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Executive Summary

In the first fiscal year of the Seek and Treat for Optimal Prevention of (STOP) HIV/AIDS provincial program (2013/14) implementation, the health system across B.C. is implementing lessons learned during the STOP HIV/AIDS pilot. These changes are making improvements along the HIV cascade of prevention and care. Work continues to ensure an equitable reach of evidence-based prevention services like sterile needles and condom distribution. HIV testing reach is being enhanced. People living with HIV are better engaged in care, treatment and support — maximising not only their own health, but supporting the population-level preventive effects of HIV therapy.

The number of newly diagnosed HIV infections in 2013/14 was 288. This was an increase over 216 in 2012/13. This was expected with expanded testing to find those living with HIV who are unaware of their infection (Goal 1).

To decrease new infections over the long term, partners are improving the quality, effectiveness and reach of HIV prevention services (Goal 2). Work to achieve equitable reach of safer sex and drug use supplies continues; however, results are variable. In 2013/14, orders of sterile needles and condoms increased in almost every region of the province, but current data indicates supply distribution is not equitable across metro, urban, rural and remote locations in British Columbia.

The other measure of prevention is the preventative effect of HIV treatment, or treatment as prevention. At the end of 2013/14, the majority of regions observed fewer people living on HIV treatment with a detectable viral load, making them unlikely to transmit the virus to others.

Improved reach and engagement of people living with HIV, and supporting early diagnoses, is a critical step to improving people's health (Goal 3). This will also maximise the secondary transmission prevention benefits of HIV treatment. To diagnose people earlier, HIV testing must effectively reach all those who need it. Outreach testing, routine offers of testing in new locations such as hospitals, and expanded HIV point of care testing resulted in all regions testing more people than they did in 2012/13. Guidance to primary care providers on routinely offering an HIV test to adults will help the system embed HIV testing and care in routine medical care for all British Columbians.

More people were tested for HIV when diagnosed with hepatitis C virus in B.C. in 2013/14, while the number of those tested for HIV when tested for syphilis was stable. It is expected that future progress reports will illustrate regional success in increasing the proportion of those diagnosed early in their illness, and decreasing the proportion of those diagnosed with advanced HIV disease.
Improving the quality and reach of HIV support services for those living with and vulnerable to HIV is another key piece of ensuring British Columbians stay as healthy as possible (Goal 4). The B.C. Centre for Excellence in HIV/AIDS estimates that approximately 90% of the over 9000 people living with HIV in B.C. are linked to care, with 53% of them living with a suppressed viral load. A significant outcome measure for this work is the proportion of those living with HIV actually receiving drug treatment. As of March 2012, 73% of people living with HIV in B.C. were actively receiving treatment. Future progress reports will illustrate improvements in this milestone.

Population-level evaluation of the STOP HIV/AIDS program is demonstrating that diagnosing people earlier in their infection and linking them to care is not only the right thing to do for the individual and for the community; it can avert health system costs (Goal 5). Future reports will include further results of this analysis.

Regions reported on how their implementation is underpinned by the guiding principles of From Hope to Health — fighting stigma and discrimination, community engagement, reach and engagement and Aboriginal engagement. With the newly formed First Nations Health Authority and our valued community partners, this report identifies the importance of these principles in ensuring everyone who needs it is reached by appropriate and effective prevention and care.
Introduction

In January 2013, the Ministry of Health released *From Hope to Health: Towards an AIDS-free Generation (From Hope to Health)*. This framework provides guidance to health authorities on incorporating HIV treatment as prevention into best practices for HIV prevention already underway in British Columbia.

*From Hope to Health* describes many of the successes from B.C.’s Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) pilot, with guidance for scaling up across B.C., and identifies evidence for enhanced primary prevention activities such as harm reduction.

**PURPOSE/SCOPE**

Government committed to annual progress reporting for three years on the goals, milestones and targets (described as “what this will mean” statements) in *From Hope to Health*. This document reports on progress from implementation in the first fiscal year (2013/14).¹ ²
First Year Progress

The three main findings are:

» Testing has increased in every region, with some non-pilot regions close to implementing a routine offer of HIV testing in acute care and family practice.

» Added intensity to ensure equitable reach of sterile needles and condoms varies across the province, and current data indicates most regions requiring further work to ensure supplies reach everyone who needs them.

» Fewer people in B.C. who are receiving treatment are living with a detectable viral load.

With their community and health system partners, health authorities are improving the reach of HIV prevention, testing and care. In addition to supporting health system partners, the B.C. Centre for Excellence in HIV/AIDS (BCCfE) is completing economic and health impact analysis on HIV Treatment as Prevention and enhancing the quality of HIV care across the province; and the Provincial Health Services Authority, including the B.C. Centre for Disease Control (BCCDC), is improving specialised women’s support programs and developing online sexual health services.

This report focuses on the five goals of From Hope to Health. Relevant milestones and targets are situated within each goal. The goals correspond to points along the HIV cascade of prevention and care, illustrated in the From Hope to Health strategic framework and below in Figure 1.³

![Figure 1: Graphic identifying the steps of the HIV cascade of prevention and care](image-url)
The BCCfe/BCCDC-developed HIV cascade of care quantifies the last six steps in the above representation of the HIV cascade of prevention and care. This shows the number of people living with HIV and aware (diagnosed), and identifies the number retained at each of the remaining steps in the cascade. Differences in the proportion of those retained at each step can be seen by gender in Figure 2.

Improving outcomes for those vulnerable to or living with HIV relies on ensuring the system reaches and engages everyone into prevention, testing, treatment and support. Work towards the goals of From Hope to Health will ensure that fewer people “fall off” the cascade at every step.

FIGURE 2: CASCADE OF CARE FOR B.C. (TOTAL, AND BY GENDER) (USED WITH PERMISSION FROM B.C. CENTRE FOR EXCELLENCE IN HIV/AIDS, 2014)
Goal 1: Reduce the Number of New HIV Infections in British Columbia

**PROGRESS IN YEAR ONE: 288 NEW HIV INFECTIONS IDENTIFIED IN 2013/14**

The number of new HIV diagnoses in B.C. has been steadily decreasing since the mid 1990’s. There were 213 new infections diagnosed in 2012/13 — the lowest ever in the province. In 2013/14, this number rose to 288 new HIV diagnoses (Figure 3).

![Figure 3: New HIV Diagnoses in 2013/14 Compared to Baseline (2012/13)](image)

Every region diagnosed more people in the first program year than 2012/13. Increases in new diagnoses are expected early in the program due to better reach of testing. Over the long term, B.C. should see a decrease in newly diagnosed infections. This will come from enhanced reach of harm reduction supplies; from more people being diagnosed early in their infection before they are able to pass the infection on; and from the preventive effects of a larger proportion of people well engaged in treatment.

Goal 2: Improve the Quality, Effectiveness and Reach of HIV Prevention Services

The HIV cascade of prevention and care starts with the number of people vulnerable to HIV but not yet infected. *From Hope to Health* focuses on two key prevention interventions:

1. Ensuring equitable reach of harm reduction supplies; and
2. Striving to support those living with HIV to be on highly active antiretroviral therapy.
TARGET: BY 2016, THERE WILL BE EQUITABLE REACH OF HARM REDUCTION SUPPLIES PROPORTIONATE TO POPULATION DENSITY IN EACH LOCAL HEALTH AREA IN THE PROVINCE.

PROGRESS IN YEAR ONE: VARIABLE

The purpose of this target is to ensure British Columbians in all communities are equitably reached with harm reduction supplies. Surveillance indicates good reach of supplies in some areas (i.e., Downtown Eastside of Vancouver) (BC Harm Reduction Strategies and Services Committee, 2013). However, research indicates that there is inequitable reach across the province, particularly in non-metro or non-urban locations (Spittal, 2007; Palmantier and Plasway, 2014).

The average distribution of supplies per 100,000 people before the STOP HIV/AIDS program was calculated for each region. Then the distribution of supplies per 100,000 people in each local health area was calculated. By 2016, local health areas that fall under the regional average are expected to enhance their service reach to meet the health authority average.

For this progress report, orders of supplies from the BCCDC Harm Reduction Supply program were instead of the number of supplies distributed to people. Only Vancouver Coastal Health was able to report on the number of sterile needles distributed to people in 2013/14. Order data for each local health area in B.C. for the baseline and first program years can be found in the accompanying technical report. This accompanying report also includes more information on how baselines and targets were calculated, parameters of data, and limitations of this method of reporting.

Averages for 2012/13 for each health authority (called “baselines”) are presented in Table 1, as well as the orders per 100,000 in 2013/14 in each region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Sterile Needle Orders* (Per 100,000 People in the Region)</th>
<th>Increase/Decrease</th>
<th>Condom Orders* (Per 100,000 People in the Region)</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Fiscal 2013/14</td>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>Interior</td>
<td>95,024</td>
<td>127,123</td>
<td>↑</td>
<td>97,407</td>
</tr>
<tr>
<td>Fraser</td>
<td>42,579</td>
<td>65,266</td>
<td>↑</td>
<td>38,335</td>
</tr>
<tr>
<td>Vancouver Coastal</td>
<td>97,623</td>
<td>149,842</td>
<td>↑</td>
<td>269,556</td>
</tr>
<tr>
<td>Vancouver Island</td>
<td>143,939</td>
<td>159,897</td>
<td>↑</td>
<td>127,663</td>
</tr>
<tr>
<td>Northern</td>
<td>167,123</td>
<td>196,161</td>
<td>↑</td>
<td>276,360</td>
</tr>
<tr>
<td>B.C.</td>
<td>74,215</td>
<td>120,096</td>
<td>↑</td>
<td>135,548</td>
</tr>
</tbody>
</table>

TABLE 1: REGIONAL AVERAGE OF ORDERS OF STERILE NEEDLES AND CONDOMS PER 100,000 PEOPLE, BY HEALTH AUTHORITY; BASELINE AND FIRST PROGRAM YEAR
The majority of regions increased their orders per 100,000 of sterile needles and condoms, with the exception of Northern Health who significantly decreased their orders per 100,000 of condoms over 2012/13. While orders have increased in general across the province, this method of reporting does not meaningfully describe if people are adequately reached by supplies in every local health area, be they urban, metro or rural parts of British Columbia. The ministry continues to work with health authorities and health system partners to find the best way for regions to report on equitable reach of harm reduction supplies to their population in each local health area of the province."

**TARGET: BY 2016, THE PROPORTION OF ALL CLIENTS ON HIV THERAPY WHO DO NOT HAVE A SUPPRESSED VIRAL LOAD WILL DECREASE BY 50%.

**PROGRESS IN YEAR ONE: FEWER PEOPLE IN B.C. ON HIV TREATMENT ARE LIVING WITH A DETECTABLE HIV VIRAL LOAD (22% IN 2013/14)**

The cornerstone of Treatment as Prevention is the understanding that people who have a suppressed viral load are far less likely to pass HIV on to another individual (Montaner et al, 2010). Figure 4 shows the proportion of those on HIV treatment with/without suppressed viral loads in 2012/13.

In 2012/13, 75% of people on HIV drug therapy had a suppressed viral load, and 25% did not. This target aims to decrease the proportion in pink by 50%, thereby increasing the grey.
The baseline proportions of those without a suppressed viral load, the first program year data, the percentage change from baseline, and the region's overall target are presented in Table 2.

<table>
<thead>
<tr>
<th>Region</th>
<th>Target for the Region</th>
<th>Proportion that do not Have a Suppressed Viral Load (Baseline)</th>
<th>Proportion that do not Have a Suppressed Viral Load (2013/14)</th>
<th>Change Over Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interior</td>
<td>15%</td>
<td>29%</td>
<td>30%</td>
<td>↑</td>
</tr>
<tr>
<td>Fraser</td>
<td>13%</td>
<td>26%</td>
<td>23%</td>
<td>↓</td>
</tr>
<tr>
<td>Vancouver Coastal</td>
<td>10%</td>
<td>20%</td>
<td>19%</td>
<td>↓</td>
</tr>
<tr>
<td>Vancouver Island</td>
<td>15%</td>
<td>29%</td>
<td>28%</td>
<td>↓</td>
</tr>
<tr>
<td>Northern</td>
<td>25%</td>
<td>49%</td>
<td>37%</td>
<td>↓</td>
</tr>
<tr>
<td>B.C.</td>
<td>13%</td>
<td>25%</td>
<td>22%</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Table 2: Baseline and First Year Progress on the Proportion of Those on HIV Treatment Who Do Not Have a Suppressed Viral Load, by Region, with Goal**

**Goal 3: Diagnose Those Living with HIV as Early as Possible in the Course of Their Infection**

This goal will be reached by enhancing the reach of HIV testing, and incorporating HIV testing into routine medical care as well as non-health services. This will ensure that people are diagnosed before they become very ill. This goal is measured by assessing the CD4 count at diagnosis for newly diagnosed infections.

**Milestone 1 – By 2016, Rates of HIV Testing in Each Health Service Delivery Area Will Be at or Above 3,500 Per 100,000 People, and Each Area Will Have Increased HIV Testing by at Least 50%.

**Progress in Year One: Non-Prenatal Testing Episodes Have Increased in Every Region.**

Vancouver and Northern Interior (including Prince George) health service delivery areas expanded reach of HIV testing through the pilot, and have since increased their testing rates dramatically (Table 3).

<table>
<thead>
<tr>
<th>HSDA</th>
<th>2009/10 Rate Per 100,000 People</th>
<th>2013/14 Rate Per 100,000 People</th>
<th>Increase in Testing Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver</td>
<td>9,221</td>
<td>18,852</td>
<td>116%</td>
</tr>
<tr>
<td>Northern Interior</td>
<td>3,422</td>
<td>6,155</td>
<td>86%</td>
</tr>
</tbody>
</table>

**Table 3: Pilot Regions Testing Rates and Increases over Baseline**
Since the beginning of the provincial program, the non-pilot health service delivery areas (HSDA) have also increased testing rates. All regions increased the rates of testing over 2012/13.

<table>
<thead>
<tr>
<th>HSDA Meeting or Exceeding 3,500 Tests per 100,000 People in 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interior Health</td>
</tr>
<tr>
<td>Fraser Health</td>
</tr>
<tr>
<td>Vancouver Coastal</td>
</tr>
<tr>
<td>Island Health</td>
</tr>
<tr>
<td>Northern Health</td>
</tr>
</tbody>
</table>

In addition to meeting the milestone of 3,500 tests per 100,000 by 2016, HSDAs were tasked with increasing testing episodes by 50%. In the first year of implementation, all non-pilot HSDA’s increased testing, percentage increases are in Figure 5. Testing rates for all HSDAs can be found in the accompanying technical document.

**Figure 5:** % Increases in HIV Testing Episodes Across B.C. By HSDA
TARGET: BY 2015, HIV TESTING WILL BE OCCURRING IN A VARIETY OF SETTINGS, WITH COMPLEMENTARY USE OF TARGETED TESTING AND ROUTINE OFFERS OF TESTING.

*From Hope to Health* identified a number of successful ways to increase the reach of HIV testing, and stated that multiple testing strategies, including a routine offer of testing in certain settings, should be implemented.18

**Interior Region** – Interior Health launched a health outreach team to better reach those not well connected to the health system, which held testing events in partnership with organizations servicing marginalized populations and youth. Training and support for HIV testing was developed for physicians, other health care providers and Aboriginal communities, laying the groundwork for acute care testing in Merritt and Vernon, and testing through family practice, in 2014/15.

**Fraser Region** – Fraser Health offered education to acute care physicians to lay groundwork for routine HIV testing, and partnered with nurse practitioners in their primary health care clinics to implement a routine offer of HIV testing. Fraser Health partnered with community to offer testing opportunities. HIV testing was offered at the Mission Friendship Centre and at multiple First Nations events, in transition homes and truck stops. Anonymous testing is available across Fraser Health, and HIV point of care testing is available in public health units in all three HSDAs.

**Vancouver Coastal Region** – Vancouver Coastal Health expanded a routine offer of HIV testing into Richmond, Lion’s Gate, Powell River, and St. Mary’s Hospital in Sechelt, and expanded their support for a routine offer of HIV testing in family practice/primary care in Vancouver, Richmond, North Shore, Powell River, and the Sunshine Coast. Enhanced outreach testing was implemented in the North Shore, Richmond and Capilano College. Access to testing for gay men and other men who have sex with men has increased to support rapid linkage to care for those who are diagnosed with acute HIV infection. HIV testing fairs and point of care training occurred in multiple First Nations communities in the region.

**Vancouver Island Region** – Many Island Health service providers have included point of care testing in their outreach visits, and Island Health supported health fair testing events hosted by local community organizations and First Nations communities. Point of care testing sites have been implemented in some First Nations communities and some correctional facilities.

**Northern Region** – Northern Health implemented a routine offer of HIV testing to admitted patients at the University Hospital of Northern B.C. and the St John Hospital in Vanderhoof. They piloted a mail out of laboratory requisition forms for HIV testing to patients. Point of care testing has been implemented at Central Interior Native Health in Prince George.

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*The STOP HIV team at the BCCDC provides clinical and policy leadership to regional health authorities and agencies of the Provincial Health Services Authority. Some examples include: the development of a rapid referral pathway for newly diagnosed clients, the expansion of acute and point of care HIV testing, targeted funding to improve access to HIV testing for gay men and men who have sex with men. The team also supports the overall monitoring and evaluation of the From Hope to Health testing projects and provides enhanced surveillance and testing data to partners.*
**Provincial Services** – BCCDC-led anonymous HIV testing was scaled up across seven sites in B.C. to decrease barriers to testing. A routine offer of HIV testing was implemented in BCCDC sexually transmitted infection clinics and tuberculosis services. Additional sites were added for acute HIV testing for gay men/other men who have sex with men. Chee Mamuk, provided training on HIV testing in eight Aboriginal communities and launched testing in two new communities.

**TARGET: BY 2015, ALL INDIVIDUALS TESTING FOR HEPATITIS C AND/OR SEXUALLY TRANSMITTED INFECTIONS WILL ALSO HAVE HAD AN HIV TEST AT THE SAME TIME.**

**PROGRESS IN YEAR ONE: SLIGHT INCREASE**
For this progress report, data is available on the following two pieces of this target:

» The proportion of those newly diagnosed with hepatitis C infection who were also tested for HIV.

» The proportion of those who were tested for syphilis who were also tested for HIV.

Interior Health, Fraser Health, Vancouver Coastal Health and Island Health increased the proportion of those diagnosed with hepatitis C who were also tested for HIV. Northern Health had a 10% decrease over 2012/13 (Figure 6). HIV testing associated with syphilis testing appears stable (Figure 7).

![Figure 6: Proportion of those with newly diagnosed hepatitis C infection with an associated HIV test, by region.](image-url)
FIGURE 7: PROPORTION OF THOSE TESTED FOR SYPHILIS THAT HAD AN ASSOCIATED HIV TEST, BY REGION

MILESTONE 2 – BY 2016, THE PROPORTION OF PEOPLE DIAGNOSED EARLY IN THE COURSE OF THEIR INFECTION WILL MEET OR EXCEED 50% IN EACH HEALTH AUTHORITY.

AND

TARGET: BY 2016, THE PROPORTION OF PEOPLE DIAGNOSED LATE IN THE COURSE OF THEIR INFECTION WILL DECREASE TO 10% OF ALL NEW DIAGNOSES.

PROGRESS IN YEAR ONE: TO BE DETERMINED WHEN MORE COMPLETE DATA AVAILABLE (2014/15 PROGRESS REPORT).

Due to a time lag in data elements, CD4 levels at diagnosis was unavailable for almost one quarter of those diagnosed in 2013/14 at the time this report was developed. Therefore, the proportion of those identified early or late in the stage of infection will begin to be reported in the 2014/15 report. Interim data for each health authority can be found in the accompanying technical document. 2012/13 data is presented in Figure 8, where pink represents those diagnosed early in the course of their infection (CD4 =>500), and red is those diagnosed late (CD4 <=200).
It is expected that over the next few years, people throughout B.C. will be diagnosed earlier in their infection. During the STOP HIV/AIDS pilot, Vancouver Coastal Health saw an increase in those diagnosed later in the course of their infection, attributing this effect to people previously unaware of their infection being engaged through new efforts. People were likely very ill when finally diagnosed through routine testing in acute care.

This similar effect could be occurring provincially. However, people moving to B.C. who were not diagnosed or treated in their home jurisdiction may continue to be diagnosed and brought into care in British Columbia. Regions will need to continue to work to reach new British Columbians and offer them care as soon as possible to keep them healthy.

**Goal 4: Improve the Quality and Reach of HIV Support Services for Those Living With and Vulnerable to HIV**

**PROGRESS TO DATE: QUALITY AND REACH OF HIV SERVICES IS IMPROVING**

Increasing the number of people retained in the steps along the HIV Cascade of Care help assess how well B.C. is supporting those living with HIV.
In the last quarter of the first year of the program (Jan. 1, 2014 - March 31, 2014) there were 9,393 people understood to be living with HIV in B.C. (BCCFE, 2014):

- 8,466 of those had been linked to care (90%)
- 7,259 were retained in care (77%)
- 6,600 were on treatment (70%)
- 6,139 were considered to be adhering to their treatment (65%), and
- 5,024 were considered virally suppressed (53%).

Quantified cascades for each region can be found in the technical appendix under this goal.

There are two milestones that will help to improve retention in care, with four targets to drive these milestones.

**MILESTONE 3 – BY 2016, OF THOSE DIAGNOSED EARLY IN THE COURSE OF THEIR INFECTION, THERE WILL BE ZERO CASE REPORTS OF PROGRESSION TO AIDS.**

ProGRESS IN YEAR ONE: TO BE DETERMINED WHEN DATA AVAILABLE (2014/15 REPORT) In 2012/13, there were three AIDS case reports for people who were originally diagnosed early in the course of their infection.

B.C.’s improvement in the quality and reach of care services for those living with or vulnerable to HIV can be quantified by decreases in progression to advanced HIV infection. This is a long term measure to identify B.C.’s ability to diagnose people early in their infection, effectively linking and retaining them in treatment and care to keep them healthy throughout their life, and ensure they do not progress to AIDS or late stage/advanced HIV infection.

**MILESTONE 4 – BY 2016, AT LEAST 90% OF THOSE MEDICALLY ELIGIBLE TO ACCESS HIV TREATMENT IN EACH HEALTH AUTHORITY WILL BE ON TREATMENT.**

Baseline Measure: 73% of those medically eligible to access HIV treatment are on treatment as of March 31, 2012 Improvement in care for those living with HIV will also be measured by the system’s ability to link them to treatment with their consent. 2012 data is presented in Figure 9. Movement on this milestone will require not only linking people to care who are newly diagnosed, but reconnecting with people diagnosed with HIV in the past who are not well engaged in care, treatment and support.

TARGET: BY 2015, THE PROPORTION OF NEWLY HIV DIAGNOSED CLIENTS WHO ENGAGE IN PARTNER NOTIFICATION WILL BE AT LEAST 75% OF ALL NEW CASES.

PROGRESS IN YEAR ONE: MOST REGIONS INCREASED THOSE WHO PARTICIPATED IN PARTNER NOTIFICATION

Partner notification provides an opportunity not only to link people who are vulnerable to HIV infection to services, but to specifically reach people who may be at very early stages of infection. Regional participation is represented in Figure 14.

FIGURE 10: PROPORTION OF THOSE NEWLY DIAGNOSED WITH HIV WHO PARTICIPATED IN PARTNER NOTIFICATION ACTIVITIES
There is significant variation in how regions collect and record data on partner notification, and therefore assessments of participation for this progress report may not be comparable among regions. Future progress reports expect to make use of a centralized collection of public health follow up through BCCDC, which will ensure regional data is comparable.

**TARGET: BY 2016 THE PROPORTION OF CLIENTS ON HIV THERAPY NOT RECEIVING STANDARD OF CARE LABORATORY MONITORING WILL DECREASE BY 50%.

**PROGRESS IN YEAR ONE: MAJORITY RECEIVING STANDARD OF CARE LABORATORY MONITORING**

Another measure of systematic support for those living with HIV is the proportion of those who receive standard of care laboratory monitoring while on HIV drug treatment. In 2012/13, 92% of people on HIV drug therapy in B.C. were receiving standard of care laboratory monitoring, and 8% were not. This target aims to reduce the proportion of pink in the figure by 50%, thereby increasing the grey.

In 2012/13, 92% of people on HIV drug therapy in B.C. were receiving standard of care laboratory monitoring, and 8% were not. This target aims to reduce the proportion of pink in the figure by 50%, thereby increasing the grey.

Regional data is presented in Table 4. Overall in B.C., proportion was stable compared to baseline.
A final way to enhance support for those living with or vulnerable to HIV is for regions to work closely with the populations they serve to ensure programs are meeting their needs.31

**Interior Region** – Interior Health funded peer navigation or peer delivered services in three contracted agencies, and debriefs with community partners and stakeholders after engagement and outreach testing or education sessions to determine if the activity met the needs of participants.

**Fraser Region** – Fraser Health holds regular meetings with community based organizations and peers, and contracts with community partners emphasize client engagement and feedback opportunities. The BCCDC Annual Drug Use survey informs harm reduction service planning. Patient voices will be included in services at Surrey Memorial Hospital. A community panel of individuals living with/vulnerable to HIV will be developed to evaluate outcomes and satisfaction with Fraser Health’s HIV follow up and services.

**Vancouver Coastal Region**32 – Inpatient surveys have been implemented on 10C at St. Paul’s Hospital. Vancouver Coastal Health partners (e.g., YouthCO - Mpowerment, Positive Living B.C. Peer Navigation program, Health Initiative for Men) are in the process of developing or have developed client satisfaction tools. Providence Health Care collects verbal feedback from their low barrier addictions groups in the Immunodeficiency Clinic.

**Vancouver Island Region** – The majority of STOP HIV/AIDS funded community organizations have either implemented or are in the process of developing a client satisfaction survey. All of the 2013/14 Island Health STOP HIV/AIDS contracts included explicit deliverables regarding formal evaluation of client satisfaction. In addition, ongoing, informal feedback is an integral part of all client interactions.

### Table 4: Baseline and First Year Progress on the Proportion of Those Not Receiving Standard Laboratory Monitoring, by Region, with Goal

<table>
<thead>
<tr>
<th>Region</th>
<th>Target for the Region</th>
<th>Proportion not Receiving Standard Lab Monitoring (Baseline)</th>
<th>Proportion not Receiving Standard Lab Monitoring (2013/14)</th>
<th>Change Over Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interior</td>
<td>7%</td>
<td>14%</td>
<td>15%</td>
<td>↑</td>
</tr>
<tr>
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**Target: By 2016, all health authorities will have initiated and evaluated client engagement and client satisfaction activities**
Northern Region – Northern Health is working with Central Interior Native Health and Positive Living North to develop a client satisfaction tool. Northern Health’s Aboriginal co-ordinator is leading the development of a client satisfaction tool, and findings will be incorporated in their Patient Journey Mapping report.

Provincial Services – BCCDC and the Oak Tree Clinic at the B.C. Women’s Hospital and Health Centre have initiated patient satisfaction surveys and used the information to inform service improvements. The B.C. Centre for Excellence in HIV/AIDS reports a client satisfaction survey for their programs will be initiated in 2014/15.

Goal 5: Reduce the Burden of Advanced HIV Infection on the Health System

PROGRESS TO DATE: WITH SUSTAINED EFFORTS TO DIAGNOSE PEOPLE EARLY AND KEEP THEM WELL ENGAGED IN TREATMENT AND CARE, BURDEN REDUCTION IS LIKELY. Missed opportunities for prevention, testing and treatment not only contribute to worse health outcomes for the individual, they can result in increased HIV transmission (Montaner et al, 2010; Montaner et al, 2014) and costs to the system and society.33

The B.C. Centre for Excellence in HIV/AIDS has identified costs to the health system (not related to highly active antiretroviral therapy medications) increase if an individual is living with a CD4 of less than 200 mm$^3$ — costs are approximately 3.4 times the costs for someone who is living with a CD4 of more than 500 mm$^3$. They found hospitalization costs comprise much of this increased cost (Nosyk et al, 2014).34

Therefore, diagnosing people early in their infection and keeping them healthy and engaged in care will not only improve their lives, but will avert costs to the health system. B.C. has already experienced a shift away from many people needing end of life care because of advanced HIV disease. This was highlighted in May 2014 by the repurposing of the dedicated AIDS ward (10C) at the St. Paul’s Hospital in Vancouver to a ward that supports those living with HIV and other complex illnesses and health issues.

The Centre will continue to evaluate the STOP HIV/AIDS program to quantify the effects of the program on costs to the health system using health utilization data from the pilot and the expanded provincial program.
Work to Support the Guiding Principles

While the guiding principles laid out in *From Hope to Health* are difficult to measure in an exact manner, it is important to report on how partners are supporting these principles in all aspects of their implementation. Each region reported on how their implementation activities are aligned with and support the purpose of the guiding principles. One piece of evaluation by the Pacific AIDS Network shows how community organizations contribute to the overarching goals of *From Hope to Health*. The analysis of the 2012/13 and future analyses can be found on the Pacific AIDS Network website.  

### Fighting Stigma and Discrimination

**Interior Region:** Development and implementation of media and marketing advisory group which includes community agencies and peers.

Completion of the Peer Navigation Report — The Road to Wellness with HIV Services on Interior Health.

**Fraser Region:** Facilitated collaboration with community, peers and Surrey Memorial Hospital to develop modules on cultural awareness and sensitivity, and the impact of stigma on HIV care.

Partnered in events with the Fraser Region aboriginal Friendship Centre around HIV positivity/living with HIV in the community.

Work with Surrey Memorial Hospital to incorporate confidentiality and respect for all in their site orientation.

**Vancouver Coastal Region:** Continued “It’s Different Now” campaign to help destigmatize HIV and normalize HIV testing. HIV testing is offered to everyone in Vancouver, and messaging identifies that “an HIV test is recommended for you, your neighbours, for everyone”.

The images used on these posters represent the diverse population present in Vancouver.

Public news releases on testing initiatives help to reduce stigma.

**Vancouver Island Region:** All STOP HIV/AIDS funded services are embedded with the following themes: Education and Awareness (for example, dissemination of information, especially in certain rural and remote communities where stigma towards HIV/AIDS may be higher); Inclusive and Non-Judgemental Approach (for example, culturally safe environments), and Normalization of HIV/AIDS Conversations.

**Northern Region:** Implementing a routine offer of HIV testing into Northern hospitals.

Continuing to expand reach of the “HIV101.ca” awareness campaign to the general public and health care workers. Partnering with local community organizations on national HIV awareness activities like the “AIDS Walk for Life.”
The Pacific AIDS Network supports the development of the Canadian HIV Stigma Index CBR Project, building partnerships, capacity, and an action-based research tool, which has been implemented in 50 countries. It will examine resilience factors that may reduce the negative impact of stigma and discrimination on the health and social well-being of people living with HIV.

Reach and Engagement

**Interior Region:** Health outreach nurses meet face to face with community partners to plan services in their region such as testing or educational events.

**Fraser Region:** In partnership with HIM, conducted community consultations in all three HSDAs with gay men and OMSM to identify differential health service needs in Fraser region.

With VCH and community-based organizations, standardized community case management services to increase referrals from Vancouver based organizations to FH to support people to be cared for in their local community.

**Vancouver Coastal Region:** Service delivery models developed in collaboration with community partners via meetings and knowledge exchanges.

Worked with Heart of Richmond to engage with current state mapping as a first step to enhance service delivery.

Continue to circle back to community tables as new contracts/programs are implemented to collect ongoing feedback on access, reach and delivery of services.

**Vancouver Island Region:** Engaged with community and health system partners to identify a number of populations of focus characterized by a greater incidence of HIV and/or greater crop-off along the cascade of care (including MSM, Aboriginal people, and youth).

**Northern Region:** Partnered with community to complete and disseminate Northern Health’s HIV patient journey mapping assessment (The Depth of Water Requires Knowledge: Listening to the Voices of the HIV Patient Journey).

Expanded funding to the Northern First Nations HIV/AIDS Coalition to improve reach and engagement of HIV prevention to First Nations communities.

Community engagement enhancing reach: Health Initiative for Men and Fraser Health

These two organizations are collaborating to open satellite health centers in New Westminster, Surrey and a site in Fraser East. The goal is to better reach gay, bisexual and men who have sex with men closer to home by providing a range of low barrier and culturally safe testing options. These centres will provide a safe space for a holistic health model for gay men in the Fraser region.
The Positive Leadership Development Institute is a partnership between the Pacific AIDS Network and the Ontario AIDS Network, which supports people living with HIV to realize their leadership potential and in many cases to actively engage in supporting STOP HIV/AIDS activities. The institute builds capacity of graduates to sit on the boards of community-based organizations, to work in peer navigator, research and support roles, and to contribute to various STOP implementation tables. One example of outcomes from the institute is the capacity and leadership developed in the Afro-Canadian Positive Network of B.C. in the Fraser region.

<table>
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<th>Community Engagement</th>
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<td><strong>Interior Region:</strong> 79 individuals engaged with the health outreach team (HOT) in 18 different communities. IHS’s HOT has provided both medical care and assistance in gaining social/economic support allowing better engagement in treatment and self-care, and support closer to home. All newly diagnosed individuals have had follow-up with the HOT team and continue to receive ongoing support, if desired.</td>
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<td><strong>Fraser Region:</strong> Implemented peer-to-peer harm reduction supply distribution, and peer to peer counselling for those living with HIV. Case management model with nurses to follow up with those identified as being “lost to follow up”, those who stopped treatment, and those who are not linked to a physician. Collaborated with Positive Health Services to actively seek clients lost to follow up.</td>
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<td><strong>Vancouver Coastal Region:</strong> Redesign of the HIV system in Vancouver has ensured that every door is the right door, meaning that everyone will have access to the same service continuum regardless of their initial access point. Highly mobile outreach team to reach and engage those living with HIV who are disengaged or need help to engage with care. Enhanced partner notification services and has put into place rapid follow-up for acute HIV infections.</td>
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<td><strong>Vancouver Island Region:</strong> Focus on “meeting people where they are” - outreach to locations frequented by certain populations which may be at higher risk of contracting HIV (homeless/cold weather shelters, women’s shelters, escort service agencies, harm reduction sites, methadone clinics, Aboriginal Friendship Centres.</td>
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<td><strong>Northern Region:</strong> Developed a screening tool to assist clinicians in identifying mental health concerns among people living with HIV. Improved referral pathways so those living with HIV can be better reached by broader, health authority wide mental health and substance use services. Supporting five First Nations youth through the Northern First Nations HIV/AIDS Coalition to better engage First Nations youth across the North in HIV prevention.</td>
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Aboriginal Engagement

**Interior Region:** Health outreach nurses actively partnering in the planning of a community engagement event involving the First Nation communities around Williams Lake, with the target of engaging First Nations health care providers and Health Directors. STOP HIV/AIDS implementation is aligned with FNHA Communicable Disease Prevention Services and Plan.

**Fraser Region:** Partnered with the FNHA, the Fraser Health Aboriginal Health Program and Friendship Centres to co-develop HIV and sexually transmitted and blood-borne infections plan in Aboriginal communities, including education and engagement; raising awareness; and building capacity for HIV testing. Partnered with Fraser Regional Aboriginal Friendship Centre and Mission Friendship Centre for services.

**Vancouver Coastal Region:** Worked with the FNHA, Vancouver Native Health, Aboriginal Strategy initiatives, Chee Mamuk, and the 14 First Nations communities to develop First Nations implementation strategy.

Initiated and engagement strategy with all 14 First Nations, including current state mapping to identify opportunities and challenges/barriers to HIV prevention, testing, treatment and support services.

**Vancouver Island Region:** Engaged with FNHA and First Nations communities to inform on the 2014-2016 VIHA implementation.

All 2013/14 Island Health STOP HIV funded service providers and community organizations consulted with local First Nations communities on program planning and service provision.

Service providers and community organizations partnered with reserve health centre staff to offer education, testing and treatment.

**Northern Region:** Continuing to partner with and fund the Northern First Nations HIV/AIDS Coalition. Partnered with the First Nations Health Authority and Chee Mamuk to improve HIV testing in First Nations communities and improve screening tools/supports for health centres servicing First Nations communities.

The First Nation Health Authority partners with communities and implementers to support culturally appropriate and safe navigation along the cascade of prevention and care.

» Forty three community health nurses have completed the community-based, culturally appropriate HIV diagnosis and treatment course.

» Participation in the B.C. HIV Continuum of Care Collaborative.

» Support for development of community readiness models to tailor programs based on the level of capacity in the community for HIV screening and other services.

» Supporting community health nurses and community health representatives to implement HIV point of care testing, pre-and post-test discussion, partner counselling and referral services.
Limitations

Data on testing, prevention and linkage to care is a cornerstone in B.C.’s ability to evaluate implementation and outcomes. The Provincial Health Services Authority’s B.C. Public Health Microbiology and Reference Laboratory is estimated to conduct more than 95% of HIV and hepatitis C virus (HCV) testing in B.C. (BCCDC, 2014), as well as all syphilis testing. Victoria General Hospital in Island Health conducts some HIV, HCV testing for their region. Testing for other sexually transmitted infections, such as chlamydia and gonorrhea, are also performed by private laboratories in the province.

Because comprehensive data sharing between Victoria General Hospital, private laboratories and the B.C. Public Health Microbiology and Reference Laboratory is not yet in place, there are critical information gaps in this year’s progress report.

Integration of comprehensive testing and results is one of the key milestones needed to support the evaluation of the From Hope to Health strategy. Therefore, it is expected that the Provincial Health Services Authority will develop and complete data linkages with both Island Health and private laboratories by the end of 2014/15 to ensure comprehensive linkages with the B.C. Public Health Microbiology and Reference Laboratory databases to support effective monitoring and evaluation of From Hope to Health and the STOP HIV/AIDS program.
Significant Health System Shifts

In October of 2013, the First Nations Health Authority (FNHA) took over responsibility for the administration of federal health programs and services formerly delivered by Health Canada’s First Nations Inuit Health Branch – Pacific Region. FNHA and has been working to address service gaps through new partnerships, closer collaboration and health systems innovation for First Nations people living in reserve communities. The historic transfer of programs, resources, assets, staff, and responsibilities from the federal government was a first for Canada.

The FNHA’s vision, values and regional focus, provide a strong foundation for innovation, transformation, and redesign of health programs and services (First Nations Health Authority, 2013). The creation of the FNHA has also allowed for more community driven processes with a First Nations perspective on wellness, which will create a path forward that will ultimately enable better health outcomes for all areas, including HIV.

In May 2014, B.C.’s Provincial Health Officer released HIV testing guidelines for primary care providers (Provincial Health Officer). The first of its kind in Canada, B.C.’s guidelines identify the value of a routine offer of HIV testing in all adult British Columbians (18-70) every five years.

The guidelines include recommendations for populations that are more vulnerable to HIV infection and carry a disproportionate burden of infection, including Aboriginal people and gay men and other men who have sex with men. These guidelines build on the lessons learned in Vancouver Coastal Health through the STOP HIV/AIDS pilot, which highlighted both the acceptability of HIV testing as a routine part of medical care, and the opportunity to diagnose and treat those living with HIV who are not traditionally reached by targeted testing programs.
Conclusion

The first year of provincial implementation of the STOP HIV/AIDS program is complete. Further improvements to the cascade of prevention and care are occurring, such as increased testing across the province. Strides have been made in enhancing reach of testing by implementing lessons learned from the STOP HIV/AIDS pilot and offering HIV tests in multiple settings.

Linkage to care is being supported by approaches such as peer support and navigation, outreach to those who are disconnected from the health system, and population-specific approaches have been initiated to ensure groups are reached by services that meet their needs.

Work continues to support collaborative implementation, particularly on ensuring equitable reach of harm reduction supplies. Partners continue to share lessons learned between and within regions to drive change in the health system to support the goals, milestones and targets and better health outcomes for those living with or vulnerable to HIV infection.
Appendix

References


**Endnotes**

1 For example, for milestones and targets that say “By 2016…,” the third progress report (covering fiscal 2015/16) will describe if that milestone or target has been met. For milestones or targets referring to 2015, the second progress report (covering 2014/15) will describe if the target has been met.

2 Because this program is accompanied by targeted funds to achieve measurable health and health system outcomes, reporting on program implementation includes data by fiscal year (April 1 – March 31).

3 After the first year of implementation, a slight change has been made to the visual representation of the HIV cascade of prevention and care. The current Therapeutic Guidelines for Primary Care in B.C. identify that “ARV therapy should be offered to all HIV-infected individuals regardless of their CD4 cell count,” save for those who are considered “elite controllers” or “long term non-progressors,” and “there is no CD4 count threshold above which starting therapy is contraindicated” (B.C. Centre for Excellence in HIV/AIDS, 2011). Therefore, the step of “people living with HIV who but do not require drug therapy” in the previous HIV cascade of prevention and care has been removed.

4 There is no existing data on the number of people vulnerable to HIV, or the number of people who are living with HIV but unaware. While they cannot be quantified currently, they are important cascade steps to recognize.

5 The B.C. Centre for Excellence in HIV/AIDS Monitoring Quarterly reports provide region-specific cascades by age, for those who self-reported as men who have sex with men and past use of injection drugs. These can be found at: http://stophivaid.ca/data-monitoring/

6 Surveillance data track new HIV infections by tracking the number of new infections diagnosed each year. This is not the same as true new infections, as people are not necessarily diagnosed in the same year they acquire HIV.

7 Highly active antiretroviral therapy is medication used to treat HIV infection.

8 Population used for per 100,000 people calculation was 15-90+ in that year in each health authority.

9 Population used was those between ages 14-99 in that year in each health authority.

10 Population density is an imperfect proxy for supply need. Please see accompanying technical document for more information.
This target was originally worded as "By 2016 the proportion of all clients on HIV therapy who are currently virally suppressed will increase by 50%." With the baseline and first program year data now available, it is clear that a target increase of 50% was not useful. Therefore, the target has been amended to decrease the number of people not receiving standard of care laboratory monitoring by 50%.

This target measures reach of testing to the general population, and therefore excludes prenatal HIV testing. Please see technical document for more information.

Tests per 100,000 people.

Testing rates per 100,000 for each HSDA can be found in the accompanying technical document. Testing episodes exclude prenatal HIV testing, contains any test done in a 30 day window, and can include multiple episodes in a fiscal year for one individual.

This does not necessarily represent all activities in the region, but instead a snapshot of new services.

Chee Mamuk is a BCCDC-led provincial program that helps to build capacity for HIV testing in First Nations communities.

Due to shared routes of transmission, one way to increase the reach of HIV testing is to ensure that people who are being tested for any sexually transmitted infection or for the hepatitis C virus are also screened for HIV infection.

Work is underway at BCCDC to ensure that data on testing for HIV at the same time as testing for hepatitis C virus is available for the 2014/15 progress report.

Those diagnosed with HIV infection at least 14 days prior were excluded.

Those diagnosed with HIV infection at least 14 days prior were excluded.

Tests done by Victoria General Hospital are not included in this data. Please see “Limitations” section.

“Missing” are those diagnosed in 2012/13 without an associated CD4 level.

Definition for these steps can be found in the technical appendix.

AIDS case reports sometimes have a significant time lag. As such, the most complete fiscal year available at the time of this report was 2012/13 (baseline year).

Because the STOP HIV/AIDS evaluation cohort includes Ministry of Health administrative databases, as well as requires the application of an algorithm to identify those living with HIV in B.C., there is a data lag for reporting. Therefore, the cohort can only be characterized for this report as of March 31, 2013.

Low numbers of new diagnoses in Northern Health and Interior Health can contribute to wide variability in percentages.

Fraser Health and Vancouver Coastal Health were unable to distinguish between people who wished to participate but had no contacts, and those who did not wish to participate. In addition, there is movement between these two regions for testing, diagnosis and public health follow up. Some regions may include people who were approached to participate but ultimately declined. The ministry is working with the health authorities and BCCDC to ensure reporting in 2014/15 is more comparable among regions.
Laboratory monitoring that is considered standard is described in the accompanying technical document.

This target was originally worded as “By 2016 the proportion of clients on HIV therapy receiving standard of care laboratory monitoring will increase by 50%.” With the baseline and first program year data now available, it is clear that a target increase of 50% was inappropriate. Therefore, the target has been amended to **decrease** the number of people **not receiving** standard of care laboratory monitoring by 50%.

Because of the work done in Vancouver Coastal Health and Northern Health through the pilot, the baseline year for those regions is 2009/10. For the other regions and B.C. overall, it is 2012/13.

This does not necessarily represent all activities, but instead a snapshot of implementation of services.

Vancouver Coastal Health/Providence Health Care community engagement information can be found here: [www.vch.ca/get_involved/community-engagement/community-engagement-reports/public-health/stop-hiv-aids/stop-hiv-aids-project](http://www.vch.ca/get_involved/community-engagement/community-engagement-reports/public-health/stop-hiv-aids/stop-hiv-aids-project)

The B.C. Centre for Excellence in HIV/AIDS is funded to evaluate the population level outcomes related to the STOP HIV/AIDS program, and one piece of this is to determine the effect of the program on costs to the health system.


Offered in collaboration with the Canadian HIV Trials Network developed by the Canadian Aboriginal AIDS Network and other national partners.
FOR MORE INFORMATION PLEASE VISIT US ONLINE:
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