Three different questionnaires were developed to target adults, youth, and children (where parents/guardians were interviewed on the child's behalf).

Since 2002, three national versions of this survey have been conducted (in addition to a pilot survey carried out in 1997) – the first of which is the RHS Phase 1 which was implemented in 2002-2003. The RHS Phase 2 was later carried out in 2008-2010. The current RHS (Phase 3), which forms the basis of this report, was implemented in all regions across Canada in 2015-2016. The sampling framework was based on: 1) random selection from band membership lists, by age group, and 2) by size of community, where large communities were automatically included in survey (>1500 pop), medium (300-1500 pop) and small (<300pop) communities were randomly selected with equal probability, and communities with a population of <75 were excluded.

This report shares key findings, conclusions, and recommendations based on descriptive statistical analyses of the RHS-Manitoba Phase 3 data, and where feasible, statistical comparison are made to the RHS 1 (2002-2003) and the RHS 2 (2008-2010).

All statistical analyses of the RHS 3, including estimated percentages and 95% confidence intervals (CIs), were conducted using SPSS v.22. Throughout the analysis that follows, instances of low cell counts (i.e., where <5 individuals responded) are suppressed to protect confidentiality. These cases do not appear in the analysis, or are marked by an "F". Instances of very high sampling variability (i.e., coefficient of variation

>33.3%) are also marked with an "F". Estimates with coefficients of variation between 16.7%-33.3% reflect moderate to high sampling variability and should be interpreted with caution, and are marked with an "E". Those who reported "don't know" or didn't answer are excluded from the calculated estimates. To compare groups, 95% CI are used. Statistically significant differences between estimates were identified by non-overlapping CIs. If the CIs around any two estimates do not overlap, the difference between the groups is said to be statistically significant. If the estimates overlap, the difference is not significant.

In some cases, cross tabulations were generated to determine the relationship between two groups (e.g., male and female).

Results from the RHS play a crucial role in understanding not only the health challenges and health care gaps in Manitoba First Nations communities, but also the strengths, sources of wellness and resilience. The results of this survey should contribute to building a dialogue that supports strategies for increased access to equitable health care, to improving

programs that support First Nations health and wellness, and to supporting policy change and development.

In Manitoba, the RHS Phase 3 was conducted in 35 First Nation communities between November 2015 and December 2016. The communities that participated in the RHS 3 reflect a wide range of experiences across southern and northern Manitoba, in both remote and accessible communities. Each of the 5 language territories (Cree, Ojibway, Oji-Cree, Dakota, and Dene) is represented in the sample, and in some cases the survey was translated to Cree.

In total, 85.5% of the targeted regional sample of 4,104 surveys were completed (i.e., 3509/4104 surveys were completed). During the data collection period, surveys were collected from:

- 1813 adults
- 789 youth
- 907 children (where parents/guardians answered on their behalf)

DEMOGRAPHIC PROFILE

Just less than one-quarter (22.18%) of all survey respondents were 55 years of age or older, and 28.8% were 18-54 years of age. Youth 12-17 years represent 22.5% of all survey respondents, and children (0-11 years of age) represent 25.8% of all respondents.

Approximately half of all adult respondents (51.9%) were female and 48.1% were male. Broken down by age group, 21.5% of male adult respondents were 55 years or older, and 26.6% were 18-54 years of age. In the case of females, 22.7% were 55 years or older and 29.2% were 18-54 years old. Approximately 1 in 5 adults (19.5%) identified as two-spirited and/or trans-gender.

Just less than half the youth who participated in the survey identified as male (49.3%) and 50.7% identified as female. 16.2% of youth identified as being two-spirited and/or trans-gender.

Just over half of the children who participated in the survey (51.3%) were male, and 48.7% were female.

SECTION 1: COMMUNITY WELLNESS

This section examines RHS data related to language knowledge and culture among Manitoba First Nations adults, youth, and children, the perceived importance of First Nations languages and culture, and the people who are said to most help youth and children understand their culture. We then examine findings related to sense of community belonging, and adult and youth perceptions of strengths, challenges, and progress in Manitoba First Nation communities. In conclusion, this section examines personal and community experiences with bullying.

The overall intent of this section is to provide insight into respondents' relationship to their First Nations language, and to better understand perspectives of health and wellness at the community-level. **Knowledge of community wellness, language, and culture is a key starting point to understanding the strengths and challenges that communities experience**. While health interventions play an important role in supporting and improving the health of First Nation communities, focusing specifically on interventions that overlook community strengths may actually work to perpetuate ill intergenerational health (FNIGC, 2018a).

Further, language and culture are important to the health and well-being of First Nations peoples (Reading, 2015). Research indicates that when connections to Indigenous languages disappear or become fragmented, communities become more vulnerable to distress. One indicator of a mentally healthy community is one that shares language (Canadian Institutes for Health Information, 2009).

LANGUAGE & CULTURE

The First Nation communities that participated in this survey sample represent five language territories: Cree, Ojibway, Dakota, Oji-Cree, and Dene. To better understand individual and family experiences related to language and culture, this section examines knowledge and practice of a First Nation languages among adults, youth, and children; the role of residential school in language loss and health; the perceived importance of language and culture; and the role of family and community members in helping children and youth understand their culture.

ADULTS

When asked which language they used most often in their daily lives, 59.7% of Manitoba First Nations adults spoke English most often, while 32.5% spoke a First Nations language most often. Of those who spoke a First Nations language most often in their daily lives, 44.6% were ≥55 years of age and 30.0% were 18-54 years of age. Cross-tabulation of age and language knowledge show that a significantly higher proportion of adults who were 18-54 years of age (62.9%, 95% CI: 55.4, 69.9) used English in their day-to-day life, compared to those 55 years or older (44.2%, 95% CI: 34.1, 54.8).

Although most respondents did speak English regularly, nearly 90% of First Nations adults (88.3%) had some knowledge of a First Nations language,

even if only a few words. While a large proportion of all adults 18 years of age and older had at least some knowledge of a First Nations language, a significantly higher proportion of older adults (≥55 years of age) (94.7%, 95% CI: 92.3, 96.4) had knowledge of the language than did younger adults (18-54 years of age) (87.0%, 95% CI: 83.0, 90.2). **At the national level, 15.3% of RHS adult respondents spoke their First Nations language most often on a daily basis. In Manitoba, this number is double, with 32.5% of adults speaking their First Nations language most often** (FNIGC, 2018b).

Manitoba First Nations adults who had knowledge of a First Nations language, were asked if they could understand, speak, read, or write in the given language (see Table 1).

Table 1: Knowledge of a First Nations language among adults

	Fluent / Intermediate*		Basic**		Cannot / A few words***	
	%	95% CI	%	95% CI	%	95% CI
How well can you understand your First Nations language?	63.2	56.8-69.2	13.2	10.4-16.7	23.6	18.5-29.5
How well can you speak your First Nations language?	58.7	52.0-65.1	13.8	10.9-17.2	27.5	22.5-33.2
How well can you read your First Nations language?	16.8	14.1-19.8	26.6	22.2-31.6	56.6	51.0-62
How well can you write your First Nations language?	10.2	8.1-12.7	21.1	17.4-25.3	68.7	64.4-72.7

**Fluent: No difficulty understanding spoken word in a variety of contexts*
**Intermediate: Able to understand main ideas in everyday speech (i.e., TV, radio) **Basic: Can understand basic phrases and vocabulary (e.g., time, simple directions) ***A few words: Can understand a few words (hello, goodbye, thank you, etc.)*

The findings in Table 1 indicate that 63.2% of First Nations adults with knowledge of a First Nations language could understand their language fluently or intermediately. These findings are similar to the RHS 1, where 61.8% of adults understood a First Nations language fluently or relatively well. These findings also indicate, however, that a significantly higher proportion of RHS 2 respondents (74.7%, 95% CI: 70.6, 78.4) had an intermediate or fluent understanding of their First Nations language compared to the RHS 3 (63.2%, 95% CI: 56.8, 69.2).

Cross tabulation with age and language indicates that **a significantly higher proportion of older adults (≥55 years of age) could understand their First Nations language fluently (76.2%, 95% CI: 69.3, 82.0), compared to younger adults (18-54 years of age), 44.5% (95% CI: 37.0, 52.3) of whom could understand their First Nations language fluently**.

When asked about speaking a First Nations language, **over half of Manitoba First Nations adults (58.7%) with knowledge of a First Nations language could speak the language fluently or intermediately.** Again, these findings are similar to the RHS Phase 1 (where 54% could speak the language fluently or relatively well). These findings are however proportionally smaller when compared to the RHS Phase 2, where 68.6% of adults could speak a First Nations language at an intermediate or fluent level. At the national level, 40.6% of adults could speak their First Nations language fluently or intermediately (FNIGC, 2018b).

Cross tabulation of adult age groups and ability to speak a First Nations language (RHS 3) indicate that **a significantly higher number of older adults (≥55 years of age) could speak their First Nations language fluently (74.7%, 95% CI: 67.6, 80.7) compared to younger adults (18-54 years of age) (39.2%, 95% CI: 31.3, 47.7).**

IMPORTANCE of LANGUAGE AND CULTURE TO HEALTH & WELL-BEING

Of those adults who attended residential school, 57.2% felt that their overall health and well-being had been negatively impacted by their attendance. Those who attended residential schools and felt it had negatively impacted their health, were then asked what contributed to this impact, and were provided with a number of possible responses. Over two-thirds (64.1%) of those surveyed identified "loss of language." A high percentage also cited "loss of cultural identity" (70.2%) and "loss of traditional religion/spirituality" (65.3%) as having a negative impact on their wellness. Isolation from family (76%) and community (75.1%) networks were also ranked high in terms of negative health impacts.

Table 2: Knowledge of a First Nations language among youth

	Fluent/ Intermediate		Basic		Cannot / A few words	
	%	95% CI	%	95% CI	%	95% CI
How well can you understand your First Nations language?	29.0[E]	19.3-41.1	26.1[E]	16.8-38.1	44.9	39.1-50.8
How well can you speak your First Nations language?	23.2 [E]	14.0-36.0	26.5 [E]	17.0-38.8	50.3	44.8-55.8
How well can you read your First Nations language?	F	F	28.0	22.7-34.0	66.6	60.0-72.7
How well can you write your First Nations language?	2.7 [E]	1.4-5.2	27.2	22.1-33.1	70.1	63.8-75.7

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

[F] *Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)*

YOUTH

Approximately three-quarters of Manitoba First Nations youth surveyed (76.1%) spoke English most often in their daily lives, while 21.2% of the youth surveyed spoke a First Nations language most often in their daily lives. Results from the national analysis of the RHS 3 indicate that 88.9% of youth speak English most often in their daily lives (FNIGC, 2018b).

While a small proportion (21.2%) of Manitoba First Nations youth spoke their First Nations language most often, 69.6% did have some knowledge of a First Nations language, even if only a few words. About one-quarter of youth respondents could understand (29.0%[E]) or speak (23.2%[E]) their First Nations language fluently/intermediately (see Table 2). Ability to speak or understand a First Nations language intermediately or fluently is similar across all three phases of the RHS.

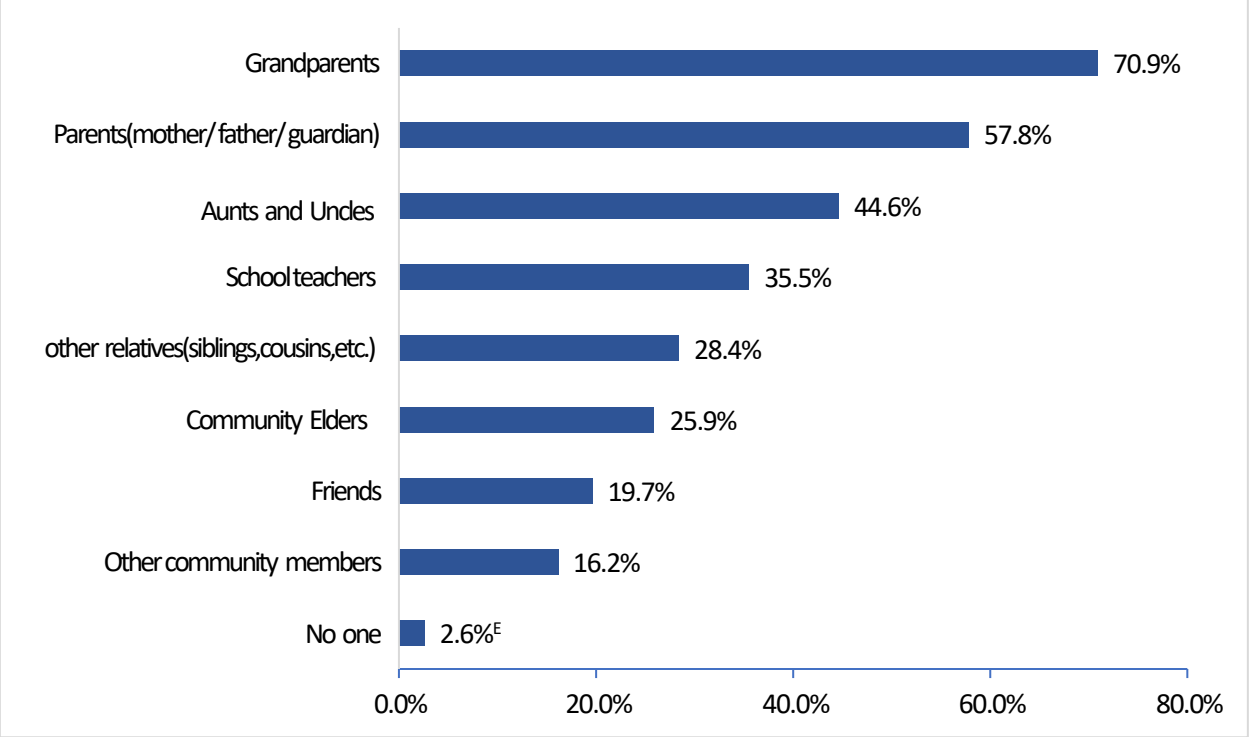
Almost 90% of the youth surveyed felt that speaking their First Nations language was important. **When asked, 88.1% of the youth strongly agreed or agreed that speaking their First Nations language was important to them. This shows a steady increase in the perceived importance of language among Manitoba First Nations youth across all phases of the RHS.** In Phase 1 of the RHS, 78.0% of youth viewed speaking a First Nations language as important, and in the RHS 2, 85.6% of youth felt that learning a First Nations language was very or somewhat important.

Youth also felt that culture was an important component of their lives. A large proportion of the youth surveyed (80.9%) strongly agreed or agreed that traditional cultural events (e.g., pow wows, sweat lodges, and community feasts), were important in their lives. Over half the youth surveyed (56.0%) reported that they

sometimes participated in their community's cultural events, while 13.5% always or almost always participated in these events.

Youth were also asked who helped them understand their culture. Grandparents, parents/guardians, and aunt/uncles are most likely to play a key role in helping youth understand their culture: 70.9% of youth reported that their grandparents helped them understand their culture, 57.8% reported that their parents/guardians helped, and 44.6% reported that their aunts or uncles helped (see Figure 1). This finding is consistent across all RHS phases, where these family members are the most frequently cited sources of support for understanding culture. Of note, **the RHS 3 shows an increased role among grandparents** (from 54.8% in RHS 2 to 70.9% in RHS 3).

Figure 1: People who help youth understand their culture



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

CHILDREN

While 69.7% of parents/guardians reported that their child spoke English most often in their daily life, **17.2% of children spoke a First Nations language most often on a daily basis.** This is proportionally higher than findings at the national level, where 6.3% of children spoke their First Nations language most often in their daily lives (FNIGC, 2018b).

More than half the parents/guardians surveyed (56.7%) also reported that their child had at least some knowledge of a First Nations language, even if only a few words. Of those children who had some

knowledge of a First Nations language, 13.4% [E] could understand their First Nations language intermediately or fluently, and 33.6% had a basic understanding. Less than a tenth (7.1% [E]) could speak their First Nations language intermediately or fluently, and 28.3% could speak some basic words and sentences. According the RHS 1, 18% of children understood a First Nations language fluently or relatively well, and according to the RHS 2, 15.4% of children could understand a First Nations language intermediately or fluently, and 13.6% could speak a First Nations language intermediately or fluently.

Although a relatively small proportion of children had an intermediate or fluent grasp of their First Nations language, **90.0% of parents/guardians strongly agreed or agreed that it was important for their child to learn a First Nations language.** Indeed, across all three surveys, approximately 90% of children's caregivers believed that it was important for their child to learn a First Nations language (i.e., 90% of caregivers surveyed in the RHS 1 viewed speaking a First Nations language as important, and 91.0% of caregivers in the RHS 2 felt that it was very or somewhat important for their child to learn a First Nations language). Parents/guardians also expressed the importance of culture in their child's life.

When asked if it was important to them that traditional cultural events be a part of their child's life (e.g., pow wows, sweat lodges, and community feasts), 82.3% strongly agreed or agreed that traditional cultural events are an important part of their child's life. Almost half of the children surveyed (47.6%) sometimes took part in their local community's cultural events, and 15.8% [E] always or almost always took part in these events.

Table 3: Knowledge of a First Nations language among children

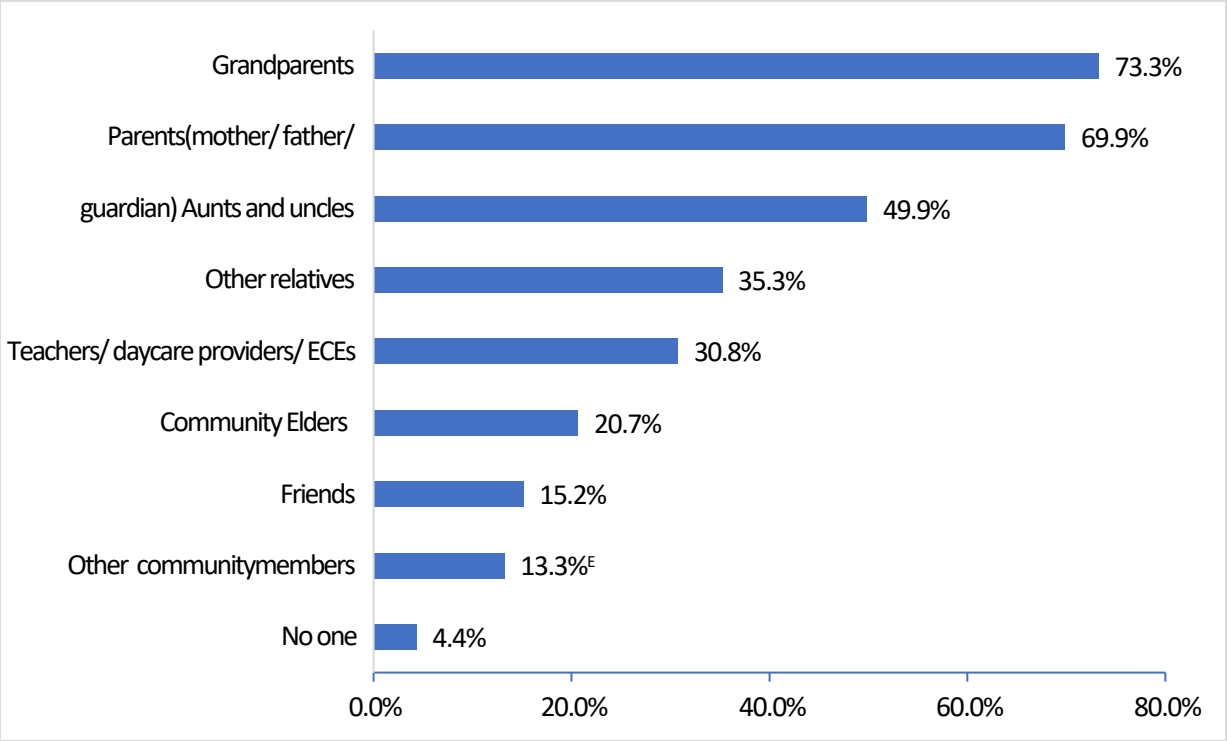
	Intermediate/Fluent		Basic		Cannot / A few words	
	%	95% CI	%	95% CI	%	95% CI
How well can your child understand their First Nations language?	13.4[E]	8.6-20.4	33.6	25-43.5	52.9	42.8-62.8
How well can your child speak their First Nations language?	7.1 [E]	3.5-13.9	28.3	20.1-38.2	64.6	55.2-72.9
How well can your child read their First Nations language?	3.5 [E]	1.8-6.7	22.9 [E]	13.3-36.5	73.6	60.4-83.6
How well can your child write their First Nations language?	F	F	21.7 [E]	11.9-36.1	76.6	62.5-86.6

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

[F] *Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)*

When asked who helped them understand their culture, children's primary caregivers reported that grandparents (73.3%) were most likely to help children understand their culture, followed by parents/guardians (69.9%), and aunts/uncles (49.9%) (see Figure 2). This finding is similar to previous phases of the RHS, where grandparents, parents/guardians, and aunts/uncles were most likely to help children understand their culture.

Figure 2: People who help children understand their culture



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

COMMUNITY STRENGTHS, CHALLENGES, & PROGRESS

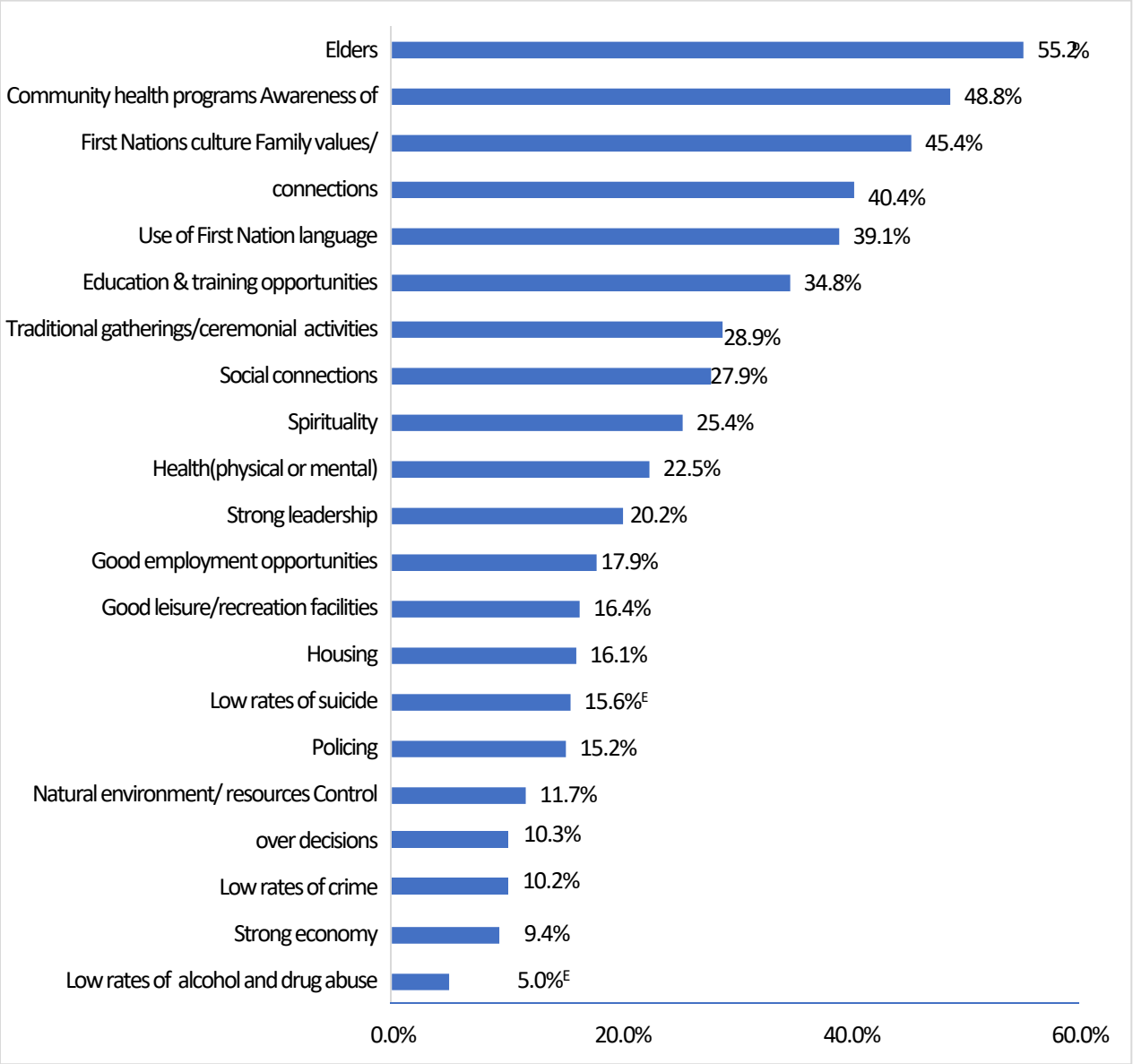
ADULTS

Most adults (78.5%) described their sense of belonging to local community as being very or somewhat strong, while 21.5% described their sense of community belonging as very or somewhat weak.

Adults were also asked to identify the main strengths in their communities. Respondents were provided with a list of 21 possible responses (see Figure 3).

Adults were most likely to identify Elders (55.2%), community health programs (48.8%), awareness of First Nations culture (45.4%), family values/connections (40.4%), and use of First Nation language (39.1%) as strengths in their communities. In the RHS 2, family values were the most commonly reported community strength.

Figure 3: Insights into community strengths, among adult respondents



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

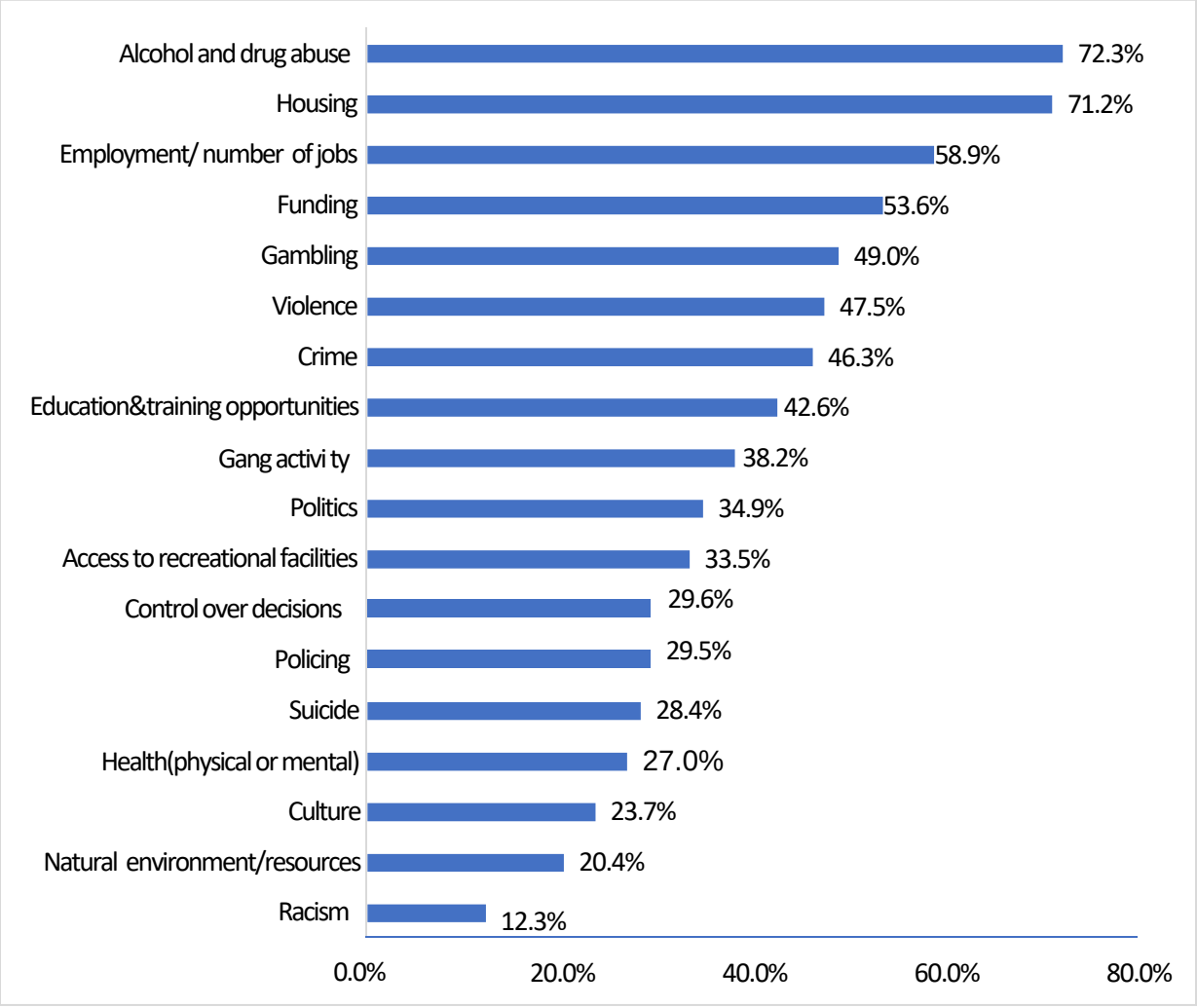
When adults were asked about the main challenges that their communities faced at the time of the survey, **respondents were most likely to report that substance use (72.3%) and housing (71.2%) were the greatest challenges in their community**. Employment/number of jobs (58.9%), funding (53.6%), and gambling (49.0%) were the next most likely areas to be identified as community challenges (see Figure 4). **These findings are similar to the RHS Phase 2** which indicated that alcohol, drugs, and housing were the most commonly reported community challenges.

Adults who identified community challenges were then asked if they felt there had been any progress/positive change in these areas in the 12 months

leading up to the survey. Approximately half to two-thirds of these adults felt that no progress or change was being made in all areas, while roughly 15-30% of adults indicated that some progress was being made across all areas. **Access to recreational facilities was most commonly reported to show good progress (7.1%), followed by culture (5.5%) and education and training facilities (4.8%).**

Of concern, adults were most likely to report that substance use (26.6%), violence (22.8%), gang activity (22.1%), and housing (20.4%) were challenges that were worsening in the communities.

Figure 4: Insights into community challenges, among adult respondents



Note: Respondents could choose more than one response

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

With respect to the two most frequently reported challenges (housing and substance use), there was some optimism about community progress in the area of substance use, with 21.3% of adults feeling that some progress had been made in their communities in the year prior. That being the case, approximately half

(50.7%) felt that no progress had been made and approximately one-quarter (26.6%) believed that the situation was worsening.

In terms of challenges related to housing, 2.4%[E] felt that good progress had been made in the 12 months prior to the survey, 31.2% felt that some progress had been made, 45.9% felt there had been no progress, and 20.4% believed the challenge of housing was worsening in their community (see Table 4).

Although adults reported a number of challenges in their communities, **most adults reported (50.5%) that in general they felt reasonably safe in their communities**, and 19.6% reported feeling very safe. About one-quarter (24.6%) felt somewhat unsafe, and 5.3%[E] felt very unsafe.

Table 4: Progress on community challenges, as reported by adult respondents

Good Progress		Some Progress	No Progress	Worsening
COMMUNITY PROGRESS	**%**	**%**	**%**	**%**
Access to recreational facilities	7.1	35.2	52.7	5.0[E]
Alcohol and drug abuse	1.5[E]	21.3	50.7	26.6
Control over decisions	2.0[E]	26.8	61.5	9.6[E]
Crime	1.5[E]	23.7	58.9	15.9
Culture	5.5	34.7	53.5	6.3[E]
Education and training opportunities	4.8	35.5	50.5	9.1
Employment/ number of jobs	2.3[E]	30.7	52.6	14.5
Funding	1.6[E]	24.6	57.2	16.7
Gambling	2.0[E]	16.7	61.4	19.9
Gang activity	3.4[E]	16.5	58.0	22.1
Health (physical or mental)	5.3[E]	33.8	52.0	8.8[E]
Housing	2.4[E]	31.2	45.9	20.4
Natural environment/resources	2.5[E]	27.6	58.5	11.3[E]
Policing	2.2[E]	30.2	57.4	10.2
Politics	1.7[E]	24.3	60.1	13.9
Racism	4.0[E]	21.3	63.9	10.8
Suicide	F	22.8	57.2	F
Violence	2.3[E]	19.0	56.0	22.8

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

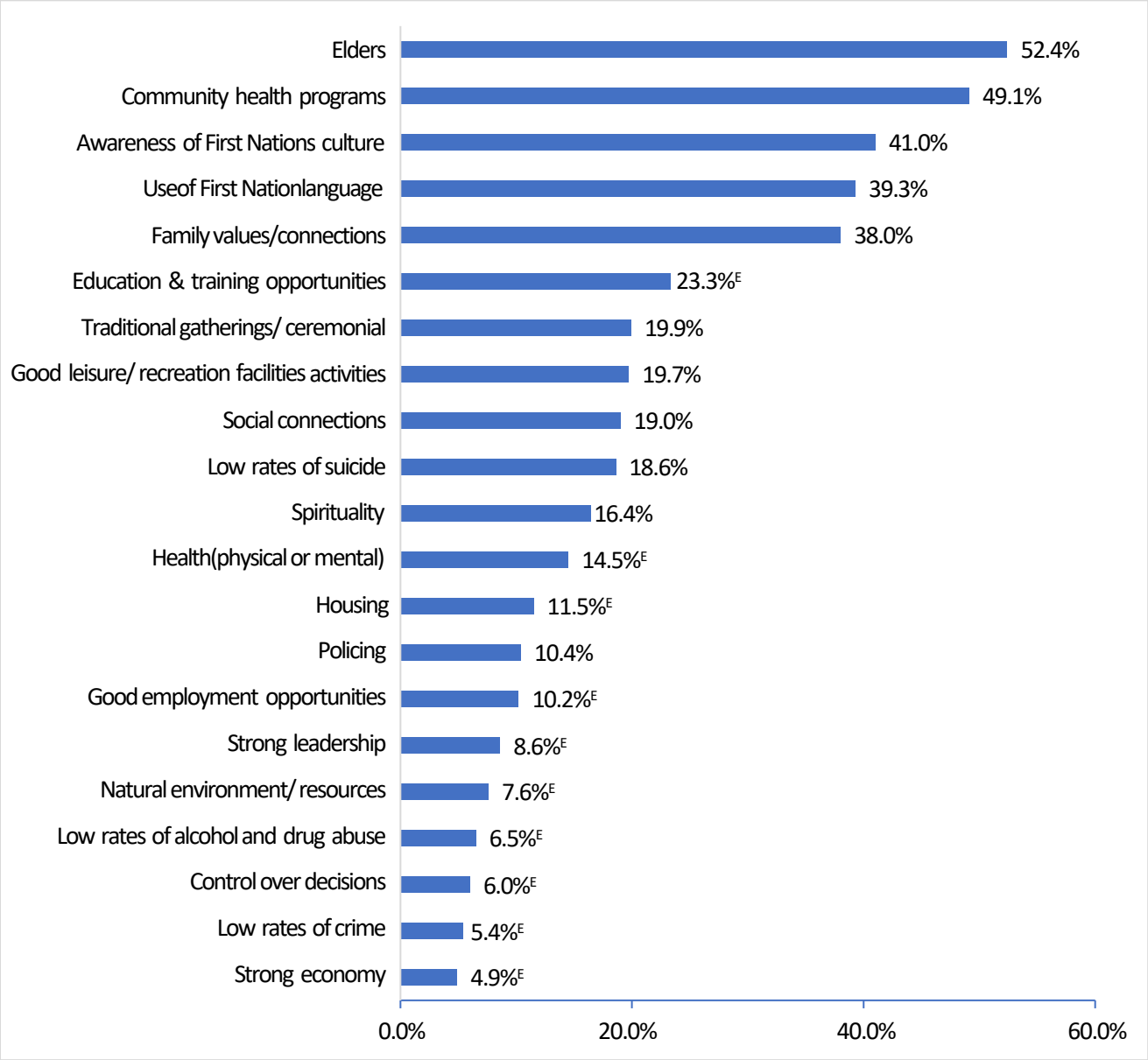
YOUTH

Almost three-quarters (72.7%) of youth felt a very strong or somewhat strong sense of belonging to their local community.

Youth 15 years of age and older were asked to identify their community's main strengths, and were provided with the same list of 21 possible responses as adults.

Manitoba First Nations youth were most likely to identify Elders (52.4%), community health programs (49.1%), awareness of First Nations culture (41.0%), use of First Nation language (39.3%), and family values/ connections (38.0%), as the main strengths in their communities. A comparison to the RHS 2 is not available.

Figure 5: Insights into community strengths, among youth respondents

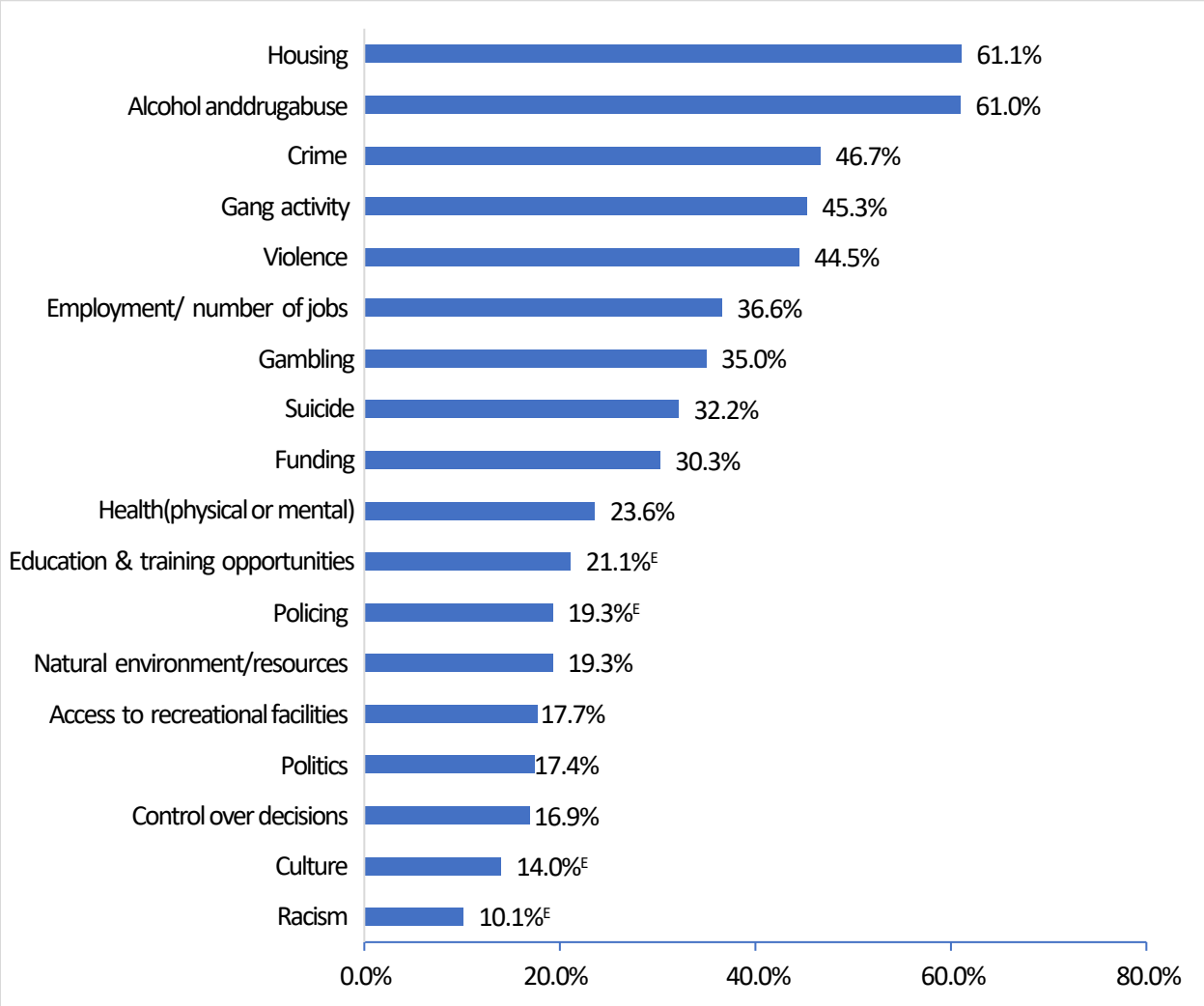


Note: Respondents could choose more than one response

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

Youth respondents were then asked to report on the main challenges they felt their communities were facing. **Youth were most likely to identify housing (61.1%) and substance use (61.0%) as challenges within their communities.** They also felt that crime (46.7%), gang activity (45.3%), and violence (44.5%) were key community challenges (see Figure 6).

Figure 6: Insights into community challenges, among youth respondents



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

Youth who identified community challenges were then asked if they felt there had been any positive change/progress in these areas within the 12 months leading up to the survey (see Table 5). **Youth were most likely to report good progress in access to recreational facilities (12.8%) and culture (11.2%).** Approximately one-third of youth felt there had been some progress in all areas. **A**

notable proportion of youth (16.0%) also recognized the natural environment and its resources as a community challenge that was worsening.
With respect to the two most frequently reported challenges identified by youth (housing and substance use), 24.4% of youth felt that substance use was worsening in their communities, and 51.1% felt there had been no progress.

With respect to housing, 7.0% [E] felt there had been good progress, and 30.5% felt there had been some progress. Over one-third (37.2%) felt there had been no progress, and 25.3% felt the housing challenge was worsening in their communities.

While the youth perceived crime, gang activity, and violence to be some of the most pressing challenges in their communities, **18.4% of youth respondents reported feeling very safe in their communities, and 57.1% felt reasonably safe.** The remaining 22.4% of youth respondents felt somewhat unsafe, and 2.1% [E] felt very unsafe.

Table 5: Progress on community challenges, as reported by youth

	Good Progress	Some Progress	No Progress	Worsening
COMMUNITY PROGRESS	%	%	%	%
Access to recreational facilities	12.8	39.0	45.0	3.2[E]
Alcohol and drug abuse	F	F	51.1	24.4
Control over decisions	F	32.3	49.3	F
Crime	F	34.7	43.2	F
Culture	11.2 [E]	39.7	43.6	5.6[E]
Education and training opportunities	8.8	44.1	37.5	9.6 [E]
Employment/ number of jobs	8.3[E]	36.4	43.9	11.5 [E]
Funding	10.2[E]	30.5	40.9	18.4 [E]
Gambling	6.2[E]	23.1	47.6	23.1
Gang activity	2.4[E]	26.4	42.0	29.2
Health (physical or mental)	8.6[E]	37.6	42.2	11.7[E]
Housing	7.0[E]	30.5	37.2	25.3
Natural environment/resources	7.8[E]	29.1	47.1	16.0
Policing	F	F	F	F
Politics	6.3 [E]	31.8	46.2	15.7 [E]
Racism	6.2[E]	31.9	50.4	11.6 [E]
Suicide	11.7	26.9	37.8	23.6
Violence	3.1[E]	29.1	38.3	29.5

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)
[F] Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)

RELATIONSHIPS & WELL-BEING: EXPERIENCES with BULLYING

Community and personal wellness are closely linked to how relationships are built, nurtured, and maintained. This section examines experiences of bullying among adults, youth, and children. Bullying disrupts healthy relationships, and can reflect a community's strengths and challenges.

ADULTS

Adults were asked if they had experienced any physical or verbal aggression towards them in the 12 months prior to the survey. Most had not, but 12.1% reported that they had often or sometimes experienced physical aggression, and 22.7% had experienced verbal aggression often or sometimes. Adults reported that the aggression was most likely to occur in the community (44.3%) or at home (44.1%). Occurrences of aggression were also reported at work or school (22.0%), and/or online (17.2%).

According to the regional component of the survey, 12.2% of adults reported that they had been bullied in some form in the 12 months prior to the survey. **Of those adults who had been bullied, 20.3% had sought – and received – help in dealing with the bullying.**

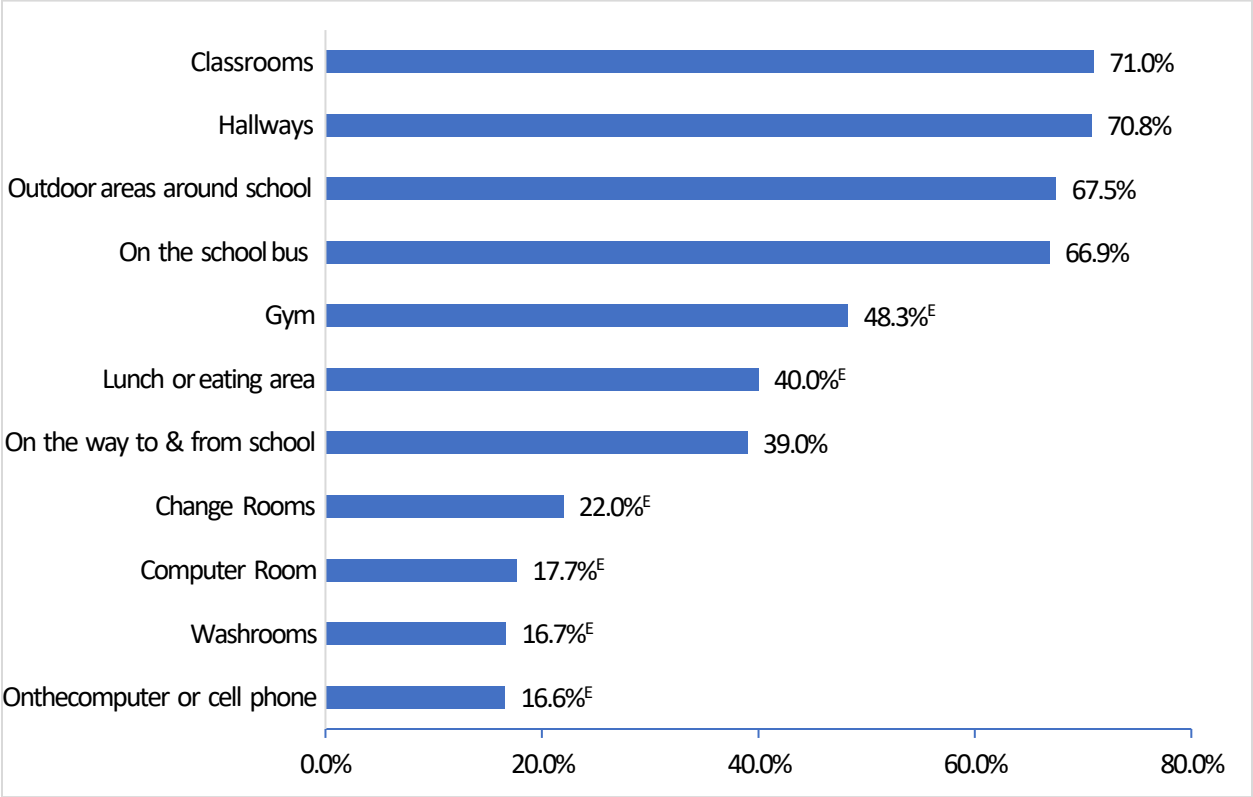
The regional component of the survey also indicates that 9.3% of adult respondents had experienced cyber-bullying.

Adults were also asked about their experiences with racism. In the year prior to the main RHS survey, 16.8% of adults reported that they had experienced racism. Most of these adults (82.0%) reported that this experience took place outside the community. Others reported that the racism had occurred in the community (13.5%[E]), at work or school (10.2%[E]), or at home (5.4%[E]). These adults show resilience to the racism they faced, in that 60.7% reported that this racism had little to no effect on their self-esteem.

YOUTH

Approximately 1 in 5 of the youth surveyed (21.5%[E]) had been bullied over the 12 months leading up to the survey, and 31.5% of youth had experienced bullying in school. Most youth thought that school bullying happened most often in classrooms (71.0%) and hallways (70.8%). Other frequent responses were that it occurred in outdoor areas around the school (67.5%), on the school bus (66.9%), or in the gym (48.3% [E]). According to the youth, it was least likely to happen on the computer or cell phones (16.6% [E]) (see Figure 7).

Figure 7: Places bullying happens most often, according to youth



E High sampling variability, interpret with caution (CV: 0.166-0.333)

Although cyber-bullying was the least commonly reported form of school bullying, 13.0% of youth reported that they had personally experienced cyber-bullying sometime over the 12 months leading up to the survey. **Over one-third (35.1%) of the youth who were cyber-bullied did not seek help in dealing with their bullying experience. Another third of youth who were cyber-bullied (33.7%) sought help, but did not receive all the help that they needed, and 31.2% E sought help, and received all the help they needed.**

When youth were asked who they would go to first if they had problems with bullying, over half (55.7%) of all youth respondents said they would go to their parents. The second most common response that was they had no one they would go to (19.8%).

Youth were also asked who they would go to first if they had a problem with physical assault. Most youth (69.8%) reported that they would go to a parent first. Others would go to another family member (6.3%), a friend their age (5.1%E), or an adult friend (0.9%E) for help. A number of youth (16.2%) reported they would go to no one.

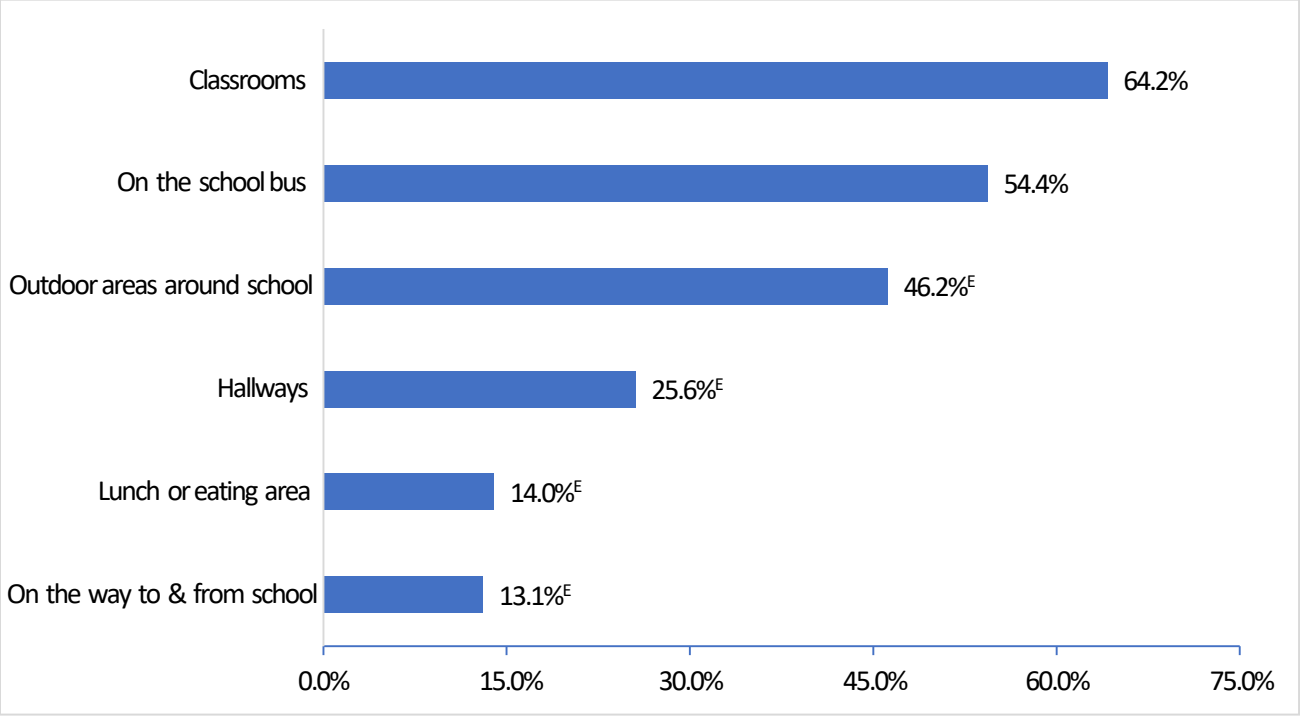
CHILDREN

According to parents/guardians, most children 5 years of age and older (79.8%) had not been bullied in the 12 months prior to the survey, but 20.2% had been bullied during this time. **A significantly higher proportion of children with ≥1 chronic health conditions (50.0%, 95% CI: 37.7, 62.2) had been bullied in the past year compared to children with no chronic health conditions (15.0% [E], 95% CI: 10.3, 21.3)**.

Parents/guardians were also asked if their child (5 years of age or older) had experienced bullying in school. Most caregivers (84.0%) reported that the child had not been bullied in school, while 16.0% stated that their child had experienced bullying.

Parents/guardians were also asked about the places they thought school bullying happened most often (see Figure 8). Most caregivers (64.2%) believed it happened in the classroom, on the school bus (54.4%), or in the outdoor areas around the school (46.2%). **Most of the children (60.7%) who had experienced bullying did seek help in dealing with it, and received all the help they needed**, while 24.7% sought help and did not receive all the help they needed, and 14.6%[E] did not seek help.

Figure 8: Places bullying happens most often, among children



[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

CONCLUSIONS & RECOMMENDATIONS

IN SUMMARY: LANGUAGE & CULTURE

Language and culture are the foundation of health and wellness in First Nations communities. They are connected to identity, emotional, and social vitality (King et al., 2009), and are used to express and maintain knowledge/ways of knowing, skills, and cultural values. Suppression or loss of language can impact wellness and community healing (NCCAH, 2016).

While most adults, youth, and children spoke English in their daily lives, **more than half of all adults, youth, and children had at least some knowledge of their First Nations language, even if only a few words. Findings also show that a higher proportion of Manitoba First Nations adults, youth, and children regularly speak their First Nations language when compared to national-level results of the RHS 3.**

About two-thirds of adult respondents who had knowledge of a First Nations language could understand or speak it intermediately or fluently. That being the case, **a significantly higher proportion of older adults (55+ years of age) could fluently speak or understand the language, when compared to younger adults (18-54)**. This demonstrates that while many adults have knowledge of their First Nations language, the older generations are more likely to be fluent speakers of their language.

Lower rates of First Nations language knowledge may be attributed to colonial policy. For example, residential school survivors reported on the negative health impacts of attending a residential school and cited loss of language, loss of cultural identity, and loss of traditional religion/spirituality as key health impacts. This being the case, we do also see resilience here. According to children's caregivers and youth respondents, grandparents are most likely to be the ones that help children and youth understand their culture. Grandparents are passing cultural knowledge to young people, even though many from this generation attended residential schools (i.e., 52.5% of adult respondents had a grandparent who attended, 48% of youth had a grandparent who attended, and 44.7% of children had a grandparent who attended).

Among youth, we see a steady increase in the perceived importance of speaking a First Nations language across all phases of the Manitoba RHS, with 88.1% of youth expressing an interest in the RHS 3 survey. Although youth are demonstrating the importance of speaking their First Nations language, only about a quarter of youth can understand or speak their First Nations language, and about one-third of youth cannot read or write in their First Nations language.

In the case of children, the results indicate a slight proportional decrease across all phases of the RHS in the ability to speak or understand a First Nations language intermediately or fluently. While a relatively small proportion of children know their language, parents/guardians indicate that interest and support for learning a First Nations language is high across all three surveys (~90%). This finding may speak to a need for additional **language programming and support for youth and children**. Revitalization of language and culture can be crucial for improving health outcomes (NCAAH, 2016). **One example may be language**

revitalization programs, where Elders/older generations work together with youth and children, where language revitalization is implemented as a health promotion strategy.

IN SUMMARY: BULLYING

While most adults and youth felt a strong or very strong sense of belonging in their communities, bullying and aggression do remain an area of concern for approximately 1 in 5 adults and 30% of youth respondents. Most who are affected by bullying or physical/verbal aggression have not sought help.

Of concern, children with chronic health conditions were more likely to be bullied than children with no health conditions.

IN SUMMARY: COMMUNITY STRENGTHS & CHALLENGES

When asked about ***community strengths***, adults and youth respondents alike most frequently cited the following areas as points of strength in their communities:

- ☐ **Elders**
- ☐ **Community health programs**
- ☐ **Awareness of culture**
- ☐ **Use of First Nations language**
- ☐ **Family Values/Connections**

In terms of ***community challenges***, adult and youth respondents similarly reported that **substance use and housing** were most likely to be challenges in their communities. These same challenges were the most commonly reported in the RHS 2.

When asked about progress made in the area of substance use, about one-quarter of adults and youth felt the situation was worsening. About one-third of adults and youth thought that here had been good or some progress in the area of housing, but 20.4% felt it was worsening.

Access to safe, adequate housing is a basic human right, and yet it remains a key challenge in Manitoba First Nations communities. Substandard housing conditions, or lack of adequate housing, have been associated with a number of health-related concerns, including the increased risk of respiratory ailments, chronic disease, and injury (NCCAH, 2017).

In terms of substance use as a community challenge, language and cultural revitalization may be viable health promotion strategies in this area. Approximately 90% youth and children expressed the importance of language and cultural activities (adults were not asked this question), and use of First Nations language and awareness of culture were seen as community strengths. Exposure to language and culture can be integral to First Nations health and well-being. Findings from the national RHS 2 also indicate that individuals who are involved in cultural and land-based activities tend to experience more physical, mental, emotional, and spiritual balance, less substance use, and less depression (FNIGC, 2012).

SECTION 2: HOLISTIC WELLBEING (Physical, Mental, Emotional, and Spiritual Health)

This section examines physical, mental, emotional, and spiritual aspects of health and well-being among adults, youth, and children. Specifically, this section analyses findings related to self-reported perceptions of mental and physical health, key factors that adults and youth feel make them holistically healthy, and perceived physical, mental, emotional, and spiritual balance among adults and youth. Caregivers of children surveyed were not asked these questions. This section also examines perceived support for mental and emotional well-being, experiences with suicide, and measures of resilience.

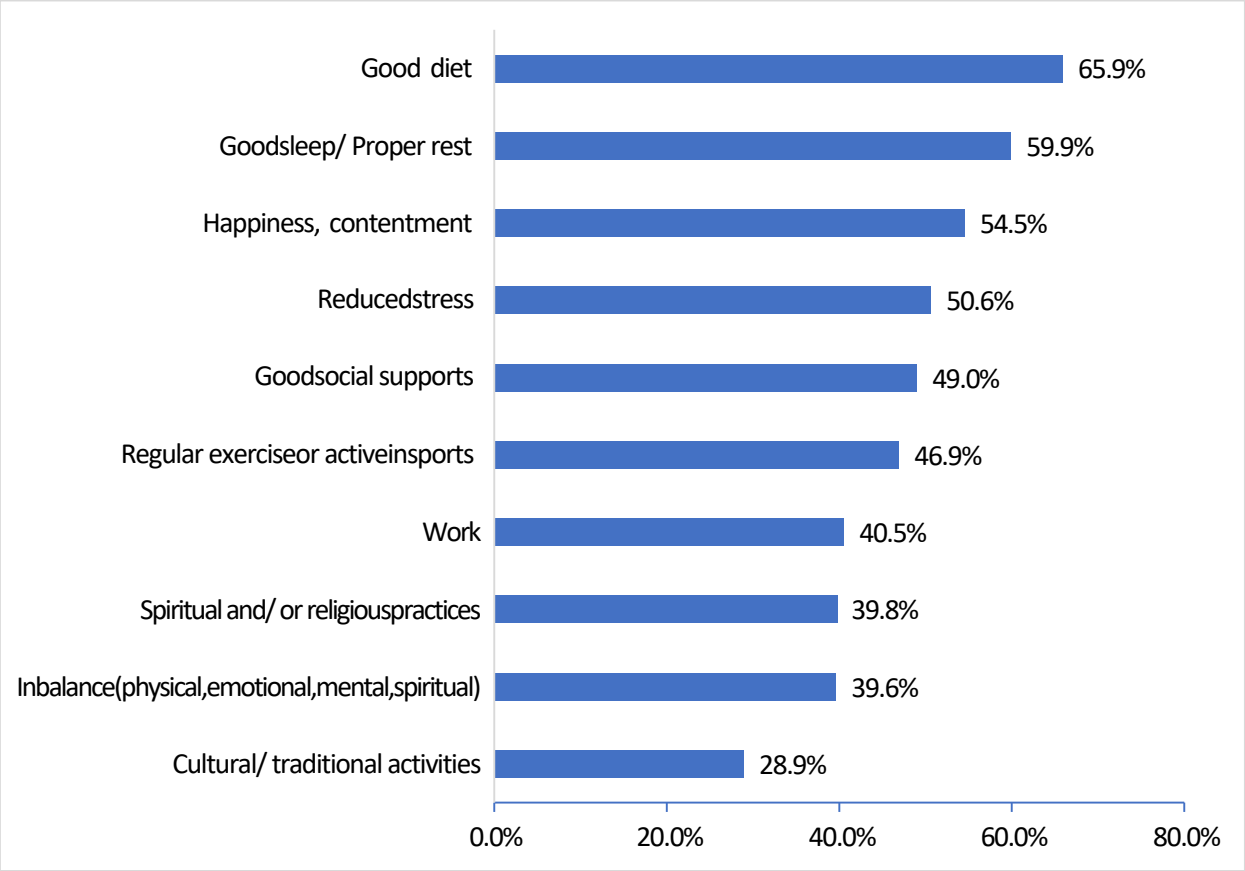
ADULTS

When asked to compare their overall health to how they felt one year prior to the survey, most adults (62.6%) reported that their health had been about the same for the past year. About one-quarter (26.5%) stated that their health was much or somewhat better than one-year prior, and 10.9% felt that their health was somewhat worse or much worse than the year prior.

In terms of mental health, slightly more than half (51.0%) of adults felt their mental health was excellent or very good. Over a third (36.0%) felt their mental health was good, and 13.0% felt it was fair or poor. Psychological distress was also measured in adults using the Kessler Psychological Distress Scale (K10), which is designed to measure anxiety and depression, based on a set of 10 questions that refer to a state of emotional or mental health. Using this measure, findings were fairly consistent with self-reported mental health, with more than half the adults surveyed (53.3%) likely to be well. The remaining 21.1% were likely to have a mild mental health condition, 13.7% were likely to have a moderate mental health condition, and 11.9% were likely to have a severe mental health condition.

Manitoba First Nation adults also reported on what made them feel holistically healthy (i.e., physically, emotionally, mentally, and spiritually). The most frequent responses included good diet (65.9%), good sleep (59.9%), happiness (54.5%), reduced stress (50.6%), and good social supports (49.0%) (see Figure 9).

Figure 9: Aspects of life that make adults feel holistically healthy



Adults were also asked how often they felt in balance physically, emotionally, mentally, and spiritually. More than two-thirds (~62-68%) of respondents felt in balance across all four aspects all or most of the time (see Table 6).

Table 6: Balance in the four aspects of life, among adults

How often do you feel in balance in the four aspects of your life?	All/Most of the time (%)	95% CI	Some of the time (%)	95% CI	Almost none/none of the time (%)	95% CI
Physically	67.6	63.1-71.7	23.2	19.4-27.4	9.3	7.4-11.5
Emotionally	65.3	60.3-70.0	26	20.9-31.8	8.7	7.0-10.8
Mentally	63.3	58.3-68.0	26.1	21.6-31.2	10.6	8.5-13.1
Spiritually	62.0	57.4-66.4	26.6	22.8-30.8	11.4	9.3-13.8

RELATIONSHIPS of SUPPORT

Adults were also asked about receiving support that contributed to their mental and emotional well-being. Approximately 1 in 5 respondents (21.6%) reported that they felt like they had needed to see or talk to someone about their emotional or mental health in the 12 months prior.

When asked who they had seen or talked to about their emotional or mental health, most adults (43.0%) reported talking to or seeing a friend. Immediate family members (36.1%) and other family members (29.2%) were also frequently reported as sources of support.

When asked about the kinds of support available when they needed it, about three-quarters of respondents (~68-75%) felt they had someone to listen to them talk, someone that they could count on when they needed it, someone who showed love and affection, someone to have a good time with, and someone to do something enjoyable with (see Table 7).

While most adults who were surveyed did feel that they had access to support from community, family, and friends approximately 10% felt that they never or almost never had the forms of support listed in Table 7 below.

Table 7: Perceptions of available support, among adults

How often is the following kind of support available to you when you need it?	All/Most of the time (%)	Some of the time (%)	Almost none/None of the time (%)
Someone you can count on to listen to you talk when you need to talk	74.0	17.2	8.8
Someone you can count on when you need help	73.1	16.9	10
Someone to take you to the doctor if you needed it	68.5	16	15.4
Someone who shows you love and affection	75.1	16.7	8.2
Someone who can give you a break from your daily routines	63.6	23.6	12.8
Someone to have a good time with	72.4	19.8	7.9
Someone to confide in or talk about yourself or your problems	68.8	22	9.2
Someone to do something enjoyable with	73.8	19	7.3 [E]

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

SUICIDE

Despite the supports available in respondents' lives, some faced experiences related to suicide. While a high proportion of adult respondents had not considered (87.0%) or attempted (89.5%) suicide, over 10% had. Specifically, 13.0% (95% CI: 10.4, 16.0) of adults had considered suicide and 10.5% had attempted it. Additionally, although a high proportion of adults (87.9%) did not have a close friend or family member die by suicide in the 12 months before the survey, 12.1% of the adults surveyed had been close to someone who had lost their life to suicide that year.

Positively, these numbers show a statistically significant decrease in the number of respondents who had considered suicide, across all phases of the RHS. In 2002-2003, the RHS 1 showed that 32.4% (95% CI: 26.5, 39.0) of adult respondents had considered suicide in their lifetime, and in the RHS 2, 19.6% (95% CI: 17.1, 22.3) of adults had thought about committing suicide. There is also a decreasing trend in suicide attempts across surveys, where the RHS 1 indicates that 16.7% of adults had attempted suicide, and the RHS 2 shows that 13.2% had attempted suicide. Findings from the RHS 1 also indicate that 18.0% of adults had lost a close friend or family member due to suicide.

Results from the current analysis show that 52.3% of the adults who considered suicide had had these thoughts as adults, and 49.9% had these thoughts as adolescents. Of those who had attempted suicide, most had done so as adolescents (61.2%) and 38.6% had done so as adults. Most adults who considered suicide (60.3%) did not seek help from a health professional.

Cross tabulation of this data with chronic health conditions shows that a significantly higher proportion of adults with one or more chronic health conditions had seriously considered suicide (18.7%, 95% CI: 14.5, 23.7) compared to adults with no chronic health conditions (7.4%, 95% CI: 5.3, 10.2). Similarly, a significantly higher proportion of adults with one or more health conditions (15.4%, 95% CI: 11.9, 19.8) had attempted suicide when compared to adults with no chronic health conditions (5.9%, 95% CI: 4.2, 8.1).

RESILIENCE

Despite challenges such as suicide faced by individuals, families, and communities, adults are demonstrating resilience and an overall sense of wellness. When asked, most adults reported that "quite a bit or a lot" of the time they could solve problems without harming themselves or others (73.9%), that they enjoyed their family/partner's cultural and family traditions (69.3%), that they tried to finish what they started (69.1%), and that their family supported them during difficult times (68.0%) (see Table 8).

Table 8: Measures of resilience, among adults

To what extent do these sentences describe you?	Quite a Bit/A Lot (%)	Somewhat (%)	Not at All/A Little (%)
I have role models in my life that I look up to	57.0	17.9	25.1
Getting and improving qualifications or skills is important to me	66.2	22.4	11.3 [E]
My family know a lot about me	65.6	19.6	14.8
I try to finish what I start	69.1	22	9 [E]
I can solve problems without harming myself or others (e.g. without using drugs or being violent	73.9	17.7 E	8.4 [E]
I know where to get help in my community	59.2	25	15.8
I feel I belong in my community	61.6	24.1	14.3
My family supports me during difficult times	68.0	20.5	11.5 [E]
My friends support me during difficult times	60.7	22.2	17.1 [E]
I am treated fairly in my community	47.9	31.4	20.7 [E]
I have opportunities to show others that I can act responsibly	64.4	25.4 [E]	10.2 [E]
I enjoy my family's/partner's cultural and family traditions	69.3	19.8 [E]	10.9 [E]

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

YOUTH

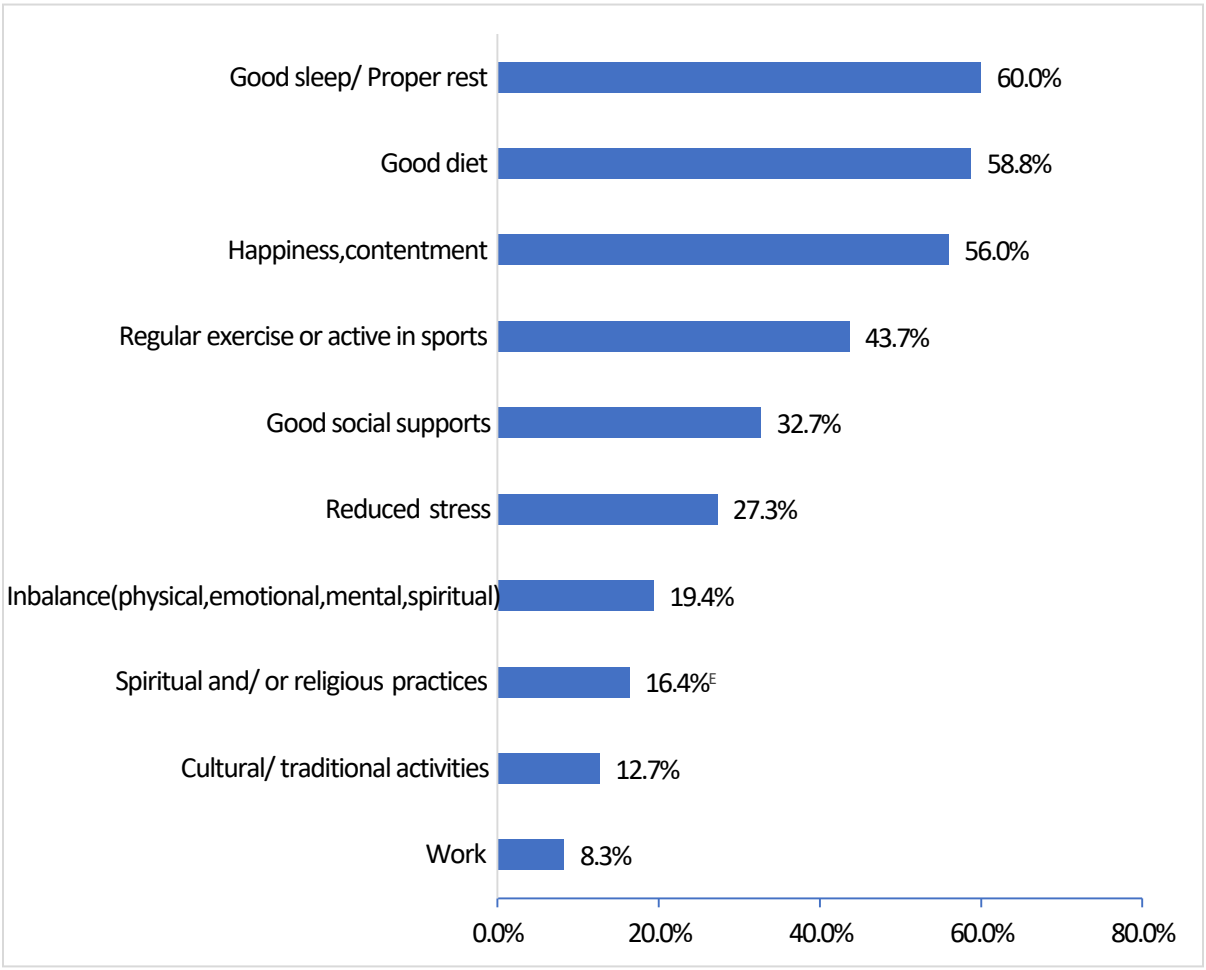
Similar to adult respondents, youth were asked to compare their general state of health with how they had felt the year prior. About two-thirds (63.1%) of the youth surveyed reported that their health was about the same as the year before, and 35.4% felt that their overall health was somewhat or much better.

When asked about their mental well-being, 50.0% of youth reported that their mental health was excellent or very good, 40.3% felt their mental health was good, and 9.6% felt their mental health was fair or poor. Self-reported mental health is fairly consistent with measures of psychological distress using the Kessler Psychological Distress Scale (K10). Most youth (69.9%)

were likely to be well according to this scale. A smaller percentage were likely to have a mild mental health condition (12.6%), a moderate mental health condition (6.1%), or a severe mental health condition (11.5%).

Manitoba First Nation youth also reported on what made them feel holistically healthy (i.e., physically, emotionally, mentally, and spiritually). A high proportion of youth stated that good sleep (60.0%), good diet (58.8%), happiness (56.0%), regular exercises and involvement in sports (43.7%), and good social supports (32.7%) were the most important things in life to feeling holistically healthy (see Figure 10).

Figure 10: Aspects of life that make people feel holistically healthy, among youth



E High sampling variability, interpret with caution (CV: 0.166-0.333)

When youth described their sense of physical, emotional, mental, and spiritual balance, most felt in balance across all four aspects all or most of the time. That being the case, youth were more likely to feel in physical (74.7%) or emotional balance (66.0%), than they were to feel in mental (59.1%) or spiritual (58.4%) balance (see Table 9).

Table 9: Balance in the four aspects of life, among youth

How often do you feel in balance in the four aspects of your life?	All/Most of the time (%)	95% CI	Some of the time (%)	95% CI	Almost none/none of the time (%)	95% CI
Physically	74.7	70-78.9	16.1	12.7-20.0	9.3	6.5-13.0
Emotionally	66.0	58.1-73.1	20.5	14.6-28	13.5 [E]	9.2-19.3
Mentally	59.1	50.1-67.6	24.8	18.1-32.9	16.1 [E]	11.0-23.1
Spiritually	58.4	50.8-65.7	26.0	19.3-33.9	15.6	11.2-21.4

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

RELATIONSHIPS of SUPPORT

When asked if they felt they needed to talk to or see someone about their emotional or mental health, 12 months prior to the survey, 8.4% [E] of youth said they did, while 91.6% reported that they did not. Youth also reported on the kinds of support that were available when they needed it. Most of the youth surveyed felt that they received the supports listed below all or most of the time (see Table 10).

Table 10: Perceptions of available support, among youth

How often is the following kind of support available to you when you need it?	All/Most of the time (%)	Some of the time (%)	Almost none/None of the time (%)
Someone you can count on to listen to you talk when you need to talk	81.5	10.7	7.7 [E]
Someone you can count on when you need help	81.6	12.4	6.0 [E]
Someone to take you to the doctor if you needed it	76.1	10.2	13.7 [E]
Someone who shows you love and affection	77.0	F	F
Someone who can give you a break from your daily routines	69.5	19.4	11.1 [E]
Someone to have a good time with	83.4	12.9	3.7 [E]
Someone to confide in or talk about yourself or your problems	74.5	15.2	10.4 [E]
Someone to do something enjoyable with	84.0	11.8	4.2 [E]

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

F Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)

SUICIDE

Despite the support of family, friends, and community, suicide remains a holistic health concern. While most youth (88.5%) had never seriously considered suicide, 11.5% had. Similarly, a high proportion of the youth surveyed (92.5%) had never attempted suicide, but 7.5%[E] had. Most youth (88.6%) reported that they did not have a close friend or family member lose their life to suicide in the 12 months prior, but 11.4% lost a close friend or family member that year.

Findings from the RHS 1 indicated that 19.2% of youth had considered committing suicide, and findings from the RHS 2 show that 14.3% had considered it. This shows a steady decrease over time. In terms of the loss of a friend or family member, proportions remain similar: 11.5% of youth had lost a friend or family member in the 2008-2010 survey.

A large proportion of youth respondents from the RHS 3 (79.8%), who had considered suicide did not see or talk to a health professional about these suicidal thoughts (while 20.2% did).

Most youth (50.8%) said they would go to a parent first if they had a problem with suicidal thoughts. Others reported they would go to a friend their age (12.5%[E]), other family members (11.3%), a principal, teacher, or counselor (2.9%[E]). A number of youth (18.3%), however, felt they had no one to go to first.

RESILIENCE

Despite some challenges to holistic well-being, youth demonstrate resilience and a

strong sense of self. When provided with a number of statements (which they could agree or disagree with), more than 80% of the youth surveyed agreed or strongly agreed that they liked the way they were (84.5%), felt they had a lot to be proud of (88.3%), felt that a lot of things about them were good (84.6%), and that when they did something they did it well (83.9%). Most youth also felt loved quite a bit or a lot (80.1%) (while 11.4%[E] felt lonely, and 9.5% [E] felt stressed).

Youth were also asked a number of questions as measures of resilience (see Table 11), and the results indicate that a high proportion of youth (approximately 70-90%) demonstrate measures of resilience in their personal, family, and community lives. Youth most frequently agreed that getting an education was important to them (88.2% of youth gave this response), that parents/caregivers knew a lot about them (84.1%), that they felt they belonged at school (81.3%), and that family supported them during difficult times (81.3%).

Table 11: Measures of resilience, among youth

To what extent do these sentences describe you?	Yes (%)	Sometimes (%)	No (%)
I have role models in my life that I look up to	74.2	19.2	6.6 [E]
Getting an education is important to me	88.2	F	F
My parents/caregivers know a lot about me	84.1	F	F
I try to finish what I start	75.1	F	F
I can solve problems without harming myself or others (e.g. without using drugs and/or being violent	79.6	F	F
I know where to go in my community to get help	73.4	18.0	8.7 [E]
I feel I belong at my school	81.3	20.7	7.9 [E]
My family supports me during difficult times	81.3	F	F
My friends support me during difficult times	70.6	22.0	7.4 [E]
I am treated fairly in my community	70.6	F	F
I have opportunities to develop skills that will be useful later in life (i.e., job skills, skills to care for others)	75.3	21.5 [E]	3.1 [E]
I enjoy my community's traditions	72.7	F	F

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

F Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)

CHILDREN

HOLISTIC HEALTH

Parents/guardians were asked questions about the emotional and mental well-being of their child. Caregivers reported that most of the children surveyed (63.8%) had gotten along with the rest of their family very well, with no difficulties over the 6 months prior to the survey. Most parents/guardians (93.8%) also felt that their child did not have more emotional or behavioural problems than other children their age (compared to 6.2%[E] who thought their child did).

RESILIENCE

Children also showed a good sense of resilience based on the questions shown in Table 12. Approximately 70-90% of parents/guardians responded positively to the statements below. In particular, most caregivers (92.0%) felt that doing well in school was important to their child, that their child had role models they could look up to (89.9%), and that the child's family cared about them when times were hard (e.g., the child was sick or had done something wrong) (89.7%).

Table 12: Measures of resilience, among children

To what extent do these sentences describe your child?	Yes (%)	Sometimes (%)	No (%)
Your child has role models they look up to	89.9	F	F
Getting an education or doing well in school is important to my child	92.0	F	F
The child's parents/caregivers know a lot about them (e.g., what makes them happy, sad)	89.1	F	F
Your child tries to finish what they start	75.6	F	F
When things don't go the child's way, they can fix it without hurting themselves or others	71.2	20.8	8.3 [E]
Your child knows where to get help	82.0	F	F
The child feels they belong at their school	84.5	F	F
The child's family cares about them when times are hard	89.7	F	F
The child's friends care about them when times are hard	84.0	F	F
The child is treated fairly in their community	86.7	F	F
The child has chances to learn things that will be useful when they're older (e.g., cooking, working, helping others)	88.7	F	F
The child likes the way their community celebrates things (i.e., holidays, festivals)	84.7	F	F

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

F Result has been suppressed due to high variability (CV: > 0.333) or low cell count (<5 cases)

CONCLUSIONS & RECOMMENDATIONS

IN SUMMARY: HOLISITIC HEALTH

Most adults reported that they felt their health was stable (62.6%) or had improved (26.5%) in the year prior to the survey, and just over half of all adults were likely to be well in terms of their mental well- being. Adults recognized the importance of good food and rest to their holistic well-being, but also the importance of emotional and mental health, like happiness and good social supports. Most youth (63.1%) felt their overall health was stable, and 35.4% felt it had improved. Most youth (69.9%) showed that they were likely to be psychologically well. Youth recognized the importance of the importance of physical activity, like sports, and good social supports to their holistic well-being.

While over 60% of all adults surveyed felt physically, emotionally, mentally, and spiritually in balance all or most of the time, approximately 30% of adults felt out of balance in these areas sometimes, or almost all of the time. This points to need for health strategies that draw on existing wellness in communities, to help restore balance to community members who might experience more challenges in these areas. Most adults (two-thirds to three-quarters of all respondents) felt like they did have emotional and mental support when they needed it.

Most youth felt physically and emotionally in balance all or most of the time, but a significantly lower proportion of youth felt mentally or spiritually in balance. Most felt support was available when they needed it.

While most adults and youth show generally good mental and emotional health, and a high proportion demonstrate measures of resilience, we do see that approximately 10% of those surveyed had considered suicide, or attempted it.

IN SUMMARY: SUICIDE AND RESILIENCE

Positively, we see a decreasing proportion of both adults and youth who have considered or attempted suicide across all phases of the RHS. In the case of adults, this difference is statistically significant. In 2002-2003, 28.0% of adults reported that they had considered suicide, and in 2008-2010, 19.6% had. The RHS 3 indicates that 13.0% had considered it. This finding is similar with youth. Although about 10% had considered or attempted suicide, these numbers show a steady decrease across all phases of the RHS. Importantly, **youth show high measures of resilience**. Over 80% reported that they liked the way they were and that they felt they had a lot to be proud of. They also reported feeling loved.

This being the case, findings from national-level RHS 3 show that First Nations youth with a health condition show higher rates of suicide ideation. This is a concern to bear in mind, as Indigenous adolescents with chronic illness do tend to experience higher emotional distress (Reading, 2009). The health of Indigenous youth can be promoted by aspects of cultural continuity such as "cultural identity and pride, awareness of colonization and its influence on the present, ability to speak one's Indigenous language, and the sharing of collective identity" (Chandler & Lalonde, 1998; Wexler, 2006). **Research indicates that First Nation communities** (in particular, this work was done in British Columbia) **with a strong knowledge of Indigenous language had reduced youth suicide rates.** Alarmingly, communities with <50% language knowledge had more than six times the number of suicides than did those with a strong language base (Hallett et al., 2007). Cultural and linguistic pride are key positive influences in mental health outcomes for Indigenous youth and **exposure to traditional teachings, land-based activities, and language learning can restore youth resiliency and overall health** (Chandler, 2014).

In policymaking and program development, it should be emphasized that suicide rates vary by community, and that not all First Nations adults or youth are at equal risk. Prevention efforts made at the population-level may fall short, because health promotion strategies may vary by community (Canadian Institute for Health Information, 2009).

SECTION 3: PHYSICAL WELL-BEING: CHRONIC HEALTH CONDITIONS & ACCESS TO CARE

This section moves to focus on the physical aspects of health and wellness. Here we examine the prevalence of chronic health conditions (including diabetes) among Manitoba First Nations adults, youth, and children. In this area, the RHS draws on western measures of health to better understand the health strengths and challenges among Manitoba First Nation communities. Although we understand that these conditions do not occur in isolation – they are shaped by, and rooted in, the relationship between health, and generations of racist colonial policies – knowledge of chronic health conditions can be important in targeting health initiatives and health promotion strategies.

Body Mass Index (BMI) and bodily injury are also examined here, as it relates to physical health. Finally, data findings on access to home care, western/conventional health care, traditional medicine, and dental care are examined.

CHRONIC HEALTH CONDITIONS

Adults were asked to identify long-term health conditions, diagnosed by a health professional, that were expected to last, or that had already lasted, 6 months or more. These were defined as chronic health conditions. Adults could choose one or more responses from a list of 34 possible conditions. **Nearly half of all adults (49.5%) reported that they had been diagnosed with one or more chronic health conditions by a health professional, while 50.5% reported that they had no health conditions**. About one-third (31.9%) of all adult respondents reported co-morbidity (i.e., the presence of two or more chronic health conditions).

Just over half of all female respondents (53.4%) reported one health condition, while 45.9% of men reported one health condition. Although a higher proportion of women reported one condition, the difference between men and women is not significant. In the case of co-morbidity, women are also more likely than men to report two or more chronic health conditions, although the difference is not statistically significant (see Figure 11).

Figure 11: Proportion of adults with chronic health conditions, by number of conditions and gender

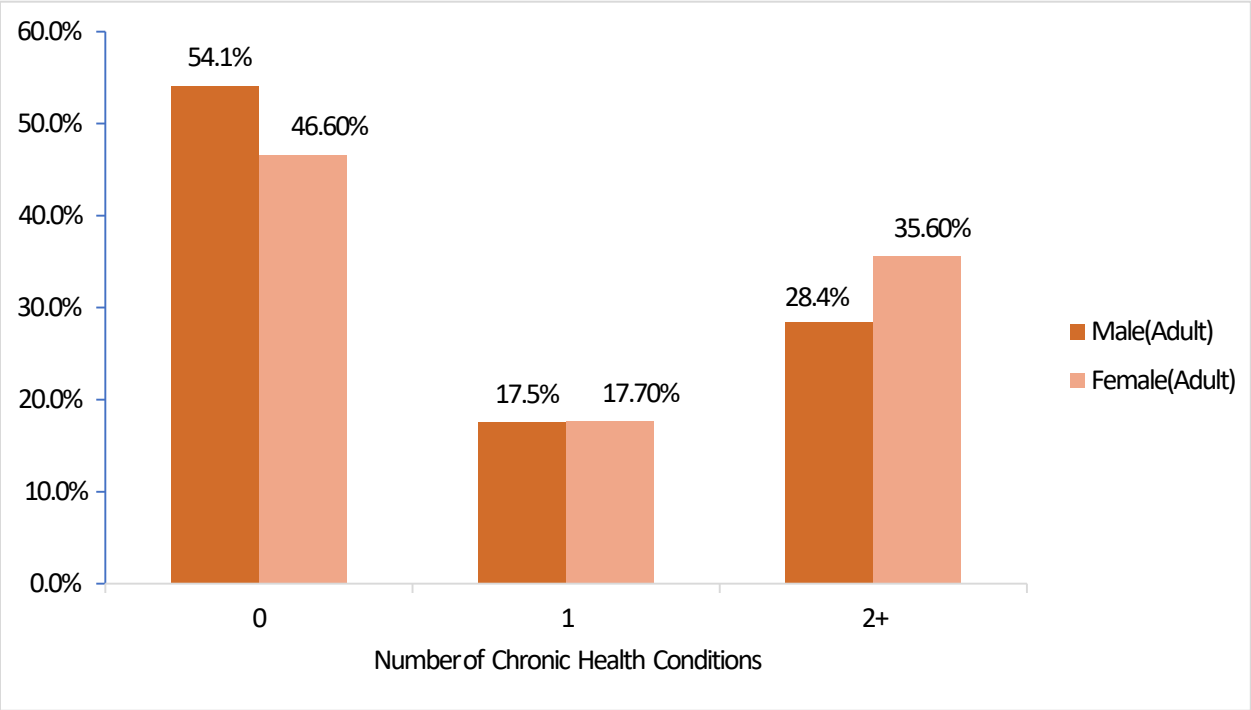
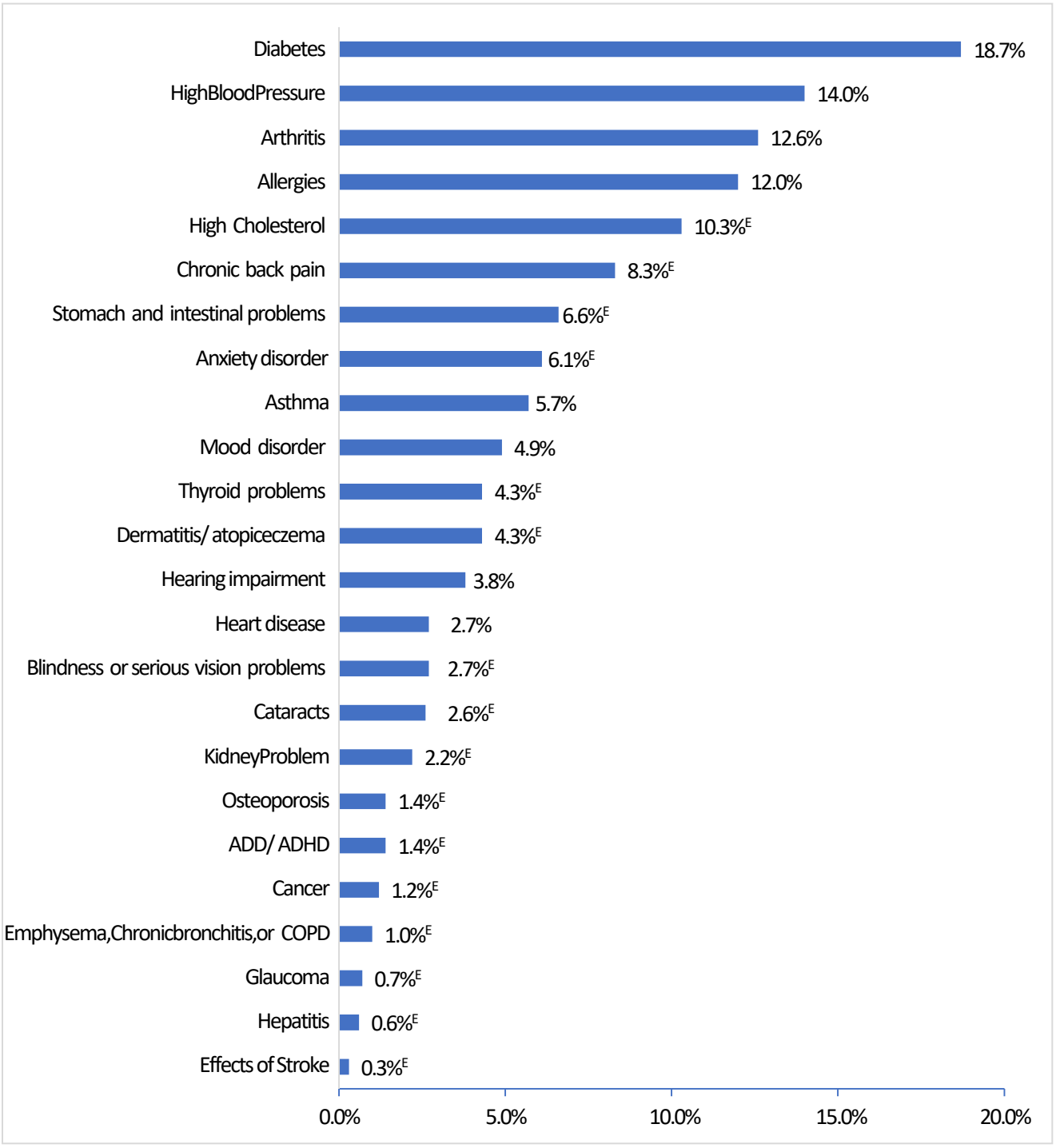


Figure 12: Prevalence of diagnosed chronic health conditions among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

ADULTS: PREVALENCE of DIAGNOSED CHRONIC HEALTH CONDITIONS

The most prevalent chronic health conditions reported by Manitoba First Nation adults were diabetes (18.7%), high blood pressure (14.0%), arthritis (12.6%) allergies (12.0%), and high cholesterol (10.3%[E]) (see Figure 12). While diabetes, high blood pressure/hypertension, arthritis, and allergies remain some of the most frequently reported chronic health conditions across all phases of the survey, **the prevalence of these health conditions shows a slight trend toward lowering across all surveys** (see Table 13).

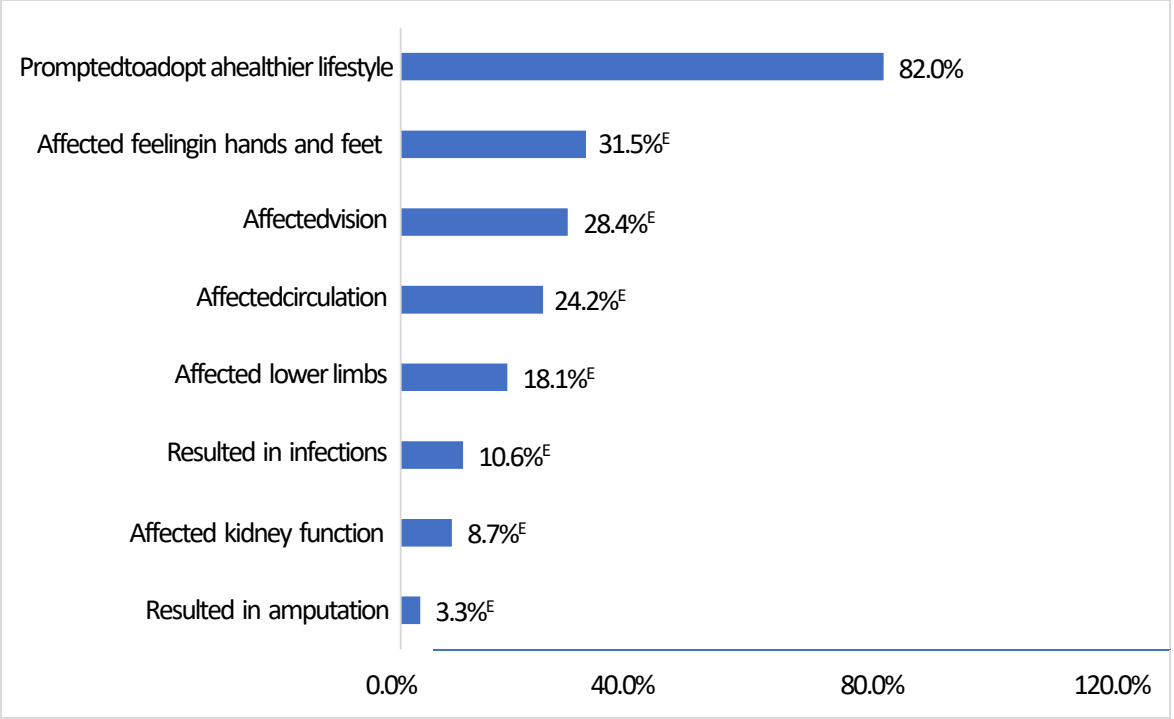
High cholesterol was not reported in the previous surveys. **Diabetes remains the most commonly reported chronic health condition among Manitoba First Nations adults, across all phases of the RHS.**

Of those adult respondents with the respective conditions (RHS 3), most were receiving treatment: 87.9% of those with diabetes, 89.8% with high blood pressure, 60.2% with arthritis, 41.4% with allergies, and 76.0% with high cholesterol were undergoing treatment and/or taking medication for the health condition.

Table 13: Prevalence of most commonly reported chronic health conditions, among adults, across all phases of the RHS

HEALTH CONDITION	RHS 3 (2015-2016)	RHS 2 (2008-2010)	RHS 1 (2002-2003)
	%	%	%
Diabetes	18.7	21.5	25.0
High blood pressure	14.0	21.8	18.2
Arthritis	12.6	15.3	20.5
Allergies	12.0	12.1	13.5

Figure 13: Impact of diabetes, among adults



Note: Respondents could choose more than one response
E High sampling variability, interpret with caution (CV: 0.166-0.333)

DIABETES

Most Manitoba First Nations adults with diabetes reported being diagnosed with Type 2 diabetes (92.6%). In terms of gender, a higher number of females (20.0%, 95% CI: 16.6, 23.8) had been diagnosed with diabetes compared to males (17.5%, 95% CI: 13.2, 22.9). Of the female respondents diagnosed with diabetes, 20.8% E were first diagnosed when they were pregnant.

Adult respondents who had been diagnosed with diabetes were asked what kind of treatment they used to manage their condition. Pills (79.9%), diet (71.4%), exercise (50.3%), and insulin (28.8% E) were most commonly reported. Respondents could also choose traditional medicine, traditional ceremonies/help from healer, or no treatment or measure, but these response categories were suppressed because there were too few cases or too high sampling variability to be reported.

Most adults with diabetes checked their blood sugar levels more than once a day (29.5%) or once a day (30.8%). That being the case, 17.7%E of respondents with diabetes had not checked their blood sugar at all in the 2 weeks prior to the survey.

When asked how their diabetes had affected them, most adults who had been diagnosed with the condition reported that it had prompted a healthier lifestyle (i.e., diet and/or exercise) (see Figure 13).

More than half of the respondents (55.3%) who had been diagnosed with diabetes were attending a diabetes clinic or seeing someone (e.g., medical doctor, nurse) for diabetes education. Of the 44.7% who were not attending a clinic, 61.5% reported that they were not attending because they no longer required diabetes education, and already had the information they needed. Others reported barriers to diabetes education such as lack of sufficient information about where to go (11.5%) and/or no diabetes clinic available in their area (6.9%). Roughly 15% (14.5%) chose not to attend a clinic.

BODY MASS INDEX (BMI)

When considering physical health, body weight can play a role in the development of chronic health conditions. Almost half of the adults surveyed were obese (47.5%) according to BMI measures, and 32.2% were overweight. **A significantly higher proportion of adults who were obese (53.3%, 95% CI: 47.8, 58.8) had one or more chronic health conditions compared to those with no chronic health conditions (41.4%, 95% CI: 35.9, 47.2).**

In the case of youth, almost half were within a "normal" weight category (44.2%), while 32.6% were overweight and 19.7% [E] were considered obese. A small proportion (3.5%[E]) were underweight. Most youth reported being very satisfied (30.7%) or somewhat satisfied (47.5%) with their weight.

Of the children surveyed, 31.1% were underweight, 29.2% were of a normal weight, 18.1% were overweight, and 21.6% were considered to be obese.

These BMI categories are based on Health Canada guidelines, which suggest that individuals weighing less than 18.5 kg/m^2 are underweight, those 18.5–24.9 kg/m^2 are normal weight, those 25–29.9 kg/m^2 are overweight and those ≥30 kg/m^2 are obese (Health Canada, 2015).

YOUTH: PREVALENCE of DIAGNOSED CHRONIC HEALTH CONDITIONS

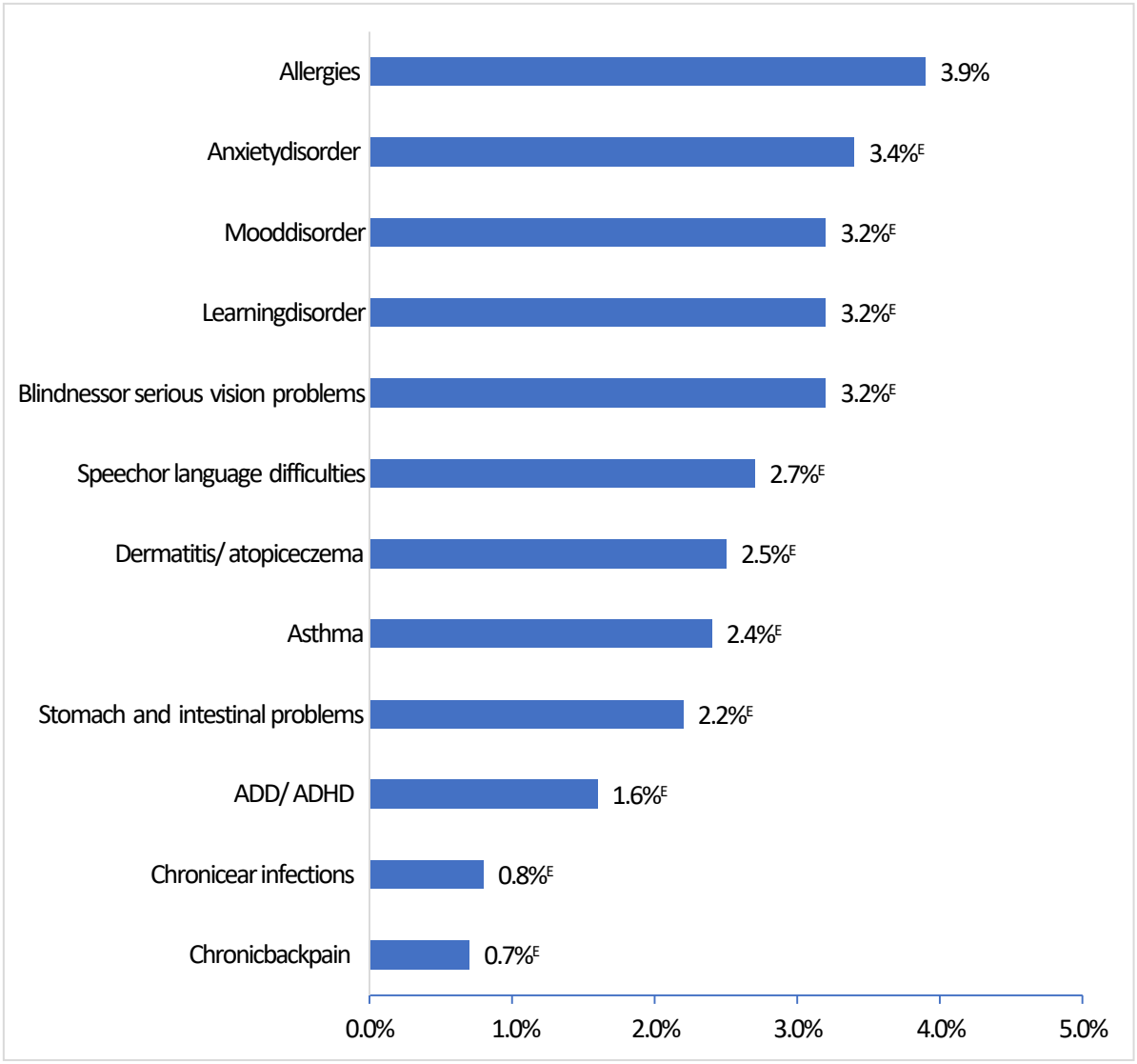
Most youth (84.1%) reported that they had no chronic health conditions, however 15.9% of youth reported being diagnosed with one or more chronic health conditions. A slightly higher proportion of female youth (19.3%) reported that they had been diagnosed with one or more chronic health conditions compared to male youth (12.8%).

Similar to adults, youth were asked to identify long-term health conditions, diagnosed by a health professional, that were expected to last, or that had already lasted, 6 months or more. They could select from a list of 28 possible conditions (Figure 14 does not list all possible conditions as some responses were suppressed due to not enough cases or too high sampling variability).

Among Manitoba First Nations youth, the most commonly reported chronic health conditions were allergies (3.9%), anxiety disorder (3.4%[E]), mood disorder (3.2%[E]), learning disorder (3.2%[E]), and blindness or serious vision issues (3.2%[E]) (see Figure 14).
This shows some difference from the RHS 1 where asthma (10.6%) and allergies (including skin) (7.9%) were the most frequently reported conditions, and the RHS 2 where chronic bronchitis (10.5%) and allergies (3.7%) were the most prevalent chronic health conditions among youth.

In the RHS 3, about one-third of youth diagnosed with the condition, were receiving treatment and/or taking medication for allergies (39.0%[E]), anxiety disorder (39.0%[E]), and learning disorder (34.4%[E]). While mood disorders and blindness or serious vision problems were also most commonly reported, treatment results cannot be reported due to high sampling variability (CV: >0.333) or small cell size (<5 cases).

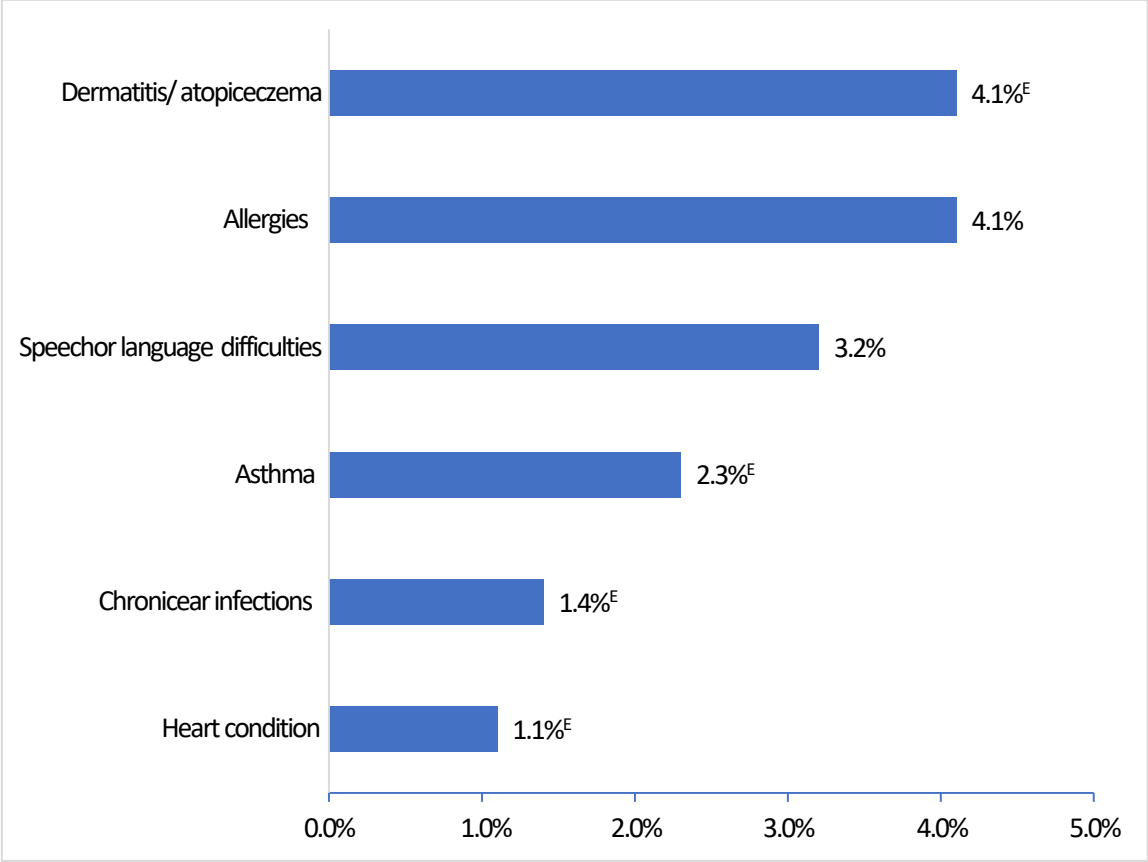
Figure 14: Prevalence of diagnosed chronic health conditions among youth



Note: Respondents could choose more than one response

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

Figure 15: Prevalence of diagnosed chronic health conditions among children



Note: Respondents could choose more than one response
E High sampling variability, interpret with caution (CV: 0.166-0.333)

CHILDREN: PREVALENCE OF DIAGNOSED CHRONIC HEALTH CONDITIONS

Parents/guardians were asked if their child had been diagnosed with a chronic health condition, and could choose one or more responses from a list of 26 possible conditions. Chronic conditions that do not appear in Figure 15 are due to low cell count (n<5) or very high sampling variability. Most children (85.4%) did not have a chronic health condition, but 14.6% of children had one or more chronic health conditions. 17.7% of male children and 11.3% of female children had one or more health conditions.

The most commonly reported chronic health conditions among children were dermatitis/atopic eczema (4.1%E), allergies (4.1%), and speech or language difficulties (3.2%).

While allergies and asthma remain some of the most frequently reported chronic health conditions among children across all phases of the survey, rates are significantly lower if we compare findings from the RHS 3 to the RHS 2 or RHS 1. Specifically, in 2002/2003, 14.9% E (95% CI: 9.3, 23.0) of children were reported to have asthma, and 10.5% E (95% CI: 6.1, 17.6) had allergies (including skin). In 2008/2010, 8.4% (95% CI: 6.6, 10.5) of children were reported to have asthma, and 8.1% (95% CI: 6.2, 10.5) had allergies. In the case of dermatitis/eczema,

prevalence has remained the same, at 4.1%.

Of those children diagnosed with the condition, most were receiving treatment: 34.5%[E] were receiving treatment for allergies, 73.2% for dermatitis/atopic eczema, 55.2%[E] for speech or language difficulties, 81.3% for asthma, 55.3%[E] for chronic ear infections, and 50.5%[E] for a heart condition.
Of the 43.8% of children who had an ear infection since birth, 41.6% had not had an ear infection in the 12 months prior to the survey, while 56.4% had one or more ear infections that year.

INJURY

Most Manitoba First Nations adults (84.2%) had not been injured in the 12 months leading up to the survey, however 15.8% of adults had been. Most of these injuries happened in their home or someone else's home (33%), in a sports field or facility (20.3%), or on a street, highway, or sidewalk (19.9%). When asked about the type of injury, most involved broken/fractured bones (20.6%[E]) or sprains/strain (26.8%). Almost half of all injured respondents attributed their injury to a fall (42.6%). When asked what they were doing when the injury occurred, most reported they were walking (35.7%) or doing sports or physical exercise (25.8%[E]).

In the case of youth, 12.6% reported they had been injured in the 12 months prior. When asked where the injury occurred, most youth reported that it happened at their home or in someone else's home (23.6%) or in a sports field/facility (32.4%). When asked about the type of injury, youth were most likely to report broken/fractured bones (23.3%[E]), sprains or strain (22.1%[E]), or scrapes/bruises/blisters (21.3%[E]). Almost half the injured youth attributed their injury to a fall (44.9%). When asked what they were doing when the injury occurred, more than half (54.8%) reported they were playing sports or doing physical exercise.

Parents/guardians reported that 6.5% of the children surveyed had an injury in the 12 months prior to the survey. Almost half of these children were injured in their home or in someone else's home (47.6%). They were most likely to be playing (43.1%[E]) or running (23.9%[E]). As a result, injuries were most commonly caused by a fall (63.7%).

ADULTS: ACCESS TO CARE

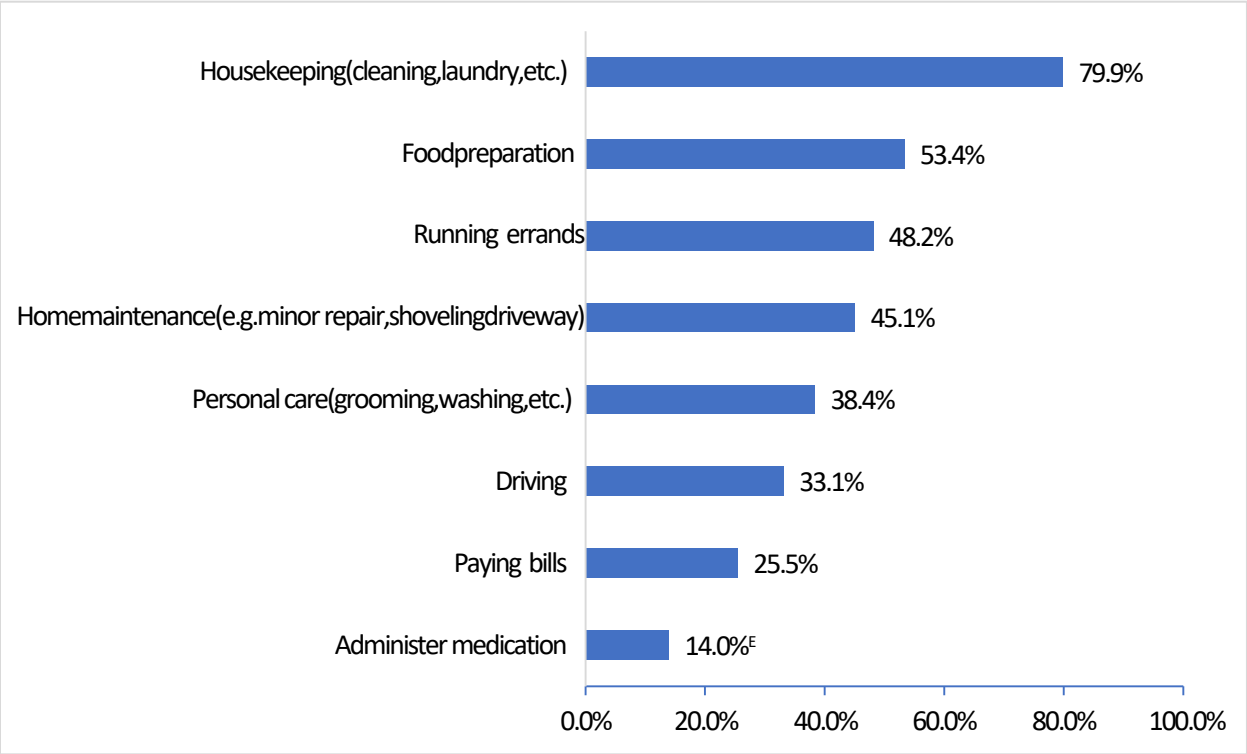
HOME HEALTH CARE

Approximately 10% of adult respondents reported that they helped with home care for a family member or friend who had a chronic condition or disability. Of those adults who provided care, most provided housekeeping (79.9%), food preparation (53.4%), and running errands (48.2%) (see Figure 16).

Most respondents did not have immediate family members that had been placed in a long-term care facility (85.6%). Of those that did, 5.7% were in facilities within their

community, and 9.3% had been placed in facilities outside the community.

Figure 16: Care provided by friend or family member for those with chronic conditions



Note: Respondents could choose more than one response

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

ACCESS & BARRIERS TO HEALTH CARE

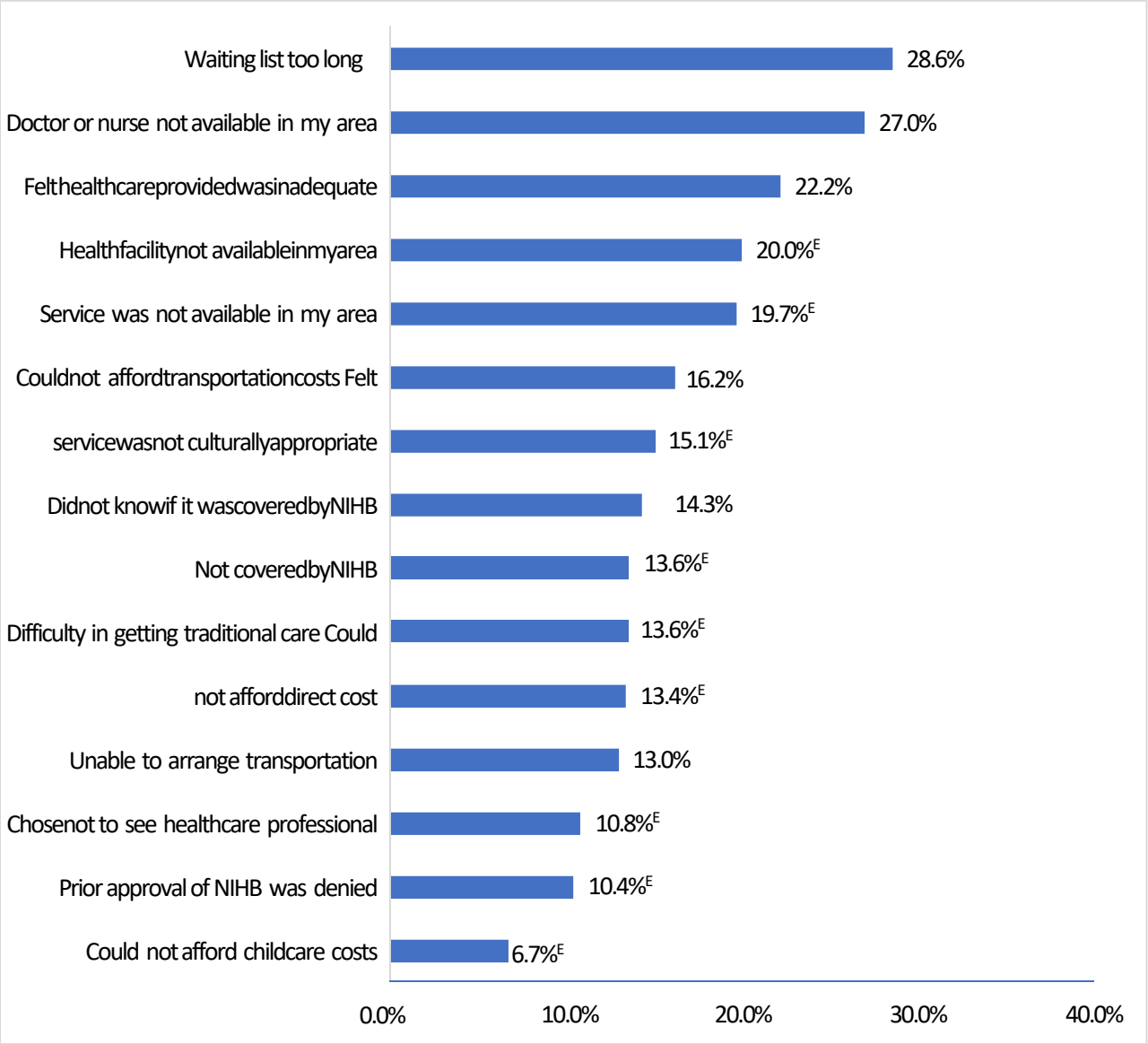
More than half of Manitoba First Nations adults (51.2%) rated the quality of the health care services in their community as fair or poor.

Further, a significantly higher proportion of adults with one or more chronic health conditions (58.8%, 95% CI: 50.6, 66.6) reported that the quality of health care services was fair or poor compared to those with no chronic health conditions (43.4%, 95% CI: 37.2, 49.9).

Just over one-third (36.5%) of the adults surveyed had not required health care during the 12 months leading up to the survey. 55.5% reported receiving all the carethey needed, while 7.7% reported not receiving all the care they needed. Those who had required health care in the past year were asked to identify any barriers to receiving care. **The most frequently reported barriers to health care were long waiting lists (28.6%), no doctor or nurse available in their area (27.0%), inadequate health care provision (22.2%), no health facility available in their area (20.0%[E]), and/or service not available in their area (19.7% [E])** (see Figure 17).

These findings are similar to previous phases of the RHS, where adults were most likely to report long waiting lists as a barrier to accessing health care (41.7% reported this in 2002/2003, and 51.2% in 2008/2010).

Figure 17: Barriers to receiving health care, among adults



Note: Respondents could choose more than one response
E High sampling variability, interpret with caution (CV: 0.166-0.333)

In terms of health care availability and quality, similar findings are found across all three surveys. **About one-quarter of respondents across all three phases of the RHS reported that the most common barriers to receiving care were that a doctor/nurse was not available in their area, that a service was not available in their area, and that access to health care was inadequate.**

In some cases (13.5%) adults used tele-health to access health care services, but most (86.5%) did not.

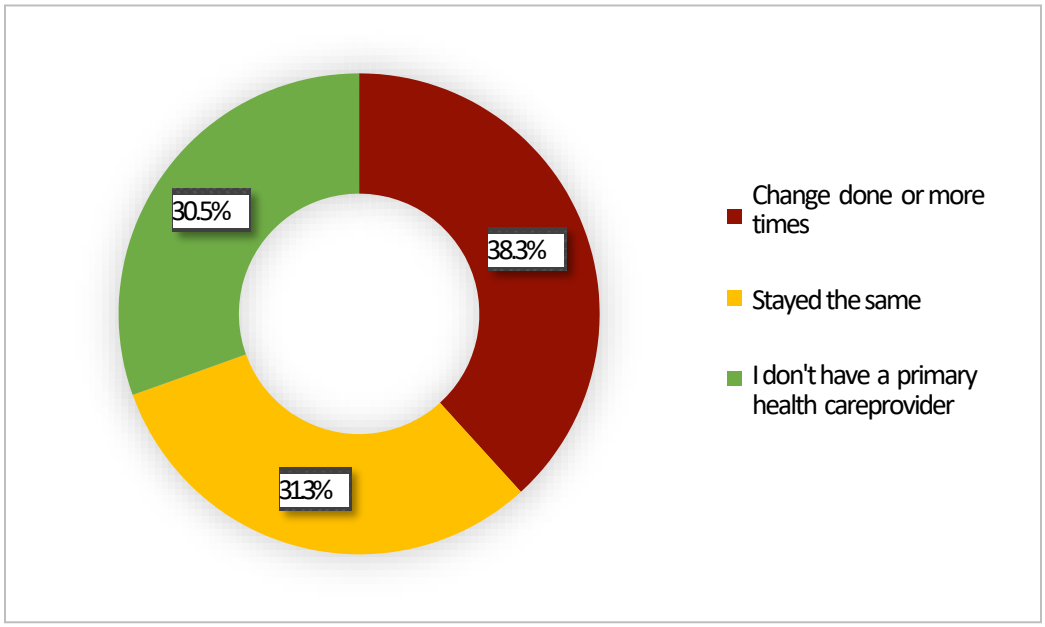
Access to adequate, continuous health care is an area of concern with one-third of adults (30.5%) reporting that they did not have a primary health care provider (i.e., family physician/RN/nurse practitioner). Of those who had a health care provider, **38.3% reported that their provider had**

changed one or more times that year (see Figure 18).

Although this question has varied across all 3 survey phases, similar findings can be found in difficulty accessing consistent medical care:

In 2008/2010, 28.4% of adults reported that a doctor or nurse was not available in their area, and 21.1% stated that the health care provided in their community was inadequate. Similarly, in 2002/2003, 23.0% of adults who had seen a doctor, indicated that they always saw a different doctor.

Figure 18: Access to primary health care provider in 12-month period, among adults



Finding also show a gap in continuity of care for adults with chronic health conditions (see Table 13). Even though there is not a significant difference between those with 0 health conditions and those with 1 or more, this table does show that 38.2% of adults with ≥1 chronic health conditions had their health care provider change during a 12-month period, and that 27.4% of adults with ≥1 chronic health conditions did not have a primary health care provider.

Table 14: Health care provision, by number of chronic health conditions among adults

TOTAL # HEALTH CONDITIONS	Did your health care provider change in the past 12 months?					
	No (%)	95% CI	Yes (%)	95% CI	No primary health care provider (%)	95% CI
0	28.3	21.7-35.9	38.4	30.0-47.5	33.4	26.9-40.5
≥1	34.4	28.0-41.3	38.2	32.3-44.4	27.4	21-34.9

NIHB & EXTERNAL FUNDING

When asked if they had any difficulties accessing health services through the Non-insured Health Benefits Program (NIHB), most adults reported 'no difficulties' (64.6%) or 'not applicable' (17.6%) (i.e., didn't need service/didn't try to access). Other frequent responses indicated that they had difficulty accessing medication (7.9%), dental care (7.4%), vision care (7.8%), and transportation services (4.8%).

In terms of medical care, 15.1% of adult respondents had to rely on external funding sources (e.g., paying out-of-pocket, using Band provided money) to pay for medical expenses outside of NIHB, in the 12 months leading up to the survey. In most cases (24.3%) external funding was used to cover the cost of medication. Just less than one in five respondents (19.8%) had relied on external funding to cover transportation services or costs (air or road), 17.6%[E] had relied on it to cover the cost of vision care, 15.4%[E] had used it to pay for dental care, and 13.6%[E] used it for escort travel.

Adults were also asked if they were aware of the services covered by NIHB (also referred to as medical services, FNIHB, or Indian Affairs). **One-quarter of the Manitoba First Nations adults surveyed (25.5%) were not aware of the services currently covered by NIHB.** One-quarter of the adults (25.1%) were aware of some of the services covered by NIHB. Just less than half (49.4%) were aware of all the services currently covered by NIHB.

ACCESS TO TRADITIONAL MEDICINE

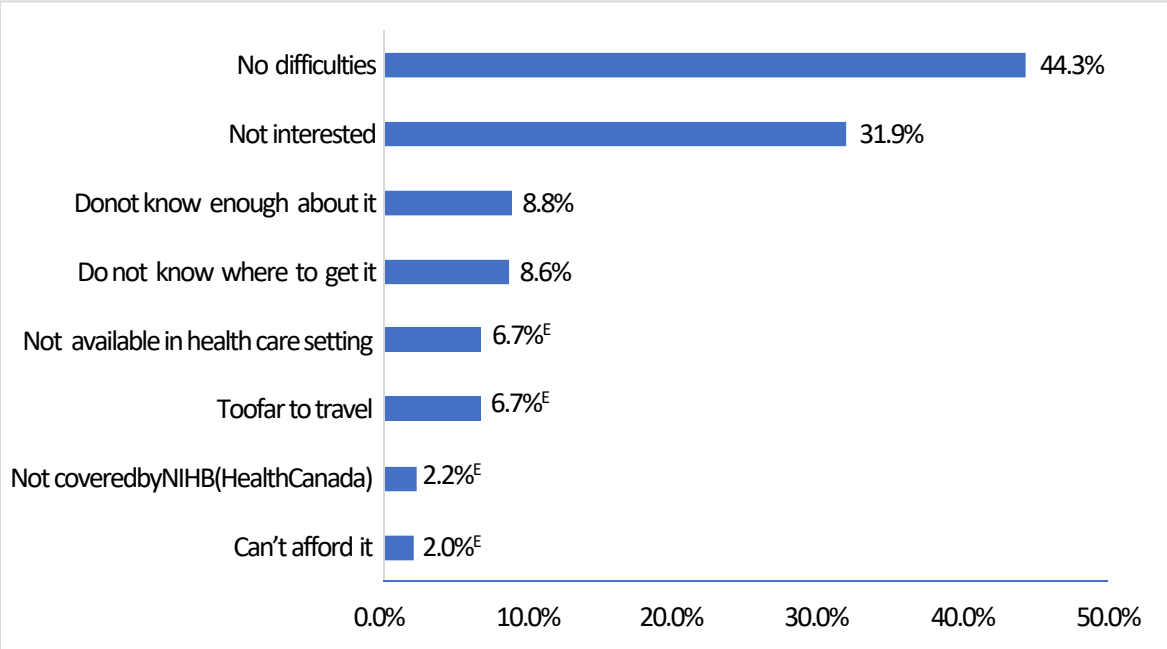
Respondents were also asked about access to traditional medicine. Traditional medicine was said to include herbal remedies, spiritual therapies, assistance from healers, or other practices. About one-quarter of the adults surveyed (24.6%) had consulted a traditional healer in the 12 months prior to the survey.

Most adults (67.5%) reported that they had *not* used traditional medicine in the year prior (32.5% had used traditional medicine). Although a proportionally lower number of respondents report using traditional medicine than in previous surveys, it is difficult to directly compare. Previous versions of the RHS asked "Do you use traditional medicine?". The RHS 3 specifically asks if the person had used traditional medicine "in the past 12 months." As a result, a higher

proportion of adults reported using traditional medicine in the RHS 1 (51.0%) and the RHS 2 (34.7%).
When asked if they had experienced barriers to accessing traditional medicine, almost half (44.3%) of Manitoba First Nation adults reported no difficulties in accessing traditional medicine, while 31.9% reported that they were not interested in traditional medicine (see Figure 19).

Despite a relatively low proportion of adults using traditional medicine, when asked, most adults (69.9%) strongly agreed or agreed that traditional spirituality was important to them. Most adults also agreed or strongly agreed (66.6%) that organized religion (e.g., Christianity, Buddhism, Islam) was important to them.

Figure 19: Barriers to accessing traditional medicine, among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

YOUTH: ACCESS TO CARE

Just over half the youth surveyed (53.8%) had visited a doctor or community health nurse in the year prior to the survey, while 29.9% had never visited a doctor or nurse. Most youth (81.8%) had not accessed a mental health service (e.g., counselling, psychological testing), while 15.9% had consulted one in the year prior. Most youth (83.8%) had also never consulted a traditional healer, while 11.5% had consulted one over the course of the past year.

CHILDREN: ACCESS TO CARE

Parents/guardians were asked if the child being surveyed had required health care in the 12 months prior to the survey: 41.5% responded no, while 57.4% reported that they had, and the child had received the

care they needed (the remaining 1.0% [E] of children had required health care but did not receive the care they needed).

Almost all children surveyed (98.8%) had received their routine vaccinations/immunizations.

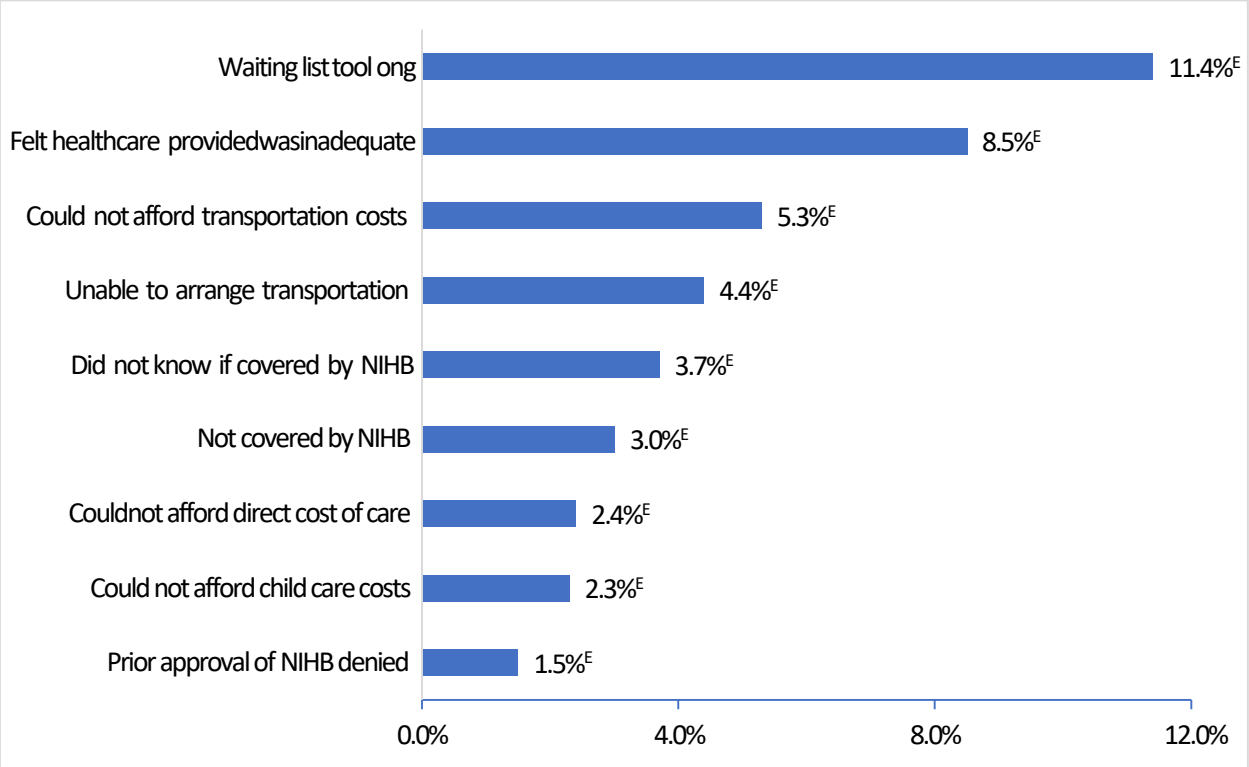
Parents/guardians were then asked to report on barriers to receiving health care for those children who had required health care during the year prior (see Figure 20). **According to parents/guardians, the most common barriers to accessing health care for their children were waiting lists that were too long (11.4% [E]), inadequate health care (8.5% [E]), transportation costs (5.3% [E]) and/or transportation arrangements (4.4% [E])**. Similarly, findings from the RHS 2 indicate that long waiting lists and inadequate health care were the most likely barriers to health care for children.

NIHB and EXTERNAL FUNDING

About 10% of adults surveyed (9.6%) reported that their child had been denied funding for medical health services, while 90.4% reported their child had not. **Over one-third of the children surveyed (34%[E]) had been denied funding for medical health services from NIHB** (while 66.0% had not).

In this vein, 7.4% of parents/guardians had to rely on an external funding sources (i.e., out of pocket, band provided money) to cover their child's medical expenses outside of NIHB, while 92.6% reported they had not. **External funding was most often used to help cover the costs of medication (47.3%), transportation services/costs (air or road (40.1%[E])**, dental care (15.1%[E]), vision care (14.6%[E]), or escort travel (12.9%[E]).

Figure 20: Barriers to receiving health care, among children



Note: Respondents could choose more than one response
E High sampling variability, interpret with caution (CV: 0.166-0.333)

DENTAL HEALTH & ACCESS TO DENTAL CARE

ADULTS

Approximately one-third of adults (30.9%) felt that the health of their teeth and mouth was excellent or very good. The remaining 36.5% felt their dental health was good, and 32.6% rated their dental health as fair or poor. About half (51.3%) of all adult respondents had dental care in the year prior to the survey, 23.8% had received dental care 1-2 years prior, and the remaining 24.9% had received dental care 2 or more years prior. A number of respondents indicated needing cavities filled or other restorative work (34.7%) and tooth extractions (21.8%).

When asked to report barriers to accessing dental care, adults were most likely to report 'no difficulties' (69.9%). The most common barriers to accessing dental care included long waiting lists (12.6%), services not covered by NIHB (5.1%E), direct cost of dental care (2.9%E), inadequate dental services (2.8%E), prior approval under NIHB denied (2.7%E), and/or transportation costs (2.0%E).

YOUTH

Less than half of the youth surveyed (43.7%) felt the health of their teeth and mouth was excellent or very good. 40.1% felt their dental health was good, and 16.3%[E] felt their dental health was fair or poor. 12.1% of the youth surveyed indicated that they had experienced problems with their teeth, or dental pain, in the past month.

Most youth had received dental care (64.7%) within the year prior to the survey.

CHILDREN

More than half of the parents/guardians surveyed (57%) reported that the health of their child's teeth and mouth was excellent or very good. About one-third (32.2%) reported their child's dental health was good, and 10.9% [E] felt it was fair or poor. More than half of the children surveyed (58.6%) had received dental care within the year prior to the survey, and 16.8% had received dental care between 1-2 years prior, and 23.1% of children had never received dental care.

About one-fifth of the children surveyed (20.2%) had been affected by Baby Bottle Tooth Decay (BBTD): 68.8% of these children had been treated for BBTD.

More than one-quarter of children were breastfed (28.5%). Most children who were fed from a bottle received formula (81.3%), milk (56.6%), or water (30.4%). A smaller proportion were bottle-fed fruit juices/drinks (21.2%), breast milk (16.0%), Kool-aid or other powdered drinks (12.3%), tea (8.1%), canned milk (5.9%[E]), powdered milk (4.2%[E]), and/or milk alternative (i.e., soy milk) (2.7%[E]) in their bottles.

CONCLUSIONS & RECOMMENDATIONS

The goal of this section was to provide a regional overview of physical aspects of health, including chronic health conditions, and to better understand barriers to accessing different forms of health care.

IN SUMMARY: HEALTH CONDITIONS

Among adults, diabetes, high blood pressure, arthritis, and allergies remain the most commonly reported chronic health conditions across all phases of the RHS. Most adults (87.9%) reported that they were receiving treatment for diabetes and 89.8% were receiving treatment for high blood pressure.

A slightly higher proportion of women reported 2 or more chronic health conditions than did men, but the difference was not significant.

Just less than half of all adults surveyed reported having one or more chronic health conditions. This is a smaller proportion when compared to the national survey: **a smaller percentage of Manitoba First Nations adults (49.5%) reported having one or more chronic health conditions when compared to the national level, where 59.8% of adults reported one or more conditions. That being the case, this does not undermine the need to continue to address the health care needs of First Nations adults in Manitoba, who still experience disproportionate barriers to adequate health care access.**

Among youth, the most commonly reported chronic health conditions were allergies, anxiety disorder, mood disorder, and learning disorder. Allergies have been frequently reported across all phases of the RHS. **About one-third of the youth diagnosed were receiving treatment for anxiety and learning disorders. This suggests a gap in care for youth experiencing mental and emotional health concerns.**

The most commonly reported chronic conditions among children were dermatitis/atopic eczema, allergies, and speech or language difficulties. Rates of allergies have proportionally decreased across all phases of the RHS.

Almost half the adults surveyed (47.5%) were obese according to BMI measures, and a significantly higher proportion of adults who were obese had one or more chronic health conditions compared to those with no chronic health conditions. That being the case, access to affordable, nutritious and traditional food sources can be challenging (see *Food and Nutrition section*), which may play a role in BMI and the onset of chronic health conditions.

Just less than half (44.2%) of the youth surveyed were of 'normal' weight, while 52.3% were overweight or obese. Children were more likely to be in a normal weight category (29.2%) or underweight (31.1%).

IN SUMMARY: DIABETES

Although rates of self-reported diabetes have positively shown a slight decline over the 3 phases of the RHS, diabetes remains the most commonly reported chronic health condition among adults. This is of concern given that diabetes can be a major risk for chronic kidney disease (CKD) (Komenda et al., 2016). Although kidney issues were not commonly reported among respondents (2.2%[E] of Manitoba First Nations adults reported kidney problems), these findings may not represent actual rates of CKD –

given its associated risk with diabetes, and the prevalent rates of diabetes among Manitoba First Nations adults.

Based on an analysis of the First Nations Community Based Screening to Improve Kidney Health and Prevent Dialysis, a CKD screening and treatment initiative, Komenda et al. (2016) found that the burden of CKD among First Nations people is more than double the general population. **Particularly high rates of CKD were found in First Nations communities that are accessible by air compared to those accessible by road**. This suggests that public health strategies are needed to better screen, triage and treat First Nations people with CKD.

Another diabetes-related study examined the association between cultural continuity, self-determination, and diabetes prevalence in Cree and Blackfoot First Nations communities in Alberta. This study shows the resilience of community, and the strength of language in restoring wellness. The research found that **culture can be a protective factor against diabetes.** In this study, Cree and Blackfoot leaders shared the importance of traditional culture as a relevant factor that influences rates of diabetes. They explained how **culture and language are the foundation of shared identity, which affects a community's health and wellbeing**. This study also used Alberta Health and AANDC data to examine diabetes rates, and found that language is a significant predictor of diabetes (Oster et al., 2014).

IN SUMMARY: ACCESS TO CARE

A significantly higher proportion of adults with one or more chronic health conditions (58.8%) reported that the quality of health care services in their community was fair or poor compared to adults with no chronic health conditions (43.4%). One-third (30.5%) of adults did not have a primary health care provider, and 38.3% had a health care provider that had changed one or more times that year. Importantly, issues with access to consistent and adequate medical care have been similar across all phases of the RHS.

The most common barriers to health care were long waiting lists, doctor/nurse not available in the area, that a service was not available in the area, and/or that access to health care/health facilities was inadequate. Gaps in continuity of care, and a shortage of adequate care remain areas of concern.

Racism is another potential barrier to health care that is not included in the RHS. Studies have shown that Indigenous patients are often treated poorly or turned away. Consequently, patients often worry that their health concerns will be dismissed. These barriers can lead to medical complications and delays in screening and treatment.

Barriers to care can result in late diagnosis, missed treatments, and lack of consistent care. One example may be in seen in cancer diagnoses. For example, **rates of cancer (1.2%[E]) may be under-reported in the RHS,** as this chronic condition may not be diagnosed in a timely way due to health care barriers such as often-changing health care providers, absence of adequate health care provision (i.e., diagnosis and treatment on-reserve), and a scarcity of health care facilities.

In terms of dental care, 30.1% of adults reported difficulty accessing care. Barriers included long waiting lists, and services not covered by NIHB. **Dental therapy programs were designed to help close gap in access to**

oral health care in First Nation communities. The loss of this program in 2011, may reduce what is already inequitable access to oral health care. With no coordinated policy approach to address the gap this has created, dental care may require First Nation-provincial partnerships to address dental care delivery (Leck and Randall, 2017).

Difficulties accessing NIHB and the need to rely on external funding can create added barriers to care. While 64.6% of adults reported that they did not have difficulty accessing health services through NIHB, and only 10% of parents/guardians reported that their child had been denied funding for medical health services from NIHB,
there is a need to increase awareness.

While the RHS findings indicate low incidences of NIHB-related barriers to care this is surprising. These numbers are unexpected due to the known obstacles related to accessing NIHB for medical care.

This includes difficulty receiving approval for urgent health and dental care.

Indeed, NIHB has been criticized by Canadian pharmacists for its **"inadequate communication of policy changes, lack of standardized scope of practice and compensation models, lack of clarity regarding patient coverage benefits, [and] inadequate travel arrangements" (Morrison, 2015, p. 217)**
Awareness may be another area of concern. One-quarter (25.5%) of Manitoba First Nations adults were not aware of the services covered by NIHB, and **25.1% were aware of some of the services covered**. Although NIHB creates restrictions in many ways, **having community members know their right to care may help to increase access to care and health promotion.** This points to a need to make this information more accessible **as a way to promote patient advocacy**.

SECTION 4: HEALTHY BEHAVIOURS & LIFESTYLE

This section examines what the RHS categorizes as "health behaviours." This includes smoking, alcohol and substance use, and sexual health among adults and youth. It also considers food security and access to healthy and traditional foods among adults, youth, and children.

SMOKING

ADULTS

Less than half of all adult respondents (47.7%) were daily smokers, and 14.6% smoked occasionally. The remaining 37.7% of all adult respondents were non-smokers. Most smokers (41.8%) were moderate smokers (10-19 cigarettes/day), 37.9% were light smokers (less than 10 cigarettes/day), and 20.3% were heavy smokers (20 or more cigarettes/day). When adults were asked if they had tried to quit smoking in the past 12 months, 44.2% had not, while **55.7% had tried one or more times**. Most adults had started smoking in their teens: 65.8% had started between 12-17 years of age.

One-quarter of the non-smokers surveyed (25.5%) had smoked occasionally, and 18.4% had smoked daily. The rest (56.1%) had never smoked. Most had quit between the age of 18-34 years (62.3%), and cold turkey/will power alone (88.2%) was the most common method of quitting.

When former smokers were asked about their reasons for quitting smoking, more than three-quarters (77.1%) did so for a healthier lifestyle. Other frequent responses included quitting due to the cost (31.0%) and out of respect for loved ones (23.4%). Adults were least likely to quit in response to doctor's orders (4.6%[E]) (see Figure 23).

YOUTH

Almost 90% of youth (86.7%) did not smoke cigarettes at the time of the survey. The remaining 8.3%[E] of the youth surveyed smoked daily, and 5.1%[E] smoked occasionally. **Most youth (74.3%) were light smokers (less than 10 cigarettes/day)**. Of the youth who smoked, 46.8%[E] had not tried to quit that year, but **more than half (53.2%) had tried one or more times to quit**.

Of those youth who had successfully quit, the most frequently reported reasons for doing so was out of respect for loved ones (where 38.2% of youth reported that this was their reason for quitting). Cold turkey/will power alone (91.7%) was the most common method for quitting smoking.

CHILDREN

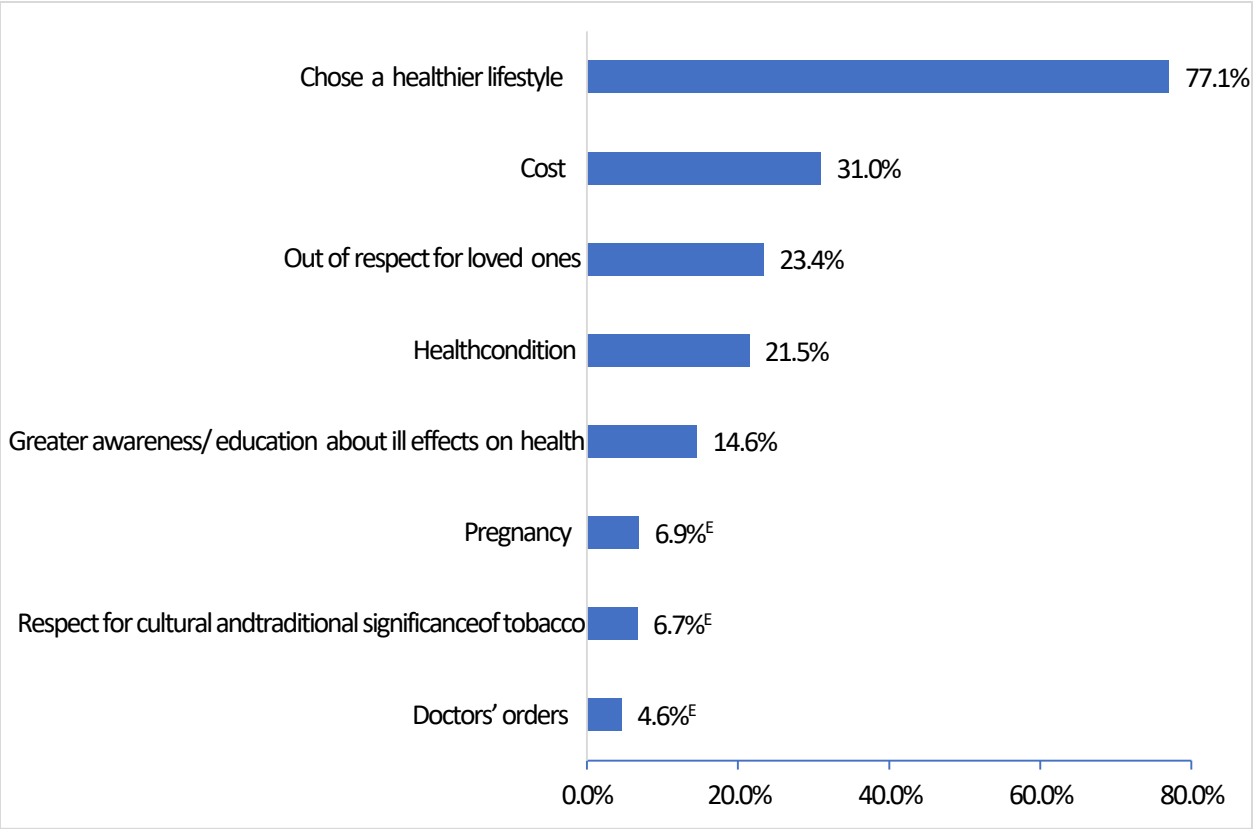
Of the children surveyed, over two-thirds (66.5%) of their mothers did not smoke at all during their pregnancy. Less than one-quarter (22.8%) smoked throughout their pregnancy, while 10.7% smoked, but quit in the 1st, 2nd, or 3rd trimester. Of those that did smoke during pregnancy, almost half (44.2%) did so occasionally, and 55.8% smoked daily.

Most parents/guardians (83.6%) reported that no one else had smoked in the household while the child's mother

was pregnant (16.4% reported that someone had smoked in the household).

Parents/guardians were asked if their child had been exposed to smoke inside their home every day or almost every day: 9.3%[E] of children had been, while 90.7% had not. Caregivers were also asked if in the month prior, their child had been regularly exposed to second-hand smoke in a private vehicle: 11.6% had been, while 88.4% had not been exposed to smoke in a vehicle.

Figure 21: Reasons for quitting smoking, among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333

ALCOHOL & DRUG USE

ADULTS

When asked if they had sought treatment for alcohol or substance use in year prior to the survey, 11.3[E]% of adults had sought treatment for alcohol use, and 9.1[E]% had sought treatment for substance use.

When asked which, if any, substances adults had used in the 12 months leading up to the survey, cannabis (29.3%) was the most commonly used non-prescription drug. The second most frequently reported non-prescription drug was cocaine, where 9.3% of respondents reported using it at least once over a one-year period. Over

one-third (35.0%) of those who had used cannabis in the year prior had done so for medical purposes.

Adults were also asked if they had used prescription pain relievers, stimulants, or sedatives in the 12 months leading up to the survey. The number who reported using stimulants is too small to report. Less than one-third (28.8%) of adults reported using pain relievers with opioids, and 5.3% had used sedatives. Of those who used these prescription drugs, 42.7% reported that they were all prescribed, and 43.9% reported that some were prescribed, while others were not.

YOUTH

When asked which, if any, substances they had used in the 12 months leading up to the survey, cannabis was the most common: 19.8% of youth reported using this non-prescription drug at least once over the one-year period. The second most frequently reported non-prescription drug was cocaine, where 1.4%[E] of respondents reported using it at least once over a one-year period.

Similar to adults, youth were also asked if they had used prescription pain relievers, stimulants, or sedatives in the 12 months leading up to the survey. Less than 10% had used pain relievers with opioids (9.0%[E]). In the case of stimulants or sedatives, numbers are too small to report.

All youth respondents were asked who they would go to first for help if they had a problem with drugs or alcohol. Youth most frequently reported that they would go to a parent (where 48.6% would go to a parent first), friend their age (15.8%[E]), or other family member. There were also a number of youth (15.8%[E]) that felt they had no one to go to first.

Youth were also asked if they had ever heard about Fetal Alcohol Spectrum Disorder (FASD). **Approximately two-thirds of youth (61.5%) had not heard about FASD, while 38.5% had**. Youth were also asked at what time during a women's pregnancy they thought it was safe to drink alcohol: 92.0% responded that it was "never a good time".

GAMBLING

Approximately two-thirds of adult respondents (60.5%) had gambled in the year prior to the survey. When those who had gambled in the past year were asked if they had ever borrowed money to do so, 42.0% reported that they had. When asked if they had bet more money than they could afford to
lose, 33.8% said they had. Most (80.3%) felt that gambling had not caused financial problems for them or their families.

SEXUAL HEALTH

ADULTS

Most adults (91.0%) reported that they had had sexual intercourse in their lifetime, and 85.5% of those who reported having had sexual intercourse in the past year had one partner. Adults most commonly reported that they did not use birth control or protective methods (41.3%). Of the birth control/protective methods that were used, the most frequently reported were condoms among males and females (38.3%) and birth control pills (9.2%). Most adults who did use birth control or protective methods did so to avoid pregnancy (42.7%) or used it as birth control and STI protection (39.4%). The remaining 17.7% used it for STI protection alone.

Slightly more than half (51.8%) of the adults surveyed had been tested for STIs, and 41.1% had been tested for HIV/AIDS. These results are similar to the RHS 2, where 35.1% of adults had been tested for HIV/AIDS.

Findings from the RHS 3 (i.e., 41.1%, 95% CI: 36.6, 45.7) show a significant increase in testing for HIV/AIDS from the RHS 1 (2002-2003), where 29.8% (95% CI: 29.8, 35.2) of respondents had been tested.

YOUTH

Most youth (85.2%) reported that they had never had sexual intercourse. Of those youth who had had sexual intercourse, most (62.9%) reported having one partner over the 12 months leading up to the survey. When asked what birth control or protective methods they used, more than half of males and females (55.3[E]%) reported using condoms, and 23.4[E]% used birth control pills. The most commonly stated reason for using birth control or protective methods was for birth control and STI protection (48.4%). Almost 40% (38.5%[E]) of youth used it to avoid pregnancy, and 13.2% [E] used it for protection from STIs. While a number of youth did use contraception, 16.1%[E] reported that they had been, or had gotten someone pregnant.

SOURCES OF SUPPORT FOR YOUTH

Almost half of all the youth surveyed (48.0%) reported that they would go to a parent for help first if they had a problem with pregnancy, and 11.6% said they would go to a medical doctor or nurse first. Almost one-quarter of youth (24.0%[E]) said they had no one they would go to first.

Just less than half of all youth (46.1%) reported that they would also go to a parent for help first if they had problems with birth control. Others (12.4%) said they would go to a medical doctor or nurse if they had a problem, other family members (5.1%), or friends their age (4.2%[E]). **Nearly one-quarter of the youth (23.0%[E]) reported they had no one to go to first for problems with birth control.**

When asked who they would go to first for help if they had a problem with relationships (i.e., boyfriends/girlfriends), youth most commonly reported that they would reach out to their parent (38.5%), friends their age (29.9%), or other family members (11.5%). Some of the youth surveyed (15.8%[E]) reported that they had no one to go to first.

Youth were also asked who they would go to first if they had a problem with sexual assault. Most youth (68.5%) said that they would go to a parent first, while 6.6%

reported they would go to another family member, and 2.8%[E] would go to a friend their age. Other youth (17.5%), however, reported they would go to no one first. **When asked, most youth (42.7%) said they would go to a parent first if they had a problem with an STI** and 17.8% said they would go to a medical doctor or nurse. **One-quarter of youth (24.7%), however felt there was no one they would go to first if they had a problem with an STI**.

Most youth (95.8%) reported that they had not been tested for STIs, and 68.7% of youth had not received an HPV vaccine (while 31.3% had received one). Most youth (96.7%) had also not been tested for HIV/AIDS.

In terms of HPV vaccination, these numbers show some improvement from the RHS 2, where 82.4% of youth had not received an HPV vaccine (17.6% had). However, fewer youth who responded to the RHS 3 had been tested for STIS and HIV/AIDS, when compared to the previous survey. In 2008-2010, 9.3% of youth had been tested for STIs, and 6.4% had been tested for HIV/AIDS. These figures, however, represent all youth respondents, some of which may not be sexually active.

Access to Resources and Testing

Importantly, in the RHS 1, 50% of Manitoba First Nations youth when asked, reported that they did not have adequate access to birth control, or information about birth control in their communities.

In the RHS 1, youth were also asked about access to information in their communities about STIs, and 53.0% reported there was not enough information available.

These questions were not asked in the RHS 2 or RHS 3, and **point to a potential gap – as identified by youth – in their access to safe, adequate information and support regarding sexual health.**

FOOD & NUTRITION

ADULTS: ACCESS TO HEALTHY & TRADITIONAL FOODS

Most adults who were surveyed had eaten traditional foods in the year prior to the survey. In particular, land-based animals (86.5%), and/or berries/wild vegetation (78.8%) were the most commonly consumed traditional foods. Bannock or fry bread was also commonly eaten (93.2%) (see Table 14). Foods that are not traditional to Manitoba (but were included in the RHS), are excluded from the analysis and proportions reported here.

When asked how often someone had shared traditional food with their household, **51.2% of adult respondents indicated that traditional foods had sometimes been shared**, and 24.9% indicated that traditional foods were often shared with their household. Less than one-quarter of respondents **(23.9%) rarely or never shared traditional foods**.

More than half of adult respondents (54.1%) reported that they had sometimes eaten nutritious, balanced meals in the 12 months prior to the survey, while **31.8% reported that they had always or almost always eaten nutritious, balanced meals**.

Table 15: Consumption of traditional foods during a 12-month period, among adults

In the past 12 months, have you eaten the following traditional foods?	Yes (%)	No (%)
Land based animals (moose, caribou, bear, deer, bison, etc.)	86.5	13.5
Fresh water fish	76.7	23.3
Game birds (goose, duck, etc.)	64.5	35.5
Small game (rabbit, muskrat, etc.)	53.1	46.9
Berries or other wild vegetation	78.8	21.2
Bannock or fry bread	93.2	6.8 [E]
Wild rice	45.8	54.2
Meat, fish, or vegetable broth	59.1	40.9

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

YOUTH: ACCESS TO HEALTHY & TRADITIONAL FOODS

Youth were most likely to report that they had eaten traditional foods such as land-based animals (75.0%), and/or berries/wild vegetation (71.7%) over the past year. Bannock or fry bread was also commonly eaten (84.2%) (see Table 15). Of the youth surveyed, 13.5% had often had someone share traditional foods with their household, and **61.0% had sometimes had traditional foods shared in their home**. **About one-quarter (25.6%) of these youth had rarely or never had traditional foods shared with their household.**

When asked about nutrition, 27.7% of youth reported that they always or almost always eaten nutritious, balanced meals (i.e., meals that contain a variety of food groups, such as protein, grains, vegetables and fruits, and dairy products). About two-thirds of the youth surveyed (60.3%) had sometimes had a nutritious, balanced meal, and 12% rarely or never ate nutritious, balanced meals.

Almost half of the youth surveyed (47.3%) always or almost always ate breakfast, 44.8% sometimes ate breakfast, and 7.9%[E] rarely or never ate breakfast.

Table 16: Consumption of traditional foods during a 12-month period, among youth

In the past 12 months, have you eaten the following traditional foods?	Yes (%)	No (%)
Land based animals (moose, caribou, bear, deer, bison, etc.)	75.0	25.0
Fresh water fish	59.7	40.3
Game birds (goose, duck, etc.)	50.3	49.7
Small game (rabbit, muskrat, etc.)	38.1	61.9
Berries or other wild vegetation	71.7	28.3
Bannock or fry bread	84.2	15.8
Wild rice	31.4	68.6
Meat, fish, or vegetable broth	36.9	63.1

CHILDREN: ACCESS TO HEALTHY & TRADITIONAL FOODS

According to parents/guardians, the children surveyed were most likely to have eaten traditional foods such as bannock or fry bread (74.9%), land-based animals (65.6%), and/or berries/wild vegetation (61.1%) (see Table 16).

In terms of sharing traditional foods, approximately two-thirds (61.9%) of children had sometimes had someone share traditional food with their household (see Figure 21).

When asked, more than half of parents/guardians (53.6%) indicated that their child had "sometimes" eaten nutritious, balanced meals (i.e., meals that contain a variety of food groups, such as protein, grains, vegetables and fruits, and dairy products) in the 12 months leading up to the survey (see Figure 22).

Most children had always or almost always eaten breakfast (69.0%), while 27.6% had sometimes eaten breakfast in the 12 months prior to the survey.

Table 17: Consumption of traditional foods during a 12-month period, among children

In the past 12 monhs, Did the child eat the following traditional food?	Yes (%)	No (%)
Land based animals (moose, caribou, bear, deer, bison, etc.)	65.6	34.4
Fresh water fish	54.9	45.1
Game birds (goose, duck, etc.)	45.6	54.4
Small game (rabbit, muskrat, etc.)	38.0	62.0
Berries or other wild vegetation	61.1	38.9
Bannock or fry bread	74.9	25.1
Wild rice	19.3 [E]	80.7
Meat, fish, or vegetable broth	29.0	71.0

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

Figure 21: Sharing of traditional foods with child's household

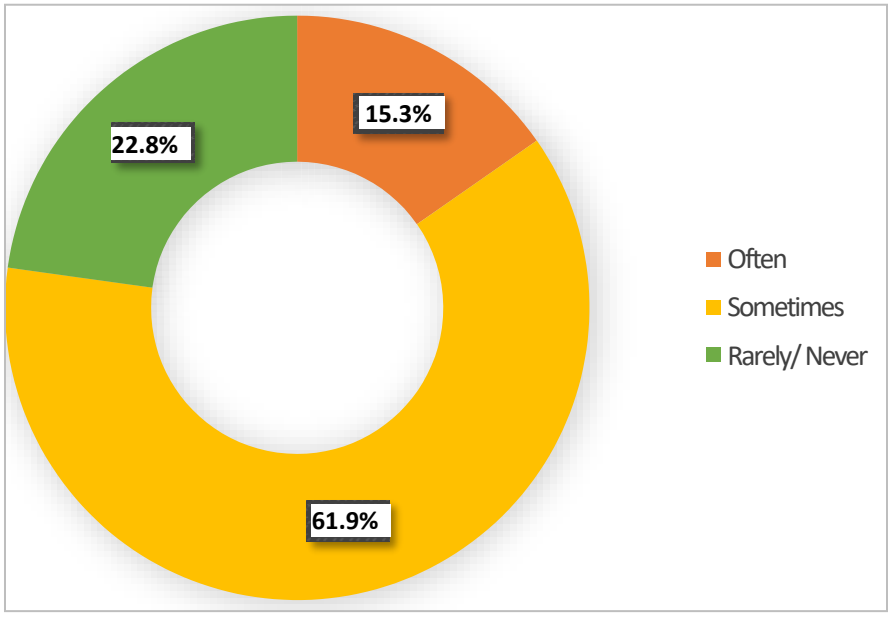
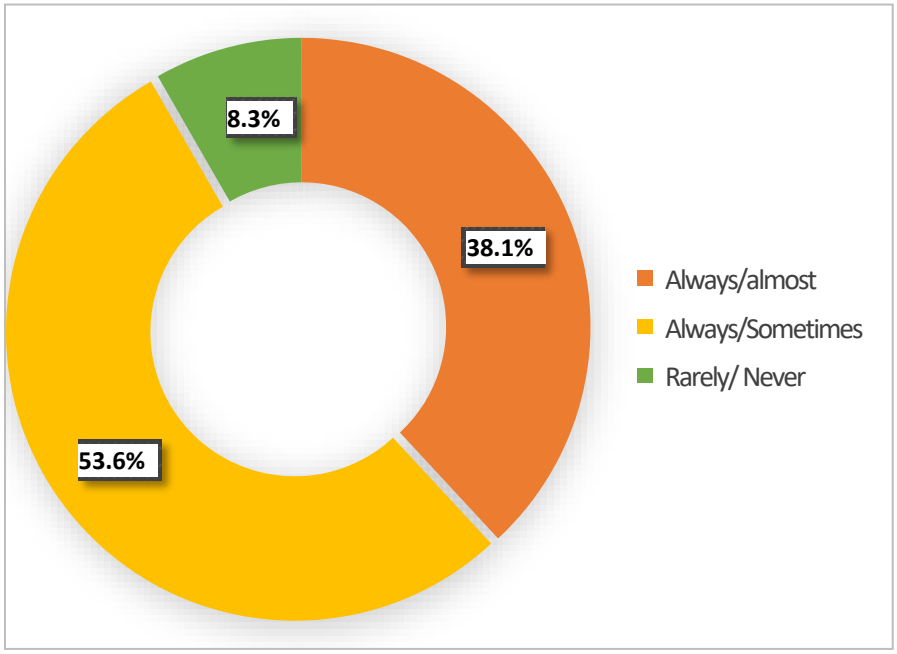


Figure 22: Access to nutritious, balanced meals, among children



FOOD SECURITY

While most adult respondents (64.2%) reported that they did not struggle to meet the basic living requirement of food over a 12-month period, 21.7% reported that they did struggle a few times a year, and 10.8%[E] struggled monthly.

Adults were also asked if in the past 12 months, they or other adults in their household had ever cut the size of their meals or skipped meals because there was not enough money for food. About three-quarters (75.9%) of respondents had not had to do this. Of the 24.1% who did, 44.5% stated that this had happened almost every month over the course of the past year (see Table 17).

Based on the responses above, **39.7% of adult respondents lived in food secure households, 43.8% lived in moderately food insecure households, and 16.5% were experiencing severe food insecurity.**

Table 18: Measures of food security among adult households

MEASURES OF FOOD SECURITY	Often/Sometimes True %	Never True %
The food that we bought just didn't last and we didn't have the money to get more.	55.0	45.0
We couldn't afford to eat balanced meals.	53.6	46.4
	Yes %	**No %**
In the past 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?	15.6	84.4
In the past 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?	22.2	77.8

FOOD SECURITY IN HOUSEHOLDS WITH CHILDREN

Adults who lived in households with children were asked a number of questions as measures of food security (see Table 18).

Of those adults who had one or more children or youth in the household, 49.2% of children were food secure, 13.4% were moderately food secure, and 37.5% were experiencing severe food insecurity.

These results show that **while a higher proportion of children were food secure than adults, a significantly higher proportion of children faced severe food insecurity compared to adults**.

Table 19: Measures of food security among adult respondent households with children

MEASURES OF FOOD SECURITY	Often/Sometimes True %	Never True %
You had to rely on only a few kinds of low-cost food to feed your child/children because you were running out of money to buy food.	48.4	51.5
You couldn't feed your child/children a balanced meal, because you couldn't afford it.	39.8	60.2
The child was not eating enough because you just couldn't afford enough food.	29.1	70.8

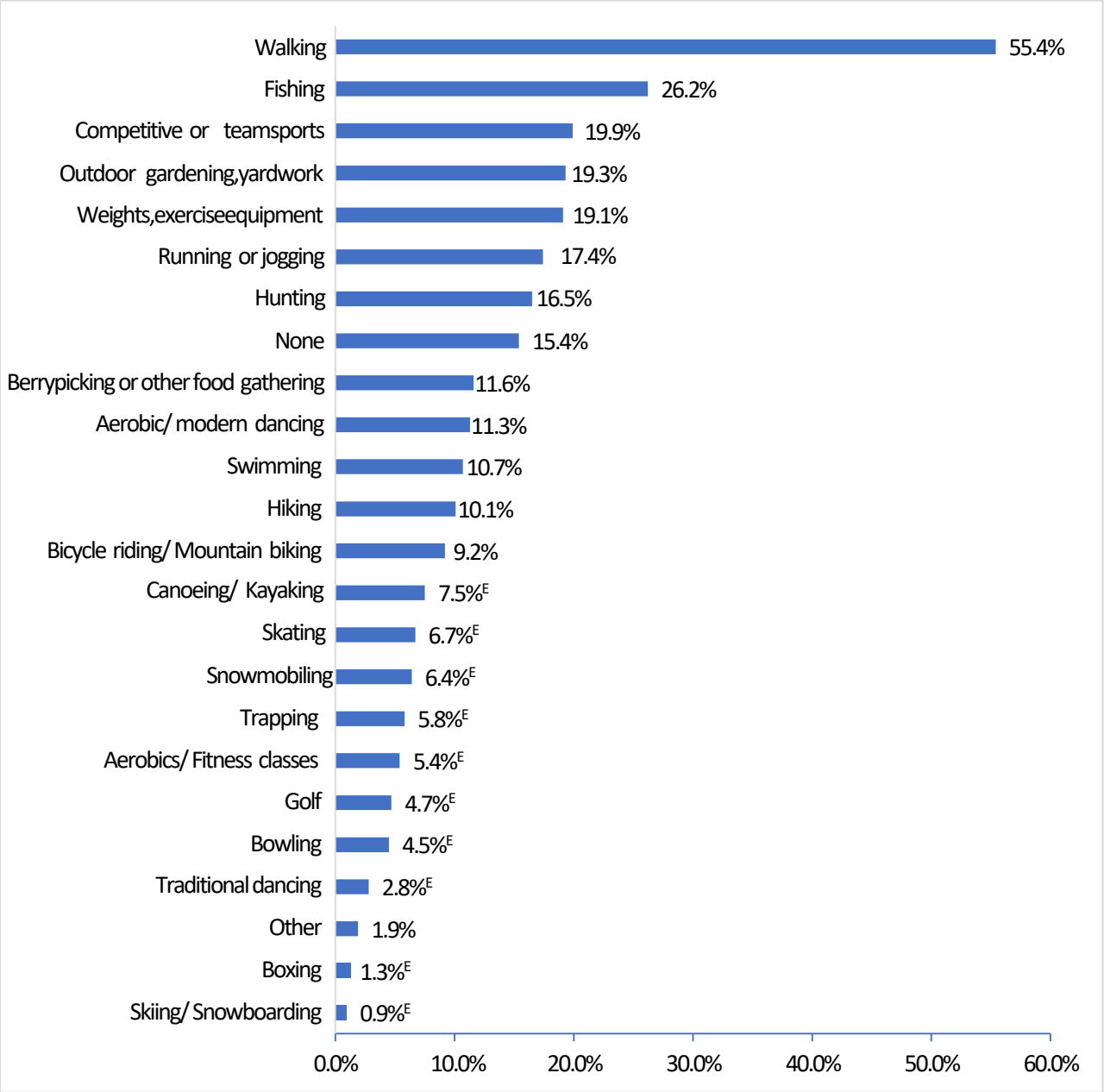
PHYSICAL & EXTRACURRICULAR ACTIVITIES

ADULTS

Adults were asked if they had participated in any physical activities in the 3 months prior to the survey, and were provided with a list of options (see Figure 24). **The most commonly reported physical activities among adults were walking (where 55.4% of respondents had done this activity), fishing (26.2%), competitive or team sports (19.9%), outdoor gardening and yard work (19.3%), and using weights/exercise equipment (19.1%)**. About **15% of adults reported that they had *not* participated in any physical activity.**

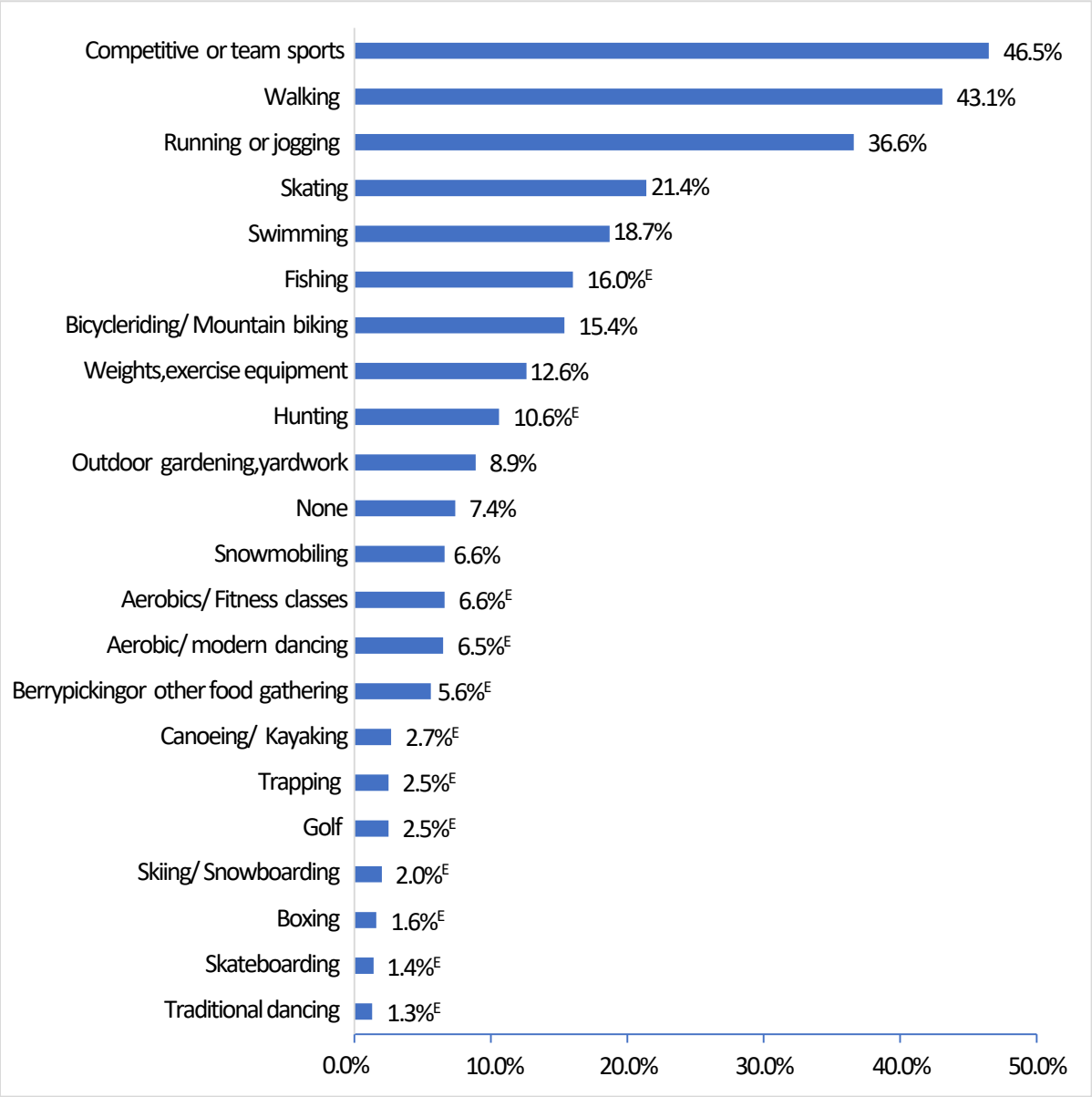
A physical activity index was calculated based on the amount of time spent participating doing physical activities (i.e., daily expenditure value). Using this index or scale, results of the analysis show that **60.2% of adults were inactive, 16.4% were moderately active, and 23.4% were active**.

Figure 22: Frequency of physical activity, among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

Figure 23: Frequency of physical activity, among youth



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

YOUTH

Most youth reported taking part in competitive or team sports (46.5%) and walking (43.1%). Other popular physical activities among youth included running or jogging (36.6%), skating (21.4%), and swimming (18.7%). **About 7% of youth had not participated in any physical activities over a 3-month period** (see Figure 25).

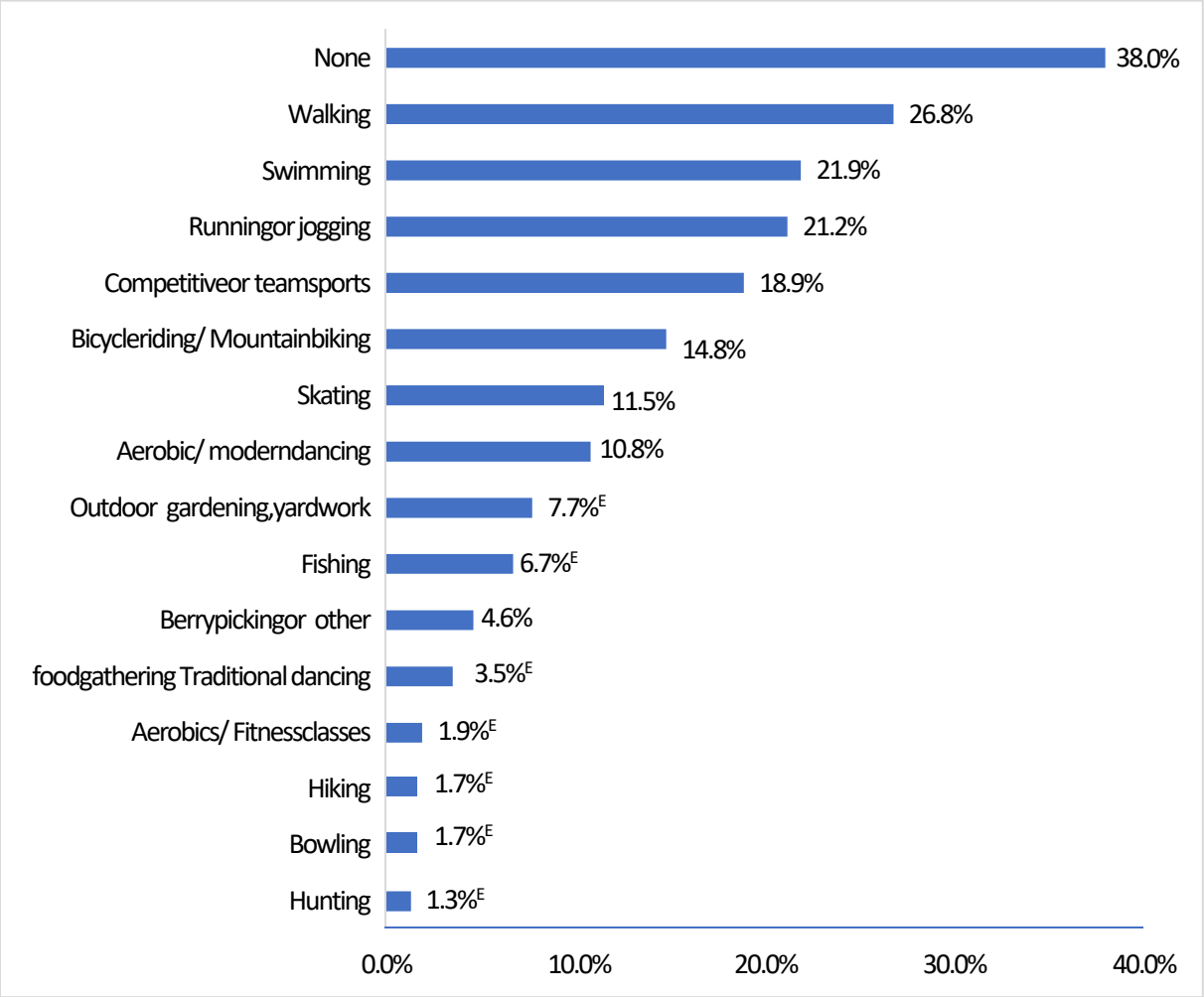
According to the physical activity index (based on daily expenditure values doing physical activities), **41.2% of youth were active, 26.6% were moderately active, and 32.2% were inactive**.

Youth were also asked about the activities they participated in outside of school hours. About two-thirds of the youth surveyed never took part in art or music groups/lessons, traditional activities, or jobs such as babysitting or tutoring. About one-third of the youth did take part in sports teams/lessons (see Table 19).

Table 20: Activities participated in outside of school hours, among youth

OUTSIDE OF SCHOOL HOURS, HOW OFTEN DO YOU…?	1 or more times/ week (%)	95% CI	Less than once/ week (%)	95% CI	Never (%)	95% CI
Take part in sports teams or lessons	30.9	26.5-35.6	28.8	22.5-36.0	40.4	32.3-49.1
Take part in art or music groups or lessons	15.2	11.9-19.1	20.0	15.9-27.4	64.9	59.6-69.8
Take part in traditional activities (e.g., singing, drumming, or dancing groups or lessons	12.1	8.8-16.6	23.8	19.5-28.7	64.1	56.3-71.2
Have a job such as babysitting, working at a store, or tutoring	15.4	11.5-20.2	24.0	19.8-28.9	60.6	53.3-67.4

Figure 24: Frequency of physical activity, among children



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

CHILDREN

Parents/guardians with children 5 years of age or older, were asked about the child's participation in physical activities over the 3 months prior to the survey. **Almost 40% of the children surveyed had not participated in a physical activity** during this time. This was the most frequent response given when asked about participation in physical activities.

Activities that children were most likely to participate in were walking (26.8%), swimming (21.9%), competitive or team sports (18.9%), and bicycle riding (14.8%). According to the physical activity index that was also used with adults and youth, **41.8% of children were inactive, 21.3% were moderately active, and 36.9% were active**.

Parents/guardians were also asked about the activities that their child participated in outside of school hours (see Table 20). In addition to the questions listed in Table 20, caregivers were also asked if the child read for fun (not for school or homework) or

was read to outside of school hours. 27.2% of parents/guardians indicate that their child read, or was read to, a few times a week, 19.6% said this occurred every day, and 22.9% that it occurred once a week. Others (20.4%) reported that the child never read, or was read to, outside of school hours.

Table 21: Activities participated in outside of school hours, among children

OUTSIDE OF SCHOOL HOURS, HOW OFTEN DOES THE CHILD…?	1 or more times/week (%)	95% CI	Less than once/week (%)	95% CI	Never (%)	95% CI
Take part in sports teams or lessons	12.9	9.9-16.5	19.8	14.2-27.0	67.3	59.8-74.0
Take part in art or music groups or lessons	5.5 [E]	3.3-8.9	17.0	13.4-21.2	77.5	71.9-82.3
Take part in traditional activities (e.g., singing, drumming, or dancing groups or lessons	5.7	4.3-7.4	18.3	15.1-22.0	76	71.9-79.7

[E] *High sampling variability, interpret with caution (CV: 0.166-0.333)*

CONCLUSIONS & RECOMMENDATIONS

This section examined healthy behaviours and lifestyle factors among adults, youth, and children. Key findings are summarized below, and recommendations are made.

IN SUMMARY: SMOKING

Most of the adults surveyed were not daily smokers (52.3%). Of those who did smoke regularly (47.7%), 55.7% had tried to quit one or more times that year. Former smokers also provided insight into what motivated them to quit: self-care and connection to family. **More than three-quarters of adults (77.1%) quit because they wanted a healthier lifestyle and 23.4% quit out of respect for loved ones**. While pregnancy was not a commonly reported reason for quitting (6.9%[E] quit for this reason), this could be for various reasons: e.g., only half the survey respondents were female, also, it cannot be assumed that all smokers are pregnant.

Most youth do not smoke: **86.7% of the youth surveyed reported that they were not regular or occasional smokers**. Of the youth that did smoke, more than half (53.2%) had tried to quit one or more times that year. **For youth, the most common motivator for quitting smoking was respect for loved ones.**

IN SUMMARY: SUBSTANCE USE

Results from the RHS show high rates of abstinence from substance and alcohol use, particularly among youth. Results from the national-level RHS also suggest a general trend to under-report substance use among adult and youth respondents (FNIGC, 2018a). **While lower rates of**

substance use may indeed be due to abstinence, it could also point to a case of under-reporting at the local and national level. This could in part be due to how the RHS questions are framed. Complex lines of questioning may decrease the likelihood of accurate responses. This could point to the **need for more streamlined and culturally sensitive RHS survey questions.**

It has been argued that "alcohol, tobacco and illicit drug use…and related health problems…are of urgent public health and policy concern", particularly among Indigenous youth (Firestone et al., 2015). But rather than overemphasize challenges such as suicide and problematic substance use in First Nation communities, we must also look to potential trauma associated with racist colonial acts (Nelson and Wilson, 2017), as well as positive ways forward, based on existing strengths and assets in communities.
Perhaps future RHS phases would benefit from a regional survey component that focuses on youths' experiences with substance use at the personal and community-level, and also their suggestions for positive change, prevention, and recovery.

Strategies to reduce substance use, build self-esteem, and connection to land and culture can act as treatment methods, or as a preventative approach. One such example is Gwekwaadziwin Miikan, a land-based youth mental health facility that recently opened on Manitoulin Island, Ontario. This program uses land-based treatment, live in aftercare, and community aftercare to support youth recovery. The goals of the program are stabilization, emotional growth, self-management skills and social skills.

Survey findings also indicate the need to support awareness and outreach about FASD. Two-thirds of youth (61.5%) had not heard about FASD.

IN SUMMARY: SEXUAL HEALTH

Among adults, we see significant an increase in testing for HIV/AIDS. In particular, 51.8% of RHS 3 adult respondents had been tested, compared to 29.8% of RHS 1 respondents.

Most youth (85.2%) reported they had never had sexual intercourse. It may be the case that youth are under-reporting sexual activity. This could be due to the survey format. **Importantly, the results of this survey should not delay access to sexual health information and resources (i.e., birth control, HPV vaccine) for youth. This information can be difficult to access depending on location.**

While 30-40% of youth reported that they would go to a parent first if they had a problem with birth control, pregnancy, or sexual assault, 15-20% of youth reported that they had no one that they would go to first for these concerns.

These gaps in knowledge of sexual health, access to resources, and testing speak to need for access to additional resources and testing –to develop strategies with youth, by youth, to better understand how to initiate approaches that reach youth, provide support networks, health information, and resources.

IN SUMMARY: FOOD SECURITY AND NUTRITION

Adults, youth, and children were asked about the traditional foods that they consumed most often. All three age groups most commonly reported that they had

eaten bannock/fry bread, land-based animals, and/or berries/wild vegetation in the year prior.

Most adults and children lived in food secure, or moderately food secure households. That being the case, **16.5% of adults experienced severe food insecurity, and 37.5% of children experienced severe food insecurity**. While a higher proportion of children were food secure than adults, **a significantly higher proportion of children faced severe food insecurity compared to adult households**.

National food policy has largely dismissed traditional food practices and systems, and acts of colonization have disrupted traditional foods sources, knowledge of the land, and have undermined the production and distribution of nutritious, affordable foods. This has left many people exposed to convenience foods that are high in fat, and low in nutritional value. **Food insecurity can contribute to chronic health conditions, obesity, and mental health challenges.**

While the RHS provides important measures, it describes food security from an economic perspective, which can miss cultural elements (e.g., how foods are acquired in culturally acceptable ways, and through traditional practices).

Access to sufficient, nutritious food is a basic human right. Access to affordable nutritious foods, and to traditional foods from the land and water, work to improve overall health. Food policy must advocate to protect, rather than violate, natural resources which are a source of food and sustenance.

IN SUMMARY: PHYSICAL & EXTRACURRICULAR ACTIVITIES

While 16.4% of adults were moderately active and 23.4% were active, **60.2% of adults were considered inactive**. This may be an area of concern, as **a lack of physical movement or activity can lead to complex health outcomes, and can also impact mental and emotional well-being**. Adults who were most likely to participate in **walking, fishing, and playing competitive or team sports**. That being the case 15% reported participating in no activity. This could in some cases be due to mobility or health issues. **These findings do point to the need for approaches that inspire adults to move their bodies, spend time outdoors, and spend time with the land**.

Most youth were involved in activity. The most commonly reported activities were **playing team or competitive sports, running or jogging, or skating**. Only 7% reported not participating in a physical activity. Most youth were active: 41.2% were active and 26.6% were moderately active; **32.2% of youth were inactive**.

Although youth were most likely to have participated in sports, when they were asked if they took part in sports teams or lessons after school, 40.4% never did. Also, 80.9% of youth felt that traditional cultural activities were important in their lives (see *Language & Culture* section), but 64.1% reported that they never took part in traditional activities outside of school hours. This could show a lack of opportunity to engage in these activities.

Remarkably, 38.0% of children took part in no physical activity. 41.8% of children were inactive, while 21.3% were moderately active and 36.9% were active. **This could point to a need for more inclusive physical and extracurricular programming for young**

children. Activities that children were most likely to engage in included **walking, swimming, and bicycle riding**.

SECTION 5: MOBILITY: MOVEMENT

This section examines reasons for moving to and from First Nations communities. It also examines a number of socio-economic determinants of health, including: education, employment and income, and housing, as these are often key driving motivators of migration.

ADULTS: MIGRATION

Less than half the adults surveyed (45.4%) had lived outside their First Nation community, while 54.6% had never lived outside their community. Respondents who had moved were asked how many times they had moved on and off their reserve in the 12 months prior. Most adults (71.1%) had not moved during this time, while 16.9% had moved once. Others had moved 2-3 times (9.6%), 4-5 times (1.2%[E]), and 6 or more times (1.5%[E]).

While living off-reserve, 50.9% of respondents had accessed services (e.g., health and education) from their First Nation community. Almost half (46.8%) of First Nations migrants had also voted in their First Nation election while living outside their community.

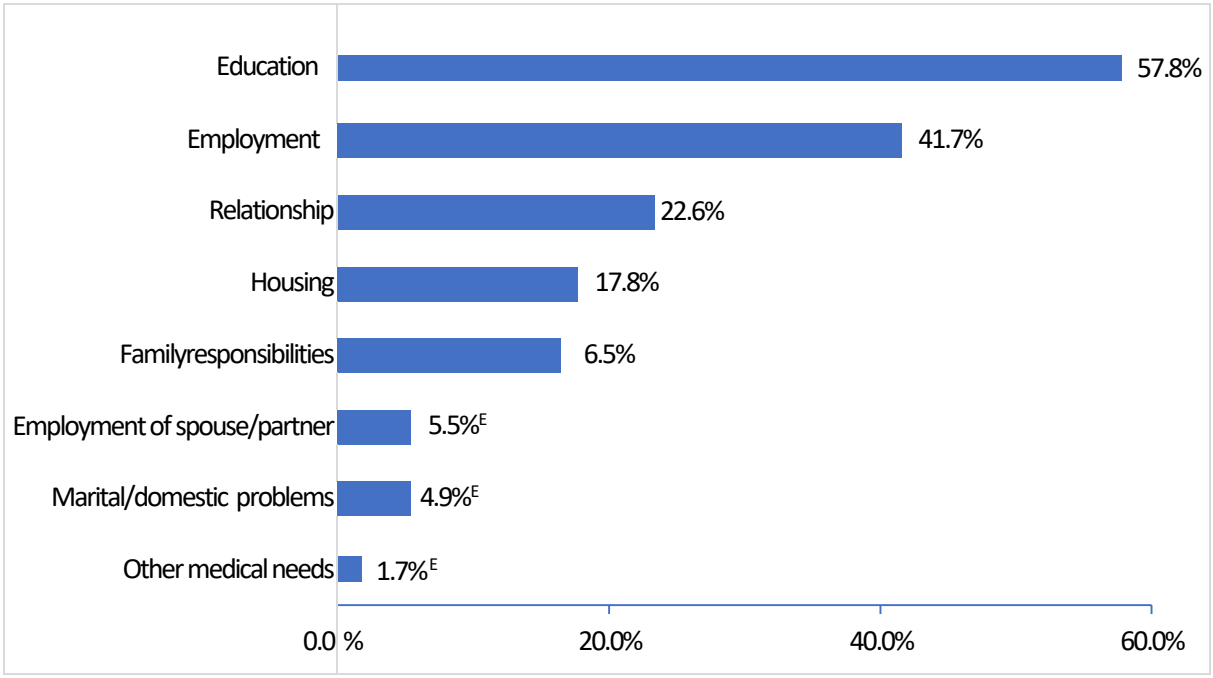
More than half of the adults who had lived outside their community (57.8%) had moved to access education. Employment (41.7%) and relationships (22.6%) were also commonly reported reasons for moving (see Figure 29). Most adults (78.8%) returned to their communities for family.

The most commonly reported reasons for returning to the community were connection to community/home (39.7%) and job opportunities (28.7%) (see Figure 30).

CHILDREN: MIGRATION

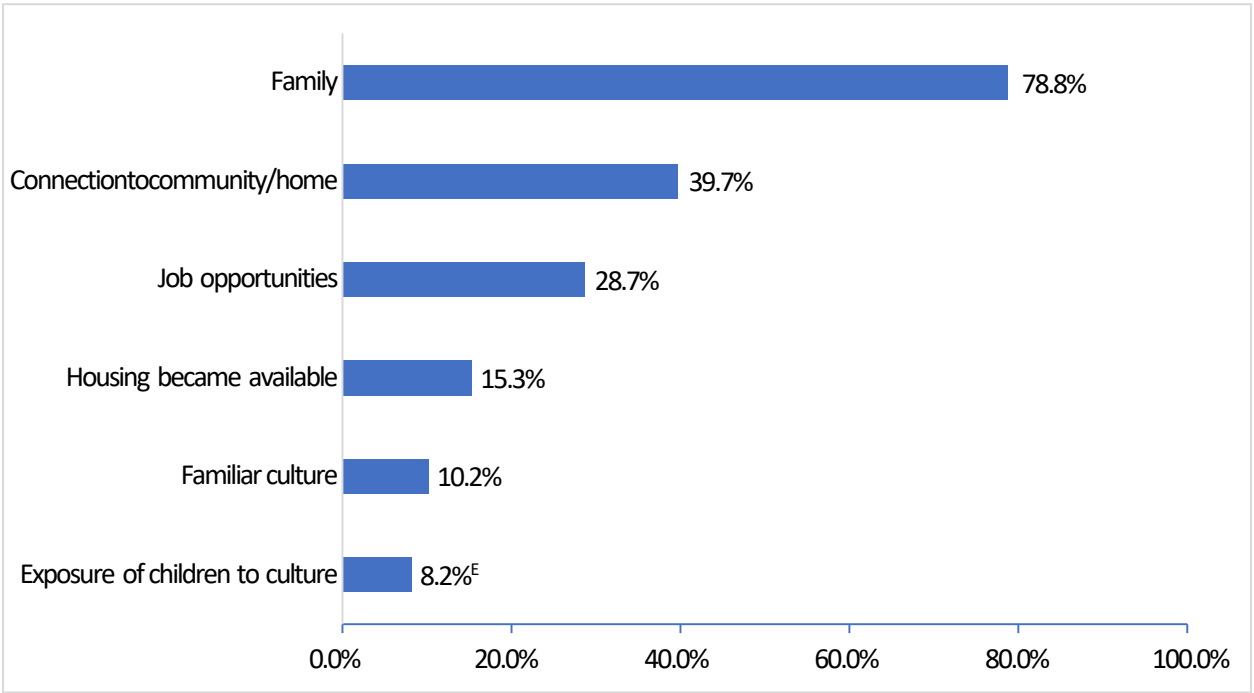
Most children surveyed (75.7%) had not moved on and off their reserve in the 12 months prior, while 24.3% had moved one or more times. While living off-reserve, 28.2% of caregivers accessed services such as health and education from their First Nation community, and 23.9%[E] voted in a First Nation election.

Figure 25: Reasons for moving away from First Nation community, among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

Figure 26: Reasons for returning to First Nation community, among adults



Note: Respondents could choose more than one response
[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

EDUCATION

SCHOOL ATTENDANCE: ADULTS

More than half the adults surveyed (52.3%) had completed a high school diploma. Of those who had graduated high school, 36.9% had completed a post-secondary diploma or training, and 9.6%[E] had completed a university degree.

SCHOOL ATTENDANCE: YOUTH

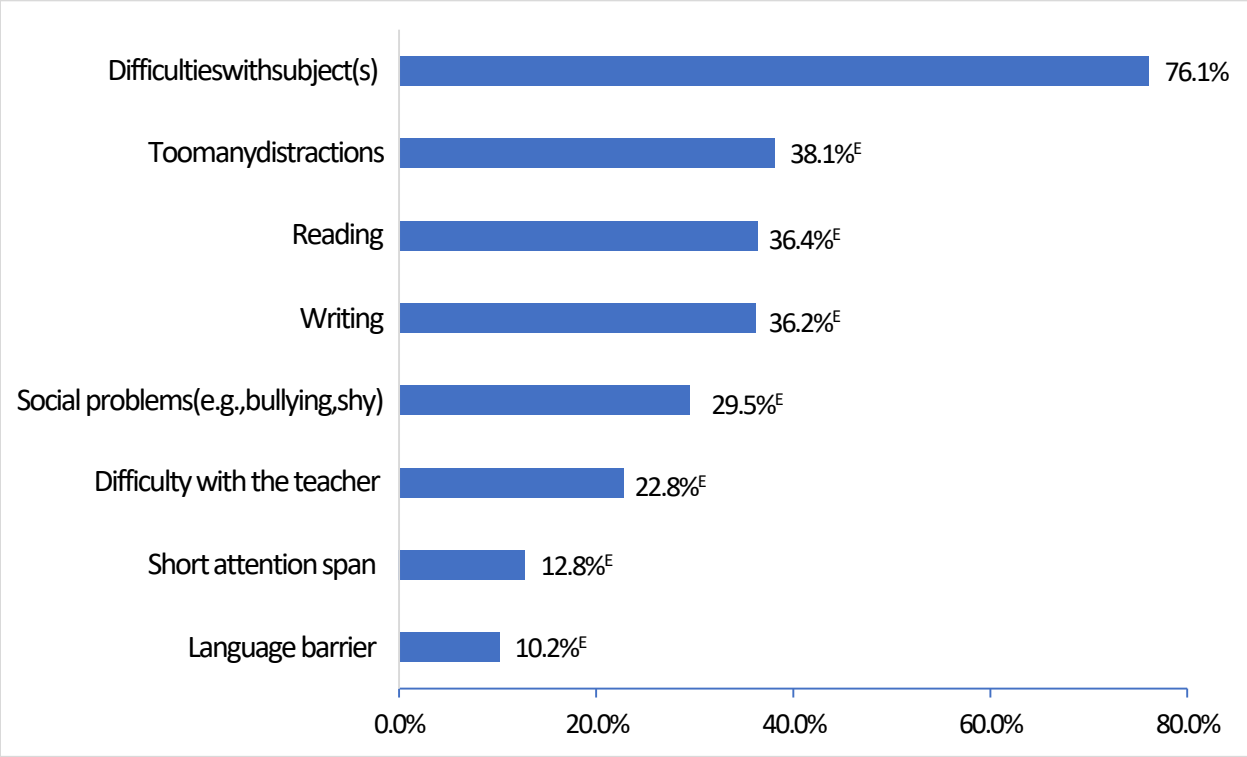
Almost all youth (91.2%) reported that they were currently attending school. Most of these youth (83.5%) stated that they liked school very much or somewhat. Only 5.4% disliked school somewhat or very much, and 11.1% were unsure. While most youth (82.9%) had never repeated a grade, 17.1% had.

When asked if they experienced problems learning in school, 18.4% reported that they did. Youth were most likely to report difficulties with particular subjects in school, like math, science, or social studies. Another commonly reported difficulty was that there were too many distractions (38.1%[E]) (see Figure 27).

ABORIGINAL HEAD START PROGRAM

Of the youth surveyed, 19.1% had attended an Aboriginal Head Start program. Similar to children, most (52.2%) had spent one year in the program. About one-quarter (23.3%) of children had attended an Aboriginal Head Start program. Of those children who attended most had spent one year in the program (46.5%).

Figure 27: Types of difficulties learning in school, among youth who reported problems learning in school



Note: Respondents could choose more than one response

[E] High sampling variability, interpret with caution (CV: 0.166-0.333)

EMPLOYMENT & INCOME

Slightly more than half the adults surveyed (55.3%) were not working at a job or business for pay at the time of the survey, while 44.7% of adults were working. When asked how many hours adults worked at their main job, 71.6% worked >30 hours/week, and 28.4 worked part-time (i.e., ≤30 hours/week). **Most adults who were working had jobs within their own First Nation community (90.0%), and more than half (59.6%) of employed Manitoba First Nation adults worked for a First Nations organization or government**.

Of the adult respondents who were not working, 44.1% were looking for employment, while 55.9% were not. **Adults who were not looking for work were most likely to be stay-at-home parents (21.4%), in poor health or with a disability (20.2%), or retired (20.0%)**. A smaller proportion stated that there was no work in their community (11.4%), or that they had given up on looking for work (11.2%[E]).

The highest proportion of adults (39.5%) reported a personal income of <$20,000/year, while 25.5% earned $20,000 - $29,999, and 27.4% earned $30,000 - $49,999. The remaining 7.6% earned >$50,000/year.

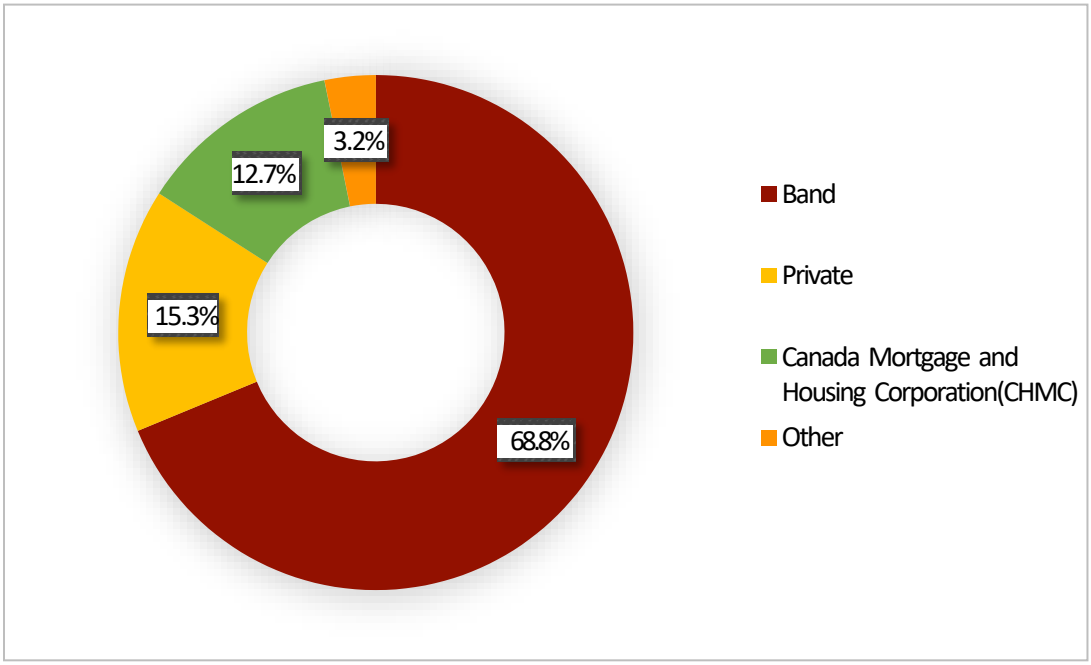
Just less than half of the adults surveyed (47.7%) received their main source of income through paid employment. Other commonly reported main sources of income were social assistance (42.8%), child tax benefit (9.2%), and employment insurance (8.4%). Note that respondents could choose more than one response.

HOUSING

HOME OWNERSHIP/RENTAL

Most adults (70.0%) lived in a primary residence that was owned by them or another member of the household, while 18.6% lived in a home that was rented by them or another member of the household. About one-quarter (25.3%) of adult respondents lived in band-owned housing. More than two-thirds of adults (68.8%) rented or owned a home through their band (see Figure 28).

Figure 28: Home ownership/rental, among adults



HOUSEHOLD REPAIRS & CROWDING

Approximately one-quarter (25.2%) of all adult respondents' homes needed major repairs, 38.2% required minor repairs, and 36.7% only needed regular maintenance. According to the RHS, major repairs include for example, defective plumbing or electrical wiring, and/or structural repairs to walls, floors, and ceiling. Minor repairs included for example, missing or loose floor tiles, bricks, shingles, defective steps, railings, and/or siding.

Most adult respondents (61.7%) did not live in crowded housing conditions (i.e., there were 0-1 people per room in the household), but 38.3% did live in a crowded household (i.e., >1 person per room in the household). Rooms included bedrooms, living rooms, and finished basements.

Based on responses from the parents/guardians of children surveyed, the same measure was used to determine household crowding. The results show that **more than half of the children surveyed (56.6%) live in crowded households (i.e., >1 person per room in the household), while 43.4% of children live in households that are not considered to be crowded (i.e., 0-1 people per room in the household)**.

Almost 40% of respondents' homes (37.8%) had had mold or mildew in the 12 months prior to the survey. From a health perspective, findings indicate that **a higher proportion of adults with ≥1 chronic health conditions (44.2%, 95% CI: 37.5, 51) live in homes with mold or mildew compared to those with no chronic health conditions (31.6%, 95% CI: 24.8, 39.2)**. While this difference is not statistically significant, it does demonstrate that more adults with health conditions have been exposed to mold or mildew in the home.

ACCESS TO CLEAN DRINKING WATER

Over half (58.8%) of all households surveyed accessed water piped in through their local or community water supply. One-quarter (25.9%) had it trucked in, 9.0%[E] used individual or shared well water, and 3.1%[E] had to collect water themselves from a water plant. **About two-thirds (62.8%) of all adults surveyed considered the main water supply in their home to be safe for drinking year-round: 37.2% did not consider their drinking water to be safe year-round**.

CONCLUSIONS & RECOMMENDATIONS

Adults were most likely to leave their First Nations community to access education or employment. Relationships were another common reason for relocating. Adults were most likely to return to reconnect with community and home, as well as for job opportunities.

IN SUMMARY: EMPLOYMENT

While just less than half the adults surveyed (44.7%) were working for pay, 44.1% were looking for employment. The 55.9% who were not looking for employment, were most likely to be retired, stay-at-home parents, or in poor health. It is however, important to note that approximately 11% of respondents could not find work in their communities, and 11% had given up looking for work, perhaps for this reason.

IN SUMMARY: EDUCATION

About one-quarter of children surveyed (23.3%) had attended an Aboriginal Head Start program, and 19.1% of youth respondents had attended the program. This program supports culture and language; education and school readiness; health promotion; nutrition; social support; and parent/family involvement for young children (Ball and Moselle, 2013). This program is an example of integrating language, culture, and family in a way that supports health and well-being. **Research has shown that First Nations language immersion in education can strengthen cultural knowledge, self-worth and identity, and children in language immersion programs tend to demonstrate better educational success** (Reyher, 2010).

IN SUMMARY: HOUSING

The relationship between housing quality and chronic health conditions cannot be overstated. **Access to safe, adequate housing is a key determinant of health**. One challenge around limited access to housing can be overcrowding – which can be associated with higher rates of infectious disease. Just over half of the children surveyed (56.6%) lived in crowded conditions, and 38.3% of adults lived in a crowded home. Mold or mildew in the home is another concern. From a health perspective, mold or mildew in the home is a significant risk factor for respiratory diseases, allergies, and is a significant determinant of chronic bronchitis (Karunanayake et al., 2017; Pahwa et al., 2017). The findings show that adults with one or more chronic health conditions are more likely to live in houses with mold or mildew than those with no chronic health conditions.

IN SUMMARY: ACCESS TO CLEAN WATER

Boil water advisories and access to clean drinking water year-round is also a point of concern, as 37.2% of adult respondents did not consider their water to be safe year-round. Drinking water in First Nation communities is at risk of contamination for a number of reasons, including industrial waste, oil and gas development, and resource extraction. Research has demonstrated that communities and families without adequate water and sanitation structures are more likely to report waterborne illnesses at all ages, and rashes in children in particular. Contaminated water or inadequate water pressure can also affect dialysis treatment. (O'Gorman and Penner, 2018).

CONCLUDING REMARKS

This report synthesizes the data findings of the RHS Phase 3 (2015-2016), conducted in 35 First Nations communities in the Manitoba region, to better understand the health and well-being of First Nations adults, youth, and children living in Manitoba. The report was organized according to 5 key themes: Community Wellness, Holistic Well-being, Physical Well-being, Healthy Behaviours and Lifestyle, and Mobility: Movement.

The goal of this report was to provide data that supports and measures overall quality of life. The goal is also to contribute to informing culturally relevant, holistic programs and service delivery that advocates for the well-being of First Nations individuals, families, and communities.

The report provides a summary analysis of indicators of health and well-being among First Nations individuals, families, and communities. It also offers some conclusions and recommendations in moving forward.

Please refer to Summary sections throughout the report, and highlighted text for key findings and recommendations.

The knowledge gained from this data can also be seen as a source of resilience and strength. This report is intended to be a living document that over time will grow to support health promotion strategies and programming, and to address gaps.

Although we discuss health challenges and ill health in this report, we also measure First Nations' indicators of success, health, and wellness. It is hoped that the findings from the RHS 3 will contribute to cultivating the wellness that *already exists* within First Nations communities living in the Manitoba region.

REFERENCES

Allan, B. and Smylie, J., 2015. First Peoples , Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, Canada.

Ball, J. & Moselle, K. (2013). Contributions of culture and language in Aboriginal Head Start in urban and northern communities to children's health outcomes: A review of theory and research. Division of Children, Seniors, & Healthy Development. Public Health Agency of Canada.

Canadian Institute for Health Information (2009). *Mentally Healthy Communities: Aboriginal Perspectives.* Ottawa: ON.

First Nations Information Governance Centre (FNIGC). (2012). First Nations Regional Health Survey (RHS) 2008/10: National Report on Adults, Youth and Children living in First Nations Communities. Ottawa, ON: First Nations Information Governance Centre.

First Nations Information Governance Centre (FNIGC). (2018a). National Report of the First Nations Regional Health Survey Phase 3: Volume One. Ottawa: ON.

First Nations Information Governance Centre (FNIGC). (2018b). National Report of the First Nations Regional Health Survey Phase 3: Volume Two. Ottawa: ON.

Hallett, D., Chandler, M.J., & Lalonde, C.E. (2007). Aboriginal language knowledge and youth suicide. Cognitive Development, 22: 392-399.

Health Canada (2015). Canadian Guidelines for Body Weight Classification in Adults [online]. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fn-an/alt_formats/hpfb-dgpsa/pdf/nutrition/cg_quick_ref-ldc_rapide_ref-eng.pdf

Karunanayake, C.P., Rennie, D.C., Ramsden, V.R., ...The First Nations Lung Health Project Research Team. (2017). Bronchitis and Its Associated Risk Factors in First Nations Children. Children, 4(103), 1-10.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. Lancet, 374(9683), 76–85.

Komenda, P., Lavallee, B., Ferguson, W., Tangri, N., Chartrand, C., McLeod, L.,…Rigatto, C. (2016). The prevalence of CKD in rural Canadian Indigenous Peoples: Results from the First Nations community based screening to improve kidney health and prevent dialysis (FINISHED) screen, triage, and treat program. AJKD, 68(4), 582-590.

Leck, V. and Randall, G.E. (2071). The rise and fall of dental therapy in Canada: a policy analysis and assessment of equity of access to oral health care for Inuit and First Nations communities. Journal for Equity in Health, 16:131.

Morrison, J. (2015). The time has come to fix the Non-Insured Health Benefits (NIHB) program. CPJ/RPC, 148(4): 217.

National Collaborating Centre for Aboriginal Health (NCCAH). (2017). Housing as a social determinant of First Nations, Inuit, and Métis health. Prince George, BC: National Collaborating Centre for Aboriginal Health.

National Collaborating Centre for Aboriginal Health (NCCAH). (2016). Culture and language as social determinants of First Nations, Inuit, and Métis health. Prince George, BC: National Collaborating Centre for Aboriginal Health.

O'Gorman, M. & Penner, S. (2018). Water infrastructure and well-being among First Nations, Métis, and Inuit individuals in Canada: what does the data tell us? Environmental Science & Pollution Research.

Oster, R.T., Grier, A., Lightning, R., Mayan, M.J., & Toth, E.L. Cultural continuity, traditional Indigenous language, and diabetes in Alberta First Nations: a mixed methods study. International Journal for Equtiy in Health, 13:92.

Pahwa, P., Karunanayake, C.P., Rennie, D….First Nations Lung Health Project Research Team. (2017). Prevalence and associated risk factors of chronic bronchitis in First Nations people. BMC Pulmonary Medicine, 17(95), 1-10.

Power, E.M. (2008). Conceptualizing food security for Aboriginal people in Canada. Canadian Journal of Public Health, 99(2):95-97.

Reading, J. (2009). The crisis of chronic disease among Aboriginal peoples: A challenge for public health, population health and social policy. University of Victoria: Centre for Aboriginal Health Research.

Reading, C. (2015). Structural determinants of Aboriginal peoples' health. In M. Greenwood, S. de Leeuw, N.M. Lindsay, & C. Reading (Eds.), Determinants of Indigenous peoples' health (3–15). Toronto: CSPI.

FIRST NATIONS HEALTH AND SOCIAL SECRETARIAT OF MANITOBA

On behalf of the Research Team:

Miigwech!

Ekosi!

Mahsi!

Wopida!

Thank you!