AN INUIT CASCADE OF CARE FRAMEWORK FOR SEXUALLY TRANSMITTED & BLOOD BORNE INFECTIONS

IKAJURNIQ 2018

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INUIT WOMEN OF CANADA

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March 2018
ISBN 978-1-988671-02-4

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INTRODUCTION

INUIT IN CANADA are experiencing high rates of sexually transmitted and blood-borne infections (STBBIs). While there is limited Inuit-specific statistical information, we know that chlamydia, gonorrhea and syphilis rates in Inuit regions are high. For example, in Nunavut in 2013, where 85% of the population is Inuit, the chlamydia rate was 11 times that of the rest of Canada, and the gonorrhea rate was 27 times higher. In 2014, the syphilis rate was more than 15 times higher.[1] While current rates of HIV in Inuit communities are low, the risk of being infected increases with the presence of other STIs. Community stakeholders fear a rapid rise in HIV unless effective prevention and treatment measures are put in place.

Inuit organizations at the national, provincial/territorial and regional levels are concerned about the short- and long-term effects of STBBIs on this young and mobile population. The national Inuit Public Health Task Group identified sexual health as a priority issue in 2015. Pauktuutit Inuit Women of Canada has been advocating for sexual health initiatives, supporting community awareness campaigns, and coordinating the Canadian Inuit HIV/AIDS Network (CIHAN) for many years. In 2017, the organization hosted a sexual health roundtable that resulted in a National Inuit Sexual Health Strategy and the formation of a National Inuit Sexual Health Network.

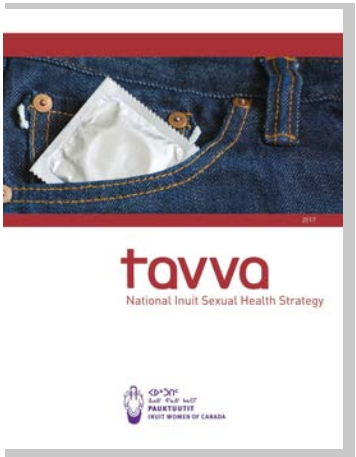
A central approach to reducing STBBIs among Inuit is the development of effective methods to increase the number of Inuit being tested, diagnosed and treated before they spread infection to others. At its inaugural meeting in November 2017, the National Inuit Sexual Health Network developed an Inuit-specific STBBI Cascade of Care. The Cascade of Care builds on best practices in prevention and treatment of STBBIs in Canada, while recognizing both the particular challenges and the known enablers in reaching, testing and treating Inuit with STBBIs in northern communities.

[1] Government of Nunavut, Reportable Communicable Diseases in Nunavut 2007 to 2014, 2016.

NATIONAL INUIT SEXUAL HEALTH STRATEGY

The National Inuit Sexual Health Strategy guided the development of the Inuit STBBI Cascade of Care. The goal of the Strategy is to:

"advocate for meaningful Inuit involvement in the design, delivery and evaluation of culturally and linguistically appropriate awareness campaigns, community actions, preventive programs and health services that enable Inuit to be sexually healthy throughout their lives."



STRATEGIC PRIORITIES

1. Enhance Inuit sexual health education
2. Address substance abuse and high risk behaviours
3. Reduce sexual violence
4. Prevent sexually transmitted and blood-borne infections (STBBI)
5. Strengthen mental health and trauma-informed supports
6. Enhance Inuit-specific research and surveillance

The Strategy identifies a number of suggested activities to prevent STBBIs, including:

- Promote awareness of the links among lack of self-esteem, gender inequality, unhealthy relationships and STBBIs;
- Reduce the stigma and fear associated with STBBIs;
- Ensure patient confidentiality, privacy and respect at all stages of testing and treatment;
- Require mandatory cultural competency training for all healthcare providers and health educators;
- Develop, implement and evaluate Inuit-specific community health models for prevention, testing and treatment of STBBIs;
- Encourage health clinics and hospitals to conduct routine screenings for a range of infections and diseases.

Finally, the Strategy recognizes the importance of the social determinants of sexual health – the context in which Inuit are at-risk for high rates of sexually transmitted and blood-borne infections:

Housing	Cost of living and food security
Education	Mental wellness
Safety and security	Intergenerational trauma
Substance abuse	Gender
Health services	Stigma and discrimination

THE CASCADE OF CARE APPROACH

The cascade of care approach was first developed to guide efforts to reduce HIV/AIDS globally. Due to a range of barriers and challenges, especially among disadvantaged populations, many people who are HIV positive are unaware of their diagnosis and continue to transmit HIV infection. Also, many who are tested and diagnosed do not have access to or stay in treatment until the virus is suppressed.

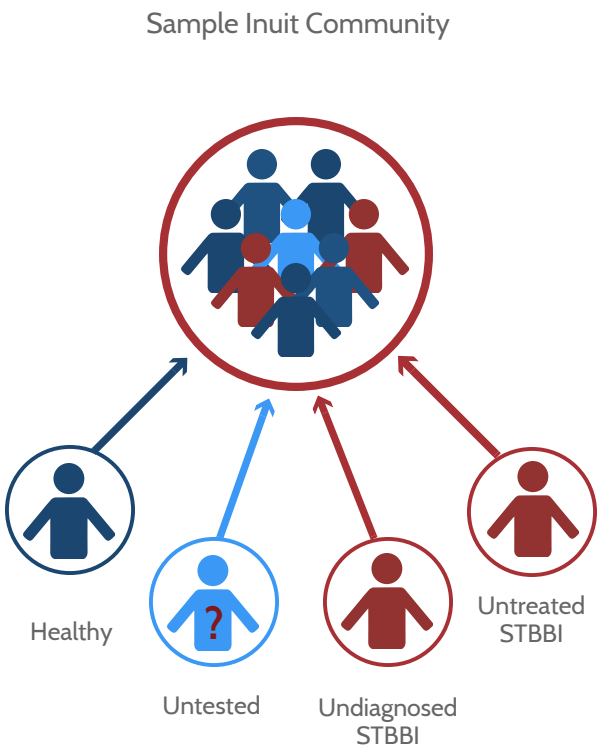
In response, the United Nations AIDS organization has set the following international targets for 2020:

- 90% of all people living with HIV will know their HIV status
- 90% of all people diagnosed with HIV will receive anti-retroviral therapy (ART)
- 90% of all people receiving ART will have viral suppression

The strategy is informally known as “90-90-90”, and modelling studies show that achieving these targets would result in the end of the AIDS epidemic by 2030.

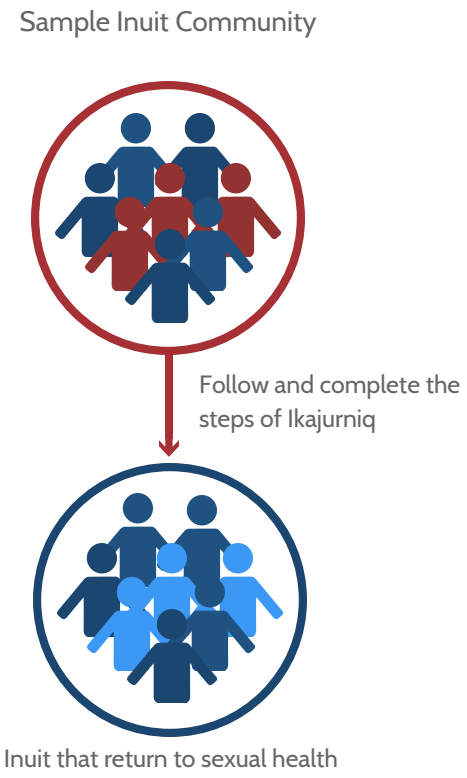
IKAJURNIQ

Ikajurniq – meaning "the act of helping" – is an Inuit-specific STBBI cascade of care that builds on the best practices in prevention and treatment of STBBIs in Canada. It recognizes both the particular challenges and the known enablers in reaching, testing and treating Inuit with STBBIs in northern communities. The Inuit sexual health network believes that the cascades of care model can and should be applied in Inuit communities. By reaching and retaining more Inuit in the testing/diagnosis/treatment cycle, the burden of all STBBIs, including bacterial STBBI, can be significantly reduced.



Inuit that have a STBBI that do not complete the cascade of care will continue to carry the STBBI and may spread the infection.

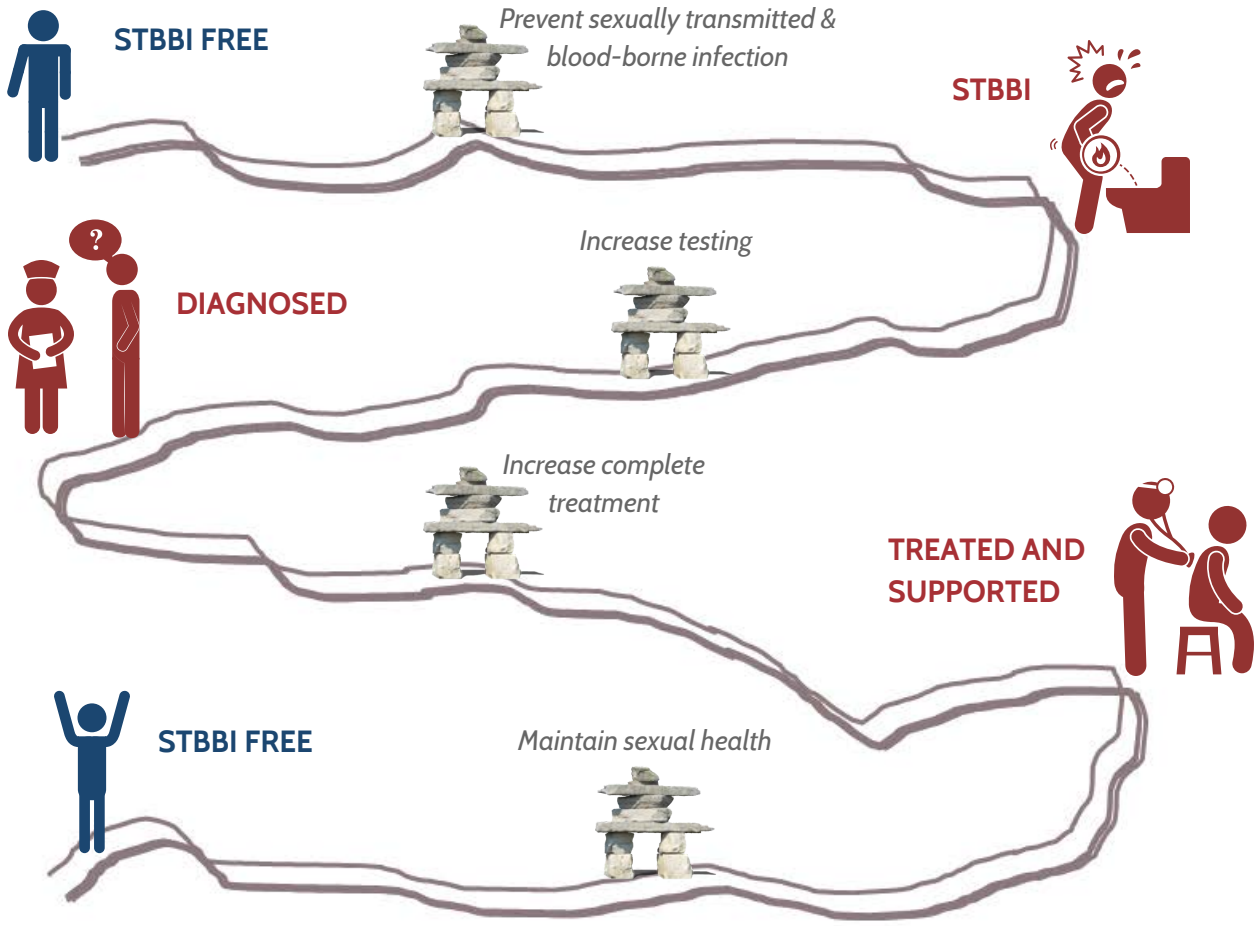
FIGURE 1



Inuit that complete the cascade of care are more likely to return to full sexual health. The full details of the cascade are found in Figure 3.

FIGURE 2

Rather than losing many patients/clients at each stage of the cascade (Figure 1) the aim is to reach all sexually active Inuit, have them get tested for STBBIs and access health services appropriate to their level of risk (Figure 2). Building on that positive alliance, those who test positive will get treated, and those who complete treatment will return to sexual health.



An Inuit-specific STBBI cascade of care that builds on the best practices in prevention and treatment of STBBIs in Canada. It recognizes both the particular challenges and the known enablers in reaching, testing and treating Inuit with STBBIs in northern communities.

FIGURE 3

ENABLERS

There are enablers at each stage of the testing, diagnosis and treatment journey that address some of the barriers that Inuit encounter in the process. These enablers increase the chances of effective treatment of STBBIs and a return to being STBBI free.

STBBI Prevention

Sexual health literacy – many Inuit lack knowledge about safe and healthy sexuality and are not comfortable seeking out information and services.

- Deliver culturally appropriate and trauma-informed sexual health education to children, youth and adults by qualified individuals in schools and in the community.

- Use peer educators and community-based wellness workers to reach those particularly at-risk for STBBIs, including youth who are out of school, those who are sexually active at a young age or are in unhealthy relationships.
- Use health apps, social media and websites to reach the sexually active population.

Reducing risk-taking behaviours –low self-esteem, unresolved trauma, boredom and poor access to preventive measures may lead to risky behaviours such as not using condoms, anonymous sex and sex under the influence of drugs and alcohol.

- Provide more easily accessible safe sex materials.
- Develop Inuit-specific messaging to increase awareness and provide positive alternatives to high-risk behaviour.
- Offer harm reduction programs and addiction treatment to reduce alcohol and drug misuse.

From Having an STBBI to Being Diagnosed

Social norms and attitudes towards STBBIs – social norms, and individual attitudes need to change so more Inuit are comfortable and confident in getting tested and diagnosed.

- Support ongoing communication, public dialogue and positive messaging to change social norms and attitudes toward STBBIs diagnosis, treatment and partner referral.
- Use social media to promote testing in the sexually active population and among youth in particular.

Reducing stigma – there is still a great deal of stigma in having a sexually transmitted infection, including HIV/AIDS, chlamydia and gonorrhea. Stigma prevents individuals from seeking care.

- Create media campaigns and deliver public health education to reduce stigma and increase testing.
- Train healthcare providers in a more open approach to testing, for example, offering testing annually without people having to ask for it.

Confidentiality – in small, close-knit communities, Inuit fear that their medical conditions and health status will become known in the community.

- Offer non-nominal testing (not using a person's name) and keep reasons for medical consultations private.
- Remind all healthcare staff on a regular basis of the importance of confidentiality in all circumstances, especially in relation to sexual health matters.
- Develop testing capacity outside of regular clinics.

Access to testing – limited availability of testing sites and times reduces the number of those who get tested.

- Provide extended hours for testing.
- Offer testing outside of traditional health care settings.
- Where it is available, enable self-testing.

From Diagnosis to Treatment

Practitioner knowledge – the rapid spread of sexually transmitted and blood-borne infections in isolated northern communities requires specialized knowledge and treatment approaches.

- Explore ways to enhance provider training and awareness, for example, webcasts, videoconferencing, off-site training, etc.
- Provide healthcare providers with desk references on STBBI testing and treatment.
- Offer remote access to sexual health specialists who are knowledgeable about the North.

Getting results and authorizing treatment – sending samples out of the community for analysis can result in a several-week delay in diagnosis. Getting authorization to begin treatment also can be delayed when physicians are working remotely.

Explore ways to reduce the time from a positive test result to treatment, for example, develop protocols allowing nurses to test and treat.

Increase laboratory capacity and make point-of-care testing available to clinics whenever possible.

Reaching patients quickly – unstable housing and fewer telephones in households combined with staff vacancies and competing health crises (tuberculosis, suicide) make it difficult to get patients into treatment quickly.

Explore better means to reach patients, for example, using text messages and messenger apps.

Increase efforts to contact patients through use of peer counsellors, youth outreach workers and community health representatives.

Tracing contacts – anonymous sex and reluctance to name contacts due to fear of violence and gossip means that others who might be infected are delayed in getting treatment or are not treated at all. Lack of partner treatment contributes to the spread of and recurring infection.

Make timely and thorough follow-up with sexual contacts a priority.

Continue awareness programs and harm reduction measures to contribute to better identification of sexual partners.

Preventing reinfection – many individuals with a STI diagnosis are at risk of re-infection.

Automatically test and treat regular sexual partners to prevent re-infection.

Create protocols for screening and re-screening to ensure clearance of original infections.

Other health issues – mental health problems, chronic health conditions and generally poor health make it difficult for some Inuit to complete the treatment cycle and get re-checked for sexually transmitted infections.

- Provide patient-centred counselling and support to help individuals manage and cope with life challenges and health issues.
- Use directly observed therapy (DOT) at the health centre or at home to increase the likelihood of a completed treatment cycle.

Overarching Considerations

Access to healthcare – most Inuit live in small northern communities where the local health centre may be under-staffed or lack sexual health programming and/or outreach capacity.

- Provincial and territorial governments and regional health authorities can reassess the allocation of health resources and ensure that outreach, testing and treatment for STBBIs are higher priorities until infection rates fall.

Culturally safe services – for Inuit, cross-cultural and cross-linguistic differences between healthcare providers and patients/clients affect each stage of sexual health care.

- Require healthcare providers to take regular cultural safety training to ensure they are well versed in Inuit values, lifestyles, family and community relationships, and sexual norms.
- Work in close cooperation with Inuit staff and community agencies to ensure programs and services are culturally appropriate and relevant to Inuit.

Trauma – Inuit continue to face the effects of colonial policies, racism (both at the individual and systemic levels) and governing systems and services that don't reflect cultural values and social structures.

- Deliver Inuit-led sexual health initiatives, family support, trauma-informed counselling and anti-racism initiatives to contribute to reduced trauma, better resilience and positive coping skills.

Self-care – due to the stresses of poverty, food insecurity, crowded housing, violence and other issues, caring for one's sexual health is not a priority concern.

- Integrate sexual health into existing programs and provide the social and practical supports needed for Inuit to be proactive about their sexual health.
- Address issues such as inadequate housing, food insecurity, and safety and security that have a direct effect on sexual health.

CONCLUSION

Inuit experience high rates of sexually transmitted and blood-borne infections and face particular challenges in completing the testing and treatment journey. The enablers described above can greatly increase the number of Inuit who successfully navigate the STBBI cascade of care.

RECOMMENDED POLICIES AND PRACTICES INCLUDE:

- ✓ Reassessing the use of health resources and ensuring that outreach, testing and treatment for STBBIs are high priorities in Inuit regions;
- ✓ Developing integrated, holistic health programs that increase awareness and promote harm reduction and self-care;
- ✓ Adopting approaches that address trauma among Inuit;
- ✓ Using peer educators, health apps and social media to reach those at-risk;
- ✓ Conducting media campaigns, delivering school education and providing non-judgemental health care;
- ✓ Applying strict confidentiality protocols and using non-nominal testing;
- ✓ Expanding access to testing through more locations and extended hours;
- ✓ Delivering regular professional development training specific to STBBIs in northern communities;
- ✓ Treating suspected sexually transmitted infections based on symptoms and allowing nurses to prescribe treatment;

- ✓ Maintaining contact with patients throughout the testing and treatment cycle;
- ✓ Providing timely and thorough contact follow-up;
- ✓ Offering patient-centred counselling and support and using directly observed therapy (DOT);
- ✓ Following up-to-date protocols for testing and drug treatment for patients/clients and their sexual partners, followed by re-testing.

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