STI/HIV Prevention and Control

2006 ANNUAL REPORT

STI HIV Prevention and Control

BC Centre for Disease Control

contents

sti/hiv prevention and control

The British Columbia Centre for Disease Control is an organization dedicated to the prevention and control of communicable diseases in British Columbia.

The Division of STI/HIV Prevention and Control is exclusively focused on the prevention and control of sexually transmitted infections (STIs), including HIV and AIDS.

- We coordinate province-wide efforts to reduce the spread and minimize the adverse effects of STIs. We do this through education programs, contact tracing and partner notification. The division works with clients both directly, through clinics and outreach workers, and indirectly, through local and regional health care providers. The health, dignity and rights of our clients are our foremost concern.
- We provide STI/AIDS-related education and training resources for health care workers throughout the province, including medical residents, interns, public health nurses and other health care providers. We participate in conferences and frequently present on STI-related subjects, both in BC and in other jurisdictions. We provide epidemiologic data analysis and consulting services, acting as the provincial reporting centre for cases of STIs, HIV and AIDS. Provincial law requires most STIs, including HIV, be reported so that trends and patterns can be accurately measured. Our role is to record, track and share this important data for the benefit of provincial health care authorities, as well as organizations and governments in national and international jurisdictions.
- As a university-affiliated organization, we participate in research and teaching related to STI/AIDS in order to remain current in our approach.
- We work with international partners in developing countries to improve their capacity to manage STIs, including HIV.

This annual report describes some of the objectives, activities and achievements that marked the past year at STI/HIV Prevention and Control. It also includes detailed epidemiology statistics. More information on many of the subjects discussed here can be found on our website at **www.bccdc.org** or through our Education and Surveillance Support at 604-660-2090.

2006

director's letter

Dr. Michael Rekart, Director

A Message from the Director

The emerging trends in the epidemiology of STIs, HIV, AIDS and pelvic inflammatory disease (PID) are well covered in this year's annual report, in the Incidence Trends section written by Dr. Mark Gilbert. And, there are many other interesting sections to help the reader comprehend where our province and our program stand with respect to STIs, HIV and AIDS. But where are we going from here?

In the next 5-10 years, I see a very different landscape:

- a fully integrated, interactive and real-time surveillance and epidemiology capacity involving BCCDC clinical databases (STI, HIV, AIDS, TB, hepatitis) and MSP health databases in support of public health program planning and evaluation
- end-to-end HIV testing and prevention including (a) timely reporting of acute, recent and established HIV infection, utilizing NAAT and avidity testing methodologies, (b) public health notification of viral load, CD4 count and ARV treatment, and (c) evidence-based prevention interventions by stage of infection
- comprehensive, province-wide herpes prevention and control including education for patients and physicians, type-specific herpes testing when indicated, reportable disease status, HSV surveillance, free-of-charge treatment and prophylaxis, and HSV vaccine preparedness
- validated and user-friendly online STI nursing certification with on-site clinical preceptorships in each Health Authority
- province-wide HPV vaccination resulting in fewer cases of venereal warts, in the short term, and fewer cases of cervical and genital cancer in the long term
- enhanced web-based programming, including (a) information for the public, (b) updated best practices guidelines for health workers, (c) expanded outreach programs to high-risk internet sites and populations, and (d) online STI/HIV prevention and management options such as partner notification by email
- expanded global health initiatives through the PHSA Global Health Program, research/development projects in Uganda and Vietnam, and interactions with a Pacific Centre for Disease Control based at BCCDC
- enhanced and expanded Aboriginal health initiatives, including implementing lessons learned from our successful initiatives, increasing the number of Aboriginal communities with an AIDS policy, and developing a PHSA/Ministry of Health Aboriginal Health consortium.

Some might say that this future is merely a dream but, in STI/HIV Prevention and Control, we can make it happen. Let's get rolling.

Michael L. Rekart

Dr. Michael Rekart
Director, STI/HIV Prevention and Control

the year in review

Clinical Activities

Street Nurse Program (STI/HIV Outreach)

The Chee Mamuk Program

Education and Communication: Meeting New Challenges

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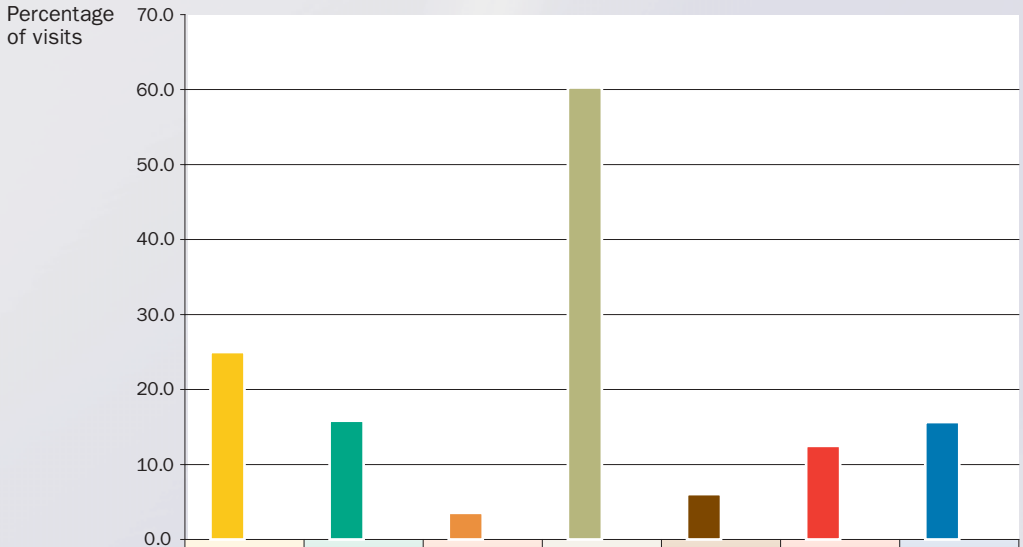
clinical activities

STI Clinic and Street Nurses

The division's patient services are delivered through two principal channels: the STI Clinic, located in the BCCDC building at 655 West 12th Avenue in Vancouver, and the Street Nurse Program, which operates from a number of locations throughout the city.

1.1 Reason For Visit • 2006



	STI Screening	STI Symptoms	Contact to STD	HIV Testing	Hepatitis	Wart Treatment	Other
Percentage	25.0	15.8	3.6	60.3	6.1	12.5	15.7
Number	4,462	2,826	634	10,755	1,081	2,228	2,793

In 2006, the STI Clinic and Street Nurse Program recorded 17,844 visits. The breakdown of clinic visits is consistent from year to year, with 2006 being very similar to previous years. The reason for most visits is screening for STIs and HIV, and management of STIs.

** Other includes: Birth control, counselling, consultation, follow-up, immigration, pregnancy test, results, TB skin testing, treatment and test of cure.*

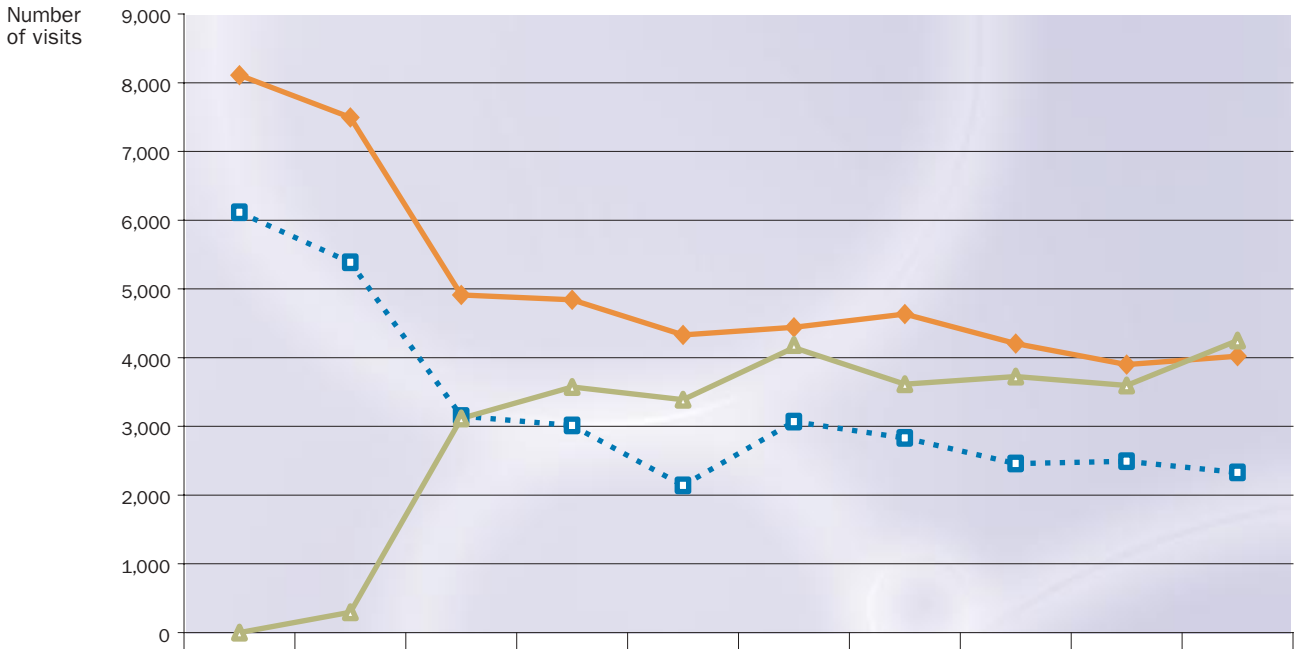
Note: Percentages do not equal 100% because one client may have several reasons for visit (e.g. HIV testing, symptoms and STI screening).

west 12th sti clinic

The STI Clinic on 12th Avenue is centrally located, easily accessible for clients, close to the downtown core and adjacent to Vancouver General Hospital. As the site of our primary clinical facility, it provides STI assessment and management services, including HIV testing, for clients from throughout the Lower Mainland. In addition, it is the centre of our epidemiology, education, research and administration activities. At this location we also:

- Conduct STI/HIV/AIDS surveillance, reporting, data management and related epidemiology services.
- Conduct and co-ordinate ongoing STI/HIV/AIDS research at our own, and affiliated, facilities.
- Provide training in STI clinical management for health care workers from across the province.
- Operate the province-wide STI/AIDS information phone line.
- Perform partner notification services.
- Maintain an STI/AIDS education resource centre for province-wide use.
- Provide administration of all division operations.

1.2 West 12th STI Clinic Visits • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
STI	8,105	7,513	4,917	4,847	4,355	4,464	4,649	4,236	3,904	4,019
HIV	6,108	5,372	3,145	3,012	2,134	3,064	2,837	2,442	2,473	2,317
STI & HIV	0	285	3,110	3,591	3,412	4,178	3,630	3,737	3,609	4,278
Total	14,213	13,180	11,172	11,450	9,901	11,706	11,116	10,415	9,986	10,614

street nurse program (sti/hiv outreach)

Over the past 3 to 5 years, the Outreach Program has evolved from primarily a service delivery program centered in Vancouver to a program that initiates new strategies and collaborates widely across the province and beyond. The Outreach team has piloted new activities in the area of STI/HIV prevention for vulnerable and at-risk populations that continue to inform research and promote evidence-based practice. The ongoing goal is to continue to build capacity for nurses and other health care professionals in all the health authorities through collaboration, education, and research.

Overview

Outreach STI/HIV prevention, testing, diagnosis, treatment, and education services are provided at Bute Street Clinic (located at the Gay, Lesbian, Bisexual, and Transgendered Community Centre in Vancouver's West End), Allouette Corrections Centre for Women, Surrey Pretrial Centre, Vancouver and Cordova Detox Centres, massage parlours, drop-in centres, shelters, hotels, and street environments.

Activity highlights

Cyber outreach

An 18-month STI information and referral service was piloted online on a "gay cruising" website. Mounting evidence from community based research highlighted the number of people who were contracting STIs from sexual partners they met online. Outreach Nurses provided information and referral services to men throughout urban and rural BC. Topics included transmission risks, healthy sexuality, safer sex, treatment, drug use issues, vaccinations, meningitis, and requests for referrals. The busy online service was subsequently integrated into regular outreach programming. The Outreach STI information and referral service has since expanded to include a site frequented by patrons of sex workers and a site that has facilitated online partner notification.

DVD Project

The Outreach Program received funding from Health Canada's Drug Strategy Initiatives fund, the National Film Board (NFB), and the British Columbia Nurses Union to produce a DVD teaching tool and manual. The Outreach Nurses worked with Canada Wild Productions and documentary maker Nettie Wild to produce the DVD "Bevel Up: drugs, users and outreach nurses." The DVD is intended for nurses, nursing students, medical students and other health care professionals. It includes a 45-minute documentary along with 3 1/2 hours of additional menu items that explore the challenges, the ethical dilemmas, and the humanness of health care professionals when working with people with substance use issues in a diversity of settings. "Bevel Up" was developed in collaboration with partners throughout the province and was produced in both French and English. The DVD production and manual will be presented to a number of university and health care sites across Canada in the fall of 2007.

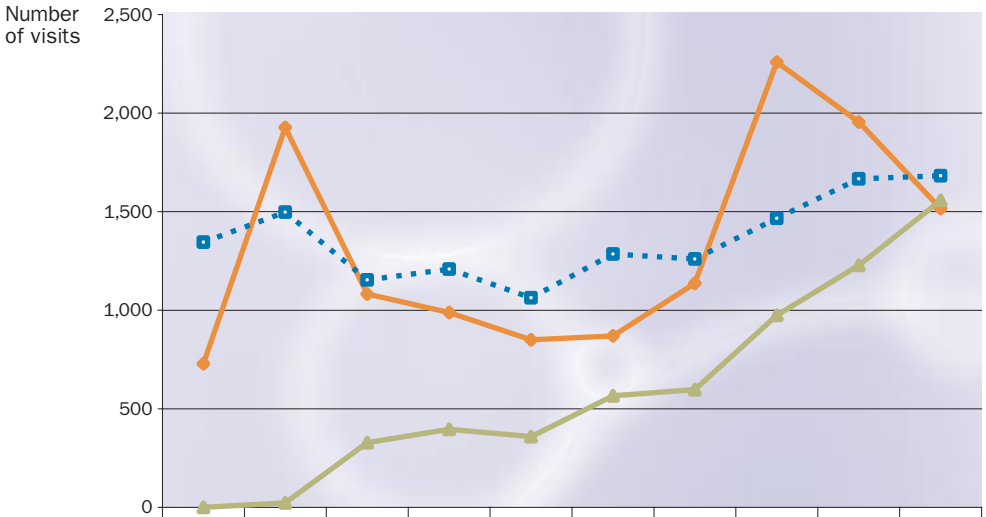
Corrections

The Outreach Program provided STI/HIV testing services to the Surrey Pretrial Centre and was expanded to include weekly services at the Allouette Correctional Centre for Women, which is located in Maple Ridge.

Health Canada Street Youth Study

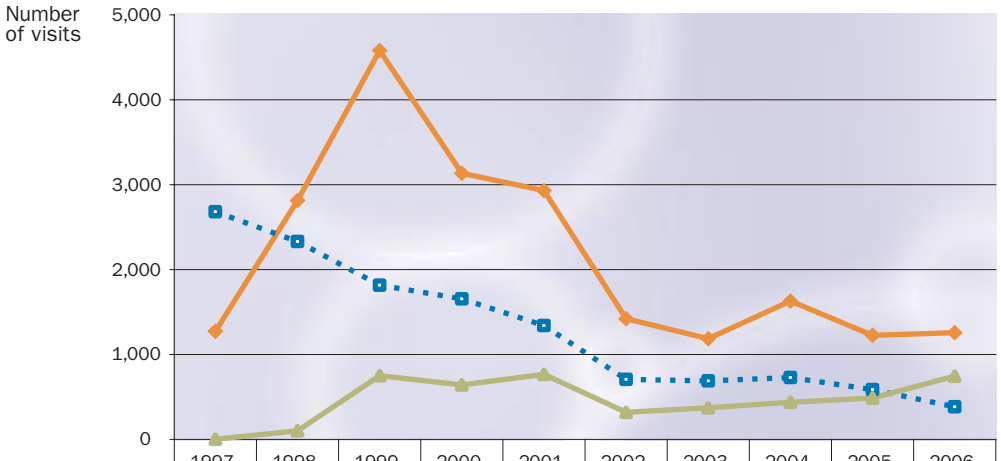
The Health Canada Street Youth Study was conducted by Outreach Nurses in Vancouver during 2006. The study included 200 youth. A national meeting to be held in Ottawa was scheduled for February 2007 to discuss the results.

1.3 Bute Street Clinic Visits • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
STI & HIV	729	1,927	1,082	988	850	870	1,136	2,259	1,955	1,516
HIV	1,345	1,498	1,154	1,209	1,063	1,285	1,260	1,466	1,667	1,682
STI & HIV	0	23	328	396	359	566	597	974	1,228	1,557
Total	2,074	3,448	2,564	2,593	2,272	2,721	2,993	4,699	4,850	4,755

1.4 Agency/Outreach Visits • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
STI & HIV	1,273	2,814	4,580	3,134	2,931	1,421	1,187	1,629	1,226	1,257
HIV	2,681	2,331	1,815	1,656	1,340	707	689	728	586	385
STI & HIV	1	101	750	642	766	319	372	437	488	744
Total	3,955	5,246	7,145	5,432	5,037	2,447	2,248	2,794	2,301	2,386

chee mamuk program

Chee Mamuk Aboriginal Program, STI/HIV Prevention and Control

The mandate of Chee Mamuk Aboriginal Program is to provide innovative, culturally appropriate, on-site, community-based HIV/AIDS and Sexually Transmitted Infection education and training to Aboriginal communities, organizations, and professionals within British Columbia.

The Chee Mamuk Program was formed in 1989 with funding provided by the Ministry of Health, developing as a result of the climbing rates of HIV/AIDS in the Aboriginal community. With a focus on spiritual, mental, emotional and physical health, Chee Mamuk provides awareness of HIV/AIDS and sexually transmitted infections using culture, community involvement and scientific information to educate Aboriginal communities. Currently, there are three full-time employees: a program manager, an educator and an administration support position, all of whom are First Nations people. The program also offers referrals and consultations, and is continuously developing and upgrading culturally appropriate education materials through such innovations as the Women's HIV/AIDS and Hepatitis Kits, condom-holder key chains, cover packaging for female condoms, youth DVDs, and HIV testing handouts with First Nations artwork and cultural teachings.

Another innovative project Chee Mamuk is commencing is Star in Your Own Stories. This project is an example of a creative, engaging, sexual health project for youth. Chee Mamuk in collaboration with the STI/HIV Outreach Program, BC Centre for Disease Control, will be contracting Good Company Communications (a new media company) to work with Kitamaat youth to create their own positive sexual health campaign.

These two projects are examples of successful models of providing sexual health education in a creative, community based, and cultural way.

In 2006, Chee Mamuk provided 69 awareness workshops and five "train the trainer" workshops, presented at thirteen conferences, and engaged in six health fairs at Aboriginal gatherings. We reached over 7,000 people. These workshops and presentations continue to grow in demand.

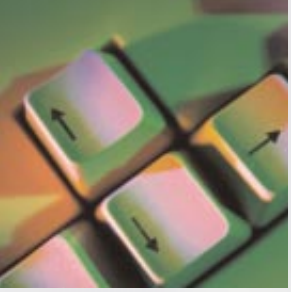
education and communication: meeting new challenges

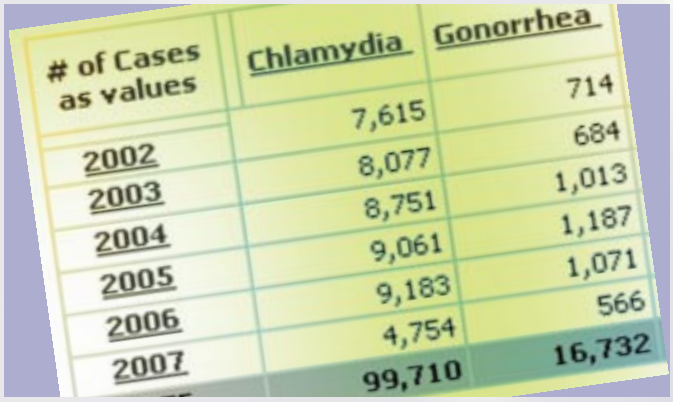
Certificate in STI/HIV Clinical Nursing Practice

In 2006 the pilot phase of the online Certificate in STI/HIV Clinical Nursing Practice was completed. Feedback from experienced STI nurses was collected and incorporated into the course. By the end of the year the course was ready to be offered to public health nurses throughout British Columbia.

The BC Centre for Disease Control is entering into a partnership with Simon Fraser University's Simulation & Advanced Gaming Environments (SAGE) for Learning department to enhance the online learning environment and develop interactive features for the STI course.

In response to the Provincial Scope of Practice legislation, with funding from the Nursing Directorate, the framework for the online Certificate in STI/HIV Clinical Nursing Practice was used to assist in the development of draft, competency-based curricula for the tuberculosis and communicable disease nursing groups within the BC Centre for Disease Control. Similarly, in partnership with the British Columbia Reproductive Care Program at Women's Hospital, a contraceptive management draft curriculum was developed.





# of Cases as values	Chlamydia	Gonorrhea
2002	7,615	714
2003	8,077	684
2004	8,751	1,013
2005	9,061	1,187
2006	9,183	1,071
2007	4,754	566
	99,710	16,732

HIV/AIDS Information System

The HIV/AIDS Information System project, known as HAISYS, was initiated to improve the accessibility, security and integration of HIV and AIDS case data. Historically, HIV and AIDS data have been housed in separate databases, impeding the ability to track the progression of the disease on a case-by-case basis. In addition, lack of functionality in the existing HIV database has prevented public health nurses from accessing case data, requiring all HIV data to be entered and managed by one or two individuals at the BCCDC.

The HAISYS application will bring together HIV and AIDS data into a single database, provide a secure means by which public health nurses can be informed of new cases requiring follow-up, and allow public health nurses to directly access and enter their own case data. The application will support consistent, efficient HIV case management practices, reduce the risk of data entry errors, and improve data analysis and research.

After an exhaustive scoping and design phase, the application is currently in development in collaboration with the Information Technology division of the Provincial Health Services Authority. The application will be made available to designated HIV nurses in BC via a secure intranet site (Private Network Gateway) and, once training has been completed, will be rolled out to the Health Authorities. Implementation is anticipated to commence in early 2008.

For more information on the HIV/AIDS Information System, please email **devon.haag@bccdc.ca**.

Panorama

In 2004, Canada Health Infoway initiated the development of a pan-Canadian communicable disease surveillance system to allow public health authorities to track communicable diseases and manage outbreaks. The resulting Public Health Surveillance System, or PANORAMA, has been designed in partnership with the provinces and territories, and is currently in the development phase. In 2006, the Division of STI/HIV Prevention and Control became an active participant in the scoping and design of PANORAMA. In this way, we can ensure that the objectives and business requirements of STI/HIV Prevention and Control will be met by the national surveillance system.

research program

Having received over $200,000.00 in new research grants and awards, STI/HIV Prevention and Control has focused its research efforts on prevention, novel laboratory testing methodologies, and enhanced surveillance. A total of eight studies were implemented in 2006, and results/interim results were disseminated in three new publications and numerous national and international research conferences. In addition, staff members involved with the research program have played an active role in data linkage projects within BCCDC and as part of the upcoming Panorama project. Highlights of 2006 are as follows:

Research Studies in 2006:

- Recent HIV Seroconversion at Time of First Positive Test: A Comparison Before and After HIV Reportability – Master's Thesis.
- Enhanced STI Surveillance in Canadian Street Youth – Phase V.
- Prevalence of and Self Sampling for High Risk (HR) Human Papillomavirus in Heterosexual men in BC.
- A Comparison of Resource Expenditure (Nursing Time) Required by HSV Clients versus Non-HSV clients at an STI Clinic.
- A survey to evaluate the acceptability and utility of an online health education and referral service for male patrons of female sex workers.
- Assessment of Sexual Health Risk Behaviours Among Indoor Sex Workers in Greater Vancouver.

- Impact of an Enhanced "Positive" Prevention Program of HIV-Infected Gay Men.
- Characteristics of Individuals who Become Repeatedly Infected with Syphilis.

Collaborations:

- Collaborated with IRMACS (Interdisciplinary Research in the Mathematical and Computational Sciences) at Simon Fraser University to begin mathematical modelling of HIV transmission.
- Collaborated with Hepatitis Services, TB Control and PHSA Laboratory Services to begin inter-agency data linkage pilot project.
- The Research Program was represented in the STI/HIV Prevention and Control Working Group for the Panorama project.

publications / conference proceedings and abstracts / presentations

Publications

Jayaraman GC, Archibald CP, Kim J, Rekart ML, Singh AE, Harmen S, Wood M, Sandstrom P. A population-based approach to determine the prevalence of transmitted drug-resistant HIV among recent versus established HIV infections: results from the Canadian HIV strain and drug resistance surveillance program. *Journal of Acquired Immune Deficiency Syndromes* 2006 ;42(1):86-90.

Morshed MG, Jones HD, on behalf of the *Treponema pallidum* Resistance Working Group. *Treponema pallidum* macrolide resistance in BC. Can Med Assoc J. 2006;174(30):349.

Conference proceedings and abstracts / presentations

Barney L, Taylor DT. "Creating a Place of Belonging". 7th Annual Alberta Harm Reduction Conference, Lethbridge, Alberta, February 2006.

Barney L, Taylor DT. "Working Together". 2006 Conference First Nations and Inuit Health Branch, Pacific Nursing Services, Richmond, BC, January 2006.

Jolly A, Taylor D, Ogilvie G, Rekart M. Evaluation of partner notification for syphilis; before and after enhanced social network strategies; Vancouver, Canada. XXVI International Sunbelt Social Network Conference, Vancouver, BC, Canada, April 24-30, 2006.

Jolly A, Taylor D, Ogilvie G, Rekart M. "Tools for Rock – the Safer Crack Use Coalition". Vancouver Harm Reduction Conference/Nursing Symposium, May 2006.

Kline D, Gold F, Canso D, Winsor Y, Stevenson J, Taylor DL, Ogilvie GS, Rekart ML. "Feasibility and Acceptability of Conducting Research with Male Patrons of Female Sex Workers". 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Ogilvie GS, Trussler T, Marchard M, Monizzorium A, Taylor DL, Rekart ML. Internet sex partner seeking as a marker for risky sexual practices in MSM. 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Ogilvie GS, Krajden M, Patrick DM, Taylor DL, Remple VP, Money DM, Hogg RS, Burdge DR, Schechter M, Rekart ML. "Antenatal Seroprevalence of HIV in British Columbia". 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Ogilvie GS. Plenary Speaker, "Equitable Access to Preventative Services". CIHR Reducing Health Disparities Research and Policy Symposium, Toronto, March 2006.

Ogilvie GS. Plenary Speaker, "HPV Vaccine". BC College of Family Physicians, October 2006.

Remple VP, Johnston C, Leclair R, Ogilvie GS, Bungay V, Patrick DM, Tyndall MW, Jolly AM, Barnett J. "Reproductive Health Status and HIV screening practices of indoor commercial sex workers in Vancouver BC". 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Remple VP, Johnston C, Leclair R, Ogilvie GS, Bungay V, Patrick DM, Tyndall MW, Jolly AM, Barnett J. "Inconsistent condom use by indoor commercial sex workers in Vancouver: A qualitative and quantitative study". 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Rivers M. The Gathering Tree, A Unique Literary and Cultural Approach to Introducing Children and Communities to HIV Awareness and Prevention. A Journey of the Past, Present, and Future: Bring the Circle Together, Healing Our Spirit, 10th Annual Aboriginal HIV/AIDS Conference, May 2006.

Rivers M. The Gathering Tree, a Children's Book on HIV, with a First Nations Storyline. XVI International AIDS Conference, Global Village, Dundas Square. Participant on the Indigenous Peoples' Best Practice Panel, August 2006.

Rivers M. "The Gathering Tree: A Children's Book on HIV with a First Nations Storyline and Youth Strengthening the Circle". Aboriginal Education Conference: Linking Literacy Through Language and Spirituality. Chilliwack, BC, February 2006.

Rivers M. Talking to Your Children about HIV/AIDS. Our Children, Our Future. First Nations Parents Conference, Vancouver, May 2006.

Rivers M. Cultural Ways of Educating Aboriginal Youth and Children on HIV/AIDS. Embracing Our Traditions, Values, and Teachings: Native Peoples of North America HIV/AIDS Conference, Anchorage, Alaska, May 2006.

Rivers M. Sharing Our Strength. Embracing Our Traditions, Values, and Teachings: Native Peoples of North America HIV/AIDS Conference, Anchorage, Alaska, May 2006.

Rivers M. Issues of Place: Living with HIV in Urban and Rural Aboriginal Communities. Springboard 2006, Positive Women's Network, Vancouver, BC, March 2006.

Rivers M. Bridges of Hope. Poster and oral presentation. Vancouver Harm Reduction Conference/Nursing Symposium, May 2006.

Rivers M. "Chee Mamuk: Chako "To Become" Coming of Age". International AIDS Conference in Toronto, August 2006.

Rivers M. "Chee Mamuk: Youth Strengthening the Circle". International AIDS Conference in Toronto, August 2006.

Rivers M. "Chee Mamuk: The Gathering Tree, a Children's Book on HIV with A First Nations Storyline". International AIDS Conference in Toronto, May 2006.

Rivers M. The Dance. Oral. Vancouver Harm Reduction Conference/Nursing Symposium, May 2006.

Sandstra I, Jones E, Gold F, Maginley J, Taylor DL, Ogilvie GS. Client Response to an On-Line HIV/STI Information and Referral Service. 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Taylor D, Jones E, MacMillan C, Moniruzzaman A, Ogilvie G. Characteristics of IDU Among Vancouver's Homeless Youth". 15th Annual Canadian Conference on HIV/AIDS Research, May 2006, Quebec, Canada.

Tran NH, Phung TTV, Rekart ML. Implementation of the etiologic STI approach at community level in Southern Viet Nam. The Vietnam HIV/AIDS/STI Community Clinics Network Project, Ho Chi Minh, Viet Nam, Kien Giang Health Services, Kien Giang, Viet Nam, British Columbia Centre for Disease Control, Vancouver, Canada. AIDS 2006 - XVI International AIDS Conference, 2006. Abstract no. CDC0624.

highlights of 2006

Change of Name

Collaborating With Chilliwack

Around the Kitchen Table

change of name

STI HIV
Prevention and Control

What's in a name? Why have we changed our name from STD/AIDS Control to STI/HIV Prevention and Control?

The maladies associated with sexual relations have had a few name changes over the years. Initially, the terms "venereal disease" (VD) and "venereology" were commonly used, originating from the Latin "Venus", the goddess of love. The highest level of academic achievement during those times was the Diploma in Venereology (Dip Ven), proudly held by our clinic physician, Dr. Hugh Jones. In the United Kingdom, VD clinics are often called "genitourinary medicine" (GUM) clinics. Later, in the 1980s and 1990s, the term "sexually transmitted disease" (STD) replaced venereal disease, perhaps reflecting the identification of a "new" group of sexually transmitted pathogens that were capable of causing systemic symptoms, signs and pathology-for instance, human immunodeficiency virus (HIV), hepatitis B, herpes and human papillomavirus (HPV).

Since the early 2000s, "sexually transmitted infection" (STI) has become the preferred term perhaps reflecting the recently recognized reality that many sexually transmitted conditions are usually asymptomatic, in effect, infections without disease. The abbreviation STI is sometimes also used for "scheduled treatment interruption", a strategy in HIV antiretroviral.

We have also replaced "AIDS" with "HIV" since our major thrust has always been issues surrounding the transmission of HIV rather than issues around the disease AIDS itself. Finally, we have added "Prevention" to signal a new and intense focus on best practices in primary prevention of STI and HIV. New laboratory technologies, recent advances in treatment, prophylaxis and vaccination, and emerging behavioural strategies to prevent STI and HIV have re-energized our mission.

collaborating with chilliwack

As In 2006, the Fraser Health Authority faced a growing syphilis outbreak in Chilliwack. BCCDC Outreach nurses, experienced in street nursing and social networking, collaborated with Chilliwack public health nurses to initiate and develop an outreach nursing syphilis strategy for the Chilliwack area. Nurses from BCCDC Outreach partnered with and mentored Chilliwack public health outreach nurses two days a week. This nursing collaboration will continue in 2007.

around the kitchen table

A current innovative project of Chee Mamuk is the Around the Kitchen Table project. It aims to empower Aboriginal women, with an emphasis on those living in remote communities, to fight the spread of HIV/AIDS by reinstating their traditional roles and joining them in a community network of support and education. Women meet in casual settings, such as around the kitchen table, and discuss topics such as sexual health, harm reduction, culture, self care, communication, traditional teachings, nutrition, relationships and HIV/AIDS.

Two women leaders in each community are chosen and trained to facilitate the Around the Kitchen Table groups in their communities. They are trained along with other interested staff and community members by Chee Mamuk and advisory team members from Children's and Women's Oak Tree Clinic, BC Centre for Excellence in HIV/AIDS, and the STI/HIV Outreach Program of the BC Centre for Disease Control. During the trainings the importance of women's traditional knowledge is emphasized and the women are encouraged to claim that role as an important one in keeping their communities alive and thriving. After being trained, the two women leaders facilitate the groups in their community over a six-month period of time. Chee Mamuk has worked in six communities so far and each community has conducted the project in their own unique way.

Cowichan Tribes included mothers, grandmothers and daughters in their group for a multigenerational approach. They participated in several cultural activities such as moccasin making, canning, and drum making. Secwepemc Nation has focused on self care and working with young women. Kelowna held sessions on nutrition, cooking, beauty but mostly gathered as a group to have discussion nights and learn about Metis and First Nation cultures. Chee Mamuk worked with one urban group, the Aboriginal Health and Safety Project, which is a group of sex trade workers in the Downtown Eastside of Vancouver. The connections between rural and urban are strong and this group of women are at particular risk for contracting HIV/AIDS. The group developed the message, "Sisterhood: Share Love, Not Needles", which was printed on key chains with flashlights for them to hand out to other women on the street.

Elizabeth Tom taught all the women to make moccasins while we shared information on HIV/AIDS, STIs and Harm Reduction.

Two communities, Skidegate Band and Carrier Nation are just getting underway. Skidegate started with a cultural sharing night with drumming and dancing groups so that they could gain support from all the clans on the project. They plan to include women from all the clans so the learning can ripple out to all the families. Burns Lake will use the theme of traditional activities that take place in each of the four seasons. All groups will weave sexual health education into their programs.

Women leaders from each of the communities will be brought together in 2007 on a retreat to share what they have learned and to network and build relationships with each other. This will provide a network of women that can problem-solve together on HIV issues in their communities and support each other through hard times.

incidence trends

Chlamydia:

The rate of chlamydia in 2006 (212.5 cases per 100,000 population) was similar to 2005 (212.9 per 100,000). This may represent a slowing of the overall increase in chlamydia rates observed in BC since 1997. Females continue to have twice the rate of infection compared to males, with the highest rates among females aged 15-24 years.

Gonorrhea:

The rate of gonorrhea dropped from 27.9 per 100,000 in 2005 to 24.8 per 100,000 in 2006. This decrease was primarily due to a decrease in the reported number of male gonorrhea cases, which was seen in all age categories. The gonorrhea rate among females has been steadily increasing since 2002, and the number and rate increased in almost all age categories (a slight decrease was observed in the 20-24 years group, although this category continued to have the highest rates of gonorrhea among females). Many Health Service Delivery Areas (HSDAs) reported similar or decreased rates of gonorrhea infection, with increases noted in parts of the Interior Health Authority and in all three HSDAs in Northern Health Authority.

Infectious Syphilis:

An increased rate of syphilis observed in 2006 (7.7 per 100,000) compared to 2005 (6.8 per 100,000) demonstrates that the epidemic of infectious syphilis in BC since 1997 has not abated. The rate in males is approximately three times that of the female rate, due to the sustained increase in infectious syphilis cases among gay, bisexual, and other men who have sex with men (MSM) in BC. The number of cases among MSM increased from 120 in 2005 to 158 in 2006 (47.0% of all cases in 2006).

While the rates of infection were similar in most HSDAs in 2006, a marked increase was observed in Fraser East and Fraser North HSDAs. Collaboration between local public health staff and the BCCDC Outreach Program identified that many of these cases had involvement with the sex trade (as sex workers or their patrons). This discovery has led to increased syphilis partner counselling and referral activities in this region.

The proportion of infectious syphilis cases among Aboriginal people has decreased slightly since 2005 (from 14.1% to 11.7%); however, Aboriginal people continue to be overrepresented among infectious syphilis cases. This is particularly true for females, who represent 38.5% of all female infectious syphilis cases in the province.

HIV:

The rate of new positive HIV infections in BC decreased in 2006 to 8.4 from 9.4 per 100,000 in 2005, decreasing slightly for both males and females. The rate of HIV infection among males is approximately four times the rate in females, due to the large number of cases among MSM. While the total number of HIV cases among MSM in 2006 is not known (due to the lag in classification of reported cases), the majority of new positive HIV infections in BC in 2006 is among MSM, continuing a trend observed since 2000.

HIV became a reportable infection in May 2003 and a system for enhanced public health follow-up for all reported first positive HIV tests has been well established since 2004. Accordingly, public health authorities have been better able to distinguish between true new positive HIV tests in BC, and individuals with a first positive test in BC who have previously tested positive outside of BC. The improved identification and exclusion of these previously positive HIV cases has contributed to the observed decline in the new positive HIV rate in BC since 2004 (see figure 5.1).

The number and rate of new positive HIV infections in BC is the best proxy indicator for HIV incidence in BC, and is the measure used in this report. For the reasons cited above, caution is advised in the interpretation of trends in reported numbers or rates of newly diagnosed HIV infections prior to 2005.

Since 2000 the Public Health Agency of Canada has conducted detuned antibody testing on available blood specimens from individuals with new positive HIV tests in BC, as part of the national HIV Drug Resistance Program. This test identifies individuals who are recently infected (within 170 days of becoming infected). For 2004 (the most recent year where data is available), 105 of 308 specimens available for testing (34.1%) were from individuals with recent infections. This proportion was similar for MSM (47 of 132 tests, 35.6%) and for injection drug use (38 of 95 tests, 40.0%).

AIDS:

The AIDS rate and new case reports increased slightly from 97 (2.3 per 100,000) in 2004 to 102 (2.4 per 100,000) in 2005. Due to delays associated with AIDS case reports, this 2006 report includes cases through 2005 only. Similar to HIV rates, the rate of AIDS cases among males was approximately four times greater than that of females.

PID/Ectopic pregnancy/Tubal infertility:

Rates of Pelvic Inflammatory Disease (PID) reported from hospitals and day surgeries in 2005 (69.9 per 100,000) was similar to the rate reported in 2004 (69.4 per 100,000). Rates of ectopic pregnancies also remained stable in 2005 at 61.5 per 100,000 compared to 62.3 per 100,000 in 2004. The rate of tubal infertility reports from hospitals and day surgeries in 2005 (27.3 per 100,000) was also similar to the rate reported in 2004 (27.8 per 100,000). The data received by STI/HIV Prevention and Control on PID, ectopic pregnancy and tubal infertility is not available for 2006 due to delays in reporting, collation and data transfer.

epidemiology

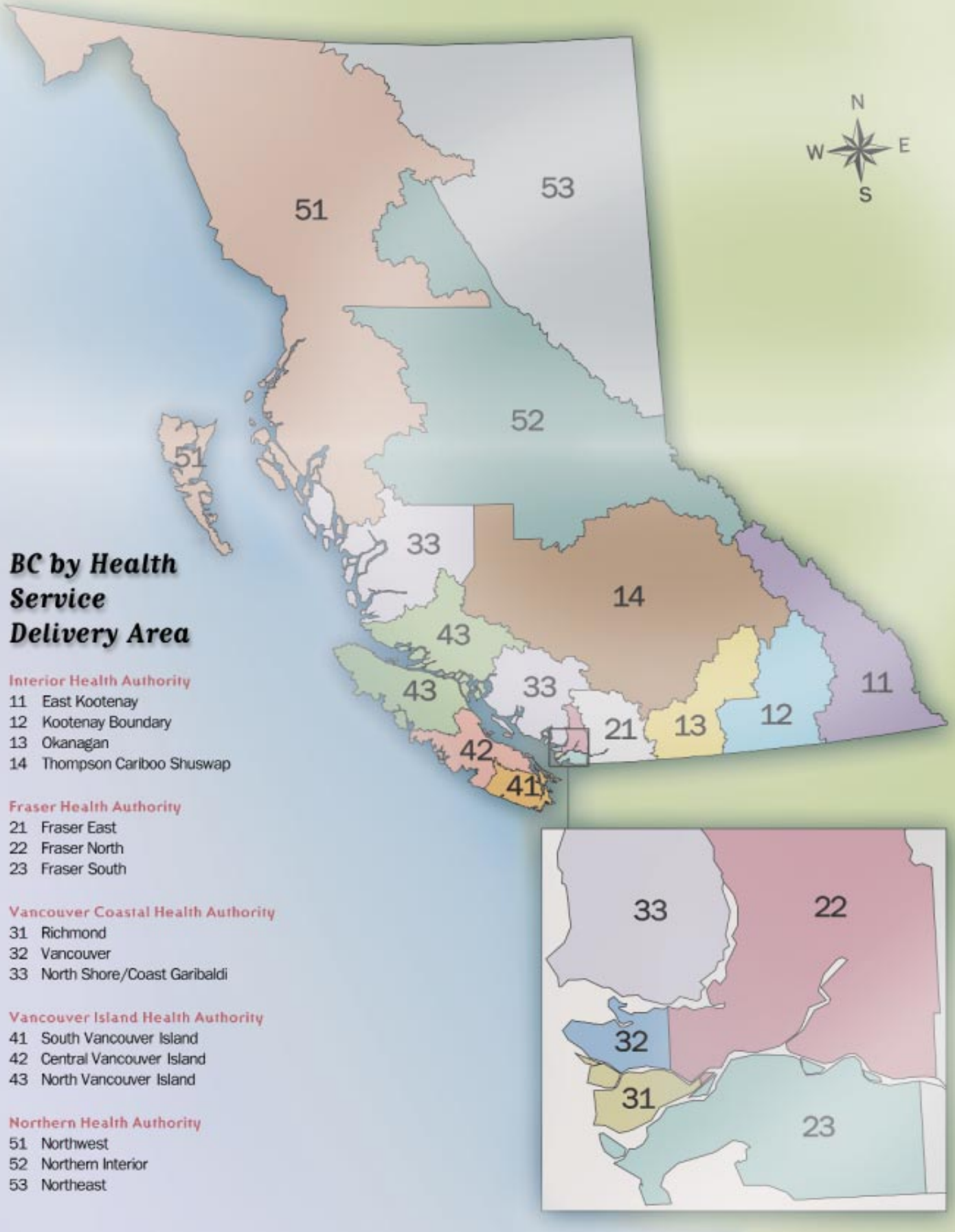
In British Columbia, provincial law requires that certain communicable infections be reported to the Medical Health Officer of the region by health care providers and laboratories. The reportable STIs are gonorrhea, chlamydia, syphilis, HIV and AIDS. HIV infection became reportable on May 1, 2003.

Mandatory reporting:

- Enables health care workers to follow up on reported infections to ensure adequate treatment and care is provided.
- Reduces the spread of infection through partner notification and other measures.
- Allows health care workers to monitor the incidence of the disease while assisting with prevention strategies.

This reporting supplies the data for our epidemiology reports of these diseases.

For information on pelvic inflammatory disease please refer to page 42.



BC by Health Service Delivery Area

Interior Health Authority
- 11 East Kootenay
- 12 Kootenay Boundary
- 13 Okanagan
- 14 Thompson Cariboo Shuswap

Fraser Health Authority
- 21 Fraser East
- 22 Fraser North
- 23 Fraser South

Vancouver Coastal Health Authority
- 31 Richmond
- 32 Vancouver
- 33 North Shore/Coast Garibaldi

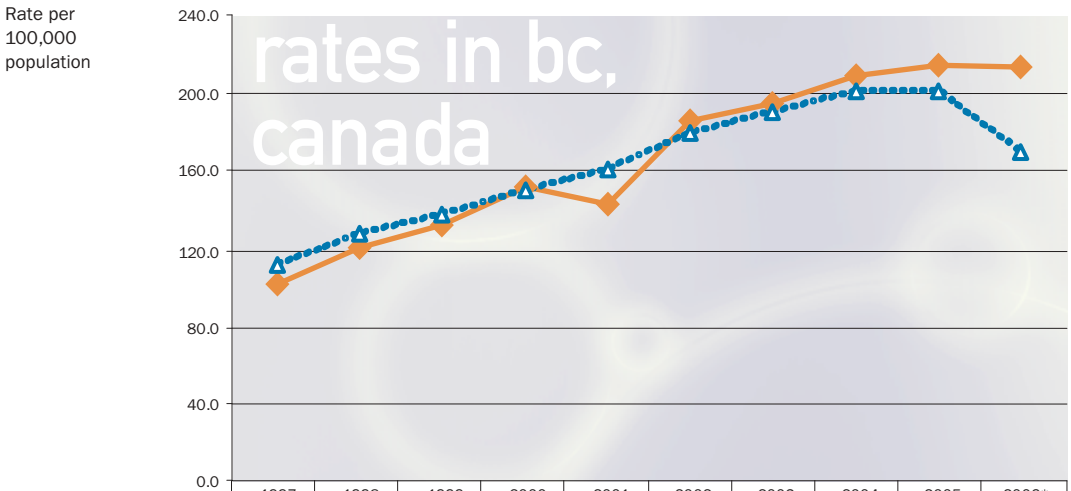
Vancouver Island Health Authority
- 41 South Vancouver Island
- 42 Central Vancouver Island
- 43 North Vancouver Island

Northern Health Authority
- 51 Northwest
- 52 Northern Interior
- 53 Northeast

chlamydia

The chlamydia rate in BC was 212.5 per 100,000 in 2006, similar to the rate in 2005 (212.9 per 100,000). There were 9,142 cases of chlamydia reported in 2006. The majority of cases are female, and women aged 15-19 and 20-24 continue to have the highest chlamydia rates at 1,353.8 and 1,496.3 per 100,000 respectively. The overall trend in chlamydia infection rates has been increasing since 1997.

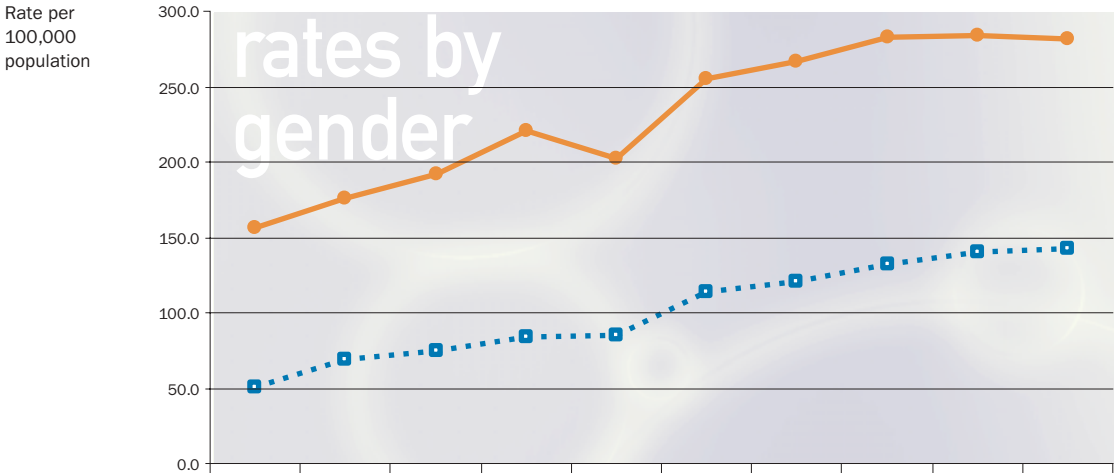
2.1 Chlamydia case reports and rates in BC • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
BC Reports	4,116	4,880	5,353	6,160	5,863	7,615	8,077	8,751	9,060	9,142
BC Rate	104.2	122.5	133.4	152.5	143.8	185.0	194.4	208.3	212.9	212.5
Canadian Rate	113.9	129.0	138.2	150.9	161.4	179.4	189.4	200.1	200.4	169.9

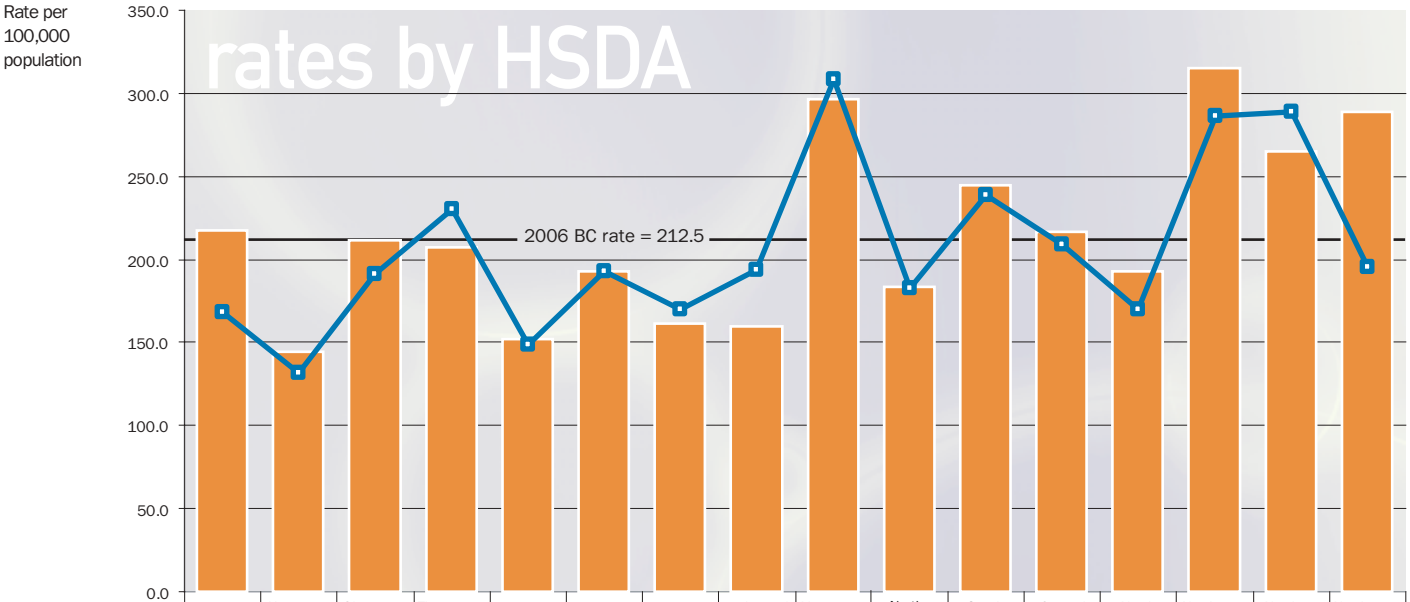
*2006 Canadian Rate is preliminary (Public Health Agency of Canada, 2007)

2.2 Chlamydia case reports and rates in BC by gender • 1997 to 2006



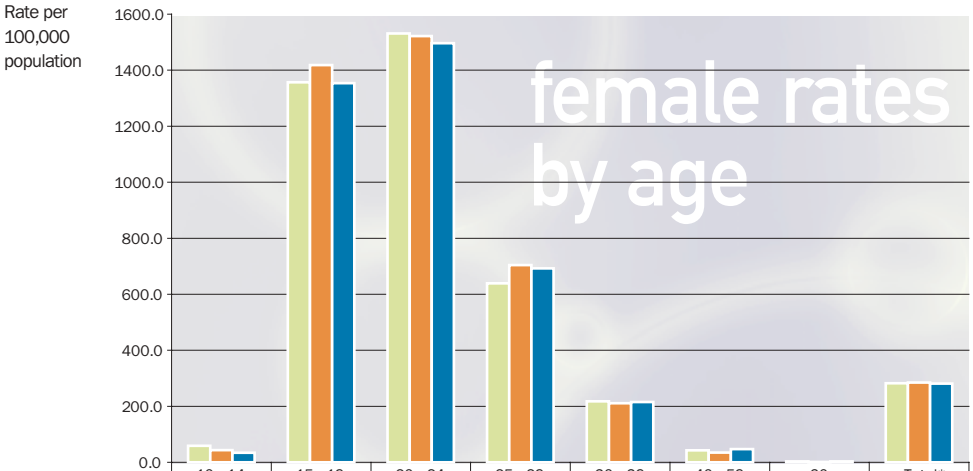
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Reports – Female	3,110	3,518	3,868	4,476	4,148	5,293	5,589	5,985	6,103	6,106
Reports – Male	1,002	1,361	1,484	1,681	1,715	2,321	2,487	2,764	2,956	3,032
Rate – Female	156.8	175.7	191.7	220.1	201.9	255.1	266.9	282.4	284.5	281.2
Rate – Male	51.0	68.7	74.4	83.8	84.7	113.7	120.7	132.7	140.2	142.2

2.3 Chlamydia case reports and rates in BC by health service delivery area • 2005 to 2006



	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2006	139	106	644	517	400	1,099	1,103	339	1,842	506	844	535	205	242	448	137
Rate 2005	217.6	144.2	211.5	206.9	151.7	193.3	161.2	159.7	296.5	183.3	245.0	216.6	193.3	315.2	265.1	288.8
Rate 2006	167.8	131.9	191.2	230.4	148.9	192.7	169.6	193.8	308.2	182.8	238.8	208.7	170.0	286.0	288.9	195.6

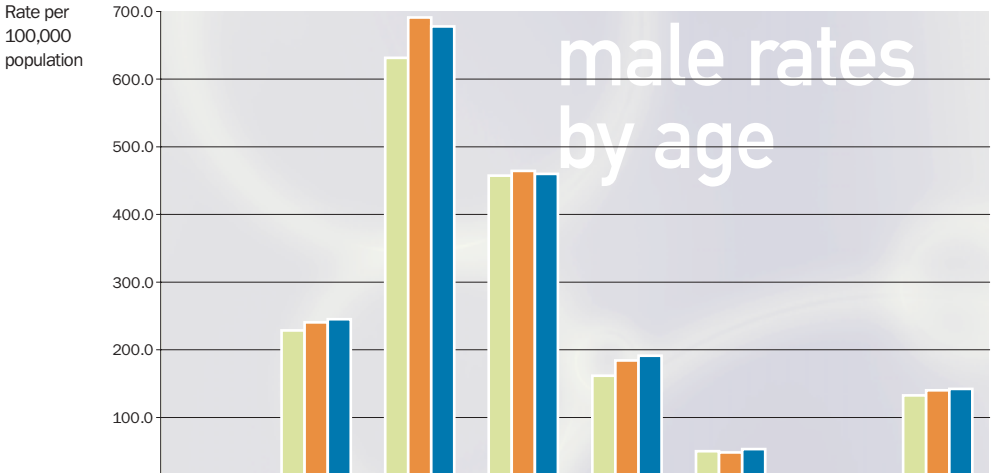
2.4 Female chlamydia rates in BC by age • 2004 / 2005 / 2006



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2004 Rate – Female	58.9	1,356.7	1,531.4	638.8	217.5	42.7	2.9	282.4
2005 Rate – Female	43.5	1,418.2	1,522.0	704.3	210.7	34.9	1.2	284.5
2006 Rate – Female	34.4	1,353.8	1,496.3	692.6	215.1	47.5	3.2	281.2

Total* - Rate includes ALL females (i.e., aged <1 to 60+ years and females with age not specified)

2.5 Male chlamydia rates in BC by age • 2004 / 2005 / 2006



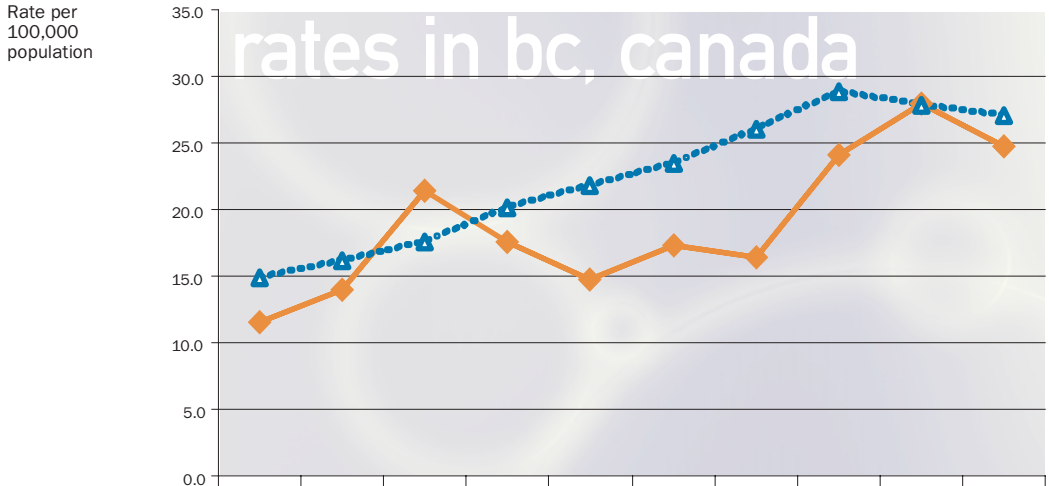
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2004 Rate – Male	0.7	228.7	631.5	457.4	161.6	50.0	7.8	132.7
2005 Rate – Male	-	240.5	691.3	464.4	184.2	48.3	4.9	140.2
2006 Rate – Male	4.5	245.2	677.9	460.0	191.3	53.2	6.3	142.2

Total* - Rate includes ALL males (i.e., aged <1 to 60+ years and males with age not specified)

gonorrhea

The 2006 gonorrhea rate for BC (24.8 per 100,000) was lower than for 2005 (27.9 per 100,000), reflecting a decrease in case reports from 1,187 to 1,066. While the number of cases in males decreased since 2005, males aged 20-24 and 25-29 have the highest rates of gonorrhea infection (73.8 and 93.7 per 100,000 respectively). The number of infections in females has been slowly climbing since 2002, with the greatest concentration among females aged 15-24. While many HSDAs observed decreases in rates of gonorrhea infection in 2006, an increase in rates was observed in all three HSDAs in Northern Health Authority.

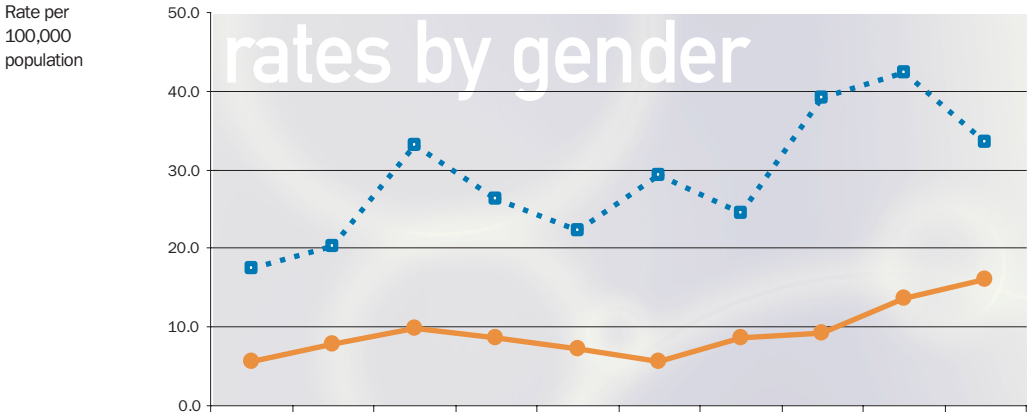
3.1 Gonorrhea case reports and rates in BC • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
BC Reports	455	558	859	707	600	714	684	1,013	1,187	1,066
BC Rate	11.5	14.0	21.4	17.5	14.7	17.3	16.5	24.1	27.9	24.8
Canadian Rate	14.9	16.1	17.6	20.1	21.8	23.5	26.0	28.9	27.8	27.1

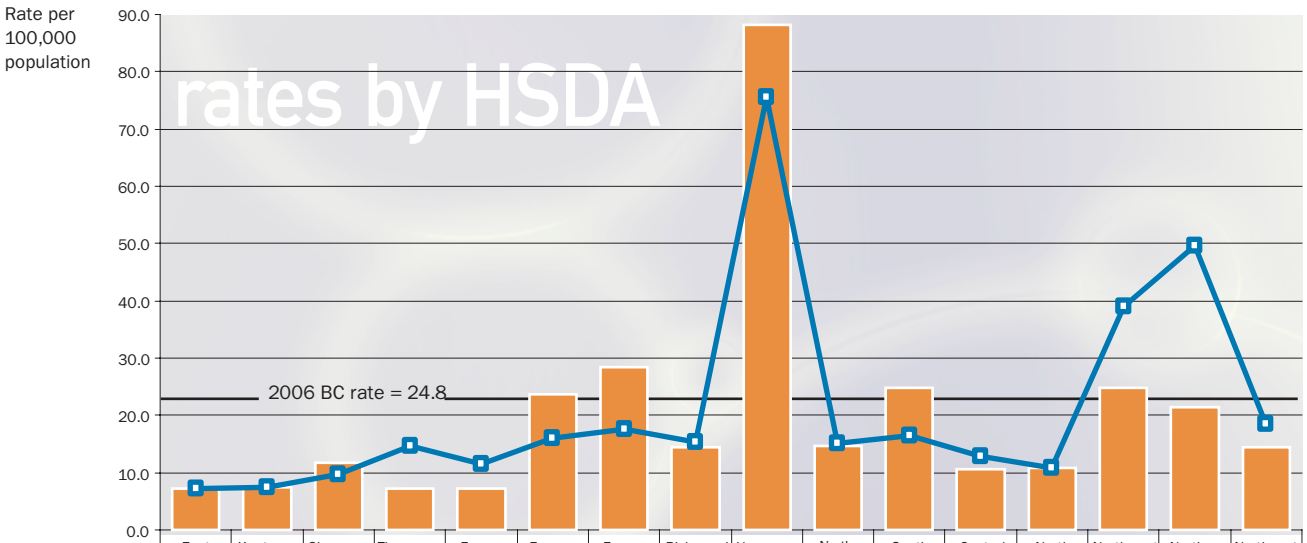
*2006 Canadian rate is preliminary (Public Health Agency of Canada, 2007).

3.2 Gonorrhea case reports and rates in BC by gender • 1997 to 2006



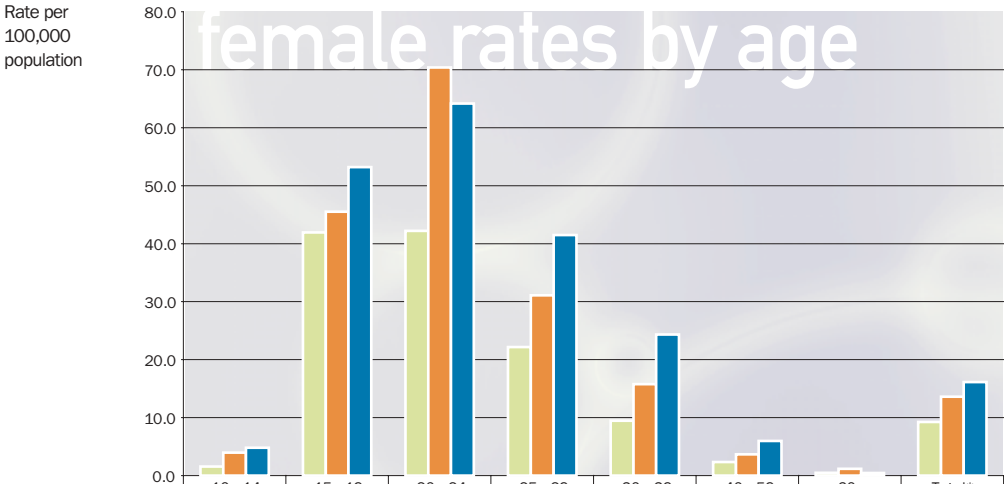
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Reports – Male	343	402	661	529	451	599	504	817	895	715
Reports – Female	111	155	197	177	149	115	179	196	292	350
Rate – Male	17.5	20.3	33.2	26.4	22.3	29.3	24.5	39.2	42.4	33.5
Rate – Female	5.6	7.7	9.8	8.7	7.3	5.5	8.5	9.2	13.6	16.1

3.3 Gonorrhea case reports and rates in BC by health service delivery area • 2005 to 2006



	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2006	6	6	33	33	31	91	115	27	451	42	58	33	13	33	77	13
Rate 2005	7.3	7.5	11.8	7.2	7.2	23.6	28.5	14.4	88.2	14.6	24.8	10.7	10.9	24.9	21.4	14.4
Rate 2006	7.2	7.5	9.8	14.7	11.5	16.0	17.7	15.4	75.5	15.2	16.4	12.9	10.8	39.0	49.6	18.6

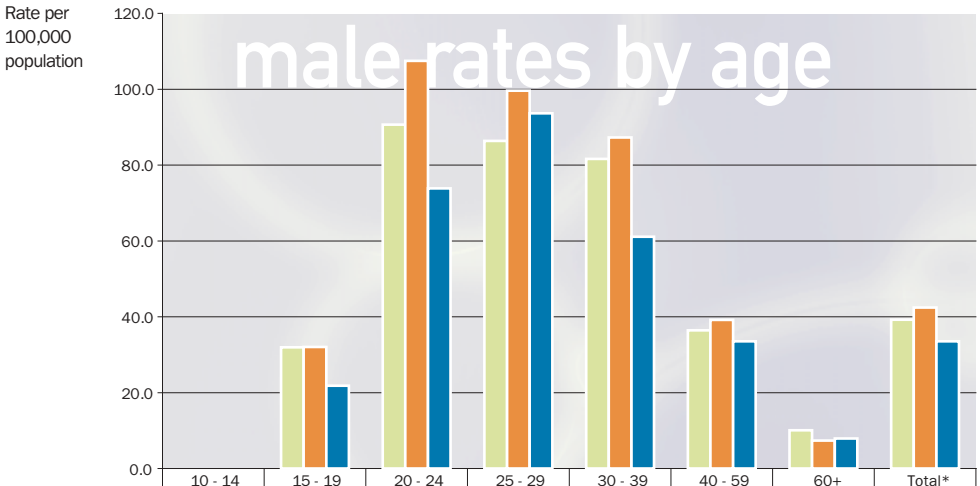
3.4 Female gonorrhea rates in BC by age • 2004 / 2005 / 2006



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2004 Rate – Female	1.6	41.9	42.2	22.2	9.5	2.3	0.5	9.2
2005 Rate – Female	4.0	45.5	70.4	31.1	15.8	3.7	1.2	13.6
2006 Rate – Female	4.8	53.2	64.2	41.5	24.3	6.0	0.5	16.1

Total* - Rate includes ALL females (i.e., aged <1 to 60+ years and females with age not specified)

3.5 Male gonorrhea rates in BC by age • 2004 / 2005 / 2006



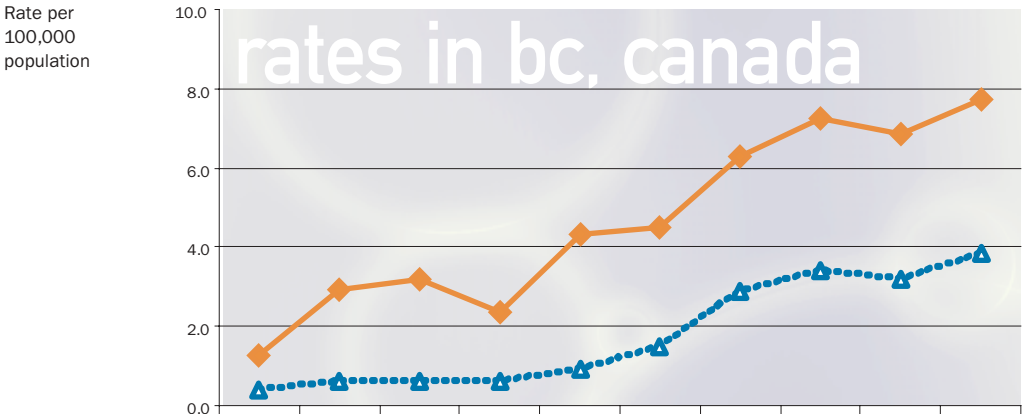
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2004 Rate – Male	-	32.0	90.7	86.4	81.6	36.4	10.1	39.2
2005 Rate – Male	-	32.1	107.5	99.6	87.3	39.2	7.4	42.4
2006 Rate – Male	-	21.8	73.8	93.7	61.1	33.5	7.9	33.5

Total* - Rate includes ALL males (i.e., aged <1 to 60+ years and males with age not specified)

infectious syphilis

The rate of infectious syphilis increased from 6.8 in 2005 to 7.7 per 100,000 population in 2006, reflecting an increase in cases from 291 to 333 cases. The majority of cases occurred among men, with the greatest concentration in men aged 30-59 and among men who have sex with men. While the greatest number of cases of infectious syphilis continue to be reported from the Vancouver HSDA, in 2006 an increased rate of infectious syphilis was observed in the Fraser East and the Fraser North HSDAs, associated with sex work. The rates of infectious syphilis have shown an overall increasing trend since the current outbreak began in 1997.

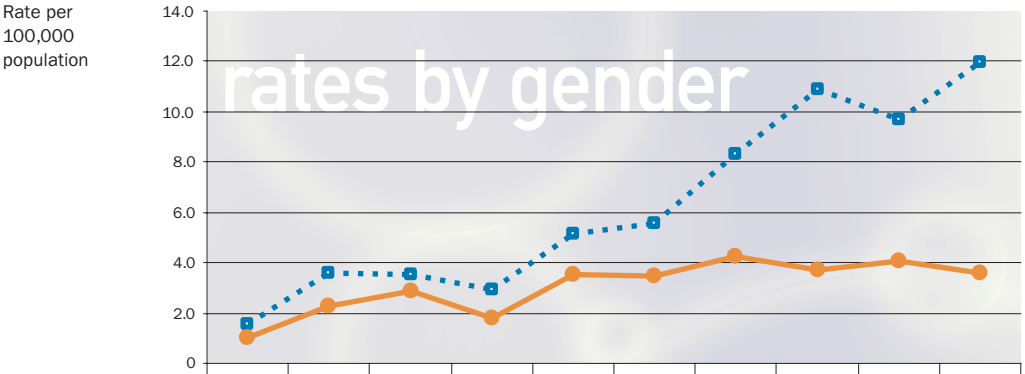
4.1 Infectious syphilis case reports and rates in BC • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
BC Reports	50	116	128	96	177	186	262	305	291	333
BC Rate	1.3	2.9	3.2	2.4	4.3	4.5	6.3	7.3	6.8	7.7
Canadian Rate	0.4	0.6	0.6	0.6	0.9	1.5	2.9	3.4	3.2	3.9

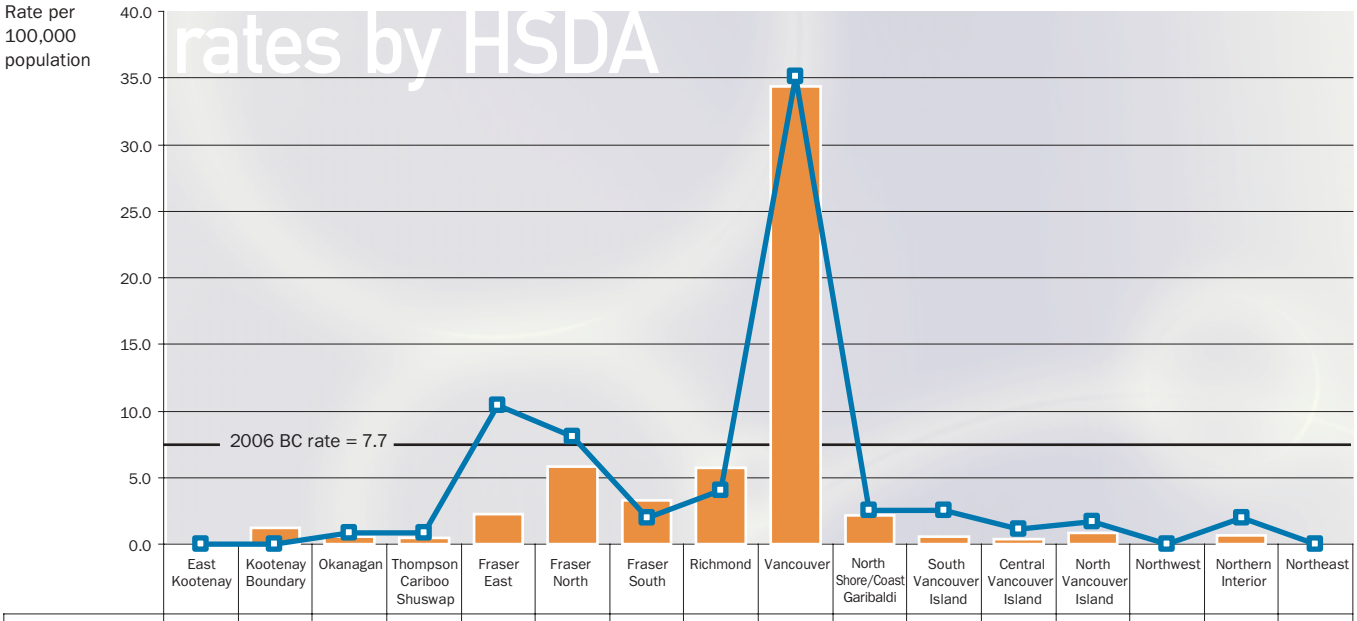
*2006 Canadian Rate is preliminary (Public Health Agency of Canada, April 2007)

4.2 Infectious syphilis case reports and rates in BC by gender • 1997 to 2006



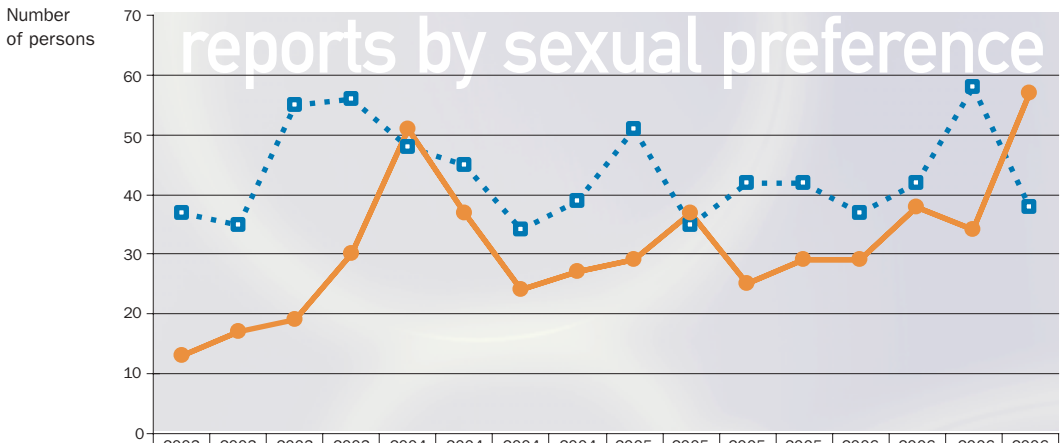
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Reports – Male	30	71	70	59	104	113	171	227	204	255
Reports – Female	20	45	58	37	73	72	89	78	87	78
Rate – Male	1.5	3.6	3.5	2.9	5.1	5.5	8.3	10.9	9.7	12.0
Rate – Female	1.0	2.2	2.9	1.8	3.6	3.5	4.2	3.7	4.1	3.6

4.3 Infectious syphilis case reports and rates in BC by health service delivery area • 2005 and 2006



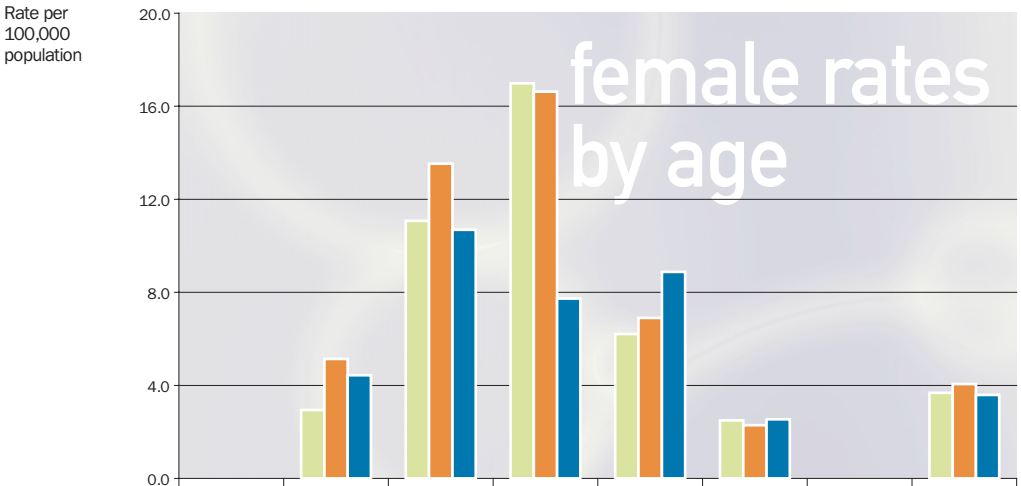
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2006	0	0	3	2	28	46	13	7	210	7	9	3	2	0	3	0
Rate 2005	0.0	1.2	0.6	0.4	2.3	5.9	3.3	5.8	34.4	2.2	0.6	0.4	0.8	0.0	0.6	0.0
Rate 2006	0.0	0.0	0.9	0.9	10.4	8.1	2.0	4.0	35.1	2.5	2.5	1.2	1.7	0.0	1.9	0.0

4.4 Infectious syphilis case reports in BC by sexual preference • 2003 to 2006



	2003 Q1	2003 Q2	2003 Q3	2003 Q4	2004 Q1	2004 Q2	2004 Q3	2004 Q4	2005 Q1	2005 Q2	2005 Q3	2005 Q4	2006 Q1	2006 Q2	2006 Q3	2006 Q4
Non-MSM	37	35	55	56	48	45	34	39	51	35	42	42	37	42	58	38
MSM	13	17	19	30	51	37	24	27	29	37	25	29	29	38	34	57

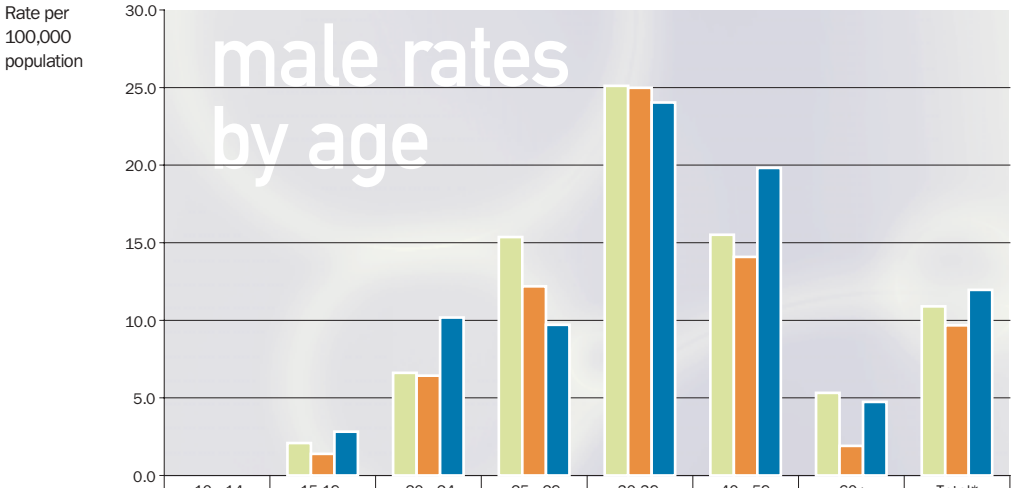
4.5 Female infectious syphilis rates in BC by age • 2004 / 2005 / 2006



	10 - 14	15-19	20 - 24	25 - 29	30-39	40 - 59	60+	Total*
2004 Rate – Female	-	2.9	11.1	17.0	6.2	2.5	-	3.7
2005 Rate – Female	-	5.1	13.5	16.6	6.9	2.3	-	4.1
2006 Rate – Female	-	4.4	10.7	7.7	8.9	2.5	-	3.6

Total* - Rate includes ALL females (i.e., aged <1 year to 60+ years)

4.6 Male infectious syphilis rates in BC by age • 2004 / 2005 / 2006



	10 - 14	15-19	20 - 24	25 - 29	30-39	40 - 59	60+	Total*
2004 Rate – Male	-	2.1	6.6	15.4	25.1	15.5	5.3	10.9
2005 Rate – Male	-	1.4	6.4	12.2	25.0	14.1	1.9	9.7
2006 Rate – Male	-	2.8	10.2	9.7	24.0	19.8	4.7	12.0

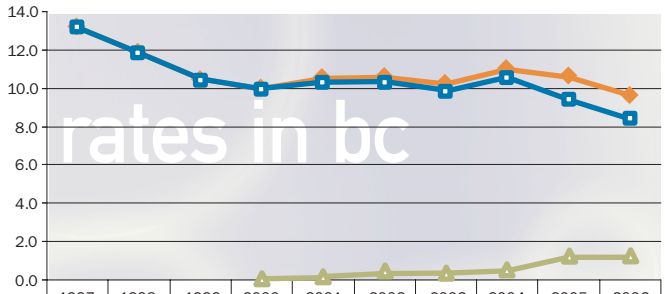
Total* - Rate includes ALL males (i.e., aged <1 year to 60+ years)

HIV

The newly positive HIV rate decreased in 2006 to 8.4 from 9.4 per 100,000 population in 2005, although this decrease is not statistically significant. While the majority of new positive HIV tests are among men, the number of new positive HIV infections decreased slightly for both men and women in 2006. Cases continue to be distributed around the province. The highest rate of new positive HIV infections is in the Vancouver HSDA (30.6 per 100,000), followed by the Northern Interior HSDA (12.3 per 100,000) and the South Vancouver Island HSDA (10.8 per 100,000). In 2006, the greatest number of new positive infections were reported among men who have sex with men. Aboriginals continue to be over-represented in new HIV reports, especially Aboriginal females who accounted for 33.8 per cent of new positive HIV reports on females in 2006.

5.1 Reported positive HIV Rates in BC • 1997 to 2006

Rate per 100,000 population

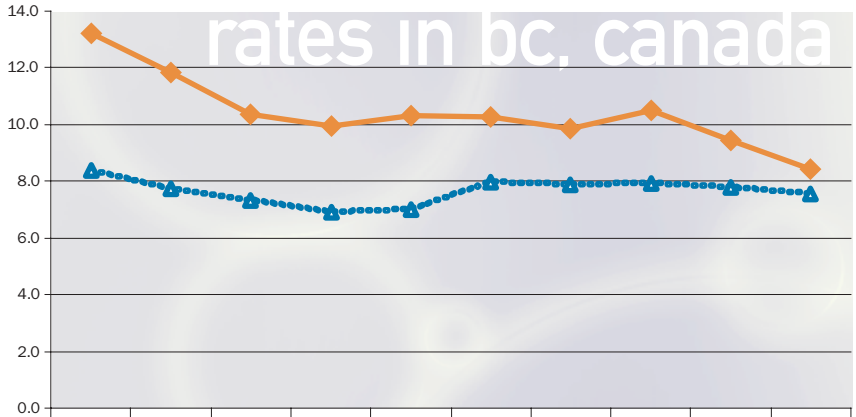


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Reports – New (+) in BC	521	471	416	401	421	422	409	442	401	363
Reports – 1st (+) in BC, Previous (+) outside BC	n/a	n/a	n/a	1	6	16	13	21	50	51
Reports – Total (+) in BC	521	471	416	402	427	438	422	463	451	414
Rates – New (+) in BC	13.2	11.8	10.4	9.9	10.3	10.3	9.8	10.5	9.4	8.4
Rates – 1st (+) in BC, Previous (+) outside BC	n/a	n/a	n/a	0.0	0.1	0.4	0.3	0.5	1.2	1.2
Rates – Total (+) in BC	13.2	11.8	10.4	10.0	10.5	10.6	10.2	11.0	10.6	9.6

Note: Caution is advised in interpreting historic trends of New Positive Rates of HIV (refer to Page 22 for explanation).

5.2 People testing newly positive for HIV in BC • 1997 to 2006

Rate per 100,000 population

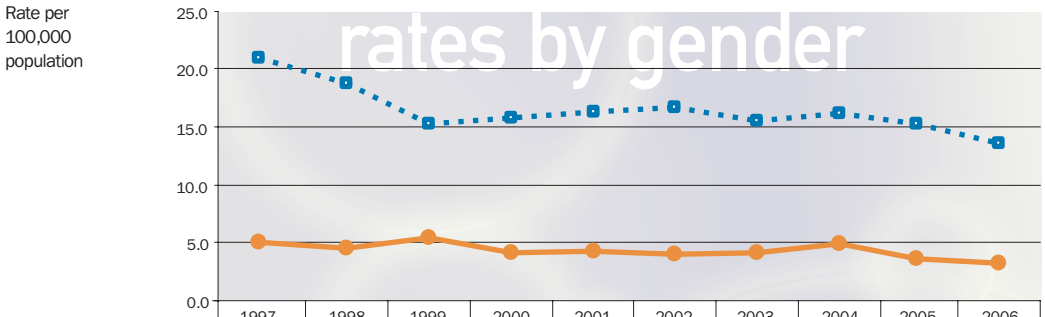


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
BC Reports	521	471	416	401	421	422	409	442	401	363
BC Rate	13.2	11.8	10.4	9.9	10.3	10.3	9.8	10.5	9.4	8.4
Canadian Rate	8.4	7.7	7.3	6.9	7.0	8.0	7.9	7.9	7.8	7.5

Note: Caution is advised in interpreting historic trends of New Positive Rates of HIV (refer to Page 22 for explanation).

*2006 Canadian rate is projected (Public Health Agency of Canada, 2007).

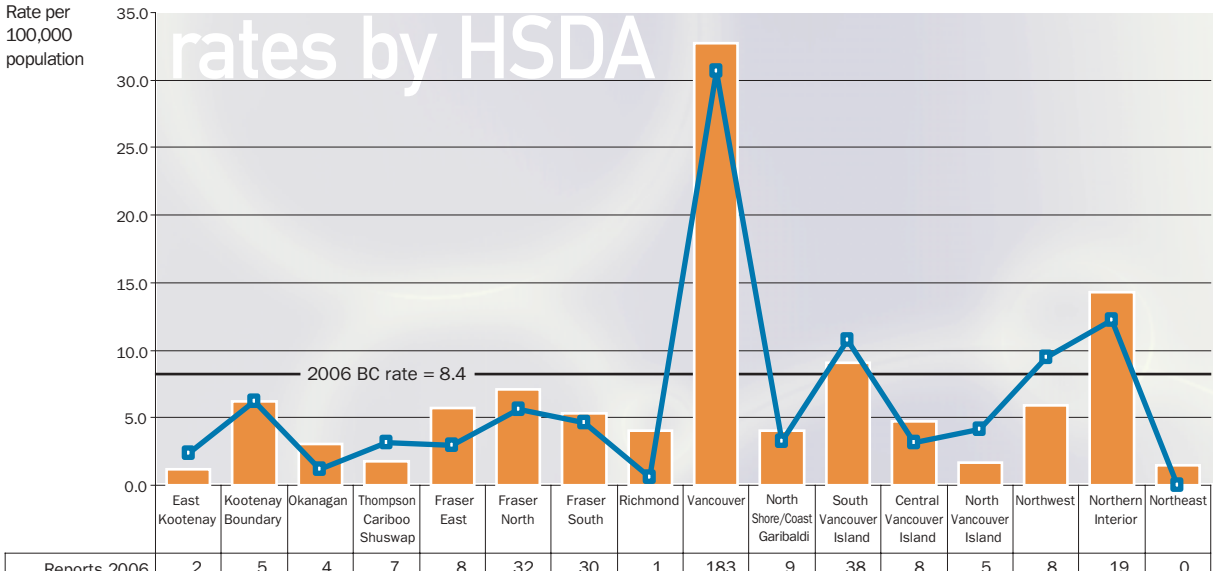
5.3 People testing newly positive for HIV in BC by gender • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Reports – Male	411	372	305	317	329	340	320	337	323	290
Reports – Female	100	90	110	83	87	82	88	105	77	71
Rate – Male	20.9	18.8	15.3	15.8	16.3	16.7	15.5	16.2	15.3	13.6
Rate – Female	5.0	4.5	5.5	4.1	4.2	4.0	4.2	5.0	3.6	3.3

Note: Caution is advised in interpreting historic trends of New Positive Rates of HIV (refer to Page 22 for explanation).

5.4 People testing newly positive for HIV in BC by health service delivery area • 2005 to 2006



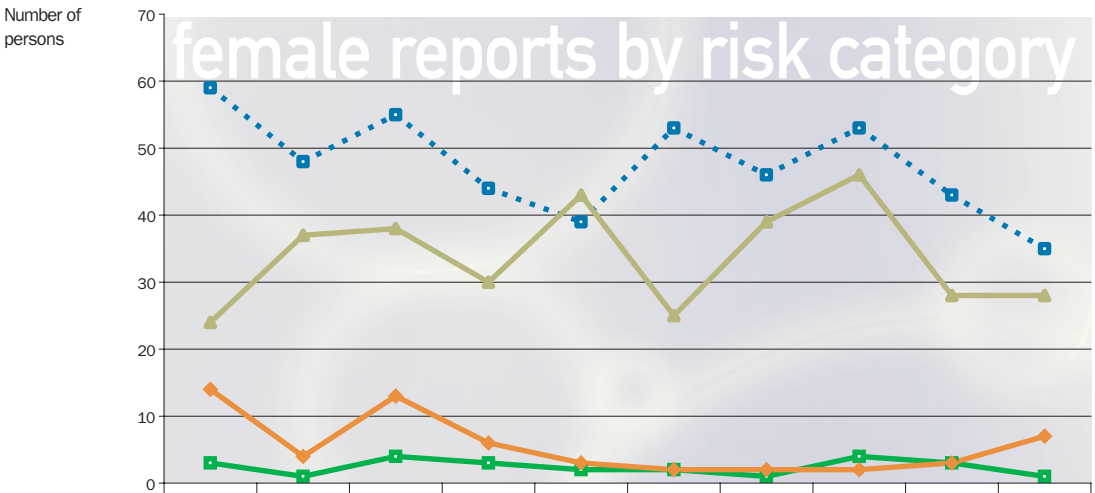
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2006	2	5	4	7	8	32	30	1	183	9	38	8	5	8	19	0
Rate 2005	1.2	6.2	3.0	1.8	5.7	7.1	5.3	4.0	32.7	4.0	9.1	4.7	1.7	5.9	14.3	1.4
Rate 2006	2.4	6.2	1.2	3.1	3.0	5.6	4.6	0.6	30.6	3.3	10.8	3.1	4.1	9.5	12.3	0.0

5.5 People testing newly positive for HIV in BC by risk category • 1997 to 2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
MSM	154	126	105	141	145	156	159	186	180	147
IDU	215	176	143	134	130	155	131	138	116	95
HET	74	95	111	70	101	92	108	101	87	68
Other	7	7	6	15	10	9	5	8	6	10
NIR/Unknown	71	67	51	41	35	10	6	9	12	43

*2006 risk values are not yet final – the number of persons in each risk category may increase as the number of unknowns decreases.
MSM = Men having Sex with Men, IDU = Injection Drug Use, HET = HETerosexual contact, NIR = No Identified Risk

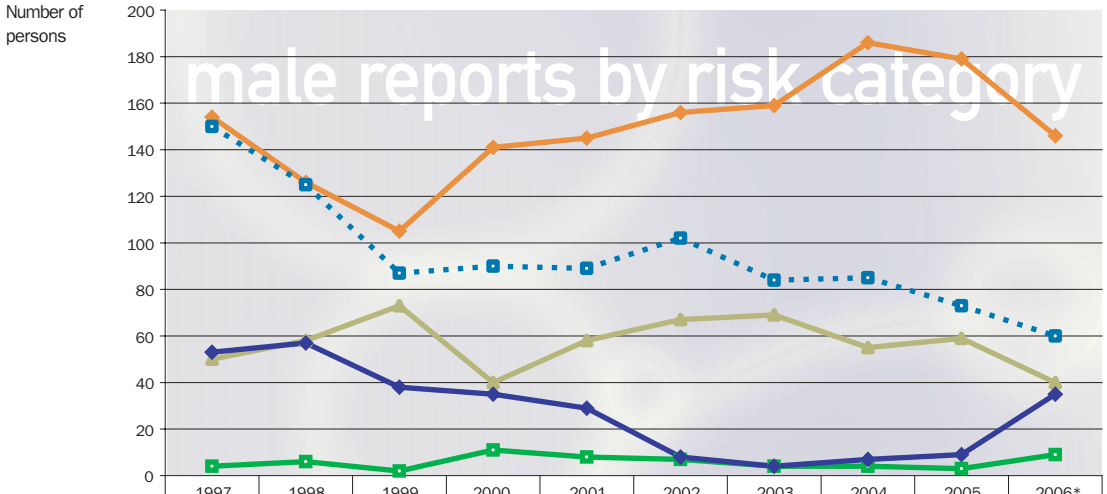
5.6 Females testing newly positive for HIV in BC by risk category • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
IDU	59	48	55	44	39	53	46	53	43	35
HET	24	37	38	30	43	25	39	46	28	28
Other	3	1	4	3	2	2	1	4	3	1
NIR/Unknown	14	4	13	6	3	2	2	2	3	7

*2006 risk values are not yet final – the number of persons in each risk category may increase as the number of unknowns decreases.
IDU = Injection Drug Use, HET = HETerosexual contact, NIR = No Identified Risk

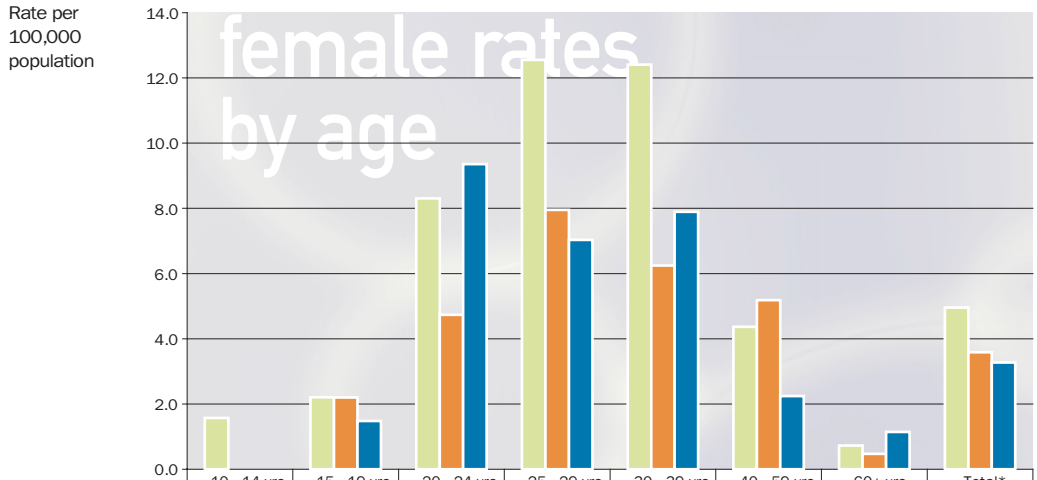
5.7 Males testing newly positive for HIV in BC by risk category • 1997 to 2006



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006*
MSM	154	126	105	141	145	156	159	186	179	146
IDU	150	125	87	90	89	102	84	85	73	60
HET	50	58	73	40	58	67	69	55	59	40
Other	4	6	2	11	8	7	4	4	3	9
NIR/Unknown	53	57	38	35	29	8	4	7	9	35

*2006 risk values are not yet final – the number of persons in each risk category may increase as the number of unknowns decreases.
MSM = Men having Sex with Men, IDU = Injection Drug Use, HET = HETerosexual contact, NIR = No Identified Risk

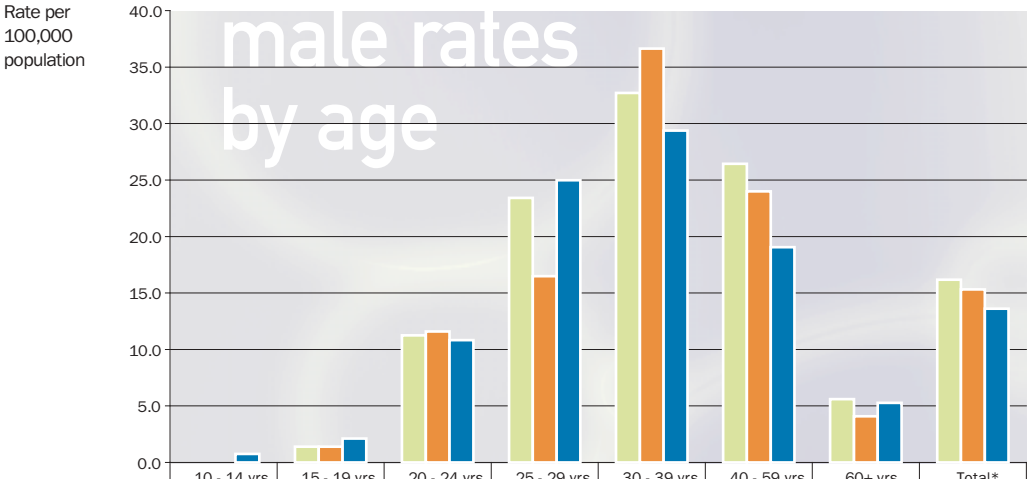
5.8 Female HIV rates in BC by age • 2004 / 2005 / 2006



	10 - 14 yrs	15 - 19 yrs	20 - 24 yrs	25 - 29 yrs	30 - 39 yrs	40 - 59 yrs	60+ yrs	Total*
2004 Rate – Female	1.6	2.2	8.3	12.6	12.4	4.4	0.7	5.0
2005 Rate – Female	-	2.2	4.7	8.0	6.2	5.2	0.5	3.6
2006 Rate – Female	-	1.5	9.4	7.0	7.9	2.2	1.1	3.3

Total* - Rate includes ALL females (i.e. aged <1 to 60+ years and females with age not specified)

5.9 Male HIV rates in BC by age • 2004 / 2005 / 2006



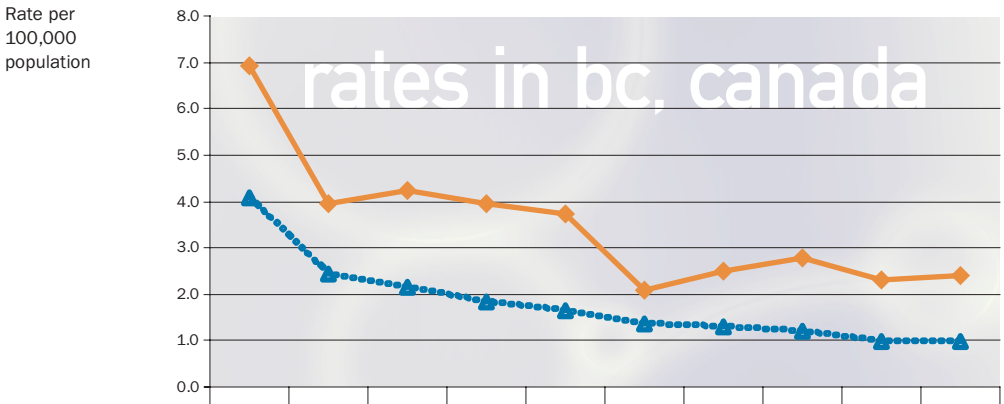
	10 - 14 yrs	15 - 19 yrs	20 - 24 yrs	25 - 29 yrs	30 - 39 yrs	40 - 59 yrs	60+ yrs	Total*
2004 Rate – Male	-	1.4	11.3	23.4	32.7	26.4	5.6	16.2
2005 Rate – Male	-	1.4	11.6	16.5	36.6	24.0	4.1	15.3
2006 Rate – Male	0.8	2.1	10.8	25.0	29.4	19.1	5.3	13.6

Total* - Rate includes ALL males (i.e. aged <1 to 60+ years and males with age not specified)

AIDS

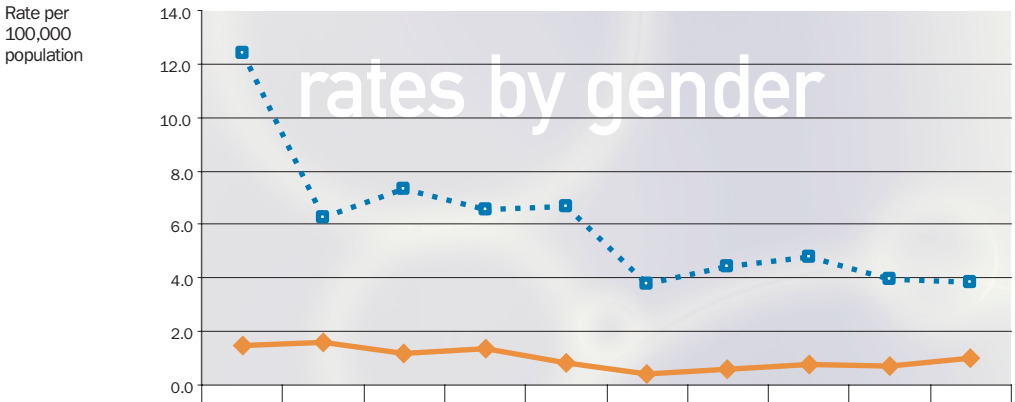
Due to the delays associated with AIDS reporting, this 2006 report includes data on AIDS through 2005 only. In 2005, the AIDS rate in BC remained stable at 2.4 per 100,000 (102 cases), compared to 2.3 per 100,000 (97 cases) in 2004. The majority of AIDS cases occurred in males, with the greatest concentration in males aged 30-59. The highest rate was recorded in the Vancouver HSDA (8.1 per 100,000).

6.1 AIDS case reports and rates in BC • 1996 to 2005



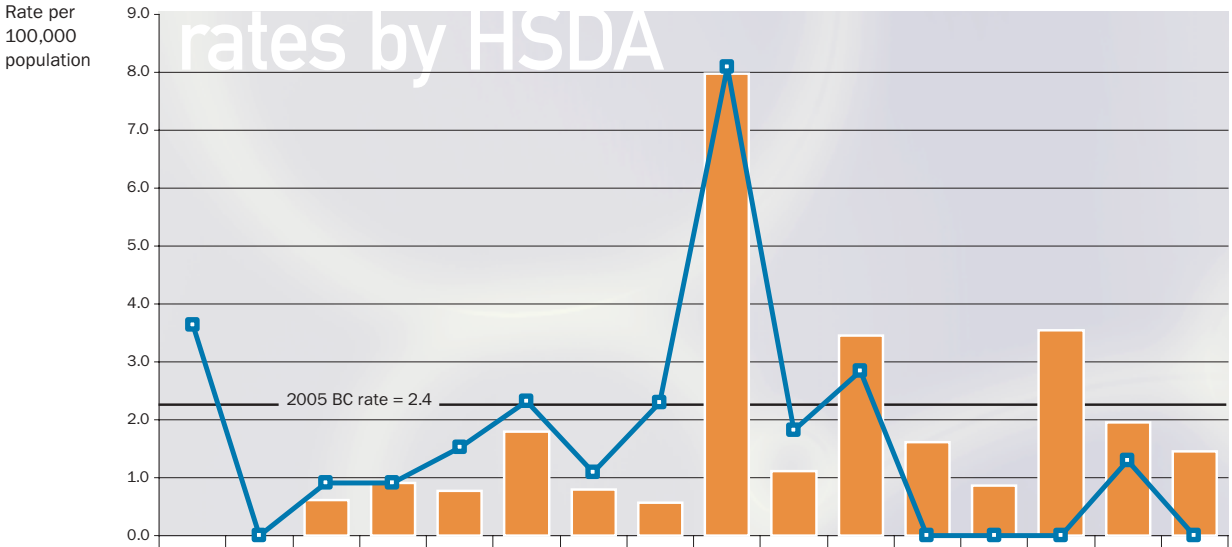
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
BC Reports	268	156	169	159	151	85	103	115	97	102
BC Rate	6.9	4.0	4.2	4.0	3.7	2.1	2.5	2.8	2.3	2.4
Canadian Rate	4.1	2.4	2.1	1.8	1.6	1.4	1.3	1.2	1.0	1.0

6.2 AIDS case reports and rates in BC by gender • 1996 to 2005



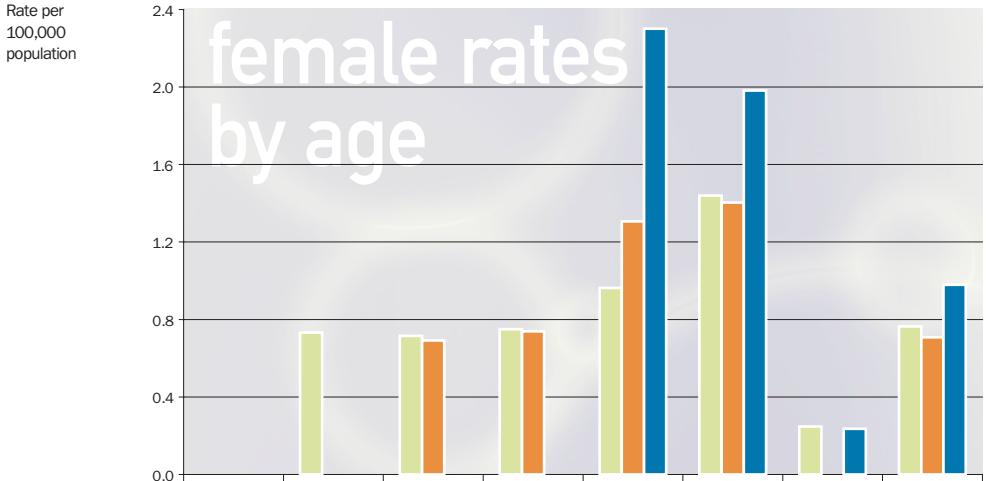
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Reports – Male	239	123	145	131	134	76	91	99	82	81
Reports – Female	29	32	24	27	17	9	12	16	15	21
Rate – Male	12.4	6.3	7.3	6.6	6.7	3.8	4.5	4.8	3.9	3.8
Rate – Female	1.5	1.6	1.2	1.3	0.8	0.4	0.6	0.8	0.7	1.0

6.3 AIDS case reports and rates in BC by health service delivery area • 2004 to 2005



	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2005	3	0	3	2	4	13	7	4	48	5	10	0	0	0	2	0
Rate 2004	0.0	0.0	0.6	0.9	0.8	1.8	0.8	0.6	8.0	1.1	3.5	1.6	0.9	3.5	1.9	1.5
Rate 2005	3.6	0.0	0.9	0.9	1.5	2.3	1.1	2.3	8.1	1.8	2.8	0.0	0.0	0.0	1.3	0.0

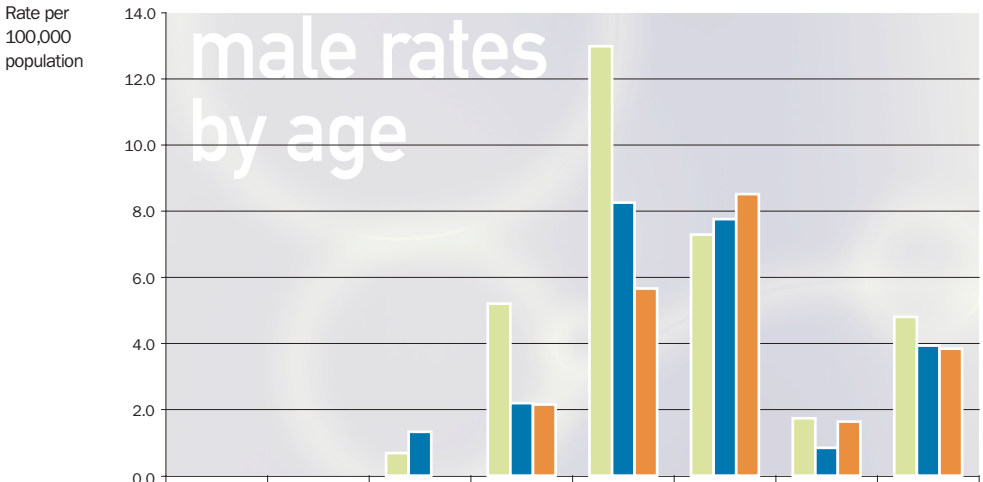
6.4 Female AIDS rates in BC by age • 2003 / 2004 / 2005



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate – Female	-	0.7	0.7	0.7	1.0	1.4	0.2	0.8
2004 Rate – Female	-	-	0.7	0.7	1.3	1.4	-	0.7
2005 Rate – Female	-	-	-	-	2.3	2.0	0.2	1.0

Total* - Rate includes ALL females (i.e., aged <1 to 60+ years and females with age not specified)

6.5 Male AIDS rates in BC by age • 2003 / 2004 / 2005



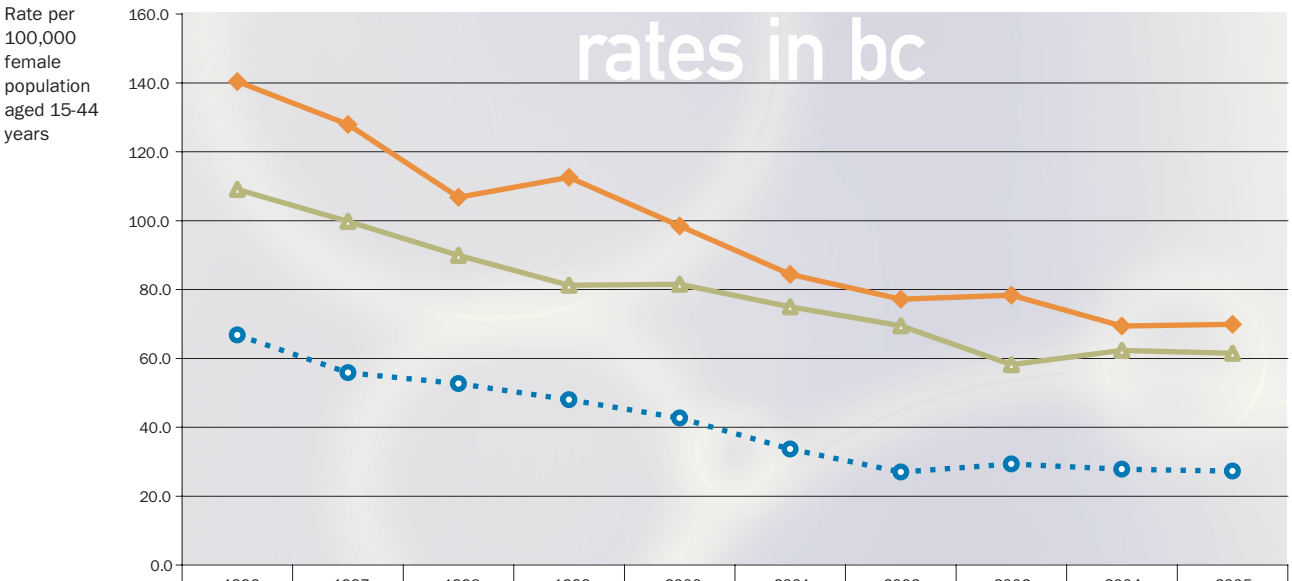
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate – Male	-	-	0.7	5.2	13.0	7.3	1.7	4.8
2004 Rate – Male	-	-	1.3	2.2	8.3	7.8	0.8	3.9
2005 Rate – Male	-	-	-	2.2	5.7	8.5	1.6	3.8

Total* - Rate includes ALL males (i.e., aged <1 to 60+ years and males with age not specified)

Pelvic Inflammatory Disease, Ectopic Pregnancy and Tubal Infertility

The rates for Pelvic Inflammatory Disease (PID) (69.9 per 100,000), ectopic pregnancy (61.5 per 100,000), and tubal infertility (27.3 per 100,000) were similar to rates reported in 2004. Because of delays in reporting and data transfer, PID, ectopic pregnancy and tubal infertility rates are reported through 2005 only.

7.1 Pelvic inflammatory disease, ectopic pregnancy and tubal infertility case reports and rates in BC • 1996 to 2005



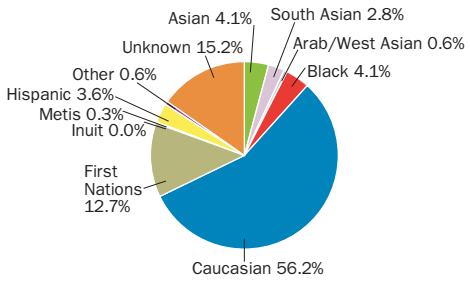
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
PID Cases	1,249	1,154	963	1,014	885	760	695	705	626	633
Ectopic Cases	970	900	811	732	733	675	626	523	562	557
Tubal Cases	594	504	475	432	384	303	243	264	251	247
PID Rate	140.4	127.9	106.8	112.6	98.5	84.4	77.1	78.4	69.4	69.9
Ectopic Rate	109.0	99.7	89.9	81.3	81.5	75.0	69.5	58.1	62.3	61.5
Tubal Rate	66.8	55.9	52.7	48.0	42.7	33.6	27.0	29.3	27.8	27.3

ethnicity

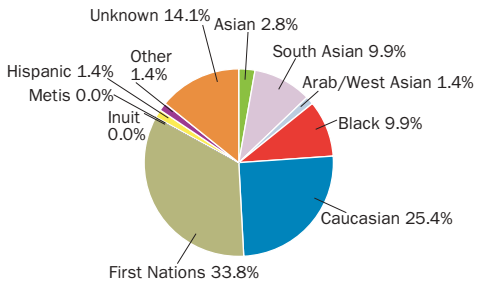
HIV and infectious syphilis continue to disproportionately affect First Nations, especially women.

8.1 Persons testing newly positive for HIV in BC by ethnicity • 2006

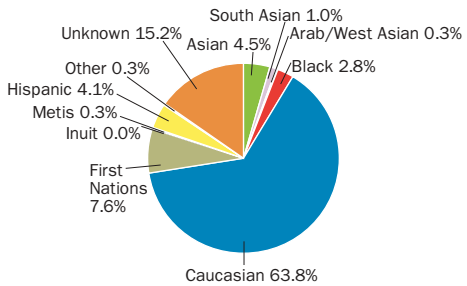
Total



Female

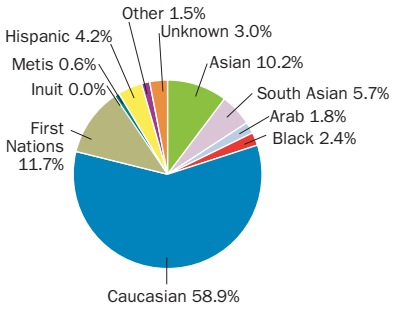


Male

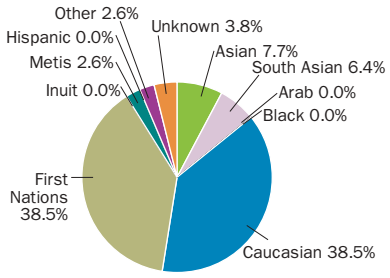


8.2 Infectious syphilis case reports in BC by ethnicity • 2006

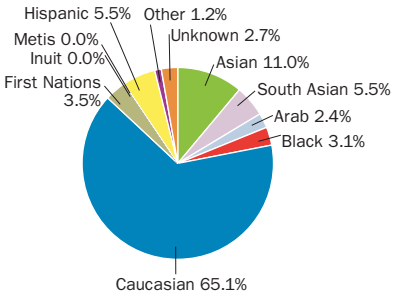
Total

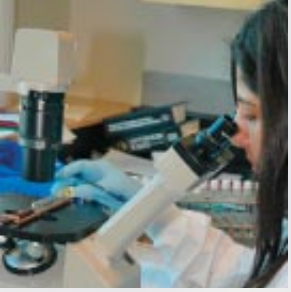


Female



Male





sources

Data for HIV and AIDS are collected through the HIV/AIDS Surveillance System. Data for other STIs are collected through the STI Surveillance System.

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2006