

# Southern Health-Santé Sud Community Health Assessment 2019



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# EXECUTIVE SUMMARY

This section summarizes the high-level findings from the 2019 Community Health Assessment (CHA) report for Southern Health-Santé Sud.

## **The population keeps growing and growing**

Southern Health-Santé Sud has a population of 204,274 which is the largest among rural health regions. The population has increased by 9% in the past five years; representing the largest percentage of growth in the province. It has the largest projected growth with an increase of 25%; expecting over 250,000 by 2030. The largest regional population increases were around bedroom communities surrounding Winnipeg and cities furthest south.

The population structure is different than Manitoba in that there is a higher percentage of children, and lower percentage of adults and older adults.

## **One of the healthiest regions in Manitoba, though increasing rates of some chronic diseases**

Life expectancy was among the highest in the province and mortality indicators remained stable over time.

The region was significantly better than the provincial average on many health outcomes including diabetes, ischemic heart disease, arthritis, osteoporosis, total respiratory morbidity, and potentially avoidable deaths.

As the population grows and ages, more people are living with chronic diseases. Rates have increased significantly over time with diabetes, total respiratory morbidity, and childhood asthma.

A major finding was around end stage kidney disease. The region is projected to experience the highest increase in the province for renal therapies by 2024.

## **Variations and health inequities within the region**

There continues to be a wide income gap with a difference of over \$52,000 between the highest and lowest districts. This is a considerable difference since the median household income for the region is about \$60,000.

The burden of disease varied within the region, with Seven Regions district consistently experiencing some of the poorest outcomes. It is well known that income is the most important social determinant of health, which may help to explain these findings since Seven Regions also has the lowest income in the region. Further, Zone 1 (northern area) also experienced some of the worst outcomes, while Zone 4 (eastern area) had some of the best outcomes.

Throughout the CHA report, it is clear that many indicators are strongly associated with income. The underlying causes of health inequities are largely social and economic in nature. The actions needed to reduce inequities go beyond the health care system and are vital to improving the health of all Manitobans.



## Chapter 1: Who Lives in Southern Health-Santé Sud?

### Population

- ▶ 204,274 residents lived in the region in 2018
- ▶ Slightly younger population compared to Manitoba
- ▶ 2,882 births annually among regional residents in current time period
- ▶ Over 16,000 new residents over five years, representing the largest percentage of population growth in the province
- ▶ Largest population growth in districts surrounding Winnipeg and cities of Morden and Winkler
- ▶ Projected percentage growth highest in the province
- ▶ Projected to grow to over 250,000 by 2030; an increase of 25% or approximately 50,000 residents
- ▶ Highest percentage of internal migrant mobility in the province
- ▶ Population density within the region was 7.1 residents per square kilometer
- ▶ Second highest dependency ratio in province, indicating higher pressure on the working-age population to support youth and older adults

### Demographics

- ▶ 13% identified as Indigenous
- ▶ 4% identified as visible minority
- ▶ 11% of population knew French well enough to conduct a conversation
- ▶ German was the leading non-official language spoken most often at home
- ▶ 14% with immigrant status
- ▶ Leading countries where immigrants were born: 1) Mexico; 2) Germany; 3) Philippines; 4) Russian Federation; and 5) United States
- ▶ Lowest percentage of lone-parent families in the province – majority led by women



## Chapter 2: What Keeps us Healthy?

### Social Determinants of Health

- ▶ Social deprivation and socioeconomic conditions better than province and improving over time
- ▶ Material deprivation worse than province but improving over time
- ▶ Regional median household income \$60,802 – similar to province
- ▶ 15% households lived in low income
- ▶ 6% reported food insecurity
- ▶ Region had highest percentage spending 30% or more on shelter expenses among rural health regions
- ▶ 29% without certificate, diploma, or degree
- ▶ Lowest unemployment in the province

### Healthy Child Development

- ▶ Preterm births lower than province
- ▶ Births small for gestational age lower than province
- ▶ In-hospital breastfeeding initiation higher than province
- ▶ 10,525 children lived in low income
- ▶ Percentage of mothers screened with three or more risk factors lowest in the province
- ▶ 27% of kindergarten children struggled to meet age-appropriate developmental expectations
- ▶ Pediatric dental extractions lower than province and decreasing over time
- ▶ Lowest percentage of 17 year olds with recommended doses for several vaccines (diphtheria, tetanus, pertussis and HPV)
- ▶ Teen pregnancy rates lower than province and decreasing over time
- ▶ Teen birth rates decreasing over time

### Personal Health Determinants

- ▶ Majority reported somewhat strong community belonging
- ▶ 54% reported making a positive health change in the past year

### Health Behaviours

- ▶ Substance use disorders significantly lower than province
- ▶ 58% identified as a regular drinker
- ▶ Lowest percentage of current smokers in the province
- ▶ 51% reported being physically active
- ▶ 27% reported consuming 5+ servings of fruits and vegetables daily
- ▶ Majority of respondents reported never using their cell phone while driving
- ▶ ATV helmet use in the region was reported 50/50

### Use of Preventative Services

- ▶ Only 48% of adults aged 65+ received influenza immunization, much below national target
- ▶ Lowest percentage of older adults immunized for pneumonia in the province
- ▶ Cancer screening lower than province for colorectal, breast and cervical
- ▶ Percent of population with dental insurance lower than province



## Chapter 3: How Healthy are we?

### Mortality

- ▶ Life expectancy among the highest in the province
- ▶ Mortality indicators remained stable over time
- ▶ Cancer leading cause of premature deaths
- ▶ Injury and poisoning leading cause of child mortality

### Cancer

- ▶ Over 2,500 residents had new cancer diagnosis
- ▶ Lung and bronchus cancer had the highest mortality rate
- ▶ 19% of cancer patients diagnosed in late stage (IV)

### Cardiovascular

- ▶ Over 26,500 residents with diagnosed hypertension (high blood pressure)
- ▶ Ischemic heart disease lower than province in the region and across 3 zones
- ▶ Heart attack rates higher than provincial average but improved significantly over time

### Diabetes

- ▶ Over 13,000 residents lived with diabetes
- ▶ Diabetes prevalence increased significantly over time regionally and in all zones but lower than province
- ▶ Lower-limb amputations decreased significantly over time
- ▶ Diabetes care eye exams higher than provincial average

### Injury

- ▶ Intentional injury related hospitalization rate lower than province and decreased over time
- ▶ Falls represented nearly 50% of all injury related hospitalizations

### Mental Illness

- ▶ 18% of residents diagnosed with a mood or anxiety disorder; lower than the province
- ▶ 1 in 10 residents age 55+ lived with dementia
- ▶ Antidepressant prescription follow-up lower than province and decreased over time
- ▶ Suicide rates lower than provincial average

### Musculoskeletal

- ▶ Arthritis and osteoporosis lower than provincial averages

### Renal

- ▶ 180 residents required dialysis or transplant
- ▶ Region is projecting highest increase for renal therapies by 2024

### Respiratory

- ▶ Over 14,000 residents living with respiratory disease
- ▶ Increasing rates of children diagnosed with asthma but lower than the province

### Sexually Transmitted Infections

- ▶ Gonorrhea increased four-fold over 4 years
- ▶ Syphilis increased six-fold over 4 years

## Chapter 4: How Well Does our Health System Meet the Population's Needs?

### Primary Health Care

- ▶ 77% of residents had at least one visit with a primary care provider
- ▶ Less than 50% received primary care within their home district
- ▶ Residents receiving majority of care from same provider lower than provincial average and decreased significantly over time
- ▶ Hospitalization rate for ambulatory care sensitive conditions decreased significantly over time
- ▶ Benzodiazepine overprescribing in the community decreased significantly over time in the region and all zones
- ▶ 84% reported having access to a regular health provider
- ▶ The most frequent reported location for minor health problems was physician's office and walk-in clinics
- ▶ Residents more likely to report waiting over 2 weeks for minor health problems than provincial average
- ▶ 45% reported excellent or very good coordination between providers



### Acute Care

- ▶ Hospitalizations decreased significantly over time
- ▶ Residents were hospitalized almost 60% within the region
- ▶ Over 85% of SH-SS hospital patients are from the region
- ▶ Hospital readmissions decreased significantly over time
- ▶ About 1 in 5 in-hospital births were by C-section and the percentage increased significantly over time
- ▶ Over 70% reported very good overall hospital experience

### Home Care and Personal Care Home

- ▶ 5,276 residents received home care services and the prevalence was lower than provincial average
- ▶ 12% aged 75+ in personal care homes (PCH)
- ▶ Median wait times for PCH admission from the hospital about 16 weeks, higher than provincial average, and increasing significantly over time
- ▶ Median wait times for PCH admission from the community about 26 weeks and higher than the provincial average
- ▶ Benzodiazepine overprescribing among PCH residents higher than provincial average

# INTRODUCTION

## Acknowledgements

The team would like to express gratitude to those that have participated and contributed to the Community Health Assessment (CHA) process. The 2019 CHA process has been a true collaboration. We would like to thank all Community Health Assessment Network members from across the province, as well as, staff at Manitoba Health, Seniors and Active Living for your continued support and guidance. Thanks to all the researchers at the Manitoba Centre for Health Policy and CancerCare Manitoba for providing the data and statistical support to our health region. We are truly blessed to have such commitment and dedication in Manitoba. If you wish to provide feedback on the report, please email: [info@southernhealth.ca](mailto:info@southernhealth.ca)

Thank you to Ariane Elizabeth Photography (Ariane Comte) for the beautiful photo on the front cover.

## Community Health Assessment in Manitoba

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.<sup>i</sup>

Understanding the health needs and assets of the people that live in Southern Health-Santé Sud is critical to effectively planning programs and services. Access to local health data supports planning for policies and programs that are responsive to communities' unique needs and will most benefit their residents.

In Manitoba, this understanding is gained through legislated CHAs. This is the 5th cycle of CHA in Manitoba.

The dates of the previous CHA cycles are as follows:

1<sup>st</sup> CHA cycle - 1997/98

2<sup>nd</sup> CHA cycle - 2004

3<sup>rd</sup> CHA cycle - 2009

4<sup>th</sup> CHA cycle - 2015

*“Community” can refer to all persons living in a certain region, or it might refer to groups of people with common characteristics or interests, for example: women, youth, seniors, cultural groups or those living with specific health issues.*

Using a population health approach, CHAs provide baseline information about the health status, determinants of health, and health system utilization of community residents. The CHA also tracks health outcomes over time, identifies opportunities for health promotion and disease prevention, and describes the conditions that contribute to health disparities.

The CHA allows us to begin to understand ourselves: who we are, our strengths, our challenges, and how our health system responds to our needs. One of the strengths of CHA is that it presents data from several time periods to reflect health trends over time to help identify areas needing priority action.

In other jurisdictions, CHA work is captured under the term “Population and Public Health Surveillance” which is defined as “the collection, analysis, interpretation, and dissemination of data about demography, socio-economic status, health status, chronic diseases as well as their protective and risk factors”.<sup>ii</sup>

## Community Health Assessment Network

The Community Health Assessment Network (CHAN) enables a coordinated approach to province-wide comparability on health issues within health regions, while recognizing and respecting the diversity among them. CHAN is a provincially coordinated, collaborative group comprised of representatives from:

- ▶ Manitoba Health Seniors and Active Living
- ▶ Department of Education (Healthy Child MB)
- ▶ Manitoba Centre for Health Policy (MCHP)
- ▶ George & Fay Yee Centre for Healthcare Innovation
- ▶ Service Delivery Organizations:
  - Shared Health/Soins communs
  - CancerCare Manitoba (CCMB)
  - Addictions Foundation of Manitoba
  - InterLake-Eastern Regional Health Authority
  - Northern Health Region
  - Prairie Mountain Health
  - Southern Health-Santé Sud
  - Winnipeg Regional Health Authority



*CHAN workshop in Winnipeg, Autumn 2018*



## CHA Purpose and Use

CHAs present local data and local interpretation of that data, foster community engagement and highlight community strengths and areas for improvement. This information enables the community-wide establishment of health priorities and facilitates collaborative action planning directed at improving community health status and quality of life.

## Community Health Assessment and the Manitoba Quality and Learning Framework

Manitoba is taking bold steps to improve access to care, quality of services and patient outcomes. Clinical leaders and health system experts from across the province are working on a provincial approach to the planning and delivery of better health care for Manitobans. This work is supported by clinical data and evidence, including the information presented in Manitoba's CHA.

As the Provincial Clinical and Preventive Services Plan guides and supports decisions about human resources, investment and clinical services, the valuable information we gather in the CHAs will help ensure clinical experts have a real understanding of our population.

Ensuring positive patient outcomes experiences is a focus and responsibility of every member of our health system. Efforts to improve quality and safety are ongoing, and will be guided going forward by a new Manitoba Quality and Learning Framework that presents a common vision and approach to quality, patient safety and accreditation.

The Framework describes the Principles and Enablers of quality health care and defines the overarching goals of our system in alignment with the Institute for Healthcare Improvement's Quadruple Aim. These four areas - Healthy Manitobans, Positive Patient Experience, Sustainable Health System and Healthy Teams – allow service delivery organizations, patients and providers to share a common understanding of our goals.

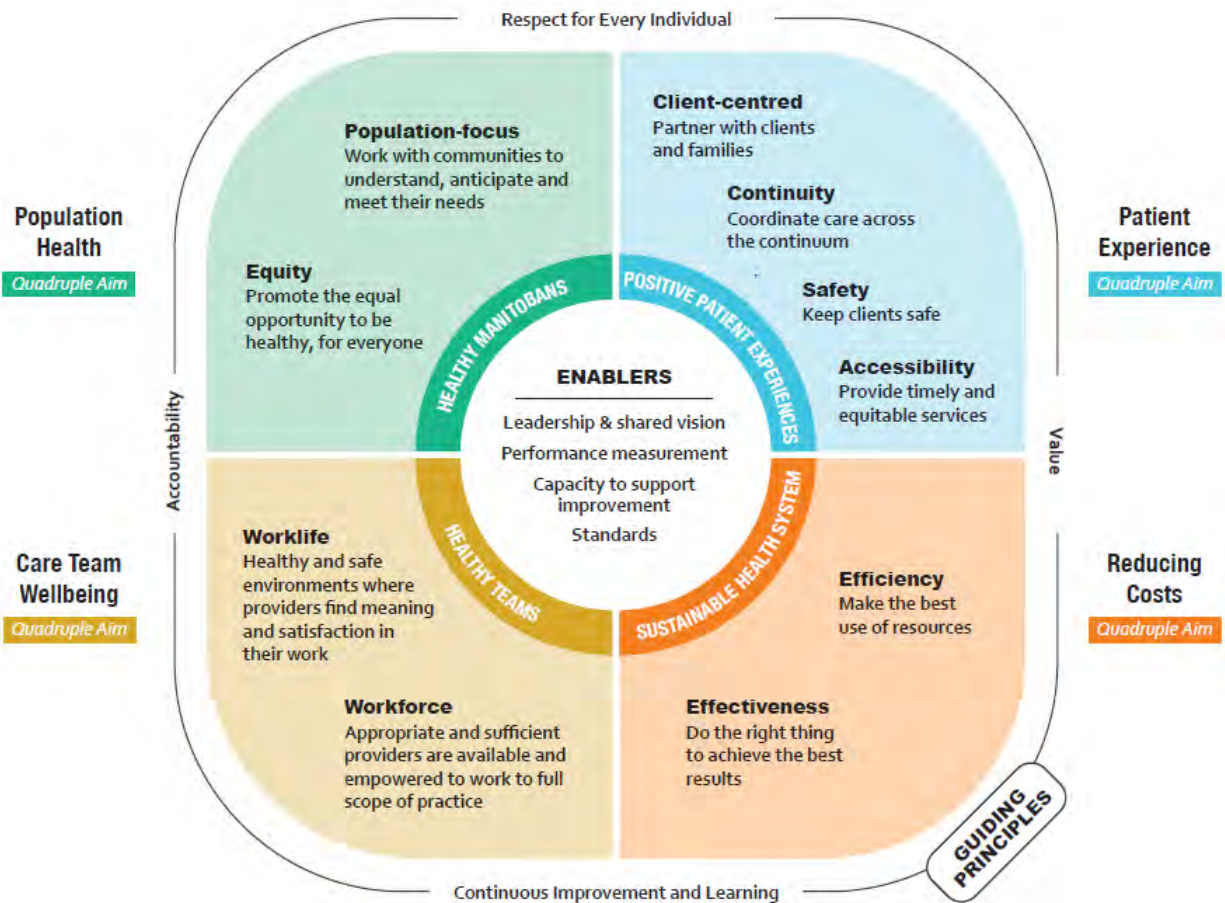
These common goals also ensure that we are able to closely monitor progress and success, by aligning the indicators included in Community Health Assessments (population health, equity, continuity of care, accessibility) with the overarching goals of the health system. Health authorities will be able to use CHA data and the Framework together to set priorities and monitor quality performance all within a culture of continuous improvement and learning.

The Framework is intended for use across the health system, by funders, policy makers, leaders, direct service providers and patients. It applies across the continuum of care, focused on improved provincial outcomes but adaptable to local needs and experiences.

For more information on the Manitoba Quality and Learning Framework, please visit <https://sharedhealthmb.ca>



The Manitoba Quality and Learning Framework (MQLF)



Provincial Template for CHA Reports

There are five health regions in Manitoba, and all have collaborated to produce CHA reports using a common template to allow for easier comparison of population health indicators across the province. While regional CHA reports will have a similar look, the content reflects findings unique to each health region. New to CHA reports are story boxes called “A Closer Look” which provide additional regional context.

## Population Health and Health Equity

To tell the story of the health and well-being of any community or population, we do so by making comparisons. We ask ourselves how that population has stayed the same over time and how it is changing. We compare the population in our health region to that of other health regions in the province; in one district (or community area) to the neighboring one. We ask ourselves why one population is healthier than another.

Many terms are used to describe differences in health among population groups including “disparities”, “inequalities”, and “inequities”. Even when intending to describe ideas that mean something quite different, these terms are sometimes used interchangeably. It is important to be clear what we mean when we use these terms.

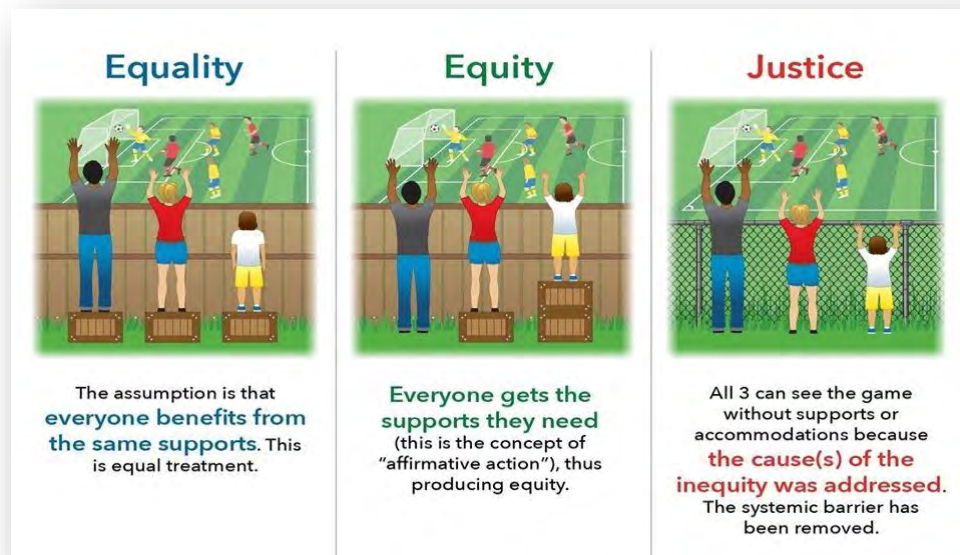
### What does it mean?

While **health disparities** and **health inequalities** can both be used to describe measurable differences in health status among population groups, the term health inequities should be interpreted differently.

**Health inequities** are *unfair* and *modifiable* because the underlying causes are largely social and economic in nature. The interventions needed go beyond health care services and supporting healthy behaviours, to the types of public policies, programs and services a society chooses. For example, decades ago, the poverty rates amongst older adults in Canada was substantially reduced by introducing a universal public pension program. Language surrounding health inequities will hopefully lead us to talk about why these differences exist and what kind of changes are likely to get at the root causes to make the biggest difference in narrowing persisting gaps among population groups.<sup>iii</sup> Conceptual differences are illustrated on the next page.<sup>iv</sup>

*“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”*

*(Braveman, P. et al 2017)*



Measuring and reporting on health inequalities has grown with each cycle of CHA. We have expanded the measurement of health inequalities when available and appropriate. In doing so, we will advance discussions and action around health equity — a growing priority for health systems and governments at all levels in Canada and internationally. This aligns with Manitoba’s **Chief Provincial Public Health Officer Position Statement on Health Equity**,<sup>v</sup> which discusses the importance of working to improve health equity as a key way to improve overall population health and as a health goal in and of itself.

“Social determinants of health are unequally distributed among population groups in our society” and these are influenced by “unequal and unfair social relations such as colonialism, discrimination, racism and gender inequity” as well as “structural drivers such as social policies and programs, economic arrangements and politics.”<sup>vi</sup> The Chief’s position statement also recognizes that the health care system and its services influence only about 25 percent of overall health outcomes, while up to 60 percent of a population’s health status is influenced by the social determinants of health and the structural drivers.<sup>vii</sup>

To provide a comprehensive picture of the health of the people living in our communities, information regarding the social determinants of health, health status measures by health region and health status changes over time is presented throughout this report.

## How are health inequalities measured?

To strengthen the measurement of health inequalities between subpopulations, Manitoba participated in a collaborative pan-Canadian expert working group to inform work by Statistics Canada and the Canadian Institute for Health Information (CIHI). The goal was to develop common equity characteristics for disaggregating health indicators. This collaborative national work resulted in recommended definitions for six equity characteristics for measuring health inequalities: age, sex, gender, income, education, and geographic location.<sup>viii</sup>

This CHA report supports measuring health inequalities by:

- Stratifying data by geographic location
- Stratification of select indicators by age groupings and sex
- Geographic disparity ratios
- Income disparity ratios
- Presenting data graphs and tables in a new way to help identify disparities or health gaps

## System Responsibility

CHAs provide a better understanding of what contributes to health inequities and what we need to address in order to advance health equity for our population.

As identified for the third round of CHA, in 2015, the evidence informs an approach to interventions to achieve more equitable population health outcomes, which address equitable access in three main areas. These include equity of access to:

### 1. Health Care Services

This is the responsibility of health and social service agencies, their boards and the various levels of government, which provide funding, oversight, planning and policy support. One example is providing services universally to the whole population and supplementing them with “targeted” services for population groups experiencing persistently poorer health and social outcomes.

### 2. Social Determinants of Health

This is the responsibility of all levels of government and the organizations to which they further delegate responsibilities, commission work and distribute funds which affects all sectors of society. Examples include approaches such as healthy community planning, inter-sectoral action on health, healthy public policy, health in all policies; health as a human right; and health among sustainable development goals.

### 3. Community Participation

An important consideration includes collaboration with populations in vulnerable situations and more likely to experience health inequities to inform priorities, directions and decisions. This includes making space at the tables where decisions are made for community voices.

The notion of equitable access is based on the pioneering work done by Whitehead and Dahlgren and international works related to the right to health to which Canada has made commitments to via international covenants, treaties and declarations.<sup>ixx</sup>

Health regions and the province overall strive to maintain and improve the health of the entire population. To this end, we are involved in population health planning which must address what contributes to those socially and economically influenced health differences among population groups. Future planning efforts must take these health equity gaps into consideration to improve overall population health outcomes; and would benefit from applying an equity analysis to all phases of planning and implementation.

Actions to mitigate health inequities among population groups is an important component of improving the overall health of all Manitobans. Health inequities are evident among several population groups including newcomers and refugees, visible minorities, persons with disabilities and people living in poverty or other types of economic or social marginalization. There is strong evidence that Indigenous peoples of Manitoba experience persistent health disparities resulting from historic and current traumatic experiences related to colonization and racism. One of the population groups most impacted by health inequities is the Indigenous peoples of Manitoba. A recent report, ***The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba***, was released in Autumn 2019 and key highlights from the report are noted below.

## First Nations People's Health in Manitoba

The Manitoba Centre for Health Policy (MCHP) and the First Nations Health and Social Secretariat of Manitoba (FNHSSM) partnered to develop a comprehensive report, entitled ***The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba***, looking at health and healthcare use patterns of First Nations people living in Manitoba. Comparisons were made between First Nations and all other Manitobans, between on and off reserve First Nations, and regional comparisons by health regions and by Tribal Council Areas. This report will “contribute to building a dialogue that supports strategies for increased access to equitable healthcare, improving programs that support First Nations health and wellness, and supporting policy change and development”.<sup>xi</sup> It is an update to the MCHP report referred to as the 2002 First Nations Atlas.

There is a widening and unequal gap between First Nations people's health and other Manitobans.

*“To understand why First Nations’ health is worse than other Manitobans, we need to first acknowledge the history of colonization and the horrendous effects it had (and continues to have) on the First Nations [peoples and their] ways of life. As part of an effort to ‘civilize’ First Nation people, many children were forcibly removed from their families and communities and placed in residential schools. In being made to adopt the European way of life, they lost much of their language, their culture, and their connection to the families and communities. The trauma from this experience is still being felt today as the pain of this loss is passed down through generations.”(Summary, p. 1)*

The Truth and Reconciliation Commission of Canada's Calls to Action, especially number 19, was the impetus for this study: “to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.”<sup>xii</sup>

While the majority of the data available was based on illness and not wellness, the report did highlight community strengths and resilience in results from the Manitoba First Nations Regional Health Survey (RHS). Compared to all other Manitobans, some of the key findings included:

- Mortality indicators are significantly worse among First Nations peoples
- Cancer screening rates are significantly lower among First Nations peoples
- Incidence of cervical and colorectal cancer are significantly higher among First Nations peoples
- Poorer mental health is seen among First Nations peoples
- First Nations peoples have substance use disorder rates three times higher
- Rates of suicide and suicide attempts are five to six times higher among First Nations peoples
- Poor health and lower physician service use indicate barriers to First Nations peoples accessing care
- First Nations peoples have more hospital use across all indicators
- There is a dramatically higher rate of opioid dispensations for First Nations peoples
- First Nations communities highlight the importance of traditional healers
- 45 percent of RHS respondents reported they have safe drinking water on reserve
- 59 percent of RHS respondents reported their houses on reserves require repair
- One in four families living on reserve include a survivor of residential schools

The health status gap between First Nations and all other Manitobans has widened since 2002.

Researchers have urged five actions to create change and improve health of the individuals, families, and communities:<sup>xiii</sup>

1. Annual reporting on progress in addressing gaps in health and access to healthcare;
2. Development of strategic initiatives for equitable access to intervention and prevention measures (including addressing racism in the health system through mandatory cultural safety

training for all staff, hiring of First Nations providers, new human resource policies for safe reporting of racist incidents);

3. Development of short- and long-term plans for the training and hiring of First Nations healthcare professionals;
4. Further development of research partnerships among MCHP, Manitoba Health, Seniors and Active Living (MHSAL), FNHSSM and Manitoba First Nations;
5. Setting First Nations on the path to borderless healthcare delivery by improving access to primary healthcare that is designated and delivered through First Nations-led partnerships.

Although the health profile of First Nations peoples is not summarized in the CHA report, we invite you to read *The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba*.

You will find the full report at:

[http://umanitoba.ca/faculties/health\\_sciences/medicine/units/chs/departamental\\_units/mchp/Landing-FNAtlas.html](http://umanitoba.ca/faculties/health_sciences/medicine/units/chs/departamental_units/mchp/Landing-FNAtlas.html)

## Power and Magic of Engagement

The core of Southern Health-Santé Sud as a service delivery organization is always the people that we serve. Service delivery organizations across Manitoba are working hard to build a health care system that meets the needs of all residents. We need to build a health care system together with the people we serve, to ensure that the needs and preferences of individuals and their families are at the center of all strategies.

Driven by Accreditation Canada and other leading organizations,<sup>xiv</sup> people-centered care is defined as an approach to care that consciously adopts individuals', caregivers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people. People-centered care is broader than patients or person-centered care encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Engagement is a key mechanism to expressing our commitment to people-centered care.

Engagement is deeply rooted in our core values of integrity, compassion, respect and excellence. It is woven throughout the Southern Health-Santé Sud Strategic Plan, Board governance policies and practices, and experiences that take place each day in our facilities and communities. It is part of the culture of the organization and guides much of the decisions made by leaders and policy-makers. Core values are nothing but words though if actions are not aligned with them. That is why Southern Health-Santé Sud is committed to a wide range of engagement strategies.



Data provides the outline but stories, experiences and people provide the colour for a complete painting.

## The Evolution of Engagement with the Community Health Assessment

Since previous CHAs, there has been a significant shift in the methodology, philosophy, and practice of engagement. As a healthcare system, we have moved from individual focus groups related to specific topics to a greater embedding of engagement as a common tool for how we do business. It is about relationships and a collaborative approach to care at all levels of the organization and beyond in our communities. It is about listening and hearing from people. It is about meaningful partnerships, trust-building and authentic interactions. Although we acknowledge there is still a long way to go before we can truly say we are people-centered in all we do, we are motivated to continue growing and learning.

## What Engagement Looks Like

As an organization, we strive to offer a variety of opportunities for people to get involved based on their interests and availability across the spectrum of engagement. Engagement opportunities are made available from the front-line and individual levels to the program and strategic levels of the organization.

Front-line/individual level engagement opportunities:

- Providing input about health care experiences through a variety of patient or resident surveys
- Sending feedback to the organization through phone calls, emails, or letters and being connected to the appropriate staff person
- Sharing personal healthcare experiences by telling stories to leadership teams or other departments as a learning opportunity for staff
- Partnering with care providers for treatment plans and other critical decisions

Program/service level engagement opportunities:

- Advisory Team membership for Cancer Care Hubs or the Regional Mental Health Team
- Quality improvement team membership (i.e., LEAN teams)
- Document Review Group membership: a virtual group that provides electronic feedback on a range of public documents, policies, handouts, posters, etc.

Strategic/system level engagement opportunities:

- Local Health Involvement Groups which provide input and advice to the Board of Directors on broad/strategic topics
- Community Stakeholder Groups made up of key stakeholders with a specific link to healthcare and health services
- Manitoba Institute for Patient Safety volunteer program which helps spread the word about safer care at both the individual and system levels



## Valuable Lessons from Local Health Involvement Group Members

Legislation for Local Health Involvement Groups (LHIGs) across Manitoba was enacted in the autumn of 2013. All health regions were tasked with developing groups that met ministerial guidelines. Since 2015, members of the Southern Health-Santé Sud LHIGs have been key stakeholders for the organization. Advisory to the Board of Directors, LHIGs are made up of community members with specific interests in broad, strategic topics that impact health and healthcare services. Over the past several years, these groups have discussed topics such as health equity, healthy communities, patient values, quality improvement, health promotion, health system transformation, patient experience, patient safety and a variety of others. The Board of Directors and the organization as a whole has learned a great deal from these groups.

The CHA continues to be a key document used to provide insight into many discussions and topics. For instance, when discussing health equity, data from the CHA was presented to the Regional LHIGs as a launching point to demonstrate how health is not distributed equally across all parts of the region. Premature mortality rates, diabetes rates and socio-economic factors index indicators were studied to help build a common understanding. LHIG members shared about some of the initiatives taking place in their communities to help address health equity. They also made it clear that data is essential but hearing directly from communities and individuals is equally essential. From those discussions, the Board of Directors made the decision to start a Health Equity inventory to learn more about additional initiatives taking place in communities. This inventory was shared widely among staff to help spread good ideas and to help connect communities working on similar projects. The LHIG work also resulted in further reports on health equity to help grow an understanding of the topic and what can be done to address some of the gaps.

Some notable comments made by LHIG members on the topic of health equity include:

- “Health equity explains that we are not all equal in many ways - some of us need more help.”
- “The health of our First Nations communities cannot and should not be ignored”

## Looking Ahead

As the provincial healthcare landscape transforms, so will the landscape of engagement. For instance, we can already see greater interest from the public in being able to provide real-time feedback about their experiences rather than participating in meetings. We have heard that people are looking to get involved in the design and planning of programs as collaborative team members rather than just as receivers of such service. We have seen an interest in developing tangible tools that make a difference for people using healthcare services.

The strategies of engagement will continue to evolve but must remain anchored to a vision of true and meaningful collaboration for all participants. We must remain flexible but creative; always listening to the needs of those we serve.

# Data Sources and Limitations

## Data Sources

The information for this report includes multiple sources of data to provide an in-depth look into the health of our population. These are referenced throughout the document in the figures and tables and include:

### 1. Administrative Health and Surveillance Data

These data measure health status and health services utilization in the province and health regions. The majority of the administrative health and surveillance data are provided by the Manitoba Centre for Health Policy (MCHP) or Manitoba Health, Seniors and Active Living, Information Management and Analytics Branch (MHSAL IMA).

MCHP data are obtained from the Population Research Data Repository, a comprehensive collection of administrative, registry, survey, and other data about residents of Manitoba. The data come from a variety of government department administrative datasets. For more detailed information about the repository, visit the MCHP: <http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?conceptID=1419>. Data presented in this report are primarily from published reports, including The 2019 RHA Indicators Atlas:

[http://umanitoba.ca/faculties/health\\_sciences/medicine/units/chs/departmental\\_units/mchp/Landing-RHA2019.html](http://umanitoba.ca/faculties/health_sciences/medicine/units/chs/departmental_units/mchp/Landing-RHA2019.html) and Mental Illness Among Adult Manitobans: [http://mchp-appserv.cpe.umanitoba.ca/reference//mh2015\\_Report\\_web.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference//mh2015_Report_web.pdf). However, home care data from the MCHP are unpublished work commissioned by MHSAL.

### 2. Canadian Community Health Survey (CCHS)

CCHS is a national cross-sectional self-reported survey on residents' health status, health determinants, and health care utilization. CCHS is designed to collect health data at the provincial and health region levels. Respondents who participated in the CCHS were selected to be representative of the provincial population and to provide reliable estimates at the health region level. It is typically collected by Statistics Canada every other year. The Manitoba sample size is 5,183 respondents. The data are weighted for representativeness and standardized to take into account certain demographic differences across health regions (e.g., age and sex), which can allow for more accurate comparisons between health regions in the province.

### **3. 2016 Census**

The 2016 Census data are used to describe population and community characteristics. The Census data provide high-quality information for communities across the province and are used to support planning for employment, education, and health care services. It is typically collected by Statistics Canada every five years.

To ensure confidentiality, Statistics Canada randomly rounds the values, including totals, either up or down to a multiple of '5' or '10.' As a result, when these data are summed or grouped, the total value may not match the individual values since totals and sub-totals are independently rounded. Similarly, percentages, which are calculated on rounded data, may not necessarily add up to 100 percent.

### **4. Healthy Child Manitoba**

Data on the Early Development Instrument (EDI) and Family First risk factors are provided by the Healthy Child Manitoba Office. For more details about the EDI program in Manitoba and other provincial reports on child health, please visit: <http://www.gov.mb.ca/healthychild/edi/>.

### **5. CancerCare Manitoba**

Cancer screening, incidence and mortality data are provided by CancerCare Manitoba from the Manitoba Cancer Registry, Screening Programs and Radiation Oncology Program. Please visit <https://www.cancercare.mb.ca/About-Us/corporate-publications>.

### **6. Canadian Patient Experiences Survey – Inpatient Care**

The 2017-2018 Canadian Patient Experiences Survey-Inpatient Care (CPES-IC) is a standardized survey patients use to provide feedback about the quality of care they received during their most recent stay in a Canadian acute care hospital. It was created by the Canadian Institute for Health Information (CIHI) and has been endorsed by Accreditation Canada to meet the accreditation requirements for patient experience surveying. The results of the survey were analyzed by the MHSAL IMA. The CPES-IC has been collected across all health regions in Manitoba since 2017.

## Data Limitations

We acknowledge that there are limitations that should be taken into consideration when interpreting the data presented in this report. A challenge of drafting large population surveillance reports using multiple data sources is the availability of the most up-to-date data. The most current data available have been used for this report; however, for some indicators (e.g., dementia prevalence, mood and anxiety disorders) the most recent data can be several years old.

Although many of the indicators are representative of the population, the information in this report may not reflect the health status and needs of Indigenous peoples living in Manitoba due to data limitations. For more information on the Health Status of First Nations people in Manitoba, please see the previous section (First Nations People's Health in Manitoba).

Some indicators (e.g., cancer-related) are not available at the zone or district level. For some indicators, statistical testing was not available to test the differences compared to the Manitoba average (e.g., Census) or the changes over time (e.g., Canadian Community Health Survey). Although differences may be noted, the statistical significance of these differences should not be inferred. Similarly, statistically significant differences were not tested across health regions, zones, and districts.

### 1. Administrative Health and Surveillance Data

The majority of the administrative health and surveillance data (e.g., provided by the Manitoba Centre for Health Policy or MHSAL IMA) rely on medical claims data. Some health providers (e.g., physicians, nurse practitioners) working in rural areas are covered under alternate payment methods (e.g., salaried), and they submit claims (shadow billings) for administrative purposes only. This may result in under-reported health services in those areas. This is particularly true for many Northern districts because much of the primary care for residents in some communities is provided by nurses and not coded into medical claims data.

In addition, some useful demographic factors such as race and ethnicity are not captured in the administrative health data repository; we also cannot assess the differences of health status and health care utilizations across these groups.

### 2. Canadian Community Health Survey (CCHS)

Due to the self-reported nature of the CCHS, recall and self-serving biases may have particular impact on certain survey questions. For example, respondents were asked about events (e.g., physical activity, fruit and vegetable consumption) occurring during the last month, and their ability to remember accurately may affect the data. In addition, respondents may choose to alter their responses in a more positive light to questions that may be perceived as more sensitive (e.g., alcohol consumption).

Respondents who participated in the CCHS were selected to be representative of the provincial population and to provide reliable estimates at the health region level. However, due to the small

number of respondents, caution is needed when interpreting some response categories and smaller geographic areas.

Since 2015, considerable changes were made to the CCHS (e.g., sample selection procedures, content, etc.). Therefore, the 2015-2016 data cannot be combined with previous cycles to examine data at smaller area levels (i.e., community areas, zones, and districts). For certain indicators deemed important to report, data used in previous cycles of the CCHS was not available this cycle.

Although the CCHS survey is representative of 98 percent of the total population, it is missing information from the other two percent of the population (e.g., the homeless, persons living on-reserve and other Indigenous settlements, full-time members of the Canadian Armed Forces, the institutionalized population and children aged 12 to 17 years old living in foster care). These groups may differ in risk for a wide range of health issues and may have different health service needs.

### **3. Census Data**

In 2011, Statistics Canada's mandatory long-form Census was abolished and replaced with a voluntary National Household Survey (NHS). The response rate to the NHS was much lower than the mandatory long-form census. Therefore, comparisons between the 2016 Census data, presented in this report, and the previous 2011 NHS cannot be made, as well as, trends since 2011 cannot be noted.

## Data Presentation and Interpretation

Most indicators in this report are presented using a population–based approach. This means that the rates or prevalence shown are based upon virtually every person living in Manitoba and excludes only those in federal penitentiaries, members of the Canadian Armed Forces, and the RCMP.

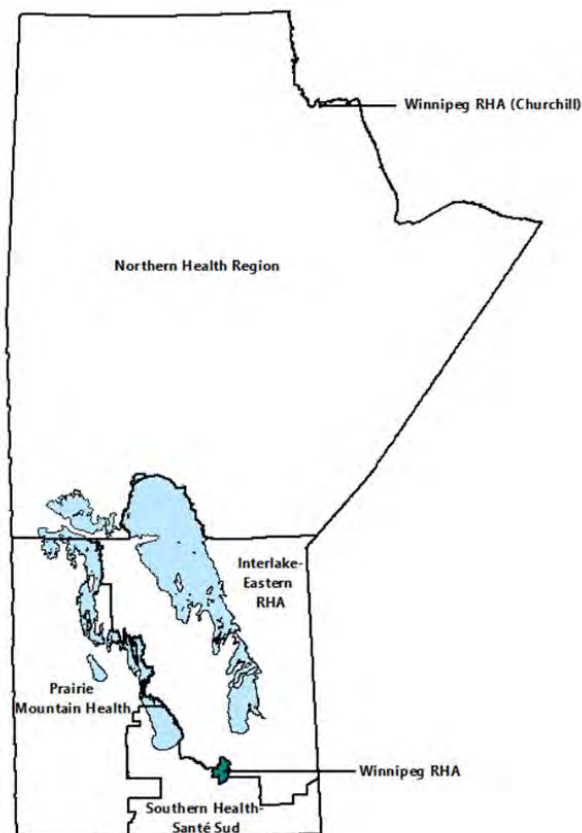
The indicators in this report are based upon where people live, not where they received services, with a few exceptions. For example, a person living in Southern Health-Santé Sud may be hospitalized in Winnipeg, but the hospitalization is attributed back to the rate for the Southern Health-Santé Sud. Thus, the results show the health and healthcare use patterns of the population living in Southern Health-Santé Sud, no matter where they receive their care.

In all cases, the latest available information is presented. Visual representations of data have been labelled and ordered in a consistent fashion throughout the report with sources clearly defined.

In this report where the term ‘Indigenous’ is used, it is referring to only those residents who have self-identified as being either First Nations, Métis or Inuit. When Southern Health-Santé Sud is used alone it refers to all residents of the health region, including those identifying as First Nations or Métis.

### Geographic Boundaries

In the majority of cases, the quantitative data is presented for the five health regions of Manitoba.



## Rates and Prevalence

In the majority of visual representations, data are presented as a rate or prevalence. Prevalence refers to the proportion of the population that has a certain condition, either at a given point in time (point prevalence) or over a period of time (period prevalence). It is an indication of how common the condition is, and therefore, has implications for the provision of services. Most indicators in this report use the concept of period prevalence over a one year, three year, or five year period.

In contrast, a rate refers to a change in state over time and is used to express the frequency of events during a given period. Many health-related events can happen to a given person more than once. For example, the physician visit rate shows how often residents visit physicians each year. Where an indicator covers a period longer than one year, the rate is annualized— that is, given as an annual average.

## Adjusted Rates and Crude Values

The indicator tables and figures in this report are labelled as ‘age and sex adjusted’ rates when results have been statistically adjusted to account for the different age and sex composition of the populations living in different areas. This adjustment allows for fair comparisons among areas with different population characteristics. Adjusted rates show what that area’s rate would have been if the area’s population had the same age and sex composition as the Manitoba population.

In some cases ‘crude values’ are presented in order to indicate the actual number of events that occurred (e.g., residents living with a particular condition) within the health region and to represent the possible burden of illness to Southern Health-Santé Sud in particular.

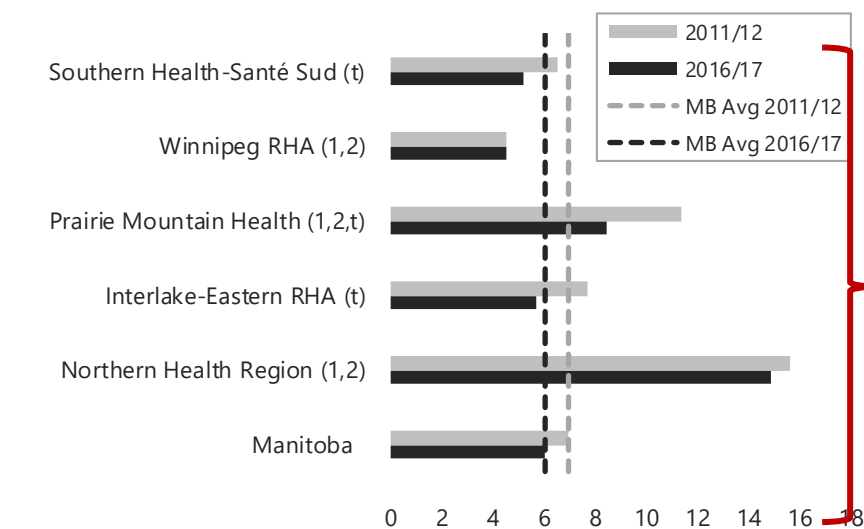
When reading this report, if the narrative referring to an indicator suggests that a difference is ‘significant’ then you know the difference is considered statistically significant ( $p\text{-value} < .05$ ) and not likely to be an annual or period fluctuation or due to chance. When a difference is not described as ‘significant’, the rate should be considered similar to the provincial average and/or the previous time period. Statistical significance was only tested for the difference compared to the provincial average and/or changes over time. There were no statistical tests completed for differences between regions, zones, and districts.

## Visualization of Data

The 2019 CHA introduces a new method of visualizing data to describe regional differences and changes over time. It captures all the components of the previously used MCHP multiple year bar charts (on the next page) but in a more condensed format.

The ORIGINAL bar graph from MCHP:

Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2016/17 (T2) and 2011/12 (T1)  
Age- and sex-adjusted per 1,000 residents aged 0-74



In the CHA reports the bar charts here are collapsed and visualized below.

For each time period, the range in values (lowest to highest) are shown on either end

The regions are ordered from lowest to highest (based on T2 for table)

T2 = recent time period  
T1 = earlier time period

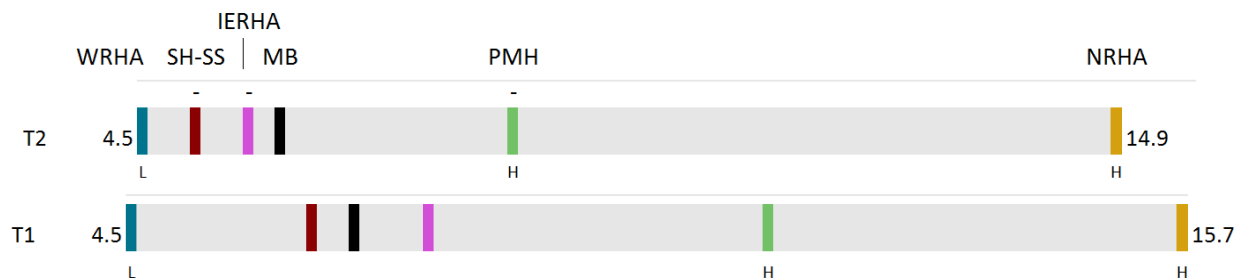
Data tables with actual values and crude counts

- 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

MCHP RHA Indicators Atlas 2019

The NEW look in CHA reports:

Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2016/17 (T2) and 2011/12 (T1)  
Age- and sex-adjusted per 1,000 residents aged 0-74



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	IERHA	MB	PMH	NRHA
T2 COUNT	3,467	1,010	861	8,023	1,522	995
T2 RATE	4.5 L	5.2 -	5.7 -	6.1	8.5 H-	14.9 H
T1 RATE	4.5 L	6.6	7.7	7.0	11.4 H	15.7 H

MCHP RHA Indicators Atlas 2019



## Graphing the two time periods:

- The line bars are stacked one on top of the other with the most recent time period on top and the earlier time period below.
- The earlier or first time period is labeled “T1” and the second or more recent time period is labeled “T2”. These labels are positioned at the extreme left end of the line bars.

## Understanding the sliding scale:

### Identifying regional data

- Bars on the sliding scale correspond to the regional values in the MCHP bar chart. To easily identify regional position, each health region and Manitoba has been assigned a specific colour.

### The range of values

- The T2 bar reflects only the range in values from the lowest regional value (WRHA 4.5) to the highest (14.9 NRHA). The horizontal bar does not show the entire scale from 0.
- The T1 bar reflects the data in the earlier time period (or in some cases, the only time period available). In the example above, the lowest value is the same for both time periods (WRHA 4.5) but the highest value extends the scale to the right (NRHA 15.7). The scale has been extended to reflect the full range of values for both time periods.
- The bookends (lowest and highest values) easily identify whether values have increased, decreased, or remained similar across the province. This is a quick way to see whether the regional disparity has widened or narrowed.

### Statistical significance (statistical significance of $p < .05$ )

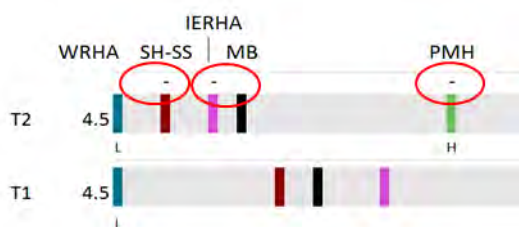
- Significant differences from the Manitoba average are shown below the RHA marker as either H (higher) or L (lower). This replaces MCHP’s symbols “1” or “2” for indicating statistical differences from the Manitoba average by time period.
- Significant changes over time are shown above the RHA marker as + (increasing) or - (decreasing). This replaces MCHP’s symbols “t” for indicating if the change over time was statistically significant for that area.

### Data table below sliding scales

- A data table follows each set of line bars showing the actual values for every health region.
- T2 COUNT reflects the crude count for only the recent time period (e.g., residents, hospitalizations, visits, etc.).
- T2 RATE presents the regional data reflected in T2 sliding scale.
- T1 RATE presents the regional data reflected in T1 sliding scale.
- Statistically significant notations as described above.
- Values are ordered from left to right, lowest to highest according to the T2 rate.

## Interpreting the data

Significant increases or decreases (statistical significance of  $p < .05$ ) in a health region's value over time (from T1 to T2) are notated by either a + (increase) or - (decrease) above the health region marker on the T2 bar and repeated in the accompanying table.



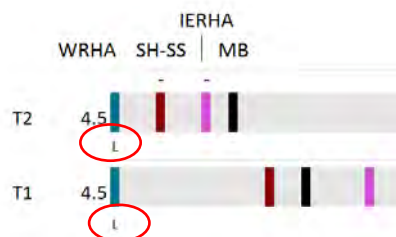
Southern Health Santé Sud, Interlake Eastern RHA and Prairie Mountain Health have all shown a significant decrease in hospitalizations for Ambulatory Care Sensitive Conditions (ACSC) between T1 and T2.

Values that are significantly different from the Manitoba average for that time period are notated by either an H (higher) or L (lower) underneath the health region marker on both the T1 and T2 bars and repeated in the accompanying table.



Prairie Mountain Health and Northern Health Region have significantly higher rates of hospitalization for ACSC than the province as a whole in both time periods.

Winnipeg RHA has significantly lower rates of hospitalization for ACSC than the province as a whole in both time periods.



SH-SS	
1,010	
5.2	-
6.6	

Southern Health-Santé Sud had an ACSC rate of 6.6/1,000 in the first time period (2011-2012) which was not significantly different than the provincial average of 7.0/1,000. The regional value has decreased significantly over time to 5.2/1,000 in the second time period (2016-2017) and remains no different than the provincial average of 6.1/1,000 in the second time period.

## Disparity Measures

There are two disparity measures shown in the report; income disparity and geographic disparity.

**Income disparity** is provided at a provincial level and is represented by the following visual for



Within each group the population is divided into five groups of approximately equal population, according to the average household income (as determined by the Census small dissemination area) called income quintiles.


- The disparity measure is reported only where there is a statistically significant linear trend between income and the indicator results and the nature of the increases or decreases are stepwise.
- The disparity is the relative difference between those in the highest income quintile and those in the lowest income quintile.

Understanding the income disparity information:

- The example above indicates that in rural quintiles, in the second time period (T2), the residents of the lowest income areas are 1.4 times more likely to have births large for gestational age than those in the highest income quintile.
- If two time periods are available, the direction of change is indicated by an arrow and the colour indicates whether the gap is narrowing (green) or widening (red).

Manitobans are split into urban and rural with urban being just the cities of Winnipeg and Brandon and rural being everyone else. In the current report, any income information is reported provincially but for rural quintiles only, which includes all of Southern Health-Santé Sud, including its cities.

**Geographic disparity** is shown at a regional level and is represented below the zone and district table by the following visual, for example inadequate prenatal care:

SH-SS Geographic Disparity Ratio		
	T1	10.5x
	T2	7.9x
	Change	-2.6 ↓

The disparity is measured between the district with the best value for the indicator and the district with the worst value. In this example, the district with the lower value is actually better, but in other indicators the reverse may be true.

Understanding the geographic disparity information:

- In the example above, the disparity measure in T1 indicates that the district with the highest value (Seven Regions) is 10.5 times more likely to receive inadequate prenatal care than the district with the lowest value (Taché). Similarly, the T2 reflects that district with the highest value (Seven Regions) is 7.9 times more likely to receive inadequate prenatal care than the district with the lowest value (Niverville/Ritchot).
- Note that the districts with the highest and lowest values may vary from T1 to T2.
- The direction of change is indicated by the arrows and the colour indicates whether the gap is narrowing (green) or widening (red). The arrow pointing down and the green font colour indicate that the disparity gap has narrowed over time.

## Zone and District Tables

Whenever available and appropriate, zone and district level data are presented in tables.

- When two time periods are available, the counts and rates or percentages of the most recent time period (labeled T2) are presented first, followed by the rates or percentages of the earlier time period (labeled T1).
- The zones are ordered by premature mortality rate from best to worse from left to right in the first row, followed by the second row (i.e., for Southern Health-Santé Sud these are ordered Zones 4, 2, 3, and 1).
- The district order varies between tables as they are ordered from best to worse, when appropriate.

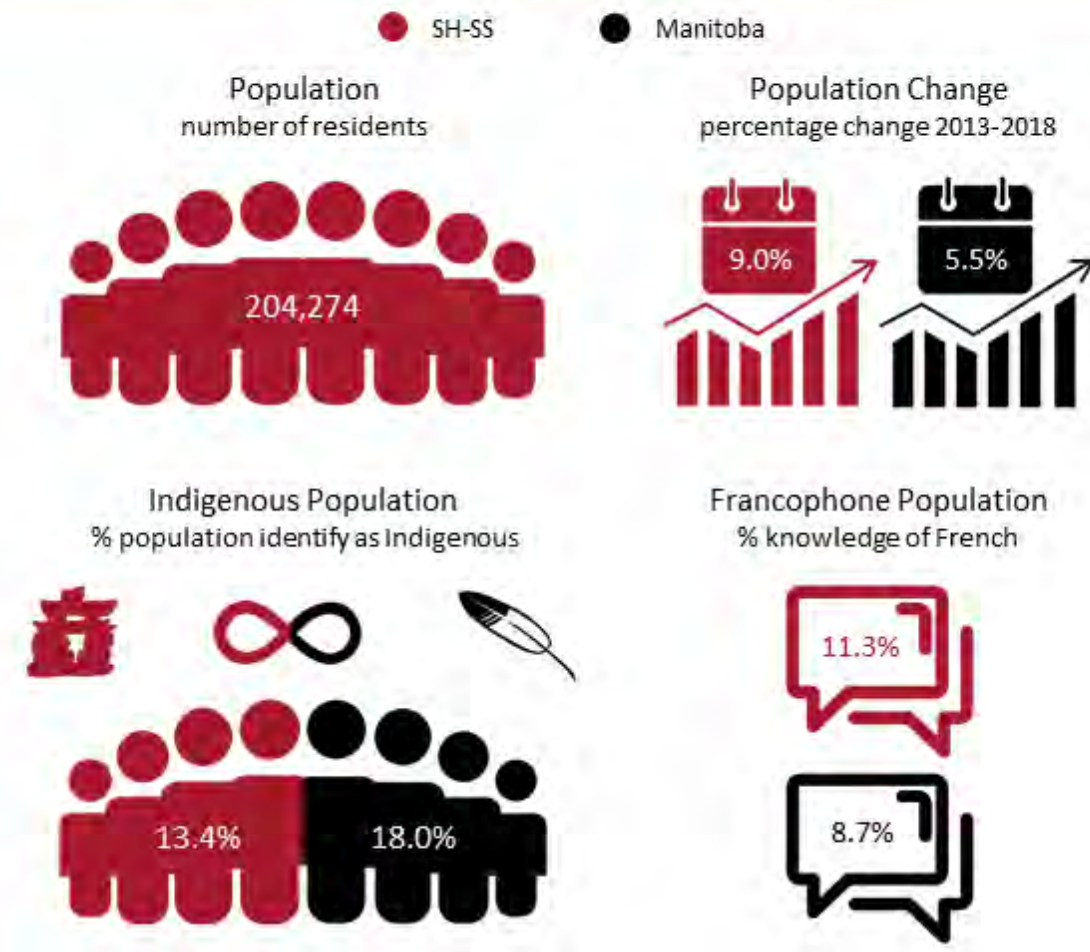
- 
- <sup>i</sup> World Health Organization. (1948). Mental health: A state of well-being, [https://www.who.int/features/factfiles/mental\\_health/en/](https://www.who.int/features/factfiles/mental_health/en/)
- <sup>ii</sup> BC Centre for Disease Control. (n.d.). Population & Public Health Surveillance. <http://www.bccdc.ca/our-services/programs/population-public-health-surveillance>
- <sup>iii</sup> The Robert Wood Johnson Foundation (RWJF). What is Health Equity? ,\_2017 <https://www.rwf.org/en/library/research/2017/05/what-is-health-equity-.html>
- <sup>iv</sup> <http://agentsofgood.org/wp-content/uploads/2017/04/Equality-vs-Equity-Illustration3.jpg>
- <sup>v</sup> Manitoba Health, Seniors and Active Living. (2018). Chief Provincial Public Health Officer Position Statement on Health Equity, [https://www.gov.mb.ca/health/cppho/docs/ps/health\\_equity.pdf](https://www.gov.mb.ca/health/cppho/docs/ps/health_equity.pdf)
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- <sup>vii</sup> In Pursuit of Health Equity: Defining Stratifiers for Measuring Health Inequality — A Focus on Age, Sex, Gender, Income, Education and Geographic Location
- <sup>viii</sup> Canadian Institute for Health Information. Pan-Canadian Dialogue to Advance the Measurement of Equity in Health Care: Proceedings Report. Ottawa, ON: CIHI; 2016. [https://secure.cihi.ca/free\\_products/Measurement\\_of\\_Equity\\_in\\_Health\\_Care\\_Proceedings\\_Report\\_EN.pdf](https://secure.cihi.ca/free_products/Measurement_of_Equity_in_Health_Care_Proceedings_Report_EN.pdf)
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- <sup>xiii</sup> Katz, A., Kinew, K.A., Star, L., Taylor, C., Koseva, I., Lavoie, J., et al. (2019). The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba. [http://mchp-appserv.cpe.umanitoba.ca/reference//FN\\_Report\\_web.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference//FN_Report_web.pdf). Accessed October 15, 2019
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# CHAPTER 1: WHO LIVES IN SOUTHERN HEALTH-SANTÉ SUD?

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# At a Glance: Who Lives in Southern Health-Santé Sud?



## Why is this chapter important?

- ▶ This chapter outlines the geography of the region as well as demographic features of our population. The unique characteristics of our region influence the factors that determine how healthy we are and have a significant impact on the need for appropriate services and programs.
- ▶ The information in this chapter is foundational to forecast future issues that will require dedicated strategies in both the short and long-term.
- ▶ Population health surveillance is essential to healthcare planning and resource allocation to ensure we develop equitable and sustainable programs and services.



# Chapter 1 Key Findings

---

Southern Health-Santé Sud is a thriving multi-cultural region covering an expanse of 27,025 km<sup>2</sup> of south central and eastern Manitoba. It is one of the fastest growing areas in the province.

---

## Population

- ▶ 204,274 residents lived in the region in 2018
- ▶ Slightly younger population compared to Manitoba
- ▶ 2,882 births among regional residents in current time period
- ▶ Over 16,000 new residents over five years, representing the largest percentage of population growth in the province
- ▶ Largest population growth in districts surrounding Winnipeg and cities of Morden and Winkler
- ▶ Projected percentage growth highest in the province
- ▶ Projected to grow to over 250,000 by 2030; an increase of 25% or approximately 50,000 residents
- ▶ Highest percentage of internal migrant mobility in the province
- ▶ Population density within the region was 7.1 residents per square kilometer
- ▶ Second highest dependency ratio in province, indicating higher pressure on the working-age population to support youth and older adults

## Demographics

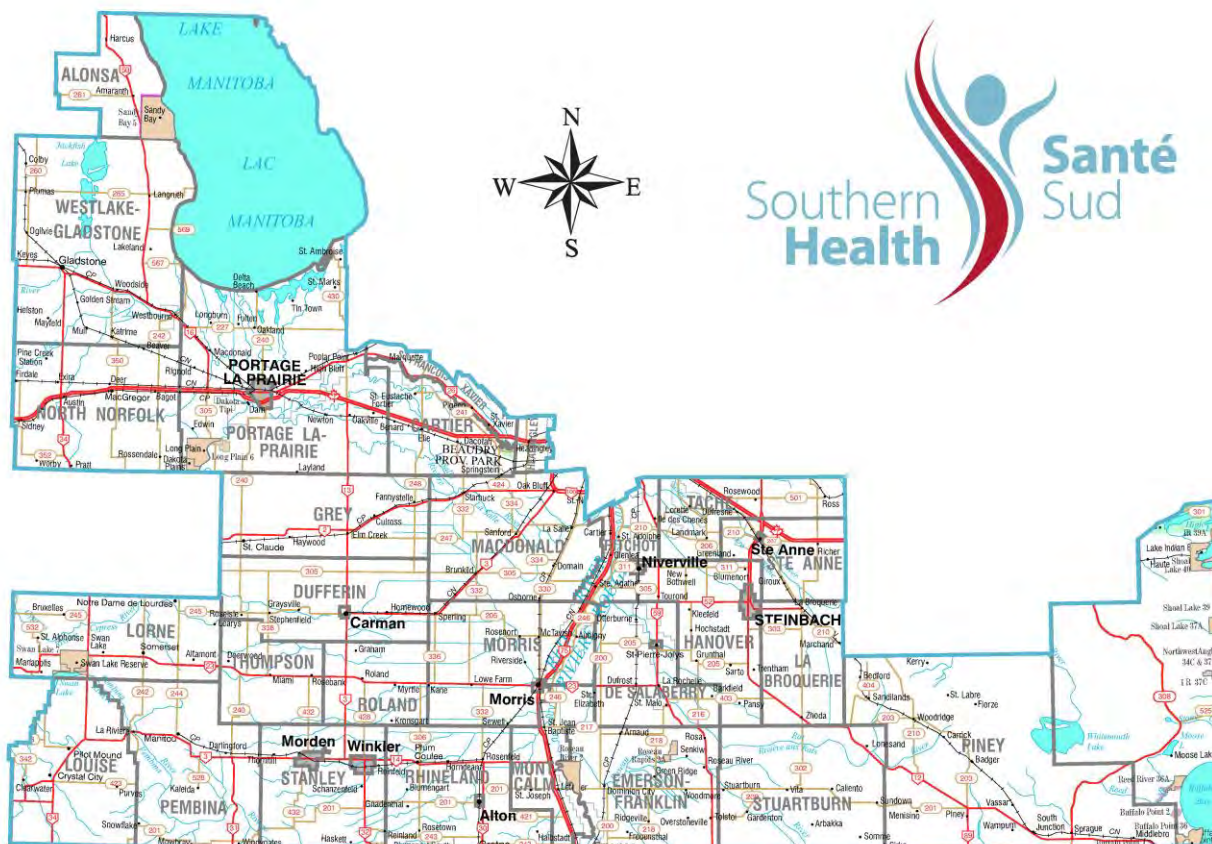
- ▶ 13% identified as Indigenous
- ▶ 4% identified as visible minority
- ▶ 11% of population knew French well enough to conduct a conversation
- ▶ German was the leading non-official language spoken most often at home
- ▶ 14% with immigrant status
- ▶ Leading countries where immigrants were born: 1) Mexico; 2) Germany; 3) Philippines; 4) Russian Federation; and 5) United States
- ▶ Lowest percentage of lone-parent families in the province – majority led by women



## Geographic Boundaries

Covering an expanse of 27,025 km<sup>2</sup> of south central and eastern Manitoba, Southern Health-Santé Sud provides health care services to residents across the region and beyond. Although we are defined by administrative boundaries, we are aligned with the rest of Manitoba to create seamless connections across the province. Everything we do is for and about creating a healthier tomorrow for all, a commitment to something bigger than ourselves. Twenty-four hours a day, every single day, hundreds of people connect with us in some way. Each individual interaction is unique and important to us. We give our communities a strong commitment to quality care, maintaining an accredited status and upholding the standards required by Accreditation Canada.

A thriving region and the most populated of the rural health regions in Manitoba, Southern Health-Santé Sud ranks as one of the fastest growing areas in the province. It has grown by 20% over the past decade, a growth rate that is the highest in the province. In the last decade, the region has experienced a dramatic influx of immigrants and refugees. People all over the world have and continue to make their home here.



Indigenous presence in the province can be traced over thousands of years. Long before the first explorers came to the region, nomadic Indigenous tribes roamed the area. Southern Health-Santé Sud is located on the original lands of Treaty 1 and Treaty 3 territory and on the homelands of the Métis Nation. We respect the treaties that were made on these territories and acknowledge the harms and mistakes of the past. We dedicate ourselves to move forward collaboratively in partnership with First Nations, Métis, and Inuit peoples in the spirit of reconciliation.

Today, the 204,274 people that live here can trace their ancestries to one or more ethnic groups. Southern Health-Santé Sud is proud of its multi-cultural heritage, which speaks to the sounds, sights, and stories of a diverse people who share this land. Provincially mandated as a designated bilingual health region, Southern Health-Santé Sud respects the linguistic duality of Canada and undertakes to provide bilingual health care services to its Francophone population.

There are 4 cities, 4 towns, 1 village, 7 municipalities, 20 rural municipalities, 1 unorganized territory, 56 Hutterite colonies, Métis and Francophone communities, a growing large Mennonite population as well as many other cultures. There are 7 First Nations communities: Long Plain First Nation, Dakota Plains Wahpeton Nation, Swan Lake First Nation, Roseau River Anishinabe First Nation, Sandy Bay Ojibway First Nation, Dakota Tipi First Nation, and Buffalo Point First Nation.

Many of the indicators in this report are organized in four smaller geographies within Southern Health-Santé Sud. In previous reports, these were referred to as “areas,” going forward they are referred to as planning “zones.” Wherever possible, the indicators are also reported at 23 district levels to provide a finer level of detail for communities. A series of municipal amalgamations came into effect as of January 1, 2015. Therefore, some changes are noted between time periods: prior to 2015, Notre-Dame-de-Lourdes was combined with St. Claude and Grey, but in the most recent time period, it is combined with Lorne/Louise/Pembina.

## ZONE 1

### District: Seven Regions

- ▶ Westlake-Gladstone Municipality
- ▶ Alonsa RM
- ▶ Sandy Bay Ojibway First Nation

### District: North Norfolk

- ▶ North Norfolk Municipality

### District: City of Portage

- ▶ Portage la Prairie City

### District: Rural Portage

- ▶ Portage RM
- ▶ Dakota Tipi First Nation
- ▶ Dakota Plains Wahpeton First Nation
- ▶ Long Plain First Nation

### District: Cartier/SFX

- ▶ Cartier RM
- ▶ St. François Xavier RM
- ▶ Headingley RM

## ZONE 2

### District: Carman

- ▶ Dufferin RM
- ▶ Carman Town

### District: Grey

- ▶ Grey Municipality

### District: Macdonald

- ▶ Macdonald RM

### District: Morris

- ▶ Morris RM
- ▶ Morris Town

### District: St. Pierre/De Salaberry

- ▶ De Salaberry RM
- ▶ St. Pierre-Jolys Village

### District: Red River South

- ▶ Montcalm RM
- ▶ Emerson-Franklin Municipality
- ▶ Roseau River Anishinabe First Nation

## ZONE 3

### District: Winkler

- ▶ Winkler City

### District: Morden

- ▶ Morden City

### District: Stanley

- ▶ Stanley RM

### District: Altona

- ▶ Rhineland Municipality
- ▶ Altona Town

### District: Roland/Thompson

- ▶ Roland RM
- ▶ Thompson RM

### District: Lorne/Louise/Pembina

- ▶ Pembina Municipality
- ▶ Louise Municipality
- ▶ Lorne Municipality
- ▶ Swan Lake First Nation

## ZONE 4

### District: Niverville/Ritchot

- ▶ Ritchot RM
- ▶ Niverville Town

### District: Taché

- ▶ Taché RM

### District: Ste. Anne/La Broquerie

- ▶ Ste. Anne RM
- ▶ La Broquerie RM
- ▶ Ste. Anne Town

### District: Steinbach

- ▶ Steinbach City

### District: Hanover

- ▶ Hanover RM

### District: Rural East

- ▶ Piney RM
- ▶ Stuartburn RM
- ▶ Buffalo Point First Nation
- ▶ Unorganized Territory

## Programs and Services

- ▶ **CancerCare/Cancer Navigation Services**
- ▶ **Elderly Persons Housing**
- ▶ **Emergency Medical Services (Ambulance)**
- ▶ **Home Care**
  - Adult Day Programs
  - Meals on Wheels
  - Personal Care at Home
  - Respite Care
  - Treatment Clinics
- ▶ **Medical Clinics**
- ▶ **Medical Officer of Health**
- ▶ **Mental Health**
  - Adult Counselling Services
  - Adult Inpatient Psychiatric Treatment (Eden Mental Health Centre)
  - Child & Adolescent Services
  - Crisis Services
  - Intensive Case Management Services
  - Mental Health Promotion, Housing and Supports
  - Psychiatry Services
  - Seniors Consultation Team
  - Shared Care
- ▶ **Midwifery**
- ▶ **Nutrition Services**
- ▶ **Palliative Care/End of Life**
- ▶ **Pharmacy**
- ▶ **Primary Health Care**
  - Chronic Disease Education
  - Family Doctor Finder
  - Medical Clinics
  - Mobile Clinic
  - My Health Teams
  - Nurse Practitioners
  - Primary Health Care Centres
  - QuickCare Clinic
  - Teen Clinics
- ▶ **Public Health-Healthy Living**
  - Families First
  - Healthy Baby
  - Healthy Living Services
    - ▶ Get Better Together
    - ▶ Healthy Communities Conference
    - ▶ Healthy Living Grants
    - ▶ Local Health Promotion
    - ▶ TeleCARE Manitoba
  - Public Health Nursing Services
    - ▶ Communicable Disease Prevention & Control
    - ▶ Early Childhood Development & Parenting
    - ▶ Harm Reduction
    - ▶ Immunizations/Child Health Clinic
    - ▶ Prenatal, Postpartum & Breastfeeding Support
    - ▶ Reproductive Health
    - ▶ School 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**

### Other Services

- ▶ **Indigenous Health**
- ▶ **Corporate Communications/Media Specialist**
- ▶ **Disaster Management**
- ▶ **Finance**
- ▶ **French Language Services**
- ▶ **Human Resources**
- ▶ **Information & Communication Technology (ICT)**
- ▶ **Quality of Care & Patient Safety**
- ▶ **Spiritual Health Care**
- ▶ **Support Services**
- ▶ **Telehealth**

### Facility-Based Services

- ▶ **Acute Care**
  - Emergency Care
  - Extended Treatment/Rehabilitation
  - Hemodialysis
  - Medical Care
  - Obstetrical Care
  - Outpatient Services
  - Respiratory Services
  - Special Care Unit
  - Surgery/Surgical Care
- ▶ **Affiliate Health Corporations**
- ▶ **Community-Owned not for Profit**
- ▶ **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**

## Population

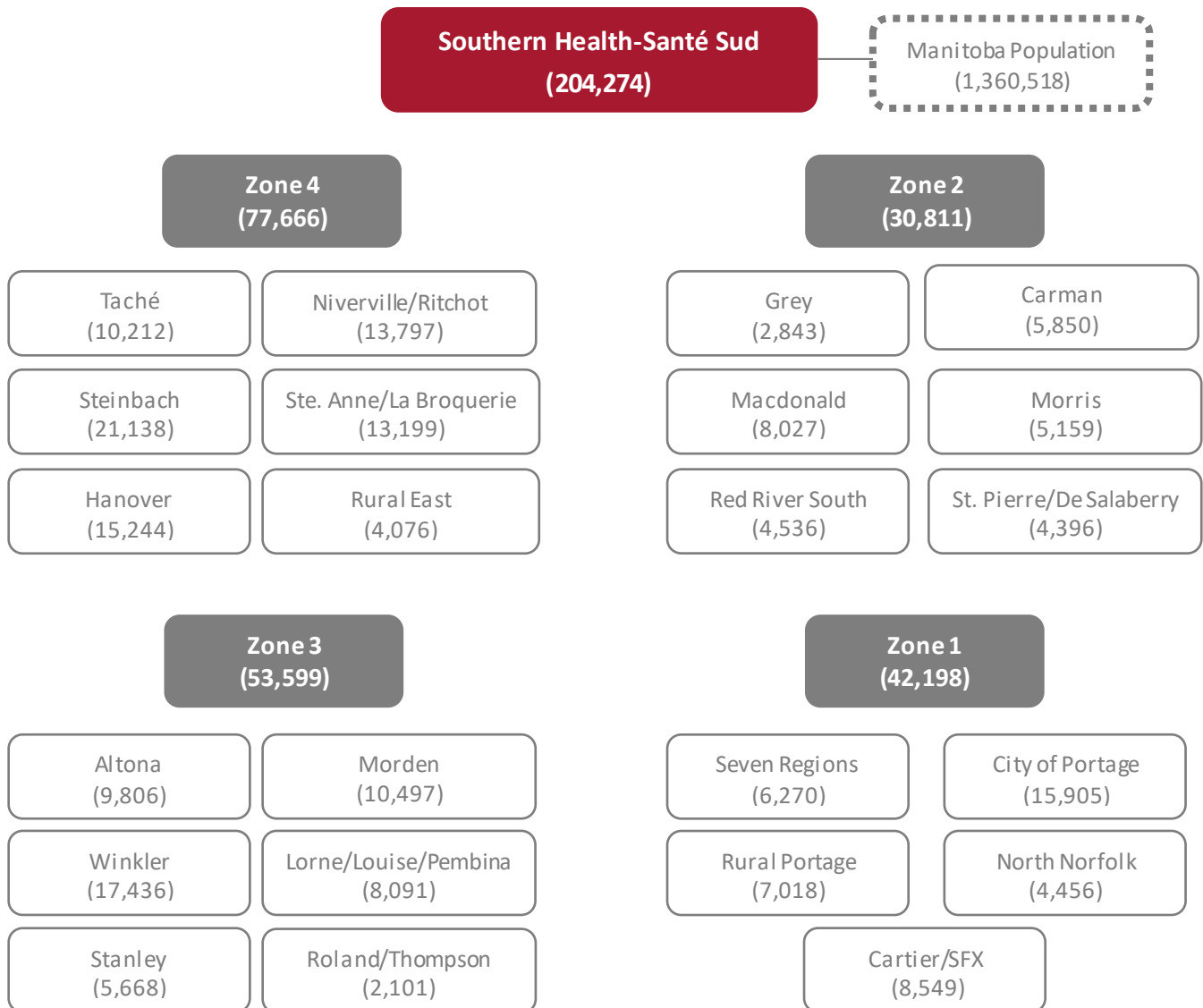
### Definition

The total number of residents living within a geographic area over a one-year time period based on a resident's current address on their Manitoba Health Card, which is updated on June 1st of every year.

### Regional Key Findings

- ▶ **Figure 1** shows that in 2018, the regional population was 204,274, representing 15% of the Manitoba population and the largest among rural health regions.
- ▶ The four cities within the region represented over 30% of the overall population.
- ▶ The most populated district was Steinbach, while Roland/Thompson was the least populated.

**Figure 1. Southern Health-Santé Sud Population by Zone and Districts, 2018**



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## Population Pyramids

### Definition

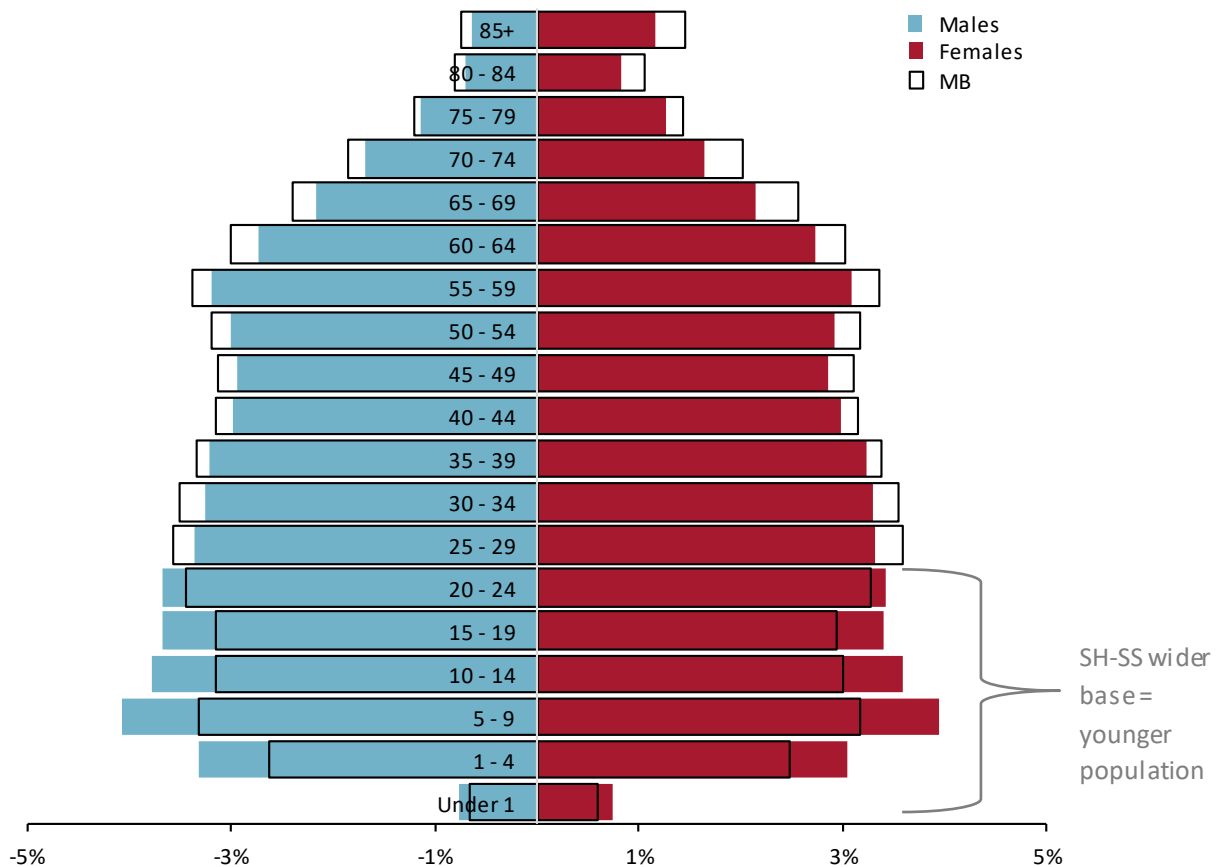
The age and sex distribution of a population living in a geographic area for a one-year time period.

### Regional Key Findings

- ▶ **Figure 2** shows that the region had a slightly wider base compared to the Manitoba population, indicating a larger percentage of younger age groups.
- ▶ **Figure 3** shows that age and sex distribution was similar across zones with the most notable difference in Zone 3, where the larger base indicated a larger percentage of younger age groups.

**Figure 2. Southern Health-Santé Sud Population Pyramid, 2018**

Percentage of population by age and sex

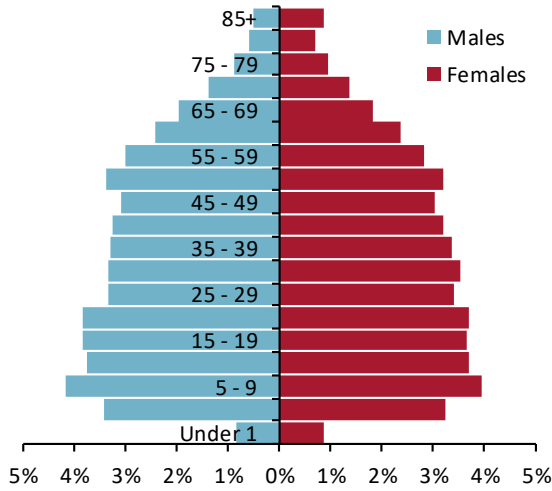


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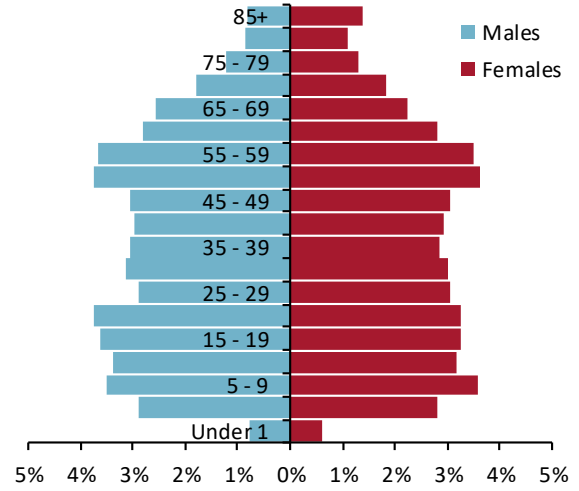
**Figure 3. Southern Health-Santé Sud Population Pyramid by Zones, 2018**

Percentage of population by age and sex

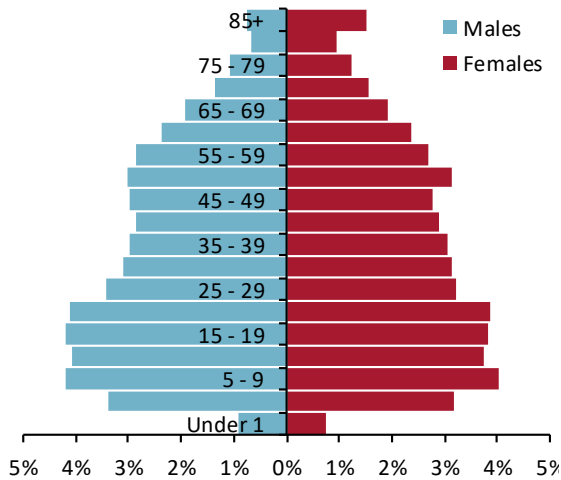
**Zone 4**



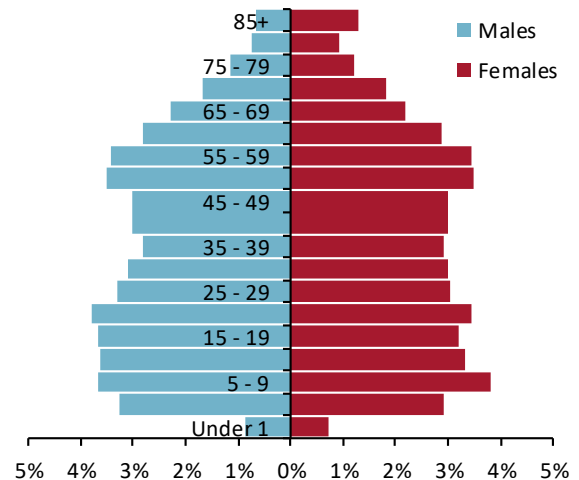
**Zone 2**



**Zone 3**



**Zone 1**



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## Birth Rate

### Definition

The rate of live births per 1,000 females aged 15 to 45, for a one-year time period.

### Provincial Key Findings

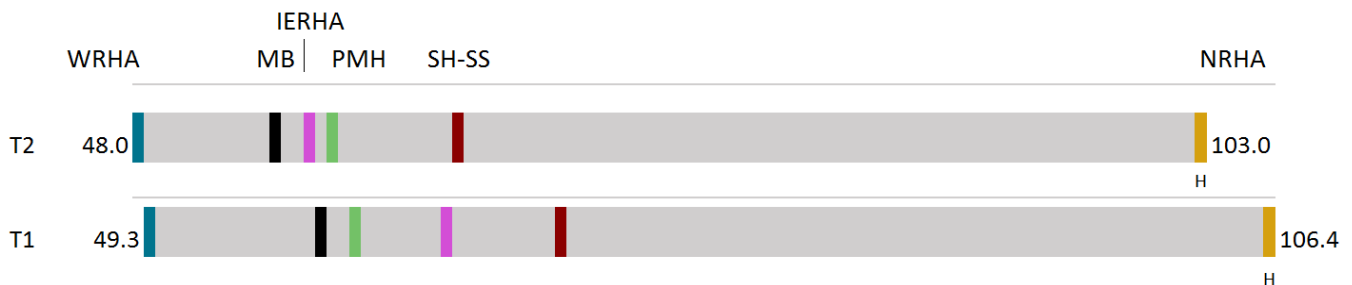
- ▶ **Figure 4** shows that the annual birth rate in Manitoba decreased slightly, but not significantly over time.
- ▶ Northern Health Region had a birth rate significantly higher than the Manitoba average in both time periods.
- ▶ Birth rates were considerably higher in rural than urban areas.<sup>i</sup>
- ▶ **Income:** Birth rates were very strongly associated with income in rural areas. Women in lower income areas had higher birth rates than those in higher income areas.<sup>ii</sup>



*Birth rates very strongly related to income*

**Figure 4. Birth Rate by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age-adjusted rate of live births per 1,000 females (aged 15-45)



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	PMH	SH-SS	NRHA
T2 COUNT	8,021	16,027	1,360	2,080	2,882	1,669
T2 RATE	48.0	55.5	57.4	58.8	65.1	103.0 H
T1 RATE	49.3	58.1	64.3	59.6	70.2	106.4 H

## Regional Key Findings

- ▶ **Table 1** shows a total of 2,882 births among women in the region aged 15 to 45 years in the current time period.
- ▶ The regional birth rate was higher compared to the provincial rate; however, this was not a statistically significant difference.
- ▶ Birth rates were similar across Zones 2, 3 and 4.
- ▶ Birth rates in Zone 1 were significantly higher than the provincial average in both time periods.
- ▶ In the current time period, there was a difference of about 65 births per 1,000 women between the lowest district of Taché and the highest district of Seven Regions: the only district significantly higher than the provincial average in both time periods.


**Table 1. Birth Rate in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age-adjusted rate of live births per 1,000 females (aged 15-45)

	T2		T1		
	Count	Rate	Rate		
<b>Manitoba</b>	<b>16,027</b>	<b>55.5</b>	<b>58.1</b>		
<b>SH-SS</b>	<b>2,882</b>	<b>65.1</b>	<b>70.2</b>		
<b>Zone 4</b>	<b>1,114</b>	<b>64.3</b>	<b>69.8</b>		
Ste. Anne/La Broquerie	206	77.4	67.0		
Steinbach	343	69.3	81.7		
Hanover	225	66.5	74.5		
Niverville/Ritchot	204	65.3	62.0		
Rural East	32	50.8	37.1		
Taché	104	48.7	62.8		
<b>Zone 2</b>	<b>381</b>	<b>62.5</b>	<b>66.5</b>		
Carman	83	74.0	72.7		
Red River South	64	72.8	80.9		
Grey	35	71.1	71.6		
Morris	74	64.2	59.2		
St. Pierre/De Salaberry	52	55.6	69.8		
Macdonald	73	51.6	56.6		
<b>Zone 3</b>	<b>782</b>	<b>66.5</b>	<b>73.5</b>		
Roland/Thompson	33	81.7	74.2		
Lorne/Louise/Pembina	118	81.7	57.9		
Winkler	291	68.8	81.1		
Altona	138	67.0	71.5		
Morden	138	63.0	70.8		
Stanley	64	55.2	83.5		
<b>Zone 1</b>	<b>605</b>	<b>76.0</b>	<b>H</b>	<b>79.8</b>	<b>H</b>
Seven Regions	117	113.5	H	115.6	H
North Norfolk	68	84.5		58.4	
Rural Portage	118	76.7		94.2	
City of Portage	206	66.4		69.9	
Cartier/SFX	96	64.0		65.1	

## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning that the gap between the districts with the lowest and highest birth rates reduced.

SH-SS Geographic Disparity Ratio		
	T1	3.1x
	T2	2.3x
	Change	-0.8 ↓

## A CLOSER LOOK...

Many regional residents give birth within the region – and this number is increasing. For instance, there were 1,791 births in Southern Health-Santé Sud facilities in 2016-2017, compared to 1,846 in 2017-2018.

These in-facility numbers, however, do not include the home births attended by midwives within the region. Midwives have been practicing in the region since 2000 and care for low-risk pregnancies, respecting and supporting each woman’s right to make choices about her care, caregiver and place of birth. Midwives give consideration to priority populations for a segment of the clientele, including but not limited to, Indigenous people, newcomers, single parents, teens and individuals that are underserved, to name a few. Over time, the total priority population numbers within midwifery caseload has increased. Evidence has shown that midwifery care increases health equity.<sup>iii</sup>

Since 2014, the number of midwives who work in Southern Health-Santé Sud has increased and as of Fall 2019 all positions are filled with 12.4 Equivalent Full Time positions. There are two geographical teams located in Winkler and Steinbach, serving the areas west and east of the region, respectively. On average from 2016 to 2018, midwives in the region attended 79 home births and 254 hospital births per year. The total annual numbers were:

	Home Births	Hospital Births
2016	68	225
2017	87	298
2018	81	241



## Internal Migrant Mobility

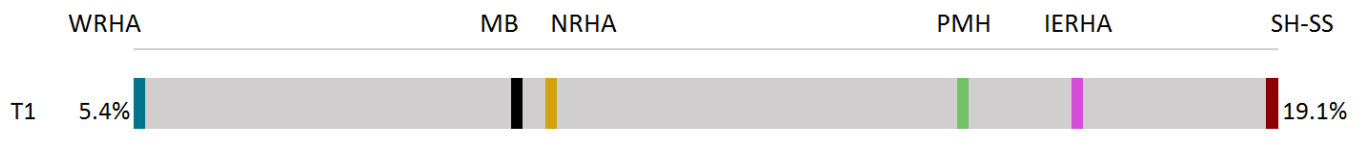
### Definition

The percentage of the population that is currently living in a different city, town, township, village or Indian Reserve within Canada compared to five years earlier.

### Provincial Key Findings

- ▶ **Figure 5** shows that the provincial 5-year mobility was 10.1%.
- ▶ The percentage of internal mobility was the highest in Southern Health-Santé Sud and the lowest in Winnipeg RHA.

Figure 5. Internal Migrant Mobility by RHA, 2016 (T1)



	WRHA	MB	NRHA	PMH	IERHA	SH-SS
T1 COUNT	36,160	117,145	6,625	22,735	19,435	32,190
T1 RATE	5.4%	10.1%	10.4%	15.4%	16.8%	19.1%

Statistics Canada Census 2016



## Regional Key Findings

- ▶ **Table 2** shows a total of 32,190 residents, almost 1 in 5, that moved to a different city, town, township, village, or Indian Reserve.
- ▶ The region had the highest percentage of internal migrant mobility in the province, with almost double the Manitoba percentage; however, differences were not tested statistically.
- ▶ There was a 9% difference between the lowest percentage in Zone 1 and the highest in Zone 4.
- ▶ Geographic disparity calculations showed that the percentage in the highest district of Niverville/Ritchot was 3.1 times higher than the lowest district of Seven Regions.

**Table 2. Internal Migrant Mobility in Southern Health-Santé Sud, 2016**

	Count	Percentage		Count	Percentage
<b>Manitoba</b>	<b>117,145</b>	<b>10%</b>	<b>SH-SS</b>	<b>32,190</b>	<b>19%</b>
<b>Zone 4</b>	<b>14,985</b>	<b>23%</b>	<b>Zone 2</b>	<b>4,900</b>	<b>19%</b>
Niverville/Ritchot	2,875	28%	St. Pierre/De Salaberry	780	20%
Ste. Anne/La Broquerie	3,120	26%	Macdonald	1,400	22%
Taché	2,630	25%	Carman	925	19%
Hanover	2,915	21%	Morris	840	19%
Rural East	790	20%	Red River South	645	17%
Steinbach	2,655	19%	Grey	310	14%
<b>Zone 3</b>	<b>7,595</b>	<b>17%</b>	<b>Zone 1</b>	<b>4,705</b>	<b>14%</b>
Roland/Thompson	490	24%	Cartier/SFX	1,225	20%
Morden	1,425	18%	City of Portage	1,715	14%
Altona	1,565	18%	Rural Portage	880	13%
Winkler	1,855	17%	North Norfolk	425	13%
Stanley	1,285	16%	Seven Regions	460	9%
Lorne/Louise/Pembina	975	15%			

Statistics Canada Census 2016

## Population Density

### Definition

The number of people per square kilometer based on the population divided by the total land area for a one-year time period.

### Provincial Key Findings

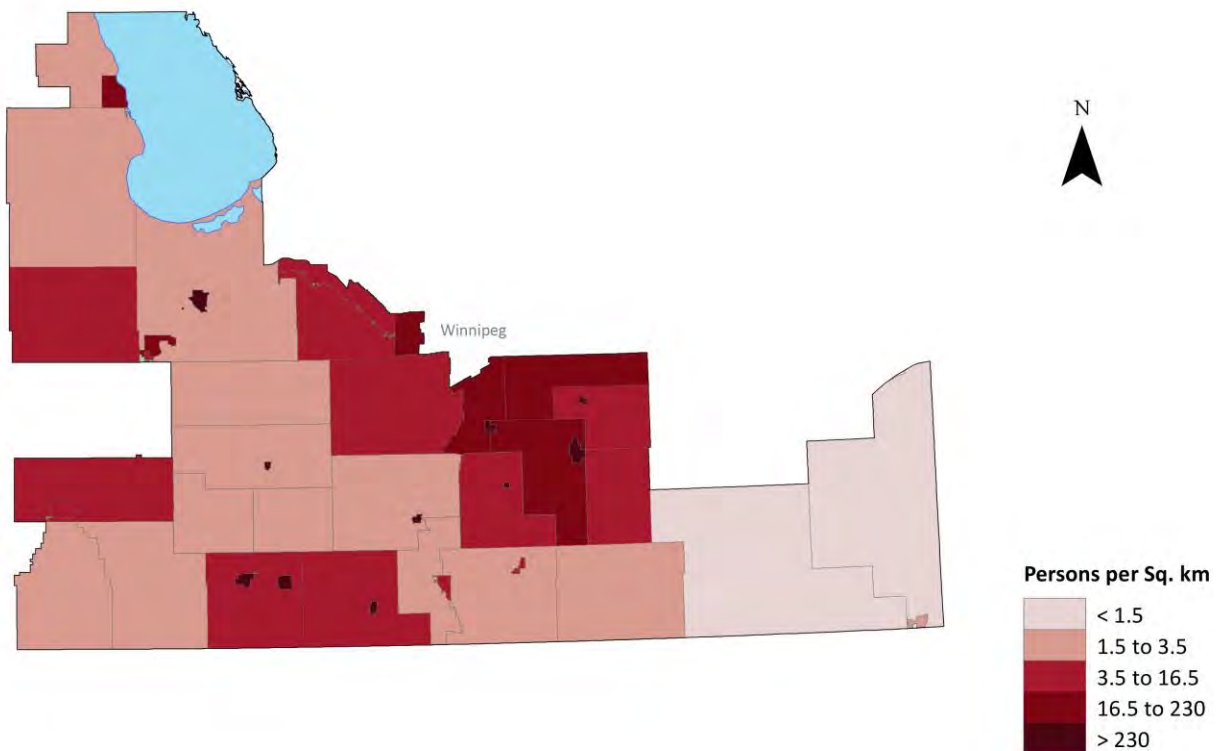
- ▶ The Manitoba population density was 2.3 residents per square kilometer.<sup>iv</sup>

### Regional Key Findings

- ▶ Population density within the region was 7.1 residents per square kilometer, which increased slightly from the previous rate of 6.5 residents; although not tested statistically.<sup>v</sup>
- ▶ The region had the highest population density among rural health regions.
- ▶ **Figure 6** shows that there was a greater population density in the municipalities surrounding Winnipeg and around the four cities within the region.

**Figure 6. Population Density in Southern Health-Santé Sud, 2018**

Population per square km



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## Population Change Over Time

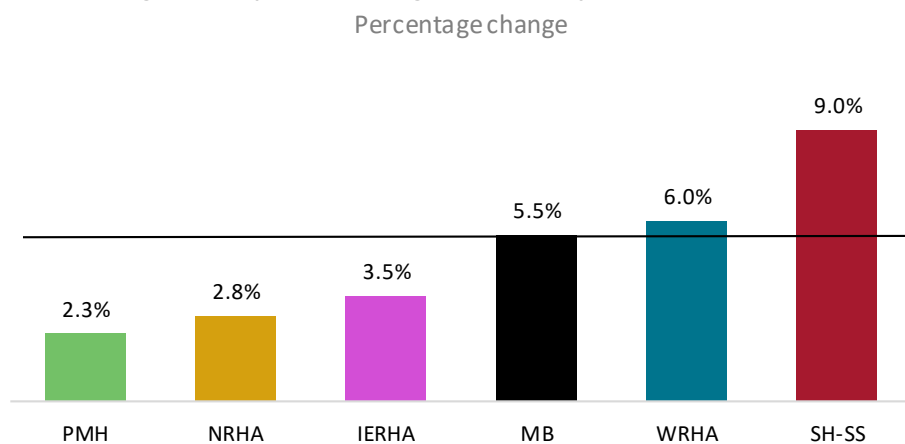
### Definition

The change in the number of people who live in a defined area over a five-year time period.

### Provincial/Regional Key Findings

- ▶ **Figure 7** shows that the population increased by 5.5% in Manitoba in the past five years.
- ▶ In Southern Health-Santé Sud, the population increased by 9% over a five-year period, representing the largest percentage of population growth in the province.
- ▶ Although Southern Health-Santé Sud was the fastest growing region, **Table 3** shows that Winnipeg RHA contributed to the majority (61.8%) of growth in the province.

**Figure 7. Population Change Over Time by RHA, 2013 to 2018**



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**Table 3. Population Change over Time by RHA, 2013 and 2018**

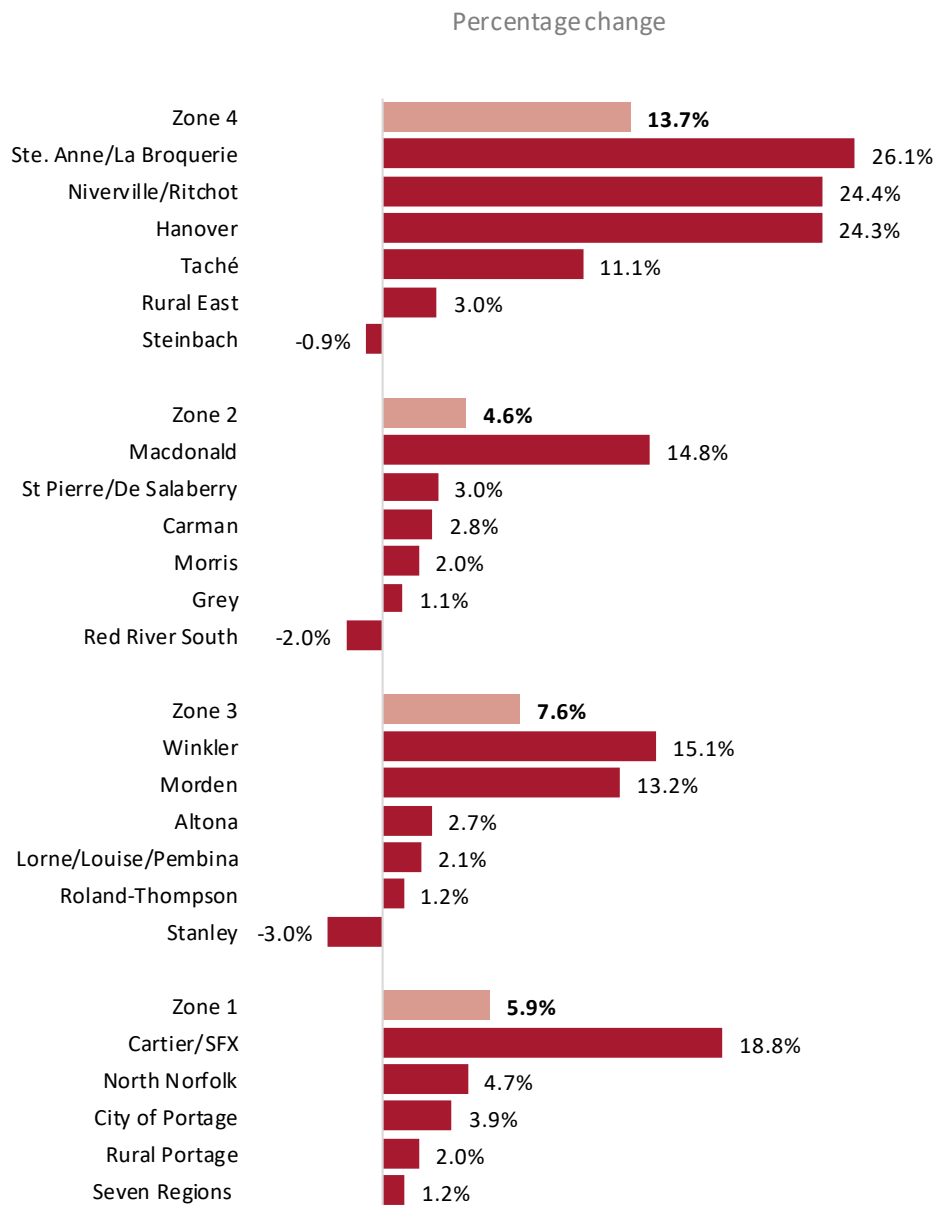
Health Region	Population 2013	Population 2018	Population Change	Contribution to Manitoba Growth
NRHA	74,731	76,847	2,116	3.0%
PMH	167,121	170,899	3,778	5.3%
IERHA	125,845	130,259	4,414	6.2%
SH-SS	187,384	204,274	16,890	23.7%
WHRA	734,187	778,239	44,052	61.8%
Manitoba	1,289,268	1,360,518	71,250	100.0%

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## Zone and District Level

- Figure 8 shows that the population increased in all zones over time with the largest increase in Zone 4.
- The population increased in the majority of districts over time with the exception of Steinbach, Red River South, and Stanley.
- The largest increases were noted in the districts surrounding Winnipeg and the cities of Morden and Winkler.

**Figure 8. Population Change Over Time in Southern Health-Santé Sud, 2013 to 2018**



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## Population Projections

### Definition

An estimate of population growth expected by 2030, based on medium forecasts of birth, death and migration rates.

### Provincial/Regional Key Findings

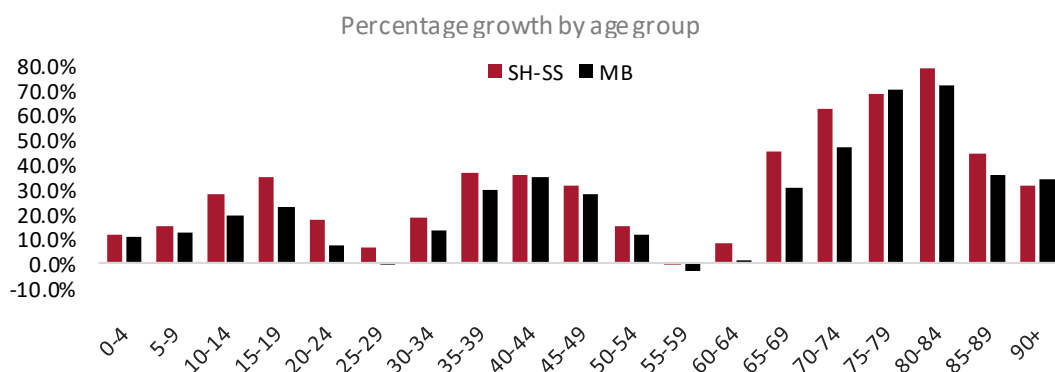
- ▶ **Table 4** shows that by 2030, the Southern Health-Santé Sud population is projected to grow to over 250,000 - an increase of 24.6%, or an estimated 50,624 additional residents.
- ▶ The population numbers below for 2018 are different than what was presented earlier because the projections were calculated in 2017.
- ▶ The region has the highest projected percentage growth in Manitoba; however, Winnipeg RHA is expecting the highest volume of residents.
- ▶ **Figure 9** shows that the projected population growth in the region is higher than in Manitoba for the majority of age groups. In the region, the greatest growth is expected among the population aged 65 to 84 years.

**Table 4. Population Projections by RHA, 2018 to 2030**

Health Regions	Population 2018	Population 2024	Population 2030	Projected Population Change	% Projected Population Growth
NRHA	77,903	75,981	86,870	8,967	11.5%
PMH	173,186	182,900	191,915	18,729	10.8%
IERHA	131,081	139,560	146,791	15,710	12.0%
WHRA	797,818	883,379	966,760	168,942	21.2%
SH-SS	206,110	231,419	256,734	50,624	24.6%
Manitoba	1,386,098	1,519,751	1,649,070	262,972	19.0%

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**Figure 9. Population Projections in Southern Health-Santé Sud and Manitoba, 2018-2030**



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## Indigenous Population

### Definition

An estimate of the Indigenous population based on self-reported “Aboriginal identity,” which includes persons who are First Nations (North American Indian), Métis or Inuk (Inuit), Registered or Treaty Indians (that is, registered under the Indian Act of Canada), and/or those who have membership in a First Nation or Indian band.

### Provincial Key Findings

- ▶ **Figure 10** shows that overall in Manitoba, 18.0% of the population identified as Indigenous.
- ▶ Percentages varied across the province with the lowest percentage in Winnipeg RHA and the highest in Northern Health Region.

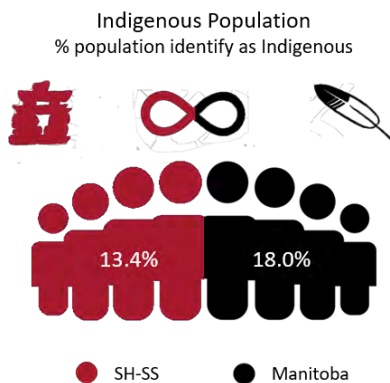
**Figure 10. Indigenous Population by RHA, 2016 (T1)**

Percentage of the population



	WRHA	SH-SS	PMH	MB	IERHA	NRHA
T1 COUNT	86,000	24,590	27,580	223,310	33,520	51,620
T1 RATE	12.2%	13.4%	17.5%	18.0%	27.3%	72.6%

Statistics Canada Census 2016



## Regional Key Findings

### SH-SS Level

- ▶ **Table 5** shows that a total of 24,590 identified as Indigenous in the region, representing approximately 13.4% of the population. This was lower than the Manitoba average; however, the difference was not tested statistically.
- ▶ Of the residents that identified as Indigenous in the region, a bit more than half identified as Métis.

### Zone Level

- ▶ The proportion of Indigenous peoples varied dramatically across zones with the lowest in Zone 3 and the highest in Zone 1.
- ▶ Of the residents that identified as Indigenous in each zone, the proportion of Métis residents was greater in Zones 2 and 4 while the proportion of First Nations residents was greater in Zones 1 and 3.

### District Level

- ▶ The proportion of Indigenous peoples varied dramatically across districts, with the lowest in Stanley and the highest in Seven Regions.
- ▶ The majority of districts with larger proportions of Indigenous peoples were located in the northern and eastern areas of the region.
- ▶ In the majority of districts, of the residents that identified as Indigenous, a greater proportion identified as Métis with the exception of the following districts with a greater proportion of First Nations residents: Red River South, Lorne/Louise/Pembina, Morden, Seven Regions, Rural Portage, and city of Portage. The majority of these districts include the seven First Nations communities located in the region.

**Table 5. Indigenous Population in Southern Health-Santé Sud, 2016**

Percentage who identified as Indigenous of the total population and percentage who identified as First Nation (FN), Métis, or Inuit of the Indigenous population

	Indigenous		FN	Métis	Inuit
	Count	%	%	%	%
<b>Manitoba</b>	<b>223,310</b>	<b>18.0</b>	<b>58.4</b>	<b>40.0</b>	<b>0.3</b>

	Indigenous		FN	Métis	Inuit
	Count	%	%	%	%
<b>SH-SS</b>	<b>24,590</b>	<b>13.4</b>	<b>43.4</b>	<b>55.0</b>	<b>0.5</b>

<b>Zone 4</b>					
	<b>8,490</b>	<b>11.9</b>	<b>19.2</b>	<b>78.9</b>	<b>0.5</b>
Ste. Anne/ La Broquerie	2,270	17.3	11.2	85.5	0.9
Rural East	695	16.9	28.1	71.2	0.0
Taché	1,875	16.2	13.6	84.8	0.5
Niverville/ Ritchot	1,600	14.2	15.0	84.4	0.6
Steinbach	1,055	6.8	41.7	56.4	0.0
Hanover	995	6.4	24.6	73.4	0.0

<b>Zone 2</b>					
	<b>3,650</b>	<b>13.1</b>	<b>32.5</b>	<b>65.5</b>	<b>1.1</b>
St. Pierre/ De Salaberry	1,145	27.2	6.6	93.0	0.0
Red River South	1,130	27.2	70.4	26.1	2.7
Morris	460	9.7	39.1	60.9	0.0
Macdonald	530	7.6	12.3	85.8	1.9
Grey	155	6.3	16.1	83.9	0.0
Carman	230	4.3	19.6	71.7	0.0

<b>Zone 3</b>					
	<b>1,725</b>	<b>3.5</b>	<b>54.5</b>	<b>44.1</b>	<b>0.0</b>
Lorne/ Louise/ Pembina	690	10.0	67.4	31.9	0.0
Morden	335	3.9	50.7	49.3	0.0
Roland/ Thompson	65	2.9	30.8	69.2	0.0
Winkler	345	2.8	46.4	52.2	0.0
Altona	160	1.6	46.9	53.1	0.0
Stanley	130	1.4	38.5	50.0	0.0

<b>Zone 1</b>					
	<b>10,720</b>	<b>30.3</b>	<b>64.5</b>	<b>34.2</b>	<b>0.2</b>
Seven Regions	3,155	57.8	94.3	5.5	0.0
Rural Portage	2,620	36.6	64.3	34.0	0.6
City of Portage	3,990	31.3	52.9	45.9	0.0
Cartier/SFX	775	11.8	9.0	87.1	1.3
North Norfolk	180	5.3	41.7	52.8	0.0

Statistics Canada Census 2016

## A CLOSER LOOK...INDIGENOUS POPULATION

"At the time of European contact, the communities of Indigenous people were thriving and in good state of health. Over centuries and through multiple practices of colonization, the state of good health for Indigenous peoples of Canada has gradually eroded and ultimately degenerated into the state of relative ill health – this characterizes not all, but many Indigenous people and communities today."<sup>vi</sup>

Addressing one of the 94 Recommendations or Calls to Action of the Truth and Reconciliation Commission's (TRC) report (# 18), we acknowledge that "the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools..."<sup>vii</sup> We acknowledge that the health and social inequities borne by Indigenous (i.e., First Nation, Métis, and Inuit) peoples in Canada, in Manitoba, and within our region are fundamentally rooted in colonialism and historical and present oppression, systemic racism, and discrimination. The inequities Indigenous people experience are part of a complicated history of trauma and relations between Indigenous people and the state.

An important step toward eliminating inequities, bettering the health of Indigenous peoples, responding to the TRC's calls to action, and redressing the harms done is building strong and trusting partnerships with Indigenous leaders and communities at all levels to bring about sustainable changes. Southern Health-Santé Sud is always working to build trusting relationships with Indigenous communities. Here are a few examples of partnerships and actions with Indigenous peoples in the region.

### HISTORICAL HEALTH PARTNERSHIP AGREEMENT

In 2016, the region was proud to sign the first Indigenous Health Partnership Agreement in Manitoba with First Nations, Métis, and Inuit people and communities in our region. We have incorporated traditional healing practices, such as smudging ceremonies and sharing circles at our facilities and developed a cultural resource toolkit, which accreditation Canada recognizes as a leading practice.

### RELATIONSHIP FRAMEWORK

Dakota Ojibway Health Services and First Nation communities, First Nations & Inuit Health Branch and Southern Health-Santé Sud are working on the development of a Relationship Framework to improve health outcomes and health care experiences of First Nations people through an integrated approach.

### JORDAN'S PRINCIPLE

Jordan's Principle is a Child-First Initiative named in memory of Jordan River Anderson, a First Nations child from Norway House Cree Nation in Manitoba. Jordan was born in 1999 with complex medical needs that could not be treated in his home community. Jordan lived for more than two years in a hospital in Winnipeg before medical staff agreed he could leave the hospital to be cared for in a family home. Because of jurisdictional disputes within and between the federal and provincial governments over who would pay costs for in-home care and support, Jordan was not able to return to this home and remained in hospital unnecessarily until his death in 2005. Jordan was five years old and had never spent a day in his family home. Under the Jordan's Principle Child-First Initiative, together with First Nation communities, rehab services in Southern Health-Santé Sud provide occupational therapy, speech pathology, physiotherapy and audiology services for children in all seven of the First Nation communities within the region.

## A CLOSER LOOK...INDIGENOUS POPULATION

To address the recommendations from TRC's report (Call to Action #23)<sup>viii</sup> and the Brian Sinclair Inquest Report (Recommendation #63),<sup>ix</sup> Southern Health-Santé Sud, in partnership with Indigenous communities, is committed to increasing the representation of Indigenous peoples within all levels of our workforce and providing cultural awareness and safety training for all health care workers. The goal is to create a culturally safe and responsive organization and minimizing the gap in health outcomes between Indigenous and non-Indigenous people.

### WORKFORCE PARTNERSHIP AGREEMENT

The Indigenous Workforce Partnership Agreement was signed in June 2010 with Indigenous, non-Indigenous organizations, local provincial and federal governments, education/training institutions and unions. The agreement aims to promote and develop initiatives undertaken by the region that encourage and support the development of an Indigenous representative workforce.

### INDIGENOUS SUPPORT WORKERS

Indigenous Support Workers participated in approximately 6,000 client/family/health provider/physician interactions per fiscal year in Southern Health-Santé Sud.

### CULTURAL AWARENESS & SAFETY TRAINING

Cultural awareness and safety training opportunities are available to staff within Southern Health-Santé Sud, including the Manitoba Indigenous Cultural Safety Training and Walk a Mile in My Moccasins.

Walk a Mile in My Moccasins is an experiential workshop that allows participants to experience, feel, and imagine what it feels like to be an Indigenous person in today's society. To date, 700 people have participated in the workshop, which is offered throughout Southern Health-Santé Sud in partnership with First Nation communities; where people walk the healing journey together. Dan Highway, one of the facilitators is a survivor of the residential school system. Participants love hearing first-hand his lived experience. He shares his experience in the schools; how it destroyed his family bond and his life dreams; the challenges he faced when he was no longer in school; and the resources and tools he used to start his healing journey.

### INTERNSHIP PROGRAMS

We are proud of the national award-winning internship program that helps Indigenous students explore careers in health care. Offered in the region since 2009, about 80% of the 250 students who have attended the program are still in school or have graduated from Grade 12.

Modeled after the high school internship program, the Indigenous Adult Health Internship Program was created in partnership with Indigenous communities and Southern Health-Santé Sud in 2015. The goal of the program is to provide adults 18 years and older, who dropped out of school before completing Grade 12 and are unemployed or under-employed, with support and guidance to either return to further their education, enroll in health care training opportunities or obtain employment within health care. Since the first program, there have been 53 candidates, 23% of which were hired by our region, while others have been hired within their communities and other organizations.



## Visible Minority Population

### Definition

An estimate of the visible minority population, defined as persons, other than Indigenous people, who are non-Caucasian in race or non-white in colour.

### Provincial Key Findings

- ▶ **Figure 11** shows that in Manitoba, 17.5% of the population identified as visible minority.
- ▶ Percentages varied dramatically between regions with the lowest in Interlake-Eastern RHA and the highest in Winnipeg RHA.

**Figure 11. Visible Minority Population by RHA**  
Percentage of the population



	IERHA	NRHA	SH-SS	PMH	MB	WRHA
T1 COUNT	2,185	2,305	6,650	11,760	216,855	193,955
T1 RATE	1.8%	3.2%	3.6%	7.4%	17.5%	27.5%

Statistics Canada Census 2016

## Regional Key Findings

- ▶ **Table 6** shows that in the region, a total of 6,650 residents identified as visible minority, representing almost 4% of the population.
- ▶ The proportion of visible minority population was relatively similar across zones.
- ▶ There was a difference of about 11% between the lowest percentage in Stanley and the highest in Steinbach.

**Table 6. Visible Minority Population in Southern Health-Santé Sud, 2016**

Percentage of the population

	Count	Percentage		Count	Percentage
<b>Manitoba</b>	<b>216,855</b>	<b>17%</b>	<b>SH-SS</b>	<b>6,650</b>	<b>3.6%</b>
<b>Zone 4</b>	<b>3,295</b>	<b>4.6%</b>	<b>Zone 2</b>	<b>740</b>	<b>2.7%</b>
Steinbach	1,815	11.7%	Grey	90	3.7%
Niverville/Ritchot	635	5.7%	Morris	160	3.4%
Rural East	145	3.5%	Red River South	115	2.8%
Taché	285	2.5%	Macdonald	180	2.6%
Hanover	230	1.5%	St. Pierre/De Salaberry	95	2.3%
Ste. Anne/La Broquerie	185	1.4%	Carman	100	1.9%
<b>Zone 3</b>	<b>1,535</b>	<b>3.1%</b>	<b>Zone 1</b>	<b>1,095</b>	<b>3.1%</b>
Winkler	665	5.4%	City of Portage	650	5.1%
Lorne/Louise/Pembina	245	3.6%	Cartier/SFX	180	2.8%
Morden	260	3.1%	Seven Regions	125	2.3%
Altona	295	3.0%	Rural Portage	115	1.6%
Roland/Thompson	20	0.9%	North Norfolk	25	0.7%
Stanley	50	0.6%			

Statistics Canada Census 2016



## Francophone Population

### Definition

Knowledge of French, as an official language, measured as the ability to conduct a conversation in French (combined French only and both French and English).

### Regional Key Findings

- Table 7 shows that in Southern Health-Santé Sud, a total of 20,745 residents knew French well enough to conduct a conversation.
- The French speaking residents in the region represented 11% of the population; higher than the Manitoba proportion and the highest across health regions.
- Percentages varied across zones with the lowest in Zone 3 and the highest in Zone 2.
- Percentages varied dramatically across districts with the lowest in Seven Regions and the highest in St. Pierre/De Salaberry.

**Table 7. Knowledge of French as an Official Languages in Southern Health-Santé Sud, 2016**  
Percentage of the population

	Count	Percentage		Count	Percentage
<b>Manitoba</b>	<b>108,555</b>	<b>8.7%</b>	<b>SH-SS</b>	<b>20,745</b>	<b>11.3%</b>
<b>Zone 4</b>	<b>10,690</b>	<b>15.0%</b>	<b>Zone 2</b>	<b>5,185</b>	<b>18.6%</b>
Ste. Anne/La Broquerie	3,325	25.4%	St. Pierre/De Salaberry	2,235	53.2%
Taché	2,920	25.3%	Grey	715	29.1%
Niverville/Ritchot	2,680	23.8%	Red River South	890	21.4%
Rural East	360	8.8%	Macdonald	705	10.2%
Hanover	725	4.6%	Morris	385	8.1%
Steinbach	680	4.4%	Carman	255	4.8%
<b>Zone 3</b>	<b>2,555</b>	<b>5.2%</b>	<b>Zone 1</b>	<b>2,320</b>	<b>6.6%</b>
Lorne/Louise/Pembina	1,370	19.9%	Cartier/SFX	990	15.1%
Morden	580	6.8%	City of Portage	780	6.1%
Roland/Thompson	70	3.2%	Rural Portage	420	5.9%
Altona	225	2.3%	North Norfolk	95	2.8%
Winkler	180	1.4%	Seven Regions	35	0.6%
Stanley	130	1.4%			

Statistics Canada Census 2016

## A CLOSER LOOK...Francophone Population

### WHY A FOCUS ON THE FRANCOPHONE POPULATION?

In Canada, linguistic duality is one of the fundamental dimensions of history. As a multicultural society, Canada's two official languages, English and French, have retained their special status as languages used in the public domain. Southern Health-Santé Sud respects the linguistic duality of Canada and undertakes to provide health care services in French to its Francophone population.

Southern Health-Santé Sud has the highest percentage of Francophones in rural Manitoba.

Access to health services in one's own language "means far more than simply respect for that person's culture: it is, at times, indispensable for improving health and for people's taking ownership of their own health."<sup>x</sup>

Miscommunication in the health and social service sector can be life-threatening. Official language communities encountering communication challenges are more likely to experience adverse events, longer hospital stays and decreased satisfaction.<sup>xix,xxiii,xxiv</sup> Further, language barriers adversely affect a patient's ability to communicate with their care team. We would have liked to present you with more data on the health of the Francophone population. Currently, the methods and processes are not in place in the databases to collect these data.

### DEFINING FRANCOPHONES: AN INCLUSIVE APPROACH

Knowledge of how many Francophones live in the region is crucial to understanding the need for French language services. There are many ways to capture the number of Francophones using Census data. In 2019, the provincial Managerial Round Table (Santé en français) recommended that designated bilingual/Francophone health service delivery organizations in Manitoba should identify their Francophone population by selecting data derived from the Census question "Knowledge of official languages," and collate responses from the "English and French" and "French only" fields. It is felt that this figure best represents the overall picture of Francophones.

### POURQUOI METTRE L'ACCENT SUR LA POPULATION FRANCOPHONE?

La dualité linguistique est fondamentalement indissociable de l'histoire du Canada. Les deux langues officielles de la société multiculturelle qu'est le Canada, le français et l'anglais, ont conservé leur statut particulier de langues utilisées dans le domaine public. Southern Health-Santé Sud respecte la dualité linguistique du Canada et s'applique à offrir des services de santé en français à sa population francophone.

Au Manitoba, c'est dans la région des servies par Southern Health-Santé Sud que l'on retrouve la proportion la plus élevée de francophones en milieu rural.

« L'accès aux services de santé dans sa langue a des retombées positives qui vont bien au-delà du simple respect pour la culture de l'utilisateur. Il s'agit d'un élément essentiel à l'amélioration de l'état individuel de santé et à l'appropriation de la santé par une population<sup>xx</sup>. » Un problème de communication dans le secteur de la santé et des services sociaux peut mettre la vie en danger. Les minorités linguistiques officielles qui éprouvent des difficultés de communication sont plus susceptibles de subir des événements indésirables, des hospitalisations prolongées et une baisse de satisfaction.<sup>xvi,xvii,xviii,xix</sup> En outre, les barrières linguistiques nuisent à la capacité d'un patient de communiquer avec son équipe soignante<sup>xx</sup>. Nous aurions souhaité vous présenter un plus grand nombre de données touchant la santé des francophones de notre région. Présentement, les méthodes et processus ne sont pas en place dans les banques de données pour obtenir ces données.

### DÉFINIR LES FRANCOPHONES : UNE DÉMARCHÉ INCLUSIVE

Il est indispensable de connaître le nombre de francophones de la région pour comprendre le besoin de services en français. Il y a bien des façons de déduire le nombre de francophones à partir des données du recensement. En 2019, la Table ronde provinciale sur la gestion (Santé en français) recommandait que les organismes désignés bilingues ou francophones pour la prestation de services de santé au Manitoba décrivent leur population francophone à partir des données découlantes de la question du recensement intitulée « Connaissance des langues officielles », en regroupant les cases cochées correspondant à « français et anglais » et « français seulement ». On a l'impression que c'est ce résultat qui représente le mieux le « tableau d'ensemble » des francophones.

## A CLOSER LOOK...Francophone Population

### WHY NOT LANGUAGE SPOKEN MOST OFTEN AT HOME?

To illustrate this, consider Janique's story: Janique's mother tongue is French. Growing up, she spoke French at home, she went to school in French and even pursued some of her post-secondary education in French. Today, Janique lives with her partner, who does not speak French. Therefore, the language they speak most often at home is English. However, when Janique seeks out healthcare services, she requests services in French or bilingual French and English. If we were to use the question "language spoken most often at home," we risk missing people like Janique and underestimate the need for Francophone services in our region.

### WHY NOT MATERNAL LANGUAGE?

To illustrate this, consider Chloe's story: Chloe's mother tongue is English. Growing up, she was raised in an English household but attended a French immersion school. Since then, Chloe has been a champion in the Francophone community. She has pursued her post-secondary education in French, now teaches in a French immersion school and volunteers in Francophone organizations in the community. If we were to use the question "mother tongue," we risk missing people like Chloe and underestimate the need for Francophone services in our region.

As the Francophone community continues to diversify, it is important to take on an inclusive approach in accordance with the Francophone Community Enhancement and Support Act (CCSM F157). The Act was adopted in 2016 and refers to persons in Manitoba whose mother tongue is French and those persons in Manitoba whose mother tongue is not French but who have a special affinity for the French language and who use it on a regular basis in their daily life. The Act was intentional in this choice of words to provide a more inclusive approach in identifying the Francophone community.

### POURQUOI NE PAS SE SERVIR DE LA QUESTION SUR LA LANGUE LA PLUS SOUVENT UTILISÉE À DOMICILE?

Pour en illustrer l'explication, attardons-nous à la situation de Janique : Janique est de langue maternelle française. Elle a grandi en parlant français chez elle. Elle a fait ses études en français et a même poursuivi certaines de ses études postsecondaires en français. Aujourd'hui, Janique vit avec un conjoint qui ne parle pas français. Par conséquent c'est en anglais qu'elle s'exprime le plus souvent à domicile. Par contre, lorsque Janique a besoin de services de santé, elle demande des services en français ou bilingues (français et anglais). Si nous devons utiliser les réponses à la question sur la langue la plus souvent utilisée à domicile, nous risquerions de ne pas compter des personnes comme Janique, et de sous-estimer le besoin de services en français dans notre région.

### POURQUOI NE PAS SE SERVIR DE LA QUESTION SUR LA LANGUE MATERNELLE?

Pour en illustrer l'explication, attardons-nous à la situation de Chloe : La langue maternelle de Chloe est l'anglais. Elle a grandi dans un foyer anglais, mais a fréquenté une école d'immersion française. Depuis, Chloe s'identifie complètement à la communauté francophone. Elle a poursuivi ses études postsecondaires en français, enseigne maintenant dans une école d'immersion française et fait du bénévolat dans des organismes francophones de la communauté. Si nous devons utiliser les réponses à la question sur la langue maternelle, nous risquerions de ne pas compter des personnes comme Chloe, et de sous-estimer le besoin de services en français dans notre région.

Étant donné que la communauté francophone continue de se diversifier, il importe d'adopter une démarche inclusive. En vertu de la Loi sur l'appui à l'épanouissement de la francophonie manitobaine (C.P.L.M. c. F157), adoptée en 2016, le terme « francophonie manitobaine » s'entend de la « communauté au sein de la population manitobaine regroupant les personnes de langue maternelle française et les personnes qui possèdent une affinité spéciale avec le français et s'en servent couramment dans la vie quotidienne même s'il ne s'agit pas de leur langue maternelle ». Cette formulation de la Loi est intentionnelle, afin que la démarche d'identification à la communauté francophone soit plus inclusive.

*“Language barriers have been demonstrated to have adverse effects on access to health care, quality of care, rights of patients, patient and provider satisfaction, and most importantly, on patient health outcomes.” - Dr. Sarah Bowen*

*Plusieurs études menées au Canada et ailleurs dans le monde ont démontré que les barrières linguistiques ont des conséquences négatives sur l'accès aux services de santé, sur la qualité des soins, sur le respect des droits des personnes, sur la satisfaction des usagers et des intervenants, et surtout, sur les résultats des traitements - Dr. Sarah Bowen*

*“Wanting to live in French is not due to a lack of language ability: even though I can function very well in English, I live in French, I think in French, I laugh in French, I cry in French, I get angry in French; I'm Francophone and I value that.” - États généraux de la francophonie manitobaine.*

*« Et ce n'est pas par manque de compétence linguistique qu'on tient à vivre en français : Même si je peux fonctionner en anglais très bien, je vis en français, je pense en français, je ris en français, je pleure en français, je me fâche en français. Je suis francophone, j'y tiens. » – États généraux de la francophonie manitobaine 2015.*



## Non-Official Languages

### Definition

Non-official languages (i.e., other than English and French) spoken most often at home as a percentage of the population.

### Provincial/Regional Key Findings

- ▶ The population that spoke a non-official language most often at home was 11.5% in Manitoba and 11.7% in Southern Health-Santé Sud.
- ▶ In Manitoba, the top five non-official languages spoken most often at home were Tagalog (Pilipino, Filipino), German, Punjabi, Mandarin, and Cree.
- ▶ **Table 8** shows that, in Southern Health-Santé Sud, the top five non-official languages spoken most often at home were German, Russian, Tagalog, Ojibway, and Spanish.

**Table 8. Leading Non-Official Languages Spoken Most Often at Home in Southern Health-Santé Sud, 2016**  
Percentage of the population

Language	Count	Percentage
German	16,830	8.9%
Russian	1,495	0.8%
Tagalog (Pilipino, Filipino)	875	0.5%
Ojibway	525	0.3%
Spanish	385	0.2%

Statistics Canada Census 2016

## Immigrant Status in Private Households

### Definition

Immigrant status refers to whether the person is an immigrant or a non-permanent resident and applies to each member of a household.

### Provincial/Regional Key Findings

- ▶ **Table 9** shows there was a total of 25,705 immigrants in the region, representing 14% of the overall population. This is lower than the Manitoba average, but the highest among rural health regions.
- ▶ There were very few non-permanent residents in the region and percentages were similar across zones and districts.
- ▶ The percentages of immigrants varied across zones with the lowest in Zone 1 and the highest in Zone 3. Percentages of immigrants also varied dramatically across districts with the lowest in Rural Portage and the highest in Stanley.
- ▶ In the region, there were 4,600 recent immigrants – arriving between 2011 and 2016.<sup>xxi</sup>

**Table 9. Immigrant Status in Private Households in Southern Health-Santé Sud, 2016**

Percentage of the population

	Immigrants		Non-Permanent		Immigrants		Non-Permanent		
	Count	%	Count	%	Count	%	Count	%	
<b>Manitoba</b>	<b>225,005</b>	<b>19.2%</b>	<b>16,245</b>	<b>1.4%</b>	<b>SH-SS</b>	<b>25,705</b>	<b>14.0%</b>	<b>1,420</b>	<b>0.8%</b>
<b>Zone 4</b>	<b>11,195</b>	<b>15.7%</b>	<b>530</b>	<b>0.7%</b>	<b>Zone 2</b>	<b>2,190</b>	<b>7.9%</b>	<b>135</b>	<b>0.5%</b>
Hanover	3,440	22.0%	140	0.9%	Morris	550	11.6%	20	0.4%
Steinbach	3,185	20.5%	190	1.2%	Red River South	385	9.3%	25	0.6%
Ste. Anne/La Broquerie	2,080	15.9%	110	0.8%	Grey	225	9.1%	10	0.4%
Rural East	585	14.2%	45	1.1%	Carman	450	8.4%	20	0.4%
Taché	1,040	9.0%	25	0.2%	St. Pierre/De Salaberry	230	5.5%	50	1.2%
Niverville/Ritchot	865	7.7%	20	0.2%	Macdonald	350	5.0%	10	0.1%
<b>Zone 3</b>	<b>10,450</b>	<b>21.4%</b>	<b>555</b>	<b>1.1%</b>	<b>Zone 1</b>	<b>1,865</b>	<b>5.3%</b>	<b>195</b>	<b>0.6%</b>
Stanley	3,150	34.9%	55	0.6%	City of Portage	815	6.4%	145	1.1%
Winkler	3,445	27.7%	240	1.9%	North Norfolk	215	6.3%	0	0.0%
Altona	1,955	20.0%	50	0.5%	Cartier/SFX	385	5.9%	20	0.3%
Morden	1,335	15.7%	115	1.4%	Seven Regions	210	3.9%	10	0.2%
Roland/Thompson	195	8.8%	10	0.5%	Rural Portage	240	3.4%	20	0.3%
Lorne/Louise/Pembina	370	5.4%	85	1.2%					

Statistics Canada Census 2016

## Immigration by Place of Birth

### Definition

This indicator measures any person who has ever been a landed immigrant or permanent resident by place of birth.

### Provincial/Regional Key Findings

- ▶ **Figures 12 and 13** show that the leading places of birth among immigrants in Southern Health-Santé Sud and Manitoba differed. In the region, almost 80% of immigrants were born in the Americas and Europe. In the province, the top two places of birth were Asia and Europe.
- ▶ **Figure 14** shows that Europe and the Americas were the leading places of birth in all zones, except Zone 1, where Asia replaced the Americas.
- ▶ The majority of zones included Germany, Mexico, the Philippines, the United States, and United Kingdom as top countries.
- ▶ In the region, the top place of birth for recent immigrants, arriving between 2011 and 2016, was the Philippines.<sup>xxii</sup>

Figure 12. Immigration by Place of Birth in Southern Health-Santé Sud, 2016

**Top 5 Countries in SH-SS**

1. Mexico (5,495)
2. Germany (4,470)
3. Philippines (1,980)
4. Russian Federation (1,920)
5. United States (1,375)

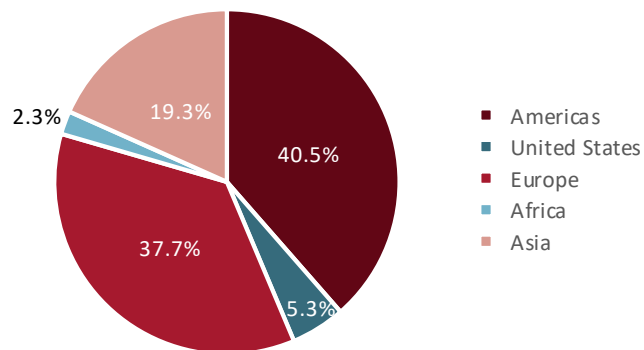


Figure 13. Immigration by Place of Birth In Manitoba, 2016

**Top 5 Countries in MB**

1. Philippines (61,755)
2. India (21,155)
3. United Kingdom (11,500)
4. Germany (10,300)
5. China (9,190)

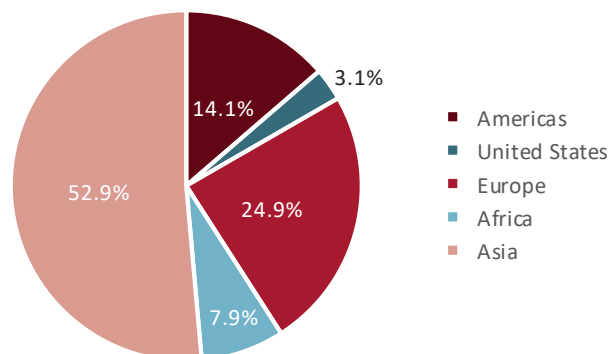
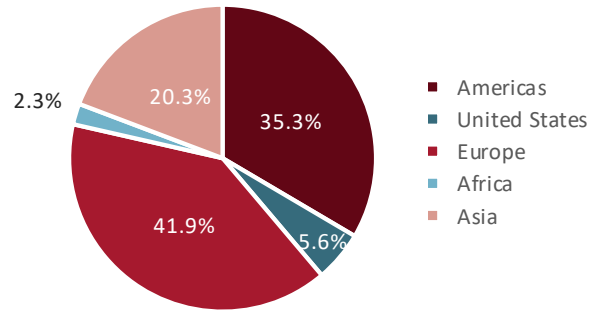


Figure 14. Immigration by Place of Birth in Southern Health-Santé Sud Zones, 2016

### Top 5 Countries in Zone 4

1. Germany (2,280)
2. Philippines (1,140)
3. Mexico (1,000)
4. Russian Federation (865)
5. United Kingdom (655)

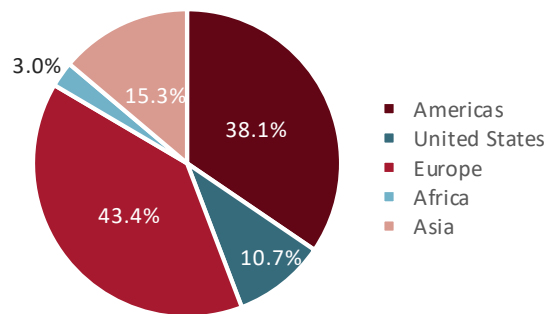
### Zone 4



### Top 5 Countries in Zone 2

1. Mexico (375)
2. United States (235)
3. Netherlands (230)
4. Germany (225)
5. United Kingdom (210)

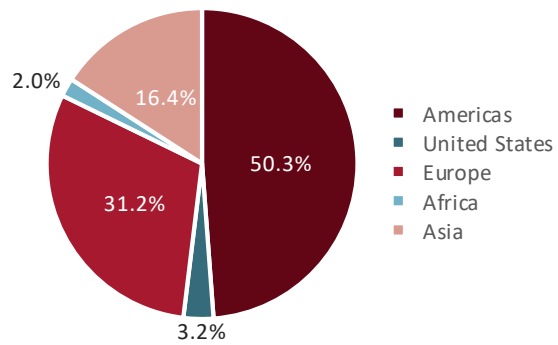
### Zone 2



### Top 5 Countries in Zone 3

1. Mexico (4,005)
2. Germany (1,775)
3. Russian Federation (990)
4. Philippines (360)
5. United States (335)

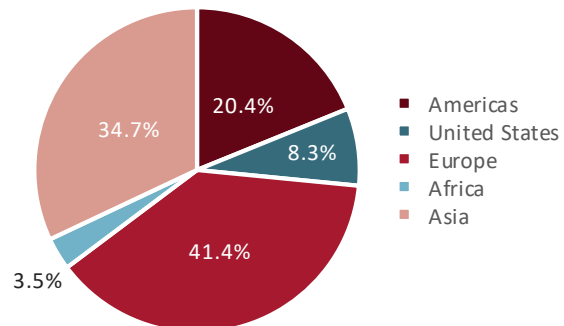
### Zone 3



### Top 5 Countries in Zone 1

1. Philippines (305)
2. United Kingdom (255)
3. Germany (195)
4. United States (155)
5. India (125)

### Zone 1



Statistics Canada Census 2016





### **A CLOSER LOOK...**

In 2016, Canada received a record number of Syrian refugees, one of its largest resettlement efforts since the 1970s. Manitoba embraced over 1,000 and Southern Health-Santé Sud welcomed a good number.

Indeed, while the region always saw itself as an important gateway from the U.S. international border, it also experienced an extraordinary event with an unusual number of refugees who were seeking asylum crossing the border.

## Lone Parent Families

### Definition

The percentage of census families composed of only one parent of any marital status (e.g., divorced, separated, widowed or never-married) living with at least one child in the same dwelling.

### Provincial Key Findings

- ▶ **Figure 15** shows that in Manitoba, 17% of families were led by a lone-parent.
- ▶ The highest percentage of lone-parent families was in Northern Health Region compared to the lowest in Southern Health-Santé Sud; however, differences were not tested significantly.

**Figure 15. Lone Parent Families by RHA, 2016 (T1)**



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	IERHA	PMH	MB	WRHA	NRHA
T1 COUNT	5,590	5,320	6,715	58,865	35,440	5,800
T1 RATE	10.9%	14.3%	14.8%	17.0%	18.3%	31.8%

Statistics Canada Census 2016



### Census Family

All members of a particular census family live in the same dwelling. A couple may be of opposite or same sex. Children may be children by birth, marriage, common-law union or adoption regardless of their age or marital status as long as they live in the dwelling and do not have their own married spouse, common-law partner or child living in the dwelling. Grandchildren living with their grandparent(s) but with no parents present also constitute a census family.

## Regional Key Findings

### SH-SS Level

- Table 10 shows that in the region, there were a total of 5,590 lone-parent families, representing the lowest percentage in the province; however, differences were not tested statistically.
- The majority of lone-parent families in the region were led by women.

### Zone Level

- The percentage in Zone 1 was about double compared to the other zones.
- The majority of lone-parent families were led by women in all zones.

### District Level

- The percentage of lone-parent families varied dramatically across districts with the lowest in Stanley and the highest in the city of Portage.
- The majority of lone-parent families were led by women in all districts. Sex distribution did, however, vary across districts with a difference of about 35% between the lowest percentage of women in the district of St. Pierre/De Salaberry and the highest in Carman.
- Geographic disparity calculations showed that the highest district of city of Portage was 5.9 times higher than the lowest district of Stanley.

**Table 10. Lone Parent Families in Southern Health-Santé Sud, 2016**

Percentage of total families

	Count	Percentage		Count	Percentage
<b>Manitoba</b>	<b>58,865</b>	<b>17.0%</b>	<b>SH-SS</b>	<b>5,590</b>	<b>10.9%</b>
<b>Zone 4</b>	<b>1,880</b>	<b>9.5%</b>	<b>Zone 2</b>	<b>800</b>	<b>9.9%</b>
Steinbach	510	11.8%	Red River South	180	15.2%
Taché	330	10.0%	Grey	70	10.1%
Rural East	120	9.6%	Morris	130	9.9%
Ste. Anne/La Broquerie	335	9.3%	St. Pierre/De Salaberry	120	9.7%
Niverville/Ritchot	290	8.8%	Carman	135	8.7%
Hanover	295	7.3%	Macdonald	165	7.8%
<b>Zone 3</b>	<b>1,090</b>	<b>8.3%</b>	<b>Zone 1</b>	<b>1,810</b>	<b>18.0%</b>
Morden	295	11.8%	City of Portage	860	24.3%
Lorne/Louise/ Pembina	210	10.7%	Seven Regions	345	24.0%
Winkler	285	8.4%	Rural Portage	400	19.0%
Roland/ Thompson	45	7.0%	North Norfolk	75	7.8%
Altona	170	6.7%	Cartier/SFX	130	6.5%
Stanley	85	4.1%			

Statistics Canada Census 2016

## Dependency Ratio

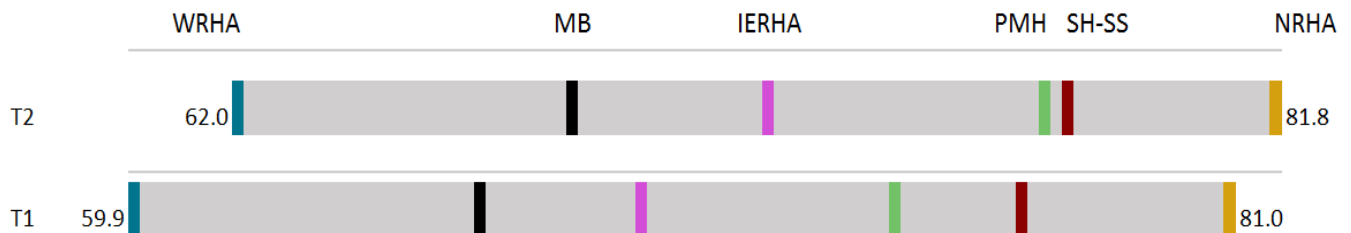
### Definition

The ratio of the combined youth population (aged 19 and younger) and elderly population (aged 65 and older) to the working age population (aged 20-64).

### Provincial Key Findings

- Figure 16 shows that the dependency ratios in the province remained relatively stable over time.

Figure 16. Dependency Ratio by RHA, 2013 (T1) and 2018 (T2)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period.

	WRHA	MB	IERHA	PMH	SH-SS	NRHA
T2 COUNT	295,339	552,950	54,570	74,595	89,385	34,562
T2 RATE	62.0	68.5	72.1	77.5	77.8	81.8
T1 RATE	59.9	66.6	69.8	74.5	77.1	81.0

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Low dependency ratios mean that there are sufficient people working who can support the dependent population. High dependency ratios indicate more pressure (e.g., financial) on the working population to care for both the young and the old dependent populations.

## Regional Key Findings

### SH-SS Level

- ▶ The dependency ratio in Southern Health-Santé Sud was higher than the province; however, the difference was not tested statistically. This may imply that the working age population in the region was under relatively more pressure to care for dependent populations.
- ▶ The high youth dependency ratio in the region suggests that there will be a large youth population moving into the working-age population in the future.

### Zone Level

- ▶ **Table 11** shows that the dependency ratio was relatively similar across zones with a slightly higher ratio in Zone 3.
- ▶ In all zones, the youth population was larger than the senior population.

### District Level

- ▶ The total dependency ratio ranged between districts from the lowest in Macdonald to the highest in Carman.
- ▶ Rural East was the only district where the number of seniors surpassed the youth population.

**Table 11. Dependency Ratio in Southern Health-Santé Sud, 2018**


Ratio of youth (aged 0-19) and seniors (aged 65+) by 100 workers (aged 20-64)

	Count	Ratio		Count	Ratio
<b>Manitoba</b>	<b>552,950</b>	<b>68.5</b>	<b>SH-SS</b>	<b>89,385</b>	<b>77.8</b>
<b>Zone 4</b>	<b>33,232</b>	<b>74.8</b>	<b>Zone 2</b>	<b>13,282</b>	<b>75.8</b>
Rural East	1,818	80.5	Carman	2,822	93.2
Hanover	6,795	80.4	Grey	1,244	77.8
Ste. Anne/La Broquerie	5,773	77.7	Morris	2,243	76.9
Steinbach	9,197	77.0	St. Pierre/De Salaberry	1,883	74.9
Niverville/Ritchot	5,584	68.0	Red River South	1,941	74.8
Taché	4,065	66.1	Macdonald	3,149	64.6
<b>Zone 3</b>	<b>24,290</b>	<b>82.9</b>	<b>Zone 1</b>	<b>18,581</b>	<b>78.7</b>
Roland/Thompson	968	85.4	Seven Regions	2,988	91.0
Altona	4,503	84.9	North Norfolk	1,994	81.0
Winkler	7,977	84.3	Cartier/SFX	3,754	78.3
Lorne/Louise/Pembina	3,691	83.9	Rural Portage	3,025	75.8
Morden	4,644	79.3	City of Portage	6,820	75.1
Stanley	2,507	79.3			

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## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning that the gap between the districts with the lowest and highest dependency ratio reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.1x
	T2	1.4x
	Change	-0.3 ↓

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# CHAPTER 2: WHAT KEEPS US HEALTHY?



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# At a Glance: What Keeps us Healthy in Southern Health-Santé Sud?

● SH-SS

● Manitoba

Low Income Measure-After Tax



Unemployment  
% of labour force



Preterm Birth Rate  
% infants born before 37 weeks  
in hospital



Pediatric Dental Extractions  
rate hospital-based extractions  
per 1,000 children under 6



Life Stress  
% report quite a bit/extremely



Physical Activity  
% report active



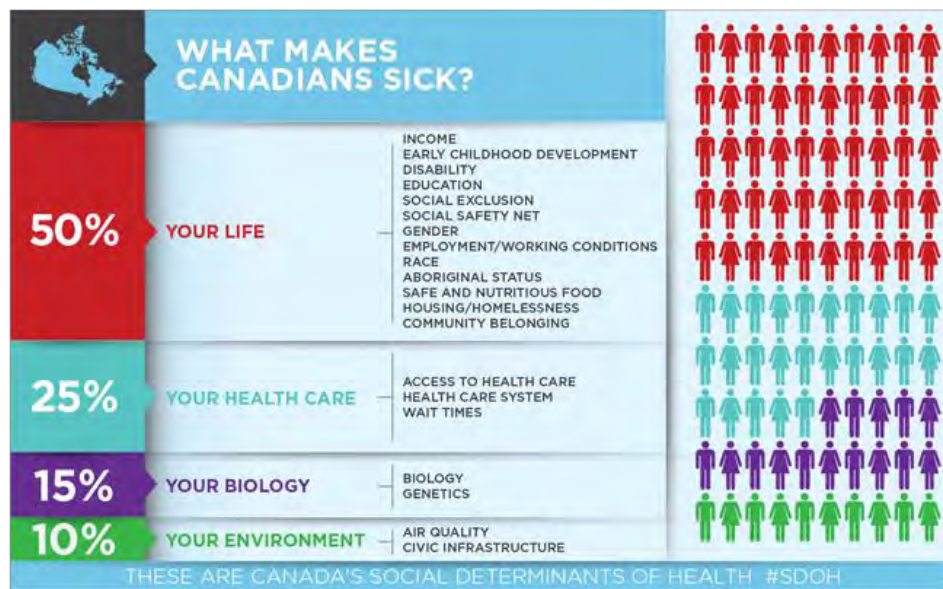
# What Influences How Healthy our Population is?

This chapter presents information regarding the social determinants of health and health status measures by geographic area in order to provide a comprehensive picture of the health of residents of the Southern Health-Santé Sud.

Interactions between the determinants of health result in differences in health status between individuals living in different geographic areas of the region and the province. Wherever possible, the report presents the health status of the population overall, and identifies population groups that experience poorer health outcomes. These comparisons are essential to assess whether gaps are widening or narrowing among population groups (based on income and geographic location). Future planning efforts must take these health gaps into consideration to improve overall population health outcomes.

According to the Canadian Medical Association (CMA), social determinants of health “are systematic social and economic conditions that influence a person’s health. They include income, housing, education, gender and race, and have a greater impact on individual and population health than biological and environmental conditions. Their impact can be even greater than that of the health care system itself.”<sup>i</sup> In 2013, the CMA published the results of the National Dialogue on Health Care Transformation.<sup>ii</sup> The dialogue took place online as well as in six town halls conducted across the country. Participants identified four social determinants of health (income, housing, nutrition and food security, and early childhood development) as having equal, if not more important, roles in determining health than the healthcare system. Other social determinants of health that were mentioned by participants as being important to health included: culture, the environment, education, and health literacy.<sup>ii</sup>

As participants in the National Dialogue on Health Care Transformation expressed, some determinants of health impact an individual’s health more than others (see image on the next page). According to the CMA, about 50% of an individual’s health is determined by their life experiences (e.g., income, early childhood development, disability, etc.). Only 25% of an individual’s health is determined by the health care they receive (e.g., access to health care, the healthcare system, wait times, etc.), and 15% is determined by an individual’s biology (e.g., genetics). Finally, the environment determines about 10% of an individual’s health (e.g., air quality, civic infrastructure, etc.).



Canadian Medical Association, n.d., cited in South East Local Health Integration Network, 2014<sup>iii</sup>

In an attempt to answer the question of what keeps Southern Health-Santé Sud residents healthy, this chapter will look at indicators related to:

- Income;
- Housing;
- Food Security;
- Education;
- Employment/Working Conditions;
- Healthy Child Development;
- Personal Health Determinants;
- Health Behaviours; and
- Use of Preventive Services.

The indicators reported in this chapter relate to the social determinants of health. However, while all determinants of health are important, data are not currently available for all social determinants at the provincial and regional levels. Further, not all determinants of health are easily modifiable or can be reasonably addressed by the region (e.g., determinants of health related to biology and genetics). It is also important to note that all factors that affect a person's health cannot be addressed solely by the healthcare system.

# Chapter 2 Key Findings

Socioeconomic conditions for Southern Health-Santé Sud improved over time and were better than the provincial average. However, there continues to be a wide income gap with a difference of \$52,000 between the lowest and highest income districts and 15% of households living in low income. On several child development indicators, the region was among the best and significantly better than the province. However, the region was significantly worse than the province on several preventative service indicators such as cancer screening, dental insurance, and the lowest in the province for many immunizations.

## Social Determinants of Health

- Social deprivation and socioeconomic conditions better than province and improving over time
- Material deprivation worse than province but improving over time
- Regional median household income \$60,802
- 15% households lived in low income
- 6% reported food insecurity
- Highest percentage spending 30% or more on shelter expenses among rural health regions
- 29% had no certificate, diploma, or degree
- Lowest unemployment in the province

## Healthy Child Development

- Preterm births lower than province
- Births small for gestational age lower than province
- In-hospital breastfeeding initiation higher than the province
- 10,525 children lived in low income
- Percentage of mothers screened with three or more risk factors lowest in the province
- 27% of kindergarten children struggled to meet age-appropriate developmental expectations
- Pediatric dental extractions lower than province and decreasing over time
- Lowest percentage of 17 year olds with recommended doses for several vaccines (diphtheria, tetanus, and pertussis, and HPV)
- Teen pregnancy rates lower than province and decreasing over time
- Teen birth rates decreasing over time

## Personal Health Determinants

- Majority reported somewhat strong community belonging
- 54% reported making a positive health change in the past year

## Health Behaviours

- Substance use disorders significantly lower than province
- 58% identified as a regular drinker
- Lowest percentage of current smokers in the province
- 51% reported being physically active
- 27% reported consuming 5+ servings of fruits and vegetables daily
- Majority of respondents reported never using their cell phone while driving
- ATV helmet use throughout the region was reported 50/50

## Use of Preventative Services

- Only 48% of adults aged 65+ received influenza immunization, much below national target
- Lowest percentage of older adults immunized for pneumonia in the province
- Cancer screening lower than province for colorectal, breast, and cervical
- Percent of population with dental insurance lower than province

# Social Determinants of Health

## Social Deprivation Index

### Definition

A composite score which includes the proportion of the population, aged 15 years and older, who are separated, divorced, or widowed, the proportion of the population that lives alone, and the proportion of the population that has moved at least once in the past five years.

### Why is this indicator important?

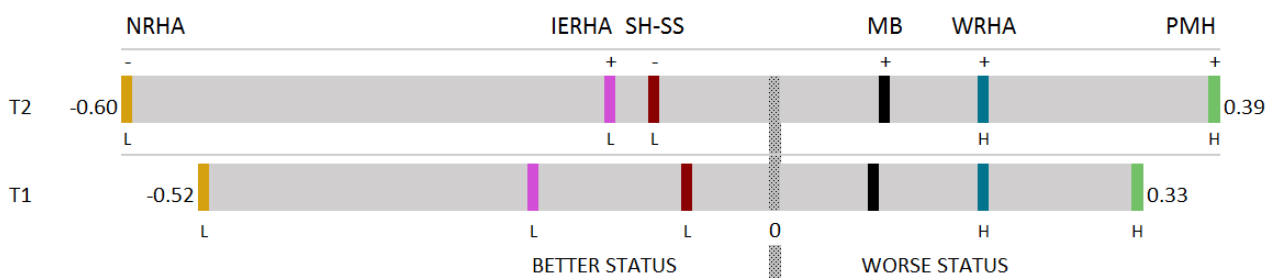
It reflects the status of relationships among individuals in the family, workplace, and the community. Scores on these indices range from -5 to +5; lower scores indicate better status or less deprivation, while higher scores indicate worse status or more deprivation.

### Provincial Key Findings

- Figure 1 shows that every health region was significantly different than the provincial average in both time periods. Scores were better in Northern Health Region, Interlake-Eastern RHA, and Southern Health-Santé Sud but worse in Winnipeg RHA and Prairie Mountain Health.
- Scores in the province and all regions changed significantly over time. They improved in Northern Health Region and Southern Health-Santé Sud but worsened in Manitoba, Interlake-Eastern RHA, Winnipeg RHA, and Prairie Mountain Health.

Figure 1. Social Deprivation by RHA, Canadian Census 2011 (T1) and 2016 (T2)

Average scores from -5 to +5



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	IERHA	SH-SS	MB	WRHA	PMH
T2 POP	77,068	128,240	198,809	1,351,359	770,185	170,521
T2 SCORE	-0.60	-0.15	-0.11	0.09	0.19	0.39
T1 SCORE	-0.52	-0.22	-0.08	0.08	0.18	0.33

## Regional Key Findings

### SH-SS Level

- Table 1 shows that the social deprivation score in the region was significantly better than the provincial average and improved significantly over time.

### Zone Level

- The scores in all zones were significantly better than the provincial average.
- Scores in Zones 3 and 4 improved significantly over time.

### District Level

- The scores were better in the majority of districts with the exception of all of the regional cities as well as St. Pierre/De Salaberry and Carman, where the scores were worse.
- About half of the districts significantly improved, while the other half significantly worsened over time.

**Table 1. Social Deprivation in Southern Health-Santé Sud, 2011 (T1) and 2016 (T2)**

Average scores from -5 to +5, lower values indicate better status

	T2		T1			T2		T1			
	Pop	Score	Score	Score		Pop	Score	Score			
<b>Manitoba</b>	<b>1,351,359</b>	<b>0.09</b>	<b>+</b>	<b>0.08</b>		<b>SH-SS</b>	<b>198,809</b>	<b>-0.11</b>	<b>L-</b>	<b>-0.08</b>	<b>L</b>
<b>Zone 4</b>	<b>74,730</b>	<b>-0.16</b>	<b>L-</b>	<b>-0.10</b>	<b>L</b>	<b>Zone 2</b>	<b>30,219</b>	<b>-0.23</b>	<b>L</b>	<b>-0.24</b>	<b>L</b>
Hanover	14,527	-0.76	L-	-0.49	L	Macdonald	7,553	-1.04	L	-1.04	L
Niverville/Ritchot	12,720	-0.50	L+	-0.59	L	Grey	2,825	-0.35	L+	-0.59	L
Taché	9,485	-0.42	L-	-0.16	L	Red River South	4,600	-0.17	L+	-0.25	L
Rural East	4,042	-0.09	L-	-0.06	L	Morris	5,102	-0.08	L-	0.06	L
Ste. Anne/ La Broquerie	13,225	-0.03	L+	-0.10	L	St. Pierre/De Salaberry	4,374	0.17	H+	-0.29	L
Steinbach	20,731	0.47	H+	0.42	H	Carman	5,765	0.40	H-	0.66	H
<b>Zone 3</b>	<b>52,661</b>	<b>0.00</b>	<b>L-</b>	<b>0.02</b>	<b>L</b>	<b>Zone 1</b>	<b>41,199</b>	<b>-0.09</b>	<b>L</b>	<b>-0.09</b>	<b>L</b>
Stanley	5,805	-0.60	L-	-0.39	L	Cartier/SFX	7,754	-0.87	L+	-1.03	L
Altona	9,753	-0.28	L+	-0.39	L	Rural Portage	7,456	-0.54	L-	-0.52	L
Roland/ Thompson	2,105	-0.09	L+	-0.12	L	Seven Regions	6,201	-0.25	L-	-0.05	L
Lorne/Louise/ Pembina	8,030	-0.06	L-	0.08		North Norfolk	4,342	-0.12	L+	-0.15	L
Winkler	16,880	0.20	H+	0.15	H	City of Portage	15,446	0.60	H+	0.57	H
Morden	10,088	0.37	H-	0.50	H						

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019



## Material Deprivation Index

### Definition

A composite score which includes average household income, unemployment rate for ages 15 years and older, and proportion of the population aged 15 and older without high school graduation.

### Why is this indicator important?

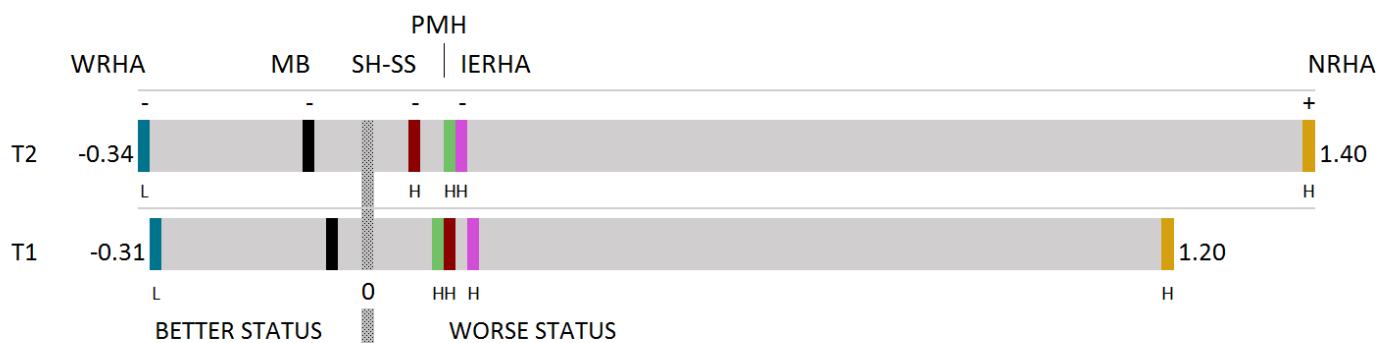
It reflects the status of wealth, goods and conveniences. Scores on these indices range from -5 to +5; lower scores indicate better status or less deprivation, while higher scores indicate worse status or more deprivation.

### Provincial Key Findings

- ▶ **Figure 2** shows that all RHAs were significantly different than the provincial average, with Winnipeg RHA significantly better and all rural health regions significantly worse.
- ▶ Material deprivation improved significantly over time in the province, Winnipeg RHA, Southern Health-Santé Sud, and Interlake-Eastern RHA. It worsened in Northern Health Region and remained the same in Prairie Mountain Health.

**Figure 2. Material Deprivation by RHA, Canadian Census 2011 (T1) and 2016 (T2)**

Average scores



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	SH-SS	PMH	IERHA	NRHA
T2 POP	770,185	1,351,359	198,809	170,521	128,240	77,068
T2 SCORE	-0.34	-0.07	0.08	0.14	0.14	1.40
T1 SCORE	-0.31	-0.05	0.14	0.13	0.17	1.20

## Regional Key Findings

### SH-SS Level

- Table 2 shows that regional material deprivation scores were significantly worse than the provincial average but improving significantly over time.

### Zone Level

- Zones 2 and 4 were significantly better than the provincial average and improving significantly over time, while Zones 1 and 3 were significantly worse and worsening.

### District Level

- The majority of districts had scores significantly worse than the provincial average with the exception of Niverville/Ritchot, Taché, Macdonald, St. Pierre/De Salaberry, and Cartier/SFX.
- All districts except Seven Regions changed significantly over time, with 14 improving and 8 worsening.

**Table 2. Material Deprivation in Southern Health-Santé Sud, 2011 (T1) and 2016 (T2)**

Average scores, lower values indicate better status

	T2		T1		
	Pop	Score	Score	Score	
<b>Manitoba</b>	<b>1,351,359</b>	<b>-0.07</b>	-	<b>-0.05</b>	
<b>SH-SS</b>	<b>198,809</b>	<b>0.08</b>	<b>H-</b>	<b>0.14</b>	<b>H</b>
<b>Zone 4</b>	<b>74,730</b>	<b>-0.13</b>	<b>L-</b>	<b>0.01</b>	<b>H</b>
Niverville/Ritchot	12,720	-0.59	L-	-0.31	L
Taché	9,485	-0.39	L+	-0.40	L
Ste. Anne/La Broquerie	13,225	-0.05	H-	-0.02	H
Steinbach	20,731	0.00	H-	0.18	H
Hanover	14,527	0.09	H-	0.14	H
Rural East	4,042	0.30	H-	0.56	H
<b>Zone 2</b>	<b>30,219</b>	<b>-0.14</b>	<b>L-</b>	<b>0.04</b>	<b>H</b>
Macdonald	7,553	-1.01	L-	-0.77	L
St. Pierre/De Salaberry	4,374	-0.10	L-	0.09	H
Grey	2,825	0.01	H-	0.28	H
Carman	5,765	0.03	H+	-0.02	H
Morris	5,102	0.27	H-	0.38	H
Red River South	4,600	0.52	H-	0.73	H
<b>Zone 3</b>	<b>52,661</b>	<b>0.44</b>	<b>H+</b>	<b>0.38</b>	<b>H</b>
Lorne/Louise/Pembina	8,030	0.03	H+	0.00	H
Morden	10,088	0.10	H-	0.14	H
Roland/Thompson	2,105	0.37	H+	0.17	H
Altona	9,753	0.43	H-	0.46	H
Stanley	5,805	0.72	H+	0.68	H
Winkler	16,880	0.74	H+	0.59	H
<b>Zone 1</b>	<b>41,199</b>	<b>0.14</b>	<b>H+</b>	<b>0.13</b>	<b>H</b>
Cartier/SFX	7,754	-0.98	L-	-0.85	L
North Norfolk	4,342	-0.01	H-	0.56	H
City of Portage	15,446	0.14	H+	-0.15	L
Rural Portage	7,456	0.43	H+	0.35	H
Seven Regions	6,201	1.31	H	1.32	H

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Socioeconomic Factor Index (SEFI)

### Definition

A composite score which combines indicators of social and material deprivation. These include average household income, proportion of single parent households, unemployment rate for those aged 15 years and older, and proportion of population aged 15 and older without high school graduation.

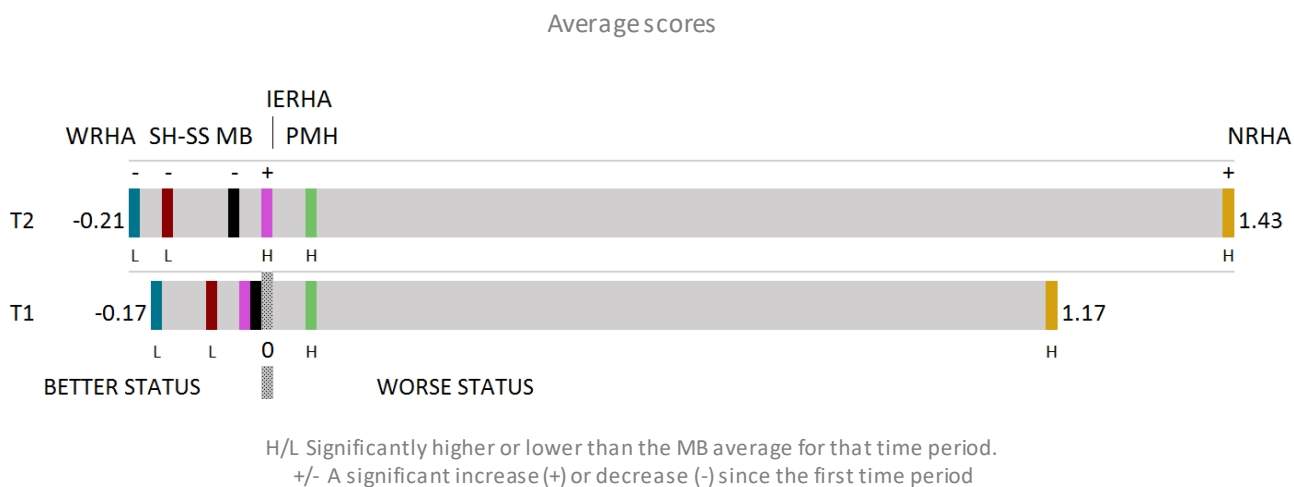
### Why is this indicator important?

It reflects the social determinants of health (e.g., income, education, marital status, and residential mobility). Scores on these indices range from -5 to +5. A score of 0 represents the Manitoba average. Lower scores indicate better status or more favourable socioeconomic conditions, while higher scores indicate worse status or less favourable socioeconomic conditions.

### Provincial Key Findings

- Figure 3 shows that all health regions were significantly different than the provincial average, with Winnipeg RHA and Southern Health-Santé Sud significantly better and Interlake-Eastern RHA, Prairie Mountain Health, and Northern Health Region significantly worse.
- Scores improved significantly over time in Manitoba, Winnipeg RHA, and Southern Health-Santé Sud, while scores worsened in Interlake-Eastern RHA and Northern Health Region.

Figure 3. SEFI by RHA, Canadian Census 2011 (T1) and 2016 (T2)



	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 POP	770,185	198,809	1,351,359	128,240	170,521	77,068
T2 RATE	-0.21   L-	-0.14   L-	-0.05   -	0.00   H+	0.06   H	1.43   H+
T1 RATE	-0.17   L	-0.08   L	-0.03	-0.03	0.07   H	1.17   H

## Regional Key Findings

### SH-SS Level

- ▶ **Table 3** shows that in the region, SEFI scores were significantly lower than the provincial average in both time periods, indicating better socioeconomic status, and improving significantly over time.

### Zone Level

- ▶ Zones 2 and 4 were significantly better than the provincial average and improving significantly over time, while Zones 1 and 3 were significantly worse and worsening.

### District Level

- ▶ Socioeconomic status, as measured by the SEFI, varied across districts with 13 significantly better than the provincial average and 9 significantly worse.
- ▶ All districts that were better than the provincial average, with the exception of Lorne/Louise/Pembina, improved significantly over time as well as Rural East, Morris, and Stanley. On the other hand, the following districts worsened significantly over time: Red River South, Altona, Roland/Thompson, Winkler, city of Portage, Rural Portage, and Seven Regions.
- ▶ Cartier/SFX had the best SEFI scores in the current time period while Seven Regions had the worse scores in both time periods.



# Social Determinants of Health

**Table 3. SEFI in Southern Health-Santé Sud, Canada Census 2011 (T1) and 2016 (T2)**

Average scores, lower values indicate better status

	T2		T1		
	Pop	Score	Score	Score	
<b>Manitoba</b>	<b>1,351,359</b>	<b>-0.05</b>		<b>-0.03</b>	
<b>SH-SS</b>	<b>198,809</b>	<b>-0.14</b>	<b>L-</b>	<b>-0.08</b>	<b>L</b>
<b>Zone 4</b>	<b>74,730</b>	<b>-0.34</b>	<b>L-</b>	<b>-0.18</b>	<b>L</b>
Niverville/ Ritchot	12,720	-0.76	L-	-0.51	L
Taché	9,485	-0.39	L-	-0.29	L
Hanover	14,527	-0.36	L-	-0.23	L
Ste. Anne/ La Broquerie	13,225	-0.26	L-	-0.22	L
Steinbach	20,731	-0.15	L-	0.03	H
Rural East	4,042	-0.05	-	0.19	H
<b>Zone 2</b>	<b>30,219</b>	<b>-0.34</b>	<b>L-</b>	<b>-0.22</b>	<b>L</b>
Macdonald	7,553	-1.20	L-	-1.07	L
Grey	2,825	-0.34	L-	-0.13	L
St. Pierre/ De Salaberry	4,374	-0.29	L-	-0.13	L
Carman	5,765	-0.14	L-	0.06	H
Morris	5,102	0.01	H-	0.05	H
Red River South	4,600	0.38	H+	0.26	H
<b>Zone 3</b>	<b>52,661</b>	<b>0.05</b>	<b>H+</b>	<b>0.02</b>	<b>H</b>
Lorne/Louise/ Pembina	8,030	-0.27	L	-0.28	L
Morden	10,088	-0.09	L-	0.00	H
Altona	9,753	-0.02	H+	-0.05	L
Roland/ Thompson	2,105	0.04	H+	-0.18	L
Stanley	5,805	0.11	H-	0.15	H
Winkler	16,880	0.30	H+	0.23	H
<b>Zone 1</b>	<b>41,199</b>	<b>0.11</b>	<b>H+</b>	<b>0.07</b>	<b>H</b>
Cartier/SFX	7,754	-1.21	L-	-1.09	L
North Norfolk	4,342	-0.23	L-	0.13	H
City of Portage	15,446	0.31	H+	0.10	H
Rural Portage	7,456	0.34	H+	0.24	H
Seven Regions	6,201	1.17	H+	1.05	H

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Median Household Income—After-Tax

### Definition

The median combined total income (after-tax, post transfer) of all members of household, aged 15 years and older, who reported income. Median household income is the amount which divides income size distribution, ranked by size of income, into two halves. That is, the incomes of the first half of the households are below the median, while those of the second half are above the median.

### Why is this indicator important?

Median household income is an important measure of income inequality that exists in communities. It is an effective measure because health regions with smaller differences between the top and bottom ends generally experience better health status than those with more disparate incomes.

### Provincial Key Findings

- ▶ **Figure 4** shows that the median household income after tax in Manitoba was \$59,093.
- ▶ Median household income ranged from the lowest in Prairie Mountain Health, to the highest in Interlake-Eastern RHA.

Figure 4. Median Household Income After Tax, 2015 (T1)



	PMH	MB	WRHA	NRHA	SH-SS	IERHA
T1 MEDIAN	\$54,014	\$59,093	\$59,510	\$60,308	\$60,802	\$61,155

Statistics Canada Census 2016

## Regional Key Findings

- ▶ **Table 4** shows that the regional median household income after tax was \$60,802. It was higher than the provincial median; however, the difference was not tested statistically.
- ▶ Zone level data not available.
- ▶ Median household income varied dramatically across districts with the lowest in Seven Regions and the highest in Macdonald.

## Geographic Disparity

- ▶ The median income in the highest district of Macdonald was 2.2 times higher than the lowest district of Seven Regions – a difference of more than \$52,000

**Table 4. Median Household Income After-Tax in Southern Health-Santé Sud, 2015**

	Median		Median
<b>Manitoba</b>	<b>\$59,093</b>	<b>SH-SS</b>	<b>\$60,802</b>
<b>Zone 4</b>		<b>Zone 2</b>	
Taché	\$78,918	Macdonald	\$94,187
Niverville/Ritchot	\$77,926	St. Pierre/De Salaberry	\$63,942
Hanover	\$65,755	Morris	\$62,201
Ste. Anne/La Broquerie	\$60,891	Carman	\$57,342
Steinbach	\$54,963	Grey	\$56,989
Rural East	\$45,945	Red River South	\$50,496
<b>Zone 3</b>		<b>Zone 1</b>	
Stanley	\$66,971	Cartier/SFX	\$89,770
Roland/Thompson	\$57,980	Rural Portage	\$59,143
Altona	\$57,165	North Norfolk	\$53,126
Morden	\$56,599	City of Portage	\$51,051
Winkler	\$53,622	Seven Regions	\$41,988
Lorne/Louise/Pembina	\$50,896		

Statistics Canada Census 2016

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

### Definition

In Canada, it is set at 50% of the median income after tax, adjusted for family size and composition.

### Why is this indicator important?

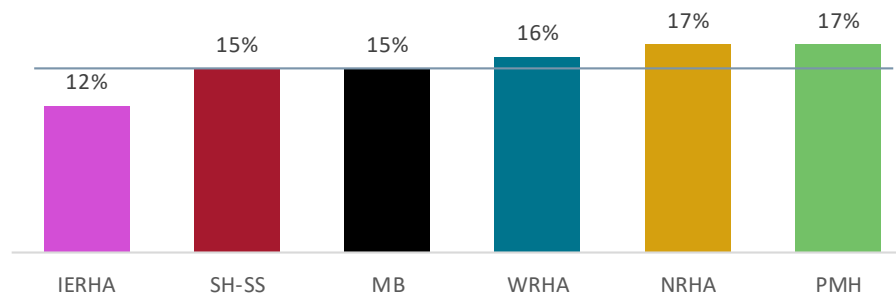
It is used internationally as a relative measure of poverty.

### Provincial Key Findings

- ▶ **Figure 5** shows that approximately 15% of Manitoban households lived in low income.
- ▶ The prevalence was similar across regions with the lowest in Interlake-Eastern RHA and the highest in Prairie Mountain Health.

**Figure 5. Prevalence of Low Income by RHA, 2016**

Percentage of private households



Statistics Canada Census 2016





## Regional Key Findings

- ▶ **Table 5** shows that 15% of households in the region lived in low income; identical to the prevalence in the province.
- ▶ Zone level data not available.
- ▶ The prevalence varied dramatically across districts, with the lowest in Macdonald and the highest in Seven Regions.

## Geographic Disparity

- ▶ The low income prevalence was 5.4 times higher in the highest district of Seven Regions compared to the lowest district of Macdonald.

**Table 5. Prevalence of Low Income in Southern Health-Santé Sud, 2016**

Percentage of private households

	Percentage		Percentage
<b>Manitoba</b>	<b>15</b>	<b>SH-SS</b>	<b>15</b>
<b>Zone 4</b>		<b>Zone 2</b>	
Niverville/Ritchot	7	Macdonald	5
Taché	10	Grey	12
Hanover	15	St. Pierre/De Salaberry	13
Ste. Anne/La Broquerie	15	Morris	14
Steinbach	17	Carman	16
Rural East	26	Red River South	19
<b>Zone 3</b>		<b>Zone 1</b>	
Lorne/Louise/Pembina	15	Cartier/SFX	7
Morden	16	Rural Portage	13
Roland/Thompson	17	North Norfolk	14
Stanley	18	City of Portage	20
Winkler	19	Seven Regions	27
Altona	20		

Statistics Canada Census 2016

## Household Food Insecurity

### Definition

The proportion of the population who reported being unable to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.

### Why is this indicator important?

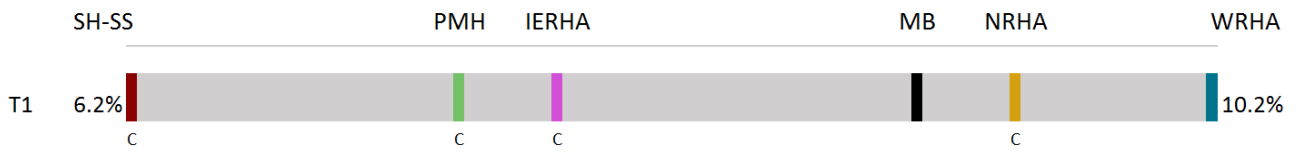
It is an important health equity indicator because it is often associated with a household’s financial ability to access food.

### Provincial/Regional Key Findings

- ▶ **Figure 6** shows that in Manitoba, 9.1% of households reported being food insecure.
- ▶ In Southern Health-Santé Sud, 6.2% of households reported being food insecure, which was the lowest in the province, although not tested statistically.

**Figure 6. Household Food Insecurity by RHA, 2015-2016 (T1)**

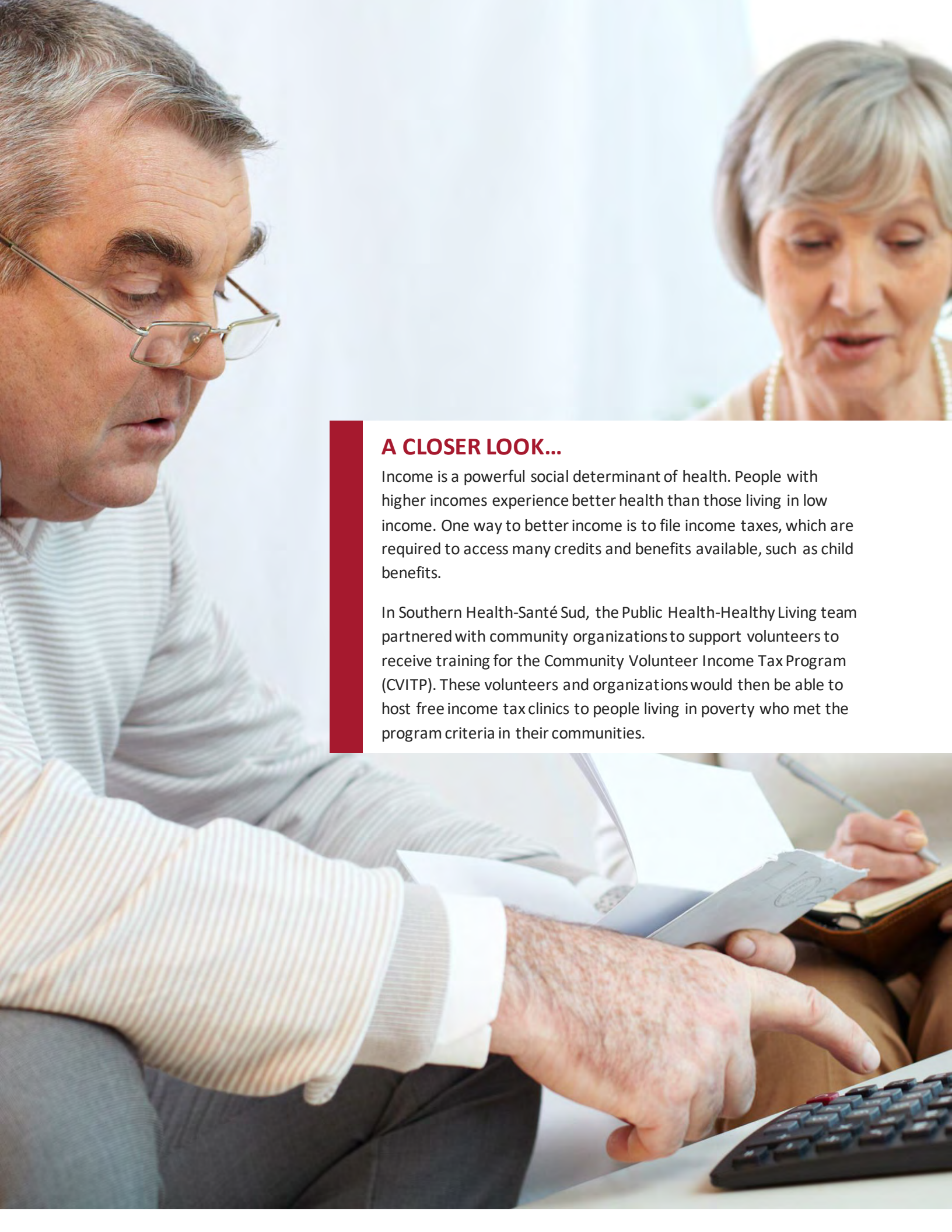
Age- and sex-adjusted proportion of weighted sample reporting ‘moderate/severely food insecure’



H/L Significantly higher or lower than the MB average for that time period  
c – estimate displayed with caution

	SH-SS		PMH		IERHA		MB		NRHA		WRHA	
T1 RATE	6.2%	c	7.4%	c	7.8%	c	9.1%		9.4%	c	10.2%	

STATISTICS CANADA CCHS 2015-2016



### **A CLOSER LOOK...**

Income is a powerful social determinant of health. People with higher incomes experience better health than those living in low income. One way to better income is to file income taxes, which are required to access many credits and benefits available, such as child benefits.

In Southern Health-Santé Sud, the Public Health-Healthy Living team partnered with community organizations to support volunteers to receive training for the Community Volunteer Income Tax Program (CVITP). These volunteers and organizations would then be able to host free income tax clinics to people living in poverty who met the program criteria in their communities.

## Housing Affordability

### Definition

The percentage of people in households that spend 30 percent or more of total household income on shelter expenses (e.g., electricity, water, municipal services, rent, monthly mortgage payments, property taxes, condo fees).



### Why is this indicator important?

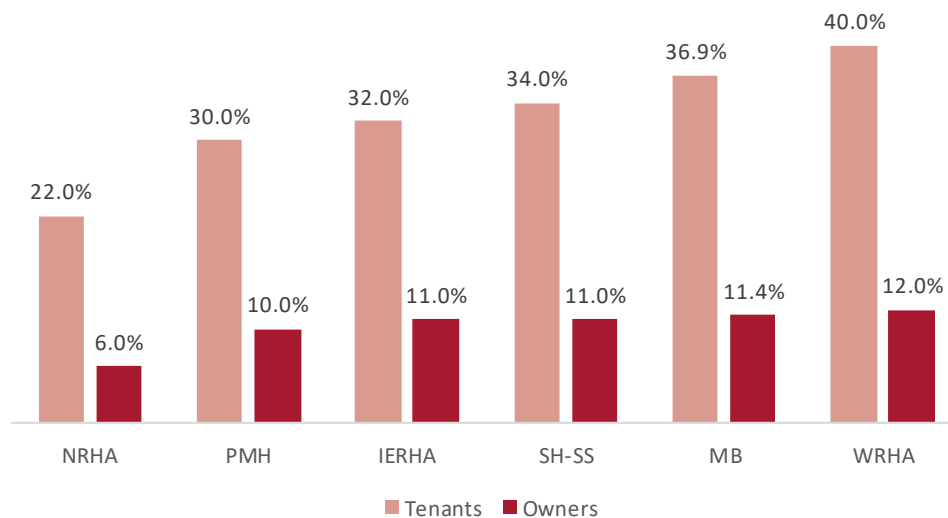
Housing is a critical component of a person's environment. Living in poor housing conditions has been linked to respiratory conditions, lead poisoning, injuries and decreased mental health.

### Provincial Key Findings

- ▶ **Figure 7** shows that in Manitoba, 36.9% of tenants and 11.4% of owners spent 30% or more of their total household income on shelter expenses.
- ▶ Percentages ranged from the lowest in Northern Health Region to the highest in Winnipeg RHA.

**Figure 7. Housing Affordability by RHA, 2016**

Percentage of tenants and owners spending 30% or more of total household income on shelter expenses



Statistics Canada Census 2016

## Regional Key Findings

- ▶ **Table 6** shows that in the region, 34% of tenants and 11% of owners spent 30% or more of their total household income on shelter expenses, similar to the provincial percentages.
- ▶ The region had the highest percentages among rural health regions.
- ▶ Zone data not available.
- ▶ There was some variability across districts. For tenants, the lowest district was Rural Portage and the highest were Steinbach, Morden, and Altona. For owners, the lowest district was Roland/Thompson and the highest was Stanley.

## Geographic Disparity

- ▶ For tenants, the highest districts were 2.2 times higher than the lowest district of Rural Portage.
- ▶ For owners, the highest district of Stanley was 2.8 times higher than the lowest district of Roland/Thompson.

**Table 6. Housing Affordability in Southern Health-Santé Sud, 2016**

Percentage of tenants and owners spending 30% or more of total household income on shelter expenses

	Tenants Percentage	Owners Percentage		Tenants Percentage	Owners Percentage
<b>Manitoba</b>	<b>36.9</b>	<b>11.4</b>	<b>SH-SS</b>	<b>34</b>	<b>11</b>
<b>Zone 4</b>			<b>Zone 2</b>		
Rural East	29	11	Red River South	23	10
Taché	33	10	Morris	25	11
Niverville/Ritchot	34	12	Grey	27	15
Ste. Anne/La Broquerie	36	14	Carman	31	7
Hanover	36	15	St. Pierre/De Salaberry	31	9
Steinbach	39	14	Macdonald	35	9
<b>Zone 3</b>			<b>Zone 1</b>		
Lorne/Louise/Pembina	20	7	Rural Portage	18	8
Roland/Thompson	29	6	Seven Regions	28	8
Winkler	35	12	North Norfolk	32	9
Stanley	35	17	Cartier/SFX	35	9
Morden	39	9	City of Portage	36	7
Altona	39	13			

Statistics Canada Census 2016

## Educational Attainment

### Definition

The proportion of the population, aged 15 years and older, by the highest level of education attained.

### Why is this indicator important?

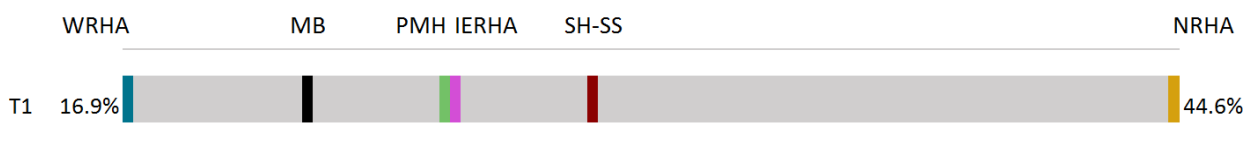
Educational attainment is widely acknowledged as a key component of socioeconomic status and is positively associated with health. Higher levels of education improve ability to access and understand information to stay healthy. Understanding levels of education is important for health planning.

### Provincial Key Findings

- ▶ **Figure 8** shows that in Manitoba, 22% of the population aged 15 years and older had not received a certificate, diploma, or degree.
- ▶ This varied dramatically across regions with the lowest in Winnipeg RHA and the highest in Northern Health Region, at nearly 45%.

**Figure 8. Educational Attainment by RHA, 2016 (T1)**

Percentage of population (aged 15+) with no certificate, diploma, or degree



	WRHA	MB	PMH	IERHA	SH-SS	NRHA
T1 COUNT	98,845	220,395	32,680	25,855	40,980	22,035
T1 RATE	16.9%	22.0%	25.7%	25.7%	29.4%	44.6%

Statistics Canada Census 2016

### Regional Key Findings

#### SH-SS Level

- ▶ **Table 5** shows that 29% of regional residents aged 15 years and older did not have a certificate, diploma, or degree, which is slightly higher than the provincial prevalence; however, the difference was not tested statistically.
- ▶ The largest proportion of regional residents had postsecondary education; however, the differences were not tested statistically.

## Zone Level

- ▶ Educational attainment was similar across zones with the most notable difference in Zone 3, where proportions of residents were approximately evenly distributed across education levels. In all other zones, the highest proportion of residents had received a postsecondary education.

## District Level

- ▶ The highest proportion of residents received a postsecondary education in the majority of districts except Altona, Roland/Thompson, Winkler, Stanley, and Seven Regions. In these regions, the highest proportion of residents had no certificate, diploma, or degree.

## Geographic Disparity

- ▶ The geographic disparity, calculated for the lowest educational attainment, was 2.1 times higher in the highest district of Seven Regions compared to the lowest district of Cartier/SFX.

**Table 7. Educational Attainment in Southern Health-Santé Sud, 2016**

	No certificate, diploma, or degree	Secondary (high) school diploma or equivalency certificate	Postsecondary certificate, diploma or degree
	%	%	%
<b>Manitoba</b>	<b>22.0</b>	<b>29.6</b>	<b>48.4</b>
<b>SH-SS</b>	<b>29.4</b>	<b>30.1</b>	<b>40.6</b>
<b>Zone 4</b>	<b>26.9</b>	<b>31.7</b>	<b>41.4</b>
Niverville/Ritchot	18.4	29.9	51.8
Taché	22.1	30.4	47.4
Steinbach	27.9	31.7	40.3
Ste. Anne/La Broquerie	28.4	32.7	38.9
Rural East	31.5	32.4	36.2
Hanover	33.3	32.9	33.8
<b>Zone 2</b>	<b>26.0</b>	<b>27.9</b>	<b>46.1</b>
Macdonald	15.2	28.1	56.5
Grey	25.3	29.2	45.6
Carman	25.5	27.5	46.9
St. Pierre/De Salaberry	26.9	28.6	44.5
Red River South	34.0	27.6	38.4
Morris	35.0	27.2	37.8
<b>Zone 3</b>	<b>35.2</b>	<b>29.6</b>	<b>35.3</b>
Morden	24.8	30.8	44.5
Lorne/Louise/Pembina	26.0	29.5	44.5
Altona	37.9	30.4	31.7
Roland/Thompson	38.0	30.7	31.3
Winkler	40.4	27.3	32.3
Stanley	43.1	30.6	26.4
<b>Zone 1</b>	<b>29.2</b>	<b>29.3</b>	<b>41.5</b>
Cartier/SFX	13.8	30.0	56.1
City of Portage	27.7	30.6	41.7
North Norfolk	29.4	33.5	37.1
Rural Portage	30.9	29.8	39.4
Seven Regions	50.6	21.4	27.7

Statistics Canada Census 2016

## Labour Force Participation

### Definition

The percentage of the population, aged 15 years and older, who reported being in the labour force.



### Why is this indicator important?

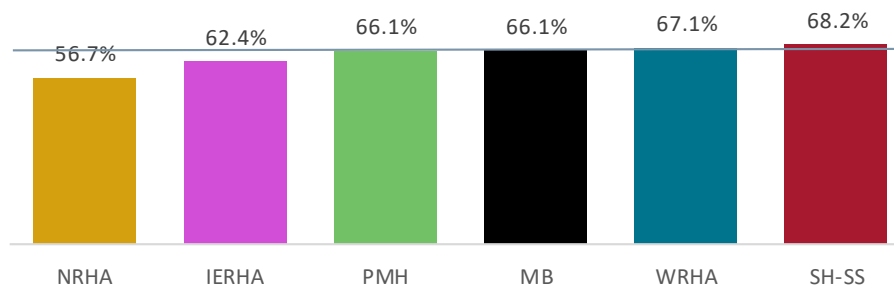
Those that are employed generally have higher levels of social inclusion, feeling they are contributing to the overall well-being of the community around them.

### Provincial Key Findings

- ▶ **Figure 9** shows that 66.1% of Manitobans aged 15 years and older participated in the labour force.
- ▶ There was little variation among regions. Percentages varied from the lowest in Northern Health Region to the highest in Southern Health-Santé Sud.

**Figure 9. Total Labour Force Participation by RHA, 2016**

Percentage population (aged 15+)



	NRHA	IERHA	PMH	MB	WRHA	SH-SS
T1 COUNT	28,045	62,670	84,155	662,150	392,120	95,160
T1 RATE	56.7%	62.4%	66.1%	66.1%	67.1%	68.2%

Statistics Canada Census 2016



## Regional Key Findings

- ▶ **Table 8** shows that a total of 95,160 regional residents aged 15 years and older (68.2%) participated in the labour force. This is the highest in the province.
- ▶ There were sex differences in the region with a higher percentage of males participating in the labour force than females; however, the differences were not tested statistically.
- ▶ Labour force participation was similar across zones, and higher for males.
- ▶ There was variation across districts with the lowest in Seven Regions and the highest in Niverville/Ritchot.

## Geographic Disparity

- ▶ The geographic disparity for overall labour force participation shows that the highest district of Niverville/Ritchot was 1.6 times higher than the lowest in Seven Regions.

**Table 8. Labour Force Participation in Southern Health-Santé Sud, 2016**

Percentage population (aged 15+)

	Total		Males	Females		Total		Males	Females
	Count	%	%	%		Count	%	%	%
<b>Manitoba</b>	<b>662,150</b>	<b>66.1%</b>	<b>70.7%</b>	<b>61.7%</b>	<b>SH-SS</b>	<b>95,160</b>	<b>68.2%</b>	<b>75.4%</b>	<b>61.0%</b>
<b>Zone 4</b>	<b>37,740</b>	<b>70.5%</b>	<b>77.8%</b>	<b>63.2%</b>	<b>Zone 2</b>	<b>14,895</b>	<b>68.5%</b>	<b>75.0%</b>	<b>61.8%</b>
Niverville/Ritchot	6,450	75.4%	80.3%	70.2%	Macdonald	4,105	74.5%	78.5%	70.4%
Hanover	8,155	73.8%	82.8%	64.7%	St. Pierre/De Salaberry	2,415	73.4%	77.5%	69.1%
Taché	6,380	73.8%	78.3%	69.1%	Morris	2,595	70.1%	81.9%	58.0%
Steinbach	8,270	68.5%	79.0%	59.1%	Grey	1,305	68.0%	74.0%	61.1%
Ste. Anne/ La Broquerie	6,645	67.9%	75.1%	60.4%	Carman	2,610	63.1%	70.7%	55.8%
Rural East	1,840	53.9%	58.9%	48.2%	Red River South	1,865	58.2%	64.2%	52.2%
<b>Zone 3</b>	<b>25,140</b>	<b>68.6%</b>	<b>78.3%</b>	<b>59.1%</b>	<b>Zone 1</b>	<b>17,395</b>	<b>63.0%</b>	<b>67.3%</b>	<b>58.9%</b>
Stanley	4,355	72.5%	86.9%	57.7%	Cartier/SFX	3,815	72.5%	75.3%	69.5%
Roland/Thompson	1,205	70.5%	75.4%	65.0%	North Norfolk	1,770	66.7%	74.4%	59.5%
Altona	4,905	68.6%	79.7%	57.3%	Rural Portage	3,630	65.5%	70.5%	60.6%
Morden	4,615	68.4%	74.9%	62.3%	City of Portage	6,295	61.9%	66.6%	57.8%
Winkler	6,405	67.6%	79.4%	56.5%	Seven Regions	1,885	47.5%	49.3%	45.4%
Lorne/Louise/Pembina	3,655	65.9%	70.0%	61.8%					

Statistics Canada Census 2016

## Unemployment Rate

### Definition

The percentage of the labour force population, aged 15 years and older, who reported being unemployed expressed as a percentage of the labour force.

### Why is this indicator important?

Unemployment is a significant risk factor for poor physical and mental health and therefore a major determinant of health inequality. It may be associated with increasingly difficult living conditions, low socioeconomic status and health and social problems.

### Provincial Key Findings

- ▶ **Figure 10** shows that 6.8% of Manitoba residents aged 15 years and older were unemployed.
- ▶ There was considerable variation among regions. Percentages ranges from the lowest in Southern Health-Santé Sud to the highest in Northern Health Region.

**Figure 10. Unemployment by RHA, 2016 (T1)**

Percentage of labour force population (aged 15+)



	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T1 COUNT	5,030	25,425	5,535	44,685	4,720	3,975
T1 RATE	5.3%	6.5%	6.6%	6.8%	7.5%	14.2%

Statistics Canada Census 2016

## Regional Key Findings

### SH-SS Level

- Table 9 shows a total of 5,030 residents aged 15 years and older in the region were unemployed and similar for men and women across the region.
- The prevalence of unemployment in the region was the lowest in the province; however, the difference was not tested statistically.

### Zone Level

- Percentages were similar across zones.

### District Level

- Percentages were similar across districts.

### Geographic Disparity

- The highest unemployment prevalence in Seven Regions was 2.3 times higher than the lowest in Cartier/SFX.

**Table 9. Unemployment in Southern Health-Santé Sud, 2016**

Percentage of the labour force population (aged 15+)

	Total		Male	Female		Total		Male	Female
	Count	%	%	%		Count	%	%	%
<b>Manitoba</b>	<b>44,685</b>	<b>6.7%</b>	<b>7.3%</b>	<b>6.1%</b>	<b>SH-SS</b>	<b>5,030</b>	<b>5.3%</b>	<b>5.4%</b>	<b>5.2%</b>
<b>Zone 4</b>	<b>1,945</b>	<b>5.2%</b>	<b>5.1%</b>	<b>5.3%</b>	<b>Zone 2</b>	<b>700</b>	<b>4.7%</b>	<b>5.4%</b>	<b>3.8%</b>
Taché	160	4.2%	4.7%	3.6%	Grey	25	3.4%	3.4%	3.5%
Niverville/Ritchot	170	4.5%	4.9%	4.1%	St. Pierre/De Salaberry	40	3.7%	3.1%	4.5%
Ste. Anne/ La Broquerie	175	5.2%	4.6%	5.9%	Carman	75	4.2%	5.3%	2.5%
Steinbach	250	5.5%	5.5%	5.7%	Macdonald	125	4.8%	5.6%	3.7%
Hanover	230	5.6%	5.0%	6.6%	Red River South	70	5.4%	6.7%	3.6%
Rural East	75	7.1%	7.2%	6.3%	Morris	110	6.2%	7.1%	4.7%
<b>Zone 3</b>	<b>1,320</b>	<b>5.3%</b>	<b>5.0%</b>	<b>5.6%</b>	<b>Zone 1</b>	<b>1,075</b>	<b>6.2%</b>	<b>6.7%</b>	<b>5.7%</b>
Roland/Thompson	35	3.7%	5.2%	1.9%	Cartier/SFX	70	3.3%	3.4%	3.4%
Altona	115	3.7%	4.0%	3.0%	North Norfolk	60	4.2%	6.1%	2.5%
Lorne/Louise/ Pembina	110	4.8%	5.7%	3.8%	City of Portage	245	7.3%	7.7%	6.9%
Stanley	100	5.3%	3.8%	7.6%	Rural Portage	165	7.4%	8.4%	6.3%
Winkler	205	6.2%	5.6%	7.1%	Seven Regions	75	7.7%	7.5%	7.4%
Morden	150	6.4%	6.2%	6.7%					

Statistics Canada Census 2016

## Industry Sectors

### Definition

The percentage of the population, aged 15 years and older, by their kind of work and the description of the main activities in their job.

### Why is this indicator important?

The type of employment, irrespective of income level, may carry with it greater health risks due to exposure to harmful substances or potential risk of injuries.

### Regional Key Findings

- ▶ **Table 10** shows that in Southern Health-Santé Sud, the leading five industry sectors were: 1) trades, transport and equipment operators, and related occupations; 2) sales and service; 3) management; 4) business, finance, and administration; and 5) education, law and social, community, and government services. These were the same leading five industry sectors as Manitoba but differ in rankings.
- ▶ The top industry sectors were similar across zones. In Zones 2, 3, and 4 the leading industry sector was trades, transport and equipment operators, and related occupations, similar to the region. The top five rankings were the same across zones 1, 2, and 4 with slight differences in rankings. In Zone 3, occupations in manufacturing and utilities was more prevalent and replaced education, law and social, community, and government services in rankings, compared to other zones; however the differences were not tested statistically.
- ▶ Industry sectors by districts are presented in the table. There are similarities and slight differences across districts.



**Table 10. Industry Sectors in Southern Health-Santé Sud, 2016**

Percentage of population (aged 15+)

	Trades, transport & equipment operators & related	Sales & service	Management	Business, finance & administration	Education, law & social, community & government	Health occupations	Manufacturing & utilities	Natural resources, agriculture & related production	Natural & applied sciences & related	Art, culture, recreation & sport
	%	%	%	%	%	%	%	%	%	%
<b>Manitoba</b>	<b>15.8</b>	<b>22.2</b>	<b>11.0</b>	<b>14.8</b>	<b>13.2</b>	<b>8.0</b>	<b>4.6</b>	<b>2.8</b>	<b>5.3</b>	<b>2.2</b>
<b>SH-SS</b>	<b>21.1</b>	<b>18.6</b>	<b>13.7</b>	<b>12.5</b>	<b>11.3</b>	<b>6.8</b>	<b>5.8</b>	<b>5.5</b>	<b>3.4</b>	<b>1.5</b>
<b>Zone 4</b>	<b>23.6</b>	<b>18.6</b>	<b>12.2</b>	<b>13.6</b>	<b>11.0</b>	<b>5.6</b>	<b>4.9</b>	<b>5.4</b>	<b>3.6</b>	<b>1.6</b>
Niverville/Ritchot	17.6	18.4	14.7	15.9	14.5	6.4	2.0	3.6	5.1	1.7
Taché	24.9	15.1	13.4	15.4	12.9	5.3	3.5	3.2	4.5	1.7
Hanover	27.2	18.8	12.0	12.1	8.4	4.9	5.4	7.4	2.4	1.7
Steinbach	19.9	21.6	10.0	13.0	10.7	6.8	8.4	4.3	3.6	1.6
Rural East	23.0	18.8	13.6	10.8	10.0	5.5	3.9	10.5	1.9	1.1
Ste. Anne/La Broquerie	28.3	17.9	11.2	12.8	9.9	4.6	4.3	6.6	3.3	1.3
<b>Zone 2</b>	<b>19.6</b>	<b>16.2</b>	<b>16.9</b>	<b>12.7</b>	<b>11.4</b>	<b>6.9</b>	<b>3.6</b>	<b>7.1</b>	<b>3.7</b>	<b>1.7</b>
Macdonald	16.3	17.4	16.9	13.9	14.1	7.0	2.8	4.2	5.9	1.6
St. Pierre/De Salaberry	20.9	16.3	11.1	13.8	12.3	6.5	5.2	7.7	4.2	1.7
Carman	18.8	15.1	19.7	10.4	11.8	6.8	3.7	6.8	4.3	2.7
Grey	21.3	11.2	21.7	8.9	10.1	8.9	1.6	13.6	1.9	0.8
Morris	23.8	17.0	15.2	12.9	7.4	5.9	4.9	8.6	2.0	2.1
Red River South	19.7	17.8	19.4	14.0	10.0	7.5	2.7	7.0	0.8	0.8
<b>Zone 3</b>	<b>20.9</b>	<b>19.7</b>	<b>13.1</b>	<b>10.8</b>	<b>9.6</b>	<b>6.9</b>	<b>9.8</b>	<b>5.3</b>	<b>2.6</b>	<b>1.3</b>
Morden	16.7	19.8	8.8	12.2	13.3	9.3	10.7	3.3	3.9	1.9
Altona	22.0	19.2	13.5	11.8	9.8	5.3	8.9	5.4	2.3	1.6
Stanley	28.5	19.4	11.6	8.6	5.9	5.1	12.1	6.8	1.3	0.9
Roland/Thompson	19.9	15.4	19.1	9.1	8.3	6.6	8.3	8.3	4.6	0.0
Winkler	19.5	22.6	9.7	11.1	10.2	6.8	13.0	2.8	2.9	1.3
Lorne/Louise/Pembina	18.0	17.1	23.5	10.2	8.5	8.5	2.3	9.4	1.8	0.7
<b>Zone 1</b>	<b>17.2</b>	<b>18.9</b>	<b>14.8</b>	<b>12.6</b>	<b>14.0</b>	<b>9.0</b>	<b>3.9</b>	<b>4.5</b>	<b>3.8</b>	<b>1.5</b>
Cartier/SFX	14.6	16.4	18.3	14.5	15.2	7.8	2.1	3.3	5.7	2.2
North Norfolk	21.0	15.0	17.8	11.9	10.8	7.9	2.8	10.2	2.3	0.6
Rural Portage	20.3	17.6	15.4	12.0	11.6	8.8	4.1	5.2	3.4	1.6
City of Portage	16.3	23.2	9.7	12.7	15.4	10.6	5.2	1.9	3.8	1.4
Seven Regions	16.0	15.7	20.8	9.6	14.6	7.3	3.9	9.3	2.2	0.8

Statistics Canada Census 2016

## Work Stress

### Definition

The proportion of residents, aged 15 to 75 years, who reported most days at their main job or business to be 'quite a bit/extremely stressful', 'a bit stressful', or 'not at all/not very stressful'.



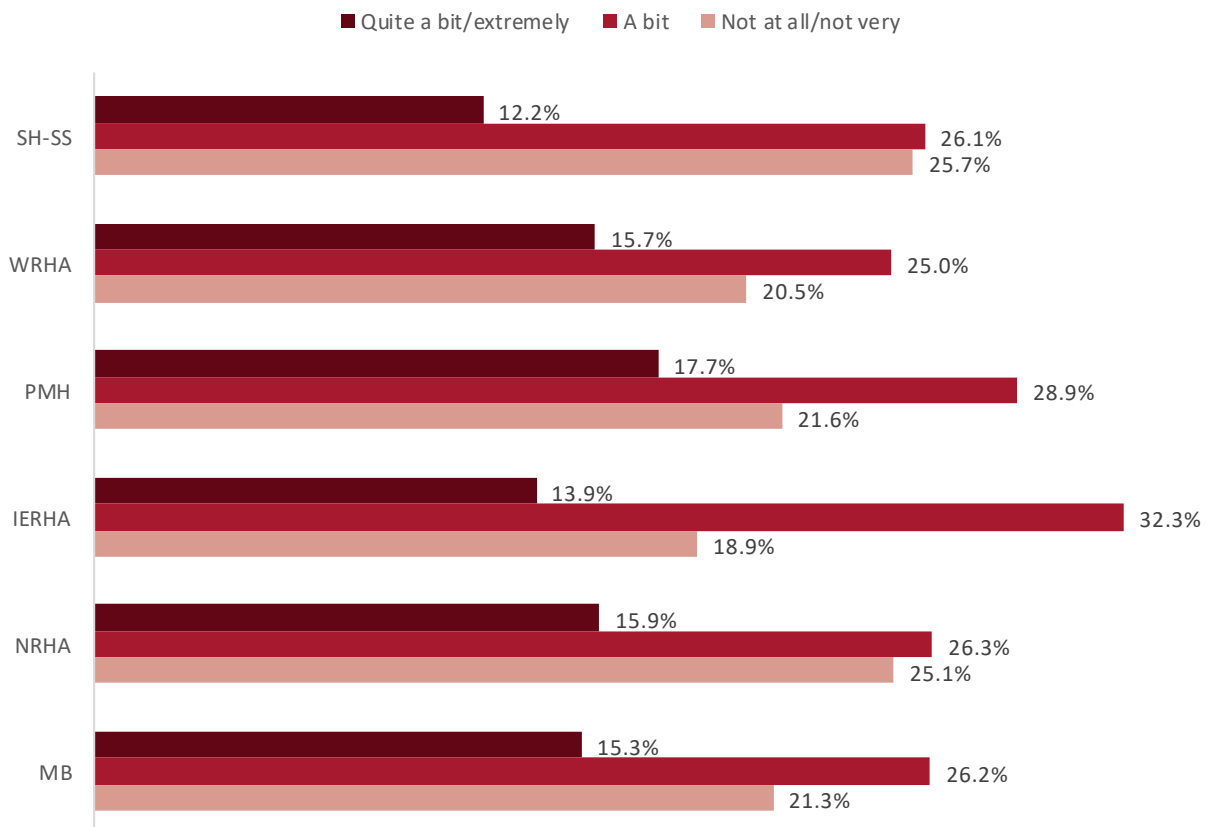
### Why is this indicator important?

Work stress is one of the most common forms of stress, which can lead to poor health and injuries.

### Provincial/Regional Key Findings

- ▶ **Figure 11** shows that in the province and all regions, the largest proportion responded experiencing 'a bit' of work stress.
- ▶ Southern Health-Santé Sud had the lowest proportion reporting 'quite a bit/extremely stressful' and the highest proportion reporting 'not at all/not very stressful' in the province'; however, they were not significantly different than the provincial average.

**Figure 11. Perceived Work Stress by RHA, 2016**  
Age- and sex- adjusted proportion of weighted sample (aged 15-75)



Statistics Canada CCHS 2015-2016

## Healthy Child Development

### Inadequate Prenatal Care

#### Definition

The proportion of women with a single, live, in-hospital birth receiving no or inadequate prenatal care, over a five-year time period.

#### Why is this indicator important?

Women who access prenatal care and receive regular prenatal visits are more likely to experience better health outcomes including a lower risk for low birth weight infant compared to women who receive no prenatal care. Inadequate prenatal care is more likely to be found in women who had less than a Grade 12 education or were younger (less than 25), living in lower income areas, on income assistance, a lone parent, socially isolated, or multiple pregnancies.<sup>iv</sup>

#### Provincial Key Findings

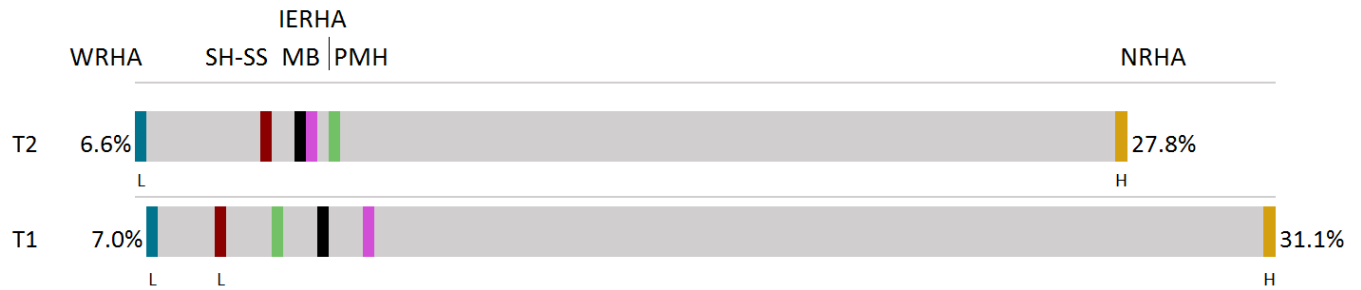
- ▶ **Figure 12** shows that, in Manitoba, a total of 7,300 women (10.3%) received inadequate prenatal care in the current time period.
- ▶ The proportion varied dramatically across health regions, with Winnipeg RHA significantly lower than the provincial average and Northern Health Region significantly higher in both time periods.
- ▶ **Income:** Inadequate prenatal care rates were significantly associated with income in both time periods, with women in lower income areas experiencing higher proportions.<sup>v</sup>



*Inadequate prenatal care  
significantly related to  
income*

**Figure 12. Inadequate Prenatal Care Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	2,117	1,139	7,300	665	971	2,391
T2 RATE	6.6% (L)	9.4% (L)	10.3%	10.6%	10.9%	27.8% (H)
T1 RATE	7.0% (L)	8.6% (L)	10.8%	11.8%	9.7%	31.1% (H)

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 11 shows that in the region, a total of 1,139 women received inadequate prenatal care in the current time period.

### Zone Level

- Percentages varied across zones with the lowest in Zone 4 and the highest in Zone 1 in both time periods.
- Zone 4 was significantly lower than the provincial average in both time periods.
- Percentages increased significantly over time in Zone 3.

### District Level

- Percentages varied dramatically across districts with the lowest in Niverville/Ritchot and the highest in Seven Regions.
- The following districts were significantly lower than the provincial average in the current time period: Niverville/Ritchot, Ste. Anne/La Broquerie, Hanover, Taché, Steinbach, Macdonald, and Cartier/SFX. While, Red River South and Seven Regions were significantly higher in both time periods.
- Percentages in Morden, Winkler, and Altona increased significantly over time.



**Table 11. Inadequate Prenatal Care in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted average annual percentage of singleton live in-hospital births

	T2		T1			T2		T1			
	Count	%	Percentage	Percentage		Count	Percentage	Percentage	%		
<b>Manitoba</b>	<b>7,300</b>	<b>10.3</b>		<b>10.8</b>		<b>SH-SS</b>	<b>1,139</b>	<b>9.4</b>		<b>8.6</b>	<b>L</b>
<b>Zone 4</b>	<b>222</b>	<b>4.6</b>	<b>L</b>	<b>4.6</b>	<b>L</b>	<b>Zone 2</b>	<b>167</b>	<b>10.4</b>		<b>8.5</b>	
Niverville/Ritchot	22	2.8	L	3.3	L	Macdonald	10	3.2	L	4.3	L
Ste. Anne/La Broquerie	35	4.4	L	3.8	L	Grey	7	3.7		s	
Hanover	49	4.7	L	5.4	L	St. Pierre/De Salaberry	14	6.7		4.8	
Taché	25	4.9	L	2.5	L	Morris	25	8.3		6.1	
Steinbach	82	5.1	L	5.3	L	Carman	47	13.5		8.6	
Rural East	9	7.2		10.4		Red River South	64	21.3	H	17.8	H
<b>Zone 3</b>	<b>391</b>	<b>10.8</b>	<b>+</b>	<b>7.0</b>	<b>L</b>	<b>Zone 1</b>	<b>359</b>	<b>12.4</b>		<b>13.9</b>	<b>H</b>
Lorne/Louise/Pembina	38	7.9		8.1		Cartier/SFX	13	3.6	L	5.2	
Morden	69	9.6	+	4.8	L	North Norfolk	28	9.1		9.7	
Winkler	129	9.8	+	6.1	L	City of Portage	90	9.1		7.9	
Altona	81	12.1	+	6.5		Rural Portage	87	14.3		18.3	H
Roland/Thompson	20	13.7		8.0		Seven Regions	141	22.5	H	25.7	H
Stanley	54	15.3		11.4							


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- There was a large decrease in geographic disparity between the districts over time, meaning the gap between the districts with the lowest and highest percentage of inadequate prenatal care reduced. However, the geographic disparity remained large with the highest districts (Seven Regions) experiencing 7.9 times more inadequate prenatal care than the lowest district (Niverville/Ritchot) in the current time period.

SH-SS Geographic Disparity Ratio	
	T1 10.5x
	T2 7.9x
	Change -2.6 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Preterm Birth Rate

### Definition

The proportion of live births with gestational age of less than 37 weeks, based on a five-year time period.

### Why is this indicator important?

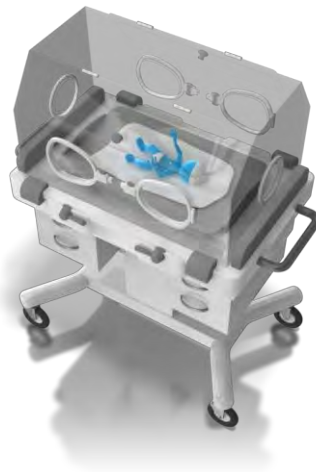
Preterm births are the leading cause of infant mortality. Preterm infants can have both short and long term health issues, including developmental disabilities, mental illnesses and respiratory conditions.<sup>vi</sup>

### Provincial Key Findings

- ▶ **Figure 13** shows that in Manitoba, there were a total of 6,089 preterm births in the current time period.
- ▶ The proportion remained stable over time in the province and all regions.
- ▶ In both time periods, Southern Health-Santé Sud was significantly lower than the provincial average, while Northern Health Region was significantly higher.
- ▶ **Income:** Preterm births were significantly associated with income in both time periods, with women in lower income areas having higher proportions.<sup>vii</sup>

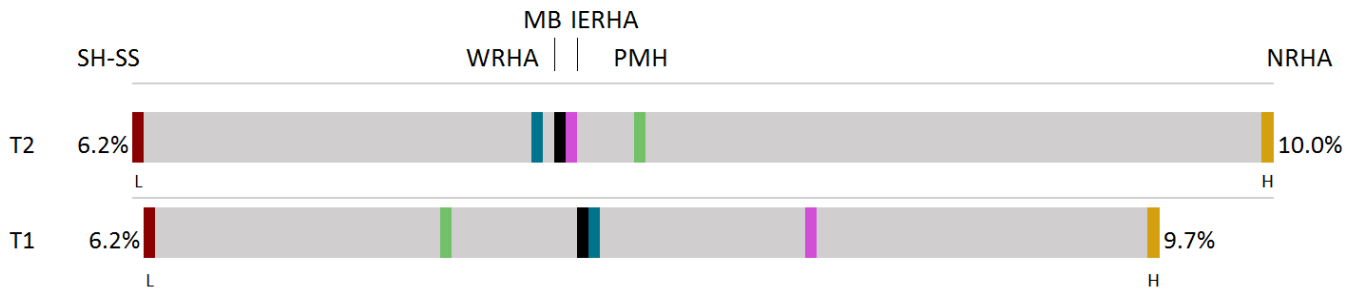


*Preterm births significantly related to income*



**Figure 13. Preterm Births by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted average annual percentage of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		WRHA		MB		IERHA		PMH		NRHA	
T2 COUNT	877		3,105		6,089		528		781		782	
T2 RATE	6.2%	L	7.6%		7.6%		7.7%		7.9%		10.0%	H
T1 RATE	6.2%	L	7.7%		7.7%		8.5%		7.2%		9.7%	H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 12 shows that in the region, there were a total of 877 preterm births in the current time period.
- In both time periods, the regional percentages were significantly lower than the provincial average.

### Zone Level

- Percentages were similar across zones.
- In both time periods, Zones 3 and 4 were significantly lower than the provincial average.

### District Level

- Percentages varied across districts with the lowest in Stanley and the highest in Seven Regions in the current time period.
- Ste. Anne/La Broquerie, Niverville/Ritchot, and Morden were significantly lower than the provincial average in the current time period.
- Percentages increased significantly in Winkler over time.

**Table 12. Preterm Births in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age adjusted average annual percentage of singleton live in-hospital births

	T2		T1			T2		T1			
	Count	Percentage	Percentage	Percentage		Count	Percentage	Percentage			
<b>Manitoba</b>	<b>6,089</b>	<b>7.6</b>		<b>7.7</b>		<b>SH-SS</b>	<b>877</b>	<b>6.2</b>	<b>L</b>	<b>6.2</b>	<b>L</b>
<b>Zone 4</b>	<b>314</b>	<b>5.9</b>	<b>L</b>	<b>6.1</b>	<b>L</b>	<b>Zone 2</b>	<b>118</b>	<b>6.2</b>		<b>6.0</b>	<b>L</b>
Ste. Anne/ La Broquerie	42	4.8	L	5.5		Grey	9	4.2		4.7	
Niverville/ Ritchot	45	4.9	L	7.1		Macdonald	20	5.1		5.7	
Taché	30	5.0		6.1		St. Pierre/ De Salaberry	14	5.9		6.9	
Steinbach	110	6.3		6.3		Carman	25	6.2		5.3	
Hanover	77	7.1		5.2		Morris	23	6.6		7.5	
Rural East	10	7.6		6.9		Red River South	27	8.9		5.3	
<b>Zone 3</b>	<b>227</b>	<b>5.6</b>	<b>L</b>	<b>5.4</b>	<b>L</b>	<b>Zone 1</b>	<b>218</b>	<b>7.4</b>		<b>7.7</b>	
Stanley	16	4.0		6.9		North Norfolk	16	4.7		6.0	
Morden	32	4.2	L	5.1		Cartier/SFX	23	5.2		5.6	
Roland/ Thompson	9	5.8		7.3		Rural Portage	44	7.1		9.0	
Winkler	85	5.9	+	3.4	L	City of Portage	76	7.6		7.7	
Lorne/Louise/ Pembina	35	6.3		7.1		Seven Regions	59	10.5		9.1	
Altona	50	6.6		6.5							


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased slightly over time, meaning the gap between the districts with the lowest and highest percentage of preterm births reduced.

SH-SS Geographic Disparity Ratio	
	T1 2.7x
	T2 2.6x
	Change -0.1 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Small for Gestational Age (SGA)

### Definition

The percentage of live hospital births in which birth weight falls below the 10th percentile of sex-specified birth weight for a given gestational age, based on a five-year time period.

### Why is this indicator important?

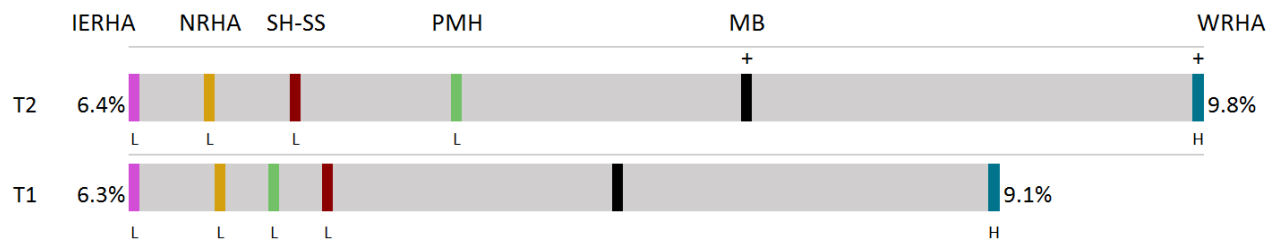
SGA infants are more likely to face both short-term and long-term health issues including diabetes, hypertension, and cardiovascular disease. SGA is often related to maternal smoking, substance use, poor nutrition during pregnancy, placental insufficiency, and other conditions.<sup>viii</sup>

### Provincial Key Findings

- ▶ **Figure 14** shows that there were a total of 6,576 SGA births in Manitoba in the current time period.
- ▶ In both time periods, all health regions were significantly lower than the provincial average except for Winnipeg RHA where percentages were significantly higher.
- ▶ Percentages increased significantly over time in the province and Winnipeg RHA.

**Figure 14. Small for Gestational Age by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	IERHA	NRHA	SH-SS	PMH	MB	WRHA
T2 COUNT	440	535	985	734	6,576	3,873
T2 RATE	6.4% L	6.6% L	6.9% L	7.4% L	8.3% +	9.8% H+
T1 RATE	6.3% L	6.6% L	7.0% L	6.8% L	7.9%	9.1% H

## Regional Key Findings

### SH-SS Level

- Table 13 shows that in the region, there were a total of 985 SGA births in the current time period.
- Regional percentages were significantly lower than the provincial average in both time periods.

### Zone Level

- Percentages were similar across zones.
- Zones 3 and 4 were significantly lower than the provincial average in the current time period.

### District Level

- Percentages were relatively similar across districts.
- Percentages in Niverville/Ritchot and Winkler were significantly lower than the provincial average.

**Table 13. Small for Gestational Age in Southern Health-Santé Sud,  
2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age adjusted average annual percent of singleton live in-hospital births

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>6,576</b>	<b>8.3</b>	<b>+</b>	<b>7.9</b>	
<b>SH-SS</b>	<b>985</b>	<b>6.9</b>	<b>L</b>	<b>7.0</b>	<b>L</b>
<b>Zone 4</b>	<b>348</b>	<b>6.5</b>	<b>L</b>	<b>6.3</b>	<b>L</b>
Niverville/Ritchot	50	5.6	L	6.3	
Taché	35	6.1		5.0	
Hanover	69	6.3		5.8	
Ste. Anne/ La Broquerie	59	6.7		6.0	
Steinbach	120	6.8		6.5	
Rural East	15	11.3		13.6	
<b>Zone 2</b>	<b>143</b>	<b>7.7</b>		<b>6.5</b>	
Morris	21	6.1		5.4	
Macdonald	23	6.2		5.1	
Carman	27	6.8		5.0	
Grey	18	8.6		S	
Red River South	30	9.7		7.7	
St. Pierre/ De Salaberry	24	10.2		12.2	
<b>Zone 3</b>	<b>252</b>	<b>6.2</b>	<b>L</b>	<b>7.0</b>	
Winkler	81	5.5	L	6.3	
Altona	44	5.8		7.4	
Stanley	26	6.6		6.2	
Lorne/Louise/ Pembina	36	6.6		7.6	
Roland/ Thompson	11	7.1		7.3	
Morden	54	7.1		7.9	
<b>Zone 1</b>	<b>242</b>	<b>8.1</b>		<b>8.4</b>	
North Norfolk	19	5.6		6.7	
Rural Portage	49	7.9		8.3	
City of Portage	85	8.4		8.0	
Cartier/SFX	36	8.5		10.4	
Seven Regions	53	8.9		8.7	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period  
s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest percentage of SGA births reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.7x
	T2	2.1x
	Change	-0.6 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17



## Large for Gestational Age (LGA)

### Definition

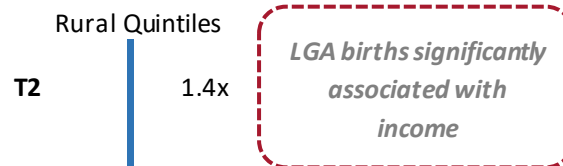
The percentage of live hospital births in which birth weight falls above the Canadian 90th percentile of sex-specified birth weight for a given gestational age, based on a five-year time period.

### Why is this indicator important?

LGA infants may have a higher risk for injury and complications during birth, fetal and neonatal illnesses and death, impaired cognitive development, childhood and adult obesity and chronic conditions such as diabetes and heart disease later in life. LGA infants can be associated with prolonged pregnancies and gestational diabetes.<sup>ix</sup>

### Provincial Key Findings

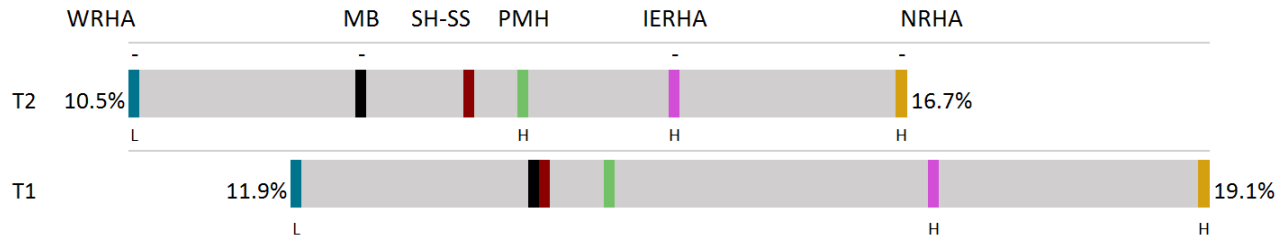
- ▶ **Figure 15** shows that in Manitoba, there were a total of 9,830 LGA births in the current time period.
- ▶ In both time periods, percentages were significantly lower in Winnipeg RHA, while significantly higher in Interlake-Eastern RHA and Northern Health Region. Prairie Mountain Health was significantly higher in the current time period.
- ▶ Percentages decreased significantly over time in the province, Winnipeg RHA, Interlake-Eastern RHA, and Northern Health Region.
- ▶ **Income:** LGA births were significantly associated with income in both time periods in rural areas.<sup>x</sup> The percentage in low income areas was 1.4 times higher than the highest income areas.





**Figure 15. Large for Gestational Age by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted average annual percentage of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	SH-SS	PMH	IERHA	NRHA	
T2 COUNT	4,213	9,830	1,887	1,356	1,026	1,337	
T2 RATE	10.5% L-	12.4%	-	13.2%	13.7% H	14.9% H-	16.7% H-
T1 RATE	11.9% L	13.8%	13.8%	14.4%	17.0% H	19.1% H	

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 14 shows a total of 1,887 LGA births in the region in the current time period.
- Regional percentages remained stable over time.

### Zone Level

- Percentages were similar across zones.
- Zone 1 was significantly higher than the provincial average in the current time period.

### District Level

- Percentages varied across districts with the lowest in Rural East and the highest in the city of Portage in the current time period.

**Table 14. Large for Gestational Age in Southern Health-Santé Sud,  
2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Maternal age-adjusted average annual percentage of singleton live in-hospital births

	T2		T1	
	Count	Percentage	Percentage	
<b>Manitoba</b>	<b>9,830</b>	<b>12.4</b>	<b>-</b>	<b>13.8</b>
<b>Zone 4</b>	<b>689</b>	<b>12.9</b>		<b>13.5</b>
Rural East	12	9.0		16.7
Niverville/ Ritchot	90	9.9		11.9
Steinbach	223	12.7		13.6
Hanover	150	13.6		13.5
Taché	82	14.1		16.4
Ste. Anne/ La Broquerie	132	14.9		11.8
<b>Zone 2</b>	<b>220</b>	<b>11.7</b>		<b>13.5</b>
Macdonald	39	10.2		11.4
Morris	36	10.4		14.5
Red River South	32	10.4		14.4
St. Pierre/ De Salaberry	26	11.0		10.5
Grey	28	13.3		16.5
Carman	59	14.7		14.4
<b>Zone 3</b>	<b>546</b>	<b>13.4</b>		<b>14.6</b>
Lorne/Louise/ Pembina	63	11.5		12.4
Morden	90	11.8		11.8
Stanley	48	12.1		15.8
Roland/ Thompson	19	12.2		17.1
Altona	108	14.3		14.0
Winkler	218	14.9		16.4
<b>Zone 1</b>	<b>432</b>	<b>14.5</b>	<b>H</b>	<b>13.7</b>
Cartier/SFX	40	9.2		13.2
Rural Portage	83	13.3		14.3
North Norfolk	48	14.1		10.9
Seven Regions	88	15.2		12.7
City of Portage	173	17.1	<b>H</b>	<b>15.0</b>

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity increased over time, meaning the gap between the districts with the lowest and highest percentages of LGA births widened.

SH-SS Geographic Disparity Ratio	
	T1 1.6x
	T2 1.9x
	Change 0.3 ↑

T1: 2011-2012, T2: 2016-2017

## Breastfeeding Initiation

### Definition

The percentage of women who deliver in hospital and initiate breastfeeding while in hospital, based on a one-year time period.

### Why is this indicator important?

Breastfeeding is a key part of the healthy development and growth of infants. It is associated with lower rates of obesity and chronic diseases such as diabetes and asthma, and better early childhood development. Breastfeeding also has health benefits for mothers including lower risk for breast cancer, ovarian cancer and osteoporosis. Some of the most significant predictors of lower breastfeeding initiation are lower income, less than Grade 12 education and inadequate prenatal care.

### Provincial Key Findings

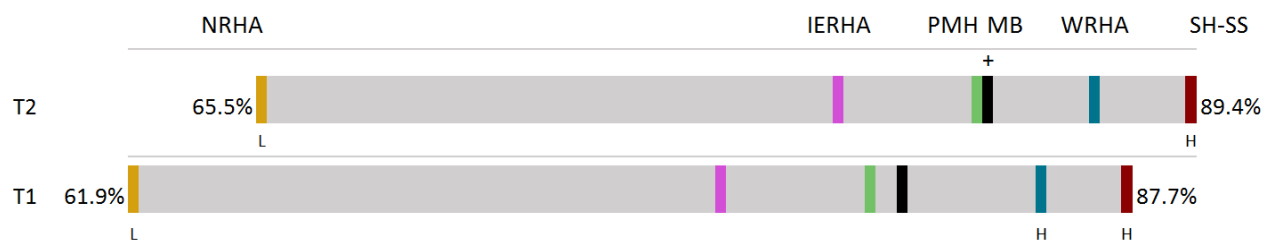
- ▶ **Figure 16** shows that in Manitoba, a total of 13,215 women who delivered in hospital initiated breastfeeding while in hospital in the current time period.
- ▶ Percentages in Manitoba increased significantly over time.
- ▶ In both time periods, percentages in Northern Health Region were significantly lower than the provincial average, while percentages were significantly higher in Southern Health-Santé Sud.
- ▶ **Income:** Breastfeeding initiation was significantly associated with income in both time periods, with women in lower income areas having lower initiation.<sup>xi</sup>



*Breastfeeding initiation  
significantly related to  
income*

**Figure 16. Breastfeeding Initiation by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Maternal age-adjusted percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	NRHA	IERHA	PMH	MB	WRHA	SH-SS
T2 COUNT	1,032	1,075	1,693	13,215	6,893	2,515
T2 RATE	65.5% L	80.2%	83.9%	84.2% +	86.8%	89.4% H
T1 RATE	61.9% L	77.3%	81.2%	82.1%	85.4% H	87.7% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 15 shows that in the region, a total of 2,515 women initiated breastfeeding in-hospital in the current time period.
- Percentages were significantly higher than the provincial average in both time periods.

### Zone Level

- Percentages varied across zones with the lowest in Zone 1 and the highest in Zone 4 in the current time period.
- Percentages in Zone 4 were significantly higher than the provincial average in both time periods.

### District Level

- Percentages varied dramatically across districts with the lowest in Seven Regions and the highest in Roland/Thompson in the current time period.

**Table 15. Breastfeeding Initiation in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


Maternal age adjusted percentage of singleton live in-hospital births

	T2			T1	
	Count	Percentage		Percentage	
<b>Manitoba</b>	<b>13,215</b>	<b>84.2</b>	<b>+</b>	<b>82.1</b>	
<b>SH-SS</b>	<b>2,515</b>	<b>89.4</b>	<b>H</b>	<b>87.7</b>	<b>H</b>
<b>Zone 4</b>	<b>1,038</b>	<b>94.2</b>	<b>H</b>	<b>91.4</b>	<b>H</b>
Steinbach	320	95.3		92.5	
Niverville/Ritchot	193	95.1		92.1	
Hanover	219	94.9		88.6	
Ste. Anne/ La Broquerie	189	94.1		90.6	
Taché	90	89.2		94.1	
Rural East	27	86.9		82.5	
<b>Zone 2</b>	<b>331</b>	<b>89.9</b>		<b>88.1</b>	
St. Pierre/ De Salaberry	47	92.8		90.2	
Grey	33	92.7		88.3	
Morris	65	92.2		94.7	
Macdonald	61	89.0		83.7	
Red River South	54	88.6		78.3	
Carman	71	87.0		93.7	
<b>Zone 3</b>	<b>692</b>	<b>91.3</b>		<b>91.5</b>	<b>H</b>
Roland/Thompson	32	97.7		99.1	
Lorne/Louise/ Pembina	108	92.0		83.5	
Altona	123	91.4		92.2	
Morden	120	91.3		89.9	
Stanley	52	91.0		93.4	
Winkler	257	90.3		92.6	
<b>Zone 1</b>	<b>454</b>	<b>77.6</b>		<b>76.4</b>	
Cartier/SFX	85	91.6		92.8	
North Norfolk	57	88.6		88.5	
Rural Portage	94	78.5		78.5	
City of Portage	148	75.5		77.8	
Seven Regions	70	62.5		53.9	L

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased slightly over time, meaning the gap between the districts with the lowest and highest percentage of breastfeeding initiation reduced.

SH-SS Geographic Disparity Ratio	
	T1 1.8x
	T2 1.6x
	Change -0.2 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Proportion of Children in Low Income

### Definition

The proportion of children, age 17 years and younger, living in low income families according to the low income measure – after tax (LIM-AT).

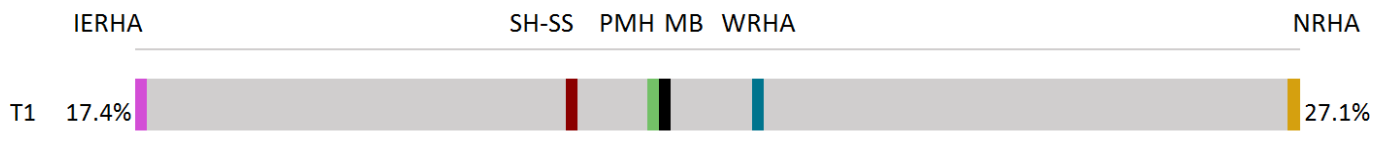
### Why is this indicator important?

Family income affects children’s access to basic necessities such as adequate housing, nutritious food, and clothing. Living in low income poses many challenges for child growth and development including early learning and care programs, and access to recreation and art programs.

### Provincial Key Findings

- ▶ **Figure 17** shows that in Manitoba, a total of 57,370 children lived in low income.
- ▶ Percentages ranged from the lowest in Interlake-Eastern RHA and the highest in Northern Health Region.

**Figure 17. Children Living in Low Income Families by RHA, 2016 (T1)**  
Percentage of children (aged 17 and younger)



	IERHA	SH-SS	PMH	MB	WRHA	NRHA
T1 COUNT	3,820	10,525	7,290	57,370	33,225	2,510
T1 RATE	17.4%	21.1%	21.8%	21.9%	22.6%	27.1%

Statistics Canada Census 2016

## Regional Key Findings

- ▶ **Table 16** shows that in the region 10,525 children lived in low income, representing 21.1% children.
- ▶ Percentages were similar across zones.
- ▶ Percentages varied dramatically across districts with the lowest in Macdonald and the highest in Seven Regions.

## Geographic Disparity

- ▶ There was a large geographic disparity with the highest district of Seven Regions 6.7 times higher than the lowest district of Macdonald.

**Table 16. Children Living in Low Income Families in Southern Health-Santé Sud, 2016**

Percentage of children (aged 17 and younger)

	Count	Percentage		Count	Percentage
<b>Manitoba</b>	<b>57,370</b>	<b>21.9</b>	<b>SH-SS</b>	<b>10,525</b>	<b>21.1</b>
<b>Zone 4</b>	<b>4,065</b>	<b>19.5</b>	<b>Zone 2</b>	<b>1,125</b>	<b>16.2</b>
Niverville/Ritchot	320	10.3	Macdonald	100	5.7
Taché	540	15.4	Grey	70	11.1
Hanover	1,075	19.4	Morris	200	15.5
Ste. Anne/La Broquerie	850	21.5	St. Pierre/De Salaberry	175	16.5
Steinbach	1,010	25.4	Red River South	215	26.1
Rural East	270	37.5	Carman	365	26.7
<b>Zone 3</b>	<b>3,630</b>	<b>25.0</b>	<b>Zone 1</b>	<b>1,705</b>	<b>22.4</b>
Lorne/Louise/Pembina	275	18.4	Cartier/SFX	125	8.2
Roland/Thompson	135	21.8	North Norfolk	105	11.9
Morden	470	22.7	Rural Portage	275	19.5
Stanley	955	25.7	City of Portage	925	30.2
Winkler	880	25.8	Seven Regions	275	37.9
Altona	915	28.7			

Statistics Canada Census 2016

## Families First – Risk Factors

### Definition

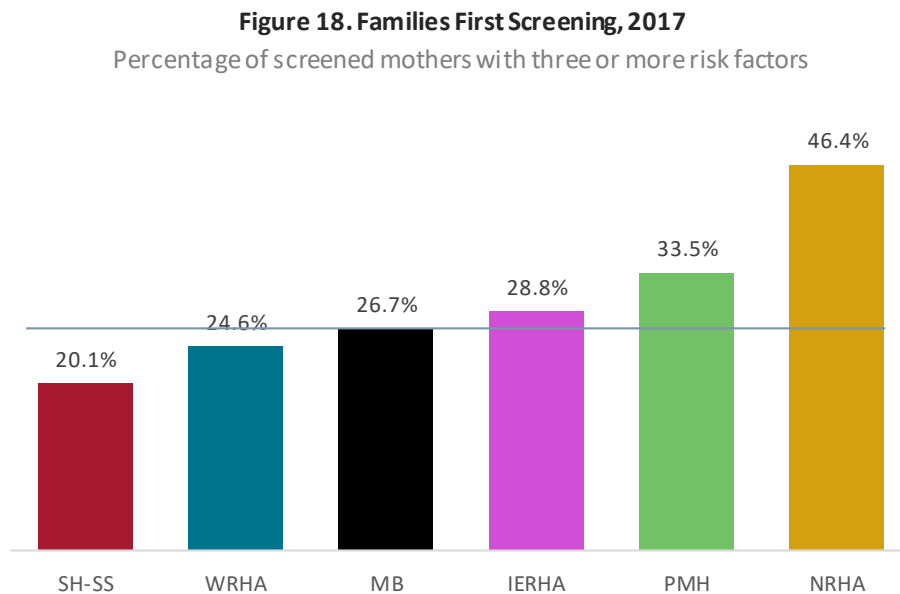
The proportion of mothers with three or more risk factors identified as leading to poor childhood outcomes, based on the regional post-partum population screened for enrollment in the Families First Program, for a one-year time period.

### Why is this indicator important?

The early years comprise a significant period of brain development and set the foundation for health and success in all aspects of life. It is used to identify families who may need further support and assistance to ensure children are raised in a healthy environment.

### Provincial Key Findings

- ▶ **Figure 18** shows that 26.7% of screened Manitoba mothers had three or more risk factors on the families first screening.
- ▶ Percentages varied dramatically with the lowest in Southern Health-Santé Sud and the highest in Northern Health Region.



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## Regional Key Findings

### SH-SS Level

- Table 17** shows that in the region, 20.1% of screened mothers had three or more risk factors on the Families First screening in the current time period. This was the lowest percentage in the province and appeared to remain relatively stable over time; however, change over time was not tested statistically.
- The most prevalent risk factor in the region was maternal depression or anxiety; however, differences compared to other risk factors were not tested statistically.
- The prevalence decreased for the majority of risk factors with the exception of maternal depression and/or anxiety which increased; however, the change over time was not tested statistically. The decrease in prevalence may, in part, be attributable to the increased number of screens conducted.

**Table 17. Prevalence of Families First Risk Factors in Southern Health-Santé Sud, 2011 (T1) and 2017 (T2)**

Percentage of screened mothers

<b>Families First Risk Factors</b>	T2	T1
Maternal alcohol use	4.0%	8.0%
Maternal smoking	6.1%	9.5%
Mother has less than high school education	16.0%	21.7%
Financial difficulties	7.4%	7.6%
Maternal depression and/or anxiety	18.2%	14.1%
<b>Three or more risk factors</b>	20.1%	19.3%
Total number of screens	2,741	2,459

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### Zone Level

- Table 18** shows that the percentage of screened mothers with three or more risk factors varied across zones with the lowest in Zone 2 and the highest in Zone 1 in the current time period.
- Generally, the percentages remained relatively stable over time; however, the differences were not tested statistically.

### District Level

- Percentages varied dramatically across districts with the lowest in Cartier/SFX and the highest in the city of Portage in the current time period.
- Percentages increased over time in a bit more than half of the districts while it decreased in a bit less than half; however, these changes were not tested statistically.

**Table 18. Families First in Southern Health-Santé Sud, 2011 (T1) and 2017 (T2)**


Percentage of screened mothers with 3 or more risk factors

	T2		T1
	Total # Screens	Percentage	Percentage
<b>Manitoba</b>	<b>12,795</b>	<b>26.7</b>	<b>28.1</b>
<b>Zone 4</b>	<b>1,132</b>	<b>19.1</b>	<b>15.8</b>
Hanover	225	16.2	19.5
Ste. Anne/ La Broquerie	209	17.3	15.6
Steinbach	305	18.0	13.9
Niverville/ Ritchot	190	20.5	16.3
Rural East	30	21.4	17.2
Taché	173	24.9	16.1
<b>SH-SS</b>	<b>2,741</b>	<b>20.1</b>	<b>19.3</b>
<b>Zone 2</b>	<b>364</b>	<b>16.9</b>	<b>19.0</b>
Macdonald	85	8.2	17.1
Red River South	34	8.8	39.5
Carman	88	15.9	19.3
Morris	80	22.8	14.5
St. Pierre/ De Salaberry	54	24.1	13.0
Grey	23	27.3	12.5
<b>Zone 3</b>	<b>769</b>	<b>20.2</b>	<b>21.0</b>
Stanley	90	12.4	14.5
Winkler	308	17.9	18.1
Roland/ Thompson	43	18.6	15.4
Morden	127	19.7	26.3
Lorne/Louise /Pembina	68	26.5	20.0
Altona	133	28.8	27.5
<b>Zone 1</b>	<b>418</b>	<b>25.7</b>	<b>25.4</b>
Cartier/SFX	80	6.3	10.8
Rural Portage	70	10.4	19.0
Seven Regions	31	16.7	27.8
North Norfolk	45	31.1	6.9
City of Portage	192	39.3	36.1

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## Geographic Disparity

- ▶ The geographic disparity increased over time, meaning the gap between the districts with the lowest and highest percentages of screened mothers with three or more risk factors widened.

SH-SS Geographic Disparity Ratio		
	T1	5.7x
	T2	6.2x
	Change	0.5 ↑

T1: 2011, T2: 2017

## Readiness for School Learning

### Definition

The proportion of kindergarten children 'vulnerable', 'at risk', and 'on track' for age-appropriate developmental expectations on the Early Development Instrument (EDI), for a one-year time period. It measures five areas of development: physical health and well-being, social competence, emotional maturity, language and thinking skills, and communication skills and general knowledge.

### Why is this indicator important?

EDI is an important measure of the well-being and health of children. It has been shown to be strongly linked to parental involvement in a child's early learning, household income levels, as well as educational outcomes later in childhood. EDI results assist communities in planning for the services and programs children need in order to learn and enjoy their school experience.

### Provincial Key Findings

- ▶ **Tables 19 to 21** show that, generally, Southern Health-Santé Sud and Interlake-Eastern RHA had some of the best EDI results (i.e., lower vulnerable, lower at risk, higher on track), while Northern Health Region had some of the poorest results (higher vulnerable, higher at risk, lower on track).
- ▶ **Table 19** shows that in Manitoba 30% of kindergarten children were vulnerable on one or more EDI domains ranging from the lowest in Southern Health-Santé Sud and the highest in Northern Health Region.
- ▶ These percentages varied across domains with some of the highest percentages of vulnerable children in the domain of communication skills and general knowledge.
- ▶ **Table 20** shows that in Manitoba, the percentage of at risk children ranged from 9.8% to 16.6%, varying across domains and health regions.
- ▶ Emotional maturity had the highest percentage of at risk children in Prairie Mountain Health and Northern Health Region, while percentages were the highest in communication skills and general knowledge for Interlake-Eastern RHA, Southern Health-Santé Sud, and Winnipeg RHA.
- ▶ **Table 21** shows that in Manitoba, the percentage of on track children ranged from 69% to 77.4%, varying across domains and health regions. On all domains, the majority of children were on track across the province.
- ▶ Physical health and well-being had the highest percentage of on track children in Northern Health Region, Winnipeg RHA, and Southern Health-Santé Sud, while percentages were the highest in social competence for Prairie Mountain Health and Interlake-Eastern RHA.
- ▶ From 2015 to 2019, percentages of vulnerable, at risk, and on track children remained relatively stable across health regions and across domains.

**Table 19. Children Vulnerable by EDI Domain by RHA, 2019**

Percentage of kindergarten children who scored below the 10<sup>th</sup> percentile based on Canadian baseline sample

	SH-SS	IERHA	MB	WRHA	PMH	NRHA
Physical Health & Well-Being	10.5	14.2	12.8	15.1	17.3	25.1
Social Competence	9.0	9.4	9.5	12.6	12.9	18.7
Emotional Maturity	10.7	11.5	11.9	14.9	14.8	22.8
Language and Thinking Skills	10.5	10.9	12.2	14.4	15.2	29.2
Communication Skills and General Knowledge	14.3	13.6	14.4	17.6	18.4	23.8
<b>Vulnerable 1+ domains</b>	<b>27.3</b>	<b>28.5</b>	<b>30.0</b>	<b>33.4</b>	<b>34.5</b>	<b>46.1</b>

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**Table 20. Children At Risk by EDI Domain by RHA, 2019**

Percentage of kindergarten children who scored between the 10<sup>th</sup> and 25<sup>th</sup> percentile based on Canadian baseline sample

	IERHA	SH-SS	PMH	MB	WRHA	NRHA
Physical Health & Well-Being	9.5	9.1	10.7	9.8	10.2	8.6
Social Competence	12.2	14.0	15.0	14.5	15.0	15.9
Emotional Maturity	13.8	17.1	16.0	15.5	14.8	20.2
Language and Thinking Skills	12.8	14.2	14.4	14.6	14.8	16.9
Communication Skills and General Knowledge	14.6	17.5	15.7	16.6	16.4	14.8

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**Table 21. Children On Track by EDI Domain by RHA, 2019**

Percentage of kindergarten children who scored above the 25<sup>th</sup> percentile based on Canadian baseline sample

	NRHA	PMH	WRHA	SH-SS	MB	IERHA
Physical Health & Well-Being	66.4	72.0	74.7	80.4	77.4	76.2
Social Competence	65.3	72.1	72.4	77.0	76.0	78.3
Emotional Maturity	57.0	69.2	70.4	72.1	72.7	74.6
Language and Thinking Skills	53.8	70.4	70.8	75.2	73.2	76.3
Communication Skills and General Knowledge	61.4	66.0	66.0	68.2	69.0	71.8

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## Regional Key Findings

### SH-SS Level

- D **Table 22** shows that in the region, 27.3% of kindergarten children were vulnerable on one or more EDI domains in the current time period but percentages remained stable over time.
- D The region had the lowest percentage of vulnerable children on one or more domains and on each domain except communication skills and general knowledge.
- D **Tables 19 to 21** show that in the region, communication skills and general knowledge was the domain with the largest percentage of vulnerable and at-risk children, while physical health and well-being had the largest percentage of on track children.

## Zone Level

- Table 22 shows that the proportions of children vulnerable on one or more EDI domain were similar across zones 2, 3, and 4 with slightly higher percentages in Zone 1; however these differences were not tested statistically.
- Percentages remained relatively stable over time; however, changes over time were not statistically tested.

## District Level

- Percentages varied dramatically across districts with the lowest in Stanley and the highest in city of Portage in the current time period.
- Percentages remained relatively stable over time across districts with a few notable exceptions: Red River South, and St. Pierre/De Salaberry, and Stanley saw large decreases while Seven Regions saw a large increase. However, changes over time were not statistically tested.

**Table 22. Vulnerable Children on the EDI in Southern Health-Santé Sud, 2015 (T1) and 2019 (T2)**


Percentage of kindergarten children vulnerable on one or more domains

	T2 Percentage	T1 Percentage		T2 Percentage	T1 Percentage
<b>Manitoba</b>	<b>30.0</b>	<b>30.0</b>	<b>SH-SS</b>	<b>27.3</b>	<b>29.0</b>
<b>Zone 4</b>	<b>26.8</b>	<b>25.7</b>	<b>Zone 2</b>	<b>23.1</b>	<b>29.6</b>
Niverville/Ritchot	24.0	22.3	Macdonald	17.7	22.5
Taché	25.6	16.1	Grey	18.2	17.2
Hanover	26.0	35.1	Morris	23.3	19.5
Steinbach	28.4	23.8	Red River South	23.7	35.4
Ste. Anne/La Broquerie	28.5	32.9	Carman	27.0	34.2
Rural East	32.4	29.2	St. Pierre/De Salaberry	29.5	43.6
<b>Zone 3</b>	<b>25.0</b>	<b>32.4</b>	<b>Zone 1</b>	<b>35.5</b>	<b>31.5</b>
Stanley	8.8	45.9	Cartier/SFX	21.6	20.6
Lorne/Louise/Pembina	23.6	30.0	North Norfolk	25.0	31.0
Winkler	26.1	34.9	Seven Regions	31.8	20.0
Morden	26.6	26.2	Rural Portage	37.0	35.1
Roland/Thompson	28.2	36.7	City of Portage	44.3	37.2
Altona	31.2	25.4			

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## Geographic Disparity

- D The geographic disparity increased over time, meaning the gap between the district with the lowest percentage of children vulnerable on one or more EDI domains and the highest percentage widened.

SH-SS Geographic Disparity Ratio		
Vulnerable on one or more domains		
	T1	2.9x
	T2	5.0x
	Change	2.1 ↑

T1: 2011, T2: 2017

## A CLOSER LOOK...



The Early Development Instrument, or the EDI for short, is a questionnaire developed by Dr. Dan Offord and Dr. Magdalena Janus at the Offord Centre for Child Studies at McMaster University. It is a questionnaire completed by kindergarten teachers that assesses the development health of children at the transition from early childhood to school age in a holistic and reliable manner.

The EDI has been used since 1998 in Canada and has been implemented in every province and territory with the exception of Nunavut. Since its first collection, the EDI has been collected on more than 1.3 million Canadian children. Although developed in Canada, the EDI is being used around the world.

The EDI data can be helpful for a variety of different users.

**Educators and school representatives** can use EDI results to help identify the strengths and needs of the children within their communities. These data allow for creating targeted programs that affect the areas identified as the greatest need. Local groups can also use the data to better advocate for changes to policies and funding.

**Government** can use EDI data to plan early childhood investment, inform policy and program development decisions, or evaluate programs. The use of EDI maps can help focus investments and identify the areas with the highest needs.

**Researchers** can use EDI data to address important questions and create new research programs to help better understand the genetic, biological, and social determinants of children's health, well-being and development. This research can help inform policy and program development.

**Link to Offord Centre for Child Studies:** <https://edi.offordcentre.com/>

**Link to Healthy Child Manitoba:** [https://www.gov.mb.ca/healthychild/edi/edi\\_reports.html](https://www.gov.mb.ca/healthychild/edi/edi_reports.html)

## Pediatric Dental Extractions under General Anesthesia

### Definition

The average annual rate of hospital-based dental surgeries involving extractions for children under the age of 6 years, per 1,000 population, over a five-year time period.

### Why is this indicator important?

Early childhood caries (ECC) (i.e., dental decay in the primary teeth in children under the age of 6 years) reflects the impact of many social inequalities including income, nutrition, and personal health practices. Monitoring pediatric dental surgery involving extraction of primary teeth gauges ongoing access to care and preventative dental services for children.



### Provincial Key Findings

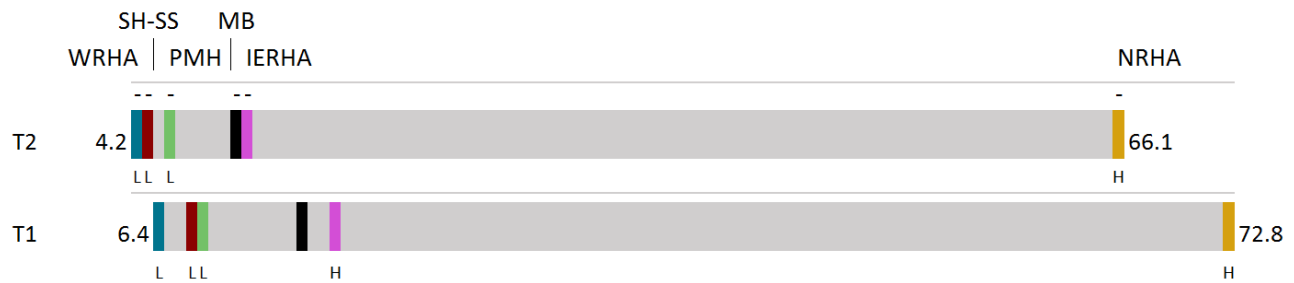
- ▶ **Figure 19** shows that a total of 5,786 children under age 6 received hospital-based dental surgeries under general anesthesia in the current time period.
- ▶ Rates decreased significantly over time in the province and all health regions.
- ▶ In both time periods, rates in Winnipeg RHA, Southern Health-Santé Sud, and Prairie Mountain Health were significantly lower than the provincial average, while rates in Northern Health Region were significantly higher.
- ▶ **Income:** Pediatric dental extraction surgeries were strongly associated with income in both time periods, with children in lower income areas having higher rates of surgery.<sup>xii</sup>



*Pediatric dental extraction surgeries strongly related to income*

**Figure 19. Pediatric Dental Extraction Surgery by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Crude average annual rate per 1,000 residents (under age 6)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA		SH-SS		PMH		MB		IERHA		NRHA	
T2 COUNT	1,060		450		448		5,786		530		3,279	
T2 RATE	4.2	L-	4.9	L-	6.8	L-	11.5	-	12.1	-	66.1	H-
T1 RATE	6.4	L	8.0	L	9.0	L	15.0		17.1	H	72.8	H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 23 shows that in the region, there were a total of 450 hospital-based dental surgeries under general anesthesia for children in the current time period.
- Regional rates were significantly lower than the provincial average in both time periods and decreased significantly over time.

### Zone Level

- Rates varied across zones with the lowest in Zone 4 and the highest in Zone 1.
- Rates were significantly lower than the provincial average in Zone 2, 3, and 4 but decreased significantly over time in all zones.

### District Level

- Rates varied dramatically across districts with the lowest in Ste. Anne/La Broquerie and the highest in Seven Regions in the current time period.
- In the current time period, rates were significantly lower than the provincial average in Ste. Anne/La Broquerie, Hanover, Steinbach, Macdonald, Morden, Altona, Stanley, Winkler, and Cartier/SFX. While rates in Seven Regions were significantly higher than the provincial average in both time periods.
- Rates decreased significantly over time in Steinbach, Morden, Stanley, North Norfolk, city of Portage, Rural Portage, and Seven Regions.



**Table 23. Pediatric Dental Extraction Surgery in Southern Health-Santé Sud,  
2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Crude average annual rate per 1,000 residents (under age 6)

	T2		T1			T2		T1			
	Count	Rate	Rate	Rate		Count	Rate	Rate			
<b>Manitoba</b>	<b>5,786</b>	<b>11.5</b>	-	<b>15.0</b>		<b>SH-SS</b>	<b>450</b>	<b>4.9</b>	L-	<b>8.0</b>	L
<b>Zone 4</b>	<b>41</b>	<b>1.2</b>	L-	<b>1.8</b>	L	<b>Zone 2</b>	<b>45</b>	<b>3.6</b>	L-	<b>6.0</b>	L
Ste. Anne/ La Broquerie	6	1.1	L	1.8	L	Macdonald	11	4.0	L	2.8	L
Hanover	9	1.2	L	1.7	L	Red River South	23	11.3		16.8	
Steinbach	14	1.3	L-	2.6	L	St. Pierre/ De Salaberry	s			s	
Niverville/Ritchot	s			s		Carman	s			4.9	L
Taché	s			s		Grey	s			6.7	
Rural East	s			s		Morris	s			3.7	L
<b>Zone 3</b>	<b>130</b>	<b>5.1</b>	L-	<b>8.4</b>	L	<b>Zone 1</b>	<b>234</b>	<b>12.7</b>	-	<b>19.4</b>	H
Morden	17	3.7	L-	7.6	L	Cartier/SFX	11	3.7	L	3.3	L
Altona	20	4.1	L	6.4	L	North Norfolk	10	5.2	-	11.2	
Stanley	15	5.3	L-	11.7		City of Portage	53	8.4	-	14.2	
Winkler	55	6.2	L	8.5	L	Rural Portage	51	13.9	-	20.9	
Lorne/Louise/ Pembina	20	6.4		9.3		Seven Regions	109	31.0	H-	43.0	H
Roland/Thompson	s			7.3							

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
s indicates data suppressed due to small numbers  
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity was large and increased over time, meaning the gap between the districts with the lowest and highest percentages of pediatric dental extraction surgeries widened.

SH-SS Geographic Disparity Ratio		
	T1	25.5x
	T2	27.8x
	Change	2.3 ↑

T1: 2011, T2: 2017

## Childhood Immunization

### Definition

Antigen-specific immunization coverage rates for children are reported as the percentage of children who received all recommended vaccine doses for diphtheria, tetanus, pertussis, measles, mumps, and human papilloma virus (HPV) by the age of 17 years. Rate of HPV immunizations is only reported for girls.

### Why is this indicator important?

Vaccines are one of the most important parts of child health programs because they can prevent death, disability, and control the spread of infectious diseases. Immunization is the single most important public health achievement in the past century, as infectious diseases have dropped from the leading cause of death to less than five percent of all deaths in Canada. For additional information, see the Routine Immunization Schedules in Manitoba:

<https://www.gov.mb.ca/health/publichealth/cdc/div/schedules.html>.

### Provincial Key Findings

- ▶ **Table 24** shows that in Manitoba, the percentage of 17 year olds who received the recommended doses varied by immunization type; ranging from 70.5% for Pertussis to 83.0% for Rubella.
- ▶ The lowest childhood immunization prevalence was noted in Southern Health-Santé Sud and the highest in Prairie Mountain Health for diphtheria, tetanus, pertussis, and HPV. For measles, mumps, and rubella, the lowest was noted in Winnipeg RHA and the highest in Northern Health Region.

**Table 24. Childhood Immunization by RHA, 2017**

Percentage of youth (aged 17) who received recommended doses

	SH-SS	WRHA	NRHA	MB	IERHA	PMH
Diphtheria	66.8%	70.1%	71.0%	71.9%	79.4%	82.1%
Tetanus	66.8%	70.1%	71.0%	71.9%	79.4%	82.1%
Pertussis	64.5%	68.9%	70.2%	70.5%	78.2%	80.6%
Measles	86.5%	63.8%	88.6%	74.3%	86.9%	87.3%
Mumps	85.9%	63.5%	88.2%	74.0%	86.9%	86.7%
Rubella	90.8%	75.2%	96.6%	83.0%	93.8%	91.0%
HPV	51.2%	62.4%	66.9%	62.7%	68.6%	73.7%

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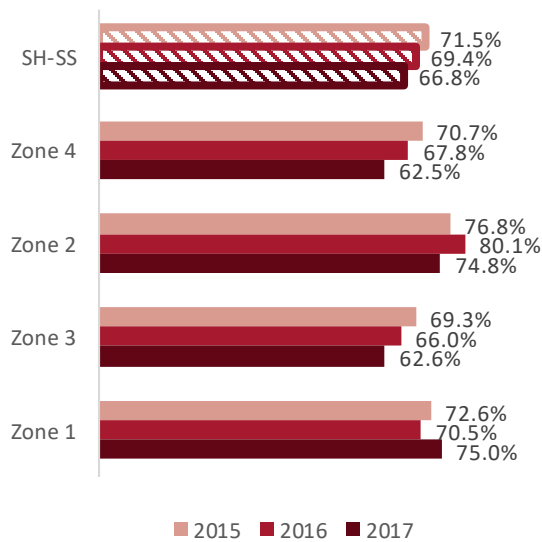
## Regional Key Findings

### Diphtheria, Tetanus, and Pertussis

- D **Table 24** shows that in the region, approximately 65-67% of youth aged 17 years received the recommended doses for diphtheria, tetanus, and pertussis in the current time period.
- D **Figure 20** shows that in the region, Zone 4, and Zone 3, both diphtheria and tetanus recommended doses saw decreases over time. The percentages for diphtheria and tetanus were identical.
- D **Figure 21** shows that in the region and all zones, pertussis recommended doses fluctuated over time with a drop in 2016.

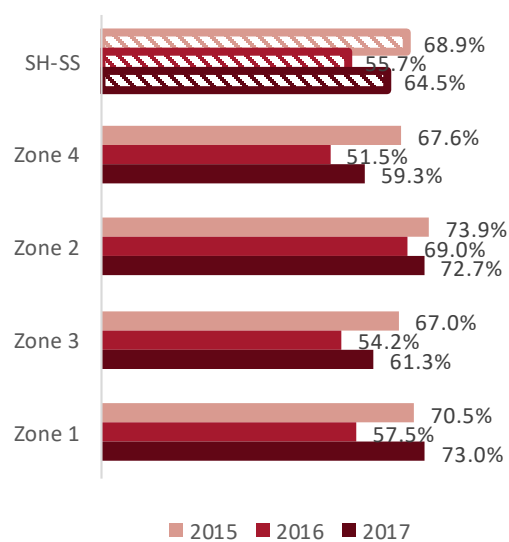
**Figure 20. Diphtheria/Tetanus Immunization in Southern Health-Santé Sud, 2015-2017**

Percentage of youth (aged 17) who received recommended doses



**Figure 21. Pertussis Immunization in Southern Health-Santé Sud, 2015-2017**

Percentage of youth (aged 17) who received recommended doses

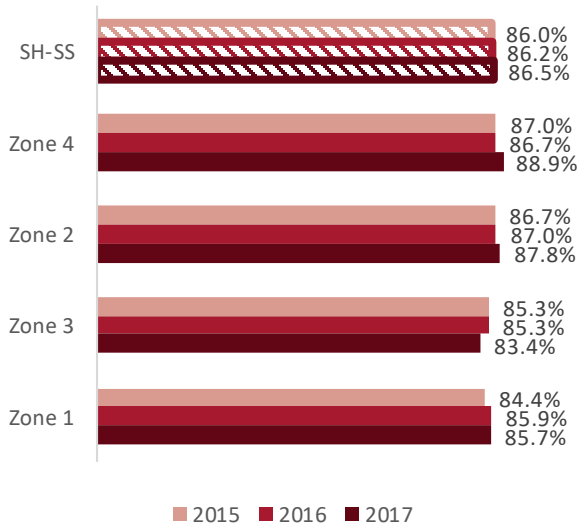


## Measles, Mumps, and Rubella

- Table 24 shows that approximately 85-91% of regional residents aged 17 years received the recommended doses for measles, mumps, or rubella in the current time period. Immunization percentages were similar across zones.
- Figures 22 to 24 show that the percentages remained relatively stable over time in the region and all zones.

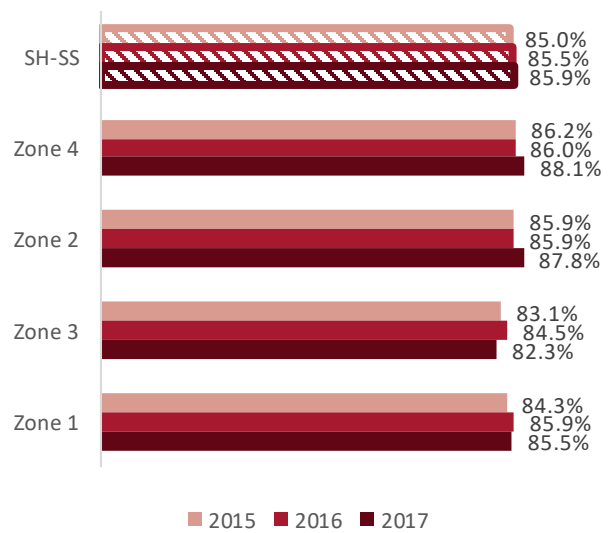
**Figure 22. Measles Immunization in Southern Health-Santé Sud, 2015-2017**

Percentage of youth (aged 17) who received recommended doses



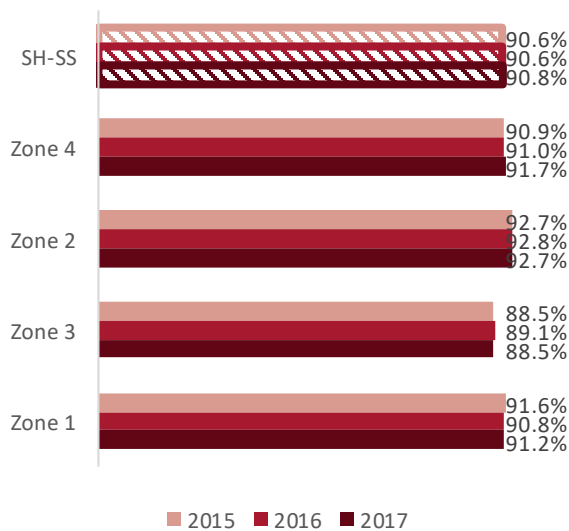
**Figure 23. Mumps Immunization in Southern Health-Santé Sud, 2015-2017**

Percentage of youth (aged 17) who received recommended doses



**Figure 24. Rubella Immunization in Southern Health-Santé Sud, 2015-2017**

Percentage of youth (aged 17) who received recommended doses

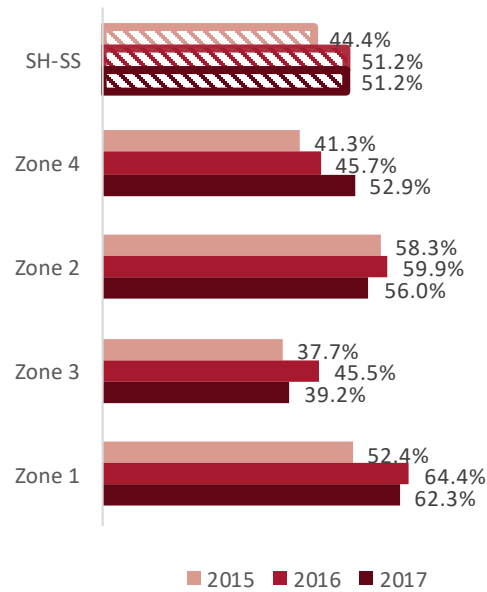


## HPV

- D **Table 24** shows that in the region, just over 50% of girls received the recommended doses of HPV immunizations in the current time period, the lowest in the province.
- D **Figure 25** shows that HPV immunization varied across zones with the lowest in Zone 3 and the highest in Zone 1.
- D The regional percentages stabilized over time. The majority of zones saw fluctuations while Zone 4 saw increases over time.

**Figure 25. HPV Immunization in Southern Health-Santé Sud, 2015, 2016, and 2017**

Percentage of girls (aged 17) who received recommended doses



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## A CLOSER LOOK...

Immunization has been one of the most successful public health interventions in the last 50 years. It protects individuals and communities by preventing the spread of disease. As more people are immunized, the disease risk for everyone is reduced. Immunization is the single most cost-effective health investment, making it a cornerstone in the effort to promote health.<sup>xiii</sup> For every \$1 spent on the measles/mumps/rubella vaccine for children, the cost saving to the health care system is \$16.<sup>xiv</sup>

The provincial immunization schedule is based on national and international recommendations and is constantly being reviewed to ensure it provides Manitobans with the optimal protection from vaccine preventable diseases. New vaccines have been added to the list of vaccines covered by Manitoba Health, Seniors and Active Living in recent years, such as the HPV vaccine that protects against human papilloma virus, which can cause some forms of cancer. Improvements in science and technology mean that vaccines are only continuing to improve on their already high quality and effectiveness.

Unfortunately, in the province, our region, and in many other areas, there appears to be increasing vaccine hesitancy with noted outbreaks. Between September 1, 2016 and June 2, 2017, there were 528 confirmed cases of mumps reported in Manitoba: 57 cases within Southern Health-Santé Sud. Prior to this outbreak, mumps was a rare illness in Manitoba for many years, with four to five cases of mumps being the typical per year in the province.

Mumps can be difficult to recognize and diagnose; patients can be spreading the infection even before they develop symptoms and the symptoms can look like other viral infections. Health care providers across the region have responded to identify and manage the cases that occurred. At times, a significant amount of effort is required. Success stories have been noted around the region where staff followed the mumps protocol and no contact tracing was required.

## Teen Pregnancy Rate

### Definition

The annual rate of pregnancies including live births, stillbirths, abortions, and ectopic pregnancies per 1,000 female residents, ages 15 to 19 years, over a five-year time period.

### Why is this indicator important?

Pregnant teens are less likely to receive early prenatal care and more likely to experience anemia, eclampsia and depressive disorders. Teenage pregnancy is often associated with high risk activities such as substance use, smoking during pregnancy, and physical or sexual abuse.<sup>xv</sup> Teenage mothers tend to have lower socioeconomic status, as well as reduced educational opportunities.<sup>xvi</sup>

### Provincial Key Findings

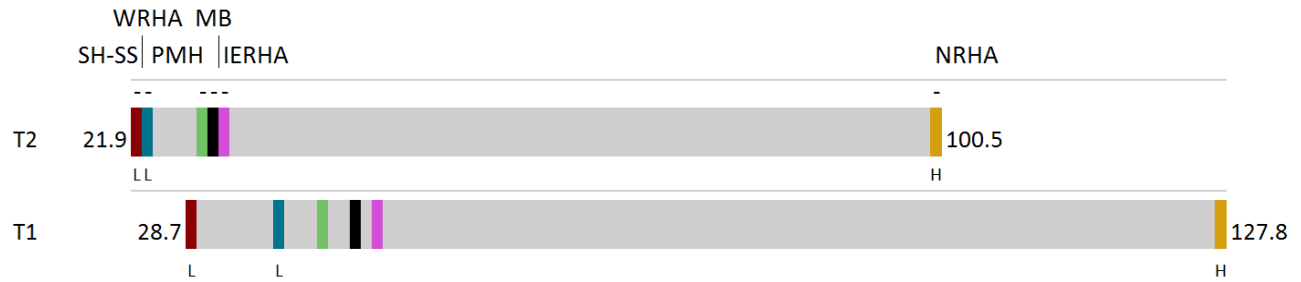
- ▶ **Figure 26** shows that there were a total of 6,679 teen pregnancies in Manitoba in the current time period.
- ▶ The teen pregnancy rate decreased significantly and dramatically in the province and in all regions.
- ▶ In both time periods, rates were significantly lower than the provincial average in Southern Health-Santé Sud and Winnipeg RHA, while they were significantly higher in Northern Health Region.
- ▶ **Income:** Teen pregnancy rates were very strongly associated with income in both time periods, with higher rates among residents of lower income areas.<sup>xvii</sup>



*Teen pregnancy rates very strongly related to income*

**Figure 26. Teen Pregnancy by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age-adjusted annual average rate per 1,000 females (aged 15-19)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	817	2,765	807	6,679	658	1,533
T2 RATE	21.9 L-	23.3 L-	29.3 -	30.0 -	30.8 -	100.5 H-
T1 RATE	28.7 L	36.8 L	40.8	44.5	46.1	127.8 H

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## Regional Key Findings

### Zone Level

- Table 25 shows that in the region, there were a total of 817 teen pregnancies in the current time period.
- In both time periods, the rate was significantly lower than the provincial average and the lowest in the province.
- Regional rates decreased significantly over time.

### Zone Level

- Rates varied dramatically across zones, with the lowest in Zone 2 and the highest in Zone 1 in both time periods.
- In both time periods, rates were significantly lower than the provincial average in Zones 2, 3, and 4, but significantly higher in Zone 1.
- Rates decreased significantly over time in Zones 1, 2, and 4.

### District Level

- Rates varied dramatically across districts with the lowest in Carman and the highest in Seven Regions in the current time period.
- Almost half of the districts were significantly lower than the provincial average, including: Taché, Niverville/Ritchot, Ste. Anne/La Broquerie, Hanover, Steinbach, Carman, St. Pierre/De Salaberry, Morris, Lorne/Louise/Pembina, Stanley, Altona, and North Norfolk. While, city of Portage, Rural Portage, and Seven Regions were significantly higher.
- Rates decreased significantly over time in Steinbach, North Norfolk, and Seven Regions but increased significantly in Stanley.



**Table 25. Teen Pregnancy Rate in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Age-adjusted annual average rate per 1,000 females (aged 15-19)

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>6,679</b>	<b>30.0</b>	-	<b>44.5</b>	
<b>SH-SS</b>	<b>817</b>	<b>21.9</b>	L-	<b>28.7</b>	L
<b>Zone 4</b>	<b>222</b>	<b>15.7</b>	L-	<b>20.9</b>	L
Taché	17	9.8	L	14.4	L
Niverville/Ritchot	21	11.8	L	15.9	L
Ste. Anne/ La Broquerie	36	18.3	L	24.1	L
Hanover	57	19.0	L	20.4	L
Steinbach	86	21.6	L-	29.7	L
Rural East	s			24.8	
<b>Zone 2</b>	<b>76</b>	<b>14.3</b>	L-	<b>20.0</b>	L
Carman	7	8.5	L	10.9	L
St. Pierre/ De Salaberry	7	10.2	L	24.1	
Morris	13	13.5	L	18.0	L
Red River South	39	45.4		52.7	
Macdonald	s			8.1	L
Grey	s			10.7	L
<b>Zone 3</b>	<b>198</b>	<b>18.5</b>	L	<b>20.7</b>	L
Lorne/Louise/ Pembina	14	10.8	L	18.7	L
Stanley	25	15.0	L+	6.7	L
Altona	31	15.7	L	23.8	L
Winkler	70	22.8		28.1	L
Roland/Thompson	10	29.6		17.5	
Morden	48	31.9		27.4	L
<b>Zone 1</b>	<b>321</b>	<b>46.7</b>	H-	<b>59.6</b>	H
North Norfolk	7	8.8	L-	25.0	
Cartier/SFX	20	18.4		14.7	L
City of Portage	105	44.9	H	55.8	
Rural Portage	78	62.9	H	72.1	H
Seven Regions	111	89.6	H-	116.6	H

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 s indicates data suppressed due to small numbers  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts was large but did experience a large decrease over time, meaning the gap between the districts with the lowest and highest teen pregnancy rate reduced.

SH-SS Geographic Disparity Ratio	
	T1 17.4x
	T2 10.6x
	Change -6.8 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Teen Birth Rate

### Definition

The annual rate of live births per 1,000 female residents, ages 15 to 19 years, over a five-year time period.

### Why is this indicator important?

Very similar to teen pregnancy rate, teen birth rates are of concern because babies born to teen mothers are at higher risk of adverse health outcomes such as low birth rate, death during infancy, and preterm birth. There are also strong economic consequences, since teenage mothers are more likely to drop out of school and have fewer economic opportunities.

### Provincial Key Findings

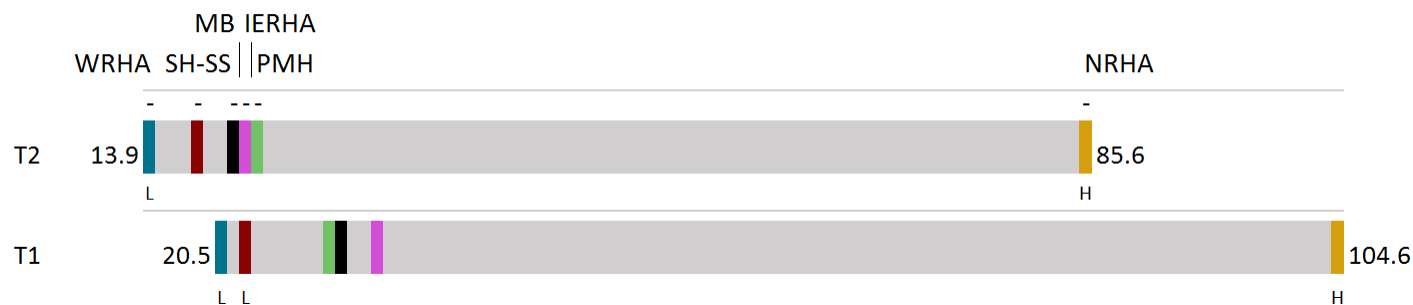
- ▶ **Figure 27** shows that in Manitoba, there were a total of 4,786 teen births in the current time period.
- ▶ Rates decreased significantly and dramatically over time in the province and in all regions.
- ▶ In both time periods, rates in Winnipeg RHA were significantly lower than the provincial average, while rates in Northern Health Region were significantly higher.
- ▶ Teen birth rates were higher among rural than urban residents.<sup>xviii</sup>
- ▶ **Income:** Teen birth rates were very strongly associated with income in both time periods, with higher rates among residents of lower income areas.



*Teen birth rates very strongly related to income*

**Figure 27. Teen Births by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age-adjusted average annual rate per 1,000 females (aged 15-19)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	1,644	691	4,786	476	619	1,290
T2 RATE	13.9 L-	18.3 -	21.5 -	22.3 -	22.5 -	85.6 H-
T1 RATE	20.5 L	21.9 L	29.7	31.6	28.4	104.6 H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 26 shows that in the region, there were a total of 691 teen births in the current time period.
- Regional rates decreased significantly over time but were no longer significantly lower than the provincial average in the current time period.

### Zone Level

- Rates varied across zones with the lowest in Zone 2 and the highest in Zone 1.
- In both time periods, rates were significantly lower than the provincial average in Zones 2 and 4 but significantly higher in Zone 1.

### District Level

- Rates varied dramatically across districts with the lowest in Lorne/Louise/Pembina and the highest in Seven Regions in the current time period.
- Rates were significantly lower than the provincial average in Niverville/Ritchot, Taché, Lorne/Louise/Pembina, and Cartier/SFX. While rates were significantly higher in Red River South, city of Portage, Rural Portage, and Seven Regions.
- Rates decreased significantly over time in Lorne/Louise/Pembina but increased significantly in Stanley.

**Table 26. Teen Births in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Age-adjusted average annual rate per 1,000 females (aged 15-19)

	T2		T1			T2		T1			
	Count	Rate	Rate	Rate		Count	Rate	Rate			
<b>Manitoba</b>	<b>4,786</b>	<b>21.5</b>	-	<b>29.7</b>		<b>SH-SS</b>	<b>691</b>	<b>18.3</b>	-	<b>21.9</b>	<b>L</b>
<b>Zone 4</b>	<b>185</b>	<b>12.7</b>	L	<b>15.7</b>	L	<b>Zone 2</b>	<b>62</b>	<b>11.6</b>	L	<b>15.1</b>	L
Niverville/Ritchot	15	8.5	L	11.4	L	Carman	6	7.3		8.5	L
Taché	16	9.3	L	10.4	L	Morris	11	11.4		14.7	
Ste. Anne/ La Broquerie	29	14.8		15.5	L	Red River South	32	37.2	H	41.5	
Hanover	49	16.3		16.0	L	Macdonald	s			5.7	L
Steinbach	73	18.3		24.7		St. Pierre/ De Salaberry	s			16.1	
Rural East	s			14.9		Grey	s			s	
<b>Zone 3</b>	<b>177</b>	<b>16.2</b>		<b>17.3</b>	L	<b>Zone 1</b>	<b>267</b>	<b>38.6</b>	H	<b>44.0</b>	H
Lorne/Louise/ Pembina	7	5.4	L-	16.7	L	Cartier/SFX	9	8.3	L	4.9	L
Altona	27	13.6		21.7		City of Portage	90	38.5	H	38.0	
Stanley	23	13.8	+	5.4	L	Rural Portage	66	53.2	H	51.0	H
Winkler	66	21.5		24.0		Seven Regions	98	79.0	H	99.2	H
Roland/Thompson	9	26.7		s		North Norfolk	s			18.8	
Morden	45	29.9		21.6							

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 s indicates data suppressed due to small numbers  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts was large but did experience a large decrease over time, meaning the gap between the districts with the lowest and highest teen birth rates reduced.

SH-SS Geographic Disparity Ratio	
	T1 20.2x
	T2 14.6x
	Change -5.6↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

# Personal Health Determinants

## Self-Rated General Health

### Definition

The percentage of residents, aged 12 years and older, who rated their overall health as ‘poor’, ‘fair’, ‘good’, ‘very good’ or ‘excellent’. Overall health was not only based on the absence of disease or injury, but overall physical, mental and social-well-being.

### Why is this indicator important?

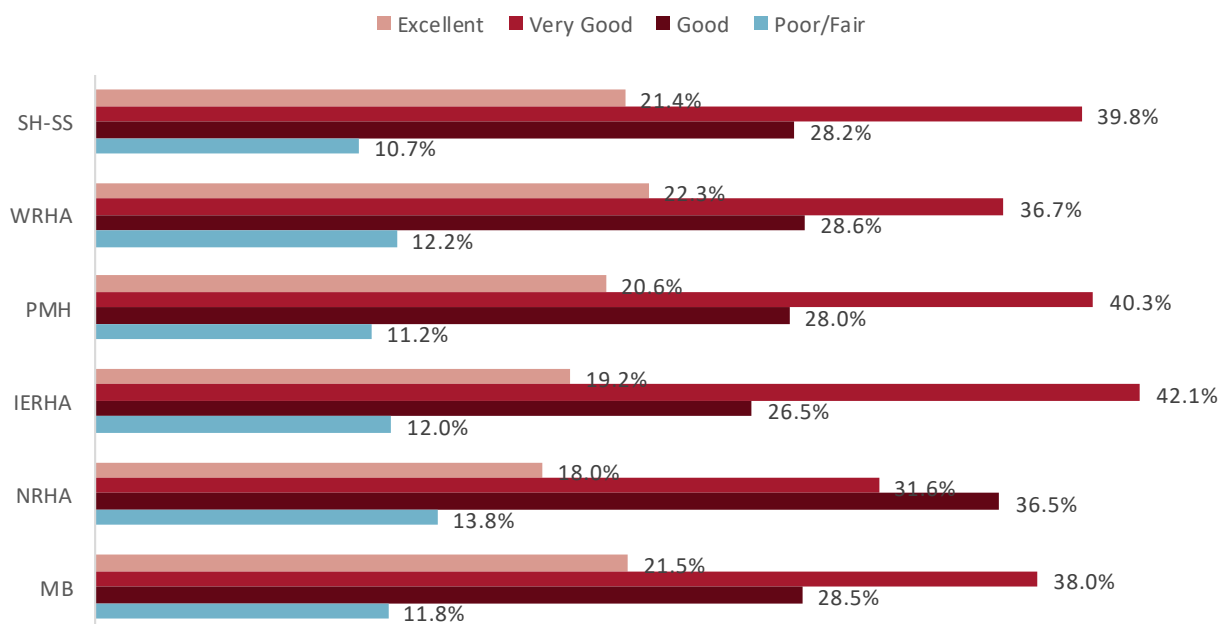
Good-to-excellent self-reported health status is associated with lower risk of mortality and use of health services. Poor self-reported health status is a good predictor of future illness and premature death.

### Provincial/Regional Key Findings

- ▶ **Figure 28** shows that a larger proportion of respondents rated their general health as ‘very good’ in the province and all regions except Northern Health Region, where the most prevalent response was ‘good’.
- ▶ In Southern Health-Santé Sud, 21.4% rated their health as ‘excellent’, 39.8% as ‘very good’, 28.2% as ‘good’, and 10.7% as ‘poor/fair’, similar to the province and the majority of other regions.

**Figure 28. Self-Rated General Health by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2015-2016

## Self-Rated Mental Health

### Definition

The percentage of residents, aged 12 years and older, who rated their mental health as ‘poor’, ‘fair’, ‘good’, ‘very good’ or ‘excellent’.

### Why is this indicator important?

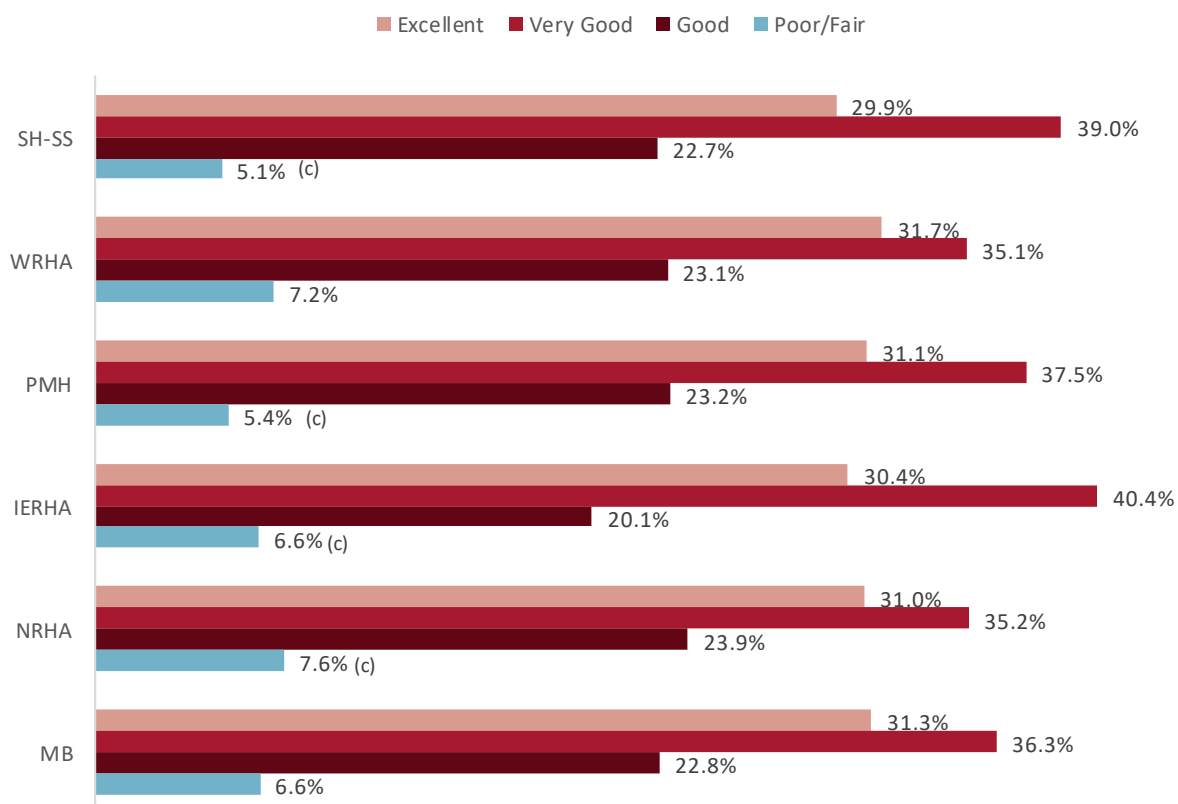
Mental health issues, including emotional health problems, can manifest at any time across the lifespan and are often related to challenges associated with changing roles and responsibilities. While perceived mental health is a subjective measure and does not directly correspond with diagnosed mental illnesses, it may still affect health service use and quality of life.

### Provincial/Regional Key Findings

- ▶ **Figure 29** shows that the largest proportion of respondents rated their mental health as ‘very good’ in the province and all regions.
- ▶ In Southern Health-Santé Sud, the majority of respondents rated their mental health as either ‘excellent’ or ‘very good’, similar to the province and the other regions.

**Figure 29. Self-Rated Mental Health by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2015-2016

## Life Stress

### Definition

The percentage of residents, aged 15 years or older, who reported most days to be ‘quite a bit stressful’, ‘extremely stressful’, or ‘not at all stressful’.

### Why is this indicator important?

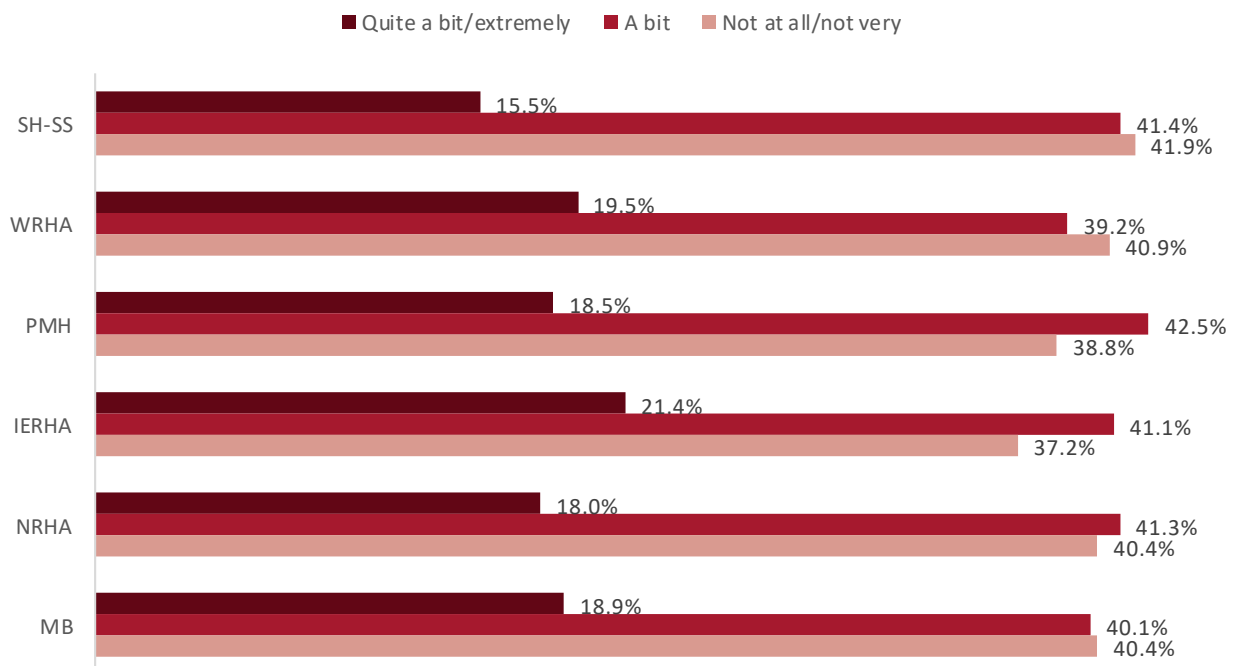
Prolonged exposure to high levels of stress can have negative consequences for health including increased risk of illness and chronic disease. Stress is often an underlying cause of high risk behaviours, such as substance use, as coping mechanisms.

### Provincial Key/Regional Findings

- ▶ **Figure 30** shows that larger proportions of respondents reported life to be ‘a bit’ and ‘not at all/not very’ stressful in the province and similarly in all regions.
- ▶ In Southern Health-Santé Sud, the majority reported either ‘a bit stressful’, or ‘not at all/not very stressful’, similar to the province and other regions.

**Figure 30. Life Stress by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2015-2016

## Sense of Community Belonging

### Definition

The percentage of population, aged 12 years and older, who described their sense of belonging to their local community as 'somewhat/very weak,' 'somewhat strong' or 'very strong'.



### Why is this indicator important?

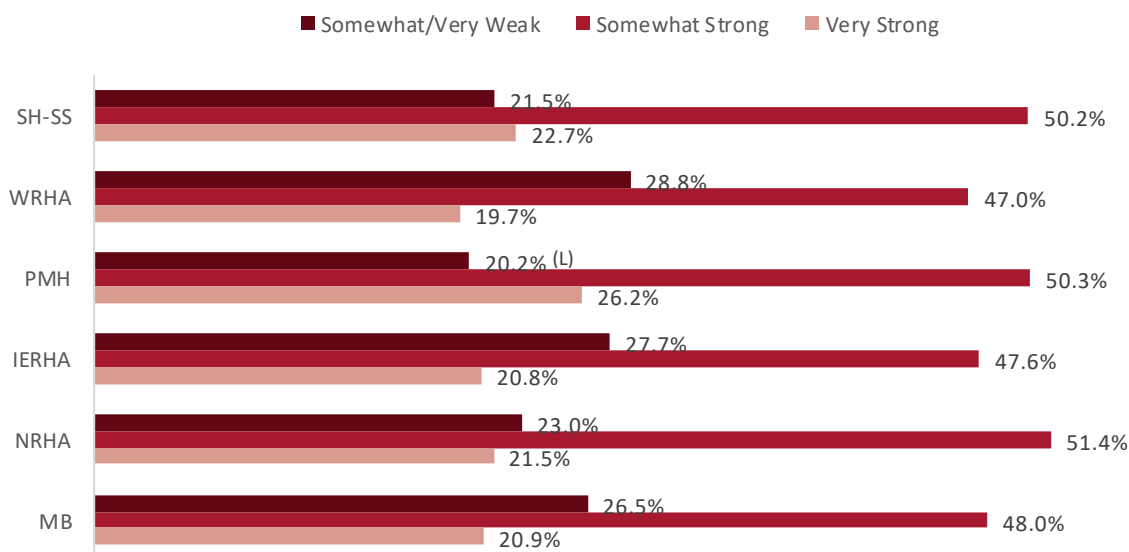
A strong sense of community belonging reflects attachments, social engagement and participation within communities which is associated with positive health outcomes. Individuals who do not have a strong sense of community belonging may experience social isolation which can be detrimental to their health. Understanding community connectedness supports an upstream approach to health promotion and illness prevention.

### Provincial/Regional Key Findings

- ▶ **Figure 31** shows that in the province and all regions, the most prevalent response was a somewhat strong sense of community belonging.
- ▶ In Prairie Mountain Health, the percentage of respondents reporting somewhat/very community belonging was significantly lower than the provincial average.
- ▶ In Southern Health-Santé Sud, the majority of respondents reported 'somewhat strong', similar to the province and other regions.

**Figure 31. Sense of Community Belonging by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.  
 Statistics Canada CCHS 2015-2016



## Changes Made to Improve Health

### Definition

The percentage of residents who reported making positive health changes in the last 12 months.

### Why is this indicator important?

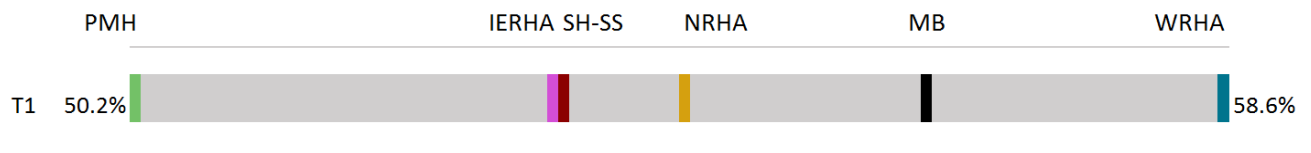
This measure provides insight into people’s decision to make changes to improve their health.

### Provincial/Regional Key Findings

- ▶ **Figure 32** shows that in Manitoba, 56.3% of respondents reported making positive health changes in the last year. Percentages were similar across regions.
- ▶ In Southern Health-Santé Sud, 53.6% of respondents reported making a positive health change in the past year.

**Figure 32. Changes Made to Improve Health by RHA, 2015-2016**

Age- and Sex-Adjusted proportion of weighted sample who reported making a positive health change



H/L Significantly higher or lower than the MB average for that time period.

	PMH	IERHA	SH-SS	NRHA	MB	WRHA
T1 RATE	50.2%	53.5%	53.6%	54.5%	56.3%	58.6%

Statistics Canada CCHS 2015-2016



## Body Mass Index (BMI)

### Definition

The percentage of residents, aged 18 years and older, who are underweight/normal, overweight or obese, based upon self-reported height and weight.

### Why is this indicator important?

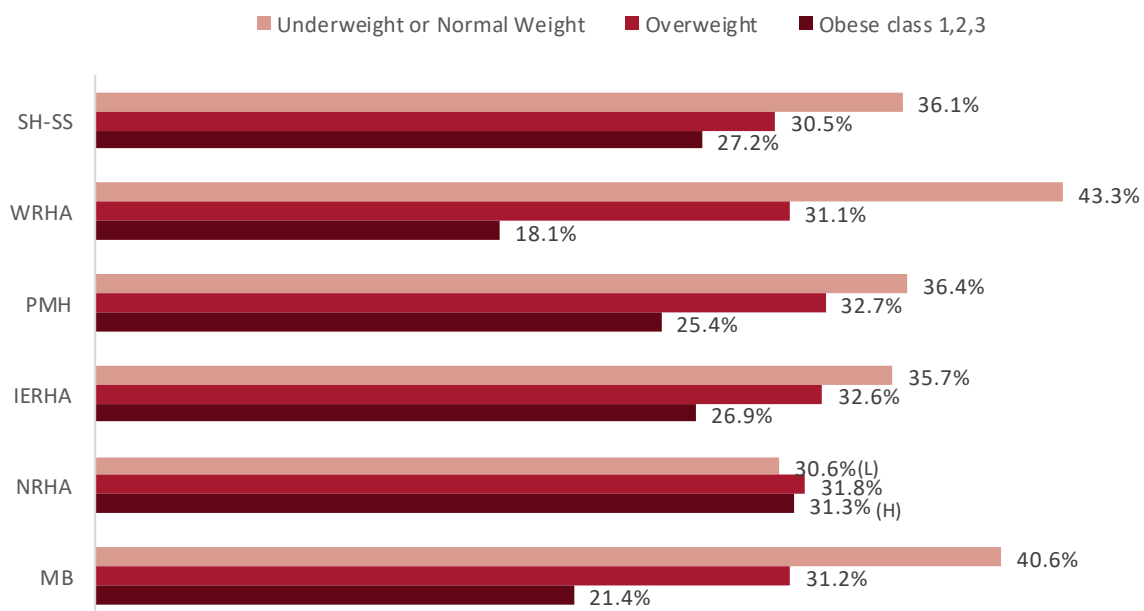
BMI is a widely used diagnostic tool used to monitor weight patterns in the population. Obesity impacts quality of life, life expectancy, is a major risk factor for a number of chronic diseases and affects the use of health services.

### Provincial/Regional Key Findings

- ▶ **Figure 33** shows that in the province and all regions except Northern Health Region, the largest proportion of respondents belonged in the underweight or normal weight BMI category.
- ▶ In Northern Health Region, the percentage of underweight or normal weight respondents was significantly lower than the provincial average while the percentage of respondents in obese class 1, 2, 3 was significantly higher.
- ▶ In Southern Health-Santé Sud, 36.1% belonged in the underweight or normal weight category, 30.5% were overweight, and 27.2% were in obese class 1, 2, 3, similar to other regions and the province.

**Figure 33. Body Mass Index by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.

(c) = estimate displayed with caution.

Statistics Canada CCHS 2015-2016

# Health Behaviours

## Substance Use Disorders

### Definition

The percentage of residents, aged 18 years and older, diagnosed with a substance use disorder (including alcohol and/or drug dependence), over a five-year time period.

### Why is this indicator important?

Substance use may be associated with injuries and deaths, vandalism, alcohol poisoning and violence. Harmful use patterns started at a young age and carried into adulthood exacerbate these problems, and prolonged substance use may lead to a number of acute and chronic disease conditions.

### Provincial Key Findings

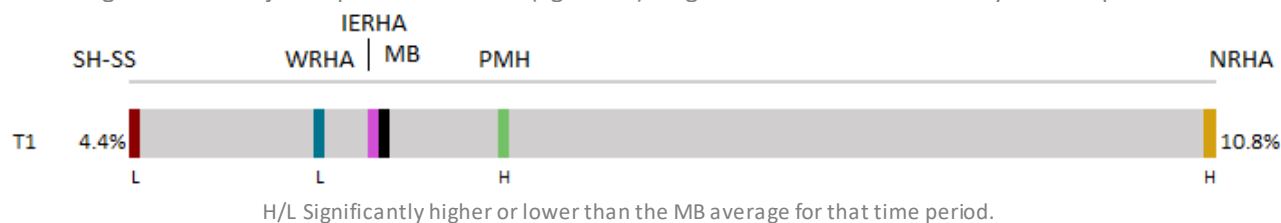
- ▶ **Figure 34** shows 5.9% of the adult population in Manitoba had a substance use disorder.
- ▶ Percentages were significantly lower in Southern Health-Santé Sud and Winnipeg RHA, while significantly higher in Prairie Mountain Health and Northern Health Region.
- ▶ **Age and Sex:** Higher for males than females across all age groups. The 65 and older age group had a lower prevalence compared to the 18-24 age group, for both males and females.<sup>xix</sup>
- ▶ **Income:** There was a significant linear trend across income quintiles, with a higher prevalence of substance use disorders as the area-level income decreased.<sup>xx</sup>



*Substance use disorders increased as income decreased.*

**Figure 34. Prevalence of Substance Use Disorders by RHA, 2010/11-2014/15 (T1)**

Age- and sex-adjusted percent of adults (aged 18+) diagnosed with disorder in five-year time period



	SH-SS		WRHA		IERHA		MB		PMH		NRHA	
T1 COUNT	5,956		32,208		5,627		58,178		8,354		5,593	
T1 RATE	4.4%	L	5.6%	L	5.9%		5.9%		6.7%	H	10.8%	H

MCHP Mental Illness Among Adult Manitobans 2018

## Regional Key Findings

- Table 27 shows that in the region, there was a total of 5,956 residents with a substance use disorder.
- The regional percentage was significantly lower than the provincial average and the lowest in the province.
- Zone level data not available.
- Percentages varied across districts with the lowest in Stanley and the highest in city of Portage.
- The majority of districts were significantly lower than the provincial average, with the exception of Rural East, Ste. Anne/La Broquerie, Red River South, Lorne/Louise/Pembina, Seven Regions, and Rural Portage, which were not significantly different and city of Portage which was significantly higher.

## Geographic Disparity

- The highest district of city of Portage was 2.6 times higher than the lowest district of Stanley.

**Table 27. Substance Use Disorders in Southern Health-Santé Sud, 2010/11-2014/15 (T1)**  
Age- and sex-adjusted percent of adults (aged 18+) diagnosed with disorder in five-year time period

	T1		
	Count	Percentage	
<b>Manitoba</b>	58,178	5.9	
			<b>SH-SS</b>
			<b>5,956</b>
			<b>4.4</b>
			<b>L</b>
<b>Zone 4</b>			
Niverville/Ritchot	289	3.6	L
Hanover	317	3.7	L
Steinbach	650	4.4	L
Taché	318	4.6	L
Rural East	154	5.2	
Ste. Anne/ La Broquerie	455	6.0	
<b>Zone 2</b>			
Morris	112	3.1	L
Macdonald	167	3.2	L
St. Pierre/ De Salaberry	105	3.3	L
Grey	121	4.3	L
Carman	194	4.8	L
Red River South	196	5.8	
<b>Zone 3</b>			
Stanley	104	2.6	L
Winkler	316	3.1	L
Roland/Thompson	48	3.1	L
Altona	217	3.3	L
Morden	312	4.7	L
Lorne/Louise/ Pembina	266	5.2	
<b>Zone 1</b>			
North Norfolk	96	3.1	L
Cartier/SFX	243	4.4	L
Seven Regions	222	5.3	
Rural Portage	284	5.6	
City of Portage	770	6.8	H

H/L Significantly higher or lower than the MB average for that time period.  
MCHP Mental Illness Among Adult Manitobans 2018

## Drug Methods

### Definition

The type of drug methods individuals reported using for illicit drug consumption over the course of their lifetime for a one-year time period.

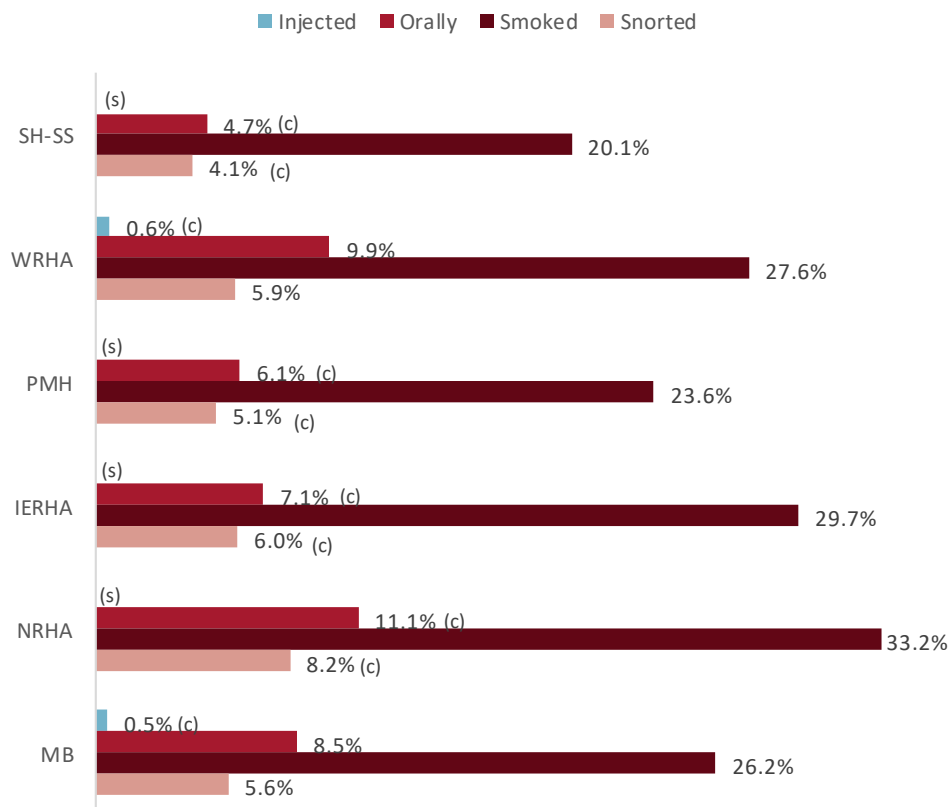
### Why is this indicator important?

Understanding methods of drug consumption help inform harm reduction interventions including public awareness, sexually transmitted blood-borne infection (STBBI) prevention and public policy.

### Provincial/Regional Key Findings

- ▶ **Figure 35** shows that the largest proportion of illicit drug users reported smoking as a method for consuming illicit substances in the province and all regions.
- ▶ In Southern Health-Santé Sud, the percentages of each drug method was the lowest in the province, although not statistically different than the provincial average.

**Figure 35. Drug Methods by RHA, 2015-2016**  
Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.

(c) = estimate displayed with caution. (s) = estimate suppressed.

Unlike the majority of CCHS indicators reported, this indicator includes 'don't know' and missing responses in the denominator  
Statistics Canada CCHS 2015-2016

## A CLOSER LOOK...

Harm reduction is a proven public health approach that reduces the adverse health, social, and economic outcomes related to variety of risk associated activities. It reduces harm to the individual, to families, and to the broader community. Harm reduction promotes health for the individual and advocates for broader health and social policy change. It does not condone or condemn any particular behavior. Harm reduction is a practical set of strategies to help people stay safer when engaging in activities that could have risk, like sex and drug use.

One area of harm reduction is reducing the harmful consequences of drug use. It recognizes the difficulties associated with drug addiction and that avoiding drugs may not be realistic for everyone. One strategy within the region is the Sterile Needle & Supply Distribution Program provided within each of the Southern Health-Santé Sud Public Health-Healthy Living offices, including support for sterile needle and supply distribution as well as used-needle drop off. Although access to sterile needles does not eliminate drug use, it does reduce the risk for blood-borne pathogens and drug related injury, such as new hepatitis C and HIV infections. Public health nurses meet with individuals at their request and are able to provide education on how to prevent the spread of infection or deal with other health effects of substance use, facilitate testing for sexually-transmitted and blood-borne infections (STBBIs) and connect people to other health and social services.

As the number of fatalities associated with opioids continued to rise in 2016, government acknowledged the risk in Manitoba. Increasing the availability of naloxone, a medication used to reverse the effects of opioids and prevent fatal overdoses is now part of a wide effort to deal with the growing number of fentanyl overdose deaths. Naloxone kits are currently available through Public Health-Healthy Living in Portage la Prairie and Steinbach, with plans to also implement in Morden and Winkler.

Harm reduction is not new to the region and we are already engaged in such practices. Harm reduction approaches can effectively engage a larger proportion of clients and populations that conventional treatment programs have difficulty reaching and help address health equity issues. Over time, by bringing together members across a number of community services, we can effectively reach who can most benefit from support, to optimize care and reduce gaps in services, as well as establish communication lines between health services.

Beginning in 2019, Public Health-Healthy Living formally partnered with Manitoba Harm Reduction Network to engage community stakeholders and peers in finding people-led solutions to address the harms associated with substance use. We continue to raise awareness about harm reduction and to build partnerships both within and outside the health care system to deliver services with compassion and without judgment in order to best meet the needs of this priority population.



## Alcohol Use

### Definition

The percentage of the population aged 12 years and older who reported using alcohol in the past week by drink amount and type of drinker (based on frequency) over the past year.

### Why is this indicator important?

Alcohol consumption is linked to over 200 different diseases, conditions and types of injuries. Drinking patterns matter – how much and how often a person drinks alcohol are key factors that increase or decrease overall health and well-being.<sup>xxi</sup>

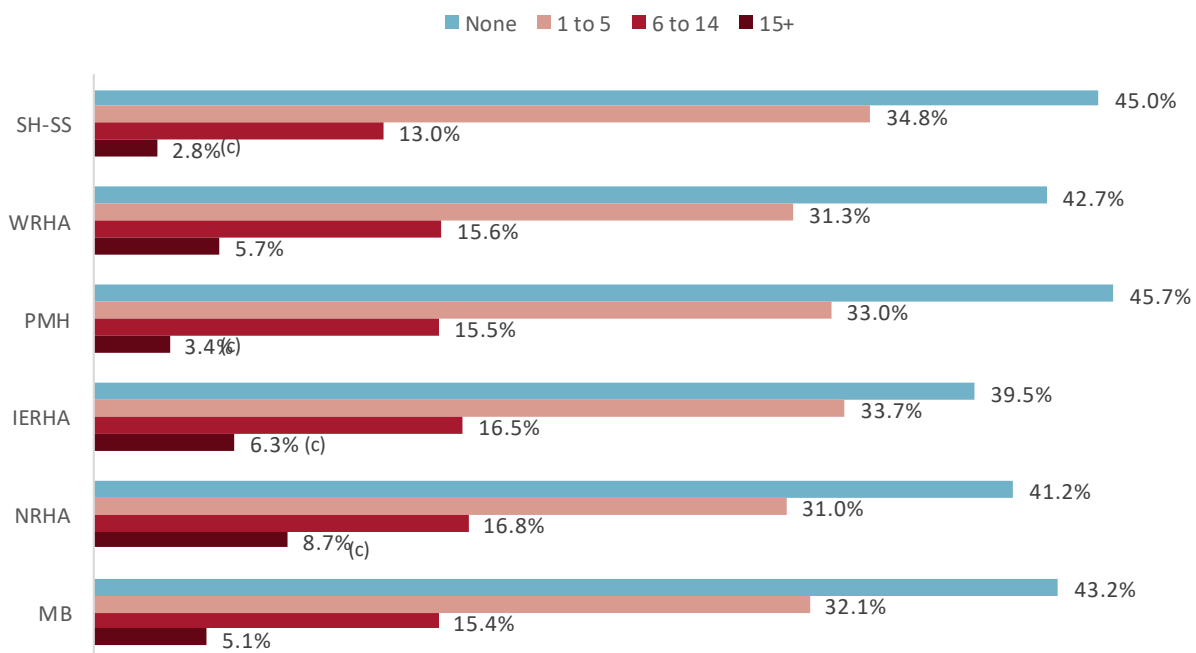
### Provincial/Regional Key Findings

#### Past Week Alcohol Use

- Figure 36 shows in Manitoba and all regions, the largest proportion of respondents reported consuming no alcohol in the past week.
- Southern Health-Santé Sud had the smallest proportions of respondents reporting consuming 6 to 14, and 15+ drinks in the past week compared to other regions, although not statistically different than the provincial average. The majority reported consuming none or 1 to 5 drinks in the past week.

**Figure 36. Past Week Alcohol Use by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



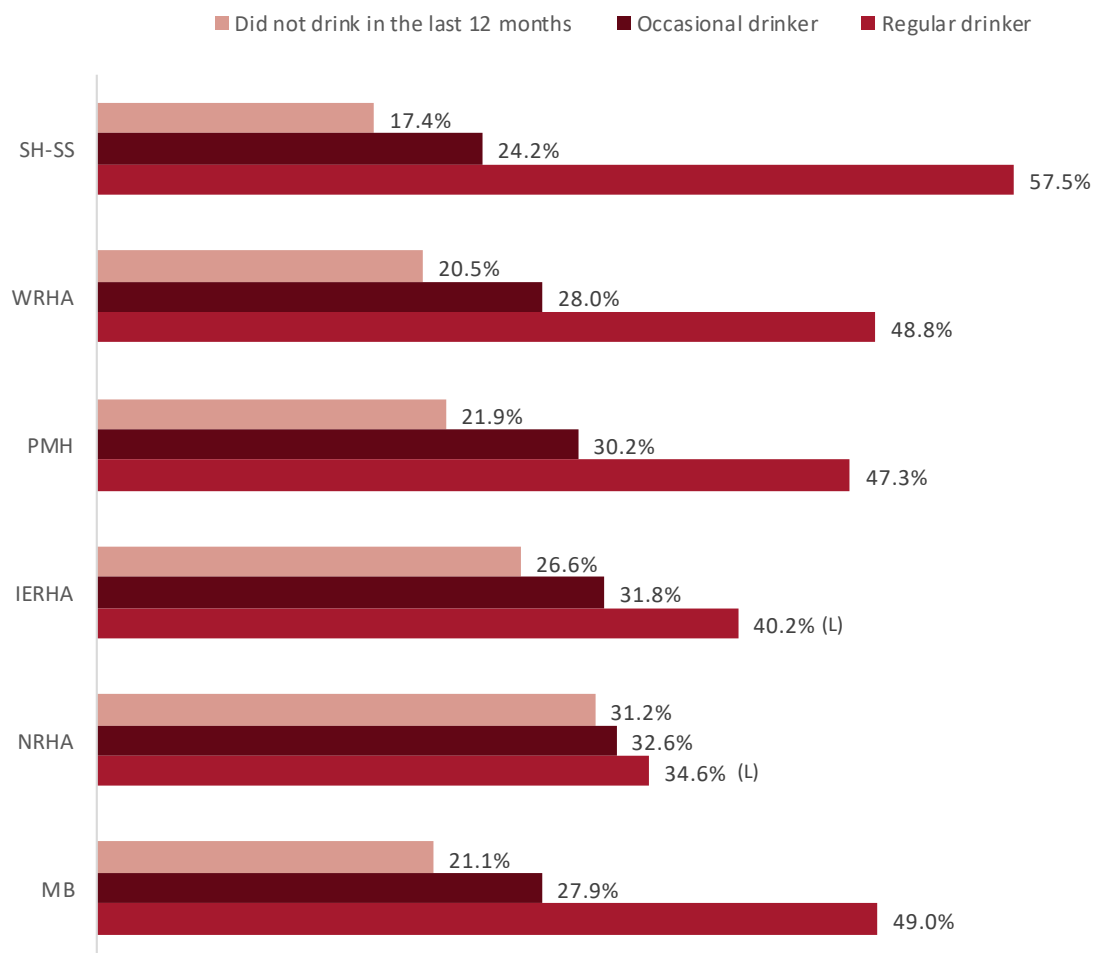
(c) = estimate displayed with caution.  
Statistics Canada CCHS 2015-2016

## Past Year Alcohol Use

- ▶ **Figure 37** shows in Manitoba and all regions, the largest proportion of respondents reported being a regular drinker, although percentages varied across the regions.
- ▶ The proportions of regular drinkers in Interlake-Eastern RHA and Northern Health Region were significantly lower than the provincial average.
- ▶ Southern Health-Santé Sud had the highest proportion of respondents identifying as regular drinkers, although it was not significantly different than the provincial average.

**Figure 37. Past Year Alcohol Use by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.  
 Statistics Canada CCHS 2015-2016



## Tobacco Use/Smoking

### Definition

The percentage of the population, aged 12 years and older, who reported being either a current smoker, a former smoker or a non-smoker over a one-year time period.

### Why is this indicator important?

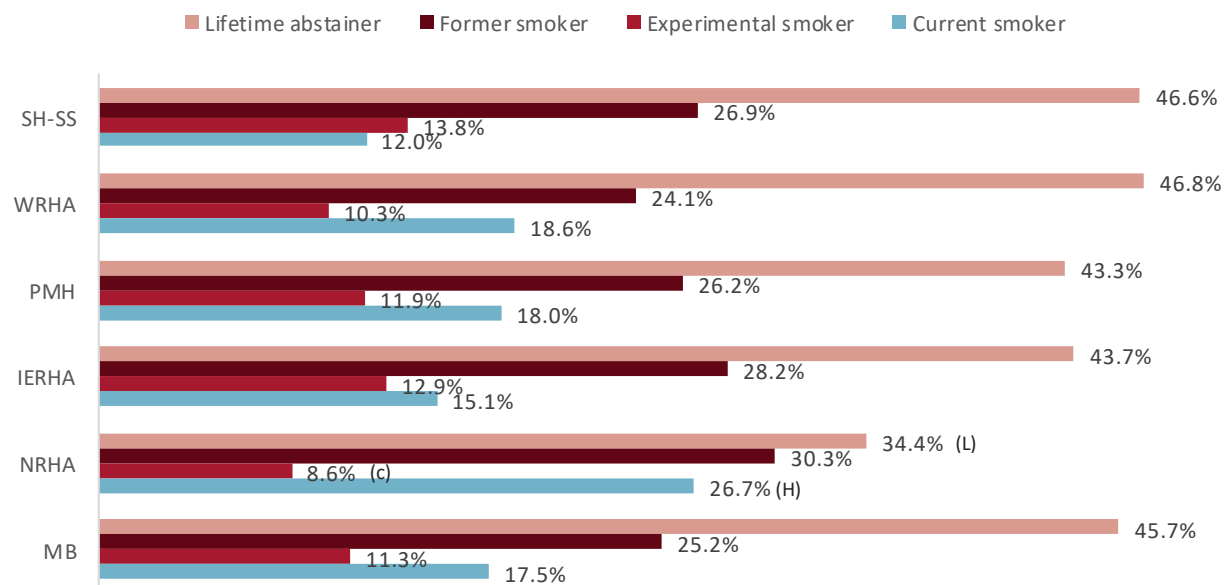
Tobacco continues to be the leading cause of preventable death in Canada. Smoking and exposure to second-hand smoke are significant risk factors for lung cancer, respiratory diseases and other health problems.

### Provincial/Regional Key Findings

- ▶ **Figure 38** shows that in Manitoba and all regions, the largest proportions of respondents reported being lifetime abstainers of tobacco.
- ▶ Compared to the provincial average, Northern Health Region had significantly lower lifetime abstainers and significantly higher current smokers.
- ▶ Southern Health-Santé Sud had the lowest percentage of current smokers, although not statistically different than the provincial average.
- ▶ In the region, 52.7% of respondents had ever used tobacco, regardless of their current status (i.e., former, experimental, or current smoker).

**Figure 38. Tobacco Use/Smoking by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.

(c) = estimate displayed with caution.

Statistics Canada CCHS 2015-2016

## Second-hand Smoke Exposure

### Definition

The percentage of the non-smokers, aged 12 years and older, who reported exposure to second-hand over a period of one year.

### Why is this indicator important?

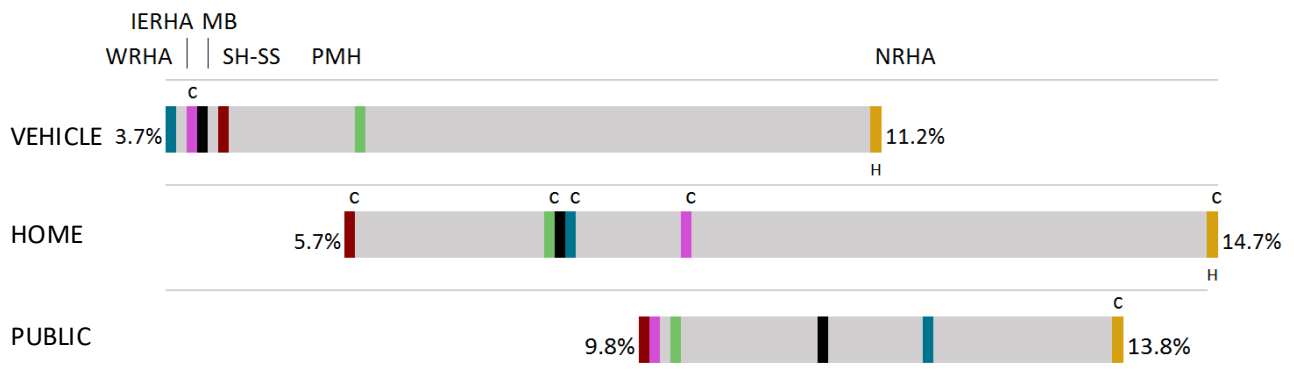
Second-hand smoke causes numerous health problems in infants and children including more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). For adults, health conditions caused by second-hand smoke include coronary heart disease, stroke, and lung cancer.

### Provincial/Regional Key Findings

- ▶ **Figure 39** shows that in Manitoba, second-hand exposure in a vehicle was 4.1%, 7.9% in the home, and 11.5% in public spaces. Similar increasing percentages were noted for all other regions, except for Northern Health Region.
- ▶ In Northern Health Region, exposure in the home and vehicle were significantly higher than the provincial average.
- ▶ Southern Health-Santé Sud had the lowest percentages of exposure in the home and in public; however, they were not significantly different than the provincial average.

**Figure 39. Exposure to Second-Hand Smoke by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample of non-smokers (aged 12+)



H/L Significantly higher or lower than the MB average. c – use with caution.

	WRHA	IERHA	MB	SH-SS	PMH	NRHA
VEHICLE	3.7%	4.0% c	4.1%	4.4%	5.8%	11.2% H
HOME	8.0%	9.2% c	7.9%	5.7% c	7.9% c	14.7% Hc
PUBLIC	12.4%	9.9%	11.5%	9.8%	10.2%	13.8% c

Statistics Canada CCHS 2015-2016

## Physical Activity – Adults

### Definition

Physical activity level of residents aged 12 years and older, based on self-reported average daily physical activity including the frequency, duration, and intensity of their participation in physical activities, over the previous three months.



### Why is this indicator important?

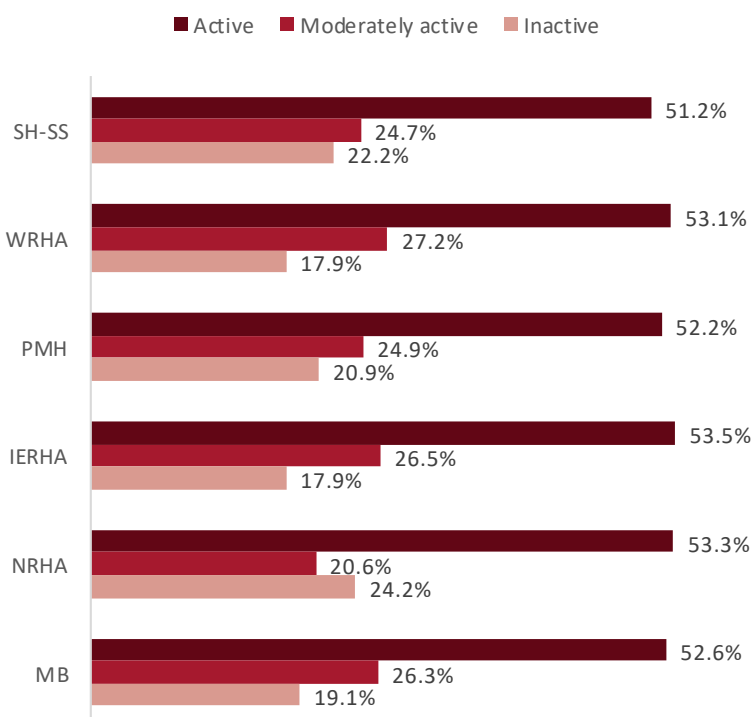
Appropriate levels of physical activity have been demonstrated to promote normal growth and bone development, foster psychological well-being, help maintain a healthy body weight and reduce the risk of several chronic diseases.

### Provincial/Regional Key Findings

- ▶ **Figure 40** shows that in the province and all regions, the largest proportion (approximately 50%) of respondents reported being physically active.
- ▶ In Southern Health-Santé Sud, the majority reported being active or moderately active, similar to the province and other regions.

**Figure 40. Physical Activity by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



#### Physical Activity

Active: 27.7+ kcal/kg/day  
 Moderate: 15.4-27.6 kcal/kg/day  
 Inactive: 0-15.3 kcal/kg/day

Three types of physical activities were included in the variable: 1) physical activity (i.e., usual daily activities, occupational-related physical activity); 2) physical activity for travel (i.e., biking or walking to school or work); and 3) leisure time physical activity (i.e., walking, running, gardening, soccer, etc.).

## Participation and Activity Limitation

### Definition

The percentage of respondents, aged 12 years and older, who reported they require help for activities of daily living because of a physical or mental condition or health issue.

### Why is this indicator important?

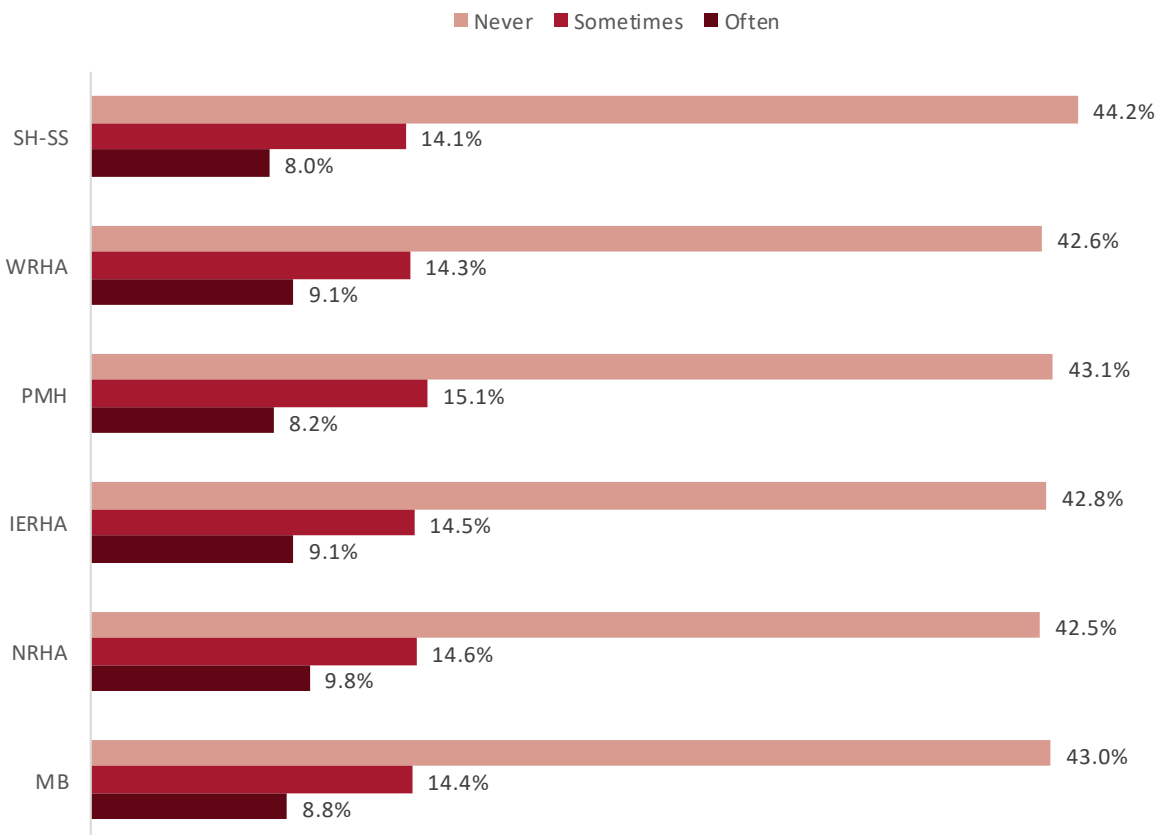
While it is imperative to measure the prevalence of specific health conditions, it is also important to understand the burden these conditions place on the daily lives of residents. The participation and activity limitation indicator helps to monitor this burden in the population.

### Provincial Key Findings

- ▶ **Figure 41** shows that the majority of respondents in the province and all regions reported never requiring help for activities of daily living because of a physical or mental condition or health issue.
- ▶ Responses were similar across regions.

**Figure 41. Participation and Activity Limitation by RHA, 2009/10-2011/12**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2015-2016

## Regional Key Findings

- ▶ **Table 28** shows that throughout the region, the largest proportion of respondents reported never experiencing participation and activity limitations.
- ▶ Percentages were similar across zones.
- ▶ There were some variations across districts with the lowest percentage of respondents experiencing limitations often in Steinbach and the highest in Rural Portage, among districts with available data.

**Table 28. Participation and Activity Limitation in Southern Health-Santé Sud, 2009/10-2011/12**

Age- and sex-adjusted proportion of weighted sample

	Never	Sometimes	Often		Never	Sometimes	Often	
	%	%	%		%	%	%	
<b>Manitoba</b>	<b>43.0</b>	<b>14.4</b>	<b>8.8</b>		<b>SH-SS</b>	<b>44.2</b>	<b>14.1</b>	<b>8.0</b>
<b>Zone 4</b>	<b>44.5</b>	<b>13.2</b>	<b>7.4</b>		<b>Zone 2</b>	<b>47.1</b>	<b>14.5</b>	<b>6.5</b>
Niverville/ Ritchot	53.9	13.4	11.4	c	Grey	59.4	17.1	6.5
Ste. Anne/La Broquerie	46.8	10.6	.	s	St. Pierre/De Salaberry	50.2	.	s
Hanover	42.6	15.3	7.8	c	Macdonald	49.7	.	s
Steinbach	40.5	13.7	5.6	c	Morris	49.5	.	s
Rural East	37.6	20.2	7.6	c	Red River South	47.7	12.0	11.4
Taché	37.5	11.1	.	s	Carman	30.8	15.8	11.4
<b>Zone 3</b>	<b>46.7</b>	<b>14.6</b>	<b>9.1</b>	<b>c</b>	<b>Zone 1</b>	<b>42.7</b>	<b>14.3</b>	<b>8.9</b>
Roland/ Thompson	52.2	.	.	s	North Norfolk	58.5	.	s
Stanley	51.3	.	.	s	Seven Regions	50.6	.	s
Winkler	47.1	13.2	10.2	c	City of Portage	40.3	12.8	8.2
Altona	46.8	15.1	11.8	c	Rural Portage	40.0	.	s
Morden	46.7	9.6	.	s	Cartier/SFX	30.9	-	s
Lorne/Louise /Pembina	40.9	15.8	7.7	c				

(c) = estimate displayed with caution. (s) = estimate suppressed.  
 Statistics Canada CCHS 2009/10-2011/12

## Fruit and Vegetable Consumption

### Definition

The percentage of the population, aged 12 years and older, who reported consuming 5 or more servings, on average, of fruit and vegetables daily.

### Why is this indicator important?

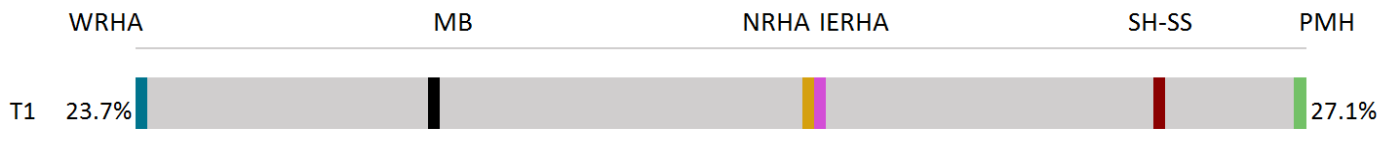
Low fruit and vegetable consumption is one of the leading factors contributing to chronic disease.

### Provincial/Regional Key Findings

- Figure 42 shows that in Manitoba, 24.6% of respondents reported consuming five or more servings of fruits and vegetables daily. Percentages were similar across regions.
- In Southern Health-Santé Sud, 26.7% reported consuming five or more servings daily.

**Figure 42. Fruit and Vegetable Consumption by RHA, 2015-2016**

Age- and sex-adjusted proportion (%) of weighted sample consuming 5+ servings per day



H/L Significantly higher or lower than the MB average.

	WRHA	MB	NRHA	IERHA	SH-SS	PMH
T1 RATE	23.7%	24.6%	25.7%	25.7%	26.7%	27.1%

Statistics Canada CCHS 2015-2016



## Sleep Time

### Definition

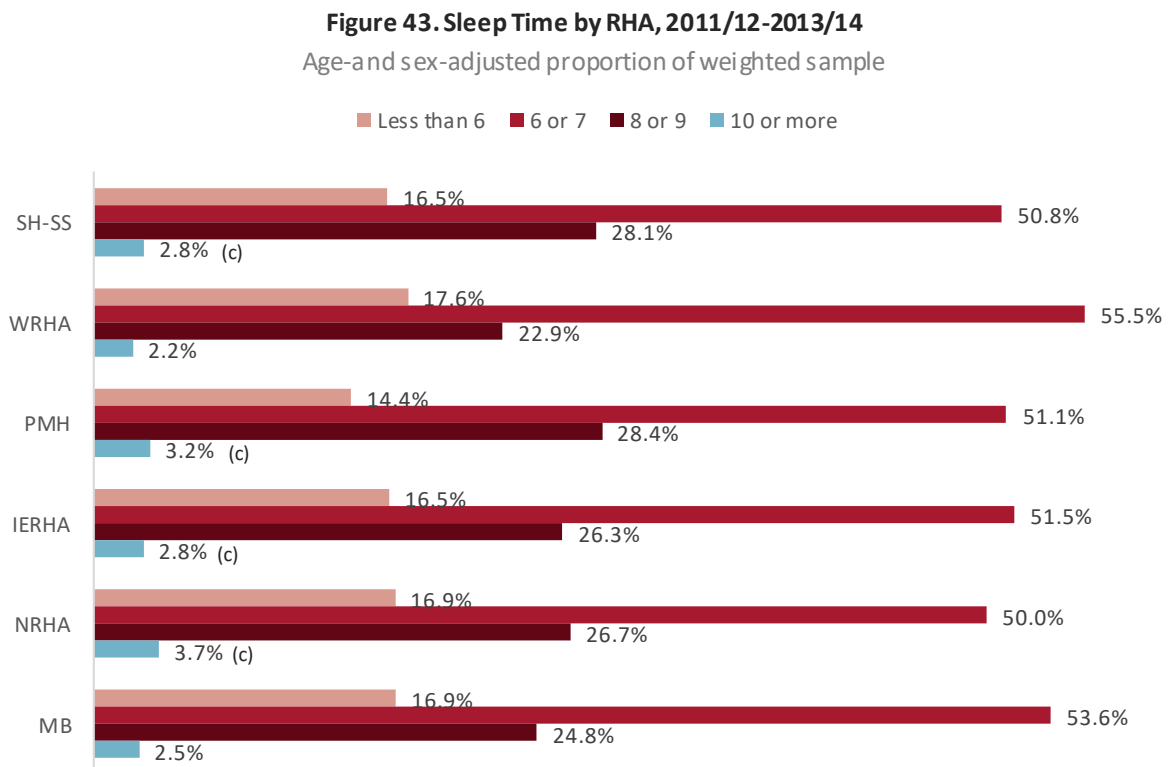
The average number of hours individuals reported they spent sleeping in a 24 hour period.

### Why is this indicator important?

Sleep is a vital component of good health and well-being throughout an individual’s life. An adequate amount of quality sleep every day can help promote good mental and physical health, quality of life and safety.

### Provincial Key Findings

- ▶ **Figure 43** shows that in Manitoba, the majority of respondents reported sleeping 6 or 7 hours.
- ▶ Percentages were similar across regions.



(c) = estimate displayed with caution.  
Statistics Canada CCHS 2011/12-2013/14

## Regional Key Findings

- Table 29 shows that the largest proportion of respondents in the region and in all zones reported sleeping 6 or 7 hours daily.
- Percentages were similar across zones. In Zone 3, the proportion of respondents reporting less than 6 hours of sleep was significantly lower than the provincial average.
- Percentages varied across districts. The most prevalent response was 6 or 7 hours in the majority of districts with the exception of Rural East which reported more frequently less than 6 hours and Carman, Grey, and North Norfolk which reported 8 or 9 hours more prevalently.

**Table 29. Sleep Time in Southern Health-Santé Sud, 2011/12-2013/14**

Age- and sex-adjusted proportion of weighted sample

Less 6	6 or 7	8 or 9	10+
%	%	%	%

Less 6	6 or 7	8 or 9	10+
%	%	%	%

<b>Manitoba</b>	<b>16.9</b>	<b>53.6</b>	<b>24.8</b>	<b>2.5</b>
-----------------	-------------	-------------	-------------	------------

<b>SH-SS</b>	<b>16.5</b>	<b>50.8</b>	<b>28.1</b>	<b>2.8</b>	<b>c</b>
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Zone 4	18.6	51.8	25.4	2.8	c
Steinbach	14.0	c 51.9	27.3		s
Taché	16.8	c 54.0	24.3	c	s
Rural East	39.1	c 37.6	c 19.3	c	s
Ste. Anne/ La Broquerie	23.1	c 38.8	c	s	s
Hanover	26.1	c 50.5	20.4	c	s
Niverville/ Ritchot		s 64.4	c	s	s

Zone 2	19.2	49.4	27.8		s
Macdonald	14.9	c 56.5	23.5	c	s
St. Pierre/De Salaberry	17.3	c 55.0	c	s	s
Carman	27.1	c 35.3	c 35.9	c	s
Red River South	31.8	c 39.6	c 25.1	c	s
Grey		s 33.2	c 43.1	c	s
Morris		s 57.9	34.7	c	s

Zone 3	10.4	L	56.4	28.1	3.1	c
Morden	11.6	c	57.2	23.8	c	s
Lorne/Louise /Pembina	12.6	c	52.7	32.2	c	s
Altona	15.8	c	49.1	30.4		s
Winkler		s	62.4	24.3	c	s
Roland/ Thompson		s	s	s	s	s
Stanley		s	52.9	c 34.9	c	s

Zone 1	18.3	48.8	29.8		s
City of Portage	15.5	c 53.2	28.7		s
North Norfolk		s 33.0	c 36.2	c	s
Seven Regions		s 43.8	c 38.0	c	s
Rural Portage		s 49.9	c	s	s
Cartier/SFX		s 42.1	c 28.4	c	s

(H/L) = significantly higher/lower than MB average.

(c) = estimate displayed with caution.

Statistics Canada CCHS 2011/12-2013/14



## Cell Phone Use While Driving

### Definition

The percentage of the population who reported using a cell phone while driving a motor vehicle, over a one-year time period.



### Why is this indicator important?

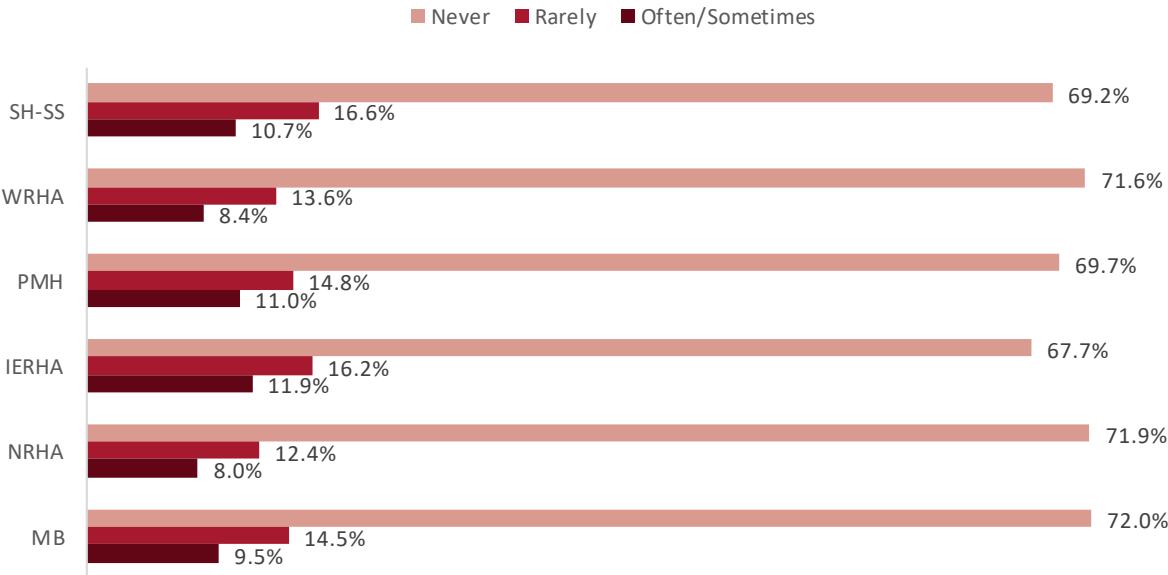
Cell phone use while driving decreases driver awareness and increases risk for collision, leading to higher levels of unnecessary injuries and fatalities. Monitoring this behaviour helps to inform the effectiveness of public education activities.

### Provincial Key Findings

- ▶ **Figure 44** shows that the majority of respondents reported never using a cell phone while driving in the province and all regions. Percentages were similar across the province.

**Figure 44. Cell Phone Use while Driving by RHA, 2011/12-2013/14**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2015-2016

## Regional Key Findings

- Table 30 shows that the majority of respondents in the region, zones, and districts reported never using their cell phone while driving.
- Percentages were similar across zones but the percentage of respondents reporting 'rarely' in Zone 1 was significantly higher than the provincial average.
- Percentages varied across districts. The percentage reporting 'rarely' in North Norfolk was significantly higher than the provincial average.

**Table 30. Cell Phone Use while Driving in Southern Health-Santé Sud, 2011/12-2013/14**

Age- and sex-adjusted proportion of weighted sample

Never	Rarely	Often/ Sometimes
%	%	%

Never	Rarely	Often/ Sometimes
%	%	%

<b>Manitoba</b>	<b>72.0</b>	<b>14.5</b>		<b>9.5</b>	
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<b>SH-SS</b>	<b>69.2</b>	<b>16.6</b>		<b>10.7</b>	
--------------	-------------	-------------	--	-------------	--

Zone 4	66.5	17.6		14.2	
Niverville/ Ritchot	70.8	.	s	10.1	c
Taché	69.5	11.5	c	18.4	c
Ste. Anne/ LaBroquerie	69.4	.	s	.	s
Rural East	66.0	.	s	.	s
Steinbach	64.5	21.6		11.7	c
Hanover	55.1	20.7	c	23.1	c

Zone 2	65.2	19.0		14.1	c
St. Pierre/ De Salaberry	78.5	.	s	.	s
Grey	78.3	c	.	s	.
Red River South	65.1	15.1	c	.	s
Carman	62.5	.	s	.	s
Macdonald	62.0	18.6	c	18.3	c
Morris	54.6	28.5	c	.	s

Zone 3	72.0	16.0		10.4	
Morden	81.0	.	s	8.5	c
Stanley	79.5	.	s	.	s
Altona	72.2	18.6	c	.	s
Winkler	67.7	18.7	c	11.6	c
Roland/ Thompson	65.6	.	s	.	s
Lorne/Louise / Pembina	65.4	18.0	c	.	s

Zone 1	64.3	23.7	H	10.7	c
Seven Regions	78.6	.	s	.	s
City of Portage	68.0	22.9		8.7	c
Rural Portage	65.3	23.1	c	.	s
Cartier/SFX	55.1	.	s	13.4	c
North Norfolk	50.6	c	38.7	Hc	.

(H/L) = significantly higher/lower than MB average.  
(c) = estimate displayed with caution. (s) = estimate suppressed.  
Statistics Canada CCHS 2011/12-2013/14

## ATV Helmet Use

### Definition

The percentage of the population who reported using a helmet while riding an all-terrain vehicle (ATV), over a one-year time period.

### Why is this indicator important?

Wearing an approved proper fitting helmet is one of the ways to reduce the risk of acquiring a head or spinal cord injury during an ATV accident. Monitoring this behaviour helps to inform public education activities.

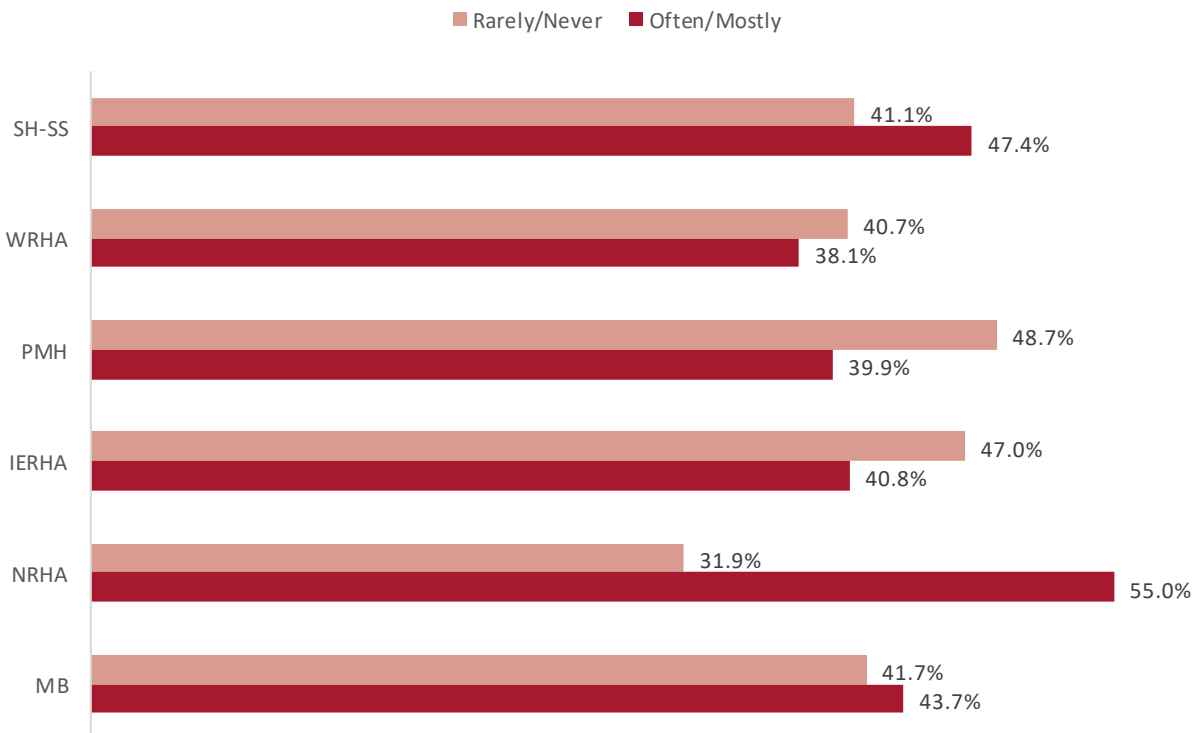


### Provincial Key Findings

- ▶ **Figure 45** shows that in the province almost 44% reported using a helmet on an ATV 'often/mostly'.
- ▶ In Winnipeg RHA, Prairie Mountain Health, and Interlake Eastern-RHA, a larger proportion reported rarely or never using a helmet; while in Southern Health-Santé Sud, Northern Health Region, and the province the proportion was larger for 'often/mostly' using a helmet.

**Figure 45. ATV Helmet Use by RHA, 2011/12-2013/14**

Age- and sex-adjusted proportion of weighted sample



Statistics Canada CCHS 2011/12-2013/14

## Regional Key Findings

- Table 31 shows that a bit more respondents in the region reported using a helmet ‘often/mostly’ than ‘rarely/never’, although the difference was not tested statistically.
- In all zones, ATV helmet use was approximately 50/50, with slightly more helmet use in Zone 4; however, the differences between zones were not tested statistically.
- Percentages varied across districts with ‘rarely/never’ responses the lowest in Ste. Anne/La Broquerie and the highest in Seven Regions, among districts with available data.

## Geographic Disparity

- The highest district reporting rarely/never using a helmet was 2.8 times higher than the lowest district.

**Table 31. ATV Helmet Use in Southern Health-Santé Sud, 2011/12-2013/14**

Age-and sex-adjusted proportion of weighted sample

	Rarely/ Never		Often/ Mostly		Rarely/ Never		Often/ Mostly	
	%		%		%		%	
<b>Manitoba</b>	<b>41.7</b>		<b>43.7</b>		<b>SH-SS</b>	<b>41.1</b>	<b>47.4</b>	
<b>Zone 4</b>	<b>37.2</b>		<b>59.0</b>		<b>Zone 2</b>	<b>45.6</b>	<b>48.5</b>	
Steinbach	.	s	75.0	H	Macdonald	.	s	59.1
Ste. Anne/ La Broquerie	27.4	c	65.0		Red River South	56.8	c	38.4
Rural East	36.7	c	58.6		St. Pierre	57.8	c	.
Taché	47.2	c	49.2	c	Carman	42.1	c	.
Hanover	55.8	c	37.5	c	Grey	55.7	c	.
Niverville/Ritchot	53.1	c	.	s	Morris	.	s	.
<b>Zone 3</b>	<b>47.0</b>		<b>44.0</b>		<b>Zone 1</b>	<b>45.7</b>	<b>c</b>	<b>50.7</b>
Stanley	.	s	72.9	c	City of Portage	38.7	c	59.0
Morden	.	s	64.3	c	Rural Portage	39.5	c	58.1
Lorne/Louise/ Pembina	47.0		53.0		North Norfolk	.	s	57.9
Roland/Thompson	.	s	46.6	c	Cartier/SFX	.	s	53.7
Altona	.	s	33.1	c	Seven Regions	77.7	c	.
Winkler	63.0	c	31.6	c				

(H/L) = significantly higher/lower than MB average.  
(c) = estimate displayed with caution. (s) = estimate suppressed.  
Statistics Canada CCHS 2011/12-2013/14

# Use of Preventative Services

## Influenza (age 65+)

### Definition

The percentage of the population, aged 65 years and older, who were immunized for influenza (received the flu shot), over a one-year time period.

### Why is this indicator important?

People 65 years and older are at greater risk of serious complications from the flu, often leading to hospitalization and death, because immune defenses become weaker with age. Monitoring the uptake of influenza vaccination helps to inform health promotion and public health interventions including public awareness messages in an effort to reach the national target of 80 percent coverage.

### Provincial Key Findings

- ▶ **Figure 46** shows that in Manitoba, approximately 55% of older adults aged 65 years and older received an influenza vaccination in the current time period.
- ▶ Percentages ranged from the lowest in Northern Health Region to the highest in Winnipeg RHA.

**Figure 46. Influenza Immunization by RHA, 2017-2018**

Percentage of older adults (age 65+)



	NRHA	SH-SS	PMH	IERHA	MB	WRHA
T1 COUNT	2,405	12,909	16,716	12,698	115,433	70,705
T1 RATE	43.2%	47.5%	53.2%	54.3%	55.2%	58.2%

IMA MHSAL 2019

## Regional Key Findings

- ▶ **Table 32** shows that in the region, a total of 12,909 adults aged 65 years and older received influenza immunization in the current time period, representing 47.5%. This is much lower than the national target of 80% coverage but similar to the Manitoba prevalence.
- ▶ Percentages were similar across zones.
- ▶ District level data not available.

**Table 32. Influenza Immunization in Southern Health-Santé Sud, 2017-2018**

Percentage of older adults (age 65+)

	Count	Percentage		Count	Percentage
Manitoba	115,433	55.2	SH-SS	12,909	47.5
Zone 4	4,362	45.8	Zone 2	2,410	52.6
Zone 3	3,104	44.4	Zone 1	3,033	49.9

IMA MHSAL 2019

## A CLOSER LOOK...

While older adults are at increased risk of serious illness from the flu, they are not the only ones. Residents of personal care homes or long-term care facilities, children under five years of age, those with chronic illnesses, pregnant women, and health care workers and first responders are among those at increased risk. An annual flu vaccine is especially important for those groups but is also recommended for everyone to protect themselves and the people close to them.

In the fall of 2018, Public Health-Healthy Living ran 73 advertised flu clinics in 59 communities and 35 unadvertised or outreach flu clinics throughout the region. They have undertaken many efforts to make the flu vaccine more accessible and remove barriers to vaccination, including:

- ▶ Choosing locations accessible or already frequently visited by older adults
- ▶ Offering flu clinics outside of regular business hours
- ▶ Outreach clinics in food banks, community centres, and low income housing complexes
- ▶ Partnerships with various medical clinics and retail pharmacies for access beyond the dates of the community clinics



## Pneumococcal (age 65+)

### Definition

The percentage of the population, aged 65 years and older, who were immunized for pneumonia (pneumococcal conjugate vaccine). Unlike influenza, this immunization is usually only given once in a lifetime, therefore the rate is cumulative.

### Why is this indicator important?

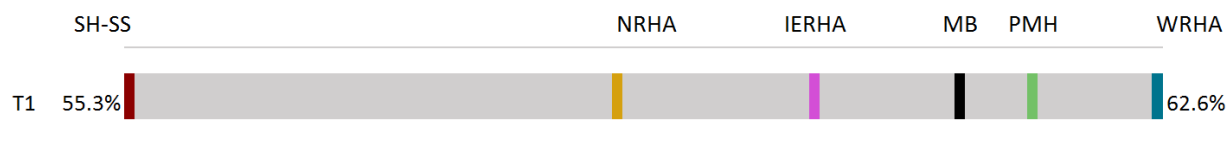
Pneumococcal disease can cause severe infections of the lungs, bloodstream, lining of the brain and spinal cord that can sometimes be fatal. A weakened immune system makes older adults at a greater risk of developing life threatening pneumococcal infections and, for those who survive, to suffer permanent damage to health, especially if living with other comorbid conditions. Monitoring the uptake of pneumococcal vaccination helps to inform health promotion and primary health care interventions.

### Provincial Key Findings

- ▶ **Figure 47** shows that 61.2% of Manitobans aged 65 years and older were immunized for pneumonia.
- ▶ Percentages ranged with the lowest in Southern Health-Santé Sud to the highest in Winnipeg RHA.

**Figure 47. Pneumococcal Immunization by RHA, 2017**

Percentage of older adults (aged 65+)



	SH-SS	NRHA	IERHA	MB	PMH	WRHA
T1 COUNT	14,992	3,255	14,024	127,881	19,445	76,165
T1 RATE	55.3%	58.8%	60.2%	61.2%	61.7%	62.6%

IMA MHSAL 2019

## Regional Key Findings

- ▶ **Table 33** shows a total of 14,992 adults aged 65 years and older were immunized for pneumonia, representing 55.3%. This is the lowest percentage in the province, although not tested statistically.
- ▶ Percentages were similar across zones.
- ▶ District level data not available.

**Table 33. Pneumococcal Immunization in Southern Health-Santé Sud, 2017**

Percentage of older adults (aged 65+)

	Count	Percentage		Count	Percentage
Manitoba	127,881	61.2	SH-SS	14,992	55.3
Zone 4	5,409	57.1	Zone 2	2,572	56.2
Zone 3	3,810	54.6	Zone 1	3,201	52.6

IMA MHSAL 2019



## Colorectal Cancer Screening

### Definition

The percentage of the population, aged 50 to 74 years, who participated in screening for colorectal cancer (including Fecal Occult Blood Test (FOBT), Fecal Immunochemical Test (FiT), Colonoscopy, and Flexible Sigmoidoscopy).

### Why is this indicator important?

In Manitoba, it is recommended that most people age 50 to 74 years do a FOBT every two years. Screening done through a regular FOBT or a colonoscopy or sigmoidoscopy has been shown to greatly reduce the chance of dying from colorectal cancer because early detection of pre-cancerous polyps often leads to more effective treatment.

### Provincial Key Findings

- ▶ **Figure 48** shows that in Manitoba 35.3% of adults aged 50 to 74 years received colorectal cancer screening in the current time period.
- ▶ In both time periods, percentages were significantly lower than the provincial average in Northern Health Region, Prairie Mountain Health, and Southern Health-Santé Sud, while Winnipeg RHA was significantly higher.
- ▶ **Income:** The income disparity remained unchanged over time. Colorectal cancer screening among residents of low income areas was 0.8 times lower than the highest income areas.

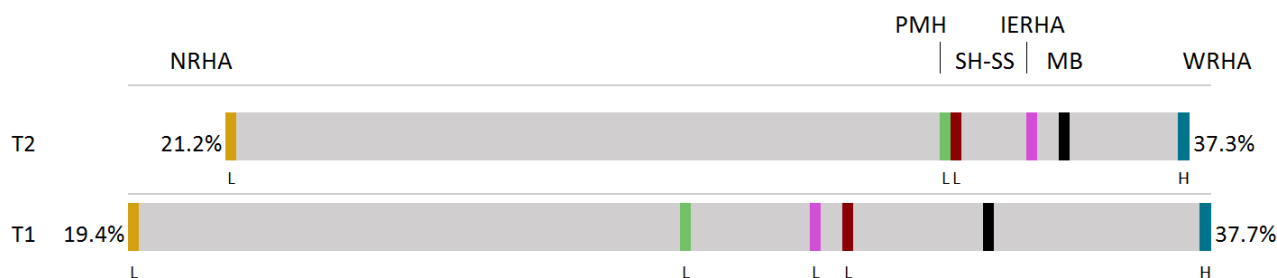


Rural Quintiles	
T1	0.8x
T2	0.8x
CHANGE	0.0



**Figure 48. Colorectal Cancer Screening by RHA, 2014-2015 (T1) and 2016-2017 (T2)**

Percentage of population (aged 50-74) any fecal test



	NRHA	PMH	SH-SS	IERHA	MB	WRHA
T2 COUNT	3,444	16,830	16,852	15,729	131,612	78,757
T2 RATE	21.2% L	33.5% L	33.5% L	34.9%	35.3%	37.3% H
T1 RATE	19.4% L	28.9% L	31.6% L	31.1% L	34.1%	37.7% H

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

## Regional Key Findings

- Table 34 shows that in the region, a total of 16,852 adults aged 50 to 74 years old received colorectal cancer screening in the current time period.
- The regional percentages were significantly lower than the provincial average in both time periods.
- In both time periods, percentages in Zones 1 and 4 were significantly lower than the provincial average, while Zone 3 was significantly higher. Zone 2 went from significantly lower in the first time period to significantly higher than the provincial average in the current time period.
- District level data not available.

**Table 34. Colorectal Cancer Screening in Southern Health-Santé Sud, 2014-2015 (T1) and 2016-2017 (T2)**

Percentage of population (aged 50-74)

	T2		T1	
	Count	Percentage	Percentage	
Manitoba	131,612	35.3	34.1	
SH-SS	16,852	33.5 L	31.6 L	
Zone 4	5,750	32.6 L	31.8 L	
Zone 3	4,680	38.1 H	36.3 H	
Zone 2	3,292	37.3 H	32.5 L	
Zone 1	3,130	27.2 L	25.9 L	

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

A photograph showing a person's legs and feet on a medical table. The person is wearing a light blue hospital gown. The legs are positioned on a black padded surface, and the feet are resting on a white surface. The background is a plain, light-colored wall.

## A CLOSER LOOK...

Wait times for colonoscopy appointments have been dramatically reduced across Southern Health-Santé Sud, thanks to a Colonoscopy Central Referral process. The project was part of the provincial 'In Sixty' Cancer initiative to reduce wait times from when cancer is first suspected to the first treatment to 60 days or less.

Colonoscopy is a vital part of screening for colon and rectal cancer. Patients are now offered the next available appointment for a colonoscopy at five health centres in the region and are given priority based upon urgency of the referral from their doctor. The Central Referral process matches patients needing a colonoscopy with the site which has the shortest wait time. The aim is for the patient to receive the test within 13 days for urgent and 27 days for semi-urgent cases.

Patients who have a higher suspicion of cancer can also be connected to nurse navigators who assist patients and their families through the cancer journey as quickly and easily as possible. A patient may also choose not to accept the first available if he or she prefers to go to a specific site.

## Breast Cancer Screening

### Definition

The percentage of females, aged 50 to 74 years, who received at least one mammogram in a two-year time period.

### Why is this indicator important?

In Manitoba, it is recommended that screening mammography be offered every two years to all women 50 to 74 years of age. Although breast cancer can occur at any age, more than 80 percent of new cases occur among women 50 years of age and older. Early detection, combined with effective treatment, remains the best option available to reduce deaths in this age group.

### Provincial Key Findings

- ▶ **Figure 49** shows that in Manitoba, a total of 106,075 women aged 50 to 69 years received at least one mammogram in the current time period.
- ▶ In the current time period, all regions were significantly different than the provincial average with Northern Health Region, Southern Health-Santé Sud, and Interlake-Easter RHA significantly lower and Prairie Mountain Health and Winnipeg RHA significantly higher.
- ▶ **Income:** The income disparity remained unchanged over time. Breast cancer screening among residents of low income areas was 0.8 times lower than the highest income residents.



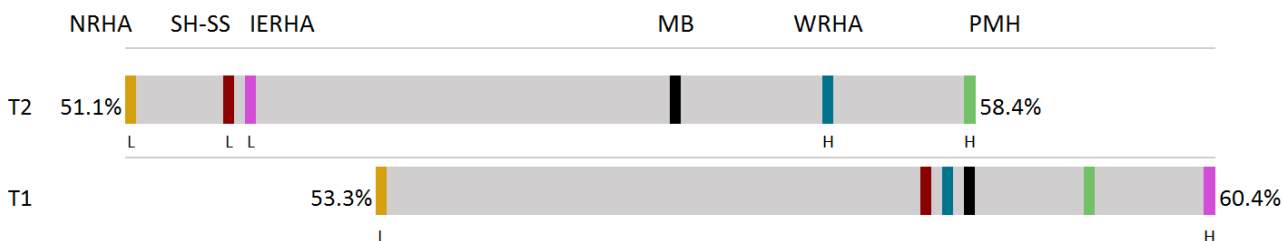
Rural Quintiles	
T1	0.8x
T2	0.8x
CHANGE	0.0



# Use of Preventative Services

**Figure 49. Breast Cancer Screening by RHA, 2014-2015 (T1) and 2016-2017 (T2)**

Percentage of women (aged 50-74) with a mammogram within the last two years



H/L Significantly higher or lower than the MB average for that time period.

	NRHA		SH-SS		IERHA		MB		WRHA		PMH	
T2 COUNT	3,695		13,087		11,429		106,075		63,072		14,792	
T2 RATE	51.1%	L	52.0%	L	52.2%	L	55.8%		57.1%	H	58.4%	H
T1 RATE	53.3%	L	58.0%		60.4%	H	58.4%		58.2%		59.4%	

CancerCare Manitoba 2019

## Regional Key Findings

- Table 35 shows that in the region, a total of 13,807 women received a breast cancer screening in the current time period.
- The regional percentage was significantly lower than the provincial average in the current time period.
- Percentages were significantly lower than the provincial average in Zones 1, 3, and 4 in the current time period. While in Zone 2, percentages were significantly higher in both time periods.
- District level data not available.

**Table 35. Breast Cancer Screening in Southern Health-Santé Sud,**

Percentage of women (aged 50-74)

	T2			T1			T2			T1	
	Count	Percentage		Percentage			Count	Percentage		Percentage	
<b>Manitoba</b>	<b>106,075</b>	<b>55.8</b>		<b>58.4</b>		<b>SH-SS</b>	<b>13,807</b>	<b>52.0%</b>	<b>L</b>	<b>58.0%</b>	
<b>Zone 4</b>	4,507	51.0	L	56.8		<b>Zone 2</b>	2,692	62.0	H	64.0	H
<b>Zone 3</b>	3,210	51.4	L	55.3	L	<b>Zone 1</b>	2,678	46.8	L	58.2	

H/L Significantly higher or lower than the MB average for that time period.

CancerCare Manitoba 2019

## Cervical Cancer Screening

### Definition

The percentage of females, aged 21 to 69 years, who were screened for cervical cancer over a two-year time period.

### Why is this indicator important?

Regular pap smears every three years can prevent or detect early cell changes that can be the precursor to cervical cancer. Risk factors associated with cervical cancer include early age of sexual intercourse, sexually transmitted infection, low socioeconomic status and smoking.

### Provincial Key Findings

- ▶ **Figure 50** shows that, in Manitoba a total of 251,718 women aged 21 to 69 years old were screened for cervical cancer in the current time period.
- ▶ In the current time period, Northern Health Region and Southern Health-Santé Sud were significantly lower than the provincial average, while Interlake-Eastern and Winnipeg RHAs were significantly higher in both time periods.
- ▶ **Income:** The income disparity remained unchanged over time. Cervical cancer screening among low income areas was 0.8 times lower than the highest income areas.



Rural Quintiles	
T1	0.8x
T2	0.8x
CHANGE	0.0



**Figure 50. Cervical Cancer Screening by RHA, 2012-2014 (T1) and 2015-2017 (T2)**

Percentage of eligible women (aged 21-69)



H/L Significantly higher or lower than the MB average for that time period.

	NRHA		SH-SS		PMH		MB		IERHA		WRHA	
T2 COUNT	12,178		34,383		30,414		251,718		26,268		148,475	
T2 RATE	55.1%	L	63.4%	L	64.6%		64.8%		65.8%	H	65.9%	H
T1 RATE	57.6%	L	66.6%		65.1%	L	66.6%		68.1%	H	67.5%	H

CancerCare Manitoba 2019

## Regional Key Findings

- Table 36 shows that in the region, a total of 34,383 women were screened for cervical cancer in the current time period.
- The regional percentage was significantly lower than the provincial average in the current time period.
- In both time periods, Zones 1 and 3 were significantly lower than the provincial average, while Zones 2 and 4 were significantly higher.
- District level data not available.

**Table 36. Cervical Cancer Screening in Southern Health-Santé Sud, 2012-2014 (T1) and 2015-2017 (T2)**

Percentage of eligible women (aged 21-69)

	T2		T1			T2		T1			
	Count	Percentage	Percentage	Count		Percentage	Percentage				
<b>Manitoba</b>		<b>64.8</b>		<b>66.6</b>							
<b>SH-SS</b>	<b>34,383</b>	<b>63.4</b>	<b>L</b>	<b>66.6</b>							
<b>Zone 4</b>	13,482	65.7	H	70.3	H	<b>Zone 2</b>	5,679	66.9	H	70.9	H
<b>Zone 3</b>	8,231	59.7	L	60.8	L	<b>Zone 1</b>	6,991	61.0	L	63.9	L

H/L Significantly higher or lower than the MB average for that time period.

CancerCare Manitoba 2019

## Dental Insurance

### Definition

The percentage of respondents who reported dental insurance coverage.

### Why is this indicator important?

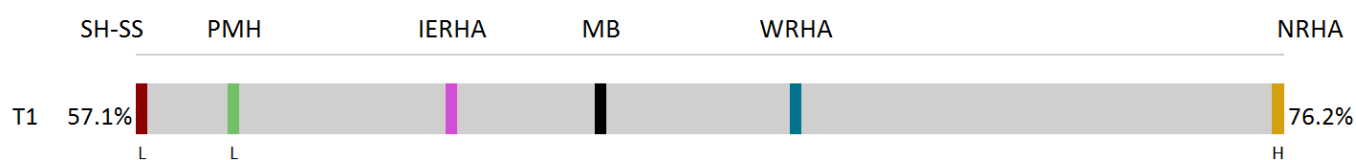
The main contributors to inequity in dental care are income and dental insurance coverage.<sup>xxii</sup> The probability of receiving any dental care over the course of a year increases markedly with dental insurance, household income, and educational attainment.<sup>xxiii</sup>

### Provincial Key Findings

- ▶ **Figure 51** shows that in Manitoba, 65% of respondents reported having dental insurance.
- ▶ The percentage with dental insurance was significantly lower than the provincial average in Southern Health-Santé Sud and Prairie Mountain Health but significantly higher in Northern Health Region.

**Figure 51. Dental Insurance by RHA, 2011/12-2013/14**

Age-and sex-adjusted proportion (%) of weighted sample with dental insurance



H/L Significantly higher or lower than the MB average.

	SH-SS		PMH		IERHA		MB		WRHA		NRHA	
T1 RATE	57.1%	L	58.9%	L	62.5%		65.0%		68.2%		76.2%	H

Statistics Canada CCHS 2011/12-2013/14



## Regional Key Findings

- ▶ **Table 37** shows that in the region, 57.1% of respondents reported having dental insurance: significantly lower than the provincial average.
- ▶ Percentages varied across zones with the lowest in Zone 3 and the highest in Zone 4.
- ▶ Percentages varied dramatically across districts with the lowest in Grey and the highest in Niverville/Ritchot.
- ▶ Percentages were significantly lower than the provincial average in Grey and Altona but significantly higher in Niverville/Ritchot.

## Geographic Disparity

- ▶ The highest district of Niverville/Ritchot was 2.6 times higher than the lowest district of Grey.

**Table 37. Dental Insurance in Southern Health-Santé Sud, 2011/12, 2013/14**  
Age-and sex-adjusted proportion (%) of weighted sample with dental insurance

	Percentage	
<b>Manitoba</b>	<b>65.0%</b>	

	Percentage	
<b>SH-SS</b>	<b>57.1%</b>	<b>L</b>

<b>Zone 4</b>	<b>66.1%</b>	
Niverville/Ritchot	85.6%	H
Ste. Anne/ La Broquerie	68.1%	
Taché	66.1%	
Steinbach	62.4%	
Rural East	51.7%	
Hanover	50.2%	

<b>Zone 2</b>	<b>63.7%</b>	
Macdonald	81.2%	
Morris	60.6%	c
Red River South	58.1%	
St. Pierre/De Salaberry	52.2%	
Carman	45.7%	
Grey	33.2%	Lc

<b>Zone 3</b>	<b>52.8%</b>	<b>L</b>
Stanley	64.6%	c
Lorne/Louise/ Pembina	63.7%	
Morden	56.9%	
Winkler	54.0%	
Roland/ Thompson	43.8%	c
Altona	35.0%	L

<b>Zone 1</b>	<b>56.8%</b>	
City of Portage	68.7%	
Seven Regions	48.7%	c
Rural Portage	46.4%	c
Cartier/SFX	46.0%	c
North Norfolk	42.8%	c

(H/L) =significantly higher/lower than MB average.

(c) = estimate displayed with caution.

Statistics Canada CCHS 2011/12-2013/14

## Dental Visits

### Definition

The percentage of respondents who reported on the annual frequency of dental visits.

### Why is this indicator important?

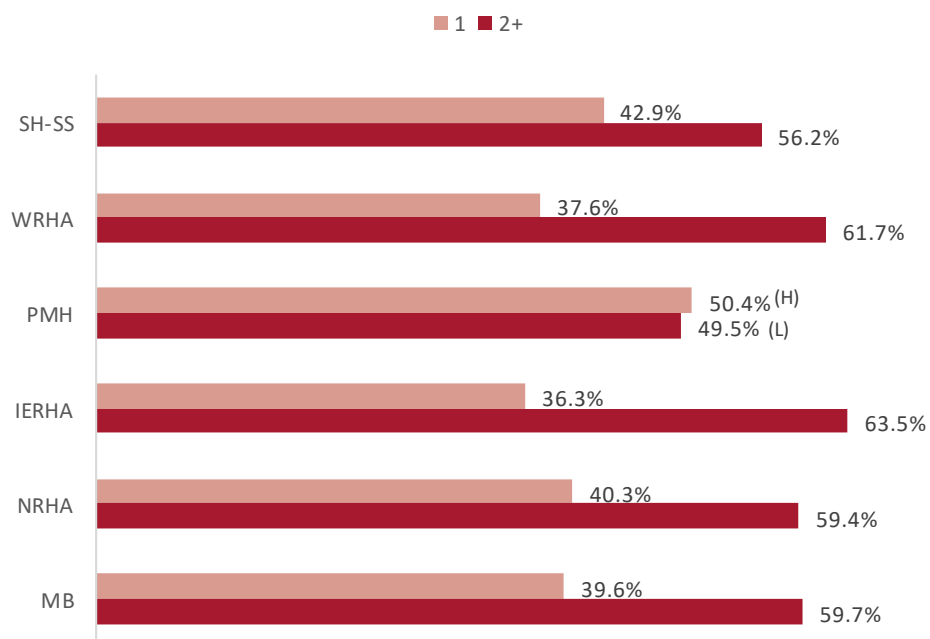
The promotion of good oral health habits such as healthy food choices, brushing teeth twice a day with fluoridated toothpaste, regular flossing and visits to a dentist can all help to prevent decay and maintain a healthy mouth for a lifetime.<sup>xxiv</sup> There is a strong association between early periodontal disease and cardiac disease in later life.

### Provincial/Regional Key Findings

- ▶ **Figure 52** shows that in Manitoba, approximately 60% of respondents reported visiting the dentist 2+ times, this was similar in the majority of regions.
- ▶ In Prairie Mountain Health, percentage of respondents reporting 1 visit was significantly higher than the provincial average while the percentage of respondents reporting 2+ visits was significantly lower.
- ▶ In Southern Health-Santé Sud, 42.9% of respondents reported one dental visit and 56.2% reported 2 or more visits, similar to the province.

**Figure 52. Dental Visits by RHA, 2015-2016**

Age- and sex-adjusted proportion of weighted sample



(H/L) = significantly higher/lower than MB average.  
 Statistics Canada CCHS 2015-2016

- <sup>i</sup> Canadian Medical Association. 2019. Social determinants of Health. Canadian Medical Association. Accessed from: <https://www.cma.ca/social-determinants-health>.
- <sup>ii</sup> Canadian Medical Association (2013). Health care in Canada: What makes us sick?: Canadian Medical Association Town Hall Report. Ottawa (ON): Canadian Medical Association.
- <sup>iii</sup> Social determinants of health infographic accessed from: <http://www.southeastlin.on.ca/Priorities/Planning/HealthLinks/HealthLinkCareCoordinationLearningProgram/ServingVulnerablePopulations/SVP102/SVP102-page2.aspx>
- <sup>iv</sup> Heaman M, Kingston D, Helewa ME, Brownell M, Derksen S, Bogdanovic B, McGowan KL, Bailly A. Perinatal Services and Outcomes in Manitoba. Winnipeg, MB. Manitoba Centre for Health Policy, November 2012.
- <sup>v</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.
- <sup>vi</sup> Public Health Agency of Canada. Canadian Perinatal Health Report, 2008 Edition. PHAC. 2008. Accessed August 29, 2019 from: <http://www.phac-aspc.gc.ca/publicat/2008/cphr-rspc/pdf/cphr-rspc08-eng.pdf>.
- <sup>vii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.
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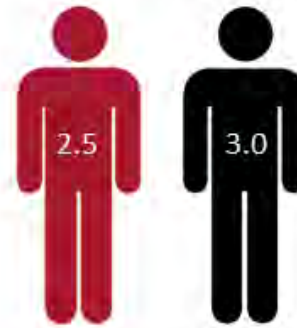
# At a Glance: How Healthy Are We?

● SH-SS      ● Manitoba

Life Expectancy



Premature Mortality Rate per 1,000 population



Infant Mortality deaths per 1,000 births



Cancer Incidence per 100,000 population



Proportion of Residents with a Mood and Anxiety Disorder



# Chapter 3 Key Findings

Southern Health-Santé Sud remains among the healthiest regions in Manitoba, with several indicators significantly better than the provincial average. The health disparity gap between districts either stayed the same or improved across 15 indicators. However, the burden of disease varied within the region, with Seven Regions district consistently having some of the poorest outcomes.

## Mortality

- Life expectancy among the highest in the province
- Mortality indicators remained stable over time
- Cancer leading cause of premature deaths
- Injury and poisoning leading cause of child mortality

## Injury

- Intentional injury related hospitalization rate lower than province and decreased over time
- Falls represented nearly 50% of all injury related hospitalizations

## Cancer

- Over 2,500 residents had new cancer diagnosis
- Lung and bronchus cancer had the highest mortality rate
- 19% of cancer patients diagnosed in late stage (IV)

## Mental Illness

- 17% of residents diagnosed with a mood or anxiety disorder; lower than the province
- 1 in 10 residents age 55+ lived with dementia
- Antidepressant prescription follow-up lower than province and decreased over time
- Suicide rates lower than provincial average

## Cardiovascular

- Over 26,500 residents with diagnosed hypertension (high blood pressure)
- Ischemic heart disease lower than province in the region and across 3 zones
- Heart attack rates higher than provincial average but improved significantly over time

## Musculoskeletal

- Arthritis and osteoporosis lower than provincial averages

## Renal

- 180 residents required dialysis or transplant
- Region is projecting highest increase for renal therapies by 2024

## Diabetes

- Over 13,000 residents lived with diabetes
- Diabetes prevalence increased significantly over time regionally and in all zones but lower than province
- Lower-limb amputations decreased significantly over time
- Diabetes care eye exams higher than provincial average

## Respiratory

- Over 14,000 residents living with respiratory disease
- Increasing rates of children diagnosed with asthma but lower than the province

## Sexually Transmitted Infections

- Gonorrhoea increased four-fold over 4 years
- Syphilis increased six-fold over 4 years



# Mortality

## Life Expectancy

### Definition

The expected length of life from birth, based on patterns of mortality in the population for the preceding five years.

### Why is this indicator important?

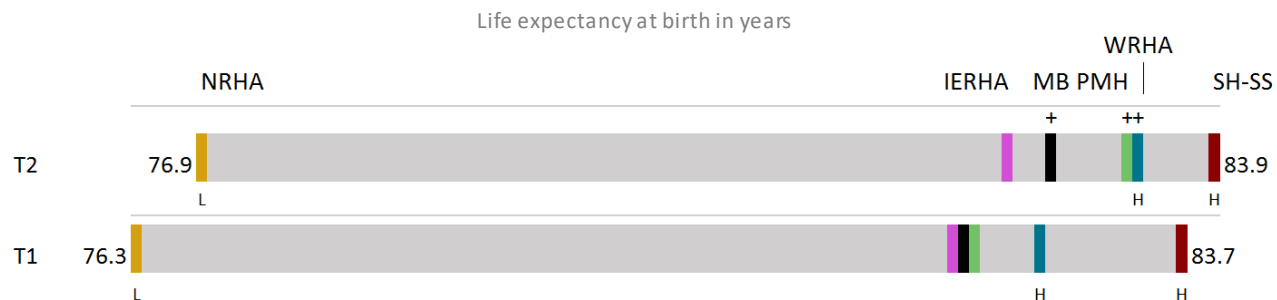
Life expectancy is one of the most widely used indicators to measure the health of a population, and the overall effectiveness of a health care system in maintaining the health status of its population.

### Provincial Key Findings

- ▶ **Figure 1** shows that **female life expectancy** increased over time in Manitoba and in all regions; however, only the changes in the province, Winnipeg RHA, and Prairie Mountain Health reached statistical significance.
- ▶ In both time periods, female life expectancy in Northern Health Region was significantly lower than the Manitoba average and significantly higher in Winnipeg RHA and Southern Health-Santé Sud.
- ▶ **Income:** Income and female life expectancy were strongly related in both time periods.<sup>i</sup> Females in the highest income areas had a life expectancy about 1.1 times longer than the lowest income areas in the current time period.
- ▶ **Figure 2** shows that **male life expectancy** increased significantly over time in Manitoba and in all regions except Southern Health-Santé Sud which did not reach statistical significance.
- ▶ In both time periods, male life expectancy in Northern Health Region was significantly lower than the provincial average and it was significantly higher in Winnipeg RHA and Southern Health-Santé Sud.
- ▶ **Income:** Income and male life expectancy were strongly related in both time periods.<sup>ii</sup> Males in the highest income areas had a life expectancy about 1.1 times longer than the lowest income areas in the current time period.



**Figure 1. Female Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)**

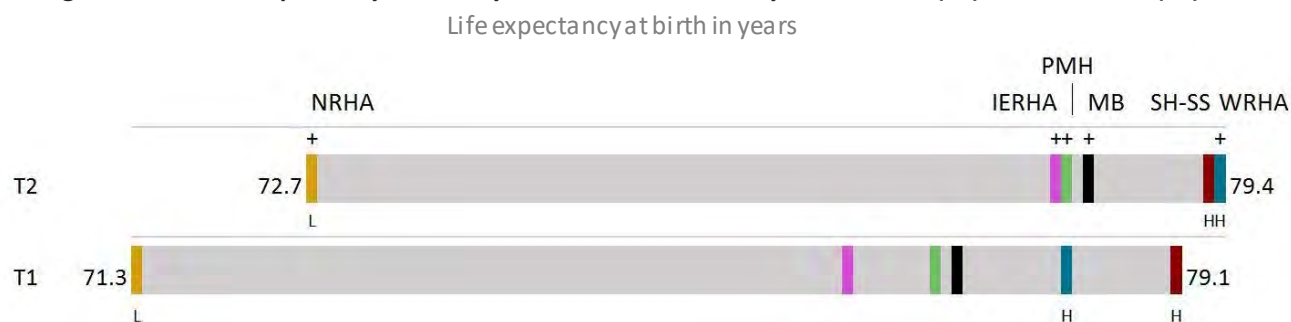


H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	IERHA	MB	PMH	WRHA	SH-SS
T2 COUNT	925	2,432	25,881	4,059	14,841	2,965
T2 RATE	76.9 L	82.5	82.8 +	83.3 +	83.4 H+	83.9 H
T1 RATE	76.3 L	82.1	82.2	82.2	82.7 H	83.7 H

MCHP RHA Indicators Atlas 2019

**Figure 2. Male Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)**



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	IERHA	PMH	MB	SH-SS	WRHA
T2 COUNT	1,177	2,786	4,144	25,781	3,294	13,605
T2 RATE	72.7 L+	78.2 +	78.3 +	78.5 +	79.4 H	79.4 H+
T1 RATE	71.3 L	76.7	77.3	77.5	79.1 H	78.3 H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- ▶ In the region, female and male life expectancy was among the highest in the province in both time periods and significantly higher than the Manitoba average.
- ▶ **Tables 1 and 2** show that life expectancy in the region remained relatively stable over time with slight, not statistically significant increases for females and males.

### Zone Level

- ▶ In both time periods, female and male life expectancy was relatively similar across zones with a difference of about 3 years between the lowest in Zone 1 and the highest in Zone 4 for both.
- ▶ In the current time period, female life expectancy was significantly higher than the Manitoba average in Zones 2, 3, and 4, while it was significantly lower in Zone 1 in the current time period (see **Table 1**).
- ▶ Male life expectancy was significantly higher than the Manitoba average in Zones 2 and 4 in both time periods (see **Table 2**).

### District Level

- ▶ **Table 1** shows that there was a difference of almost 12 years for **female life expectancy** between the lowest district of Seven Regions and the highest district of Macdonald in the current time period.
- ▶ In the current time period, female life expectancy was significantly higher than the Manitoba average in Niverville/Ritchot, Hanover, Steinbach, Macdonald, St. Pierre/De Salaberry, Carman, and Morden, but significantly lower in Seven Regions.
- ▶ The districts which increased significantly over time for female life expectancy included St. Pierre/De Salaberry and Carman, while Taché, Roland/Thompson, and Rural Portage decreased significantly.
- ▶ **Table 2** shows that there was a difference of over 10 years for **male life expectancy** between the lowest district of Seven Regions and the highest district of St. Pierre/De Salaberry in the current time period.
- ▶ In the current time period, male life expectancy was significantly higher than the Manitoba average in Niverville/Ritchot, Taché, St. Pierre/De Salaberry, Macdonald, Morden, and Cartier/SFX, while it was significantly lower in city of Portage and Seven Regions.
- ▶ The districts which increased significantly over time for male life expectancy included Niverville/Ritchot, St. Pierre/De Salaberry, and Rural Portage, while Stanley decreased significantly.

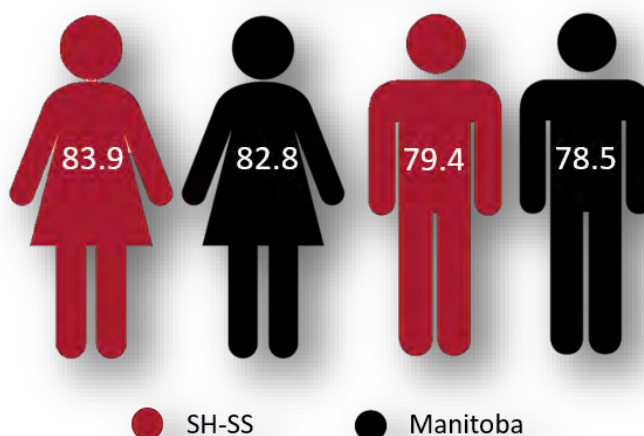
**Table 1. Female Life Expectancy in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Life expectancy at birth in years

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>25,881</b>	<b>82.8</b>	<b>+</b>	<b>82.2</b>	
<b>SH-SS</b>	<b>2,965</b>	<b>83.9</b>	<b>H</b>	<b>83.7</b>	<b>H</b>
<b>Zone 4</b>	<b>826</b>	<b>84.9</b>	<b>H</b>	<b>84.4</b>	<b>H</b>
Niverville/Ritchot	100	86.0	H	85.8	H
Hanover	115	85.9	H	86.8	H
Taché	56	85.8	-	96.5	H
Steinbach	307	85.7	H	85.4	H
Rural East	77	83.8		81.1	
Ste. Anne/ La Broquerie	171	82.8		82.4	
<b>Zone 2</b>	<b>485</b>	<b>84.6</b>	<b>H</b>	<b>83.4</b>	
Macdonald	42	91.2	H	87.6	H
St. Pierre/ De Salaberry	69	86.5	H+	82.6	
Grey	44	85.7		80.5	
Carman	147	85.5	H+	82.4	
Morris	96	82.8		85.0	
Red River South	87	81.7		84.2	
<b>Zone 3</b>	<b>891</b>	<b>84.2</b>	<b>H</b>	<b>84.9</b>	<b>H</b>
Roland/Thompson	24	87.6	-	99.1	H
Stanley	28	87.1		91.2	H
Morden	168	86.8	H	86.2	H
Altona	164	84.6		86.1	H
Winkler	259	84.1		84.2	
Lorne/Louise/ Pembina	248	81.7		83.8	
<b>Zone 1</b>	<b>763</b>	<b>81.5</b>	<b>L</b>	<b>81.4</b>	
Cartier/SFX	69	85.8		87.4	H
North Norfolk	64	83.9		83.6	
Rural Portage	97	81.3	-	85.1	
City of Portage	406	81.2		80.5	
Seven Regions	127	79.3	L	79.3	

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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## Life Expectancy



**Table 2. Male Life Expectancy in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Life expectancy at birth in years

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>25,781</b>	<b>78.5</b>	<b>+</b>	<b>77.5</b>	
<b>SH-SS</b>	<b>3,294</b>	<b>79.4</b>	<b>H</b>	<b>79.1</b>	<b>H</b>
<b>Zone 4</b>	<b>967</b>	<b>80.6</b>	<b>H</b>	<b>80.1</b>	<b>H</b>
Niverville/Ritchot	116	82.4	H+	79.6	
Taché	77	82.0	H	81.3	H
Hanover	138	80.8		81.0	H
Ste. Anne/ La Broquerie	189	80.6		80.0	H
Steinbach	319	80.2		80.1	H
Rural East	128	79.7		80.6	
<b>Zone 2</b>	<b>540</b>	<b>80.2</b>	<b>H</b>	<b>79.3</b>	<b>H</b>
St. Pierre/ De Salaberry	58	84.9	H+	79.0	
Macdonald	77	82.3	H	83.0	H
Carman	136	81.2		77.9	
Grey	66	79.1		80.9	
Morris	104	78.0		81.1	
Red River South	99	77.3		77.8	
<b>Zone 3</b>	<b>943</b>	<b>79.0</b>		<b>79.4</b>	<b>H</b>
Morden	180	81.4	H	80.0	
Altona	154	80.2		79.7	
Stanley	51	79.5	-	84.5	H
Winkler	257	78.8		80.3	H
Roland/Thompson	36	78.1		80.7	
Lorne/Louise/ Pembina	265	76.3		76.7	
<b>Zone 1</b>	<b>844</b>	<b>77.4</b>		<b>77.1</b>	
Cartier/SFX	84	81.9	H	80.6	
Rural Portage	113	80.3	+	76.9	
North Norfolk	87	79.9		79.6	
City of Portage	415	75.5	L	76.5	
Seven Regions	145	74.5	L	76.0	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

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## Geographic Disparity

- The geographic disparity between the districts with the lowest and highest life expectancy remained unchanged over time for both males and females.

SH-SS Geographic Disparity Ratio	Female Life Expectancy	Male Life Expectancy
	<b>T1</b> 1.2x	<b>T1</b> 1.1x
	<b>T2</b> 1.2x	<b>T2</b> 1.1x
	Change 0.0	Change 0.0

T1: 2007-2011, T2: 2012-2016

## Total Mortality Rates

### Definition

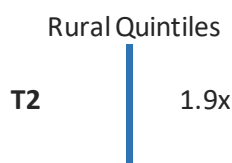
The total average annual number of deaths, per 1,000 population, for a five-year time period.

### Why is this indicator important?

Mortality statistics provide a valuable measure for assessing community health status and are useful when formulating health plans and policies to prevent or reduce premature mortality and improve overall quality of life.

### Provincial Key Findings

- ▶ **Figure 3** shows there were 51,723 deaths in Manitoba in the current time period.
- ▶ The total mortality rate decreased over time in Manitoba and in all regions; however, none of the changes were statistically significant.
- ▶ Total mortality rate in the Northern Health Region was significantly higher than the provincial average in both time periods.
- ▶ **Income:** Income and total mortality rates were strongly related in both time periods.<sup>iii</sup> Residents' mortality rate in low income areas was about 1.9 times higher than the highest income areas in the current time period.
- ▶ The leading causes of death in Manitoba were circulatory diseases and cancer followed by respiratory diseases, mental illness, and injury and poisoning. The two top causes alone (circulatory and cancer) comprised almost 60% of deaths in the province and were the top two causes in all regions.

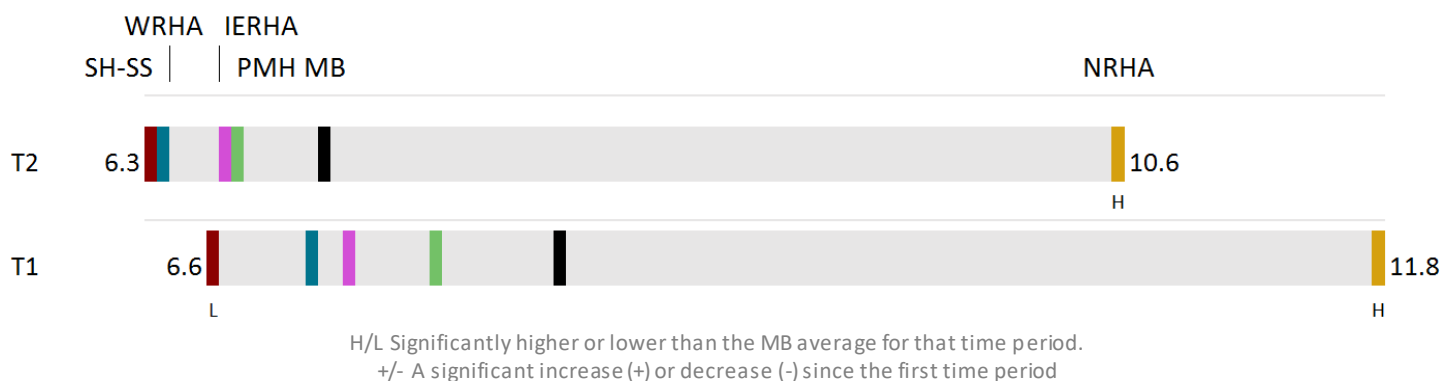


T2: 2012-2016

*Total mortality rates strongly related to income*

**Figure 3. Average Annual Total Mortality Rate by RHA, 2007-2011 (T1) & 2012-2016 (T2)**

Age- and sex-adjusted rate per 1,000 (all ages)



	SH-SS	WRHA	IERHA	PMH	MB	NRHA
T2 COUNT	6,266	28,477	5,225	8,218	51,723	2,103
T2 RATE	6.3	6.3	6.7	6.7	7.1	10.6 H
T1 RATE	6.6 L	7.0	7.2	7.6	8.2	11.8 H

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## Regional Key Findings

### SH-SS Level

- Table 3 shows there were 6,266 deaths in the region in the current time period.
- The regional total mortality rate was among the lowest in the province in the current time period; however, not significantly different than the Manitoba average.
- The total mortality rate in the region remained relatively stable with a slight, not statistically significant decrease.
- Table 4 shows that the leading causes of deaths in the region were circulatory diseases, cancer, respiratory diseases, injury and poisoning, and mental illness in the current time period. This ranking was similar over time with one notable exception: mental illness increased, while nervous system decreased. Similar to Manitoba, the top two causes comprised about 60% of deaths. The remaining leading causes were the same in the province with some differences in rankings.

### Zone Level

- Table 3 shows that rates were relatively similar across zones.
- Zone 2 and Zone 4 had significantly lower rates compared to the Manitoba average in the current time period.

## District Level

- ▶ In the current time period, districts varied from the lowest in Macdonald to the highest in Seven Regions.
- ▶ The following districts were significantly lower than the provincial average in the current time period: Niverville/Ritchot, Taché, Hanover, Macdonald, St. Pierre/De Salaberry, Morden, and Cartier/SFX. The city of Portage and Seven Regions had significantly higher rates.
- ▶ Over time, total mortality rates decreased significantly in St. Pierre/De Salaberry and Carman, while it increased significantly in Stanley.

**Table 3. Total Mortality Rates in Southern Health-Santé Sud, 2007-2011 (T1) & 2012-2016 (T2)**

Age- and sex-adjusted rate per 1,000 (all ages)

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>51,723</b>	<b>7.1</b>		<b>8.2</b>	
<b>SH-SS</b>	<b>6,266</b>	<b>6.3</b>		<b>6.6</b>	<b>L</b>
<b>Zone 4</b>	<b>1,798</b>	<b>6.2</b>	<b>L</b>	<b>6.6</b>	<b>L</b>
Niverville/Ritchot	218	5.7	L	6.6	
Taché	134	5.5	L	5.7	L
Hanover	253	6.1	L	6.0	L
Steinbach	627	6.4		6.7	L
Rural East	206	7.4		7.7	
Ste. Anne/ La Broquerie	360	7.1		7.5	
<b>Zone 2</b>	<b>1,025</b>	<b>6.6</b>	<b>L</b>	<b>7.2</b>	
Macdonald	119	5.1	L	5.1	L
St. Pierre/ De Salaberry	127	5.4	L-	8.0	
Carman	283	6.6	-	8.4	
Grey	110	7.0		7.1	
Morris	200	7.6		6.4	
Red River South	186	8.0		7.4	
<b>Zone 3</b>	<b>1,835</b>	<b>7.1</b>		<b>6.8</b>	<b>L</b>
Morden	348	6.0	L	6.5	L
Altona	318	6.8		6.7	
Stanley	79	6.4	+	4.4	L
Roland/Thompson	60	6.2		4.7	L
Winkler	517	7.2		7.1	
Lorne/Louise/ Pembina	513	8.9		8.1	
<b>Zone 1</b>	<b>1,608</b>	<b>8.5</b>		<b>8.6</b>	
Cartier/SFX	153	5.8	L	6.0	L
North Norfolk	151	7.2		7.1	
Rural Portage	211	7.7		8.3	
City of Portage	821	9.4	H	9.32	
Seven Regions	272	9.6	H	9.31	

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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**Table 4. Leading Causes of Mortality in Southern Health-Santé Sud, 2007-2011 (T1) & 2012-2016 (T2)**


Average annual crude percentage of deaths (all ages)

Condition	T2		T1
	Count	Percentage	Percentage
Circulatory	1,867	30.0%	30.7%
Cancer	1,742	28.0%	27.2%
Respiratory	512	8.2%	7.8%
Injury and Poisoning	429	6.9%	6.7%
Mental Illness	410	6.6%	5.1%
Nervous System	263	4.2%	4.6%
Endocrine and Metabolic	257	4.1%	5.9%
Digestive	254	4.1%	3.7%
Ill-Defined Conditions	118	1.9%	2.1%
Genitourinary and Breast	102	1.6%	2.1%

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## Geographic Disparity

- ▶ The geographic disparity between the districts decreased slightly over time, which means that the gap between the districts with the lowest and highest rates has reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.1x
	T2	1.9x
	Change	-0.2 ↓

T1: 2007-2011, T2: 2012-2016

## Premature Mortality Rate

### Definition

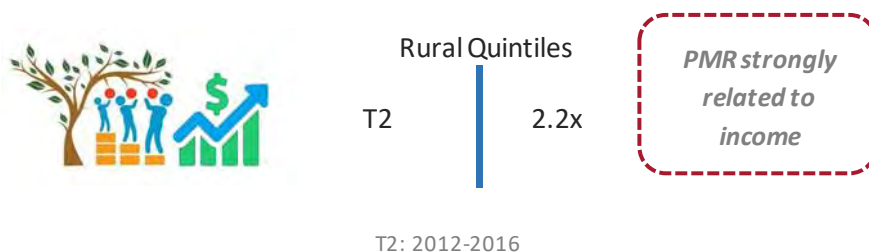
The average annual number of deaths before the age of 75 years, per 1,000 population, for a five-year time period.

### Why is this indicator important?

Premature mortality rate (PMR) is an important overall indicator of population health status with high rates indicating poor health. These rates are often correlated with morbidity and self-rated health as well as socioeconomic indicators such as food security, housing, and education level.

### Provincial Key Findings

- ▶ **Figure 4** shows a total of 19,915 Manitobans died prematurely in the current time period.
- ▶ PMR remained stable over time in Manitoba and in all regions with slight, not statistically significant decreases.
- ▶ PMR in the Northern Health Region was significantly higher than the provincial rate in both time periods.
- ▶ **Income:** Income and PMR were strongly related in both time periods.<sup>iv</sup> Residents' PMR in low income areas was 2.2 times higher than the highest income areas in the current time period.
- ▶ The leading causes of premature death in Manitoba were cancer, circulatory diseases followed by injury and poisoning, respiratory diseases, and digestive diseases. The two top causes alone (cancer and circulatory diseases) comprised almost 60% of all premature deaths. There was variation across regions; however, cancer was the top cause in all regions except Northern Health Region.



**Figure 4. Premature Mortality Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death before age 75 per 1,000 residents (aged 0-74 years)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	IERHA	MB	NRHA		
T2 COUNT	2,334	10,563	2,702	2,253	19,915	1,456		
T2 RATE	2.46	2.64	2.79	2.90	2.98	5.44	H	
T1 RATE	2.52	L	2.87	3.25	3.26	3.29	5.83	H

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## Regional Key Findings

### SH-SS Level

- Table 5 shows that a total of 2,334 people died prematurely in the region in the current time period.
- The region had the lowest rate in the province in both time periods; however, it was not significantly different than the provincial rate in the current time period.
- PMR remained stable over time with a slight, not statistically significant decrease.
- Table 6 shows the leading causes of premature death in were cancer, circulatory diseases, injury and poisoning, respiratory diseases, and digestive diseases. The top three causes remained the same over time however, the remaining top 10 causes varied slightly. In contrast to total mortality, cancer claims more lives prematurely than circulatory diseases. However, together, they still account for about 60% of premature deaths. The most frequent causes of mortality in the region were similar to Manitoba with the exception of congenital anomalies being within the leading 10 causes in the region and some differences in ranking.

### Zone Level

- Table 5 shows similar PMR rates across zones.
- In both time periods, Zones 2, 3, and 4 had significantly lower premature mortality rates compared to the Manitoba average.

## District Level

- There was variation across districts from the lowest rate in Niverville/Ritchot to the highest in Seven Regions in the current time period.
- Many of the districts within Zone 4 also had significantly lower rates compared to the provincial average in the current time period: Niverville/Ritchot, Taché, Hanover, Steinbach, as well as Macdonald, St. Pierre/De Salaberry, Morden, and Cartier/SFX in other zones. On the other hand, city of Portage and Seven Regions had significantly higher rates.
- PMR increased significantly over time in the district of Morris.

**Table 5. Premature Mortality Rate in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death before age 75 per 1,000 residents (aged 0-74 years)

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>19,915</b>	<b>3.0</b>		<b>3.3</b>	
<b>SH-SS</b>	<b>2,334</b>	<b>2.5</b>		<b>2.5</b>	<b>L</b>
<b>Zone 4</b>	<b>704</b>	<b>2.3</b>	<b>L</b>	<b>2.4</b>	<b>L</b>
Niverville/Ritchot	95	1.91	L	2.3	L
Taché	79	2.0	L	2.3	L
Hanover	107	2.2	L	1.9	L
Steinbach	195	2.3	L	2.2	L
Rural East	72	2.6		2.8	
Ste. Anne/La Broquerie	156	2.8		2.8	
<b>Zone 2</b>	<b>371</b>	<b>2.4</b>	<b>L</b>	<b>2.6</b>	<b>L</b>
Macdonald	69	1.95	L	1.8	L
St. Pierre/De Salaberry	45	2.0	L	2.9	
Carman	67	2.2		2.9	
Grey	37	2.4		2.7	
Morris	75	3.1	+	2.0	L
Red River South	78	3.2		3.8	
<b>Zone 3</b>	<b>594</b>	<b>2.7</b>	<b>L</b>	<b>2.5</b>	<b>L</b>
Morden	102	2.3	L	2.6	
Altona	100	2.5		2.2	L
Stanley	54	2.6		1.7	L
Roland/Thompson	29	2.7		2.6	
Winkler	175	2.9		2.5	L
Lorne/Louise/Pembina	134	3.0		3.1	
<b>Zone 1</b>	<b>665</b>	<b>3.3</b>		<b>3.4</b>	
Cartier/SFX	78	2.0	L	2.1	L
North Norfolk	56	2.6		2.7	
Rural Portage	116	3.2		4.0	
City of Portage	294	3.8	H	3.5	
Seven Regions	121	4.5	H	4.3	

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

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**Table 6. Leading 10 Causes of Premature Mortality in Southern Health-Santé Sud, 2007-2011 (T1) & 2012-2016 (T2)**

Condition	T2		T1
	Count	Percentage	Percentage
Cancer	905	39.3%	39.9%
Circulatory	480	20.8%	20.6%
Injury and Poisoning	269	11.7%	12.5%
Respiratory	118	5.1%	4.7%
Digestive	114	4.9%	3.8%
Endocrine and Metabolic	88	3.8%	5.7%
Nervous System	82	3.6%	3.2%
Congenital Anomalies	54	2.3%	1.5%
Infectious and Parasitic	42	1.8%	
III-Defined Conditions	42	1.8%	1.6%

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## Geographic Disparity

- ▶ The geographic disparity between the districts decreased slightly over time, which means that the gap between the districts with the lowest and highest rates has reduced marginally.

SH-SS Geographic Disparity Ratio		
	T1	2.5x
	T2	2.4x
	Change	-0.1 ↓

T1: 2007-2011, T2: 2012-2016

## Infant Mortality

### Definition

The average annual number of deaths prior to one year of age, per 1,000 live births, over a five-year time period.

### Why is this indicator important?

Infant mortality is considered to be one of the most important indicators of child and overall population health and the well-being of a society over time. This is a health equity indicator as it is largely driven by social determinants of health and helps to inform planning of appropriate upstream interventions.

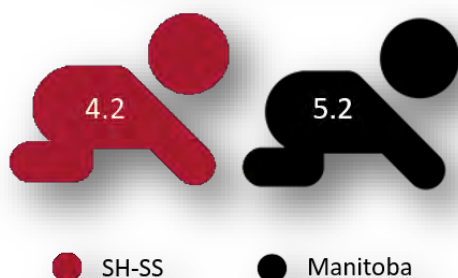
### Provincial Key Findings

- ▶ **Figure 5** shows that in Manitoba, there were 407 infant deaths in the current time period.
- ▶ The rate for infant mortality decreased significantly over time in Manitoba and Winnipeg RHA.
- ▶ Rates in the Northern Health Region were significantly higher than the provincial average in both time periods.
- ▶ **Income:** Income and infant mortality were significantly associated in both time periods, with higher infant mortality rates in lower income areas.<sup>v</sup>



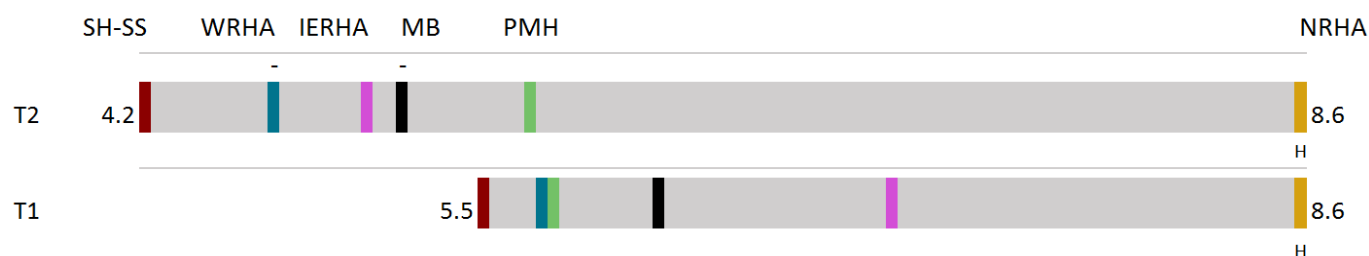
*Infant mortality  
significantly  
related to income*

Infant Mortality  
deaths per 1,000 births



**Figure 5. Infant Mortality Rates by RHA, 2007-2011(T1) and 2012-2016 (T2)**

Maternal age-adjusted average annual rate per 1,000 live births (aged under 1 year)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	IERHA	MB	PMH	NRHA
T2 COUNT	59	182	35	407	57	73
T2 RATE	4.2	4.7 -	5.1	5.2 -	5.7	8.6 H
T1 RATE	5.5	5.8	7.1	6.2	5.8	8.6 H

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## Regional Key Findings

### SH-SS Level

- Table 7 shows there were 59 infant deaths in the region in the current time period.
- Regional infant mortality was the lowest in the province in both time periods; however, it was not significantly different than the Manitoba average.
- Infant mortality remained stable over time with a slight, not statistically significant decrease.

### Zone Level

- In the current time period, rates ranged from the lowest in Zone 4 to the highest in Zone 1. However, counts were low in every zone.
- In the current time period, only Zone 4 had a significantly lower rate compared to the provincial average and decreased significantly over time.

### District Level

- District level data not available due to small sample sizes.

**Table 7. Infant Mortality in Southern Health-Santé Sud, 2007-2011(T1) and 2012-2016 (T2)**

Maternal age-adjusted average annual rate per 1,000 live births (aged under 1 year)

	T2		T1	
	Count	Rate	Rate	
<b>Manitoba</b>	<b>407</b>	<b>5.2</b>	<b>6.2</b>	
<b>SH-SS</b>	<b>59</b>	<b>4.2</b>	<b>5.5</b>	
<b>Zone 4</b>	13	2.5	L-	5.5
<b>Zone 3</b>	17	4.2		4.2
<b>Zone 2</b>	9	4.8		6.2
<b>Zone 1</b>	20	6.7		6.8

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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## Child Mortality

### Definition

The average annual number of deaths amongst children, aged 1 to 19 years, per 1,000, for a five-year time period.

### Why is this indicator important?

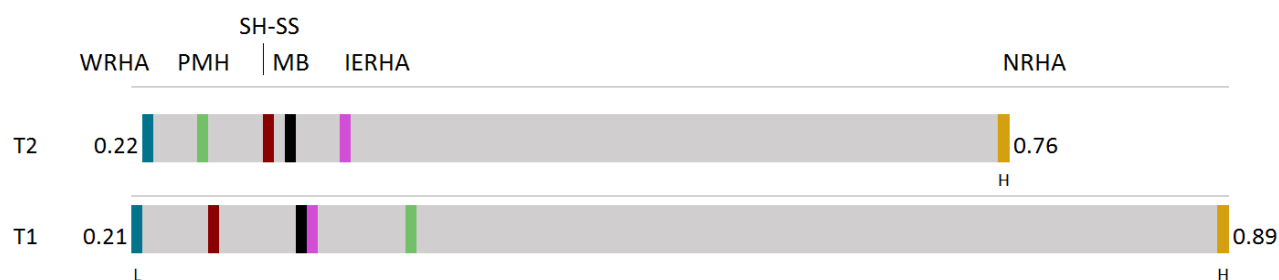
Similar to infant mortality, child mortality is an important indicator of overall population health and the well-being of a society over time. This is a health equity indicator as it is largely driven by social determinants of health and helps to inform planning of appropriate upstream interventions.

### Provincial Key Findings

- ▶ **Figure 6** shows that in Manitoba, 472 children died in the current time period and rates remained relatively stable over time.
- ▶ Mortality rates were considerably higher for rural compared to urban children.
- ▶ Rates in Northern Health Region were significantly higher than the provincial average in both time periods.
- ▶ **Income:** Income and child mortality were strongly related in both time periods, with higher mortality rates among children living in low income areas.<sup>vi</sup>
- ▶ The leading causes of child mortality in Manitoba were injury and poisoning, cancer, nervous system disorders, congenital anomalies, and respiratory disorders. Injury and poisoning was the most common cause of mortality for children for all regions. The three leading causes of death have remained consistent over time.

**Figure 6. Child Mortality Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of deaths per 1,000 residents (aged 1-19 years) per year



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	PMH	SH-SS	MB	IERHA	NRHA
T2 COUNT	174	50	79	472	51	94
T2 RATE	0.22	0.26	0.30	0.31	0.35	0.76 H
T1 RATE	0.21	0.39 L	0.26	0.32	0.33	0.89 H

## Regional Key Findings

### SH-SS Level

- ▶ **Table 8** shows a total of 79 children died in the region in the current time period.
- ▶ Rates remained stable in the region over time with a slight, not statistically significant increase.
- ▶ **Table 9** shows that the leading causes of child mortality in the region were similar to the province. Injury and poisoning was the top cause and has remained in this place over time. The others are cancer, nervous system diseases, and congenital anomalies.

### Zone Level

- ▶ **Table 8** shows that child mortality varied between zones from the lowest in Zone 4 to the highest in Zone 3 in the current time period.
- ▶ Child mortality in Zone 3 increased significantly over time.

### District Level

- ▶ District level data not available due to small sample sizes.

**Table 8. Child Mortality in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of deaths per 1,000 residents (aged 1-19 years) per year

	T2		T1			T2		T1	
	Count	Rate	Rate	Rate		Count	Rate	Rate	
Manitoba	472	0.31		0.32					
SH-SS	79	0.30		0.26					
Zone 4	18	0.18		0.18					
Zone 3	32	0.42	+	0.20					
Zone 2	11	0.29		0.41					
Zone 1	18	0.34		0.37					

+/- A significant increase (+) or decrease (-) since the first time period  
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**Table 9. Top 5 Causes of Child Mortality in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Condition	T2		T1
	Count	Percentage	Percentage
Injury and Poisoning	41	50.6%	55.9%
Cancer	14	17.3%	
Nervous System	9	11.1%	
Congenital Anomalies	6	7.4%	
All Others	11	13.6%	44.1%

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## Potential Years of Life Lost—All Deaths

### Definition

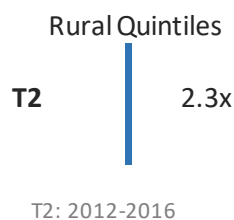
The life lost when a person dies between the age of 1 to 74 years. For each death, the PYLL value is calculated as the difference (in years) between age at death and 75 years of age. Average annual rates are calculated per 1,000 population, for a five-year time period.

### Why is this indicator important?

PYLL is more sensitive to deaths at younger ages than other mortality indicators.

### Provincial Key Findings

- ▶ **Figure 7** shows that rates remained relatively stable in Manitoba and across all regions.
- ▶ PYLLs in Northern Health Region were the highest and significantly higher than the provincial average in both time periods.
- ▶ **Income:** Income and PYLL were strongly related in both time periods.<sup>vii</sup> Residents' overall PYLL in low income areas were 2.3 times higher than the residents in the highest income areas in the current time period.
- ▶ Data from IMA MHSAL 2019, identified the leading causes of PYLL in Manitoba were injury, cancer, circulatory diseases, digestive disorders, and respiratory diseases in 2011/12-2015/16.



*PYLL strongly  
related to  
income*

**Figure 7. Potential Years of Life Lost by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of PYLL per 1,000 residents (aged 1-74 years)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	37,007	163,408	40,289	315,700	33,708	32,157
T2 RATE	44.8	45.2	49.5	52.3	55.7	110.8 (H)
T1 RATE	41.8	47.2	57.8	54.1	57.2	108.1 (H)

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## Regional Key Findings

### SH-SS Level

- ▶ PYLL was the lowest in the province in both time periods; however, it was not significantly different than the Manitoba average.
- ▶ **Table 10** shows that PYLL remained stable in the region over time with a slight, not statistically significant increase.
- ▶ Data from IMA MHSAL 2019 identified the leading causes of PYLL in the region were cancer, injury, circulatory diseases, digestive diseases, and respiratory diseases in 2011/12-2015/16. They remained relatively the same since 2006/07-2010/11 with digestive and respiratory diseases replacing each other in ranking. The top cause of PYLL in the region was cancer compared to injury in the province.

### Zone Level

- ▶ PYLL varied considerably between zones with the lowest in Zone 4 and the highest in Zone 1, with approximately 28 years difference.

### District Level

- ▶ In the current time period, PYLL varied dramatically between districts with the lowest in St. Pierre/De Salaberry and the highest in Seven Regions, with approximately 68 years difference.
- ▶ PYLL decreased significantly over time in Rural East.


**Table 10. Potential Years of Life Lost All Deaths in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**  
Age- and sex-adjusted average annual rate of PYLL per 1,000 residents (aged 1-74 years)

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>315,700</b>	<b>52.3</b>		<b>54.1</b>	
<b>SH-SS</b>	<b>37,007</b>	<b>44.8</b>		<b>41.8</b>	
<b>Zone 4</b>	<b>10,826</b>	<b>33.7</b>		<b>33.0</b>	<b>L</b>
Niverville/Ritchot	1,569	27.3		40.4	
Steinbach	2,879	29.4		27.8	
Taché	1,314	30.7		28.6	
Rural East	850	38.7	-	95.4	
Ste. Anne/La Broquerie	2,172	39.2		37.6	
Hanover	2,042	43.9		25.1	
<b>Zone 2</b>	<b>5,689</b>	<b>42.6</b>		<b>46.6</b>	
St. Pierre/De Salaberry	546	19.4		34.3	
Carman	972	35.4		50.1	
Macdonald	1,245	41.7		33.3	
Grey	562	47.2		78.1	
Red River South	1,231	53.6		60.8	
Morris	1,133	60.4		34.7	
<b>Zone 3</b>	<b>9,721</b>	<b>47.5</b>		<b>37.6</b>	
Morden	1,377	29.1		38.4	
Stanley	1,008	40.5		19.9	
Winkler	2,831	45.1		42.8	
Altona	1,801	51.5		28.5	
Roland/Thompson	559	68.7		45.5	
Lorne/Louise/Pembina	2,145	73.1		48.7	
<b>Zone 1</b>	<b>10,771</b>	<b>61.6</b>		<b>56.7</b>	
Cartier/SFX	1,314	37.1		33.9	
City of Portage	4,355	60.0		50.8	
North Norfolk	937	62.0		81.4	
Rural Portage	1,955	70.6		57.3	
Seven Regions	2,210	87.6		83.1	

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased over time, which means that the gap between the districts with the lowest and highest rates reduced.

SH-SS Geographic Disparity Ratio	
	T1 4.8x
	T2 4.5x
	Change -0.3 ↓

T1: 2007-2011, T2: 2012-2016

## Potential Years of Life Lost—Unintentional Injuries

### Definition

The PYLL for all unintentional injuries, for example falls, motor vehicle accidents, or drowning per 1,000 population aged 1 to 74 years, for a five-year time period. Note that the data source and years differ from PYLL – all deaths presented on the previous page.

### Why is this indicator important?

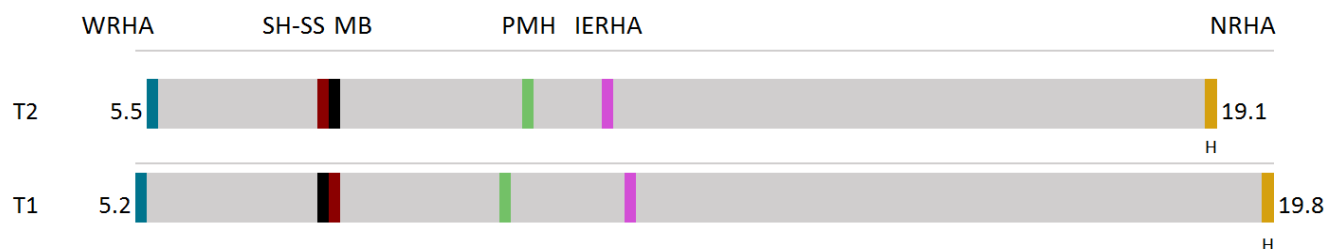
Unintentional injuries contribute significantly to PYLL and can be used to help identify the need for injury prevention strategies.

### Provincial/Regional Key Findings

- ▶ **Figure 8** shows that PYLL caused by unintentional injuries remained stable over time in Manitoba and all regions.
- ▶ Rates in Northern Health Region were significantly higher than the provincial average in both time periods.
- ▶ Rates in Southern Health-Santé Sud were similar to the provincial rate and remained relatively stable over time.

**Figure 8. PYLL due to Unintentional Injury by RHA, 2006/07-2010/11 (T1) and 2011/12-2015/16 (T2)**

Age- and sex-adjusted PYLL rates per 1,000 residents (aged 1-74 years)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	PMH	IERHA	NRHA
T2 COUNT	17,962	6,449	44,662	7,566	5,975	6,710
T2 RATE	5.5	7.6	7.8	10.3	11.3	19.1 H
T1 RATE	5.2	7.9	7.8	10.0	11.7	19.8 H

IMA MHSAL 2019

## Potential Years of Life Lost—Suicide

### Definition

The PYLL for all suicides per 1,000 population aged 1 to 74 years, for a five-year time period. Note that the data source and years differ from PYLL – all deaths presented previously.

### Why is this indicator important?

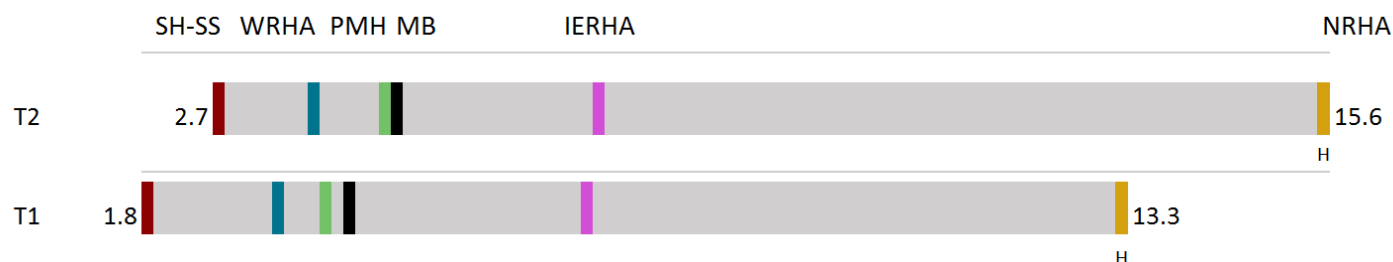
Suicide is one of the main causes of premature death. There is potential to positively impact society overall through strengthening mental health awareness, early identification of suicidal thoughts, and timely referral to appropriate supports.

### Provincial/Regional Key Findings

- ▶ **Figure 9** shows that PYLL caused by suicide remained relatively stable over time in Manitoba and across all regions.
- ▶ PYLL rates due to suicide in Northern Health Region were the highest in the province and significantly higher than the provincial average in both time periods.
- ▶ In Southern Health-Santé Sud, PYLL rates due to suicide were the lowest in the province in both time periods; however, they were not significantly different than the provincial average.

**Figure 9. PYLL due to Suicide by RHA, 2006/07-2010/11 (T1) and 2011/12-2015/16 (T2)**

Age- and sex-adjusted PYLL rates per 1,000 residents (aged 1-74 years)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	2,465	12,451	3,564	27,455	3,548	5,427
T2 RATE	2.7	3.9	4.7	4.9	7.2	15.6 H
T1 RATE	1.8	3.5	4.0	4.3	7.0	13.3 H

MHLS IMA 2019

## Potentially Avoidable Deaths

### Definition

The average annual rate of avoidable deaths before age 75, per 1,000 population (aged 0-74), for a five-year time period. Avoidable deaths include those that could be avoided through primary prevention efforts, such as lifestyle modifications, immunizations, and health promotion initiatives.

### Why is this indicator important?

Potentially avoidable deaths provide insight on the effectiveness of disease prevention policies, health promotion, and health care in preventing premature deaths.

### Provincial Key Findings

- ▶ **Figure 10** shows the number of potentially avoidable deaths in Manitoba was 13,699 in the current time period.
- ▶ The rate significantly decreased over time in Manitoba and all regions except Southern Health-Santé Sud.
- ▶ In both time periods, Southern Health-Santé Sud and Winnipeg RHA had significantly lower rates than the provincial average, while Northern Health Region had significantly higher rates.
- ▶ **Income:** Income and potentially avoidable deaths were strongly related in both time periods.<sup>viii</sup> Residents' rate of potentially avoidable deaths in low income areas was about 2.2 times higher than the highest income areas in the current time period.



Rural Quintiles  
T2 2.2x

T2: 2012-2016

*Potentially  
avoidable deaths  
strongly related to  
income*



**Figure 10. Potentially Avoidable Death Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of avoidable deaths before age 75 per 1,000 residents (ages 0-74 years)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	1,539	7,272	1,856	13,699	1,587	1,074
T2 RATE	1.74   L	1.98   L-	2.08   -	2.11   -	2.15   -	3.83   H-
T1 RATE	1.84   L	2.16   L	2.34	2.33	2.48	4.22   H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 11 shows there were a total of 1,539 potentially avoidable deaths in the region in the current time period.
- The regional rate was significantly lower than the Manitoba average in both time periods.
- The rate remained stable over time with a slight, not statistically significant decrease.

### Zone Level

- Rates were similar across zones.
- In both time periods, Zones 2, 3, and 4 had significantly lower rates compared to the Manitoba average.

### District Level

- Rates were similar across districts, with the lowest in Taché and the highest in Seven Regions in the current time period.
- The following districts had significantly lower rates compared to the current provincial average: Taché, Niverville/Ritchot, Steinbach, , St. Pierre/De Salaberry, Macdonald, Altona, and Morden. On the other hand, city of Portage and Seven Regions had significantly higher rates.
- Over time, significant decreases were noted in St. Pierre/De Salaberry and Rural Portage, while Morris increased significantly.

**Table 11. Potentially Avoidable Deaths in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**


Age- and sex-adjusted average annual rate of avoidable deaths before age 75 per 1,000 residents (ages 0-74 years)

	T2		T1			T2		T1			
	Count	Rate	Rate	Rate		Count	Rate	Rate			
<b>Manitoba</b>	<b>13,699</b>	<b>2.1</b>	-	<b>2.3</b>		<b>1,539</b>	<b>1.7</b>	L	<b>1.8</b>	L	
<b>Zone 4</b>	<b>442</b>	<b>1.4</b>	L	<b>1.5</b>	L	<b>Zone 2</b>	<b>256</b>	<b>1.7</b>	L	<b>1.9</b>	L
Taché	46	1.1	L	1.24	L	St. Pierre/De Salaberry	27	1.2	L-	2.1	
Niverville/Ritchot	62	1.2	L	1.6	L	Grey	20	1.3		1.9	
Steinbach	114	1.3	L	1.6	L	Macdonald	50	1.4	L	1.3	L
Hanover	78	1.6		1.20	L	Carman	48	1.6		2.1	
Ste. Anne/La Broquerie	93	1.7		1.7		Morris	54	2.3	+	1.4	L
Rural East	49	1.8		1.7		Red River South	57	2.4		2.6	
<b>Zone 3</b>	<b>375</b>	<b>1.7</b>	L	<b>1.7</b>	L	<b>Zone 1</b>	<b>466</b>	<b>2.3</b>		<b>2.5</b>	
Altona	57	1.4	L	1.6	L	Cartier/SFX	58	1.5		1.3	L
Morden	66	1.5	L	1.7		North Norfolk	33	1.6		1.5	
Roland/Thompson	17	1.6		1.8		Rural Portage	83	2.3	-	3.1	H
Winkler	101	1.7		1.5	L	City of Portage	207	2.7	H	2.6	
Stanley	40	1.9		1.19	L	Seven Regions	85	3.2	H	3.4	H
Lorne/Louise/Pembina	94	2.1		2.2							

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased over time, which means that the gap between the districts with the lowest and highest rates reduced.

SH-SS Geographic Disparity Ratio	
	T1 2.9x
	T2 2.5x
	Change -0.4 ↓

T1: 2007-2011, T2: 2012-2016

## Unintentional Injury Causing Death

### Definition

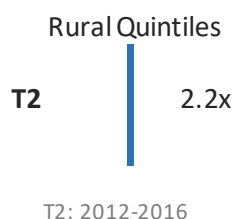
The number of deaths due to unintentional injury, per 1,000 population, for a five-year time period.

### Why is this indicator important?

This indicator focuses on the accidental causes of death such as motor vehicle accidents, drowning, falls, burns, and poisonings. Unintentional injuries are one of the leading causes of death in Canada and worldwide.

### Provincial Key Findings

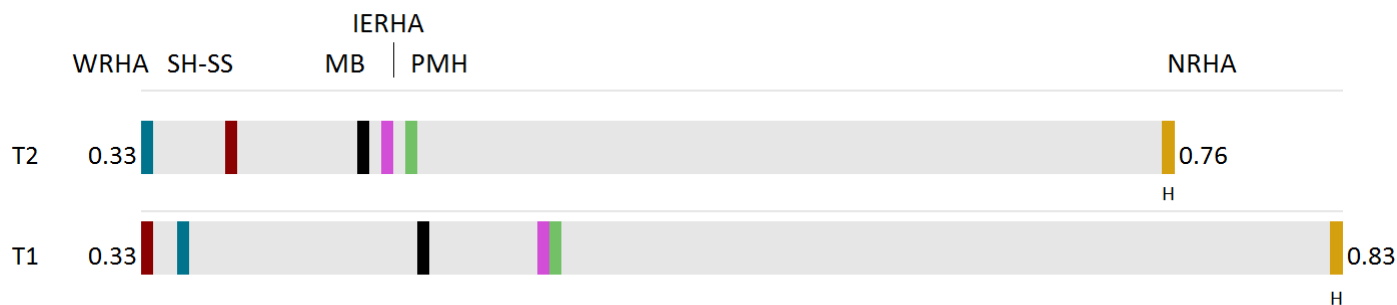
- ▶ **Figure 11** shows that in Manitoba, 2,774 unintentional injuries causing death occurred in the current time period.
- ▶ The rates remained relatively stable over time in the province and across all regions.
- ▶ Northern Health Region had significantly higher rates than the provincial average in both time periods.
- ▶ **Income:** Income and unintentional injury deaths were strongly related in both time periods.<sup>ix</sup> Residents' rate of unintentional injury deaths in low income areas was 2.2 times higher than the highest income areas in the current time period.



*Unintentional injury causing death strongly related to income*

**Figure 11. Unintentional Injury Causing Death by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted rate per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	1,356	338	2,774	295	471	240
T2 RATE	0.33	0.37	0.42	0.43	0.44	0.76 H
T1 RATE	0.35	0.33	0.45	0.50	0.50	0.83 H

MCHP RHA Indicators Atlas 2019

## Regional Findings

### SH-SS Level

- Table 12 shows that in the region, there were a total of 338 unintentional injuries causing death in the current time period.
- The regional rate remained relatively stable over time.

### Zone Level

- Rates varied across zones with the lowest in Zone 4 and the highest in Zone 1 in the current time period.
- Only Zone 4 had significantly lower rates compared to the provincial average in both time periods.

### District Level

- There was considerable variation across districts with the lowest rate in Morden and the highest rate in Roland/Thompson in the current time period.
- Lorne/Louise/Pembina was significantly higher than the provincial average and increased significantly over time.

**Table 12. Unintentional Injury Causing Death in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex- adjusted rate per 1,000 residents

	T2		T1	
	Count	Rate	Rate	
<b>Manitoba</b>	<b>2,774</b>	<b>0.42</b>	<b>0.45</b>	
<b>SH-SS</b>	<b>338</b>	<b>0.37</b>	<b>0.33</b>	
<b>Zone 4</b>	<b>76</b>	<b>0.19</b>	<b>0.25</b>	<b>L</b>
Hanover	11	0.21	0.32	
Steinbach	24	0.24	0.33	
Ste. Anne/ La Broquerie	14	0.27	0.24	
Niverville/Ritchot	13	0.28	0.31	
Taché	10	0.30	0.24	
Rural East	s		0.59	
<b>Zone 2</b>	<b>69</b>	<b>0.40</b>	<b>0.35</b>	
St. Pierre/ De Salaberry	6	0.27	s	
Carman	12	0.34	0.59	
Macdonald	12	0.43	0.30	
Grey	7	0.48	0.50	
Red River South	15	0.64	0.57	
Morris	17	0.66	0.33	
<b>Zone 3</b>	<b>96</b>	<b>0.33</b>	<b>0.22</b>	<b>L</b>
Morden	8	0.15	0.24	
Winkler	17	0.22	0.31	
Altona	19	0.41	0.27	
Lorne/Louise/ Pembina	39	0.80	H+	0.33
Roland/Thompson	9	0.93	s	
Stanley	s		s	
<b>Zone 1</b>	<b>97</b>	<b>0.46</b>	<b>0.42</b>	
Cartier/SFX	10	0.33	0.33	
Rural Portage	14	0.47	0.73	
City of Portage	43	0.52	0.59	
Seven Regions	17	0.57	0.47	
North Norfolk	13	0.63	0.35	

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts increased over time; meaning the gap between the lowest and highest districts widened.

SH-SS Geographic Disparity Ratio	
	T1 3.1x
	T2 6.2x
	Change 3.1 ↑

T1: 2007-2011, T2: 2012-2016

# Cancer

## Cancer Incidence — All & Top 4

### Definition

The number of new cases of all invasive cancers, breast, prostate, lung, and colorectal cancer per 100,000 population, for a two-year time period.

### Why is this indicator important?

Annual statistics on cancer incidence are an important part of predicting future utilization of CancerCare services and can provide insight into the effectiveness of and access to screening programs

### Provincial Key Findings

- ▶ **Figure 12** shows a total of 19,422 new diagnoses of cancer in Manitoba in the current time period.
- ▶ The rate did not change significantly over time provincially nor across regions.
- ▶ Interlake-Eastern RHA and Northern Health Region's rates were significantly higher than the provincial average in the current time period.
- ▶ The cancers with the top incidence rates in Manitoba were lung and bronchus, breast, colorectal, and prostate cancers.
- ▶ **Age and Sex:** The incidence rates were higher among residents aged 75 years and older for all types of cancer and among males for all invasive, colorectal, and lung and bronchus cancers.
- ▶ **Income:** The income disparity for prostate cancer incidence remained stable over time. The disparity is different than in other indicators; whereas male residents in low income areas had a 0.8 times lower prostate cancer incidence rate compared to the highest income areas. The lower rate among residents of low income areas may be attributable to a screening bias.

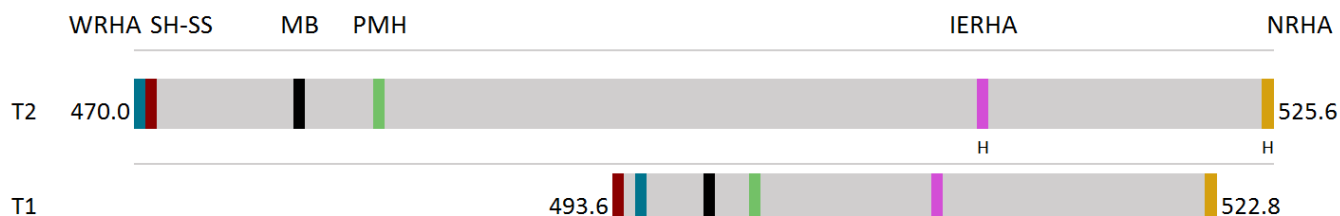


Prostate Cancer Rural Quintiles	
T1	0.8x
T2	0.8x
CHANGE	0.0

T1: 2011-2013, T2: 2014-2016

**Figure 12. All Invasive Cancers – Incidence rate by RHA 2011-2013 (T1) and 2014-2016 (T2)**

Age-standardized incidence rates per 100,000 residents



H/L Significantly higher or lower than the MB average for that time period.

	WRHA	SH-SS	MB	PMH	IERHA	NRHA
T2 COUNT	11,073	2,517	19,422	2,860	2,272	720
T2 RATE	470.0	470.9	478.4	482.3	511.8 H	525.6 H
T1 RATE	494.9	493.6	498.2	500.8	509.2	522.8

CancerCare Manitoba 2019

## Regional key findings

### SH-SS Level

- Table 13 shows a total of 2,517 new cases of cancer in the region in the current time period.
- The rate remained stable over time with a slight, not statistically significant decrease.
- Table 14 shows that in the current time period, the leading cancer incidence rates in the region were colorectal, lung and bronchus, breast, and prostate. Breast cancer incidence was significantly lower than the provincial average.

### Zone Level

- Table 13 shows that cancer incidence rates were more or less similar across zones in the current time period.
- In the current time period, the rate in Zone 3 was the lowest in the region and significantly lower than the provincial average.
- The incidence rates for the top types of cancer varied across districts (see Table 15) with lung and bronchus the highest in Zones 1 and 2 and colorectal the highest in Zones 3 and 4.
- Only lung and bronchus rates in Zone 3 were significantly lower than the provincial average.

### District Level

- District level data not available due to small sample sizes.

**Table 13. Cancer Incidence — All cancers in Southern Health-Santé Sud, 2011-13 (T1) and 2014-16 (T2)**

Age-standardized incidence rates per 100,000 residents

	T2		T1			T2		T1		
	Count	Rate	Rate	Rate		Count	Rate	Rate		
<b>Manitoba</b>	<b>19,442</b>	<b>478.4</b>		<b>498.2</b>		<b>2,517</b>	<b>470.9</b>		<b>493.6</b>	
<b>Zone 4</b>	873	483.0		475.6		<b>Zone 2</b>	461	496.8		505.4
<b>Zone 3</b>	609	433.8	L	475.9		<b>Zone 1</b>	574	476.2		529.1

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

**Table 14. Top 4 Cancer Incidence Rates in Southern Health-Santé Sud, 2011-2013 (T1) and 2014-2016 (T2)**

Age-standardized incidence rates, per 100,000 population

Cancer	T2		T1	
	Count	Rate	Rate	
Colorectal	341	64.5		65.5
Lung and bronchus	329	62.1		59.9
Breast	296	55.5	L	69.3
Prostate	281	52.0		57.8

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

**Table 15. Top 4 Cancer Incidence Rates in Southern Health-Santé Sud by Zone, 2014-2016**

Age-standardized incidence rates, per 100,000 population

Cancer	Zone 4	Zone 2	Zone 3	Zone 1
Colorectal	62.4	54.9	66.5	71.1
Lung and bronchus	57.8	85.3	44.3	71.3
Breast	54.0	70.9	53.3	49.4
Prostate	56.7	45.3	48.0	54.4

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019



## Cancer Mortality — All & Top 4

### Definition

The rate of death for all cancers, breast, prostate, lung and bronchus, and colorectal cancers, per 100,000 population, for a two-year time period.

### Why is this indicator important?

Cancer mortality statistics provide insight into the treatment success for cancer.

### Provincial/Regional Key Findings

- Table 16 shows that mortality rates for all invasive cancers have remained fairly stable in Manitoba over time.
- In both time periods, mortality rates were significantly higher than the provincial average in Northern Health Region.
- The top four cancers causing death in Manitoba were lung and bronchus, colorectal, breast, and prostate cancers, which was similar for Southern Health-Santé Sud (see Table 17).
- Lung and bronchus mortality rates were significantly lower in the region compared to the provincial average, in the current time period.
- Age and Sex:** The cancer mortality rate was higher among residents aged 75 years and older for all top 4 diagnoses, and in males for colorectal and lung and bronchus cancers.

**Table 16. Total All Invasive Cancers Mortality Rates by RHA, 2011-2013 (T1) and 2014-2016 (T2)**

Age-standardized incidence rates, per 100,000 population

	WRHA	SH-SS	MB	PMH	IERHA	NRHA
T2 COUNT	4,727	1,072	8,348	1,311	942	296
T2 RATE	200.6	205.9	206.5	211.0	218.4	263.5 H
T1 RATE	206.6 L	205.4	208.2	204.3	212.6	278.4 H

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

**Table 17. Top 4 Cancer Mortality Rates in Southern Health-Santé Sud, 2011-2013 (T1) and 2014-2016 (T2)**

Age-standardized incidence rates, per 100,000 population

Cancer	T2		T1	
	Count	Rate	Rate	
Lung and bronchus	227	43.4 L	48.1	
Colorectal	132	25.7	27.0	
Prostate	77	15.4	12.8	
Breast	75	14.5	12.6	

H/L Significantly higher or lower than the MB average for that time period.  
CancerCare Manitoba 2019

## Cancer Late Stage (IV) Diagnosis – All & Top 4

### Definition

The percentage of all cancer patients diagnosed at a later stage (IV), for a two-year time period.

### Why is this indicator important?

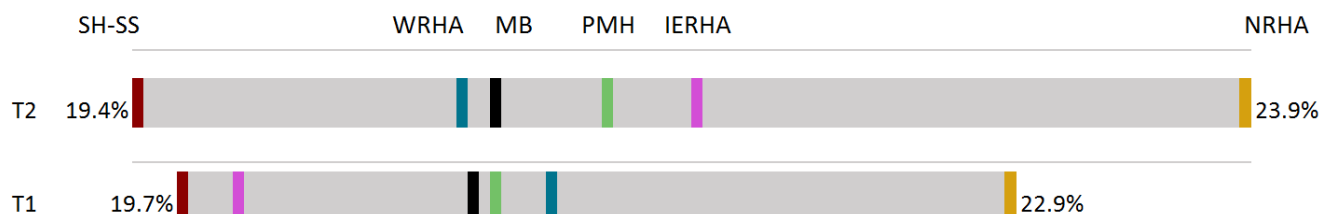
In late-stage diagnoses, cancer has already spread to other parts of the body and has a significantly worse outcome than cancer diagnosed during earlier stages. Data on late-stage cancer diagnosis helps to identify where to focus cancer awareness campaigns, screening programs and how to improve access to diagnostic tests.

### Provincial Key Findings

- ▶ **Figure 13** shows a total of 4,064 Manitobans diagnosed with late stage cancer in the current time period.
- ▶ The proportion diagnosed with late stage cancer has remained relatively stable over time in Manitoba and in all regions.
- ▶ **Age and Sex:** The proportion of cancer patients diagnosed at late stage was higher in males and patients aged 50 years and older.

**Figure 13. Total Invasive Cancers Diagnosed at Stage IV, by RHA 2011-2013 (T1) and 2014-2016 (T2)**

Percentage of cancer patients



H/L Significantly higher or lower than the MB average for that time period.

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	489	2,300	4,064	610	493	172
T2 RATE	19.4%	20.8%	20.9%	21.3%	21.7%	23.9%
T1 RATE	19.7%	21.1%	20.8%	20.9%	19.9%	22.9%

CancerCare Manitoba 2019

## Regional Key Findings

### SH-SS Level

- Table 18 shows a total of 489 cancer patients were diagnosed at late stage (IV) of their cancer in the region in the current time period and the percentage remained relatively stable over time.
- The regional percentage was the lowest in the province in both time periods; however, it was not statistically different than the Manitoba average.
- Almost half of all diagnosed cases for lung and bronchus cancer were diagnosed at late stage (see Table 19).

### Zone Level

- Table 18 shows that percentages were similar across zones.

### District Level

- District level data not available due to small sample sizes.

**Table 18. Total Invasive Cancers Diagnosed at Stage IV in Southern Health-Santé Sud, 2011-13 (T1) and 2014-16 (T2)**  
Percentage of cancer patients

	T2		T1			T2		T1		
	Count	Percentage	Percentage	Percentage		Count	Percentage	Percentage		
Manitoba	4,064	20.9%	20.8%		SH-SS	489	19.4%	19.7%		
Zone 4	167	19.1%	20.0%		Zone 2	82	17.8%	19.5%		
Zone 3	118	19.4%	19.5%		Zone 1	122	21.3%	19.7%		

CancerCare Manitoba 2019

**Table 19. Top 4 Cancer Late Stage (IV) Diagnosis in Southern Health-Santé Sud, 2011-2013 (T1) and 2014-2016 (T2)**  
Percentage of cancer patients

Cancer	T2		T1
	Count	Rate	Percentage
Lung and bronchus	154	46.8%	49.8%
Non-Hodgkin Lymphoma	35	31.5%	36.5%
Colorectal	60	17.6%	22.2%
Prostate	46	16.4%	15.1%
Breast	14	4.7%	7.9%

CancerCare Manitoba 2019

## Cancer Survival—All & Top 4

### Definition

The percentage of residents still alive five years after a cancer diagnosis for all cancers, breast, prostate, lung and bronchus, or colorectal cancer, for a five-year time period.

### Why is this indicator important?

Data on cancer survival can be used to assess the effectiveness of cancer treatment and prevention strategies.

### Provincial Key Findings

- ▶ **Table 20** shows that cancer survival remained relatively stable in the province and the majority of health regions.
- ▶ In the current time period, the percentage in Prairie Mountain Health was significantly higher than the provincial average.
- ▶ In Manitoba, the top 4 cancers for five-year relative survival rate in the current time period were prostate (91.1%), breast (88.0%), colorectal (64.9%), and lung & bronchus (23.1%) cancers.
- ▶ **Age and Sex:** Cancer survival rate was high among female cancer patients, and patients aged 15-44 for colorectal and 15-54 for lung and bronchus cancers. Cancer survival rates were also high among females aged 65-74 for breast cancer, and males aged 55-64 for prostate cancer.

**Table 20. Cancer Survival – All Cancers by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age-standardized percentage

	NRHA		WRHA		SH-SS		MB		IERHA		PMH	
T2 RATE	53.9%		61.8%		62.0%		62.0%		62.3%		63.9%	H
T1 RATE	45.7%	u	61.0%		58.9%		60.0%		54.7%		62.6%	

H/L Significantly higher or lower than the MB average for that time period.

u indicate unstable findings  
CancerCare Manitoba 2019

## Regional Key Findings

### SH-SS Level

- Table 21 shows that cancer survival in the region increased slightly over time; however, the change was not tested statistically.
- The top 4 cancer survival percentages in the current time period were prostate (91.1%), breast (87.1%), colorectal (61.6%), and lung and bronchus (22.7%) cancers, similar to the province.

### Zone Level

- Cancer survival for all invasive cancers were relatively similar across zones.
- There were no major changes in percentages over time; however, the differences were not tested statistically.
- Zone-specific findings for the top 4 types of cancer for survival are not reported due to unstable findings in some zones for colorectal, breast, and prostate cancers.

### District Level

- District level data not available.

**Table 21. Cancer Survival – All Cancers in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age-standardized percentage

	T2		T1			T2		T1	
	Percentage		Percentage			Percentage		Percentage	
<b>Manitoba</b>	<b>62.0%</b>		<b>60.0%</b>		<b>SH-SS</b>	<b>62.0%</b>		<b>58.9%</b>	
<b>Zone 4</b>	62.4%		66.1%	H	<b>Zone 2</b>	64.3%		60.3%	
<b>Zone 3</b>	61.5%			s	<b>Zone 1</b>	60.6%		55.5%	

H/L Significantly higher or lower than the MB average for that time period  
 s indicates data suppressed due to small numbers  
 CancerCare Manitoba 2019

# Cardiovascular

## Hypertension Prevalence

### Definition

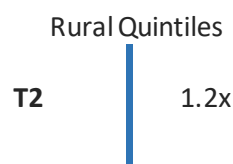
The percentage of residents, aged 19 and older, diagnosed with hypertension (high blood pressure), for a one-year time period.

### Why is this indicator important?

Hypertension is a risk factor for a number of cardiovascular conditions. Accurate assessment of the hypertension burden helps to guide prevention efforts and treatment choices, which may lead to reductions in heart-related morbidity and mortality.

### Provincial Key Findings

- ▶ **Figure 14** shows that 219,507 Manitoba residents lived with diagnosed high blood pressure in the current time period.
- ▶ Hypertension prevalence remained stable over time in the province and in all regions.
- ▶ Hypertension prevalence in the Northern Health Region was significantly higher than the Manitoba average in both time periods and Interlake-Eastern RHA in the current time period.
- ▶ **Income:** Income and hypertension prevalence were significantly related.<sup>x</sup> Hypertension prevalence among residents in low income areas was about 1.2 times higher than the highest income areas in the current time period.

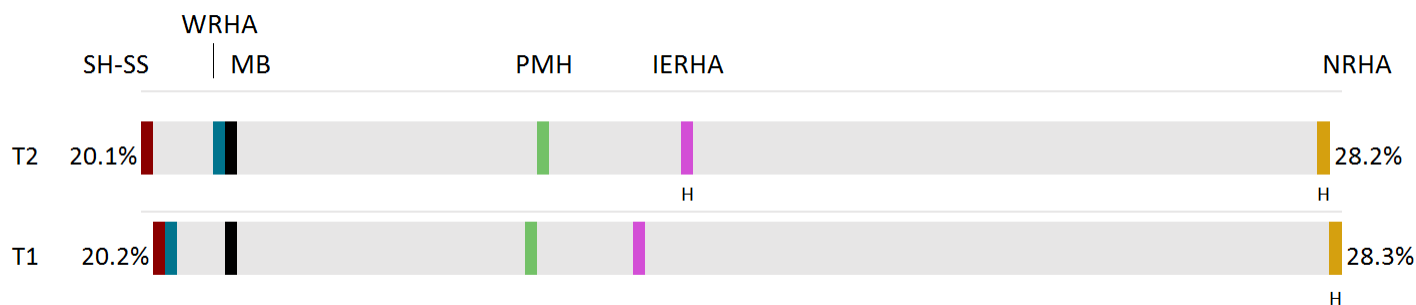


T2: 2016-2017

*Hypertension prevalence significantly related to income*

**Figure 14. Prevalence of Hypertension by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of residents (aged 19+ years) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	26,699	125,460	219,507	31,977	25,134	9,392
T2 RATE	20.1%	20.7%	20.7%	22.8%	23.8% H	28.2% H
T1 RATE	20.2%	20.2%	20.7%	22.8%	23.5%	28.3% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 22 shows a total of 26,699 residents with hypertension in the region in the current time period and percentages remained relatively stable over time.
- Regional hypertension prevalence was the lowest in the province in the current time period; however, it was not significantly different than the Manitoba average.

### Zone Level

- Percentages were relatively similar across zones.
- All zones had significantly lower hypertension prevalence compared to the Manitoba average in both time periods.

### District Level

- Hypertension prevalence varied between districts from the lowest in Carman and Stanley to the highest in Seven Regions in the current time period.
- Percentages were significantly lower in the current time period across many districts, including: Hanover, Niverville/Ritchot, Taché, Steinbach, Carman, Grey, Morris, Stanley, Lorne/Louise/Pembina, Winkler, North Norfolk, and city of Portage.
- Hypertension prevalence decreased significantly over time in Carman, Lorne/Louise/Pembina, and Morden, but increased significantly in St. Pierre/De Salaberry.

**Table 22. Hypertension Prevalence in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of residents (aged 19+ years) diagnosed with disorder

	T2		T1			T2		T1			
	Count	Percentage	Percentage	Percentage		Count	Percentage	Percentage			
<b>Manitoba</b>	<b>219,507</b>	<b>20.7</b>		<b>20.7</b>		<b>SH-SS</b>	<b>26,699</b>	<b>20.1</b>		<b>20.2</b>	
<b>Zone 4</b>	<b>9,192</b>	<b>19.4</b>	<b>L</b>	<b>18.9</b>	<b>L</b>	<b>Zone 2</b>	<b>4,472</b>	<b>18.8</b>	<b>L</b>	<b>19.4</b>	<b>L</b>
Hanover	1,347	18.5	L	17.5	L	Carman	946	17.5	L-	20.5	
Niverville/Ritchot	1,459	19.1	L	18.5	L	Grey	412	18.0	L	20.5	
Taché	1,041	19.4	L	18.5	L	Morris	700	18.8	L	20.2	
Steinbach	2,728	19.9	L	19.1	L	St. Pierre/ De Salaberry	679	19.4	+	17.2	L
Ste. Anne/ La Broquerie	1,766	20.1		20.2		Macdonald	1,001	19.8		18.3	L
Rural East	851	20.3		20.7		Red River South	734	20.8		20.9	
<b>Zone 3</b>	<b>6,948</b>	<b>19.4</b>	<b>L</b>	<b>19.9</b>	<b>L</b>	<b>Zone 1</b>	<b>6,087</b>	<b>19.9</b>	<b>L</b>	<b>19.9</b>	<b>L</b>
Stanley	465	17.5	L	17.0	L	North Norfolk	599	18.6	L	18.4	
Lorne/Louise/ Pembina	1,331	18.4	L-	20.3		City of Portage	2,454	19.6	L	19.3	
Winkler	1,877	18.8	L	19.2		Cartier/SFX	1,093	19.8		20.3	
Morden	1,596	20.4	-	22.6	H	Rural Portage	1,004	19.9		20.3	
Roland/Thompson	321	21.1		19.1		Seven Regions	937	23.4		23.0	H
Altona	1,358	21.3		19.6							


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

### Geographic Disparity

- ▶ The geographic disparity decreased slightly, which means that the gap between the districts with the lowest and highest prevalence reduced.

SH-SS Geographic Disparity Ratio		
	T1	1.4x
	T2	1.3x
	Change	-0.1 ↓

T1: .2011-2012, T2: 2016-2017



## Ischemic Heart Disease Prevalence

### Definition

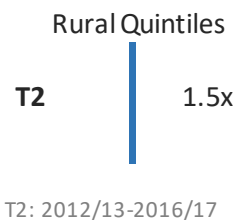
The percentage of residents, aged 19 and older, diagnosed with ischemic heart disease (IHD) for a five-year period.

### Why is this indicator important?

IHD (also known as coronary artery disease) is a major cause of death and disability in Canada. IHD prevalence helps to gain insight into the success of prevention, program planning, and IHD management efforts.

### Provincial Key Findings

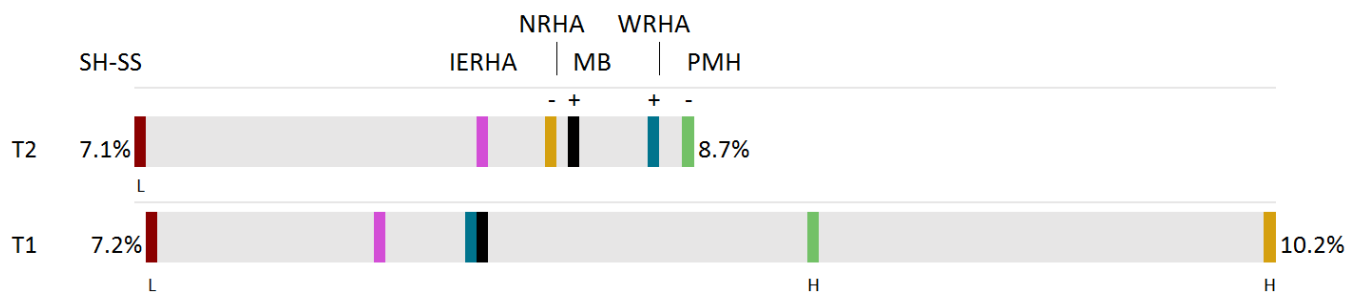
- ▶ **Figure 15** shows that 82,339 Manitobans lived with diagnosed IHD in the current time period.
- ▶ The prevalence has significantly increased in the province and Winnipeg RHA, while it decreased significantly in Northern Health Region and Prairie Mountain Health.
- ▶ **Income:** Income and IHD were strongly related in both time periods.<sup>xi</sup> The prevalence of IHD among residents in low income areas was 1.5 times greater than the highest income areas in the current time period.



*IHD strongly related to income*

**Figure 15. Prevalence of Ischemic Heart Disease by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age- and sex-adjusted percent of residents (aged 19+ years) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		IERHA		NRHA		MB		WRHA		PMH	
T2 COUNT	9,458		8,908		2,539		82,339		47,935		13,094	
T2 RATE	7.1%	L	8.1%		8.3%	-	8.3%	+	8.6%	+	8.7%	-
T1 RATE	7.2%	L	7.8%		10.2%	H	8.1%		8.1%		9.0%	H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 21 shows a total of 9,458 residents had a diagnosis of IHD in the region, in the current time period.
- IHD prevalence in the region was significantly lower than the provincial average, and remained stable over time.

### Zone Level

- IHD prevalence was relatively similar across zones, with the lowest in Zone 3 and the highest in Zone 1.
- The prevalence in Zones 2, 3, and 4 was significantly lower than the Manitoba average in the current time period.
- IHD prevalence increased significantly over time in Zone 3, and decreased significantly in Zone 2 over time.

### District Level

- IHD prevalence ranged between districts from the lowest in Stanley to the highest in Seven Regions in the current time period.
- The prevalence in city of Portage, Rural Portage, and Seven Regions were significantly higher than the Manitoba average.
- Over time, IHD prevalence increased significantly in Altona, while it decreased significantly in Carman.

**Table 23. Ischemic Heart Disease Prevalence in Southern Health-Santé Sud  
2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age- and sex-adjusted percentage of residents (aged 19+ years) diagnosed with disorder

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>82,339</b>	<b>8.3</b>	<b>+</b>	<b>8.1</b>	
<b>SH-SS</b>	<b>9,458</b>	<b>7.1</b>	<b>L</b>	<b>7.2</b>	<b>L</b>
<b>Zone 4</b>	<b>3,168</b>	<b>7.4</b>	<b>L</b>	<b>7.6</b>	
Taché	286	7.8		8.2	
Hanover	434	8.4		9.3	
Niverville/Ritchot	458	9.0		9.1	
Ste. Anne/ La Broquerie	589	9.1		9.1	
Steinbach	1,060	9.2		9.7	H
Rural East	341	9.8		10.3	H
<b>Zone 2</b>	<b>1,536</b>	<b>6.6</b>	<b>L-</b>	<b>7.2</b>	<b>L</b>
Carman	353	7.3	-	9.2	
St. Pierre/ De Salaberry	218	7.8		8.9	
Morris	248	8.0		8.5	
Grey	152	8.0		8.6	
Macdonald	302	8.9		9.0	
Red River South	263	9.1		8.9	
<b>Zone 3</b>	<b>2,287</b>	<b>6.5</b>	<b>L+</b>	<b>6.1</b>	<b>L</b>
Stanley	116	6.5		6.1	
Altona	385	7.3	+	5.5	L
Winkler	621	7.6		6.8	L
Lorne/Louise/ Pembina	483	7.6		7.5	
Roland/Thompson	104	8.5		8.0	
Morden	578	8.8		9.0	
<b>Zone 1</b>	<b>2,467</b>	<b>8.3</b>		<b>8.0</b>	
Cartier/SFX	318	8.4		8.7	
North Norfolk	232	8.9		7.9	
City of Portage	1,100	10.5	H	10.2	H
Rural Portage	430	11.5	H	10.2	H
Seven Regions	387	11.6	H	11.4	H


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest prevalence reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.1x
	T2	1.8x
	Change	-0.3 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Heart Attack Rate

### Definition

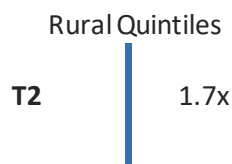
The annual rate of death or hospitalization due to acute myocardial infarction (AMI, or heart attack) per 1,000 population, aged 40 and older, for a five-year time period.

### Why is this indicator important?

Heart attacks are one of the leading causes of death in Manitoba. Understanding AMI rates, in combination with other cardiovascular indicators, is important in the planning of public awareness campaigns and health promotion interventions, as well as the allocation of resources in response to the demands on acute care services.

### Provincial Key Findings

- ▶ **Figure 16** shows 10,235 adults in Manitoba died or were hospitalized due to a heart attack in the current time period.
- ▶ Heart attack rates declined significantly over time in the province and all regions, except Northern Health Region.
- ▶ **Income:** Income and heart attack rates were strongly related in both time periods.<sup>xii</sup> The heart attack (AMI) incidence rate among residents in low income areas was 1.7 times higher than the highest income areas in the current time period.

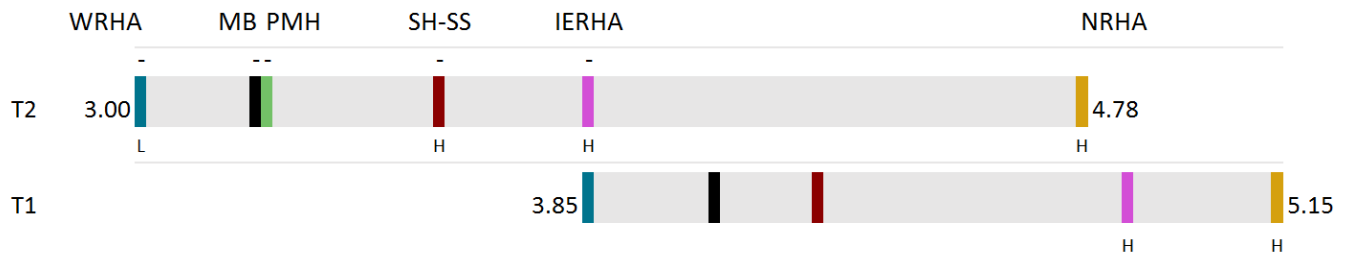


*Heart attack strongly related to income*

T2: 2012-2016

**Figure 16. Heart Attack (AMI) Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents (aged 40+ years)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA		MB		PMH		SH-SS		IERHA		NRHA	
T2 COUNT	5,366		10,235		1,577		1,470		1,304		438	
T2 RATE	3.00	L-	3.24	-	3.24	-	3.58	H-	3.86	H-	4.78	H
T1 RATE	3.85		4.08		4.28		4.28		4.87	H	5.15	H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 24 shows 1,470 regional residents died or were hospitalized due to a heart attack in the current time period.
- Heart attack rates in the region were significantly higher than the provincial average but decreased significantly over time.

### Zone Level

- Heart attack rates were relatively similar across zones.
- Zone 1 was significantly higher than the provincial average in the both time periods.
- Heart attack rates decreased significantly over time in Zones 2, 3, and 4.

### District Level

- Heart attack rates varied between districts from the lowest in Macdonald to the highest in Seven Regions in the current time period.
- The districts significantly higher than the provincial average included: Red River South, city of Portage, Rural Portage, and Seven Regions.
- Rates decreased significantly over time in Hanover, Lorne/Louise/Pembina, Altona, and Morden.

**Table 24. Heart Attack Incidence Rate in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents (aged 40+ years)

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>10,235</b>	<b>3.2</b>	-	<b>4.1</b>	
<b>SH-SS</b>	<b>1,470</b>	<b>3.6</b>	H-	<b>4.3</b>	
<b>Zone 4</b>	<b>447</b>	<b>3.4</b>	-	<b>3.9</b>	
Hanover	51	2.7	-	4.1	
Taché	41	3.1		3.5	
Niverville/Ritchot	58	3.1		3.2	
Rural East	43	3.2		4.5	
Ste. Anne/La Broquerie	87	3.7		4.8	
Steinbach	167	4.1		4.0	
<b>Zone 2</b>	<b>235</b>	<b>3.2</b>	-	<b>4.0</b>	
Macdonald	29	2.3		3.4	
St. Pierre/De Salaberry	25	2.4		3.9	
Morris	33	2.8		3.6	
Grey	22	3.1		3.7	
Carman	70	3.9		5.2	
Red River South	56	5.2	H	4.0	
<b>Zone 3</b>	<b>368</b>	<b>3.3</b>	-	<b>4.5</b>	
Lorne/Louise/Pembina	73	3.0	-	5.0	
Winkler	92	3.2		3.6	
Altona	65	3.3	-	5.0	
Stanley	24	3.6		4.3	
Morden	92	3.8	-	5.3	
Roland/Thompson	22	4.8		3.1	
<b>Zone 1</b>	<b>420</b>	<b>4.6</b>	H	<b>4.9</b>	H
Cartier/SFX	39	2.8		2.8	
North Norfolk	33	3.3		4.0	
City of Portage	189	5.0	H	5.1	
Rural Portage	83	5.9	H	7.0	H
Seven Regions	76	6.0	H	5.6	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

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## Geographic Disparity

- The geographic disparity for heart attack incidence rates increased over time, which means that the gap between the districts with the lowest and highest rates widened.

SH-SS Geographic Disparity Ratio		
	T1	2.5x
	T2	2.7x
	Change	0.2 ↑

T1: 2007-2011, T2: 2012-2016



## A CLOSER LOOK...

Southern Health-Santé Sud was the first rural Emergency Medical Services (EMS) in Manitoba to develop and implement a protocol to address a very serious type of heart attack: ST-Elevation Myocardial Infarction (STEMI). The goal of this protocol is to expedite transport of a patient directly to where they can receive the necessary intervention for patients with this condition. Trials began with Intermediate Care Paramedics in Fall 2017 and expanded to primary care paramedics in Spring 2018.

## Congestive Heart Failure Prevalence

### Definition

The percentage of residents, aged 40 and older, diagnosed with congestive heart failure (CHF), for a three-year time period.

### Why is this indicator important?

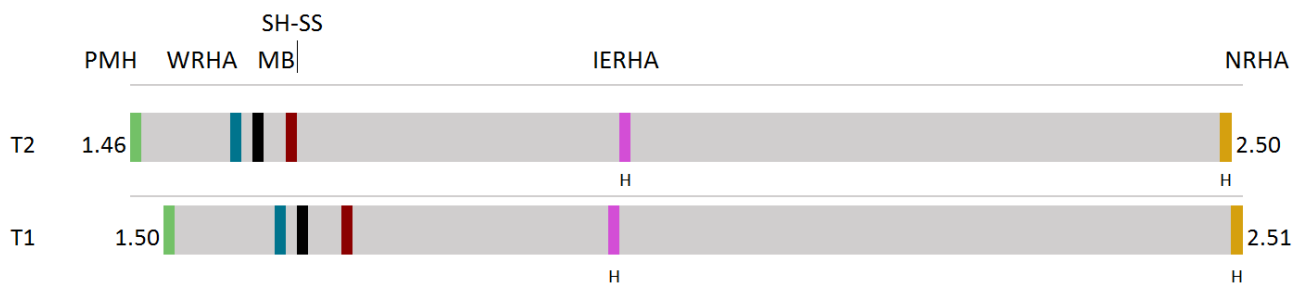
Cardiovascular disease, including CHF, is the leading cause of death in Manitoba. Understanding CHF prevalence is important in the planning of public education and health promotion initiatives, as well as allocation of resources in response to symptom severity, reserved prognosis, and high costs of treatment.

### Provincial Key Findings

- ▶ **Figure 17** shows that 10,461 Manitoba adults lived with diagnosed CHF in the current time period.
- ▶ The prevalence of CHF remained stable over time in the province and in all regions.
- ▶ In Interlake-Eastern RHA and the Northern Health Region, the prevalence of CHF was significantly higher than the provincial average in both time periods.
- ▶ **Income:** There was a significant relationship between income and CHF prevalence in both time periods, with higher prevalence among lower income areas.<sup>xiii</sup>

**Figure 17. Prevalence of Congestive Heart Failure by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted average annual percent of residents (aged 40+ years) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	PMH	WRHA	MB	SH-SS	IERHA	NRHA
T2 COUNT	1,478	5,959	10,461	1,325	1,247	386
T2 RATE	1.46	1.57	1.59	1.62	1.93 H	2.50 H
T1 RATE	1.50	1.61	1.63	1.67	1.93 H	2.51 H

MCHP RHA Indicators Atlas 2019



## Regional Key Findings

### SH-SS Level

- ▶ **Table 25** shows that 1,325 regional adults lived with diagnosed CHF in the region in the current time period.
- ▶ CHF prevalence remained stable over time.

### Zone Level

- ▶ CHF prevalence was similar across zones.

### District Level

- ▶ CHF prevalence was also similar across districts.
- ▶ CHF prevalence decreased significantly over time in Niverville/Ritchot, while it increased significantly in Taché, Red River South, and Altona.

**Table 25. Congestive Heart Failure Prevalence in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted average annual percentage of residents (aged 40+ years) diagnosed with disorder

	T2		T1	
	Count	Rate	Rate	
<b>Manitoba</b>	<b>10,461</b>	<b>1.6</b>	<b>1.6</b>	
<b>SH-SS</b>	<b>1,325</b>	<b>1.6</b>	<b>1.7</b>	
<b>Zone 4</b>	<b>455</b>	<b>1.7</b>	<b>1.7</b>	
Niverville/Ritchot	51	1.4	- 2.3	
Ste. Anne/ La Broquerie	73	1.6	1.4	
Taché	37	1.8	+ 0.9	
Hanover	68	1.9	2.4	H
Steinbach	169	2.0	1.9	
Rural East	57	2.3	2.0	
<b>Zone 2</b>	<b>201</b>	<b>1.4</b>	<b>1.3</b>	
Macdonald	23	1.1	1.4	
St. Pierre/ De Salaberry	23	1.1	0.8	
Grey	17	1.3	2.2	
Carman	57	1.5	1.5	
Morris	35	1.6	1.6	
Red River South	46	2.3	+ 1.4	
<b>Zone 3</b>	<b>398</b>	<b>1.7</b>	<b>1.8</b>	
Stanley	13	1.3	1.9	
Morden	82	1.6	2.2	
Lorne/Louise/ Pembina	80	1.6	2.0	
Winkler	125	2.0	2.2	
Altona	80	2.0	+ 1.4	
Roland/ Thompson	18	2.2	1.6	
<b>Zone 1</b>	<b>271</b>	<b>1.5</b>	<b>1.5</b>	
Cartier/SFX	33	1.4	1.4	
City of Portage	109	1.4	1.8	
Seven Regions	46	1.9	1.7	
North Norfolk	36	2.0	2.0	
Rural Portage	47	2.0	1.3	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

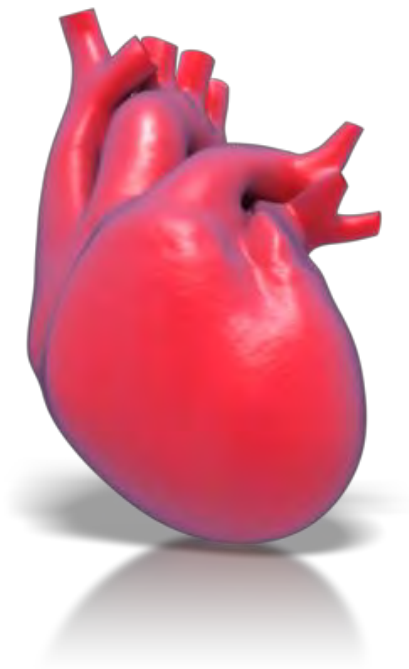
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity decreased, which means that the gap between the districts with the lowest and highest prevalence of CHF reduced over time.

SH-SS Geographic Disparity Ratio		
	T1	3.0x
	T2	2.1x
	Change	-0.9 ↓

T1: 2011-2012, T2: 2016-2017



## Stroke Rate

### Definition

The number of hospitalizations or deaths due to stroke, as a rate per 1,000 residents, aged 40 and older, for a five-year time period.

### Why is this indicator important?

Stroke is one of the leading causes of adult disability and death. Stroke rates, along with other cardiovascular indicators, describe levels of cardiovascular health in the population.

### Provincial Key Findings

- ▶ **Figure 18** shows there were 7,857 strokes among Manitoba residents in the current time period.
- ▶ Rates decreased significantly over time in the province, Prairie Mountain Health, Winnipeg RHA, and Interlake-Eastern RHA.
- ▶ Stroke rates were significantly higher in Northern Health Region for both time periods, and significantly lower in Prairie Mountain Health in the current time period.
- ▶ **Income:** Income and stroke rates were strongly related in both time periods, with higher stroke rates in lower income areas.<sup>xiv</sup>

**Figure 18. Stroke Rates by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death/hospitalization for stroke per 1,000 residents (aged 40+ years)



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	PMH	SH-SS	WRHA	MB	IERHA	NRHA
T2 COUNT	1,076	921	4,494	7,857	816	357
T2 RATE	2.13 L-	2.31	2.43 -	2.48 -	2.56 -	4.68 H
T1 RATE	2.52	2.45	2.65	2.69	2.84	4.56 H

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## Regional Key Findings

### SH-SS Level

- Table 26 shows that 921 regional residents died or were hospitalized for a stroke in the region, in the current time period.
- Stroke rates were stable over time.

### Zone Level

- Stroke rates were similar across zones.

### District Level

- Rates were relatively similar across districts.
- Stroke rates decreased significantly in St. Pierre/De Salaberry, while North Norfolk increased significantly over time.

**Table 26. Stroke Rate in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex-adjusted average annual rate of death/hospitalization for stroke per 1,000 residents (aged 40+ years)

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>7,857</b>	<b>2.5</b>	-	<b>2.7</b>	
<b>Zone 4</b>	<b>294</b>	<b>2.37</b>		<b>2.5</b>	
Hanover	29	1.7		2.6	
Taché	25	2.3		2.2	
Steinbach	103	2.4		2.5	
Niverville/ Ritchot	42	2.5		2.3	
Ste. Anne/ La Broquerie	58	2.6		3.3	
Rural East	37	2.8		2.1	
<b>SH-SS</b>	<b>921</b>	<b>2.3</b>		<b>2.5</b>	
<b>Zone 2</b>	<b>149</b>	<b>2.1</b>		<b>2.6</b>	
Macdonald	17	1.6		2.7	
St. Pierre/ De Salaberry	18	1.7	-	4.0	
Carman	42	2.2		2.6	
Morris	26	2.2		1.8	
Grey	17	2.4		1.8	
Red River South	29	2.7		2.5	
<b>Zone 3</b>	<b>262</b>	<b>2.3</b>		<b>2.39</b>	
Stanley	6	1.1		s	
Roland/ Thompson	6	1.4		s	
Altona	43	2.1		2.2	
Winkler	75	2.4		2.7	
Lorne/Louise/ Pembina	61	2.4		3.2	
Morden	71	2.8		1.9	
<b>Zone 1</b>	<b>216</b>	<b>2.43</b>		<b>2.38</b>	
Cartier/SFX	21	1.7		1.8	
Seven Regions	29	2.3		2.7	
North Norfolk	23	2.4	+	0.8	L
City of Portage	108	2.7		3.0	
Rural Portage	35	2.8		2.3	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

**Geographic Disparity**

- ▶ The geographic disparity decreased over time, which means that the gap reduced between the districts with the lowest and highest stroke rates.

SH-SS Geographic Disparity Ratio		
	T1	5.2x
	T2	2.5x
	Change	-2.7 ↓

T1: 2007-2011, T2: 2012-2016

**A CLOSER LOOK...**

Telestroke is a program that provides specialized emergency care to stroke patients in rural communities. In early 2019, it was expanded to three regional centres in Southern Health-Santé Sud: Bethesda Regional Health Centre, Boundary Trails Health Centre, and Portage District General Hospital. By working remotely with stroke specialists available 24 hours a day, local emergency physicians can help patients receive timely care and increase the likelihood of recovery.



# Diabetes

## Diabetes Incidence

### Definition

The average number of residents newly diagnosed with diabetes (Type 1 and 2) per 100 person years, for a three-year time period.

### Why is this indicator important?

Diabetes is a significant public health issue. Diabetes incidence provides perspective on the number of new cases of diabetes and can help focus prevention and control efforts going forward.

### Provincial Key Findings

- ▶ **Figure 19** shows 25,603 Manitobans were newly diagnosed with diabetes in the current time period.
- ▶ Overall, diabetes incidence has remained relatively stable in Manitoba and most regions, with the exception of a significant increase in Prairie Mountain Health.
- ▶ In the current time period, the rates in Southern Health-Santé Sud were significantly lower than the provincial average, while Prairie Mountain Health, Interlake-Eastern RHA, and Northern Health Region were significantly higher.
- ▶ **Income:** Income and diabetes incidence were strongly related in both time periods.<sup>xv</sup> Diabetes incidence among residents in low income areas was about 2.2 times higher than the highest income areas in the current time period.



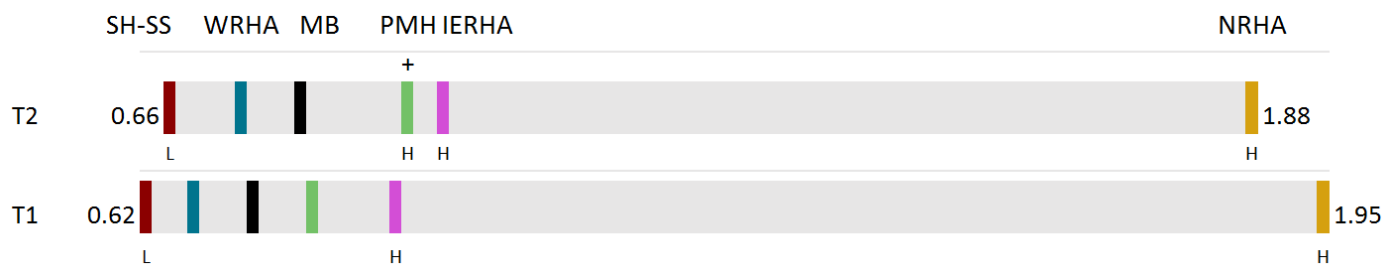
Rural Quintiles  
T2 | 2.2x

*Diabetes  
incidence strongly  
related to income*

T2: 2014/15-2016/17

**Figure 19. Incidence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)**

Age- and sex-adjusted incidence rate per 100 person-years for residents (all ages)



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	2,847	13,901	25,603	3,599	3,044	2,052
T2 RATE	0.66 (L)	0.74	0.80	0.92 (H+)	0.97 (H)	1.88 (H)
T1 RATE	0.62 (L)	0.69	0.74	0.81	0.91 (H)	1.95 (H)

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 27 shows a total of 2,847 regional residents were newly diagnosed with diabetes in the current time period and the rate remained relatively stable over time.
- The region had the lowest rate in the province and significantly lower than the provincial rate in both time periods.

### Zone Level

- Diabetes incidence was similar across Zones 2, 3, and 4, which were significantly lower than the provincial average in both time periods.
- Zone 1 had rates significantly higher compared to the provincial average and increased significantly over time.

### District Level

- Diabetes incidence varied across districts from the lowest in Stanley to the highest in Seven Regions in the current time period.
- In the current time period, the districts significantly lower included: Hanover, Niverville/Ritchot, Steinbach, Ste. Anne/La Broquerie, Taché, Macdonald, St. Pierre/De Salaberry, Carman, Stanley, Roland/Thompson, Winkler, Altona, Morden, and Cartier/SFX. On the other hand, Rural Portage and Seven Regions had significantly higher rates.
- Rates increased significantly over time in Morris, city of Portage, and Rural Portage.

**Table 27. Diabetes Incidence in Southern Health-Santé Sud, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)**

Age- and sex-adjusted incidence rate per 100 person-years for residents (all ages)

	T2		T1			T2		T1			
	Count	Rate	Rate	Rate		Count	Rate	Rate			
<b>Manitoba</b>	<b>25,603</b>	<b>0.80</b>		<b>0.74</b>		<b>SH-SS</b>	<b>2,847</b>	<b>0.66</b>	<b>L</b>	<b>0.62</b>	<b>L</b>
<b>Zone 4</b>	<b>892</b>	<b>0.55</b>	<b>L</b>	<b>0.52</b>	<b>L</b>	<b>Zone 2</b>	<b>451</b>	<b>0.58</b>	<b>L</b>	<b>0.52</b>	<b>L</b>
Hanover	117	0.44	L	0.44	L	Macdonald	79	0.42	L	0.40	L
Niverville/Ritchot	144	0.54	L	0.49	L	St. Pierre/De Salaberry	60	0.52	L	0.42	L
Steinbach	265	0.55	L	0.51	L	Morris	76	0.59	+	0.38	L
Ste. Anne/La Broquerie	152	0.55	L	0.58		Grey	47	0.59		0.59	
Taché	124	0.55	L	0.45	L	Carman	99	0.60	L	0.59	
Rural East	90	0.72		0.64		Red River South	90	0.78		0.73	
<b>Zone 3</b>	<b>601</b>	<b>0.51</b>	<b>L</b>	<b>0.54</b>	<b>L</b>	<b>Zone 1</b>	<b>903</b>	<b>0.92</b>	<b>H+</b>	<b>0.76</b>	
Stanley	45	0.37	L	0.39	L	Cartier/SFX	93	0.47	L	0.43	L
Roland/Thompson	22	0.40	L	0.44		North Norfolk	76	0.69		0.57	
Winkler	155	0.46	L	0.55	L	City of Portage	353	0.89	+	0.70	
Altona	108	0.48	L	0.49	L	Rural Portage	197	1.14	H+	0.86	
Morden	120	0.50	L	0.53	L	Seven Regions	184	1.45	H	1.31	H
Lorne/Louise/Pembina	151	0.67		0.66							


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity increased over time, which means that the gap between the districts with the lowest and highest diabetes incidence rates widened.

SH-SS Geographic Disparity Ratio	
	<b>T1</b> 3.4x
	<b>T2</b> 3.9x
	<b>Change</b> 0.5 ↑

T1: 2009/10-2011/12, T2: 2014/15-2016/17



## Diabetes Prevalence

### Definition

The percentage of residents diagnosed with and treated for diabetes (Type 1 and 2), for a three-year time period.

### Why is this indicator important?

Diabetes can lead to serious complications (such as cardiovascular disease, vision loss, kidney failure, nerve damage or amputation) and premature death. As the Canadian population continues to grow and age, the number of Canadians living with diabetes is also expected to continue to increase.<sup>xvi</sup>

### Provincial Key Findings

- ▶ **Figure 20** shows about 120,201 Manitobans were living with diagnosed diabetes.
- ▶ Diabetes prevalence increased significantly over time in the province and all regions.
- ▶ In the current time period Southern Health-Santé Sud's was significantly lower than the provincial average, while Interlake-Eastern RHA, Prairie Mountain Health, and Northern Health Region were significantly higher
- ▶ **Income:** Income and diabetes prevalence were strongly related in both time periods.<sup>xvii</sup> Diabetes prevalence among residents in low income areas was 2.2 times higher than the residents in the highest income areas in the current time period.



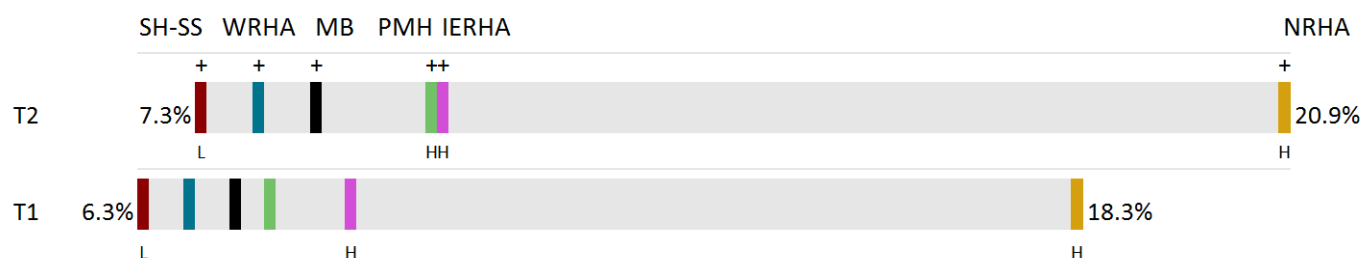
Rural Quintiles  
T2 | 2.2x

*Diabetes prevalence  
strongly related to  
income*

T2: 2014/15-2016/17

**Figure 20. Prevalence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)**

Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		WRHA		MB		PMH		IERHA		NRHA	
T2 COUNT	13,103		65,004		120,201		17,593		14,040		9,733	
T2 RATE	7.3%	L+	7.9%	+	8.6%	+	10.1%	H+	10.3%	H+	20.9%	H+
T1 RATE	6.3%	L	7.0%		7.6%		8.1%		9.1%	H	18.3%	H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 28 shows 13,103 residents of all ages lived with a diagnosis of diabetes in the region in the current time period and the prevalence increased significantly in the region over time.
- The region had the lowest diabetes prevalence in the province and significantly lower than the Manitoba average in both time periods.

### Zone Level

- Like diabetes incidence, the prevalence was similar across Zones 2, 3, and 4, which were significantly lower than the provincial average in both time periods.
- Zone 1 had the highest prevalence in the region; however, not statistically different than the provincial average.
- All zones increased significantly over time.

### District Level

- There was a considerable difference of almost 10% between the lowest district of Stanley and the highest district of Seven Regions in the current time period.
- In the current time period, diabetes prevalence was significantly lower in Hanover, Taché, Niverville/Ritchot, Ste. Anne/La Broquerie, Steinbach, Macdonald, Morris, Carman, Grey, St. Pierre/De Salaberry, Stanley, Winkler, Roland/Thompson, Morden, Altona, Cartier/SFX, and North Norfolk. However, both Rural Portage and Seven Regions were significantly higher.
- Diabetes prevalence increased significantly over time in Niverville/Ritchot, Steinbach, Rural East, Morris, St. Pierre/De Salaberry, Red River South, Altona, North Norfolk, city of Portage, Rural Portage, and Seven Regions.

**Table 28. Diabetes Prevalence in Southern Health-Santé Sud, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)**  
Age- and sex-adjusted percentage of residents (all ages) diagnosed with disorder

	T2			T1	
	Count	Percentage		Percentage	
<b>Manitoba</b>	<b>120,201</b>	<b>8.6</b>	<b>+</b>	<b>7.6</b>	

	T2			T1	
	Count	Percentage		Percentage	
<b>SH-SS</b>	<b>13,103</b>	<b>7.3</b>	<b>L+</b>	<b>6.3</b>	<b>L</b>

Zone 4					
Zone 4	4,210	6.6	L+	5.6	L
Hanover	564	5.5	L	5.0	L
Taché	476	5.9	L	5.3	L
Niverville/Ritchot	672	6.3	L+	5.1	L
Ste. Anne/ La Broquerie	775	6.4	L	5.9	L
Steinbach	1,300	7.0	L+	5.7	L
Rural East	423	7.6	+	6.2	

Zone 2					
Zone 2	2,142	6.8	L+	5.8	L
Macdonald	380	5.3	L	4.6	L
Morris	310	6.2	L+	4.9	L
Carman	446	6.4	L	5.7	L
Grey	210	6.7	L	5.6	L
St. Pierre/ De Salaberry	315	6.8	L+	5.5	L
Red River South	481	10.1	+	8.3	

Zone 3					
Zone 3	2,958	6.2	L+	5.8	L
Stanley	184	4.5	L	4.3	L
Winkler	766	5.7	L	5.4	L
Roland/Thompson	119	5.8	L	5.8	
Morden	620	6.1	L	5.9	L
Altona	552	6.4	L+	5.0	L
Lorne/Louise/ Pembina	717	7.6		7.0	


  

Zone 1					
Zone 1	3,793	9.4	+	7.5	
Cartier/SFX	442	5.8	L	5.0	L
North Norfolk	314	7.1	L+	5.6	L
City of Portage	1,465	8.8	+	6.9	
Rural Portage	791	11.3	H+	8.4	
Seven Regions	781	14.3	H+	11.9	H

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
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## Geographic Disparity

- ▶ The geographic disparity increased over time, which means that the gap between the districts with the lowest and highest diabetes prevalence widened.

SH-SS Geographic Disparity Ratio		
	T1	2.8x
	T2	3.2x
	Change	0.4 ↑

T1: 2009/10-2011/12, T2: 2014/15-2016/17

## Lower Limb Amputation Due to Diabetes

### Definition

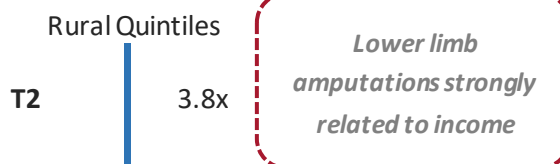
The percentage of residents with diabetes, aged 19 and older, who had a lower limb amputation either below or including the knee, for a five-year time period.

### Why is this indicator important?

Individuals with diabetes are more likely to be hospitalized with a non-traumatic lower limb amputation than the non-diabetic population.<sup>xviii</sup> Lower limb amputations amongst diabetics are an indication of poor disease management and can lead to increased morbidity and mortality. There is a strong relationship between lower limb amputation due to diabetes and overall health status of vulnerable populations. This indicator helps to plan focused upstream education and equitable access to disease prevention efforts.

### Provincial Key Findings

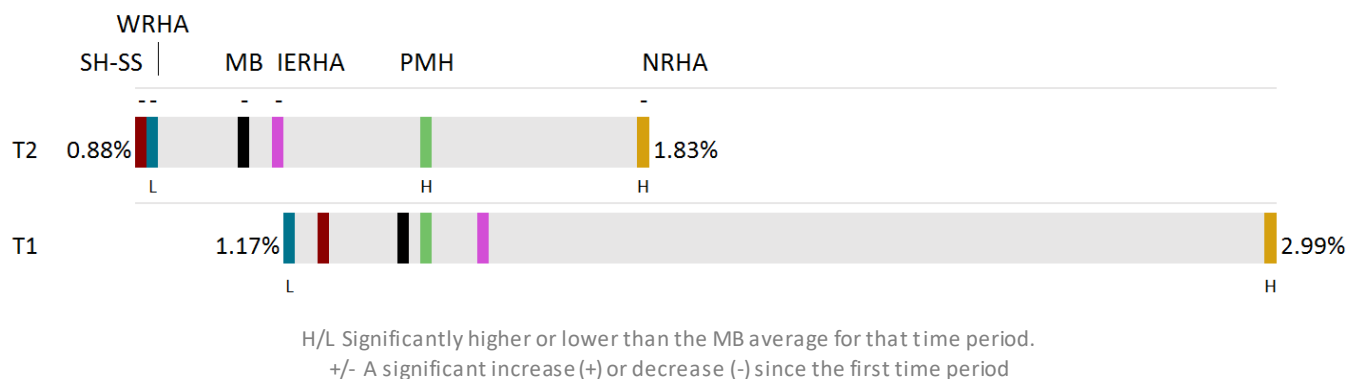
- ▶ **Figure 21** shows 1,197 Manitobans aged 19 years and older had a lower limb amputation due to diabetes in the current time period.
- ▶ The percentage decreased significantly over time provincially and across all regions except Prairie Mountain Health.
- ▶ In the current time period, Winnipeg RHA was significantly lower than the provincial average, while Prairie Mountain Health and Northern Health Region were significantly higher.
- ▶ **Income:** Income and lower limb amputations due to diabetes were strongly related in both time periods.<sup>xix</sup> The percentage of lower limb amputations due to diabetes among residents in low income areas was 3.8 times higher than the highest income areas in the current time period.



T2: 2012/13-2016/17

**Figure 21. Lower Limb Amputations Among Residents with Diabetes by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age- and sex-adjusted percent of residents with diabetes (aged 19+ years) who had an amputation



	SH-SS	WRHA	MB	IERHA	PMH	NRHA						
T2 COUNT	107	538	1,197	157	235	142						
T2 RATE	0.88%	-	0.91%	L-	1.09%	-	1.16%	-	1.42%	H	1.83%	H-
T1 RATE	1.23%		1.17%	L	1.39%		1.54%		1.42%		2.99%	H

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## Regional Key Findings

### SH-SS Level

- Table 29 shows a total of 107 regional residents who had lower limb amputations due to diabetes in the current time period.
- In the current time period, the region had the lowest percentage of lower limb amputations due to diabetes in the province; however, it was not significantly different than the Manitoba average.
- Lower limb amputations due to diabetes in the region decreased significantly over time.

### Zone Level

- There was variation across zones, with the lowest in Zone 4 compared to the highest in Zone 1.
- In both time periods, Zone 4 was significantly lower compared to the provincial average. Zone 1 was significantly higher; however, the percentage decreased significantly over time.

### District Level

- Data for many districts have been suppressed due to small number of cases.
- Of the available data, Seven Regions was significantly higher than the provincial average in both time periods.

**Table 29. Lower Limb Amputations Due To Diabetes in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Age- and sex-adjusted percent of residents with diabetes (aged 19+ years) who had an amputation

	T2		T1	
	Count	Rate	Rate	
<b>Manitoba</b>	<b>1,197</b>	<b>1.09</b>	<b>-</b>	<b>1.39</b>
<b>SH-SS</b>	<b>107</b>	<b>0.88</b>	<b>-</b>	<b>1.23</b>
<b>Zone 4</b>	<b>18</b>	<b>0.46</b>	<b>L</b>	<b>0.57</b>
Steinbach	7	0.58		0.69
Niverville/Ritchot	s			s
Taché	s			0.00
Hanover	s			s
Rural East	s			s
Ste. Anne/ La Broquerie	s			s
<b>Zone 2</b>	<b>16</b>	<b>0.77</b>		<b>1.09</b>
St. Pierre/ De Salaberry	0	0.00		s
Red River South	6	1.32		1.79
Macdonald	s			s
Carman	s			s
Grey	s			s
Morris	s			s
<b>Zone 3</b>	<b>18</b>	<b>0.62</b>		<b>0.93</b>
Stanley	0	0.00		0.00
Roland/ Thompson	0	0.00		0.00
Morden	7	1.22		s
Altona	s			s
Winkler	s			s
Lorne/Louise/ Pembina	s			1.94
<b>Zone 1</b>	<b>55</b>	<b>1.63</b>	<b>H-</b>	<b>2.37</b>
City of Portage	13	1.00		1.28
Rural Portage	12	1.76		2.98
Seven Regions	24	3.50	<b>H</b>	5.05
Cartier/SFX	s			s
North Norfolk	s			s

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 s indicates data suppressed due to small numbers  
 MCHP RHA Indicators Atlas 2019

### Geographic Disparity

- ▶ A large geographic disparity was noted but it decreased over time, which means that the gap between the districts reduced.

SH-SS Geographic Disparity Ratio	
	<b>T1</b> 7.3x
	<b>T2</b> 6.0x
	<b>Change</b> -1.3 ↓

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Diabetes Care - Eye Exams

### Definition

The percentage of residents with diabetes, aged 19 and older, who had an eye exam in a given year, as defined by a visit to an ophthalmologist or an optometrist.

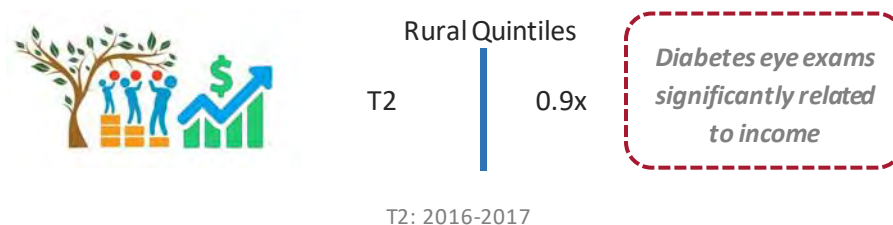
Note: Eye exam rates may be underestimated in Manitoba. Services provided by general practitioners and family physicians may not be included, as there is no specific tariff for this service. Furthermore, although all residents with diabetes qualify for annual eye exams without having to pay for the service, some may not indicate their diabetic status to the provider, in which case the provider may bill the patient directly. If that occurs, there would be no record of the visit in medical claims data.

### Why is this indicator important?

Diabetic eye problems (such as diabetic retinopathy, cataract, and glaucoma) are common complications of diabetes and may lead to visual loss or even blindness. The Canadian Association of Optometrists recommends that individuals with diabetes should see their optometrists for an eye examination when they are first diagnosed and at minimum, once a year after. More frequent eye exams may be recommended.<sup>xx</sup>

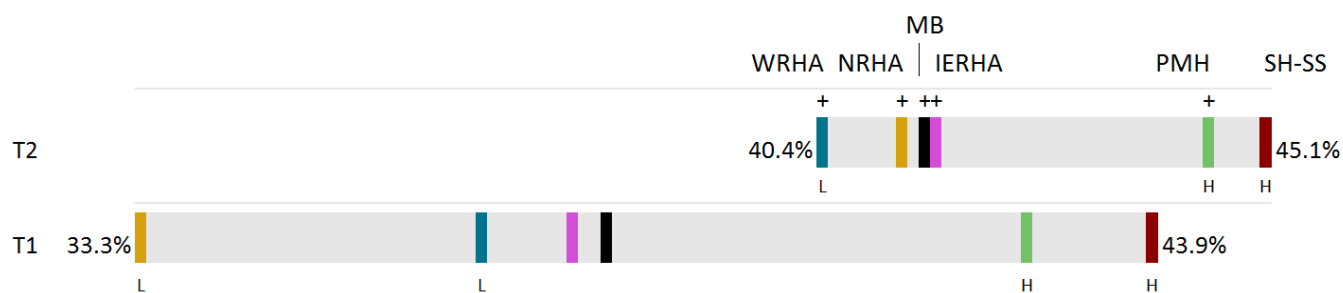
### Provincial Key Findings

- ▶ **Figure 22** shows 50,112 Manitobans with diabetes had an eye exam in the current time period.
- ▶ The percentage increased significantly over time provincially and across all regions except Southern Health-Santé Sud.
- ▶ In both time periods, Winnipeg RHA was significantly lower than the provincial average while Southern Health-Santé Sud and Prairie Mountain Health were significantly higher.
- ▶ **Income:** Income and eye exams for diabetes were significantly related in both time periods.<sup>xxi</sup> The percentage of eye exams among residents in low income areas was 0.9 times lower than the highest income residents in the current time period.



**Figure 22. Diabetes Care: Eye Examinations by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Crude percent of residents (aged 19+ years) with diabetes who had an eye exam



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	WRHA		NRHA		MB		IERHA		PMH		SH-SS	
T2 COUNT	26,292		4,026		50,112		5,857		7,831		5,909	
T2 RATE	40.4%	L+	41.4%	+	41.7%	+	41.7%	+	44.5%	H+	45.1%	H
T1 RATE	37.0%	L	33.3%	L	38.3%		37.9%		42.6%	H	43.9%	H

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## Regional Key Findings

### SH-SS Level

- Table 30 shows 5,909 regional residents with diabetes had an eye exam in the current time period.
- The region was significantly higher than the provincial average in both time periods.
- Diabetes eye exams in the region remained relatively stable over time with a slight, not statistically significant increase.

### Zone Level

- In the current time period, there was variation across zones with the lowest in Zone 1 and the highest in Zone 3.
- Zones 2 and 3 were significantly higher than the provincial average in the both time periods.
- Zone 1 experienced a significant increase over time.

### District Level

- In the current time period, there was considerable variation across districts with the lowest in Rural East and the highest in Morden.
- Carman, Morden, Altona, and Lorne/Louise/Pembina were significantly higher than the provincial average in the current time period.



**Table 30. Diabetes Care: Eye Examinations in Soutehrn Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Crude percentage of residents (aged 19+ years) with diabetes who had an eye exam

	T2			T1	
	Count	Percentage		Percentage	
<b>Manitoba</b>	<b>50,112</b>	<b>41.7</b>	<b>+</b>	<b>38.3</b>	
<b>SH-SS</b>	<b>5,909</b>	<b>45.1</b>	<b>H</b>	<b>43.9</b>	<b>H</b>
<b>Zone 4</b>	<b>1,777</b>	<b>42.2</b>		<b>43.3</b>	<b>H</b>
Niverville/Ritchot	307	45.7		41.9	
Steinbach	577	44.4		45.8	H
Ste. Anne/ La Broquerie	328	42.3		44.7	
Taché	189	39.7		38.9	
Hanover	220	39.0		46.1	
Rural East	156	36.9		36.4	
<b>Zone 2</b>	<b>1,012</b>	<b>47.2</b>	<b>H</b>	<b>44.9</b>	<b>H</b>
Carman	235	52.7	H	56.1	H
Macdonald	193	50.8		46.3	
St. Pierre/ De Salaberry	143	45.4		36.9	
Red River South	215	44.7		37.1	
Morris	136	43.9		47.2	
Grey	90	42.9		43.3	
<b>Zone 3</b>	<b>1,539</b>	<b>52.0</b>	<b>H</b>	<b>50.9</b>	<b>H</b>
Morden	365	58.9	H	57.3	H
Stanley	98	53.3		45.1	
Altona	288	52.2	H	50.2	H
Lorne/Louise/ Pembina	368	51.3	H	50.8	H
Roland/Thompson	61	51.3		55.1	H
Winkler	359	46.9		47.0	H
<b>Zone 1</b>	<b>1,581</b>	<b>41.7</b>	<b>+</b>	<b>37.9</b>	
North Norfolk	139	44.3		42.9	
Rural Portage	345	43.6		37.5	
City of Portage	626	42.7		38.6	
Cartier/SFX	173	39.1		41.5	
Seven Regions	298	38.2		33.5	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity decreased slightly over time, which means that the gap reduced between the districts with the lowest and highest percentage of residents with diabetes who had an eye exam.

SH-SS Geographic Disparity Ratio	
	<b>T1</b> 1.7x
	<b>T2</b> 1.6x
	<b>Change</b> -0.1 ↓

T1: 2011-2012, T2: 2016-2017

# Injury

## Injury Hospitalization - Intentional

### Definition

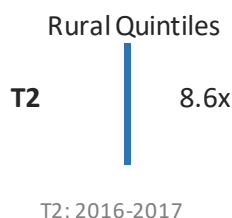
The number of residents who stayed in hospital at least one day with a primary diagnosis of intentional injury (e.g. self-inflicted, assault) per 1,000 population, for a one-year time period.

### Why is this indicator important?

This indicator helps us to understand the effectiveness of intentional injury public awareness efforts and informs program planning and resource allocation.

### Provincial Key Findings

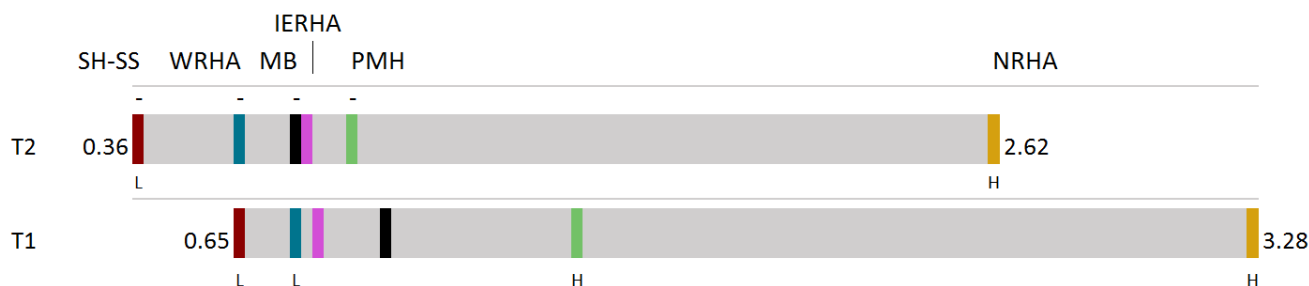
- ▶ **Figure 23** shows 1,015 intentional injury hospitalizations in the current time period in Manitoba.
- ▶ The rates decreased significantly over time in the province, Southern Health-Santé Sud, Winnipeg RHA, and Prairie Mountain Health.
- ▶ In both time periods, Southern Health-Santé Sud was significantly lower than the provincial average while Northern Health Region was significantly higher.
- ▶ **Income:** There was a large income disparity between hospitalization rates due to intentional injuries, where residents in low income areas had rates about 8.6 times higher than the highest income areas in the current time period.



*Intentional injury hospitalization significantly related to income*

**Figure 23. Intentional Injury Hospitalization Rates by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rates per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	IERHA	PMH	NRHA						
T2 COUNT	66	480	1,015	94	146	200						
T2 RATE	0.36	L-	0.65	-	0.80	-	0.82	-	0.94	-	2.62	H
T1 RATE	0.65	L	0.81	L	1.04		0.87		1.54	H	3.28	H

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## Regional Key Findings

### SH-SS Level

- Table 31 shows a total of 66 regional residents were hospitalized due to intentional injuries in the current time period. As mentioned previously, the regional rate was significantly lower than the provincial average and decreased significantly over time.

### Zone Level

- There was some variation across zones, with the lowest in Zone 4 and highest in Zone 1 in the current time period.
- Zone 4 was significantly lower than the Manitoba average and decreased significantly over time.

### District Level

- District level data not available due to small sample sizes.

**Table 31. Intentional Injury Hospitalization Rates in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rates per 1,000 residents

	T2		T1			T2		T1			
	Count	Rate	Count	Rate		Count	Rate	Count	Rate		
Manitoba	1,015	0.80	-	1.04		SH-SS	66	0.36	L-	0.65	L
Zone 4	12	0.19	L-	0.64		Zone 2	9	0.37		0.68	
Zone 3	18	0.43		0.47		Zone 1	27	0.79		1.29	

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

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## Injury Hospitalization - Unintentional

### Definition

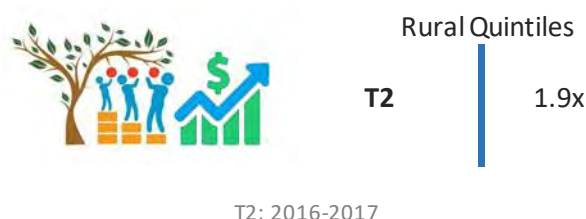
The number of residents who stayed in hospital at least one day with a primary diagnosis of unintentional injury (e.g. falls, motor vehicle accidents, drowning) per 1,000 population, for a one-year time period.

### Why is this indicator important?

Measuring unintentional injury hospitalization rates helps to understand the adequacy and effectiveness of prevention efforts.

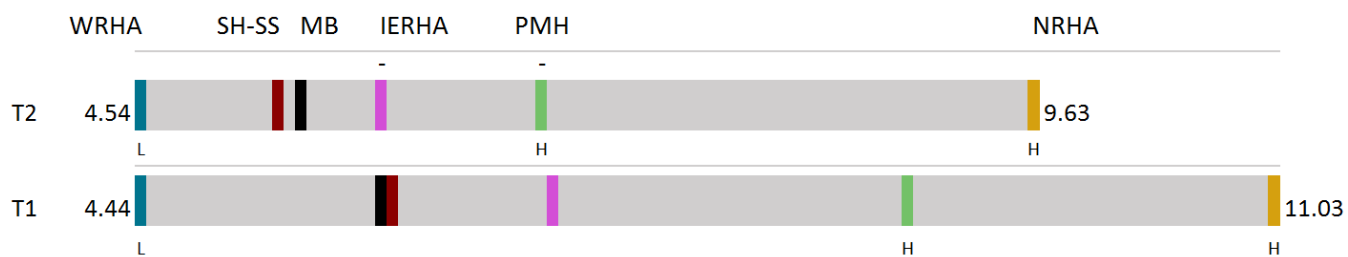
### Provincial Key Findings

- ▶ **Figure 24** shows 7,449 Manitobans were hospitalized for unintentional injuries in the current time period.
- ▶ In both time periods, Winnipeg RHA was significantly lower than the provincial average, while the rates in Prairie Mountain Health and Northern Health Region were significantly higher.
- ▶ Prairie Mountain Health and Interlake-Eastern RHA decreased significantly over time.
- ▶ **Income:** Hospitalization rates due to unintentional injuries among residents in low income areas were 1.9 times higher than the highest income areas in the current time period.
- ▶ The leading causes in Manitoba were falls, suffocation, poisoning, struck by or against an object, and being an occupant in a motor vehicle accident. Falls remained the leading cause across regions over time.



**Figure 24. Unintentional Injury Hospitalization Rates by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rates per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	3,738	971	7,449	763	1,298	512
T2 RATE	4.54   L	5.32	5.42	5.89   -	6.78   H-	9.63   H
T1 RATE	4.44   L	5.97	5.90	6.90	8.91   H	11.03   H

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## Regional Key Findings

### SH-SS Level

- Table 32 shows a total of 971 regional residents were hospitalized due to unintentional injuries in the current time period.
- Regional rates remained stable over time with a slight, not statistically significant decrease.
- Table 33 shows the leading causes of injury hospitalization in the region in the current time period were predominantly falls followed by being an occupant in a motor vehicle accident, suffocation, other land transport, and poisoning. Falls remained the leading cause over time.

### Zone-Level

- Table 32 shows that rates were similar across zones.

### District Level

- In the current time period, there was variation across districts with the lowest rate in Morris and the highest in Seven Regions.
- In the current time period, Niverville/Ritchot and Morris were significantly lower than the provincial average, while Lorne/Louise/Pembina and Seven Regions were significantly higher in both time periods.
- Ste. Anne/La Broquerie, Morris, and Roland/Thompson decreased significantly over time.

**Table 32. Unintentional Injury Hospitalization Rates in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rates per 1,000 residents

	T2		T1			T2		T1		
	Count	Rate	Rate			Count	Rate	Rate		
<b>Manitoba</b>	<b>7,449</b>	<b>5.4</b>		<b>5.9</b>		<b>971</b>	<b>5.3</b>		<b>6.0</b>	
<b>Zone 4</b>	<b>312</b>	<b>4.8</b>		<b>5.6</b>		<b>156</b>	<b>5.2</b>		<b>5.6</b>	
Niverville/Ritchot	32	3.1	L	3.9		Morris	13	2.5	L-	5.6
Ste. Anne/La Broquerie	45	3.9	-	6.3		Macdonald	25	4.0		3.8
Hanover	47	4.3		5.9		St. Pierre/De Salaberry	22	4.9		4.3
Taché	37	5.3		5.5		Red River South	27	5.9		5.6
Steinbach	119	6.0		6.2		Grey	19	6.6		7.4
Rural East	32	6.4		5.0		Carman	50	6.9		7.2
<b>Zone 3</b>	<b>270</b>	<b>5.6</b>		<b>5.6</b>		<b>Zone 1</b>	<b>234</b>	<b>5.9</b>		<b>7.2</b>
Altona	36	4.0		5.2		Cartier/SFX	25	3.8		3.0
Roland/Thompson	8	4.1	-	11.6	H	City of Portage	92	5.2		7.0
Morden	46	4.3		4.7		North Norfolk	24	5.6		8.0
Winkler	80	5.4		4.5		Rural Portage	38	6.2		6.3
Stanley	24	6.2		4.7		Seven Regions	55	9.7	H	11.3
Lorne/Louise/Pembina	76	8.1	H	8.8	H					

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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**Table 33. Leading Causes of Injury Hospitalizations in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


Percentage of total injury hospitalizations

Injury	T2		T1
	Count	Percentage	Percentage
Falls	521	49.2%	51.4%
Occupant, MVA	78	7.4%	5.0%
Suffocation	77	7.3%	-
Other land transport	69	6.5%	6.4%
Poisoning	62	5.9%	9.4%

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## Geographic Disparity

- ▶ The geographic disparity decreased slightly over time, meaning the gap between the districts with the lowest and highest unintentional injury hospitalization rates reduced.

SH-SS Geographic Disparity Ratio		
	T1	3.9x
	T2	3.8x
	Change	-0.1 ↓

T1: 2011-2012, T2: 2016-2017

## A CLOSER LOOK...

Given that falls are the leading cause of injury hospitalizations in the region, it is crucial to prevent falls within the community. However, Southern Health-Santé Sud also adopts many beneficial strategies to prevent falls in its institutions. To date, many factors have improved the reduction of falls and injuries from falls, including fall mats, bed alarms, bed positioning, and mobility supports.

Each hospital audits for fall risk on the care units twice a year and more frequently as needed. All patients are assessed for risk of falls including patients coming in for day surgery. Care providers ensure the bed is in the lowest position and a call bell is immediately available or attached to the patient gown. There is a symbol placed on the door of the patients room if they have been assessed as a fall risk. A communication whiteboard in each patient room has enhanced quick identification of fall risk.

Whiteboards are noted by staff to be a significant benefit to identifying risk for falls and communicating this risk to all people who enter the patient room. The communication whiteboard is a dry erase board located at each bedside that serves to document aspects of the patient's care, including the fall risk. This is a helpful communication tool between the patient, family, and care providers. The whiteboard has visual identifiers and checkboxes to individualize each patient's fall risk. This is a quick reference for staff when they enter the room. The whiteboard also indicates how the patient can mobilize and transfer out of bed as another visual cue to assist caregivers and families. The whiteboards are updated every nursing shift and when the patients fall risk status changes.

## Hip Fracture Hospitalization Rate

### Definition

The rate of individuals admitted to an acute care hospital with a hip fracture, per 100,000 population, aged 65 and older, for a five-year time period.

### Why is this indicator important?

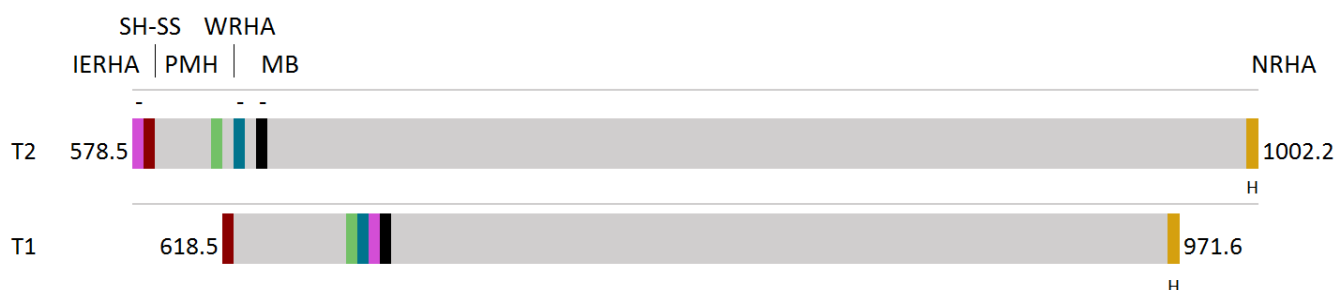
Hip fractures are associated with high morbidity and mortality rates in older adults. Individuals with hip fractures are at significantly increased risk for further fractures.

### Provincial Key Findings

- ▶ **Figure 25** shows that 5,637 Manitobans were admitted to an acute care hospital with a hip fracture in the current time period.
- ▶ Over time, rates have decreased significantly in the province, Interlake-Eastern RHA, and Winnipeg RHA.
- ▶ Northern Health Region was significantly higher than the provincial average in both time periods.

**Figure 25. Hip Fracture Hospitalization Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age- and sex-adjusted rate per 100,000 residents (65 years and older)



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	IERHA	SH-SS	PMH	WRHA	MB	NRHA
T2 COUNT	478	643	927	3,295	5,637	159
T2 RATE	578.5	-	612.3	621.6	627.9	1002.2 H
T1 RATE	673.0	618.5	664.1	667.9	674.0	971.6 H

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## Regional Key Findings

### SH-SS Level

- Table 34 shows a total of 643 regional residents were hospitalized for a hip fracture in the current time period.
- Rates in the region remained relatively stable over time with a slight, not statistically significant decrease.

### Zone Level

- Rates varied with the lowest in Zone 2 and the highest in Zone 1 in both time periods.

### District Level

- There was considerable variation between districts from the lowest in Morris to the highest in Seven Region; however, none of the districts were significantly different than the provincial average.

**Table 34. Hip Fracture Hospitalization Rate in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Age- and sex-adjusted rate per 100,000 residents (65 years and older)

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>5,637</b>	<b>627.9</b>	<b>-</b>	<b>674.0</b>	
<b>SH-SS</b>	<b>643</b>	<b>584.0</b>		<b>618.5</b>	
<b>Zone 4</b>	<b>173</b>	<b>536.8</b>		<b>630.8</b>	
Rural East	12	350.8		519.3	
Hanover	19	419.9		573.6	
Taché	9	438.2		630.8	
Niverville/ Ritchot	22	541.9		536.5	
Ste. Anne/ La Broquerie	32	553.1		658.1	
Steinbach	79	636.8		698.0	
<b>Zone 2</b>	<b>104</b>	<b>532.5</b>		<b>549.0</b>	
Morris	11	327.7		421.4	
Grey	7	364.0		s	
Red River South	16	542.7		686.9	
Macdonald	12	554.0		348.7	
Carman	37	600.6		689.7	
St. Pierre/ De Salaberry	21	703.8		572.8	
<b>Zone 3</b>	<b>208</b>	<b>614.5</b>		<b>578.2</b>	
Winkler	55	562.2		604.3	
Altona	35	569.5		485.1	
Lorne/Louise/ Pembina	54	682.5		551.4	
Roland/ Thompson	8	684.4		776.0	
Morden	54	685.7		617.4	
Stanley	s			s	
<b>Zone 1</b>	<b>158</b>	<b>645.4</b>		<b>715.6</b>	
Cartier/SFX	13	478.7		801.0	
North Norfolk	13	498.7		772.6	
Rural Portage	16	566.8		583.2	
City of Portage	82	646.8		655.9	
Seven Regions	34	927.4		939.5	

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

s indicates data suppressed due to small numbers

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## Geographic Disparity

- ▶ The geographic disparity between the districts increased slightly over time, meaning the gap between the districts with the lowest and highest hospitalization rates widened.

SH-SS Geographic Disparity Ratio		
	T1	2.7x
	T2	2.8x
	Change	0.1 ↑

T1: 2007/08-2011/12, T2: 2012/13-2016/17

# Mental Illness

## Mood & Anxiety Disorders

### Definition

The percentage of adult residents diagnosed with mood and anxiety disorders, for a five-year time period.

### Why is this indicator important?

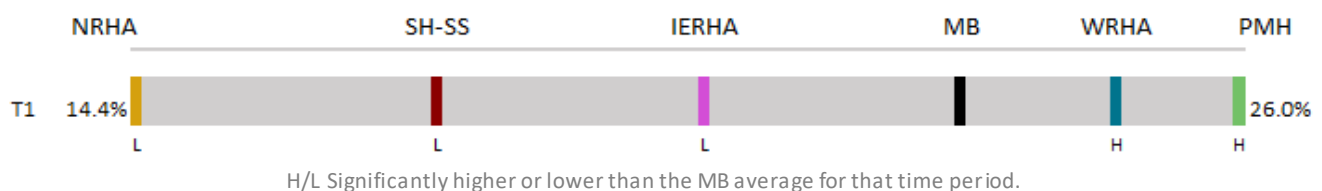
Mood and anxiety disorders frequently coexist with other chronic diseases and/or conditions. For example, the early onset of depressive and anxiety disorders are associated with an increased risk of developing heart disease, asthma, arthritis, chronic back pain, and chronic headaches in adults.<sup>xxii</sup> This prevalence rate combines depression and anxiety measures together as they are difficult to separate based on coding limitations.

### Provincial Key Findings

- ▶ **Figure 26** shows there were 228,982 Manitobans with a diagnosis of mood and anxiety disorders.
- ▶ Northern Health Region, Southern Health-Santé Sud, and Interlake-Eastern were significantly lower than the provincial average; however, Prairie Mountain Health and Winnipeg RHA were significantly higher.
- ▶ A higher prevalence of mood and anxiety disorders was found in urban areas compared to rural areas, which could, in part, be due to access of services.
- ▶ **Income:** The prevalence of mood and anxiety disorders increased in areas of lower income.<sup>xxiii</sup>

**Figure 26. Prevalence of Mood and Anxiety Disorders among Adults by RHA, 2010/11-2014/15 (T1)**

Age- and sex-adjusted percent of adults (aged 18+ years) diagnosed with disorder in five-year time period



	NRHA	SH-SS	IERHA	MB	WRHA	PMH
T1 COUNT	7,148	23,814	20,287	228,982	142,171	34,287
T1 RATE	14.4% L	17.7% L	20.4% L	23.2%	24.7% H	26.0% H

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## Regional Key Findings

### SH-SS Level

- Table 35 shows a total of 23,814 regional residents diagnosed with mood and anxiety disorders.
- The regional percentage was significantly lower than the Manitoba average.

### Zone Level

- Zone level data not available.

### District Level

- There was a considerable difference between the lowest percentage in Stanley compared to the highest in Cartier/SFX.
- All districts were significantly lower than the Manitoba average with the exception of Taché, Grey, and Cartier/SFX which were not significantly different.

### Geographic Disparity

- The prevalence of mood and anxiety disorders in the highest district of Grey was 2.3 times higher than the prevalence in the lowest district of Stanley.

**Table 35. Mood & Anxiety Disorders in Southern Health-Santé Sud, 2010/11- 2014/15**

Age- and sex-adjusted percentage of adults (aged 18+ years) diagnosed with disorder in five-year time period

	Count	Percentage	
<b>Manitoba</b>	<b>228,982</b>	<b>23.2</b>	
<b>SH-SS</b>	<b>23,814</b>	<b>17.7</b>	<b>L</b>
<b>Zone 4</b>			
Hanover	1,248	14.5	L
Rural East	462	14.6	L
Steinbach	2,776	18.2	L
Ste. Anne/ La Broquerie	1,431	18.3	L
Niverville/Ritchot	1,662	21.0	L
Taché	1,445	21.5	
<b>Zone 3</b>			
St. Pierre/ De Salaberry	462	13.7	L
Red River South	554	15.8	L
Carman	798	17.9	L
Morris	704	18.5	L
Macdonald	985	18.8	L
Grey	656	22.3	
<b>Zone 2</b>			
Stanley	387	10.0	L
Altona	1,025	14.9	L
Roland/Thompson	239	15.1	L
Morden	1,079	15.3	L
Winkler	1,595	15.4	L
Lorne/Louise/Pembina	983	18.0	L
<b>Zone 1</b>			
North Norfolk	378	11.9	L
Seven Regions	597	13.9	L
Rural Portage	817	15.9	L
City of Portage	2,247	18.7	L
Cartier/SFX	1,284	23.3	

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP Mental Illness Among Adult Manitobans 2018

## Dementia Prevalence

### Definition

The percentage of residents, aged 55 and older, diagnosed with dementia for a five-year time period.

### Why is this indicator important?

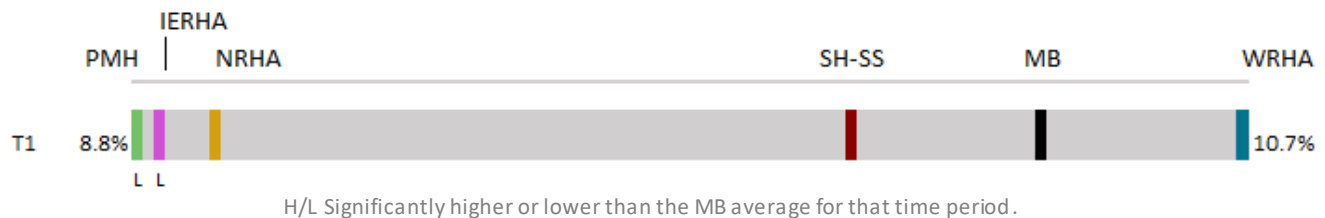
Dementia refers to symptoms and signs associated with a progressive deterioration of cognitive functions that affects many Canadians' daily activities.<sup>xxiv</sup> Prevalence estimates are useful to better understand the burden of this disease in the community.

### Provincial Key Findings

- ▶ **Figure 27** shows there were 34,912 Manitobans diagnosed with dementia.
- ▶ The percentage was significantly lower than the provincial average in Prairie Mountain Health and Interlake-Eastern RHA.
- ▶ **Income:** The dementia prevalence increased in areas of lower income.<sup>xxv</sup>

**Figure 27. Prevalence of Dementia among Adults by RHA, 2010/11 - 2014/15 (T1)**

Age- and sex-adjusted percentage of adults (aged 55+ years) diagnosed with disorder in five-year time period



	PMH		IERHA		NRHA		SH-SS		MB		WRHA	
T1 COUNT	5,073		2,785		565		4,191		34,912		20,952	
T1 RATE	8.8%	L	8.9%	L	8.9%		10.0%		10.3%		10.7%	

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## Regional Key Findings

### SH-SS Level

- Table 36 shows a total of 4,191 residents aged 55 years and older lived with a diagnosis of dementia in the region.

### Zone Level

- Zone level data not available.

### District Level

- Dementia prevalence varied across districts from the lowest in St. Pierre/De Salaberry to the highest in Winkler.
- Rural East, St. Pierre/De Salaberry, and Cartier/SFX were significantly lower than the provincial average, while the percentages were significantly higher in Winkler and city of Portage.

### Geographic Disparity

- Geographic disparity calculations showed that the prevalence of dementia in the highest district of Winkler was 1.9 times higher than the prevalence in the lowest district of St. Pierre/De Salaberry.

**Table 36. Dementia Prevalence in Southern Health-Santé Sud, 2010/11-2014/15**

Age- and sex-adjusted percentage of adults (aged 55+ years) diagnosed with disorder in five-year time period

	Count	Percentage	
<b>Manitoba</b>	<b>34,912</b>	<b>10.3</b>	
<b>SH-SS</b>	<b>4,191</b>	<b>10.0</b>	
<b>Zone 4</b>			
Rural East	102	7.5	L
Taché	70	8.1	
Hanover	147	8.2	
Steinbach	422	9.6	
Ste. Anne/La Broquerie	211	9.6	
Niverville/Ritchot	175	12.2	
<b>Zone 2</b>			
St. Pierre/De Salaberry	76	6.98	L
Macdonald	74	8.3	
Red River South	111	9.5	
Morris	134	10.3	
Grey	133	10.6	
Carman	260	11.7	
<b>Zone 3</b>			
Stanley	34	7.2	
Roland/Thompson	42	7.8	
Lorne/Louise/Pembina	242	9.6	
Altona	217	9.7	
Morden	314	11.1	
Winkler	445	12.9	H
<b>Zone 1</b>			
Cartier/SFX	77	7.04	L
Rural Portage	99	7.9	
North Norfolk	83	8.0	
Seven Regions	149	10.4	
City of Portage	574	12.6	H

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP Mental Illness Among Adult Manitobans 2018

## Antidepressant Prescription

### Definition

The percentage of residents with a physician diagnosis of depression, plus a new prescription for antidepressants filled within two weeks, and who had at least the recommended follow-up of three subsequent physician visits within four months, for a five-year time period.

### Why is this indicator important?

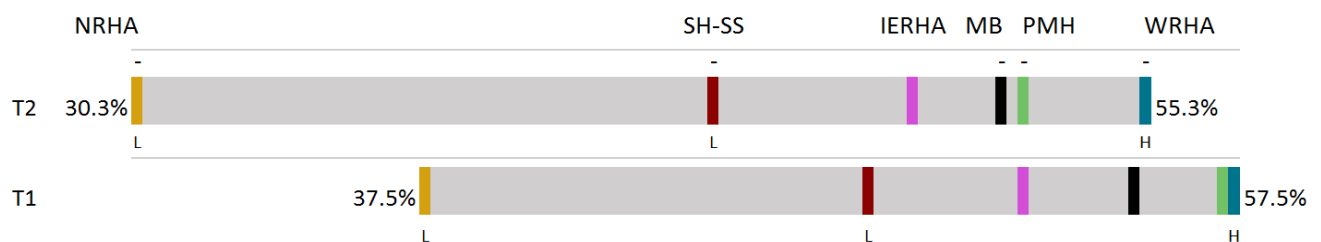
Regular follow-up after initial diagnosis of depression is essential to track patient response to antidepressant medication and modify treatment if necessary. Antidepressants may not have a clinical effect for some time after initiation and patients with major depression are at risk for suicide. Antidepressant prescription follow-up is a quality of care indicator and important part of a treatment regime.

### Provincial Key Findings

- Figure 28 shows 13,717 Manitoba residents with antidepressant prescription follow-up in the current time period.
- The percentage decreased significantly over time in Manitoba and all regions, except Interlake-Eastern RHA.
- In both time periods, Northern Health Region and Southern Health-Santé Sud were significantly lower than the provincial average, while Winnipeg RHA was significantly higher.
- Income:** In rural areas, antidepressant prescription follow-up was significantly higher among residents of higher income areas in both time periods.<sup>xxvi</sup>

**Figure 28. Antidepressant Prescription Follow-up by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Crude percentage of new depression patients who received 3+ physician visits in four months



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	NRHA		SH-SS		IERHA		MB		PMH		WRHA	
T2 COUNT	350		1,676		1,413		13,717		2,140		8,092	
T2 RATE	30.3%	L-	44.7%	L-	49.7%		51.7%	-	52.4%	-	55.3%	H-
T1 RATE	37.5%	L	48.5%	L	52.3%		54.9%		57.2%		57.5%	H

## Regional Key Findings

### SH-SS Level

- Table 35 shows a total of 1,676 regional residents with antidepressant prescription follow-up in the current time period; representing 44.7%.
- The rate in the region was significantly lower than the provincial average and decreased significantly over time.

### Zone Level

- Rates were similar across zones.
- Zones 1, 3, and 4 were significantly lower than the Manitoba average in the current time period.
- Zone 3 decreased significantly over time.

### District Level

- There was considerable variation across districts from the lowest in Seven Regions to the highest in Macdonald in the current time period.
- In the current time period, Winkler was significantly lower than the provincial average and decreased significantly over time.

**Table 37. Antidepressant Prescription Follow-up in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Crude percentage of new depression patients who received 3+ physician visits in four months

	T2			T1	
	Count	%		%	
<b>Manitoba</b>	<b>13,717</b>	<b>51.7</b>	-	<b>54.9</b>	
<b>SH-SS</b>	<b>1,676</b>	<b>44.7</b>	L-	<b>48.5</b>	L
<b>Zone 4</b>	<b>688</b>	<b>46.0</b>	L	<b>48.4</b>	L
Taché	106	53.0		55.8	
Niverville/Ritchot	125	48.1		59.2	
Hanover	123	47.5		39.1	L
Rural East	37	47.4		36.9	
Steinbach	199	42.4		46.2	
Ste. Anne/La Broquerie	98	42.4		50.2	
<b>Zone 2</b>	<b>263</b>	<b>48.5</b>		<b>45.6</b>	L
Macdonald	83	62.4		48.3	
Grey	27	57.4		57.8	
Morris	50	47.6		50.5	
Carman	32	42.1		45.1	
Red River South	37	41.1		36.8	
St. Pierre/De Salaberry	34	37.4		35.4	
<b>Zone 3</b>	<b>367</b>	<b>42.1</b>	L-	<b>50.9</b>	
Morden	81	46.6		50.0	
Lorne/Louise/Pembina	76	45.8		47.8	
Stanley	31	44.9		52.7	
Altona	84	42.4		51.5	
Winkler	84	36.1	L-	52.5	
Roland/Thompson	11	34.4		50.0	
<b>Zone 1</b>	<b>358</b>	<b>42.8</b>	L	<b>47.9</b>	L
Cartier/SFX	69	46.9		58.9	
Rural Portage	73	45.3		44.5	
North Norfolk	26	43.3		35.6	
City of Portage	157	42.3		50.1	
Seven Regions	33	33.7		34.8	

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

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## Geographic Disparity

- ▶ The geographic disparity between districts increased over time, meaning the gap widened between the districts with the lowest and highest antidepressant prescription follow-up.

SH-SS Geographic Disparity Ratio		
	T1	1.7x
	T2	1.9x
	Change	0.2 ↑

T1: 2007/08-2011/12, T2: 2012/13-2016/17



## Suicide Rates

### Definition

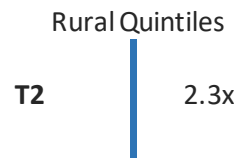
The average annual rate for which suicide was listed as the cause of death, per 1,000 population, aged 10 and older, for a five-year time period.

### Why is this indicator important?

High rates of suicide are an important indication of the mental health of communities and underlying trauma. Suicide rates are one indication of the effectiveness of mental health prevention and promotion initiatives.

### Provincial Key Findings

- ▶ **Figure 29** shows there were 993 suicides in Manitoba in the current time period.
- ▶ In both time periods, Northern Health Region had significantly higher suicide rates than the provincial average, while Southern Health-Santé Sud was significantly lower.
- ▶ The suicide rates in the province and all regions have not significantly changed over time.
- ▶ **Income:** Income and suicide rates were strongly related in both time periods.<sup>xxvii</sup> Suicide rates among residents in low income areas were 2.3 times higher than the highest income areas in the current time period.

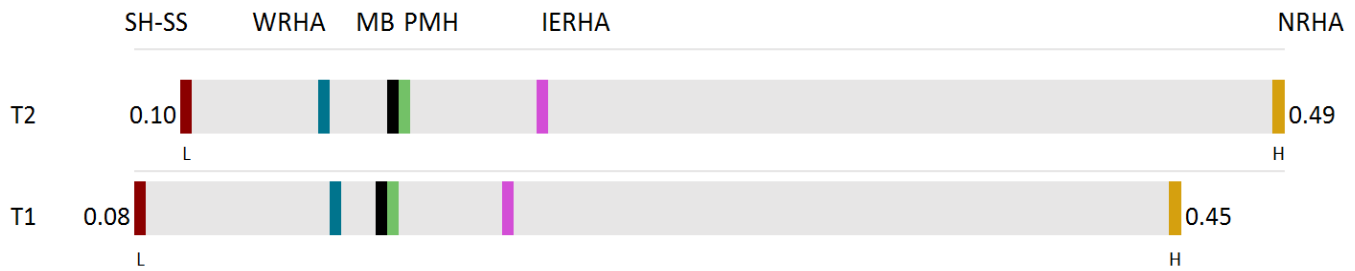


T2: 2012-2016

*Suicide rates  
strongly related  
to income*

**Figure 29. Average Annual Suicide Rates by RHA, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex- adjusted per 1,000 residents (age 10+ years)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	83	503	993	136	118	139
T2 RATE	0.10	L	0.15	0.17	0.23	0.49
T1 RATE	0.08	L	0.15	0.17	0.21	0.45

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## Regional Key Findings

### SH-SS Level

- Table 38 shows there were a total of 83 suicides in the region in the current time period.
- In both time periods, the region had the lowest suicide rate in the province and significantly lower than the provincial average.
- Suicide rates remained relatively stable over time.

### Zone Level

- Suicide rates were similar across zones.

### District Level

- District level data not available due to small sample sizes.

**Table 38. Suicide Rates in Southern Health-Santé Sud, 2007-2011 (T1) and 2012-2016 (T2)**

Age- and sex- adjusted per 1,000 residents (age 10+ years)

	T2		T1
	Count	Rate	Rate
Manitoba	993	0.17	0.17
SH-SS	83	0.10	L
Zone 4	28	0.10	0.10
Zone 3	21	0.10	0.05
Zone 2	11	0.09	0.06
Zone 1	23	0.13	0.09

H/L Significantly higher or lower than the MB average for that time period.

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# Musculoskeletal

## Arthritis Prevalence

### Definition

The percentage of residents, aged 19 and older, diagnosed with arthritis (rheumatoid or osteoarthritis), for a two-year time period.

### Why is this indicator important?

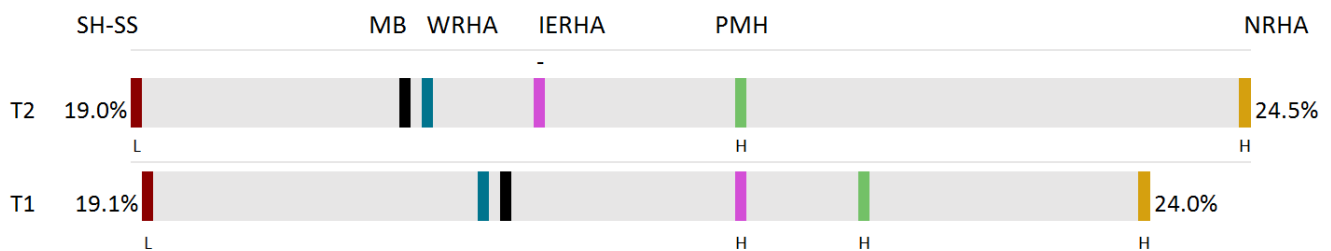
Arthritis is a chronic condition that seriously impacts quality of life, functional independence, and physical ability of many Manitobans.

### Provincial Key Findings

- ▶ **Figure 30** shows there were 213,054 Manitobans with arthritis in the current time period.
- ▶ In both time periods, arthritis prevalence in Southern Health-Santé Sud was significantly lower than the provincial average, while Prairie Mountain Health and Northern Health Region were significantly higher.
- ▶ The prevalence of arthritis decreased significantly over time in Interlake-Eastern RHA.
- ▶ **Income:** Income and arthritis prevalence were significantly related in both time periods, with arthritis prevalence higher among residents of lower income areas.<sup>xxviii</sup>

**Figure 30. Prevalence of Arthritis by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Age- and sex-adjusted percent of residents (aged 19+ years) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	MB	WRHA	IERHA	PMH	NRHA
T2 COUNT	26,121	213,054	124,475	21,994	29,921	10,304
T2 RATE	19.0% L	20.4%	20.4%	21.0% -	22.0% H	24.5% H
T1 RATE	19.1% L	20.9%	20.8%	22.0% H	22.6% H	24.0% H

## Regional Key Findings

### SH-SS Level

- Table 39 shows 26,121 regional residents with a diagnosis of arthritis in the current time period.
- In both time periods, the region had significantly lower prevalence compared to Manitoba.

### Zone Level

- Percentages were similar across zones with Zones 2 and 3 significantly lower than the province.

### District Level

- Arthritis prevalence varied across districts from the lowest in Stanley to the highest in Rural Portage, in the current time period.
- In both time periods, the prevalence was significantly lower than the provincial average in Hanover, Morris, Stanley, Winkler, and North Norfolk.
- Over time, arthritis prevalence decreased significantly in Carman and Stanley, while it increased significantly in Steinbach, St. Pierre/De Salaberry, and Seven Regions.

**Table 39. Arthritis Prevalence in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**


Age- and sex-adjusted percent of residents (aged 19+ years) diagnosed with disorder

	T2		T1			T2		T1			
	Count	Percentage	Percentage	Percentage		Count	Percentage	Percentage			
<b>Manitoba</b>	<b>213,054</b>	<b>20.4</b>		<b>20.9</b>		<b>SH-SS</b>	<b>26,121</b>	<b>19.0</b>	<b>L</b>	<b>19.1</b>	<b>L</b>
<b>Zone 4</b>	<b>9,502</b>	<b>19.6</b>		<b>19.1</b>	<b>L</b>	<b>Zone 2</b>	<b>4,084</b>	<b>18.2</b>	<b>L</b>	<b>19.0</b>	<b>L</b>
Hanover	1,474	18.2	L	16.8	L	Morris	589	16.3	L	16.6	L
Taché	1,126	19.3		20.6		St. Pierre/ De Salaberry	597	18.1	+	15.9	L
Niverville/ Ritchot	1,593	19.7		19.5		Carman	861	18.4	-	21.2	
Steinbach	2,781	20.0	+	18.8	L	Macdonald	967	18.9		20.6	
Rural East	724	20.5		19.5		Grey	405	19.1		19.0	
Ste. Anne/ La Broquerie	1,804	20.7		20.8		Red River South	665	20.0		19.8	
<b>Zone 3</b>	<b>6,631</b>	<b>18.8</b>	<b>L</b>	<b>19.4</b>	<b>L</b>	<b>Zone 1</b>	<b>5,904</b>	<b>20.1</b>		<b>19.8</b>	
Stanley	425	13.9	L-	16.1	L	North Norfolk	498	16.4	L	16.2	L
Winkler	1,840	17.8	L	19.0	L	Cartier/SFX	1,068	19.8		20.4	
Roland/ Thompson	278	19.3		18.1		Seven Regions	812	20.7	+	18.1	L
Altona	1,247	19.7		20.8		City of Portage	2,463	20.9		21.1	
Morden	1,508	20.3		19.4		Rural Portage	1,063	21.6		20.9	
Lorne/Louise/ Pembina	1,333	20.7		21.3							

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
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## Geographic Disparity

- ▶ The geographic disparity between the districts increased, meaning the gap between the districts with the lowest and highest arthritis prevalence widened.

SH-SS Geographic Disparity Ratio		
	T1	1.3x
	T2	1.6x
	Change	0.3 ↑

T1: 2010/11-2011/12, T2: 2015/16-2016/17



## Osteoporosis Prevalence

### Definition

The percentage of residents, aged 50 and older, diagnosed with osteoporosis, for a one-year time period.

### Why is this indicator important?

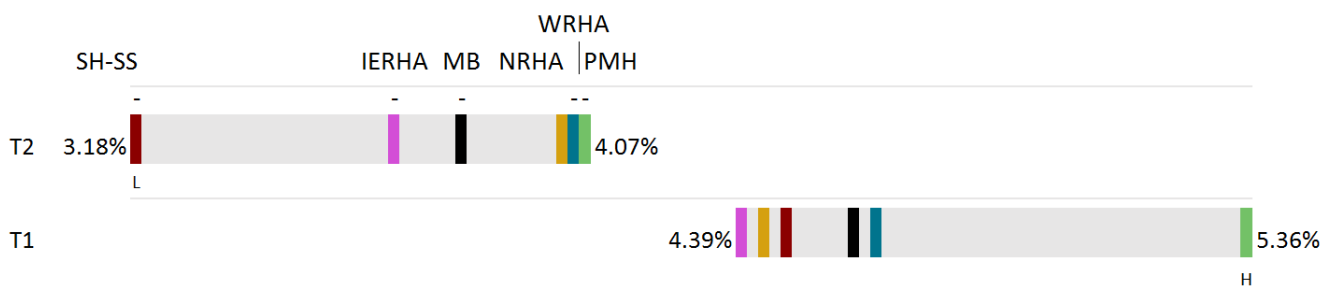
Osteoporosis is a disease that leads to a reduction in bone density and causes bones to become weak and more likely to fracture. The most common injuries associated with osteoporosis are fractures of the wrist, spine and hip. Osteoporosis prevalence provides valuable insight for planning patient education regarding preventive measures and treatment options to reduce fractures and hospitalizations, and improve quality of life.

### Provincial Key Findings

- ▶ **Figure 31** shows 17,104 Manitobans with osteoporosis in the current time period.
- ▶ The prevalence of osteoporosis decreased significantly in Manitoba and in all regions, except Northern Health Region.
- ▶ In the current time period, osteoporosis prevalence was significantly lower than the provincial average in Southern Health-Santé Sud.
- ▶ **Income:** Income and osteoporosis prevalence were not significantly related.<sup>xxix</sup>

**Figure 31. Prevalence of Osteoporosis by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percentage of residents (aged 50+ years) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	IERHA	MB	NRHA	WRHA	PMH
T2 COUNT	1,635	1,626	17,104	450	10,721	2,600
T2 RATE	3.18% L-	3.70% -	3.83% -	4.03%	4.05% -	4.07% -
T1 RATE	4.48%	4.39%	4.60%	4.42%	4.65%	5.36% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 40 shows a total of 1,635 regional residents with osteoporosis in the current time period.
- As previously mentioned, the region had significantly lower prevalence than the province in the current time period.
- Osteoporosis prevalence in the region decreased significantly over time.

### Zone Level

- Percentages were similar across all zones and decreased significantly over time.
- Zone 1 was significantly lower than the Manitoba average in the both time periods.

### District Level

- The prevalence was relatively similar across districts.
- City of Portage was significantly lower than the Manitoba average in the current time period.
- Over time, the prevalence decreased significantly in Red River South, St. Pierre/De Salaberry, Carman, Winkler, Lorne/Louise/Pembina, Morden, Seven Regions, and city of Portage.

**Table 40. Osteoporosis Prevalence in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percentage of residents (aged 50+ years) diagnosed with disorder

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>17,104</b>	<b>3.8</b>	-	<b>4.6</b>	
<b>SH-SS</b>	<b>1,635</b>	<b>3.2</b>	L-	<b>4.5</b>	
<b>Zone 4</b>	<b>529</b>	<b>3.2</b>	-	<b>4.1</b>	
Ste. Anne/La Broquerie	92	2.9		3.7	
Steinbach	156	2.9		3.9	
Hanover	75	3.1		4.0	
Rural East	54	3.6		4.1	
Niverville/Ritchot	93	3.8		5.5	
Taché	59	4.2		4.2	
<b>Zone 2</b>	<b>313</b>	<b>3.4</b>	-	<b>5.1</b>	
Morris	40	2.8		3.4	
Red River South	38	3.0	-	4.9	
St. Pierre/ De Salaberry	42	3.0	-	5.9	
Grey	30	3.5		5.4	
Carman	94	3.7	-	5.9	
Macdonald	69	4.4		5.5	
<b>Zone 3</b>	<b>483</b>	<b>3.3</b>	-	<b>5.4</b>	
Winkler	106	2.6	-	5.5	
Altona	70	2.8		3.8	
Stanley	23	3.1		4.3	
Roland/Thompson	21	3.9		6.9	
Lorne/Louise/ Pembina	128	4.0	-	6.3	
Morden	135	4.1	-	5.9	
<b>Zone 1</b>	<b>310</b>	<b>2.7</b>	L-	<b>3.6</b>	L
Rural Portage	40	2.4		2.7	
Seven Regions	36	2.6	-	4.3	
City of Portage	136	2.6	L-	3.7	
North Norfolk	35	2.9		3.8	
Cartier/SFX	63	3.4		3.9	

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

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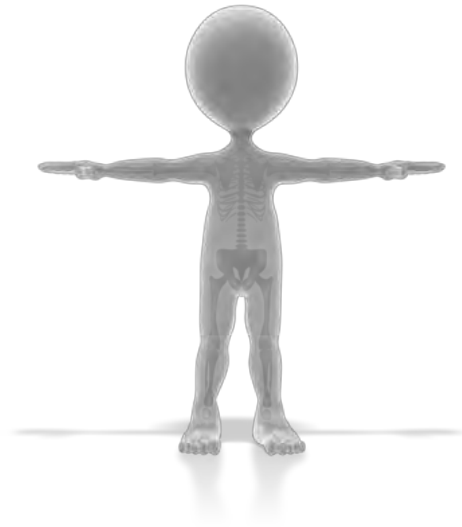


## Geographic Disparity

- ▶ The geographic disparity between the districts decreased, meaning the gap between the districts with the lowest and highest osteoporosis prevalence reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.6x
	T2	1.8x
	Change	-0.8 ↓

T1: 2011-2012, T2: 2016-2017



# Renal

## Chronic Kidney Disease Prevalence

### Definition

The percentage of residents, aged 18 years and older, diagnosed with chronic kidney disease.

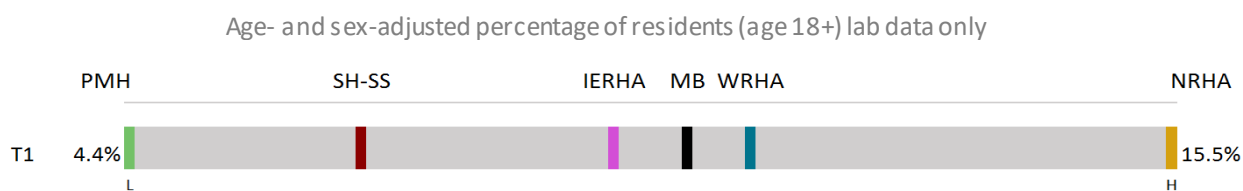
### Why is this indicator important?

Chronic kidney disease (CKD) often starts slowly and develops without symptoms over a number of years, sometimes leading to serious damage before diagnosis. Understanding how many residents live with chronic kidney disease and where they live helps with program planning and resource allocation. Appropriate care can slow the progression of the disease, reduce complications and enhance quality of life.

### Provincial/Regional Key Findings

- ▶ **Figure 32** shows 37,534 adult Manitobans were living with chronic kidney disease in Manitoba, which represents about 10% of the adult population.
- ▶ Percentages in Prairie Mountain Health and Soutehrn Health-Santé Sud were significantly lower than the provincial prevalence, while Northern Health Region was significantly higher.
- ▶ **Age and Sex:** The disease prevalence was 7 times higher among residents aged 65 years and older compared to those aged 18 to 44 years. The prevalence was 1.5 times higher in females than in males.
- ▶ **Income:** The lowest income areas had a higher prevalence of CKD compared to the highest income areas.<sup>xxx</sup>
- ▶ In Southern Health-Santé Sud, a total of 1,964 adults were diagnosed with CKD laboratory data in the current time period; representing about 7% of residents 18 years and older.

**Figure 32. Prevalence of Adults with Chronic Kidney Disease by RHA, 2012 (T1)**



H/L Significantly higher or lower than the MB average for that time period.

	PMH	SH-SS	IERHA	MB	WRHA	NRHA
T1 COUNT	730	1,964	3,262	37,534	30,084	1,491
T1 RATE	4.4%   L	6.9%   L	9.6%	10.4%	11.0%	15.5%   H

MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

## End Stage Kidney Disease

### Definition

The number of residents with end stage kidney disease (ESKD) per 1,000 population. ESKD is based on a patient's use of renal replacement therapies (dialysis or kidney transplant).

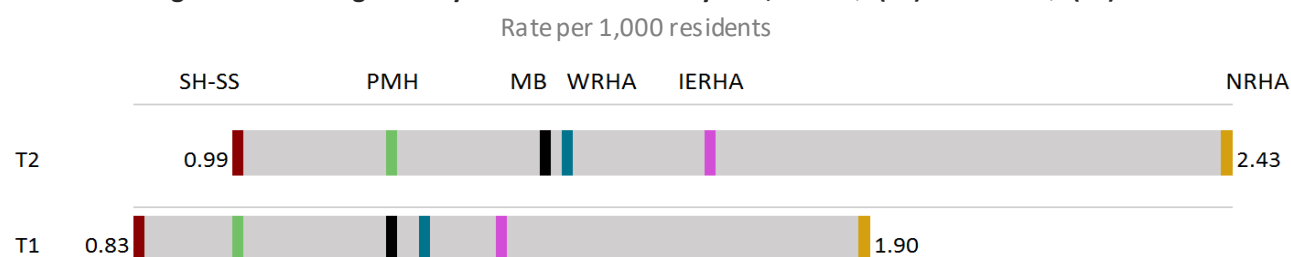
### Why is this indicator important?

ESKD is increasing in Canada, and Manitoba has the highest rate of kidney disease in the country. ESKD is a serious chronic condition because of associated high mortality, negative impact on quality of life and high cost of kidney transplants. Diabetes is the most common cause of ESKD, so it is important to address comorbidities in prevention education, treatment options and resource allocation.

### Provincial/Regional Key Findings

- ▶ **Figure 33** shows 1,833 Manitoba residents living with ESKD in the current time period.
- ▶ Rates increased significantly in all regions from 2004 to 2012.
- ▶ In Manitoba in 2012, 1,236 adults with ESKD had dialysis and 597 had a kidney transplant.
- ▶ **Age and Sex:** The crude rates were higher for residents aged 65 years and older and for males.
- ▶ **Income:** There were higher rates in the lowest income areas compared to the highest income areas.<sup>xxxi</sup>
- ▶ In Southern Health-Santé Sud, 180 residents lived with ESKD in the current time period.
- ▶ The regional rate was significantly lower than the provincial average.
- ▶ In the region in 2012, 104 of adults received dialysis and 77 received a kidney transplant.

**Figure 33. End Stage Kidney Disease Prevalence by RHA, 2007 Q2 (T1) and 2012 Q2 (T2)**



	SH-SS	PMH	MB	WRHA	IERHA	NRHA
T2 COUNT	180	200	1,833	1,066	206	181
T2 RATE	0.99	1.21	1.45	1.47	1.68	2.43
T1 RATE	0.83	1.00	1.22	1.26	1.37	1.90

MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

## Observed and Projected End Stage Kidney Disease

### Definition

The observed (2004-2012 (Q2)) and projected (2012 (Q3)-2024) number of residents living with ESKD, by treatment type.

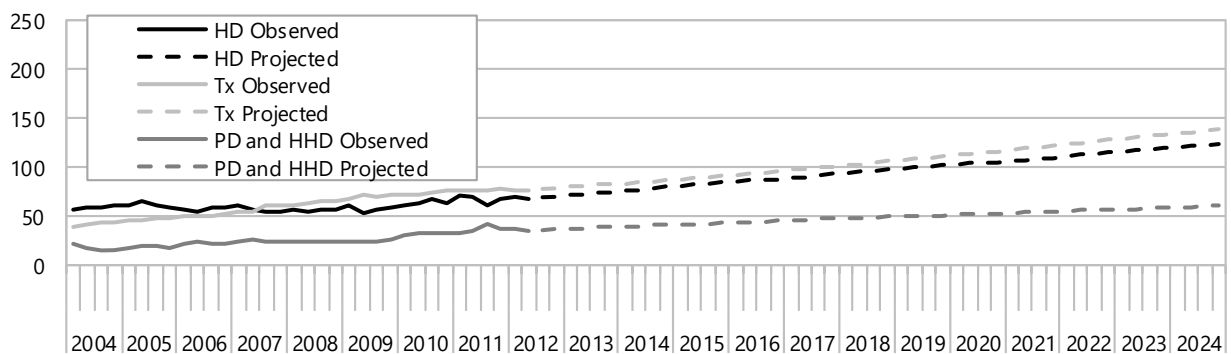
### Why is this indicator important?

Manitoba has the highest prevalence of ESKD in Canada and current projections predict a significant increase by 2024. ESKD projections help to plan prevention initiatives, deliver coordinated health care services and allocate appropriate resources to meet the service demand.

### Provincial/Regional Key Findings

- ▶ The number of Manitobans living with ESKD is projected to increase by 68% by 2024, and almost 3,100 residents will require renal replacement therapy (RRT).
- ▶ In the province, the predicted annual increase in residents receiving RRT is 4.3% for centre-based hemodialysis, 3.2% for home-based dialysis (peritoneal and home hemodialysis), and 4.5% for kidney transplants.
- ▶ The most significant increases are projected in Southern Health-Santé Sud and Northern Health Region.
- ▶ Approximately half of all patients requiring RRT in Manitoba live with diabetes. By 2024, the number of residents with diabetes requiring hemodialysis is projected to increase by 89% compared to 35% among residents without diabetes.
- ▶ **Age:** The number of residents aged 65 years and older on hemodialysis is projected to increase by 89% by 2024 with more modest increases in the younger population.
- ▶ **Figure 34** shows that Southern Health-Santé Sud increases are projected for all RRTs from 2012 to 2024. RRTs are projected to increase by 82% for centre-based hemodialysis (68 to 124), 80% for kidney transplants (77 to 139), and 74% for home-based dialysis (35 to 61). These increases are considerably higher than for the Manitoba population.<sup>xxxii</sup>

**Figure 34. Observed and Projected Number of Patients with End Stage Kidney Disease by Treatment Type in Southern Health-Santé Sud, 2004-2024**



HD: Centre-based hemodialysis, Tx: Kidney transplant, PD and HHD: Peritoneal dialysis and home hemodialysis.

## A CLOSER LOOK...

Southern Health-Santé Sud is projected to experience the greatest increase in people on each type of renal therapy, possibly because of its aging population. An aging population and an increasing prevalence of diabetes are two key factors in the increasing and expected growth in the number of Manitobans who develop chronic kidney disease. Maintaining diabetes prevalence at its current state may contribute to the most significant decrease in renal replacement therapy and centre-based hemodialysis.<sup>xxxiii</sup>

Previous research shows that end stage kidney disease rates are higher and increasing among Indigenous people compared to non-Indigenous people in Canada.<sup>xxxiv</sup> Large health disparities noted across Manitoba, particularly among First Nations communities, suggest the need for targeted and early prevention and intervention efforts.<sup>xxxv</sup>

# Respiratory

## Total Respiratory Morbidity Prevalence

### Definition

The percentage of residents diagnosed with a respiratory disease (asthma, chronic or acute bronchitis, emphysema, or chronic airway obstruction).

### Why is this indicator important?

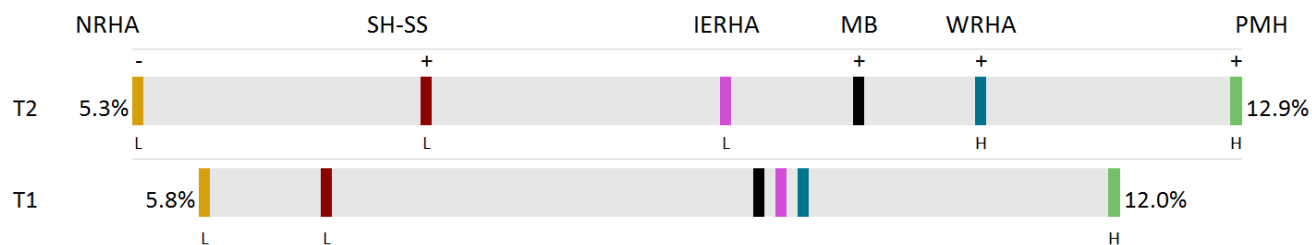
Total respiratory morbidity (TRM) is a good overall measure of the proportion of the population that experiences breathing issues. Understanding prevalence helps to plan prevention efforts, coordinate services between community and acute care, and provide effective supports to enhance quality of life.

### Provincial Key Findings

- ▶ **Figure 35** shows 143,607 Manitoba residents with respiratory disease in the current time period.
- ▶ In the current time period, every health region was significantly different than the provincial average, with Northern Health Region, Southern Health-Santé Sud, and Interlake-Eastern RHA significantly lower and Winnipeg RHA and Prairie Mountain Health significantly higher.
- ▶ Over time, percentages in the province, Southern Health-Santé Sud, Winnipeg RHA, and Prairie Mountain Health increased significantly, while Northern Health Region decreased significantly.
- ▶ **Income:** Income and total respiratory morbidity were only significantly related in the first time period.<sup>xxxvi</sup>

**Figure 35. Prevalence of Total Respiratory Morbidity by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	MB	WRHA	PMH
T2 COUNT	3,829	14,679	12,632	143,607	88,789	23,371
T2 RATE	5.3% L-	7.3% L+	9.4% L	10.3% +	11.1% H+	12.9% H+
T1 RATE	5.8% L	6.6% L	9.8%	9.6%	9.9%	12.0% H

## Regional Key Findings

### SH-SS Level

- ▶ **Table 41** shows a total of 14,679 regional residents with a respiratory disease in the current time period.
- ▶ In both time periods, the prevalence in the region was significantly lower than the Manitoba average; however, it increased significantly over time.

### Zone Level

- ▶ The prevalence was relatively similar across zones.
- ▶ The prevalence across all zones was significantly lower than the Manitoba average.
- ▶ Zones 2, 3, and 4 increased significantly over time.

### District Level

- ▶ The prevalence varied across districts from the lowest in Stanley to the highest in Macdonald in the current time period.
- ▶ The rates were significantly lower than the provincial average in the majority of districts in the current time period, except Red River South, Macdonald, and Cartier/SFX which were not significantly different.
- ▶ Over time, Carman, Seven Regions, and city of Portage experienced a significant decrease. On the other hand, districts that experienced a significant increase included Hanover, Steinbach, Rural East, Ste. Anne/La Broquerie, Taché, St. Pierre/De Salaberry, Morris, Red River South, Macdonald, Winkler, Altona, Morden, and Cartier/SFX.




**Table 41. Total Respiratory Morbidity Prevalence Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**  
Age- and sex-adjusted percentage of residents (all ages) diagnosed with disorder

	T2			T1	
	Count	%		%	
<b>Manitoba</b>	<b>143,607</b>	<b>10.3</b>	<b>+</b>	<b>9.6</b>	
<b>SH-SS</b>	<b>14,679</b>	<b>7.3</b>	<b>L+</b>	<b>6.6</b>	<b>L</b>
<b>Zone 4</b>	<b>5,674</b>	<b>7.6</b>	<b>L+</b>	<b>6.3</b>	<b>L</b>
Hanover	881	6.1	L+	4.8	L
Steinbach	1,552	7.3	L+	5.3	L
Rural East	338	7.5	L+	5.6	L
Ste. Anne/ La Broquerie	1,046	7.6	L+	6.8	L
Niverville/Ritchot	1,025	7.8	L	7.6	L
Taché	832	8.6	L+	7.1	L
<b>Zone 2</b>	<b>2,419</b>	<b>7.6</b>	<b>L+</b>	<b>6.7</b>	<b>L</b>
Carman	311	5.0	L-	6.2	L
St. Pierre/ De Salaberry	308	6.6	L+	5.0	L
Morris	379	7.0	L+	5.5	L
Grey	234	7.7	L	8.4	
Red River South	440	9.0	+	6.4	L
Macdonald	747	9.4	+	8.2	L
<b>Zone 3</b>	<b>3,097</b>	<b>5.8</b>	<b>L+</b>	<b>4.6</b>	<b>L</b>
Stanley	186	3.2	L	2.6	L
Winkler	772	4.5	L+	3.7	L
Roland/Thompson	112	5.1	L	5.0	L
Altona	647	6.4	L+	3.5	L
Morden	711	6.6	L+	5.6	L
Lorne/Louise/ Pembina	669	7.7	L	7.0	L
<b>Zone 1</b>	<b>3,489</b>	<b>8.1</b>	<b>L</b>	<b>8.7</b>	<b>L</b>
North Norfolk	289	6.3	L	5.7	L
Seven Regions	423	6.6	L-	9.0	
Rural Portage	636	8.2	L	8.5	
City of Portage	1,389	8.4	L-	9.3	
Cartier/SFX	752	9.2	+	8.1	L

H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period  
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest total respiratory morbidity prevalence reduced.

SH-SS Geographic Disparity Ratio		
	T1	3.6x
	T2	2.9x
	Change	-0.7 ↓

T1: 2011-2012, T2: 2016-2017



## Asthma Prevalence for Children

### Definition

The percentage of residents, aged 5 to 19 years, diagnosed with asthma, over a two-year time period.

### Why is this indicator important?

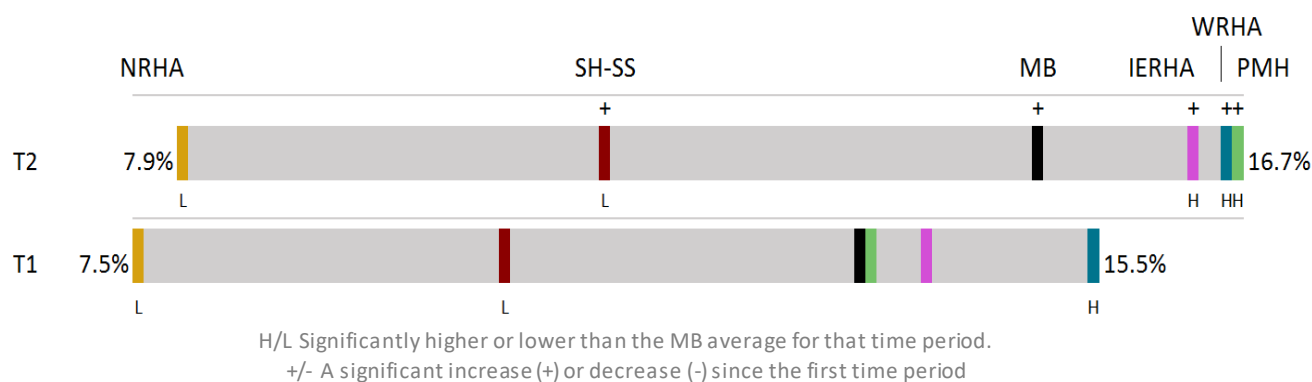
Asthma is the most common chronic disease in children.<sup>xxxvii</sup> Timely and appropriate education and treatment help children and their families living with asthma learn how to manage the condition effectively.

### Provincial Key Findings

- ▶ **Figure 36** shows there were 38,424 children with asthma in the current time period in Manitoba.
- ▶ The prevalence increased significantly over time in Manitoba and all regions except Northern Health Region.
- ▶ In both time periods, rates in Northern Health Region and Southern Health-Santé Sud were significantly lower than the provincial average. While rates were significantly higher in Winnipeg in both time periods and in Prairie Mountain Health and Interlake-Eastern RHA in the current time period.
- ▶ Asthma prevalence was higher for urban than rural areas.
- ▶ **Income:** Income and child asthma prevalence were significantly associated in both time periods. Unlike many other health outcomes, residents in higher income areas had higher rates of asthma prevalence.<sup>xxxviii</sup>

**Figure 36. Child Asthma Prevalence by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Age- and sex-adjusted average annual percentage of residents (aged 5-19 years)



	NRHA	SH-SS	MB	IERHA	WRHA	PMH
T2 COUNT	1,680	5,085	38,424	3,738	22,037	5,325
T2 RATE	7.9% L	11.4% L+	15.1% +	16.4% H+	16.7% H+	16.7% H+
T1 RATE	7.5% L	10.6% L	13.6%	14.1%	15.5% H	13.7%

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 42 shows 5,085 regional children with an asthma diagnosis in the current time period.
- In both time periods, the prevalence was significantly lower than the Manitoba average; however, it increased significantly over time.

### Zone Level

- The prevalence was relatively similar across zones.
- The prevalence was significantly lower than the provincial average in Zones 1, 3, and 4.
- Over time, child asthma prevalence increased significantly in Zone 3.

### District Level

- There was variation across districts with the lowest rate in Stanley and the highest in Macdonald.
- Rates were significantly lower than the province in Hanover, Ste. Anne/La Broquerie, Steinbach, Carman, Stanley, Winkler, Roland/Thompson, Altona, Lorne/Louise/Pembina, Seven Regions, and North Norfolk.
- There was a significant increase in Steinbach, Rural East, Morris, Winkler, Altona, and Morden.

**Table 42. Child Asthma Prevalence Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**


Age- and sex-adjusted average annual percentage of residents (aged 5-19 years)

	T2		T1			T2		T1			
	Count	%		%		Count	%		%		
<b>Manitoba</b>	<b>38,424</b>	<b>15.1</b>	<b>+</b>	<b>13.6</b>		<b>5,085</b>	<b>11.4</b>	<b>L+</b>	<b>10.6</b>	<b>L</b>	
<b>Zone 4</b>	<b>2,003</b>	<b>11.6</b>	<b>L</b>	<b>11.1</b>	<b>L</b>	<b>865</b>	<b>13.8</b>		<b>12.6</b>		
Hanover	330	8.3	L	8.8	L	Carman	115	10.1	L	10.5	
Ste. Anne/La Broquerie	312	10.3	L	11.3		Morris	133	12.0	+	8.6	L
Steinbach	517	11.5	L+	9.9	L	St. Pierre/De Salaberry	103	12.4		12.5	
Rural East	83	12.4	+	8.7	L	Grey	82	14.9		14.3	
Taché	337	14.8		13.6		Red River South	151	15.2		12.5	
Niverville/Ritchot	424	15.0		14.9		Macdonald	281	16.8		16.3	
<b>Zone 3</b>	<b>1,165</b>	<b>9.3</b>	<b>L+</b>	<b>7.5</b>	<b>L</b>	<b>Zone 1</b>	<b>1,052</b>	<b>11.9</b>	<b>L</b>	<b>12.6</b>	
Stanley	110	6.2	L	5.7	L	Seven Regions	128	8.0	L	9.9	L
Winkler	343	8.0	L+	6.3	L	North Norfolk	89	9.3	L	8.6	L
Roland/Thompson	40	8.4	L	7.1	L	Rural Portage	215	12.5		13.6	
Altona	239	9.8	L+	7.8	L	Cartier/SFX	220	13.4		13.5	
Lorne/Louise/Pembina	166	10.9	L	9.6	L	City of Portage	400	13.5		14.4	
Morden	267	13.3	+	10.4	L						

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest child asthma prevalence reduced.

SH-SS Geographic Disparity Ratio		
	T1	2.9x
	T2	2.7x
	Change	-0.2 ↓

T1: 2010/11-2011/12, T2: 2015/16-2016/17



## Asthma Care: Controller Medication Use

### Definition

The percentage of residents, all ages, diagnosed with asthma receiving medication recommended for long-term control of their disease.

### Why is this indicator important?

Asthma controller medications control the inflammation in the airways and prevent asthma symptoms.<sup>xxxix</sup>

### Provincial Key Findings

- ▶ **Figure 37** shows there were 25,107 Manitobans diagnosed with asthma receiving medication in the current time period.
- ▶ The rates of asthma care remained stable over time in Manitoba and in all regions.
- ▶ **Income:** Income and asthma care were not significantly related but trends suggested that residents of higher income areas had higher rates of recommended asthma care.<sup>xl</sup>

**Figure 37. Asthma Care by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Crude percentage of residents with asthma receiving at least one prescription for inhaled steroids



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	PMH	SH-SS	IERHA	MB	NRHA	WRHA
T2 COUNT	3,218	2,716	2,652	25,107	1,503	14,813
T2 RATE	61.7%	62.3%	63.5%	64.3%	65.2%	65.3%
T1 RATE	62.5%	65.2%	63.3%	64.1%	66.9%	64.1%

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 43 shows a total of 2,716 regional residents diagnosed with asthma who received at least one prescription for inhaled steroids in the current time period.
- The percentage of recommended asthma care remained stable over time.

### Zone Level

- Asthma care varied slightly between zones from the lowest in Zone 1 to the highest in Zone 4 in the current time period.
- Over time, asthma care decreased significantly in Zone 3.

### District Level

- Asthma controller medication use varied between districts from the lowest in Roland/Thompson to the highest in Niverville/Ritchot in the current time period.

**Table 43. Asthma Care by RHA in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Crude percentage of residents with asthma receiving at least one prescription for inhaled steroids

	T2		T1			T2		T1		
	Count	%	Count	%		Count	%	Count	%	
<b>Manitoba</b>	<b>25,107</b>	<b>64.3</b>		<b>64.1</b>		<b>SH-SS</b>	<b>2,716</b>	<b>62.3</b>		<b>65.2</b>
<b>Zone 4</b>	<b>965</b>	<b>65.8</b>		<b>66.5</b>		<b>Zone 2</b>	<b>504</b>	<b>64.7</b>		<b>69.6</b>
Rural East	69	56.6		62.0		St. Pierre/ De Salaberry	62	54.9		59.6
Taché	123	58.6		64.0		Morris	78	61.4		71.3
Ste. Anne/ La Broquerie	189	64.9		64.6		Macdonald	105	66.0		70.4
Steinbach	258	67.5		69.9		Red River South	123	67.6		63.5
Hanover	143	69.4		68.2		Carman	80	68.4		75.9
Niverville/Ritchot	183	71.8		66.3		Grey	56	69.1		83.1
<b>Zone 3</b>	<b>516</b>	<b>59.8</b>	<b>-</b>	<b>68.1</b>		<b>Zone 1</b>	<b>731</b>	<b>58.4</b>		<b>59.8</b>
Roland/Thompson	20	45.5		72.7		Seven Regions	95	52.5		52.2
Altona	67	51.9		67.2		City of Portage	297	55.8		55.8
Winkler	130	58.3		68.0		Rural Portage	180	60.8		64.9
Stanley	35	59.3		59.6		Cartier/SFX	109	65.3		69.4
Lorne/Louise/ Pembina	121	62.4		70.6		North Norfolk	50	66.7		66.3
Morden	143	66.8		67.9						

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity between the districts with the lowest and highest percentage of recommended asthma care did not change over time.

SH-SS Geographic Disparity Ratio		
	T1	1.6x
	T2	1.6x
	Change	0.0

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## A CLOSER LOOK...

A growing and aging population has meant that more people are living with chronic diseases. Even though prevalence may not change, it is important to note that a disease may impact more people within the region.

Programs and services in Southern Health-Santé Sud are available for residents living with chronic conditions. The Chronic Disease Education Team (CDET) offers comprehensive patient education through group sessions including Diabetes Health, Heart Health, and Gut Health. Patients find it very easy to follow, learn, and feel they are well taken care of. In one instance, a client offered their gratitude to the CDET team for their support in managing her diabetes as she learned insulin management following her new diagnosis of diabetes when she was admitted to hospital with a myocardial infarction.

In addition, Get Better Together is a 6-week workshop that can help support clients to live better with any chronic condition. The sessions cover topics from controlling pain, managing frustration or fatigue, healthy eating, and more. One participant said “It’s a safe place to talk about things with each other, while you are looking to improve your own health.”



# Sexually Transmitted Infections

## Chlamydia Rate

### Definition

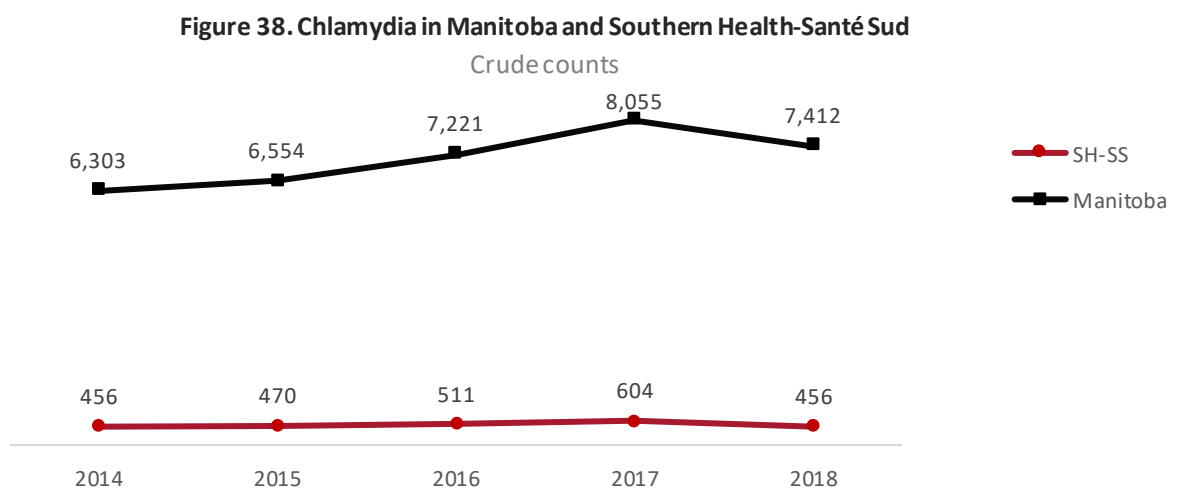
The number of reported cases of chlamydia, per 100,000 population.

### Why is this indicator important?

Chlamydia is the most common bacterial sexually transmitted infection (STI). Symptoms usually begin two to six weeks after infection but are often overlooked. Left untreated, chlamydia can lead to painful health problems and infertility. It can also be transmitted from mother to child during childbirth. Timely access to health information, and early diagnosis and treatment, will help prevent many complications associated with this infection.

### Provincial/Regional Key Findings

- ▶ **Figure 38** shows that in 2018, a total of 7,412 chlamydia infections were reported in Manitoba which corresponds to a rate of 544.8 cases per 100,000 population.
- ▶ In Manitoba, chlamydia infections increased from 483 to 545 cases per 100,000 population over a five-year time period.
- ▶ **Age and Sex:** The incidence of chlamydia was much higher among females than males. The highest incidence was observed among those in the age groups 20-24 years, followed by 25-34 years.
- ▶ In 2018, the highest incidence rate was in Northern Health Region (2,216 per 100,000) compared to the lowest rate in Southern Health-Santé Sud (218 per 100,000).
- ▶ In Southern Health-Santé Sud, there was a total of 456 chlamydia cases in 2018. The number of cases has remained relatively stable over time.



epiVIEW is under active development and validation of the numbers is ongoing  
Data presented were extracted August 8, 2019  
MHSAL IMA 2019

## Gonorrhea Rate

### Definition

The number of reported cases of gonorrhea, per 100,000 population.

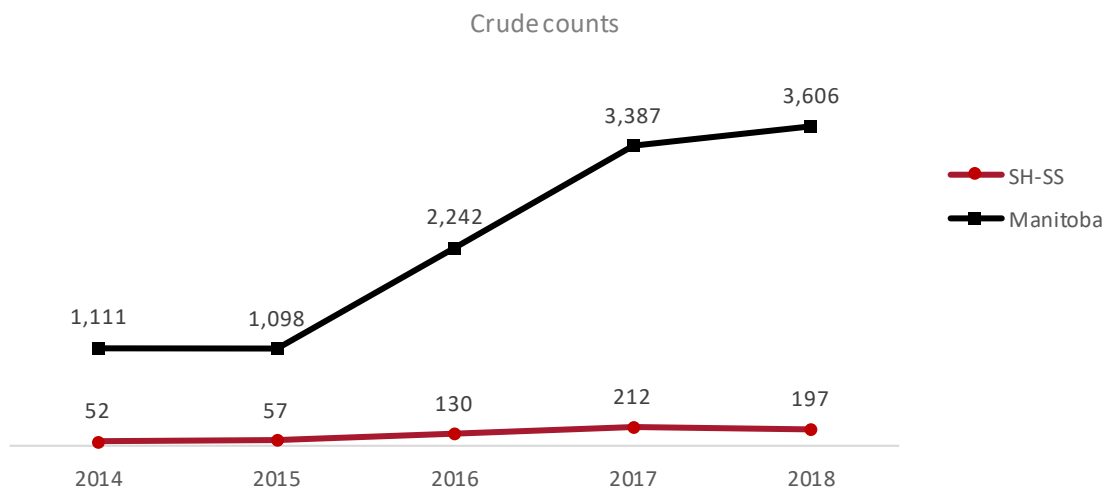
### Why is this indicator important?

Gonorrhea, commonly referred to as the ‘Clap’, is on the rise in Canada and can cause very serious complications when left untreated. Gonorrhea can be cured with the right medication; however it is becoming increasingly resistant to antibiotics. Gonorrhea can lead to pelvic inflammatory disease in women and infertility in both women and men. Understanding gonorrhea incidence helps to plan public awareness campaigns to promote safer sex and regular screening. Timely access to early diagnosis and treatment will prevent many complications associated with this infection.

### Provincial/Regional Key Findings

- ▶ **Figure 39** shows that in 2018, a total of 3,606 gonorrhea infections were reported in Manitoba, which corresponds to a rate of 265 cases per 100,000 population.
- ▶ From 2015 to 2018, gonorrhea cases increased considerably from 83.2 per 100,000 to 265 cases per 100,000.
- ▶ **Age and Sex:** The incidence of gonorrhea was higher among females compared to males, especially among the 25 to 34 age group.
- ▶ In 2018, the highest incidence rate was in Northern Health Region (1,180 per 100,000) compared to the lowest rate in Southern Health-Santé Sud (93 per 100,000).
- ▶ In Southern Health-Santé Sud, there was a total of 197 gonorrhea cases in 2018. The number of cases increased over time.

**Figure 39. Gonorrhea in Manitoba and Southern Health-Santé Sud**



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 Data presented were extracted August 8, 2019  
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## Human Immunodeficiency Virus Rate

### Definition

The proportion of new Human immunodeficiency virus (HIV) reported cases, per 100,000 population.

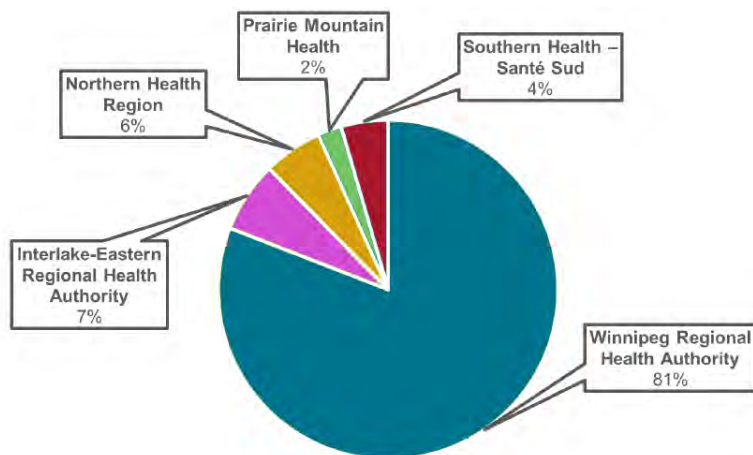
### Why is this indicator important?

HIV is a retro virus that attacks the immune system and can cause a number of serious health problems and opportunistic infections. It is most commonly transmitted through sexual activity and sharing of needles and drug equipment. Timely access to early diagnosis and treatment helps people with HIV live longer, healthier lives, and reduces the risk of HIV transmission. HIV is a measure of equity because vulnerable populations and those living in poverty are disproportionately at risk. Understanding HIV incidence helps to plan public awareness campaigns to promote safer sex and drug use, and allocate resources to support appropriate access to testing and treatment.

### Provincial/Regional Key Findings

- ▶ In Manitoba, there were 89 new positive HIV cases reported in 2017. This is a decrease of 20 cases compared to the 109 new HIV cases in 2016. Of the 89 new positive HIV cases, 64 were diagnosed in Manitoba, and 25 were introduced into Manitoba from other provinces or countries.
- ▶ The Manitoba rate was roughly equivalent to the national rate (6.6 cases per 100,000 compared to 6.5 cases per 100,000, respectively).
- ▶ **Age and Sex:** The incidence was higher in males compared to females. The average age of diagnosis was 39 years for males compared to 36 years for females.
- ▶ **Figure 40** shows that the vast majority of new HIV cases were reported in Winnipeg RHA.
- ▶ In Southern Health-Santé Sud, there were 4 new cases of HIV in 2017.

**Figure 40. Proportion of New HIV Cases by RHA, 2017**



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To learn more about HIV in Manitoba visit:

<https://www.gov.mb.ca/health/publichealth/surveillance/hiv/aids/docs/de-c2017.pdf>

## Syphilis Rate

### Definition

The number of reported cases of syphilis, per 100,000 population.

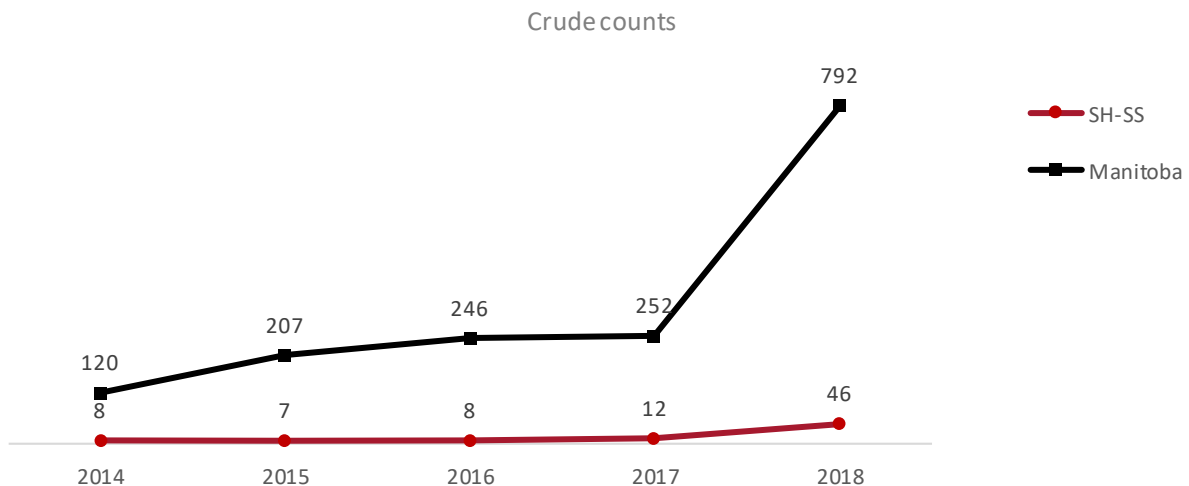
### Why is this indicator important?

Syphilis is a bacterial infection, usually spread by sexual contact. It can have very serious complications if left untreated, but it is simple to cure with the right treatment. Manitoba has seen clustered outbreaks of this infection in recent years. Timely access to health information, and early diagnosis and treatment, will help prevent many complications associated with this infection.

### Provincial/Regional Key Findings

- ▶ **Figure 41** shows that in 2018, a total of 792 syphilis infections were reported in Manitoba, corresponding to a rate of 58 cases per 100,000 population.
- ▶ The rate of reported syphilis infection increased dramatically in the province from 9 to 58 cases per 100,000 population over time.
- ▶ The Winnipeg RHA experienced unprecedented spike in syphilis infection rates in 2018.
- ▶ The Northern Health Region had considerably higher incidence rate compared to other health regions.
- ▶ **Age and Sex:** The majority of infectious syphilis cases were reported in males, with the highest incidence in the age group of 20-29 years old.
- ▶ In Southern Health-Santé Sud, there were 46 syphilis infections in 2018. There was almost a six-fold increase over time.

**Figure 41. Syphilis in Manitoba and Southern Health-Santé Sud**



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 Data presented were extracted August 8, 2019  
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## A CLOSER LOOK...

Sexually transmitted infections (STIs) are the most common infectious diseases of public health importance in North America. They are infections that are spread primarily through person-to-person sexual contact. The second major route of transmission for some STIs is blood-to-blood contact, such as when sharing needles among injection drug users. They can also be transmitted from mother to child during pregnancy and childbirth.<sup>xli</sup>

There has been an ongoing syphilis outbreak in Manitoba since 2014.<sup>xlii</sup> While rates remain high in males, the rising number of pregnant women diagnosed with syphilis is especially concerning. Lack of prenatal care and substance use have been identified as factors in these situations.<sup>xliii</sup> Pregnant women can pass on the infection to their unborn baby during pregnancy or childbirth. This is called congenital syphilis and may lead to birth defects or stillbirth. Congenital syphilis can be prevented through safer sex practices and regular prenatal testing. Syphilis is treatable with antibiotics. Follow-up testing is also important.

In response to the outbreak, a Regional Sexually Transmitted Blood Borne Infections (STBBI) Outbreak Response Committee was created in 2019. This is an interdisciplinary team with representation from First Nations communities and organizations including Shared Health–Diagnostic Services and many Southern Health-Santé Sud departments, including Public Health-Healthy Living, Primary Health Care, Acute Care, Staff Development and Infection Prevention and Control, and Mental Health. The goals of the committee include:

- ▶ Building system capacity related to harm reduction, STBBIs, and substance use
- ▶ Increasing contact with prenatal populations
- ▶ Increasing access to STBBI testing and treatment and harm reduction supplies
- ▶ Building community capacity and understanding

- <sup>i</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
- <sup>ii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
- <sup>iii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
- <sup>iv</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
- <sup>v</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
- <sup>vi</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019. Vi Sidebotham P, Pearson G. Responding to and learning from childhood deaths. *BMJ* 2009;338:b531.
- <sup>vii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2019.
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**CHAPTER 4:  
HOW WELL DOES OUR HEALTH  
SYSTEM MEET THE POPULATION'S  
NEEDS?**

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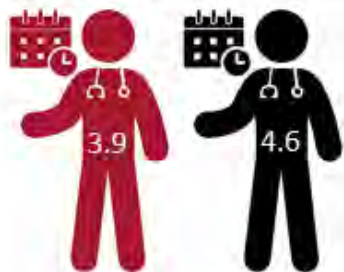


# At a Glance: How Well Does our Health System Meet the Population's Needs?

● SH-SS

● Manitoba

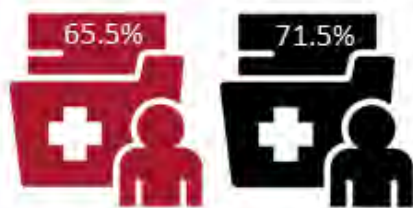
Physician and Nurse Practitioner Visits  
average # of visits per resident



Ambulatory Consultation  
percentage of residents referred



Majority of Care  
% with 50%+ visits from same provider



Benzodiazepine Overprescribing  
% community dwelling older adults 75+



Wait Time for Minor Health Problem  
% 3 days or less



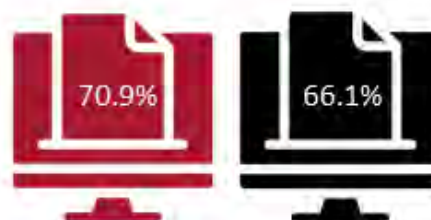
Use of Hospitals  
% with 1+ admission



Caesarean Section  
% in-hospital births



Patient Experience Survey  
% very good overall hospital experience



# Chapter 4 Key Findings

Southern Health-Santé Sud does not significantly distinguish itself from the other regions in how well our population’s needs are met within the health care system, and there was some notable variation within the region. Zone 4 consistently experienced some of the best outcomes while Zone 1 had some of the poorest outcomes. Among indicators with available data, the disparity gap between districts improved in about half and widened in the other half.

## Primary Health Care

- 77% of residents had at least one visit with a primary care provider
- Less than 50% received primary care within their home district
- Residents receiving majority of care from same provider lower than provincial average and decreased significantly over time
- Hospitalization rate for ambulatory care sensitive conditions decreased significantly over time
- Benzodiazepine overprescribing in the community decreased significantly over time in the region and all zones
- 84% reported having access to a regular health provider
- The most frequent reported location for minor health problems was physician’s office and walk-in clinics
- Residents more likely to report waiting over 2 weeks for minor health problems than provincial average
- 45% reported excellent or very good coordination between providers



## Acute Care

- Hospitalizations decreased significantly over time
- Residents were hospitalized almost 60% within the region
- Over 85% of SH-SS hospital patients are from the region
- Hospital readmissions decreased significantly over time
- About 1 in 5 in-hospital births were by C-section and the percentage increased significantly over time
- Over 70% reported very good overall hospital experience

## Home Care and Personal Care Home

- 5,276 residents received home care services and the prevalence was lower than provincial average
- 12% aged 75+ in personal care homes (PCH)
- Median wait times for PCH admission from the hospital about 16 weeks, higher than provincial average, and increasing significantly over time
- Median wait times for PCH admission from the community about 26 weeks and higher than the provincial average
- Benzodiazepine overprescribing among PCH residents higher than provincial average

# Primary Health Care

## Use of Physicians and Nurse Practitioners

### Definition

The percentage of residents who received at least one ambulatory visit in a fiscal year. Ambulatory visits include all contact with physicians and nurse practitioners, except during inpatient hospitalization and emergency department visits.

### Why is this indicator important?

Regular examinations and consultations are important to help identify risk factors and problems before they become serious. When conditions are identified early, treatments are usually much more effective. Understanding how many people see a physician or nurse practitioner may help to identify access barriers to services and reflects the effectiveness of the primary care system.

### Provincial Key Findings

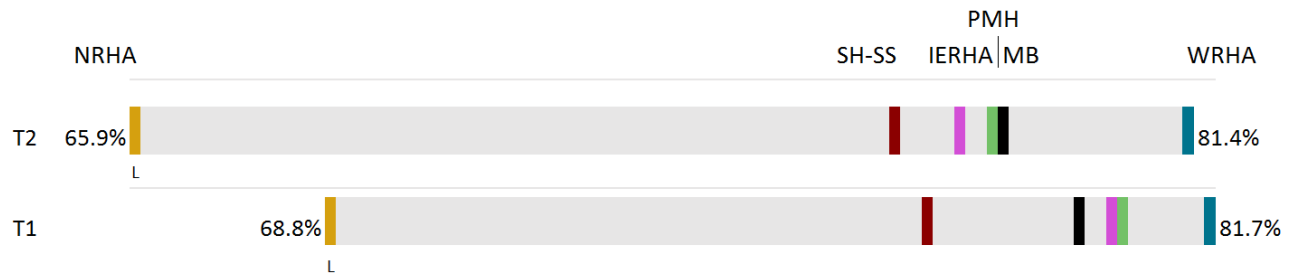
- ▶ **Figure 1** shows 78.7% of Manitobans saw a physician at least once in the current time period.
- ▶ The percentages remained stable over time with a slight not statistically significant decrease. This trend was observed across all regions.
- ▶ **Income:** Use of physicians and nurse practitioners was significantly related to income in rural areas in the current time period. The percentage of residents with at least one visit was lower for residents of lower income areas.<sup>i</sup>



*Use of physicians and nurse practitioners significantly related to income*

**Figure 1. Use of Physicians and Nurse Practitioners by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex- adjusted percent of residents with at least one ambulatory visit per year



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	PMH	MB	WRHA
T2 COUNT	47,460	149,798	101,307	135,770	1,072,087	636,040
T2 RATE	65.9% L	77.2%	78.1%	78.6%	78.7%	81.4% (+)
T1 RATE	68.8% L	77.6%	80.2%	80.3%	79.9%	81.7%

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 1 shows a total of 149,798 residents received at least one visit with a physician or nurse practitioner in the region in the most current time period.
- The regional percentage remained stable over time.

### Zone Level

- The percentages were relatively similar across zones.

### District Level

- There was about a 15% difference between the lowest percentage in Stanley and the highest in Macdonald.
- Districts with percentages significantly lower than the provincial average included Hanover, Rural East, Morris, Carman, Roland/Thompson, and Stanley.
- The percentage increased significantly over time in St. Pierre/De Salaberry, while it decreased significantly in Carman.

**Table 1. Use of Physicians and Nurse Practitioners Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percentage of residents with at least one ambulatory visit per year

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>1,072,087</b>	<b>78.7</b>		<b>79.9</b>	
<b>SH-SS</b>	<b>149,798</b>	<b>77.2</b>		<b>77.6</b>	
<b>Zone 4</b>	<b>56,023</b>	<b>76.6</b>		<b>75.4</b>	
Taché	7,486	79.0		77.7	
Niverville/ Ritchot	10,059	78.4		79.6	
Steinbach	15,696	76.1		72.8	L
Ste. Anne/ La Broquerie	9,760	74.1		75.5	
Hanover	10,093	71.6	L	69.5	L
Rural East	2,929	68.7	L	64.6	L
<b>Zone 2</b>	<b>23,024</b>	<b>75.5</b>		<b>77.2</b>	
Macdonald	6,174	80.2		81.4	
Grey	2,188	74.9		77.8	
St. Pierre/ De Salaberry	3,294	73.1	+	64.5	L
Red River South	3,408	72.6		74.8	
Morris	3,722	71.8	L	73.9	
Carman	4,238	70.6	L-	78.7	
<b>Zone 3</b>	<b>38,647</b>	<b>75.3</b>		<b>76.9</b>	
Lorne/Louise/ Pembina	6,447	77.9		78.1	
Morden	7,860	76.6		76.7	
Winkler	12,097	73.1		75.2	
Altona	7,024	73.0		74.5	
Roland/ Thompson	1,508	70.2	L	74.8	
Stanley	3,711	65.5	L	68.4	L
<b>Zone 1</b>	<b>32,104</b>	<b>78.5</b>		<b>77.8</b>	
Cartier/SFX	6,288	79.3		81.6	
City of Portage	12,317	78.7		78.3	
Seven Regions	4,648	75.3		73.1	
Rural Portage	5,676	75.3		76.3	
North Norfolk	3,175	72.2		69.4	L


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

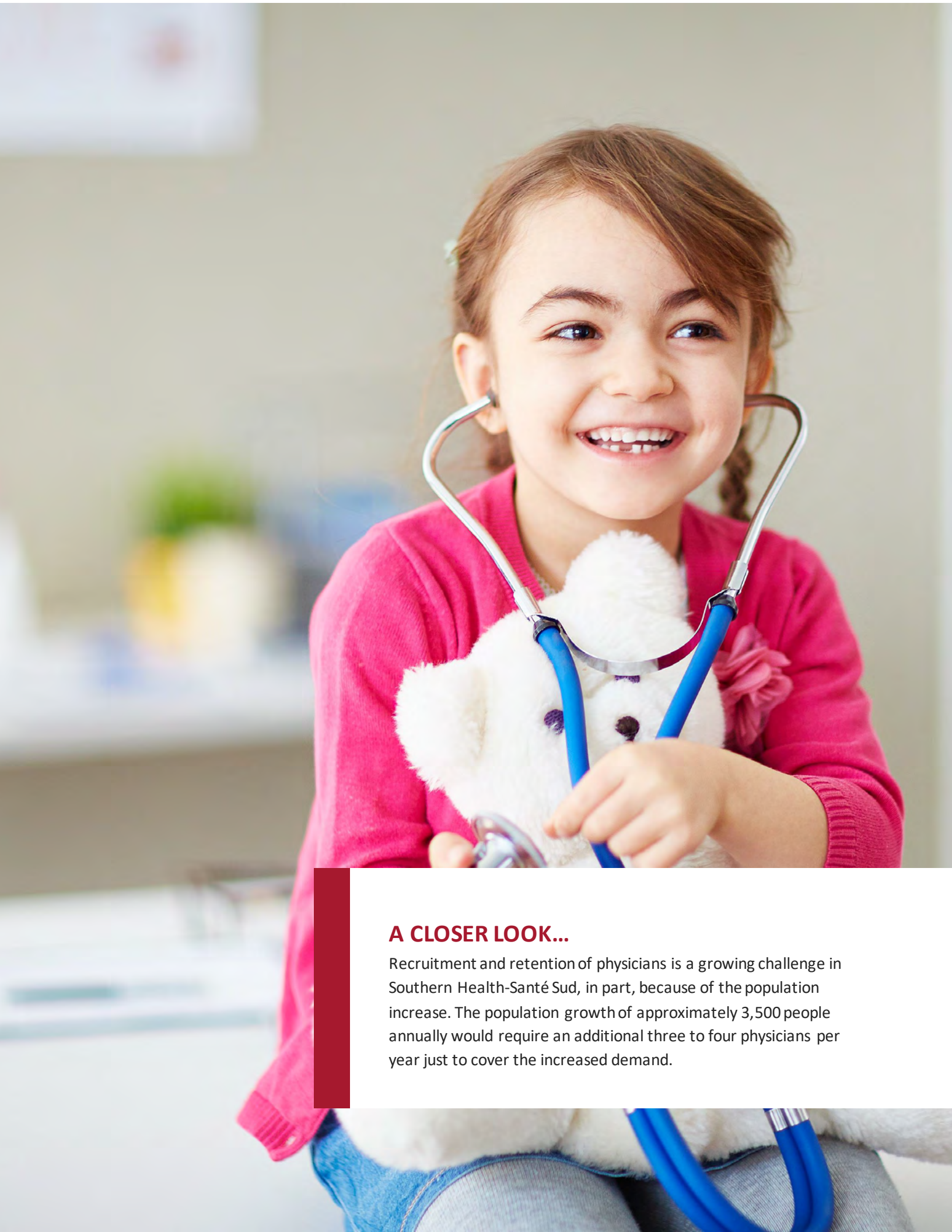
MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts decreased slightly over time, meaning the gap between the districts with the lowest and highest percentage residents with a minimum of one physician or nurse practitioner visit reduced.

SH-SS Geographic Disparity Ratio	
	T1 1.3x
	T2 1.2x
	Change -0.1 ↓

T1: 2011-2012, T2: 2016-2017



### **A CLOSER LOOK...**

Recruitment and retention of physicians is a growing challenge in Southern Health-Santé Sud, in part, because of the population increase. The population growth of approximately 3,500 people annually would require an additional three to four physicians per year just to cover the increased demand.

## Ambulatory Visits to Physicians and Nurse Practitioners

### Definition

The average number of visits to physicians and nurse practitioners per resident in a given year. Ambulatory visits include all contact with physicians and nurse practitioners: office visits, walk-in clinics, home visits, personal care home visits, visits to outpatient departments and prenatal visits. Exclusions include inpatient hospitalization and emergency department visits.

### Why is this indicator important?

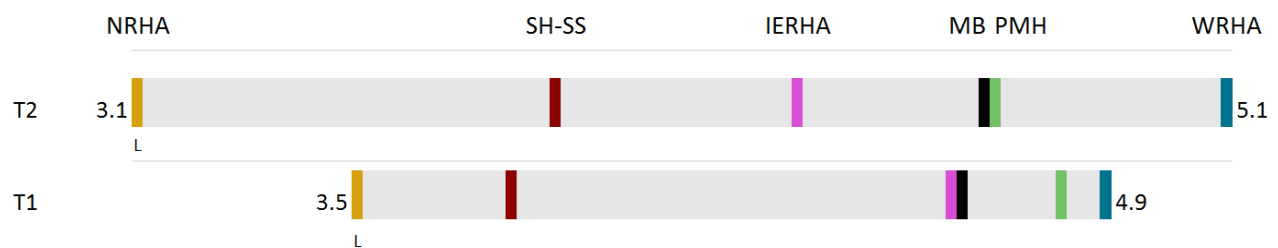
Ambulatory visit rates may reveal issues related to access to primary care, and how well the healthcare system manages ongoing care for patients outside the hospital setting, especially for individuals living with a chronic condition(s). This measure provides insight into whether a region is moving towards a primary care centred model that focuses on appropriate resources and supports in the community setting and reduces unnecessary hospitalizations.

### Provincial Key Findings

- ▶ **Figure 2** shows there was an average of about 5 visits to physicians and nurse practitioners per Manitoba resident in the current time period.
- ▶ The rate of visits in Manitoba remained stable over time and only Northern Health Region was significantly lower compared to the province in both time periods.
- ▶ The most frequent causes for physician visits in Manitoba in the current time period were: circulatory (10.1%), health status and contact (9.5%), respiratory (9.4%), mental illness (9.4%), and musculoskeletal (8.7%). These varied across the regions.

**Figure 2. Ambulatory Visit Rates by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rate of ambulatory visits to all physicians per resident



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	MB	PMH	WRHA
T2 COUNT	208,501	747,581	573,982	6,299,699	821,641	3,936,761
T2 RATE	3.1 L	3.9	4.3	4.6	4.6	5.1
T1 RATE	3.5 L	3.8	4.6	4.6	4.8	4.9

## Regional Key Findings

### SH-SS Level

- ▶ **Table 2** shows a total of 747,581 physician and nurse practitioner visits in the region in the current time period.
- ▶ The average number of visits remained stable over time, with about four visits per resident.
- ▶ **Table 3** shows the leading causes of physician and nurse practitioner visits in the region including circulatory disorders, musculoskeletal conditions, ill-defined conditions, respiratory disorders, and health status and contact. The rankings have remained relatively similar over time with one notable exception: circulatory disorder visits increased while health status and contact visits decreased. The leading causes in the region were similar to Manitoba with the exception of ill-defined conditions being within the top 5 causes in the region, rather than mental illness and some differences in ranking.

### Zone Level

- ▶ **Table 2** shows that the average number of visits were similar across zones.
- ▶ Zone 2 had a rate significantly lower than Manitoba in the current time period.

### District Level

- ▶ The average number of visits were similar across districts.
- ▶ Districts with rates significantly lower than Manitoba in the current time period included Hanover, St. Pierre/De Salaberry, Morris, Carman, Roland/Thompson, Stanley, and North Norfolk.
- ▶ Rates increased significantly over time in St. Pierre/De Salaberry, while they decreased significantly in Carman.





**Table 2. Ambulatory Visit Rates in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rate of a ambulatory visits to all physicians per resident

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>6,299,699</b>	<b>4.6</b>		<b>4.6</b>	
<b>Zone 4</b>	<b>278,015</b>	<b>3.9</b>		<b>3.7</b>	<b>L</b>
Niverville/Ritchot	52,661	4.3		4.6	
Taché	36,197	4.2		3.8	
Steinbach	80,816	4.0		3.5	L
Rural East	16,096	3.7		3.2	L
Ste. Anne/ La Broquerie	47,254	3.7		3.8	
Hanover	44,991	3.6	L	3.3	L
<b>Zone 3</b>	<b>191,158</b>	<b>3.8</b>		<b>3.8</b>	
Morden	41,495	4.0		3.9	
Lorne/Louise/ Pembina	34,459	4.0		4.4	
Altona	35,596	3.9		3.6	L
Winkler	57,318	3.7		3.8	
Roland/ Thompson	7,199	3.4	L	3.6	
Stanley	15,091	3.34	L	3.2	L
<b>SH-SS</b>	<b>747,581</b>	<b>3.9</b>		<b>3.8</b>	
<b>Zone 2</b>	<b>115,285</b>	<b>3.7</b>	<b>L</b>	<b>3.9</b>	
Macdonald	32,586	4.5		4.6	
Red River South	17,843	3.9		3.9	
Grey	10,980	3.7		4.0	
St. Pierre/ De Salaberry	15,671	3.5	L+	2.7	L
Morris	17,365	3.4	L	3.5	L
Carman	20,840	3.26	L-	4.4	
<b>Zone 1</b>	<b>163,123</b>	<b>4.0</b>		<b>3.8</b>	
Cartier/SFX	32,984	4.4		4.7	
City of Portage	65,035	4.1		3.9	
Seven Regions	22,722	3.8		3.5	L
Rural Portage	27,745	3.8		3.7	
North Norfolk	14,637	3.5	L	3.1	L

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

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**Table 3. Leading Causes of Ambulatory Visits in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Condition	T2		T1
	Count	Percentage	Percentage
Circulatory	71,594	9.56%	8.49%
Musculoskeletal	68,048	9.09%	9.28%
Ill-Defined Conditions	67,777	9.05%	9.17%
Respiratory	66,873	8.93%	8.48%
Health Status and Contact	66,850	8.93%	9.99%

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## Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest average of ambulatory physician visits reduced.

SH-SS Geographic Disparity Ratio		
	T1	1.8x
	T2	1.4x
	Change	-0.4 ↓

T1: 2011-2012, T2: 2016-2017

## A CLOSER LOOK...

A nurse practitioner is a registered nurse who has taken additional training and is able to work unsupervised at a higher level of practice, handling many primary care needs that, in the past, patients would have seen a physician for.

In the region, we have developed a successful model that allows our nurse practitioners to collaborate with physicians and to consult them on issues that fall outside of their scope of practice. As of 2018-2019, there were 21 nurse practitioners working in various locations across the region.

As of 2005, visits to nurse practitioners were also included in the medical claims data system. Because nurse practitioners and some physicians may be covered under alternate payment methods (e.g., salary), it is possible that these billings are under-reported, although they are encouraged to submit shadow billing claims. In previous Community Health Assessments, nurse practitioners were not included in the calculations. However, because these visits now comprise a small but growing proportion of visits (i.e., almost 2%),<sup>ii</sup> they have been added into the current Community Health Assessment.

## Location Visits to Physicians or Nurse Practitioner

### Definition

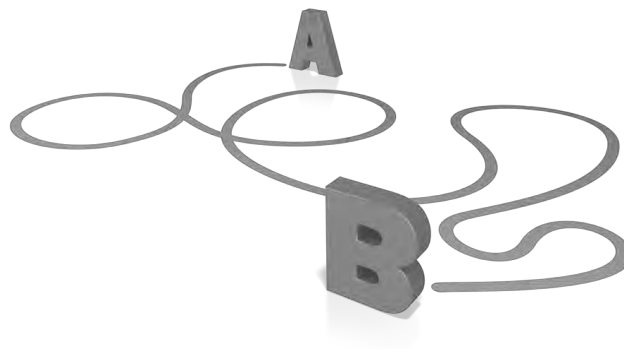
The percentage of visits by residents of each health region to general or family physicians or nurse practitioners: within the patient's health region district; elsewhere in their health region; in another health region or in Winnipeg.

### Why is this indicator important?

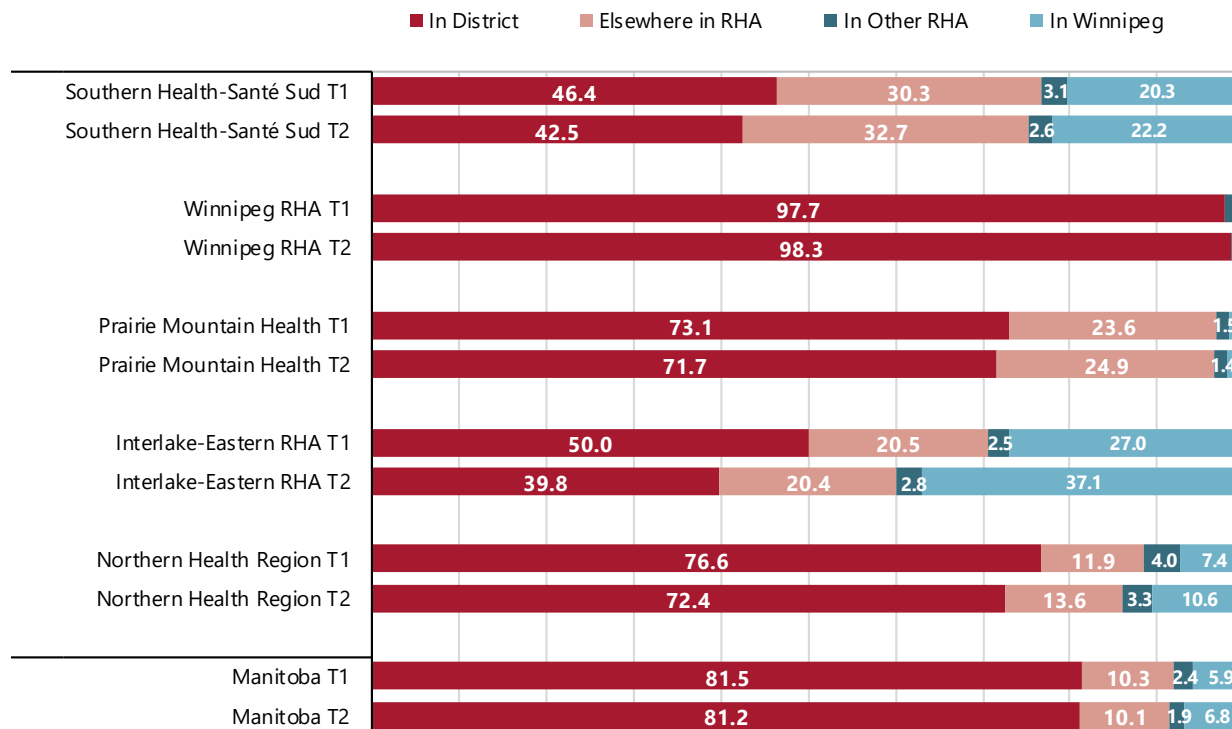
Where residents access primary care provides valuable insight regarding challenges related to availability and accessibility of services, which helps to plan and allocate resources appropriately.

### Provincial/Regional Key Findings

- ▶ **Figure 3** shows the location of visits to physicians or nurse practitioners in Manitoba was stable over time. More than 80% of all visits occurred in the district where the resident lived.
- ▶ The location of visits varied across all health regions. Residents in Winnipeg RHA received almost all of their visits within their home district. While residents in Southern Health-Santé Sud and Interlake-Eastern RHA were more likely to have to travel, with less than 50% of their visits within their home district and a large portion of visits in Winnipeg.
- ▶ In Southern Health-Santé Sud, only 42.5% of visits to family physicians and nurse practitioners were within the residents' home district in the current time period. This percentage is almost half the Manitoba average; however, the difference was not tested statistically.
- ▶ Although not tested statistically, the percentage decreased slightly over time within the region.
- ▶ The majority of remaining visits were located elsewhere in the region and in Winnipeg, respectively and both experienced slight increases over time. The large percentage of visits within Winnipeg likely reflects the proximity of the region.
- ▶ Zone and district level data not available.



**Figure 3. Location Visits to Physicians or Nurse Practitioners by RHA, 2011-2012 (T1) and 2016-2017 (T2)**



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## Ambulatory Consultations

### Definition

The percentage of ambulatory consultations in a given year. These consults occur when a physician, nurse, or other allied health professional refer a patient to another physician (usually a specialist or surgeon) or nurse practitioner.

### Why is this indicator important?

Health professionals will often refer patients to another provider due to the complexity, obscurity, or seriousness of a condition. Patients may also request a second opinion. This indicator yields important information about initial access to specialist care, which is particularly important in rural areas where patients use specialist services less frequently due to access issues.

### Provincial Key Findings

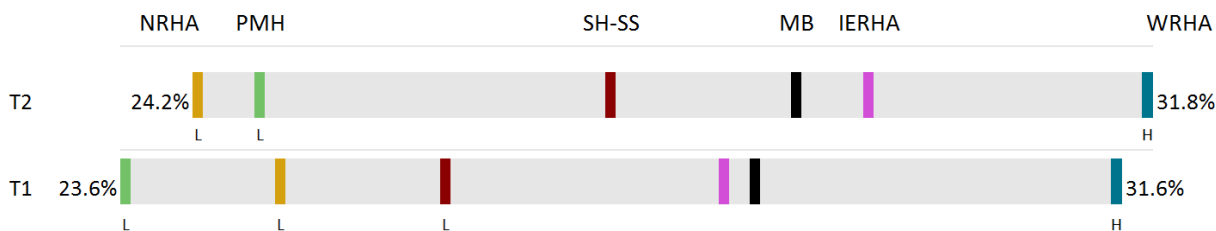
- ▶ **Figure 4** shows that consultations in Manitoba remained stable over time with a slight, not statistically significant increase. This trend was also observed across all regions except Northern Health Region.
- ▶ In both time periods, consultations in Winnipeg RHA were significantly higher than the provincial average, while Northern Health Region and Prairie Mountain Health were significantly lower in the current time period.
- ▶ **Income:** Ambulatory consultation was significantly related to income. Residents of lower income areas had fewer consultations than those in higher income areas.



*Ambulatory consultations  
significantly related to income*

**Figure 4. Ambulatory Consultations by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percentage of consults (first referral)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		PMH		SH-SS		MB		IERHA		WRHA	
T2 COUNT	15,537		44,304		52,645		402,497		40,948		248,592	
T2 RATE	24.2%	L	24.8%	L	27.5%		29.0%		29.6%		31.8%	H
T1 RATE	24.9%	L	23.6%	L	26.2%	L	28.7%		28.4%		31.6%	H

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## Regional Key Findings

### SH-SS Level

- Table 4 shows there was a regional total of 52,645 ambulatory consultations in the current time period.
- The percentage remained stable over time with a slight not statistically significant increase.

### Zone Level

- There were similar percentages across zones in the current time period.
- Ambulatory consultation percentages increased significantly over time in Zones 1 and 3.

### District Level

- Percentages varied across districts from a low in Seven Regions to a high in Macdonald in both time periods.
- Rates increased significantly over time in city of Portage and Seven Regions.

**Table 4. Ambulatory Consultations in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

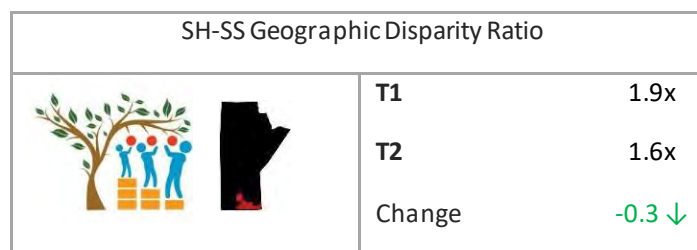
Age- and sex- adjusted percentage of consults (first referral)

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>402,497</b>	<b>29.0</b>	<b>28.7</b>		
<b>SH-SS</b>	<b>52,645</b>	<b>27.5</b>	<b>26.2</b>		<b>L</b>
<b>Zone 4</b>	<b>18,932</b>	<b>27.6</b>	<b>28.2</b>		
Niverville/Ritchot	3,652	30.2	32.4		
Taché	2,486	28.1	28.3		
Steinbach	5,260	27.0	26.6		
Rural East	1,235	25.8	23.1		
Ste. Anne/ La Broquerie	3,210	24.9	26.7		
Hanover	3,089	24.4	26.9		
<b>Zone 2</b>	<b>8,911</b>	<b>30.0</b>	<b>29.1</b>		
Macdonald	2,593	36.5	34.8		
Carman	1,825	29.5	28.2		
St. Pierre/ De Salaberry	1,258	28.1	29.8		
Grey	766	26.5	26.9		
Red River South	1,191	25.9	24.3		
Morris	1,278	25.2	24.6		
<b>Zone 3</b>	<b>13,719</b>	<b>28.0</b>	<b>25.3</b>	<b>+</b>	<b>L</b>
Morden	3,369	32.4	29.1		
Roland/ Thompson	589	28.4	25.1		
Winkler	4,079	26.8	23.1		
Lorne/Louise/ Pembina	2,297	26.4	27.1		
Stanley	1,203	25.5	20.9		<b>L</b>
Altona	2,182	23.8	21.6		<b>L</b>
<b>Zone 1</b>	<b>11,083</b>	<b>27.9</b>	<b>24.5</b>	<b>+</b>	<b>L</b>
Cartier/SFX	2,370	31.5	33.6		
City of Portage	4,500	28.7	23.3	<b>+</b>	
Rural Portage	1,884	25.2	22.9		
North Norfolk	1,012	24.3	20.6		<b>L</b>
Seven Regions	1,317	22.9	18.6	<b>+</b>	<b>L</b>

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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### Geographic Disparity

- ▶ The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest ambulatory consultation rates reduced.



T1: 2011-2012, T2: 2016-2017

## Majority of Care—Continuity

### Definition

The percentage of residents who received at least 50% of their ambulatory visits from the same physician (general practitioner, family practitioner, pediatrician or internal medicine specialist) or nurse practitioner over a two-year time period.

### Why is this indicator important?

Continuity of care allows for a stronger patient-healthcare provider relationship and correlates with better health outcomes, improved patient satisfaction, and fewer hospitalizations.

### Provincial Key Findings

- ▶ **Figure 5** shows that the proportion of Manitoba residents receiving more than 50% of their visits from the same primary physician or nurse practitioner remained stable over time with a slight, not statistically significant decrease. The only statistically significant decrease was in Southern Health-Santé Sud.
- ▶ Northern Health Region and Southern Health-Santé Sud had significantly lower rates than the provincial average in both time periods.
- ▶ **Income:** Majority of care was significantly related to income in rural areas. Residents of lower income areas were less likely to receive a majority of their visits from a single provider.<sup>iii</sup>

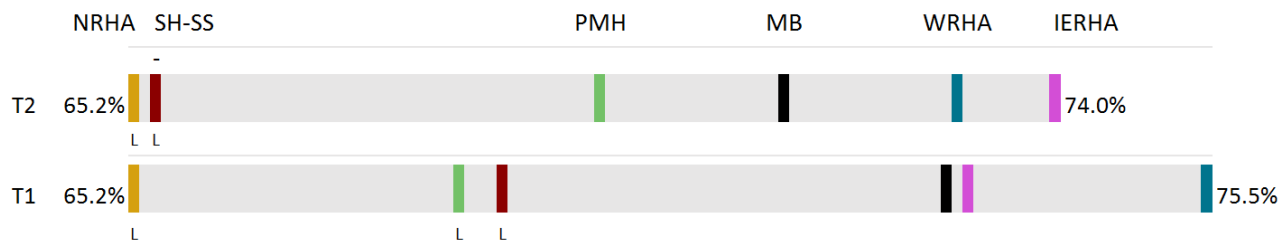


*Majority of care significantly related to income*



**Figure 5. Majority of Care by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Age- and sex-adjusted percentage among those with 3+ visits



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		SH-SS		PMH		MB		WRHA		IERHA	
T2 COUNT	23,297		81,909		86,156		668,305		409,578		66,321	
T2 RATE	65.2%	L	65.5%	L-	69.7%		71.5%		73.1%		74.0%	
T1 RATE	65.2%	L	68.8%	L	68.4%	L	73.0%		75.5%		73.2%	

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## Regional Key Findings

### SH-SS Level

- Table 5 shows 65.5% of regional residents received the majority of care from the same physician or nurse practitioner in the current time period.
- The regional percentage was significantly lower than the provincial average in both time periods and decreased significantly over time.

### Zone Level

- Percentages varied across zones from the lowest in Zone 1 to the highest in Zone 4.
- Zones 1 and 3 were lower than the provincial average in both time periods.
- Percentages decreased significantly over time in Zone 4, while they increased significantly in Zone 1.

### District Level

- There was about a 22% difference between the lowest district of city of Portage and the highest district of Niverville/Ritchot in the current time period.
- In the current time period, several districts were significantly lower including Steinbach, Hanover, Grey, Carman, Lorne/Louise/Pembina, Roland/Thompson, Winkler, Stanley, North Norfolk, Rural Portage, and city of Portage.
- Percentages decreased significantly over time in the majority of districts in Zone 4 (except Rural East), as well as Macdonald, St. Pierre/De Salaberry, Grey, Altona, and Cartier/SFX. On the other hand, it increased significantly in Rural Portage and city of Portage.

**Table 5. Majority of Care in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**


Age- and sex-adjusted percentage among those with 3+ visits

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>668,305</b>	<b>71.5</b>		<b>73.0</b>	
<b>SH-SS</b>	<b>81,909</b>	<b>65.5</b>	<b>L-</b>	<b>68.8</b>	<b>L</b>
<b>Zone 4</b>	<b>31,775</b>	<b>69.3</b>	<b>-</b>	<b>79.5</b>	<b>H</b>
Niverville/Ritchot	6,224	75.3	-	79.5	H
Taché	4,632	73.4	-	80.3	H
Rural East	1,808	71.9		76.9	
Ste. Anne/ La Broquerie	5,555	69.8	-	79.9	H
Steinbach	8,686	64.5	L-	78.7	H
Hanover	4,870	62.8	L-	79.2	H
<b>Zone 2</b>	<b>13,062</b>	<b>67.7</b>		<b>71.0</b>	
Morris	2,298	75.1		76.3	
Macdonald	3,731	71.1	-	76.4	
Red River South	1,998	68.7		73.4	
St. Pierre/ De Salaberry	1,737	67.0	-	79.0	
Grey	1,136	59.4	L-	67.3	
Carman	2,162	59.1	L	56.1	L
<b>Zone 3</b>	<b>20,612</b>	<b>65.4</b>	<b>L</b>	<b>66.7</b>	<b>L</b>
Altona	4,012	67.7	-	71.6	
Morden	4,425	67.3		68.5	
Lorne/Louise/ Pembina	3,819	66.8	L	64.8	L
Roland/ Thompson	790	64.0	L	64.9	L
Winkler	5,897	61.6	L	63.3	L
Stanley	1,669	59.8	L	64.0	L
<b>Zone 1</b>	<b>16,460</b>	<b>59.4</b>	<b>L+</b>	<b>56.2</b>	<b>L</b>
Cartier/SFX	3,687	69.0	-	74.0	
Seven Regions	2,626	66.9	+	57.8	L
North Norfolk	1,581	60.4	L	60.2	L
Rural Portage	2,681	55.4	L+	50.2	L
City of Portage	5,885	53.8	L+	49.0	L

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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### Geographic Disparity

- The geographic disparity between the districts decreased over time, meaning the gap between the districts with the lowest and highest percentage of residents receiving the majority of care from the same physician or nurse practitioner reduced.

SH-SS Geographic Disparity Ratio	
	<b>T1</b> 1.6x
	<b>T2</b> 1.4x
	<b>Change</b> -0.2 ↓

T1: 2010/11-2011/12, T2: 2015/16-2016/17

## Ambulatory Care Sensitive Conditions Hospitalization Rate

### Definition

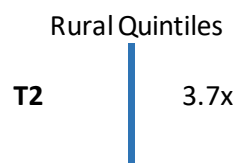
The annual hospitalization rate per 1,000 population, aged 0 to 74 years, for ambulatory care sensitive conditions (ACSC) which include a group of 25 diseases and diagnoses (e.g., asthma, angina, gastroenteritis, congestive heart failure) for which primary health care may be more appropriate than hospital care.

### Why is this indicator important?

Lower rates reflect better access to good quality primary health care. Appropriate management and control of ACSC in the community could potentially reduce the need for hospitalization and improve quality of life, improve efficiency in resource utilization and reduce health spending for chronic conditions.

### Provincial Key Findings

- ▶ **Figure 6** shows that the rate of hospitalization for ACSC in Manitoba remained stable over time with a slight not statistically significant decrease.
- ▶ Southern Health-Santé Sud, Interlake-Eastern RHA, and Prairie Mountain Health showed significant decreases over time.
- ▶ Rates varied across regions, with Winnipeg RHA significantly lower than the provincial average and Prairie Mountain Health and Northern Health Region significantly higher in both time periods.
- ▶ **Income:** ACSC were very strongly related to income.<sup>iv</sup> Hospitalization for ACSC among residents of lower income areas was 3.7 times higher than residents in the highest income areas.

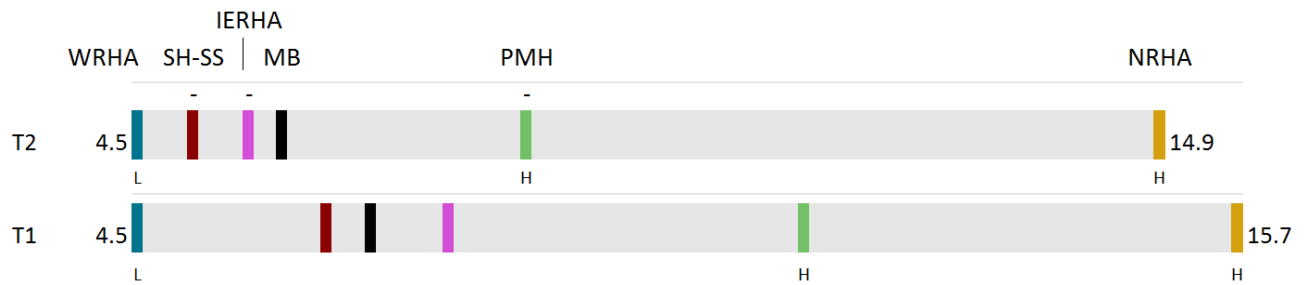


*ACSC very strongly related to income*

T2: 2016-2017

**Figure 6. ACSC Hospitalization Rates by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

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



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	IERHA	MB	PMH	NRHA
T2 COUNT	3,467	1,010	861	8,023	1,522	995
T2 RATE	4.5	5.2	5.7	6.1	8.5	14.9
T1 RATE	4.5	6.6	7.7	7.0	11.4	15.7

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## Regional Key Findings

### SH-SS Level

- Table 6 shows a regional rate of 5.2 hospitalizations for ACSC per 1,000 residents aged 0-74 years in the current time period.
- The regional rate decreased significantly over time.

### Zone Level

- Rates varied slightly between zones, from the lowest in Zone 4 to the highest in Zone 1.
- The rate in Zone 4 was significantly lower than the provincial average in both time periods and decreased significantly over time.

### District Level

- There was a large variation between districts, with the lowest in Taché and the highest in Seven Regions in the current time period.
- In the current time period, districts with significantly lower rates included Taché, Niverville/Ritchot, Hanover, Ste. Anne/La Broquerie, Macdonald, and Cartier/SFX. While the rate in Seven Regions was significantly higher than the provincial average.
- Rates decreased significantly over time in Taché, Niverville/Ritchot, Steinbach, Carman, Lorne/Louise/Pembina, and city of Portage.

**Table 6. ACSC Hospitalization Rates in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


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

	T2		T1		
	Count	Rate	Rate	Rate	
<b>Manitoba</b>	<b>8,023</b>	<b>6.1</b>		<b>7.0</b>	
<b>SH-SS</b>	<b>1,010</b>	<b>5.2</b>	<b>-</b>	<b>6.6</b>	
<b>Zone 4</b>	<b>262</b>	<b>3.4</b>	<b>L-</b>	<b>5.2</b>	<b>L</b>
Taché	17	1.9	L-	3.8	
Niverville/Ritchot	26	2.0	L-	4.2	
Hanover	43	3.3	L	4.5	
Ste. Anne/ La Broquerie	47	3.4	L	4.2	
Steinbach	91	4.2	-	6.6	
Rural East	38	6.5		7.1	
<b>Zone 2</b>	<b>149</b>	<b>4.6</b>		<b>4.8</b>	<b>L</b>
Macdonald	21	2.6	L	1.0	L
Morris	18	3.3		3.4	
Carman	22	3.5	-	7.2	
St. Pierre/ De Salaberry	28	5.1		3.5	
Red River South	31	6.2		7.8	
Grey	29	9.0		7.6	
<b>Zone 3</b>	<b>285</b>	<b>5.5</b>		<b>6.2</b>	
Stanley	14	2.7		3.1	L
Winkler	72	4.5		5.9	
Altona	44	4.5		3.8	L
Morden	56	5.6		3.3	L
Roland/Thompson	19	8.3		5.1	
Lorne/Louise/ Pembina	80	9.1	-	16.1	H
<b>Zone 1</b>	<b>314</b>	<b>7.6</b>		<b>9.2</b>	
Cartier/SFX	23	2.7	L	2.8	L
North Norfolk	24	5.1		5.6	
City of Portage	117	7.1	-	11.2	H
Rural Portage	59	7.7		9.3	
Seven Regions	91	15.3	H	13.8	H

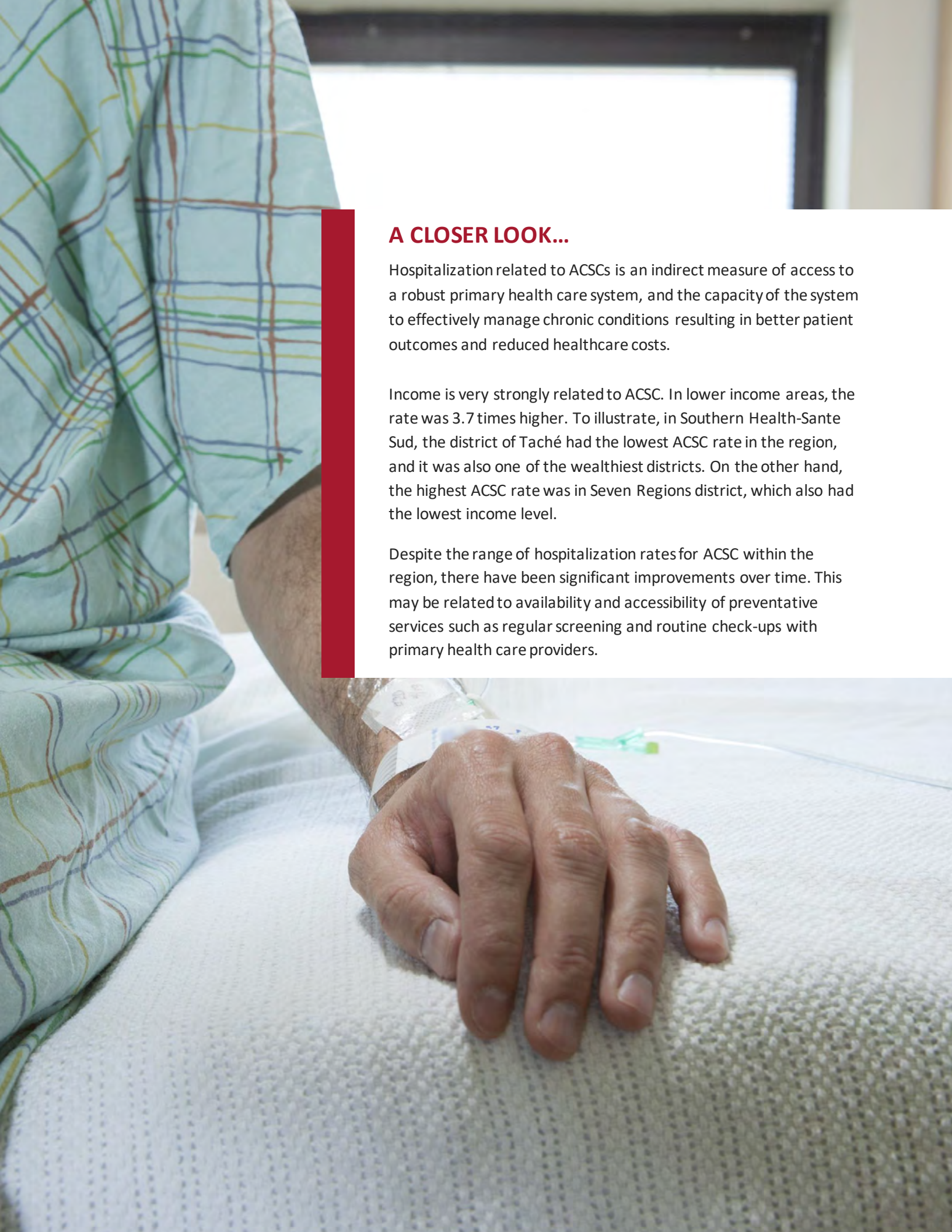
H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
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### Geographic Disparity

- There were large geographic disparities between the districts with the lowest and highest ACSC hospitalization rates; however, there was also a large decrease in disparity over time (i.e., the gap reduced).

SH-SS Geographic Disparity Ratio	
	T1 15.5x
	T2 8.2x
	Change -7.3 ↓

T1: 2011-2012, T2: 2016-2017



## A CLOSER LOOK...

Hospitalization related to ACSCs is an indirect measure of access to a robust primary health care system, and the capacity of the system to effectively manage chronic conditions resulting in better patient outcomes and reduced healthcare costs.

Income is very strongly related to ACSC. In lower income areas, the rate was 3.7 times higher. To illustrate, in Southern Health-Sante Sud, the district of Taché had the lowest ACSC rate in the region, and it was also one of the wealthiest districts. On the other hand, the highest ACSC rate was in Seven Regions district, which also had the lowest income level.

Despite the range of hospitalization rates for ACSC within the region, there have been significant improvements over time. This may be related to availability and accessibility of preventative services such as regular screening and routine check-ups with primary health care providers.

## Benzodiazepine Overprescribing Community-Dwelling Older Adults

### Definition

The percentage of residents, aged 75 years and older, living in the community (excluding those who live in a personal care home) who had at least two prescriptions for benzodiazepines, or at least one prescription for benzodiazepine dispensed with more than a 30-day supply.

### Why is this indicator important?

Benzodiazepines are medications widely used to treat seizures, anxiety and insomnia, however use by seniors is not recommended as it poses serious safety concerns including increased risk for confusion, memory loss, poor coordination and muscle control potentially leading to falls and fractures.

### Provincial Key Findings

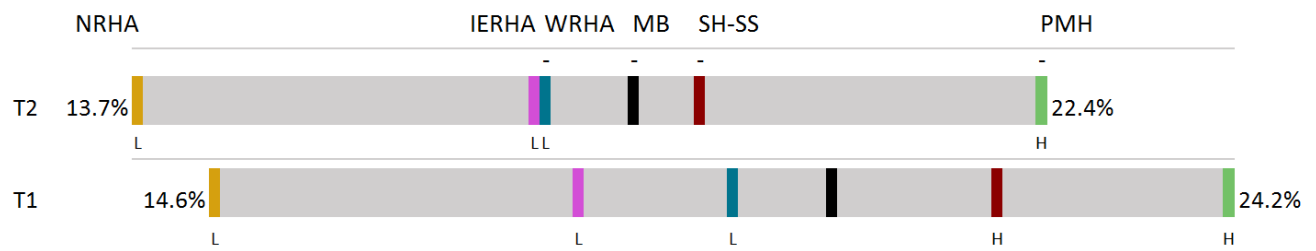
- ▶ **Figure 7** shows that in Manitoba, there were 30,430 community dwelling older adults who had benzodiazepine overprescribing in the current time period; representing over 18% of this age group.
- ▶ The percentages decreased significantly over time in the province and across many regions, including Winnipeg RHA, Southern Health-Santé Sud, and Prairie Mountain Health.
- ▶ In both time periods, the percentages in Northern Health Region, Interlake-Eastern RHA, and Winnipeg RHA were significantly lower than the provincial average, while Prairie Mountain Health was significantly higher.
- ▶ **Income:** Benzodiazepine use and income were significantly related. A higher percentage of residents in lower income areas received the drugs.<sup>v</sup>



*Benzodiazepine use  
significantly related  
to income*

**Figure 7. Benzodiazepine Overprescribing for Community-Dwelling Older Adults by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Crude percentage of non-PCH older adults with 2 prescriptions or more than a 30-day supply (aged 75+)



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	IERHA	WRHA	MB	SH-SS	PMH
T2 COUNT	467	2,933	17,052	30,430	4,034	5,895
T2 RATE	13.7% L	17.6% L	17.6% L-	18.5% -	19.2% -	22.4% H-
T1 RATE	14.6% L	18.0% L	19.5% L	20.4% L	22.0% H	24.2% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 7 shows a regional total of 4,034 community-dwelling older adults with benzodiazepine overprescribing in the most current time period; representing over 19% of this age group.
- The percentages decreased significantly over time in the region.

### Zone Level

- There was little variation across zones.
- Zone 4 was significantly higher than the provincial average in both time periods.
- Over time, percentages decreased significantly in all zones.

### District Level

- There was variation across districts with the lowest in Grey and the highest in St Pierre/De Salaberry.
- In the current time period, both Grey and Rural Portage were significantly lower than the provincial average, while Steinbach and St. Pierre/De Salaberry were significantly higher in both time periods.
- Districts that experienced a significant decrease over time included Hanover, Ste. Anne/La Broquerie, Carman Altona, Morden, and Lorne/Louise/Pembina.



**Table 7. Benzodiazepine Overprescribing for Community-Dwelling Older Adults in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**


Crude percentage of non-PCH older adults with 2 prescriptions or more than a 30-days supply (aged 75+)

	T2			T1		
	Count	Percentage	Change	Percentage	Change	Significance
<b>Manitoba</b>	<b>30,430</b>	<b>18.5</b>	<b>-</b>	<b>20.4</b>		
<b>SH-SS</b>	<b>4,034</b>	<b>19.2</b>	<b>-</b>	<b>22.0</b>		<b>H</b>
<b>Zone 4</b>	<b>1,299</b>	<b>20.0</b>	<b>H-</b>	<b>22.5</b>		<b>H</b>
Rural East	115	15.8		17.7		
Hanover	154	17.3	-	23.9		
Taché	77	18.5		18.2		
Niverville/ Ritchot	155	20.4		20.3		
Ste. Anne/ La Broquerie	259	20.8	-	25.6		H
Steinbach	539	22.0	H	23.4		H
<b>Zone 2</b>	<b>715</b>	<b>18.7</b>	<b>-</b>	<b>22.0</b>		
Grey	45	12.06	L	13.9		
Macdonald	90	17.0		13.8		L
Morris	111	17.6		21.4		
Carman	229	18.6	-	26.3		H
Red River South	102	20.3		20.8		
St. Pierre/De Salaberry	138	25.2	H	26.4		H
<b>Zone 3</b>	<b>1,175</b>	<b>19.3</b>	<b>-</b>	<b>23.0</b>		<b>H</b>
Roland/ Thompson	32	13.0		16.5		
Stanley	35	16.5		20.4		
Altona	204	18.4	-	22.2		
Morden	299	19.9	-	23.5		
Winkler	343	20.0		22.3		
Lorne/Louise/ Pembina	262	20.0	-	25.1		H
<b>Zone 1</b>	<b>845</b>	<b>18.1</b>	<b>-</b>	<b>20.2</b>		
Rural Portage	80	12.14	L	16.2		
North Norfolk	86	15.9		15.3		
Seven Regions	120	18.1		20.9		
Cartier/SFX	116	18.7		22.1		
City of Portage	443	20.4		21.9		

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

### Geographic Disparity

- The geographic disparity between the districts increased over time, meaning the gap between the districts with the lowest and highest percentage of community benzodiazepine overprescribing widened.

SH-SS Geographic Disparity Ratio	
	<b>T1</b> 1.9x
	<b>T2</b> 2.1x
	<b>Change</b> 0.2 ↑

T1: 2007/08-2011/12, T2: 2012/13-2016/17

## Access to a Regular Health Care Provider

### Definition

The percentage of Manitobans, aged 12 and older, who reported that they have access to a regular health care provider, over a two-year time period.

### Why is this indicator important?

A regular health care provider can offer preventative care, healthy lifestyle choices, treatment for common medical conditions and referrals to specialists when needed. Having a regular primary care provider can help improve lives and save money on hospital admissions, emergency room visits and surgeries.<sup>vi</sup>

### Provincial/Regional Key Findings

- ▶ **Figure 8** shows that approximately 4 out of 5 Manitobans reported having access to a regular health care provider.
- ▶ Access to a regular health care provider was consistent across health regions, with the exception of Northern Health Region which was significantly lower than the provincial average.
- ▶ **Table 8** shows that the leading reasons for not having a regular health care provider in Manitoba were: no need for a regular health care provider, provider left or retired, didn't try to find one, other, and none available in area. These leading reasons were similar across health regions.
- ▶ In Southern Health-Santé Sud, 83.6% of respondents reported having a regular health care provider.
- ▶ The leading reasons for no provider in the region were similar to Manitoba with the exception of no one taking new patients being within the top five reasons in the region.

**Figure 8. Access to a Regular Health Care Provider by RHA, 2015-2016**

Age- and sex-adjusted percentage



H/L Significantly higher or lower than the MB average.

	NRHA		MB		WRHA		SH-SS		IERHA		PMH
T1 RATE	66.6%	L	83.2%		83.4%		83.6%		84.8%		85.8%

Statistics Canada CCHS 2015-2016

**Table 8. Leading Reasons for Not Having a Primary Health Provider in Southern Health-Santé Sud, 2015-2016 (T1)**

Age- and sex- adjusted percentage

Condition	SH-SS		MB	
	Percentage		Percentage	
No need for a regular health care provider	33.8%		31.3%	
Provider left or retired	33.2%		27.3%	
Did not try to find one	20.9%	c	24.3%	
No one taking new patients	9.8%	c	10.5%	c
None available in area	9.3%	c	12.0%	c

c estimate displayed with caution  
Statistics Canada CCHS 2015-2016

## A CLOSER LOOK...

Rural Manitobans in particular often face unique challenges in accessing health care services as a result of our province’s natural geography, dispersed population, and inclement weather. Long travel times, travel expenses, loss of work time, and arranging child care are realities that make access to health care difficult for many of our rural residents. As a result, we need to innovate and use existing resources and technologies, such as MB Telehealth, to overcome barriers to accessing care.

MB Telehealth is available in Southern Health-Santé Sud in 16 locations across the region. In a recent survey, 450 people who responded said that Telehealth has helped to ease the burden of illness and of maintaining wellness.



## Type of Place for Minor Health Problem (Primary Care)

### Definition

The percentage of Manitobans, aged 12 and older, who reported the type of place they usually went for a minor health problem, such as a doctor's office, walk-in clinic, or emergency department, over a two-year time period.

### Why is this indicator important?

Many minor health problems can be treated through self-care or over the counter medicines from a pharmacist. Accurate understanding of where residents seek medical care for minor health problems better informs the region of the accessibility of primary care services and education required to ensure optimal use of healthcare resources.

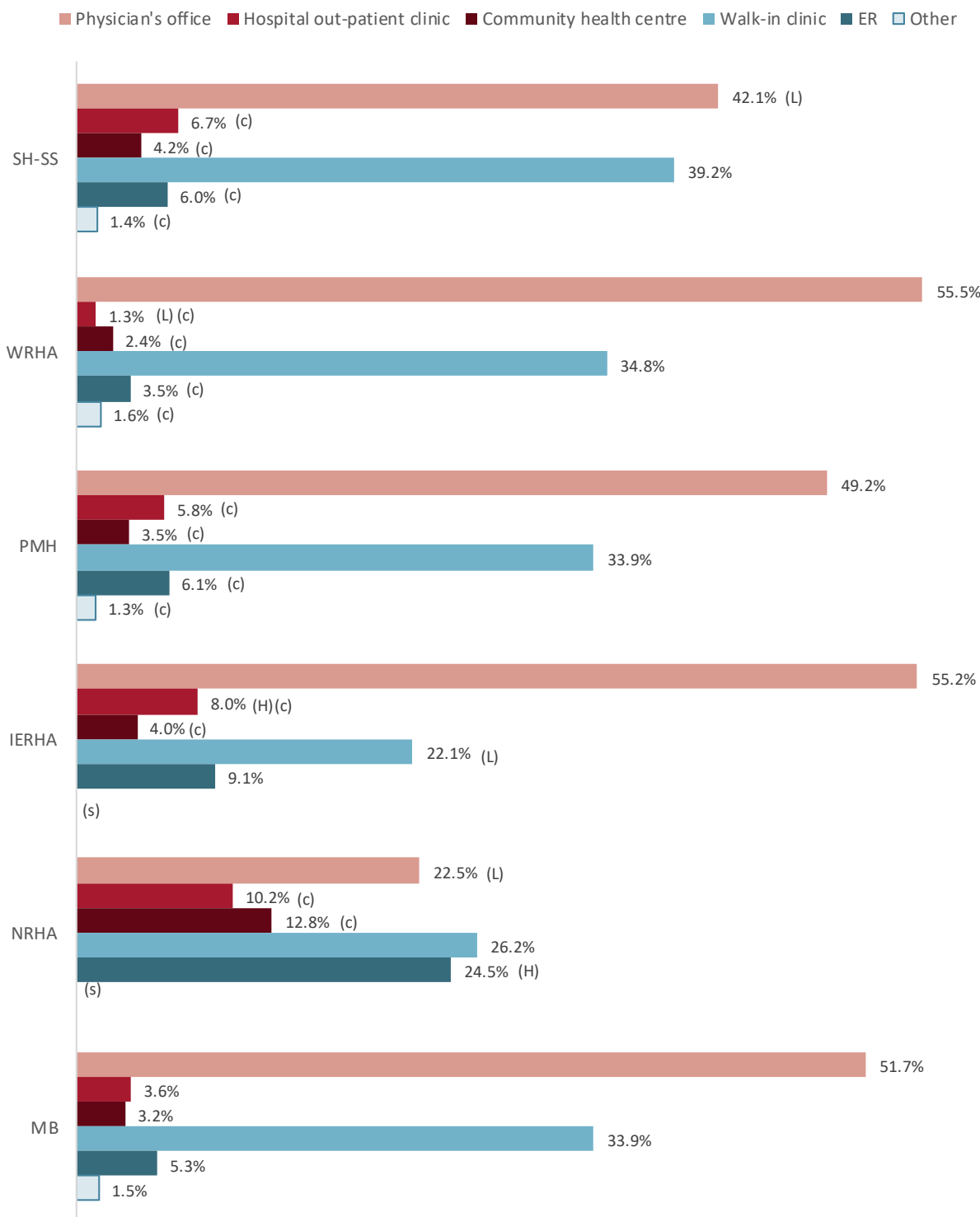
### Provincial/Regional Key Findings

- ▶ **Figure 9** shows that the most commonly reported place residents went for a minor health problem was the physician's office followed by walk-in clinic in Manitoba and all regions except Northern Health Region.
- ▶ Visits for minor health problems to a physician's office in Southern Health-Santé Sud and Northern Health Region, to a hospital outpatient clinic in Winnipeg RHA, and to walk-in clinics in Interlake-Eastern RHA were significantly lower than the provincial average. On the other hand, visits to hospital outpatient clinics in Interlake-Eastern RHA and visiting the ER for minor health problems in Northern Health Region were significantly higher.
- ▶ In Southern Health-Santé Sud, 90% of respondents reported having a place to go for immediate care for minor health problems.
- ▶ The most common places for minor health problems in the region were physician's office, walk-in clinic, hospital outpatient clinic, emergency room, and community health centre.



**Figure 9. Type of Place for Minor Health Problem by RHA, 2015-2016 (T1)**

Age- and sex-adjusted percentage



(H/L) = significantly higher/lower than MB average.  
(c) = estimate displayed with caution. (s) = estimate suppressed.  
Statistics Canada CCHS 2015-2016

## Wait Time for Minor Health Problem

### Definition

The wait time for a medical appointment with their regular health care provider for a minor health problem, by Manitobans aged 12 and older, over a two-year time period.

### Why is this indicator important?

While not all waits are avoidable, repetitive long waits could be a sign of inadequate resources or scheduling issues.

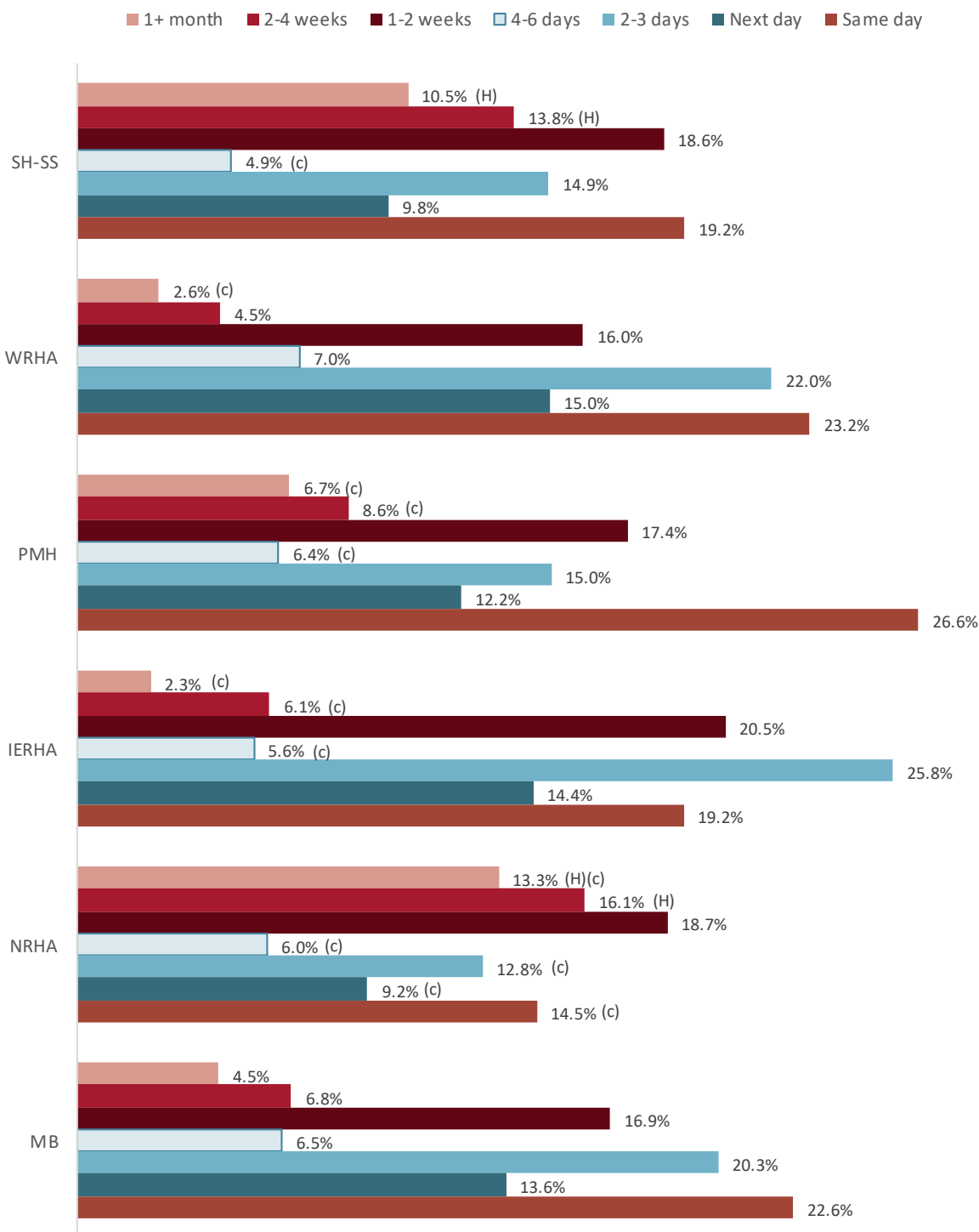
### Provincial/Regional Key Findings

- ▶ **Figure 10** shows nearly 57% of Manitoba and 44% of Southern Health-Santé Sud respondents indicated that the wait time for getting an appointment for a minor health problem was 3 days or less.
- ▶ Southern Health-Santé Sud and Northern Health Region had the largest percentages of residents waiting over 2 weeks for an appointment for a minor health problem and significantly higher than the Manitoba average.



**Figure 10. Wait Time for Minor Health Problem by RHA, 2015-2016**

Age- and sex-adjusted percentage



(H/L) = significantly higher/lower than MB average.  
(c) = estimate displayed with caution. (s) = estimate suppressed.  
Statistics Canada CCHS 2015-2016

## Coordination between Health Professionals and Other Providers

### Definition

The level of coordination between their regular health care provider and other health professionals using a five scale rating, reported by Manitobans, aged 12 and older, over a two-year time period.

### Why is this indicator important?

Monitoring coordination of care between providers is one way to assess fragmentation of health services. Patients perceive interruptions in care as unreasonable as they navigate the healthcare system.<sup>vii</sup> Patient input is necessary to achieve safer, more effective and efficient care, and bridge the gaps that remain along healthcare pathways.

### Provincial/Regional Key Findings

- ▶ **Figure 11** shows about 46% of Manitoba respondents reported positively about the coordination between health care providers.
- ▶ Responses were similar across health regions.
- ▶ In Southern Health-Santé Sud, 45% of respondents reported excellent or very good coordination.

**Figure 11. Coordination between Health Care Providers, 2015-2016 (T1)**

Age- and sex-adjusted percentage of 'Excellent/Very Good' in weighted sample

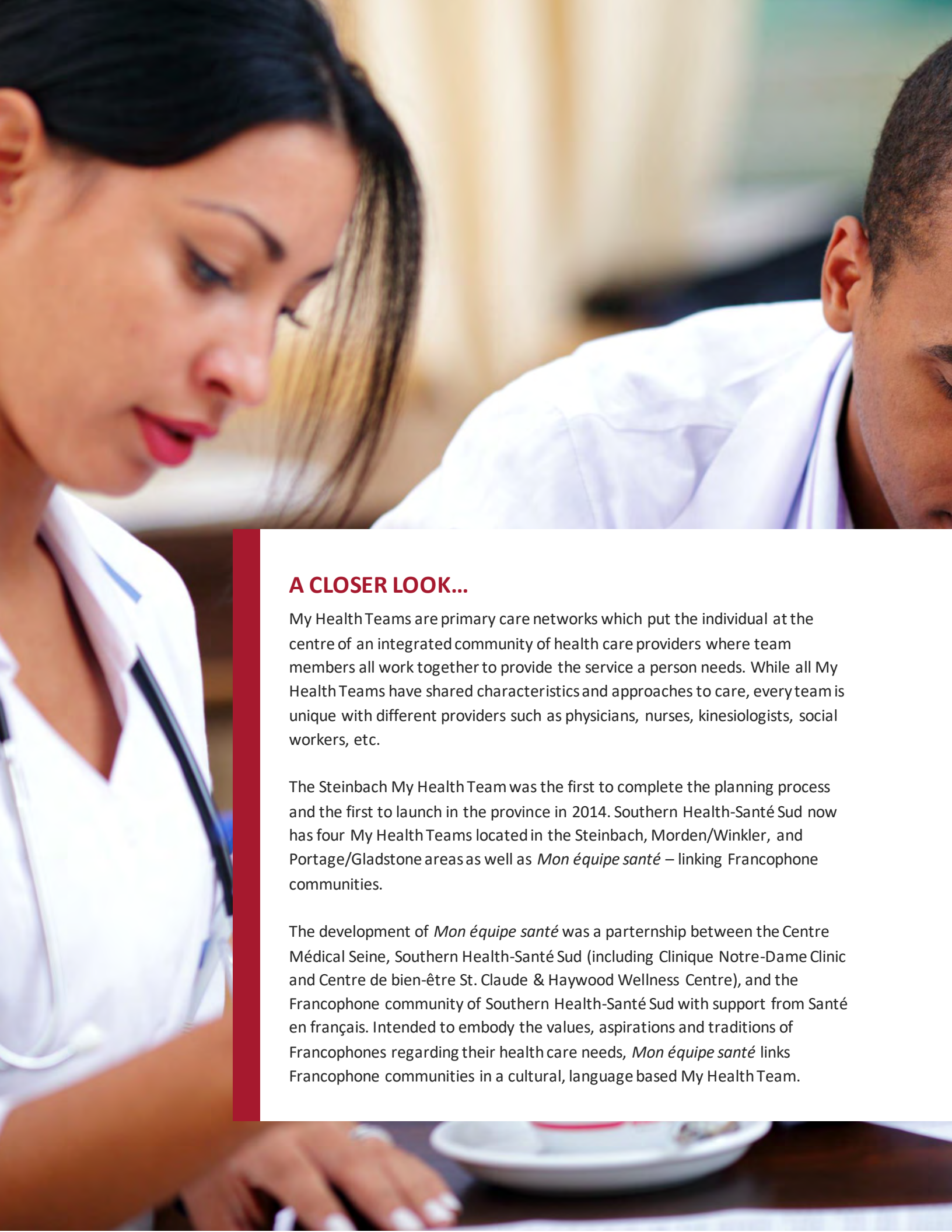


H/L Significantly higher or lower than the MB average.

	PMH	SH-SS	NRHA	WRHA	MB	IERHA
T1 RATE	44.6%	45.0%	45.6%	45.9%	46.3%	50.5%

Statistics Canada CCHS2015-2016





## A CLOSER LOOK...

My Health Teams are primary care networks which put the individual at the centre of an integrated community of health care providers where team members all work together to provide the service a person needs. While all My Health Teams have shared characteristics and approaches to care, every team is unique with different providers such as physicians, nurses, kinesiologists, social workers, etc.

The Steinbach My Health Team was the first to complete the planning process and the first to launch in the province in 2014. Southern Health-Santé Sud now has four My Health Teams located in the Steinbach, Morden/Winkler, and Portage/Gladstone areas as well as *Mon équipe santé* – linking Francophone communities.

The development of *Mon équipe santé* was a partnership between the Centre Médical Seine, Southern Health-Santé Sud (including Clinique Notre-Dame Clinic and Centre de bien-être St. Claude & Haywood Wellness Centre), and the Francophone community of Southern Health-Santé Sud with support from Santé en français. Intended to embody the values, aspirations and traditions of Francophones regarding their health care needs, *Mon équipe santé* links Francophone communities in a cultural, language based My Health Team.

# Acute Care

## Use of Hospitals

### Definition

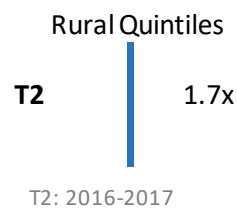
The percentage of residents who were admitted to an acute care hospital at least once in a fiscal year.

### Why is this indicator important?

Hospitalizations can indicate the level of illness in the population, capacity of community-based supports and accessibility of hospital care for local residents.

### Provincial Key Findings

- ▶ **Figure 12** shows that hospital use decreased over time in all regions. However, the changes were only statistically significant in Manitoba, Southern Health-Santé Sud, and Prairie Mountain Health.
- ▶ **Income:** Hospital use was strongly related to income.<sup>viii</sup> The percentage among residents in the lowest income areas was 1.7 times higher than the residents in the highest income areas.

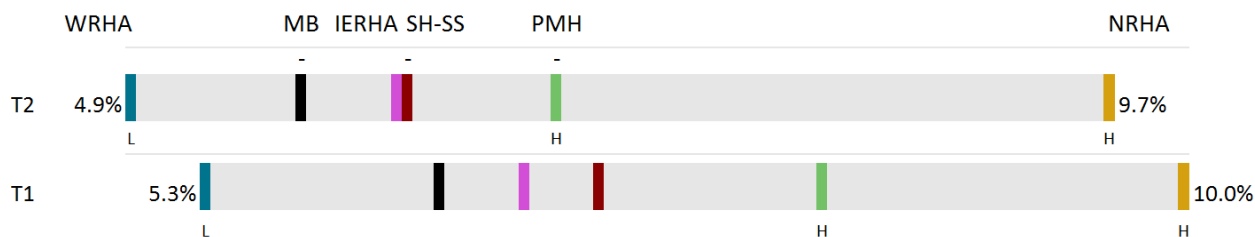


*Hospital use  
strongly related  
to income*



**Figure 12. Use of Hospitals by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of residents (all ages) with at least one inpatient hospital stay per year



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	SH-SS	PMH	NRHA
T2 COUNT	39,999	80,193	8,232	11,736	13,107	6,317
T2 RATE	4.9% L	5.8%	6.2% H	6.2% H	7.0% H	9.7% H
T1 RATE	5.3% L	6.5%	6.9% H	7.2% H	8.3% H	10.0% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 9 shows a total of 11,736 regional residents with at least one inpatient hospital stay in the current time period.
- The percentage decreased significantly over time.

### Zone Level

- Hospital use was relatively similar across zones.
- In both time periods, Zone 1 was significantly higher than the Manitoba average.
- Over time, hospital use decreased significantly in Zones 2 and 4.

### District Level

- Hospital use varied across districts from the lowest in Macdonald to the highest in Seven Regions, in both time periods.
- In both time periods, Taché and Macdonald were significantly lower than the provincial average while Lorne/Louise/Pembina and Seven Regions were significantly higher.
- Over time, districts that experienced significant decreases in hospital use included Hanover, Steinbach, St. Pierre/De Salaberry, Carman, and Rural Portage.

**Table 9. Use of Hospitals in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


Age- and sex-adjusted percentage of residents (all ages) with at least one inpatient hospital stay per year

	T2			T1	
	Count	Percentage		Percentage	
<b>Manitoba</b>	<b>80,193</b>	<b>5.8</b>	<b>-</b>	<b>6.5</b>	
<b>Zone 4</b>	<b>3,970</b>	<b>5.58</b>	<b>-</b>	<b>6.7</b>	
Taché	406	4.6	L	5.1	L
Niverville/Ritchot	600	4.8		5.6	
Hanover	702	5.4	-	6.8	
Rural East	282	5.5		6.5	
Ste. Anne/ La Broquerie	749	5.7		6.3	
Steinbach	1,231	5.8	-	7.2	
<b>Zone 2</b>	<b>1,706</b>	<b>5.61</b>	<b>-</b>	<b>6.6</b>	
Macdonald	310	4.2	L	4.4	L
Morris	269	4.9		5.7	
St. Pierre/ De Salaberry	235	4.9	-	6.4	
Red River South	294	6.0		7.1	
Grey	186	6.1		6.6	
Carman	412	6.1	-	7.8	
<b>Zone 3</b>	<b>3,260</b>	<b>6.3</b>		<b>6.9</b>	
Stanley	237	4.8		5.8	
Altona	537	5.6		5.5	
Winkler	978	6.0		6.8	
Morden	655	6.0		6.4	
Roland/ Thompson	140	6.3		6.5	
Lorne/Louise/ Pembina	713	7.8	H	8.8	H
<b>Zone 1</b>	<b>2,800</b>	<b>7.0</b>	<b>H</b>	<b>7.9</b>	<b>H</b>
Cartier/SFX	377	4.9		4.8	L
North Norfolk	261	5.8		6.4	
City of Portage	1,134	6.8		7.8	H
Rural Portage	510	7.0	-	8.3	H
Seven Regions	518	8.6	H	9.3	H

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity between the districts with the lowest and highest percentages of hospital use remained unchanged over time.

SH-SS Geographic Disparity Ratio		
	T1	2.1x
	T2	2.1x
	Change	0.0

T1: 2011-2012, T2: 2016-2017

## Inpatient Hospitalization Rate

### Definition

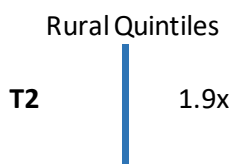
The total annual number of inpatient hospitalizations per 1,000 population. Multiple admissions of the same person are counted as separate events.

### Why is this indicator important?

The number of hospital admissions per resident can provide insight into the chronic nature of many health conditions, patient capacity to self-manage, capacity of community based supports and utilization of inpatient hospital services over time.

### Provincial Key Findings

- ▶ **Figure 13** shows there were 109,146 inpatient hospitalizations among Manitoba residents in the current time period.
- ▶ The overall inpatient hospitalization rate decreased significantly over time in Manitoba, Interlake-Eastern RHA, Southern Health-Santé Sud and Prairie Mountain Health.
- ▶ In both time periods, rates for Winnipeg RHA were significantly lower than the provincial average, while Northern Health Region and Prairie Mountain Health were significantly higher.
- ▶ The most frequent causes of hospitalizations in Manitoba were pregnancy and birth (17.9%), digestive disorders (10.7%), circulatory diseases (10.4%), injury and poisoning (8.8%), and respiratory diseases (8.1%). The most frequent causes of hospitalizations did not change much over time. Pregnancy and birth was the leading cause in all health regions, followed by either circulatory diseases or digestive disorders.
- ▶ **Income:** Inpatient hospitalization rates and income were very strongly related.<sup>ix</sup> The percentage was 1.9 times higher among the residents in the lowest income areas compared to the resident of the highest income areas.

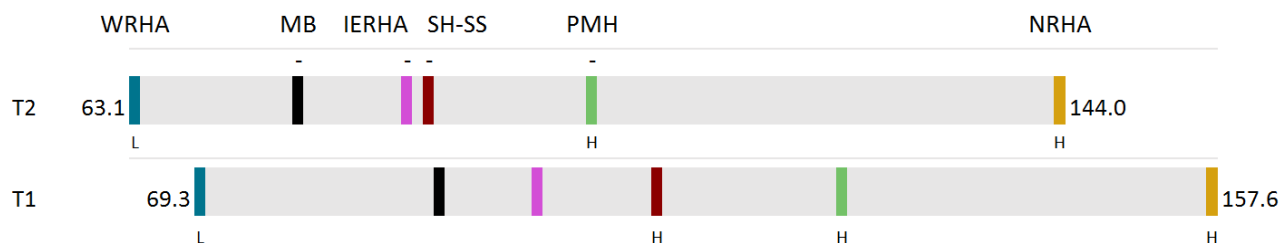


T2: 2016-2017

*Inpatient hospitalization rates very strongly related to income*

**Figure 13. Inpatient Hospitalization by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted rate of hospitalizations per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	SH-SS	PMH	NRHA
T2 COUNT	51,182	109,146	11,493	16,573	19,717	9,016
T2 RATE	63.1 L	78.4 -	87.5 -	89.7 -	103.7 H-	144.0 H
T1 RATE	69.3 L	90.6	98.9	109.2 H	125.3 H	157.6 H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 10 shows a total of 16,573 inpatient hospitalizations for regional residents in the current time period.
- The inpatient hospitalization rate decreased significantly over time.
- Table 11 shows the leading causes of hospitalizations in the region included pregnancy and birth, digestive diseases, circulatory diseases, health status and contact, and respiratory diseases. The leading causes of hospitalizations remained similar over time with the most notable differences being the increase of digestive and respiratory diseases in rankings. These causes were similar to Manitoba with the exception of health status and contact as one of the top five causes in the region instead of injury and poisoning.

### Zone Level

- Table 10 shows that rates varied considerably between zones from the lowest in Zone 4 to the highest in Zone 1.

### District Level

- There was a large variation of almost 100 hospitalizations per 1,000 residents between the lowest district of Macdonald and the highest district of Seven Regions in both time periods.
- Rates in Seven Regions were significantly higher than the Manitoba average in both time periods.

**Table 10. Inpatient Hospitalization Rate in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex- adjusted rate of hospitalizations per 1,000 residents

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>109,146</b>	<b>78.4</b>	<b>-</b>	<b>90.6</b>	
<b>SH-SS</b>	<b>16,573</b>	<b>89.7</b>	<b>-</b>	<b>109.2</b>	<b>H</b>
<b>Zone 4</b>	<b>5,431</b>	<b>79.6</b>		<b>101.3</b>	
Taché	508	63.2		73.0	
Niverville/Ritchot	741	65.2		81.4	
Hanover	992	81.0		103.4	
Ste. Anne/ La Broquerie	1,007	83.1		94.0	
Steinbach	1,743	85.1		113.8	
Rural East	440	87.0		101.2	
<b>Zone 2</b>	<b>2,398</b>	<b>83.7</b>		<b>98.4</b>	
Macdonald	377	59.1		63.3	
Morris	350	68.2		83.9	
St. Pierre/De Salaberry	359	83.0		95.5	
Carman	609	92.2		119.1	
Grey	269	93.4		105.5	
Red River South	434	94.4		107.0	
<b>Zone 3</b>	<b>4,678</b>	<b>94.5</b>		<b>105.2</b>	
Stanley	309	71.4		93.1	
Altona	743	81.1		82.7	
Winkler	1,408	89.0		103.9	
Morden	950	91.3		96.9	
Roland/Thompson	204	92.3		106.6	
Lorne/Louise/ Pembina	1,064	118.2		151.4	<b>H</b>
<b>Zone 1</b>	<b>4,066</b>	<b>108.1</b>		<b>125.8</b>	<b>H</b>
Cartier/SFX	452	67.5		68.7	
North Norfolk	360	88.4		102.0	
City of Portage	1,629	101.7		128.2	
Rural Portage	749	111.7		136.0	
Seven Regions	876	156.7	<b>H</b>	164.6	<b>H</b>

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019


**Table 11. Most Frequent Causes of Inpatient Hospitalization in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**

Condition	T2		T1
	Count	Percentage	Percentage
Pregnancy and Birth	3,954	23.8%	21.4%
Digestive	1,695	10.2%	10.1%
Circulatory	1,638	9.9%	11.2%
Health Status and Contact	1,418	8.6%	9.2%
Respiratory	1,281	7.7%	6.9%

MCHP RHA Indicators Atlas 2019

**Geographic Disparity**

- ▶ The geographic disparity between the districts increased slightly over time, meaning the gap between the districts with the lowest and highest rates widened.

SH-SS Geographic Disparity Ratio		
	T1	2.6x
	T2	2.7x
	Change	0.1 ↑

T1: 2011-2012, T2: 2016-2017





## Hospital Days for Acute Care

### Definition

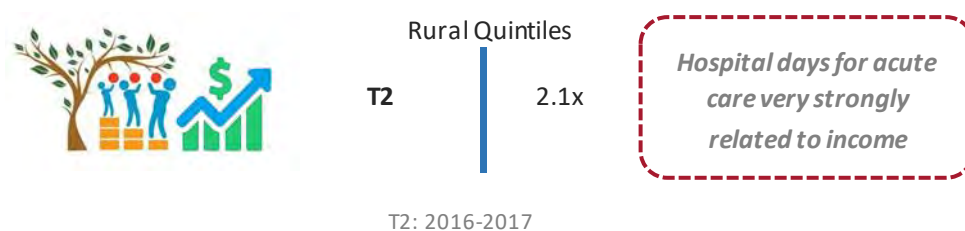
The number of days of hospital care provided to patients who are acutely ill and require medical care or surgery for treatment of disease or severe illness (excluding newborns), per 1,000 population, for a one-year time period.

### Why is this indicator important?

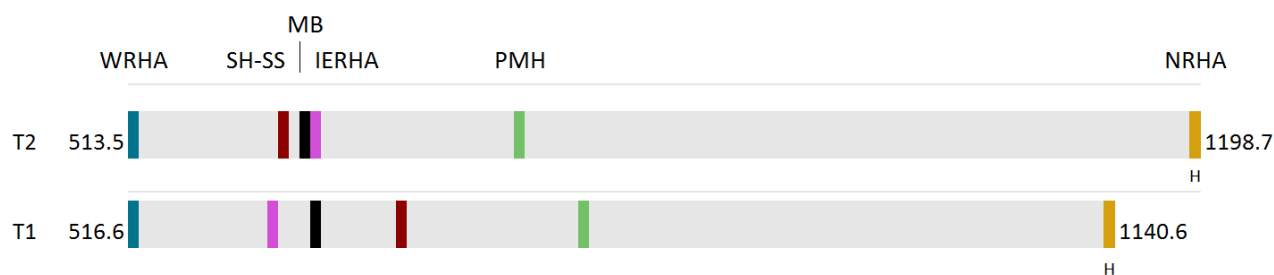
Providing targeted care and timely discharge from hospital results in better patient outcomes and reduced financial cost to the healthcare system.

### Provincial Key Findings

- ▶ **Figure 14** shows that in Manitoba, the number of hospital days for acute care remained stable over time with a slight, not statistically significant decrease.
- ▶ There was considerable variation in hospital days for acute care across all health regions, with the lowest in Winnipeg RHA and the highest in Northern Health Region, which had significantly higher rates than the province in both time periods.
- ▶ In Manitoba, the most frequent causes of hospital days were circulatory diseases (11.7%), health status and contact (11.7%), mental illness (11.1%), injury and poisoning (9.3%), and respiratory diseases (9.5%). The top causes did not change much over time.
- ▶ **Income:** Hospital days for acute care were very strongly related to income.<sup>x</sup> The rate among the residents of the lowest income areas was 2.1 times higher than the residents of the highest income areas.



**Figure 14. Hospital Days for Acute Stays (Excluding Newborns) by RHA, 2011-2012 (T1) and 2016-2017 (T2)**  
Age- and sex-adjusted per 1,000 residents (all ages)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	412,097	109,142	844,018	87,076	159,209	52,871
T2 RATE	513.5	618.4	628.4	634.4	766.0	1198.7 H
T1 RATE	516.6	690.3	636.2	611.1	806.2	1140.6 H

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## Regional Key Findings

### SH-SS Level

- Table 12 shows that rates remained stable over time in the region with a slight, not statistically significant decrease.

### Zone Level

- There was variation across zones from the lowest rate in Zone 4 to the highest rate in Zone 1 in the current time period.

### District Level

- There was a considerable difference of about 834 days between the lowest district of Cartier/SFX and the highest district of Seven Regions in the current time period.
- In both time periods, Seven Regions was significantly higher than the provincial average; indicating that this population had a higher proportion of more acutely ill residents that required hospitalization.

**Table 12. Hospital Days for Acute Care (Excluding Newborns) in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


Age- and sex-adjusted per 1,000 residents (all ages)

	T2		T1			T2		T1	
	Count	Rate	Rate	Count		Rate	Rate		
<b>Manitoba</b>	<b>844,018</b>	<b>628.4</b>	<b>636.2</b>		<b>SH-SS</b>	<b>109,142</b>	<b>618.4</b>	<b>690.3</b>	
<b>Zone 4</b>	<b>34,697</b>	<b>540.2</b>	<b>671.4</b>		<b>Zone 2</b>	<b>16,418</b>	<b>544.1</b>	<b>578.2</b>	
Niverville/Ritchot	4,668	442.0	536.9		Morris	2,339	424.6	460.7	
Ste. Anne/ La Broquerie	5,696	516.2	573.1		Macdonald	2,485	436.6	488.6	
Taché	3,142	526.9	411.8		St. Pierre/ De Salaberry	2,333	544.7	532.9	
Hanover	5,577	535.7	547.2		Carman	4,918	556.1	690.7	
Steinbach	11,499	545.5	666.9		Grey	1,633	595.8	490.2	
Rural East	4,115	693.2	635.7		Red River South	2,710	647.2	664.2	
<b>Zone 3</b>	<b>30,677</b>	<b>619.0</b>	<b>630.6</b>		<b>Zone 1</b>	<b>27,350</b>	<b>805.2</b>	<b>794.0</b>	
Stanley	1,464	505.2	- 759.4		Cartier/SFX	2,043	420.5	478.3	
Winkler	9,028	581.5	674.9		North Norfolk	3,057	665.4	501.8	
Altona	5,793	597.0	506.4		City of Portage	11,590	692.1	795.3	
Morden	6,824	621.1	620.6		Rural Portage	4,174	696.3	752.8	
Lorne/Louise/ Pembina	6,276	628.4	660.8		Seven Regions	6,486	1,254.6	H 1,147.7	H
Roland/ Thompson	1,292	655.6	628.2						

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

### Geographic Disparity

- The geographic disparity between the districts increased over time, meaning the gap between the districts with the lowest and highest rates of hospital days for acute care widened.

SH-SS Geographic Disparity Ratio	
	T1 2.8x
	T2 3.0x
	Change 0.2 ↑

T1: 2011-2012, T2: 2016-2017

## Where Residents Were Hospitalized: Hospital Location

### Definition

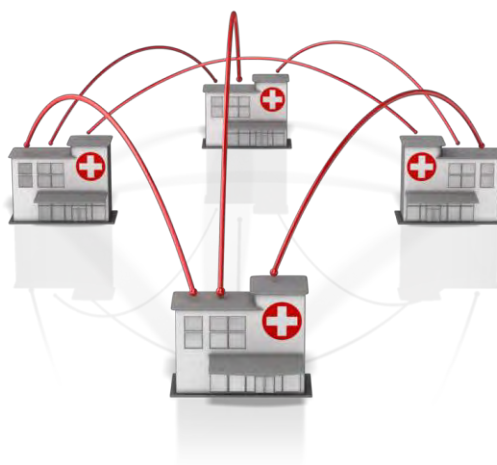
The percentage of all hospitalizations of residents by location: within their home health region, in another health region, in Winnipeg or out-of-province, for a one-year time period. If a patient transfers to another hospital, each stay is counted as a separate event and attributed to the appropriate location.

### Why is this indicator important?

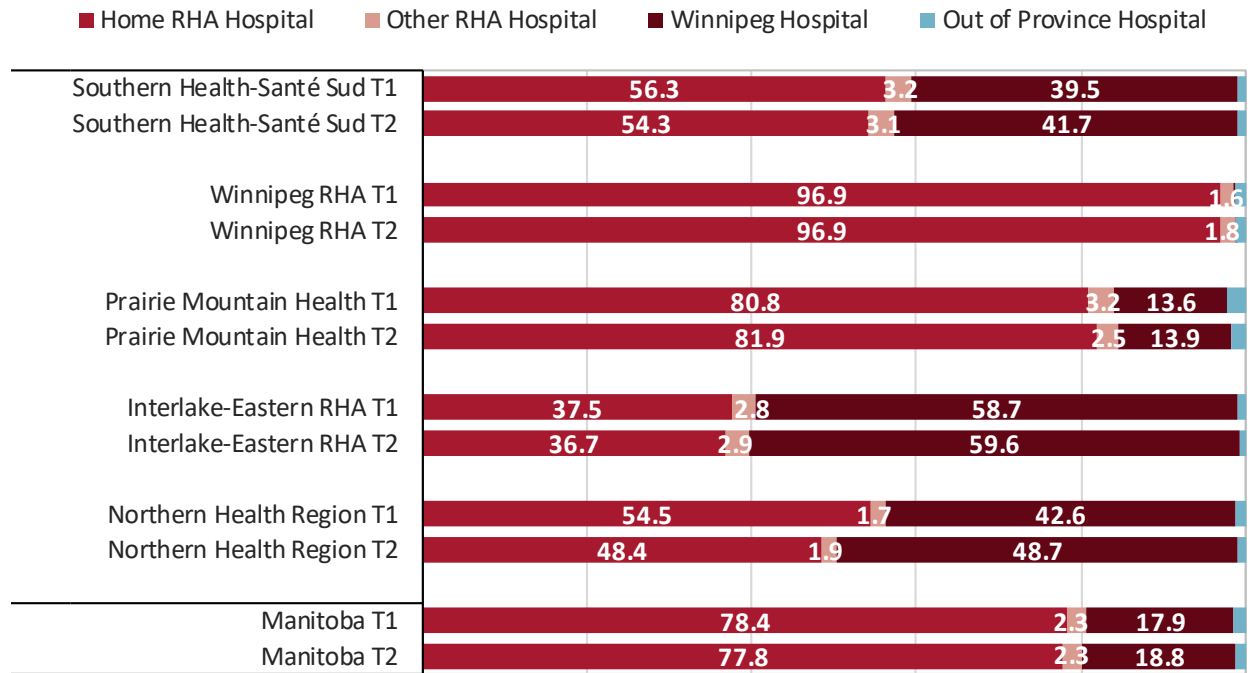
Understanding where residents were hospitalized and the proportion of residents who travel to receive appropriate healthcare services is important for healthcare resource planning to meet resident needs and address barriers to care.

### Provincial/Regional Key Findings

- ▶ **Figure 15** shows that in every RHA, the majority of residents were hospitalized either in their home region followed by Winnipeg (among rural RHAs), with the exception of Interlake-Eastern RHA. This has remained stable over time.
- ▶ Hospitalization location differed slightly when examining separate hospital stays and hospital days. Rural RHAs had greater percentages of hospital days within their region compared to hospital separations; however, these differences were not tested statistically.
- ▶ In Southern Health-Santé Sud, the majority of residents were hospitalized within the region, followed by within Winnipeg, in another RHA, and out of province.
- ▶ These percentages have remained relatively stable over time; however, the changes were not tested statistically.
- ▶ The percentage of residents receiving care within the region was greater for hospital days than hospital separations; however, the difference was not tested statistically.



**Figure 15. Where RHA Patients Went for Hospitalization, 2011-2012 (T1) and 2016-2017 (T2)**



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## Hospital Days for Alternate Level of Care Stays

### Definition

The number of days of hospital care provided to patients (excluding newborns) who were designated as alternate level of care (ALC), per 1,000 population, for a one-year time period. A patient may be designated as ALC if they are occupying an acute care hospital bed but no longer require the intensity of resources and services provided in an acute care setting.

### Why is this indicator important?

Reducing the number of ALC hospital days helps to ensure patients are cared for in the most appropriate setting and that hospital resources are used more efficiently, resulting in substantial cost savings for the healthcare system.

### Provincial Key Findings

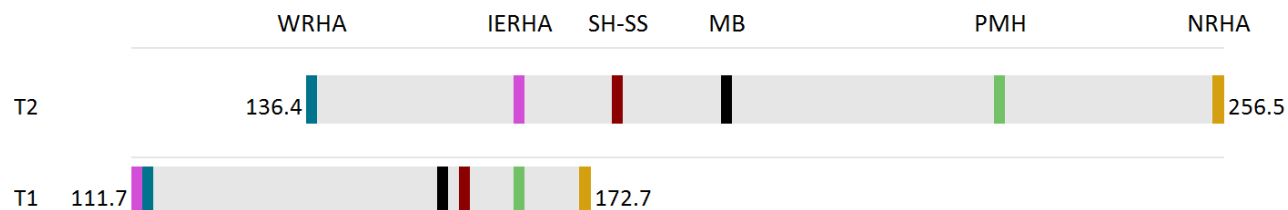
- ▶ **Figure 16** shows that the rate remained stable over time in Manitoba with a slight, not statistically significant increase. This trend was observed across all regions.
- ▶ Northern Health Region and Prairie Mountain Health had the highest hospital days for ALC; however, the rate was not statistically different than the Manitoba average.
- ▶ **Income:** Hospital days for ALC were very strongly related to income. Residents of lower income areas had much higher rates than residents of higher income areas.<sup>xi</sup>



*Hospital days for ALC  
very strongly related to  
income*

**Figure 16. Hospital Days for ALC Stays (Excluding Newborns) by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted per 1,000 residents (all ages)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	SH-SS	MB	PMH	NRHA
T2 COUNT	73,640	31,748	45,593	243,007	56,826	6,878
T2 RATE	136.4	164.6	176.3	191.7	227.5	256.5
T1 RATE	113.4	111.7	157.3	153.4	164.6	172.7

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 13 shows that hospital days for ALC remained stable over time in the region with a slight, not statistically significant increase.
- The majority of ALC coded patients within the region are awaiting placement for a personal care home bed.

### Zone Level

- Rates varied across zones from the lowest in Zone 4 to the highest in Zone 2.

### District Level

- There was a difference of about 536 days per 1,000 residents between the lowest district of Stanley and the highest district of Morris.
- Niverville/Ritchot, Macdonald, and Stanley had rates significantly lower than the Manitoba average in the current time period.
- Over time, rates in Niverville/Ritchot and Macdonald decreased significantly, while rates in Morris and Cartier/SFX increased significantly.

**Table 13. Hospital Days for ALC Stays (Excluding Newborns) in Southern Health-Santé Sud, 2011-2012 (T1) and 2016-2017 (T2)**


Age- and sex-adjusted per 1,000 residents (all ages)

	T2		T1	
	Count	Rate	Rate	
<b>Manitoba</b>	<b>243,007</b>	<b>191.7</b>	<b>153.4</b>	
<b>Zone 4</b>	<b>9,137</b>	<b>136.9</b>	<b>107.3</b>	
Niverville/Ritchot	173	23.9	L- 130.4	
Hanover	1,155	69.2	78.9	
Rural East	969	75.5	73.9	
Ste. Anne/La Broquerie	1,457	131.0	65.5	
Steinbach	4,327	149.3	91.4	
Taché	1,056	256.3	90.3	
<b>Zone 3</b>	<b>12,270</b>	<b>162.1</b>	<b>181.3</b>	
Stanley	47	16.2	L 69.6	
Roland/Thompson	57	33.4	60.6	
Lorne/Louise/Pembina	2,585	115.7	88.7	
Morden	2,138	126.1	167.9	
Winkler	4,322	181.7	117.6	
Altona	3,121	187.2	379.2	
<b>SH-SS</b>	<b>45,593</b>	<b>176.3</b>	<b>157.3</b>	
<b>Zone 2</b>	<b>11,204</b>	<b>215.7</b>	<b>178.8</b>	
Macdonald	130	16.6	L- 323.1	
St. Pierre/De Salaberry	924	41.9	57.9	
Carman	4,245	123.4	83.3	
Red River South	757	154.9	109.6	
Grey	2,463	187.1	302.3	
Morris	2,685	552.4	+ 73.0	
<b>Zone 1</b>	<b>12,982</b>	<b>191.0</b>	<b>133.0</b>	
Rural Portage	175	39.8	96.3	
City of Portage	6,294	122.7	146.8	
Seven Regions	3,243	127.1	44.7	
Cartier/SFX	85	307.6	+ 25.5	
North Norfolk	3,185	352.2	173.2	

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

### Geographic Disparity

- There were large geographic disparities between the districts with the lowest and highest rates of hospital days for alternate level of care in both time periods. There was also a large increase in the geographic disparity over time, meaning the gap between the lowest and highest districts widened.

SH-SS Geographic Disparity Ratio	
	T1 14.8x
	T2 34.1x
	Change 19.3 ↑

T1: 2011-2012, T2: 2016-2017



## Hospital Catchment: Where Patients Using RHA Hospitals Came From

### Definition

The percentage of all hospitalizations by residents of each health region within the resident’s home health region, another health region, Winnipeg, or out-of-province, for a one-year time period.

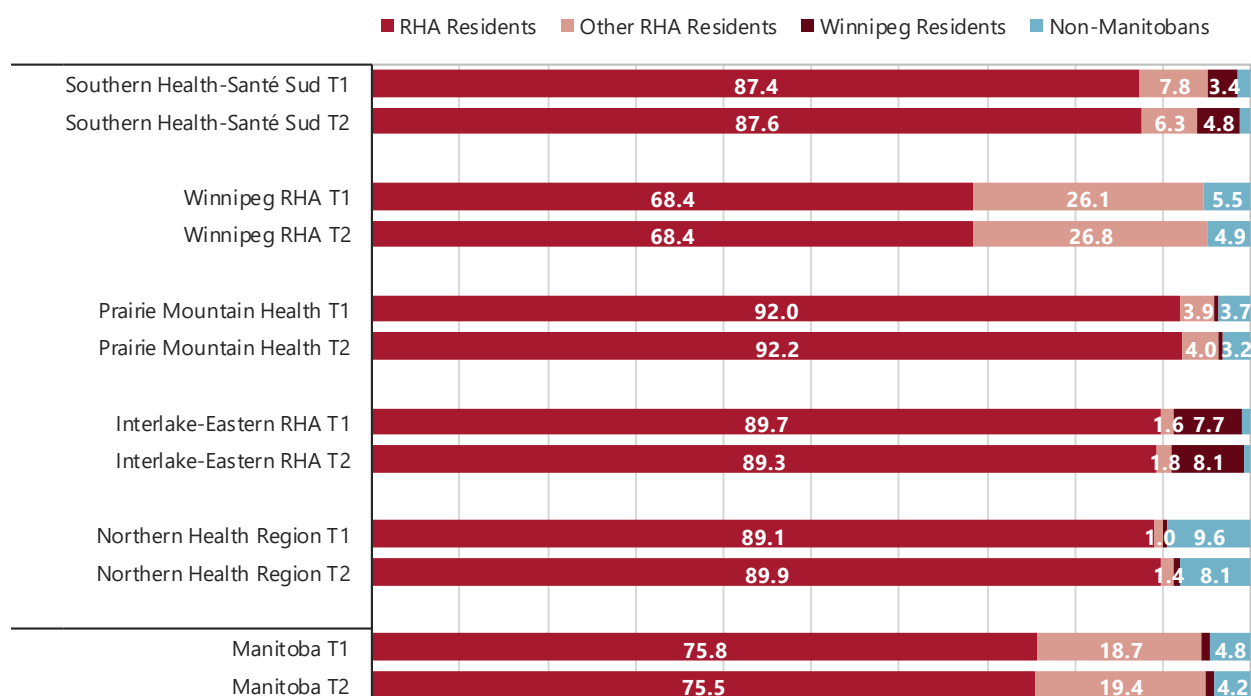
### Why is this indicator important?

Where residents are hospitalized provides valuable insight into the availability and accessibility of acute care services, which helps to plan and allocate resources appropriately.

### Provincial/Regional Key Findings

- ▶ **Figure 17** shows that in every RHA, the majority of hospital patients were residents of that region. These findings have remained stable over time.
- ▶ Almost 5% of care in Manitoba hospitals were for out-of-province residents.
- ▶ In Southern Health-Santé Sud, 87.6% of hospital patients were regional residents.
- ▶ Out of the rural regions, Southern Health-Santé provided the highest percentage of hospital care to residents from other regions.
- ▶ These regional percentages remained stable over time; however, the changes were not tested statistically.

**Figure 17. Where RHA Patients Came for Hospitalization, 2011-2012 (T1) and 2016-2017 (T2)**



## Hospital Readmission Rate

### Definition

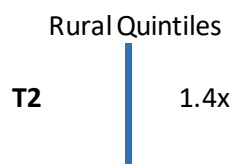
Unplanned inpatient readmissions to an acute care facility (the same or different hospital) within 30 days, following discharge, for a one-year time period.

### Why is this indicator important?

Hospital readmission is a nationally used indicator of overall health system performance. Although readmission may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to review practices, including discharge planning and continuity of services after discharge. Reducing hospital readmissions is a recognized strategy to improve patient outcomes and reduce healthcare costs.

### Provincial Key Findings

- ▶ **Figure 18** shows there were 8,642 hospital readmissions among Manitoba residents in the current time period.
- ▶ Over time, percentages decreased significantly in Southern Health-Santé Sud.
- ▶ In both time periods, Winnipeg RHA residents had significantly lower percentages than the provincial average, while the percentages were significantly higher in Prairie Mountain Health and Northern Health Region.
- ▶ **Income:** Hospital readmission rates were strongly related to income.<sup>xii</sup> The residents of the lowest income areas had 1.4 times more readmissions compared to the residents of the highest income areas.

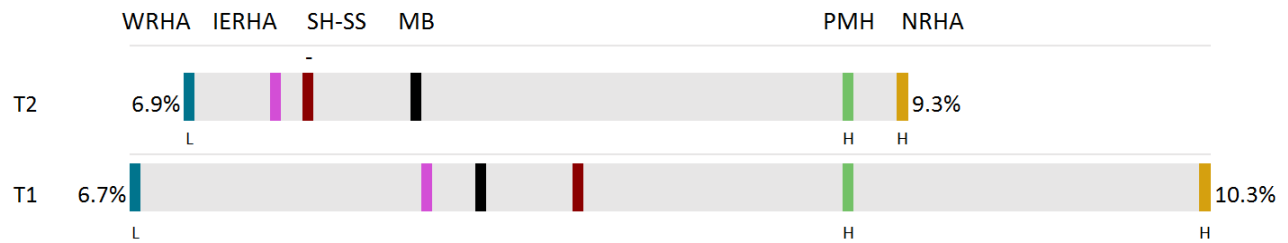


T2: 2016-2017

*Hospital readmissions  
strongly related to  
income*

**Figure 18. Hospital Readmissions by RHA, 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of hospital episodes with a readmission within 30 days of discharge



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	SH-SS	MB	PMH	NRHA
T2 COUNT	3,865	861	1,225	8,642	1,877	806
T2 RATE	6.9% L	7.2% +	7.3% -	7.7%	9.1% H	9.3% H
T1 RATE	6.7% L	7.7% +	8.2% +	7.9%	9.1% H	10.3% H

MCHP RHA Indicators Atlas 2019

## Regional Key Findings

### SH-SS Level

- Table 14 shows 1,225 hospital readmissions within 30 days of discharge in the region in the current time period.
- Hospital readmission rates decreased significantly over time.

### Zone Level

- There were similar rates across zones.
- Zone 4 was significantly lower than the provincial average in the current time period.
- Zone 1 decreased significantly over time.

### District Level

- In the current time period, rates ranged from the lowest in North Norfolk to the highest in Seven Regions.

**Table 14. Hospital Readmissions in Southern Health-Santé Sud, , 2011-2012 (T1) and 2016-2017 (T2)**

Age- and sex-adjusted percent of hospital episodes with a readmission within 30 days of discharge

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>8,642</b>	<b>7.7</b>		<b>7.9</b>	
<b>Zone 4</b>	<b>356</b>	<b>6.5</b>	<b>L</b>	<b>7.4</b>	
Taché	23	4.5		5.8	
Niverville/ Ritchot	39	4.7		6.4	
Ste. Anne/ La Broquerie	54	5.3		6.2	
Steinbach	127	6.7		8.5	
Rural East	35	7.4		6.3	
Hanover	78	8.4		6.9	
<b>SH-SS</b>	<b>1,225</b>	<b>7.3</b>	<b>-</b>	<b>8.2</b>	
<b>Zone 2</b>	<b>195</b>	<b>7.6</b>		<b>7.3</b>	
Morris	19	4.9		7.6	
Macdonald	21	5.1		4.6	
Grey	22	7.4		6.8	
Red River South	36	8.0		7.5	
St. Pierre/ De Salaberry	32	9.0		7.9	
Carman	65	9.4		7.7	
<b>Zone 3</b>	<b>376</b>	<b>7.5</b>		<b>8.3</b>	
Altona	43	5.8		8.0	
Winkler	118	7.7		7.2	
Morden	91	8.1		7.1	
Roland/ Thompson	18	8.5		7.7	
Lorne/Louise/ Pembina	104	8.9		10.1	
Stanley	s			6.6	
<b>Zone 1</b>	<b>298</b>	<b>7.4</b>	<b>-</b>	<b>9.0</b>	
North Norfolk	13	3.6		6.1	
Cartier/SFX	24	4.8		5.7	
Rural Portage	38	6.3		8.2	
City of Portage	141	7.7		9.0	
Seven Regions	82	10.1		11.6	H

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- ▶ The geographic disparity increased over time, meaning the gap between the districts with the lowest and highest hospital readmission rates widened.

SH-SS Geographic Disparity Ratio	
	T1 2.5x
	T2 2.8x
	Change 0.3 ↑

T1: 2011-2012, T2: 2016-2017

## Caesarean Section

### Definition

The percentage of caesarean section (C-section) procedures for in-hospital births among female residents for a two-year time period.

### Why is this indicator important?

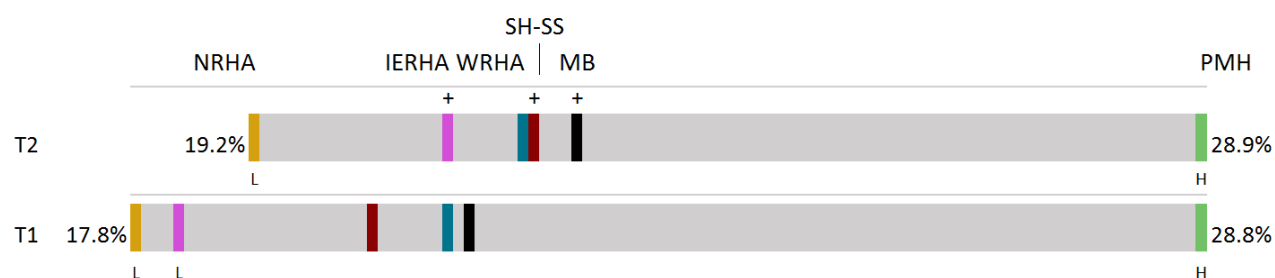
C-sections are associated with a greater risk of maternal morbidity, negative maternal and infant health outcomes, and higher costs to the health care system. C-section prevalence is often used to monitor clinical practices, with an implicit assumption that lower rates indicate more appropriate and efficient care.

### Provincial Key Findings

- ▶ **Figure 19** shows there was a total of 7,446 C-sections among Manitoba females in the current time period.
- ▶ Over time, the percentage of C-sections increased significantly in Manitoba, Interlake-Eastern RHA, and Southern Health-Santé Sud.
- ▶ In both time periods, Prairie Mountain Health had a significantly higher percentage of C-sections, while Northern Health Region was significantly lower than the provincial average.
- ▶ **Age:** The proportion of C-sections for women 40 years of age and older was generally higher than all other age groups.

**Figure 19. Caesarean Sections by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Maternal age-adjusted average annual percent of singleton in-hospital births



H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		WRHA		SH-SS		MB		PMH	
T2 COUNT	584		586		3,813		1,276		7,446		1,183	
T2 RATE	19.2%	L	21.2%	+	21.9%		22.1%	+	22.5%	+	28.9%	H
T1 RATE	17.8%	L	18.4%	L	21.1%		20.4%		21.4%		28.8%	H

## Regional Key Findings

### SH-SS Level

- ▶ **Table 15** shows a regional total of 1,276 C-sections; representing about 22% of in-hospital births.
- ▶ The percentage of C-sections increased significantly over time.

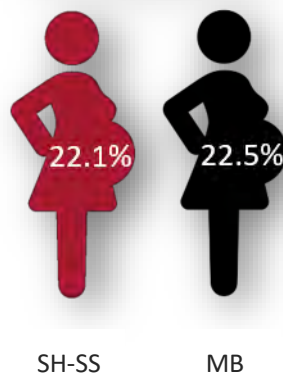
### Zone Level

- ▶ The percentages varied between zones from the lowest in Zone 4 to the highest in Zone 1.
- ▶ In the current time period, Zone 4 was significantly lower than the provincial average, while Zones 1 and 3 were significantly higher.
- ▶ Over time, C-sections increased significantly in Zone 3.

### District Level

- ▶ In the current time period, there was a difference of almost 28% between the lowest district of Hanover and the highest district of Rural East.
- ▶ In the current time period, Hanover was significantly lower than the provincial average, while Rural East and Seven Regions were significantly higher.
- ▶ Stanley and Roland/Thompson experienced significant increases over time.

Caesarean Section  
% in-hospital births



**Table 15. Caesarean Sections in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Maternal age-adjusted average annual percent of singleton in-hospital births

	T2			T1	
	Count	Percentage		Percentage	
<b>Manitoba</b>	<b>7,446</b>	<b>22.5</b>	<b>+</b>	<b>21.4</b>	
<b>Zone 4</b>	<b>389</b>	<b>17.6</b>	<b>L</b>	<b>19.1</b>	
Hanover	64	13.7	L	17.9	
Taché	36	16.8		18.4	
Niverville/ Ritchot	67	16.8		16.3	
Ste. Anne/ La Broquerie	70	17.1		21.9	
Steinbach	124	18.9		19.7	
Rural East	28	41.5	H	29.5	
<b>SH-SS</b>	<b>1,276</b>	<b>22.1</b>	<b>+</b>	<b>20.4</b>	
<b>Zone 2</b>	<b>154</b>	<b>19.7</b>		<b>15.9</b>	<b>L</b>
Macdonald	27	15.5		17.7	
St. Pierre/ De Salaberry	17	17.5		14.7	
Morris	26	18.7		11.9	
Grey	16	19.9		15.0	
Carman	38	23.3		18.4	
Red River South	30	25.0		16.9	
<b>Zone 3</b>	<b>422</b>	<b>26.2</b>	<b>H+</b>	<b>19.8</b>	
Lorne/Louise/ Pembina	44	19.0		16.2	
Altona	74	25.9		19.8	
Winkler	160	26.6		22.4	
Morden	77	27.0		19.9	
Stanley	47	30.8	+	17.3	
Roland/ Thompson	20	31.7	+	13.1	
<b>Zone 1</b>	<b>311</b>	<b>26.4</b>	<b>H</b>	<b>26.2</b>	<b>H</b>
Cartier/SFX	36	19.5		17.2	
North Norfolk	32	24.1		16.4	
City of Portage	103	26.1		30.9	H
Rural Portage	65	26.2		25.3	
Seven Regions	75	33.6	H	29.6	


H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

MCHP RHA Indicators Atlas 2019

## Geographic Disparity

- The geographic disparity increased over time, meaning the gap between the districts with the lowest and highest percentages of C-sections widened.

SH-SS Geographic Disparity Ratio	
	T1 2.6x
	T2 3.0x
	Change 0.4 ↑

T1: 2010/11-2011/12, T2: 2015/16-2016/17

## Vaginal Birth after Caesarean Section (VBAC)

### Definition

The percentage of female residents aged 15 to 54 giving birth vaginally, in a five-year period, who had previously had at least one delivery by caesarean section (C-section).

### Why is this indicator important?

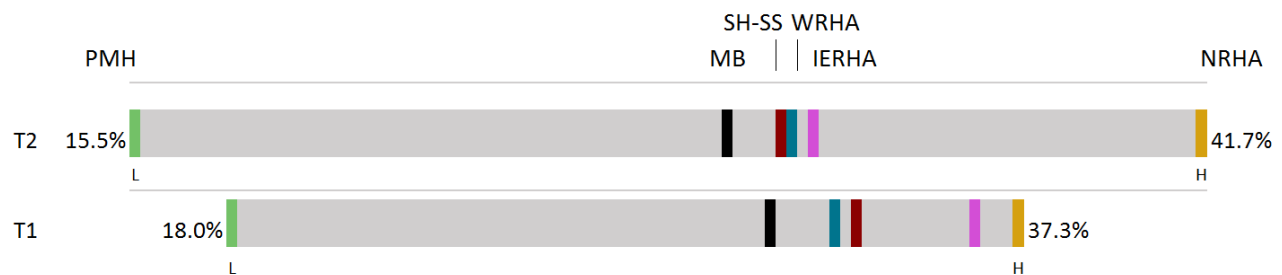
Vaginal birth is a safe option for many women who previously had a C-section and is preferred because there is less risk to the mother and a shorter recovery time. Clinical practice guidelines recommend women who had a previous C-section be offered the opportunity to deliver vaginally following discussion about maternal and perinatal risks and benefits with their healthcare provider.

### Provincial Key Findings

- ▶ **Figure 20** shows there were 2,847 VBACs among Manitoba females in the current time period.
- ▶ In both time periods, Prairie Mountain Health was significantly lower than the provincial average, while Northern Health Region was significantly higher.
- ▶ **Age:** The majority of women who had a VBAC were between the ages of 25 to 34 years.

**Figure 20. VBAC by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted percent of births among females with previous C-section



H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period

	PMH	MB	SH-SS	WRHA	IERHA	NRHA
T2 COUNT	230	2,847	549	1,450	232	384
T2 RATE	15.5% L	30.2%	31.5%	31.7%	32.4%	41.7% H
T1 RATE	18.0% L	31.2%	33.2%	32.7%	36.3%	37.3% H

MCHP RHA Indicators Atlas 2019



## Regional Key Findings

### SH-SS Level

- Table 16 shows a total of 549 VBACs in the region in the current time period; representing 31.5%.

### Zone Level

- Percentages ranged from the lowest in Zone 1 to the highest in Zone 4.

### District Level

- In both time periods, there was a difference of about 40% between the lowest district of city of Portage and the highest district of St. Pierre/De Salaberry.

**Table 16. VBAC in Southern Health-Santé Sud, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)**

Maternal age-adjusted percent of births among females with previous C-section

	T2		T1		
	Count	Percentage	Percentage	Percentage	
<b>Manitoba</b>	<b>2,847</b>	<b>30.2</b>		<b>31.2</b>	
<b>Zone 4</b>	<b>205</b>	<b>35.6</b>		<b>35.6</b>	
Rural East	s			s	
Hanover	41	38.1		32.6	
Steinbach	75	37.1		35.5	
Niverville/ Ritchot	31	36.3		45.2	
Taché	22	33.6		35.7	
Ste. Anne/ La Broquerie	31	32.8		32.7	
<b>Zone 2</b>	<b>71</b>	<b>33.5</b>		<b>41.1</b>	
St. Pierre/ De Salaberry	12	61.1		62.5	H
Morris	13	35.8		39.5	
Macdonald	13	34.9		38.5	
Red River South	14	33.3		30.4	
Carman	12	26.2		39.7	
Grey	7	23.5		39.5	
<b>Zone 3</b>	<b>157</b>	<b>30.3</b>		<b>33.6</b>	
Lorne/Louise/ Pembina	29	45.9		35.8	
Roland/ Thompson	7	39.0		61.4	
Stanley	19	31.4		40.2	
Altona	29	30.1		23.2	
Morden	27	27.5		31.3	
Winkler	46	25.4		33.7	
<b>Zone 1</b>	<b>116</b>	<b>27.3</b>		<b>25.6</b>	
Cartier/SFX	22	36.1		32.5	
North Norfolk	14	32.0		35.0	
Seven Regions	28	28.2		26.6	
Rural Portage	21	25.1		24.6	
City of Portage	31	22.4		20.4	

H/L Significantly higher or lower than the MB average for that time period.


+/- A significant increase (+) or decrease (-) since the first time period

s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019

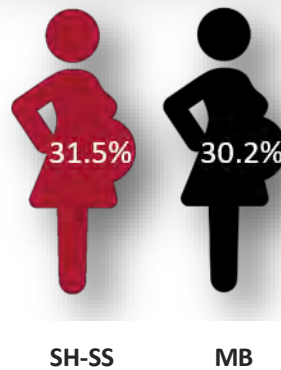
**Geographic Disparity**

- ▶ The geographic disparity decreased over time, meaning the gap between the districts with the lowest and highest percentages of VBACs reduced.

SH-SS Geographic Disparity Ratio		
	T1	3.1x
	T2	2.7x
	Change	-0.4 ↓

T1: 2010/11-2011/12, T2: 2015/16-2016/17

**Vaginal Birth after C-Section**  
% among women 15-64 years



## Canadian Patient Experience Survey—Inpatient Care

### Definition

The percentage of adult patients participating in the Canadian Patient Experience Survey – Inpatient Care (CPES-IC), over a one-year time period, who reported positively about the quality of care they received during a recent hospital stay. It excludes patients admitted for primary mental health diagnosis or from a mental health facility, admitted from correctional facilities, discharged to personal care homes, or selected for the survey in the last 12 months within the same hospital.

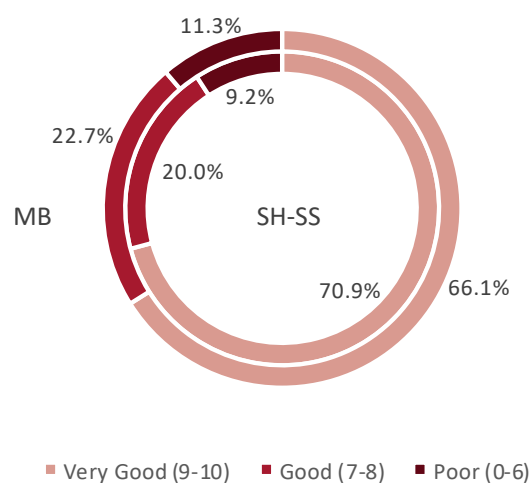
### Why is this indicator important?

This survey is a partnership between all health regions and the Manitoba government, as part of a larger initiative across Canada that supports comparison of patients’ experiences across the country. It supports quality improvement initiatives at all service delivery sites, informs hospital care and supports accreditation processes.

### Provincial/Regional Key Findings

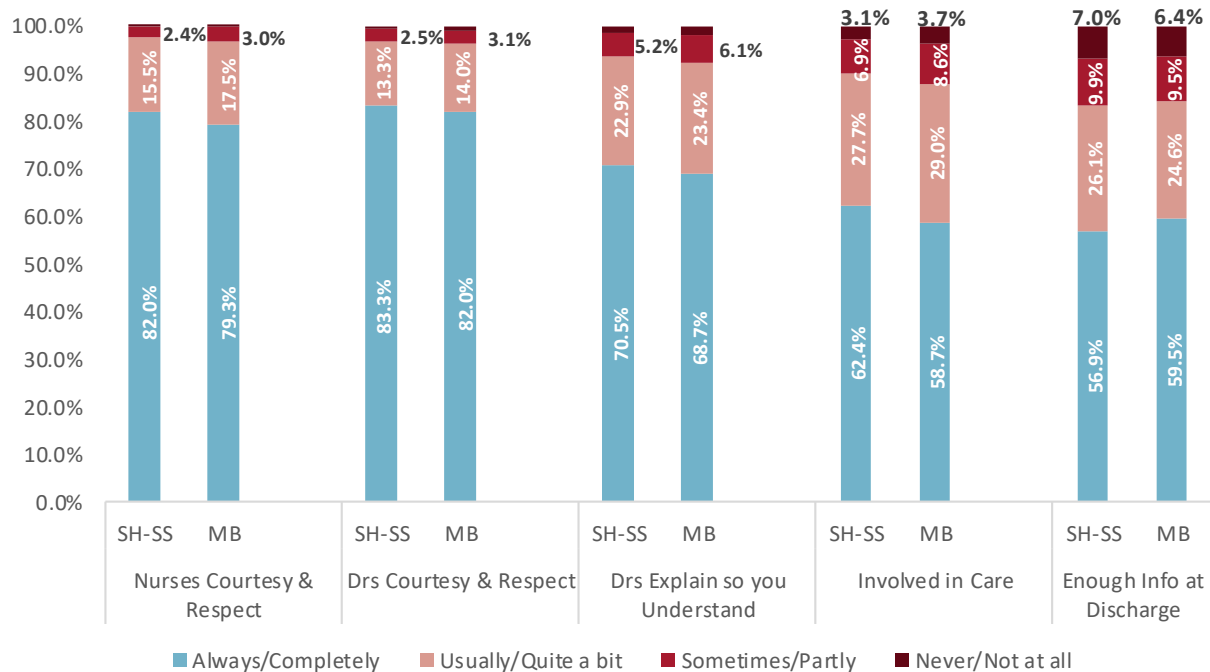
- ▶ In Southern Health-Santé Sud, a total of 1,894 inpatients completed the CPES-IC with a response rate of 44%. The response rate was among the best in the province and about 10% greater than the response rate for Manitoba (33.4%).
- ▶ **Figure 21** shows that the majority of inpatients reported a very good overall hospital experience in the region and the province.
- ▶ **Figure 22** shows that the majority of inpatients responded positively to key questions in the region and the province. Fewer inpatients reported very good involvement in their care and completely receiving enough information at discharge in both the region and the province.

**Figure 21. Overall Hospital Experience Rating in Southern Health-Santé Sud and Manitoba, 2017-2018**



Non-applicable responses removed from denominator

Figure 22. Responses to the CPES-IC in Southern Health-Santé Sud and Manitoba, 2017-2018



Non-applicable responses removed from denominator

**Questions from survey**

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did doctors treat you with courtesy and respect?
3. During this hospital stay, how often did doctors explain things in a way you could understand?
4. Were you involved as much as you wanted to be in decisions about your care and treatment?
5. Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?

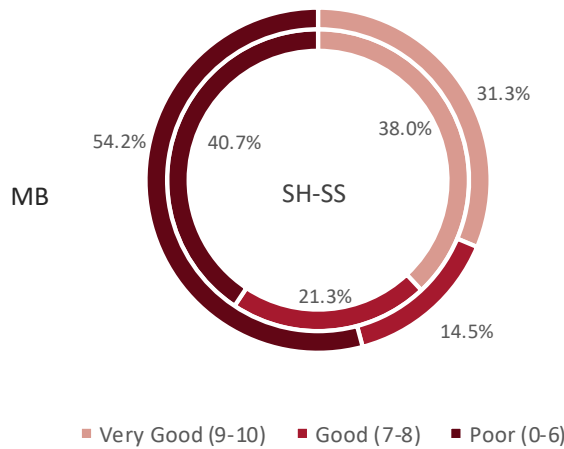
**A CLOSER LOOK...**

The Canadian Patient Experience Survey – In patient Care is a 49 question survey with 10 new questions added around patient safety and services in French. Upon discharge, patients are mailed a copy of the survey to complete at home. Patients also have an online option and a French option. All Regional Health Authorities in Manitoba are now using the same survey and data collection for rural regions is coordinated provincially. For more information about the survey, please visit <https://www.cihi.ca/en/patient-experience>

## French Language Services

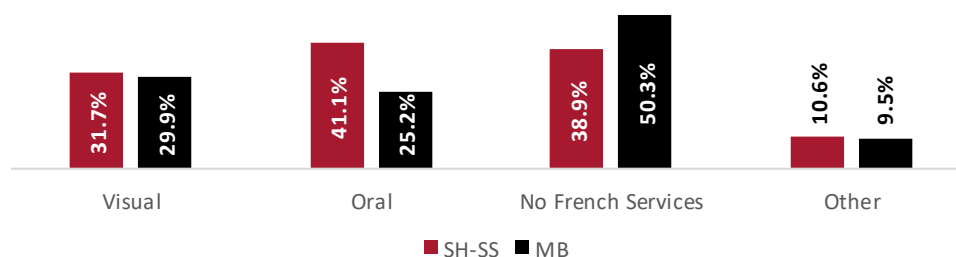
- In Southern Health-Santé Sud, 11% of respondents spoke French well enough to conduct a conversation, compared to 8% in Manitoba.
- Figure 23** shows that 38% of respondents in Southern Health-Santé Sud had positive overall ratings of quality of French language services, compared to 31% for Manitoba. However, for both the region and the province, the largest percentage of patients rated their experience as poor compared to any other category, although not tested statistically.
- Figure 24** shows that oral French services in the region were offered more frequently than other types and compared to the province; however, these differences were not tested statistically. The percentage of inpatients reporting not receiving French language services was lower in the region compared to the province; however, remained high.

**Figure 23. Inpatients’ Ratings of Overall Experience of Quality of French Language Service in Southern Health-Santé Sud and Manitoba, 2017-2018**



Non-applicable responses removed from denominator

**Figure 24. How were French Language Services Offered to Inpatients in Southern Health-Santé Sud and Manitoba, 2017-2018**



Non-applicable responses removed from denominator  
Not mutually exclusive categories

## A CLOSER LOOK...

### How do we meet the needs of the Francophone population?



#### ACTIVE OFFER

Active offer is a set of measures taken to ensure that French language services are readily available, easily accessible and comparable to that of services provided in English. In other words, it means informing the client at first point of contact that English and French services are available. The objective of active offer is to ensure that the client feels completely welcome and comfortable to communicate in the official language of their choice. Active offer starts off with a simple greeting such as 'hello-bonjour'. It's that easy.

#### RECRUITMENT AND RETENTION OF DESIGNATED BILINGUAL POSITIONS: IT TAKES A VILLAGE!

A consistent, regional approach is used to designate positions in Southern Health-Santé Sud. Every effort is made to fill our Southern Health-Santé Sud designated bilingual positions with bilingual staff. As part of the recruitment and selection process, managers are encouraged to connect with existing internal and external networks to reach broader community stakeholders in an attempt to recruit new potential employees.

In 2018, Southern Health-Santé Sud received a Leading Practice recognition from the Health Standards Organization (HSO) for its approach regarding recruitment and retention into Designated Bilingual Positions – a Standardized, Integrated and Collaborative Approach. Developed as a first in Manitoba, this electronic, cost neutral practice responds to challenges related to consistently achieving standardized recruitment, selection, monitoring and reporting of over 600 designated bilingual positions (DBPs). This practice provides standardized steps and checkpoints in recruiting and filling DBPs with bilingual incumbents to meet the ultimate goal of providing the right service, at the right time, by the right health care provider.

#### OFFRE ACTIVE

L'offre active est un ensemble de mesures prises pour s'assurer que les services en français soient immédiatement accessibles, facilement accessibles et comparables à ceux offerts en anglais. Autrement dit, il s'agit d'informer les bénéficiaires dès le premier point de contact que les services sont offerts en français et en anglais. L'objectif de l'offre active est de s'assurer que les bénéficiaires se sentent bien accueillis et à l'aise de communiquer dans la langue officielle de leur choix. L'offre active commence par un simple message d'accueil comme « hello – bonjour ». C'est aussi simple que ça.

#### RECRUTEMENT ET MAINTIEN DE L'EFFECTIF AUX POSTES DÉSIGNÉS BILINGUES : ÇA PREND TOUT UN VILLAGE!

Southern Health-Santé Sud applique une procédure régionale cohérente pour désigner ses postes bilingues. On fait tout ce qu'il faut pour doter les postes désignés bilingues de Southern Health-Santé Sud par du personnel bilingue. Dans le cadre de la procédure de recrutement et de sélection, on recommande aux gestionnaires d'établir des liens avec les réseaux internes et externes existants, en vue d'entrer en contact avec plus d'intervenants communautaires dans le dessein de recruter de nouveaux employés potentiels.

En 2018, l'Organisation de normes en santé (HSO) a reconnu Southern Health-Santé Sud pour sa « pratique exemplaire » en matière de recrutement et de maintien de l'effectif aux postes désignés bilingues par une méthode normalisée, intégrée et collaborative. Une première au Manitoba, ce concept électronique, sans incidence sur les coûts, permet de relever les défis d'application constante d'une procédure normalisée de recrutement, de sélection, de suivi et de déclaration pour plus de 600 postes désignés bilingues (PDB). Cette pratique prévoit des étapes et des points de contrôle normalisés pour le recrutement et la dotation des PDB par des candidats bilingues, afin d'atteindre l'objectif ultime de fournir le bon service en temps opportun, par le prestataire de soins qui convient.

## SH-SS DESIGNATED BILINGUAL POSITIONS (DBPs) (March 2019)

607 DBPs  
 358 DBPs filled by bilingual incumbents  
 195 DBPs filled by non-bilingual incumbents  
 54 DBPs vacant

### VILLA YOUNVILLE DBPs

104 DBPs  
 74 DBPs filled by bilingual incumbents  
 24 DBPs filled by non-bilingual incumbents  
 6 DBPs vacant

## FIRST OF ITS KIND: A NATIONAL STANDARD ON OFFICIAL LANGUAGES

Released in 2018, *Access to Health and Social Services in Official Languages* is a national standard which aims to improve access to health and social services across the continuum of care for Canada's official language communities. Essentially, this standard specifies the requirements for health and social service organizations to promote access and delivery to safe health and social services in the patient's preferred or required official language. In 2016, Southern Health-Santé Sud participated in a pilot exercise to test the initial framework of the national standard. Carried out as an optional Recognition Program concurrent to the Accreditation cycle, the program will evaluate quality at each level of Recognition through the use of outcome, process, and structural indicators.

## SH-SS POSITIONS DÉSIGNÉES BILINGUES (PDBs) (en mars 2019)

607 PDBs  
 358 PDBs occupés par des titulaires bilingues  
 195 PDBs par des titulaires non-bilingues  
 54 PDBs vacants

### VILLA YOUNVILLE PDBs

104 PDBs  
 74 PDBs occupés par des titulaires bilingues  
 24 PDBs occupés par des titulaires non-bilingues  
 6 PDBs vacants

## PREMIÈRE DU GENRE : UNE NORME NATIONALE SUR LES LANGUES OFFICIELLES

Adoptée en 2018, la norme nationale intitulée *L'accès aux services de santé et aux services sociaux dans les langues officielles* vise à améliorer l'accès des deux langues officielles du Canada à des services de santé et des services sociaux dans le continuum des soins. Essentially, cette norme précise les exigences auxquelles les organismes de santé et de services sociaux doivent satisfaire pour promouvoir l'accès et la prestation de services de santé et de services sociaux sécuritaires dans la langue officielle préférée ou requise du patient. En 2016, Southern Health-Santé Sud a participé à un exercice visant à mettre le cadre initial de la norme nationale à l'essai. Appliqué en tant que programme de reconnaissance facultatif, simultanément avec le cycle d'agrément, le programme évaluera la qualité à chaque niveau de reconnaissance au moyen d'indicateurs de résultat, de méthode et de structure.



# Home Care and Personal Care Homes

## Home Care Prevalence

### Definition

The prevalence rates of person years for active clients receiving one or more home care services, by type of service (health care aides/home support worker and nursing services), for a two-year time period.

### Why is this indicator important?

Home care use provides insight into services and supports provided (such as personal care, nursing care and home support) to help individuals remain at home and live independently in their community. An aging population, and an increase in those living with chronic conditions, will result in the need for additional home care support services.

### Provincial Key Findings

- ▶ The overall prevalence of home care use for all ages was 3.3% per person-year; 43,157 Manitoba residents received one or more home care services.
- ▶ **Figure 25** shows that, in Manitoba and Southern Health-Santé Sud, the prevalence was higher among residents who were female and aged 85 years and older.

### Health Care Aid/ Home Support Work Services

- ▶ A total of 29,149 Manitoba residents received health care aid (HCA) and home support work (HSW) services, representing a prevalence of 2.2% in the province.
- ▶ In Manitoba and Southern Health-Santé Sud, the prevalence was higher among residents who were female and aged 85 years and older.

### Nursing

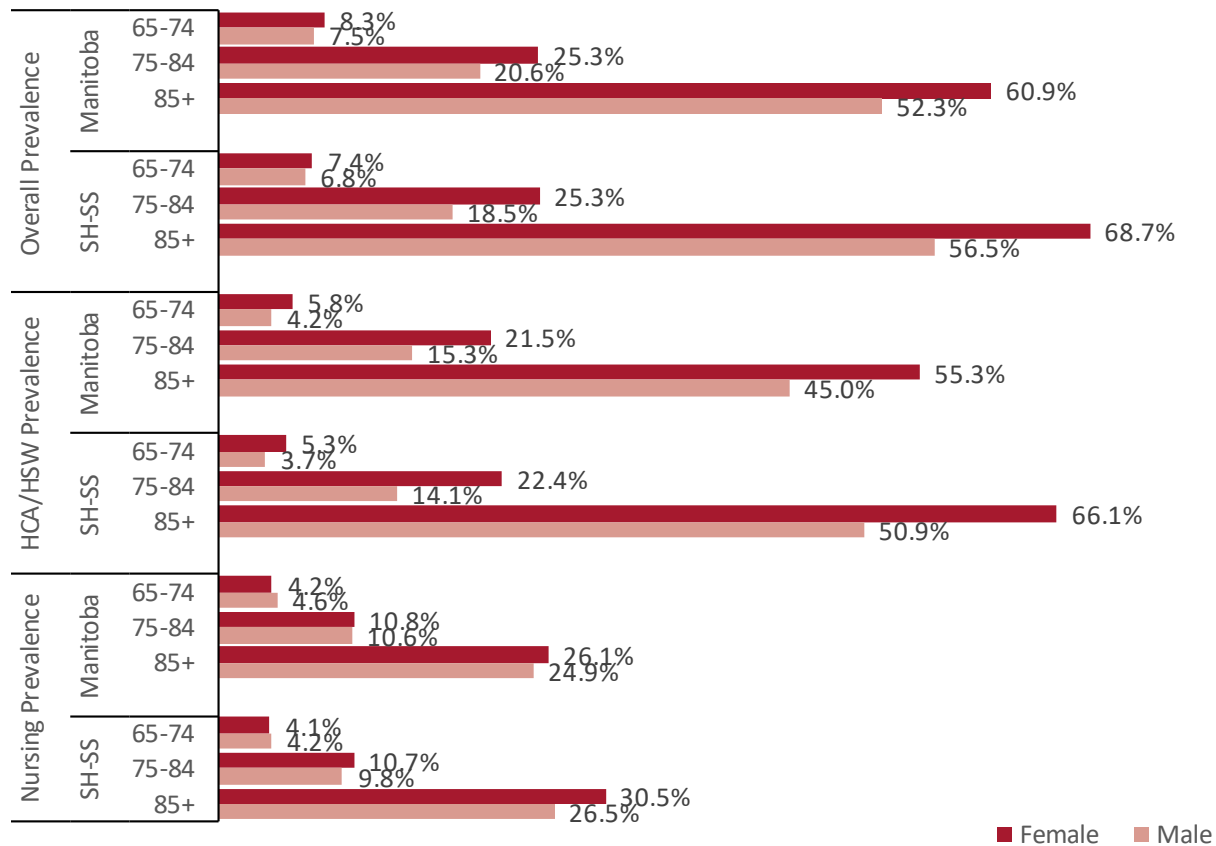
- ▶ A total of 23,442 Manitoba residents received home care nursing services, representing a prevalence of 1.8% in the province.
- ▶ In Manitoba and Southern Health-Santé Sud, the prevalence was higher among residents aged 85 years and older for both males and females.



# Home Care and Personal Care Homes

**Figure 25. Home Care Prevalence by RHA, 2013/14-2014/15 (T1)**

Crude percentage per person year



Preliminary data tables from work being commissioned by the provincial health department

## Regional Key Findings

### SH-SS Level

- Table 17 shows a total of 5,276 residents received home care services in the region.
- The prevalence was significantly lower than the Manitoba average.

### Zone Level

- All zones had similar overall home care prevalence and significantly lower than the Manitoba average.

### District Level

- The overall home care prevalence was significantly lower than the Manitoba average in the majority of districts. However, Rural East, St. Pierre/De Salaberry, Carman, Lorne/Louise/Pembina, and city of Portage were significantly higher than the provincial average.

### Geographic Disparity

- The geographic disparity was large with the overall home care prevalence 7.5 times higher in the highest district of Rural East compared to the lowest district of Stanley.

# Home Care and Personal Care Homes

**Table 17. Home Care Prevalence in Southern Health-Santé Sud, 2013/14-2014/15 (T1)**

Crude percentage per person year

	T1				T1		
	Count	Percentage			Count	Percentage	
<b>Manitoba</b>	<b>43,157</b>	<b>3.3</b>		<b>SH-SS</b>	<b>5,276</b>	<b>2.8</b>	<b>L</b>
<b>Zone 4</b>	<b>1,825</b>	<b>2.7</b>	<b>L</b>	<b>Zone 2</b>	<b>905</b>	<b>3.0</b>	<b>L</b>
Taché	132	1.4	L	Macdonald	114	1.7	L
Niverville/Ritchot	221	2.0	L	Morris	130	2.6	L
Hanover	291	2.3	L	Red River South	120	2.6	L
Steinbach	675	3.2		Grey	127	3.3	
Ste. Anne/La Broquerie	331	3.2		St. Pierre/De Salaberry	166	3.9	H
Rural East	175	4.5	H	Carman	248	4.4	H
<b>Zone 3</b>	<b>1,304</b>	<b>2.7</b>	<b>L</b>	<b>Zone 1</b>	<b>1,242</b>	<b>3.1</b>	<b>L</b>
Stanley	35	0.6	L	Cartier/SFX	132	1.9	L
Winkler	359	2.4	L	Rural Portage	185	2.5	L
Altona	260	2.7	L	North Norfolk	113	2.6	L
Roland/Thompson	60	2.8		Seven Regions	184	3.0	
Morden	302	3.3		City of Portage	628	4.2	H
Lorne/Louise/Pembina	288	4.2	H				

H/L Significantly higher or lower than the MB average for that time period.  
Preliminary data tables from work being commissioned by the provincial health department



## Residents in Personal Care Homes

### Definition

The percentage of residents, 75 years and older, who live in a personal care home (PCH), for a one-year time period.

### Why is this indicator important?

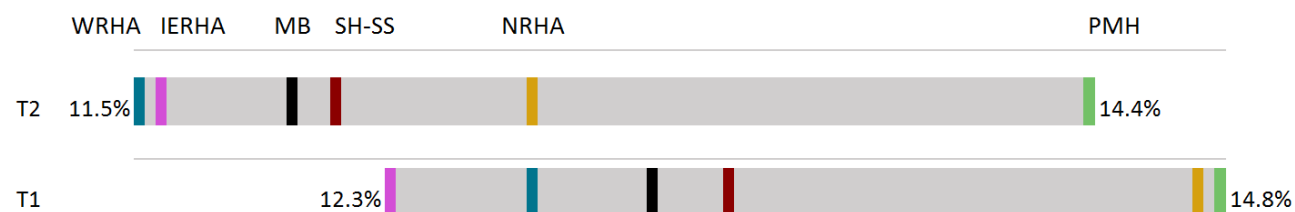
As the population continues to age, it is important to monitor the proportion of residents living in PCHs to anticipate increasing healthcare resource requirements.

### Provincial Key Findings

- ▶ **Figure 26** shows there were 21,719 Manitoba older adults living in PCH.
- ▶ The percentage in Manitoba and all regions remained stable over time with slight, not statistically significant decreases.

**Figure 26. Residents in PCH by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Age- and sex-adjusted average annual percent of residents (ages 75+)



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	MB	SH-SS	NRHA	PMH
T2 COUNT	12,663	1,705	21,719	2,584	310	4,457
T2 RATE	11.5%	11.6%	12.0%	12.1%	12.7%	14.4%
T1 RATE	12.7%	12.3%	13.1%	13.3%	14.7%	14.8%

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## Regional Key Findings

- ▶ **Table 18** shows a total of 2,584 regional residents living in PCHs in the current time period; representing 12% of this age group.
- ▶ The percentage remained stable over time with a slight, not statistically significant decrease.
- ▶ Percentages were similar across zones.
- ▶ The percentage in Zone 3 was significantly higher than the provincial average in the current time period.
- ▶ District level data not available.

**Table 18. Residents in Personal Care Homes—Zone Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Age- and sex-adjusted average annual percent of residents (ages 75+)

T2		T1
Count	Percentage	Percentage

T2		T1
Count	Percentage	Percentage

<b>Manitoba</b>	<b>21,719</b>	<b>12.0</b>		<b>13.1</b>	
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<b>SH-SS</b>	<b>2,584</b>	<b>12.1</b>		<b>13.3</b>	
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Zone 4	741	12.0		13.1	
Zone 3	891	13.1	H	13.6	

Zone 2	402	10.8		11.8	
Zone 1	550	12.5		14.4	

H/L Significantly higher or lower than the MB average for that time period.  
MCHP RHA Indicators Atlas 2019

## Level of Care on Admission to Personal Care Homes

### Definition

The percentage of residents, aged 75 and older, admitted to a personal care home (PCH) at each level of care, for a two-year time period.

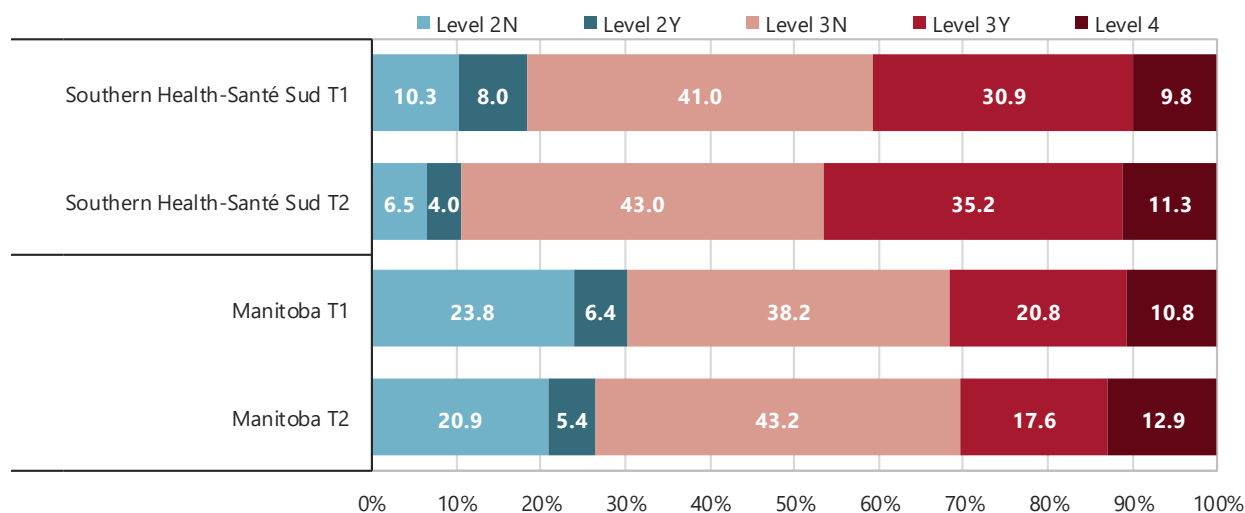
### Why is this indicator important?

Understanding levels of care upon admission provides an indication of accessibility and affordability of alternate housing options and community based support for seniors requiring minimal care, and the resources required to meet more intensive care needs, across the continuum of care.

### Provincial/Regional Key Findings

- ▶ **Figures 27 and 28** show that, similar to Manitoba, the percentage of residents admitted to PCHs requiring higher levels of care increased in the region and within each zone over time; however, the changes were not statistically tested.
- ▶ The majority of admissions in both time periods were Level 3 (both requiring and not requiring close supervision).
- ▶ Residents admitted to PCHs in the region required higher levels of care compared to the provincial average; however, the differences were not tested statistically.
- ▶ **Figure 28** shows that Zones 3 and 4 saw greater decreases in Level 2 admissions over time; however, the changes were not tested statistically.

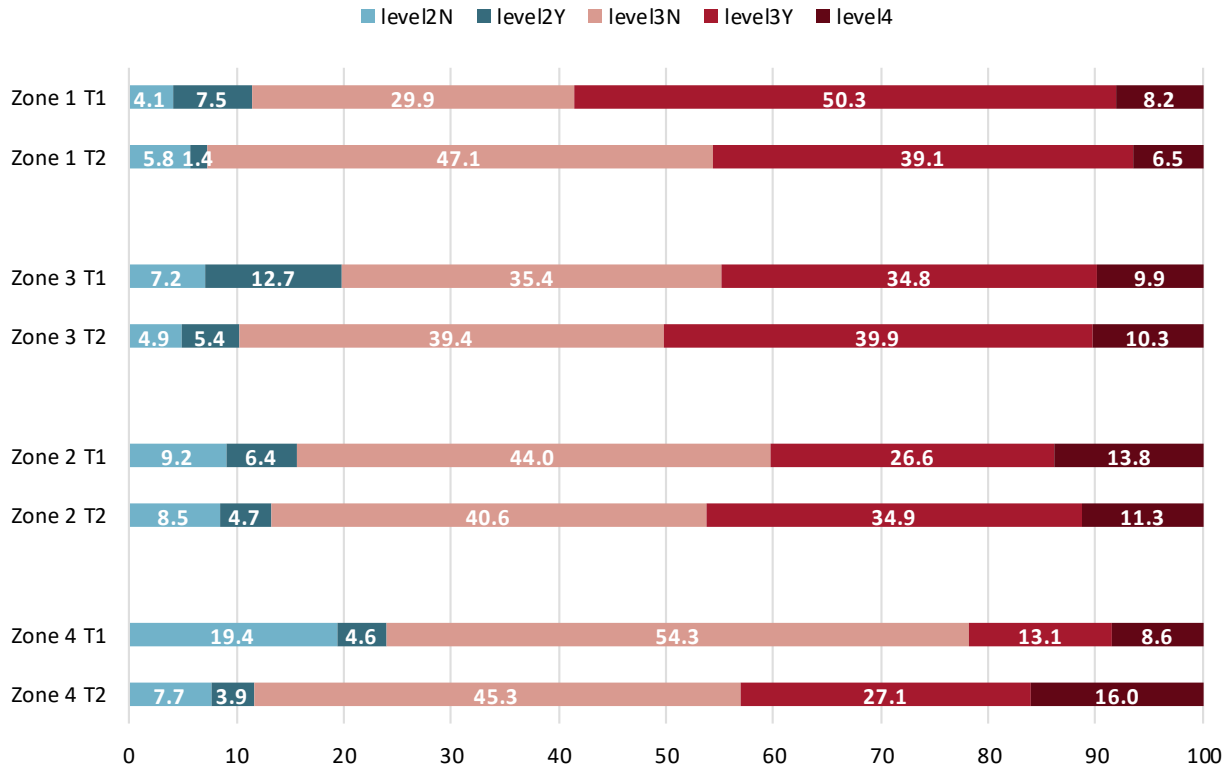
**Figure 27. Level of Care on Admission to PCH in Manitoba and Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**



Y indicates requirement for close supervision  
 N indicates no requirement for close supervision  
 MCHP RHA Indicators Atlas 2019

# Home Care and Personal Care Homes

**Figure 28. Level of Care on Admission to PCH in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**



Y indicates requirement for close supervision  
 N indicates no requirement for close supervision  
 MCHP RHA Indicators Atlas 2019

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.

## Median Wait Times for Personal Care Home Admission

### Definition

The median length of time (in weeks) from initial assessment to admission to personal care home (PCH) among residents, aged 75 and older, for a two-year time period.

### Why is this indicator important?

Admission to PCH is largely driven by the demand for PCH beds, personal preference of facility and the ability of the healthcare system to prepare rooms in a timely fashion. Peneled individuals often wait in a hospital or require extensive home care services and other supports in the community. Reducing the median wait for admission to PCH helps to ensure residents are cared for in the most appropriate setting and that resources are used more efficiently.

### Provincial Key Findings

#### Admission from Hospital

- ▶ **Figure 29** shows that in the current time period, there were 2,717 Manitoba residents admitted to PCHs from hospital. The median wait times for PCH admission was 2.5 weeks.
- ▶ In both time periods, all rural health regions were significantly higher than the provincial average; however, Winnipeg RHA was significantly lower.
- ▶ There was a significant decrease in median wait times for PCH admission from hospital in Manitoba and Winnipeg RHA over time, while Southern Health-Santé Sud had a significant increase.

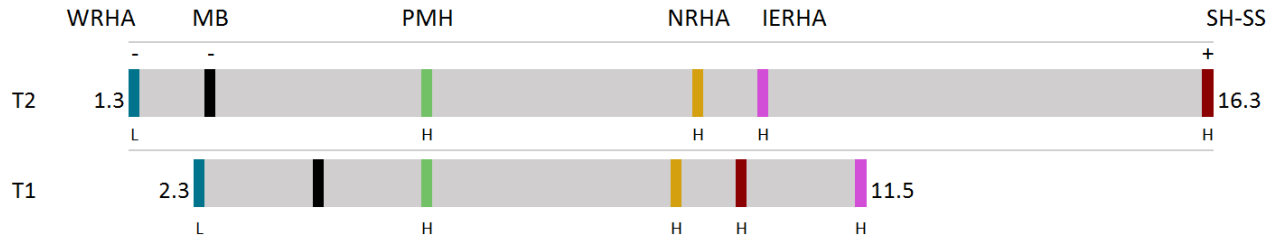
#### Admission from Community

- ▶ **Figure 30** shows that in the current time period, there were 2,403 Manitoba residents admitted to PCHs from the community. The median wait time for PCH admission was 8.1 weeks.
- ▶ Median wait times for PCH admission from the community did not change significantly over time. However, wait times decreased significantly in Interlake-Easter, while they increased significantly in Northern Health Region.
- ▶ In the current time period, all rural health regions were significantly higher than the provincial average; however, Winnipeg RHA was significantly lower.

# Home Care and Personal Care Homes

**Figure 29. Median Wait Times for PCH Admission from Hospital by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

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



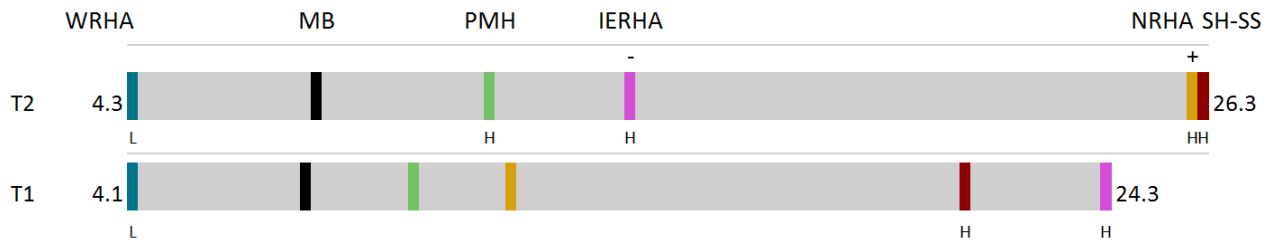
H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	PMH	NRHA	IERHA	SH-SS
T2 COUNT	1,510	2,717	609	45	216	327
T2 RATE	1.3 L-	2.5 -	5.5 H	9.3 H	10.1 H	16.3 H+
T1 RATE	2.3 L	4.0	5.5 H	8.9 H	11.5 H	9.9 H

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**Figure 30. Median Wait Times for PCH Admission from Community by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

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



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	PMH	IERHA	NRHA	SH-SS
T2 COUNT	1,423	2,403	388	226	53	301
T2 RATE	4.3 L	8.1	11.5 H	14.5 H-	26.0 H+	26.3 H
T1 RATE	4.1 L	7.8	10.0	24.3 H	12.1	21.4 H

MCHP RHA Indicators Atlas 2019



## Regional Key Findings

### SH-SS Level

- ▶ **Tables 19 and 20** show a total of 327 PCH admissions from the hospital and 301 from the community, in the current time period.
- ▶ The region had the highest median wait times in the province and significantly higher than the Manitoba average in both time periods.
- ▶ Median wait times increased over time; however, only the change in wait times from hospital settings was statistically significant.

### Zone Level

- ▶ **Table 19** shows there was a difference of about 11 weeks in wait times from hospital between the lowest in Zone 3 and the highest in Zone 1.
- ▶ In the current time period, wait times from the hospital were significantly higher than the Manitoba average in all zones.
- ▶ Zone 4 increased significantly over time.
- ▶ **Table 20** shows a difference of 15.5 weeks in wait times from the community between the lowest in Zone 2 and the highest in Zone 4.
- ▶ Zones 1, 3, and 4 had wait times from the community significantly higher than the Manitoba average in both time periods, while Zone 2 was no longer significantly higher in the current time period.

### District Level

- ▶ District level data not available.

# Home Care and Personal Care Homes

**Table 19. Median Wait Times for PCH Admission from Hospital in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

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

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>2,717</b>	<b>2.5</b>	<b>-</b>	<b>4.0</b>	
	<b>SH-SS</b>	<b>327</b>	<b>16.3</b>	<b>H+</b>	<b>9.9</b>
Zone 4	79	18.7	H+	6.2	
Zone 3	117	9.0	H	8.7	H
	Zone 2	58	12.3	H	14.2
	Zone 1	73	20.2	H	13.6

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

**Table 20. Median Wait Times for PCH Admission from Community in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

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

	T2			T1	
	Count	Rate		Rate	Rate
<b>Manitoba</b>	<b>2,403</b>	<b>8.1</b>		<b>7.8</b>	
	<b>SH-SS</b>	<b>301</b>	<b>26.3</b>	<b>H</b>	<b>21.4</b>
Zone 4	102	32.0	H	29.7	H
Zone 3	86	24.3	H	21.4	H
	Zone 2	48	16.5		18.6
	Zone 1	65	26.5	H	19.9

H/L Significantly higher or lower than the MB average for that time period.  
 +/- A significant increase (+) or decrease (-) since the first time period  
 MCHP RHA Indicators Atlas 2019

## Benzodiazepine Overprescribing—Personal Care Homes

### Definition

The percentage of older adults, 75 and older, who had at least two prescriptions for benzodiazepines or at least one prescription for benzodiazepines with a greater than 30 day supply per year, in a two-year time period.

### Why is this indicator important?

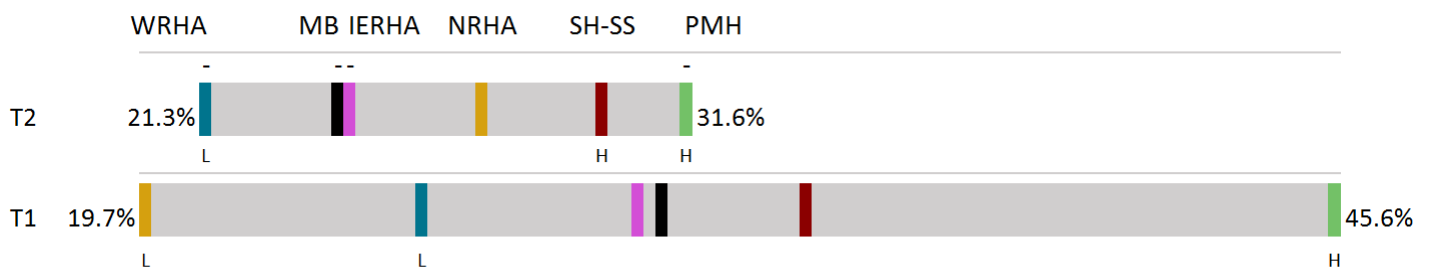
Benzodiazepines are medications widely used to treat seizures, anxiety and insomnia, however use by older adults is not recommended as it poses serious safety concerns including increased risk for confusion, memory loss, poor coordination and muscle control potentially leading to falls and fractures.

### Provincial Key Findings

- Figure 31 shows that in Manitoba, 4,298 PCH residents aged 75 years and older received Benzodiazepines in the current time period.
- The percentages decreased significantly in Manitoba, Winnipeg RHA, Interlake-Eastern RHA, and Prairie Mountain Health. Northern Health Region was the only region that saw an increase over time, although not statistically significant.
- Percentages were significantly lower than the provincial average in Winnipeg RHA but significantly higher in Southern Health-Santé Sud and Prairie Mountain Health.

**Figure 31. Benzodiazepine Overprescribing for PCH Older Adults by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Crude percentage of PCH older adults (ages 75+) with 2 prescriptions or more than a 30-day supply



H/L Significantly higher or lower than the MB average for that time period.  
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	NRHA	SH-SS	PMH
T2 COUNT	2,322	4,298	417	65	269	1,225
T2 RATE	21.3% L-	24.4% -	24.4% -	27.2%	29.7% H	31.6% H-
T1 RATE	25.9% L	31.0%	30.6%	19.7% L	34.1%	45.6% H

## Regional Key Findings

### SH-SS Level

- ▶ **Table 21** shows a total of 269 PCH residents with overprescribed benzodiazepine in the region; representing almost 30% of the PCH population.
- ▶ The regional percentage was significantly higher than the Manitoba average.
- ▶ The percentage of benzodiazepine overprescribing remained stable over time with a slight, not statistically significant decrease.

### Zone Level

- ▶ Percentages were relatively similar across zones.
- ▶ Zone 4 was significantly higher than the provincial average; however, it decreased significantly over time.

### District Level

- ▶ District level data not available.

**Table 21. Benzodiazepine Overprescribing for PCH Older Adults in Southern Health-Santé Sud, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)**

Crude percentage of PCH older adults (ages 75+) with 2 prescriptions or more than a 30-day supply

T2		T1
Count	Percentage	Percentage

T2		T1
Count	Percentage	Percentage

Manitoba	4,298	24.4	-	31.0	
----------	-------	------	---	------	--

SH-SS	269	29.7	H	34.1	
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Zone 4	223	30.3	H-	36.9	
Zone 3	s			28.9	

Zone 2	20	35.1		45.5	
Zone 1	26	23.4		21.7	

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019



### A CLOSER LOOK...

Southern Health-Santé Sud has a total of 22 personal care homes with a total of 1,218 beds with an additional 10 Behavioural Treatment Unit beds located throughout the region. Eight 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 region.

In 2017, the new Tabor Home personal care home (pictured above) opened its doors in Morden. Months later, staff, volunteers, visitors, and residents were still expressing their wonder and appreciation. One resident was now spending time in the living areas of the house, seeking out staff interaction, and participating in activities. The benefit of a new environment with smaller contained houses, new equipment, and improved air circulation may have positively contributed to the reduced infection rates.

The province is now moving forward on additional personal care homes in the region. By 2021, there will be an additional 40 personal care beds in Carman and 83 in Steinbach.

<sup>i</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>ii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>iii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>iv</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>v</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>vi</sup> Macinko J, Starfield B, Shi L, Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv.* 2007; 37(1):111-26. Review. PMID:17436988; <https://www.ncbi.nlm.nih.gov/pubmed/17436988>

<sup>vii</sup> "Care Coordination Measures Atlas Update," Agency for Healthcare Research and Quality. Accessed May 27, 2019. <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html>

<sup>viii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>ix</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>x</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>xi</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

<sup>xii</sup> Fransoo R, Mahar A, The Need to Know Team, Anderson A, Prior H, Koseva I, McCulloch S, Valdivia J, Johansson C. The 2019 RHA Indicator Atlas. Winnipeg, MB. Manitoba Centre for Health Policy, Autumn 2019.

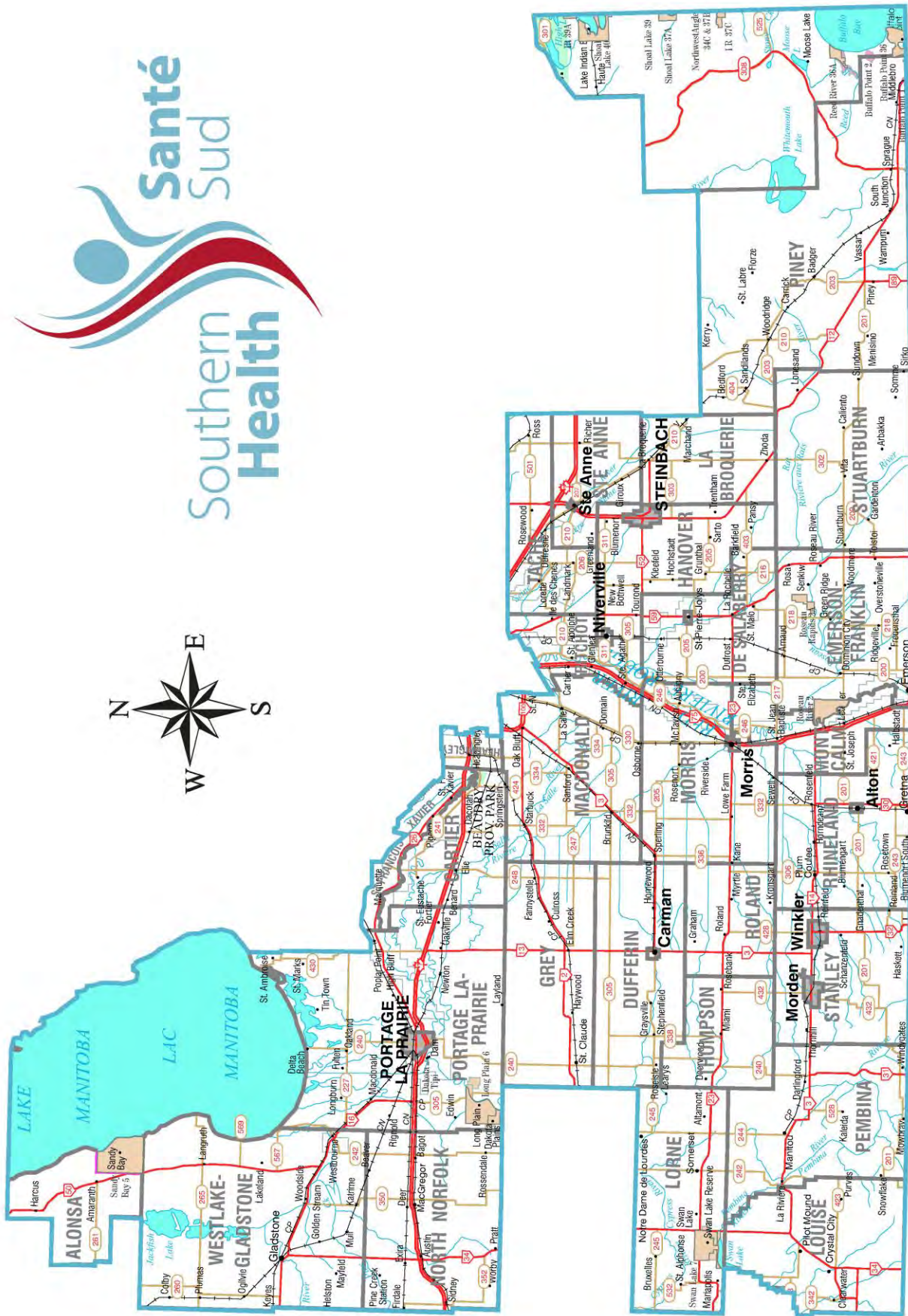
# APPENDICES

## Acronyms

<b>ACS</b>	Ambulatory Care Sensitive
<b>ACSC</b>	Ambulatory Care Sensitive Conditions
<b>ALC</b>	Alternate Level of Care
<b>AMI</b>	Acute Myocardial Infarction
<b>ATV</b>	All Terrain Vehicle
<b>BMI</b>	Body Mass Index
<b>CCHS</b>	Canadian Community Health Survey
<b>CDET</b>	Chronic Disease Education Team
<b>CHA</b>	Community Health Assessment
<b>CHAN</b>	Community Health Assessment Network
<b>CHF</b>	Congestive Heart Failure
<b>CIHI</b>	Canadian Institute for Health Information
<b>CKD</b>	Chronic Kidney Disease
<b>CPES-IC</b>	Canadian Patient Experiences Survey-Inpatient Care
<b>CT</b>	Computed Tomography Scans
<b>CVITP</b>	Community Volunteer Income Tax Program
<b>DBP</b>	Designated Bilingual Positions
<b>ECG</b>	Electrocardiogram
<b>EDI</b>	Early Development Instrument
<b>EMS</b>	Emergency Medical Services
<b>ESKD</b>	End Stage Kidney Disease
<b>FiT</b>	Fecal Immunochemical Test
<b>FNHSSM</b>	First Nations Health and Social Secretariat of Manitoba
<b>FOBT</b>	Fecal Occult Blood Test
<b>HCA</b>	Health Care Aid
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPV</b>	Human Papilloma Virus
<b>HSO</b>	Health Standards Organization
<b>HSW</b>	Home Support Work
<b>ICT</b>	Information & Communication Technology
<b>IHD</b>	Ischemic Heart Disease
<b>IERHA</b>	Interlake-Eastern Regional Health Authority
<b>IMA</b>	Information Management and Analytics Branch
<b>LGA</b>	Low for Gestational Age
<b>LGBTQ</b>	Lesbian Gay Bisexual Transgender Queer or Questioning
<b>LHIG</b>	Local Health Involvement Group
<b>LIM-AT</b>	Low Income Measure-After Tax
<b>MB</b>	Manitoba
<b>MCHP</b>	Manitoba Centre for Health Policy
<b>MHSAL</b>	Manitoba Health, Seniors and Active Living



<b>MQLF</b>	Manitoba Quality and Learning Framework
<b>MRI</b>	Magnetic Resonance Imaging
<b>MVA</b>	Motor Vehicle Accident
<b>NHS</b>	National Household Survey
<b>NRHA</b>	Northern Regional Health Authority or Northern Health Region
<b>PCH</b>	Personal Care Home
<b>PDB</b>	Postes désignés bilingues
<b>PMH</b>	Prairie Mountain Health
<b>PMR</b>	Premature Mortality Rate
<b>PYLL</b>	Potential Years of Life Lost
<b>RCMP</b>	Royal Canadian Mountain Police
<b>RHA</b>	Regional Health Authority
<b>RHS</b>	First Nations Regional Health Survey
<b>RM</b>	Rural Municipality
<b>RRT</b>	Renal Replacement Therapy
<b>SEFI</b>	Socioeconomic Factor Index
<b>SFX</b>	St. François Xavier
<b>SGA</b>	Small for Gestational Age
<b>SH-SS</b>	Southern Health-Santé Sud
<b>SIDS</b>	Sudden Infant Death Syndrome
<b>STBBI</b>	Sexually Transmitted Blood-Borne Infection
<b>STEMI</b>	ST-Elevation Myocardial Infarction
<b>STI</b>	Sexually Transmitted Infection
<b>TRC</b>	Truth and Reconciliation Commission
<b>TRM</b>	Total Respiratory Morbidity
<b>URIS</b>	Unified Referral Intake System
<b>VBAC</b>	Vaginal Birth After C-Section
<b>WRHA</b>	Winnipeg Regional Health Authority



## Quick Facts

<b>Our Residents</b> Population: 204,274 As of June 1, 2018	4 cities	7 First Nation communities
	4 towns	20 rural municipalities
	1 village	7 municipalities
Southern Health-Santé Sud is a designated bilingual health authority and has the fastest growing population in Manitoba.		
Our Staff	6,000	4,800 Southern Health-Santé Sud employees 1,200 Affiliate & Community Owned Not for Profit sites
Clinics	20	Includes medical clinics, teen clinics, & QuickCare
My Health Teams	4	Steinbach Morden/Winkler Portage/Gladstone Mon équipe santé - linking Francophone communities
Acute Care Sites	14	3 regional centres 9 acute centres (including 1 affiliate sites)
CancerCare	3	Regional centres only
Telehealth Sites	16	
Transitional Care Sites	5	
Personal Care Homes	22	Including 7 affiliate sites and 1 community owned not for profit
EMS Stations	20	
Mental Health Sites	2	Crisis Stabilization Unit (Steinbach) 1 affiliate (Winkler)
Community Services	are located in many communities 20 Public Health-Healthy Living 19 Home Care 16 Mental Health <i>For more information, visit <a href="http://www.southernhealth.ca">www.southernhealth.ca</a></i>	
As of October 10, 2019		

Affiliate Health Corporation and Community Owned Not for Profit sites operate through a signed Service-Purchase Agreement with Southern Health-Santé Sud.