Priorities for Action in Managing the Epidemics:

HIV/AIDS in B.C.

(2003 – 2007)

2007 Annual Progress Report
Acknowledgments

The 2007 Annual Progress Report reflects the efforts and support of many community organizations and individuals, including British Columbians living with HIV and AIDS. The Ministry of Healthy Living and Sport recognizes the commitment and dedication of local community agencies and partners in providing care, treatment and support to those most affected or most vulnerable to the HIV epidemic. These include marginalized and hard-to-reach populations in communities and regions throughout the province. The knowledge and trust developed by these organizations in their work with clients – often those most vulnerable to disease and least able to access treatment – are essential for a comprehensive and effective community-based response to HIV.

In addition, the Ministry would like to acknowledge the leadership and efforts of B.C.’s health authorities in providing the resources and infrastructure for the effective and equitable delivery of HIV services across the province. The Ministry also recognizes and appreciates the groundbreaking research, extensive surveillance, and clinical innovations of the BC Centre for Excellence in HIV/AIDS, the BC Centre for Disease Control, and the Oak Tree Clinic.
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Executive Summary

In September 2003, the Ministry of Health Planning and Ministry of Health Services released Priorities for Action in Managing the Epidemics: HIV/AIDS in BC (2003 – 2007). This policy framework aimed to support and guide British Columbia’s response to the HIV/AIDS epidemic. It focused on four goals or key areas over a five-year period: prevention; care, treatment and support; capacity development; and coordination and cooperation.

Within the Priorities for Action framework, the prevention goal includes an ambitious target: to reduce the incidence of HIV infections and the annual rate of reported cases by 50 per cent by the end of 2007. A key activity in support of this goal and target is HIV testing. In 2007, the number of people reached for HIV testing in the province continued a pattern of annual growth, increasing by 2.5 percent.1 Greater access to and uptake of HIV testing services have been important steps in increasing the number of people aware of their infection, and therefore able to access care and treatment services, and prevent infections among others.

In 2007, 395 new HIV infections were reported within B.C., which represents a rate of 9.1 infections per 100,000 people.2 Although the 2007 rate was lower than the rate of the 2001 baseline year, it was not low enough to reach the target for 2007 of 5.2 cases per 100,000 people – a 50 percent reduction from the baseline.

Significant and sustained reductions in HIV infection rates require increased emphasis on disease prevention, especially efforts to reach disproportionately affected populations such as gay men and Aboriginal people. For 2007, each health authority reported outputs of a range of broad-based and targeted prevention activities. Within the year, approximately 100 broad-based prevention and education initiatives reached almost 370,000 people, while about 215 targeted prevention activities reached a reported 673,424 people throughout the province.3

In the area of care, treatment and support, the Priorities for Action framework aims to increase by 25 percent the number of individuals with HIV who are accessing appropriate services. One way to measure such an increase is to look at the proportion of people with HIV on highly active antiretroviral therapy (HAART), or treatment for HIV. In British Columbia, the proportion of people living with HIV and on HAART was approximately 45 percent in 2007, surpassing the year’s target of 38 percent and up from the baseline of 30 percent in 2001.4 These results well exceed the annual target for the year, and have done so now for five consecutive years. This indicates that the reach of and engagement in HIV treatment services, and by extension care, has improved over this five-year period.

Although good progress has been made towards this target, certain populations remain underserved in HIV-specific care and treatment and at particular risk of HIV-related illnesses. On a broad level, women and Aboriginal people are proportionately

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2 Ibid.

3 BC Health Authorities. Unpublished program and service output data; data incomplete in some instances. 2008.

underrepresented within the provincial HIV drug treatment program. Targeted efforts that are gender-specific and culturally appropriate are required to reach these populations and shift the balance accordingly.

The third goal of the framework focuses on improved capacity across the health care system to respond to HIV. In 2007, the BC Centre for Excellence in HIV/AIDS continued developing and refining projections of the population level benefits that might be realized through expanded access to HAART within B.C.. Results suggest that increased engagement of people eligible for HAART would lead to further decreases in the incidence of HIV-related illness and death and, as well, decreases in new HIV infections annually. This promising work could prove to be very helpful in shaping the future of the HIV response on both a local and a global level.

The fourth and final goal of Priorities for Action is fostering a coordinated response and collaboration among stakeholders across the health care system. Key strategies focus on service integration, vulnerable populations, information sharing, and approaches informed by best practices. In 2007, the ‘Renewing Our Response’ Leaders Team presented seven goals related to HIV among Aboriginal people in B.C. to representatives of governments, funding bodies and health authorities. From this presentation emerged a commitment to work together in a coordinated manner on these goals, guided by B.C.'s tripartite First Nations Health Plan. In another example, the third annual BC Gay Men’s Health Summit also focused on collaboration to promote a holistic approach to gay men’s health-related programs and services within the province.
Introduction, Purpose and Scope

In September 2003, the B.C. Ministries of Health Planning and Health Services released Priorities for Action in Managing the Epidemics: HIV/AIDS in BC (2003 – 2007). The purpose of this policy framework is to support British Columbia’s response to HIV/AIDS by guiding health authority and community efforts to address the disease – one of the most serious public health challenges locally and internationally. Priorities for Action focuses on four goals or key areas for managing the epidemic over a five-year period:

1. **Prevention** – to reduce the incidence of HIV infection by 50 per cent over five years;

2. **Care, treatment and support** – to increase by 25 per cent the proportion of individuals with HIV who access appropriate care, treatment and support services;

3. **Capacity development** – to enhance the province’s capacity for monitoring the HIV epidemic;

4. **Coordination and cooperation** – to create and sustain support for this province-wide approach.

The 2007 Annual Progress Report documents progress for the 2007 calendar year in achieving the goals and targets established within Priorities for Action. For this report, data has been collected by the BC Ministries of Health Services and Healthy Living and Sport, the BC Centre for Disease Control (BCCDC), the BC Centre for Excellence in HIV/AIDS (BCCfE), the province’s health authorities, service providers, and community partners. In order to foster consistent data collection, templates have been developed in consultation with representatives from each regional health authority and the Provincial Health Services Authority (PHSA) to measure outputs related to each goal. All stakeholders continue to work together to define province-wide data requirements and to achieve some standardization for reporting and evaluation of services.

This report looks at the final year covered within the Priorities for Action framework and marks related progress in responding to and managing the HIV/AIDS epidemics in British Columbia. In 2007, significant steps have been taken to improve care, treatment and support services, while greater efforts are needed to enhance health promotion and prevention services.

To assist with future planning and policy development, this 2007 Annual Progress Report will be followed by an overall evaluation of the Priorities for Action framework for the full term or five-year period. The planned evaluation will highlight key learnings and lay the groundwork for development of new goals for improving prevention efforts and managing the HIV/AIDS epidemics more effectively.
HIV Epidemiology

New HIV Infections\(^5\)

The Human Immunodeficiency Virus (HIV) attacks the human immune system and leaves individuals vulnerable to infections, chronic illnesses, and cancers. The virus is transmitted from an infected individual through body fluids, such as blood, semen, vaginal fluids, and breast milk. This can occur through unprotected sexual intercourse, sharing of needles, and vertical transmission from a mother to a child in vitro, in delivery or through breastfeeding. Currently, there is neither a proven vaccine nor a cure for HIV disease.

In monitoring the epidemic, true incidence of HIV refers to the number of new infections that have occurred within a specified time period, such as a calendar year. Estimates of HIV incidence are largely based on surveillance data from health authorities and service providers, reflecting the number of people testing newly positive for HIV each year. Surveillance data tend to understate the magnitude of the HIV epidemic as the data are based on testing records and do not include individuals who remain untested or undiagnosed. Surveillance data are also subject to reporting delays, under-reporting and changing patterns in testing behaviours. In addition, HIV is a chronic infection with a long clinical course, and many people may be diagnosed years after infection. Although these cases are counted as newly diagnosed HIV infections, they are not true incident cases. Consequently, the number of people testing newly positive for HIV does not necessarily reflect the actual number of new HIV infections for the year or specific period.

The reporting process for HIV cases and the collection of HIV-related patient history have improved greatly since HIV was made a reportable condition in 2003 and an enhanced system for follow-up by public health nurses was implemented across the province. In addition, between 2005 and 2007, the BC Centre for Disease Control developed and improved algorithms for the detection and elimination of duplicate positive HIV tests within the surveillance data; these algorithms have been applied to all data from 1995 and onwards. With these improvements in place, health authorities can better monitor and respond to new HIV diagnoses, and can distinguish new B.C. cases from those who have tested positive outside the province previously. These surveillance improvements have contributed in part to an overall decrease in the rate of newly reported HIV-positive test results within B.C. since 2004.

According to 2007 surveillance data, there was once again an increase in the number of people tested for HIV within B.C.. The available data indicates that 176,017 HIV tests were performed in B.C. in 2007. This represents an increase of 2.5 percent over the 171,748 tests performed in 2006 and an increase of 30.3 percent over the 135,049 tests of 2001, the baseline year for data established within Priorities for Action.

In 2007, the number of persons testing newly positive for HIV in B.C. was 395 – an increase of 10.6 percent from the 357 reported cases in 2006 but 6 percent below the total of the baseline year of 2001.

The HIV infection rate in B.C. correspondingly increased in 2007 – the first time since 2004. The rate of newly reported HIV infections per 100,000 population within the province was 9.1 in 2007, up from 8.3 in 2006 but again still lower than the baseline rate of 10.3 in 2001.

By way of comparison, the national rate of newly reported HIV infections was 7.5 cases per 100,000 population for Canada in 2007. The provincial rate for B.C. remains higher than the national rate and among the highest in the country, illustrating the province’s on-going, disproportionate burden of HIV disease.6

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Overall, men accounted for the majority of new HIV infections in B.C. in 2007, with a rate of 14.2 cases per 100,000 population or 308 males testing newly positive within the province. The rate of new HIV infections among women was 3.8 cases per 100,000 or 84 persons. In 2007, 8 new HIV infections were reported among women as a result of pre-natal screening for the disease, 2 cases fewer than 2006. Generally, women have lower rates of new HIV infections than men across various ethnic communities and population groups, with the exception of Aboriginal women who have had more newly diagnosed HIV infections than Aboriginal men each year since 2005.
In 2007, there was a 1 percent increase over the previous year in the proportion of new HIV infections reported among Caucasian and Hispanic residents of B.C. The proportion of newly identified cases remained the same for Asian and South-east Asian British Columbians across both years, while new infections reported among black populations in the province dropped proportionally by 1 percent.

The number of Aboriginal people testing newly positive for HIV in B.C. was 53 in 2007, down by one reported case from 2006. In 2007, Aboriginal people accounted for 13.4 percent of all persons testing newly positive for HIV, despite comprising approximately 5 percent of the province’s population. Aboriginal women accounted for a highly disproportionate 35.7 percent of all females newly diagnosed with HIV in B.C. Aboriginal men accounted for 7.5 percent of all males newly diagnosed with HIV in 2007 – still a disproportionate representation but less pronounced than among Aboriginal women.

Gay men and other men who have sex with men (MSM) – including MSM who use injection drugs – accounted for approximately 43.3 percent of new HIV infections acquired in B.C. in 2007. This proportion has increased significantly since a low point in 2001, when this population group accounted for 34.5 percent of newly diagnosed HIV infections.

The number of new HIV infections attributable to risk through heterosexual contact also increased in 2007 from the previous year. New infections in this category increased by 12 cases or 16.9 percent from 2006 to 2007.

People who use injection drugs (IDU) – excluding IDU who are also MSM – accounted for approximately 26 percent of new HIV infections acquired in B.C. in 2007. For IDUs, the number of newly identified HIV infections in the province has dropped over 3 years from 119 in 2005, to 110 in 2006, to 101 in 2007.

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In B.C., the breakdown of newly reported HIV infections by age has remained relatively consistent for men between 2006 and 2007. Most new infections occurred among persons ages 30-49 years, and the highest concentration was found among men 30-39 years of age. The situation is quite different for women. Most new infections occurred among women 20-29 years of age, with the highest concentration shifting to younger women each year. From 2006 to 2007, the proportion of HIV infections among women 20-29 years of age increased by 10 percent.

2006

- 50+ 14%
- 40-49 15%
- 30-39 32%
- <20 4%
- 20-29 34%

2007

- 50+ 14%
- 40-49 17%
- 30-39 24%
- <20 1%
- 20-29 44%

Source: BC Centre for Disease Control, Division of STI/HIV Prevention and Control, September 2008.

Each health authority region reported an increase in the number of people with newly diagnosed HIV infections in 2007, as compared to 2006. However, the share of all newly reported infections in BC for each health authority region has remained relatively constant despite these increases.

Share of Newly Reported HIV Infections by Health Authority, 2006 and 2007

2006

- VCH 52%
- FHA 20%
- VIHA 15%
- IHA 5%
- NHA 8%

2007

- VCH 53%
- FHA 2%
- VIHA 5%
- IHA 7%
- NHA 8%

Source: BC Centre for Disease Control, Division of STI/HIV Prevention and Control, September 2008.

In British Columbia, each regional health authority is sub-divided into at least 3 health service delivery areas (Interior Health has four such areas). At the health service delivery area (HSDA) level, the rate of persons testing newly positive for HIV has generally increased in 2007 from 2006, with 10 out of 16 HSDAs reporting more newly identified cases. The largest increase occurred in the Northern Interior HSDA within the Northern Health Authority (NHA), where the
rate rose from 13.2 cases per 100,000 population in 2006 to 16 in 2007. The largest decrease occurred in the Northwest HSDA, also within Northern Health; the rate of new HIV infections in this HSDA dropped from 10.3 cases per 100,000 in 2006 to 6.5 cases in 2007 – a decrease of almost 37 percent.

Change in Rate of Persons Testing Newly Positive for HIV in BC by HSDA per 100,000 population, 2006-2007

<table>
<thead>
<tr>
<th>Health Service Delivery Area</th>
<th>2006</th>
<th>2007</th>
<th>Change 2006 - 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond</td>
<td>0.5</td>
<td>2.2</td>
<td>+1.7</td>
</tr>
<tr>
<td>Vancouver</td>
<td>28.8</td>
<td>30.7</td>
<td>+1.9</td>
</tr>
<tr>
<td>North Shore</td>
<td>2.9</td>
<td>4.7</td>
<td>+1.8</td>
</tr>
<tr>
<td>South Vancouver Island</td>
<td>10.8</td>
<td>9.9</td>
<td>-0.9</td>
</tr>
<tr>
<td>Central Vancouver Island</td>
<td>3.5</td>
<td>3.8</td>
<td>+0.3</td>
</tr>
<tr>
<td>North Vancouver Island</td>
<td>3.4</td>
<td>5.9</td>
<td>+2.5</td>
</tr>
<tr>
<td>Fraser East</td>
<td>3.0</td>
<td>5.5</td>
<td>+2.5</td>
</tr>
<tr>
<td>Fraser North</td>
<td>5.6</td>
<td>6.4</td>
<td>+0.8</td>
</tr>
<tr>
<td>Fraser South</td>
<td>4.6</td>
<td>4.5</td>
<td>-0.1</td>
</tr>
<tr>
<td>Northwest</td>
<td>10.3</td>
<td>6.5</td>
<td>-3.8</td>
</tr>
<tr>
<td>Northern Interior</td>
<td>13.2</td>
<td>16.0</td>
<td>+2.8</td>
</tr>
<tr>
<td>Northeast</td>
<td>0.0</td>
<td>1.5</td>
<td>+1.5</td>
</tr>
<tr>
<td>East Kootenay</td>
<td>2.6</td>
<td>0.0</td>
<td>-2.6</td>
</tr>
<tr>
<td>Kootenay Boundary</td>
<td>5.1</td>
<td>3.9</td>
<td>-1.2</td>
</tr>
<tr>
<td>Okanagan</td>
<td>1.2</td>
<td>2.7</td>
<td>+1.5</td>
</tr>
<tr>
<td>Thompson Cariboo</td>
<td>3.2</td>
<td>2.7</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

Source: BC Centre for Disease Control, Division of STI/HIV Prevention and Control, September 2008.

The Priorities for Action framework sets targets to be achieved incrementally each year over the five-year period from 2003 to 2007. The framework’s prevention target calls for a reduction by 50 percent in the number of persons testing newly positive for HIV by the end of 2007. Using the 420 new infections reported in 2001 as a baseline, this target translates into 210 or fewer people newly diagnosed with HIV for the 2007 calendar year.

In 2007, the total number of new HIV infections reported was 395. This total is lower by 6 percent than the baseline year of 2001. However, this does not represent a large enough reduction to meet the five-year goal and 2007 target specifically.

The limited progress achieved towards the framework’s prevention target at the end of 2007, combined with the small increase of new infections reported within the year, support the on-going need for evidence-based prevention efforts for people most vulnerable to HIV across all health authorities. Clearly, expanding efforts to prevent new infections remains a priority for B.C.
Goal #1: Prevention

The Priorities for Action framework emphasizes the importance of HIV prevention activities for both broader public awareness and the benefit of specific vulnerable population groups. Ideally, prevention and education activities focus on helping people understand and learn about HIV-related risks and correspondingly mitigate risky behaviours.

Broad-based interventions help to inform the general public about the basics of HIV transmission and prevention. As well, they can help to reduce stigma and discrimination associated with the disease.

Targeted prevention efforts address individual, social and environmental risk factors leading to HIV infection within specific population groups. Information and resources delivered in this context must be appropriate for and accessible to diverse communities over the life span. These interventions focus on populations with greater vulnerability to and increased risk of HIV, such as gay men and other men who have sex with men, Aboriginal peoples, injection drug users, incarcerated persons, street involved youth, and women. For people living with HIV, prevention efforts aim to reduce any potential harms associated with unsafe sex and unsafe drug use, as well as to foster improved personal health and well-being.

Prevention Progress in 2007

Each of the province’s health authorities reported on a range of HIV prevention activities that occurred in 2007. Some of these activities were intended to educate the broader public on issues related to HIV and other blood-borne diseases, while other initiatives were intended to mitigate the significant vulnerability to HIV experienced by certain populations. Health authorities delivered some of these educational and prevention activities directly through public health and other health system services. Additionally, they each engaged community organizations in the delivery of many other services and programs for their respective regions.

Although there are still some gaps in the outputs reported, the available data indicates a greater number and range of activities delivered by health authorities and community partners in 2007 over previous periods.

For reporting purposes, health authorities were asked to record prevention activities and data in two categories: broad prevention or educational activities for the general public; and, targeted activities for a specific population group at risk. In 2007, approximately 100 broad-based prevention and education activities reached almost 370,000 people throughout the province, while about 215 targeted prevention activities reached a reported 673,424 people.

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8 BC Health Authorities. Unpublished program and service data; data incomplete in some instances. 2008.
Broad-based Prevention

Among the many broad-based prevention efforts reported in each health region, some new activities were initiated in 2007. The following list highlights a few of these efforts, newly introduced within the 2007 calendar year:

- Within the Provincial Health Services Authority, the Positive Women’s Network organized and delivered two special educational presentations. One presentation focused on emerging prevention technologies (such as microbicides) and gender differences in access, uptake and applicability of these technologies. The other presentation provided information about the new Human Papillomavirus (HPV) vaccine for girls and women, and some considerations specific to HIV.

- In 2007, AIDS Vancouver introduced a program to deliver prevention workshops for diverse communities and settings. Prevention educators have been presenting these workshops in various settings within the Vancouver Coastal Health region based on the specific needs of groups and organizations, or the profile of individuals attending an event.

- In the Fraser Health Authority’s Fraser East HSDA, the Mennonite Central Committee of BC hosted a series of concerts to raise community awareness of HIV/AIDS, and to generate donations to support local programs.

- As part of the activities within the Vancouver Island Health Authority, AIDS Vancouver Island initiated a Red Ribbon awareness campaign on World AIDS Day at a local semi-professional hockey game.

- In Northern Health Authority, Positive Living Northwest in Smithers created a public service announcement for local radio to increase awareness of HIV in the community. With the same intended goal, Positive Living North in Prince George launched an AIDS Awareness Week campaign within the Northern Interior HSDA.

<table>
<thead>
<tr>
<th>Health Authority</th>
<th>Number of Activities</th>
<th>Estimated Number of People Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Health Services</td>
<td>29</td>
<td>176,311</td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>12</td>
<td>64,390</td>
</tr>
<tr>
<td>Fraser Health</td>
<td>22</td>
<td>10,019</td>
</tr>
<tr>
<td>Vancouver Island Health</td>
<td>19</td>
<td>27,388</td>
</tr>
<tr>
<td>Northern Health</td>
<td>10</td>
<td>90,802</td>
</tr>
<tr>
<td>Interior Health</td>
<td>3</td>
<td>169</td>
</tr>
</tbody>
</table>

Source: BC Health Authorities; Data incomplete in some instances. 2008.
Targeted Prevention

Health authorities also reported a variety of new targeted prevention activities for 2007. The following list includes some examples of such initiatives launched within the 2007 calendar year:

• In the Provincial Health Services Authority, the BC Persons with AIDS Society developed and delivered two HIV prevention workshops for gay men. One workshop focused on young gay men, and was delivered through the “Totally Outright” young gay men’s leadership course. The other workshop focused on positive prevention for gay men, and it was offered at the annual Gay Men’s Health Summit in Vancouver.

• Within Vancouver Coastal Health, the supervised injection facility in Vancouver (Insite) began offering HIV point-of-care testing to clients as part of an overall range of services to prevent HIV and other blood-borne diseases among those who use injection drugs. This new service helps to identify individuals living with a previously undiagnosed HIV infection, link them to care and treatment if required, and counsel them on risk reduction strategies.

• At Fraser Health Authority, the Surrey Delta Immigrant Services Society’s ‘Divercity’ program initiated a number of activities in 2007 that focus on South Asian women and youth. Many of these initiatives use beauty shops as an access point for these communities.

• In 2007, AIDS Vancouver Island (AVI) initiated three new targeted prevention activities within Vancouver Island Health Authority. The organization hosted three sexual health days, reaching 575 secondary school students, in order to increase understanding of HIV, sexually transmitted diseases, and safer sex practices. AVI also delivered a workshop at a youth body-art event on safer body modification practices. In addition, the organization piloted the GEAR outreach program within the Victoria region, targeting people who are highly vulnerable, street-involved injection drug users.

• Within Northern Health Authority, Positive Living North’s outreach for young forensic offenders, established in 2007, helps participants to consider the impact that HIV infection might have on their happiness and well-being as a complement to information about risk reduction. The group consists of individuals with severe personality and attachment disorders, as well as sex offenders.

Targeted Prevention Activities by Health Authority, 2007

<table>
<thead>
<tr>
<th>Health Authority</th>
<th>Number of Activities</th>
<th>Estimated Number of People Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Health Services</td>
<td>37</td>
<td>21,387</td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>69</td>
<td>294,823</td>
</tr>
<tr>
<td>Fraser Health</td>
<td>59</td>
<td>98,917</td>
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<tr>
<td>Vancouver Island Health</td>
<td>19</td>
<td>182,312</td>
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<tr>
<td>Northern Health</td>
<td>18</td>
<td>3,525</td>
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<tr>
<td>Interior Health</td>
<td>13</td>
<td>72,460</td>
</tr>
</tbody>
</table>

Source: BC Health Authorities; Data incomplete in some instances. 2008.
Priorities for Action in Managing the Epidemics: HIV/AIDS in B.C.

Harm Reduction Supplies

Access to harm reduction supplies, such as condoms and sterile injection equipment, is an important strategy for the prevention of HIV and hepatitis C, especially among populations with greater vulnerability to the disease. In 2007, through the provincial Harm Reduction Strategies and Services program, the BCCDC supplied the province’s health authorities with 3.26 million male condoms and 34,000 female condoms for distribution to individuals. This represents a significant increase in demand over the 2.7 million male condoms and 29,000 female condoms supplied for this purpose in 2006. The same pattern of growth can be observed in requests for needles and syringes. In 2007, BCCDC provided 5.37 million brand-new needles and syringes to the health authorities, compared to over 4.4 million in 2006.

Each health authority delivers a set of services related to the distribution of clean needles, collection of used needles, and the recovery of improperly discarded needles. These harm reduction services are either delivered directly by the regional health authority in question and/or by their contracted community-based agencies. Currently, inconsistent reporting of data from these initiatives prevents a comparative analysis of outputs across health regions.

Methadone Maintenance

Methadone Maintenance Treatment (MMT) is an effective substitution treatment for heroin addiction. It is delivered orally, thereby reducing the risk of HIV transmission through potentially unsafe injection practices. According to data reported by the College of Physicians and Surgeons, the number of people receiving this form of treatment increased from approximately 8,207 in 2006 to 8,985 in 2007 in British Columbia, an increase in coverage of approximately 9.5 percent.

Number of Clients Enrolled in the BC Methadone Maintenance Program, 2006 and 2007

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Number of Clients (MMT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>8,207</td>
</tr>
<tr>
<td>2007</td>
<td>8,985</td>
</tr>
</tbody>
</table>


Progress Summary: Prevention

Prevention of HIV disease remains a provincial priority. In 2003, a target of a 50 percent reduction in newly reported HIV infections was established within the Priorities for Action framework to inspire progress related to prevention. As mentioned above, some progress has been made toward this end in 2007.

The number of HIV tests performed in the province continued a pattern of annual growth, increasing by 2.5 percent in 2007. Establishing greater access to and uptake of HIV testing services is an important strategy for reducing the number of people who are living with

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9 BC Centre for Disease Control. BC Harm Reduction Strategies and Services Committee, 2008
HIV but are unaware of their infection. Such services can act as a link for newly diagnosed individuals to appropriate care and treatment services, and to important information to reduce the risk of disease transmission to others.

In 2007, the rate of newly identified HIV infections per 100,000 population in B.C. increased by 9.6 percent from 2006.\textsuperscript{12} Growth in the number and/or rate of newly identified HIV infections within the province is an undesirable trend that conflicts with the goals of Priorities for Action. Despite this increase, the 2007 rate is still 11.7 percent lower than the baseline year of 2001, but this is not low enough to approach and meet the target of 5.2 cases per 100,000 set for 2007.\textsuperscript{13}

Although there has been an overall cumulative decrease in the rate of newly reported infections and some positive progress, greater efforts are required to achieve a significant reduction in HIV incidence as required within the Priorities for Action framework. To achieve enhanced progress and move closer to original targets, evidence-based prevention efforts must continue to be a priority for reducing the impact of HIV on individuals at risk, and by extension the health care system.

In moving this work forward, particular consideration must be extended to prevention efforts with men who have sex with men as well as Aboriginal people. More than 20 years into the HIV epidemic here in British Columbia, gay men and other men who have sex with men (MSM) continue to be one of the population groups most vulnerable to and affected by HIV/AIDS. This corresponds to similar patterns and findings in a number of jurisdictions around the world. Renewed prevention efforts are required for gay men, and this work needs to consider the evolving social and environmental factors within the gay community, as well as emerging evidence regarding new approaches and techniques.

In addition, renewed prevention efforts need to address the impact of HIV/AIDS on Aboriginal people and particularly Aboriginal women. In British Columbia, Aboriginal people are affected disproportionately by HIV despite small decreases recently in new infections. Each health authority and region has some level of HIV prevention programming and services in place for Aboriginal people and communities. To extend the reach and improve access to these services, prevention efforts must address the deeply rooted determinants of HIV vulnerability in Aboriginal people, such as the legacy of the residential school system, higher than average rates of suicide among youth, and problematic substance use. In particular, prevention efforts must be accessible and meaningful for Aboriginal women, who clearly experience greater vulnerability to the disease than their male peers.

These prevention priorities remain consistent with those identified within the previous Progress Report for calendar year 2006.

\textsuperscript{12} Ibid.
\textsuperscript{13} Ibid.
Goal #2: Care, Treatment and Support

HIV care, treatment and support services refer to a range of community-based and health care services required for managing the epidemic, slowing disease progression, and improving quality of life for people living with HIV and AIDS.

Care and treatment services include HIV primary care, specialist care, drug treatment, mental health, addictions services, supported self care, hospital care, home and community care, and end-of-life care. Both primary and specialist care may include antiretroviral therapy and assessment of complications.

The majority of HIV primary care service in B.C. is provided by general practitioners and family doctors in private practice. These services are also available through hospitals, emergency departments or community clinics in each health authority or region for those without access to a physician. In addition, specialist care is provided on referral by a small number of HIV specialists throughout the province, including physicians at the BCCfE and the Oak Tree Clinic at BC Women’s Hospital and Health Centre.

Support services focus on improving care and treatment outcomes for individuals with HIV and reducing vulnerability to accelerated disease progression for some higher-risk populations. Support services include information, referrals, community-based case management, and peer support for people with HIV and AIDS. Such services are designed to address the social determinants of health, such as income, employment, housing, and social support.

HIV Drug Treatment Coverage

The globally accepted standard treatment for HIV is highly active antiretroviral therapy (HAART), which combines at least three drugs from two or more different classes of antiretrovirals (ARV). The aim of antiretroviral therapy is the long-term suppression of replication of the HIV virus. This leads to improved immune system function which, in turn, prevents illnesses, extensive hospital utilization, and mortality related to HIV and AIDS.

Currently, the most reliable and available measure of the level of appropriate care and treatment services for HIV in B.C. is the proportion of the total number of people believed to be living with HIV (the prevalent population) who are actively on HAART. In 2007, an estimated 10,420 people were living with HIV in B.C. (based on 2005 HIV prevalence estimates and the most recent data available from the Public Health Agency of Canada). Of this total, approximately 5,927 people were enrolled in the provincial HIV Drug Treatment Program (DTP) managed by the BCCfE, including 4,665 participants actively on HAART. This translates into a coverage level of approximately 45 percent of the HIV prevalent population, surpassing the target established within Priorities for Action of 38 percent coverage for the year.

Targeted Increase for the Proportion of Individuals Engaged in HAART Treatment, 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent Increase required from Baseline</th>
<th>Proportion of HIV Population on HAART required to reach Targets</th>
<th>Number of Individuals actually on HAART</th>
<th>Estimated Proportion of HIV Population on HAART</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>25</td>
<td>38%</td>
<td>4665</td>
<td>45%</td>
</tr>
</tbody>
</table>


There have been annual increases consistently within B.C. in the number of people who are engaged in HIV care and treatment – using HAART coverage as an indicator of progress – since the baseline year of 2001. Each year, more people have accessed HIV care and treatment, consistently exceeding treatment targets set out within the Priorities for Action framework.

The number of participants in the DTP has increased across all health authorities over the five-year period of the framework. In 2007, the largest regional share of active participants in the program was 59 percent (2,736) in Vancouver Coastal Health, up slightly from 58 percent in 2006. This is followed by Fraser Health with 21 percent (997) and Vancouver Island Health Authority with 12 percent (551) of the active participants in the provincial Drug Treatment Program.

Number of Drug Treatment Program Participants on ARV Treatment by Health Authority of Residence, 2003-2007


In 2007, approximately 30.5 percent (1421) of active DTP participants were people who use injection drugs, a 5.7 percent increase in injection drug user participants over 2006. The number of individuals from this population group on HAART increased across all health authorities between 2006 and 2007.
In 2007, 21.3 percent of individuals with newly reported HIV infections were women, though they comprise only 15 percent of people who are currently accessing treatment. This under-representation suggests that more focused and effective efforts are needed to engage women in appropriate care, treatment and support. Such efforts need to focus on more accessibility and support with gender-appropriate services, with particular attention paid to needs defined by culture, language, and regional contexts.

Aboriginal people also continue to be underrepresented in the provincial Drug Treatment Program. This is the case despite rates of newly reported HIV infections and estimated HIV prevalence that continue to be higher among Aboriginal people than non-Aboriginal people in the province. Clearly, as is the case with HIV prevention, there is a need to improve efforts and engage Aboriginal people with HIV in appropriate care and treatment services.
Services for Aboriginal people living with HIV need to be culturally appropriate and consider the following:

- A greater presence of Aboriginal front-line service providers;
- Professional development and training opportunities on Aboriginal cultures for health service providers;
- Delivery of care and treatment services in a manner informed by traditional healing practices;
- Partnerships with Aboriginal AIDS organizations;
- Seamless delivery of services across all jurisdictions.

**Population Health Outcomes**

Appropriate ongoing care for people living with HIV includes regular testing to monitor a variety of indicators that reflect the progression of HIV disease. One of the most common of these tests assesses the volume of CD4 cells within a blood sample. CD4 cells are part of the human immune response, and an individual’s CD4 count can reflect the state of the health of one’s immune system. A higher CD4 count generally means a stronger immune system, and with a higher CD4 count, the individual’s immune system is better prepared to prevent illnesses and infections.

The BCCfE collects and houses the results of CD4 testing performed across the province in order to inform decisions about HIV treatment. Using this data, median CD4 levels can be calculated for the entire population enrolled within the provincial Drug Treatment Program. The table below represents the median CD4 counts in 2006 and 2007 for people living with HIV enrolled in the DTP. The data is broken down by health authority region and gender.

<table>
<thead>
<tr>
<th></th>
<th>2006 Male</th>
<th>2006 Female</th>
<th>2007 Male</th>
<th>2007 Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCH</td>
<td>440</td>
<td>340</td>
<td>440</td>
<td>360</td>
</tr>
<tr>
<td>VIHA</td>
<td>370</td>
<td>330</td>
<td>390</td>
<td>375</td>
</tr>
<tr>
<td>FHA</td>
<td>410</td>
<td>345</td>
<td>430</td>
<td>350</td>
</tr>
<tr>
<td>NHA</td>
<td>330</td>
<td>300</td>
<td>330</td>
<td>280</td>
</tr>
<tr>
<td>IHA</td>
<td>390</td>
<td>400</td>
<td>390</td>
<td>380</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>420</strong></td>
<td><strong>340</strong></td>
<td><strong>420</strong></td>
<td><strong>360</strong></td>
</tr>
</tbody>
</table>

*Source: BC Centre for Excellence in HIV/AIDS. Drug Treatment Program. 2008.*

For males, median CD4 counts were constant between 2006 and 2007 in Vancouver Coastal Health, Interior Health, and Northern Health; in the same period, median counts for males improved slightly in Vancouver Island and Fraser Health Authorities.

For females, the trends differ slightly. Overall, CD4 counts for females have improved in Vancouver Coastal Health, Fraser Health, and Vancouver Island Health Authorities; however, median CD4

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counts decreased in Northern Health and Interior Health indicating an associated decrease in overall health status on a population level for women living with HIV in these two regions.

The viral load test is another regular laboratory procedure for people living with HIV. The viral load test measures the volume of RNA from the HIV virus within a blood sample. This volume is considered to correspond proportionally to the volume of HIV virus itself within the sample, and by extension within the individual’s overall blood stream. In contrast to a CD4 count, a low viral load count is a good test result, generally indicating lower levels of HIV within an infected individual. The viral load test is used primarily to assess trends over time, reflecting the effectiveness of various treatment options and formulations. Patient viral load results are also collected and housed centrally within the Drug Treatment Program at the BCCfE.

Generally, median viral load levels were consistently low for those enrolled in the Drug Treatment Program across the province, indicating a good level of program success in achieving positive patient outcomes. The one notable exception was women in Northern Health who had a median viral load level more than 3 times higher than their male peers in 2007. This corresponds with the decrease in median CD4 count reported for this population as noted above. Given that the reported incidence of HIV among Aboriginal women in the North is very high, this result reinforces the need to focus on appropriate ways to engage and retain Aboriginal women in HIV care and treatment.

**Community Support**

In 2007, community organizations throughout British Columbia continued with efforts to engage vulnerable populations in HIV care, treatment and support. In each health authority region, community support services and activities continued to reach many people.

**Community Support Services by Health Authority - 2007**

<table>
<thead>
<tr>
<th>Health Authority</th>
<th>Number of Activities</th>
<th>Estimated Number of People Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Health Services</td>
<td>39</td>
<td>42,786</td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>29</td>
<td>362,743</td>
</tr>
<tr>
<td>Fraser Health</td>
<td>27</td>
<td>4,973</td>
</tr>
<tr>
<td>Vancouver Island Health</td>
<td>15</td>
<td>8,384</td>
</tr>
<tr>
<td>Northern Health</td>
<td>5</td>
<td>98</td>
</tr>
<tr>
<td>Interior Health</td>
<td>10</td>
<td>15,693</td>
</tr>
</tbody>
</table>


New community support services and activities were introduced in 2007 within each of B.C.’s health authorities. Some examples of new activities for the calendar year are highlighted as follows:

- In Interior Health, the AIDS Society of Kamloops began to offer Reiki therapy to the agency’s lower-income clients. As well the Society initiated a weekly peer support group for people living with HIV or an HIV/HCV co-infection.

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17 BC Health Authorities. Unpublished program and service data; data incomplete in some instances. 2008.
• Within Northern Health, Positive Living North worked with the health authority to initiate planning for a shelter with a walk-in clinic. The shelter/clinic is intended to help meet the needs of highly marginalized people living with or vulnerable to HIV in the Prince George area.

• The Fraser Health Authority worked with the Mennonite Central Committee of BC to establish an HIV support worker to help meet the various needs of people living with HIV in the Fraser East HSDA. In 2007, Fraser Health also began reaching out to Aboriginal people living with HIV and HCV in the region through a formal partnership with the Klahowehya Aboriginal Centre.

• The BC Persons with AIDS Society, supported by Provincial Health Services Authority, launched its Treatment Information Blog as a new element of its highly successful Treatment Information Program. The Blog provides a user forum, and notes topics of potential interest. Individuals are encouraged to participate directly in the online discussions.

Progress Summary: Care, Treatment and Support

Within British Columbia, the proportion of people living with HIV and actively on HAART was approximately 45 percent in 2007, exceeding the year’s target of 38 percent coverage as established by Priorities for Action. As data related to engagement in HAART is the most reliable indicator available, this coverage rate serves as a proxy for measuring broader engagement in HIV care and treatment.

For those engaged in care and treatment and enrolled within the provincial Drug Treatment Program database, available data related to median CD4 and viral load counts suggests a generally improved level of success in maintaining the health of people living with HIV. However, while some progress has been made in engaging people in appropriate HIV care, treatment and support, there are certain population groups that continue to be underserved and at heightened risk of HIV-related illness, disease transmission, and premature death. New approaches are required for improving engagement within HIV-related care and treatment services for women and Aboriginal people in British Columbia. Such approaches need to address barriers related to gender, ethnicity, socioeconomic status, and sexuality. The services also need to be delivered with a clear understanding of culture, characteristics specific to each region, and traditional healing practices. Trends related to median CD4 and viral load counts indicate that such development of such services is a particular priority in the province’s North.

According to 2007 data available from health authorities, community organizations across the province continued to deliver support services to an increasing number of people living with HIV. These services are an important component of a comprehensive and integrated continuum of care for people with HIV/AIDS. Efforts to strengthen the links between community support programs and clinical services are needed to increase uptake of care and treatment by underserved populations.

Goal #3: Capacity Development

The third goal of the Priorities for Action framework is to enhance the province's capacity for monitoring the HIV epidemic, related trends, and service needs over five years. This goal includes strategies for expanding research related to HIV/AIDS, developing an enhanced surveillance system with existing data sources, and evaluating services with health authorities. Capacity development helps curb the spread of the HIV epidemic and provide effective care, treatment and support services for people living with HIV/AIDS. In 2007, progress continued with significant efforts to improve HIV surveillance, access to HIV testing, and uptake of HIV treatment.

HIV Point of Care Testing

Currently, British Columbia provides high quality standard HIV testing to all individuals through a laboratory-based system in the province. People using standard HIV testing usually receive results within one to two weeks.

Taking advantage of a recently approved kit developed and manufactured here in British Columbia, a working group with representatives from the Ministry of Healthy Living and Sport, BCCDC and health authorities began exploring pilots for use of HIV Point of care (POC) or 'rapid' HIV tests to supplement and expand standard testing efforts. POC tests can be used by a health care provider in both clinical or outreach settings. Unlike standard testing, individuals tested with POC kits can receive preliminary test results on the same visit.

The potential availability of point of care HIV test kits, along with confirmation of positive results through standard lab-based testing, can assist in providing increased screening opportunities for vulnerable populations and hard-to-reach individuals, and by extension reduce the number of individuals with HIV who are unaware of their infections. These efforts open the door to vital HIV care and treatment services for target populations and groups. In late 2007 the first health authority pilot of POC testing began in Vancouver Coastal Health at Insite, Vancouver’s supervised injection facility. BC Corrections also began using POC testing within 3 provincial correctional facilities in 2007.

HAART Treatment to Enhance Prevention

The BC Centre for Excellence in HIV/AIDS (BCCfE) provides a number of key functions that contribute significantly to the province-wide response to HIV/AIDS. Among these contributions is the management of the program that distributes HIV medications in B.C. – the provincial Drug Treatment Program mentioned previously.

The introduction of Highly Active Antiretroviral Therapy (HAART) in 1996 as the gold standard of HIV treatment has led to significant improvements in HIV-related morbidity and mortality. Evidence gathered by the BCCfE also suggests that engaging infected individuals in successful, sustained HAART treatment greatly reduces the likelihood they will transmit HIV to others. Recent population-based research demonstrates that widespread access to HAART can reduce mortality and illness related to HIV, and can also enhance traditional prevention efforts to reduce HIV incidence and prevalence. These benefits increase over time in proportion to the number of people taking HAART.

people eligible for treatment who are actively treated with HAART. Expanded uptake of HAART could also yield long-term cost-avoidance for the health care system by averting HIV infections and the corresponding direct and indirect costs associated with HIV-related illnesses.

In 2007, the BCCfE began exploring what might be required to expand the uptake of HAART treatment among eligible individuals here in B.C. – these efforts continued into 2008. On an international level, the conceptual framework underscoring this work has increasingly become the focus of dialogue and media attention related to HIV/AIDS, and potential changes in the overall global response to the pandemic.

**BC’s Viral Hepatitis Framework**

In May 2007, the Ministry of Health released Healthy Pathways Forward: A Strategic Approach to Viral Hepatitis in British Columbia, which represents a renewed provincial approach to hepatitis A, B and C. This strategic framework was developed in collaboration with health authority representatives and in partnership with BCCDC’s BC Hepatitis Services Division, established by the province to support evidence-based and performance-based approaches for the prevention and management of viral hepatitis infections.

The framework’s vision for healthy pathways toward a hepatitis-free B.C. focuses on efforts to improve health and wellness by reducing vulnerability, and presents a roadmap for achieving this by setting four health system goals: improving prevention; extending program and service reach; enhancing capacity; and developing partnerships. Healthy Pathways Forward emphasizes greater integration and efficiency, and it provides a complementary approach for reducing vulnerability to all blood borne diseases. The specific challenges of responding to co-infections and blood borne disease, such as HIV, inform many of the framework’s suggested strategies.
Goal #4: Coordination and Cooperation

The fourth goal focuses on building broad support for the approaches within the Priorities for Action framework and increasing coordination and cooperation among HIV/AIDS stakeholders across the health system. This can be seen to include activities for fostering collaboration among stakeholders at the community, regional, provincial and federal levels. Successful collaboration supports integration of prevention, surveillance, and treatment activities for HIV/AIDS, hepatitis C and co-infections. Key strategies focus on service integration, vulnerable populations, information sharing, and best practices.

Collaborative Action

In 2006, representatives from the province’s Aboriginal AIDS Service Organizations – with support from Provincial Health Services Authority – formed the ‘Renewing Our Response’ Leaders Team to respond to the HIV-related vulnerabilities and needs of Aboriginal people in a coordinated and collaborative manner. The team identified seven goals out of a total of twenty-four recommendations resulting from a provincial Aboriginal HIV/AIDS forum held in the spring of 2005:

1. Increase coordination among funding agencies and address barriers to HIV/AIDS services;
2. Increase funding and supports for Aboriginal program development and service delivery;
3. Create and evaluate culturally appropriate policies and strategies for Aboriginal people;
4. Build capacity and collaboration among stakeholders;
5. Support innovative resource development;
6. Empower Aboriginal people living with HIV to develop peer support, training, and self advocacy skills; and,
7. Build capacity and support with community and research agencies to conduct culturally appropriate research on prevention, surveillance, treatment, and care in Aboriginal communities.
In late 2007, the ‘Renewing Our Response’ Leaders Team presented these seven goals to representatives of governments, funding bodies and health authorities. From this presentation emerged a commitment to work together on these goals, guided by B.C.’s tripartite First Nations Health Plan.

In the North of the province, the Northern Aboriginal HIV/AIDS Task Force continued its multi-stakeholder and multi-jurisdictional work planning responses to the rising rates of HIV among Aboriginal people within the region. In 2007, the Task Force led efforts to provide leadership training to Aboriginal youth in the North. Youth who received this training are expected to use their knowledge and skills to educate peers in home communities about HIV and risk reduction practices. This work was supported by a number of Task Force partners, including the B.C. Ministry of Health and the Northern Health Authority.

In 2007, the third annual BC Gay Men’s Health Summit focused on developing and promoting a holistic approach to gay men’s health. Sponsored in part by the BC Ministry of Health and organized by the Community Based Research Centre, this event looked at shaping a renewed, collaborative community-based response to gay men’s health issues.
Conclusion

The 2007 Annual Progress Report provides a retrospective examination of the HIV epidemic in B.C. and the effectiveness of the associated provincial response for managing the epidemic locally.

Focus on HIV Prevention and Testing

Prevention is identified as a key priority within the Priorities for Action framework and remains a provincial priority for reducing the number of new HIV infections that occur annually within B.C.

In British Columbia, the number of individuals living with HIV and AIDS in 2007 is conservatively estimated at 10,420 based on 2005 data from the Public Health Agency of Canada – the most recent year for which HIV prevalence estimates are available. The estimated proportion of that HIV prevalent population unaware of their infection is 27 percent, or approximately 2,800 people.\(^{20}\) In response to this, the number of HIV tests performed in the province continues to increase, growing once again in 2007 by 2.5 percent.\(^{21}\) Greater access to and uptake of HIV testing services must continue to be supported in order to reduce the number of people living with an undiagnosed HIV infection, and to help them access appropriate care and support services.

In 2007, the rate of newly identified HIV infections per 100,000 population in B.C. increased by 9.6 percent from 2006, a direction that conflicts with the goals of Priorities for Action. Despite this increase, the 2007 rate is still 11.7 percent lower than the baseline year of 2001, but this is not low enough to approach and meet the target of 5.2 cases per 100,000 set for 2007, or an overall decrease of 50 percent from the baseline year.\(^{22}\)

Prevention efforts must remain an on-going priority for work towards achieving original targets and improving progress. Emphasis must continue to be placed on improving efforts to reach communities and populations vulnerable to HIV, and particular attention must be paid to engagement of disproportionately affected populations such as gay men and Aboriginal people within meaningful and relevant prevention programming.

More HIV Treatment and Support Services

HIV care, treatment and support services refer to a range of community-based and health care services required for managing the epidemic, slowing disease progression, and improving quality of life.

In B.C. in 2007, the proportion of the HIV prevalent population actively on treatment for the disease (HAART) was approximately 45 percent, surpassing the year’s target of 38 percent. This is the fifth consecutive year that this treatment coverage rate has exceeded annual targets.\(^{23}\) As a broad measure of success, the increased number of people accessing treatment and support services can be seen to suggest a corresponding increase in the reach of HIV care services.

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\(^{22}\) Ibid.

However, although progress has been made in engaging more people within HIV care and treatment services, certain population groups continue to be underserved and at risk of accelerated HIV disease progression. New or adapted approaches are required for improving the uptake of HIV-related care and treatment services among women and Aboriginal people living with the disease in B.C. Such approaches will require an understanding of existing service barriers, as well as gender, culture, and traditional healing practices.

**New Approaches**

Innovative approaches and tools for HIV surveillance and prevention help combat this epidemic locally and internationally. As part of a comprehensive approach to management of HIV disease, the use of antiretroviral therapy may also offer strategic help with enhancement of existing approaches to prevention. The research and modeling efforts related to this, led by the BCCfE, may offer an additional, valuable tool to help reach provincial prevention targets in future periods. As well, this work may have significant potential to contribute to the global response to the epidemic.

**Future Directions**

The 2007 Annual Progress Report will be followed by a more thorough analysis and evaluation of the Priorities for Action framework. This additional report will adopt a more longitudinal approach to analysis – looking at trends over a five year period – and will assist the province with future planning and policy development related to management of the provincial HIV epidemic. Through this initiative and beyond, the Ministry of Healthy Living and Sport will continue working with other ministries, health authorities and community agencies to define and refine province-wide goals, and to strengthen prevention and support services for HIV/AIDS across British Columbia.
# Appendix #1: Priorities for Action Goals and Objectives

**PREVENTION:** To reduce the incidence of HIV infection by 50% over the next 5 years

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce incidence of HIV infection among the most vulnerable groups by 50% over the next five years</td>
<td></td>
</tr>
<tr>
<td>To reduce proportion of seropositive individuals who are unaware of their HIV infection by 50% over the next five years</td>
<td></td>
</tr>
<tr>
<td>To sustain effective systems of care for women living with HIV and ensure no infants are born with HIV over the next five years</td>
<td></td>
</tr>
</tbody>
</table>

**CARE, TREATMENT AND SUPPORT:** To increase proportion of HIV+ individuals linked to appropriate care, treatment and support services by 25% over the next 5 years

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure HIV+ individuals are aware of care, treatment and support services available in their communities</td>
<td></td>
</tr>
<tr>
<td>To ensure care, treatment and support services are available for and accessible to vulnerable groups of HIV+ individuals</td>
<td></td>
</tr>
<tr>
<td>To ensure HIV+ women from the most vulnerable groups access antiretroviral therapy at the same rate as women in the general population</td>
<td></td>
</tr>
</tbody>
</table>

**CAPACITY:** To enhance the province’s capacity to monitor the HIV epidemic over the next 5 years

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To strengthen the province’s ability to reach and inform persons who may be unaware of their HIV infection</td>
<td></td>
</tr>
<tr>
<td>To strengthen the province’s ability to anticipate epidemiological trends and service needs in HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>To improve epidemiological and other knowledge about HIV/AIDS among health authorities and community-based organizations</td>
<td></td>
</tr>
</tbody>
</table>

**CO-ORDINATION AND CO-OPERATION:** To create and sustain broad-based support for the approach outlined in Priorities for Action

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To strengthen the policy, program and service co-ordination among provincial ministries, health authorities and AIDS service organizations</td>
<td></td>
</tr>
<tr>
<td>To integrate prevention, surveillance and treatment activities associated with HIV/AIDS and Hepatitis C</td>
<td></td>
</tr>
<tr>
<td>To contribute more fully to international efforts to combat HIV/AIDS in developing countries</td>
<td></td>
</tr>
</tbody>
</table>