Southern Health Santé Sud

2014

A picture of our health

Community Health Assessment

Acknowledgements

The work of the Community Health Assessment (CHA) in Southern Health-Santé Sud is very much an ongoing process. Although the statistics are compiled into one report, there was a lot of work that happened behind the scenes in preparation for the five-year comprehensive report. Choosing the indicators was a provincial collaboration with members of the Community Health Assessment Network (CHAN), with careful consideration to ensure that they are robust and measureable over time. While this is fourth cycle for CHA in Manitoba, it really is the first report for Southern Health-Santé Sud.

Within Southern Health-Santé Sud, the CHA working group is a sub-committee of the Decision Support Team. The goal of the team was to produce a report which is both informative and inspirational for many years to come. In addition to our team, this process would not be successful without the generous support and leadership of our CEO, Kathy McPhail.

CHA working group: (from left to right) Trish Braun, Ales Morga, Dr. Shelley Buchan, Jane Curtis, Shawna Moodie, Claudette Lahaie
Missing: Dr Anna Johnston, Cynthia Carr

First and foremost, sincere appreciation is extended to the Board of Directors for Southern Health-Santé Sud who have been fully engaged and committed to the entire CHA process. The team also hopes that your involvement with CHA has been valuable in preparation for the Strategic Planning process.

We no longer live in a time where data shortage is an issue. Although we are always striving to fill in gaps, the amount of population health information available in our province is impressive. Thank you to the Senior Leadership Team and Regional Leadership Team for your insight. Your feedback has really helped to shape the CHA key themes for our region.

The generous cooperation of regional residents is gratefully acknowledged. The team would like to express gratitude to those that have participated and contributed to the CHA process. Statistics alone cannot paint a true picture of health. Your willingness to engage with the Regional Health Authority helps to make information real and relevant.

Special thanks, to the Corporate Communications staff for the beautiful design and formatting of this report.

Finally, we would like to thank all the staff at the Acute Tertiary and Specialty Care Branch and Health Information Management at Manitoba Health Healthy Living and Seniors for your continued support and guidance with the CHA process in Manitoba. As well, thanks to all the researchers at the Manitoba Centre for Health Policy and CancerCare Manitoba for providing the data and statistical support to our region. We are truly blessed to have such commitment and dedication in Manitoba.

If you wish to provide feedback to the report, please email: **amorga@southernhealth.ca**

Dedication

This report is dedicated to the memory of **Dr. Patricia Martens**, who was a passionate and dedicated researcher and Director of the Manitoba Centre for Health Policy.

Pat was also very proud to live in the rural region of Southern Health-Santé Sud. She opened her heart and home to the community of Kleefeld. Wherever she went, Pat spoke with gratitude for the care she received by all the care providers who were involved in her care as she battled cancer.

As a trailblazer, Pat has greatly impacted the CHA process through her wisdom and expertise. As a friend and colleague she is sadly missed, but as our teacher her legacy lives on forever. We will always remember to think upstream and remember to "shift and squish" so that all residents of the region will have equitable access to health care.

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About the Assessment

CHA in Manitoba

A community health assessment identifies and measures the health status of the population of a given health authority. It is a dynamic, ongoing process undertaken to identify the strengths and needs of the community, to enable the community-wide establishment of health priorities, and to facilitate collaborative action planning directed at improving community health status and quality of life. (CHA Guidelines, 2009)

It is a legislated requirement that each health region assess the health of their population. *The Regional Health Authorities Act* defines the primary duties of the regional health authorities (RHAs), which include:

- Assess health needs in the health region on an ongoing basis;
- Develop priorities and objectives for the provision of health services which meet the health needs in the health region and which are consistent with provincial objectives and priorities;
- The CancerCare Manitoba Act requires CancerCare Manitoba to consult with regional health authorities and others in preparing an annual health plan;
- The Regional Health Authorities Amendment Act (Bill 38, 2011) has added a requirement that health authorities publish community health assessment reports on their websites.

The first comprehensive CHA reports were completed at the time of regionalization, in 1997 and 1998; the second comprehensive CHA reports were completed in 2004; subsequent CHA reports are submitted on a five year cycle.

The intended uses of the CHA reports include:

- To inform the health authorities' strategic planning process
- To inform the health authorities' communities and stakeholders
- To inform evidence-informed decision making in the health authorities
- To inform the Manitoba Health strategic planning process
- To inform evidence-informed decision making in Manitoba Health

CHA Indicators

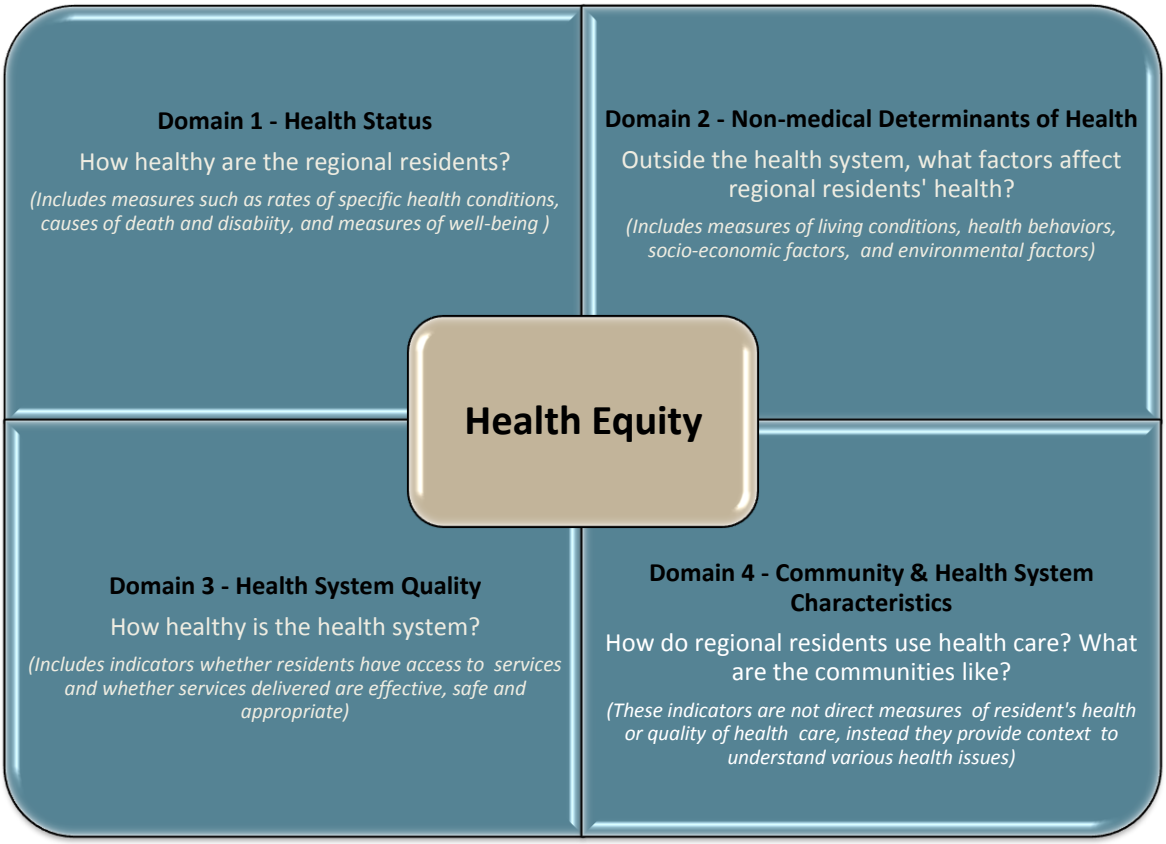
The Community Health Assessment – Indicator Review Committee (CHA-IRC) went through an extensive review process to select indicators for the 2014 CHA cycle. The goal of this working group was to recommend a common and comparable set of health indicators for the CHA that describes the health and burden of illness experienced by their residents, and describes the way health services are used in Manitoba. In addition, CHA-IRC enabled a co-ordinated approach to CHA that allowed province-wide comparability on health issues within health authorities, while recognizing and respecting the diversity among health authorities. As a working group, CHA-IRC completed an environmental scan of indicators that were used in other sources measuring population health and health status. As illustrated on the following page, the framework used for CHA indicator selection was adapted from A Citizen's Guide to Health Indicators (2011) which was developed by the Canadian Institute for Health Information. As well, experts were consulted throughout to further the selection process. The list was narrowed down to a set of 80 core CHA indicators which would be mandatory for reporting and met the following five criteria:

1. **Important and Relevant**
   - The indicator reasonably reflects efforts to reduce health risks and improve health status and health systems.
   - The indicator is understandable, relevant, and useful for health planning.
2. **Valid**
   - This indicator actually measures what it is claiming to measure.
3. **Possible**
   - The indicator is currently collected at the regional health authority and provincial level.
   - The indicator supports meaningful comparisons over time and place.
4. **Meaning**
   - The indicator is sensitive and reflects change in the phenomena it is intended to measure.
5. **Implications**
   - The indicator is amenable to action and supports evidence to motivate change.

This report is structured to include the 78 core indicators required, plus many more that are important to describing the unique needs of Southern Health-Santé Sud. Wherever possible, indicators are reported at both the regional and district levels – to provide more details at local geographic levels. The chapters are organized as follows:

Chapter 1 provides an overview of the region; **Chapter 2** includes demographic indicators that help to understand the people living in the region; **Chapter 3** reviews all the indicators that describe the health of regional residents including health status, health behaviors and disease prevention; **Chapter 4** includes indicators about how regional residents use various types of health services; **Chapter 5** is a special section dedicated to community engagement activities and the voices within communities.

CIHI FRAMEWORK USED FOR CHA INDICATOR SELECTION.



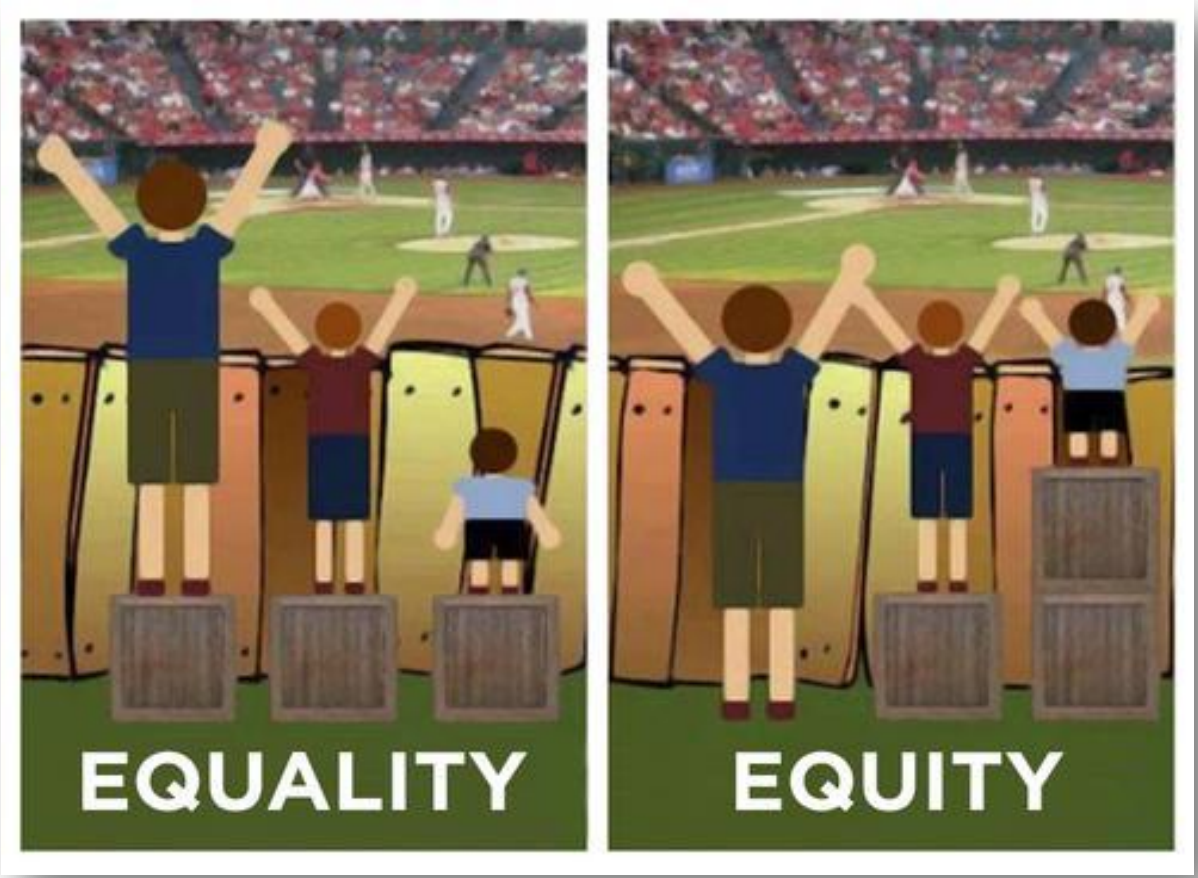
Health Equity

Evidence shows that people belonging to certain population groups tend to experience disparities in their health status, access to services and the quality of care received. Factors such as gender, race, sexual orientation, immigration status, income and education can influence a person's access to timely, appropriate and high-quality care.

Health equity is concerned with creating equal opportunities for good health for all and reducing avoidable and unjust differences in health among population groups.

Equitable access to health services that is based on need, fairness in the distribution of health care resources, provision of culturally competent care and focus on the most health-disadvantaged groups can significantly reduce disparities in health outcomes among population groups and enhance the wellbeing of underprivileged populations.

Throughout this report, look for this equity symbol next to indicators that are showing differences in health status among groups in regional populations.



The terms equity and equality are sometimes used interchangeably, which can lead to confusion because while these concepts are related, there are also important distinctions between them.

As depicted in the illustration above, **equity** involves trying to understand and give people what they need to enjoy full, healthy lives. **Equality**, in contrast, aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality aims to promote fairness and justice, but it can only work if everyone starts from the same place and needs the same things.

Data Limitations

We acknowledge that the information in this report may not specifically reflect the health status and needs of Aboriginal residents because of data limitations. Much of the data sources are reliant on residents self-identifying themselves as Aboriginal or the research (eg., Statistics Canada - Canadian Community Health Survey) is only conducted off-reserve. CHAN has identified this as a gap area and is striving to gather reliable statistics for future CHA cycles.

Additionally, in 2011, Statistics Canada's mandatory long-form census was abolished and replaced with a voluntary National Household Survey (NHS). While it was mandatory, the long-form census had a response rate of 94%, however the NHS is closer to 65% at the regional level for Southern Health-Santé Sud. Unfortunately, no information is available at municipal level which was previously possible with the long-form census. An addendum to this report will be posted as soon as reliable sub-regional data becomes available.

Executive Summary

One of the five regional health authorities in the province, Southern Health-Santé Sud spreads over 27,025 km^2 with 29 rural municipalities, 4 cities, 12 towns and 5 villages. Southern Health-Santé Sud also brings together a vibrant collage of rich cultures and talented people with histories that run as deep and proud as the flowing waters of the Red River that joins them. Over 190,000 people make up the population of this diverse region. There are seven First Nation communities and fifty-six Hutterite colonies throughout the area. Aboriginal people in the region represent 12% of the overall population, and are relatively young in comparison. Approximately 70% of rural French-speaking Manitobans live in the region representing nearly 11% of its population. There is also a large and growing population of Mennonite, German-speaking, Ukrainian and other cultures.

Southern Health-Santé Sud provides services across the continuum of care. Our team thrives in an atmosphere of innovation and success while still enjoying a relaxed, healthy rural lifestyle complete with a strong sense of community and all the modern conveniences.

Southern Health-Santé Sud offers a wide range of health care opportunities to its more than 5,600 employees and physicians. We are proud to partner with the many communities in our region in delivering quality health care.

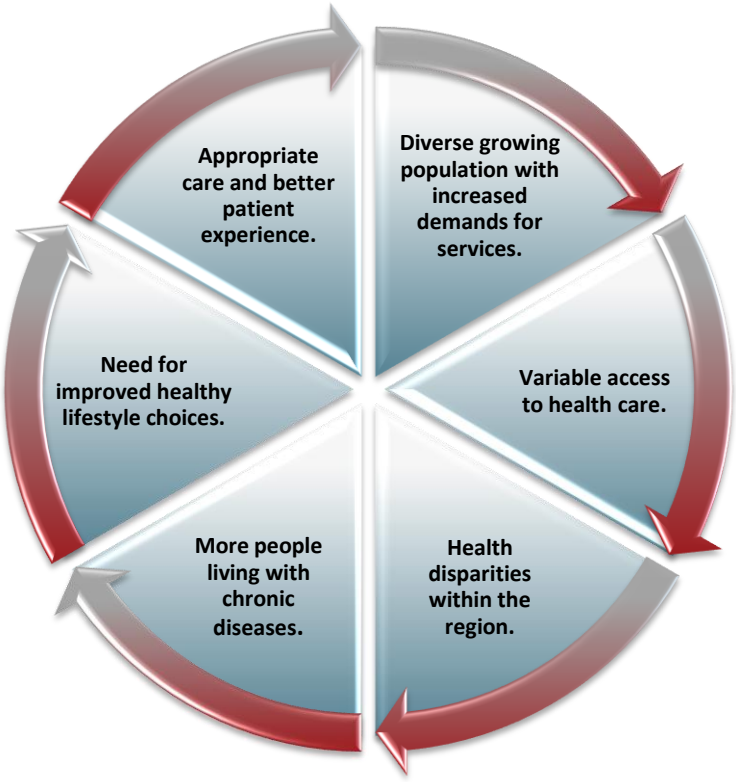
Key Themes

The Board of Directors is firmly committed to strategic planning guided by CHA evidence. The Regional Leadership team, along with the Board of Directors, came together in May 2013 for a workshop to review CHA findings. This was a large gathering with over 100 people in attendance, and from this day a number of key themes emerged.

As illustrated on the following page, it was clear that Southern Health-Santé Sud had:

- A diverse and growing population with increased demands for services;
- Variable access to care;
- Health disparities within the region;
- More people living with chronic diseases;
- Need for improved healthy lifestyle choices;
- Appropriate care and better patient experiences.

KEY CHA THEMES, SOUTHERN HEALTH-SANTÉ SUD



1. A diverse growing population with increased demands for services.

Some key facts and statistics
❖ Health Care professional shortage continues to challenge demand for services.
❖ We continue to be the fastest growing RHA in Manitoba – 20% population growth over past decade.
❖ Currently there are 190,841 residents living in the region with an annual growth rate of 1.8%.
❖ Population projections are expecting continued growth in region - estimating that our population will grow to 230,000 residents by 2024 and over 270,000 residents by 2034.
❖ Population growth is across all age groups and in many areas of the region, however, the four cities within the region account for the majority of the increases.
❖ We have a relatively young population with high fertility rate (2.28 region ; 1.78 province) – there are approximately 2,800 births per year within the region.
❖ Our Aboriginal population represents 12% of our overall population – relatively young population compared to region.

- Recent immigrants represent almost 13% of our overall population – profile of overseas immigrants changing to represent countries from all around the world. Top three countries: Germany, Russia and Phillipines.
- Over 80% of our residents reported European origins – higher than the provincial rate (71%).
- As population is aging there is a rising pressure on long term care services. Senior population has already increased by 4.1%. PCH bed equivalent needs will increase over the next 20 years – across the region ranging from 67% to 117%.
- There is a significant increase over time in median wait times for PCH admission from hospital and from community. Higher than the provincial averages. From hospital increased from 8.2 weeks to 10.8 weeks - compared to 5.14 weeks for province. From community increased from 17.4 weeks to 22.6 weeks - compared to 11.3 weeks for the province.

2. Variable access to health care.

Some facts and statistics

- Wait times increasing for community services (eg, mental health, rehabilitation).
- Language access – over 40 different non-offical languages spoken.
- Sixty-nine per cent of residents received a majority of care over a two-year period from the same physician – lower than provincial average (73%).
- Over 85% of all visits to specialists occurred outside the RHA – majority in Winnipeg.
- 22.9% of residents (ages 50-74) had a Fecal Occult Blood Test (FOBT) in past two years, or flexible sigmoidiscopy or colonoscopy in past five years – below provincial rate at 31.9%.
- Breast assessment wait time (from screening to diagnosis) is 25 days – longer than the provincial average of 21 days.
- "BreastCheck" is a provincially monitored screening program. For our region, 61% of women aged 50-69 had at least one mammogram in past two years – similar to provincial rate.
- "CervixCheck" is a provincially monitored screening program. For our region, 58.7% of women aged 18-69 received at least one Pap test in the past three years – similar to provincial rate.

3. Health disparities within the region.

Some key facts and statistics
❖ Premature mortality rate decreased over time from 2.84 to 2.53 deaths per 1,000 residents aged 0 to 74 years – as the lowest rate in province, this shows that the region has among the healthiest populations. Manitoba rate is 3.12 deaths per 1,000 (0-74 years).
❖ Variations of health status exist within region: • Healthiest Districts (PMR below MB average): MacDonald, Stanley, Altona, Hanover, Cartier/SFX, Niverville/Ritchot, Steinbach, Winkler, Morris, and Taché • Least Healthy Districts (PMR higher than MB average but not significantly): Rural Portage, Red River South, City Portage, Seven Regions
❖ Almost 12% of population identified themselves as being an Aboriginal person (First Nations (North American Indian), Métis or Inuk (Inuit)) and a large majority live in the least healthy districts as per PMR.
❖ Education levels lower than province: • Higher proportion of residents without a high school diploma (SH-SS 23.4% compared to MB 17.2%) - aged 25-64 years • Lower proportion of resident with a post secondary certificate, diploma or degree (SH-SS 49% compared to MB 57%) - aged 25-64 years
❖ Employment rate higher than the province (SH-SS 65.5% to MB 63.1%).
❖ Unemployment rate lower than province (SH-SS 5.1% to MB 6.2%).
❖ Median household total income higher than the province ($59,014 (SH-SS) compared to $57,299(MB)).

> *"We need more events that bridge the gap, blur the lines and support understanding of fellow community members."*

4. More people living with chronic disease.

Some key facts and statistics

- Population growth has meant that more people are living with chronic diseases. Even though prevalence rates may not change, it is important to note that a disease may impact more people within the region.
- More people are living with diabetes, from 8,341 to 10,124. Diabetes prevalence (type 1 or 2) also increased over time in our region from 7.6% to 8.3% of the population ages 19 and older. However, incidence (number of new cases) decreased over time from 0.78 to 0.68 cases per 100 person-years. Both prevalence and incidence rates lower than Manitoba.
- People living with arthritis increased slightly from 22,016 to 23,399. Prevalence did not change over time, remaining at 19%, which is the lowest rate in the province.
- More people living with hypertension, from 26,232 to 29,674. Prevalence rate did not change over time, remaining at 24%, which is the lowest rate in province. As well, hypertension incidence was the lowest in the province and decreased over time from 3.20 to 2.65 cases per 100 person-years.
- Prevalence of mood and anxiety disorders decreased over time from 20.4% to 19% - which is lower than provincial rate of 23.3%. However, the number of people living with mood and anxiety disorders increased slightly from 26,883 to 27,893.
- Less people living with ischemic heart disease (IHD), from 8,856 to 8,344. IHD prevalence decreased over time in our region from 8.27% to 6.91% of the population 19 and older, which was the lowest rate in the province.
- The stroke rate for our region decreased over time from 2.89 to 2.39 strokes per 1,000 residents aged 40 and older per year. This was the lowest rate in the province.
- Heart attack rate for our region has increased (but not significantly) over time from 4.00 to 4.25 per 1,000 residents aged 40 and older per year.
- Less people living with respiratory diseases from 13,048 to 11,756. Overall, Total Respiratory Morbidity prevalence decreased in our region from 8.1% to 6.8% of the population (all ages).
- Cancer incidence rate at 434.2 cases per 100,000 people – lower than the provincial rate. Previously the rate was lower at 413.6 cases per 100,000, so new cases of cancer have increased over time.
- Cancer survival rates are similar to provincial averages.

  Lung cancer – 17.3% (SH-SS) compared to 21.7% (MB)

  Colorectal cancer - 70.1% (SH-SS) compared to 61.6% (MB)

  Breast cancer - 84.7% (SH-SS) compared to 84.9% (MB)

  Prostate cancer - 94.8% (SH-SS) compared to 91.7% (MB)

5. Need for improved healthy lifestyle choices.

Some key facts and statistics
❖ Proportion of residents aged 65 and older receiving a flu shot decreased significantly from 57.9% to 50.8% - lower than the provincial average (55.8%).
❖ The percent of residents aged 65 and older receiving a pneumococcal vaccination decreased slightly from 62.2% to 60.1% - lower than the provincial average (65.8%).
❖ Low rates of self-reported physical activity levels – 53% inactivity level among adults, 18% inactivity among youth.
❖ 21.3% of adults would be classified as "obese", based on self-reported height and weight.
❖ 20.8% smoking rate for region - similar to the provincial rate at 19.6%. Among youth (grade 7-12), 9% reported that they currently smoked (occasionally or daily).
❖ Only 36% of youth reported eating fruit and/or vegetables 7 or more times per day.
❖ Binge drinking (5 or more drinks of alcohol within a couple of hours): 19% adults, 14% youth. Manitoba rate at 22%.
❖ 11% of students reported using illegal, prescription or over-the-counter drugs for the purposes of getting high.
❖ Mental Health among youth: 60% reported flourishing mental health; 36% reported moderate mental health; 4% reported languishing mental health.
❖ Only 28% of youth reported getting 9 or more hours of sleep on school nights.
❖ Only 32% of youth reported that they always or often use sun/UV protection.
❖ The top three causes of injury-related deaths in the region were motor vehicle, poisoning, and falls.

> *"Sitting is the new smoking. We have the information to make healthier lifestyle choices but most of us don't do it."*

6. Appropriate care and better patient experience.

Some key facts and statistics
❖ Challenge with appropriate care environments for aging populations. More people living with dementia, from 3,202 to 3,772. Dementia prevalence increased slightly from 9.4% to 9.9% of the population aged 55 and older. Both rates were below Manitoba averages.
❖ Challenge with appropriate care environments for hospitalized patients: Hospitalization and days of care: highest rate in province for ALC patients awaiting placement for PCH (20.8%). Manitoba rate is 14.3%.
❖ Challenge with appropriate care environments for community residents: The proportion of community-dwelling seniors (aged 75+) using Benzodiazepines decreased slightly over time – however it is higher than provincial average (22% compared to 20%).
❖ Overall increases in level of care on admission to PCH – fewer in lower care needs (Level 2(N/Y) decreased from 28.9% to 18.1%), and more residents with higher care needs (Level 3/4 increased from 71% to 81.7%).
❖ Overall median length of stay (LOS) in PCH decreased over time from 2.48 to 2.24 years – similar to provincial LOS of 2.21 years.
❖ 96.3% - overall average satisfaction score for outpatient cancer care (SH-SS residents).
❖ 48.5% - average score for satisfaction of emotional support for cancer patients (SH-SS residents).
❖ 73.4% - average score for pain management satisfaction of cancer patients.(SH-SS residents).

> *"Patient input provides a venue and opportunity for healing."*

Overview of Region

Chapter 1

Overview of Region

1.1. Vision, Mission, and Values

Our Vision:

Together leading the way for a healthier tomorrow.

Our Mission:
Our mission is to support people and communities by providing innovative, sustainable and quality health services to achieve optimal health.

Our Values:

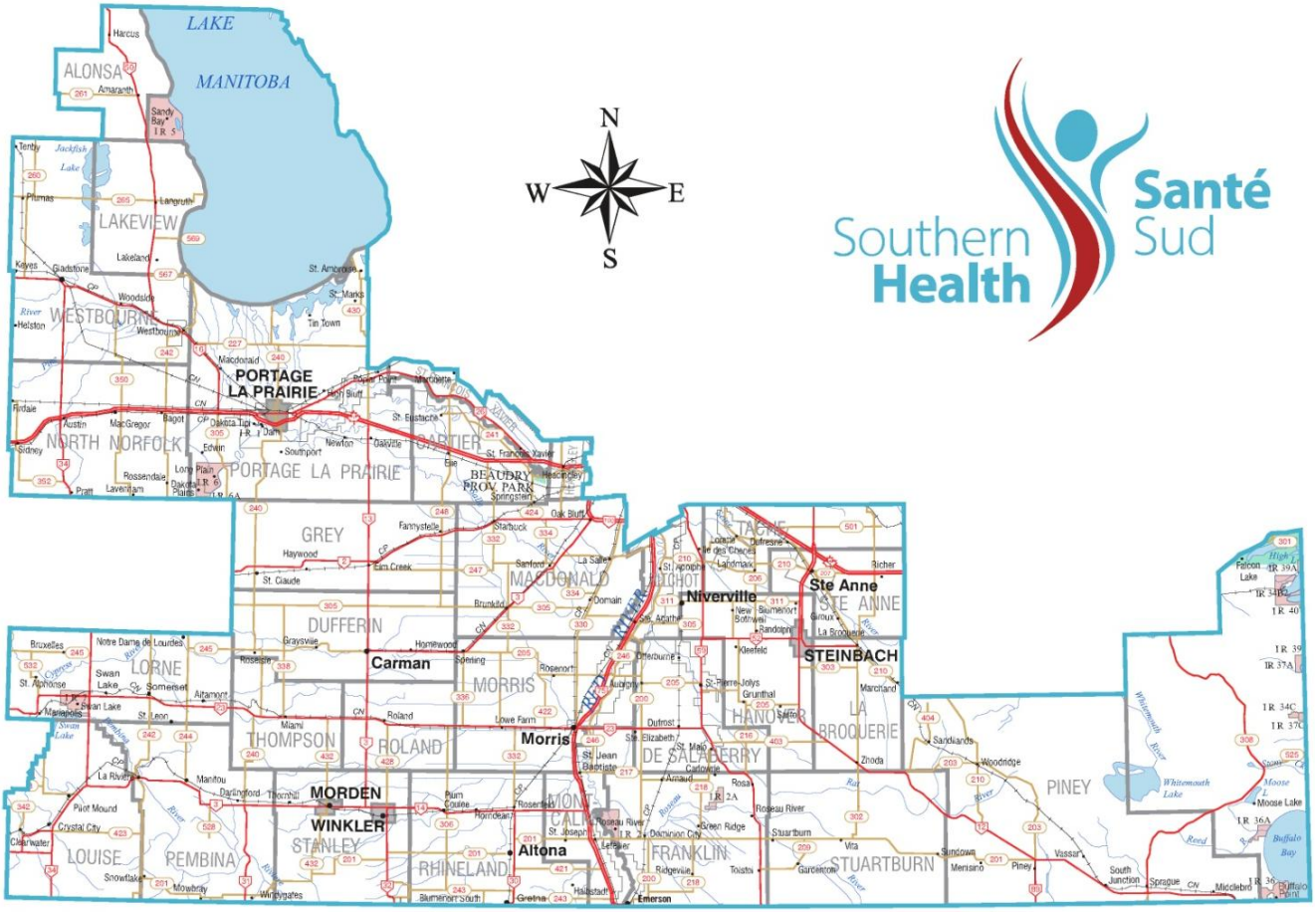
1.2. Board ENDs (Strategic Directions)

- **Healthy People and Healthy Environment**
- **Accessible Health Services**
- **Safe, People-centred, Quality Health Care**
- **Sustainable, Accountable and Responsive Health Organization**

1.3. Map

As illustrated in the map below, Southern Health-Santé Sud, covers an area of 27,025 square kilometers in southern Manitoba. It stretches up from the 49th parallel and borders the United States of America to the south, and the Ontario border to the east. The region lies along the route of the Trans-Canada highway, and includes the south-west edge of Lake Manitoba down to the Pembina escarpment in the west.

The region includes 4 cities, 17 towns and villages, 28 rural municipalities, and 1 unorganized territory. As well, there are 7 First Nations communities, and 56 Hutterite colonies throughout the region.



1.4. List of Municipalities and Districts

The indicators in this report are broken down by regional level (compared to other regions and the province). Wherever possible, the indicators are also reported at 23 district levels to provide a finer level of detail for communities. Please note that some municipal areas have since amalgamated, however the data sources used in this report were produced prior to these mergers which used the following breakdowns:

NORTH AREA

District: Seven Regions
- RM Lakeview
- RM Westbourne
- RM Alonsa
- Gladstone Town
- Sandy Bay First Nation

District: MacGregor
- MacGregor Town
- RM Norfolk

District: Portage
- Portage la Prairie City

District: Rural Portage
- RM Portage
- Dakota Tipi First Nation
- Dakota Plains First Nation
- Long Plain First Nation

District: Cartier/SFX
- RM Cartier
- RM St. François Xavier
- RM Headingly

MID AREA

District: Carman
- RM Dufferin
- Carman Town

District: St. Claude/Notre Dame
- St. Claude Village
- Notre Dame de Lourdes Village

District: MacDonald
- RM MacDonald

District: De Salaberry/St. Pierre
- RM De Salaberry
- St. Pierre Jolys Village

District: Red River South
- RM Montcalm
- RM Franklin
- Emerson Town
- Roseau River First Nation

District: Morris
- RM Morris
- Morris Town

WEST AREA

District: Winkler
- Winkler City

District: Morden
- Morden City

District: Stanley
- RM Stanley

District: Altona
- RM Rhineland
- Altona Town
- Gretna Town
- Plum Coulee Village

District: Roland/Thompson
- RM Roland
- RM Thompson

District: Rural West
- RM Pembina
- RM Louise
- RM Lorne
- Crystal City Village
- Somerset Village
- Manitou Town
- Pilot Mound Town
- Swan Lake First Nation

EAST AREA

District: Niverville/Ritchot
- RM Ritchot
- Niverville Town

District: Taché
- RM Taché

District: Ste. Anne/La Broquerie
- RM Ste. Anne
- RM La Broquerie
- Ste. Anne Town

District: Steinbach
- Steinbach City

District: Hanover
- RM Hanover

District: Rural East
- RM Piney
- RM Stuartburn
- Buffalo Point First Nation
- Unorganized Territory

1.5. List of Programs and Services

In collaboration with the community and partners, Southern Health–Santé Sud endeavours to provide access to appropriate services in the appropriate setting as demonstrated by the many programs and services delivered in the region. We strive to deliver a seamless continuum of care that supports our clients at every stage of their lives.

- **Elderly Persons Housing**
- **Emergency Medical Services (Ambulance)**
- **Healthy Living**
  - Get Better Together program
  - Health Corners
  - Healthy Communities Conference
  - Healthy Living Together Program
  - TeleCARE Manitoba
- **Home Care Services**
  - Adult Day Programs
  - Meals on Wheels
  - Personal Care at Home
  - Respite Care
- **Medical Clinics**
- **Medical Officer of Health**
- **Mental Health**
  - Crisis Stabilization Unit
  - Adult Counselling Services
  - Adult Inpatient Psychiatric Treatment (Eden Mental Health Centre)
  - Child & Youth Services
  - Employment Support Services
  - Housing Support Services
  - Intensive Case Management Services
  - Mental Health Crisis Services
  - Psychiatric Services
  - Safehouse
  - Seniors Mental Health Services/Mental Health Service for Older Adults
- **Midwifery**
- **Nutrition Services**
- **Palliative Care**
- **Pharmacy**
- **Primary Health Care**
  - Chronic Disease Self-Management (Diabetes)
  - Medical Clinics
  - Primary Health Care Centres
  - QuickCare Clinic
  - Teen Clinic
- **Public Health Services**
  - Families First
  - Healthy Baby (Growing with Mom & Super Start)
  - Public Health Nursing Services
  - Communicable Disease Prevention & Control
  - Immunizations/Child Health Clinic
  - Postpartum & Breastfeeding Support
  - Prenatal Education
  - Reproductive Health
  - School Health
  - Travel Health
  - URIS- Unified Referral Intake System
- **Rehabilitation**
  - Audiology
  - Occupational Therapy
  - Physiotherapy
  - Speech Language Therapy
- **Services to Seniors/ Congregate Meal Program**
- **Supports for Seniors in Group Living**

Facility-Based Services

- **Acute Care**
  - Chemotherapy
  - Emergency Care
  - Extended Treatment/Rehabilitation
  - Hemodialysis
  - Intensive Care
  - Medical Care
  - Obstetrical Care
  - Respiratory Services
  - Surgery / Surgical Care

Affiliate Health Corporations

- Eden Mental Health Centre
- Heritage Life Personal Care Home
- Menno Home for the Aged
- Prairie View Lodge
- Rest Haven Nursing Home
- Rock Lake Health District Hospital
- Rock Lake Health District Personal Care Home
- Salem Home Inc.
- St. Adolphe Personal Care Home
- Tabor Home Inc.
- Villa Youville

- **Lab & Imaging Services**
  - Cardiac Stress Testing
  - Computed Tomography (CT Scans)
  - Electrocardiogram (ECG)
  - Laboratory
  - Magnetic Resonance Imaging (MRI)
  - Mammography
  - Ultrasound
  - X-ray
- **Personal Care Homes**
- **Transitional Care**

Other Services

- Aboriginal Program
- Communications/Media Relations
- Disaster Management
- Finance
- French Language Services
- Handivan Services
- Human Resources
- Information Technology
- Quality of Care & Patient Safety
- Spiritual Health Care
- Support Services
- Telehealth

1.6. About the Region – "A Picture of our Health"

Like a panoramic landscape painted on a canvas, the picture of health in Southern Health-Santé Sud reveals a variety of perspectives that may impact on its overall image. We begin by sketching some very broad strokes about the geography, ecology and history to give us some background on the character and unique features of this area.

In May 2012, South Eastman Health/Santé Sud-Est Inc. and the Regional Health Authority – Central Manitoba Inc. merged. Now known as Southern Health-Santé Sud, the new region covers an expanse of 27,025 square kilometers of southernmost Manitoba. An important gateway to the province from the U.S. international border, Southern Health-Santé Sud stretches from the 49th parallel up to the Trans-Canada Highway from the Ontario border to Winnipeg, and then follows the south-west edge of Lake Manitoba down to the Pembina escarpment in the west.

Southern Health-Santé Sud lies in the prehistoric bed of Glacial Lake Agassiz. While the topography in the east is primarily that of Canadian Shield lakes and forest, the west is predominantly prairie grassland and rolling pastures. At its heart is the Red River Valley, a natural floodplain, which has been flooded repeatedly through the centuries, impacting the lives of the people in the surrounding land. Other major watercourses include the Assiniboine and Whiteshell Rivers. Major flood-control programs such as the Red River Floodway and diversion on the Assiniboine River and protection by dikes have been undertaken.

Situated at the center of the continent, this region experiences significant temperature changes: very cold winters and warm, humid summers with exposure to numerous weather systems throughout the year. The continental climate can bring blizzards, extreme cold, and severe wind chills such as experienced in the winter of 2013-2014. On the other hand, summertime can bring strong thunderstorms and tornadoes from warm moist air masses such as the F5 tornado that hit Elie, rated the strongest in Canadian history. Nevertheless, the area has often been called the important part of the 'bread basket' of Canada and the world because its fertile soils are conducive to producing rich and abundant agricultural crops. There is also a noteworthy market gardening industry and livestock sector.

As shown in petroglyphs at Bannock Point, and in archeological digs in Sandilands Forest Reserve, Native presence in the province can be traced over thousands of years. Ancient Mound-Builders also left their burial and ceremonial mounds throughout the area to mark their passage. Long before the first explorers came to the region, nomadic Aboriginal tribes roamed the area. They enjoyed the natural bounty of plentiful fishing and hunting grounds. As European settlers arrived in the area, the Ojibway and Chippewa relied on the strength of their cultural identity to adapt to new conditions. Today, in Southern Health-Santé Sud we have seven First Nations communities:

- Long Plain First Nation
- Dakota Plains First Nation
- Swan Lake First Nation
- Roseau River Anishinabe First Nation
- Sandy Bay First Nation
- Dakota Tipi First Nation
- Buffalo Point First Nation

In those very early years of settlement in southern Manitoba, hunting and trapping constituted the first "commercial industry" sustaining Aboriginal people, the Métis and voyageurs. Prior to 1870, the Métis and French settled along the Red and Assiniboine Rivers, and, in the Portage la Prairie area, an important trading post was established. This was followed by English colonists from Ontario and French-speaking settlers from Quebec. With Manitoba's federation with Canada in 1870, and the completion of land surveys along the river, other lands were made accessible for homesteading. In the mid 1870s blocks of land were set in reserve for group settlers. "The first Mennonites came to Manitoba in 1874 and settled in the "East Reserve" (Steinbach) located north and east of the Rat River. A second reserve (Rhineland and Stanley) was established west of the Red River, along the border towards the Pembina Mountains, in 1876.[1]"

Today, just over 190,000 people live in Southern Health-Santé Sud tracing their ancestries to one or more ethnic groups including Aboriginal, British, Dutch, French, German (including Mennonites, Hutterites and Kanadiers from Mexico and South America), Polish, Ukrainian and many others. As a thriving cultural region and the most populated of the rural Regional Health Authorities, Southern Health-Santé Sud ranks as one of the fastest-growing areas in the province. Over the past decade, it has grown by 20%, a growth rate double the provincial average. This means that more than 30,000 new people live in this region. Two factors have played major roles in this impressive population growth: the region's above average birth rate, and immigration movement from overseas and elsewhere in Canada.

Four cities now balance their rural heritage with the amenities of growing urban life. There are 12 towns, 5 villages, 28 municipalities and 1 unorganized territory. (Chapter 2 presents the population of municipalities and incorporated communities.)

Some notables in Southern Health-Santé Sud:

- West Hawk Lake, in the Whiteshell is the deepest in Manitoba (111 m), believed to have been created by a meteorite.
- The first county municipality formed in Manitoba was Westbourne in 1877, followed by Portage la Prairie in 1878.
- The first (1937) co-operative financial institution in Manitoba was the Caisse Populaire in St.Malo.
- The first Ford dealership in Western Canada was in Steinbach.
- Nellie McClung, a resident of Manitou in the 1890s, led the fight for female suffrage.
- The first field of rust-resistant Thatcher wheat in the West was at Arnaud.
- 70% of rural French-speaking Manitobans live in Southern Health-Santé Sud.
- Western Canada's first grain elevator was erected in 1879 in Niverville.
- Located in Morden, the Canadian Fossil Discovery Centre houses the largest collection of marine reptile fossils in Canada.

[1] Friesen, J. 1963-64. Expansion of Settlement in Manitoba, 1870 – 1900. MHS Transactions, Series 3, 1963-64 season

In the 21st century, many of the day-to-day activities and yearly events continue to reflect the rich diversity of cultures, a prosperous agricultural land base, and related processing, service and recreational industries. Seasonal festivals and entertainment continue to celebrate our heritage. Sports events are numerous: in/outdoor swimming, tennis, ATVing, golfing on spectacular courses, wildlife sanctuaries, baseball, soccer. Camping, fishing and hunting are also popular. Winter activities include hockey, curling, in/outdoor skating, ice fishing, snowmobiling, and cross country skiing with miles of groomed trails and downhill skiing.

The pioneering spirit that helped to settle and build this region lives on, and the capacity for leading the way for a healthier tomorrow together is evident in the vibrant and ambitious modern community that exists today.

> *Healthy places are those designed and built to improve quality of life for all people who live, work, worship, learn and play within their borders – where every person is free to make choices and a variety of healthy, available, accessible, and affordable options.*
>
> *-Centre for Disease Control and Prevention*

The People of Southern Health-Santé Sud

Chapter 2

The People of Southern Health-Santé Sud

2.1. Chapter Highlights

This chapter describes the characteristics of the Southern Health-Santé Sud population. It looks at current demographic indicators and projections into the future. Additionally, this chapter reviews the other descriptive information and socioeconomic indicators.

Population Characteristics

- The Southern Health-Santé Sud region has a slightly younger population compared to Manitoba overall.
- The region had the fastest growing population over the past decade at 20%. The region contributed almost a quarter (24%) of Manitoba's overall population growth in that time period.
- The region's growth has occurred in all age groups but the fastest growing age categories were in the 55-64 years (47% growth) and 64-74 years (41% growth).
- The majority of population growth in the region occurred around the four cities (Steinbach, Winkler, Morden, Portage la Prairie) and around municipalities closer to Winnipeg (St. Francois Xavier, MacDonald, Taché and Niverville/Ritchot).
- Population projections for Manitoba are expecting that Southern Health-Santé Sud region will have the highest growth rate in the province achieving a population of 303,600 by 2042.
- This rural region has well over half of its residents (61%) living in communities of under 1,000 people.
- Just under one in eight residents in the region (11.9%) identifies themselves as Aboriginal. Of the Aboriginal population in the region, the majority reported Métis identity (56%) followed by First Nations (42.2%). The remainder of this population identified as Inuit, multiple identities or other (1.6%).
- The on-reserve Aboriginal population in the region is much younger than the regional population.

Immigration, Language and Marital Status

- In the region, 13% of the population has immigrated from another country. About a third of the immigrant population arrived between 2006 and 2011.
- Immigrants in the region are primarily from Europe (53.6%) and Asia (26.7%). The top five source countries in the region are from Germany, Russia, Philippines, United Kingdom, and India.

- The proportion of french-speaking residents (3.9%) is much higher than the provincial average (1.6%).
- Of residents who reported speaking a non-official language (12.7% of population), German was the most predominant language (84.8%), while Obijway was the most common Aboriginal language (3.0%).
- The region had the lowest proportion of lone-parent families at 10.3%. Three-quarters of those lone-parent families were headed by females.

Education Attainment and Income

- Overall, education attainment levels were lower in the region compared to Manitoba. The region had a higher proportion of people who had not completed high school (32.3% versus 25.1% in Manitoba) and fewer people with some postsecondary education (14.1% versus 25.8% in Manitoba) or with postsecondary certification (13.5% versus 33.7% in Manitoba).
- While median household income in the region was similar to Manitoba's, the region did have a slightly higher prevalence of low income households (17.0% versus 16.4%) compared to Manitoba.
- The socioeconomic factor index which combines education, income and employment indicators showed that the region overall had a similar index to the provincial overall. On a district level, MacDonald had the best status while the Rural East had a poorer status.

Employment

- Labour force participation rates were found to be better in the region compared to Manitoba overall. Unemployment rates were also comparatively lower.
- The labour force was divided fairly evenly in a number of sectors namely manufacturing (12.1%), health care and social assistance (11.7%), agriculture, forestry, fishing and mining (11.4%) and retail trade (10.1%).

Children

- Readiness for school learning indicators used to assess kindergarten students in Manitoba showed that the region has seen slight improvements over time particularly for physical health and social competence.
- Families First data showed that risk factors for new mothers such as low education attainment and smoking are going down, while mothers reporting depression or anxiety appear to be increasing.

2.2. Population

Population Pyramids

The population pyramids below illustrate the age distribution of Southern Health-Santé Sud and Manitoba (**Figure 1** and **2**). The wider base of the pyramid for Southern Health-Santé Sud, shows that the region has a slightly younger population compared to Manitoba.

Figure 1. Manitoba Population Pyramid 2014.

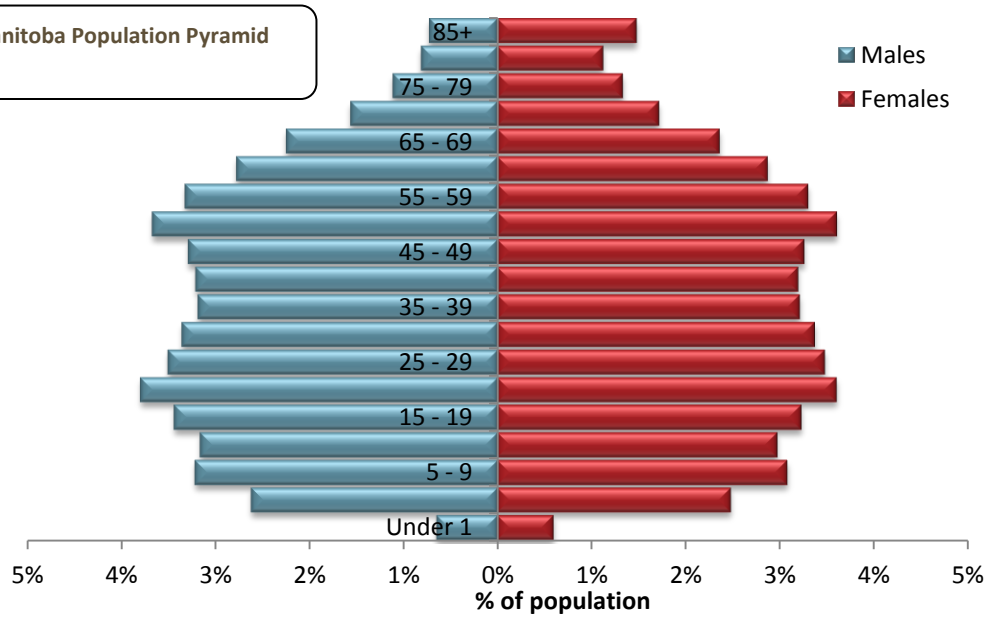
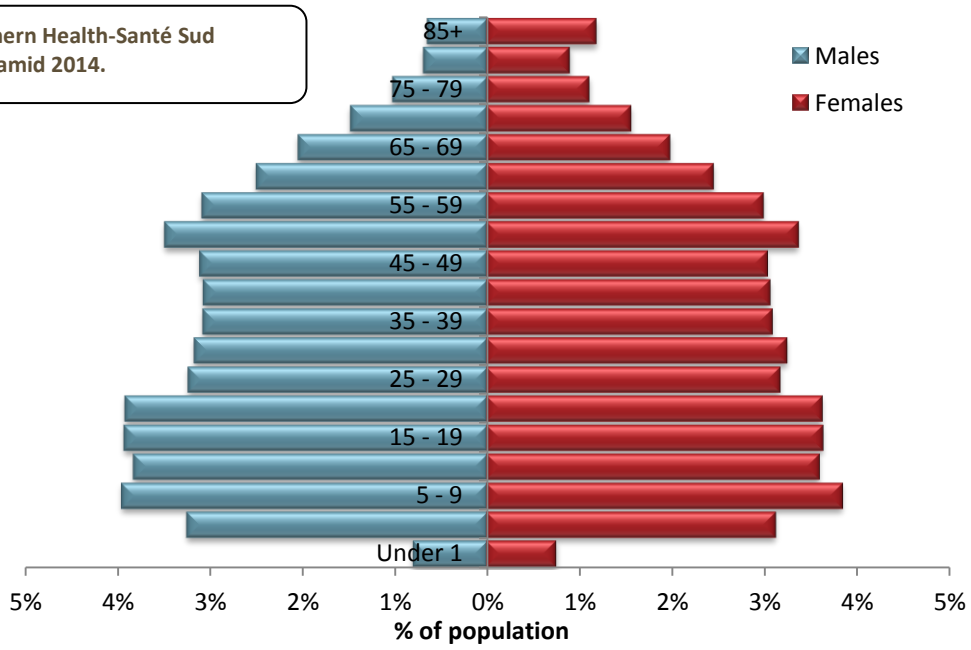


Figure 2. Southern Health-Santé Sud Population Pyramid 2014.

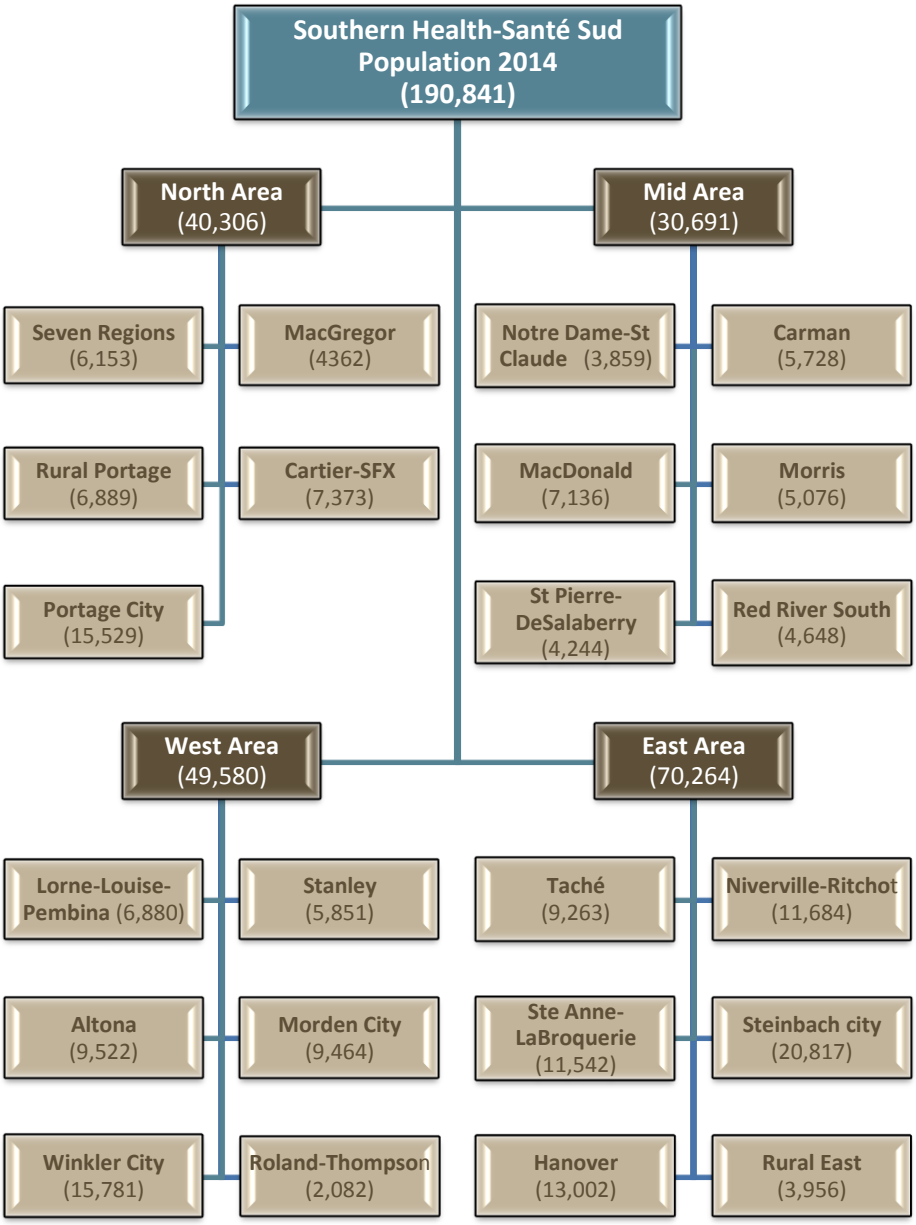


Source: Manitoba Health, Population Report 2014

Population 2014

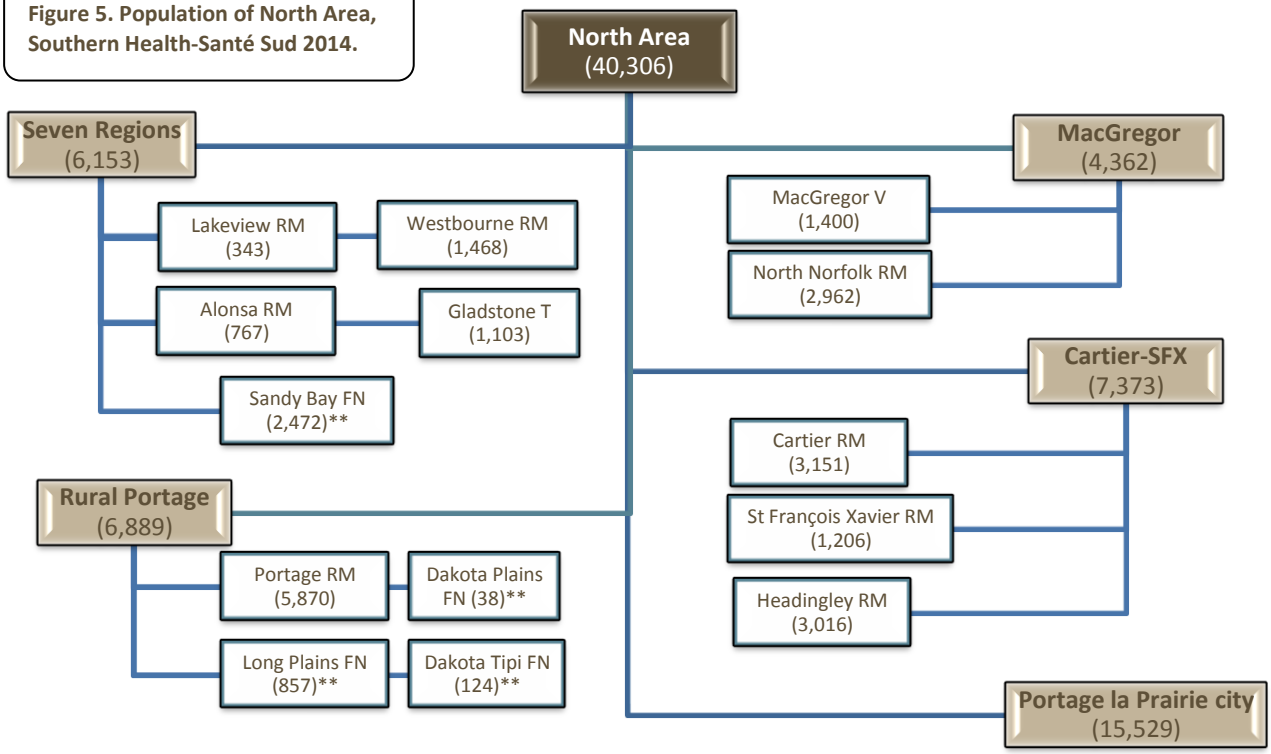
The most current data available for population counts in Manitoba is 2014. The database is updated annually on June 1st based on health records of residents, and a population report is produced by the end of each year by Manitoba Health - Health Information Management Branch. The Manitoba Health database is considered a reliable and accurate estimate of population sizes, and is helpful for understanding trends and therefore useful for health planning purposes. It is however, the Aboriginal population count is under-reported, therefore please go to page 22 for additional information.

Figure 3. Population of Southern Health-Santé Sud and Districts, 2014.



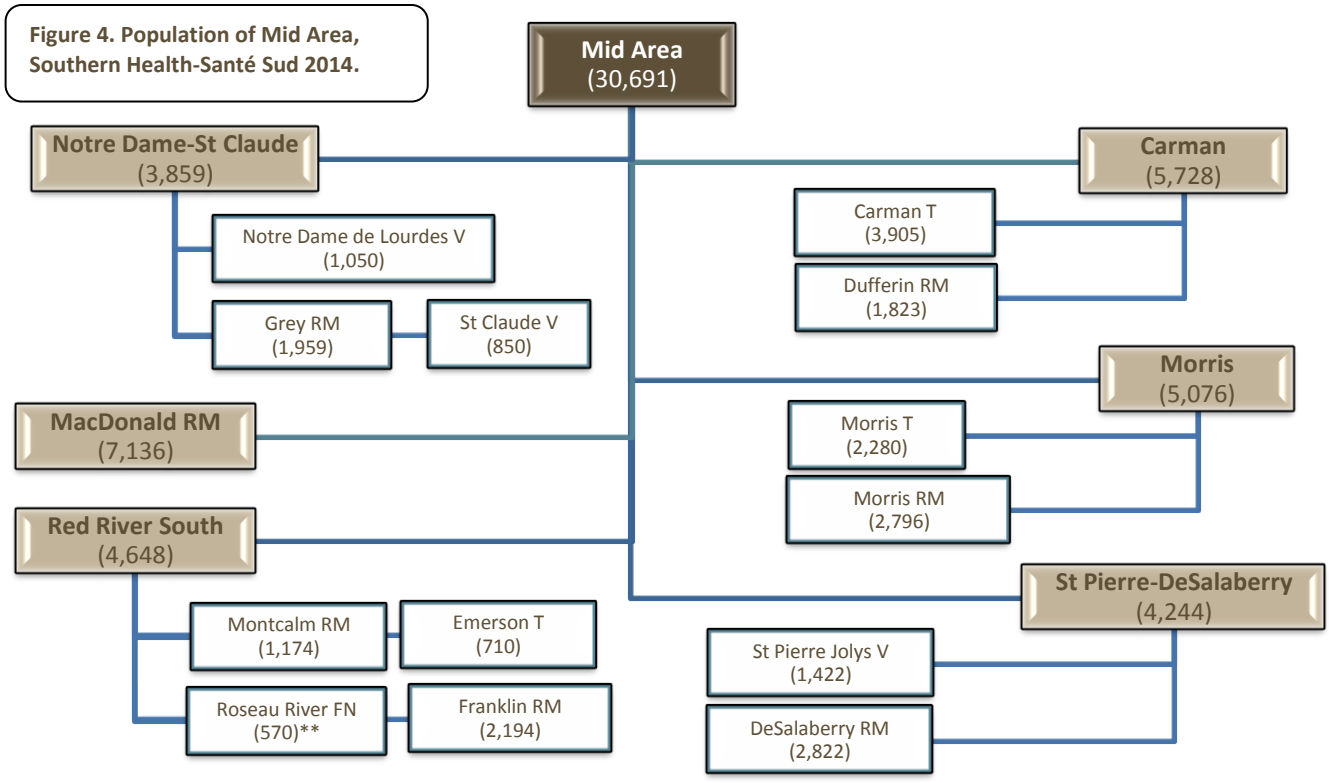
Source: Manitoba Health, Population Report 2014

Figure 5. Population of North Area, Southern Health-Santé Sud 2014.



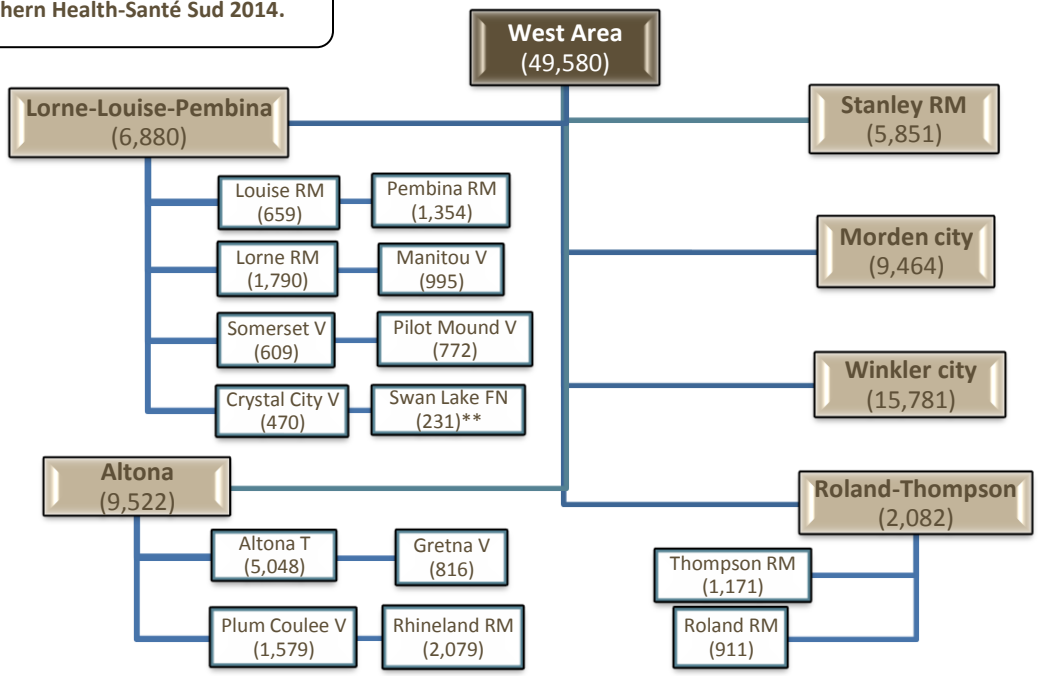
Source: Manitoba Health, Population Report 2014 **see page 22 for Aboriginal Population

Figure 4. Population of Mid Area, Southern Health-Santé Sud 2014.



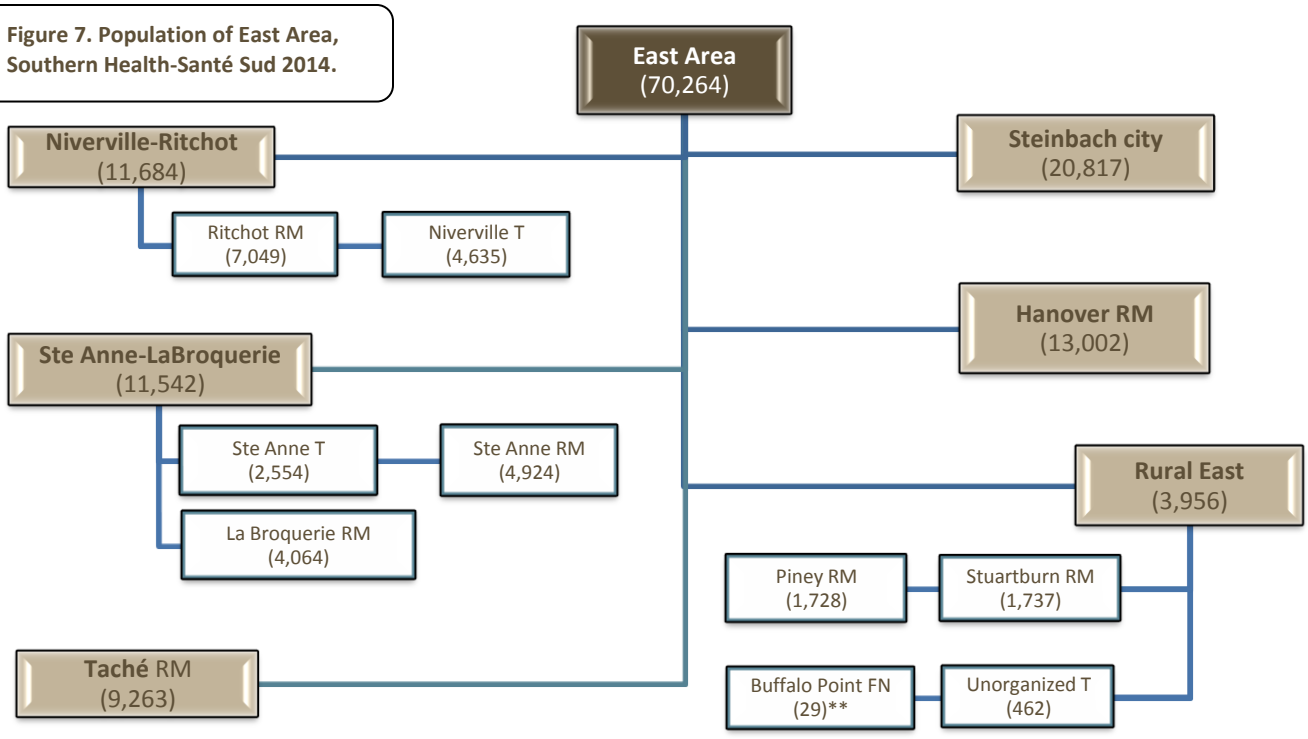
Source: Manitoba Health, Population Report 2014 **see page 22 for Aboriginal Population

Figure 6. Population of West Area, Southern Health-Santé Sud 2014.



Source: Manitoba Health, Population Report 2014 **see page 22 for Aboriginal Population

Figure 7. Population of East Area, Southern Health-Santé Sud 2014.

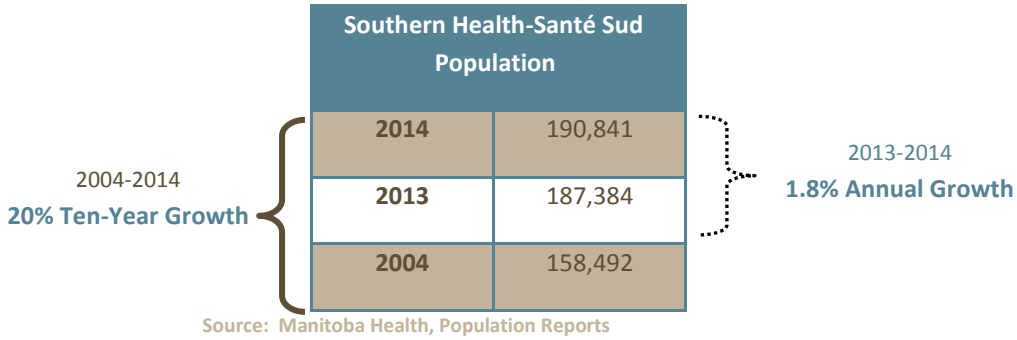


Source: Manitoba Health, Population Report 2014 **see page 22 for Aboriginal Population

Population Growth

As shown in **Figure 8**, the 2014 population for the Southern Health-Santé Sud was **190,841** with an annual growth rate of 1.8%, and a ten-year growth rate of 20%. This translates to 3,457 more residents in one year from 2013 to 2014 – approximately the size of the town of Carman. Over a ten-year period, the region has grown by 32,349 residents – a population growth equivalent to the size of Steinbach and Morden cities combined.

Figure 8. Annual and Ten-Year Population Change, Southern Health-Santé Sud.

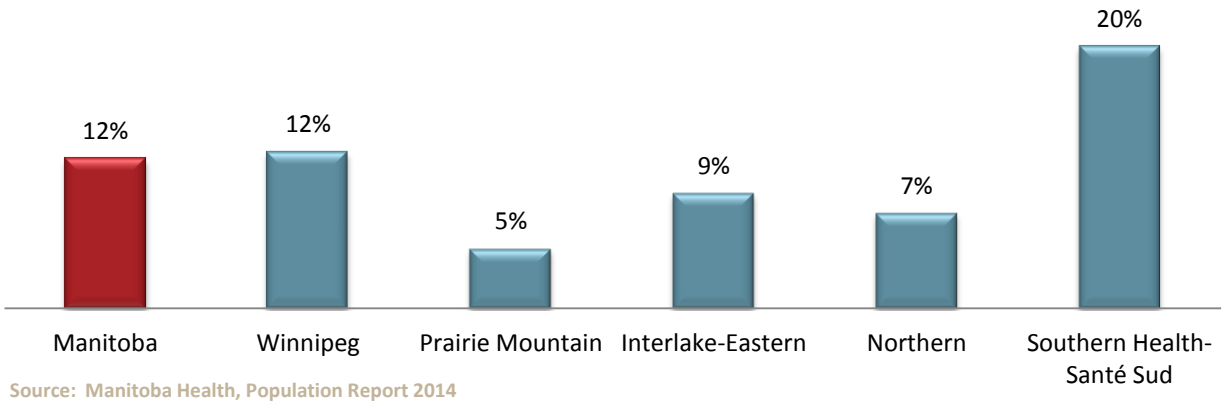


Source: Manitoba Health, Population Reports

Manitoba RHA Comparisons

As shown in **Figure 9**, Southern Health-Santé Sud had the fastest growing population in Manitoba over the ten year period 2004 to 2014.

Figure 9. Manitoba Regional Health Authorities Population Change 20014-2014.



Source: Manitoba Health, Population Report 2014

It is noted that although Southern Health-Santé Sud is the fastest growing region, it did not contribute to the majority of growth in the province. Over the past decade, Manitoba has grown over 136,000 residents (**Table 1**). The 12% growth in Winnipeg during this time period represented over 80,000 new residents and almost 60% of the Manitoba growth. Nevertheless, Southern Health-Santé Sud's contribution was 24% - almost a quarter of the provincial growth!

Table 1. Population Change Among Manitoba Regional Health Authorities, 2004-2014.

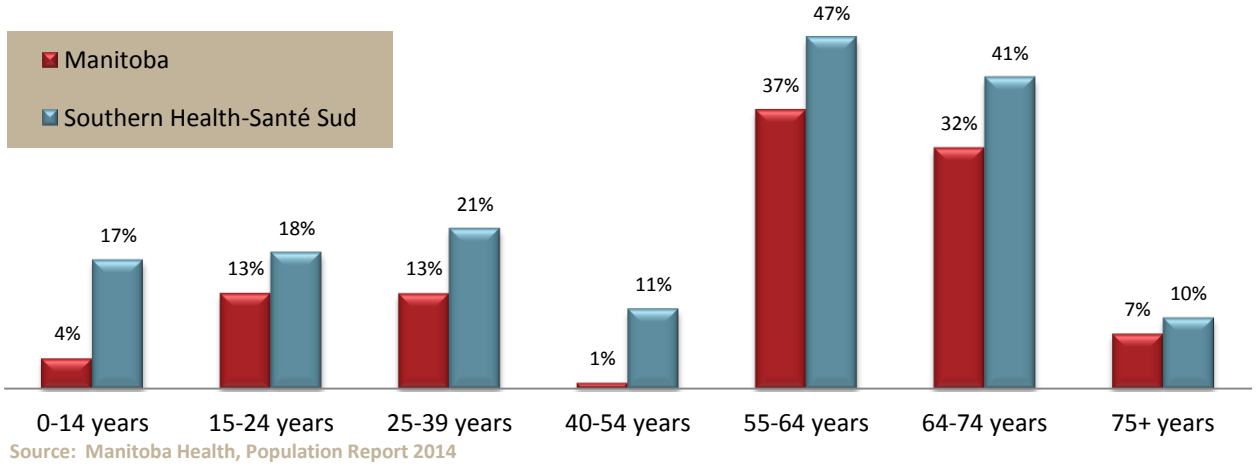
Regional Health Authority	Population 2004	Population 2014	Population Change	Contribution to Manitoba Growth
Winnipeg (WRHA – incl Churchill)	664,418	745,603	81,185	59%
Prairie Mountain Health	160,379	167,842	7,463	5%
Interlake-Eastern	116,237	126,674	10,437	8%
Northern	70,140	75,349	5,209	4%
Southern Health-Santé Sud	159,492	190,841	32,349	24%
Manitoba	1,169,666	1,306,309	136,643	100%

Source: Manitoba Health, Population Report 2014

Age Group Comparisons

As illustrated in **Figure 10**, Southern Health-Santé Sud is also growing across all age groups. While Manitoba has only grown by 4% in the youngest age group (0-14), this region has grown by 17%. The graph also depicts an aging population with the fastest growing cohort between 55-74 years ("baby boomers").

Figure 10. Population Change by Age Group, Manitoba and Southern Health-Santé Sud, 2004-2014.



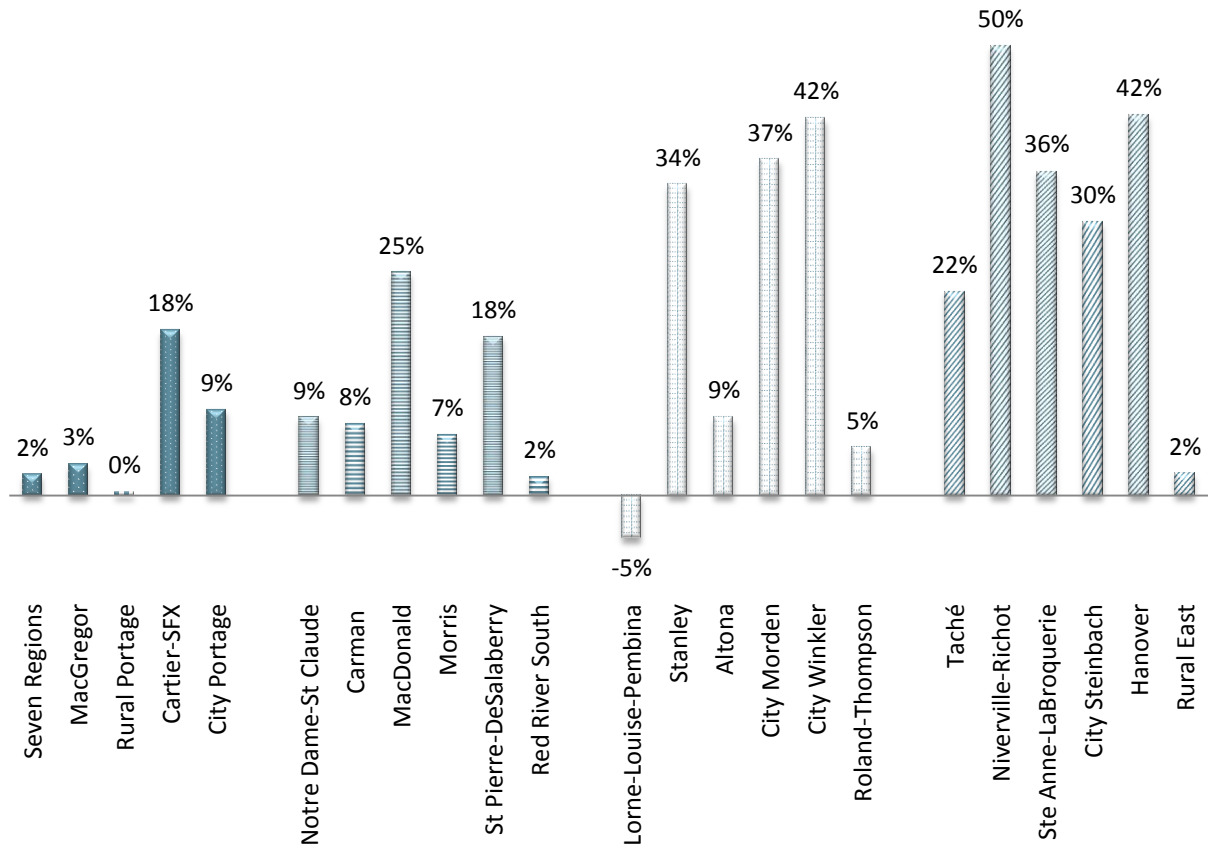
Source: Manitoba Health, Population Report 2014

District Population Changes

Figure 11, shows the population growth across the region. The district of Niverville-Ritchot experienced the highest rate of growth at 50%, whereas Lorne-Louise-Pembina district decreased by 5%. In general the majority of growth was in and around communities closer to Winnipeg – Cartier/SFX, MacDonald, Taché, and Niverville/Ritchot. In addition, the region has experienced growth around Winkler, Morden and Stanley districts. The four cities within the region were responsible for 40% of the regional population growth. The rural and remote districts experienced very little population change – Seven Regions, MacGregor, Rural Portage, Red River South, Lorne/Louise/Pembina, and Rural East.

Please refer to **Table 2** for a further breakdown by districts.

Figure 11. Population Growth by Districts, Southern Health-Santé Sud, 2004-2014.



Source: Manitoba Health, Population Report 2014

Table 2. Population Change Among Districts, Southern Health-Santé Sud 2004-2014.

Districts and Area	Population 2004	Population 2014	Population Change	% Change
Seven Regions	6,014	6,153	139	2.3%
MacGregor	4,217	4,362	145	3.4%
Rural Portage	6,864	6,889	25	0.4%
Cartier-SFX	6,236	7,373	1,137	18.2%
Portage la Prairie City	14,191	15,529	1,338	9.4%
Subtotal North Area	37,522	40,306	2,784	7.4%
Notre Dame-St Claude	3,554	3,859	305	8.6%
Carman	5,310	5,728	418	7.9%
MacDonald	5,727	7,136	1,409	24.6%
Morris	4,756	5,076	320	6.7%
St.Pierre/DeSalaberry	3,611	4,244	633	17.5%
Red River South	4,554	4,648	94	2.1%
Subtotal Mid Area	27,512	30,691	3,179	11.6%
Lorne-Louise-Pembina	7,219	6,880	-339	-4.7%
Stanley	4,357	5,851	1,494	34.3%
Altona	8,766	9,522	756	8.6%
Morden city	6,907	9,464	2,557	37.0%
Winkler city	11,145	15,781	4,636	41.6%
Roland-Thompson	1,978	2,082	104	5.3%
Subtotal West Area	40,372	49,580	9,208	22.8%
Taché	7,563	9,263	1,700	22.5%
Niverville-Ritchot	7,711	11,684	3,873	49.6%
Ste. Anne-LaBroquerie	8,503	11,542	3,039	35.7%
Steinbach city	15,995	20,817	4,822	30.1%
Hanover	9,160	13,002	3,842	41.9%
Rural East	3,862	3,956	94	2.4%
Subtotal East Area	52,894	70,264	17,370	32.8%

Source: Manitoba Health, Population Report 2014

Population Growth

In May 2014, the Centre for Healthcare Innovation released a report called the ***Manitoba Population Projections Report: 2013-2042***. It was created using a Cohort Component Model, which has been used extensively by Statistics Canada, and other provincial ministries of health. The components of the model include:

- Births
- Deaths
- Migration (including international, inter-provincial, and intra-provincial)

Each of these components was further developed using historical trends of birth rates, death rates and migration trends. The baseline population used was 2012, and from there researchers were able to estimate the population growth by regional health authority until 2042. They also included a separate analysis on projections for Manitoba's First Nation population.

The projections in this report calculated seven different scenarios – high(H), medium(M), and low(L) rate of change for each component (birth, death, and migration). The scenario that regional health authorities are using is the "MMM" which assumes a medium change in birth rates, medium change in death rates, and medium migration trend.

Key Findings (based on MMM scenario)

- As shown in **Table 3**, Manitoba's population is expected to grow to 1,822,500 by 2042.
  - Average annual growth rate at 1.2%.
  - Approximately 18,000 more people per year.
- Net migration will be the main driver of the province's population growth.
- The largest increase is expected in the older population (65+ years) – by 2042 it could double in size and represent between 19-23% of the overall population.

> *The immigrant population, which contains many women of childbearing age, will also have a positive impact on the number of births in the province.*
> *-Centre for Healthcare Innovation*

- Southern Health-Santé Sud has the highest expected growth rate in the province (1.7% annually).
- The population size within this region: 222,200 (by 2022), 262,200 (by 2032), and 303,600 (by 2042).

Table 3. Population Projections Based on MMM Scenario, Regional Health Authorities, 2022-2042.

Regional Health Authority	% Annual Growth Rate	Population 2022	Population 2032	Population 2042
Winnipeg (WRHA – incl Churchill)	*1.3%*	*850,500*	*967,500*	*1,070,300*
Prairie Mountain Health	0.7%	180,500	191,800	201,000
Interlake-Eastern	0.7%	137,700	148,300	154,000
Northern	0.8%	81,200	87,400	93,600
Southern Health-Santé Sud	1.7%	222,200	262,200	303,600
Manitoba	1.2%	1,473,400	1,657,200	1,822,500

Source: Centre for Healthcare Innovation, Manitoba Populations Projections 2013-2042.

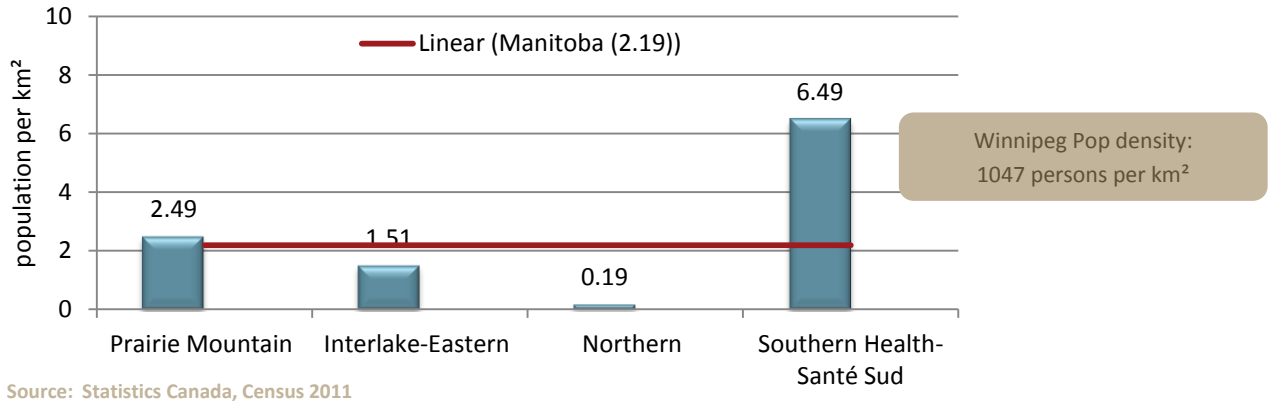
Population Density

Southern Health-Santé Sud covers a land area of 27,025 square kilometers. With a population of 190,841, this region accounts for about 15% of the people living in Manitoba. The size of the population combined with the land area results in a population density of 6.49 persons per square kilometre (see **Figure 12**).

Key Findings

- The population density for Manitoba was 2.19 persons per square kilometer.
- Winnipeg, as an urban centre, has the highest population density at 1047 persons per square kilometer.
- Southern Health-Santé Sud has the highest population density among rural regional health authorities.

Figure 12. Population Density by Regional Health Authority, 2011.



Source: Statistics Canada, Census 2011

Rural Population

Rural population is defined as having fewer than 1,000 persons and a population density below 400 persons per square kilometer. According to the 2011 Census, more than 6.3 million Canadians were living in rural areas however this number has been dropping over the years. For Southern Health-Santé Sud, about 61% of residents live in rural settings compared to 28% of Manitobans, and only 1% of Winnipeggers (**Table 4**).

Table 4 Proportion of the Population that is Rural, 2011.

Regional Health Authority	% Rural
Winnipeg (WRHA – incl Churchill)	1%
Prairie Mountain Health	50%
Interlake-Eastern	78%
Northern	61%
Southern Health-Santé Sud	61%
Manitoba	28%

Source: Statistics Canada, Census 2011.

2.3. Aboriginal Population

Getting estimates on the number of Aboriginal residents is complicated because the sources of this information are based on self-report – that is relying on a person self-identifying as Aboriginal. The information that Manitoba Health tracks in the population registry is considered a reliable and accurate for the overall population however, this source is not representative of the Aboriginal population.

Within the region, concerted efforts have been made to address this data gap. Southern Health-Santé Sud's Aboriginal Health Services keeps up to date records and ongoing conversations with on-reserve band membership clerks. In addition, the population numbers are also cross-checked to the information derived from the Aboriginal Affairs and Northern Development Canada website (www.aandc-aadnc.gc.ca) First Nations Profiles section.

As mentioned in *Chapter 1-Overview*, there are seven First Nations communities within Southern Health-Santé Sud. As of January 2015, there were 8,391 people living on-reserve and 6,925 people living off-reserve (**Table 5**). It is important to note that there are many First Nations people currently residing in the region and accessing health care services who are not registered and are not represented in the numbers provided below. There are many reasons why a First Nations person is not registered:

1. They may not have applied for registration
2. They may have been denied in the registration process due to incomplete documentation
3. They may be waiting for confirmation of their application

Table 5. First Nations Population by Community, Southern Health-Santé Sud, 2015.

First Nation Community	On-Reserve Population	Off-Reserve Population	Total Aboriginal Population
Long Plain FN	2,232	2,003	4,235
Dakota Plains FN	178	89	267
Swan Lake FN	596	776	1,372
Roseau River Anishinabe FN	1,174	1,386	2,560
Sandy Bay Ojibway FN	3,954	2,240	6,374
Dakota Tipi FN	212	171	383
Buffalo Point FN	45	80	125

Source: Southern Health-Santé Sud

Aboriginal Identity

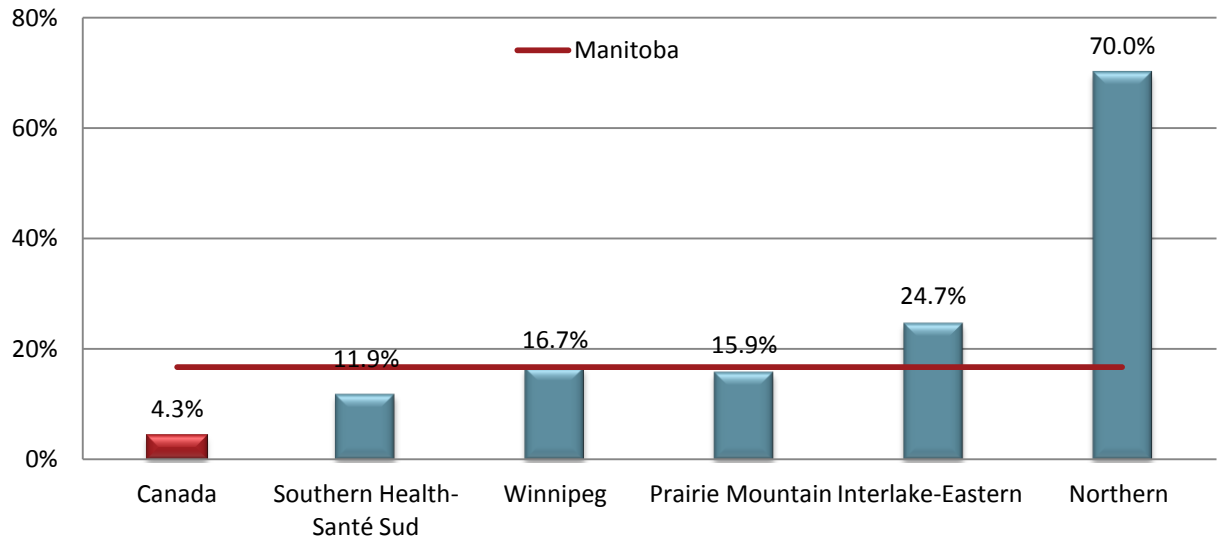
According to the 2011 NHS, there were 195,895 residents who reported Aboriginal identity (**Table 6**). Manitoba has a considerably higher Aboriginal population proportion compared to Canada (16.7% vs 4.3%). As illustrated in **Figure 13**, the Northern RHA had the highest proportion of Aboriginal population (70%) within Manitoba. For Southern Health-Santé Sud, just over one in ten residents (11.9%) identified as Aboriginal - almost 20,000 people. The breakdown of the Aboriginal population within the region can be found in **Table 7**. Among them, about 56% were Métis, followed by First Nations at 42.4%, and Inuit at only 0.1%. Approximately 0.7% reported multiple identities and 0.8% as other.

Table 6. Aboriginal Identity Population, 2011.

Regional Health Authority	Number of People	Percent of Total Population
Winnipeg (WRHA – incl Churchill)	73,390	11%
Prairie Mountain Health	24,710	15.9%
Interlake-Eastern	29,340	24.7%
Northern	48,700	70%
Southern Health-Santé Sud	19,700	11.9%
Manitoba	195,895	16.7%
Canada	1,400,685	4.3%

Source: Statistics Canada, National Household Survey 2011.

Figure 13. Aboriginal Population by Regional Health Authority and Canada, 2011



Source: Statistics Canada, Census 2011

Table 7. Southern Health-Santé Sud Aboriginal Population, 2011.

Aboriginal Population	Number of People	Percent of Total Population
First Nations	8,380	42.4%
Métis	11,065	56.0%
Inuit	25	0.1%
Other	145	0.8%
Multiple identities	145	0.7%
Total Aboriginal Population	19,700	100%

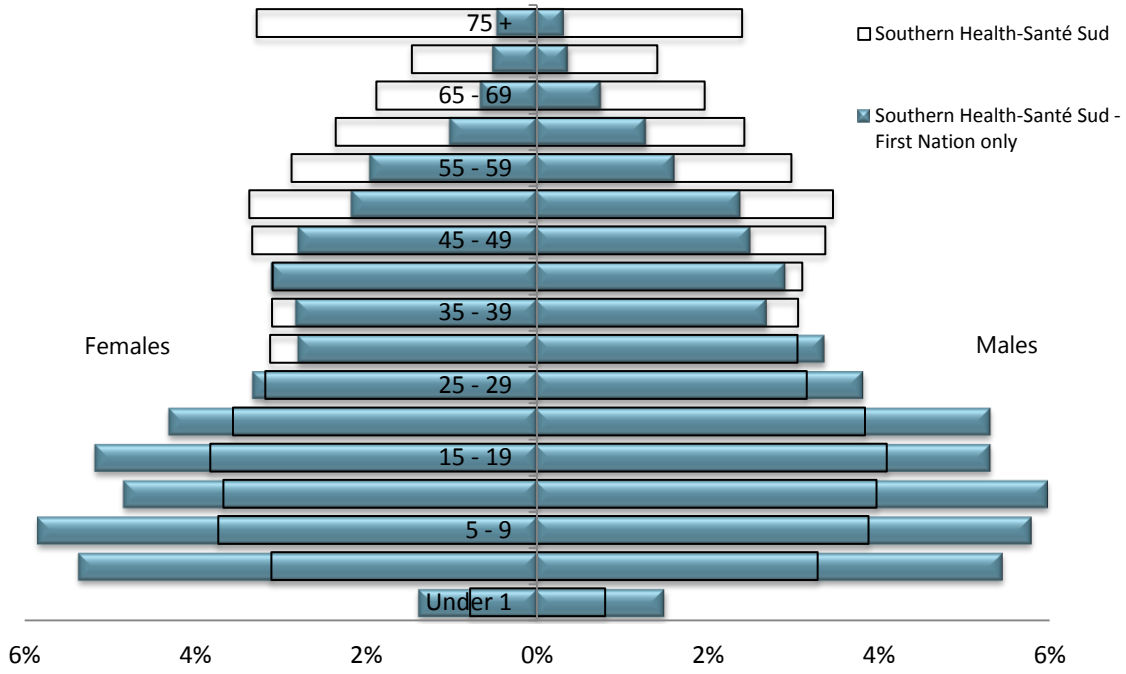
Source: Statistics Canada, National Household Survey 2011.

> *We need to "work on more collaboration with Aboriginal communities. How health care is covered with Aboriginals creates a barrier to services for that population"*
>
> *-Swan Lake FN Healthy Communities Conference*

Younger Population

Figure 14 shows the population pyramid for Southern Health-Santé Sud First Nations residents who lived on reserve in 2014. It is clear that the First Nations population (blue bars) within the region has a much wider base and narrow top indicating a much younger population with few people in the older age groups.

Figure 14: Southern Health-Santé Sud Aboriginal Population, 2014.



Source: Manitoba Health, Population Report 2014

Growing Fast

Manitoba's First Nations population is projected to increase from 93,200 in 2012 to 171,500 by 2042 – almost twice its size. The annual growth rate is 2.3%. The combination of the high fertility rate and young First Nations population create a positive natural increase throughout the projection period (Manitoba Population Projections Report: 2013-2042 – MMM scenario).

2.4. Immigration

Citizenship

Citizenship refers to the legal citizenship status of a person. Citizenship can be by birth or naturalization, and a person may have more than one citizenship. A person may be stateless meaning they may have no citizenship. **Table 8** shows the citizenship of residents living in Southern Health-Santé Sud compared to the rest of Manitoba. The data show that 94.2% reported Canadian citizenship, which is similar to the provincial rate of 93.2%. As well, the majority of Canadian citizens were 18 years and older (SH-SS 71.2% compared to MB 76.3%).

Table 8. Citizenship Status, Southern Health-Santé and Manitoba, 2011.

Citizenship Characteristics	Southern Health-Santé-Sud		Manitoba	
Canadian citizens	**156,790**	**94.2%**	**1,099,405**	**93.6%**
Under 18 years	45,085	28.8%	260,670	23.7%
18 years and older	111,705	71.2%	838,735	76.3%
Non-Canadian citizens	**9,625**	**5.8%**	**74,940**	**6.4%**
Total – all persons	166,410		1,174,345	

Source: Statistics Canada, National Household Survey 2011.

Immigrant Status

Table 9 shows that the majority of residents in Southern Health-Santé Sud were born in Canada, with 12.9% of residents being born in a country outside of Canada. The results also show that majority of immigrants arrived before 2000 (47.8%), but that a fairly large proportion came between 2006 and 2011 (31.7%). These recent immigrants account for 6,835 new residents (approximately 4% of the overall population). Non-permanent resident refers to persons with work or study permits and refugees – which is only a small proportion of residents (0.5%).

Table 9. Immigrants Status, Southern Health-Santé Sud and Manitoba, 2011.

Immigrant Characteristics	Southern Health-Santé-Sud		Manitoba	
Canadian-born residents	**144,010**	**86.5%**	**981,200**	**83.6%**
Immigrant residents	**21,550**	**12.9%**	**184,505**	**15.7%**
Before 2000	10,305	47.8%	102,630	55.6%
Between 2001-2005	4,410	20.5%	24,200	13.1%
Between 2006-2011	6,835	31.7%	57,655	31.2%
Non-permanent residents	**855**	**0.5%**	**8635**	**0.7%**
Total – all persons	166,415		1,174,345	

Source: Statistics Canada, National Household Survey 2011.

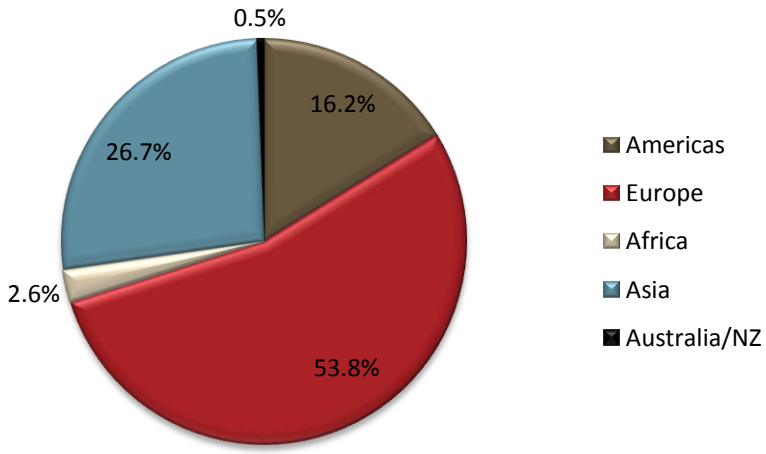
Recent Immigrants by Place of Birth

Figures 15 and **16** shows the place of birth for recent immigrants who arrived between 2006 and 2011. The results show that for Southern Health-Santé Sud, the vast majority came from Europe (53.8%) followed by Asia (26.7%). However, for Manitoba, the reverse was true – the majority of recent immigrants came from Asia (68.4%) and only 13.3% came from Europe.

A large proportion of recent immigrants into Manitoba came from the Philippines – over 22,000 people. Within Southern Health-Santé Sud, Germany and Russian Federation still predominate as top countries of birth. However, immigrants are coming from all over the world with increasing numbers from Asia and the United Kingdom.

Figure 15. Southern Health-Santé Sud Recent Immigration by Place of Birth, 2011.

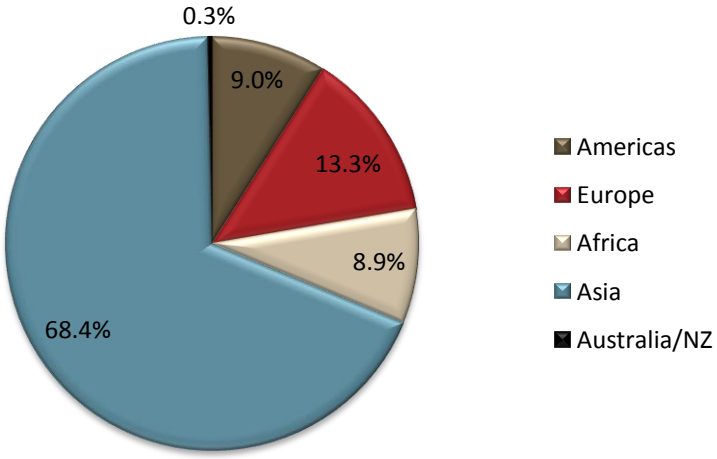
Southern Health-Santé Sud
Top 5 Countries
1.Germany (2585 people)
2.Russian Federation (825 people)
3. Philippines (735 people)
4. United Kingdom (160 people)
5. India (120 people)



Source: Statistics Canada, National Household Survey 2011.

Figure 16. Manitoba Recent Immigration by Place of Birth, 2011.

Manitoba
Top 5 Countries
1.Philippines (22,815 people)
2. India (6095 people)
3. China (3335 people)
4. Germany (3050 people)
5. Russian Federation (1570 people)



Source: Statistics Canada, National Household Survey 2011.

> *Canada is a multicultural society whose ethnocultural make-up has been shaped over time by immigrants and their descendents. Each new wave of immigration has added to the nation's ethnic and cultural composition. Over time, patterns of immigration have shifted. Historically, most immigrants came from Europe. More recently, the largest group of newcomers to Canada has come from Asia (including the Middle East). Data from the 2011 National Household Survey (NHS) showed that Canada is a nation with an ethnocultural mosaic as indicated by its immigrant population, the ethnocultural backgrounds of its people, the visible minority population, linguistic characteristics and religious diversity.*
>
> *-Statistics Canada*

2.5. Language

Language Spoken Most Often at Home

Table 10 shows what we know about language in our region and how we compare to Manitoba. Overall, 83.5% of regional residents reported speaking English compared to 87.6% for Manitoba. Not surprisingly, Southern Health-Santé Sud had a higher proportion of the population speaking French most at home compared to the province (3.9% vs 1.6%). It is noted that 11% of the region's population are considered bilingual, able to conduct a conversation in French only or in French and another language. As well, the region had higher percent reporting non-official languages compared to Manitoba (12.7% vs 10.9%).

Table 11 shows the breakdown of non-official languages within the region. Almost 90% of respondents reported German and Russian as their language most often spoken at home. Within Aboriginal languages spoken, Ojibway was selected in all cases.

Table 10. Language Spoken Most Often at Home, 2011.

Language Characteristics	Southern Health-Santé-Sud		Manitoba	
English	139,900	83.5%	1,007,325	87.6%
French	6,535	3.9%	17,950	1.6%
Non-official languages	21,380	12.7%	125,280	10.9%
Total response – all persons	167,815		1,174,345	

Source: Statistics Canada, National Household Survey 2011.

Table 11. Non-Official Languages, Southern Health-Santé Sud, 2011.

Non-official languages	Southern Health-Santé-Sud	
Aboriginal (Ojibway)	645	3.0%
Dutch	150	0.7%
German	18,135	84.8%
Russian	930	4.3%
Spanish	245	1.1%
Tagalog (Filipino)	365	1.7%
Ukrainian	135	0.6%
Other	775	3.6%
Total Non-official languages	21,380	

Source: Statistics Canada, National Household Survey 2011.

2.6. Family Structure

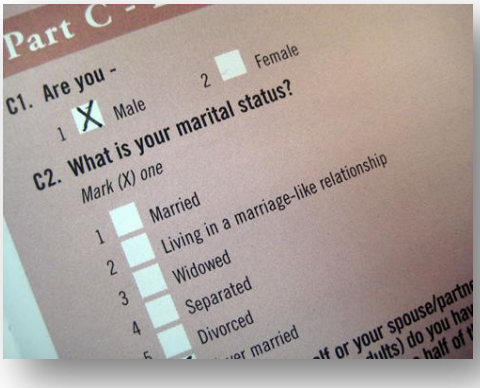
Marital Status

Table 12 shows what we know about marital status of residents (age 15 and older) in Southern Health-Santé Sud compared to Manitoba. Within the region, a higher proportion of residents (age 15+) reported being married or living common-law compared to the province (64.7% compared to 57.2%). As well, more residents reported being married rather than living common-law (91.2% compared to 8.8%). Of the residents who reported being single, the divorce rate was lower for the region versus the provincial average (9.1% compared to 12.5%).

Table 12. Marital Status, Southern Health-Santé Sud and Manitoba, 2011.

Marital Status	Southern Health-Santé-Sud		Manitoba	
Married or living common-law	**86,330**	**64.7%**	**558,510**	**57.2%**
Married	78,770	91.2%	480,140	86.0%
Living common-law	7,565	8.8%	78,370	14.0%
Not married or living common-law	**47,160**	**35.3%**	**418,600**	**42.8%**
Single	33,475	71.0%	282,465	67.5%
Separated	2,395	5.1%	23,620	5.6%
Divorced	4,290	9.1%	52,215	12.5%
Widowed	7,000	14.8%	60,300	14.4%
Total responses – all persons, 15+	133,490		977,105	

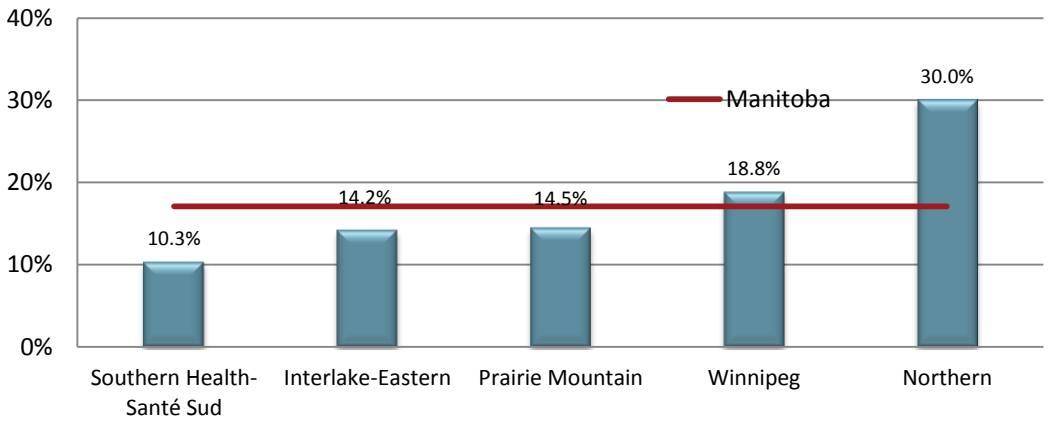
Source: Statistics Canada, National Household Survey 2011.



Lone-Parent Families

In 2011, there were 4805 lone-parent families living in Southern Health-Santé Sud. Of these, the majority were headed by a female (75%). **Figure 17** shows that the region has the lowest proportion of lone-parent families (10.3%) in the province. In contrast, Northern region has the highest rate of lone-parent families at 30%.

Figure 17. Lone-Parent Families by Regional Health Authority, 2011.



Source: Statistics Canada, National Household Survey 2011

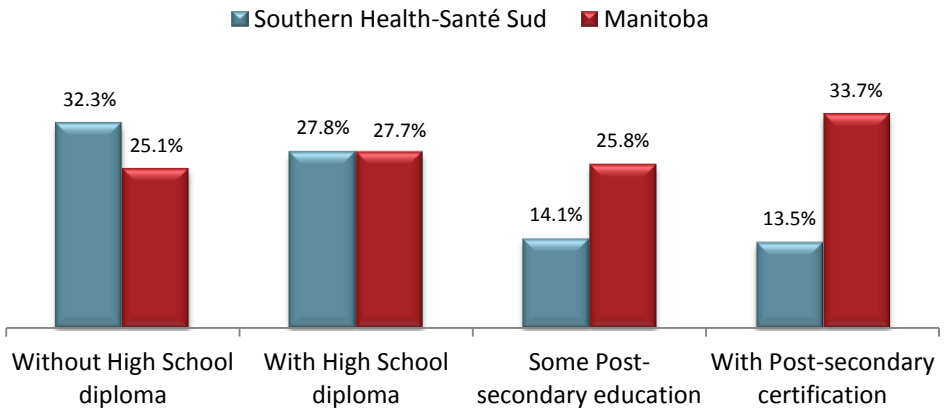
2.7. Education

Education and income are two main indicators of socio-economic status and important determinants of health. A direct relationship has been found between education and health status. Educational attainment also reflects what skills are available to society and the labour market. The following categories are used to measure educational attainment: without high school diploma, with high school diploma, some post-secondary education, and post-secondary certification. Post-secondary certification includes trade certifications, college diplomas, and university degrees.

Key Findings

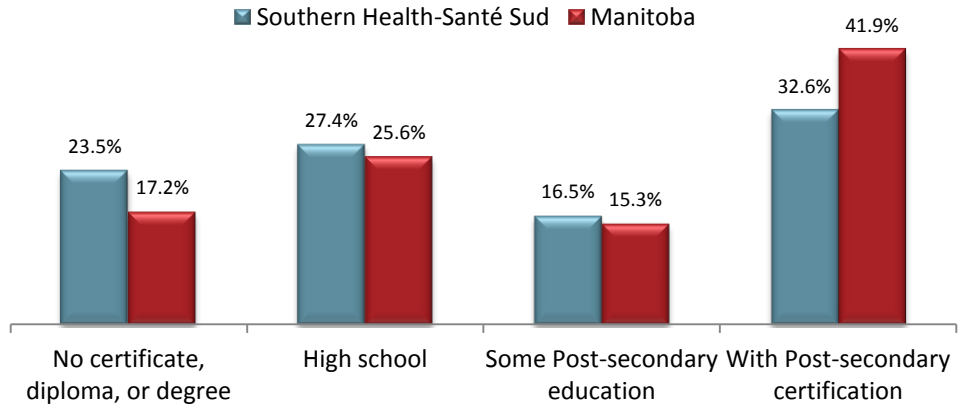
- **Figure 18** shows the highest level of education achieved for the people aged 15-24 years.
  - Southern Health-Santé Sud had a higher proportion of residents without a high school diploma compared to Manitoba (32.3% versus 25.1%)
  - As well, Southern Health-Santé Sud had a much lower proportion of residents with some post-secondary education (14.1% versus 25.8%), and with post-secondary certification (13.5% versus 33.7%)
- **Figure 19** shows the highest level of education achieved for the people aged 25-64 years.
  - Southern Health-Santé Sud had a higher proportion of residents without a high school diploma compared to Manitoba (23.5% versus 17.2%)
  - As well, Southern Health-Santé Sud had a much lower proportion of residents with post-secondary certification (32.6% versus 41.9%)
- **Figure 20** compares the two age groups lacking a high school diploma or equivalency. It shows that among both age groups, Southern Health-Santé Sud had a greater proportion of people with lower education levels.

Figure 18. Highest Level of Educational Attainment, Aged 15-24 Years, 2010.



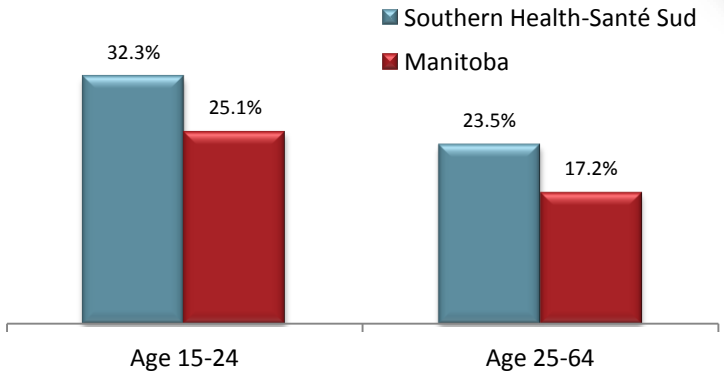
Source: Statistics Canada, National Household Survey 2011

Figure 19. Highest Level of Educational Attainment, Aged 25-64 Years, 2010.



Source: Statistics Canada, National Household Survey 2011

Figure 20. Proportion of Residents with Less than High School, 2010.



Source: Statistics Canada, National Household Survey 2011

2.8. Income

Median Individual and Household Income

Median income is the middle value which divides the income distribution into two halves – 50% of incomes are below the median and 50% are above the median. Median income is more useful at population levels because it is less affected by outliers (eg. really high or low incomes) that impact average incomes. The median provides a more accurate picture of what "average" people in the population earn. Median incomes are also another way to determine income inequality among groups of people.

According to the 2011 NHS, the median individual income for Southern Health-Santé Sud was $28,107, slightly lower than the Manitoba median of $29,029 (see **Table 13**). The table also shows income gaps between regions - Winnipeg having the highest median income and Northern the lowest. In addition, a gender difference is evident with males earning considerably more than females, across all regions.

Table 13. Median Individual Income (Age 15+) by Gender and Regional Health Authority, 2010.

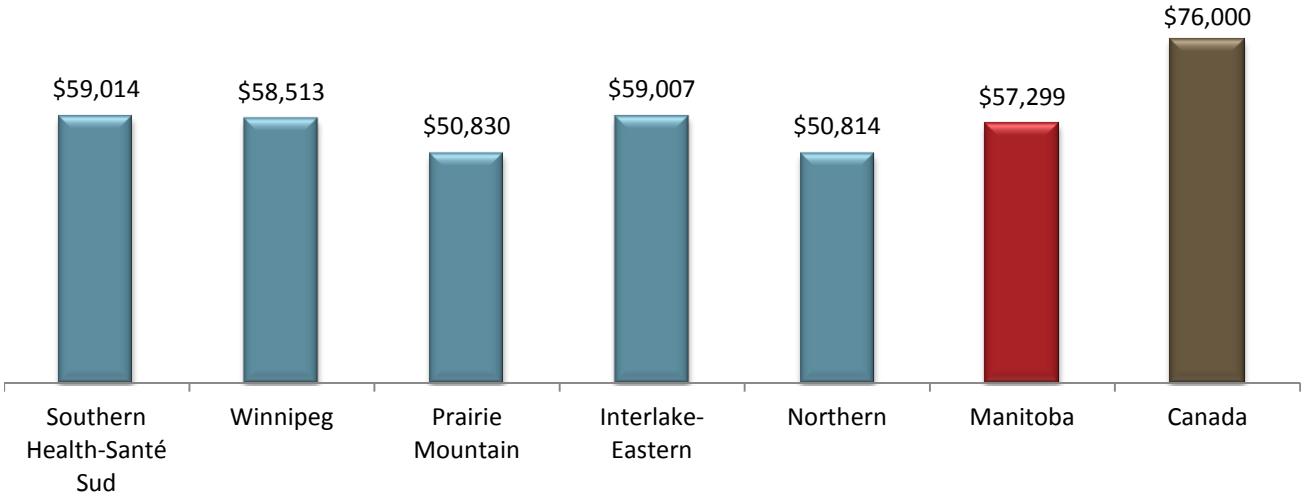
Regional Health Authority	Total	Male	Female
Winnipeg (WRHA – incl Churchill)	$30,461	$36,062	$21,551
Prairie Mountain Health	$27,190	$33,011	$22,521
Interlake-Eastern	$28,136	$35,367	$22,585
Northern	$18,570	$22,323	$16,780
Southern Health-Santé Sud	$28,107	$35,588	$21,551
Manitoba	$29,029	$35,055	$24,227

Source: Statistics Canada, National Household Survey 2011.

Figure 21 illustrates the median income of households among regional health authorities. It shows that the median family income in Canada is $76,000, while for Manitoba this is $57,299. Within the province, variation exists among regions with lowest median values reported in Northern and Prairie Mountain. For Southern Health-Santé Sud, the median household income was $59,014. This indicator, in particular, would be useful when presented at district level to show variation within the region. Unfortunately, data from the 2011 NHS is unavailable at this time due to delays at Statistics Canada. Once validated, an addendum will be added to this report including income indicators.

With increasing financial pressures, lone-parent households can be particularly vulnerable. As mentioned earlier, the majority of single-parents are females generally earning less than males. Although not depicted in a graph, the median income of lone-parent families living in Southern Health-Santé Sud was $40,270, which was lower than the Manitoba median of $41,379.

Figure 21. Median Household Income by Regional Health Authority, 2010.



Source: Statistics Canada, National Household Survey 2011

After-Tax Low-Income Measure (LIM-AT)

The low income estimates reported in the 2011 NHS was the after-tax low-income measure (LIM-AT). It is a fixed percentage (50%) of median adjusted after-tax income of households observed at the person level – 'adjusted' means that household needs are factored (eg. number of members within a household). As shown in **Table 14**, Southern Health-Santé Sud had the highest prevalence of low income households (17%) in the province. Manitoba had a higher rate than Canada (16.4% compared to 14.9%).

Table 14. Prevalence of Low Income Based on LIM-AT by Population in Private Households, 2010.

Regional Health Authority	Prevalence Rate
Winnipeg (WRHA – incl Churchill)	16.4%
Prairie Mountain Health	17.6%
Interlake-Eastern	13.5%
Northern	16.7%
Southern Health-Santé Sud	17.0%
Manitoba	16.4%
Canada	14.9%

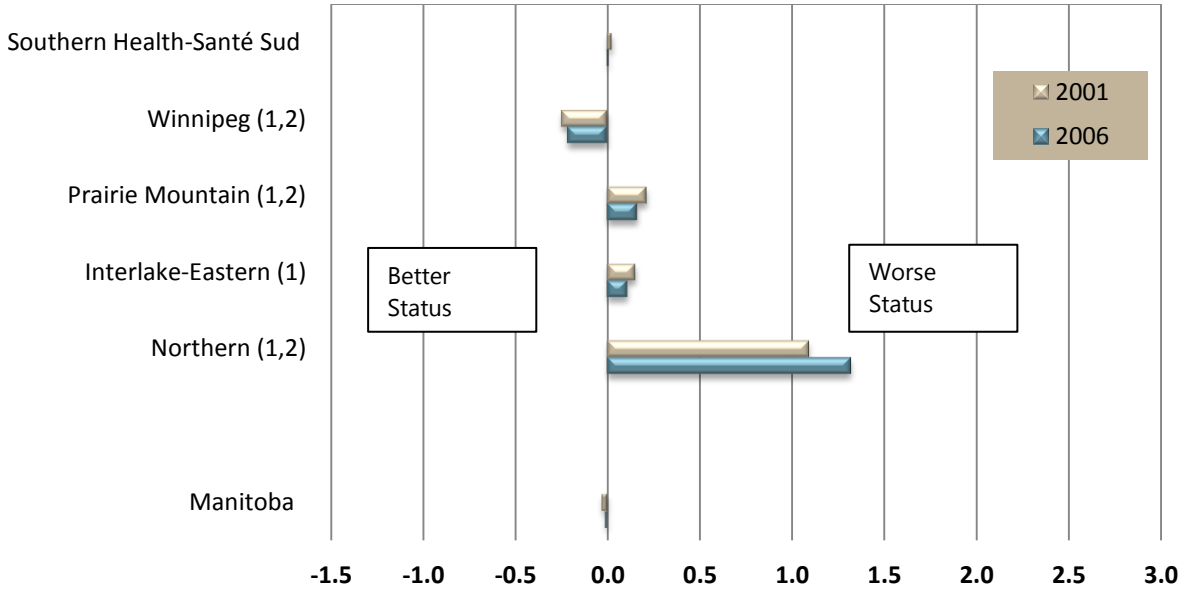
Source: Statistics Canada, National Household Survey 2011.

Socioeconomic Factor Index (SEFI)

SEFI is a composite index based on area-level Canadian Census (2001 and 2006) data using four variables: average household income, proportion of lone-parent households, unemployment rate for residents aged 15 and older, and proportion of the population (age 15 +) without high school graduation. A zero SEFI score represents the Manitoba average, with lower scores representing better health status and higher scores indicating worse health status (see **Figure 22**). Overall, Southern Health-Santé Sud had a SEFI score right at the provincial average. Winnipeg had lower SEFI scores (better status), while Prairie Mountain and Northern had significantly higher scores (worse status).

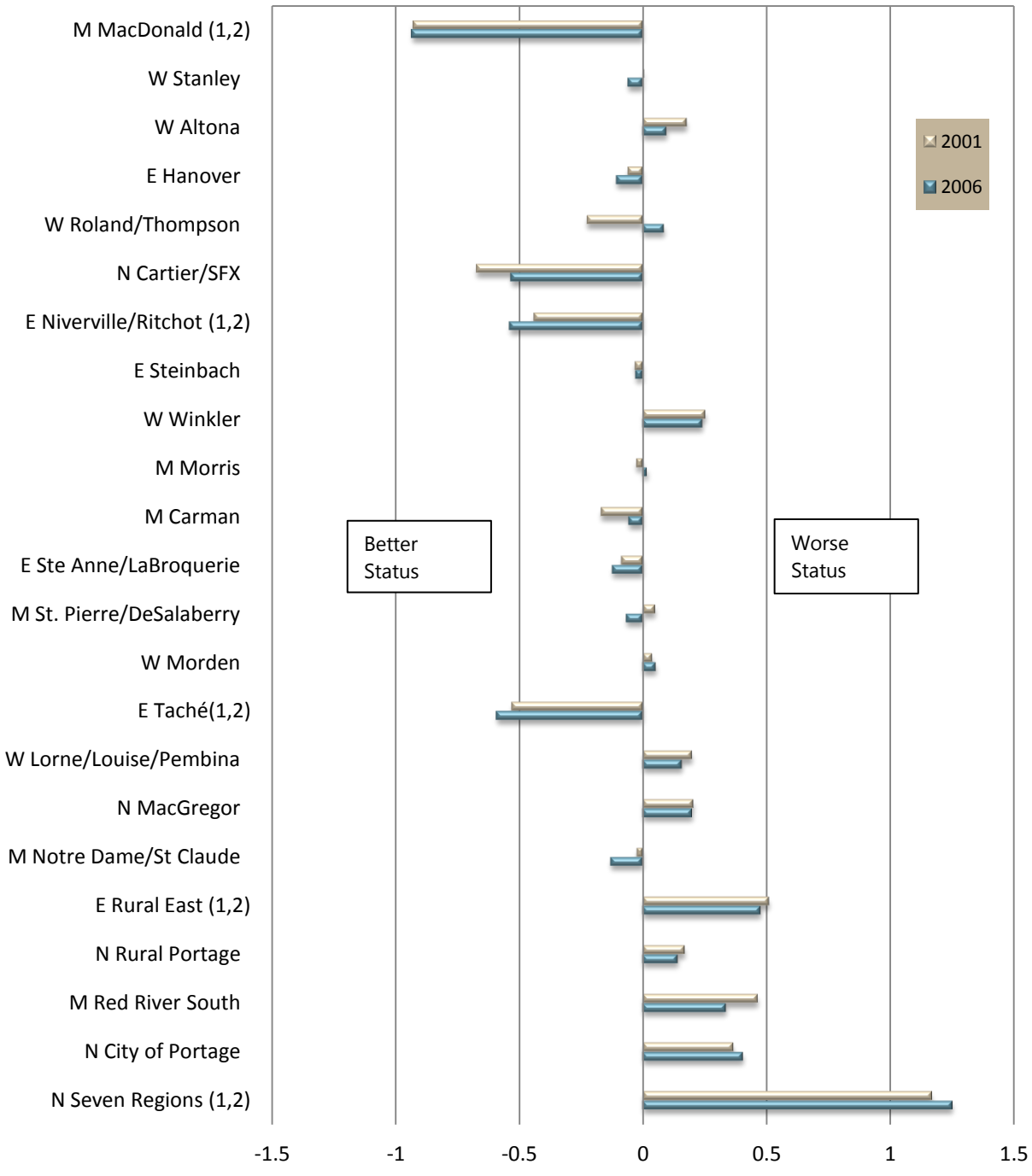
Figure 23 shows the variation of SEFI scores within the region. MacDonald had the best status (lowest SEFI scores) in the region, while Seven Regions had the worst (highest SEFI scores). Other districts with good socioeconomic status included Niverville/Ritchot and Taché, while Rural East had significantly higher scores (worse status).

Figure 22. Socioeconomic Factor Index (SEFI) by RHA, Census 2001 and 2006.



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 23. Socioeconomic Factor Index by District, Census 2001 and 2006.



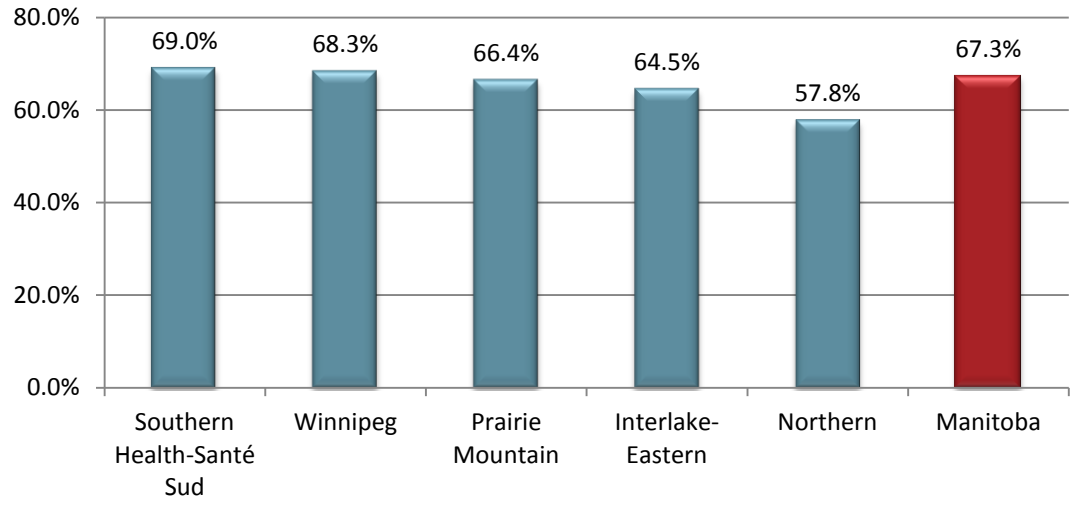
1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

2.9. Employment

Labour Force Participation Rate

Labour force participation rate includes the percentage of the population (age 15+), who reported currently being in the labour force at the time of the survey. This indicator includes full-time and part-time employment. As shown in **Figure 24**, the labour force participation rate for Southern Health-Santé Sud was 69%, which is slightly higher than the Manitoba average of 67.3% in 2011.

Figure 24. Labour Force Participation Rate (Age 15+) by Regional Health Authority, 2011.



Source: Statistics Canada, National Household Survey 2011

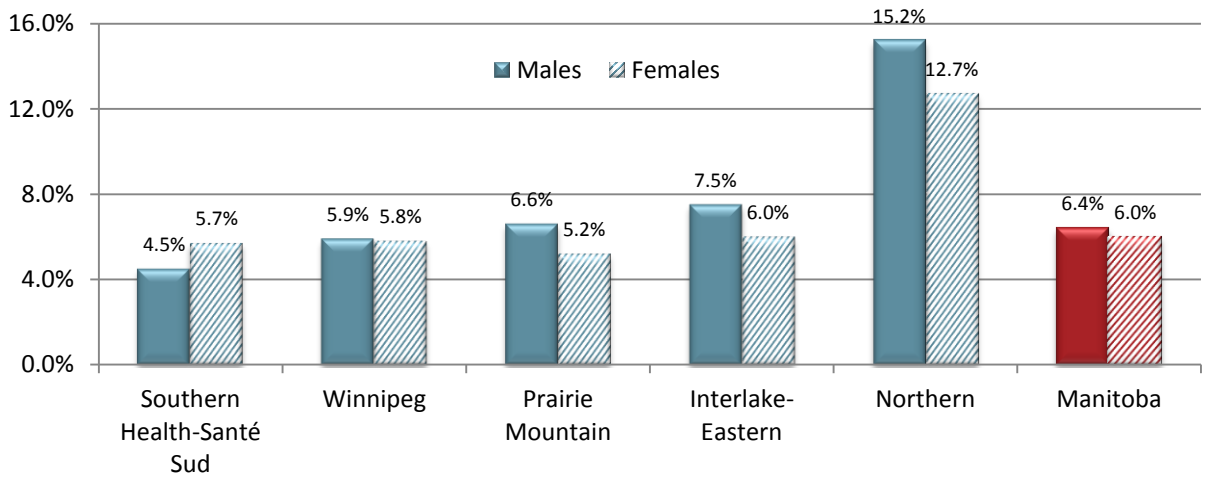
Unemployment Rates

Unemployment rate refers to the proportion of the labour force (age 15+) who reported being without paid/self-employed work and were available for work at the time of the survey. This includes people who:

(a) had actively looked for paid work in the past four weeks; or
(b) were on temporary lay-off and expected to return to their job; or
(c) had definite arrangements to start a new job in four weeks or less

Figure 25 shows the unemployment rate by gender. In contrast to other regions, Southern Health-Santé Sud had a higher unemployment rate for women (5.7%) compared to men (4.5%). Overall, unemployment rates in the region were among the lowest in the province, with noticeably higher rates in Northern.

Figure 25. Unemployment Rate (Age 15+) by Gender and Regional Health Authority, 2011.



Source: Statistics Canada, National Household Survey 2011

Industry Sectors

Table 15 shows the breakdown of the labour force in Southern Health-Santé Sud by industry sectors. The top four sectors within the region included: manufacturing (12.1%), followed by health care and social assistance (11.7%), agriculture, forestry, fishing, and hunting (11.4%), and retail trade (10.1%).

Table 15. Breakdown of Labour Force Industry Sectors, Southern Health-Santé Sud, 2011.

Agriculture; forestry; fishing and hunting	11.4%	Real estate and rental and leasing	1.1%
Mining; quarrying; and oil and gas extraction	0.5%	Professional; scientific and technical services	3.0%
Utilities	0.8%	Management of companies and enterprises	0.0%
Construction	9.0%	Administrative and support; waste management and remediation services	2.3%
Manufacturing	12.1%	Educational services	7.9%
Wholesale trade	2.8%	Health care and social assistance	11.7%
Retail trade	10.1%	Arts; entertainment and recreation	1.4%
Transportation and warehousing	6.2%	Accommodation and food services	4.4%
Information and cultural industries	0.9%	Other services (except public administration)	4.6%
Finance and insurance	3.6%	Public administration	6.2%

Source: Statistics Canada, National Household Survey 2011.

2.10. Housing Affordability

Table 16 shows the breakdown of shelter costs in Southern Health-Santé Sud compared to Manitoba. Housing affordability is measured as the percentage of the population who report spending 30% or more of their total household income on shelter costs (utility bills, property taxes, mortgage payments, condominium fees, and rent).

Key Findings

- Overall, 16.9% of households (owner and tenant) within the region spent 30% or more of their total household income on shelter costs. There was a difference in rates depending on whether a resident was a home-owner or a tenant.
    - 13.5% of residents who owned their homes spent 30%+ on shelter costs (13% for Manitoba).
    - 32.1% of residents who rented spent 30%+ on shelter costs (35.4% for Manitoba).
- The median monthly mortgage for regional residents was $790, which is similar to the provincial median of $780.
    - The median value of homes within Southern Health-Santé was $199,940, which was lower than the provincial median of $219,915.
- The median monthly rent for regional residents was $632, compared to $689 for Manitoba.
- Of the households in the region who were home-owners, the majority had a mortgage (60.3%). This rate was comparable to the Manitoba average of 57%.
- Of the households in the region who were tenants, 20.4% lived in subsidized housing. This rate was also comparable to the Manitoba average of 19.9%.

Table 16. Shelter Costs, Southern Health-Santé Sud and Manitoba, 2011.

Owners	**Percent of households with mortgage**	**Median Monthly Costs**	**Spend 30%+ of total HH income on shelter costs**
Southern Health-Santé Sud *(Median value: $199,940)*	60.3%	$790	13.5%
Manitoba *(Median value: $219,915)*	57.0%	$780	13.0%
Tenants	**Percent of households with subsidized housing**	**Median Monthly Rent**	**Spend 30%+ of total HH income on shelter costs**
Southern Health-Santé Sud	20.4%	$632	32.1%
Manitoba	19.9%	$689	35.4%
		Total (owner and tenants)	16.9%

Source: Statistics Canada, National Household Survey 2011.

2.11. Children

Licensed Child Care Spaces

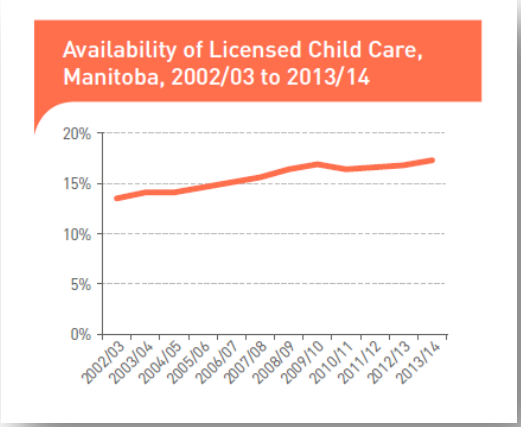
As women have entered the workforce in greater numbers, access to licensed child care spaces has become a growing concern. It is estimated that 70% of Canadian mothers with children under six years are working moms. Access to quality early learning and child care is essential to supporting healthy child development. In Manitoba, parents can register online for a licensed child care space, either in a centre or home-based by visiting the following website:

https://direct.gov.mb.ca/cdchtml/html/internet/en/index.html

In Manitoba, a person can provide private home child care, without a provincial license, to a maximum of four children under age 12. No more than two of these children can be under age 2. These numbers include the care provider's own children and any other children living in the home. However, the provincial government does not monitor unlicensed private home child care.

The 2013/2014 *All Aboard Annual Report* reported that there were 32,555 spaces in Manitoba, including 21,778 for preschool and 10,777 for school-age children. Overall, this represents 17.3% of Manitoba children under the age of 12 having access to a regulated child care space. This is an improvement over the 13.5% rate back in 2002-2003, as illustrated below.

An excerpt from All Aboard Annual Report 2013/14 showing increased access to licensed child care in Manitoba.



http://www.gov.mb.ca/allaboard/pubs/all_aboard_annual_report_2013_14

Readiness for School Learning

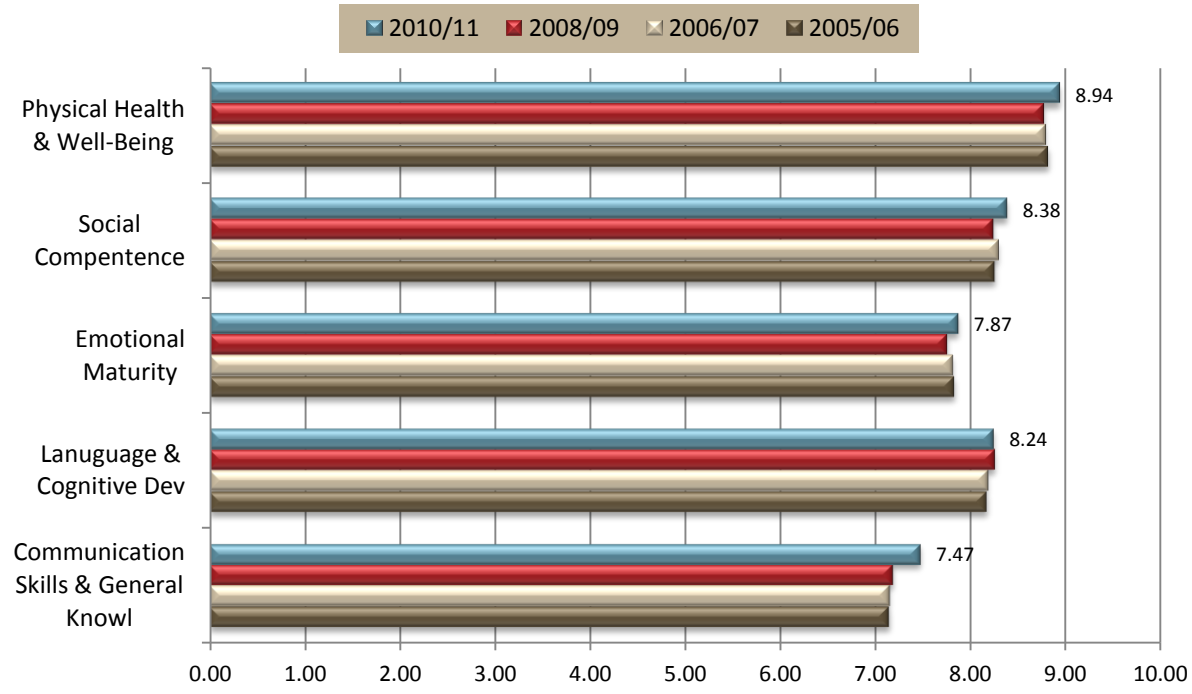
The Early Development Instrument (EDI) is completed by kindergarten teachers, once every two years, on children in their classroom. The EDI is a population-based survey gauging the readiness for school learning among Manitoba children in the following five domains:

- Physical health and well-being
- Social competence
- Emotional maturity
- Language and cognitive development
- Communication skills and general knowledge

EDI results are shared with school divisions, schools and communities to help identify the ***strengths and needs*** of young children so communities can make informed decisions to support early childhood development.

Figure 26 shows the average scores in Southern Health-Santé Sud across all five EDI domains. For the region this involves approximately 2,000 kindergarten children each survey cycle. Over time, results have improved slightly. Among regional children, the domain with the highest scores is in physical health and well-being - average scores were 8.94 in 2010/2011. Lower scores were observed in the areas of emotional maturity (7.87) which looks at children's ability to concentrate on tasks, help others, show patience, and control aggression. As well, communication skills and general knowledge had low average scores (7.47) which could reflect a larger proportion of ESL/FSL children who may have difficulty understanding the language of instruction in school.

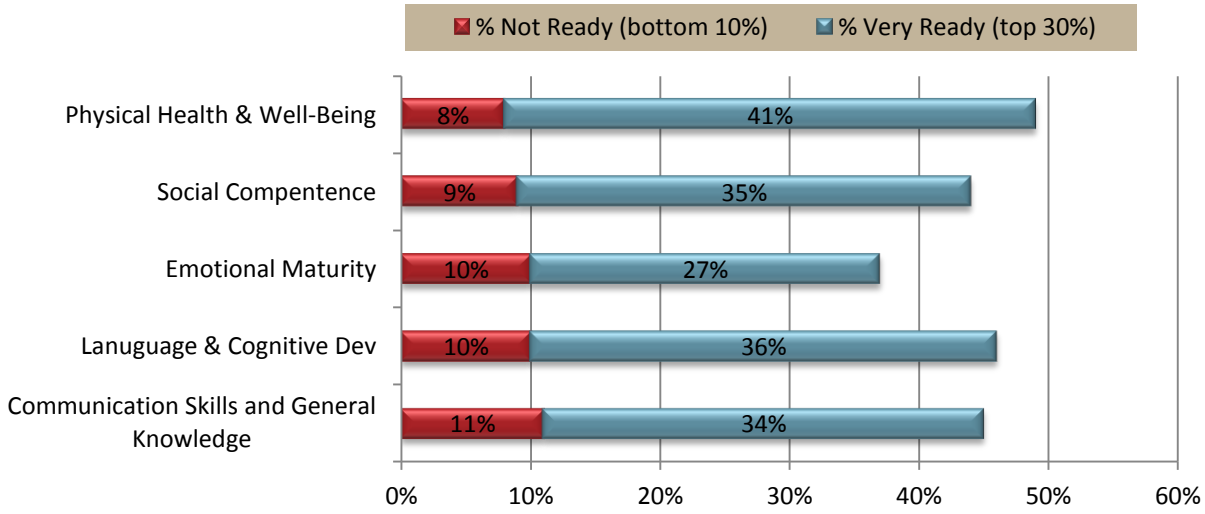
Figure 26. Early Development Instrument Average Scores by Domain, Southern Health-Santé, 2005-2011.



Source: Healthy Child Manitoba, Special Run 2005-2011

Figure 27 shows the proportion of children with scores that fall within the top 30th percentile (very ready) and bottom 10th percentile (not ready) by the five domains. According to a normal distribution, one would expect 10% or fewer children in this category. Overall, Southern Health-Santé Sud had slightly more children 'not ready' in communication skills and general knowledge, whereas the other domains had 10% or few children at-risk. A greater proportion of regional kindergarten children would be considered 'very ready' in physical health and well-being.

Figure 27. Early Development Instrument, "Not Ready" and "Very Ready" by Domain, Southern Health-Santé Sud, 2005-2011.



Source: Healthy Child Manitoba, Special Run 2005-2011

Families First Program – Risk Factors

Families First is a free program delivered across the province by community public health. It offers home visiting supports to families with young children, from pregnancy to school entry. Home visitors support positive parenting by developing strong family relationships, connect families with community resources, and share information about parent/child attachment. Every year, births are screened for eligible program risk factors. Follow up occurs with all families who score positive for being at-risk to determine if they would benefit from home visiting supports.

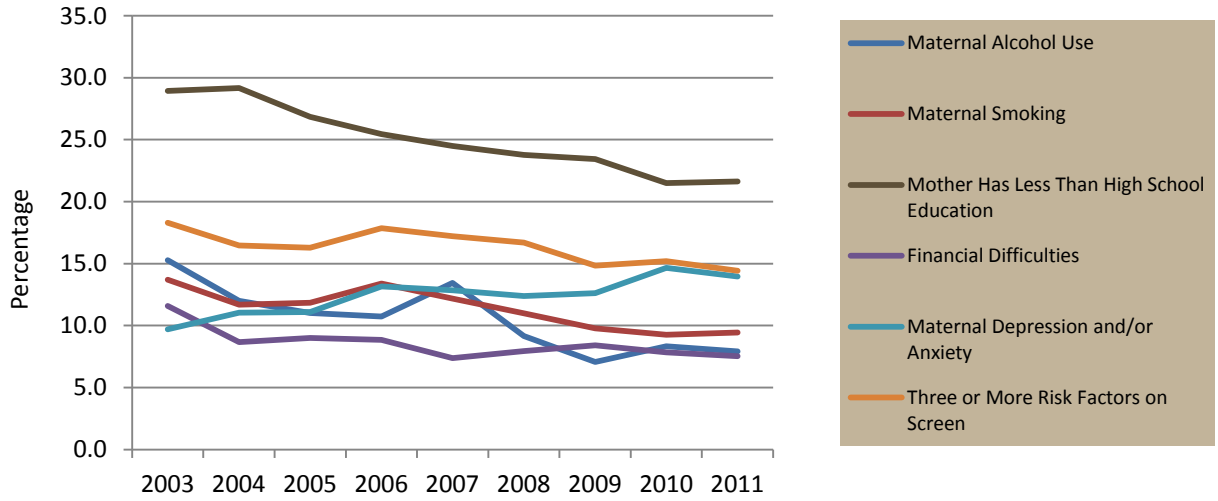
Table 17 shows the proportion of mothers within the region who were screened by risk factor. Of the 2,493 mothers with newborns who were screened, the following were reported: 7.9% alcohol use; 9.4% smoking, 21.6% less than high school education, 7.5% financial difficulties, and 13.9% depression and/or anxiety. Just over 14% of all mothers scored positive on three or more risk factors. **Figure 28** shows that the prevalence of mothers reporting depression and/or anxiety seems to be increasing, whereas the other risk factors are showing improvements over time.

Table 17. Prevalence of Families First Risk Factors, Southern Health-Santé Sud, 2011.

Families First Risk Factors	Prevalence Rate 2011
Maternal alcohol use	7.9%
Maternal smoking	9.4%
Mother has less than high school education	21.6%
Financial difficulties	7.5%
Maternal depression and/or anxiety	13.9%
Three or more risk factors on screen	14.4%
Number of screens	2,493

Source: Healthy Child Manitoba, Special Run 2011.

Figure 28. Families First Program Risk Factors, Southern Health-Santé Sud, 2003-2011.
Prevalence rates of risk factors for poor child outcomes based on risk factor percentages (%) of the regional post partum population screened for enrollment in the Families First Program.



Source: Healthy Child Manitoba, Special Run 2003-2011

Teen Pregnancy Rate and Live Birth Rate

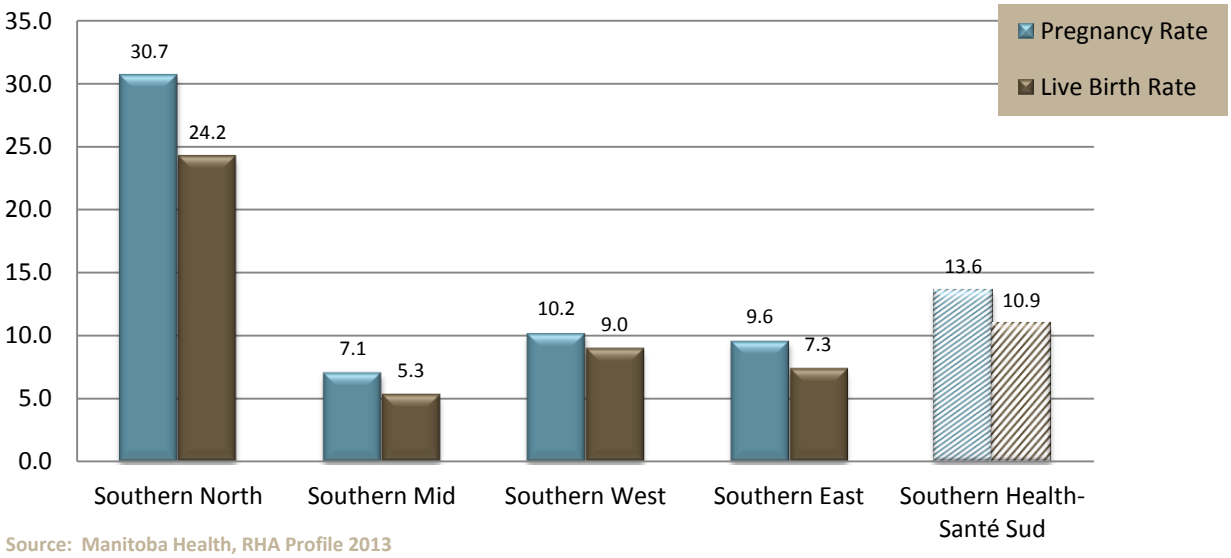
Teen pregnancy is considered a major public health issue in many countries. Teens that become pregnant have a greater risk of health problems (e.g., anaemia, hypertension) and other socio-economic factors (e.g., lower education, financial difficulties). This indicator measures the rates of pregnancies per 1,000 females age 15-19 years. As shown in **Table 18**, Southern Health-Santé Sud had the lowest teen pregnancy rate in the province at 13.6%, and the teen live birth rate was also low at 10.9%. However, **Figure 29** provides a further breakdown by areas within the region. It shows that rates in `Southern North' was considerably higher – teen pregnancy at 30% and teen live births at 24.2%.

Table 18. Prevalence of Teen Pregnancy and Live Birth Rates by Regional Health Authority, 2012/13.

Regional Health Authority	Teen Pregnancy Rate	Teen Live Birth Rate
Winnipeg (WRHA – incl Churchill)	15.5%	8.9%
Prairie Mountain Health	18.6%	14.2%
Interlake-Eastern	17.0%	12.6%
Northern	51.6%	43.1%
Southern Health-Santé Sud	13.6%	10.9%
Manitoba	18.4%	12.8%

Source: MCHP, RHA Atlas 2013

Figure 29. Teen Pregnancy and Teen Live Births by Area, Southern Health-Santé Sud, 2012-2013.
Rates per 1,000 females age 15 to 19.

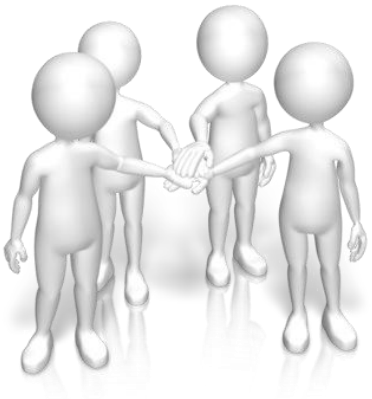


Source: Manitoba Health, RHA Profile 2013

2.12. List of Figures

2.13. List of Tables

Health of the People of Southern Health-Sante Sud



Chapter 3

Health of the People of Southern Health-Santé Sud

3.1. Chapter Highlights

This chapter examines the health practices and lifestyles of Southern Health-Santé Sud residents and the potential impacts on the mortality and burden of disease in the region. It also tries to look at health practices and prevention initiatives that most influence health status. Similarly, this chapter analyzes chronic disease and conditions that have the greatest effect on residents in the Southern Health-Santé Sud region.

Mortality

- Southern Health-Santé Sud remains among the healthiest regions in Manitoba. Premature Mortality Rate (PMR) decreased significantly over time and was statistically lower than the provincial average. Within the region, several districts experienced statistically significant declines during the two time periods.
- Cancer and circulatory diseases continue to be the top two leading causes for premature death in the region accounting for slightly over 60% of deaths under 75 years of age. However for all deaths, a greater proportion of people in the region die of circulatory disease compared to cancer.
- The total mortality rate in the region declined from 7.54 deaths per 1,000 to 6.83 which is the lowest among Manitoba RHAs and statistically below the Manitoba average. Several Southern Health-Santé Sud districts had rates statistically below the Manitoba average.
- The region had the highest life expectancy among Manitoba RHAs with a significant increase in the Southern Health-Santé Sud region between 2002-2006 and 2007-2011.
- Rates for Potential Years of Life Lost (PYLL) decreased in the region both overall and for cancer and circulatory disease though the decreases were not considered statistically significant. The only PYLL rate studied that showed an increase in the region was for respiratory disease.

Chronic Disease Burden

- In general, population growth has meant that more people are living with chronic diseases. Even though prevalence rates may not have changed, the diseases have impacted more people within the region.
- In terms of the burden of illness, there is a mixed picture in the region with cardiovascular disease prevalence and heart attack rates showing slight increases while ischemic heart disease prevalence and stroke rates experiencing significant decreases over time.

- Cancer incidence rates overall in the region were significantly lower than the Manitoba average. The region was also below the provincial average for each of the major cancers of lung, breast, prostate and colorectal cancer.
- Cancer survival rates were significantly higher in Southern Health-Santé Sud compared to the Manitoba average.
- With respect to mental illness, the region generally had a lower prevalence rate for mental health-related conditions such as mood and anxiety disorders, dementia and substance abuse in comparison to other Manitoba RHAs.
- Diabetes incidence rates and the lower limb amputation rates both declined significantly. As well, diabetes prevalence has increased significantly which implies that people with diabetes are living longer. Increases in prevalence also suggests earlier detection, and improvements in people taking better care of their chronic disease.
- Incidence and prevalence for respiratory conditions, such as asthma, were found to be declining in the region and well below the Manitoba average.
- Other chronic conditions such as arthritis and osteoporosis recorded regional declines in prevalence which were statistically significant.

Health Practices and Lifestyle

- Self-perceived physical and mental health survey results show the region is generally consistent with Mantioba wide findings.
- Body Mass Index (BMI) findings demonstrate that over half of adults in the region are either overweight (37%) or obese (22%). Almost three-quarters of youth (73%) are considered to have a normal, healthy weight range. Girls tended to perceive themselves as overweight more so than boys.
- Over half of all residents (53%) in the region reported being inactive which is higher than the Manitoba average of 45%. There was a wide range of inactivity levels of between 33-64% in the region's districts. Among youth, activity levels were higher with 82% of youth active or moderately active though activity rates decline as youth get older.
- With respect to healthy eating indicators, only one third of residents in the region were eating fruits and vegetables 5 or more times daily. Eating habits of youth in the region were also of concern as less than half of youth reporting having the recommended level of fruits and vegetables, milk and alternatives and meat and alternatives. Poor eating habits were also evident among youth with 1 in 5 (21%) reporting that they did not eat breakfast and 23% indicating they eat 3-6 servings of salty and sugary snacks.
- The Southern Health-Santé Sud region had slighty lower binge drinking rates and smoking rates among youth in comparison with provincial rates.
- Use of safety equipment such helmets and life jackets by youth continues to be low in the region despite injuries being the high cause of death among children and youth.
- Less than half (47% on weekdays, 28% on weekends) of youth in the region got the recommended 9 or more hours of sleep each night.

Disease Prevention

- For communicable diseases, rates for campylobacter (often contracted in rural and farm settings) and lyme disease (transmitted through tick bites) were highest among Manitoba RHAs.
- Sexually transmitted infection rates were found to be lower in the region for both Chlamydia and Gonorrhea in comparison to the Manitoba average. Rates were highest among 15-19 and 20-24 year olds.
- Adult immunization rates have been falling and significantly lower than the Manitoba rate for both influenza and pneumococcal disease. Child immunization rates were found to be lower in the region compared to the Manitoba rate at younger ages (1, 2 and 11), but due to public health program efforts rates were higher than Manitoba by age 17.
- Cancer screening rates offers a mixed picture with breast and colorectal cancer screening rates in the region significantly lower than the Manitoba average while cervical screening rates were significantly higher.
- For child health indicators, the region performed well with the highest breast feeding initiation rates in Manitoba along with significantly lower rates of inadequate prenatal care and dental extractions compared to the provincial average.

3.2. Health Status

Premature Mortality Rate

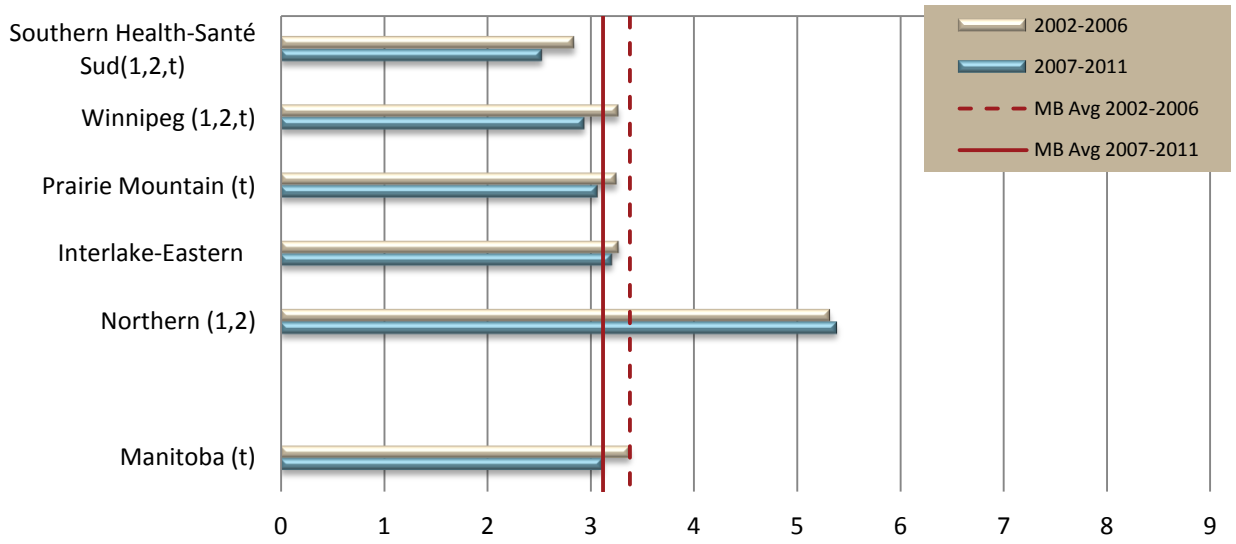
Definition: The annual number of deaths occurring before the age of 75 (per 1,000 under 75 years). Average annual rates were calculated for two 5-year time periods, and were age and sex adjusted to the Manitoba population for the same time periods.

Many health researchers consider Premature Mortality Rate (PMR) as the single best indicator of health status of a population. Populations with a higher PMR tend to have poorer health overall, and a higher utilization of health services.

Key Findings

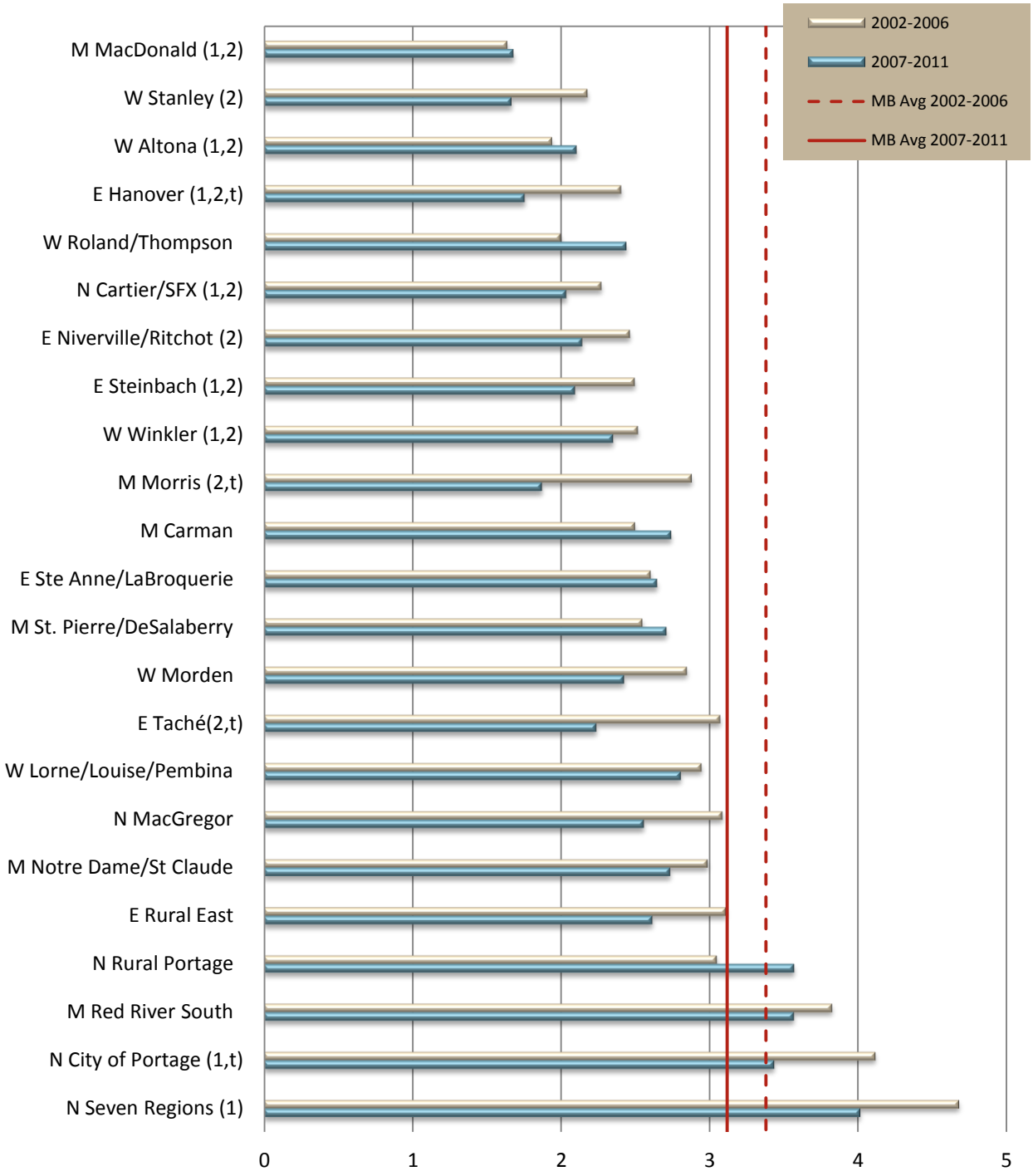
- PMR in Manitoba decreased over time from 3.38 to 3.12 deaths per 1,000 under the age of 75 years. This decrease suggests that health status of Manitobans is improving gradually over time.
- PMR among our regional residents decreased from 2.84 to 2.53 deaths per 1,000 under the age of 75 years. This is the lowest (best) rate compared to other regions and significantly better than the Manitoba average. (**Figure 1**)
- **Figure 2** illustrates the variation we see within our region. PMR ranged from a low of 1.68 (MacDonald) to a high of 4.0 (Seven Regions) deaths per 1,000 under the age of 75 years.
- Districts significantly lower (better) than Manitoba average: MacDonald, Stanley, Altona, Hanover, Cartier/SFX, Niverville/Ritchot, Steinbach, Winkler, Morris, Taché. No districts significantly higher (worse) than Manitoba in the most recent time period.

Figure 1. Premature Mortality Rate by RHA, 2002-2006 and 2007-2011.
Age-and sex-adjusted average annual rate of death before age 75 per 1,000 residents under age 75.



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 2. Premature Mortality Rate by District, Southern Health-Santé Sud, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death before age 75 per 1,000 residents under age 75.



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Source: MCHP, RHA Atlas 2013

Leading Causes of Premature Death

Definition: The most frequent causes of premature death before the age of 75. Cause of death from Vital Statistics death records were grouped for a 5-year time period, and shown as average annual crude rates.

Note: "Circulatory diseases" includes heart attack and stroke.

Key Findings

- **Table 1** shows that between 2007-2011, the top causes of premature death (before age 75) in Manitoba were cancer (36.4%), followed by circulatory diseases (21.9%), injury and poisoning (13.8%), respiratory diseases (5.39%), and endocrine and metabolic disorders (5.06%).
- In our region, the top causes of premature death were similar to Manitoba: cancer (40.0%), circulatory diseases (20.7%), injury and poisoning (12.3%), endocrine and metabolic disorders (5.7%) and digestive diseases (3.7%).
- Cancer and circulatory diseases claim almost 60% of all premature deaths.

Table 1.Most Frequent Causes of Premature Mortality Death, SH-SS and Manitoba, 2007-2011.
Average annual crude percent of deaths among residents under age 75

Cause of Premature Death	Southern Health-Santé Sud	Manitoba
Cancer	40.0%	36.4%
Circulatory Diseases	20.7%	21.9%
Injury and Poisoning	12.3%	13.8%
Endocrine and Metabolic Disorders	5.7%	5.06%
Respiratory Diseases	4.6%	5.39%
Digestive Diseases	3.7%	4.7%
Nervous System	3.1%	2.8%
Ill-defined Conditions	2.0%	1.6%
Congenital Anomolies	1.6%	-
Perinatal Conditions	1.7%	-
Mental Illness	-	1.6%
Infectious Diseases	-	1.7%
All others	4.4%	5.0%

Source: MCHP, RHA Atlas 2013

Total Mortality Rate

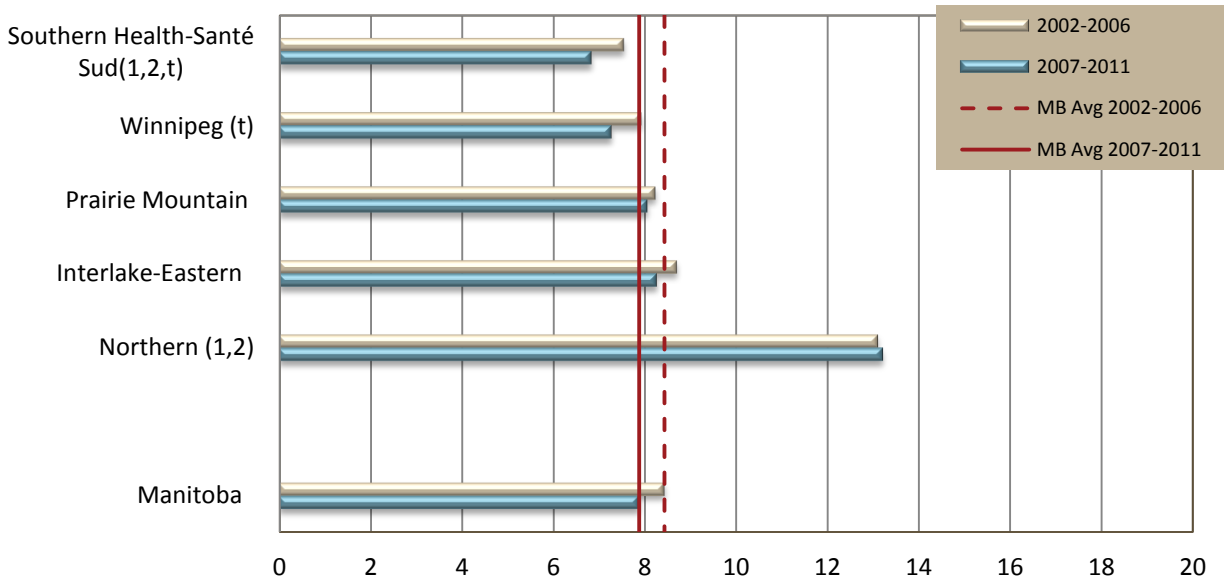
Definition: Total mortality rates are calculated as the total number of deaths among all residents (all ages and causes) per 1,000 residents in the region. Average annual rates were calculated for two 5-year time periods, and were age and sex adjusted to the Manitoba population for the same time periods.

Mortality rates are a good measure of the overall health of a population, and are closely related to life expectancy. It is helpful to review mortality rates, as it gives us a solid basis from which to measure changes over time.

Key Findings

- Total mortality rate for Manitoba decreased over time from 8.43 to 7.88 deaths per 1,000 residents per year, but this change was not significant.
- Among our regional residents, total mortality rate decreased from 7.54 to 6.83 deaths per 1,000 per year. This is the lowest (best) rate compared to other regions and significantly better than the Manitoba average. **(see Figure 3)**
- **Figure 4** illustrates the total mortality rate ranges from a low of 4.22 (Stanley) to a high of 9.06 (City of Portage) deaths per 1,000 residents.
- Districts significantly lower (better) than Manitoba average: MacDonald, Stanley, Hanover, Roland/Thompson, Cartier/SFX, Steinbach, Morden, and Taché. No districts significantly higher than Manitoba in the most recent time period.

Figure 3. Total Mortality Rate by RHA, 2002–2006 and 2007–2011.
Age- and sex-adjusted average annual rate of death per 1,000 residents per year.



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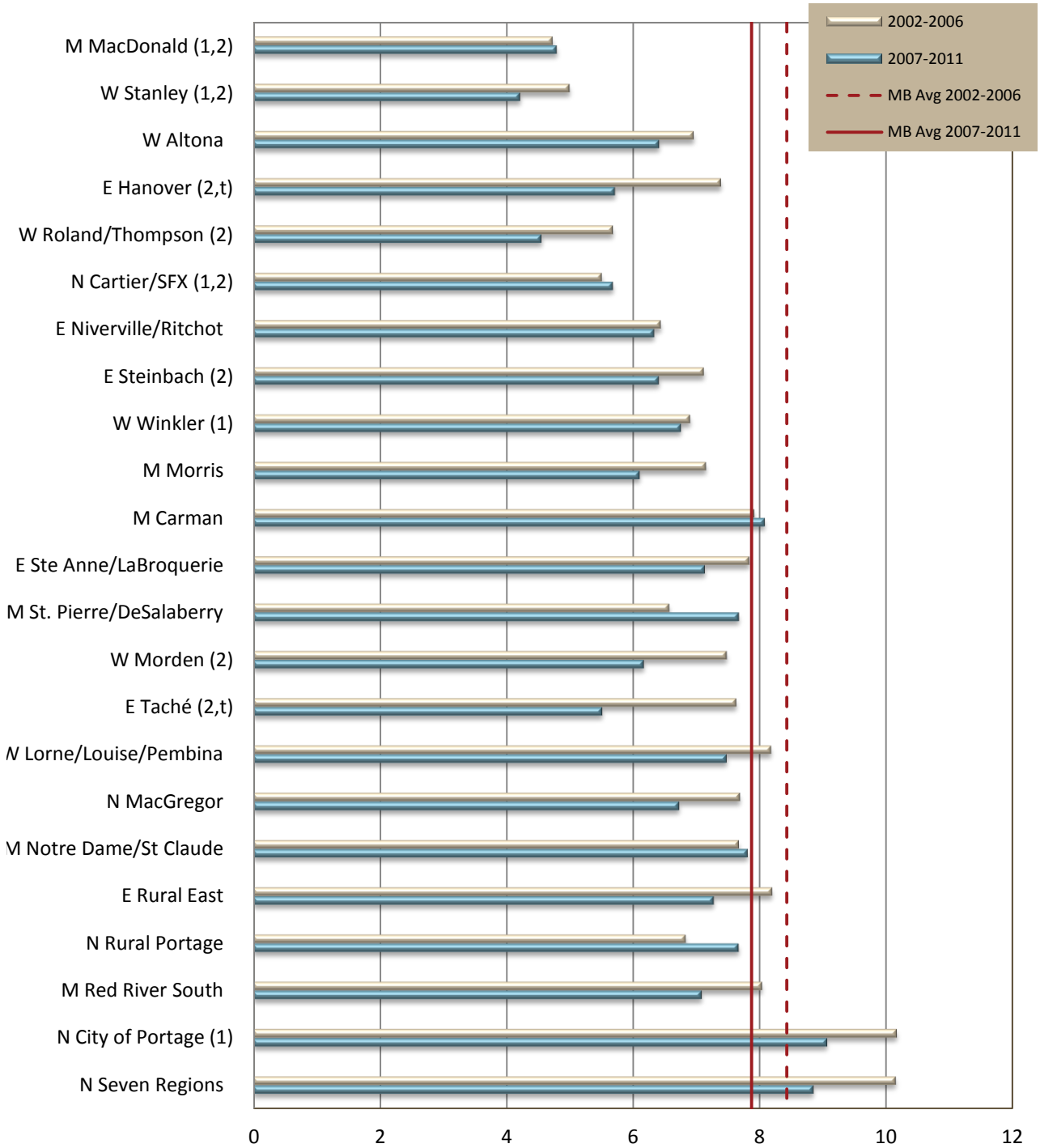
Source: MCHP, RHA Atlas 2013

Figure 4. Total Mortality Rate by District, Southern Health-Santé Sud, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death per 1,000 residents per year



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Leading Causes of Death

Definition: This indicator measures the percentage of all deaths represented by their most prevalent causes. Cause of death from Vital Statistics death records were grouped for a 5-year time period, and shown as average annual crude rates.

Note: "Circulatory diseases" includes heart attack and stroke.

Key Findings

- **Table 2** shows that between 2007-2011, the top causes of death in Manitoba were circulatory diseases (30.2%), cancer (27.1%), followed by respiratory diseases (8.4%), and injury and poisoning (7.5%).
- In Southern Health-Santé Sud, the top causes of death were similar to Manitoba: circulatory diseases (30.7%), cancer (27.1%), followed by respiratory diseases (7.8%), injury and poisoning (6.6%), endocrine and metabolic disorders (5.9%).
- Unlike premature deaths, circulatory disease claims more lives than cancer. However together, they still account for almost 60% of deaths overall.

Table 2. Most Frequent Causes of Death, SH-SS and Manitoba, 2007-2011.
Average annual crude percent of deaths among residents under age 75.

Cause of Death	Southern Health-Santé Sud	Manitoba
Circulatory Diseases	30.7%	30.2%
Cancer	27.1%	27.6%
Respiratory Diseases	7.8%	8.4%
Injury and Poisoning	6.6%	7.5%
Endocrine and Metabolic Disorders	5.9%	4.8%
Nervous System	4.6%	3.9%
Digestive Diseases	3.7%	3.9%
Mental Illness	2.5%	5.9%
Genitourinary & Breast	2.1%	2.2%
Ill-defined Conditions	2.1%	1.9%
All others	4.1%	3.8%

Source: MCHP, RHA Atlas 2013

Life Expectancy

Definition: Life expectancy is the expected length of life from birth, based on death rates occurring in the population using Provincial Vital Statistics records for a 5 year period of time.

Life expectancy is one of the most widely used indicators to measure the health of a population, and the overall effectiveness of a health care system in maintaining the health status of its population. With each passing decade, life expectancy is increasing and the gender gap is steadily narrowing.

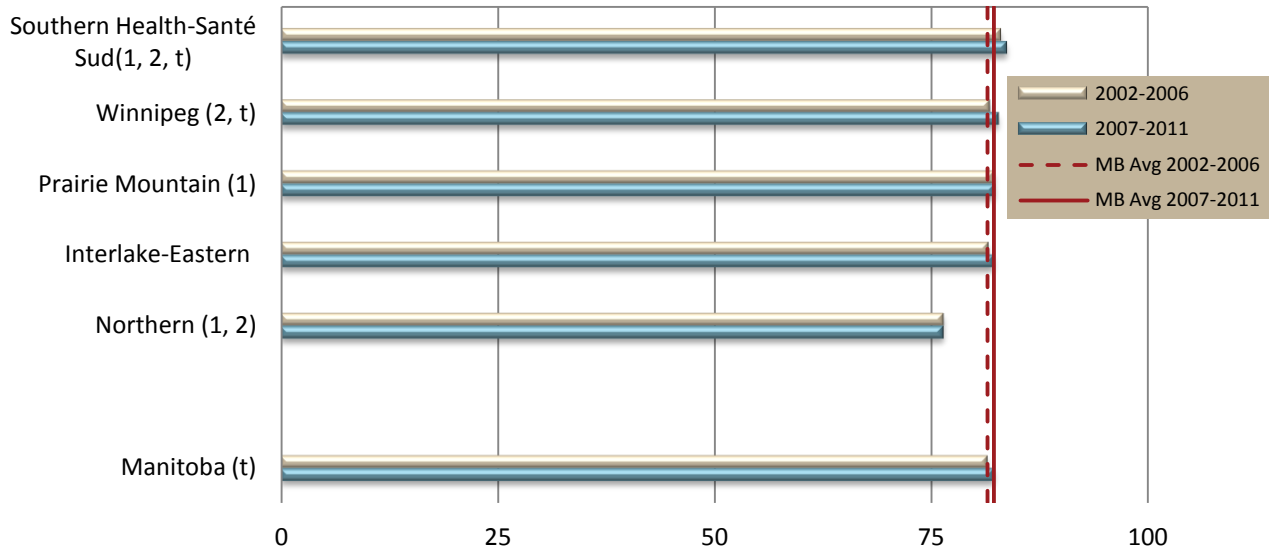
Key Findings

- As shown in **Figure 5** and **6**, life expectancy in Manitoba increased significantly over time for males and females. For males, the increase was from 76.5 to 77.5 years, while for females it was from 81.5 to 82.2 years.
- In our region, life expectancy was the highest in the province and has increased significantly over time.
    - Female life expectancy in Southern Health-Santé Sud increased from 83.0 to 83.7 years.
    - Male life expectancy in Southern Health-Santé Sud increased from 77.7 to 79.2 years.
- District level information for this indicator is not presented in this report but is available in the RHA Atlas 2013. It is important to interpret district levels for this indicator with caution (eg Taché or Roland/Thompson) as these values were based on relatively small populations and a low number of deaths. For instance, very long lives lived by a few people may have affected these results.

Female life expectancy = 83.7 years

Male life expectancy = 79.2 years

Figure 5. Female Life Expectancy by RHA, 2002-2006 and 2007-2011.
Life expectancy (at birth) in years.



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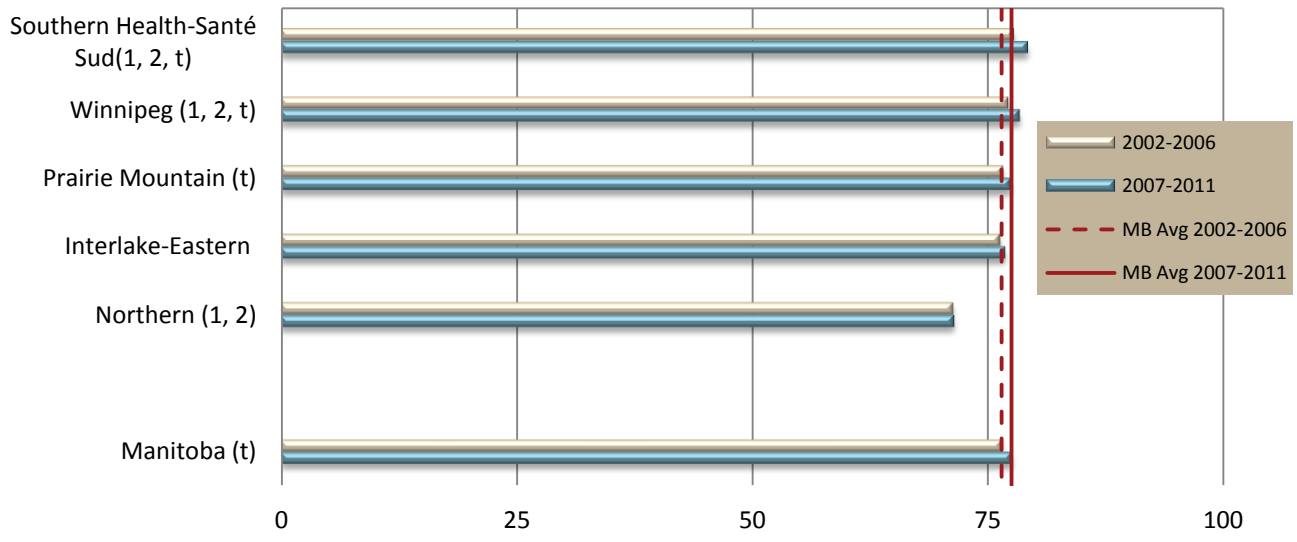
Source: MHCP, RHA Atlas, 2013

Figure 6. Male Life Expectancy by RHA, 2002-2006 and 2007-2011.
Life expectancy (at birth) in years



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Source: MCHP, RHA Atlas, 2013

Potential Years of Life Lost (PYLL)

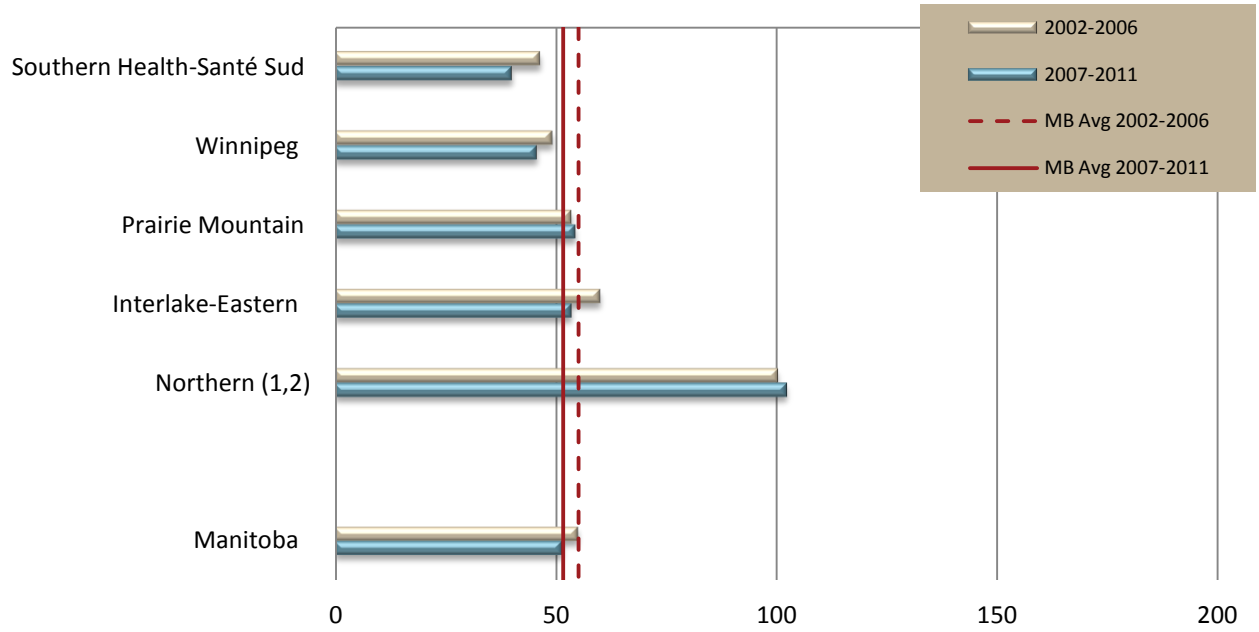
Definition: The potential years of life lost (PYLL) is the number of years of life "lost" when a person dies "prematurely" – before the age of 75. It is the sum, for all persons dying (before age 75, excluding infant deaths) of the years those persons would have been expected to live. For example, a person dying at age 50 has lost 25 years of life.

This indicator highlights the loss to society as a result of youthful or early deaths. Populations with lower health status tend to have higher PYLL rates.

Key Findings

- Over time, PYLL in Manitoba has been stable, at 55.0 to 51.5 years per 1,000 (aged 1 to 74 years). This change was not statistically significant.
- PYLL among regional residents improved from 46.5 to 49.2 years per 1,000 (aged 1 to 74 years), although this was not a significant change. **(see Figure 7)**
- **Figure 8** illustrates the variation we see within our region, though none were statistically significant from the provincial average. However, the rates did decrease significantly over time in the district of Stanley, whereas in the district of Rural East the increase was significant.

Figure 7. Potential Years of Life Lost by RHA, 2002–2006 and 2007–2011.
Age- and sex-adjusted average annual rate of PYLL per 1,000 residents aged 1-74



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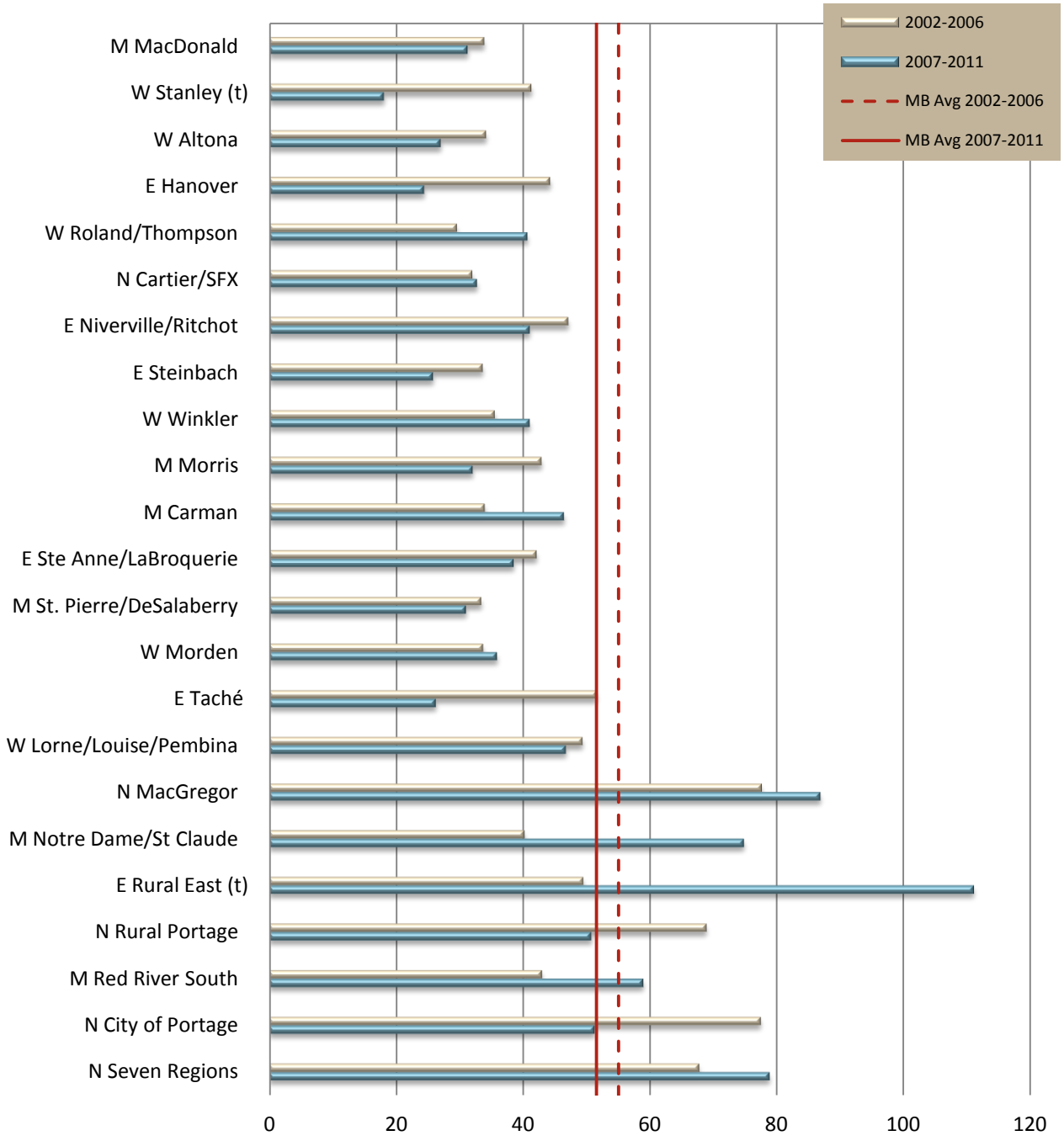
Source: MCHP, RHA Atlas, 2013

Figure 8. Potential Years of Life Lost by District, Southern Health-Santé Sud, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of PYLL per 1,000 residents aged 1-74



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Source: MCHP, RHA Atlas, 2013

PYLL Due to Cancer

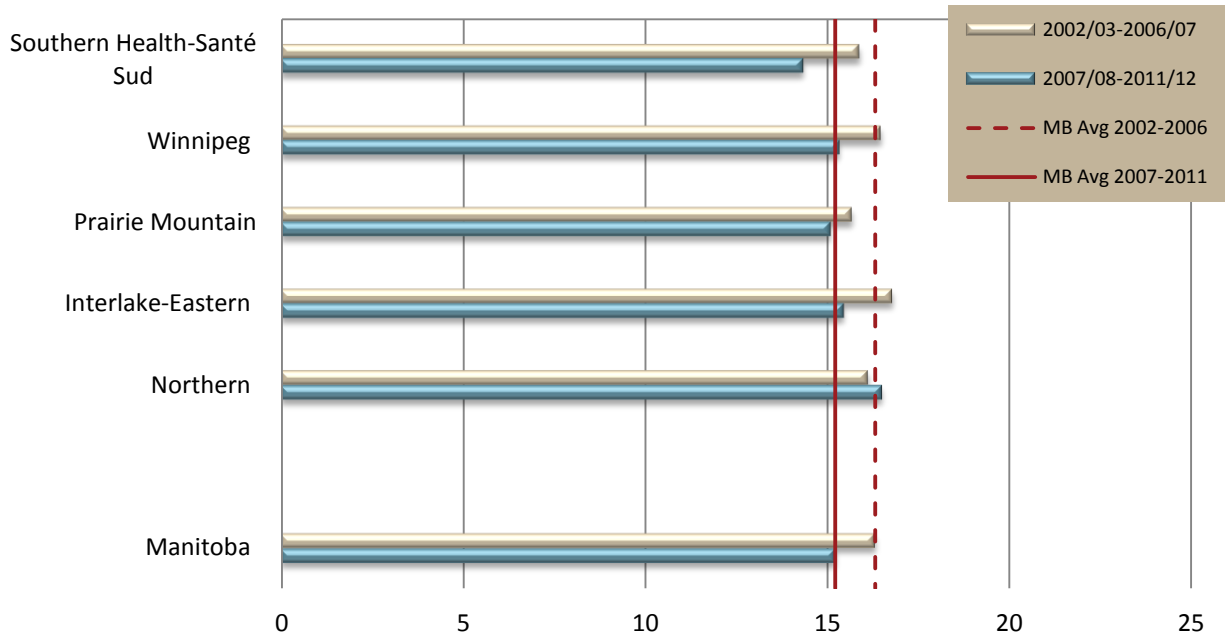
Definition: The potential years of life lost (PYLL) due to cancer is the number of years of life "lost" when a person dies prematurely (before the age of 75) from malignant cancers.

Cancer is typically a disease of older populations. Although deaths due to cancers certainly occur, the impact on younger populations is not as great compared to injury.

Key Findings

- As shown in **Figure 9**, PYLL due to cancer in Manitoba was stable over time, and reduced slightly from 16.3 to 15.2 years per 1,000 (aged 1 to 74 years).
- In Southern Health-Santé Sud, PYLL due to cancer decreased over time, but not significantly. Among regional residents the rate changed from 15.9 to 14.3 years per 1,000 (aged 1 to 74 years).
- District level data was not available due to small numbers.

Figure 9. Cancer PYLL by RHA, 2002/03–2006/07 and 2007/08–2011/12
Age- and sex-adjusted annual rate per 1,000 residents aged 1-74



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s indicates data suppressed due to small numbers
Source: Manitoba Health, RHA Profile 2013

PYLL Due to Circulatory Disease

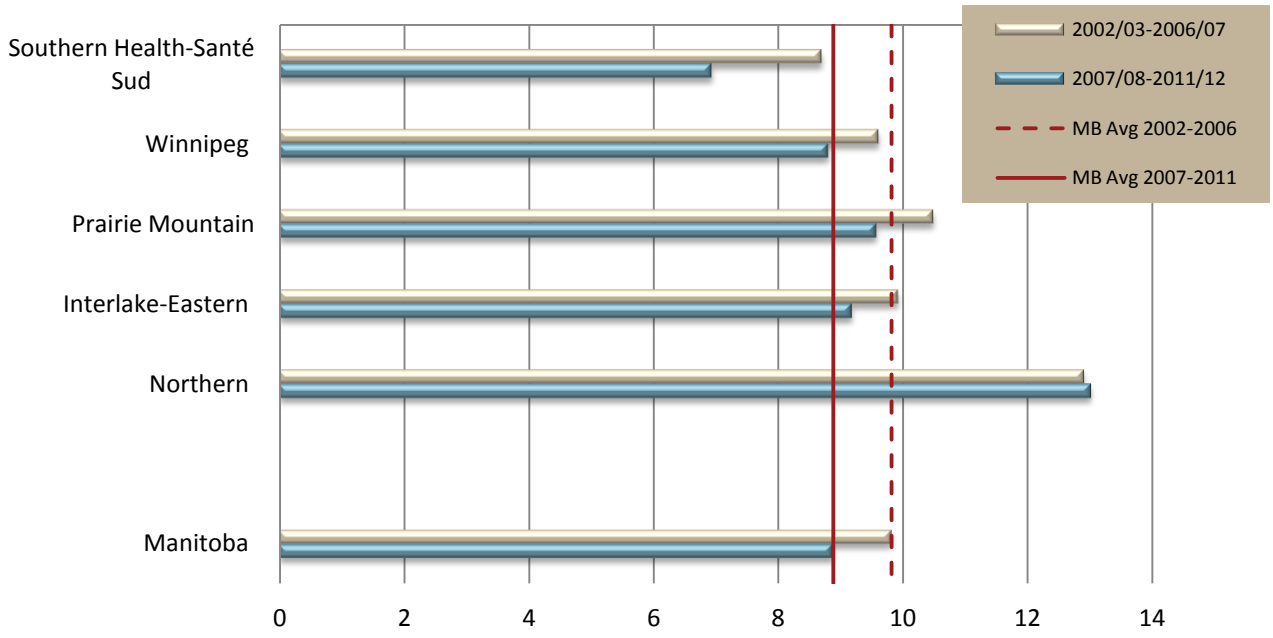
Definition: The potential years of life lost (PYLL) due to circulatory diseases is the number of years of life "lost" when a person dies prematurely (before the age of 75) from any circulatory diseases.

Heart attack and stroke are among the most common causes of death in the country, and can impact younger adults to a greater degree than other chronic diseases.

Key Findings

- As shown in **Figure 10**, PYLL due to circulatory diseases in Manitoba was stable over time, and reduced slightly from 9.8 to 8.9 years per 1,000 (aged 1 to 74 years).
- In Southern Health-Santé Sud, PYLL due to circulatory diseases decreased over time, but not significantly due to the wide range of confidence intervals. Among regional residents the rate changed from 8.7 to 6.9 years per 1,000 (aged 1 to 74 years).
- District level data was not available due to small numbers.

Figure 10. Circulatory PYLL by RHA, 2002/03–2006/07 and 2007/08–2011/12
Age- and sex-adjusted annual rate per 1,000 residents aged 1-74



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: Manitoba Health, RHA Atlas 2013

PYLL Due to Respiratory Disease

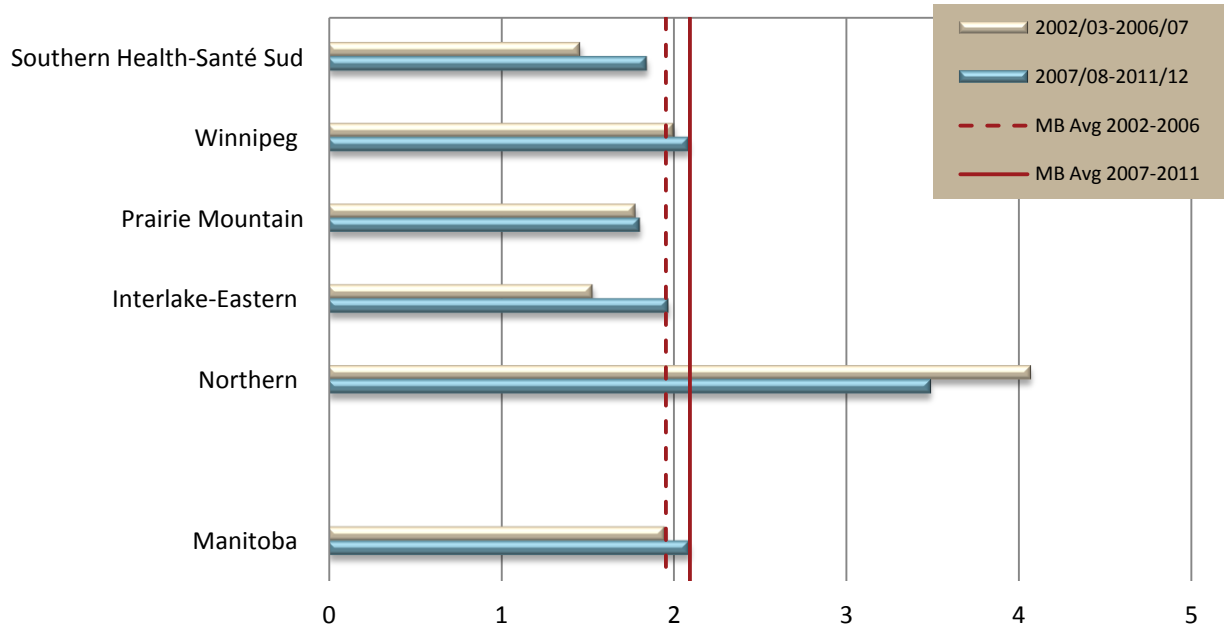
Definition: The potential years of life lost (PYLL) due to respiratory diseases is the number of years of life "lost" when a person dies prematurely (before the age of 75) from any respiratory diseases.

PPYL death due to respiratory disease is quite low, however it does seem to be related to health status as seen below in northern regions of the province.

Key Findings

- As shown in **Figure 11**, PYLL due to respiratory diseases in Manitoba was stable over time, and increased slightly from 1.9 to 2.1 years per 1,000 (aged 1 to 74 years).
- In Southern Health-Santé Sud, PYLL due to respiratory diseases increased over time, but not significantly. Among regional residents the rate changed from 1.5 to 1.8 years per 1,000 (aged 1 to 74 years).
- District level data was not available due to small numbers.

Figure 11. Respiratory PYLL by RHA, 2002/03–2006/07 and 2007/08–2011/12
Age- and sex-adjusted annual rate per 1,000 residents aged 1-74



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: Manitoba Health, RHA Atlas 2013

3.3. Injury

PYLL Due to Unintentional Injuries

Definition: The potential years of life lost (PYLL) due to unintentional injuries is the number of years of life "lost" when a person dies prematurely (before the age of 75) from any unintentional injuries. Annual average rates were calculated over a ten year period.

Injuries are the most preventable causes of death and yet the leading cause of death among young Canadians. In 2004, it was estimated that injuries cost $19.8 billion in health care costs and lost productivity. It has a great impact on PPYL as younger people generally suffer injuries more than other age categories. The risks and types of injuries vary by age, sex, and geography.

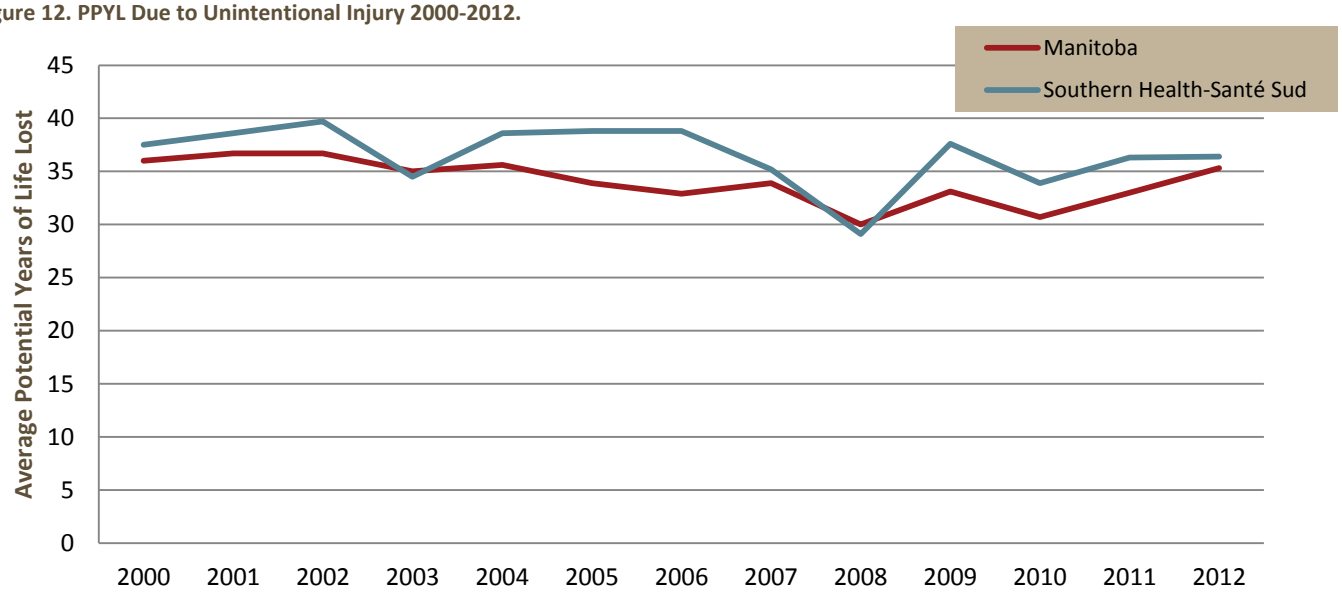
Key Findings

- As shown in **Figure 12**, PYLL due to unintentional injuries in Manitoba decreased slightly over time until 2010. For Manitoba, the PYLL rate was 35.3 years per 1,000 (under 75 years) in 2012.
- In comparison, Southern Health-Santé Sud rates were slightly higher than the province. In 2012, the PYLL rate for unintentional injuries was 36.4 years per 1,000 (under 75 years).
- From 2000-2012, unintentional injuries were responsible for 781 deaths among regional residents (approximately 65 deaths per year).
- District level data is not available due to small sample sizes.

Southern Health-Santé Sud Top Causes of Unintentional Injury Deaths (2000-12)

1. Motor Vehicle Collisions
2. Poisoning
3. Falls

Figure 12. PPYL Due to Unintentional Injury 2000-2012.



Source: Epidemiology and Surveillance Unit, Injuries Report 2000-2012

Injury Hospitalization

Definition: This indicator measures the number of people who stayed in hospital at least one day with a primary diagnosis of injury (intentional or unintentional).

Injury has a major impact on the lives of Canadians. Injury is also a leading cause of hospitalization for children, young adults and seniors, with consequences that can last a lifetime. Unintentional injuries include accidents such as a motor vehicle collisions, while intentional injuries include injuries as a result of suicide or homicide attempt.

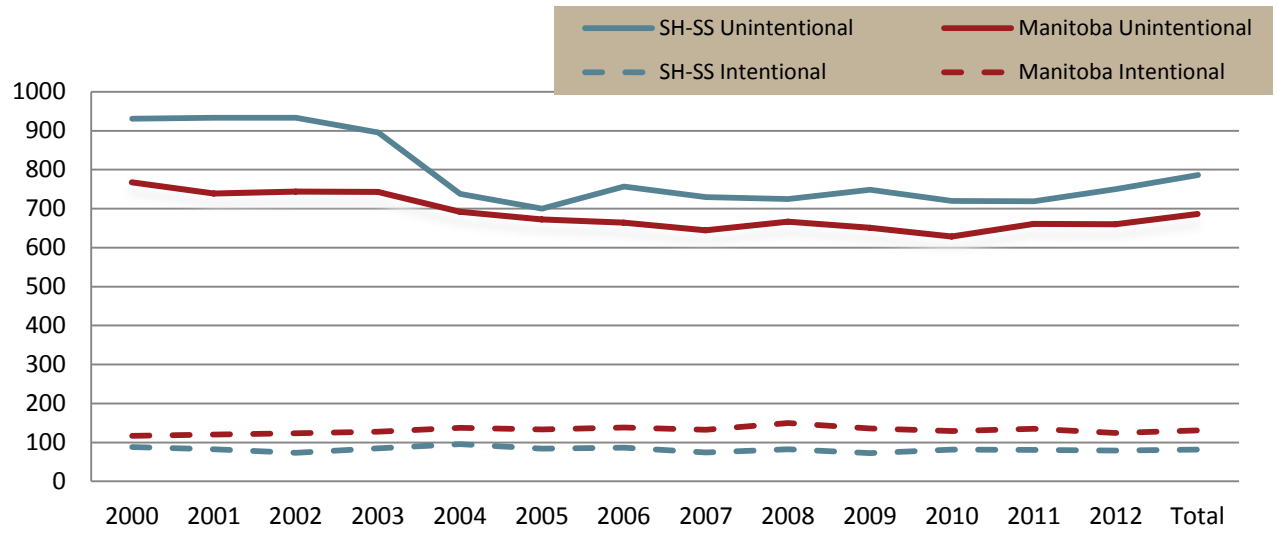
Key Findings

- As shown in **Figure 13**, there are many more hospitalizations due to unintentional injuries compared to intentional injuries.
- For Manitoba, the average unintentional injury hospitalization rate was 701.8 per 1,000 population.
- Southern Health-Santé Sud rate was lower at an average of 761.1 per 1,000 population for unintentional injury hospitalizations.
- For Manitoba, the intentional injury hospitalization rate was 130.8 per 1,000 population.
- In comparison, Southern Health-Santé Sud rates were considerably lower at 80.4 per 1,000 population for intentional injury hospitalizations.
- Between 2000-2012 injury hospitalizations represented 6.7% of all hospitalizations within the region with an average of length of stay of 7 days.

Southern Health-Santé Sud Top Causes of all Injury Hospitalization (2012)

1. Falls
2. Motor Vehicle Collisions
3. Self-inflicted
4. Transport, other
5. Struck by or against

Figure 13. Injury Hospitalization Rates, Southern Health-Santé Sud and Manitoba, 2000-2012.
Age-standardized rate of injury per 1,000 population.



Source: Epidemiology and Surveillance Unit, Injuries Report 2000-2012

PYYL Due to Suicide

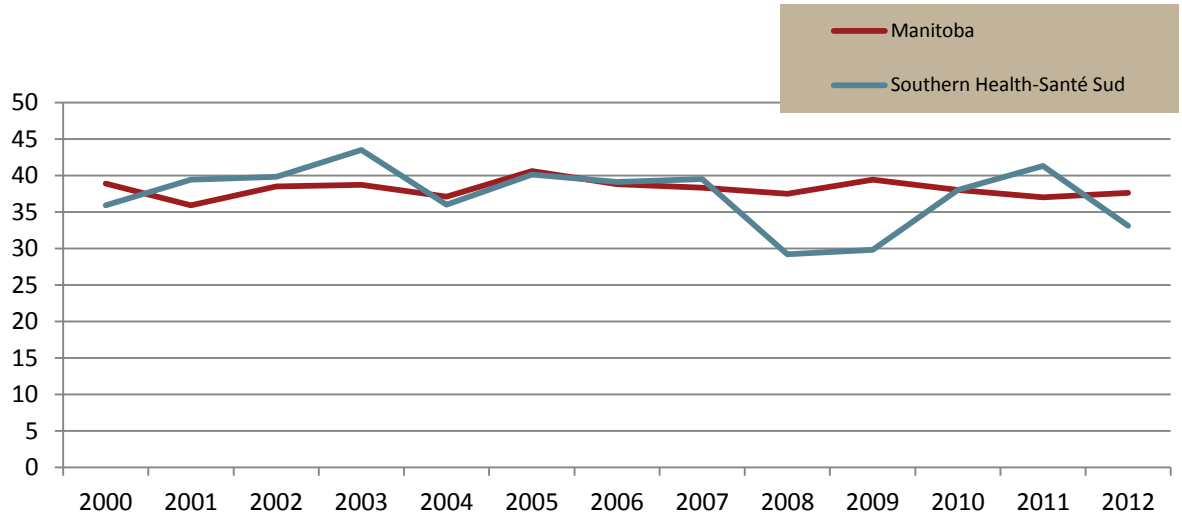
Definition: The potential years of life lost (PYLL) due to suicides is the number of years of life "lost" when a person dies prematurely (before the age of 75) from taking their own life.

Suicide is the act of intentionally causing one's own death. Mental Health experts suggest that a suicidal person is feeling so much pain that they see no other option. They feel they are a burden to others, and in desperation see death as way a to escape their overwhelming pain and anguish. Suicide prevention strategies (eg, Reclaiming Hope) help to raise awareness about suicidal thoughts and behaviours, in particular targeting youth.

Key Findings

- As shown in **Figure 14**, PYLL due to suicide in Manitoba has fluctuated somewhat over the years. For Manitoba, overall average PYLL due to suicide was 38.2 years per 1,000 (under 75 years).
- In comparison, Southern Health-Santé Sud average PYLL rate due to suicide was similar at 37.1 years per 1,000 (under 75 years).
- From 2000-2012, suicide was responsible for 163 deaths among regional residents (approximately 16 deaths per year).
  - The suicide rate for the region was 7.6 per 100,000 population which is lower than the provincial rate of 12.0 per 100,000 population.
- In Southern Health-Santé Sud, suicide was more common among men (81%).
- In Southern Health-Santé Sud, suicide was more common among middle-aged residents between 35-54 years (40%).

Figure 14. PYLL Due to Suicide, Southern Health-Santé Sud and Manitoba, 2000-2012.
Average PYLL per injury, under the age of 75.



Source: Epidemiology and Surveillance Unit, Injuries Report 2000-2012

3.4. Children

Infant Mortality

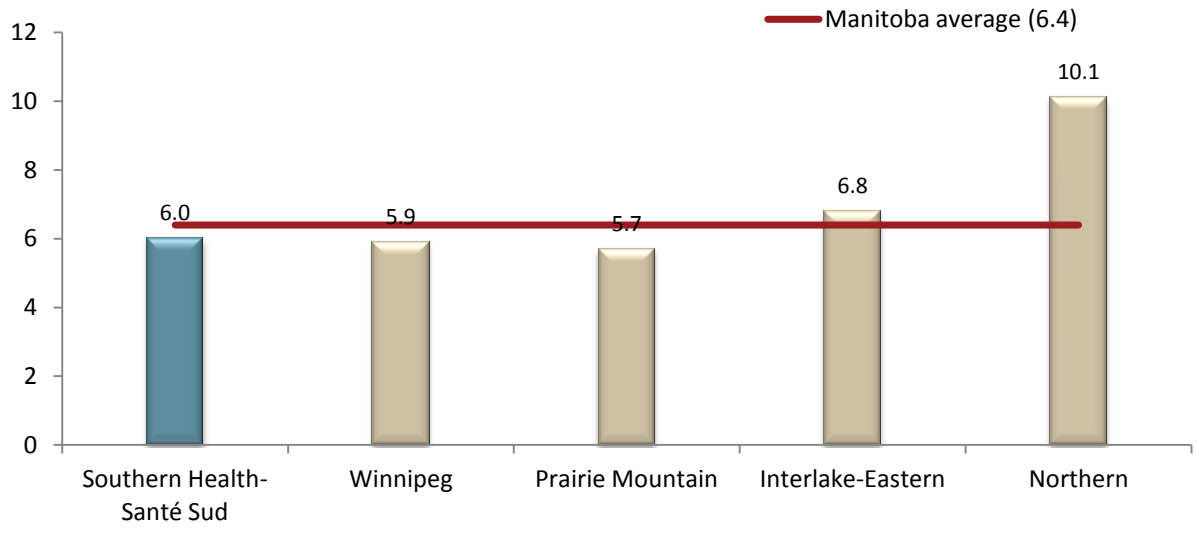
Definition: Proportion of live births weighing 500 grams or more that die within 0 to 364 days of birth, per 1,000 live births for a given period of time (excludes stillbirths and infants less than 500 grams or 20 weeks of gestation).

Infant mortality is another important health indicator about the overall health status of a population. Many health experts see the infant mortality rate as a key indicator of child health and the well-being of a society over time. It also indicates health disparities between different populations.

Key Findings

- As shown in **Figure 15**, the Manitoba rate for infant mortality was 6.4 per 1,000 live births.
- Variations of infant mortality among regions is observed, with highest rates in Northern RHA.
- Southern Health-Santé Sud infant mortality rate was slightly lower than the province at 6.0 per 1,000 live births.

Figure 15. Infant Mortality by RHA, 2007/08 – 2011/12.
Crude rate of infant deaths per 1,000 live births.



Source: Manitoba Health, RHA Profile 2013

Child Mortality

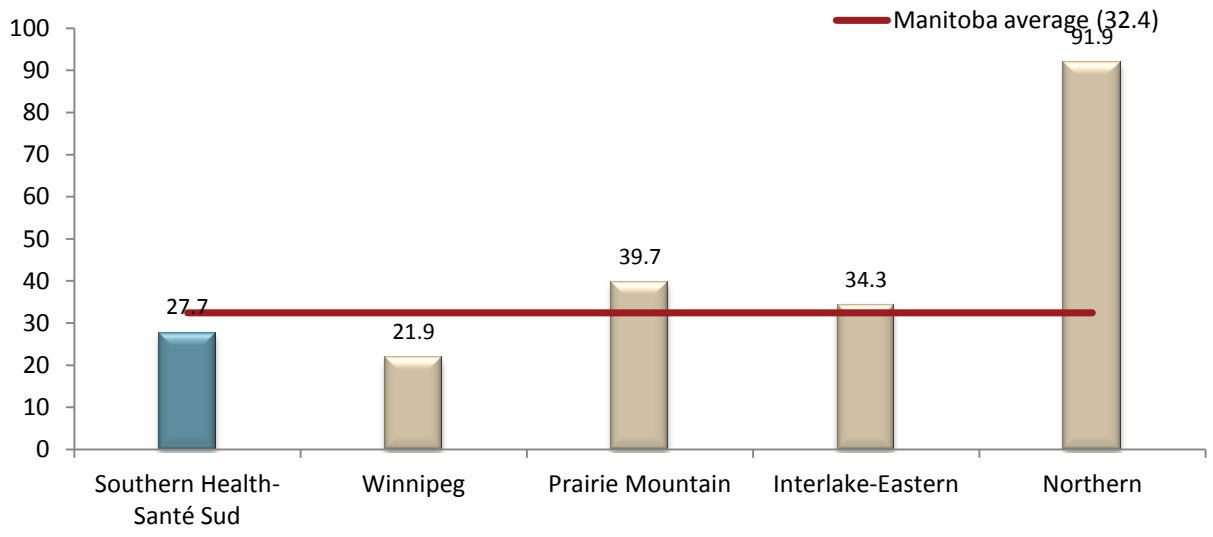
Definition: The total number of deaths aged 1 to 19 years divided by the total population of the same age in that time period. Reported as rate of deaths per 100,000 children aged 1 to 19 years, for a given period of time.

In Canada, injuries are the leading cause of death among children and youth, accounting for 57% of deaths in this age group. Cancer is the second leading cause of death among children and youth (10%).

Key Findings

- As shown in **Figure 16**, the Manitoba rate for infant mortality was 32.4 per 1,000 (age 1-19 years).
- Once again variations of child mortality are observed among regions. The child mortality rate for Northern is almost threefold compared to the provincial rate.
- Southern Health-Santé Sud infant mortality rate was lower than the province at 27.7 per 1,000 (age 1-19 years).

Figure 16. Child Mortality by RHA, 2007/08 – 2011/12.
Crude rate of infant deaths per 1,000 live births.



Source: Manitoba Health, RHA Profile 2013

Preterm Births

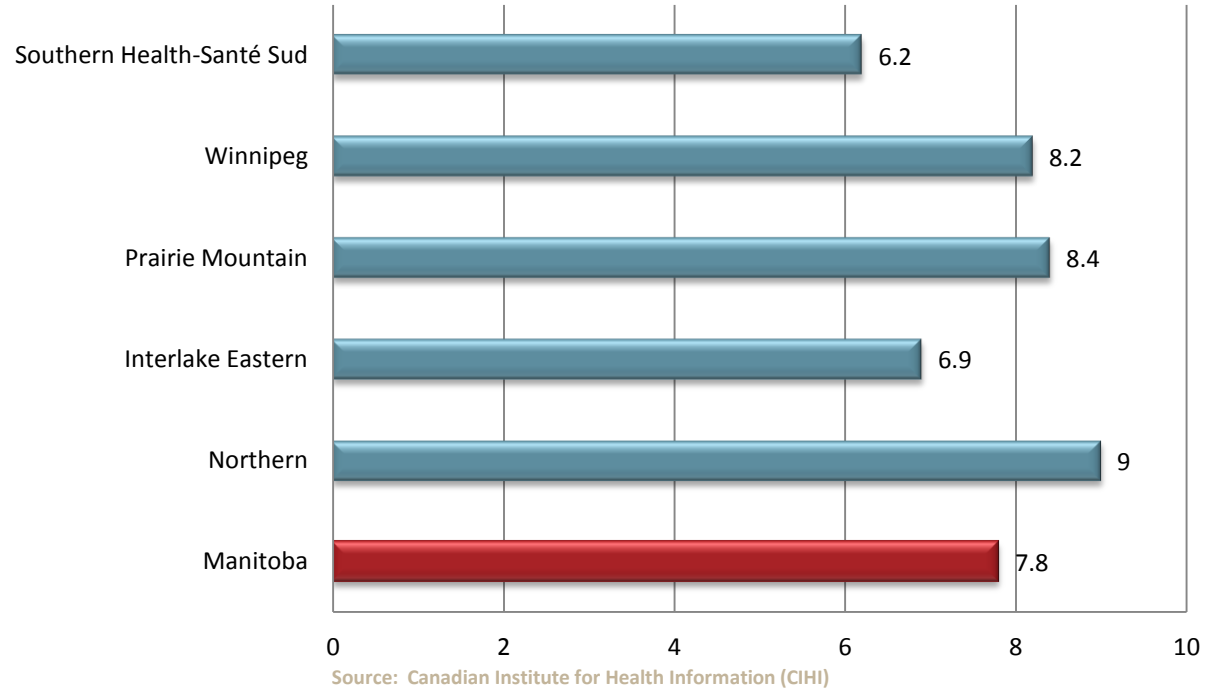
Definition: The proportion of live infants who were born prematurely (prior to 37 weeks gestation).

Preterm birth is an important perinatal health problem across the world. The recent increase in preterm births in Canada is largely attributable to changes in frequency of multiple births, earlier obstetrical intervention, and the use of ultrasound-based estimates of gestational age.

Key Findings

- As shown in **Figure 17**, the Manitoba preterm birth rate was 7.8%. The highest rate among RHAs was observed in Northern.
- Southern Health-Santé Sud preterm birth rate was lower than the province at 6.2% of all live births.

Figure 17. Preterm Birth Rate by RHA, 2007-2010.
The number of live born infants prior to 37 weeks gestation as a proportion of all live births.



Source: Canadian Institute for Health Information (CIHI)

Small for Gestational Age

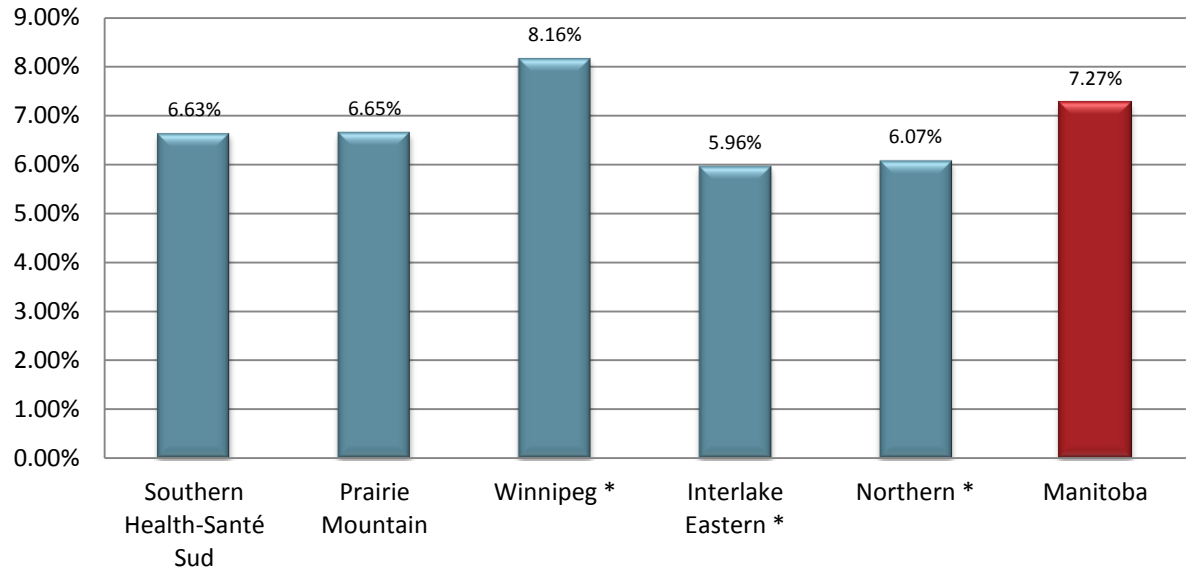
Definition: The number of live births whose birth weight is below the standard 10th percentile of sex-specific birth weight for a given gestational age, expressed as a proportion of all live births.

Low birth weight is a key determinant of infant survival, health, and development. Low birth weight infants are at a greater risk of health issues such as visual problems, respiratory disease and learning disabilities.

Key Findings

- As shown in **Figure 18**, the Manitoba rate for small for gestational age was 7.3%. The highest rate among RHAs was observed in Winnipeg.
- For Southern Health-Santé Sud, the rate of small for gestational age was slightly lower than the province at 6.6%.

Figure 18. Small for Gestational Age by RHA, 2004/05 – 2008/09.



* statistically significant (high/low)
Source: MCHP, Perinatal Report 2012

Large for Gestational Age

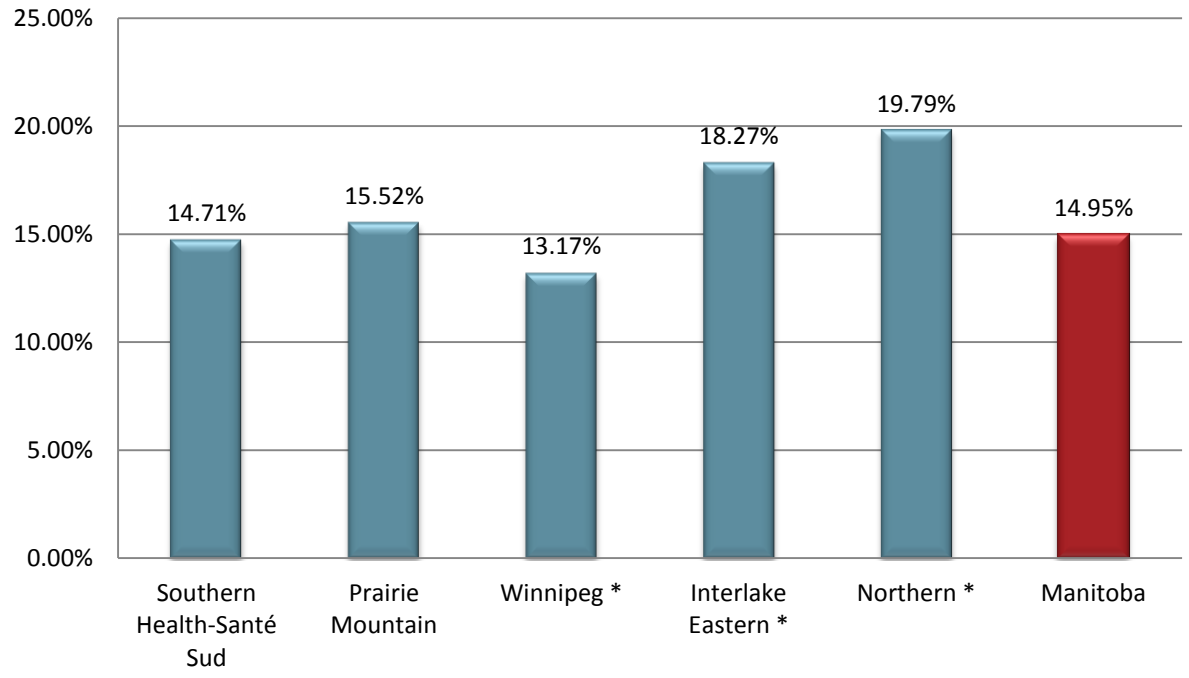
Definition: The number of live births whose birth weight is above the standard 90th percentile of sex-specific birth weight for a given gestational age, expressed as a proportion of all live births.

Increasing concern is now being paid to the rising rates of infants born large for their gestational age. This indicator is related to excessive weight gain during pregnancy and maternal diabetes. Large infants are also at a greater risk for caesarean delivery, resuscitation, and special care nursery admission.

Key Findings

- As shown in **Figure 19**, the Manitoba rate for large for gestational age was 14.9%. The highest rate among RHAs was observed in Northern.
- For Southern Health-Santé Sud, rates of large for gestational age was similar to the province at 14.7%.

Figure 19. Large for Gestational Age by RHA, 2004/05-2008/09.



* statistically significant (high/low)
Source: MCHP, Perinatal Report 2012

3.5. Illness Burden

3.5.1. Cardiovascular Disease

Cardiovascular disease is a major cause of death across Canada. The three main components include ischemic heart disease (**coronary artery disease**), acute myocardial infarction (**heart attack**), and cerebrovascular disease (**stroke**). In addition, hypertension (**high blood pressure**) is a major risk factor for heart attack and stroke.

Hypertension Prevalence

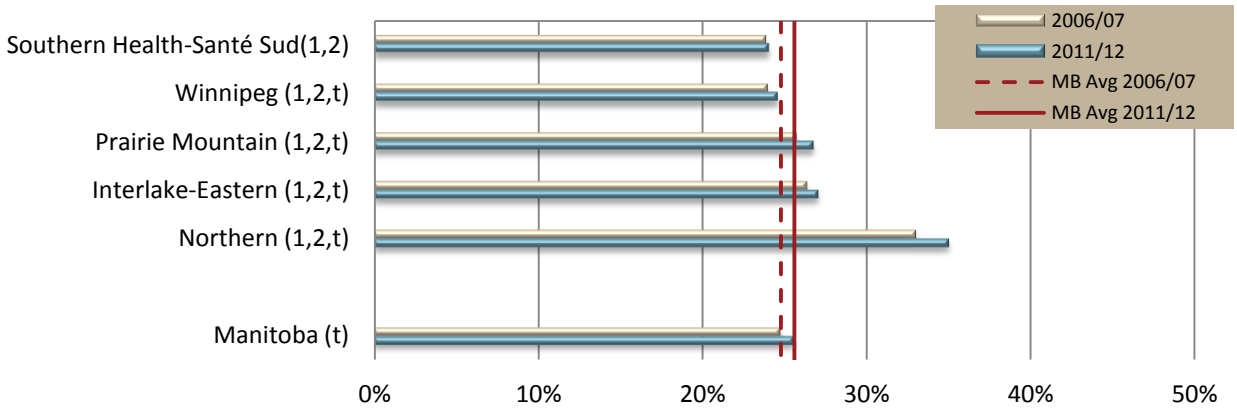
Definition: The percent of residents aged 19 and older with hypertension comparing two time periods – 2006/07 and 2011/12.

Hypertension is the medical term for "high blood pressure", which is a major risk factor for heart attack, stroke and other cardiovascular problems. Normal blood pressure in adults is defined at a reading of 120 over 80, while hypertension is at a reading of 140 over 90 or higher. Appropriate treatment of high blood pressure is extremely important.

Key Findings

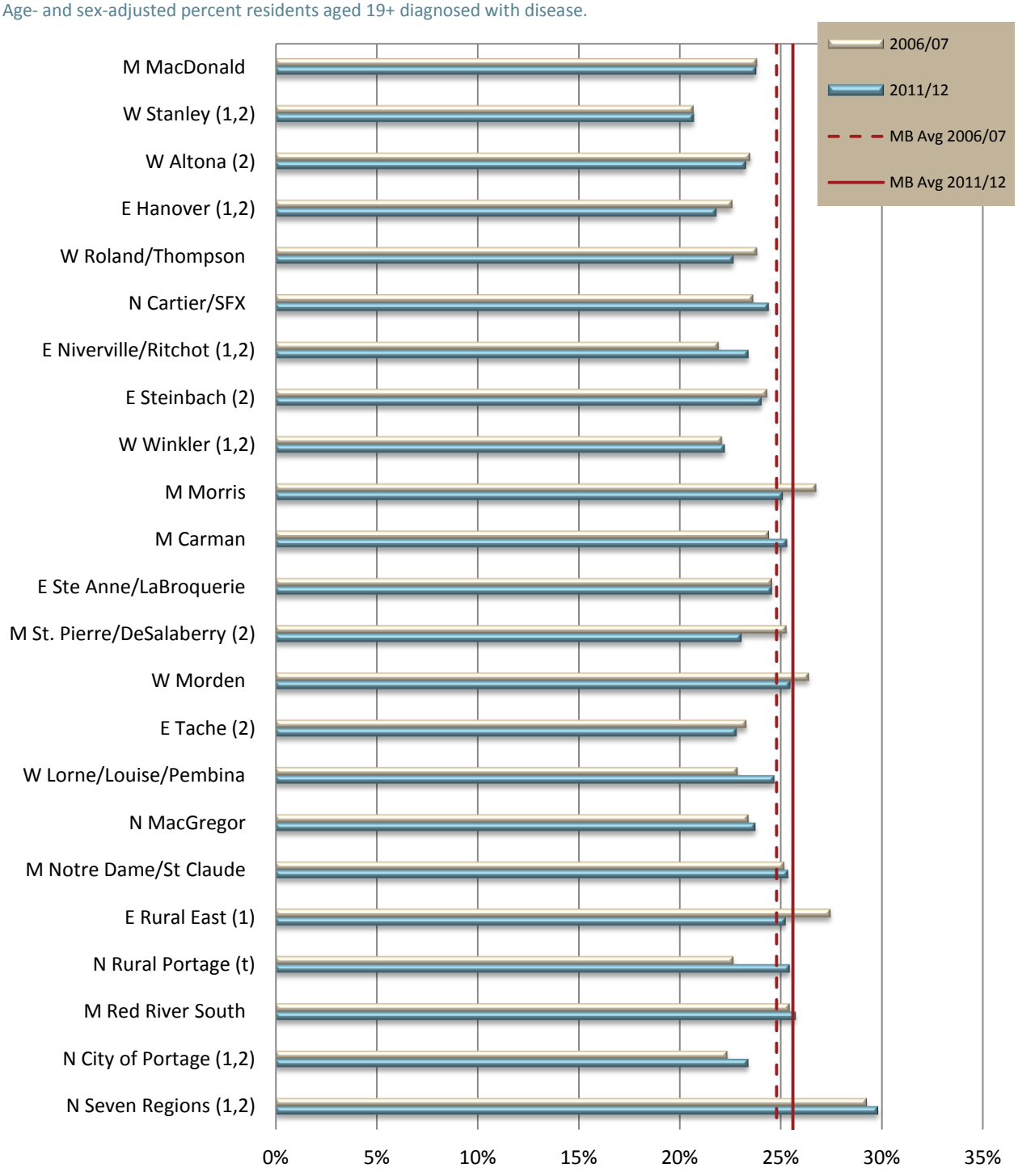
- As shown in **Figure 20**, hypertension prevalence increased significantly in Manitoba from 24.8% to 25.6%. Prevalence increased over time in all regions, except Southern Health-Santé Sud.
- For the region, hypertension prevalence did show a slight increase from 23.9% to 24.1% of the population aged 19 and older.
- Within the region, hypertension prevalence ranged from a low of 20.7% in Stanley, to a high of 29.8% in Seven Regions. Rates were lower than the provincial rate in the following districts: Stanley, Altona, Hanover, Niverville/Ritchot, Steinbach, Winkler, St. Pierre/De Salaberry, Taché, and City of Portage. However, the rate was significantly higher than the provincial rate in Seven Regions. See **Figure 21**.

Figure 20. Prevalence of Hypertension by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent residents aged 19+ diagnosed with disease.



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 21. Prevalence of Hypertension by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent residents aged 19+ diagnosed with disease.



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Ischemic Heart Disease Prevalence

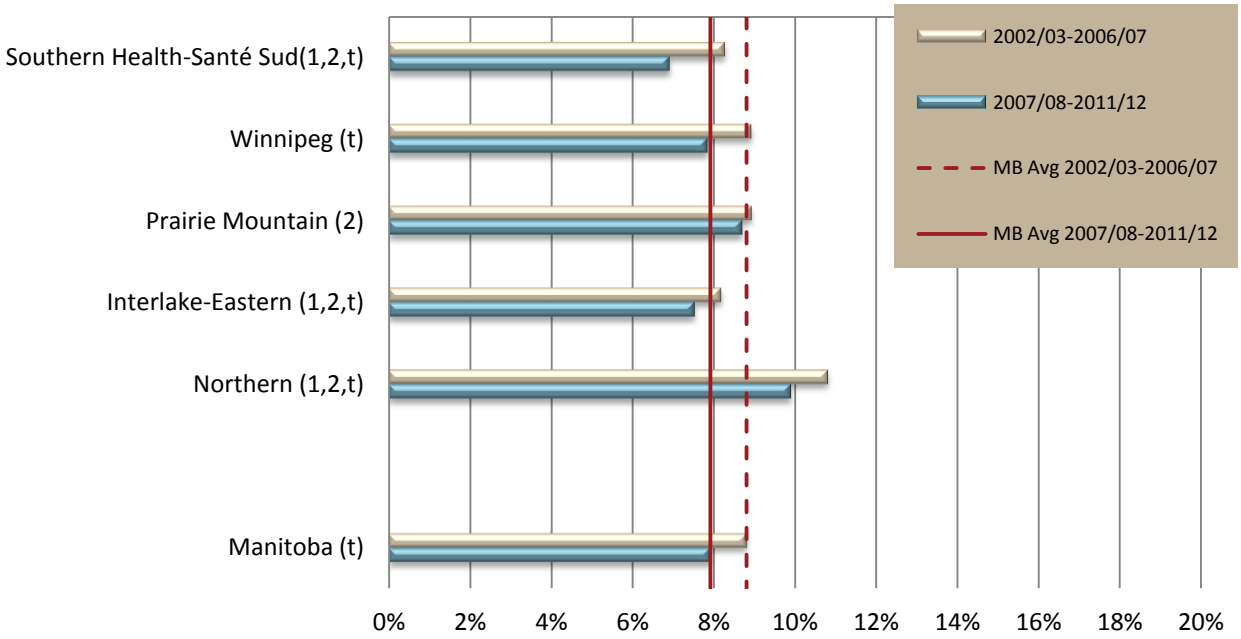
Definition: The percent of residents with ischemic heart disease (IHD) in residents age 19 or older. It is defined by a combination of data including physician visits, hospitalizations, and prescription drugs over a five-year period.

Ischemic heart disease is also known as "coronary artery disease". It develops when the coronary arteries (the major blood vessels that supply our heart with blood, oxygen, and nutrients) become damaged or diseased. Plaque can build up in the arteries which decrease blood flow to the heart. Eventually, the decreased blood flow may cause chest pain, shortness of breath and can lead to a heart attack. Often, IHD can develop over decades unnoticed.

Key Findings

- As shown in **Figure 22**, IHD prevalence decreased significantly in Manitoba from 8.8% to 7.9%. This decrease was reflected in all regions except Prairie Mountain.
- For Southern Health-Santé Sud, IHD prevalence did show a significant decrease from 8.3% to 6.9% of the population aged 19 and older.
- There was large variation within districts, ranging from 4.5% in Altona to over 9.0% in Seven Regions. Significant decreases over time were observed in many of the districts. IHD prevalence was lower than the provincial average in the following districts: Stanley, Altona, Taché, Lorne/Louise/Pembina, and MacGregor. See **Figure 23**.

Figure 22. Prevalence of Ischemic Heart Disease by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent residents aged 19+ diagnosed with disease.



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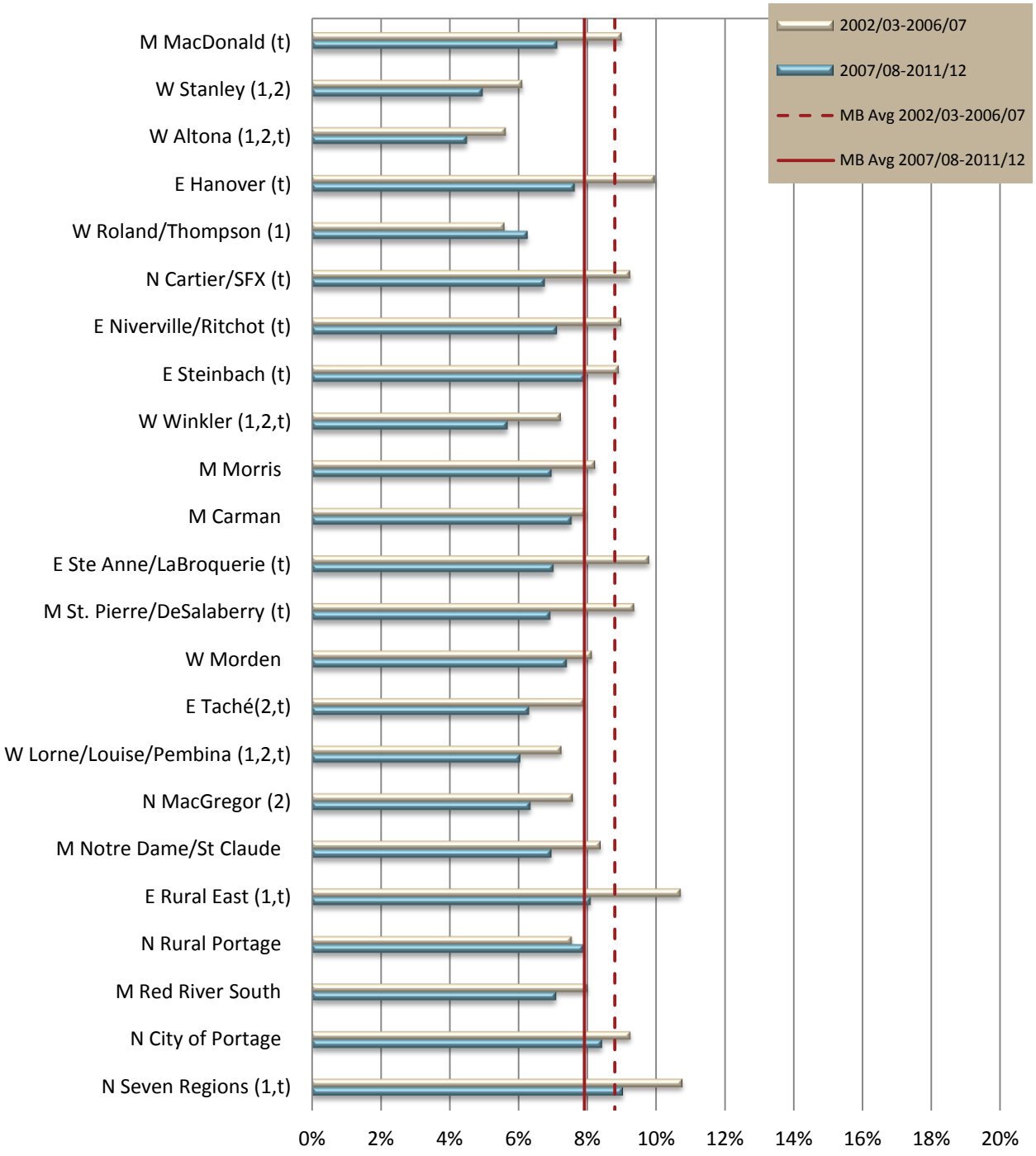
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 23. Prevalence of Ischemic Heart Disease by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent residents aged 19+ diagnosed with disease.



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s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Heart Attack (AMI) Rates

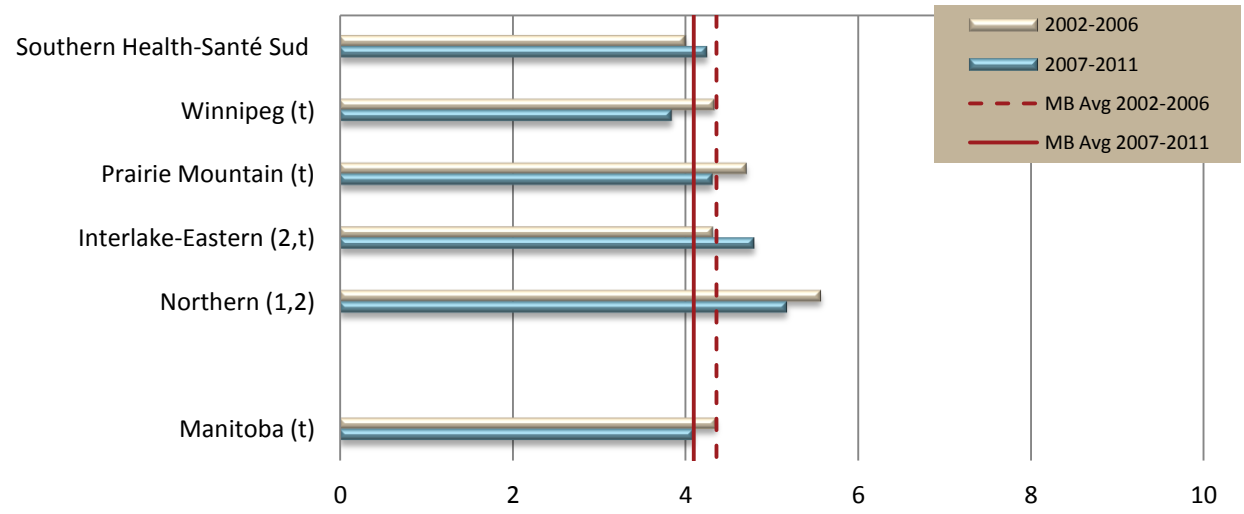
Definition: The rate of death or hospitalization due to acute myocardial infarction (AMI) per 1,000 residents age 40 or older over a five-year period. It is defined by a hospitalization (of at least 3 days), or AMI listed as a cause of death.

Acute myocardial infarction is the medical term for "heart attack". It is a leading cause of death in Canada. A heart attack usually occurs when a blood clot blocks the flow of blood through a coronary artery. The interrupted blood flow that occurs during a heart attack can damage or destroy part of the heart muscle.

Key Findings

- As shown in **Figure 24**, AMI rates for Manitobans decreased significantly over time from 4.36 to 4.09 per 1,000 residents age 40 and older per year. Rates in Winnipeg and Prairie Mountain Health decreased, while Interlake-Eastern increased.
- For Southern Health-Santé Sud, AMI rate did increase from 4.00 to 4.24 (per 1,000 residents age 40 and older), however this increase was not significant.
- There was large variation within districts, however only Carman and Rural Portage rates increased significantly over time. See **Figure 25**.

Figure 24. Heart Attack (AMI) Rate by RHA, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents aged 40+.



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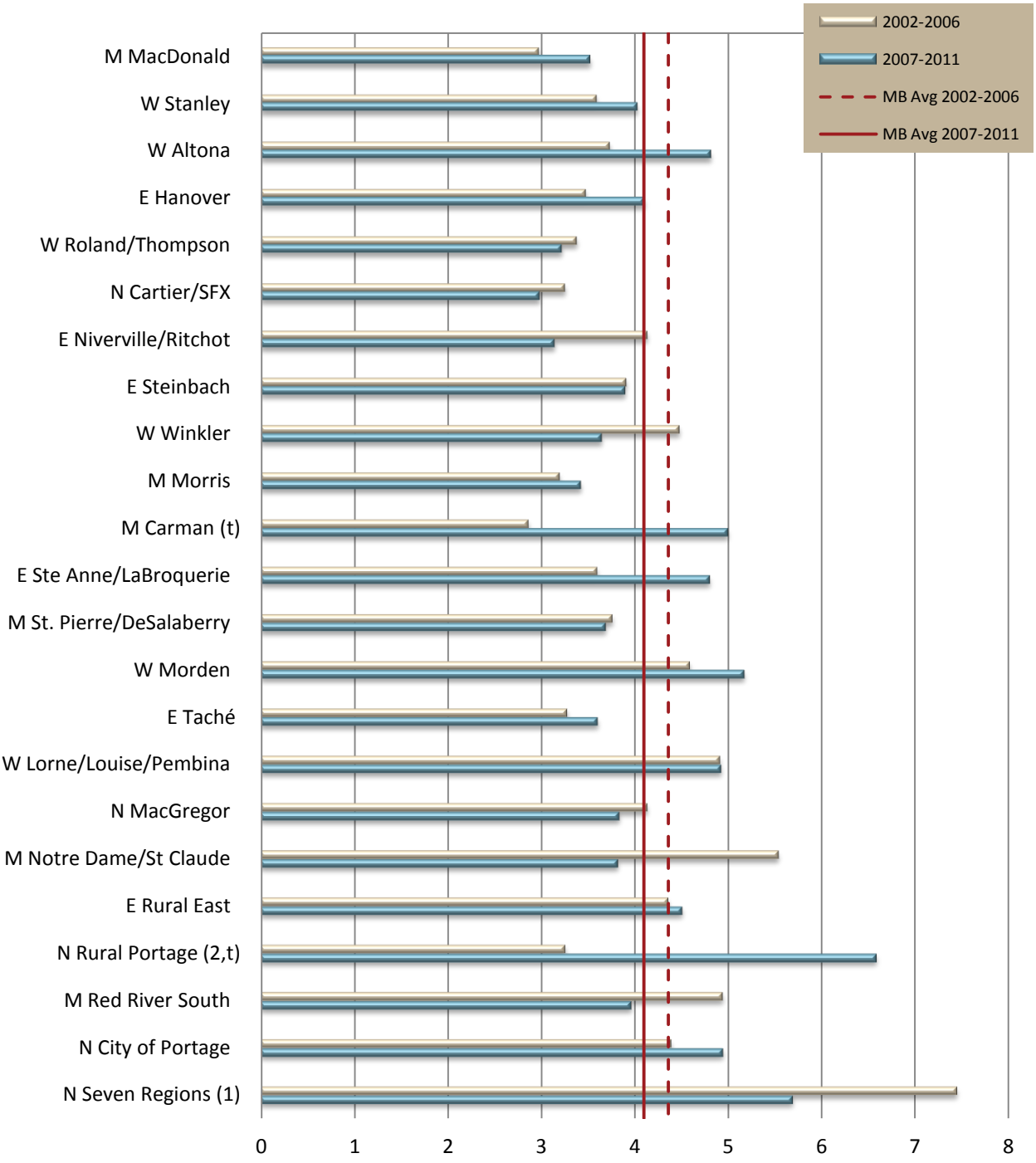
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 25. Heart Attack (AMI) Rate by District, Southern Health-Santé Sud, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents aged 40+.



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Stroke Rates

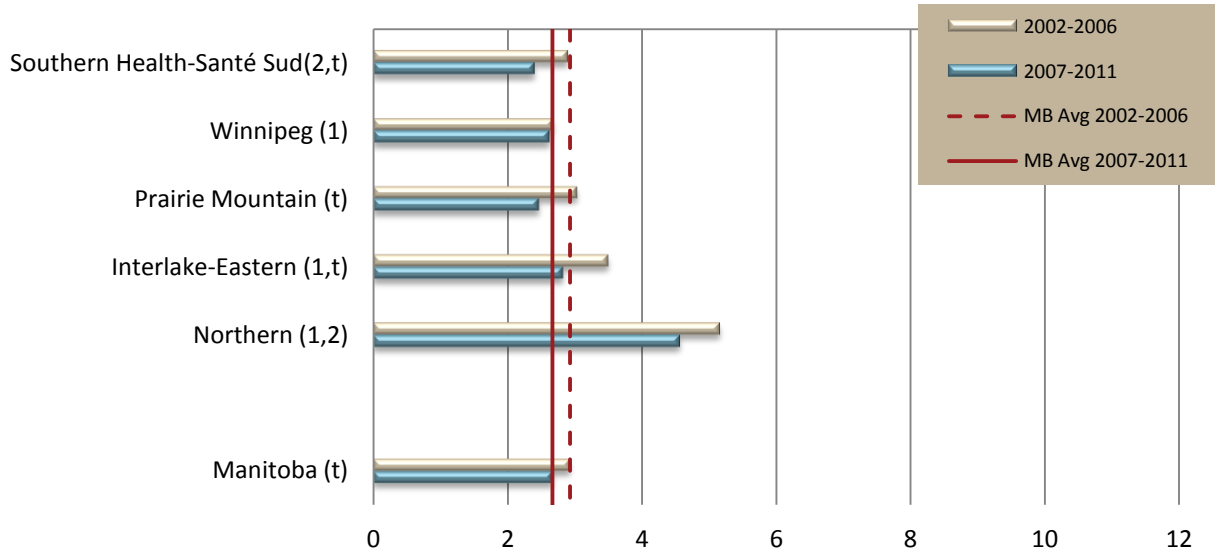
Definition: The rate of death or hospitalization due to stroke per 1,000 residents age 40 or older over a five-year period. It is defined by a hospitalization or stroke listed as a cause of death.

Stroke is an important cause of death and disability in Canada. Six percent of all deaths in Canada are due to stroke, with more than 14,000 Canadians dying from stroke each year. A stoke occurs when the blood supply to part of a brain is interrupted or severely reduced, depriving brain tissue of oxygen and food. Within minutes, brain cells begin to die. Prompt treatment is crucial and early action can minimize brain damage.

Key Findings

- As shown in **Figure 26**, the stroke rate for Manitobans decreased significantly over time from 2.93 to 2.66 per 1,000 residents age 40 and older per year. Rates in Northern were the highest in the province.
- For Southern Health-Santé Sud, the stroke rate did decrease over time from 2.89 to 2.39 (per 1,000 residents age 40 and older). This rate was below the Manitoba average and the change was significant over time.
- There was variation within districts, and some areas were suppressed due to small numbers. However the rate for Morris, Morden, and MacGregor decreased significantly over time. See **Figure 27**.

Figure 26. Stroke Rate by RHA, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death or hospitalization for stroke per 1,000 residents aged 40+.



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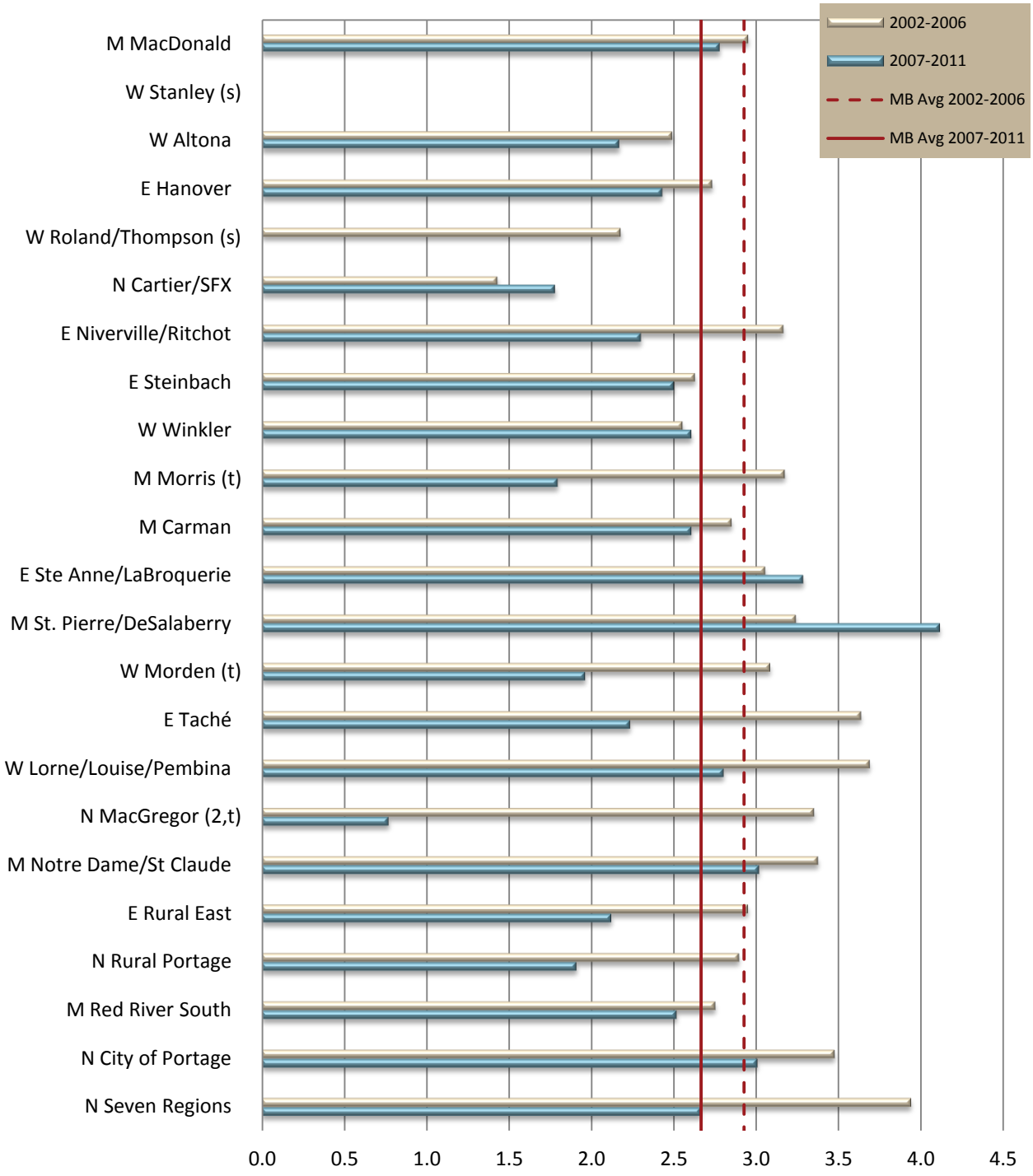
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 27. Stroke Rate by District, Southern Health-Santé Sud, 2002-2006 and 2007-2011.
Age- and sex-adjusted average annual rate of death or hospitalization for stroke per 1,000 residents aged 40+.



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

3.5.2. Cancer

Cancer Incidence

Definition: The age standardized rate of all new cases of cancer per 100,000 population.

Cancer is a term used to describe a group of 200+ diseases. The common feature of these diseases is that abnormal cells divide without our bodies' usual biological growth control mechanisms. They are then able to invade surrounding tissue and spread to other parts of the body (metastasize) through our blood and lymph systems. Most types of cancer are named for the organ they start in, and/or the type of cell that is involved.

Cancer is another major cause of death across Canada – especially premature death. Manitoba's cancer patient journey initiative known as "**IN SIXTY**" aims to reduce the time of suspicion of cancer to first treatment to no longer than 60 days by 2016. Improvements across the health care system are being made to improve the cancer system for all Manitobans.

Key Findings

- As shown in **Table 3**, in Manitoba, the incidence (number of new cancer diagnosis) has remained fairly stable over time at 471.2 new cases per 100,000 population. This incidence rate is generally similar to other provincial rates and the Canadian national rate.
- For Southern Health-Santé Sud, cancer incidence overall is 434.2 per 100,000 which is significantly lower than the Manitoba average.
- Cancer incidence varies by type and region (see **Table 4** to **7**)
  - Lung cancer incidence rates are similar to the province, except Northern is significantly higher.
  - Breast cancer incidence rates are similar to the province, except Northern is somewhat lower.
  - Prostate cancer incidence rates are similar to the province, except Interlake-Eastern is somewhat higher.
  - Colorectal cancer incidence rates are similar to the province, except Northern is somewhat higher.

Table 3. Cancer Incidence, by RHA, total-all invasive cancer types 2008-10.
Age-standardized incidence rates per 100,000 people

Regional Health Authority	Age-standardized rate
Southern Health-Santé Sud	434.2*
Winnipeg	475.7
Prairie Mountain	476.5
Interlake-Eastern	471.8
Northern	523.3
Manitoba	**471.2**

*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Table 4. Lung Cancer Incidence, by RHA, 2008-10.
Age-standardized incidence rates per 100,000 people.

Regional Health Authority	Age-standardized rate
Southern Health-Santé Sud	60.7
Winnipeg	67.9
Prairie Mountain	72.7
Interlake-Eastern	67.8
Northern	115.1*
Manitoba	**68.8**

*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Table 5. Breast Cancer Incidence, by RHA, 2008-10.
Age-standardized incidence rates per 100,000 women.

Regional Health Authority	Age-standardized rate
Southern Health-Santé Sud	112.4
Winnipeg	127.9
Prairie Mountain	113.7
Interlake-Eastern	126.1
Northern	92.1
Manitoba	**122.6**

*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Table 6. Prostate Cancer Incidence, by RHA, 2008-10.
Age-standardized incidence rates per 100,000 men.

Regional Health Authority	Age-standardized rate
Southern Health-Santé Sud	116.2
Winnipeg	117.4
Prairie Mountain	108.7
Interlake-Eastern	126.5
Northern	101.7
Manitoba	**116.4**

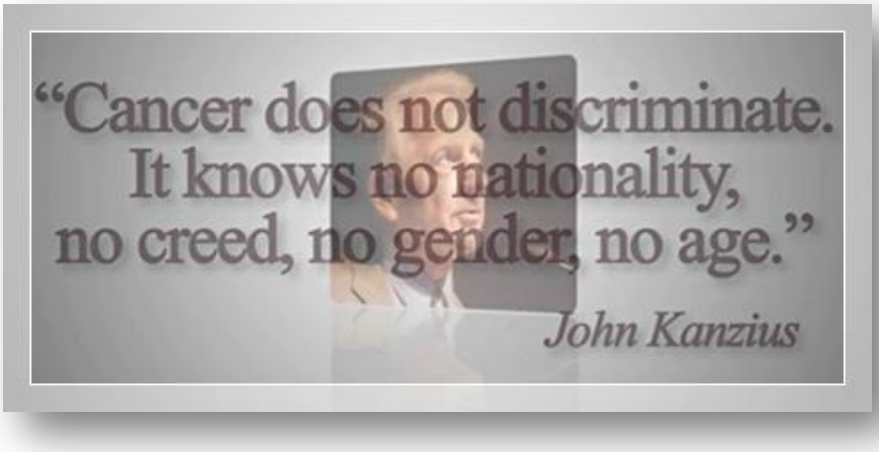
*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Table 7. Colorectal Cancer Incidence, by RHA, 2008-10.
Age-standardized incidence rates per 100,000 men.

Regional Health Authority	Age-standardized rate
Southern Health-Santé Sud	64.2
Winnipeg	65.2
Prairie Mountain	76.4
Interlake-Eastern	74.8
Northern	84.5
Manitoba	**68.3**

*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

> *Reporting region-specific incidence can help focus efforts to prevent and reduce the burden of cancer in Manitoba. Ideally, cancer incidence should be reduced in all regions across the province.*
> *-CancerCare Manitoba*



Cancer Mortality

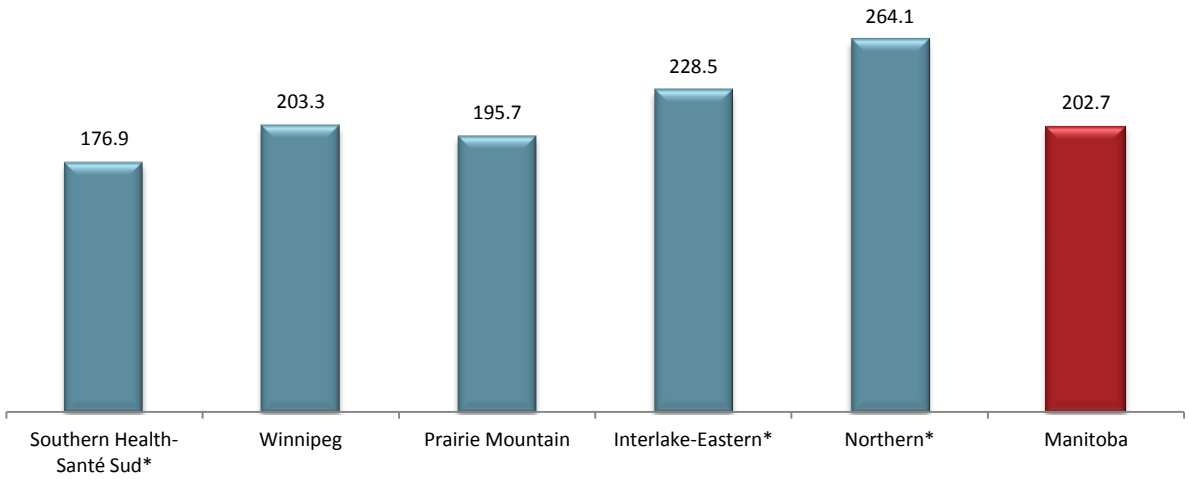
Definition: The age standardized rate of death due to cancer (and by top four common types) per 100,000 population.

The leading cause of cancer deaths provides important information to see where cancer prevention strategies should be targeted.

Key Findings

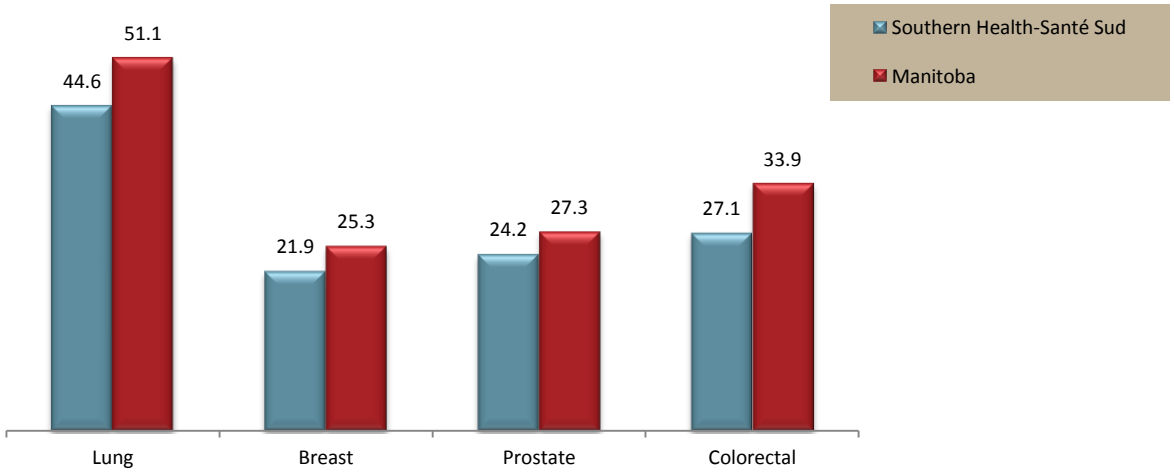
- As shown in **Figure 28**, total cancer mortality for Manitoba was at 202.7 deaths per 100,000 population. Over the past few decades cancer mortality has decreased for Manitobans, and has been similar to the national rate.
- For the Southern Health-Santé Sud, cancer mortality (total-all invasive) was significantly below the Mantioba average – 176.9 per 100,000 between 2008-10.
- For all leading causes of cancer, mortality for Southern Health-Santé Sud was somewhat lower compared to the provincial rate (see **Figure 29**).
- Lung cancer has the highest mortality followed by colorectal, prostate, and then breast cancer.

Figure 28. Total All Invasice Cancer Mortality by RHA, 2008-2010.
Age-standardized rate per 100,000 people.



*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Figure 29. Leading Causes of Cancer Mortality, Southern Health-Santé Sud and Manitoba, 2008-2010.
Age-standardized rate per 100,000 people.



*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Cancer Survival

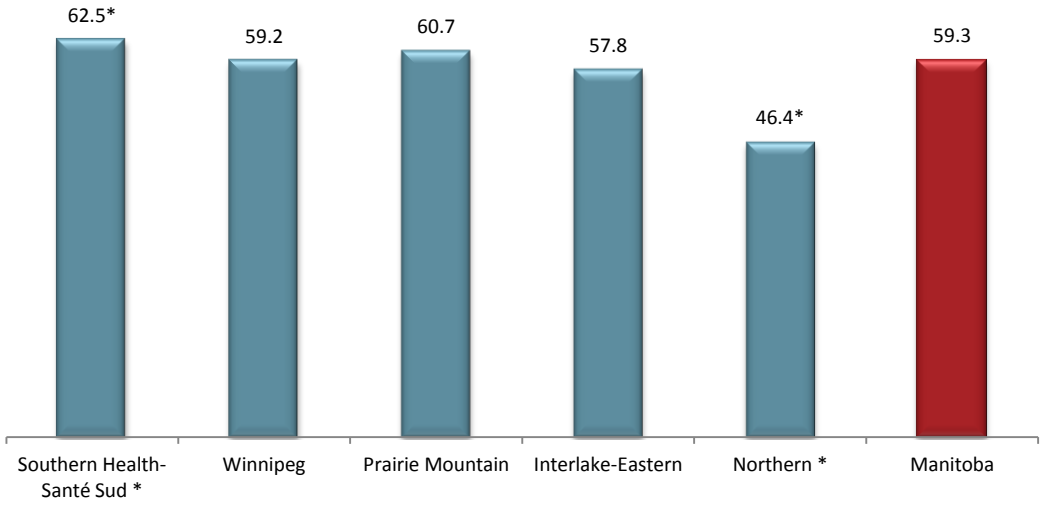
Definition: This indicator measures the percentage of individuals who have been diagnosed with cancer, who are still alive during a five-year time interval.

Five-year relative survival ratio is a way of comparing survival of people who have cancer with those who don't. It shows how much cancer shortens life, and is an important indicator showing the advancement of cancer treatments. Better survival is often an indication of better access to screening, diagnostic testing, as well as, effective treatment. Cancer survival is poorest when the disease is found at later stages.

Key Findings

- As shown in **Figure 30**, overall cancer survival for Manitoba was 59.3% from 2008-10, which was similar to the previous estimate of 59.4%.
- For Southern Health-Santé Sud, cancer survival was the highest rate among regions at 62.5% overall. This rate was also significantly higher compared to the provincial average.
- As shown in **Table 8**, five-year survival was highest in patients diagnosed with prostate cancer, followed by those diagnosed with breast, colorectal, and lung cancers.
- Lung cancer had the highest mortality and lowest survival rate. However, it is important to note that Manitoba had the best lung cancer survival rate in Canada – and this is even true when compared to many other countries in the world.
- Survival rates by types of cancer vary somewhat, but not significantly among regions.

Figure 30. Cancer Survival by RHA, 2008-2010.
Age-standardized five-year relative survival (%).



*Significantly different from Manitoba rate (p<0.05).
Source: Manitoba Cancer Registry

Table 8. Cancer Survival by Type, by RHA, 2008-10.
Age-standardized five-year relative survival (%).

Regional Health Authority	Lung	Breast	Prostate	Colorectal
Southern Health-Santé Sud	17.3	84.7	94.8	70.1
Winnipeg	22.8	85.4	91.6	60.3
Prairie Mountain	20.4	89.0	92.3	64.7
Interlake-Eastern	20.8	76.9*	91.2	62.2
Northern	21.9	78.4[1]	74.7*[1]	35.3*[1]
Manitoba	**21.7**	**84.9**	**91.7**	**61.6**

*Significantly different from Manitoba rate (p<0.05).
[1]Interpret with caution due to low numbers.
Source: Manitoba Cancer Registry

[sur • vi • vor]
To beat the odds, one with great courage and strength, a true inspiration

3.5.3. Mental Illness

Mood and Anxiety Disorder Prevalence

Definition: The percent of residents (age 10+) with mood and anxiety disorder over a five-year period. This is a new indicator which was previously reported separately for depression and for anxiety.

Mood and anxiety disorders include: depression; episodic mood disorders (bipolar, manic); anxiety (anxiety, phobic, obsessive-compulsive); dissociative and somatoform disorders; and adjustment reaction. Over one million Canadians suffer from some form of depressive illness.

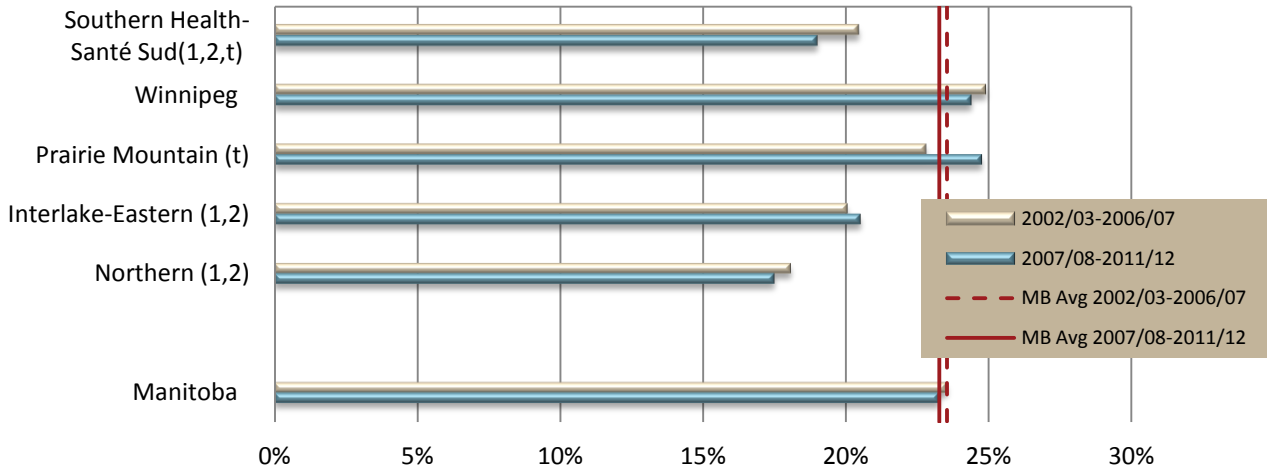
Key Findings

- As shown in **Figure 31**, the prevalence of mood and anxiety disorders was stable over time in Manitoba, with a small decrease from 23.5% to 23.3%. Prairie Mountain rates had a significant increase over time.
- For Southern Health-Santé Sud, prevalence for mood anxiety decreased from 20.5% to 19% - this was a significant change and a lower rate compared to Manitoba.
- In terms of actual numbers (crude rates), mood and anxiety disorder affects nearly 28,000 – or approximately 1 in 5 residents.
- As shown in **Figure 32**, mood and anxiety prevalence rates ranged within the region from a low of 12.8% in MacGregor to a high of 23% in Notre Dame/St Claude – however these were still lower than provincial averages.

Mental illnesses can take many forms, just as physical illnesses do. Mental illnesses are still feared and misunderstood by many people....but the fear will disappear as people learn more about them.

Many people have mental health concerns from time to time – but it becomes an illness when ongoing signs and symptoms cause frequent stress and affect ability to function day to day.

Figure 31. Prevalence of Mood and Anxiety Disorders by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of residents aged 10+ diagnosed with a disorder.



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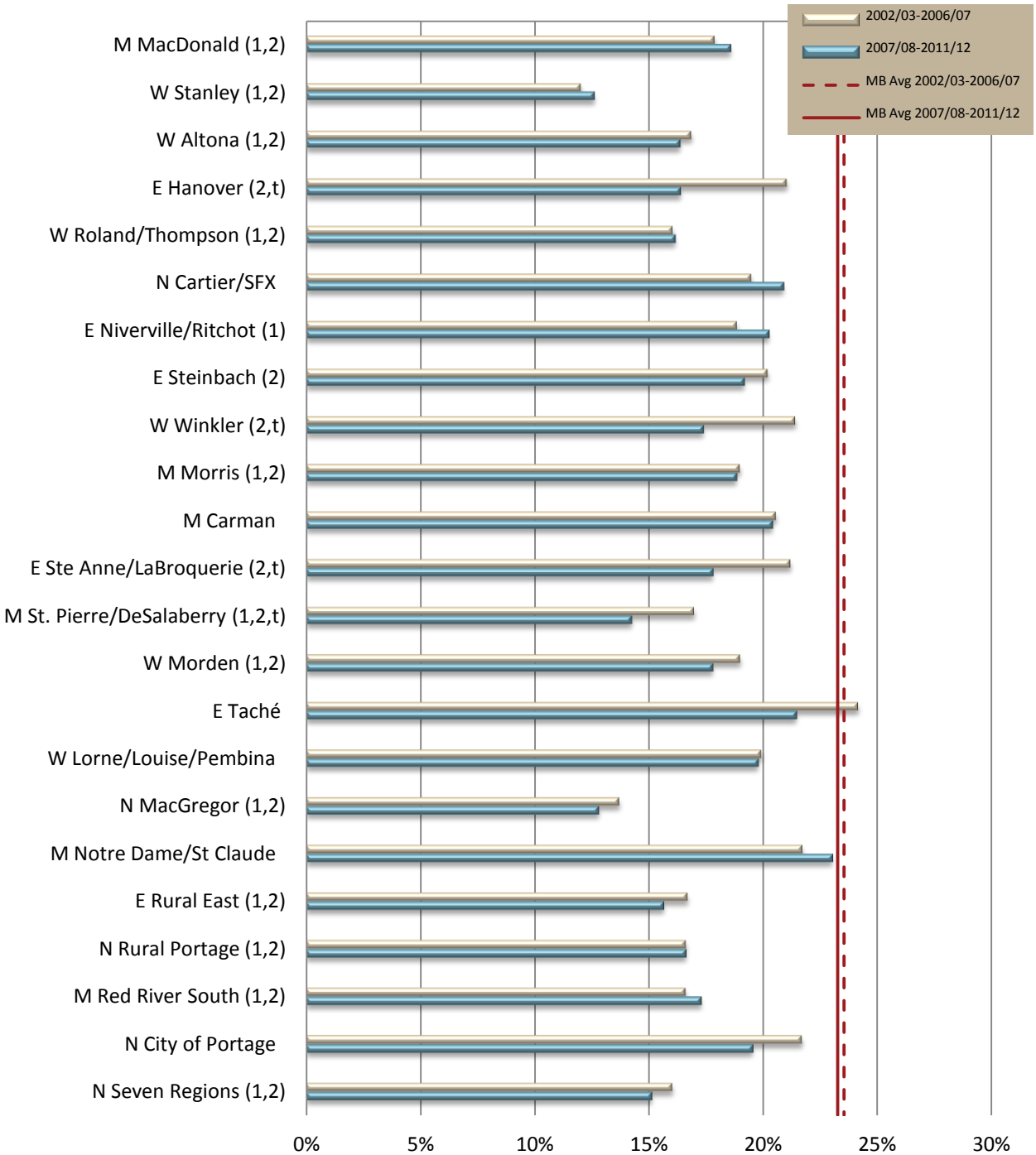
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 32. Prevalence of Mood and Anxiety Disorders by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.

Age- and sex-adjusted percent of residents aged 10+ diagnosed with a disorder.



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Source: MCHP, RHA Atlas 2013

Dementia Prevalence

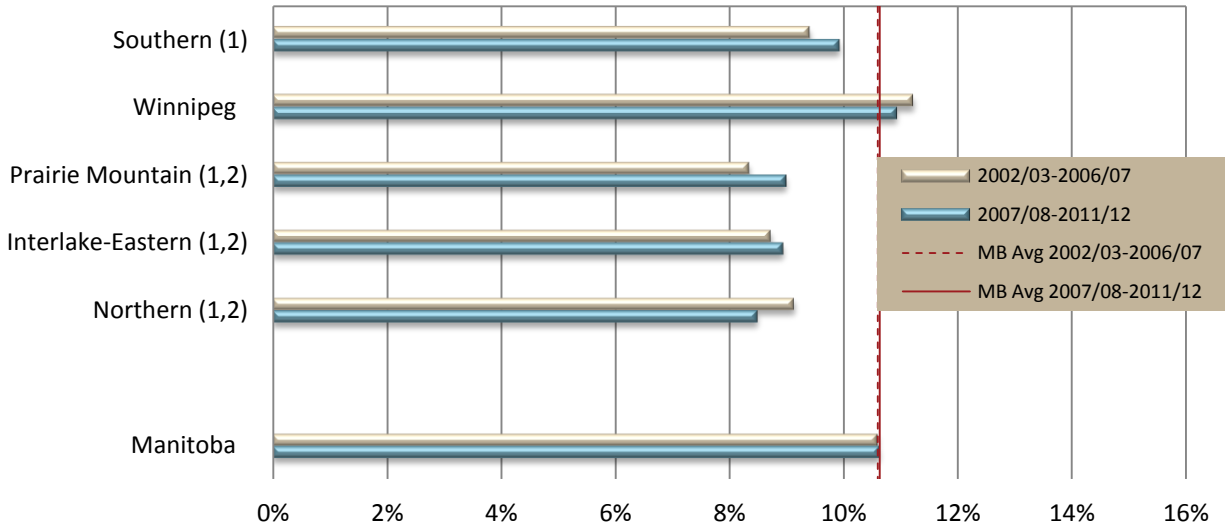
Definition: The percent of residents (age 55+) with dementia over a five-year period.

Dementia is not a specific disease. It is a term that describes a wide range of symptoms associated with a decline in memory or thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease is the most common and accounts for 60 to 80 percent of cases. Vascular dementia, which occurs after a stroke, is the second most common dementia type. Incidence and prevalence of dementia is expected to rise considerably with the aging population.

Key Findings

- As shown in **Figure 33**, the prevalence of dementia was stable over time in Manitoba at 10.6% of the population aged 55 and older.
- For Southern Health-Santé Sud, prevalence of dementia increased from 9.4% to 9.9%, although this was not a significant change.
- Prevalence rates ranged within the region from 6.8 to 12.9% as shown in **Figure 34**. However, only St Pierre/DeSalaberry was significantly lower at 7.0% compared to the Manitoba average. As well, rates in Carman and Red River South increased significantly over time.

Figure 33. Prevalence of Dementia by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of residents aged 55+ diagnosed with disorder.



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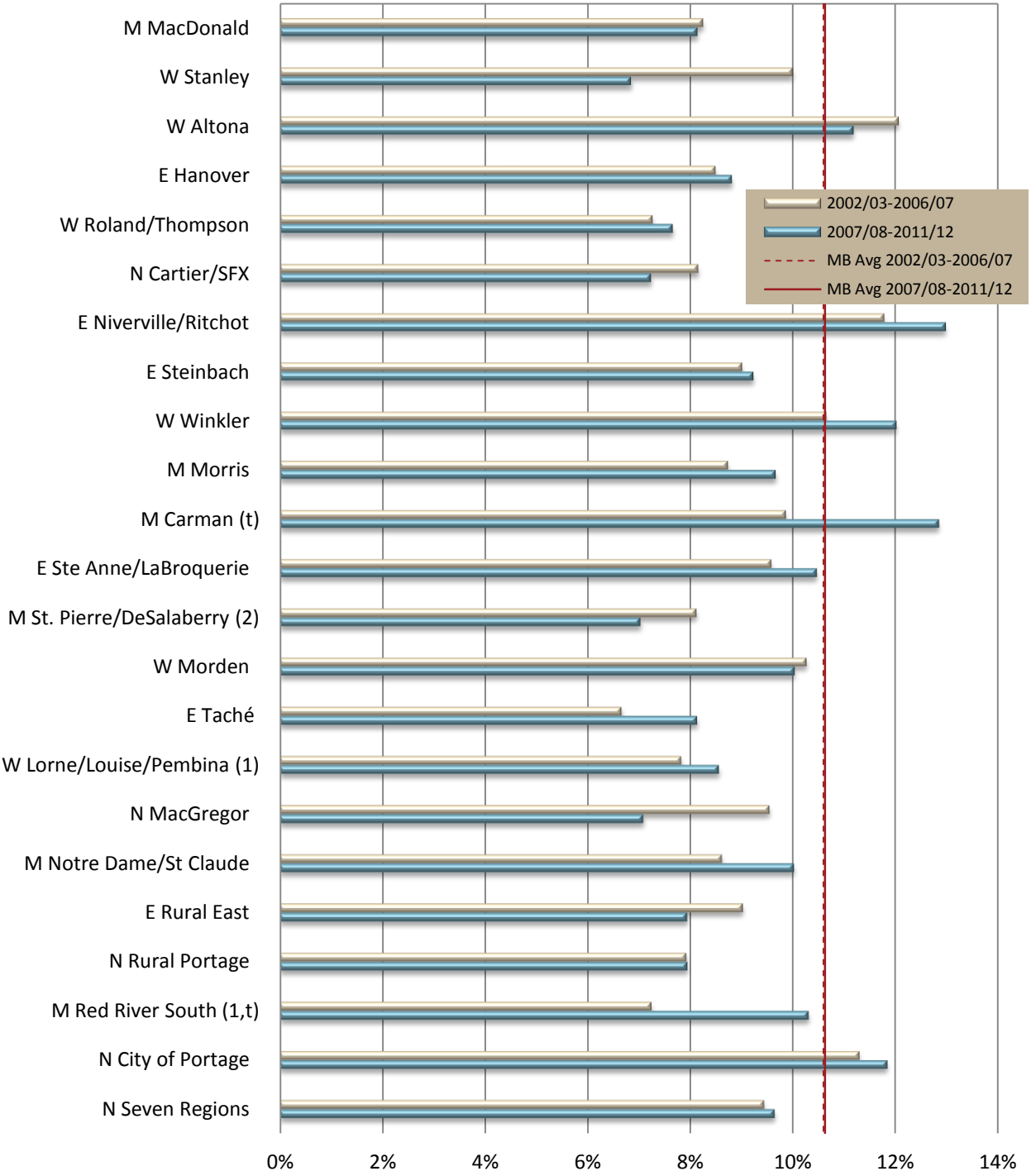
Source: MCHP, RHA Atlas 2013

Figure 34. Prevalence of Dementia by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of residents aged 55+ diagnosed with disorder.



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Source: MCHP, RHA Atlas 2013

Substance Abuse Prevalence

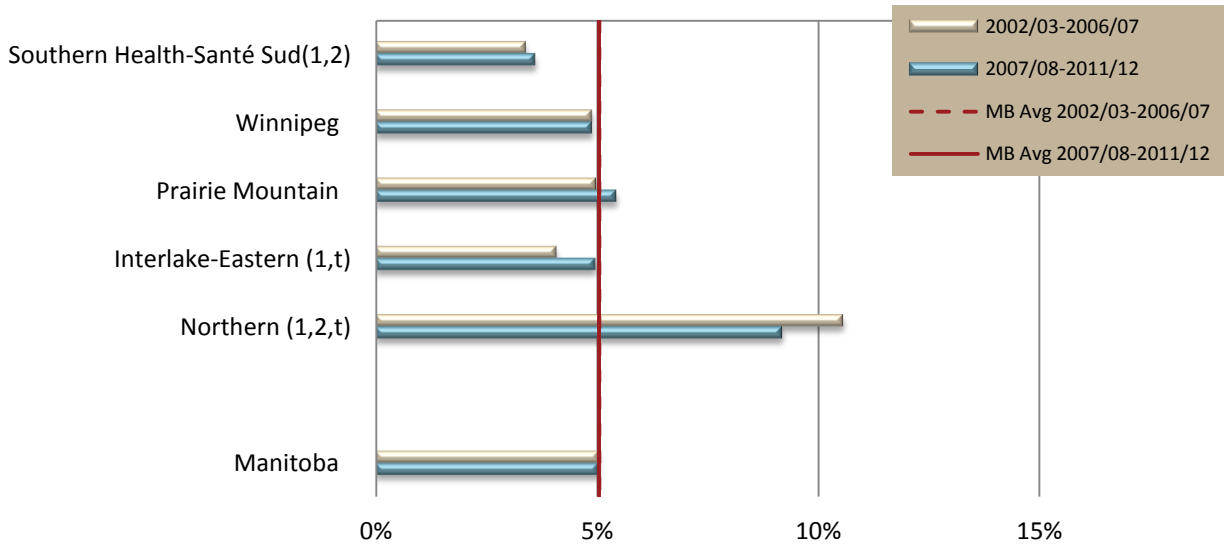
Definition: The percent of residents (age 10+) with substance abuse, over a five-year period. It is defined by at least one hospitalization or physician visit.

Substance abuse includes alcoholic or drug psychoses or dependence. Substance abuse can influence the onset, course, and outcome of mental illness. The links between mental health and substance abuse problems are complex. These problems can develop independently as a result of common risk factors, or can lead to the other as a result of self-medication or prolonged distress.

Key Findings

- As shown in **Figure 35**, the prevalence rate of substance abuse for Manitoba was stable at 5% of residents ages 10 and older. Northern RHA was higher at 9.2% but showed a significant decrease, and Interlake-Eastern showed a significant increase over time.
- For Southern Health-Santé Sud, prevalence for substance abuse increased from 3.4% to 3.6% - a rate that is significantly lower than the Manitoba rate.
- As shown in **Figure 36**, substance abuse prevalence did range somewhat throughout the region, although rates were below the provincial average. Over time, substance abuse prevalence did increase significantly in the following districts: MacDonald, Winkler, Morris, and Morden.

Figure 35. Prevalence of Substance Abuse by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of residents aged 10+ diagnosed with disorder.



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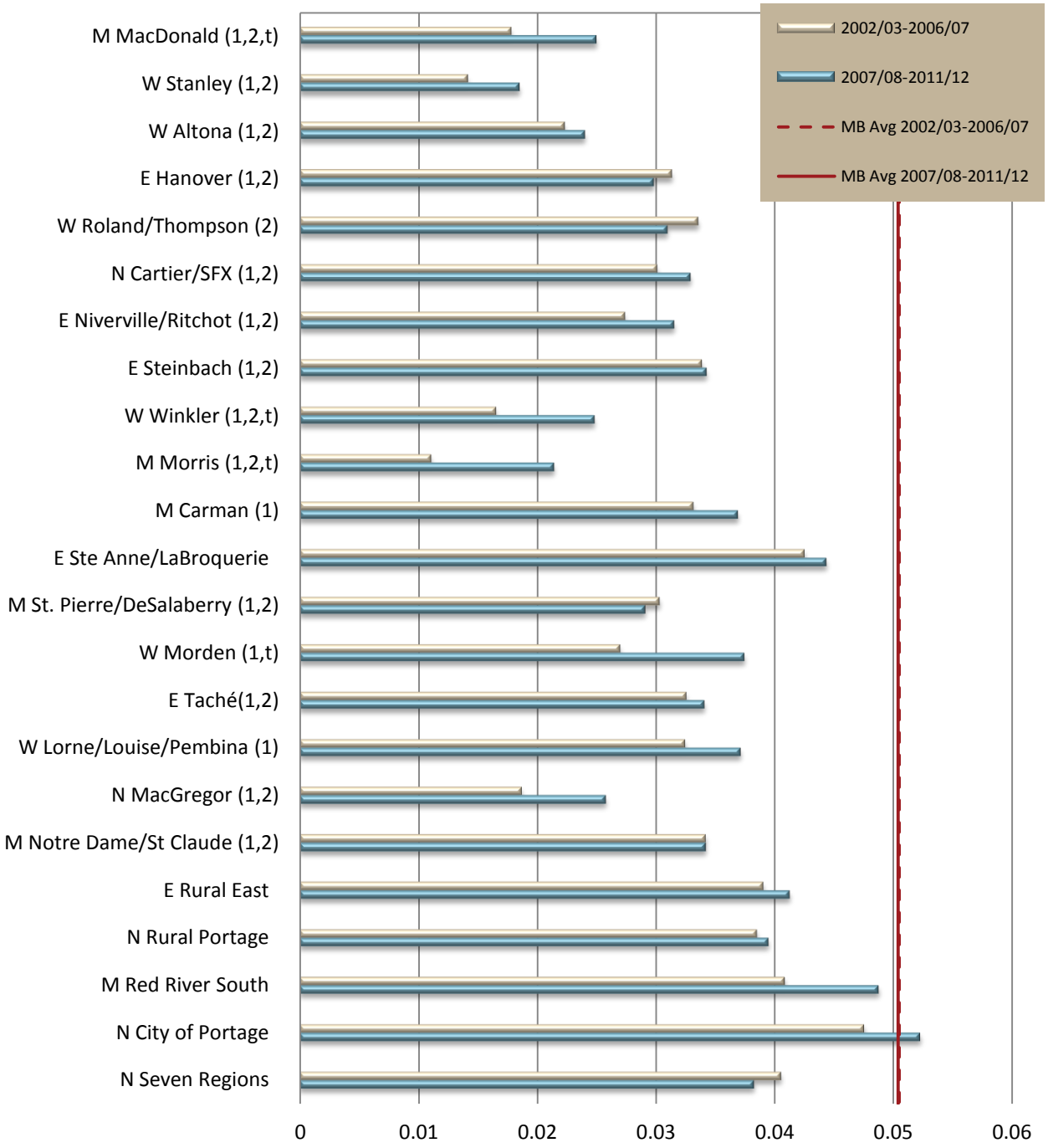
Source: MCHP, RHA Atlas 2013

Figure 36. Prevalence of Substance Abuse by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of residents aged 10+ diagnosed with disorder.



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Source: MCHP, RHA Atlas 2013

3.5.4. Diabetes

Diabetes Prevalence and Incidence

Diabetes is a significant chronic disease which is having a major impact on Canadians and the health care system.

Increase in prevalence of diabetes is likely due to longer survival of people living with diabetes (e.g. better self-care, medications), and early identification efforts of the disease.

Prevalence Definition: The percent of residents (age 19+) with diabetes over a three-year period. This includes both type 1 and type 2 diabetes.

Type 1 diabetes is a chronic condition in which the pancreas produces little or no insulin, a hormone needed to allow sugar (glucose) to enter cells to produce energy. Various risk factors include genetics and exposures to certain viruses. Although type 1 diabetes usually appears during childhood or adolescence, it can begin in adults, too.

Type 2 diabetes is a chronic condition that affects the way your body metabolizes sugar (glucose), either by resisting the effects of insulin or not producing enough insulin to maintain normal glucose levels. Risk factors include obesity, apple-shaped figure, age (65+), sedentary lifestyle, family history, and diabetes in pregnancy. More common in adults, type 2 diabetes increasingly affects children as childhood obesity grows.

Key Findings

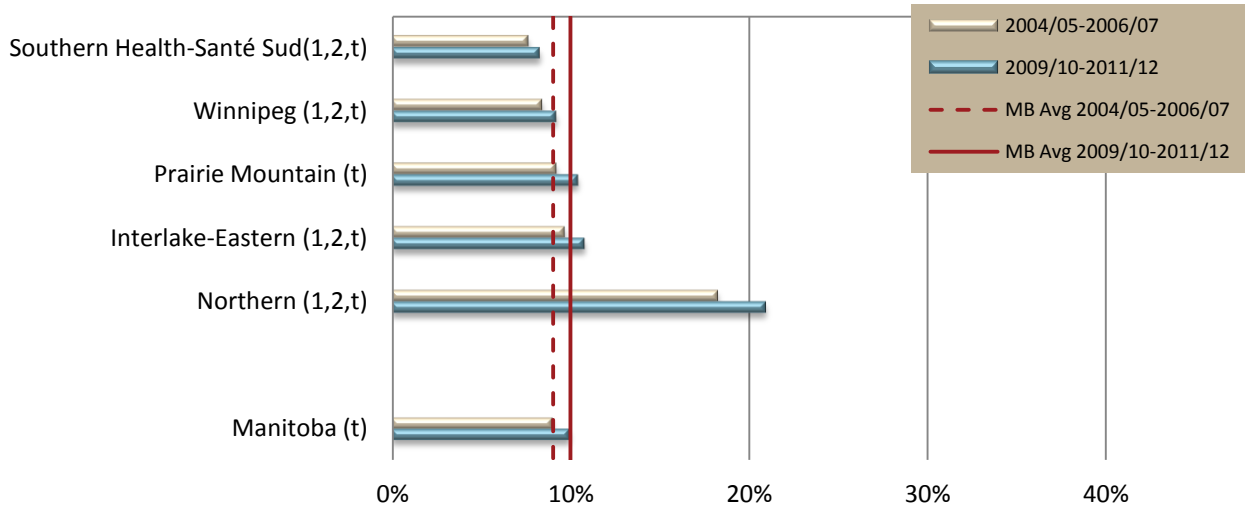
- As shown in **Figure 37**, the prevalence of diabetes for Manitoba increased over time from 8.99% to 9.96% of the population aged 19 and older. All regions showed a significant increase over time, with highest rates in Northern RHA.
- For the Southern Health-Santé Sud, prevalence for diabetes increased from 7.6% to 8.3%. This was a significant increase although lower than Manitoba. Diabetes illness increased from 8,341 to 10,124 residents.
- Diabetes prevalence ranged within the region. See **Figure 39**.
    - The rate was higher than Manitoba in Seven Regions.
    - The rates were lower than Manitoba in the following districts: MacDonald, Stanley, Altona, Hanover, Cartier/SFX, Niverville/Ritchot, Steinbach, Winkler, Morris, Carman, St. Pierre/DeSalaberry, Morden, Taché, MacGregor, and Notre Dame/St. Claude.
    - The rates increased significantly over time in: Rural Portage, and Seven Regions.

Incidence Definition: The number of new cases for residents (age 19+) with diabetes (type 1 or 2) per 100 person years. This is a new indicator.

Key Findings

- As shown in **Figure 38**, the incidence of diabetes in Manitoba decreased from 0.908 to 0.851 cases per 100 person-years.
- For the region, incidence rates decreased from 0.764 to 0.672 cases per 100 person years, which translates to 618 new cases per year.
- Within the region, diabetes incidence rates were significantly higher than Manitoba in Seven Regions district, and showed an increase over time. In the majority of other districts throughout the region, incidence rates tended to decrease over time. See **Figure 40**.

Figure 37. Diabetes Prevalence by RHA, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



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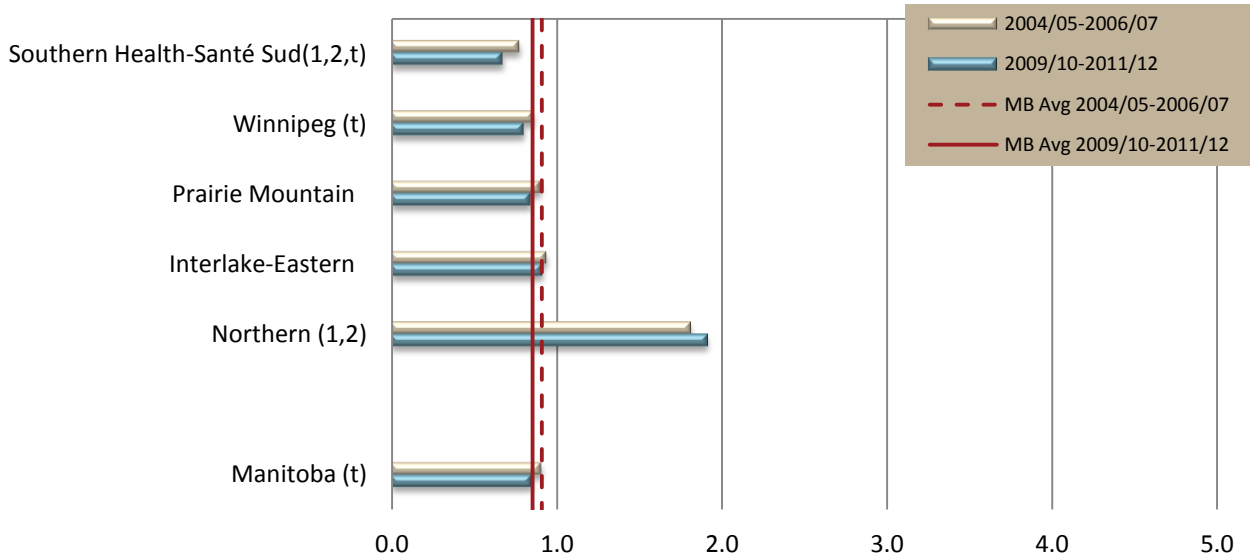
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 38. Diabetes Incidence by RHA, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



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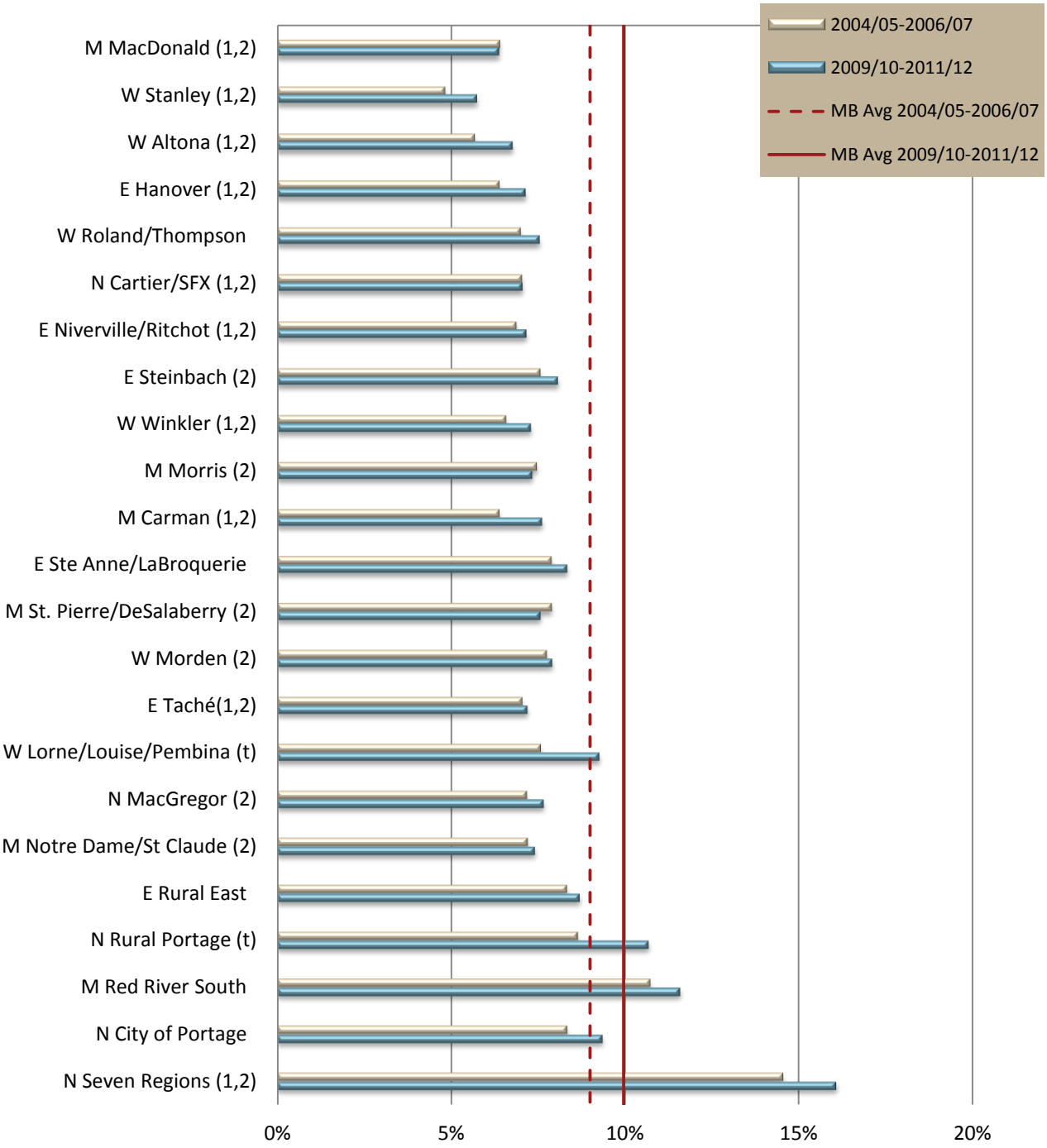
Source: MCHP, RHA Atlas 2013

Figure 39. Diabetes Prevalence by District, Southern Health-Santé Sud, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



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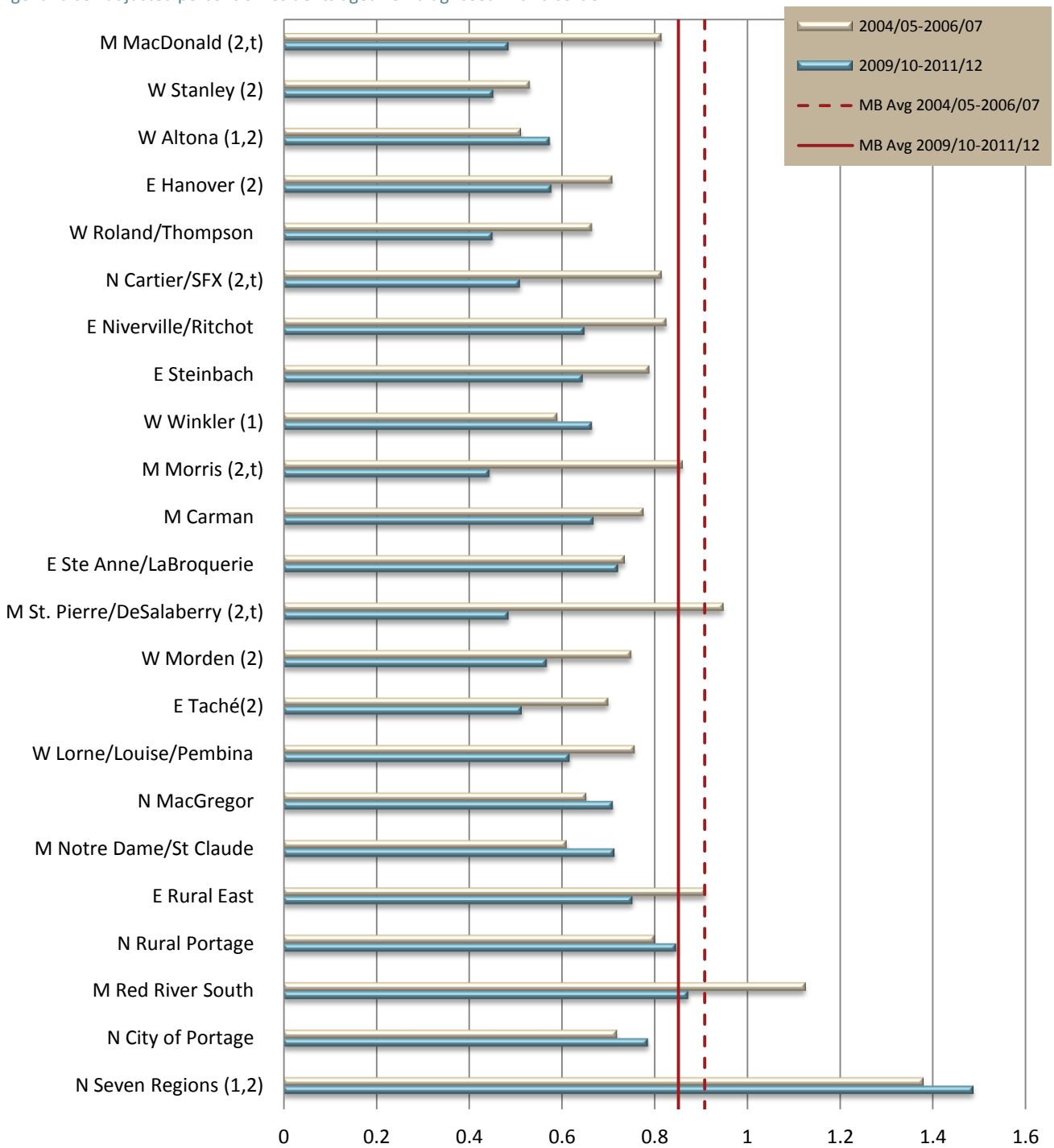
Source: MCHP, RHA Atlas 2013

Figure 40. Diabetes Incidence by District, Southern Health-Santé Sud, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



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Source: MCHP, RHA Atlas 2013

Lower Limb Amputation due to Diabetes

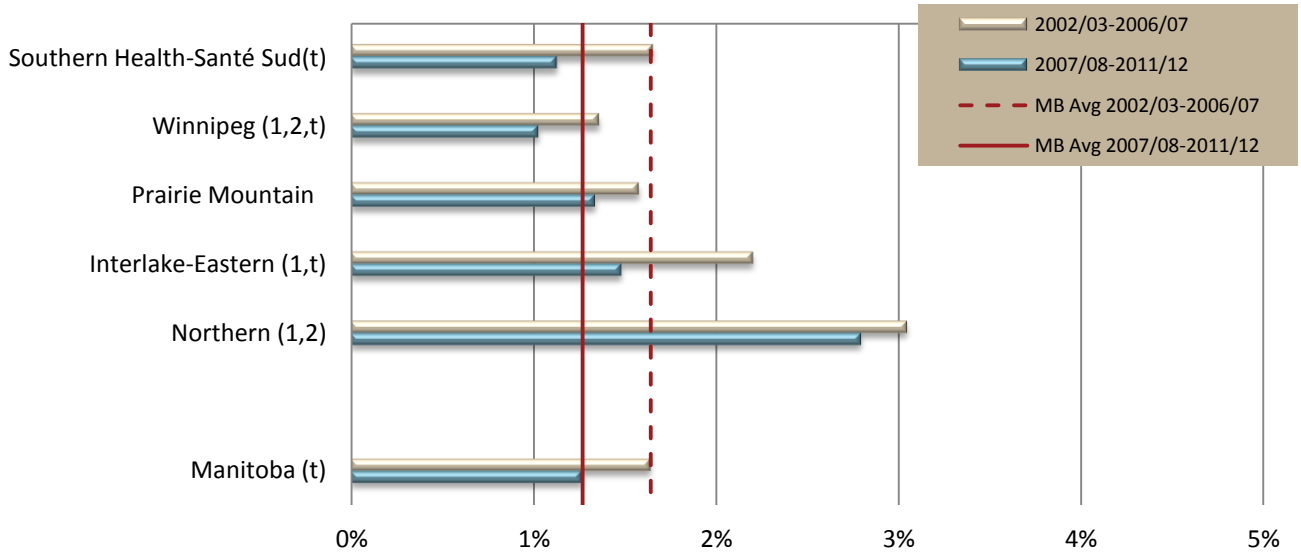
Definition: The percent of residents (age 19+) with diabetes who had a lower limb amputation, over a five-year period. This includes below or including the knee.

Individuals with diabetes, who have lower limb amputation, have higher mortality rates and a lowered quality of life. Treatments are painful and time consuming, requiring frequent hospitalizations with patients needing assistance with daily living. Effective foot care for those with diabetes can often avoid the need for amputation.

Key Findings

- As shown in **Figure 41**, the proportion of people with diabetes who had a lower limb amputation decreased from 1.64% to 1.27%. Decreases were observed in the majority of regions across the province.
- For Southern Health-Santé Sud, the proportion of lower limb amputation among residents with diabetes decreased significantly from 1.65% to 1.13%.
- Within the region, rates were suppressed in many districts due to small numbers as shown in **Figure 42**. What is apparent however, is that rates were higher in districts which included First Nation communities. Highest rates were observed in Seven Regions, which includes Sandy Bay First Nation.

Figure 41. Lower Limb Amputation Among Residents With Diabetes by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Age- and sex-adjusted percent of people with diabetes (aged 19+) who had an amputation in a five-year period



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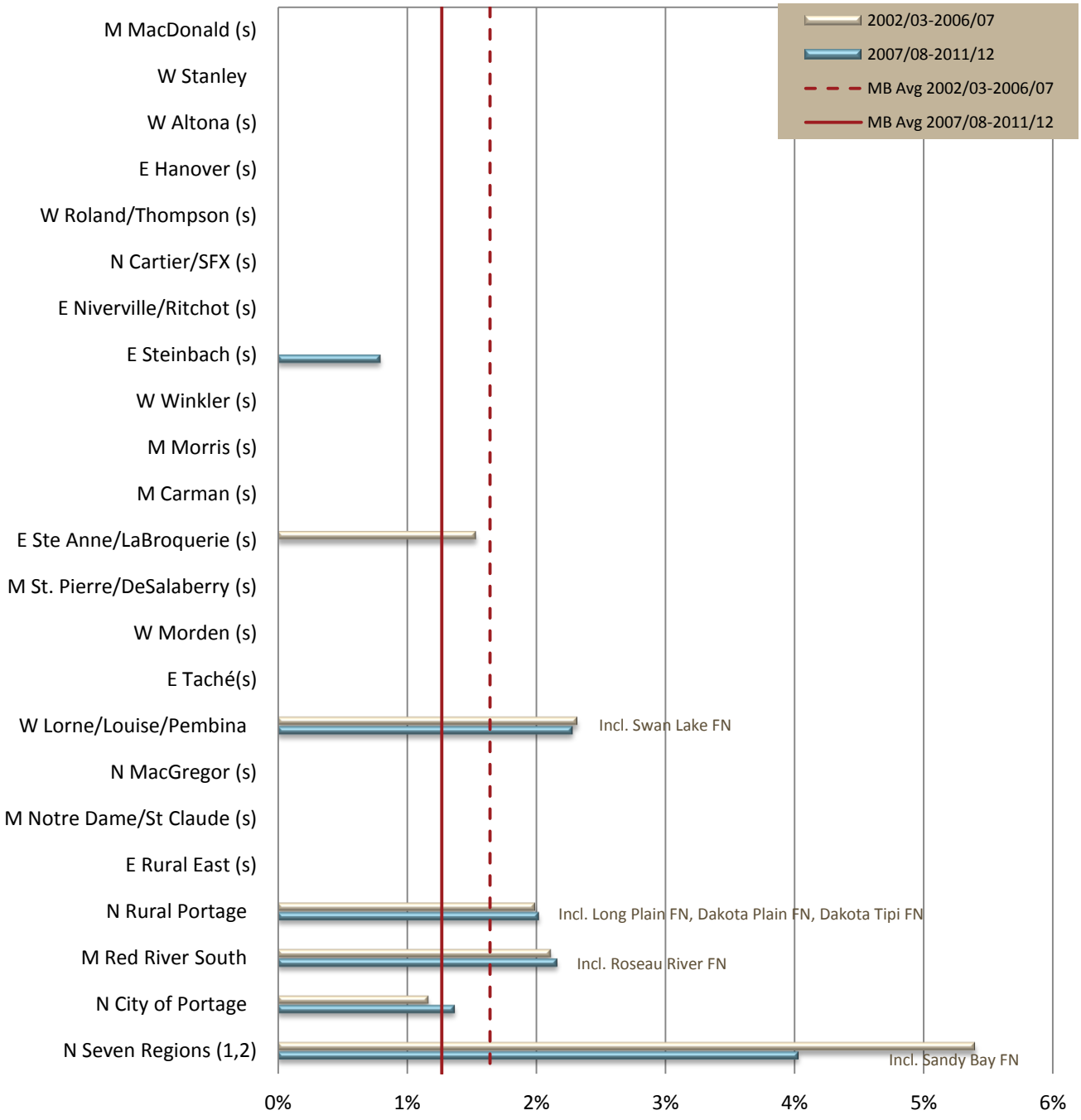
Source: MCHP, RHA Atlas 2013

Figure 42. Lower Limb Amputation Among Residents With Diabetes by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.

Age- and sex-adjusted percent of people with diabetes (aged 19+) who had an amputation in a five-year period



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Source: MCHP, RHA Atlas 2013

3.5.5. Respiratory

Total Respiratory Morbidity Prevalence

Definition: The percent of residents with a respiratory disease in a one-year period.

Total respiratory morbidity includes asthma, chronic or acute bronchitis, emphysema, or chronic airway obstruction.

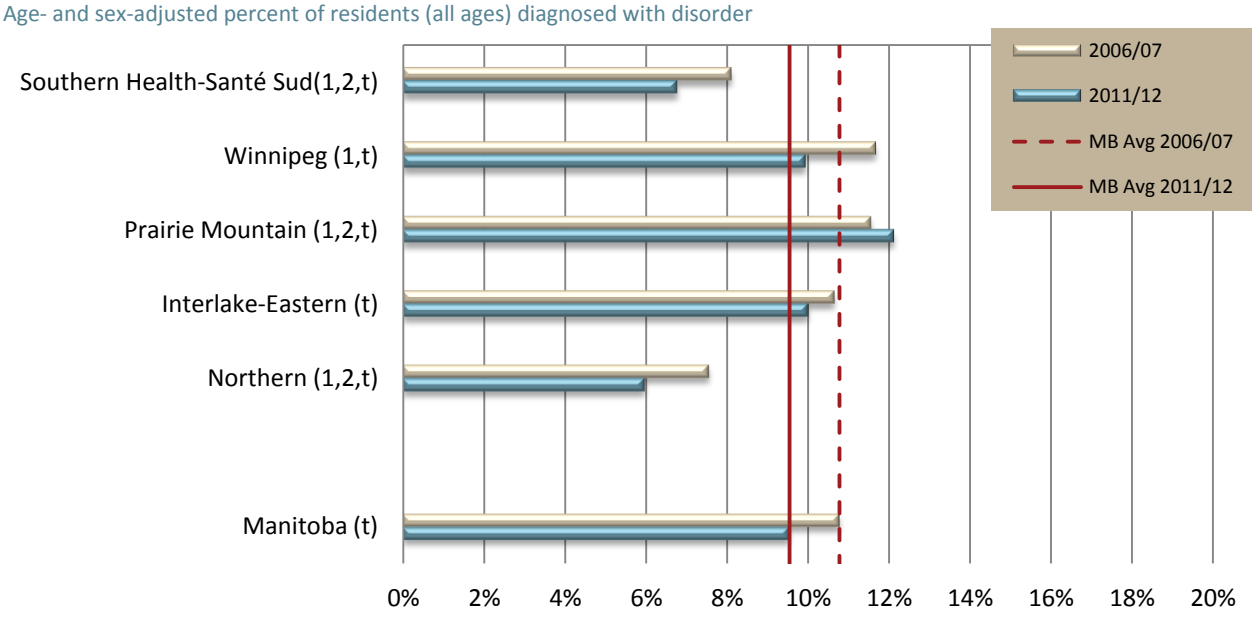
Chronic respiratory diseases affect the airways and other parts of the lung. They affect all ages – children, teens, adults, and seniors.

These diseases all have a major impact not only on the individual with the disease, but on the family, the community, and the health care system.

Key Findings

- As shown in **Figure 43**, total respiratory morbidity prevalence decreased in Manitoba from 10.8% to 9.5% of the population.
- For Southern Health-Santé Sud, total respiratory morbidity prevalence also decreased from 8.1% to 6.8%. This was a significant change over time and lower than the Manitoba rate. Respiratory illnesses affect almost 12,000 residents.
- As shown in **Figure 44**, rates within the region ranged from a low of 2.7% in Stanley district to a high of 10% in Portage City. However, the majority of districts showed rates much lower than Manitoba, and a decreasing trend over time.

Figure 43. Prevalence of Total Respiratory Morbidity by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder



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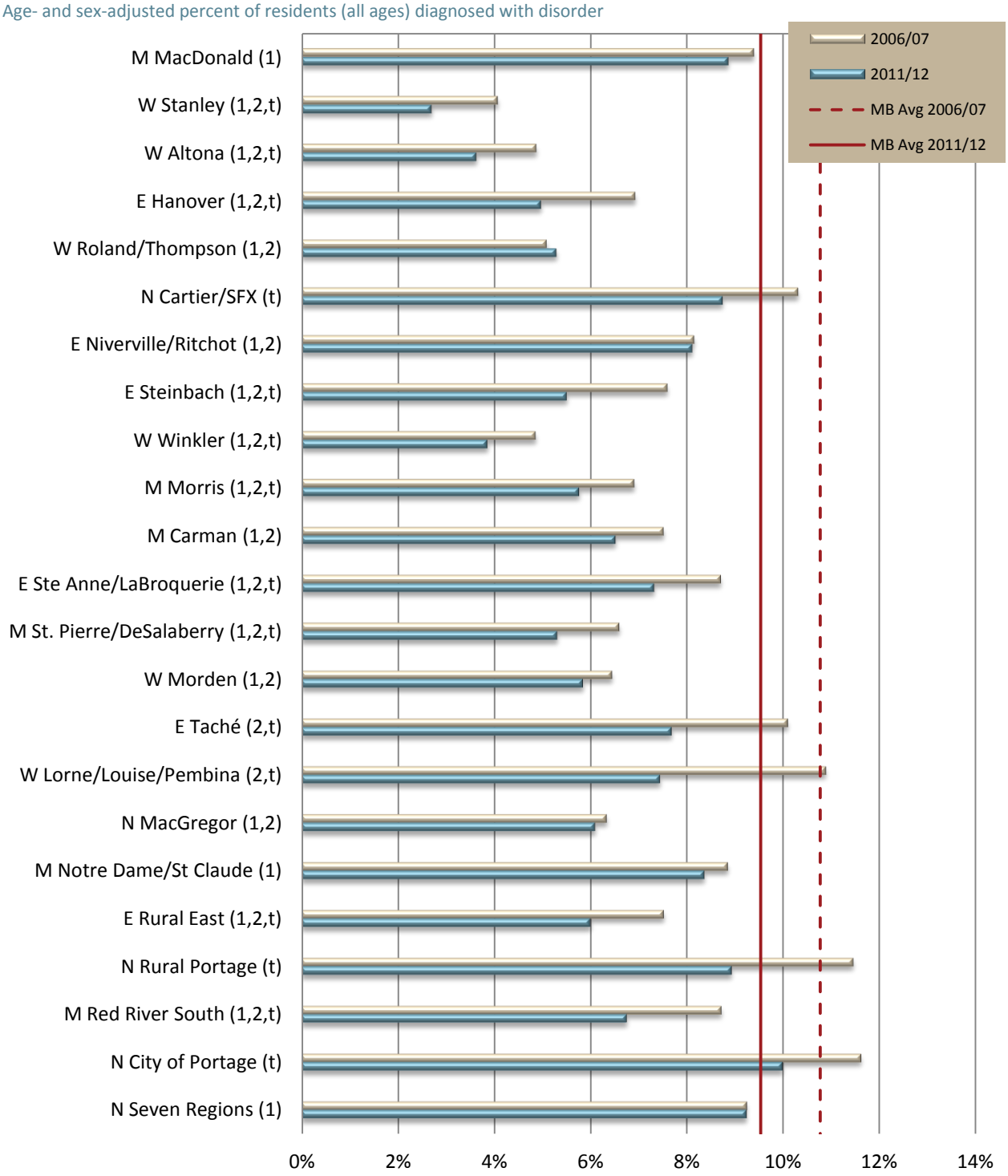
Source: MCHP, RHA Atlas 2013

Figure 44. Prevalence of Total Respiratory Morbidity by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder



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Source: MCHP, RHA Atlas 2013

Asthma Rate

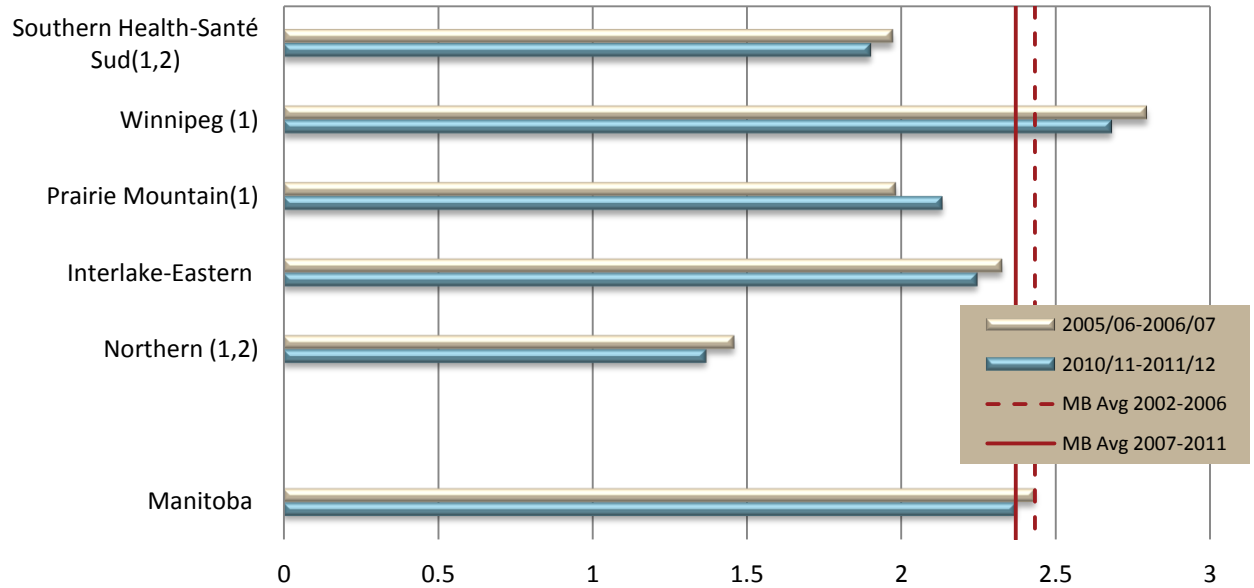
Definition: The percent of residents diagnosed with asthma within a two-year period, expressed as a rate per 100.

Asthma is a condition in which airways narrow and swell, and produce extra mucus. This can make breathing difficult and trigger coughing, wheezing and shortness of breath. For some, asthma is a minor nuisance while for others it can be a major problem interfering with daily activities. Children and teens tend to have the highest prevalence of asthma, however the disease affects more adults than children.

Key Findings

- As shown in **Figure 45**, the rate of asthma in Manitoba decreased minimally over time from 2.43% to 2.37% per 100 residents per year.
- For Southern Health-Santé Sud, the asthma rate was lower than Manitoba and decreased slightly from 1.97% to 1.90% per 100 residents per year.
- Within the region, asthma rates were varied as shown in **Figure 46**. The following districts were below Manitoba average: Stanley, Altona, Winkler, Morris, Carman, Morden, Lorne/Louise/Pembina, MacGregor, Rural East, and Seven Regions. Increasing rates over time was observed in Portage city, while Hanover, Steinbach, and Taché decreased significantly.

Figure 45. Asthma Rate by RHA, 2005/06–2006/07 and 2010/11–2011/12.
Age- and sex-adjusted annual rate per 100 residents per year



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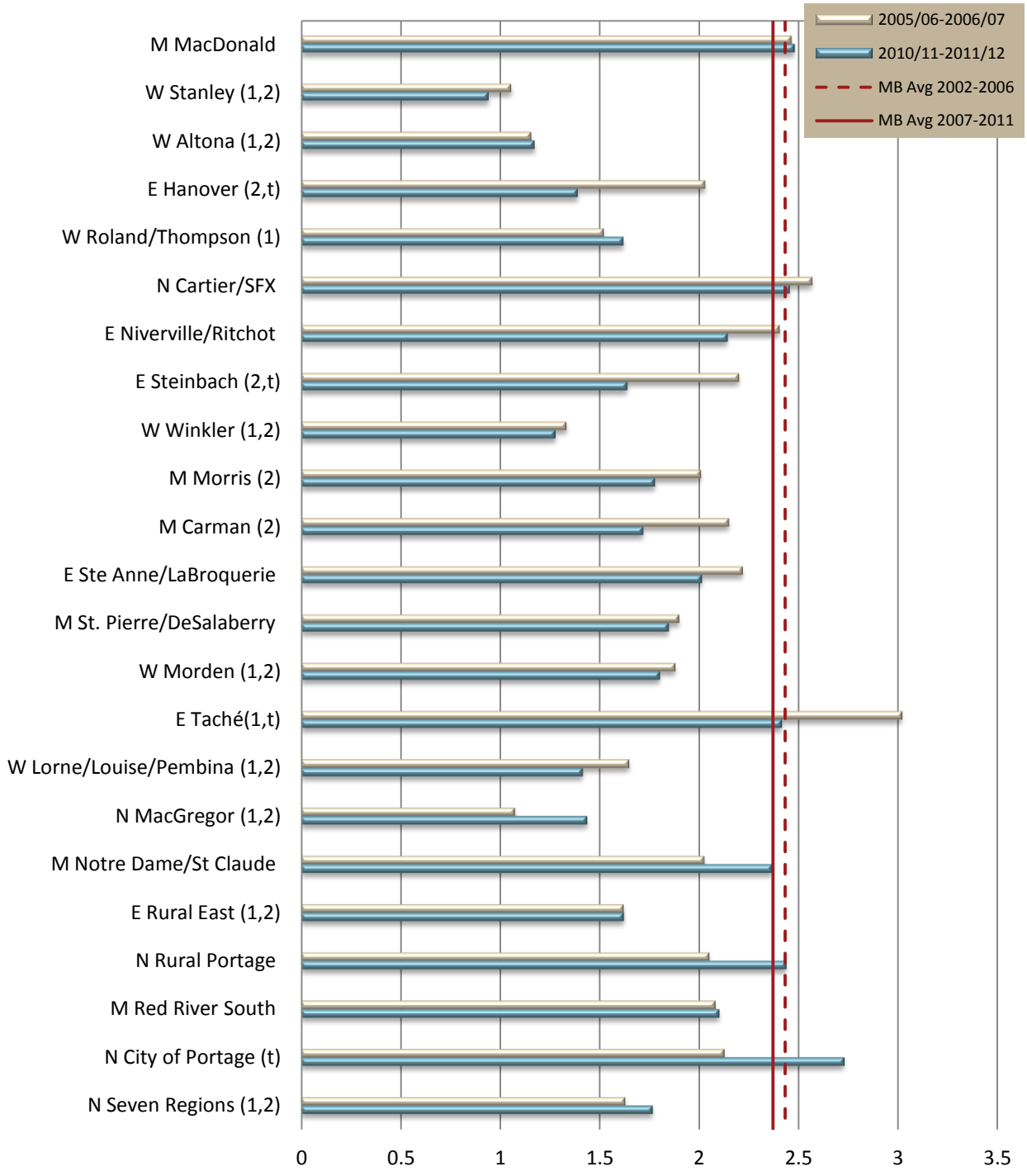
Source: MCHP, RHA Atlas 2013

Figure 46. Asthma Rate by District, Southern Health-Santé Sud, 2005/06–2006/07 and 2010/11–2011/12.
Age- and sex-adjusted annual rate per 100 residents per year



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Source: MCHP, RHA Atlas 2013

3.5.6. Arthritis

Arthritis Prevalence

Definition: The percent of residents (age 19+) diagnosed with arthritis in a one-year period. This includes rheumatoid and osteoarthritis.

Arthritis is inflammation of one or more joints. The main symptoms include joint pain and stiffness, which typically worsens with age. Rheumatoid arthritis is an autoimmune disorder that first targets the lining of joints, while osteoarthritis causes cartilage to break down.

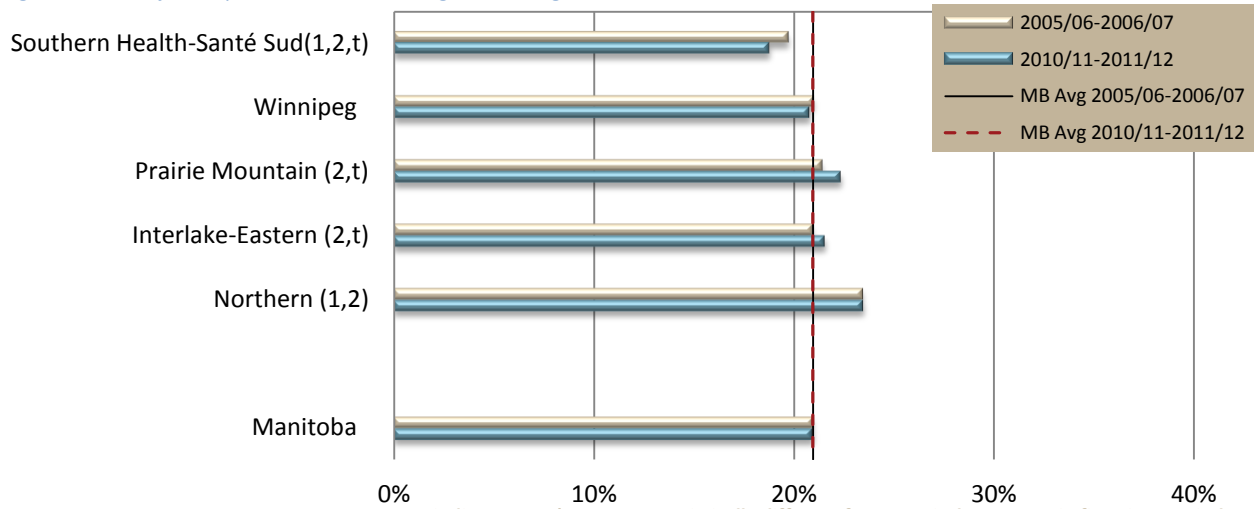
Over 4.6 million Canadian adults (almost 1 in 6) are affected by arthritis.

Arthritis can strike anyone at anytime - regardless of age, physical condition, or ethnic background. It can bring devastating and debilitating effects.

Key Findings

- As shown in **Figure 47**, prevalence of arthritis remained stable at 21%. Rates were highest in Northern RHA, while Interlake-Eastern and Prairie Mountain showed increases over time.
- For Southern Health-Santé Sud, arthritis prevalence showed the opposite trend and decreased from 19.7% to 18.8%. This was a significant change over time and lower than the Manitoba rate. Arthritis affects almost 24,000 residents.
- As shown in **Figure 48**, rates within the region ranged from a low of 15% in St. Pierre/DeSalaberry to a high of 21% in Carman. However, the majority of districts were below the Manitoba rate, and showed a decreasing trend over time.

Figure 47. Prevalence of Arthritis by RHA, 2005/06-2006/07 and 2010/11-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



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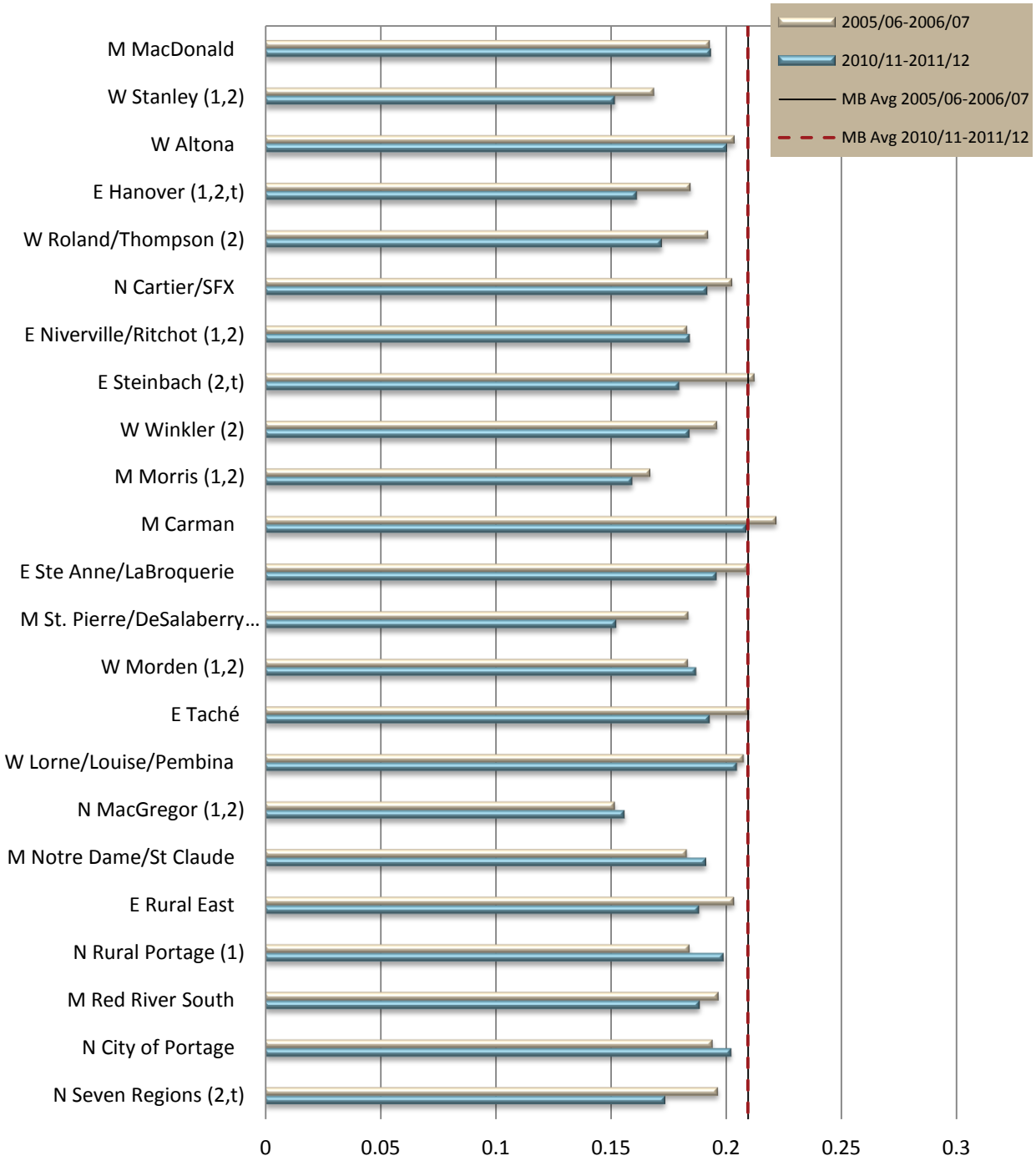
Source: MCHP, RHA Atlas 2013

Figure 48. Prevalence of Arthritis by District, Southern Health-Santé Sud, 2005/06-2006/07 and 2010/11-2011/12.
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

3.5.7. Osteoporosis

Osteoporosis Prevalence

Definition: The percent of residents (age 50+) diagnosed with osteoporosis in a three-year period.

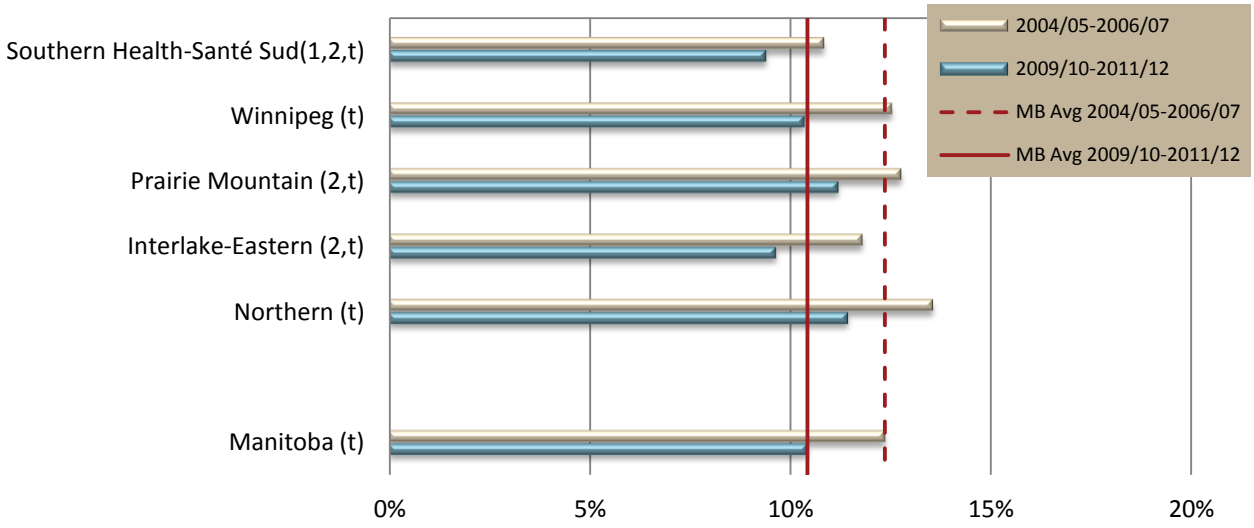
Osteoporosis causes bones to become weak and brittle. Even mild stresses like bending over or coughing can cause a fracture, particularly in the hip, spine, and wrist. Osteoporosis occurs when the creation of new bone doesn't keep up with the removal of old bone. Caucasian and Asian women are at highest risk.

Osteoporosis can result in disfigurement, lowered self-esteem, reduction or loss of mobility, and decreased independence. The majority of hip fractures are osteoporosis-related.

Key Findings

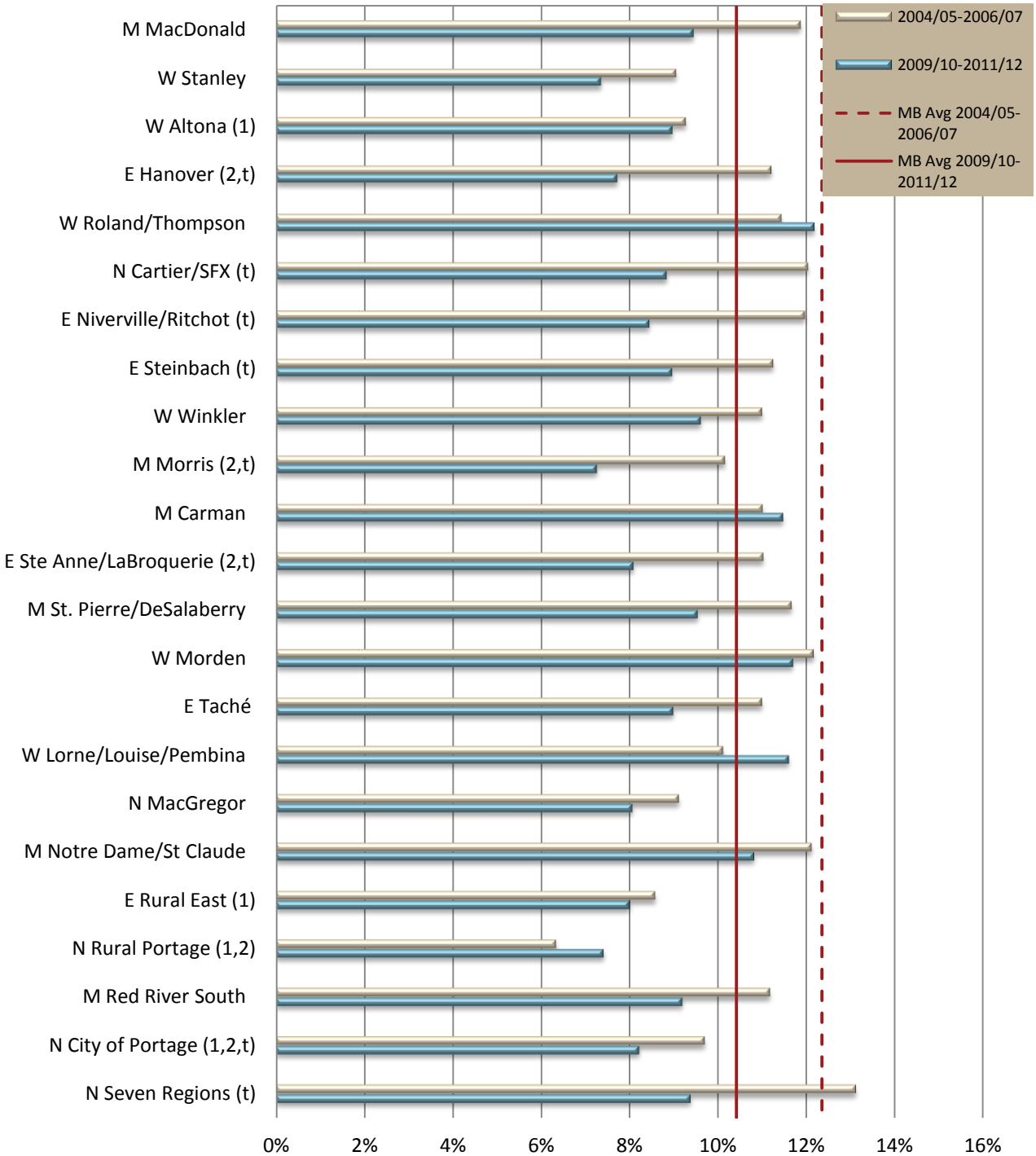
- As shown in **Figure 49**, osteoporosis prevalence for Manitoba decreased over time from 12.4% to 10.4% of the population aged 50 and older. This decrease was observed in all regions.
- For Southern Health-Santé Sud, osteoporosis prevalence decreased from 10.8% to 9.4%. This was a significant change over time and lower than the Manitoba rate. Osteoporosis affects approximately 4,600 residents.
- As shown in **Figure 50**, within the region osteoporosis prevalence also showed a decreased trend in the majority of districts. Rates fluctuated from a low of 7.3% in Stanley to a high of 12% in Roland/Thompson (however this was not statistically higher than Manitoba).

Figure 49. Prevalence of Osteoporosis by RHA, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 50+ diagnosed with disorder



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 50. Prevalence of Osteoporosis by District, Southern Health-Santé Sud, 2004/05-2006/07 and 2009/10-2011/12.
Age- and sex-adjusted percent of residents aged 50+ diagnosed with disorder



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

3.5.8. Communicable Disease

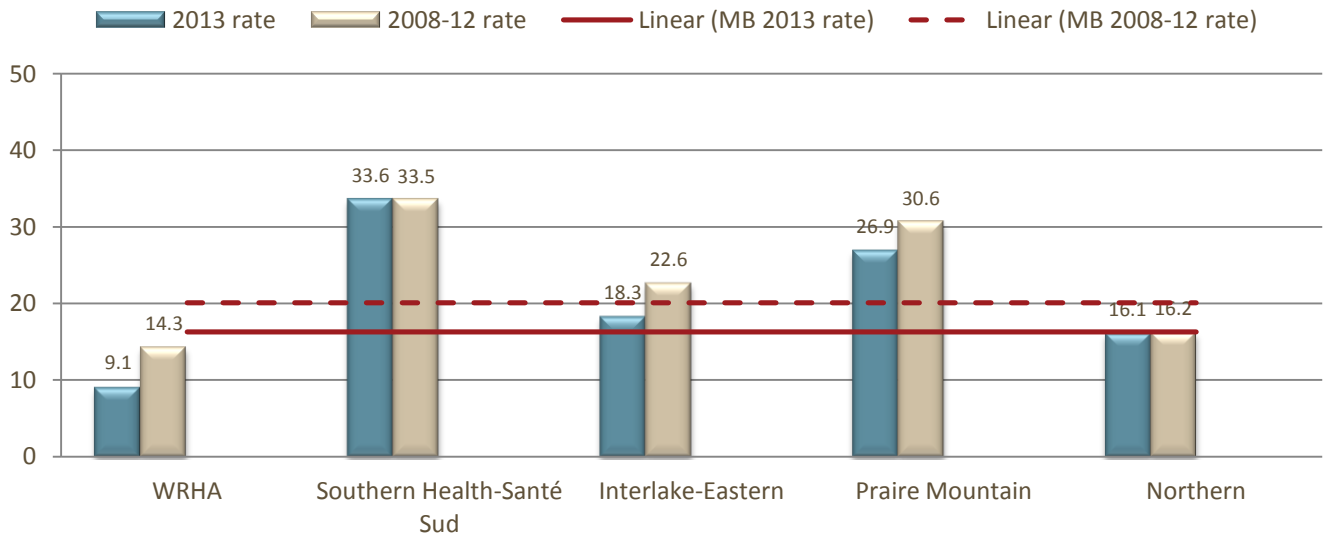
Communicable diseases (primarily viruses and bacteria) spread from one person to another or from an animal to a person. These microbes can spread via the air, food and water as well as through blood or other bodily fluid.

A disease outbreak is when the number of cases of the disease is in excess of what would normally be expected in a geography or season (eg., Ebola outbreak in West Africa).

Enteric: Campylobacter

Campylobacter is one type of enteric disease (or illness) – these are defined as gastrointestinal infections. This communicable disease is more common in rural settings and outbreaks of *Campylobacter* have most often been associated with consuming unpasteurized dairy products, contaminated water, poultry, and produce as well as handling sick animals (i.e. pets and farm animals). As illustrated in **Figure 51**, Southern Health – Santé Sud had the highest rates of campylobacteriosis, both in 2013 and in the 5-year average (33.6 cases and 33.5 cases per 100,000 population, respectively). Both Southern Health–Santé Sud and Prairie Mountain Health consistently had campylobacteriosis incidence rates above the provincial rate from 2008 to 2013.

Figure 51. Campylobacteriosis Incidence Rates by RHA, 2013 and 2008-12 average.
Rates per 100,000 population

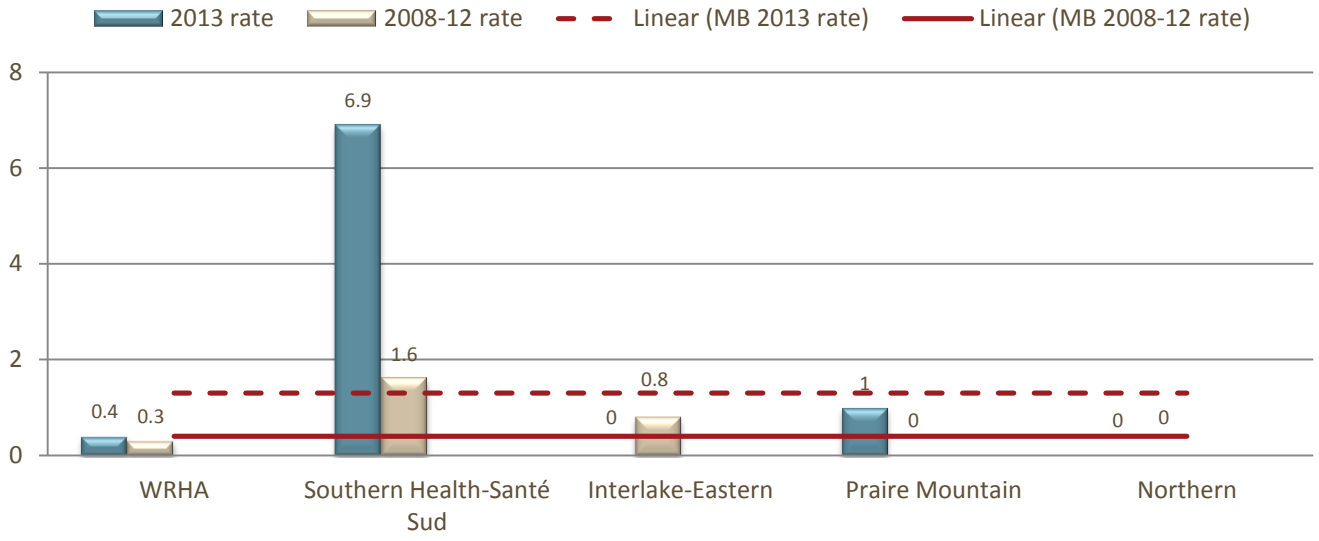


Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

Zooinotic: Lyme Disease

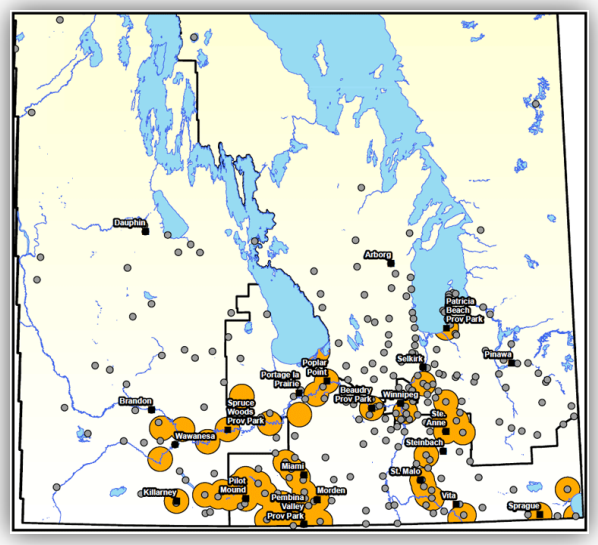
Zooinotic diseases are communicable diseases which are, or are capable of being, transmitted to humans through insects and animals. Lyme disease is caused by a bacterium (Borrelia burgdorferi) that is transmitted through the bite of an infected blacklegged tick. As shown in **Figure 52**, Southern Health-Santé Sud carried the largest burden of Lyme disease (6.9 cases per 100,000 population in 2013); its incidence rates increased by about 6 cases per 100,000 population between 2008 and 2013 while the other RHA's incidence rates remained constant. This higher incidence of cases in Southern Health-Santé Sud corresponds with where the majority of the endemic areas for lyme disease in ticks are found geographically, as illustrated in the map below – which clearly shows is within the region.

Figure 52. Lyme Disease Incidence Rates by RHA, 2013 and 2008-12 average.
Rates per 100,000 population.



Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

Note areas in yellow are considered lyme disease risk areas



Vaccine Preventable Diseases

Vaccine preventable diseases (VPDs) are communicable diseases that are preventable through immunizations. As shown in **Table 9** below, six types of VPDs were confirmed in Manitoba (2013): haemophilus influenzae, invasive meningococcal disease, invasive pneumococcal disease, mumps, pertussis, and typhoid. In total, there were 165 cases in 2013 with invasive pneumococcal disease being the most prevalent. Overall, Manitoba has very few VPDs due to the long standing vaccine programs in this province. However, these diseases have not disappeared so ongoing participation in vaccincation programs is important to ensure outbreaks do not occur in the region or province.

Table 9. Vaccine Preventable Diseases in Manitoba, 2010-2013.

	2010		2011		2012		2013	
Disease Name	Number of Cases	Incidence[1]	Number of Cases	Incidence[1]	Number of Cases	Incidence[1]	Number of Cases	Incidence[1]
Diptheria	1	0.1	1	0.1	0	0	0	0
Haemophilus influenza[2]	12	1.0	14	1.1	14	1.1	14	1.1
Invasive meningococcal disease (IMD)[2]	10	0.8	2	0.2	2	0.2	9	0.7
Invasive pneumococcal disease (IPD)	175	14.2	130	10.4	154	12.0	132	10.2
Measles	1	0.1	0	0	0	0	0	0
Mumps	2	0.2	7	0.6	6	0.5	1	0.1
Pertussis[2]	53	4.3	30	2.4	119	9.4	7	0.5
Rubella congenital	0	0	1	0.1	0	0	0	0
Rubella confirmed	2	0.2	0	0	1	0.1	0	0
Typohoid	6	0.5	8	0.6	6	0.5	2	0.2

[1] Cases per 100,000 population

[2] Diseases of rare occurrence

Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

Sexually transmitted infections (STIs), are generally acquired by sexual contact. The organism that causes the infection may pass from person to person in blood, semen, or vaginal and other bodily fluids. STIs have a wide range of symptoms which can affect the general health, well-being, and reproductive capacity of an individual.

For more information, and a full list of sexually transmitted infections, please visit:

http://www.phac-aspc.gc.ca/std-mts/faq-eng.php

Public Health Agency of Canada

STI - Chlamydia

Definition: The number of cases diagnosed with chlamydia per 100,000 population in 2013.

Chlamydia is the most common bacterial sexually transmitted infection (STI). When symptoms are present, they usually begin two to six weeks after infection. These symptoms often are overlooked, however, and untreated infection can lead to serious complications, such as fertility problems (and even death).

STI - Gonorrhea

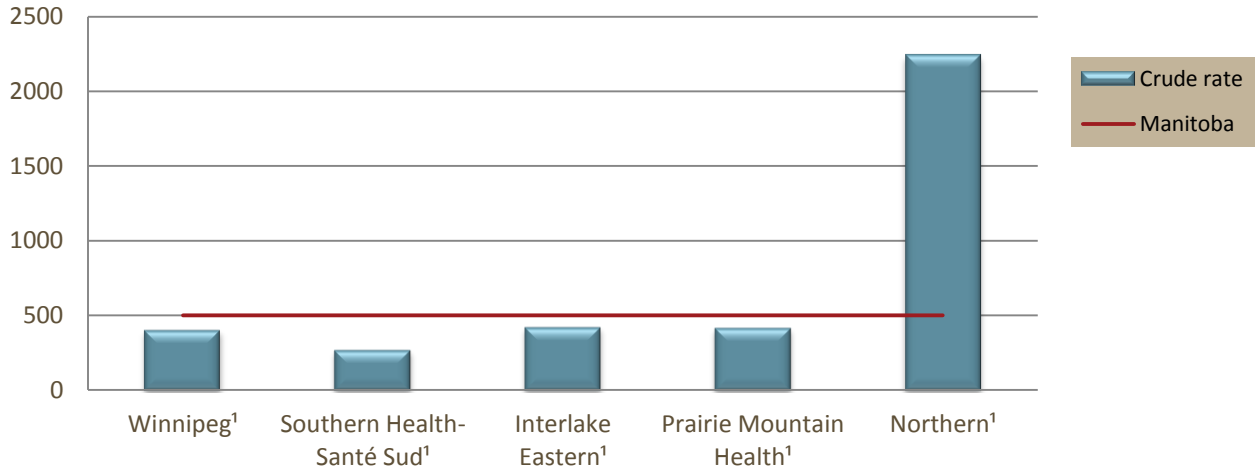
Definition: The number of cases diagnosed with gonorrhea per 100,000 population in 2013.

Gonorrhea is a bacterial STI that can cause infertility. It is on the rise in Canada and becoming increasingly resistant to antibiotics. After 20 years of decline in Canada, the rates of reported gonorrhea cases have risen more than 53% over the past ten years. The recent rise is attributed to people not using safer sex methods.

Key Findings

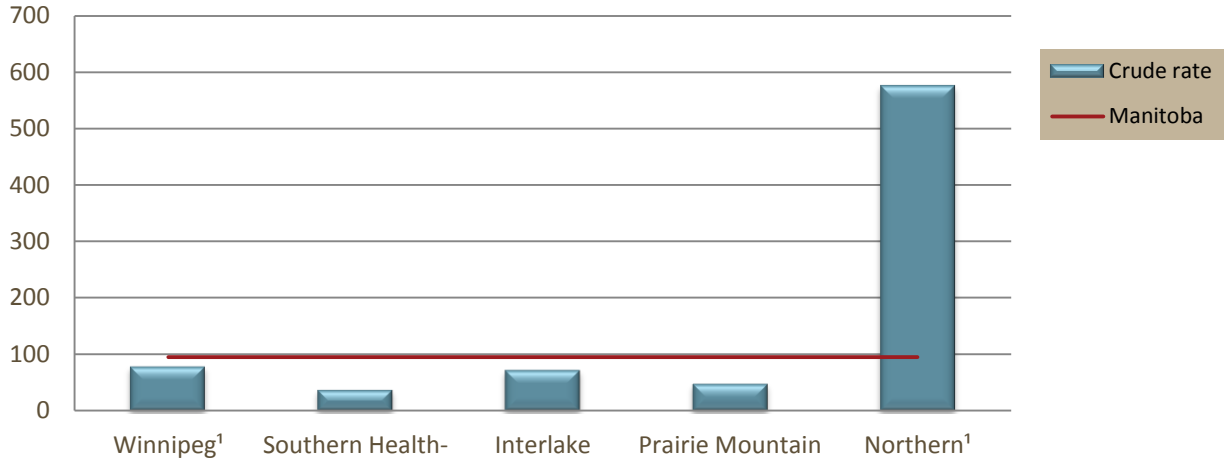
- As shown in **Figure 53**, the Chlamydia rate for Manitoba was 500 cases per 100,000 population in 2013.
- As shown in **Figure 54**, the Gonorrhea rate for Manitoba was 95 cases per 100,000 population in 2013.
- Rates for both STIs were considerably higher in Northern RHA.
- For Southern Health-Santé Sud, STI rates were lower than Manitoba rates. For Chlamydia, the rate was 272 cases per 100,000 population. While for Gonorrhea, the rate was much lower at 38 cases per 100,000 population.
- The highest rates of these STIs were seen in the age 15-19 and 20-24 age groupings, as shown in **Figure 55**. Chlamydia was by far more commonly reported.

Figure 53. Chlamydia Rates by RHA, 2013.
Crude rates per 100,000 population.



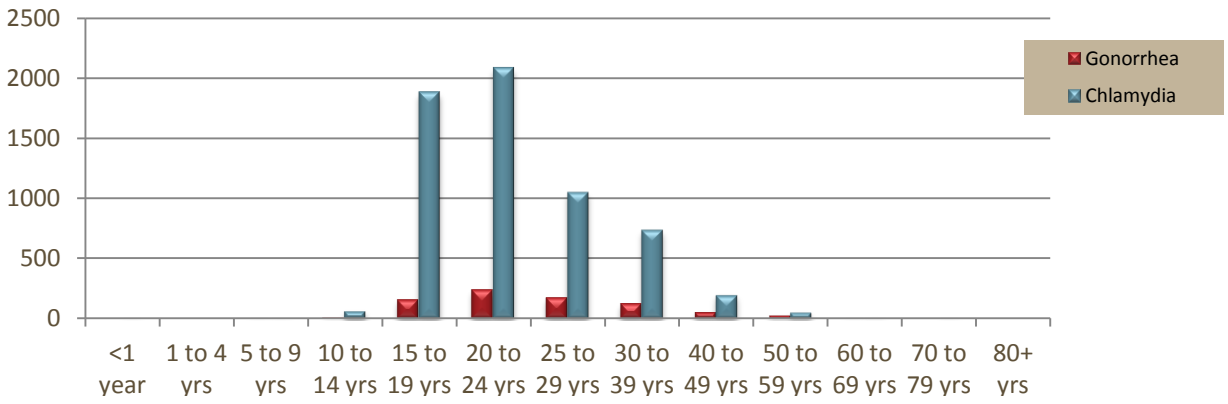
Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

Figure 54. Gonorrhea Rates by RHA, 2013.
Crude rates per 100,000 population.



Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

Figure 55. Total Gonorrhea and Chlamydia Cases by Age, Southern Health-Santé Sud, 2012.



Source: Manitoba Annual Summary of Communicable Diseases, epiReport, 2013

STI - HIV

Definition: The number of cases diagnosed with human immunodeficiency virus (HIV**)** per 100,000 population in 2013.

HIV infection leads to a decreased ability for the body to effectively manage disease-causing viruses, bacteria and fungi. HIV infection can progress to AIDS, a chronic and deadly disease. HIV infection is largely preventable through safer sex methods. It is estimated that over 71,000 Canadians are living with HIV (including AIDS), with 25% unaware that they have the disease.

Key Findings

As reported by Manitoba Health, Annual Statistical Update: HIV and AIDS Report, 2012.

- At the end of 2011, Manitoba had the third highest reported rate of new HIV cases among provinces and territories.
- 74 newly positive HIV cases in 2012 (compared to 80 new cases in 2011) – decrease by six cases.
- Majority of new cases were male (61%) with an average age of 39.8 years.
- The majority of new cases reported residence in Winnipeg (74%).
- The total number of HIV cases for Southern Health-Santé Sud is quite low – 85 cases since 1985. In 2012, there were six new cases reported within the region.
- In Manitoba, there were seven new cases of AIDS and three deaths reported due to AIDS.

3.6. Health Behaviours

An understanding of health behaviours is key to planning good health promotion and disease prevention interventions. Behaviours are influenced and function at many different levels - individual, family, and community – and it is important to implement strategies at all these levels to see positive change. As well, the health sector can not do this alone. This upstream approach involves partnership to be truly effective.

In Canada, we get much of the information about health behaviours through a survey conducted by Statistics Canada called the "Canadian Community Health Survey". As well, in Manitoba, a provincial collaborative called Partners in Planning for Healthy Living conducted a survey specific to youth called the "Manitoba Youth Health Survey". Together these surveys provide a quick look into the healthy living of the residents of the region. Although these surveys are self-reported (that is relying on what people are telling us they are doing), they have been shown to be reliable and valid tools for assessing health behaviours at population levels. **This section of the report will provide information from both of these surveys**.

Canadian Community Health Survey (CCHS)

A telephone cross-sectional survey that collects information related to health status, health care utilization, and health determinants for the Canadian population. Statistics Canada has implemented this survey annually since 2007. The overall sample size across Canada is 65,000. However, it is possible to combine cycles of data collection to get information for smaller geographic areas. The CCHS is an important single data source of self-reported health data. However, a limitation is that the survey is off-reserve household so it does not include First Nations communities, full-time member of Canadian Forces, or people living in institutions (eg. PCH).

2012-13 Manitoba Youth Health Survey (YHS)

A paper-based cross-sectional census survey completed by grade 7 to 12 students in schools across Manitoba. Overall 476 schools and over 64,000 students participated. There have been two cycles of the YHS: 2009 and 2012. The next cycle is planned for 2016.

The purpose of the YHS is to create a health behaviours database that can be used for health planning, evaluation and decision-making at all levels. The survey tool includes questions regarding: physical activity, mental wellbeing, tobacco use, alcohol and substance abuse, injury prevention, sleep, UV/sun protection, and sexual health.

http://www.southernhealth.ca/publications.php?cat=4
http://partners.healthincommon.ca/data-access/

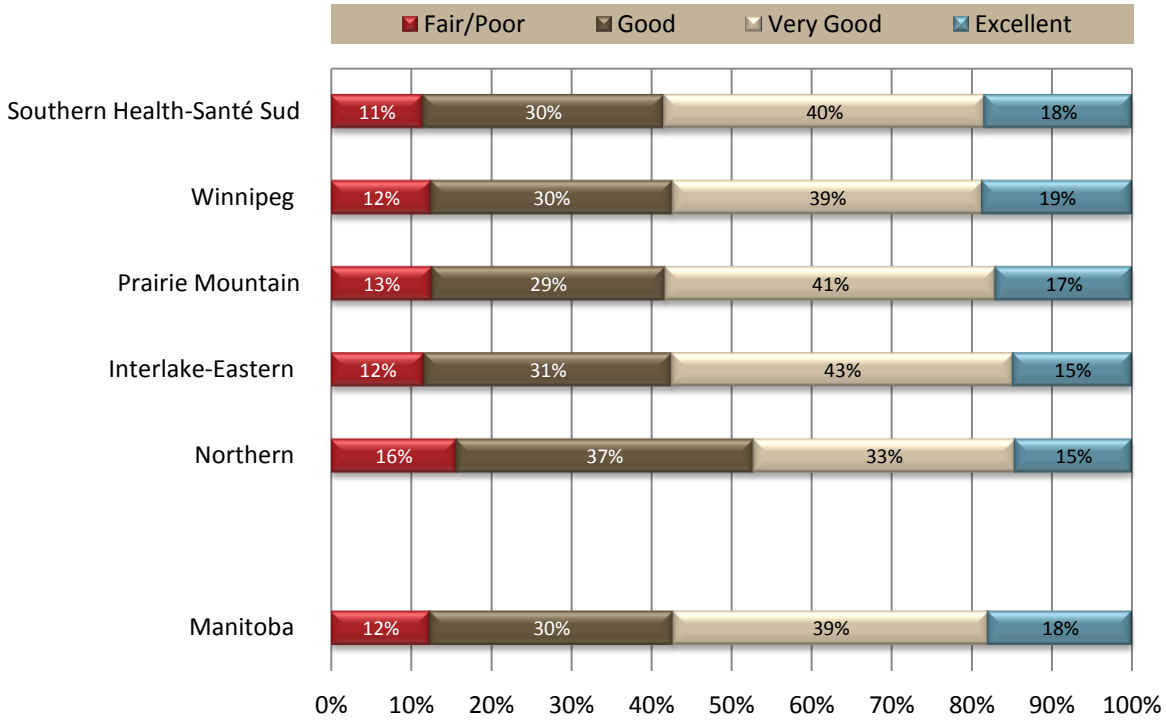
3.6.1. Self-Perceived Health

Definition: The percent of residents (age 12+) who rate their physical health on a scale of poor/fair to excellent. Based on time trend data from the Canadian Community Health Survey (CCHS), this indicator provides a general indication of how the population perceives their physical health.

Key Findings

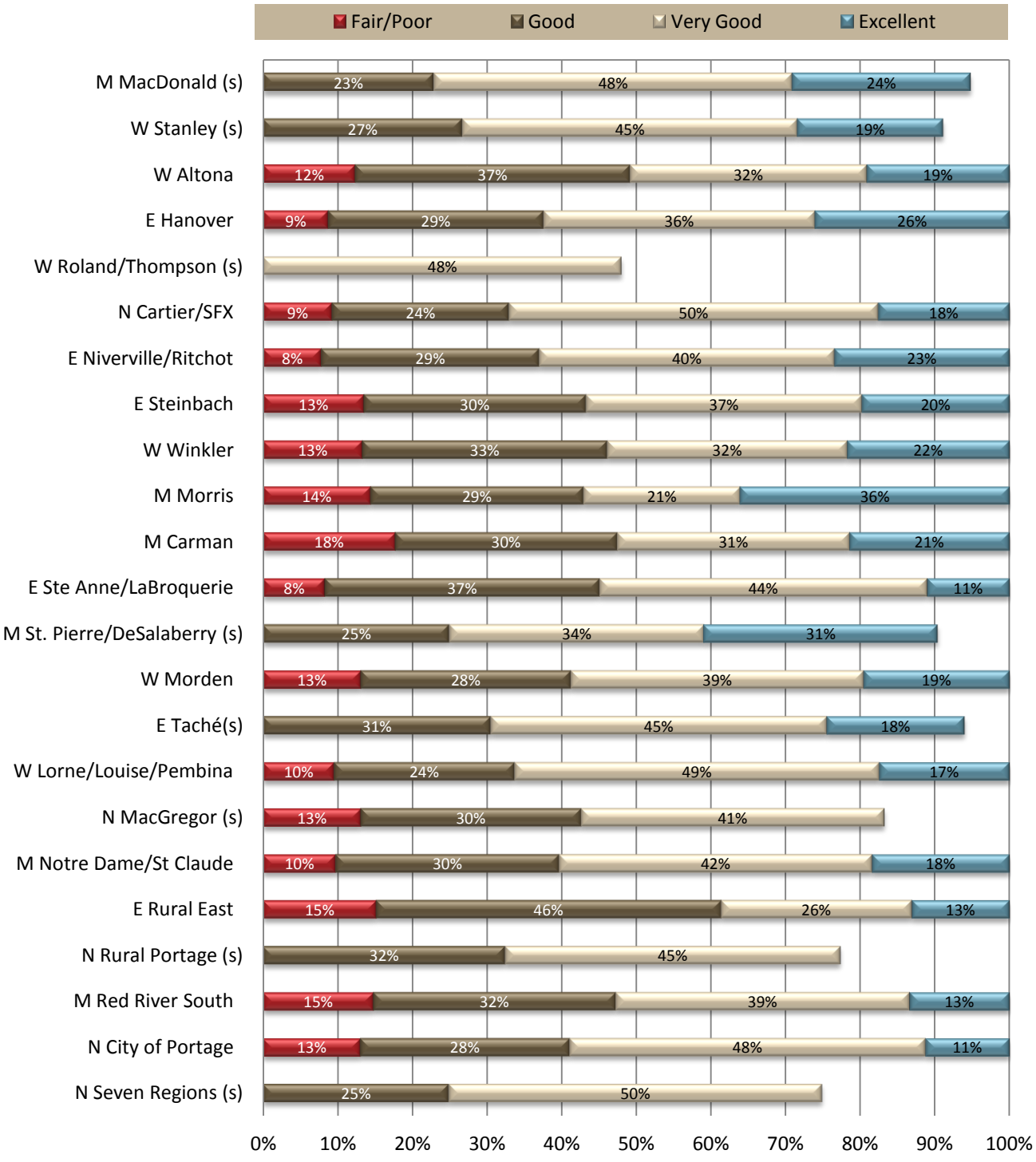
- As shown in **Figure 56**, the percent of residents in Manitoba who rated their physical health as "very good" or "excellent" was 57%. About 12% of Manitobans perceived their physical health as poor or fair.
- For Southern Health-Santé Sud, rates were similar to Manitoba: 58% very good-excellent, 11% poor or fair.
- As shown in **Figure 57**, within the region self-rated physical health varied substantially. As well, data for some districts were suppressed due to small numbers.

Figure 56. Self-Perceived Health by RHA, combined CCHS 2007-08, 2009-10 and 2011-12.
Age and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013

Figure 57. Self-Perceived Health by District, Southern Health-Santé Sud, combined CCHS 2007-08, 2009-10 and 2011-12.
Age and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

3.6.2. Physical Health Functioning

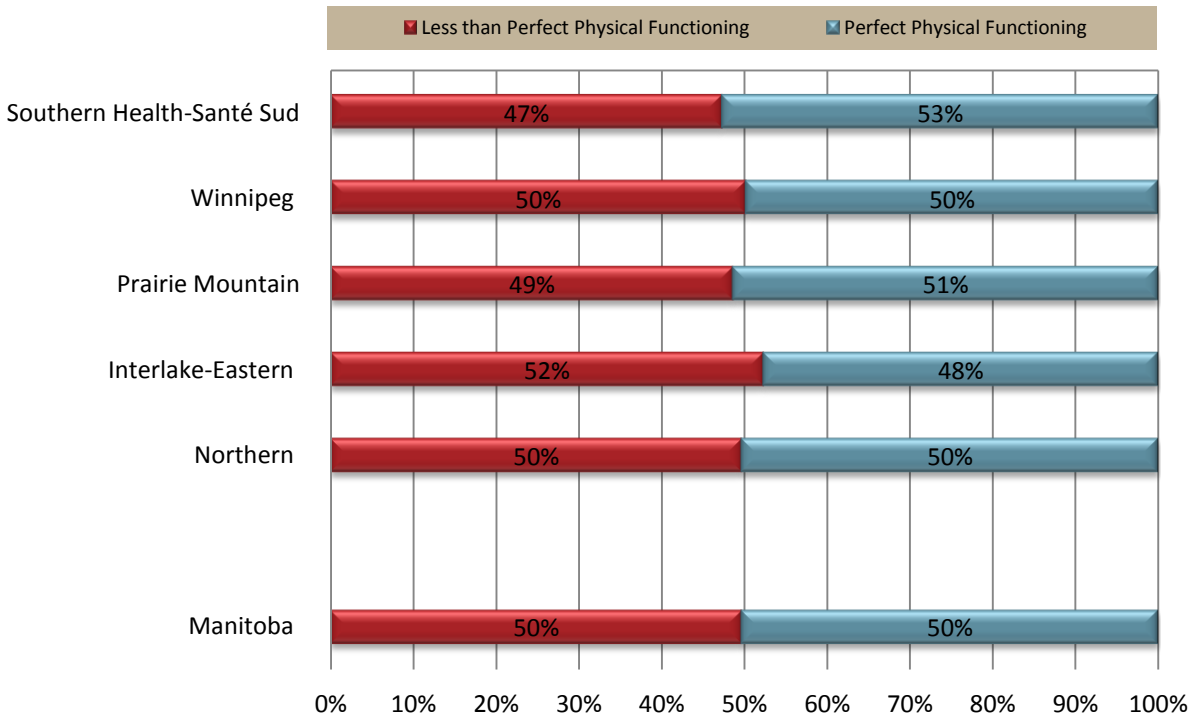
Definition: The percent of residents (age 12+) who scored from perfect to less than perfect on CCHS physical health scale.

The physical functioning scale is a derived measure from the SF-36 questionnaire, addressing overall health status and functioning on a scale of 0 to 100, with higher scores indicating better physical functioning health. A majority of respondents received a perfect score, so this indicator shows the proportion of the population with a score of 100 vs all others. It is based on time trend data from the Canadian Community Health Survey (CCHS). This measure can help to provide more detailed information on the overall health status of an individual beyond the self-rated indicator.

Key Findings

- As shown in **Figure 58**, 50% of Manitobans scored perfect scores on the physical functioning scale.
- For Southern Health-Santé Sud, rates were slightly better than provincial scores, with 53% scoring perfect on the physical functioning scale.
- As shown in **Figure 59**, Stanley district had the highest percentage of perfect scores (74%), while Rural East district had the lowest percentage perfect scores (46%).

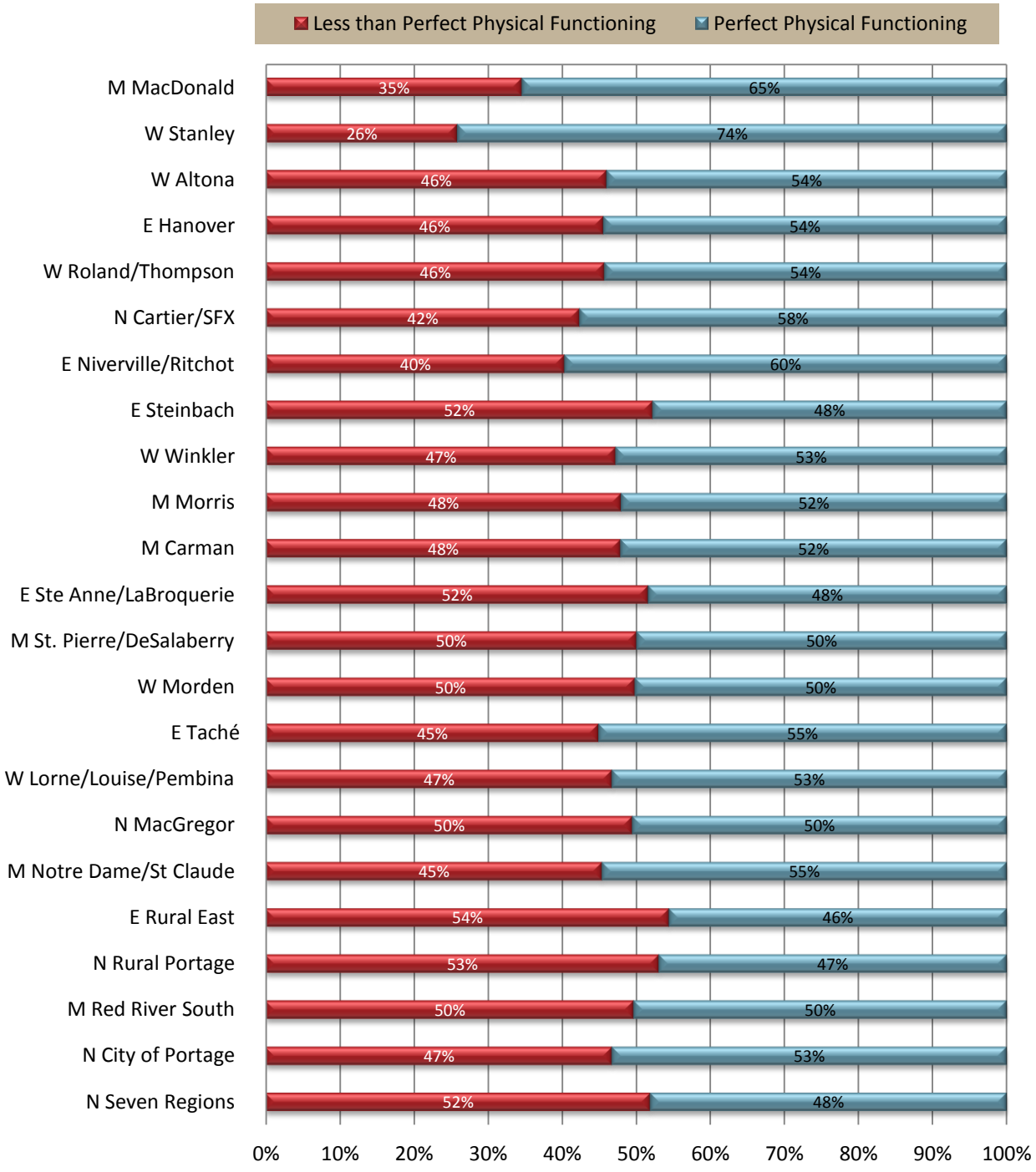
Figure 58. Perfect Physical Functioning (SF-36) by RHA, combined CCHS 3.1 2005, 2007-08, and 2009-10.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

Figure 59. Perfect Physical Functioning (SF-36) by District, Southern Health-Santé Sud, combined CCHS 3.1 2005, 2007-08, and 2009-10.

Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates

Source: Manitoba Health, RHA Profile 2013.

3.6.3. Mental Health

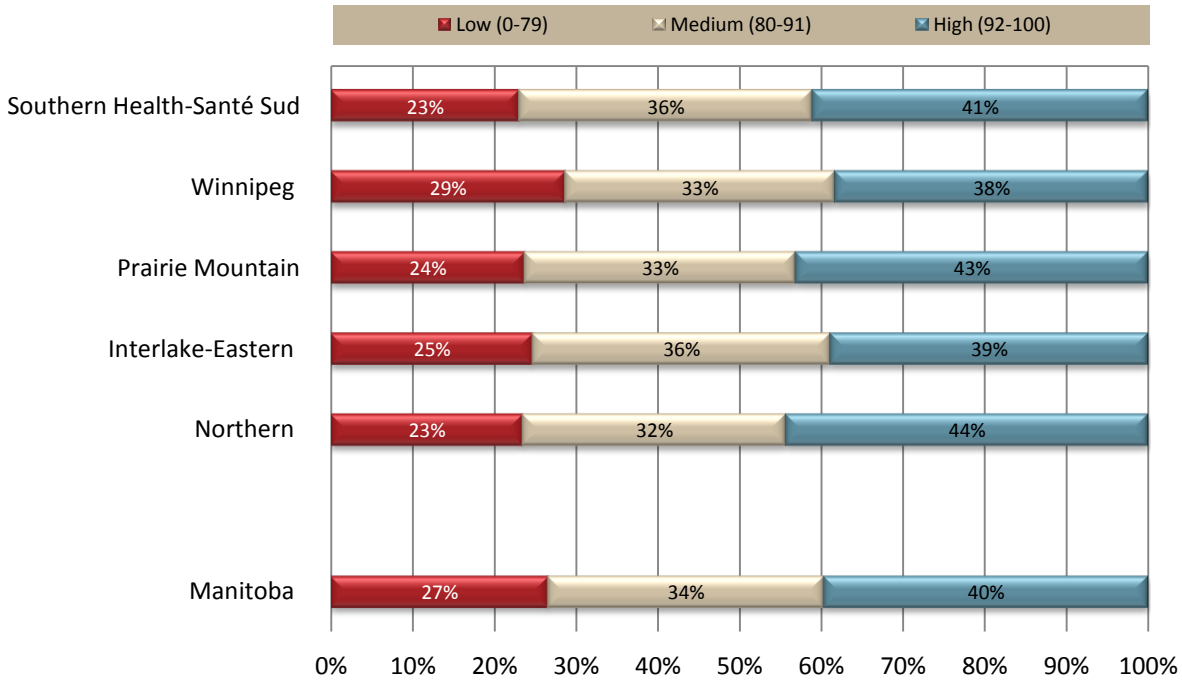
Definition: The percent of residents (age 12+) who scored from low to high on the CCHS mental health scale.

The general mental health scale is a derived measure from the SF-36 questionnaire. The scale is used to score overall mental health on a scale of 0 to 100, with higher scores indicating better mental health.

Key Findings

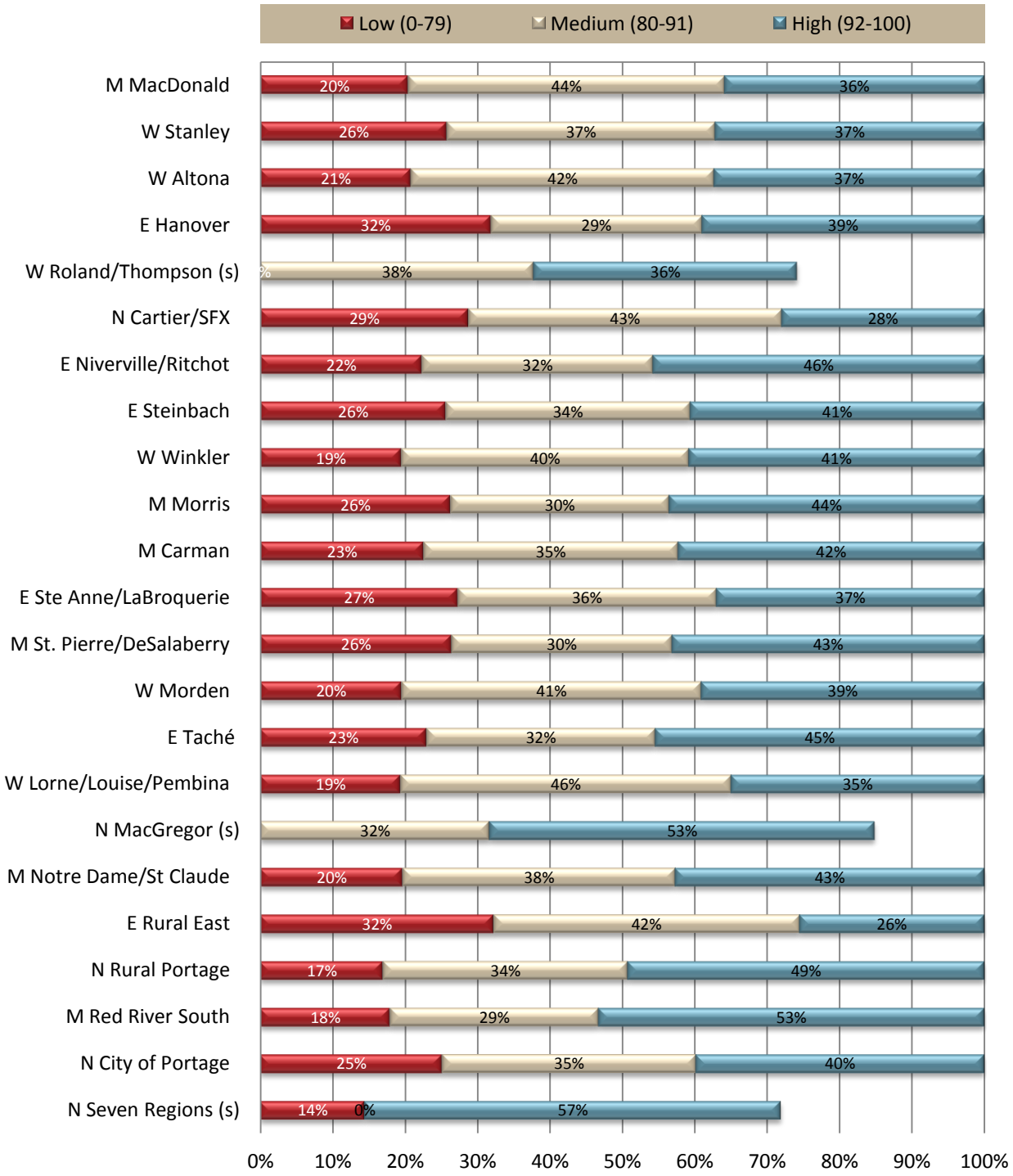
- As shown in **Figure 60**, for mental health functioning, 40% of Manitobans scored "high", while 27% scored in the "low" range of this scale.
- For Southern Health-Santé Sud, rates were once again similar to Manitoba: 41% high, 36% medium, 23% low.
- As shown in **Figure 61**, Rural East district had both the smallest percentage on the high scale (26%), and the largest percentage on the low scale (32%).

Figure 60. General Mental Scale (SF-36) by RHA, combined CCHS 3.1 2005, 2007-08, and 2009-10.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, HIM, 2013

Figure 61. General Mental Scale (SF-36) by District, Southern Health-Santé Sud, combined CCHS 3.1 2005, 2007-08, and 2009-10.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013

Healthy emotional and social development in childhood lays the foundation for good mental health and resilience throughout life. Students have better mental health when they have positive relationships with others. As **Table 10** shows below, youth in Southern Health-Santé Sud rated high on all questions related to school and community connectedness. Rates were lower in terms of students' feeling involved in their communities, however this was comparable what is reported at the provincial roll-up.

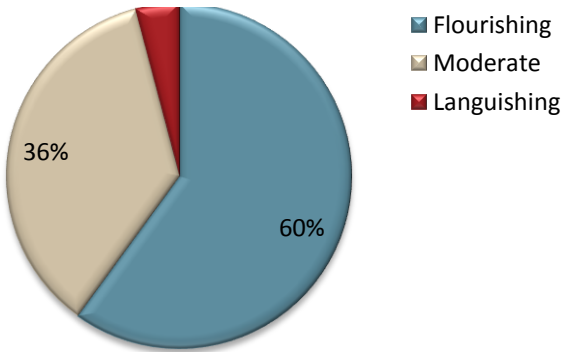
Table 10. School and Community Connectedness for Youth, Southern Health-Santé Sud, 2012.

Proportion of students who agree with each statement	Grades 7-12 Students
I feel close to the people at this school	82%
I feel I am part of this school	87%
I am happy to be at this school	84%
I feel safe at my school	92%
I feel safe in my community	94%
I feel safe in my home	98%
I have at least one close friend that I can share things with	94%
I feel my family supports me	94%
I feel involved in my community	69%

Source: Manitoba Youth Health Survey, 2012

Based on responses to statements related to thoughts and feelings, students were placed into one of three categories along a mental health continuum. Results in **Figure 62** indicate that within Southern Health-Santé Sud, 60% of students reported flourishing mental health, 36% reported moderate mental health, and 4% reported languishing mental health. These results were comparable to the provincial roll-up.

Figure 62. Mental Health Continuum for Youth, Southern Health-Santé Sud, 2012



Source: Manitoba Youth Health Survey, 2012

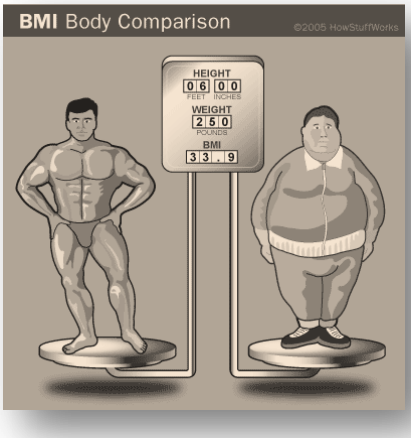
Feelings of Hopelessness

40% of students responded "yes" when asked whether during the past 12 months whether they felt so sad or hopeless that they stopped doing some usual activities for awhile. The provincial rate, in comparison, was 45%.

3.6.4. Body Mass Index

Definition: The Body Mass Index (BMI) indicator refers to the proportion of the population who fall into specific weight categories. This indicator is reported using two sources: for the adult population (18+ years) using the CCHS, and for the youth population using the findings from the 2012 Manitoba Youth Health Survey (YHS).

BMI is a common method of determing if an individual's weight is in a healthy range based on their height. The index range is as follows: under 18.5 (underweight), 18.5-24.9 (healthy weight), 25-29.9 (overweight), and 30 or higher (obese). The YHS calculated BMI specifically for children and teens, as recommended by the Centre for Disease Control. Therefore, reporting looks a bit different. For more information, please visit **http://nccd.cdc.gov/dnpabmi/Calculator.aspx.**

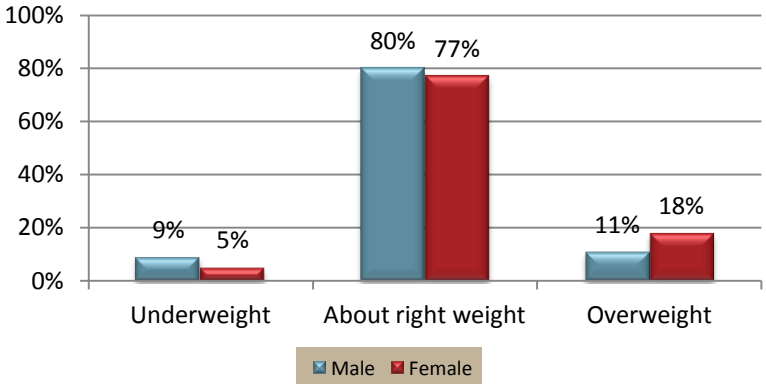


As illustrated in the graphic, BMI may overestimate body fat in people who have a more muscular build. However, it is still a widely used indicator to measure population health risks associated with obesity.

Key Findings

- According to the CCHS combined cycles, approximately 41% of adults (18+) living in Southern Health-Santé Sud would be in the underweight or normal weight range. (**Figure 64**).
- As shown in **Figure 64**, the majority of our adult population would fall in the overweight or obese categories (59%).
  - Overweight (BMI 25-29.9) = 37%
  - Obese (BMI 30+)= 22%
- As shown in **Figure 65**, the majority of our youth (73%) would fall in the normal healthy weight range.
  - Underweight (BMI under 18.5) = 4%
  - Normal healthy weight (18.5-24.9) = 73%
  - Overweight/Obese (25+) = 23%

Figure 63. Youth Perceptions of Body Weight by Gender, Southern Health-Santé Sud, 2012



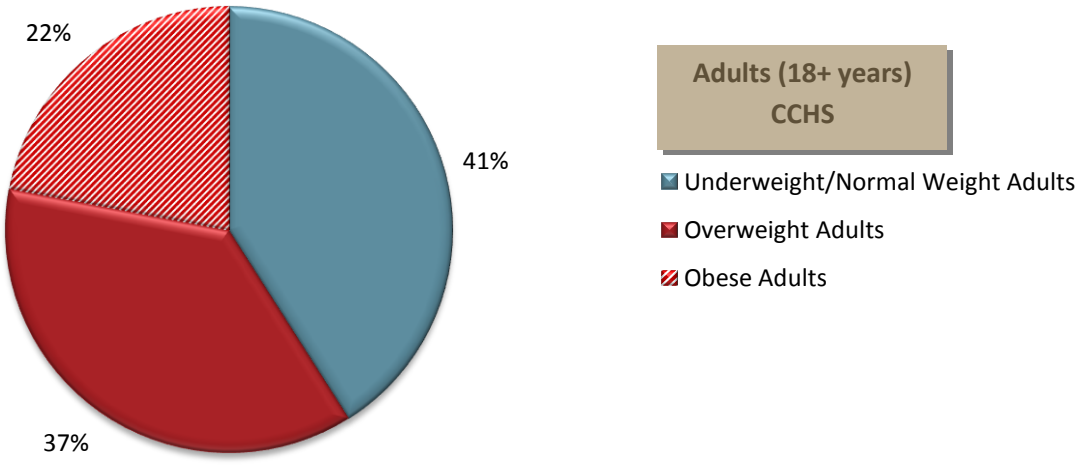
Source: Manitoba Youth Health Survey, 2012

Perceptions of Body Weight (Figure 63)

Boys more likely to perceive themselves as underweight or about right weight.

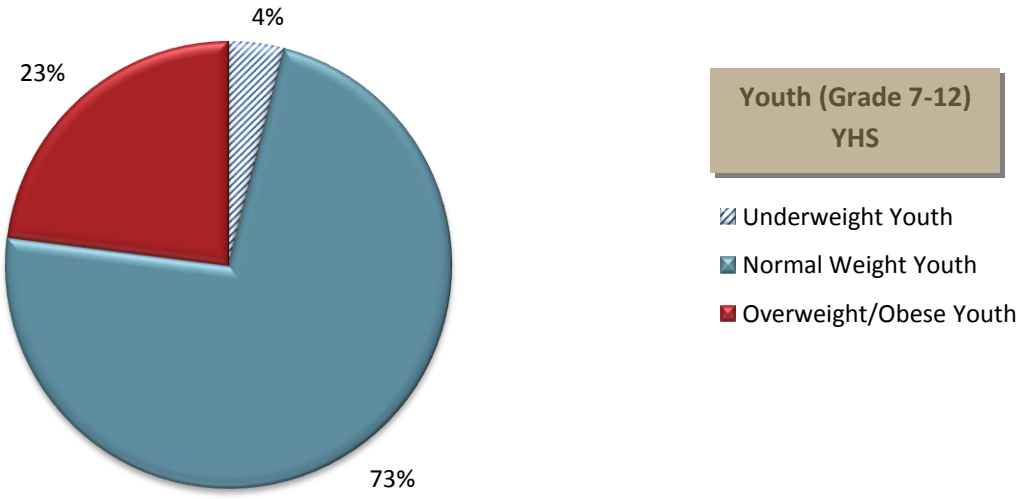
Girls more likely to perceive themselves as overweight.

Figure 64. Body Mass Index for Overall Population, Southern Health-Santé Sud, Combined CCHS cycles 3.1 2005, 2007-08, 2009-10, and 2011-12.
Age - and sex-adjusted percent of weighted sample aged 18+



Source: Manitoba Health, RHA Profile 2013

Figure 65. Body Mass Index for Youth, Southern Health-Santé Sud, 2012.
Grade 7-12 Students



Source: Manitoba Youth Health Survey, 2012

3.6.5. Physical Activity

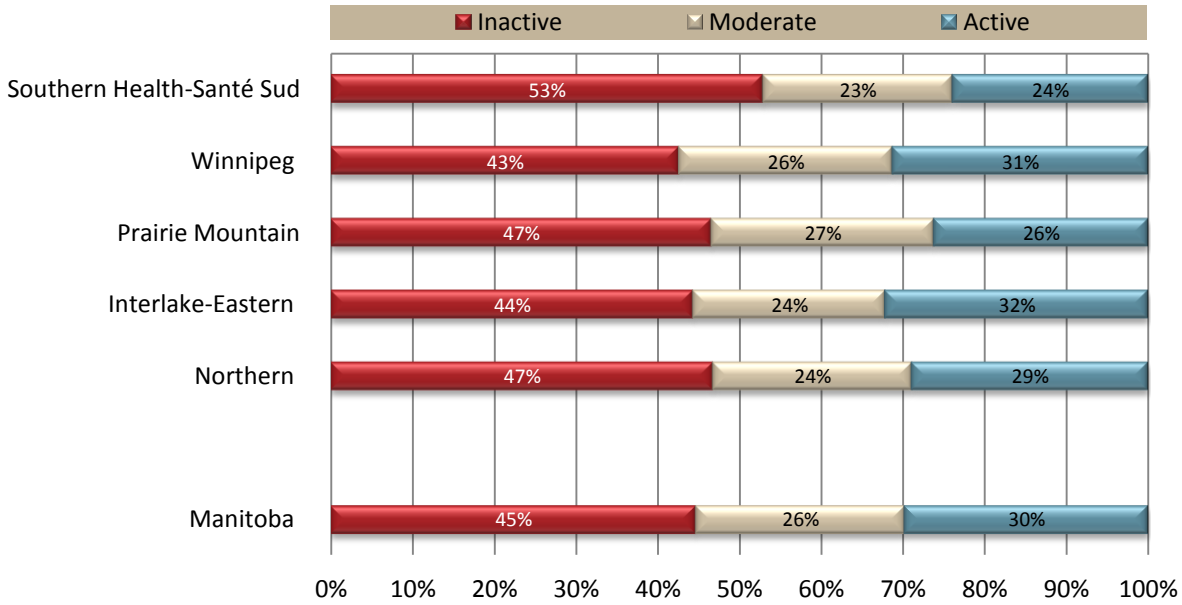
Definition: This indicator is a derived variable based on the average daily energy expenditure values calculated from a number of questions regarding physical activity for travel (eg. biking or walking to school or work), and leisure time activity (eg. walking, biking, running) within the past three months. The percentage of the population (age 12+) were then grouped into three categories: active, moderate, or inactive. Data based on time trend data from the CCHS.

Active living is important to healthy living and disease prevention. Regular physical activity is one of most important things someone can do for their health to control weight, strengthen bones and muscles, improve balance to prevent falls, and improve mental health. Adults are recommended to have 150 minutes per week of moderate cardio activity (eg. raising heart rate to break sweat) in addition to muscle-strengthening activity twice per week.

Key Findings

- According to the CCHS combined cycles, approximately 47% of Manitobans (age 12+) reported physical activity levels classified as inactive, compared to 56% as moderate or active combined. (see **Figure 66**)
- For Southern Health-Santé Sud, inactive rates were higher at 53% while moderate or active rates were lower at 47%.
- As shown in **Figure 67**, rates varied within the region. Data was suppressed due to small numbers, and interpretation should be made with caution. However, a number of districts showed inactivity levels that were higher than the regional rate: Stanley, Altona, Hanover, Winkler, MacGregor, Notre Dame/St. Claude, Rural Portage, and Red River South.

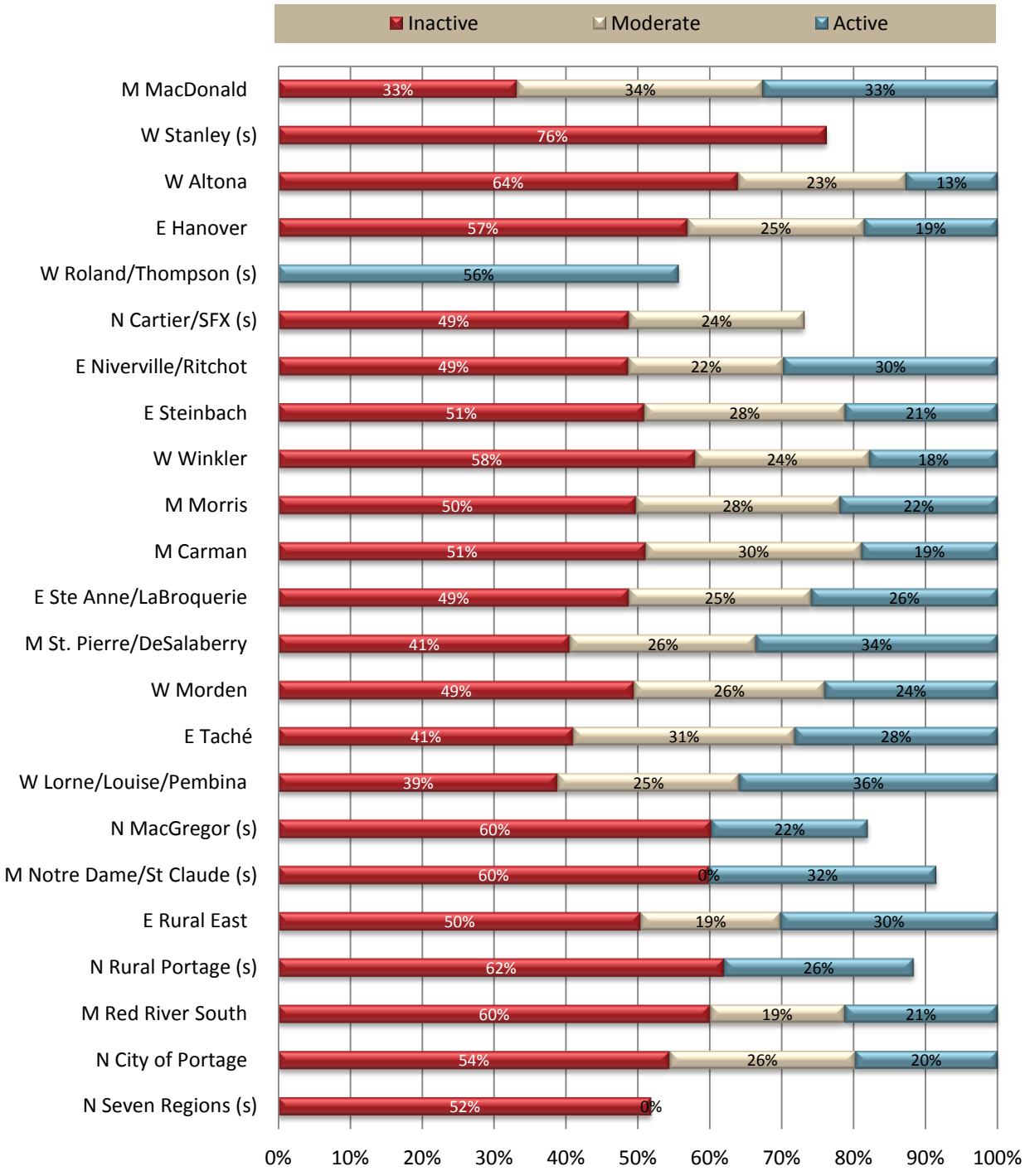
Figure 66. Physical Activity Level (leisure and travel) by RHA, Combined CCHS cycles 3.1 2005, 2007-08, 2009-10, and 2011-12.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

Figure 67. Physical Activity Level (leisure and travel) by District, Southern Health-Santé Sud, Combined CCHS cycles 3.1 2005, 2007-08, 2009-10, and 2011-12.

Age - and sex-adjusted percent of weighted sample aged 12+

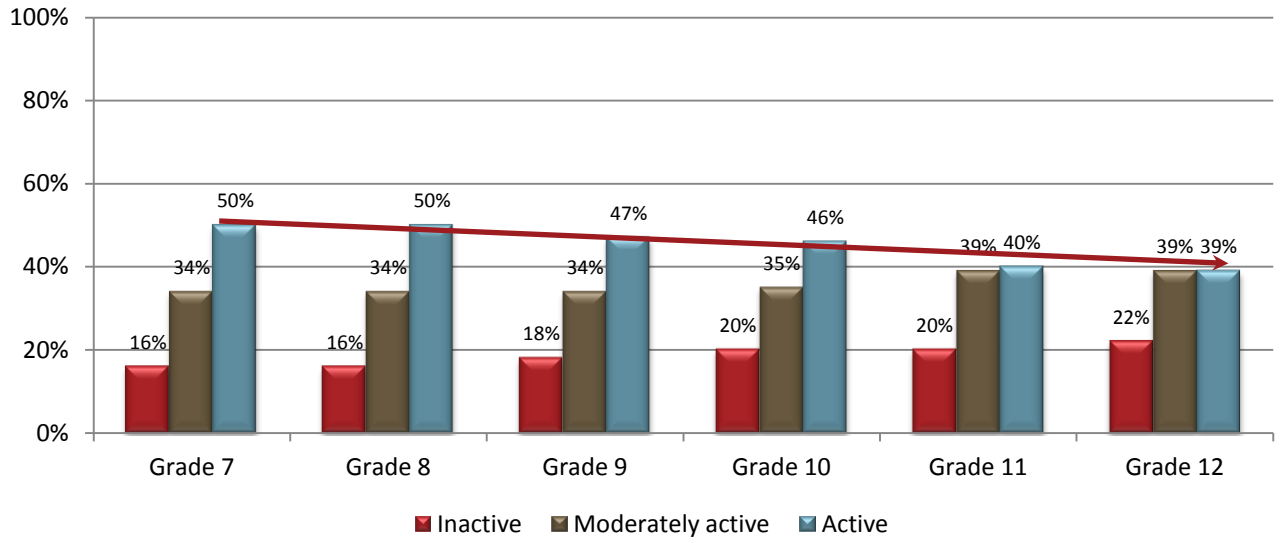


(s) = bars supressed due to small numbers or highly variable rates

Source: Manitoba Health, RHA Profile 2013

For health benefits, youth ages 12 to 17 years should accumulate at least 60 minutes per day of moderate to vigorous intensity physical activity. Students were asked a series of questions regarding their physical activity and based on responses were placed in one of three categories: inactive, moderately active, and active. As shown in **Figure 68,** activity levels were lower in older grades. Overall for youth across all grades in Southern Health-Santé Sud: 46% were active, 36% were moderately active, and 18% were inactive – these rates were comparable to provincial levels.

Figure 68. Physical Activity Level for Youth By Grade, Southern Health-Santé Sud,, 2012



Source: Manitoba Youth Health Survey, 2012

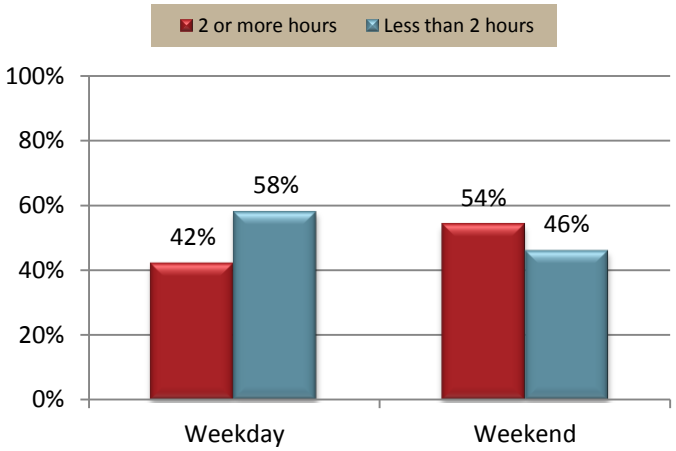
Physical activity with friends

According to the Centers for Disease Control and Prevention (CDC), having friends who are physically active increases youth participation in physical activity.

75% of students in Southern Health-Santé Sud reported that three or more of their closest friends were active.

Screen Time (Figure 69)
42% students reported screen time of 2 or more hours during weekdays. However, weekend rates increased to 54% (2 or more hours).

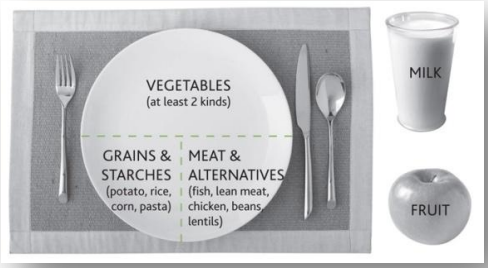
Figure 69. Screen Time for Youth, Southern Health-santé Sud, 2012



Source: Manitoba Youth Health Survey, 2012

3.6.6. Healthy Eating

Definition: The healthy eating indicator refers to average daily consumption of fruits and vegetables that the population (age 12+) reported they consumed.



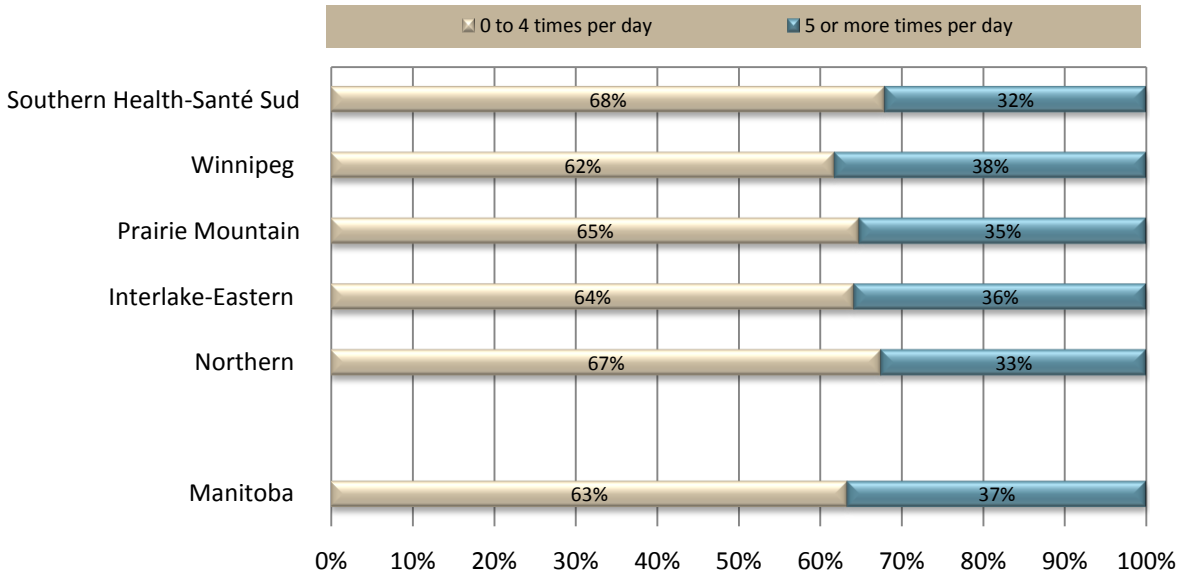
Healthy eating is fundamental to good health and is a key element in human development from birth to later stages in life. In the CCHS, this indicator is a derived variable that indicated the total number of times per day the respondent eats fruit and vegetables (eg. not the number of servings eaten).

Key Findings

- According to the CCHS combined cycles, approximately 37% of Manitobans (12+) reported eating fruits and vegetables 5 of more times per day. (see **Figure 70**)
- The daily consumption of fruits and vegetables (5 or more times per day) for Southern Health-Santé Sud was lower at 32%.
- As shown in **Figure 71**, rates varied within the region. Some data was suppressed due to small numbers. The highest rates were found in St Pierre/De Salaberry (50%), followed by MacDonald (48%) and Lorne/Louise/Pembina (47%).

Figure 70. Average Daily Consumption of Fruits and Vegetables by RHA, combined CCHS cycles 2007-2008, 2009-2010 and 2011-2012.

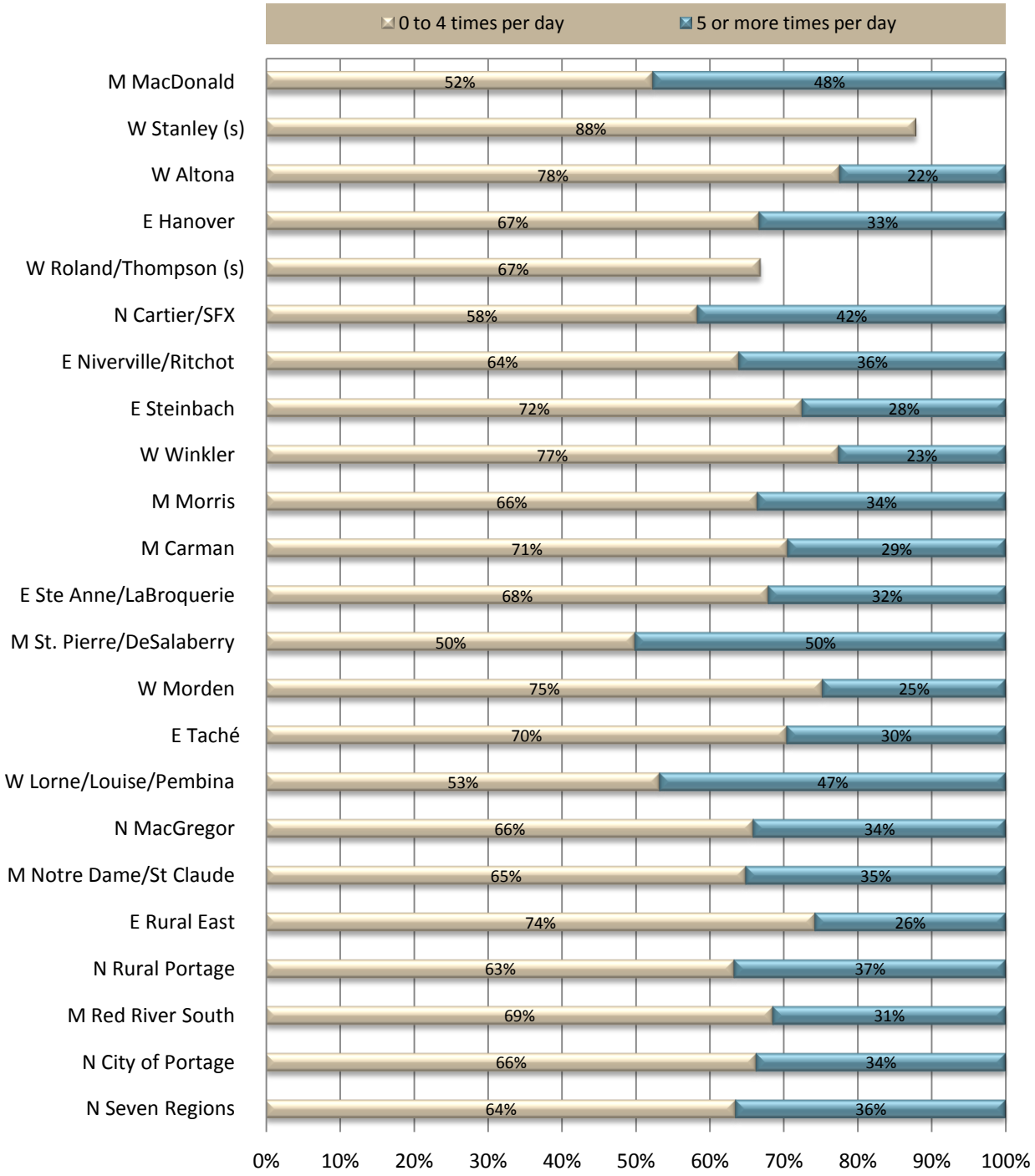
Age- and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

Figure 71. Average Daily Consumption of Fruits and Vegetables by District, Southern Health-Santé Sud, combined CCHS cycles 2007-2008, 2009-2010 and 2011-2012.

Age- and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates

Source: Manitoba Health, RHA Profile 2013.

Eating Behaviours of Youth

With busy schedules and availability of high calorie, low nutrition choices, accessing healthy food can be a challenge. Eating well and learning how to make healthy food choices are of particular importance during childhood and adolescence. The eating behaviours of youth in Southern Health-Santé Sud are presented in **Table 11**. Overall, these results demonstrate the need for effective nutrition education both in schools and community.

Table 11. Eating Behaviours of Youth, Southern Health-santé Sud, 2012

Vegetables and Fruit **Students**		**Grade 7-12**
Students who reported eating fruits and vegetables 7 or more times per day	*Includes fruit (not fruit juice), green salad, carrots, potatoes (not french fries), other vegetables*	36%
Milk and Alternatives		
Students who reported consuming milk and alternatives 3 or more times per day	Includes cheese/yogurt and milk (white, chocolate, soy)	22%
Meat and Alternatives		
Students who reported eating meat and alternatives 2 or more times per day	Includes meat or fish (not fried), eggs, nuts, and meat alternatives	38%
Salty and Sugary Snacks		
Students who reported consuming salty/sugary snacks 3 to 6 times per day	Includes potato chips, granola bars, chocolate, and cookies	23%
Fast Food		
Students who reported consuming Fast Food 3 to 6 times per day	Includes hot dogs, hamburgers, fries, pizza, or chicken nuggets	5%
Soft Drinks		
Students who reported consuming soft drinks 3 or more times per day	Pop/soda (not including diet), slurpees, and slushies	11%
Meal Habits		
Students who reported not usually eating breakfast		21%
Not having time as reason for not eating breakfast		61%
Students who reported not usually eating lunch		11%
Students who usually or most often ate their evening meal with people they live with		89%

Source: Manitoba Youth Health Survey, 2012

3.6.7. Binge Drinking

Definition: This indicator refers to the percentage of the population (age 12+) who reported drinking 5 or more alcoholic drinks on one occasion.

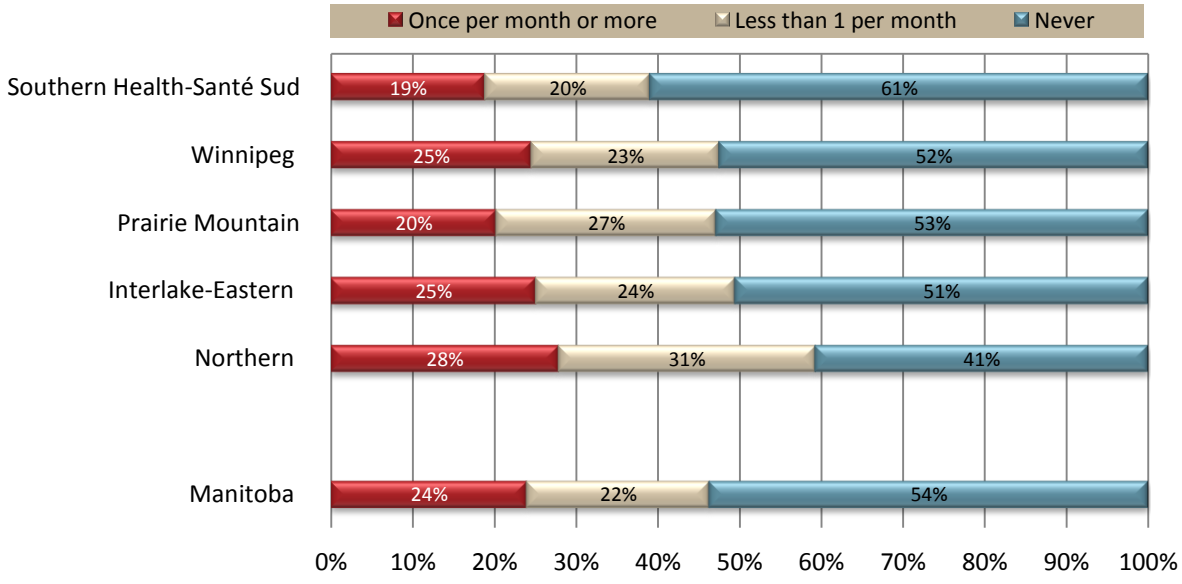
Binge drinking is a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. Heavy alcohol use increases the risk for chronic diseases, and is highly associated with unintentional injuries (eg. car crashes, falls, drowning) and intentional injuries (eg. sexual assault, domestic violence). In the CCHS, one drink was defined as: one bottle or can of beer/glass of draft, one glass of wine/wine cooler, or 1 ½ ounces of liquor.

Binge Dinking in Youth
14% of all grade 7 to 12 students reported consuming five or more drinks of alcohol within a couple of hours on at least one day in the past month. (Source: Manitoba Youth Health Survey, 2012)

Key Findings

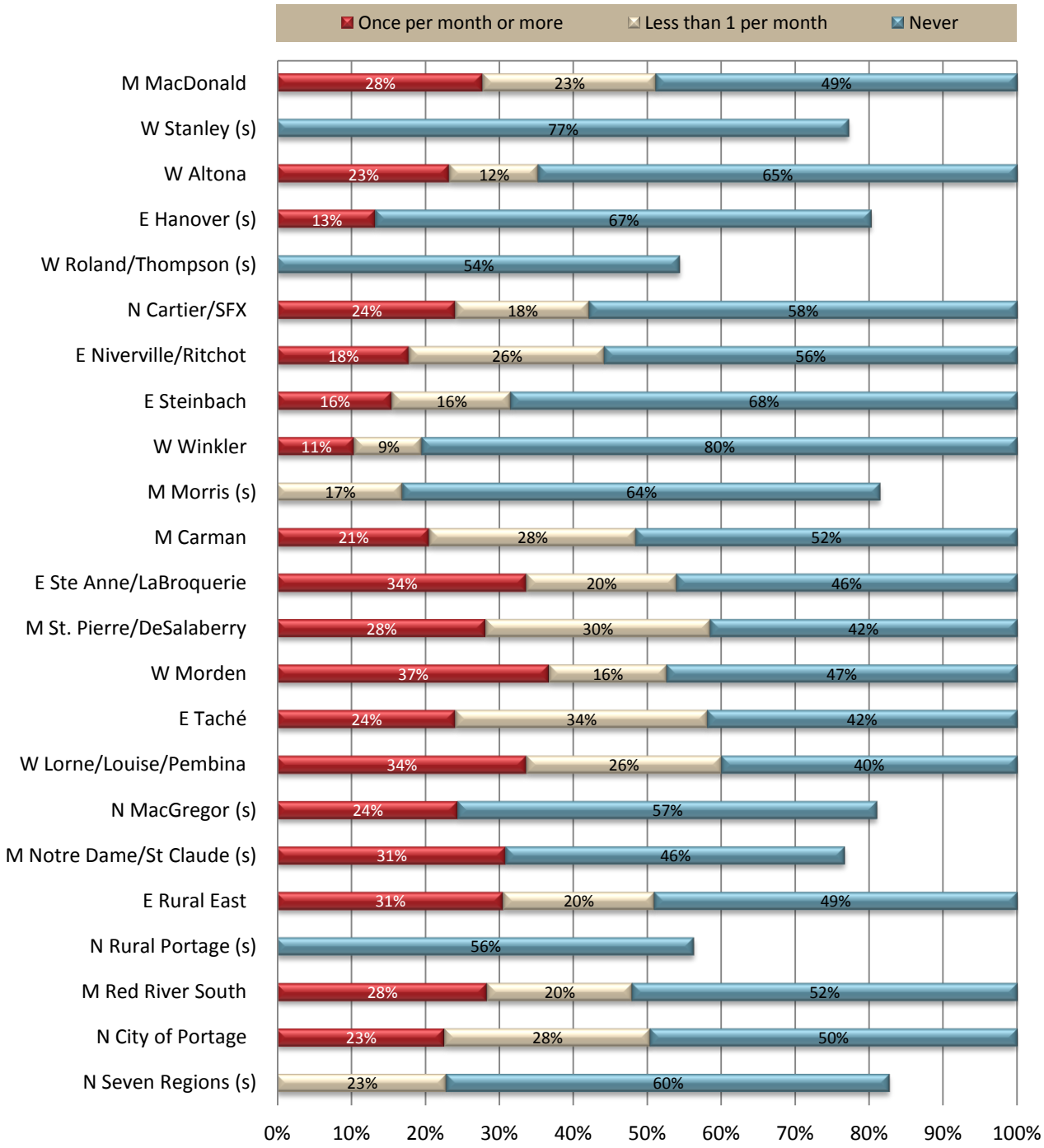
- According to the CCHS combined cycles, 24% of Manitobans (12+) reported binge drinking once per month or more. A further 19% reported binge drinking less than once per month. (see **Figure 72**)
- In comparison, Southern Health-Santé Sud had among the lowest rates in the province (20% - once per month +, 19% - less than once per month).
- As shown in **Figure 73**, rates varied within the region. Some data was suppressed due to small numbers. The highest rates for binge drinking were in Lorne/Louise/Pembina, followed by Taché and St.Pierre/DeSalaberry.

Figure 72. Binge Drinking by RHA, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

Figure 73. Binge Drinking by District, Southern Health-Santé Sud, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.
Age - and sex-adjusted percent of weighted sample aged



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

3.6.8. Tobacco Smoking

Definition: This indicator refers to the percentage of the population (age 12+) who reported being a current smoker – either daily or occasional.

Smoking tobacco is the leading cause of preventable death in Canada. Smokers and other tobacco users are more likely to develop chronic diseases and die earlier than people who don't use tobacco. Smoking is also the leading cause of lung cancer, and has been a contributing cause of many other forms of cancer (eg. mouth, throat, stomach, liver, kidney, bladder, ovary, cervix). Cigarettes contain nicotine, a highly addictive substance found naturally in tobacco, which can make quitting very difficult. To date, Health Canada is advising Canadians not to use electronic smoking products, as these products may pose health risks and have not been fully evaluated for safety, quality, and efficacy by Health Canada.

Smoking in Youth

9% overall currently smoked

6% overall smoked cigars or cigarellos

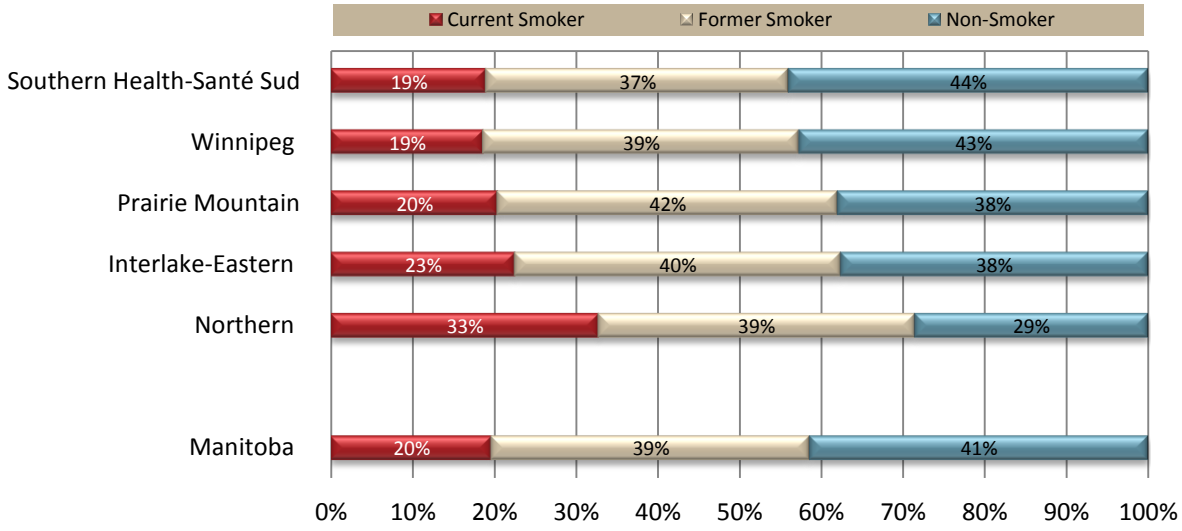
3% overall used chewing tobacco, snuff or dip

Source: Manitoba Youth Health Survey, 2012

Key Findings

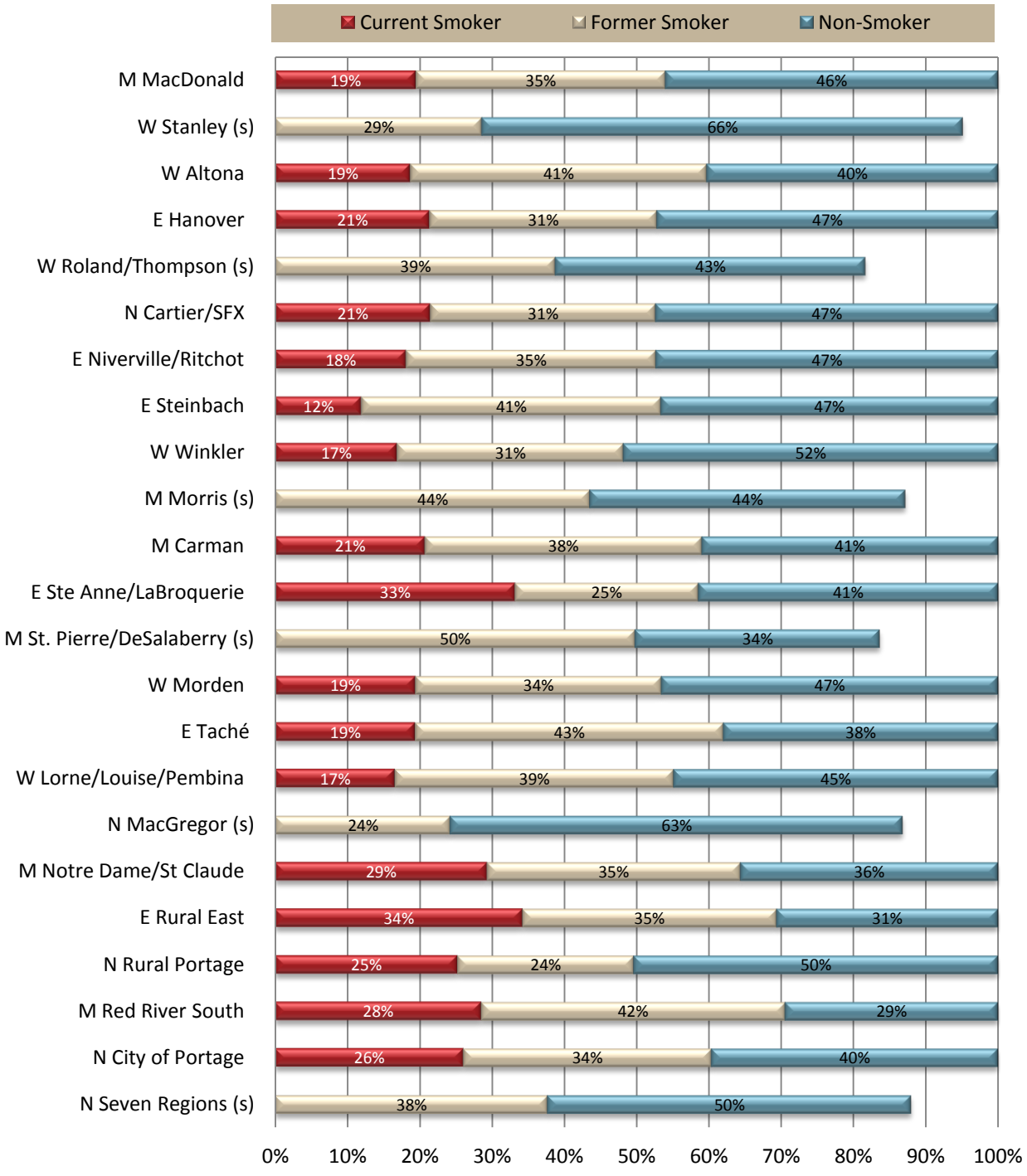
- According to the CCHS combined cycles, 20% of Manitobans (12+) reported being current smokers. A further 39% reported being former smokers, and 41% were non-smokers (see **Figure 74**).
- In comparison, Southern Health-Santé Sud had among the lowest smoking rates in the province (19% current smokers, 37% former smokers, and 44% non-smokers).
- As shown in **Figure 75**, rates varied within the region. Some data was again suppressed due to small numbers. The highest rates for tobacco smoking were in Rural East (34%) and Ste. Anne/LaBroquerie (33%).

Figure 74. Tobacco Smoking Rates by RHA, combined CCHS 2007-2008, 2009-2010, and 2011-2012.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

Figure 75. Tobacco Smoking Rates by District, Southern Health-Santé Sud, combined CCHS 2007-2008, 2009-2010, and 2011-2012.
Age - and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013.

3.6.9. Youth Sexual Health

Sexual attitudes and behaviors are established during the time leading up to and throughout adolescence. Healthy sexuality is a positive and life-affirming part of being human. However, sexual activity among teens can pose health risks such as unwanted pregnancy and sexually transmitted infections (STIs).

Overall, 81% of students reported that they have not had sex. The most common age that students reported first having sex was 15 years old.

Of the students who reported having sex, condoms were the most common method of protection reported. However, 12% of these students indicated using no method to prevent STIs and pregnancy.

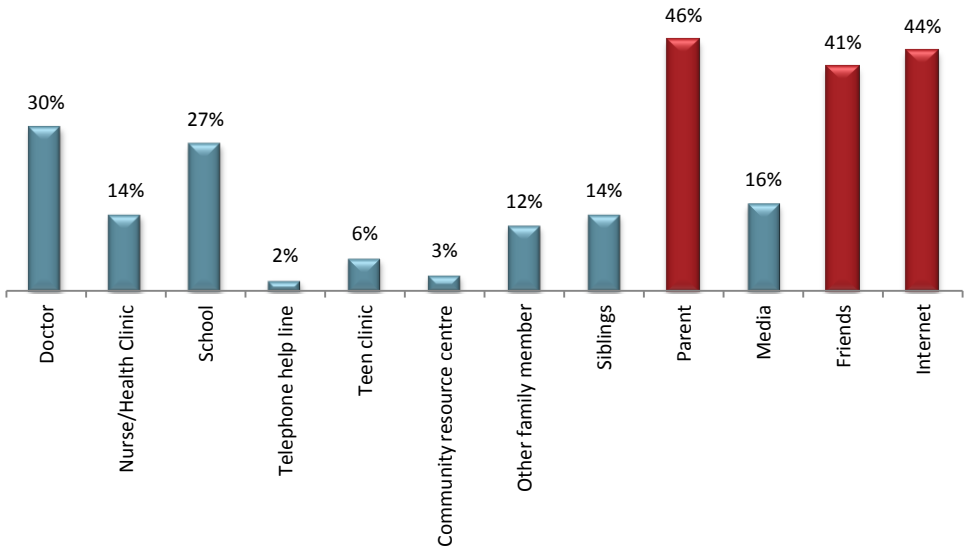
Adult acceptance of youth sexuality makes it easier for teens to recognize that they are sexual beings and ask for assistance when they need it. Students reported where they preferred to access information on sexuality, puberty, birth control and STIs which are presented in **Figure 76**. The top three responses included parents (46%), followed by internet (44%) and friends (41%).

Due to the sensitive nature of many of these questions, the healthy sexuality section of the YHS was optional. Depending upon the school division, this section was completed by:

a) All students in grade 7-12
b) Only grade 9-12 students
c) No students in grade 7-12

Therefore, the results of this section are based upon a subset of responses of participating students.

Figure 76. Where youth preferred access informaiton about sexual health, Southern Health-Santé Sud, 2012.



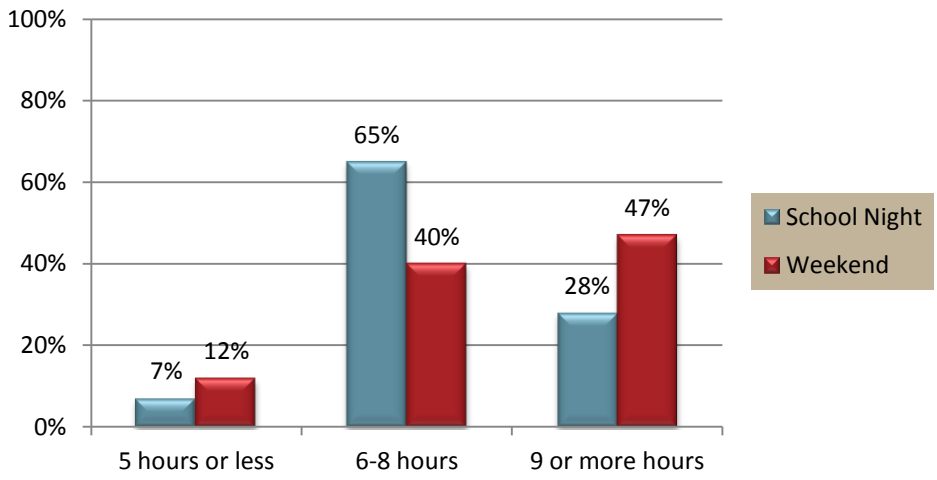
Source: Manitoba Youth Health Survey, 2012

3.6.10. Other Youth Health Behaviours

Sleep Time

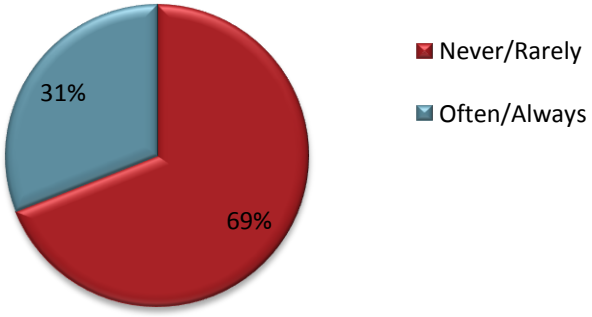
Adequate sleep is a critical factor in youth health and health-related behaviours. There is a significant correlation between sleep quality and mental wellbeing. Youth require 9 to 9 ½ hours of sleep per night, but as **Figure 77** shows the actual sleep time for this group is less.

Figure 77. Sleep Time for Youth, Southern Health-Santé Sud, 2012



Source: Manitoba Youth Health Survey, 2012

Figure 78. Use of Sun/UV Protection for Youth, Southern Health-Santé Sud, 2012



Source: Manitoba Youth Health Survey, 2012

Sun/UV Protection

Prevention of sun/UV damage is most important in youth because the effects of sun/UV exposure are cumulative over the lifetime.

However, 69% of students reported that they never or rarely used sun/UV protection (**Figure 78**).

Use of Safety Equipment

Injury is the top cause of death among children and youth. Most injuries are both preventable and predictable. However, the use of safety equipment among youth in Southern Health-Santé Sud continues to be low, as demonstrated in **Table 12.**

Table 12.Use of Safety Equipment for Youth, Southern Health-Santé Sud, 2012.

Proportion of students who reported "always"	Grades 7-12 Students
Use of helmet while cycling	6%
Use of helmet while riding ATV, snowmobile, dirt bike	48%
Use of seatbelt while in motor vehicle	75%
Wearing a life vest when in small boat	49%

Source: Manitoba Youth Health Survey, 2012

3.7. Disease Prevention

3.7.1. Immunizations

Influenza (age 65+)

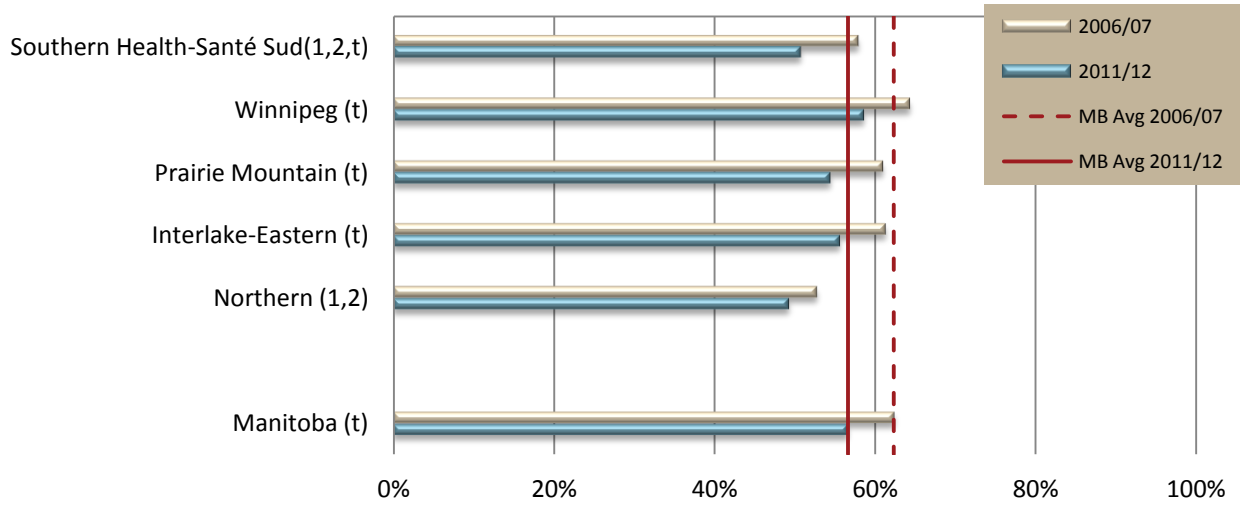
Definition: The percentage of residents aged 65 and older who received an influenza immunization in a year - 2006/07 compared to 2011/12.

Influenza immunization (aka "flu shot") is particularly important for seniors over 65 years of age, as this age group has the highest rate of hospitalization and death from flu. Common complications of the flu for seniors includes bacterial infection and pneumonia. Getting the flu shot helps to reduce the risk of serious complications and life-threatening illness.

Key Findings

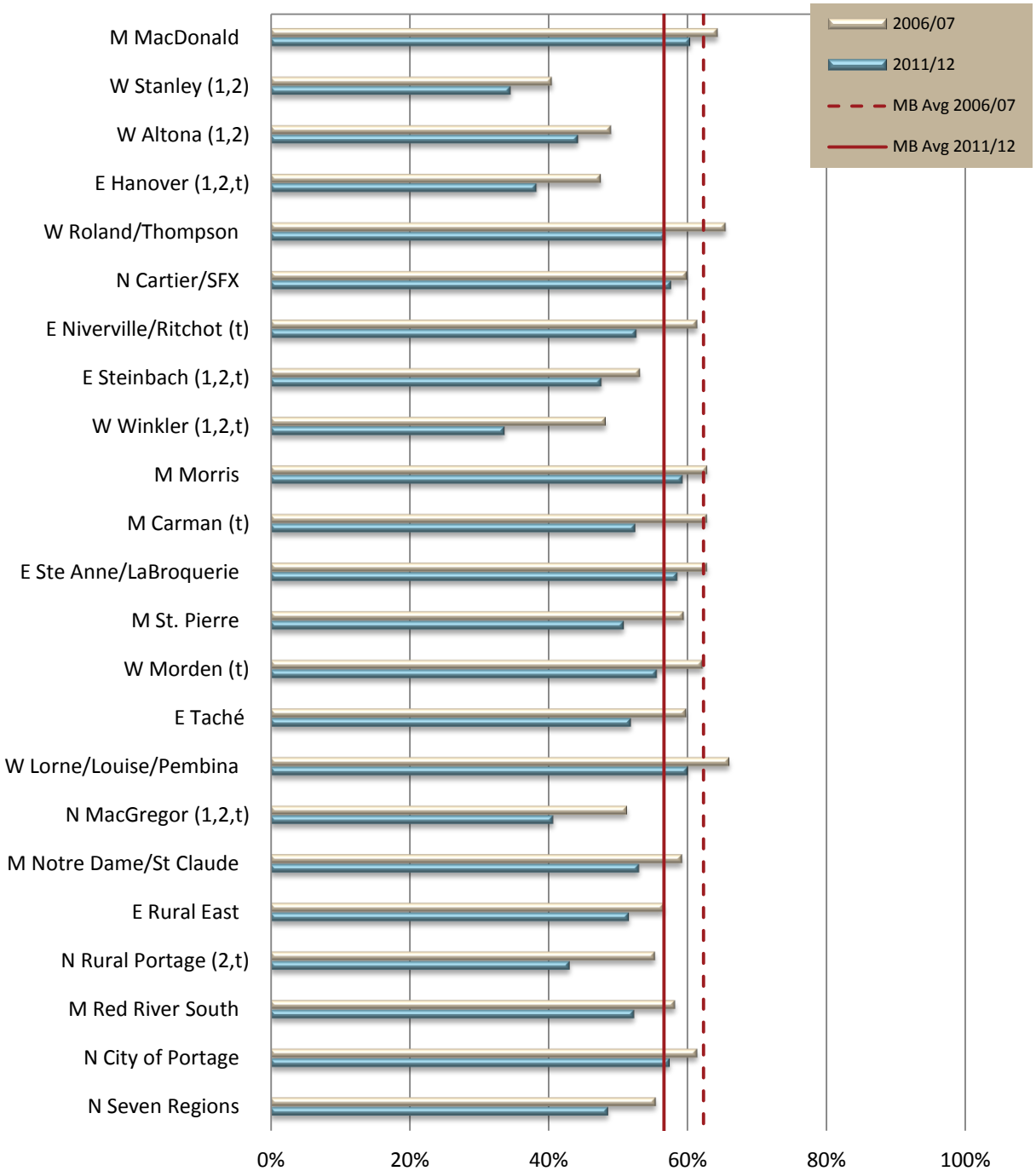
- As shown in **Figure 79**, in Manitoba, the proportion of residents aged 65 and older receiving an influenza immunization decreased significantly from 62.3% to 56.6%. Rates declined across all regions (only Northern RHA rate was not statistically significant).
- In Southern Health-Santé Sud, influenza immunization rates were significantly lower than the province and decreased over time from 57.9% to 50.8%.
- District level information is presented in **Figure 80**. Rates ranged from a high of 60.4% in Stanley to a low of 33.7% in Winkler. Over time, rates decreased significantly in the following districts: Hanover (38.3%), Niverville/Ritchot (52.6%), Steinbach (47.6%), Winkler (33.7%), Carman (52.5%), Morden (55.6%), MacGregor (40.7%), and Rural Portage (43.0%).

Figure 79. Influenza Immunization Rate by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents 65+ who received influenza vaccination



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 80. Influenza Immunization Rate by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents 65+ who received influenza vaccination



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Pneumococcal (age 65+)

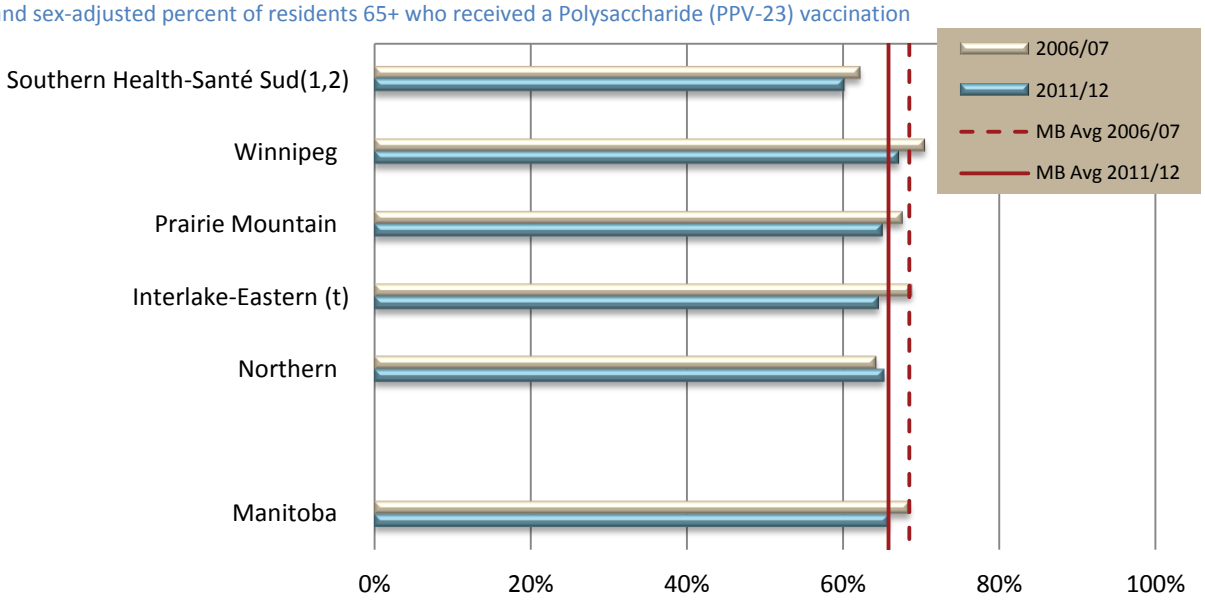
Definition: The percentage of residents aged 65 and older who received an pneumococcal immunization in a year - 2006/07 compared to 2011/12.

In Canada, there are about 500,000 cases of pneumococcal disease every year. In particular, older adults with health conditions (eg, heart, lung, diabetes) are at higher risk for complications compared to the general population. This bacterial infection is a common complication of seasonal influenza. This disease has become more resistant to antibiotics, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through immunizations even more important.

Key Findings

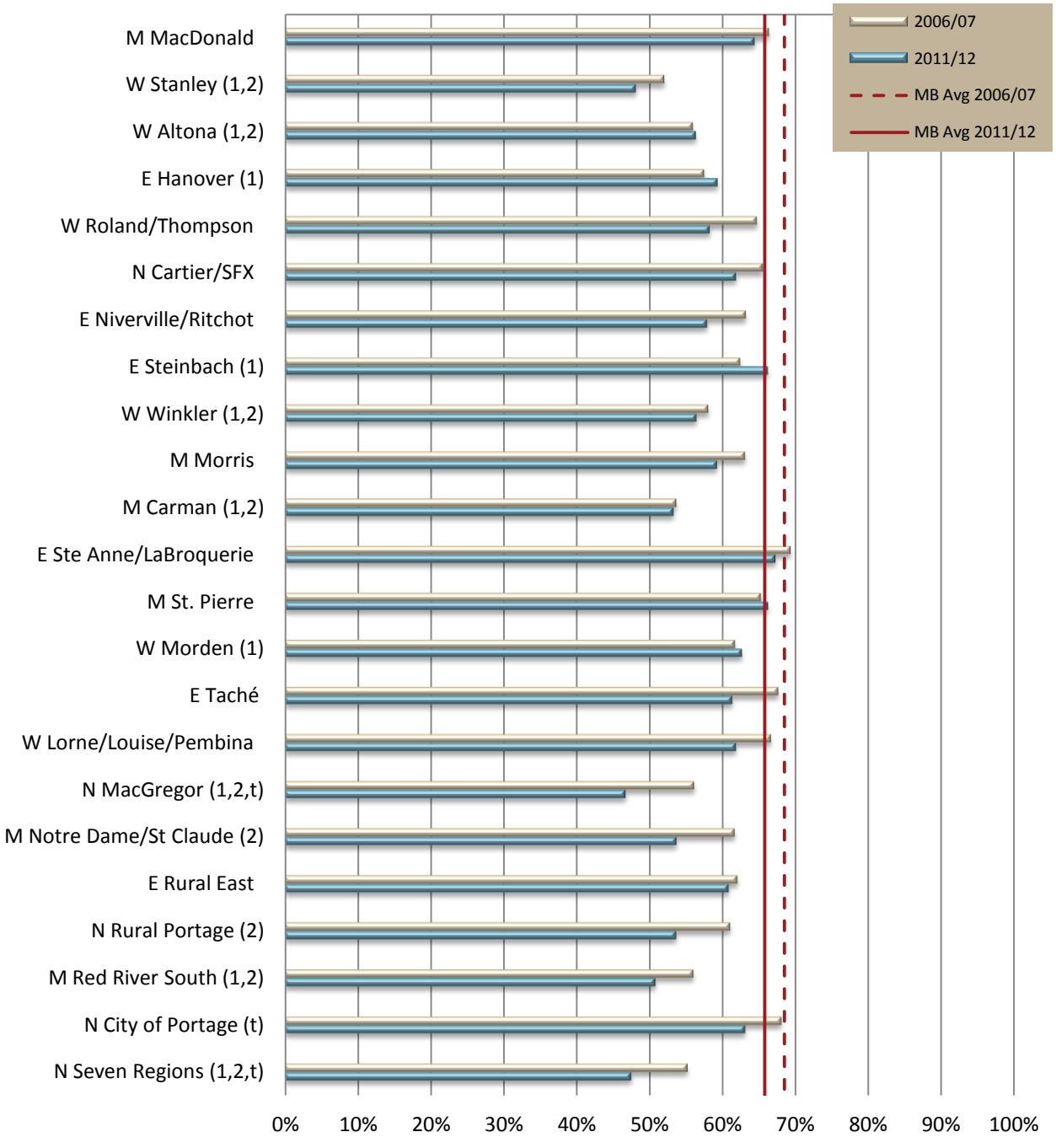
- As shown in **Figure 81**, in Manitoba, the proportion of residents aged 65 and older receiving a pneumococcal immunization decreased slightly from 68.5% to 65.8%.
- In Southern Health-Santé Sud, pneumococcal immunization rates were significantly lower than the province in both time periods, and decreased slightly over time from 62.2% to 60.1%.
- District level information is presented in **Figure 82**. Rates that were significantly lower than the provincial average in many districts including: Stanley (48.1%), Altona (56.4%), Winkler (56.4%), Carman (53.3%), Hanover (38.3%), Niverville/Ritchot (52.6%), Winkler (33.7%), Carman (52.5%), MacGregor (46.7%), Notre Dame/St.Claude (53.7%), Rural Portage (43.0%), Red River South (50.8%) and Seven Regions (47.5%). It is interesting to note that Steinbach was the only district that showed a small increase from 62.4% to 66.2%.

Figure 81. Pneumococcal Immunization Rate by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents 65+ who received a Polysaccharide (PPV-23) vaccination



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 82. Pneumococcal Immunization Rate by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents 65+ who received a Polysaccharide (PPV-23) vaccination



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Childhood Immunizations

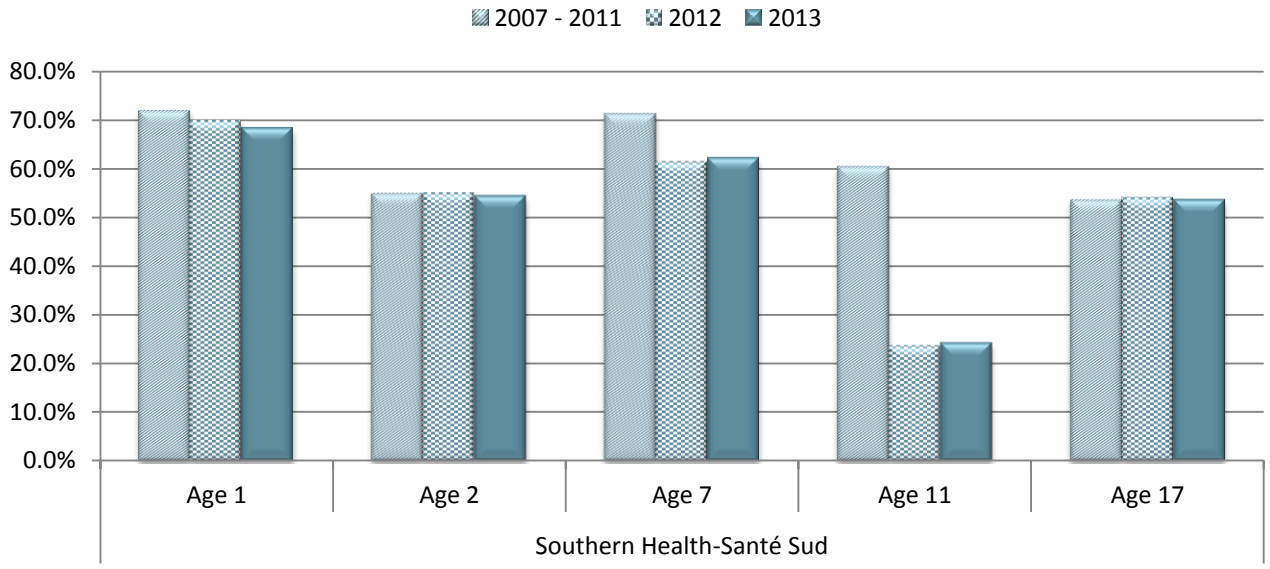
Definition: This indicator measures the proportion of children (age 1, 2, 7, 11, 17) that have received the complete immunization schedule (see **Table 13** below).

Vaccines are one of the most important components of child health programs. Vaccines help the immune system learn how to recognize and fight the germs that cause diseases, and are known to be very safe. Due to vaccines, not many Manitobans and Canadians get sick or die from vaccine-preventable diseases.

Key Findings

- **Figure 83** shows the immunization coverage by age group for Southern Health-Santé Sud – overall rates tended to decrease as children get older which is similar trend among all regional health authorites.
- Among 1 year olds – the 2013 regional rate was 68.3%, which is lower than the provincial rate of 78.2%. As illustrated in **Figure 83,** coverages rates for this age group have also decreased over time.
- Among 2 year olds – the 2013 regional rate dropped to 54.4% compared to 60.1% for the province.
- Among 7 year olds – the 2013 regional rate was 62.2%, which is similar to the provincial rate of 62.3%. This increase in coverage is likely due to the catch up period where parents immunize their children prior to entry into the school system.
- Among 11 year olds – the 2013 regional rate was 24.3%, which is similar to the provincial rate of 27.3%. Please note that in 2012 there was a change to the vaccine program so these rates are not comparable to previous years.
- Among 17 year olds – the regional rate was 53.6% which is higher than the provincial rate of 46.4%, likely due to efforts made by public health with reminder letters and regular review of immunization records.

Figure 83. Complete Immunization Rates By Age, Southern Health-Santé Sud, 2007-2013.



Source: Manitoba Immunization Monitoring System – Annual Report 2012/13

Table 13. Manitoba Health Childhood Immunization Schedule.

2, 4, AND 6 MONTHS
❖ One needle at each visit to protect against diphtheria, tetanus (lockjaw), pertussis (whooping cough), polio, and haemophilus influenza type b. (5 in 1 vaccine) ❖ Another needle at 2 and 4 month visits to protect against pneumococcal infections ❖ Another needle at 2 and 4 month visits to protect against rotavirus infections
12 MONTHS
❖ One needle to protect against measles, mumps, rubella, and varicella infections (4 in 1 vaccine) ❖ Another needle to protect against pneumococcal infections ❖ Another needle to protect against meningitis (C type) infections
18 MONTHS
❖ One needle to continue protection against diphtheria, tetanus (lockjaw), pertussis (whooping cough), polio, and haemophilus influenza type b. (5 in 1 vaccine)
4-6 YEARS
❖ One needle to continue protection against measles, mumps, rubella, and varicella infections (4 in 1 vaccine) ❖ Another needle to continue protection against diphtheria, tetanus (lockjaw), pertussis (whooping cough), polio (4 in 1 vaccine)
9-10 YEARS (GRADE 4)
❖ One needle for continued protection against meningitis (C type) ❖ Three-dose series of needles to protect against hepatitis B
11-12 YEARS (GRADE 6 GIRLS ONLY)
❖ Three-dose series of needles to protect against human papillomavirus (HPV)
14-16 YEARS
❖ One needle to continue protection against diphtheria, tetanus (lockjaw), and pertussis (whooping cough) (3 in 1 vaccine)

Source: http://www.gov.mb.ca/health/publichealth/cdc/div/schedules.html#school

3.7.2. Cancer Screening

Breast Cancer Screening (Mammography)

Definition: The percent of women ages 50-69 who had a screening mammogram in the last two years.

"BreastCheck" is a provincial mammography screening program operated by CancerCare Manitoba. It is recommended that all women between 50 and 69 years of age be screened for breast tumors or cancer, every two years. The goal of BreastCheck is to reach 70% of Manitoba women in this age group.

Key Findings

- **Table 14** shows that 63.8% of all Manitoba women (50-69 years) did have a mammogram within the past two years, and there was some variations across regions. The lowest rate was in Northern (55.0%). Rates are also provided for women who would have received their mammogram via BreastCheck.
- For women living in Southern Health-Santé Sud, breast cancer screening rates were lower than the provincial average at 61.6% for this time period.

Table 14. Percent of Women (Age 50-69) who had A Mammogram in the Past Two Years, By RHA, 2008-10.

Regional Health Authority	% Screened (all mammograms)	% Screened (BreastCheck only)
Southern Health-Santé Sud	61.6%*↓	56.5%
Winnipeg	64.2%	55.3%*↓
Prairie-Mountain	66.1%*↑	59.6%*↑
Interlake-Eastern	62.8%	58.5%*↑
Northern	55.0%*↓	50.8%*↓
Manitoba	63.8%	56.2%

*Significantly different than Manitoba average .
Source: CancerCare Manitoba- Community Health Assessment 2013-14

Cervical Cancer Screening (Pap test)

Definition: The percent of women ages 20-69 who had a screening pap test in the last three years.

About 45 women in Manitoba are diagnosed with cervical cancer each year. The majority of these women have not had a Pap test in five years or more. The good news is that research shows regular Pap tests can prevent up to 80% of cervical cancer. As well, the HPV vaccine will also help prevent the onset of cervical cancer. "CervixCheck" is a provincial mammography screening program operated by CancerCare Manitoba. It is recommended that all women between 20 and 69 years of age be screened for cervical cancer, every three years.

Key Findings

- **Table 15** shows that 66.8% of all Manitoba women (20-69 years) did have a Pap test within the past three years. The lowest screening rates was in Northern (61.9%).
- For women living in Southern Health-Santé Sud, cervical cancer screening rates were higher than the provincial average at 70.5% for this time period.

Table 15. Percent of Women (Age 20-69) Who Had A Pap test in the Past Three Years, By RHA, 2009-12.

Regional Health Authority	% Screened
Southern Health-Santé Sud	70.5%*↑
Winnipeg	70.1%*↑
Prairie-Mountain	67.2%
Interlake-Eastern	71.0%*↑
Northern	61.9%*↓
Manitoba	66.8%

*Significantly different than Manitoba average .
Source: CancerCare Manitoba- Community Health Assessment 2013-14

Colorectal Cancer Screening (FOBT or scope)

Definition: The percent of men and women ages 50-74 who had a Fecal Occult Blood Test (FOBT) in the past two years, or flexible sigmoidoscopy/colonoscopy in the past five years.

"ColonCheck" is a provincial colorectal cancer screening program operated by CancerCare Manitoba. This program invites average risk individuals (no symptoms or personal history of colorectal cancer, no diseases of colon requiring scopes) between 50 and 74 years to be screened with a FOBT.

Key Findings

- **Table 16** shows that only 31.9% of all Manitobans (50-74 years) were screened for colorectal cancer using a FOBT. Rates were extremely low in Northern (1.5%) and highest in Winnipeg (40.4%). The table also shows rates for Manitoba by factoring in both FOBT and scopes.
- For men and women living in Southern Health-Santé Sud, colorectal cancer screening rates were lower than the provincial average – 22.9% FOBT only and 37.8% FOBT and scopes.

FOBT Home kit

Table 16. Percent of Men and Women (Age 50-74) Who Had A Fecal Occult Blood Test (FOBT) in the Past two Years, or a Flexible Sigmoidoscopy/Colonoscopy in the Past Five Years, By RHA, 2009-10.

Regional Health Authority	% Screened (FOBT only)	% Screened (FOBT or scope)
Southern Health-Santé Sud	22.9%*↓	37.8%*↓
Winnipeg	40.4%*↑	51.9%*↑
Prairie-Mountain	20.6%*↓	39.0%*↓
Interlake-Eastern	24.4%*↓	39.1%*↓
Northern	1.5%*↓	12.9%*↓
Manitoba	31.9%	45.2%

*Significantly different than Manitoba average .
Source: CancerCare Manitoba- Community Health Assessment 2013-14

3.7.3. Child Health

Breastfeeding Initiation

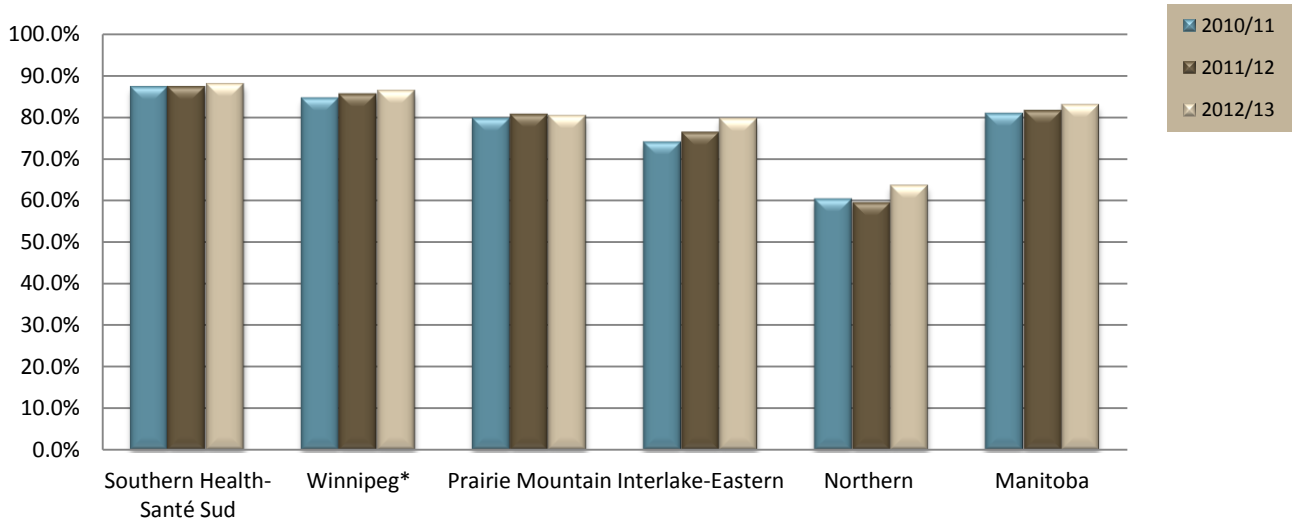
Definition: The proportion of women who deliver in hospital and initiate breastfeeding (either breast only or breast and bottle) while they are in hospital.

Breastfeeding has been recognized by the World Health Organization and other national bodies as a key contributor to the healthy growth and development of infants. Not only does it reduce the incidence of allergies and infections, but it enhances cognitive development. As well, the benefits to mothers include a faster return to pre-pregancy weight, stronger bones later in life, and lower rates of breast and ovarian cancer. Health Canada promotes exclusive breastfeeding for the first six months of life – although any amount is beneficial.

Key Findings

- **Figure 84** shows that breastfeeding initiation rates have gone up slightly in the province over the years – this increase has been seen across all regions.
- Southern Health-Santé Sud, has the highest rates of breastfeeding initiation compared to other regions. Rates have remained steady at approximately 87%.
- **Figure 85** shows breastfeeding initiation rates broken down by the four administrative areas within Southern Health-Santé Sud. Results show that rates were similar across Southern-Mid, West, and East at around 90%, while Southern—North was lowest at only 76%.
- Bethesda Regional Hospital in Steinbach received ***Baby Friendly*** designation in January 2014 – a first in the province!

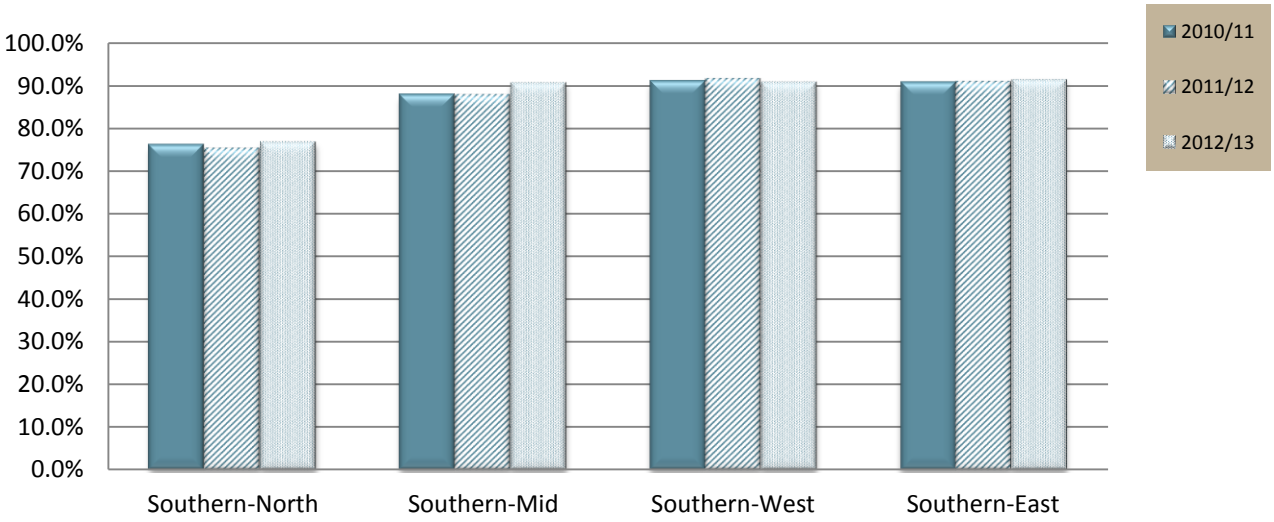
Figure 84. Breastfeeding Initiation Rates For In-Hospital Live Births by RHA, 2010-2013.



* Data for Winnipeg - Churchill supressed for 2012/13

Source: Manitoba Health, RHA Profile 2013

Figure 85. Breastfeeding Initiation Rates For In-Hospital Live Births by Area, Southern Health-Santé Sud, 2010/11-2012/13.



Source: Manitoba Health, RHA Profile 2013

In 1992, WHO/UNICEF began a world-wide accreditation process called the **Baby Friendly Hospital Initiative** (BFHI), which designates hospitals complying with the Ten Steps to Successful Breastfeeding and the WHO International Code of Marketing of Breast Milk Substitutes as "Baby Friendly" – over 20,000 hospitals are accredited in 156 countries to date. In Canada, the Breastfeeding Committee for Canada has designated 6 hospitals, 3 birthing centres and 13 community facilities to date as accredited. In Manitoba, Bethesda Regional Hospital in Steinbach was designated in January 2014.

The Baby Friendly Initiative is

- a coordinated program that enables hospital/maternity/community facilities to protect, promote and support breastfeeding
- an international accreditation process which evaluates hospital/birth centre/community policies/practice of breastfeeding.

Inadequate Prenatal Care

Definition: The proportion of women with no or inadequate prenatal care as determined used the Revised Graduated Index of PNC utilization (R-GINDEX). This is a new indicator.

R-GINDEX is based on the following three variables:

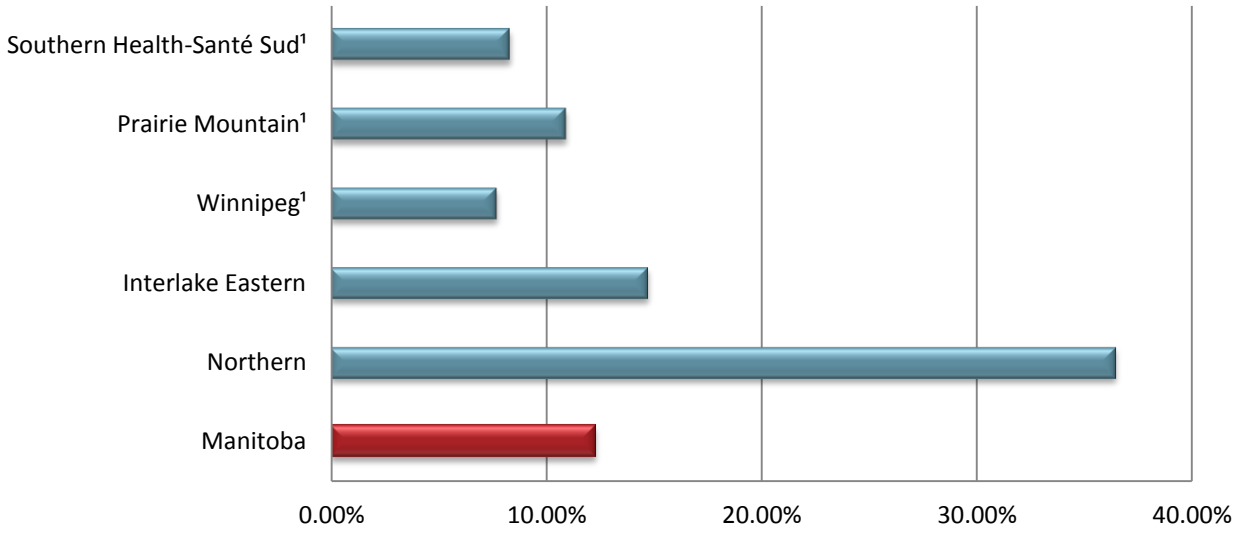
1. gestational age of infant (date of birth)
2. trimester during which prenatal care began (date of first prenatal visit)
3. total number of prenatal visits during pregnancy

Prenatal visits are very important for the health of both infant and mother. Health care providers can educate mothers on important health issues (eg, nutrition, exercise, immunization, weight gain, abstaining from drugs and alcohol). Health professionals also have an opportunity to instruct expecting parents on the benefits of breastfeeding, injury and illness prevention, monitor for health-compromising conditions, and help them prepare for the new emotional challenges of caring for an infant. Mothers who receive late (defined as beginning in the third trimester of pregnancy) or no prenatal care are more likely to have babies with health problems.

Key Findings

- **Figure 86** shows that the Manitoba rate for inadequate prenatal care was 12.3%.
- Regional rates varied with lowest rates in Winnipeg at 7.7% compared to over 36% in Northern.
- The rate for inadequate prenatal care for Southern Health-Santé Sud was 8.3%.
- District level rates for this indicator are not available.

Figure 86. Inadequate Prenatal Care by RHA, 2007/08-2008/09.
Percentage of women with no or inadequate prenatal care.



[1] signficantly different rate compared to Manitoba average.
Source: MCHP, Perinatal Services and Outcomes in Manitoba 2012

Dental Extraction Surgeries

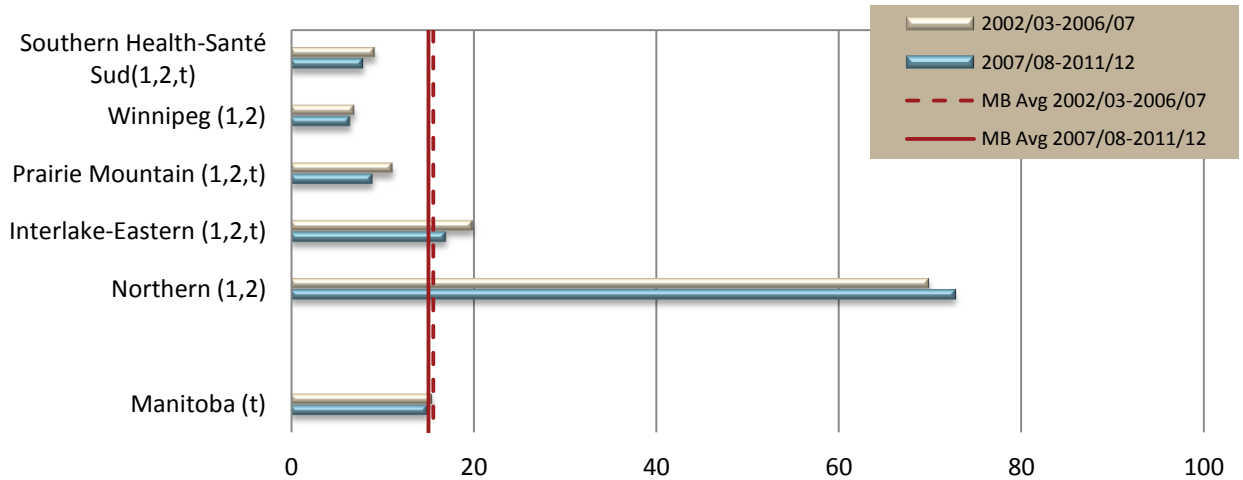
Definition: The rate of dental extraction surgeries per 1,000 residents ages 0 to 5 years, based on hospital codes. This indicator includes young children who have severe dental problems which requires surgical treatment and general anesthesia.

"Early childhood caries," the technical term for rotting baby teeth, are generally preventable. If caught early, it's treatable with fillings or varnishes at a dentist's office. But this infectious disease can lead to poor growth, behavioural problems, poor learning and sleep loss. The Canadian Dental Association recommends that infants see a dentist within six months of getting their first tooth or by one year of age, in order to catch small problems early. Dentists suggest using water containing fluoride and avoiding sugary snacks, since children with more sugary diets tend to have a more harmful bacteria in their mouths that cause tooth decay.

Key Findings

- **Figure 87** shows that the Manitoba rate for dental extraction surgeries decreased significantly over time to 15 per 1,000 under age 6.
- Rates were related to PMR and were much higher in Northern than any other region – 72 per 1,000 under age 6.
- Southern Health-Santé Sud was the lower than the provincial rate and decreased significantly over time to 8 per 1,000 ages 0 to 5 years.
- **Figure 88** shows the district rates within the region. Some data were suppressed due to small numbers. Many district rates were lower than provincial averages except for Seven Regions which was significantly higher at 43 per 1,000 under age 6.

Figure 87. Dental Extraction Surgery Rate by RHA, 2002/03-2006/07 and 2007/08-2011/12
Crude average annual rate per 1,000 residents under age 6



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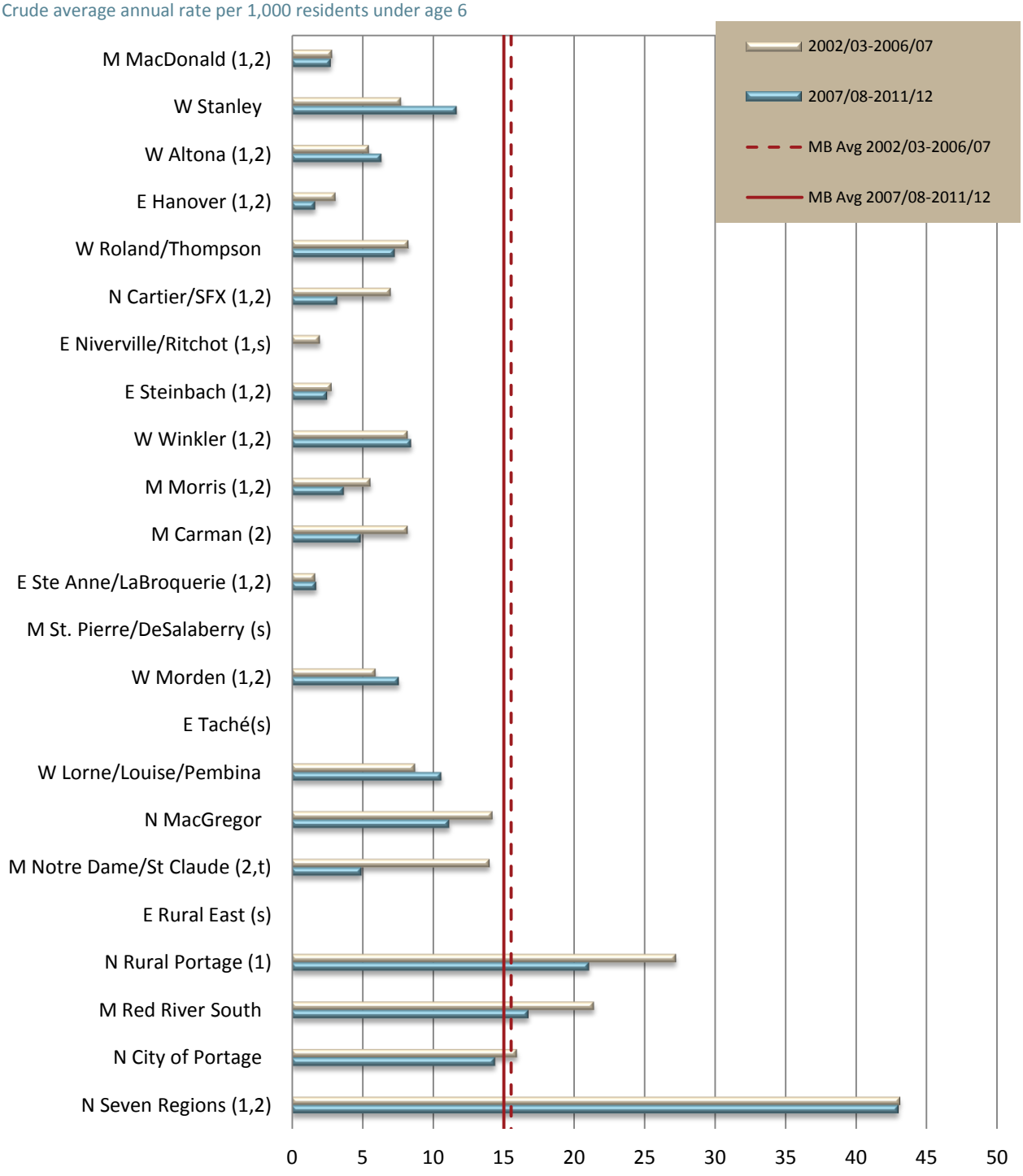
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 88. Dental Extraction Surgery Rate by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.
Crude average annual rate per 1,000 residents under age 6



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Source: MCHP, RHA Atlas 2013

3.8. List of Figures

3.9. List of Tables

How People are using Health Services

Chapter 4

How People are using Health Services

4.1. Chapter Highlights

This chapter examines how Southern Health-Santé Sud residents are using health services. In particular, this chapter examines use of hospital services, primary care services and long term care services. As well, a few quality indicators were included to help get an understanding about quality of primary care.

Hospital Services

- Hospital beds per capita was lower in the Southern Health-Santé Sud than in Manitoba overall, decreasing from 2.82 to 2.52 per 1,000 residents between 2006/07 and 2011/12.
- In 2011/12 Southern Health-Santé Sud residents had approximately 31,000 hospitalizations with 56.3% of them occurring within the region and approximately 40% in Winnipeg. During this time period, the region was responsible for just over 20,000 hospitalizations, with the majority occurring for residents within the region (87.3%).
- Hospital use in the region showed a slight decrease over time from 7.5% to 7.1% of residents, slightly higher than the provincial rate although not significant.
- Rates for short term hospital stays in the Southern Health-Santé Sud region declined from 309 to 255 days per 1,000 residents, which is similar to the provincial average.
- Rates for long terms stays (including transitional care facilities) increased slightly from 581 to 586 days per 1,000 residents while declining provincially.
- The top four causes for hospitalization in the region were digestive disorders, pregnancy and birth, health status and contact, and circulatory with little change over time.
- The hospitalization rate for Ambulatory Case Sensitive conditions among Southern Health-Santé Sud residents decreased significantly from 9.1 to 6.0 per 1,000 residents with wide range of rates within the region.
- The readmission hospitalization rate for Southern Health-Santé Sud decreased from 9.6% to 8.8%, a statistically significant drop.

Physician Services

- For Southern Health-Santé Sud, the proportion of residents with at least one physician visit remained steady and close to the provincial average. Physician use rates were below the provincial average in Stanley, Hanover, Steinbach, St. Pierre/DeSalaberry, MacGregor, and Rural East.
- Southern Health-Santé Sud ambulatory care rates were found to be statistically below the Manitoba average.

- Health status and contact was the most common reason for physician visits in the region with musculoskeletal as number two reason. This is similar with findings for the province overall.
- About three-quarters of physician visits by regional residents were found to be within Southern Health-Santé Sud with almost half (46%) in their home district.
- The location of specialist visits for Southern Health-Santé Sud residents was mainly in Winnipeg (83%) with 15% of visits within the region.
- Similar to the provincial average, 86% of Southern Health-Santé Sud residents reported having a regular medical doctor. Of the residents who reported not having a regular medical doctor, slightly over half (51%) said they are looking for one.

Quality of Primary Care

- Southern Health-Santé Sud rates for antidepressant follow up were lower than provincial averages, decreasing significantly from 53% to 48%. Districts with rates significantly lower than the provincial average include Hanover, Steinbach, St. Pierre/DeSalaberry, MacGregor, Rural East, Red River South, and Seven Regions.
- For Southern Health-Santé Sud, asthma care rates increased slightly from 63% to 65%, similar to the provincial average.
- Eye exam rates for diabetes in Southern Health-Santé Sud were significantly higher than the provincial average and increased significantly over time from 36% to 43%. The Seven Regions district had significantly lower eye exam rates.
- Rates of benzodiazepine prescribing for community seniors in Southern Health-Santé Sud was significantly higher than the province for both time periods, decreasing slightly from 23% to 22%. Within the region, rates were significantly higher in the Steinbach, Carman, Ste.Anne/LaBroquerie, St.Pierre/DeSalaberry, and Morden districts.

Personal Care Homes

- The proportion of residents age 75 and older who lived in a PCH in the region decreased from 12.8% to 11.5%.
- The median wait time for PCH admission while waiting in hospital increased significantly from 8.16 to 10.8 weeks which was higher than the provincial average.
- Regional PCH wait times while waiting in the community were also higher than the provincial average and increased from 17.4 to 22.6 weeks while waiting in community.
- The median length of stay for PCH residents in Southern Health-Santé Sud was similar to the Manitoba average and decreased from 2.48 to 2.24 years at all levels of care. Stays ranged from 4.60 years for Level 1/2N to 1.46 years for Level 4.
- Compared to the province, Southern Health-Santé Sud had a greater proportion of PCH residents with admissions at higher levels of care. More than 4 of 5 residents were admitted at either Level 3 or 4 (81.8%).

4.2. Hospital Services

Hospital Bed Supply

Definition: The number of acute care beds per 1,000 population.

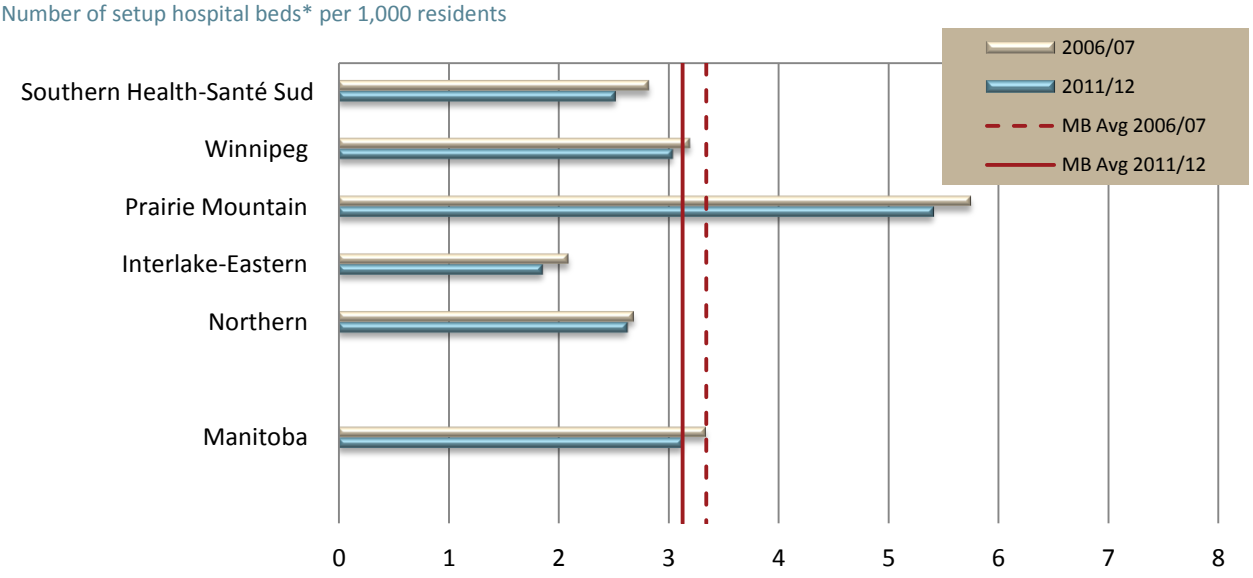
The bed counts come from "setup" data maintained by MHHL. These values should be interpreted with caution as the actual number of beds in use can vary throughout the year, and beds can also be used for non-acute care (e.g., transitional care). However, this indicator is useful in that it provides an overall picture of relative supply of beds across the province and the change over time. Regions with considerable population growth, like Southern Health-Santé Sud will likely show a decrease in beds per capita over time.

> *"I was very impressed with the hospital cleanliness, care and all of the staff. I felt very safe there."*
> *Community Member*

Key Findings

- Statistical testing was not done on this indicator to measure comparisons among regions.
- **Figure 1** shows that the provincial supply of hospital beds decreased from 3.35 to 3.13 per 1,000 residents. Prairie Mountain has the highest hospital bed supply.
- For Southern Health-Santé Sud, hospital beds per capita was lower than Manitoba. As well, rates decreased over time from 2.82 to 2.52 per 1,000 residents.
- **Table 1** shows a breakdown of acute care facilities within the region. In 2014, there were a total of seventeen hospitals (including three regional hospitals), one mental health centre, and one crisis stabilization unit. In total, there were 415 acute care beds, 42 transitional care beds, and 38 psychiatric beds.

Figure 1. Hospital Bed Supply by RHA, 2006/07 and 2011/12 .
Number of setup hospital beds* per 1,000 residents



* Bed numbers were copied from Manitoba Health data. Statistical testing is not performed on supply measures.
† The Churchill Health Centre has 28 beds, 7 of which serve as Personal Care Home beds.
Source: MCHP, RHA Atlas 2013

Table 1. Hospitals in Southern Health-Santé Sud, 2014.

Name of Facility	Location	# Acute Beds	# Other Beds
Altona Community Memorial Health Centre	Altona	22	
Carman Memorial Hospital	Carman	25	
Rock Lake District Health Centre	Crystal City	16	
Emerson Health Centre	Emerson		4*
Seven Regions Health Centre	Gladstone		14*
MacGregor Health Centre	MacGregor		6*
Pembina-Manitou Health Centre	Manitou		8*
Morris General Hospital	Morris	23	
Notre Dame Medical Nursing Unit	Notre Dame de Lourdes	9	
Portage District General Hospital	Portage la Prairie	88	
St Claude Health Centre	St Claude		10*
Lorne Memorial Hospital	Swan Lake	18	
Eden Mental Health Centre	Winkler		30**
Boundary Trails Regional Health Centre	Morden-Winkler	96	
Hôpital Ste. Anne	Ste. Anne	21	
Centro Medico-Social DeSalaberry District Health Centre	St. Pierre Jolys	14	
Bethesda Regional Health Centre	Steinbach	73	
Steinbach Crisis Stabilization Unit	Steinbach		8**
Vita and District PCH	Vita	10	

*Transitional care beds - awaiting placement for PCH

**Psychiatric beds

Source: Southern Health-Santé Sud

Transitional Care Facilities

Approximately 7 to 10 years ago, some facilities have shifted their ER and acute care services due to human resource challenges to transitional care where they are able to accommodate patients with longer term needs, often awaiting placement for PCH. These five facilities include Emerson Health Centre (Emerson), St. Claude Health Centre (St. Claude), Pembina Manitou Health Centre (Manitou), Seven Regions Health Centre (Gladstone), and MacGregor Health Centre (MacGregor).

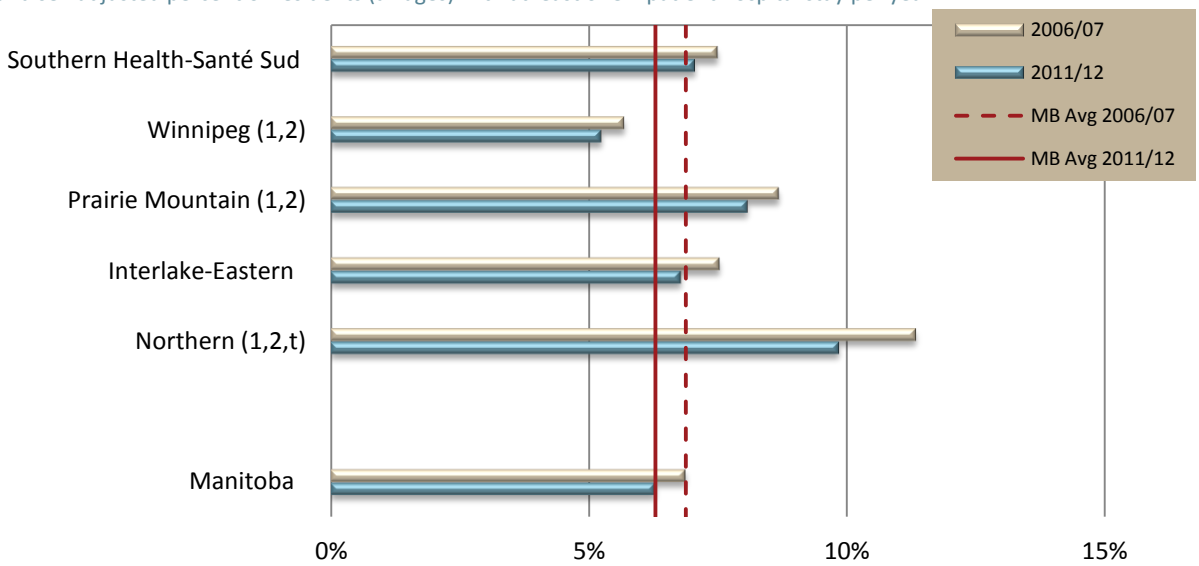
Use of Hospitals

Definition: The percent of residents who were admitted to an acute care hospital at least once in a fiscal year. Average annual rates were calculated for two 5-year time periods, and were age and sex adjusted to the Manitoba population for the same time periods

Key Findings

- **Figure 2** shows that hospital use in Manitoba decreased over time from 6.88% to 6.29%, though not statistically significant. Large variation in hospital use was observed across regions from 5% of Winnipeg residents to almost 10% of Northern residents.
- For Southern Health-Santé Sud, hospital use showed a slight decrease over time from 7.5% to 7.1% of residents. This is a higher rate compared to Manitoba, although not significant.
- **Figure 3** shows the rates within the region. Overall, there were few differences among regional residents. However, rates for hospital use were statistically higher than the provincial average in Carman (7.9%), Lorne/Louise/Pembina (9.2%), Rural Portage (8.3%), Portage City (8.0%) and Seven Regions (11.6%). Rates for Seven Regions, although highest in the region, did decrease significantly over time.

Figure 2. Use of Hospitals by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents (all ages) with at least one inpatient hospital stay per year.



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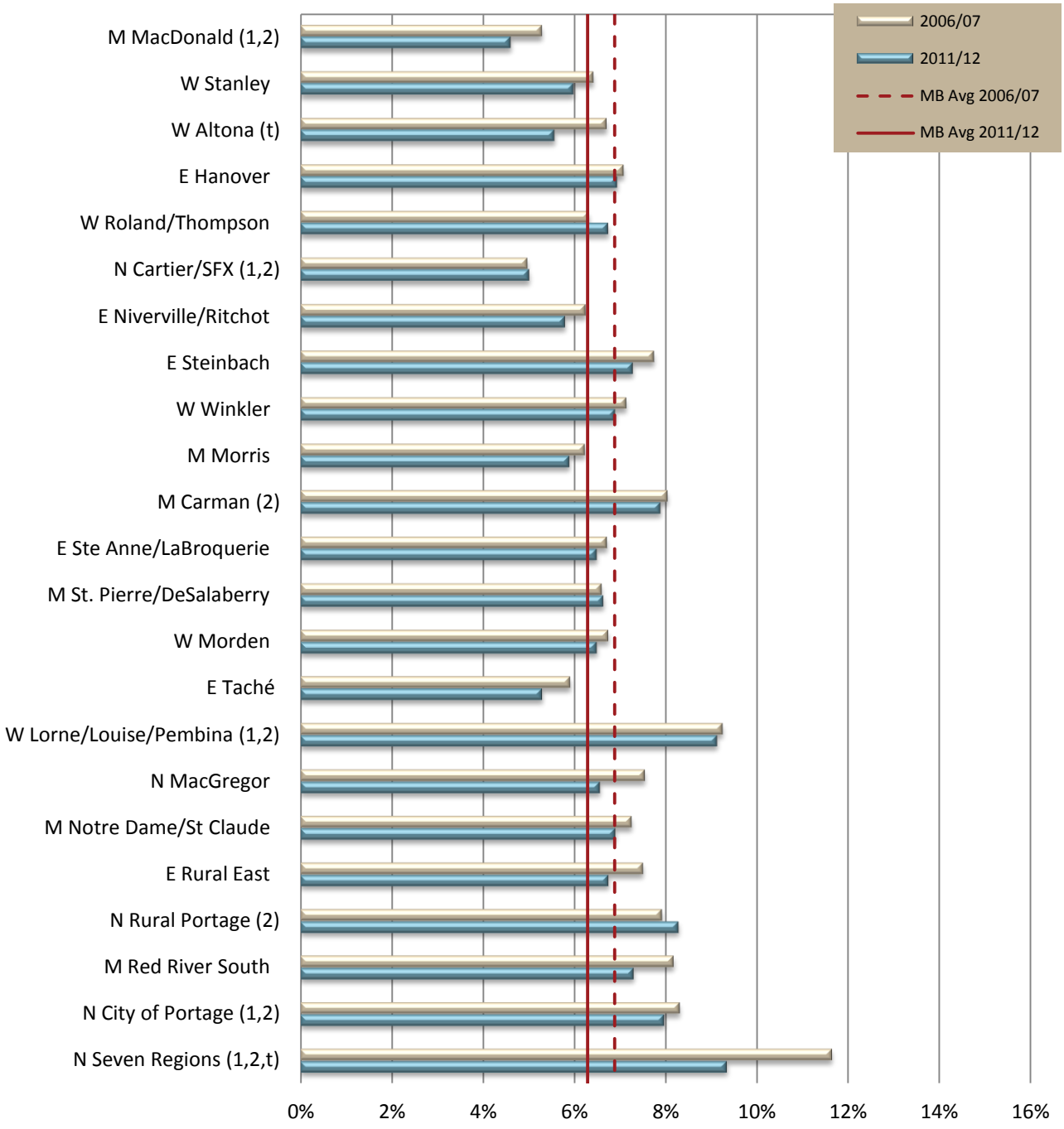
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 3. Use of Hospitals by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents (all ages) with at least one inpatient hospital stay per year.



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Source: MCHP, RHA Atlas 2013

Where Residents Were Hospitalized

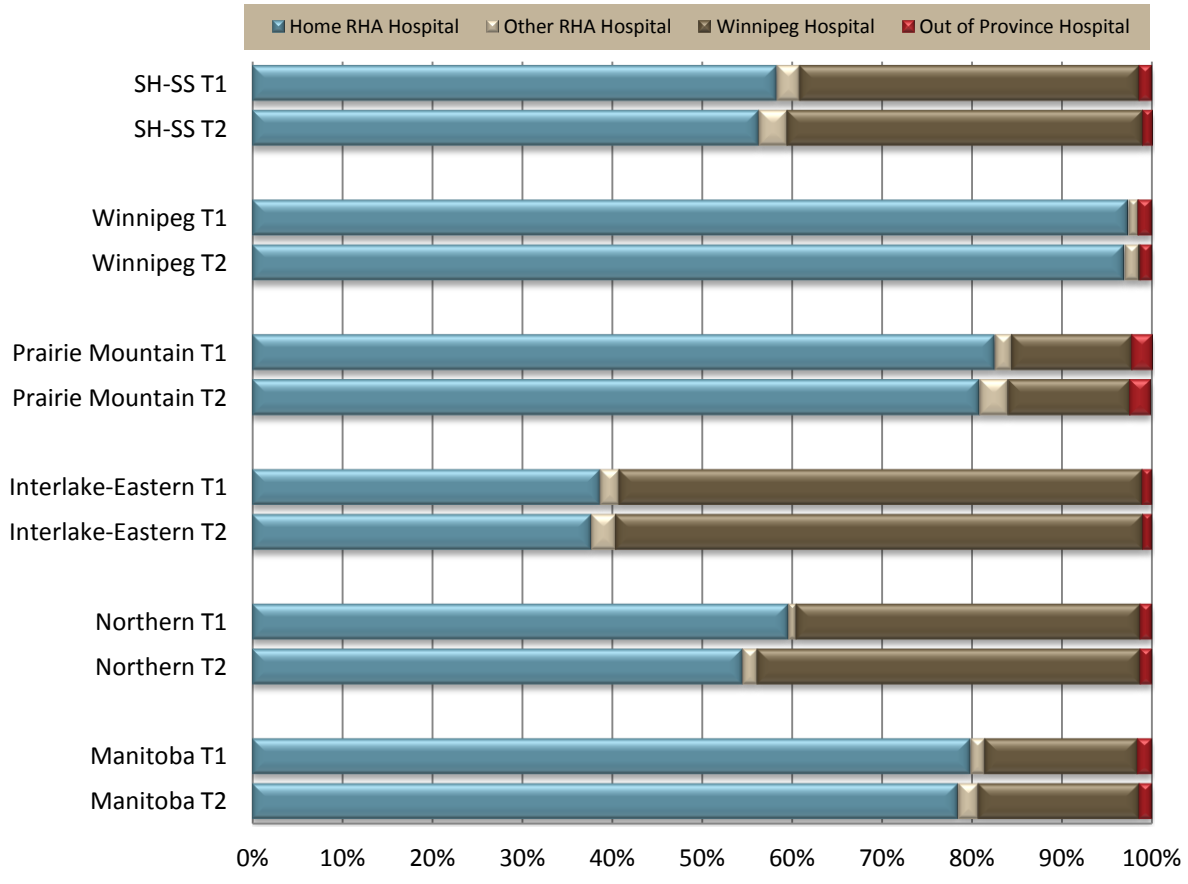
Definition: The percent of hospitalizations that occurred in a hospital within the resident's own RHA, in another RHA, in Winnipeg, or out-of-province.

This indicator looks at what proportion of residents travelled outside their RHA for hospitalization. Regions that have more local hospitals will tend to see less travel to outside RHAs or Winnipeg.

Key Findings

- **Figure 4** shows that the majority of Manitobans are hospitalized within their home RHA. Over time, the rate decreased slightly from 79.8 to 78.4% of residents staying within their RHA – however variation exists among regions, Interlake-Eastern with the lowest proportion.
- In 2011/12 Southern Health-Santé Sud residents had about 31,000 hospitalizations each year, with 56.3% of them occurring within the region. Approximately 40% of hospitalizations for regional residents occurred in Winnipeg.

Figure 4. Where RHA Patients Went for Hospitalizations, 2006/07 and 2011/12.
T1=2006/07 and T2=2011/12



Source: MCHP, RHA Atlas 2013

Where Patients Using RHA Hospitals Came From

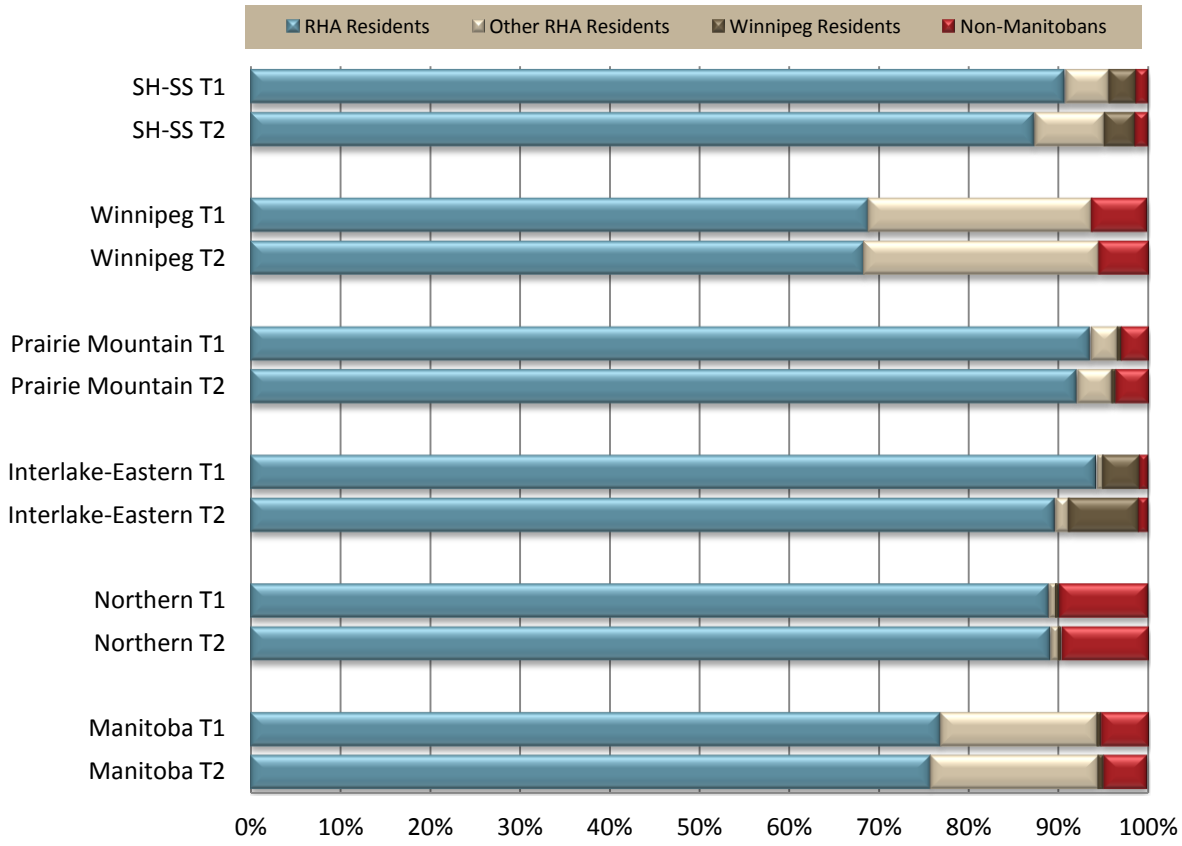
Definition: The percent of all the hospitalizations based on where the residents were coming from: within their RHA (Home), from another RHA, from Winnipeg, or out-of-province.

This indicator looks at hospital catchment to see what proportion of the services are provided to residents within the region and compared to those who are travelling from outside the region.

Key Findings

- **Figure 5** shows that the majority of hospital patients in Manitoba came from their own RHA (75.8%) and the proportion of these rates has been stable over time. Not surprisingly, Winnipeg had a greater proportion of hospital patients coming from outside the RHA.
- In 2011/12 Southern Health-Santé Sud had just over 20,000 hospitalizations, with 87.3% of them occurring for residents within the region.
- Approximately 40% of hospitalizations for regional residents occurred in Winnipeg.

Figure 5. Where RHA Hospital Patients Came From for Hospitalizations, 2006/07 and 2011/12.
T1=2006/07 and T2=2011/12



Source: MCHP, RHA Atlas 2013

Hospital Days – Short Stays and Long Stays

Definition: The number of hospital days used in short stays (under 14 days) and long stays (14+ days) per 1,000 residents per year.

A reduction in the number of hospital days used, as well as the number of "long stays" may be an indication of more efficient use of hospital resources through efforts to move patients to more appropriate settings.

Key Findings

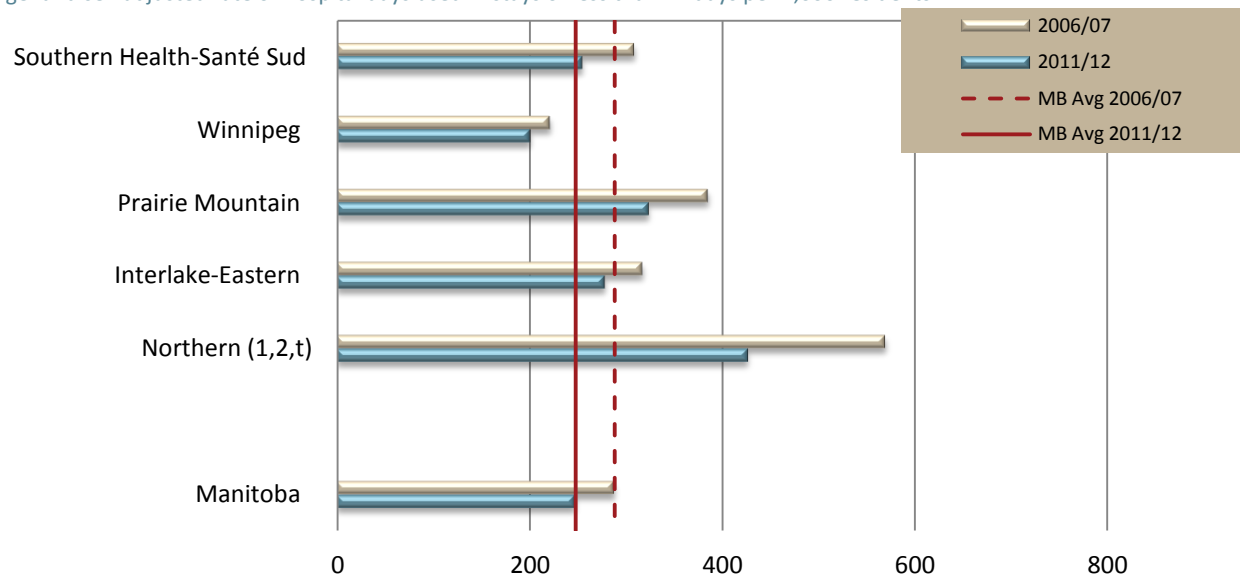
- **Figure 6** shows that the number of days used in short stays in Manitoba decreased slightly from 288 to 247 days per 1,000 residents.
    - Rates for Southern Health-Santé Sud went from 309 to 255 days per 1,000 residents, which is similar to the provincial average.
- **Figure 7** shows that the number of days used in long stays in Manitoba decreased from 640 to 567 days per 1,000 residents.
    - Rates for Southern Health-Santé Sud increased slightly from 581 to 586 days per 1,000 residents.

Three regional hospitals from left to right: Portage Health Centre (Portage la Prairie), Bethesda Regional Health Centre (Steinbach), Boundary Trails Health Centre (Morden-Winkler).

> *"We have no expectations of perfection – but there is an expectation of quality of care."*
> *Patient Experience Working Group*

Figure 6. Hospital Days Used in Short Stays by RHA, 2006/07 and 2011/12.

Age- and sex-adjusted rate of hospital days used in stays of less than 14 days per 1,000 residents



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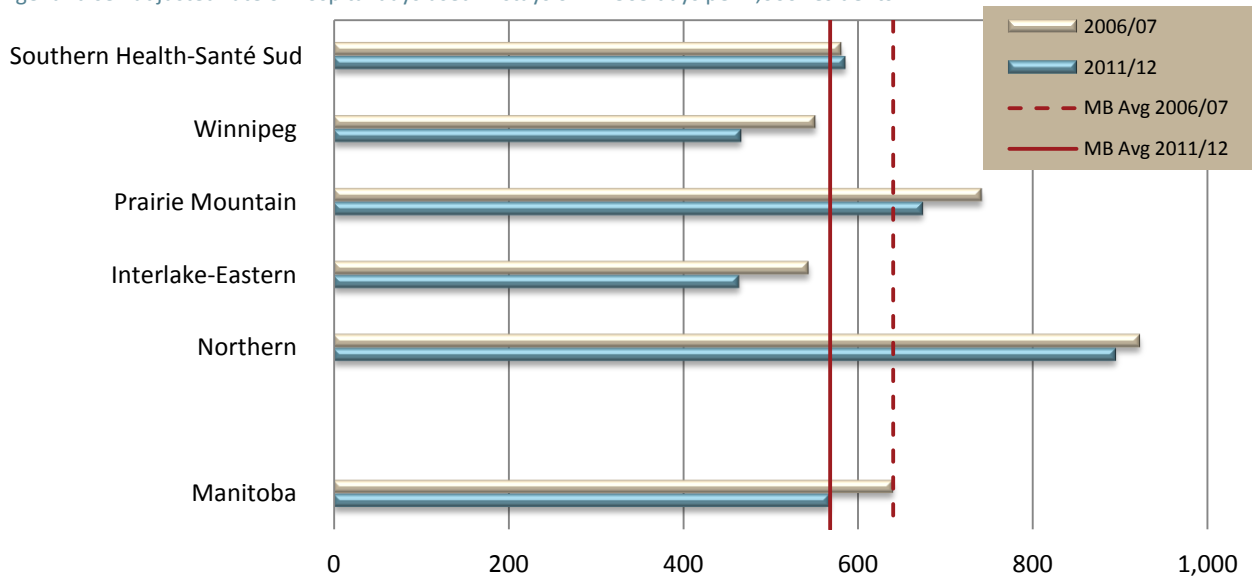
Source: MCHP, RHA Atlas 2013

Figure 7. Hospital Days Used in Long Stays by RHA, 2006/07 and 2011/12.

Age- and sex-adjusted rate of hospital days used in stays of 14-365 days per 1,000 residents



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Source: MCHP, RHA Atlas 2013

Causes of Hospitalizations

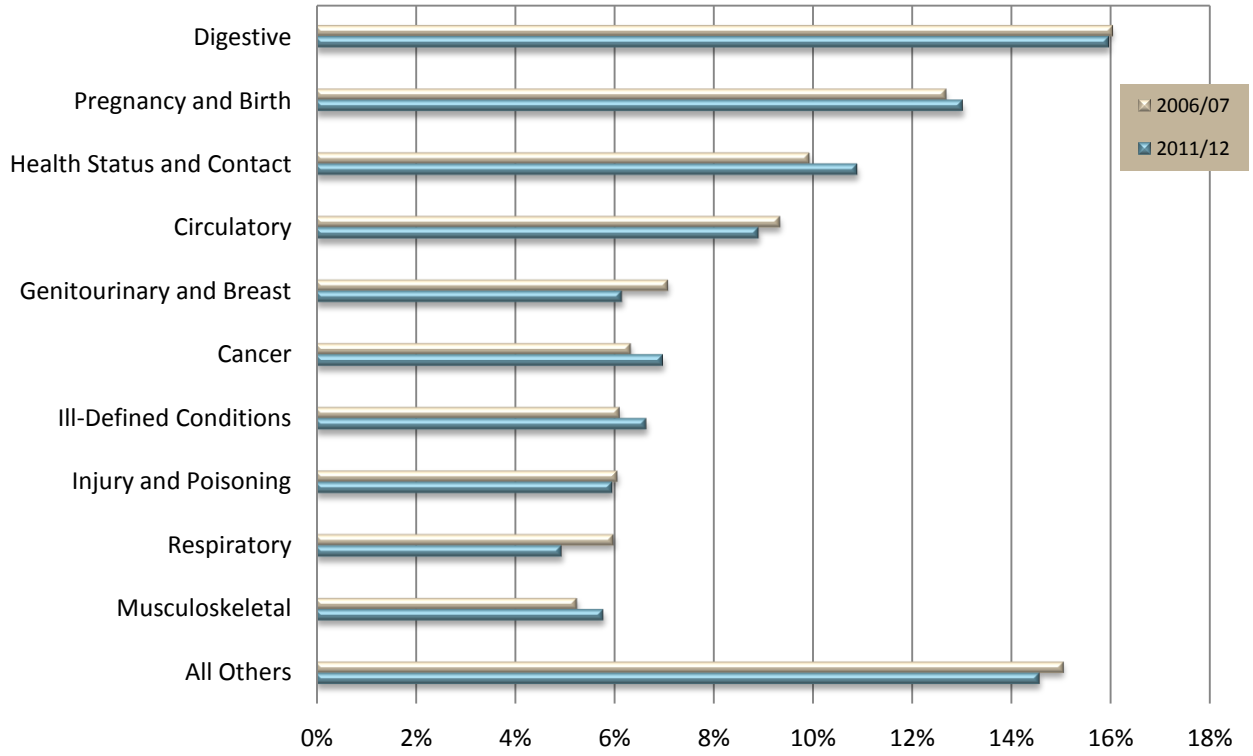
Definition: The most frequent reasons for inpatient hospitalizations and day surgeries for 2006/07 and 2011/12.

Looking at hospitalization by specific causes provides an idea of which diseases or disorders place the greatest demand on acute care services.

Key Findings

- **Figure 8** shows that the most frequent causes of hospitalization in Southern Health-Santé Sud did not change much over time.
- The top four causes for hospitalization in the region were: digestive disorders; pregnancy and birth; health status and contact; and circulatory.
    - Health status and contact is a broad category including a large number of issues not connected to specific diagnosis or disease such as colonoscopy, sterilization procedures, and palliative care.

Figure 8. Causes of Hospitalizations in Southern Health-Santé Sud, 2006/07 and 2011/12.
Average annual crude percent of hospitalizations.



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Source: MCHP, RHA Atlas 2013

Hospitalization Rate for Ambulatory Care Sensitive Conditions

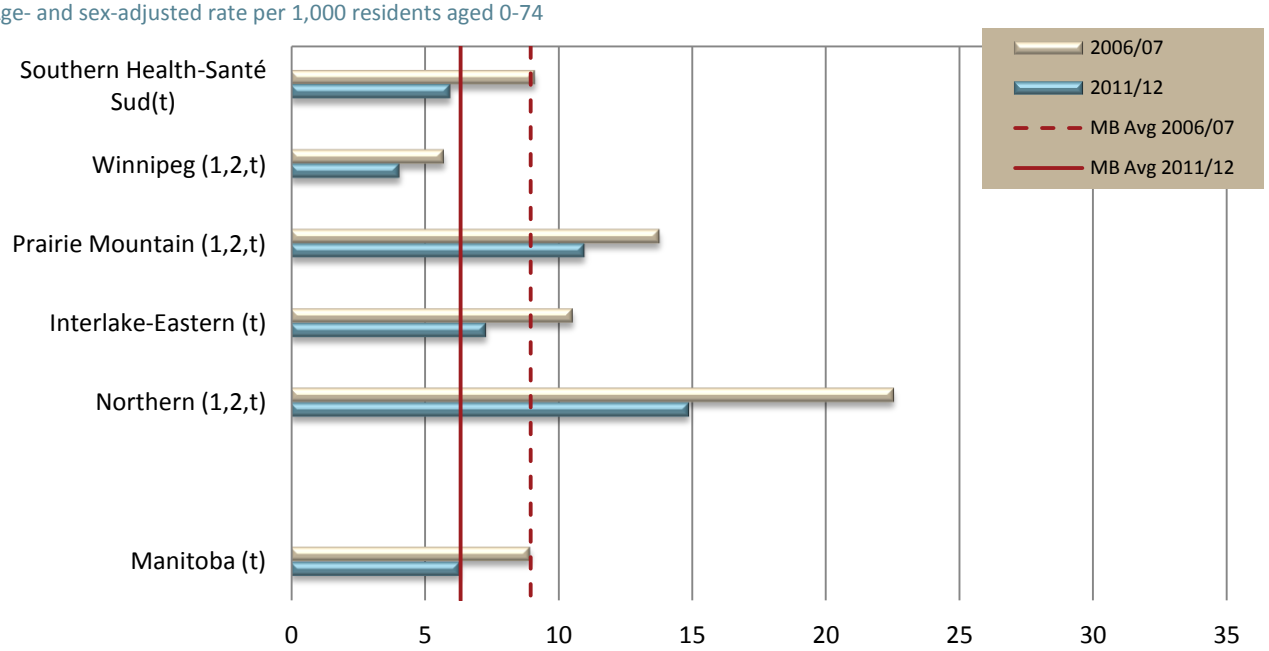
Definition: The hospitalization rate per 1,000 residents under 75 years for ambulatory care sensitive (ACS) conditions.

This indicator, although it refers to hospitalization, is actually an important measurement of access to good quality primary care. ACS conditions are a group of 17 diseases (e.g., asthma, angina, gastroenteritis, congestive heart failure) which, if managed appropriately by a physician or community program, should not result in a person becoming so ill that they require hospitalization. Lower rates reflect better access to primary care.

Key Findings

- **Figure 9** shows that the rate of hospitalization for ACS conditions decreased significantly over time from 9.0 to 6.3 hospitalizations per 1,000 residents (0-74 years). Higher rates were observed in Northern and Interlake-Eastern, however both regions showed decreases.
- The hospitalization rate for ACS conditions among Southern Health-Santé Sud residents also decreased significantly from 9.1 to 6.0 per 1,000 residents.
- **Figure 10** shows the rates among districts within the region. A number of districts had rates significantly lower than the provincial average including: MacDonald, Stanley, Cartier/SFX, and Morden. As well, a few districts had rates significantly higher than the Manitoba average including: Lorne/Louise/Pembina, Portage city, and Seven Regions.

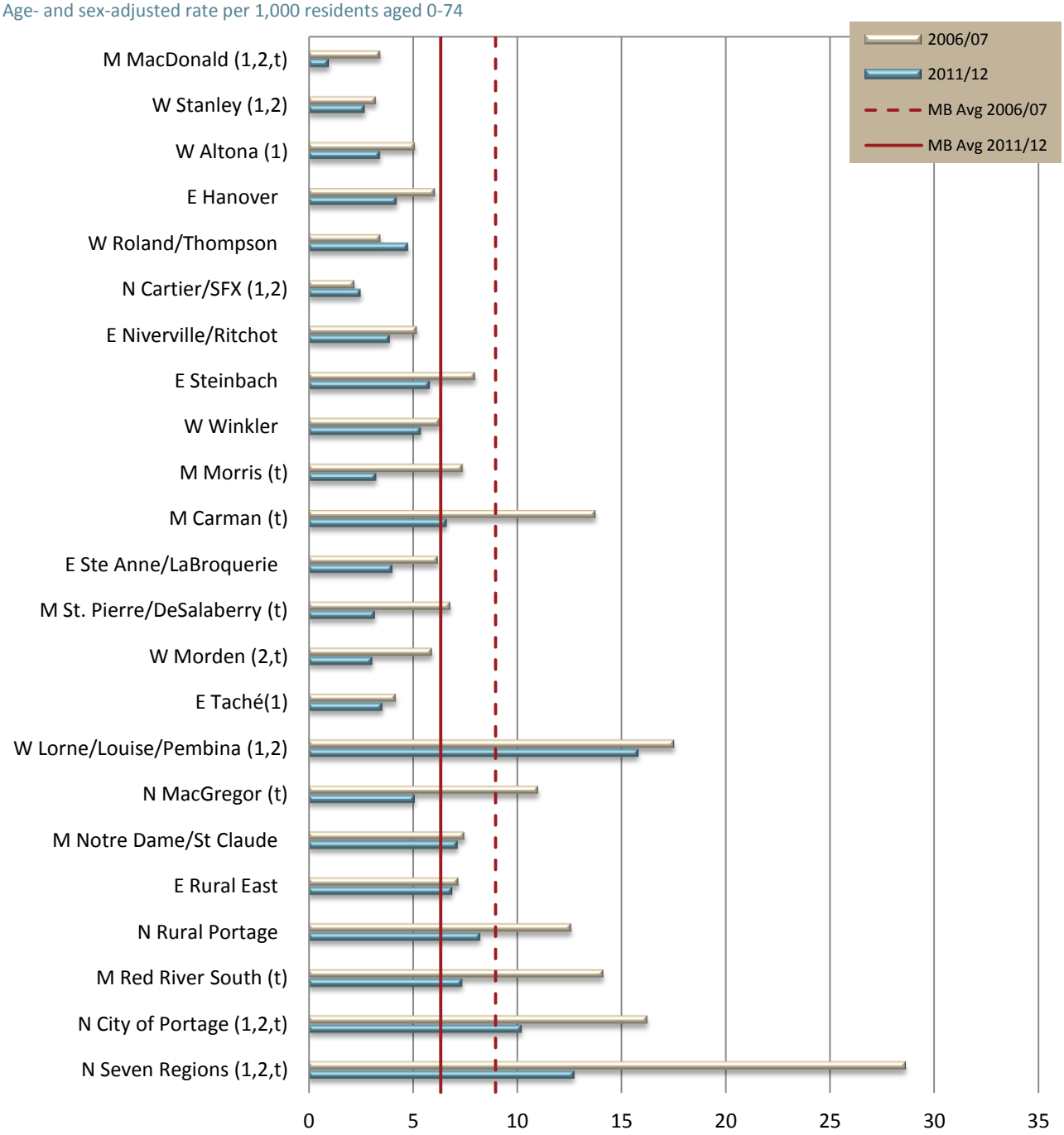
Figure 9. Hospitalization Rate for Ambulatory Care Sensitive Conditions by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted rate per 1,000 residents aged 0-74



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 10. Hospitalization Rate for Ambulatory Care Sensitive Conditions by District, Southern Health-Santé Sud, 2006/07 and 2011/12.

Age- and sex-adjusted rate per 1,000 residents aged 0-74



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP RHA Atlas 2013

Hospitalization Readmission

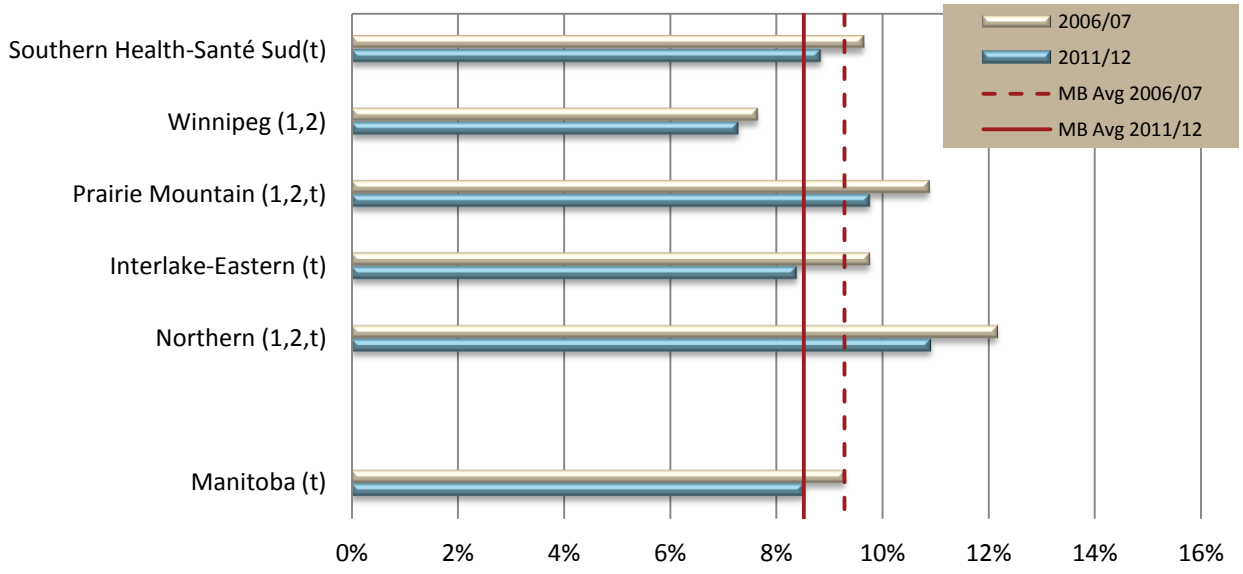
Definition: The percent of hospital episodes after which the patient was admitted again to any hospital within 30 days of discharge. Only unplanned inpatient readmissions were included.

Although readmission may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge.

Key Findings

- **Figure 11** shows that hospitalization readmissions (within 30 days) decreased significantly in Manitoba over time from 9.28% to 8.52% of all hospital episodes.
- The readmission hospitalization rate for Southern Health-Santé Sud decreased significantly from 9.6% to 8.8% - similar to provincial averages.
- **Figure 12** shows the rates within the districts. Only Rural East rate reached a statistically significant decrease over time. Rates did vary markedly across districts.

Figure 11. Hospital Readmission by RHA, 2006/07 and 2011/12
Age- and sex-adjusted percent of hospital episodes with a readmission within 30 days of discharge



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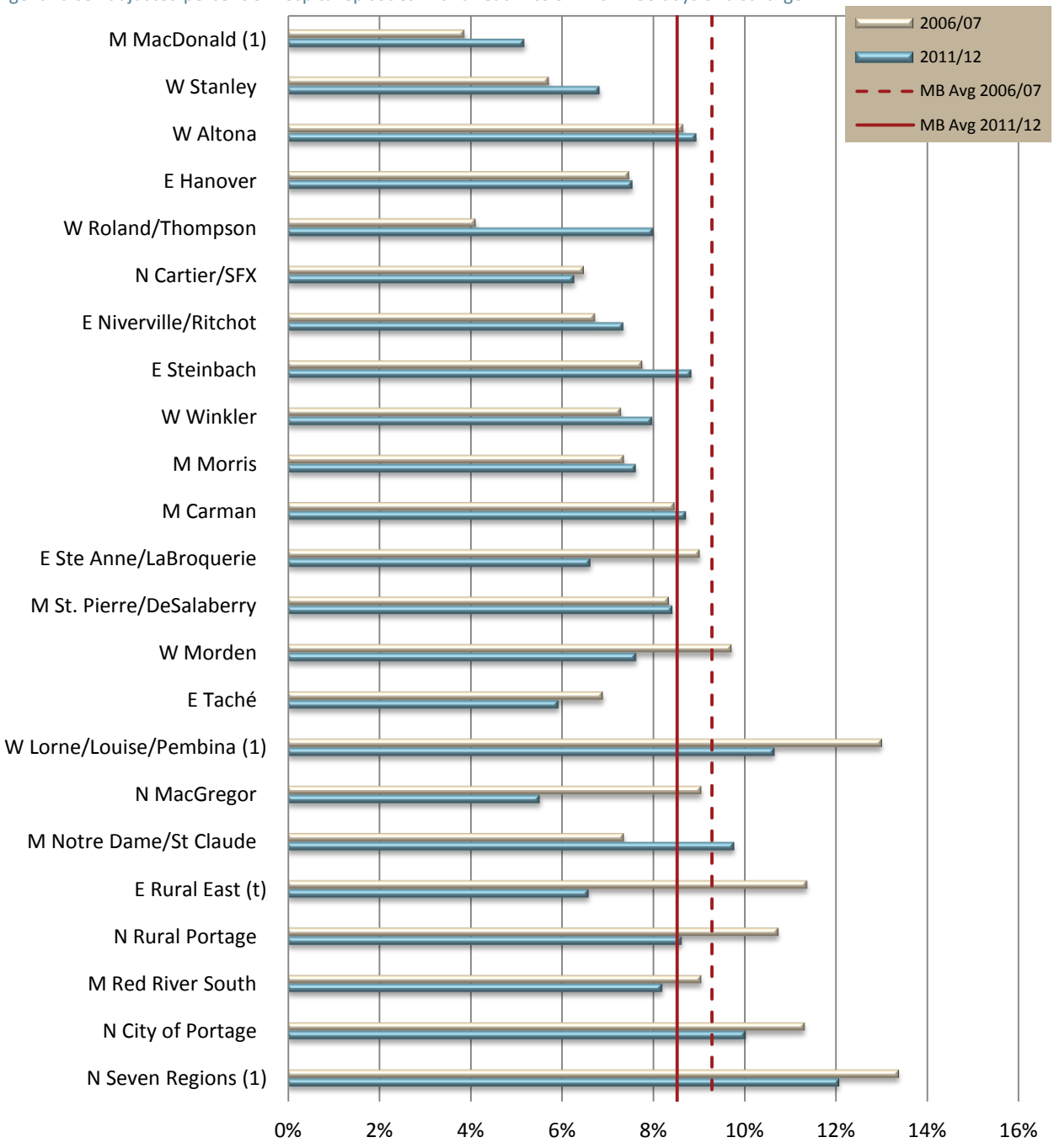
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 12. Hospital Readmission by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted percent of hospital episodes with a readmission within 30 days of discharge



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

4.3. Physician Services

Use of Physicians

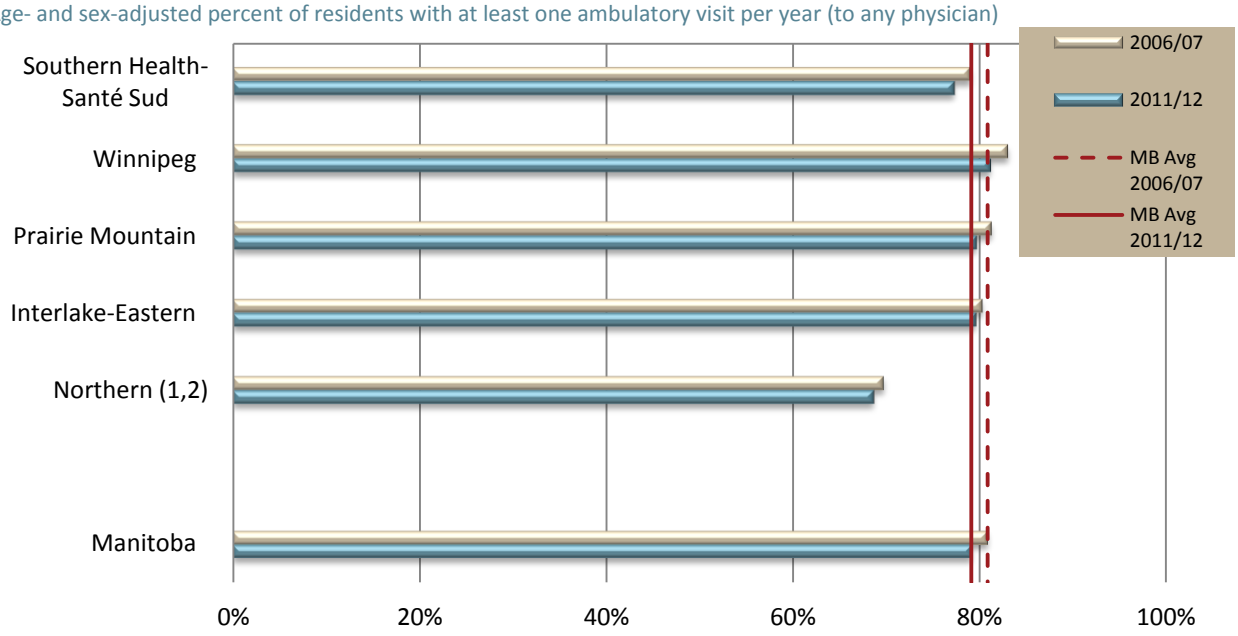
Definition: The percent of residents (all ages) who received at least one ambulatory visit (e.g., general and family practitioners, specialists) in a fiscal year.

Ambulatory visits include all contacts with physicians, except during inpatient hospitalization and emergency department visits. This is an important indicator of access to primary care services.

Key Findings

- **Figure 13** shows that the proportion of Manitobans with at least one physician visit in a year did not change much over time, from 80.9% to 79.1%.
- For Southern Health-Santé Sud, the proportion of residents with at least one physician visit was similar to the provincial average. The rate was stable over time with a slight decrease from 79% to 77%.
- **Figure 14** shows the variation within the region. Physician use rates were lower than the provincial average in the following districts: Stanley, Hanover, Steinbach, St. Pierre/DeSalaberry, MacGregor, and Rural East. In addition, rates decreased significantly over time in Hanover, Steinbach, and St. Pierre/DeSalaberry.

Figure 13. Use of Physicians by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted percent of residents with at least one ambulatory visit per year (to any physician)



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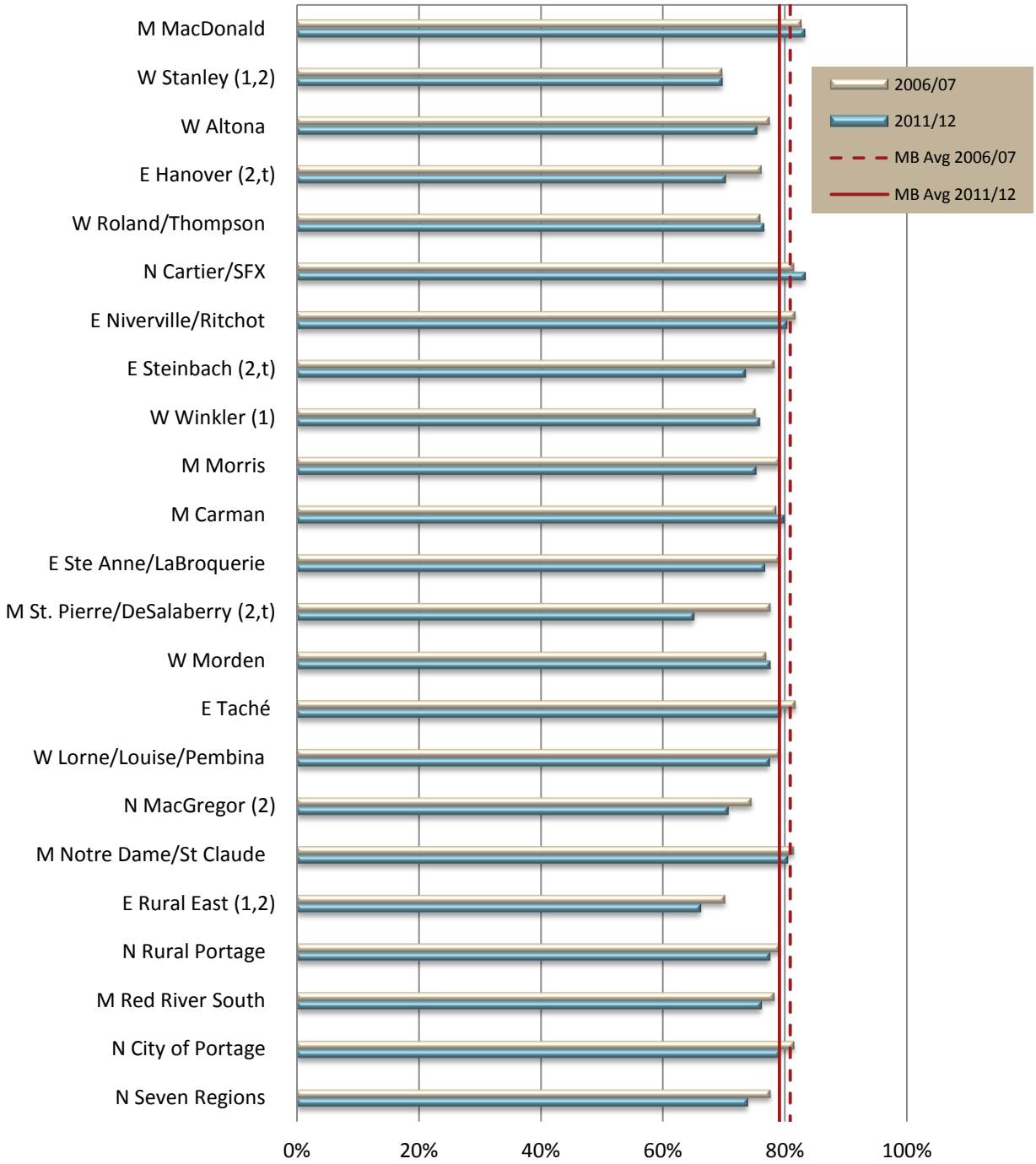
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 14. Use of Physicians by RHA, 2006/07 and 2011/12.

Age- and sex-adjusted percent of residents with at least one ambulatory visit per year (to any physician)



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Source: MCHP, RHA Atlas 2013

Physician Visits (Ambulatory Care Rate)

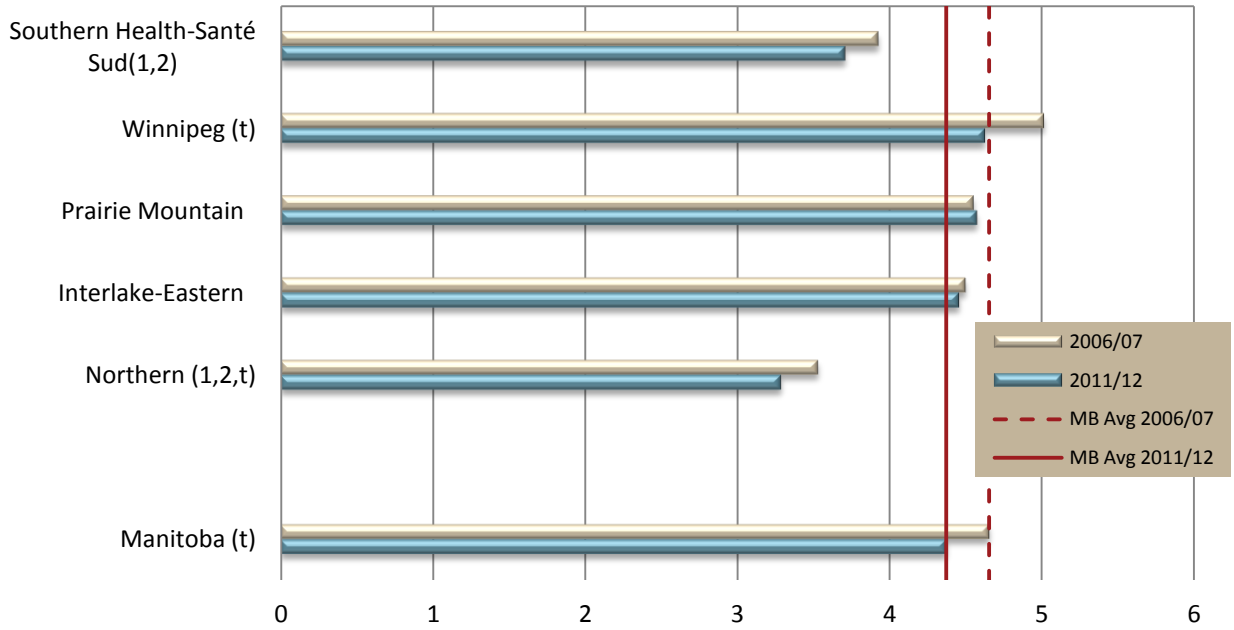
Definition: The average number of visits to physicians per resident (all ages) in a given year.

Ambulatory care visits include all contact with physicians: office visits, walk-in clinics, home visits, personal care home visits, visits to outpatient departments, and prenatal visits. Only inpatient hospitalization and emergency department visits were excluded. The ambulatory care rate is a key indicator for how well the health care system is managing ongoing care for patients outside the hospital setting.

Key Findings

- **Figure 15** shows that the rate of ambulatory care visits in Manitoba decreased significantly over time from 4.7 to 4.4 per resident.
- For Southern Health-Santé Sud, ambulatory care rates decreased slightly from 3.9 to 3.7 per resident – both significantly lower than Manitoba averages.
- **Figure 16** shows the variation within the region. As with the previous indicator (use of physicians), ambulatory care rates were lower than the provincial average in many of the same districts: Stanley, Hanover, Steinbach, St. Pierre/DeSalaberry, MacGregor, Rural East, as well as, Roland/Thompson and Seven Regions. In addition, rates decreased significantly over time in Steinbach and St. Pierre/DeSalaberry.

Figure 15. Ambulatory Visit Rate by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted rate of ambulatory visits to all physicians per resident



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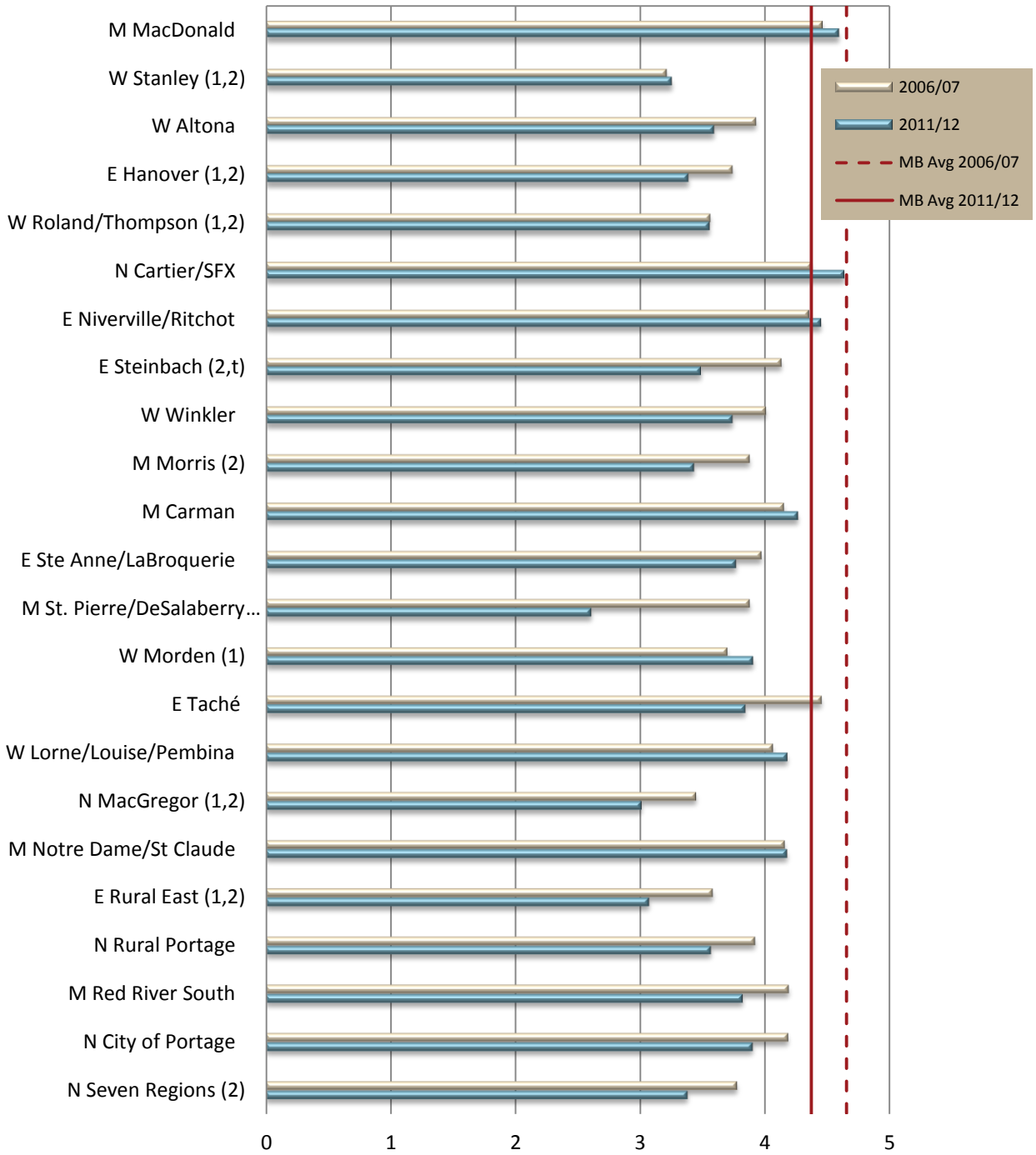
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 16. Ambulatory Visit Rate by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted rate of ambulatory visits to all physicians per resident



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Source: MCHP, RHA Atlas 2013

Cause of Physician Visits

Definition: The average annual number of physician visits by most frequent category of illness in a given year.

Physician utilization patterns offer important information about whether patients are being provided care in appropriate settings. Physician visits can be an effective way to manage chronic diseases. As well, without access to physicians, health problems can become more serious and lead to hospitalization.

Key Findings

- **Table 2** shows that the top reason for physician visits in Manitoba and Southern Health-Santé Sud was health status and contact – responsible for almost 10% of all visits to physicians.
    - The majority of visits in this category are for general medical exams. It also includes well-baby care, contraceptive management, and other exams. For these visits patients were not presenting for a specific health issue.
- For Southern Health-Santé Sud, musculoskeletal was the second most common reason, responsible for 9.3% of physician visits. This is a similar rate for Manitoba; however mental illness was more common at 9.6%.
- An ill-defined condition was the third most common reason for physician visits in the region at 9.2%.
    - The majority of visits in this category are primarily visits for chest and respiratory symptoms, abdominal and pelvic symptoms, and "general" symptoms. For these visits patients were experiencing a specific health issue but it was not clear which category it should be assigned.

Table 2.Top Causes of Physician Visits, Southern Health-Santé Sud and Manitoba, 2011/12.

Southern Health-Santé Sud		Manitoba	
Health status and contact	10.0%	Health status and contact	9.7%
Musculoskeletal	9.3%	Mental illness	9.6%
Ill-defined conditions	9.2%	Musculoskeletal	9.3%
Respiratory	8.5%	Respiratory	9.3%
Circulatory	8.5%	Circulatory	9.0%
Nervous system	7.7%	Ill-defined conditions	8.2%
Mental illness	7.2%	Nervous system	7.4%
Genitourinary and breast	6.4%	Endocrine and metabolic	6.8%
Endocrine and metabolic	6.0%	Genitourinary and breast	5.8%
Skin disorders	5.7%	Skin disorders	5.3%
Injury and poisoning	4.8%	Injury and poisoning	4.7%
All others	16.8%	All others	14.9%

Source: MCHP, RHA Atlas 2013

Majority of Care

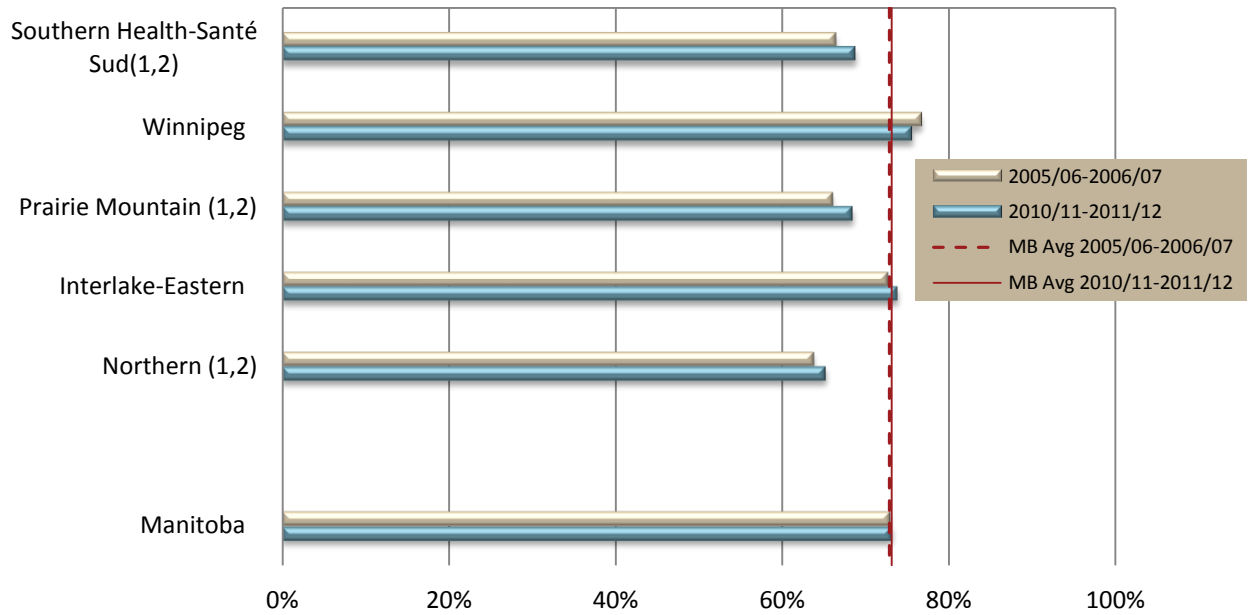
Definition: The percent of residents (all ages) who received at least 50% of their care from the same physician over a two-year period. This indicator was formerly known as "continuity of care".

Primary physicians could include general practitioners, family practitioners, and pediatricians. For seniors, these can also include internal medicine specialists. Continuity of health service allows for a more permanent relationship between patients and providers to be built. Improved continuity of care is also correlated to better screening, recognition of unidentified problems, better immunization, fewer hospitalizations, and improved patient satisfaction.

Key Findings

- **Figure 17** shows that the Manitoba rate remained stable at 73% of residents receiving the majority of care from the same physician.
- For Southern Health-Santé Sud, majority of care rates increased slightly from 66% to 69% which was lower compared to provincial averages.
- **Figure 18** shows the considerable variation within the region. Rates were significantly higher than the provincial average in Hanover, Niverville/Ritchot, Steinbach, Ste. Anne/LaBroquerie, and Taché. However, many districts had significantly lower rates: Stanley, Roland/Thompson, Winkler, Carman, MacGregor, Notre Dame/St. Claude, Rural Portage, Portage city and Seven Regions.

Figure 17. Majority of Care by RHA, 2005/06-2006/07 and 2010/11-2011/12.
Age- and sex-adjusted percent of residents getting more than 50% of their visits from the same physician (among those with 3+ visits)



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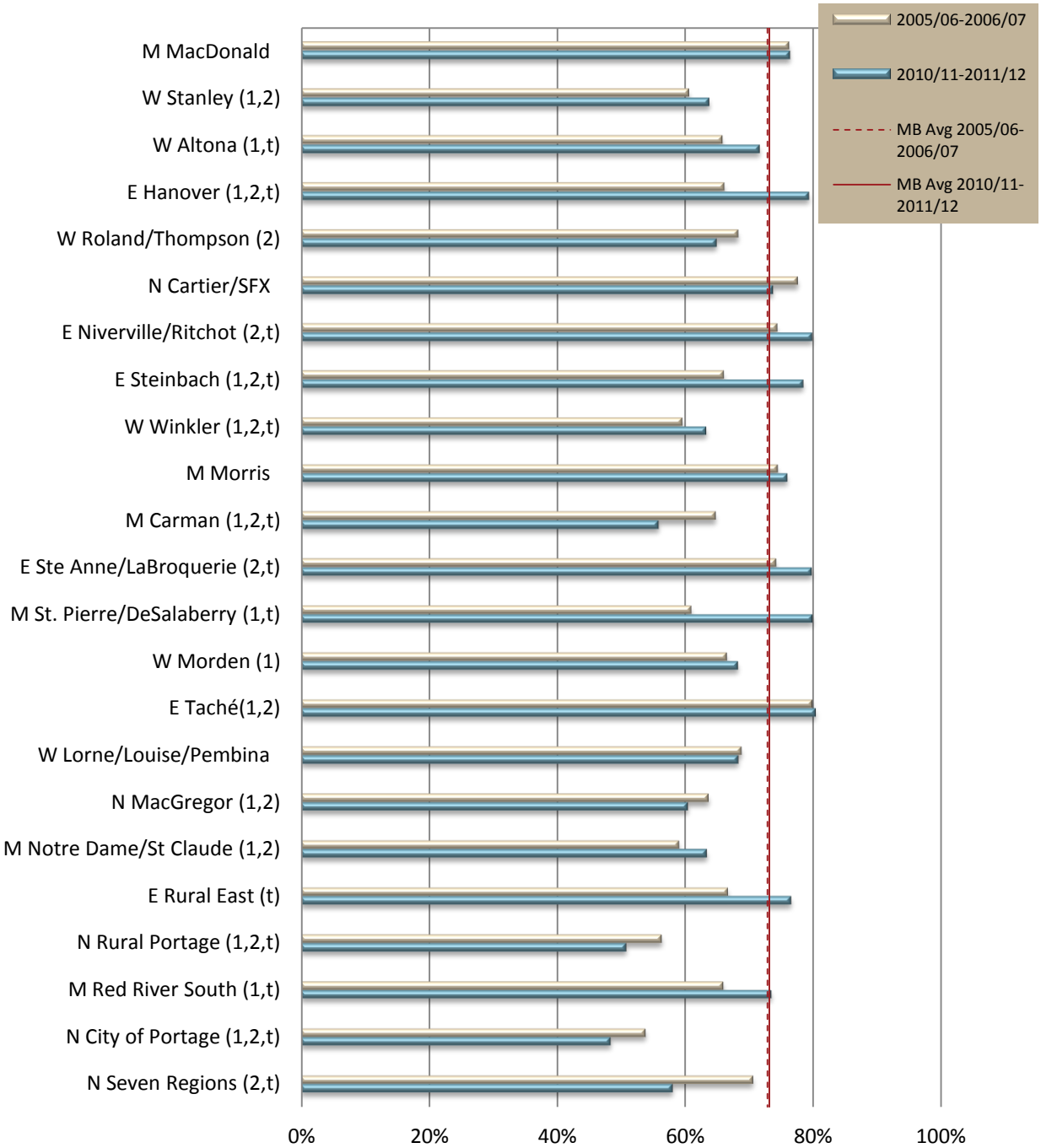
Source: MCHP, RHA Atlas 2013

Figure 18. Majority of Care by District, Southern Health-Santé Sud, 2005/06-2006/07 and 2010/11-2011/12.
Age- and sex-adjusted percent of residents getting more than 50% of their visits from the same physician (among those with 3+ visits)



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Source: MCHP, RHA Atlas 2013

Ambulatory Consultation Rates

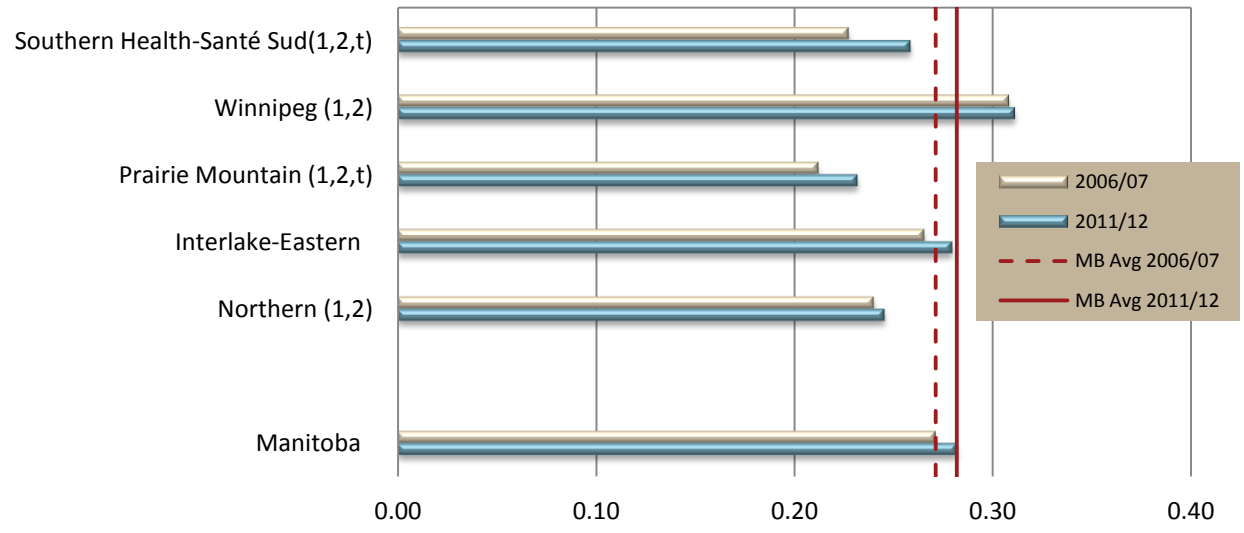
Definition: The average annual number of ambulatory consultations per resident (all ages) in a given year. These occur when one physician refers a patient to another physician (usually a specialist or surgeon).

Typically, physicians will make a referral for a patient because of complexity, obscurity, or seriousness of a condition. As well, patients may request a second opinion. However, the ambulatory consultation rate is considered the best indicator of access to specialist care. This is particularly important in rural areas as patients use specialist services less frequently due to access issues.

Key Findings

- **Figure 19** shows that the consultation rate increased slightly in Manitoba from 0.27 to 0.28 per resident. In both time periods, consultation rates in Winnipeg were higher than average, while for other regions they were lower (except for Interlake-Eastern).
- For Southern Health-Santé Sud, consultation rates increased significantly over time from 0.23 to 0.26 per resident – lower than the provincial average.
- **Figure 20** shows the variation within the region. Consultation rates were significantly higher than the provincial average only in MacDonald, and the following districts were lower: Stanley, Altona, Winkler, MacGregor, and Seven Regions. In many districts, rates did increase over the two time periods, except for Seven Regions.

Figure 19. Ambulatory Consultation Rate by RHA, 2006/07 and 2011/12.
Age- and sex-adjusted rate of consults per resident (first referral)



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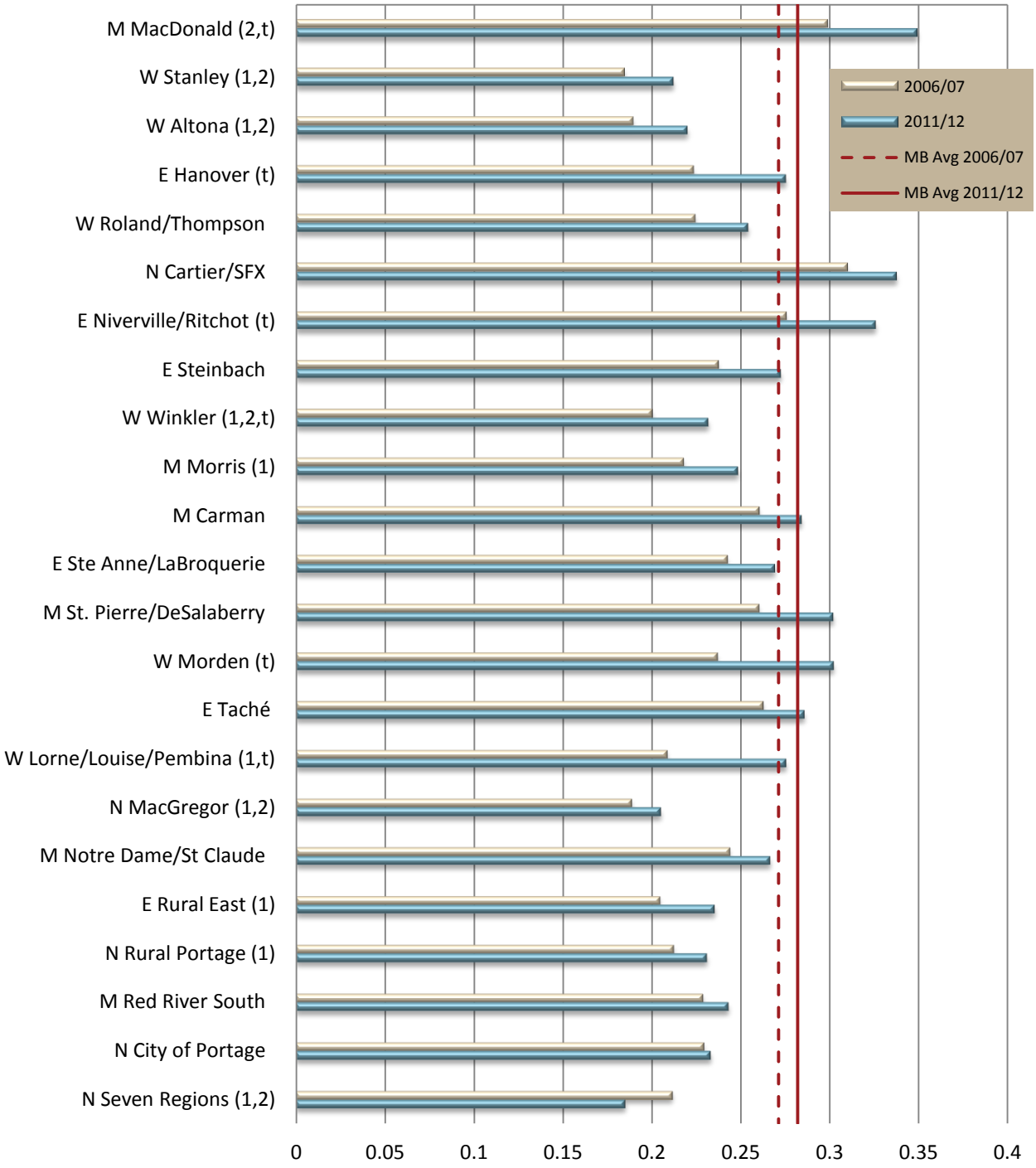
Source: MCHP, RHA Atlas 2013

Figure 20. Ambulatory Consultation Rate by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Age- and sex-adjusted rate of consults per resident (first referral)



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Source: MCHP, RHA Atlas 2013

Location of Visits

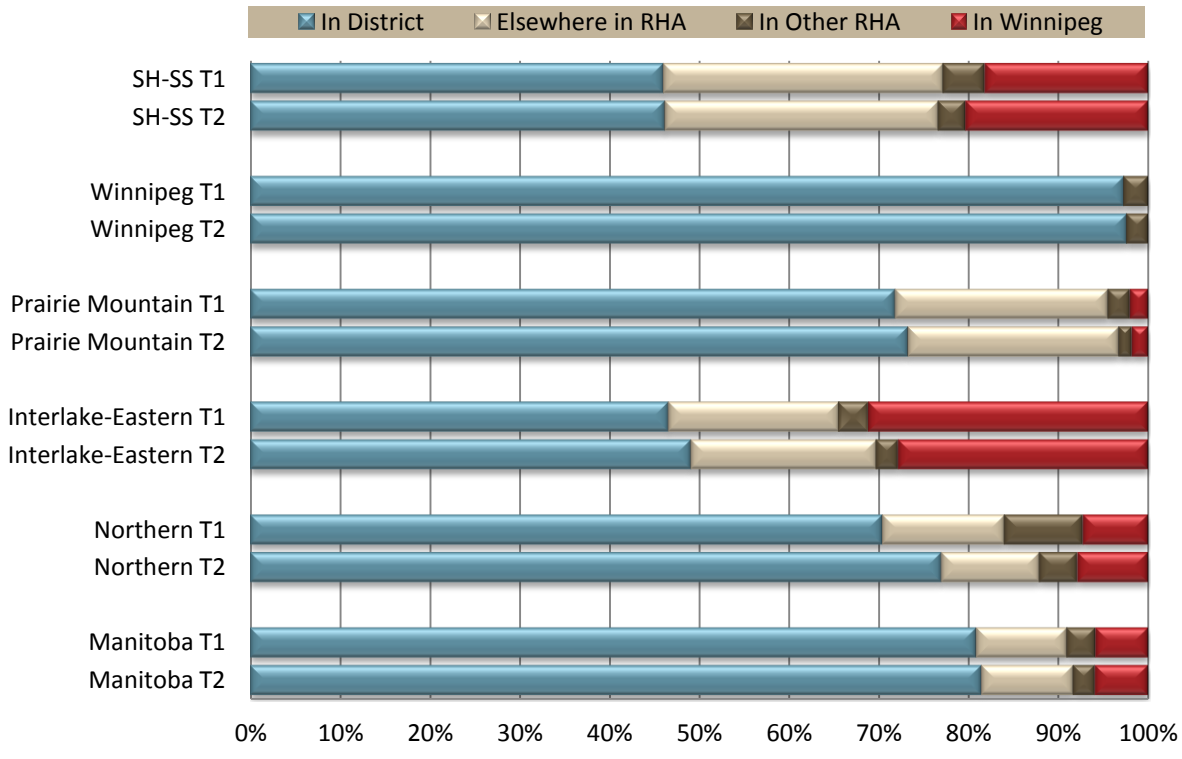
Definition: The percent of ambulatory care (general/family) and specialist visits by location.

Visit location rates provide information on whether residents in the region are travelling to get the care they need with general/family and specialist providers. Travelling for care may create patient stress which can hinder willingness to seek care before illnesses become worse. This is an important indicator of access to care.

Key Findings

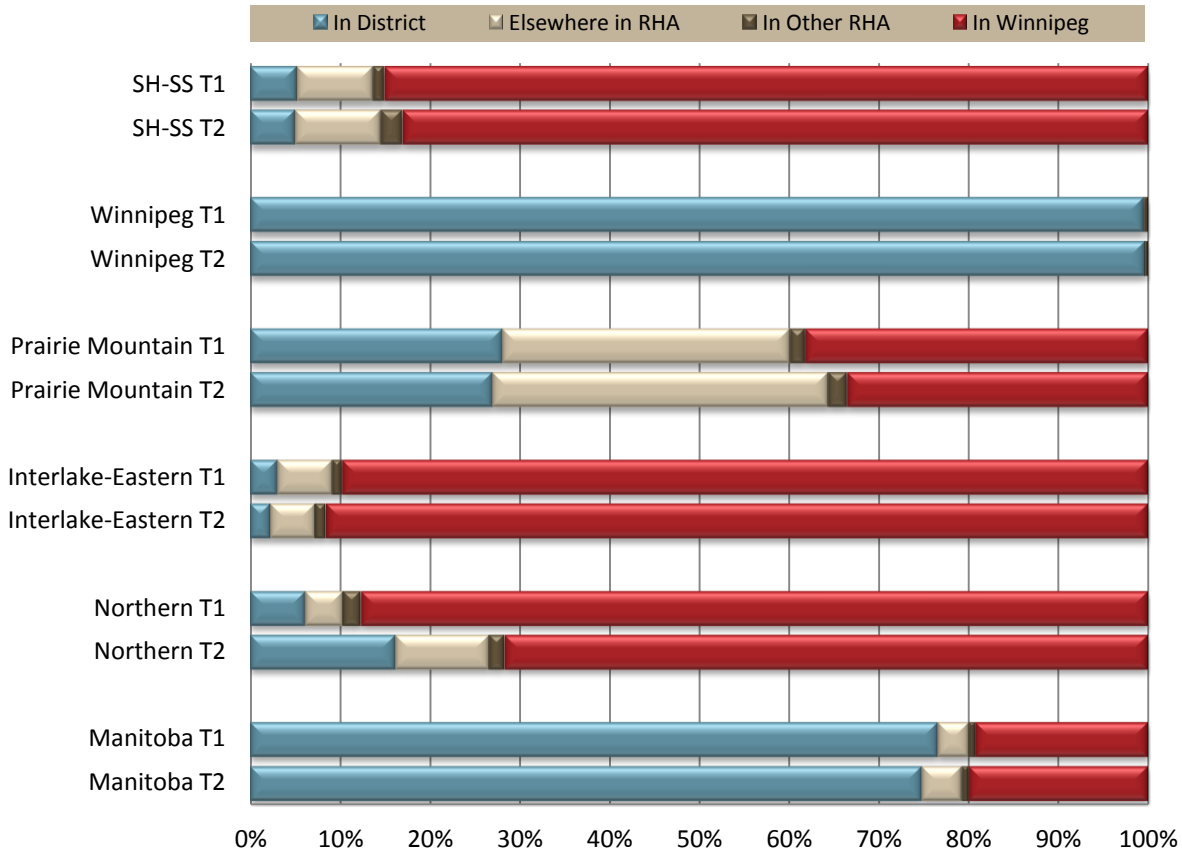
- **Figure 21** shows that the location of visits to general/family practitioners was stable in Manitoba over time. Overall, 80% of all visits to GP/FPs occurred within the patient's home district, however this was strongly influenced by high rates in Winnipeg.
- For Southern Health-Santé Sud, location of visits to GP/FP was a different picture: 46% (in district); 30% (elsewhere in RHA); 3% (other RHA); 20% (Winnipeg). Rates were stable over time.
- **Figure 22** shows that the location of visits to specialists was also stable in Manitoba over time. Over 74% of all visits to specialists occurred within the patient's home district, again this was strongly influenced by high rates in Winnipeg.
- For Southern Health-Santé Sud, location of visits to specialists paints a different reality: 5.0% (in district); 10% (elsewhere in RHA); 2% (other RHA); 83% (Winnipeg). Rates were stable over time.

Figure 21. Location of Visits to General/Family Practitioners by RHA, 2006/07 and 2011/12.
T1=2006/07 and T2=2011/12



Source: MCHP, RHA Atlas 2013

Figure 22. Location of Visits to Specialists by RHA, 2006/07 and 2011/12.
T1=2006/07 and T2=2011/12



Source: MCHP, RHA Atlas 2013

Regular Medical Doctor

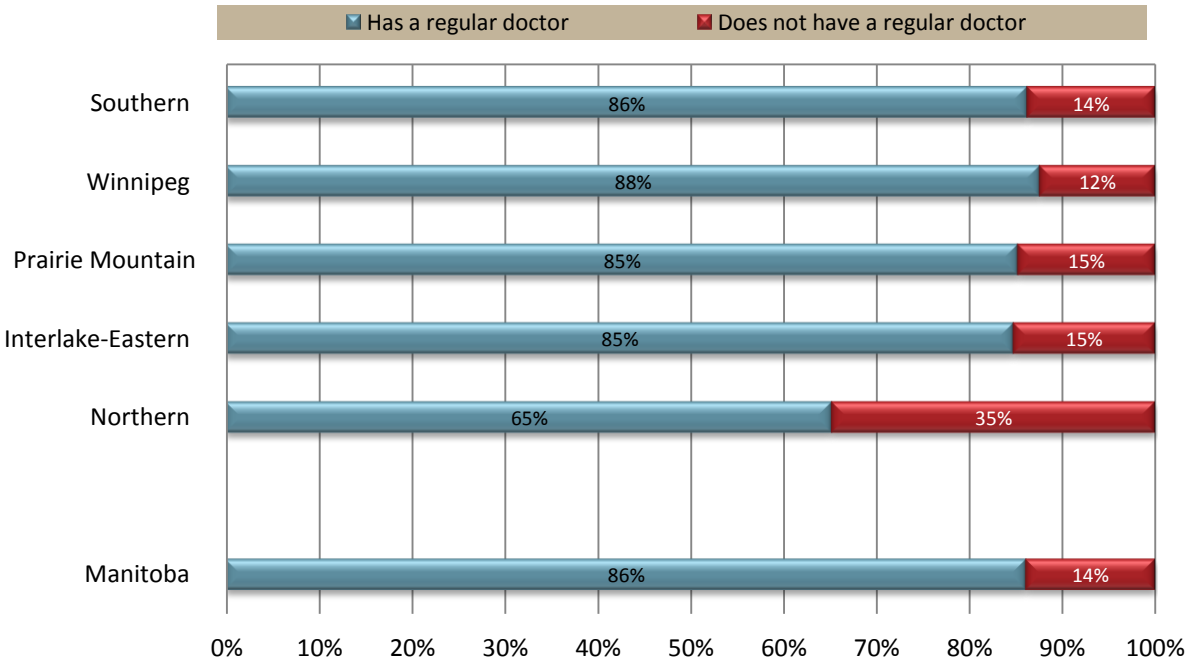
Definition: The proportion of residents (age 12+) who reported having a regular medical doctor. Based on self-report combined cycles of CCHS.

Access to primary care services is an important concern for residents. The health system has also put more emphasis on health promotion and prevention strategies, and having regular access to primary care places less reliance on acute care services. Today we have more physicians than ever before. However, while the numbers are increasing overall, some rural practices are still struggling with doctor shortages.

Key Findings

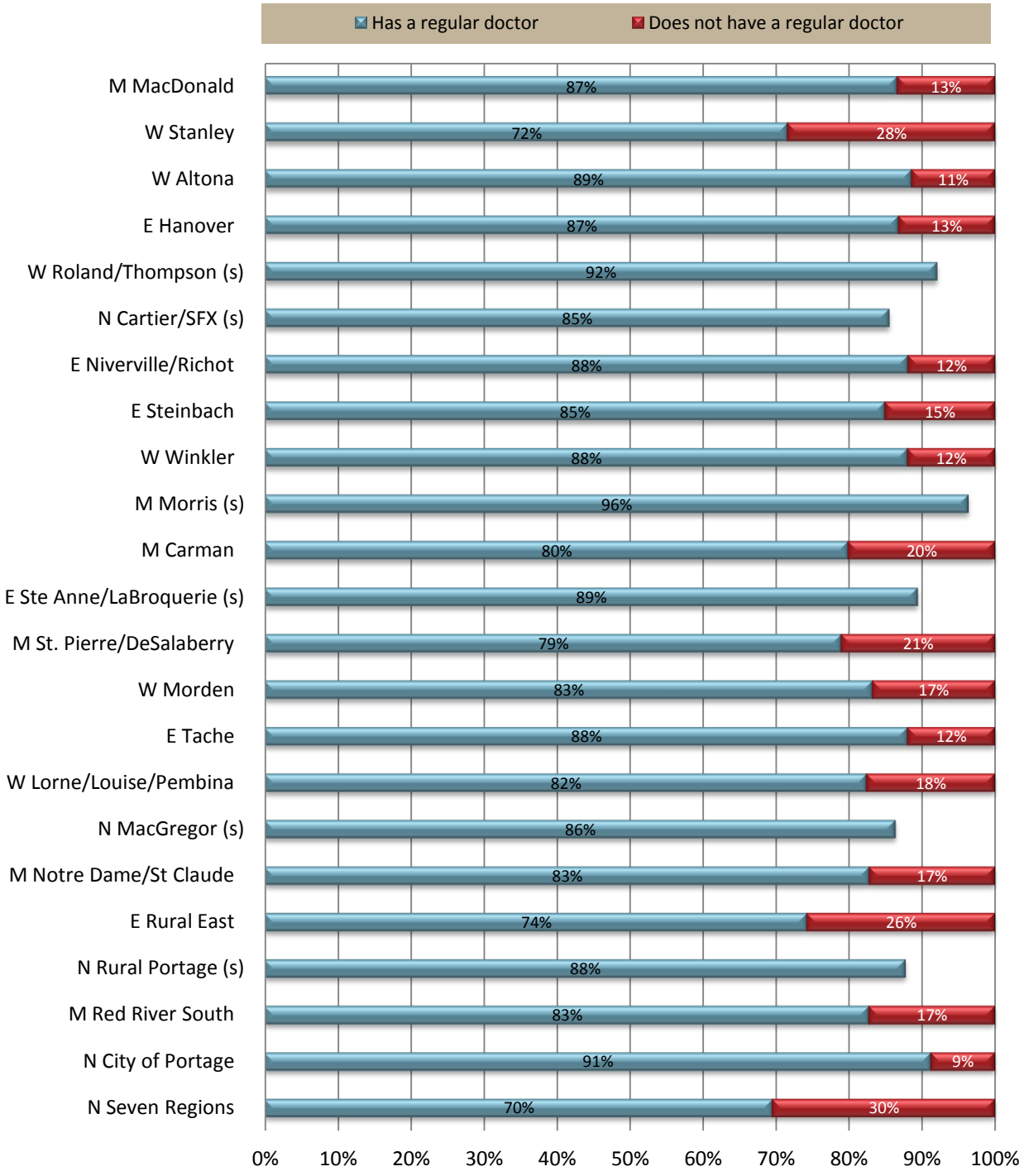
- **Figure 23** shows that 86% of Manitobans reported that they have a regular medical doctor, which means that about 14% would be without.
- Similar to the provincial average, Southern Health-Santé Sud also had about 86% of residents reporting they had a regular medical doctor.
- **Figure 24** shows the rates within the region – please note that some areas are suppressed due to small numbers. Lower rates were reported in: Stanley, St. Pierre/DeSalaberry, Rural East, and Seven Regions. Again, interpretation of district level should be made with caution.

Figure 23. Regular Doctor by RHA, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.
Age-and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013

Figure 24. Regular Doctor by District, Southern Health-Santé Sud, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.
Age-and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013

Looking for a Regular Doctor

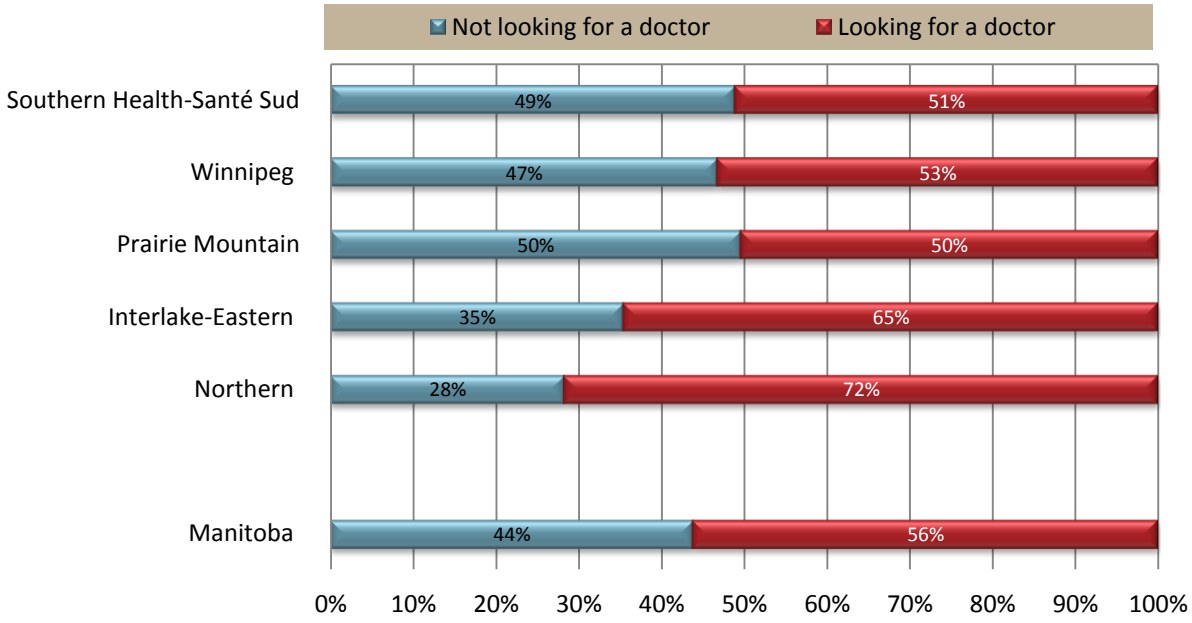
Definition: The percent of residents (age 12+) who reported they were looking for a doctor and those who were not. Based on self-report combined cycles of CCHS.

Even though it is based on a self-report data, this indicator helps to paint a picture about what proportion of residents would be considered "unattached" to regular primary care services – the proportion of residents without a regular doctor who are looking for one.

Key Findings

- **Figure 25** shows that of the Manitobans who reported not having a regular doctor (estimated at 14% of overall population), about 56% said they are looking for a doctor. This roughly translates to 86,000 people for this time period.
- For Southern Health-Santé Sud, of the residents who reported not having a regular medical doctor, about 51% said they are looking for one – estimated 12,000 residents for the time period.
- **Figure 26** shows the variation within the region. Many areas are suppressed due to small numbers, so interpretation should be made with caution. Districts with a greater proportion of residents (70%+) looking for a regular doctor include: Cartier/SFX, Steinbach, and Rural East.

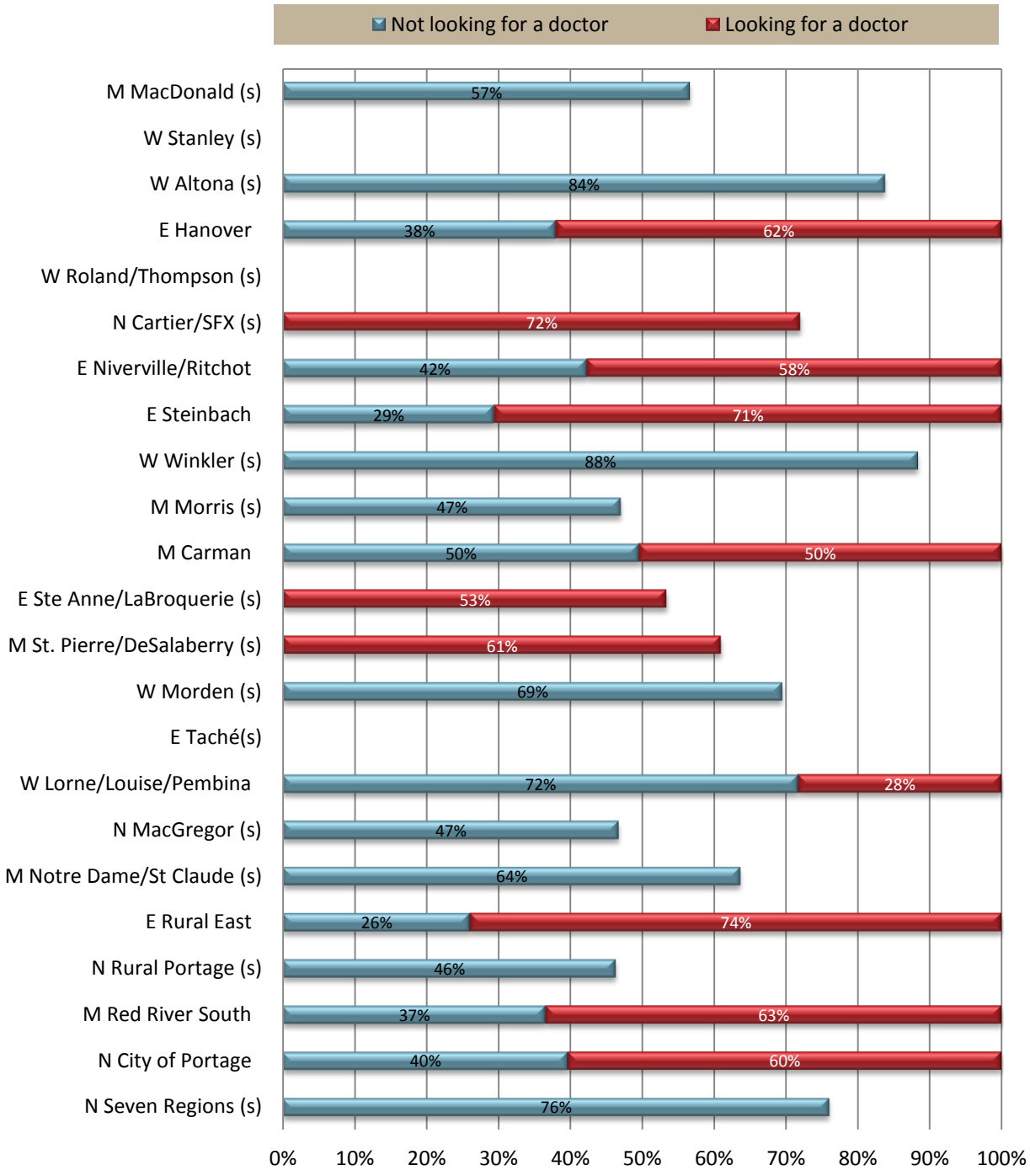
Figure 25. Looking for a Regular Doctor by RHA, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.
Age-and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates
Source: Manitoba Health, RHA Profile 2013

Figure 26. Looking for a Regular Doctor by District, Southern Health-Santé Sud, combined CCHS cycles 2007-2008, 2009-2010, and 2011-2012.

Age-and sex-adjusted percent of weighted sample aged 12+



(s) = bars supressed due to small numbers or highly variable rates

Source: Manitoba Health, RHA Profile 2013

4.4. Quality of Primary Care

Monitoring the quality of primary health care is a crucial step towards defining areas for improvement, as well as observing the impact of change. The indicators in this section are just a sampling of ways this can be measured in our province. However, this area of work is still developing and greater emphasis on measuring patient experiences with all areas of our health system will help to further our understanding.

Antidepressant Prescription Follow-up

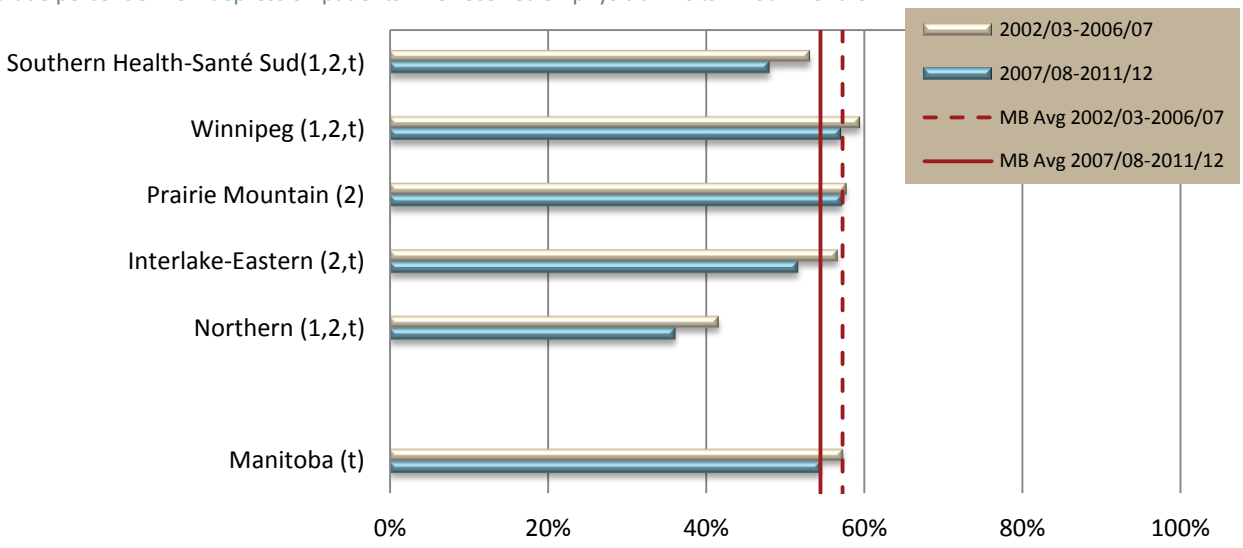
Definition: The percent of residents (all ages) with a prescription for antidepressants who had three or more follow-up physician visits within four months of the prescription being filled. Crude percents are presented for two time periods.

The majority of depression medication is prescribed by primary care physicians. Concerns have been raised about the side effects of antidepressants so it is important for physicians to carefully monitor patients and ensure that medications are effective in treating depression.

Key Findings

- **Figure 27** shows that the rate of antidepressant prescription follow-up for Manitoba decreased significantly from 57.3% to 54.5%.
- Southern Health-Santé Sud rates were lower than provincial averages, and decreased significantly from 53% to 48%.
- **Figure 28** shows that many district level rates were below Manitoba averages, and many showed a decreasing trend over time. The following districts were significantly lower than Manitoba: Hanover, Steinbach, St. Pierre/DeSalaberry, MacGregor, Rural East, Red River South, and Seven Regions.

Figure 27. Antidepressant Prescription Follow-Up by RHA, 2002/03-2006/07 and 2007/08-2011/12.
Crude percent of new depression patients who received 3+ physician visits in four months



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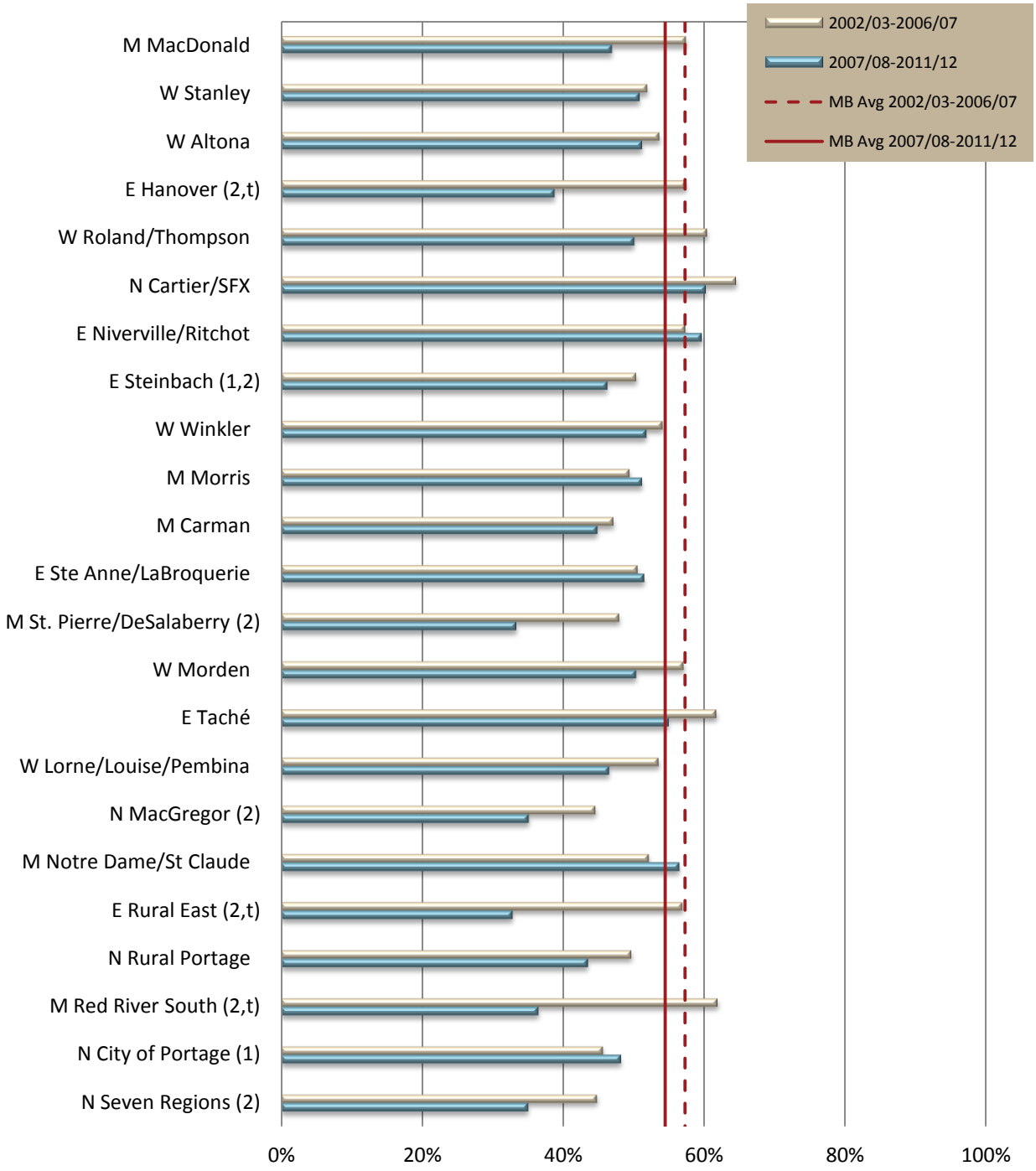
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 28. Antidepressant Prescription Follow-Up by District, Southern Health-Santé Sud, 2002/03-2006/07 and 2007/08-2011/12.
Crude percent of new depression patients who received 3+ physician visits in four months



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Source: MCHP, RHA Atlas 2013

Asthma Care

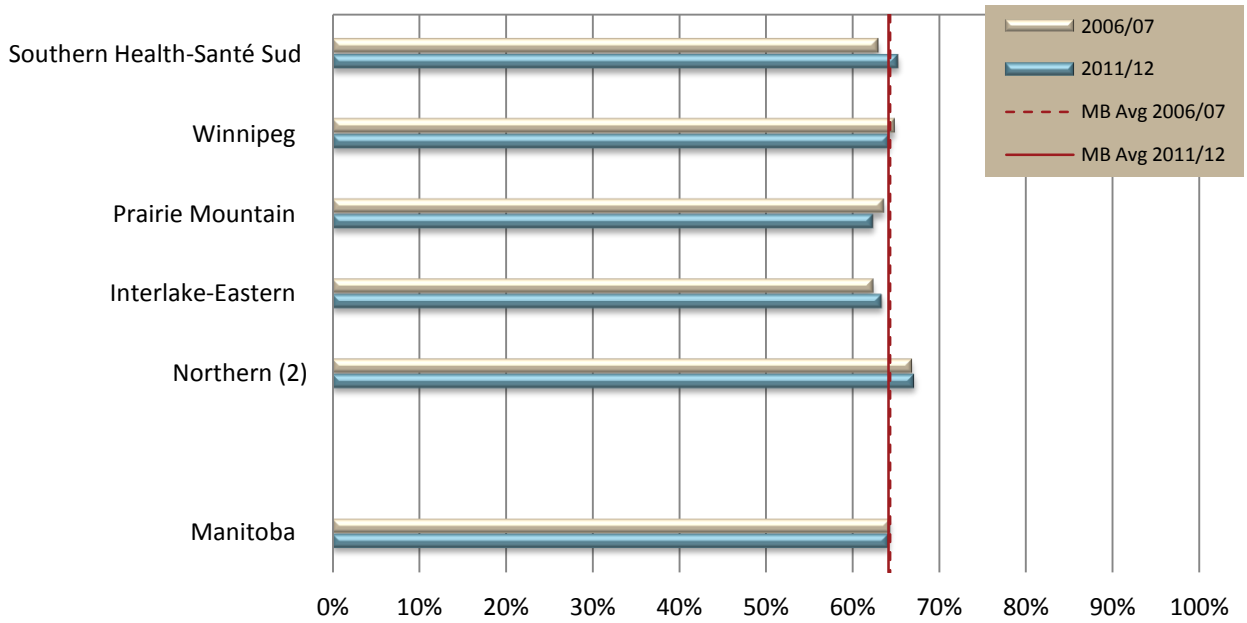
Definition: The percent of residents (all ages) with asthma receiving medication recommended for long-term control if their disease. Crude percents are presented for two different years.

Recommended long-term controller medications include: inhaled corticosteroids, leukotriene modifiers, adrenergics, and other drugs for obstructive airway diseases.

Key Findings

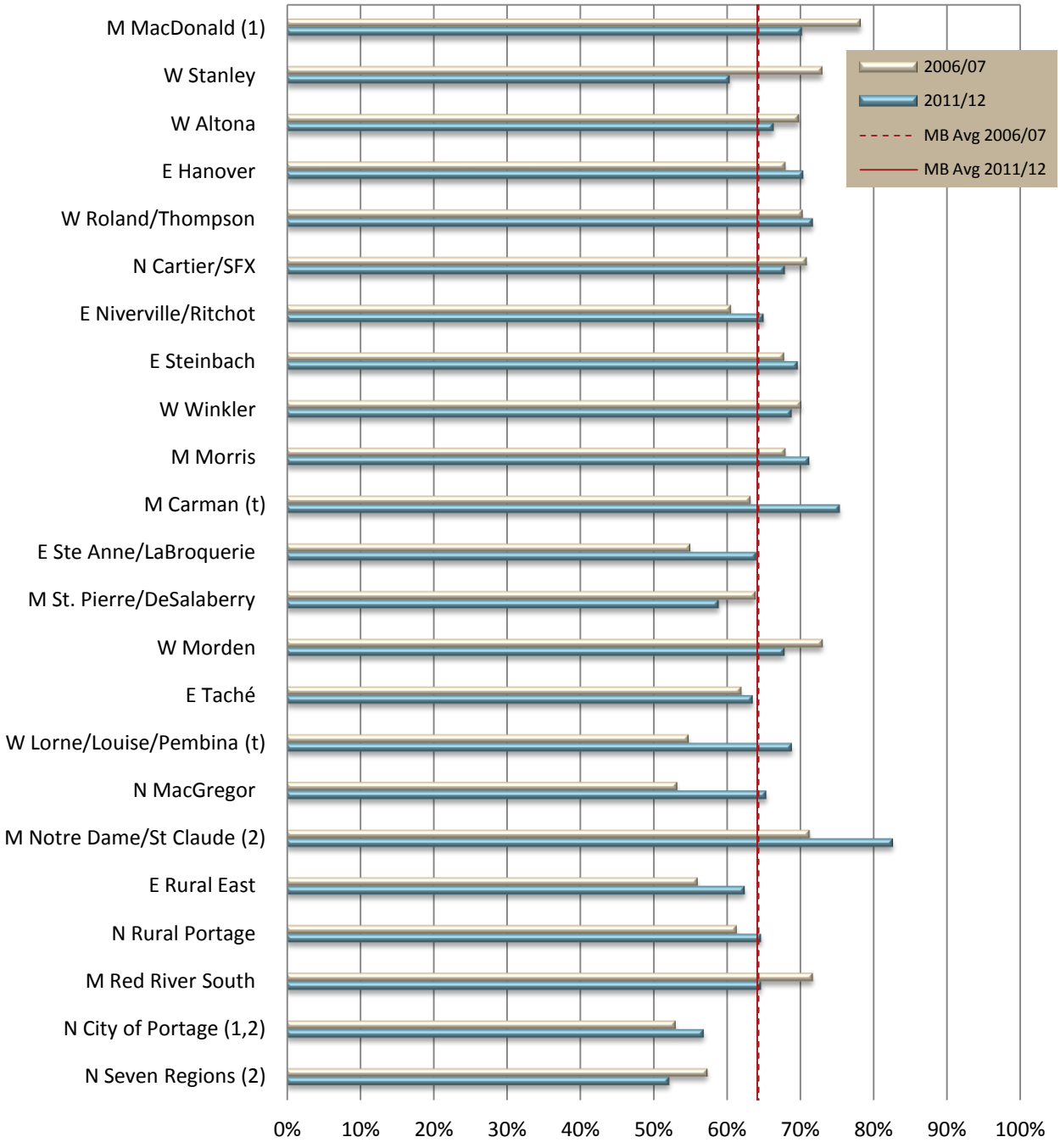
- **Figure 29** shows that there was no change in the proportion of residents with asthma receiving prescriptions for long-term control (64%).
- For Southern Health-Santé Sud, rates increased slightly from 63% to 65% - similar to the provincial average.
- **Figure 30** shows the rates within the region. There was remarkably little variation among districts. The only district that was significantly higher than the provincial average was Notre Dame/St. Claude.

Figure 29. Asthma Care by RHA, 2006/07 and 2011/12.
Crude percent of residents with asthma receiving at least one prescription for inhaled steroids



1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 30. Asthma Care by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Crude percent of residents with asthma receiving at least one prescription for inhaled steroids



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Diabetes Care – Eye Exams

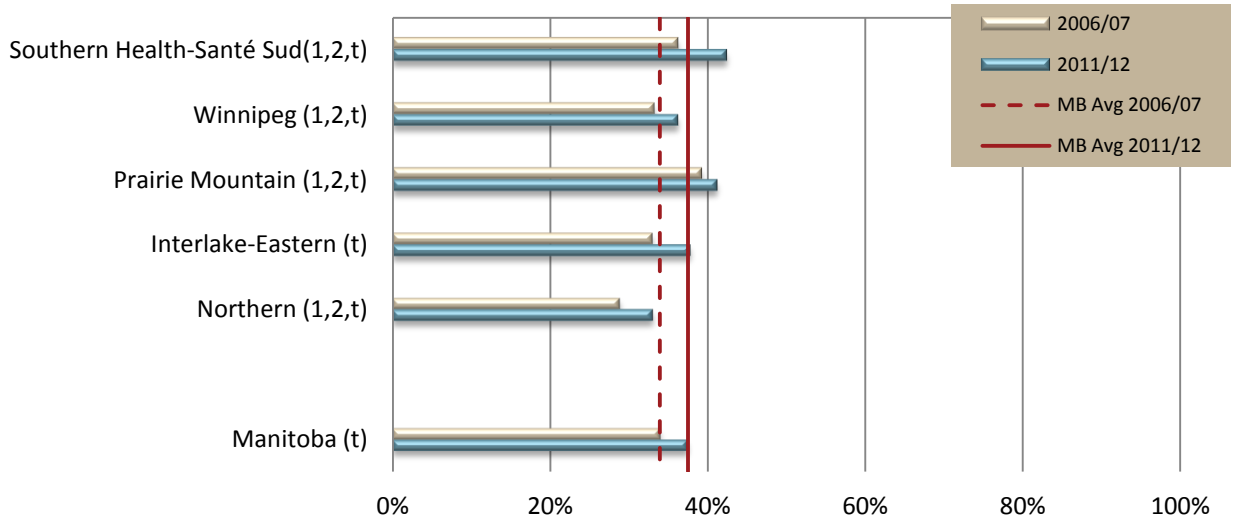
Definition: The percent of residents (age 19+) with diabetes who had an eye exam by an ophthalmologist or optometrist. Crude percents are presented for two different years.

Eye exams are a critical component of ongoing care for people living with diabetes to avoid loss of eye sight and to improve quality of life. It is an important indicator to monitor as it relates to chronic disease management.

Key Findings

- **Figure 31** shows that the proportion of Manitoba residents with diabetes receiving an eye exam increased over time from 33.9% to 37.5%.
- For Southern Health-Santé Sud, rates were significantly higher than the provincial average and increased significantly over time from 36% to 43%.
- **Figure 32** shows the rates within the region. Many districts were above the provincial average – which is positive news. However, Seven Regions had significantly lower eye exam rates.

Figure 31. Diabetes Care: Eye Examinations by RHA, 2006/07 and 2011/12.
Crude percent of residents aged 19+ with diabetes who had an eye examination



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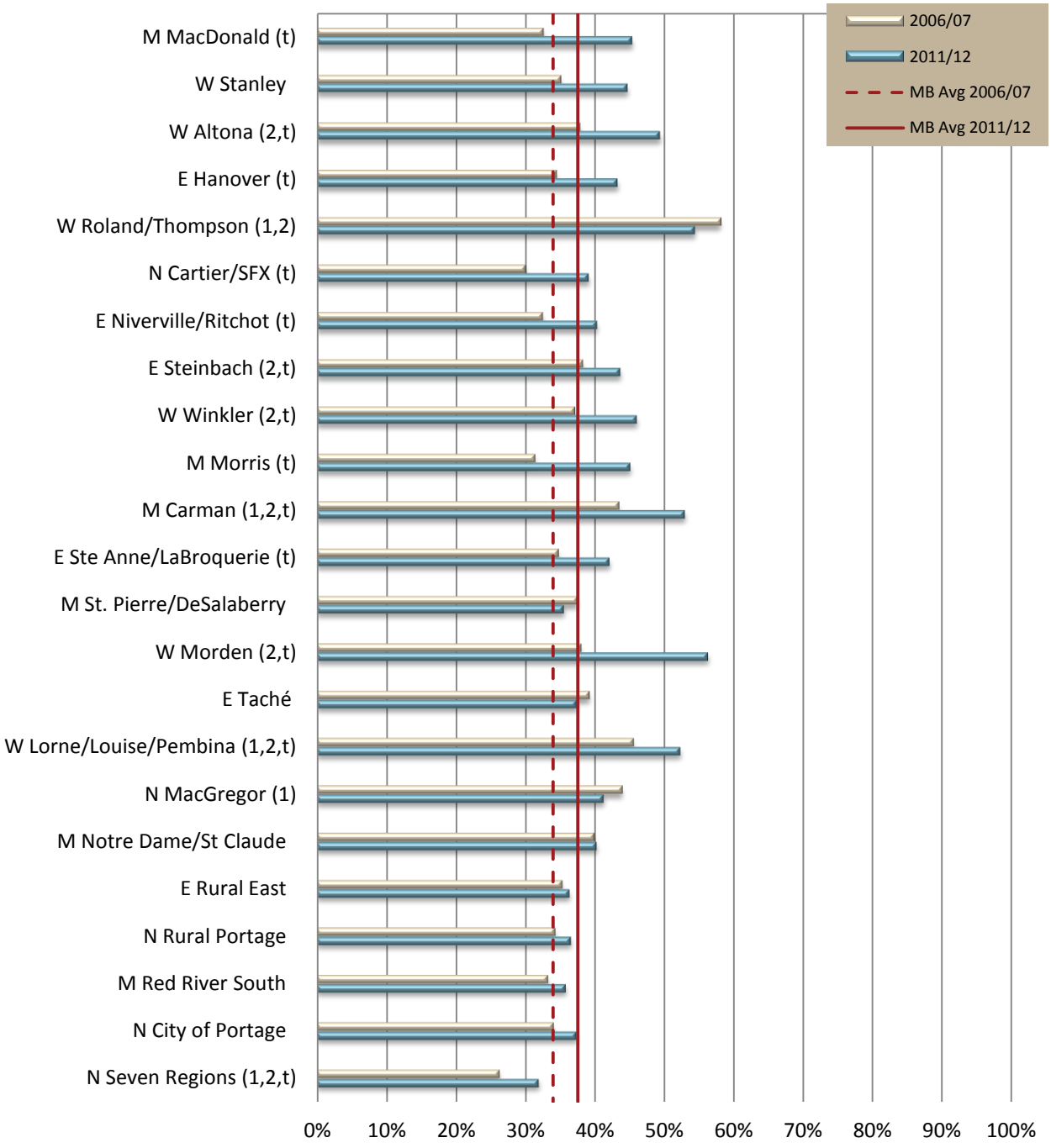
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 32. Diabetes Care: Eye Examinations by District, Southern Health-Santé Sud, 2006/07 and 2011/12.
Crude percent of residents aged 19+ with diabetes who had an eye examination



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s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Benzodiazepine Prescribing - Community

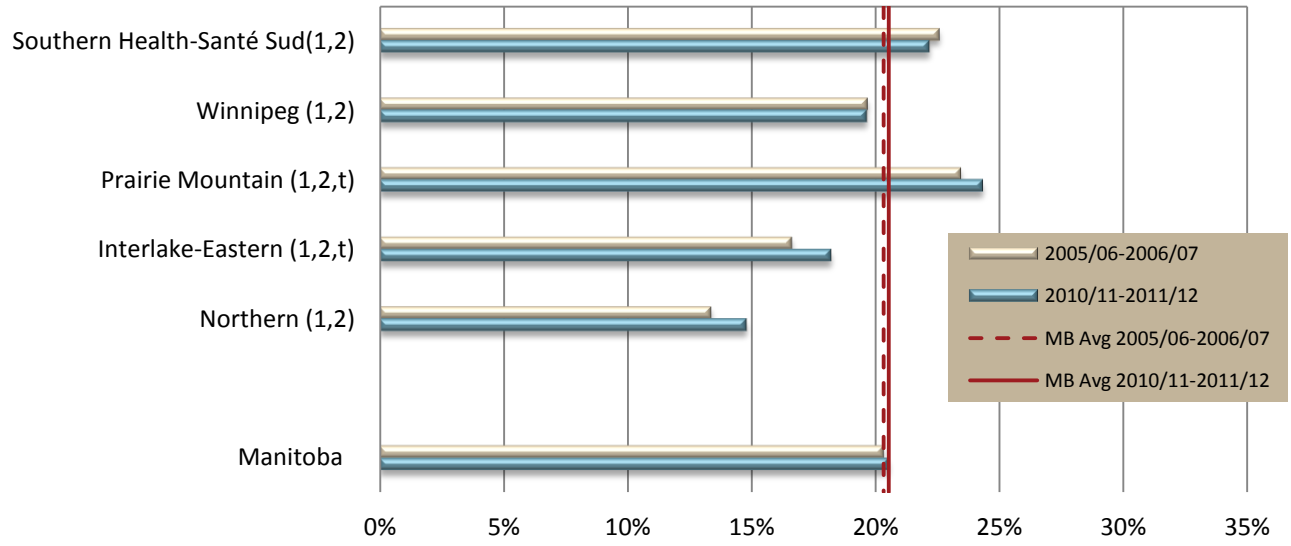
Definition: The percent of residents (age 75+) living in the community who had at least two prescriptions for benzodiazepines (or one prescription with more than a 30 day supply). Crude percents are presented for two different years.

Benzodiazepines are a class of psychoactive drugs used to treat anxiety, insomnia and a range of other conditions. It is a widely prescribed medication, especially among elderly patients. Benzodiazepines have sedative, hypnotic and muscle relaxant properties. Short term use of these medications is considered generally safe and effective. However, long term use is very controversial because it is addictive, and can cause an increased risk of falls among frail seniors. Lower rates are better.

Key Findings

- **Figure 33** shows that overall for Manitoba, rates were stable over time at about 20% for prescriptions among seniors who live in the community.
- For Southern Health-Santé Sud, rates of benzodiazepine prescribing for community seniors were significantly higher than the province for both time periods, but decreased slightly from 23% to 22%.
- **Figure 34** shows the variation within the region. The following districts were significantly higher than provincial averages: Steinbach, Carman, Ste.Anne/LaBroquerie, St.Pierre/DeSalaberry, and Morden.

Figure 33. Benzodiazepine Prescribing for Community Seniors by RHA, 2005/06-2006/07 and 2010/11-2011/12.
Crude percent of non-PCH seniors 75+ with 2+ prescriptions or more than a 30-day supply



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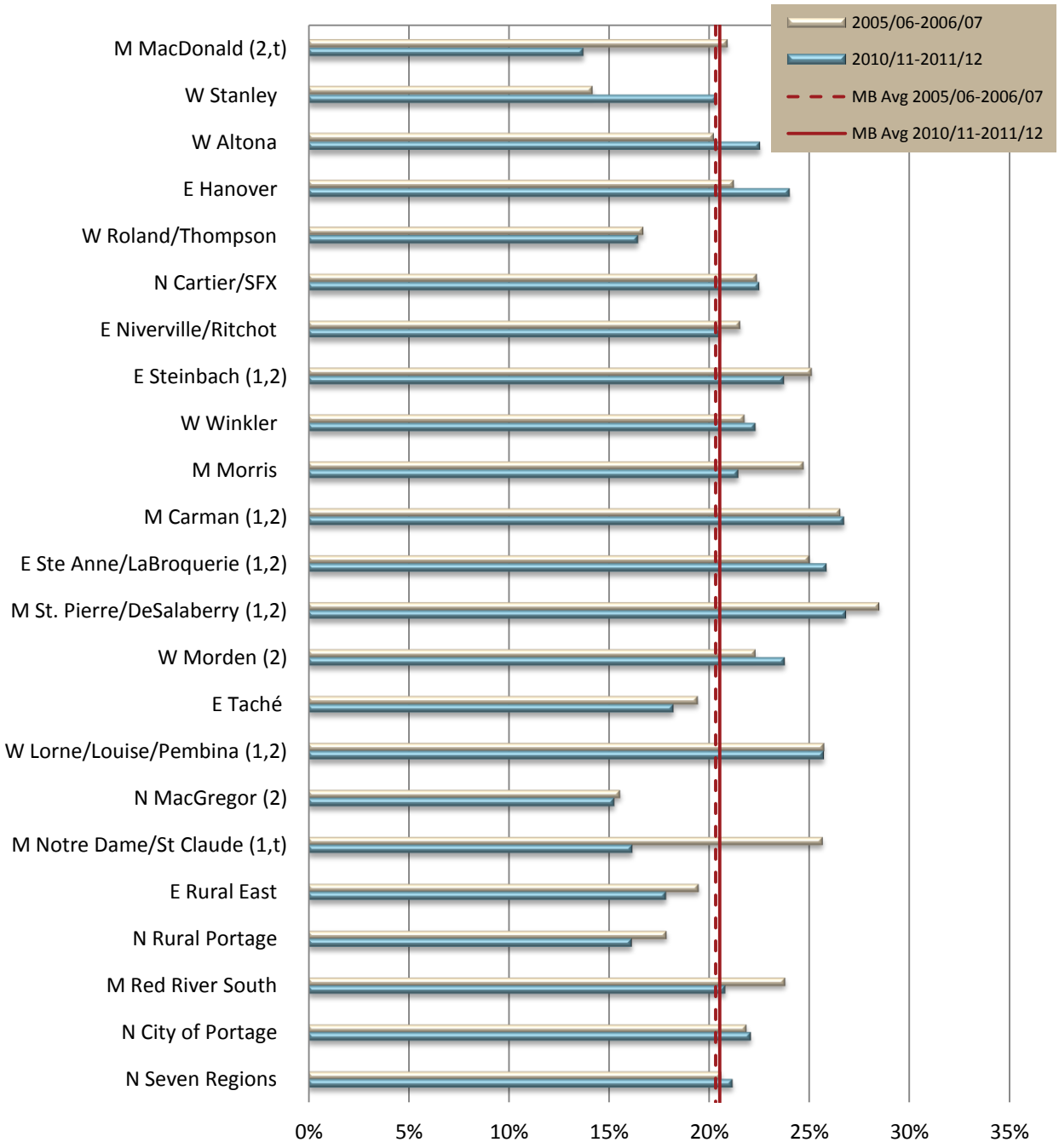
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Figure 34. Benzodiazepine Prescribing for Community Seniors by District, Southern Health-Santé Sud, 2005/06-2006/07 and 2010/11-2011/12.

Crude percent of non-PCH seniors 75+ with 2+ prescriptions or more than a 30-day supply



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers

Source: MCHP, RHA Atlas 2013

Benzodiazepine Prescribing – Personal Care Homes

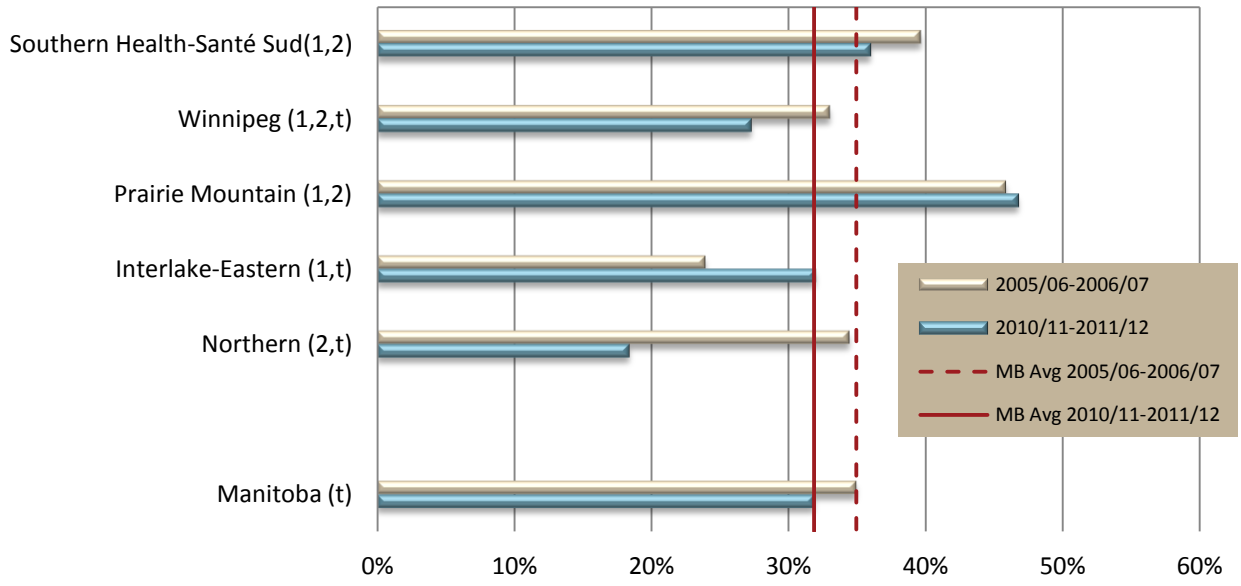
Definition: The percent of residents (age 75+) living in a personal care home who had at least two prescriptions for benzodiazepines (or one prescription with more than a 30 day supply). Crude percents are presented for two different years.

As explained in the previous indicator, the use of benzodiazepines are not recommended so lower rates are better.

Key Findings

- **Figure 35** shows that overall for Manitoba, the proportion of PCH residents age 75+ receiving benzodiazepines prescriptions decreased significantly over time from 35% to 32%.
- Once again, rates for Southern Health-Santé Sud were significantly higher than the province for both time periods, but decreased slightly from 40% to 36%.
- District level rates were not available due to small numbers.

Figure 35. Benzodiazepine Prescribing for Residents of Personal Care Homes by RHA, 2005/06-2006/07 and 2010/11-2011/12
Crude percent of PCH seniors 75+ with 2+ prescriptions or more than a 30-day supply



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s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

4.5. Personal Care Homes (PCH)

Supply of PCH beds

As shown in **Table 3**, Southern Health-Santé Sud has a total of 22 personal care homes located throughout the region. Seven of these facilities are `affiliate' which means they are health corporations and community owned non-for-profit facilities that operate through a signed service-purchase agreement with the RHA. As of 2014, there were a total of 1189 PCH beds in the region. There are currently 10,670 residents who are age 75 and older, therefore the bed ratio for Southern Health-Santé Sud is 111 PCH beds per 1,000 age 75+. As population aging gathers momentum with the baby boom generation, the pressure on long term care services is expected to increase.

Table 3. Personal Care Homes in Southern Health-Santé Sud, 2014.

Name of Facility	Location	Affiliate	# PCH Beds
Pembina Manitou Health Centre	Manitou		18
MacGregor Health Centre	MacGregor		20
Third Crossing Manor	Gladstone		50
Douglas Campbell Lodge	Portage la Prairie City		60
Lions Prairie Manor	Portage la Prairie City		136
Boyne Lodge	Carman		70
St. Claude Pavillon	St. Claude		18
Foyer Notre Dame	Notre Dame des Lourdes		60
Altona and District Health Centre	Altona		65
Emerson PCH	Emerson		20
Red River Valley Lodge	Morris		40
Repos Jolys PCH	St. Pierre Jolys		22
Rock Lake Health District PCH	Pilot Mound	Yes	24
Prairie View Lodge	Pilot Mound	Yes	30
Salem Home, Inc.	Winkler City	Yes	146
Tabor Home Inc.	Morden City	Yes	60
Heritage Life PCH	Niverville	Yes	80
Bethesda Place PCH	Steinbach City		60
Resthaven Nursing Home	Steinbach City	Yes	60
Menno Home	Grunthal		40
Villa Youville Inc	Ste. Anne	Yes	66
Vita and District PCH	Vita		44

Source: Southern Health-Santé Sud

Residents in PCH

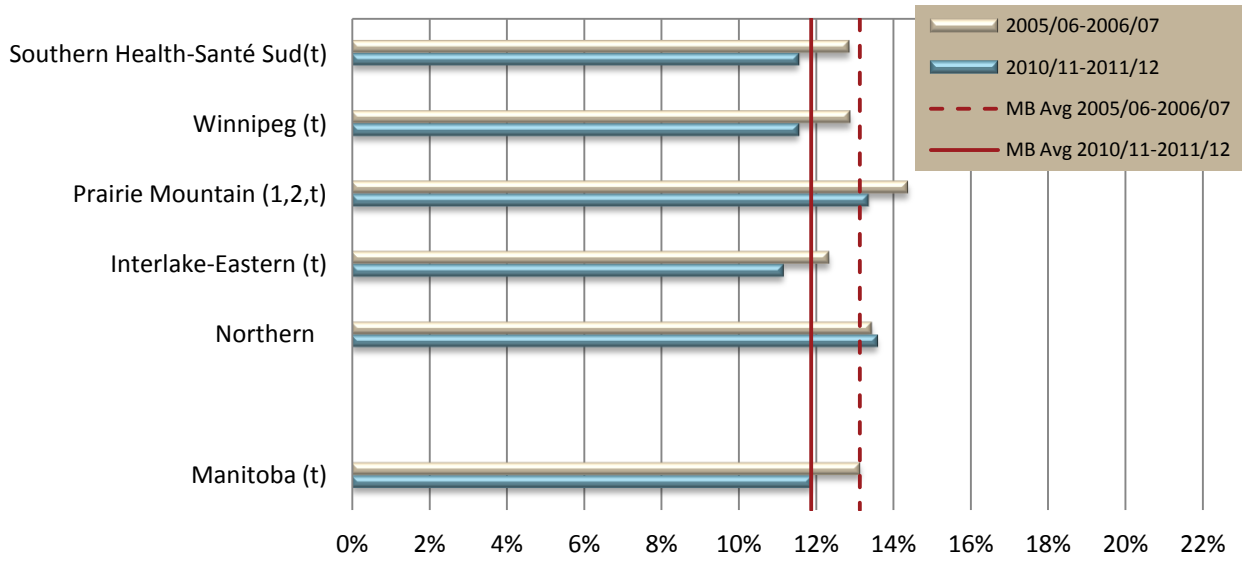
Definition: The proportion of residents (age 75+) living in a personal care home for two time periods. Rates are age and sex adjusted.

A personal care home (PCH) is an option when an individual needs 24-hour nursing care due to significant physical or mental deterioration. Personal care homes are designed for individuals who can no longer safely remain at home or in a supportive housing environment. Approximately 90 per cent of PCH beds are used by individuals aged 75+ years. Over the next decade, the baby boom effect (1946-66) will compound existing pressures on Manitoba's PCH bed supply. The population aging process will be a lengthy and steady process, with the peak starting in 2021 (early Baby Boomers turn 75 years) and continue until 2041 (late Baby Boomers turn 75 years).

Key Findings

- **Figure 36** shows that in Manitoba, 11.9% of residents age 75+ were living in a PCH which was decrease from the previous time where the rate was 13.1%. Overall, the decrease was reflected in all regions, except Northern.
- For Southern Health-Santé Sud, the proportion of residents age 75 and older who lived in a PCH decreased from 12.8% to 11.5%.
- District level rates were not available.

Figure 36. Residents in Personal Care Homes by RHA, 2005/06-2006/07 and 2010/11-2011/12
Age- and sex-adjusted average annual percent of residents 75+ living in a PCH



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Source: MCHP, RHA Atlas 2013

Median Wait Times for PCH Admission

Definition: The median length time (in weeks) for residents to be admitted to a PCH after being assessed as requiring PCH placement – either while waiting in hospital or living in the community. Rates are age and sex adjusted.

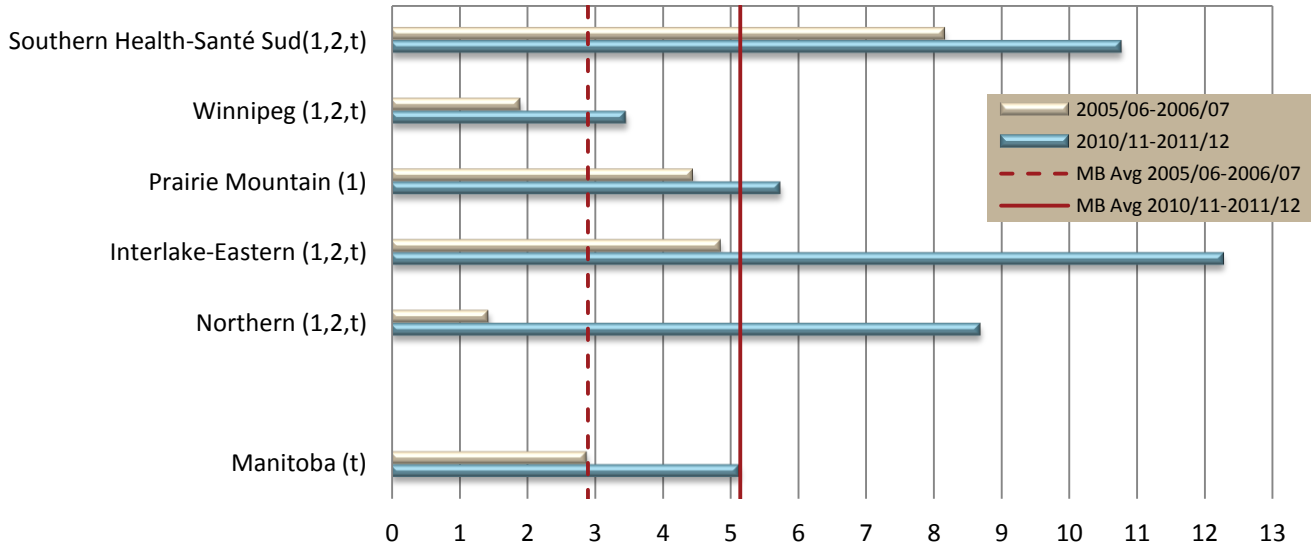
Wait times are important indicators about access and also how responsive the health care system is in processing new admissions. Wait times are impacted by availability of beds in a region.

Key Findings

- **Figure 37** shows that there was a significant increase in Manitoba for median wait times for PCH admission (from hospital) from 2.89 to 5.14 weeks. Wait times varied dramatically by region and increased significantly for all except Prairie Mountain.
- For Southern Health-Santé Sud, the median wait time for PCH admission while waiting in hospital increased significantly from 8.16 to 10.8 weeks – both time periods were higher than provincial averages.
- **Figure 38** shows the median wait time for PCH admission while still living in the community. Overall rates were higher compared to those waiting in hospital; however there was only a small increase in the province from 10.7 to 11.3 weeks.
- For Southern Health-Santé Sud, the median wait times for PCH were once again higher than provincial averages and increased from 17.4 to 22.6 weeks while waiting in the community.

Figure 37. Median Waiting Times for Personal Care Home Admission from the Hospital by RHA, 2005/06-2006/07 and 2010/11-2011/12.

Age- and sex-adjusted median number of weeks from assessment to admission by residence prior to admission per 1,000 residents 75+



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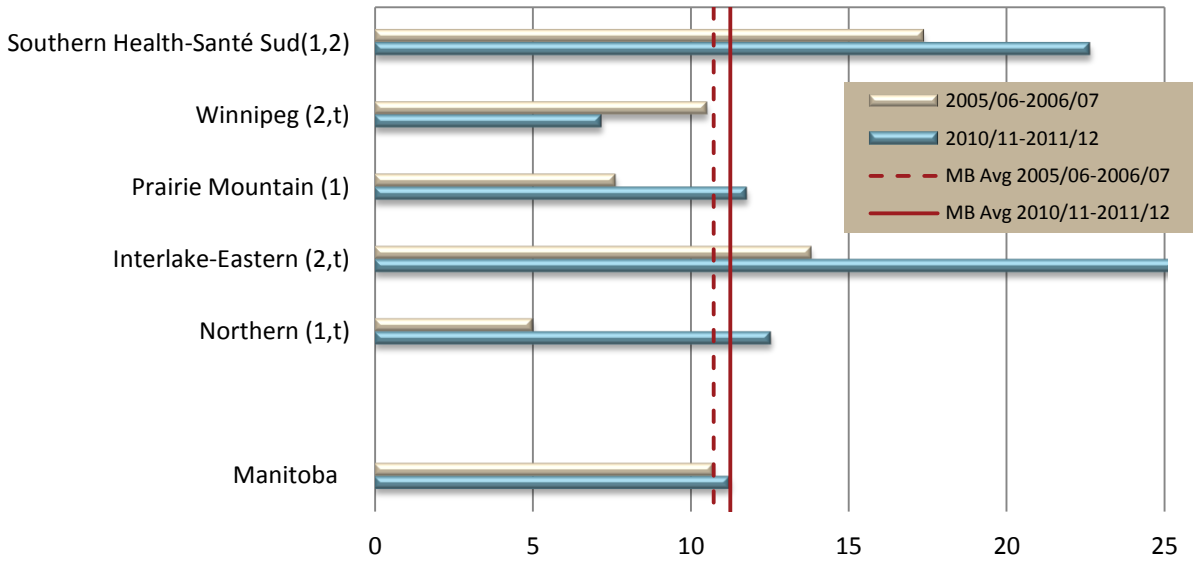
Source: MCHP, RHA Atlas 2013

Figure 38. Median Waiting Times for Personal Care Home Admission from the Community by RHA, 2005/06-2006/07 and 2010/11-2011/12.

Age- and sex-adjusted median number of weeks from assessment to admission by residence prior to admission per 1,000 residents 75+



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t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Median Length of Stay – PCH

Definition: The median length of stay (in years) for PCH residents (age 75+) by levels of care on admission.

Key Findings

- **Table 4** shows that over time, the median length of stay for PCH residents in Manitoba has decreased from 2.45 to 2.21 years (all levels).
- A PCH resident is assessed for their care needs and "levels" are assigned (1 to 4 scale) based on intensity of care that is required.
- In general, as level of care increased the length of stay decreased because higher levels indicate more frailty and intensity of care required. For example, the average length of stay for a Level 4 PCH resident was only 1.51 years (Manitoba, Time 2).
- For Southern Health-Santé Sud, the median length of stay for PCH residents was similar to the province and slightly decreased from 2.48 to 2.24 years (all levels).
- The length of stay for the region also depended on the level of care – ranging from a median of 4.60 years for Level 1/2N to only 1.46 years for Level 4.

Table 4. Median Length of Stay in PCH, in Years by Levels of Care, by RHA, 2005/06-2006/07 and 2010/11-2011/12.

Regional Health Authority	Time	All Levels	Level 1/2N	Level 1/2Y	Level 3N	Level 3Y	Level 4
Southern Health-Santé Sud	1	2.48	3.34	1.60	2.86	1.19	1.77
	2	2.24	4.60 (t)	2.72	1.80 (t)	2.05 (t)	1.46
Winnipeg (incl. Churchill)	1	2.46	3.23	1.37	2.49	1.29	1.67
	2	2.14 (t)	3.21	3.15 (t)	1.69 (t)	2.00 (t)	1.38
Prairie Mountain	1	2.41	3.10	1.06	2.66	1.05	2.24
	2	2.31	3.11	2.08 (t)	1.86 (t)	1.81 (t)	1.63
Interlake-Eastern	1	2.69	3.57	1.02	3.32	0.744	1.52
	2	2.23	6.37 (t)	2.69 (t)	2.41	1.85 (t)	1.56
Northern	1	1.64	2.49	s	1.40	1.10	1.01
	2	1.99	2.53	2.13	1.36	2.19	1.40
Manitoba	1	2.45	3.23	1.35	2.66	1.18	1.71
	2	2.21 (t)	3.32	2.69 (t)	1.76 (t)	1.96 (t)	1.51

Time 1 = 2005/06-2006/07 Time 2 = 2010/11-2011/12
t = indicates statistically significant change from T1 to T2 at p <0.05
s= indicates data suppressed due to small numbers
Source: MCHP, RHA Atlas 2013

Level of Care on Admission to PCH

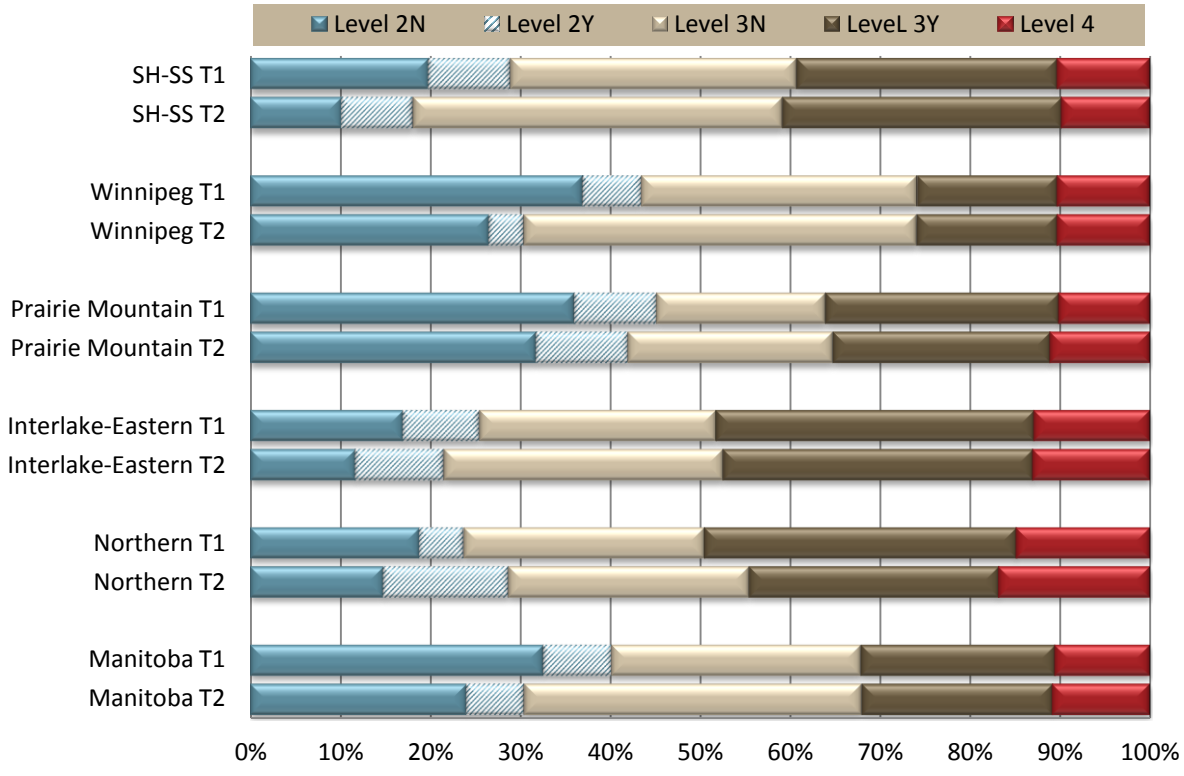
Definition: The distribution of levels of care assigned to PCH residents (age 75+) upon admission. Crude rates are shown for two time periods.

Level 1 represents the lowest level of care and Level 4 represents the highest. However, there were no PCH residents admitted with Level 1. As well, a "Y" after the level of care indicates whether a resident may need closer supervision due to behavioural issues.

Key Findings

- **Figure 39** shows that over time, there has been an increase in level of care upon admission of PCH residents, with a reduction in Level 2 (from 40% to 30%) and increase in Level 3 and 4 admissions (from 60% to 70%).
- Compared to the province, Southern Health-Santé Sud had a greater proportion of PCH residents with admissions at higher levels of care.
    - Level 2N/2Y decreased from 28.9% to 17.9%
    - Level 3N/3Y increased from 60.6% to 71.9%
    - Level 4 was relatively stable from 10.3% to 9.9%

Figure 39. Level of Care on Admission to Personal Care Home for Residents Age 75+ by RHA, 2005/06-2006/07 and 2010/11-2011/12.
T1=2005/06-2006/07 and T2=2010/11-2011/12



Y indicates requirement for close supervision
N indicates no requirement for close supervision
Source: MCHP, RHA Atlas 2013

4.6. List of Figures

4.7. List of Tables

Community Engagement

Chapter 5
Community Engagement

5.1. Chapter Highlights

This chapter examines what residents and staff of the region are saying about health and health care services in their communities. Community engagement is an essential component of providing safe, timely and appropriate care to the population of over 190,000 individuals. This chapter is about listening to the comments and stories of those served by Southern Health-Santé Sud.

Community engagement activities in the region generated six key themes:

1. The population is changing and the health care system needs to change with it
2. Access to health care is uneven across the region with a wide range of barriers to access
3. Health disparities are evident among rural communities and aboriginal population
4. More people are managing their chronic conditions
5. How to encourage people to make healthy choices
6. How to improve the patient experience with an appropriate level of care

Population Changes

- Community engagement participants noted the increase in regional population which is having both positive and negative impacts on communities adjusting to this increase.
- It has affected the ability of the region to cope with additional demand on health care resources as well as addressing the specific cultural and linguistic needs of the new population.
- These demographic changes will require the region to rethink both the mix of health care services offered and how it is delivered.

Access to Health Care

- Access to health care is dependent on many factors. While some barriers to access are obvious such as availability of the service, other factors can also play a role.
- Community engagement sessions revealed that the inconvenience of travel, affordability, language and culture, organizational barriers and stigma can also impact a person's ability to access health care.

Health Disparities

- Aboriginal people and individuals in rural and remote communities are suffering from poorer health status compared to other residents in the region.
- There are specific challenges in both these groups that community engagement participants felt needed to be addressed as a regional priority.

Chronic Disease

- People in the region are living longer with chronic conditions which are impacting communities and the health care system.
- The consequences of this means that primary care resources are being used more frequently, that adult children of seniors are being relied on to provide more support to their aging parents and more people are aware of how their personal lifestyle choices impact their health.

Healthy Choices

- Community engagement participants noted the challenges in making positive changes to live a healthier lifestyle. Participants did feel that improved infrastructure such as bike paths and community centres would help to encourage the adoption of healthier lifestyles.
- More knowledge and awareness of nutrition and dietary options was also cited as something the region could do to encourage healthy choices.

Appropriate Care and Better Patient Experience

- Health care staff in the region discussed this theme frequently, trying to balance both the need to provide efficient and cost effective health care with the desire to optimize the patient experience.
- Communication was considered a vital part of the patient experience, ensuring that the patient's viewpoint is heard.

5.2. Community Engagement

What does health look like in Southern Health-Santé Sud? The data and numbers reviewed throughout the course of the CHA process undeniably begin to form a visual representation. However, in isolation the innumerable indicators collected do not provide a complete image. The question cannot be effectively answered without also recognizing that our health is fundamentally influenced by the community. Like the artist who uses various layers of colors and medium to achieve an overall desired effect, adding community insight into the picture paints a multi-dimensional portrait of health in Southern Health-Santé Sud.

Founded in 2012 from the merger of two, hitherto separate regional health authorities, Southern Health-Santé Sud's understanding of "Community" was, from the very beginning, of great consequence to the new organization. While invested in building new and long-term relationships, the Board of Directors and staff embarked on a journey of learning about the great diversity of people who live within the community. Today, just over 190,800 people with varied ethnic origins and over 69 languages spoken live in Southern Health-Santé Sud. The Aboriginal population represents 12% of the overall population –while recent immigrants represent almost 13%. The profile of overseas immigrants is increasingly representing countries from all around the world. Only through the gathering of these diverse perspectives and compelling stories from the community can we begin to understand the complex details of health in our region and eventually see the" big picture".

> ***"Staff need to listen to, engage and communicate with patients to provide the best care possible."***
>
> ~Southern Health-Santé Sud Patient Experience Charter

The CHA consultation process is essentially "linked" to ongoing community engagement efforts across the Region. It includes existing formal approaches and events as well as informal channels, going where the people are and having conversations with residents regarding shared values about health. Southern Health-Santé Sud participates in a substantial number of ongoing community-based stakeholder groups across the region. Through local stakeholder groups positively engaging with the Regional Health Authority, communities can take up issues themselves, thus creating strong local voices.

Additionally, Local Health Involvement Groups (LHIGs) which are designed to provide input and perspectives to Southern Health-Santé Sud Board of Directors on health and health services are another critical component across the community engagement continuum. The local groups were created through the provincial government's amendments to the *Regional Health Authority Act* in 2012. In the fall of 2012, a joint government and RHA working group solicited public feedback to determine how the groups could best function. In Southern Health-Santé Sud, consultations were held in seven communities across the region (two were held in French). At the public meetings, participants were divided into small groups and asked for their feedback about several possible scenarios for LHIGs. An online survey was also conducted. Their comments were captured by note-takers and subsequently compiled and analyzed by staff at Manitoba Health, Healthy Living and Seniors.

LHIGs are made up of community members, a board member and some staff. They are currently in various stages of the planning process. For example, in consultation with Santé en Français, a French-speaking LHIG is organized under the auspices of the *Tables de Concertations du Centre* and *Sud-est*.

It is also important to acknowledge that community engagement can occur at all levels of the organization and within the work environment where the exchange of experiences with groups and individuals offer different kinds of

knowledge and learning. A Patient Experience Planning Committee comprised of patients, family and staff developed a Patient Experience LHIG Charter and a Patient Experience Group has been formed and is currently active.

With the CHA providing a canvas to paint a picture of health in the region, some specific activities provided the medium to form the images that help describe the health of people in Southern Health-Santé Sud:

> *"We can begin by doing small things at the local level, like planning community gardens or looking out for our neighbors. That is how changes takes place in living systems, not from above but from within, from many local actions occurring simultaneously."*
>
> *Grace Lee Boggs*

> *"Our mission in this new century is clear. For good or ill, we live in an interdependent world. We can't escape each other. Therefore, we have to spend our lives building a global community of shared responsibilities, shared values, shared benefits.*
>
> *Bill Clinton*

5.3. Summary of Community Engagement Activities

Table 1, provides a summary of community engagement activities that are part of CHA process for Southern Health-Santé. Some of these activities are specific to the region, and others are part of a provincial collaborative. Please note that this is not an exhaustive list of all engagement activities for the region, but rather a summary of the information incorporated into this chapter.

As noted in the introductory chapter, six key themes emerged early on from the Southern Health-Santé Sud CHA data:

- The region has a diverse, growing population with increased demands for services
- There is variable access to healthcare in the region
- There are health disparities within the region
- There are more people living in the region with chronic diseases
- There is a need for improved lifestyle choices
- There is a need for appropriate care and a better patient experience

The remainder of this chapter will focus on what community members, patients, families and staff have said about each of these themes.

Table 1. CHA Engagement Activities, Southern Health-Santé Sud, 2009-2014.

Surveys	Year Completed	Description
Youth Health Survey	2009, 2012	A school-based survey completed by grade 7-12 students across public schools throughout Manitoba. The survey asks questions about health behaviours in areas of physical health, healthy eating, mental well-being, tobacco and alcohol/substance use, injury prevention and healthy sexuality.
Acute Care Surveys	2014-ongoing	Sent to all patients who had a recent stay in one of the regions' facilities to give feedback about the care they received
Resident Surveys	ongoing	Residents/family members of the regions' Long Term Care Centres fill out surveys about their experiences
Cancer Care Surveys	2007-2011	Patients being treated for cancer were asked to fill out a survey about the care they received
Staff Surveys	2014	In alignment with Accreditation processes, staff of the region are regularly surveyed regarding Patient Safety Processes and Worklife Experiences.
Healthy Communities Conference		
	2014	An annual health promotion conference put on by representatives of a particular community in partnership with Southern Health-Santé Sud.
Annual Public Meetings (APM)		
	Annually – every fall	A planned consultation with all participants attending the

		meeting is designed to solicit responses from the community to specific questions. ▸ In 2013 we asked, *"In the last 5 years, how has the health needs of you and your family changed? Has this changed the type of health services you use? How has the health of your community changed? Why?"* ▸ In 2014, following a presentation of the highlights of some of the preliminary findings of the CHA we asked, "*What are the main health issues in your community and how can Southern Health-Santé Sud work better with communities in achieving better health for everyone?"*
Board of Directors and Leadership		
	Ongoing	Ongoing validation and conversations are held at these tables to analyze, theme, categorize and put data into action.
Dakota Ojibway Tribal Council		
	Ongoing	Coordinating and planning continues with Dakota Ojibway Tribal Council (DOTC) members to further prepare the proposal documentation for the "Blurring the Lines" Health Services Integration Fund (HSIF) project.
Public Health-Healthy Living Projects		
	Ongoing	Public Health Nurses and Healthy Living Staff connect regularly with individuals, communities and groups to support their healthy living priorities. Communities set goals and healthy living staff work with them to find approaches and initiatives that are evidence informed that can help them address their goals and priorities.
Environmental Scan		
	September 2014	The Regional Leadership Forum did an Environmental Scan to further assist in the identification and prioritization of emerging issues.
My Health Team		
	2014-present	Work on the Primary Care Network /My Health Teams has involved community members along with physicians and other stakeholders to review the health status of the population of interest in the area to be served by the My Health Teams.
PCH Review		
	2012-present	A comprehensive assessment determining PCH bed needs in the region and involved engaging various members of the community to look at future needs.

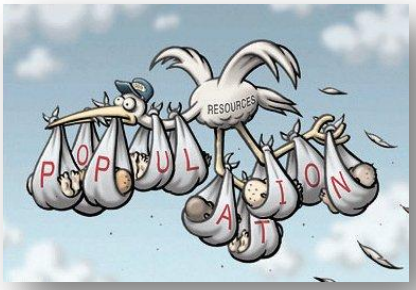
Source: Southern Health-Santé Sud

5.4. A diverse, growing population with increased demands for services.

The numbers don't lie. It is clear that the demographics of the region are changing rapidly all around us. The region is home to residents from a wide array of countries, who speak more languages with more cultural backgrounds than ever before. In addition to the immigration numbers, we know that fertility rates also contribute to the growing population in addition to the fact that we are living longer.

Community Changes

These changes are clearly felt in the community. When asked about how their communities have changed in the past five years, community members who attended our Annual Public Meeting in 2013 responded with:



"Our schools are overflowing"
"Lots of growth in area"
"Many people are moving to our community to retire"
"Increased ethnic groups"
"Lack of affordable housing in my community with so many people moving in"
"Lots of young families"
"More women are using midwifery services"

While some cultural groups are experiencing tremendous growth and cultural thriving, others have noticed different changes. Based on a consultation event held at Swan Lake First Nation during a Healthy Communities Conference, a community member shared a specific concern about recent changes in her community:

"The decline of our language and vicariously the cultural teachings inherent in it."

Service Demands

The growing population has a direct impact on health services. As the number of people requiring services increases, the concern is that our services and human resources can't keep up with the demand. A local community member voiced her concern by saying:

"They could use extra staff, such as health care aids to help out. They are a very busy place."

In responding about a recent stay at a local facility, a patient noted:

"Many staff are staying longer than their shift just to be able to finish off whatever they were doing. The doctor whose care I was in ended up working a double-shift the first day of my stay."

Pressures from the change in demographics are felt throughout the system. The addition of more cultures and more languages in our region create additional challenges to health staff. At a staff consultation, a staff member commented that:

"More multicultural activities in our area would be good so we could get a better understanding of the various cultures in our area."

Over 100 members of the public attended Southern Health-Santé Sud's 2nd Annual Public Meeting in Niverville in 2014. Round table discussions were held and asked the question: What are the main health issues in your community?

The responses were clear. The vast majority of the concerns were around the sustainability of the health care system in local communities. Residents showed clear concern for the demands on services and the innovation and creativity required ensuring continuity.

When speaking about ER services at his local facility, one community member said:

"There's a need to explore alternative models to our present ER systems that will serve our citizens needs, yet still be achievable within the realities of our community's health care resources."

Several people showed specific concern for the aging population of our region, noting that current resources won't support the growing number of seniors in our region.

Looking to the Future

Many members of the public during this consultation noted the importance of innovation and of trying to do things differently to ensure that the public will have the health services they require. To ensure the sustainability of our health care system, tough decisions often need to be made.

"Courage is needed to redirect health resources from acute to preventative and chronic services."
"How can we utilize the services that are already there?"
"Hospital focus may not be ideal. Hospitals do not equal health. Maybe ramping up community services would help."
"All of the health care services and facilities in our local region can collaborate for the benefit of all communities."
"It can be difficult to look at the long-term but we need to spend more time doing that."

> *"We cannot keep doing what we have always done expecting better/different results."*

And the result of these difficult decisions can often become a positive thing for the community. One participant said:

"When ER closes, it isn't always the disaster that people perceive it to be. We now have a good paramedic service."

5.5. Variable access to health care.

Access to health services is a complex issue. It includes the availability of a specific service but it also includes much more. Gaining access is a completely different angle to consider. Gaining access to services can be dependent on a person's finances, on their culture/language, physical ability or other social barriers that would get in the way of accessing the services they need. Therefore access to services needs to consider all of these barriers to get a true understanding of what prevents people from getting the care they may require.

Primary Care Services

Access to physicians is clearly an important entry point to healthcare for most individuals. Over 100 people who came to the Annual Public Meeting in 2014 discussed community health issues. An important concern that emerged consistently is having access to a doctor or other primary health provider.

"We can't keep doctors in our community. Because of that, our emergency has been cut down."
"We have a revolving door of doctors in our town."
"It takes me longer to get an appointment with my doctor"
"Doctors in area are short term and our community is elderly- this is hard for these folks."

Mental Health is another service that the community members felt needed to be expanded. This sentiment has been shared at several round table and focus group discussions:

"We need more mental health workers to avoid wait times."
"More Mental Health resources are needed in the community where people live."
"We need to make it easier for people to get seen."
"My community needs education on Mental Health issues- right now there is none."

Access Barriers

People in our region struggle to gain access to health services for a variety of reasons. Many of these following realities have been shared by many community members:

<u>Transportation and Financial Resources</u>

"We are fortunate to have the services in the facility available in this community. Others are not so fortunate."
"Healthcare for people in rural sites can be difficult. Physicians rotate sites and public is unaware where MD's are. For some who lack transportation and resources, it is a struggle to get to on-call locations."
"It's a long drive to Winnipeg for specialist appointments."
"I'm seeing an increasing gap between the rich and poor."

<u>Language and Culture</u>

"It was very important to speak my mother tongue (francais) to the doctors & staff"

"We need better communication as well as attitude from health providers. I've seen a lot of providers (ie doctors, nurses, medical admin) have such a negative attitude in terms of facial, tone of voice etc when they speak to people including myself."
"There needs to be reciprocal respect!! Cultural competency of service providers would help me take better control of my health."
"I need to be listened to and understood."

Organizational Barriers

"I struggle with finding the right telephone numbers for the different areas of service"
"Health system is too frustrating, so it deters young people from using services."
"I wish I knew earlier that a doctor's referral is NOT needed for many of the services you have."

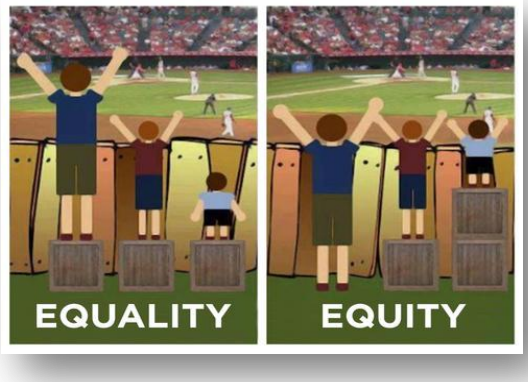
Psychological Barriers (Mental Health Services)

"The services are there, but so is the stigma attached to using them."
"I know there are a lot of services but sometimes people with a mental illness would rather go where they are not known"

> *I'm an educated business woman with a background in healthcare- but I felt afraid to admit to having Mental Health issues and seek help. Having my wise colleague available in the moment I needed her helped me seek out services. If I had to wait until I was home and do it on my own, I don't know if I would have done it."*

5.6. Health disparities across the region.

Reviewing data presented in previous chapters, it's impossible to avoid a troubling fact: health is not shared equally by everyone in our region. Whether that can be explained by access, education, living conditions or other social determinants of health, it's not totally clear. What is clear is that we all have work to do in regards to equity.



The concept of equity differs from that of equality. Equality says everyone should get the same programs and services equally, regardless of need. Equity says that everyone should have the same opportunity to be healthy as the rest of the population. In some instances, that may mean targeted programs where it's clear that a specific population or community is struggling. It may mean redesign of services according to need. One patient expressed:

"Equity sounds like a great concept, until it affects me and the services I can/can't receive." (Pt Exp Group)

Aboriginal Health

While it's a difficult concept to accept, the reality is that many pockets of our region are suffering terribly from poor health. This is especially true in many of the First Nations communities. At a Healthy Communities Conference held at Swan Lake First Nation, members of that community voiced their specific concerns. Even though there is a strong desire for health, there are barriers that are very difficult to overcome.

"Our community needs a wider selection of healthy food choices at our local grocery store".
"In order for me to take better control of my health, there needs to be equality in access to health and cultural competency of service providers."
"We need adequate low-income housing."
"I feel the major health issues in my community are mainly alcohol abuse and mental illness. As a community, we need to come together."

One workshop participant even commented that she would have liked to have seen more of her community represented at the event but voiced her concern by saying that:

"During health workshop days like this, [instead of coming here] people are busy gambling."

To ensure the health of all residents of Southern Health-Santé Sud, there were specific words of advice that were shared by Aboriginal residents to help move things forward:

"We need to INVITE, AUTHORIZE, & ARRANGE for health authority staff to visit First Nation communities for cultural awareness and community outreach/education."

"We need more events that bridge the gap, blur the lines and support understanding of fellow community members"
"There is not enough care/respect in hospitals."
"Increase the cultural competency of service providers. Prevention and promotion activities with respect to the Indigenous view."
"Work on more collaboration with Aboriginal communities. How health care is covered with Aboriginals creates a barrier to services for that population"
"More face-to-face on reserve with health providers from the RHA"

Remote Rural Communities

Rural and remote communities are another population of identified need. Compared to other parts of our region, people living in these areas have poorer health. In general, these areas are older and declining in numbers. Access to services is often a concern in regards to transportation and family supports.

"How do you get elderly to activities when transportation is an issue?"

"The older generation expects their children to do everything for them."

One community member at the public meeting said:
"Folks feel they are at the end of the district and are being forgotten."

Another individual mentioned that the regional health authority needs to think differently about certain populations:

"Need to be more creative to meet the needs of those patients who do not have access to health care services as others do- there is an equality issue"

5.7. More people living with chronic disease.

Health needs of families and communities change greatly over time. The evidence indicates that more people in our region are being diagnosed with chronic diseases but because of medical advances and other important factors, these people are also living longer with these conditions.

Effects of Chronic Diseases

Community members have been noting the changes personally and locally:

"In our community, people are living longer and have more complex health issues because of their age".
"Our community has increased diabetes rates, cancer rates."
"I can't believe how many people suffer with mental health issues."
"People are living longer with more complex health issues: there are issues that come from both of these things."

Impacts on Communities

These pressures are clearly being felt in communities and homes across the region. While the facts and figures speak to the increase in chronic conditions, the real impact is always felt at the community level. While the majority of chronic conditions generally occur in the aging population, several people noticed a recent change in their communities:

"Seems to be younger people than ever with dementia."
"I've noticed increased diagnoses of cancer- especially with younger people."
"Stress related illness is increasing"

In 2013, the health authority asked 100 residents and staff about how their health and that of their families has changed in the past 5 years. Three themes emerged from those discussions:

1. There are increasing health needs as aging occurs
2. The realities of the sandwich generation- young families with aging parents
3. Residents are taking more responsibility for their own health

Increasing health needs

"I have fewer scheduled doctor's visits. Now the visits are more emergent."
"I'm at the age where I need to see my physician more (increased cholesterol)."
"My children have moved out and now I have to manage my own health concerns."

Sandwich generation

"I am now a part of the sandwich generation- caring for aging parents who have chronic diseases"
"We have a history of diabetes and heart attacks in our family and right now, we're caring for my father-in-law whose dementia is progressing quickly."
"Right now I'm the caregiver for my aging parent who required hip replacement, cancer treatment and long-term dementia. However, this isn't a long-term solution."

Taking responsibility for personal health

"I make sure to wear my pedometer and try to get at least 10,000 steps/day."
"The messages are finally drilling home."
"The Baby Boomers in my community have been pushing for a 24 hour fitness centre."

5.8. Need for improved healthy choices.

Health promotion and education about healthy lifestyle choices is readily available these days. Almost everyone can agree that exercise and making healthy food choices will help increase physical ability, decrease many negative health conditions and improve overall functioning. People also generally agree that smoking is a poor lifestyle decision.

Unfortunately, being able to make lifestyle changes to support ones' health is where things always get difficult. Translating the knowledge everyone has about health into practical daily lifestyle decisions is a personal decision. When asked what gets in the way of living a healthy life, participants at the 2014 Healthy Communities Conference said:

"To take better control of my health, I need to completely stop everything I'm doing and start off fresh with help from somewhere- of course, I would also need some will-power and commitment."
"In our community, we need structure in peoples' lives- otherwise it leads us to ill health, smoking and eating processed foods."
"There is a lack of healthy food choices in my community."

To put it plainly, a community member at the 2013 Annual Public Meeting stated:

> *"Sitting is the new smoking. We have the information to make healthier lifestyle choices but most of us don't do it."*

Fitness and Exercise

According to the Canadian Community Health Survey, only 45.4% of people in the region ages 12+ reported moderate or active levels of physical activity during leisure time compared to the Manitoba rate of 53.5%.

A few people have suggested that better infrastructure would benefit the active community:

"Our towns really need better infrastructure to help support active lifestyles (bike racks, safe walking paths or ski trails)."
"We need to advocate for free and open access to community school gyms- especially in winter."

Healthy Eating

There is a strong consensus among several Southern Health-Santé Sud residents that healthy eating plays a large role in overall health. Several advisory council, annual meeting and conference participants have made comments about the value of a good diet.

"I would benefit from more education about diet and wellness."
"I started buying a new vegetable or fruit each time I go to the grocery store and research how to cook it. It gets me trying new things and makes it interesting."
"There are just so many diet fads and nutrition fallacies."

The next generation is also learning from the examples being set. One participant was worried about his teenage son:

"Telling my kids about safe alcohol consumption is important but being a good role model will have more impact"

5.9. Appropriate care and better patient experience.

Staff and community members alike have spoken loudly about the critical importance of appropriate care and the expectation of a better patient experience.

Appropriate Care

Regional staff members speak to this topic regularly. It is a theme that emerged strongly from a full day workshop in 2014 that was held reviewing data from this report. There are two angles to appropriateness of care: appropriateness of a service and appropriateness of the setting in which care is provided. It can be difficult to measure either of these things because what one person considers suitable may not be the same as the next.

For example, CancerCare Manitoba rolled out an Ambulatory Oncology Survey to cancer patients in our region in 2011. When asked how satisfied patients were with their outpatient care, satisfaction was rated at 96.3%. But when asked about the emotional support they received, patients only rated that at 48.5%. Recently, Cancer Navigation Nurses have been put in place to help provide a fuller spectrum of care for cancer patients.

Another example is a person with Alzheimer's disease who requires a specialized environment to ensure the best care. Unfortunately, many of the facilities are not appropriately equipped for these specific conditions.

Better Patient Experience

Appropriateness often boils down to a better patient experience. The health authority receives feedback from patients in a variety of ways: electronic, bedside, telephone calls, letters, etc.

Patients from the Patient Experience Group stressed the value and utmost importance of the patient experience when they said:

> *"It's an amazing gift- the positions of caregivers!"*
> *"Providers can impact a patients' emotional health or emotional scarring."*

Early feedback from a recent acute care survey in the region reveals mixed feelings about experiences in hospitals.

"They cared for me just as a family should care for each other"
"Nurses should consider using formal names when conversing with one another and not just the patient's room number".
"I was very impressed with the hospital's cleanliness, care and all of the staff. It's a very well organized hospital with great care given to health. I felt very safe there."
"It was my first experience with a rural hospital and I was really impressed with everything and everyone."

Communication is Key

A theme that has emerged from patient feedback in regards to the patient experience is communication: communicating with the patient and communication between staff.

"We need to educate patients that their voices matter."
"Patient input provides a venue and opportunity for healing."
"My discharge was a little disorganized because communication between night staff and day staff. Nothing was written that I was to be discharged in the morning or how many doses of medication I was to have before I could go home."
"I think staff and doctors need to listen more carefully to what a patient has to say, what is wrong or what could help them and talk to them about it."
"Everything about the stay was quite satisfactory other than communication between doctors on call, my family doctor and the nurses. This made things very confusing and frustrating."

Patient Experience Local Health Involvement Group

To address the patient experience and patient safety concerns in the region, Southern Health-Santé Sud launched a Patient Experience Local Health Involvement Group. This group is made up of local residents who have all been patients or family members of patients. Many of these members have experienced a critical incident and have chosen to contribute to making the system safer and more pleasant for others. As part of their early work, a Patient Experience Charter was developed (see **Figure 1**). This charter clearly states the intentions of the group and the actions they plan on taking with the support of the health authority.

The Patient Experience Charter is becoming a fundamental document in the strategic planning of the region and integrated into work of staff. One staff member put it clearly:

> *"Collaborating is good for everyone- patients and professional practitioners."*

Figure 1. Patient Experience Charter, Southern Health-Santé Sud, 2014.

Patient Experience Charter

Purpose:

- *We will share, listen to, understand, learn from and respond to patient experiences in a timely and appropriate fashion.*
- *We will create system and culture change within all levels of the organization to better support the patient experience.*
- *We will help create a more balanced relationship between patients and care providers.*
- *We will expand on positive experiences and create an atmosphere to move forward from negative experiences (both for the patient and the care provider)*
- *We will provide opportunities for patients to become integrated in the workings of the organization.*
- *We will move patient safety issues forward to ensure that each patient receives quality health care*
- *We will create clear and simple processes, tools and resources for patients to communicate their experiences (both positive and negative).*
- *We will increase public/staff/board awareness of patient safety and patient experience issues.*

Guiding Principles:

- *Staff need to listen to, engage and communicate with patients to provide the best care possible.*
- *Healthcare needs to be a more balanced relationship between provider, patient and the family*
- *Humility in healthcare is essential*
- *Patients need and deserve hope and respect*
- *Our goal is to achieve sincere person-centred and dignity care*
- *We recognize the wide variety of sensitivities and personal preferences that exist because of peoples' experiences and will work to educate ourselves and others as to what they might be*

5.10. Conclusion.

Although we can have a glimpse or snapshot of what health looks like today in Southern Health-Santé Sud, there is the occasional white space… the suggestion of a larger story to be told. With an ever-growing population, the image will also change and fluctuate. So whereas numbers are but for a moment in time, the community will always be there to provide insight and to provide some perspectives on the shapes and colors of the "big picture". Community engagement is essential.

5.11. List of Figures

5.12. List of Tables

Appendix

Appendix

Primary Data Sources

There are many data sources used in the making of this report, and all sources are referenced throughout all the tables and figures. The following is a list of primary data sources for the majority of the statistics:

- Statistics Canada, 2011 Census
- Statistics Canada, 2011 National Household Survey
- Statistics Canada, combined cycles 2007-2012, Canadian Community Health Survey
- Manitoba Health, Healthy Living and Seniors – Health Information Management
- Manitoba Health, Healthy Living and Seniors – Communicable Disease Control
- Manitoba Health, Healthy Living and Seniors – Epidemiology and Surveillance Unit
- Healthy Child Manitoba Office
- Manitoba Centre for Health Policy
  - The 2013 RHA Indicators Atlas
  - Perinatal Services and Outcomes in Manitoba, 2012
- Canadian Institute for Health Information (CIHI)