

Harm Reduction Product Distribution in British Columbia

Stephanie S. Harvard, MSc¹

Warren D. Hill, PhD²

Jane A. Buxton, MBBS, MHSc, FRCPC^{2,3}

ABSTRACT

Objectives: The British Columbia Centre for Disease Control (BCCDC) tracks the distribution of all harm reduction products subsidized by the BC government, including needles and syringes, sterile water vials, alcohol swabs, condoms, and lubricant. This study measures the distribution of harm reduction products in BC, identifies regional variation in distribution, and estimates the supply/demand ratio for needle and syringe units.

Methods: Using three years of administrative data (2004-2006) from the BCCDC, the quantity of harm reduction products distributed was calculated by Health Service Delivery Area (HSDA). Regional hepatitis C virus (HCV) case report rates were calculated to reflect potential variation in IDU populations at the HSDA-level and the number of needle and syringe units distributed per reported case of HCV was calculated and ranked by HSDA. To compare the demand for sterile injecting equipment to the distribution, the number of illicit drug injections per year was approximated using established estimates of IDU populations in BC and Vancouver.

Results: Marked regional variation exists in the rates of harm reduction product distribution per 100,000 residents aged 15-64. The average number of needle and syringe units distributed annually in BC from 2004-2006 was 5,382,933. The estimated number of injections per year in BC is 24,951,144, suggesting the province distributed 21.5% of the units required to cover all illicit drug injections in the province.

Discussion: Harm reduction product distribution is not equitable between BC HSDAs. The current level of distribution of sterile injecting equipment is inadequate to provide a clean needle for every injection.

Key words: Harm reduction; needle-exchange programs; British Columbia; substance abuse; intravenous

La traduction du résumé se trouve à la fin de l'article.

1. Formerly at BC Centre for Disease Control, Vancouver, BC; now at Collaboration for Outcomes Research and Evaluation, Faculty of Pharmaceutical Sciences, University of British Columbia, Vancouver, BC

2. BC Centre for Disease Control, Vancouver

3. School of Population and Public Health, University of British Columbia, Vancouver, BC

Correspondence and reprint requests: Jane Buxton, BC Centre for Disease Control, 655 West 12th Avenue, Vancouver, BC V5Z 4R4, Tel: 604-660-8747, Fax: 604-660-2094, E-mail: jane.buxton@bccdc.ca

Acknowledgements of support: At the time of the study, Stephanie Harvard was supported by the Canadian Institutes of Health Research and the Western Regional Training Centre for Health Services

In November 2004, to reduce the incidence of drug-related harms, the British Columbia (BC) Ministry of Health implemented a renewed harm reduction framework. This framework is communicated in provincial government publications and reflected in policies within health services agencies, including the BC Centre for Disease Control (BCCDC).¹ Since 2004, the BCCDC has organized and tracked the distribution of all products subsidized by the provincial government to reduce drug-related harms (harm reduction products). A provincial harm reduction committee, with representation from the Health Authorities, the Ministry of Health, and the BCCDC, is responsible for implementing the BC Harm Reduction Supply Services (BCHRSS) policy:

*Each Health Authority and its community partners will work together to provide a full range of harm reduction services within their respective jurisdictions. Core components include, but are not limited to: referrals, advocacy, education, and supplies distribution. These services are aimed at reducing harms from injection and other drug use.*²

This study examined the “supplies distribution” component of the BC harm reduction policy, with the primary objective of identifying regional variation in the quantity of harm reduction products distributed between 2004 and 2006. In this period, BCCDC was mandated to distribute needles and syringes, sterile water vials, alcohol swabs, male and female condoms, and lubricant. The distribution of this spectrum of harm reduction products is consistent with the World Health Organization’s stated objective to ensure access to the “essential prevention package”³ shown to be effective in preventing human immunodeficiency virus (HIV) and hepatitis C virus (HCV) among injecting drug users (IDUs).^{4,5} This study measures the distribution of these WHO-recommended products as a means of evaluating current IDU-targeted HIV and HCV prevention in BC.

As a secondary objective, we aimed to approximate the supply and demand ratio for needle and syringe units using estimates of IDU populations. However, because estimates of IDU populations are subject to error, and not available for Health Service Delivery Areas (HSDAs),

TABLE I

Harm Reduction Products Distributed (2004-2006) and Hepatitis C Virus Case Reports (1992-2006) by Health Service Delivery Area (HSDA)

HSDA	Safer Sex Products		Sterile Equipment		Needles & Syringes		Hepatitis C Virus		Rate ratio‡
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate†	
Vancouver	1,441,134	329,267	3,138,605	717,100	2,913,833	665,745	13,752	220.5	3020
South Vancouver Island	403,811	167,467	1,042,437	432,316	884,667	366,886	5249	156.2	2349
Kootenay Boundary	305,731	558,502	109,533	200,093	133,367	243,631	906	113.2	2153
Thompson Cariboo Shuswap	492,021	319,363	246,033	159,696	252,200	163,699	2816	128.7	1272
Northwest	420,024	707,195	94,112	158,457	74,067	124,706	991	111.5	1118
Northern Interior	661,378	602,145	229,180	208,655	139,867	127,340	1975	124.2	1026
Central Vancouver Island	355,261	212,212	167,133	99,836	249,033	148,758	3711	159.4	933
North Vancouver Island	136,979	166,600	109,807	133,552	121,167	147,368	2089	177.5	830
Okanagan	218,207	100,764	203,667	94,049	174,433	80,550	3838	131.8	611
North Shore/Coast Garibaldi	157,641	81,507	66,667	34,470	98,300	50,825	2561	94.5	538
East Kootenay	16,038	27,736	12,300	21,271	19,700	34,068	650	81.1	420
Fraser South	147,429	33,038	222,067	49,764	187,400	41,995	6509	111.7	376
Northeast	9061	18,653	6333	13,037	10,200	20,997	644	97.5	215
Fraser East	183,159	103,911	107,800	61,158	76,433	43,363	5140	219.7	197
Richmond	51,392	40,450	5333	4198	9533	7504	1070	61.4	122
Fraser North	734,012	182,804	24,950	6214	38,733	9646	7249	132.3	73
Median	261969	167034	109670	96942	127267	102628	2689	126.4	720.8
Q1	144817	71243	56238	31170	65233	40013	1050	108.0	336
Q3	438024	321839	223845	169795	202808	152493	5167	157.0	1157

* Average annualized rate per 100,000 population aged 15-64 (2004-2006)

† Average annualized rate per 100,000 population aged 15-64 (1992-2006)

‡ Rate ratio calculated as annualized needles and syringe distribution rate/ annualized hepatitis C virus rate

we also compared product distribution rates to HCV case report rates among BC HSDAs. Regional HCV case report rates may provide an indirect measure of IDU prevalence and therefore reflect potential demand for sterile injecting equipment. Regions with higher HCV case report rates are likely to have higher numbers of IDUs, as more than 70% of prevalent infections in Canada are attributable to IDU⁶ and the prevalence of HCV among IDUs in BC is between 82 and 88%.⁷⁻⁹ Although the potential for HCV transmission through non-injection drug use (e.g., through the sharing of crack pipes) has been recognized, the relative contribution of this risk factor to HCV prevalence is unknown.^{10,11}

METHODS

Product distribution was tracked using the BCCDC pharmacy database, which contains all orders for harm reduction products, including quantity requested, units of distribution (e.g., 12 per box, etc.), and order destination (i.e., health unit or community agency). Order dates were available for each product invoice. Product data were analyzed for the 2004-2006 fiscal years. To facilitate analysis and limit the number of products to compare, all product orders within this timeframe were reviewed and assigned into three groups: 1) needle and syringe units, 2) other sterile equipment (i.e., alcohol swabs and sterile water vials), and 3) safer sex products (i.e.,

condoms and lubricant). All product order destinations were assigned to the appropriate HSDA. Product totals were calculated for the three product groups. In order to include in the unit totals the small quantity of needles and syringes (approximately 15%) that are distributed as separately packaged units, needles were counted as one unit, while syringes were not counted. Needles with syringe attached were counted as one needle and syringe unit. The product total for other sterile equipment was calculated as the total number of alcohol swabs and sterile water vials combined, while the product total for safer sex products was calculated as the total number of condoms and single-use packets of lubricant combined. P.E.O.P.L.E. 30 (Population Extrapolation for Organization Planning with Less Error, run cycle 30, May 2006) was used to estimate the number of individuals aged 15-64 for each HSDA. Population-based distribution rates (number of products distributed per 100,000 residents aged 15-64) were calculated for the three product groups. Annualized HCV case report rates for each HSDA were calculated from newly identified HCV cases aged 15-64 reported to iPHIS (Integrated Public Health Information System) from 1992-2006. Rates were calculated by dividing the number of HCV cases reported in each year by the population aged 15-64 the same year, summing the case report rates produced for each year from 1992-2006,

and dividing by the number of years of observation (15). The annualized HCV case report rates produced by this method represent the number of cumulative reported HCV cases from 1992-2006 and do not reflect true HCV incidence or population-based prevalence. Descriptive statistics included medians and interquartile ranges for harm reduction products distributed and for HCV case report rates.

To determine whether needle and syringe distribution rates were proportional to HCV case report rates, each HSDA's average annualized needle and syringe distribution rate was divided by its annualized HCV case report rate to produce a rate ratio approximating the number of needle and syringe units distributed per reported case of HCV. To estimate the demand for sterile injecting equipment, approximate numbers of illicit drug injections per year in BC and Vancouver were calculated following a published method.¹² The mean number of injections per day for 1) cocaine, 2) opiates, and 3) other drugs were multiplied by the proportion of IDUs using each drug and then multiplied by the estimated number of IDUs in 1) BC, 2) Vancouver. The estimated daily number of injections was converted into a yearly total and divided by the average number of needle and syringe units distributed per year for the study period. Estimated numbers of injections per day per drug category were obtained from a Montreal cohort of IDUs.¹² The proportion of IDUs in BC

who use each drug was estimated using data reported from Insite, a supervised injection site operated by Vancouver Coastal Health that records the substances injected by each visitor.¹³ The estimated numbers of IDUs in BC and in Vancouver's Downtown Eastside were taken from the 2004 Canadian Addiction Survey and from reports by Vancouver Coastal Health.^{14,15}

RESULTS

Table I illustrates harm reduction products distributed and HCV case report rates by HSDA, rank ordered by the ratios of annualized needle and syringe distribution rates to annualized HCV case report rates. HCV case report rates are highest in urban areas and HSDAs with correctional facilities and/or high proportions of Aboriginal populations.

Based on the totals from the BCCDC pharmacy database, the average number of needle and syringe units distributed annually from 2004-2006 was 5,382,933. The estimated number of injections per year in BC is 24,951,144 (Table III). The provincial supply distribution therefore meets 21.5% of the total number of needle and syringe units required to cover all illicit drug injections in BC. Within Vancouver, an average annual total of 2,913,833 needle and syringe units were distributed. As an estimated 8,000 IDUs reside in Vancouver (Table IV), this indicates that needle and syringe distribution met 34% of the demand in the region.

DISCUSSION

This study illustrates some limitations of harm reduction product distribution in BC. First, marked regional variation exists in the rates of product distribution per 100,000 residents aged 15-64, suggesting that harm reduction services are not equitable across the province. Lower rates of distribution in some BC regions raise the question whether these regions have a lower prevalence of IDU and therefore less need for sterile injecting equipment. For the purpose of this question, regional HCV case report rates may be illustrative of IDU prevalence and the study demonstrates that even in HSDAs with the highest rates of HCV case reports, the rates of

TABLE II

Demographics of British Columbia's Health Service Delivery Areas

Health Service Delivery Area	Population*	Area (km ²)	Density†	Aboriginal‡ (%)
Vancouver	618,469	132	4684.5	2
South Vancouver Island	361,744	2358	153.4	2.8
Kootenay Boundary	77,731	29,022	2.7	3.1
Thompson Cariboo Shuswap	218,887	119,069	1.8	10
Northwest	77,360	261,580	0.3	25.1
Northern Interior	144,335	170,890	0.8	11.2
Central Vancouver Island	258,376	12,370	20.9	7.3
North Vancouver Island	118,665	40,322	2.9	7.1
Okanagan	334,344	21,320	15.7	3.5
North Shore/Coast Garibaldi	273,868	54,229	5.1	4.2
East Kootenay	78,415	45,294	1.7	5.1
Fraser South	659,306	845	780.7	2.1
Northeast	67,349	184,814	0.4	13.3
Fraser East	268,467	12,595	21.3	4.9
Richmond	182,806	129	1419.8	0.7
Fraser North	570,330	2296	248.4	1.9
Total BC	4,310,452	924,815	4.7	4.4

* Based on 2006 Census

† Number of persons per km²

‡ Proportion of population reporting Aboriginal identity (BC Stats)

TABLE III

Estimated Number of Injections per Year in BC

Drug	Estimated Proportion IDU Using Drug*	Estimated Number IDU Using Drug†	Mean (Median) Injections/day‡	Estimated Number Injections/year
Cocaine	.41	9559	3.1 (1.1)	10,816,008
Opiates	.54	12,590	2.9 (2.5)	13,326,515
Other	.05	1166	1.9 (0.4)	808,621
Total	1.00	23,315	3.0 (1.4)	24,951,144

* Canadian Community Epidemiology Network on Drug Use

† Based on 1% of BC population 15-64 (Canadian Centre on Substance Abuse: Canadian Addiction Survey)

‡ Remis et al., *J Acquir Immun Def*, 1998¹²

TABLE IV

Estimated Number of Injections per Year in Vancouver

Drug	Estimated Proportion IDU Using Drug*	Estimated Number IDU Using Drug†	Mean (Median) Injections/day‡	Estimated Number Injections/year
Cocaine	.41	3280	3.1 (1.1)	3,711,320
Opiates	.54	4320	2.9 (2.5)	4,572,720
Other	.05	400	1.9 (0.4)	277,400
Total	1.00	8000	3.0 (1.4)	8,561,440

* Canadian Community Epidemiology Network on Drug Use

† Vancouver Coastal Health

‡ Remis et al., *J Acquir Immun Def*, 1998¹²

distribution of sterile injecting equipment are variable. In some BC regions, rates of needle and syringe and other sterile product distribution are in the second-lowest quartile, while HCV case report rates are in the highest quartile.

In BC, harm reduction products supplied by the BCCDC are subsidized by the Ministry of Health, with budgetary deficits covered by the BCCDC through the Provincial Health Services Authority. However, operating capital is derived from individual Health Authority (HA) and distribution site budgets, which may influence product distribution. Product distribution may also be affected by policy decisions made at individual sites or within

HSDAs. Individual distribution sites are free to order the range of available products in any quantity and there is no standardized suite of products that must be distributed. Furthermore, no system exists to record and evaluate the distribution practices at individual sites. In this study, the distribution of all three constructed categories of harm reduction products was found to vary by HSDA. For example, certain regions with high distribution rates for safer sex products have low distribution rates for needles and syringes and other sterile equipment, though the infrastructure for the distribution of these materials clearly exists. In other regions, the rates of distribution of needle and syringe units are

not proportionate to the rates of distribution of other sterile equipment (i.e., alcohol swabs and sterile water).

This study aimed to approximate the number of illicit drug injections per year as a measure of the demand for sterile injecting equipment. However, the estimates here of the number of injections per year in BC and Vancouver are subject to limitations. First, the estimated numbers of IDUs in BC and Vancouver used here may be low; one source cites an estimate of Vancouver IDUs that is 50% higher than that employed here.¹⁶ Second, the estimates here incorporate mean numbers of daily injections for each drug category from a study of Montreal IDUs; comparable data for BC have not been published and IDUs in BC may differ in this regard. Although a federal surveillance project that tracks injection drug use in select cities across Canada has provided new data on drug use in Victoria, BC, the published results are aggregated and cannot be used to determine the proportion of IDUs using specific drugs or the frequency of injection within each of these groups.¹⁷ Third, data on the proportions of IDUs injecting cocaine, opiates, and other drugs were obtained from Insite and it is unknown how well these data represent the pattern of use among all IDUs in BC. Notably, a recent report from Montreal indicates that 70% of local IDUs inject cocaine as their primary drug;¹⁸ if the proportion of IDUs in BC injecting cocaine were to be similarly high, then the number of daily injections estimated here would be low.

Despite its limitations, the estimate here of the number of injections per year in BC suggests that the province is meeting less than a quarter of the demand for sterile needles and syringes. While it is unknown what quantity of needles and syringes is provided to IDUs in BC by means other than the provincial program, this finding is consistent with recent descriptions of sub-optimal levels of distribution in other regions. For example, in 2001-2002, among 25 countries in Central and Eastern Europe and Central Asia, Aceijas and colleagues estimated that 19 countries met less than 5% of demand for sterile injecting equipment, 5 countries met between 5 and 15%, and 1 met less than 20%.¹⁹ In 2000-2001, only 20% of injections were reportedly covered by syringe exchange

programs in London, while 25% were covered in both Brighton and Liverpool.²⁰ In Australia, 30,841,294 needle and syringe units were distributed in 2004 for approximately 74,000 regular injecting drug users – providing each just over one needle and syringe per day.²¹ These findings, and ours, suggest that the current level of coverage provided by needle and syringe distribution programs is inadequate to provide a clean needle for every injection.

REFERENCES

1. BC Ministry of Health. Harm reduction: A British Columbia Community Guide. Vancouver, BC: BC Ministry of Health, 2004. Available online at: <http://www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf> (Accessed July 24, 2007).
2. BC Centre for Disease Control. BC Harm Reduction Supply Services Policy and Guidelines. Vancouver, BC: BC Centre for Disease Control, 2004. Available online at: <http://www.bccdc.org/download.php?item=1040> (Accessed July 24, 2007).
3. World Health Organization. Biregional strategy for harm reduction: HIV and injecting drug use. Geneva, Switzerland: World Health Organization, 2005. Available online at: http://www.wpro.who.int/publications/PUB_92_90611952.htm (Accessed August 8, 2007).
4. World Health Organization. Evidence for Action: Effectiveness of Sterile Needle and Syringe Programming. Geneva: World Health Organization, 2004. Available online at: http://www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf (Accessed August 8, 2007).
5. Van Den Berg C, Smit C, Van Brussel G, Coutinho R, Prins M. Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: Evidence from the Amsterdam Cohort Studies among drug users. *Addiction* 2007;102:1454-62.
6. Zou S, Forrester L, Giulivi A. Hepatitis C update. *Can J Public Health* 2003;94(2):127-29.
7. BC Centre for Disease Control. Enhanced Hepatitis Strain Surveillance System (EHSSS) Review. Vancouver, BC: BC Centre for Disease Control, 2005.
8. Patrick DM, Tyndall MW, Cornelisse PG, Li K, Sherlock CH, Rekart ML, et al. Incidence of hepatitis C virus infection among injection drug users during an outbreak of HIV infection. *CMAJ* 2001;165(7):889-95.
9. Wood E, Kerr T, Stoltz J, Qui Z, Zhang R, Montaner JS, et al. Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility. *Public Health* 2005;119(12):1111-15.
10. Fischer B, Powis J, Firestone Cruz M, Rudzinski K. Hepatitis C virus transmission among oral crack users: Viral detection on crack paraphernalia. *Eur J Gastroenterology Hepatology* 2008;20:29-32.
11. Tortu S, McMahon J, Pouget E, Hamid R. Sharing of noninjection drug-use implements as a risk factor for hepatitis C. *Subst Use Misuse* 2004;39:211-24.
12. Remis RS, Bruneau J, Hankins CA. Enough sterile syringes to prevent HIV transmission among injection drug users in Montreal? *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18(Suppl 1):S57-S59.
13. Canadian Community Epidemiology Network on Drug Use. Vancouver Drug Use Epidemiology. Vancouver, BC: Canadian Community Epidemiology Network on Drug Use, 2005. Available online at: http://www.city.vancouver.bc.ca/fourpillars/pdf/report_vancouver_2005.pdf (Accessed July 5, 2007).

...continues

RÉSUMÉ

Objectifs : Le BC Centre for Disease Control (BCCDC) suit la distribution des produits de réduction des méfaits subventionnés par le gouvernement de la Colombie-Britannique (aiguilles et seringues, flacons d'eau stérilisée, compresses alcoolisées, condoms, lubrifiants). Nous avons voulu mesurer la distribution de ces produits dans la province, repérer les écarts régionaux dans cette distribution et estimer l'écart entre l'offre et la demande pour les ensembles seringue-aiguille.

Méthode : Nous avons calculé le nombre de produits de réduction des méfaits distribués par zone de prestation de services de santé (Health Service Delivery Area, HSDA) en prenant trois années de données administratives du BCCDC (2004 à 2006). Nous avons aussi calculé les taux de déclaration régionaux des cas d'infection par le virus de l'hépatite C (VHC) pour tenir compte des écarts possibles dans les populations d'utilisateurs de drogue par injection (UDI) dans chaque zone, puis calculé et classé selon la zone le nombre d'ensembles seringue-aiguille distribués par cas déclaré de VHC. Pour comparer la demande d'accessoires d'injection stériles aux quantités distribuées, nous avons calculé le nombre approximatif d'injections de drogues illicites par année à l'aide des estimations établies des populations d'UDI en Colombie-Britannique et à Vancouver.

Résultats : Il existe des écarts régionaux marqués dans les taux de distribution des produits de réduction des méfaits par tranche de 100 000 habitants (15 à 64 ans). Le nombre moyen d'ensembles seringue-aiguille distribués annuellement dans la province entre 2004 et 2006 était de 5 382 933. Le nombre estimatif d'injections par année dans la province était de 24 951 144, ce qui donne à penser que la Colombie-Britannique n'a distribué que 21,5 % des ensembles nécessaires à toutes les injections de drogues illicites sur son territoire.

Discussion : La répartition des produits de réduction des méfaits entre les zones de prestation de services de santé de la Colombie-Britannique est inégale. Les quantités actuelles d'accessoires d'injection stériles que l'on distribue sont insuffisantes pour que chaque injection se fasse avec une aiguille propre.

Mots clés : réduction des méfaits; programmes d'échange de seringues; Colombie-Britannique; toxicomanie; drogue intraveineuse

14. Canadian Centre on Substance Abuse. Canadian Addiction Survey 2004. Ottawa, ON: Canadian Centre on Substance Abuse, 2004.
15. Vancouver Coastal Health. Injection drug use in the DTES. Vancouver, BC: Vancouver Coastal Health, 2003. Available online at: http://www.vch.ca/sis/docs/SIS_Info_Sheet.pdf (Accessed July 5, 2007).
16. Vancouver Coastal Health. Saving Lives: Vancouver's Supervised Injection Site. 2006. Available online at: http://www.vch.ca/sis/docs/insite_brochure.pdf (Accessed January 15, 2008).
17. Public Health Agency of Canada. I-Track: Enhanced surveillance of risk behaviours among injecting drug users in Canada. Ottawa: Public Health Agency of Canada, 2006. Available online at: http://www.phac-aspc.gc.ca/i-track/sr-re-1/pdf/itrack06_e.pdf (Accessed January 15, 2008).
18. Prithwish D, Cox J, Boivin JF, Platt RW, Jolly AM. Rethinking approaches to risk reduction for injection drug users: Differences in drug type affect risk for HIV and hepatitis C virus infection through drug-injecting networks. *J Acquir Immune Defic Syndr* 2007;46(3):355-61.
19. Aceijas C, Hickman M, Donoghoe MC, Burrows D, Stuijke R. Access and coverage of needle and syringe programmes (NSP) in Central and Eastern Europe and Central Asia. *Addiction* 2007;102:1244-50.
20. Hickman M, Higgins V, Hope V, Bellis M, Tilling K, Walker A, Henry J. Injecting drug use in Brighton, Liverpool, and London: Best estimates of prevalence and coverage of public health indicators. *J Epidemiol Community Health* 2004;58:766-71.
21. Razali K, Thein HH, Bell J, Cooper-Stanbury M, Dolan K, Dore G, et al. Modelling the hepatitis C virus epidemic in Australia. *Drug Alcohol Depend* 2007;91(2-3):228-35. Epub 2007 Jul 31.

Received: October 4, 2007

Accepted: April 3, 2008



Public Health in Canada: Strengthening Connections

La santé publique au Canada : Renforcer les liens

Canadian Public Health Association 2009 Annual Conference

**June 7-10, 2009
Winnipeg Convention Centre
Winnipeg, Manitoba**

Canada has made significant contributions to our global understanding of what determines health and human development across the life course. With the release of reports from the Chief Public Health Officer, the WHO Commission on the Social Determinants of Health and the Senate Subcommittee on Population Health, we have been challenged to go beyond the health sector to address the key factors that have an impact on the public's health.

At the foundation of its success, the public health response in Canada has created and strengthened numerous partnerships within the health sector and beyond. The CPHA 2009 Annual Conference will be a forum for sharing our progress on addressing the structural silos that create health inequalities in our society.

For further information, please contact:

CPHA Conference Services
Telephone: 613-725-3769, ext. 126
E-mail: conference@cpha.ca
www.conference.cpha.ca

Conférence annuelle 2009 de l'Association canadienne de santé publique

**Du 7 au 10 juin 2009
Winnipeg Convention Centre
Winnipeg (Manitoba)**

Le Canada a apporté de nombreuses contributions à la connaissance mondiale des facteurs qui déterminent la santé et le développement humain au cours de la vie. La publication des rapports de l'administrateur en chef de la santé publique, de la Commission des déterminants sociaux de la santé de l'OMS et du Sous-comité sénatorial sur la santé des populations nous met au défi de voir plus loin que les soins de santé et d'aborder les grands facteurs qui ont des répercussions sur la santé du public.

Pour relever ce défi, les milieux de la santé publique au Canada ont créé et renforcé de nombreux partenariats à l'intérieur et à l'extérieur du secteur de la santé. La conférence annuelle 2009 de l'ACSP se veut une tribune où l'on partagera les progrès accomplis vers l'abolition des structures hiérarchiques qui produisent des inégalités en santé dans la société canadienne.

**Pour de plus amples renseignements,
veuillez communiquer avec :**

Services des conférences de l'ACSP
Téléphone : 613-725-3769, poste 126
Courriel : conference@cpha.ca
www.conference.cpha.ca