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EPI NORTH

The Northwest Territories Epidemiology Newsletter

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Suicide In The NWT: A Recent Analysis

Over the course of the last decade, increased attention has been directed to the problem of suicide in the Northwest Territories. The Canadian national rate of suicide is 12.3/100,000.[1] A previous epidemiological report, *Suicide in the NWT: A Descriptive Review*,[2] examined NWT suicide trends from 1980 to 1997, and analyzed details of suicides for the years 1994 to 1997. During the eleven-year period, the suicide rate in the eastern NWT (Nunavut) ranged from four to seven times the national average. Through the same time period, the suicide rate in the western NWT was 20 suicides per 100,000, or 1.5 times the national average. By analyzing the details of suicidal deaths, the Department of Health and Social Services is better able to identify high-risk populations and target suicide prevention strategies.

Two years after the creation of Nunavut Territory, the Department was interested in reviewing the profile of suicide in the current NWT to determine:

- What is the updated picture of suicide in the NWT?
- How has our understanding of suicide shifted after division?
- What are important factors for caregivers to consider?

The Office of the Chief Coroner (NWT) maintains details of suicide deaths and provided the data used in this review. This review covers the five-year period from 1997 to 2001 and analyzes a total of 51 suicides.

While numbers may appear *small* due to our smaller population, few people remain untouched by the experience of suicide in the NWT. Detailed coroner's files clearly document the ripple effect of suicide. Consider a snapshot of the number of people, and the degree of trauma, behind these numbers:

- The person, often a close family member, who finds the body;
- The community coroner, who attends to the body and the scene, certifies the death, arranges for the body to be stored or sent out for autopsy;
- The nurses/RCMP, who attempt to resuscitate, pronounce death, collect photos/evidence, take tissue samples from the body for toxicology tests;
- The person (family, friend, caregiver) who identifies the body;
- The person who cleans the blood/scattered tissues from the scene;
- Grief-stricken family, friends, neighbours, teachers, whose grief from previous losses/suicides is triggered once again;
- Survivors, those family members left behind, who agonize over questions such as: How could s/he have felt such despair? How could we not know? or What could we have done?
- RCMP who interview friends/family about the circumstances;
- Counsellors and caregivers who provide debriefing, and who may experience direct trauma from the death and/or indirect or vicarious trauma from hearing the details; and

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Northwest Territories Health and Social Services

HOW TO REACH
EPINORTH

Letters to the editor and articles are welcome but may be edited for space, style and clarity. Please contact the Managing Editor for article guidelines. All submissions must be sent electronically.

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What You Told Us

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Thank you to everyone who responded to the readership survey that appeared in the Fall 2001 issue of *EpiNorth*. Readers provided excellent information on what they like and don't like about the newsletter and had terrific suggestions for articles. In fact, several readers indicated an interest in submitting articles to future issues, which is really appreciated.

A total of 45 surveys were received for a response rate of approximately 10%. Not every respondent answered every question. Twenty-six (58%) surveys were received from within the NWT, six (13%) from Nunavut, and 12 (27%) from outside these borders. Respondents primarily came from a wide variety of health and social services-related occupations including: nurses, doctors, program managers, pharmacists, social workers, executive directors of community organizations, and staff from Health Canada, the GNWT, SRHB, health centres, and occupational health.

Questions five to seven in the readership survey asked readers about *EpiNorth's* format. Most of the remaining questions were about its content. Generally speaking, readers really like *EpiNorth* the way it is. Out of 45 respondents, 42 (93%) replied that the length of the newsletter is appropriate, 41 readers (91%) find *EpiNorth* easy to read, and 39 (87%) like receiving *EpiNorth* four times a year. Only four respondents expressed any dissatisfaction with the way *EpiNorth* is currently presented.

Regarding content, 37 respondents (82%) indicated that they found *EpiNorth* to be a good reference tool and every respondent indicated that the information provided in *EpiNorth* was either useful (31 or 69%) or somewhat useful (12 or 27%) in their work.

Respondents were asked to indicate topic areas they would like to see covered in upcoming issues of *EpiNorth*. They are listed below in order of preference: health promotion (indicated by 55% of respondents), aboriginal health (55%), mental health (49%), social issues (47%), communicable disease (47%), epidemiology (44%), non-communicable disease (42%), and health services (38%).

Respondents also added other topics they would like to see in coming issues of the newsletter. They generally fit into three broad categories as follows:

- **Health/medical information:** alternative medicine, environmental health issues, more coverage of health issues in individual communities and boards, and discussions of determinants of health.
- **Program information:** overview of Health & Social Services with a section highlighting individuals involved, rotating updates on organizations with a focus on health, information on population health programs, best practices and evaluation research.
- **The human context:** anecdotal pieces to accompany scientific topics, opinion pieces from the field and more articles on social services-related topics.

EpiNorth will endeavour to cover these topics in coming issues. Of course, readers are always welcome to contribute articles if they feel motivated to do so. *EpiNorth* contact information can be found on this page – all calls are welcome.

Readers were asked to rate different topic areas of *EpiNorth* in terms of their usefulness on a scale of 1 (not useful) to 5 (very useful). Responses were averaged and scored as follows:

1. the *northern perspective* on health issues averaged 4.6,
2. *scientific topics* covered in *EpiNorth* averaged 4.3,
3. *Health.online* averaged 4.0,
4. *social topics* covered in *EpiNorth* averaged 3.9, and

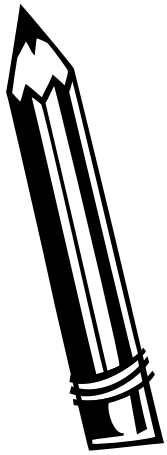
5. *conference and workshop information* averaged 3.9.

The *Notifiable diseases* section was not included in this survey question. Six people were proactive and wrote on their surveys that *Notifiable diseases* was important to them. Because of this, I suspect that if this section had been included in the rating question it would have scored fairly high.

Two Nunavut respondents asked that *EpiNorth* provide more statistics and information from Nunavut in the newsletter. *EpiNorth's* mandate is to provide quality information on disease patterns and trends and health determinants relevant to the people of the NWT. Nevertheless, articles from Nunavut contributors are always welcome and all submissions will be considered for publication.

Given the broad support for *EpiNorth's* current format and content, the newsletter will remain largely unchanged (if it's not broken, don't fix it). The newsletter is also intended to provide an opportunity for all those involved in health promotion, disease prevention and disease control activities to share their experience and exchange information with regard to new initiatives, best practices and program evaluations. You, the readers, have indicated that by and large we are meeting these goals. I appreciate and thank you for all the suggestions you have made. I'll do my best to get those into *EpiNorth* soon. I would also like to thank the *EpiNorth* board members and Scientific Editor for their support and ideas over the past several months.

In this issue. This issue of *EpiNorth* touches on a variety of topics including: 1) suicide trends in the NWT since Division and information for caregivers intervening with people in crisis; 2) male socialization and mental and physical health challenges they face as a result of this socialization; 3) a discussion of the challenges faced by the NWT Advisory Committee on Immunization regarding program planning; and 4) updates on active living activities supported by the GNWT over the last several months.



These topics can be viewed from the general perspective of wellness – a theme that has influenced the NWT's health and social services for years and was first highlighted by the Department's Community Wellness Strategy in 1995. Since the adoption of this strategy, many community groups have worked to develop their own Wellness Plans in an effort to confront the absence of wellness they see around them everyday. I invite you to read this issue of *EpiNorth* with a view to expanding your appreciation of the dimensions of wellness.

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Men: No Time To Be Silent

Recently, we participated in a traditional healing ceremony for men led by two Aboriginal Elders. During this ceremony, the Elders invited all the participants to celebrate all aspects of our being. This was a powerful reminder of the importance of good health in all aspects of one's life, including the mental, emotional, physical and spiritual dimensions. These four dimensions cannot exist in isolation of each other and are essential to good health. This article discusses challenges facing boys and men regarding their health from this multidimensional perspective. The information may not be all that new to you but it will remind you of the need to pay attention to the complex nature of men's health needs.

How Males are Socialized

In recent years, society has moved towards a more well-rounded definition of the male identity. Nevertheless, the context in which boys are raised in our present society continues to emphasize certain attitudes that males must adopt in order to establish a sense of identity consistent with social expectations. Some aspects of the identity boys and men are expected to develop and adhere to include: be strong physically and emotionally, solve your own problems, be self-sufficient, don't ask for help, don't pay attention to your feelings and, most importantly, make sure you separate from your parents, especially your mother.

Because of this pressure from society, boys and men are put in virtual straightjackets. They become emotionally restricted and are most comfortable releasing their emotional pain through anger and action. This leaves males, when in pain, more vulnerable to adopting aggressive behaviours or abusing substances, which in turn involve higher-risk behaviour and the potential for more serious consequences. As a result of this process, many youths and men face various health and social challenges throughout their lives.

Some of these challenges are evident when one considers the status of men's physical and emotional health. In the NWT in 1997, mental disorders (such as alcohol dependency, other drug abuse and major depression) were the single largest cause of hospital admissions for men and accounted for 18% of male admissions. For women, mental disorders ranked fourth and accounted for 10% of all female admissions. Men were also likely to be hospitalized because of injuries or poisoning, including head injuries and broken bones, and this category accounted for 14% of male admissions versus 7% for women.[1]

The situation is similar for NWT outpatient visits in 1997. For men, the category of injury and poisoning accounted for 26% of visits and was the primary reason for male outpatient visits. For women, this reason accounted for 16% of visits. Finally, regarding mortality, between 1991 and 1998, injury and poisoning was the main cause of death for men (accounting for 27% of deaths) and for women the main cause of death was cancer (at 29%). Deaths by injury and poisoning for women accounted for 15% of deaths.[1] These statistics are alarming and highlight the violence and risk taking present in the lives of many men.[a]

It's Hard to Seek Help

Identifying and responding to men's mental health concerns can be problematic when we consider the feelings, thought processes, values and attitudes mentioned above that men are encouraged by society to maintain. Furthermore there has been little attention given to the frequency with which male children have been physically, emotionally, and sexually abused or the consequences of this experience in adult life.[2] So, many health practitioners are unaware of the challenges their male patients have and continue to face. In our society, admitting to being a victim is largely viewed as feminine, to the extent that men do not recognize or conceive of themselves as victims.[3] This perception starts in early childhood and continues into adulthood. This, in the long run, discourages men from seeking help or speaking out about their

a See also Sandy Little's article *Suicide in the NWT* on page 1

difficulties. It is considered something that a woman does. The result is that men are likely to avoid counselling when they are in trouble because it means admitting that something is wrong. Furthermore, therapy challenges notions of masculinity by encouraging men to admit their fears, failures and vulnerabilities. This makes accessing and then continuing with therapy a formidable task for men.

Male Sexuality

Male sexuality is another health issue that we would like to raise in this article. It is a topic that is often difficult to talk about. Sex and sexuality are part of who we are. Our sexuality presents many challenging questions, including: What do I do with these aspects of my being? How do I treat my own sexuality with respect? How do I treat the sexuality of others with respect?

Just as there is a socialization process around being male, society also shapes our attitudes, beliefs and images around male sexuality. For instance, men who sleep around are likely to be seen as studs or as sewing their wild oats. These are images that tend to promote potentially unhealthy behaviour. As well, some men feel pressured to use harmful, body-enhancing substances to develop the muscular male physique promoted by the popular media. This socialization along with negative sexual experiences men may have had in the course of their lifetime can result in problems in every dimension of life. When men mix substance abuse, emotional needs and the normal physical pleasures of sexuality with disrespectful attitudes towards women and socially-induced definitions of male sexuality, the stage is set for harmful experiences for both men and women.

Men who have difficulty managing their sexual experience and as a result are convicted of criminal offences face multiple problems. Many men who are convicted for inappropriate sexual behaviour have themselves been sexually abused.[4] Men who were sexually abused as children carry all the shame, fear, embarrassment and anger that go along with that negative experience. Many of these men witnessed as young children, adult men and women engaging in sexual activity indiscriminately often while under the influence of alcohol or drugs. Some men were exposed to pornographic magazines and videos when they were children. All of these things shaped their attitudes so that when they became adults they thought it was normal, among other things, to engage in sexual activity with a partner who was in no position to give consent to the behaviour.

All the negative attitudes, beliefs and behaviours associated with inappropriate sexual experiences also have a tremendous impact on relationships. This is more concretely seen in poor communication and problem solving in relationships as well as more complex challenges such as the inability to develop healthy and appropriate intimacy. These challenges are only compounded by the distorted socialization men experience. This makes it difficult for men to ask for help when it comes to physical health problems let alone a problem around their relationships or sexuality.

Change in Life

There is a growing body of knowledge around issues for men in their early to mid 50s, which are often referred to as *midlife crisis*. Men experience changes in the body, interpersonal relationships, social, psychological, sexual and spiritual dimensions of their life.[5] These changes are only now being recognized and given serious consideration. Men may express concern about increased fatigue, short-term memory loss, indecisiveness, lowering of sexual desire and a longing for intimacy coupled with a fear of getting too close. Once again, the issue for men is being able to talk about these changes without loss of self-esteem.

Men and the Health Care System

Clearly, there is more to the physical complaint for which most men will seek help at a clinic or hospital. So, what could be done differently

"When men mix substance abuse, emotional needs and the normal physical pleasures of sexuality with disrespectful attitudes towards women and socially-induced definitions of male sexuality, the stage is set for harmful experiences for both men and women."

when responding to men as a health professional? Maybe the first thing we could do is consider our own attitudes about the role of men and women in society and how this influences our responses to them as individuals. When men approach you with concerns about their health, this could be an opportunity to pay attention to all aspects of their well being, including their mental, emotional, physical and spiritual being.

It is important to pay attention to the physical ailments presented by men while recognizing that these may be masking other concerns. As a health practitioner, you may want to pay attention to the following: 1) Alcohol and drugs are often used to medicate or cover up some form of pain, including emotional pain. If you suspect an alcohol or drug abuse issue, consider that this issue may be covering up an underlying emotional problem. 2) If you notice that a man is having difficulty with memory blocks, or there are large gaps in recalling personal history, after eliminating any physical contributing factors, explore the possibility that these could be related to either substance abuse or a history of emotional or psychological trauma. 3) Look for the regular occurrence of injuries, accidents, and high-risk and/or self-harming behaviour with regard to work (i.e. in the contract trades), recreational activities (such as hunting and trapping) and driving motor or recreational vehicles. 4) Pay attention to defensiveness or over reaction to questions about the man's health. These may suggest there are other things going on for the individual emotionally. This is where patience and attention is especially required.

The language used with patients can promote a therapeutic connection and openness to explore some of the emotional dimensions of their experience. With men in particular, avoid using language that suggests or focuses on *victim* aspects of their experience. Instead, frame the issue in the context of a legitimate male problem. The use of metaphors and images from a typical male lifestyle such as hunting or trapping, sports activities or work situations, may help the man feel comfortable enough to disclose more about what is really going on in his life aside from the physical ailment. Even using simple masculine phrases such as: *step up to the plate* or *take the bull by the horns* help ease discomfort among male clients. Building this type of connection will not only contribute to a more accurate diagnosis, it will help the patient address the underlying issues contributing to the problem.

Finally, reassure the individual by normalizing his experience. For example, tell him his emotional response is normal and that it is common to experience this range of feelings in response to this situation. It is natural to feel sad, hurt, embarrassed and even angry in response to this situation. This may provide the necessary bridge for the man to accept assistance from other health professionals with the skill and knowledge to deal with the more complex aspects of the individual's problem.

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Romeo and Bruce have recently collaborated on an article to be published in August 2002 in a book (co-edited by Bruce) titled Spirituality and Social Care: Contributing to Personal and Community Well-being.

A Balancing Act: Immunization Program Planning

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Health providers are often asked questions about immunization program planning. "Why is meningococcal vaccine not provided to children but a chickenpox vaccine is offered to all 12 month olds?" "Why do we continue to vaccinate for diseases such as polio that people don't see anymore in this country". Common public perception is captured by this parent's query: "Surely chickenpox is not as serious as meningitis. Children die from meningitis, not from chickenpox!" This perception was validated in the 2001 Canadian Immunization Survey in which 95% of parents surveyed rated the seriousness of six selected diseases and the degree of concern they had over their child contracting these diseases. The results suggest that parental concern over a child contracting an illness is correlated to how serious parents believe a disease is. Meningitis was perceived as the most serious condition, followed by hepatitis B, polio, whooping cough, measles and lastly chickenpox.

When making decisions about what new vaccines to introduce into the routine childhood immunization schedule, is it enough to respond to public perception alone? How does a jurisdiction decide whether to use public money to fund a new immunization program? There are a myriad of other factors, besides public acceptability of the program, that are taken into consideration in the decision-making process. There are several frameworks to aid decision making. One that has most recently been used by the NWT Advisory Committee on Immunization (NWTACI) is based on a national analytical framework being proposed to evaluate candidate vaccines as they become available for use in Canada. The framework[2] is organized into broad categories containing several criteria that are presented and then discussed thoroughly allowing for discourse, debate and finally consensus on a recommendation of what vaccine ought to be introduced, for which population group and in what manner.

This paper will explore a few of the key areas to illustrate the complexity of decision making and the need to examine beyond the emotion that is evoked by diseases whose pathology is severe.

Burden of Disease

Firstly, it is important to look at the epidemiology of the disease. This informs us about such things as the incidence, morbidity and mortality, clustering, time trends, seasonal and graphic variations, sequelae rate and loss of life years related to the disease. These are some of the key factors that the NWT Advisory Committee considers in trying to understand the burden of the disease and the implications and costs to society as a whole and to the health system in particular.

Both chickenpox and meningitis are endemic in Canada. Chickenpox is highly contagious with high incidence in the childhood population. It is estimated that there are 350,000 to 410,000 cases in Canada annually with 170,000 to 210,000 physician visits and 2,000 admissions to hospital for 13,000 in-patient days. In the NWT there are 250 to 500 cases of chickenpox reported annually. Canadian data from a variety of sources estimate that 30% to 50% of children see a doctor and 0.2% to 1.5% are admitted to hospital each year. Complications occur in otherwise healthy children in 5 to 10% of chickenpox cases. Approximately one-half of the complications are secondary bacterial infections due to Staphylococcus aureus and group A beta-hemolytic streptococcus (GABHS). Do children die from chickenpox? Public perception rarely attributes death to chickenpox and, while the fatality rate is low, deaths do occur. The 1987 to 1996 surveillance data show that there were one to 16 deaths per year (total of 53) attributable to chickenpox with children less than 10 years of age accounting for 26% of reported deaths.[5] A 13 month old died from chicken pox in the NWT in 1999.

In contrast, there is low prevalence of invasive meningococcal disease (IMD) in Canada with

"Public perception rarely attributes death to chickenpox and, while the fatality rate is low, deaths do occur."

periods of increased activity occurring approximately every 10 to 15 years. Incidence varies with different serogroups, age groups, geographic location and time. IMD can be caused by serogroups A, B, C, Y and W-135. Serotypes B and C predominate in developed countries. Recently in the UK and now in Canada (Alberta, BC, Manitoba, Quebec, Ontario), there has been an increase in the proportion of cases due to serogroup C, a virulent strain contributing to the highest case fatality among the 15-19 age group. This has generated high levels of public anxiety. It is estimated that 45% of all IMD cases are caused by serogroup C and this translates into an average of 111 group C cases per year with highest incidence among children <5 years of age followed by those 15-19 years of age. In the NWT, there were no cases of IMD reported in the past 3 years, one adult case with no confirmed serogroup in 1998, one case in a child with no confirmed serogroup in 1997, and two cases in children in 1996 (one serogroup C; one serogroup B). No reports occurred in 1993, 1994 or 1995. In Canada, fatality rates are 14% and sequelae rates are 15%. Of the 4 cases reported in the NWT since 1993, there has been one fatality.[4]

Social and Economic Costs and Benefits

Publicly funded vaccines must compete for funding with other public health programming. The new generation vaccines are entering the market at approximately $75.00 per dose in comparison to older vaccines such as combined diphtheria and tetanus vaccines at less than $2.00 per dose. There is limited ability for health budgets to absorb these additional costs. Cost-effectiveness studies help to put the cost into relative perspective but the era of immediate benefits appears to be behind us.

The estimated cost per individual case of chickenpox is $353.00 making it a costly disease to society and the health system. Unpublished calculations of the cost per case of meningococcal C disease estimates one case to cost significantly more than one case of chickenpox due in large part to the severity of the disease and its sequelae. Clearly, while the severity of meningococcal disease is greater than chickenpox, the burden of disease and its cost to society and to the health system is greater from chickenpox than from invasive meningococcal disease because of the sheer volume of cases per year and the relative magnitude of effects on Canadian families. Does this mean that we ignore meningococcal vaccine? The answer is no. But the approach to vaccination may differ as we look for the most effective and efficient way to minimize the potential threat of IMD.

Vaccine Characteristics, Alternative Strategies and Feasibility

New vaccines are continually being introduced to the Canadian market but before they are licensed for use they are subjected to efficacy and safety trials. Some vaccines will not be licensed for all age groups and numbers of doses needed to produce an immunogenic response may differ. Booster doses are sometimes required but more often with new vaccines we await results of longitudinal studies that offer evidence that boosting is necessary to maintain protective antibody levels before making decisions on booster doses. Numbers of doses, their timing and how they correspond to other immunization encounters are also important considerations from an economic as well as an implementation perspective.

What are the possible immunization strategies and which would be most effective for the intended purpose? Will they be accepted by the public and by the health provider who must administer yet another vaccine to a child? These are important questions. The strategy chosen may differ depending upon whether the goal is to eliminate disease or to control disease. Should the vaccine program be targeted for *at risk* populations or be universal? Should there be a catch-up program or no catch-up? What is the relative cost-effectiveness of the various strategies under consideration? What is the impact on workload and do the health providers support the new vaccine?

In the NWT, varicella vaccine was first introduced for high-risk groups (susceptible women of childbearing years, health care workers, children with leukemia on the paediatrician's recommendation). In the fall of 2001, it was introduced into the routine immunization schedule to be offered at 12 months of age. In 2002, as the pre-Kindergarten screening programs are underway, this group should be targeted for catch-up if they have not already had chickenpox disease. All other susceptible pre-schoolers are also eligible to receive varicella vaccine.

The NWTACI chose a targeted approach to deal with the menigococcal situation that plagued some regions of the country last year by recommending those most at risk (i.e. adolescents and young adults leaving the territories to study in southern provinces) receive a quadrivalent meningococcal vaccine. Those living in dormitories were especially encouraged to receive vaccination. This met with tremendous positive response and the recommendation will stand again for this year as we continue to see IMD activity in neighbouring provinces. Ongoing surveillance of disease activity warns of potential dangers and allows for an outbreak response to be mounted when warranted. The Health Protection Unit continuously monitors for outbreak activity as a matter of course.

Conclusion

Deciding which vaccines should be introduced is a complex process and one that the NWTACI takes seriously. Use of an analytical framework offers the structure to ensure a complete and balanced approach to decision making around programs aimed at addressing vaccine-preventable disease. Public perception cannot and should not be ignored. Nevertheless, decisions in the interest of public health must also take into consideration all the key factors for a balanced, fiscally-responsible approach that produces the greatest amount of benefit to the overall population.

Changes to the NWT immunization schedule are communicated through the dissemination of Clinical Practice Notices and accompanying background discussion and position papers prepared by the NWT Advisory Committee on Immunization. As health practitioners, we need to take the time to share our knowledge in ways that help parents and guardians understand the reasons for immunization decisions. Universal vaccine programs that acquire high rates of coverage keep diseases, such as measles, in check. Elders still remember the measles epidemics that devastated their communities when they were young. National Immunization Week (May 12-18, 2002) gives us the opportunity to celebrate the successes of immunization and commit to keeping vaccine-preventable disease in abeyance through continued high vaccine coverage.

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The Active Road to Health

"Children today are not getting enough regular physical activity. This is leading to a variety of problems including diminished attention in class, increased levels of obesity, and generally poor health."

Helping the people of the Northwest Territories lead healthier lives is a priority for the Government of the Northwest Territories. Being physically active is one of the best ways people can improve their health. As a consequence, the Government of the Northwest Territories and its partners support many recreation and sport programs that enable people to be more active. This article briefly outlines some of the initiatives the GNWT has recently been working on in the areas of recreation and sports.

In an effort to bring better coordination to the recreation and sport system in the NWT, the Sport and Recreation Section of the Department of Municipal and Community Affairs (MACA) distributed a discussion paper to partner organizations in the fall of 2001. The paper solicited feedback on where MACA could place a greater emphasis in the recreation and sports system. The Department met with partner organizations in early January 2002 to discuss the responses and figure out the next steps. It is still early in the process, but initial feedback from our partners suggests they would like to see increased investment in the recreation and sport system. Three main areas of investment were identified. They include: 1) support for better recreation facility maintenance, 2) investment in community recreation and sport programs, and 3) more support for the recruitment, retention and recognition of volunteers and community recreation staff.

The Sport and Recreation Section has also been energetically promoting *active living*. Positive lifestyles that combine regular physical activity, proper nutrition and non-smoking contribute greatly to the health of NWT residents. In early December 2001, MACA joined efforts with Health and Social Services and the NWT Recreation and Parks Association to deliver the workshop: *Communicating Active Living*. Delegates came from a variety of health, sports and recreation agencies. The goal of the workshop was to enable delegates to think more strategically about who their target audience is and how best to get messages to those people. This workshop included information on social marketing theory and communication trends to help delegates learn better techniques for promoting their activities or messages. Delegates also spent time learning about the demographic profile of northern residents and the media available for communicating with their target audiences.

In the late fall 2001, Municipal and Community Affairs was pleased to attend the *National Roundtable on Active School Communities* with a representative from Health and Social Services. At this roundtable discussion with education, health and recreation leaders from across Canada, we learned that physical inactivity is becoming an increasing concern within the school community. Children today are not getting enough regular physical activity. This is leading to a variety of problems including diminished attention in class, increased levels of obesity, and generally poor health.

The Department of Education, Culture and Employment has recently completed a review of the elementary school physical education curriculum and will soon be introducing changes that will emphasize an active living approach (see *Active Living at School,* p.11). As well, MACA, HSS and ECE continue to meet regularly on common issues to promote active living in the NWT.

We have just over 41,000 people in the NWT, 55% of whom do not get enough physical activity to benefit their personal health. We have levels of smoking and rates of Type II Diabetes that far exceed the national levels. The situation is clear. We need to continue to work together to help the people of the NWT lead more active and healthier lives.

We all have a role to play. The GNWT and its partners can continue to support recreation and sport programs, but it is up to individuals to choose to be more active. It is time for NWT residents to move from thinking about being active to becoming more active.

The United Nations declared April 7, 2002 as World Health Day. This year's theme *Move for*

Physical Activity

- In 1999, almost half (45%) of adults in the Northwest Territories were considered to be active enough for optimal health benefits;
- This leaves 55% of adults in the NWT inadequately active;
- 25% are moderately active but not yet active enough for health;
- 8% are only somewhat active; and
- 13% are sedentary. (Canadian Fitness Lifestyle Research Institute, Physical Activity Monitor, June 2000)

- 3 out of 5 Canadian children from ages 5 to 17 are not active enough for optimal growth and development. (Canadian Fitness Lifestyle Research Institute, Physical Activity Monitor, June 2000)
- Much of the physical activity in the north comes from on-the-land activities such as hunting, fishing, gathering and camping. (Government of the NWT, Municipal and Community Affairs)
- All NWT residents have access to a basic recreation facility but, generally speaking, the larger the community the more recreation facilities residents are able to access. (Government of the NWT, Municipal and Community Affairs, Facilities Survey, 1999/2000)
- The cost of participation and/or equipment to participate in some recreation programs is still a barrier for many people in the north. (Government of the NWT, Municipal and Community Affairs)

For more information on active living check out the Canadian Fitness and Lifestyle Research Institute website at www.cflri.ca.

Health highlights the link between physical activity and health. With World Health Day in mind, why not start making some changes in your life. There are many ways to be active, from playing sports to brisk walking to dancing or even walking the dog. What are your plans for being more active?

Active Living at School

Elaine Stewart,
Early Childhood and School Services Coordinator
Education, Culture & Employment

In the fall of 2001, the Department of Education, Culture and Employment gathered a group of educators from across the NWT who have responsibility for teaching Grade K - six Physical Education (PE). The goal of the meeting was to review the elementary PE curricula of the western provinces with a view to replacing the now outdated NWT program. After careful evaluation, the Alberta curriculum and guide to implementation was unanimously selected for its strengths of clear and concise outcomes, user friendliness, and high quality online supports for teachers. Like most recently developed PE curricula, the Alberta resource also has a strong emphasis on active living. In recent years, PE curricula have moved away from a sports emphasis to a range of activities that include alternate environments and fitness pursuits. Games and sports are still featured but within an active-for-life context that also includes activities such as hiking, skiing and dance, as well as learning activities that promote body awareness and acceptance. Schools will be further encouraged to consider whether they could benefit from a school-wide program that extends the principles of active living beyond the PE class. Programs such as Alberta's *Ever Active Schools* are designed to support active and healthy living in the total school environment and community beyond.

To view the Alberta curriculum and teaching resources go to: http://www.learning.gov.ab.ca/physicaleducationonline

For more information on a school-wide active living program, go to: http://www.everactive.org

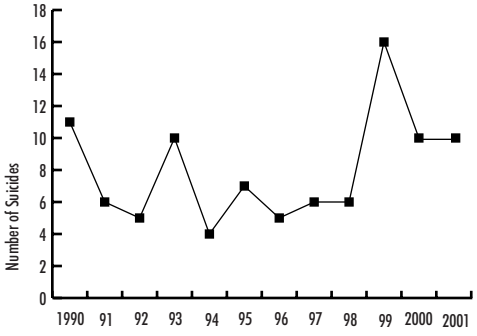
Suicide...continued from page 1

- The NWT Coroners Office, who complete the file, counsel families, frequently attend to the scene, and review all the details for recommendations, reports, and/or inquests.

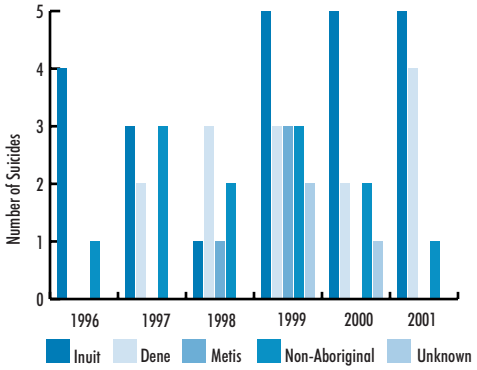
When I review these files in the role of mental health consultant, the pain in these files is palpable. The stories and pictures contained within are unforgettable, as are the memories that the surviving families and friends carry. Each number on the following graphs represents not only a death, but a life that was connected with other people, and filled with such overwhelming pain that killing themselves seemed the only option for these individuals.

Number of Suicides in the NWT (1990 – 2001)

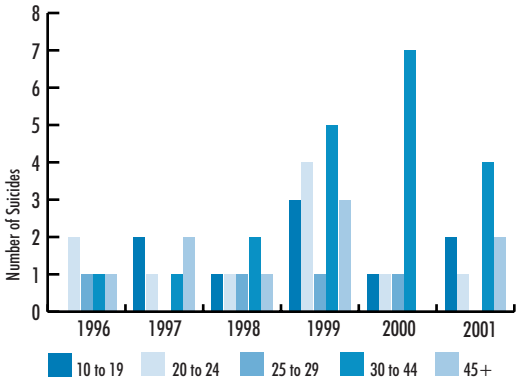
As a result of the small population in the NWT, any fluctuations in suicide deaths will cause a significant change in suicide rates. By tracking suicide statistics over several years, trends become more evident. The NWT saw a decline in suicides during the mid-1990s to a point where the suicide rate was slightly higher than the national average. Since division, NWT crude rates have increased. The 1999-2001 three-year average is 12/40,000 which translates into 30/100,000. Age-adjusted rates for the period 1997-2001 (indirect method), which allow summary comparison between populations with differing age structures, are 26.5/100,000 or approximately 2 times the national average.[a]



Suicides by Ethnicity. Inuit and Inuvialuit people continue to be at highest risk of suicide with 19 of 51 suicides (37%).



Suicides by Age Group. Persons between the ages of 30 and 44 accounted for 19 of the 51 suicides (37%) during this time period. Youth and young adults ages 12 to 19 and 20 to 24 years accounted for the next highest number of suicides (20% and 18%, respectively). If grouped together, these two groups (youth and young adults) comprise the highest risk age group.



Suicides by Ethnicity and Gender. Inuit males comprise the largest group of suicidal deaths, followed closely by Dene and non-Aboriginal males. Males completed a total of 44 of the 51 suicides (or 86%).

	Dene	Inuit	Metis	Non-Aboriginal	Unknown	Total
Male	13	17	3	8	3	44
Female	1	2	1	3	0	7

a Age-standardization is a mathematical technique that adjusts rates in a way that minimizes the effect of differing population age structures (in this case Canada and NWT). This is useful when comparing suicide rates between populations because the risk is age related. The adjusted rate represents the NWT suicide rate that would have occurred if the NWT had the same population age structure as Canada.

Method. A self-inflicted gunshot was the most common method of suicide (58%), with a noticeable increase in gunshot deaths in 1999. In 1999 and 2000, an increasing number of people used hanging as their method of suicide. The other methods of suicide were carbon monoxide poisoning and jumping out of a window.

	Hanging	Gunshot	Overdose	Other
1997	1	6	0	1
1998	0	5	1	1
1999	6	10	0	0
2000	7	2	1	0
2001	1	7	2	0
Total	15	30	4	2

Marital Status. The marital status of each suicide was calculated. Thirty-eight of the 51 suicides (74%) in this five year period were completed by single people or people who were separated from their partners. The close emotional support available in a healthy marriage or common-law relationship may prove to be a significant protective factor for many people.

	Single	Common law	Married	Separated
Male	24	9	4	7
Female	2	0	0	5

Presence of Others. The majority of suicides (35 of the 51, or 68%) were completed with other people present on the premises if not actually in view of the deceased. Even people who lived alone sometimes completed suicide in the presence of others. These suicides have tremendous impact on those present. This fact may be significant to consider when teaching people about intervention and warning signs, and when debriefing.

	Lived alone	Lived with others	Total
Died alone	4	12	16
Died with others	6	29	35
Total	10	41	51

Criminal Charges. Forty-three per cent (43%) of those who died by suicide had involvement with criminal activities. In eight cases (16%), criminal charges were pending prior to the death by suicide. In fourteen cases (27%), the deceased had a history of criminal acts resulting in charges. In four cases, the person had a history of prior charges as well as pending charges.

Emotional and Health History. Twelve of the deceased (23%) were known to have chronic health problems. Ten (20%) were known to have a history of on-going psychiatric problems, most frequently a diagnosis of depression. Where detailed research information has been collected, a history of violence in the family (witnessing family violence, experiencing physical or sexual abuse) or a history of perpetrating violence against others is beginning to emerge. Further research will be needed to confirm this as a common theme.

Previous Attempts and Statements. One third (17 of 51) of the deceased had a known history of either previous suicide attempts or was known to have threatened suicide. Nearly one third of the deceased (15 of 51) had stated their intentions to complete suicide prior to their death. This factor may be significant when targeting prevention and intervention efforts. We need to take all threats and attempts seriously, as an expression of severe emotional pain.

Recent Death or Suicide. The recent death either by suicide or other causes, of a family member or friend was found in over one third (37%) of the cases reviewed. In a few cases, survivors reported that the deceased had talked about suicidal deaths that had occurred up to ten years before. When grief is accumulative or unresolved, it may further impair a person's coping abilities.

Emotional State at the Time of Suicide. When friends or family were interviewed after the suicidal death, they reported that the deceased exhibited depression in 25 of the 51 suicides, or 49%. Emotional distress was reported in 8 of the suicides reviewed (anxiety, violence, concern about pending criminal charges or consequences). In 9 cases, both depression and emotional distress were noted just before the suicide.

"Inuit males comprise the largest group of suicidal deaths, followed closely by Dene and non-Aboriginal males."

Use of Alcohol and/or Drugs.

A significant number (35 of 51, or 69%) of people were noted to have a history of alcohol and/or drug abuse. This is consistent with the previous suicide report.[2] Nevertheless, the profile shifts slightly from the past report when only one third of suicides involved intoxicants at the time of death. The new profile indicates an increase to more than half the completed suicides (28 of 51, or 55%) involving alcohol and/or drugs at the time of death.

	History of alcohol and/or drug abuse	Involvement at time of suicide
Alcohol Only	12	17
Drugs Only	2	3
Both Alcohol & Drugs	21	8
TOTAL	35	28

Discussion and Conclusions

In contrast to a gradual decline in suicide rates in the mid-1990s, the NWT has recently experienced an increase in suicidal deaths. A significant increase in suicides in 1999 may contribute to a shift in the picture of who is at risk. Aboriginal males (particularly Inuit), aged 30 to 44, appear to be at highest risk for suicide in the NWT. Closely following this group are youth (up to 19 years) and young adult (20–24 years) Aboriginal males. In almost all age categories, Inuit and Inuvialuit represent the highest numbers of completed suicides.

A review of life events after the fact identifies many issues in people's lives that may be additional risk factors linked with suicide:

- Aboriginal (particularly Inuit) and male;
- history of threats of suicide or suicide attempts;
- history of alcohol or drug use;
- history of losses (particularly unresolved grief around previous deaths/suicides of family/friends);
- absence of close partner (separated or single marital status); and,
- depression or emotional distress (related to change in life circumstances, family situation, chronic health or psychiatric problems and/or pending criminal charges).

Suicide continues to be understood as a complex phenomenon and is not easily attributed to one factor in an individual's environment or personality. Frequently, we search for one critical precipitating event that may have led to the suicide. In many cases, it is difficult to understand the precipitating event as being so significant that it would lead the person to consider suicide. It appears that an accumulation of traumatic events and a paucity of coping resources play a significant role over time. Improved data collection about exposure to violence (witnessing as a child, experiencing familial or residential school abuse, or perpetrating abuse on others) may help increase our understanding of risk and protective factors for suicidal behaviour.

Many social factors in the NWT may contribute to chronic stress and poor mental health and merit further study with respect to suicide. In addition, new research is exploring the possibility of genetic susceptibility to suicide.[3]

Limitations To This Review

Where suicide research forms[b] were completed post-suicide, we could analyze more details from the person's life experiences. In cases where research forms were not completed, it is not possible to draw conclusions with the same certainty.

More importantly, a review of completed suicides provides only a limited picture of the crisis in the NWT. The World Health Organization estimates there are as many as 20 attempts for every suicidal death.[4] In the NWT, this would translate to roughly 200 suicide attempts each year. It is critical to track and analyze suicide attempts so communities and caregivers can deal with underlying trauma and mental health issues to prevent future deaths.

b Suicide research forms are completed by the community coroner or caregiver following a death by suicide. The forms track items such as the circumstances of the death (method, location, toxicology results), personal history (previous attempts, history of trauma and substance use) and potentially significant life events (pending criminal charges, recent life stressors, etc).

Implications For Caregivers

Suicide is a serious mental health problem in the NWT. When reviewing suicide details, family and caregivers frequently report awareness of the individual's distress, but in many cases, they felt uncertain about how they could help. Youth may need particular help in learning to *tell someone* when they suspect a friend has suicidal thoughts or plans. Once caregivers and health providers recognize a person at risk of suicide, there are several interventions that they can use:

- **Ensure the person's immediate safety:** restrict or remove means of committing suicide; enlist friends/family/professionals to monitor the person; invoke the Mental Health Act if necessary.
- **Show empathy and care:** listen, take threats or gestures seriously, and recognize a suicide attempt or suicidal statement is a serious indicator of emotional pain. Facilitate access to mental health supports or referrals for treatment.
- **Discuss suicide directly:** it will not induce suicidal behaviour in an individual, but it may help create safety for someone considering suicide.
- **Promote community wellness and build protective factors:** problem-solving and interpersonal skills, good physical and mental health, healthy social environments and cultural connectedness are important protective factors against suicide.

And for caregivers:

- **Practice good self-care:** ensure you have emotional supports, opportunities to debrief or consult, and stress-reduction techniques to build personal mental health.

REFERENCES

1 www.statcan.ca/english/Pgdb/People/Health/health01.htm

2 Isaacs, Sandy, et al. *Suicide in the NWT: A Descriptive Review.* Yellowknife, NT: Artisan Press, 1998.

3 Roy, A., et al. "The Genetics of Suicidal Behaviour", *The International Handbook of Suicide and Attempted Suicide.* Chichester: John Wiley and Son, 2000.

4 Langlois, Stephanie and Morrison, Peter. Suicide Deaths and Suicide Attempts. *Health Reports* 13(2) Ottawa: Statistics Canada, January 2002.

ADDITIONAL REFERENCES

Suicide Prevention Information & Resource Centre (SPIRC) at Mheccu, UBC SPIRC publishes a newsletter and has a downloadable list of recommended journal articles related to best practices in suicide prevention at www.mheccu.ubc.ca/SPIRC/publications/readings.cfm as well as user-friendly at-a-glance fact sheets at www.mheccu.ubc.ca/SPIRC/publications/factsheets

Suicide Information and Education Centre (SIEC), Calgary (403) 245-3900 www.siec.ca
SIEC maintains a database, publishes plain language bulletin (Alert) and information kits on specific aspects of suicide prevention, intervention, and postvention

Statistics Canada
Suicide rates (Canada) by age, gender (last update 1997) www.statcan.ca/english/Pgdb/People/Health/health01.htm

Canadian Mental Health Association
Produces pamphlets on a variety of mental health subjects, including suicide and grief www.cmha.ca

Northwest Territories Suicide Prevention Training Program (NTSPT) 15 day training program developed for community members to increase their skill in responding to, and preventing, suicide in the NWT. Contact Health and Social Services Mental Health Consultant at (867) 873-7926. The Department maintains the Suicide Database and resource information.

Office of the Chief Coroner
Investigates all sudden and unexpected deaths, which includes all suicides, in the NWT. Collects detailed information through Suicide Research Form. (867) 920-8713.

The writer acknowledges the contributions of the following peer reviewers: Dr. Veronica Horn (Inuvik Regional H&SS Board), Ms. Judy Desjarlais (NWT Suicide Prevention Steering Committee), Ms. Cathy Menard and Mr. Percy Kinney (Office of the Chief Coroner of the NWT).

HEALTH.online

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Department of Health & Social Services

Wellness.online

Just what *is* wellness? No matter who you ask, or what website you go to in order to find some sort of definition you will soon learn that wellness will signify something different to governments, organizations, and individuals alike. Yet, despite the differences that might exist, online research establishes a general perception of wellness as a *life-long process of educating oneself to make the right choices and decisions in order to develop a balanced lifestyle.* The following three Internet sites provide useful and timely information to keep oneself informed to make these healthy lifestyle choices.

According to the *National Wellness Institute,* wellness encompasses six dimensions through an active process of becoming aware of and making choices toward a more successful existence. The six dimensions are:

- Social
- Occupational
- Spiritual
- Physical
- Intellectual
- Emotional[1]

Although the Institute's website (www.nationalwellness.org) recommends that you purchase a membership in order to reap the full benefits (i.e. the *TestWell Assessments* which determine your overall wellness status); a little browsing proves that the website has lots to offer even without one. For example, not only does this site provide credible links to free wellness resources and the *National Wellness Speakers Bureau*, but it also houses links to several Wellness Software Programs that you may find valuable to use in wellness programming (most of which are **FREE**)! One of the software programs offered is the *CESD-R*, which is a revised version of the *Center for Epidemiologic Studies of Depression* instrument for self-reporting symptoms of depression. Designed to help individuals learn about themselves, this instrument has also aided health professionals in providing good health care. Other software programs include: Workpace (ergonomics package – free for 30 days); Abstinence Monitor (helps you battle various addictions – free); Diet Watch Diary (charts, data, news, tips – free) and many more!

The Department of Health and Wellness within the Government of New Brunswick defines wellness as enabling people to reach and maintain their personal potential in their communities through five aspects of well-being: emotional; mental; physical; social; and spiritual.[2] The Department's website (http://www.gov.nb.ca/hw-sm/hw/index.htm) maintains easy to follow links and also includes a direct link to the Health Canada website, news releases, health resources organized by topic, current research initiatives, a listing of services provided, organizational structure, regional charts and more. The most useful part of this website is that it houses a large database of other sources of health information found on the Internet to include regional, Canadian, American and International sites with topics ranging from infectious diseases to statistics! No matter what stage of health and wellness research you are at, this website is definitely worth browsing.

Health Canada's website uses the term *healthy living* to imply wellness and states, "keeping yourself informed to make healthy food and lifestyle choices is an important way to improve your overall health and sense of well-being."[3] Although the Healthy Living's website (http://www.hc-sc.gc.ca/english/lifestyles/index.html) does not speak specifically to dimensions, it does include a vast amount of information on the following topics which can be related to the six dimensions mentioned earlier:

- Food and Nutrition
- Physical Activity
- Alcohol and Drug Abuse
- Family Violence
- Mental Health
- Safety and Injury
- Sexuality
- Smoking

continued on page 18

IN brief...

West Nile Virus

Craig Nowakowski,
A/Senior Environmental Health Officer
Stanton Regional Health Board

West Nile virus is a mosquito-borne virus that was first seen in the West Nile province of Uganda, Africa. Outbreaks have occurred in Egypt, Israel, South Africa, France, Russia and Romania. The first outbreak to occur in North America was in the summer of 1999, in the New York City area. The outbreak included 62 confirmed cases (primarily elderly), with seven deaths, including a visiting Canadian. It is very similar to St. Louis encephalitis virus, which is found in the United States. Many experts believe that the virus was first introduced into North America from an infected individual or through an imported infected bird.

Media coverage of the virus has, to some extent, given the incorrect impression that this virus is very dangerous. During the 1999 outbreak, many people were infected with the virus and didn't even know it. The risk of becoming seriously ill as a result of infection with West Nile virus is low. Based on previous outbreaks of WN virus, most people infected experience either no symptoms at all, or only mild flu-like symptoms. The virus is rarely fatal. Only in more severe cases is hospitalization or intensive supportive therapy required. The elderly, young, or people with suppressed immune systems are at highest risk.

How is the Virus Transmitted?

Transmission of the virus begins with certain types of mosquitoes when they feed on infected birds. The virus may be injected into an animal or human during blood feeding by a mosquito. There are several different species of birds throughout the United States and Canada that can carry West Nile virus. The group that seems to be the most prevalent carrier is *corvids*, which include crows, ravens and blue jays. Many mosquito species can become infected with West Nile virus; however, the *Culex* species appears to have been the mosquito species most commonly infected during the outbreaks in the United States. In certain parts of Canada there have been roughly 20 species of mosquitoes identified to be infected with West Nile virus.

What is Being Done in Canada and the NWT?

In February 2002, the *Third Annual West Nile Virus Review and Planning Workshop* was held in Ottawa, Ontario. Representatives from federal and provincial/territorial government agencies were once again brought together to develop guidelines and recommendations to address possible exposure of West Nile virus to Canadians. Also included in the workshop were representatives from the Department of National Defence, the Pest Management Regulatory Agency, the Canadian Food Inspection Agency, the Canadian Cooperative Wildlife Health Centre, First Nations Inuit Health, and the National Wildlife Health Center in the United States.

The guidelines developed stress the importance of surveillance, education and prevention. The main purpose of surveillance is to identify West Nile virus in dead birds, mosquitoes, and domestic and wild animals as early as possible so that steps may be taken to reduce the risk of disease in people.[1]

To date, only the province of Ontario has had any confirmed positive birds and mosquitoes. There is yet to be a positive human case of West Nile virus anywhere in Canada. Nevertheless, surveillance and monitoring continue throughout most of Canada, as there is still much to learn about this virus and its hosts.

At the present time, the GNWT is monitoring the West Nile virus situation throughout North America, with special attention being paid to other provinces and territories. However, due to climate conditions of the North, it is not expected that West Nile virus will have an impact in our region in the near future. If conditions change and the threat of West Nile virus to the Northwest Territories should increase, consideration will be given to increased surveillance and sampling programs.

For more information on West Nile virus, check out the following web page from Health Canada: http://www.hc-sc.gc.ca/pphb-dgspsp/wnv-vwn/index.html

REFERENCES

1 http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/info/wnvrsk_e.html

CONFERENCES & workshops

Jasmin Mirza, Ph. D.
Community Wellness Consultant
Health Promotion Unit
Department of Health & Social Services

Community Wellness Forum

On January 23-24, 2002, the Government of the Northwest Territories in collaboration with the Northern Secretariat, Health Canada, hosted a Community Wellness Forum in Yellowknife. This forum was a follow-up of a prior Wellness Forum held in April 2001.

More than 40 participants attended the Forum. These included front-line community workers from every region in the NWT and representatives from the Departments of Health and Social Services and Education, Culture and Employment.

The forum focused on the following issues:

- How to improve the overall delivery of wellness programs and reduce the administrative burden these programs currently impose on small communities;
- How wellness programs could work together more effectively; and
- How governments could be more supportive to wellness programs in general.

The central theme of the forum was to explore options of Integrated Service Delivery at the community level. One highlight of the 2-day event was a presentation by Ms. Margaret Gauvin, Director of Child and Family Integrated Services, Katavik Regional Government, Quebec. Ms. Gauvin outlined an integrated family and child service delivery model that is being successfully implemented in the Nunavik region of northern Quebec. This presentation created some enthusiasm among the forum participants, who split into small group sessions to discuss what an Integrated Service Delivery model could look like in their own communities, and what needed to happen for such a model to become reality.

The idea of a territorial Wellness Council that could oversee the development of Integrated Service Delivery throughout the Northwest Territories was introduced. The Wellness Council could comprise representatives from the Northern Secretariat, the GNWT, Aboriginal organizations, community-based front-line workers, community members and other stakeholders. Although the reaction to a territorial Wellness Council was mixed, participants offered input into its potential structure and function.

At the close of the Community Wellness Forum, members of the small group working sessions identified participants for a Working Group that will follow-up and identify solutions to some of the issues raised during the Wellness Forum.

A summary report of the Wellness Forum can be obtained from the Department of Health and Social Services, Health Promotion Unit, GNWT.

Wellness.Online...continued from page 16

Much like the rest of Health Canada's websites, this site is bilingual, user-friendly and maintains easy to follow links. Each *healthy living* topic site includes a brief description and is housed with numerous links to programs, publications, guides, resources and more. The limitation of this website is that it tends to keep you within the confines of the information available at or specifically partnered with Health Canada. Nevertheless, this should not limit the browser's ability to keep him or herself informed enough to make healthy choices.

1 National Wellness Institute. "Definition of Wellness". 2002. Online. http://www.nationalwellness.org/home/definitionofwellness.asp

2 Government of New Brunswick. Department of Health and Wellness. *First Report of the Select Committee on Health Care: Wellness Strategy Report.* New Brunswick: Legislative Assembly of New Brunswick, April 2001.

3 Health Canada. "Healthy Living." 2002. Online. http://www.hc-sc.gc.ca/english/lifestyles/index.html

The 93rd Annual Conference of the Canadian Public Health Association

Vicki Lafferty
President,
NWT/Nunavut Branch
Canadian Public Health Association

The 93rd annual conference of the Canadian Public Health Association will take place in Yellowknife, July 7-10, 2002. The conference, entitled *Our Environment, Our Health*, will bring renewed understanding to the interrelationships between the environment and our health.

Sub-themes for the conference are:

- Healthy Beginnings;
- Globalization;
- Linking Environment and Health; and
- Evolution of Health Governance.

Each of these areas provides an opportunity to share the evidence of best practice by critically looking at the challenges and successes in research, community action and policy development.

Conference keynote speakers will include:

- Dr. Nick Drager, Coordinator, Globalization, Cross-Sectoral Policies and Human Rights, WHO;
- Dr. Graham Chance, Chairperson, Advisory Council, Canadian Institute of Child Health;
- Dr. Jeffrey Wigand, Smoke-Free Kids, Inc.; and
- Dr. Ilona Kickbush, Professor and Head, Division of Global Health, Yale University.

We will also be featuring a *town hall* session that will focus on the health and social impacts of resource development. The session will raise awareness about sustainability issues and highlight contributions that individuals, communities, governments, and businesses can make to support local, national or global sustainable development. The session will be led by a moderator and include a group of panelists representing public health, the Aboriginal community, and the oil and gas sector.

There are a number of pre-conference workshops, concurrent sessions and workshops on the sub-themes of: Healthy Beginnings, Globalization, Linking Environment and Health, and Evolution of Health Governance. Special guests include the Honourable Ethel Blondin-Andrew, Secretary of State, Children and Youth. She will chair a workshop on International Health in which she will provide opening remarks in support of families, children and youth.

For more information about the conference or to register, check out CPHA's website at http://www.cpha.ca/english/conf/93rdAnl/93conf.htm.

The Canadian Public Health Association (CPHA) will be holding their 93rd Annual Conference in Yellowknife, 7-10 July 2002. The conference will be co-sponsored by the NWT/Nunavut CPHA Branch. The NWT/Nunavut Branch is looking for individuals who would be interested in hosting a "billet" during the conference. If interested, please contact Jo-Anne at 920-6907 (w) or 873-2586 (h).

The CPHA is a not-for-profit, voluntary association representing public health in Canada. For more information visit www.cpha.ca

NOTIFIABLE diseases

by Region: for the Northwest Territories (NWT) January 2002 - March 2002[a]

		January - March 2002	Cumulative Totals - 2002
		NWT	NWT
Vaccine Preventable Diseases	Hepatitis B	0	0
	Haemophilus Influenzae	0	0
	Influenzae A	4	4
	Influenzae B	0	0
	Pertussis	12	12
Sexually Transmitted/ Bloodborne Diseases	Chlamydia	126	126
	Gonorrhea	33	33
	Hepatitis C	12	12
	Hepatitis, Other	0	0
	Syphilis	0	0
Diseases by Direct Contact/ Respiratory Route	Chicken Pox	32	32
	Group A Strep	0	0
	Invasive Strep Pneumoniae	2	2
	Legionellosis	0	0
	Meningitis, Pneumococcal	0	0
	Meningitis, Other Bacterial	0	0
	Meningitis, Unspecified	1	1
	Meningitis, Viral	0	0
	Meningococcal Infections	0	0
	Respiratory Syncytial Virus	28	28
	Tuberculosis	0	0
Enteric, Food and Waterborne Diseases	Botulism	0	0
	Campylobacteriosis	2	2
	Cryptospiridosis	0	0
	E.Coli 0157:H7	1	1
	Giardiasis	3	3
	Hepatitis A	0	0
	Salmonellosis	2	2
	Shigellosis	1	1
	Tapeworm Infestation	0	0
	Trichinosis	0	0
	Yersinia	0	0
Vectorborne/Other Zoonotic Diseases	Brucellosis	0	0
	Malaria	0	0
	Rabies Exposure	0	0
Antibiotic resistant microorganisms	Methicillin-resistant Staph.Aureus	1	1
	Vancomycin-resistant Enterococci	0	0

NWT HIV Infections Reported from 1987 to2001

	Age Group at Diagnosis							*Gender*		*Risk Category*					
Total	0-9	10-14	15-19	20-29	30-39	40-49	50-59	60+	Female	Male	MSM[b]	MSM/ IDU[c]	IDU	Hetero-sexual	Perinatal	Blood Products
32	2	0	0	7	14	6	1	2	6	26	17	1	4	7	2	1

a Statistics are based on currently available data and previous data may be subject to change.
b Men who have sex with men
c Injection Drug User