Aboriginal People

The burden of illness is very different for Aboriginal people in the WHR compared to non-Aboriginal people and compared to other Aboriginal people in the province. As a result, a unique combination of determinants of health and health outcomes exists for Aboriginal people in the WHR.

While recognizing the diversity of individual needs and strengths, a population health approach responds to the collective needs and strengths of the entire population. The term population health emphasizes, more than just health outcomes as issues that need to be addressed, but it also emphasizes the determinants of health known to influence the health and well-being of the entire population.

The population health profile for Aboriginal people in the WHR contains the following:

- Population Characteristics
- Health Issues
- Determinants of Health
- Summary of Findings

This profile is limited to the collection, review and synthesis of major reports on Aboriginal peoples at local, provincial and national levels. The information provided in this profile is made possible through the successful work of many organizations and individuals. While information is available on many health outcomes and determinants of health, there remain notable gaps of information requiring further attention. Substantial dialogue and consultation are required to discuss these findings, identify other key health issues, set priorities and collaboratively develop programme strategies and interventions with the goal of improving the health of Aboriginal peoples living in the WHR.

The information in this profile is provided for Aboriginal peoples, including First Nations, Métis and Inuit peoples, where possible. Please note that when data or a report are referred to that specifies a particular Aboriginal population, e.g. First Nations, then the text reflects the particular population.

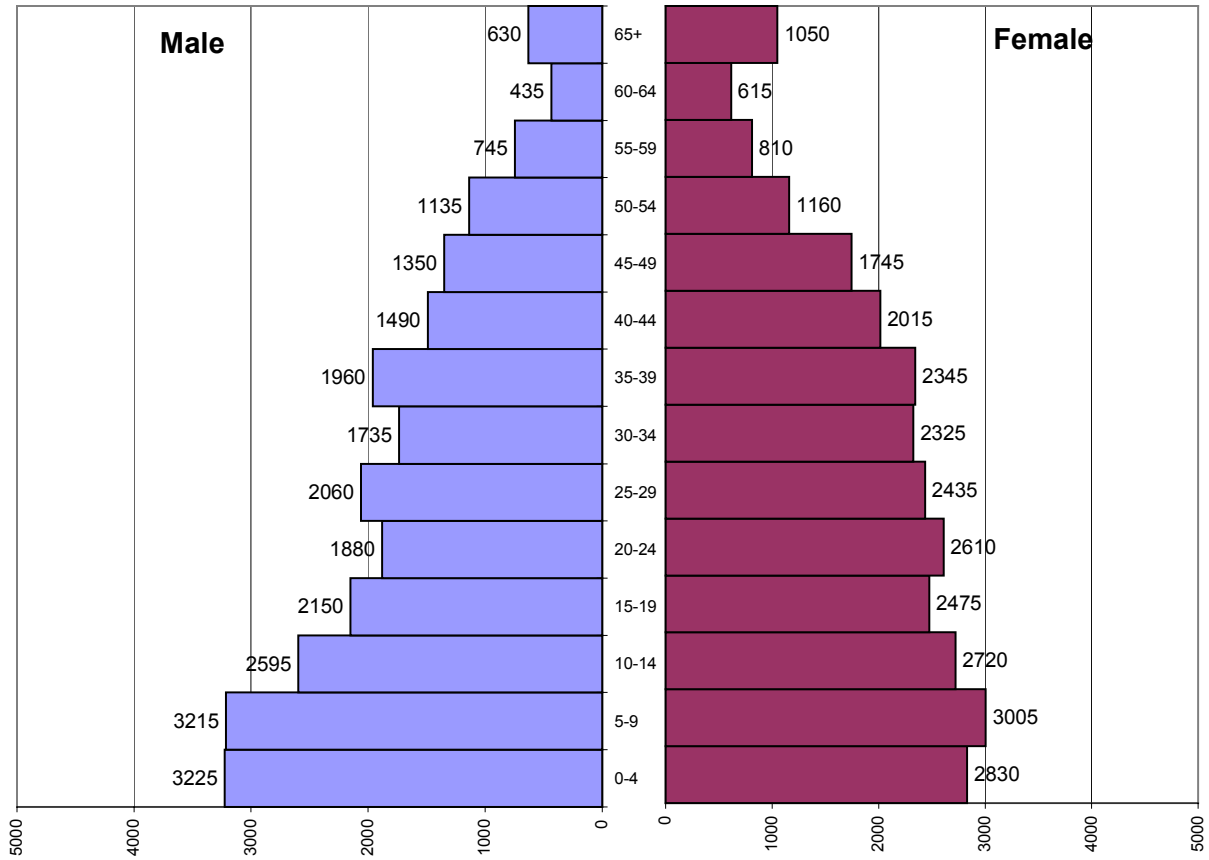
Population Characteristics

The demography of the population forms the foundation of our community health assessment. The most basic pieces of information - the age and sex distribution of the population - form the outline of a picture of the population. Information in such areas as family structure, ethnicity, economic, social environment and housing describes population characteristics that enhance our understanding of this population. Every community has characteristics that make it unique, with both strengths and challenges to overcome. In this section, we describe some of these characteristics for the Aboriginal population living in the WHR. This information is derived from the Census Data Consortium, Statistics Canada Custom Order, Census of the Population 2001 (referred to as 2001 Census in this report) and found in the *Aboriginal Census Profile* (available on-line: http://www.wrha.mb.ca).

Age and Sex Distribution

2001 Population Pyramid of Aboriginal Persons (Based on Self - identity) by Age and Gender

Total Population (20% sample data)



	Male	Female	Both Genders
Total All Ages	**24605**	**28140**	**52745**

Source: Canadian Census 2001, Statistics Canada

Overall the Aboriginal population is younger than the non-Aboriginal population living in the WHR. In the WHR, 42.1% of the Aboriginal population (based on self-identification) are children and youth, 19 years of age and under. This is a smaller proportion of children and youth compared to other Aboriginal peoples in Manitoba (45.6%) and in Canada (42.7%). However, the proportion of Aboriginal peoples who are children and youth is substantially higher than that of the entire WHR (42.1% versus 25.3%). In contrast, a much smaller proportion of the Aboriginal population is senior citizens (aged 65 years and older): 3.2% in the WHR, 3.7% in Manitoba and 4.1% in Canada. While for the WHR overall, a much larger proportion of the population is seniors (13.9%).

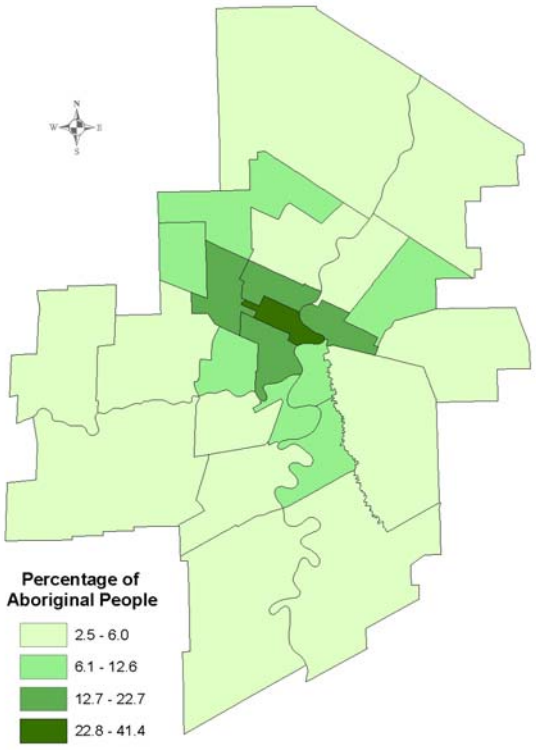
In the WHR, the Aboriginal female to male ratio is greater for females than males, although males tend to outnumber females in the younger age groups and females tend to outnumber males in the older age groups. For those persons 80 years and over females tend to outnumber males. The female to male ratios are similar to that of the WHR as a whole (see *WHR Overview, CHA Report 2004*).

The shape of the population pyramid is like a triangle; a shape found in many developing countries with poor health status indicating a very large young population, but one that steadily declines with age. This is a very different population structure from the region as a whole.

Distribution of the Aboriginal Population

- The proportion of the population who are Aboriginal is substantially higher in Point Douglas 10B, Downtown 11B, Inkster 9B, Point Douglas 10A and River East 7A.
- For the above Neighbourhood Clusters, between 20-40 per cent of the population is Aboriginal.

Percentage of Aboriginal Persons in the WHR, 2001



Ethnicity

The WHR is well known for its cultural diversity. Eight and a half per cent of individuals comprising the WHR population identified themselves as Aboriginal. According to Statistics Canada, Winnipeg has the largest proportion of the urban Aboriginal population of the major cities in Canada[1]. This is higher than that for Canada as a whole, where 3.3% of the population is Aboriginal. In Manitoba, 13.6% of the population identified itself as Aboriginal. The proportion of the population that is Aboriginal varies between the community areas within the WHR. The highest proportions are found in the Point Douglas, Downtown, and Inkster Community Areas at 25.9%, 17.1%, and 14.0%, respectively.

'Aboriginal' is a term used to describe anyone identifying himself or herself as a registered First Nations (living either on or off reserve), Métis and Inuit. Of the total self-identified Aboriginal population within the WHR, 41.9% identified North American Indian, 55.5% as Métis and 0.3% as Inuit as the ethnic origin. As for Manitoba, individuals comprising the Aboriginal population identified themselves as North American Indian (60.2%), Métis (37.9%) and Inuit (0.2%). In Canada, these were 62.9%, 29.9% and 4.6% respectively. A greater proportion of the WHR Aboriginal population identified itself as Métis, whereas a greater proportion identified itself as North American Indian for both Manitoba and Canada.

Family Structure

The WHR is home to many different types of families. "Families shape and are shaped by the communities and societies in which they are embedded."[2] According to Statistics Canada, Canadian families have become more diverse over the past twenty years.[3] This has been attributed to increases in separation, divorce, remarriage,

[1] Canada. Statistics Canada. *2001 Census: Analysis Series Aboriginal peoples of Canada: A demographic profile*. Ottawa: Government of Canada, 2003.
[2] Vanier Institute of the Family. *Profiling Canada's Families II*. Ottawa: Vanier Institute of the Family, 2002.
[3] Canada. Statistics Canada. *Profile of Canadian families and households: Diversification continues.* Ottawa: Government of Canada, 2002.

common-law unions, and lone parent families. This is also influenced by a general decline in fertility rates and an increase in the ageing population. Statistics Canada routinely measures components of family structure through the Census. Although the Census definitions of family may be limiting in some aspects, it is important to note that the Census provides the best available information on family structure. In this section, selected information on family structure in the WHR is presented. Further detail can also be found in the Data Book, CHA Report 2004.

The majority of people in the WHR (81.7%) are considered members of *census families*.[4] [5] Similarly, the majority of Aboriginal residents (81.3%) are in *census families.* In Manitoba, 86.7%, and in Canada, 86.1% of Aboriginal persons live in census families. According to Statistics Canada, senior citizens are more likely to live alone than other members of a population.[2] The proportion of Aboriginal senior citizens (65 years of age and older) in the WHR that live alone is 73.3%, which is similar to Manitoba at 71.1% and Canada at 69.9%. The proportion of senior citizens in WHR that live alone is 34.9%.

About one quarter of Aboriginal people (15 years of age and older) is married, at 26.4% which is lower than the 49.1% for the WHR overall. About 14.0% of the WHR Aboriginal population is in a common-law relationship higher than that for the WHR overall, at 6.9%. For Aboriginal people in Manitoba and Canada, 14.6% and 16.9% respectively live in a common-law relationship. For the Aboriginal population in the WHR, a greater proportion of is divorced (10.3%), compared to 6.9% for Manitoba, and 7.4% for Canada.

The majority of Aboriginal children within the WHR are living with a single parent (53.5%). There are more female single parent families (89.0%) than male single parent families (11.1%). This is substantially lower in both Manitoba and Canada, where Aboriginal children in single parent families account for 38.5% and 37.5% respectively.

Economic Characteristics

For the Aboriginal population of the WHR, differences in median income exist between both sexes. The median income for Aboriginal women is $13,252 and for Aboriginal men is $17,113. Median is used to indicate that 50% of the female population has an annual income of more than $13,252, while the other 50% of the female population has less than $13,252 in annual income. Both incomes are much lower than those for all females in the WHR ($18,215) and for all males ($28,410). However, the income for Aboriginal women and men in the WHR is higher compared to Aboriginal women and men in Manitoba and Canada. These differences in income between women and men are greater in the WHR than in Manitoba and Canada.

Poverty

People living in poverty face difficult challenges that may ultimately have an effect on their health and well-being. Special attention needs to be paid to this issue as more than half of Aboriginal children live in poverty in the WHR. Census information on poverty is provided using 'low-income cut-offs' also known as LICOs.[6] These (low incomes) vary by family structure and geography.

Approximately 59% of all Aboriginal children in Census families live at or below the poverty line. This measure is subdivided to report incidence of children living in low-income status for both two-parent and single parent

[4] An *economic family* refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law or adoption. Canada. Statistics Canada. *2001 Canadian Census Dictionary* (rev. ed.). Ottawa: Government of Canada, 2004.

[5] A *census family* refers to a married couple (with or without children of either or both spouses), a couple living common-law (with or without children of either or both partners) or a lone parent (of any marital status), with at least one child living in the same dwelling. A couple living in common-law can be of the opposite or same sex. Children in a census family include grandchildren living with their grandparent(s) but with no parents present. Census families are a subset of economic families. Canada. Statistics Canada. *2001 Canadian Census Dictionary* (rev. ed.). Ottawa: Government of Canada, 2004.

[6] Low Income Cut Off (LICO): Defined by Statistics Canada as the income level at which families (or unattached individuals) spend 20% more than the average on food, shelter, and clothing (the basic necessities). This is assumes that a household paying 20% more that the average for the basic necessities would be in economic constraint. LICO values are updated annually and are based upon national family expenditure data gathered in previous years. They are determined by community size and family size, not age group or province. Canada. Statistics Canada. *2001 Canadian Census Dictionary* (rev. ed.). Ottawa: Government of Canada, 2004.

families. In the WHR, Aboriginal children who were living in a female single parent family were two and a half times more likely to be living at or below the low-income cut-off than those in two-parent families (80.9% and 35.6% respectively). In addition, Aboriginal children living in single parent families headed by males were also more likely than two parent families to be living at or below the low-income cut-off (63.4% versus 35.6%). These estimates of poverty for Aboriginal children in the WHR are substantially higher than those found in other Aboriginal children in Manitoba and in Canada. This supports the growing evidence of child poverty issues in an urban Aboriginal population as a key factor that influences the health and well-being of this population.

Another measure of poverty is the spending of more than 30% of household income on shelter. For Aboriginal people in the WHR, 46.7% of tenants spend 30% or more of their household income on shelter costs, i.e., rent. This is higher than that for Manitoba (44.2%) and similar to that for Canada (46.4%). There are more Aboriginal people spending more than 30% of their household income on shelter compared to all tenants in the WHR (46.7% Aboriginal people versus 38.0% WHR overall).

Health Issues

Overall Health Status

Premature mortality rate (PMR) is not only considered a mortality rate, but also an indicator of perceived health and overall health status.[7] Older First Nations adults (50 years of age and older) reported lower life satisfaction associated with worse health and worse social circumstances.[7] In the Winnipeg Health Region, registered First Nations people have a substantially higher premature mortality rate than all other residents.[8] In Manitoba, both 'on-reserve' and 'off-reserve' registered First Nations people have a high PMR, with very little difference between them.[8] A reduced health status is also reflected in the difference in life expectancy between registered First Nations and all other residents (68 years for registered First Nations males versus 76 years for all males; 73 years for registered First Nations females versus 81 years for all females).[8]

The potential years of life lost (PYLL) for registered First Nations people is substantially higher than that of all other Manitobans.[8] For registered First Nations, the potential years of life lost is 2.5 or 3 times greater than the rest of the population (158 years per 1000 versus 63 for males and 103 years per 1000 versus 36 for females respectively).[8] Similarly, the PYLL for all Canadian Aboriginal peoples in 1982-1985 was 2.8 times higher than the rate for all Canadians.[8] Death rates are higher in the First Nations population than in the general Canadian population. In particular from 1986-1990, the infant mortality rate was 13.8 per 1000 live births for First Nations infants, compared to 7.3 per 1000 for all Canadian infants in the same period.[8]

A higher death rate and a population dying at younger ages reflect an overall health status for Aboriginal people that is worse than many other populations in the Winnipeg Health Region.

Diabetes

Diabetes treatment prevalence rates (age and sex adjusted) for registered First Nations in Manitoba are more than four times higher than for all other Manitobans (189 versus 45.4 per 1000 population, or 18.9% versus 4.5% respectively).[8] Many studies have shown a substantial increased risk of diabetes in the Aboriginal population.[9] Based on 1997 data from the First Nations and Inuit Regional Health Survey, the age-adjusted prevalence of diabetes among Canadian First Nations peoples and Labrador Inuit was 11% for men and 16% for women. A national report recently showed 4% prevalence for both men and women in the general Canadian population.[10] Longitudinal comparisons also indicate that diabetes prevalence is increasing among Canadian

[7] Carstairs, V and Morris, R. Deprivation and Health in Scotland. Aberdeen, Scotland: Aberdeen University Press, 1991 as cited in Martens, P. et al. (2002). The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study, Manitoba Centre for Health Policy.

[8] Martens, P. et al. (2002). *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Manitoba Centre for Health Policy.

[9] Young, TK (2003) *Review of research on Aboriginal populations in Canada: relevance to their health needs.* BMJ. 327:419-422.

[10] Canadian Institute for Health Information. Improving the Health of Canadians, Health Canada, 2004.

First Nations people. Between 1991 and 1997, self-reported diabetes prevalence increased among all age groups of Aboriginal peoples.[11]

> **In summary, the Aboriginal people have a higher rate of diabetes compared to that for non-Aboriginal people. There also appears to be an increasing trend of both incidence and prevalence of diabetes in the region for Aboriginal people.**

Other Chronic Diseases: Cancer and Cardiovascular Disease

While information on either the incidence or prevalence of chronic disease is minimal for both Aboriginal and non-Aboriginal populations, there is some recent information indicating that this is a much larger issue in the Aboriginal population than the non-Aboriginal population. For example, there is a higher risk of cervical cancer for Aboriginal women.[12] Higher rates of arthritis (17.2%), high blood pressure (12.6%), heart problems (4.8%), and diabetes (7.6%) are self-reported by Aboriginal people 15 years and older.[13]

There is very little information in the literature about cardiovascular disease in this population. Recently, one measure reported by the Manitoba Centre for Health Policy was hypertension treatment prevalence. Similar hypertension prevalence rates were found for both registered First Nations and all others within the WHR.[8] High rates of hypertension among Canadian First Nations populations have been reported in the First Nations and Inuit Regional Health Survey. Hypertension rates may underestimate the true prevalence of high blood pressure or be masked by many other health issues in a population.

> **In conclusion, chronic diseases, in particular cancer and cardiovascular disease, affect a greater proportion of the Aboriginal population compared to the non-Aboriginal population.**

Communicable Disease: Sexually Transmitted Infections and Blood Borne Pathogens

In Canada, First Nations people experience a higher rate of pertussis (3 times higher), chlamydia (7 times higher), hepatitis A (5.3 times higher) and shigellosis (almost 20 times higher).[14] Even though trends over time for many of the health status measures show a movement in the right direction, the trend with respect to infectious diseases is the reverse. Even the proportion of AIDS cases contracted by Aboriginal peoples has increased from 1.0% in 1990 to 7.2% in 2001.[14]

> **In conclusion, communicable diseases, especially sexually transmitted infections, affect a greater proportion of the Aboriginal population than the non-Aboriginal population. Due to the burden of illness in this population communicable diseases are health issues for the Aboriginal people.**

Injury

Injury mortality rates are extremely high among Aboriginal people in Canada. These rates are up to 6.5 times higher than the 1996 national rate of 28 per 100,000 population. [14] In the 1980s, the leading cause of injury mortality for Aboriginal people was motor vehicle traffic, which accounted for 29% of injury deaths, followed by suicide, which accounted for 21% of injury deaths. [14]

Overall injury hospitalization rates for registered First Nations people of Manitoba were 3.7 times higher than the rate for all other Manitobans (30.4 versus 8.3 hospitalizations per 1000 respectively).[8] The main cause of injury

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[11] Young, T.K. et al. (2000) *Type 2 diabetes mellitus in Canada's First Nations: Status of an epidemic in progress.* Canadian Medical Association Journal. 163(5):561-6.

[12] Young, T.K. et al. (2000) *Monitoring Disease Burden and Preventive Behaviour with Data Linkage: Cervical Cancer Among Aboriginal People in Manitoba, Canada*. American Journal of Public Health:90(9).

[13] Statistics Canada, Aboriginal Peoples Survey, Table 2.5, cited in *Eagle's Eye View*. Aboriginal Task Group, United Way of Winnipeg, 2004.

[14] Canada. Health Canada (2003) *A Statistical Profile on the Health of First Nations in Canada.* Ottawa: Government of Canada.

hospitalization for registered First Nations people (of Manitoba) was 'violence' (31.6% of the total), with 17.1% due to 'violence by others' and 14.5% due to 'violence to self'.[8] For registered First Nations people (of Manitoba), the category of 'falls' represented about one-fifth of the injury hospitalizations (21.8%). Whereas registered First Nations people living 'off-reserve' have a slightly higher proportion of injury hospitalizations due to 'violence by others' compared to those living 'on-reserve' (20% versus 15.1%), though 'violence to self' proportions were similar (14.6% versus 14.5%).[8]

In summary, injury mortality rates for Aboriginal people are extremely high. The rates of hospitalization due to injury are substantially higher for Manitoba registered First Nations people compared to other Manitobans. The seriousness of the burden and impact of injury on the population should also be considered, especially given the increase in death due to injury in the WHR in the latter half of the 1990s.

Mental Health

Suicide and substance abuse are most often cited as significant health issues among Aboriginal peoples.[9] In 1999, suicide accounted for 38.0% of all deaths in youth (10 to 19 years of age) and 23.0% of all deaths in adults (20-44 years of age).[14] The First Nations suicide rate has been reported to be 2.1 times the Canadian population's suicide rate.[14] However, suicide occurs five to six times more frequently among First Nations youth compared to non-Aboriginal youth.[15] First Nations males appear to be at greater risk of completed suicides, while First Nations females attempt suicide much more often.[14] In the WHR, community areas with high proportions of Aboriginal peoples tend to have high rates of suicide.

Although substance abuse is often reported as a serious health issue among Aboriginal communities, there is limited current and comparable information on this issue available.[14] According to the 1991 Aboriginal Peoples Survey, 73.0% of First Nations respondents said that alcohol was a major problem in their communities and 59.0% said that drug abuse was a problem.[16]

Mental health issues are of concern in the WHR due to information gaps and the need for increased monitoring within the region. Suicide is also of concern due to its health, social and economic impacts, particularly within the Aboriginal population in the WHR.

Infant, Child and Maternal Health

The Aboriginal population tends to show poor outcomes for many infant and maternal health indicators. Registered First Nations children have far lower complete immunization rates than all other Manitoban children at ages one (62% versus 89%) and two (45% versus 77%); some of which may be due to underreporting.[8] Registered First Nations children in Winnipeg had an overall rate of 69.2%, which is 20% lower than the rate for all other Winnipeg children (89.1%).

The overall breastfeeding initiation rate for registered First Nations newborns was 57.1%, with a slightly lower rate for those living 'on-reserve' (54.3%).[8] These rates are substantially lower than for all other Manitoban newborns whose rate is 80.5%. Breastfeeding initiation rates in general are lower in those areas having populations with a poorer health status.[8]

To summarize, overall infant and maternal health are a concern for the Aboriginal population as all available indicators are comparatively worse than those in the non-Aboriginal population. Low rates of immunization and breastfeeding initiation also contribute to overall infant and maternal health issues.

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[15] Canada. Health Canada and the Advisory Group on Suicide Prevention. (200_) *Acting on what we know: preventing youth suicide in First Nations.* Available on-line: *http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/publications/preventing_youth_suicide.htm.*

[16] As cited in: Health Canada (2003) *A Statistical Profile on the Health of First Nations in Canada.* Ottawa: Government of Canada.

Respiratory Illness

Respiratory illnesses also continue to be persistently higher among Aboriginal peoples than non-Aboriginal people. In Canada, the tuberculosis rate among Aboriginal peoples continues to be much higher than that of the non-Aboriginal population (8 to 10 times higher).[14]

Another respiratory illness often cited in general population health measures is the prevalence of asthma. Almost 11% of the Aboriginal population reported having asthma.[13]

> **In summary, in the Aboriginal population respiratory illness, including tuberculosis, is a health issue due to the size and seriousness of the issue.**

Health Service Utilization

Preliminary measures of health service utilization highlight disparities with respect to access, availability and appropriateness of care for Aboriginal people. Some examples are provided below.

Preventive Measures and Primary Care

- In Winnipeg, registered First Nations have 1.6 times the physician visit rate compared to non-Aboriginal people (8.3 versus 5.2 respectively). Registered First Nations peoples use of specialists is about two-thirds the proportion compared to non-Aboriginal people in the WHR (21.7% versus 32.2%).[12]
- Fewer Aboriginal women are getting regular Papanicolaou tests (also known as the Pap test) than non-Aboriginal women. The national cervical cancer screening programme recommendations for Papanicolaou testing have not been achieved in Aboriginal women (except for women 15-19 years of age).[12]
- Although mammography rates for all Manitoban women fall short of the goals of the screening programme, the rate for registered First Nations women is less than half the rate for all other Manitoban women (26% versus 56%).[8] Results from the 1994 National Population Health Survey (NPHS) indicated that among the Canadian population, 60% of women have had a mammography test. In 1997, the Manitoba First Nations Regional Health Survey reported that only 20% of First Nations women reported having had a mammography. In addition, the Manitoba Centre for Health Policy reported that 13.7% of all 'off-reserve' registered First Nations women had a mammography test.[8]

Acute Care

- Hospital separation rates for registered First Nation people are more than double that for all other non-Aboriginal people.[8] In Winnipeg, the total days of hospital care is much higher for Registered First Nations than for all other non-First Nations people (1.86 days versus 0.99 days per person).[8]

Other Procedures

- Diabetes prevalence rates are 4.2 times higher for registered First Nations people compared to all other non-Aboriginal people (18.9% versus 4.5%), however the population prevalence of amputation due to diabetes is 16 times higher (3.1 versus 0.2 per 1000, ages 20 through 79).[8] The high amputation rate related to diabetes, at 16 times the rate for all other non-Aboriginal people, also points to the need for diabetes education and information to assist in diabetic management.[8]

Although the information on health and health issues is not as comprehensive as one may desire, there is strong evidence to support the unique issues in this population and its emergence as the dominant influence in the overall health of the region.

The following health issues among Aboriginal people in the Winnipeg Health Region were identified:

- **Chronic Diseases: Diabetes, Cancer, Cardiovascular Disease**
- **Communicable Diseases**
- **Injury**
- **Infant and Maternal Health**
- **Mental Health**
- **Premature Mortality**
- **Respiratory Illnesses, including tuberculosis**

It is important to note that although the leading health issues are similar to the WHR population overall, the evidence reflects a greater burden of illness for the Aboriginal population in terms of severity and size of the problem. Some evidence shows an improvement in the trends, however the disparity in health outcomes between the Aboriginal population and the non-Aboriginal population persists.

Determinants of Health

There are many factors that contribute to the health and well-being of individuals and an entire population. These are often referred to as determinants of health and represent one component of the Population Health Assessment Framework.

Determinants of Health

- **Income and Social Status**
- **Social Support Networks**
- **Social Environments**
- **Education and Literacy**
- **Employment and Working Conditions**
- **Physical Environment**
- **Biology and Genetics**
- **Personal Health Behaviours**
- **Healthy Child Development**
- **Health Services**
- **Culture**
- **Gender**

Indicators are reported on for each of the 12 determinants of health in the Data Book, CHA Report 2004. Although, the Data Book provides information on each of the determinants of health separately, it is important to recognize that the factors influencing one's health are often interrelated. For example, personal health behaviours, such as diet and smoking, differ considerably for persons with different education levels.

The determinants of health form the cornerstone of a population health approach. This moves the focus from the individual to the population. There is a large amount of research that has demonstrated the influence of the determinants of health on the health status of a population. The following section highlights the determinants of health for this community area.

Income and Social Status

Income and social status is thought to be the most influential health determinant. Higher income and social status is associated with better health. This leads to better living conditions, such as better housing, food and transportation. Improvements in these living conditions ultimately affect one's health and, therefore, the health of the population. Research suggests, however, that the degree of control over one's circumstances in life affects health at a biological level. This degree of control is usually mediated by income and social status.[17] The elements described in **Economic Characteristics** in the **Population Characteristics** section provide important information on this health determinant in the Aboriginal population.

Social Support Networks

People who have support from families and friends tend to have better health. This includes having someone to confide in, count on in a crisis, and feeling loved and cared for. Studies have shown that the more social contacts people have the lower their premature death rates. The elements described in **Family Structure** in the **Population Characteristics** section provide information about the social support health determinant.

[17] Health Canada (2004). *Population Health Approach*. Accessed April 29, 2004. Available On-Line at: http://www.hc-sc.gc.ca/hppb/phdd/index.html

Social Environments

The concept of social environment expands the importance of social support from family and friends to social support from the community. The latter is the relationship of the individual to the community and vice versa. This includes one's sense of belonging to and safety in a community. It also includes one's participation in the community. Volunteerism and community vitality are key themes of this determinant.

Transience or mobility of a population is important to the stability of the social environment. A less mobile population is more stable, and provides opportunity to build strong community networks. Mobility status is determined in the Census by asking the question: "Have you moved in the past year or the past five years?"

The Aboriginal people in the WHR are more 'mobile' than the WHR as a whole. In the WHR, the proportion of Aboriginal people that moved in the past year was 30.8% and in the past five years was 67.1%. The proportion of the WHR population who moved in the past year was 15.0%. While that for the past five years was 42.1%. For Aboriginal people, the WHR one-year mobility measure is higher than that for Manitoba (21.0%) and that for Canada (22.0%), thus indicating that there is a more mobile Aboriginal population in the WHR.

Another measure of the social environment is the 'number of people living in a house' and 'housing problems'. In the Manitoba First Nations Regional Health Survey (1998), 73% indicated that four or more people were living in the house, compared with 37% of non-Aboriginal people. [18] When asked to report on housing problems, 20% of the Manitoba First Nations people reported 'overcrowding in the house' as a major problem, and 70% reported 'housing availability' as a major problem in their community.[18] It has been reported that there is an association between overcrowding and tuberculosis rates in Canada. [14]

Education and Literacy

It is well documented that education levels of a population are tied to economic characteristics, as those individuals who achieve higher levels of education are more employable and tend to earn more income. In addition, literacy (the ability to interpret the written word and numbers) is considered to be a determinant of health, as it may influence the ability to use health information, which is largely written. Literacy levels in a population can be indirectly measured through educational attainment levels.

For Aboriginal people, 11.3% of the population 15 years and older have less than a grade nine level of education which is lower than that for Canada and that for Manitoba, 14.9% and 17.5% respectively. While it appears that more Aboriginal people have attained a higher education level compared to Aboriginal people in Canada, this percentage is still higher than that of the WHR overall, at 7.7%. With regard to post-secondary education, a smaller proportion of the Aboriginal population attended primary and secondary school and continued onward to attain a university degree (6.0%) compared to the WHR overall (16.0%). A similar trend is noted for Aboriginal people in Manitoba and Canada.

Employment and Working Conditions

Employment has a significant effect on all aspects of health and well-being. Unemployment and underemployment, as well as stressful or unsafe working conditions, are associated with poorer health. Some dimensions of the employment and working conditions that exist in the WHR are presented, including the unemployment rate, the labour force participation rate, and hours of unpaid work.

The unemployment rates among Aboriginal people are generally at least twice as high compared to other residents in the WHR. For many community areas, unemployment rates for Aboriginal people are at least double, with some community areas having eight times the overall WHR unemployment rate.[8] At the time of the 2001 Census, 15.0% of the WHR Aboriginal population aged 15 years and older was unemployed; this was much greater than that for the overall WHR, at 6.0%.

[18] Manitoba First Nations Regional Survey, 1998.

According to the 2001 Census, Aboriginal youth 15 to 24 years of age had an unemployment rate of 21.0%, which is substantially higher than that of the overall WHR youth, at 11.0%. However, the unemployment rate for Aboriginal youth in the WHR is lower than those for Aboriginal youth in Canada and Manitoba, at 26.0% and 27%, respectively.

The labour force participation rate for the general population was examined for those 15 years of age and older. In 2001, for Aboriginal people in the WHR this was 64.0%, which is similar to that of the overall WHR, at 68.0%. There appears to be a difference in labour force participation between males and females (15 years of age and over) in the overall WHR: it is higher for males than for females. This is also evident Aboriginal people, where the labour force participation rate was 65.0% for males and 54.0% for females (15 years of age and over).

Labour force participation is further examined by categorizing into two age groups: youth 15-24 years of age and adults 25 years of age and older. There is little difference in labour force participation rates between the sexes in the youth population. However, the difference between the sexes in labour force participation is more pronounced in adults 25 years of age and older. For Aboriginal people, the labour force participation rate was 75.0% for males and 59.0% for females 25 years and older. This difference is similar to that seen among Aboriginal people in Manitoba and Canada.

One possible reason that women have lower labour force participation rates is that they are more likely to be involved in unpaid work such as childcare or eldercare. The proportion of Aboriginal women in the WHR that spent *any* amount of time providing unpaid childcare was 53.9% for females and that for males was 38.6%.[19] Slightly higher proportions are observed for Aboriginal women and men in Manitoba and Canada. In addition, as the hours increased, a greater percentage of females than males reported looking after children without pay. For example, 19.3% of Aboriginal women reported that they spent 60 hours or more providing unpaid childcare compared to 7.6% of Aboriginal men.

Eldercare can be examined using Statistics Canada data for provision of 'unpaid care or assistance to seniors'. In the WHR, about 19.9% of Aboriginal people 15 years of age and older reported that they spent *any* amount of time providing eldercare.[20] This is similar to that for the overall WHR, at 19.1%. Again, the difference between the sexes is more evident when increased hours spent providing eldercare was examined. Similar proportions are reported for Manitoba and Canada.

While workforce participation and employment outcomes for Aboriginal people are worse than those found in many other populations in the WHR, the urban Aboriginal population offers the promise of a young and growing labour supply that could alleviate many of these labour shortages.[21]

Physical Environment

The physical environment, in which we live and work, can have an effect on health. This determinant comprises two areas: the 'natural' environment (which includes the air, water, food and soil), and the 'built' environment (such as dwellings). As previously noted, according to the Manitoba First Nations Regional Health Survey (1998) 20% of the Manitoba First Nations respondents reported 'overcrowding in the house' as a major problem, and 70% reported 'housing availability' as a major problem in their community.[18]

Biology and Genetics

The human body is a complex biological system. Genetic and environmental factors begin to interact at an early stage in life, and continue to interact throughout one's lifespan. For some diseases, a strong genetic component is present, and little can be done to change predisposition to certain diseases or health issues. However, environmental influences in the form of the determinants of health may significantly improve health outcomes,

[19] *Any* refers to those that spend less than five hours, 5-14 hours, 15-29 hours, 30-59 hours, or 60 hours or more providing unpaid childcare; this excludes those who reported 0 hours (Data Book, CHA Report 2004).
[20] *Any* refers to those that spend less than five hours, 5-9 hours or 10 hours or more providing unpaid care or assistance to seniors; this excludes those who reported 0 hours (Data Book, CHA Report 2004).
[21] Hanselmann C. (2001) *Urban Aboriginal People in Western Canada: Realities and Policies.* Canada West Foundation.

assisting the individual to reach his or her full health potential. For example, it is known that individuals with strong family history of cardiovascular disease should be monitored for high blood pressure and abnormal lipid profiles. These individuals can also be encouraged to maintain a healthy lifestyle to minimize the risk of developing cardiovascular disease at a young age. There are currently no indicators measured for this determinant in the CHA Report, 2004.

Personal Health Behaviours

This refers to the actions that a person can take to prevent disease and to live a healthy lifestyle. It is important to recognize that personal choices that affect lifestyle are influenced by social, economic and environmental factors. For example, exposure to recreation and recreational facilities contributes positively to personal health, economic, social and spiritual needs and healthy child development. Research suggests that an individual's mental health benefits from exercise and physical activity, as they reduce depression and anxiety and promote self-esteem. As a result, a population's health, well-being and quality of life, as well as its communities and environment are enhanced.

Healthy Child Development

Healthy children grow up into healthy adults. A child's development is greatly affected by experiences early in life. A loving, secure environment helps children to develop trust, self-esteem, and the ability to form positive relationships. These contribute to children's readiness to learn (education), and to their health especially as they grow and develop. Throughout this chapter, a few indicators of healthy child development have been discussed. Of particular importance are single parent families and child poverty found in the **Population Characteristics** section of this chapter. The reader is also directed to the Data Book, CHA Report 2004 for additional information on selected indicators of healthy child development in the WHR.

Health Services

The health services continuum of care includes treatment and secondary prevention of disease. Of the 12 health determinants, it appears to have the least affect on health and well-being of the population. Information on use of health services has been presented in the **Health Issues** section of this chapter. The Data Book, CHA Report 2004 also contains information on indicators of health services in the WHR.

Culture

Culture affects health on several levels. Cultural values may influence socio-economic status of individuals within a culture. There may be loss or devaluation of language and culture (resulting in stigmatization and marginalization) and lack of access to culturally appropriate health care. In addition, language barriers may limit access to health information and health services. Together or alone, these have an impact on health. The elements described under **Ethnicity** in the **Population Characteristics** section provide information about this health determinant.

Gender

This refers to the attitudes, behaviours, values, relative power, and influence that society confers upon the two sexes. Many health issues are influenced by gender-based social status or roles. For example, suicide rates are much higher for males than for females in the WHR and in all of Canada. The literature suggests that the gender difference for suicide in developed countries may be partly explained by the changes in gender roles for men and women.[22] There are many indicators listed in the Data Book, CHA Report 2004, which provide information on gender differences at the regional level.

Each of the determinants of health is important in its own right. At the same time, the determinants of health are interrelated. Understanding the influences of the determinants of health on the health issues is key to improving the health of the population.

[22] Hawton, K. 2000. Sex and suicide. British Journal of Psychiatry. 177:484-485.

Other Findings

Additional information continues to surface, highlighting areas of need and potential for this population. The following collection of summaries highlights the lessons learned from a variety of local, provincial and national projects on health outcomes, determinants of health, health resources and policy.

***Eagle's Eye View*[23]**

The *Eagle's Eye View* presents a snapshot of the Aboriginal community living in Winnipeg. The factors that influence the health and well-being are presented using the Aboriginal Life Promotion Framework to describe the Aboriginal community today, identify accomplishments and challenges.[23] This is an excellent resource to support discussions and identify opportunities for collaborative action.

***First Nations/Metis/Inuit Mobility Study*[24]**

The issues identified in this study were primarily related to those non-medical determinants of health. The majority of people moved to Winnipeg for family, employment and education reasons. Social supports were considered an issue particularly in the delivery of social assistance programs, access to safe and affordable housing, employment services, education and medical services. Access to referral systems and services was limited and most accessed these services by dropping in.

***The Health of Manitoba's Métis Population and their Utilization of Medical Services*[25]**

This study presented an assessment of health status of the Métis people based on data linkage of the Manitoba Métis Federation (MMF) membership lists. The study looked at physician utilization, hospitalizations, diabetes and cancer rates. Although the sample was small, the trends indicated that the Métis population appeared to be similar to the First Nations populations as opposed to Manitobans in general. The data are limited in several ways. MMF Membership is not necessarily comprised of only Métis people (there has not traditionally been a set of criteria for membership and no differentiation between Métis and affiliate status membership). Individuals more than 15 years of age are generally registered as members, thus youth and children are not well represented. The majority of individuals were from one particular RHA. In addition, not all Métis people are members of the MMF.

***Aboriginal Views on Their Health and Health Care: The Métis*[26]**

Views about health and health care issues were identified in a recent telephone survey of Métis persons in British Columbia, Saskatchewan and Ontario. This document indicated that the Métis considered their health status to be poorer than other Canadians. Perceived health status has been closely linked to Premature Mortality. Premature mortality rates have been found to be higher for Aboriginals persons (fed study, MCHP study), which connect the findings between self-reported health status and outcomes such as premature death.

Key issues from the telephone survey are primarily focused on health care and non-medical issues:

- Cultural awareness - Lack of awareness of Métis culture and issues,
- Limited access to culturally appropriate medical services,
- Lack of awareness and support for use of traditional medicines
- Access to services - difficult to access services or appointments with physicians, difficulty accessing appropriate specialty services, Lack of respectful service delivery by health care providers

[23] Aboriginal Task Group, United Way of Winnipeg. (2004) *Eagle's Eye View*. United Way of Winnipeg.
[24] Institute of Urban Studies, Western Economic Diversification Canada, Assembly of Manitoba Chiefs, and Manitoba Métis Federation. (2003) *First Nations/Métis/Inuit Mobility Study 2003*.
[25] Kliewer, E. et al. (2002) *The Health of Manitoba's Métis Population and their Utilization of Medical Services*. CancerCare Manitoba and Manitoba Health.
[26] The Strategic Counsel. (2002) *Aboriginal Views on Their Health and Health Care: The Métis*.

Urban Aboriginal People in Western Canada: Realities and Policies[27]

Past public policy has had a negative impact on generations of Aboriginal people. Therefore, the federal, provincial and municipal governments, with the urban Aboriginal community, must work together to develop differentiated policies to address the socio-economic needs of the urban Aboriginal community. There are many fields in which urban Aboriginal people are shown by the demographic data to be facing particularly acute challenges. In addition, this research has identified gaps in current policies as no one government has taken primary responsibility for creating policies to support the needs of urban Aboriginal people.

Shared Responsibility: Final Report and Recommendation of the Urban Aboriginal Initiative[28]

Summary of findings:

- The Aboriginal population of Canada is increasingly urban.
- Aboriginal people are a visible presence in Western Canada's major cities.
- Urban Aboriginal people are not a homogenous group.
- Aboriginal people will play a large part in the future of Western Canada's major cities. Aboriginal people have a much younger age structure than the non-Aboriginal population and the urban Aboriginal labour force can play a prominent role in alleviating future shortages of skilled labour.
- The Government of Canada does not fund urban transition programmes for Aboriginal people to the same extent that it funds transition programmes for recent immigrants to Canada.
- Aboriginal people tend to have lower educational levels, lower labour force participation rates, higher unemployment rates and lower income levels.
- Aboriginal people are more likely to be in lone parent families, have poorer health status, have higher rates of homelessness and greater housing need.
- Aboriginal people are overrepresented in the criminal justice system – both as victims and as offenders – and are more likely to experience domestic violence.
- No order of government is willing to assume primary responsibility for urban aboriginal policy.
- None of the governments had urban Aboriginal policies in the areas of family violence, childcare, addictions or suicide.

Need for long-term objectives

- A commitment to long-term objectives to improve conditions among urban Aboriginal people. Although it would be ideal to be able to achieve the goal sooner, governments should acknowledge that the objective might take as long as three generations – 60 years – to accomplish. The alternative to making – and keeping – such a commitment is for governments to continue to fund costly remedial services for increasingly large urban Aboriginal populations.

Promising practices that have been identified\

- Recognizing the importance of urban Aboriginal issues
- Co-operating nationally and regionally (i.e. municipality-driven census)
- Emphasizing and building social capital
- Listening to the community
- Separating politics from programme delivery
- Approaching issues holistically
- Cultivating the right people
- Keeping a client focus
- Allowing flexibility
- Simplifying application processes
- Considering service location carefully
- Emphasizing Aboriginal delivery

[27] Hanselmann, C. (2001) *Urban Aboriginal People in Western Canada: Realities and Policies.* Canada West Foundation.
[28] Hanselmann, C. (2003) *Shared Responsibility: Final Report and Recommendations of the Urban Aboriginal Initiative.* Canada West Foundation.

Summary of the Findings

Data available for this report indicate that the WHR Aboriginal population has a health status that is reduced in comparison to that of many other populations in the WHR. Aboriginal people experience higher rates of illness for many of the health measures investigated in this report than those reported for non-Aboriginal people. They also compare less favourably for many of the determinants of health compared to those reported for non-Aboriginal people. The combination of demographic characteristics, health outcomes and health determinants contribute to a higher burden of illness experienced by many Aboriginal people in the WHR.

While differences exist between Canada's Aboriginal peoples, in particular the First Nations (Aboriginal), Métis and Inuit peoples, there are some common themes that emerge from the information reviewed. Isolation, undermining and devaluation of culture and tradition are social influences that have an impact on many of the health outcomes of Aboriginal people. Opportunities to improve health outcomes include a focus on the issues across the lifespan for children, youth, adults and older adults.

Common Themes:

- Limited social support structures, social environments and lower socio-economic status provide the foundation for a population with a health status that is below average when compared to other populations in the WHR.
- The major health issues for Aboriginal people in the WHR are:
    - Chronic Diseases:
        - Cancer
        - Cardiovascular Diseases
        - Diabetes
    - Communicable Diseases
    - Infant and Maternal Health
    - Injury
    - Mental Health
    - Premature Death
    - Respiratory Illnesses, including tuberculosis
- In addition, the overall health issues identified at the regional level are equally important to the Aboriginal people in the WHR.

Opportunities:

- Partnerships with the municipal and provincial governments, as well as local organizations to get more relevant and reliable data regarding the factors that have an impact the health of people in Winnipeg, particularly the Aboriginal population.[28]
- Enhance or develop screening programmes for diabetes, hypertension, and other chronic diseases.
- Increase awareness and understanding of cultural concepts pertaining to specific illnesses; and of potential sensitivity to cultural barriers[12]; and traditional medicines.[26]
- Improve access to services – in particular culturally appropriate services
- Focus on the health issues across the lifespan for children, youth, adults and older adults.
- Support cultural continuity and community control in order to influence the health of Aboriginal peoples.

In order to build a population health profile for the Aboriginal Peoples of the Winnipeg Health Region, this report has examined information in the following areas: population characteristics, health outcomes, and determinants of health. This profile highlights common themes and opportunities, which may be used to improve the health of the population. The report can be used to support dialogue, decision-making and planning efforts in the region.