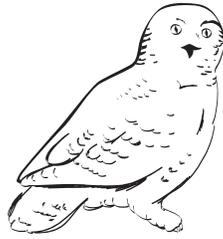


EPI



NORTH

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Winter 1999/2000

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The 1999 Health Status Report: A question of accountability.

On December 13, 1999, the Minister of Health and Social Services released the NWT Health Status Report, the first document of its kind to focus on the post-division Northwest Territories. This issue of EpiNorth profiles the third chapter from the report, an overview of the NWT population's health status.

*André Corriveau,
Chief Medical Health
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and Social Services*

As the Minister mentions in his preface, the report *"is intended to inform the public, policy makers and health practitioners about the health and well-being of the population in general..., about the major determinants of health in the Northwest Territories, and to highlight some of the challenges and opportunities that lie ahead."* The report is also a key component of our accountability covenant within the health & social services' network in terms of providing timely feedback from our health information systems.

However, it is also important to point out that this project could not have been achieved without the support of all front line health and social services providers who, on a daily basis, contribute to the many databases that serve as a source from which this kind of information can be produced.

Indeed, the apparently inconsequential tasks of registering births and deaths, filling up forms for the disease registries or the Community Health Management Information System, completing and coding hospital discharge summaries, etc., represent the very foundation upon which all the rest of our health information structure rests. Front line workers are also frequently asked to collect additional information as well as support or be directly involved in surveys to provide more data on individual knowledge and attitudes, lifestyles, behaviours or other risk factors. All these are tasks that take time away from direct service delivery, often appear burdensome and seldom provide (if ever) rewards.

However, it is through these many contributions that, over time, we can develop health information databases capable of providing quality longitudinal data that can then be analysed and turned into useful information. The Health Status Report is thus a closing of the loop in the broad accountability framework, and to this extent, we can all be proud of it. Furthermore, this report is only the first product of a series that we intend to renew on a 3-year cycle. Work has already begun on special reports dealing with smoking and injuries. By this time next year, we also hope to have completed an in-depth report on the health & social services delivery system.

Public reporting on the health and well being of the population is the best means to place health status front and centre in the public eye. In turn, this allows the public to make more informed judgements about the challenges, organisation and performance of our service delivery system, and equally important, to ask more searching and relevant questions.

Everyone will benefit from a more effective information feedback loop. We need to provide accurate and timely information to those who must decide on priorities and funding allocations. However, workers on the front line also need feedback on the outcomes of their work so that they can better gauge their progress as well as set new goals and objectives and develop appropriate workplans. When all is said and done, it still boils down to effective team work!

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FEATURE ARTICLE

Population Health Status

This article is a feature presentation from the 1999 Health Status Report. Selected articles will be published from the 1999 Health Status Report in EpiNorth to highlight current health topic "hot-spots" in the NWT. A complete copy of the report may be downloaded from the Health and Social Services website (<http://www.hlthss.gov.nt.ca/publicat.ht>) or a limited number of copies are still available and can be requested from André Corriveau, Director, Population Health, Department of Health and Social Services, Tel: (867) 920-8867.

At the beginning of this new millennium, what is the health status of Northwest Territory (NWT) residents? The World Health Organization defines health as "...a complete state of physical, mental (spiritual and emotional) and social well being." To get a better picture of the health of Canadians, a National Population Health Survey¹ was conducted in 1994/1995 and included respondents from the NWT. There were a number of indicators used to estimate population health status. However, for the purposes of this general review, self-rated health status and psychological well-being were only chosen for reprint.

Self-Rated Health Status

Participants in the National Population Health Survey were asked to rate their overall health as either "excellent," "very good," "good," "fair," or "poor." Research indicates that this type of self-rated health is a useful and surprisingly accurate indicator of population health status, as it correlates strongly with several "objective" measures of health status.²

Figure 1 shows that about 23% of the Northwest Territories residents indicated they had excellent health, about 40% rated their health as very good, another 28% said they had good health and about 9% described their health as fair or poor.

While Canadians on the whole were slightly more likely to rate their health as excellent, they were also more likely to rate their health as fair or poor. However, the differences between the Northwest Territories and Canada were very small.

Men were more likely than women to rate their health as excellent, and women were slightly more likely to rate their health as fair or poor, but the differences between the two groups were small.

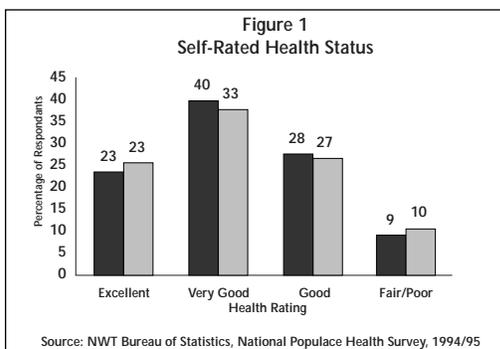
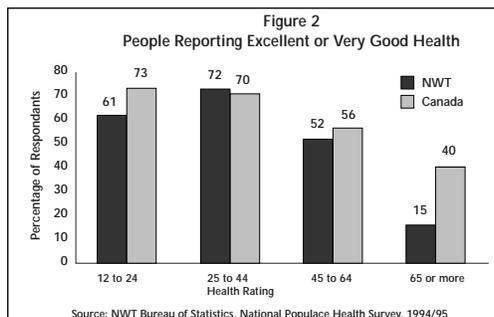


Figure 2 presents information on the proportion of individuals ratings themselves in excellent or very good health, by age groups.



Individuals between 12 and 24 years of age in the Northwest Territories were less likely than people between 25 and 44 years of age to rate their health as excellent or very good (61% compared with 72%). This Northwest Territories finding differs from the national results where 73% of the 12-24 year old population rated their health as excellent or very good. The difference may indicate that young people in the Northwest Territories do not feel as healthy as their Canadian counterparts.

Given the small number of people 65 and older who were interviewed in the Northwest Territories, the estimates for this age group should be treated with caution.

There was a significant drop in self-reported excellent or very good health status for those over the age of 45. This drop is particularly marked in the segment of the population 65 years and older. Only an estimated 15% of the Northwest Territories residents in this age group rated their health as excellent or very good, compared with 40% in Canada as a whole.

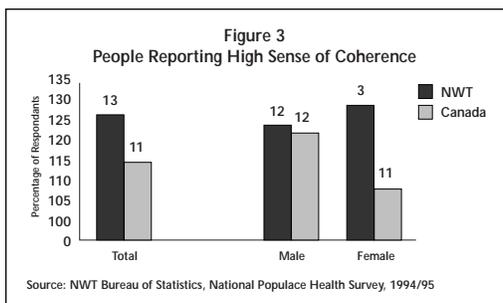
Psychological Well-Being

Psychological well-being is another measure of positive health. Well-being and life satisfaction are important elements in the overall concept of quality of life. As the Report on the Health of Canadians pointed out:

"Well-being, or positive health, can be defined as consisting of those physical, mental, and social attributes that permit the individual to cope successfully with challenges to health and functioning. One measure that closely fits this conception of well-being is "sense of coherence", which is a view of the world that (a) events are comprehensible, (b) challenges are manageable, and (c) life is meaningful. There is

ample evidence that a strong sense of coherence is conducive to coping successfully with stressors ... and maintaining good health.”

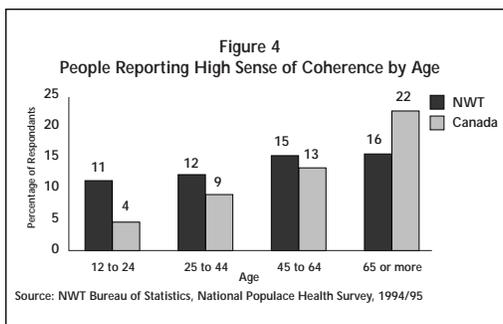
In the National Population Health Survey, people were asked a series of questions designed to measure this sense of coherence. The survey results indicated that in the Northwest Territories, an estimated 13% of those 18 years of age and older who answered the questions had a high sense of coherence, compared with 11% in Canada. As Figure 3 shows, there were no real differences in the percentage of men and women in the Northwest Territories who had a high sense of coherence.



Figures 3 and 4 should be treated with caution because 11% of those interviewed in the Northwest Territories did not respond to these questions. More critically, 27% of those 65 years of age and older did not respond, which means that for this group the estimates are based on a small number of individuals.

People in the Northwest Territories were slightly more likely to report a high sense of coherence than people in Canada as a whole in all age categories except those 65 years of age or over.

As Figure 4 shows, this difference was particularly evident for those between 18 and 24 years of age, where the sense of coherence for youth in the Northwest Territories was higher than for their counterparts in the rest of the country.



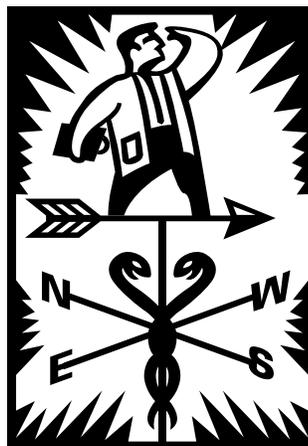
The picture was just the opposite for people 65 years and older in the Northwest Territories, who were less likely to report a high sense of coherence. An estimated 16% of those who answered the questions in this age group reported a high level of coherence, compared with 22% in Canada as a whole. However, apart from this age group it appears that the proportion of the population in the Northwest Territories who feel that life is meaningful, events are comprehensible and challenges are manageable, is as high as the proportion in the population in the country as a whole.

1996 National Population Health Survey

The 1996 National Population Health Survey results should be available soon. Anyone interested in obtaining further information for population health status should contact the Research and Analysis Unit, Population Health, Department of Health and Social Services, Tel: (867) 920-8946.

Footnote:

- 1 The National Population Health Survey is a longitudinal survey begun in 1994/95. In the Northwest Territories, 450 people 12 years of age or older took part in the survey.
- 2 Report on the Health of Canadians: Technical Appendix, Health Canada, 1999.





By André Corriveau
 Chief Medical
 Health Officer
 Director,
 Population Health,
 Department of Health
 and Social Services

The Canadian Health Network: Information you can trust, at your fingertips!

In November 1999, I was invited to join the Advisory Board of Directors of the Canadian Health Network (CHN), a new and growing network, bringing together resources of leading Canadian health organizations and international health information providers.

The resources provided through this network are intended to help Canadians take care of themselves and the people they care about, with tips on how to improve one's health and well-being. Through the CHN, health intermediaries will also find a useful array of resources on disease prevention and health promotion.

The CHN Website

The CHN site, at www.canadian-health-network.ca, is easy to navigate and full of relevant and useful information. It provides a single door of entry to a wide range of information on healthy living and preventing illness, including a broad range of topics such as abuse, addictions, AIDS, allergies, asthma, cancer, child health, disabilities, immunizations, mental health, nutrition, senior's issues, workplace health, and much more.

CHN Overview

There is no Internet-based health information network like it in the world - a partnership of government and non-governmental organizations working together to provide trustworthy information that helps people make appropriate choices about health and well-being. This initiative is one of the offshoots from the February 1999 Federal Budget, when the Government of Canada announced major investments in health information and communications technologies.

During the past months, CHN has been growing by leaps and bounds with now well over 400 partners in the health field, reaching from coast to coast and in both official languages. CHN has two main categories of partners - Regional Operating Partners and Affiliate Partners. While they share an overall responsibility to build credibility for CHN, each has a very different role within it.

The Regional Operating Partners (one Western and one Eastern) provide leadership in ensuring that CHN reflect regional uniqueness and achieve more complete access to appropriate local and regional resources. The primary responsibility of Regional Operating Partners is to coordinate the collection and dissemination of regional resources on health promotion and disease prevention.

Affiliate Partners provide leadership and content expertise in a health topic or population group area. They will support the Regional Operating Partners by identifying, developing and selecting quality resources, and responding to consumer and health intermediary inquiries in both official languages.

While the initial focus has been to develop an Internet-based service, the longer-term view is to provide multi-mode access (for example, a 1-800, email, or fax back) to reflect varied needs and preferences. These alternate means of access will be explored through pilot projects with provincial/territorial partners.

I encourage all of you who can to explore this novel internet site and to provide feedback, either directly, or through myself, so that needs of northern residents may be better understood and met by CHN.

Injury mortality in the Northwest Territories (NWT), 1991-1996*

By Daojun Mo,
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Introduction

The most recent NWT Health Status Report established that injury is one of the most serious health issues affecting the residents of NWT.¹ Specifically, injury is one of the leading causes of death and is the top cause for premature deaths in the NWT.¹ However, the frequency of injury mortality may not be evenly distributed in the NWT subpopulations. Therefore, in order to assist decision-makers to rationalize limited human and financial resources available for injury prevention, a population-based study was conducted to quantify the relative risks of injury mortality across subpopulations in the NWT.

Methodology

The general population was divided into subpopulations, which were defined by age, sex, ethnicity, geographic location of community, defined by latitude and longitude, and the remoteness, denoted by either "regional centre" (Yellowknife, Hay River, Fort Smith and Inuvik) or "remote" communities. These various factors were assumed to be associated with injury mortality.

SAS software version 6.12 was used in all data extraction, and data analysis. Descriptive statistical analysis was conducted to obtain injury mortality rates among the subpopulations.

A multivariate unconditional logistic regression was applied to study the role of each putative risk factor in the injury mortality when all other variables were considered. Odds Ratios (OR) were computed as the measurement of the relative risks of injury deaths among subpopulations.^{2,3,4} An OR greater than 1 for a subgroup means a higher relative risk of dying from injuries. For example, an OR of 1.5 for one particular subpopulation would indicate that this subpopulation is 50% more likely to have an injury death than the reference group.

Results

One hundred and ninety seven cases of injury mortality were identified from the Vital Statistics Database of Statistics Canada for the period 1991-1996. Descriptive analysis showed that higher injury mortality rates were observed among aboriginal people, males, ages older than 14, people living in remote communities, and at



Table 1

Description of Injury Mortality Cases and Controls, NWT, Canada, 1991-1996

| Characteristic | | Injury Case | (%) | Control | (%) | Rate (/100,000 person - years) |
|----------------|-----------------|-------------|-------|---------|-------|--------------------------------|
| Sex | Female | 47 | 23.9 | 20153 | 47.9 | 38.9 |
| | Male | 150 | 76.1 | 21940 | 52.1 | 113.9 |
| Age | 0-14 | 15 | 7.6 | 11460 | 27.2 | 21.8 |
| | 15-64 | 155 | 78.7 | 29050 | 69.0 | 88.9 |
| | 65 and over | 27 | 13.7 | 1583 | 3.8 | 284.3 |
| Remoteness | Regional centre | 108 | 54.8 | 28991 | 68.9 | 62.1 |
| | The remainder | 89 | 45.2 | 13102 | 31.1 | 113.2 |
| Latitude | 66 and below | 135 | 68.5 | 34812 | 82.7 | 64.6 |
| | above 66 | 62 | 31.5 | 7297 | 17.3 | 141.6 |
| Longitude | 109-112 | 12 | 6.1 | 2925 | 6.9 | 68.4 |
| | 113-114 | 61 | 31.0 | 19173 | 45.5 | 53.0 |
| | 115-118 | 38 | 19.3 | 8262 | 19.6 | 76.7 |
| | 119-136 | 86 | 43.7 | 11723 | 27.9 | 122.3 |
| Ethnicity | Inuit | 47 | 23.9 | 4365 | 10.4 | 179.5 |
| | Dene | 76 | 38.6 | 12295 | 29.2 | 103.0 |
| | The remainder | 74 | 37.6 | 25433 | 60.4 | 48.5 |
| Total | | 197 | 100.0 | 42093 | 100.0 | 78.0 |

Source: Injury deaths were from Death Database, Statistics Canada Control subjects were from the Mainframe of Health Administration Information System of GNWT Ethnicity information from NWT Vital Registry was added to Death Database, Statistics Canada

* Does not include data for Nunavut

| Table 2 | | | | | |
|---|--------------------------|----------|------------|-------------|------------|
| Odds Ratios (ORs) and 95% Confidence Intervals (CIs) for Injury Mortality, NWT, Canada 1991-1996 | | | | | |
| Characteristic | | Crude OR | 95% CI | Adjusted OR | 95% CI |
| Sex | Female | 1.00 | | 1.00 | |
| | Male | 2.93 | 2.11-4.07 | 2.90 | 2.09-4.03 |
| Age | 0-14 | 1.00 | | 1.00 | |
| | 15-64 | 3.52 | 2.62-4.72 | 3.39 | 2.55-4.52 |
| | 65 and over | 12.38 | 6.89-22.26 | 11.50 | 6.47-20.42 |
| Remoteness | Regional centre | 1.00 | | 1.00 | |
| | The remainder | 1.82 | 1.38-2.42 | 1.51 | 1.13-2.02 |
| Latitude | 66 and below | 1.00 | | 1.00 | |
| | above 66 | 2.20 | 1.62-2.97 | 2.04 | 1.50-2.79 |
| Ethnicity | Non-aboriginal and Metis | 1.00 | | | |
| | Dene | 2.12 | 1.54-2.93 | | |
| | Inuit | 3.70 | 2.56-5.34 | | |
| * The variable ethnicity did not enter the model | | | | | |
| Source: Injury deaths were from Death Database, Statistics Canada Control subjects were from the Mainframe of Health Administration Information System of GNWT Ethnicity information from NWT Vital Registry was added to Death Database, Statistics Canada | | | | | |

| Table 3 | | | | | | | |
|---|---------------|--------|------|---------|------|---------------|-----------|
| The Association between Ethnicity and Injury Mortality, by Community Size and Latitude, NWT, Canada, 1991-1996 | | | | | | | |
| Ethnicity | | Injury | % | Control | % | Adjusted OR** | 95% CI |
| <i>Remote community and latitude 66 and below</i> | Inuit | 1 | 1.9 | 86 | 0.9 | * | |
| | Dene | 46 | 86.8 | 6811 | 73.3 | 2.51 | 1.13-5.57 |
| | The remainder | 6 | 11.3 | 2398 | 25.8 | 1.00 | |
| <i>Remote community and latitude above 66</i> | Inuit | 26 | 72.2 | 2112 | 55.5 | 2.33 | 1.12-4.87 |
| | Dene | 9 | 25.0 | 1254 | 32.9 | * | |
| | The remainder | 1 | 2.8 | 441 | 11.6 | 1.00 | |
| <i>Regional community centre and latitude 66 and below</i> | Inuit | 5 | 6.1 | 871 | 3.4 | 3.35 | 1.33-8.46 |
| | Dene | 21 | 25.6 | 3730 | 14.6 | 2.39 | 1.44-3.97 |
| | The remainder | 56 | 68.3 | 20918 | 82.0 | 1.00 | |
| <i>Regional community centre and latitude above 66</i> | Inuit | 15 | 57.7 | 1296 | 37.3 | 2.42 | 1.10-5.30 |
| | Dene | 0 | 0.0 | 500 | 14.4 | * | |
| | The remainder | 11 | 42.3 | 1676 | 48.3 | 1.0 | |
| * did not show significant effect in the modeling | | | | | | | |
| ** age and sex adjusted | | | | | | | |
| Source: Injury deaths were from Death Database, Statistics Canada Control subjects were from the Mainframe of Health Administration Information System of GNWT Ethnicity information from NWT Vital Registry was added to Death Database, Statistics Canada | | | | | | | |

Table 4
Percent of Injury Mortality Types by Community Size and Latitude, NWT, Canada, 1991-1996

| Injury type | Remoteness | | Latitude | | | | | |
|----------------------------------|------------------|----------|---------------|---------------|----------------------|------|-----------------|------|
| | Regional (n=108) | centre % | Remote (n=89) | communities % | 66 and below (n=135) | % | above 66 (n=62) | % |
| <i>Unintentional</i> | | | | | | | | |
| Land & air transport nondrowning | 25 | 23.1 | 21 | 23.6 | 26 | 19.3 | 20 | 32.3 |
| Drownings | 16 | 14.8 | 22 | 24.7 | 27 | 20.0 | 11 | 17.7 |
| Falls | 4 | 3.7 | 6 | 6.7 | 9 | 6.7 | 1 | 1.6 |
| Fires and burns | 4 | 3.7 | 10 | 11.2 | 9 | 6.7 | 5 | 8.1 |
| Cold exposure | 3 | 2.8 | 5 | 5.6 | 6 | 4.4 | 2 | 3.2 |
| Poisoning | 6 | 5.6 | 7 | 7.9 | 7 | 5.2 | 6 | 9.7 |
| Explosion | 6 | 5.6 | 0 | 0.0 | 6 | 4.4 | 0 | 0.0 |
| Suffocation | 1 | 0.9 | 0 | 0.0 | 1 | 0.7 | 0 | 0.0 |
| Other unintentional | 10 | 9.3 | 1 | 1.1 | 9 | 6.7 | 2 | 3.2 |
| <i>Intentional</i> | | | | | | | | |
| Suicide | 24 | 22.2 | 9 | 10.1 | 24 | 17.8 | 9 | 14.5 |
| Homicide | 2 | 1.9 | 6 | 6.7 | 6 | 4.4 | 2 | 3.2 |
| <i>Intention undetermined</i> | | | | | | | | |
| | 7 | 6.5 | 2 | 2.2 | 5 | 3.7 | 4 | 6.5 |

Source: Injury deaths were from Death Database, Statistics Canada

a latitude >66 degrees (P<0.01) (Table 1). The general model in logistic regression including all the putative risk factors except the variable ethnicity showed consistent results with the descriptive analysis (Table 2).

In order to study the role of the variable ethnicity in injury mortality, the NWT was stratified into 4 regions by remoteness and latitude: regional centre and latitude ≤66, regional centre and latitude >66, remote and latitude ≤66, and remote and latitude >66. The logistic models for each sub-region consistently presented the effects of the variable ethnicity after adjustment for age and sex (Table 3). The Inuit presented higher risk of injury mortality in all regions except in the region of remote community and latitude ≤66. In contrast, the Dene demonstrated higher risk in two regions, of which latitudes were ≤66 degrees (Table 3).

Discussion

In general, we observed higher injury mortality rates (relative risks) among aboriginal people, males, ages older than 14, those living in remote communities, and at a latitude >66 degrees among the NWT residents during the period 1991-1996. These general observations are consistent with other injury studies in the circumpolar region.^{5,6} In addition to these observations, the subpopulation living >66 degrees latitude presented a higher relative risk (adjusted OR=2.04, Table 2).

The majority of injury deaths (55%) occurred in regional centres (Table 1), although the relative

risk of injury for these communities was lower than that for the remote communities (OR=1.00 versus 1.51) (Table 2). The reason for this apparent contradiction is that the majority of the NWT population lives in regional centre (69% of the 42093 residents). The injury prevention programs initiated in these communities may target the population where the majority of injury deaths occurred. And since most injuries are preventable⁷, the overall injury mortality may be expected to decrease in the near future if the ongoing prevention programs are effective and efficient.

The grim fact, however, is that the other 45% of injury deaths occurred in the remote communities where the population only accounted for 31% of the total population of the NWT (Table1). Injury prevention tends to be more difficult in these areas due to a number of factors including: geographic isolation, small scattered population, less awareness of risk, difficulty in language communication, higher expenses related to equipment improvement for dealing with the environment (e.g. poorer quality of roads), less available human resources (e.g. hospital services, professional fire department staff), lower income per capita, smaller municipal tax base, and lower levels of education. The prevention of injuries may be even more difficult for the people living in remote communities >66 degrees latitude, where an even higher relative risk (OR=3.08) exists [estimated by multiplying the odds ratios of remote communities (OR=1.51) and >66 degrees latitude (OR=2.04) (Table 2)]. Thus, the

initiating and strengthening of injury prevention programs in remote areas remain an important challenge in the future.

It should be noted that the major causes of injury mortality both in the regional centre and remote communities were motor vehicles, drowning, and suicide. In addition, remote communities had a higher proportion of deaths from fires and burns (Table 4). There are existing prevention programs in the regional centre communities for the prevention of these four major injuries. Therefore, it is recommended that such programs be extended to remote small communities.

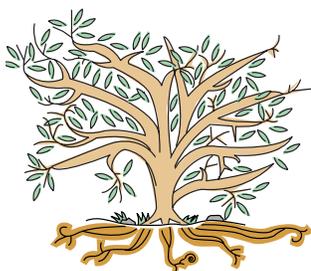
Aboriginal people are predominant subpopulations in the remote communities and consistently showed higher risks of injury mortality in the stratified analysis (Table 3). 87% of injury deaths in remote communities ≤ 66 degrees latitude were Dene, and 72% of injury deaths in remote communities >66 degrees latitude were Inuit. Thus, those at highest risk of injury deaths were aboriginal people in remote communities. Based on this information, it is suggested that the injury prevention programs in these communities should be planned to target the aboriginal people.

The limitation of this report is that the factors (ethnicity, gender, age, remoteness, and latitude) under the study are only proxy indicators associated with the injury mortality. The environment, equipment, and personal factors (eg: lifestyle) surrounding the injuries are the real causal factors.⁷ Therefore, injury surveillance programs should be developed to exam these causal factors to provide more detailed information for the prevention of injuries in the NWT.

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By Elsie De Roose,
Consultant,
Nutrition with
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Health Promotion Update

Healthy Choices, Healthy Children is the theme of the Government of the Northwest Territories (GNWT) Department of Health and Social Services' Health Promotion Strategy. It is one of seven major strategies identified in the Business Plan. This strategy is in its first year of the implementation, although it follows many years of development. A detailed description of the strategies' main priorities and directions was presented in the 1999 spring issue of EpiNorth¹.

Health promotion is "the process of enabling individuals and communities to increase control over and to improve their health".² Therefore, health promotion is a comprehensive strategy for improving health which recognizes the interaction between individual health-related behaviours and the social, political, physical and economic environment in which individual lifestyle choices are being made. Current best practices and research clearly shows the significant long-term impacts that can be

obtained by focusing health promotion efforts from the prenatal to adolescent years.³

However, the Health Promotion Strategy needs "activities" in all the branches of the model (or in each of the seven strategic directions) and can only succeed if each branch is strong - by working together and through community development. Therefore, the Department, regional health and social services boards, communities and organizations must all work together at all levels to address the issues that impact and improve health status over the long-term.

The priority areas of the territorial Health Promotion Strategy address the long-term outcomes of issues, including: healthy pregnancies, tobacco reduction and cessation, active living, healthy eating, HIV/AIDS, Fetal Alcohol Syndrome/Fetal Alcohol Effects, and dental health.

Why These Priority Areas?

| | |
|---|---|
| Healthy Pregnancies | <p>Birth weight is a good indicator of an infant's health and it's need for services during the first few years of life. While there is fewer low birth weights now than in the past, low birth weight is still a problem. Low birth weight is related to a mother's health - nutritional status, smoking, alcohol use or drug abuse - as well as level of care during pregnancy.⁴</p> <p>The following health problems are associated with low birth weight:</p> <ul style="list-style-type: none"> • 3 times more likely to have neuro-developmental handicaps • more likely to be affected by health disorders such as high blood pressure, cardiovascular disease, diabetes, etc. in adulthood.⁵ <p>In Canada, it has been estimated that the prevention of just 5% of low birth weight babies would save \$25 million in two years.³</p> |
| Tobacco Reduction and Cessation | <ul style="list-style-type: none"> • The 1993 School Tobacco Survey (done in all territorial schools) found that approximately 55% of teens 15-19 are smokers (in this age group, girls [63%] smoke more than boys [48%]). This is almost double the National average for the same age group. • The 1999 Labour Force Survey by NWT Stats Bureau reports that 41% of all people over 15 years old in the NWT use tobacco. The National Canadian average is 29%.⁷ |
| Active Living | <ul style="list-style-type: none"> • The percentage of Canadians over 18 who are active has increased by 1% every year, from 21% in 1981 to 37% in 1995 • This 16% increase in physically activity between 1981-1985 translated into savings of \$9 billion in reduced costs of health care, health insurance, sick leave, disability coverage, group life insurance and lost revenue from taxes. <p>However, the cost to the Canadian healthcare system for treating obesity-related diseases remains staggering. The Cost of Obesity in Canada study estimated that the treatment of obesity-related diseases consumes \$1.8 billion, or 2.4% of total healthcare expenditures each year: \$650 million treating hypertension, \$400 million to treat Type II diabetes and almost \$350 million to treat coronary heart disease. It should be noted that this is likely an underestimation of the true costs of treating obesity-related diseases and that the cost is more likely 4% of the Canadian healthcare budget.⁸</p> |
| Healthy Eating | <ul style="list-style-type: none"> • Approximately 1 in 5 children in Canada live below the poverty line. This estimate used to be 1 in 7.⁹ • Research indicates that children who eat breakfast do better at school; are less likely to feel anxious or depressed; and are less often to be described by their teachers as hyperactive or disruptive. |
| HIV/AIDS | <ul style="list-style-type: none"> • In Canada the annual rate of new HIV infections has risen by 33 % over the past five years from 2,700 to 4,000.¹⁰ • By reducing the rates of new infections to 1,700 per year by 2001, Canada could save \$4 billion¹⁰ <p>Prevention and awareness of the risks for HIV remain important issues in the NWT. For example, The Fort Smith Metis Council has developed a video and compact disc focusing on the risk of HIV (and hepatitis C) transmission via Intravenous Drug Use. As well AIDS Yellowknife, in partnership with several government departments, has implemented a Inmate Peer Education Program at the Yellowknife Correctional Centre, providing an important HIV/AIDS resource for inmates and their communities.</p> |
| Fetal Alcohol Syndrome, Fetal Alcohol Effects and related disorders | <p>The cost of providing the needed supports to a child/person with Fetal Alcohol Syndrome (FAS) is estimated to be in excess of 2 million per individual.¹¹</p> <p>A territorial FAS Awareness Strategy has been designed to promote understanding of the root causes of why some women abuse alcohol during pregnancy. This endeavor is a collaborative effort with the NWT Status of Women Council and the Aboriginal Birth Families in Recovery (NWT) with support from the Health Promotion Strategy Fund.</p> |
| Dental Health - Aboriginal Children* | <ul style="list-style-type: none"> • A survey conducted in 1996/97 shows that the average number of teeth affected by decay for NWT/Nunavut aboriginal children is unacceptably high. Children surveyed were aged 6 and 12 years, and had DMFT (decayed, missing, or filled teeth) rates of 7.26 and 3.67 respectively.¹² DMFT rates under 2.0 are desirable for these age groups and it is becoming increasingly common in southern dental practices for children to have DMFT of 0 (ie. no dental decay). • The financial cost of treating dental disease is high, especially in the north, where dental teams have to travel to communities without full-time clinics, and where people may be referred out for emergency or specialist treatment: approximately \$10,000,000/year for the total population of NWT and Nunavut. • The human costs of this preventable disease are substantial: <ul style="list-style-type: none"> • children with advanced disease often require surgical treatment to extract and/or fill decayed teeth that may be painful for months prior to surgery; • youngsters without teeth cannot chew properly, and may suffer from a failure to thrive; • if primary teeth are extracted prematurely, it can lead to misalignment of the permanent teeth, resulting in the need for expensive orthodontic treatment, decreased self-esteem in adolescents concerned with appearance, and difficulty in efficient brushing of teeth later in life. <p>The NWT/Nunavut DMFT rates are comparable to those for aboriginal children living on reserves in southern Canada (as determined in the survey) but are much greater than necessary, and demonstrate the need for improvement. With an emphasis on the importance of improved nutrition, good oral hygiene practices (especially the daily use of fluoridated toothpaste from the time of tooth eruption onwards) and regular attention by a dental professional, the decay rate can be significantly reduced.</p> |

* A comprehensive survey for the total NWT/Nunavut population has not been conducted

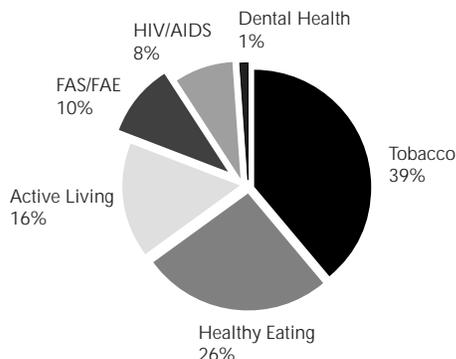
Project Profile: Sir John Franklin Highschool Tobacco PSA Production

A grade 9 class received funding from the GNWT Department of H&SS, Health Promotion Strategy funding to learn the production skills necessary to produce two CBC Public Service Announcements(PSA) to address tobacco use for students by students. The students learned skills from a local production company, researched the topics, wrote the script, chose the cast, manned the cameras and sound equipment, and edited the final copy. A production company added the finishing touches to make it CBC compatible. CBC is now airing one of the PSA's free of charge. The process has raised the profile of tobacco and has been beneficial to students, the school, Yellowknife Health and Social Services, and the Department.

The Health Promotion Strategy Fund

The Health Promotion Strategy Fund is one way in which these priority areas are being addressed. The initiative involves provides funding to support community-based/regional activities that focus on the territorial priorities. Figure 1 details the allocation of funding in each priority area to date.

Figure 1
Allocation of Health Promotion Funds (September - December 1999)



Projects Supported by Regional Health and Social Service Boards and Communities

15 projects have been supported by the Regional Health and Social Services boards and communities with joint assistance from the Health Promotion Strategy fund and other sources of funding (Table 1).

Putting Leaves on the Health Promotion Willow

Each community-based project adds leaves to the many branches of the Health Promotion Willow. Once we have the leaves placed on their appropriate branch and the evaluation done, we can see how health promotion can be part of everyday life.

For more information on the Health Promotion Strategy and Health Promotion Fund, contact the Health Promotion Team toll-free at 1-800-661-0782 or visit the Department of Health and Social Services website (www.hlthss.gov.nt.ca).

Health Promotion Team

- Lona Hegeman, Reproductive Health
- Rick Tremblay, Consultant, Health Promotion
- Marilyn Plummer, Brighter Futures
- Peter Hall, Health Information Analyst
- Gillian Burses, Manager
- Marylee Crozier
- Elsie De Roose, Consultant, Nutrition

| |
|---|
| Polly's Place, Hay River Nutrition initiative for young children |
| FAS Action, Inuvik FAS/FAE Prevention W/shop |
| Charles Yohin School, Nahanni Butte School Breakfast and Healthy Eating |
| AIDS Yellowknife, Yellowknife AIDS Prevention and education |
| Sir John Franklin/YKHSS*, Yellowknife Tobacco PSA's |
| Tulita Wellness Agency, Tulita Health Education on tobacco reduction aimed at youth |
| William MacDonald School, Yellowknife School Nutrition Education |
| Lutsel K'e HSS, Lutsel K'e School Bf program, dental health program, FAS/E w/s |
| Fort Liard HC, Fort Liard HIV/AIDS prev. for school |
| Deh Cho HSS, Fort Simpson Youth tobacco initiatives/video prod for region |
| St. Micheal's Children's Committee, Rae Youth recreation and active living program |
| Halmet of Tulita, Tulita Nutritious snacks for a day-camp program |
| Hay River PHu/Board, Hay River Promotion of healthy pregnancies/joint work with Growing together |
| YK Safe Communities, Yellowknife Injury Prevention via w/shop |
| Sir John Franklin High School, Yellowknife Sending 4 youth to DARE program |

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The Emerging Issue of Hepatitis C Virus (HCV): Program and Resource Planning

*By Wanda White,
Communicable
Disease Consultant,
Department of Health
and Social Services.*

The data on hepatitis C in Canada, although only recent, has already provided enough information on the disease's epidemiology and pathology to identify it as a costly threat to the Canadian public. In 1991, the Northwest Territories (NWT) made Hepatitis C a reportable disease; and in 1992, the Laboratory Centre for Disease Control recommended that hepatitis C be added to the list of reportable diseases in Canada. Then, in 1998, the Krever Commission brought to the forefront the impact hepatitis C has had on Canada's blood supply.¹

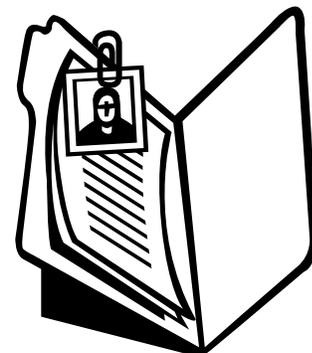
To identify those who may have contracted hepatitis C from the blood supply in the NWT, a Lookback/Traceback initiative was implemented. Specifically, direction was taken from the recommendations of the Krever Commission which stated, "that all hospitals undertake reviews of their records in order to identify former patients who received blood products between 1978 and May 1990; and that, where such records are still in existence, the hospitals directly notify those patients that they received a blood transfusion, inform them about risks of HCV infection, and provide counselling about the advisability and availability of HCV testing."²

The Canadian public health and medical community have provided guidelines, standards and educational material to meet these objectives. However in areas such as the NWT, access to relevant information and adequate support services at the community level has often been limited by geographical disparity, continuous turnover of health professional staff, and constraints with regard to resources and technology. Therefore, an environmental scan was implemented to identify and prioritize needs, and to further define required management and support for those with hepatitis C.

Background

The medical community had for many years documented the risk of post transfusion hepatitis as non A and non B hepatitis but the actual cause of the infection was unknown.³ Only an indirect liver enzyme test was available which could identify and exclude people potentially infected with the disease. This test, however, was deemed to be too unspecific by the Canadian Red Cross and, therefore, not utilized in Canada.

In 1989 a diagnostic test for HCV was developed which enabled the identification of the causative agent resulting in hepatitis disease (inflammation and infection of the liver which can lead to serious sequella, such as cirrhosis and hepatocellular carcinoma). However, it was still not known that most of those who became infected with post transfusion hepatitis, would also carry and potentially transmit the disease to others.

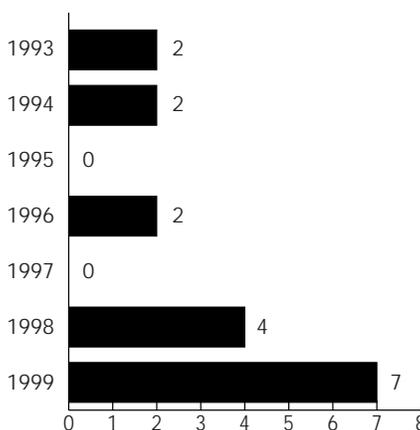


Hepatitis C in the NWT*

To date, there have been 184 cases of hepatitis C identified in the NWT and the numbers appear to have significantly increased in the last two years. Hepatitis C screening is still needed for over fourteen hundred people who received blood transfusions in the NWT.^{4,5}

Only a small proportion of these cases have been attributed to blood and blood products (Figure 1).⁶ Rather, intravenous drug use (IDU) has been the most commonly cited risk factor for contracting hepatitis C in the NWT (and Canada) (Figure 2).

Figure 1
Cases of Hepatitis C in the NWT, Blood Transfusion (1993-1999)



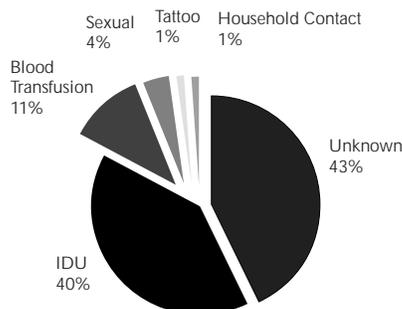
*Data does not include cases from Nunavut.

Hepatitis C toll-free information lines (from anywhere in Canada)

Health Protection Unit,
Department of
Health and Social Services
1-877-359-9919

Canadian Liver
Foundation
1-888-557-5516.

Figure 2
Hepatitis C in the Northwest Territories -
by Source of Infection (1993-1999)



Needs Identification

Many health professionals in the smaller communities did not have experience with screening and managing newly diagnosed cases. To assist front-line health care providers and practitioners, the Department of Health and Social Services (H&SS) implemented several initiatives including setting up a toll free number and developing health care worker and patient pamphlets about the disease.

The response from the toll-free line indicated that there was still inadequate resources to deal with the hepatitis C problem. As a result, a problem-orientated environmental scan was implemented to identify the dimensions of the health care need and provide guidance to the health care system to more effectively respond to the evolving hepatitis C issue.^{7,8}

Design

The duration of the survey was scheduled for 2 weeks and every health unit in the NWT was surveyed. A more comprehensive scan would have been desirable but was not possible due to the time sensitive nature of the issue - screening of those who received blood products was to begin immediately.¹⁰

The survey tool was developed jointly between the Department of Health and Social Services' health information analyst, epidemiologist, and communicable disease consultant. The survey design consisted primarily of closed-end questions due to the specific, time sensitive nature of the information and the short-time frame for data collection.^{11, 12}

Four principal areas were addressed in the survey: identification of resources available, prioritization of resources still required for screening, prioritization of resources for management and treatment, and community level support that would help patients cope with the diagnosis of Hepatitis C. These four areas were chosen because they were the most frequently identified areas of concern by the

public and health care professionals calling the toll-free helpline.

The identification of resources for testing was separated from management and treatment, since the response time to supply these extra resources to the field was of immediate concern.

Results

Thirty-four survey questionnaires were sent out to three different professional groups. Eighteen were sent to community health centres, five to public health units, and eleven to medical clinics throughout the NWT. It was suggested that each unit respond to the survey collectively to encourage discussion.

Twenty-one responses were received in the two week time frame: 10 from health centres, 4 from public health units, and 7 from medical clinics. The result was an overall response rate of 62%. This high response rate in the two-week time period emphasizes the interest and importance of this issue to the health care providers.

The environmental scan revealed the following:

- All respondents acknowledge they had some access to expert advice, and relevant patient pamphlets.
- Two main areas for additional screening resources were identified: the need for more recent explicit information about HCV testing (noted by at least half of the respondents) and prevention information at a low literacy level to promote healthy lifestyles (10 respondents).
- There were a number of additional resources identified for management and treatment of patients. The top five priorities included: access to expert advice, community support groups, new brochures, current literature and relevant patient pamphlets.
- No clear priority for community level support for health care providers and patients could be identified from the scan. Example of responses included: increased visits by the communicable disease consultant, available home care, greater number of adequately trained mental health professionals, appropriate support groups, community-based needle exchange program, and access to information on alternative therapies.

Discussion

These results not only provided input to improve the day-to-day activity of the hepatitis C program, but also provided the health care system with a framework to guide choices and direct the future development of hepatitis C programs for the long term.⁹

"By surveying, understanding, and addressing patients needs and desires, healthcare delivery systems may allocate resources more appropriately to better serve the community".⁹

In the short term, the scan identified a priority need for explicit testing guidelines and prevention education resources. Specifically, accessible, low literacy client information will be an issue for all participants in the process. One appropriate avenue may be to develop videos and other visual tools to assist with teaching and coping with the disease. As well, the results strongly indicate that there is a need to continue assisting with the coordination of care and support for health practitioners and the general public. Therefore, there will be continued access to expert advice, and coordination of investigation and consultation which will be facilitated by the Health Protection Unit for health practitioners; and, support will continue with a toll-free number even after hospitals in the NWT have completed their Lookback/Traceback efforts for the general public.

For the longer term, the high percentage of respondents and positive feedback supports the need for continued scanning of the environment for the purposes of making the Hepatitis C Lookback/Traceback program responsive to continued evolving issues as the program progresses. Partnerships will also be further developed with Health Canada and community organizations (eg, AIDS Yellowknife) to supplement resources and materials for patient support, screening and community based education programs. To coordinate activities, a strategic plan will be developed in conjunction with the federal government, local health and social services boards, and community groups guided by the information acquired in this environmental scan, current research, and expert advise.

Limitations

This survey was developed without a pretest, and the study tool has not been utilized in the past. As well, the utilization of predefined, close-ended questions could bias the feedback of the respondents. However, the participation of experts was sought, such as the health analysis and epidemiologist, to provide feedback in place of a pretest to test the reliability and the validity of the survey. It should also be noted that the needs of patients were not fully assessed (only one open-ended question in the survey was included). Health Canada data collected in 1998 from direct hepatitis C patient interviews will be used as a supplemental source of information.

Conclusion

The problem-orientated environmental scan identified priorities for additional resources to enhance the ability of the system to respond to needs that are emerging in the hepatitis C community. These identified resources will assist the health care practitioners and patients to better cope with the diagnosis, management, and support required in the future; and the data from the scan will act as a base source of information to provide guidance and improve decision making to develop effective NWT community-specific programs. Support for these programs will be achieved through immediate and long-term planning with the continued involvement of federal, territorial and community agencies.

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By Dr. Penny Sutcliffe,
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Cause for Concern: HIV/AIDS Among Aboriginal People in Canada



Recently released Health Canada statistics about HIV/AIDS give cause for concern about the impact of the epidemic on Aboriginal¹ people in Canada. This information is particularly relevant to the Northwest Territories (NWT) which has an Aboriginal population of more than 50%.

To plan for effective HIV/AIDS prevention and management programs in the territories, it is essential that we understand the details of the epidemic among Aboriginal people in Canada. This article describes the national picture and outlines the implications for the NWT.

HIV/AIDS Ethnicity Data

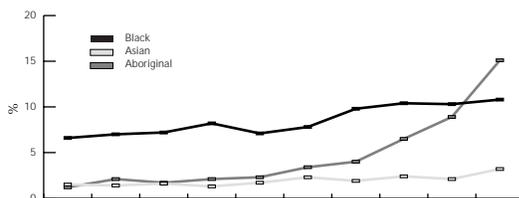
With the cooperation of the provinces and territories, Health Canada collects and analyzes information on the AIDS (acquired immunodeficiency syndrome) and HIV (human immunodeficiency virus) epidemic in Canada. Ethnicity data has been collected for AIDS diagnoses since 1982 (the year the first case of AIDS was diagnosed in Canada). For HIV infections, ethnicity data has been collected only since 1998.

Reporting on AIDS ethnicity has improved over time from 85.5% of cases in 1982 to 94.9% in 1998. HIV ethnicity information is less complete with only 24.5% of all positive HIV tests having associated ethnicity data in 1998.

AIDS Reported Cases not Decreasing among Aboriginal People

Overall, the number of AIDS cases reported annually in Canada is declining; this is likely due to the availability of new, more effective treatments. Hidden in the declining statistics, however, is the changing ethnicity patterns with differences particularly for Aboriginal Canadians.

Figure 1
Percent Distribution of Reported AIDS Cases with Known Ethnicity by Selected Ethnicity Group, Canada 1990-1999



Source: Health Canada. *HIV & AIDS in Canada Surveillance Report to June 30, 1999. November 1999.*

Of the 16,628 cumulative total AIDS cases reported in Canada (1982 to June 30, 1999), 341 were reported as Aboriginal; and as figure 1 illustrates, the percentage of Aboriginal people among AIDS case reports with known ethnicity is increasing. Specifically, the proportion of reported AIDS cases among Aboriginals in Canada increased from 1.2% to 15.1%. Conversely, the proportion of reported AIDS cases among whites in Canada declined from 88.7% (1990) to 65.6% (1999) in the same time period. Therefore, although Aboriginal people represent only 2.4% of all AIDS cases with reported ethnicity, the underlying trend is an increase in the representation of Aboriginal persons among AIDS reports with known ethnicity information.

A higher percentage of the total number of Aboriginal AIDS cases were diagnosed at a younger age (29.3% vs 17.2% diagnosed less than 30 years of age).

And a final concerning characteristic of the epidemic is the relative stability of Aboriginal AIDS case reporting in the context of overall declining numbers in Canada (Figure 2).

It should be noted that the figures below likely under-estimate the true number of Aboriginal AIDS cases. Under-estimations are due to a variety of factors including under-reporting of ethnicity, delays in reporting and mis-classification of ethnicity status.

HIV: Significant Proportion of Aboriginal People among Positive HIV Results

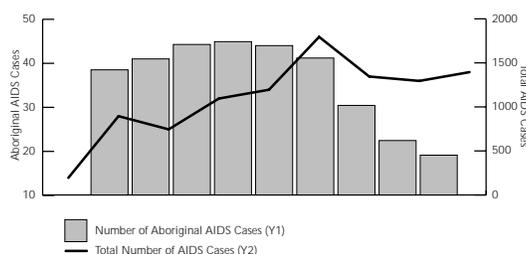
Of the 565 (24.5%) positive HIV tests for which ethnicity was reported in 1998, 20% were among Aboriginal people. Preliminary data for the first 6 months of 1999 indicate a similar trend with a figure of 21.8%. Although these figures are based on only a quarter of all positive HIV test results (i.e. those for which ethnicity information was reported), it is concerning that 1 in 5 were identified as Aboriginal.

Table 1 indicates that upon further analysis, several other key characteristic differences emerge between Aboriginal and non-Aboriginal reported HIV cases. In comparison to non-Aboriginals, Aboriginal people who test positive for HIV are more likely to be female, younger and to inject drugs at the time of HIV diagnosis.

¹ "Aboriginal" refers to First Nations, Inuit and Métis.

Although it is important to consider these characteristics when planning HIV prevention programs, it must be remembered that the figures

Figure 2
Aboriginal and Total Canadian AIDS Case Reports by Year of Diagnosis, Canada 1990-1998



Source: Health Canada. *HIV/AIDS and Ethnicity in Canada. HIV/AIDS Epi Update. November 1999.*

are based on only one quarter of positive test results for 1998.

HIV/AIDS - Implications for the NWT

As the national picture of the HIV/AIDS epidemic for Aboriginal people in Canada emerges, it will be important to carefully consider the implications for the NWT. However, given the diverse people and communities that make up the Aboriginal population in Canada, it cannot be assumed that the national picture will necessarily reflect circumstances within the NWT.

What then are the facts that we do know about the HIV/AIDS epidemic in the NWT?²

1. The cumulative totals (1982 to June 30, 1999) of AIDS cases diagnosed and positive HIV test reports in the NWT was 16 and 32, respectively. While these figures are low, there is likely some degree of under-diagnosis and under-reporting of HIV and AIDS in the NWT due to factors such as, access to testing, acceptance of testing, and testing outside of the territory.
2. The male:female ratio of positive HIV test reports in the former NWT has been low in

comparison to Canada as a whole (4:1 for the NWT vs 7:1 for Canada). This means that a person in the NWT is more likely to be female upon HIV diagnosis.

3. Although the NWT figures are based on small numbers, the percent distribution in exposure categories for AIDS cases diagnosed in the NWT are somewhat different from those in Canada as a whole. Of particular note is the percent of heterosexual transmission observed in the NWT (Table 2).
4. The rates of other sexually transmitted diseases in the NWT are elevated in comparison to national rates. This raises concern about potential and real HIV infection rates in the NWT.

No one is immune to HIV infection. The recent

Table 2
Comparison of Exposure Category Distribution for all AIDS Case Diagnosed (by Percent) to June 30, 1999.

| Exposure Category | NWT | Canada |
|---|------|--------|
| MSM | 31.1 | 73.0 |
| MSM/IDU | 6.3 | 4.5 |
| IDU | 0 | 5.6 |
| Recipient of Blood | 6.3 | 1.8 |
| Heterosexual Contact (sexual contact with a person at risk) | 50.0 | 5.9 |
| Perinatal Transmission | 6.3 | 0.9 |

Source: Health Canada. *HIV/AIDS and Ethnicity in Canada Surveillance Report to June 30, 1999.* November 1999.
MSM = men who have sex with men
IDU = injection drug users

national data on HIV/AIDS among Aboriginal people in Canada serves us notice to not be complacent in the face of this ongoing epidemic.

We need to learn from this information and take a sharp look at our prevention and management efforts in the NWT. Understanding the characteristics of this epidemic among Aboriginal people nationally and locally is critical to successful efforts to reduce HIV infections and AIDS diagnoses in the NWT.

Table 1
Comparison of Positive HIV Test Results: Aboriginal vs non-Aboriginal by Gender, Age and Exposure Categories (in Percent) 1998

| | Male | Female | 20-29 | 30-39 | MSM | IDU |
|----------------|------|--------|-------|-------|------|------|
| Aboriginal | 55.9 | 44.1 | 33.6 | 44.2 | 13.3 | 63.4 |
| non-Aboriginal | 79.9 | 20.1 | 19.0 | 41.4 | 30.9 | 37.4 |

Source: Health Canada. *HIV/AIDS and Ethnicity in Canada. HIV/AIDS Epi Update. November 1999.*
MSM = men who have sex with men
IDU = injection drug users

² Statistics include both NWT and Nunavut Data.

By Lona Hegeman,
Consultant,
Reproductive Health,
Department of Health
and Social Services

Inmate Peer Educators: HIV/AIDS Training and Awareness Project

Inmate Peer Educator Training is an initiative supported by the Department's Health Promotion Unit for HIV/AIDS prevention and awareness at the Yellowknife Correctional Centre. The project is administered by AIDS Yellowknife¹ and provides the men enrolled in this training-program with skills in conveying critical information on HIV prevention, transmission and related issues. The Inmate Peer Educators present HIV/AIDS workshops and skits at all NWT correctional sites, including a bush-camp. As well, the educators present HIV/AIDS prevention and awareness information at community gatherings in Yellowknife and in surrounding communities.

The Health Promotion Strategy Fund provides the Inmate Peer Educators with funds for producing HIV prevention and awareness materials. This information is distributed to inmates following the Peer Educators' presentations and a care package with HIV/AIDS information and condoms are available for inmates upon their release from corrections.

A preliminary evaluation of the impact of the Inmate Peer Educators at the Yellowknife Correctional Centre (YCC) is encouraging:

1. YCC's Deputy Warden states that "the Inmate Peer Educators demonstrated remarkable success and guards are confiscating far less tattooing equipment since the Inmate Peer Education Program was initiated in April, 1999". This encouraging initial development will be monitored by Yellowknife Correctional Centre staff and the Inmate Peer Educators.
2. Feedback from the written evaluations following the presentations has been positive and constructive. Analysis of the written evaluations is planned for a future EpiNorth publication.

3. Calls to the NWT 1-800 HIV/AIDS Information Line increased² by 32.0% following the introduction of the Inmate Peer Educator presentations. This preliminary result is seen as a significant development by HIV/AIDS Information Line staff, volunteers and board members.

The Health Promotion Unit is funding the expansion of the Peer Educator Training to include: CPR Training and Certification (Infant, Child and Adult); First Aid Training and Certification; Tuberculosis Awareness Training and Communication Skills Training.

Gains, such as these achieved with the Inmate Peer Educators, are only realized when collaboration and a shared vision exists with all partners involved. The partners in this initiative include:

AIDS Yellowknife, GNWT Department of Justice and Yellowknife Correctional Centre, NWT HIV/AIDS 1-800 Information Line³ (1-800-661-0782) operated by the Canadian Mental Health Association (NWT), HIV/AIDS Prevention and Community Action programs of Health Canada.

For more information, please contact Lona Hegeman, Consultant, Reproductive Health, Health Promotion Unit, Population Health Division at 1-800-661-0782.

Footnotes:

- ¹ Health Canada ACAP funding provided
- ² November 1998 to November 1999 statistics
- ³ The NWT HIV/AIDS 1-800 Information Line is also funded by the Department.



Mental Health!

For your mental health and well-being, take the time to be aware of your stress level and your coping mechanisms.

Mental health is recognized nationally in May of each year with assistance and resources from the Canadian Mental Health Association (CMHA). A week is dedicated to raise awareness of mental health issues, promote positive mental health, and provide information and education about stress and mental disorders.

This year, CMHA - NWT Division chose to mark Mental Health Week in February (6-12) to recognize the impact of winter darkness and stress on many people in the NWT. This year's theme was "Daily Stress: It Can Knock You Off Balance".

However, mental health should be a focus through-out the year! Information on mental health may be obtained from the CMHA - NWT Division. The division distributes information packages across the NWT and maintains a resource library on mental health issues.

For more information, contact:

Canadian Mental Health Association
NWT Division
(867) 873-7042

Western Arctic Helpline
7-11 p.m. nightly
(867) 920-2121 or 1-800-661-0844

Stanton Regional Hospital
Mental Health Clinic
(867) 920-2001

References

- 1 Review of Best Practices in Mental Health Reform. Report for the Federal, Provincial, Territorial Advisory Network on Mental Health. Ottawa: Health Canada, 1997
- 2 Health Status Report. Northwest Territories: Department of Health and Social Services, 1999.
- 3 Cynadar, Mac. Proceedings of the Honda conference on the determinants of population health. Toronto: Canadian Institute of Advanced Research, 1993.
- 4 GNWT Suicide Data Base. Department of Health and Social Services, 1999.

By Sandy Little,
M.S.W., C.S.W.
Mental Health Consultant,
Department of Health
and Social Services



Mental Health Facts

- 2% of the Canadian population experience serious mental illness.¹
- 10% of the Canadian population has a psychiatric diagnosis.¹
- Depression is the most common form of mental illness.²
- Individuals exposed to stress, who have poor coping abilities, have decreased immune system functioning and higher susceptibility to physical illnesses.³
- Mental health issues were the main reason for hospitalization of men in the Northwest Territories NWT (1997).²
- There were 16 suicides in the NWT in 1999 - the average number of suicides for the previous 5 years (1994-1998) is 6.⁴

Helpful ways to cope with stress

1. Eat well and keep physically active.
2. Identify signs and symptoms of stress in your life.
3. Learn stress reduction strategies.
4. Keep a sense of humor.
5. Set realistic goals and priorities.
6. Find a trusted person to talk about feelings.

Conferences / Workshops

Below is a list of health related conferences and workshops being hosted in the upcoming year. If you would like to list an upcoming conference or workshop please email, fax or mail in the information to EpiNorth.

Canadian Public Health Association (CPHA) - 91st Annual Conference
Ottawa, Ontario, 22-25 October 2000

"Health for all by the Year 2000" is the focus of the conference this year. Practitioners and those interested in health are invited to reflect on the progress governments have made on assisting people in attaining a level of health that would allow them to lead a socially and economically productive life. The conference is organized into themes:

Health of First Nations; Mental Health; Inequity and Health for All; Innovative Approaches to Health for All; and International Health.

The CPHA also has a number of health publications and videos which range in content to suit a variety of audiences including the general public, school children, and health care professionals. For further information please contact the CPHA.

Contact:
Canadian Public Health Association,
400-1565 Carling Avenue,
Ottawa, Ontario, K1Z 8R1
Tel: 613-725-3769, Fax: 613-725-9826
E-mail: hrc/cds@cpha.ca or conference info:
conferences@cpha.ca. Internet: www.cpha.ca

By Lona Hegeman,
Consultant,
Reproductive Health,
Department of Health
and Social Services

*"I feel so alone
in my role as a foster
parent of a child
with special needs.
I just need a buddy."*

(Foster Mother,
Fort Simpson,
September, 1999)

NWT Foster Family Support Line Launched

The Health Promotion Unit has provided funding and developmental assistance for a toll-free Foster Family Support Line for the Northwest Territories (NWT).

Foster families are important resources in the ongoing challenge of promoting healthy childhood in all NWT regions and communities. Foster parenting is a demanding role and NWT foster parents identified the need for support mechanisms that aid discussion of issues pertaining to foster care without fear of breaching confidentiality.

The Foster Family Support Line (NWT) will assist in providing a confidential, peer support network. The result may not only increase support for the 165 NWT foster families but also may act to retain a greater number of foster parent families.

The Foster Family Support Line (NWT) will be available as of December 21, 1999 and NWT foster parents are encouraged to call the line with inquiries and to discuss concerns. As well, NWT foster parents can¹ receive regularly scheduled phone calls from the Support Line Team comprised of experienced foster parents willing to share their expertise and a range of coping strategies.

The effectiveness of the toll-free line will be monitored over the next 12 months. The results will be published in EpiNorth.

Anne Kennedy is involved in the launch of the toll free line and welcomes your inquiries at (867) 920-7160.

Footnote:

¹ Frequency of calls will be weekly to monthly and will be established by each foster family utilizing the Foster Family Support Line for support purposes.

By Wanda White,
Communicable Disease
Consultant,
Department of Health
and Social Services.

HIV Infection and AIDS: Information for Health Professionals

The revised 1999 edition of the *NWT HIV Infection and AIDS: Information for Health Professionals Manual* is now available from the Health Protection Unit, Department of Health and Social Services. Copies are being sent to all Health Centres, Physician's Offices and Health Care Institutions in the Northwest Territories. Since this manual is an in-depth revision of the 1987 HIV Manual, please discard all previous copies.

The manual is intended to assist health professionals in the Northwest Territories and guide their practice with regard to screening and testing for HIV infection and AIDS. Topics covered in the manual include:

- HIV/AIDS Information
- HIV Testing Guidelines
- Pre-test and Post-test pamphlets for patients
- Reporting Forms for positive tests

The manual is produced in a loose-leaf format to facilitate updating, as new information becomes available. It will also be available on the Department's web site at <http://www.hlthss.gov.nt.ca/publicat.htm>.

Please contact the Health Protection Unit (phone: 867-920-8646, fax 867-0442) if you require additional information, or if you would like to order additional documents contained in the manual. Any feedback will also be greatly appreciated.

Notifiable Diseases by Territory and Region: for the Northwest Territories (NWT) and Nunavut (NU), July 1999 - December 1999

| | July-December 1999 | | 1999 Totals | | Regional Totals - 1999 | | | | | |
|---|-----------------------------|-----|-------------|-----|------------------------|------------|--------|----------|-----------|-----|
| | NWT | NU | NWT | NU | Inuvik | Fort Smith | Baffin | Keewatin | Kitikmeot | |
| <i>Vaccine Preventable Diseases</i> | Hepatitis B | 1 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 |
| | Influenzae | 0 | 0 | 1 | 3 | 0 | 1 | 1 | 2 | 0 |
| | Pertussis | 61 | 6 | 94 | 11 | 0 | 94 | 0 | 7 | 4 |
| <i>Sexually Transmitted/Bloodborne Diseases</i> | Chlamydia | 234 | 421 | 450 | 769 | 189 | 261 | 367 | 234 | 168 |
| | Gonorrhoea | 35 | 63 | 89 | 112 | 31 | 58 | 96 | 9 | 7 |
| | Hepatitis C | 19 | 4 | 35 | 10 | 8 | 27 | 7 | 2 | 1 |
| | Hepatitis, Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Syphilis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Chicken Pox | 77 | 169 | 170 | 313 | 101 | 69 | 140 | 66 | 107 |
| <i>Diseases by Direct Contact/Respiratory Route</i> | Group A Strep | 3 | 1 | 4 | 2 | 0 | 4 | 1 | 0 | 1 |
| | Invasive Strep Pneumonia | 3 | 9 | 7 | 10 | 0 | 7 | 10 | 0 | 0 |
| | Legionellosis | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 1 |
| | Meningitis, Pneumococcal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Meningitis, Other Bacterial | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Meningitis/Unspecified | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| | Meningitis, Viral | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Meningococcal Infections | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Tuberculosis | 6 | 14 | 16 | 24 | 1 | 15 | 22 | 2 | 0 |
| | Botulism | 2 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 |
| <i>Enteric, Food and Waterborne Diseases</i> | Campylobacteriosis | 5 | 0 | 9 | 0 | 3 | 6 | 0 | 0 | 0 |
| | Cryptosporidiosis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | E.Coli 0157:H7 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| | Food Poisoning | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Giardiasis | 7 | 5 | 10 | 10 | 3 | 7 | 1 | 1 | 8 |
| | Hepatitis A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Salmonellosis | 6 | 4 | 9 | 7 | 1 | 8 | 3 | 3 | 1 |
| | Shigellosis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Tapeworm Infestation | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 |
| | Trichinosis | 0 | 36 | 0 | 41 | 0 | 0 | 32 | 9 | 0 |
| | Yersinia | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| <i>Vectorborne / Other Zoonotic Diseases</i> | Brucellosis | 0 | 2 | 1 | 4 | 1 | 0 | 1 | 0 | 3 |
| | Malaria | 1 | 1 | 2 | 1 | 0 | 2 | 0 | 1 | 0 |
| | Rabies Exposure | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

HIV Infections Reported in NWT Residents

| YEAR | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| NWT | 2 | 1 | 1 | 2 | 1 | 8 | 0 | 2 | 0 | 2 | 0 | 1 | 0 |
| NU | 0 | 1 | 2 | 1 | 2 | 1 | 3 | 0 | 0 | 0 | 1 | 0 | 0 |

Errata: The 1999 Spring and Fall Issue incorrectly reported one case of HIV infection in the NWT. The 1999 Fall Issue stats were for the months April - June, 1999 not January - June, 1999. The number of chicken pox cases in Nunavut in the 1999 Fall Issue should be 90 not 66.

By Kim MacAulay,
Injury Prevention
Coordinator,
Inuvik Regional
Health Board

Marilyn Plummer,
Community Wellness
Consultant,
Health Promotion,
Department of Health
and Social Services

Inuvik Injury Prevention Program

The Inuvik Injury Prevention Program has launched an injury surveillance tool for the Inuvik Health Board service area.

This tool will be used by communities to establish needs and define local priorities for future injury prevention initiatives. Existing injury-related programs will be identified to meet these needs and, where necessary, safety initiatives will be launched to address various common safety issues.

The following is a list of plans for the first year of the program:

- 1) Implement surveillance tool and collect data.
- 2) "Train the trainer" safe snowmobile course.
- 3) Develop traveling safety presentation to disseminate general safety information to the communities.
- 4) Lobby for better enforcement/legislation of safety issues.
- 5) Develop a local injury prevention newsletter incorporating data and events.
- 6) Establish a "positive rewards" campaign.
- 7) Ice Safety, Cold Weather and Dog Safety awareness campaigns in schools.

- 8) Car Seat Safety Campaign.
- 9) Bike Rodeo.
- 10) Disseminate information through TV, newspaper ads, posters, pamphlets, and radio in the communities.

Kim MacAulay - Frontline Defense

Kim MacAulay is the newest member of the injury prevention unit in Inuvik. She graduated from Dalhousie University in May 1999 with a Bachelor of Science in Health Education. Her career started as an intern for the Nova Scotia Child Safety and Injury Prevention Program where she coordinated a pilot of the P.A.R.T.Y. (Preventing Alcohol and Risk-Related Trauma in Youth) program. Then, she was contracted to coordinate the Nova Scotia Power Children's Safety House. The Safety House was a traveling model home about the size of a small trailer with 4 small rooms demonstrating ways for parents to make their home safer for their children. Welcome Kim!

References

- ¹ "Injury Mortality", Health Status Report, Northwest Territories: Department of Health & Social Services, 1999, p 33.

Fast Facts: Injuries in the NWT¹

Motor vehicles (21%), suicide (16%) and drowning (14%) cause the majority of injury mortality in the NWT.

Injuries accounted for nearly half of all premature deaths - average age at death of injury was 38 years old, as compared with 57 for all other causes of death.

50% of potential years of life lost (PYLL) for men are due to deaths from injury; it accounts for 27% for women.

EpiNorth is a publication of the Department of Health & Social Services. Contributions are welcome and should be sent to the Managing Editor by e-mail or regular post (electronic copy). Inclusion of material in EpiNorth does not preclude publication elsewhere. Views expressed are those of the authors and do not necessarily reflect departmental policy.