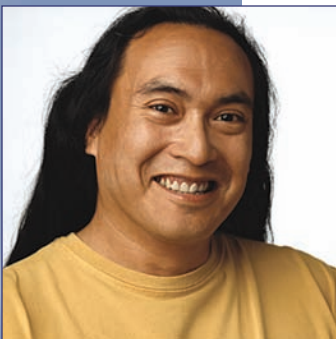


Priorities for Action in Managing the Epidemics: HIV/AIDS in B.C. (2003-2007)

2005 ANNUAL PROGRESS REPORT



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The Ministry of Health would also like to acknowledge the concerted efforts of the Provincial Health Services Authority, Vancouver Coastal Health Authority, Fraser Health Authority, Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority in strengthening the capacity to deliver effective HIV services throughout British Columbia. In particular, the Ministry would like to recognize the excellent contributions of the BC Centre for Disease Control, the BC Centre for Excellence in HIV/AIDS and the Oak Tree Clinic.

The Ministry of Health would also like to thank the many community-based organizations in British Columbia that work tirelessly to deliver much needed HIV services to marginalized and hard to reach populations across the province. The community plays a critical role in helping to ensure a robust and sustainable response to HIV.

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Introduction

In September 2003, the Ministry of Health released *Priorities for Action in Managing the Epidemics: HIV/AIDS in BC (2003 – 2007)* to guide British Columbia's response to the HIV/AIDS epidemic. This directional document reflects the regionalized delivery of HIV services framed by a vision of British Columbia (BC) as a leader in managing the HIV epidemic. It outlines a set of comprehensive strategies that include health promotion, prevention, harm reduction, testing, diagnosis, contact tracing, partner notification, care, treatment and support.

Priorities for Action also establishes four goals in the areas of prevention, treatment, capacity and collaboration. The prevention and treatment goals address the health status of British Columbians while the capacity and collaboration goals address the health system. The prevention goal is to reduce the annual number of new HIV infections by 50% by 2007. The baseline is the number of people testing newly positive for HIV in 2001, or 440 new infections. In 2005, the target was to avert 132 new HIV infections, thereby reducing the number of people testing newly positive to 308 in 2005.

Year	% Reduction from Baseline Required	HIV Infections to be Averted	Projected HIV Infections if Targets are Achieved	Actual HIV Infections Reported
2003	10	44	396	418
2004	20	88	352	442
2005	30	132	308	410
2006	40	176	264	tbd
2007	50	220	220	tbd

The treatment goal is to increase the proportion of HIV-positive individuals who are linked to appropriate care, treatment and support by 25 per cent by 2007. One way to measure this increase is to look at the proportion of HIV-positive individuals in BC on highly active antiretroviral therapy (HAART). In 2001, approximately 30 per cent of the estimated HIV prevalent population was on HAART. In 2005, the treatment target was to have 35 per cent HAART coverage in BC.

Year	% Increase from Baseline Required	Proportion of HIV Prevalent Population on HAART Required to Reach Targets
2003	5	32 %
2004	10	33 %
2005	15	35 %
2006	20	36 %
2007	25	38 %

Priorities for Action contains a commitment to reporting annually on progress in achieving the four goals. In August 2005, the Ministry of Health published the inaugural *2004 Annual Progress Report* which reviewed initiatives across the province that were clear examples of the strategic efforts outlined in *Priorities for Action*. This report laid the foundation for monitoring the status of the HIV epidemic and the effectiveness of British Columbia's response.

Purpose and Scope

The purpose of the *2005 Annual Progress Report* is to document progress made in the 2005 calendar year in achieving the prevention, care and treatment, capacity and coordination goals contained in *Priorities for Action*. At present, the core indicators for monitoring progress are:

Prevention	Care/Treatment	Capacity	Coordination and Cooperation
HIV surveillance data HIV testing patterns HIV incidence estimates HIV prevalence estimates	HAART uptake/coverage AIDS-related mortality Life expectancy/PYLL index HIV/AIDS acute care utilization	Research Knowledge exchange Inter-professional education Monitoring capacity HIV service planning and implementation	Collaboration Global engagement

Additional indicators and data sources are being considered for future progress reports. For progress related to prevention, this may include measures of HIV vulnerability, knowledge, skills, attitudes and behaviour change at the population level. For care and treatment, this may include measures of HIV disease progression, adherence to drug treatment, and community health service utilization. For capacity and coordination, this may include measures of stakeholder relationships, systemic policy change and service integration.

The data presented in the *2005 Annual Progress Report* has been obtained from the Ministry of Health, BC Vital Statistics, BC Statistics, BC Centre for Disease Control, BC Centre for Excellence in HIV/AIDS, Oak Tree Clinic and health authorities and their institutional and community partners. For this report, the Ministry of Health piloted the use of standardized templates to collect consistent output data on each goal from the health authorities. There was considerable variation in the ability of each health authority to generate the data, as well as in the quality of the submitted data. Some health authorities reported in detail on their efforts to achieve the targets, while others only reported on a few overall outputs. This reflects a lack of standardized data collection for HIV-related activities among health authorities.

The Ministry of Health commits to working with health authorities to clearly define province-wide data needs and to achieve some measure of standardization for the purposes of comparative analysis. For future reports, data collection instruments will be linked to core-monitoring indicators and available data sources. These instruments, along with a schedule for data collection and reporting, will be developed jointly by the Ministry and health authorities.

It should be noted that HIV surveillance data understates the magnitude of the HIV epidemic. This data is based on testing records and does not include individuals that remain untested and, therefore, undiagnosed. Surveillance data is also subject to reporting delays, under-reporting and changing patterns in HIV testing behaviour, and cannot be considered indicative of true HIV incidence. HIV is a chronic infection with a long clinical course and many people may be diagnosed years after infection. Consequently, the number of people testing newly positive for HIV in a given year does not reflect the actual number of new infections for that period.

HIV and Health System Stewardship

The World Health Organization (2000) describes stewardship as the essence of good government. It is the careful and responsible management of the health and well-being of the population. Stewardship is also about establishing the best and fairest health system possible and guiding overall health system performance.

For the BC Ministry of Health, a stewardship approach to HIV/AIDS means actively supporting a wide range of health system actors to achieve the *Priorities for Action* prevention and treatment goals, as well as actively removing barriers and fostering opportunities to achieve the capacity and coordination goals. Health system actors include people living with HIV, at risk populations, health authorities and their institutional and community partners, physicians and allied professionals, researchers and policymakers, pharmaceutical companies, Aboriginal leaders and First Nations communities and other levels of government.

In its stewardship role, the Ministry supports the achievement of HIV-related population health and health system outcomes through intelligence generation, strategic policy direction, development of the capacity and tools for effective policy implementation, building and sustaining relationships with key health system partners, ensuring the structure and management culture of the health system are conducive to achieving shared outcomes, and through accountability¹.

¹ Travis, P et al (2002). Towards Better Stewardship: Concepts and Critical issues. World Health Organization

Overview of HIV/AIDS in British Columbia

HIV Disease

HIV is the human immunodeficiency virus that causes the gradual destruction of the immune system, leaving the infected person vulnerable to progressive illness, and opportunistic infections and cancers. HIV is transmitted through contact with infected body fluids, including blood, semen, vaginal fluids and breast milk. It is most often transmitted through unprotected sexual intercourse or sharing of needles and other injection equipment. The presence of sexually transmitted infections, such as herpes simplex, gonorrhoea, syphilis and/or chlamydia, increases the risk of HIV transmission.

HIV infections are diagnosed through the detection of antibodies specific to HIV within a blood sample. In people who are newly infected with HIV, antibodies usually reach detectable levels from three weeks to three months after infection. Test results that indicate the presence of such antibodies are considered 'positive' and are confirmed through follow-up screening before results are communicated to patients.

HIV testing in BC is routinely available through a family physician or a public health clinic. Testing is also done in other health care settings, such as hospitals. Most of the laboratory work related to processing HIV tests is performed by the BC Centre for Disease Control (BCCDC). The STD/AIDS Division at the BCCDC collects all HIV test data to ensure regional public health follow-up on new cases, as well as to track new and emerging developments in the epidemic.

HIV disease progression is measured primarily by increases in plasma viral load and decreases in CD4 cell count. Viral load refers to the amount of HIV in a person's blood. The higher the viral load, the faster the CD4 cell count is expected to decline. A high viral load also increases the efficiency of HIV transmission. CD4 cells are lymphocytes (white blood cells) responsible for coordinating much of the immune response and are one of the main targets damaged by HIV. Healthy people have CD4 cell counts of 400 to 1,400 cells per cubic millimeter. An HIV-infected person with a CD4 cell count below 200 cells per cubic millimeter has a severely compromised immune system and is at risk of rapid disease progression, opportunistic illnesses and premature death.

AIDS, Acquired Immune Deficiency Syndrome, is a technical term used to mark a late stage in the progression of HIV disease. It is a consequence of advanced HIV infection. Without treatment, AIDS-defining conditions (opportunistic infections) occur on average about 10 years after a person becomes infected with HIV.

There is no vaccine to prevent HIV infection, nor is there a cure for AIDS. The disease is both incurable and 100 per cent preventable. Recent advances in antiretroviral drug therapy have dramatically extended the length and quality of life for many HIV-positive persons. Today, with appropriate and timely access to treatment and support, HIV can be managed largely as a chronic disease.

HIV Treatment

The standard treatment for HIV is highly active antiretroviral therapy (HAART), which combines at least three drugs from at least two different classes of antiretrovirals. The aim of antiretroviral therapy is the long-term suppression of viral replication, which leads to improved CD4 counts and, in turn, prevents HIV-related illnesses, hospital utilization and AIDS-related mortality. Current treatment guidelines established by the BC Centre for Excellence in HIV/AIDS (BCCfE) recommend starting therapy when HIV-positive, asymptomatic individuals have a CD4 count of approximately 200 cells per cubic millimeter, or at anytime if they develop an AIDS defining illness, regardless of CD4 count.

HIV primary care is the medical management of HIV up to and including the initiation of antiretroviral therapy and the management of limited complications. HIV specialist care includes outpatient antiretroviral therapy management, assessment of outpatient complications of HIV and inpatient specialty care. General practitioners and family doctors in private practice provide the majority of HIV primary care in BC. For those individuals without access to a physician, HIV primary care is available through community or hospital-based clinics and/or emergency wards at hospitals in each health authority. HIV specialist care is provided on referral by a small number of infectious disease and other types of specialists throughout the province. These physicians are backed up by the HIV specialists at the BCCfE and the Oak Tree Clinic at BC Women's Hospital and Health Centre in Vancouver.

The BCCfE develops therapeutic guidelines for HIV management, including accidental exposure, opportunistic infections and antiretroviral therapy. It provides integrated HIV primary and specialist care to patients in downtown Vancouver through the Immuno-Deficiency Clinic (IDC) at St. Paul's Hospital, as well as complex care to individual patients across the province on a referral basis. The BCCfE also provides consultation support to BC physicians who provide care to people living with HIV and continuing education for physicians, nurses and allied health professionals.

The Oak Tree Clinic develops best practices for HIV drug treatment for women and children and provides consultation support to BC physicians who provide HIV care to female patients. The clinic also provides specialist care for children, youth and women living with HIV – including pregnant women – and delivers support services for affected families. In the lower mainland, most pregnant women with HIV are referred to Oak Tree Clinic for services aimed at improving maternal health and preventing the transmission of HIV from mother to child. The clinic offers two pediatric outreach clinics a year in Victoria, where local doctors work with Oak Tree specialists to treat patients.

HIV Epidemiology

HIV Prevalence²

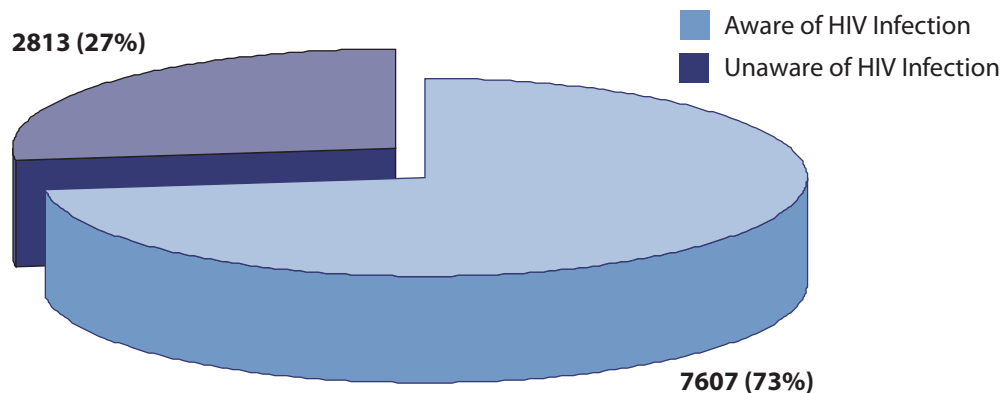
At the end of 2005, an estimated 8,600 - 12,200 people in B.C. were living with HIV and AIDS, for estimated median prevalence of 10,420 people. This represents approximately 18 per cent of the estimated 58,000 Canadians living with HIV and AIDS in 2005. The HIV prevalence range in B.C. remains approximately the same as the last available estimate compiled by the Public Health Agency of Canada for the calendar year 2002 (8,000 – 13,000).

In 2005, HIV prevalent infections in B.C. were found primarily among gay men and other men who have sex with men (43 per cent or 4450 infections), injection drug users (36 per cent or 3800 infections) and individuals who attribute their infections to heterosexual exposure (18 per cent or 1800). One per cent of HIV prevalent infections were among people from HIV-endemic countries and another one per cent was attributable to other causes, such as blood transfusion and/or occupational exposure.

HIV prevalent infections rose steadily during the 1980's, corresponding to the initial rise in HIV infection in the B.C. population. This rise reached a plateau in the early to mid 1990's, likely as a result of both increased mortality and effective prevention interventions. Prevalent infections began to rise again in the late 1990's due to ongoing new infections within the province and the impact of new treatments that enabled HIV-positive individuals to live longer, effectively reducing HIV-related mortality.

A continuing challenge is the number of individuals living with HIV who are unaware of their infection. The Public Health Agency of Canada estimates that in 2005, approximately 27 per cent of people living with HIV/AIDS in Canada were unaware of their infection. While this estimate is lower than in previous years, efforts to engage this population in appropriate care, treatment and support remain a priority.

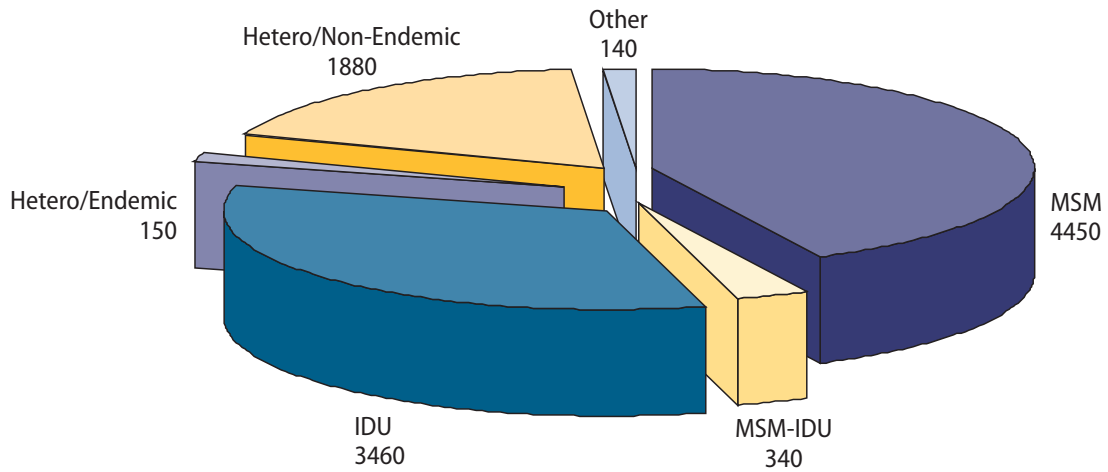
B.C. HIV Prevalence Estimates (2005)



Source: Public Health Agency of Canada. Surveillance and Risk Assessment Division

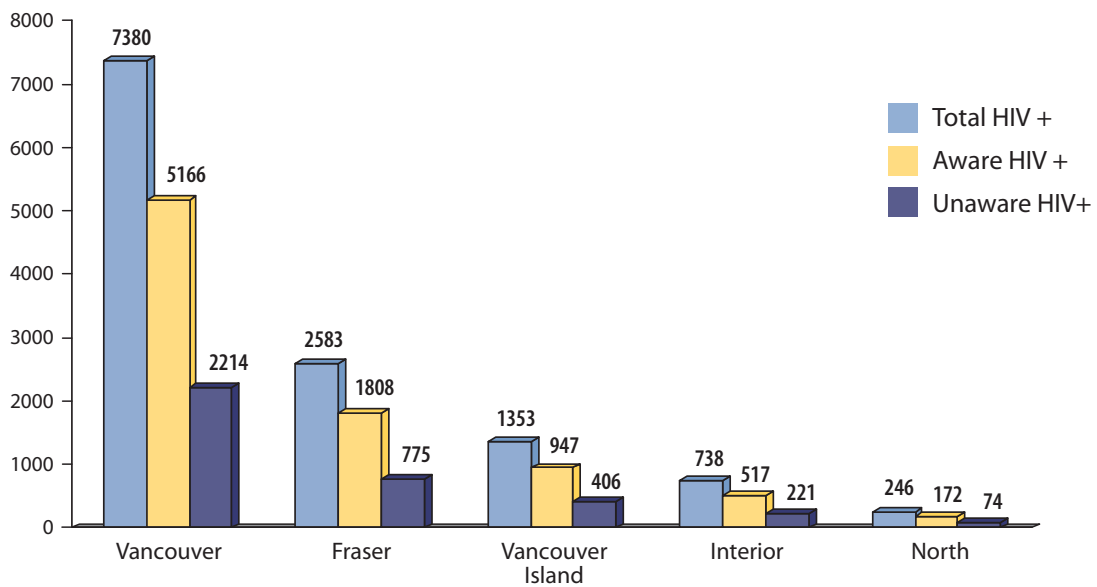
² Public Health Agency of Canada. Surveillance and Risk Assessment Division

B.C. HIV Prevalence Estimates by Risk Category (2005)



Source: Public Health Agency of Canada. Surveillance and Risk Assessment Division

B.C. HIV Prevalence Estimates by Health Authority (2005)



Source: BC Centre for Excellence in HIV/AIDS, based on upper limit of BC HIV prevalence range, unpublished data, 2006

Newly Identified HIV Infections in 2005^{3,4}

In 2005, the rate of newly reported HIV infections in B.C. fell to 9.7 cases per 100,000 population, the first time since 1985 that this rate has dropped below 10 cases. This represented 410 new infections for the year, down 7.7 per cent from 444 in 2004.

Men accounted for the majority of new infections, with an overall rate of 15.7 cases per 100,000 population (80.2 per cent of the total), while women accounted for a rate of 3.7 per 100,000 in 2005 (19.6 per cent of the total). Aboriginal British Columbians accounted for 12.7 per cent of new infections in 2005.

In Canada, the rate of new HIV infections was 7.7 cases per 100,000 population, or 2,483 new infections in 2005. Although the infection rate in B.C. fell between 2004 and 2005, it still remained well above the national rate. New infections in B.C. represented approximately 16.5 per cent of the total number of new infections in Canada in 2005, slightly higher than the province's 13.2 per cent share of the total Canadian population.

% of Newly Reported HIV Infections in 2005	B.C.	Canada
Among Males	80.2 %	73.6 %
Among Females	19.6 %	25.4 %
Among Aboriginal Peoples	12.7 %	22.7 %*

*percentage of total among provinces that report ethnicity data

Priorities for Action sets an ambitious goal of 50 per cent reduction in the number of persons testing newly positive for HIV in B.C. by 2007, using 2001 data (440 new infections) as the baseline. This target is to be met incrementally over the years 2003 to 2007. The annual target for 2005 was 308 people testing newly positive for HIV. The actual number of new HIV infections reported in 2005 was 410. Although this is a decrease from the previous year, it does not represent a large enough reduction to meet the 2005 target. Clearly, evidence-based prevention aimed at populations most vulnerable to HIV must remain a high priority for all health regions.

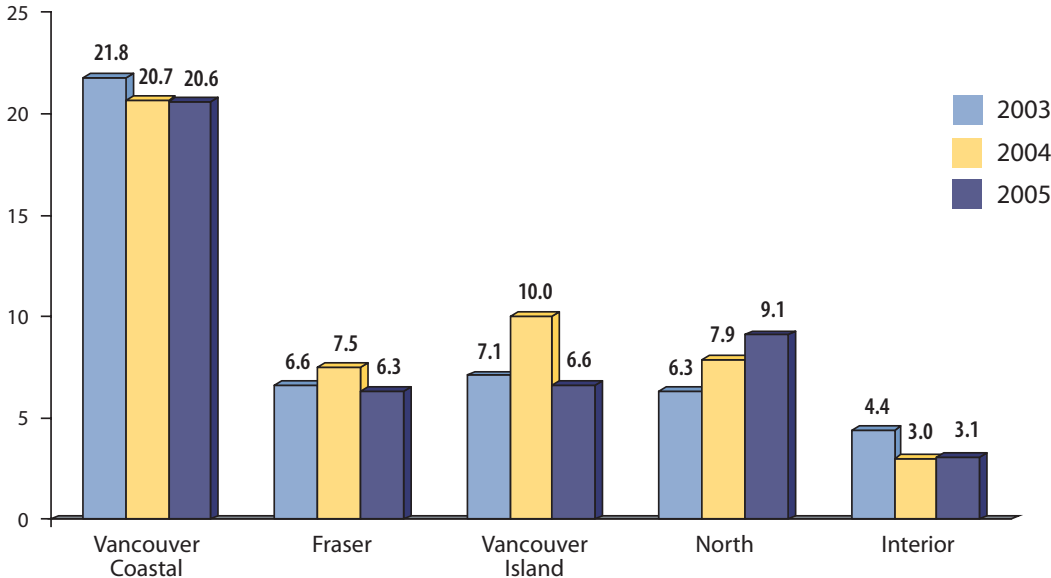
In 2005, the number of HIV tests performed in B.C. increased 8.3 per cent from 154,208 in 2004 to 166,938. Approximately 28 per cent of these tests were performed to screen expectant mothers for HIV. Because this type of testing is routinely recommended, changes in these testing totals may simply represent fluctuations in the number of pregnancies in B.C. If these tests are subtracted, approximately 120,544 HIV tests were performed in 2005 due to concerns about personal risk. This represents a 4.9 per cent increase over 2004 for the same sub-group.

³ BC Centre for Disease Control, Soul Access Project, PowerPlay Cube

⁴ Surveillance and Risk Assessment Division (2006). HIV and AIDS in Canada Surveillance Report to December 31, 2005. Public Health Agency of Canada.

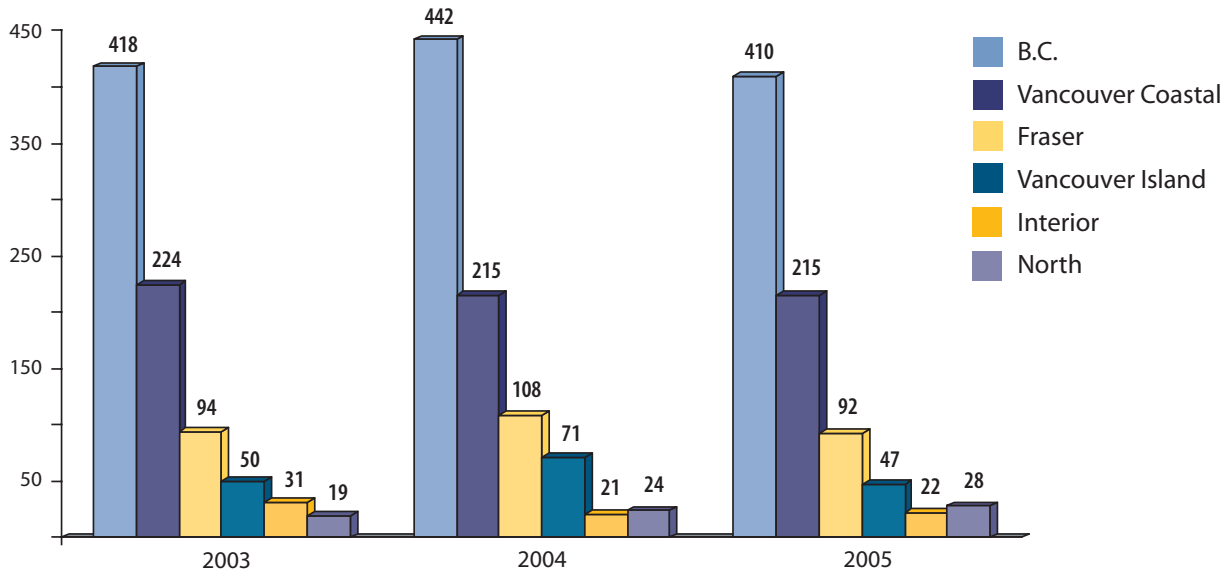
Across the health regions, Vancouver Coastal Health Authority (VCH) continues to have the highest rate of newly identified HIV infections at 35.3 cases for men and 30 cases for women per 100,000 population. VCH accounted for 53 per cent (253) of all new infections in B.C. in 2005. The Interior Health Authority (IHA) had the lowest rate of HIV infection with 4.6 cases for men and 1.7 cases for women per 100,000 population in 2005. IHA accounted for 6 per cent (22) of new infections in B.C. Overall, four of the five regional health authorities reported a decline in the rate of new HIV infections between 2003 and 2005, with the exception of the Northern Health Authority (NHA) where rates increased from 6.3 cases (19) in 2003 to 9.1 cases (28) in 2005 per 100,000 population. The increase in B.C.'s North has been driven largely by injection drug use and its associated risks, especially among Aboriginal youth.

Rate of Persons Testing Newly Positive for HIV in B.C. by Health Authority (per 100,000 population), 2003-2005



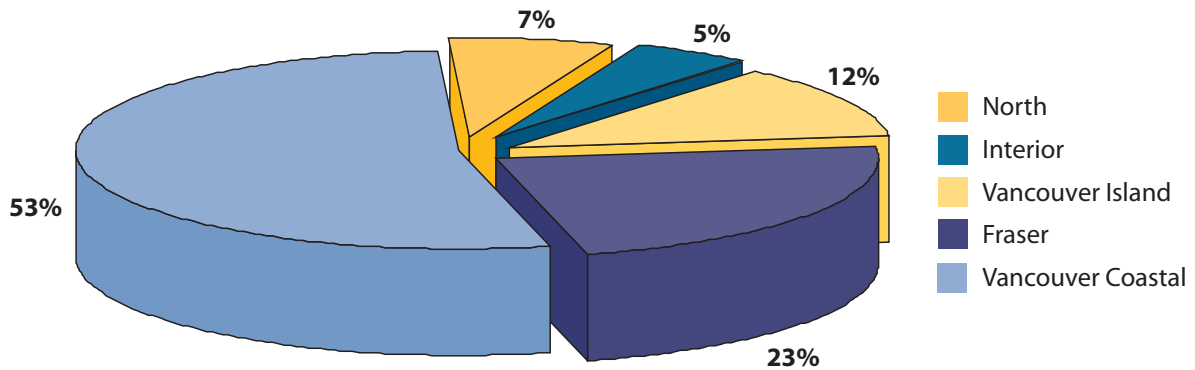
Source: BCCDC, Unpublished surveillance data

Number of Persons Testing Newly Positive for HIV in B.C. by Health Authority, 2003-2005



Source: BCCDC, Unpublished surveillance data

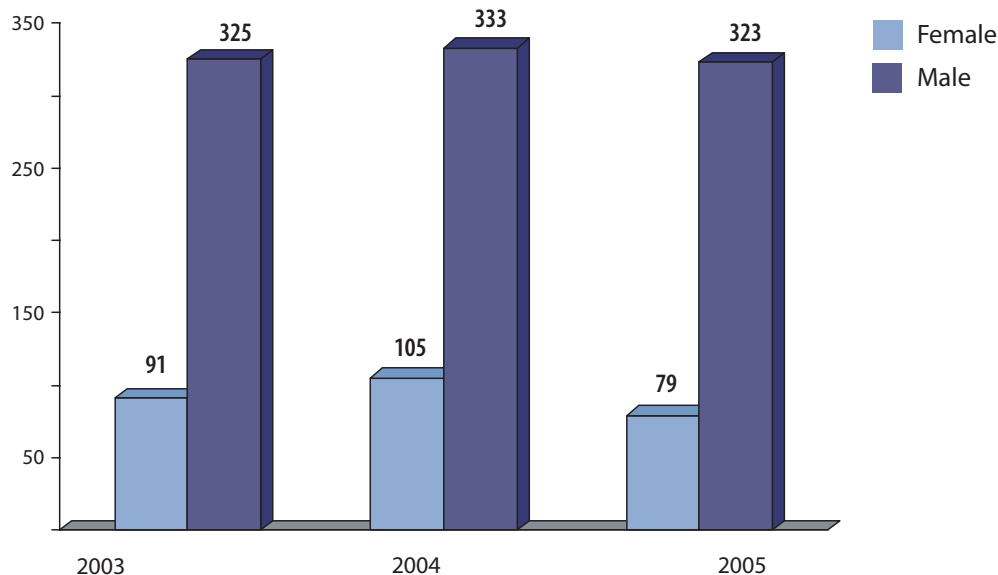
Share of Persons Testing Newly Positive for HIV by Health Authority (2005)



Source: BCCDC, Unpublished surveillance data

A gendered analysis of new HIV infections by health authority reveals some interesting differences. In the Vancouver Island Health Authority (VIHA), the decrease in new HIV infections from 2004 to 2005 was mainly accounted for by fewer positive test results among women, which dropped from 27 (38 per cent) in 2004 to nine (19 per cent) in 2005. In NHA, the increase from six new infections in 2004 to 10 in 2005 was mainly accounted for by more Aboriginal women receiving positive tests. In the Fraser Health Authority (FHA), the decrease in new infections from 108 in 2004 and 92 in 2005 was primarily accounted for by fewer men receiving positive test results -- 80 (74 per cent) in 2004 and 68 (74 per cent) in 2005.

Number of Persons Testing Newly Positive for HIV in B.C. by Gender, 2003-2005



Source: BCCDC, Unpublished surveillance data

Within the health authorities, rates of newly reported HIV infections tend to vary from one health service delivery area (HSDA) to another. In most HSDAs, the number of people testing positive for HIV each year is small, therefore, caution is warranted in drawing conclusions about emerging trends. However, many HSDAs experienced an increase in new HIV infections in 2004 and a decrease in 2005. HIV became a reportable disease in May 2003 and it is likely that this, along with enhanced contact tracing, partner notification and testing of at risk populations by health authorities, led to an increase in of new HIV infections identified in 2004. Successful partner notification efforts may also be partly responsible for declines in HSDA rates in 2005, as a larger proportion of HIV-infected individuals became aware of their status and presumably adopted safer sexual and drug use behaviours.

Overall, rates of newly reported HIV infections have remained static or declined slightly in most HSDAs over the past 3 years. Two HSDAs – Thompson Cariboo Shuswap and Vancouver – have seen declines in HIV rates over this period of 2 or more cases per 100,000. However, contrary to provincial trends, data from four HSDAs indicate increases in the rates of newly reported HIV infections. Fraser East and Northwest HSDAs had increases of 2.8 and 2.3 cases respectively between 2003 and 2005, although both reported declines within the last year. In the same period, Kootenay Boundary reported a 3.8 case increase, jumping from 2.5 cases in 2003 to 6.3 cases per 100,000 last year (with no new cases reported in 2004). The largest increase can be seen in the Northern Interior HSDA, which reported a 4.3 case increase between 2003 and 2005.

Rate of New Positive HIV Tests by Health Service Delivery Area (per 100,000 population)

Health Service Delivery Area	2003	2004	2005	Change 2003-2005
Richmond	3.5	4.1	4.0	0.5
Vancouver	35	33	33	-2.0
North Shore	4.5	4.4	4.0	-0.5
South Vancouver Island	10.5	13.3	9.5	-1.0
Central Vancouver Island	4.1	7.7	4.8	0.7
North Vancouver Island	3.5	5.1	1.7	-1.8
Fraser East	3.2	7.3	6.0	2.8
Fraser North	8.7	10.1	7.5	-1.2
Fraser South	6.1	5.3	5.4	-.07
Northwest	3.6	9.5	5.9	2.3
Northern Interior	9.9	7.8	14.2	4.3
Northeast	1.0	6.0	1.5	0.5
East Kootenay	1.2	1.2	1.2	0
Kootenay Boundary	2.5	0	6.3	3.8
Okanagan	5.0	4.6	3.4	-1.6
Thompson Cariboo	5.5	2.3	2.3	-3.2

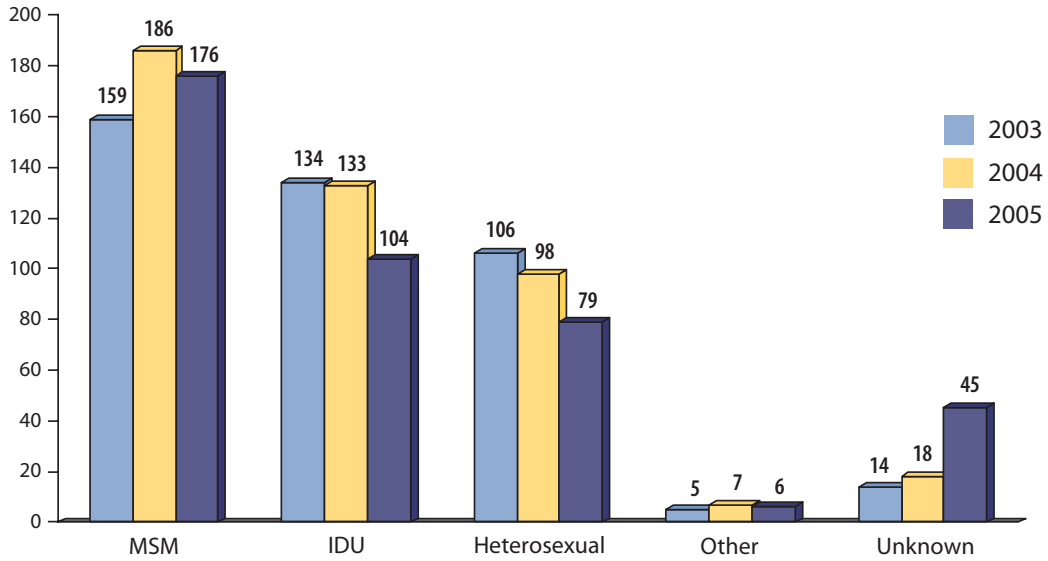
Source: BCCDC, Unpublished surveillance data

The number of new HIV infections detected through the screening of expectant mothers has declined by 50 per cent since 2003 (10 cases in 2003 versus 5 cases in 2005). While FHA had the largest number of positive tests found during perinatal screening in 2003 (6 cases), NHA had the largest number in 2005 (3 cases). From 2003 to 2005, there were no confirmed cases of vertical transmission of HIV from mother to child in B.C.

Gay men and other men who have sex with men (MSM) accounted for 44 per cent of persons testing newly positive for HIV in 2005 in B.C. The number of MSM who tested positive for HIV fell to 176 in 2005 from 186 in 2004, but was still up from 2003 when only 159 persons tested positive for HIV. Approximately 77.8 per cent of these new infections were reported within VCH. The number of new infections among intravenous drug users (IDUs) in B.C. was down to 104 in 2005 from 134 in 2003, part of a consistent downward trend in this population group that began in 2002. The number of new infections identified in B.C. within a correctional facility in 2005 was five. This is consistent with the previous year, but is half of the 10 new infections in 2003. Voluntary testing for HIV with pre- and post-test counselling is available in both provincial and federal correctional facilities.

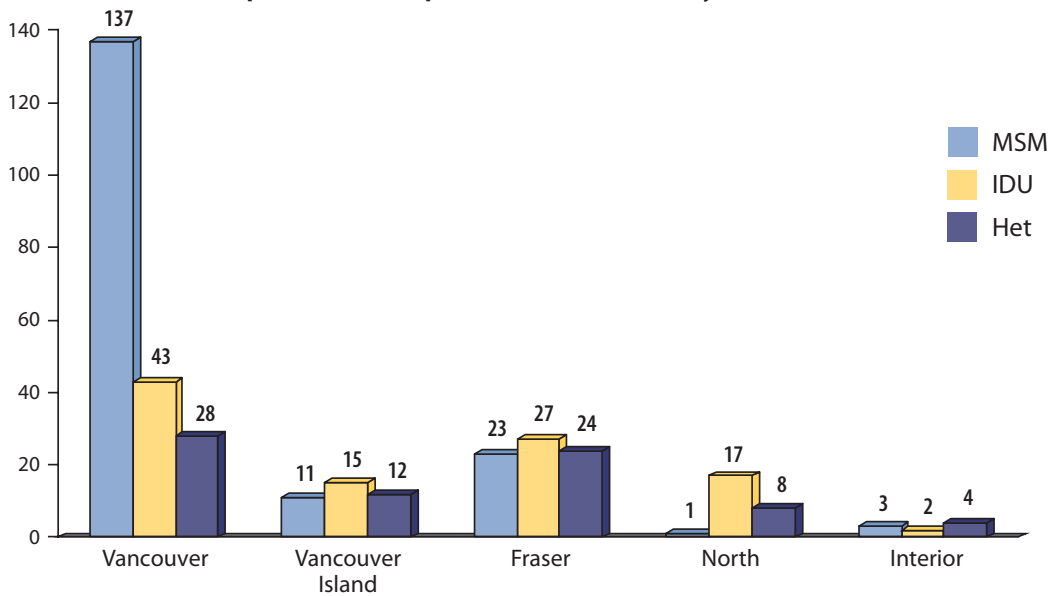
In 2005, the number of HIV tests performed in B.C. increased 8.3 per cent to 166,938, up from 154,208 in 2004.

Number of Persons Testing Newly Positive for HIV in B.C. by Population Group, 2003-2005



Source: BCCDC, Unpublished surveillance data

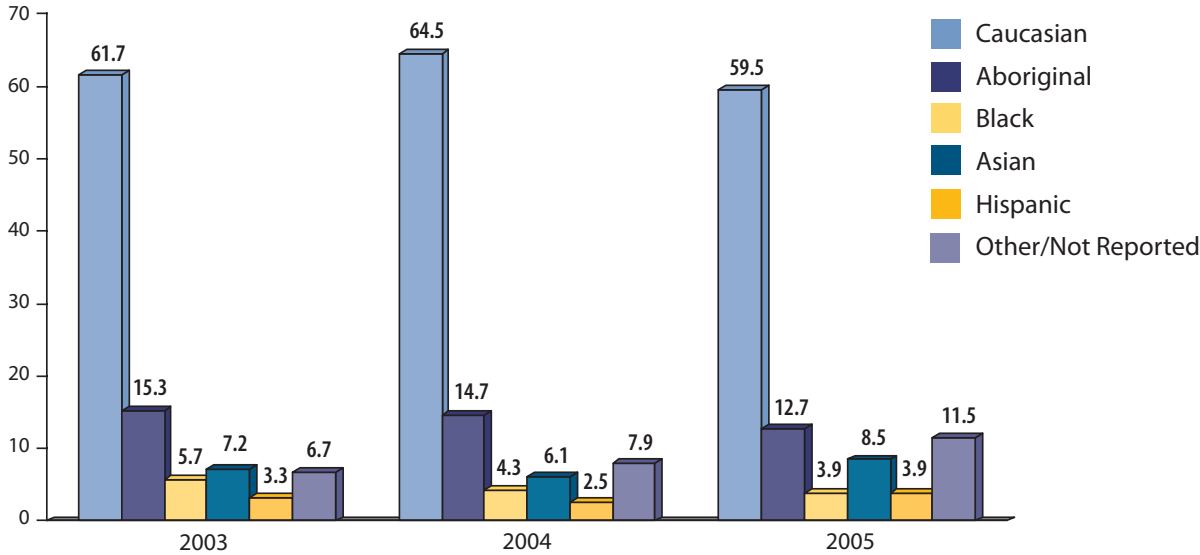
Number of Persons Testing Newly Positive for HIV by Population Group and Health Authority, 2003-2005



Source: BCCDC, Unpublished surveillance data

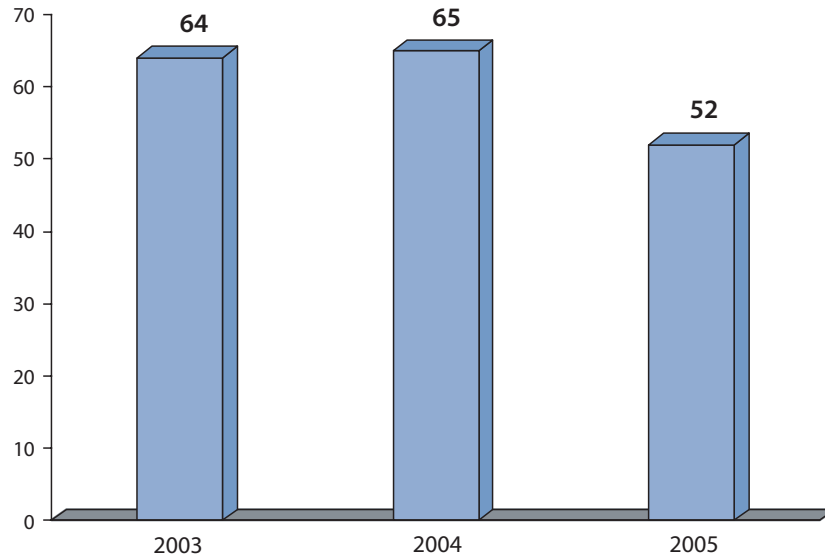
The majority of individuals in B.C. who tested positive for HIV in 2005 were Caucasian (67 per cent), with Aboriginal people – First Nations, Inuit and Metis – comprising the next largest category of new infections (14 per cent). The number of new HIV infections among Aboriginal people has fallen from 66 in 2002 to 48 in 2005. However, as Aboriginal British Columbians comprise an estimated 4 per cent of the province’s population, they are still overrepresented among new HIV infections. Data also suggests that a small increase in new HIV infections among people of Asian decent occurred between 2003 and 2005 (30 in 2003 compared with 35 in 2005). Generally, women have a lower rate of new HIV infections than men across all ethno-cultural groups, with the exception of the Aboriginal population, where the number of new positive tests in 2005 was roughly the same for women and men.

Percentage of Persons Testing Newly Positive for HIV in B.C. by Ethnicity, 2003-2005



Source: BCCDC, Unpublished surveillance data

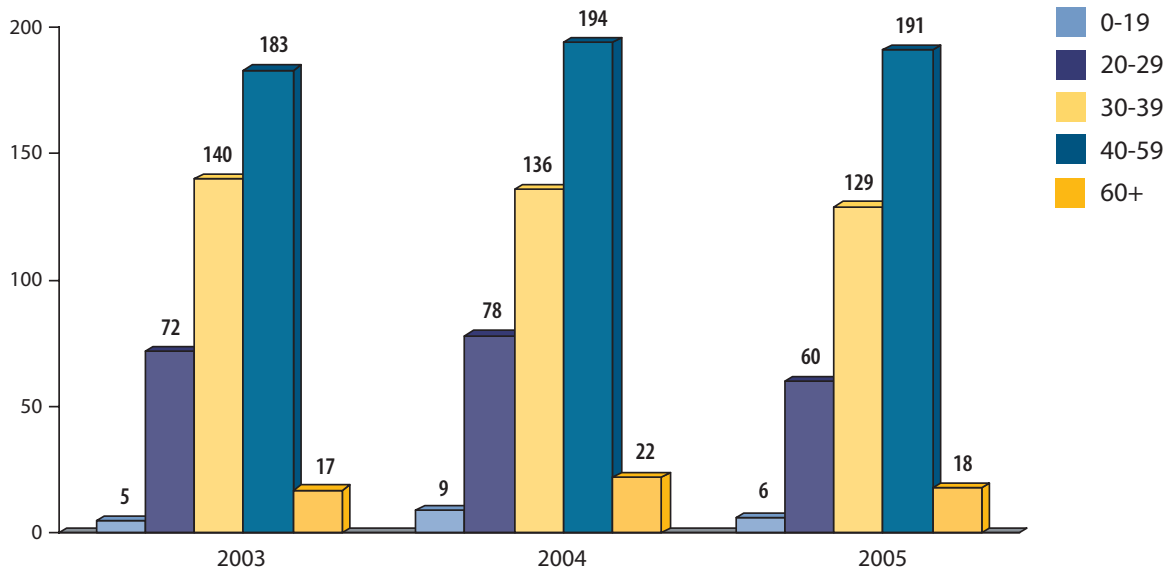
Number of Aboriginal Persons Testing Newly Positive for HIV in B.C., 2003-2005



Source: BCCDC, Unpublished surveillance data

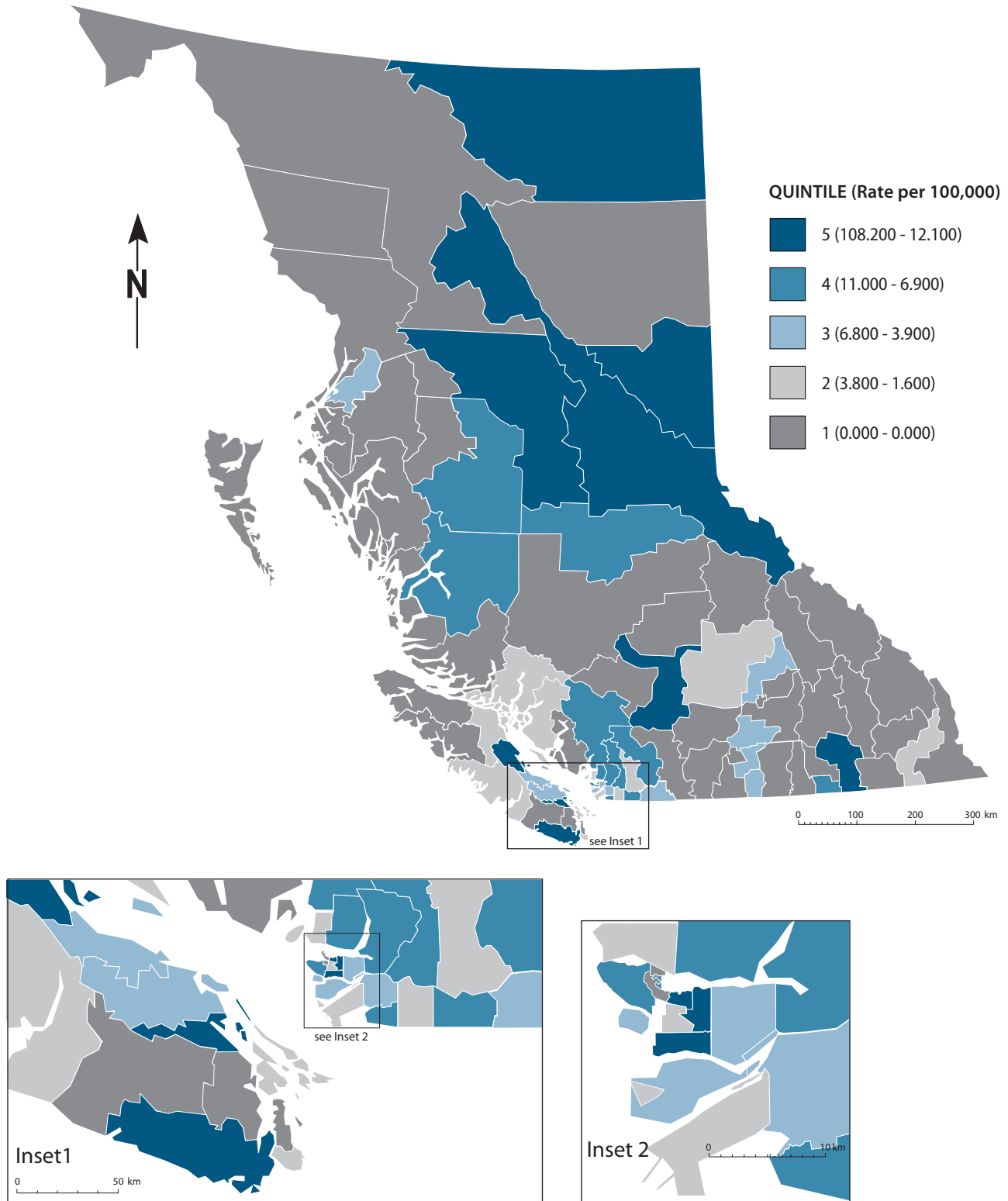
The breakdown of newly reported infections by age in B.C. remained relatively consistent from 2003 to 2005. Most new infections were found among individuals between the ages of 30-59 years.

Number of Persons Testing Newly Positive for HIV in B.C. by Age, 2003-2005



Source: BCCDC, Unpublished surveillance data

New HIV Infections by Local Health Area, British Columbia, 2005



Goal #1: Prevention

To reduce the number of new HIV infections by 50% between 2003 and 2007

Introduction

Priorities for Action acknowledges that effective HIV prevention must encompass activities that are aimed at both the general population and specific population groups that experience increased vulnerability to HIV infection. While broad-based prevention and education efforts can help to address long-standing issues of HIV-related stigma and discrimination, it is the highly focused efforts to engage the most vulnerable population groups that will enable B.C. to meet the ambitious prevention goal in Priorities for Action.

Targeted prevention efforts address specific individual, social and environmental risk factors leading to HIV infection in identifiable population groups. For people who are already infected with HIV, targeted prevention seeks to reduce the harms from unsafe sex and unsafe drug use and to maintain individual health and well-being. These interventions are critical to successful engagement of populations, such as gay men, other men who have sex with men, injection drug users, Aboriginal people, incarcerated persons, street-involved youth and women.

In B.C., there remains a clear need for strategic prevention planning to address the individual risk factors and social determinants of health in order to reduce HIV vulnerability and incidence. The research and evaluation literature, as well as the experiences of B.C. communities and other jurisdictions, clearly demonstrate what works in preventing HIV transmission. To achieve the annual HIV prevention targets, a comprehensive and coordinated response to HIV prevention both within and between health authorities is required in B.C. Strategic prevention efforts are most effective when they are evidence-based, tailored to meet local needs, culturally relevant, delivered in partnership with the community, regionally coordinated and aligned with provincial prevention priorities.

Public Education⁵

The Sexually Transmitted Disease/AIDS Control Division of BCCDC coordinates province-wide efforts to reduce the spread of sexually transmitted infections (STI) and HIV and to minimize their adverse health effects. Educational activities delivered through BCCDC are aimed at both the general population and at-risk populations throughout B.C.

⁵ Program data, BC Health Authorities

In 2005, BCCDC delivered HIV-specific education activities to approximately 11,900 people across the province. Special initiatives included an education program on HIV prevention and transmission for remote communities, campaigns to promote immunizations among HIV-positive populations, nurse outreach programs targeting vulnerable populations in downtown Vancouver and new men's wellness programs on northern Vancouver Island.

In 2005, B.C.'s regional health authorities and their community partners offered a broad range of public education activities geared toward the needs of their particular communities and geographic locations. Many of the educational materials were translated into languages other than English, including Spanish, Chinese, Korean, Japanese, Vietnamese and Punjabi.

In 2005, FHA worked with the Sto:lo Nation to provide HIV and STI educational activities. In VIHA, the Victoria AIDS Resource & Community Service Society initiated the "Labels Stick" campaign for the general public to raise awareness about HIV stigma and discrimination during World's AIDS Day, 2005. AIDS Vancouver Island initiated a Queer Youth Community Development Project providing peer education to school-based youth using interactive theatre and games.

In VCH, public education activities were aimed at both the general population of urban Vancouver and at risk populations, such as men who have sex with men, injection drug users and street involved youth. Education activities for the general population ranged from information libraries, telephone hotlines and educational displays in public places to safer sex campaigns associated with World AIDS Day and free condom distribution in bars, restaurants and at public events.

In IHA, public education services were delivered by community agencies in urban centres (Kelowna) and smaller communities (Shuswap). Informational services and activities were offered to both the general public and at risk populations. The Williams Lake Boys and Girls Club, for example, offered information sessions for high-risk teens, pregnant women, street-outreach, as well as general adult education sessions.

In NHA, wide-ranging educational activities were delivered through community agencies and public health units alike. HIV education for school-based youth was offered throughout the many small and rural communities in the region. Community-based Positive Living North offered HIV prevention education for the general public and information services designed specifically for Aboriginal communities. Positive Living Northwest initiated HIV education programs for Aboriginal people that were led by Aboriginal staff and delivered through art shows, on-site needle exchanges and meal programs.

At present, inconsistent approaches to collecting data on HIV-related activities and outputs among health authorities makes comparative analysis difficult. With this in mind, the following table reports on some of the HIV-related educational activities across the province.

Health Authority	# of Educational Activities	# of People Reached
Provincial Health Services	149	11,994
Vancouver Coastal Health	23	27,941
Fraser Health	4	230
Norther Health	40	1,664
Vancouver Island Health	2005 data not available	2005 data not available
Interior Health	2005 data not available	2005 data not available

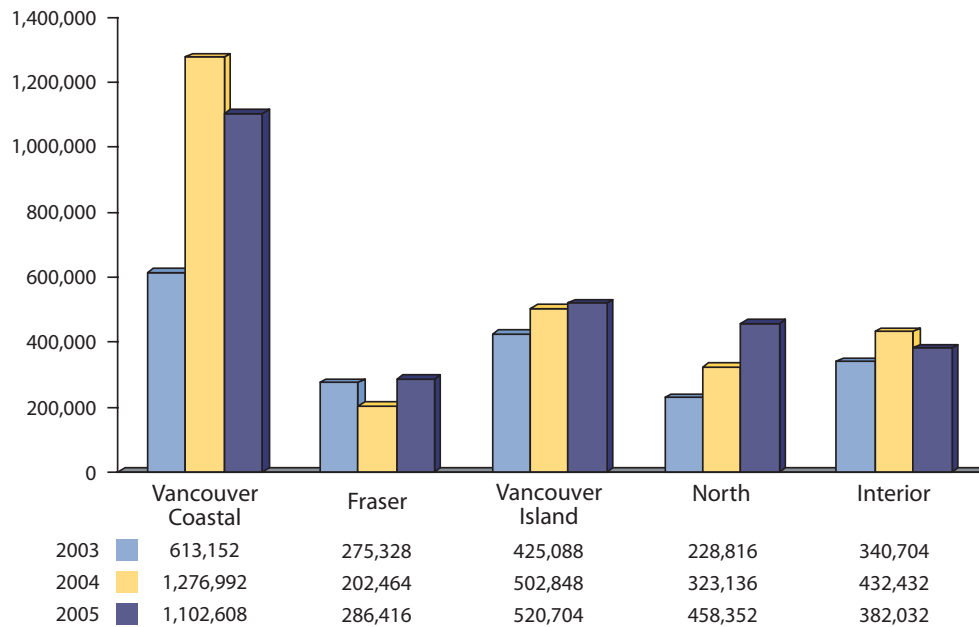
The B.C. Ministry of Education is currently revising the curriculum requirements for health and personal planning education. The proposed curriculum will require formal instruction in HIV/AIDS, starting in elementary school. The new curriculum will also articulate HIV-related learning outcomes for students in grades 6-12 and achievement indicators that must be monitored by teachers.

Targeted Prevention^{6,7}

Harm and Risk Reduction Supplies

Expansion of low threshold harm and risk reduction initiatives has been identified as a key strategy to prevent the spread of HIV and hepatitis C. The province continues to support low threshold initiatives through the free distribution of harm and risk reduction supplies. During 2005, BCCDC provided over 2.7 million male condoms and almost 31,500 female condoms to the five regional health authorities. This compares favorably to 2003 where approximately 1.8 million male condoms and over 19,000 female condoms were distributed province-wide. BCCDC also provided over 3.4 million needles through the health authorities in 2005, a significant increase over 2003 when almost 2.7 million needles were distributed.

Number of Male Condoms Supplied to Health Authorities, 2003-2005



Source: BC Centre for Disease Control, Harm Reduction Policy and Supplies Committee

Sexual Health and Risk Reduction

Sexual health initiatives focus on factors that contribute to individual and population vulnerability to the sexual transmission of HIV. Successful initiatives take into account a variety of social factors, biological factors and the role of other sexually transmitted infections in increasing risk of HIV infection. Activities are tailored to meet the needs of target populations with respect to gender, sexuality, age and culture. Sexual health education includes practical information about methods to reduce risk of sexually transmitted infections. It also includes provision of related resources, such as condoms and instruction on their proper use.

⁶ BC Centre for Disease Control, Harm Reduction Policy and Supplies Committee

⁷ Program data, BC Health Authorities

In 2005, health authorities and their community partners delivered HIV-related sexual health services to a variety of population groups in a number of settings. In VCH, initiatives that addressed HIV prevention in the context of broader sexual health and well-being were offered to gay men, youth and street-involved women.

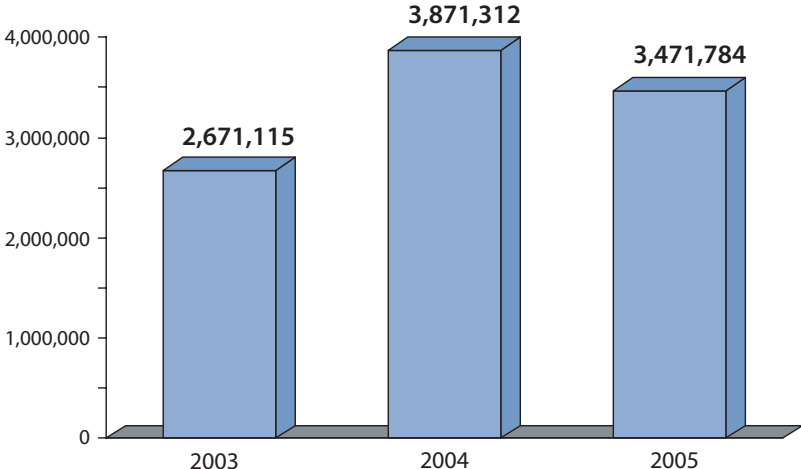
In NHA, public health nurses spoke to classes in junior and senior high schools about sexual health, focusing on prevention of sexually transmitted diseases and reproductive health issues. In both IHA and FHA, similar work was performed by public health nurses and educators, some of whom were employed by community-based agencies, such as the FHA's Lower Mainland Purpose Society.

Within Provincial Health Services Authority (PHSA), the BCCDC's STD/AIDS Control Division engaged in a broad range of sexual health-related activities throughout the year, from identification and treatment of sexually transmitted diseases to training and support of professionals across the province. Many of these initiatives were delivered to Aboriginal groups and communities through the division's Chee Mamuk program. In 2005, B.C. Persons with AIDS Society aimed at improving the sexual health of HIV-positive people, while the Positive Women's Network focused on women's reproductive health and emerging, women-centred prevention technologies, such as microbicides.

Needle Exchange Services

Sterile syringes distributed to injection drug users across the province are largely supplied through a centralized purchasing program coordinated by BCCDC. In 2005, BCCDC reported that 170 service delivery points across the province ordered syringes from this program. Between 2003 and 2004, the number of syringes supplied to these access points increased by approximately 45 per cent and then decreased by 10 per cent between 2004 and 2005. Although annual changes in this program are driven in part by the logistics of the ordering process, health authorities also reported a 6 per cent decrease in the number of syringes distributed in 2005. This may reflect changes in patterns of illegal drug consumption, including the mode of administration and/or the choice of drug.

Total Number of Syringes Distributed, 2003-2005

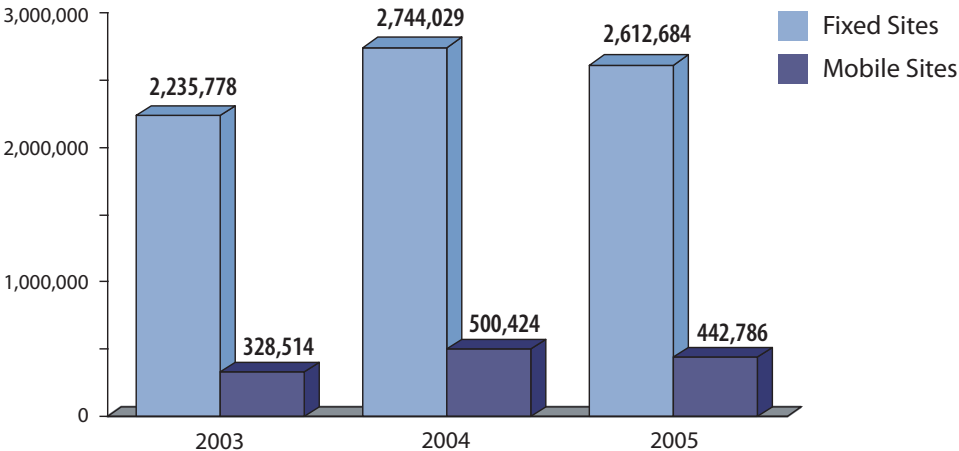


Source: BC Centre for Disease Control, Harm Reduction Policy and Supplies Committee

In 2005, VCH continued its commitment to decentralizing and expanding needle exchange services aimed at reducing the potential harm to individuals and the community. One of its key accomplishments in 2005 was the implementation of a needle exchange training initiative that provided instruction to service providers in safety, client engagement and other harm reduction topics. VCH also held its first meeting with needle exchange providers from across the health authority. VCH's ongoing commitment to the delivery of an expanded and coordinated approach to addictions services appears to be paying off. In 2005, the number of new HIV infections in VCH attributable to injection drug use was down 24.6 per cent from 2003.

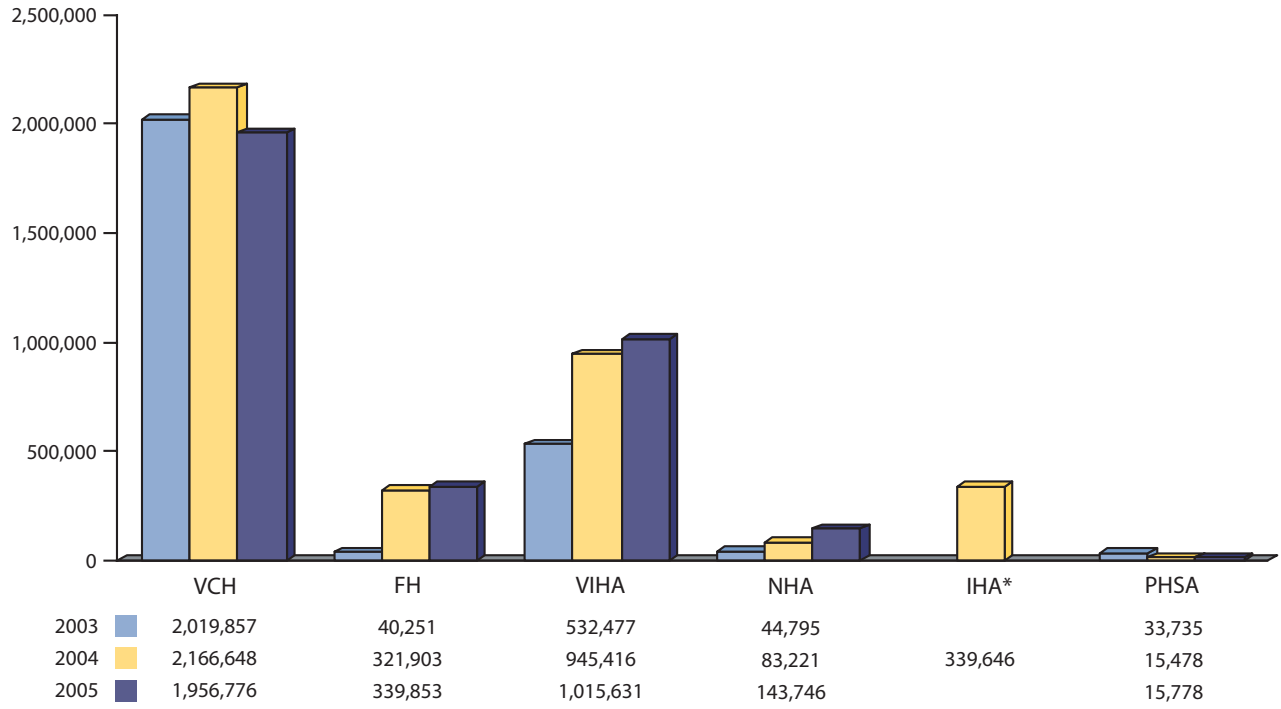
IHA has taken a community development approach to increasing access to clean syringes and safe disposal of used needles in the Thompson/Cariboo/Shuswap area. This approach, which is supported by highly engaging social marketing materials, has sparked interest in other health authorities, as well as in other provinces and territories across Canada.

Number of Syringes Distributed by Outlet, 2003-2005



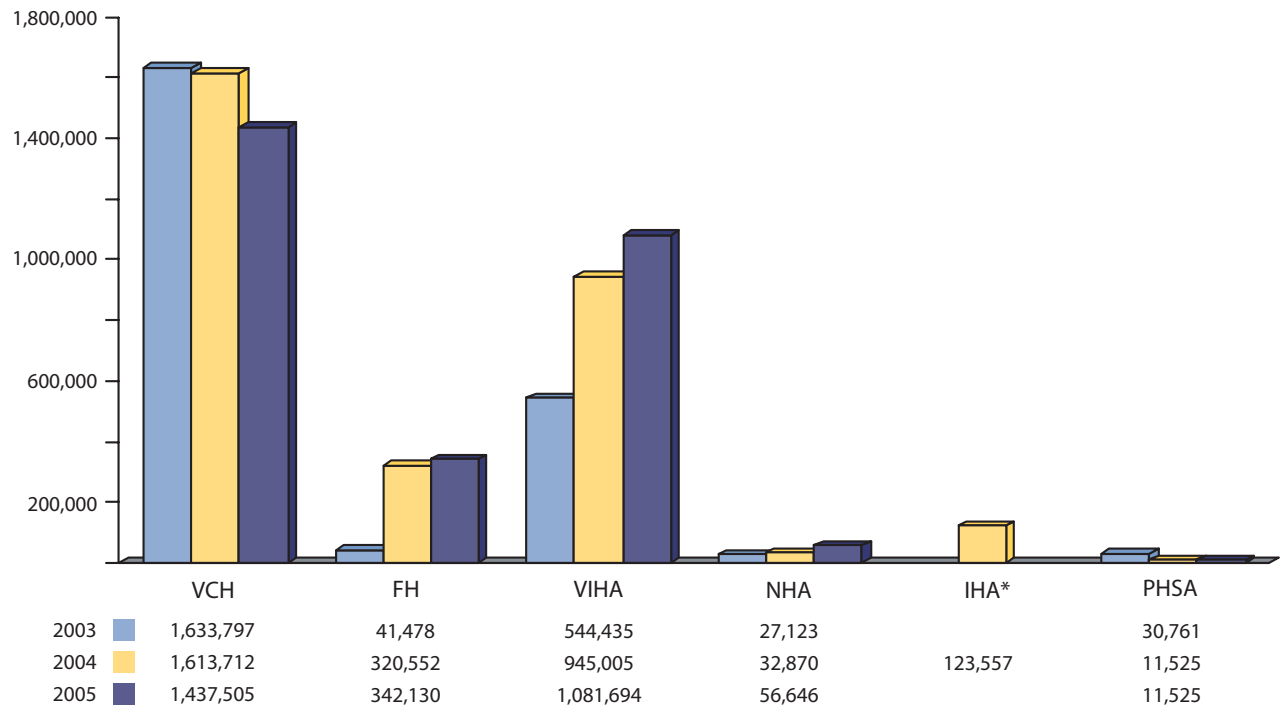
Source: BC Health Authorities; Data incomplete in some instances

Number of Syringes Distributed by Health Authority, 2003-2005



Source: BC Health Authorities; *IHA Data not available for 2003 and 2005

Number of Syringes Collected by Health Authority, 2003-2005



Source: BC Health Authorities; *IHA Data not available for 2003 and 2005

Methadone Maintenance Treatment⁸

Methadone Maintenance Treatment (MMT) is an effective substitution treatment for heroin addiction. It is delivered orally, thereby reducing the risk of HIV transmission through injection. According to data reported by the College of Physicians and Surgeons, the number of British Columbians receiving MMT had increased from approximately 7,868 in 2001 to 8,270 in 2004. However, in their 2005 annual report, the College reported 7,465 people enrolled as MMT clients, a decrease of 9.7 per cent from the previous year. Reasons for this decrease are not well understood at this time.

Year	% of MMT Clients
2001	7,868
2002	8,273
2003	8,124
2004	8,270
2005	7,465

Most people receiving MMT reside in VCH and FHA, although significant numbers reside in VIHA (e.g. Victoria, Nanaimo and North Island) and in IHA (e.g. Thompson/Okanagan areas).

Since the early 1990's, B.C. Corrections has recognized the need to continue MMT for clients who were receiving treatment before incarceration. Prior to 2005, there was limited ability to initiate MMT while incarcerated in provincial correctional facilities, unless the client was pregnant, living with HIV, or a recovering drug user at risk of relapse. Early in 2005, in response to escalating need and a clear medical recommendation, the initiation of MMT in provincial prisons was expanded to meet demand.

⁸ College of Physicians and Surgeons of British Columbia, Annual Reports.

Supervised Injection⁹

In September 2003, VCH opened Insite, North America's first legally sanctioned, supervised injection site as a scientific research project. Insite is a clean, safe environment where users can inject their own drugs under the supervision of clinical staff. Nurses and counsellors provide on-site first aid and wound care, as well as referral to primary health care, addictions and mental health services.

The BCCfE is formally evaluating Insite with the goal of assessing whether a supervised injection site will reduce the harms associated with injection drug use to individuals and the community. The evaluation findings, published in leading, peer-reviewed scientific journals over the past two years, clearly demonstrate the efficacy of Insite in reducing adverse health and social consequences of injection drug use:

- Insite is leading to increased uptake into detoxification programs and addiction treatment (*New England Journal of Medicine*, June 2006).
- Insite has not led to an increase in drug-related crime (*Substance Abuse Treatment, Prevention, and Policy*, May 2006).
- Insite has reduced the number of people injecting in public and the amount of injection-related litter in the Downtown Eastside, both notable improvements for people who live and work in the neighbourhood (*Canadian Medical Association Journal*, September 2004).
- Insite is attracting the highest-risk users, those more likely to be vulnerable to HIV infection and overdose, and who were contributing to problems of public drug use and unsafe syringe disposal (*American Journal of Preventive Medicine*, August 2005).
- Insite has reduced overall rates of needle sharing in the community, and among those who used the supervised injection site for some, most or all of their injections, 70 per cent were less likely to report syringe sharing (*The Lancet*, July 2005).
- Nearly one-third of Insite users received information relating to safer injecting practices. Those who received help injecting from fellow injection drug users on the streets were more than twice as likely to have received safer injecting education at Insite (*The International Journal of Drug Policy*, July 2005).
- Insite is not increasing rates of relapse among former drug users, nor is it a negative influence on those seeking to stop drug use (*British Medical Journal*, January 2006).
- Insite is preventing overdose deaths and reducing hospital visits (*The International Journal of Drug Policy*, July 2006).

Progress Summary: Prevention

Although the numbers and rates of newly reported HIV infections are beginning to move in the right direction across most health service delivery areas, the target for reduction in new infections in B.C. was not achieved for 2005. In order to accomplish more significant reductions in HIV incidence, intensified efforts to engage population groups that are most vulnerable to HIV/AIDS remain a priority. Such efforts must be tailored to meet the specific prevention needs of populations and communities at greatest risk of infection in each health authority.

⁹ Findings from the BC Centre for Excellence in HIV/AIDS. For more information and specific references, visit: www.cfenet.ubc.ca.

Goal #2: Care, Treatment and Support

To increase the proportion of HIV-positive individuals linked to appropriate care, treatment and support services by 25 per cent between 2003 and 2007

Introduction

HIV care, treatment and support services refer to the range of community and hospital-based services that are needed to slow disease progression and improve quality of life for people living with HIV and AIDS. Care and treatment services include primary care, HIV primary and specialist care, HIV drug treatment, mental health and addictions services, supported self care, hospital care, home and community care, and end of life care. Support services include information, case management, advocacy and peer support for people living with HIV and AIDS, as well as services that address the social determinants of health, such as income, housing, social support and employment. Support services are aimed at improving care and treatment outcomes for HIV-positive individuals and reducing vulnerability to HIV for at-risk populations.

Currently, the most reliable measure of engagement in appropriate HIV care and treatment is the proportion of the total HIV population on highly active antiretroviral therapy (HAART). Other indicators measure access to care but not necessarily access to appropriate care. For example, increased hospital admissions for acute care may indicate a lack of available or accessible community care options for people living with HIV. Meaningful and reliable data on community care service utilization is also difficult to obtain and is not easily comparable across health authorities.

HIV Drug Treatment ¹⁰

The BCCfE manages the provincial HIV/AIDS Drug Treatment Program (DTP) which distributes antiretroviral drugs and other anti-HIV medications at no cost to individuals who are eligible for drug treatment. In 2005, an estimated 10,420 people were living with HIV/AIDS in B.C. That same year, approximately, 5,323 people were enrolled in the DTP, of whom 3,948 were on HAART and a further 1,375 people were not on any medication due to supervised treatment interruptions, side effects, toxicities, drug resistance or improving viral loads and CD4 counts. The proportion of the HIV prevalent population in B.C. on HAART in 2005 was approximately 38 per cent, up from the baseline of 30 per cent in 2001, and surpassing the 2005 target of 35 per cent coverage.

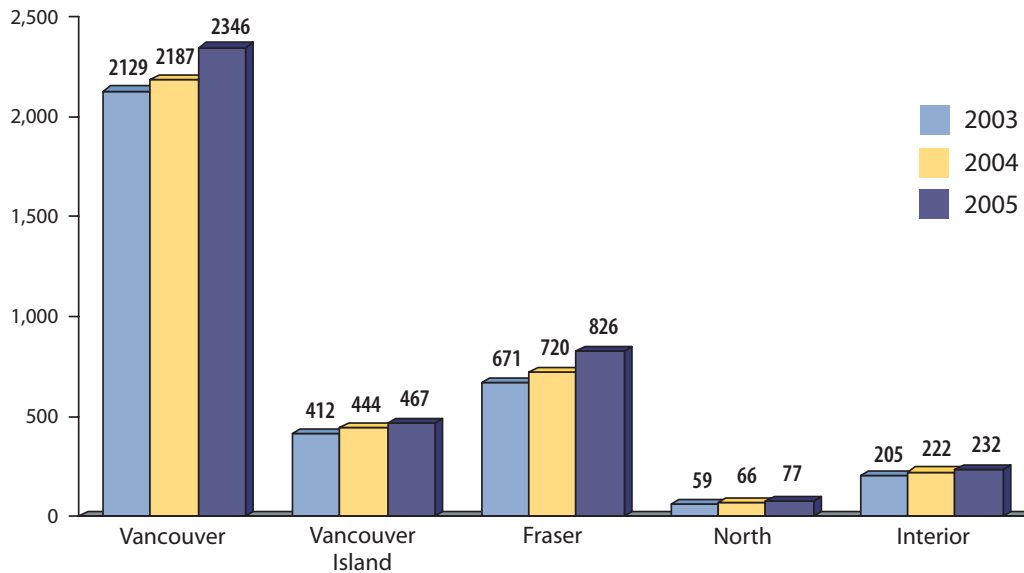
At this point in time, the BCCfE estimates that approximately 50 per cent of the total HIV population in B.C. is in medical need of drug treatment. These are individuals with AIDS-defining illnesses or CD4 counts of 200 or below. By this calculation, approximately 5,210 people in B.C. were medically eligible for HAART in 2005. With 3,948 people on HAART, the province achieved approximately 76 per cent coverage of the medically eligible HIV population in 2005. It should be noted that HIV prevalence estimates and calculations of HAART coverage based on those estimates are subject to considerable interpretation.

¹⁰ BC Centre for Excellence in HIV/AIDS, Drug Treatment Program.

While not articulated as a specific target within Priorities for Action, B.C. is striving to have all people living with HIV who fall within current treatment guidelines, and who wish to be on treatment, on HAART by 2007.

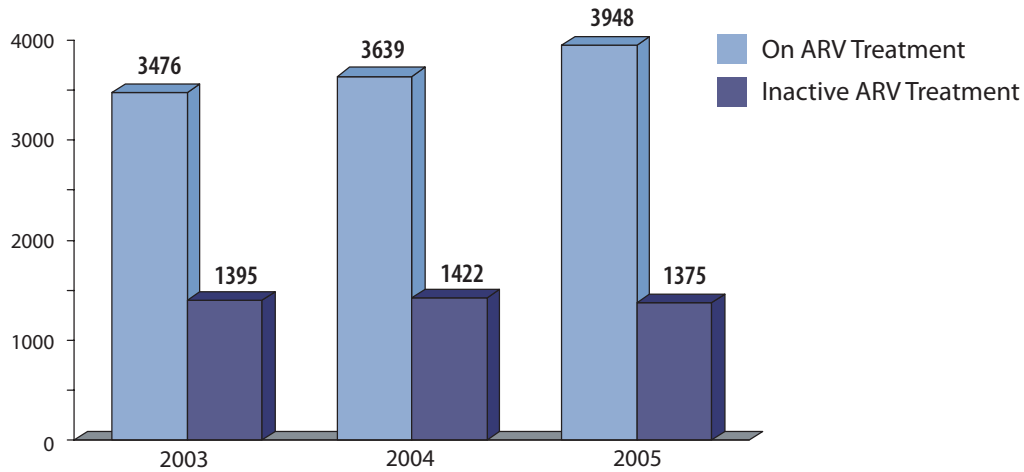
In 2005, the highest concentration of active DTP participants (e.g. those on HAART) occurred in VCH with 60 per cent (2,346), followed by FHA with 21 per cent (826) and VIHA with 12 per cent (467). The number of active participants rose across all health authorities between 2003 and 2005. The largest increase occurred in VCH, where 217 individuals initiated HAART during that period. NHA experienced the largest proportional increase, with 31 per cent more people on HAART between 2003 and 2005.

Number of Drug Treatment Program Participants Currently on ARV Treatment by Health Region, 2003-2005



Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

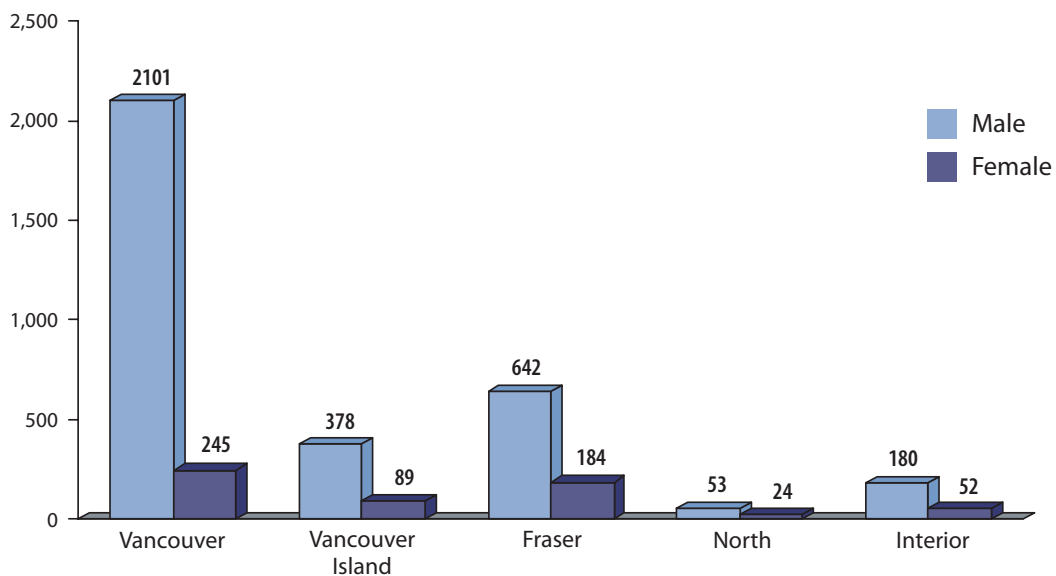
Number of Persons in B.C. on ARV Treatment Compared to Number of Inactive Participants, 2003-2005



Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

Of the active DTP participants in 2005, only 15 per cent (594) were women, yet approximately 22 per cent of reported HIV infections over the last decade have been among women. This suggests that more focused efforts are needed to engage women who are medically eligible for drug treatment in appropriate care, treatment and support.

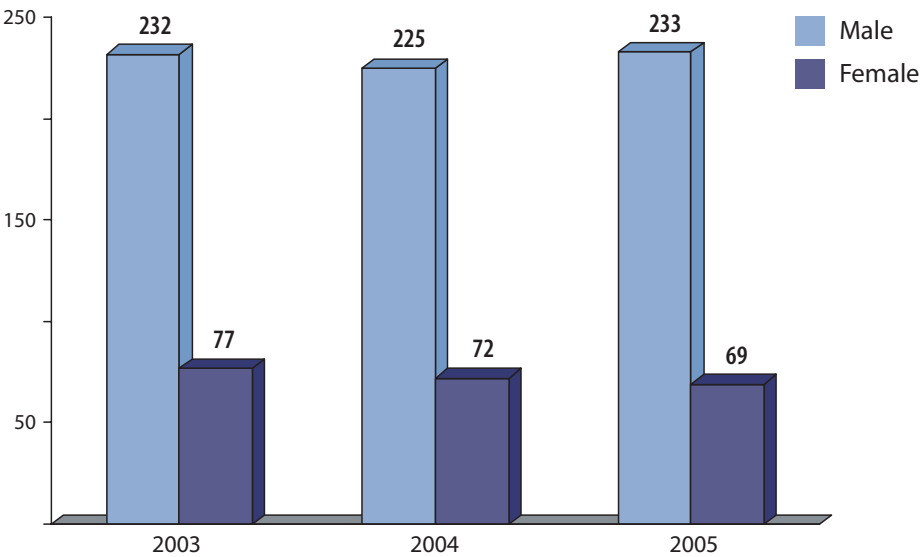
Number of Drug Treatment Program Participants Currently on ARV Treatment by Gender and Health Authority, 2005



Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

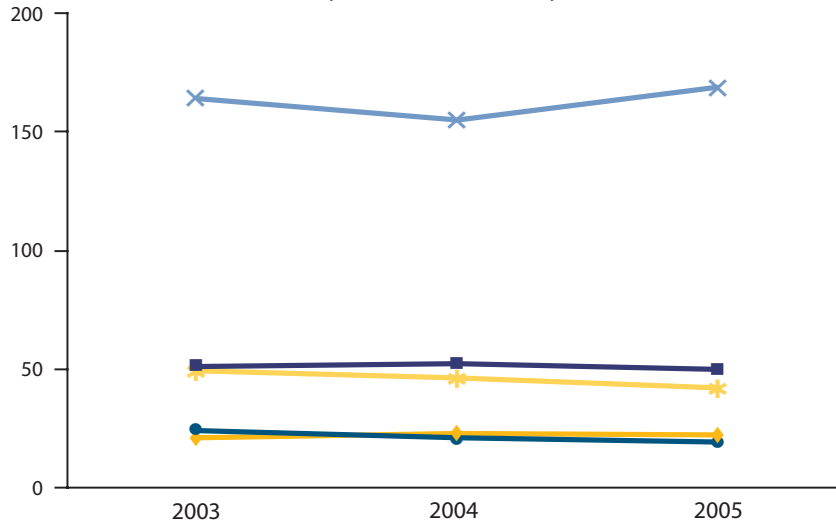
In 2005, 7 per cent (302) of active participants were Aboriginal people, and 24 per cent (965) were injection drug users. Between 2003 and 2005, the number of Aboriginal people taking HAART decreased across all health authorities except VCH. There is clearly an opportunity to improve efforts to attract and retain HIV-positive Aboriginal people in treatment. In contrast, the number of injection drug users engaged in the program increased in all health authorities except IHA.

Number of Aboriginal Persons Currently on ARV Treatment by Gender, 2003-2005



Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

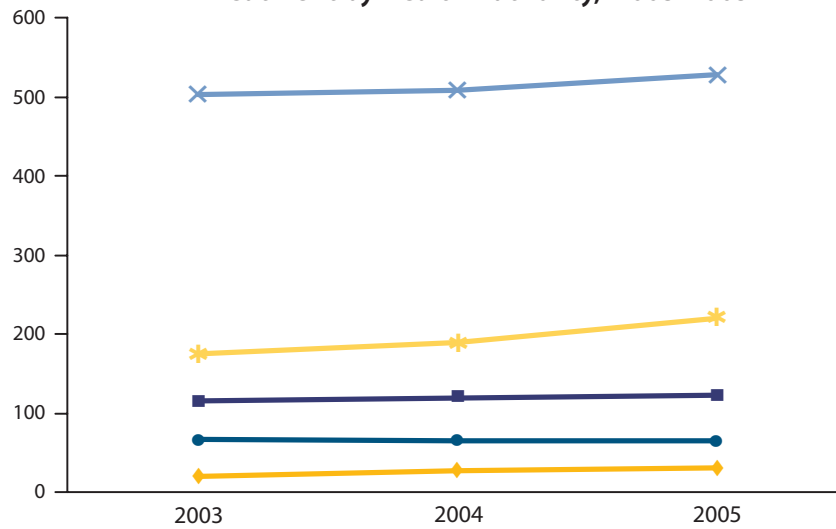
Number of Aboriginal Persons Currently on ARV Treatment by Health Authority, 2003-2005



	2003	2004	2005
VCH	164	155	169
VIHA	49	46	42
FH	51	52	50
NHA	21	23	22
IHA	24	21	19

Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

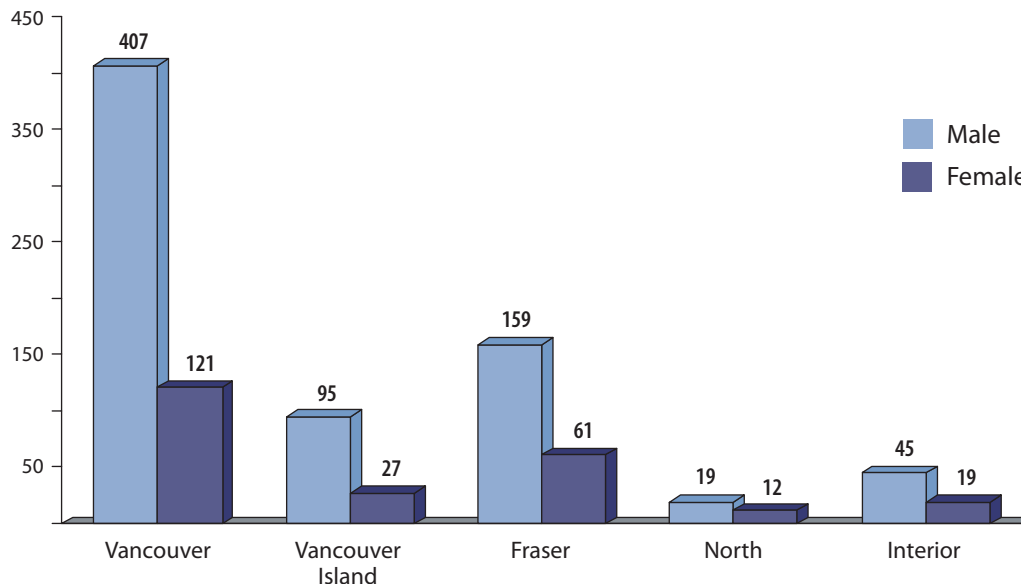
Number of Intravenous Drug Users Currently on ARV Treatment by Health Authority, 2003-2005



	2003	2004	2005
VCH	503	508	528
VIHA	116	119	122
FH	174	190	220
NHA	20	27	31
IHA	66	65	64

Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

Number of Intravenous Drug Users Currently on ARV Treatment by Gender and Health Authority, 2005



Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program, 2005

Overall, the treatment of HIV-positive people in B.C. has been very successful. The death rate among people ever associated with the DTP decreased from 130 deaths per 1,000 patients in 1994 to less than 40 deaths per 1,000 in 2005. Survival has increased from 20 to 44 years and the potential years of life lost (an indicator of preventable death) has decreased tenfold from approximately 5,000 person years to 500 per 1,000 patients ever treated during the same period. Since the introduction of HAART a decade ago, the total number of AIDS-attributed deaths in B.C. has decreased from 295 in 1995 to 145 in 2005, a decrease of more than 50 per cent.

HIV Acute Care¹¹

The number of people in B.C. admitted to hospitals for HIV/AIDS-related acute and rehab care increased by approximately 36 per cent between 2003 and 2005. Of the people admitted to hospital for HIV-related acute care in 2005, 27 per cent were women – up from 22 per cent in both 2004 and 2003. As noted above in the HIV Drug Treatment section, the proportion of women currently on HAART appears to be low relative to the proportion of new infections occurring among women. This seen alongside increasing use of HIV-related acute care services by women indicates the need to engage women earlier in appropriate care and treatment.

The largest concentration of admissions in each health authority occurred in the 31-50 year age groups. In VCH, there were significantly more admissions in the 51-60 year age group in 2003, 2004 and 2005 compared to the other health authorities. The highest overall increase in HIV-related hospital admissions was in the FHA, a 66 per cent increase in 2005 over the previous year. This may reflect a need for access points within FHA for both HIV-specific primary and specialist care.

Community Support¹²

AIDS service organizations and other community agencies across the province play an important role in the ongoing health and well-being of people living with HIV/AIDS. These organizations are directly connected with the individuals and populations in B.C. that experience the greatest vulnerability to HIV/AIDS and are ideally positioned to engage newly infected individuals with the health system. Many of the services provided by community organizations complement those delivered by the health authorities, thereby contributing to a robust continuum of care and support.

In NHA, the activities delivered by the community support a regional model of service delivery that emphasizes continuity of care. This model links services across the continuum so HIV-positive individuals experience as few barriers as possible. The model is supported by coordinating mechanisms, such as the Prince George Regional Partners in HIV Committee. NHA will be expanding the service delivery model and its supporting infrastructure into underserved areas of the health authority.

Within PHSA, organizations such as the BC Persons with AIDS Society, Healing our Spirit Aboriginal AIDS Society and the Positive Women's Network deliver peer support programs, services and information resources across the province. These agencies assist people living with HIV to navigate a complex health system and legislative environment.

¹¹ Discharge Abstract Database, Information Resource Management, Knowledge Management & Technology Division, BC Ministry of Health

¹² Program data, BC Health Authorities

In Vancouver, the Dr. Peter Centre provides a unique combination of drop-in health support services and residential care for HIV-positive individuals with serious, ongoing health challenges. Supported in part by both PHSA and VCH, the Centre has demonstrated that its activities and programs reduce use of acute care services among clients¹³. Other support programs delivered within VCH provide assistance with key determinants of HIV vulnerability, such as housing, income support and access to medical care.

In 2005, VIHA funded community organizations to provide a range of support services to HIV-positive individuals in poor health, including housekeeping, grocery shopping and transportation to medical appointments. Almost all health authorities reported provision of some form of nutritional support to individuals through contracted community agencies. This support ranged from hot meals to supplemental food items specific to the needs of HIV-positive people. Between 2004 and 2005 the provision of nutritional support increased by 6 per cent across reporting health authorities.

From the available data, it is clear that many community care programs that existed in each health authority in 2003 continued to exist in 2005 and served more people living with HIV/AIDS. Program output data from PHSA, VCH and NHA reflects a 50 per cent increase in the number of people who received community support services between 2004 and 2005.

In the correctional system, continuity of care for HIV-positive inmates remains a significant issue for policy makers and service providers at both the provincial and federal level. As a structured environment, prison is an effective setting for HIV drug treatment. Recent evidence indicates that while prison terms of more than 12 months result in greater adherence to antiretroviral therapy and suppression of viral load, the inmates are often unable to maintain the same level of adherence upon release¹⁴. This highlights the need for post release strategies to ensure the continuation of HIV care, including support for treatment adherence, in order to protect the health of inmates, their families and their communities.

The Federal/Provincial/Territorial Advisory Committee on AIDS has identified the need to develop release planning guidelines in collaboration with their national counterparts in the correctional system. In B.C., improved efforts to provide appropriate care, treatment and support for inmates living with HIV, both prior to and after release into the community remain a high priority.

In 2005, approximately 27 federal inmates and 73 provincial inmates received antiretroviral therapy (ARV) in correctional facilities in B.C.

Year	B.C. Provincial Inmates on ARV	B.C. Federal Inmates on ARV
2003	54	0
2004	69	16
2005	73	27

Source: BC Centre for Excellence in HIV/AIDS, Drug Treatment Program

¹³ Kerr, T. et al. (2002). Assessing the impact of an adult day program on hospital utilization by persons living with HIV/AIDS. *J Acquir Immune Defic Syndr*. September 1;31(1):117-9.

¹⁴ Palepu, A. et al. (2004). Initiating highly active antiretroviral therapy and continuity of HIV care: the impact of incarceration and prison release on adherence and HIV treatment outcomes. *Antiviral Therapy*. October 9(5):713-9.

Progress Summary: Care, Treatment and Support

Between 2001 and 2005, the proportion of the estimated HIV prevalent population on drug treatment increased by 8 per cent overall, exceeding the increase required to meet the 2005 target established by *Priorities for Action*. In the same period, health authorities and their community partners provided more services to more individuals living with HIV to assist them in managing their disease. Clearly, much progress has been made in expanding access to care, treatment and support.

Despite this success, there are population groups that remain under-represented in HIV care and treatment. More effort is needed to engage a larger proportion of HIV-positive Aboriginal people, women and marginalized people in care and treatment.

Goal #3: Capacity

To enhance the province's capacity for monitoring the HIV epidemic by 2007

Introduction

The third goal of *Priorities for Action* is to increase capacity to curb the spread of the HIV epidemic and provide quality and sustainable care, treatment and support services for infected individuals. In 2005, progress towards this goal was achieved through expanded medical and social research, increased dissemination of best practice information to health authorities and their community partners, increased inter-professional training and education and enhanced capacity for service planning and monitoring at the regional level.

Research

Sound research evidence is critically important in stemming the tide of HIV infections and limiting the health and social consequences of HIV and AIDS. In 2005, both BCCDC and BCCfE led the way in research and knowledge translation. Researchers at BCCfE published 58 peer reviewed journal articles on topics ranging from drug treatment to the social impacts of North America's first supervised injection facility, Insite, and presented papers at several international conferences.

In 2005, BCCDC researchers focused on the sexual transmission of HIV and examined risk behaviours and characteristics of populations vulnerable to sexually transmitted infections, including sex workers, street-involved youth and drug-dependant prison inmates. Findings were presented at a national and international conference, and two manuscripts were developed for publication in peer-reviewed journals. BCCDC also led an evaluation of HIV reportability for the Provincial Health Officer, as well as the assessment of antenatal sero-prevalence of HIV and hepatitis C in B.C., which is intended for future publication.

Knowledge Exchange

Knowledge exchange is a key issue for individuals working in HIV/AIDS. Policy makers and service providers need timely access to evidence to support and improve their practice. In 2005, BCCfE increased the accessibility of its published papers and professional education materials by making these resources available on its website. BCCDC began developing resources to support a series of workshops for health authorities on best practices in HIV/AIDS and communicable disease prevention. Oak Tree Clinic continued providing support to primary care physicians across B.C. with HIV-positive women patients. Clinic staff engaged in outreach activities, demonstrating and fostering best practice directly within clinical settings. The Centre for Addictions Research at the University of Victoria expanded the capacity of its Communication and Resource Unit which operates a knowledge translation website. Through this website (www.silink.ca), health care and other service providers can access the latest findings on HIV and drug use.

Inter-Professional Education

BCCDC serves as the provincial training site for medical residents, interns and public health nurses interested in learning about STI and HIV prevention. In 2005, through its Chee Mamuk Aboriginal HIV/HCV program, the STD/AIDS Division provided prevention education to First Nations communities and Aboriginal organizations across the province. The Division also provided training for clinicians on pre- and post-test HIV counselling and took a lead role in the scale up of public health activities related to HIV reportability.

Oak Tree Clinic operates a clinical teaching site affiliated with the University of British Columbia (UBC). In 2005, students from the Faculties of Medicine, Nursing, Pharmacy, Nutrition and Social Work had clinical rotations with various specialists in the clinic. The clinic offered students a unique experience using multi-disciplinary team approach to HIV/AIDS care for women and children. Health professionals from around the world participated in exchanges at Oak Tree Clinic to learn in a clinical environment.

BCCfE provides education and training for physicians, nurses and allied health professionals in HIV care and treatment. The HIV Preceptorship program is a three-month clinical rotation for physicians in the Immuno-deficiency Clinic (IDC) at St. Paul's Hospital in Vancouver. Clinical rotations in the IDC are available for medical residents, visiting fellows and medical students from UBC and other Canadian and international universities. AIDS Care Rounds are presented bi-monthly at St. Paul's Hospital, where a range of speakers addresses state of the art issues in the management of HIV. Twice a year, the BCCfE presents a symposium on the latest developments in antiretroviral (ARV) therapy. The AIDS Care Rounds and ARV updates are available on the BCCfE website.

For nurses and allied professionals, BCCfE offers undergraduate courses in HIV prevention and care in collaboration with the UBC School of Nursing and the UBC College of Health Disciplines. In 2005, 36 nursing students and 30 health disciplines students took the HIV courses. The BCCfE provides continuing nurse education through the ABC Treatment Outreach program, guest lectures and workshops by the BCCfE outreach nurse educator, training partnerships with BCCDC, nurse education satellites at conferences and support for HIV-related community collaborations across the province.

The ABC Treatment Outreach program, offered by the BCCfE in conjunction with the BC Persons with AIDS Society, provides basic HIV education to health service providers throughout the province. The ABC program is delivered by HIV-experienced physicians, nurses and consumer advocates. It is tailored to meet the needs of local health service providers and people living with HIV/AIDS. Topics include HIV epidemiology, natural history, disease progression, opportunistic infections, HIV and HCV co-infection and approaches to HIV primary care. In 2005, the ABC program was delivered to over 560 people in 12 communities: Salt Spring Island, Victoria, Parksville, New Westminster, Mission, Chilliwack, Abbotsford, Sechelt, North Vancouver, Kelowna, Penticton and Prince George.

In 2005, VIHA provided training to University of Victoria (UVic) nursing students and health workers on HIV and injection drug use in acute care settings. AIDS Vancouver Island hosted a workshop for service providers on sexual health issues for gay, bisexual and transsexual men. Victoria AIDS Resource & Community Service Society provided education sessions on relationship dynamics and HIV prevention, care and treatment to nursing students at UVic and continuing care assistants at Camosun College.

In 2005, VCH offered a three-day harm reduction course to train drug users to become peer-training facilitators. VCH is committed to fostering community development for HIV/AIDS and to this end offered training for volunteers in community-based agencies throughout the region.

FHA hosted a number of professional development activities in 2005 that reached over 300 people. These activities aimed to increase HIV knowledge among physicians, social workers, outreach workers, youth workers, parenting groups and interested members of the public.

In 2005, NHA undertook several HIV-related professional development initiatives. Among these were workshops on pre- and post-test counselling and partner notification for public health nurses in Fort St. John, Dawson Creek, Chetwynd, Tumbler Ridge and Fort Nelson. Workshops were offered to allied service providers, including youth forensics staff and emergency dental clinic workers. In-service training to standardize needle exchange services across the health region was held in conjunction with public health and mental health and addictions teams.

Monitoring Capacity

An important component in the province's ability to monitor the HIV epidemic is the capacity to identify emerging epidemiological trends, risk populations and service needs.

BCCDC maintains surveillance data on newly reported HIV infections across the province. Efforts to determine population level characteristics of people testing newly positive for HIV are co-ordinated with physicians and public health nurses to ensure the confidentiality of individual records. In 2005, the BCCDC initiated efforts to determine the extent of HIV, hepatitis C and tuberculosis co-infection. Results of this work will provide evidence to inform future policy and program development in the area of integrated communicable disease management. Access to BCCDC's secured, web-based HIV surveillance data allowed health authorities to form a better understanding of the effect of HIV and other sexually transmitted infections on local communities and populations.

The BCCfE maintains a confidential patient registry that monitors British Columbians who undergo drug treatment for HIV and AIDS. This database tracks the health status, geography, demographics and prescribing history of every patient. The BCCfE is able to monitor health outcomes, costs and utilization of health services

through linkages with other health databases in the province. The drug treatment database allows the BCCfE to accurately predict future antiretroviral therapy resource needs and transmit this information to government in the form of budget forecasts.

The BCCfE also maintains several targeted surveillance cohorts to monitor HIV risk behaviours, incidence and prevalence among vulnerable populations in B.C. These cohorts include the long standing Vancouver Injection Drug Use Study (VIDUS 1 and 2), the Downtown Eastside Vancouver community health and safety evaluation cohort (CHASE), the Vancouver safe injection site evaluation cohort (SEOSI) and two new cohorts that monitor drug-using street youth (ARYS) and survival sex workers (MAKA) in downtown Vancouver. In 2005, the BCCfE managed the CEDAR cohort which studied the HIV risk behaviours of drug-using Aboriginal youth in Prince George. The BCCfE has also established a virtual cohort (ACCESS) that actively links all HIV-positive individuals from its surveillance cohorts to appropriate HIV care and treatment.

The Oak Tree database follows HIV-positive women, pregnant women, infants and children, as well as non-HIV-positive infants born to HIV-positive mothers in order to monitor their health on a longitudinal basis. Over 300 mother-infant pairs are included in this provincial database, which tracks health and treatment indicators. Oak Tree Clinic plays an important leadership role in the Canadian Perinatal HIV Surveillance Project which collects health and treatment data on HIV-positive mothers and their infants. Currently, there are 2,000 mother-infant pairs in the national database. All children born to HIV-positive mothers in Canada are registered in this system.

VIHA, in partnership with Health Canada, operates the I-TRACK Surveillance Project which monitors risk behaviour and the prevalence of HIV and hepatitis C among people who inject drugs. This study has been implemented in five Canadian cities, including Victoria. In 2005, the second phase of the Victoria study was completed and results were provided to community agencies for planning purposes¹⁵. Planning also commenced in 2005 for a similar M-TRACK project, monitoring risks and disease prevalence among men who have sex with men.

In 2005, the Canadian Community Epidemiology Network on Drug Use (CCENDU) released the site report for Vancouver. This study monitors drug use and its adverse consequences at the community level. Vancouver is one of 12 participating urban sites across Canada. Each site collects, collates and interprets recent data in major drug use areas including prevalence, treatment, morbidity, HIV/AIDS and hepatitis C¹⁶. The Vancouver site report is developed by BCCDC in partnership with health authority, institutional and community stakeholders.

¹⁵ Results of phase I and phase II of the Victoria study are available on the web at: www.viha.ca/mho/publications_brochures_newsletters_forms/

¹⁶ Copies of the CCENDU 2005 Vancouver site report can be found on the web at: www.vancouver.ca/fourpillars/pdf/report_vancouver_2005.pdf

Service Planning and Implementation

In 2004, the health authorities began developing HIV service plans to support the implementation of *Priorities for Action*. In 2002, VCH had developed a high level strategic plan for HIV which it intended to use as the basis for redesigning HIV services in the Vancouver health service delivery area. As of December 2005, service plans were underway in FHA, VIHA, IHA and NHA. These health authorities were given until March 31, 2006 to submit Board-approved HIV or blood borne pathogen service plans to the Ministry of Health.

Health Authority	HIV/AIDS Service Plan
Provincial Health Services	<ul style="list-style-type: none"> ■ <i>Provincial Health Services Authority HIV Service Plan for Women and Children</i> (December 2003). ■ <i>Provincial Health Services Authority HIV/AIDS Strategic Framework</i> (completion pending).
Vancouver Coastal Health	<ul style="list-style-type: none"> ■ <i>Meeting the Challenge: a Framework for Integrated HIV Services in Vancouver and Richmond</i> (May 2002).
Fraser Health	<ul style="list-style-type: none"> ■ <i>HIV/AIDS in Fraser Health Authority: Prevention, Care, Treatment, Support – Needs Assessment and Business Plan</i> (March 2006).
Vancouver Island Health	<ul style="list-style-type: none"> ■ <i>Closing the Gap: Integrated HIV/AIDS and Hepatitis C Strategic Directions for Vancouver Island Health Authority: 2006/07 – 2008/09</i> (April 2006).
Interior Health	<ul style="list-style-type: none"> ■ <i>Interior Health's Action Plan for Blood-Borne Pathogens, 2006-2009: Embracing a Healthy Future</i> (March 2006).
Northern Health	<ul style="list-style-type: none"> ■ <i>Meeting the Challenge: A Blood-Borne Disease Strategy for Northern Health, 2005-2009</i> (July 2006).

The Provincial Health Services Authority (PHSA) began development of a strategic plan for HIV/AIDS in late 2005. This plan builds on some of the recommendations that emerged from a planning forum held in March 2004, as well as the *HIV Service Plan for Women and Children* released in 2003.

In addition to this planning exercise, PHSA along with Chee Mamuk, Healing Our Spirit, and the Red Road Aboriginal HIV/AIDS Network hosted a forum for Aboriginal communities and service providers in March 2005. The forum was held to review response to HIV/AIDS among Aboriginal people in B.C., and recommendations emerging from the forum were published in *Renewing Our Response: Provincial Aboriginal HIV/AIDS Forum*.

Goal #4: Coordination and Cooperation

To create and sustain broad-based support for the approach outlined in Priorities for Action

Introduction

The fourth goal of *Priorities for Action* is increased coordination and cooperation among HIV/AIDS stakeholders across the health system. Successful collaboration between health system partners supports the achievement of HIV-related population health outcomes through information sharing, service integration, dissemination of best practices specific to local contexts and engagement of vulnerable populations. Collaboration requires that all partners become more strategic in their approach to policy development and service delivery, particularly in a time of scarce resources.

Collaboration

In 2005, health authorities, provincial agencies and community-based organizations were well represented on HIV-related national committees and coordinating bodies, including the Canadian AIDS Society, Canadian Aboriginal AIDS Network, Canadian Association of Nurses in AIDS Care and the Canadian AIDS Treatment Information Exchange.

At the provincial level, the BCCDC, BCCfE and provincially mandated community organizations, such as BC Persons With AIDS Society, Positive Women's Network, Healing Our Spirit: BC Aboriginal HIV/AIDS Organization and Red Road Aboriginal Network, worked closely with the PHSA, Ministry of Health and the regional health authorities to support the regionalized delivery of effective HIV prevention, care, treatment and support services.

At the regional level, VCH hosted regular meetings with community-based HIV service providers to foster networking, address program implementation issues and share professional development opportunities. The Vancouver-based Needle Recovery Sweeps Coordinating Committee met regularly to address issues related to the recovery and safe disposal of publicly discarded used needles. The Vancouver HIV/AIDS Care Coordinating Committee continued to strengthen the capacity of institutional and community-based organizations and their respective health authorities to respond to the changing nature of the HIV epidemic in Vancouver and the Lower Mainland.

Within FHA, the HIV/AIDS Planning Task Group continued to meet throughout 2005 to develop a regional HIV service plan. Although the group was largely focused on planning, the meetings have also become opportunities for information sharing and discussion of program developments and changes within the health authority.

In NHA, the multi-stakeholder Northern Aboriginal Youth in Crisis Task Force was established to respond to the increase in new HIV and hepatitis C infections among young Aboriginal injection drug users in the Prince George area. Membership includes NHA, First Nations communities, Aboriginal service providers, community HIV service organizations, Health Canada's First Nations and Inuit Health Branch, the Public Health Agency of Canada and the BC Ministry of Health. This group is working to improve access to services for vulnerable populations in the North through information sharing and improvements in service delivery.

In 2005, planning got underway for *Positive Gathering 2006*, a provincial conference for and by HIV-positive people and their allies in B.C. and hosted by the Pacific AIDS Network. The purpose of the Gathering is to share experiences, learn from peers, build collaborative working relationships and devise strategies for more effective prevention, care, treatment and support.

Global Engagement

On World AIDS Day 2005, the Positive Women's Network and its global partners launched an international blueprint addressing issues that fuel the HIV/AIDS epidemic for women on a worldwide basis: stigma, discrimination, treatment and research challenges. The Blueprint is the result of work by an international coalition of HIV-positive women, Canadian and international HIV organizations, advocates and women in health care. The coalition's goal is to influence governments to provide adequate funding for women-specific HIV/AIDS prevention and support services¹⁷.

In 2005, B.C. researchers and clinicians welcomed visitors from around the world. The Oak Tree Clinic offered site visits for international visiting practitioners. The clinic provided consultation and other support to the Elizabeth Glaser Pediatric AIDS Foundation and Médecins Sans Frontières to establish an antiretroviral implementation program in Africa, and to the Canadian Society for International Health (CIDA funded) to establish a mother and child HIV program in Kiev, Ukraine. Oak Tree Clinic also assisted in the development of nutritional guidelines for HIV-positive people living in the Caribbean.

In late 2005, the Dr. Peter Centre and the BCCfE hosted an informal visit from a delegation from the Yunnan Province in China. The visit was part of a larger initiative in the Yunnan Province to identify best practices in the care and treatment of HIV-positive injection drug users.

During 2005, PHSA assisted with the translation of the *Canadian Consensus Guidelines for the Care of HIV-positive Pregnant Women* into Russian and made this resource available on the web.

¹⁷ Copies of the Blueprint for Action on Women and HIV/AIDS can be found on the web at:
www.pwn.bc.ca/pdf/Blueprint_Manifesto_Dec_05.pdf

Conclusion

The *2005 Annual Progress Report* is a retrospective examination of the HIV epidemic in B.C. and the effectiveness of the provincial response to managing the epidemic. Based on available data, the diagnosed portion of the HIV epidemic appears to have slowed in 2005, with newly reported HIV infections falling below 10 cases per 100,000 population in B.C. for the first time in two decades.

The estimated number of British Columbians living with HIV and AIDS in 2005 remained essentially the same as in 2002, when HIV prevalence estimates were last compiled by the Public Health Agency of Canada. The estimated proportion of people in B.C. who were living with HIV but unaware of their infection in 2005 dropped slightly to 27 per cent of the HIV prevalent population. At the same time, the number of HIV tests performed in B.C. in 2005 increased just over 8 per cent to nearly 167,000 tests, which may reflect progress in reaching those in the province who are unaware of their HIV infection.

Prevention: Missing the Targets

The *2005 Annual Progress Report* highlights the need for more strategic HIV prevention planning across the province. The number of people testing newly positive for HIV declined in 2005 from the 2001 baseline of 440 to 410 new infections. However, this decrease was not sufficient to reach the 2005 target of 308 new infections.

As in previous years, the majority of new HIV infections in the province occurred among gay men and other men who have sex with men, injection drug users and individuals who attributed their exposure to heterosexual contact. Aboriginal people, women and marginalized populations, such as street-involved, sexually exploited, mentally ill and/or incarcerated persons, continue to be at significant risk of infection.

In order to have a greater impact on HIV incidence, prevention efforts must be more evidence-based, harm reduction-oriented, comprehensive and integrated within and among health authorities to better engage vulnerable populations. It is critical that health authorities and their community partners understand where the most pressing needs are with respect to HIV vulnerability in their respective regions, and that they focus their prevention efforts accordingly. Progress has been achieved to some extent through the development of regional HIV or blood borne disease service plans in each health authority. These service plans now need to be fully implemented using integrated and highly coordinated approaches.

Care and Treatment: On Track, but New Approaches Required

In terms of treatment, approximately 38 per cent of the HIV prevalent population was engaged in antiretroviral therapy in 2005, up from the 2001 baseline of 30 per cent coverage and surpassing the 2005 target of 35 per cent coverage. It should be noted that approximately 50 per cent of the HIV prevalent population in B.C. is estimated to be in medical need of drug treatment (e.g. these individuals have AIDS-defining illnesses or CD4 counts of 200 or below). In 2005, B.C. achieved an estimated 76 per cent coverage of the medically eligible subset of the HIV prevalent population.

As noted above, women, Aboriginal People and marginalized populations experience significant vulnerability to HIV disease. Within these populations, people living with HIV continue to be under-represented in care and treatment programs, including antiretroviral therapy.

Greater effort is required among health authorities and provincial health agencies to engage all medically eligible individuals in HIV drug treatment, especially those from hard to reach populations, as well as to link more people living with HIV to appropriate care and support in their communities.

Monitoring Future Progress

The province acknowledges the difficulty in monitoring HIV-related activity at the local and regional level, and linking this activity to the achievement of population health and health system outcomes. In its stewardship role, the Ministry of Health is committed to working with the health authorities, provincial health agencies and other health system partners to improve how we define and monitor HIV-related performance and, more importantly, how we intend to use this performance information to refine our efforts to better manage the HIV epidemic in B.C.

Appendix #1: Potential Future Directions

This section summarizes suggestions of key informants at the health authorities, the office of the Provincial Health Officer, provincial health agencies and community organizations on potential opportunities for strengthening the provincial response to HIV/AIDS. These recommendations are intended to promote dialogue and future collaborative action among health system partners.

General Recommendations

- Increase targeted funding for HIV prevention, care, treatment and support, as well as for organizational development of community-based HIV consumer and service organizations.
- Ensure HIV service contracts are responsive to current priorities and reflect an evidence-based approach to service provision.
- Create initiatives to address stigmatization related to HIV/AIDS across the continuum of health promotion, prevention, harm reduction, care, treatment and support.

Prevention

- Develop strategic prevention plans that are comprehensive, evidence-based, measurable and highly coordinated within and between health authorities.
- Expand the scope of harm reduction programs and ensure they are evidence-based, gender and culturally sensitive and meet the diverse needs of urban and rural communities and at risk populations, including men who have sex with men, intravenous drug users and Aboriginal persons.
- Expand the provincial harm reduction supply program to support growth at the regional level.
- Increase the number of public health nurses devoted to HIV reportability to ensure that partner notification is carried out in a comprehensive manner throughout the province.
- Broaden the scope of evidence-based HIV prevention in public school settings, include people living with HIV and community based organizations in the development of curriculum and ensure it is delivered by trained educators.
- Investigate and implement new approaches that encourage changes in risk behaviors among men who have sex with men.
- Increase access to supervised injection facilities and availability of such services.
- Foster increased enrolment of injection drug users in methadone maintenance treatment.

Care, Treatment and Support

- Increase access to integrated HIV primary and specialist care at the regional level through clinics supported by a network of community physicians in each health service delivery area.
- Ensure clients seeking care and treatment have adequate income assistance, housing, transportation and psychosocial support to utilize appropriate services.

- Ensure transportation costs to bring isolated or marginalized people to the services they need and/or to bring service providers to the people who need them most are covered by the system of HIV care.
- Increase opportunities for physician training, particularly related to prescribing antiretrovirals and other HIV medications, and for training allied health professionals (nutritionists, pharmacists, social workers, case managers).
- Create innovative ways to engage HIV and/or hepatitis C positive individuals in supportive care and treatment to prevent secondary transmission of diseases.
- Expand community-based case management services that would link HIV-positive people with critical resources and information in their local communities and throughout the province.
- Ensure that care, treatment and support information and resources are available in culturally appropriate forms.
- Continue to expand the reach of HAART to include a greater proportion of those eligible for such treatment, and as a result improve their health and decrease their infectiousness.

Capacity

- Improve the Province's capacity to conduct real time surveillance of HIV risk behaviours, incidence and prevalence, especially among vulnerable populations.
- Strengthen the capacity of health authorities and their community partners to conduct outcome evaluation of HIV/AIDS services and incorporate evaluation results into future service planning and resource allocation.
- Explore using new forms of HIV testing technology to identify HIV incident cases and provide opportunities to identify and treat individuals with acute HIV infections in order to reduce their viral load and infectiousness.

Collaboration

- Strengthen collaboration between health authorities and federal authorities at the regional level, including Correctional Services Canada, the Public Health Agency of Canada and Indian and Northern Affairs to better support vulnerable populations.
- Provide a centralized access point in each health service delivery area to link individuals to appropriate HIV and hepatitis C services and maintain an active referral network of harm reduction, prevention, care, treatment and other support service providers.
- Ensure mechanisms exist at the community and regional level to enable health disciplines to share information and coordinate care for persons with HIV/AIDS, particularly between physicians and public health officials.

Appendix #2: Priorities for Action: Goals, Objectives, Strategies

PREVENTION: To reduce the incidence of HIV infection by 50 per cent over the next 5 years.	
Objectives	<ul style="list-style-type: none"> ▶ To reduce incidence of HIV infection among the most vulnerable groups by 50 per cent over the next five years. ▶ To reduce proportion of seropositive individuals who are unaware of their HIV infection by 50 per cent over the next 5 years. ▶ To sustain effective systems of care for women living with HIV and ensure no infants are born with HIV over the next 5 years.
Key Strategies	<ul style="list-style-type: none"> ▶ Ensure that current and future HIV/AIDS-related prevention efforts across the province effectively engage the most vulnerable populations. ▶ Expand provincial support for low-threshold harm-reduction initiatives, including supervised consumption sites, needle exchange and addiction treatment services, and a randomized trial of prescribing controlled substances, and ensure that they are accessible and culturally appropriate to populations most at risk of HIV infection. ▶ Monitor and evaluate the public health reporting requirement for HIV infection under the Health Act, including provisions for anonymous, voluntary partner notification. ▶ Expand HIV testing capacity, education and prevention efforts in the province's correctional facilities; review the effectiveness of HIV/HCV prevention strategies in provincial jails and assess opportunities for innovative and measurable interventions to reduce HIV/HCV transmission; develop partnership with Correctional Service Canada to enhance HIV/HCV services in federal institutions in B.C. ▶ Create an HIV/AIDS roundtable involving B.C. ministries and health authorities, Health Canada and First Nations organizations to identify and pursue efforts to address the HIV epidemic among Aboriginal people.

CARE, TREATMENT AND SUPPORT: To increase proportion of HIV+ individuals linked to appropriate care, treatment and support services by 25 per cent over the next 5 years.	
Objectives	<ul style="list-style-type: none"> ▶ To ensure HIV+ individuals are aware of care, treatment and support services available in their communities. ▶ To ensure care, treatment and support services are available for and accessible to vulnerable groups of HIV+ individuals. ▶ To ensure HIV+ women from the most vulnerable groups access antiretroviral therapy at the same rate as women in the general population.
Key Strategies	<ul style="list-style-type: none"> ▶ Ensure that HIV/AIDS-related care, treatment, support and prevention services across the province effectively engage the most vulnerable populations. ▶ Work with the BC Medical Association and the BC College of Physicians and Surgeons to expand the provincial methadone program and the range of addictions treatment options. ▶ Work with the BC College of Physicians and Surgeons to increase the number of physicians providing HIV/AIDS care and treatment, and expand innovative training programs for key health-care providers. ▶ Monitor and evaluate the public health reporting requirement for HIV infection under the Health Act, including provisions for anonymous, voluntary partner notification. ▶ Develop the capacity to provide continuity of care and bridging services for HIV+ individuals at time of discharge from federal and provincial correctional institutions in B.C.

CAPACITY: To enhance the province's capacity to monitor the HIV epidemic over the next 5 years.	
Objectives	<ul style="list-style-type: none"> ▶ To strengthen the province's ability to reach and inform persons who may be unaware of their HIV infection. ▶ To strengthen the province's ability to anticipate epidemiological trends and service needs in HIV/AIDS. ▶ To improve epidemiological and other knowledge about HIV/AIDS among health authorities and community-based organizations.
Key Strategies	<ul style="list-style-type: none"> ▶ Support the expansion of HIV/AIDS-related medical and social research undertaken in B.C. and explore alternate means of disseminating new knowledge. ▶ Develop an effective sentinel surveillance system through linking existing data sources that will enable the province and health authorities to anticipate new epidemiological trends and service needs with regard to HIV/AIDS, hepatitis C and other co-infections. ▶ Identify and disseminate best practices information to health authorities, local government and AIDS service organizations and other community-based organizations on a timely basis. ▶ Work with health authorities in planning, monitoring and evaluating HIV/AIDS services, including the public health follow-up for partners of newly reported HIV-positive individuals.

CO-ORDINATION AND CO-OPERATION: To create and sustain broad-based support for the approach outlined in <i>Priorities for Action</i>.	
Objectives	<ul style="list-style-type: none"> ▶ To strengthen the policy, program and service co-ordination among provincial ministries, health authorities and AIDS service organizations. ▶ To integrate prevention, surveillance and treatment activities associated with HIV/AIDS and Hepatitis C. ▶ To contribute more fully to international efforts to combat HIV/AIDS in developing countries.
Key Strategies	<ul style="list-style-type: none"> ▶ Create mechanisms for encouraging co-ordination and co-operation among stakeholders. ▶ Forge new partnerships with Correctional Services Canada, Health Canada and Indian and Northern Affairs to foster co-ordination and co-operation in efforts directed at vulnerable populations. ▶ Support efforts to share the province's HIV/AIDS knowledge and experience with countries in the developing world. ▶ Explore an enhanced role for the Provincial Health Services Authority in contributing to provincial co-ordination and the identification and dissemination of best practices.



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