among First Nations and some immigrant populations); availability of healthy, affordable food in rural and remote areas; and public awareness of healthy lifestyles and choices.

Such complexity means Ottawa must coordinate prevention initiatives at provincial, territorial, federal and nongovernmental levels, says Karen Philp, vice president of public policy and government relations for the Canadian Diabetes Association.

Philp says the Association hopes a Health Canada policy review of the 6-year-old Canadian Diabetes Strategy (announced by Health Minister Tony Clement last year and awaiting terms of reference), will result in the Canadian Diabetes Association and other organizations becoming partners with the 3 orders of government in diabetes response planning, rather than having them serve as outside advisors.

From 1999–2005, the federal government spent $115 million on various projects under its diabetes strategy, including $58 million for an Aboriginal Diabetes Initiative. A national system for surveillance of chronic disease based on provincial and territorial health administration data was also developed. The Aboriginal initiative has been renewed at $190 million over 5 years under the First Nations and Inuit Health Branch at Health Canada. The Canadian Diabetes Strategy, now run under the Healthy Living and Chronic Disease Strategy, has an $18 million budget for 2006–07 with its future to be decided after the review.

The Association is also working on developing fact-based diabetes management approaches with the University of Western Ontario. The 2 recently partnered to launch a $5 million Chair of Diabetes Management and National Management Diabetes Strategy. Each has committed $1 million and both are seeking private funding sources to generate the remaining $3 million. The search has also begun to find a chair holder.

The Canadian Diabetes Association states that it believes a national pharmacare plan is needed to ensure no Canadian, particularly those with diabetes and other chronic diseases, spends more than 3% of their annual income on medication, devices or supplies prescribed by a physician.

While new strategies are being sought, Philp also urges medical practitioners to use the Canadian Diabetes Association's Clinical Practice Guidelines (www.diabetes.ca/cpg2003/chapters.aspx).

"They are evidence-based; they will tell you how to optimize the management and support for your patients with diabetes." Revised guidelines will be published in 2008. — Pauline Comeau, Ottawa

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Hospitals to report *C. difficile* and MRSA

Commencing next year, acute-care hospitals, nursing homes and other institutions will be asked to report their rates of either *Clostridium difficile* or methicillin-resistant *Staphylococcus aureus* as part of the process for obtaining Canadian Council on Health Services Accreditation (CCHSA).

But unlike increasing numbers of hospitals in the United States, where new legislation is forcing mandatory public disclosure of nosocomial infection rates, the Canadian institutions will not have to make their numbers public.

In Canada, performance measures in the area of patient safety, including infection control, are an "integral part" of the CCHSA's new accreditation program, says President and CEO Wendy Nicklin.

"We're being asked by clients and by our stakeholders to be more specific in this area because of the priority," says Nicklin. The CCHSA will request that all institutions seeking accreditation report on whichever infection is more pressing; *C. difficile* or MRSA.

Starting this year, CCHSA accreditation will be mandatory in Quebec. While not mandatory in other provinces, CCHSA accreditation is necessary for hospitals with Royal College of Physicians and Surgeons of Canada-approved residency programs.

The Council will use the information to help institutions resolve infection problems by providing them with prevention and control standards, Nicklin says, stressing that reporting infection rates is part of a quality improvement exercise, not a licensing requirement for the 923 institutions (and 3750 sites) it serves.

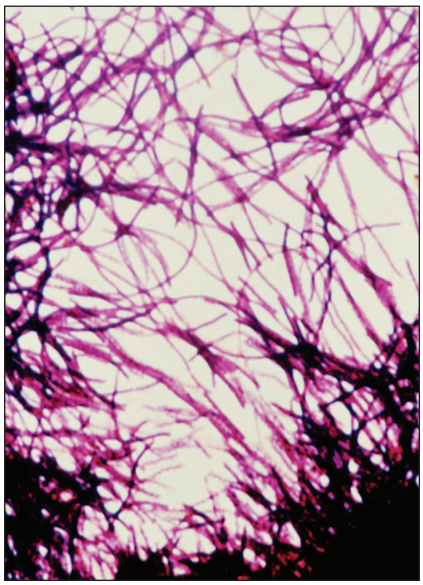
Although the Council encourages institutions to share their report externally, they aren't, and won't be required to do so. "It is their report to share," Nicklin says. "We release aggregate data and information about what the survey reports have shown and trends related to the nature of the recommendations."

By contrast, hospitals in the US will increasingly have no choice about releasing their infection information. As of February 2007, 14 US states had passed legislation requiring hospitals to publicize their rates of hospital-acquired infections. In addition, California and Rhode Island require hospitals to report on how well they are following infection control policies. Nevada and Nebraska report hospital infection rates to their respective health departments, but don't share the information with the public. Another 18 states are considering bills that would require some kind of public reporting of hospital infection rates.

Infections are one of the top 3 adverse events that patients in hospitals face, so the accreditation program is needed to improve patient safety, says Dr. Susan Brien, the Canadian Patient Safety Institute's director of operations for Quebec, Nunvaut and Atlantic Canada.

"One of the things that we know about the safety and quality business is that if you don't measure it, it doesn't change," Brien says, arguing that once institutions begin to collect the information about infection rates, their commitment to preventing and reducing hospital-acquired infections will improve.

Although Brien thinks it's important that patients know what the infection situation is at the hospitals that serve them, she's not convinced public reporting is the best way to pass on that information. Instead, she'd like to target hospital boards and surgeons.



US Centers for Disease Control and Prevention

The Canadian Nosocomial Infection Surveillance System is surveying 48 sentinel institutions to measure the incidence of a virulent strain of *C. difficile*.

"I think surgeons need to know their own infection rates," says Brien, a neurosurgeon. "As part of the standard consent process they need to disclose what the infection rates are for the patient, so the patient can make the appropriate decision."

Hospital boards are responsible for the quality of care within their organizations, so month-to-month updates would help them track improvements in infection rates by specialties and monitor high-risk infections like *C. difficile* and MRSA, she says.

Once institutions know what their infection rates are, they need to communicate that widely throughout the hospital to encourage infection control procedures, like hand-washing, Brien stresses.

Concern about the prevalence and virulence of *C. difficile* and MRSA has been rising, particularly since the so-called Quebec strain of *C. difficile* was credited with causing as many as 2000 deaths. Thus far, though, only Quebec and Manitoba have made *C. difficile* a reportable disease, even though the move was recommended for all provinces by the Public Health Agency of Canada's National Notifiable Disease Working Group.

The Canadian Nosocomial Infection Surveillance System is surveying 48 sentinel institutions to measure the incidence of a virulent strain of *C. difficile*, says Shirley Paton, director of Health-Care Acquired Infections at the Public Health Agency of Canada. Thus far, it has found that the strain involved in the original Quebec outbreak has migrated to every province except PEI, which does not have a sentinel hospital. "It's obviously spread very rapidly. There's still a lot more to find out about it, like when and how the extra toxins are being produced," Paton says.

The program has been monitoring MRSA since 1995, and has discovered that rates are rising steadily. Such developments have left the Public Health Agency increasingly concerned about the emergence of community-acquired MRSA and *C. difficile*, Paton says.

Canada has more to do in terms of understanding and communicating infection rates both within hospitals and in the community, she adds. Among the problems is comparing posted public data in the absence of comparable reporting standards. For instance, should hospitals report the presence of the *Staph. aureus* organisms, she asks, which may or may not result in outbreaks, or only report outbreaks of MRSA? Unless a standard is agreed upon, it will hard for patients to compare institutional performance, Paton says. But the Canadian Council on Health Services Accreditation's new program "is a huge first step." — Laura Eggertson, Ottawa

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Canadian physicians help fight RVF in Kenya

Canadians can stake a claim in helping contain a major outbreak of a virulent new strain of Rift Valley Fever (RVF) that recently killed 150 Kenyans and 40 Somalis.

The virus is a mosquito-born pathogen that primarily affects livestock but humans can get infected through mosquito bites or contact with blood or other secretions from infected livestock, particularly during the slaughtering process. The virus also appears to be transmissable through raw milk.

But its spread was limited during the recent outbreak through a series of measures, such as restricting livestock movement, banning slaughters, wearing mosquito resistant clothing, using mosquito nets, and injecting vaccines in livestock, says Heinz Feldmann, head of the special pathogens program at the Public Health Agency of Canada's National Microbiology Laboratory in Winnipeg.

Feldman was 1 of 3 infectious disease specialists, along with Allen Grolla and Robbin Lindsay, whom PHAC dispatched to Kenya as part of an international effort to arrest the spread of RVF, for which there is no effective human vaccine. Canada also sent a mobile laboratory in aid of the World Health Organization-led initiative.

"We provided support in laboratory diagnostics as well as support in entomology/ecology," Feldmann told *CMAJ*. "The support for the outbreak has discontinued but we will establish a presence in Kenya in the future to assist in outbreak and public health questions."

The RVF virus causes hemorrhagic fever that is similar to Marburg and Ebola but is less virulent. Dr. Kariuki Njenga of the Centers for Disease Prevention and Control in the Kenyan capital of Nairobi, says the virus has not changed since it was first discovered in 1930, but changes in infection patterns are being tracked. The last major RVF outbreak occurred in 1997 during the El Nino rains, and killed more than 300 Kenyans. No outbreak outside sub-Saharan Africa was reported until September 2000, when cases were confirmed in Saudi Arabia and Yemen.

RVF in humans is characterised by fever, headaches and bleeding through the mouth and nose. The WHO says about 1–2% of those infected reach the severe hemorrhagic stage; and about half of those die. Feldmann said ribavirin treatment was used for such clinical cases but efficacy "was not really demonstrated."—Wairagala Wakabi, Kampala, Uganda

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