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Family Violence: Another Look

In conducting some background research for this article it was not hard to find information. Family violence is a fairly common topic and has been written about, studied, surveyed and serviced. We run campaigns around it, we educate people on it, and we alleviate the consequences of it by hiding women and children in shelters. The judicial system condones it with lenient sentences and the churches prefer it remain a private matter between man and wife. This article invites discussion and action. It is meant to assist the reader in understanding the links between gender inequalities and violence against women.

Herstory

Twenty years ago (1981) in the House of Commons, member Margaret Mitchell raised the issue of wife battering and her male colleagues laughed. The resulting public outcry was loud and clear. The report "Wife Battering in Canada: The Vicious Circle" cited back then, that one in ten Canadian women were beaten by her partner. And they laughed. Women began organizing and talking and writing and soon the Canadian government was made to recognize that family violence was an epidemic.

In 1965, Ontario became the first province to require reporting of child abuse. No link was made between violence in the household and the abuse. Seven years later, Canada's first shelter for abused women was opened in Vancouver. In 1982 the National Clearinghouse on Family Violence was established. The first Canadian initiative to address family violence was launched in 1988 followed by the second in 1991, the third in 1997. In 1993 the Canadian Panel on Violence Against Women released a report, *Change the Landscape: Ending Violence ~ Achieving Equality*. This report has been a valuable resource for this paper and is recommended reading.

The terms *wife battering, spousal abuse, domestic violence* and *family violence* are misleading and inaccurate because they tend to cloud the issues underlying the violence against women. ***Wife, family, spouse*** **place women in relation to another instead of acknowledging women as individuals.** Glenda Sims, President of the Canadian Advisory Council on the Status of Women in 1989, said, "We cannot use gender-neutral language. We do not speak of domestic violence or family violence, because when we use those terms we tend to hide the victims and protect the perpetrator."[1]

Roots of Violence Against Women

If society were to engage openly in discussions about sexism, inequalities and power imbalances maybe then we can begin to face the roots of violence against women. However, these discussions can be a delicate balancing act.

A proposed United Nations Declaration on the Elimination of Violence Against Women* describes the persistence of violence against women as

> a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and which have prevented women's full advancement. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared to men.[2]

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* The UN Commission on the Status of Women approved the draft in March 1993.

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Northwest Territories Health and Social Services

HOW TO REACH
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From a Whisper to a Scream: Battered Women in the NWT

Abuse can occur in any relationship, although women, children, the elderly, and the disabled are most often targeted because they tend to be in positions of dependence. The abuser is usually someone who uses his or her position of power to cause victims to suffer. The focus of this article is abuse by a man towards his female partner.

The Department of Health & Social Services funds the following five transition houses, or safe shelters: Alison McAteer House in Yellowknife, The Family Support Centre in Hay River, Sutherland House in Fort Smith, the Inuvik Transition House, and the Tuk Women and Children's Centre in Tuktoyaktuk. The bulk of data presented in this article is gathered from these shelters.

Women Experiencing Abuse

In the 2000/2001 fiscal year, 257 women were admitted to NWT safe shelters. Seventy percent (70%) of women admitted to these shelters were between the ages of 20 and 40. Thirty-nine percent of these women were admitted for emotional abuse, while 35% were admitted because they were physically assaulted (see figure 1). On discharge, 35% of these women returned to their abusive partner (see figure 2). In total during the 2000/01 fiscal year, women and children spent 8,343 bednights in NWT shelters and there was an average of 23 women and children in shelters every day.[1]

A one-day snapshot of shelters across Canada in 1998 showed the rate of women in shelters per 100,000 women in the population was 18.2 for Canada as compared to 145.7 for the NWT.[2] While the rate of shelter use depends on many factors, this dramatic difference appears to indicate that there is an epidemic of wife assault in the NWT, especially when one considers many cases go unreported.

Admissions of women to NWT shelters are highest from those communities with shelters. The simple reason being, it is easier to access a shelter for a woman in a community in which a shelter is located than it is for a woman from an isolated community to access shelter in a community hundreds or perhaps thousands of kilometres away. In *Family Violence in Canada: A Statistical Profile 2000*, the authors report that rates of spousal violence for people living in urban settings are comparable to those living in rural settings.[3] The difference in the experience of women living in remote communities is they face difficulty getting the help they need to cope with the violence in their lives. There are fewer services available to women in remote communities and it may be more difficult for women in smaller communities to speak out, especially if they have moved there to be with their partner. As well, the woman may feel she does not have the resources she needs to actually travel to a shelter.

The RCMP's Northwest Territories statistics provide further information on battered women. In 2000/2001 there were 374 reported incidents of spousal assault by a male perpetrator, while there were only 50 reported incidents of spousal assault by a female perpetrator.[4] CHMIS data demonstrate that each year between 1994 and 1998, an average of 85 women and 27 men visited either health centres, emergency rooms or their family doctor for reasons of assault by their partner.[5] These are the individuals who were assaulted and actually came forward to helping professionals. There are many, many more unreported incidents of abuse that are kept quiet. In the report *Family Violence in Canada: A Statistical Profile 1999*, the author states that family violence is under reported and, as a consequence, is underestimated by professionals and society due to factors such as secrecy surrounding the issue, dependency of the victim on the perpetrator, lack of knowledge about available help, and repercussions for reporting the event (i.e. fear of further violence by the batterer).[6]

Research carried out in southern jurisdictions shows that nearly three in ten Canadian women (29%) who have ever been married or lived in a

common-law relationship have been physically or sexually assaulted by a marital partner at some time during that relationship. Nearly one quarter of those women (22%) have never told anyone about the abuse.[7] This means, not only did the women not go to a shelter or to the police, they did not even disclose the abuse to their closest friend. Thus, only a fraction of abused Canadian women actually access medical attention, the RCMP or a safe shelter.

There has been little research done specifically focusing on the issue of violence against women in the NWT, however those individuals working in the field feel the information gathered in southern jurisdictions also holds true in the NWT. Shelter workers report that many northern women simply stay at home or with friends until their bruises heal. They also report that women find it extremely difficult to disclose the details of the abuse. Women admitted to shelters will, on admission, report being emotionally abused and will only disclose that they are also being physically abused during subsequent admissions when they have had an opportunity to build a relationship of trust with a shelter worker. Thus, the statistic of 35% of admissions to shelters being related to physical violence does not represent the full extent of the problem even among those women who are actually seeking help.

In *Family Violence in Canada: A Statistical Profile 2000,* the authors state that younger people, individuals living in common-law relationships, and individuals with partners who drink heavily are at greater risk of experiencing spousal violence.[3] These situations would describe many northern women. While shelter statistics do not currently report on the use of alcohol by the abusive partner, we know anecdotally from the RCMP that alcohol abuse is a significant factor in many crimes in the NWT.[8]

Children Who Witness Abuse

There were 364 admissions of children, 16 years of age and under, to NWT shelters in 2000/2001. Forty-seven percent (47%) of these admissions were children five years of age and younger.[1] Younger children are especially vulnerable in situations of exposure to woman abuse because of their dependence on their parents.[9] Parents tend to underestimate the extent of the violence their children witness and its impact. Many children suffer from post-traumatic stress disorder (PTSD) because of what they experience at home. These children are frequently misdiagnosed as having attention deficit hyperactivity disorder (ADHD) in part because the attending clinician fails to raise the issue of violence in the home, and the symptoms of both disorders are very similar. "Children are not just background furniture at the scene; they are highly traumatized individuals who are most in need when their principal caretakers are also in crisis".[10]

Implications for Practice

It can be difficult to ask a woman whether she is being physically abused by her partner and many times health care providers find themselves puzzled by a woman's responses to the abuse she is experiencing. Nevertheless, many battered women report that the first disclosure they made about the violence they were experiencing was the result of someone directly asking them if they were being abused. Although battered women see their family physicians during the course of their experience with battering, family doctors often do not detect the problem, in part because they may not ask about the issue. In fact, health care providers may complicate the situation by prescribing sedatives or antidepressants that increase a woman's likelihood of committing suicide or put her at risk for further violence.[11]

Physical signs of woman abuse include some of the following:

- injuries sustained that do not fit the history given;
- evidence of previous injuries or injuries that are at different stages of healing;
- injuries to the head, neck, face, throat, chest, abdomen, or clusters of multiple injuries;
- injuries to the bone or soft tissue (broken teeth, pulled out hair, jaw fractures, black eyes, perforated ear drum, strangulation marks, evidence of sexual assault);

Figure 1

Reason for Admission to NWT Shelters in 2000

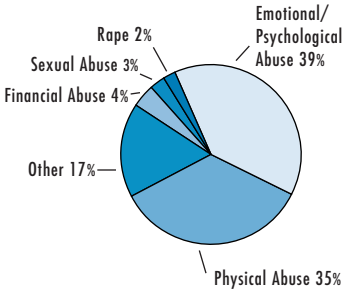
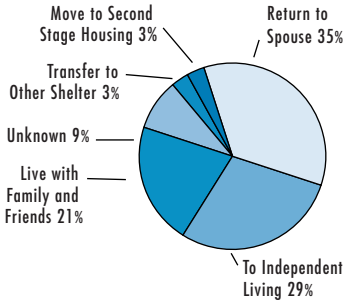


Figure 2

Departure Plans of Women Using NWT Shelters 2000/2001



- multiple visits to an emergency department; and
- gunshot and stabbing wounds are highly suspicious unless there is evidence that the attack was not by a partner.[11]

Battering in an intimate relationship never occurs in the absence of emotional violence.[12] Women report that they find the emotional abuse, especially if it is long term, to be more damaging than the physical assaults because the emotional abuse leaves the woman feeling demeaned, hopeless, and powerless.[3]

Psychological or emotional abuse should be considered when there is:

- fear of or anger towards the male partner;
- stress or post traumatic stress disorder;
- anxiety disorders or depression (e.g. sleep and appetite disturbances; fatigue; chronic headaches; reports of severe crying spells; feelings of isolation; suicidal thoughts; acute anxiety; chronic pains without an identifiable cause; headaches; back, chest, or abdominal pain; gastrointestinal and abdominal complaints; palpitations; dizziness; abnormal skin sensations; and shortness of breath).[11]

Also consider the presence of abuse if there are frequent occurrences of gynecological problems, pelvic pain, frequent or long-term use of prescribed minor tranquilizers, pain medications or psychoactive drugs, a history of psychiatric illness or substance abuse.[11]

It is important to help the patient recognize the range of abusive behaviours she is enduring and let her know that she does not deserve this treatment. Supporting battered women is difficult and complex work. An important point to keep in mind is that they find the sharing of their story of abuse very difficult. We should never assume that we know the full extent of the violence that has been committed against them. Victims may never feel they are able to speak freely.[13]

Shelter workers report that the full scope of the violence a woman experiences is usually revealed over a period of time, involves many meetings, the development of a relationship of trust, and the space for the victim to assess for herself the extent and full impact of the violence. Many women also minimize their experience when first disclosing to a health care provider. It is crucial for doctors, nurses and all front line staff working with women experiencing violence, to understand the complex nature of abuse disclosure, the tendency for victims to blame themselves, and the societal pressures that cause women to return to abusive relationships.

REFERENCES

1. *Family Violence Database:* Department of Health & Social Services, GNWT.
2. Statistics Canada. *The Daily*. Ottawa: Canadian Centre for Justice Statistics, June 11, 1999.
3. Bunge, Valerie Pottie, and Daisy Locke, eds. *Family Violence in Canada: A Statistical Profile 2000*. Ottawa: Statistics Canada, Canadian Centre for Justice Statistics, 2000.
4. RCMP, Operational Statistics Reporting System.
5. CHMIS database: Department of Health & Social Services, GNWT.
6. Fitzgerald, Robin. *Family Violence in Canada: A Statistical Profile 1999*. Ottawa: Statistics Canada, Canadian Centre for Justice Statistics, 1999.
7. Rodgers, Karen. *Wife Assault: The Findings of a National Survey.* Ottawa: Statistics Canada, Canadian Centre for Justice Statistics,1994.
8. Johnson, Sergeant Phil. RCMP spokesperson, G Division. Personal interview. October, 2001.
9. Suderman, Marlies, and Peter Jaffe. *A Handbook for Health & Social Services Providers and Educators on Children Exposed to Woman Abuse/Family Violence*. Ottawa: Health Canada, Family Violence Prevention Unit, 1999.
10. *IBID*: 16.
11. Ferris, Lorraine, Asifa Nurani, and Laura Silver. *A Handbook Dealing With Woman Abuse and the Canadian Justice System: Guidelines for Physicians*. Ottawa: Health Canada, Family Violence Prevention Unit, 1999.
12. Evans, Patricia. *The Verbally Abusive Relationship*. Massachusetts: Adams Media Corporation, 1996.
13. Coombes, Jane. *Managing Safety by Knowing the Risks: Current Dilemmas in Improving Women's Safety.* Unpublished article, 1999.

Point-of-Care HIV Testing

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Knowing the Human Immunodeficiency Virus (HIV) status of a client is critical. HIV test results are used in choosing medical interventions that can reduce HIV transmission and treat Acquired Immunodeficiency Syndrome (AIDS) diseases.[1] Point-of-care (POC) HIV testing is HIV testing that is done by a health care provider, such as a doctor or nurse, in the clinic or hospital. In this article, background information on POC testing is reviewed as well as some implications of using POC HIV testing in the NWT. Recommendations are also made regarding the specific situations in which POC HIV testing should be used in the NWT. These situations include:

- treatment of healthcare workers or emergency responders following incidents such as needle stick injuries;
- pregnant women who have not received prenatal screening;
- critically ill patients who are suspected of suffering from AIDS-related diseases; and
- screening of local blood donors in emergency situations.

Using POC HIV testing in the situations above means the decision to start therapy can be based on absolute risk[a] rather than relative risk.[b] The current NWT Post Exposure Prophylaxis (PEP) Guidelines recommend treatment within two hours of exposure to achieve the best results.[2] To improve client outcomes, it is essential in these situations that HIV test results are known as soon as possible.

Background

Although NWT HIV rates are comparable to the rest of Canada's, at 3/100,000,[3] there are factors present in the NWT that put Northerners at greater risk for the transmission of HIV. These factors include the fact that sexually transmitted disease (STD) rates in the NWT are ten times the national average, and Hepatitis C rates are three times. As well, the 1999 Health Status Report notes that, in the NWT, up to five percent of pregnant women receive either late or no prenatal care.[4]

Method

The standard screening test for the antibody to HIV is the enzyme immunoasssay (EIA). This requires a venous blood specimen and equipment that can only be found in a laboratory. Confirmation of test results takes several days.[5] EIA testing cannot be done in the NWT and must be sent to Edmonton's Provincial Laboratory. The turn-around-time (TAT) in the NWT varies from three days for the regional hospital to more than two weeks in isolated communities.[6] The long TAT presents a problem for clinicians who need immediate results in order to make decisions about post exposure prophylaxis for health care workers and emergency responders, women in labour, and to assess for HIV infection when AIDS diseases are suspected. Point-of-care (POC) HIV testing is relatively new, and received Canadian licensing in May 2000. POC HIV screening tests can provide results in less than thirty minutes. Specialized equipment is not required and any health care provider can be trained to administer the test.

Evidence

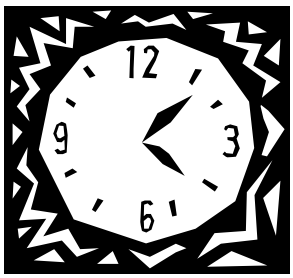
POC HIV testing improves TAT and is easy for health care providers to use.[7] The test costs 25 dollars per kit compared to 23 dollars for EIA, which makes the test cost neutral.[6]

A 1998 study on POC HIV testing interventions reported that decisions on case management were made 74 minutes earlier than with EIA in a hospital *(95%, CI 68 to 80 minutes, P<0.0001)*. This influenced critical treatment in 120 out of 859 patients *(13.9%, CI 11.7% to 16.5%)*. Interobserver variability ranged from zero to seven in some instances, which still resulted in agreement that 59 out of the 859 patients received critical care more quickly *(6.6%, CI 5.3% to 8.8%)*. POC HIV testing resulted in significantly faster decision making and experienced clinicians perceived that this produced a time critical benefit for 6.9% of patients.[8]

Reviews of POC HIV testing also demonstrate that there is a significant reduction in TATs. Thirty minutes is the norm with POC, with a

a confirmed exposure to HIV

b when HIV test results are not known



range of five minutes to one hour. Depending on location, two to seven days is the norm for results from standardized EIA *(95%, CI of 0.5 to 9.5 days)*. The improvement in TAT allows earlier and more appropriate intervention.[3, 5]

Health Canada and Centres for Disease Control (CDC) reviewed the predictive value of POC HIV testing. Sensitivity[c] was noted to be greater than 99.0% and specificity[d] was cited at greater than 99.5%. Both groups agree that there is a trade-off in POC HIV testing between sensitivity and specificity. A minimum of five out of every one hundred positive tests will be false. Therefore, the resultant positive predictive value[e] is estimated at 95%.[3, 5]

The reviewers report that improved cost-effectiveness is expected with POC HIV testing, but it will be affected by many factors. Early intervention and appropriateness of care were two variables considered. Opportunity savings in shipping, time, and unusable specimens will decrease program costs. Also, since specificity is very high at 99.5%, there is no need to repeat negative test results. This means the client does not have to make a return visit, which adds to the efficiency of POC-HIV testing. The data to date from both reviews does not quantify cost effectiveness or efficiency. Since the tests are only now being introduced for broad use, the data on outcome benefits, adverse outcomes and costs are absent from current literature. The literature neither projects a return on this investment nor compares the costs associated with widespread use of POC compared to EIA. For small segments of the population, such as those exposed to HIV and babies born to HIV positive mothers, time of knowing affects effectiveness of treatment (28%, CI 22% to 35%). The outcome of not intervening carries a relative risk factor 28.5%. Therefore, the two reviewers agree for targeted groups where treatment interventions are known to be effective, the extra costs associated with POC testing should decrease person life years lost (PLYL).[3,5]

The positive predictive value of 95% in populations where the prevalence of HIV is low, which is the case for the majority of Canadian and American populations, is a potential problem. This problem, noted in an open-ended survey with the Arctic Nurse Leadership Network (2000),[9] is the potential effect of false positive test results on populations with high rates of despair. Aboriginal people in the NWT have a suicide rate five times that of Canada.[4] Mental health and social support services are either in short supply or unavailable in isolated communities, and it can take more than two weeks for confirmation of POC HIV tests. This could result in extreme anxiety for the patient. With a confirmed HIV test, the health care provider would ensure the patient is directed for counselling. Community health nurses in the NWT have voiced concerns about the availability of resources to address the results of a screening test where the percentage of false positives is as high as five percent in a low prevalence population. This is a potential harm that deserves serious consideration.

Decision on Practice

The above considerations provide some support for the use of POC HIV testing in at risk populations where early intervention can improve outcomes. The literature supports that TAT is critical when an intervention such as post exposure prophylaxis is needed.[1, 5, 8] Costs associated with widespread use are not available and with increased screening in the NWT, the projections of potential harm will need to be established. Thus, at this time in the NWT, widespread POC HIV testing would not be feasible due to the potential harm from false positive tests. Mental health resources are not currently available to support the patient during the two-week waiting period required to confirm test results, and this could result in self-harm for the patient. Also, at the local level, resources would have to be increased due to the use of health professionals' time to conduct the test. The evidence firmly supports that in instances where testing contributes to improved clinical

c the probability of testing positive if the disease is truly present

d the probability of screening negative if the disease is truly absent

e the ability of a screening test to identify positive test results

outcomes, POC HIV testing should be available. Despite the concern about false positive POC HIV testing in low prevalence populations, the potential good achieved in the defined clinical situations below will improve the outcome for the individual, and still not adversely affect the broader population which will require ongoing HIV screening. Therefore, a targeted POC HIV testing program should be introduced. The NWT Laboratory Advisory Committee has approved the following recommendations.

Recommendations for Point-of-Care HIV Testing in the Northwest Territories

- *Source and contact testing for decision-making for post-exposure prophylaxis.* Injured workers may need to begin expensive and potentially dangerous antiretroviral therapy while waiting for HIV results. These medications are most effective when used within two hours of exposure.[1] POC HIV testing could decrease the unnecessary use of these medications, and aid in making more appropriate follow-up decisions surrounding care.[8]
- *Pregnant women without prenatal screening.* Knowledge of maternal HIV status at the time of delivery is critical to achieve the best outcomes for the infant.[5] Use of antiretrovirals in newborns in the first two days after delivery has been demonstrated to reduce the transmission of HIV from the infected mother to her infant in the perinatal period.[1, 5] The availability of POC HIV testing to determine serological status during labor will allow timely intervention to reduce risk of HIV transmission to the newborn.
- *Critical illness in patients with unknown HIV serological status.* The rapid identification or exclusion of HIV infection may have an important immediate and beneficial effect on patient management with regard to enhancing both diagnostic and treatment regimes.[1,5, 8]
- *Screening of local blood donors in emergency situations.* Stanton Regional Health Board and HH Williams Hospital in Hay River still use a local donor list, and Canadian Blood Services has set a standard that donors are to be screened every three months for transmissible diseases. POC HIV screening can be used in emergency after the initial assessment.[10]

REFERENCES

1. Health Canada. 2000. Point-of-Care HIV testing using simple/rapid HIV test kits: Guidance for Health-Care Professionals. CCDR. 26-07: 49-59.
2. Northwest Territories. *HIV Infection and AIDS: Information for Health Professionals.* Yellowknife: Department of Health & Social Services, 1999.
3. Canada. Department of Health. Notifiable Diseases Annual Summary, 1998. Ottawa: Minister of Health, 2000.
4. Northwest Territories. *The NWT Health Status Report.* Yellowknife: Department of Health and Social Services, 1999.
5. Centres for Disease Control. *Rapid HIV Tests: Questions/Answers.* Ottawa: Health Canada, 2001. Available online: http://www.cdc.gov.hiv/pubs/rt/rapidqas.htm
6. Goldsmith, Chris. Technical Supervisor, Core Laboratory, SRHB. Personal interview. February, 1, 2001.
7. Quebec. *Fast check HIV-1/2 (Whole Blood): For in vitro diagnostic use.* Montreal: Biochem ImmunoSystems Inc, 2000.
8. Kendall, J., B. Reeves & M. Clancy. 1998. Point of care testing: Randomized controlled trial of clinical outcomes. BMJ. 316: 1052-1057 .
9. Network teleconference. October, 2000.
10. Canadian Blood Services. *Standards for Blood Safety.* Ottawa: Health Canada, 2000.

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Diabetes Surveillance in the NWT

Canadian Diabetes Strategy (CDS)

The Canadian Diabetes Strategy (CDS) is a five-year strategy that was implemented in the 1999/2000 fiscal year to address the chronic disease of diabetes in Canada. CDS will spend $115 Million over the 5 years on four key areas: the Aboriginal Diabetes Initiative; Prevention and Promotion; National Coordination; and the National Diabetes Surveillance System (NDSS). This article focuses on the NDSS.

National Diabetes Surveillance System

The National Diabetes Surveillance System is a response to the lack of information around diabetes from a broad range of stakeholders in Canada. The NDSS has been in development over the last three years and is now ready for implementation. It is governed by a multi-sectoral body of stakeholders.

The main goal of the NDSS is to develop, facilitate, and coordinate national, provincial, territorial, and Aboriginal diabetes surveillance. This will begin with the implementation of a standardized model for core surveillance. This core model will involve the production of nationally comparative data on diabetes prevalence and incidence, as well as comparisons of mortality, diabetes-associated diseases, and health care utilization rates in the population with diabetes compared to the population without diabetes.

Canada will be the first country in the world to produce dynamic, thoroughly comparable data on diabetes using the full population base. This offers an unprecedented opportunity to create a detailed picture of diabetes in a developed country.[1]

What We Know Now

Current knowledge about diabetes in Canada is inadequate, since diabetes is not a reportable disease. In 1996, it was estimated that there were 60,000 new cases diagnosed each year. Nevertheless, it is suspected that actual current incidence may be twice that figure. Mortality statistics indicate that diabetes is the seventh leading cause of death in Canada. This accounts for 16.8 deaths per 100,000 population and the loss of 25,000 person-years of life before age 75.

Between 1.2 million and 2 million Canadians over 12 years of age, or about 3.2% of the population, have diabetes. This figure rises to 6% for those over 40 and 10.4% for those over 65. Existing surveys indicate a prevalence among Aboriginal populations over 15 years of age of 10%, rising to 22.8% for those over 65. These figures are just estimates however, based on methods of self-reports in surveys. They do not offer firm evidence on which to base specific plans for change.[1] It is expected, however, that the existing diabetes trends seen in some Aboriginal populations in Canada will soon be seen in the NWT if traditional lifestyle and eating patterns continue to diminish and change.[2,3]

NDSS in the NWT

The NDSS position in the Northwest Territories has recently been staffed and is based in the Research and Analysis Unit of the Department of Health and Social Services. In the NWT, three databases will be set up for the NDSS in accordance with national standards. These include: 1) Territorial Registry of Insured Persons; 2) Physician Claims; and 3) Hospital Discharge Data. The data will be extracted from several different sources in the NWT as follows:

- *Territorial Registry of Insured Persons* – Health Insurance Registry;
- *Physician Claims* – Medicare, Territorial Hospital Information System (THIS), and Community Health Management Information System (CHMIS); and
- *Hospital Discharge Data* – Territorial Hospital Information System and the Canadian Institute for Health Information (DAD-CIHI)

The data will be set up in national software created and supplied by NDSS which will allow the following to be determined: a) incidence (the number of newly diagnosed cases of diabetes each year), b) prevalence (the total number of existing cases of diabetes), c) complications of diabetes, and d) health service use by people with diabetes. In the NWT, data dating from 1995 to the present will be used to gather an accurate picture of the disease. All personal identifiers will be removed from each record to protect privacy.

November is Diabetes Awareness Month

- The incidence of diabetes is doubling every 15 years in Canada.
- Every 8 minutes a new person is diagnosed with diabetes in Canada.
- Heart disease is the most common complication of diabetes; it is 2 to 4 times more common in people with diabetes.

The NWT baseline data is then submitted to NDSS at Health Canada and added to the national database. All provinces and territories must use the NDSS national software so that all diabetes data is consistent throughout the country. This software has already been piloted in the three Prairie Provinces.[4] It is scrutinized by all users and updated by the NDSS National Coordinator based on feedback from users. NDSS information products will be disseminated in routine annual reports and ad hoc special reports in a coordinated fashion under the direction of the NDSS Steering Committee. The first report will be released in 2002.

Implementation

The three phases of the NDSS implementation involve:

Phase 1: ensuring the core surveillance model is operating in provinces and territories and at Health Canada. This will begin with the linkage and analysis of 5 to 7 years of physician claims, hospitalization and insurance coverage data to monitor trends in diabetes and associated complication rates, and estimate related health care costs;

Phase 2: expanding the scope of the system through enhanced analysis of existing data, including the integration of an Aboriginal component within the NDSS;

Phase 3: providing critical information for planning and evaluating prevention and control strategies (e.g., baseline data, benchmarks, and standards), as well as responding to new research findings and indicating areas for further investigation.

Why is Diabetes Surveillance Important?

The creation of territorial, provincial and national diabetes databases is essential in the fight against diabetes. Accurate statistics will create a true picture of the disease and its related complications and costs. These in turn will enable the development of the following in the NWT:

- policies relating to diabetes care and management;
- programs and projects to prevent and manage diabetes;
- the projection of costs for health services and facilities related to diabetes in the future; and
- tracking future trends in the NWT for the incidence, prevalence, and complications of diabetes.

For more information:

NWT NDSS: (867) 920-3109

REFERENCES

1. *Moving Together Toward a National Diabetes Strategy – Symposium Proceedings*. Montreal, QC, February 18 – 20, 2001. Health Canada, 2001.
2. Archibald, Linda. *Health System Renewal: Towards an Understanding of the Inuit Specific Approach by Inuit Organizations*, National Inuit Health Information Conference Inuvik, NT. June 26 – 28, 2001. Health Canada, 2001.
3. Wong, Mabel and Onalee Randall. 1998. Diabetes in First Nation People. EpiNorth 10,4: 8-9.
4. Svenson, Larry. Final Report: Demonstration of the Proposed National Diabetes Surveillance System in the Three Prairie Provinces. Health Surveillance, Population Health Division, Alberta Health and Wellness, February 2001.

What is Diabetes?

There are two types of diabetes. Type 1 diabetes is an autoimmune disease that causes the destruction of the pancreas and thereby the cessation of insulin production. Type 2 diabetes, the most common form of diabetes, can best be explained as the insufficient absorption of glucose from the bloodstream into the cells (for example, muscle, fat, liver, and brain). In both types, when the glucose level in the blood remains high over a long period, complications such as atherosclerosis, kidney damage and failure, nerve damage, blindness, and amputations may result. Diabetes is a chronic disease and the risk of onset of Type 2 increases with age and poor lifestyle choices. In some groups, such as the Aboriginal population, a genetic predisposition also increases the risk of developing diabetes.

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Women's Nutrition Part 3
Gestational Diabetes Mellitus

It is well established that the health of women and their children is strongly influenced by nutritional well being ***before, during, and after*** pregnancy.[1]

In this third and last article in the series on women's nutrition (see also Spring and Summer 2000), information on gestational diabetes mellitus will be reviewed.

Gestational Diabetes Mellitus (GDM) is defined as any degree of glucose intolerance that starts or is first recognized during pregnancy.[2] The prevalence of GDM in a given population varies widely, reflecting a greater incidence among First Nations, African-American, Spanish or Asian ethnicities.[4] Gestational Diabetes Mellitus usually lasts only for the duration of the pregnancy and rarely persists after the baby is born.[3] Nevertheless, the cost of diagnosis and treatment outweighs the cost of poor outcomes with no treatment.[4]

When a woman is pregnant, her need for insulin increases due to the demands placed on her body by the growing baby. GDM develops when the demand for the body's natural insulin cannot be met. Pregnancy hormones create a resistance to the body's natural insulin, further increasing the need for insulin. Usually enough insulin is released to move the glucose from the blood into body cells; however, in GDM there is not enough insulin so blood glucose levels stay high. Consistently elevated blood glucose levels, if untreated, interfere with the healthy development of the baby.[3] Therefore, diagnosis should not be taken lightly.

Prevalence of GDM Unknown in the NWT

Gestational Diabetes Mellitus occurs in 3 - 5% of pregnancies (1 in 20) in the general population.[4] Although risk assessment for gestational diabetes should be done at the first prenatal visit, GDM is usually found during routine prenatal examination when the blood and urine are checked for glucose. Most pregnant women in the NWT are screened for gestational diabetes using a non-fasting, 50mg glucose challenge test at 24 – 28 weeks gestation or earlier if risk factors are present.

Statistics about GDM in the Northwest Territories are not currently available because diabetes is not a reportable disease. Currently in Canada, through the Canadian Diabetes Strategy, each province and territory is developing baseline data for diabetes incidence, prevalence, complications, and costs associated with the disease. (See article Diabetes Surveillance in the Northwest Territories on page 8). This baseline data should be completed across Canada by the end of 2002 and will provide nationwide statistics on diabetes.

What are the Risk Factors for Gestational Diabetes?[3,4]

- strong family history of diabetes
- previous still birth
- previous large-for-dates baby (9 lbs or 4 kg)
- previous gestational diabetes
- maternal age greater than 30
- glucose in the urine
- ethnicity
- fetal malformation (usually congenital heart defects or neurological defects)
- frequent abortions
- more than 5 pregnancies
- recurrent UTI's or vaginal yeast infections
- maternal obesity - Body Mass Index (BMI) >29

Maternal Obesity – a Concern in the NWT

Recent information from the National Population Health Survey suggests that among women of childbearing age (20 - 44 years), maternal obesity may be cause for concern in the NWT. Although 11% of women between the ages of 20 and 44 years had a low or insufficient body weight, 19% reported some excess weight and 21% reported being overweight compared to 14% and 14% respectively in Canada. (Table 1). *Being overweight is a strong risk factor for GDM.*

Table 1

Body Mass Index, Women 20 - 44 Years of Age Northwest Territories and Canada, 1994

	NWT		Canada	
Women	# women	%	# women	%
20 - 44 years	7,894	100	5,779,776	100
Insufficient Weight	837	11	931,218	16
Acceptable Weight	3,327	42	2,785,903	48
Some Excess Weight	1,501	19	792,892	14
Over Weight	1,661	21	799,535	14
Not Applicable	201	3	211,911	4
Not Stated	367	5	258,317	4

Source: 1994 National Population Health Survey; provided by NWT Bureau of Statistics
Note: Calculation of Body Mass Index excludes pregnant women

What are the Effects of GDM for the Mother?[3,4]

- possibility of delivery by C-section
- increased risk of birth trauma
- increased urinary tract infection
- development of pregnancy induced hypertension
- edema – 10 – 22 % incidence
- pre-term labour – 10% incidence
- hydramnios – 5% for GDM and 18% for pre-existing diabetes.
- mothers generally do not feel well, feel tired
- increased risk of diabetes later in life (e.g. there is a 15% chance of GDM after 8 –10 years and a 40% chance after 40 years
- there is less risk if women maintain their ideal body weight

What are the Risks for the Baby?[3, 4]

- macrosmia (large, fat baby: >10 pounds or 4.5 kg) – may make delivery more difficult and may require a C-section
- shoulder dystocia
- neonatal hypoglycemia (low blood sugar in newborn)
- prolonged new born jaundice
- low blood calcium
- respiratory risk syndrome – breathing problems at birth
- increased risk of obesity, glucose intolerance or Type 2 diabetes later in life

General Guidelines on the Treatment and Management of Gestational Diabetes Mellitus

Depending on the services available, women diagnosed with GDM may be referred to the following health professionals: an obstetrician, endocrinologist, a diabetes nurse educator and/or dietitian, to learn how to care for herself and maintain a healthy pregnancy.

In the NWT, women with GDM are managed by their general practitioners (community physicians) and may be referred to Internal Medicine at Stanton Medical Centre, or to an endocrinologist in Edmonton for a more rigorous assessment, if needed.[5] The patient receives instruction regarding blood glucose monitoring, insulin (if needed), diet and exercise from the Diabetes Nurse Educator and Registered Dietitian.

Healthy Eating and Weight Gain. Usually, women with GDM will be referred to a dietitian. To eat correctly, the pregnant woman needs to understand how meal planning relates to blood glucose control. Amounts and kinds of foods needed and how to plan meals and snacks is important especially when coupled with the increase in nutrients needed during pregnancy. For obese women (BMI >30), a 30% calorie restriction (about 1,800 cal/day) has been shown to reduce hyperglycemia and plasma triglycerides.[6] Obese women may do well with a moderate calorie restriction to avoid weight gain. See the adapted guidelines for weight gain for women with GDM (Table 2):

Table 2

Weight Gain Guidelines for GDM[4]

Guidelines For Gestational Diabetes Weight Gain Ranges (adapted from the US Institute of Medicine)		
Body Mass Index (BMI kg/m2)	Recommended Total Weight Gain in Pregnancy	Expected Weekly Weight Gain During 2nd and 3rd Trimesters
BMI < 20	12.5 – 40 kg (20 – 40 lb)	0.5 kg/week
BMI 20 – 27	11.5 – 15 kg (25 – 35 lb)	.45 kg/week
BMI > 27	7.0 – 11.5 kg (15 – 25 lb)	0.3 kg/week

Blood Glucose Monitoring. Women with GDM will need to be taught how to monitor their own blood glucose using strips and some type of meter. This method seems to work better than monitoring of plasma glucose during prenatal

Visit the website at http://www.hc-sc.gc.ca/hppb/nutrition/bmi/index.html to calculate your body mass index and to find more information on this topic.

checks with a doctor.[6] Women may need to test 4 – 7 times a day, depending on her health and health care provider recommendations. Ideally, it is recommended to aim for blood glucose levels that are ≤5.3 mmol/L before a meal and ≤7.8 mmol/L one hour after eating a meal. Urine glucose monitoring is not useful in GDM though urine ketone monitoring may be helpful in detecting insufficient calorie or carbohydrate intake in women treated with calorie restriction.[6]

Regular Activity. Women should be encouraged to start or continue a program of moderate exercise. This has been shown to lower maternal glucose concentrations. Exercise helps to control blood glucose levels by creating a demand for glucose in the body cells and helping insulin function more effectively. Some women who require insulin can decrease insulin requirements by increasing physical activity. Ideally, exercise should occur one hour after eating to avoid hypoglycemia.[3,6]

Insulin. If diet and exercise are not sufficient to maintain blood glucose control, insulin may be required. Oral glucose-lowering agents are not recommended during pregnancy as they can cause harm to the developing fetus.[3,6]

Breastfeeding. As always, breastfeeding should be encouraged in women with GDM.[6]

After the Baby is Born

After a woman with GDM gives birth to her baby, her blood glucose levels usually return to normal. If she used insulin during the pregnancy, she will no longer need it. A woman with Type 1 or Type 2 diabetes that required insulin before pregnancy will continue to need insulin or oral agents after the baby is born.

Post-partum follow-up is summarized here:

- Check fasting blood glucose within 48 hours post-partum, assess if BG >6.0 mmol/L
- Promote healthy eating, discuss food choices to meet nutrient needs when breastfeeding
- Advise patient regarding weight reduction strategies as needed to reach BMI 20-25 and encourage a program of regular exercise.
- An OGTT (75g, 2 hours) should be performed 6 weeks to 6 months postpartum to rule out glucose intolerance or diabetes.[4]

It is important for women with GDM to understand that they are now at increased risk of developing Type 2 diabetes at some point. In fact, 40 – 50% of women with GDM will go on to develop diabetes within 15 years.[3]

Prevention is Key

Helping women maintain a healthy body weight, eat a healthy diet and get regular exercise can reduce the risks of developing Gestational Diabetes Mellitus. Health care providers and community workers can help to provide avenues for active living and healthy eating. Follow-up support and encouragement is also important. Based on the increasing Canadian and Northern population rates of being overweight, it is more important than ever to concentrate our efforts on the promotion of active living and healthy food choices for all ages, but particularly for women in the child-bearing years.

References

1. Health Canada. *Nutrition for a Healthy Pregnancy, National Guidelines for the Childbearing Years*. Ottawa: Minister of Public Works and Government Services Canada, 1999.
2. Metzger B.E. and D.R. Coustan, eds. 1998. Proceedings of the Fourth International Workshop-Conference on Gestational Diabetes Mellitus, Diabetes Care 21, Suppl 2: B1-B167.
3. Johnson, Susanne. Nutritionist. Aboriginal Diabetes Initiative, Health Canada. Educational materials and personal interview. September 2001.
4. Harden, Leslie and Beryl Schultz. 2001. Gestational Diabetes Mellitus. Canadian Diabetes Care Guide. 5: 1-3.
5. Diabetes Education Program, Stanton Medical Centre. Personal interview. September 2001.
6. http://www.findarticles.com/cf_dls/m0CUH/1_23/59175335/print.jhtml

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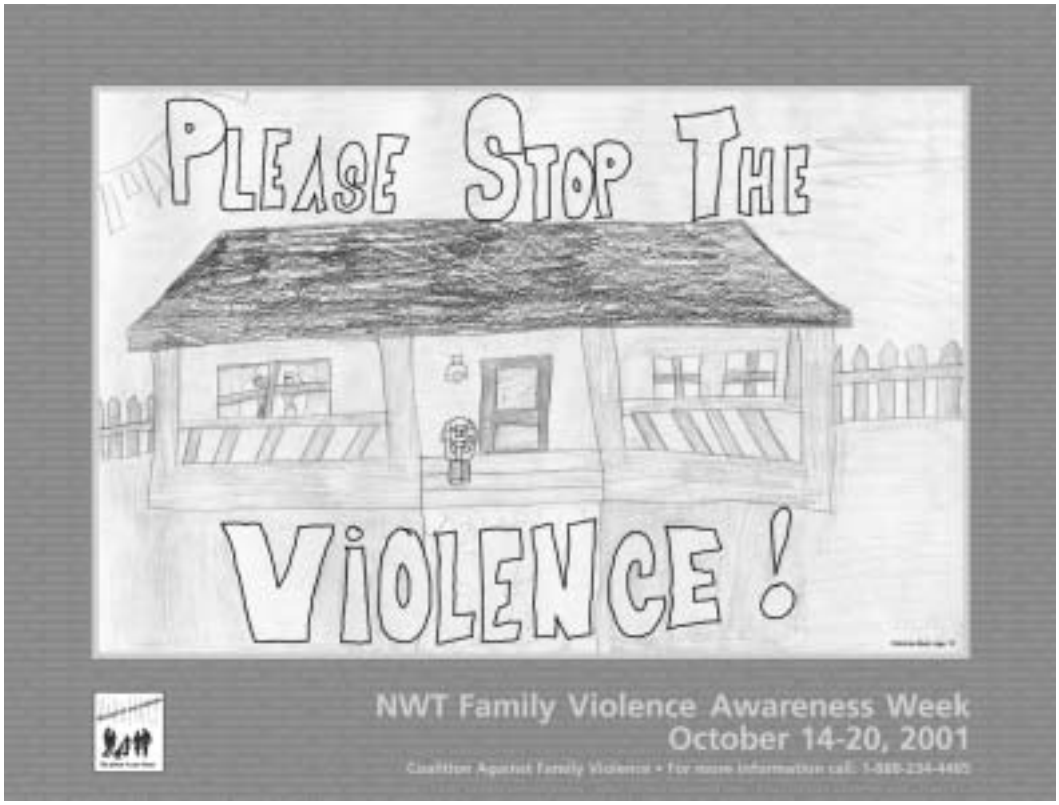
Understanding the concept of patriarchy is essential to our analysis of the nature of gender inequality and its impact on the vulnerability of women to violence, and of our society's tolerance of male violence against women.[3] The social constructs and dynamics of our society are characterized by gender-specific roles. Reverend Jamie Scott of the Church Council on Justice and Corrections believes that violence stems from the existence of a "pecking order." This means "somebody feels we are not as important as they are. This kind of attitudinal stuff is the nurturing ground for abuse in relationships," says Rev. Scott.[4] The pecking order from dating to globalization remains a powerful force for the status quo.

Working to end the violence in our society is a multi-tasking role – protecting, nurturing and educating on one hand while on the other, working to change the very systems that feed the violence. And women have taken on this struggle to organize to protect themselves. They found the means to establish shelters and to talk about what the violence is and the costs of this behaviour to our communities and country. In writing about understanding gender fairness and the violence against women in a report called *The Justice House,* author Katherine Peterson states:

> for no other segment of society do we require, need and publicly support refugee camps, otherwise known as women's shelters. While recognizing the necessity of safe places for women, we continue to tolerate the conduct which gives rise to the existence of shelters. Violence is not a "family" issue, it is not a "domestic" issue, it is not a "women's" issue. It is an issue for all of society to address.[5]

Dimensions of Violence

With violence against women defined in and articulated in various ways we have established programs and addressed issues to each element. This work required that the violence be defined in terms that society could understand and cope with. It was also necessary to obtain the required



funding to, for example, open shelters for women and children. Women also worked to broaden the understanding of the areas of abuse within a family or relationship to include child abuse, parent abuse, dating violence, and elder abuse. Dimensions of violence vary only somewhat in each of these areas of violent relationships. In many instances the violence women suffer entails a combination of all these dimensions. Violence is a continuum that ranges from verbal abuse to murder. It is a cycle that continues generation after generation.

Physical Violence: Can range from pushing and shoving, to hitting, beating, torture and murder.

Sexual Violence: Is any form of non-consensual sexual touching to rape.

Psychological Violence: Encompasses various tactics to undermine a woman's self-confidence, such as taunts, jeers, insults, abusive language, and threats of physical violence or isolation.

Financial Violence: Withholding or maintaining control over all or substantial amounts of money; denial of access to employment opportunities; being cheated out of inheritance, or other income by denying access to financial records and knowledge of investments or debts.

Spiritual Violence: Erodes or destroys an individual's cultural or religious beliefs through ridicule or punishment. Residential schools are the most heinous example of the interrelationships between racism, sexism and violence.

The Human Costs

Having identified the dimensions of violence against women, how do we measure the costs of this violence? The physical, emotional and psychological toll is impossible to quantify. Some women are paralyzed by the experience to the point of being afraid to leave the home; others are unable to sustain relationships; some are unable to keep their jobs due to stress and worry because of the violence. Years of abuse or a single incident can cause nightmares for years and can make physical contact or a healthy sexual relationship impossible.[6]

Any form of violence that a woman experiences can have serious damaging effects on her physical, mental and spiritual well-being, and that of her children. In comparing a sample group of women and children who had left a violent environment with women and children of a comparable group who had not experienced violence, a Quebec study concluded:

> The health of these women and their children was distinctly different from that of the general population, and they were affected first of all by the problems of mental health… women who have escaped violence for good are in better mental health, but this separation is above all beneficial for the children. These findings [of the study] suggest that the improved health of abused women and especially that of their children, is conditional on their breaking away from the violent spouse.[7]

The gathering of statistics (see *From a Whisper to a Scream* on page 2) can only be established by those cases reported to the authorities. A large number of cases are still not reported. Of those women who reported being victims of spousal violence in the Violence Against Women Survey (1993), only one-quarter (26%) had reported an incident of violence to police.[8]

The Financial Costs

To track the monetary costs one would have to coordinate all the services and institutions a battered woman and possibly her children would have to attend. This includes everything from the initial police intervention to health care, from legal costs to social housing to allow the victim to re-establish her family. Health care costs would include the costs of prescriptions for anxiety, anti-depressants, sleeping pills, painkillers, emergency treatment, ambulance services, hospital stays, counseling and the cost of rehabilitative services such as physiotherapy or occupational therapy. The

social costs would include an expensive range of social services and supports which must be maintained on an ongoing and emergency basis: costs of shelter stays and transitional housing, child welfare services, mental health clinics, educational needs of victims, special programs, educational initiatives and awareness campaigns on violence.

In Canada, two studies have estimated that the financial costs of violence against women are very significant. In 1995, Dr. Tanis Day reported in an aptly titled study called "The Tip of the Iceberg", that the total annual measurable costs relating to health and well-being alone amount to over $1.5 billion. Almost all data collected related to visible physical or sexual violence only.[9]

The second study of the same year, "Selected Estimates of the Costs of Violence Against Women", contains the results of preliminary research on the economic costs of violence against women. These costs too are significant and are given under four policy areas:

Social services/education: $2,368,924,297
Criminal justice: $871,908,583
Labour/employment: $576,764,400; and
Health/medical: $408,357,042.[10]

The total annual cost of $4.2 billion represents a bare minimum of the total costs of violence against women to Canadian society.[11]

Violence as a Factor in the Determinants of Health

In 1994 Health Canada adopted a population health approach to further its continuing mandate to maintain and improve the health of Canadians. This approach recognizes that many factors, in addition to the health care system, have a strong influence on health. It promotes prevention and positive action on determinants that affect the health of the population as a whole, or that of specific population groups.[12] (see determinants of health box on page 16)

The Determinants of Health is the generic term given to the factors and conditions that have an influence on health. These determinants do not act in isolation of each other; their complex interactions with each other have an even more important impact on health.[13] Considering the facts and discussions in this paper, the recognition of the extent of violence and the impacts warrant inclusion in the determinants of health. Gender analysis should also be applied to each determinant. There are several areas for this inclusion: *social support networks* could include violence against women in the risk factors. Under *social environments*, an examination of the *values and rules of a society* could undergo gender analysis. *Personal health practices* and *coping skills* could acknowledge the social inequalities in determining *healthy choices and lifestyles,* and finally *healthy child development* could recognize the effects of violence on children experiencing or witnessing the violence.

Summary

Despite, and perhaps because of, the progress women have made to stop the violence and gain equality, many obstacles still exist and these include:

- active resistance of those who are threatened by change;
- funding and resource shortages as governments cut spending;
- institutional barriers that perpetuate historical inequities;
- social attitudes and traditions that are resistant to change; and
- systemic denial of inequalities, racism, sexism, violence.

Key Determinants of Health

Income and Social Status
Social Support Networks
Education
Employment/Working Conditions
Social Environments
Physical Environments
Personal Health Practices and Coping Skills
Healthy Child Development
Biology and Genetic Endowment
Health Services
Gender
Culture

In the Northwest Territories, the statistics reported in *From a Whisper to a Scream (*page 2) are staggering. Addressing violence in the north requires an understanding of the aboriginal communities, their struggles and their history. Commenting on the value changes affecting many aboriginal communities, the author (Mary Fingers, 1994) of a Treaty 7 study wrote:

> It's an absence of values. Before the values were so strong, so stringent that to step over those boundaries would mean severe, maybe, ostracization or the family would do something. Because the values were so strong then, individuals would have to think quite hard before they did something. Because they had so much strength and spirited value that such thoughts never entered their mind. But now there are so many things that are eroding our culture.[14]

Everyone, men and women from every race, culture and class have a responsibility to break the cycle of violence and we can do this by:

- ✓ Listening and believing women in their stories of violence;
- ✓ Healing the violence in your own life;
- ✓ Making your home free of violent behaviours and toys;
- ✓ Using your time, energy and money to promote women's equality;
- ✓ Speaking out against violent images and words;
- ✓ Helping girls protect themselves;
- ✓ Helping boys understand that non-violent behaviours are brave acts;
- ✓ Encouraging those who commit violence to get help; and
- ✓ Remembering the women who have died as a result of our violent society.

More interest and studies are coming forward on the role of men in this movement to stop the violence against women. While usually attracting little sympathy, violent men also suffer psychologically. Guilt and remorse, feelings of helplessness, anxiety and depression, often result in suicide or murder-suicides.[15] It is obvious that not only individuals, but society in general has much to gain in stopping the violence. The human toll and financial costs to society make violence against women a major public health problem. The time to act is now. While annual Family Violence Awareness Weeks bring awareness to the devastation of families and communities caused by violent behaviours, it is everyone's responsibility to carry the work into everyday living.

To address issues and solutions to family violence in the NWT, the Status of Women Council organized a coalition of service agencies, government departments, schools, seniors and the RCMP to work on issues related to or consequential of family violence. The Coalition Against Family Violence has a mandate to work collectively to improve the response to family violence and its prevention and to identify tangible means of addressing family violence issues and the needs of those people affected by violence.

References

1. Russell, Mary, Jill Hightower and Gloria Gutman. Stopping the Violence: Changing Families, Changing Futures. (Canada: British Columbia Institute on Family Violence, 1996), p. xviii.
2. Canada. Canadian Panel on Violence Against Women. *Changing the Landscape: Ending the Violence ~ Achieving Equality [Final Report of the Canadian Panel on Violence Against Women].* Ottawa: Minster of Supply and Services, 1993, p. 6.
3. IBID, p. 14.
4. Child & Family Canada. Stopping Family Violence: Steps Along the Road. p.2. hhtp://collections.ic.gc.ca/child/docs/ooooo124.htm.
5. Peterson, Katherine. *The Justice House: Report of the Special Advisor on Gender Equality.* Yellowknife, Department of Justice: 1992, p. 18.

6. Canada. Canadian Panel on Violence Against Women. *Changing the Landscape: Ending the Violence ~ Achieving Equality [Final Report of the Canadian Panel on Violence Against Women].* Ottawa: Minster of Supply and Services, 1993, p. 11.
7. Chenard, L., H. Cadrin and J. Loiselle. État de santé des femmes et des enfants victimes de violence conjugale. Rimouski, Que: Département de santé communautaire, Centre hospitalier régional de Rimouski, Octobre, 1990, p. 71
8. Canadian Report to UN on Violence Against Women, August 1999.
9. Day, Tanis. *The Health-Related Costs of Violence Against Women in Canada: The Tip of the Iceberg.* London, Ontario: Centre for Research on Violence Against Women and Children, 1995.
10. Greaves, Lorraine. *Selected Estimates of the Cost of Violence Against Women and Children.* London, Ontario: Centre for Research on Violence Against Women and Children, 1995.
11. IBID.
12. Health Canada. *Population Health Fund.* April 1999.
13. IBID, p. 2.
14. Culture and Community. Chapter 11 Stopping Family Violence.
15. Donovan, Robert J., et al. 2000. Targeting Male Perpetrators of Intimate Partner Violence: Western Australia's Freedom from Fear Campaign. Health Promotion Journal of Australia. 10(2): 78-83.

Family Violence Crisis Lines in the NWT

FAMILY VIOLENCE SHELTERS

Alison McAteer House, Yellowknife
24 hours - Toll Free **1-866-223-7775**
Hay River Family Support Centre
24 hours - Call Collect **1-867-874-6626**
Inuvik Transition House
24 hours - Call Collect **1-867-777-3877**
Sutherland House, Fort Smith
24 hours - Call Collect **1-867-872-4133**
Tuk Women & Children's Centre.. 1-867-977-2070

FAMILY VIOLENCE SUPPORT PROGRAMS

Yellowknife Women's Centre ... 1-867-873-9131
Aklavik
Community Counselling Services .. **1-867-978-2935**
Fort Good Hope Victims of
Violence Advocacy Program **1-867-598-2728**
Fort Providence
Family Life Program **1-867-699-3801**

VICTIMS SERVICES

Yellowknife ..... **(867) 920-2978**
Hay River ..... **(867) 874-7212**
Fort Smith ..... **(867) 872-5911**
Inuvik ..... **(867) 777-5493**
If you live outside these centers and need help with your **Victim Impact Statement call collect...(867) 920-6911**

OTHER HELP/SUPPORTS

Kid's Help Phone
Toll Free **1-800-668-6868**
Western Arctic Help Line/AIDS Info Line
Toll Free **1-800-661-0844**
Yellowknife ..... **(867) 920-2121**
Status of Women Council of the NWT
Toll Free **1-888-234-4485**
Yellowknife ..... **(867) 920-6177**
Senior's Information Line
Toll Free **1-800-661-0878**
Legal Services Board
Yellowknife, collect calls accepted **1-867-873-7450**
Beaufort Delta Legal Services Clinic
Toll Free **1-800-661-0704**
Inuvik ..... **(867) 777-2030**
The Law Help Line - free confidential legal information
Tues. & Thurs. 6:00 to 8:30 p.m.
Toll Free **1-867-873-3130**
Yellowknife ..... **(867) 920-2360**

Family Violence Awareness Week
October 14-20, 2001

Northwest Territories Health and Social Services

HEALTH.online...

Martha Lamon,
Managing Editor, EpiNorth
Research & Analysis
Department of Health & Social Services

The National Clearinghouse on Family Violence is at www.hc-sc.gc.ca/nc.cn. This is a website operated by Health Canada with current information about violence within the family and new resources being used to address it. The Clearinghouse helps Canadian communities work towards eliminating family violence by sharing the latest research findings and information on prevention, protection and treatment of domestic violence.

You will find a listing of relevant articles, fact sheets, project reports, information kits, and videos on family violence prevention available from partner libraries. Also available are a directory and referral service of resource people and organizations responding to family violence, annotated bibliographies regarding family violence and a reference collection and on-line bibliographic searching of approximately 10,000 books, periodicals and articles on family violence.

If you are having trouble finding what you need you can call 1-800-561-5643 or 613-952-6396 for help. All services and publications are provided free of charge. For more information visit the website or write to National Clearinghouse on Family Violence, Health Promotion & Programs Branch, Health Canada, Address Locator 1918C2, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, K1A 1B4.

IN brief...

Tobacco PSA Follow-up Survey Results

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Manager
Health Promotion Unit
Department of Health & Social Services

A media campaign against tobacco was launched during National Non-Smoking Week in January 2001 and re-aired in March as part of the GNWT's Tobacco Harm Reduction and Cessation Initiatives. The campaign included TV ads on CBC and APTN, ads in NNSL newspapers, and radio spots. The television advertisements were put together by Yellowknife high school students and directly targeted the teen population. Health and Social Services has made tobacco addiction among NWT residents a special focus, and this media campaign represented that initiative.

The Health Promotion Unit of the Department of Health & Social Services randomly surveyed 20% of the population of each community in the NWT available by telephone. Out of a total 1,018 calls, 305 (30%) persons responded (picked up the phone). Out of that group, 165 (54%) took the time to talk to a Health Promotion researcher. And out of that group, 86 (52%) decided to respond to the questions.

Of the 86 respondents, 35 persons (41%) saw ads in the newspaper, 15 persons (17%) heard ads on the radio, and 51 persons (59%) saw anti-tobacco ads on television.

Eighty five percent (85%) of respondents would like to see more anti-tobacco information in the future, with the majority of those persons (80%) wishing to see more information and ads on TV. Posters around town and information in schools were also popular choices for anti-smoking information availability.

Some notable comments from the respondents:

- "Advertising should feature prominently in schools. Kids can still learn to avoid smoking and tobacco, whereas adults are set in their ways."
- "I'm not a smoker, but I would like to see more information about ETS (environmental tobacco smoke), because that affects everyone."
- "The campaigning is good, but we have to reach young kids as well. Television is a good place for this because kids watch it often."
- "I don't think advertising is effective for stopping people from smoking."
- (From a number of respondents) "I'm a smoker so I don't pay attention to those ads."

Although there were a few respondents who didn't recall the GNWT media campaign, they pointed out that they had noticed the federal initiative of new graphic labels on cigarette packs.

CONFERENCES & workshops

The Canadian Institutes of Health Research

Elsie De Roose, P. Dt., Consultant, Nutrition, Department of Health and Social Services

On September 27, 2001, representatives from The Canadian Institutes of Health Research held a one-day workshop at the Smokehouse Restaurant in N'dilo. They were seeking information about research issues in the NWT. Discussions during the workshop focused on the need to build the capacity for northerners to do their own research and the research topics most relevant to the NWT. Suggested topics were diabetes, arthritis and traditional medicine.

The delegation of CIRH representatives included Dr. Jeff Reading, Institute of Aboriginal People's Health; Dr. Diane Finegood, Institute of Nutrition, Metabolism and Diabetes; David Fibbs, Director of Partnerships; and Jeanette Thomas, CIHR Corporate. NWT delegates included staff from the Department of Health and Social Services, the Council for Disabled, Stanton Regional Hospital, Yellowknives Dene First Nation, and Community Wellness Coordinators from Fort Providence. A report will be prepared by the CIHR and further discussions are planned with representatives from the NWT.

The Canadian Institutes of Health Research (CIHR) is the major federal agency responsible for funding health research in Canada. It aims to excel in the creation of new health knowledge, and to translate the knowledge from the research setting to the real world. The anticipated results are improved health for Canadians, more effective health services and products, and a strengthened health care system.

CIHR consists of 13 "virtual" institutes (see side bar), each headed by a Scientific Director and assisted by an Institute Advisory Board. The institutes work together to shape a national health research agenda for Canada. For more information about CIRH, please visit their website at www.cihr.ca, or call 613-941-2672.

- Institute of Aboriginal People's Health
- Institute of Cancer Research
- Institute of Circulatory and Respiratory Health
- Institute of Gender and Health
- Institute of Genetics
- Institute of Health Services and Policy Research
- Institute of Healthy Aging
- Institute of Human Development, Child and Youth Health
- Institute of Infection and Immunity
- Institute of Musculoskeletal Health and Arthritis
- Institute of Neurosciences, Mental Health and Addiction
- Institute of Nutrition, Metabolism and Diabetes
- Institute of Population and Public Health

The National Aboriginal Diabetes Association (NADA)

is hosting the 2nd National Conference on Diabetes and Aboriginal Peoples from January 24 to 27th, 2002 in Quebec City.

Conference Highlights include the following:

- sharing circles
- scientific, education and community sections
- exhibits
- workshops
- plenary sessions
- banquet and entertainment
- aboriginal arts and crafts

Who should attend?

- people who are affected by diabetes, their families and their communities
- community, regional and national leaders
- community development workers and school teachers
- health care providers
- scientists and those involved in diabetes research

Registration fees range from $150 to $250 depending on membership. Register before December 15th, 2001.

Call Ms. Francine Vincent at (418) 842-1540 or e-mail: fvincent@cssspnql.com for more information.

NOTIFIABLE diseases

by Region: for the Northwest Territories (NWT) July 2001 - September 2001*

		July - September 2001	Cumulative Totals - 2001	Regional Cumulative Total - 2001	
		NWT	NWT	Inuvik	Fort Smith
Vaccine Preventable Diseases	Hepatitis B	0	0	0	0
	Haemophilus Influenzae	0	1	1	0
	Influenzae A	0	3	0	3
	Influenzae B	0	17	9	8
	Pertussis	0	0	0	0
Sexually Transmitted/ Bloodborne Diseases	Chlamydia	140	382	148	234
	Gonorrhea	42	124	39	85
	Hepatitis C	3	31	6	25
	Hepatitis, Other	0	0	0	0
	Syphilis	0	0	0	0
Diseases by Direct Contact/ Respiratory Route	Chicken Pox	10	36	18	18
	Group A Strep	0	0	0	0
	Invasive Strep Pneumoniae	3	7	0	7
	Legionellosis	0	0	0	0
	Meningitis, Pneumococcal	0	0	0	0
	Meningitis, Other Bacterial	0	0	0	0
	Meningitis, Unspecified	0	0	0	0
	Meningitis, Viral	0	0	0	0
	Meningococcal Infections	0	0	0	0
	Respiratory Syncytial Virus	1	17	6	11
	Tuberculosis	1	5	0	5
Enteric, Food and Waterborne Diseases	Botulism	0	0	0	0
	Campylobacteriosis	3	8	0	8
	Cryptospiridosis	0	0	0	0
	E.Coli 0157:H7	2	2	0	2
	Giardiasis	2	10	1	9
	Hepatitis A	1	2	0	2
	Salmonellosis	0	3	1	2
	Shigellosis	0	1	0	1
	Tapeworm Infestation	0	0	0	0
	Trichinosis	0	0	0	0
	Yersinia	0	0	0	0
Vectorborne/Other Zoonotic Diseases	Brucellosis	0	0	0	0
	Malaria	0	0	0	0
	Rabies Exposure	0	0	0	0
Antibiotic resistant microorganisms	Methicillin-resistant Staph.Aureus	0	0	0	0
	Vancomycin-resistant Enterococci	0	0	0	0

HIV Infections Reported by Year

	1987	88	89	90	91	92	93	94	95	96	97	98	99	2000	01
NWT	2	1	1	2	1	8	0	2	0	2	0	1	0	0	1

**Statistics are based on currently available data and previous data may be subject to change.*